

Community Support for Newcomer Families: A Literature Review

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Abstract

As part of a larger study titled "[Integration Trajectories of Immigrant Families](#)", this literature review looked at who provides support for newcomer settlement and integration, and how they are funded. The reviewed studies assessed why support was important, whether the existing supports were sufficient, and what else could be done. Beyond formal and informal support specific to newcomer integration, housing and health were identified as two areas of critical need and as important points of comparison with non-immigrant Canadians. Common across the paper's three sections on settlement supports, housing, and health were the grey areas pertaining to the service mandates of programs and departments; the coping mechanisms that newcomers and their allies develop to make integration happen; and the barriers to accessing services that include discrimination and differential incorporation. It is recommended that future studies should focus on how different migration pathways affect housing and healthcare needs. They should ask how communities can tailor support to the diverse needs of families, consider how informal community support is leveraged by the government, and examine the ways in which established immigrants facilitate the orientation and integration of more recent newcomer families.

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Introduction

The literature on Canadian immigrant integration is vast and varied, covering topics from employment to education, official language acquisition to entrepreneurship, sense of belonging to political participation, and housing to health. Immigrant families have been investigated for their abilities to integrate based on cultural, linguistic, socioeconomic, and generational differences. However, there is still room to advance this knowledge further by looking at how immigrant families cope with these various challenges throughout their integration pathways, over an extended period of time. Moreover, in a climate of rapid changes to settlement service funding, an investigation into how families are impacted by their ability to access services they need would be both timely and informative. Despite the continuing and significant cuts to settlement funding by the federal government, integration remains—at least nominally—a pillar of Citizenship and Immigration Canada's (CIC) mandate; thus, a clearer understanding of the community's role in facilitating integration will aid in understanding how well (or poorly) settlement policies are matching up with practice.

In this working paper we present an overview of the existing literature pertinent to the issue of how communities support the integration trajectories of immigrant families, with the intention of identifying gaps in our collective knowledge. The results of this work, as well as those of other papers in the RCIS Working Paper series, are intended to inform the direction of research inquiry and the methodological approach of future work by the Ryerson Centre for Immigration and Settlement (RCIS) in collaboration with

community partners. In addition, our results will be relevant to the larger community as well as settlement workers, policy makers, and researchers.

Framing the Inquiry

As this paper focuses on the theme of community support, it is necessary to elaborate on our understanding of this concept and to explain how this perspective has informed the direction of our inquiry. We define *community* as a collection of people with common interests, beliefs, and goals. Based on this loose definition, *community support* can be understood as either formal (such as within a polity) or informal (such as in a kinship network or religious group). In the context of immigration, we conceive of formal community supports as those services that are geared explicitly to newcomers. These are generally programs managed by government departments and non-government organizations. Informal support, then, refers to unofficial ways in which newcomers get assistance, often filling in the gaps in service left by formal arrangements. Examples of informal assistance could include goodwill gestures from a social network or service group, or simply a collective coping mechanism. It is important to acknowledge as well that informal support is often provided by settlement workers for services above and beyond their job descriptions.

With these definitions in place, we identified three guiding questions that formed the analytical framework for our literature review. First: who provides support to immigrant families? That is, what government programs, nonprofit organizations, community associations, religious groups, or private individuals make up the social safety net for newcomer families? Second: how are these supports funded? This question takes into consideration the formal and informal funding pathways for immigrant support services. Third: why are these supports important, and finally: what other supports are needed? This last question attempts to tease out the essential or most commonly required services. In line with the above questions, we aim to acquire a clearer picture of whether the formal support system is efficiently and effectively helping newcomer families to integrate in their adopted country.

There are perhaps dozens of aspects in which immigrants seek and obtain settlement support. To name a few: adults need to find jobs, both for survival and commensurate with their skill level; children may struggle with learning a new language or fitting in at school; refugees may suffer from mental illness or posttraumatic stress following upheaval in their homeland; families face the immediate struggle of finding an appropriate place to live; and the turmoil of migration can cause fractures in family relationships. Other published and planned [RCIS Working Papers](#) directly address policy change (Root et al., 2014), labour and work, children and youth, violence against women, and intergenerational conflict. This paper will not duplicate their focus. The first section of this literature review will instead examine what is best described as the formal supports that are currently in place for newcomers, and whether they are publicly or privately funded. We have also attempted to identify common areas of critical need for newcomer families, both during initial settlement and over their lifecycles. While there are many possible areas of study, we chose to focus more narrowly on housing and health as two areas of critical need. The existing literature suggests that immigrants' residential trajectories and health statuses are important points of comparison between

immigrant and non-immigrant Canadians, and that immigrants among themselves have different health outcomes over their life cycles. By maintaining a focus on these two areas of critical need, we were able to achieve a greater depth of understanding of their impact. Furthermore, findings about these specific issues may serve as a model for understanding outcomes in other areas of settlement.

Over the course of this critical review, a number of themes emerged in concert with our inquiry questions. It became clear that community supports can be viewed in the framework of supply and demand: "What services do immigrant families require? What is available to them?" This thread is evident throughout the three sections that follow: formal and informal settlement services, housing, and healthcare. We then framed our understanding of the research gaps in terms of demand for, and supply of, settlement support. The concluding section summarizes these gaps and suggests possible questions for future research.

Formal and Informal Settlement Services

The intent of this first section is to provide a comprehensive understanding of the types of settlement services that exist in Canada so as to clearly identify any gaps. However, as we discovered, service provision is not as cut-and-dry as one might think when many (often overlapping) policies and jurisdictional mandates come into play. What follows is a basic overview of services and resource allocation. This leads to a closer look at refugee service provision, which the literature suggests can be a complex arrangement between sponsors and the government. Next, we consider the literature on how informal support networks aid integration trajectories. The recommendations that conclude this section segue into a closer examination of immigrant housing and health.

An Overview of Settlement Services, Resources, and Locations

Most commonly, settlement services are thought of as those offered under CIC's mandate. However, provincial and municipal levels of government offer their own services, and private organizations step in to provide other types of support when there is a gap.

From the federal side, CIC provides funding for several major programs, including the Immigrant Settlement and Adaptation Program (ISAP), Language Instruction for Newcomers to Canada (LINC), Job Search Workshops (JSWs), Host (a volunteer-newcomer matching program), Settlement Workers in Schools (SWIS), and Resettlement Assistance Programs for refugees (RAPs). Wang and Truelove (2003) conducted an in-depth study of ISAP and LINC (which together represent 88% of all settlement funding) by examining the geographical distribution of the programs in relation to newcomer settlement patterns. The second goal of the Wang and Truelove study was to evaluate the National Evaluation Formula, a mathematical model created by CIC to decide how funding should be allocated among the provinces and territories. The analysis used a number of techniques, including buffering, the Index of Dissimilarity, and the Location Quotient to determine whether the spatial distribution of settlement service locations and the distribution of funding corresponded with the communities in which newcomers have chosen to settle. Wang and Truelove (2003) concluded that settlement services are reasonably well dispersed in Ontario, but the concentration of services in the traditional urban core reception centres runs counter to

the current preference for immigrants to settle in suburban locations, as well as to the government's preference for them to settle in rural areas.

