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

PART 3: LIFE, NINE MONTHS, AFTER LEAVING THE HOTEL

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CONTENTS

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1. BACKGROUND

'Everyone In' initiative

During March 2020, the UK Government implemented a ground-breaking policy initiative, known nationally as the 'Everyone In' initiative. This aimed to provide temporary and emergency accommodation for everyone experiencing rough sleeping and a range of other forms of homelessness throughout the UK during the COVID-19 pandemic. The primary aim of the initiative was to reduce the impact of COVID-19 on people facing homelessness and to prevent deaths. By July 2021, published data suggested that 37,000 people had been supported by Everyone In, and, of these, over 26,000 had been moved into longer-term accommodation[1].

In London, Everyone In 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 2020 and July 2021, researchers from the National Addiction Centre, King's College London, undertook a research project to better understand the views and experiences of people accommodated in the London hotels. After securing ethical approval (King's College London Research Ethics Committee: CREC-HR-19/20-18676) and access permissions, the researchers recruited a cohort of hotel residents to participate in a qualitative longitudinal (telephone-based) interview study. The study had three distinct stages and took the form of 'rapid research'. 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. They are also well-suited for researching sensitive topics and for capturing the views of people who may have limited literacy.

Study stages

[1] The Kerslake Commission (2021) *"The Kerslake Commission on Homelessness and Rough Sleeping. Interim Report."* https://www.commissiononroughsleeping.org/

Stage 1 of the study (conducted between June 2020 and September 2020) involved interviews with 35 hotel residents while they were accommodated within one of two London hotels involved in Everyone In. Each resident was invited to participate in a series of short 20-minute telephone interviews over a period of 5-7 days to explore their lives within the hotel.

Stage 2 of the study (conducted between July 2020 and December 2020) involved efforts to re-contact all 35 residents immediately after they left the hotel to understand how they experienced the transition to move-on accommodation. Of the 35 participants, 28 were successfully re-contacted and invited to participate in five 'follow-up' telephone interviews (of variable length, conducted a week apart, over one month).

Stage 3 of the study (conducted between April 2021 and July 2021) involved attempts to re-contact all 28 participants from Stage 2, nine months after they had left the hotel where they were staying when recruited to the study. One short follow-up telephone interview (25-30 minutes) was conducted with each participant to understand their recent experiences and current circumstances, focussing particularly on their accommodation, experiences of COVID-19 and vaccine uptake, relationships, substance use, health, use of technology, and views on the future. Of the 28 participants completing a Stage 2 interview, 13 were successfully re-contacted and re-interviewed for Stage 3.[2]

Study procedures

All interviews followed a semi-structured interview guide and were conducted by telephone. Participants were reimbursed with a £40 gift voucher redeemable at a supermarket of their choice on completion of all their Stage 1 'in hotel' interviews. They additionally received a £50 gift voucher on completion of all five Stage 2 interviews and a third voucher with the value of £10 on the completion of a final Stage 3 interview. Participants who completed all three stages of the study therefore received a total of £100 in gift vouchers that were redeemable at retailers chosen by participants.

Study limitations and strengths

We do not claim that those interviewed were representative of all people experiencing rough sleeping or of all people given temporary and emergency accommodation during the 'Everyone In' initiative. Various factors beyond our control influenced sampling for the study;

[2] Stage 3 interviews occurred after the roll-out of a national vaccine campaign (which started in December 2020) and during the Government's 2021 'roadmap out of lockdown'. The latter consisted of Four Steps towards easing many of the restrictions introduced in England as measures to control the spread of COVID-19. These Four Steps were implemented during March 2021-July 2021. All Stage 3 interviews were completed before 19 July 2021, the so-called 'Freedom Day' (marking the end of Step 4) when almost all COVID-19 legislation, regulations and restrictions were removed in England. By this time, approximately 70% of the adult population had been fully or partially vaccinated.

for example, the research was undertaken at short notice and without any formal funding; recruitment occurred during the initial national lockdown when social distancing regulations were in full force; and it was not possible to interview everyone who contacted the research team at Stage 1 as some people did not have English as their first language and we had no access to interpreters. Furthermore, nearly all people who participated at Stage 1 (n=32/35) were accommodated in just one COVID Protect hotel. However, as a qualitative study, our findings are not meant to be generalisable. Instead, they provide important information and insights that quantitative studies and numbers could not reveal.

Report aims

Key findings from Stages 1 and 2 have already been documented in two reports[3,4] and are summarised briefly in the next section to provide context. The principal aim of this report is to provide a rapid and accessible overview of key findings from the Stage 3 interviews, covering participants' lives during the nine months after leaving the hotel.

[3] Neale, J., Bowen, A., Brobbin, E., 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. https://osf.io/rt7j9/

[4] Neale, J., Bowen, A., Brobbin, E., Craft, S., Drummond, C., Dwyer, G.-J., Finch, E., Henderson, J., Hermann, L., Kelleher, M., Kuester, L., McDonald, R., Parkin, S., Radcliffe, P., Roberts, E., Robson, D., Strang, J., Turner, R. and Metrebian, N. (2021) "*Experiences of being housed in a London hotel as part of the 'Everyone In' initiative. Part 2: Life after the Hotel.*" National Addiction Centre, King's College London: London. https://osf.io/rt7j9/

2. KEY FINDINGS FROM PARTS 1 AND 2

In this section, we summarise key findings from the Stage 1 ('in hotel') and Stage 2 ('after hotel departure') interviews in order to provide contextual information to facilitate interpretation of the Stage 3 ('nine months after leaving the hotel') findings.

Participant characteristics

At Stage 1, the 35 study participants were aged between 21 and 75 years old, most identified as male, and most were born outside the UK. They included asylum seekers, refugees and people with no legal immigration status. 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. Overall, they described rough sleeping and staying in hostel accommodation as negative and, for some, a fearful experience. Most arrived at the hotel during the spring and summer of 2020 feeling frightened and/or with low expectations about the Everyone In initiative.

