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Incorporating individual community assets in neighbourhood houses: Beyond the community-building tradition of settlement houses

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Abstract
As a global movement, neighbourhood houses (NHs) are found in urban communities all over the world. Following the community-building tradition of early settlement houses, NHs have been actively nurturing and mobilizing community assets to serve the local community, but it is not known whether NHs have incorporated these assets in their infrastructure. This article reports the findings of a clearinghouse survey of 15 NHs in Metro Vancouver, Canada, which indicate that they nurtured community assets and incorporated them into their infrastructure as paid staff. Yet at the leadership level, the incorporation falls short of ethno-racial minority members from the community.

Keywords
Community assets, community building, neighbourhood houses, settlement houses, Vancouver

Introduction

The first settlement house (SH), Toynbee Hall, was set up in East London in 1884 by Rev. Samuel Barnett and his wife Henrietta. In less than two decades after its establishment, the Settlement House Movement spread widely from England to continental Europe, North America and as far as

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Japan (Johnson, 1995). Today, the legacy of SHs has spread to every continent except Antarctica (IFS, n.d.) Although they are direct descendants of the early SHs, most IFS members now carry a new label – neighbourhood house or centre (hereafter NH) – which, as Landers suggests, are 'today's settlements' (Landers, 1998 cited in Koerin, 2003: 55). Although most of these NHs are not survivors of the settlement era (Husock, 1993), they have inherited the community-building tradition from the early SHs (Chesler, 1996; Yan, 2004).

Despite their long global history of serving urban communities, NHs have received disproportionally low attention from social work researchers, particularly outside North America. The last two decades have seen only a handful of studies on NHs. With one exception (Yan and Lauer, 2008), these studies have looked only at NHs in the United States tending to focus on their financial challenges (Fabricant and Fisher, 2002), capacity and services (Koerin, 2003; Poole and Colby, 2002), functions in connecting people in the community (Lauer and Yan, 2013; Yan and Lauer, 2008) and efforts in community building (Hirota et al., 1997; Yan and Sin, 2010). While these studies consistently find that NHs have committed to and been successful in generating community assets as a community-building process, they raise the concern of the negative impacts of over-reliance on government funding on NHs' community-building capacity. Some of these studies also found that NHs have mobilized the community assets that they nurtured as volunteers to compensate their financial shortage. However, no study has explored how NHs have further incorporated these community assets into their own infrastructure, particularly its leadership.

In this article, we report the findings of a clearinghouse survey of all NHs in Metro Vancouver, an ethno-racially diverse metropolitan centre on the west coast of Canada. The findings of the survey confirm the financial concern raised in other recent studies. However, when looking further at these NHs' human resources (including board of directors, staff and volunteers), we discover that NHs take the community assets that they have nurtured and substantially incorporate them into their infrastructure to serve local (ethno-racially diverse) residents. Through this incorporation, many service users, who are ethno-racial immigrants, have become staff and volunteers. However, at the leadership levels, such as executive director and the board of directors, the incorporation of ethno-racial minorities is disproportionately weak. We end this article with some suggestions of how NHs can further improve their incorporation of local individual community assets.

A great tradition of settlement houses: Community building

In view of the disintegrating social fabric of contemporary civil society, the SH's community-building tradition and its unique community-service-cum-organizing approach (Yan, 2004) have appealed to some social scientists, who advocate for 'bringing back the settlement house' (Husock, 1993) as a policy measure – to revitalize declining communities in metropolitan centres (Yan, 2004), to rebuild government–community partnerships (Giddens, 1998; Marks, 1993) and to generate social capital (Putnam, 2000). However, these appeals have been based largely on historical imagination about the past success of SHs (Husock, 1993). Empirically, not much has been done to study how NHs, that is, 'today's settlements', have kept the SH's tradition of community building, particularly in increasingly ethno-racial diversified communities and under the financial constraints imposed by a neoliberal welfare regime.

