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

PART 1: LIFE IN THE HOTEL

October 2020

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1. INTRODUCTION

During the spring of 2020, the UK Government implemented a ground-breaking policy initiative to provide temporary accommodation for everyone experiencing rough sleeping and a range of other forms of homelessness during the COVID-19 pandemic. Approximately 15,000 people were placed into emergency accommodation. 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).

Between July and October, researchers at 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 (one COVID protect and one COVID prevent hotel). After securing the necessary ethical approvals and access permissions, a team of trained volunteer researchers from 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 short interviews occurring over the following month. 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 interviews after they left the hotel. This report summaries key findings from the in-hotel interviews only.

Recruitment for the study occurred during lock-down when social distancing regulations were in full force. A researcher visited the hotels, handed out the study information sheets and consent forms, and spoke very briefly to any resident who was present. Those who were interested were invited to opt into the study by phoning or texting a bespoke study mobile telephone number. It was not possible to interview everyone who contacted the research team as some people spoke almost no English and involving an interpreter was not possible for reasons that will be discussed in subsequent publications. Thirty-three of the thirty-five residents who participated were accommodated in just one COVID Protect hotel. Some residents were anxious about sharing their personal information. Two residents withdrew from the study early in the interview process, although the data they provided prior to withdrawing are included here for completion. We do not claim that those interviewed are representative of all people accommodated in the London hotel initiative or the 'Everyone In' initiative. Caution should therefore be taken when interpreting the study findings.

2. PARTICIPANT CHARACTERISTICS

Demographics

Participants were aged between 21 and 75 years old (mean 48 years) and just under a quarter of the 35 participants (n=7) were women. Less than a third (n=11) had been born in the UK and three were born in other European countries. The remainder came from Algeria; Angola; Antigua; Brazil; Ecuador; Eritrea; Ghana; Iran; Iraq; Jamaica; Nigeria; Guinea; South Africa; Togo; Trinidad; and the US. Several reported that they were asylum seekers, refugees or had no legal immigration status.

Relationships

Nearly all were single, separated, divorced or widowed (i.e. very few said they were in a current relationship). One person was living with her partner (for whom she was also a carer) in the hotel room. Just under a half (n=16) had children (some adult children), but only one described being in current regular face-to-face contact with a child. Five described irregular contact (in person or by letter, email or social media) with children. One participant said he had a dog that he shared with his girlfriend and another said he had left two dogs behind to move into the hotel.

Education and employment

Just under a third (n=10) had had further or higher education (including two who had PhDs), whereas just over a third (n=13) said that they had no formal qualifications at all. Although a small number had not worked for many years, most had a history of working until fairly recently (last year or two). A few participants had had professional jobs, and many had worked in the hospitality sector. Other industries included retail; sales; nursing; IT; hairdressing; banking; engineering; labouring; courier; warehouse/packing; sports coach; and nursery nurse. Several participants said they engaged in unofficial cash-in-hand work as they had been unable to secure official work due to their immigration status. A few said they had lost their jobs or been fired recently, two had given up work to become carers, and one was furloughed.

Housing history

Some participants reported that they had previously owned a home of their own (often in another country). Others explained that they had previously had their own local authority or private tenancy (house, flat, bedsit etc). A significant minority explained that they had never had their own home. Most participants said that they had been homeless for less than five years. The longest period of homelessness reported was 30 years (by someone who said they enjoyed being homeless) and the shortest period was four nights.

Whilst homeless, people reported sleeping in a wide range of places, including in hostels and shelters, in YMCAs, in bed and breakfast hotels, on the streets, in churches, in abandoned

buildings and squats, in hallways, under staircases, in parks, in tents, in cars, on benches, sofa surfing, on buses, at airports, in a crack house, in a shop, and with hook ups for sex. Participants routinely referred to homelessness as being traumatic, frightening, cold and uncomfortable, although a few said they enjoyed it and valued the freedom and/or social contact with other people on the streets.

Experiences of institutional accommodation

Eight participants had spent time in prison either in the UK or overseas and others said they had been arrested or spent time in police cells but never imprisoned. Reasons for imprisonment were diverse (including being a political prisoner, drugs offences, non-payment of child maintenance, and violence). Five participants had been in the armed forces (all overseas), a few had been in home office housing or a detention centre or refuge, and one had stayed in a residential treatment centre for substance use disorder (not in the UK).

Summary

The demographic profile of the study participants needs to be considered in any interpretation of the study findings. Participant characteristics likely reflect the characteristics of people eligible for, and willing to accept, COVID Protect accommodation. Participants had a wide age range, were overwhelmingly male, and largely came from outside of the UK. Some were asylum seekers, refugees or had no legal immigration status. Most were single, had few family ties and often kept themselves to themselves. Many had qualifications, had worked, and had had stable housing within the last few years. Most found the experience of homelessness negative, uncomfortable and frightening.

3. LIFE BEFORE THE HOTEL

Sleeping

Before they moved to the hotel, participants mostly reported sleeping outdoors or in public locations: i.e. on the streets; in parks/woods; in or near churches; on buses; at an airport; on a bench; in a tent; or in a car. Several described feelings of fear, lack of safety and anxiety. Others said that they had been sleeping in a shelter, hostel, hotel, or sofa surfing. One had been in a hospital and another had slept with men in return for a room overnight. Most had been alone, but some had been sleeping alongside other people who were homeless. Often people said that they had slept in a range of locations over a relatively short period of time.

Income

Less than a third of participants (n=9) said that they had been in receipt of UK state welfare benefits before they moved to the hotel. Several (n=6) said they had had a paid job. Others described receiving donations or handouts from people in the street, charities, friends, family or people in their 'community'. Several participants reported cash-in-hand work, begging and busking. A very small number said they had savings or a pension and one reported stealing. In contrast, others said they received no benefits or had no recourse to public funds prior to the hotel and emphasised that they did not commit crime.

Food

Less than a third of participants (n=9) said that they bought food (either with their own money or with money given to them by others) before moving into the hotel. Many reported that they were given food on the streets (including by other people experiencing rough sleeping); or by friends; community members; charities; churches; and the Red Cross. Some said that they went to foodbanks, soup kitchens or homelessness services, or received food in shelters where they were staying or from places where they worked. A small number begged for food. In contrast, others emphasised that they did not use soup kitchens or foodbanks.

Washing and bathing

Participants frequently said that before moving into the hotel they had washed at homelessness services, shelters, day centres, churches, charities, or temporary accommodation. Some described washing at the homes of friends or family. Many others described bathing surreptitiously in toilets at sports centres, train stations, libraries, cafes, parks and places of work. Three people also said that they paid to use washing facilities (courtesy of a friend, a 'hook-up', and a train station respectively).