Living in the hotel

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

Moving to next step accommodation

By their Stage 2 interviews, participants (n=28) had been moved to a wide range of temporary housing. Many described the moving out process as negative, with some stating that it was traumatic and distressing as they were not given time to prepare or pack. Whilst some felt they had been supported during the moving process, others did not. Indeed, many said that communication had been poor and a few complained that staff in move-on accommodation were unhelpful or rude. Participants did not typically report having been involved in any move-on planning and they often stated that their new accommodation was of a lower standard than the hotel where we had first interviewed them. In this regard, many complained that move-on accommodation was dirty, noisy, lacking in basic amenities, too small, unsafe, or without privacy. They also expressed concerns about what would happen to

them next. Participants who were happier at Stage 2 tended to be those who had moved into accommodation that was self-contained and had cooking facilities. Within a month of leaving the hotel, one participant had returned to rough sleeping (in a tent) and only one had obtained permanent (i.e., not temporary) accommodation.

COVID-19

During their Stage 1 interviews, participants often reported that they were anxious about COVID-19, even though only a few had tested positive. Participants articulated a good understanding of how to protect themselves from the virus and were proactive in social distancing, hand washing, and wearing face coverings. When asked, many said that it was easier to maintain social distance in the hotel compared to within hostels and on the streets.

At Stage 2, some participants were worried about COVID-19, but others were not. Those who were anxious often referred to their age/being older and having underlying health problems, as well as concerns relating to their move-on accommodation (such as living with or near people who were not taking precautions against COVID-19). In addition, some participants were worried about a further wave of the virus, the dangers posed by the virus to others, and harms to the economy. Additionally, several were confused by the changing lockdown rules.

Health

At Stage 1, participants reported a wide range of physical health problems which were often being treated before they had moved into the hotel. They also routinely described mental health problems but did not seem to be well-connected to mental health services prior to the pandemic. Despite having access to medical treatment within the hotel, many participants said that they had untreated mental and physical health problems.

At Stage 2, participants continued to report a wide range of health problems and often complained that their physical and/or mental health was deteriorating. Many participants attributed poor physical health to their poor diet and/or poor food in move-on accommodation; although some 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, there was still evidence of unmet physical health needs exacerbated by delays in securing appointments and treatment. As in their Stage 1 interviews, access to mental health care remained comparatively limited even though some participants were beginning to contact specialist services.

Substance use

At Stage 1, most participants said that they did not require support services for alcohol and other drug use[5] and those who were receiving treatment did not identify any difficulties relating to lockdown changes and social distancing within services. Many participants smoked tobacco and some notable changes in tobacco smoking behaviours within the hotel were reported, with some participants smoking more and others smoking less. The distribution of free tobacco harm reduction products (particularly e-cigarettes) appeared to reduce some tobacco consumption.

At Stage 2, many participants continued to report that they did not use alcohol or other drugs problematically and so did not need support. Those who were receiving opioid pharmacotherapy sometimes referred to administrative challenges when trying to transfer their treatment to different substance use service providers, especially those located outside the London area. However, none said that they were currently using street-opiates. Smoking patterns remained changeable with limited interest in smoking support and smoking cessation. Participants were, nonetheless, generally positive about having options for tobacco harm reduction, although the cost of e-cigarettes and refills impeded their use.

Relationships

Despite having relatively limited relationships whilst rough sleeping, many participants managed to sustain these during their stay in the hotel by using mobile phones (often given to them by the hotel staff). There were few reports of conflict or disputes between residents in the hotel, although many participants acknowledged that they stayed in their rooms and 'kept themselves to themselves' to avoid both 'trouble' and COVID-19. Those involved in long-standing visa/permit applications reported reduced contact with their previous informal social networks (usually compatriots in locations throughout London).

Participants' relationships with staff and other residents from their original hotel did not tend to endure after they were moved on to next step accommodation. Occasionally participants felt let down by hotel staff who did not contact them as promised or failed to respond to their messages. At Stage 2, some participants were isolated and lonely, some maintained pre-existing relationships via phone calls and social media, and some met family, friends or professionals in person when they could. The level of contact was, however, variable and influenced by geographical proximity, access to mobile devices, the pre-existing nature of relationships, and COVID-19 restrictions.

Use of technology

[5] 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.

Most participants at Stage 1 reported good IT literacy and were willing to help other residents who were less familiar with mobile technology. Participants were, however, reliant on both the mobile phones given to them by the hotel staff and the free hotel WiFi. Mobile phones (especially smartphones, some of which were issued by the hotel) were used for phone calls, texts, video calls, accessing social media, and keeping occupied within the hotel rooms[6].

At Stage 2, participants were using mobile phones to stay in touch with family, friends, and services; to access information; as a source of entertainment; and as a practical tool for completing personal tasks, including job searching. Although many participants were still dependent on the mobile phone given to them in the first hotel, staying connected to a network via a data package or WiFi 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.

Views on the future

At Stage 1, many participants were keen to leave the hotel, even though a few were anxious about the prospect of moving on. Overall, participants' accommodation expectations were relatively modest. In addition to support with finding accommodation, they often expressed needs for help with money, employment, legal matters, and health problems.

At Stage 2, participants again articulated their desire for safe, stable, secure and self-contained accommodation. They also frequently said that they wanted a job to make money, keep busy, and support themselves; settled immigration status; better health and health care (including a better diet); a more productive life; some relatively basic material possessions; and improved relationships with others (especially family members). Overall, there seemed to be nothing exceptional about their goals which appeared to be modest and community oriented.

[6] Not all participants had been offered a free mobile phone or smartphone with free credit.

