The London School of Economics and Political Science

CARE IN LIMBO:

AN URBAN ETHNOGRAPHY OF HOMELESNESSNESS AND CARE WORK IN ATHENS

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Declaration

I certify that the thesis I have presented for examination for the PhD degree of the London School of Economics and Political Science is solely my own work.

I warrant that this authorisation does not, to the best of my belief, infringe the rights of any third party. I declare that my thesis consists of 99, 275 words.

Maria-Christina Vogkli

Abstract

This dissertation explores the intersection of care, homelessness and urban space in a context of austerity and a profound lack of resources. Based on an eight-month urban multi-sited ethnography in Athens (July 2017- February 2018), this research draws upon data collected through observation, visual methods and interviews with frontline staff, outreach workers and homeless people. Conducted at a time of multiple crises for the Greek capital, this ethnography offers a grounded analysis of urban marginality, vulnerability and care. It focuses on the urban landscape of care for homeless people. In exploring this landscape, this research unravels the different social, spatial and institutional relations that shape the interconnection of homelessness and care. It considers both macro-level and contextual factors affecting the socio-spatial formation of this landscape in the city and micro-level manifestations of care through relationships and spaces of care. Paying attention to both homeless people and care workers, I position care relationships at the epicentre of a landscape unfolding on an interpersonal, organisational, local and national level. In this regard, this dissertation provides both a panoramic view of the city and a close-up analysis of an array of spaces: from exterior, public spaces to interior, mundane spaces where care meets homelessness and other forms of vulnerability. These include the city's Municipal Centre for the Homeless (the Municipality), its hostels and a night shelter, a drop-in centre and various public locations including a central Park. The dissertation demonstrates that the landscape of care was a space of shared vulnerability and fragilities, not just for the homeless people seeking care, but also across the organisations and workers committed to care. Revealing different dimensions of being deprived of a home, I reconceptualise homelessness as a condition of ontological insecurity. I argue that homelessness was perpetuated by the complex landscape of care as it played a role in pushing homeless people from conditions of marginality to extreme psychological and material marginality. Bringing together theories of care, care ethics and geographical perspectives on care, I analyse various encounters between homeless people and their care workers, which were shaped by an array of obstacles, adverse conditions and insufficient resources – financial, human, material, emotional and spatial. Ultimately, I show that the efforts of care workers to provide more tailored care, and of homeless people to receive it were undermined to such an extent that care workers and homeless people drifted apart, leaving care in limbo.

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Chapter 1

Introduction

Less than a twenty-minute walk away from the iconic Syntagma Square where consumption, entertainment as well as economic and political power were prominent, my research unfolds around Athens' second most significant square, Omonoia Square. Despite their geographic proximity, the socio-spatial dynamics between these two squares were completely different and attested to the socio-spatial disparities in the Athenian urban space. Around Omonoia Square, urban marginality and lack of vital resources were visible in the materiality of the public space, in the multiple organisations of care and an array of mundane spaces – some visible to passers-by and others more hidden – where destitution was especially pronounced. It is in this area that I spent eight months conducting an urban and multi-sited ethnography. By shadowing homeless people, care workers, and their exchanges both in the public space and in organisations of care, my aim was to unravel the various processes and relations that co-constituted homelessness, care and urban space. For homeless people, this part of the city was appropriated as a space to survive and get by and as an area where resources could be secured. Simultaneously, this was an area where fear, threat, insecurity and control were experienced daily by them. For their care workers, this was an area of heightened vulnerability to which they responded by providing care with the limited resources at their disposal. Looking at both caregivers and care receivers, my ethnography seeks to explore the conditions that produce urban marginality and exclusion, and to highlight the role of space in care provision and homelessness.

Homelessness signifies intersected forms of exclusion, vulnerability and severe forms of destitution. Its complex nature encapsulates structures of care, social relations, personal welfare, psychosocial effects, as well as material conditions bound to the socio-economic and urban conditions in a specific setting (Doherty *et al.*, 2008, p. 310). In recent research on homelessness in Athens, Arapoglou and Gounis (2017, p. 1) describe homelessness as 'one of the most potent symbols of the social shock induced by the global financial crisis and the uneven consequences of austerity in large cities of Europe and the USA'. Indeed, the exacerbation of this alarming problem has in recent years been linked with the withdrawal of the welfare state and austerity policies cutting public

expenditure in most European countries (FEANTSA, 2011; Serme-Morin, 2019). With the exception of Finland[1], all other European countries and their capitals have seen a significant increase in homelessness (Abbe Pierre Foundation - FEANTSA, 2017, 2018). According to the European Federation of National Organisations working with the Homeless (FEANTSA), over 700,000 people are sleeping rough or in emergency and temporary accommodation in Europe on any single night (ibid).

Despite housing being protected as a constitutional right (Article 21 in the Greek Constitution), homelessness in Greece was only recognised as a social problem in the 1990s (Arapoglou and Gounis, 2015, p. 1). The prolonged economic crisis, whose effects rendered 21,500 people visibly homeless in the wider metropolitan area of Athens – gave prominence to homelessness as a social policy issue (Arapoglou and Gounis, 2017). Indicative of the limited attention it had received as a policy issue until then is the lack of a consistent and concrete policy approach (Kourachanis, 2020). The absence of official data on homeless people (Fitsiou and Kourachanis, 2019) is also telling for the management of homelessness on a policy level. However, in 2012 an operational definition of homelessness was first included in Greek legislation within a context of increased housing assistance brought about by a harsh austerity environment. These adverse conditions resulted from the national fiscal crisis Greece entered in 2010, when Greece required financial assistance from the International Monetary Fund (IMF), the European Central Bank (ECB) and the European Commission (EC). Since then, Athens – Greece's largest city and capital – has become a site of multiple systemic crises.[2] These were political, financial and humanitarian – and from 2015 the so-called international 'refugee crisis' involving the arrival of over a million refugees between 2015-2016.

During my fieldwork between 2017 and 2018, Athens was an urban setting of pronounced inequalities, precarity and dispossession. From 2013 to date, Greece has had the highest level of unemployment in Europe with rates between 21.5% and 27.5% in the period 2013-2017 (Eurostat, 2020a). Youth unemployment ranged from 58.3% in 2013 –

[1] Finland was the only European country which saw a decrease of 10% due to the implementation of a long-term and integrated homelessness strategy based on viewing homelessness as a housing problem and a violation of fundamental rights (Abbe Pierre Foundation - FEANTSA, 2017, 2018).

[2] I refer to crisis as a relational set of forces and impacts that play out across highly asymmetrical geopolitical relations, in which Greece is positioned as the subject of international fiscal disciplining and of European border arrangements.

an all-time high nationally – to 43.6% in 2017 (Eurostat, 2020b). A report of the Parliamentary Budget Office published in 2014 stated that in a country of less than 11 million, approximately '2.5 million were living below the poverty line, while 3.8 million were in direct danger of crossing the line' (Karagkounis, 2017, p. 654). These conditions turned Athens into a city where multiple groups struggled to survive, secure basic means and gain a sense of security. The intersection of different crises, the implementation of austerity measures and the ensuing deprivation led to the emergence of multiple landscapes of care in the city. These consisted of municipal agencies, national and international non-governmental organisations (NGOs), philanthropic foundations, faith-based organisations (FBOs), soup kitchens, outreach teams and grassroots initiatives. To cover for the deficiencies and gaps of the retreating welfare state, such landscapes became central for care provision in contemporary Athens, as they took on the responsibility of caring for various groups, such as vulnerable Greeks, homeless people, drug users, refugees and migrants.

I focus on the landscape of care for homeless people which extended around Omonoia Square. My analysis provides a grounded perspective of the city, its urban margins, as well as the socio-spatial manifestation of care. I treat care as an ethical category which is broadly defined as 'the provision of emotional and practical support' (Milligan and Wiles, 2010a, p. 737). This definition is broad enough to capture a variety of aspects and dimensions of care that appeared in my fieldwork. These include viewing care as a type of work involving both practical and emotional labour; as a close relationship between caregivers and care recipients; as a practice; as a response to needs; and as disposition of acting in ways that adhere to certain ethical values resulting from a framework of care ethics (see below). Putting care for homeless people at the centre of my project involves attending to a specific type of care highlighting aspects of vulnerability, dependency, urgency to care, and how these were co-constituted through the city. If the marginalisation of homeless people renders them unable to independently secure the means for their own survival, to survive they become dependent on the city and the resources offered by organisations comprising the landscape of care. For this reason, I argue, to study homelessness – and as a matter of fact any form of vulnerability – means to study care. Care is both highly contextual and relational. In this regard, as homelessness – especially rough sleeping – is primarily an urban phenomenon, care for homeless people is also predominantly situated in cities and affected by their socio-

economic and urban environment.[3] Hence, my project seeks to take the reader from the exterior spaces of the city to interior spaces where care and homelessness intersect with each other on an everyday basis.

My dissertation tacks between the macro-level and contextual analysis of the city and the intimate micro-level analysis of care and homelessness. It provides a ground-level examination of the individuals navigating the landscape and spaces of care for homeless people at both the caregiving and care receiving end. In so doing, my aim is to capture the relations between the city and the landscape of care as a whole; between the landscape of care and individual spaces of care; and between homeless people and care workers - defined broadly as the frontline staff in direct contact with homeless people. In unravelling these relations, my main research questions are:

1. What are the relationships between homelessness, space and care and how do they structure and reconfigure each other?

2. What are the broader (macro-level and contextual) factors that influence, shape, and constrain these relationships?

3. How does the landscape of care manifest at a micro-level in relationships between caregivers (i.e. care workers) and care recipients (i.e. homeless people) as well as in spaces of care provision in the city?

The relations I trace are social, spatial, financial, institutional and emotional. It is these relations that made up the landscape of care for homeless people and affected the ability of care workers to effectively engage in caregiving activities and for homeless people to receive care and facilitate their survival on the street. Public spaces in the city where homelessness becomes visible are not viewed as independent, but rather as the product of the complex relations this project seeks to illuminate. Similarly, the city is viewed as the constellation of these relations and processes taking place on an international and national level. Rather than viewing the city either solely as a space of intense regulation and control, or merely as a space of openings and opportunities, it is understood as a

[3] Rural homelessness has also been studied but is considered to be comparatively less in numbers than urban one (Cloke, Milbourne and Widdowfield, 2002). Aspects of invisibility and the different manifestations of space in rural and urban areas have also contributed to that (ibid).

complex site involving both punitive and caring elements (DeVerteuil, 2014). Starting from the street and the city, one can trace connections that point to contextual factors. These factors encapsulate socio-economic, housing and policy aspects, and relationships between spaces and people, including between homeless people and care workers or the latter and their employers. To link these relations and processes among the city, its institutions, organisations and agents, I adopt a multi-sited approach to urban ethnography. This analysis requires both a panoramic observation of the city and close-up attention to spaces relevant to care and homelessness. While keeping in mind broader processes and relations, I zoom into different providers and spaces of care within the city. These include a municipal agency and its municipal soup kitchen, a drop-in centre, the hostels and night shelters for homeless people, a public Park and other city locations, occupied by homeless people and visited by outreach teams.

To analyse these relations, I draw on three different sets of literature. First, I engage with the literature of homelessness with a specific focus on analyses of urban space that relate with the experience of homeless people in the city both vis-à-vis its punitive and caring elements. Second, I engage with theories of care and care ethics, which have provided my wider understanding of care. Third, I engage with theories on geographies of care with a focus on landscapes and spaces of care. The latter differentiates itself from literatures on homelessness, as geographies of care study various forms of vulnerability beyond homelessness and interpersonal exchanges of care. I seek to contribute to these literatures by bringing them together and providing a situated account of care and care ethics in a city undergoing multiple crises. Consequently, this exploration serves as an opportunity to think about new dimensions of care and socio-spatial formations of vulnerability at times of crises and limited resources. My thesis aims to contribute to these literatures and develop a dialogue between them. I wish to enrich our understanding of care and care ethics by examining how space – as a resource, its physical characteristics and as an environment where relationships develop – shapes care. My analysis also contributes to our understanding of landscapes of care from a methodological perspective. By employing a multi-sited urban ethnography, my project situates this landscape of care in the city of Athens, but also in individual spaces where relationships of care develop. Finally, by positioning homelessness in this network of relations, highlighting its ontological dimension and reflecting on the experience of being deprived of a home, I investigate how landscapes and systems of care can also contribute

to this form of extreme marginalisation when they are under-resourced and unable to operate in ways adhering to an integrated approach to care.

By situating care in the wider network of social, spatial and institutional relations of the landscape of care, my thesis aspires to analyse the processes that produce urban marginality in contemporary cities hit by austerity and acute forms of exclusion. I argue that the landscape of care for homeless people in Athens was a highly differentiating and fragile space of shared vulnerabilities across organisations, givers and receivers of care, and that being severely under-resourced led to reinforcing inequalities and creating new ones. Besides the socio-economic context which may lead to homelessness because of high unemployment, exclusion and poverty, by depriving them of a home the landscape of care positioned homeless people in a state of ontological insecurity (Giddens, 1990). This state of being and relating to others, institutions and the world is characterised by extreme emotions of constant fear, loneliness, anxiety and distrust. I argue that despite being individually experienced, these emotions are conditioned to wider systemic aspects and institutional characteristics of the landscape of care, which made the already marginalised homeless people experience even more acute forms of psychological and material marginalisation. In addition, because of scarce resources, understaffing and ever-increasing pressures, the ability of care organisations to provide for homeless people was also rendered fragile and complex. All care workers on the frontline were substantially affected by these conditions, as their precarious employment impacted their own ability to survive and make ends meet. Except for this financial form of vulnerability, care workers were also rendered emotionally vulnerable as a result of going above and beyond their role, while lacking the necessary resources and support to cope with the extreme pressures evident in their spaces of work. Ultimately, agency to give and receive care was removed to such an extent from both care workers and homeless people that care was left 'in limbo', limited to crisis management and basic provision. In this regard, homeless people and care workers mirror each other in a relational process that imprints itself on the city space.

Homelessness

Definitional issues and explanations of homelessness

When engaging with homelessness either from a conceptual, research, or policy perspective, the definition of the homeless person is inherently challenging, as clearly identifying the different manifestations of homelessness is complex. To recognise homelessness as a problem that spans across the different geographies of Europe and to tackle definitional issues that appear in the study of homelessness, the European Typology of Homelessness and Housing Exclusion (ETHOS) was launched in 2005.[4] This functioned as an empirical and policy tool which facilitated the collection of statistical data in a more consistent manner across Europe. ETHOS categories attempt to cover all living conditions distinguishing between rooflessness, houselessness and living in insecure or inadequate housing. In all categories, ETHOS perceives homelessness as a process rather than a static phenomenon, a perspective dominating contemporary studies of homelessness (Piliavin *et al.*, 1996; Culhane and Kuhn, 1998; Ravenhill, 2008; Fernee, Oldersma and Popping, 2010). The legal definition of homelessness in Greece (Article 29, L.4052/2012) took an expansive approach regarding who was to be considered homeless and recognised all four categories of the ETHOS typology (Kourachanis, 2020).

[4] The MPHASIS project (2009) funded by the European Commission has examined the robustness of the ETHOS model in twenty European member states and has concluded the usefulness of the model with regards to the categorisation of homelessness for the European context (Edgar, 2012, pp. 219-220).

Table 1: ETHOS - The European Typology of Homelessness and Housing Exclusion

Conceptual Category		Operational Category		Living Situation		Generic Definition
ROOFLESS		1	People Living Rough	1.1	Public space or external space	Living in the streets or public spaces, without a shelter that can be defined as living quarters
		2	People in emergency accommodation	2.1	Night shelter	People with no usual place of residence who make use of overnight shelter, low threshold shelter
HOUSELESS		3	People in accommodation for the homeless	3.1	Homeless hostel	Where the period of stay is intended to be short term
				3.2	Temporary Accommodation	
				3.3	Transitional supported accommodation	
		4	People in Women's Shelter	4.1	Women's shelter accommodation	Women accommodated due to experience of domestic violence and where the period of stay is intended to be short term
		5	People in accommodation for immigrants	5.1	Temporary accommodation / reception centres	Immigrants in reception or short term accommodation due to their immigrant status
				5.2	Migrant workers accommodation	
		6	People due to be released from institutions	6.1	Penal institutions	No housing available prior to release
				6.2	Medical institutions (*)	Stay longer than needed due to lack of housing
				6.3	Children's institutions / homes	No housing identified (e.g by 18th birthday)
		7	People receiving longer-term support (due to homelessness)	7.1	Residential care for older homeless people	Long stay accommodation with care for formerly homeless people (normally more than one year)
				7.2	Supported accommodation for formerly homeless people	
INSECURE		8	People living in insecure accommodation	8.1	Temporarily with family/friends	Living in conventional housing but not the usual or place of residence due to lack of housing
				8.2	No legal (sub)tenancy	Occupation of dwelling with no legal tenancy illegal occupation of a dwelling
				8.3	Illegal occupation of land	Occupation of land with no legal rights
		9	People living under threat of eviction	9.1	Legal orders enforced (rented)	Where orders for eviction are operative
				9.2	Re-possession orders (owned)	Where mortagee has legal order to re-possess
		10	People living under threat of violence	10.1	Police recorded incidents	Where police action is taken to ensure place of safety for victims of domestic violence
INADEQUATE		11	People living in temporary / non-conventional structures	11.1	Mobile homes	Not intended as place of usual residence
				11.2	Non-conventional building	Makeshift shelter, shack or shanty
				11.3	Temporary structure	Semi-permanent structure hut or cabin
		12	People living in unfit housing	12.1	Occupied dwellings unfit for habitation	Defined as unfit for habitation by national legislation or building regulations
		13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding	Defined as exceeding national density standard for floor-space or useable rooms

Note: Short stay is defined as normally less than one year; Long stay is defined as more than one year.
This definition is compatible with Census definitions as recommended by the UNECE/EUROSTAT report (2006)

(*) Includes drug rehabilitation institutions, psychiatric hospitals etc.

Source: FEANTSA
(https://www.feantsa.org/download/en-16822651433655843804.pdf)

Categorisations, such as ETHOS, are useful for methodological reasons or for specifying needs of different subgroups. However, they need to be used critically, as homelessness is not a uniform experience for the different groups identified in such classifications (Meanwell, 2012). Specifying the sub-group of this study while being sceptical of classifications resulted in a tension between designing this project from a methodological perspective and encountering the complicated lives of homeless people. Aware of the various types of homelessness, I decided to narrow my focus on people who at the time of my research or in the recent past fell under the ETHOS categories of roofless or houseless. This methodological choice was based on the fact that these categories live under conditions that render them more directly exposed to the city and its open spaces. In addition, being deprived of core resources, they experience a higher degree of vulnerability, interacting regularly with the landscape of care and its agents.

Yet, becoming familiar with the journeys of homeless people, it became apparent that even this subgroup is itself diverse, complex and encapsulates intersecting forms of vulnerability. My exchanges with homeless people over a period revealed that in reality, homeless people can shift multiple times from one category to another. Especially in contemporary cities, like Athens, where precarity and vulnerability are pronounced, one can rapidly move from a category of inadequate housing to no housing at all. After being evicted, Chloe was sleeping rough, but at the time of our interview was renting a small studio through her income as a 'Big Issue' Vendor. Katianna was living in the night shelter but was about to return to the street because of the difficult conditions there. After a year on the street, Mr Dimitris was living in a basement but was dependent on the landscape of care for various resources. With his asylum application pending, Ali was unable to secure accommodation and was sleeping rough on a paved street under the Acropolis. All those using drugs, having infectious diseases or facing mental health issues were excluded from accommodation. As a result, although I focused on two ETHOS categories for methodological reasons, this subgroup includes homeless people with different needs and experiences of vulnerability, such as problems deriving from substance abuse, mental and physical health issues or different migration and asylum statuses. In addition, another reason that one ought to remain sceptical of classifications dominant in homelessness studies, is that they can entail the danger of creating hierarchies. On a policy level, this can lead to categories of deservingness among homeless

people regarding their access to support, resources and care, as was the case for my participants (see specifically Chapter 4).

In addition to definitional problems, explanations of homelessness add another layer of complexity to the study of homelessness. While 'individualistic' and 'structural' explanations are the dominant sets of explanations in the literature, I adopt a hybrid approach. Specifically, I do not focus on personal vulnerabilities and behaviours of homeless people, such as mental ill health and addictions. Neither am I locating the causes of homelessness solely on broader forces such as 'rising economic marginality and shrinking affordable shelter resources' (Takahashi, 1996, p. 291). Rather, my aim is to link the two. This hybrid approach seeks to place homelessness in a context of exclusion, vulnerability and deprivation while connecting it with broader issues of social and housing inequalities, increased poverty levels, reduced welfare provision and institutional aspects vis-à-vis the wider system of care for homeless people. Adhering to my overarching aim of linking micro- and macro-level factors, this approach allows us to address variations of intersecting vulnerabilities and exclusion at the individual level (e.g. gender, race, ethnicity, addiction and health problems) and explore how these are dealt with on the structural or institutional level, by agents of care provision and the city, while considering the context in which homelessness and care are situated.

Within my wider definition of homelessness, I especially focus on it as a condition of ontological insecurity (see Chapters 4 and 5). Following Bluden and Drake's (2015, p. 205) definition of homelessness 'as a lack of home' characterised by 'a deficit of ontological security', my research aspires to enrich our conceptualisation of homelessness. The notion of ontological security relates to the unconscious, feelings of trust and a sense of belief that one can tackle hazards of life (social, ethical, spiritual and biological) (Laing, 1960, p. 39). Antithetical feelings denote a sense of ontological insecurity. To cope with potential threats and danger, sustain hope and therefore achieve ontological security, Giddens underlines the importance of trust as a factor allowing one to rely on others (Giddens, 1991, pp. 38–9). Trust is an integral part of care and for homeless people it is what is at stake in their interactions with care workers or institutions.

The distrust and fear many of my participants described are interlinked with lacking the security of a home (see Chapter 5). Home serves as a space which facilitates

the creation of what Giddens (1990, p. 39) described as 'a protective cocoon'. This idea is key for understanding the differences between housing and home, and why people without houses are not called houseless or unhoused, but homeless. Housing relates primarily to the physical, material shelter (Tomas and Dittmar, 1995). In contrast, home is a multi-dimensional concept (Parsell, 2012, p. 159), which emphasizes that it is 'subjectively experienced' (Parsell, 2012, p. 159) and encapsulates meanings on 'social, emotional, spiritual *and* material levels' (emphasis added) (Leith, 2006). Echoing other authors (Daly, 1996; Mallett, 2004; Hartmann, 2014) who have analysed different facets of home, Dupuis and Thorns (1998, p. 29) have from a sociological perspective identified four markers which, when met, allow for the maintenance of ontological security at home. Specifically, they state the home is:

> (i) The site of constancy in the social and material environment.
> (ii) A spatial context in which the day-to-day routines of human existence are performed.
> (iii) A site where people feel most in control of their lives because they feel free from the surveillance that is part of the contemporary world.
> (iv) A secure base around which identities are constructed.

The first of Dupuis and Thorns' markers relates primarily to the material conditions of home, while the three latter markers refer to its emotional and psychological aspects. The interrelation of home and ontological security explains why being "at home" or "not at home" has become a stock measure of our existential health'(Tuedio, 2002) and therefore ontological security.

While the deprivation of home for homeless people is discussed in the literature, only a few authors have systematically discussed the ontological dimension of not having a home (Somerville, 1992; Tuedio, 2002; Johnson and Wylie, 2010; Blunden and Drake, 2015). Reflecting on homelessness through the notions of home and ontological security can provide a basis for re-conceptualising the lived experience of homelessness. Concretely, one can understand how core emotional and psychological dimensions of the lived experience of homelessness are conditioned to wider structural and institutional processes evident in contemporary cities and systems of care affected by austerity and multiple pressures. These include feelings and experiences of criminal victimisation (Fitzpatrick, Gory and Ritchey, 1993; Lee and Schreck, 2005; Newburn *et al.*, 2005; Newburn and Rock, 2006; Bramley and Fitzpatrick, 2018), stigmatisation (Phelan *et al.*,

1997; Belcher and DeForge, 2012) and the experience of homelessness by women (Johnson and Kreuger, 1989; Hill, 1991; Casey, Goudie and Reeve, 2008; Phipps *et al.*, 2019). Hence, this approach affords us opportunities to reconsider the lived experience and reproduction of homelessness. It also raises questions about the nature of care required by homeless people and whether spaces of care can alleviate or reinforce feelings of ontological insecurity. In sum, this approach does not remove homeless people from their context. Rather, it follows Snow et al.'s (1994) position of contextualising homelessness and linking the micro-experiences of homeless people on the street with wider systems, such as the landscape of care, and the city more broadly.

Homelessness and Care: Ethical and Policy Perspectives

Care is a multi-dimensional concept that appears in lay, sociological and policy discourses. In our everyday life, care is commonly used to denote warm and giving emotions or practices within the intimate, interpersonal or family contexts. In policy debates, it often emerges as part of discussions on welfare provision on a national or local level and the landscapes that surround it. On a global level, it has appeared in analyses of migration, political economy and international scale events. As an analytical tool, it allows for a 'bridging of public and private' and an analysis of care both at the macro-level and the micro level (Daly and Lewis, 2000). At the macro level, it is related to 'the political economy of provision by and among the different sectors' (ibid. p. 286), the division of care labour, the responsibilities of care work, care infrastructures, the resources allocated to care spaces and care activities, as well as shifts and changes in the distribution of care by different providers. The micro-level of care alludes to the distribution of care and identity of carers on a familial and a community level, the economic and social dimensions of care work, the nature of care relationships between caregivers and care recipients and the conditions under which care takes place. Viewing homelessness through the lens of care is analytically beneficial for it explores both the interpersonal encounters between homeless people and caregivers *and* macro-level factors regarding welfare policies and the political significance of care.

To understand the exchanges between givers and recipients of care, namely between frontline staff and homeless people, I draw on care ethics. Care ethics has expanded from social psychology and Carol Gilligan's seminal book *In a Different Voice* (1982) to many other disciplines, including sociology, geography and policy (Duncan and

Edwards, 1999; Smart and Neale, 1999; Massey, 2004; Popke, 2006; Lawson, 2009; Mcewan and Goodman, 2010). Within my research, care ethics has allowed me to analyse the different scales of the landscape of care, because of an emphasis on context, relationships, and needs, as well as an understanding of individuals as fundamentally relational and interdependent. Revealing power relationships and how society and the state treat care and vulnerability makes care a concept engaging with deeply political questions, such as: the responsibility of the state to play a caretaking role; who is deemed worthy of care; how vulnerability is understood; the distribution of tasks; the allocation of (public) resources dedicated to the work of care; the characteristics and potentially the vulnerability characterising those who are involved in formal or informal care work.

The role of the state as a caretaker safeguarding the wellbeing of its citizens is especially relevant vis-à-vis care provision for homeless people. From this perspective, the life-sustaining role of care as an activity that allows us to 'repair and maintain our world' is especially significant (Tronto and Fisher, 1990, p. 40). As such, care is understood as an adhesive part of social reproduction, as a social process and practice for the continuous improvement of society and the preservation of life (ibid). These features of care become even more prominent because homelessness is underpinned by extreme marginalisation and destitution which jeopardise the lives of homeless people. As a result, the care responsibility of the state to ensure the survival of homeless people is part of a wider political question of state responsibilities, as well as economic and social policies.

My approach to care has been informed by and draws on care ethics, which emphasizes the importance of care relationships and needs. Amongst theorists of care ethics, Noddings (2002b, 2002a) explicitly deals with homelessness arguing for a social policy driven by care. At the core of her analysis is the home as a publicly recognised need, which is necessary for the preservation of life and the response to universal needs, such as basic ones (physical and biological needs) as well as safety and security (Braybrooke, 1987; Noddings, 2002b). Considering its wider significance, home is necessary for satisfying biological, emotional, financial, material and practical needs. Underscoring its importance, Noddings highlights the need for 'a caring community [..] justified in saying "You may not live on the street" (Noddings, 2002a, p. 447). In other words, Noddings supports an institutional housing plan allowing for a minimum degree of coercion. This housing plan emphasizes the negotiation of needs and incentives for

those coerced to achieve greater levels of interdependency (ibid. p. 450-453). In policy and homelessness studies, Noddings' suggestion from a care ethics perspective broadly corresponds to the 'housing first' approach. Developed by clinical psychologist Sam Tsemberis for homeless people with complex needs, the 'housing first' approach advocates a policy of rapid provision of permanent housing to persons who are homeless. This homelessness policy supports the provision of housing independent of whether homeless people have mental health or addiction issues (Tsemberis and Henwood, 2013; Blunden and Drake, 2015). In line with care ethics, it promotes showing respect, warmth, compassion and commitment towards service users for as long as they need (Pleace and Bretherton, 2012).

A focus on needs, rather than agency or rights, allows the care approach to tackle many long-standing ethical and policy issues that arise in debates around care for homeless people. My understanding vis-à-vis homelessness and care has been shaped by the housing first approach in terms of policy and the care approach discussed by care ethicists, like Noddings. The principles and values of care ethics on an interpersonal, ethical and policy level have particularly informed my analysis of the city and its spaces, as well as of care and the care relationships developing between homeless people and care workers. In what follows, I present how I operationalised the landscape of care as a concept to analyse care provision for homeless people in Athens.

Landscape of Care: A multi-sited and multi-scalar site of care provision

This thesis defines a landscape of care as 'the spatial manifestation of the interplay between socio-structural processes and structures that shape experiences and practices of care' (Milligan and Wiles, 2010a, p. 738). In my research, I operationalise the landscape of care as a caring network consisting of providers (spaces of care). This landscape is located in the city and has specific institutional, contextual and urban arrangements and characteristics. Following Lawson (2007, p. 6) who linked geography and care ethics, I analyse different embodied caring practices both as multi-sited (i.e. in different spaces of care) and as multi-scalar. Therefore, I analyse the structure of the landscape of care as a whole, as well as its individual spaces and the systemic linkages between them. Employing a methodology of urban and multi-sited ethnography, I use it as a conceptual and analytical tool to explore the care provided to homeless people on different scales: the interpersonal, the organisational, the local and the city. Hence, rather than using it as a

metaphor, as Milligan and Wiles (2010a) do, I seek to reveal its different scales and the contextual aspects of care vis-à-vis care for homeless people. I also aim to provide a grounded perspective of the landscape of care ranging from the intimate relationships developing between care workers and homeless people to spaces of care provision and the city. In this endeavour, I consider macro-level factors in relation to this landscape's urban, spatial and institutional features, its specific socio-economic context and the impact of such factors on relationships and spaces of care.

Milligan and Wiles' concept of landscapes of care stems from a wide set of geographical research on care (Conradson, 2003b; Milligan and Wiles, 2010a; Cloutier *et al.*, 2015, p. 2012; Moosa-Mitha, 2016) which looks at the psychological, social and cultural aspects of care with an emphasis on geography and space. This spans across various forms of caregiving, such as within the medical and health sector, at home, and drop-in centres. Within geographies of care, there are two main strands of research alluding to different spatialities of care. The first (Conradson, 2003a; Milligan and Wiles, 2010a) focuses on embodied, emotional and proximate exchanges of care, wherein care is the 'physical and emotional labour' expressed as the 'proactive interest of one individual in the wellbeing of another' (Conradson, 2003a, p. 451). Similar to the landscapes of care is the concept of 'carescapes' (Bowlby, 2012). This is understood as the wider sociospatial service context shaping 'caringscapes'. The latter relates to concrete caring activities taking place among individuals in organisations (Mckie, Gregory and Bowlby, 2002; McKie *et al.*, 2008; Bowlby, 2012). This conceptualisation focuses on the time-space relationship and on the metaphor of travel through certain terrains. The second research strand (Smith, 1998; Silk, 2000; McNamara and Morse, 2004) focuses on embodied experiences, which unfold in spaces beyond our immediate lives. My dissertation seeks to engage with the first strand of research and emphasizes the embodied and direct relationships of care developing between care workers and homeless people.

Dear and Wolch (1987) use the concept of landscape to denote the interrelated processes that in the aftermath of deinstitutionalisation produced 'service-dependent' ghettos for homeless people with mental health problems in the inner cities of North America. More generally, a landscape is 'both a material fact and a representational social construct', where 'substantive material forms and the unfolding social practices are mutually and recursively constituted' (Setten and Brown, 2009, p. 191). As such,

landscapes become sites of contention and struggles where identities are negotiated and reproduced, and where the legitimacy and authority of spaces and people are claimed and contested (ibid). Don Mitchell (2003) suggests that landscapes are constructed and reconstructed through labour, exploitation and struggles through the manipulation and control of certain people, behaviours and resources. Hence, as he argues, landscapes often turn into landscapes of injustice. As a landscape of care puts care at its epicentre, often the injustices taking place derive precisely from the nature of care as a form of labour, be it physical or emotional. These often involve aspects of dependency, vulnerability, responsibility, allocation of resources and power. As a result, although one might research a landscape, it is often the case that landscape research often deals 'with *other things* [original emphasis] than just the landscape itself' (Mitchell, 2003, p. 790). In the case of landscapes of care, this idea is emphasized by the contextual nature of care.

As shown in Figures 1 and 2, rather than focusing solely on dyadic relationships, I view care as a multidirectional network. This network involves practical and affective relationships (Milligan and Wiles, 2010a), but these are co-constituted through the relationships and interactions of different care providers (spaces of care), the institutional framework it operates within, and the urban and socio-economic context of the city.

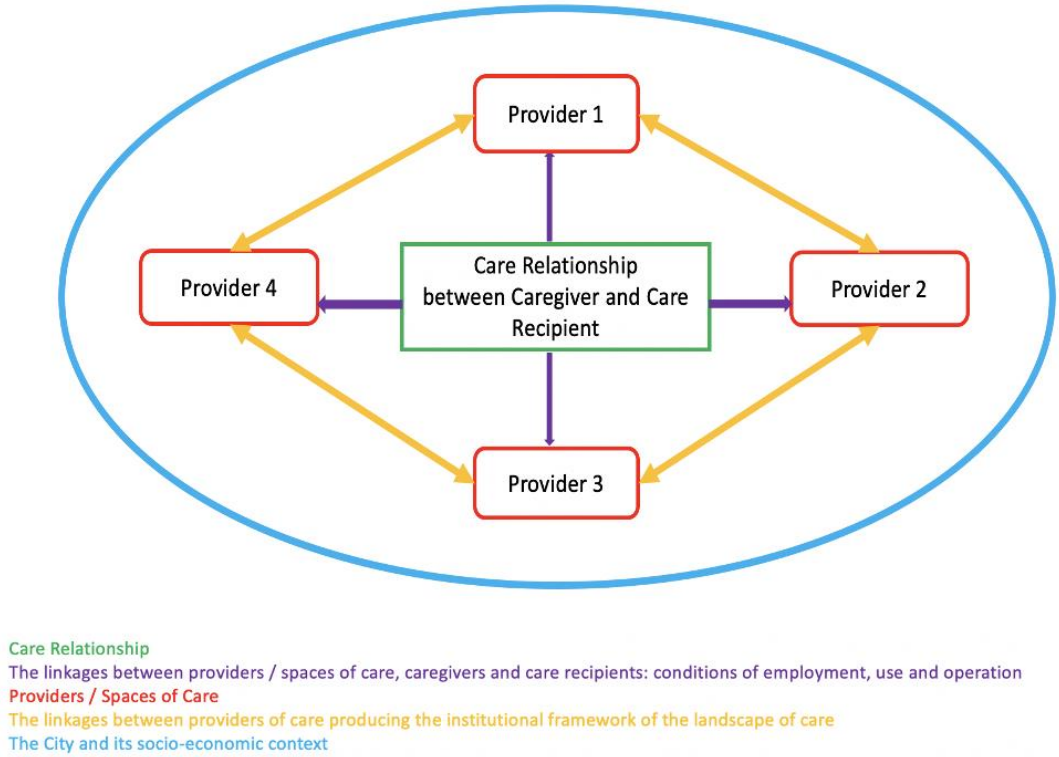

Figure 1. Visualisation of the Landscape of Care

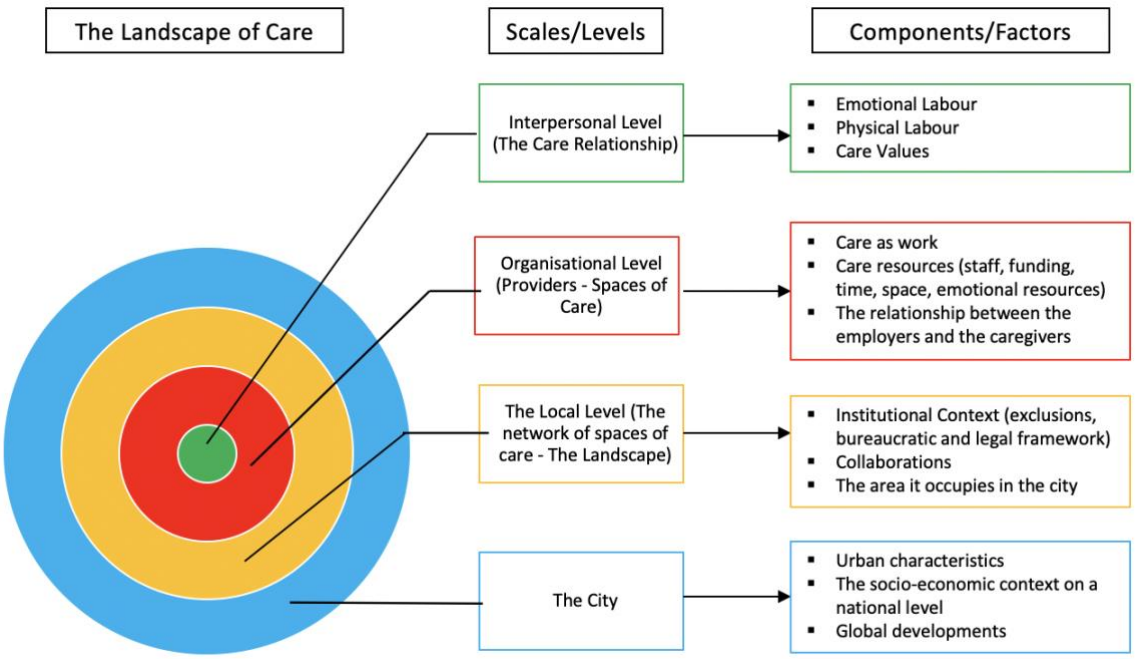

Figure 2. The scales and components of the Landscape of Care

The interpersonal scale: Relationships, needs and emotional labour

To demonstrate their significance according to my fieldwork data, I position the interpersonal relationships between caregivers and care receivers at the centre of the landscape (see Figures 1 and 2). Some of the care relationships I studied were eventually characterised by high degrees of personal familiarity and obligation. Yet, all care relationships in the landscape of care started as what Thomas (1993, p. 652) has called 'contingent caring relationship[s]', namely they develop 'between strangers […] brought together through the response of statutory or voluntary services to an acknowledged need'. The two parts of these relationships are the care workers at the caregiving end and the homeless people at the care receiving end. Care workers include all those who were frontline staff and in direct contact with the homeless people. These involve both support personnel (receptionists, administrators, cleaning personnel, drivers, soup kitchen personnel, interpreters), outreach workers and what was called in Athens 'social scientists', namely graduates of different disciplinary backgrounds, such as sociology, anthropology, social work and psychology with no specific professional social work training outside their studies.

Notwithstanding lay understandings of the term 'care workers', which for example in the UK context can denote staff who have not received substantial formal training, I have decided to use this term for all frontline staff to highlight and reinstate two key components of their role. First, defining care broadly as both the emotional and material support, this term highlights the caring role they fulfil in their encounters with homeless people. As in the case of homeless people, categorisations often conceal important deficiencies or create hierarchies. In the context of limited resources, like the Greek one, there was more that linked the different categories of caregivers than differentiated them. Regardless of whether they belonged to the support personnel or to the 'social scientists', the training they received from their respective organisations was limited. Nonetheless, all of them shared crucial similarities resulting from coping with the same pressures. These resulted from working for many groups of care recipients in under-resourced spaces and from their precarious employment status. These conditions often blurred the roles between them and made the support personnel perform caregiving tasks that should normally be undertaken by the social scientists and *vice versa*.

In the landscape I studied, relationships of care held significant value as it was through them that homeless people were able to create positive connections, solve issues and receive support. Care ethicists (Gilligan, 1982; Tronto, 1993; Noddings, 2010a) have stressed the importance of care as a relationship, and interconnectedness and interdependence as its key features. For example, Noddings (2003, 2010a, p. 18) argues that the establishment, maintenance, and enhancement of caring relations is the primary interest of care ethics. Although they are neither equal nor symmetrical, care relationships develop in dyadic exchanges between the 'one-caring' and the 'cared-for'. Hence, Noddings conceptualises care ethics as a relational ethic (Noddings, 2010a). To describe care relationships and the values that characterise them, Tronto and Fisher set out four different phases of care. They link each of them with four different ethical values of care which can also function as evaluative criteria signalling whether each phase has been completed. Concisely, Tronto (1993, p. 127) describes them as:

> caring about, noticing the need to care in the first place; taking care of, assuming responsibility of care; care-giving, the actual work of care that needs to be done; and care receiving, the response of that which is cared for to the care. From these four elements arise the four ethical elements of care: attentiveness, responsibility, competence and responsiveness.

This definition of care is useful because it provides a unified understanding of caring processes and lays out the ethical elements that need to be met for an integrated care approach. These ethical elements also serve as a compass for what can produce good enough caring and what can be perceived as an ethical failing.

Another component emphasized by care ethics and integrally linked with care relationships is the response of needs. In the process described above by Tronto, it is precisely the response of needs that brought care workers and homeless people together. For Ruddick (1998, p. 11), 'meeting the needs of other people is paradigmatic of care' and signals the final phase of an integrated and complete approach to care. This phase is underpinned by the acknowledgement of the reception of care – an aspect especially important for 'caring' organisations (Noddings, 2015, p. 74). Needs can be physical, material, emotional or social. However, it is rare that needs belong solely to one category. For example, responding to the basic need of having a home implies the fulfilment of other categories of needs. Accordingly, the failure of responding to one's need for a home

might point to unmet needs or the emergence of additional new ones. This made the work of care workers even more complex and puzzling. Braybrooke (1987) argues that for one to address a higher need, one needs to address other lower level needs. For care workers responding to the needs of homeless people, this could imply that before securing a home, other lower level needs should be addressed. These could involve the arrangement of bureaucratic issues, the provision of food, clothing, healthcare and psychosocial support. For this reason, reflecting on needs is not solely important on a micro-level of care relationships. Rather, it can illuminate the macro-level of care provision. For example, they can indicate the design of policies and welfare tasks on a state level (Wiggins, 1987) or when they become acknowledged, they can create new forms of rights (Noddings, 2005).

While the care relationships between homeless people and care workers often revolved around practical support and the latter were employed to fulfil certain tasks as part of paid labour, a great deal of emotional labour was also required. As emotion, care relates to the commitment to someone's wellbeing and an engagement with their inner life (Gheaus, 2005, p. 24). Although, as Noddings suggests, different levels of emotion are involved in all forms of care, the importance of emotion becomes even more pronounced when we distinguish between caring and caregiving. While caring is part of 'a moral way of life, one that may be invoked in every human encounter', 'caregiving points to a kind of work – paid or unpaid' (Noddings, 2010a, p. 20). To transform caregiving into caring for/about, care workers had to engage in a significant amount of *emotional* labour. The notion of emotional labour is linked with the management of emotions in work contexts. It is defined as 'the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place' (Hochschild, 1983, p. 7). In the sociological literature, the concept of emotional labour has been used to understand both interactive work and the role of organisation, structure and social relations of service jobs, and the factors shaping individuals' efforts to express and regulate emotions (Wharton, 2009).

Care ethics attribute epistemological value to the understanding of emotions and emotional connections as sites of power or as the outcome of power relations (Lawson, 2007). As a 'demanding and skilled work' (James, 1992, p. 500), aspects of training and skills for managing emotions and challenging situations are important for assessing, acting

and reacting according to the needs of care recipients. In the everyday encounters between homeless people and care workers, emotions could vary from encouragement, support, empathy, compassion and affection to sadness, fear, guilt, anger, disrespect and indifference. Homeless people highly depended on the relationships between care workers and themselves to escape homelessness and in these exchanges, emotions mattered. These connections could prove positive and empowering or, if ineffective, they could further marginalise homeless people by estranging them from a support network. As Jaggar (1989, p. 156) argues, emotions are an inherent part of what problems are considered worth investigating and the solutions considered worthy of acceptance. For homeless people, emotions were key for how they were viewed and how their problems were dealt with, as they could be prioritised, addressed or neglected. From this perspective, whether the values dictated by care ethics (attentiveness, responsibility, competence and responsiveness) were included in relationships of care is a significant dimension my project explores.

The organisational scale: Spaces of care

Relationships of care were not independent, but rather they were shaped by and reliant on care providers, which, following Conradson (2003b), I call spaces of care. These made up the organisational level of the landscape of care as I operationalise it. According to Conradson (2003a, p. 508), spaces of care in the city may be understood as 'a socio-spatial field[s] disclosed through the practices of care that take place between individuals'. The landscape of care for homeless people consisted of spaces of care where homeless people could secure resources and receive care. These included public providers, NGOs, outreach teams, shelters, drop-in centres, soup kitchens, faith-based organisations, hostels and similar settlements. This landscape was constructed as a locality by distant and global events which manifested themselves as crises in the Athenian urban milieu. Following the effects of the 2008 global financial crisis, spaces and agents of care experienced a substantial reduction of resources at a time when responsibilities of care had been relocated or extended to their realm. Simultaneously, multiple groups in the city were in urgent need of care.

Space is not viewed as passive backdrop, but instead as a factor shaping relationships of care. Different spaces allow for different kinds of care relationships

depending on who the care provider is, what the purpose of each space of care is, and what dynamics develop within it. Each micro-ethical space where individuals foster care relationships is viewed as the extension of the macro-ethical space of global relationships, including local and national policy contexts (Cloutier *et al.*, 2015, p. 769). Therefore, rather than viewing spaces of care as independent organisational spatialities, they are understood as being produced through the systemic and institutional relations between all agents involved in care provision for a certain group. These embodied and organisational spatialities are complex and fragile spaces, brought about through a shared accomplishment by those providing care and those visiting them to receive care.

Viewed as nodes within a larger urban and institutional network, such spaces played multiple roles and took on different qualities. First, these spaces can be analysed in material terms, as they offered crucial material resources to homeless people. Johnsen et al. explain 'how soup runs and daycentres are often the only accessible means of clothing, bathing facilities, daytime shelter, and essential nutrition available to rough sleepers' (Johnsen, Cloke and May, 2005, pp. 794–5). In this sense, it is crucial to keep in mind the life-sustaining role that such spaces play in the city and the implications of having insufficient resources to fulfil this role. The complexity to respond to one's need and one's ability to do so is heavily reliant on resources. Tronto (1993, p. 110) stresses their importance for good care and includes as key resources time, material goods and skills. When I refer to resources throughout the thesis, I involve these three forms of resources and I add emotional resources and space (i.e. sufficient infrastructure, size and materiality). Their built structure and infrastructure, their materiality and physical layout, their bodies and objects, as well as their size are all a testament to the resources such spaces have at their disposal, but also to the ensuing quality of care they are able to offer.

Despite the significance of their materiality, spaces of care remain what Giddens (1984, p. 118) calls 'locales', namely settings of interaction produced through communication and copresence. Hence, while the first incentive among homeless people visiting spaces of care was to secure material resources (food, clothing etc) or satisfy corporeal care needs (showers, laundry), one of these spaces' central functions was that they served as spaces where relationships between caregivers and care recipients could develop. Therefore, by offering a caring support network, spaces of care are important avenues for care recipients to build a sense of trust and security. When considering spaces

of care as spaces where relationships unfold, it is crucial to keep in mind the relationship between care workers and their employers. The latter defined the characteristics of the former's working conditions which in turn imprinted themselves on the operation of care spaces and their engagement in care relationships.

The local level: A geographic and institutional network of spaces of care

My analysis of the different scales of this landscape includes the local level. Here, my attention focuses on the way care providers functioned as a whole. This network appeared both as an institutional and a geographic network. While wandering the streets of the geographic area of Athens' inner city around Omonoia Square, where organisations supporting homeless people operated and homeless settlements proliferated, I engage with questions such as: Where are homelessness and marginality situated in the urban space and how are they experienced? What factors hinder/facilitate interactions between agents of care and homeless people? What are the implications of providing care in a site of heightened vulnerability where the intersection of crises and the lack of resources become more pronounced for spaces and workers of care? What is the role of the state in this part of the inner city? How do homeless people appropriate the urban space? What kind of materialities appear in this part of the city and how do they differ from other areas of central Athens? How is this area shaped by time, processes and institutions of control and care?

Treating the landscape of care not merely as a sum of spaces, but rather as a network with spatial and institutional connections allows for an engagement with a literature focusing on the interconnection of homelessness and urban space. This literature is dominated by two main approaches: one punitive and one that highlights spaces and responses of care and support. In his analysis of New York during the early 1990's recession, Neil Smith (1996) coins the term revanchism to describe urban policies aiming at the reclaiming of prime spaces, such as parks and sidewalks, by upper classes, and the resultant banishment of poor and homeless people through punitive tactics. Davis's (1990) work in Los Angeles's Skid Row has also described the oppressive policies of containment and 'sadism of downtown streets' endured by homeless people (ibid, p. 236). Revanchist approaches against the homeless involve the criminalisation of certain practices such as begging, their exclusion from the urban space and the development of

architectural devices against the homeless, such as CCTV cameras, anti-homeless benches and spikes in certain spaces that could be appropriated by homeless people for sleep (Doherty *et al.*, 2008).

Rather than limiting my attention to such policies, I favoured a more complex and not one-sided or selective analysis. As DeVerteuil (2014) argues, punitive urbanism can co-exist with more supportive structures assembled within the voluntary sector. In earlier work, De Verteuil et al. (2009, p. 646) explain 'that to frame homeless geographies exclusively in terms of 'collapse' is to ignore the increasingly varied and complex geographies of homelessness that characterize the contemporary city'. In this way, I seek to further problematise care provision for homeless people and spaces where this becomes available. As shown throughout the thesis, the street is a space of fear and potential criminalisation, a space where ontological insecurity can instil among homeless people, and a space that manifests wider exclusionary policies affecting homeless people and constraining care workers in their support of the former. Yet, it is also a space where homeless people and outreach workers meet. It is a space of exchange were valuable information about available support, medical information and organisations can be shared or emotional care can be provided through conversation. Untangling the different limitations care workers faced in their encounters with homeless people sheds light on how the institutional framework of the landscape of care shaped homelessness and care provision. For example, a tight bureaucratic structure imposed exclusions on homeless people and minimised the ability of care workers to provide care. Furthermore, collaborations were also evident among care providers (see Chapter 3). Consequently, the city can be hostile and threatening through police violence, increased regulation or exclusions from care. Yet, simultaneously, it involved efforts among providers to collaboratively respond to more care needs and spaces where homeless people can develop care relationships. The homeless people's routines and urban experience encompass care *and* control, and therefore both are equally important for our understanding of homelessness and vulnerability in the city.

Unravelling the role of different spaces and the connections between them is also important for understanding wider processes of welfare restructuring and rescaling that often emerge at times of austerity, uncertainty and fiscal retrenchment (Chorianopoulos and Tselepi, 2019, p. 81). Such developments promote collaboration, competitiveness

and devolution of duties *(ibid)*. Exploring the organisational scale of the landscape of care can reveal whether collaborations have a positive effect and whether spaces of provision eventually operate as spaces of care, sustenance or containment of populations. For example, DeVerteuil and Wilton (2009), who explore an addiction treatment system of six detox programmes in Canada, show that the latter *simultaneously* functioned as spaces of care, sustenance and control. Most importantly, they explain that the shifting relationships between care, sustenance and control depict broader changes of welfare restructuring and rolling back of the welfare state. Such changes are often brought about through dismantling welfare state programmes, devolving complex problems to the local level and introducing commercial or non-profit entities (Peck, 2001; Peck and Tickell, 2002) into systems of provision. Therefore, while partnerships between public and third-sector providers of care – often enabled through the financial support of private sector – may allow for place-specific policymaking, one needs to reflect on how such developments shift the characteristics of care provision.

To critically analyse such developments in relation to the landscape of care as a whole and in relation to its individual spaces, care ethics provide a compass for the quality of care offered and of the relationships between institutions. To this end, Kouki (2021) calls for engaging with care ethics as a way of moving away from the bureaucratic and rationalised routines that appear in humanitarian work and moving towards emphasizing mutuality, interdependence and mutuality and contextualising care. From this perspective, care ethics allow for critically exploring processes of welfare restructuring, different types of provision –ranging from basic provision to care incorporating ethical values. Accordingly, care ethics can also highlight deviations from such values. This gains more importance because the national socio-economic context in which the landscape of care operated was underpinned by multiple crises and extreme austerity that often resulted in deviations from the values endorsed by care ethics. For this reason, the macro-level of such landscapes should not be neglected. In what follows, I describe the context in which the landscape of care for homeless people unfolded in Athens in a detailed way.

The City: Setting the Scene

The city I encountered when I arrived in Athens in July 2017 was a European capital that had turned into a site of multiple intersected crises: political, economic and humanitarian. The political crisis was interlinked with the financial crisis which came

about after the sudden termination of steady economic growth and the requirement of financial assistance by the PASOK government in 2010. During my fieldwork, Greece was entering the seventh year of harsh austerity measures and neoliberal reforms. These were prerequisites of a successive series of bailout loans by its foreign creditors (IMF, ECB and EC), collectively known and referred to by the Greek media and citizens as the 'Troika'. These reforms and austerity measures included an extensive deregulation of the labour market, a massive privatisation of Greek assets, significant cuts in public expenditure, severe cuts to pensions, wages and salaries, as well as heavy taxation (Koukiadaki and Kretsos, 2012; Karamessini, 2015; Pagoulatos, 2017; Antoniadou and Karagkounis, 2020). Public social spending was reduced by 36% between 2009 and 2014 (Karanikolos and Kentikelenis, 2016). Indicative of the retreat of the welfare state are the cutbacks of 40% in the health sector between 2009 and 2013 – the highest in Europe (Karagkounis, 2017, p. 654). To meet the demands of its creditors and the required wider structural adjustments, only one hiring was allowed for every ten people retiring in the public sector, resulting in serious understaffing (Pentaraki, 2019). State budget allocations to municipalities were reduced by 60% (Karamessini, 2015) – a critical development as municipalities were key welfare providers in the country.

On a political level, the crisis was underpinned by the succession of eight different governments and seven Prime Ministers who attempted to manage this unprecedented crisis. With an election campaign entitled 'Hope is on the way!'[5], SYRIZA and Prime Minister Alexis Tsipras were in power from January 2015 to June 2019, covering the entirety of my fieldwork. Despite the high expectations initially raised by SYRIZA's programme, disappointment and division became widespread after SYRIZA accepted an agreement that had been rejected by over 61% of the Greek electorate in the July 2015 referendum. Concisely, Karagkounis (2017, pp. 658–9) presents the main measures of this agreement, already in place at the time of my fieldwork:

> tax rises; a major overhaul of the state pension system; spending cuts amounting to approximately 13 billion €; a massive privatization programme for Greek

[5] For more details, see the television advertisement of the party: https://www.youtube.com/watch?time_continue=20&v=iDrgWH8_ZY4&feature=emb_title.

assets, which is scaled up to 50 billion €; a humiliating condition of limited sovereignty; and disciplinary supervision from the EU.

What was gradually unfolding in Greece was the transformation of a financial crisis into a humanitarian crisis. In 2015 – two years before my fieldwork – Greece had lost a quarter of its GDP, its debt was already deemed unsustainable and unemployment was skyrocketing (IMF, 2015). Signs of poverty and crisis had become visible in the socio-economic life of Greece and the urban space of Athens. Homeless settlements were increasing, as were closed down shops. In a statement issued by the Greek Office of Medicines du Monde early in 2011, the discourse of a humanitarian crisis appeared to describe the growing numbers experiencing conditions of extreme poverty and the inability of the state to deliver services to those in need (Cabot, 2019, p. 756). Late in 2011, Alexis Tsipras, the leader of the SYRIZA party, also declared that 'this that we are living is not an economic crisis, it is a humanitarian crisis' (Cabot, 2019, p. 755). This term emphasized the growing problems of poverty and exclusion from access to social services regarding food and healthcare *(ibid)*.

During the beginning of my fieldwork in July 2017, many organisations participating in the landscape of care for homeless people were involved in managing another crisis that hit Greece – the 'so-called' international 'refugee crisis'. Over one million refugees arrived between 2015-2016 and 200,000 arrivals in 2017 and 2018 (the years of my fieldwork) (UNHCR, 2020), at a time when Greece was unprepared and ill-equipped to provide shelter support to them. While in 2017 most were placed in transit sites or closed facilities (hotspots), some families with young children and unaccompanied minors were still visible in urban public areas. After arriving from warzones – primarily Syria – to Europe after life-threatening crossings over sea and land, thousands of destitute refugees were trapped in conditions of marginality they were unable to control. These involved complicated, slow and ineffective bureaucratic procedures and asylum applications; a repressive management of refugee arrivals through the hotspot approach based on detention and foreclosure facilities established formally through the 2016 EU-Turkey agreement; and the consequences of the 2013 Dublin Agreement III dictating the EU member state considered responsible for processing asylum applications (Rozakou, 2017; Kourachanis, 2018; Parsanoglou, 2020). Often determined by the asylum seeker's first country of entry into the EU, high numbers of applications were waiting to be processed by Greece. In this context of scarce resources and with an urgent need to care

for them, organisations and outreach teams expanded their groups of service users to include refugees. However, caring and supportive responses were accompanied by anti-immigrant and racist discourses, fuelled by the rise of the extremist far-right Golden Dawn party which espoused Neo-Nazi ideas and grew from relative insignificance to 17-18 seats in parliament.[6]

The crises Greece was undergoing highlighted the crisis in the model of the Familistic Welfare Capitalism evident in many southern European countries. This is 'a type of national political economy where the family plays a double role both as the main provider of welfare to its members and as a key agent in the reproduction of its politico-economic institutional arrangements' (Papadopoulos and Roumpakis, 2013). In the absence of a structured network of social interventions, the informal institution of the immediate and extended family functioned as a crucial caretaker and shouldered its members' housing needs (Arapoglou, 2004; Simiti, 2015; Tzifakis *et al.*, 2015; Kourachanis, 2020). Yet, it was no longer able to do so. In particular, unstable working conditions and ever reducing disposable income drastically shrank the capacity of families to consolidate, mobilise and redistribute resources for the social protection and care of vulnerable members (Papadopoulos and Roumpakis, 2012; Karagkounis, 2017). Therefore, families were rendered unable to function as a safety net protecting vulnerable members. Indicative of the desperation and the effects of the weakening of families as crucial caretakers is the 'unprecedented increase in suicide rate attributed to economic hardship' (Karagkounis, 2017, p. 654). In a country that once had the lowest suicide rate in Europe, the suicide rate increased by over 40% between 2010 and 2015 (Klimaka, 2015). Similarly, the at-risk-of-poverty or social exclusion rate increased from 28.1% in 2008 to 35.7% in 2015 (Eurostat, 2017; OECD, 2014, as cited in Antoniadou and Karagkounis, 2020).

All these developments had turned the city into a site of overlapping crises (Cabot, 2019), dispossession, vulnerability and exclusion. Thousands of Greeks experiencing the effects of the crisis faced an unprecedented deterioration of their living standards, deprivation and threats of eviction because of their inability to cover housing costs. Approximately 7,950 lived in non-conventional dwellings and another 13,651

[6] Following violent attacks against migrants and a left-wing artist, in October 2020 it was convicted of being a criminal organisation.

people in dwellings unfit for habitation according to the national census of 2011 (Arapoglou & Gounis, 2014). Despite the high rate of homeownership in Greece, the crisis brought about evictions and foreclosures. According to the Bank of Greece, 31% of housing loans were non-performing in 2016 and evictions from private rented housing increased from 11,000 in 2010 to 14,500 in 2013 (Arapoglou and Gounis, 2017, p. 71), putting thousands of people at risk of becoming homeless. The inability of households to afford heating during the winter, electricity, rent, bills and adequate food (Karagkounis, 2017, p. 654) rendered many invisible homeless. I met many of them in various spaces of care trying to secure resources they could not afford themselves. Many of my participants also narrated how being unable to cover mortgage and rent arrears or being overburdened by housing costs, they ended up sleeping rough. [7] Although to a much lesser extent, similar problems were also faced by care workers who often had difficulty covering all of their living and housing expenses.

Other vulnerable groups in the city included homeless and non-homeless drug users. The reported number of HIV infections among injecting drug users had risen significantly from 15 in 2010 to 522 in 2012 due to low or reduced levels of funding for preventive intervention (Karanikolos *et al.*, 2013; Karagkounis, 2017). In addition, preliminary data from 2013 suggest a doubling in incidents of tuberculosis among the population in comparison to 2012 (Kentikelenis *et al.*, 2014). The health crisis developing among these vulnerable populations demonstrates the effects of austerity on the city. In 2009-10, a third of outreach programmes were cut because of scarcity of funding and the number of syringes and condoms distributed to drug users fell by 10% and 24% respectively (ibid).