Ethno-racial diverse community and NHs

SHs' community-building tradition has a focus on connecting people with diverse backgrounds in the community. As the most prominent forefather of the Settlement House Movement, Samuel Barnett openly advocated the SH as a 'mechanism of connection' (Meagham, 1987). Endorsing Barnett's philosophy, Jane Addams, the founder of Hull House, saw the SH as a bridge between

immigrants and the host society. As she said in her seminal work *Twenty Years at Hull House* (Addams, 1961),

> It seemed to me that Hull House ought to be able to devise some educational enterprise which should *build a bridge* between European [immigrants] and American experiences in such wise [*sic*] as to give them both more meaning and a sense of relation. (p. 156; author's italics)

Many SHs, like Hull House, might have been a bridge between European immigrants and America's largely White, Anglo-Saxon Protestant population. However, the role of SHs in connecting and working with ethno-racially diverse populations has not been without controversy. Despite the shared vision of Barnett and Addams – that the SH be a mechanism of connection – there have also been strong critiques of this seemingly liberal notion of bridging, or cultural pluralism (Lissak, 1989). At least some SHs have been agents of assimilation (Lissak, 1989) and of class and racial segregation (Lasch-Quinn, 1993; Spratt, 1997). Herbert Gans (1964), a prominent sociologist, openly questioned the social work profession, which has deep roots in the Settlement House Movement and was the main operator of SHs in the 1960s. Gans wondered whether the White, middle-class mentality of SHs might hamper them from connecting with and serving racialized poor people.

Today's NHs are mostly located in ethno-racially diverse communities, which has become a major challenge for them with regard to actualizing the SH's community-building tradition. Unlike the early 1900s, today's immigration context is highly racialized. According to the International Organization for Migration (2013), in 2010, out of the total number of international migrants 74–95 million people moved from the Global South to the Global North. Global migration has led to an influx of ethno-racially diverse immigrants into many urban communities in metropolitan centres in the Global North (Sassen, 1996). The competing and conflicting needs and interests among these increasingly diverse populations may have further fragmented urban communities (Yan, 2004).

Thus, for contemporary NHs which are located in these urban communities, both bringing these ethno-racially diverse people together and breaking the traditional White, middle-class mentality have become even more challenging. Recently, this observation was bolstered by the findings of two exploratory studies on NHs, one in San Francisco (Yan and Sin, 2010) and one in Vancouver (Yan and Lauer, 2008). These two studies also provide some insight into how contemporary NHs have tried to actualize the SH tradition in ethno-racially diverse communities. In a nutshell, they have adaptively devised different community-building strategies to connect newcomers and local people, bringing them together to share their cultures and to solve collective problems (Yan et al., 2009). These strategies include providing flexible services for all age groups, organizing community cultural events, creating inclusive platforms for various community interests and building coalitions with other organizations (Yan et al., 2009). Among all strategies, promoting volunteering may be the most commonly used and effective way for NHs to bring people together.

Community assets and financial challenges

Indeed, volunteering is part of the great community-building tradition of SH. Under the notion of local democracy, which extends civic democracy from the political to the social domain (Lasch, 1965; Yan, 2004), the members of SHs are not seen as service users. They are also 'citizens' of SHs (Ospina and Su, 2009) who not only help decide how their needs are going to be met, but also take part in organizing themselves to meet these needs. Volunteering is also an asset-building process. Kretzmann and McKnight (1993) conceptualize community assets in three categories: individuals, associations and institutions. Individuals in the community have many gifts and skills (Kretzmann and McKnight, 1993).

Intriguingly, volunteers, as a form of individual community assets, are also useful for NHs in dealing with their financial challenges. As Rose (2001) argues, historically, financial problems had always been 'a regular nightmare' of early SHs. Unlike the early SHs, today's NHs have become over-reliant on public funding, which tends to be short-term programme-based. As Fabricant and Fisher (2002) discovered, this kind of funding limits NHs' community-building mandate and service flexibility and weakens their infrastructure, that is, as frontline staff, senior managers and board members. Yet, as Hirota et al. (1997) found in a case study of four NHs in New York, despite the tremendous financial challenges, NHs have maintained SH's community-building tradition by strengthening 'individual and neighborhood assets', and building 'collective capacity to address community problems' (p. 3). Very often, NHs do this by promoting and organizing volunteering activities among local residents.

In both San Francisco and Vancouver, NHs have actively nurtured volunteerism among their service recipients and local residents, many of whom are recent immigrants (Yan and Lauer, 2008; Yan and Sin, 2010). Through volunteering in NHs, individuals discover, nurture and convert their gifts and skills into resources to reciprocally serve their own community. The participation of volunteers in NHs, which is multifaceted – board management, programme planning and delivery, and administration – has become a major source of human resources for NHs. As Koerin (2003) found, at some NHs in New York, 'full time staff is supplemented with over 400 volunteers annually' (p. 58). Volunteers are a critical human resource that allows NHs to maintain their services.