3. METHODOLOGICAL DETAIL SPECIFIC TO STAGE 3

All Stage 3 interviews were designed to take place nine months after each participant had left the hotel where we had first interviewed them. As some participants had moved into next step accommodation between July 2020 and September 2020 and others had remained in the hotel until it closed at the end of September 2020, the Stage 3 interviews took place between April 2021 and July 2021. As such, Stage 3 interviews were completed after the rollout of the national vaccine campaign (that commenced in December 2020) and before so-called 'Freedom Day' (19th July 2021), when almost all legal requirements relating to COVID-19 social distancing and isolation were removed as part of the 're-opening' of society. In other words, the Stage 3 interviews occurred during a period when COVID-19 restrictions in England were easing but were not yet over.

One researcher was responsible for re-contacting and re-interviewing all participants. Of the 28 people involved in Stage 2, thirteen were re-interviewed. Twelve could not be contacted and three said that they no longer wished to participate in the study. Twelve interviews were conducted by telephone and one interview was conducted by email at the request of the participant. This participant, who had returned to rough sleeping, reported that telephone contact was problematic and so preferred the researcher to email questions to which responses were provided using a public access computer within a community library. The interviews covered similar topics to the Stages 1 and 2 interviews, with the intention being to build a picture of the participants' lives and experiences over the nine-month period since leaving the hotel.

Participants

The thirteen participants who completed Stage 3 interviews included eleven men and two women (age range 29-76 years). Six were born in the UK (and identified as 'British') and seven had been born in other parts of the world. Ten identified as Black or as having another minority ethnic background (including mixed heritage). Three participants identified as White British. Five who did not identify as British were involved in complex immigration issues, in which their right to reside and access public funds while in the UK were under review by the Home Office.

Eleven of the thirteen participants were single and two were married but separated. Seven had children, but none had regular contact. Six had tertiary level qualifications (including master's and doctorate qualifications), three had vocational qualifications, two had secondary school certificates, and two had no formal qualifications. Those who did not identify as British typically said that they had obtained their educational/vocational achievements in their country of birth/origin.

PART 3 FINDINGS

4. ACCOMMODATION

Accommodation over the last nine months

Participants had been moved to a range of accommodation since leaving the hotel where we had first interviewed them. This accommodation included other hotels still operating within the Everyone In initiative but operated by a wider range of providers; shared flats; independent flats; accessible apartments; hostels; and houses of multiple occupancy (HMOs). At the time of their Stage 3 interview, six of the thirteen participants had been formally 'moved on' once and seven had been 'moved on' more than once. Only one stated that their current tenancy was confirmed beyond 2021. Most of the accommodation described by participants in Stage 3 was geographically dispersed around the Central and Greater London areas, although some had been moved on to neighbouring counties or to other regions within the UK.

'Moved on once' (n=6)

After the closure of the hotel where they had first been interviewed, three participants had been moved to another 'Everyone In' hotel where they remained at Stage 3. All three had long-term health conditions and all three had problems relating to their right to remain in the UK (and were involved in complex negotiations to have permits and visas reviewed and/or updated). At Stage 3, two of these three participants were still in the same room they had been allocated nine months previously. The third had been moved to a second, more accessible, room within the same hotel because of their worsening mobility.

In addition, two participants continued to live in the temporary move-on accommodation that they had been allocated nine months earlier. Both lived in self-contained, single person flats, received welfare benefits, and reported feeling comfortable and positive. Despite this, they also described a lack of basic amenities and concerns about how long they could stay before having to move again. Lastly, one participant had been moved on to another Everyone In hotel but had chosen to leave the UK during October 2020. This participant had been sleeping rough in a makeshift tent in woodland next to a motorway in a major European city since leaving the UK. However, this person stated that the decision to return to rough sleeping had been entirely their own 'choice'.

'Moved-on more than once' (n=7)

Over half of the thirteen participants (n=7) reported that they had been moved on more than once since leaving the hotel where we had originally interviewed them. Five had been moved twice and two had been moved multiple times. Of the five participants who had been moved

twice, two said that they had known in advance that they would need to move a second time because they were waiting for the completion of renovations and repairs on longer-term accommodation. In contrast, three described their second move as being unplanned and unexpected. Two had been moved a second time after complaining about the poor standard of their first move-on accommodation whilst a third had been moved twice between Everyone In hotels because of mental health problems and immigration-related issues (this participant was in their third Everyone In hotel at Stage 3).

Both participants who had experienced three or more moves in the last nine months stated that they had major mental health problems (one reported post-traumatic stress disorder and one reported being recently diagnosed with borderline personality disorder). Both believed that their mental health problems had contributed to their repeated moves, noting that they had been unable to settle because of co-residents in shared accommodation. One of these participants had eventually been moved to a self-contained accessible flat and been provided with a mobility vehicle. However, they had not been able to use this yet as the local authority concerned had still not assisted with the required documentation (a mobility badge and parking permit) for road use/parking. The second participant had moved between several flats and shared properties which they said were poor standard, unhygienic and uninhabitable because of rodents. This participant described multiple disputes with landlords and local authorities, which were ongoing at their Stage 3 interview.

Opinions about move-on accommodation

All participants expressed a degree of concern and anxiety about their accommodation circumstances over the previous nine months. Some, especially those with visa/residency issues, said that they did not know how long they would be staying (or allowed to stay) in their current accommodation. Others were uncertain about how long their rent would be paid and what would happen to them if/when their current temporary tenancy or lease expired. One person was concerned that they might have to return to rough sleeping if their current living arrangements (including UK residency) were not soon approved by the Home Office.

