



**EXPERIENCES OF BEING HOUSED IN A
LONDON HOTEL AS PART OF THE 'EVERYONE
IN' INITIATIVE**

**PART 2: LIFE IN THE MONTH AFTER LEAVING
THE HOTEL**

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1. BACKGROUND

'Everyone In' initiative

During the spring of 2020, the UK Government implemented a ground-breaking policy initiative (the 'Everyone In' initiative) to provide temporary accommodation for everyone experiencing rough sleeping and a range of other forms of homelessness during the COVID-19 pandemic. The primary aim of this initiative was to reduce the impact of COVID-19 on people facing homelessness and to prevent deaths. By September 2020, over 29,000 vulnerable people had been supported. In London, the initiative was overseen by the Greater London Authority and the 33 London borough councils, which brought together multiple services and agencies to provide temporary accommodation for over 5,000 people. Most of these people were placed in hotels that were organised in a three-tier system of care: i. COVID Care hotels (accommodating people testing positive for, or displaying and reporting symptoms of, the disease); ii. COVID Protect hotels (accommodating people who were asymptomatic but considered most vulnerable to the disease because of their age or underlying health conditions); and iii. COVID Prevent hotels (accommodating people who were asymptomatic and deemed less vulnerable to COVID-19).

The study

Between June and December 2020, researchers from King's College London undertook a rapid research project to better understand the views and experiences of people accommodated in two of the London hotels. After securing the necessary ethical approvals and access permissions, a team of trained volunteer researchers based at the National Addiction Centre, King's College London, undertook semi-structured telephone interviews with 35 hotel residents. Each resident was invited to participate in a series of short 20-minute interviews in order to capture detailed insights into their lives within the hotel. When residents left the hotel, they were invited to participate in a further five 'follow-up' interviews occurring over the next month. The follow-up interviews were undertaken in order to understand how people who had been accommodated in the hotels experienced the transition to move-on accommodation. Participants were reimbursed with a £40 shopping voucher of their choice on completion of all of their 'in hotel' interviews and a further £50 shopping voucher on completion of all five 'follow-up' interviews.

Report aims

This purpose of this report is to provide a rapid and accessible overview of key findings from the 'follow-up' interviews. Findings from the 'in hotel' interviews have been presented

previously¹, but are précised in the next section to assist the reader. We do not claim that those interviewed were representative of all people experiencing rough sleeping or of all people accommodated in the ‘Everyone In’ initiative. As a qualitative study, our findings are not (and are not meant to be) generalizable. Qualitative methods were chosen because they generate detailed descriptions of people’s feelings, opinions and experiences, including how and why these may change over time; are very well-suited for researching sensitive topics; and assist people who may have limited literacy to express themselves. In short, qualitative research can provide important information and insights that quantitative studies and numbers do not reveal.

Despite the many strengths of qualitative research, various factors beyond our control influenced sampling for our study; for example, the research was undertaken at short notice and without any formal funding; recruitment occurred during the initial national lock-down when social distancing regulations were in full force; and it was not possible to interview everyone who contacted the research team as some people spoke almost no English and we had no access to interpreters. Furthermore, nearly all residents who participated were accommodated in just one COVID Protect hotel. Nonetheless, the findings we present provide detailed and unique insights into the views and experiences of a group of people who were accommodated within the ‘Everyone In’ initiative, so enabling us all to better understand and learn from what happened when they moved on.

¹ Neale, J., Brobbin, E., Bowen, A., Craft, S., Drummond, C., Dwyer, G.-J., Finch, E., Henderson, J., Hermann, L., Kelleher, M., Kuester, L., McDonald, R., Metrebian, N., Parkin, S., Radcliffe, P., Roberts, E., Robson, D., Strang, J., & Turner, R. (2020) “Experiences of being housed in a London hotel as part of the ‘Everyone In’ initiative. Part 1: Life in the Hotel.” National Addiction Centre, King’s College London: London. DOI 10.17605/OSF.IO/RT7J9

2. 'IN HOTEL' INTERVIEWS: SUMMARY

This section summarises key findings from the earlier interviews (conducted between June 2020 and September 2020) with the 35 study participants whilst they were living in the hotel.

Participant characteristics

Participants were aged between 21 and 75 years old (mean 48 years), mostly male (n=28) and mostly born outside the UK (n=24). Some were asylum seekers, refugees or had no legal immigration status. Overall, they experienced rough sleeping and hostel accommodation as negative and frightening. Prior to moving into the hotel, participants had generally spent their time on the streets, seeking refuge in public or semi-public spaces, and living hand-to-mouth with little or no income. Many had accessed practical support (food, showers, shelter etc) from a wide range of services, but few had received any emotional support or care from those services. They had arrived at the hotel feeling fearful and with low expectations.

