When Crises Meet:

An examination of the role of soup runs and day centres in responding to homelessness in Dublin and how the ability of these services to provide spaces of care in the city has been affected by the outbreak of COVID-19.

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1. Introduction

On the 29th of February 2020, the National Public Health Emergency Team announced the first case of Coronavirus in Ireland. Less than two weeks later, the first death in the country due to the virus was confirmed. On this same day the World Health Organisation held a media briefing in which the Director-General of the organisation stated: "We have […] made the assessment that COVID-19 can be characterised as a pandemic", emphasising that it is not just a public health crisis but a crisis that will "touch every sector" (WHO, 2020). With Ireland's first national briefing on the 12th of March announcing the closure of schools, colleges and childcare facilities effective immediately, it became clear that the ensuing measures that would be taken to slow the spread of the virus were going to have a profound effect on 'normal' life. On the 24th of March the government advised all non-essential retail outlets to close and this was followed by the Taoiseach's second national address on the 27th of March, which announced stricter public health measures, with the main message being to stay at home.

This advice however, would either not be an option or pose significant challenges for a number of people in the population, particularly those experiencing homelessness. In fact, around this time, a number of organisations including the European Federation of National Organisations working with the Homeless (FEANTSA), the European Pubic Health Alliance (EPHA) and the United Nations (UN) issued statements in which they expressed concerns regarding the vulnerability of those experiencing homelessness in relation to COVID-19 and highlighted a number of ways in which this group is at risk. Firstly, many of the measures aimed at the general population such as staying at home, self-isolating and practising good hand hygiene, are not possible for those who have no place to live. For those staying in temporary or emergency accommodation, such as hostels, night shelters and even family hubs, adhering to these guidelines may also be difficult, as in these spaces there are often many people to one room and hygiene facilities are shared, putting them at a higher risk of transmission. Secondly, homeless people are a medically high-risk population as they are disproportionately affected by poor health and disability (FEANTSA, 2020). Respiratory disease is common among homeless populations (FEANTSA, 2020) and some suffer from complex health issues, including tri morbidity (EPHA, 2020). Lastly, homeless people face a number of barriers to accessing health care and public health information. Given the vulnerability of this group, FEANTSA issued a statement calling on all public authorities at local, regional, national and European levels to work with homeless service providers to ensure

that resources and attention flow to measures taken to meet the special requirements of people experiencing homelessness in the context of COVID-19 (FEANSTA, 2020).

The vulnerability of those experiencing homelessness outlined here is particularly concerning in an Irish context, as Ireland is currently experiencing a homelessness crisis. In fact, according a report from the European Social Policy Network "homelessness is at its highest recorded level ever in Ireland" (Daly, 2019, p. 6). The rapid growth of homelessness in Ireland, particularly in the past five years, has been described as "hyperinflation" (O'Sullivan, 2020, p. 13), with it being noted that very few other countries have experienced such a dramatic increase in homelessness in such a short space of time (O'Sullivan, 2020, p. 73). While there are a 'constellation' of factors which have driven the current problem of homelessness and housing exclusion (Daly, 2019, p. 6), the most prominent factor in this explanatory constellation is the housing market and this has been well-documented in the literature.

The movement towards a neoliberal style of governance is most often cited as the driver behind changes in housing policy which have fuelled the housing and homelessness crisis (McLaren and Kelly, 2014). For example, the provision of social housing has been completely transformed under neoliberal policies, intensified by the austerity regime which followed the economic crisis (See: Finnerty, O'Connell and O'Sullivan, 2016; Hearne, Kitchin and O'Callaghan, 2014; Hearne and Redmond, 2014). Over the last three decades these policies have shifted the responsibility of supplying social housing from the state and local authorities to the market (Hearne and Murphy, 2018). During the Celtic Tiger years (mid 1990s to the late 2000s) also, many existing social housing units in Dublin were regenerated through public private partnerships which led to a decline in existing social housing stock and an increase in rental prices in newly built units. Such changes in the provision of social housing 'have served to erode' existing social housing infrastructures (Hearne, Kitchen and O'Callaghan, 2014) and despite the fact that the rate of construction and acquisition of social housing has gradually increased from 2015, demand still massively outstrips supply (O'Sullivan, 2020, p. 74). The present trend is that private accommodation is coming to replace, rather than complement social housing.

This trend has been further solidified through rent subsidies for private market rented accommodation such as the Rent Supplement and the Housing Assistance Payment (HAP), provided to low income families by the state. It has been argued that this system of supplementing rent has become a de facto, marketized quasi social housing sector (Daly, 2019; Hearne and Murphy, 2017) and Byrne and Norris (2019) have argued that it has come to replace

social housing in Irish housing policy. These rent supplements, upon which many low income families rely, however, are less secure than social housing tenancies as the rental market is not very strongly regulated and landlords can terminate tenancies with relative ease (O'Sullivan, 2020). Moreover, the reliance on and increased demand for private rented accommodation, at least before the outbreak of the virus, contributed to the affordability crisis which manifested itself in spiralling rents, which, it has been argued, further provides a rationale for landlords to terminate tenancies in order to command higher market rents (O'Sullivan, 2020).

Clearly both housing policy and market forces played a predominant role in driving the current housing affordability and accessibility crisis and thus while historically and contemporaneously there has been a pervasive view that homelessness was the consequence of a range of individual failings such as addiction and mental illness, the changing demographics of those experiencing homelessness, particularly the rise in homeless households, drew attention to the centrality of housing markets in creating homelessness (O'Sullivan, 2016). It is this 'hyperinflation' and perhaps also this changing demographic, which have given rise to a 'gamut' of responses to homelessness in recent years, including additional emergency accommodation, preventative services and an 'extraordinary range' of street-level responses (O'Sullivan, 2020, p. 15). These have grown particularly in Dublin where the issue of homelessness is most acute. In fact, of the 6614 homeless adults recorded by the Department of Housing, Planning and Local Government in Ireland in February 2020, 4550 were concentrated in the Dublin region (Department of Housing, Planning & Local Government, 2020). The definition of homelessness upon which these figures are based however, refers only to: "those individuals accessing state-funded emergency accommodation arrangements that are overseen by housing authorities" (Daly, 2019; based on the Dept. of Housing Planning and Local Government). In other words, these figures do not include those members of the population sleeping rough, the hidden homeless, those in long-term supported accommodation or families in domestic violence refuges (Daly, 2019). There is, however, a biannual rough sleeper count carried out by the Dublin Region Homeless Executive (DRHE), the lead statutory local authority in response to homelessness in Dublin provided by Dublin City Council, which recorded 128 rough sleepers in the Spring of 2019 and 90 in the winter of 2019 (homelessdublin.ie, 2020a; 2020b). While the drop in numbers in the winter might seem like an improvement, it may only be due to short-term seasonal differences, with people who would not usually seek emergency accommodation perhaps doing so due to harsher weather conditions, or people being taken in by family or friends coming up to Christmas for example. Regardless of these fluctuations and potential reasons behind them, there are a significant

number of people either sleeping rough or in emergency or temporary accommodation in Dublin.

Much like homelessness is concentrated in Dublin, so too is the Coronavirus, with over 50% of reported cases in the country in mid-April located in Dublin (Power and O'Brien, 2020). It is in densely populated areas where the risk of transmission is highest and this applies to environments from the city level all the way down to densely populated accommodation spaces such as shelters and hostels, and service spaces such as day centres and soup kitchens. The risk of infection and frequently changing measures against COVID-19 pose challenges to both homeless people and the services offered to them. Early news reports drew attention to the increased risks facing this already vulnerable population, with concerns being raised by members of this population: "During the first few days of this crisis the homeless were forced to frequent restaurants, cafés and pubs in order to feed themselves and avail of toilets and bathrooms […] Today almost every business in Dublin is closed and still the homeless roam the streets for hours on end with nowhere to go for toilet facilities and must stand in out of the weather, or cook for themselves." (Halpin et al., 2020). The closure of retail units and public space has a knock-on effect on the daily lives and routines of many homeless, as explained by Louisa Santoro CEO of the Mendicity Institute: "There are people who would spend a day in the bookmakers, others who might sit up until 10 o'clock at night in McDonald's, and those who might use a gym or whatever for a shower. These places have now all disappeared" (McDermott, 2020).

This plight was added to as many services, particularly day centres and soup runs, found it increasingly difficult to adhere to social distancing protocols. Early reports showed that services were hopeful that they could remain in operation: "We like to think that we will always be out and we will always show up" (Denise Caroll, Group Coordinator Homeless Street Café, in: Bromwell, 2020). However, this hope was short lived with many services having to cease or adjusting service operations (Freyne, 2020; McDermott, 2020). However, as per the list of essential services issued by the government on the 28th of March, 'social work and social care activities (including homeless services including outreach)', 'community and voluntary workers, working in a publicly commissioned service, not otherwise included on the list, deployed to assist in the delivery of essential services' and 'volunteer services operating under the local authority emergency management framework in accordance with public health guidance' were allowed to remain active (Government of Ireland, 2020a). These circumstances gave rise to the question of how the landscape of homelessness services in Dublin has been

affected by COVID-19 and led to the formulation the specific objectives of this thesis outlined below.

1.1 Specific Objectives

The overarching research question of this thesis is:

> *What role do soup runs and day centres play in responding to homelessness in Dublin and how has the ability of these services to provide spaces of care been affected by the COVID-19 pandemic?*

The focus of this research is on the non-accommodation based service spaces of the soup run and day centre in Dublin. Given the rise in responses to homelessness since the growth of the crisis over the past five years, this research first sets out to provide a detailed overview of the current landscape of homelessness service provision in Dublin, conceptualising the service space of soup runs and day centres as 'spaces of care' (Conradson, 2003) and aims to provide an insight into how these services function under 'normal' circumstances. It then moves on to examine the practical ways in which public health advice, emergency plans and the risk of infection changed these spaces, before investigating the experience of service providers in relation to these changes and how they have impacted their ability to provide care, with some insight being offered into the experiences of service users amidst the pandemic. This gives rise to three sub questions:

- ⇒ *What is the current structure of the landscape of homelessness service provision in Dublin city?*
- ⇒ *How have spaces of care changed in light of the COVID-19 pandemic?*
- ⇒ *How have service providers experienced this change and its effect on their ability to provide care?*

This thesis begins by providing a review on the geographical literature around responses to homelessness, before moving on to discussing the concept of 'spaces of care' (Conradson, 2003), paying attention to the structural characteristics of these spaces, the factors which influence service providers' ability to provide care and the varying perceptions of service users of these spaces. It then turns to look at research at the intersection of homelessness,

homelessness services and pandemic outbreaks, outlining the ways in which the ability to provide care may be compromised under the extraordinary conditions of a pandemic. This is followed by a detailed account of the research methods used, which in turn is followed by a presentation and analysis of the results gathered, placing them in the context of the literature outlined previously, before finally offering a concluding discussion on the role of non-residential services in responding to homelessness and the overall effect of COVID-19 on these services in Dublin.

2. Literature Review

2.1 Early Research on Responses to Homelessness

2.1.1 The Punitive Framing

To understand contemporary debates around the geographies of, and responses to, homelessness and the methodology for examining the service spaces under consideration in this thesis, it is necessary to look at the context out of which such debates emerged. Early research on the geographies of homelessness, particularly in North America, focused on punitive measures introduced in cities in the late 1980s and 1990s, which aimed to 'cleanse' the streets of homeless people. A punitive framing of responses to homelessness emerged as a result, consisting of three main strands: the carceral city (Davis), the revanchist city (Smith), and the post-justice city (Mitchell). Much of the original inspiration for this framing emanated from Davis' *City of Quartz,* in which he discussed how changes in the built environment of Los Angeles and increased policing created a "strategic armoury of the city against the poor" (Davis, 1992, p. 160), resulting in a 'carceral city' in which homeless people were excluded from 'prime' Downtown spaces and contained in Skid Rows. This degrading of homeless geographies and the broader 'malign neglect' (Wolch and Dear, 1993) of homeless people lead Smith to identify a 'revanchist' shift in urban policy in New York City. Here, revanchism manifested itself as the drive to reclaim prime city spaces by the upper classes from street criminals, minorities, poor and especially homeless people (DeVerteuil, 2006; DeVerteuil et al., 2009). This was achieved through policing public space and 'quality of life' and 'anti-camping' ordinances. Mitchell (1997, p. 311) argued that this (re)regulation of public space led to the "annihilation of homeless people", stripping them of their right to the city (DeVerteuil, 2006). Mitchell viewed these developments as a move beyond revanchism towards a "post-justice" city "no longer defined by the struggle for social justice … [but rather the] question of the best way to exterminate homeless people" (Mitchell, 2001, p. 81).

The main driver behind the punitive measures upon which these theories are based is the rise of entrepreneurial and imaged city. As cities become increasingly globalised, they stand in competition with one another to attract and retain investors, tourists, visitors and upmarket consumers. To present an image of the city attractive to this clientele, homeless people, visibly poor and other marginalised groups are pushed out of prime city spaces through anti-homeless and public space ordinances introduced by "increasingly entrepreneurial city managers" (May and Cloke, 2014, p. 895). Not only is the visible presence of homeless people unappealing to

city managers, but it has also been argued that their presence is seen as representative of failures of the state (Cloke et al., 2008), further incentivising the introduction of such measures.

As Doherty et al. (2008) explain, public space is an essential component of the daily life of homeless people, whether rough sleepers, hostel dwellers or others who are inadequately housed and the introduction of public space ordinances and bans can eliminate spaces of hard-won safety and security and disrupt routines of mobility, sociability and hygiene (Langegger and Koester, 2016). The loss of such spaces and disruption of routines may render people 'visibly' homeless, depriving them of a fundamental right of the city: anonymity (Langegger and Koester, 2016) and makes the "question that daily confronts every homeless person […] what to do with the day" (Snyder, 1982, quoted in Kawash, 1998, p. 328) more complicated.

Punitive measures continue to be used today, for example Langegger and Koester (2016) recently discussed the introduction of a camping ban in Denver and there is also evidence of the exclusion of 'undesirables' from public space in Europe, through restrictions on begging and sleeping rough (Doherty et al., 2008; O'Sullivan, 2012). These are also linked with the desire to present an attractive image of the city. However, it has been acknowledged that the regulation of street homelessness has been less punitive and pervasive in Europe than in the USA (Doherty et al., 2008; Johnsen et al. 2018).

Nonetheless, this punitive framing has formed the basis of research in this field and come to dominate certain understandings of responses to, and geographies of, homelessness. Though not the immediate focus of this research, this body of work is vital not only because it draws attention to the geographies of homeless people and the role of public space in their lives, but also because it provoked a discussion around other responses to homelessness, opening up a dialogue between this framing and other ways of analysing responses. Cloke, May and Johnsen feature prominently in this discussion, contending that to focus exclusively on this framing and its associated methods of control and containment may "blind us to other developments" (Johnsen et al., 2005a, p. 788) and it was upon such sentiments that geographers began to investigate more accommodating responses to homelessness.

2.1.2 Accommodating Responses

Early work in this field began with DeVerteuil (2006) who observed that in Los Angeles, parallel to attempts to clear people off the streets, there had been rapid growth in the shelter system. He sought to identify the extent to which this seemingly more accommodating response might provide an empirical and theoretical counterweight to more punitive responses. Focusing

on the role of the local state in providing these shelters, he found that it was limited and uneven and thus proposed an alternative concept, 'poverty management' to better capture the more ambivalent and managerial nature of this response. This concept has been described as: "organised responses by elites and/or the state directed generally at maintaining the social order and more particularly at controlling poor people" (Wolch and DeVerteuil, 2001). DeVerteuil (2006) explains that there are various poverty management strategies which can be deployed and embedded within larger rationales of how to best manage the homeless, ranging from more supportive measures (e.g. welfare) to punitive ones (e.g. incarceration). Despite the more ambiguous role of the state in providing these shelters, within this framework they were interpreted as embedded within the larger institutional context that encouraged the expedient removal and institutionalisation of visibly homeless people from prime urban locations. In other words, as the term 'management' suggests, these shelters were bound up in the state's aim to contain and control homeless people, with May and Cloke (2014) arguing that in these circumstances service providers position themselves within a 'shadow state' (Wolch, 1990).

However, as Cloke et al. (2010) argue, it is a considerable and reductive leap to assume that providing welfare services for homeless people can only be understood in these terms. Rather than consider only how the state has sought to control the homeless or how other organisations and services may be bound up in these aims, others have examined the way in which the state and others seek to 'care' for homeless people (DeVerteuil et al., 2009). For example, research by Johnsen et al. (2005a) argues that parallel to a rise in punitive and managerial responses there has also been a rise in an 'urge to care', evident in a growing number of spaces of care such as night shelters, hostels, day centres and soup runs. While shelters may be offered by a number of different service providers including the state, private and third sector, day centres and soup runs are predominantly offered by third sector organisations that is, non-statutory, not-for-profit or volunteer organisations, often emerging as *ad hoc* spaces that attend to the immediate needs of the socially marginalised. These more compassionate responses to homelessness often evolve into permanent features of the urban landscape (Evans, 2011) and may become an integral part of the 'everyday geographies of survival' fashioned by the urban homeless (Mitchell and Heynen, 2009). It has been argued that they maintain a critical layer of social protection that can mean the difference between life and death for some homeless people (Evans, 2011). This is significant as in Ireland there is an almost exclusive reliance on the voluntary sector for homelessness service provision (Daly, 2019).

