
'You can judge them on how they look...': Homelessness Officers, Medical Evidence and Decision-Making in England

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› **Abstract** *Unusually in the international context, in England the landmark Housing (Homeless Persons) Act 1977 provided a set of justiciable rights to homeless people. Local authorities have a duty to assist homeless people who meet a set of eligibility criteria set out in the Act. One of the criteria, 'vulnerability', often requires consideration of medical evidence. Homelessness officers are the key actors in deciding whether or not an applicant is 'vulnerable'. Previous research has often contended that there is both bias against some high need groups and inconsistency in the decisions made by local authorities in relation to vulnerability under English homelessness law. This paper builds on those critiques by examining decision-making in relation to the use of medical evidence in homelessness cases in England. It explores how homelessness officers assess the 'expert' medical evidence that is put to them, how far they rely on their own intuition and judgement, and the other factors that influence their ultimate decision. The study was able to investigate the intersection between law, administration, and medicine and add to the evidence base in the operation of English homelessness legislation.*

› **Keywords** *Homelessness, UK homelessness law, medical evidence, vulnerability, housing rights, welfare rights.*

Introduction

Significantly, and unusually in the international context (Fitzpatrick and Stephens, 2007), the landmark Housing (Homeless Persons) Act 1977 gave homeless people in Great Britain a set of justiciable 'rights' and imposed duties on local authorities to assist homeless people who met a set of eligibility criteria. The legislation has been commended as providing 'a strong and effective framework for prioritising the housing needs of the most vulnerable' (Loison-Leruste and Quilgars, 2009: 95). Indeed international evidence suggests that it has led in the UK to a housing system that makes it more difficult for social landlords to exclude the most vulnerable households from the social rented sector (Fitzpatrick and Stephens, 2007).

Nonetheless the operation of the legislation has also been subject to much criticism because of the breadth of discretion given to local authority homelessness officers (Lidstone, 1994, Cowan, 1997, Cramer, 2005). Such discretion can lead to both subjective and personal decision-making by officers with ideas of merit and expectations about behaviour becoming part of the decision-making process (Cowan 1997; Cramer 2005). It can also lead to inconsistencies in decision-making between authorities (Loveland, 1995), with some authorities using gate-keeping practices to deny rights to the homeless (Anderson and Morgan, 1997; Homeless Link, 2004; Pawson, 2007).

This paper, using data from an Economic and Social Research Council (ESRC) funded project, builds on those critiques by examining decision-making in relation to the use of medical evidence in homelessness cases. It explores how far homelessness officers assess the 'expert' medical evidence that is put to them, how far they rely on their own intuition and judgement, and the other factors that influence their ultimate decision. In conducting a detailed examination of the use of medical evidence in local authorities' homelessness decision-making processes, the paper seeks to demonstrate the different information that local authorities take into account when assessing whether applicants are vulnerable. In particular we consider where medical evidence is obtained from and how it is weighed up by officers when deciding cases. It considers the extent to which 'vulnerable' applicants are socially constructed by officers and assesses whether the inconsistency and unfairness reported by past research on the interpretation of 'vulnerability' by local authority homelessness officers was present in decisions about vulnerability that were specifically linked to medical evidence.

UK Homelessness Legislation

The 1977 legislation originally applied throughout Great Britain. However, since devolution the systems in Scotland (particularly) and Wales (to a lesser, but increasing extent) have diverged. The focus of this paper is on England and the legislation that is now contained with the Housing Act 1996, Part 7. Within the law, there are five 'obstacles' (Robson, 1981) which homeless people have to overcome to be found eligible for the main homelessness duty. These are to be 'homeless' (see further below), 'eligible' (certain persons from overseas, notably asylum seekers, are ineligible), not 'intentionally homeless' (a deliberate act that would cause someone to lose their home such as rent arrears, anti-social behaviour or giving up reasonable housing), to have a 'local connection' (this could be family, a job or having lived within that local authority area for a specific amount of time) and finally to be in 'priority need' (Fitzpatrick *et al*, 2009).