Several participants described on-going difficulties associated with their current living environments. These included disputes and conflict with other residents or flatmates in shared accommodation, poorly furnished properties, and accommodation that was cold, damp, or ‘infested’ with rodents. One participant who had recently received a diagnosis of borderline personality disorder was currently living in an HMO and described frequent episodes of self-harm (cutting their arms with a blade to deliberately ‘feel pain’). This participant said that their self-harm was a way of ‘controlling suicidal thoughts’ exacerbated by sharing accommodation with noisy, aggressive, and argumentative co-residents. Meanwhile, the participant reporting post-traumatic stress disorder described how they had recently attempted suicide (by taking ‘pills’) after being physically abused by a co-resident

whilst living in a building with rodents, where people exhibited anti-social behaviour and where another resident had committed suicide. This participant said that their own suicide attempt had been discovered by people conducting routine room checks and, after a night spent in hospital for observation, they had been relocated to different accommodation.

The four participants who were still living in Everyone In hotels expressed dissatisfaction with their accommodation, stating that they felt confined in their rooms, had little or no social contact, and were experiencing declining health. They also said that some of the staff managing their current hotels were less supportive and less professional than the staff who had managed the hotel where we had first interviewed them. As in Stages 1 and 2, all four participants stated that the quality of the food in the hotels was poor and unsuitable for dietary needs and/or cultural preferences. For example, one participant mainly ate sandwiches whilst trying to manage type 2 diabetes; a second was given a weekly allowance to buy food from specific shops which hotel staff then heated in a microwave; a third routinely made 2-hour bus journeys to obtain food that they preferred from friends; and the fourth reluctantly accepted the situation as something that could not be changed.

Of the thirteen study participants, three were generally positive about, and content with, their current accommodation. However, these individuals still had concerns about being able to pay their rent and not knowing when their tenancies would end. Another participant, who had been living in a poorly furnished flat for nine months, said they were willing to endure current discomfort as they were expecting the local authority to rehouse them in premises on a more permanent basis at some point in the future. Meanwhile, participants who were living in self-contained accommodation or shared accommodation with cooking facilities tended to be less worried about their diet and nutrition than those still living in a hotel.

Summary:
Participants had been moved to a range of accommodation types over the last nine months, and only one had a tenancy beyond 2021. Four (who all had long-term health conditions and problems relating to their immigration status) were still living in an Everyone In hotel and a fifth had voluntarily left a hotel to return to rough sleeping. Just over half (n=7) had been moved more than once, with two participants experiencing three or more moves. All participants had been concerned and anxious about their accommodation over the last nine months and several described difficult living circumstances involving disputes with other residents, poorly furnished properties, and accommodation that was cold, damp, noisy or had problems with rodents. One participant linked their self-harming and another linked a suicide attempt to their housing difficulties. Those still living in an Everyone In hotel described social isolation, declining health, conflict with other residents, little support from staff, and concerns about their diet. In contrast, only a few participants reported feeling comfortable in their current move-on accommodation, and even these had concerns about future rent payments and the uncertain length of tenancy/leases.

5. COVID-19 & VACCINE UPTAKE

At Stage 3, four of the thirteen participants believed that they had had COVID-19 at some point during the pandemic. Of these, three stated that they had made full recoveries following minor symptoms. However, one reported being hospitalised for three weeks during January 2021. At the time of their interview five months later, this person reported on-going extreme fatigue, lethargy, and shortness of breath which, when asked, they believed to be 'long-covid'.

Regardless of their accommodation circumstances at Stage 3, almost all thirteen participants expressed concerns about COVID-19. Several participants were worried about the on-going 'threat' of COVID-19, the potential for 'a third wave'[7], and the uncertainty of multiple COVID-19 variants (especially the Delta variant). Participants located around central London were additionally concerned by the 'large crowds of people' they frequently observed in the streets and on public transport.

Almost all participants stated that they continued to follow the hygiene and protection/safety measures that they had adopted throughout the previous year. These included hand cleansing (in accommodation and when outdoors, using soap and water, and hand gels); wearing face coverings when outside; and attempting to minimise social contact with others. In addition, many living in London chose to avoid crowds; preferring to stay alone or to socialise only with people in their immediate social networks or in their shared/communal accommodation.

Despite this generally high level of concern and caution, two participants expressed doubts that the virus existed. One participant noted that '(we) tend to hear more about (COVID-19) than actually see it'. Another thought that the virus was a hoax, and that COVID-19 was being introduced into the population by the vaccine programme.

COVID-19 vaccine uptake

Six of the thirteen participants had been fully vaccinated with two doses of the Astra Zeneca or the Pfizer vaccine, and another had been fully vaccinated with a single dose of the Johnson & Johnson vaccine. Those who were fully vaccinated reported that they had had no hesitancy in accepting the invitation and confirmed that they were happy to have been vaccinated, stating that it was necessary to 'save lives' and to 'survive'. Whilst some reported experiencing some side effects, they had all made full recoveries.

[7] One participant used this term at a time when a 'third wave' had not been formally identified or announced by Public Health England.

In addition, three participants had received a first dose and said that they were looking forward to their second. Of these, one participant stated that they had accepted the vaccine mainly to overcome any future difficulties associated with not owning any (actual or hypothetical) 'vaccine passport'. This was because the participant wanted to bring a relative to the UK and hoped that being vaccinated would facilitate future international travel. None of these three partially vaccinated participants reported any side effects.

Four participants were, however, unwilling to be vaccinated (i.e., had been offered the vaccine but refused), of whom three were adamant that nothing would change their minds about this decision. The four unvaccinated participants included one of the two participants who expressed doubts that the virus existed (the other had been vaccinated). All four unvaccinated participants identified concerns about the long-term effects of the vaccine, including the unknown impact on fertility, 'growth of an extra limb', 'blindness', and potential death. These participants stated that they preferred to wait and observe any negative health outcomes of the vaccine programme in the wider population.