Among these populations were the visible homeless, namely those sleeping rough, or with a temporary place to sleep in institutions or shelters. From 2010, their number increased by 40%, amounting to 9,100 in the wider metropolitan area in 2013 and to 21,500 in 2016, with three quarters of the latter being of foreign origin either waiting for asylum or relocation (Arapoglou and Gounis, 2017). Furthermore, a pilot study measuring

[7] In 2016, poor households in Greece spent 75% of their disposable income on housing – the largest proportion in Europe – and 40.5% of total households were overburdened by housing costs (FEANTSA, 2018). In the same year, 15.3% of the total population and 24.9% of poor households had mortgage and rent arrears, a 60% increase in the period between 2010 and 2016 (ibid).

the number of homeless on one single night in May 2018 estimated that in Athens 793 people were considered roofless, namely sleeping rough, in shelters, hostels and supported accommodation (Dimoulas, 2018) These estimates suggest a significant increase in rough sleepers. However, through my contact with NGO officials and homeless people, this could be an underestimation of the actual number of rough sleepers. Homeless people underscored that underestimation could resulted from the study taking place close to the summer when many homeless people move from the city centre to the suburbs and the islands for temporary work. Outreach workers often highlighted the increase they were witnessing, and my daily observations captured multiple homeless settlements in the city or mattresses and syringes on the ground. People were sorting out garbage to find food, useful items or material that could be recycled. Such images also proliferated in media reports and became associated with the decay of the city during the years of the crisis. The city I encountered was a city of marginality and exclusion.

This shared continuum of precarity (Cabot, 2019) led to the emergence of at least three different landscapes of care in the city, comprised of various formal and informal spaces of provision for multiple groups: one for housed but vulnerable people unable to access basic goods, one for migrants and refugees, and one for vulnerable groups in the city (homeless people, drug users, sex workers, and populations having contracted or at risk of contracting HIV). The first landscape was operated by institutional actors, such as NGOs, the Church or the Municipality, or by grassroots networks of volunteers (e.g. doctors, pharmacists, psychologists, social workers). Through collective action and community-level redistribution of donated surplus goods, these volunteers formed welfare structures in an attempt to provide help to those excluded from formal welfare systems (Cabot, 2016; Teloni and Adam, 2018). Spaces run by formal institutions included spaces such as the social grocery, the social pharmacy and the social laundry based at the Municipality of Athens. Informal spaces involved social/solidarity clinics and pharmacies on a local level, anti-middleman distribution cooperatives promoting the solidarity economy or time banks where services were exchanged(Cabot, 2016; Teloni and Adam, 2018; Kotronaki and Christou, 2019).[8] The second landscape involved NGOs, grassroots initiatives and occupied spaces, such as the self-organised squat of the City Plaza hotel

[8] For example, one hour of language classes for one hour of child care.

hosting over four hundred refugees. Finally, the third landscape was the one my research focused on. It involved NGO and municipal spaces, drop-in centres, hostels, shelters, hostels, outreach teams, soup kitchens and spaces run and funded through the collaboration of NGO and philanthropic foundations. Although most of the organisations started with an initial focus on a specific population, many of them redirected or expanded their focus in order to respond to the increasing groups in need of care and/or attract more funding (Arapoglou and Gounis, 2017, p. 91). In this sense, it is important to note that albeit different, these landscapes intersected with one another and were not completely distinct– something with significant implications both for caregivers and care recipients (see Chapter 3).

Thesis Outline

In **Chapter 1**, I presented my theoretical approach to care, homelessness and the landscape of care – both as a conceptual and operational construct – and I set the scene for my research. **In Chapter 2,** I discuss my methodological perspective and my approach to ethnography. I analyse the different challenges faced when conducting a multi-sited urban ethnography from constructing a research field to analysing the city as a whole and its individual spaces of care. By presenting the different stages of shaping this thesis from its conception to the writing process, questions of trust, power, positionality and motivation are discussed. Before presenting the practicalities and the limitations of organising a multi-sited ethnography, attention is also given to considerations, such as ethics, risks, access and self-care in research.

Chapter 3 turns to the arrangement of care on the city level and untangles the main elements that constitute it. It examines how the landscape of care unfolded in Athens and presents the area it occupied, the spaces that comprised it and their main spatial, temporal and institutional characteristics. In addition, illuminating the global, national and local factors shaping this landscape of care, I analyse the impact of austerity measures and intersected crises (financial, the 'so-called' refugee and humanitarian), on organisations, workers and recipients of care. In so doing, this chapter argues that the landscape of care was a space of shared fragility and vulnerability across its spaces as well as givers and receivers of care.

The next two chapters deal with the local scale of the landscape of care and its institutional nature. **Chapter 4** looks at aspects of care regarding the accommodation homeless people could access. First, it analyses its discursive formation and how sin-talk and sick-talk led to the construction of categories of care deservingness for homeless people. These entailed stigmatising features or led to the exclusion of certain categories of homeless people from accommodation. Subsequently, it investigates the process of applying for a hostel accommodation and shows how obstacles, uncertainty and disappointment could constitute discouraging factors when homeless people considered seeking accommodation. Finally, this chapter describes the living conditions in the hostels and the night shelter of the city, demonstrating that acquiring a sense of ontological security was impossible for most of their residents. Rather, patterns of institutionalisation appeared among the hostel residents and patterns of care avoidance were prevalent among those staying at the night shelter. Consequently, by depriving homeless people of ontological security and often shaping their decision to return to the street, the landscape of care played a crucial role in reproducing homelessness in the city.

Moving our attention from inside spaces of accommodation to outside spaces, **Chapter 5** looks at three different experiences of being without a home in the public space. Specifically, it explores rough sleepers in the city centre, homeless women primarily located at the outskirts of the centre and a home-making process by a rough sleeper in an underpass. Bringing together the literatures of home and ontological security, I show that these different manifestations of homelessness were interwoven with characteristics and processes of the landscape of care. I show that the ontological insecurity among rough sleepers might be individually experienced but is produced structurally. Specifically, it is bound to the deficiencies and exclusions of the landscape of care and the interactions between agents of care and homeless people. I argue that the landscape of care pushed homeless people from marginalisation to extreme forms of marginalisation on a psychological, embodied and material level.

Drawing on care ethics, the last three empirical chapters of the thesis attend to the organisational and the interpersonal scale of the landscape of care, and in particular to three spaces of care and the relationships developing there between homeless people and their care workers. **Chapter 6** deals with the experiences of homeless people while navigating the landscape of care and seeking municipal care. In so doing, it zooms into

the space of the Municipality, a public provider of care which played a key role in defining the configuration of homelessness in Athens. Shedding light on the three main aspects of care provision, it investigates the relationships developing between homeless people and care workers at the municipal social services, during their encounters with the municipal outreach work and at the municipal soup kitchen. I argue that rather than relationships of care encompassing the values of care ethics, care workers were only able to *manage* homelessness. Affected by various pressures, such as a lack of resources and the bureaucratic nature of the landscape of care, care remained on a level of administrative support and life-sustenance or was interwoven with processes of control, regulation and disciplining. These conditions stripped care workers of their ability to provide care in an effective and creative way and contributed to rendering homeless people even more subordinate.

Chapter 7 delves into a drop-in centre located in Athens' inner city and analyses the interconnection of care ethics and space. Specifically, by systematically analysing the different rooms and areas of the drop-in centre, I discuss how relationships of care developed there and how different needs were responded to. This chapter deals with care provision, professional and ethical dilemmas and practices unfolding in a voluntary space of care undergoing multiple pressures. By illuminating the perspective of care workers and homeless people, it reveals the impact of pressures and insufficient resources on both the caregiving and care receiving end. It argues that space should be understood more than a background of care. Rather its size, use, physical layout and characteristics were key factors in shaping relationships of care. This chapter also discusses experiences of vulnerability and precarity by care workers and the responsibilities of employers towards care workers, maintaining that when care workers become vulnerable, their ability to care is jeopardised.

The last empirical chapter, **Chapter 8**, moves our attention back to the city and a public, central Park where outreach teams provided care to homeless drug users. By using the literature on outreach work, this chapter conceptualises a new category of spaces of care, 'bottom-up' spaces of care. This category of spaces is understood as islands of deprivation and vulnerability in the city. They are formed through the occupation of public spaces by marginalised groups, but as both other city locations discussed in the thesis and the Park demonstrate, these spaces are co-constituted by the landscape of care

and the wider urban context. Analysing the dynamics in such spaces is important as they can reveal systemic weaknesses affecting both care workers and homeless people. For this reason, this chapter explains the different tensions, constraints and difficulties faced both on the caregiving and the care receiving end, leading both parts to ultimately drift apart.

Finally, in the **Conclusions**, I sum up the main findings of the empirical chapters, bring their main threads together and outline the key contributions of this thesis. I emphasise the role of space, resources and contextual factors shaping landscapes of care and formations of vulnerability in contemporary cities. I end this chapter by discussing policy implications regarding systems of care for homeless people and by pointing out areas for further research.

Chapter 2

Methods

Introduction

Returning to my hometown after almost five years, Athens simultaneously engendered a sense of familiarity and unfamiliarity. Homeless settlements and poverty had visibly increased before I left the city late in 2013. However, the prolonged effects of the crisis had further accentuated various aspects of vulnerability in the city. The harsh austerity measures had rendered socio-economic adversity an ever-present topic of conversation amongst most Greeks. From young unemployed Greeks and families struggling to make ends meet to even more pronounced forms of destitution in the public space, concern over one's ability to survive manifested itself in the social, economic and urban life of Athens. Despite being familiar with the city, now this crisis-scape had become the object of my study. On my way to an organisation through Omonoia Square which would come to denote the beginning of my daily fieldwork and where Nasos who would become one of my participants slept rough, many questions begged for an answer: How do you organise an urban ethnography in a city of shared precarity? How can one maintain both a panoramic and a close-up view of the city? How does one make sure that homelessness is not portrayed solely as a lived experience but its production through complex socio-spatial and institutional relations is also analysed? How does one attend to its public manifestations and to different sub-groups within it? How does one gain the trust of such marginalised and vulnerable individuals? How would aspects of positionality and risk present themselves in the field and later in writing? What I did not know in this first journey to this organisation was that my research would end up being not just an ethnography of homelessness, but also of care work. The immersion in spaces where homelessness and care work intersected with one another, as well observing the relationships between homeless people and care workers would at times prove emotionally challenging, requiring strategies of self-care. In what follows, I demonstrate how I dealt with these methodological questions and present the multiple difficulties that appear in an urban ethnography of heightened vulnerability.

An urban multi-sited ethnography

My research positions itself as an urban multi-sited ethnography of homelessness and care. Borne out of anthropological research, ethnography facilitates the study of shared meanings produced through social relationships and the collection of data regarding the social worlds and everyday lives of individuals. In doing so, it foregrounds thick description (Geertz, 1973). As a way of capturing and presenting data, thick description aims at creating a sense of 'you are there' (James, 1977). In my approach to ethnography, I follow Wacquant's definition:

> ethnography was defined […] as social research based on the close-up, on-the-ground observation of people and institutions in real time and space, in which the investigator embeds herself near (or within) the phenomenon so as to detect how and why agents on the scene act, think and feel the way they do (Wacquant, 2016, p. 5).

These qualities have rendered ethnography a well-suited approach to study housing-related topics and hard-to-reach and vulnerable populations (Hoolachan, 2016). The length of the fieldwork and the development of relationships between the researchers and the researched allows for the necessary time to gradually engage in relationships of trust. For this reason, ethnography has proven to be a methodological approach for a wide range of work on homelessness (Duneier, 1999; Ravenhill, 2008; Bourgois and Schonberg, 2009; Cloke, May and Johnsen, 2010; Jackson, 2015; Knight, 2015; Hall, 2017; Smith and Hall, 2018), and urban marginality and poverty more widely (Beckett and Herbert, 2011; Auyero, 2012; Wacquant, 2016; Desmond, 2017). My work is inspired by and hopes to build on, the sum of these ethnographic studies.

As an urban ethnography, my focus is on disentangling the impact of 'larger forces of urban life' and of the socio-spatial formations of the city on the lives of participants. (Ocejo, 2012, p. 4). Rather than understanding social problems as 'just happening to exist within cities' (ibid), the urban space and the urban context of cities shape people's lives, systems and landscapes of care, as well as different manifestations of destitution. Place is not conceptualised as mere description, but rather as constructed object functioning as an integral part of the analysis. Be it in the foreground or background, place is not a mere container of social life. Rather, it 'both shapes and is shaped by the processes and interactions happening there'; it is 'invested with spatial,

material, and symbolic elements by the people, networks, and institutions that construct the social' (Corcoran, Abrams and Wynn, 2019, p. 98). I argue that place – and space – is an integral part of my analysis. Either implicitly or explicitly, its contours, the fabric of the city, and the spaces I studied are key components of my arguments. In this sense, whilst sometimes noticed at first glance and others not, the physical location and the materiality of the spaces discussed in this thesis are a primary element of how care and homelessness present themselves in the city. As a city undergoing multiple crises, Athens had become a site where the effects of austerity, the retreat of the welfare state and the lack of resources manifested themselves in various dilapidated buildings, homeless settlements, the presence of various vulnerable groups of people in the public space or images of people searching in the city's bins. The location of the landscape of care at the urban margins and the broader socio-spatial dynamics of the territory it occupied (see Chapters 3 and 8) as well as the lack of spatial resources in spaces of care (see for example the lack of shower facilities in Chapter 7) all produce certain opportunities and constraints for care provision and the groups involved in it – homeless people and care workers alike.[9] As a result, spaces are considered central, not uncredited, social actors.

Foregrounding place and space and revealing their significance is integrally linked with the methodological strategies and practices of conducting an urban, multi-sited ethnography. Firstly, walking though the city and venturing down its streets has shaped my thinking of everyday urban life. Not only did I manage to observe the city's physical composition, different social interactions and how these two intersect, but also the nitty-gritty of the city: the signatures of homelessness and care work, be they worn mattresses on the streets, a pair of empty shoes next to someone's sleeping bag, used needles or heavy rucksacks with water bottles. The materiality of this paraphernalia but also of territory and streets occupied by the landscape of care, not as clean and with less light in comparison to other areas of central Athens, was a testament to the socio-spatial conditions characterising care provision and its spaces (see Chapter 3). This perspective has been key to exploring the city through the eyes of homeless people and care workers in an embodied way. In wandering the city with them, I elicited their perspective on it. Outreach workers often shared memorable stories of their outreach work, described how

[9] Similarly, a detailed spatial analysis in Chapter 6 shows that the infrastructure of the municipal social services affected care by obstructing listening, while the lack of sufficient shower facilities resulted in tensions and undermining care in Chapter 7.

the city had changed during the crisis, and whether in the past homeless people used to occupy areas we passed through. Homeless people discussed which areas they avoided and why, whether organisations were nearby and what they thought of each, or areas that invoked memories for them. This approach to urban ethnography relies on the premise that to study cities as a larger whole, the ethnographer needs to step 'out of their comfort zone' and become 'an investigator' (Timmermans and Prickett, 2019, p. 61). In my research, this involved visiting spaces and areas of the city I would not otherwise usually go to and trying to understand the ways organisations worked both from the perspective of care workers and homeless people.

Seeing that a variety of public locations in the city and spaces were crucial for the landscape of care and homelessness was what led me to embrace a multi-sited approach to ethnography. Multi-sited field studies have emerged as a methodological approach suitable for exploring spatially dispersed fields (Falzon, 2015). Originating in the work of George Marcus (1995, p. 105), in multi-sited research the ethnographer establishes some physical presence in the field and tries to identify an association or connection among various sites. Instead of a 'substantialist' approach to ethnography which studies characteristics of groups, multi-sited ethnography adopts a relational approach exploring the 'intersections of multiple networks', specifically through spanning from streets to state institutions and NGO centres. (Desmond, 2014, p. 555). Desmond (2014) argues that it is the ethnographer's responsibility to take different positions in the field. This is why my ethnographic exploration of the landscape of care spans across sites, examining relations of homelessness between state actors, community groups and those who are rendered without a home. To study homelessness means to understand the relations and processes that construct homelessness. To study homelessness in the city means to reveal the processes taking place in the urban milieu that intersect with homelessness. In the context of Athens, this explicitly connects to spaces defining the experience of homelessness in the city, namely spaces visited daily by homeless people to receive care. To study care provision is to study the relationships between caregivers and care-recipients and all the factors and processes that mediate them. For this reason, in studying the field of the landscape of care, I have aimed at unravelling the social relations that connect the spaces and actors that comprise it and looking at the uneven ways in which power unfolds within them.

Conducting a multi-sited ethnography poses a set of methodological, conceptual and practical challenges, which primarily derive from the construction of the field. Indeed, it is the ethnographer's task and responsibility to construct the field and delineate its urban boundaries, actors and sites in a justifiable way. In this sense, ethnographers also become 'fieldmakers', a term that needs to be used with caution as 'fields are always made, are never natural' (Coleman and Hellermann, 2011, p. 3). The different sites of a field are 'substantially continuous, but spatially non-contiguous'(Falzon, 2009, p. 2). As a result, one's research field can expand and contract during one's fieldwork. In my work, the different spaces of care were all substantially linked by a relation to care and homelessness. Yet, they were physically distant from one another.

This posed the methodological challenge of defining which spaces, areas and agents of the city should be regarded as part of the field: what to include and what to exclude. In constructing the field, my strategy aligned with Marcus's emphasis on *following* and in particular, following and staying with the movements of a particular group of initial subjects' (Marcus, 1995, p. 106). With the ultimate aim of following care, I centred on following care workers providing care and homeless people seeking care. Rather than assuming a pre-existing field, I adhered to an inductive approach which would allow the field to emerge through the data. Hence, I decided to follow, both conceptually and physically, the routes and connections pinpointed by my participants, both homeless people and care workers. Through interviews and observations, it became obvious that certain areas, spaces, organisations and people would repeatedly emerge. A detailed analysis of the areas and the spaces is provided in Chapter 3. In sum, it includes spaces, areas and organisations in the vicinity of Omonoia Square that appeared significant for care and homelessness. Spaces and sites focusing on providing care exclusively to refugees were excluded.[10] In maintaining a panoramic view of this dispersed urban landscape while paying close attention to an array of public and closed spaces also posed a practical challenge. The practicalities of closely following those configuring care and homelessness and being with the landscape (Marcus, 1995) are explained at the end of my chapter when I explain how I organised my ethnography

[10] A brief discussion of the impact of the refugee crisis on the landscape of care on homeless people is included in Chapter 3, as it affected care workers and homeless people, as well as care provision more generally.

Methodology

Ethnographic observation

Ethnographic observation was one of my main methodologies for data collection. This involved keeping both jotted and detailed notes, photos and conducting numerous interviews. While all care workers were aware of my role and interest in their lives as a researcher, the time to be introduced to homeless participants was not always in place. Bryman (2012, p. 445) argues that ethnographers often move between these roles at different times of their research and each role comes with their own sets of advantages and disadvantages. In closed spaces of care, I was introduced to homeless participants through the personnel of these spaces as 'a researcher' or as 'someone who would like to interview you about your life'. Eventually and with time, the purpose of my presence there became known among the service users of the various spaces and data were collected with their full knowledge. In contrast, in public settings I mostly maintained an overt role and not being able to invest the required time, I adhered to a passive observational role with limited interaction. There, I mostly observed without partaking in the exchanges between the care workers and the homeless people, who became aware of my role, if they asked. As a result, while in closed spaces I was able to collect more detailed data and conduct follow up interviews and conversations, in public settings the scope of data gathered was constrained by the interactions and behaviours I was able to observe.

'Multi-sited ethnography has also inspired the 'mobile methods' ethnographic approach, an itinerant strategy that recommends collecting data by 'observing people's mobility,' 'walking with,' 'stalking,' or 'lurking around others' (Falzon, 2015, p. 104). This is also in congruence with Marcus's (1995, p. 106) prompting to stay with specific groups of people. In my research, this took the form of shadowing outreach teams and accompanying them across various sites and locations. The three outreach teams I shadowed, which I call the municipal, the daytime and the night-time teams, used different strategies for locating and engaging with homeless people. The municipal team navigated the city both through walking and using a car. The daytime team solely walked, and the night-time used a car to move from one location to the next.

These different modes of moving from one site to the next also allowed for a different research experience. In elaborating the advantages of walking interviews, Evans and Jones (2011, p. 850) distinguish between *mobile methods* and what they describe as *sedentary methods in motion*. In particular, they highlight a distinct difference between the experience of interviewing participants, 'say, on a train, where movement is experienced as a visual flow through windows and the primary haptic sensation is merely that of background vibration' and the experience of cycling (ibid). Furthermore, Adams and Guy (2007) argue that walking allows the researcher and the participant to be 'exposed to the multi-sensory stimulation of the surrounding environment'. At times of shadowing 'walking' outreach teams, a much more intimate and condensed experience of the city emerged, as I became privy to the exchanges between homeless people and outreach care workers. The embodied experience of walking through the city enriched the data collection. In contrast, driving through the city to reach homeless people reported by citizens or from one location to another facilitated care provision in distant locations and the observation of these encounters. In addition, the time I spent in the car allowed for a higher level of involvement in the conversations between care workers and me or among themselves, during a time that they were not actively engaged in care provision. Kusenbach (2003, p. 463) calls the practice 'go-alongs'. As a hybrid between participant observation and interviews, this method entails:

> accompanying individual informants on their 'natural' outings and – through asking questions, listening and observing – actively exploring their subjects' stream of experiences and practices as they move through, and interact with, their physical and social environment.

As a result, data regarding homelessness and the city collected through the car's windows was complemented with data deriving from exchanges with the driver and the care workers of these teams. This type of data captured their relationships, attitudes towards their work and previous notable experiences they felt would be of value to me.

Finally, in terms of mobile ethnographic methods, my experience as a passive observer of what was called 'Invisible Tours' facilitated further exploration of the city from the perspective of a homeless person and shaped my conceptualisation of the landscape of care. Enabled by an organisation equivalent to the UK's 'Big Issue', a vendor took on the role of a guide and presented the city through his/her eyes as a homeless

person and former rough sleeper. These tours were open to the public and ticketed at six euros. They took place every Saturday morning with the aim of rehabilitating former and current rough sleepers, who shared information on the services provided by different organisations and their experiences from sleeping rough. Pinpointing significant locations and organisations in the city in a two-hour tour, this guide provided a detailed account of places, areas and activities taking place in the urban milieu related to homelessness.

Interviews

I used interviews in conjunction with ethnographic observation. Numerous unstructured interviews took place with homeless people and care workers in various spaces in the city. Most of them either constituted follow-up conversations after semi-structured interviews, short discussions to clarify certain aspects of what I was witnessing in the field, or daily interactions that still produced important data. The vast majority of my interview data derives from 30 semi-structured in-depth interviews with homeless people and care workers (see Appendices A and B). Out of those, 21 were with homeless people (15 male and 6 female) and 9 with professionals, namely frontline care workers and managers (3 male and 6 female). Semi-structured interviews facilitate rapport, empathy, the elicitation of stories and the collection of richer data (Smith and Eatough, 2007). All semi-structured interviews were recorded and transcribed. The majority took place in one-to-one settings in quiet and removed rooms of the organisations I worked with, while a few of them took place in public spaces, such as central squares and benches. Through these interviews, I was able to gather more detailed data vis-à-vis my research questions, complement and verify my observational data, but also establish closer relationships with participants and develop trust.

Two different interview guides existed for the two sets of participants. The interview guide for homeless people focused on their personal story and their daily routines and habits. Albeit not the focus of my research, the life history of each participant with which each interview was initiated proved useful for enhancing trust and presenting genuine interest in each individual. It also allowed for a more complex understanding of the factors that led each participant to homelessness. Emphasis was given to their relationship with agents operating in the city, such as outreach teams, other homeless people and the police. Through these questions, it was possible to understand their

trajectories and routes in the city, as well as the emotions they associated with certain areas of the urban milieu. For instance, such emotions involved fear, care, control, disgust, and compassion. Finally, questions explored the nature and quality of care they received in different spaces of care, as well as their relationships with care workers. All homeless people I interviewed were recommended by their social worker or were approached by me after my asking for permission to conduct an interview with them. This strategy was employed to protect the homeless and to ensure that their emotional state allowed them to open up and share their thoughts.

My participants were recruited through purposive and snowball sampling. Bryman (2012, p. 418) explains that as a non-probability form of sampling, 'the goal of purposive sampling is to sample cases in a strategic way, so that those sampled are relevant to the research questions being posed'. For this reason, my sample comprised homeless people who at the time of the interview or in the past had slept rough on the streets of Athens. Furthermore, a minority of my participants were recruited through the snowball technique. While both Greeks and migrants are included in my sample, I made sure that their level of Greek or English allowed for accuracy and mutual understanding. Semi-structured interviews with care workers took place at the offices of their organisations and aimed at revealing their perspective on homelessness and care provision. In terms of the former, questions focused on the deficiencies and problems homeless people faced, changes they might have witnessed during the financial crisis and overall characteristics of homeless people and facets of homelessness in Athens. Based on their professional insights, staff shed invaluable light on the complexities defining the experience of homelessness and more specifically, on their own perspective on particular categories of homeless people or individual cases. Regarding care provision, the interviews explored the workers' motivations behind working in spaces of care for homeless people, their previous and current experiences of providing care, their daily experiences and difficulties of working in such an environment and their relationships with their colleagues and management. A great deal of the interview was spent on discussing their perception of their relationships with homeless people and potential obstacles they encountered in providing care.

On average, interviews lasted between 50 minutes and an hour and a half. Being able to invest time to participate in interviews was different for homeless people and care

workers. On most days, homeless people had ample time and even if they had to attend scheduled appointments with doctors and/or other organisations, they were happy to make time for an interview. On the contrary, care workers were always short of time, as their days were busy and full of appointments and meetings. As a result, within such a pressing daily professional life, interviews had to be rescheduled multiple times and many of them were interrupted and other follow-up interviews arranged. Despite such difficulties, both sets of participants showed willingness to make the necessary time and were happy to share details and respond to questions in an open manner. The time they invested and their willingness to touch upon sensitive and personal issues can be interpreted as viewing the interview as an opportunity to be listened to. The need and desire to express their feelings and be listened to in a non-judgemental way from someone who had no additional demands from them rendered the interviews a welcome interruption from their routine daily lives and interactions with others.

Recognising the differences between my own personal and professional life and their own stressful and emotionally burdened lives – on a professional level for the care workers and a more general level for the homeless – I was conscious of my status as an outsider despite my efforts to gain a perspective as an insider. The latter 'is a native of that particular geographic area, culture, or acutely aware of social norms whereas an outsider does not possess any of the previous listed characteristics' (Venegas and Huerta, 2010). For me, this distinction underpinned my approach to interviewing. For this reason, I asked non-directive, open-ended questions which allowed for a 'guided conversation' (Lofland and Lofland, 1995), where I as an active listener allowed my participants to express themselves freely. This facilitated establishing rapport and trust with the interviewees. Over half of my participants verbally thanked me for 'taking the time and listening to them' and mentioned that rarely is someone interested in their own stories. When asked at the end of the interview whether there was something that she would like to add, Gianna said: 'Thank you for listening. Just this…and I love you'. Although we had spent relatively little time together, Gianna's spontaneous response sheds light on the need people had to be listened to[11]. That research interviews offered the opportunity to be listened to is well documented and has been argued to have a possible therapeutic value (Dickson-Swift *et al.*, 2016). The desire to be listened to manifested itself differently

[11] Indeed, spaces and opportunities for homeless people to be listened by care workers and for the latter by their management were limited (see Chapters 6 and 7).

in the interviews with care workers. For them, interviews served as an opportunity to vent their frustration, anger and disappointment in relation to their working environments. The fact that interviews took place in rooms further away from the main offices and the assurances they received about confidentiality allowed them to freely express their true feelings. Gradually, I became aware of some of the positive and negative feelings employees felt for one another, towards their management and their organisations or homeless people.

Whilst interviewees were eager to share their stories, there were moments of vulnerability and emotional sensitivity that required negotiation. Amongst other facets, Lee and Renzetti (1993, p. 6) argue that sensitive topics include 'research intruding into the private sphere or delving into some deeply personal experience' and the 'study of social control and deviance'. Sensitive topics in my interviews with homeless people included domestic violence, moments of fear or attack on the street, traumatic childhood memories, experiences from war and fleeing one's country, violent interactions with the police or in prisons and detention centres, deviance, and illegal activities. For example, Mr Dimitris an elderly Greek man, had traumatic childhood memories, as he became homeless as early as thirteen years old when his father forbade his staying at the house on the grounds that 'he was weak' and he already had another son. Throughout his interview, he spoke and echoed the pain he had endured as a thirteen-year-old boy. His behaviour showed the level of vulnerability and pain he had experienced from the perspective of a young boy rather than that of an elderly man. In speaking about the experience of interviewing a female victim of domestic violence and reflecting on the power dynamics, Hydén (2008, 223) concludes that 'it was not the violence as such that placed [one] in a culturally low position but the message it carried: you are unloved'. This remark is useful in understanding that in interviews, like the one described by Hydén or the one I had with Mr Dimtris, sensitivity might arise not solely from the structural and material conditions of situations such as homelessness. Feelings of abandonment and exclusion, lack of care and other emotions resulting from material deficiency also play a prominent role and manifest the emotional effects of material deprivation, which might be more enduring and starker than material deprivation *per se*.

Another case was my interview with Vana, a Romanian woman in her 60s who had lived in Greece for many years and was married to a Greek man. Reliving her

moments at the hostel appeared to be extremely traumatising for her, as she was narrating incidents of emotional bullying that she had experienced. Seeing her distressed, I suggested interrupting or ending the interview or changing the topic of our conversation. However, she continued. At the end of our interview, I asked whether she would like to add something. Initially, she asked about my research, how my life was and what days I plan to be at the drop-in centre. Subsequently she said: 'You know I want to help you, because you are such a sweet young girl. And I also had a daughter.' Taken by surprise, I asked her how come she had not mentioned having a daughter during the interview. Then she explained: 'Well, that was many years ago. I was pregnant but did not keep the baby. That's why I want to help you. You could have been her. You seem to be the age she would have been today.'

Ely et al. (1991, p. 49) argue that 'if we undertake the study of human lives, we have to be ready to face human feelings'. Following this thread, Dickson-Swift et al. (2016) spoke of the importance of showing care, empathy, patience and compassion and of responding to participants as human beings. In cases like the ones described above, I adhered to these values and 'made space for sensitive topics' (Hydén, 2013), whilst offering them the possibility of interrupting our conversation. Space can be made through moments of silence, letting the participants guide the conversation, and even offering literally physical space by leaving the room for a few minutes and the participant on their own. I employed all these strategies in different interviews. When listening to their stories, empathy was essential and appeared to enhance trust in my relationship with participants both during and after the interview. This could have resulted from the fact that it was in these moments the power dynamics between myself as a researcher and the participants were minimised and our interaction was primarily based on sharing aspects of human vulnerability.

Visual methods

I employed two kinds of visual methods in my study: photographs and maps. I composed maps in order to understand the cartographies and trajectories of homeless people in the city. Through ethnographic observation and by asking homeless people and their care workers in semi-structured interviews about the spaces they visit in the city, I was able to understand significant locations for homelessness and homeless people. In

addition, I managed to understand the nature of resources and care that homeless people associated with each of these spaces. Finally, I was able to understand the views and experiences of homeless people in different areas of the city. These maps helped me delineate the boundaries of the landscape of care for homeless people and were useful in constructing my research field. In order to enrich my data set, photographic data were also collected. This was conducted by distributing disposable cameras to homeless people and asking them to capture spaces and moments from their daily life in the city. After agreeing with participants they would like to participate in this aspect of the research, I distributed four cameras and three were returned to me. Photos were also taken by myself during ethnographic observation. Photographs are considered a useful way to convey pictorially something that words cannot easily convey (Ball and Smith, 1992; Ravenhill, 2008). With two of my participants, this was accompanied with Photo Elicitation Interviewing (PEI), namely 'inserting a photograph into a research interview' (Harper, 2002, p. 13).[12] In this case, the homeless people were asked to share their thoughts and explain why they had taken each picture and what each picture meant to them. Photographs are seen as a way of 'evoking feelings, memories and thoughts' (Padgett *et al.*, 2013) and as a way of expanding sensory awareness, as both verbal and visual means are used in the interview process.

Visual data have extensively been used on studies of homelessness and homeless people (Johnsen, May and Cloke, 2008; Ravenhill, 2008; Bukowski and Buetow, 2011; Padgett *et al.*, 2013). My aim was to use photographs to make the 'invisible visible' (Bukowski and Buetow, 2011) and as a means of developing a more collaborative and participatory form of research. These visual data comprise a form of situated knowledge capturing the perspective of homeless people into the materiality and the socio-spatial dynamics of the city space. These photographs revealed spaces that were not known to me through interviews and fieldwork, and placed emphasis on the homeless' experience of the city. They also highlighted significant others and important incidents homeless people had in their lives. One of my participants had photography as a hobby and was especially happy to be sharing the pictures with me. Another used to be a photographer and had a digital camera; as a result, his pictures were digital. Ceding power to participants can be a powerful way of letting them decide the focus of the research, and therefore

[12] The third participant had limited time when returning the camera.

creating more equal relationships and fostering trust. One of those participants said: 'We have become friends now through these pictures', while another considered returning to his job as a professional photographer. Despite these positive accounts, this method was not fully successful, as the majority of my participants were in distressing situations or did not have the time and mental space to invest in such an activity. Nonetheless, the photographs of these three participants along with mine are included in the data corpus.

Addressing Methodological Challenges of an Ethnography of Homelessness: Trust and Accessing Homeless People

Trust

Developing relationships of trust with participants is a crucial aspect of any research project. Earning the respect and trust of homeless people incurs an added layer of complexity because of the additional vulnerabilities they have endured and the disappointment they have experienced by formal institutions. This was facilitated by being introduced by their care worker, who already had their trust. In discussing trust, I would like to describe two of my initial encounters with participants, which resulted in antithetical outcomes regarding trust. My first encounter was with 67-year old Vassilis, who described himself as 'not the classic homeless', as he came 'from an upper-middle class' family', 'had money all his life, but unfortunately never took money seriously'. He was interested in music and had taken up the responsibility of watering the flowers of the drop-in centre's terrace, where he spent his time away from others. When I introduced myself as a researcher doing a PhD in homelessness and being interested in his story, his reaction was not welcoming. At first, he said: 'We can talk if you want to, but that's it. I don't want to give an interview.' I decided to sit down with him, and I then reiterated my suggestion that he participate in the research and I have our conversation recorded. He then said: 'Look, I understand you mean well, but I have seen so many others like you. Last year there was another researcher and I gave him an interview. But I have never seen him again or heard from him again. I have no idea what his findings were. What makes you different? You all do your research, but our situation does not change. Nothing has changed for the homeless.' However, a couple of weeks later, Vassilis approached me and decided to give an interview. Since then, we established a close relationship and every time, we were both in the drop-in centre, we would spend some time sharing our weekly

news at the terrace in the summer months and in the library over the winter. Vassilis' words underscore dilemmas about who ultimately benefits from research on such sensitive topics, as well as power differentials in research. To tackle such issues, I showed attentiveness both as a listener and as an observer, I demonstrated my willingness to understand their predicament and I discussed my findings with two homeless people.

The second encounter I would like to share is with Katianna, a 53-year-old half-Greek, half-Russian woman who was staying at the night shelter. She was suffering from multiple sclerosis and on the day of our interview she had a verbal fight with her social worker and a member of the support personnel. While she agreed on giving an interview, half an hour into it she started losing her temper. She became irritated with my questions, started questioning the research framework and she was getting confused about whether my expertise was in psychology, social psychology, statistics or sociology and what the outcome of the research would be.[13] The turning point was my question of how she coped with the winter, to which she responded: 'I apologise in advance, but I can't be polite. I find your question silly and I am allergic to stupid questions. How many years have you studied?' After replying, I explained to her that other homeless people have argued that in winter there is more support precisely because of the extreme weather conditions. However, she said: 'Yes, but have you seen anyone dying because of a heatstroke? I think you should ask better questions, since you are supposed to be a researcher and have studied homelessness. You remind me of the social worker. You people just cannot understand what it means to be homeless. Look, I am a haunted animal. I had a difficult day. I am sorry, but I don't think I can continue with the interview.' I thanked her, gave her a leaflet from the Municipality with all the available services and wished her good luck. That was our last exchange.

At the heart of these two exchanges are trust and power. The identity of the researcher can both facilitate and impede the development of trust, which in turn can be dependent on power and a perceived authority researchers may have. Coming into an interview, participants have their own set of preconceptions and views. Hence, trust needs to be gained and power needs to be negotiated. Presenting oneself as a researcher is entwined with various expectations and demands, which need to be fulfilled for trust

[13] I had explained all of these aspects at the beginning of the interview, before asking her to sign an informed consent form.

to develop. With Vassilis, this related to reassuring him about the outcome of the interview and that it would be beneficial for homeless people and their predicament. Vassilis appeared to display 'research-fatigue' resulting from his past experiences from researchers which generated disappointment for him. What, in my view, overcame his distrust and suspicion was my consistent presence at the drop-in centre and my relationship with other homeless people. These are likely to have been interpreted as a genuine motivation and interest which ultimately changed his initial attitude. It needs to be noted that I was only able to invest this time, because I conducted an ethnography, which allows for the required time to build rapport and trust. It is for this reason that ethnographic research is considered well-suited for research with vulnerable groups (Cloke, May and Johnsen, 2010). Such exchanges like the one with Vassilis offer an opportunity to reflect on the aims of research itself along with one's research participants. Such interactions create a space where the purposes of the research can become co-defined both by the participants and the researcher. These conversations engendered a sense of ethical obligation regarding the purposes of this research from the perspective of the participants and made me reflect on how the findings can be disseminated to organisations and participants alike, through workshops and research summaries which could be sent to the management of different spaces.

Although the outcome of my encounter with Katianna was unfortunately different, there are some lessons that can be taken from it. In discussing ethical dilemmas when researching homeless youth, Ensign (2003, p. 46) argues that having experienced 'a series of harmful past and present experiences with various adults and institutions in their young lives, they are highly distrustful of adults and institutions'. Despite the age difference, this holds true for older homeless people such as Katianna. In vocalising her distrust towards me and my research, she demonstrated a high level of emotional exhaustion, manifested in the way she viewed my questions. Associating me with her social worker, whom she had had a conflict with, and having discussed in our interrupted interview negative feelings towards other institutions comprising the landscape of care suggest that gaining one's trust is a multi-faceted issue. First, in Katianna's eyes being a researcher presupposed having a deep knowledge of the research topic. As a result, my strategy of assuming no prior knowledge and asking open questions was not successful in my interview with her. While this was key in establishing trust and minimizing the power dynamics with other participants, in this case it caused tension.

Second, the time one chooses to do an interview is crucial. This was not a good day for Katianna, and while I was aware of it, I mistakenly thought our interview could become a space for her to open up and discuss her complaints. Conducting an interview with her also related to the difficulty of recruiting female interviewees. Finally, her social worker introducing us is also likely to have played a role in her being sceptical towards me. The very strategy that was successful in enhancing trust with other interviewees proved ineffective in my interaction with her. My exchange with Katianna exemplifies how sensitive the dynamics with one's participants can be, especially when they belong to a vulnerable group. In retrospect, I would have changed my approach to interviewing by being more flexible. Instead of setting my own themes, as broad as they might have been, our exchange could have been smoother had I given her the space to speak about the topics she felt comfortable with and had I chosen another day for our interview. This could have facilitated rapport and trust to develop and a more lasting relationship to foster.

Mediating research relationships

As my initial contact with homeless people was through care workers – a strategy employed for the protection both of the participants and myself – my interactions with them were mediated by conditions imposed by the care workers. It is likely that this filtered perspective could result in potential biases. To ensure this would be minimised, the overwhelming majority of my relationships with my participants became autonomous after the initial introduction by their care workers. However, this was not possible in the case of my work with outreach teams in public spaces. The limited time, the short and intermittent exchanges care workers had with homeless people and the fact that their encounters were in the public space meant that I was not able to establish the rapport and relationships I had with other participants. While my ethnographic data remain rich and capture the interactions and the dynamics of these spaces, my position flitted between being a passive observer and gathering data filtered through the perspective of the care workers. This proved more difficult in the case of those sleeping rough in the Park (Chapter 8). The time constraints imposed through the practices of outreach teams and the substances consumed by many of those congregating there constituted barriers in getting first-hand and detailed accounts of their lives. For this reason, in the respective

chapter I only include observational data I collected over a period of months and the accounts of people I was able to establish contact with.

Data Collection, Data Analysis and Writing-Up

From conception to the end of the fieldwork: Re-learning the city and positionality in the field

Exploring how homeless people experienced the urban space at a time of crises and limited resources involved my spending eight months in Athens working with organisations, outreach teams and homeless people. By spending time in these spaces and with two sets of participants, care workers and homeless people, the focus gradually shifted from homelessness *per se* to including all those involved in its management. This was a natural consequence of spending time not solely with homeless people, but also with care workers and outreach teams in different parts of the city. I was preoccupied with understanding the dynamics of the people I encountered and with delving in their social world and the city – a space very familiar to me as I was born in Athens and had spent five years as a student living in the city centre. Yet, I had to re-learn the city from the viewpoint of the marginalised and those involved in providing care to them. This along with delineating the boundaries of the landscape I explore was my primary focus during the first two months of my research which were highly exploratory. During this period, I was re-introduced to the city and its spaces, which constantly proved to be simultaneously highly familiar and unfamiliar. Even though my university classes took places five minutes away from Omonoia Square (see chapter 3) and I spent considerable time in nearby Exarheia at a time when homelessness and vulnerability had already been visible, I would never have thought of the activities and dynamics taking place behind the square and on small streets close to it were it not for the outreach teams I worked with and the homeless people who shared this knowledge with me.

When discussing with a participant about my wish to visit a faith-based organisation, he offered to take me there, but he added: 'But not in this coat. This will draw attention and believe me you will get robbed. Also, don't bring your phone with you'. This exchange was crucial in reflecting on my own positionality in the field. One's positionality imprints itself on one's presentation of self in the field in multiple ways.

While I had paid attention to wearing simple and unassuming clothes – I was usually in jeans or a track suit and a jumper – and my coat was not expensive, clothes and objects are interpreted differently when working with destitute and marginalised groups. My positionality as a white Greek woman of middle-class background who has never experienced this level of emotional and material marginalisation plays a role in the unfolding of one's research. Despite my genuine motivation for researching this topic, I was aware of how issues of power and positionality could be raised. In the field, such differences resulting from my own socio-economic background were not directly communicated with me, but as the incident above reveals they might have been at play without being openly articulated to me. If anything, the data collected by the overwhelming majority of my participants, as well as their willingness to share their accounts and take me to areas and spaces important to them almost suggest the opposite. This is not to say that my own privileged positionality did not shape my own interactions with them. Rather, my positionality was also interwoven with how I gradually became known in the field. Often called the 'young girl who is doing research for the university' presented a different self that minimised power differentials. Creating this perception was not something I consciously intended to do. Yet, this perception participants had formed involved its own vulnerabilities (young age, being female) and this facilitated the fostering of research relationships, as my position did not evoke a sense of threat or risk.

Another way I became known was 'someone who would like to interview you'. In combination with my willingness to listen to their stories in a non-judgemental way, this resulted in a misunderstanding regarding my role in the field. This became apparent through my interaction with Rena. To gain public attention which would help her house forty cats living with her in an abandoned building (see Chapter 6), she approached me months after our first meeting in which she refused to give an interview. Despite our daily contact, rather than a researcher, she thought I was a journalist. Unaware of the difference between a research and a media interview, she wanted to speak publicly on television to increase the likelihood of her cats being adopted. This illustrates both her desire to be listened to and make her story known but also how the jargon of research can be misinterpreted by participants. Such issues are interlinked with using a vocabulary that might be unknown to participants due to educational or language differences. As a result, one needs to be aware of how words commonly used among researchers can take different meanings for those outside the research community.

Data analysis and leaving the field

After eight months when theoretical saturation (Glaser and Strauss, 1967, p. 61) was reached, my fieldwork came to an end. I decided to take a step back and spend time trying to make sense of the data. My data corpus consisted of ethnographic fieldnotes, interview transcripts, maps, photographs and some artefacts, such as leaflets and a chocolate distributed in one of the soup kitchens. To organise and code my data, I used the NVivo software and I followed an inductive data-driven approach to thematic analysis (Braun and Clarke, 2006). Inductive thematic analysis is conducted at a micro-sociological level of analysis emphasizing the importance of groups, cognition, identity/self, performance, emotion (Fine and Fields, 2008, p. 130) and interaction, and exposes the process of categorizing upon meaning structures and of structuring mental categories that define specific perceptions of the social world (ibid, p. 136).

As a result of the thematic analysis of the data collected in Athens the focus of my research shifted as I became conscious of the fact that my data did not point solely either to the urban space, or homelessness, it was much more complex and multi-layered. What I was primarily witnessing were the efforts of care workers to provide care and the efforts of homeless people to receive it. The context in which this played out was a city in the midst of a prolonged financial crisis with diminishing financial, human, emotional and spatial resources and defined by heighted vulnerability and marginality. Interestingly, this realisation coincided with the account I was relaying to one of my supervisors as she was discussing with me in the middle stages of my fieldwork, and I said:

> The system of homelessness is broken. Everyone is just so exhausted. And not just the homeless people. Their care workers too. And no one can turn for help to anyone. Organisations are understaffed and there is no money to get more people. So, then the homeless can't get the help they need, and care workers are burnt out.

These problems, the lack of resources available to organisations and the urgent need of homeless people to be cared for were manifested in the fragility characterising the spaces I studied. It is, for this reason, that care and the landscape of care became central concepts in my research.

A notable aspect of this research phase was that whilst I had formally ended my fieldwork months before, leaving the site and staying with the data was a difficult process. After returning to London, I was worried and kept asking how the care workers and homeless people I befriended were, how they were coping with the challenges this thesis describes, and how homeless people were doing with their health issues. In a recorded follow-up interview through skype with a care worker trained in psychology, he said to me:

> You've also become institutionalised. We are all leaving [i.e. resigning] the [name of care provider]. It is time for you to go on with your research. We will be in touch anyway but stop worrying about us. Much as you think about it, things won't change.

This skype call turned into a wake-up call that facilitated my disengagement from the field. Snow (1980, pp. 110–114) explains how disengagement can be an 'anxiety-producing experience' and how the intensity of fieldwork relationships might be a barrier. Similar to Snow, I had also come to know some of the participants not merely as such, but as 'very real, warm and personal human beings' (ibid, p. 112) who shared with me their personal stories, their worries for financial and family matters, as well as health and legal problems. Disengagement for me meant reducing the frequency of seeking contact with participants. Nonetheless, I still remain close to one care worker and two homeless people with whom I keep in touch through social media and when I am back in Athens.

Writing up: positionality and motivation

The writing-up phase came with its own set of challenges. In addition to its inherent difficulties, writing this thesis was further complicated by the responsibility borne when writing about such a vulnerable and marginalised population. This was enhanced by incidents, like the one described above with Vassilis, who was initially suspicious of me as a researcher. This was further accentuated when in the middle of central London, in a prestigious and modern university library, I was writing about destitute people still enduring the consequences of extreme poverty, exclusion and isolation. Similarly, their care workers continued struggling in their professional lives while trying to provide care to those for whom society and the state were not able to care for. This form of overidentification I had found myself slipping into made me question

the motivation behind doing a doctoral thesis on this topic and reflect on the responsibility one has towards their research participants. After all, I would be able to finish this process with a high-level university qualification, while many of my participants would be in the same predicament. Snow (1980, p. 112) discusses how overidentification with a group and dwelling between his research subject and sociological categories made him 'question the point of it all'. For him, the solution was to disengage. Weinberg and Williams (1972, p. 179) have argued that 'the greater the extensity (that is, the more subjects and territories), and the less the intensity (that is, the diffuseness and totality of the personal relationships), the easier it is to disengage'.

In my research experience, this was not the case, as I felt quite immersed in the problem of homelessness manifested in the lives of the homeless. In particular, what I found disheartening and difficult to write about were the connections between the homeless and the care workers and what appeared to be a dead end in both sides' lives. The difficulty of a homeless person to issue an ID because of the attached costs which made them unable to claim benefits or have a medical operation. The deep desire of a care worker to resign and change professions was obstructed by the high unemployment rate in Athens and her need to support her pensioner mother. While these issues imprint themselves on the lives of individuals, the problems are structural. This made me realise that this thesis was only able to tell the stories of those involved in care provision in Athens, make them known, and voice the stories of the marginalised fairly and accurately.

This takes me to the second difficulty of the writing process regarding issues of power, risk and responsibility when describing the lives and the world of marginalised groups. To avoid the risk of reproducing stereotypes which can lead to stigmatising forms of knowledge production, I had to remain conscious of my own positionality and of the risk of unintentional othering. Indeed, rather than viewing one's privileged positionality as precluding one to study or write on the experiences of marginalised groups, I argue that writing calls for more reflection of the inherent risks and of the sensitive nature when providing the perspective of such groups. Taking up this responsibility, what I hope to have done in this thesis is to link the suffering, poverty and marginalisation experienced by homeless people and the valuable, yet exhaustive and deeply precarious work conducted by professionals with power and aspects of structural violence. According to Farmer (2003, as cited in (Bourgois and Schonberg, 2009), structural violence refers to

how the political-economic organisation of society wreaks havoc on vulnerable categories of people. In doing so, I have tried to depict the specific experiences of the people described throughout the thesis in as much detail and accuracy, while explaining how they were (re-)produced and affected by the wider adverse socio-economic context of care provision.

Practical Considerations: Ethics, Risks and Access

An extended discussion of my approach to ethics and how I coped with issues of sensitivity and trust runs through this chapter. Yet, some more conventional considerations to ethics also need to be mentioned. This research was approved by the LSE's Ethics Committee. To protect the participants' identity, all data are anonymised and pseudonyms are used, with one exception (see Chapter 5). For this reason, all pictures included do not reveal facial characteristics. Data were securely stored and encrypted with a password only known to the researcher. To minimize emotional distress, the homeless were accessed via organisations which work with them. I have been guided by them and their professional expertise at every stage to ensure that I did not act in any way that was likely to cause distress or harm to the participants. An informed consent and background letter were given to all participants I met through organisations. During this process, I took the time to ensure they were aware of the research aims and how the data collected would be managed. Yet, it was not possible to obtain consent from every person in the field, as in many cases our interaction was brief or did not allow for the time and space for us to properly go through this process. Access was secured separately with each organisation and institution. Initial access was granted to one organisation because I had previously conducted research there. In other cases, access was secured through my personal network and through organisations I was already working with and were kind enough to recommend me.

Risks and challenges were also faced during my fieldwork. These involved personal safety, risks in relation to others' wellbeing and homeless people asking my personal information (address, social media, phone number). The latter were carefully managed by explaining to homeless people that the gatekeeper-organisation had my details and I could easily be reached through them. When asked about my personal details, I explained that for the duration of the project I could not share any. In two cases of a homeless man and a homeless woman, I shared my phone number after a couple of

months of developing trust through regular contact with them, I also saw them outside the organisation on central squares. After the completion of my fieldwork, I shared my social media with both care workers and homeless people. In relation to personal safety, a common fear revolved around stepping onto exposed, used needles either on my way to and from organisations. To prevent this as well as minimise the likelihood of a theft, I paid attention to wearing unassuming clothes, not carrying valuables and wearing suitable shoes. In areas of congregation by homeless drug users, many of whom were under the influence of drugs, I closely followed the advice of outreach teams, who provided a layer of emotional and physical protection, as I was usually standing behind them. Instead of demonstrating fear, which can place an ethnographer in a 'victim' role, my demeanour as researcher was to be cautious, understanding and open, while making sure I was perceived as a 'friendly outsider' not interested in purchasing or using any substances (Williams *et al.*, 1992). When leaving the site at a late time, I was never alone and along with other care workers we safely returned home or accompanied each other to train stations and bus stops. My whereabouts and expected time of return were also shared with family members. Finally, while harm could be regulated in relation to myself, it was more complex when the risk involved the harm of others. For example, a homeless person shared suicidal thoughts in a way that appeared concerning to me and in another case, a homeless person discussed his wish to become violent towards refugees sleeping close to him. In these two cases, being worried about the wellbeing of the former and of refugees, I made a judgement call and confidentially discussed these issues with their care worker.

Self-care in Research

While emotions are crucial and have widely been discussed in qualitative research, their impact on researchers is frequently ignored, underestimated (Vincett, 2018) or remain on a bureaucratic level of getting ethical approval from school committees. This thesis deals with the notion of care and as such, it is deemed important that some dimensions regarding the care for the researcher also be discussed. Doing research is a solitary and difficult experience. Hoolachan (2016, p. 35) argues that lengthy fieldwork can result in exhaustion. Not the length, as much as the intensity of working with a vulnerable group and conducting a multi-sited ethnography led me to experience both physical and emotional exhaustion. The physical exhaustion was linked to the 'following', an integral part of any multi-sited ethnography, but even more so, because my ethnography involved mobile groups, such as outreach teams and homeless people.

Indeed, urban ethnography is believed to be 'some of the most immersive ethnographies with late hours, unexpected developments that require one to drop everything and follow a research subject' (Timmermans and Prickett, 2019, p. 54). In an effort to always be present and follow outreach teams and homeless people often in unpleasant weather conditions at day and night, physical exhaustion was a natural consequence.

Emotionally, the exhaustion derived from my constant presence in the field and witnessing the obstacles and the dead ends experienced by the care workers and the homeless people. The peak of this emotional exhaustion came, when a homeless woman I was close with spent Christmas in jail (Chapter 5), which made me think I would never see her again. Immersing myself in this world involved internalising the emotions of my participants. The emotional and practical complexity in the lives of homeless people and their care workers resulted from various types of vulnerabilities, such as emotional vulnerability, health risks, exclusion from formal health provision, lack of housing, legal problems, precarity of work and burnout. Experiencing, listening and documenting the distressing, traumatic and powerful stories of the homeless people and their care workers made me experience anger, disappointment and anguish. While in the field I was only able to recognise the physical exhaustion. Returning to London, the data analysis and the beginning of writing accentuated these negative feelings. These emotions manifested themselves in the writing process and eventually my writing process slowed down. After an informal break from the data which I spent on reading, I was able to return to writing.

To minimise the effect of such experiences requires an active engagement of the researcher with a form of self-care. Vincett (2018) has described his own strategies of self-care against compassion fatigue, including 'mental time-out', 'social support', and 'emotional proximity and distance'. Despite the necessity of immersing oneself in a world and engaging with research groups and spaces, it is equally necessary to take breaks and get distance from the field, have an available support network, and be able to reflect on one's own needs. For me, taking a break and leaving the site even for half a day came initially with guilt, as I thought I would miss important data. With time, I also felt guilt-ridden when missing the days homeless people had their weekly appointments with the care workers and when the latter were less busy and, hence, more available for an interview.

Keeping in mind that ethnography is an embodied experience, this presupposes setting physical boundaries in terms of the time one is able to invest in their research and emotional boundaries in terms of one's personal involvement in research relationships. It was only three months into my fieldwork I understood that feeling guilty for not missing potential interviewees was not sustainable, and I decided to integrate into my research routine a Friday morning coffee for some hours. I used this break to reflect on the incidents and data I had gathered during the week, to make sense of them and to see if any potential connections emerged among them. At this time, I also started creating a weekly itinerary of when organisations and outreach teams operated in certain parts of the city. This itinerary allowed me to organise my following in a more concrete and purposeful way. These were key strategies for ensuring self-care and a healthy distance from the research process.

Organising a Multi-sited Field and Navigating the Landscape of Care: Aspirations and Limitations

The landscape of care was diverse and operated in different spaces and modalities in relation to their operation times, locations and degrees of accessibility (see Chapter 3). Some spaces were static and others mobile; some provided care on a daily basis, while others scheduled interventions on certain days of the week. Some operated in external public spaces and others in indoor ones. This meant that it was highly dynamic in that every day different kinds of care providers operated in different ways. It was not just care provision that was versatile. The differences in the operational and spatial characteristics also had an impact on the enclaves of the city where care was provided. The areas where care providers appeared also transformed when temporary spaces of care and mobile outreach teams would operate, as homeless people would gather to receive care and would disperse after each provider of care departed (see Chapter 3). For example, the arrival of outreach teams meant that more homeless people would gather. On certain squares and pedestrians where outreach teams offered needle exchange, passers-by would reduce, and drug dealers would appear. In other cases, empty church courtyards would be full of homeless people waiting to be served.

Following all these different spaces and the groups they attracted was a compound enterprise. From a practical perspective, the 'doing' of conducting an

ethnography involving so many sites was complex and tough to negotiate, as one is required to attend and immerse oneself in various spaces and locations at different times. I tackled this challenge by composing a weekly schedule of times and locations in which different spaces of care operated. In the exploratory phase of my research, a rough and, subsequently, more specific weekly temporal rhythm of the landscape of care emerged. On certain days and times of the week, certain outreach teams were on the streets. Similarly, I became familiar with the scheduled appointments of certain people at the drop-in centre and with the times certain public spaces of care, such as the shower-bus and soup kitchens, operated. There was no regular day as such, but a day could entail observations at the drop-in centre, followed by a couple of hours with an outreach team and later observation at the municipal soup kitchen and then back at the drop-in centre for an interview. On other days, my time would be split between two sites and sometimes, I would just stay in one, usually the drop-in centre. Jottings were written in the different spaces of care and detailed fieldnotes were written every evening or the next morning.

When one's field is the city, another practical challenge that emerges relates to when the fieldwork is supposed to start and end each day. After the centrality of Omonoia square in my research became apparent (see Chapter 3), I decided to start my ethnographic fieldwork the moment I reached the square in the morning and end it after crossing it in the evening. Such spatial routines which turn the ethnographer into a circumambulist become a route to ethnographic knowledge (Falzon, 2015, p. 106), as they adhere to a strategy of 'being with the landscape' (Marcus, 1995). Evidently, the tactics of 'following the people' and 'being with the landscape' were the foundation of navigating the landscape of care and its spaces. In addition, they were crucial for the production of versatile and rich data and facilitated my capturing the connections between the city, homelessness and care across time and space.

Multi-sited ethnography has been accused of lack of depth on the grounds that following and moving around does not allow for the production of thick description. I addressed this issue by prioritising a certain site as my primary focus at different times of my research. For example, my initial focus for some months was the Park, then the drop-in centre and then the Municipality. By immersing myself into these spaces and familiarising myself with the people and the dynamics present in them, I was able to develop trust and gather rich ethnographic data. Nonetheless, I remained conscious of

keeping a close eye on what was happening in other spaces of care by paying them brief visits every couple of days or arranging interviews on their premises. This was facilitated by the spatial proximity of the majority of these spaces. In addition, even at times when I was physically in one space, there were times that I would gather data about other spaces. For instance, there were multiple occasions on which I would see employees from one organisation I worked with on the phone to employees from another organisation I was studying, and most often homeless people I met at one organisation were found at another.

The nature of the connection between these sites has been a contentious point in relation to whether the plurality of sites is a matter of in-betweenness or merely multi-sited-ness (Boccagni, 2019). In other words, is multi-sited ethnography just a matter of multiple sites or is there a substantive connection between the sites explored? Albeit not conscious of it at the onset of my research, I suggest that the spaces I studied are substantively connected in various ways. They all operated in an urban milieu which during my fieldwork became a space facing multiple challenges resulting from the financial and refugee crisis. In some cases, this was formally articulated through a number of collaborations, such as the municipal soup kitchen and the night shelter (see Chapter 3). At large, a number of aspects connected these spaces and their groups: financial and funding constraints, a common bureaucratic and institutional environment, the care workers' desire to provide care whilst experiencing pressures, a high level of work precarity, and the homeless people's hope to receive care in these spaces and ease their survival on the street. Keeping in mind the high level of fragmentation (see Chapter 3), as each space was only able to respond to isolated needs, all the nodes of the landscape of care had to be visited daily by homeless people. For this reason, the connections between these spaces were real, ever present and shaped all the landscape's constituent parts.

While what I hope to have provided is a picture of the landscape of care as a socio-spatial network where the city, homelessness and care intersect in multiple ways, I do not claim that what is presented here is the 'whole' of the social reality of what comprises the landscape of care. Much as I made conscious efforts to collaborate with and include as many organisations as possible, certain organisations/spaces of care were not part of my research. In some cases, such as the hostels, my analysis draws solely on

interview data. In turn, my account of the Park draws heavily on ethnographic data, informal conversations with homeless people and interviews with care workers. Furthermore, claiming any form of holism would go against ethnography's commitment to the mundane, the micro, the everyday and the intimate. Tracing the relations between the intimate, the local and the national scale is one of the aims of my research. Most importantly, what I present here is a snapshot of the landscape of care for homeless people in Athens capturing its dynamics and characteristics in the period I conducted my research. No claims for generalisability are made.

Conclusions

In this chapter, I laid out the methodological approaches constitutive of this dissertation. I presented my perspective on ethnography with an emphasis on its urban and multi-sited dimension and I explained my strategies of moving across spaces and delineating the relations across them, between the state and the citizen, as well as between vulnerability and the city. In this regard, I also explained the implications of undertaking research in a city troubled by profound austerity and inequality. With a focus on positionality, motivational and emotional aspects, I unpacked questions of power as much as trust, as well as aspects of self-care among researchers, ethics, risks. In the next chapter, I start my exploration of the landscape of care for homeless people by focusing on its fragility, vulnerability and pressures.