Of these more accommodating responses, accommodation-based responses have received more attention in the literature than non-accommodation based services. Cloke, May and Johnsen have largely contributed to filling this gap in the British context, however, the focus in Irish literature has remained on accommodation-based responses such as Family Hubs (Hearne and Murphy, 2019), emergency shelters (Waldron, O'Donoghue-Hynes and Redmond, 2019) and Housing First initiatives (Manning, Greenwood and Kirby, 2018). Thus, the focus now turns to the non-accommodation based responses of the soup run and day centre and the spaces of care they may give rise to, in an attempt to broaden the research on responses to homelessness in Ireland.

2.1.3 Conflicting Views on Accommodating Responses

To say that non-accommodation based responses have received no attention in an Irish context, however, would be untrue. In a recent publication from O'Sullivan (2020) these responses are subject to criticism, a sentiment reflective of a wider consensus among a number of geographers. The appropriateness of such responses and the care they provide within the wider landscape of responding to homelessness has been the subject of much debate (see: Crane et al., 2005; Lane and Power, 2009; Shelter, 2005), with some describing them as responses that "soothe rather than solve homelessness" (Parsell and Watts, 2017) and "jobs of roadside repair" (Smith and Hall, 2018). A common criticism of soup runs is that they help sustain a potentially damaging street lifestyle, doing little to help people move off the streets (Lane and Power, 2009; Shelter, 2005). Moreover, Parsell and Watts (2017, p. 67) argue that these kinds of responses "serve to distract from the underlying and largely structural causes of homelessness" and that a focus on, and celebration of, these kinds of interventions risks normalising ameliorative responses that, at best, marginally and temporarily improve the well-being of those on the street, and at worst, undermine their well-being.

Similarly wary of such responses and the praise they receive is O'Sullivan (2020), who raises the question of whether they are successful in resolving homelessness or whether they contain and ameliorate the worst aspects of the experience of literal homelessness by providing temporary shelter and basic sustenance. He comments that the range of volunteer-led initiatives that exist today "enable" people to live on the streets (O'Sullivan, 2020, p. 34) and that while individual acts of kindness and compassion are well-intentioned they are "ineffective" and in some cases, even "counter-productive" (O'Sullivan, 2020, p. 45), painting it as something that

can be solved through individual acts of compassion and donating to "underfunded NGOs in order to allow for the provision of tea and toiletries." (O'Sullivan, 2020, p. 112).

However, it must be realised that both O'Sullivan's and Parsell's evaluation of these services is in relation to their ability to end homelessness. For them the solution lies in housing, arguing that "the majority of services provided to people who are homeless *would* be superfluous *if* we provided them with housing" (Parsell, 2018, p. 94; emphasis added). Yet even O'Sullivan acknowledges that the biggest drivers of homelessness are not being tackled in Ireland and so demand for these services looks set to remain. Furthermore, what they fail to acknowledge is that, as Cloke et al. (2010, p. 93) mention, volunteers are often "the first to admit that they do not hold the solution to homelessness". It is argued that service providers are both aware of the structural causes of homelessness and that their service does not directly contribute to tackling these causes. With this in mind, as Conradson (2003, p. 521) so aptly argues when discussing these services: "care should be taken […] to avoid criticising […] drop-in centres [and soup runs] for failing to achieve something that in a sense lies beyond their core or realistic remit". Thus, in the following section attention turns to what *does* lie within the remit of these services and what they *can* achieve, presenting a more nuanced reading of such spaces.

2.2 Spaces of Care

Previous work on soup runs and day centres used the concept of spaces of care to analyse the spaces that they create (Johnsen et al., 2005a; 2005b). Spaces of care are defined by Conradson (2003, p. 508) as: "socio-spatial field[s] disclosed through the practices of care that take place between individuals". Here care is conceived of in a general sense as the proactive interest of one person in the well-being of another and the articulation of that interest in practical ways (Conradson, 2003). Drawing on Kearns and Gesler (2002), Johnsen et al. (2005b) explain that used in this sense care refers to a more holistic sense of human welfare that goes beyond the physical to encompass the social and emotional domains. Thus, care can be present in everyday encounters between individuals who are attentive to each other's situation, provide practical assistance or listen to the other (Conradson, 2003). Academic discussions around the geographies of care typically make a distinction between the partiality of care for those who are 'nearest and dearest' such as family and friends and the universalism of care for the geographically distant 'other' (Sack, 1997; Smith, 1998). The spaces of care discussed here are said to provide care for the 'nearby other', people who are spatially proximate but socially

distant from ‘mainstream’ society (Johnsen et al., 2005b). In keeping with this broader conceptualisation of care, it is argued that within soup runs and day centres, care for the nearby other is articulated in material and practical, but also social and emotional ways, with each playing an important role in giving care to those experiencing homelessness.

2.2.1 Material Resources and Practical Support

Firstly, soup runs and day centres provide material resources to those experiencing homelessness. It has been argued that the basic sustenance provided by these services is vital to “keep homeless people alive” (Evans and Dowler, 1999, p. 180; see also: Johnsen et al., 2005b; Shelter, 2005) and that this provision minimises the need for people to resort to what Carlen (1996) refers to as ‘survivalist crime’ (Johnsen et al., 2005a). These services may provide other resources such as clothing, bedding and hygiene products and day centres can go a step further again by providing other basic utilities such as lavatory and bathing facilities, laundry services and storage spaces. By offering the facilities to wash oneself and one’s clothes, day centres also provide a means of mitigating some of the stigma of life on the street, as often an unkempt appearance is associated with being homeless, rendering people ‘visibly’ homeless. It has also been argued that the provision of material resources provides a ‘vital safety net’ for those facing shortfalls in the system, these might be individuals for whom welfare benefits are not enough to cover basic food or accommodation costs, or individuals who are excluded from or may not be reached by other services (Johnsen et al., 2005b).

However, these services must be understood as offering more than material resources (Cloke et al., 2010). It has been argued that both soup runs and day centres provide important signposting services (Lane and Power, 2009; Shelter, 2005). Soup runs can direct people towards other services such as day centres, hostels and more specialised support services. Furthermore, as they are set up in public, they are quite accessible and thus often form the first point of contact for groups such as newly homeless, street homeless or those who have fallen through the cracks with homelessness services, providing a platform from which they can make their first steps towards exiting homelessness. Day centres can offer information and advice in a more formal, private setting. Furthermore, they often have team members specifically trained to help clients navigate social welfare and homelessness service systems.

2.2.2 Social and Emotional Support

Care can also be articulated in closely intertwined social and emotional ways. As Smith and Hall (2018) point out, the temporary territories created by soup runs can form important sites of social interaction, where service providers and users may spend some time in conversation which may offer homeless people a "bit of cheer" (Cloke et al., 2010, p. 115). Soup runs create these spaces by temporarily claiming and converting outdoor public spaces such as car parks and pavements into what have been described as spaces of compassion, or, if service providers are searching for potential clients they may enter a space already claimed by a homeless person. The creation of these spaces gives service providers room for the expression of care and service users a chance to receive care (Johnsen et al., 2005b; Smith and Hall, 2018), providing a means for people to demonstrate to those on the street that there are people that care about them and that they are worth something (Evans and Dowler, 1999) and this 'recognition' of service users in these spaces is an important aspect of the 'therapeutic relationships' characteristic of this work and spaces of care (Gordon, 1999).

Therapeutic Relationships

In fact, Conradson (2003) argues that the extent to which a service space can be considered a space of care is largely determined by the extent to which therapeutic relationships make up part of the service provided. Therapeutic relationships have a positive effect on individuals; this may be immediate, helping individuals to feel at ease in their environment or they might have wider, 'more enduring' effects such as instilling confidence in clients to explore new opportunities (Conradson, 2003). Essentially, they have the potential to facilitate or promote the well-being of others, which can extend beyond formal or professionalised interactions into 'domains where humour and play may be as important as serious discussions' (Conradson, 2003, p. 508), thus therapeutic encounters can be part of everyday interactions.

Conradson, based on the work of humanist psychologist Carl Rogers, contends that three core conditions must be present in encounters with individuals for them to be successful therapeutic relationships: congruence, unconditional positive regard and empathic warmth. Congruence is sometimes described as authenticity or genuine presence, and is referred to as the need to engage openly and honestly with clients. Unconditional positive regard is variously summarised as "non-possessive, warmth, caring, prizing [and] acceptance" (Nelson-Jones, 2001, p. 99) and empathic warmth is described as "sensing the client's private world as if it were your own" (Rogers, 1957, p. 99), in other words, listening to clients, being empathetic

towards them and having understanding for their situation without exacting personal judgement.

Conradson argues that these conditions are significant not only within formal therapeutic relationships but human relationships and social settings more broadly which brought him to contend that: "We might therefore think of spaces of care emerging within a drop-in centre to the degree that the core conditions are manifest within volunteer–user relations" (Conradson, 2003, p. 512). Conradson explains that when a volunteer seeks to relate in a supportive fashion with a user through activities such as listening, befriending and offering practical advice, their actions will likely overlap with these notions of congruence, unconditional positive regard and empathic warmth. Thus, interacting with clients in an open, accepting, non-judgemental way, be it through a chat or a more formal service, enables therapeutic relationships to form, which is a clear articulation of care and further marks service spaces out as spaces of care.

A Safe Space

Day centres also provide sites for social interaction and therapeutic encounter. It has been argued that they offer a chance to alleviate the loneliness and social isolation that some of those experiencing homelessness may feel (Cloke et al., 2010). More importantly perhaps they offer service users a place to simply 'be', in which homeless people can drop the pretence that is often an integral part of life on the streets: trying not to *appear* as homeless. What these spaces offer service users then is an opportunity to feel 'normal' (Cloke et al., 2010). In fact, it has been argued that day centres can be understood as 'spaces of license' (Parr, 2000). These are spaces in which people have the license to appear or act in ways which may not be seen as 'normal' in other environments, yet through a collaboration between staff and service users an environment is produced where 'unusual norms' and 'unusual normal performances' are rendered acceptable. Open to the expression of difference in this way, day centres offer respite from the stigma homeless people may be subject to in other environments (Cloke et al., 2010). For others, they may offer respite from frightening or depressing hostel environments or refuge from the threat of violence experienced in temporary accommodation or on the streets (Johnsen et al., 2005a), providing a space where people 'don't need to be tough to survive' and can temporarily discontinue the more aggressive performances entered into on the streets for the purposes of their own protection (Cooper, 2001). Thus, it is argued what they offer is a safe space.

2.2.3 Inclusive Spaces

Another defining characteristic of spaces of care is that they tend to be open, inclusive environments. As soup runs take place in public space, they tend to be (on the surface at least) the most inclusive emergency services. As outlined in the literature, they typically operate under a 'no questions asked' policy, do not require referrals from other agencies, question the 'deservedness' of service users or place conditions on the receipt of care (Johnsen et al., 2005b). Day centres are also viewed as welcoming, inclusive spaces as most operate under 'open-door' policies. This openness and inclusivity is important because as mentioned previously these services provide a safety net to those facing shortfalls in the system, for example individuals who have not been given resources to which they have a statutory right, those who may not have enough income left for food and other resources or who may have no access to cooking facilities and those who have been excluded from or may not want to access other, more formal, services.

In sum, soup runs and day centres give rise to spaces of care by providing environments in which service providers can articulate their interest in the well-being of 'nearby others' in practical ways. This care can be articulated through the provision of important material resources such as food and clothes and through giving practical help and advice. However, it can also encompass social and emotional domains, for example, by setting up temporary territories, soup runs provide sites for social interaction with service users, a space of compassion where they may bring clients some cheer and allow service providers to demonstrate to their service users that there are people who see them and care for them. Within the service spaces of both soup runs and day centres care may be articulated through therapeutic relationships, which promote the well-being of clients and form an integral part of spaces of care. Day centres are also sites of social interaction and moreover have been described as spaces of respite as they alleviate some of the loneliness associated with homelessness and provide service users with a break from stigmatisation and a chance to feel normal through the creation of spaces of license. They are also spaces of refuge in the sense that they provide a break from the threat of violence or fear that might be experienced in other environments in which those experiencing homelessness may spend time. Past research has also shown that they try to extend their services, and in turn care, to as many as possible by having an open and inclusive ethos, where generally no questions are asked about whether a person 'deserves' to be there. Thus, it is argued that what they try to create are inclusive environments where service users feel comfortable and safe.

2.3 Factors Shaping Spaces of Care

However, even those who conceptualise soup runs and day centres in a positive light warn against the "romantic tendencies" implicit in the notion of spaces of care (Johnsen et al., 2005a). Spaces of care are co-constructed, relational environments (Conradson, 2003) and are contingent upon individual subjectivities (Carey et al., 2009). Thus, what is experienced by one person as an inclusive and safe space, may for another be experienced as a space of fear or unease (Carey et al., 2009). These complexities "inspire careful consideration of the factors shaping the internal dynamics of care" within these spaces (Johnsen et al., 2005a, p. 796). Thus, to analyse these spaces and the extent to which they may be considered spaces of care, it is necessary to look at their internal dynamics.

Johnsen et al. (2005a) argue that day centres are shaped by three main factors: the guiding principle and ethos of organisations and the type of environment they seek to create, the interactions between staff/volunteers and service users and the relationships between different groups of service users. These are inextricably linked in practice and coalesce in many ways to create different infrastructural, social and emotional dynamics within spaces (Johnsen et al., 2005a). While Johnsen et al. (2005a) use these factors to examine the internal dynamics of day centres, in this thesis they are also applied to the discussion of the temporary spaces of soup runs (Cloke et al., 2010). Furthermore, rather than focus exclusively on ethos, the first factor is broadened to consider the influence of a number of structural characteristics on the manner in which care is provided and consumed.

2.3.1 Structural Characteristics

When looking at the structure of an organisation a number of factors can be taken into consideration such as their history, organisational affiliation, ethos and funding. The history of an organisation may influence their ethos and the manner in which services are provided in the present. In their examination of day centres in Britain, Cloke et al. (2010) discovered that most started as small-scale endeavours, often as soup runs or kitchens, had religious roots and were almost entirely dependent on donations and volunteers. From these beginnings they identified four main trajectories along which centres developed. Those which developed along the first trajectory remained true to their original aims, seeing provision for the poor as part of their duty as Christians. Those who developed along the second retained their religious ethos but 'professionalised' in the sense that the majority of staff are paid and service users are provided with a greater range of facilities and higher levels of support. Those who developed along the

third path ‘professionalised’ in a similar way but relinquished their original religious ethos in favour of a more secular approach – actively pursuing statutory grants. The fourth type of organisation evolved out of the statutory sector. These are projects most commonly set up by former social workers who developed their own organisation to redress gaps in existing service networks. They tend to be highly ‘professionalised’, employing paid staff, utilising statutory grants and offering intensive support to service users. Thus, depending on their history and developmental path, services may provide different supports in different ways.

Different forms of ethos or ‘impulses towards care’ can influence who is considered deserving of care or the type of user a service attracts (Cloke et al., 2005). In her research on British day centres, Waters (1992) provides a framework that distinguishes between three main types of approach to service delivery. The first is rooted in Christian philanthropy, has an ethos of open and non-interventionist acceptance and aims to provide a place where people can just ‘be’. The second approach is better characterised as an ethos of empowerment, where service users are provided with access to advice and resources but are free to choose their level of engagement with these services and within the third approach, service provision is conditional upon the expression of a desire for rehabilitation and change. Thus, ethos influences whether there are conditions on the receipt of care and the rules within these spaces and only those willing to engage with the conditions and abide by the rules are ‘deserving’ of care. Soup runs are characterised by an ethics of open acceptance and typically, regardless of their formally articulated ethos, take a person’s presence as evidence of their need and thus their ‘deservedness’ (Cloke et al., 2010). Different approaches to service delivery and ethos may thus influence the internal dynamics of spaces, creating spaces which may be more appealing to certain individuals than others.

Organisational affiliation also plays a role in shaping service spaces. This refers to the type of organisation providing a service, be it the state, private provider or not-for-profit body and whether this organisation works with any other organisations. An increasing trend in service provision in the third sector is the collaboration with governments, with services receiving contractual statutory funding (Carey et al., 2009). This often goes hand in hand with a process of “bureaucratisation” or “professionalisation” (Fyfe and Milligan, 2003), which is often viewed as detrimental to services because their objectives may become more closely aligned with those of the state and their ethos may take on a rehabilitative approach to meet the targets which are a condition of funding. Some organisations may reject such funding as for them it equates to giving up autonomy, whereas for others it may play an important role in securing finances needed to continue operating (Cloke et al., 2010). Partnership with the state

also illustrates that some services operate within a 'shadow state' capacity. However, Carey et al. (2009) argue that professionalised services may still be accommodating spaces of care, because staff and volunteers play a role in how organisational ethos is put into practice and thus can mitigate any potential negative effects of professionalisation (Cloke et al., 2010).

2.3.2 Relationship Between Service Providers and Service Users

The second factor shaping the internal dynamics of spaces of care is therefore the relationship between service providers and users. Existing research on hostels for homeless has identified staff-client relationships as *the* most important feature influencing the experiences of residents (Harrison, 1996; Neale, 1997). Accordingly, Johnsen et al. (2005a) contend that these relationships are key in shaping the experiences of people in day centres. They argue that for service users, the most positive interactions with staff are ones that construct the day centre as a space of license. Furthermore, Cloke et al. (2010) contend that the ideal encounter between staff and service users alike is a dialogic one (Conradson, 2003), in which staff listen to service users, responding to the needs of clients as they are defined by service users themselves. Building such relationships is important for the appropriate type of care to be provided.