Yet, Wang and Truelove's study precluded a string of cuts to federal settlement services, which saw many service centres close or reduce programming in spite of continually increasing numbers of new arrivals. Lo et al. (2007) used a similar geographical analysis approach to look at settlement services in the Toronto Census Metropolitan Area, but in contrast to the earlier study, they found that there is a spatial mismatch between supply and demand for settlement services, particularly for newer immigrant groups that do not have an established tradition of immigration to Canada. The authors call for an increase in and allocation of settlement funding so as to better serve the needs of newcomers where they need it most. Later, working with a different team, Lo et al. (2010) investigated the actual usage patterns of newcomers to settlement services and surveyed them for length of residency, income level, and rates of satisfaction. Highlights from this study include the fact that areas which are higher-income but more sparsely populated by newcomers were better served than more immigrant-dense but low-income areas. Respondents reported that when they were aware of and had access to services, they were generally satisfied. The aforementioned three studies have in common the need for continual evaluation of service provision in terms of needs and location, as the immigrants arriving today are not the same, nor do they settle the same way, as those of even a decade ago.

While the bulk of the responsibility for immigration is on the federal government, as a shared duty, the provinces also have a mandate to provide settlement services. Though it is not within the scope of this paper to review each province's policies, the policy report produced by Ontario's Ministry for Citizenship and Immigration (2012) is reviewed as one example. Although the report focuses mostly on the Provincial Nominee Program, employment statistics, and foreign credential recognition, it does recognize that there is room for improvement in service delivery, in which the province can provide support. Some programs that are specifically mentioned include official language training (ESL is funded by the province through local school boards), bridging programs, internships and mentorships, support for temporary foreign workers, and cooperation initiatives among key agencies.

In the same vein, municipalities that are typically immigrant reception centres, like Toronto, also provide programs geared toward easing settlement within their jurisdictions. The City of Toronto's Social Development, Finance and Administration Department is responsible for newcomer initiatives, which include settlement workers in city facilities, recreational programming, RAPs, and public health projects geared to newcomers (Social Development, Finance and Administration, 2012). Furthermore, as the city has declared itself to be a "sanctuary city" in 2013, Toronto has made a conscious effort to reduce access barriers to city services for non-status immigrants (Sidhu, 2013). In recent months, other Canadian cities such as Hamilton have followed this lead.

In the private sector, universities and colleges are the first point of contact for many international students and potential immigrants. Kilbride and D'Arcangelo (2002) looked at the needs of newcomer youth enrolled in technical programs at a Toronto community college and analyzed the degrees and sources of support. The most common needs of these students were language assistance, program-specific help,

financial aid, social-emotional support from an ethno-racial peer or from any good friend, and help with general education courses. There were two important findings to this study: first, that needs differed by the characteristics of the student (i.e., by gender, immigration status, and origin); and, second, that the students did not feel that the college had sufficient support to meet their needs. Most interesting for this review, however, is the notion that the students often felt that the *informal* sources of support—friends, teachers, etc.—were the only options available to meet certain needs.

Newcomers Giving Back to the Community

Some might argue that integration has been achieved when a newcomer can move beyond their immediate personal needs and begin participating in the social and civic aspects of their community. Winnemore (2005) suggests that the federally-funded settlement programs such as LINC, ISAP, Host, and even the citizenship ceremony itself, help newcomers build cultural capital and social abilities that eventually facilitate their civic participation. However, while the sentiments behind both CIC-funded programs and Winnemore's article are sincere, it is important that the values propagated through these programs and the manner in which they are expressed be subject to challenge. For instance, Winnemore lauds the Settlement Workers in Schools program for encouraging volunteerism, but a counter-narrative might be that many newcomers feel compelled—or are advised by employment counsellors—to volunteer in order to gain “Canadian experience.” Along these lines, Lee's (1999) study of immigrant women working in the settlement sector in British Columbia found that the women saw volunteering as having mixed effects. Volunteers, they said, benefit from the social aspect of their work, and get extra language and cultural competency practice, but they are often stuck in low-skilled office positions that do not reflect their abilities or offer any chance for upward mobility in the sector. This is just one facet of Lee's main finding, which is that the settlement sector, as it is currently managed, systematically exploits and ghettoizes immigrant women by limiting and devaluing their skills, all in the name of “Canadian work experience.” By challenging the notion that immigrants need Canadian experience at all, settlement programming that is founded on this assumption can undergo closer scrutiny. It may be found that certain programs meant to enable integration are actually having the opposite effect.

Relationships with Sponsors

It may be unconventional to portray sponsorship agreements as a form of “community support,” but given the codification of social safety net responsibilities within the sponsorship contracts, we believe it is reasonable to include them under this heading. Sponsorship agreements range from individual (such as between spouses) to collective (such as “group-of-five”¹) arrangements. From the government's point of view, the purpose of the sponsorship agreement is to allow the entry of a migrant who would not otherwise be eligible to immigrate to Canada on his or her own merits, while removing the burden of publicly-funded social support in the event that his or her settlement

¹ “Group-of-five” refers to a type of sponsorship agreement. According to Lanphier, the 1976 Immigration Act “permits groups of five or more persons to sponsor one or more immigrants or refugees. A provision unique among resettlement countries, it invites public intervention and implementation in a process exclusively attached to the nation-state” (2003, 238).

trajectory faces difficulties. From the privately-sponsored individual's perspective, they are assured (at least legally) financial assistance during their initial migration. We would therefore propose a conceptualization of sponsorship agreements as occupying a grey area between formal and informal support. However, much of the research exposes the gaps between legal responsibility and reality, as well as the myriad forms of abuse that this type of "support" can lead to.

The feminist critique of these sponsorship policies has been strong, with scholars pointing out that female spouses are far more likely to be sponsored than male spouses. Sponsored individuals are vulnerable because their legal status in Canada is dependent on an ongoing positive relationship with their sponsor. In the event that this relationship breaks down, the sponsored individual may feel that they are unable to leave their home, or be unwilling to report abuse for fear of being deported. The report by Côté et al. (2001) for the Status of Women Canada Committee exemplified, through ethnographic accounts, how sponsored women who have not yet obtained permanent residency status are systematically isolated and excluded from society because they are ineligible to participate in the formal labour market, settlement programming, or to access social assistance.