Chapter 3

The landscape of care for homeless people in Athens:

A space of shared fragility and vulnerability

Introduction

This chapter turns explicitly to the city of Athens and examines the characteristics and arrangement of care in the inner city – an area characterised by pronounced disparities, a marked withdrawal of the state, straddling growing needs and decreasing resources. I argue that the landscape of care for homeless people can be understood as a space of shared vulnerability and fragilities across care recipients, care workers and organisations committed to care. By analysing the main constitutive elements and spaces of the landscape of care, this chapter reveals the socio-spatial formations of vulnerability and care and their positioning and contextualisation within a crisis-scape city like Athens. To this end, this chapter explores connections across the global, national and intimate scales through which marked disparities unfold. I describe the various facets of care provision in Athens and its developments and changes of recent years. To untangle the various elements constituting the landscape of care for homeless people, I first locate the landscape of care in the urban milieu of Athens and map the providers and resources of care for homeless people. Subsequently, I discuss how the so-called 'refugee crisis' and the financial crisis resulted in intersecting landscapes of care, but also intersecting forms of vulnerability and competing groups of care recipients. I then focus on how organisations were affected by the financial crisis and how limited funding impacted their work and the nature of care provision. The final section explores the intimate level of care and the emotions and pressures experienced by the care workers.

Locating the Landscape of Care in the City

Mr Nasos was at Omonoia Square day and night. Despite his old age, he slept rough on a marble landing outside the side entrance of an old building. Omonoia is the second biggest public square in Athens after Syntagma Square, Athens' most iconic square. It is around Omonoia Square that most organisations comprising the landscape of care were located, making it its lived geographical centre. Omonoia 'Concord' Square

is a cement covered central square which in fact is 'a roundabout with highways leading towards almost every direction of the urban complex' (Dalakoglou, 2013, p. 30). 1.3 km away from Omonoia Square through the busy Panepistimiou Avenue that connects them, sits Syntagma Square. While both squares are significant locations in the city centre of the Greek capital, Syntagma Square manifests a centre of wealth, power, consumption and entertainment. It is surrounded by multiple government buildings, including the Parliament, the Presidential and the PM's mansions, luxury hotels, theatres and popular highstreets. In contrast, Omonoia Square manifests different forms of deprivation leading to additional stigmatisation for those occupying this area.

Being a central transport hub connecting the city with the suburbs and the port of Piraeus, Omonoia Square had historically been an arrival point for internal and external migration flows (Noussia and Lyons, 2009; Balampanidis, 2020). On various corners one could find old used mattresses and worn out empty rucksacks left by homeless people spending their day and night on and around the square. During the night, drug users also used the square to buy and take drugs. Before the municipal cleaning team started work early in the morning, needles with fresh blood lay on the pavement. During my observations with the outreach teams, it became clear that nearby in an area full of hotels and cinemas showing pornographic films, sex work was also occurring between old Greek male clients and unaccompanied minor males. On the small roads around the Square, old houses were used for prostitution, signified by a small light outside their main door that was on both night and day. Five minutes from the square, at the end of Sokratous Street, a deserted and dilapidated space, Theatrou Square (see Figure 3), provided a space for homeless people and drug users to sleep at night. Behind the big, renovated and evocatively lit neoclassical National Theatre building located just a few metres away from Omonoia Square, drug dealing and consumption were commonplace. On the eastern side of the square, the Metaxourgeio area was 'at the epicentre of conflicting socio-spatial dynamics' (Balampanidis and Polyzos, 2016), simultaneously experiencing regeneration through fashionable bars, galleries and other spaces attracting young professionals, and an increased presence of marginalised groups on small pedestrianised roads which functioned as drug markets and spaces for sex work.

Figure 3. Theatrou Square where many homeless people slept during the night

The landscape of care extended itself around Omonoia Square which had become 'emblematic of the 'decaying' central Athenian materiality and socialities, but also side by side with the 'brightness' of Syntagma Square (Dalakoglou, 2013) or the cultural life of Metaxourgeio. In this sense, the city I studied was not just a city of social disparities in which homelessness had become a prevalent feature, but also a city shaped by marked spatial divisions, in which entertainment and consumption occurred alongside dilapidation, desperation, state abandonment and a lack of care for the vulnerable groups occupying this urban enclave. It was in this spatially confined area around Omonoia Square that care providers were concentrated, with the two furthest organisations just half an hour walk apart (see figure 5). Such inner-city locations are attractive to non-governmental organisations because of ease of accessibility to direct services and visibility for advocacy services (DeVerteuil, 2015, p. 92, Kittay, 2001). Indeed, by being located in

a more or less unified area with close proximity among providers, the landscape of care in Athens maximised accessibility to its clientele, since many of them were not able to travel long distances to access services.[14] In addition, the long-term decline in the property values for commercial and residential use (Noussia and Lyons, 2009) and a large number of vacant buildings and hotels in the area attracted organisations which were able to reduce their fixed costs and rents at a time of scarce resources and funding.

[14] Public transport was free for those who had acquired a certificate of homelessness, issued by non-governmental organisations.

Figure 4. Personal belongings stored in a phone booth close to Omonoia

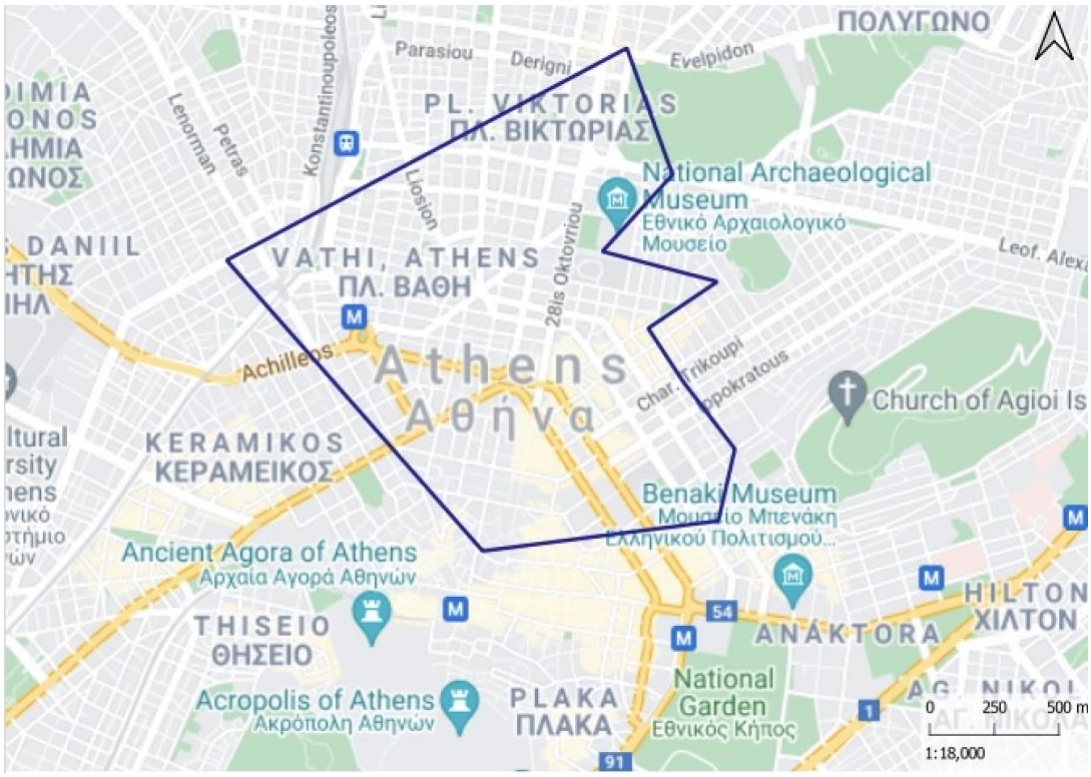

Figure 5. The location of the Landscape of Care during my fieldwork (2017- 2018) (Scale: 1:18,000)

(Source: Base map: 'Map data ©2015 Google' (Google Roads). Polygon area: Manual Digitisation using QGIS Desktop 3.16.3.)

Working in a devalued part of the city where support and provision from the state was erratic and limited meant that care organisations became the 'go to' place for all the needs of diverse marginalised groups. As a result, additional pressures were put on organisations and outreach teams who often had to interrupt their workflow and invest time in groups beyond their initial focus. Lacking the necessary resources and unable to provide tailored care to groups outside their remit, both outreach teams and organisations either turned certain individuals away and redirected them to more specialised organisations or restricted their support to a psychosocial one (a brief conversation, potentially provision of food or other materials and medical information). For example, in this context, when encountering drug users outreach teams could not respond to the users' need for kits with clean needles and other material for drug consumption, as these were only available to organisations focusing solely on this group. Similarly, organisations in the vicinity of Omonoia square were visited daily by homeless drug users and unaccompanied refugee minors. Despite hoping to get help there, for reasons of safety

active drug users were not allowed inside organisations not dedicated to this population and were redirected to specialised organisations. Unaccompanied minors were asked to wait because of their heightened vulnerability, but this waiting could last from hours to days, leading to some never returning. As a result, taking on the burden of caring for multiple groups despite their limited resources resulted in additional obstacles both for care organisations and care recipients.

Notwithstanding the limited state provision, state control was especially pronounced. Early in the morning and after sunset, armed police officers and municipal police checked the documents of migrants and patrolled the streets around Omonoia Square on an almost daily basis. Adhering to a zero-tolerance policing and a broken windows strategy (Kelling and Wilson, 1982), the role of the Greek police in this area was one of surveillance and control. Daily checks of documents and sweeps targeted especially vulnerable groups, such as migrants, homeless people, sex workers and drug users. The police of the local 'Omonoia police station' have been accused of physical and excessive verbal abuse against detainees (Amnesty International, 2012; Statewatch News Online, 2019), which was also discussed by some of my interviewees. For this reason, in addition to support, securing resources and care, the area occupied by the landscape of care also denoted intimidation, fear and potential violence to the homeless people navigating it.[15]

The Landscape of Care for Homeless People and its Spaces

The landscape of care can be visualised as a social and spatial network, with nodes representing spaces of care, namely providers and organisations where homeless people can access various care resources, such as food, showers, laundry, clothes, healthcare, medical and psychological support and social services (see Figure 6). Although a network, this was a differential network in which varying needs received varying approaches and capacities for care.

[15] Most recently, queer activist Zak Kostopoulos died of multiple fatal injuries having been beaten up by police officers on Gladstonos St., a street nearby Omonoia Square (Amnesty International and Eleni Kostopoulos, no date) after entering a jewelery shop and being perceived to be a thief and drug user, which was never proven to be the case.

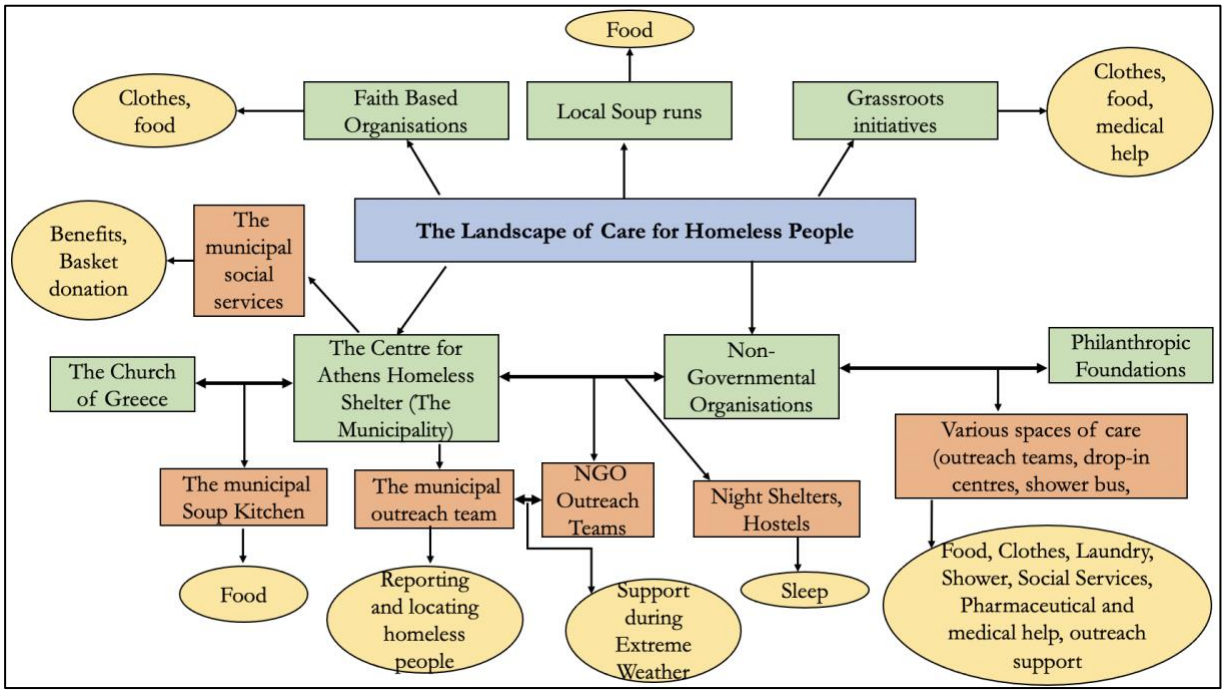

Figure 6. The Network of Care Providers and Care Resources

One can easily grasp how the network of care developed in the city and what kind of resources were available to homeless people by looking at the Guide of the Homeless (see Figure 7). This was a small booklet published by the Municipality. It provided information to homeless people about survival in Athens and was distributed by the Municipality itself, care workers and outreach teams. The booklet was divided into five sections: accommodation, food, personal hygiene/clothing, healthcare and social services for socially vulnerable people. It was in Greek and English and was geared towards all vulnerable populations in Athens at the time of my research: homeless people, refugees and drug users. Although available to all of these groups, some groups, such as the active drug users, were not allowed in all spaces of care and could only receive care from outreach teams. The division of care (see Figures 6 and 7) meant that care organisations responded in highly varied ways, to vital, yet differing, needs of homeless people. As a result, the landscape of care in the context of Athens did not embrace an integrated approach to care needs. The absence of a framework that could allow one to leave the street and be rehoused with the support of organisations and the state engendered high levels of fragmentation and a disruption in the continuum of care. This created several obstacles for care workers who had to continuously redirect vulnerable individuals to other organisations and collaborate with them for their support.

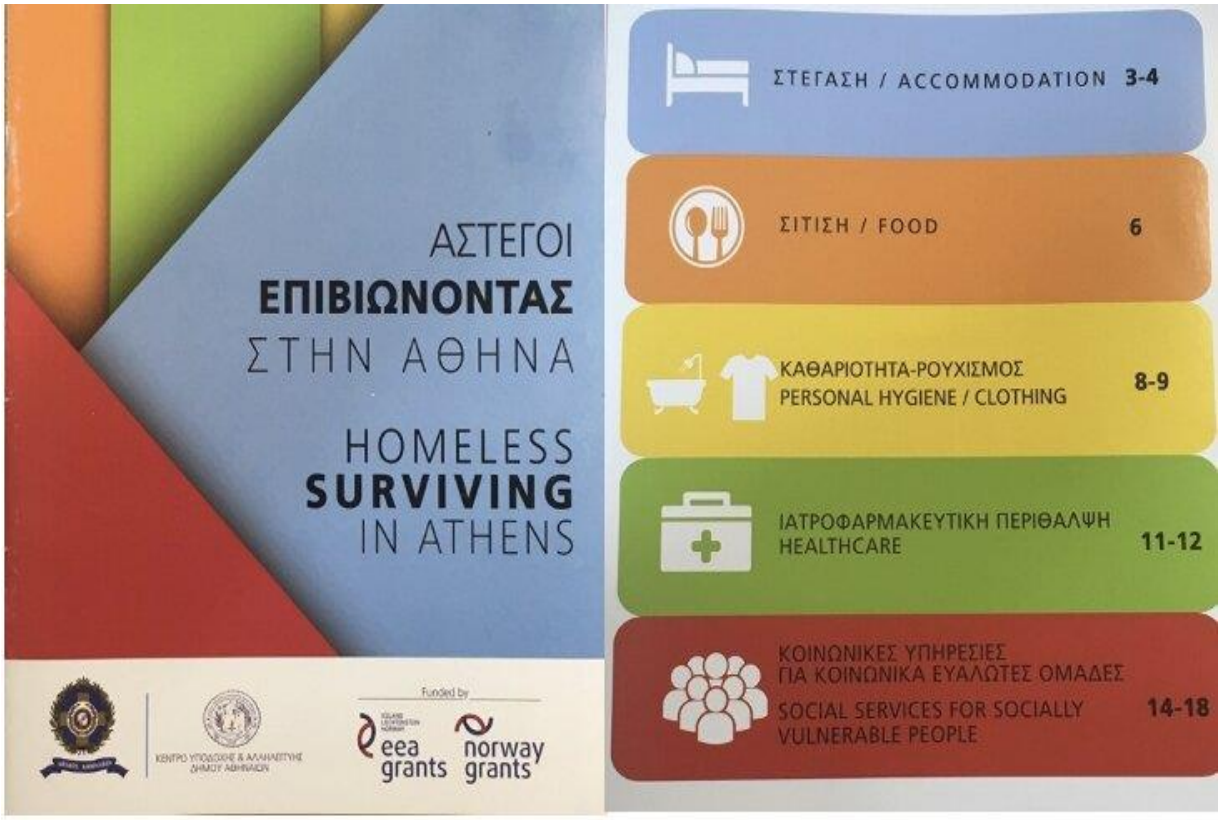

Figure 7. The Survival Booklet distributed by the Municipality to homeless people and other vulnerable groups (cover and contents page)

Different geographical spaces of care produced varied relationships, but also encompassed differential capacities to provide care. Each space I visited had different social and institutional arrangements, situated care practices and power-relations within them, regarding both employment relations and the relationships between caregivers and care-recipients. This is why the space in which relationships of care take place is so crucial and why for 'geographers care is not just interpersonal relations, but also *people-place relationships* (emphasis added)' (Milligan and Wiles, 2010b, p. 738). Spaces of care operated in different modes and had different institutional (public, voluntary, collaboration between public and voluntary sector), spatial (open or gated and static or mobile) and temporal (permanent or temporary) characteristics (see Table 2). The differences among spaces of care created different conditions, constraints and opportunities for care provision. Spaces of care can also be sub-divided according to their spatial accessibility. Care spaces that operate in public spaces, such as a square or parks are 'open' while those that operate in private or fenced spaces are 'gated' and, therefore, presuppose a level of control in relation to who can access these spaces. One can differentiate between 'mobile'

spaces of care, such as outreach teams, and 'static' services in fixed spaces in the city. Finally, the temporal dimension of care provision involves 'permanent' spaces that have a consistent and permanent space, and 'temporary', spaces operating in specific pre-defined locations and for a limited amount of time, for example weekly soup runs. In Table 3, I present the basic characteristics of the spaces where I conducted fieldwork and which emerged in the data analysis as significant in the lives of homeless people. All these spaces of care along with their characteristics defined 'institutional homeless geographies throughout the city' (Bourlessas, 2019, p. 5) and depict the city's 'institutionalised context of care' (Tronto, 2010, p. 160) for homelessness.

Table 2: Defining characteristics of spaces of care

Characteristic	**Category**	**Definition**
Institutional Status	Public	Belongs to a state institution.
	Voluntary	Belongs to a third Sector Organisation.
	Collaboration between the public and voluntary sector	Collaboration of state institutions and voluntary organisations.
Spatial Dimension (Spatial Accessibility)	Open	Accessed with no restrictions through the public space.
	Gated	It is a gated or fenced space that can only be accessed at the discretion of those operating the space of care.
Spatial Dimension (Mode of Operation)	Static	The space of care operates in a fixed location in the city.
	Mobile	The space of care wanders through the city.
Temporal Dimension	Permanent	It operates during normal working hours.
	Temporary	It only operates for a limited time on certain days of the week known to homeless people.

Table 3: Institutional, Spatial and Temporal Characteristics of the Spaces of Care

Care Provider /Space of care	Institutional Status	Spatial Dimension		Temporal Dimension	Data Sources
		Accessibility	Mode of Operation		
The Municipality (KYADA)	Public	Gated	Static	Permanent	Ethnographic observation and interviews
The municipal soup kitchen	Collaboration between the public and the voluntary sector (Municipality and Church of Greece)	Gated	Static	Temporary	Ethnographic observation and interviews
Municipal Outreach team	Public	Open	Mobile	Temporary	Ethnographic observation and interviews
Municipal Kiosk	Collaboration between the public and the voluntary sector (As a space it belongs and is funded by the Municipality but is run by organisations)	Open	Static	Temporary	Interviews
Non-Governmental Organisations (NGOs)	Voluntary	Gated	Static	Permanent	Ethnographic observation and interviews
NGO Outreach teams	Voluntary	Open	Mobile	Temporary	Ethnographic observation and interviews
Shower Bus	Voluntary	Open	Static	Temporary	Ethnographic observation and interviews
Hostels	Public	Gated	Static	Permanent	Interviews

Night Shelter	Collaboration between the public and the voluntary sector (Municipality and third sector organisations)	Gated	Static	Temporary	Interviews
Faith Based Organisations (FBOs)	Voluntary	Gated	Static	Permanent	Interviews
Local Soup Runs	Voluntary	Open	Static	Temporary	Interviews
Public Laundry	Voluntary	Open	Static	Temporary	Interviews
'The Chocolates'	Voluntary	Open	Static	Temporary	Ethnographic Observation and Interviews

Geographically and organisationally, the Centre of Athens Homeless Shelter, known amongst organisations and homeless people as ***The Municipality***[16] (KYADA) lay at the centre of the landscape of care. It played a central role in the management of homelessness in Athens and coordinated the actions of other providers. The Municipality was a public, gated, static and permanent 'space of care'. I focused my research on the *municipal social services* where I spent two to three times a week over a period of two months and I spent a similar amount of time at the *municipal soup kitchen* which operated through a collaboration between the Municipality and the Church of Greece. According to the accounts of employees, around 400 meals were distributed at the soup kitchen daily. I also shadowed the *municipal outreach team* for several weeks, for around five hours at a time. This team used a car in its outreach visits, thus being able to conduct both pedestrian visits and visits to the suburbs and locations further away from the inner city. Its role primarily involved locating homeless people reported by citizens to the Municipality,

[16] Although I call it 'The Municipality', this term does not refer to the Municipality of Athens as a whole, but a part of it that was focusing its work on homelessness. The name reflects the way it was known among providers of care and homeless people.

redirecting them to organisations and producing reports for their records, which were also sent to the citizens who had initially reported the homeless person's location.[17]

The largest number of care providers were supplied by the numerous ***Non-Governmental Organisations (NGOs)***, which focused their work on providing support for vulnerable populations. Most of them were founded after 1994, as a sign of the strengthening of civil society during that period and drew funding from the EU and the Greek state. They played a prominent role in the management of the economic crisis and since 2011, in shaping the discourse of the 'humanitarian crisis' (Arapoglou and Gounis, 2018, p. 90) to denote the tremendous effects of the financial crisis on the Greek population (See Chapter 1). The vast majority of NGOs operated as gated spaces of care as they were located in private buildings and were not accessible through public space. Whilst an appointment was not always needed, access was regulated. They operated in fixed and well-known locations to the homeless people on a permanent basis. I worked with three different organisations for different lengths of times. I spent most of my time at one of these organisations which hosted the drop-in centre (see Chapter 7), using it as a base for my research.

In addition to the NGOs which had a clear secular orientation, there were also ***Faith Based Organisations (FBOs)***. My insights on FBOs derive solely from interviews and conversations with professionals and homeless people. These suggest that, just like the secular organisations, the faith-based ones did not exclude people based on their religion or ethnicity but embraced inclusivity regarding care. Johnsen (2014) who explores how faith becomes entangled in voluntary organisations suggests that the involvement of faith can relate to an organisations' administrative, environmental, funding and other programmatic elements, such as their mission, founding, affiliation, governance, staff, support, target group and care practices. In addition, Johnsen explains that the ethos of Faith Based Organisations (FBOs) adheres to care provision as a response to religious imperatives to combat social injustice and care for vulnerable members of society. Many of them were either affiliated with the Greek Orthodox or the Catholic Church and some were branches of their international organisations. Both the

[17] See George's home-making process in Chapter 5 and the story of a homeless man in Kypseli in Chapter 6 for the work of the municipal outreach team.

secular and faith-based organisations offered similar services, i.e. shower and laundry facilities, food and clothes distribution, medical advice and pharmaceutical aid.

Figure 8. A Prayer at a Faith-based organisation in Athens visited by Paris, a former photographer and resident at the night shelter
(Source: Paris)

A number of ***NGO outreach teams*** operated in the centre of Athens in areas known to be occupied by homeless people. These depict a form of mobile care provision, as they wandered through the city to provide help and advice to its most vulnerable populations. In particular, their aim was to establish contact with those either spending part of or the entire day on the street or not visiting spaces of care. Only the outreach teams which belonged to NGOs focusing solely on drug users were able to engage in needle exchange. In contrast, outreach teams operating as part of NGOs which supported vulnerable and homeless people in general did not provide needles but only psychosocial support and necessary items (condoms, water bottles, donated sandwiches). I collaborated with two different outreach teams, which I call the 'daytime' and the 'night-

time' team based on the time they operated. I conducted extensive ethnographic observation with both of them and followed them in different parts of the city. My account on the Park (see Chapter 8) draws on ethnographic data collected during their outreach interventions and interview data with their care workers.

Figure 9. An outreach team with their van at a drug market after working overnight in the centre of Athens

At certain times and days, a number of temporary spaces of care emerged for a short period of time in specific locations of the city. One of these temporary spaces involved ***local soup runs***. They operated on specific days and times in public locations such as parks and squares outside local churches. Most operated on a neighbourhood level and were run by volunteers of local parishes or philanthropic foundations. The locations of these soup kitchens were well-known among homeless people and their food was often preferred, as it was prepared in smaller batches than the food of the municipal soup kitchen and considered tastier. Local parishes belong to a wider network of 'religious

philanthropy' funded by the Church of Greece in which homelessness is viewed as a form of poverty and volunteers perform their religious duties by providing food to those in need through voluntary work (Arapoglou, 2004, p. 635).

Figure 10. A local soup run
(Source: Andreas, a participant residing at a night shelter and on the street)

An additional temporary space of care was a ***shower bus*** operated by an NGO on a central square of Athens, located five minutes away from the Municipality and ten minutes away from Omonoia Square. There, homeless people could shower twice a week and speak to outreach workers who helped them solve personal issues or redirect them to more suitable spaces of care. Some homeless people preferred going to the shower bus than indoor spaces of care because no specific appointment was required, and the waiting time was much shorter. Another temporary space of care was a ***laundry van,*** run again by an NGO. Its arrival attracted a large number of homeless people unable to access any alternative laundry facilities. It operated four times per week in Athens and each of its visits lasted four to six hours. All of its locations were on central squares, close to shelters and at another space of care, called SinAthina. This was a ***kiosk*** owned by the

Municipality of Athens that could be booked for free by various organisations and groups of citizens for various purposes such as education, healthcare, welfare and support. Although this was a static space located across from the municipal market for meat and fish, some of the organisations for homeless people had booked this space and provided services to them at certain times and days. Out of these spaces, I spent some weeks on the shower bus, where I conducted ethnographic observation and interviews while my data regarding the other spaces derive from interviews.

Figure 11. The Laundry Van
(Source: Andreas)

Figure 12. The Municipal Kiosk

Three gated spaces of care provided accommodation spaces where homeless people could sleep. These were two ***hostels and one night shelter.***[18] The two hostels were located in two vacant hotels near Omonoia Square. Their owners had agreed to provide these spaces for low rent to the Municipality to house homeless people. The hostels demonstrate how empty properties could be utilised at times of crises in a city, securing an income for their owners and housing for vulnerable citizens. In the hostels, the clientele were allowed to spend their entire day there and store their belongings. The night shelter residents had to leave at 7am and were allowed to return at 7pm without being able to store their belongings there in the interim period. The night shelter was developed through a collaboration between the Municipality's Centre for the Homeless and an international NGO. It accommodated 55 people 'legally residing in the country'

[18] One more night shelter was located in Piraeus and some of its residents travelled every day by train to use the services in the centre of Athens. In addition, another hostel operated in a hidden location for female victims of domestic abuse.

(sic) and was co-funded by the Attica District. Both of these spaces operated on stringent exclusionary criteria which precluded individuals with mental health issues, infectious diseases and a criminal record from applying for accommodation. One hostel could house 145 homeless people, including twenty women and seven children. The second had a capacity for 40 people, far below the accumulative number of people sleeping rough in Athens. According to the overnight count in May 2018, out of the 793 homeless people in the Municipality of Athens, 233 were housed in hostels and shelters and 202 in supported apartments[19] (Dimoulas, 2018). Consequently, 354 homeless people were deprived of any form of accommodation. Women accounted for 8.7% of the overall Athenian homeless population. This study was exceptionally valuable for a more accurate portrayal of homelessness and provided, previously unavailable, significant statistical data. These statistics clearly showed the shortage of housing facilities, as more than half of the homeless people in Athens had no space to sleep, other than in public.

All the above spaces belonged to the geographical area occupied by the landscape of care. For homeless people, such spaces depicted nodes of a defined socio-spatial network which they navigated by moving from one space to the next. Yet, by constraining their movement into this area of the city as all organisations were located there, the landscape of care turned the homeless people into drifting bodies in a state of both mobility and fixity. As Bourlessas (2018), argues the homeless spent their days 'drifting purposefully'. Moving through the public space in their journeys from one organisation to the next, to spaces of personal importance to them or by avoiding areas initiating a sense of danger to them, homeless people constructed routes based on a carefully thought-out rational defined by where their needs could be satisfied, resources could be secured, or other significant activities could take place. For example, some moved through this part of the city to reach the locations where they would sell the 'Big Issue' or to collect recycling items which they then exchanged for income at recycling factories. Yet, this state of mobility was intertwined with spatial experiences of immobility and fixity: fixed in this part of the inner city; fixed in the locations where personal belongings were stored; fixed in a car that provided a roof in the night-time; fixed in the hostel. This fixity was an integral part of the homeless people's everyday lives. Similarly, incidents of forced immobility were expressed when homeless people were obliged to leave the night

[19] These were apartments housing vulnerable citizens for a limited period of time.

shelter every morning or when different agents moved the homeless people and their belongings. Therefore, the landscape of care needs to be conceptualised as a space where organisations operated as 'moorings' (Hannam, Sheller and Urry, 2006) and as a space where the travelling and the mobility of the homeless bodies were produced through complex social, spatial and institutional relations creating opportunities and constraints

Intersecting Landscapes of Care and Competing Groups of Care Recipients

The national financial crisis which evolved into a humanitarian one, and the international refugee crisis (see Chapter 1) significantly impacted both care organisations providing for homeless people and the latter as care recipients. Therefore, although my research focuses solely on the landscape of care for homeless people, it is still important to reflect on the ramifications of these crises. These contextual factors defined the operation of the landscape of care on an urban, organisational, financial and interpersonal level, as scarce resources were stretched for various groups of vulnerable people. Hence, I explore the effects of how the same spaces operating as part of the landscape of care for homeless people became intersected with landscapes of care geared towards other populations, such as vulnerable but housed Greeks or refugees. As will be shown, this increased the fragility of these spaces in relation to the focus of their work, their funding arrangements, and the competition and hostility between the groups that met in these spaces.

First, the landscape of care for homeless people intersected with the landscape of care for refugees. Because of the retreat of the Greek welfare state, many local organisations took on the responsibility to care for this vulnerable population. Therefore, the personnel and spaces of organisations providing care to homeless people became involved in the support of refugees who found themselves in a new country following traumatic experiences and with an urgent need to be cared for. These developments affected how different populations received care in these spaces, as well as the control and management of available resources. In the following interview extract with Katerina – an NGO manager who had been working on the arena for more than a decade – the effects of the refugee crisis on the organisations and on the management of homelessness are outlined:

> The refugee crisis has affected us in many ways - both negative and positive. To start with, it greatly led to a, relatively for Greece, quick management of and response to many refugees through the creation of housing schemes. This was never done for the native homeless. In any case, autonomous flats were provided, other spaces, hotels were given to them. […] Now, the negative aspect is that this created a two-speed system for issues regarding homelessness, because all of a sudden - and please don't get me wrong, of course these people are entitled to it - this system created and enhanced xenophobic and racist beliefs and division.

This official explains how a two-speed system of care was established. While various housing spaces were provided to refugees, homeless people were not able to access the same spaces or have the equivalent access to care. According to Katerina, this discrepancy led to a danger of engendering xenophobic sentiments, which were already prevalent in Greek political life because of the rise of the neo-Nazi Golden Dawn party. I asked Katerina why NGOs had quickened their response. She explained that the substantial number of people who were suddenly visible everywhere in the city attracted larger amounts of funding resources from both national and international funds, with the latter playing a key role in the quick response to the problem. The landscape of care was suddenly exposed to an unprecedented crisis that re-directed the focus of these organisations. In turn, in need of resources themselves, many organisations absorbed international funding by creating programmes specifically for refugees and became involved in the management of the humanitarian, 'refugee crisis' (Kourachanis, 2018). This led many organisations to shift their focus from the groups they traditionally worked with and turned their attention to providing care for the refugees. To this end, two members of one organisation were moved to the Greek Islands, temporarily reducing the number of care workers at the Athens branch. This redirection of focus has significant implications for the allocation of funding among organisations to match 'specific geographical or thematic areas of needs whose boundaries shift over time according to changes in government priorities and programmes' (Milligan and Power, 2009, p. 576).

The result of the refugee crisis was that two vulnerable groups whose daily survival was at stake were competing for resources and care provision. In a conversation, a care worker at the drop-in centre shared their view that some money that had become available should be invested in homeless Greek men, as many schemes and organisations

were available at the time to both refugees and women. In Athens, 66.3%[20] of the homeless population were men and 53.3% were Greek (Dimoulas, 2018). Despite being overrepresented in the overall population, support for Greek men was insufficient. Although several participants questioned why the approaches and resources available to refugees were not invested in Greek citizens, it was only interviewee Michalis who expressed this opinion in a racist and hostile manner.

Michalis was in his mid-fifties and slept in an abandoned car in an area close to Athens. He was separated from his wife and two children. Each morning, he went to the Municipality for food and visited other organisations. In the afternoon, he visited his children and took them to extracurricular activities. Throughout his interview, he expressed anger about various things. He blamed the then left-wing SYRIZA government for the deterioration of his financial situation, suggesting it was the then Prime Minister Tsipras's fault that his wife decided to separate from him after being together for eighteen years, after he became unemployed and could no longer afford to contribute to their children's needs. He expressed homophobic ideas and annoyance towards drug users who were visible in the urban space of Athens. At the end of the interview, when I asked him whether he would like to add anything, he said:

> Yes, I would like to say something that I have been thinking about for a while now. These containers…They need to be built here too. These containers for the illegal immigrants [sic] who now make the choice to cross the sea and could get drowned and come here. Why don't I get the same help? Since I also found myself in this situation, *we* [i.e. native Greeks] (original emphasis) should get into the containers first, and then they [i.e. the refugees] can. […] This is absolutely necessary because this exact moment we are speaking, there are young people on the street abandoned in dirt. [These containers] should be given to the Greek have-nots or the Greek homeless, *after they really check whether they are actually have-nots and homeless* (original emphasis). […] Because then you have the sixty-year-old man who goes to the municipal soup kitchen although he gets a pension of 800 euros and then he goes and gets my food from the soup kitchen. Why?... […] And then they are asking me whether I am a racist. What racist? Are you joking me? We have put them all [i.e. the refugees] in ready containers and they have electricity, water, everything. And I have nothing. Twenty-four months I served in the Greek army, I have given my entire life. And they have more rights than me? The SYRIZA voters say I am a racist. Is this how you call it? I call it an old

[20] In this study, the researchers were not certain about the sex of 25% of the cases, as in some cases sex was concluded through observation.

> bloody asshole.[21] To be honest, I want to bomb all of those who came to my country without asking me and now I have been thrown in a car without anyone paying attention to me. […] And then you have the NGOs giving them money- big money from what we hear- and they torment me about getting or not getting 90 euros.[22]

The highly racist views evident in Michalis's words come with a great sense of discomfort. However, rather than concealing such views, analysing them reveals important dimensions of the relationship between contextual factors and care provision. The political and socio-economic environment in which the landscape of care operated resulted in extreme adversity for various vulnerable groups, a profound lack of resources for organisations and the rise of anti-immigrant ideas in the public discourse. Especially fuelled by Golden Dawn whose agenda espoused highly xenophobic, sexist and nationalist ideas (See Chapter 1), deep cleavages of discrimination and racism were prevalent in Greek political life in this context of growing deprivation and in the light of intersecting forms of vulnerability. Despite not explicitly admitting to being a member or influenced by this party, Golden Dawn especially attracted those who had served in the Special Forces, like Michalis had. Although Michalis was the sole participant who expressed these views in such a racist manner, some of his words echo other participants' interviews. The idea that what was provided to the refugees should also be provided to Greek homeless people was mentioned by almost half of my participants. Arenas such as landscapes of care where vulnerable groups meet to facilitate their survival become spaces where wider contextual tensions can become more pronounced. Being under-resourced further contributed to discriminatory views appearing as it was unable to care for all groups of care recipients in an integrated way.

Many care workers who found themselves working in the two-speed system also raised their concern about creating 'deserving' and 'undeserving' categories of care recipients. This did not just relate to the refugees, but also to vulnerable Greek citizens who were not as destitute as rough sleepers or hostel and night shelter residents. Such citizens were the neo-homeless (neo-astegoi) and the neo-poor (neo-ptohoi), two terms used extensively by the media. The term neo-homeless was used to denote a category of

[21] This is a Greek expression which shows that someone is perceived as stupid or has been taken for a ride.

[22] He refers to the monthly 'Social Solidarity' state benefit given to vulnerable citizens, including some homeless people.

housed, yet extremely vulnerable, well-educated Greek citizens who became unemployed during the crisis and were unable to pay their utility bills (Alamanou *et al.*, 2013; Mavridis and Mouratidou, 2018). As a result, they fall into a wider category of homelessness, as the quality of their housing conditions rendered them deprived of human dignity. In addition, the neo-poor group belonged to affluent or middle class backgrounds but had their income reduced to such an extent that they were unable to meet essential expenses, thereby experiencing a drastic deterioration of both income and quality of life (Panourgia, 2017). Both of these groups reveal the dramatic deterioration of living standards during the financial crisis and the different forms of vulnerability that appeared.

Although care providers maintained that categorising citizens could lead to categorising levels of care deservingness, the homeless people I spoke to felt that less vulnerable people often used scarce resources that were not as vital for their survival. Interestingly, the perception that there were people taking advantage of resources in various spaces of care emerged both among some homeless people and a limited number of care workers. It manifested itself in three different spaces. At the drop-in centre, one care worker said she felt uncomfortable giving clothes to some people who appeared not to be in absolute need of them but had created a habit of receiving clothes on a monthly basis. In addition, questions were raised by many care workers in relation to those accessing the drop-in centre only for a coffee, not making use of the social services or the laundry and shower facilities. However, as will be discussed in the next section, the management had requested that everyone visiting be registered for funding-related reasons. Some homeless people also raised the question of who should be eligible for certain benefits. Many said that at the municipal soup kitchen some of the service-users were able to afford food, but the portions given to them were going to their pets.

Similar tensions resulting from the co-existence of various vulnerable, competing groups were also discussed in relation to another space, 'The Chocolates'. This space became known with this name by homeless people because of the donation of chocolates. In this open space funded and run by a philanthropic foundation, every Thursday morning, around two hundred people would go and queue for these sweets. Many of them were Greek. Some were elderly and others were accompanied by children. The space of the Chocolates became known to me through a homeless woman, Dimitra, who took me there. On our way there, Dimitra told me that the Chocolates was a popular

location as such treats were not easily sourced by homeless people and that many elderly, housed people were not able to afford chocolates and would offer them as gifts to their grandchildren. This was one of the spaces that homeless people and other financially vulnerable people mingled and waited together for hours. During our walking interview, Dimitra emphatically said that not all of those people were sleeping rough. In contrast, she argued that they were considerably better off than most homeless people. In a concealed way, she pointed out all those having mobile phones or nice and clean shoes while whispering that these are things most homeless people could not have. She stressed that she understood this was the only option some of those people had to obtain a chocolate for themselves or the children in their families. However, she raised the question of whether spaces of care should focus their work on more destitute citizens, deprived of even the most vital necessities, such as housing, food and clothing.

Figure 13. The road where 'The Chocolates' take place

Figure 14. The queue at 'The Chocolates'

What are the implications of giving and receiving care in a context of shared deprivation? Why and how are hierarchies of care deservingness and vulnerability constructed? Here, the socio-economic and political context in which the landscape of care operated had a direct impact on the lack of resources to provide for all groups in need and on the rise of xenophobic and discriminatory sentiments. In this context of precarity and pronounced inequalities, the landscape of care became an arena of competition over resources. Instead of introducing further eligibility criteria for accessing resources such as housing for the refugees or clothing and chocolates for other groups, spaces such as the drop-in centre, the municipal soup kitchen and the 'Chocolates' illustrate the implications of feeling that one had resources withdrawn from oneself and invested in other groups. On the caregiving end, seeing limited resources being given not to the ones most in need also resulted in discomfort among some care workers. Spaces such as those described above also reveal that in such extreme and urgent conditions where care provision becomes a prerequisite for responding to basic needs and preserving

life, prioritising care needs and care groups becomes extremely difficult. When the welfare state does not have the resources to take up care responsibilities for all vulnerable members, different care providers become responsible for supporting different groups beyond their capacity in a fragmented way. This resulted in landscapes of care becoming spaces of tension, heightened vulnerability, pressures and challenges mirroring the wider context of shared inequalities and exclusion from care and playing a role further crystallising racist and discriminatory ideas.

The Effects of the Financial Crisis on Providers of Care

The tensions described in the previous section are related to the devolution of social welfare provision to third parties, such as municipal organisations and NGOs, as a result of austerity. Despite having taken up the responsibility of social reproduction that had previously belonged to the state, NGOs can be less well-resourced and accountable than the nation state (Lawson, 2007; Moosa-Mitha, 2016).[23] This relocation of care from the state and the family to municipal authorities and NGOs can prove problematic and jeopardise care provision. For example, Anna, a senior NGO official, explained that, like familial and state care providers, NGOs experienced financial pressures because of a reduction of the statutory funding they depended on prior to the crisis. These included an inconsistent cash flow, and the ensuing jeopardised continued operation of their schemes. Anna emphatically stated:

> Some of our programmes like the hostels for migrants or the daycentres, which are co-funded, would not have remained open, if it wasn't for the private funds. They would have closed four times by now, because we would have needed to fire our staff and rehire them after 2 or 6 months.

As a result, while in the decade before the financial crisis the main sources of funding for care providers were public and EU grants, during the crisis, the NGOs and the Municipality were funded by private companies and charitable foundations (Arapoglou and Gounis, 2017, p. 93). This was part of a wider development within the landscape of care that involved the establishment of extensive collaborations developed between public providers of care, NGOs, companies and philanthropic foundations. To

[23] In a 2014 survey out of approximately 120,000 service users close to 113,000 (94.2%) were served by NGOs, 664 (5.5%) by local authorities and 325 (0.3%) by public agencies (Arapoglou et al., 2015, p. 146).

underpin such collaborations resulting in a devolution of state powers, and, therefore, care responsibilities the term 'new-welfare mix' has been coined regarding civil society in Greece (Arapoglou & Gounis, 2017; Bourikos & Sotiropoulos, 2014; Simiti, 2015).[24] Operationally, such partnerships resulted in the NGOs holding a primary role often responsible for the operation of different spaces and the Municipality playing a secondary, coordinating role, making available infrastructure.

For example, an active and extensive collaboration was the coordinated action between organisations and outreach teams during extreme weather conditions when the municipal outreach team informed the outreach teams of NGOs about specific locations of homeless people reported by citizens. Subsequently, the NGO outreach teams provided care to homeless people or informed them about centres that had opened to protect them during this time. Both on a financial and operational level, the municipal soup kitchen was run through a collaboration between the Municipality, which was providing the space and personnel, and the Church of Greece, which also provided the personnel and the catering of the food. The night shelter also came about through a collaboration between the local branch of an international NGO whose employees were responsible for the shelter's operation, the Municipality which provided the building and the Attica District which funded it. In addition, several programmes run by the Municipality, such as the social grocery and social pharmacy,[25] were co-funded by the Municipality and other companies, supermarkets and philanthropic foundations. These forms of collaboration were central to the continuous operation and the funding of various spaces of care. They have also proliferated as a consequence of being a precondition for securing EU funding and facilitating local authorities unable to hire more staff or as a way to secure resources for necessary supplies (Arapoglou *et al.*, 2015, p. 146). Two thirds of the 77 recorded projects in the 2014 survey conducted by Arapoglou and Gounis (2017, pp. 91–2) came about through partnerships between different providers. Despite being necessary, such partnerships further enhanced fragmentation for care recipients and engrafted care with neoliberal principles, such as

[24] Within many modern welfare states, such collaborations have taken place and are understood as the outcome of 'the recent financial and economic crises on governmental budgets' (Corte et.al. 2017, p. 1175).

[25] These were branches of the Municipality focusing on providing for the housed and financially vulnerable such as neo-poor citizens who were unable to afford basic goods and pharmaceutical drugs

efficiency, competitive performance management and accountability measures (Milligan and Power, 2009; Baines and Cunningham, 2015).

Resulting from a context of scarce resources and cost-saving, these partnerships resembled the approach of New Public Management (NPM). This is 'a style of organizing public services towards the efficiency and efficacy of outputs' (Lapuente and Walle, 2020, p. 461). NPM has been accused of stripping welfare practitioners of the ability to exercise control and autonomy over their work and of shifting their work from meeting their clients' needs to standardising and routinizing complex processes (Cortis and Eastman, 2015). In Athens, this resulted in organisations prioritising the quantification of care, rather than tailored care provision. In particular, the time available to care workers to engage in care relationships and to get to know the care recipients was reduced. The creation of spreadsheets, internal reports or reports sent to citizens became a priority (see chapter 6). In an effort to secure or renew previous funding contracts, the managerial tiers of these organisations had to present to private funders both the need for their funding as well as the impact their previous funding had on service users. To do so, care workers were put under pressure to register as many service users as possible, thereby expanding the focus of the organisation but also the scope of the populations care workers provided for. This finding is in congruence with Arapoglou and Gounis' study (2017, p. 91), which also highlighted an expansion of providers' focus beyond their initial target group. Similarly, both the municipal and NGO outreach teams put emphasis on recording the number of outreach interventions and the characteristics of homeless people I encountered. These are all aspects that are in line with more neoliberal understandings of care that foregrounded notions of measurability and efficiency. As a result, integrating these elements in care provision created obstacles for care workers who had to juggle satisfying such requests from their management with the needs expressed by care recipients.

The Care Workers: Vulnerability, Precarity and Pressure

Lawson argues that the extension of market relations and the control over crucial resources in private hands 'are producing new geographies of inequality that reflect the changing realities of who has access to care and who does care work' (Lawson, 2007, p. 2). Inequalities did not solely pertain to recipients of care, but also caregivers. This was interwoven with the effects of austerity on the care workers I studied in Athens. Gender

inequalities were easily detected in spaces of care, as there was an overrepresentation of female care workers. Only one male care worker was employed in each of the municipal social services and the social services at the drop-in centre. Thomas (1993, p. 655) argues that 'it is not simply a question of most carers being women, but, more profoundly that caring is part of the socially constructed self-identity of women. It is an expression of the 'feminine' in our society'. Reproducing gender stereotypes is a crucial factor to why non-profit social services are a highly gendered arena, a well-discussed topic in the literature (Acker, 2006, 2012; Charlesworth, 2010; Baines *et al.*, 2020). This literature suggests NGOs tend to adopt the gendered assumption that care workers can work long and flexible hours unimpeded by care or social responsibilities (Baines *et al.*, 2020). Because of its similarities with unpaid care work and the assumption that women have – like in the home – an endless capacity to care, regardless of pay or working conditions (Themudo, 2009; Charlesworth, 2010; Matthew and Bransburg, 2017; Baines *et al.*, 2020), NGOs were likely to attract female employees. Especially in a context of cost-saving and efficiency (Baines and Cunningham, 2015, p. 189), such as the one the landscape of care operated in, the overrepresentation of women among the care workers can be linked with devaluing women's skills on the grounds of being perceived as inherent 'natural' traits, ultimately leading to 'the undervaluation of women's pay and conditions within care' (McDonald and Charlesworth, 2011).

The Greek Association of Social Workers (SKLE) notes that Greek social workers who often staff NGO and municipal agencies involved in care provision for homeless people have experienced unemployment, significant salary reductions, delays in payments and uncertainty (Poulopoulos, 2012; Pentaraki, 2015; Karagkounis, 2017). These conditions generated high levels of precarity among care workers in my study, all of whom were working on short, fixed-term contracts (8-12 months)[26] and earning low wages. While the financial manager of a Greek NGO argued that wages in the NGOs sector had remained stable (Tzifakis et al., 2017, p. 18), all frontline staff I encountered explained this was not the case. In particular, they highlighted that wages before tax *appeared* to be the same, but tax deductions which were previously the responsibility of the employer, were now borne by employees. In addition, care workers at the drop-in

[26] It is not clear to me whether this was the case before the crisis. However, earlier in the crisis when I conducted research at the drop-in centre, there was not such a level of uncertainty and anxiety regarding wages and working conditions were not communicated to me by the employees.

centre often complained about wage delays and wage reductions of 20%, in a climate where they said staff had been reduced by 50%. These are anecdotal accounts that I cannot triangulate, but staff reduction was something visible to me, as I had also conducted fieldwork in previous years. These conditions rendered the care workers financially vulnerable and increased feelings of anxiety and stress.[27] The example below reveals how care workers felt while already dealing with an exceptionally stressful professional life.

One day, I bumped into a young female social worker I knew from the social services. She was waiting for the Municipality director and seemed very worried. Hesitantly, I asked her if she was ok. 'I am not sure. I hope so', she replied, asking her boss if she would be receiving her signed contract from the Director on time. Later that day, I saw the young social worker again. I asked her whether it was all ok in the end. She responded:

> Yes, I just needed a signature from the Director by the end of yesterday, so I was pretty stressed. I needed it for my contract as I am also applying for some other jobs, because this contract is coming to an end in a couple of months. So, I have no idea what I will do. On the one hand, I feel good because social workers are really employable at the time of the crisis, but of course it's always difficult having your contract end every eight months or so.

Vradis (2014, p. 498) raises the question of what a major global financial crisis looks like in a crisis-scape.[28] He asks: 'How may it feel, what kind of form and shape may it take in the mundane and in the common, in the spaces of our everyday coexistence' (ibid.). The above account speaks volumes to what it was like to provide care in a crisis-ridden city like Athens. The need to care for various groups and the proliferation of NGOs in Athens made care workers more easily employable. Indeed, care workers who resigned from organisations were quickly employed elsewhere. Nonetheless, being employed on fixed term contracts increased the uncertainty felt by care workers who every 8-12 months had to wait until their contract was renewed or find a job in a different organisation. In some cases, care workers kept working in one organisation unpaid until funding for the

[27] Such conditions have also been condemned by the Union for Employees at Non-Governmental Organisations (SVEMKO - Union of Non-Governmental Employees, 2017).
[28] This is a term coined in this conference which explored the effects of the crisis on the city of Athens to describe the crisis-ridden landscape that unfolded during this time.

respective project they were employed in was renewed. These conditions along with unsustainable funding, lack of resources and a difficult professional environment increased stress among care workers.

In two of the spaces I worked in, these conditions caused tension between frontline care workers and the management, which led to some care workers organising collective committees to claim their wages and argue for better working conditions. However, the tensions between care workers and managerial tiers portray their competing priorities. The management prioritised the registration of high numbers of service users to ensure the continuous operation of these organisations. In contrast, care workers were preoccupied with the different challenges of caring for individual care recipients. Hence, there was a tension between adhering to a measurable approach to care and fostering care relationships. In this sense, there was a conflict between an imposed and a felt accountability. 'Accountability has both an external dimension in terms of 'an obligation to meet prescribed standards of behaviour' (Chisolm, 1995, p. 141) and an internal one motivated by 'felt responsibility' as expressed through individual action and organizational mission (Fry, 1995)'. The coexistence of these two types of accountability created tensions between the managerial tiers and the frontline care workers, as the former adhered more to an imposed accountability in order to secure more funding, while the 'felt' accountability was more prominent amongst care workers.

The distance between the managerial tiers and frontline care workers was further increased as managers were generally physically absent, attending external appointments or in offices in separate buildings or on different floors. Not being able to witness the tensions, obstacles and precise exchanges between care workers and homeless people also resulted in the management occasionally interfering and changing rules that were hard for care workers to impose in the first place. The fact that the care workers felt their managers were ignorant about their daily struggles and the issues they were facing on the frontline further estranged the two. These factors deeply affected the care workers emotionally, making them feel substantially unsupported in significantly stressful environments, transforming spaces of care into spaces of intense pressure. Many of them had been on the frontline for years and were working long hours, including weekends. Occasionally, NGO care workers were even contacted on their personal phone on their days off to get advice about how to manage a case or answer questions. Furthermore, when they had to

attend external appointments, such as at hospitals, disability or asylum committees,[29] they would attend even if these were outside their working hours, as they could not control the time of the appointment, which took months to arrange. The lack of personnel also led to a blurring of roles within spaces of care. For example, outreach workers would work in social services and 'social scientists' operated as support personnel. Petros, one of the drop-in centre's care workers said in his interview:

> We are experiencing multiple pressures. We are severely understaffed. Often we need to leave our primary work, and take up additional roles, either at the reception downstairs or here where users sign in, or help with the laundries… The only thing I haven't been asked to do so far is be the doctor. All this is an additional reason for exhaustion and as a result, your work is delayed, and you have many tasks pending. And when you come back to it, you don't know where to start.

This quote reflects the high workload and the significant lack of staff, leading to care workers taking up many different tasks and responsibilities. All care workers I encountered were overstretched and struggled to cope with the challenges in their professional life, resulting in high levels of stress and anxiety. Therefore, the vulnerability among care workers was not solely economic, but also emotional.[30] Exhaustion, frustration and a general burnout resulting from their intensified emotional labour were widespread in all spaces of care in Athens. Burnout can be very pronounced among long serving social workers or those who work very long hours (Mackie, 2008, p. 6), as was the case for most of the care workers I shadowed. Jokes about their own mental health were prevalent. For example, when bringing homeless people and other service users to psychiatric committees and appointments, care workers said the doctors should also check whether they were 'mentally ok'. Other times, on their way out of organisations they jokingly said to their colleagues that they might not return to their posts, as they may be asked to stay at psychiatric units themselves. Except for coping mechanisms, these common exchanges across spaces of care additionally highlighted the embodied nature of the vulnerability care workers were experiencing, while they felt anxiety was jeopardising their mental health. Such emotions have been understood as 'emotions of

[29] These are committees certifying one's disability or one's asylum status and then provide either benefits or the asylum status.

[30] The Greek literature on social work during the crisis (Karagkounis, 2017; Antoniadou and Karagkounis, 2020; Pentaraki, 2019; Pentaraki and Dionysopoulou, 2019) has also documented these aspects of care workers' experience and has underscored the high levels of their insecurity.

austerity' (Clayton, Donovan and Merchant, 2015) and reveal how embodiment, the working environment and emotions become all intertwined (McDowell, 2009). The very conditions of care and care work exacerbated these conditions which had a profound impact on the personal and psychological health of care workers.

In my research, care workers appeared very deeply engaged with their work and were constantly worrying both for their clients and themselves. Many ended up working from home after the end of their working day. The difficulty of drawing boundaries between their professional and personal life was accentuated by the lack of supervision and the limited training available to them. The importance of training is interlinked with viewing care as a practice, namely as something both learnt and improvable (Philip, Rogers and Weller, 2012, p. 5). Nonetheless, care workers, especially those employed during the time of my research, were affected by the absence of training as they had to learn many things ad hoc. Due to understaffing, no mentoring framework was in place to explain procedures to them. As a result, care workers heavily relied on their disciplinary background to engage with care recipients and other tasks. For this reason, psychologists applied more psychotherapeutic methods in their exchanges with service users, while social workers adopted a more practical stance. In addition, no specific training was provided by organisations in relation to handling care recipients with specific needs. Care workers had to depend on prior knowledge from working with other vulnerable populations in other organisations and on sporadic knowledge gained through conferences, most of which related to the management of the 'refugee crisis' and drug use. As a result, they lacked concrete knowledge about handling urgent complex care needs in challenging and urgent scenarios. Rather, they were dealing with clients ad-hoc using whatever was available to them at the time.

In no spaces of care were care workers able to access supervision. Despite expressing the need for having someone to talk to, as Antoniadou and Karagkounis's (2020) research concluded, supervision was considered a luxury. When I asked an NGO manager about this deficiency, she argued that care workers had the option to have a supervisor in the past, but they did not attend regularly. Karagkounis (2018) argues that the absence of supervision in Greek third-sector organisations relates to traditionally using the support from colleagues as an established method of coping with difficulties. Indeed, supervision was informally introduced in the weekly collective meetings care

workers organised. These meetings can be viewed as forms of micro-resistance in the highly convoluted environments care workers found themselves in. Nonetheless, with the exception of these meetings, care workers were, in Grootegoed and Smith's (2018, p. 1940) words, 'muddling through', namely 'a pattern whereby workers keep going, and carry out their work in situations of continuous, unresolved emotional dissonance'. This was the case for most of the care workers in this research, who as shown throughout this thesis, struggled on various levels.

Conclusions

By using the landscape of care as an analytical framework, this chapter has sought to grasp the interconnections between transnational, national and local developments and the intricacies of care on an intimate and everyday level. In sum, this chapter has demonstrated that the landscape of care was a space experiencing multiple pressures and various forms of inequalities and vulnerabilities. This relates to how susceptible care is to contextual factors. Indeed, to study and understand a landscape of care in a multi-faceted way is to provide its context. This allows us to see what shapes care provision, care spaces and care relationships. Initially, I provided some key characteristics of the landscape of care, such as fragmentation and lack in the continuum of care. The spaces constituting the landscape of care were located in a relatively condensed area of the city centre, where it not only reshaped certain parts of the city, but also defined care and homelessness as being parts of the same vicious cycle. While this area of the city led the provision of care, it was also defined by urban marginality and vulnerability. The level of deprivation and limited state support created heightened pressure for organisations and spaces of care to respond to marginalised groups' needs. In addition to various marginalised groups, the landscape of care became a space manifesting intersecting forms of vulnerability, as various groups needed care. In this context of shared deprivation and austerity, organisations were unable to satisfy the needs of all care groups. This resulted in both competition over resources and the crystallisation of racist and discriminatory ideas.

The general financial climate in Greece and the resultant retreat of the welfare state increased the fragility, uncertainty and constraints among care providers in Athens. The rolling back of the welfare state resulted in a chain of events that made NGOs a central caretaker in a new-welfare mix, where public bodies retained a secondary role. However, because of the limited available resources in NGOs at a time when they were

most needed, the organisations' operation became fragile and unstable. Being reliant on private donations for funding and cash flow required a shift from prioritising the needs of care recipients to adjusting their operation to raise funds and satisfy the demands of donors. Engrafting care provision with the requirements of private donors had a significant impact on spaces of care and jeopardised the quality of care. Most importantly, what was happening in Athens might display early signs of a neoliberal transformation of care, where market logics become interwoven with the provision of care. This was especially pronounced in how the intensification and the precarity of care work was experienced by care workers, who ended up emotionally and financially vulnerable, with limited support from their management. In this regard, my exploration of the landscape of care and the relationships between caregivers and care recipients echoes and reiterates previous work (Poulopoulos, 2012; Ioakimidis, Santos and Herrero, 2014; Pentaraki, 2015) that highlights the precarity experienced not only by recipients of care, but also by care workers.

Chapter 4

The hostels and the night shelter:

Seeking 'Home-Care' through the Landscape of Care?

Introduction

Moving from the macro-level of the city, I now turn to the local scale of the landscape of care and its institutional framework. To denote the difference between having or not having 'a roof over' their head, homeless people often referred to being 'outside' and 'inside'. To echo this differentiation, this chapter focuses on gated institutional accommodation, while the next chapter deals with experiences in the public space. Specifically, this chapter traces the process of applying for accommodation in the city's two hostels and night shelter and the living conditions in these spaces. While the former provided a permanent base for their residents, the latter could only be accessed between 7pm and 7am (see Chapter 3). I explore both adjacently because of their shared characteristics in terms of how they were discussed and experienced by their occupants and as they were the only spaces in Athens offering accommodation to homeless people.[31]

This chapter seeks to highlight the disparity between the articulated need of homeless people for 'home-care' and the accommodation provided by the landscape of care. I use the term 'home-care' to denote a central need expressed by homeless people in their interviews, namely the need of having a space they can call 'home' by being able to acquire a sense of ontological security (Laing, 1960; Giddens, 1991). When asked about their views on the hostels or the night shelters or whether they had initiated a process to secure a place there, almost all interviewees referred to their need for a home, highlighting this need was not satisfied in the available accommodation spaces. Specifically, the homeless people underscored that what they were looking for was a non-institutional space, be it small or large, as a basis for their emotional, physiological, territorial and

[31] In congruence with other researchers (Dimoulas, Kourachanis and Kazani, 2019; Fitsiou and Kourachanis, 2019), I also observed that the Housing and Reintegration Programme which offered targeted housing interventions primarily selected people with financial disadvantages, but no other social disadvantages, such as rough sleeping. Indicatively, only 4.6% of the beneficiaries were living in institutions prior to the programme (ibid).

physical safety. In so doing, homeless people differentiated between the private and self-defined idea of a home, and having rudimentary or basic 'institutional' – and often temporary – spaces, where one is reduced to being a body which has to comply with various regulations to maintain a place in overcrowded and adverse conditions.