However, previous research has shown that the ability of service providers to produce an inclusive, safe environment and to foster and maintain relationships can be compromised. Underfunding, lack of resources and staff/volunteer shortages are often cited as factors which threaten services' ability to operate. These factors will put those who are working under pressure (Cloke et al., 2010), compromising their ability to provide care as they may be overstretched, which in turn may influence their interactions with clients negatively. Inadequate premises or poor-quality interiors can limit the range of services that can be provided, the amount of people that can be catered for and how "welcoming" a space is (Johnsen et al., 2005a, p. 801). It is also argued that some aspects of working with service users can in themselves be draining (Cloke et al., 2010), for example, listening to difficult stories, handling stressed service users and diffusing tense situations.

Service environments are thus socially fragile and potentially volatile, which can be made more acute by the unpredictable nature of some service users. By nature of being open and inclusive, services may welcome clients which can pose a risk to the safety of these spaces. This threat is greater for soup runs, as service providers have no 'ownership' over the spaces they use and the extent to which they can impose rules on what constitutes 'acceptable' or 'unacceptable' behaviour is limited. Secondly, as these spaces have no tangible boundaries and

everyone technically has a right to be there, if a service user is being problematic, a service provider cannot actually remove them from the premises; often the most they can do is refuse to serve them (Cloke et al., 2010, p. 106). In day centres, on the other hand, formal rules provide staff with an explicit codification of what constitutes 'acceptable' and 'unacceptable' behaviour and these rules are often tangibly expressed in signs adorning a building's interior (Cloke et al., 2010). Furthermore, day centres have the means to make modifications to their premises to make them 'safer', for example by introducing CCTV and formal reception areas to 'vet' service users, and closing off 'nooks and crannies'. Service providers can also forcibly remove individuals exhibiting 'inappropriate behaviour' from the premises (Waters, 1992). Such measures hark back to punitive measures and it could be argued that they make these spaces "sites of social control" (Johnsen et al., 2005a, p. 801). However, Cloke et al. (2010) found that such measures actually increased service users' feelings of security and thus they argue that they should not be seen as attempts to contain or to exclude, but rather as attempts to protect an open ethos by securing the safety of those using centres (Cloke et al., 2010, p. 140). Some modifications, however, such as the physical separation of service providers from service users have been read by service users as a physical manifestation of distance between service providers and users and may create a barrier to providing care.

2.3.3 Relationship Between Service Users

This brings us to the third factor shaping the internal dynamics of services, the relationships between service users. As spaces of care can be volatile, they can be frightening to potential service users, especially as an open ethos can attract a diverse range of service users; young and old, men and women, newly homeless and those who have been homeless for some time, as well as people suffering from mental illness and addiction (Cloke et al., 2010, p. 132). The potential mix of groups, combined with the fact that those who are homeless may be stressed, anxious or overwhelmed can contribute to an unpredictable and tense atmosphere in these environments, which can deter potential service users, suggesting that attempts to include will also exclude.

Citing Rowe and Wolch (1990), Johnsen et al. (2005a) explain that especially for newly homeless these spaces can be 'alien' and daunting. Given that service users and street homeless are predominantly male, some service spaces can be particularly intimidating for women and some may avoid using them altogether (for further research on the geographies of homeless women, see: Casey et al., 2008; May et al., 2007). Johnsen et al. (2005a) found that women

who did engage with these services were often accompanied by a partner or were well versed in navigating these spaces. In larger cities, there may be services that cater specifically to certain groups or naturally develop into spaces frequented by particular subgroups and the threat of conflict within such services may be lower. Those in need may also avoid using certain services due to "stigma by spatial association" (Duncan, 1983, p. 96) as they do not want to be 'seen' as homeless. Those who frequent soup runs naturally have a higher chance of being seen as homeless.

Lastly, Johnsen et al. (2005a) observed that service users judge each other in terms of who is 'deserving' of care, with those who are homeless due to factors such as an eviction or mental illness (i.e. no fault of their own), seen as more deserving of care than those who are more competent and able to choose alternative lifestyles. Cloke et al. (2010) also explain that assessments of deservedness are often made with reference to a person's housing status, with the genuinely homeless (i.e. those sleeping rough) considered more deserving than those in hostels, who in turn are understood as more deserving than those who are 'housed'. Furthermore, perceptions of deservedness are strongly shaped by the way in which service users relate to staff, with people who contravene social norms of etiquette being subject to overt disapproval (Johnsen et al., 2005a, p. 804). It was observed that in such situations service users often 'self-police' these spaces (ibid.). Thus, the coming together of different groups within these spaces can potentially lead to tensions arising within service spaces or people avoiding certain service spaces altogether.

Thus, the extent to which a service space operates as a space of care depends on the coming together of three dynamics: the structural characteristics of a service, staff/volunteer-client relationships and client-client relationships. As has been shown above the history, ethos, affiliation and funding of a service may shape the rules and regulations of a service and thus the service environment. Staff/volunteer-client relationships can easily be put under pressure or compromised and tensions between clients can further threaten spaces of care. The type of space that emerges when these dynamics come together then will influence a potential service user's perception of the space and decision whether to avail of the service. This decision is made more complex under the circumstances of a pandemic, especially as service providers are presented with new, unique challenges.

2.4 Impact of Pandemics on Homelessness and Homelessness Services

A pandemic can pose a huge threat to the ability to provide care, having an impact on service spaces, providers and users. Given the relative recency of the outbreak of COVID-19, research around this pandemic is only beginning to emerge. Furthermore, research that looks specifically at the effect of this virus on homeless services is limited. Nonetheless, disease outbreaks are becoming more common, for example in the previous two decades viruses such as Severe Acute Respiratory Syndrome (SARS) and H1N1 have threatened the health and security of people around the world (Ali and Keil, 2008) and there exists a substantial body of research which looks at the effect of these viruses on homelessness, particularly in a Canadian context (Buccieri and Schiff, 2016; Buccieri and Gaetz, 2015; International Centre for Infectious Diseases, 2010).

2.4.1 Homelessness and Health

Most of this work tends first to outline how those experiencing homelessness face higher risks during a pandemic, as Blickstead and Shapcott (2009) point out: "while everybody is affected by a pandemic, everyone is not affected equally". In fact, the reality that people from lower socio-economic classes are disproportionately affected by pandemic outbreaks was observed in research as far back as the Spanish Flu in 1918 -1919 (Sydenstricker, 1931). In contemporary research, the increased risk that those experiencing homelessness face is generally framed in terms of greater medical risk and increased susceptibility to infection due to social determinants of health.

Those who are medically at risk will experience poorer health outcomes following infection and in some cases even death (International Centre for Infectious Diseases, 2010). Homeless people, specifically those living on the streets or in shelters, are often characterised by poorer health (Hwang, 2001). Among the wide range of medical problems they may suffer from are pulmonary diseases, diabetes and respiratory issues, positioning them in this medically at risk category.

However, it must be made clear that it is the state of homelessness itself and the attendant poor living conditions which make homeless people prone to poorer health to begin with. As Mikkonen and Raphael (2010, p. 7) explain, living conditions are primary factors shaping health and these have become known as the social determinants of health. People experiencing homelessness often live in environments conducive to the spread of disease (Tsai and Wilson, 2020), for example, people living on the streets or other informal settings such as

encampments or abandoned buildings, as well as settings such as shelters or hostels, might not have regular access to hygiene supplies or shower facilities and poor hygiene facilitates virus transmission. Where there is regular access to such facilities, they are often shared between a large number of people, furthermore, most of the aforementioned settings are congregate living spaces in which many people may share one room, again both increasing the risk of transmission.

In such living conditions it may be difficult for homeless people to adhere to public health advice and this has been emphasised in a myriad of articles and reports (Blickstead and Shapcott, 2009; Buccieri and Gaetz, 2015; Buccieri and Schiff, 2016). For example, social distancing, self-isolation and quarantining are very difficult to implement in congregate settings, if possible at all. Staying 'at home' is not an option for those with no home and avoiding contact with others is difficult for those reliant on services to meet their daily needs. Thus, the social determinants of health, i.e. living conditions, of those experiencing homelessness make them more vulnerable during a pandemic, subjecting them to an increased risk of infection.

2.4.2 Pandemic Planning

The evident vulnerability of those experiencing homelessness during disease outbreaks and the more recent occurrences of SARS and H1N1, led to another dominant trend in this field: the evaluation of emergency and/or pandemic preparedness plans from a social justice or equity perspective (Uscher-Pines et al., 2007). The overarching sentiment emerging in these accounts is that vulnerable groups, including those experiencing homelessness, must be included in such plans. What was observed in emergency plans for previous disease outbreaks was that much attention was directed towards protecting members of the population who are at heightened risk of medical complications (Bourgoin and O'Sullivan, 2010). However, within this framing, homeless people are often overlooked. As a result, Bourgoin and O'Sullivan (2010) stress that vulnerability seen through the lens of the social determinants of health must also be acknowledged in emergency plans.

Furthermore, Bourgoin and O'Sullivan (2010) discuss of the importance of looking "beyond medical risk" in pandemic planning, not only interpreting 'risk' as the risk of infection but also different ways in which socio-economically disadvantaged groups can be made vulnerable during an outbreak. For example, the 'daily resilience' of those with lower incomes and/or in poorer living conditions may be weakened if their ability to meet their daily needs

and access to supportive care is compromised and a daily dependence on soup kitchens and food banks can be an additional social risk factor for people. Thus, while it is important to ensure that all high risk populations are identified in pandemic plans, it is equally important to identify the needed supports which can mitigate social risk and minimise the impact of pandemics on disadvantaged populations (O'Sullivan and Bourgoin, 2010, p. 22).

2.4.3 Impact on Homelessness Services

However, as Buccieri (2016, p.5) points out, supports or services which feature in the daily lives of those experiencing homelessness, which typically play a role in mitigating some of the more 'usual' risks they are exposed to, face 'unique' challenges during pandemics. Both the threat of infection and public health guidelines can affect the operation of homeless services. Research by Leung et al. (2008) outlines how homeless services experienced the SARS outbreak, emphasising that shelters, drop-in centres and soup kitchens, are at an increased risk of disease outbreaks. Through interviews with a range of stakeholders in homeless services including volunteers and staff at shelters, drop-in and health centres, they identified some of the main challenges faced by service providers at that time. They found that services felt inadequately prepared to respond to the crisis and often struggled to obtain guidance and assistance. The main challenges arose in the areas of communication, for example service providers received few formal directives and response strategies from public health officials; isolation and quarantine – many homeless people did not have the ability to self-isolate or quarantine; and resource allocation – some providers felt that resources devoted to outbreak planning would have been better spent on housing or other services. However, the most significant challenges and those most relevant to this research were those around infection control.

The threat of disease outbreak was one of the biggest concerns of service providers. In an attempt to control the spread of infection many shelters and drop ins enhanced their basic infection control procedures, encouraging frequent hand-washing or sanitizer use, use of masks and gloves by staff, and increased surface cleaning. However, they found that policies varied widely across agencies due to a lack of specific guidelines. Furthermore, the cost and limited availability of supplies meant facilities often had to source their own personal protective equipment (PPE). Similarly, work on the effect of H1N1 on homelessness and homeless services mentioned that the most vocalised concerns among service providers related to staff becoming infected (Buccieri and Gaetz, 2015). The risk of infection poses a threat to the

continued operation of services, as it may make staff stressed or anxious, which can affect their ability to provide care or it may lead to them not attending work at all and staff shortages are one of the main factors which put services under pressure. The concerns of staff may be made more acute if they do not have access to the appropriate protective equipment. Measures introduced to facilitate better hygiene and enable operation in adherence with public health guidelines may change the overall dynamic of spaces with increased physical and social distances being placed between users and providers through physical protection measures and modifications to premises.

Leung et al. (2008) also mentioned that many agencies considered scaling back or eliminating services altogether out of concern around disease spread and one of the biggest 'lessons learned' by the service providers they interviewed, was that decisions to cease operations had to weigh up concerns around the spread of infection against homeless people's essential need for food and shelter and find a balance that they deemed appropriate. Such a decision is made more complicated by the knock-on effect that the closure or reduced operation of services could have for service users. As O'Sullivan and Bourgoin (2010, p. 5) emphasise: "For people who depend on daily supports from service providers such as the food bank, shelters, or home care, interruptions in essential services for even a day or two can have devastating consequences", especially if other sources of food and shelter are closed due to public health guidelines.

Disease containment procedures which can lead to the closure or alteration of services may also be deleterious to the mental health of people experiencing homelessness (Tsai and Wilson, 2020). Speaking generally, Usher et al. (2020) explain that changes to usual ways of life can make people feel anxious and unsafe and that the need for social support is greatest in times of adverse situations. Additionally, recent work by Brooks et al. (2020) on the psychological impacts of quarantine, identified a number of stressors associated with quarantine, for example having inadequate basic supplies, such as food items and medication, as well as the frustration, boredom and sense of isolation associated with being in confinement, loss of daily routines, and reduced social and physical contact with others. While these stressors were not based on the experience of those experiencing homelessness and homeless people may not be in quarantine or self-isolation themselves, they highlight ways in which disease containment procedures can affect a person's mental health, on top of existing concerns around infection. Thus, if soup runs and day centres close, homeless people may have their daily routines disrupted and access to essential resources compromised. Furthermore, what is for

some an important site of social and emotional support will be taken away and this at a time when, as Usher et al. (2020) explain, it may be more vital than ever.

Early research on the impact of COVID-19 on homeless services has recognised similar challenges in continuing services and the potential effects that the removal of services may have on clients. Again, research in Canada is prominent in this field, with Buchnea et al. (2020) documenting how youth homelessness services have managed to adapt under pandemic circumstances, discussing both the challenges they have faced and the successful ways they have managed to adapt. Other recent publications concerning homelessness and COVID-19 reiterate the need for the inclusion of this vulnerable group in pandemic plans, and furthermore, that both their voices and the voices of community groups working with vulnerable populations contribute to and feature in plans (Marston, Renedo and Miles, 2020).

In sum, existing research at the intersection of homelessness and disease outbreaks has emphasised how those experiencing homelessness are a medically at risk group as many may already have poorer health. Conversely, it has emphasised how the social determinants of health of those experiencing homelessness make them prone to poor health in the first place and in turn increase their risk of obtaining an infection. Research has also emphasised the importance looking 'beyond medical risk' when considering how those experiencing homelessness can be made vulnerable during a pandemic. The closure of homelessness services can compromise people's ability to access basic but vital resources and remove from them a form of social and emotional support with potential negative effects on their mental health. Research has shown that service providers need to find a balance between minimising the spread of infection and ensuring that these needs are met. Given how recent the outbreak of COVID-19 is, and the fact that Ireland have never experienced a virus of this scale, research on the impact of a pandemic on services in Dublin is limited. Thus, this research aims to identify which challenges have been faced by service providers in Dublin thus far, how or whether they have managed to deal with these and how they assess the risks facing clients.

3. Methodology

3.1 Introduction

The following section describes in detail the various methods employed to answer the research question, which is as follows:

> *What role do soup runs and day centres play in responding to homelessness in Dublin and how has the ability of these services to provide spaces of care been affected by the COVID-19 pandemic?*

The objective of this research was to provide an overview of the service landscape and responses to homelessness in Dublin with a focus on the role of soup runs and day centres, examining how these provide spaces of care in the city, before looking at how responses have been affected by COVID-19 and the restrictions that accompanied it, once again with a focus on soup runs and day centres, looking in particular at service providers' experience of this time and how their ability, and the ability of their service, to provide care might have been challenged or compromised. This gave rise to three sub questions:

- ⇒ *What is the current structure of the landscape of service provision in Dublin?*
- ⇒ *How have spaces of care changed in light of the COVID-19 pandemic?*
- ⇒ *How have service providers experienced this change and its effect on their ability to provide care?*

The analysis of documents, desktop research, and in-depth interviews were employed to answer these questions and data collection took place from February until June 2020.

3.2 Methods Used for Data Collection and Analysis

3.2.1 Document Analysis

Responding to Homelessness – Normal Circumstances

The first component of the research process entailed creating a detailed overview of the contemporary landscape of homelessness service provision in Dublin, to provide insights into how services function under normal conditions and how this may vary from service to service. Three documents were drawn upon for this component (Table 1).

Table 1: Documents for Mapping Service Landscape		
Document Name	**Document Type**	**Commissioned by**
Homelessness Services in Europe	Comparative Report	European Observatory on Homelessness (EOH)
National Strategies to Fight Homelessness and Housing Exclusion in Ireland	Thematic Report	European Social Policy Network (ESPN)
Rebuilding Ireland: Action Plan for Housing and Homelessness	National Action Plan	Government of Ireland

The EOH report examines and compares homelessness service provision across Europe, by breaking homelessness services into sub-categories: emergency accommodation, temporary accommodation, non-residential services including day centres, food distribution and outreach, and housing-focused support. These categories were used as a guide for the examination of the service landscape in Dublin. Furthermore, it provided some detailed information on some of these responses in Dublin.

The ESPN report and the most recent national action plan for housing and homelessness provided a deeper insight into the structure of service provision and responses to homelessness in Ireland. The former gave an insight into the overall response to housing exclusion and homelessness in Ireland including state and third sector responses and the latter an insight into state-led responses. Both were generally used to gain information on state-led, accommodation-based responses.

Responding to COVID-19

In terms of responses to COVID-19, two sets of documents were deemed relevant for inclusion in the analysis of responses (Table 2). As mentioned in the literature review, previous research analysing pandemic plans examined the extent to which those experience homelessness are featured in such documents, whether they are considered an at risk or vulnerable group and how their vulnerability is framed. The national action plan for COVID-19 was assessed with the same criteria in mind using key terms such as ‘vulnerable’, ‘risk’, ‘homeless(ness)’ and ‘services’ as a guide for analysis. The HSE and HPSC guidance documents were examined to see if they provided any guidelines for soup runs and day centres.

