

# **From Multiculturalism to Superdiversity? Narratives of health and wellbeing in an urban neighbourhood**

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## **Abstract**

The nature, speed and scale of contemporary migrations represent a major challenge for human services and for social work practice. The concept of ‘superdiversity’, to date largely used in European academic circles, signals a new complexity in the debates about how best to respond to need in migrant-related diversity. This paper draws on this concept to explore the implications for social work practice and for service delivery. It reports on a study undertaken with residents in one ‘superdiverse’ neighbourhood in Melbourne, Australia. Utilising the superdiversity lens, this paper explores three key propositions of the superdiversity thesis namely: diversification, locality, and the need to shift beyond ethno-focal based approaches in service delivery models. The study finds considerable support for the added value of using a superdiversity lens to inform responses to need in migrant neighbourhoods but signals cautionary notes on the wholesale adoption of the superdiversity perspective, noting the significance of co-ethnic tracks in help-seeking behaviour.

**Key words:** migrants; superdiversity; health and wellbeing; urban.

## **Introduction**

The superdiversity thesis has entered social work. A concept rapidly gaining ground in European academic circuits (Vertovec, 2007), superdiversity is being applied in the field of health and social welfare

(Boccagni, 2014; Geldof, 2016; Phillimore, 2011, 2014; Van Robaeys et al., 2016;). The thesis holds that in an increasingly globalised world the speed and scale of migration has been accelerated, producing changes in the nature of migration patterns, increased demographic complexity and generating new types of issues and problems at the local level, particularly in urban contexts. The trend sees not only smaller numbers of people moving from many places to many places but carrying with them a complex individualised patterning of variables of difference (Vertovec 2011). These transformations, it is argued, have profound implications for public policy and professional practices (Phillimore, 2011) to the extent that traditional approaches to ethnic diversity are found wanting. The conventional orientation of service delivery has focussed on ethno-national categories, seeking to understand key barriers in access to services and to meet the needs of specific cultural groups based on the assumption of ethnicity as the primary cause of need for services or of disadvantage (Boese & Phillips, 2011; Henderson & Kendall; 2011; Paradies, 2006). This multicultural approach has also dominated in empirical enquiry, with researchers focussing on a particular national group(s) in their samples and the identification of their perceived needs and experiences (*inter alia* Warburton 2009) and/or on specific categories of need, such as the settlement of refugees (Sampson & Gifford 2009). Arguably, such an approach misses the complexities of the contemporary moment. Evidence from a range of contexts indicates migration statuses as increasingly complex, dynamic and diverse, as are the prospects and opportunities for new migrants in contemporary urban settings given their varying legal status (Meissner & Vertovec, 2015).

The descriptive force of superdiversity is compelling and, it is argued, is rapidly outstripping longstanding versions of multiculturalism as an explanatory frame in research, policy and practice. Service delivery is being challenged in response to this contemporary phenomenon as is the multicultural literacy of the average professional. Boccagni (2015), for example, argues that this conceptual transition offers *added value* to the theoretical map of social work, to the development of empirical work with migrants and to social work practice with migrants.

This paper reports on a study that explores the notion of superdiversity through the narratives of health and wellbeing of residents in one superdiverse neighbourhood in Melbourne, Australia. It pursues three specific and interconnected propositions fundamental to the superdiversity thesis (Meissner & Vertovec 2015) in order to draw out implications for shifts in the theoretical, policy and practice orientations in social work:

- complexity in demographic status as a result of global trends in migrant diversification
- the significance of locality – specifically the urban environment
- the need to shift from ethno-focal or community-based approaches in service delivery

Increasingly, attention is being given to the notion of localised welfare states, and this ‘scaling’ is of particular significance when dealing with the politics of social provision (Williams, 2016; Evers et. al., 2006). This paper will illustrate the significance of locality in accessing services and understanding need and how this relates to a new complexity in ethnic profile.