In exploring the discrepancies between the needs of homeless people and what was offered by the landscape of care, this chapter examines the process of accessing accommodation from the perspectives of homeless people and care workers. First, it sheds light on the different discourses regarding homelessness that appeared in spaces of care. This allows us to understand how the landscape of care was positioned vis-à-vis homelessness, but also how different discourses resulted in different eligibility criteria that excluded certain categories of homeless people from accommodation. Second, it explores the exchanges between the homeless applying for accommodation and the care workers at the municipal social services. Effectively, the bureaucratic procedures of 'home-care provision' and the different categorisations delayed or excluded many rough sleepers from care. Next, I describe the difficult living conditions in the spaces of the hostels and the night shelter, which often functioned more like spaces of containment than spaces of 'home-care'. Being under-resourced and not providing the personal care homeless people needed had serious implications for their residents, as it led to patterns of care avoidance and institutionalisation.

Through investigating these defining aspects of 'home-care', this chapter sheds light on its discursive formation and the characteristics of accommodation it offered. In turn, these defined the experience of homelessness in the city and the boundaries regarding the type of care frontline workers were able to offer. I argue that the landscape of care did not incorporate the provision of 'home-care'. Rather, by merely providing a 'roof over one's head', the landscape of care failed to give homeless people a sense of ontological security and therefore played a role in perpetuating homelessness in the city. The stigmatising discourses, conditionalities of care and categorisation of care deservingness, processes of waiting, uncertainty, and feelings of ontological insecurity among the homeless meant the landscape of care further marginalised the latter by alienating them from spaces of care and hindering their options for exiting homelessness.

Conditionality, Deservingness and Discourses of 'Home-Care'

Before exploring the available accommodation and the conditions of providing it to homeless people, it is crucial to reflect on how the landscape of care made sense of homelessness more broadly and what kind of discourses developed in its spaces and amongst its agents, as these defined the features of the care provided. A central institution in the management of homelessness in Athens was the Municipality. It was involved in all stages of accessing accommodation, ranging from the establishment of eligibility criteria for certain groups to the interview process to apply for a place, as well as the operation of the hostels and night shelter. An officer of the municipal social services discussed the characteristics of homeless people in her interview:

> So, their [the homeless people's] characteristics, from what we know about them, are that a large category are the drug users, accounting for 60%. […] Then, you have the homeless who are sleeping rough because this is their philosophy or… based on their own way of thinking, they have decided that they want to remain on the street. […] Another special category, which we are not accepting to our hostels are those with mental health issues. And the dangerous cases are reported by our street-work team to the prosecutor who then dictates a psychiatric assessment. As for the drug and alcohol addicts, there are no hostels for the time being.

This municipal officer refers to the stringent exclusionary criteria that precluded certain individuals from applying for accommodation, which the Municipality's guidelines set out "a medical certificate stating that one does not suffer from any communicable diseases, a psychiatric assessment and a clean criminal record" (2000).

While the terminology of complex needs was not openly used in the Greek context, it is implied in the distinction that the Municipality establishes through its eligibility criteria. In particular, both in the academic literature and in the policy making of various national contexts,[32] a classification of homeless people between those 'with

[32] For example, in the UK homeless people who have 'developed additional mental and physical health needs, substance misuse issues and have contact with the criminal justice system' (CRISIS, no date) are collectively known as people with complex (support) needs. Similarly, the category of 'priority need' homeless people in the UK encompasses individuals who are especially vulnerable 'old age; mental illness or learning disability or physical disability; having been looked after, accommodated or fostered and is aged 21 or more; having been a member of Her Majesty's regular naval, military or air forces; having been in custody; ceasing to occupy accommodation because of violence from another person or threats of violence from another person which are likely to be carried out; or, any other special reason'.

complex needs' and 'no complex needs' establishes who has access to what kind of care. In the case of Athens, being classified as a homeless person 'with complex needs' resulted in exclusion from the accommodation spaces.[33] In addition to the categories stated by the municipal officer and in the Municipality's guidelines, the FEANTSA report (Fondation Abbé Pierre - FEANTSA, 2019, p. 24) on housing exclusion in Europe adds that to be able to apply for accommodation in Greece one needs to be 'legally residing in the country', excluding refugees and undocumented migrants. Hence, the landscape of care did not adhere to an inclusive care framework. Instead, conditionality of care and categories of care deservingness resulted in exclusions for many homeless people in Athens. Indeed, those excluded and labelled as 'complex needs' were the most vulnerable, including drug users.[34] In this sense, within the landscape of care vulnerability appeared to be inversely proportional to the level of 'home-care' one was able to access, rendering those most vulnerable unable to access 'home-care.

These exclusions from care and the characteristics attributed to homeless people alluded to a construction of homelessness through discourses described by Teresa Gowan's ethnography of homelessness in San Francisco as 'sin-talk' and 'sick-talk'. According to Gowan (2010, p. xxi), sin-talk and sick-talk are 'discursive logics' each of which 'represents a structure of meaning […], a magnetic force that lends coherence, authority and legitimacy to everyday speech and practices within the field of homelessness'.[35] Sin-talk was integrated in the municipal officer's vocabulary and language as homeless people were perceived as potentially dangerous and homelessness as a choice stemming from one's life philosophy. This discourse constructs homelessness 'as moral offence' and homeless people as deviant, failed and risky to themselves and others, as their predicament resulted from past choices 'to pursue self-indulgent, [and] destructive desires' (ibid, p. 71). Rather than unravelling systemic and structural causes,

[33] In Spring 2020, a hostel for 70 active drug users was established in the centre of Athens but was not in place during my fieldwork.

[34] A pilot study which took place in May 2018 concluded that 15.6% of homeless people admitted to consuming substances, while the same question responded by researchers through observation takes this number to 39.2% (Dimoulas, 2018). Nonetheless, despite a prevalence of this problem among the homeless population, this was an issue not addressed by spaces of care for homeless people, as homeless drug users were excluded from formal accommodation, until and only if they decided they wanted to enter a dry rehabilitation programme in NGO spaces focusing solely on drug use.

[35] Gowan also discusses system-talk which adheres to an understanding of homelessness 'as the product of systemic injustice and instability'.

sin-talk views the individual as having ultimate agency. Therefore, their predicament is deemed to result from personal incompetence or irresponsibility, leading to homeless people being considered undeserving (Rosenthal, 2000, p. 113).

Sin talk was interwoven with the practices of the Municipality in various ways and defined the interactions between care workers and homeless people as well as the characteristics of care provision. Many of the encounters between the municipal outreach team and homeless people ended with the care worker concluding that they were not interested in being accommodated in the hostels or the night shelter, saying that 'there is nothing else we can do'. Therefore, it was very rare that follow-up visits would take place. For the municipal outreach team, these homeless people were viewed as 'service-resistant', namely as unwilling to receive the care available to them. Again, homelessness was perceived as an individual's choice, resulting in a negation of care. In addition, the intervention of the Public Prosecutor was also advised when homeless people were perceived as a risk to themselves or others.[36] The intervention of an agent of the criminal justice system strips homeless people from the freedom and control to define their own lives. Simultaneously, it establishes a management of homelessness based on criminalisation.

In contrast to sin-talk which was primarily employed by the Municipality, sick-talk was much more widespread and defined which categories of homeless people received care and which became ever more marginalised. Sick-talk constructs homelessness 'as a symptom of individual pathologies, especially substance abuse and mental illness' (Gowan, 2010, p. 262). Sick-talk was especially evident when homeless people with complex needs were precluded from applying for accommodation on the grounds of consuming drugs and alcohol or having mental[37] and physical health issues. Rosenthal (2000, p. 113) describes this category of homeless people through the image

[36] To protect people requiring hospitalisation for psychiatric issues and those around them, the responsibility falls under the Public Prosecutor who then orders the intervention of medics.

[37] A report for the long-established UK NGO "Crisis" by Rees and the Public Health Resource Unit (2009, pp. 1–2) defines mental health: 'Mental ill health includes both common mental health problems and psychotic disorders. Common mental health problems include generalised anxiety disorder, mixed anxiety and depressive disorder, depressive episode, phobias, obsessive-compulsive disorder and panic disorder. Psychotic disorders include schizophrenia, schizotypal and other delusional disorders, manic episodes and bipolar affective disorder and other affective disorders with psychotic symptoms.'

of 'lackers', who hold no responsibility for their predicament. However, whilst they are deemed deserving of charity and aid, they 'do not deserve autonomy or equal respect' (ibid). Rather, any solutions will be determined by others.

Ingrained in the eligibility criteria of access to accommodation, sick-talk was prevalent and reproduced in almost all care spaces. In the exchanges among both municipal and NGO care workers, it appeared through the use of the acronym 'PSY'[38] - a secret jargon used daily by care workers to refer to homeless people with severe mental health issues. This jargon signalled to care workers that certain homeless people required more careful treatment or that they would eventually be found ineligible for accommodation. From my observation, the 'PSY' category comprised those who were not considered functional, did not adhere to social norms and behaviours, had severe suicidal thoughts and generally presented more conspicuous patterns of behaviour. Although, according to the municipal guidelines, a psychiatric assessment was required in order to be housed at a hostel, in practice it was care workers who often made an ad hoc decision based on a subjective assessment of who belonged to this category.[39] As a result, homeless people never saw a psychiatrist. Therefore, the lack of a concrete assessment framework resulted in the eligibility criteria being interpreted in different ways by each care worker and organization. This accentuated the power of care workers to facilitate or hinder pathways into accommodation. Sick-talk was interwoven with an implicit understanding of homelessness based on medicalisation through which previously nonmedical conditions are understood under the rubric of disease and illness (Conrad, 1992). Through this lens, homelessness can be understood 'as medicalisation by proxy' (Wasserman, 2011, p. 31). Sick-talk further contributes to conceptually conflating homelessness with addiction and mental health. In this sense, such discourses entail the danger of ultimately perpetuating 'the medicalisation of poverty' (Gowan, 2010, p. 193).

Through adopting these medicalised and individualistic explanations of homelessness, such discourses produce categories of deservingness and 'service worthiness' (Marvasti, 2002, pp. 616–7). The lack of specialised care workers and of a concrete approach on assessing mental health in practice contributed to the establishment

[38] From the first three letters of the word psychiatric as pronounced in Greek.
[39] See also the encounter between a homeless man and the municipal outreach team in Chapter 6.

of such discourses and high levels of arbitrariness.[40] Contrary to the mission stated on the Municipality's guidelines, instead of rehabilitation, such arbitrary decisions were part of procedures which further marginalised the overwhelming majority of homeless people with 'complex needs' and estranged them from care workers and care spaces. Furthermore, they instilled feelings of worthlessness and powerlessness among homeless people who found themselves unable to change or control the course of their lives.

To articulate her disagreement and frustration with how the landscape of care operated, Jenny an NGO outreach worker and psychologist by training stated:

> I think that in Athens in the hostels you will only find the elite of the homeless: those with no mental health issues. I have no idea how someone who is sleeping rough will have no depression - because this [i.e. depression] is also a mental health problem. How will their self-mechanism not be defeated? These are no drug users! they have no communicable diseases! [ironically] I have no idea how this is possible, but they are the elite of the homeless. I hope that efforts will be made to create spaces for the groups who are on the streets. I know this sounds very utopian, but I know it can happen. In Portugal, I think, the hostels are not just for these categories. They do not distinguish whether the person they will accommodate is a user or has mental health issues. […] In Greece, there is not a single space available for a homeless drug user.

Jenny opposed the eligibility criteria that constructed homelessness through medicalised discourses of sick-talk. For her, there was an inherent contradiction, as communicable and mental health issues – two main exclusionary criteria from accommodation – are integral parts of the lived experience of being a homeless person, sleeping rough, being in close proximity with unknown others and/or using public facilities. Her personal view is supported by the literature, as Snow et al. (1986) among others, argue that mental health issues such as depression need to be understood as *symptoms* [emphasis added] of homelessness rather than causes of it.

Behind the discrepancy between the municipal officer's and Jenny's quotes lies a distinction corresponding to two different sets of causes for homelessness. On the one

[40] As shown in Chapter 6, such arbitrary decisions were also evident with respect to physical health problems, as a disabled man was also excluded from accommodation after the decision of a municipal officer. In this example, the problem of fragmentation of care also contributes to the making of such arbitrary decisions, as there are no spaces responding to homeless people with complex needs.

hand, the municipal officer adhered to an understanding of homelessness based on individual explanations laid out in the Municipality regulations. On the other, Jenny emphasized the structural deficiencies within the landscape of care failing to respond to complex needs arising from vulnerabilities produced through the lived experience of homelessness. This should come as no surprise since each of these participants operated in and represented two different agents and levels of care, with the municipal officer belonging to a bureaucratic, state care provider, and Jenny to a provider of the third sector. The fact that the Municipality viewed homelessness in this way determined the experience of homelessness in Athens. However, individualistic explanations of homelessness engender feelings of self-blame among the homeless. Most importantly, they can easily conceal the societal factors which may result in and perpetuate homelessness, such as poverty and barriers to care. For example, mental health problems among the homeless population and especially of those in urban centres appeared to have significantly worsened especially during the crisis when various mental health services experienced significant budget cuts (Fitsiou and Kourachanis, 2019, p. 50). As a result, by ascribing individualistic explanations to homelessness, the significance of allocation of resources and the effects of scarce resources is disguised.

Regarding the lived experience of homelessness and care provision, though, such explanations create gradations of deservingness and conditionality with respect to 'home care' and one's ability to acquire ontological security. Being denied the opportunity to apply for a hostel meant not being deemed deserving enough to have a place in one of the accommodation spaces. Scholars in the field of international studies (Marlow, 2002; Krolikowski, 2008; Browning, 2016) have argued that one's ontological security is considerably enhanced through identifying one's self with a broader collective, as this can contribute to community building. While these scholars primarily referred to entities, such as the nation state, the landscape of care remains an expression of the welfare state, and hostels and shelters can provide spaces where one's ontological security is increased. Nonetheless, the landscape of care produced categories and hierarchies of care deservingness. From an international relations perspective, Delehanty and Steele (2009, p. 526) show how it is possible to actively undermine the security of certain groups through denying their desire to achieve a sense of emotional and physical security or by making it conditional. As a result, care, exclusion, control, and power were all intertwined

in the daily practices and encounters between care workers and homeless people in spaces of care and reduced the sense of security among the latter.

Waiting to Apply for a Hostel

If a homeless person had 'no complex needs' and belonged to what Jenny called 'the elite of the homeless', they were eligible to apply for accommodation at the hostels. Due to a shortfall in hostel availability in the Athens area (see Chapter 3), less than a 30% of the homeless people of Athens could secure a place in either the night shelter or the hostels (Dimoulas, 2018). In a 2018 study, only 1% of homeless people stated that they were making use of the latter (ibid). As shown in Chapter 6, uncertainty, fragmentation of care and processes of waiting were integral parts of the encounters between homeless people and spaces of care. These characteristics also defined the application process, which took place in the space of the municipal social services[41] (see Chapter 6). There, Afroditi and Nasia, two female care workers in their 30s both on short-term contracts, oversaw applications. Every day from 9am, they waited for accommodation applications.

When available, one of the care workers would go and invite an applicant inside. On one side of the desk were Afroditi and Nasia and on the other was the applicant. The initial purpose of the interview was to make sure that they did not meet any of the exclusionary criteria for getting a place at a hostel (substance and/or alcohol addiction, communicable diseases, disability). If the applicant admitted to the consumption of drugs, the interview stopped, and Afroditi and Nasia explained which organisations were able to offer rehabilitation help and which offered accommodation as part of a 'dry programme'.[42] If the applicant did not fall into any of the ineligible categories for accommodation, Afroditi and Nasia proceeded with conducting a short life interview in order to understand the personal story and the current housing status of each person. During the interview, one of them kept notes and the other one listened and asked questions. In this way, one care worker was able to attend to the administrative and bureaucratic aspects of the process, while the other was able to listen carefully and show

[41] While I discuss the encounters of homeless people with the Municipality in Chapter 6, I have decided to include the application process here as it is more specific to accessing accommodation in Athens.

[42] These were schemes operated by NGOs that did not offer methadone as a drug substitute. They often offered accommodation as part of their rehabilitation approach.

attentiveness to the needs and life story shared by each applicant. Despite not having received specific training from the Municipality, being young and patient allowed Afroditi and Nasia to actively listen to each person. However, the only care they were able to provide within the context of a bureaucratic and administrative led environment amounted to declining or accepting each application.

If the homeless person was actually sleeping rough, this had to be verified. This could occur either by a citizen having already reported someone sleeping rough and the characteristics of the reported person matched those of the applicant's or by arranging for the municipal outreach team to investigate the spot the person had mentioned. Afroditi and Nasia also informed those who satisfied the criteria that whatever the case may be, they had to undergo a number of medical examinations and provide relevant documentation. This included several administrative and medical documents, such as a tax statement, proof of identification, X-Rays and other medical examinations. FEANTSA argues that obtaining such administrative documents constitutes a barrier to accessing accommodation for people who have found themselves outside administrative processes and support services (Fondation Abbé Pierre - FEANTSA, 2019). As a result, even though someone might have been eligible to apply for accommodation, uncertainty regarding their ability to complete an application arose because the applicant might not be able to gather the required documentation. The fact that the application involved many stages meant that each homeless person had to have a high level of patience and made the receipt of complete care an exceptionally difficult enterprise. In this process, Afroditi and Nasia were rendered gatekeepers in a selection process underpinned by referrals to other social, judicial or health agencies required for the long list of documents and certification that homeless people had to collect to prove their eligibility to apply for accommodation (Arapoglou, 2004, p. 627). Simultaneously, this process allowed for shifting the caring responsibility between different agencies and leaving a homeless person in limbo without receiving care.

The different layers and high level of uncertainty were manifested in the way each interview ended. After discussing all the administrative details, Afroditi and Nasia emphatically stated: 'You just need to understand that the waiting list is very long. We will do our best but securing a place in a hostel is really difficult, as you know. In any case, after you bring all the required documentation, we will be in touch if you get a place'. This

was the concluding phrase of almost all interviews I observed. In some cases, the manager of the municipal services, whose desk was next to Afroditi and Nasia's desk and was able to overhear the conversation between the care workers and the applicant, also intervened. To emphasize the uncertainty regarding one's application, she also confirmed the low likelihood of getting a place while simultaneously being preoccupied with administrative tasks or on her way to another employee's desk. The way the care workers announced this to applicants succeeded in minimizing expectations of those sleeping rough and gave an accurate picture of what to expect. However, it also estranged homeless people from this space of care and increased a sentiment that they would not be able to receive the 'home-care' they needed. This established feelings of loneliness among homeless people who were often left unaided in their daily struggle to survive on the street.

Nonetheless, the small hope of being housed still endured among the applicants who were sleeping rough and some applicants visited the social services to check whether their application had progressed. One day, a homeless man in his 50s came to check on his application. The manager of the municipal social services then replied to him that they had tried to get in touch with him, but his number could not be reached. He said he had not lost his phone but there was a time that he was not able to charge it, and this must have been the reason he could not be contacted. The manager of the municipal social services explained that because the waiting list for the hostels was very long and people had been waiting for over three months, he had lost his place. Disappointment was painted all over his face, explaining after a sigh that he had been waiting for a 'long, long time'. Being informed by phone further enhanced uncertainty as losing or having one's belongings or phone stolen is commonplace among those sleeping rough. Consequently, even if someone was lucky enough to be offered a place in a hostel, this method of contact was not straightforward and reliable.

Time for destitute citizens is experienced saliently, as slowness and the feeling of being stuck trigger feelings of uncertainty. Similar to the experience of asylum-seekers' waiting at detention centres (Griffiths, 2013, p. 271), homeless people are rendered unable to imagine a future, as they do not know when their application will be processed or what the outcome will be. This is enhanced by their limited access to information and their lack of understanding about the processes involved. However, the nature of this uncertainty and how it derives from relational processes warrants further analysis. Waiting

for something does not necessarily mean that what is being anticipated will actually arrive. As in Beckett's (1954) famous play, Estragon and Vladimir wait for Godot, who never comes despite the boy telling them he will arrive tomorrow. During their long wait, their desperation makes them even contemplate suicide.[43] Similarly, homeless people are kept waiting and wondering if, when and what outcome processing their application would bring about. As a result, receiving care was deeply interwoven with uncertainty and prolonged waiting, both of which add to the suffering endured by homeless people.

Such encounters raise questions regarding the nature of care provided at the municipal social services. While both the care workers and the homeless people wished to give and receive care respectively, care provision was taking place in an adverse environment. Constrained by the bureaucratic and administrative facets of their encounter, no relationship of care was able to be initiated, since the environment and the bureaucratic aims of their communication constrained it to a momentary encounter of care. Underpinned by uncertainty, such encounters opposed the endeavours of the care workers and led to a further marginalisation of each homeless person. Although many of the homeless I encountered thought that making this application was a waste of time in the first place and described some appalling conditions for the residents of some hostels (see later in the chapter), those who did take a step towards receiving care with the aim of rehabilitation were faced with disappointment. Being aware of these problems, all my interviewees had no plans of applying for accommodation. In addition, encounters with the municipal outreach team revealed that some rough sleepers had indeed applied for accommodation, but had not heard from the Municipality. This made some view the outreach team in a hostile or suspicious way as they thought that despite having taken all the necessary steps to receive care, their efforts were met with no response. In these instances, the municipal outreach care workers explained that the outreach team was separate from the social services who oversaw the application process, but this suspicion remained.

Feelings of disappointment among the applicants were exacerbated by the lengthy and uncertain waiting in the process of applying for a hostel and the low probability of getting a place. Waiting for 'home-care', the most crucial need in a homeless person's life,

[43] As shown in Chapter 5, suicidal thoughts were discussed by some of my participants in their interviews.

becomes prolonged under conditions of vulnerability and fear while on the street. Most importantly, though, it becomes a strategy of exclusion and deterrence as when homeless people know the wait for shelters is long, they stop applying for accommodation (Auyero, 2012; Herring, 2019a). As a result, as the dream of getting a place might never be realised the landscape of care played a role in rendering the experience of time endless and uncertain for homeless people. All these factors and the lack of sufficient housing meant that the needs of those visiting the municipal social services to be housed could not be met and that relationships of care were hindered. However, as with all other spaces comprising the landscape of care, this too was a space responding to multiple pressures and challenges while in need of resources itself (see Chapters 3, 6 and 7).

The Hostels and the Night-Shelter: In Search of 'Home-Care'

Living conditions: Lack of privacy and control, disturbed sleep and ontological insecurity

This section will explore the way homeless people made sense of the hostels and the night-shelter, describe the latter's living conditions, and the role these played in perpetuating homelessness in Athens. Charis, a former hostel resident and rough sleeper, reflected on his own primary need at the time of our interview. Like the majority of my interviewees, he was in need of 'home-care' in order to escape homelessness. He said:

> I have been at the hostels, but look I want a room. My own room. Even if it is 15 sq. m. Something that is mine. Where I can be myself and only if I want to will someone be allowed in. Somewhere where I can put my stuff, read a book, listen to the radio and sleep when I want, for however long I want. Are you asking me what I really need? This is what I need. And above all, I need work. They [the state] are giving me 200 euros but honestly, I have no idea why.[44] 200 euros are not enough to rent a home, pay the bills and eat. I want this room. My own room, some support in the first year and a job. At the night shelter you just get a bed and at the hostels, it's the same but you just have the bed for the whole day. Is this enough to get someone off the streets you think?

In searching for a home, homeless people appeared to be looking for a space that would allow them to escape homelessness and rebuild their lives. Like other participants, Charis

[44] He refers to the monthly Social Solidarity Benefit which consisted of 100 euro in cash and 100 in a debit card that could be used in certain supermarkets.

emphasises having a secure space, even a small one, where he can store his belongings. While this allows for human agency, he also stresses that he would like to have control of who enters his domain and when he can sleep and for how long. In essence, in wishing for his own room, Charis sought a 'protective cocoon', providing him with safety from 'existential anxieties', independence, and the chance to get 'on with the affairs of day-to-day life' and develop his own identity (Giddens, 1991, pp. 39–40). Charis' words describe home as a space with a physical, emotional and symbolic meaning. Home can serve as a space of caring relationships and can provide one with emotional and physical well-being, a sense of privacy and control and a space to relax and enjoy leisure time (Moore, 2000; Dumbleton, 2005). All of these characteristics are crucial to the role of a home and explain how the need for 'home-care' was defined by their need to appropriate ontological security.

Zakarol (as cited in Kent, 2016, p. 2) argues that 'both exogenous and endogenous influences shape ontological security'. For this reason, it is useful to reflect on how this applies to the material and social conditions evident in the hostels and the night shelter. Rather than spaces of care where sentiments of ontological security could develop, these spaces were primarily experienced by the homeless as spaces of containment providing solely a roof and a bed. One homeless person described people at the night shelter as sleeping 'on top of each other' while another like 'sardines', underscoring the overcrowded conditions. These phrases illustrate the lack of personal space people experienced there – an aspect underlined by a high number of participants. Giddens (as cited in Dupuis and Thorns, 1998, p. 27) argues that ontological security is developed in the private realm, where 'people's basic security systems can be restored'. For those at hostels and shelters, one could assume that this would be possible, as the risks and adverse conditions experienced for those sleeping rough were not evident there. However, Ali who had been a night shelter resident alluded to a number of difficulties experienced there which hindered their ability to receive 'home-care':

> Things there are tough. A big room packed with twenty people. One person gets up and goes to the living room to smoke. Another one goes to the toilet and bangs the door. Another one coughs and wakes us all up. How am I supposed to sleep?

Spending the night in spaces of containment meant that a number of people with different needs and habits interrupted the other occupants' sleep as they had to share the same room. Sleep was not an enjoyable and restful experience, but rather a reminder of the compromises one had to make to secure a place in the available accommodation spaces. Goffman (1961) discusses how inmates of 'total institutions' have no control over their sleeping conditions because they have to conform to rules, routines and timetables. Night shelters can be conceptualised as 'total institutions' to the extent that residents have a pre-defined visiting time during which they can sleep there, in conditions they have almost no control over (Dupuis and Thorns, 1998; Leith, 2006; Parsell, 2012). In essence, by further enhancing feelings of ontological insecurity among its residents, the night shelters undermined their role as spaces of home-care. Nettleton *et al.* (2012) explain how sleep can be experienced as a risky behaviour by the homeless residing in hostels and shelters. In particular, they argue that such spaces can provide warmth, water, food and access to support services; inadequately resourced, however, they can be experienced as 'volatile environments and inimical to sleeping'.

An NGO official pointed to the emotional risks appearing when sleeping and spending the night in a space of containment with many others:

> The night shelters do not offer privacy. They do not offer security. Because again you are exposed to a large group of people, and if you are alone, most probably you won't be able to make it there for long. Either because of the space's temporary use or just because you cannot coexist with others easily. And this is something many of us cannot do, not just homeless people.

This official's words highlight the difficulties arising from living in a space where many people need to co-exist and different personalities might clash. This was particularly evident in Vana's case. She was a sixty-year-old former dancer from Poland. She came to Greece three decades ago when she met her Greek husband. However, he was violent towards her and she decided to leave their house. After spending more than a year hidden in a park, she went to the night shelter. She had a fragile voice and was extremely shy. Very rarely did she spend time with the other service users at the drop-in centre, and never wanting to cause any inconvenience, she was always willing to wait for a shower or see a care worker. When asked about the conditions at the night shelter, she initially became upset, as her time there was particularly traumatic. She explained that all she

witnessed there was bullying. She admitted being 'psychologically and physically' abused by two other female residents, who did not 'respect her space' and were 'lying to her about things'. In addition, she had some of her clothes stolen from her. It was these lies that 'started driving her crazy' and made her feel she had to 'constantly protect her back', thus accentuating feelings of fear and insecurity at the night shelter. When a psychiatrist started prescribing strong medication to help her cope with these issues, she decided she preferred to leave this space as she felt she was 'losing herself'.

Vana's feelings need to be conceptualised in relation to ontological security as an emotional, unconscious phenomenon. This could explain her strong reaction during our interview. In particular, instead of being able to enjoy emotional and physical security, the shelter's space engendered for Vana feelings of mistrust, anxiety and a sense of danger both on a physical and mental level, as she felt her existence was being jeopardised. Laing (1960, p. 43) explains how micro - everyday - events can become signifiers of ontological security. Lacking the required resilience to survive in such a space of containment entailing various emotional and physical risks and unable to receive a sense of security and care explains how the hostels and the night-shelter perpetuated or even increased the level of vulnerability experienced by residents.

Patterns of institutionalisation: Holding onto the hostel

Experienced as spaces of containment merely providing a roof and a bed and unable to offer the material, emotional and social dimensions of a home resulted in two conflicting conditions among the residents of the hostels and the night shelter. At the opposite end of the spectrum to patterns of care avoidance unfolding at the night shelter discussed in the next section, institutionalisation set in among hostel residents. Being allowed to remain in their premises the entire day was a risk stressed by both a resident and a municipal officer. The latter said that once at a hostel, many people 'develop the philosophy that they just wanted to stay there and do nothing'. Despite the efforts of the hostel's social services, many people 'rested on their laurels' (sic) and 'were not interested in looking for work'. Makis, a sixty-year-old hostel occupant and a 'Big Issue' vendor, explicitly used the word when asked about the lives of people staying there:

> Institutionalisation. It is a word that you get out of with great difficulty if it comes your way. Out of the 140 people, only 4 people are working – all for the Big Issue. […] Then you have all those who have this thing 'institutionalisation'. They wake up in the morning for a bit, watch a bit of television, they eat, they might have a coffee, sleep a bit in the afternoon, wake up again early in the evening, watch a bit of television, eat, sleep again. This is their life. They are resigned.

In adhering to these routines described by Makis, hostel residents appeared to be searching for a sense of ontological security, as routines could provide predictability, familiarity and a regularised way of following well known time-space paths or courses of action (Dupuis and Thorns, 1998, p. 33). The repetition and predictability of rigid day-to-day routines can provide a perception of psychological security. This can function as a crucial 'bulwark against threatening anxieties' as the discipline of routine can provide a 'formed framework' (Giddens, 1991, p. 39). Routines have been viewed as a way of instilling a level of order (Browning, 2016) and of shaping one's self identity and biographical narrative as they can provide a sense of continuity that can help someone 'answer questions about doing, acting and being' (Kinnvall, 2004, p. 746).

The search for ontological security was accompanied by a general feeling of emotional resignation. When asked about the conditions at the hostel, Angelos, another occupant explained that for him more important than the building's conditions were its residents and their ability to keep clean and have casual showers, as according to his interview no more than fifty out of the 120 residents showered regularly. For him, this stemmed from an overriding feeling of emotional resignation experienced by many residents, reflecting the abandonment they were experiencing from the state and welfare services. As a result, Angelos contradicted the view expressed by the municipal officer who viewed homeless people as 'having rested on their laurels' and not showing interest in finding work. For Angelos, the latter was a direct result of these spaces' conditions, the welfare state's retreat and the national economy. Even for Makis who partook in various activities, such as the theatre and being a tour guide in 'invisible tours'[45] organized by the 'Big Issue', leaving the hostel was not a risk he was willing to take. He explained that even though he was lucky enough to have a job as a 'Big Issue' vendor, his income varied. In addition, the financial situation of Greece would not necessarily mean he would be able to retain employment. Therefore, he said he would not risk his place at the hostel, as no

[45] Ticketed city tours with homeless people as guides who showed tourists and citizens of Athens spaces in the city which held a special significance for them (also see Methods Chapter).

one would guarantee him a chance to return if renting a house on his own did not work out. These examples show that these residents were in need of care both during and after their transition out of homelessness. However, the fragmentation of care evident in the overall structure of the landscape of care made homeless people perceive leaving the hostels as a risky undertaking, because occupants would be severing their hard-earned ties with spaces of care. Yet, even the residents of the hostels who had managed to overcome all the systemic problems linked with uncertainty and waiting, were not able to acquire a sense of ontological security there.

Patterns of care avoidance: Leaving the night shelter

While institutionalisation loomed over the hostel residents who lost their autonomy and spent day and night on the hostel premises, it was a common response among the night shelter's residents to prioritise freedom and autonomy – therefore deciding to leave the night shelter. Consequently, this resulted in patterns of care avoidance from accommodation spaces. Care avoidance is a term coined by Schout, de Jong and Zeelen (2011) after a study of secondary sources with the aim of theorising public mental health care. Their aim was to construct a portrait functioning as an ideal type which could explain the reasons informing the unwillingness of certain groups to receive care. They define care avoidance as a 'condition wherein clients do not seek assistance and do not attend appointments although they are in need of help' (Schout, de Jong and Zeelen, 2011, p. 665). For these authors, care avoidance as a portrait is accompanied, reproduced and reinforced by another portrait, namely care paralysis. Care paralysis is defined as 'the inability to help clients with multiple and complex problems by social services and care facilities' (ibid). At the opposite end of care avoidance stands trust and at the opposite end of care paralysis stands initiative, which the authors suggest as a solution to care paralysis. Care avoidance is part of a process which takes one 'from marginalisation to extreme marginalisation' (ibid, p. 669). It is explained by anomie, i.e. the 'feeling of not belonging to society', and related to a feeling of superfluousness when people have been on the sideline for a long time (ibid).

An aspect of the problematic conditions permeating life at the night shelters and contributing to high levels of care avoidance was the widespread complaint about lice and bedbugs. This led Andreas to leave the shelter only two days after he started sleeping

there. Although he had been elated at securing a place there, two days later he pointed to a number of bites on his legs and arms, explaining that this was the reason he had decided to leave. Care workers also expressed hesitation in sending people to the night shelters because of the conditions there. Similar concerns emerged about questionable hygiene conditions. In his study on social media use by homeless people, Wasselmann (as cited in Hartmann, 2014) concluded that homeless people attribute to the notion of home the possibility of retreat and quietness. Nonetheless, the occupants of the night shelter could exercise no control over the unwelcoming and at times harmful living conditions. Such spaces were, therefore, not experienced as spaces of refuge and failed to provide a sense of privacy and security to their residents.

Another common complaint which contributed to patterns of care avoidance were the strict rules regarding the times homeless people had to go to the night shelter, i.e. between 7pm and 7am. On a practical level, the night arrival time constituted a daily curfew for the hostel residents. On the contrary, the morning departure time can be understood as a reverse curfew. I asked Dimitra how it felt leaving the night shelter every morning:

> Do you know, my sweet darling, what winter actually is, what it means to have sleet outside and having someone tell you: 'Get out'. And then [you spend] all day there. Go to one place to search for food. Another to have your shower. Another one to wash your clothes and then go back [to the night shelter] again in the evening. This means being on the street all day like hobos. So, why should I stay there? Give me a good reason to stay at the night shelter. And keep in mind… The people that run the shelter were nice to me, but this thing was just not working for me. Whether you want it or not you need to go out. In the rain, in the cold weather, in the sleet, in the snow and spend your entire day on the streets. What do you think of that? And all this despite my serious heart and other health issues, they still tell me to go out.

Dimitra's words echo Jackson's view regarding the processes of surveillance and control in the night shelter and how such regulations seek to create a disciplining environment and create obedient bodies in the Foucauldian sense (Jackson, 2015, p. 111). Lyon-Callo (2000) links regimes of surveillance and discipline with medicalising discourses that make homeless people 'self-blaming' and 'deviant'. As discussed earlier in the chapter, sin-talk and sick-talk were prevalent in the landscape of care and played a role in governing homeless people through regimes and systems that enhanced surveillance.

Being free of surveillance has been identified as one of the markers for ontological security deriving from home (Dupuis & Thorns, 1998). Nonetheless, Dimitra's life as a night shelter resident was a life of surveillance and disciplining underpinned by being forced to leave early in the morning regardless of the weather conditions or her health issues. Instead of creating an environment that can retain the homeless on their premises by providing a care aiming at rehabilitation through enhancing their sense of ontological security, the night-shelter imposed night and day curfews. This made homeless people perceive themselves as undesirable and unable to enjoy the same rights and emotional and physical security as those who have a home. This finding coincides with Rensen's (2004, p. 98) research on sleep and homeless people in Amsterdam, where he stresses that 'many homeless people avoid these institutions because of their 'rules' and 'atmosphere'. Similarly, Chloe, a 'Big Issue' vendor, formerly sleeping rough and privately renting at the time of our interview emphatically said:

> At the shelter they just provide you with a space for sleep. Nothing else. If you don't throw a given person out at 9am and, instead, you manage to keep them inside and occupied with something, make them interested in something, let them feel they can relax, have a hot shower, sit, they will not make a fuss and decide to go out onto the street again. This thing whereby you give them security between 7pm to 7am and then make them leave is just not working.

Chloe advocates that for spaces to function more like a home, they should meet needs beyond that of mere sleep. She emphasises the need for a welcoming space, allowing the residents to relax and enjoy a hot shower. To be deprived of these amenities only functions as a reminder of the differences between being housed and homeless. In establishing these regulations, the landscape of care crystallised one's identity as a homeless person. Dimitra's reference to feeling like 'hobos' as a consequence of having been forced out on the street from the night shelter is revealing of how such regulations shape one's self identity as a care recipient and what their role is in the process of becoming homeless. Following Goffman (1959), McCarthy (2013, p. 54) explains how 'the sense of self is intimately connected to the social, to how we are seen by others and made to be seen by others'. Such feelings of rejection stemmed from the inability of these spaces to develop trust with their residents. Despite being an integral component of both care and ontological security, securing a place at the shelter required that one accept both the adverse conditions and the forced departure each morning.

Starting to sleep rough: How the landscape of care shapes the street

Not having received 'home-care' in available accommodation made homeless people perceive the conditions of the former and the street as comparable. In this comparison, some homeless people preferred the public space despite the increased danger and marginalisation, as there they could exercise a level of autonomy, agency and control over the lives and routines – a finding supported by the literature explaining why rough sleepers may make this decision (Moore *et al.*, 1995; Herring, 2019a). Indeed, four homeless people admitted that the conditions in these more institutional spaces were so bad for them that they felt they had been forced to sleep rough on the street if they were to exercise more freedom and independence. In thinking about sleep and homelessness, Duneier (2000) urges us to think about the act of sleeping among homeless people, emphasizing their own perspective on social conditions, rather than our own. In this regard, each individual's decision to sleep rough is integrally linked with the compromised care available to homeless people in gated spaces of accommodation. For Vana, the way the hostel personnel spoke to her was a key reason behind her decision to leave the hostel. In particular, when she approached the management to find a solution regarding the emotional and physical attacks by one of her roommates, she was told: 'Find a way to live together. If you like it here, fair enough. If not, you can always leave'. These words allude both to the pressures the hostel personnel may experience and to how the homeless people may feel unwelcome in spaces of care.

Similarly, Mr Nasos, a 65-year old Greek man, became homeless when his welfare benefit stopped and he was no longer able to pay his rent. Not having reached retirement age he was not able to get a pension. For this reason, he initially started sleeping at the night shelter. However, he ended up spending five years sleeping rough on Omonoia Square:

> I was living at the night shelter and when I went there, I had a pack of sugar, a pack of cheap cigarettes and a pack of instant coffee. For you, these might be nothing. But it had taken me long to find the money to buy them. So, I go into the room and there were four other people and I tell them, 'Guys, if you want coffee, cigarettes, feel free to have one.' So, I wake up the next day and when I was about to make a coffee, I realised I had nothing. I did a good deed and they took everything from me. I searched everywhere. I tried finding someone from the management to speak to and there was absolutely no one. Not even in terms of accommodation was there someone responsible. So, I understood I would

> never be able to be proven right or find the truth. So, I went to the reception and said to them: 'Can you please return my papers [i.e. the agreement signed between Mr Nasos and the night shelter]?' And I ripped them up and threw them in the bin'. I thought, 'If they are to steal from me, I'd rather be out on the street. There [i.e. the shelter] you are supposed to go just in your clothes, nothing else. I understand being robbed outside. But inside the night shelter, playing with my own mind and lying to me? And that was it. I started sleeping here [Omonoia Square]. At least, here some people will check on me, bring me something to eat. It's not ideal, but what can I do?

Accounts, like Mr Nasos's, constitute forms of care avoidance illustrating the consequences of accommodation spaces failing to provide a sense of home to their residents. The emotional precarity and difficult living relationships with other residents and the administration, as well as a feeling of always being on guard created a sense of distrust towards gated accommodation spaces. Such feelings of distrust have been understood as a persistent existential anxiety or dread (Giddens, 1990, p. 99). To escape this unbearable situation, some homeless people avoided the care offered and through their own 'overall logic' claiming a space on the street constituted a reasonable decision. Consequently, still in need of care, many rough sleepers slept in the city centre, remaining in the vicinity of organisations. Yet, such decisions are not solely examples of care avoidance. Rather, they point to systemic deficiencies which explain how the landscape of care, specifically hostels and the night shelter, shape the street and play a role in perpetuating homelessness. As in the case of the Park (Chapter 8), spaces occupied by rough sleepers in the city centre reveal the complex institutional relations within the wider structure of the landscape of care.

Conclusions

This chapter has dealt with the discrepancy between the need of homeless people for 'home-care' and the characteristics of accommodation spaces in Athens. By positioning homelessness in the wider context of the landscape of care, it sheds light on the institutional framework both homeless people and their care workers were navigating. Its discursive formation was highly exclusionary, as it established conditional categories of care deservingness and precluded many homeless people from 'home-care'. Although homeless people urgently needed a space of safety, privacy and emotional support to escape the dangers of the street and restructure their lives and selves, homeless people were only able to access spaces with challenging conditions that did not allow the response to their needs. Parsell and Parsell (2012) argue that homelessness should be

viewed within a context of opportunities and constraints. Aware of the bureaucratic obstacles and the difficult living conditions in the city's overcrowded and under-resourced hostels and night shelter, some homeless people preferred the street. With taking this option, homeless people avoided the disappointment that was evident in all stages of securing accommodation and living there. Many were aware that both inside and outside would face loneliness, fear and threat. The problematic experience of living in gated and institutional accommodation pointed to the quality of care offered by spaces of care, ultimately involving both punitive and exclusionary elements (DeVerteuil, 2014).

In this regard, it is not just homelessness but also care that needs to be seen within a context of opportunities and restrictions. On the level of the landscape of care, the exclusions and restrictions discussed in this chapter meant that the system of care provision inherently allowed for a *management* of homelessness, rather than an escape from it. On the level of care relationships developing between homeless people and care workers, the restrictions imposed by the landscape of care resulted in removing agency from the care workers operating in various public and gated spaces of care explored in the thesis. Following the regulations of the landscape of care and aware of the low likelihood for homeless people securing a space at the hostels, care workers had limited options for helping homeless people escape homelessness. On the city level, these restrictions resulted in the proliferation of spaces of urban marginality and territorial stigmatisation and the perpetuation of rough sleeping (see Chapter 8 and George's home in Chapter 5). Although gated spaces of accommodation offered a 'home as roof' (Somerville, 1992, pp. 532–3), they were unable to provide a 'home as roots' (ibid). The latter is interlinked with acquiring a sense of ontological security, a source of identity and meaningfulness. Despite being protected in an indoor space from the weather and the dangers outside, the homeless did not view the hostels and the night shelter as providers of 'home-care', as they failed to replicate the conditions of a home. Instead, they remained spaces of containment, where one's physical and ontological security were jeopardised. The processes of institutionalisation and daily curfews reduced care to the provision of basic, temporary shelter. Consequently, it did not incorporate a sense of home and did not respond to the rough sleepers' need of being taken from the street to rehabilitation and regaining ontological security. Therefore, such spaces played a role in the crystallisation of the predicament and identity of their residents as homeless people. Reaffirming the stigmatising idea of homeless people being deemed undeserving of a

home-like place was part of a process of both material *and* psychological marginalisation. As a result, within homelessness - already a situation of deep exclusion- additional layers of exclusions occurred. 'Not caring about an object, situation or idea means we do not want to waste time and energy on them, that we are not interested in making them part of our lives' (Gheaus, 2005, p. 9). In the next chapter, I discuss how rough sleepers navigated the street and tried to acquire a sense of ontological security in the public space.

Chapter 5

From marginalisation to extreme marginalisation: Experiences of homelessness and ontological insecurity among rough sleepers

Introduction

After analysing the limited access to 'home-care' in gated accommodation, I now turn my attention to spaces outside of the institutional domain to explore how the landscape of care produced different experiences of rough sleeping. Drawing on the literature around ontological security and its relationship with home, this chapter explores the emotional dimensions of homelessness through the notion of ontological (in)security. Reflecting on the experience of being without a home through this lens is considered useful for understanding the lived experience of homelessness in the public space. In their search for emotional and physical security, homeless people have relatively limited 'options' regarding where they will spend the night. Despite their efforts to negotiate homelessness, their lives were characterised by constant physical threat, violence, anxiety, loneliness, aspects of social invisibility, dehumanisation and self harm. Exploring the emotional repertoires of homeless people provides a more nuanced understanding of their needs, their engagement in care relationships, and how these relationships in turn shape their embodied response to care. I start by looking at rough sleepers, the majority of whom were male and located in the city centre. Subsequently, I turn to the experiences of homeless women who were located on the outskirts of the city. Finally, I explore processes of homemaking outside institutional life and the efforts of homeless people to create a home for themselves without interacting with the landscape of care.

I argue that the different experiences of homelessness are produced by the landscape of care and are characterised by different degrees of ontological insecurity, from heightened anxiety and fear to individual efforts to gain a sense of relative autonomy and control in the public space. Despite its embodied and individual experience, I situate ontological insecurity in a nexus of institutional and socio-spatial relations defined by the

landscape of care, its exclusions, deficiencies and responses. Therefore, in analysing experiences of being deprived of a home I explore ontological security in relation to care and homelessness. By denying homeless people a home – a space of ontological importance interlinked with experiences of privacy, autonomy and control – I show how the landscape of care pushed homeless people to conditions of heightened marginality and perpetuated homelessness in the city.

Sleeping Rough in the City Centre: Living with Ontological Insecurity

Sleeping rough: A signifier of ontological insecurity and situated precarity

The vast majority of the homeless people I spoke to were sleeping rough outside entrances to churches, or on sideways and pavements. Some of them used cardboard boxes, sleeping bags and blankets donated by organisations and outreach teams. The care provided to rough sleepers was limited to sporadic donations of such items and occasional visits lasting between five and ten minutes, aimed at informing rough sleepers about organisations and available resources. Ending up sleeping rough appeared to be bound to the characteristics of the available provision and the negative experiences in gated accommodation spaces discussed in Chapter 4.

The phrase 'sleeping rough' does not always allow one to fully and automatically conceive its meaning: its lived experience and the emotional and practical reality of homeless people's lives. While 'rough' relates to having absolutely nowhere to stay, as the phrase suggests, a central component of sleeping rough derives from a distinctive experience of sleep that differentiates rough sleepers from non-homeless/housed people. Sleep is an essential part of human experience, an essential aspect for our biological and emotional wellbeing and therefore a basic human right (Williams, 2011; Nettleton, Neale and Stevenson, 2012). Despite its significance, the lived experience of sleep among rough sleepers is understudied from a sociological perspective.[46] One notable exception is Rensen's work on sleeping among rough sleepers in Amsterdam. He views sleep as a 'gruelling task', underpinned by 'a specific set of social conditions that makes it difficult if not impossible to separate rest and sleep from other basic necessities' (Rensen, 2004,

[46] More broadly, sleep remains an understudied subject of inquiry both from an anthropological and a sociological perspective (Steger and Brunt, 2003; Meadows, 2005; Williams, 2005; Glaskin and Chenhall, 2013).

pp. 96, 106). Unable to conform to the social norms of sleep and normative conventions regarding the time and place of sleep, rough sleepers fall into the category of what Williams (2007, p. 322) has called, the 'anarchic, deviant, stigmatised sleeper'. He argues that 'rough […] sleepers are not simply disadvantaged, both symbolically and materially, but quite literally disembedded, if by that we mean without bed or abode.' (ibid, pp. 323–324). In other words, this experience of disturbed sleep is interlinked with an extreme form of material deprivation and situated precarity.

The homeless people's disembedded state imprinted itself on their sleep, which was also in a betwixt state. All my participants were heavily impacted by the lack of quality sleep. As they said, during the night 'only one of my eyes were sleeping and the other one had to be wide-open' or their 'eyes on the face might have appeared closed but were fully alert behind closed eyelids'. These expressions reveal how unfulfilling and stressful their sleep was as a result of an omnipresent threat to their physical wellbeing and personal belongings. Rensen (2004) calls this sleeping practice that deters a rough sleeper from sleep 'half sleep'. Challenging my question about what he did when he woke up every day, Charis, a former hostel resident and rough sleeper at the time of our interview, explained that the real question is whether he ever sleeps. Describing how anything one has, even a pair of trousers, may be stolen or worse, one can even be 'killed' or 'attacked', he emphasized it is impossible to fully sleep on the pavement in the open space.

Most importantly, Charis and Makis, who at the time of our interview was a hostel-resident and a 'Big Issue'[47] Vendor, discussed how this experience of sleep contributed to high anxiety, ultimately jeopardising their mental health. Charis said 'that a person's [quality of] sleep constitutes half of his very being' and rhetorically asked: 'How can you be sane without sleep?'. Makis described the numerous times he 'would sit bold' [πετάγεται] and his 'blood would stop' during the night, hearing someone coming close to him or even when a car would brake. In other words, the experience of disturbed sleep underpinned by conditions of constant threat and terror becomes a signifier of a lack of ontological security among homeless people. Indeed, lack of sleep is linked as a cause of health problems and impaired social functioning (Cappuccio, Miller and Lockley, 2010). This experience of sleep was interwoven with a risk of victimisation. While violence on

[47] The name is different in Greek, but it corresponds to the Big Issue in the U.K.

the part of gangs and Golden Dawn members (see Chapter 1) against rough sleepers was mentioned by two participants, violence among homeless people and between homeless drug users and dealers was described as rife by many rough sleepers spending the night in the city centre. Rather than just mere fear about a specific object or threat, the homeless people described an experience of generalised anxiety and panic, risking their mental and physical wellbeing.

Without abode: Loneliness, worthlessness and lack of dignity

The idea of home is ensconced with ideas and experiences of privacy, autonomy, security and territorial control over an area (see Chapter 1). In contrast, not having a home has crucial emotional ramifications, resulting in a form of psychological marginalisation. However, the latter was interlinked with an extreme form of material deprivation evident in homelessness, as the lack of access to crucial resources often led homeless people to breaking multiple social norms. Doing so resulted in feelings of worthlessness and a negative shift in the self-perception of homeless people. For example, Dimitra expressed her frustration at not being able to access clean public toilet facilities, as she was not allowed to use lavatories in shops, and public lavatories were especially dirty and thus avoided by her for hygiene reasons. Because of this, she made the decision to relieve herself 'on the street and in places behind cars and trucks, on squares and in public parks', which Dimitra described as 'utter humiliation'. Being unable to comply with social norms that dictate private spaces are used for such biological needs, responding to these basic corporeal needs and self-care was experienced as a violation of her self-respect, self-dignity and a dehumanization of her self-perception. While such emotions are individually experienced, they are conditioned to the wider constraints imposed by the landscape of care and the city on homeless people. In turn, this psychological marginalisation has structural outcomes, as it strips homeless people of any motivation to escape their predicament, which ultimately results in a perpetuation of homelessness in the city.

Additionally, not having a home resulted in forced immobility, a state of being stuck and unable to gain a sense of autonomy and independence. For instance, Fanis was working two to three times a week at the municipal market but was unable to secure a safe space to store his belongings during his time there. For this reason, he left his things

at the entrance of a church on Koumoundourou Square. Although he felt lucky to be earning an income by being employed, his belongings and daily wages were stolen on various occasions, while he was at work. As a result, in his effort to make a living, Fanis had to take a daily risk of losing everything because he did not have a secure sleeping and storage space. Fanis's example reveals a tension between one's intention to leave homelessness and navigating the inherent problems of being homeless. On the one hand, Fanis tried to escape homelessness by becoming independent through work. On the other, he tried to gain a sense of territorial control over an area where he could store his belongings safely. Unable to do so, Fanis appeared to have accepted being in a vicious cycle of working to afford basic goods and occasionally having his belongings stolen. Trying to navigate the inherent challenges of homelessness underpinned by the inability to separate one's space of sleep and other realms of life (Rensen, 2004, p. 106), some of my participants put efforts into establishing relationships with restauranteurs and owners of nearby shops. This strategy allowed them to develop some mobility or sense of autonomy, as this support network could keep an eye on their belongings for a limited time, when they left their spot. Relying on this support network even for a limited amount of time was important as for the overwhelming majority of my participants trust was absent in relationships with other homeless people. In contrast, their contact was limited to the cases where this was necessary, such as in spaces of care like the Municipality. [48]

Therefore, loneliness was described as an integral element of the lived experience of homelessness. Yet, it was also related to and further accentuated by the cutting of ties with family and friends. When experienced positively, family life is often associated with the idea of home as well as practical and emotional safety, contributing to a sense of ontological security (Newton, 2008, p. 222). However, because of the dilapidating effects of the financial crisis on the Greek family unit, it could no longer maintain its caretaking role, estranging family members who prior to the crisis could provide or receive support. The possibility of remaining in touch with their family members or seeking help from them was out of the question for most of my participants. For example, Costas was convinced that following an investigation of a private detective initiated by his wife and son, they were aware of his whereabouts. However, because after losing his job, he was unable to provide the financial support he previously did, he felt he was no longer

[48] Only three of my participants mentioned having developed friendships with other homeless people.

perceived as 'a good father and husband'. Nevertheless, he never considered reaching out to them as this would require breaking the rule he had taught his son, i.e. that asking others for help and favours was a sign of weakness, and hence a lack of personal dignity. Convinced they were no longer interested in him, he ripped up the pictures of his ex-wife and son, explaining that every time he looked at them, he burst into tears and was reminded of his previous life. Similarly, the 55-year-old Katerina did not want to approach her mother and sister out of shame that she could no longer be the person they knew, providing them with presents and fulfilling their wishes. After being made redundant from a nursery and seeing no prospects of finding work soon as most employers preferred younger employees who received lower wages and were considered more productive, she was sleeping rough. In order not to disclose her predicament she preferred contacting them at times chosen by her.

Despite the complex and difficult aspects of their daily life, turning to their relatives and friends for help was perceived as a compromise of their self-dignity, namely of their self- or inner worth defining their (self)-perception and treatment by themselves and others (Miller and Keys, 2001, p. 332). The loss of a home, the social stigma of homelessness and relying on others and services for one's survival have all been viewed as reasons for which the homeless lose their sense of (self)-dignity. Not disclosing their situation appeared to be a 'self-preservation strategy' homeless people employed. It helped them avoid a 'total loss of self-identity' – which ontologically insecure people may fear (Laing, 1960, pp. 43–45) – and keep a core of their identity intact in relation to themselves and others.

Becoming homeless: 'Being invisible'

The breakdown of family ties not only increased feelings of abandonment or isolation, but also manifested a disruption with the homeless people's past. This was crucial both in relation to ontological security and internalising the identity of the homeless person. While continuity may be a component of ontological security as part of one's relationship to oneself and one's sense of 'being in the world', homelessness is at the other end of spectrum, a condition characterized by impermanence and discontinuity in relation to oneself (Giddens, 1990, p. 92; Kinnvall, 2004, p. 747). For instance, Makis,

who at the time of our interview was a hostel resident, reflected on the time he was sleeping rough:

> When you are on the street, you do nothing but be on the street. You cannot be who you were. You cannot and you don't even want to become who you were. Because you just cannot do the same things. Especially during the time I was sleeping rough, I was not myself. I was lost. I was in another dimension. It was not me, but someone else. Now that I am at the hostel, I have decided to erase this time from my memory. I have decided it was not me who was on the street.

Makis' reflection responds to one of the questions raised by Giddens (1990, p. 93) regarding the experience of discontinuity vis-à-vis self-identity. He argues that one of the questions emerging when one lacks ontological security is, 'Am I the same person today as I was yesterday?'. As ontological insecurity can lead to people experiencing more than one self, Makis' words not only demonstrate the discontinuity and disruption of his self-identity while sleeping rough, but also allude to him experiencing more than one self. This new self is deeply intertwined with the emotional ramifications of being homeless but also with social, material and financial deprivation. These factors prevented homeless people from engaging in any activities unrelated to homelessness, leaving them with no other choice but to 'do nothing'. After leaving the street and sleeping at a hostel, he appeared to be adhering to a third self that was neither the self he had experienced during his rough sleeping nor the self that defined him prior to this[49].

The process of becoming homeless and the ensuing feelings of ontological insecurity were intertwined with a rough sleeper's daily interactions with passers-by. These interactions were shaped by the constant exposure of homeless people in the public space. In particular, Somerville (1992) explains how a lack of privacy can result in feelings of powerlessness among homeless people, as they have no territorial control over a space. Hence, distressing incidents making homeless people vulnerable to others were prevalent. For example, Costas reflected on some of his most memorable incidents on the street:

> There were two things that really killed me. The first one is that people were pretending not to see me. It was as if I was invisible and they were indifferent. I never asked anyone to give me money or anything else. Just a glance was enough.

[49] This was an in-between self, encapsulating elements of the two other selves. Concretely, he remained a hostel resident and 'Big Issue' Vendor, but also took up multiple hobbies, such as theatre and singing.

> And second when a mother pulled her son away because I stank and she told him, 'Make sure you never become like him'. These things killed me.

Costas' words provide a rich understanding of how a homeless person feels when interacting with others and internalising certain negative characteristics ascribed to them. Everyday incidents, like the ones described by Costas, can constitute important signifiers for ontological security. This defining feature of homelessness, sleeping outside, can result in negative reactions, precisely because 'this transient mode of sleeping represents a violation of social mores and because the very presence of homeless people on the streets is seen as threatening' (Nettleton, Neale and Stevenson, 2012, p. 326). Another incident described by Costas involved being derided by a group of women who donated female underwear to him while laughing. Such incidents of public humiliation are bound to being without a home and therefore having no protection against harassing behaviours of passers-by, such as negative public judgements and emotional humiliation.

Costas's words also highlight the idea of 'being invisible' which was shared by other participants. Drawing on Richard Sennett's work on respect, Newburn and Rock (2006) discuss how social invisibility experienced by rough sleepers is linked with that 'peculiar lack of respect which consists of not being seen, not being accounted as a full human' (Sennett, 2003, p. 13). Similarly, Fanis said he was 'like a tree, a piece of wood. Like a chair not moving, not speaking. Just being there.' 'Being invisible' or liking oneself with a soulless object, like a 'piece of wood' alludes to a situation of nonexistence, where one's presence is disregarded by others. Not attracting a passer-by's gaze can accentuate feelings of worthlessness, degradation, loneliness, abandonment and marginalisation, as one has nobody to turn to for help. In their research into loneliness among homeless people, Hemberg *et al.* (2019, p. 6) argue that loneliness is associated with feelings of anxiety or a sense that one no longer has a meaning in life. Such feelings were crystallised through negative reactions of passers-by who explicitly showed disapproval and frowned upon homeless people. This speaks to the nature of care homeless people might need from accommodation spaces and more broadly spaces comprising the landscape of care and in particular, the empowering role agencies of care are required to play in helping homeless people escape homelessness.

However, the idea of being invisible did not just relate to interpersonal events but was further systemically reinforced by the treatment of homeless people by the landscape of care. For example, when Dimitra visited a police station to re-issue a new ID required for arranging an operation, a very old arrest warrant for some unpaid promissory notes in 2006 was detected on the system. Dimitra was about to start a job. Yet, to cancel out her offence, she had to serve one tenth of her sentence which was forty days of imprisonment. During her time at prison, Dimitra was 'feeling invisible', powerless and lonely as 'if anything happened to her, no one would know'. Yet, feeling invisible was not just her own experience. She 'had become invisible' to her care worker who was unable to track her down due to lack of communication and coordination between agents in the city and because of Dimitra's inability to access a phone. It was not until weeks later that Dimitra's care worker received a phone call from her. Subsequently, her care worker started visiting her in prison twice per week to check how she was coping and to bring her underwear and clothes. After her release, Dimitra had lost the job and returned to wandering the streets to collect 'recycling cans' for income. Known as 'the little cans, this activity involved collecting recyclable items from rubbish bins and returning them to a recycling factory.

The lack of coordination also rendered Paris invisible. As he was a regular of the drop-in centre, his sudden disappearance made care workers assume he had passed away. However, they were unable to confirm this with any other institutions, such as hospitals or the night shelter.[50] After months of visiting the drop-in centre and other organisations, Andreas was another service user unable to be located by his care worker. When I saw him on the street months later and explained how worried Pinelopi, his care worker, was about him, he said:

> Pinelopi means well. She has a huge heart and I know how much she is trying to help me. But I am getting tired of being dragged from organisation to organisation and not finding a solution. I prefer being here with my pals. From time to time we also smoke a joint (laughs).

[50] In March 2021, it was confirmed to me that Paris had died in an abandoned building. His body was found there a year after his death. It is assumed that unable to find accommodation or seek help elsewhere, he found refuge in this building after an operation.

The cases described above explain how 'becoming invisible' goes beyond the emotional experience of rough sleepers on the street. Rather, it was interwoven with processes and characteristics defining how the landscape of care treated homeless people and how the fragmentation and lack of joined-up coordination resulted in certain individuals 'falling through the cracks of provision' (Dwyer *et al.*, 2015, p. 11) and becoming invisible from care providers.

Dehumanisation, shame and self-harm

The experience of being without a home, feeling invisible or having of one's dignity violated by being insulted, treated unjustly or attacked contributed to feelings of dehumanisation among rough sleepers. Such experiences negatively defined their self-identity by instilling feelings of worthlessness and accentuated their sense of ontological insecurity. For example, Ali admitted that he felt 'disgusting, an absolute nothing' and that every time he closed his eyes before trying to sleep he just had the phrase 'you are nothing' stuck in his mind. Similar feelings were shared by Charis. Asked whether he would consider getting involved in a romantic relationship, he responded negatively and when I asked why, he replied:

> I know I should but we are going through difficult times and everyone is looking to secure their future: find a house and have some money. To have a relationship you need to have some savings. Can any relationship work like this? I am not a human. I have no house, I sleep on the street. I am spending my day from organisation to organisation. What woman would like this? Would you date a homeless person? I bet not.