How time was spent

Before moving into the hotel, participants mostly reported that they had spent their time at services, day centres or charities or said that they were out on the streets (occasionally begging and occasionally with other people who were homeless). Several said they had spent

their days at work, and a few described going to a library, church, McDonalds, or arts centre, going for a walk, being in the park, being at a transport hub (train station or airport), being in an immigration centre, or being in hospital. Whilst some spent time with other people who were homeless, others avoided other people who were living on the streets. Only a few spoke of spending time at the home of a friend or family member.

Summary

Before moving into the hotel, participants had mostly spent time in services, on the streets or seeking refuge in public or semi-public spaces. Many were living hand-to-mouth with little or no income. Their food was often donated by services, other people who were homeless, friends, family and the public, and many were sleeping outdoors or in public locations. Participants often washed at services or in public toilets. As a group, they could be described as 'street homeless'.

4. MOVING INTO THE HOTEL

Hearing about the hotel

Participants mostly said that they had heard about the hotel from St Mungo's or other charities and services, shelters, and outreach services. In addition, a few had heard about the hotel from the council or other people who were homeless, or had been 'picked up' and 'sent' to the hotel from the streets or airport. One person had been discharged to the hotel from the hospital. A couple had been sent via taxi. Whilst some reported being initially suspicious or uncertain of what was happening, at least one had proactively made himself visible to services so that he would be accommodated. Others referred to their 'dawning realisation' of the seriousness of the pandemic.

Most participants did not know of anyone who had refused to come to the hotel – but often qualified this by stating that they did not really know or mix with other people on the streets. Overall, participants tended to think that people were scared and so very happy to come to the hotel; besides they had 'no choice'. Despite this, several participants were aware of some people who had refused to come to the hotel and thought that this might be because it was easier to make money on the streets, people wanted a flat, or people were too used to rough sleeping. One person said that some people came to the hotel and then left after a day because they could not cope with the rules, the authority, or being 'shut in'. Another explained that he had himself initially refused to move into a hotel because the first hotel offered to him was in a different town far from his family.

Personal possessions

Participants mostly said that they had no or very few possessions, so it had been possible to bring everything with them to the hotel. A few had left belongings in a safe place, in a shelter, hidden, or with friends and began to retrieve these as lockdown eased. A few said that they had had to leave some possessions behind, and one person had given his tent to someone else who was homeless. One had had their belongings stolen at the train station. Several participants commented that they had very few clothes or material possessions and this was a concern for them (particularly their lack of shoes and other clothes).

Expectations of the hotel

Expectations of the hotel prior to moving in were mixed. Some participants said they had had no idea of what to expect or didn't think about it as they were just scared. Others said they liked the idea of the hotel but had kept their expectations low. One or two said that they were nervous, fearful or suspicious or had been reluctant to move in. Additionally, one person said they had heard that the food was poor, and another said they were expecting that it would be noisy and they would have to share a room. Once there, many said that they were surprised and pleased as the hotel surpassed their expectations and some said that they could

not believe it and were excited and relieved. Indeed, one explained how they cried with relief when they saw the room. Only one or two said it was as they had imagined.

Summary

Participants' move into the hotel had often been relatively fast and characterised by anxiety, uncertainty and low expectations. There was little sense that people had had much choice about moving into the hotel and most had come with the few possessions they owned. Participants were, however, overwhelmingly surprised and very pleased when they saw the accommodation.

5. VIEWS AND EXPERIENCES OF THE HOTEL

Overall views of the hotel

Participants' experiences of the hotel were overwhelmingly positive. Accordingly, they used terms such as: 'fantastic', 'brilliant', 'paradise', 'nothing bad to say' and 'it saved my life' as well as 'good', 'very good' and 'better than expected'. Only a small number of participants said that they did not like or found it mostly negative.

Positive aspects of the hotel

Participants particularly appreciated the hotel staff and referred to their kind and caring approach. They also said that they valued being 'looked after' and treated 'without discrimination'. Indeed, they described staff as 'brilliant', 'great', 'friendly', 'lovely', 'helpful', 'empathetic', 'polite', and 'doing their best'. Participants were also very positive about the rooms and facilities (having their own bed, shower, toilet, phone, electronic-cigarette, and wi-fi), cleanliness and tidiness (including twice weekly room service) and having their own personal space. In addition, they appreciated having three meals a day (including halal, vegan and healthy food), being able to store their medications safely, and the location of the hotel which afforded nice walks. One person also said she valued being able to self-isolate as she was 'vulnerable'.

Many participants also reflected on how the hotel offered them safety, privacy, warmth, security, quiet, and somewhere to be out of the rain. One or two noted how this had enabled them to establish a daily routine, make contact with a solicitor, get advice on benefits, and progress their 'recovery' from addiction (the hotel provided 'a kick up the ass' – even though being in the hotel was a bit 'weird' at first). Additionally, one participant mentioned that it was good to see people he hadn't seen for a few years.

Negative aspects about the hotel

Many participants said that they had no complaints about the hotel. Where complaints were received, this was mostly in respect of the food, which was variously described as 'poor quality', 'tasteless', 'lacking in choice and variety', 'unreliable', 'late arriving', 'wrong temperature', not culturally suitable, not medically suitable (for people who were diabetic), lacking in vegetables and salad, and insufficient (or in one case too much). Some also reported that the food had made them unwell, they had had to go to the shop to buy additional food or they had gone an entire day eating nothing but crisps or chocolate. Several participants said that they wanted more control over their food and so would have liked a fridge or microwave to prepare meals themselves.

A few participants additionally complained that the hotel bedrooms were dusty, lacked air and were claustrophobic or that they were bored or sometimes felt socially isolated in the hotel. One or two participants reported that the staff had a 'bad attitude' or were unhelpful,

or that other residents were noisy or antisocial. One participant complained that visitors were not allowed into the rooms and one said that nobody had helped them to retune the television which was frustrating. One or two explained that they did not like the situation they were in but thought that the hotel was OK and others expressed concerns about what would happen to them once the hotel closed.

Money in the hotel

Many participants explained that they had no income or money at all in the hotel (noting that they had not begged or received any benefits). Some said that this was not currently a problem as they were receiving food (and 'a vaper') and did not need to spend. A small number had received occasional money from a charity or community members, were receiving a pension, were on furlough, or were receiving benefits. Additionally, a few had started to receive benefits (Universal Credit) since being in the hotel.