### **Superdiversity and social work**

The concept of superdiversity, first coined by Steven Vertovec (2007) encapsulates both the increased spread, speed and scale of migrations but also the “diversification of diversity” (Vertovec, 2007 p.1025). New migrants arrive in countries of transition or destination, often in small numbers from a range of places across the globe and encompass a wide range of variables of diversity beyond their ethnic status, including gender, age, labour market capacities and capital, legal status, rights and entitlements and personalised trajectories. As new migrants often settle in urban spaces that have hosted previous waves of migration, new complexities become layered on top of existing patterns of diversity, creating localised ecologies with specific dynamics that pose challenges to public service delivery. Phillimore (2014) has pointed out that it is not that diversity is new to urban contexts but the novelty, complexity and unpredictability of superdiversity, arising as a result of contemporary global connectedness, that presents fresh

challenges. Arguably, this makes it difficult to consider diversity simply in group or community terms in the ways in which previous cohort migration could be seen. The current understanding of migration and diversity in an urban context requires revision.

It is proposed that these new migrants have few social ties in cities of destination and experience isolation and marginalisation not incumbent on groups that form a more critical mass. They may have little experience of navigating services, find themselves in language enclaves, experience high level of exclusion and even face animosities from more established minority and majority residents in specific neighbourhoods (Stewart et al., 2008). In addition, superdiverse neighbourhoods experience residential transience which undermines the formation of social networks, erodes trust and hampers civic investment and participation (Griffiths and Halej, 2015).

What the superdiversity thesis has brought to the fore is increased attention to the relative import and dynamic of intersectionalities of difference that take us beyond ethnic determinism (Boccagni, 2015); increased attention to the notion of superdiverse neighbourhoods as places and spaces of change (Pemberton & Phillimore, 2016) and increased attention to innovation in provisioning, both formal and informal that can address the need for more personalised social service delivery (Griffiths and Halej 2015).

Just a handful of discussion papers and studies have engaged with the concept of superdiversity and social work to date (Van Robaeys et al., 2016; Geldof, 2016; Boccagni, 2015). The thrust of the argument is that social work is ahead of the game (Van Robaeys et al., 2016; Boccagni, 2015) in an era in which diversity is a 'normalised' dimension of practice and engaging with ethical complexity part of the established professional repertoire. Even if empirical evidence is limited, considerable confidence is placed in the theoretical bedrock and value base of the profession to accommodate superdiversity. Both Boccagni's discussion paper and Van Robaeys et al.'s empirical research do argue, however, that the superdiversity lens advances the theoretical and practice terrain in its ability to elucidate differentiation and counter the tendency towards ethnic essentialism and over-

culturalisation and “to inform practitioners about important characteristics of contemporary urban working contexts” (Van Robaeys et al., 2016, p. 11). This qualitative study is more circumspect, raising some searching questions in advancing debates about superdiversity and engaging with Meissner and Vertovec’s caution that, “superdiversity can and should always be critically interrogated, refined and extrapolated by way of fresh data” (2015, p. 542).

## **The study**

This small scale study set out to explore the ways in which a diverse group of residents in one superdiverse neighbourhood mobilise, utilise and combine services around their health and wellbeing needs from within and beyond the suburb boundaries both literally and virtually. The study aimed to illustrate these practices and draw out the implications of superdiversity for formal service delivery. Residents were asked about the kinds of things they do to stay healthy and well and invited to discuss the strategies they adopt to maintain good health and wellbeing, about their encounters with formal health services in the locality and beyond, and about connectedness to their local community. The WHO definition of ‘health’ underpins the study: “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” (1946). Participants accordingly might include personal health practices, social support networks, their social and physical environment, safety and feelings of wellbeing.

## **The study context**

Australia is recognised as one of the most successful multicultural nations in the world (Kymlicka, 2012). Cities such as Melbourne have developed and expanded with waves of migration from the ‘old’ European migrations, particularly between the 1950s – 1970s that brought large numbers of relatively homogenous groups of people from the UK and Europe, and following the end of the White Australia policy in the 1970s steady blocks of migrants from countries such as Vietnam, China, and India (Colic-Peisker, 2011). Melbourne has the same percentage of overseas born as London and is ranked the