The overwhelming majority of my participants employed the phrase 'I am not a human' in their interviews. In Greek, this phrase denotes the idea of not qualifying as a full human being. Often used in everyday language to juxtapose people with animals, the phrase 'I am a human' implies the former are superior to the latter. In contrast, the phrase 'I am not a human' denotes that one has lost human dignity to such an extent that one has become worthy of disdain and contempt from others. To show his need for being treated with respect and dignity, Makis explained how someone becoming friends with him on Facebook makes him feel accepted like 'a normal human being again'. Hartmann (2014, p. 655), who studied the use of social media by homeless people, argues that through creating a virtual social network, a sense of belonging and privacy, social media allow

homeless people to engage in a form of 'homing'. This digital 'process of creating a home in the sense of a safe environment' as a basis for ontological security' (ibid) appeared to function as a way to overcome systemic problems outside the control of homeless people and get a sense of home.

Despite the use of social media by a small minority of participants, the lack of home engendered feelings of ontological insecurity and dehumanisation. Seltser and Miller (1993, pp. 93–4) explain that homeless people are 'individuals without a future, without a project, without hope'. Therefore, their self-identity is crucially disrupted, resulting in ontological insecurity. Seeing no positive prospects of escaping homelessness (see Chapter 4 regarding the process of being housed in an accommodation space) increases feelings of fear, solitude, loneliness and rejection. Often describing their situation as unbearable, the mental health of homeless people was affected. For Mr Nasos, this presented itself through the consumption of large quantities of alcohol. He reflected on the reasons behind this habit:

> I do it to drown my sorrow in it [i.e. the wine]. What I am going through is very tough. Inside, psychologically it is a big burden. If you can understand me, do so. It is a burden. It is not pleasant for me. If I had a way to escape this situation, I would find a better place to go. Some people have told me to go to their house for one night to sleep and have a shower. I am not sure they even mean it but even if they do, one night will not make a difference. I will be out again the following day and I will also have lost my spot, where everyone knows me.

This quote highlights the constraints and difficulties faced by rough sleepers and how alcohol is used as a coping mechanism to ease the pain of homeless people. Drug and alcohol consumption were discussed by some of my participants as a way of coping with all the emotionally painful aspects of homelessness, facilitate one's sleep and negotiate the difficulties and risks of the night. In other words, drugs and alcohol were discussed as ways of making the unsafety, angst and personal vulnerability of sleeping rough more bearable. This state of ontological insecurity was perceived by many homeless people as inescapable due to the deficiencies of care in Athens, leading many to acts of self-harm.

Emotions of guilt deriving from feelings of wrongdoing, and shame in relation to their self-perception further reinforced anxiety, self-blame and the internalisation of stigma among homeless people. Costas felt guilty for not being able to find a job.

However, when I reminded him of the unemployment problem nationally, he maintained that others who cannot find jobs do not get disappointed, but he 'was let down and resigned'. More emphatically, Andreas stated that 'when you find yourself on the street, it means that you have made some sort of mistake. It is never the case that you become homeless for no reason'. The sin-talk evident in some of the practices of the Municipality (see Chapter 4) appeared to be internalised by homeless people who, rather than attending to other contextual factors at play, took complete responsibility for their predicament. Feelings of inadequacy and shame for becoming homeless and the lack of agency to escape homelessness manifested in feeling trapped. This feeling led some of my participants to contemplate suicide. For Costas, suicidal thoughts resulted from not finding a solution and having to cope with immense emotional and practical difficulties. Not finding any worth in one's life and an escape from the deep existential anxiety underpinned by being deprived of place they could call 'home', made some of these rough sleepers view suicide as a way of putting an end to this unbearable situation.

Gendered Aspects of Negotiating Homelessness and the Landscape of Care: The Experience of Homeless Women in the City

In addressing the question of shared fragility and conceptualising the landscape of care as a space of shared vulnerabilities, this section will illuminate the experiences of homeless women. Because of additional forms of vulnerabilities, the journeys of homeless women were much more complex and characterised by a particular kind of loneliness and solitude. This stemmed from a dialectical relationship between them and the landscape of care, which ultimately rendered them invisible from agents of care in the city. This was shaped by the conscious efforts of women to remain hidden so as to reduce the likelihood of victimisation and by the lack of a tailored approach among outreach teams to detect and provide care to them. In contrast to men who in my research were primarily located in the city centre, almost all of my female participants preferred areas on the outskirts of the Greek capital, situated further away from care organisations. In central Athens, accommodation could be more easily secured for women both because they were proportionally fewer than men and because certain organisations focused solely on caring for women. However, homeless women preferred concealed locations in order to reduce a fear of victimisation which is frequently experienced by them because of lack of protection in the public space (Nyamathi, Leake and Gelberg, 2000). Therefore, connections with women were more difficult to establish, and women were more likely

to remain undetected by outreach teams, who would only go to the suburbs to find a specific person reported to them, and if they had a car.

The journeys of Chloe and Gianna from the time they were rendered homeless until they found a space they could call 'home' are revealing in terms of the gendered experience of homelessness, care receiving and the city. As a result of a fear over their physical safety from exposure to strangers and their efforts to secure a space of sleep, the lived experience of homelessness was for women much more compound and multi-layered. Chloe was 68 years old, born and raised in Psychico, an upper-middle class suburb of Athens, where she owned a clothes shop. Although she fought to keep her shop open, in 2011 she received two large bills one for tax and another from a bank. As she had mortgaged her house in order to buy the shop but she was unable to pay it, the bank possessed and sold her house. Since that day, Chloe had various experiences of homelessness and occupied several spaces in the city to secure sleep for herself. Initially, she slept on a bench in a small square close to her shop. For a week, she slept on this bench protected by her dogs, who provided her with company and safety during the night. She admitted feeling terrified of being raped, robbed or even killed. Her love for her dogs was so strong that they, rather than herself, became a priority in terms of securing food. For this reason, some portions of food given to her by a restaurant owner went to the dogs. A week later, a former client of hers passed by coincidentally and recognized her. To help her, she suggested Chloe stay in a storage room and in exchange look after her mother. Chloe was also allowed to keep her two dogs, which for her was non-negotiable, and she started working as a carer for elderly and infirm women.

In the following months, she eagerly tried to find a more permanent job. However, this job search was full of emotional challenges, disappointment and desperation. Although in most cases phone calls with job advertisers the response was 'I will get back to you', one of them explained to her: 'Let me be honest. You have a serious problem. My lady, you are at an age that you can't help us. You are at an age that you yourself might be in need of care very soon'. Understanding the effects of her old age and the high unemployment rate made her fully realise that 'things were very, very tough' and there were no work prospects for her. Being convinced that without work she would not be able to escape homelessness, she attempted suicide. She had already put her leg over a terrace rail when one of her dogs pulled her back at the very last second. After

recovering from the shock and desperation, she made the decision she would do everything to survive. Soon after, she coincidentally heard a 'Big Issue' advert on the radio. After calling and getting once again the response 'We will get back to you', she spent a 'torturous' week waiting in agony. She described this week as a 'real martyrdom', and she likened it to the day the auctioneer came to value her shop. To stop this unbearable pain, she called and demanded an answer. They replied they were happy to have her as vendor and ever since, she worked as a 'Big Issue' vendor, while continuing staying in the storage room.

A year later, in 2013, she managed to save enough income to rent a studio flat. There, she was able to have a home-like space where she enjoyed some privacy and independence and had 'her flowers, her pots and her two dogs'. Sustaining this home was not easy, as her income from the 'Big Issue' varied between 300-400 euros monthly and up to 500 at Christmas and other holidays. Suffering from lung disease, much of her income went toward medicine and some went to buying the magazines. The 'Big Issue' had given her two essential things of existential importance to her: a support network and a home. This support network provided her with dignity and security, as she felt that someone would take care of her and was assured that any problems would not be left unnoticed. In her own words, it gave her 'the certainty that I exist, that I am not a surplus, a left over in my own life'. On the other hand, this home served as a secure and stable basis to return to after work, but also as a space around which she built a routine of looking after her dogs, developing her personal interests, such as reading, and rebuilding her social life. Such day-to-day activities can protect one from anxiety and a sense of threat that was so prominent in Chloe's time of sleeping rough. In other words, this space enhanced her sense of ontological security.

Gianna, who was 53 years old when interviewed, had a different story. Her biological mother had abandoned her, and she had been brought up by her godmother. During her childhood, she had limited contact with her biological mother, limited to occasional visits where the latter pretended to be her aunt. Gianna described her mother as very 'harsh' and as someone who 'despised me'. Eight years before our interview, the death of her godmother and her biological father, rendered her without any support network. Although she was trying to survive on her own, two serious operations left her unable to work and with no income for a house. Traumatic events like the ones prevalent

in Gianna's life are both understood as a predictor of being at risk of homelessness (Ravenhill, 2008) and as a factor regarding one's ability to attain ontological security (Giddens, 1991). As a result, when thinking about home, homelessness and ontological security, one's life history explains how one is rendered ontologically insecure. For Gianna, such feelings were present since childhood, but were further triggered by other life events and reached a peak during her time being roofless.

Gianna's first location as roofless was on a beach close to Athens where for a short period of time she used the sunbeds to sleep. However, when winter arrived, the sunbeds were removed, and the restaurants providing her with food and a limited support network closed. Subsequently, she moved to two suburbs of Athens, Pagkrati and Imitos, two areas she knew well, because she had friends there who were aware of her sleeping rough. She spent that year as 'a rambler' moving from place to place. During this period, her spaces of sleep varied, and she was exposed to the elements and potential violence. She was either sleeping on a bench or in a makeshift construction of three carton boxes and some bed linen. To access toilet facilities, she went to McDonalds. Gianna's predicament has been described by 'rootlessness' and 'a lack of abode' (Somerville, 1992). Both are understood as the opposite of two of the six key signifiers or dimensions regarding home. The former denotes a condition of homelessness characterised by ontological insecurity and a feeling of being lost. The latter signals an experience of spatial insecurity. To alleviate such feelings and gain some protection, she befriended five dogs who looked after her during the night.

Gradually, she became friends with a coffee shop owner and asked him whether she could spend the nights in his shop in exchange for cleaning and serving the dishes. This coffee shop served as the most secure space of sleep she had had in more than a year. Notwithstanding, her sleep lasted an hour and a half as the last customers left at 3.00am and the shop opened at 5.00am. Applying for unemployment benefit with the help of a friend gave her a more stable income. It was then that she approached her biological mother, and despite their traumatic past, she hesitantly asked her whether she could stay with her. Her mother agreed in return for 100 euros a month. Since then, they had lived together in a place that for Gianna was what she called home at the time of our interview. Because her mother's pension and the unemployment benefit could not cover all their expenses, she agreed to marry a foreigner, who wanted a Greek citizenship, for

1,000 euros. She had mixed feelings about this decision as 'life forced her to make' it, but when later she could not afford legal assistance to get a divorce, her regret started to grow. While staying with her mother, she managed to get work as a municipal cleaner on a fixed 8-month-contract. These eight months allowed Gianna to buy essentials for herself and their house, such as eyeglasses, a bed and an oven. Yet, after this job ended, Gianna started earning some income through 'the little cans'. For this reason, she spent her day walking from the centre of Athens to a recycling factory two hours away on foot and searching anything recyclable in rubbish bins on her way there. For 75 cans, she received 1 euro back and on average she was earning 20-30 euros per week.[51]

Both Chloe's and Gianna's stories reveal gender differences regarding the experience of homelessness and in relation to their exchanges with the landscape of care. Although relationships between men did not involve trust, being in close proximity to one another provided a layer of protection. In contrast to men who remained in the city centre during the night and visited organisations in the daytime, homeless women had a much lonelier experience of homelessness. As Chloe and Gianna describe, their first days were characterised by constant threat and a fear of exposure to violence. To minimise this risk of victimisation and not draw the attention of strangers, they actively tried to remain hidden in locations with lower levels of criminality outside the city centre. The ensuing solitude they endured was particular in the sense that it constituted a self-imposed survival strategy protecting them from physical risks. Nevertheless, this isolation also estranged them from care providers, such as outreach teams who could not trace them and provide support. Their increased spatial mobility also played a role in their remaining under the radar of organisations, as they often changed locations whenever they felt unsafe or had the opportunity to occupy safer spaces, such as the room offered to Chloe by one of her former customers or the coffee shop offered to Gianna. Hence, negotiating homelessness and the city, women were more likely to experience a complicated journey on an emotional and spatial level interwoven with additional forms of vulnerability, fears and limited access to care spaces.

[51] I asked whether she had considered becoming a 'Big Issue' vendor but she explained standing for so long was not for her because of her health issues and her busy schedule of visiting organisations and caring for her mother.

To alleviate this sense of solitude and increase their protection, pets became a crucial ally offering protection and reducing their sense of loneliness. In addition, Labrecque and Walsh (2011, p. 89) argue that having a companion-animal gave homeless people motivation, a sense of accountability and a feeling of being needed. Chloe spoke about her relationship with her pets, which offered her both care and companionship:

> I always had this view but now it is even stronger. The one who is weak and vulnerable, we should not throw them out to the street or give them a kick so that they go even lower. I have had these animals many years. One for fifteen years. The other fourteen. I have been through everything with them. Now that they are old, I cannot just throw them out to the street. I would never be able to do what these people who leave their pets out on the street do.

Chloe's words explained why her dogs were a priority for her. When no one else was there for her, these dogs were both her link to the past and the only ones looking after her during her time sleeping rough. Her words are also reflective of her relationship to her own self, as both Chloe and her dogs shared vulnerability because of old age and common memories, linking her to her past self. In addition, the possibility of abandoning dogs out in the street is reminiscent of how homeless people might be feeling after being on the street without sufficient care. She even maintains that her sentiment of not abandoning whoever is vulnerable, including her old dogs, has grown stronger after she became homeless herself. In terms of the landscape of care, this reveals an additional exclusion in relation to available spaces of sleep for homeless owners of pets, as pets were not allowed in accommodation spaces. The relationship Chloe had with her dogs and the care she received from them provides an explanation behind the unwillingness of homeless people to abandon their pets if and when a space at a hostel or shelter becomes available to them.

For both Chloe and Gianna, the process of securing a space they can call home came with significant exchanges and a loss of personal independence. Chloe had to work under difficult and precarious conditions. Despite her immense gratitude towards the 'Big Issue' and its employees because of their constant support and care for her, it was in many cases that her earning an income depended on being exposed to the weather and various forms of risk. For example, she said:

> Two years ago, a panhandler stole my bag. And I did not only have the rest of the magazines in it, but also all of my money. Everything I had to take care of my animals and to get food for myself. It was 70 euros. A huge amount for me! And they stole all of my papers, my medicine, everything. He was dragging me so strongly and although I was yelling for help, no one came. As I say this, I am indeed ashamed of the human race.

This was the second time that Chloe had been a victim of theft and violence, with all of her earnings and possessions disappear. While fears of theft were prevalent among all my participants, homeless women were also scared of physical attacks and being unable to defend themselves. To engage in money earning activities, homeless women were often in the public space on their own and in danger. Therefore, Chloe's ability to retain her home and a sense of privacy was preconditioned to taking the risk of being attacked or robbed while selling the magazines. Aware of how unlikely it was to find a different job and grateful for the support network and the home the 'Big Issue' offered to her, she was willing to make this compromise.

To maintain her house and provide for herself and her mother, Gianna engaged in an exchange of getting married solely for financial reasons. Interestingly, while many women enter homelessness as 'escapers' (Johnson, Gronda and Coutts, 2008) from conflict and domestic abuse, for Gianna it was homelessness and the resulting lack of financial resources that made her lose a great deal of personal autonomy and independence. This account further stresses the importance of ontological security in relation to experiences and meanings of home amongst homeless women. Despite Gianna's exchange of getting married to afford rent, she was faced with an improbable dilemma of not being able to cover the legal costs for divorce, making her feel trapped in this situation.

The resulting loss of independence and sense of ontological insecurity were further reinforced by structural reasons that related to one's employment status. The short-term and fixed-contract nature of Gianna's employment as a municipal cleaner did not let her escape the precarity she experienced prior to this job. Therefore, while her income allowed her to purchase basic appliances for her home, after the end of her contract she remained unable to file for divorce or pay rent. To retain her home and cover living expenses, the physically exhausting and financially uncertain form of work through the 'little cans' was her only option. Similar to Chloe, Gianna's uncertain income made it

impossible for her to secure stable housing. Therefore, she also experienced a reduced, yet continuing, sense of ontological insecurity. Thinking about the unique vulnerabilities and the experience of homelessness among women characterised by an intense form of solitude is especially significant. These obstacles reduce the likelihood of women to resolve homelessness, which often results in having 'unstable mental health […] and access support services on an as-needed-basis and in a revolving-door manner' (Finfgeld-Connett, 2010, p. 466). Unable to address their needs, women's position as homeless can be crystalised and their urgent need to receive care could be left unnoticed.

The Making of a Home in a Train Underpass: In Search of Ontological Security Outside Institutional Life

A number of different spaces in the city showcased the desire of homeless people to create homes for themselves in the public space, outside institutional life. The existence of these spaces was revealed through outreach work not in the city centre, but in the fringes of the centre, where locations were not as exposed and criminality not as pronounced as in the inner-city. Spaces under bridges and disused abandoned arcades were utilised by homeless people to construct their homes. Both a municipal outreach worker in informal conversations and a municipal official in a formal interview explained that such spaces emerged in the city as some homeless people chose homelessness 'as a lifestyle choice'. This phrase echoes Arapoglou and Gounis' (2017, p. 98) finding that a municipal outreach team member claimed that 'street work 'proved' that the homeless are 'homeless by choice' (see also Chapter 4).

Despite the views held by some municipal workers, such spaces need to be understood both as a desire to attain a sense of ontological security through the creation of home-like spaces and as ways of circumventing regulations, exclusions and deficiencies imposed on homeless people by the landscape of care (see Chapter 4). As Moore et al. (1995) explain, being homeless in a squatter settlement enables a range of activities, which hostels limit. Through claiming and decorating their own personal space, homeless people can experience qualities of home, such as feelings of independence, control and security and an expression of their identity. Browning (2016) argues that 'when the security of 'home' is lost, when home no longer feels like home, or one's belonging in the communal home is questioned, then people may begin looking for alternative homes in order to

provide a sense of ontological security'. Viewed through these lenses, such alternative homes provided homeless people with a way to respond to a care need not met in formal accommodation spaces. These spaces constituted an attempt to create a stable base of privacy, autonomy and control and manifest the persistent desire of homeless people to attain ontological security. Canter (1983) argues that the desire for home is a goal toward which people behave in a purposive manner. Following Duneier (2000), I explore George's home by investigating the 'overall logic' and the perspective of homeless people in relation to the meaning they attribute to such spaces serving as alternative homes and the role such spaces play vis-à-vis ontological security.

George's[52] home (Figure 15) was located in a train underpass on the outskirts of the city centre, approximately a twenty-minute drive from the Municipality. I visited this space with the municipal outreach team on a cold December day after multiple phone calls from citizens. According to neighbours, George was Greek and approximately forty years old. His house took up most of the space on the two sides of the underpass, allowing only a thin pathway for passers-by. Although George was not there, the space and the various handwritten signages functioning as urban traces told a story about him and his personality. As shown in Figure 15 rather than just claiming a space solely for a mattress or a sleeping bag, like most homeless people in the city centre, George divided it into smaller spatial sections centred around certain furniture. Each section served a different function, just like they would in a home. The space around the bed resembled the bedroom (Figure 16). At the head of the bed, makeshift shelving provided a space to store things. A type of living room was created through the presence of an old armchair. Next to it, a small Christmas tree with a signage wishing passers-by Merry Christmas decorated the space in the Christmas spirit. On top of the armchair hung a string on which clothes were drying. Across the armchair at the end of the bed, the rest of the furniture made up the living room consisting of a makeshift table with a glass surface and an ashtray, another stool, and a plastic storage box on which a note with the word 'Glasses' was written. Finally, behind the makeshift shelving, a space for cleaning materials, a mop and a basin, was located across a storage cupboard (Figure 17).

[52] I revisited the spot and received his permission to use these pictures in my thesis and other publications, explaining they would be publicly available.

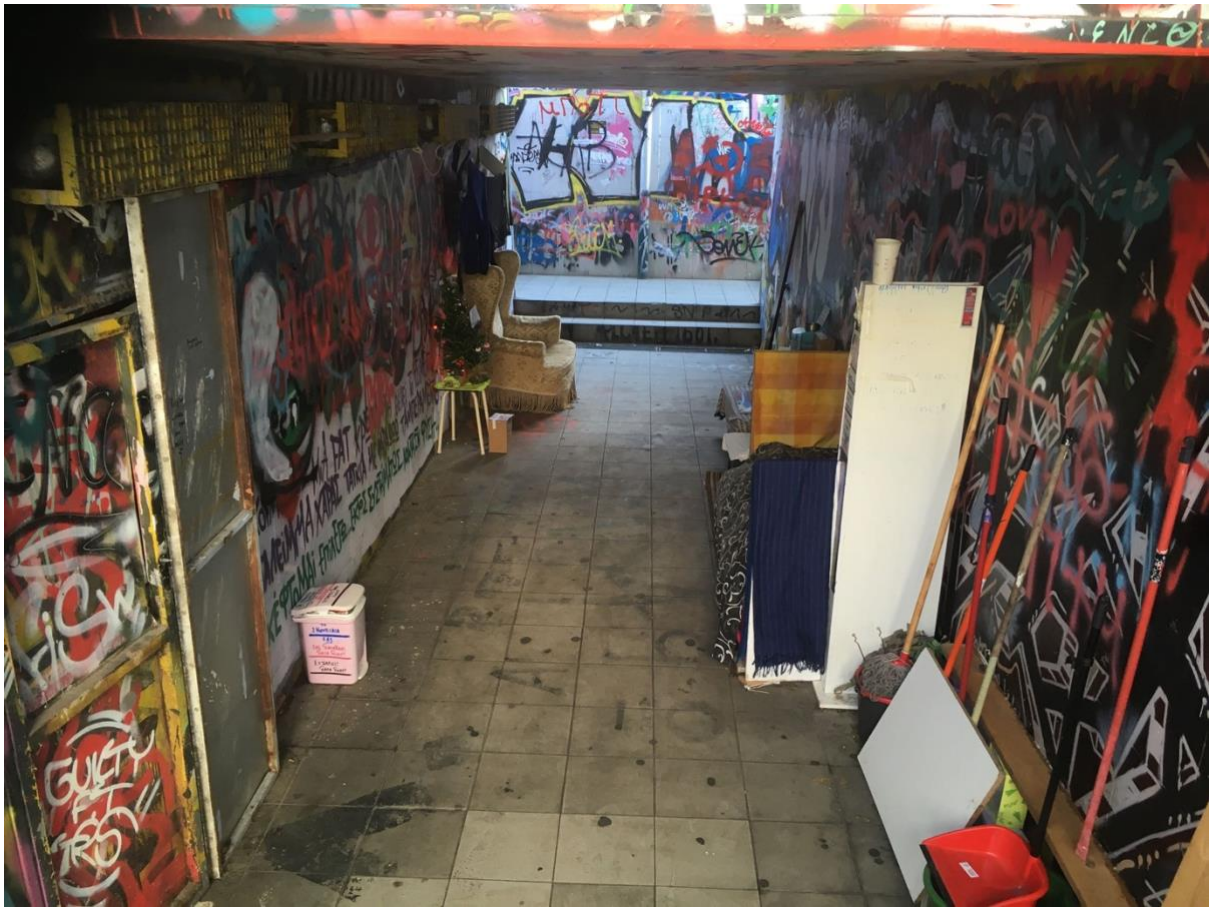

Figure 15. George's home

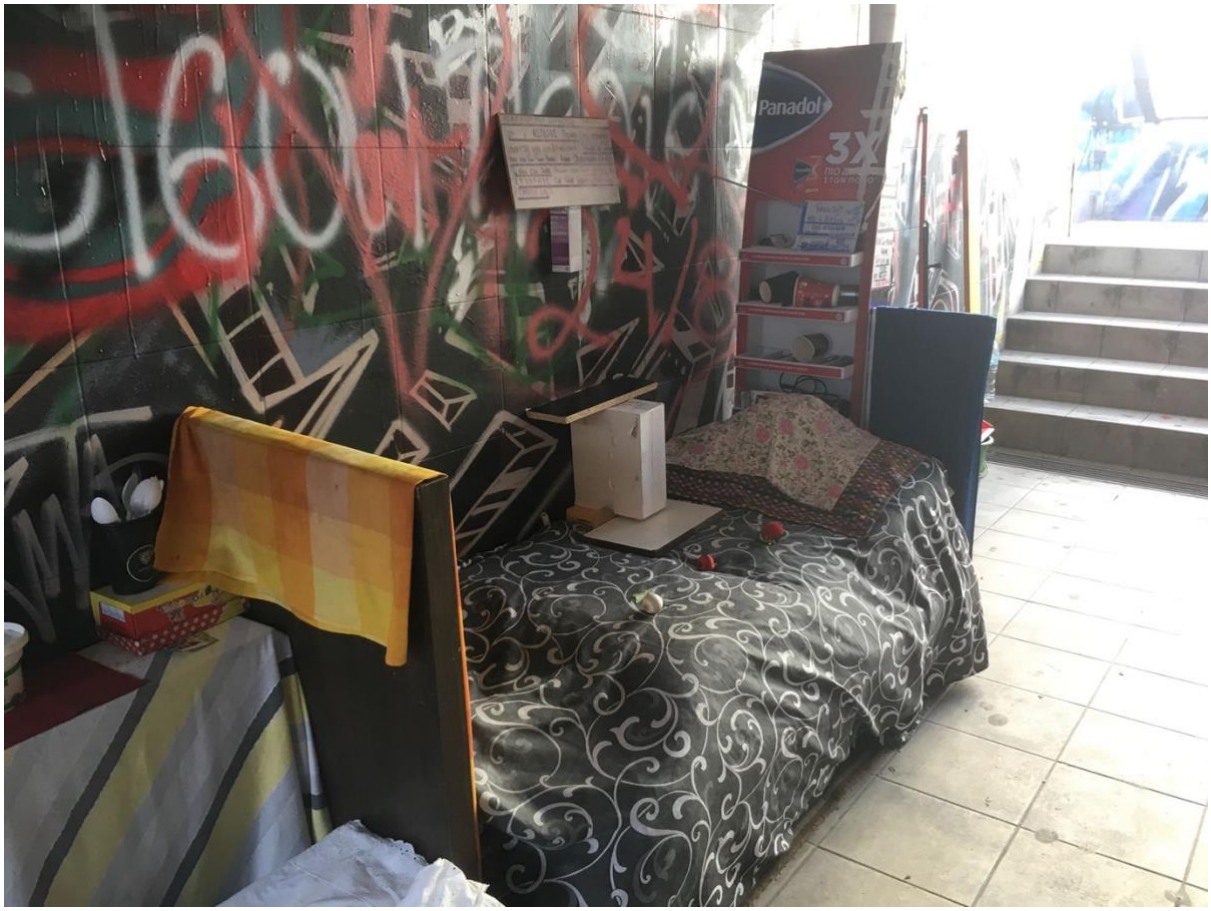

Figure 16. George's bedroom

Figure 17. George's Storage Space and a Sign

'Whoever dares to rob a homeless person, is committing a sacrilege. In essence, he is stealing…his...own mind!! I have no hard feelings, because I would like to think you are also a homeless person'

This home-like space answered to many of George's needs while independently searching for ontological security. First, claiming this space and turning it into a home

where he could store his belongings allowed him to gain a degree of control and privacy and, as a result, secure a sense of belonging and a degree of autonomy. A sense of stability in day-to-day life enhances a sense of ontological security through the autonomy of bodily control and establishing predictable routines. To this end, George created different areas, where he could engage in and move between different activities, such as cooking, reading, sitting, sleeping, and doing the laundry. An important aspect of this space, illustrating the value it signified for him, was the detail that had gone into the decoration and the carefully written signage. Dupuis and Thorns (1998, p. 36) explain how decoration is associated with being able to control the environment of a space by adapting it in a way that suits oneself. All these elements were vital in reconfirming George's sense of being in the world. Finally, the construction of this space suggested the wide range of skills George employed. His ample imagination in painstakingly collecting and assembling a variety of furniture and small items was ever-present in this space. This space manifested a high level of agency and his determination to create a home-like structure, which could not be secured through the landscape of care. Such spaces in the city reveal the multiple experiences of rough sleeping and the active efforts homeless people make to engage and navigate homelessness. The process of 'becoming, being and moving on from homelessness' is a meaningful one and involves an active management of various situations (Rivlin and Moore, 2001, p. 329). For George, this meaning entailed claiming a space for himself. To this end, on the inner surface of the storage cupboard door, he introduced himself (Figure 18). In marker, two phrases were written on the door: 'George the Homeless has lived here since 28/11/2017' and slightly higher, 'Help to the Homeless'. For George, this space appeared to be strongly interlinked with an expression of his own identity. This homelike space functioned as a platform to communicate to passers-by various messages about himself, his situation and how he wanted to be perceived by others. In the following pictures, some of the signage, evident in various corners and on furniture are presented.

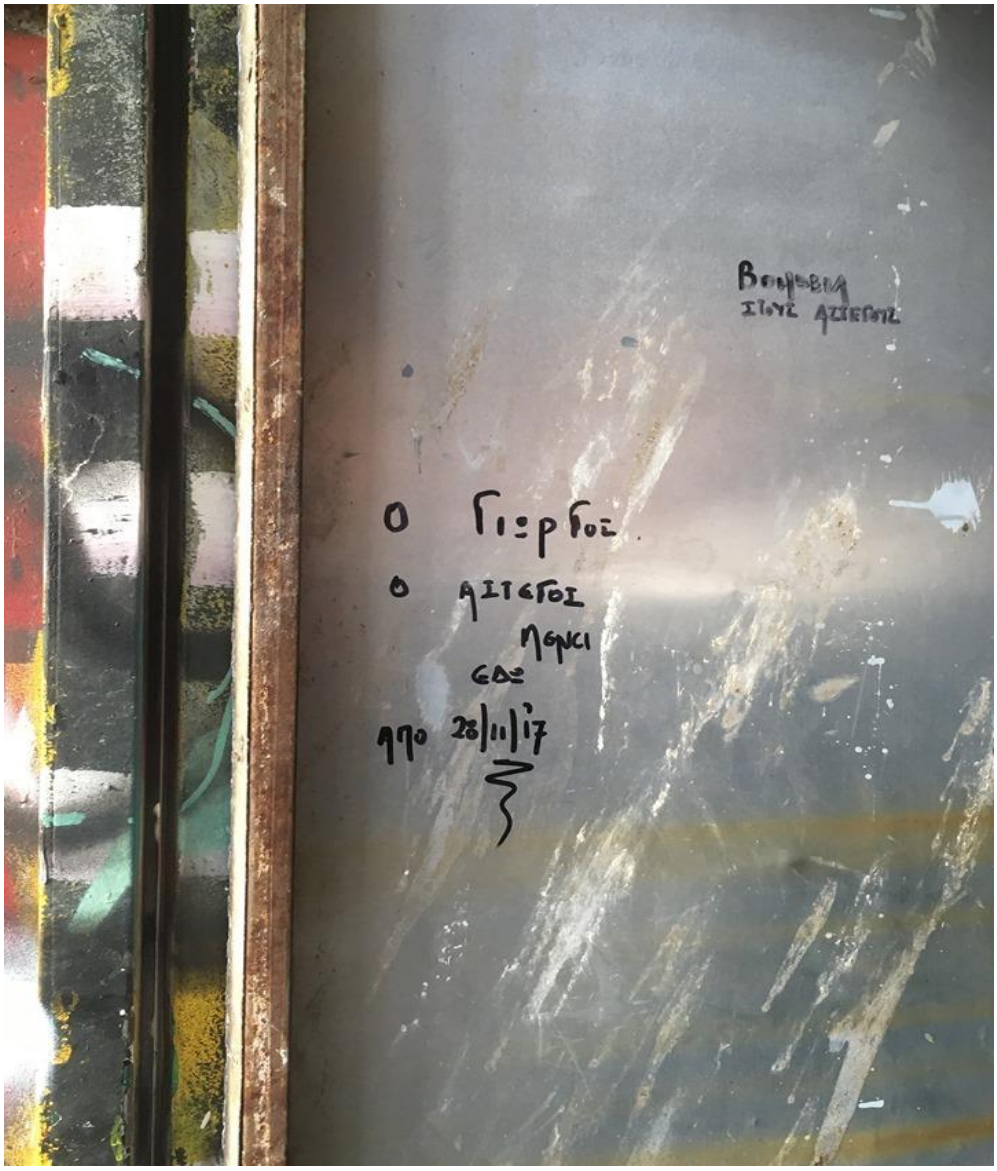

Figure 18. George's 'signature'

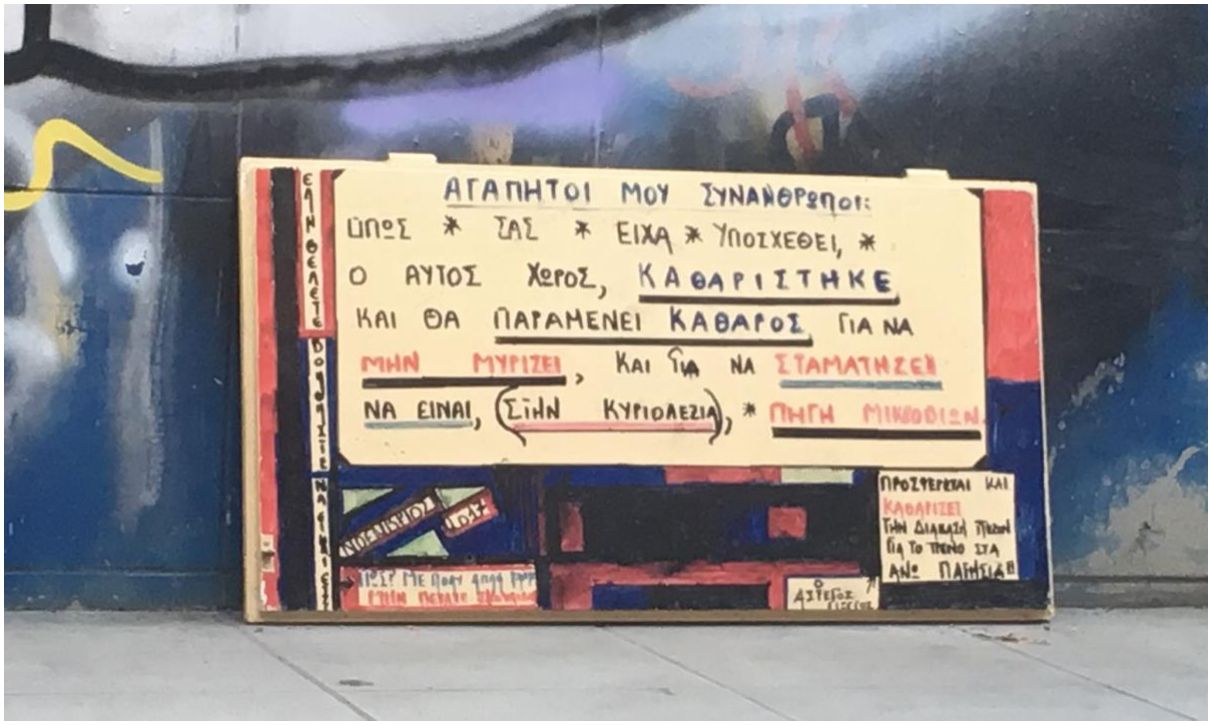

Figure 19. One of George's signages

Translation:

MY DEAR FELLOW PEOPLE,
AS * I * HAD * PROMISED * YOU,
THIS SPACE HAS BEEN CLEANED
AND WILL REMAIN CLEAN SO THAT
IT DOES NOT SMELL AND SO THAT IT STOPS
BEING (LITERALLY), * A SOURCE OF GERMS

THE HOMELESS GEORGE
HAS OFFERED TO CLEAN
THIS PASSENGERS' UNDERPASS
UNDER THE TRAIN LINES IN
ANO PATISIA[53]

PUT SIMPLY,
DO NOT THROW RUBBISH

NOVEMBER 2017

[53] The name of the area the underpass was in.

Figure 20. Next to the signage shown in Figure 19, the rubbish bin of George's home
Translation:

PLEASE THROW
ALL RUBBISH HERE
PLEASE

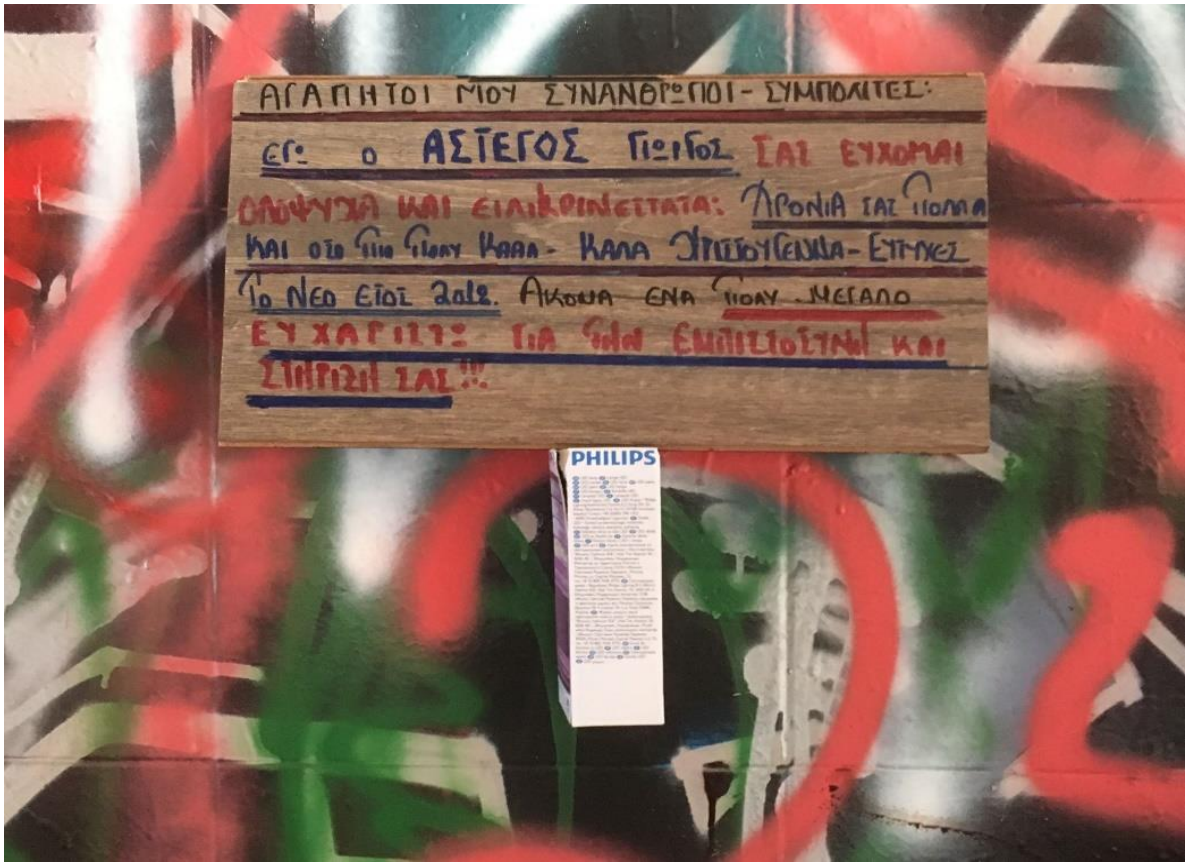

Figure 21. One of George's signages sending wishes to passers-by

Translation:

DEAR FELLOW MEN – CO-CITIZENS,
I THE HOMELESS GEORGE
WHOLEHEARTEDLY AND MOST SINCERELY WISH YOU:
MERRY CHRISTMAS
AND ALL THE VERY BEST – HAPPY CHRISTMAS – WISHES FOR THE NEW YEAR 2018. WHAT IS MORE, A VERY BIG THANK YOU FOR YOUR TRUST AND SUPPORT!!!

Figure 22. George's Christmas Tree and wishes on signages

Translation:

GOOD MORNING AND HAPPY HOLIDAYS
IF YOU WISH, SOME SMALL HELP FOR THE…
NECESSITIES FOR THE HOLIDAY SEASON
AND FOR CHRISTMAS (GEORGE THE HOMELESS)

ON A MORE GENERAL NOTE
I THANK YOU
ONCE MORE
FOR EVERYTHING!!

Figure 23. George's glasses case and storage boxes and on top of them wishes on cardboard

Translation:

GLASSES	ATTENTION!! I GEORGE SINCERELY AND WHOLEHEARTEDLY WISH YOU HAPPY HOLIDAYS AND MERRY CHRISTMAS WISHES FOR THE NEW YEAR YOUR DREAMS, MY WISHES

The above pictures reveal various aspects of George's presentation of self. Firstly, this space underscored how bound his own identity to being homeless was, as in various signs, he calls himself 'George the homeless' or 'the homeless George'. Kinnvall (2004, p. 748) argues that as one's ontological insecurity increases, one attempts to 'securitise subjectivity' and adhere to one stable self-identity. Similarly, Snow and Anderson (1987) have coined the term 'embracement' to denote one of the stages of identification among

homeless people.[54] Embracement refers to 'the verbal and expressive confirmation of one's acceptance of and attachment to the social identity associated with a general or specific role, a set of social relationships, or a particular ideology' (ibid, p. 1354). The construction of this space and the strong presence of signage all related to George's presented self-identity as homeless. Except for securitising his own subjectivity as a homeless person, this could be perceived as a defensive strategy around the messages he wanted to communicate to passers-by or institutions. For example, the phrase in Figure 19 shows the complexity of how such spaces can be used to negotiate stigmatizing attributes such as the dirt and bad smell associated with being homeless. The reaction of the public regarding George's home was twofold. While some phone calls to the Municipality highlighted that passers-by feared going through the underpass at night because of George, others called to express concern about his wellbeing and asked the intervention of the Municipality to protect him. Similarly, passers-by at the time of the municipal visit expressed respect and care as well as disgust and a sense of danger. By keeping this space clean and tidy, George appeared to increase his chances of keeping neighbours' complaints at bay.

Additionally, this strategy protected his space from the landscape of care's hygiene control regulations. Specifically, when a homeless person claimed a space and had a lot of belongings, the municipal outreach team produced a report stating that a 'source of infestation' with 'risk to public health' had been observed. Subsequently, the municipal cleaning services would remove all of one's belongings. In this sense, George's place-making process involved 'making sense of, inhabiting and/or modifying the physical form and content of a particular place' (Thanem, 2012, p. 444). Such practices can be viewed as a form of spatial micro-resistance vis-à-vis the controlling aspects of the landscape of care. In his work regarding coping and resistance strategies to urban planning, Thanem argues that homeless people employ various spatial tactics to 'fragment and subvert the strategies of city officials, business owners and other dominant actors' (ibid). Similarly, George resisted the possibility of social control manifested in the removal of his belongings that could be imposed on him by the Municipality. In addition, through micro-practices of impression management (ibid), he presented himself as someone not complying with stigmatising aspects of homelessness. On the contrary, he went to great

[54] According to Snow and Anderson, the other stages of identification are 'distancing' and 'fictive story telling'.

lengths to stress the opposite: appearing harmless, kind and understanding regarding cleanliness in a public area. In this way, he managed to survive in a relatively private space protected from the weather. Despite demonstrating a level of agency and various skills, some days after we visited the spot, the municipal cleaning services ultimately removed George's belongings on the grounds of creating 'a source of infestation' 'posing risks to public health'. This was a form of urban social control that neglected the efforts, time and meaning behind George's space. Hence, the sense of ontological security he was searching for was ultimately denied to him. The importance this space had for George was revealed two weeks later, when George returned to the same spot and started creating a home for himself again.

Such forms of banishment constituted disciplinary practices and appeared to be part of the overall structure of the landscape of care, as they were initiated by the municipal outreach team and the report they composed. In particular, the fact that the municipal team visited locations after complaints or phone calls from residents seemed to be linked with Herring's (2019b) complaint-oriented policing of homelessness in San Francisco. In this approach of criminalising homelessness, the police operated within a broader bureaucratic field of poverty governance and the regulation of homelessness was the result of a crisis of complaints by callers, politicians and organisations. In Athens, this role was taken up by the municipal outreach team, grafting elements of control and policing onto its caring role. As all visits conducted by the municipal outreach team were initiated by citizens, its interventions were limited to either providing information for available resources or the removal of one's belongings. Such practices reveal two conflicting perspectives regarding the ontology of home. On the one hand, the official perspective of the Municipality viewed this space as an illegal home, not adhering to its formal criteria of what constituted a home. On the other hand, George considered this home-like space a way to gain a sense of ontological security and a level of control, privacy and autonomy. As a result, such spaces reveal two opposed understandings of home: the normative one, adopted by the state, and the alternative one, adopted by homeless people. It is on the basis of negating this alternative perspective of home that the landscape of care activated its controlling and disciplinary practices, and the municipal outreach team produced reports for the destruction of such constructions (see Chapter 6).

Homeless people in Athens were brought to a dead-end. On the one hand, the landscape of care was unable to provide them with a home and the ensuing sense of ontological security. On the other hand, one's personal belongings were likely to be identified by the municipal outreach team as a 'source of infestation'. Therefore, rough sleepers, like George, were obstructed from independently attempting to attain a sense of ontological security through collecting the necessary items that would allow them to create home-like spaces outside institutional life. This dead-end led to further marginalisation on an emotional, material and existential level, as rough sleepers were stripped of one of their few chances to provide themselves with a sense of home. Consequently, the only option amongst many rough sleepers was to move to the city centre and sleep rough with limited personal belongings. While their access to organisations was easier there, in the inner-city criminality and exposure to violence were pronounced. Therefore, there, their sense of ontological insecurity would be more heightened. In this sense, the landscape of care pushed homeless people to more extreme forms of marginality characterised by higher degrees of ontological insecurity and material deprivation. This explains how the emotional wellbeing and the decreased morale experienced by some homeless people regarding their chance to escape homelessness were conditioned to wider systemic aspects of the landscape of care and the interactions of homeless people with various agents.

Conclusions

This chapter has argued that homelessness is shaped by the deficiencies of the landscape of care. The regulations of the landscape of care and its interactions with homeless people positioned them differentially by gender and age in urban space. While in certain cases risk factors, such as childhood traumatic events, may result in the loss of one's sense of security, this chapter has suggested that ontological insecurity and emotions of fear, anxiety and loss of privacy are further shaped by the wider conditions of the landscape of care which deprived many homeless people of a home. Through exploring different experiences and conditions of homelessness, this chapter has revealed that ontological insecurity is a crucial part of one's becoming homeless. Rather than thinking about routes in and out of homelessness – as most of the literature does, the findings of this chapter suggest that it might be more accurate to think about routes *through* homelessness. Indeed, many of the accounts reflect that homeless people move between being completely roofless and having places in accommodation spaces or even

a home. Regardless of the status, routes through homelessness are defined by different degrees of ontological security, gender and geographies.

Rough sleepers experienced the highest levels of insecurity, lack of autonomy and privacy, material deprivation and feelings of anxiety and fear. The journeys of homeless women through the city were more complex as a particular kind of loneliness functioning both as a coping and isolating mechanism rendered them invisible from agents of care. In their search for ontological security without interacting with the landscape of care and outside institutional life, some homeless people engaged in homemaking processes on the outskirts of the city. Yet, such attempts were obstructed by agents of the landscape of care and the city. By entailing aspects of control and not providing tailored care, the landscape of care pushed homeless people to more advanced forms of material and psychological marginalisation characterised by a sense of ontological insecurity and associated feelings of worthlessness, powerlessness, loneliness, fear and distrust. These emotions shaped homeless people as recipients of care. As they defined their relationships with other spaces of care, they constituted a common obstacle care workers had to overcome in various spaces. In the next chapter, I discuss how relationships and exchanges of care unfolded at the city's Municipality.

Chapter 6

The Municipality:

A space of sustenance and basic provision

Introduction

While in the previous three chapters I dealt with the local and institutional scales of care, the next three chapters focus on the interpersonal scale and the relationships of care developing between individual care workers and homeless people in different spaces of care. Care ethics and the maintenance, development and enhancement of care relationships can provide a framework for reversing the emotional and material marginalisation experienced by rough sleepers. Both care ethics and social work theory have emphasized the importance of relationships between caregivers and care receivers or, in social work terms, between workers and clients (Biestek, 1961; Trevithick, 2003; Meagher, 2004). Inspired by the work of Auyero on benefit claimants in Argentina (2012), I wish to contribute to his analysis of temporal disciplining through processes such as waiting and systematisation of provision by expanding my focus, from the recipients of care to processes on both sides of the counter. Reflecting on both caregiving and care receiving allows us to see the dialectical relationship between them and how the conditions of care provision equally impact both care workers and homeless people.

I will explore the conditions of care provision in a public provider of care, the Municipality. Based in an old, imposing and spacious building close to Omonoia Square, between the Drama School of the National Theatre and an international medical NGO, it could be accessed through two different entrances. While the back entrance led to the biggest state-run soup kitchen in Athens, its main entrance leading to the municipal social services was located on one of Athens' central avenues. Every morning, hundreds of people queued at the back entrance waiting for hours to secure two food portions with the first serving at noon. The space of the social services was equally busy. It hosted the municipal outreach team responsible for the two hostels' accommodation applications (see Chapter 4) and the municipal social services responsible for donations, benefit and

other types of application. Having to respond to dozens of care recipients from many different groups, the care workers were overwhelmed with the practical, administrative and bureaucratic aspects of care.

The Municipality was central to the configuration of homelessness in Athens and was one of the first spaces visited by homeless people beginning to sleep rough. For this reason, it was there that the homeless people 'learnt' the rules and constraints of navigating the landscape of care and receiving care. Experiencing the pressures of insufficient space, large numbers of care recipients, limited resources and staff meant that care was restricted to basic provision. This encapsulated life-sustenance as well as bureaucratic and administrative support. The combination of pressure and placing care within systems of management, control and regulation had a negative impact on both care workers and homeless people. The former experienced a lack of creativity and power to control and oversee the passage of homeless people. Rather, working in a fragmented system, their encounters were brief and did not allow for identifying and responding to any needs beyond bureaucratic aid and life-sustenance. Homeless people experienced an assertion of power over their bodies and were rendered subordinate during their exchanges with care workers. In the case of the outreach team, this was achieved through its controlling processes, i.e. monitoring the homeless people and the spaces they occupied. In the municipal social services and the soup kitchen, disciplining processes resulted from socio-spatial systems of waiting creating uncertainty, disappointment and loss of control both in how homeless people spent their time in the Municipality and in their wider lives. As a result, waiting was an additional experience of subordination which already characterises homeless people's lives. The three main agents and spaces of the Municipality were the social services, outreach work and food provision at the municipal soup kitchen. Unable to provide care and adhere to care ethics, the Municipality's role was restricted to managing and regulating homelessness.

The Municipal Social Services

One of the spaces demonstrating how the landscape of care for homeless people intersected with landscapes of care for other vulnerable groups (see Chapter 3) were the municipal social services. Despite being located at the Centre of Athens Homeless Shelter, the municipal social services did not provide care exclusively to homeless people.

The municipal social services were primarily used by housed people, living in precarious conditions or unable to afford basic goods. Many would visit the municipal social services to apply for benefits, arrange bureaucratic issues or to register themselves at the social pharmacy and grocery (see chapter 3). Demonstrating the level of need and vulnerability at the time of the crisis, these spaces were responding to life sustenance and administrative support needs.

As was prevalent in the landscape of care, the municipal social services was a highly gendered space with only one male social worker out of the eight social workers. These were: four providing administrative support, two responsible for the hostel applications (see Chapter 4) and one responsible for outreach work. They were all supervised by an older female manager who was also based in this room. All were on short term contracts and although they had a social work degree, they had received no specific training for their role at the municipal social services. Rather, they had to learn on the spot how to adapt to the different aspects of their role and cope with the pressures.

The social services were open to the public from 9am to 3pm. Thereafter, social workers devoted the rest of their day to administrative work until the end of their shift at 5pm. Just before 9am, the first service users started arriving and formed a queue. Most care workers arrived twenty minutes before the beginning of their shift and used this time to socialise and discuss their personal lives: from their interests such as cinema, shopping and make-up trends to their romantic lives. This time for camaraderie was necessary for developing stronger bonds among care workers coping with the same daily pressures. As 9am approached, the atmosphere would get heavier and care workers began to sigh. To make it through the pressure-filled day, coffee cups had to be full. To lighten the mood, care workers joked with one another and asked: 'Who knows what we will see today and whether we will survive?' At times, people queuing would knock on the door, only to be told to wait until 9am, when care workers would open the door to the public.

At precisely 9am, a social worker who had taken up the role of managing and regulating the queue, asked everyone whether they were ready for the day to start. An affirmative answer led her to the door with a small pack of post-it notes. There, she wrote a number and gave one to each person in the queue. In number order, they were then allowed to enter. Throughout the day, the social worker taking on the additional task of

regulating the queue would interrupt her work every half an hour and go outside to distribute post-it notes with queue numbers. Outside, those waiting appeared anxious but also patient at the same time. Their conversations revolved around the documents needed for certain benefits and whether they had managed to get done what had been requested in their last visit. Those visiting for the first time asked those who had been in the past how long they had to wait. Most people spent over an hour waiting despite being uncertain of whether their reason for coming would be seen to. Resulting from a lack of personnel to respond to the number of service users, this type of waiting has been characterised as scarcity-based waiting (Gasparini, 1995, p. 32; Bailey, 2018, p. 12) and was part of a spatial sequence systematising the provision of care and engrafting it with regulation. While a few of those waiting were visiting to apply for a hostel, most of them wanted to see social workers to complete benefits applications or register for the social grocery and pharmacy services (see Chapter 3).

Although the exchanges between those visiting the social services and the care workers could serve as an opportunity for a further investigation of the former's predicament and needs, they were restricted to prioritising paperwork and the administrative and bureaucratic facets of care. In this context, no further relationships of care aiming at identifying and attending to deeper needs could develop. Emphasizing paperwork, rather than care relationships, can be the result of a trade-off between seeing everyone for a short time without emotional engagement or few with quality time. The provision of bureaucratic care resulted in the names, stories and vulnerabilities of those entering the space of the municipal social services either remaining unexplored or being briefly mentioned as part of completing sections of applications. Absorbed by their computer screen and going through files, care workers often disregarded the conversations between families visiting them or the details of their predicament. Instead, their focus was on understanding whether all the documentation and eligibility criteria for the applications were satisfied.

Despite the fact that in some cases traumatic events or difficult aspects of the lives of the service users were mentioned, the care workers briefly shared their understanding but quickly steered the conversation back to whether the individuals fulfilled the criteria for the benefit applications or other schemes provided by the Municipality. Tax statements, medical examinations, documents from disability and other

committees and certified copies of personal documents comprised part of a long list of required documents. The care workers seemed to know all of them by heart, presumably because of how many times they had to repeat them. Indeed, the names of documents was what dominated the conversations at the municipal social services. Many applicants missed certain documents or had misunderstood what was necessary. Therefore, before any further conversation began, care workers checked that all necessary documents were present. If documents were missing, their needs were not further investigated. Instead, the conversation stopped and applicants were immediately told to leave and return when their files were complete. As a result, conversations remained short and restricted to sharing financial, bureaucratic and legal information rather than focusing on the wellbeing of those visiting the centre.

For Yuill and Mueller-Hirth (2019), two different temporalities appear in social work: paperwork time and compassionate time. 'Paperwork time is linear, instantaneous and accelerated, requiring social workers to juggle multiple competing demands and needs. Compassionate time is more developmental and cyclical and requires slower engagement'(ibid, p. 1532). Paperwork time reflects the structural changes affecting social work in the neoliberal era of speed and high, competing demands. According to these authors, compassionate time encompasses a temporality following the rhythms of the care recipients' needs and practicing the craft and skills of social work. However, despite being desired by social workers, it often becomes 'subordinated and marginalised by paperwork and rendered as a fleeting and occasional experience' (ibid, p. 1544). By being required to prioritise paperwork and a bureaucratic perspective on care, the attention of municipal care workers shifted away from the relationships of care and a compassionate attitude towards the suffering and the precarious situations described by the care recipients. In his ethnographic study of Greek bureaucracy, Herzfeld (1992, p. 1) has argued that the state produces symbolic categories of insiders and outsiders, thus producing a 'rejection of common humanity', which he calls 'bureaucratic indifference'. Such categorisations appeared in relation to who could be seen by care workers and who not, and also who was deemed eligible for benefits and who was not.

To cope with the high number of service users and the overwhelming number of different tasks and responsibilities, care workers had no other choice than to view and conduct care work in an emotionally detached and often mechanistic way. In addition,

providing care in a fragmented system of care meant that even if care workers were willing to provide further care to homeless and vulnerable people, there was no continuity in the system of the Municipality. Rather than enhancing care relationships with the service users, what was required from them was the task of routine form-filling and a mechanical delivery service to those waiting. Hayley and Meagher (2004, p. 244) argue that 'the fragmentation and routinisation of social work and the concomitant loss of opportunities for the exercise of creativity, reflexivity and discretion in direct practice' are part of a de-professionalisation of social work. These characteristics also result in an increasing bureaucratisation of their work, a lack of professional autonomy and a loss of control over the progress of the service users.

Yet, in some extremely sensitive conversations the coping mechanisms of staying detached broke down, and a deep emotional engagement developed between the care workers and their service users. Such a moment was the exchange between a female care worker and a man in his fifties who was applying for a benefit. I still remember the disappointment in the man's face when it was confirmed to him that he was not eligible because his income was eight euros above the threshold for applying. In contrast to the usual reaction of care workers, this care worker shared her sadness. She explained how sorry she was and how she would love to have been able to do more. Such moments of empathy illustrate the feelings experienced internally by the care workers while externally responding to the workload of care in a professionalised way. They also exemplify that even when care is part of a formalised environment and restricted to a superficial response to bureaucratic needs, an element of human contact in care relationships endures.

Nonetheless, the lack of spatial resources and personnel did not allow the time and space for deeper care relationships to foster. Working in a crammed room where both social workers and service users were required to share desks and applicants did not have enough chairs to sit on meant that a space for confidential conversations was absent. In addition, the growing queue created an omnipresent sense of pressure for everyone in the social services. This queue also reveals the dilemma care workers found themselves in on a daily basis: either people would be kept waiting or the staff would not be able to devote sufficient time to each of the people visiting. In the end, each appointment lasted around ten minutes of paperwork time. During these ten minutes, neither the care workers nor I as a researcher were able to find out more about the service users. Rather,

most of them seemed to be eager to escape the social services as many had waited for over an hour by the time their appointment was over. While care workers were only able to provide care in a rushed way in order to see all those waiting, those seeking care experienced their visits at the municipal social services primarily as waiting time, as in the ten available minutes no meaningful exchanges or relationships of care were able to develop. These conditions further estranged the homeless people from the care workers and reduced the quality of care received by the former. Simultaneously, language barriers in the case of migrants, complex financial and bureaucratic issues and complex family and housing arrangements added to a sense of exhaustion among care workers who sighed or rolled their eyes after each service user left and before the next one was about to sit across them. These facial expressions are expressive of the burnout experienced by care workers of the landscape of care (see Chapter 3).

Their burnout was further exacerbated by the scope of tasks they were required to take up and the groups they were looking after. Weeks before Christmas in 2017, the requirements of the Municipality towards the care workers shifted in terms of the nature and direction of caregiving. From administrative and bureaucratic undertakings of caregiving and conducting outreach work and interviews for housing applications, the priority of the care workers became calling lottery winners of Christmas baskets, donated by a large Greek supermarket chain. Through a collaboration between the private and the public realm, such donations proliferated because the role of the welfare state and the family as key caretakers was reduced (see Chapter 1). Redirecting their work to making phone calls, rather than taking appointments, underpins the lack of personnel and how staff became involved in caring on a life-sustaining level. Here, scarce resources were invested into providing 150 winning families with food to help them enjoy Christmas. Yet, this could not be secured for everyone in need.

During Christmas all employees got involved in this process and only one member of the personnel remained focused on seeing those visiting the social services. While this person was processing benefit applications, a loud atmosphere of disorganisation and chaos was unfolding among the rest of the employees. Surnames of people were being shouted from one end of the room to the other to give the necessary information regarding the collection of the basket. People who had a missed call from the Municipality were calling back. Some were very happy to find out they were winners,

whereas others who were not winners explained how much their families needed this basket, imploring the employees to make an exception for them. The task of calling the winners was further complicated by communication difficulties. Some people had provided a wrong number in their application form, others had their phones switched off, and others were migrants unable to fully understand Greek. Not always having an interpreter or someone available to speak English or French, the most popular languages spoken among migrants, the care workers often lost their patience and were disheartened as they could not arrange for them to collect their Christmas baskets. To complete all applications within the deadline set by the management, members of the outreach team and the two female social workers responsible for hostel applications were also recruited to help out. Hence, outreach work was reduced and the waiting lists for the hostels grew.

Analysing the details of the two competing tasks at the municipal social services, namely the benefit applications and the donation of baskets, turns to the nature of caring in cities hit by multiple crises, where the need for care was pronounced and multifaceted. The insufficient number of care workers and the need to respond to an array of groups resulted in different ethical and practical dilemmas. From a care ethics perspective, Held (2006, p. 33) and Noddings (2010, p. 21) have insisted on the importance of face-to-face relationships and caring attitudes. However, when care takes on primarily bureaucratic characteristics or is constrained to the duration of a phone call taking place from a distance, care relationships cannot develop. This has serious implications. First, although the care provided was crucial, as the completion of benefit applications could increase the available income for vulnerable citizens and grocery baskets could provide food, this type of care remained solely focused on material and financial support or life-sustenance. The brief and disembodied communication between homeless people and care workers did not allow for the identification of other needs that care recipients may have had. Limited to the celebration of Christmas and Easter or the gathering of required documentation, no continuous, engaged or personalised support could develop at this space of care.