Living in the hotel

Participants tended to rate the hotel more highly than other places where they had recently stayed, and they particularly valued the kindness of the hotel staff, the room facilities, and the warmth, safety and privacy afforded by having their own space. They were very reluctant to be critical, except in respect of the food which they described as lacking in choice, of poor quality, and unsuitable for dietary needs relating to medical conditions or culture. Some participants reported that the hotel had provided them with an opportunity to take stock of their lives and address their substance use or physical, emotional and financial problems. Although they experienced some boredom and loneliness within their rooms, most were very resourceful in terms of finding stimulating activities, taking exercise, and trying to look after themselves as best they could.

COVID-19

Many participants reported being very anxious about COVID-19 although only one or two had tested positive during the pandemic. During their interviews, participants articulated a good understanding of how to protect themselves from the virus and were proactive in socially distancing, hand washing and mask wearing. When questioned, many said that it was easier to socially distance in the hotel than outside the hotel in hostels and on the streets.

Relationships

Participants had relatively limited relationships and contacts whilst rough sleeping but had often managed to retain these during their stay in the hotel by using mobile phones (provided

by the hotel) to stay connected. There were few reports of conflicts or disputes between residents in the hotel, but many participants preferred to stay in their rooms and 'keep themselves to themselves' to avoid both 'trouble' and COVID-19.

Substance use

Most participants said that they did not require treatment for alcohol and other drug use², but those who were treated seemed to respond positively. Despite this, many smoked tobacco. There were some notable changes in tobacco smoking behaviours within the hotel, with some smoking more and others smoking less. Participants' smoking behaviours were affected by a variety of psycho-social and environmental factors, with the distribution of free nicotine replacement (particularly e-cigarettes) appearing to help reduce some tobacco consumption.

Health

Participants collectively reported a very wide range of physical health problems which were often being treated before they moved into the hotel. They also routinely reported mental health problems but did not seem to be well-connected to mental health services prior to the pandemic. Despite the provision of medical treatment on site, participants continued to report untreated mental and physical health problems.

Use of technology

Most participants had good IT literacy and were willing to help other residents who were less familiar with mobile technology. Participants were, however, very reliant on mobile phones given to them by the hotel staff and on the free hotel wi-fi for calls, texts, video calls and social media. The phones were also valuable in enabling the participants to keep themselves occupied within their rooms.

Move-on

Participants tended to have little information about when they would be leaving the hotel and where they would be moving to, and this caused them a great deal of stress and anxiety. Although they had relatively modest expectations about move-on accommodation, they tended to acknowledge that they would need further support with a range of practical and medical issues.

² This finding suggests that the study participants may not be representative of people experiencing rough sleeping more generally, given the high levels of substance use commonly reported by this population.

3. 'FOLLOW-UP' INTERVIEWS: METHODS

Of the 35 hotel residents originally interviewed, 28 participated in the follow-up stage. The remaining 7 participants could not be contacted or declined to participate. The first follow-up interviews were conducted within a few days of each resident leaving the hotel and then further interviews were repeated on a weekly basis for the next four weeks. Each interview was conducted by telephone, lasted approximately 20 minutes, and covered similar basic topics in order to build up a picture of the resident's life and experiences over the month since leaving the hotel.

Nearly all interviews were completed by the same trained volunteer researcher who had completed the resident's 'in hotel' interviews. Most participants ($n=24/28$) completed all five follow-up interviews (3/28 completed three follow-up interviews and 1/28 completed four follow-up interviews). The analyses presented are therefore based on a total of 153 interviews, all conducted during the second half of 2020 when lockdown measures were easing, and the new tier structures were in their early phases (the first follow-up interview was conducted in July 2020 and the last was conducted in November 2020). The participants who completed follow-up interviews included 23 men and 5 women. Eleven had been born in the UK, 2 had been born in Europe and 15 had been born in other parts of the world.

4. NEW ACCOMMODATION

Type of move-on accommodation

Participants reported moving on to a wide range of accommodation forms. These included: other hotels within the 'Everyone In' initiative; hostels; bed and breakfast hotels; shared flats; independent flats; houses of multiple occupation; supported accommodation; and a detention centre. One person went travelling abroad and another resorted to a tent after the accommodation he was offered turned out to be in an area he did not know and away from all his contacts. Although most participants were only moved once in the month after they left the hotel, about a quarter were moved twice and one was moved multiple times. Almost all remained in the London area, but a small number requested, and were provided with, move-on accommodation in other parts of the UK. Two participants wanted 'reconnection' travel fares back to Europe rather than accommodation. However, by the end of the interviews, only one of these had had help purchasing a train ticket; the other was still waiting to hear about a flight. Only one participant reported that his move-on accommodation was permanent ('a council flat'). The others all remained in temporary accommodation and hoped for a further move to somewhere more stable and permanent in the not-too-distant future.

Moving out of the hotel

When asked about their experiences on the day they moved out of the hotel, most participants said that a taxi had been called to take them to their new accommodation. These taxi rides were often shared with another resident who was also moving out. One female participant said that the hotel staff had refused to order her a taxi even though she was unwell and very distressed, so she had called an ambulance to take her to the hospital where she had stayed overnight. Many participants complained that they were given very little notice that they had to leave (sometimes a few hours) and one said that someone had 'banged on his door' to announce that the taxi was 'already on its way'; consequently, there was little or no time to prepare mentally or to pack. Several participants reported that the moving out process had been distressing and traumatic and one woman described leaving as 'sad' and 'emotional'. On arriving at her new accommodation, another woman said there was no furniture so she could not move in until the following day and one man reported that he had struggled to get into his accommodation for an hour because there had been a problem with the key.