Table 2: COVID-19 Response Plans		
Document Name	**Corporate Author**	**Date Published**
Ireland's National Action Plan in response to COVID-19 (Coronavirus)	Government of Ireland	16.3.20
Coronavirus (COVID-19) guidance for Homeless and Vulnerable groups (V1.2)	Health Protection Surveillance Centre (HPSC) & Health Service Executive (HSE)	4.3.20
Coronavirus (COVID-19) guidance for settings for vulnerable groups (V2)	HSPC & HSE	14.3.20
Coronavirus (COVID-19) guidance for homeless and other vulnerable group settings (V3)	HSPC & HSE	15.4.20

3.2.2 Desktop Research

Responding to Homelessness – Normal Circumstances – Profiles of Service Providers

While the aforementioned documents provided sub-categories for the analysis of homelessness services and an insight into mainly state-led responses, further information was required on third sector and non-residential responses. Desktop internet research was used to build a more detailed overview of non-accommodation based responses and profiles of the organisations providing such services. This was deemed the most appropriate method as many of the organisations that provide these services have their own websites, furthermore, it was the most suitable and time-efficient manner to collect data in a remote fashion. The order of sources listed in Table 3, mirrors the chronological steps taken to fulfil these tasks, reflecting the path taken to navigate the internet to obtain the required information.

Table 3: Sources of Information Used to Build Profiles of Soup Run & Day Centre Service Providers
Existing & Experiential Knowledge
Desktop Internet Research via Search Engine
Online Newspaper Articles
Orientation Talks / Phone Calls with Service Providers
Official Websites of Organisations
Social Media Profiles of Organisations

First a list of organisations which offer soup run or day centre services in Dublin was compiled (Appendix I). It is important to note that this list is based only on organisations which provide at least one of these services and furthermore that it is by no means definitive as there are a

vast amount of groups operating in Dublin, some of which are smaller in scale and potentially do not have an online presence.

Existing knowledge of organisations providing such services formed the basis of this list. Then a broad internet search of 'homeless(ness) services Dublin' led to the discovery of further organisations. Past observation and experience of the city provided knowledge of common locations in which services operate and with this knowledge another internet search was carried out using location names and key terms such as 'soup run', 'homeless', 'Dublin' and 'service'. Online newspaper articles were particularly useful for providing information on smaller organisations, often leading to their social media profiles. From visiting the social media profiles of organisations on Facebook and Twitter, a type of snowball effect occurred, as many organisations were connected on these platforms. Early exchanges with organisations over email and phone also drew attention to other organisations.

Once this list was compiled, an as extensive profile as possible was built of each service. The structural characteristics deemed relevant for inclusion in these profiles were based on those, mentioned in the literature review, considered by Johnsen et al. (2005a; 2005b) in their examination of day centres and soup runs in Britain: history, ethos, organisational affiliation and funding. While Johnsen, May and Cloke issued a national survey to gain information on the structural characteristics of services throughout Britain, given that this research focuses on one city and many organisations have either their own website or social media profile that had already been listed, it was deemed appropriate to use these resources to gather information on their structural characteristics.

Responding to COVID-19

Desktop internet research was also used to establish an overview of the national public health measures introduced in Ireland as a response to the pandemic. The most reliable sources found were the government's own website (gov.ie) and the Citizens' Information website (citizensinformation.ie), as well as articles from news sources including RTE, The Irish Times, and TheJounral.ie. Mapping the introduction of restrictions and what they entailed was deemed relevant as many of these measures had either a direct or indirect effect on both service providers and those experiencing homelessness.

3.2.3 Interviews & Live Web Sessions

The most important data collected were in-depth, semi structured interviews with homelessness service providers. The term service providers refers to anyone, staff or volunteer, working in a day centre or with a soup run. A total of nine interviews were carried out, six phone interviews, of which two were with the same provider (the first occurred earlier in the research process and it was deemed necessary to carry out a follow-up interview at the same time as the others) and three email interviews. Given that these services are based in Dublin and research was being done remotely, phone and email interviews were deemed appropriate interview methods. Interviews took place over a two-week period at the beginning of June, this was useful because at this point services had been operating under lockdown conditions for almost three months and had several weeks experience of and become familiar with their changed service environment.

The majority of organisations on the list (Appendix I) were contacted, either via email or direct message on their social media profiles. It was established that services could be further broken down into soup tables, soup runs/outreach and day centres and so the aim was to organise at least one interview with a service provider from each group. The type of service providers interviewed can be seen in Table 4.

Table 4: Interview Format and Participants

Type of Service	Interview Format	Organisation	Role
Soup Table	Email	Homeless Street Café	Group Coordinator
Soup Table	Phone	A Lending Hand	Team Leader
Soup Run	Phone (x2)	Mustard Seed Soup Run (MSP)	Project Leader
Soup Run / Outreach	Live Web Session	Inner City Helping Homeless (ICHH)	CEO
Day Centre	Phone	Capuchin Day Centre	Co-director
Day Centre	Phone	The Light House	Operations Manager
Day Centre	Email	Merchant's Quay Ireland	Staff member
Day Centre	Email	¨	¨
Day Centre	Phone	Mendicity Institution	CEO

Before interviews were carried out an interview guide was made (Appendix II). The questions about normal operations and how they were affected by COVID-19 were based largely on the factors Johnsen et al. (2005a; 2005b) identify as influencing spaces of care (See: Literature Review 2.2 & 2.3). The interview guide was tailored slightly for each interview depending on

the type of service and the amount of information already obtained on their response to COVID-19.

Phone Interviews

Where possible, an initial informal phone call was held with interviewees in advance of the interview to explain the objectives of the research. This proved useful as it helped to build rapport with the interviewee and allowed them time to think about the topics. For the interviews where the first time talking to the interviewee was the day of the interview, time was taken at the beginning to describe the project and its aims. Interviews varied in length from 20 minutes to an hour and permission to record was received from all interviewees. Interviews were transcribed on the day they took place. Phone interviews were the preferred medium as they facilitated a fluid conversation, allowing the interviewee to talk freely and in detail about issues that were important to them.

Email Interviews

The interview guide was used to compose a concrete list of questions for email interviews. These were also tailored to the organisation in question. In each email the aims of the research were described and guidelines for answering questions and further contact details were given. Email interviews were more structured by nature and answers were generally limited to the questions listed. Nonetheless, they provided very relevant information. As this format was already textual in nature, replies were transferred into a 'transcript' document of their own.

Live Web Session

One prominent organisation, Inner City Helping Homeless, hosted three live video sessions on their response to COVID-19 during the research period, each lasting around an hour and a half. These sessions took place on their Facebook page and viewers were able to participate by sending questions via email in advance or by commenting as the session was ongoing. The first session was actively participated in; questions relating to the research were sent and were answered during the session. The other two sessions were watched without participation. Rather than transcribing the whole sessions, as they did not exclusively relate to this thesis, when topics from the interview guide or that had been mentioned in other interviews arose, all relevant information was noted and important quotes were transcribed.

Analysis of Interview Data

Immediately after completing interviews, receiving email responses and while watching the live web sessions, notes were made on prominent themes, issues, and topics mentioned. Based on these, early analysis and comparisons of transcripts and the literature review, a number of deductive and inductive codes were developed (Hennink et al., 2011) and then all transcripts were analysed in accordance with these codes (Appendix III).

3.3 Limitations

It is worth mentioning that planning and work for this thesis began before the outbreak of COVID-19 in Europe and the original idea behind the research was to analyse 'spaces of care' in Dublin in detail by carrying out participatory field research with at least one of the services mentioned thus far. Upon the outbreak of the virus it became clear that such a project would no longer be possible. However, as work on the literature review and framework had already been carried out, it was decided that the thesis would still look at homelessness services in Dublin using the concept of 'spaces of care', but now with the added dimension of examining how COVID-19 impacted these services.

Furthermore, much of the research referenced in the literature review that examined these responses to homelessness and the internal dynamics of spaces of care, was based to some extent on participatory methods and observation (Conradson, 2003; Evans, 2011; May, Cloke and Johnsen, 2010; Parr, 2000). As travel was not advised at this time and these organisations were under huge pressure, such an approach would not have been possible. Research on these spaces had to occur remotely through interviews.

Previous work in this field also included interviews with members of the homeless community that used services but this was not possible given the circumstances. Thus, interviews could only be arranged with service providers and the insights gained on the dynamics of these spaces are based solely on the point of view of service providers that were interviewed. Furthermore, when providers discuss those experiencing homelessness, this is taken to mean those that use their services, which is not representative of the whole homeless population. Also on account of not being able to use participatory methods to provide an insight into the dynamics of one, or a smaller number of services, the decision was made to look at the landscape of homelessness service from a broader point of view, before looking at soup runs and day centres in more detail.

Organising interviews was difficult in some cases as service providers were either under pressure or had shut down, the latter was particularly the case with soup runs and tables. It must also be mentioned that there is a limited number of day centres in Dublin and thus the number of potential interviewees from such services was relatively small. However, those that participated in interviews are among the most prominent.

Previous research at the intersection of homelessness services and pandemic outbreaks was limited, especially in the case of Ireland, which had never experienced a situation such as this before. Finding a way to combine the literature on spaces of care and the limited research on homeless services and pandemics, and in turn incorporating this into interviews, was challenging. Thus, though it was the intention of the interviews to focus on the concept of spaces of care and factors which shape them, some of the questions asked in interviews were more generally about the impact of COVID-19, with service providers raising a number of other issues not directly in keeping with the theoretical framework, yet still deemed highly important and relevant for inclusion.

Lastly, this research was carried out at a time when the virus itself, responses to it and research on it were starting to grow and changing constantly. These are ever developing and thus it is important to note that this research is based only data gathered in a fixed time period of February to June.

4. Results and Analysis

4.1 Responding to Homelessness in Ireland

Ireland operates a relatively complicated service infrastructure in relation to those who are homeless (Daly, 2019). The state, local authorities, private and third sector all play a role in responding to homelessness or housing exclusion in some way. This section first looks at the main aspects of the national approach to fighting homelessness and housing exclusion, as reflected in national policy and discussed by Daly (2019), before looking at who is responsible for the provision of homelessness services more specifically, viewing the sector in accordance with the categories used by the EOH: emergency accommodation, temporary accommodation and non-residential services which are non-housing focused including day centres, food distribution and outreach and those which are housing focused.

4.1.1 National Strategies to Fight Homelessness and Housing Exclusion

Ireland's general strategy in place for homelessness has three main pillars: income supplementation with rent, housing-based responses and support services (Daly, 2019). The former two comprise the prioritised pillars of the Irish approach (Daly, 2019) and part of Ireland's most recent national level strategy *Rebuilding Ireland.*

Rent Supplements

The provision of rent supplements by the state to low-income groups have become common practice in Ireland (Byrne and Norris, 2019; Daly, 2019; Hearne and Murphy, 2017). This type of housing support was introduced in 1977 as the Rent Supplement with a second scheme, the Housing Assistance Payment (HAP), introduced in 2014. Under this scheme recipients pay a weekly wage-based contribution to their local authority which pays the landlord rent. There is also the Rental Accommodation Scheme (RAS), where the local authority finds private sector accommodation for qualified tenants and enters a direct contract with the landlord to lease the property for a minimum of four years. Some 86,000 tenants were in receipt of one of these schemes in 2016 (Hearne and Murphy, 2017).

Housing-based Responses: Housing Provision

Ireland's policies on homelessness and housing exclusion also focus heavily on housing provision, the main focus of *Rebuilding Ireland.* In fact, four of the five pillars in this plan –

accelerate social housing, build more homes, improve the rental sector, utilise existing housing – relate directly to housing provision. In terms of accelerating social housing the plan outlines the aim of delivering an additional 50,000 social housing units in the period to 2021 and in terms of building more homes it outlines the aim of increasing the overall supply of new homes to 25,000 per annum by 2020 as well as a Rapid Build programme. Thus, increasing housing stock forms a large part of Ireland's approach to tackling homelessness.

Other aspects of housing provision, more directly linked to tackling existing homelessness, include the introduction of a Housing First programme, mainly in Dublin, which can be accessed by long-term, recurrently homeless people with complex needs (EOH, 2018). The of the national plan aim to increase Housing First tenancies has been achieved (Daly, 2019). The plan also recognises that hotel and B&B accommodation is not appropriate for families and in 2017, Family Hubs, a form of collective living for families with common facilities and services and private bedroom facilities, emerged as a response to this. Today there is a heavy reliance on this accommodation.

The plan also mentions ensuring that there are sufficient emergency beds available in urban centres, leading to the discussion of the homelessness services sector more specifically, looking at who is responsible for providing which services and under which pillar of the national approach these fall.

4.1.2 Provision of Homelessness Services

Local authorities have primary statutory responsibility for the provision of homeless services and general legal responsibility for the provision of housing for adults who cannot afford to provide it themselves (Daly, 2019). They may help with accommodation either by providing housing directly or through arrangements with voluntary housing organisations or other voluntary bodies, or they may provide funding to voluntary bodies for emergency accommodation and for long-term housing for homeless people (Daly, 2019).

Emergency and Temporary Accommodation

Providing emergency and temporary accommodation is part of the national response to homelessness, falling under housing-based responses. There is no operational distinction between what constitutes 'emergency' and 'temporary' accommodation (EOH, 2018). However, Daly (2019) outlines three sub-categories of this type of accommodation (Table 5).

Table 5: Emergency and Temporary Accommodation Types	
Type	**Description**
Private Emergency Accommodation	- may include hotels, B&Bs and other residential facilities used on an emergency basis
Supported Temporary Accommodation (STA)	Includes: - hostels offering congregate, temporary, transitional housing with on-site professional support - services designed for specific groups that provide temporary accommodation for homeless people also within these groups (lone parents, young people leaving social services, ex-offenders and people with addictions) In Dublin: - temporary accommodation for lone adults is mainly in the form of supported housing services for homeless men and mixed gender services – less support for women - STA services for the groups outlined above also
Temporary Emergency Accommodation	- generally emergency accommodation with little to no support - includes homeless shelters (single-site buildings offering bedrooms and shared living rooms/dormitories) for single adults who are sleeping rough - some provide meals, some charge a fee, can be short- or long-term In Dublin: - range of supported emergency accommodation where some one-night only beds can be accessed - only one dedicated emergency service: MQI Night Café

Most emergency and temporary accommodation services are provided by not-for profit agencies on contract from local authorities (Daly, 2019, p. 7) and commercial for-profit entities, with an increased reliance on hotels and B&Bs, with no local authority providing any direct temporary or emergency accommodation (O'Sullivan, 2020, p. 13). Thus, there is a high dependence on the not-for-profit sector for service provision (Daly, 2019), which goes beyond the accommodation-based responses discussed above.

Non-Residential Services

The last pillar of the Irish approach to responding to homelessness is the provision of support services. The EOH research looks at support or non-residential services, under two headings: non-housing focused services, such as day centres, food distribution and outreach services and housing-focused support services, designed to enable homeless people to enter and sustain a new home, this includes the likes of Housing First previously discussed.

The service infrastructure in this field is vast and complex. The voluntary sector plays a huge role in providing supports, with the state's involvement relatively limited to providing grants and funding to certain programmes and organisations. Thus, the nature and structure of these services largely reflect the mission and vision of these voluntary bodies (O'Sullivan,

2016). Organisations providing non-residential services in Dublin can be broadly broken down into three categories (Table 6).

Table 6: Organisations Providing Non-accommodation Based Support Services

Registered Charity in Receipt of Statutory Funding		Registered Charity		Non-Registered Groups	
Name of Organisation	**Year Est.**	**Name of Organisation**	**Year Est.**	**Name of Organisation**	**Year Est.**
Focus Ireland	1985	Inner City Helping Homeless (ICHH)	2013	A Lending Hand	2012
Capuchin Day Centre	1969	Mustard Seed Soup Run (MSP)	2006	Hope for Homeless	(FB Page 2016)
Merchant's Quay Ireland (MQI)	1969/1989	Feed Our Homeless	2017	Homeless Mobile Run	(FB Page 2015)
Dublin Simon Community	1969	The Light House (part of Dublin Christian Mission)	-	Grubs Up Homelessness Services	(FB Page 2019)
Crosscare	1941	Homeless Ministry - Dublin Central Mission	-	Fighting for Humanity: Homelessness	(FB Page 2015)
Peter McVerry Trust	1983	Muslim Sisters of Éire**	-	Homeless Street Café	2016
Ana Liffey Drug Project	1982	St. Joseph's Penny Dinners	-	Friends Helping Friends	(FB Page 2017)
Mendicity*	1818	Guild of the Little Flower	-		
		Missionaries of Charity	-		

* this service does not receive any statutory funding for its day and food service.

** have received sponsorship from state bodies such as the Dept. of Justice and Equality, however, it is unclear whether these were directly for their soup table.

Included in this table are organisations which provide at least a day centre or food distribution service. However, some also provide temporary or emergency accommodation and for many these services only make up a small part of what they do. This is by no means a definitive list of the organisations providing these services, as there is a plethora of initiatives around Dublin, many of which may have little to no online presence.