For sponsored refugees, there is the possibility of more formal support. Lanphier (2003) itemizes four different avenues of sponsorship and their corresponding (but differentiated) support systems: 1) under the Sponsorship Agreement Holder (SAH) provision, the private Group of Five undertakes all financial and social support; 2) under the Resettlement Assistance Program (RAP), Citizenship and Immigration Canada undertakes all financial assistance while funding settlement programming either directly or through contracts with NGOs; 3) under the Joint Assistance Sponsored (JAS) program, the individual is sponsored by both a private sponsor and the government; 4) finally, the Community Sponsorship program allows larger groups and organizations, such as universities or businesses, to undertake the financial sponsorship responsibility. The terms of these agreements range from 1 to 2 years.

Lanphier (2003: 249) points out that there have been disparities between sponsors' pledged support and the actuality of sponsors leaving the task of settlement and orientation up to overburdened NGOs. He suggests that social cohesion policy needs to be cognizant of "newcomers' potentially multi-local and transnational identities" by encouraging sponsored refugees to become sponsors in turn, allowing newcomers more autonomy when "shaping their immigration pathways" while "alleviating the burden" on the state. On the one hand, Lanphier's point seems to empower the refugee and eliminate some of the time and energy wasted while waiting for sponsorship approval. On the other hand, there is the concern that streamlining the government's responsibilities by offloading duties onto private sponsors – even as a community – will have adverse effects on the quality of sponsorship, as it may concede consistency of delivery for expediency. Nevertheless, it is our understanding that Lanphier's suggestion was for the government to include resettled refugee communities in the process rather than to substantially alter the sponsorship arrangements as they currently stand.

Lanphier's study relied on copious references to a different project by the Centre for Refugee Studies and CERIS (2001), which provided a retrospective look at the relationships between sponsors and Kosovar refugees in the late 1990s. This study reported that most sponsors were able to maintain a good relationship with the

sponsored families, and helped connect them to the services they needed. However, sponsors also reported that the families had difficulty entering the labour market and that access barriers (such as a lack of childcare) prevented female family members from attending language classes. Most sponsors were satisfied with their working relationship with CIC, although some sponsors thought there could have been better orientation prior to the sponsored families' arrival, and CIC should have designated officers to work on the sponsorship program to avoid miscommunication. In the recommendations, it should also be noted that sponsors underscored the importance of the Interim Federal Health Program (IFHP) for sponsored families and recommended better coordination between CIC, Revenue Canada, and medical professionals. These findings from 2001 are especially poignant given the more recent policy changes and funding reductions to the IFHP in 2012.

Informal Support Networks

Supporting Lanphier's recommendation to acknowledge and utilize migrants' transnational connections, a number of other studies have concluded that migration can be eased with shared experiences. Extensive survey research by Lamba and Krahn (2003) investigated the social networks of refugees in Canada. The researchers found that both the familial and community social capital they retained from their homelands, as well as their networks developed during resettlement, aided their settlement experience in Canada. Furthermore, they found that the transnational networks actually resulted in further sponsorship of homeland refugees. Simich, Beiser, and Mawani (2003) conducted in-depth interviews with government-assisted refugees (GARs) on the role of sharing their settlement struggles and successes with those who provide social support. From their analysis, Simich and colleagues suggest that refugees seek affirmation in their shared experiences. While the informational or instrumental supports provided by social networks can be important positive influences on new arrivals, settlement workers also reported frustration due to misinformation that reaches newcomers, sometimes even before they land. A different article by Simich (2003) underscores the strength of social supports in instigating secondary, internal migrations, as GARs move closer to their extended family and social networks. Simich's paper also analyzes how the bureaucracy seeks to control and limit these internal movements, which she suggests is in direct contradiction to the refugees' preferences and best settlement outcomes.

Here we see the idea that "community support" can come from ethnonational or kinship associations, and that this care system is as valuable to integration as formal settlement programming. Furthermore, denying newcomers their support network can be harmful. Rousseau et al. (2003) conducted a longitudinal study of Congolese families who had been separated and reunited. Not only was the separation damaging to the individual family members' ability to adapt, but the physical distance was also found to create emotional rifts that could not always be healed after reunification. Another transnational study by Waters (2011) found that transnational relationships undertaken by choice have a powerful impact on a family's ability to "stick it out" in their country of settlement. The women in Waters' study all had "astronaut" spouses who worked in the homeland. Although most of them felt more settled and socially integrated after eight years, a few had regressed and become more isolated. All of the women admitted to at

least contemplating return migration at some point, and agreed that the separation had been hard on their families. Both the Waters and Rousseau studies underscore the significant benefit that family support has on individual immigrants' ability to integrate into society as a whole.

Recommendations

This section has highlighted a number of important themes which deserve to be explored in more detail. First, the literature demonstrates that the line between formal and informal support for newcomers can be blurry, even when organizational mandates appear to be clear. Second, we can see that there are many instances where governments, organizations, or individuals move beyond their jurisdiction to fill identified gaps. Third, as many scholars, interviewees, and service providers have pointed out, the needs of newcomers are dynamic and constantly in flux, meaning that programs require constant evaluation.

Housing

Immigrant housing progression is a useful indicator of settlement and integration. This section outlines some of the main problems that result from housing stagnation, followed by an overview of the most common research approaches, theories, and concepts used to understand housing patterns. Three themes that emerged from the literature are then elucidated: barriers to housing mobility, the significance of culture and race, and the role that institutions play in helping or hindering immigrants' housing integration. The last theme helps tie this section back to the community support focus, allowing us to identify what has been done and what needs improvement.

Problems with Housing Stagnation

The term "stagnation" is used here not in the sense of families physically remaining in the same residential space, but rather as a nomenclature for housing patterns which do not show signs of social or economic improvement. Thus, a family may move frequently throughout their early years in Canada, but that does not mean they move into better or more sustainable environments. It may also refer to housing "tenure," such as tenancy instead of homeownership (Murdie, 2003). An upward housing trajectory is generally assumed to be one in which the household moves from low-rent tenancy in cramped quarters to higher-quality, more spacious and likely higher-cost dwellings, with homeownership being the ultimate sign of housing stability. There are a few problems with these assumptions, however. First, the notion of owning a home as the final marker of residential success speaks to a traditional Western value system, which some cultures (and, indeed, younger generations of Canadians) may not agree with (Owusu, 1998). Furthermore, in an economy of ever-increasing housing prices, as in Canada's major cities, the dream of homeownership is out of reach for many. Second, the size or cost of a family home needs to be considered in relation to its household income. As Gopikrishna (2012) and others have pointed out, housing should not cost more than about one third of the household income if financial stability is to be maintained. Third, the number of individuals residing within a household, and the appropriateness of that dwelling for the family, needs to be taken into consideration.