Several participants said that they had not received much support with moving out, although some added that they did not want much support. In contrast, a few residents reported more positive experiences. Four said that they had been given (or had asked for) train fares instead of a taxi (because it was a cheaper or faster means of transport) and some explained that they

had been able to take their time and move out gradually over a period of days. A small number of participants also said that the hotel staff had asked them if they needed 'pots or pans', bedding or other basic essentials or had helped them to pack or move their suitcase, which they appreciated. In addition, a few described receiving support from caseworkers, support workers or organisations managing their move-on accommodation, such as a call to check everything was OK or help securing furniture or white goods prior to, or after, moving in.

Feelings about move-on accommodation

Participants routinely expressed concern and anxiety as they did not know how long they would be staying in their new accommodation, how long their rent would be paid and what would happen to them next. Two were also confused and disoriented as they did not know where (geographically) they were in London (beyond a hotel in a noisy area). Others spoke of their uncertain immigration status, including fears about violence and brutality in their home countries, and concerns about what would happen to them if they had to return there.

Many participants also noted that the accommodation to which they had been moved was of a much lower standard than the hotel in which we had first interviewed them (in the original hotel, they had had their own room and bathroom which had been cleaned regularly by hotel staff). Nearly half (thirteen) were unhappy with their move-on accommodation; eight were ambivalent; three were unhappy with their first move but pleased with a second move; two were happy with their first move but negative about a second move; and two were very happy with their new living arrangements.

Reasons for being unhappy with move-on accommodation

The main reason participants gave for being unhappy with their move-on accommodation was poor standards. In this regard, participants spoke of being moved into accommodation that was dirty ('filthy'), noisy, lacking in basic amenities, too small, unsafe, lacking in privacy, and/ or windowless. Participants variously complained of rats; bedbugs; dirty shared toilets and showers; lack of heating, electricity or gas; windows without curtains; problems with sinks, lights, radiators; no usable cooking facilities; no washing machine; and noisy nearby roads which made it difficult to sleep. Three additionally said they had no furniture. Two said they preferred to sleep or urinate outside because the accommodation was so bad. Others complained that they were living with people who were dealing drugs, injecting drugs, smoking or using other substances, had severe mental health problems, shouted and screamed, or did not wear masks or socially distance.

Those who had been moved to other hotels additionally reported problems with the food, stating that it was limited in choice, inedible, or unsuitable for people with diabetes. Meanwhile, two who were living in more self-contained accommodation said that they did

not have enough money to feed themselves. Other reasons participants gave for being unhappy were being rehoused away from people and areas that they knew or at a distance from places they had to be, such as hospitals, or finding that the accommodation was not what they expected or had been promised (for example, shared rather than self-contained or unfurnished rather than furnished). A few participants also complained that staff in move-on accommodation were unhelpful or rude, that keyworkers changed all the time, or that nobody communicated with them or only responded very slowly to their queries.

Reasons for being happy with move-on accommodation

One of the two participants who was very happy with his move-on accommodation was living in a shared flat over a shop in a quiet area out of central London. The place was owned by a housing association and had just been painted. The participant said he was getting on well with his new flat mate with whom he could spend time relaxing. The other participant who was very pleased with his new accommodation said he had moved into a new flat on his own, felt he was getting all the support he needed, and was enjoying the quiet. Other participants who expressed positive views about their new accommodation valued being housed somewhere that was self-contained, not shared, and had cooking facilities. Where accommodation was shared, participants appreciated having flatmates or others living in the accommodation who were 'quiet', 'clean' and 'not using substances'. Area was also important, with most participants preferring housing that was closer to any family and known community members, in quieter areas, and near places they liked to walk and visit.

Summary:

Participants moved on to a wide range of temporary housing. Many had a negative experience of the moving out process, with some describing it as traumatic and distressing as they were not given time to prepare or pack. Whilst some felt they had been supported, others did not and a few complained that staff in move-on accommodation were unhelpful or rude and communication was poor. Overall, there was little sense of participants being involved in any move on planning. Participants often described their move-on accommodation as being of a lower standard than the hotel where we had first interviewed them. In this regard, they complained that they were now living in places that were dirty, noisy, lacking in basic amenities, too small, unsafe, lacking in privacy, and windowless. They also routinely expressed concern and anxiety about what would happen to them next. Poor and inedible food continued to be a problem for those who had moved to other hotels. Participants who were happier tended to be those who had moved into accommodation that was self-contained, not shared and had cooking facilities. Within a month, one participant had returned to sleeping in a tent and one had permanent accommodation.

