NFCC
Fire Central
Programme Office

Equality of Access to Services and Actions for the Vulnerable Rehoused Homeless

1. Introduction

1.1 This paper is one of a suite of documents used as part of our Community Integrated Risk Management planning. A number of groups have been identified as potentially being at greater risk of fire or are potentially not accessing services such as Safe and Well visits.

1.2 There are a range of equal access cases presented which require focus and additional resources to evaluate further whether this is the case. In our CRMP public consultations we will outline that we want to work with people in our communities to understand further any issues from their perspectives that mean we need to re-design services or access pathways. We would want to do this in partnership with communities.

1.3 As a public service focused on excellent service to our customers, we need to ensure equality of access to our services for every person in permanent, temporary residence or transit through our counties and metropolitan areas.

1.4 We know through our incident data that certain groups are more likely to have a fire and they include people who are living with Dementia, mobility issues, and mental health issues.

1.5 There are however other groups who aren't necessarily showing as being at higher risk of a fire but they may not be accessing our services such as Safe and Well visits or reporting fires because of other barriers which may be language, perceived prejudice and other societal factors.

1.6 Equality of access means actively seeking to engage these groups who may be unaware or choosing not to access services from us and other public sector providers.

1.7 We need to work to reduce fire risk and other life risk across all the people and that needs different approaches. Within our equality of access approach, we also need to:

- Identify all the communities and customers that make up the FRS area.
- Consider how we improve the provision of FRS services as well as access to employment opportunities with FRS to include all our communities across a range of variables including ethnicity, disability, gender, sexual orientation, religion or belief and age.
- Learn from and enhance good practice identified through equality monitoring.
- Use the results of equality monitoring to mitigate any adverse impact of our services and employment processes on groups within our diverse communities.
- Eliminate any unlawful discrimination identified through equality monitoring.
- Promote good community relations.
- Use appropriate engagement techniques including social marketing to inform and focus on behaviours to help customers adopt safer ways of living.

1.8 Data, academic evidence and case studies inform our people impact assessments. These now need refining by contributions and insights from community-based groups such as specialist charities, faith groups and associations. Fire Services equally need to consider how we look at our service provision. This paper is intended to start the conversation.

2. Why we need to focus on equality of access to services for homeless people returning to regular community living

2.1 From the outset it is important to stress this paper has some urgency and our understanding is limited; the issues described have been exacerbated by Covid-19. The recent extremely high number of homeless returning to housed accommodation is unprecedented.

2.2 Historically the numbers of homeless people rehomed year on year has been small, meaning there is little meaningful data on which to statistically draw from. Equality of access means actively seeking to engage these groups who may be unaware or choosing not to access services from us and other public sector providers.

2.3 Early research into the approach of rehousing by Kings College London indicates a significant proportion of previously homeless people remained vulnerable during the first few years and required long-term support to maintain a tenancy and prevent a return to homelessness.

2.4 Living independently is not easy for people and adaption takes time, indeed many find it hard to cope after several years. The research found a quarter of rehoused homeless researched were after five years struggling to look after their accommodation and manage everyday tasks and were living in dirty or squalid conditions. Many of these had mental health or substance misuse problems and had little or no experience of living alone. A few were hoarding, and parts of their accommodation had become inaccessible. For just over a third (35%) of the participants in the study their accommodation was in serious disrepair: they were experiencing problems with damp and mould, faulty heating or wiring or damage caused by floods and leaks. People in both social housing and the private-rented sector were affected by poor living conditions.

2.5 The recent swell in numbers is not only a cause for concern in terms of support and resources but in terms of fire, reported incidents of suicide, dwelling fire and near misses, enabled us to investigate what appears to be a pattern of risk. A correlated suicide and dwelling fires in Dover are perhaps the starkest reminders of the extreme vulnerability of this group of people at this point in time.

2.6 Professional judgement and intelligence from all supporting sectors and partners passionately reinforce the need for comprehensive intervention and support as part of the delivery of this governmental objective. Those involved need to recognise the complexity of this group; little or no thought to fire safety, social, health and economic challenges and high prevalence of poor mental health, having been disassociated from regular society in some cases for extensive periods of time. There is a unanimous view by partner agencies that if measures are not taken swiftly there

soon will be so much data on lost lives, both through more fires and suicides that would be accountable to no action being taken, or possibly taken too slowly.