The focus of this paper is on this last criterion of priority need, but it is worth noting that the definition of what constitutes 'homelessness' in the legislation is very broad by European standards. Alongside people living rough and living in emergency accommodation, the Act also defines people in accommodation in which they could not be 'reasonably expected to live' as being 'homeless'. In practice, this means people in housing they have no legal right to occupy, which is seriously substandard, which is overcrowded or in which there is a risk of gender based (domestic) or other violence are defined as 'homeless'. This is a broader definition of homelessness than that contained, for example, in the European Typology of Homelessness and Housing Exclusion (ETHOS)¹ as the English definition includes households that are defined in ETHOS as in situations of 'housing exclusion' rather than 'homelessness'. Many EU member states also define 'homelessness' in narrower terms than the 1977 English legislation (Baptista *et al*, 2012).

Any homeless household can ask for assistance, in the form of advice and information, from a local authority. The authority must conduct enquiries into the case if they have reason to believe that the applicant is homeless. If, following those enquiries, the authority concludes that an applicant is homeless, eligible, not intentionally homeless and found to be in priority need, he or she is owed the main homelessness duty. If they do not have a local connection to the authority to which the application is made, the duty can be transferred to a local authority in which they do. Since amendments in 1996 and 2002, the main homelessness duty is now, technically, to provide temporary accommodation until settled housing becomes available. In practice, almost all local authorities provide temporary accommodation and then work to provide homeless people found eligible for the main homelessness duty with settled housing. This settled housing has usually been in the

¹ <http://www.feantsa.org/spip.php?article120>

social rented sector, although since amendments to the legislation which came into force in 2012 the private rented sector is likely to play an increasingly significant role (Wilson, 2013).

Applicants who are rejected have a right to seek an internal review of the decision and to appeal to the county court against the review decision on 'a point of law' (Housing Act 1996, ss.202, 204). It is this legal right for individual applicants to challenge decisions, albeit limited, which gives the legislation its justiciable quality.

Local authority decision-making

Despite being characterised as giving rise to legal rights, there is within the legal framework a large space for the exercise of discretion by officers. This has been the focus of a number of studies (Loveland, 1995; Cowan, 1997; Halliday, 2000a, 2000b, 2004; Cowan and Halliday; 2003). In exercising it local authority staff interpreting homelessness law have been portrayed as working in an environment that 'can be characterised as a space where law and alternative normative influences co-exist' (Halliday, 2004, p.87). In addition to legal norms, Halliday suggests a range of other normative systems: financial management, performance audit and political pressure exist as influences in interpreting the law. Each of these may bring pressure for officers to exercise their discretion in a particular way.

In addition, Halliday (2000b) contends that homelessness decision-making appears to be 'professionally intuitive' and that 'bureaucratic knowledge' amongst officers is socially constructed. He explains that case workers learn to understand what a case 'is about'. They gain a professionally intuitive sense of what is the 'real story' behind a homelessness application and this can inform the nature of the casework which follows (Halliday, 2000b, p.465).

Further to this, Cramer (2005) notes that gender influences the way homelessness officers socially construct applicants and view their cases. She concludes (2005, p.749): 'Homeless people themselves were seen as drawing on or fitting in with, particular gender roles and to behave against these roles and rules affected the sympathy housing officers showed to the case'. Several researchers have concluded that it is not uncommon for local authorities to make inconsistent and unlawful decisions, and for these to go unchallenged by applicants (Hunter, 2007).

Priority Need and 'Vulnerability' Decision-making Under Homelessness Legislation in England

The priority need category is important because it differentiates those groups to whom a full housing duty is owed and those for whom only advice and assistance is available. Priority need is a particularly key criterion for 'single' applicants, i.e. those who do not fall within the priority need categories of being pregnant or having dependent children. To qualify for the main duty, a single applicant must be 'vulnerable as a result of old age, mental illness or handicap² or physical disability or other special reason, or with whom such a person resides or might reasonably be expected to reside' (Housing Act 1996, s. 189(1)(c)). The categories of priority need were extended in 2002 by the Homelessness (Priority Need for Accommodation) (England) Order 2002. However, while some of the extended categories require an assessment of vulnerability, none expanded the categories of priority need in a way that necessarily required the consideration of medical evidence. It is thus in cases where an applicant is asserting that they are vulnerable under s.189(1)(c) that medical evidence most often comes into play.³