Spending time in the hotel

Participants spent their time in the hotel in a variety of ways. Only a few said they were bored; some of whom said they smoked (including cannabis) to pass the time. Most, however, seemed to fill their days with a range of activities. About two thirds referred to taking a daily walk and/or doing exercises in their room (and one went for a run), with some emphasising the importance of exercise and fresh air for their mental health. About a third referred to watching TV, and other common room-based activities included reading and writing (especially poetry). Others said that they sewed; listened to music; drew; worked or studied on their laptop; looked at the news on their phone; participated in zoom meetings, online classes, discussion groups and fora; played computer games; chatted to other hotel residents; relaxed; meditated; or slept. Very few reported face-to-face contact with family or friends, although one person was visiting and caring for their father each day.

Comparing the hotel with other accommodation

When participants compared the hotel to the places where they had been living prior to the pandemic, they almost unanimously preferred the hotel, explaining that it was cleaner, warmer, safer, and more comfortable, and it offered security, privacy, dignity and relief. One person described it as moving 'from hell to heaven' and another emphasised how having the hotel room was particularly important during the pandemic. In contrast to living in shelters, participants liked the fact that they could go to bed and get up when they wanted, stay in during the day (unlike shelter accommodation where people have to leave during the day), had no bills to worry about, did not have to share space with others, did not have to mix with people who were using alcohol and other drugs, could receive help from staff (including with benefits), and had less need for substances 'to escape'.

Suggested improvements to the hotel

Many participants did not have any suggestions for how the hotel could be improved. The most common suggestion was better food, including access to cooking facilities, or a microwave or fridge in the room. Other individuals referred to having windows that opened properly or better air conditioning, having access to a hospital or GP for a health problem, more information on what will happen after lockdown, and more staff to help with benefits.

Summary

Most participants were very positive about the accommodation and rated it more highly than other places they had recently lived. They particularly appreciated the kindness of the staff and having access to the room facilities, warmth, safety, and privacy. Some noted how this had helped them to take stock and begin to sort out their lives out. The most negative feature of the accommodation was the food, which was considered to be poor quality, tasteless, lacking in choice and unsuitable for many diets. A few participants were also bored or felt socially isolated. Aside from better food, participants had limited suggestions for improving the hotel. Whilst many had no money, the hotel provided them with essentials, and some had been able to sort out their benefits with the help of the hotel staff. Although many spent much of their day in their room, most managed to find stimulating activities and many enjoyed going out for walks and taking exercise; recognising that this was important for their mental health.

6. ALCOHOL AND OTHER DRUG (AOD) USE

AOD use prior to being accommodated in the hotel

Some participants reported that they had never used alcohol or other drugs in their lives, some described themselves as social drinkers, and some said that they had used alcohol and/or a range of other drugs over the years. Many participants said that they were not using any substances prior to entering the hotel and only a few described regular or heavy alcohol or other drug use prior to lockdown. More people reported heavy drinking than heavy use of other drugs, but only a few said that they considered their substance use to be problematic (although others seemed unsure about how problematic their drinking or drug use was).

AOD use whilst living in the hotel

A few participants described occasional alcohol or cannabis use in the hotel, but there was no evidence of significant drug or alcohol use whilst being accommodated. Although participants mostly said that there had been no change in their substance use since COVID-19 or since moving into the hotel, many had not been using substances anyway. One participant said that they had resumed using cannabis in the hotel and another reported drinking more since the pandemic. In contrast, several said that they were drinking or using drugs less often. The main reasons for these reductions were not having money; less social interaction; feeling stable and more relaxed in the hotel; trying to be healthier; and receiving treatment (including prescribed alcohol) in the hotel. Notably, some participants reported that people with addiction-related problems had sometimes been moved out of the hotel to other hotels. Several participants also complained that hotel residents often smoked cannabis outside the building.

Addiction related treatment and support

Few participants identified a personal need for, or were receiving any form of, support with their substance use prior to moving into the hotel. A very small number said that they had had some form of support or treatment (residential treatment, community detoxification, one-to-one support, group work, Alcoholics Anonymous or Subutex) at some point in the past (sometimes overseas) and three entered the hotel with prescribed methadone or buprenorphine. Participants mostly reported no changes in treatment during their stay in the hotel, and a few said they had refused treatment in the hotel. A very small number had, however, received new help (e.g. a new prescribed drug or prescribed alcohol) and one or two said they had reduced and come off medication successfully. One participant in receipt of methadone prior to the hotel stated that their treatment had continued in the hotel and they had now stopped using heroin and crack cocaine. Another who had been prescribed alcohol since moving into the hotel had reduced his drinking.

There was no evidence of buying or selling medications in the hotel and participants who were receiving medications described the ease of being able to store this in their room, in a

safe, or in a fridge in the hotel (this was especially important given that regulation of supervised consumption had eased during lockdown). Two participants reported other behavioural addictions, one of whom had received help with this whilst being accommodated. Overall there seemed to be little demand for addiction-related treatment in the hotel and where any support had been received, this seemed to have been appreciated. The prescription of alcohol is a relatively novel and potentially promising intervention that appears to warrant further evaluation with this population.

Summary

Participants seemed happy overall with the level of support received for substance use – even though there was no evidence of many people being initiated into treatment. The most notable finding was that so few participants identified addiction-related needs and many reported total abstinence. This is surprising given high levels of substance use found in most studies of rough sleeping. These findings therefore need to be considered cautiously and with reference to the particular demographics of the people recruited and interviewed who may not reflect residents in other hotels and other people experiencing rough sleeping nationally.

7. SMOKING

Smoking prior to the hotel

Several participants reported that they had never smoked, and several said that they had smoked in the past but not recently. Reasons for stopping smoking included becoming homeless and not being able to afford cigarettes, trying to get healthier, and ill-health. Most participants, however, said that they were smoking prior to moving into the hotel and the amounts and types of cigarette consumed varied (from occasionally to 20 a day). Those smoking roll ups tended to smoke more (up to 20 a day) than those smoking cigarettes (up to 10 a day). Factors influencing smoking included time of day (e.g. not before midday), socialising (only smoking with others), alcohol (only smoking whilst drinking), asthma (reduced smoking), COPD (reduced smoking), having money (more smoking), having less money (smoking roll ups), and being able to get cigarettes or tobacco from others (more smoking). Some participants said that they would smoke either cigarettes or roll ups depending on what people gave them. Only one person discussed smoking butts from the street - if he had no money or other tobacco.