2.7 For some Covid-19 as dual diagnosis because of their mental health will not currently be supported by practitioners, due to the pandemic. Therefore, no interventions will be taking place as rough sleepers move to temporary accommodation and then on to permanent. Councils alone are struggling to provide personalised support due to encountering bureaucratic barriers to help. This includes overly onerous requests for proof of homelessness and identity, having to make an application online, and referrals from other public authorities not being accepted until crisis point. Through early intervention it has been identified that working directly with the NHS, and third sector organisations such as Porchlight and Outreach we can more directly identify people requiring access to our services. Furthermore, through community safety visits (safe and well) as a sector we can potentially be a conduit to signposting for mental health issues to other services.

3. Background

3.1 The Rough Sleeping Strategy set out a plan to halve the number of rough sleepers by 2022 and end it by 2027. However, Covid-19 has exposed the extreme vulnerability of this community and highlighted the need to expedite the government's response. This means in many cases planned housing delivery has not yet been met and demand has outstripped the homes available although if presented a "validated" homeless person would be found accommodation.

3.2 It is important to stress that whilst some people's homelessness is associated with addiction in combination with severe mental illness and other support needs, this isn't the bulk of homelessness. For example, there are around 3,000 people living rough in England at the moment (Gov.UK, 2020) but around 93,000 households who local authorities have found 'homeless' (under the terms of the homelessness laws) and provided with temporary accommodation (eg. hotels, bed and breakfast, other forms of temporary housing) and within those 93,000 households there are around 120,000 children (Gov.UK, 2020).

3.3 Most people who are homeless aren't really any more likely to start a fire than the general population. That said, risk stems from standards in some of the lower end of the private rented sector (which is often used to rehouse homeless people) and within some temporary accommodation. Here the issue is that the accommodation isn't up to specification; it might contain bad wiring, lack a working smoke alarm or have other issues that make fire more likely. Furthermore, there's less inspection of properties and accommodation than there was because competing demands and finite resources to Environmental Health services in local authorities.

3.4 The Housing Rights Service reports that chronic entrenched homelessness, serial homelessness and at risk/circumstantial homelessness all share the vulnerabilities ranging from poor life skills and a disconnect from family and community to serious physical and mental health issues. They report the solution in all cases revolves around multi-agency support.

3.5 Likewise, vulnerability and resilience of homeless ex-servicemen shows that mental and physical health difficulties were challenges leading to homelessness in veterans (Armes et al). So,

by default organisations and services can expect that when visiting newly-housed homeless veterans they will need to be able to sign-post for mental health support.

3.6 In both cases the use of alcohol and drugs are a challenge to ending homelessness, so with a government determination to help keep this community housed, if we take just that one vulnerability and apply it to fire safety in the home for example, we can again see that the newly-housed homeless have unprecedented challenges.

3.7 There is a lack of daily living skills in homeless to re-housed persons in that they have often lost basic living skills through living outside of mainstream society; no longer being able to cook safely for example (Pleake, 2019).

3.8 Lastly the very term homeless is given to people because they are held to be 'vulnerable', whether through age, mental illness or 'at risk' due to the likelihood of drug or alcohol use, although this also includes victims of abuse or racial harassment.

3.9 If Government is able to meet its objective, the numbers will be unprecedented. The lack of every day living skills associated with being housed, or safety awareness (whether fire or other), along with an acceptance of such a high level of mental illness alone, necessitates focus and requires interaction between organisations to provide assistance and services to this group of people.

3.10 Pre Covid-19 there was a Ministry of Housing plan with the LGA to eradicate homelessness over a four-year period with a £381 million spend. Covid-19 and the subsequent immediate housing of all discernible homeless people has brought this plan forward in a leap, with an immediate spend intended of £160 million to keep many of the current people housed.