Summary

By Stage 3, nearly a third of the participants believed that they had had COVID-19. Almost all expressed concern about the virus and almost all continued to follow the hygiene and protection/safety measures that they had adopted throughout the previous year. These included hand cleansing, wearing face coverings when outside, and attempting to minimise social contact with others. In addition, many chose to avoid crowds, preferring to stay alone or to socialise only with people in their immediate social networks or shared/communal accommodation. Nine participants had been fully or partially vaccinated against COVID-19, but four expressed concerns about the long-term negative health effects of the various vaccines and said that they did not want to be vaccinated currently. In addition, two expressed doubts that the virus existed (although one of these two had been vaccinated).

6. HEALTH

Physical health

As most of the 35 participants recruited into Stage 1 of the study had initially been accommodated in a COVID Protect hotel, many had multiple physical health problems (as already described in the first report). At Stage 3, twelve of the thirteen participants reported continued or new health problems. These included: type 2 diabetes, mobility issues, high blood pressure, hepatitis, glaucoma, spinal cord injury, nerve damage, disturbed sleep patterns, muscular pains, and a range of difficulties associated with teeth, vision, hearing, skin, and internal organs (heart, kidney, liver and lungs).

A few participants also reported concerns about weight gain or weight loss. For example, one person was worried about their recent weight gain which they attributed to their pre-existing type 2 diabetes; whereas another said that they had lost so much weight that some of their clothes no longer fitted (the participant attributed this weight loss to the poor standard and quality of food in their current Everyone In hotel). As documented earlier, one participant also reported long-term effects of COVID-19. After being hospitalised for three weeks in January 2021, this participant described on-going difficulty walking and breathing combined with lack of energy and extreme fatigue. These problems made it more difficult for the participant spend time outdoors and so they had taken to walking the corridors of the hotel where they were currently living for exercise to assist their recovery.

Support for physical health

All participants reporting physical health problems said that they were accessing treatment via a GP or hospital. Sometimes this was by telephone and sometimes via face-to-face appointments. Several participants also said that they were now on waiting lists for MRI scans or routine surgery and one reported on-going treatment for hepatitis that involved regular hospital visits. Participants who had been rehoused in the community reported no difficulties attending GP or hospital appointments when needed and had no difficulties collecting medications dispensed from their allocated/nominated community pharmacies. Participants still living in Everyone In hotels similarly identified no problems with prescriptions, which were generally supplied monthly and could be stored in the fridge within their hotel room.

Alongside professional support, several participants described taking proactive steps to manage their own physical health. For example, two participants said that they now attended gyms to help manage diabetes or to improve their overall mobility, whilst two others explained how they used the environment within or around their accommodation, such as stairwells, for exercising to maintain their strength and stamina.

Mental health

Consistent with previous stages of this study, many participants (n=9) reported a range of mental health issues, often associated with stress, depression, and anxiety. One person thought that their 'changeable mood' was caused by daily cannabis use, but all others attributed their poor mental health, partially or wholly, to social and environmental factors, such as their current living situation, lack of finances, uncertain immigration status, loneliness and isolation, and boredom (occasioned by COVID-19 and social distancing regulations). One participant, who had received a recent diagnosis of borderline personality disorder, reported that they had recently started self-harming (arm cutting) as a mechanism for 'stopping suicidal thoughts'. Meanwhile, another, who reported post-traumatic stress disorder, said that they had recently attempted suicide and spent a night in hospital.

Support for mental health

Of the nine participants who reported some form of mental health problem, five said that they were receiving formal support (this included both participants who reported suicidality or self-harming). These five participants described regular contact with community-based services and access to support workers and/or clinical case workers, with one having open access to a psychiatric outpatient department. The four participants who reported mental health conditions with no support (or medication) reported more generalised mental health problems (such as stress, depression and anxiety) and stated that they did not need any intervention for this at the time of interview. These participants said that their poor mental health was not an immediate priority for them, was something that they believed they could self-manage, or, in one case, was likely to have been caused by frequent cannabis use.

Summary:
Participants in Stage 3 reported a wide range of existing and new physical health problems, with many stating that their overall health was deteriorating. Several attributed their poor physical health to their current diet and food in their move-on hotels. Most reported having contact with health care providers and being in receipt of support, with some also taking action to manage their own physical health.

Chronic and acute mental health problems also continued at Stage 3. Those experiencing the most severe forms of mental ill-health now appeared to have regular access to mental health care and were in contact with specialist services. Others experiencing more generalised mental health problems did not always feel that accessing formal support was a priority for them and did not believe that they needed formal support.

7. SUBSTANCE USE

Alcohol and other drug (AOD) use

As in earlier stages of the study, most participants at Stage 3 reported that they did not use alcohol or other drugs (problematically or recreationally) and so did not need support with these issues. One participant stated that their cannabis use (which they attributed to boredom, isolation, and mental health issues) had increased and become problematic between January 2021 and May 2021. However, this participant explained that they had now stopped all cannabis use and were, instead, smoking a few hand-rolled cigarettes each day (which they described as an 'after effect of smoking so much cannabis').

Two participants continued to receive opioid pharmacotherapy (for heroin use), and both reported that their prescriptions had been successfully transferred, by Stage 3, to a new provider and their preferred pharmacy. At Stage 2, one of these participants had wanted to reduce from a daily dose of 60mg methadone to 'about 30mg' and then switch to buprenorphine. However, at Stage 3, this participant was still on 60mg methadone and expressed disappointment at the lack of change, which they attributed to reduced treatment options in the more provincial area to which they had chosen to move. The second participant continued to receive the same daily dose of 12mg oral buprenorphine that had been received throughout the study and expressed no complaints about their prescription or treatment programme. Whilst this participant had occasionally used heroin in addition to buprenorphine during the previous nine months, this had stopped by Stage 3 because the participant stated that the heroin had had no effect and the prescribed buprenorphine was preventing opioid withdrawal symptoms.