Registered Charities in Receipt of Statutory Funding

These organisations are the oldest in the service landscape. Many have religious roots and began as drop-in centres offering at the minimum food, for example Focus Ireland, Merchant's Quay Ireland (MQI) and the Capuchin Day Centre. Crosscare a faith-based organisation to this

day, emerged as a response to the needs of people 'living in appalling conditions around the city' and the Peter McVerry Trust began as a hostel for boys impacted by homelessness. Both the Dublin Simon Community and Mendicity Institution have secular origins, with the former starting as a soup run founded by students and the latter by Dublin businessmen. The Ana Liffey Drug Project was the first 'low-threshold – harm reduction' service in Ireland.

These organisations have grown immensely since established, with each now offering a vast range of services, assuming distinct positions within the service landscape. The Capuchin Day Centre's primary function remains providing food, however, it now offers a range of other material resources, hygiene facilities and health services. The Ana Liffey Drug Project's primary aims have also remained unchanged, offering open-access drop-in and assertive outreach services. As well as their food service, Mendicity operate employment and integration services for service users who came to Ireland in search of work. MQI is the day centre which offers the widest range of services, including crisis support and addiction services. Focus Ireland, the Simon Community, the Peter McVerry Trust play a prominent role in the provision of housing-based responses be it prevention services, finding housing or re-housing clients, or providing emergency or supported temporary accommodation. However, they all still operate drop-in and/or soup run services, which in often remain the first point of contact between services and their clients.

Registered Charities

These can be divided into faith-based organisations and secular groups. The faith-based groups St. Joseph's Penny Dinners, Guild of the Little Flower and Missionaries of Charity offer a drop-in food service at set times and days of the week. The Light House also offers a drop-in food service, however, it has longer hours and provides further supports and thus is a more typical day centre. The Muslim Sisters of Éire have a soup table, The Homeless Ministry of the Dublin Central Mission operates a soup run and the Mustard Seed Soup Run (MSP) has both a walking a team and mobile van service. The secular groups Inner City Helping Homeless (ICHH) and Feed Our Homeless, began as soup runs and now are quite well established not-for-profit organisations. The main service they offer is nightly emergency outreach and they are both active in advocating on behalf of their service users.

Non-Registered Groups

For two groups the year in which they were established was verified, for the others, the date in which their Facebook (FB) profiles were established was taken as a benchmark for this. It is

likely that most groups were established after 2010, with the majority really growing after 2014, reflecting the concurrent rise in homelessness. These groups generally provide a soup table service in prime urban locations such as the G.P.O., the Bank of Ireland building and Grafton Street. Each group generally goes out one or two nights a week and between all of them, there is typically at least one soup table in one of these locations for every night of the week. They mainly provide food, clothing, sleeping bags and toiletries. One of the groups interviewed mentioned that they also provide books, a barber and vet service, explaining that each group probably has their 'own take on how [they] do things'. They are entirely voluntary and depend on donations and fundraising.

4.2 Creating Spaces of Care in Dublin

Having established an overview of responses to homelessness in Ireland, as well as a more detailed account of the type of homelessness services offered in Dublin, particularly the organisations offering non-residential services, this research takes a step further by examining how a number of these organisation operate as spaces of care. As seen in the previous section soup runs and day centres provide both material and practical support, however, these are just part of the way in which care can be articulated within these spaces. Interviews with service providers (Table 4), shed light on further ways in which care is articulated within these spaces and some of the fundamental features of their approach towards care. The information presented is based mostly on interview data with some supplementary information from the desktop research. Thus, for the rest of this section when discussing soup runs and day centres it is the service providers in Table 4 that are referred to.

4.2.1 An Open and Inclusive Space

All of the services have an open, inclusive ethos and put little, if any, conditions on the receipt of care. In some cases the presence of people at their service alone is taken as evidence of their need, as one interviewee explains: "we … feel anyone willing to queue for a bowl of food in a busy public street has a need of some description". Also central to the ethos of most groups is that they 'don't ask questions'. For some this has exceptions, for example in matters around child protection or one day centre which offers wrap-around supports asks clients questions when they first present to offer them "as many supports and advice" as possible. Nevertheless, all providers mentioned the importance of making service users feel welcome and included by creating an atmosphere that makes them feel comfortable and like they are part of something,

as one provider explained: “what was priority for us was that there was a sense of … community. So that they could come and be involved with … an atmosphere that feels like they are part of a community, that they’re cared for”.

While ‘everyone is welcome’, each service attracts and engages with a slightly group of service users depending on their structure and the particular services they offer, giving each service a slightly different position within the wider service landscape. Naturally, soup tables are the most ‘open’ service as they set up in public space. Both soup tables described a wide range of service users, with ages ranging from families with young children to the elderly. One provider explained the majority of their service users would be homeless; a mix of rough sleepers and those in emergency accommodation. However, newly released prisoners, people who might not be homeless but are “struggling to feed themselves after bills are paid”, students and elderly people who live alone but struggle to cook were also among the service users described. Both services said that men made up the majority of their clients and one group explained that the majority of their service users are non-nationals.

The mobile soup runs serve a slightly different clientele. The outreach teams of ICHH operate after hostels have closed and thus engage with rough sleepers who may have tried access accommodation but could not and thus are “bedded down for the night”. They may also engage with people who ‘choose’ to sleep rough or that are excluded from the system, describing themselves as the “last port of call for those individuals whether that be for a sleeping bag, a chat, cup of tea, cup of coffee, whatever that might be”. MSP also serves mainly rough sleepers, typically looking after people in more secluded locations. They engage with people suffering from alcoholism, addiction and mental health illnesses. However, their core group of clients consists of people who never go into emergency accommodation, who typically have a well-established location in which they stay. This core group would generally not drink or take drugs and these are “the clients that … [they] so much want to look after”.

Each day centre also attracts and caters to a slightly different group of service users. The Capuchin Day centre is perhaps the busiest and despite offering a number of other services, the provision of food remains its primary function. This centre has a designated family area and provides day-to-day essentials for children and babies and although they mentioned having “all different types” of service users, it was emphasised that they try to support families and young mothers especially. The Light House, on the other hand, has no family area, as a result they do not see many families but rather male and female adults, of which a small percentage are sleeping rough and many more are in city run hostels. They also have clients who have gotten permanent housing but continue to attend the centre. Mendicity is a low-threshold centre

and as it offers many of its services in Russian, Polish, and Romanian, it attracts many non-nationals. It was explained that they see a lot of people who arrive into the country looking for work and people who are migrants in and often 'at the bottom layer of' the work force. Many of their service users have no income and find themselves 'outside' of the accommodation system. They also mention serving marginalised groups, who are in housing but "not really doing that well". MQI, also a low-threshold service, provides a wide range of services; a drop-in food service, crisis support, mental health services, a health promotion unit, a nursing/doctor and dentist service and a needle exchange and safer injecting service. It was explained that many of their service users thus would be homeless, suffering from complex issues such as addiction and mental health illnesses. They also encounter clients experiencing domestic abuse who present seeking support and people who have stable jobs and/or families but avail of their health services. Previously, their typical demographic would have been middle-aged men, however, they are seeing more young people, particularly care-leavers, older people and people who are becoming homeless for economic reasons.

4.2.2 A Non-judgemental Approach

Despite the fact that each service has a different format, range of services and groups of clients, the fundamental features of their approach to giving care and the way in which care is articulated, is similar for all groups. Having an open, inclusive ethos is one defining characteristic of services' approach to care, another is treating clients with respect, dignity and without judgement, as captured by one provider who explained that it is important to "treat people as people … not just as a homeless 'thing'" (Co-director, Capuchin Day Centre). This seemed important to service providers because as they explained, some of their clients are subject to social stigma and in some cases completely ignored, resulting in clients' self-esteem being negatively affected:

> I was chatting to someone the other day that had asked someone that was on the streets for many years … what the worst thing would be … surprisingly the person's answer was 'the way people look at me' (Operations Manager, The Light House)

> They would describe hours and hours of not being spoken to or acknowledged, walking non-stop or being moved from sitting. Basically of feeling invisible (Group Coordinator, Homeless Street Café)

By treating their clients with respect, they can allow them to feel seen and show them that they are cared for. This aspect of their interactions with clients marks service spaces out as sites where clients are provided with a break from the stigma they may be subject to elsewhere. Accepting clients for who they are then, can mitigate negative feelings they may have about themselves and promote their well-being, and this, reflects one of the core conditions for successful therapeutic relationships discussed in the literature: unconditional positive regard.

4.2.3 Building Relationships

Service providers mentioned how important it was to build on such interactions and develop meaningful relationships and even friendships with clients. Nonetheless, one interviewee explained: "the relationship with clients definitely doesn't develop overnight". However, each provider mentioned different techniques used to overcome this. In many cases "It is the small things first, saying their first name, a hand shake, sitting with them having a tea or coffee, listening to their personal stories and building that rapport and trust". One soup table provider explained that they get to know their clients' favourite things like books and deserts and try to include them as part of their offerings, staying at their table after the "initial frenzy", offering tea, coffee and said deserts in an attempt to create an environment that "is encouraging to stick around and chat". The soup runs mentioned the importance of stopping, spending time and chatting with their clients, despite being mobile. They explained that as they are out every night, they quickly become familiar with and build relationships with clients. One interviewee even mentioned that they were called as a next of kin for a former client, indicating just how close some of these relationships are. One day centre emphasised that it is important not to create a 'them versus us', and so rather than have staff and volunteers behind a counter, they have them 'out in the tables' with clients. This idea of being out on the floor and linking in with clients was also mentioned by service providers in MQI.

These steps enable providers to form 'tremendous' friendships with service users and it is argued that central to friendships are the qualities of being open, honest and empathetic towards the other, which are closely aligned with the other core conditions required for successful therapeutic relationships: congruence and empathic warmth. Thus, as the central elements of service providers' approach to care discussed thus far, overlap with the three core conditions for therapeutic relationships (Conradson, 2003), it is argued that here too, spaces of care are marked by the presence of such relationships.

4.2.4 Positive Effect of Relationships

These relationships have the potential to promote the well-being of others and service providers felt that they enhanced their ability to give care: 'with the friendships we've built up we're able to support them [service users] more". Service providers highlighted several ways in which these relationships had a positive effect on clients and the dynamics of service spaces. They played a role in marking service spaces out as sites of social interaction, which is a big draw for clients: "some clients are there for the social factor, sit at a table with friends having a tea or coffee or even to have a chat with staff". Providing such a space seemed important to service providers because they were aware that: 'people come because they don't have relationships … they're lonely'. Thus, providers felt that their service may play a role in alleviating some of the loneliness experienced by their clients and understood that this did not have to be complicated: "I think that for a lot of them it's a chat even".

It was also observed that within these relationships, the articulation of care through chatting and lending an ear can provide quite a meaningful emotional support or rather informal mental health support:

> It is [frightening] when somebody is very distraught … not in a good place … crying and upset … our main thing there is that we would listen … because sometimes … in their talking and telling you how they feel that actually can be very helpful for them … and very therapeutic for them. So … we very much try and let them talk and talk and talk and you know let totally get off their chest what has them … in the state that they're in (Project Leader, MSP)

Furthermore, clients who are more comfortable with service providers may be more likely to confide in them and thus experience the therapeutic effect of speaking to someone:

> When you build up these relationships they are extremely beneficial when the client is going through a crisis and feels comfortable to come to you with the problem or issue (Staff member, MQI-1).

This type of support may be particularly important to those on outside of the service system who do not have access to more formal supports.

These spaces can also provide clients with a break from the sometimes harsher outdoor environment and constantly being on the move, because as one provider explained, even though people might go to a café or restaurant for a break, it can be difficult for them to fully

relax: “I mean you might be able to sit down and have a cup of tea in McDonalds … but you’re kind of on borrowed time” and so what they try to provide, as the same interviewee explained, is: “somewhere where they can sit for a few hours and not be moved along … you know, [somewhere that is] very much their space”. Even those staying in emergency accommodation need such a space because many facilities are not 24-hour, meaning people have to leave in the morning and cannot return until the evening.

> They would come to our service as they have nowhere to go during the day … they come to our service to access the basic needs of food, shelter, warmth, the use of toilet, shower facilities (MQI-1)

Thus, care is also articulated through this desire to offer clients a place of respite, an environment where they can relax, which is particularly the case in day centres.

In the literature review, spaces which provide service users with social and emotional support, a break from stigma, loneliness and violence and with a place where they feel welcome and comfortable, much like the conditions and approach to care described above, are also described as safe spaces. However, here it was found that creating a safe space also took on quite a literal meaning for MQI. For example their crisis contact service aims to provide people with a safe space to seek and receive support with sensitive issues. Furthermore, the supports they offer to drug users, provide them with a safe space to inject and exchange needles and be monitored in:

> many clients would have been brought into our service and monitored if they were extremely effected on drugs … Clients would present to our service knowing they have just used heroin and have a feeling of safety that staff are there to medically intervene if they were to overdose. (Staff member, MQI)

Thus, providing a safe space can take on different meanings for service providers depending on the type of services being offered and on the other side of this, what is viewed as a safe space for clients vary depending on their own particular needs.

4.2.5 Barriers to Care

Creating the desired safe and inclusive environment can be challenging and a person’s ability to provide care can be compromised at times. For soup runs poor weather can be a huge

impediment, the increase in numbers they have witnessed over the past few years was also described as challenging. For example, the Homeless Street Café explained went from serving around 70 people when they started, to serving anywhere up to 300 a night, which required extra volunteers, donations, cooks, clothes and equipment, all of which took time, effort and expenditure to organise. Furthermore, these items need to be collected, stored and transported each week, so now this service which was first run from a car boot requires a van and multiple volunteer cars. One interesting challenge mentioned by a soup table was that "no one wants a soup kitchen on their business doorstep". As many of the soup tables set up in prime locations, one provider mentioned receiving complaints from businesses, Gardaí and clampers who, while being sympathetic to what they do, would "prefer if it was somewhere else".

Most other challenges encountered by providers under normal circumstances were similar for all services. Firstly, as mentioned in the literature review, these service spaces are socio-spatial environments and thus as one provider explained: "in any space that is filled with … people, in any environment there is potential for conflict". Thus, issues that arise in all services usually revolve around tensions in staff-client and client-client relationships. The most frequently cited cause of tensions posing a threat to a safe environment was the behaviour of clients who may be intoxicated, on drugs or suffering from poor mental health.

> we'd have security issues. We'd have people who would be fighting or watching each other on the street and coming here, that kind of thing … people would have … a lot of psychiatric issues (Co-director, Capuchin Day Centre)

> the biggest challenge is … when you get people that are either … intoxicated on drugs or something like that and you get someone you know acting out … where there's inappropriate behaviour a fight starts, confrontations start … that would be probably the biggest challenge … it maybe it happens once or twice a month (Operations Manger, The Light House)

However, both soup tables explained that when tensions arise, their service users usually diffuse the situation:

> I would go as far as to say they are protective of us and the street café itself and any disrespect in the queue is quickly diffused by our regular service users (Group Coordinator, Homeless Street Café)

> when one person starts at our table there's another 349 homeless people there that are respectful, that don't want trouble and they're so appreciative of us going out to help them, they'll all turn on that one person (Team Leader, Lending Hand)

One soup run said that they experience hardly any trouble, which is likely because most of their service users are regulars with whom they have built good relationships. However, very rarely they come across a service user who has overdosed or is suicidal and have to call for further support.

Having good relationships with clients, as seen with the soup tables, but also day centres was cited as a valuable tool for diffusing tense situations. However, in some more serious cases clients are asked to leave or more extreme measures are taken, but these often go against the principles of services and the environment they try to provide. For example, after an extreme incident with a client, one day centre decided to increase its security, only to realise that this was not how they wished to operate:

> we spent the next couple of days with the door closed and … people would knock and … we would let them in. It was really cumbersome and it was unwelcoming and … we kind of thought you know ok as an experiment that's probably not for us … People see a lot of closed doors ... there's lots of place where they're not welcome and we don't want to make this one more (CEO, Mendicity Institution)

In sum, all services have an open, inclusive ethos yet depending on their format and the set of services they offer attract slightly different groups of service users. For most groups beyond the provision of essential resources, their priority is creating an environment in which service users feel welcome and included and which provides them with a break from some of the stigma, loneliness and tiring aspects of being on the streets. Establishing therapeutic relationships plays an important role in creating such an environment and they are central to enhancing the level of support providers feel they can give. While the coming together of these elements has led to spaces of care being described as safe spaces, it was observed that for more specialised services providing a safe space can take on different, more literal meanings. Furthermore, all services mentioned that there are factors which can pose a threat to these safe spaces and cause tensions within relationships. This understanding of how services provide spaces of care under normal circumstances forms the background against which the impact of COVID-19 will be examined.

4.3 Responding to COVID-19

Now that a better impression of the service landscape has been created and an insight into how service providers create spaces of care has been gained, the research turns to examine how the pandemic and responses to it developed, starting with the state-led responses outlined below.

4.3.1 Public Health Measures

The first national address announcing measures to reduce the spread of COVID-19 occurred on 13 March. Given the sudden nature of this announcement and the sharp rise in the number of cases of COVID-19 in the country, particularly Dublin, that followed, homelessness services were suddenly in a precarious position. Over the next number of weeks an increasing amount of restrictions were announced and remained in place until the first, slight easing of restrictions on 5 May, followed by the official 'Phase 1' of the reopening of society and economy on 18 May (Table 7). This is the period of particular interest to this research.

The most significant measures for both the homeless population and service providers were the closure of retail outlets, cafés and restaurants, leisure centres and public spaces including libraries. The strictest measures, which perhaps marked the beginning of the most trying period for these groups, were announced on 27 March when the 'lockdown' was introduced. Initially these restrictions were to last for at least two weeks, however, they remained in place for over seven weeks. Though for most service providers there was no question around whether they would keep operating, there was some ambiguity around what was considered an 'essential service', before the official list of such services was published on 28 March (Government of Ireland, 2020a).