Smoking in the hotel

Whilst some participants (n=6) reported smoking the same whilst living in the hotel as prior to the hotel, others smoked less (n=9, including 3 participants who had switched to vaping and stopped smoking tobacco). In contrast, others smoked more than before moving into the hotel (=2) and several participants (n=4) said that they had restarted smoking (albeit relatively few cigarettes a day). The main reason for smoking less was now having an electronic-cigarette, and also having no money and not being allowed to smoke in the hotel. The main reasons for smoking more or restarting seemed to be boredom or coping with stress. One participant said that they were smoking less as they had no money but had started to pick up and use butts from off the ground. Meanwhile, another participant who reported that he was smoking more in the hotel said that he wanted to stop smoking for good. Several participants referred to different groups of residents ('cliques' based on nationality and substance smoked [cannabis v tobacco]) who smoked outside the hotel in the car park and did not social distance until security came out to enforce this.

Access to tobacco

Several participants reported that accessing tobacco was easy in the hotel as there were shops nearby. In contrast, a small number of participants reported that it was harder to access tobacco in the hotel than on the streets because they did not have money, it was a walk to the shop, and they were reliant on tobacco from others (participants reported accessing tobacco from other hotel residents, friends, and family). One person also said that they had stopped picking up butts from the ground since COVID-19.

Nicotine Replacement Therapy (NRT) prior to the hotel

Participants tend to use the term 'vapes', 'vapers' and 'e-cigarettes' interchangeably. Quite a few (n=9) reported that they had tried NRT (vapes, e-cigarettes, gum, patches, nicotine tablets) before moving into the hotel. However, none particularly liked them. One person who had vaped felt that vaping worked but believed that his nicotine intake had increased by using them; another complained that NRT products (patches and tablets) given to him in hospital had made him unwell and didn't help him; and another felt that they hadn't really smoked enough to benefit from NRT. Others were concerned that NRT (and particularly vapes/e-cigarettes) were bad for people's health.

NRT within the hotel

Quite a few participants had not been offered and were not aware that NRT was available in the hotel (however some were non-smokers and at least one was not interested anyway). A couple of participants commented that they had been offered e-cigarettes but not patches or gum. Additionally, two participants said that they had not been offered NRT but were aware (from other residents) that it was available and so had asked for it – this included one woman who did not smoke but had asked for an e-cigarette as she did not want to start smoking. More participants had, however, been offered NRT than not offered it. A couple had refused NRT, including one person who said that the cartridges were expensive (despite them being provided for free in the hotel) and believed he could stop smoking without.

Several participants said that they had accepted e-cigarettes offered in the hotel, thought they were OK or helpful, and sometimes used them (particularly when they could not be bothered to go downstairs and outside to smoke). One participant said that they liked vaping whilst another said it made him cough and hurt his throat. Three participants appeared to have stopped smoking tobacco since vaping. A few participants said that it was 'great' or a good idea that e-cigarettes were being offered, especially to people who might not otherwise be able to afford them and had other health problems.

Desire for smoking support

Only one participant expressed a desire for support with quitting smoking whilst in the hotel and only a few expressed a desire for smoking-related support (invariably in the form of vaping products) when leaving the hotel. For example, one participant commented that e-cigarettes are expensive so having them provided is helpful, and another wanted to continue vaping started in the hotel after leaving. A small number of participants said that the timing for stopping smoking was not right for them just now, or that they liked smoking tobacco products, or that they used tobacco with cannabis. Additionally, one participant felt that the best strategy to address smoking would be to prevent boredom amongst hotel residents.

Summary

Overall there was a high smoking prevalence although the amount smoked was quite variable. There were also notable changes in smoking patterns within the hotel, with some smoking more and others smoking less. Smoking behaviours seemed to be predominantly affected by cost, health, socialising, availability (including of NRT), boredom, stress and hotel regulations. There was relatively limited interest in NRT, but participants tended to appreciate having this offered and the vapes were helpful in reducing some tobacco consumption.

8. PHYSICAL AND MENTAL HEALTH

Physical health problems

Reflecting the fact that nearly all participants were recruited from a COVID Protect hotel, most reported one or more physical health problems (often multiple problems) and only three participants reported no physical health problems at all. The most common problems described were diabetes, back problems, high blood pressure and asthma (all reported by five or more participants). Three participants had HIV and two had hepatitis C. Other problems reported by more than one participant were dental problems, eye problems, muscle and joint problems, heart problems, stomach problems, sleeping problems, skin problems, leg problems, feet problems and anaemia. In addition, individual participants identified alcohol dependence, hernias, shoulder pain, hay fever, epilepsy, nerve damage, tinnitus, high heart rate, fibroids, arthritis, shortness of breath, lupus, chest pains, allergies, eczemas, knee pain, gout, deep vein thrombosis, and injuries from assault. Interestingly, a small number of participants reported that their health had improved since being in the hotel, with one participant ascribing this to having proper rest and being able to shower regularly.

Support with physical health problems prior to COVID

Over half the hotel participants reported that they were taking some form of prescribed medication, inhaler or cream prior to the pandemic. Two had not long previously completed a course of physiotherapy, one had recently had an operation, one was prescribed protein shakes and one took over-the-counter medications. Others had recently been to hospital, seen a HIV specialist, seen a chiropractor, or been to a walk-in centre. One participant explained that he struggled to manage his diabetes when in shelters as there was insufficient privacy to inject insulin and another said that he had not always taken his HIV medication when homeless.

Support with physical health problems whilst in the hotel

Several participants said that they were receiving on-going support from their GP whilst in the hotel (either in person or by phone), and others said that they now had access to the hotel nurses who helped them access their medications. One participant explained how the hotel had arranged an appointment for him at a sexual health clinic and had also organised a taxi to take him there; another said that he was receiving formal help with his health for the first time since arriving in the UK; another said that he was now taking his HIV medication consistently; another was now managing his diabetes; and another commented that the hotel was testing all its residents for HIV and hepatitis.

A small number of participants said that they had lost contact or had less contact with their GP during the pandemic, had had hospital appointments cancelled due to COVID-19, were not receiving their regular blood tests, or were still waiting for a hospital appointment. One participant explained how difficult and expensive it was to travel across London to his doctor's

surgery from the hotel. Another explained that a friend had offered to collect and deliver his medication. Two participants with health problems were currently receiving no medical support.