While one might think that to be homeless is in itself to be vulnerable, the homelessness law and associated guidance (DCLG, 2006) in England provides quite limited assistance to local authorities as to what precisely is meant by 'vulnerable.' The Code of Guidance summarises (although without acknowledging the source) the decisions in a number of cases where 'vulnerability' has been considered by the courts. The leading case is that of *R. v Camden LBC, ex p Pereira* (1998) 31 HLR 317, CA, which stated that vulnerability means an applicant being 'less able to fend for himself than an ordinary homeless person so that injury or detriment to him will result where a less vulnerable man will be able to cope without harmful effects.' What the *Pereira* test establishes is that when making a decision about vulnerability, the authority must look forward to the future, i.e. it is an assessment of risk: *Osmani v. Camden L.B.C.* [2004] EWCA Civ 1775; [2005] HLR 22 (Hunter, 2007).

However, while there is broad guidance from legal precedent, local authorities retain a high degree of discretion in how they interpret the homelessness law and have been under increasing central government policy pressure to reduce the number of homeless acceptances and to pursue homelessness prevention as an alternative policy (ODPM Select Committee, 2005).

² i.e. a learning difficulty or disability.

³ It is also relevant once a full duty has been accepted if an applicant wishes to contest the suitability of accommodation offered on medical grounds. However, decisions on the suitability of accommodation are often made by different officers from those considering vulnerability.

Previous research has suggested that inconsistencies exist in how 'vulnerability' is interpreted by local authorities and the decline in the number of acceptances is not necessarily simply a reflection of better preventative techniques and other policy improvements. Some evidence indicates that local authorities can sometimes act as 'gate-keepers' deliberately employing a narrow definition of vulnerability (and other statutory criteria) in order to limit the numbers of people to whom duty is owed, particularly when available social rented stock is under extreme pressure (Carlen, 1994; Lidstone, 1994; Anderson and Morgan, 1997; Homeless Link, 2004; Pawson, 2007). Research has also found that social housing landlords can also be resistant to housing homeless people, mostly due to concerns centred on housing and area management problems associated with people with high support needs and spatial concentrations of workless populations, not just in England, but also in France and much of Northern Europe (Bretherton and Pleace, 2011; Pleace *et al*, 2011; Ball, 2012).

Medical evidence and vulnerability

The use of medical evidence is an important, and contentious, issue within debates about the interpretation of 'vulnerability', and has been central to a number of court cases in recent years. The courts have found that if an applicant provides his or her own evidence and the local authority has no basis for refuting it, then it must be accepted (see *R v. Bath C.C., ex p Sangermano* (1984) 17 HLR 94, a case of learning impairment). The case law suggests that in most cases, however, local authorities seek to provide their own medical evidence or advice, rather than simply accepting that put to them by the applicant. Significantly, in giving evidence to the ODPM Select Committee (2005, p.24), the Housing Law Practitioners' Association argued that when deciding whether a person is in priority need by reason of vulnerability through physical or mental health, authorities pay little attention to consultant reports supplied by the applicant and shore up their decision that an applicant is not in priority need by obtaining favourable decisions from their own (in-house) district medical officers who will invariably (with some notable exceptions) provide negative advice despite their own lack of expertise, the limited information before them and the absence of any attempt to meet the applicant to assess his medical condition first-hand.

Such practice sometimes leads to a 'battle' in court between the experts for the applicant and the local authority regarding whether an applicant should be deemed 'vulnerable' and therefore owed the main homelessness duty (see *Bellouti v. Wandsworth LBC* [2005] EWCA Civ 602; [2005] HLR 46). A common thread in many such court cases has been the use of a particular private company, which provides services to over 50 local authorities in the UK. The practice of that company is generally not to medically examine or even meet applicants, but rather give a medical opinion based on the written evidence the local authority has compiled

(Marshall, 2007). Their decisions have featured in a number of court cases: *Bellouti v. Wandsworth LBC* [2005] EWCA Civ 602; [2005] HLR 46; *Khelassi v. Brent L.B.C.* [2006] EWCA Civ 1825; *Shala v. Birmingham C.C.* [2007] EWCA Civ 62; [2008] HLR 8; *Wandsworth LBC v. Allison* [2008] EWCA Civ 354 (see Hunter, 2007). Concerns regarding whether local authorities were being encouraged to externalise consideration of medical evidence (Marshall, 2007), were sufficient for questions to be raised about the practice in Parliament in 2006 (Hansard, 2006).