fifth most diverse city in the world according to International Organisation for Migration (IOM, 2016). As with most cities the settlement of these ethnic groupings was spatially marked with discrete suburbs reflecting a dominant ethnic community cluster marking out a recognisable Italian quarter, a Greek area, Jewish, Vietnamese and so on. A departure from this migrant patterning of the city has come with more recent migrations which see relatively small numbers of people coming from a greater number of countries from across the world. A quantitative shift has occurred as today 57.9% of Melbourne's population have one or both parents born overseas. The city is beginning to manifest key characteristics of superdiversity with extremely heterogeneous areas emerging where many new arrivals do not become part of established ethnic clusters and where no one ethnic group dominates. This is occurring against the backdrop of differential recourse to rights and resources held by various groups: national (Indigenous) minorities, ethnic majorities, immigrant minorities and ethnic minorities, all of which shapes the picture of contemporary diversification. Australia has an elaborate and sophisticated net of settlement services, especially in relation to humanitarian arrivals [new migrants being guaranteed 6 months dedicated support on arrival] and a longstanding and buoyant ethno-specific organisational infrastructure operating in major cities.

The study suburb, Footscray, which sits within the local government area of Maribyrnong, represents an interesting case study of this effect. Maribyrnong has the second most ethnically diverse population in Victoria, with 40% of residents born outside Australia of which 29% have arrived in Australia within 5 years prior to the 2011 census. Residents come from more than 135 different countries and speak over 80 languages (ABS Regional data 2016).

In Footscray itself, those overseas born rise to 59% of the population, only 8.7% coming from countries in Europe. Footscray has a long history of diversity, once being a centre for Greek, Italian and former Yugoslav migrants. Today, the largest minority ethnic groups are Vietnamese and Indian (9.4% and 7.3%). There is a small Chinese population (4.9%) and a small middle band of countries represented by

1-200 people, mainly Africans, Europeans and New Zealanders. The area has seen a major increase in residents from Sudan, Ethiopia, Somalia, Bangladesh, Sri Lanka and Myanmar since the last census, including a large proportion of refugees and international students. Footscray's linguistic landscape is characteristic of the new diversity of Melbourne with some 35% of the overseas born population being from non-English speaking backgrounds. Aboriginal and Torres Strait Islander people account for 0.5% of the area's population. In Footscray, one in five residents have a disability (17%); 8.8% are unemployed and 58% have access to the internet at home (ABS Regional data 2016).

The area has begun to undergo gentrification and housing affordability has reduced. Considered to be well serviced with health and social care support Footscray has a major health centre, The Neighbourhood House (located in West Footscray), a nearby hospital, and University, with the Maribyrnong council explicitly foregrounding approaches to multiculturalism.

## **Methods**

In-depth, semi-structured, qualitative interviews were conducted with 15 residents in the suburb of Footscray between November and December 2015. The interviews were undertaken by a community researcher, herself multilingual and of migrant background (9 years in Australia) who had been a resident in Footscray between 2011 and 2015. Based on her local knowledge she utilised maximum variation sampling to establish a wide range of cases in order to identify important common patterns that cut across difference (Phillimore, 2014). Each new participant in the study would accordingly manifest a set of combined characteristics not already present in the sample. No attempt was made to select participants on the basis of vulnerability or expressed need. A demographic data form covered factors such as age, gender, marital status, languages spoken, faith, ethnicity, time in Australia and in the neighbourhood, employment status, visa status, housing, and educational level.

The inclusion criteria stipulated residence in Australia of over 18 months in order to ensure they were beyond the net of formal settlement services. The age of respondents ranged 28-78, 9 women and 6 men; 4 respondents identified as single and 9 partnered (2 non response), 7 identified with a religious faith including Buddhist, Muslim, Catholic, Hindu and Christian faith groups. The majority of respondents were unemployed, in casual work or studying, with the period of residence ranging from 1.5- 48 years. A range of countries was represented in the sample including Vietnam (n=2), Italy (n=2), India (n=4), Hong Kong, Ethiopia, Fiji, Philippines, Ireland, Scotland and New Zealand.

Six of the respondents were identified through existing networks in the community; the remainder (n=9) were recruited via the West Footscray Neighbourhood House, a multi-purpose community centre delivering a range of projects including a playgroup, English language classes. All interviews were conducted in English and interviews lasted approximately 60 minutes with no interview lasting longer than 90 minutes. Respondents were given a \$40 gift voucher on completion of the interview.