When a dwelling is not sufficient in size and number of bedrooms, does not provide adequate privacy for its inhabitants, and there are limited options for the tenants to be able to improve this situation, they are often referred to as the “hidden homeless” (Chan et al., 2005; Fiedler et al., 2006; Tananescu & Smart, 2010; Preston et al., 2010; Gopikrishna, 2012). This term especially applies to multiple families inhabiting a dwelling intended for a single family (Gopikrishna, 2012). Hidden homelessness occurs most often among new immigrants as a “coping strategy” that prevents them from becoming homeless in the absolute sense. It is a kind of “bottom-up self-help” by which families make use of kinship networks to share housing or ethnic community support to reduce the burden of rent (Chan et al. 2005, X). Hidden homelessness is most likely to occur among recent immigrants (Fiedler et al., 2006), particularly refugee populations (Chan et al., 2005), and can be found in the inner suburbs of major metropolitan cities like Toronto, Montreal, Calgary, and Vancouver (Fiedler et al., 2006; Tananescu & Smart, 2010; Preston et al., 2010). However, it is notoriously difficult to measure, given the various types of precarious housing situations, and the strategies for quantifying it vary by researcher (methods will be examined in closer detail in the following subsection).

Nevertheless, there is some agreement regarding the possible causes of hidden homelessness, which include a lack of government prioritization for its prevention, a lack of awareness of housing resources among immigrants, and societal conditions such as rising house prices, limited affordable rental stock, and long waiting lists for public housing (e.g., Gopikrishna, 2012; Murdie, 2003; Chan et al., 2005). There is concurrence as well on the negative impacts of hidden homelessness on children’s educational attainment and overall immigrant health as summarized by Gopikrishna (2012).

When there is a pattern of multiple families packed into single-family units in an apartment complex or residential neighbourhood, the resulting spatial concentration of immigrants can lead to more widespread social problems. Ghosh (2012) explains how “vertical neighbourhoods” (high-rise apartment buildings) can be “spaces of hope and despair” for immigrants who feel simultaneously grateful for the opportunity to live in Canada and stuck in a cycle of poverty. Many authors have found that ethnic clusters, or “enclaves,” can have a detrimental effect on labour market outcomes (Hou & Picot, 2003) and bridging the divide with mainstream society (Owusu, 1999). Spatial concentrations of immigrant groups result in other problems as well: recent arrivals who find residency in at-risk areas are often excluded from Canada Mortgage and Housing Corporation’s core housing need estimates (Fiedler et al., 2006). Chain migration, a factor in high degrees of concentration, can lead to newcomers becoming over-dependent on their family and friends for support (Owusu, 1999). Although Owusu’s research lent support to the social class thesis (that lower-income households are more likely to cluster), Wayland (2010) argues that a high degree of racial concentration is not necessarily associated with greater neighbourhood poverty. Rather, she argues that the proximity to racial or ethnic peers can aid in forming social networks, and points out that households with more limited income have fewer choices about where they can make their homes. Nevertheless, Hou & Picot’s (2003) research proves that the number of ethnic enclaves in Vancouver, Toronto and Montreal is growing; they show how increased exposure to co-ethnic neighbours and job market segregation are positively

correlated, and significantly correlated for Black communities specifically. While scholars do not agree on the positive or negative impacts of life within an ethnic enclave, it is clear that the integration trajectories for immigrants who do live in racially or ethnically concentrated areas will differ from those who live in more diversified neighbourhoods. It is also clear that spatial concentration is an ongoing and increasing trend.

Housing trajectories are also indicators of social mobility or immobility. Many scholars have pointed out that some immigrants fare better than others and that the failures of certain groups can be traced to larger systemic issues. For instance, Hulchanski (1997) asserts that housing trajectories take place within the context of macro-level societal processes, while Mattu (2002) adds that housing career stagnation is just another spoke in some newcomers' cycle of deprivation. Tananescu and Smart (2010) summarize the literature on rates of immigrant home ownership, noting that while immigrants have historically had more successful housing careers than Canadian-born individuals, recent studies (e.g., Haan, 2005) have shown dramatic decreases. Tananescu and Smart (2010), among others, have suggested that social capital is a primary factor in immigrants' abilities to own their places of residence; however, there are certainly other explanations for this, as will be enumerated below.

Influential Theories and Concepts

While most authors contribute new research or a different perspective to the dialogue around newcomer housing, there are a few recurring concepts which deserve greater attention here. The first is Hulchanski's (1997) "differential incorporation," which asserts that the relationships that newcomers have with institutions lead to different integration outcomes in the long run. This analysis identifies three levels of incorporation: the *macro* (societal) level, at which institutional arrangements are made; the *meso* (group) level, at which groups experience unequal access to the basic needs of society; at the *micro* (household) level, at which households make decisions about their housing trajectories that are based on experiences with institutions. A different project by Murdie et al. (including Hulchanski) in 1999 put this framework into practice, analyzing the differential housing trajectories exhibited by Polish, Jamaican, and Somali newcomers. The macro-meso-micro distinctions are particularly useful for the purposes of our project, as they provide a conceptual framework for analyzing how policies affect families.

A second recurring theory is that of social capital; that is, how social connections (either within or outside of one's ethnic group) can be valuable or even essential in the process of housing progression. Most authors who incorporated the social capital concept into their analysis agreed that it was at least *useful* as a strategy for obtaining suitable (or even emergency) housing (Hou & Picot, 2003; Owusu, 1999). On the other hand, Tananescu & Smart (2010) sought to identify the limits of its usefulness in their analysis, as they looked for situations in which a reliance on one's social support actually retarded or blocked their housing trajectory. Bergeron & Potter (2006) added that social capital on its own is not sufficient for a successful housing career. Success is moderated also by age, country of origin, and immigration category. Future research should bear these limits in mind.