It has been said that the housing profession as such is relatively under-professionalised (see Franklin and Clapham, 1997; Franklin, 2000; Clapham *et al.*, 2000; Furbey *et al.*, 2001; Casey and Allen, 2004). Whilst none of these studies have looked directly at homelessness officers, Halliday's (2000a; 2000b) work on the operation of homelessness law suggests this is also the case for homelessness officers. Given this relative lack of 'professionalisation', wherein homelessness officers are generally of lower professional status than social workers for example, it might be anticipated that homelessness officers could be strongly influenced by medical views. In other areas of decision-making, such as mental health tribunals, the use of medical evidence has been described as leading to decisions that are made 'on the fraught borderland between law and medicine' (Richardson and Machin, 2000 p.110). Evidence from mental health tribunals suggests that decisions may be over-influenced by the views of the 'expert' medical member in reaching their legal conclusions (Richardson and Machin, 2000) and that it can be difficult to challenge medical evidence and to find independent medical experts (Campbell, 2008).

However it may be that in administrative decision-making not all medical expertise is accorded the same weight. Gulland (2011) reports that in applications for Employment and Support Allowance (ESA⁴) in the UK, administrative decision-makers are devaluing the evidence provided by professionals and claimants themselves in order to 'objectively' filter 'true' and 'false' claims. ESA decisions are made by Jobcentre Plus staff based on a test administered by health care professionals, together with the form filled out by the applicant and reports from the applicant's General Practitioner (GP) (a family doctor). Gulland concludes (2011, p.76) "The evidence produced by the medical assessment is more highly valued because it can be easily assimilated into quantifiable 'objective' facts and also has the additional moral status of 'medical' and therefore 'scientific' evidence. This contrasts strongly with evidence provided by claimants themselves... which is regarded as subjective and untrustworthy. The evidence provided by GPs, while having the moral status of 'medical' evidence, does not have the strength of that provided by the 'objective'... test."

⁴ See <https://www.gov.uk/employment-support-allowance>

Given the findings of Halliday (2000b; 2004), it might be expected that homelessness officers would develop a socially constructed understanding of medical evidence, which is influenced, at least in part, by the relative 'authority' (Lukes, 2005) attributed to its source. The legitimacy or significance accorded to various forms of medical evidence may thus differ depending on its source (e.g. the applicant themselves or doctors employed directly by the authority) or the nature of the evidence (e.g. from a doctor who has direct knowledge of the applicant compared to one just commenting on written evidence). Halliday's work also suggests that administrative norms, the socially constructed 'bureaucratic knowledge' of 'what a case is about' among homelessness officers, which is important to their decision making, may sometimes lessen the potential influence of medical evidence on decisions, even if that evidence comes from a highly respected source (Halliday, 2000b).

The Study

The study employed a mixed-method case study approach with case studies located in three different local authorities across England. The authorities (London Borough, Northern City and Eastern Town⁵) were purposively selected to include both urban and rural jurisdictions, large and small authorities (in terms of the annual number of homelessness applications), and different approaches to assessing medical evidence (with at least one council employing the services of external medical consultants). In order to understand the day-to-day decision-making practices of homelessness officers, detailed empirical work was required and thus the case studies in each area were comprised of four elements.

Firstly, a semi-structured in-depth interview was carried out with the local authority Housing Options⁶ manager (or senior representative in an equivalent role), which explored each local authority's organisational policies and procedures as regards the use of medical evidence (in both applications and reviews), and explored the rationale behind the different approaches adopted.