However, despite the noble notion of having local people to help local people, the idea of community asset is not without controversies. As MacLeod and Emejulu (2014) point out, the idea of community asset building may ironically fall prey to the neoliberal welfare ideology. The idea and practice of asset-based development become an excuse for the state to justify its erosion of support for social programmes. Governments now can argue that 'individuals, families, and community groups will be able to fill this vacuum through their local knowledge, assets, and energy to rebuild local services on their own terms and in ways that meet their interests and needs' (MacLeod and Emejulu, 2014: 431). In other words, volunteering, as a form of individual community asset, becomes a form of free labour to compensate the shortage of government funding.

Organizational and professional boundary

Coupled with this neoliberal agenda is the problem of professionalization. There are ample discussions in the literature about how professionals (or paid staff) from community organizations nurture, map and mobilize community assets. However, there is not much in the literature discussing how community organizations incorporate community assets, particularly at the individual level, into its own infrastructure. There seems to be an implicit boundary organizationally that keeps community assets out of the organizational structure and professionally positions the action of community asset building as a professional activity orchestrated by paid staff. Likewise, in the NH literature, despite the emphasis on volunteers' participation in its operation, it is not clear how volunteers are involved in the day-to-day decision-making process except at the board of director level.

Trolander (1987) has long criticized NHs for their reliance on professionalized infrastructure, which has weakened their ability for community building. This is particularly so if professionals are hired from outside the community. They lack an understanding of the local needs and context. It also takes them time to navigate through local dynamics that may be influencing NHs' efforts in community building. The professionalization of NHs' infrastructure may lead to the detachment of staff from the community that they serve and professional imperialism which dictates the needs of local residents. Keeping individual community assets outside the infrastructure of NHs can therefore be problematic, particularly in ethno-racially diverse communities where many volunteers are

residents from an ethno-racial minority background (Green, 2010). Echoing Gans' comment about the White, middle-class mentality of NH staff and management, these may further solidify the barriers of race and ethnicity, which in turn could hamper NHs' commitment to the community-building tradition of SHs.

In brief, as reflected in the limited literature, despite facing a few major challenges, NHs, as 'today's settlements', have tried hard to maintain the great community-building tradition of SHs. Through promoting and facilitating volunteerism among service users and local residents, they nurture and mobilize community assets to address collective problems. However, despite the comprehensive involvement of volunteers at different levels of operation, there is little information about how individual community assets transcend the organizational and ethno-racial boundaries and are incorporated into the NHs' infrastructure. To fill the knowledge gap, we conducted a clearinghouse survey of the programmes, finances and infrastructure of NHs in Metro Vancouver (MV), focusing particularly on how they incorporate ethno-racially diverse community assets into their infrastructure.

Methodology

This clearinghouse survey is part of a four-year university—community collaborative research project which aims to examine how the NH, as a place-based third-sector approach, helps local urban community residents face the emerging complex challenges within the community. As an ethno-racially diverse metropolitan centre on the west coast of Canada, MV, a region with 23 small municipalities, is one of the top three immigrant destinations in Canada. In 2006, racial minorities comprised 41.7 per cent of the population of MV, and a majority of these were also immigrants (Statistics Canada, 2007). Meanwhile, MV has the second largest and most vibrant cluster of NHs in Canada. When the research project started, there were 15[1] neighbourhood houses in MV, with a history dating back to 1938 (Association of Neighbourhood Houses of British Columbia (ANHBC), n.d.). Of the 15 NHs, 10 are located on the east side of the City of Vancouver, which was the earliest developed urban centre of the region. Most ($N = 11$) NHs serve a neighbourhood equivalent to four to six census tracts, each of which has a population of 2500 to 8000 persons (Statistics Canada, 2012). Four NHs, mainly located in the suburbs, serve a much larger area.

As a preliminary data collection activity of this four-year project, the clearinghouse survey served two major purposes. First, the snapshot inventory (mainly for the 2012–2013 fiscal year) of these NHs' resources, assets and services was meant to provide background information for other research components of the larger study. Therefore, the survey includes items such as ownership of venue, opening hours, sources and nature of funding, programmes and number of participants, number of volunteers and their hours of service, and information on staff and members of boards of directors. Second, to understand how NHs have incorporated into their infrastructure the individual community assets they have generated, we specifically asked for the following information concerning board members and staff: (a) immigrant status, (b) connection (living or working) with the local neighbourhood, (c) race, ethnicity and language(s) and (d) usage of the NH's services. Although data collected from the latter items provided particularly useful information, we here report all the findings of the survey as they are useful in helping us to understand the operation of today's NHs.