5. RELATIONSHIPS

On-going contact with the hotel staff

After move-on, participants reported relatively limited contact with staff from the hotel where they had initially been interviewed. Their responses on this issue were, however, often quite difficult to interpret as they were routinely unsure about who worked at which agencies and what roles people held. This confusion tended not to worry participants too much. Not all said that they wanted or needed support, and those who did tended to be more focused on the delivery of the support itself rather than on the agency providing it. Thus, participants worried about whether or not they were going to receive help with benefits, legal advice, furniture, or getting their prescriptions transferred to a closer pharmacy rather than on who was actually doing this for them.

Despite this, a few participants who wanted support felt upset and let down when particular workers did not contact them as promised or failed to respond to their calls or messages. Several participants mentioned they had re-established contact with some hotel staff when moving to another hotel managed by the same organisation, a few reported that they had returned to their original hotel to collect post and had chatted to the security guards, and a couple spoke fondly of particular staff members who had gone out of their way to help them.

On-going contact with other hotel residents

Participants likewise tended not to stay in regular contact with other residents from their first hotel. Some participants said that residents from their original hotel had been moved with them to another hotel, so they still saw them. Several others explained that they had stayed in touch with one or two other residents initially via WhatsApp or phone calls, but this had tended to fade out over the month. Whilst a few participants seemed to regret this or said that they missed the camaraderie of their first hotel, others stated that they did not really like to stay in touch with people, were 'not bothered', or felt those relationships were negative and best left behind.

Contact with family

During their follow-up interviews, several participants reaffirmed that they had no contact with family members; reminding the interviewer that their family was overseas, close relatives were deceased, or relationships with relatives were strained. Other participants were, however, in contact with family members (more or less regularly) by phone calls, emails, texts, WhatsApp messages, Facebook or video calls. Additionally, a few participants saw relatives in person (more or less frequently), noting that they were now living closer to

family or were able to invite family members round to their homes to visit. One participant also explained that family members had helped him by giving him goods for his new home. The nature and frequency of these contacts were, however, dictated by a range of factors, including relatives being local enough for visiting; COVID restrictions preventing visits; turbulent or strained relationships making frequent contact unworkable; and limited phone credit, not having access to a working phone, and being unfamiliar with video calling prohibiting digital contact.

Contact with friends

Overall, contact with friends followed a similar pattern to contact with family. For many, communication was relatively limited and conducted by phone or online only. Nonetheless, some had face-to-face contact which seemed to increase if people had been moved back to areas where they knew people and decrease if people had been moved to new areas. For example, a few participants said that they met friends in parks or for walks, coffee or lunch. Several participants also said that they had a small number of friends who provided them with material assistance or general practical support (food, cash, phone credit, access to washing facilities, and/ or help with phone and IT issues). In contrast, others described friends as being 'flaky' or said they argued and then made up again. Whilst a few explained that they were trying to build new social relationships and networks by attending courses or joining online or face-to-face groups to meet like-minded people, others (particularly those still housed in a hotel) emphasized that they continued to spend a lot of time alone and were lonely.

Summary:

Participants' relationships with staff and other residents from their original hotel did not tend to endure after they moved on. Occasionally participants felt let down by hotel staff who did not contact them as promised or failed to respond to their messages. However, for the most part, participants were more focused on receiving the support they needed rather than on the agency that provided that support. Participants, meanwhile, had varied relationships with family members and friends. Some were very isolated and lonely, some retained contact with people more or less frequently via phone calls and online, and some also had people whom they were able to see in person, including a few who had friends or relatives who provided them with a degree of material and practical support. The level of contact maintained was, however, influenced by a range of factors such as geographical proximity, phone access, the pre-existing nature of relationships, and COVID-19 restrictions.

6. SUBSTANCE USE

Alcohol and other drug (AOD) use

Consistent with the 'in hotel' interviews, many participants reported that they did not use alcohol or other drugs problematically and so did not need support with this. A few participants talked about smoking cannabis, but only one expressed a desire for more support. This participant explained that her cannabis use had decreased since leaving the hotel (where she had smoked due to boredom) and she now wanted to stop as it was making her feel 'lazy', 'apathetic' and 'depressed'. Despite this, she continued to smoke with friends and to 'help her sleep'. Meanwhile, a recent effort to stop with a friend had failed. A second participant felt that his cannabis use wasn't a problem; a third felt that the support available wouldn't help him; and a fourth believed that her cannabis use had decreased already and would stop once her accommodation situation was 'sorted'.

Only two participants stated that they needed help with drinking. One felt that he was in danger of relapse so had applied for help from a service and was still waiting to hear back. A second had been receiving prescribed alcohol in the first hotel, but his prescription had been disrupted when he moved to another hotel. He felt that his new alcohol worker was disrespectful and said that the new hotel staff were telling him that he had to buy his alcohol from now on. This participant had started drinking again by his third interview and was lost to the study after that point.