Secondly, a focus group was undertaken with frontline homelessness officers who have handled applications and/or reviews involving medical evidence. These involved between four and six participants, depending upon the size of each local authority. Given their immense value as a tool in studies examining sensitive issues

⁵ These geographic descriptors are used as pseudonyms for each of the study areas throughout the rest of the paper so as to preserve their anonymity.

⁶ The homelessness officers that assess eligibility are generally located in Housing Options teams. A Housing Option team administers the homelessness law but also has a role in homelessness prevention.

(Barter and Renold, 1999; Rahman, 1996; Schoenberg and Ravdal, 2000), vignettes – short written scenarios intended to elicit responses to typical situations (Hill, 1997) – were used to explore how officers would deal with particular cases. Although hypothetical, the scenarios used were loosely based on ‘real’ (anonymised) cases, where medical evidence had been used, to ensure they were plausible. The utilisation of uniform vignette ‘scenarios’ across all the case studies enabled consistent comparison of different organisational cultures.

Thirdly, individual homelessness application case files were examined in detail. Across the local authority areas forty-one case files of the most recent decisions (including both cases that were accepted and rejected), where a decision on vulnerability involved taking into account applicants’ medical issues, were examined. In addition, nine of these cases proceeded to internal review (the first stage in any challenge to the decision) and the review stage of the case file was also examined.⁷ This enabled the research team to consider ‘real’ cases and assess the actual medical evidence that was requested and provided in the case and how influential that medical evidence was in the final decision.

Finally, following the case file analysis, a semi-structured in-depth interview took place with the officer(s) handling each individual case. The researchers conducted forty-six interviews with decision-making homelessness officers regarding the individual decisions on each of the case files that had been analysed, including those that went on to review. With reference to each case, interviews explored: officers’ understanding of and response to the medical evidence before them; whether they sought particular types of medical evidence; how and to what extent medical evidence (from various sources) influenced their decision on the case; the other factors taken into account (e.g. council policy, targets, ‘intuition’ etc.); and their understanding of the application of the law to that particular case.

In summary, fieldwork across the three case studies comprised a total of three Housing Options manager (or equivalent) interviews, three focus groups involving a total of fourteen frontline homelessness officers, analysis of forty-one case files and forty-six in-depth interviews with homelessness officers and review officers. The data was analysed using thematic analysis, a theoretically flexible approach to analysing qualitative data (Braun and Clarke, 2006). Thematic analysis allows the researcher to combine the systematic element of the analysis of the frequency of codes with the analysis of their meaning *in context*, enabling the subtlety and complexity of a truly qualitative analysis (Joffe and Yardley, 2003).

⁷ The number of review cases to arise during the study period was small reflecting the relatively low number of cases recorded annually in England (Cowan and Halliday, 2003).

Findings

This section of the paper outlines the typical processes involved in a homelessness application where 'vulnerability' based on medical issues was being assessed. This is followed by a discussion of the core factors that were found to be important in officer decision-making.

Application process in cases of 'vulnerability' linked to medical need

In all three authorities, decision-making started with an initial assessment of the applicant's housing options, which included whether the applicant met the statutory criteria for homelessness enquiries to be made. In two of the authorities these were conducted separately by housing advice or housing options officers before being passed onto specialist homelessness officers. In one authority (Northern City) officers combined both functions and would carry out the initial assessments as well.

In all three boroughs the enquiries into homelessness were conducted by officers who had generally interviewed the applicant (occasionally interviews and further investigations were carried out by different officers). However the processes, which then followed, were very different in each authority. While all three authorities would look to the applicant's own GP for information, in only one area was this the main (and often only) source of information sought. In Northern City a standard letter requesting information was sent to all GPs. Unlike in the other two authorities, however, there was no specialised internal advice available, although there was some evidence that officers would on occasion seek information and advice from officers with expertise whose job was to advise on the suitability of accommodation and needs of applicants for support when being housed.

However even in the other two authorities references to internal services were not standard and/or routinised. In London Borough a 'medical assessment officer' was employed who was used mainly in relation to physical health issues, as this was where her main expertise lay. Although there was a formal referral process, case workers often discussed cases with her on a fairly informal ad-hoc basis. Where information was sought from other medical professionals such as the applicant's GP or other medical professionals treating the applicant, she would write to them and compile a report based on the information received. However, in cases involving mental health issues applicants were referred to a separate assessment service. Applicants referred here were interviewed again and a detailed assessment of support needs was carried out with a decision given within a set time-frame.