The survey was administered either by each NH's executive director or by his/her designated staff member. Due to some technical problems, including multiple types of employee status, a lack of centralized registration for all volunteers and ethical concerns about privacy of personal information, the survey did not attempt to obtain information from individual board members, staff members and volunteers. Information on service users and volunteers is thus largely a rough estimation based on the incomplete records and general observation of the staff. Each NH was asked

to provide aggregated information according to their own databases. With the diligent efforts of all participating NHs, we collected information on 80 per cent of all the board members and staff.

Findings

The findings of the clearinghouse survey confirmed a few observations made in previous studies: NHs are accessible local facilities, they serve the multiple needs of local residents, they achieve substantial mobilization of volunteers in day-to-day operations and they face financial challenges. More importantly, they make great efforts to recruit a significant number of ethno-racially diverse service users and local residents as staff to provide multi-cultural and multi-lingual services to the ethno-racially diverse population of the neighbourhood that they serve. However, in terms of leadership, the incorporation of ethno-racial minorities at the decision-making level (the board and senior management) is less obvious than at the operational level (frontline and volunteers).

Accessibility

Although only five out of the 15 NHs in MV own its own premises, others have secured long-term and low-rent (as low as $1 per year[2]) leases from the municipal government ($N=7$) or from other public institutions ($N=2$). Only one rents its premises from a private landlord. Many have occupied their current premises almost since their inauguration. This stability makes them identifiable and accessible to residents of the neighbourhoods that they serve. On average, they are open 51.2 hours per week during the daytime, and 11 of them reported being open in the evenings with an average of 12.5 evening hours per week. All reported that they often open at the weekend to accommodate the requests of local residents and organizations. A membership system is common to all these 15 NHs, but they charge only a minimal membership fee, ranging from $1 to $15. Most reported that they waive or offer lower fees for low-income users.

Accessibility is also reflected in the programmes offered. In the SH tradition, NHs offer multiple services to all members of the family (Koerin, 2003; Yan, 2004). In fiscal year 2012–2013, these 15 NHs offered a total 444 programme activities – one-off events, short-term and long-term group activities, structured drop-in services (e.g. family drop-in) and one-on-one information referrals – which together served a total of 209,864 persons-in-frequency. Many of these 444 programmes served more than one age group, with 158 related to the needs of children, 152 to family, 137 to seniors and 103 to youth. When asked about the top five ethnic groups among their service users, 14 NHs put Chinese at the top of the list. The next most common responses were Latin American ($N=9$) and Southeast Asian ($N=9$), followed by Caucasian/Canadian ($N=7$) and South Asian ($N=6$).

Funding

The budgets of these NHs vary greatly. In the 2012–2013 fiscal year, three NHs had a budget of less than $200,000, seven had budgets of around $1–2 m, and five had budgets of more than $3 m. Out of the 444 programmes, 381 (86%) were fully or partially supported by funding from different levels of government – provincial ($N=182$, a total of $15,376,567), municipal ($N=133$, $2,908,053) and federal ($N=66$, $2,217,530) (Figure 1).

As Figure 2 indicates, close to 60 per cent of this government funding lasted for three years or less either on renewable terms ($N=152$) or on non-renewable terms ($N=106$). Meanwhile, out of the 115 programmes funded by the United Way and other charitable foundations, the majority ($N=101$) were funded on renewable terms of less than three years or on non-renewable terms (Figure 2).

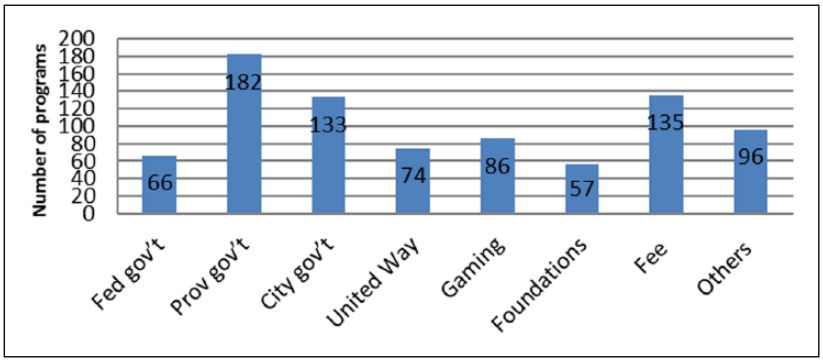

Figure 1. Programme funding sources.
Note: Many programmes received funding for more than one source.