Ethical review and approval for the study was undertaken under RMIT University ethics protocol. All respondents signed a consent form.

## **Findings**

### **Demographic diversity**

The participants were selected to demonstrate a range of diversity of status in one locality. In several respects each reflected the complex intersections signalled by the superdiversity perspective. A 28 year old female Italian student with no local social network on a temporary visa encountering a sexual health issue (#2); a 30 year old mother from India of Muslim faith with one child locally and one child transnationally with temporary residency and no social network expressing deep loneliness (#15); a Tamil woman with permanent residency looking for a job (#13), a 54 year old male Fijian who talked about being “sad but not lonely” (#5) and a 67 year old male New Zealander on a disability pension living in community housing (#11).

Their stories spoke to what Boccagni has noted as the dynamic of their plural status: “shifting trajectories that situationally put different salience on these intersection differentiations” (2015, p. 613), thus making problematic any attempt to impose category or homogeneity on their experience.

The participants’ status was mobilised in different ways in their accounts. For example, for the Italian student her lack of entitlement to health care costs and irregular hours of work meant she had delayed seeking help for her condition which had exacerbated. For her, ethnicity and language had no bearing on her help-seeking, indeed she stated, “others may have more difficulties... people from India, Asia and Africa who have a different culture whereas European is not seen as different and therefore not such a difficult situation” (#2). By contrast, for the Indian mother, her Muslim faith meant she could not go to the local male doctor without her husband, so she had moved on in search of a female doctor but had then to rely on her husband further to take her on public transport thus restricting her freedom of movement; “here life is so lonely...in India you can go where you like ...” (#15).

The complex demographic illustrates not just a static diversity of status but more critically raises the questions of the role of other intersectional variables of status and asks when and for what purpose ethnicity/culture is mobilised by individuals as relevant to their experience. In this example, legal status and entitlement are brought into view as orchestrating health and wellbeing decisions for one and gender and faith for another. Here the superdiversity approach eschews an over-reliance on ethnic essentialism and decentres culture as the organising principle for intervention. It normalises and restates the simultaneously relevant multi-dimensional aspects of migrant differentiation.

### **Broad conception of health and wellbeing**

Generally, the health literacy of the respondents was high with references to healthy diet, exercise, nutrition, and mental and spiritual health and wellbeing achieved through association, self-help practices

such as yoga, singing, meditation and complementary medicines. A strong theme related to the spiritual self and the role of spiritual health.

“Mentally we should be optimistic. We visit the temple at least once a fortnight so that we have peace of mind and children get used to our culture” (#13 Tamil female).

“Prayer keep you positive” (#9 Indian male).

References to ‘home remedies’, ‘traditional medicines’, and peripheral health services including acupuncture, homeopathy and naturopathy were not uncommon. Preventative measures, which in some cases were marked as ‘cultural’, ‘traditional’ or from country of heritage or background heritage, including complementary medicines appeared to be used at the mild end of health conditions or as a first step but with clear signals that they were not in themselves seen as a panacea. One of the respondents, a second generation Vietnamese resident, living in Melbourne for 28 years, talked about her mother’s “curious advice” to rub onion on her head for a hair loss condition and referred to use of mum’s recipe drinks as a source of comfort harking back to her childhood and to Vietnamese traditions (#1). A Tamil female uses “ginger tea but I will also take Panadol...we use English [Western] medicines but as far as possible we try to go with the herbal remedies” (#13).

The use of complimentary medicines was linked to control over one’s own health, self-help and an emphasis on autonomy from services in attempts to resolve own health issues.

“I try to control myself. I can’t depend on the tablet, I ready to fix myself back to normal’ (#12 Vietnamese female)

And, “It depends on the sickness because with Chinese medicine it takes longer. Specialist advise me not to use it.”

The role of culture in health beliefs and practices is well known (Purnell, 2014). In common with other research, the majority of participants in this study looked beyond Western conceptions of health as sickness to a holistic conception of wellbeing (Stewart et al., 2008). They combined health knowledges – lay and formal - rather

than seeing them as either/or; used internet for research, family and community advice and saw a range of remedies as the starting point on a continuum or matrix that would include formal services at some point. Their first recourse was not to formal services but several recognised a tipping point: “I try to get recovered with my own body. I don’t trust much in the medicines. I give my body time. If it’s not working, then I go to the GP” (#14 Indian female).