Eastern Town, by contrast, relied very heavily upon information from their in-house intensive support worker who was allocated to clients with higher support needs. This support worker did not have any professional medical qualifications or training herself, but instead gathered information from external sources and indeed the

clients through her regular contact with them. The two larger authorities (Northern City and London Borough) had contracted to have access to a third-party private service (MedicReview⁸). The MedicReview service was staffed by a small group of doctors. The procedure in this instance was to have all the documents that had been collected and held by the local authority faxed or emailed to MedicReview, which would then respond with an assessment of 'vulnerability'. MedicReview staff did not conduct a medical examination or even meet the applicant at any point during their assessment. The evidence showed that even within authorities different levels of use were made of MedicReview, with some officers stating that they had never made a referral, while noting that other teams did make greater use.

Thus the information on which decisions were based was not collected in a standardised manner and could be subject to input from a range of different persons, some with medical expertise, some without, some who had interviewed or were otherwise familiar with the applicant, and some who only saw the paper evidence.

Once the information had been collected a decision to accept or reject the applicant was made, often in consultation with the homelessness manager. The research showed that the manager, who in most cases has had little or no contact with the applicant, had priority of decision where there is any dispute in the assessment. They might advise that additional input into decision-making be sought from either the internal or external sources set out above.

Processes influencing decision-making

The research found several processes influencing and interacting with one another in decision-making. It was not necessarily the case that any one of these processes was in itself determinative of the outcome, that is, whether or not the applicant was deemed to be owed the main homelessness duty. There were variations in the influence of each factor, often depending on the extent to which an application was contested and thus exposed to more scrutiny.

'First impressions'

Given existing documentation of the way applicants are socially constructed by officers (see above) we were interested to what extent (if at all) first impressions made at the initial interview might be influential. The interviews with senior management gave some indication that initial impressions of the applicants were important. There was further support for this during the interviews with frontline officers when looking retrospectively at some of their cases. Certainly, physical infirmity (e.g. walking with a stick, shortness of breath, amputated limbs) was seen as a strong indicator of vulnerability even before any information had been collected. The influence of first impressions was also particularly acute where presentation might

⁸ Not its real name.

indicate that an applicant was not able to engage sufficiently with the application process. These findings suggested that *looking* ill, while not in and of itself necessarily a determinant of the eventual outcome of an application, created a sense of sympathy and empathy among some homelessness officers.

Your first interview is usually the most important. The first interview, how they present themselves, is very important and that kind of gives you your gut feeling of how you feel about his conditions.⁹

I think, from memory, not so much his physical appearance but the way he presented, he didn't really engage very well.... [He] wasn't particularly communicative, not very real eye contact; he was just sort of present but not really engaging. His key worker did most of the work.

He himself didn't...seem like he was a vulnerable person 'cos he was talkative, the way he was dressed, his behaviour, everything, he never showed any signs of any form of mental health issues whatsoever.

'Appropriate' behaviour

Previous research into homelessness services has suggested that 'shorthand' constructs of 'worthy' and 'difficult' service users are routinely developed by homelessness professionals and that snap judgements, based on assumed characteristics can inform some responses by service providers (Hutson and Liddiard, 1994, Cramer, 2005). For homelessness officers, a key basis for determining 'vulnerability' was whether someone showed capacities in understanding and using the homelessness system. From a homelessness officer's perspective an applicant could appear to be 'too clever' or too 'tuned in' to local authority procedures to be seen as vulnerable. Suspicions were reported to be raised by homelessness officers when an applicant seemed to 'know the system' a little too well.

... I mean him, even how he interacted in the interview, he didn't come across as like, like someone that was, you know what I mean, that was not intelligent. In fact he, he seemed quite intelligent and he seemed to know what, what he was talking about... I mean he's acknowledging that there are some issues in his life that he has to sort out. In my experience, I mean if you've got serious mental health issues, you wouldn't be able to have that, that, that sort of reasoning.