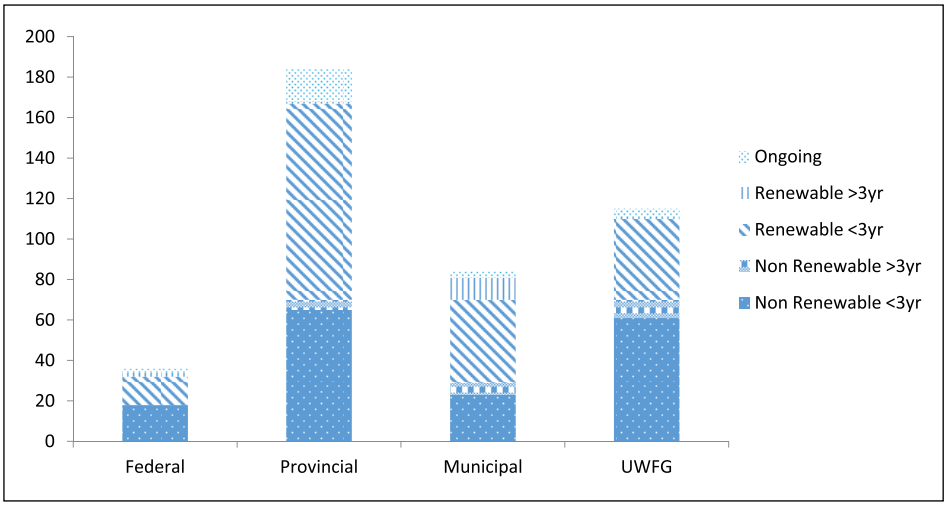

Figure 2. Programme funding by type.

Fees were another major funding source – 28.6 per cent ($10,688,992) of these NHs' total revenue. This is largely due to the fact that almost all of them operate child day-care services. In Canada, this service is only partially funded by the government, so most users pay on a sliding scale according to household income. A final source of total revenue, donations, was minimal (1.3%, $467,030).

Volunteers

All the 15 NHs reported intensive use of volunteers in their service. In the 2012–2013 fiscal year, 360 (83%) of the 444 programmes had used volunteers and these volunteers contributed an average of 15,000 hours to each NH, which is equivalent to 7.8 full-time-equivalent positions. All these NHs have their own volunteer-registration system, but not all volunteers were registered. A total of over 3672 people were recorded in these NHs' registration systems, for an average of 250 registered volunteers at each NH. Most (70%) of the volunteers were women. More than half (55%) were

adults (25–59 years old); the rest were seniors (22%) aged 60 years or above and youth (22%) aged 13–24 years. Other than English, 19 languages were documented in the survey, with Chinese, Spanish, Korean, Tagalog and Vietnamese the five most common. In all, 35 per cent of the registered volunteers were immigrants, and 52 per cent had been service users of NHs. This is an important indicator of the SH's tradition of nurturing local individual community assets from their own users.

Board of directors

The size of the boards of these 15 NHs ranged from 6 to 15 people. The four newest and smaller NHs tended to have smaller boards, with six or seven members. The rest had 10 or more members.[3] The survey collected information on 129 (81%) of the 160 total members. As indicated in Table 1, 65 per cent of them ($N=84$) were women. As for age distribution, 33.3 per cent were between 25 and 40 years old, 24.6 per cent between 41 and 50 years, 19 per cent between 51 and 60 years and 16.7 per cent over 60 years. When asked whether they had lived or worked in the neighbourhood served by their NH, 101 (78%) of them either had lived or were currently living there, and 44 (34.1%) either had worked or were currently working in this neighbourhood. Yet a great majority of them ($N=110$, 85%) had never used the services of the NH.

Ethnically, a great majority identified themselves as Canadian ($N=55$) and Caucasian[4] ($N=30$). The largest ethnic minority group on these 15 different boards was Chinese ($N=18$). Interestingly, in terms of native language, eight NHs reported they had board members who could speak Spanish, in addition to five NHs with Chinese speakers and four with Hindi speakers. Meanwhile, 27.5 per cent of all board members were identified as racial minorities. Only 27 per cent ($N=33$) of the 129 board members were immigrants, among whom a great majority ($N=27$, 21%) had been in Canada for more than 10 years.

Many of them were professionals working in different fields[5] such as business, finance and administration ($N=29$), management ($N=18$), social science, education and government service ($N=22$) and art, culture and sport ($N=10$). A few ($N=15$) were retirees. Only a handful (6.3%) were younger than 25 years old. Over half (54%) had served on the board for less than 3 years, 21 per cent for 3–5 years and 20 per cent for 5–10 years. Only 5 per cent had been on the board for more than 10 years. This reflects regular turnover on these boards.