As already mentioned, the ethnic enclave concept has been widely used and hotly debated within the field. However, it is worth reiterating here because of the range of ways in which it has been employed. For instance, while Hou and Picot (2003) talk about the significance of network associations built at the neighbourhood level for labour market outcomes, Rose and Ray (2001) optimistically assert that same-origin refugees are supported within their neighbourhoods and are not isolated from the majority cultural groups in Montreal (however, the authors stop short of stating that they are actually integrated with the mainstream). Murdie and Teixeira's (1997) study looked at the enclave formation issue from the angle of sources of housing information, but perhaps surprisingly found that while the Portuguese respondents sought information from same-group sources, this did not always lead them to choose housing in Portuguese-dominated neighbourhoods. Granted that Portuguese immigrants do not make up a large proportion of today's immigrants and are a group with a historic pattern of migration, this particular study may or may not be useful for understanding housing patterns among newer immigrant groups. Nevertheless, studies such as the ones mentioned here demonstrate the flexibility of the ethnic enclave concept.

A third concept is "core housing need," as defined by Canada Mortgage and Housing Corporation (CMHC) (1991, cited in Wayland, 2010). According to CMHC (no date), "A household is said to be in core housing need if its housing falls below at least one of the adequacy, affordability or suitability, standards and it would have to spend 30% or more of its total before-tax income to pay the median rent of alternative local housing that is acceptable." This categorization is useful because it encompasses a number of variables which may be present, and which all contribute to making its situation precarious.

Study Methods

It is worth noting that there have been a wide range of methods and techniques used to describe the housing situations of immigrants. Part of the reason for the differing approaches is the disciplinary overlap: geographers are interested in housing and tend to employ numerical data and spatially-oriented tools of analyses, whereas sociologists are more likely to be interested in the individual experiences of families based on their location, collecting verbal data. Quantitative studies often utilize surveys (Dion, 2001; Mattu, 2002; Owusu, 1999; Bergeron & Potter, 2006; Murdie, 2003; Rose & Ray, 2001; Murdie & Teixeira, 1997), census data (Hou & Picot, 2003), and geographic indicators (Fiedler et al. 2006). Qualitative research tends toward key informant interviews and focus groups (e.g., Murdie, 2005; Ghosh, 2012).

Mixed methods are a popular way to bridge quantitative and qualitative approaches with a combination of questionnaires, interviews, and focus groups (Tananescu & Smart, 2010; Mensah & Williams, 2013; Hulchanski, 1997; Smith & Ley, 2008; Zine, 2009). The mixed-methods approach generally provides a more holistic picture, whereas the qualitative or quantitative reports tend to provide evidence to either refute or affirm an existing theory.

Barriers to Upward Housing Movement

The literature on barriers in immigrant housing is extensive, providing considerable evidence for the argument that not all households are equal. Some of the noted barriers are found in formal and informal criteria for acquiring housing, wherein the potential tenant is required to demonstrate certain personal characteristics which may be unchangeable (e.g., primary barriers such as skin colour or gender) or changeable (e.g., secondary barriers such as level of income or accent) (Hulchanski, 1997). Mattu (2002) suggests that when an immigrant is discriminated against based on their personal characteristics (such as racial profiling during job search) it impacts their ability to succeed in other areas such as access to affordable housing: they get caught in a “cycle of deprivation.” Danso and Grant (2000) make note of a similar concept in their work, although they also emphasize that the housing market itself is highly discriminatory. They stress that the lack of affordable housing puts low-income tenants in a particularly precarious position within the “core housing need” demographic, a point which is reiterated by many (e.g., Wayland, 2010; Mensah & Williams, 2013; Murdie, 2003; Rose & Ray, 2001; Zine, 2009). The core housing need problem is exacerbated by insufficient shelter allowance from social services, especially for GARs (Ryan & Woodill, 2000). Reinforcing some of the remarks noted above, Skaburskis (2004) noted eight types of affordability problems: geography, demography, migration/immigration, ethnicity, income recipients, income source, employment, and education. A final point, which continues to be a point of contention among academics, comes from Tananescu and Smart’s (2010) assertion that immigrants’ bonding social capital can be a liability without any bridging capital.

As several authors have identified discrimination or difference insensitivity as primary housing barriers (Mensah & Williams, 2013; Dion, 2001; Owusu, 1999; Danso & Grant, 2000; Ryan & Woodill, 2000), this idea deserves further attention. Some disambiguated examples of discrimination from the literature include: anti-refugee sentiment from CIC and the public (Ryan & Woodill, 2000); income discrimination (Hulchanski, 1994); discrimination based on SIN number, as refugees possess conspicuous SINs starting with a 9 (e.g., Murdie, 2005); sociospatial exclusion (Smith & Ley, 2008); and systemic oppression based on race, class, gender, religion, sexuality, age, mental health status, and disability (Zine, 2009).

Other Significant Factors

Beyond access barriers and discrimination, immigrants’ housing selection is informed by their personal experiences and free choice. Cultural practices influence some immigrants’ preference for a proximity to kin (Owusu, 1999), or preferences in the actual structure or layout of the home (Mensah & Williams, 2013). Murdie (2005) considered how a migrant’s pathway of arrival might affect their ability to secure housing, when comparing government-sponsored refugees to asylum seekers (based on Renaud et al.’s 2003 study of refugees in the labour market). Gender has also been explored as a contributing factor, with women and men using different social support networks to find housing (Rose & Ray, 2001). It is essential that researchers not just focus on the barriers that shape housing trajectories for immigrants, but that we also acknowledge and factor in their personal agency as well.

The Role of Institutions

As this paper focuses on community support, it is necessary to give some attention to the ways in which institutions provide guidance or financial aid for newcomer housing. We have already made mention of Hulchanski's theory of differential incorporation, which suggests that institutional arrangements can shape housing trajectories. Social assistance is one form of services provided by public institutions, which is subject to constant scrutiny by the public and academics alike (e.g., Tananescu & Smart, 2010; Ryan & Woodill, 2000). As mentioned by Wayland (2010), there is actually no mandate within CIC's settlement services to address housing, so social assistance or emergency housing grants from charitable organizations are the only recourse for newcomers who cannot meet their housing needs independently. Additionally, privately-funded refugee help centres, such as Romero House, provide a first residence and guidance for some families (Ryan & Woodill, 2000). Some provinces or municipalities fund housing assistance services or awareness campaigns, such as Ontario's Housing Help Centres, though these are not newcomer-specific (Gopikrishna, 2012). Yet a major problem with this scattered approach to formal housing help is that newcomers either are not aware of the services on offer, or are uncomfortable seeking out help. Zine (2009) found that few Muslim and Latin American respondents went to formal agencies for support.