Mental health problems

About a third of the participants (n=12) reported having no mental health issues, with a few describing themselves as being 'happy people'. In contrast, others reported a range of mental health problems ranging from mild to serious. Most commonly participants reported depression (n=15) followed by anxiety (n=8). Two made reference to suicide attempts and one to suicidal ideation. Additional problems reported by individual participants included an eating disorder, bipolar disorder, personality disorder, psychosis, paranoia, stress, loneliness, PTSD, fear, and memory problems. One participant described being 'abused' by his father. A few participants said that their mental health had deteriorated since the start of the pandemic, a few said that living in the hotel had improved their mental health (it was less stressful and there was less to worry about in the hotel than on the streets), and one commented that their anxiety had increased in the hotel because of fear and uncertainty about the hotel closing.

Support with mental health problems prior to COVID

Many participants reported that they had never received any help with their mental health, with some qualifying that they did not need or want any help of this kind. Several reported that they had received help with mental health as children whereas others described receiving prescribed antidepressants or medications for anxiety as adults. A few also described time-limited forms of psychiatric support including counselling and community mental health support (one participant had had a recent stay in a psychiatric hospital) and others indicated that they had received support from a GP.

Support with mental health problems whilst in the hotel

Since moving into the hotel, there had been relatively few changes in the mental health support participants said that they had received. One participant had lost the support of her social worker but was receiving a 'listening call' once a month instead, another participant had swapped to online support with a key worker through the recovery college, and another said he was now receiving good support from family and friends. One participant said that the hotel had helped him by creating an environment in which he could work on his mental health and well-being, for example by taking a break from situational challenges, reading self-help books, and changing negative behaviours.

In terms of new formal support since moving into the hotel, one participant said they had started receiving anti-depressants, and another had started to have phone contact with a key worker and therapist which he said he liked. Another participant said their GP was trying to refer her for more counselling and another said they would be interested in receiving some

mental health support but had not been offered any. One participant said she had not told, and would not tell, the hotel staff about her anti-anxiety medication.

COVID-19

The majority of participants were confident that they had not had COVID-19. Many had been tested in the hotel and, in one case, in hospital before an operation. Several others said that they had had COVID-like symptoms but tested negative. Only one participant reported that he had tested positive for COVID, although he was asymptomatic. Another was certain he had had it, along with various family members whom he had continued to see despite being unwell.

Participants were fairly evenly split (50/50) in terms of being worried or not about COVID-19. Those who were worried often flagged their vulnerability/ underlying health conditions and said that they felt safer in the hotel and tried to keep safe by social distancing. Several also said that they were worried about other people catching it (particularly family members) rather than themselves. Those who weren't worried sometimes said this was because they were cautious, wore a mask, and kept away from other people. One person said he believed in God for protection and another said that he did not care if he caught it as dying would be 'a way out'.

When specifically asked about any safety measures they took, most referred to social distancing (n=18), isolating themselves in their room (n=6), or socialising less than usual (n=3). Relatedly, several referred to staying inside, not using public transport, and no or limited use of the hotel lift. Many spoke of the two-meter rule. In addition, a small number commented that they had surprised themselves by enjoying self-isolating and being away from others. Many (n=13) spoke of wearing a mask (which the hotel provided) and others discussed washing their hands (n=6) or using hand gel (n=4). One said they always showered after going out, one wore gloves, and another said they cleaned their own room rather than letting the hotel staff into their space. One person said that they prayed and exercised for mental strength. Only a few seemed to not understand how to keep themselves or others safe.

Summary

Unsurprisingly given that the hotel was a COVID Protect hotel, participants tended to report a very wide range of physical health problems and many had multiple problems. Most (although not all) seemed to have had some form of medication or treatment for their physical ailments prior to moving into the hotel. Whilst there was some negative disruption to physical health treatment because of COVID, several participants reported that they had accessed new support or treatment via the hotel. Furthermore, a few said that simply being in the hotel had helped their physical health improve. Nonetheless, there was still evidence of unmet need.

Participants also routinely reported mental health problems, particularly depression and anxiety. Some explained that the pandemic had harmed their mental health whereas others felt that moving to the hotel had improved it. Overall, however, participants did not seem to be well-connected to mental health services prior to moving into the hotel and this did not seem to change whilst in the hotel. Whilst not all participants wanted help with their mental health, there again seemed to be clear evidence of unmet need.

Many participants said that they had been tested for COVID but only one (possibly two) participants had had a positive result. Many were very worried about the virus, usually because of their underlying health conditions. Meanwhile, others were not concerned. Most participants understood ways of staying safe from the virus and proactively tried to socially distance or isolate themselves from others, wore masks, and/or washed and sanitised their hands.

9. GENERIC SUPPORT AND SERVICE USE

Pre-COVID support and service use

Many participants said that they had previously received support from housing or housing-related services (especially shelters), but also from charities, day centres, resource centres, outreach and street services, food kitchens, churches and, to a lesser extent, a refugee or migrant centre or youth centre. Aside from housing-related support, this comprised practical assistance, such as access to food or showers, somewhere to wash clothes or charge a phone, a sleeping bag, shelter from the rain, cups of tea, advice, money, and supermarket vouchers. Occasionally, people said that they had received emotional support, or benefitted from having someone to talk to/ listen to them and access to classes or group sessions.

A few participants also said that they had received support from the Home Office, detention centres and legal aid, and one participant had been on an employment support scheme. Others explained that they had received informal support from family and friends, the public (who gave food, money and tobacco) and other people who were homeless and in a similar situation (who were able to offer encouragement and moral support and signposting to other services). In contrast, others reported that they had had no help and support prior to the pandemic. Whilst a small number of participants clarified that they did not want support, had refused help or would rather do things for themselves, others said that they had been refused help, offered inadequate support, or offered support that was 'limited', 'useless', or 'made no difference'.

Most participants expressed gratitude for the support they had received prior to COVID, describing it as helpful or very helpful. One participant also said that it would be impolite to complain or ask for any more support. Others were, however, more critical of the support they had previously received. For example, some explained that they did not like shelters which were noisy, lacked privacy and were often hectic with people 'misbehaving'; did not like services that asked many questions; thought staff attitudes were poor or judgemental; or found particular services difficult to access because of limited opening times, distance and the cost of travel.

Changes in support and service use during the pandemic

Whilst a few participants said that they had had no changes in their support since COVID-19, most highlighted the hotel accommodation and/or the support provided by St Mungo's. In this regard, participants identified the receipt of food, the hotel room and its facilities, and access to the hotel support workers and nursing team. Some participants also explained how St Mungo's staff were helping or had helped them to access benefits, move on housing, mental health support, a GP, and legal advice (particularly in respect of immigration status). A few also noted how they had received additional support from services and organisations

outside of the hotel, including money to top up a travel card, access to online lectures, food packages, a social worker, and help in relation to migration.