This working environment did not encourage the enhancement of the emotional skills required in care work. Instead, the role and nature of care work conducted by care workers was stretched to a customer service, mechanistic and administrative approach to care, estranging them from care values and skills. Juggling different tasks of care in an

under-resourced and understaffed environment ultimately resulted in frustration, exhaustion and burnout amongst care workers. Because of these conditions, a sense of powerlessness instilled in care workers and imprinted itself on their daily professional life. This related to the purpose, content and nature of their work but also their ability to make changes to their working environment. For homeless people, receiving care in a unified office where the pronounced lack of resources – time, space, and staff –resulted in a perception of being unable to receive tailored care. Specifically, as the municipal social services were shouldering the burden of an array of care tasks and responding to the needs of different care groups, there was a perception amongst rough sleepers that this was not a space where their specific needs could be met. Similarly, vulnerable citizens visiting the social services were entering a space where care reception came with hurdles and limited itself to bureaucratic help. In this sense, such an environment shapes both care workers and homeless people as givers and receivers of care. Characterised by experiences of waiting, short exchanges and an apparent lack of compassion, the care received by homeless people shaped them as subordinate 'patients of the state'. 'On the other side of the counter', if we are to reflect on Auyero's (2012) research, the spatial and working conditions experienced by care workers, as well as the nature of the work required of them were the defining factors that 'taught them' to espouse a detached way of doing their job and a bureaucratic, administrative approach to care.

Waiting for the Municipal Outreach Team?: Difficulties of Care Fragmentation in Providing and Receiving Outreach Care

One of the desks at the social services belonged to Ioanna, a young social worker who was conducting the municipal outreach work. Her role entailed two components. First, she conducted outreach visits in locations of rough sleepers raised to the Municipality by citizens, and second, she composed reports that she subsequently sent to these citizens or any agents of the city that had to intervene. Two to three times per week, she left the Municipality in the morning with one of the municipal drivers, Spiros. While the driver was not formally part of the team, he kept Ioanna company and if the locations of the homeless were hidden, he accompanied her there. Their ability to do outreach work was dependent on whether the car was being used for other purposes, such as driving the

director to appointments or bringing food to the soup kitchen. As a result, despite the growing list of locations, Ioanna was not always able to do outreach work. In the car, conversations involved the route they would take, the narration of previous incidents from their outreach work, as well as Spiros' and Ioanna's family lives and personal interests. Joking about their own mental health and burnout was also common. Humour functioned both as a way of reducing the difficult nature of their work and as a way of bonding with Spiros who at times showed little understanding regarding how one can become homeless.

Even before meeting homeless people, Ioanna was already constrained regarding the care she would be able to offer. Firstly, the exclusions regarding drug use, disability and mental health (see chapter 4) precluded Ioanna from suggesting accommodation to a large number of rough sleepers. Furthermore, she was working in a fragmented systems of services characterised by a lack of 'cross-sectional' continuity in care (Durbin *et al.*, 2006). Consequently, Ioanna was unable to ensure the reception of a comprehensive range of services by homeless people in accordance with their needs.

Ioanna's line manager as well as manager of the social services explained in her interview how homeless people turn into a 'hot potato' or a 'ball that each institution gives to the next because no institution wants to take up their responsibility'. This also contributed to a 'revolving door' phenomenon, making homeless people return back to the street after spending a temporary stay at institutions, like hospitals or prisons. In the same interview, this manager narrated an incident of a homeless drug user who refused to go to hospital with the ambulance the care workers had called despite his leg being broken. He wanted to stay with his friend, as they were waiting for a drug dealer to arrive. After being convinced, the homeless drug user got into the ambulance. However, ten minutes later he regretted it and asked to get out. They left him close to where the dealer was. Laughing, the municipal manager said: 'Do you understand the absurdity? Not only did we not help him, but we also took him to the dealer! If we had taken him to the hospital, he would have just gone to the dealer some hours later. Waste of time for everyone [laughs]'. Care workers were accustomed to the powerlessness vis-à-vis their role, as they had no ability to positively define the care that would be provided. 'The inability of workers to achieve their objectives and their belief that they lack control over their own activities and the operation of their workplace' have been viewed as factors

resulting in burnout, which could ultimately entail even a danger of alienation (Keefe, 1984, p. 152).

Even if Ioanna put effort into creating relationships of care with rough sleepers, she had no power or control over her work activity as she was unable to house them. During my fieldwork, neither Ioanna nor any other outreach or care worker managed to rehouse any of the rough sleepers I met. Care workers appeared to be accustomed to this reality. Although care workers valued their contact with individuals on a human level and they were able to record the needs of homeless people, the care provided through the municipal outreach work was primarily ingrained in a system of control and monitoring. In the absence of an integrated care approach, Ioanna focused her work on the administrative tasks of composing reports. The composition of such reports should not be 'mistaken for a neutral bureaucratic task'; instead they constitute 'the distillation of various power relations that shape the lifeworld of both the service user *and* the social worker' [original emphasis] (Yuill, 2018, p. 284). As Yuill argues, it is the report, not the service user, which 'becomes the *de facto* object of labour: the product of what they do'(ibid). Pösö and Eronen (2015) have also discussed the role of reports as part of linear temporal trajectories for service users that do not allow for the complexity of service users' needs and lives. These reports played a role in being able to keep records of the outreach team's work and gather information with respect to the geographies and characteristics of homelessness in Athens. Yet, their most significant function was to manage and regulate homelessness and the spaces occupied by homeless people through processes of control, underpinned by assessing their locations, characteristics and behaviours and managing the risk they could pose to themselves and others. Such procedures are part of criminalising and stigmatising not the status of being homeless *per se* but certain behaviours, such as camping or loitering, that are integral to the lived experience of homelessness (Lyon-Callo, 2012).

These factors were intertwined with additional limitations, demonstrated in the following encounter between Ioanna and a homeless man living in Kypseli, a neighbourhood close to the city centre. After a number of repeated phone calls from different citizens, we visited a spot on a small square surrounded by three roads in Kypseli. The homeless man there was in his fifties. He was disabled and one of his legs was amputated as a result of a workplace accident. Ioanna introduced herself and said she

was working for the Municipal Centre for Homeless People. He briefly introduced himself as Emilios, but he appeared hesitant to share more information. Many homeless people were hesitant or completely avoided giving any kind of information away and engaging in any conversation with the member of the outreach team. As Kinsella (2012) argues, homeless people may be better conceptualised, not as 'feared' but as 'fearing' subjects. This fear seemed to relate to the possibility of the municipal team taking actions against them. Such actions could entail the intervention of the public prosecutor or the police which could result in the temporary hospitalisation or imprisonment of homeless people or in the removal of their belongings by the municipal cleaning services. Such reactions are interlinked with the ontological insecurity experienced by rough sleepers and their distrust towards institutions. In contrast to the control exercised through regulatory socio-spatial processes at the municipal social services and soup kitchen, outreach encounters took place at spaces not under the control of caregivers but in public spaces chosen and occupied by homeless people. For this reason, the arrival of the outreach teams was interwoven with a violation of the privacy and the space of homeless people.[55] These were obstacles Ioanna had to overcome in each of her visits.

To overcome Emilios' hesitation, establish rapport between them and identify his needs, Ioanna asked him several questions about his disability, where he came from and whether he was living in the neighbourhood. His answers were short. Despite the communication difficulties, Ioanna insisted on gathering as much information as possible, as they could be useful for the composition of the report that would follow. Gradually, Ioanna succeeded in starting a conversation with him. He first said that he was not living there and all the clothes and things around him did not belong to him. Emilios claimed they belonged to others who were sleeping rough on the square during the night. With regards to the food around and on the bench he was sitting on, he also denied it belonged to him. He insisted it was brought by the kids who played on the square in the afternoons. His story was not coherent and Ioanna did not fully believe it. She whispered to me: 'Maybe he is PSY[56] or he is drinking a lot'. To further investigate whether he was homeless, as residents were saying, or whether he had a house, Ioanna asked for his home

[55] For example, this was the case in one of the 'bottom-up spaces' discussed in Chapter 8.
[56] An abbreviation for Psychiatric Case.

address. The address he gave was indeed a specific residential address in the vicinity of the square.

This left Ioanna wondering about the veracity of his story and whether the ambiguity around his predicament related to a mental health issue. Unwilling to share any further information, he insisted he was 'just spending his afternoon there'. Inevitably, unaware of Ioanna's intentions and what would follow after this visit, it was difficult for Ioanna to gain his trust. Gradually, neighbours, some of whom had called the Municipality to report his location, started gathering on the square. Not to jeopardise her own relationship with Emilios, Ioanna told them to wait a bit further away while she was speaking to the man. The man explained he came from Romania and had been working and living in Greece for the past 22 years. The last five he had been in this neighbourhood, but he no longer had any contact with his wife and son. When asked whether and what he might need, he started showing signs of annoyance again and turned his back to Ioanna whenever she moved to face him. In the end, he stopped the conversation by saying firmly that there was nothing he needed. In reality, as she did in similar occasions, the only available care Ioanna could offer would be to inform him about the two daily servings at the municipal soup kitchen and some NGOs which may be able to help him. Unable to secure housing for infirm people, Ioanna was again powerless to provide any tailored care.

Despite these difficulties, Ioanna also had to speak to and manage the expectations of the three neighbours waiting for her. In contrast to his claim of being called Emilios, the neighbours insisted his name was Anastasis and he had been sleeping on one of the square's benches every night for the past twenty days. All three of them stressed to Ioanna that something should be done as the cold months were about to start and 'helpless' as he was, 'he could die'. The three neighbours showed immense interest and explained that he had no support network and had indeed suffered a working accident. According to the neighbours, he had been drinking and everyone in the neighbourhood was helping and bringing him food. Ioanna explained to the neighbours that all the Municipality could offer was the soup kitchen and she should speak to her manager about the possibility of any further housing support. Although most neighbours were worried about him, the owner of an off-license on the square expressed his annoyance and worry to Ioanna, explaining that 'women are scared of crossing the square

on their own in the night'. Both caring and negative responses from residents were important to the municipal outreach team, as complaints regarding the presence of the homeless man and reports from worried residents had to receive a formal response explaining the intervention and the actions taken by the team.

First thing in the morning Ioanna shared this with the manager of the municipal social services and outreach team. The manager explained that being disabled, this homeless man should normally go to a care home for the infirm who cannot care for themselves [ξενώνας για μη αυτοεξυπηρετούμενος]. Nonetheless, she added:

> Although the formal procedure would be to initiate an entire procedure of an outreach visit, the composition of a formal report and then do an application to a hostel…As this procedure is quite time-consuming and might not lead anywhere, we will need to proceed with a prosecutor's order.[57]

The answer of the municipal outreach team reveals an insensitiveness to the needs of clients and an emphasis on procedural behaviour, both of which can be understood as signs of care paralysis (Schout, de Jong and Zeelen, 2011). Indeed, the wider institutional environment of care provision stripped care workers of their ability to provide care effectively and limited their role to one of 'street-level bureaucrats' (Lipsky, 1980), managing rather than caring for rough sleepers. Guided by a need to make their work more predictable and controllable, care workers adhered to the simplifying assumptions produced through the landscape of care which categorised homeless people into those 'deserving' and 'undeserving' of care.

Yet, responses such as the one from this manager also entailed a component of indifference regarding not providing the care this homeless man needed. Herzfeld (1992) explains how indifference constitutes a form of alienation resulting both from organisational constraints and aspects of care deservingness (see Chapter 4), like the ones

[57] Such orders were used when someone was considered harmful to themselves or others. Under the prosecutor's orders, police officers visit the location and after arresting the respective person take them to a psychiatric hospital. There, the medical team proceeds with a psychiatric assessment and decides whether and for how long one person should stay at the hospital. Since this procedure takes place under the prosecutor, the individual has no say. After the period decided by the medical team passes, if the homeless person is not helped by the social services of the hospital, they might return back to the street and to the situation they had been in before their arrest.

evident in the landscape of care. As a result, the detachment from the suffering of this homeless man expressed in this manager's decision stemmed from the highly bureaucratised environment this team operated within. The exhaustion of working in a bureaucratic environment and the belief that following the formal procedure would be 'time-consuming and might not lead anywhere' made care workers more estranged from the needs of homeless people. In contrast, they prioritised *managing* the incident by involving agents of control, like the prosecutor and the police. For Ioanna, seeing her manager deal with this case in this way played a role in her learning how to manage such cases in future.

Tronto (1993) places emphasis on not just being aware of others' needs but also being in a position to take up the responsibility and the competency to respond to their needs. But this was not an option for the care workers in this team. As no subsequent caring and rehabilitative action could be taken for homeless people ineligible for accommodation, a reproduction of 'care avoidance and care paralysis' (Schout, de Jong and Zeelen, 2011) was the end result. This often led to suspicion and estrangement between care workers and homeless people and pushed the latter to more extreme forms of marginalisation and subordination. This was underpinned by a lack of control homeless people had over their lives and the often negative encounters they had with institutions and agents of the city. Being a caregiver in this context delineated the limits of Ioanna's work as the exclusionary aspects of the landscape of care hindered the development of a deeper relationship of care.

The Municipal Soup Kitchen: Waiting for food

The food provided at the municipal soup kitchen was central to the life-sustenance of more than half of the homeless people in Athens, who sourced their food from there on a daily basis, at 12 noon and 4.30pm, all year round. Despite alternative but smaller-scale sources of food in the city, being the only public soup kitchen in Athens and offering food consistently for many years, it was the most reliable and common source of food. This is why its two servings created a temporal daily rhythm for homeless people across Athens. According to the personnel working there, over 400 people attended every day and over 550 portions of food were distributed. This soup kitchen

had come about through a collaboration of the Municipality, offering the space and the personnel, and the Church of Greece which was responsible for funding and arranging the outsourcing of the food to a catering company. In contrast to the municipal social services, the care workers of the soup kitchen had no relevant training or qualification. Two male administrators were part of the Municipality's support personnel – often working as drivers or transporting goods across Athens – while two women were volunteering for the Greek Orthodox Archbishopric.

The high turnout reveals the high levels of food needed in the city but was also linked with the fact that no proof of homelessness or any other identification card was required. Therefore, it attracted people from all groups of the homeless population. The vast majority were rough sleepers, including those with and without complex needs, and a small minority of housed but vulnerable citizens. Attracting many rough sleepers, the space of the municipal soup kitchen was a meeting point among homeless people, who often shared important information regarding new organisations and benefits. More than half of my participants explained that it was the first space of care they visited after sleeping rough and it was there that they usually secured food. Although most homeless people said that on the street real friendships cannot develop, three of my participants had met their close friends at the municipal soup kitchen after becoming homeless. Manolis, a homeless man, commented on how becoming dependent on a soup kitchen for food and starting to mingle with other homeless people became central to his accepting that 'he had become homeless' and 'was no longer able to provide for himself'. Manolis also explained that it was 'at the municipal soup kitchen he understood that the smartest thing would be to quietly do what organisations wanted if he was to fill his stomach'. Therefore, the daily experience of attending the municipal soup kitchen familiarised homeless people with the rules and expectations of navigating the landscape of care. Despite the empowering role this space could play, it further crystalised their identity as homeless people. Through an entanglement of temporality, space and power, this space was primarily experienced as space of waiting, rather than a space of care.

In the soup kitchen, the systematisation of care was manifested in a highly regulating system of a predefined and strict spatial sequence those served had to follow. Following both Ayuero (2012, p. 32) and other authors (Schwartz, 1974, 1975; Bailey, 2018), waiting is as a relational process of power relations and subordination. 'The

quotidian stories of waiting […] provide a critical insight into the everyday socio-spatial constitution of power not despite, but because of their very banality' (Secor, 2007, p. 42). The waiting experienced daily by homeless people in Athens may appear as a banal part of their daily routine; yet, it entailed a commitment of their resources, time and fortitude. When processes of waiting appear in spaces of care, it is often the case that waiting can be highly critical and life changing. This was the case for the homeless people at the municipal soup kitchen trying to secure support and care, such as food, as this defined their ability to survive on the street. In this exchange, the homeless became the dependent members waiting for care from the independent members, namely the care workers. This process rendered the former vulnerable and powerless and the latter powerful. In addition to viewing it as a power structure and a process of subordination, waiting can also point to systemic issues, such as chronic shortages or deficiencies in how state-providers dealt with homelessness.

The queue on the pavement: An experience of forced waiting

In contrast to the safe area of the main entrance to the municipal social services used by a group of vulnerable - but not as destitute as rough sleepers - citizens, the waiting for the soup kitchen took place in an urban setting linked with marginality and deprivation. Until the soup kitchen opened its doors, the pavement around the back entrance leading to the soup kitchen was in a relatively unsafe part of the city. In this way, the hundreds of rough sleepers remained 'hidden' from the eyes of passers-by using main avenues of Athens. In contrast, they mingled only with other homeless people and homeless drug users some of whom spent the night on the delipidated and deserted 'Theatrou Square' which was close by. In addition, not accessing the soup kitchen through the main entrance minimised the contact between homeless people and the employees of the Municipality and further reduced opportunities to develop trust among the two parties. Having said that, these two different groups of care recipients had different care needs. Hence, they also required a different treatment by care workers. From this perspective, this spatial strategy of channelling care needs through different entrances allowed for a more tailored approach to care and for less distraction for the personnel of the social services who were already working under immense pressure.

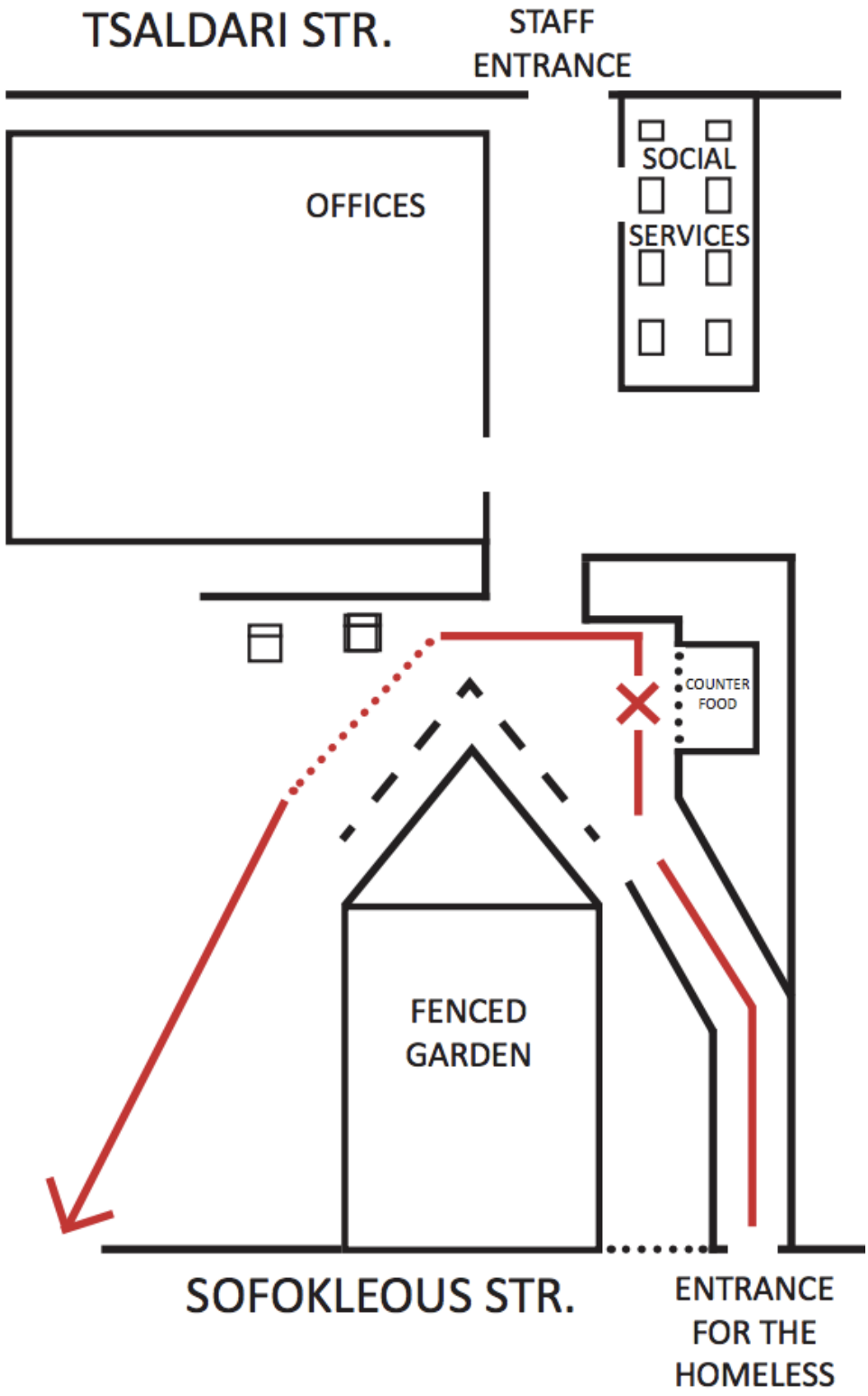

Figure 24. The strictly defined spatial sequence homeless people followed at the municipal soup kitchen

Coming, waiting and leaving (X is the counter and the dotted line denotes the area of food consumption used briefly by some homeless people)

The queue for the soup kitchen started at least two hours before the first serving. One of those who patiently waited for food was Mr. Dimitris, an elderly man. At the time of our interview, he was living in a basement of a block of flats in Kypseli, half an hour from the Municipality building. Before that, Mr Dimitris had been sleeping on a bench in the busy Kypseli square for over a year. At around 9 in the morning, he would leave Kypseli and walk towards Sofokleous Street, where the back door of the municipal soup kitchen was located. Mr Dimitris was severely visually impaired and was not able to see further than a metre away. Additionally, mobility problems rendered his journey from Kypseli to the soup kitchen a long and painful one. The lengthy waiting experienced by Mr Dimitris and other homeless people while queuing on the pavement right outside the entrance further reinforced the exclusion evident in the lived experience of homelessness. This queue was asserting a 'governmental power', highlighting the unequal experience of waiting for the powerless and the subordination homeless people endured in their endeavour to receive care (Singer, Wirth and Berwald, 2019).

For Mr Dimitris it was especially important to be first in the queue so as not to walk into something or anyone while waiting. These two hours were experienced as squandered by Mr Dimitris and all others who could have spent their time in a more productive way, for instance by applying for a job or going to the doctor. Therefore, for him and everyone else in the queue, this time constituted a form of 'pure waiting' (Bailey, 2018, p. 14), pointing to an experience of time as an 'unused present'. This is a form of waiting associated with lost costs, lost opportunities and the lost value of foregone alternatives (ibid). The length of time spent waiting only to get food might have taken up to an entire day for some of my participants who due to difficulties in moving across the city decided to spend many hours of their day there in order to secure a second portion of food at 16.30. As a way to satisfy their basic need for food and facilitate their daily survival on the street, rough sleepers endured this form of forced waiting. Being reliant on the soup kitchen was discussed as shameful by some of my participants. For example, Fotis said that asking for food made him feel 'he is not a whole human being', as 'having both two arms and legs' should mean that he should be able to sustain himself. Waiting accentuated such feelings as to secure basic resources one spent hours at this space.

This waiting took place under especially problematic conditions. Firstly, the space on the pavement outside the Municipality was not covered and left the crowd of people waiting exposed to the elements. Second, all those waiting were forced to mingle despite their past negative incidents on the street or tensions among different groups (see Chapter 3). Mr Dimitris described the queue as a space where all kinds of unrelated people were squeezed into a queue less than two meters wide. There, they had to forcibly co-exist in close proximity with one another for hours every day. This daily experience alludes to the 'spatial trauma of waiting, while being deprived of breathing and moving space' (Berwald, 2019, p. 149). Such emotions of suffocation and bodily constraint were discussed by many of my participants who, similar to the hostel and the night shelter residents, experienced spaces of care as spaces of waiting, containment and suffocation (see Chapter 4). In some cases, these emotions led to incidents of tension in which housed people protested against rough sleepers who they saw as dirty. In other cases, the queue exuded a sense of threat, especially for elderly homeless people, like Mr Dimitris, or some of my female participants, who described fearing homeless drug users as their behaviour was considered unpredictable. Therefore, for some of my participants, rather than a space of care, this was a space of fear where tension could result in physical threats or injuries. Primarily taking up a life-sustaining approach to care, attentiveness to the gendered dimensions of care or additional facets of vulnerability could not be considered in this space of care.

Entering the space of the municipal soup kitchen: Tension and motivations of care

The soup kitchen opened its door every day at noon. Through the entrance reserved for the homeless, there was a small fenced garden, where only the Municipality's staff were allowed to enter. The fenced garden demarcated this space from the area where the homeless queued. In contrast to the queue on the pavement, this part of the queue was covered with a long and narrow canopy. When I got to the soup kitchen, I stood in a protected area close to the serving canteen and was warned by one administrator to stay there as what would follow would be a 'jungle'. This echoes Arapoglou and Gounis's (2017, p. 98) finding of an administrator naming the same space the 'yard of the damned'. Two other participants had also warned me, in their interviews, not to have anything valuable on me if I went there, as thefts and violence were prevalent. They advised me to

just follow the queue, get my food and leave as quietly as possible. They even mentioned that at times people carry small knives on them and if they see something they want or they are treated in a way that makes them angry, they draw their knives. Although I did not witness anyone carrying a knife, the atmosphere was one of hostility, aggravation, and friction both among the homeless and between them and the care workers.

Figure 25. The queue of homeless people patiently waiting one after the other to be served

Having waited for a long time and being hungry as the soup kitchen meal was for many the first meal of the day, people were pushing and trying to make it quickly to the canteen.[58] To control the crowd and coordinate the queue, the male administrators employed the following tactic: they would allow approximately ten or fifteen people in at a time and keep the rest of the crowd some metres away from the counter. This system of waiting manifested a 'spatial expression of power' regulating the bodies and structuring the time of the waiting subjects (Singer, Wirth and Berwald, 2019, pp. 2–3) through stopping and starting the queue. Stopping the queue was not always received positively by those waiting, as each time they were stopped, the homeless saw their hope of being served jeopardised. As Schwartz (1974, p. 856) explains 'to be kept waiting an unusually

[58] This was the first meal of the day served at the Municipality and for many of those waiting, it was the first meal after the second portion served at the Municipality the previous day at 4.30 pm.

long time is to be the subject of an assertion that one's own time (and, therefore, one's social worth) is less valuable than the time and worth of the one who imposes the wait'. For the homeless people who had already tolerated a number of obstacles, the regulation of the queue was a form of socio-spatial control exercised on their bodies. In other words, while the interruption of the queue every ten or fifteen people was an inevitable strategy so that everyone was calmly served, it also taught them how to be 'patients of the state' (Auyero, 2012). In addition to queuing for hours before the beginning of the soup kitchen, shorter sequences of waiting appeared any time the administrator stopped homeless people from approaching the counter. Despite increasing safety of homeless people who at times demonstrated signs of aggression, this stop-and-go tactic was primarily experienced as a form of power asserted on those waiting. It 'taught them' to comply with the rules, disciplining and control they would endure daily while securing food. Consequently, while satisfying this biological need, homeless people were again shaped as subordinate recipients of care. Their patience was tested emotionally, temporally and even physically, as their hungry bodies were squeezed among others at a time that they urgently needed food.

However, this assertion of power was not always left unchallenged. One of the main causes of tension was the quality of the food perceived as dubious and bad. In one instance, a homeless man in his 30s standing at the back was stopped by the administrator, who was part of the support personnel of the Municipality. He then shouted to the administrator standing close to the canteen: 'Is it good today? Are we having lentils with rice again?'. The administrator then responded: 'It is good… Fit for a dog!'. These humiliating and disrespectful words were met with an ironic answer from the homeless man: 'Since I am a dog myself, then it should be ok… To a dog I am giving it anyway, right?'. This exchange shows both the stigmatising stereotypes enforced by care workers and the apathy experienced by the homeless man who had to endure such treatment to secure a meal. Simultaneously, it functioned as an intimidating and disciplining display for the rest of the crowd waiting. Such incidents of smaller scale took place and revolved around the two male administrators' derogatory comments regarding homeless people's appearance and behaviour. Banks' (2016, p. 42) work on situated ethics highlights the importance of 'identity work', namely 'the work people do through talk, interaction and demeanour to construct and negotiate who they are'. Nonetheless, the tension between quality of care, quantity of recipients and lack of resources and staff did not allow for the

time to develop relationships of care adhering to humanity, values of good care and identity work. Unable to initiate and develop relationships of care through empathy and attentiveness to the needs of homeless people, the care workers undermined the role of the municipal soup kitchen as a space of care taking values of communication, trust and respect – namely what Tronto (2013) has called 'caring with' – into its practices. Rather, the care workers' focus remained on processing the queue as quickly as possible, in a mechanistic and often disconnected way from the daily suffering of the care recipients.

Such incidents need to be contextualised in relation to the immense pressure which placed both caregivers and receivers into a deeply uncomfortable and unhappy position. The socio-spatial experience and the management of the queue were key to the nature of care provision and the exchanges between homeless people and care workers. While the patience of the homeless people was tested in their effort to get what they deemed to be an inadequate portion of food after many hours of waiting, the care workers of the soup kitchen (the canteen personnel and queue administrators) were responsible for the straining task of providing two servings of food to over 400 people every day. Seeing a crowd, rather than individuals, care workers were unable to speak with each homeless person and offer them tailored care. In contrast, any differentiating characteristics in the homeless people's personal stories or specific needs were eliminated. Therefore, even people who urgently needed care and support, like the exceptionally vulnerable Mr Dimitris, could only get a portion of food from this space of the Municipality.

When institutions take up a caring responsibility towards such a high number of people without investing the necessary resources, the quality of care is likely to decrease. Both the way of managing homeless people and the incident of calling a human a dog illuminates much deeper issues. Being responsible for feeding the overwhelming majority of homeless people in Athens, all of whom had different emotional and physical vulnerabilities requires a significant level of training and knowledge. Yet, the lack of such training, sufficient personnel and the repetitive nature of providing care to homeless people twice a day all shaped the practices and relationships of care at the municipal soup kitchen. Tronto (1993, p. 108) has argued that for a practice of care to exist, 'thought and action need to be interrelated' and 'directed towards some end'. However, the resource limitations regarding space and personnel and the urgent need to care for a crowd, rather

than individuals with care, precluded the possibility of encompassing the values of care ethics. The motivation behind taking up a caregiving role in the first place is also a crucial factor in the values one incorporates into care provision. Such a motivation might not necessarily derive from one's intention to care for a vulnerable population and respond to their needs, but may be linked with religious motivations or as part of retaining a job as a source of income – not an unlikely scenario because of the high unemployment rates in Greece. If this is not accompanied with a genuine interest in caring for any group of care recipients, it is likely that under the pressures of care, especially when this is provided in under-resourced environments, stigmatising practices might appear. This could explain why the care workers of the municipal soup kitchen were unable to establish engaged relationships of care with the homeless people, which in turn reinforced a negative self-perception among homeless people and increased the likelihood of breaking any possible links they may want to establish with spaces of care.

The exchange of the food and the dispersion of the 'crowd': Undermining trust through the quality of food

Between the homeless and the care workers was a counter made up of metal bars resembling those in prisons and functioning as a barrier and a layer of protection for the staff. Behind it were two female volunteers from the Church of Greece. Accurately and swiftly, they were giving away the food along with a sealed plastic bag containing two slices of bread. The well-discussed division of care labour and the overburdening of women in such contexts is prominent here. While the regulation and control of the queue was taken up by two men, the strenuous work of distributing the food was taken up by women. As was the case more broadly in the landscape of care, gender stereotypes determined who took up caring responsibilities (see Chapter 3). The two female volunteers never spoke to the homeless people except if the latter thanked them for the food. Then, they responded by saying 'Welcome', and moved on to the next person waiting. Without the additional staff and support, rather than an opportunity for human contact and a care relationship to develop, the exchange between these women and the homeless people involved limited expression and was disconnected and care remained on its life-sustaining level.

Figure 26. Homeless people approaching the counter

The tension between serving good quality food to fewer recipients or ensuring a low-quality portion for large numbers resulted in complaints, as quality was compromised. Complaints regarding the dubious origins of the food and flavour were rife. Often, they were openly expressed to the administrators or they were discussed amongst those waiting. Two of my participants mentioned that consuming such a high level of carbs every day – mainly rice and pasta – made their blood sugar increase above the normal levels. Not having the ability to eat nutritious and varied food is another reminder for the homeless that they are perceived as undeserving of good care, further shaping them as subordinate recipients of care**.** Notably, Costas a homeless man in his mid-forties, confessed in our interview that he gave a meal of chicken and rice from the soup kitchen to some stray dogs, who left after smelling the food, without eating it. This convinced him that the food was not good. Reminiscent of the verbal incident which led a homeless man calling himself a dog, such events made homeless people suspicious of

the food served at the soup kitchen and of its role as a space of care. This reveals that even when care remains on a life-sustaining level of basic provision, matters of quality are crucial in relation to how care is received and how it can shape the recipients' self-identity and perception of the care provider.

The insecurity and anger experienced by many of the homeless people I spoke to alluded to a lack of trust towards the personnel of the soup kitchen. The American philosopher Anette Baier interprets trust as 'letting other persons (or institutions like firms or nations) take care of something the truster cares about, where such "caring for" involves some kind of discretionary power' (1994, p. 105). Trust appears when one relies 'on another's competence and willingness to look after, rather than harm things one cares about which are entrusted to the caregiver' (1995, p. 128). Sevenhuijsen (2003, p. 185) also draws our attention to power and responsibility as integral components of trust. Specifically, the dependent care-recipient holds the responsibility of relying on the trustor and caregiver, whilst the latter attends to the wellbeing of the care recipient without abusing their vulnerability. Similar to the care workers of the municipal social services, the pressure of responding to such a high number of people estranged the care workers of the municipal soup kitchen from the values of care and rendered them unable to attend to the needs of homeless people.

Figure 27. The area used by homeless people to have their meal

To avoid leaving and coming back later because of his mobility problems, after receiving his portion, Mr Dimitris waited again and immediately queued for the second serving of the day taking place four hours later. Mr Dimitris ended up leaving the space of the Municipality at 5pm every day, after seven hours. For most others, the quick dispersion of the queue at the end of the soup kitchen showed how weak the bonds between the homeless people and this space of care were. After being forced into a disciplining system of waiting, homeless people scattered in various corners of the yard. Usually alone or in some cases with friends, they sat on a bench or on the ground and ate the portion of food they were just served. Some of them tasted the food and then packed it away to eat it somewhere more quiet. It was then that one could understand the extent to which these people did not want to be next to each other while queuing. To secure two portions of food through the municipal soup kitchen, the vast majority of homeless people in Athens had to endure a daily experience of distressing and challenging waiting. To avoid it, a few of my participants who had been sleeping rough for a long time found

alternative spaces for food serving smaller numbers of people. However, until becoming aware of alternative sources of food, the overwhelming majority of homeless people endured these intense processes of waiting which shaped them as subordinate recipients of care and taught them to comply with the rules and regulations of navigating the landscape of care.

Conclusions

The space of the Municipality has helped us understand what the consequences are when a space of care turns into a space of pressure and what is at stake when spaces of care do not adhere to a framework of care ethics, but instead revolve around managing pressure. Reflecting on both caregiving and care receiving allows us to see how a focus on management, rather than care, and subordination through control, bureaucratic processes and waiting mirrored each other in this space of care. These outcomes were a manifestation of the multiple pressures experienced by care workers 'on the other side of the counter'. Whilst formally belonging to the wider landscape of care for homeless people in Athens, this space responded to groups and needs beyond those of the homeless. Yet, the resources to take up this wide array of caring responsibilities were insufficient, and the pressures were ever-increasing. Dartington (2010) explains how scarce resources can make professionals have no other option than becoming 'deviant' to their identity and caring approaches.

For care workers, working in a space of pressure resulting in tensions between satisfying basic needs to more care recipients or deeper needs to less care, meant that care was restricted to bureaucratised, administrative and life-sustaining facets. Rather than fostering care relationships, care workers had no control and professional autonomy over their work and the progress of their clients. This resulted in a sense of powerlessness and an estrangement from the values of care ethics and the latter's focus on relationships. All these rendered care workers unable to go beyond the management of homeless people. For the latter, this was constrained to life-sustaining care through donations and food portions, bureaucratic support throughout a benefit application, or even care engrafted with elements of control, as was the case of the outreach team. Such forms of care pose the danger of recipients becoming even more vulnerable, as the space of the Municipality was unable to identify and be attentive to deeper needs.

However, this chapter does not suggest that such spaces have no role to play in landscapes of care provision. It is precisely because of how vital the forms of care provided that the care workers of spaces like the Municipality continued to provide care and that the homeless people continued visiting this space to receive bureaucratic care in the municipal social services or material care at the soup kitchen. What this chapters seeks to highlight is that – especially when spaces of care belong to intersected landscapes of care and provide to more than one group of care recipients – it is crucial to secure the necessary resources to provide care in accordance with a framework of care ethics. Such resources include personnel, financial resources and space. To this end, taking into account the care workers' views vis-à-vis the level of report writing, the allocation of funds, the use and length of time required to create a meaningful care relationship and the repertoire of skills employed, as Yuill (2018) suggested, could be beneficial. Reintroducing aspects that facilitate care workers regaining control over the process of their work could help them incorporate values of care ethics into their work and attend to the needs of care recipients. This necessitates resources, attention to training and an incorporation of ethical values into systems of care in different institutions.

In contrast, the structural characteristics of the landscape of care, such as its fragmentary and exclusionary aspects and the lack of resources, rendered care workers unable to attend to the needs of such a high and diverse number of care recipients. Ultimately, these conditions resulted in an estrangement between the municipal care workers and the homeless people. Although usually resources refer to available funding and personnel, this chapter has highlighted the role of spatial resources for care. The lack of space created additional pressures and resulted in care workers and homeless people experiencing the space of the Municipality as a suffocating space. It is this relationship between space and care that constitutes the focus of the next chapter. In doing so, I look at a drop-in centre, a space providing to lower numbers of care recipients, thereby fostering different and more engaged relationships of care.

Chapter 7

The drop-in centre:

The socio-spatial layout of care ethics and ethics work

Introduction

Moving my attention from aspects of bureaucratic, outreach and life-sustaining care by a public provider of care, I now explore a drop-in centre, operating as part of a voluntary organisation in Athens' inner city. This chapter analyses care relationships from a spatial perspective and positions them in the macro-environment of the city and the institutional framework of the landscape of care. In exploring the environment and the relationships of care in the drop-in centre, I bring the literature of care ethics in dialogue with Banks' (2016) work on situated ethics which draws our attention to the world of social workers and practitioners. I expand on Banks' work by extending my focus to include support and other personnel working in the drop-in centre. The care relationships discussed here encapsulate emotional, practical and work dimensions of care. Drawing on Tronto (1993) and Held (2006), Banks (2016, p. 44) views relationship work as a prominent part of care ethics and defines it as the work of engaging with others, building relationships of trust, attending and responding to needs, getting to know people and caring for and about them over time (ibid). To acknowledge the embeddedness of ethical issues and the account of practitioners, she coins the term 'ethics work', which:

> encompasses reasoning, but also includes work on emotion, identity, roles and responsibilities. All these elements are inter-connected in the complex world of practice, which can be analysed in many different ways to highlight the work practitioners do in the ethical sphere. (Banks, 2016, p. 35)

Different aspects of everyday life, such as the 'conversations, interactions, actions, demeanours, arguments' described in this chapter construct the ethical sphere care workers navigated. They gain importance as they are interlinked with issues of rights, responsibilities, harms and benefits (ibid, p. 36). From this perspective, following Banks (2016) this chapter contributes to our understanding of care provision not solely from a

philosophical perspective on care ethics. In contrast, I shed light to the difficulties, dilemmas and constraints that appear in applied care ethics in everyday practice and spaces of care.

I have sought to develop Banks' work in two ways. Firstly, I provide an ethnographic account of how care ethics and ethics work develop from the perspective of both caregivers *and* care recipients. Secondly, by conducting a grounded analysis of different areas within the drop-in centre, I emphasize the spatial dimension of care. By exploring how different spaces and rooms in the drop-in centre manifest different care needs, I illuminate various professional and ethical dilemmas, complex relationships of care and tensions. In this sense, a close attention to the dynamics and interactions in differing rooms reveals the applied dimension of ethics work in spaces of care. This reveals the perspective of both homeless people appropriating this space and receiving care, and of the care workers struggling daily to provide care in a complex space of multiple pressures. It is through this lens that I investigate the highly convoluted and fragile dynamics, relationships and practices of care between givers and recipients of care.

Simultaneously, the spatial environment of the drop-in centre impacted on how it served as a space of work and how it shaped care relationships and practices. In contrast to the Municipality, the drop-in centre's personnel held a wide range of roles: social workers, support and medical personnel and volunteers (a hairdresser and a librarian). Despite having considerably less available space than the Municipality, the drop-in centre highlights the importance of utilising the available space according to care ethics. Doing so, the drop-in centre hosted a number of different rooms where each of these personnel were based. By systematically examining each of these rooms, I investigate their role in sustaining and broadening the functions of this care space, enhancing care relationships and responding to more needs. I argue that space is more than a background of care. Rather, its use, size and availability are key factors for care ethics to be in place. In addition, by exploring the relationships between care workers and their management, and the former's status as employees, this chapter also explores aspects of care towards the carers and experiences of vulnerability amongst caregivers. In this regard, this chapter problematises aspects of the employers' responsibilities towards frontline staff. It suggests that when care workers are under-resourced and/or feel unsupported and

precarious in relation to their employment, the very core of care and the ability of care workers to provide it is jeopardised.

The Area and Entrance: Care eligibility, Tension and Control

The drop-in centre operated as part of an NGO with extensive experience in working with vulnerable populations (see Chapter 3). Not being a public provider of care like the Municipality and unable to utilise public buildings, it was not situated in an imposing building. Rather, it was situated on the fourth and fifth floor of an old block of flats (πολυκατοικία), rented by the organisation. Being on a small side road close to a busy avenue, it was less visible to passers-by. Yet, it was well-known among homeless and other vulnerable people in the city. It was located a short distance away from the Municipality, Omonoia Square and a central tube station, close to one of the hostels. As with other spaces of care, it occupied an area of high criminality, more deserted in the day than in the evening and the night. Many of those visiting the area were clients of the brothels operating close by, which despite being open most of the day were often frequented by their clients in the evening hours. One of these was located opposite the entrance of the drop-in centre. With its door ajar, it signalled whether it was open. Around the corner, homeless drug users congregated on another small road which had turned into an informal drug market. Right outside the entrance of the centre, a couple of homeless people were usually sleeping on the pavement or a thin mattress and worn rugs pointed to this being a regular occurrence.

The entrance to the drop-in centre was at street level. Based on demand, the drop-in centre was open for men on Wednesdays, Fridays, Saturdays and Sundays. On Monday mornings until 2pm it opened for women, on Monday afternoons for transgender women and on Tuesdays and Thursdays for families, the vast majority of which were migrants. This division facilitated addressing different sets of needs and prevented the mixed use of showers by men and women. According to the register and the conversations I had with care workers, 100-120 people used the services of the drop-in centre on a daily basis. The drop-in centre was visited by a quarter of the people who were visiting the Municipality. Yet, this was another space of care facing multiple pressures, a lack of sufficient spatial resources and an urgent need to care for various groups. Most of those visiting were much more destitute than those visiting the municipal social services and the number of service users was high enough to create daily tensions and dilemmas

among the care workers of the centre. The centre was also visited by different vulnerable groups. With the exception of active drug users, the drop-in centre accepted all groups seeking help, such as homeless people with serious mental and other health issues, people included in the wider definitions of homelessness, refugees, migrants, unaccompanied refugee children, migrant families with children and asylum-seekers. Providing for so many varied groups, the drop-in centre functioned as a space of the intersected landscapes of care which emerged after the retreat of the welfare state and its inability to take up caring responsibilities towards them (see Chapter 3). These conditions posed challenges both to the care workers and the homeless people visiting the drop-in centre, as well as the centre more broadly.

In combination to an entrance to care, this space also involved controlling processes, such as the checking of eligibility criteria and the rules regarding the operation of the drop-in centre, resulting in frequent tensions. This eligibility check was conducted by the support care worker doing what was known among the drop-in centre's personnel as 'door'. Spatially, the barrier to care was manifested in the counter, the desk and the glass barrier separating and protecting the care worker from those visiting. In addition, there was a small locked door close to the seat so only those with a key could reach the area behind the desk. This door was put at the entrance after a violent incident between a homeless drug user and a care worker which put the latter's health at risk. However, the door was not always kept locked, making the person 'doing door' vulnerable to potential attacks. These were very rare and usually resulted from the loss of patience on the part of homeless people. Standing behind the counter, the person doing 'door' made sure everyone going into the drop-in centre was not under the influence of drugs and was sticking to the time and day of their weekly scheduled slot as noted on the back of the card given to registered members of the drop-in centre. If the person was a newcomer, the care worker spoke on the phone to a care worker within the drop-in centre, who found them an available appointment, known as 'New Card' among the care workers. In contrast, if the person seemed to be under the influence of drugs, the person doing 'door' explained to them this space did not accept drug users and redirected them to other spaces of care working with drug users.

Any refusals or barriers to care were not received calmly, but with tension, anger and at times shouting by those visiting the drop-in centre.[59] Tensions arose when some people, such as homeless drug users, were denied access, when newcomers were told to come back another time to get a 'New Card appointment', or those with an appointment who were later than the allowed half an hour window around their scheduled weekly slot. On other occasions, tensions arose when one of the care recipients saw someone else being allowed to enter the drop-in centre before them, despite arriving later than them. Such reactions of frustration, verbal attack and disappointment were expressive of the powerlessness and lack of control that characterises the lived experience of being homeless or depending on spaces of care for one's survival. For example, being unable to store or hide one's belongings before travelling to the drop-in centre, having to walk instead of using public transport while carrying one's belongings, urgently feeling that a matter must be discussed with a care worker or experiences of prolonged waiting in other spaces of care (see Chapters 4 and 6) were reasons that could result in delays and ensuing tensions at the entrance. Being a space of tension where the access to care was controlled meant that in some cases this was the last time homeless people visited this space of care. For them, the drop-in centre was perceived as a space where they were not welcome or could not find solutions to their problems.

The Reception: Iokasti's Role and the Care for the Carer

Four floors above the entrance was the drop-in centre's main floor where spaces were organised and run by the care workers. One of the spaces revealing the experience of caregiving from the perspective of carers was the reception, on the left side of the lift. The main receptionist was called Iokasti. While Iokasti was employed as a support worker, her role was much more complicated and entailed a plethora of multifaceted responsibilities. She was in her mid-thirties and her dream was to follow a creative profession which was related to what she had studied. However, as her mother was a pensioner and her father had passed away, she had to work wherever she could. She had been at this organisation for more than six years. Iokasti's daily life as a carer demonstrates a number of issues around caregiving. Firstly, it speaks to the level of multi-tasking required when taking up multiple responsibilities of care. Independent of her job title as

[59] Because of their heightened vulnerability, the only group allowed an immediate appointment were unaccompanied refugee children.

support worker, the boundaries between being support personnel and actual care workers (i.e. social workers) became blurred. As a receptionist she was responsible for registering service users. After arriving, the homeless people had to register and state whether they wanted to have a shower and/or do a laundry, see a social worker, a hairdresser and/or a doctor. However, this first encounter also involved seeing how each person was doing psychologically. In certain cases, she informed the social services' care workers that someone particularly emotionally vulnerable had to be seen sooner. As a result, Iokasti's role was not limited to being solely part of the support personnel; she also had to employ emotional skills to make a judgement about prioritising who should be seen first.

Secondly, despite her formal role as support personnel – usually as a receptionist – she also took up managerial, administrative and organisational responsibilities in addition to her daily tasks. These ranged from arranging repairs and maintenance for the drop-in centre and the organisation of events, to creating monthly schedules for the days each person would work and when their days off would be. Most importantly, though, Iokasti was the 'go-to' person in the drop-in centre or what Jane Jacobs (1961) has called a 'public character', namely a self-appointed person serving as the eyes of a space and connecting members of an informal network. Being spatially located in a place where she could see most of the drop-in centre's areas and rooms, she was the one most aware of who was coming in and out for external appointments or outreach work. Both care workers and care recipients were constantly asking her questions about all kinds of issues, such as the whereabouts of people, as well as organisational and other matters.

All these additional caring tasks taken up by Iokasti show that when dealing with such a vulnerable population in a space facing multiple and complicated pressures, being a carer might extend beyond one's formal role to emotional, managerial and administrative tasks and dealing with urgent needs. Iokasti's abilities were necessary to enable different dimensions of care and for the operation of the drop-in centre as a space of care. Yet, taking up all these roles and responding to a range of needs had negative implications for Iokasti emotionally with her often demonstrating signs of irritation and frustration. On a daily basis, she would abruptly avoid questions or she would not be happy to respond back to someone's 'Good Morning'. Behind this behaviour was a loss of patience that Iokasti and many other care workers of the drop-in centre were experiencing with regards to the broader conditions within the drop-in centre and a tense

relationship with the management (see below). These care workers received no supervision or training for this specific setting, two factors that further obstructed care workers from drawing boundaries between their professional and personal life.

In contrast to the municipal care workers who seemed to view the tasks attached to their caring role as obligation, the care workers in the drop-in centre explained in their interviews that their motivation derived from the close bonds they had developed with the service-users. The emphasis on the care relationships they had fostered with service users were bound to serving lower numbers of people than at the municipal services (see Chapter 6) and therefore getting to know them and learn their stories. It had taken months for some of the homeless people to trust and create deep relationships of care with the care workers. Hence, each of them was unique and had an inherent value to care workers, making them equally involved in these relationships. When asked about what made her continue working there, Iokasti said in her interview: 'It is the people of course! These people… When they smile, it makes me happy.' Disregarding her own daily stress, Iokasti's words and her motivation to conduct care work alludes to Pettersen's (2012, p. 367) notion of altruistic care, namely this kind of care seen as 'a selfless, compassionate, and spontaneous act, the focus of which is the concrete other's immediate needs'. Such expressions of care appeared at the drop-in centre as the service created time to invest and develop relationships of care. The care workers placed emphasis on gaining the homeless people's trust, something especially difficult, as homeless people were often disappointed by other processes in the landscape of care and suspicious towards care workers. Therefore, this enterprise involved trial and error both on the part of the care worker and the homeless person. The process of understanding each other's boundaries and intentions occasionally involved tensions between them. Yet, in most cases, it ended with reconciliation and a reinstatement of trust and good will from the care worker towards the care recipient. In this regard, the fact that care workers had previously demonstrated altruistic forms of care was important for the maintenance of these relationships.

The Living Room: A Space of Licence, and Going Above and Beyond care

Diagonally from the reception, within sight of Iokasti, was the living room. To be able to monitor those in the living room, it was important for Iokasti or anyone else at the reception to be able to physically observe what was happening there. Despite this monitoring, a collaboration between staff and service users rendered this area a 'space of license' (Parr, 2000) for homeless people, namely a space where unusual norms and preferences would be accepted. This allowed homeless people to exist with a level of acceptance and security absent in public spaces where they or their belongings could be removed. Creating a space of license came with the trade-off of occasional serious incidents of verbal violence between some users of the space or towards the care workers. Nonetheless, those not following behavioural norms without physical aggression were mostly accepted without complaints from the staff. This was also relevant for people whose physical health was exceptionally vulnerable. For example, for Mohammed, an HIV positive drug user, and Abdal, who suffered from tuberculosis and hepatitis, the living room was also a space of refuge (Dean, 1999; Johnsen, Cloke and May, 2005, p. 795), as they were given a free pass.[60]

For others, the living room served as a space of rest. Unthreatened by street dangers (see Chapter 5), some homeless people used the living room as a secure space for sleep and rest. As a result, it also became a space responding to a crucial physical need. The living room also operated as a space for socialisation and exchange. While watching television and having a tea or a coffee, the homeless were waiting for a social worker or doctor, for their clothes to be washed or for a shower to become available. In the hope of finding an opportunity, some borrowed a newspaper from the reception to look for job advertisements. The time spent in the living room while watching television and reading the newspapers was one of the few occasions homeless people had to be informed about political and social matters. These are emotional forms of care that allow the homeless people to engage in activities not directly related to their homelessness. Weil

[60] This was given to a very limited number of service users. For reasons of increased vulnerability, those with free passes were allowed to visit the drop-in centre and spend as much time as they wanted there.

insists on meeting the other not only as a unit in a collection, or a specimen from the social category labelled 'unfortunate,' but as a man, exactly like us' (1977, p. 51). For this reason, the drop-in centre had a variety of spaces responding to needs beyond the ones resulting from being homeless. Rather, viewing them 'exactly like us', homeless people were also able to join a book club giving them access to books, socialising and two additional afternoons protected from the elements. By not reducing them to one single identity as homeless, such spaces helped them redefine their personal identity and interests. Although Snow and Anderson (1987, p. 1348) argue that identity work is primarily achieved among the homeless through talk, spaces, such as the drop-in centre's library were also crucial for contributing to positive identity work.

While for homeless people visiting the drop-in centre the living room mainly provided a space where they could feel secure and escape the fear and constant exposure of the street, it was the care workers who strived to make it more than just this. In doing so, the personnel of the drop-in centre went well beyond the requirements of care ethics. In order to facilitate the fostering of a bond between the homeless people and the drop-in centre and because of the insufficient personnel, care workers also took up the responsibility of maintaining the living room as a clean space. Independent of whether they belonged to the social services, the organisation's outreach team or the support personnel, at the end of each tiring working day, the care workers devoted time to clean the living room and all other spaces and facilities of the drop-in centre. Other activities that went beyond their formal duties as care workers included the preparation of food each morning and at noon. This allowed the living room to function as a space of food consumption. Donated by bakeries and restaurants, food was picked up at the premises of each donor and brought to the drop-in centre. Then, care workers divided it into single portions in the kitchen. Food donation is a form of life-sustaining care facilitating the survival of these marginalised populations. Despite the efforts of the drop-in centre's personnel to respond to this need, food provision was not consistent, as it depended on when and whether businesses donated food. In contrast to the meals of the Municipality, these were snacks, sandwiches and pasties. On the rare occasion that a complete meal like chicken and rice was available, portions were given to vulnerable people and families with children. Therefore, homeless people were unable to rely on the food provided there. Nonetheless, they were able to satisfy their hunger in between the meals provided by the Municipality.

The above examples are only a fraction of the activities that manifest how the care workers went beyond their formal work role. For example, Eleana, a care worker from the social services, spent half a day washing and dyeing the hair of Flora, a homeless transgender woman, in order to remove head lice. Dimosthenis, a member of the support personnel who was also in the outreach team because of being a former drug user himself, took up the responsibility of helping homeless and vulnerable people complete their tax statements so that they could secure benefits more easily. 'Going above and beyond' one's formal duties proves one's genuine motivation for care and exceeds 'the remit of one's paid role and contractual obligations' (Brown *et al.*, 2019, p. 224). This is crucial for how care relationships among the personnel and the care recipients develop and is useful when it comes to interactions that require a level of trust and genuine care. However, it also exemplifies how the scope of care labour expands and intensifies during times of limited resources and austerity. Not being able to invest in hiring more care personnel, the drop-in centre's personnel had to take up more responsibilities. In Brown *et al.*'s research (2019), it was precisely the factor of being constantly crisis-driven that allowed for such manifestations of care and made many social workers paradoxically perceive this reality as a norm or a necessary part of their social work practice.

Going above and beyond one's role comes with an interesting contradiction. On the one hand, care workers extended their role to administrative and accountancy work, making food, creating time schedules and cleaning the spaces of the centre. All these constitute direct or indirect forms of care. All were necessary for care relationships to develop, the space of care to function in an accommodating way and to help the homeless people visiting the centre survive longer through food provision. On the other hand, this meant that care workers could invest less time in nurturing care relationships. Rather than being at their post, they often had to interrupt their formal work and engage in other activities. In the case of Dimosthenis, this meant that he would occasionally not join the outreach team or Jenny the leader of the outreach team who was involved in the food preparation, would end up delaying her departure from the drop-in centre to conduct outreach work. In the case of Eleana, dyeing the hair of this transgender woman took half a day, during which she was unable to see any other people waiting for her. Yet, knowing Flora for a long time and how vulnerable she was as a sex worker and transgender woman sleeping rough, Eleana prioritised helping her. Engaging or not in

such activities was a daily dilemma among care workers and without a concrete approach set by the management, care workers decided ad-hoc how to go about such cases.

The Social Services: Obstacles and Disruptions in Care Relationships

The social services were located in a bigger room on the right side of the lift and across the laundries. There, five care workers helped care recipients (homeless people, refugees, neo-poor and people in a precarious financial position) with all sorts of problems: from bureaucratic issues and applying for a benefit to sharing deep and traumatic life events. While the municipal care workers often provided care in an emotionally distanced way, the five care workers of the drop-in centre were deeply engaged in relationships of care and their role as carers was a central part of their professional and personal lives. Their ability to provide more personalised care in their weekly contact with service users created a sense of obligation for care workers precisely because they were able to see most of the homeless people on a one-to-one basis. Therefore, follow-ups were possible, and having longer appointments they were able to gradually understand details about each recipient's life and personality. This type of unmediated and consistent contact enabled the conditions of 'caring for' concrete persons in direct relationships (Noddings, 1984). The focus on creating long-term relationships in this space was to rehabilitate and empower homeless people to take control over their lives and take the necessary steps to escape their difficult predicament. In this sense, they focused on alleviating the instilled emotions of ontological insecurity, powerlessness, fear and extreme marginalisation resulting both from the experience of homelessness and their interaction with different institutions in the city. Despite prioritising 'relationship-work' (Banks, 2016), this space of care was an under-resourced environment where care workers often had to provide urgent care with limited support. In addition, tensions resulting from the care workers' relationship with the management made them feel unaided in their daily struggle to provide care. The resulting emotions of frustration, exhaustion and burnout were prominent among care workers and presented themselves in all facilities and forms of care provided in this space of care. A variety of factors obstructed care workers from adhering to values of care ethics and undermined the efforts of care workers to conduct relationship-work.

A space to be listened to?

In order to establish trust, listening was vital. Yet, being in a unified space and in close proximity to one another, the space of the social services could not function as a space of listening. Hence, confidentiality and privacy were compromised for anyone sharing their personal stories or emotions, as they could be overheard or seen by others in the office. As many conversations were taking place at the same time, the atmosphere was loud and chaotic. Therefore, some care workers had to raise their voice to be heard by elderly service users. In other cases, the atmosphere was loud because of anger and rage expressed by care recipients. Such feelings appeared when effort, and therefore also trust, was put in by a homeless person to initiate a procedure which did not produce the desired results. For example, when efforts to apply for a benefit, issue an ID or even arrange medical examinations were not successful, some homeless people lost their patience and reacted by shouting and leaving the social services offices.

Such a chaotic and loud environment raises questions about whether the act of listening, at the epicentre of care relationships, could take place in this space. Listening is a prerequisite for care ethics and responding to needs, as it is the act that allows the carer to understand the needs of the care recipient. It is the time when a carer can really get to know the care recipient and ask in Weil's words (1977, p. 51): 'What are you going through?' Weil's emphasis is on attention and attentiveness, values central to care ethics. The carer listens to and observes the cared-for. Weil writes, 'This way of looking is first of all attentive. The soul empties itself of all its own contents in order to receive the being it is looking at, just as he is, in all his truth' (ibid). Although it is questionable whether all care relationships allow for an emptying of the soul, listening is an integral act of care ethics that allows understanding one's expressed rather than assumed needs. It should be noted though that an 'emptying of the soul' did take place at the social services in many cases. Homeless people shared deeply personal stories about how they had lost their home and ended up contemplating suicide. People with mental health issues experienced a breakdown. Others spoke about their journey from their home country to Athens and their experiences of war, torture and abuse. With the help of interpreters, unaccompanied refugee children spoke about their experiences sleeping rough and how they travelled to Athens. Everyone had to share a personal and detailed account of how they ended up on the street during their New Card appointment.

All these emotionally charged conversations took place in a loud environment, in sight of strangers and unknown others. As the carer listened to each person asking for help and care, they experienced what has been called 'motivational displacement' (Noddings, 2010a, pp. 18–20, 2010b, p. 9). This refers to the carer putting aside their own purposes and goals by observing or listening with the intention of understanding the other's predicament, needs and emotions. This requires attentiveness, empathy, compassion and sensitivity on the part of the carer and is a complex enterprise setting high and complex aims. However, it is vital for a relationship of care to develop and for the cared for to place trust and reciprocity in this relationship. In this sense, space should not be regarded as just the background or environment, but a crucial factor shaping relationships of care. The space of the social services hindered the nurturing of relationships based on motivational displacement. And although reciprocity and genuine care were part of the relationships at the drop-in centre, the physical environment of the social services undermined care ethics and posed a challenge to the bond between homeless people and care workers.