Several respondents saw helping others as having a positive bearing on their own wellbeing. The power of gift, of sharing, volunteering and looking beyond self was seen as connected to feelings of positive health. This theme forms a strong continuity with existing research on migrant perceptions of health and wellbeing (Stewart et al., 2008). The superdiversity lens can indicate not simply that these factors have thematic relevance across a variety of ethnic groups but also that they pertain irrespective of length of residence.

### **Transnational connections**

All of the respondents, except a 78-year old Italian female, used social media to keep in touch with friends and family, to take and share advice on health conditions and most mentioned the internet as a source to supplement health knowledge. Interviewee #1 saw Skype as important to her mental health. Addressing a generalised other she commented: “I have some emotional pain so I want to Skype with you”. This evidence of ‘emotional transnationalism’ (Takeda 2012) was just one form of many instances of transnational care and reciprocity that featured in in their stories. In discussing wellbeing, one interviewee (#9) spoke about generating laughter for the benefit of others and said he “writes jokes on Facebook” for friends and family. Family connections were mapped in the participants’ accounts, some local, some trans-local, some transnational. Some attested to discussing their health with family members overseas, others did not want to burden relatives but transnational connectedness was a feature in all accounts.

The natural to and fro between family and friends is hardly surprising but for several these transnational connections hold greater significance in terms of health and wellbeing and access to health care.

Two mothers in the sample had gone home to give birth to their children to ensure social support – one reported an exeat of: “from when I was four months pregnant and till my son was 5 months” (#13). One respondent had an 8 year old living in India, whom she could only speak to at weekends because of school hours (#15). Another respondent had foodstuffs and jeans coming over with his brother from Fiji (#5). He also described how the main reason for coming to Australia was his daughter’s diagnosis with child diabetes. In interview, (#4) one respondent reported his brother had visited recently and brought ‘traditional medicine’ from Ethiopia and was now selling it locally. He made reference to his financial support of his mum and younger brother back home which was built into his equation about access to health and wellbeing in Australia.

These forms of transnationalism are significant to understanding the support needs and capabilities of migrant communities as confirmed in the literature (Schrooten et al., 2015). These migrants, irrespective of length of residence in Australia, maintained transnational lives that had crucial significance to the ways in which they mobilise and mix sources of support and care. The paucity of available networks of compatriots at local level *may* make these transnational connections even more potent in superdiverse neighbourhoods and they are clearly an important dimension of the local micropolitics of care.

### **Perceptions of formal health provision**

All respondents had used formal health providers and several were linked to a major health centre in the locality. The level of satisfaction with this provider varied with a common issue being the long waiting times. Navigations of the formal health system included considerations of cost, proximity, waiting times, time paucity and distance, perceptions that elsewhere had better services or a better clientele, and perhaps most significantly, ethnicity (including intersections with gender, language and faith) was evident as a strong orienting factor in choice, irrespective of time spent in the country or legal status.

The literature is typically ambivalent about the issue of ethnic matching in health care delivery (Cabral et al., 2011). Nevertheless, this

represented a strong and spontaneous theme across this diverse sample of individuals. A Vietnamese female (#1) referred to this issue as being at a point of transition. As a child her father used to take her to a Vietnamese doctor but she argued that the doctor, having current skills irrespective of his/her origin, was now more important to her. An Ethiopian man (#4) has a “family doctor” that he sought out as his wife doesn’t speak English so well. The family can speak Amharic with their chosen GP and he says this is “more comfortable than with a European doctor”, so he has told his two sisters to use this doctor as well. “If she goes to another doctor I have to be there all the time”, he reported. This doctor is based in another suburb but there is also a doctor in Footscray who speaks Arabic and Amharic, “so even the Sudanese people go there as well”, he stated. An Indian woman (#13) described how she chose the doctor by her name alone as “every community has the same name”. She saw her as “closely related to our culture, so she knows about children in our country...we communicate both in English and Tamil”. Interviewee #1 said, “In the Vietnamese culture it’s difficult to bring mental health to the forefront – he (dad) would scoff at seeing a professional and I don’t know if there are any Vietnamese psychiatrists about ...”, followed by a reference to his language needs.