A few participants were ambivalent or negative about the support received from the hotel. For example, one participant was critical about the lack of communication particularly in relation to move on that was creating stress for her and other residents, another felt that staff attitudes varied, and one felt that offers of help from staff were a bit 'empty'. Most, however, were very positive about the support received from the hotel, noting that the hotel staff were friendly, helpful and 'wonderful', listened to them and made them feel 'looked after' (which was contrasted with support received from council staff who 'do not care'). One participant stated that their support was 'unified' (ie. joined up) for the first time, one said they were receiving more support than before, and two commented on how the hotel had 'saved their lives'.

Unmet support needs

Approximately half the participants identified some form of unmet support need (in addition to the need for a home). Some thought they needed more support with their physical health, additional clothing, or more money. Individual participants also identified a need for further support with their mental health, better communication on move on from the hotel staff, a job, aftercare when reducing from methadone, a flight home to Europe, a solicitor to help with a family problem, help with managing finances, and access to face-to-face groups.

Summary

Prior to the pandemic, many participants were receiving basic forms of practical support (food, access to showers, somewhere to wash clothes etc) from a range of services. Access to emotional support was less common and some participants were receiving no support at all. Some participants also said that they received informal support from family, friends, the public and peers. Meanwhile, others stated that they did not want or need support at all. Most participants were very grateful for the support they had received prior to the pandemic, even though a few were critical. During the pandemic, most participants seemed to be receiving support from the hotel and hotel staff. Again participants were mostly very positive about this support, although many identified additional assistance that they felt they needed.

10. RELATIONSHIPS

Relationships before the hotel

Participants reported a range of types of relationships and contacts before moving into the hotel, including with family (parents, children, spouses, ex-spouses), friends, partners, ex-partners, church friends, friends and acquaintance who were also homeless, and hook ups. One or two saw family and friends regularly, others had family or friends they saw from time to time, and some said that they didn't really have any relationships at all (for some this was from choice as they preferred to be alone, keep themselves to themselves, or not see people whilst homeless). Where participants reported relationships, these were often with people whom they hadn't seen for some time, saw infrequently, or only had contact by phone, text, email or letter. Notably, many had family overseas whom they hadn't seen for many years or children or family from whom they were estranged.

Relationships within the hotel

Participants seemed able to retain many of their pre-pandemic relationships whilst they were in the hotel via phone calls, texts, emails, WhatsApp, video calling, Facebook, chatrooms, online church services and other social media (particularly during the earlier stages of the pandemic). This was often facilitated by the phones given to the participants in the hotel and the free wi-fi. Several participants had also established friendships with other people in the hotel, including relationships formed whilst outside the hotel smoking. A couple of participants reported a loss of relationships with other people they knew who were still homeless, noting that this was either because these friends did not have a phone or because they wanted to avoid these people as they were using substances. One person also reported that he had lost contact with people whilst he had been in the hotel because he didn't have a smart phone himself.

Avoiding people

Only a few people in the hotel said that they were trying to avoid specific individuals (either people in the hotel or outside) as these individuals were 'stalking them' or likely to cause them trouble because of a shared history. A few others said that they were trying to avoid particular groups of people (such as people using substances or 'old friends who were bad for their self-esteem'). One individual referred to another hotel resident who had been accused of rape in a car park and who was taken away by the police. More often, participants reported that they were not seeking to avoid anyone in particular and had not had any conflict with anyone in the hotel; however, they preferred to stay in their room and 'keep themselves to themselves'. This was sometimes because they were wary or anxious of people who 'misbehaved' or who were rowdy, noisy or potentially caused trouble, but often because they were simply trying to socially isolate or socially distance in their rooms as they had been told. As lock-down eased, some of these participants began to socialise a little more. Others, meanwhile, said that they did not avoid anyone or feel they needed to avoid anyone as they

felt safe and looked after in the hotel, and one individual noted that "The only person I'm trying to avoid is my previous self".

Social distancing

Almost all participants knew, understood the reasons for, and said that they complied with basic social distancing rules, and needing to wash hands and wear a face mask. Some also explained how they tried to avoid public transport, the hotel lift or wore gloves etc. Only one participant reported that the rules were difficult to understand and only one seemed not to understand social distancing. Many participants said that they did not mind socially distancing and a couple even said that they 'liked' or 'loved' it. Some were, however, more negative and said that they found it hard to do or did not like it; for example, because it made them feel lonely, isolated or alien.

Most participants seemed to think that it was easy to socially distance in the hotel but more difficult to comply outside (e.g. in shops or post offices). Indeed, many participants commented that it was difficult to keep distant from people when you are sleeping on the streets, in a hostel or shelter, begging, or attending a soup kitchen. This is because people are often sleeping very close together (up to 25 people in one room in some shelters), sharing items, handling money, or receiving food or handouts, and do not have access to water to wash their hands. In contrast, one person thought that it would be relatively easy to socially distance when on the streets as other people avoid you anyway.

Summary

Participants reported a range of relationships and contacts before moving into the hotel, but these were often with people whom they hadn't seen for some time, saw infrequently, or only had contact with by phone, text, email or letter. After moving into the hotel, participants tended to retain their relationships using phones, texts, video calls and other online sources. For the most part relationships within the hotel seemed harmonious with few reports of conflict or disputes, although many participants preferred to stay in their room and 'keep themselves to themselves'. Almost all participants knew, understood the reason for, and said that they complied with basic social distancing and related rules. Overall, participants thought it was easier to socially distance in the hotel than when living on the streets or in hostels and shelters.

11. USE OF TECHNOLOGY

Technology owned

Participants' ownership of technology was varied. Although most had a phone, some only had a very basic non-smart phone, others had a cheap smart phone and some had both. Very often the smart phone had been given to the participant by the hotel staff and some had been given a non-smart phone by another service. Others had been given phones by friends or family. Although a few participants had phone contracts or paid a monthly top up (sometimes paid for by friends or family or St Mungo's), most were reliant on the free hotel wi-fi. One participant said that she had an outstanding phone bill of £400. In addition, several participants reported that they had a tablet and/ or laptop computer. Some, however, said that they did not have these devices with them in the hotel (they were stored with family or friends) or these devices were actually broken or not functioning.

When explaining why they did not have phones, computers or tablets, most said they could not afford it and a couple said that laptops were too heavy to carry around. One person said that they preferred using the library, one felt it was inappropriate to beg if they had a phone, one said they didn't need a computer, one said they did not know how to use technology, one disagreed on ethical grounds (stating that technology is often produced from minerals mined in central Africa), and one said that they would not be able to charge a device. More generally, participants reported that charging phones in the hotel was easy but more difficult when on the streets; meaning that participants often had to be creative about charging phones in cafes, public toilets, blocks of flats, tourist information centres, or transport hubs. A few participants also reported that they had had phones and other devices stolen on the streets.