He didn't present as vulnerable to me, to be honest....again he knew... the procedure in regards to approaching the Council and the kind of questions he would be asked.

⁹ Unless stated otherwise, all quotes are taken from frontline homelessness and review officers.

Nonetheless impressions of appropriate behaviour were not necessarily always determinative. Officers did sometimes report that the way an applicant presented at interview did not always correspond with the final outcome assessment of vulnerability.

At the beginning I wasn't sure if it was a fifty/fifty chance because I've dealt with ADHD and autism before, but it's kind of depending on the severity of it. It's really hard to tell at initial, at an initial stage. So I couldn't really say at the initial stage of the application which way it was going to go really.

'Gut feeling'

The two previous headings are closely related to what might be termed 'gut-feeling'. While, as noted below, the research showed that medical evidence and advice of medical professionals, and more importantly the way in which this information is used, was important in assessing vulnerability, a substantial element of the decision-making process was found to rest upon 'gut feeling' and what homelessness officers attributed to professional intuition. This finding appears to echo the results of some earlier research, suggesting that homelessness officers relied heavily on their own feelings alongside reference to various sources of information and reference to senior managers (Halliday, 2000b).

I think you start with the gut feeling, the sort of feel you have for a case, and then you kind of work with that... You do get the odd one. But generally I think our gut feelings are pretty good indicators.

I think it just comes with time doesn't it? I must sound like an old... [laughter] When you start doing this job it's almost like you've been thrown in with the lions. You rely an awful lot on your colleagues for support and advice. And then the more you do it, you find that certain scenarios kind of repeat themselves.

Medical knowledge

Despite these intuitive feelings, the officers across the local authorities were absolutely clear in acknowledging that they did not have sufficient medical expertise to make decisions without assistance. Officers sometimes reported that they had interpreted an applicant's case as particularly severe, only to find that the medical professionals from whom they requested an opinion of vulnerability would then suggest otherwise.

... we're not medically trained, to be honest. I mean, fair enough, I can read a letter, think oh my God, you know, he is vulnerable, but then I can't make that decision. This is why we've got a medical advisor, this is why we have MedicReview, so we can refer it to get an opinion from them. And I just went by [the medical advisor's] opinion because obviously she's the one who deals with medical evidence and knows which... client should be vulnerable based on their medical health.

Homelessness officers generally did not deviate from the advice given by advisors, particularly internal medical advisors.

I'm not in a position to obviously issue any information or recommendation from a medical point of view. So if we have a team of, you know, professional doctors and, and our medical advisor as well saying that she's not vulnerable, there's not that much I can do to override that.

However, there was some distrust of MedicReview, particularly in relation to the speed with which assessments were made and a decision given, often within 24 hours, as well as the lack of an actual physical examination by a doctor.

MedicReview don't actually meet the client. They will just base their opinion on the information that we provide, or that we gather, and what the client has provided as well.

This scepticism about MedicReview extended to those cases that reached review stage. It was mentioned that while generally MedicReview would make an assessment of no 'vulnerability'; this would almost always be overturned by MedicReview if the case went to a review.

... there wasn't really that much additional information that they considered in terms of... (review officer) didn't really gather anything of any significance that, that wasn't already known in order for them to overturn the decision. But...this is just something that, that, you know, MedicReview do. I don't really know why. But they will tell the caseworker that they don't feel...that the applicant's vulnerable but then they would sort of change their mind and issue a totally different recommendation when it comes to the review stage. I don't know why but it, it's a pattern that we do see...

If information gathered by frontline officers did not result in an adequate level of confidence in making a decision on an applicant's vulnerability, the officers would seek the advice of a senior colleague. The research suggested that senior staff tended to follow the medical advisor or MedicReview advice in those instances when frontline officers passed on cases where there was ambiguity.

But because we're not medically trained, 9 out of 10 times we do agree with the medical advisor's recommendation. It's only when you feel so strongly about a client that you do sometimes go against the medical adviser's opinion. But I usually speak to a senior and he usually agrees with the medical advisor's negative recommendation! (laughter). He's like 'no'.