Staff

The 15 NHs together hired a total of 922 employees in the year the survey was conducted. The survey did successfully gather comprehensive information from 733 (80%) of them; unfortunately, for some items we did not receive responses from all the staff. The size of staff, which reflects the capacity of each NH, also varied greatly: less than 30 people ($N=5$), 31–60 people ($N=4$), 61–90 people ($N=4$) and over 150 people ($N=2$). Table 1 shows the demographic information of the staff. Among these 733 staff, 65 per cent were female and 35 per cent were male. Close to 55 per cent were 40 years old or younger. The rest were either 41–50 years old (22.8%) or older than 50 years (22.5%).

Over 60 per cent ($N=461$) of the staff were either former or active service users of NHs. Similarly, over half (55.6%, $N=414$) were either current or former residents in the neighbourhoods they were serving. We asked each NH to list the languages that were spoken by three or more staff members. Other than English, 51 languages were reported. All 15 NHs reported having staff who could speak Chinese, 14 NHs reported French speakers, 11 NHs reported Hindi and Spanish speakers and eight reported Portuguese and Urdu speakers. For staff ethnicity, Chinese topped the list with 103 people, South Asian was second with 43, Latin American/Hispanic/Spanish was third

Table 1. Demographic statistics for neighbourhood house board members and staff.[a]

	Board members (%)	Staff (%)
Sex		
Male	35	65
Female	65	35
Age (years)		
<25	6.3	12.8
25–40	33.3	42.0
41–50	24.6	22.8
51–60	19	17.9
>60	16.7	4.4
NH service user		
Never	65	37.2
Former user	25.5	42.4
Active user	6.5	20.4
Living in the neighbourhood		
Current resident	68.1	43.1
Former resident	11.6	12.5
Immigrant status		
Canadian born	73	50.5
Immigrant over 10 years	21	31.5
Immigrant 6–10 years	2	10.1
Immigrant <6 years	4	7.6
Ethnic identity		
Canadian	67.5	39.5
Chinese	14.3	21.0
Latin American	2.4	6.0
Filipino	–	5.1
South Asian	3.2	3.5
Other	12.6	24.9
Top five languages spoken		
	English	English
	French	Chinese
	Spanish	French
	Chinese	Hindi
	Hindi	Spanish

NH: neighbourhood house.
[a]All percentages are based on the total number of staff and board member information available for each question.

with 36 and Filipino was fourth with 25. This list is very similar to that of the top five ethnic groups among these NHs' service users.

Meanwhile, 44.7 per cent of all staff were identified as racial minorities, half Canadian-born and half immigrants. Among the latter group, a great majority (63.5%) had lived in Canada for more than 10 years. Unfortunately, due to the aggregate nature of the data, it was not possible to analyse the ethno-racial backgrounds of different levels of staff. However, according to our observations, at least at the executive director level, only three were ethno-racial minorities.

In terms of education and training, as indicated in Table 2, less than 15 per cent of the staff had only a high school diploma. Close to half (45.7%) of the staff had only a college diploma, 27.5 per

Table 2. Education and employment status statistics for neighbourhood house.[a]

Education	%
High school diploma	14.9
College diploma	45.7
Undergraduate degree	27.5
Post-graduate degree	11.9
Professional qualifications	
Early childhood education	22.8
Social service related	21.5
Children and youth services	16.5
Social work	5.2
Other	34.3
Years of service	
<3	34.5
3–5	23.9
5–10	25.8
>10	15.8
Employment status	
Regular, continuous	82.2
Contract, term	17.7
Hours per week	
35 or more	46.9
21–34	26.8
11–20	13.2
10 or less	13.2
Type of position	
Managerial	15.8
Programme staff	67.8
Support staff	9.3
Others	7.1

[a]All percentages are passed on the total number of staff information available for each question.

cent held an undergraduate degree and 11.9 per cent had a postgraduate degree. In terms of professional qualifications, the top three fields were early childhood education ($N=189$), social service related (not including social work) ($N=144$) and children and youth service ($N=111$). Only 35 staff reported having formal social work training.

Most of the staff had been at these NHs for a relatively short time; 34.5 per cent had worked in the NH for less than three years and 23.9 per cent for three to five years. Although a quarter (25.8%) of the staff had 6–10 years of experience, only 15.8 per cent had served for over 10 years. This result may reflect high turnover. Although most are hired as 'regular' staff on continuous terms, just over half, that is, 54.1 per cent ($N=352$), of them were working full-time, in other words, 35 or more hours per week. Among all the part-time regular staff, 178 people (27.3%) were working 21–35 hours per week, and 18.5 per cent of all the regular staff were working less than 21 hours per week. Only 17.8 per cent of the staff were classified as 'contract' staff, that is, with limited-term positions. Most (87.1%) 'contract' staff worked part-time, that is, less than 35 hours per week. Of the 659 staff whose situation was identifiable from the information provided by the NHs, a great majority were programme staff (67.8%). Only 15.8 per cent were identified as managerial staff, with 9.3 per cent as support staff.