Technology used

Participants mostly seemed to prefer using their phones rather than larger devices (computers or tablets). Indeed, several participants reported that they used their phone every minute of the day and one reported that their phone had 'saved them'. Phones were used for making and receiving calls and texting, but also for a variety of other internet-based activities such as listening to the radio, listening to music, watching TV, getting news, Facebook, Instagram, and other social media, video calls, writing blogs, banking, writing poetry, playing games, reading the bible, and research. Laptops and tables were sometimes used for research, attending classes, producing artwork, applying for benefits and jobs, and working.

Nearly a third of participants (n=24) said that they used social media (Facebook, SnapChat, Instagram, Twitter, Linked in, Viber, YouTube, Grindr or dating apps) and a few commented on how they liked to use Facebook as a 'voyeur' to see what others are doing. Meanwhile, over half the participants (n=21) reported that they used or had previously used video calling (mostly WhatsApp, but also Zoom, Facetime, Skype and Vivo). Many really appreciated the option of video calling, although a few said that they disliked video calling and preferred face-

to-face contact. Other apps used included banking apps, email, cross stitch design, recovery college, TikTok, gaming apps, a couch surfing app, Fitbit, a sign language app, Amazon, podcasts, language apps, educational apps, google, and music apps (including Spotify and Shazam).

IT literacy

Participants generally reported that they would have no problems setting up and using a smart phone or helping others to use one. Only a small number of participants said that they did not know how to do this and would need support (and one participant said they did not want a smart phone). For many participants the problem would not be setting up and using the phone but being able to pay the bills if they did not have access to free wi-fi.

Despite a generally good level of IT literacy, quite a few participants said that they would appreciate receiving help with IT, particularly with using computers. Several participants reported that they had received IT support from the hotel reception and others said that they had been helped by family or friends or library staff in the past. Others said they would simply go to a computing shop or look up the problem themselves if they needed IT support. Meanwhile, many participants said that they would be able and willing to help others with IT problems. Indeed, some were very keen to do this and/or said they had already helped others, including other residents in the hotel.

Summary

Most participants had a phone, but this had frequently been given to them. Participants often could not afford data and so were reliant on the free hotel wi-fi. Charging phones was also a challenge on the streets but not in the hotel. Most participants used their phones daily for a very wide variety of activities, particularly staying in contact with people and keeping themselves occupied in the hotel. Participants generally reported good IT literacy in relation to smart phones but said they would appreciate receiving IT support, particularly with computers. Many participants said that they would be able and willing to help others with IT problems. Indeed, some were very keen to do this and/or said they had already helped others.

12. LEAVING THE HOTEL

Knowledge about leaving the hotel

At the time of their last interview within the hotel, the majority of participants had no information or idea about when they would be leaving or where they would be going. Although those interviewed in August and September were slightly more likely to have an idea of what would happen next, this was seldom far in advance of their leaving date. This uncertainty caused worry and stress for many participants, some of whom seemed unable to think about and plan for what might happen next or assumed that they would be made homeless again. Those interviewed in June were often given leaving dates in July which were then changed as the hotel contract was extended.

In August and September, participants commonly reported that they were waiting for people or organisation (St Mungo's, a key worker, a charity, the Home Office) to speak to them about their rehousing. Those who had information about their move on accommodation were generally pleased even though they often still had limited details. Others were sometimes reluctant to push for any further information, with some stating that they already felt very grateful for what they had received and didn't feel it was polite to ask for more.

Desire to leave the hotel

Many participants expressed a desire to leave the hotel, often as soon as possible, stating that they were 'ready to move on'. Others were more ambivalent, stating that they had really appreciated being in the hotel but were also ready to move – provided that they had somewhere to move on to. In this respect, a few participants noted that they trusted staff/professionals to find them somewhere appropriate when the time was 'right'. In contrast, other participants explained that they did not want to leave the hotel and were stressed, distressed, worried and anxious at the prospect.

Participants generally articulated few preferences regarding the type and location of move on accommodation, although some emphasised particular areas, and one highlighted the importance of securing accommodation with appropriate support for her partner. A few participants seemed happy to return to their lives as they were before COVID-19 – so long as they were not at risk of the virus. In contrast, one participant stated that he was more concerned about his immigration paperwork, and lack of phone credit, clothes, food and oyster top up than the specifics of any move on accommodation.

Support with departure

In addition to help securing accommodation, participants identified a range of other support needs for their move on. These including assistance securing a job, a work permit, a bank account, benefits, money, education, immigration status, a solicitor to help with their asylum application, a hospital appointment for a skin condition, medical care for cataracts, mental

health support, counselling, clothes, help with caring for a partner, help returning to home country, and after care following methadone reduction. In contrast, a few participants highlighted their independence and clarified that they would not need support after they moved on.

Ideal place to live

When asked where they ideally wanted to live, most said London or near to London. A small number wanted to live elsewhere in the UK or overseas, and a few said they would live anywhere. A very small number specified particular characteristics of their ideal areas, such as quiet, an area they know, somewhere they can work, close to a relative, or near people from their own community. In terms of the accommodation specifically, participants generally expressed a desire for independent accommodation, usually their own flat or studio flat. One person wanted their own room with shared facilities, and another said they would be happy with just 'a roof over their head'. Two people dreamed of having their own place on a plot of land but recognised that that was not likely in the short term.

Summary

Participants tended to be given very little information about move on and this was often a source of anxiety and stress for them. Overall, participants were reluctant to make any demands and seemed to trust staff and professionals to help them appropriately. When offered accommodation, participants tended to be satisfied and grateful. Although many were very keen to leave the hotel, a few were very anxious about the prospect of moving on. In addition to support with finding accommodation, participants often articulated other support needs, including needing help with money, employment, legal matters, and health problems. Overall, participants' accommodation expectations were relatively modest.