Four participants reported that they were receiving opioid replacement therapy (unsupervised methadone or buprenorphine) and all four stated that they were sticking to their medication and not using other substances 'on top'. Three were happy with their current treatment, although two were considering moving to a closer service/pharmacy and the third said he now wanted to reduce his dosage slowly. The fourth participant was having problems getting his prescription organised after a move away from London, but this seemed to have been arranged by his final interview. A fifth participant had stopped using substances (except cannabis) and now wanted some support to join a gym or boxing club to prevent him from relapsing; however, he did not think this support would be available during the pandemic.

Smoking

Although many participants were tobacco smokers, they generally did not see this as a major problem and interest in smoking support remained low, as in the initial interviews. Smoking patterns continued to change (up and down) in response to a range of psycho-social and environmental factors such as stress, anxiety, accommodation status, money, availability of cigarettes, being in the 'right headspace' to not smoke, and friendship groups. Only a small

number of participants stated that they wanted to give up smoking tobacco. Despite this, participants continued to be generally positive about having options for nicotine replacement even if they were not interested currently. Several participants reported that they had used or were still using the 'vape' given to them by the hotel and found it helpful. However, they said that the cartridge refills were expensive so were uncertain that they would be able to use the device going forwards. Others spoke positively of nicotine patches or gum. A few participants also said that they would, or might, talk to their doctor or other services about options for nicotine replacement in the future.

Summary:

Many participants reported that they did not use alcohol or other drugs problematically and so did not need support with this. Of those who were using drugs or alcohol, few wanted additional support. One or two had, however, delayed transferring their treatment to new services when moving areas, and a couple had encountered challenges when swapping providers. This included one participant who had been receiving prescribed alcohol and said his prescription was being stopped after his move to a new hotel. Those who were still receiving opioid replacement therapy seemed to be doing well in treatment and not using other substances on top. Although many participants smoked tobacco, interest in smoking support and smoking cessation remained low. Nonetheless smoking patterns were changeable (up and down) and participants tended to be positive about having options for nicotine replacement even if they were not interested in addressing their smoking currently. The cost of e-cigarettes and refills was, however, identified as a potential barrier to their continued use following move on from the hotel.

7. HEALTH

Physical health

As most participants had initially been accommodated in a COVID Protect hotel, they had a wide range of physical health problems (already described in our first report). At follow-up, several participants explained how their health conditions (diabetes, headaches, eye problems, high blood pressure, and sleeping difficulties) were worsening because their move-on accommodation did not have cooking facilities and/ or provided unsuitable food. For example, several participants complained that food they were given was inappropriate for their diabetes and one participant stated that it was impossible to manage his blood sugar levels as there was no privacy to inject his insulin. Another participant had cirrhosis of the liver and said his health was deteriorating because he could not eat healthily and had no money to buy other food; another believed his headaches were caused by not eating enough; and another reported a problem with his bowel that he felt was being aggravated by his current poor diet. All had been moved onto other hotel accommodation.

Several participants also referred to the onset or worsening of aches and pains in their joints, back, hips, legs, feet and neck and one female participant described a recent infection that had caused a period of incontinence. These conditions often compounded other longstanding health problems including HIV, hepatitis B and C, asthma, and heart and lung problems. In contrast, some participants reported that they did not have health problems or that their health had recently improved; a change which some related to eating better and putting on weight after moving to new accommodation where they could cook for themselves and, in one case, after receiving protein shakes whilst in the first hotel.

Support for physical health

Many participants reported that they were on medications and/ or had regular GP and hospital appointments (phone consultations and sometimes in person contact for X-Rays and scans). Despite this, there was still evidence of unmet physical health need, with some complaining that staff in new hotels were not helping them. Several participants additionally stated that they needed to register with a GP or find a GP and/ or pharmacy closer to where they were now living. Meanwhile others had non-urgent health needs that were becoming urgent because they had not made appointments (particularly overdue eye tests, an appointment for new reading glasses and, in one case, a physiotherapist appointment). A few participants also believed that they needed more exercise.

Mental health

Consistent with the 'in hotel' interviews, some participants maintained that their mental health was good, but many others reported depression, stress and anxiety. Some participants described feeling 'up and down', whereas others said that they were very low, had no motivation, and/ or felt unable to leave their accommodation. A small number of participants said that they had felt suicidal within the last month and one had recently been hospitalized and assessed as being at risk of self-harm. Another participant spoke of post-traumatic stress disorder whilst another referred to voices in his head. Some participants complained that their mental health had deteriorated because of their current accommodation. Others attributed their deteriorating mental health to being isolated and lonely for too long, having nothing to do, worrying about the political situation and violence in their home country, tiredness, needing help with practical problems, and smoking cannabis.

Support for mental health

Comparatively few participants who reported mental health problems said that they had received support for this. A small number were taking anti-depressants or other medications, but most did not seem to want these (indeed, one was reluctant to contact her GP in case she was prescribed anti-depressants, and another was annoyed with his GP for prescribing anti-depressants). Several participants had spoken to therapists or counsellors and views on this were mixed. Some had found talking helpful, and some would have liked more regular support of this nature. Others were less certain that talking helped or found it awkward speaking on the phone to somebody they did not know. A few participants were waiting to hear back about counselling and one participant was waiting to see a psychiatrist. Another participant received and valued regular in-person visits and daily check-in calls from an outreach mental health team. Others explained how they tried to improve their own mental health independently through exercise, online courses, meditating and chanting, being creative, trying to encourage themselves, or sewing. Ironically, one participant commented on how they had received lots of offers of support with their mental health, but their mental health was good and so they did not need this.