As per this list, in the category 'Human health and social work activities', social work and social care activities (including homeless services including outreach) were considered essential and in the category 'Community/voluntary Services', community and voluntary workers, working in a publicly commissioned service, not otherwise included on the list, deployed to assist in the delivery of essential services and volunteer services operating under the local authority emergency management framework in accordance with public health guidance were also mentioned as essential services. While the position of registered charities seemed secure, the position of non-registered groups was uncertain. It transpired that both the travel restrictions and ban on the gathering of crowds made it difficult for these groups to operate. However, exactly how these measures effected groups is discussed in more detail in section 4.4 Making Changes and 4.5 Challenges as a result of COVID-19.

Table 7: Summary of Public Health Measures

Date Introduced	Main Measures
13.3.	- Closure of schools, colleges and childcare services and cultural institutions - Indoor gatherings of more than 100 people should be cancelled - Outdoor gatherings of more than 500 people should be cancelled - People should continue to go to work, but those who can work from home should do so - Shops, cafes and restaurants to stay open
24.3.	- Closure of all non-essential retail outlets, theatres, clubs, gyms, leisure centres, hairdressers, betting shops, marts, markets, casinos, bingo halls, libraries and similar outlets, playgrounds and holiday/caravan parks - All restaurants and cafes limited to takeaway and delivery services - A ban on all organised indoor and outdoor social events. - People should stay home apart from going to the shops for essential supplies such as food and medicine or medical and dental appointments - Other allowable journeys are for those travelling to take care of others or to take physical exercise - Social gatherings limited to a max. of four people unless they are from the same household - No unnecessary travel should take place within Ireland or overseas - People should only leave home to go to work where attendance at a workplace is essential
27.3.	Everybody must stay at home, in all circumstances, except: - To travel to and from work for the purposes of work only where the work is an essential health, social care or other essential service or cannot be done from home - To shop for food or household goods or collect a meal - To attend medical appointments or collect medicines and other health products - For vital family reasons, such as providing care to children, elderly or vulnerable people - To take brief individual personal exercise within 2km of your own - All public and private gatherings of any number of people outside a single household or living unit are prohibited - Adult community education centres and local community centres will be shut - Shielding or cocooning introduced for those over 70 years of age and specified categories of people who are extremely vulnerable to Covid-19 - All public transport and passenger travel will be restricted to essential workers and people providing essential services
10.5.	- Restrictions introduced on 27.3. extended until 5.5.
1.5.	- 'Roadmap for Reopening Society and Business' published - Most restrictions to remain in place for a further two weeks
5.5.	- Possible to go up to 5km outside of home for purposes of exercise - People cocooning advised to continue to do so - however, possible to exercise within 5km of home as long contact with all other people is avoided
18.5.	- Phase 1 of 'reopening'

4. 3.2 Policy Approach

Beyond the national public health guidelines the government issued *Ireland's National Action Plan in response to COVID-19 (Coronavirus)* in mid-March. This plan states that the actions

being taken within the health service and across Government are driven by three main goals: "to minimise the risk of becoming unwell for all people in Ireland", "to minimise, in particular, the health, wellbeing and social impact for people in Ireland who may be at greater risk from COVID-19 through minimising the risk of illness for them while working to maintain their quality of life" and "to minimise the social and economic disruption associated with the COVID-19 outbreak and the public health measures needed to respond to it". The first two are significant as they emphasise the desire to minimise both the amount of people who become ill with COVID-19 and the broader social impact for people who may be at greater risk. Those considered 'at risk' groups are those "most at risk of complications if they catch COVID-19", such as "older people and those who have a pre-existing medical condition (e.g. heart disease, lung disease, diabetes, liver disease etc.)". However, "socially vulnerable" groups are also recognised, including people who live in sheltered housing and those engaging with addiction or homeless services. The document goes on to explain that these groups will need additional supports and arrangements in the context of COVID-19 and an 'Action Framework' is outlined, of which Action 4 "Caring for our people who are at risk and vulnerable" mentions that the government, community and voluntary sector should be enabled in meeting the specific needs of socially vulnerable people and Action 15 for "Sectoral Services", including "Homelessness Services", mentions issuing homelessness services specific guidance to all local authorities and service providers, providing for additional outreach teams to offer accommodation to rough sleepers and developing measures to reduce demand for emergency accommodation, as actions either taken already or to be taken later.

Correspondingly, the HSE and HPSC, published a homelessness services specific guidance document for "homeless and vulnerable group settings" (Table 2). However, as the homelessness services that the state provides are mostly accommodation-based responses, the "settings" that this document refers to are "congregate settings or facilities managed by staff" such as "direct provision centres, hostels, hubs or residential settings." In other words, this document and the measures it outlines, apply only to accommodation-based homelessness services provided by the state in some capacity and as the document further highlights, generally only those who are registered as homeless have access to these services: "In Dublin, homeless services mainly cater for those who are registered as homeless and on PASS system". Thus, while this document is useful for the operation of temporary and emergency accommodation, it does not apply to other homeless settings such as day centres or soup runs. Much like the group they cater to, the consideration of these services in policy planning was minimal.

In terms of the response from the Department of Housing, according to statements on their website the Department implemented a range of measures to protect those in Emergency Accommodation during the crisis. The only two press releases publicly issued by the Department during the whole research period, stated that local authorities had secured additional emergency accommodation to "ensure that there is sufficient capacity to allow for the isolation of confirmed or suspected cases of COVID-19" and by mid-April it was reported that over 1,000 additional beds had been created for emergency accommodation in Dublin (Kilraine, 2020). At this time, DRHE had also changed its Central Placement Service to an appointment only service for safety reasons. How these responses affected homeless services across Dublin, especially those interviewed, is discussed in the following section.

4.4 Making Changes

All of the services in Table 4 were affected by COVID-19 in some way. By the end of March, the soup tables had shut down, mobile teams introduced extra safety measures and decreased in size and most day centres changed to a take-away service. Through talking to service providers an insight was gained into exactly what kind of changes were made and the factors involved in making decisions around changes or ceasing operation.

4.4.1 Soup Tables

Soup tables were in the most precarious position when restrictive measure were introduced. Service providers expressed how important it was to them to keep operating, but it became increasingly difficult to operate in keeping with public health guidelines. This was realised by one group after an incident with the police, who threatened to shut them down if social distancing was not adhered to in their queue:

> So when I got to my table I was … like a referee like I was running up and down … and all I kept saying was 'please stand two meters apart, they're going to shut us down' (Team Leader, A Lending Hand)

The other group explained that their 'hand was forced' when lockdown measures were introduced:

> Our street café just blatantly did not follow the guidelines to allow us to continue running given we would have a crowd of 100 people in our queue potentially at a time and that we were travelling … to provide the service. (Group Coordinator, Homeless Street Café)

The decision to stop operating was also made in the interest of the safety of clients and volunteers. In fact, both soup table co-ordinators fell ill themselves. One interviewee explained that they thought they had COVID-19, so to protect their clients and volunteers they came off the streets. The other interviewee, a health care professional, explained that they had contracted COVID-19 and would be working in an environment with the virus and thus "could not responsibly continue", explaining that they "had the responsibility of not passing this virus on to … service users who were vulnerable".

Nonetheless, staying at home made one provider feel 'helpless' and 'angry', so they found new ways to help, for example by sharing their resources with other services. The other co-ordinator expressed similar feelings: "It was a little distressing for our group who have been operating for four years to be at home knowing our service users were struggling so we were always trying to find a method of continuing" and so they started a mobile soup run, for which they had to 'totally diversify' and learn how to provide resources on a walk-around basis. They also introduced PPE and tried to adhere to social distancing.

4.4.2 Mobile Services

The mobile services also expressed how important it was to keep operating. Both organisations provide services to particular groups, with one reaching out to those on the streets after hostels have closed and the other looking after their core group of clients that do not want enter into emergency accommodation. This made it all the more important to them to continue: "the majority of our clients are regulars and that's … why it's so important that we … kept going each night" (Project Leader, MSP). The position of these services was more secure as they are both registered charities and as one provider explained come under the government guidelines of essential work. Their main concern was finding a way to keep operating that would protect volunteers and the vulnerable, while offering the maximum level of service possible, to do this changes were made. Both groups stopped their walking teams, with one provider explaining that it would be too hard for a walking team to stick to social distancing. However, they were able to adapt their mobile operations, i.e. vans, with relative ease: "we were able to adapt to that very quickly and very easily … it wasn't a major thing". At the height of the lockdown phase, MSP only had one experienced driver going out each night, whereas they would usually

also have a companion and PPE was introduced. As their van is a former chip van they serve from behind a counter anyway, but since the pandemic they also installed a protection screen. They have since resumed going out with two people. ICHH reduced their number of outreach teams from five to two, tried to ensure that HSE guidelines were adhered to and also introduced PPE, expressing just how essential this was: "we definitely wouldn't been able to continue doing what we do without ensuring that we had PPE put in place for our volunteers".

4.4.3 Day Centres

Day centre staff also emphasised the importance of continuing and were likewise faced with the dilemma of how best to serve clients while ensuring the safety of staff, volunteers and clients. For three of the day centres, this was done by changing to a take-away service. Despite being made in a short time, these decisions required careful consideration. One day centre for example consulted its medical team and decided that on account of the small size their space and corresponding difficulty of implementing social distancing, the safest thing would be to move to take-away. Service users were however allowed to eat their meals in the church next door, thus, despite closing its doors "nobody needs to go hungry and … that's our primary thing" (Co-director, Capuchin Day Centre). For another day centre, an incident made it clear that remaining open would put the health and safety of staff, volunteers and clients at risk:

> we actually had a guy come into our café [he] was coughing in a way that was like I've never seen anybody, probably, cough and he's in the middle of our dining rooms … coughing up a storm … and he also kind of refused to leave … and so you know at that point I remember thinking … 'wow we can't keep doing this' (Operations Manager, The Light House)

However, before they closed they surveyed other homelessness services and upon realising that no service was offering an end of day service, decided to fill that gap by providing "a good meal pack" between four and six. They also went from operating five days a week to operating daily. To further ensure the safety of team members and clients food was served from behind a screen and social distancing rules applied to their queue. Both of these day centres reduced the number of people working so that social distancing could be adhered to inside.

MQI also switched to serving take-away meals and continued to offer contact crisis work and an emergency doctor and nursing service at the door, as well as a take-away needle exchange service. It was emphasised that it was 'vital' to continue offering services as there was a demand to support homeless and active drug users during this crisis. They did however

close their showers and toilets. Within the service staff were split into smaller teams to prevent cross overs.

Interestingly, the day centre that decided not to close its doors mentioned that they would have happily done so. However, they also mentioned that their usual clients would not be among the group that were "going to be swept up into comfortable Air B&Bs and provided with ample services", and so they first looked to see how responses unfolded elsewhere. As most services moved to take-away, they recognised that clients needed a place where they could go inside and use facilities: "so we said okay even if we are not feeding everybody if we have a place where people can come in, charge their phone, go to the toilet you know … that became important".. This demand outweighed any option they may have had to close and so they introduced long-term changes to make the service more safe; they increased their service from five to seven days, put up signs, removed furniture, removed three of their consulting rooms to create more space and had a shower built and washing machine installed, describing these as "absolute necessities". They changed staff hours and split staff into three 'cells', so that minimal time was spent in the building and not all staff were working together, meaning that there would be continuity if someone became ill.

Each service had to take different factors into account when making decisions around closing or introducing changes. For soup tables public health guidelines made it difficult to keep operating, while the position of registered soup runs and day centres was more secure. Nonetheless, they had to introduce changes, which for some was straightforward but for others involved difficult decisions and/or required a lot of work. Earlier it was pointed out that one of the biggest challenges faced by service providers in past pandemics was weighing up concerns around the spread of infection against homeless people's essential need for food and shelter when making decisions to cease operations (Leung et al., 2008). The decisions of the services here essentially came down to the same thing. However, what was deemed an essential need was interpreted differently by different services. Most felt that by providing food they were continuing to meet clients' most essential needs, while also ensuring the least risk of an infection outbreak. However, for MQI, this also meant continuing to provide specialised supports for clients with complex needs and for Mendicity it meant ensuring clients had access to a safe indoor space, with hygiene facilities and other services, however here risk of infection might be higher. Thus, in the context of a pandemic the concept of providing a safe space takes on a whole other dimension and the articulation of care is changed. The impact of these decisions and changes on the articulation of care is discussed in the following section.

4.5 Challenges as a Result of COVID-19

Although all interviewees felt that they and the service they work for had done their best to remain in operation and provide care given the circumstances, with services operating on an altered basis, the way in which care could be articulated was much more limited and service providers felt that their ability to provide care had been compromised in some ways. Not only did services face a number of practical challenges, but moreover fundamental principles of their approach towards care, such as their open ethos, relational nature, the respect and dignity they try to give clients and generally providing a safe space, were challenged. Many services also experienced an increase in demand, putting further pressure on already strained services.

4.5.1 Practical Challenges

For services, changing the way in which they operate was accompanied by practical challenges. For the Street Café changing to a walking team involved acquiring trolleys, putting all meals in take-away containers and sourcing PPE, which took time and increased operation costs. They also mentioned how difficult it was to carry 'a range of necessities' with trolleys alone, often having to prioritise what to carry and return to their cars to restock. As mentioned previously for soup tables, ensuring that social distancing was adhered to in queues was an issue and for the day centres that remained open on a take-away basis, this was also cited as a big challenge. The introduction of infrastructural changes in Mendicity, such as a new shower, washing machine and removal of consultation rooms, was costly and a logistical challenge as they had to find a builder willing to work outside of their service hours and take a risk by being there. Again the mobile teams encountered the least difficulties, with one group explaining that apart from one incident when they were waved down on a busy street and attracted a crowd, everything went "very smoothly". This was largely due to the fact that their core group of clients were "very tuned in" as regards COVID-19, acting respectfully and even wearing masks.

4.5.2 From Inclusion to Exclusion

Service providers found the introduction of changes difficult as they challenged the open and inclusive ethos that lies at the heart of these services and led to services becoming exclusive in many ways. For example for the Street Café moving to a walking team meant that they were not able to serve as many people: "This process of walking around town means we spend roughly three and a half hours covering about half the amount of people we would manage in

one and a half hours at the table". Naturally, changing to a take-away service resulted in day centres becoming exclusive as they closed their doors to service users.

A change in relationships

Becoming more exclusive meant that the relational aspect of care which service providers value and plays a huge role in making service users feel welcome, providing them with a site for social interaction, was taken away. Service providers were conscious that their ability to provide care was compromised as a result of this:

> the hard part for us and for them is, we've very little interaction, we've only interaction with one person at the door handing out the meal. We don't have interaction so ... we can't support them in the same way (Co-Director, Capuchin Day Centre)

The loss of this relational aspect was commented on by another day centre employee, who nonetheless, felt that even though their service is "much less relational" it is still "providing a very practical need".

The relationships between service providers and clients and the ability of providers to give social and emotional support was compromised by social distancing precautions and the wearing of PPE, which it was explained can 'hamper communication'. This was difficult when meeting distressed clients:

> A man sobbed and sobbed telling us his circumstances the other night during our outreach and it was heart-breaking for us to not be able to stand close, give him a comforting touch or even sit with him for a while (Group Co-Ordinator, Homeless Street Café)

Furthermore, some of the new modes of operating stood in conflict with the principle of treating clients with respect and dignity. For example, soup tables usually set up their service and allow people come to them. However, changing to a walking service, meant that they would be entering their clients private space when trying to provide care and this may not always be welcome:

> when we operate a table it is an open invitation for people to visit us if they decide to but with the mobile outreach we are conscious we are entering their space uninvited and unannounced. This can be an intrusion and may be difficult for people with mental health difficulties, addiction

> issues or for a number of other reasons. We need to proceed with a level of caution … respecting privacy and space (Group coordinator, Homeless Street Café).

While they are mindful of clients' privacy, the risk of being intrusive or that the interaction is less dignified for clients exists.

Treating clients with the same level of dignity and ensuring their privacy was respected was very difficult for service providers in MQI, who continued to offer their crisis contact service at the door or on the street. Staff members felt that dealing with clients' issues outside made it "extremely difficult to complete an appropriate, meaningful and beneficial intervention". Additionally, social distancing rules had to be adhered to, further increasing the difficulty of delivering their usual 100% confidentiality service:

> we are unable to bring the client into an office in the right environment with a cup of tea and having an intervention. Now we are sitting on a curb outside the service or at the front door where clients disclose the most personal information about themselves. A woman presented newly to the service stating her husband has been physically abusing her, she travelled … as there was not many services she could access … this intervention was done standing out the front of the service where she disclosed extremely personal information, she was visibly upset and paranoid that others were listening while having to adhere by the 2 meter social distancing (Staff member, MQI)

This highlights the importance of the right environment for both service providers and users when providing care. A safe space allows for the privacy of the client to be respected, allowing them to feel comfortable, in turn enabling service providers to give the most appropriate advice and the best level of care.

For this day centre closing doors, also meant taking away a safe space for drug users. Not being able to provide their full safer injecting, needle exchange and monitoring services was a large concern for service providers and led to some difficult situations:

> both clients were across from the service and overdosed …Usually these clients would have come into the service and have the feeling of security that if they did go over we are there to help, luckily it happened outside the service for us to see and run over and assist (Staff member, MQI)

By closing their doors day centres took a safe space away from clients and undermined the relational nature of their care, in turn compromising their own ability to provide care.