3.11 In 2020, after two incidents mentioned in one town alone, including a serious house fire and suicide in the space of four weeks with re-housed homeless, organisations including KFRS, NHS, Porchlight, Emmaus and Outreach identified particular vulnerabilities in this sector that were not supported with equal access to services that potentially could have prevented both of these incidents.

3.12 The original project discussions centred around all of these organisations working towards a pilot in Dover forming an advisory/work group with the aim of ensuring that newly-housed homeless could access services and advice that could make them immediately less vulnerable, whether safe and well visits for home safety or mental health services. **This approach is infinitely scalable.**

3.13 Additionally, we have newly formed links with the Royal British Legion (RBLI) who are looking to support veterans with resettlement programmes and rehabilitation for PTSD. Again, we are in early discussions but this work falls naturally in this overarching project and RBLI can actually provide additional resource to this work-stream.

3.14 Now that the high vulnerability of these people has been identified, along with mass re-housing of homeless throughout the country, it can be seen as both a necessity to act upon this intelligence promptly, but also provides an opportunity to plan and resource services together in an efficient and effective manner.

4. Fire and other incident risks

4.1 As mentioned there have already been known incidents. The picture nationally needs to be understood. A serious house fire and a suicide in the space of four weeks, both involving re-housed homeless customers is impossible to overlook.

4.2 Figures from the Office for National Statistics show that suicide is the second most common cause of death among people who are homeless in England and Wales.

4.3 Many homeless people live with mental health problems, which may have been the cause of their homelessness or as a result of it and are among the most vulnerable individuals in the community.

4.4 Homeless veterans are also more likely to have alcohol and drug related problems and some have been found to have Post Traumatic Stress Disorder (PTSD). Partnership working with organisations such as the Royal British Legion (perhaps nationally) and other charities working with homeless veterans is essential.

4.5 Mental illness and homelessness create a cycle of functional impairment that results in an inability to achieve and retain the basic skills necessary for living independently putting people at even greater risk of fire.

4.6 The health and wellbeing of people who experience homelessness is poorer than that of the general population. They often experience the most significant health inequalities. The longer a person experiences homelessness, particularly from young adulthood, the more likely their health and wellbeing will be at risk. Co-morbidity among the longer-term homeless population is not uncommon.

4.7 Recent Office for National Statistics reports show that the mean age of death of homeless people is 32 years lower than the general population at 44 years, and even lower for homeless women, at just 42 years.

4.8 Whilst Councils have had significant success considering the demands Covid has placed upon them, a shortage of affordable housing is an inevitable blocker and it cannot be ignored that as a result, assuring the standard of housing provision will be stretched to its limits. The charity Shelter has already raised concerns over the use of private rentals, highlighting “conditions in the private rented sector are often poor, with 35% of the sector currently classed as ‘non-decent’. Poor housing conditions, particularly those that may cause a fire such as poor wiring are obvious concerns to us a sector.

4.9 Using KFRS' rehoused homeless initiative as an example, it has provided basic fire safety advice and signposting to other services to ensure that as Kent's homeless are rehoused, they are able to access services and advice that could instantly make them less vulnerable, whether this is a safe and well visit or signposting those who need it to mental health advice.

5. Employment opportunities

5.1 The homeless will very rarely be in employment and at least while living on the streets will not on the whole be looking for employment (the lack of fixed abode being an obvious barrier). There is potential that with re-housed homeless having access to Services with a fixed address that further opportunities will arise.

5.2 There are groups and charities that support and encourage gaining of employment such as Emmaus. There is some opportunity for the sector to consider how we might assist such charities through our resources. Many services have developed a comprehensive coaching and mentoring programme and perhaps volunteer networks may be able to offer a wide range of life skills to share, as well as hard resources, such as being able to print a CV.

6. Conclusions

6.1 Before 2020 and Covid-19, data and statistics for the homeless were literally that; about the homeless, their vulnerabilities living on the streets, drug issues and their lack of public safety.

6.2 The serious fire and a suicide highlight that even with relatively low numbers of people re-housed, there is a disproportioned potential for life-risk. Thankfully even without data there is a wealth of professional knowledge available from the different services working with the homeless and now the re-housed homeless, who unanimously list off the vulnerabilities of this emerging sector. These include fire safety knowledge, cooking knowledge or safety and the level of mental health within this group.