Summary:

Participants reported a wide range of health problems and often said that their physical and/ or mental health was deteriorating. Commonly participants attributed poor physical health to their current poor diet and poor food in move-on hotels. In contrast, other participants felt that their physical health had improved after moving to accommodation where they could cook for themselves. Although participants seemed to be generally well-connected to doctors and hospitals for their physical health care and medication, there was still evidence of unmet physical health needs exacerbated by delays in securing appointments and treatment. As in the 'in hotel' interviews, mental health problems were both chronic and acute, and access to mental health care remained comparatively limited

even though some were now in contact with specialist services. Participants expressed a general dislike of anti-depressants and were often unsure about talking therapies. Instead, some tried to improve their own mental health through exercise, online courses, meditating, chanting, and other activities.

8. COVID-19

As also found in the 'in hotel' interviews, participants were fairly evenly divided in terms of whether or not they were worried about COVID-19. Those who said they were not worried tended to explain that this was because they took precautions and had little contact with others (often spending most of their time alone and keeping distant from others when out). For example, they stated that they wore face masks; had gloves; and washed or sanitized their hands frequently. Two people also reported that they believed they had already had the virus, one said he did not feel worried by meeting or being infected by other family members, and one expressed hope for a vaccine. Nonetheless, these participants still sometimes articulated more generalized worries about other people becoming infected, other people dying, a second wave of the virus, unemployment, recession, and the long-term impact on other people's health. Two participants also said that they found the general situation and changing lockdown rules confusing.

Participants who said they were concerned about COVID-19 were often very anxious indeed. They also took precautions, expressed a degree of confusion at the tier rules and worried about another wave or peak. Additionally, they tended to describe how they were personally vulnerable because of underlying health problems (diabetes, heart problems, respiratory problems); age; and/ or difficulty wearing face masks (because of hypertension or asthma). Some also spoke of situational factors linked to moving out of the safety and relative isolation of the first hotel, such as now being accommodated in shared housing with strangers who did not take precautions; living with or near strangers who smoked; being rehoused in a particularly busy and crowded area of London; and recent close proximity to someone who had tested positive for COVID-19. One participant felt better, however, after everyone in her shared house had been told to wear masks in communal areas and a community support officer had visited to check that people were complying.

Summary:

Participants were fairly evenly divided in terms of whether or not they were worried about COVID-19, and, following their stay in the first hotel, seemed very well briefed on the risk factors for contracting the virus and the precautions they should take to avoid this. Nonetheless, many were very anxious because of factors beyond their control (such as underlying health problems and age) and issues related to their current accommodation (such as living with or near others who were not taking precautions). In addition, some voiced concerns about the likelihood of a further wave of the virus, the dangers to others, and economic damage. Additionally, several expressed a degree of confusion about the changing tier system and lockdown rules.

9. USE OF TECHNOLOGY

Phone use

Although all participants had a mobile phone, the nature and frequency of their phone use varied. Some participants said that they used their phone all the time/ 'every minute of the day', whereas others only used their phone occasionally. Phones were routinely used for staying in touch with family and friends (by voice calls, video calls, text, WhatsApp, Facebook and email); contacting services (e.g. housing organisations, GPs, hospitals, drug treatment services, or benefit agencies); web searching; taking pictures or videos; entertainment (watching television and films, listening to music, playing games, accessing YouTube); travel-related activities (maps, booking coaches, paying for bus fares, translation); writing poetry; shopping; and jobhunting or looking for volunteering opportunities.

Whilst most participants were still using the phone given to them in their first hotel, some were using a phone that they had had prior to that and others were using a phone that they had acquired since leaving their first hotel. A couple of participants had two phones whilst others only had a non-smart (basic) phone or a phone that was broken or not fully functional (for example, one participant's phone could not make calls and another's phone had problems with audio). Other factors that inhibited phone use were having no credit, having no or poor access to wi-fi, not being able to charge devices, having their contract terminated because of not paying the bill, and not fully understanding how their phone or apps worked.

Other devices

Several participants said that they owned other devices besides their phone (for example an iPad, Kindle, smart TV or laptop computer). These devices had sometimes been donated to the participant by a friend, relative or charity. One participant mentioned that the hotel had a laptop that he could use for job hunting, emails and completing government forms, and another spoke of visiting libraries in order to access the Internet. One person with an iPad said she did not know how to use it, and another said her iPad was locked and she could not afford to pay £20 to unlock it. A further participant had an Ipod Touch, but no charger for it since leaving the first hotel.