However, even the day centre that kept its door open, became exclusive in ways. As social distancing had to be implemented within the centre, only a certain number of people could be let in, thus it was decided that only regular service users would be allowed enter the centre while these measures were in place. While no one presenting at the door was turned away immediately, people still had to be refused, which was very difficult: "that was a really unpleasant element over the period of time … having to turn people away … it's not what we're about".

4.5.3 Increase in Demand

On top of the challenges outlined above, most services experienced an increase in demand. Soup tables mentioned seeing lots of new faces, one day centre went from serving 100-120 meals a day to serving over 300 and another went from serving 550 meals a day to serving 850. Only MSP, with its core group of clients, did not mention a significant increase in clients.

A number of reasons were cited for this increase. Firstly, the closure of retail, commercial and public spaces under public health guidelines and the closure or reduced operation of homelessness services had a knock-on effect for those still in operation. Usually cafés, restaurants and soup runs would be available as sources of food for those experiencing homeless. Furthermore, such spaces and shopping centres would provide people with somewhere to spend time. When the majority of these shut down, services still in operation gained new clients. Secondly, many providers mentioned that a lot of their new clients were people who had recently lost their jobs, some had somewhere to live but could no longer make ends meet, whereas for others this resulted in missing rent payments and becoming homeless. Furthermore, one provider explained that some of their clients would have been paid under the table, meaning that they could not claim social welfare benefits or the COVID-19 payment, leaving them with no source of income at all. Thirdly, one provider mentioned that some of their new presentations were part of the 'hidden' homeless in vulnerable housing situations that were unable to remain in their living situation, for example people sleeping on a friend's couch that were asked to leave given the circumstances. Fourthly, around 500 to 600 people were temporarily released from the prison service to prevent the spread of COVID-19 and many of these entered onto the streets or were registered as newly homeless.

Additionally, a large number of people in hostels began "taking their chances" on the streets as they felt that hostel accommodation was not safe. While it must be acknowledged

that even in non-pandemic circumstances there are some people who simply do not wish to enter the hostel system, these were people who had access to beds but decided to give them up:

> people that are in hostel style facilities … now at the moment are leaving hostels in order to go back onto the streets. Many are looking for tents, the reason why is because there's big, big issues in regard to hygiene within the hostel facilities … many individuals that are in those hostels, are in those hostel units with multiple other people in the room and it's against the chief medical officers advice to be sleeping in a room with anybody else that's not part of your immediate family (CEO, ICHH)

Moreover, for people who *did* want to access emergency accommodation, especially the newly homeless, it became increasingly complicated to register as homeless and thus be eligible for accommodation. For the services that help clients with registration and accessing accommodation this was one of the biggest sources of frustration, especially as the local authority announced that over 1,000 extra beds were made available as part of their COVID-19 response. It was explained that in order to register as homeless a person had to be seen as sleeping rough:

> A huge challenge we are facing is that many people are presenting as newly homeless and rough sleeping, due to current circumstances they must be verified rough sleeping twice and sometimes three times to be registered as homeless. This was a massive challenge for us as our hand were tied (Staff member, MQI)

One of the outreach teams described registering newly homeless as "pandemonium" as there was confusion around who was responsible for registration at this time:

> when we look at the registration process of homelessness … the message that has come across over the last couple of weeks is go to point A to register, when you go to point A, they tell you go to point B, they tell you to go to point C, there's a big issue in regard to who is responsible for registration. Is the assertive outreach? Is it central placement services? Is it the DRHE? All the one really but in regard to trying to get people registered … it's been very difficult (CEO, ICHH)

Another provider felt that the system was failing to deal with people in the 'here and now' and explained that this 'kind of not allowing or not dealing with new presentations … in any

proactive way' has been very 'cumbersome', further providing insight into how the central placement service had been redirecting those trying to register:

> dealing with the central placement service as we do every day … if somebody … finds themselves here, sleeping rough in Dublin … they [Central Placement Service] will try and push them towards either an embassy if they're not Irish or another local authority area if they've ever been in another local authority. Now you know … you're kind of thinking okay look let's deal with this here and now and the here and now is I have a person in the morning, who slept outside last night and they are in Dublin. But you know they'd be very keen to push back and … not bring somebody into services. (CEO, Mendicity Institution)

It was pointed out that this advice involved travelling, which would have been against public health guidelines and those receiving this direction were not provided with any further support such as a bus ticket to fulfil such a task. The reality one service provider explained was that some of their clients slept outside for weeks while they tried daily to contact the central placement service. Again, this was particularly frustrating given that extra emergency beds had been made available and though these were reserved for those who needed to self-isolate, it seemed illogical to one interviewee, to have beds lying empty when there were people trying to access accommodation:

> so instead of saying okay look … we're paying for isolation units, we're paying for you know … high support beds, we're paying for these things anyway and just because you don't have a COVID positive patient doesn't mean that it should be idle (CEO, Mendicity Institution)

Evidently, there was no perfect way to keep operating. Adapting services brought practical challenges, such as learning how to operate as a walking team, managing social distancing in queues and within services, operating with smaller teams, and costly infrastructural changes. Beyond this, new modes of operating stood in conflict with some of the key characteristics of spaces of care in Dublin such as their open, inclusive and non-judgemental ethos, relational nature and ability to provide clients with a safe space. For mobile teams PPE and social distancing made it difficult to communicate with clients and furthermore, lend an ear and the informal emotional support discussed previously. While closing doors for day centres meant that they could provide a material resource to a large amount of clients, it was at the expense of providing clients with a safe space and the relational aspect of their care. Becoming

exclusive in this way was particularly concerning for one day centre who could not guarantee a safe space for clients presenting in crisis or drug users. On the other hand, the day centre that kept its doors open was able to provide a safe space in which clients could chat, relax, wash themselves and charge their phones, but this was at the expense of having to turn away new clients, thus becoming exclusive in a different way. Increased demand put services under further pressure; an increase that showed no signs of alleviation as people continued to leave hostels facilities and newly homeless could not register or access beds. This frustrated service providers as it hindered their ability to care for their clients. This leads to the final part of this section namely, service providers' impression of what the biggest challenges for their service users have been, which in turn will shed some light on exactly how this group are vulnerable under these circumstances.

4.6 Framing Risk

In the context of a pandemic those experiencing homelessness are usually seen as vulnerable in the sense that they are at a greater risk of health complications from the virus and/or more likely to obtain infection due to their social vulnerability, or rather their social determinants of health. However, service providers in Dublin mentioned several other ways in which their clients were vulnerable during this time, some of these were indeed regarding the increased risk of infection and consequent medical complications, whereas others were as a result of the exacerbation of some of their existing vulnerabilities, such as the increased difficulty of accessing hygiene facilities, food, and support services. This section focuses on what service providers perceived as some of the biggest challenges facing their clients, be they issues that they have witnessed themselves or been told about by clients.

4.6.1 Concerns Around COVID-19

When service providers were asked what their clients' main concerns were at this time, the extent to which concerns around COVID-19 featured varied from service to service and client group to client group. Service users of soup tables were described as "fearful because they knew how vulnerable they were" and "very anxious about becoming ill with it" and as mentioned previously the regular clients of MSP were "very tuned in". Nonetheless, clients of this service still voiced concerns around the virus, for example a client who usually stays in the same secluded location, became alarmed by an increase in people passing this space:

> he's in this residential area and what's happening is … with COVID-19 and the restrictions there's an increase in traffic going by him and especially joggers … now he's very concerned about that, that he would get COVID-19 (Project Leader, MSP)

Another one of their clients in a hostel was concerned about the lack of social distancing in this accommodation and expressed concerns that some of the residents may have had COVID-19, such concerns often lead to people leaving hostel facilities.

4.6.2 Hygiene

Those concerned about the virus expressed concerns around maintaining good hygiene. Under normal circumstances, many of those experiencing homelessness, especially the street homeless, would rely on a small number of day centres, cafés, restaurants and public amenities for hygiene facilities. However, as lockdown measures were introduced and services started to close, access to hygiene facilities became limited:

> a lot of individuals that would normally use the likes of restaurants and toilets and … public amenities to shower have not been able to do that because of the restrictions that are in place and a lot of places that have closed down (CEO, ICHH)

> They were also concerned they could not follow government guidelines on how to protect yourself. They had no access to toilets and washbasins, they had no access to showers and they had no access to hand sanitiser or PPE. (Group Coordinator, Homeless Street Café)

One provider felt that public amenities should have been made available to the homeless to enable them to follow public health guidelines:

> we've got public facilities and amenities that are there and we should be using those public facilities and amenities … in order to allow people to ensure that they can access appropriate hygiene and to ensure that they can use toilets, ensure that they can use showers as well (CEO, ICHH)

Throughout this time the demand for hygiene facilities persisted, in fact service providers in one day centre mentioned turning away clients asking for toilets or showers and another mentioned that clients were going into the sea to wash themselves. As mentioned earlier, one provider recognised both the need for, and lack of, available services and installed a shower.

Above all having access to sanitisation is a basic necessity and furthermore, maintaining a clean appearance is important to many homeless people as they do not want to appear as homeless. What the pandemic and lockdown measures made clear is that access to sanitisation facilities for those experiencing homelessness, especially street homeless, is already limited and an event such as this can remove their access to these facilities overnight.

4.6.3 Unchanged Needs

Conversely, there were some clients who expressed no major concerns around COVID-19. One soup run provider explained that for the minority of their clients who might suffer from addiction or poor mental health the whole "COVID thing wouldn't really mean that much". For many of Mendicity's clients, who are non-native English speakers, information on keeping healthy was unclear and had to be translated. Others explained that their service users were just 'plugging' along and that for some, good hygiene and health were not a huge priority anyway:

> the homeless community certainly is not a community that necessarily has good hygiene or … health habits (Operations Manager, The Light House)

> if you're sleeping outside, you're a heavy smoker and you're drinking … you're tired, your health isn't great anyway (CEO, Mendicity)

Those experiencing homelessness are a group already in crisis: "they have been in crisis before COVID-19 and this is … almost just a continuing of this crisis", and so for many, the priority of ensuring that their own basic needs were met, whatever they may be, remained unchanged, and this was more important than any direct concerns around the virus. In fact, those experiencing homelessness became more vulnerable at this time, as in some cases it became increasingly difficult to meet these needs.

4.6.4 Access to Food

Access to food became more limited. The multitude of food distribution services that operate in normal circumstances are representative of the scale of the existing demand for food and upon the outbreak of the virus this need did not disappear. However, as the majority of these, as well as cafés and restaurants, closed, for some time at least, it became more difficult to access food. Furthermore, emergency accommodation often has no cooking facilities and it was mentioned that during this time some accommodation facilities were either not providing

food or that portions were very small, thus people continued to rely on external services for sustenance. Regular clients of MSP were almost exclusively reliant on this service throughout the pandemic; the project leader mentioned that clients had told him they brought them through COVID-19. Thus, those experiencing homelessness at this time were at a heightened risk of going hungry.

4.6.5 Routine, Structure, Social Interaction

Service providers also expressed concerns about how isolating this time may be for clients:

> I think, this escalates even more of the loneliness and nothing to do for the homeless community because there's, you know, you can't even, you know there's not even that business on the streets that there would normally be (Operations Manager, Light House)

One provider mentioned that clients were eager for restrictions limiting services to end, because has been observed, for some people services provide an important source of social interaction. The closure of public and commercial spaces such as libraries and cinemas, was also cited as an issue for service users, because these spaces can form a large part of people's routine. As mentioned in the literature changes to usual ways of life can make people feel anxious and unsafe (Usher et al., 2020) and thus the disruption of routine and the isolation felt due to the loss of safe spaces to relax and interact with others can have a knock-on effect on the mental health of those experiencing homelessness. In fact, one service that had set up a support phone line for service users mentioned that "There has been an increase in number of calls daily to clients who are staying in accommodation as some have not left their accommodation since mid-March and their mental health is deteriorating because of it" and they were aware of the loss these closures were for some: "I do feel that the clients themselves might feel that due to not physically be able to come into the service and have the social aspect, they might feel let down".

4.6.7 High Risk Groups

Lastly, those experiencing homelessness with more complex needs, can become even more vulnerable at this time. The closure of safer injecting facilities and a monitored space for high risk drug users, increased the risks facing clients who would usually avail of these facilities. Furthermore, it was mentioned that some of those released from the prison service had

addiction issues before entering the service and thus were at risk of engaging in the habit again or of being badly affected if they do engage:

> There was a cluster of people released from prison at the start of Lockdown … which led to many people being put out onto the streets with no plans or accommodation put in place, these clients were presenting who hadn't used in 8 months to a year and their tolerance was very low which was a risk to overdose (Staff Member, MQI)

Concerns were expressed that clients who were working towards being, or were already, drug-free, may relapse: "Some clients who were drug free are at risk of relapsing due to not having 1:1 meetings [for example] AA/NA/CA, these are all online at the moment and not all clients would have access to a computer" (Staff member, MQI). Other services were also moved to an online or phone format and it was mentioned that these were out reach for some people as again, many people would not have access to a computer and while many would have a phone, with most places closed, there were less places to charge phones and thus avail of such service. It was also mentioned that there are some people who "would be out of depth with that type of service". Thus, anyone without access to these modes of communication, especially those who might rely on specialised support services such as drug users, or people with mental illnesses were highly vulnerable at this time.

Other groups mentioned who were at an increased risk at this time were those experiencing domestic abuse, who in some cases had "no means of escape from their perpetrator" as one concerned provider explained. It was also mentioned that as a result of being asked to move by the police, some rough sleepers had gone to more suburban areas. However, this could have made them more vulnerable as it meant that they have less access to the few services still being offered in the city.

The above challenges highlight ways in which those experiencing homelessness, a group already in crisis as many service providers were keen to emphasise, were made more vulnerable at this time. Having limited access to hygiene facilities, food, as well as places to socialise and relax, not to mention accommodation, is a fact of many homeless people's daily lives before COVID-19 and the increased difficulty in accessing these during the pandemic brought these issues into sharper focus. Furthermore, those suffering from more complex issues are already quite vulnerable in terms of both their physical and mental health and are at a high risk of experiencing negative outcomes as a result of changes in services. This highlights, as

O'Sullivan and Borgoin (2010) pointed out, that when planning for a pandemic it is important to "look beyond medical risk" because while those experiencing homelessness are medically at risk and have a higher chance of catching the virus due to their social determinants of health, they are also vulnerable in the sense that so many of the supports that they rely on from something as basic as the provision of food, to something specialised like safer injecting facilities or mental health support, could fall away and put them at risk of hunger, loneliness, poor hygiene, mental health problems, overdose and relapsing, to name a few. As one provider put it: "homelessness has not gone away because of COVID-19 and … it hasn't gotten any better through COVID-19".

5. Discussion and Conclusion

The aim of this thesis was to examine the role of soup runs and day centres in responding to homelessness in Dublin and how the ability of these services to provide spaces of care was affected by COVID-19. To fulfil this aim the thesis presented its findings in two parts: first, a discussion of these services under normal circumstances, then a discussion of these services since the outbreak of COVID-19.

To begin with it was established that these services do not fall under the prioritised pillars of the national approach to responding to homelessness, which are centred around housing, but rather under the pillar of 'support services' which are typically provided by third sector organisations. The number and type of support services that exist is vast, even looking only at those that provide soup run or day centre services, organisations range from well-established, registered organisations which often receive statutory funding and generally offer a wide range of services, to organisations that do not receive any statutory funding including faith-based and secular groups whose primary service is typically the provision of food in a day centre or outreach capacity, to smaller non-registered groups which are completely voluntary, generally providing soup tables.

Then following the work of Cloke, May and Johnsen (2010; Johnsen et al., 2005a; Johnsen et al., 200b) who, in reaction to punitive measures and the corresponding framing of responses to homelessness, used the concept of 'spaces of care' (Conradson, 2003) to examine the seemingly more accommodating responses of soup runs and day centres in Britain, the same services were examined in Dublin to shed some light on services that are relatively understudied in an Irish context, which has thus far generally focused on accommodation-based responses. It was established through desktop research and in-depth interviews that much like their British counterparts, these services provide material resources and practical support but also social and emotional support to clients. Each service attracts and caters to a different group of clientele depending on their format and type of services offered, however, the range of service users described was expansive including all age groups, street homeless, those in emergency accommodation and housed clients, different nationalities and clients with complex needs, illustrating just how widespread homelessness is in the city and how many rely on these services for support.

Then this thesis looked at state responses to COVID-19, highlighting that under public health guidelines, only the services classed as 'essential' by the government were officially able to continue operating. Furthermore, while the national action plan in response to COVID-

19 identified ‘socially vulnerable’ people, including those engaging with homelessness services as an at risk group and stated the importance of meeting their special needs, part of this plan to provide additional outreach teams to offer accommodation to rough sleepers and develop measures to reduce demand for emergency accommodation did not align with the experience of service providers on the ground. Moreover, while the HPSC and HSE published guidance documents for ‘homeless and other vulnerable group settings’, these were only for accommodation-based services and thus were not relevant for soup runs and day centres meaning these services had to make their own decisions about how or whether to continue operating. The service landscape was completely altered and the availability of care was much more limited and this often made those experiencing homelessness even more vulnerable at this time.

In conclusion and to answer the research question, first and foremost the role of soup runs and day centres in responding to homelessness in Dublin is to ensure that the immediate needs of those experiencing homelessness are met and this role became more apparent and indeed important upon the outbreak of COVID-19. This role is fulfilled in the first instance through the provision of food, material resources, as well as the provision of practical support by giving clients information and advice. Some services provide further support through health services, hygiene facilities, employment and integration services and specialised supports for clients with complex needs.