6.3 There seems an obvious risk that without the intervention and services being offered, we will likely be reporting on more house fires and even suicides in the future, as currently there are no firm plans or a facilitator across our organisations. Without such a facilitator the segmentation of the re-housed homeless will likely remain.

6.4 Services can take this role first and foremost to ensure basic fire safety, cooking safety and home safety can be provided, as we would any other vulnerable group.

6.5 Due to the mass re-housing and current situation the relative luxury of time has been urgently reduced. This does however brings in itself a risk, in that the time frame to be effective in this role is immediate. (Covid-19 restrictions permitting). These should include:

- How we can reliably identify the addresses of the newly-housed homeless for partners to access and offer supporting mechanisms; additionally, how to identify re-housed veterans.

- How we can resource safe and well visits in a timely manner, as a high-risk referral. There is a strong likelihood of high visit numbers being required in this newly identified vulnerable sector.
- How Protection Teams working in partnership with Local Authority Housing Teams can ensure that accommodation used to rehouse the homeless meets regulatory compliance both under the Housing Act 2004 and the Regulatory Reform (Fire Safety) Order 2005, when applicable.
- Consider how the different services can signpost each other effectively, being realistic that most early intervention will likely be from the Fire Sector with a regular need to signpost for mental health support for these customers.

6.6 At the present time the numbers within this group are relatively low. Intersectionality of identity and an understanding of the consideration to associated issues is limited although we know many have a veteran or military background.

7. Activity/Risk Group:	
7.1 Starting rehoused homeless engagement initiative	
Actions:	7.2 The addresses of newly-housed homeless can be sketchy at best. It is incumbent on services to work with organisations such as Porchlight, Emmaus, and outreach to identify these addresses and offer services including Safe and Well visits. Fire services can also act as the conduit to share this information with NHS and relevant Services. 7.3 If there is not a formal process in place for visiting this identified vulnerable group, Services should work with NHS, Porchlight, Emmaus, and Outreach to formalise such a process (discussion on whether the service start the process with a safe and well visit). Additionally, a process should be agreed for sign-posting each other's service to offer mental health support; the Community Safety App under development by Police being an integral part of sharing information. 7.4 We recognise the challenges of the immediate volume of interaction with the number of re-housed homeless. With this in mind services may wish to pilot engagement allowing for test on the level of resource. This is a constructive measure to support this activity. 7.5 Evaluation will be the establishment of a robust process that ensures our ability to reach newly-housed homeless people in a timely and effective way.

8. Activity
8.1 Creating Royal British Legion and Armed Forces Network Champions

Actions	8.2 Work with the Armed Forces Network champions for veterans that are re-housed or homeless to:- • Better understand how to engage with the Armed Forces Community. • Understand how we can support their organisation to help this group. • Work jointly on Homeless and Veterans, if possible, as a resource.

9. Activity	
9.1 Develop guidance for services for conducting rehoused homeless safe and well approach	
Actions:	9.2 NFCC to provide services with some introductory advice to embark on rehoused homeless engagement. This document (appendix 1) is also for consultation.

10. Glossary of Terms

10.1 Statutory Homelessness - A household is considered statutorily homeless if they do not have a legal right to occupy accommodation that is accessible, physically available and which would be reasonable for the household to continue to live in, as well as households who currently have the right to occupy suitable accommodation, but that are threatened with homelessness within 56 days.

10.2 Sources/Bibliography

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Contributors

This document is completed with great thanks to: Porchlight

Guidance to Support Re-Housed Homeless Fire Safety Visits

NFCC
Fire Central
Programme Office

Equality of Access to Services and Actions for the Vulnerable Rehoused Homeless

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11. Introduction

11.1 This information on re-housed homeless visits can be read alongside the Re-housed homeless equality of access paper that gives background to the necessity of personal visits to people in this highly vulnerable group. Provided here is some basic information and guidance to consider on the unique challenges that can be expected on such visits to be able to be effective in reducing fires and improve safety behaviours with re-housed homeless residents.