Several participants emphasized that they wanted, or hoped, to secure an iPad or laptop or computer soon so that they could use it for additional or 'more serious' tasks such as writing, preparing a CV, completing forms, job searching, reading, getting organised, and keeping busy. A few participants also explained that it was difficult to type or write on a phone, and one noted that he struggled to complete tasks, such as paying his rent, by phone as his eyesight was too poor for such a small screen.

Accessing data

A small number of participants said that they had a monthly phone contract which they paid for with their benefits or that they relied on friends or family to help them out by 'topping up' their data. Other participants were still using (and very grateful for) the data package given to them in the first hotel. Some, however, had no phone credit left and so were completely reliant on free wi-fi for using their devices or, in one case, prebooking a phone in the hotel reception. Wi-fi was very important to many participants who said that it enabled them to stay connected to the outside world, keep busy, study or work. Some participants who had moved out of the hotel system said that they missed the free wi-fi. Meanwhile, those who had moved into new hotels sometimes complained that the wi-fi there was weak and this created a major problem for them as they needed to go to the hotel reception in order to be able to perform any tasks online.

Summary:

Although participants' use of phones and other IT devices varied, most relied on technology to a greater or lesser extent. Phones were used to stay in touch with family and friends but also provided a communication channel to services, a means to information, a source of entertainment and a practical tool for completing tasks, including job searching. Many participants were still using and dependent on the phones given to them in the first hotel, although staying connected to a network via a data package or wi-fi often became challenging after move-on. Charging devices and understanding how to use them could also be problematic. Although some participants wanted additional devices with larger screens so they could complete more tasks, the cost of purchasing these devices was often a barrier unless participants received help from a friend, family member or supportive charity.

10. THE FUTURE

When participants were asked what they needed or wanted for the future, most spoke of accommodation related issues; specifically, they wanted a house or somewhere to call 'home'; a place they would feel safe and secure; a place in which they would feel settled and from which they would not have to move again; a place that was not shared; and a place where they could cook. One person said they did not want to be homeless again whilst another said he wanted to return to living on the streets as soon as it was safe.

Many also stated that they wanted a job or to set up a business so they could make money, keep busy, support themselves, 'pay their way', buy things for their new home, provide for their children, and 'be a good citizen'. Two participants identified a desire for education and training, two said they needed to get their social security benefits sorted, and one stated that he had to sort out a bank card that wasn't working. More broadly, several participants said that they wanted to 'sort their lives out', 'make a contribution to society', be more creative, be more independent, be more organised, and work on their new home or garden.

Resolving their immigration status in order to work and settle were also important goals for several participants. Two others looked forward to a time when they could travel again and leave the UK. Additionally, many identified health-related needs and goals. These included having better food, a more varied diet and an opportunity to cook for themselves; sorting out their medications (including opioid replacement therapy and an alcohol prescription); securing mental health support; establishing better mental and physical health; sleeping better; doing more physical activity and getting fitter; finding a GP closer to their new accommodation; securing help in stopping smoking cannabis; and getting new glasses.

Some participants additionally said that they wanted material possessions such as a television, clothing, a microwave, books, a laptop, blinds for their window, a car, and data for their phone. One female participant wanted personal protective equipment (PPE) so she could secure a new job in a nail bar. A couple of participants also wished for the end of the pandemic and a return to 'normality'. Others hoped for new or better relationships with friends, children and partners and one wanted to have his dogs back with him. Lastly one or two spoke in more fatalistic terms about not making plans or not looking too far into the future as life cannot be controlled.

Summary:

When thinking about the future, participants talked mainly about their desire for accommodation that was safe, stable, secure and self-contained; a job or employment to make money, keep busy, and support themselves; settled immigration status; better health

and health care (including a better diet); a generally more settled and productive life; some relatively basic material possessions; and improved relationships with others. There was nothing exceptional about their goals which appeared to be reasoned, modest, and community oriented.

11. CONCLUSIONS

Lessons learned

The aim of the follow-up interviews was to better understand how people who had been accommodated in the hotels experienced the transition to move-on accommodation. Findings revealed that the process of moving out of the hotel had been difficult and traumatic for many residents and it seems likely that this might have been prevented, or at least reduced, if residents had been given more information, particularly about the location and type of their move-on accommodation, and more time to prepare and pack on the day of the move. Offers of practical support and transport might also have been conveyed more clearly and applied more consistently.

Our first report showed that residents were very appreciative of the hotel accommodation and were reluctant to be critical of any aspect, except the food. They particularly valued the kindness of the hotel staff, the room facilities, and the warmth, safety and privacy afforded by having their own space. Follow-up interviews revealed that these same residents were often critical of their move-on accommodation. Moreover, the extreme nature of some of their complaints suggested that some were being housed in accommodation that might not be deemed 'suitable' according to the homelessness code of guidance for local authorities.

The importance of food and diet had featured in our initial interviews but became even more prominent in the month after residents left the hotel. The reported consequences of poor nutrition, unsuitable diets, insufficient food, and an inability to prepare their own meals were serious, particularly for those with diabetes. Participants variously attributed worsening eyesight, high blood pressure, sleeping problems and poor mental health to not eating properly and, accordingly, articulated a strong desire for accommodation with cooking facilities where they could prepare their own food.