The term ‘family doctor’ was frequently used to signal a doctor that could meet cultural and linguistic needs. Across the sample the desire for ethnically matched provision was expressed, sometimes referenced to language, sometimes more broadly to culture. That said, there was an evidence of some mixing and matching that took in considerations of cost and of the skill of the doctor: “I’m not 100% with one doctor, some are cheap but they give wrong advice” (#12).

Overall, the interviews reveal a number of aspects that inhibit access to formal health care including irregular hours, religious requirements, time and money, waiting times, lack of identification with the profile of clients at a health provider, whilst ethnic tracks remain evident and purposeful in relation to language, association, cultural maintenance and child welfare. It appears that even in superdiverse

neighbourhoods, co-ethnicity remains important in shaping agency and action.

### **Locality, association and belonging**

The dynamics of welfare need, recognition of need and provision vary by place (Williams, 2016). Residents' experience of accessing welfare services in their suburb and elsewhere vary according to their previous experience, needs, knowledge of rights and entitlements and approaches to identifying and utilising services (Phillimore, 2011). While Australian social welfare research, with few exceptions, has tended to downplay or neglect the issue of ethnicity in place (Sampson & Gifford 2009), studies elsewhere have shown that local welfare structures and place shape not only access to services but also many aspects of their content (Brondeel et al., 2014). The notion of 'area affects' is closely associated to help-seeking behaviour and wellbeing (Atkinson & Kintrea, 2004) but little is as yet known about how migration and localised welfare regimes impact on access to services for the residents of superdiverse localities in Australia.

Several of the respondents referenced the major health care centre in Footscray and spoke to a mental map of the area which included a key pharmacy, a sleep clinic, a large general hospital and a neighbourhood house. Other points of association were mentioned with local services being augmented by trans-local forays in search of choice and bolstered by the mobilisation of self-care strategies. Temporal elements shine through the navigations each respondent makes in accessing patterns of support, care and health care. Distance and proximity were mentioned, time waiting, not much time, time passing and time spent. There were references to another time. For instance, #9 said, "I was healthy in India, I was used to a very different environment – things didn't affect me", and #10 spoke of "having the doctor for a long time" and it being important that it was the same doctor as her daughter and family. #9 spoke of being "ahead of time" early in the morning when things are fresh "and the oxygen is good" as conducive to his wellbeing. Movement across the city and public transport to formal health care was frequently mentioned with good transport links and proximity to the city valued.

Access to services within and outside the suburb was affected also by physical mobility and/or limitations to this. In the transcripts, a New Zealand man (#11), disabled and previously homeless, describes the parameters of his shopping trip as proscribed by his mobility scooter. He spoke of the freedom to go over to shops in a nearby suburb and then with “still heaps of charge” make his way to the cheap shops in Footscray, “everything is wonderful except my health...now I’m finding out there’s a network there that you can have food in your mouth even if you’ve got no money”. He spoke of considerable support services for disabled people and at the same time expressed no small measure of welfare enmity towards neighbouring ‘Asians and the Africans’ claiming that – “they all get looked after”.

Residents in this sample had lived in Footscray for anything between 1.5 years and 48 years. Most of the interviewees would not wish to live elsewhere, either because they got used to the neighbourhood, because they liked its diversity or perhaps as a result of being constrained by lack of affordable alternatives. One participant (#15), a Muslim woman with a young child, expressed a desire to move to the northern suburbs which have a higher proportion of Muslim population and better access to Islamic services, particularly schools.

The interviews revealed both tensions and rewards of multicultural living, all participants acknowledging the diversity of the area and its issues, including poverty, drug issues, perceived criminality and ‘the crazy season’ (#3 female New Zealand-Chinese), the vulnerabilities of newcomers transitioning in the community, stress and loneliness. They attested to a place that is both diverse and welcoming. However, there were very few references to neighbours as friends or confidants. Most did not have contact with neighbours or talk to strangers much. A Scottish participant (#8) who had lived in the area for three years and had young children observed Footscray as highly multicultural but with little cross cultural connectedness. The respondent’s networks evident in the scripts were smaller, ethnically determined networks of family and friends and religious association. Neighbourliness was not a factor apparent in this study. Ethnic friends and association were far more potent.