Discussions and implications

The results of this clearinghouse survey are limited by certain technical barriers. Some of the information, such as that of the service users and volunteers, was based on rough estimates. The aggregated information of the board members and staff information also prevented any advance statistical analysis, such as cross-tabulation. However, as an exploratory study, this survey does offer some interesting evidence to shed light on the resources and services of NHs and on their incorporation of local individual community assets – local residents and service users – into their infrastructure.

The findings confirm some of what has been previously reported in the literature. First, although it is difficult conceptually to define 'neighbourhood', if we treat each census tract as a neighbourhood, then most NHs in MV serve several neighbourhoods. Geographically, they are very close to most area residents, probably within walking distance. Second, these NHs are highly accessible in terms of their premises, opening hours and membership fees. Third, most provide multiple services to different age groups. Fourth, these NHs have substantially nurtured and mobilized volunteers to support their services. Last but not least, while the budgets and sizes of these NHs vary greatly, they all share the same financial predicament – relying heavily on the government's short-term and often non-renewable funding.

Indeed, the financial predicament has made it difficult for NHs to recruit and retain staff. Despite the government's rhetoric about rebuilding community, funding for community programmes is diminishing. The short/non-renewable funding model has led to a precarious part-time employment workforce in NHs. The neoliberal welfare regime prefers using a competitive process to allocate resources (Levin et al., 2006). The process pushes down the cost, that is, staff salaries. Contrary to Trolander's argument, NHs today may face a challenge of de-professionalization. As Fabricant and Fisher (2002) found in their study of NHs in New York, this financial predicament weakens NHs' infrastructure and human capital. Likewise, all these 15 MV NHs have only slim central administrative support systems, which are generally not funded by the government's programme-based funding. The relatively short years of service among the staff may reflect a high turnover rate. Budget concerns in turn limit staff qualification requirements. This may explain the low percentage of staff holding a Bachelor's degree or above.

That said, for better or worse, NHs' response to this financial situation may have, intentionally and unintentionally, provided the opportunity to incorporate into their infrastructure the individual community assets that they have nurtured. The results of this clearinghouse study show that a great number of the staff serving in these NHs are local residents and service users who are ethno-racial minorities, largely from immigrant backgrounds. The Canadian labour market is notorious for marginalizing immigrants (Hum and Simpson, 2004; Yssaad, 2012). For many immigrants, NHs – from which they have received help, learned new skills and made personal connections (Yan and Lauer, 2008) – are not only an ideal place to make contributions to the community, they can be a good stepping stone to their first job in Canada.

Trolander (1987) warns us that over-reliance on professionals (or paid staff) from outside the community may cause NHs to become disconnected from local residents and to drift away from its community-building mandate. However, most NHs serve a small community where residents may not have all the skills and qualifications that an NH needs in order to provide high-quality services to local residents. Therefore hiring professionals from outside the community is inevitable. Meanwhile, both nurturing and hiring local residents to serve local residents are important to NHs. These locally nurtured staff – that is, immigrants and previous service users – may help address some of the concerns raised in the literature. These locals are well aware of the culture of the organization as well as the dynamic of the local community. As both residents in the neighbourhood and users of the NHs, they bring local knowledge to their work and ground their services on

fellow residents' needs. As previous studies (Yan and Lauer, 2008; Yan and Sin, 2010) have found, this multi-ethnic and multi-lingual workforce is seen by NH leadership as an important tool for building community. It is an important linchpin of NHs' connection with local residents, particularly ethno-racial minority immigrants. It is also an important service resource, as NHs serve ethno-racially diverse populations.

Hiring ethno-racially diverse service users as staff is a good indicator of how these NHs incorporate local individual community assets as resources to serve residents. However, we are cautious about drawing conclusions on how successful this incorporation has been at the leadership level. At the board of director level these 15 NHs do have a substantial number of local residents, but the number of ethno-racial minorities is still relatively low. Similar observations can be made at the executive director level. The lack of ethno-racial minorities at the top of the organizational hierarchy raises the question of how sensitive the senior decision-making process is to the needs of ethno-racially diverse residents. Echoing the concern of Gans (1964), it also raises the question of how successful these NHs have been in breaking racial and ethnic lines in their community-building commitment.