Only one participant described alcohol as being an issue for them at Stage 3. Others either did not drink at all or only drank socially. The one participant who reported a problem stated that his drinking was 'no more and no less' than during earlier stages of the pandemic. However, he had been buying alcohol from a local supermarket and drinking alone at home. This participant was now receiving support for his drinking via online meetings with a caseworker (using Zoom) and said that he was now 'declaring all-out war on the bottle'.

Smoking

At Stage 3, most participants reported that they did not currently smoke, had stopped smoking some time ago, or had never smoked. One person who formerly smoked cigarettes explained that they had only recently stopped smoking (during the three weeks prior to their Stage 3 interview) by participating in a smoking cessation programme run by a local community organisation.

Only four participants reported current smoking, and none regarded this as being problematic or requiring support. One described daily use of a few hand-rolled cigarettes (as a consequence of increased cannabis use during lockdown - see above); one said that they had been smoking more because of lockdown and the pandemic; another stated that they only had 'a puff on a half of a cigarette' occasionally; and the fourth did not report their smoking frequency or amount.

Summary

At Stage 3, most participants continued to report that they did not use alcohol or other drugs problematically and did not require any support or assistance with substances. Both participants who were in receipt of opioid pharmacotherapy seemed stable and said that they were not using street-opiates in addition to their prescribed medicine (although one would have preferred to switch from methadone to buprenorphine). Only four participants reported that they currently smoked tobacco cigarettes, and none appeared to want support with their smoking behaviour.

8. RELATIONSHIPS

On-going contact with the hotel staff

At Stage 3, almost all participants reported no on-going contact with staff from the hotel where they had initially been interviewed[8]. For many, this did not seem to be a concern as they were living in new accommodation and were in regular contact with other keyworkers, caseworkers, and primary/secondary care practitioners. Despite this, one person stated that they had sent a 'thank you' card to staff at the hotel where we had first interviewed them for providing support during their stay whilst another said that they were sorry they had not contacted the hotel staff to thank them for the changes those staff had made to their life.

Two participants expressed disappointment at the lack of ongoing contact with hotel staff from their Stage 1 interviews. These individuals felt that they had been passed on to other agencies/organisations and had been left to fend for themselves without support. One of these participants stated that 'their case' had been handed to another agency, but no assistance had been received as the participant was no longer homeless or rough sleeping and so no longer met the inclusion criteria for support. The other had attempted to contact staff from their Stage 1 hotel for support but had not received a reply.

Participants who continued to live in Everyone In hotels at the time of their Stage 3 interview reported having minimal contact with the staff managing those hotels. Any contact typically occurred whilst food was being handed out and all forms of communication were described as minimal. One participant said that hotel staff at the time of their Stage 3 interview were less helpful than those at the time of their Stage 1 interviews.

On-going contact with other hotel residents

Only three participants reported any form of current communication with other residents from their first hotel. This comprised telephone calls and exchanging text messages (as part of 'checking up on each other'). One person stated they had also previously met other residents in Central London to socialise and to see each other once more. The other ten participants chose not to have any ongoing contact with former co-residents of the first hotel.

Participants still living in Everyone In accommodation at Stage 3 generally stated that they avoided social contact with other people in their current hotel and in the local area. The reasons they gave for this were to avoid people considered anti-social; to adhere to national

[8] It is important to note that there was no formal expectation that hotel staff should maintain contact with residents after they had been moved to alternative accommodation.

social distancing rules; to follow hotel 'house rules' regarding no socialising in other people's rooms; poor personal health; and preferring to be alone.

Contact with family and friends

During their Stage 3 interviews, just over half the participants (n = 7) reported that they had little to no contact with either friends or family. For these individuals, social contact (whether physical or electronic/virtual) was almost non-existent, with participants spending most of their time alone. This was particularly the case for participants involved in visa/immigration issues with the Home Office, who reminded the interviewer that their friends and family were in other countries, often with limited access to technology. Despite this, one participant who was still housed in a hotel said that the easing of lockdown had enabled him to travel across London to visit pre-pandemic friends and to obtain food that was more appropriate for his dietary needs.

In contrast, three participants (all born overseas) stated that they were in frequent electronic contact with family members. This involved online conversations using Facebook, WhatsApp, Zoom and Skype. Additionally, three participants (all identifying as British) said that they had been able to re-establish physical contact with family because they had been rehoused closer to relatives and/or communities where they had long-standing connections. As a result, one was now able to meet with parents several times a week, another was able to make regular visits to a 'massive family' dispersed across London, and another described being able to 'surround myself with positive and supportive people'.

Summary

Participants' relationships with staff and other residents from the hotel where we had first interviewed them did not typically endure after they had been moved on. Although two participants felt let down by hotel staff in this regard, the majority seemed relatively unconcerned given they were now receiving support from other sources. Those still resident in Everyone In hotels at Stage 3 did not report engaging with, or receiving support from, staff working in their current hotel.

Only a few participants had stayed in contact with residents from their first hotel and those still living in an Everyone In hotel typically kept themselves to themselves. Just over half of all participants at Stage 3 reported that they had little or no contact with family or friends. A small number of participants who had been born overseas stayed in touch with relatives via social media and video-calling. Additionally, three British participants reported that they had been able to re-establish and benefit from regular physical contact with friends and relations after being rehoused in communities where they had previous connections.

9. USE OF TECHNOLOGY

Mobile phone ownership

Of the 25 participants eligible for Stage 3 interviews, nine (over a third) had phone numbers that were no longer in service when the researcher tried to contact them. It is not, however, possible to say whether these nine individuals had current access to other mobile devices or were now without a phone. The remaining fifteen participants (when including the three participants who opted out of the study at this point) were in possession of a mobile phone, which they used to answer the researcher's call.