Recommendations for Further Research

Both the works consulted and our review of the literature suggest a number of possible areas for future study. Wayland (2010) recommends a review policy for systemic barriers. As the existing literature provides comprehensive coverage of the many ways in which immigrants and service providers feel they are blocked from service access, it seems like a logical next step to scrutinize policy from this regard. Another area which may provide insight on spatial mismatching has been suggested by Owusu (1999), who calls for disaggregated data on journey-to-work, especially for processing and industrial jobs. In addition, we would like to call for disaggregated data on journey-to-work for service jobs such as those done by immigrant women. Gopikrishna (2012) identified the paucity of the current measures of hidden homelessness, recommending the use of an income cut-off or Municipal Property Standards Act measurement for more accurate hidden homeless estimates. For those families whose housing careers have stagnated according to current research, it is important to know how this outcome impacts the second generations' integration patterns. Finally, similar to Murdie's (2005) work, further studies could differentiate integration trajectories based on pathways of migration.

Health Care Services

The examination of literature related to health care is significant to this topic for two reasons. First, health is an immediate and an ongoing need for both immigrants and native-born Canadians; therefore, it can be observed and measured comparatively and over time. As such, health makes sense as an integration "trajectory." Secondly, the fact that Canadian healthcare is considered to be "universal," and thus a function of society as a whole and a (mostly) undisputed government responsibility, means that the substantive realities of health can be held up to a normative community standard. Moreover, health maintenance is often a family affair. Notions of propriety and

expectations of one's physician are not only determined by family, but also by sociocultural norms. Thus, healthcare links the individual, the family, and the community in very specific and measurable ways. This section considers the contributions of various scholars under the subheadings of theory, methods, patterns of healthcare use, variations across marginalized groups, coping strategies, and calls for further research.

Theories

Patterson's (1988) Family Adjustment and Adaptation Response (FAAR) model provides an understanding of how families cope with health-related stressors. The model takes into account the individual, family, and the community as three interacting systems. The family system attempts to maintain balance by engaging its resources and coping behaviours. According to Patterson, families go through cycles of adjustment, crisis, and adaptation. Although this is an older study and was not referenced by any of the other studies in this section, this theory is relevant and descriptive of many of the patterns described by other scholars. Patterson had intended the model to describe "biopsychosocial" phenomena; that is, the model was meant to be applied "for the integration of concepts across levels of systems," and thus could be put to use to describe a variety of aspects affecting newcomer family integration trajectories.

Similarly, Berry's (1997) acculturation model has been applied in many diverse situations that factor into immigrants' successful socialization. For instance, after finding a negative correlation between the level of immigrants' self-reported mental illness or disorder and an increased level of social support, Puyat (2013) utilized Berry's model to explain that "integrated" groups (as opposed to assimilated, marginalized, or separated groups) benefit from in-group support for dealing with the stresses of adjusting to the mainstream culture. Lai and Hui (2007) and Green et al. (2005) made similar claims as to how immigrant groups make use of their social networks as a coping strategy (more on this below). In the same vein, Putnam's (1993, 2000) understanding of *bonding* and *bridging* social capital (as it pertains to public policy and health policy in particular) has been extremely influential in the field. Szreter and Woolcock (2004) have since contributed to these findings, adding the concept of *linking* social capital, which is defined as the capacity of an institution to connect with the populations it is meant to serve (interestingly, Putnam has since defended his original work (2004), claiming that institutional *mechanisms* were intended to account for this *linking* concept). Each of the above theories and their corresponding concepts, if not explicitly mentioned in the literature, are easily discerned in the findings.

Study Methods

Both quantitative and qualitative methods have been used in immigrant health trajectory research. Although these methods generally yield different types of results, overlap and reinforcement can be found across much of the literature and are therefore worth explicating. Most of the quantitative work has made use of large-scale, multi-purpose national surveys such as the National Longitudinal Survey of Children and Youth, the Canadian Community Health Survey, the National Public Health Survey, the General Social Survey(s), the Canadian Census, and the Longitudinal Survey of Immigrants to Canada (Beiser et al., 2002; Dunn & Dyck, 1998; Eyles et al., 1995; Kim et al., 2013; Malenfant, 2005; McDonald, 2006; McDonald & Kennedy, 2004; Newbold, 2005; Pérez,

2002; Puyat, 2013; Taylor et al., 2011; Wu et al., 2005). There were also research-specific surveys of both medium and small scales (Kirmayer et al., 2004; Kirmayer et al., 2007; Lai & Hui, 2007; Taylor et al., 2011). The quantitative approach tended to focus on variables such as immigrant vs. non-immigrant, visible minority or ethnic group status, self-reported health behaviours, and changes over time. The benefit of this approach is that these survey-based studies allow the researcher to identify broad patterns over time and space. The limitation is that they do not account for unforeseen variables.

Qualitative studies proved to be useful in filling this gap, as they were generally more open or exploratory in their analytical approach. This literature review uncovered ethnographic studies that made use of interviews and/or focus groups geared towards immigrant women (Grewal et al., 2005; Neufeld et al., 2002; Weerasinghe et al., 2000; Weerasinghe & Mitchell, 2007); stakeholders in immigrant health (Clifford, 2004); specific ethnic communities (Dong et al., 2011; Grewal et al., 2005; Groleau & Kirmayer, 2004; Maticka-Tyndale et al., 2007; Whitley et al., 2006); and families (Leduc & Proulx, 2004). The downside to the qualitative studies was that they were at times too specific and lacked practical suggestions for change, or they were too small or regional in sampling the participants. However, as stated above, much of the particular work done by the qualitative or ethnographic research benefited the study by providing a human voice for the problems identified in the at-large quantitative studies.

When talking about “health,” it is necessary to differentiate which type of health one is referring to, as the outcomes vary for each. For instance, many studies looked at physical health or health in general (Dunn & Dyck, 2000; Eyles et al., 1995; Green et al., 2005; Grewal et al., 2005; Leduc & Proulx, 2004; Maticka-Tyndale et al., 2007; McDonald, 2006; McDonald & Kennedy, 2004; Newbold, 2005; Pérez, 2002; Salant & Lauderdale, 2003; Taylor et al., 2011; Weerasinghe et al., 2000; Weerasinghe & Mitchell, 2007; Wu et al., 2005). Others focused on dental care (Dong et al., 2011; Lai & Hui, 2007) or mental health (Beiser et al., 2002; Groleau & Kirmayer, 2004; Guarnaccia & Lopez, 1998; Kirmayer et al., 2007; Kirmayer et al., 2004; Malenfant, 2004; Patterson, 1988; Puyat, 2013; Whitley et al., 2006). Long-term care is a branch of healthcare that deserves more attention in the literature, but nonetheless there is at least one study that specifically discusses this topic (Neufeld et al., 2002).