As a final note, it is important to point out the role of the social work profession in contemporary NHs. The SH has been a major legacy which shapes the social change mandate and community practice tradition of the social work profession (Hayes, 1998). As reflected in the data, only a handful of staff in these NHs had formal social work qualifications. Also, according to our understanding of the 15 executive directors, one had a Bachelor of Social Work (BSW) and one a Master of Social Work (MSW). Many different factors may be causing this low involvement of the social work profession. Salary is certainly a factor. At least in Canada, social work positions in child welfare and health-related fields are paid much better than those in community service organizations, including NHs. It has been long argued that the prevalent therapeutic orientation of social work practice has pushed many social work graduates away from community practice, such as work in NHs (Specht and Courtney, 1994; Yan and Tsui, 2007). The low involvement of social work professionals in NHs raises the question of whether social work is losing its connection with its community practice and social change roots.

In brief, this study was not meant to provide an evaluative perspective of what NHs have done. As a clearinghouse study, it took stock of what NHs have had in terms of its resources, programmes and infrastructure. While the findings have echoed many similar observations of previous studies, they also raise a few questions that will need more in-depth and thorough studies. Before concluding, we have several suggestions of how to further strengthen NHs' capacity to build community in increasingly ethno-racial diverse communities.

First, funding is the number 1 concern. As existing studies have shown, lack of public funding has hampered NHs from performing their traditional role in community building. We agree with the analysis of MacLeod and Emejulu (2014) that simply asking the community to rely on its own assets, for instance volunteers, is not enough. It merely perpetuates the neoliberal welfare agenda of privatizing state responsibility to individuals in the community. Some scholars have already suggested the idea of bringing back SHs (Husock, 1993; Putnam, 2000) or supporting community-based organizations (Giddens, 1998) as a public policy option to strengthen the urban community. If these suggestions are valid, government may need to take this suggestion more seriously and consider more flexible and supportive funding models that can enhance the capacity of place-based community organizations, like NHs, to better serve the needs of local communities.

Second, despite their efforts to incorporate ethno-racial minorities into their infrastructure, many are still trapped at the frontline positions, most of which are short-term and part-time, which is itself a reflection of the marginalization of immigrants in the Canadian labour market. Thus, NHs will need to take tangible action to demonstrate their commitment to breaking ethno-racial lines at

the leadership level. Indeed, as Ospina and Su (2009) observe, ethno-racial diversity at the leadership level has the potential to create a hybrid vision of a collective identity of the organization, to appeal to collective resources embedded in the community and to empower ethno-racial minorities to participate in the community.

Third, social work educators should take a more proactive role in bringing the Settlement House Movement, one of the two major historical roots of the social work profession, back to the social work curriculum. This reconnection, which can be done through classroom learning, class projects and (more directly) field practicum, can also be useful in nurturing social work students' awareness of the historical roots and social change mandate of the profession, expanding their skills in the meso- and macro-practice and, hopefully, developing an interest and commitment in joining NHs to serve the community.[6]

In sum, as civil society organizations grounded in the local community, NHs are critical in building bridges not only among residents, but also between civil society and the state. Some recent studies, albeit limited in number, in both the United States and Canada, have shown that NHs have a strong commitment to and have made great effort to honour the community-building tradition of SHs. The 15 NHs in MV have further shown that while more will need to be done to elevate the incorporation of local ethno-racial minority individuals into leadership positions, these NHs have moved beyond the SH's tradition of merely nurturing and mobilizing individual community assets – they have incorporated them into their own organizational infrastructure to better serve the local community. To end our discussion, we would like to reiterate that the NH, as 'today's settlements', is a worldwide movement. To fully capture the movement and how and how well NHs in different countries honour the SH's community-building tradition, more studies are required at both the local and international levels.

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Notes

1. Unfortunately, the newest neighbourhood house (NH) was closed down recently due to financial problems. To honour its participation, however, we decided to include its information in this article.
2. This is in Canadian dollars.
3. Seven of the 15 NHs are members of the Association of Neighbourhood Houses of British Columbia (ANHBC) which is governed by a board of governors (BoG). However, each of these seven NHs has its own community board, which is highly autonomous in deciding the direction of services. Each community board also has one representative sitting on the BoG. For this study, with the advice from ANHBC, we decided to include information only on members of the community boards.
4. Conceptually, some of the labels used by the respondents are actually racial instead of ethnic. However, since these were the labels used by the respondents, we decided to report according to their answers.
5. These classifications are based on Canada's National Occupational Classifications.
6. We would like to thank one of the reviewers for helping us to better articulate the benefits of reconnecting social work students with NHs.

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