Twelve of the thirteen Stage 3 participants said that they were currently using their own phone and not a mobile phone issued to them during their stay at the hotel where we had first interviewed them (only one person continued to use a hotel issued phone, although three reminded the researcher that they had never been offered any phone in their first hotel). Some said that their hotel issued mobile device was no longer working (although a few had kept the device), and two had transferred the SIM card to a different mobile phone. The types of phones owned by the thirteen participants included smartphones but also 'old' phones that offered limited functionality, such as calls, texts, and basic Internet access.

Mobile phone use

As in previous stages of the study, the nature and frequency of phone use by the thirteen Stage 3 participants varied greatly. Generally, phones were used for staying in touch with family and friends (by voice calls, video calls, text messages, WhatsApp, Facebook and email); keeping in contact with services (e.g., housing organisations, GPs, hospitals, drug treatment services, or benefit agencies); entertainment (watching television and films or listening to music); online shopping; and jobhunting/employment applications. One participant had also used their device to plan a reunion of compatriots based in Sheffield, Newcastle, Glasgow and London, which was to be held when COVID-19 restrictions were eased. As in other stages of the study, factors that inhibited phone use (and to some extent phone ownership) were having no credit, having no or poor access to WiFi (e.g., weak signal or slow download speed), and not being able to charge device batteries (particularly when rough sleeping).

Other devices

Whilst a few participants said that they owned other devices, such as an iPad, smart TV or laptop computer, these devices had often been given to the participant by a friend, relative or charity. One participant also visited community libraries to access a computer and use the Internet free of charge (whilst also owning an older model of a mobile telephone).

Accessing data

Participants' ability to pay for credit and top up their mobile data varied greatly. Some relied only on incoming calls/texts and others depended on the WiFi within their accommodation. One participant who was still living in an Everyone In hotel relied upon the hotel's WiFi for running his small online business but criticised the bandwidth (speed) as being 'too slow' (and the lack of peripheral devices such as printers) for his needs. Another participant regularly switched mobile service providers to take advantage of special online offers and to find the best data/call bundles available.

Summary:
Mobile phones issued to participants in the first hotel now appeared to be out of service. Indeed, only one participant continued to use the mobile phone given to them in the first hotel, although two others had transferred their SIM card to another mobile device. Twelve of the thirteen people interviewed stated that they were now using a personal mobile phone: typically, a smartphone or older phone with basic functionality.

Participants' use of mobile phones and other devices varied, but most involved in Stage 3 relied on mobile technology to maintain contact with family, friends, and compatriots (in the UK and overseas) as well as with services and organisations. Mobile devices were also used as a source of entertainment and for work/employment reasons. Factors inhibiting the use of mobile phones and other devices included poor access to, and cost of, data; no or poor WiFi access; and difficulties charging devices.

10. VIEWS ON THE FUTURE

When participants were asked what they needed or wanted for the future, most spoke of issues relating to improved mental and physical health, moving to better accommodation, securing employment and (where relevant) establishing a right to reside in the UK. Often, these issues were interlinked. For example, participants involved in the immigration system routinely said they wanted paid employment, which would in turn lead to financial independence, housing security, and better mental and physical health. Despite this, they generally felt pessimistic about the future given lengthy immigration system procedures and uncertainty about the outcome and consequences of not being granted 'right to remain'.

In terms of employment, most participants wanted to work on a self-employed basis, although some hoped for a 'regular job' in order to be financially independent. Securing paid work was, however, again dependent on immigration, housing, and health status. Participants currently living in HMOs generally expressed a desire to move to accommodation that would provide them with greater privacy, security, independence, and, ultimately, better mental health. Meanwhile, the four participants who were still living in an Everyone In hotel said that they wanted a better diet after leaving the hotel as they believed this would improve their health. Participants who reported long-term physical and mental health conditions aspired to increased mobility, better health, and greater independence.

One participant who had recently found full-time employment (via an employment agency) was hopeful of eventually 'finding a partner, getting married and having children'. A few others, including three participants now living in self-contained flats, said that they were generally optimistic and positive (despite having a wide range of physical and mental health problems), as their new move-on accommodation had enabled them to begin to live more socially and financially independent lives.

Summary:
When thinking about the future, participants talked mainly about their hopes and goals for improved mental and physical health, secure accommodation, employment, and (where relevant) a right to reside in the UK. For many, these issues where interlinked. For some, obtaining employment – especially self-employment – was conditional upon their immigration status, securing more independent accommodation, and improving their health. Most expressed a desire to work and make wider contributions to society. Participants who seemed more positive with their current situation tended to be those who were more settled in their move-on accommodation and were now living relatively independently.

11. CONCLUSIONS

Key findings

The aim of Stage 3 was to understand participants' recent experiences and current circumstances nine months after leaving the hotel where we had originally interviewed them. We found that participants had moved around a lot, and only one person had secure accommodation beyond 2021. More than half had been moved on more than once and multiple moves seemed to be associated with having complex mental health problems. Four participants (all with outstanding immigration and complex health issues) were still living in an Everyone In hotel. Current hotel accommodation was often rated poorly in comparison with their previous Everyone In hotel, with participants stating that they were isolated, had little contact with or support from hotel staff, were dissatisfied with the food, and felt that their mental and physical health were deteriorating.

A minority of participants had been moved to self-contained accommodation and/or accommodation closer to families and friends. These individuals seemed the most contented and optimistic as well as the most financially and socially independent. As at Stage 2, we found that access to cooking facilities seemed to be critical in terms of participants feeling able to maintain a good diet and health more generally. Participants' views on their accommodation over the last nine months were, however, overwhelmingly negative and included reports that their housing circumstances had caused, and continued to cause, stress and anxiety as they worried about the standard and permanency of their accommodation, their right to remain, and/or disputes with co-residents in shared properties. These concerns in turn contributed to reported worsening physical and mental health, including episodes of self-harm and suicidality.