An interesting question raised by the superdiversity perspective is whether quantitative diversity reflects qualitative diversity. In short, how diversity is experienced by residents. Pemberton and Phillimore (2016) in the context of the UK, discuss migrant place-making in superdiverse neighbourhoods and argue that beyond single ethno-national settlement:

“Superdiverse neighbourhoods are not just third spaces where diversity is tolerated but liminal spaces where no dominant neighbourhood identity becomes embedded. Thus, once established as such, they are places that new arrivals can identify with in various ways – through newness, ethnicity, faith or language” (2016, p.15).

Their claim is that places where a common neighbourhood identity is based around diversity and ‘embedded’ are conducive to what they call ‘ideal’ place-making by contrast with areas where the speed and constant churn of newcomers undermines affinity with place (see also Colic-Peisker & Robertson, 2015). Our study gives some support to Pemberton and Phillimore’s claim, with several of the respondents making reference to Footscray’s image as a diverse community. Just one example might be: Footscray means “I can feel like myself here and I don’t know that you can do that in many places in Melbourne ... what makes it stronger is that we are all different here and we feel like we are underdogs...the struggle brings people together” (#1 female Vietnamese).

That said, there is some evidence in the study that the ethnic tracks that feature large in association serve important functions for the residents’ wellbeing, but are not exclusive. This is typified by one Vietnamese respondent (#12) who discusses with the researcher her two churches and their relevance. There is “the Vietnamese one” and the one where “all multicultural people come to the Church” which she later refers to as “the English [usually meaning Western] one”. She states that she likes to be involved in both of them and takes the children to the English one so that they can “join in, make their life better” and to the Vietnamese one: “for the spirit, ... for the Vietnamese language” and to learn how to help other people and not to discriminate.

These features of locality, association and belonging, of neighbourliness (or its absence) in support and care are enhanced via a superdiversity analysis. This perspective revitalises a situational approach to understanding need. More tentatively this study suggests that below the surface of quantitative superdiversity, ethnic enclaves continue to exist and be mobilised in the city and co-ethnicity is still an important orchestrating factor in shaping everyday lives, choices and opportunities.

## **Discussion and Conclusion**

Superdiversity has emerged as an influential explanatory frame in Europe in the field of migration studies, challenging the reliance on the uncertainties of multiculturalism (Meissner & Vertovec, 2015). Policy and practice approaches that might have worked in the past are no longer seen as relevant in the new landscape of diversity of peoples, place and changing identifications and expectations (Berg & Sigona, 2013; Ambrosini & Boccagni, 2015).

This small scale, qualitative study illustrates some of the key dimensions and considerations evoked by adopting a superdiversity lens. Three propositions of the superdiversity approach were considered: demographic complexity, locality and ethno-specific service delivery. The study revealed the complex axis of identifications as they come to bear on help-seeking behaviour, prompting us to consider the relative salience of ethnic (and other) factors in shaping health and welfare experiences. As such this line of enquiry takes us beyond monolithic, ethno-cultural categories of difference to suggest more complex and nuanced understandings of the multiple axes of identification that pertain to an individual's circumstances.

The study also served to highlight the significance of place in understanding how responses to need are mobilised (Williams, 2016) and to recognise the distinctiveness of areas of settlement in cities that don't reflect one dominant ethnic group but pose new issues of cohesion, settlement and the identification of needs as a result of their complex diversity. Within this, transnational connections emerged as

significant, perhaps explained by reference to thin social networks available in the locality.

This study has pointed to the agency of individuals in responses to their wellbeing as they draw on a matrix of services formal and informal, virtual and corporeal, local, trans-local and transnational in complex combinations. It has identified a range of considerations that impact upon their health and wellbeing decisions, with a strong emphasis on autonomy and self/family help over recourse to formal services. The data confirms the role of spirituality and religious association as linked to support and care (Crisp, 2010), and the resource and resourcefulness embedded in neighbourhoods is established as an important factor.