11.2 Note: **Although Fire Service personnel are included in the input provided**, **all relevant information is either provided for or reviewed by Homeless and rough-sleeper professionals**.

11.3 These professionals themselves are used to an ongoing struggle to explain to other professional services that homeless and re-housed homeless are indeed unique in their large scope of challenges during interaction for effective changes in behaviour. Therefore this information and guidance enables services outside of current homeless professional care services to have peer reviewed information and shared knowledge to allow for a safer, more efficient and effective visit.

12. Why re-housed homeless visits are a priority

- With mass re-housing of previously homeless people this is a new dynamic of people suddenly housed throughout the UK
- Within just a few months it is clearly evident that re-housed homeless people are already showing in rising statistics of burns, house fires, fatalities and suicides and yet they will not automatically show in reported data unless Fire Services become familiar with vulnerability of people within this group and work with homeless sector professionals.
- People within this vulnerable group are almost unique in their lack of socially conditioned life skills (as a simple example: they may not have operated a kettle in 10 years!), so therefore personal risk or risk mitigation around smoking, candles, fire alarms, escaping a fire, etc. many not even be currently considered.
- This is further exasperated by alcohol and drug dependencies and often compromised mental health (usually not yet treated as they have been away from mainstream society).
- There is an obvious limit (again due to numbers suddenly housed) for the homeless care-professionals to be able to refer all the people that require it.

13. Equality of Access

13.1 Hopefully this information demonstrates the need to assure people in this highly vulnerable sector of the community have equal access to Fire Service Services.
Fire Services need to be proactive in making actual visits, as this is not a community where we can afford to wait for referrals that on the whole could never take place due to sheer numbers and limitations for other care professionals.

14. Homeless / re-housed homeless tendencies / behaviour profile

14.1 Rather than a detailed delve into cause and effect of homelessness and behaviours, which are lengthy and complex, the following points are provided in direct relation to a visit:

- 85% of homeless/re-housed homeless have registered mental health problems.
- A large percentage of these (including also within the other 15%) will have dependencies, whether alcohol related or drug related.
- Often people will have lacked mainstream socialisation, isolation and complex human interactions will often have been missing from these people's lives- resulting in anything from shyness and seeming to be ignoring you, to barked replies and even the possibility of complete hostility when spoken to.
- Violent behaviour (due to often diagnosed mental illness) from a minority of re-housed homeless is an occasional possibility, but the homeless care professional is usually well versed on behaviour patterns and how / when to cancel a visit with the resident.
- The usual, or recognised 'life-skills' from living within a home/premises will likely be absent – resulting in a severe lack of deemed safe living behaviours. This paired with alcohol or drug related dependencies OR mental health problems, and often both makes people in this community, particularly vulnerable.
- It would be remiss to not mention that obviously some re-housed homeless are able to communicate really clearly and with humour and good conversation. But realistically these are often the people that will re-introduce to everyday society at some point, so less likely long-term homeless, and more of a minority in this group.

Homeless and re-housed homeless care-professional peer input:

To provide emphasis that this guidance is not solely for the Fire and Rescue Service in view and approach, we collected views and guidance from care professionals that work with this vulnerable sector in their primary role, as summarised below.

This level of detail allows us to not take pre-conceived ideas and opinions based on the vulnerability of communities we already work in but allows for a peer led review on the most efficient and effective way of interacting.

Equality of Access to Services and Actions for the Vulnerable Rehoused Homeless

The following are some care professional quotes and emphasis on some cautionary information. As with many of the fire service personnel, these care professionals are often calling on other experiences, in care homes, working with older or younger people, alcohol or drug dependencies, etc. before describing working with the homeless and re-housed homeless as a comparison.