13. CONCLUSIONS

Key Findings

The analyses presented offer insights into the characteristics, needs and wishes of people who are homeless but also particularly vulnerable to COVID-19. Although caution should be taken in generalizing the findings to other people experiencing rough sleeping or homelessness, the insights gained should still be useful as the UK moves into the winter of 2020 and the next stage(s) of the pandemic. The key findings are as follows:

1. Participants were mainly male, born outside the UK, and often had a fragile immigration status.
2. Participants generally experienced rough sleeping and hostel accommodation as negative and frightening.
3. Prior to moving into the hotel, participants had spent a lot of their time on the streets, seeking refuge in public or semi-public spaces, and living hand-to-mouth with little or no income.
4. Participants had arrived at the hotel fearful and with low expectations but were mostly very pleased when they saw the accommodation.
5. 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.
6. Participants were very appreciative of the hotel accommodation and reluctant to be critical, except in respect of the food.
7. 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.
8. Although some participants experienced boredom and loneliness within their rooms, most were very resourceful in terms of finding stimulating activities, taking exercise, and trying to look after themselves.
9. Most participants did not require treatment for alcohol and other drug use, but those who were treated seemed to respond positively.
10. Many participants smoked and there were notable changes in smoking behaviours within the hotel, with some smoking more and others smoking less.
11. Participants' smoking behaviours were affected by a variety of psycho-social and environmental factors, with the distribution of free NRT (particularly e-cigarettes) helping to reduce some tobacco consumption.
12. Participants reported a very wide range of physical health problems which were often being treated before they moved into the hotel.
13. Participants also routinely reported mental health problems but did not seem to be well-connected to mental health services before moving into the hotel.

14. Despite the provision of medical treatment within the hotel, participants continued to report untreated mental and physical health problems.
15. Many participants were very anxious about COVID-19 but only one or two had tested positive during the pandemic.
16. Participants had a good understanding of how to protect themselves from the virus and were proactive in socially distancing, hand washing and mask wearing.
17. Most participants felt that it was easier to socially distance in the hotel than outside the hotel in hostels and on the streets.
18. Prior to the pandemic, many participants 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.
19. Participants tended to very grateful for all practical support they received before and during the pandemic, although many still had unmet practical needs.
20. Participants had relatively limited relationships and contacts prior to the pandemic but tended to retain these during their stay in the hotel by using mobile phones to stay connected.
21. 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 the virus.
22. Participants were 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 and to keep themselves occupied within their rooms.
23. Most participants had good IT literacy and were willing to help other residents who were less familiar with mobile technology.
24. 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.
25. Participants had relatively modest expectations about move on accommodation but appreciated that they would need further support with a range of practical and medical issues.

Implications

Who was accommodated in the hotel and how can they be supported going forwards?

Findings suggest that people accommodated in the COVID Protect hotel were likely to be male and unlikely to be British nationals. They had diverse support needs (language, legal, financial, practical, physical health, psychological, and emotional) but limited links to support systems. Many did not have long histories of homelessness and were often anxious and frightened by sleeping on the streets and in hostels. They had most contact with charities and third sector services, some contact with formal health systems, and limited access to social and emotional support. As a group, they were unlikely to seek out or ask for support, so seem likely to require

outreach or assertive forms of assistance to bring them into services in the future. Once contacted, they are likely to be grateful for any help offered.

Did living in the hotel protect people from COVID-19?

The hotel seemed to do a very good job of protecting its residents from COVID-19. Only one (possibly two) people said that they had had the disease and there were no reports of transmissions between residents. Participants had an excellent understanding of social distancing and other protective measures and reported very good compliance. They were also conscious that it was easier to socially distance in the hotel than on the streets or in hostels and shelters. One reason why compliance might have been so good was that residents were very fearful of catching the disease but also keen to avoid other people in the hotel who might be noisy or disruptive or using substances. Another reason seemed to be that the hotel catered for all residents' basic needs, meaning that they did not have to go out. Moving people experiencing rough sleeping back into hotels could further protect them if the pandemic continues.

Did living in the hotel provide an opportunity to address addictions?

Residents presented as a resourceful group of people who were keen to look after themselves mentally and physically. They also seemed to perceive the hotel as an opportunity to rest, reset and recover. There were few who reported substance use disorders requiring treatment. However, screening and offering support, including for other behavioural addictions and traumas, were clearly important. Indeed, those who were treated for a substance use disorder identified improvements whilst living in the hotel (with the prescription of alcohol warranting further investigation amongst this population). Levels of smoking were meanwhile high, whilst motivation to address smoking was relatively low. Nonetheless, smoking behaviours changed (positively and negatively) within the hotel in response to economic, social and structural factors (such as less income, changes in social activity, and hotel rules) and also by the availability of NRT (particularly electronic cigarettes). Thus, even though the demand for NRT was low, its availability was positively received and had some modest benefits.

If the hotel were to be recommissioned, what aspects should be repeated?

Residents of the hotel were very grateful for the accommodation provided to them. They were especially appreciative of the kindness of the staff, the room and its facilities, and the fact that it afforded them warmth, safety, and privacy. That the room was of an 'unexpectedly' good standard undoubtedly made them more willing to stay in their rooms. The provision of mobile phones and wi-fi (with support on how to use these when needed), meanwhile, enabled them to stay in contact with people and occupy their time. The non-judgemental and caring attitudes of the hotel staff, the good standard of the accommodation and the provision of technology collectively seemed to be important components in the

success of the accommodation and should thus be repeated if the hotel needs to be recommissioned.

If the hotel were to be recommissioned, what should be done differently?

Residents were particularly critical of the hotel food, which seemed to be lacking in choice and poor quality. If the hotel were to be recommissioned, it would seem important to review other ways of providing meals so that they afforded residents more choice and better catered for diverse medical, religious and cultural diets. Some opportunity for residents to cook for themselves or to have a small fridge or microwave would be highly valued. Whilst residents received support and referrals to other services from the hotel staff, they continued to have many unmet needs as they departed from the hotel. A more co-ordinated and assertive approach to providing support services would have likely been appreciated by many residents. Whilst providing residents with detail about their move on arrangements was undoubtedly difficult due to factors beyond the control of the hotel staff, this uncertainty caused residents a very high level of stress and anxiety. Some of this worry would have probably been avoided if staff had been able to give residents more information and had communicated with them more regularly and openly about when and where they would be going next.

Next steps

Interviews with participants after they leave the hotel will be completed by mid-end of November 2020. These interviews are capturing residents' experiences of leaving the hotel, move on accommodation, ongoing formal and informal support, experiences and concerns about COVID-19, and needs and wishes for the future. The data will be analysed in December 2020 and used to produce another short report in January 2021. Aspects of the data presented, and the methodology used, will also be further analysed and submitted for peer review and formal publication. The research team is additionally seeking funding to conduct and analyse interviews with key decision-makers, staff and volunteers involved in delivering the hotel accommodation as this will enable them to provide a more comprehensive evaluation of the initiative.

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