Waiting for Petros: Working with limited resources in an intersected space of care

Being part of the intersected landscapes of care, welcoming groups of care recipients with different levels of care needs and vulnerability (see Chapter 3) affected the quality of care relationships developing between homeless people and care workers at the social services. The impact of insufficient staff on relationship work is articulated by Eleana one of the social services' care workers who presented the reality of the social services in her interview:

> For instance, today I was on my own at the social services, because another social worker was off today, since she was working in the weekend. The other one took a day off. The third one had an out of the office appointment with a client. The other two guys who formally belong to the street work team but help us whenever they are not doing outreach work, had to do outreach work today. It was just me with an intern, who in the end started taking cases herself because I was just drowning in workload and simply couldn't do everything myself. I didn't like giving work to this intern but couldn't do otherwise. It was not ok for her to work with people she has never seen before or to sit down with people she doesn't know and do things with them. I couldn't even follow what she was doing because I had so many other things to do. This is chaos. We are under-resourced. We don't have enough personnel. We are far too few. […] It's simple. Less people will receive less service, bad quality services. The quality will reduce. I am not on a production line. I am not just putting screws. I just can't see one after another.

> I cannot do both: really devote time to work on a deeper level with my cases, and also see 15 cases.

Eleana's words vividly present the strain the area of the social services were under and how it impacted the quality of care work. In her interview, Eleana explained that in the previous year, the personnel of the drop-in centre had decreased by eight people. Because of this, members of the outreach team were also recruited to support the social services. As the drop-in centre operated seven days a week, some of the employees took time off on weekdays. Therefore, the number of employees shifted every day. Eleana's frustration and explanation that 'she is not putting screws' speaks volumes about the constraints and complexities of conducting relationship work in such a work environment. Being under-resourced, Eleana had no other choice than get the intern involved, although she was not familiar with the work or the personal stories of the service users. In this context, it was inevitable for care relationships to become even more fragile and be impacted by these conditions. On the care receiving end, this resulted in homeless people waiting longer to see their care workers. In navigating the landscape of care, homeless people were accustomed to being kept waiting (see Chapter 6). Despite seeing comparably less people than the Municipality, the nature of relationship work means it takes longer, and working with insufficient personnel, homeless people had to wait without knowing how long it would be until they saw their case worker.

This demonstrated in Mohammed's experience of waiting in the living room for his care worker, Petros, who was at the social services seeing other service users. Three months into my fieldwork, Mohammed had been sitting in the living room and urgently wanted to speak to his care worker, Petros. He had been trying to speak to Petros for days. Mohammed was in a poor psychological state and Iokasti suspected this could be linked with his substance abuse. Because he had a special relationship with Petros, he said he desperately needed to speak to him. However, Petros, who had also formed a special relationship with Mohammed, could not find time to see him. While rushing to accompany a newcomer who had to be taken urgently to the hospital at this specific moment as an interpreter was available, Petros saw Mohammed waiting on his way out of the office and to the lift. He said to him apologetically: 'I will come back. I have absolutely no clue when. But I will - I know you have been waiting for me'. The next day, Petros was preoccupied with a transgender and abused woman from Pakistan and her male friend who admitted considering committing suicide in the coming days, if he was

not able to receive care and find a solution to his problems soon. Because of the urgency of this situation and having secured an interpreter speaking their language from another NGO, the appointment could not be postponed. After spending more than three hours speaking to them, being mentally exhausted and not having had lunch, Petros disappeared into the kitchen.

Three days later, Mohammed had still not seen Petros despite coming to the centre every day. Iokasti at the reception knew that Mohammed was at a low ebb and was trying to be supportive, but her role was to be a support worker and not a social worker seeing care recipients. Eleana also approached Mohammed who was sitting quietly at the living room, hoping that Petros would come for him every time he was coming out of the social services. She suggested he spoke to her instead of Petros. He thanked her but he responded he needed to speak with Petros. Without showing frustration, Mohammed was determined to only see Petros because of the strong bond they had developed. Petros was familiar with his life story and emotional difficulties. It took another four days for Mohammed to see Petros on a Saturday afternoon, when not many people were at the drop-in centre. Despite being dependent on him, because of their mutual trust, Mohammed was understanding about how much work Petros had and how many people had to be seen. This story is relevant to the concern raised by Noddings (1984) with regards to the number of people one can genuinely care for. As with other care workers, Petros was rationing the distribution of care (Brown *et al.*, 2019, p. 224). This involves making decisions and negotiating one's time and workload while a need for realism over how caseloads and care are managed is in place.

Deciding the right course of action and making justified ethical judgements, like the one Petros made, depicted a form of 'reason work' (Banks, 2016, p. 43) which the drop-in centre's care workers engaged in daily while juggling a high caseload and responsibilities. In this case, Petros had to decide how he would prioritise who he would see first and while this couple were strangers to him and no prior care relationship between them was in place, he made a call to respond to their needs because of their situation's urgency. The decision of delaying this conversation appeared to take into account the trust Mohammed had in him. In addition to one's need to be listened to and the emphasis care recipients put on specific care workers, such incidents demonstrate what it means to provide and receive care in a space of care facing a number of competing

pressures. Care workers often complain about having inadequate resources for their tasks (Tronto, 2010, p. 165). However, the impact of insufficient staff and multiple needs on the quality of care and relationship work is profound. While Petros was able to demonstrate *attentiveness* towards Mohammed by recognising Mohammed's need to be cared about (Tronto, 1993, p. 127), working in such an environment did not allow him to be *responsive* towards his need, therefore subverting good care. Yet, precisely because of the deep relationships and the trust they had developed over time, their relationship was not jeopardised because of this incident.

Caring for Rena's cats: Drawing boundaries in relationship work

Trained as a psychologist, Petros emphasized the importance of relationship work with service users. He had invested a lot of time in understanding their stories, traumas and personality traits. The homeless people knew he really cared for them and he went to great lengths to support them and respond to their needs. One of his cases was Rena. In her late forties, Rena who came from Romania was suffering from mental health issues. She was living with over sixty stray cats that had been keeping her company and who, she said, were also protecting her from mice. She lived in an abandoned building that the owner now wanted to prevent access to and therefore she had to vacate this space. This perturbed Rena who was becoming anxious, not knowing where she and her cats would end up sleeping. Rena would only accept being housed if the cats could go with her. Similar to Chloe and Gianna, two other women who loved their pets and had prioritised the pets' wellbeing over theirs (see Chapter 5), abandoning the cats was out of question for Rena, who often said 'these cats have a better soul than most people'. To respond to this need of hers, Petros spent weeks calling dozens of cat shelters, organisations and even women's monasteries asking them to offer a room for her and the cats.

As with other care workers at the drop-in centre, Petros went above and beyond the remit of his paid duties. This problematises what could be understood as time necessary for care provision. In particular, rather than the time directly invested in a relationship or activity of care, this example shows that the time required for the ultimate reception of care might stretch to seemingly unrelated activities, such as calling cat shelters. Investing time for such activities goes beyond traditional understandings of care but massively affects how care relationships are shaped. Rena had eventually been

persuaded to agree to being housed after her cats had found shelter, but Petros was unable to secure a shelter for the cats. This substantially jeopardised their relationship and trust. Rena had become very angry at Petros as she thought he could not understand her connection with the cats.

Eventually, Petros decided that boundaries had to be drawn and told Rena there was nothing else he could do for the cats. Considered a vital part for the practice of social work (Dietz and Thompson, 2004), boundaries are 'limits that allow for a safe connection based on the client's needs' (Peterson, 1992, p. 74). Imposing them posed an ethical dilemma for Petros who was aware of how this could further damage his relationship with Rena. This dilemma revolved around showing 'limitless' or 'mature care'. Drawing on Pettersen (2012), Brown et al. (2019) explain that 'limitless care' draws on altruism and is unconditional, selfless and spontaneous. Taking into account questions around equity, distribution and resources, the alternative is 'mature care', namely 'a stance that recognises that care is relational and compassionate but not limitless' (Brown *et al.*, 2019, p. 227). Pettersen (2012) argues for mature care explaining that it might serve the long-term interests of the care recipient, while limitless care is hard to control, unsustainable and assumes that care givers have unlimited resources and time. Seeing that the limitless care he had initially demonstrated by investing time into calling cat shelters did not yield any positive results and aware of the reduced time other care recipients received from him, Petros stopped looking for shelters. This came as part of a wider realisation that that it was time the boundaries of their relationship were redefined and he waited for Rena to re-approach him. Banks (2016, p. 40) refers to this kind of boundary work as a 'reframing exercise' that aims at reinstating one's professional boundaries as social worker. However, boundary making can prove how fragile and sensitive care relationships are. As he had expected, Rena interrupted her relationship and communication. Six weeks later Rena decided to respond to Petros who had only been saying hello to her in the interim period and this restarted their relationship within these new boundaries.

The Showers, the Laundry Room, the Hairdresser's Room and the Doctor: Care of the Body

Despite the fact that relationships of care were fragile, the drop-in centre managed to respond to an array of corporeal needs, through caring for the homeless peoples'

bodies. The bodies of those sleeping rough are testaments to the daily inequalities and suffering they endure daily. One's 'corporeal self represents a barometer of the conditions in which it functions' (Higate, 2000, p. 103). In this sense, not having regular access to shower facilities or lavatories were all barriers that constitute the bodies of homeless people as sites of production of these social and urban inequalities, resulting from being unable to access basic resources (showers, laundry, shampoo etc). This structurally imposed suffering is imprinted on their marginalised bodies, inscribed on their embodied subjectivities and consequently, on their self-perception. I have discussed in Chapter 5 how a lack of access to lavatories made Dimitra feel humiliated and how the very experience of rough sleeping led to feelings of dehumanisation.

Four spaces on the first floor of the drop-in centre were devoted to alleviating these systemic problems and feelings among homeless people, by responding to crucial corporeal needs. When care is focused on the body, it incorporates different spheres: the biological, the social, the moral and the political (Moss & Dyck, 1996; Parr, 2002). Milligan *et. al* argue that when thinking about care from this perspective, it 'is viewed as representing a category through which we might explore the negotiation of these spheres at different scales of action (individual, institutional and societal) in the practice and production of the body.' (Milligan *et al.*, 2007, p. 137). While the care provided at the doctor's office primarily revolved around medical care through the provision of primary healthcare, the care functions of these other rooms were not as straightforward. Yet, they were vital in forming a strong bond between the homeless people and the drop-in centre, as the latter played a positive role of 'identity work' (Banks, 2016) for those visiting the centre.

The importance of the shower and laundry facilities to the lives of homeless people was repeatedly verbally emphasized before my interviews with some of my participants. It was common that when I was seeing someone with whom I had arranged an interview, they would insist on doing the interview after they had their shower. Usually this was accompanied by the phrase: 'Let me become a person (άνθρωπος)[61] first and I will come and do the interview right after this'. This alludes to an experience of the body as something inappropriate, dirty, and potentially shameful that even made some

[61] In Greek this phrase signifies being a human being enjoying others' respect and looking as expected.

participants feel they were losing their identity as human beings. By having a shower and washing their clothes, the homeless people visiting the drop-in centre seemed to regain their genuine personal identity and were happy to expose themselves socially to others and to me as a researcher. The doctor's medical care and the spaces of the showers and laundries were reducing the embodied marginality experienced by the homeless. In the case of the drop-in centre, cleaning one's body and wearing clean clothes while also having access to medical care is crucial for one's wellbeing and maintaining a healthy body. This was all part of the identity work achieved at the drop-in centre.

As a result, although the drop-in centre did not have ample space, utilising it in a way that responds to multiple needs was valuable. Having sufficient space is in and of itself significant for a care space to function as such. Responding to different needs through using space for multiple purposes explains why the homeless people I encountered spoke positively about the drop-in centre and kept coming back. During an 'Invisible Tour' showing us spaces of importance to him, Makis, a homeless person, said when we arrived outside the drop-in centre:

> This is where it all started for me and I started getting back on my feet. This has nothing to do with me. These lovely people, the social workers helped me, showed me the showers, the laundry and spoke to me in a way that no one else had in a long time. And every time I pass this place, I think of them and how much they helped me. They made me feel like a human again.

Makis stresses how important this space was for him. Yet, the provision of this vital form of care did not come without obstacles and difficulties. Having a shower and doing the laundry constitutes a form of care towards one's body and health. One of the few shower facilities was at the drop-in centre I spent most of my fieldwork at. Each registered service user had a specific weekly appointment for a shower and doing their laundry. However, this was not a straightforward or easy undertaking because of the number of users at the drop-in centre. The phrase '[*Surname*]-Shower' or '[*Surname*]-Laundry' or '[*Surname*]-Laundry and Shower' were perpetually shouted by the receptionist to those waiting in the living room. The cacophony of voices in this area was enough to create a sense of disorganisation and chaos. Similarly, another care worker on the corridor right outside the laundry facilities was shouting to the care worker at the reception, 'SHOWERS:

TWO!' or 'LAUNDRIES: THREE!', signalling the number of available showers and laundries.

The insufficient number of laundries and showers created many problems for those waiting in the living room. One common problem was that some service users had arguments and shouted, insisting they did not want to share a laundry with another person, thinking the other person was sick, too dirty or just because they simply did not like them. This shows how caregiving and care receiving can be a much more complicated matter in practice than it first appears. On the one hand, the care workers did not have the care resources - more washing machines in this case - to satisfy these requirements. On the other hand, if they did, it would allow a stigmatising attitude some service users had towards others to crystallise and potentially be used to demean others in the future. On the care receiving end, homeless people articulated their desire their clothes should not be mixed with others. This made them believe their bodies were protected from others' illnesses and diseases. In addition, some seemed to want to distinguish themselves from others who had additional vulnerabilities to them as this would put them in more exclusionary categories. For example, one person sleeping in an abandoned building did not want to have their clothes washed with someone who was sleeping rough on the street, as the former thought they were better off than the latter. In order to find a solution, the care worker responsible for the laundries would ask the person who did not want their clothes washed with someone else's to wait longer if they wanted this. Care ethics emphasize the importance of personalised care and responding to needs as they are expressed by each individual. However, all these factors constitute constraints in providing and receiving care in a space of multiple pressures and rendered the practice of care ethics a convoluted enterprise for all involved. Similar to the low quality of food at the municipal soup kitchen (see Chapter 6), this is another reminder for rough sleepers that if they are to receive care, they have no choice but to compromise in ways they would not expect to as housed people.

One of these compromises was linked with the amount of time each person was able to use the shower. Resulting from a lack of necessary resources, such as water, the number of service users having a shower at the same time meant that there was not enough hot water for everyone. Despite the efforts of the care workers to limit each shower to ten minutes, this led to tension and endless negotiations between the care

workers and the homeless who were shouting from the shower 'I am coming!' but would take up to ten further minutes before coming out. The reaction of those who wanted to have longer showers should not be surprising as for some this was the only shower they would have for an entire week. In addition, the fact that showers were used simultaneously by multiple people for hours meant that some people had to have a cold shower or to wait for hot water to become available. For those having a weekly slot close to noon, waiting could mean not being able to attend the municipal soup kitchen. Not having enough space to meet the service users' needs creates complex ethical dilemmas for care workers. In the case of the drop-in centre, the positive identity work taking place in its space was engrafted with compromises regarding the care the centre were able to offer and the quality of care received by homeless people.

While care through provision of showers and laundries came with a set of compromises hindering personalised care, the existence of a volunteer hairdresser provided a form of care in relation to one's personal appearance and according to one's wishes. From a simple haircut to dyeing and cutting hair, homeless people were able to tailor their looks without restrictions. As the experience of homelessness might also include an alteration of one's options for modifying one's appearance, accessing a hairdresser created a solution to this issue. The hairdresser was very happy to accommodate anyone's needs except if this meant he would not be able to see others. In this sense, this was one of the few chances homeless people had to define the care they received without compromise. In contrast, this hairdresser enhanced the positive identity work the drop-in centre was offering to its users. The relationship of care that had developed between the hairdresser and the homeless people was a warm one. Often their exchanges involved humour from both sides, showing how comfortable they both felt with one another. This hairdresser was the only one available to many of the people sleeping rough on the streets of Athens. However, four months into my fieldwork the hairdresser found a job. While he was happy to stay at the drop-in centre on the condition that he was paid, the necessary financial resources could not be secured. This saddened all those who lost this form of essential care after the hairdresser left, as they were not able to substitute it elsewhere.

The Kitchen: A Private Space for Self-Care for the Care Workers

The kitchen was on the right side of the lift, at the end of a corridor, it was a private space for the staff. The counter outside and a curtain blocking the view into the kitchen demarcated the professional and personal boundaries between the care workers and the homeless. The drop-in centre was a complicated space. The consequences of pressures internal to the drop-in centre and working as part of this complex landscape while caring for a vulnerable population resulted in exhaustion among care workers. The close engagement they had with homeless people and the provision of all forms of care – emotional, practical, bureaucratic – both contributed to the care workers' exhaustion and their motivation to care further. As Iokasti's earlier quote shows, it was the people who kept her working there and 'muddling through' this complex professional reality. All these components were crucial factors in the burnout experienced by care workers across the landscape of care.

Often the conversations held by care workers at the kitchen involved sharing emotions of anger, frustration, desperation, disappointment or concern. It was also a time of introspective reflection on their relationships with other colleagues and the management, professional dilemmas and specific cases of homeless people that were facing particularly difficult and traumatic moments in their lives. Other care workers used the kitchen as a space where they could just 'shut down' as they were not in an emotional state to participate in conversations. Like Iokasti, who did not respond to someone's 'Hello' or 'Good morning', both care workers and interpreters explicitly said they would rather be left alone, as they were close to their limits. In other words, the kitchen was a space where a break could be taken from their caring role. Often, this break was when they were having their lunch. Seeing many people and having different responsibilities each day meant that lunch time was not set. This time was also used to socialise with other care workers whose breaks coincided with their own.

Exemplary of the care workers' need for isolation, privacy and an interruption from caregiving activities was a small space next to the storage room and behind the kitchen. When not needed, interpreters would 'hide' in this room in order to escape the chaotic situation evident in the other areas of the centre or to avoid being found when they had reached an emotional limit of being involved in care provision. In some cases when I had discovered someone hiding there, they asked me not to disclose to others that

I had seen them. Except in emergency situations, the decision of a care worker to be isolated was normalised and rather than frowned upon, such behaviours were respected, especially when a care worker had a difficult day. To support each other and alleviate each other's feelings, care workers used the kitchen as a space of (self-)care by temporarily relinquishing their caregiving role and becoming cared for by other care workers. Noddings (2010b, p. 10) argues that part of mature relationships of care involves parties exchanging places regularly and becoming cared for, rather than caring. In the case of the care workers I encountered, the lack of supervision precluded them from being cared for by a supervisor with whom they would be able to share their own perspective and emotions. As a result, this was a role taken up by other care workers, who often encouraged their colleagues to keep a distance from certain roles and cases that appeared to be overwhelming for them.

In her work on self-care and social workers, Dalphon (2019) argues that self-care encompasses all of the following realms of a social worker's life: 'emotional, psychological, physical, spiritual, professional and relational'. It is an ethical responsibility in order to be able to provide care (ibid). Self-care and burnout are clearly correlated (ibid) and for this reason, it should not be overlooked by an organisation and a space of care focusing on maintaining relationships of care which promote the values of care ethics. In an interview with the drop-in centre's manager towards the end of my fieldwork, I asked her about how she felt regarding the drop-in centre, whether she thought care workers are affected by being on the frontline in terms of their personal and professional life and the way they can then take care of the service users. At first, she was defensive and, then she said:

> They are affected in many ways. However, everyone has two options. You either become creative or you will just feel cancelled out by the profession you chose to do. This is everyone's personal responsibility. And how one evolves and faces the difficulties in one's professional life is also important. There is no profession with no difficulties. [….] The profession of the social worker became even more important during the crisis and there are even more vacancies for social workers during the crisis. The people [the social workers] might be in an extreme situation, but – to be cynical about it – they would be even more so if they had no job. […] The everyday life of these people is extremely difficult precisely because of the nature of their work, as the everyday life of a social worker at a hospital would be, or at psychiatric hospital. […] The only way for them not to have a burnout is to find escapes on a personal level- there are no other choices. But this is linked with their own professionalism and their ability to set boundaries to their

> profession. […] For example, I might have a case and I will still think about this case, but I still need to cook for my kids after I leave work.

The manager appears to lay the responsibility on the care workers to become creative and to approach their work life in a healthier way in order to deal with their burnout more effectively. Tronto (1993, pp. 131–3) suggests that responsibility is another ethical element of care. Using the parental care towards children as an example, she defines responsibility as 'something we did or did not do' which results in the engendering of care needs and as 'embedded in a set of implicit cultural practices, rather than in a set of formal rules or series of promises'. However, what the space of the kitchen and the manager's quote demonstrate are three different forms of responsibility. Firstly, there was a responsibility of care workers towards the homeless people. Second, there was a responsibility for caring for one's self and finally, the responsibility of caring towards the carers.

The space of the kitchen was a common space where their tense relationship with the management was discussed. Often, they accused the management of not understanding the challenges and dynamics of frontline care or their own needs as carers. When arguing for self-care the management seemed to neglect an important aspect of the care workers' lives: that the close relationships between homeless people and care workers generated a sense of obligation and ethical responsibility for the latter. Care workers were going to great lengths to care for homeless people. Emphasizing humanity and the importance of caring for any individual in need and saying that it was often only them who could provide support and solutions to the homeless people, they extended their duties and working hours, often unpaid. Doing unpaid overtime can be understood as a way of performing care work according to one's ethical values and as an invisible resourcefulness to soften the impacts of austerity (Aronson and Sammon, 2000; Clayton, Donovan and Merchant, 2015; Grootegoed and Smith, 2018).

Additional strains on the care workers involved their marked insecurity regarding their own wages, being paid on time and the end of the funding contract that backed the scheme they were employed in (see Chapter 3). Tackling both the intrinsic complexities of care work and their own anxieties regarding their employment and financial state made care workers experience emotions linked with facets of ontological insecurity. Unable to

plan their professional and personal future, working in an extreme environment of multiple pressures with limited resources and juggling various responsibilities of care at the same time instilled feelings of powerlessness, exhaustion, anxiety and stress among care workers. In this sense, both the care workers and the homeless people were experiencing emotions that jeopardised their ability to provide and receive care.

Conclusions

This chapter has explored the socio-spatial layout of care and care ethics in a drop-in centre for homeless people in the centre of Athens. By looking at the different functions of each room and the different care activities taking place within them, one can more fully identify the response to different care needs and, potentially, those needs that are not met. Reflecting on the spatial aspect of care, space has been more than a backdrop for care relationships. Although this drop-in centre had considerably less space than the Municipality, it utilised space in a way that adhered to care ethics. For this reason, homeless people had access to the majority of its rooms and care workers were able to respond to more needs. The different rooms, such as the living room, the library and the hairdresser, reveal that the drop-in centre went beyond responding solely to basic needs of life-sustenance. Instead, it contributed to a positive identity work by treating homeless people in a way that did not reduce them solely to one single identity. Because of their regular visits and receiving support from different care workers, the basic, corporeal needs (laundry, showers, medical support) were able to be satisfied in a more personalised way and through relationships of care. Yet, as this chapter demonstrated, this came with tensions and dilemmas resulting precisely from the lack of spatial and other resources to respond to the number of care recipients.

By considering the macro-level factors shaping spaces and relationships of care, it becomes evident how the lack of available financial, emotional and spatial resources rendered the drop-in centre a fragile space of multiple pressures. To cope with these pressures and respond to systemic deficiencies, these care workers were going above and beyond traditional activities of care. The close and consistent contact and the number of people both allowed for closer engagements of care and a commitment to values of care. Yet, they also created dilemmas and resulted in exhaustion and burnout among care workers. Remaining committed to a set of ethical and often altruistic values of care while working in under-resourced environments hit by austerity, care workers worked long

hours and expanded their caring role. Often, they experienced traumatic feelings, such as burnout and stress, and an overburdening of different responsibilities. This is especially concerning for the values of care ethics as 'this can lead to interlaced frameworks of power and powerlessness where the care-recipient may be dependent on the care-worker to meet their fundamental needs, but the care-worker may also be vulnerable not only to the actions of the care-recipient but to the interests of their employer as well' (Kittay, 2001, p. 561).

If care is to be provided sustainably according to the requirements of care ethics, the needs and the wellbeing of carers are equally important to the those of the care recipients. In addition, because of the lack of resources, various sets of dilemmas regarding whose care should be prioritised or tensions between taking up practical and administrative or emotional responsibilities of care were prevalent. In this sense, this chapter has supported the literature which maintains that spaces of care both shape and are shaped by the care relationships within them (Conradson, 2003b; Johnsen, Cloke and May, 2005; Bowlby, 2012). Indeed, the quality of care homeless people were able to receive was reliant on the support care workers had. Nonetheless, the close relationships and the different kinds of needs that this drop-in centre responded to constituted it as a space of refuge, licence and corporeal care for homeless people. In the next and final empirical chapter of this thesis, I move my attention outwards: to the city. In so doing, I discuss the dilemmas and obstacles underpinning experiences of caregiving and care receiving in a public Park in the centre of Athens.

Chapter 8

Drifting Apart: Outreach work in a 'bottom-up' space of care

Introduction

After analysing two gated spaces of care, the Municipality – a public provider of care – and the drop-in centre – a voluntary space – my attention moves back to the city and an open space of care, namely one publicly accessed without restrictions. By looking at a public Park in central Athens, this chapter develops our understanding of spaces of care through a new category, 'bottom-up' spaces of care. 'Bottom-up' spaces of care are realms of vulnerability and deprivation formed through the occupation of public spaces by marginalised groups. Elsewhere in the thesis, spaces like George's home in the train underpass (see Chapter 5), the small square occupied by a homeless man in Kypseli (see Chapter 6), as well as the benches, alleyways and entrances to buildings where many of my participants were sleeping rough can be understood as such spaces. Around contemporary cities these spaces are prevalent and include public spaces occupied by homeless people, refugees and migrants or other marginalised groups.[62] They differentiate from other 'open' spaces of care (see Chapter 3) where outreach teams or other agents of the city operate as the location of outreach work is not defined by caregivers. For example, the public laundry, the shower bus, different local soup runs or the municipal kiosk were all spaces of care produced through the initiative of organisations. Consequently, by choosing the location of outreach work, organisations were also able to define the conditions of care provision. In contrast, the location of 'bottom-up' spaces, such as the Park or pavements where outreach teams met homeless individuals, were not defined by caregivers.

However the fact that the location of such spaces is defined more by care recipients does not mean that such spaces are produced through independent decisions, involving autonomy and agency. In particular, while at first glance such spaces *appear* to be produced by an individual's or a group's decision to occupy a public space, they are the result of wider systemic and often exclusionary processes taking place at the state or

[62] For example, the Victoria Square near the Park I explore has been occupied by refugees several times and has served as a space where they can sleep and get by.

city level and in the realm of care provision. In this sense, they are shaped by complex institutional processes. These types of spaces are testaments to specific and advanced forms of socio-spatial vulnerability constructed through wider systems which limit the autonomy of certain groups, leaving them no option other than occupy contained public spaces. Care provision manifests itself in these spaces either through its absence and neglect towards those occupying 'bottom-up' spaces, or by appearing sporadically. Often, this results from constraints faced by caring agents or from institutional processes excluding certain categories of vulnerable groups from care provision. In this sense, 'bottom-up' spaces are shaped by the city, belong to landscapes of care and therefore form part of the complex and often varied configuration of local care provision. Accordingly, 'bottom-up' spaces can point to limitations in institutional systems of care and constraints affecting caring agents and the production of marginality and vulnerability in contemporary cities. As an additional category of *spaces* of care, their distinct characteristic is that territorially they are defined by the care recipients – rather than caregivers. However, because neither caregivers nor care recipients explicitly have the control of this space and their exchanges can be brief due to external factors and interventions, a high level of commitment and strong motivation are required by outreach workers.

I focus on the second biggest and greenest public Park in the city, the 'Pedion tou Areos' Park where two established drug markets operated. This chapter examines a specific form of care provision, outreach work, and a specific experience of homelessness among drug users who live in or pass through the Park. Shadowing two outreach teams, I explore how care provision and the relationships between the outreach workers and the homeless were affected by the public nature of the Park and systemic problems of the landscape of care. By providing an ethnographic analysis of this space, this chapter explains how care and homelessness, or vulnerability more broadly, are co-situated and intertwined in the urban milieu and how a range of territories emerge as 'bottom-up' spaces of care in the city. Urban territories like the Park further complicate the difficulties and obstacles both for caregivers and care receivers, as their exchanges took place in a space not explicitly controlled by either party. In contrast, this Park was a contested space in Athens, shaped by multiple agents and conditions that did not always contribute to an environment conducive to care ethics and effective care provision.

In thinking about care in this chapter, I use the literature of outreach work. Rather than waiting for homeless people to seek services at a specific place, outreach workers 'go to where people are' as the site-based social services may not be accessible by certain categories of groups (Olivet *et al.*, 2010, p. 53). A crucial part of outreach work is engagement which refers both to 'engagement in services' and 'the process of building a trusting relationship' (ibid, p. 54). A concise definition of outreach work is:

> a contact-making and resource-mediating social activity, performed in surroundings and situations that the outreach worker does not control or organise, and targeted at individuals and groups who otherwise are hard to reach and who need easy accessible linkage to support (Andersson, 2010, p. 68) (as cited in Andersson, 2013, p. 184).

Key to outreach work is the intention to reconnect groups in need of care with spaces and networks of care provision. It has been presented as a method of approaching and 'developing trusting and engaging relations with […] populations, often but not necessarily with the intention to link them with and foster access to human services' (Grymonprez and Roose, 2019, p. 2).

Despite being the last empirical chapter of this thesis, it also reflects on a number of issues discussed throughout the thesis: the importance of equipping care workers with sufficient training and resources; the employer's responsibility to be attentive to the their needs; as well as wider institutional conditions produced through the structure of the landscape of care, such as the fragmentation of care and various care exclusions. The public and complex territory of the Park made these characteristics more accentuated. By discussing the experience of homeless drug users, it highlights the systemic and exclusionary conditions affecting both care recipients and outreach workers, whose efforts were substantially constrained and undermined. Despite these obstacles, outreach teams intervened and made efforts to provide care. In this sense, the Park combined exclusionary and inclusionary care processes, thereby retaining a unique place in the landscape of care.

After explaining how the Park became a 'bottom-up' space of care and how it is situated in the urban terrain of Athens, I discuss the dynamics and main care practices employed by outreach teams in the two drug markets of the Park. Finally, I discuss how

a number of tensions resulting from a set of unresolved ethical and practical dilemmas both among outreach workers and homeless people led to an estrangement between them. When working with limited support in complex and under resourced environments, the endeavours of outreach workers and the quality of care are undermined to such an extent that a sense of alienation and meaninglessness can be instilled among some of the outreach workers, making homeless people and care workers drift apart.

The Park: The Production of a 'Bottom-up' Space of Care

The main entrance to the Park is located on the corner of the busy Alexandras Avenue and Mavromateon Street. The latter is a tree-lined street filled with large apartment buildings built in the 1930s. These apartments house upper middle-class residents who enjoy the stunning views over the green scenery of the Park. Across these apartments on Mavromateon Street is the second of twelve entrances to the Park. Named after the Roman Campus Martius, translating into the 'Field of Mars', the Park was one of the main promenades and open public entertainment areas for Athenians since 1880. For decades, pedestrians and families strolled the popular 'Heroes Avenue', lined with sculptures honouring historical figures of Greek history. In recent years, it has become a complex and contested part of the Athenian milieu both as a public space in itself and a public space of care provision. After the 1990s, the area surrounding the Park started to deteriorate. To the disappointment of many Athenians and residents, its three main entertainment outdoor theatres and cafeterias popular during the 1960s closed. The area between the Park and Victoria train station, only a short walk away from the Park and one stop away from Omonoia train station, became linked with high criminality, sex work, prevalent drug use and drug dealing (TA NEA, 1999). In the last decade, the areas surrounding the Park were facing their own sets of challenges, such as Kypseli, one of the most densely populated neighbourhoods of Greece (ELSTAT - Hellenic Statistical Authority - 2001) or Exarheia – a contested area with regular clashes between radical political groups and the police.

During the day, the bus-stops on Mavoromateon Street were populated by commuters departing from there to other inner-city locations or regional areas of Greece. In between the train station and the Park's entrance on Mavromateon Street was the back entrance to Athens University of Economics and Commerce. Because of the lack of

resources in the university sector, its buildings appeared more abandoned than in the past. The socio-spatial shift of the Park was further exacerbated by the conditions resulting from the financial crisis as the latter led to the interruption of the Park's 9.5 million euro regeneration process (STAR TV, 2018). The yearly book festivals changed location. The social reconfiguration of the Park was also linked to a jurisdiction conflict regarding the responsibilities of Attica District for the area within the Park's railings and those of the Municipality of Athens for the pavements outside its railings.

The overall change of the area, its administrative limbo and its proximity to the university buildings were key factors that shaped the Park as a 'bottom-up' space of care where various marginalised groups congregated either for long parts of the day or even making it their home. In the aftermath of the 1967-1974 dictatorship, the passing of a law protecting "the free circulation of ideas" and forbidding the interference of the police in university grounds except under direct orders of the University Senate, became the pretext for clashes between the police and students, anarchist groups as well as asylum seekers.[63] Being opposite the university led many homeless people, drug users and migrants to occupy the Park, as taking advantage of this law many of them were close to university grounds where they could find refuge in case of police sweeps.[64] Because of its maze-like structure, pockets of them could be seen outside the Park's main paths in between the high trees and bushes, benches, and vandalised statues. During the night, observational data collected through shadowing outreach teams indicated that extensive male-to-male sex work occurred in deeper areas of the Park.[65] During the hot summer months, the Park with its dense foliage and tree canopies offered a cool shelter for homeless people who would either sit on the abandoned benches to smoke, or use its water fountains to wash themselves, their clothes and other belongings. In the summer

[63] Most recently, in 2011, 300 migrants used the premises of the Law School and took part in a hunger strike protest in order to claim a legal status.
[64] Another established drug market operated outside the Law School and in previous years, the area outside the National Technical University was also congregated by drug users.
[65] One of the outreach teams I shadowed distributed condoms to men engaging in male-to-male sex work in the early evening. Research and media sources, as well as care intervention remained sporadic in relation to this group.

of 2015, over 200 refugees used the Park as a 'home' from warzones, finding refuge in the tents they had put up.[66]

The Park became a 'recognised' 'bottom-up' space of care after the establishment of two drug markets, drawing the attention of care organisations which included the Park in their care territory. Focusing my fieldwork on these markets, I visited these areas shadowing outreach teams. What I label 'the daytime drug market' was created in 2012, after a police sweep that transferred drug users from the drug market adjacent to the National Technical University to this Park. It occupied a dusty clearing behind the railings to the left of the Mavromateon side entrance, known as 'little door' among the outreach workers. Obscured only by bushes sporadically placed along the perimeter of the Park, drug users remained there until the sunset consuming substances. They then relocated to the night-time drug market onto the pavement right outside the Park and just a few meters away from the daytime market. There, the homeless drug users would hang out from dusk to dawn, waiting for the Park to open. The drug markets were visible to residents overlooking the Park from their balconies, passers-by and passing cars. Although the daytime market was slightly hidden as it operated inside the Park and in between trees, it was still visible to all those waiting at the bus stop located less than three meters away from the side entrance to the Park.

According to the outreach workers, the main substances consumed in both of these drug markets were sisa and thai. Sisa, also known as the 'cocaine of the poor', was either inhaled through a glass pipe or injected. Outreach workers estimated that sisa users lived on average 6-12 months due to the toxicity of its ingredients which included battery acid and chlorine which could become lethal. Sisa cost around five euros per crystal and was a substance only consumed at the drug markets of this Park. A suppressant opioid, thai - short for thai heroin - was a cheaper version of heroin, which was primarily injected but could also be inhaled. Like sisa, thai was also cheap ranging from three to five euros per dose. Outreach workers suggested that a thai user would be 'completely changed after 2-3 months of use'. Various types of psychotropic drugs, such as 'boublé'[67], were also sold there and consumed in combination with other illegal substances. According to

[66] For an analysis of the effects of the refugee crisis on the landscape of care for the homeless population in Athens, see chapter 3.
[67] A strong sleeping pill consumed mainly during the night so that users could sleep and treat their withdrawal symptoms

Alexandros, the manager of an outreach team, these cheap drugs appeared at the onset of the crisis and signalled the emergence of addiction to more than one substance. He underscored that these low quality drugs, which can 'immobilise your entire body system' [i.e. body], signalled the beginning of domestic production of drugs as a means of earning money by 'creating basic labs at home' using simple household and cleaning materials, 'such as ethanol, alcohol, chlorine and battery acid'.

The conditions at the Park and the congregation of various marginalised groups resulted in significant frustration among the residents and a proliferation of critical media reports. The media framed the Park as a ghettoised area where negligence led to high public health risk, danger and high criminality. The limited lighting and a number of rumours among outreach workers, occupants of the Park and surrounding residents in relation to rapes, murders, stabbings and even cannibalism created a sense of danger among passers-by and even outreach workers, who felt unsafe to conduct systematic care work in areas deeper inside the Park. While these rumours were never substantiated, they often came up during my fieldwork and showcase an overall atmosphere of perceived danger, violence and lack of control with respect to the Park. To tackle these issues, the residents created a committee called 'We insist on the Pedion tou Areos Park', a name implying their wish to make the Park accessible to them again.

These conditions contributed to the Park becoming a 'bottom-up' space of care congregated by multiple groups. It was because of the visible bodies of these vulnerable groups in a central location that made the Park a public territory of urban marginality, social exclusion and heightened vulnerability. In this process, the city plays a defining role. Grosz (1995) argues that bodies and cities are mutually constitutive. The body is considered active in the production and transformation of the city. However, for the body as a concrete, material organisation of flesh and bones to become a human body, it requires the intervention of the "Other (the language and rule-governed social order)" (Grosz, 1995, p. 104). In this sense, it is the city 'in its particular geographical, architectural, and municipal arrangements' that socially co-constitutes the body (ibid, p. 110). By refusing the caring responsibility towards the marginalised groups of the Park and precluding them from access to housing and systematic material support and care and by allocating only scarce resources to the Park and its outreach teams, the city co-produced the stigmatised corporeality evident in different areas of the Park. In turn, the

bodies of the marginalised 're-inscribe[d] the urban landscape' (ibid, p. 111) by producing what was perceived as a stigmatised territory.

Hence, while 'bottom-up' spaces *appear* to emerge autonomously in the public space, they are linked with wider structural processes taking place in the social and economic life of cities. In the case of the Park, the concentration of vulnerability was interlinked with wider institutional and systemic aspects of the landscape of care, exclusions from 'home-care' it reinforced against drug users (see Chapter 4), as well as police tactics that transferred the drug market to the Park. Being in an administrative limbo meant that no agency took responsibility for the Park, exacerbating conditions of marginalisation and health risks. In the absence of formal and systematic provision, the need and urgency to care became even more pronounced in this part of the city. To compensate for the lack of formal provision, it was the outreach teams that took up the caring responsibility towards these groups occupying the Park and strived to provide care to them despite the limited resources at their disposal.

Obstacles and Practices of Care Provision in a 'Bottom-Up' Space of Care

The outreach teams

Out of the six outreach teams (five NGO and one municipal – see chapter 3) operating in Athens, only two entered the Park to conduct care work for reasons potentially linked with danger. Due to their time of arrival, I call one the 'daytime team' and the other the 'night-time team'. Both of these teams had a parent organisation: the former operated as part of the drop-in centre and the latter as part of an organisation fighting for the prevention of HIV transmission. The aims of both teams were to engage with clients, provide psycho-social support, distribute essentials and link service-users with appropriate organisations. The daytime team consisted of Jenny (a psychologist), Dimosthenis (a social worker), Panagiotis (a former drug user who was hired at the drop-in centre as support personnel) and Mahmoud (an interpreter for Farsi and Arabic). On the other hand, the night-time team was larger with: three permanent members, including their leader, Michael, one interpreter and two volunteers.

Both teams visited the Park once or twice a week. The daytime team started from the drop-in centre. Members involved in additional caring responsibilities often delayed the departure of the outreach team, resulting in frustration for Jenny. Occasionally, she decided to conduct outreach with fewer members, even if this meant that there were only one or two members with her. Aware that the lack of personnel would impact on the quality of their work and increase the sense of risk among outreach workers, Jenny felt tensions rising between her and others who did not share her work ethos. Yet, she was aware of the pressures her organisation was facing and as she had limited support from the management, she often put up with this. Consequently, problems within organisations extend themselves to outside spaces of care. After filling their backpacks with water bottles, deodorants, condoms, and occasionally sandwiches, they left the drop-in centre and carried these heavy bags across Athens to reach the Park. During their half an hour walk, they stopped whenever they found rough sleepers, distributed items while informing them about available organisations and handed them essential items. Hall and Smith (2013, p. 281) have emphasized the role of walking in outreach as this is the only way to reach certain spaces or look closer and engage with clients.

In contrast to the 'footwork' (ibid) adopted by the daytime outreach team, the night-team team had a van at its disposal and were more consistent in the way they organised their outreach work. They usually met at a central square early in the evening and prepared themselves for an all-nighter. Equipped with coffee and sandwiches to make it through the night, they waited for everyone to get in their van. Their first stop was the Park, where they stayed between one and one and a half hours. Next, they drove to another drug market outside the Athens Law School. Lastly, at around 6am they went to sex workers and prostitution houses, where they provided condoms and informative leaflets to both clients and sex workers for the prevention of HIV. As sex work and extensive drug use – two high risk activities for HIV transmission – took place at the Park, they included it in their territory of care provision. A deficiency discussed both by Michael and Jenny was their organisations' inability to secure clean injections for needle exchange, as neither organisation prioritised drug use. For this reason, the material support of their outreach work was limited to distributing essentials. In addition, their outreach work related to making contact, making efforts to initiate positive social change processes and provide medical and other information regarding the organisations where addicts can seek suitable help.

Like most other outreach workers in the landscape of care, the outreach workers had received limited specialist training from their organisation. They picked up most of what they knew on the job from more experienced outreach workers; to a great extent, decisions were made ad hoc. A large part of outreach work comprises of 'managing contingency', both because of the uncertainty it involves as outreach workers operate in an area they cannot control and because of its 'open-ended character' which conceives contact making as 'an attempt and not a final solution' (Andersson, 2013, p. 183). Trained as a psychologist and having significant experience of working with adolescent and adult drug users in different rehabilitation programmes, Jenny was familiar with various aspects of outreach work with users. To gain more specialist knowledge, Michael was also completing a master's programme in epidemiology and addiction. While they were able to draw on this set of knowledge, contact making in a public setting required competence and 'skills to initiate and maintain communication under conditions that do not stimulate reciprocity and relational action' (Andersson, 2013, p. 176). Skills considered valuable include staff self-care, teamwork, boundaries and ethics, personal safety, relationship-building skills, motivational interviewing, basic medical care, conflict de-escalation, effective referral and linkages (Kraybill, 2002; Olivet *et al.*, 2010, p. 67)

Because of the complex nature of such caregiving roles and the sense of disappointment often resulting from it, motivation is a crucial element for outreach teams, as this can define one's commitment and values. Indeed, Mikkonen et al. (2007, p. 17) argue that 'outreach work is primarily an attitude and only after that a method'. While the members of the daytime team engaged in outreach work because of their personal as well as their organisation's focus on vulnerable groups, the night-time team had a more concrete motivation manifested in their motto 'from the community to the community'. Because many members of the outreach team's organisation were HIV carriers themselves or belonged to high-risk groups, the commitment to care work derived from a feeling of responsibility to provide information and support to high-risk groups and those already affected by the virus. Rhodes (1993) has underscored the positive role of peer influence and peer educators and their inclusion in outreach teams has been considered valuable, as they 'acquire a specialist understanding' and can 'reveal the 'codes' and 'language' of the street which helps other members understand what they see and hear' (Sarradon-Eck, Farnarier and Hymans, 2014, p. 255). Dimitra, a service user of the drop-in centre, discussed in her interview that she would like to become a peer-worker in an outreach team, as she thinks she has the skills to communicate with homeless people

from a perspective based on her own lived experience, as she 'know[s] what these people are going through'. While the daytime team included Panagiotis, a former drug user, being part of the drop-in centre's support personnel resulted in him conducting outreach work irregularly.

The daytime and the night drug market: Care practices and dynamics

For the outreach workers visiting the daytime and the night-time drug market, a key problem resulted from the limited knowledge they had regarding the characteristics of the care recipients. As the Park has not been included in studies or the overnight counting of the homeless population in Athens for reasons of safety, the general characteristics of this population were not entirely known to the outreach teams. Their main insights derived either from sporadic knowledge and data collected through small-scale surveys conducted by and shared among organisations or from previous encounters with users on the street or in rehabilitation schemes. Not having a clear idea about the particular characteristics and personal stories of each care recipient, the quality of care the outreach workers were able to provide was severely constrained. Reminiscent of the large group of homeless people queuing at the municipal soup kitchen, upon their arrival at the market outreach workers came across a large indistinctive group of care recipients who were unaware when each outreach team would visit them.

What brought these individuals together was their preoccupation with drugs, a pronounced vulnerability and deprivation. Excluded from spaces of care, the lives of the homeless at the Park revolved around the world of substances: finding them, cooking them, meeting the drug dealer, sharing drugs paraphernalia, earning the money necessary for their dose through beggary and sex work, injecting or inhaling them and experiencing the physical and emotional consequences of being deprived of them. As a result, when the outreach workers approached the homeless to initiate conversations, prioritising an array of other things linked with their dependency on drugs the homeless were not always emotionally and practically available to reciprocate these efforts. Instead of simplifying or pathologizing it, drug use needs to be contextualised with regards to the exclusion of drug users from most gated spaces of care and from accessing continuous support. Left with nothing else than their body, drugs provide a 'pain intolerance', a 'chemical intervention'

and a 'solution' (Singer, 2001). For example, the consumption of certain drugs or alcohol facilitated sleeping (a difficult activity in a public space in the first place), whilst other drugs stopped one from having negative or traumatic thoughts – conditions and emotions intrinsic to homelessness, such as loneliness, self-blame and potentially, depression (see Chapter 5).

In his ethnographic work of young homeless and unemployed people, Blackman (1997) explains how the body becomes a last resort of personal capital, when no other options are left under the condition of homelessness. 'A growing body of epidemiological evidence corroborates the use of drugs, including risky drug use, as a response to social discrimination and social stress in high risk environments' (Sarang *et al.*, 2010, p. 814). Homeless people at the Park used their bodies as the only thing in their possession in order to negotiate this discrimination and exclusion. According to outreach workers, a number of homeless drug users, both male and female, used their body to engage in sex work in order to earn money to buy drugs. Similarly, the proximity and availability of substances to homeless people occupying the Park constituted an 'easy solution' to ease their pain and facilitate their getting by in the city. Blackman discusses how 'bombarding the body with a variety of substances […] could be seen as gaining pleasure by extending the body to its limits; in other cases, such experiences were achieved at the cost of self-inflicted injury' (Blackman, 1997, pp. 118–9).

Despite this initial image of a crowd of care recipients absorbed in the world of substance abuse, paying closer attention to both drug markets reveals structures of hierarchies, romantic relationships and friendships. Located just within the borders of the Park, the daytime drug market took place within a clearing, with shrubbery dotted all around. The floor of the market was filled with drug paraphernalia, such as needles and pipes used for injecting and smoking different substances, and empty torn boxes of hypnosedon[68] and other pills. Breathing was difficult because of the strong smell of sisa combined with the dry atmosphere and the earthy smell of soil spraying up in the air. Litter was also strewn across the floor, along with the personal belongings of the various users and dealers, who used the Mavromateon entrance to enter and exit the Park throughout the day. Because of its dense vegetation and the dynamics among those

[68] A psychoactive drug prescribed for insomnia, also known as Rohypnol.

occupying it, the daytime drug market was called by some of my participants 'the jungle'. Calling it 'a supermarket', Alexandros (the manager of the night-time outreach team) said this market was so established that everyone who wanted to buy substances in Athens went there.

Figure 28. The daytime drug market (12 July 2018)
(Source: 'If you want to see how hell looks lie, come to the Pedion tou Areos' by Dimitris Kalantzis, retrieved from http://www.postmodern.gr/an-thes-na-deis-pos-moiazei-i-kolasi-ela-sto-pedion-toy-areos/, used under CC BY-NC-SA 2.0 license)

While I was waiting for the outreach team on the pavement outside the Park on the first day I visited the drug market, I noticed the homeless drug users on the other side of the fence looking at me suspiciously. To understand the dynamics of the Park, Ahmed's account was especially valuable as in the past he had slept rough there for three years and at the time of our interview he was an interpreter at the drop-in centre. In this sense, he brought inside knowledge both as a rough sleeper and as someone working in a care organisation. He explained that because they are over-policed, until users identify a visitor's motives, they are suspicious of new faces.

> When I go now back to the Park to observe them, they always have that kind of suspicious look. That look asks a lot of questions: Who is this person? Who is

> this woman? Is she a drug dealer or a drug user they can speak to because they want some information? If you go there, you will see they will send a woman to find out if […] you are a friend or a threat to them. When they find out you are not involved with anything [that could be threatening to them, for example connected to the police], they stop caring about you.

As pedestrians rarely used the path surrounding the market, those making the decision to come closer or jump over the parapet into the area of the drug market were easily noticed. In contrast to the irregular presence of outreach teams sometimes a week, the drug users established a presence in this space by occupying the drug market daily. As a result, there was an assumption that this was a space belonging to them. This echoes the literature widely supporting the idea that rough sleepers perceive the public places where they reside as home (Zufferey and Kerr, 2004; Parsell, 2011). For this reason, outreach teams recognised and attended to the right to privacy homeless people had in these areas and carefully assessed whether their arrival was a suitable time to enter the market or whether they had to wait. Times of tension or when a homeless person was using drugs were not considered an acceptable time to enter the market or initiate any conversation with them.

While at times clients from outside the Park appeared to buy drugs in the Park, most homeless drug users scattered around in groups of twos and threes, sharing the drugs between them sitting around on fallen logs as benches, or at the edge of the clearing to take their doses alone, away from the others. The users were emaciated, sometimes with shaking hands and scabs in various places of the body. Some were barely conscious, while others were agitated and constantly examining their surroundings. As Ahmed explained, those sleeping or spending most of their day at the drug market formed 'a very complicated community, not easily understood by outsiders'. Even Katerina, a homeless non-user, spending her days in the Park explained she was intimidated by this group of homeless drug users and preferred 'keeping a distance and not approaching the market, as weird things happen there'. Like Ahmed, she alluded to incidents of stabbings and violence.

The majority of users were male, and age and ethnicities varied. Their age was very difficult to assess because of the effects of drugs on their appearance. An old refugee, who according to other users, came from Afghanistan was 'cooking' drugs with his 13-year-old grandson, who was endearingly called 'the Afghan child' by the homeless drug

users. They stood out in the middle of the market. Because of their knowledge about cooking and creating glass pipes, they held a higher status and others queued around them to buy pipes, each costing one euro. Lower status was attributed to those who could not control their behaviour or newcomers. Romantic relationships were also evident. These appeared to entail elements of both affection and control, as the men requested to know the whereabouts of their female partners, and not informing them often resulted in conflicts between them.

Outreach workers explained that the overall atmosphere of the market was highly dependent on whether the homeless drug users had recently consumed drugs and whether the specific substance made them hyperactive or completely inactive and still. The substances users had consumed were defining for whether they would be able to engage in conversations with outreach workers. In some cases, drug users had delirious conversations with no logical flow. In contrast, when oppressive substances were used, drug users appeared sleepy and some of them were falling asleep while standing and bending forward. Some of the outreach workers joked and called this a 'new yoga position'. According to Rowe et al. (2016, p. 60), outreach work 'can be stressful and workers do not earn generous salaries'; hence humour is used as 'a compensating strategy'. As Ng and McQuistion (2004) argue, the use of humour in outreach work creates an easy going atmosphere contributing to the informal character of their work. In addition, the outreach teams I shadowed used humour to facilitate a perception of them as non-judgemental, 'friendly visitors' (Andersson, 2013) arriving at the drug market to offer care and support.

To find a way to engage and make contact with each of those at the market, the daytime team used a large standalone tree trunk which had fallen on the ground to distribute the items they had brought with them. This trunk almost served as a border between the outreach workers and the homeless and as a table to put their backpacks on. Distributing these items was a complex enterprise that involved a division of tasks in order to ensure safety, efficiency and speed, as the drug users gathered around them and formed a queue. For this reason, one person – usually Jenny as she was more experienced - handed out the items and had a brief chat with the drug users who discussed how they were coping. The drug users also had the chance to receive condoms or deodorant. On the summer days, they wanted water and in winter, they needed some hot tea, which

outreach teams did not offer as the number of the outreach workers was insufficient to carry tea in addition to everything else. According to each user's need, these items were taken out of the backpack and given to Jenny by another outreach worker standing behind her. A third person was observing the surrounding area to ensure the safety of both outreach workers and drug users, as the latter often walked around with an exposed used needle in their hands and some others could be fighting. Despite working in a public territory of care not under their control, both Michael and Jenny confessed they had never felt in real danger from the drug users during their outreach work. In contrast, they said they are 'little souls who need love' and 'completely harmless', and in the few occasions that risk was likely, for example by being mistakenly pricked by a used needle, it was 'the other users who protected them'. This was something I witnessed myself at a different drug market in Athens. This co-existence of risk and a sense of perceived safety among the staff echoes the idea that 'an outreach site can simultaneously be both safe and unsafe' depending on the outreach workers' knowledge of the setting and the number of available staff (Fisk *et al.*, 1999, p. 240).

The exchange of the items allowed homeless people to initiate a conversation with outreach workers when *the former* were ready. Such conversations served as an opportunity to further understand the needs of the homeless people and learn their personal stories. Jenny waited and only initiated a conversation if she already knew someone or if a user seemed to be in a particularly difficult emotional state. Most of these conversations were very brief, less than one or two minutes long, as the queue was growing and the overall conditions at the drug market involved a level of risk. In some cases, homeless people seized the chance and expressed the need for a longer conversation, saying to Jenny: 'I would like to speak to you afterwards'. After serving everyone at the queue, she approached these individuals and took them to the outskirts of the drug market, where they could have a quiet and private conversation. Many of the questions asked by the homeless people revolved around medical issues, such as suspected or diagnosed hepatitis after using the same needle with carriers of certain viruses. In other cases, medical emergencies were related to serious injuries. In cases of medical emergencies, such as in the case of a user with a screw protruding from his hand, the lack of specialist first aid training and the absence of a predefined approach to collaboration between organisations constrained the care outreach workers could offer. Consequently, the only option outreach workers had was to redirect the users to

organisations where they could get tested for diseases or to hospitals for treatment and aid.

To control the Park and ensure that no one remained inside in the night, a private security team was employed by the District of Attica. This private security team drove to the Park's deepest parts aiming to evacuate it from all visitors. At night, the homeless drug users would hang out just outside the entrance, waiting for the Park to open in the morning. On cold nights, they lit a fire and gathered around it while waiting to buy their preferred substance. Others waited for the time the dealer came around to sell. The time of the dealer's arrival was the main topic of conversation among the users, since some of them were already suffering withdrawal symptoms. As soon as they obtained their longed-for substance, the drug users consumed it on a little corner of the pavement. The sense of relief drawn on their faces revealed the intense pleasure the drug offered as it entered their veins or was inhaled through their nose.

The night outreach team engaged in similar practices to the daytime team. However, inspired by their desire to support their community, the night-time team were more proactive in initiating care relationships and interactions. Not waiting for the drug users' initiative allowed outreach workers to establish a larger number of care relationships and follow their development and personal struggles. The night drug market consisted to a great extent of rough sleepers who spent the night there. Therefore, their drug use was intertwined with extreme deprivation and poverty, the consequences of sleeping rough, poor health, family and bureaucratic issues as well as potential migration or asylum-seeking problems. To highlight the level of deprivation experienced especially by female homeless drug users, Alexandros said in his interview:

> Imagine now… Being a woman and having your period while sleeping rough on the street. […] And of course, many of the homeless women engage in sex work occasionally or permanently.

The level and complexity of the deprivation encountered by outreach workers was prominent. Aiming at the prevention of HIV transmission, the night team informed the users about the dangers linked with the consumption of specific substances and reminded them not to share needles or have unprotected sex. In this way, outreach workers

emphasized the importance of sharing information as a way of providing care and protecting the users' wellbeing and health.

The motivational work conducted by outreach workers in the night team often involved hesitantly asking drug users whether they would consider joining a rehabilitation programme.[69] Some were very negative because of prior experiences in certain programmes, maintaining that 'one day they would manage on their own'. Others absolutely precluded joining a 'dry' programme, namely one that did not provide methadone as a drug substitute. For HIV positive users, joining a programme was a more complicated matter. When the outreach workers mentioned some names of specific clinicians working in public hospitals who were working with such a population, drug users became very angry and upset. They recalled bad experiences with them and shared that they felt these clinicians were 'too strict' and 'not understanding of their situation and dependency'. In another case, a female user was especially angry as a specific clinician had played a negative role 'in having the custody of her child taken away from her'. Such cases reveal the time and negotiation required for homeless drug users to reach a point of self-determination and voluntarily take positive steps to escape addiction and homelessness, especially when such incidents of care avoidance are explained by a suspicion resulting from earlier negative experiences with available services (Maeseele, Bie and Roose, 2013, p. 625) .

The outreach work was substantially defined by the public nature of the Park and the specific location of the night drug market. This market took place on the pavement behind the building wall of the Green Park café. Behind them and to the left of this building, hidden in trees, young drug dealers sold drugs through a permanently closed side entrance with railings. Evidently, although being in the Park during the night was supposed to be forbidden, drug dealers remained there and indeed, in an easily visible space. According to Ahmed, both drug users and dealers destroyed parts of the fence and

[69] In Greece, there are three main different rehabilitation programmes with distinct approaches. The first one is a methadone state programme. The second one was a dry programme (i.e. without substitutes) which according to practitioners and users followed more disciplinary methods. The third one was also dry but it embraced a more holistic approach based on psychoanalysis and art exercises. It was the latter that most care workers and homeless people I spoke to preferred and seemed to have the better results in terms of not going back to drugs. The responses of drug users were mixed, but the provision to meet demand of those willing to enter a programme was sufficient.

easily jumped inside the Park during the night, knowing that the security team were unable to control all of its areas. In contrast to the official view, it was common knowledge among drug users, homeless people in the city and outreach workers that various groups remained in the Park after it closed. This had significant implications for the work provided by outreach teams. Firstly, the most vulnerable groups of those sleeping rough in the Park and those engaging in sex work remained unaided and unattended in deeper parts of the Park as outreach workers were unable to enter the Park after its closure. Secondly, even though the drug dealers were easily visible when selling drugs behind the fence close to the pavement, I never observed any interaction between the police and the drug dealers despite the former's presence at and around the Park. In his analysis of the 24-hour city while shadowing an outreach team and speaking about the night-economy, Smith and Hall (2013, p. 91) explain how the night-city is characterised by increasing processes of deregulation and regulation. The presence of the security team, the sweeps and police control for the most vulnerable people, the homeless drug users enhanced regulation. In contrast, deregulation emerged as leaving certain areas (the area where sex work is conducted in the night time) and groups within the Park (drug dealers[70] and sex workers[71]) alone made the Park an unattended territory where activities of the informal economy continued to jeopardise public health and the health of the groups involved.

Providing care alongside competing agents

Working in a 'bottom-up' space of care meant that outreach workers were conducting care work in a complex space not under their control. This often undermined their own work and efforts. Side by side with the outreach workers who tried to engage with the drug users – often with insufficient personnel – substances were readily available. The occasional and inconsistent presence of outreach teams at best twice per week could not overturn the dynamics and consequences of the power, authority and control ceded to other groups with a regular and permanent presence at the Park. These groups involved drug dealers, whose interests competed with the goals of outreach work. Consequently, on countless occasions, homeless drug users would respond affirmatively to outreach workers who persuaded them to enter rehabilitation programmes. Yet, the next minute

[70] Drug dealers can also belong to vulnerable groups, as many of them engage in it because they are migrants and cannot find labour in the formal economy.
[71] Sex workers entered the park from unattended side entrances and destroyed parts of the park's fence.

they were buying from the dealers less than two metres away. Such incidents made outreach workers experience immense disappointment as their efforts did not yield positive results. To cope with these emotions and to stress the contradiction drug users fell into, they occasionally utilised humour. One outreach worker said sarcastically to a user approaching the dealer to buy: 'I can see how much you want to go to rehab. Were you not just telling me you want to go back to a programme? It has been so many years, have you not got tired?'. And the drug user replied: 'You are right… But what can I do? It [the day I will stop] is not going to be tonight.' In this context, any attempts and time invested in motivational work appeared futile, entailing the risk of alienation from their commitment and values regarding outreach work.

Figure 29. The night-time drug market on the pavement of Mavromateon Street
(Source: 'Green Park. A terrestrial hell on Mavromateon Street' by Dimitris Kalantzis, retrieved from http://www.postmodern.gr/green-Park-mia-epigia-kolasi-stin-odo-mavrommateon-video/, used under CC BY-NC-SA 2.0 license)

Care work was further complicated and undermined when outreach teams encountered the police. The presence of the police in the Park was prominent and appeared both in my observational data and in formal and informal interviews with my participants. The very first day we stepped into the daytime drug market, Jenny, turned to me and said ironically: 'It's our lucky day, it seems'. Through the trees in the middle of this area, a couple of police officers were banging against the trees with their truncheons

and were shouting to their drug users: 'Next time, it will be your turn'. Suddenly, they saw the outreach workers and stopped. They questioned the police about what they were doing. The officers responded: 'And who are you? We are in the middle of an investigation.' This led to a short argument between them, which ended with the police officers saying: 'If you have work to do here, you should ask for permission. And if you see us again, you shouldn't come here.' In another case, the police wanted to proceed with a stop and search investigation of the outreach workers, while the latter were distributing condoms to sex workers. One of them had an antiretroviral HIV pill on her pocket and when found by the police, they accused them of having drugs. This led to the arrest of the outreach workers followed by an intimate cavity body search in the cell of a police station. These two incidents expose the lack of collaboration between organisations belonging to the landscape of care and other important agents of the city, such as the police, who were unaware of the outreach teams and their role in the city. They also reveal that working in the public space outreach workers can become vulnerable not necessarily because of reasons directly linked with the dynamics between them and the groups they care for.