Aynsley Rastofsk- (Practice Manager, Serveco): *"The one thing we see again and again with well-meaning partner services providing advice to the homeless is their need to give over a certain amount of information from their organisation. This sector of vulnerable people will often take in one or two points effectively at a maximum. My advice is to concentrate on what would provide them the most effective safety advice and concentrate on repeating those points once or twice. The good news is that if this is the method used – those one or two points are often well received and are remembered making for a safer environment and safer customer'.*

Noel beamish- (Outreach Manager): ***"****I value the opportunity to have the Fire Service personnel come to our accommodations and speak with our residents or guests. They have a similarly held level of respect as the Police and other emergency services and importantly are listened to. Fire safety is one of the most important things that these vulnerable residents need to pick up on, for themselves and others that they live with. Messages need to be simple to understand and at a very basic level. Getting residents to interact when presenting information is important. This approach is reasonably effective even amongst those with some mental health diagnosis, mild or fairly severe."*

Jasbir Johnson- (Strategic housing and partnership): "*If you were to work with let's say young offenders, you may be able to generalise somewhat with a pattern of behaviour. For example, maybe hostile behaviour and drug use., and the experiences would likely be similar, or regular with that group. Importantly they would likely demonstrate reasonable safety behaviours for the most part. But one of the unique challenges working with the re-housed homeless as a vulnerable group is that they are not so easily generalised. Behaviours that indicate a likely understanding of any slightly detailed safety advice, in reality will not be understood effectively. This is due to living outside of housed society for so long, with such home safety behaviours not being considered for many years. Therefore, concentrating on simple key messages is very important for successful interaction."*

Robert Archibald- (Kent fire and Rescue Service Education officer): *"Understandably when I talk to other people in the vulnerable people sector, they will strike up comparisons such as 'it must be similar to people with dementia' or 'it must be like where older pensioners in a care-home do not have capacity for the safety information'. I then explain: only if you consider that just when you are thinking that you recognise a particular behaviour, you can (for example) say something that causes a sudden hostile outburst and rather that what you were originally believing was a mental capacity consideration, can actually be a quite severe mental illness instead."*

Penny Heron – (NHS England / homeless working): "*Having worked with the homeless and winter shelters, etc. for several years I have come to understand that even with all the same people week on week, one week it could be peaceful and even friendly, with say the same person shy and reclusive and the usual friendly joker. But another week you could simply be offering a*

cup of tea to the same person and get a sudden 'What are you looking at?' and what could be perceived as threatening behaviour. Or you could witness someone spitting in another person's food (as a more extreme behaviour), or sharps found in the toilet. With time you learn to not take it as anything personal but that it is part of the 85% of people living with mental health problems in this sector. Anyone moving into a closer working relationship, giving safety advice or volunteering in this sector would need to understand that first."

Porchlight care worker – (*anon.*): "*I have worked with different groups of people including people with limited English and limited understanding through either mental capacity or culture, but if there was one thing I'd emphasise whilst working with the homeless and re-housed homeless, it's that you usually have a very short window to get a maximum of one or two messages across clearly. This is not usually down to mental capacity, but to a very common tendency to not want to interact for very long, that has developed from life on the streets and quality human interaction being rare and importantly very often not wanted".*

15. Types of Visit

15.1 County by county, and town by town there is a huge variation of the methods in which the homeless have been housed. Examples include; outreach teams and projects that had existing premises for housing have been filled to capacity. Some county councils have housed homeless people in bed and breakfasts (possibly even the whole of the building, but also with existing renting customers). Other models based on 'Winter Shelters' have re-purposed hotels, and buildings for solely re-housed homeless accommodation.

15.2 However, some towns, either due to lack of this kind of premises or interpretation of Covid rules and stipulations have housed individual homeless people throughout single living accommodation. In short almost every town and city has its own model ranging from multi-occupancy in large numbers to small numbers, and single occupancy with the added challenge of different homeless services and charities working within their own way.

16. Therefore, there are basically 3 types of suggested visit:

16.1 Multi- Occupancy (complete): Where the premises owner (usually along with local homeless charity) can arrange socially distanced 'group-talks' with usually groups of 5-10 people at a time. Sometimes the premises owner will stipulate that the talk is mandatory from a safety perspective to the residents, whilst other times it will be completely their choice to attend. This will likely reflect in attendance numbers!