In our first report, we concluded that the hotel accommodation had provided participants with an important opportunity to rest, take stock of their lives, and secure help with a range of physical, emotional and financial problems. The follow-up interviews indicated that this good work was often unravelling within a month of people leaving the hotel. In particular, participants reported that their physical and mental health were deteriorating, and there were signs that, without proactive hotel support, some were losing contact with services: by, for example, not moving to more local healthcare providers and missing routine appointments.

In terms of relationships with professionals, family and friends, our participants described variable levels of contact. Whilst a few had supportive relationships, others said they had nobody helping them. Some wanted or needed relatively little company, whereas others felt

isolated and lonely; moreover, several complained that they had been let down by professionals who had not contacted them as promised. It is obviously very difficult to know who wants contact and impossible to meet everyone's relationship needs. Nonetheless, it seems important to remember to ask people directly about their support networks in order to identify any major gaps and to find ways of keeping people connected to others whenever possible.

Mental health problems were widely reported during the 'in hotel' interviews and often seemed worse by the follow-up interviews (sometimes exacerbated by move-on accommodation and sometimes by the ongoing impact of the pandemic). Although some had accessed formal mental health support, they struggled to find solutions through medications, such as anti-depressants, or through counselling or therapy. Indeed, some participants believed that they needed practical support with their accommodation and other life problems, rather than additional health care. Meanwhile, participants often engaged in self-help strategies, such as exercise, meditation and being creative, to try and improve their mental health. Where possible professionals might encourage and support these endeavours alongside the provision of any formal/ professional treatment.

Although participants identified relatively few needs for help with alcohol and other drug (AOD) problems, we continued to find evidence that people who received opioid replacement therapy benefitted from this. Nonetheless, participants did not always manage to change health care providers easily when they moved accommodation and AOD treatment could be disrupted. Interest in smoking cessation also remained low, despite high levels of smoking. However, participants appreciated having nicotine replacement as an option and a few continued to use this. Given that the cost of e-cigarettes and related products can be high, it seems wise to offer these freely on an on-going basis whenever possible.

At follow-up, participants continued to articulate a very good understanding of COVID-19 and issues relating to its spread, so indicating that the hotels had been very successful in educating people on the risks of infection and key protective strategies during the pandemic's early stages. Reflecting this, many participants were concerned about the virus, particularly if they were physically vulnerable and/ or living in shared move-on accommodation or near people who were not socially distancing or following basic hygiene practices (indeed one participant was very relieved when formal rules on wearing a face mask were introduced and enforced in her shared house). This suggests that more might need to be done in terms of educating a wider range of people on the risks of living in shared spaces and regulating communal areas if necessary.

Participants were very reliant on mobile phones for staying in touch with family, friends, and services; accessing information; occupying their time; and applying for jobs and benefits. The mobile phones and data packages provided in the first hotel remained a lifeline for many,

particularly given the expense of buying mobile technology and the lack of readily available free wi-fi. The return on well-being from offering participants a relatively inexpensive phone with data package has been enormous and is therefore worth continuing whenever resources permit. Meanwhile, larger devices (iPads and computers) could benefit many. Schemes for procuring and distributing these, along with basic training in their use, would be very valuable going forwards.

When participants were asked what they hoped for in the future, their requests were arguably predictable. Alongside safe, secure and self-contained accommodation, they wanted jobs, legal immigration status, better health, to work and be productive, some basic material possessions and improved relationships. Some also expressed a desire for the end of the pandemic. Whilst these may not all be instantly achievable, particularly when needs are high and resources are stretched, they remind us that the wishes and goals of people experiencing rough sleeping are often not too different from the wishes and goals of most members of society.

In July 2020, the Ministry of Housing, Communities and Local Government outlined the Next Steps Accommodation Programme. This promised the financial resources needed to support local authorities and their partners in ensuring that provision established through the Everyone In initiative would continue for an appropriate length of time, giving people a planned transition to more sustainable interim accommodation options until longer-term move-on accommodation could be found. Our findings illustrate how the move-on options being provided are not always meeting the needs of people previously housed in the Everyone In initiative. Moreover, the move-on accommodation offered has sometimes undermined the good work completed with individuals during earlier stages of the pandemic.

Data limitations

We repeat that our data are generated from a qualitative study. As such, the findings cannot be generalized to other areas or all people helped by the Everyone In initiative. Our participants were mainly recruited from one COVID Protect hotel and this will have affected their characteristics and needs. Furthermore, that COVID Protect hotel was owned by a well-known hotel chain and managed by a very experienced homelessness charity. The quality of accommodation and support provided may therefore have been better than that available to people accommodated in other hotels and areas. We obviously recognise the enormity of the task involved in helping people experiencing rough sleeping who often have complex needs, especially during a pandemic when staffing levels and budgets are stretched. Nonetheless, our findings provide a glimpse into what can be achieved when people who are homeless are offered warmth, safety and care; and, also, how rapidly gains can be lost if we fail to continue to invest.

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