However, through viewing these services as spaces of care it was learned that their role expands further than this. Characterised by their inclusive and non-judgemental approach to care, centred around building therapeutic relationships with clients (Conradson, 2003), these services play a role in alleviating some of the hardships experienced by their clients such as loneliness, stigma, despair, constantly being alert and even fear, by providing them with safe spaces in which they can receive social and emotional support. Beyond the conceptualisations of spaces of care or safe space presented by Cloke et al. (2010), some services in Dublin provided a safe space in a more literal sense, for example for crisis contact and injecting services.

Upon the outbreak of the pandemic, however, the role of many of these services became limited to the provision of food and some specialised services. Nonetheless, with many soup runs, cafés and restaurants shut down, especially during the lockdown phase of the response to COVID-19, these services experienced an increase in demand as they were some of the only sources of sustenance available to those in need at this time, as confirmed by one provider who explained that their clients told them they “brought them through COVID-19”, verifying the

supposition that these services are "vital to keep homeless people alive" (Evans and Dowler, 1999).

Thus, in relation to debates around whether such services are the 'right' way of responding to homelessness, it is argued that services should be evaluated by what lies within their "core or realistic remit" (Conradson, 2003) and in terms of their overarching aims, which could be short- or long-term. Thus, while O'Sullivan criticises these services for enabling people to live on the streets, describing them as ineffective and counter-productive, it is evident that these services are an emergency response to an emergency situation, firstly, the homelessness crisis and now the pandemic, dealing with people's needs in the 'here and now', as opposed to directly tackling the structural causes of homelessness over a long-term trajectory, which many critics of these 'accommodating' responses argue is the best way to tackle homelessness. This, however, is not disputed, in fact, this thesis actually highlights the need for structural change, as clearly there is a high demand for emergency services both before and since the outbreak of COVID-19. However, what a virus as such as this makes clear, is that in the short-term there will be, and are, people in need of emergency relief that cannot wait for larger structural changes to occur.

Despite this vital role and the fact that service providers felt that they had done their best to provide care given the circumstances, their ability to provide care was compromised by COVID-19. While under normal circumstances, much like in the research of Cloke, May and Johnsen (2010), often the biggest challenge facing service providers revolved around problematic service users and/or tensions in staff-client or client-client relationships, posing a threat to the safety of spaces of care, obviously since the outbreak of COVID-19 the biggest threat to safety became the virus. Thus, just as Leung et al. (2008) observed in homelessness services in Toronto after SARS, service providers in Dublin had to weigh up concerns around the risk of infection outbreak against clients' essential needs and the greatest challenge became providing a service that met the needs of clients as best as possible, while also minimising the risk of infection.

While during SARS in Toronto, public health authorities did not mandate the closure of any homelessness service sites and providers elected to continue their core operations, the effect of COVID-19 and public health measures on services in Dublin was more varied. As a result of public health guidelines and in the interest of the safety of staff, volunteers and clients, some services closed, while others introduced a number of changes. Most soup runs had to shut down, as they could not operate under lockdown conditions, mobile soup runs were able to continue but had to reduce team sizes and introduce extra safety measures and all but one of

the day centres interviewed changed to a take-away or 'at the door' service. As a result, for most service providers the articulation of care became limited to providing sustenance, material resources and in some cases crisis support and specialised services for drug users as well as assistance with registering for accommodation.

These new modes of operating compromised the ability of service providers to provide care as they stood in conflict with fundamental features of their approach to care. All services became exclusive in a sense, either not being able to serve as many clients or by not allowing clients to enter their service space. By closing their doors, day centres were not able to provide their usual social and emotional support to clients and even for those services operating on a mobile basis the relational element fell away as PPE and social distancing hampered communication with clients. Furthermore, some modes of operating made it difficult to treat clients with the usual level of respect and dignity, for example, services operating as a mobile teams for the first time mentioned the new risk of intruding on their clients' private space and other providers mentioned that dealing with clients' personal issues at the door made it difficult to provide appropriate support. Furthermore, services helping clients with accessing accommodation felt that their ability to provide care had been compromised as it became increasingly difficult to register new presentations and in turn get access to beds.

Service providers expressed concerns around what the changed capacity of their service and other supports meant for their clients. Clearly this group of the population are vulnerable to infection due to their social determinants of health. However, as providers emphasised, this is a group already in crisis and some of the challenges that their clients faced as a result of the crisis, beyond their increased risk of infection, such as difficulty in accessing food, hygiene facilities and accommodation, as well as the reliance on services and public space for social interaction and other services for specialised support, already existed and were simply brought into sharper focus by the pandemic, confirming the importance of "looking beyond medical risk" in pandemic planning (O'Sullivan and Bourgoin, 2010). Furthermore, while previous research highlighted the role that public space can play in the lives of those experiencing homelessness and the disruption or loss that punitive measures can cause (Langegger and Koester, 2016), this thesis illustrated how public health measures can cause similar disruption. Based on the effect of these measures, the concerns voiced by service providers about their clients and the results presented, a number of recommendations are made both for further pandemic planning and research.

5.1 Recommendations for Pandemic Plans

As the first recorded case of COVID-19 in Ireland was only in February of this year and there is no vaccine as of yet, a rise in the number of cases or a second wave is expected, especially as the government begins to ease restrictions and re-open the economy, in fact this trend is already beginning to be observed.

Thus going forward it is vital to ensure that basic sustenance continues to be provided to those who need it. Thus, far the move to a take-away service has enabled day centres to cater to this need and mobile service have also adapted well. However, perhaps soup tables should also be allowed operate if stricter measures are introduced again, to ease the pressure on other services still operating. This would require PPE and social distancing measures.

It also recommended that access to hygiene facilities is improved, even if strict measures come into place again. As maintaining good hand hygiene is one of the main pieces of public health advice to reduce the risk of obtaining infection, access to hand washing or sanitiser is necessary at the bare minimum. However, increasing access to lavatory and shower facilities should also be taken into consideration. Service providers who usually offer these services might consider introducing some kind of a 'safe' or staggered system for accessing these, perhaps where they are used at certain times on certain days or through registration. Furthermore, the local authority might consider introducing hand washing or sanitisation systems around the city and/or increase access to public toilets at the risk of the user.

The provision specialised support services for some of the most vulnerable members of the homeless population, such as those suffering from addiction or poor mental health, in some kind of physical capacity should also be considered going forward, again perhaps with prior registration and with physical distance and PPE because as was observed, service providers were very concerned about high risk clients whose support services either completely stopped or changed to phone or online formats. Naturally re-opening day centres might also be considered, especially to provide those experiencing homelessness with a space to spend time and receive social and emotional support. However, this still seems like a high risk move and depends upon future developments and what providers deem most safe.

Lastly, while perhaps the local authority did not experience an increase in demand for emergency accommodation at this time (a natural consequence of the lack of people being registered as homeless), service providers experienced a constant demand for help with registration and accommodation from clients. Thus, it is recommended that first, the local authority issues clear guidance on who is responsible for registering those presenting as newly

homeless and that perhaps the requirement of being verified as homeless is suspended during a pandemic. Instead, perhaps, the word of service providers could be taken as verification, accelerating registration. Secondly, it is recommended that the local authority considers making extra emergency accommodation acquired at this time accessible to all of those in need of a bed not just those who have to self-isolate, especially given the closure of some emergency accommodation around the city, increased demand, dense hostels and increased difficulty of life on the streets.

5.2 Future Research

Opportunities for further research are both manifold and vital. Firstly, when it is safe and possible to do so, research might look into the experience of service users throughout this time. This will enhance the understanding of the kinds of challenges they faced and what the most essential needs of this group are, in turn enabling services to cater to these as best as possible. Secondly, as this research concerns only those experiencing homelessness who use the soup runs and day centres in question, other work might look at the experience of other members of the homeless population of this time, for example the hidden homeless, families or even newly homeless.

In connection with this future research might examine the impact of COVID-19 on other homeless settings such as temporary or emergency accommodation including hostels, long-term supported temporary accommodation and family hubs, or on services provided by organisations which are more closely affiliated with the state, as many of those which were the subject of this thesis operated independently of the state and it would be interesting to see if their responses and the challenges they faced varied.

Lastly, as service providers expressed concerns that the number of homeless people is set to increase in Dublin as a result of the economic impacts of the virus, for example already some of the measures taken to protect socio-economically vulnerable members of the population such as the rent freeze and eviction moratorium are going to be changed or removed, increasing the risk of many members of the population entering into homelessness, it would be interesting to investigate the experience of these services at later point to see if they continue to experience an increase in demand, changed clientele, and/or different challenges. All of the above potential avenues for research will enhance planning and preparation for future waves of this virus or even other viruses which may occur in later months or years.

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Appendices

Appendix I: List of Service Providers and Websites

List of organisations that are soup runs or day centres by name or that offer these services:

- Focus Ireland
- Capuchin Day Centre
- Merchant's Quay Ireland
- Simon Community
- Cross Care
- Peter McVerry Trust
- Ana Liffey Drug Project

- Inner City Helping Homeless
- Mustard Seed Soup Run
- Feed Our Homeless
- The Light House
- Mendicity
- DCM – Homeless Ministry Abbey St Methodist Church

- A Lending Hand
- Hope 4 Homeless
- Homeless Mobile Run
- Grubs Up Homeless Services
- Fighting for Humanity: Homelessness
- Muslim Sisters of Eire
- Homeless Street Café
- Friends Helping Friends
- Divine Mercy Soup Run

- St. Joseph's Penny Diners
- St. Agatha's Food Centre (Crosscare)
- Missionaries of Charity
- Guild of the Little Flower / Little Flower Penny Dinners
- St. Brigid's Food Centre (Crosscare)

Information Sources for these organisations:

- Focus Ireland
  - Website - www.focusireland.ie
  - Twitter - https://twitter.com/focusireland
  - Facebook - https://www.facebook.com/focusirelandcharity
  - YouTube - https://www.youtube.com/user/focusireland

- Capuchin Day Centre
  - Website - https://www.capuchindaycentre.ie

- Merchant's Quay Ireland
  - Website - https://mqi.ie/
  - Facebook - https://www.facebook.com/MerchantsQuayIR/
  - YouTube - https://www.youtube.com/user/MerchantsQuayIreland
  - LinkedIn - https://www.linkedin.com/company/merchants-quay-ireland/
  - Twitter - https://twitter.com/MerchantsQuayIR
  - Instagram - https://www.instagram.com/merchantsquayir/

- Simon Community
  - Website - https://www.dubsimon.ie/
  - Facebook - https://www.facebook.com/DublinSimonCommunity/
  - Instagram - https://www.facebook.com/DublinSimonCommunity/
  - Twitter - https://twitter.com/Dublin_Simon
  - LinkedIn - https://www.linkedin.com/company/dublin-simon-community/
  - YouTube - https://www.youtube.com/user/DublinSimonCommunity

- Cross Care
  - Website - https://crosscare.ie/
  - Facebook - https://www.facebook.com/Crosscare1/
  - Twitter - https://twitter.com/crosscare1

- Peter McVerry Trust
  - Website - https://pmvtrust.ie/
  - Facebook - https://www.facebook.com/petermcverrytrust/
  - Twitter - https://twitter.com/PMVTrust
  - Instagram - https://www.instagram.com/pmvtrust/
  - YouTube - https://www.youtube.com/user/petermcverrytrust
  - Linkedin - https://www.linkedin.com/company/peter-mcverry-trust/

- Ana Liffey Drug Project
  - Website - https://www.aldp.ie/
  - Facebook - https://www.facebook.com/analiffey
  - Twitter - https://twitter.com/analiffey
  - LinkedIn - https://www.linkedin.com/company/ana-liffey-drug-project/

- Inner City Helping Homeless
  - Website - https://ichh.ie/
  - Twitter - https://twitter.com/ICHHDUBLIN

    - Facebook - https://www.facebook.com/InnerCityHelpingHomeless
    - Instagram - https://www.instagram.com/ichhdublin/

- Mustard Seed Soup Run
    - Website- https://www.mustardseedsouprun.com/

- Feed Our Homeless
    - Website - https://feedourhomeless.ie/
    - Facebook - https://www.facebook.com/feedourhomeless/
    - Twitter - https://twitter.com/fohomeless
    - LinkedIn - https://www.linkedin.com/company/feed-our-homeless/

- The Light House
    - Website - http://dcmlive.ie/the-light-house/
    - Facebook - https://www.facebook.com/pages/category/Nonprofit-Organization/The-Light-House-Dublin-537365859692181/

- Mendicity
    - Website - http://www.mendicity.org/
    - Facebook - https://www.facebook.com/mendicityinstitution/

- DCM – Homeless Ministry Abbey St Methodist Church
    - Website - https://www.dublincentralmission.ie/abbey-street/homeless-ministry

- A Lending Hand
    - Facebook - https://www.facebook.com/A-Lending-Hand-101732673493965/

- Hope for Homeless
    - Facebook - https://www.facebook.com/HopeforhomelessDublin/

- Homeless Mobile Run
    - Facebook - https://www.facebook.com/Homeless-mobile-run-1838065363086610/

- Grubs Up Homeless Services
    - Facebook - https://www.facebook.com/Grubs-Up-Homeless-Services-2343027572649044/

- Fighting for Humanity: Homelessness
    - Facebook - https://www.facebook.com/pages/category/Community/Fighting-for-HumanityHOMELESSNESS-946943248709376/

- Muslim Sisters of Eire
    - Website - https://msoe.ie/index.php/about-msoe
    - Twitter - https://twitter.com/msoe_dublin?lang=en
    - Facebook - https://www.facebook.com/muslimsisterofeire/

- Homeless Street Café
    - Facebook - https://www.facebook.com/pages/category/Cause/The-Homeless-Street-Cafe-1427529000626672/

    - Twitter - https://twitter.com/homeless_cafe?lang=en

- Friends Helping Friends
    - Facebook - https://www.facebook.com/friendshelpingfriendsire/

- Divine Mercy Soup Run

- St. Joseph's Penny Diners
    - Website - https://gardinerstparish.ie/about/

- St. Agatha's Food Centre

- Missionaries of Charity

- Guild of the Little Flower / Little Flower Penny Dinners
    - Website: https://www.littleflowerpennydinners.ie/

- St. Brigid's Food Centre

Appendix II: Interview Guide

Background Information

Could you start by explaining what your role in the organisation is?

When was this organisation established and why?

Opening Questions → Normal Circumstances

Who can avail of your service? How do you decide this?
- Who 'deserves' care according to your organisation?
- Do you agree with this?
- How do you make a decision on this?
- Conditions, requirements, expectations

Who typically uses your service?
- Typical demographic of service user: street homeless, temporary accommodation, male/female, age
- *Could you give me an example or a story of a regular user?*

Why do you think people attend this service?
- Dependent on material resource – food, blankets?
- Advice? Other help?
- Would you say that clients attend for other reasons?
    - Social interaction/support, break from stigma / violence, place to feel normal

What are the main aims of your service?
- Priorities: food, further support, getting people off the streets short-term/long term etc

How would say this service fits in with the wider service landscape?
- i.e. why is this service important

What is the most important aspect of this service to you?

What type of an environment do you seek to create?
- Describe
- Their role in this

How would you describe your relationship with service users?
What is important to you in these relationships?

What kind of challenges do you face in your daily work (under normal circumstances), if any?
- Enough staff or funding, hostile service users, lack of resources

Do these challenges ever compromise the quality of the service / your ability to provide care?

Key Questions → Impact of COVID-19

How did you come to the decision to remain open during this time?

- How important was it to you?
- What factors did you have to take into consideration when making this decision?
    - Needs of clients, risk of infection, safety of staff and service users, availability of PPE, public health advice
    - Classified as 'essential service' ?

or

How did you come to the decision to stop operating at this time?

- Was this a difficult decision to make?
- What factors influenced this decision?

What measures did you introduce / changes did you make in order to remain in operation?

- Change in main aims/priorities i.e. only food instead of also social space, reduced hours, reduced capacity, physical health and safety measures

What were these changes guided by?

- Role of public health advice and government guidance?

Were these changes difficult to implement?

- E.g. availability of PPE
- Reduction in workers

How do you think these changes impacted your service as a whole? / Have these changes affected your ability to provide care to service users?

What have been some of the biggest challenges? Can you give some examples?

- Have you had to turn people away → how does that make you feel?

How have COVID-19 and the changes made influenced the overall environment / atmosphere? / How would you describe **the atmosphere?**

- From your point of view
- For the clients, do you think?

Has your relationship to clients changed?

Have the needs of service users changed during this time?

- Increase in demand or new clients? – Demographic
- What are the biggest challenges facing clients at the moment?
- What are clients' main concerns? Unchanged?
- *Do you feel that their needs are recognised?*
- *Any idea where they spend their time?*

Closing Questions → Reflection
Did you feel prepared to deal with this situation?

Was there any help or guidance from the state?

Is there anything (that you have changed or implemented) that you would say have worked particularly well?

Is there anything you have learned already that would have made the situation more manageable?

Do you expect a rise in demand for your services in the coming weeks and months? How will you prepare for this?

In sum:

- Do you think X has successfully managed to continue operating as a 'space of care', providing an inclusive, safe environment for service users throughout the pandemic? How important was this to you?

To end and round up:

- Summarise back to them, how I think:
    - It offers a space of care
    - How it functions
    - The meaning it has for homeless in Dublin
    - How this has changed

  → **Ask if they agree and if they would like to add anything**

Appendix III: Code Tree for Interview Analysis