16.2 Multi-Occupancy (part): Where the premises layout doesn't lend itself to a safe communal area, (often bed and breakfast with a number of re-housed homeless). Although several one-to-one visits may seem preferable, often as a visit is started with one resident, another who may refuse to be seen alone will 'tag along' and listen in and be attentive, even ending up 3 or 4 residents. Therefore, this kind of 'hallway visit' has been included as it will happen whether planned or not and can actually be effective with people you would not otherwise have access to.

Homeless care professionals echo that this is sometimes the way to a successful visit with it being as near community based as some of these people may experience.

16.3 Individual Visits: These will nearly always be undertaken with a homeless care professional. Apart from the fact that 99% of the time the individual will not even be accessible without someone they know well, the behaviours previously described mean that from a safety perspective this is the likely required approach. However, even without the safety considerations, this group of the community have strong distrust issues and usually struggle with interaction with any stranger, so for an effective, meaningful visit they will want someone attending that they know.

17. Considerations for Re-housed Homeless Visiting

17.1 Safety

- Drug paraphernalia – Needles / substances: Could be discarded and out of plain sight (this being a further risk). To mitigate this, it is suggested that protective shoes with puncture proof soles should be worn. There could be consideration of sharps boxes being available to visiting bodies if not for use then for provision to resident to reduce self-harm.

- Joint Visits – in reality re-housed homeless residents will only likely be seen by the Fire Service if already organised by a homeless care professional. Even then attending a visit is by choice for the resident. However, in most cases these workers do succeed in arranging the visit, due to having possibly the only working relationship that exists with them.

17.2 Additionally, the care professional will have the most knowledge of the individual, with their particular behavioural challenges, whether there is a chance of mood-swings, what the interaction level is and the most effective way of communicating with them.

18. Interaction

- Due to previously living on the streets with very little quality human interaction it is common that the resident will not make very much eye contact, and will very often be displaying signs of feeling awkward from the outset with any stranger.

- There will be little to no trust, and as a ‘fire officer’; the usual trusted fire service brand has little value at this point, with most visits being agreed more due to an expected need of compliance ‘to keep the roof over their heads’, than believing the reason for the visit is for their own wellbeing.

- This often results in a difficulty of the visiting care professional being able to discern whether the offered advice is being absorbed. If more vocal, a continued repeating of ‘yes’, and offered compliance can be expected.

‘It's usually as many yes’s as needed to get you back out of the door, so that they can return to their own company’. **NHS health Worker - Penny Smith** Penny also advises *‘Keep any advice to just one or two points to be effective*’. As residents have more interaction with everyday people

over the coming months and even years, building trust there may be the opportunity for a more interactive conversation. Initially though (and especially with safety points from what are in effect strangers), keep it simple, instructive and to the point.'

19. Recommended Safety Advice for re-housed homeless residents

19.1 As previously mentioned, there is a strong likelihood that the information that will be retained by the re-housed homeless resident is going to be limited due to a lack of human interaction and understanding of the most basic of life skills. Therefore, the suggested basic information could be limited to:

19.2 Smoking

- **Smoke in provided smoking areas**
- **Never smoke in bed / fall asleep while smoking**
- **Extinguish cigarettes properly (think of a cigarette as a small fire burning)**

19.3 Fire Alarms

- **If a Fire (smoke) alarm sounds in the building do NOT stay in your room waiting for it to 'hopefully' stop**
- **On hearing a fire alarm you should follow the evacuation plan of the building**

19.4 Escape Plans

- **Be sure of the safest and quickest way to get out of the building if there was a fire**
- **Think and remember a second route out of the building if the first route is impossible to use safely**

20. Summary on effective fire safety input

20.1 Although already in the quotes section the following wording was agreed to have the best content as a summary by the different organisations and services included:

20.2 '*The one thing we see again and again with well-meaning partner services providing advice to the homeless is their need to give over a certain amount of information from their organisation. This sector of vulnerable people will often take in one or two points effectively at a maximum. My advice is to concentrate on what would provide them the most effective safety advice and concentrate on repeating those points once or twice. The good news is that if this is the method used – those one or two points are often well received and are remembered making for a safer environment and safer customer'* **'**