Katerina, a homeless woman, stated in her interview that the presence of the police made her feel more secure at the Park and Michael, the leader of the night team, recognised cases of respectful treatment of the users by police. However, the overwhelming majority of my participants narrated a number of incidents of police violence and mistreatment. Ahmed discussed that during his three years sleeping rough he experienced the strip and search procedures as a non-human activity. He maintained that leaving him naked in a public location and searching 'even inside of him' made him feel that he is 'not a human'. Michael also narrated incidents of police violence against an underaged user with the use of truncheons. More broadly, Michael explained:

> In general, incidents of violence are very common. […] I have told users that they should make a formal complaint. 'No one can hit you just because you are drug users.' There is a law… it's not as if you cannot use any of your legal rights just because you are a user.

Ahmed's and Michael's words highlight the dehumanising aspects, a violation of their rights and a public humiliation involved in these experiences.[72] These emotions of daily fear and dehumanisation among homeless drug users resulting from such practices echo the experience of ontological insecurity among rough sleepers described in Chapter 5. However, in addition to being bound to the lived experience of homelessness and the exclusions the landscape of care produced, institutions such as the police also played a role in psychological marginalisation and violence against homeless people. Such policing practices targeting vulnerable populations are 'institutionalised expressions of social and moral regulation' which 'reproduce […] and reinforce underlying, social injustices, fears and inequalities' (Sarang *et al.*, 2010, p. 815). Except for the vulnerability which may be experienced by outreach workers, these experiences speak volumes about how the work of outreach workers can be undermined when working alongside agents who play an antithetical role to care. If the goals of outreach work are to give homeless people 'back their right as citizens in society by enabling them to regain access to their human rights (to housing, social protection, civil rights, and culture', as Sarradon-Eck et al. (2014, p. 260) argue, or from a more transformative perspective to grant them citizenship rights that can make them feel 'full and valued members […] in conditions of equality' (Eiroa-Orosa and Rowe, 2017), the role of the police opposed these efforts.

Drifting apart: Unresolved Dilemmas and Tensions in Reciprocity of Care

The previous section described the dynamics unfolding in a 'bottom-up' space of care and presented a plethora of tensions and obstacles faced by outreach workers whose ability to provide effectively care was significantly constrained. The approach to care adopted by outreach teams was dictated by harm reduction. In this framework, the practitioner maintains a personal opinion but the client's view and desire are respected and prioritised (Logan and Marlatt, 2010, p. 201). For this reason, the kind of relationships cultivated by the daytime and the night outreach team were based on respect and acceptance of the judgements and wishes of homeless people. Prioritising self-

[72] Sarang et. al (2010) analyse the multiple impact of policing practices on drug users in Russia and how these span from the direct violation of health and rights to indirect reproduction of social suffering, including physical violence and torture.

determination in combination with the effects of psychoactive substances – resulting in 'possessing the user, submerging the true self' (Room, 2001, as cited in Room, 2005, p. 146) – subverted the caregiver's capacity to provide care and brought about various ethical and practical dilemmas. These factors limited the ability of outreach workers to take initiative in engaging drug users in care relationships and rendered outreach work a process of waiting for homeless people to approach outreach workers when or if they decided to. The following exchange manifested the tensions and difficulties that appear.

One day, I was with the outreach workers visiting the area users occupied in the daytime. Under a tree, we saw a young woman we had not seen before. It was not clear whether she has consumed drugs or not, but she was hanging out with one of the regulars, a Greek man in his forties. Jenny approached her: 'Hey, we haven't seen you around here. What's your name?'. Her name was Magda and she was in her late twenties. As she told Jenny, it was her first day in the Park. She left her house which was in the countryside because she had issues with her mother and her mother's partner. While she was speaking, Jenny recalled that she knew her from a programme for underaged drug users. Magda confirmed this and said she had stopped using drugs ten years ago. Jenny said: 'And now from all the places you could have gone, you decided to come here? With all these other great people, eh?' Magda laughed defensively. Jenny asked: 'So, what are you thinking of doing? Going back to it? After all these years?...' Madga mumbled: 'No… I don't want to stay here. I just came here because I needed something. Just for once…just to get a fix, to calm me down'. While having his arms around Magda, the man said to Jenny: 'Yes that's what I am telling her too.' Seeing he was keeping her close to him, Jenny said ironically: 'I can see this.'

Jenny then tried to speak to Magda about her issues and told her it was a shame to go back to drugs. From time to time, the man interrupted Madga and appeared to be taking control of the conversation and dictating Madga's views. The power dynamic developing between them frustrated Jenny who told him forcefully: 'Can you please let her speak for herself?'. Jenny then took Magda a bit further away from the man and the two of them spoke for a while. In the end, Jenny wrote down her name, the address of the drop-in centre and the day and time of her appointment on a piece of paper. They had agreed to meet to find solutions to her problems. The appointment was arranged for the following day. Magda never came. A week later we saw her again with the same man.

Jenny said disappointedly with a fake laugh: 'I was waiting for you, but you didn't come.' Magda apologised and admitted that Jenny was right, but neither approached the other.

The effects of the substances and the public location of the encounters between the outreach workers and homeless drug users highly undermined the work and endeavours of outreach teams. In the above encounter, the public location hindered conducting a confidential conversation. At the same time, responding to the over 50 users usually occupying each drug market was challenging given the very limited time the few outreach workers were able to invest in each care recipient. Hence, any relationship-building or effective form of 'linkage work' were unable to develop. Andersson (2013, p. 175) has defined 'linkage work' as the work of 'connecting to and cooperating with other services'. Linkage work is essential to ensure people are supported in a continuing help process (ibid). Being in a position to engage in this kind of work is essential because having outreach workers not resourced with housing to respond to needs of rough sleepers could represent a potentially unethical practice (Parsell, 2011, p. 340).

Yet, the capacity of the outreach teams I shadowed to engage in this kind of care was pre-defined by the wider structure and characteristics of the landscape of care, the exclusions towards homeless people with complex needs, the fragmentation of care and the prevalent issue of scarce resources. As a result, the motivational work provided by outreach teams was constrained to repeated discussions attempting to convince the drug users to go to the recommended organisations on their own, as accompanying them was not a practice employed by outreach workers. For drug users, whose lives were so closely linked with certain areas of the city where drugs could be sourced, short geographic distances like the one from the Park to a hospital or to a drop-in centre were emotionally 'much longer', as they involved the decision to abstain from drugs and prioritise one's needs or health.

As an experienced outreach worker who was familiar with the majority of problems arising in care, Jenny had an idea about how to provide care and respond to many of the dilemmas outreach workers faced at the Park. She wanted to create a permanent kiosk at the Park where she would be able to develop stable relationships with the homeless people congregating there. She said:

> Look…. What we do is important but if we want to be really serious this whole thing is a bit of a joke… […] But anyway, if we really want to do something all I need is a kiosk in the Park. To be able to get to know each of them and for them to know me. Going some times a week is just not enough. If we stay there, I can guarantee that in the end I will make them [the homeless people] do something actually meaningful, starting from collecting the rubbish and the used needles around the Park, taking care of the trees. I just need resources. I cannot just turn up on my own.

Having a permanent kiosk at the Park would provide a solution to a plethora of practical and ethical dilemmas faced by outreach workers. A main ethical dilemma posed to outreach workers engaged in harm reduction was between paternalism and self-determination. Pelto-Piri *et.al.* (2013) define paternalism as a perspective wherein based on their professional knowledge and integrity, professionals deliver care in the best interests of the patient to provide relief and comfort and to promote and restore health. However, this stance is antithetical to self-determination and 'a voluntariness of clients to 'choose' a life without professional interventions' (Ferguson, 2007; Maeseele, Bie and Roose, 2013, p. 627). The existence of a kiosk would allow for the required time needed by drug users to reach this decision and would ensure the availability and proximity of immediate support. Harm reduction as a specific form of care provision was a gradual process, and progress was not a one-way street or something to be taken for granted by the outreach workers. Both for the outreach workers and the homeless people, it involved trial and error, steps forward and steps backwards, feelings of indifference, disappointment and small victories.

For this reason, ample time and the ability for outreach workers and homeless people to get to know each other were essential. Rather than a 'stop and go' approach (Hall and Smith, 2013) lasting for a few minutes, information had to be collected from each individual and care relationships had to be developed. 'Maintaining the caring relation makes it possible for both parties to suggest revisions in the mutual understanding of needs' (Noddings, 2015, p. 77). Within a framework of care ethics, an integral part of this process is to know each and every individual in as much depth as possible. For this reason, 'a close interaction', a 'small-scale service delivery', 'committed involvement of professionals in a fixed territory' and 'a discretional space for professionals to develop initiatives', like Jenny's idea, are only some of the essential features Schout et al. (2011) define as crucial for care practices.

For Jenny, the existence of such a kiosk could have a transformative value as a permanent presence at the Park could engage drug users in activities not related to their addiction, such as rubbish collection and looking after the trees. Jenny had discussed her idea of a permanent kiosk with her manager but neither the money nor the support was available. Elsewhere in the city, certain residents opposed a shower bus for homeless people visiting their area, expressing a NIMBY ('not in my backyard') attitude on the grounds it would attract homeless people to their residential location. The likelihood of a similar attitude being expressed by the residents next to the Park cannot be overruled. Nonetheless, the absence of a permanent presence had serious consequences for the relationships between outreach workers and homeless people. Instead of creating ways to facilitate a closer engagement between them, the encounters of outreach workers and homeless people remained fragmented and erratic, lasting only for the limited time the outreach teams were at the Park. Hence, both parts of these relationships drifted apart.

To reveal the emotions, tensions and estrangement among homeless people and outreach workers the concept of touch appears useful. Touch is a form of affective care that speaks to the 'body work' evident in various caring professions, such as healthcare practitioners, beauticians, therapists and childcare personnel (Cohen, 2011). Most importantly, it is an embodied form of emotional care resulting from a desire to connect, communicate and to show compassion, support and empathy – all of which are exceptionally relevant within an ethics of care approach. Both at the Park and in other city locations where I shadowed outreach teams, there were instances when the homeless drug users wanted to introduce themselves to the outreach workers through a handshake or give them a hug to show their gratitude for the help they had received. Instead of instances that brought the care receivers and caregivers closer, tension appeared during these moments as many homeless drug users were suffering from infectious diseases and had open wounds or scabs. 'To touch and to be touched deepens awareness of the embodied character of perception, affect, and thinking' (Bellacasa, 2017, p. 96). It 'also has a political significance' (ibid), since fostering haptic relationships goes beyond the optic politics of representation, evident in traditional practices of care that form harm reduction. Specifically, while the practices of care (developing relationships of care, distributing items and giving information, conversations from a distance) all rely on a sensorial experience based on vision and thus distance, haptic care is a proximate and embodied form of care.

Such moments of seeking touch need to be contextualised as an expression of a care need on the part of homeless people to make a step towards the outreach workers and to cultivate a more intimate and engaging relationship with them. Yet, homeless people were only faced with awkward responses of hesitation on the part of the outreach workers, who aware of the health risks posed to themselves, tried to avoid it. For example, when a homeless drug user offered a handshake to Jenny she responded by touching him on the arm with the hand that she had a medical glove on or by touching the drug user with a fist on a part of their body that *she* chose. In this way, she made sure that she was in control of touching him on an area without any scabs or open wounds. All these are brief moments revealing the homeless people's articulated need to connect to a relationship with someone not belonging to the world of substances, but, on the contrary, with someone who had come to provide care. This attempt can demonstrate, amongst other things, a way to introduce oneself, gratitude, and the beginning of a friendship.

From a different perspective, it also appears to serve as an opportunity to 'test' the nature of the relationship developing between the homeless people and their outreach workers. For instance, another occasion involving a different outreach worker, an attempt to receive haptic care led to an incident of verbal tension. The outreach worker tried to joke around and wrap up the conversation they had in order to avoid being touched but the homeless person responded: 'You don't want to touch me, eh? I am dirty, eh? You all come here to help us but even all of you don't want to be touched by us dirty people?'. The outreach worker started to move away from this person saying: 'It's not that. But I need to go and speak to the rest of you to see what they need'. A similar incident took place between an outreach worker and a homeless drug user with the former explaining their organisation's guidelines prohibiting touching clients. Another interaction also escalated to an exchange of verbal tension with the homeless person saying to the outreach worker: 'You are scared that I will give you some sort of illness, eh?'. In this case the outreach worker utilised humour as a strategy for escaping this moment and said in a laughing way: 'No, how do you know that I don't have something myself?'. In the eyes of the homeless person, this was not a convincing response and he replied: 'What do you have?'. The outreach worker responded he had an open cut, and it would not be nice to touch him in case there was any blood. Again, this was not perceived as a truthful answer, and the user said in an ironic tone: 'Really? Show me then! Where is your cut? There is

no cut. You just need to find an excuse. But, well, I understand your position… What else can you do anyway? But then don't come and say to us that you all care for us…'.

In these fleeting moments, an array of problematic facets affecting the landscape of care became visible: the lack of spatial and material resources to respond to the users' needs for intimate relationships which manifested itself in their need for touch; the fears among outreach workers for their own health; the drug users' deep desire for support concealed by the effects of substances; and the lack of public spaces, like the kiosk, where drug users could turn to whenever they decided they needed support, a conversation with outreach workers and a framework that can help them escape substance abuse and homelessness. This shaped a negative perception among the homeless of themselves, the outreach workers and the relationships between them. As shown in the above incidents, the internalisation of shame and worthlessness are especially apparent in how homeless people described themselves and their bodies as 'dirty' or as carriers of 'illnesses'. Shame is '[…] a painful emotion responding to a sense of failure to attain some ideal state… In shame, one feels inadequate, lacking some desired type of completeness or perfection' (Nussbaum, 2006, p. 184). These words echo the dehumanising feelings shared between the ontologically insecure rough sleepers described in Chapter 5. Dealing with such emotions creates an additional barrier for outreach workers.

The moments of tension to reciprocate the need for touch are also revealing for the outreach workers, whose efforts to offer care were cancelled out. Five months into my fieldwork, the attitude of two outreach workers towards the value of their work changed. Dimosthenis and Panagiotis announced to Jenny their decision to stop coming for outreach work at the Park. When I discussed this decision with them, Dimosthenis said 'there is no point, we can't do anything there', while Panagiotis, a former user himself, said: 'It is in the hands of users when they will decide they want to stop. I can't face seeing them doing this to themselves'. Their words reveal a sense of disappointment and a meaninglessness towards the value they attributed to the outreach work both in the Park and elsewhere in the city. There, when not monitored by Jenny they had also minimised their engagement with rough sleepers and selectively chose who to speak to or in some cases used this time to do personal errands not linked with outreach.

While Jenny's year-long commitment to caring for drug users and the strong motivation reinforced through the night-time team's motto 'from the community to the community' helped them maintain a caring attitude and continue to provide care despite all these obstacles, the cases of Dimosthenis and Panagiotis reveal the effects of constraints on some outreach workers. Their inability to provide care effectively and to oversee the progress of homeless people engendered a sense of meaninglessness and powerlessness towards their work. Such feelings have been viewed as alienation from care. In contrast, while Dimosthenis and Panagiotis recognised the vulnerability of drug users, they also viewed their interventions as worthless, something shared by Jenny who described it as 'a bit of a joke'. The lack of 'opportunities for individual choice, control, decision making, or creativity' have been understood as factors contributing to occupational alienation (Stadnyk, Townsend and Wilcock, 2010, p. 339). Jenny's inability to create a permanent kiosk and a cancellation of her creativity, as well as the lack of control to ensure effectiveness and care continuity for drug users resulted in a sense of alienation among outreach workers and ultimately in care paralysis, namely an inability to provide care (Schout, de Jong and Zeelen, 2011). The hesitation for physical touch appears to reflect the ever-increasing distance and suspicion between outreach workers and homeless people, leaving 'care in limbo'.

Conclusions

What can 'bottom-up' spaces of care tell us about vulnerability, homelessness, care and the city? By analysing the relationships of care and the exchanges between outreach workers and homeless people, this chapter has sought to discuss care through the lens of outreach work. In doing so, it has shown that in 'bottom-up' spaces a plethora of moral and practical dilemmas can emerge. As in other spaces of care, the importance of equipping outreach teams with ample resources and personnel is crucial. However, this holds even more for 'bottom-up' spaces of care as outreach workers cope with difficulties and dilemmas in territories and conditions not under their control. A central moral dilemma faced by outreach workers related to the care recipients' willingness to engage in care. This was often limited to 'a choice between either entering regular care and accepting the conditions provided or slipping from social workers' grip and disappearing out of sight' (Maeseele, Bie and Roose, 2013, p. 623; Maeseele, Roose and Bouverne-De Bie, 2015). However, kiosks, as Jenny suggested, highlight how having a permanent and open space for care recipients to visit whenever they are ready can find a solution to this

dilemma and reiterates the significance of spatial resources. Unfortunately, the teams I shadowed had neither the spatial and material resources nor the sufficient personnel to provide care in the complex space of the Park. In the absence of sufficient support and resources – emotional, spatial, human, financial – care was completely obstructed, and vulnerability was perpetuated. For this reason, such spaces of care need to be understood as part of wider institutional landscapes unfolding in contemporary cities.

Bottom-up spaces of care allow us to view mundane micro-spaces, such as pavements occupied by rough sleepers or the Park, in a more complex way by understanding the processes that shape them as spaces or urban formations of concentrated vulnerability. Rather than viewing these spaces independently or as spaces produced through an individual's choice, when we take into account the landscapes they belong to, we can more fully grasp the factors that shape them. All 'bottom-up' spaces explored in this chapter and throughout the thesis show how systemic problems, such as the lack of resources, the fragmentation of care, the importance of having support from parent organisations or exclusions from 'home-care' shape 'bottom-up' spaces of care. These adverse conditions estranged caregivers and care receivers. In public spaces the effects of such conditions are accentuated and often resulted in homeless people refraining from reciprocating or responding to the care provision. Ultimately, the outreach workers' endeavours were undermined in the eyes of the homeless drug users who perceived the outreach workers' coming to the drug market as insincere. For outreach workers, these conditions instilled a sense of meaninglessness regarding outreach work and alienation from their commitment and values of care.

Reflecting on touch as a form of care highlighted how care workers and homeless people become estranged despite their mutual need to connect when the context and resources for such a connection are problematic. This form of haptic care, a fundamental form of embodied care, highlights the tensions and hesitation among homeless people who challenged the authenticity of outreach work taking place at the drug market and other locations in the city. The incidents of care avoidance described in this chapter in the case of Magda or those sceptical of various rehabilitation programmes reiterate this hesitation or negation of care which appeared in many other incidents described throughout the thesis. These incidents, brief as they may be, speak volumes about what constitutes care, how it is perceived and what is negotiated among the care workers and

the homeless people. More emphatically, Noddings (as cited in Smith, 1998, p. 29) states that 'caring for distant peoples is care in name only: we cannot care for people we do not know'. However, engaging with haptic care illustrates that care can be provided in geographical proximity, yet in emotional distance. This resulted in incidents of tension between care workers and homeless people. When care workers are ill-equipped and homeless people end up questioning the intentions of care workers, 'bottom-up' spaces of care inevitably proliferate in cities, vulnerability is reproduced, and care remains in limbo.

Chapter 9

Towards a reconceptualization of homelessness and urban marginality through landscapes of care

Landscapes of Care as Socio-spatial and Institutional Networks of Urban Marginality and Shared Fragility

My dissertation demonstrated that an investigation of urban marginality is interlinked with an exploration of urban landscapes of care. Homelessness and other forms of urban marginality are caused by wider structural processes, such as national unemployment. However, after one is rendered homeless, one often becomes excluded from formal systems of state provision. Hence, relying on any available support to survive becomes a necessity. This support can be secured through spaces providing for a certain vulnerable population, the sum of which I defined in this thesis as a landscape of care. As socio-spatial networks constructed through complex relations, landscapes of care manifest the socio-spatial configuration of both care and vulnerability in cities. Therefore, a comprehensive understanding of the lived experience of homelessness is intertwined with the landscape of care for homeless people and the areas of the city where homelessness and care appear. To disentangle the configuration, processes and relations constructing the landscape of care for homeless people, I explored three interrelated questions: the relationships between homelessness, space and care; the broader (macro-level and contextual) factors shaping these relationships; and the manifestation of the landscape of care in spaces of care in the city and in interpersonal relationships between care workers and homeless people. An operationalisation of the landscape of care as multi-sited and multi-scalar necessitated an analysis of its manifestation on different scales and in various sites. Its sites included spaces of care with diverse operational characteristics (see Chapter 3). It involved municipal organisations, NGOs, outreach teams, soup kitchens, philanthropic foundations and faith-based organisations. In terms of scales, the landscape unfolded citywide, locally, on the organisational level of spaces of care and through interpersonal relationships.

Through an eight-month urban and multi-sited ethnography including observation and interviews with homeless people and care workers, I unravelled the complex dynamics of care provision in an array of spaces and relationships. Following

the lives and routes of homeless people and care workers in a relatively unified area of Athens' inner city, I became privy to their daily challenges and struggles, the complex relationships between them, the spaces they encountered one another, the spaces where homeless people got by and lived, and the working environments of care workers. Navigating the landscape of care entailed visiting public and gated areas of extreme destitution and witnessing the convoluted exchanges between homeless people and care workers. What was at stake in these spaces and encounters was the core meaning of life and care: the survival of homeless people. In this part of the city, urban marginality, intersected forms of vulnerability and the retreating welfare state were especially prominent. There, it was the landscape of care that had taken up the primary responsibility for life sustenance and social reproduction. The burden of fulfilling this role and preventing homeless people from entering a circle of constant destitution and ever-increasing deterioration had fallen on the shoulders of care workers operating in multiple public and gated spaces of care. This complex enterprise of caregiving was shaped by: a set of social, spatial, institutional and operational relationships; relationships between spaces of care; and the effects of macro-level factors, such as the global financial crisis and the 'so-called' refugee crisis. These macro-level events had a tangible impact on the micro-level of spaces and relationships of care.

As a whole, the landscape of care functioned as a socio-spatial network of care in which different spaces provided different types of resources and responded to various needs. Such needs involved life-sustenance, bureaucratic and administrative support, outreach work, food provision, as well as the involvement in care relationships with care workers. This network involved elements of collaboration, resulting in operational relations between spaces of care. For example, some organisations offered spaces and personnel, and others provided funding. Such a collaboration was the one between the Church of Greece and the Municipality (see Chapter 6), or the collaboration between the Municipality and an NGO for the operation of the night shelter. Collaboration also appeared between outreach teams in extreme weather conditions. At a time of exceptionally scarce resources, these operational relationships between spaces of care facilitated overcoming funding and other constraints as well as responding to the needs of the ever-increasing number of those requiring support in Athens. However, despite these collaborative elements, care provision was highly fragmented. While navigating the landscape of care to receive care, homeless people were unable to receive integrated care and continued to visit spaces of care responding to isolated needs. Consequently, to meet

as many needs as possible, homeless people spent their days moving from one organisation to the next. Therefore, despite ensuring the operation of spaces of care, collaborations do not necessarily imprint on the experience of care reception in a positive way. In contrast, the landscape of care was experienced as a network of fragmented care both by homeless people and by their care workers who often had to redirect the former to different organisations.

Both socio-spatially and operationally, the landscape of care was shaped by a set of intersected crises developing on the national and international level. The consequences of these crises portrayed macro-level factors that shaped homelessness, care and the city. First, the 2008 global financial crisis led to the implementation of harsh austerity measures and heightened vulnerability across different groups of citizens. Unemployment, the retreat of the welfare state and increased housing costs were among the factors that contributed to a shared precarity across Athens, resulting in an increase of Greeks experiencing destitution and homelessness. Meanwhile, the 'so-called' refugee crisis created the need to respond to another vulnerable group of care recipients. At a time when Greece was unprepared for their arrival, over one million destitute refugees urgently required support (UNHCR, 2020). The combination of these macro-level factors had a direct impact on the city and the landscape of care for homeless people. On an urban level, they transformed Athens into a capital where vulnerability was omnipresent, marked by homeless settlements, heroin needles on the ground, people shooting up on different corners or people searching rubbish bins for food or recyclables. When wandering the streets, outreach workers could come across anyone: a refugee family with a new-born whose mother gave birth on the street; homeless people with open wounds requiring urgent hospital care; homeless people who had left the night shelter and despite the cold weather had nothing to cover themselves; homeless drug users crying because social services had taken their children away from them and were looking for their next dose; unaccompanied minor refugees in need of care; housed citizens on the verge of starting to sleep rough. The work of care workers providing care in gated spaces of care was equally challenging and spanned across a wide range of vulnerable people facing various extremely difficult situations: a transgender rough sleeper who was beaten up on the street while conducting sex work; an elderly rough sleeper with cancer who could not be hospitalised; homeless people for whom disability or other committees were arranged but not attended despite the possibility of securing disability benefits; homeless people

with no patience left demanding urgent solutions, and others starting to consume drugs and/or alcohol.

Next to sites of consumption, such as Syntagma Square and some of its neighbouring wealthy areas, the landscape of care occupied a large area of the city where vulnerability was pronounced. There, the role of the state was ambivalent, operating as an agent of control and policing, and as a retreating caretaker, transferring its caring responsibilities to care providers, such as NGOs located in the vicinity of Omonoia Square. Many of them were included in the landscape of care for homeless people, making them part of the intersecting landscapes of care providing for populations beyond their initial target groups (see Chapter 3). In this context, the landscape of care had taken up caring responsibilities towards homeless people, refugees and vulnerable, housed Greeks. In other words, despite the multiple challenges they faced and the nature of caregiving, these organisations and their workers were shouldered with the overwhelming responsibility of alleviating the various consequences of global and national crises and ensuring the survival of a wide range of care recipients. These consequences imprinted themselves on the urban area where care workers and homeless people gave and received care. The common urban context shared by all spaces involved in the landscape of care for homeless people further hindered the efforts of care workers, as there the lived experience of homelessness was often entangled with drug use, prostitution and physical or mental health issues.

In addition, the socio-spatial manifestation of homelessness was also co-constituted through a set of institutional relations that defined different degrees of care deservingness and care exclusions (see Chapter 4). By excluding certain groups from accommodation spaces, sleeping rough in the public space was the only option for many homeless people. It was through this exclusionary institutional framework that spaces, such as drug markets, parks and pavements occupied by homeless people, proliferated in the city. Although they may *appear* to be the result of independent decisions made by homeless individuals, these spaces, which I called "bottom-up" spaces of care, depicted socio-spatial expressions of vulnerability produced through systemic aspects of the landscape of care. As a result, when outreach teams visited these spaces, they were working in conditions not under their control.

This nexus of socio-spatial and institutional relations imprinted itself on the urban space and reconfigured homelessness in the city by shaping different experiences of homelessness characterised by different geographical locations and degrees of destitution. Some homeless people who had secured places in accommodation spaces, such as the hostels and the night shelter, were able to endure the difficult living conditions there. For some of their residents, homelessness was intertwined with institutionalisation in hostels. For others the street appeared as a relatively 'better option'. Either aware of the conditions in available accommodation or after leaving their places in night shelters, the street allowed homeless people to gain a sense of relative control over their lives – something they could not have as residents of the hostels and the night-shelter. Most of them ended up sleeping rough with limited belongings in Athens' inner city, where criminality and fear were pronounced. Others engaged in home-making processes in hidden locations away from the inner-city. For homeless women, seeking care through the landscape of care was not straightforward, as there was no tailored strategy for locating and developing bonds with them. This was further complicated by the hidden locations they preferred at the outskirts of the city centre to increase their safety. Remaining undetected by outreach teams, these women experienced a particular form of loneliness chosen by themselves as a self-imposed coping strategy to protect themselves from perceived threats. Despite their different lived experiences, all these living arrangements were underpinned by a lack of privacy, relative autonomy and insecurity. Most importantly, they were interlinked with the inability of homeless people to access housing and obstructed pathways to care.

Looking at the organisational and interpersonal levels of the landscape of care, the effects of crises, its complex and exclusionary institutional framework and aspects of care fragmentation become visible. These adverse conditions turned spaces of care into spaces of pressure and rendered their operation, workers and care relationships extremely fragile. The macro-level factors and contextual features of care provision manifested themselves on the micro-level in a set of challenges, dilemmas and tensions as well as a prominent vulnerability across spaces, givers and recipients of care. The lack of financial resources jeopardised the continuous operation of spaces of care. In addition, it resulted in financial precarity among care workers who often worried about their own salaries and whether they could make ends meet. As a precondition for securing funding in a context where their operation was uncertain, spaces of care prioritised registering as high a

number of service users as possible. Therefore, a shift from providing tailored, high quality care to forms of care that can be measured and quantified was becoming increasingly evident. Prioritising registering users further increased the pressures experienced by care workers on the frontline who often had to decide between satisfying their employers' demands and the needs of homeless people. When time, space and personnel are invested in such activities, time and emotional resources to engage in care relationships are reduced. Care workers were in a constant dilemma between providing personalised support and seeing many recipients of care for less time. In all spaces of care, care workers juggled many different responsibilities and displayed signs of immense exhaustion and fatigue. Especially in the drop-in centre, the care workers often worked unsociable hours and embraced an altruistic commitment to care which was underpinned by going above and beyond their formal role and investing themselves emotionally in relationships of care. While this allowed for an adherence to care ethics, it also proved unsustainable, as burnout was prevalent among care workers. The applied form of care ethics requires ample resources to support the complex endeavour of caregiving according to values, such as attentiveness, responsiveness and responsibility, Consequently, the tension between quality of care and responding to the needs of everyone visiting spaces of care was ever-present across the landscape of care. Ultimately, both homeless people and care workers were rendered disappointed and unable to engage with one another.

Space is not just a background of care provision, but a defining factor. The scarce spatial resources were another factor that severely constrained the ability of spaces of care to adhere to care ethics and resulted in problematic experiences of care provision. In many spaces of care, such as the Municipality, the hostels or the night shelter, experiences of waiting and containment were prevalent. The waiting homeless people endured at the Municipality under challenging conditions only to receive what they perceived as bad quality food was interwoven within a systematisation of care. There, the lack of personnel and the high pressures meant that spaces were designed in a way which allowed only brief exchanges of care and compromised the quality of care received. Such spaces of care discipline homeless people, ultimately engrafting care with elements of power. Similarly, the lack of space resulted in a compromised quality of care in accommodation spaces which were unable to provide home-like spaces to homeless people. Such practices estrange homeless people from spaces of care and function as reminders that they are

perceived as marginalised and of a lower status. The utilisation of space considering care ethics and the response of needs allowed for closer engagements of care in the drop-in centre. Although more needs (laundry, showers, hairdresser, social services, food provision, socialisation) could be satisfied in its different spatial zones, the lack of sufficient spatial resources resulted again in compromises of care. Spaces for private conversations were not available. Shower facilities could only be used for a limited time. Laundry facilities had to be shared. Consequently, spatial resources should not be undermined as they profoundly define care spaces and relationships. Rather, they are crucial for the quality of care received. This holds even more for homeless people precisely because their predicament hinders any access to private spaces and alternative facilities.

The institutional framework of the landscape of care did not just define different experiences of homelessness; it also affected relationships and spaces of care. For example, the complex bureaucratic framework created the need for administrative support and often moved the attention of care workers away from engaging in care relationships to gathering required documentation for benefit applications. In other cases, complex bureaucratic procedures and the inability to obtain required documents rendered care workers unable to provide support to homeless people, such as helping them receive healthcare, apply for accommodation or resolve legal issues. Additionally, eligibility criteria prevented care workers from helping homeless people considered ineligible to apply for accommodation. Therefore, the lack of an integrated approach to care resulted in responding solely to isolated needs and made it extremely difficult for care workers to place homeless people into pathways enabling them to permanently escape homelessness. These examples illustrate that relationships of care were often pre-defined by such contextual and institutional factors and regulations. Another critical factor was the support from employers to frontline care workers. The physical absence of managers in spaces of care and the perception of feeling unsupported further complicated the professional lives of care workers who managed various ethical and practical dilemmas daily while also working under immense pressures. In addition to financial precarity, the vulnerability of care workers diminished the emotional resources required for engaging in complex relationships of care.

On the care receiving end of these relationships, homeless people experienced daily the outcomes of the problematic conditions within the landscape of care diverging from care ethics. The encounters with the municipal team involved elements of controlling and inspecting the public areas occupied by rough sleepers. The integration of such agents and regulations reiterate the idea that care and control can co-exist (DeVerteuil, 2014). Yet, the entanglement of care and control had extremely adverse consequences on the lives of the homeless in Athens. The various regulations of the landscape of care dictated the removal of homeless people or their belongings when occupied areas were viewed as sources of infestation, or where homeless people were perceived as dangerous to themselves or others. Such practices push homeless people to more extreme forms of marginalisation and homelessness. In outreach encounters with other teams, the support could only be momentary and intermittent consisting of psychosocial support through a brief conversation and limited material support. While space could be briefly experienced as a place where care can be received during brief exchanges, its experience was primarily underpinned by restriction, lack of privacy and autonomy, heightened fear, violence and insecurity for homeless people. Both in the public space and in spaces of accommodation, the experience of space among homeless people involved high levels of anxiety, loneliness and a high likelihood of criminalisation or risk towards one's physical and emotional health. By embracing and implementing disciplining and exclusionary regulations, the landscape of care hindered any efforts of homeless people to acquire a sense of ontological security and reaffirmed their predicament as homeless both materially and psychologically. Consequently, it undermined any motivation of rough sleepers to escape homelessness and of care workers to effectively provide care to them.

Being a space of shared vulnerability across givers and recipients of care rendered the landscape of care a network merely managing homelessness, rather than supporting homeless people to escape from it. Instead of empowering homeless people and care workers to engage in care provision, it restricted itself to basic provision and life-sustenance. For care workers, this meant that their efforts were undermined, and agency was removed from them. In relation to care recipients, the landscape of care produced a dependency among homeless people who had no other choice for survival than to receive basic limited care through available spaces. Unable to provide integrated care, homeless people did not have access to the material and emotional support required for one to

leave the street and be rehoused effectively. Therefore, the landscape of care played a role in the perpetuation of homelessness in the city and the proliferation of "bottom-up" spaces of care and other realms of vulnerability. The outcomes of care exclusions and obstructed pathways to 'home-care' became especially apparent in encounters between outreach teams and rough sleepers. In public areas, suspicion was evident between some homeless people and outreach workers, and a sense of alienation and meaninglessness appeared among some outreach workers towards their work. Unable to secure the necessary resources (space, time, personnel, financial and emotional) and affected by the adverse conditions, homeless people and care workers ultimately became estranged from one another, care remained in limbo and urban marginality was reproduced.

In crisis-ridden cities of shared vulnerability and destitution, a complex analysis of landscapes of care provides opportunities to reconceptualise homelessness and other socio-spatial manifestations of vulnerability. To untangle the relationships between care, vulnerability and the city, operationalising the landscape of care as multi-sited and multi-scalar proved analytically useful. By paying attention to intimate exchanges of care, the dynamics within spaces of care and different spaces and encounters between care agents and homeless people in the city, I attempted a more complete examination. Emphasizing interpersonal relationships between givers and recipients of care and positioning them in the wider landscape of care allows for an understanding of how micro- and macro-level factors interact with one another and shape care provision. For example, one can understand how broader factors create dilemmas and tensions on the micro-level of spaces and relationships of care. This kind of analysis required providing a close-up *and* a panoramic view of care provision and vulnerability. To achieve this, employing an urban and multi-sited ethnography contributed to a grounded analysis of the city, homelessness and care. In this regard, my dissertation has further developed the literature around geographies of care by suggesting a methodological framework based on gaining an inductive understanding of such landscapes through 'following' (Marcus, 1995). My aim here was to understand the different agents, temporal rhythms and spatial manifestations of care by identifying the areas of the city, spaces of care and groups included in this landscape. Simultaneously, as an ethnography of vulnerability and care, I also discussed the different methodological challenges of studying vulnerable groups, like homeless people, but also their care workers. A comprehensive exploration of care necessitates understanding the perspectives of those both at the giving and receiving ends of care. It

was through this kind of examination focusing on a relational analysis of landscapes, spaces, and exchanges of care that a more nuanced analysis of applied care was achieved. Accordingly, looking at care – as an articulated need of vulnerable populations – this type of exploration investigates the conditions of urban marginality in a way that prioritises the needs of socially excluded groups.

Time, Gender and Emotions as Dimensions of Landscapes of Care

Reflecting on the landscape of care as a whole, there are some threads that appeared repeatedly, and were, consequently, key to the socio-spatial manifestation of care and to the contour of care provision. One of them was time. Bowlby (2012) has alluded to the effects of time on care exchanges and has extensively discussed various dimensions of time in relation to care and space – from the scheduling of caring activities to individual time-space trajectories in terrains of care. Similarly, time in my research imprinted itself as a significant dimension on spaces and relationships of care, as well as on the city. As one of the key operational features characterising spaces of care, time differentiated them between permanent (e.g. NGOs) and temporary (e.g. outreach teams and weekly soup kitchens) (see Chapter 3 – defining in this way for how certain resources could be secured. In addition, a weekly and daily scheduling of caring activities offered by the landscape of care shaped homelessness and the urban space creating particular rhythms of care. Of great importance to organisations and homeless people was the time of the two (later reduced to one) daily servings of the municipal soup kitchen which attracted most of the city's homeless population. The time of other small-scale soup-runs, organisations and outreach work also defined where homelessness and care would appear in different parts of the city. This created a spatial rhythm across the terrain of the landscape of care, with homeless people required to migrate across the terrain to access various spaces of care or attend to different needs. Certain areas of the city were appropriated and used by vulnerable groups receiving care on a weekly basis.

The length and features of time spent in spaces of care directly impacted on the quality of care received. In the hostels, where residents were allowed to stay throughout the day but no pathways into independent housing were in place, time appeared extended, leading to patterns of institutionalisation. In the municipal soup kitchen, time was experienced as slow, protracted and lost. Having only a brief exchange with volunteers whilst receiving food meant that this space of care was primarily experienced as a space

of waiting, adding to the subordination homeless people endured daily. Both at the municipal social services and the municipal soup kitchen, time was a central aspect of the systematisation of bureaucratic or life-sustaining care. In the night shelter, being only allowed to stay at night did not allow for relationships of care to develop or needs to be met. Rather, it was a space experienced as a space of confinement often avoided by homeless people, and ultimately perpetuating homelessness in the city.

In other spaces, the lack of time pointed to contextual adversities, the reducing quality of care and insufficient resources. The limited time in the shower facilities which had to be constantly negotiated by the care workers at the drop-in centre – a space of multiple pressures – compromised the quality of care received. The momentary exchanges between outreach workers and homeless people at the Park weakened the bonds of homeless people with spaces and workers of care. Consequently, their relationships with the landscape of care were jeopardised. In this regard, time should not be viewed solely as a dimension of landscapes of care or 'carescapes' (Bowlby, 2012). Rather, its role needs to be systematically interrogated vis-à-vis how it shapes the socio-temporal life of cities, systems of care in contemporary cities, spaces and relationships of care, and ultimately the quality of care provision. In other words, time is a crucial aspect for ensuring care ethics in their applied form. When it comes to the reception of care by such vulnerable and disenfranchised populations, like homeless people, the importance of time is further underscored, because ample time, commitment and continuous support become prerequisites for gaining the trust of those who may have become distrusting towards state and other institutions. In contrast, when time is not invested, such groups of people become further excluded from society. As disappointment is further experienced in the interactions of homeless people with formal institutions and they fall through the cracks of the (welfare) state, they become even more marginalised and the likelihood of their reintegration into society and escaping homelessness, diminishes.

Another prominent aspect of the landscape I studied was that it was highly gendered – a finding coinciding with the literature on the gendered nature of NGO social services (Acker, 2006; Baines *et al.*, 2020). With the overwhelming majority of care workers being female, vulnerability was further crystalised in the landscape of care. Female social workers are often employed based on an assumption of having an endless capacity to care irrespective of the financial and professional conditions. On the care

receiving end, most recipients were men. Homeless men were disproportionately represented in relation to the number of accommodation spaces. Therefore, many of them slept rough in the inner city, where pronounced criminality rendered the risk of victimisation an integral part of their daily life. In contrast, homeless women, especially the elderly ones, who had more pathways into housing outside the landscape of care (e.g. through monasteries or hostels for female victims of abuse), were rendered invisible as a result of choosing concealed locations at the outskirts of the city. Its gendered nature further highlights the shared vulnerability across givers and recipients of care and provides an explanation for the fragility evident across the landscape of care.

Throughout the thesis, emotions were a prominent feature of all spaces of care. For this reason, I argue for a closer dialogue between the literature on landscapes and spaces of care with emotional geography and the sociology of emotions. In addition, I suggest that spaces of care should also be explored as spaces of emotions. Emotion in landscapes and spaces of care reveals an interplay between people's emotions and place (Davidson and Bondi, 2004). Emotions are individually experienced. Yet, conceptualised as 'felt and sensed reactions that arise in interactions between people, objects and places' (Fahnøe, 2018, p. 18), they yield explanatory value in relation to understanding the impact of systemic, structural and contextual factors of landscapes of care. Viewed in this way, emotions can be viewed as reactions to problematic or positive aspects vis-à-vis the socio-economic, policy, spatial and work environment in which care takes place. In my research, emotions were not only shaped by the landscape and spaces of care, but in turn they shaped the landscape of care too. The emotions of anxiety, frustration, anger, depression, burnout, precarity, insecurity and vulnerability experienced amongst care workers were produced by extremely complex and adverse professional environments and a need to cope with multiple pressures while feeling unsupported. In this regard, emotions can further problematise our understanding of the responsibilities of employers and their relationship with frontline staff. As a reaction to the effects of limited resources, many of the emotions experienced by care workers fell into the category of emotions of austerity (Clayton, Donovan and Merchant, 2015). Feelings, such as meaninglessness, alienation and resignation, experienced by some outreach workers point to the systemic difficulties they faced while providing care. The state of ontological insecurity was also described by rough sleepers through emotions, which were integrally linked with how the landscape of care shaped the lived experience of homelessness, the homeless people's interaction with

its agents and the lack of support they felt. Positive emotions, such as satisfaction, hope, empathy, gratitude and fulfilment, were also evident in dyadic exchanges between care workers and homeless people when aims were achieved, a mutual understanding was reached, or needs were responded to. In the spaces I studied, positive emotions were the result of persistence, an adherence to values of care ethics, cultivating close interpersonal relationships based on trust and empathy, and efforts to respond to the needs of homeless people in a personalised manner.

Emotions were not only experienced within the spaces comprising the landscape of care. Different perceptions towards certain spaces of care were also expressed in highly emotional terms. For example, the municipal soup kitchen was linked with emotions of fear, threat and frustration because of the waiting homeless people endured and the ensuing brief exchanges with care workers. The hostels and the night shelter were also described in negative terms: as spaces so unattractive to service users that the street appeared for some as a preferred environment. From this perspective, emotions are entwined with power relations of dependency and point to macro-level and contextual factors shaping the experience of care receiving in spaces of care. Therefore, rather than being neglected as a micro-level experience, emotions can spotlight on systemic difficulties linked with the characteristics of the landscape of care, but also on the factors contributing to the reproduction of vulnerability in cities. To this end, I explained how ontological insecurity was also produced by and reliant on the landscape of care and city's management of homelessness.

Care in Limbo: The Ontological Dimension of Care and its Relationship to Contextual Factors and Resources

According to care ethics, care can only be completed after its reception has been acknowledged. My analysis stresses resources as a factor defining the threshold of what can be qualified as care and what cannot. Resources involved monetary, material, spatial and emotional ones as well as personnel. While the literature of care often deals with material, emotional, ethical or political manifestations of care, its ontological dimension in relation to the world of practitioners has been neglected. This ontological dimension of care relates to ensuring the security of spaces, relationships, givers and receivers of care from a material, human, emotional, financial and spatial perspective. From a care

ethics perspective, Tronto (1993, p. 110) argues that 'resources for adequate care will generally be more scarce than those engaged in caring might like' and views the issue of resources as a political question regarding 'which caring needs should receive which resources'. Yet, rather than a matter of accepting the reality of insufficient resources and prioritising aspects of their allocation, my thesis has dealt with it as a much more central and integral part of care provision and applied care ethics. What was described throughout the thesis were the efforts of caregivers to provide care and of homeless people to receive it. Having ill-equipped care workers and spaces of care removed agency from care workers to such an extent that care could not be provided.

Consequently, there is a point after which the lack of resources renders care unattainable. Rather than dealing with the inherent challenges of care, care workers were dealing with multiple tensions and ethical dilemmas, compromising the quality of care received by homeless people. How much time can be invested when hundreds of recipients are waiting? How can one prioritise care ethics and a need for attentiveness and tailored support in this environment? How can one ensure good quality food for hundreds of homeless people? How can one secure space in organisations where various groups must be seen for different purposes? The dilemmas between providing care for many and quality for few was present in all spaces of care. Addressing such ethical and practical dilemmas resulted in fatigue and disappointment among care workers and homeless people alike. Resources cannot be endless but when they are so limited as they were in the landscape I studied, care can only remain in limbo with both receivers and givers of care experiencing exhaustion and fragility as a result of managing these dilemmas.

The impact of this is revealed in the following incidents. One took place during and two after my fieldwork. These incidents can be understood as the tipping point after which pressures and adverse conditions rendered care provision an impossible enterprise. The first incident reveals the extent to which care workers can 'muddle through' (see Chapter 3 and 7) while providing care. On one hand, this 'muddling through' allowed care relationships to develop and needs to be met. On the other, it can lead to caregivers reaching their limits. This is what happened some months after the end of my fieldwork, when resignations of care workers started to grow quickly in a space of care. Having discussed with care workers the reasons for their resignation, they described a realisation

and acceptance that their own wellbeing and mental health were becoming jeopardised by their work. This emotional insecurity, coupled with the financial insecurity they were experiencing, led everyone except two people to resign from this space of care. These resignations were part of an additional tension between the care workers' intention to care for care recipients and protecting their own wellbeing. Such resignations are telling about the effects of burnout among caregivers. However, they also result in a loss of professional knowledge and experience in spaces of care and undermine the emotional investment of care workers to engage in specific relationships of care. Following these resignations, care relationships were interrupted between caregivers and homeless people with the latter losing someone whom they had trusted and who could help them escape homelessness.

The features of spaces where care provision takes place also help us gain an understanding of the ontological dimension of care. Spaces need to provide conducive environments for care provision and to feel secure for both providers and recipients of care. The Park is a case in point. There, outreach workers worked in an environment not controlled by them. Instead, other agents and factors obstructed their efforts to care. The open nature of the Park, the various ethical dilemmas and an array of institutional problems rendered the encounters of outreach workers with homeless people momentary. Because of the insufficient spatial, human and emotional resources available to outreach teams, neither the space of care nor the conditions for establishing care relationships were in place. This stigmatised territory of heightened vulnerability was 'dissolved' a couple of months after my fieldwork with repeated sweeps and interventions by the police, checking and arresting drug users. Nonetheless, after the market moved, a similar setting functioning as a drug market was established less than fifty meters away from the Park and the two drug markets I studied. In a small side road opposite one of the Park's entrance, vulnerability was again visible in the city, and another 'bottom-up' space of care appeared. This development reveals how destitution is reproduced when care is not fully provided, and needs are not met. A further exploration of the required resources among outreach workers working in 'bottom-up' spaces of care, from pathways to drug markets, appears necessary. Having said that, it is equally crucial to identify how wider processes and systems of (insufficient) care can contribute to the proliferation of such spaces in cities and the displacement of populations.

The consequences of care reception being in limbo become apparent in the following incident. Throughout the thesis, I described multiple occasions where homeless people were unable to receive the care they needed. But how far can the consequences of feeling that one has nowhere to turn for support stretch? In the middle of my fieldwork, a refugee who had been sleeping rough for over a year visited a space of care and threatened to set himself, the care workers and the building alight. As care workers explained, this refugee was especially traumatised by his dangerous journey to Greece and leaving his wife and children in their home country alone. After overcoming an array of obstacles, this refugee could not wrap his head around the fact that he was again in such an extreme state of destitution and danger, like sleeping rough. However, what made him reach the decision of going to this organisation with a bottle of petrol to be lit with a lighter was that for a long period he felt unheard. The person who later became his care worker explained:

> His main issue was that no one was listening to him. No one was paying any attention to him or his needs. He was knocking on doors to get help and one door was closing after the other. They were promising they would get in touch and no one ever did. Indeed, he had said that he would proceed with this action, but again he was ignored. He was so desperate he did not want his own life and he was willing to lose it because in this way he would bring all these problems he was facing to light. We are seeing so many people every day, and to an extent we have become accustomed to being unable to help. We have lost our ability to make right judgements and we have no training to handle such risky scenarios. We are burnt out.

This is the most serious case I recorded during my fieldwork. While this behaviour cannot be generalised for all homeless people, it demonstrates what can happen when care is in limbo for a prolonged time. What are the consequences of not having one's needs responded to? What is the outcome of care workers being 'burnt out'? What are the consequences of having a landscape of care that has become a site of shared fragility, insecurity, pressure and desperation across organisations, workers and recipients of care? In a way, this refugee's decision to set everything and everyone alight was an extreme response to how the landscape of care operated.

Unravelling the effects of limited resources and care is part of an overall argument against austerity and in favour of care ethics. To prevent incidents such as the above as well as the exhaustion of care workers and the reproduction of urban marginality,

resources are necessary to form a sustainable and integrated system of care provision. Care provision is a complex enterprise in and of itself. When additional factors increase the fragility inherent in care, spaces and workers of care are unable to fulfil their role. Subsequently, care recipients are likely to question whether care can eventually be received, become estranged from landscapes of care and enter circles of constant marginalisation. To avert such negative consequences and allow everyone involved in care provision (spaces, givers and recipients of care) to engage in it effectively, everyone needs to enjoy a sense of security. This security is emotional, monetary, physical, spatial and material. While Tronto (1993, p. 110) accepts it is often that caregivers might wish to have more resources, my research reveals how scarce resources can render care unable to materialise. When the lack of resources is extreme and conditions profoundly compete with care ethics, the reception of care is rendered unachievable. In such an adverse context, the efforts of caregivers and care recipients to provide and receive care and the intention of spaces of care to function as such are undermined to such an extent that care remains in limbo.

Policy Implications

My exploration of the landscape of care was highly context dependent. Therefore, I do not make any claims of generalisability or of a holistic understanding of the landscape of care I studied. However, one can draw conclusions about systems of care in cities experiencing multiple crises and increased forms of vulnerability. Landscapes of care can emerge for various reasons, including as a response to failures of the formal state or to multiple forms of destitution. Especially in cities experiencing austerity and a notable lack of resources, such landscapes may consist of providers not belonging to the formal welfare state. Rather, NGOs, philanthropic foundations or activist initiatives may become central caretakers for those falling through the cracks of formal welfare provision or when the state can no longer care for all its vulnerable members.

From a policy perspective, the findings of my dissertation have implications for designing policies and landscapes for vulnerable groups. First, either when developing or evaluating a landscape of care, the care relationships between frontline staff and vulnerable recipients of care should be foregrounded. Integrating values of care ethics is also useful as the latter emphasise key aspects of care: relationships and needs of care, different stages of care from meeting an unknown vulnerable person to reception of care,

as well as care as work. In other words, introducing care ethics into the design and delivery of housing support allows for a bottom-up approach to care, in which policies are designed according to the needs of the homeless people as these are articulated to frontline staff. In this way, pathways into housing reflect the specific trajectories and lived experiences of homeless individuals.

Relationships of care appeared a crucial avenue for homeless people to make positive steps. Particularly for marginalised groups, who may find themselves outside mainstream society and institutional processes, relationships cultivating trust are valuable. It is these human exchanges that can empower homeless people and instil in them a belief that they can escape their predicament through available support. As Makis said, the care workers at the drop-in centre made him feel 'like a human again' (Chapter 7), or in Chloe's words: 'The Big Issue gave me my dignity back' (Chapter 5). Such feelings do not reflect their relationships with spaces of care, but primarily with care workers who took the time to listen to them, empower them and show the values care ethics champion: attentiveness, responsibility, competence and responsiveness. Securing the necessary time and space – both physical and emotional – to understand one's needs through listening, and prioritising attentiveness and responsiveness are key for establishing trust and relationships of care. And while competence was often undermined because of the lack of resources and insufficient training, the willingness to take up the responsibility of cultivating a care relationship was often very valuable in the eyes of homeless people. From this perspective, the relationships unfolding between frontline care workers and homeless people and the spaces in which they develop need to be understood as avenues of re-integration into society.

Macro-level factors, such as the effects of austerity, and contextual factors regarding the socio-historic context imprint themselves on relationships and spaces of care. Space and sufficient resources were necessary for the use of different facilities in accordance with care ethics. For example, I discussed how the use of shower and laundry facilities created dilemmas for care workers who were unable to allow their use in a way that would take homeless people's needs into account. Similarly, I demonstrated how the lack of personnel and the high number of service users rendered the space of the municipal soup kitchen primarily a space of waiting. Policymakers need to attend to the spatial characteristics of spaces of care: Is there a space to have a confidential and private

conversation? Are space and time used as means of systematising care or are they contributing factors to developing care relationships and responding to needs? How can public 'bottom-up' spaces of care and spaces of outreach work transform into spaces of care, rather than of momentary exchanges? What kind of space is needed to protect relationships of care from agents not belonging to landscapes of care, such as the police, drug dealers or cleaning agencies? Designing spaces of care while considering these factors is crucial for allowing them to function as avenues for displaced populations to rehabilitate and empower themselves. Equally important is to understand how each space is positioned in the wider institutional, urban and socio-spatial network of care.

Interactions with the landscape of care can further increase the vulnerability of its users through its own processes and characteristics. Emphasizing relationships provided an explanation for why the reception of care was jeopardised in Athens and what obstructed the efforts of care workers and recipients to give and receive care. Analysing the landscape of care as a network from the perspective of givers and recipients of care can further elaborate whether landscapes of care play a role in reproducing vulnerability. In my own research, homelessness was the result of complex structural causes ranging from the national financial crisis, unemployment and international conflicts to domestic abuse and addiction. However, interacting with different care providers in the landscape of care often left homeless people unsupported or unable to receive the complete care they needed. Its different exclusionary characteristics and processes, the absence of an integrated approach, the systems and conditions encountered in different spaces of care resulted in an estrangement of homeless people from the landscape of care and a crystallisation of their predicament. In addition to the reproduction of vulnerability through the landscape of care, it is equally crucial to look at aspects that may render care workers vulnerable.

In relation to care provision for homeless people, I also make the case for the significance of 'home-care', as a form of care resulting from providing a home, rather than merely a roof or a shelter. The main features of 'home-care' revolve around basic dimensions of ontological security: privacy, autonomy, a sense of trust, emotional and physical security, a sense of control and a space to engage with one's interests beyond one's identity as a homeless person. Stressing the importance of providing a space of a home argues for the implementation of housing-first policies from yet another

perspective: that a home serves as a space where one can attain a sense of ontological security and develop strategies of reintegration through systems of care. Consequently, modes of housing support, such as housing-first, should adhere to the values endorsed by care ethics and the emphasis of the latter on care relationships. It is in care relationships that frontline caregivers can respond to the homeless people's needs for ontological security and a home. To avoid patterns of institutionalisation or return to the street through revolving-door phenomena, this support needs to be continuous, even after one leaves available accommodation. Addressing the need for a home and the need for ontological security requires cross-disciplinary theoretical and policy work that further develops the housing-first approach to homelessness by attending to non-material support (Padgett, 2007). To achieve that, incorporating care ethics and securing the necessary resources for systems and givers of care is of paramount importance. In Athens, the dilemma between providing 'home-care' for a few or basic provision for more people resulted in the reproduction of homelessness. Resources are not infinite, but incentives can be given for the appropriation of empty buildings, especially in crises-ridden cities like Athens.

The provision of 'home-care' is not solely important for rough sleepers. Rather, it can be extended to various displaced populations finding themselves without a home or losing a sense of ontological security. These may include refugees and migrants but also victims of domestic violence, ex-offenders and military veterans. Engaging with care provision through the notion of ontological security enriched our understanding of care as it demonstrated that care should not be viewed either as emotional or as material. In contrast, the provision of material support is interwoven with supporting individuals emotionally and helping them gain a sense of security and rebuild their lives. For this reason, policies aiming to address homelessness or effectively support displaced populations need to take a holistic perspective and attend to the different needs of these groups.

Expanding Understandings of Landscapes of Care

Regarding future engagements with geographies of care, and in particular the thread of landscapes of care, viewing care through the lens of applied care ethics is a useful opening. This would enrich our understanding of care, not just as a philosophical matter, but rather in its applied, everyday form. Hence, the dilemmas, obstacles or 'dead-

ends' of care can be grasped in more tangible ways and contextualised in the world of practitioners. Doing so allows for a dual perspective of both care workers and recipients of care, precisely because of the emphasis of care ethics on care relationships and response to needs. Positioning these two aspects in wider landscapes of care – from welfare policy landscapes to landscapes of care for the elderly, migrants or refugees – could be useful for connecting micro- and macro-level factors.

To this end, specifying the level of required resources and their characteristics can also be further investigated: What kind of resources are needed for care to be in place, so that care workers are in a position to provide care in the first place and recipients of care to receive it? What is crucial here is the differentiation between care and momentary support. According to care ethics, a homeless person's wish to escape homelessness ought to be met as a care need. My thesis has demonstrated that this is a complex endeavour requiring constant negotiation and addressing lower-level needs, such as the arrangement of bureaucratic and legal issues and food provision. Yet, for a landscape of care to function as such, it should not limit its role to the provision of momentary and intermittent practical support. From this perspective, further research could problematise when a landscape of care functions as such or whether it remains on a level of service provision. Furthermore, homelessness should be seen in relation to the landscapes for homeless people unfolding in cities. In this way, one can better understand the geographies of homelessness and provision, how the two connect with one another, and whether landscapes of care contribute to the reproduction of homelessness in cities.

A closer engagement between theories of care and theories of ontological (in)security can illuminate how care and vulnerability intersect with each other. This kind of theoretical engagement can further problematise our understanding of care by showing that there is not a clear dichotomy between material and emotional support. Rather, keeping in mind that extreme material deprivation can result in extreme forms of psychological marginalisation which might in turn contribute to the further production of vulnerability and urban marginality among already vulnerable groups. Therefore, the need to combine the provision of both material and emotional care is further emphasized. Finally, comparative studies of landscapes of care focusing on the same group of care recipients – for example, comparing the landscape of care for homeless people in Athens with the equivalent in London – could function as a way of studying the socio-spatial

manifestation of vulnerability and care in different contexts. This could serve as an opportunity to develop our understanding of how different macro-level, contextual and policy factors shape care provision and how they might be ameliorated.

APPENDIX A

Interviewees living under conditions of homelessness[73]

Table 4: Interviewees living under conditions of homelessness

Name[74]	Age	Living Condition at time of interview	Previous Living Condition
Gianna	53	Privately Renting	Rough Sleeping
Mr Dimitris	78	Occupying Basement[75]	Rough Sleeping
Vana	60	Living with family member	Rough Sleeping, Hostel Resident
Vassilis	67	Occupying Basement	Rough Sleeping
Katianna	53	Night Shelter Resident	Rough Sleeping
Nasos	65	Rough Sleeping	Night Shelter Resident
Paris	53	Night Shelter Resident	Rough Sleeping
Andreas	54	Rough Sleeping	Night Shelter Resident
Michalis	55	Sleeping in a car	Rough Sleeping
Dimitra	62	Hostel Resident	Rough Sleeping, Night Shelter Resident
Ali	44	Rough Sleeping	Unknown
Makis	61	Hostel Resident	Rough Sleeping
Angelos	58	Hostel Resident	Hostel Resident
Fanis	49	Rough Sleeping	Rough Sleeping
Katerina	55	Occupying Empty Building	Rough Sleeping
Costas	53	Support Housing	Rough Sleeping and Occupation of Basement
Chloe	68	Privately Renting	Rough Sleeping
Charis	51	Rough Sleeping	Hostel Resident
Ahmed[76]	47	Privately Renting	Rough Sleeper
Jacob	50	Rough Sleeping	Rough Sleeping
Markos	59	Rough Sleeping	Unknown

[73] Only information of interviewees is included and not of participants whose information I gained through observation, as in some of these cases I could not solicit such information.

[74] Pseudonyms are used for all my interviewees.

[75] In the case of Mr Dimitris and Vassilis, basements in blocks of flat were given to them free of charge by friends.

[76] After sleeping rough at the Park for more than three years, Ahmed had become an interpreter at the drop-in centre and was renting privately.

APPENDIX B

Interviewees (care workers and managers)[77]

Table 5: Interviewees (care workers and managers)

Name[78]	**Disciplinary Background**	**Position**
Katerina	Social work	NGO Official
Anna	Unknown	NGO Official
Petros	Psychology	Social Services (care worker)
Jenny	Psychology	Outreach worker
Iokasti	This detail has been redacted to protect the identity of the research participant	Support Personnel
Eleana	Anthropology	Social Services (care worker)
Unnamed	Social work	Municipal Manager
Alexandros	Unknown	Manager of outreach team
Michael	Epidemiology and Addiction	Leader of outreach team

[77] I have included only information of interviewees and not of participants whose information I gained through observation, as in some of these cases I could not solicit such information.
[78] Pseudonyms are used for all my interviewees.

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