Patterns and Rates of Usage

Much of the quantitative research sought to uncover patterns in how healthcare is used by immigrants. Leduc and Proulx (2004) observed a “triphasic” pattern in which immigrant families moved through the evaluation, selection, and adoption of health care services. Most significantly, these three phases indicate that immigrant families’ usage evolves over time from ad hoc to regularized usage of sources of care. This study seems to state the obvious in terms of acculturation cycles. The fact that the immigrant families involved are not differentiated based on ethnocultural attributes, language ability, geographical location (they were all sourced from the same local clinic), or socioeconomic status means that the results of that study cannot easily be extrapolated for immigrants at large or even specific groups. Moreover, one might assume that the same results would be true for a native-born family which moved cities or provinces and was unfamiliar with the local healthcare landscape, but because Leduc and Proulx

(2004) did not include a comparison with native-born Canadians, there is no point of reference for this concept in their study.

Nevertheless, other researchers have differentiated patterns of care usage in worthwhile ways. For instance, Bowen's (2001) work demonstrated how patients with language barriers have trouble initially accessing service, and how individuals with low official language fluency may have higher rates of specialist or diagnostic service usage but lower rates of mental health service usage. Dong et al. (2011) examined a single ethnocultural group, Chinese immigrants, and found a culturally distinct pattern of usage in dental services: that is, Chinese are likely to seek services in Canada or China for acute problems, but self-treat chronic oral diseases. Lai and Hui (2007) further differentiated within the Chinese community, observing that older immigrants, Quebec residents, and those with poor health had lower rates of usage, whereas Hong Kongese immigrants, those who had lengthier Canadian residency, those with better social support networks, and those with dental problems had higher rates of dental service usage. These three studies emphasize the importance of considering several variables in one's research design, whether the study is quantitative or qualitative, as overly generalized patterns may not be useful when it comes to identifying access barriers and recommendations for eliminating them.

Other studies have been designed specifically to identify barriers to accessing health services. Given the fact that healthcare coverage is "universal" in Canada, one might assume that economic status does not factor into access to services. However, a number of studies have sought to dispel this notion. Eyles et al. (1995) attempted to identify a pattern of unequal accessibility based on the government's increased attention to "cost containment" (i.e., neoliberal principles) throughout the 1980s and early 1990s. Although they could not confirm a direct correlation with the cost-saving policies, their study showed that older individuals and women's usage of health services noticeably declines as these individuals age.

Dunn and Dyck's (2000) work is premised on the perspective that socioeconomic factors are as important as medical care and health behaviour factors in determining human health status. Using data from the National Population Health Survey, they found that there was no clear pattern of association between socioeconomic factors, immigration, and health outcomes, even though they determined that socioeconomic status was more impactful on immigrant health status than for non-immigrants. The findings from Dunn and Dyck's (2000) study are somewhat fuzzy, as the authors generally conclude that immigrants' experiences influence their health outcomes in complex ways.

In another study, Beiser et al. (2002) looked at the impact of poverty and family process on the mental health of immigrant children. They found that poverty had an indirect impact on children's mental health status, as they received backlash from the poverty-related stress experienced by their parents. Furthermore, children living in "persistent" poverty were more likely to experience mental stress than those living in "transient" poverty, regardless of immigration status. This finding is useful because it highlights the marginalizing effects of poverty for all Canadians, and also underscores how crucial successful settlement is for the health of future generations.

Overall, these studies demonstrate that "universal healthcare" is not so universal when it comes to access, particularly when socioeconomic status is taken into

consideration. It would be interesting to see a study along the lines of Eyles et al. (1995) conducted with immigrants in mind, looking at the recent two decades.

In Canada, where hundreds of languages are spoken but only two are official, it is inevitable that communication presents as a common barrier to accessing health care. In fact, Bowen (2001) asserts that language is the predominant barrier to initial healthcare access, above cultural beliefs and practices. When patients do manage to access healthcare, there is evidence from several studies that immigrants with language barriers may receive lower-quality care, as their pain, symptoms, or prior health records are inadequately communicated (Bowen, 2001). Moreover, doctors and translators face communication dilemmas which they may be tempted to circumvent unethically (Bowen, 2001; Clifford, 2004; Green et al., 2005).

Family members are also negatively impacted by language barriers in health care. For example, Green et al. (2005) provide a narrative account of how youths, who often have a better grasp of official languages than their parents, are often engaged as translators and mediators in health care. They argue that these youths' contributions should be conceptualized not only as inappropriate and inadequate interpreting, but also as a contribution to the informal economy of healthcare. Although Green et al. have a point with regard to recognizing the value of such informal contributions, there is a danger in putting so much value on them: it may cause policymakers to assume that family is a reasonable replacement for formal interpretation in the healthcare economy.

The Impact of Race, Gender, and Other Marginalizing Personal Traits

It has been well-established in the literature that immigrant women face different challenges and barriers to accessing health services than their male or native-born counterparts (Grewal et al., 2005; Kim et al., 2013; McDonald, 2006; Neufeld, 2002; Weerasinghe et al., 2000; Weerasinghe & Mitchell, 2007). Weerasinghe et al.'s (2000) exploratory research on female immigrants in Nova Scotia accounted for a range of ethnocultural perspectives, finding that many of their focus group participants had experienced dissatisfaction with diagnosis and prescription, communication problems with their service provider, and cultural clashes between their own beliefs and Western medicine. A second study by Weerasinghe and Mitchell (2007) elaborated on these barriers, finding that service providers' lack of cultural knowledge was the main reason for cultural insensitivity, which the women saw as a barrier to adequate service provision. Family influence also plays a role in immigrant women's health outcomes. For example, Grewal et al.'s (2005) ethnographic study found that the women felt well-supported by their families, although the authors argue that mental health issues were less likely to be divulged outside the family, leading to abusive relationships. The authors call for more research on the role of familial relationships in women's health.

Immigrant women's family roles are dynamic, as they frequently act as formal or informal caregivers for dependents requiring intensive, long-term care. Neufeld et al. (2002) investigated these women's ability to connect with community resources and found that social networks were essential to their initial access; most community services lacked outreach mechanisms that would help make this initial connection. Regarding health trajectories over the initial settlement period, Kim et al. (2013) found sufficient evidence in their statistical samples to conclude that women and minority ethnic groups may be more vulnerable to social changes, based on their comparatively

worse health outcomes. Given the perspectives provided directly by immigrant women in the ethnographic studies mentioned above, it seems unfair and perhaps simplistic to conclude that women and minorities are less capable of integrating; rather, a fairer and more productive conceptualization is that they require differential outreach and accessibility strategies than are currently being used. Further research may look into possible strategies to tackle these specific problems.