The key aim of the Everyone In initiative had been to protect people from COVID-19. As we have reported previously, this was successfully achieved in the first Everyone In hotel and the legacy of that appeared to continue at Stage 3 with participants still being alert to the virus and reporting ongoing frequent handwashing, use of face coverings, and social distancing (although social distancing exacerbated social isolation and loneliness for some). In addition, most had accepted offers of vaccination. Despite this, accounts of having had the virus had increased, with one report of long-term COVID-19 symptoms. By Stage 3, two participants were also expressing doubts that the virus existed and four did not want to be vaccinated. Without further research it is difficult to understand why these participants held anti-vaccination views and what, if anything, might have been done previously or could be done in the future to change their minds.

Overall, participants said that their physical and mental health had declined over the last nine months, which many directly attributed to their housing situation, stress, diet, uncertain immigration status, and social isolation. Nonetheless, participants did now seem to be in contact with appropriate health care providers, which suggests that the Everyone In initiative had been instrumental in connecting them to services. Furthermore, as we also found in earlier stages, some participants were proactive in trying to look after their own health through diet and exercise. Whilst most participants did not use alcohol or other drugs and so said that they did not need support from substance use services, a small number were receiving treatment for alcohol or heroin use. These individuals seemed to be relatively stable in treatment, with some evidence of desire to reduce their prescribed opioid medication further. None of the people who smoked tobacco was, however, interested in addressing their smoking behaviour and we cannot predict how willing they might have been to consider tobacco harm reduction if this had been more proactively recommended or offered to them over the previous nine months.

A small number of British participants reported supportive relationships with family, friends, and case/key workers whom they saw regularly. Others maintained important relationships through mobile phones and online media. Nonetheless, many, particularly those experiencing immigration problems, had limited social interaction with others and a few had almost no social interaction at all; a situation that had often been worsened by the pandemic and social distancing regulations. Current accommodation appeared to be a key factor undermining or enabling personal support networks. For example, those still living in an Everyone In hotel seemed particularly isolated and lonely, whereas those who had been moved to areas near family, friends and community members reported feeling more connected and positive. Although some participants had established meaningful relationships with staff and other residents whilst in the first hotel where we had interviewed them, these relationships did not tend to endure after that hotel closed.

In earlier reports, we described the importance of information and communication technology, including the value of the free phones and WiFi given to participants within the first hotel. Although we cannot comment on the fifteen participants who were not reinterviewed, it is evident that mobile technology remained critically important to the thirteen participants who continued to be involved in our research at Stage 3. Specifically, participants used their phones to stay in touch with friends, family and services but also for other activities such as entertainment, shopping and job hunting. Moreover, mobile phones seemed particularly important given participants' restricted access to computers and other hardware. Use of mobile phones was, however, limited by having no money to buy credit, poor access to or slow WiFi, and not being able to charge mobile devices. This further confirms how important the phones and WiFi provided in the first hotel were and reveals the extent of participants' digital poverty and marginalisation by Stage 3.

Finally, we turn to participants' hopes and expectations for the future. Again, consistent with earlier stages of our study, participants reported relatively modest and realistic wishes and goals. These included better mental and physical health, better accommodation, finding paid work, establishing their right to reside in the UK, eating better food and being more independent (particularly financially independent). Equally, we note how two participants now living in self-contained flats said that they felt more comfortable and secure – even though their accommodation was far from perfect and their accommodation status was still uncertain going forwards. This reminds us that the hopes and goals of people who have experienced rough sleeping are often not too different from those held by wider society. Furthermore, even modest steps towards independent living can make a huge difference to the quality of life overall.

Data Limitations

We repeat that our data are generated from a qualitative study. As such, the findings cannot be generalised to other areas or to 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. Aside from their poor health, we note that most participants at Stage 1 identified as male and most were born outside the UK; and, at Stage 3, most participants again identified as male and only three of 13 identified as White British. Furthermore, the COVID Protect hotel from which we recruited participants 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. In addition, we were only able to re-contact and re-engage thirteen of our 28 Stage 2 participants. We cannot comment on the circumstances of the fifteen participants who were not re-interviewed. Whilst we hope that they were not contactable because their lives had improved, they had obtained new phones, and/or they did not want to speak with us (and be reminded of their time in the hotel), it is equally possible that they may have returned to rough sleeping and were as lost to services as they were to the study.

Conclusion

We recognise the enormity of the task involved in helping people experiencing rough sleeping who often have complex needs and uncertain immigration status, especially during a pandemic when services, staffing levels and budgets are stretched. Nonetheless, our Stage 1 findings provided a glimpse into what can be achieved when people who are homeless are offered warmth, safety, and care. Our Stage 2 findings then showed how rapidly gains can be lost if that supportive environment is removed and we fail to continue to invest. By Stage 3, a more unequal picture seemed to be emerging. After nine months, we saw how a minority

of participants, who were moved on to more self-contained accommodation and/or close to people whom they knew, seemed more content, optimistic and independent. In contrast, others were reporting deteriorating physical and mental health and increasing isolation. Those with uncertain immigration status were living in the most difficult of circumstances and appeared to be faring worst of all. Participants' housing situation, health, immigration status, and relationships were interacting with each other, and the combined effect either improved or (more typically) worsened individual circumstances. Yet again, this seems to show how caring for, and investing in, people can have longer-term benefits whilst denying people good quality housing and support creates further misery, harms people, and will ultimately cost all of society at a future time. As the pandemic continues into the autumn of 2021, it seems that we can still choose to invest, or we can do nothing and all pay later.

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