In relation to the question of shifts beyond the conventions of the multicultural approach the jury is out. On the basis of our evidence we are less convinced of Phillimore's assertion that the emergence of superdiversity renders the provision of culturally specific services impossible (2014). The type of packages individuals in this study assembled for their care and support continued to flag the significance of ethnic tracks in their help-seeking behaviour. Arguably, detailed exploration of the continuities and discontinuities rather than either/or of ethno-specific or generic diversity provision is the way forward. The significance of ethnic tracks in help-seeking activity irrespective of length of residence do suggest the continued salience of co-ethnicity in the mobilisation of support and care even within superdiverse neighbourhoods. That is, residents put considerable effort into maintaining co-ethnic ties for a number of instrumental reasons associated with wellbeing. What will be important to consider are the nature and types of departures from this bonding that are made by residents in place.

The implications of superdiversity for service providers, including social work practitioners, are beginning to become apparent (Boccagni, 2016; Geldof, 2016). As such it calls for a sophisticated, multicultural literacy on the part of practitioners that moves beyond us and them categories of traditional multicultural approaches, a process that as yet has only marginally been evidenced (Van Robaeys et al., 2016). The

*'Beyond Bricoleur'* practitioner (Dran, 2014) may need to become more attuned to utilising the kaleidoscope of the superdiversity lens; but to focus simply on the skills and aptitudes of front line workers is to miss important shifts that need to take place in organisational and institutional cultures.

Consultation and collaborative mechanisms will need to become more refined in this era of extended personalisation and organisations will need to review the models they deploy to respond to diversity (Seeleman et al., 2015), including attention to the diversity of their workforce. This does not come without resource considerations that form a useful tension with the more personalised provisioning implied and prompt the search for alternatives and new types of partnership between formal, informal and not-for profit sectors. Superdiverse neighbourhoods present new demands but also generate innovations as a response to localism and to cuts in government funding which deserve investigation. New service models will need to be developed, new collaborators and alliances and new levers for intervention at scalar levels of the city will need to form a more substantive part of the professional repertoire (Williams, 2016).

The tentative nature of this study rests on its small scale. Despite the rich transcriptions, a caveat must be that respondents were most often speaking in their second or third language; that they were clearly more capable respondents in terms of navigating their own health care and wellbeing, perhaps by virtue of their recruitment via The Neighbourhood House; and the inclusion criteria of 1.5 years' residency will have missed some of the newness and churn of the most recent arrivals.

In concluding, some cautionary notes need to be signalled about any wholesale jumping on board the superdiversity bandwagon. Indeed, some have considered it yet another Eurocentric idea (Piller, 2014), seemingly more novel and unique than it actually is. Its 'newness and novelty', as asserted by Phillimore (2014) is disputed against the historical record (De Brock, 2015) or in particular world regions (Piller, 2014) and its application and relevance clearly varies according to a number of contextual factors within nation states (Meissner &

Vertovec, 2015). Arguably Australia, as a settler society, is and always has been superdiverse even if the nature of that diversity has changed over time and the normalisation of diversity has not always been embedded in public policy circles.

It should be recognised that this perspective underplays ‘visibilities’ of difference (Colic-Peisker, 2009) and the orchestrating power of racism and other structural factors in shaping the lived experiences of individuals. The systemised nature of exclusion of some groups in society can easily be overlooked within a perspective that focuses on individual rather than group recognition and that neutralises power differences. In its focus on everyday lived experience, superdiversity may neglect the import of collective mobilisation and the strategic essentialism minority groups themselves deploy for political leverage and the history of those mobilisations. There is a sense that if you are looking for it, you will find superdiversity; but it may be that continuities and especially those embedded in migrant politics and the associated infrastructures may be of far greater import to securing responsive service delivery than a reactive focus on newness and novelty. In the light of neo-liberal disaffection with multiculturalism in Europe, Ambrosini and Boccagni (2015) found a significant persistence of multicultural–style practices in urban level migrant policies and funding streams, albeit reframed, at least in pragmatic recognition of cultural differences.

Nevertheless, superdiversity represents an interesting shift in refining service delivery, ‘*a conceptual work in progress*’ (Meissner & Vertovec 2015. P. 542) and has the potential to introduce for research and for practice greater social complexity in responding to migrant-related diversity.

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