Coping Strategies

Many studies argued that the existence of (ethnic) social support plays a significant role in an individual's health outcomes (Puyat, 2013; Lai & Hui, 2007; Neufeld et al., 2007), fitting in well with Putnam's social capital theory as it applies to healthcare. Immigrants lean on family and friends to provide services that should be supplied by the government-funded healthcare regime, such as interpretation (Green et al., 2005) or long-term care (Neufeld et al., 2002). However, Salant and Lauderdale's (2003) overview of acculturation theory studies of immigrant health is critical of the typical measures in these studies, such as time; they argue that the research yields results that are fragmented (by physical or mental classifications) and are limited in understanding of diverse group experiences.

With this critique in mind, there are many culture-specific studies which use both qualitative and quantitative strategies to identify barriers and strategies for accessing healthcare. A study by Maticka-Tyndale et al. (2007) specifically looked at the sexual health needs of Iranian immigrants to Canada; the barriers and access strategies were similar to those mentioned by the women in Neufeld et al.'s (2002) study. In the course of a narrative-led study, Groleau and Kirmayer (2004) found that social acceptance or stigma were culture-related models that explained mental health access barriers in Vietnamese immigrants. Similarly, in their study of West Indians who did not seek treatment for mental illness, Whitley et al. (2006) reported that social stigma, perceived dismissiveness by healthcare professionals, and a cultural preference for non-medical cures impacted the group's connection to available treatment. Other culture-specific studies have already been outlined earlier in this paper (Lai & Hui, 2007; Grewal et al., 2005; Dong et al., 2011). The takeaway from these studies is twofold: 1) group-centred research has divulged group-specific needs, and 2) there are seemingly immense variations of immigrant populations and health needs to study. Nevertheless, each study contributes, in a different way, to better understanding for policymakers and service providers, identifying areas of overlap among communities that can maximize the impact of service changes.

Research that shows comparative data between native-born and foreign-born Canadians is a useful launchpad for policy analysis, as many of the studies demonstrate a clear difference in health outcomes between these groups. A common concept in immigrant health is the "healthy immigrant effect," which is the notion that immigrants arrive in Canada in comparatively better health than the average Canadian, but that this advantage slowly erodes throughout the settlement process until their health status is the same or worse than the average native-born. McDonald and Kennedy (2004) sought conclusive evidence of this theory in Nova Scotian immigrants and found strong support for the presence of the healthy immigrant effect in chronic conditions; however, there was weak support for this idea as it pertains to self-assessed

health. A further study by McDonald (2006) compared health behaviours such as consumption of alcohol, tobacco, fruits, and vegetables, as well as vigorous physical activity, and concluded that the native-born white community's lifestyle choices have significant positive influence on the behaviours of immigrants and native-born minorities in their process of integration.

Additionally, Newbold (2005) found that immigrants were neither more nor less likely to self-rate their health as fair or poor, although native-borns were less likely to transition to poor health over time. Wu et al. (2005) identified the important point that the reasons for unmet healthcare needs differ between immigrants and non-immigrants. Dunn and Dyck's (2000) work points to the significance of socioeconomic status for immigrants over Canadian-born, as mentioned above. With regard to mental health outcomes, Kirmayer et al. (2007) show that native-born Canadians are significantly more likely to access mental health services, while Malenfant's (2004) work emphasizes the differences in suicide risk. All of the above studies show that the health trajectories of immigrants (and in some cases, Canadian-born minorities) vary substantially from those of native-born Canadians; thus, healthcare should not be a "one size fits all" endeavour.

Further Research

Recent proactive work in health care research is targeting specific high-risk communities. An innovative study by Taylor et al. (2011) followed the health decision trajectories of two groups of South Asian adult ESL students: one group was taught from a Hepatitis B awareness curriculum, while the control group was taught a generic physical health curriculum. After six months, a follow-up survey found that the students who were explicitly taught about their health risks and given the language and cultural tools for addressing them were significantly more likely to understand those risks and seek out testing. This is just one example of how access barriers can be broken down through targeted prevention, intervention, and linguistic empowerment. While many of the studies in this section have extolled the need for culture, language, or status-specific health measures, there was a dearth of research and literature demonstrating practical implementation of anti-oppression strategies.

There are two other calls for more research that are worth mentioning. The first came from Bowen (2001), who suggested looking into how interpretation services might reduce the costs of healthcare by preventing unnecessary medical care. The second, from Weerasinghe et al. (2000), is that healthcare providers need to be included in the research. We would like add to this, emphasizing that the voices of the informal providers deserve to be heard and included in the dialogue, particularly where immigrant women take on this role for their families.

Conclusion

This literature review has examined community supports for immigrant families ranging from formal and institutionalized settlement services to the informal safety nets that newcomers rely on when their needs fall through the cracks of the established regime. By focusing on housing and health, two areas of recognized need but chronically underappreciated as settlement-specific services, we are able to explore the extensive literature that supports the argument for the inclusion of informal services during initial

settlement and throughout the life cycle. Some common threads across all three sections of this paper are the barriers immigrants experience to accessing services, including discrimination and differential incorporation; the grey areas pertaining to the service mandates of programs and departments, which affect immigrant access and settlement service providers as they attempt to negotiate those borders; and the coping mechanisms created by newcomers and their allies to make settlement and integration happen in spite of systemic barriers or shortcomings.

Given these common threads, we have identified a number of gaps in our collective knowledge, or areas that could use more in-depth exploration. These include:

- The role of community organizations in resettlement programming such as refugee sponsorships
- The role of Canadian (including established immigrant) families (such as host family) in providing informal support to fill the gaps left by formal institutions
- The shift of settlement services from formal (i.e., government-funded) to informal support networks and the impact of this on the health and housing trajectories of newcomer families
- The impacts of pre-arrival migration experiences and immigration pathways on an immigrant family's ability to access services
- A gendered analysis of community supports
- Variations in settlement experience among different types of family structure and the implications for need and access to services

Going forward, we propose to address some of these shortcomings in a large-scale project that will involve collaboration between academics, community organizations, and immigrant families. The research gaps identified here suggest the following research questions about service provision, barriers to accessing existing services, and the determination of the most appropriate and effective service providers:

- 1) How do the housing and healthcare needs of immigrant families with different pre-migration experiences or pathways of arrival differ from one another? Does current service provision reflect this?
- 2) How can communities provide tailored support for the diverse health needs of the newcomer families?
- 3) How are informal community supports for refugee resettlement being leveraged by the government? Is this approach in the best interest of refugees?
- 4) In what ways do established immigrants facilitate the orientation and integration of the newcomer families (including the housing and health trajectories)?

We hope that, by taking into consideration the differentiated arrival pathways and integration trajectories of a wide variety of families who come to Canada, we will be better able to assess supply and recommend improvements to meet settlement service demands.

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