General practitioners

There was, however, much more doubt shown about the objectivity of those who had actually medically examined the applicant, typically their own GP. While GP accounts were not requested across all the areas, usually due to financial constraints, in the two areas that did use them, it was generally felt that GPs tended to be 'on the side of' the applicant. There was a perception among homelessness officers that GPs often exaggerated their patients' conditions so as to enable an assessment of vulnerability. It was assumed that GPs did not understand vulnerability in the specific terms of the homelessness legislation; rather, their assessments were based on a far more generic definition of 'vulnerability'. Consequently, some homelessness officers thought that an assessment undertaken by internal medical assessors or MedicReview would be more objective and accurate, because it used the criteria within the homelessness legislation and case law to assess vulnerability.

I think with our assessors they are more objective really, and they're just going to look at it as the facts stand, I think.

Intriguingly, the greatest degree of ambivalence towards medical evidence obtained from an applicant's GP came from the local authority that relied upon GP reports most heavily – although some similar views were also expressed in the other two authorities. As noted, Northern City in each case requested a full report from the GP in order to assess patients' vulnerability but distrust in the assessments was high among these homelessness officers.

I do worry about how objective the applicant's consultants and GPs are going to be. Because they're always going to try their best for their patients, aren't they? Obviously they're professional people and I'm not suggesting that they would deceive you, but they may kind of embellish someone's symptoms in order for them to secure housing.

Furthermore, during the case file analysis in this area it was evident that if the GP stated the applicant was 'vulnerable', the officer responsible would often make further checks or disagree. However, it was almost always the case in instances where the GP stated an applicant was 'not vulnerable' that the officer would accept this assessment. When a GP had said an applicant was not vulnerable, this would often be presented as the 'evidence' in the non-priority need decision letter that would then be sent to the applicant informing them of the negative decision given by the local authority.

Medication, dosage and the Internet

A striking feature in homelessness officers' decision making was their regular referral to levels of dosage of medication. Medication, and particularly the dosage prescribed, was used as a very important proxy of vulnerability for some homelessness officers. Decisions about the supposed 'severity' of a condition were sometimes being made by officers who were not medical professionals based on assessments of dosage level.

...dosage to us is very important as well, if it's a high dosage then that indicates the person could be vulnerable based on the high dose. If it's a standard or a very low one, you can always argue, well you're not priority, although you're on medication but they're just standard or they're the low dosage.

Because, I mean in order for MedicReview to, to sort of come up with an opinion that sort of information would be important for them, because obviously this is the big difference between kind of taking 40mgs of Fluoxetine to them taking 100mgs of Fluoxetine. So that basically gives an idea, well if he's on that sort of heavy medication then obviously he may have mental health issues that would impede his daily activity.

While some knowledge of dosage was built up through experience, officers frequently felt they needed to consult other sources in order to assess the implications of different prescription levels. For this type of information in particular the Internet was used as a source of information. Homelessness officers would often check websites such as Net Doctor or search for information using Google about an illness, what specific medication was for, the effects this could have on the applicant and what different dosage levels signified.

... you see I know some of them because obviously, well dealing with, with cases like on a daily basis, I would know what Aspirin is...but the rest I would usually Google them...go into the Net Doctor and just see which one is, well you know, what is this one and what's this... how you would use it, for what kind of illness.

Benefit entitlement

In a similar vein, the type and extent of welfare benefits homeless applicants were receiving were also taken into consideration. In cases where degrees of welfare benefit entitlement were used, the practice was justified on grounds that any necessary medical assessments had already been undertaken to ascertain the level of benefit to which the individual is entitled. To do so again would, in the opinion of some homelessness officers, entail a waste of public resources. The

welfare benefit most often referred to was Disability Living Allowance (DLA), which if being received at the 'higher rate', but not the 'lower rate' was widely seen as signifying vulnerability¹⁰.

...if somebody's in receipt of higher rate DLA, for care in particular, then that gives us a very good indication that they are vulnerable. If somebody's on a lower rate DLA we would generally, you know, there's a chance that they would not be a priority need.

Role of the applicant

Applicants' personal perspectives and opinions tended to have little influence on the decision-making process, with their role rarely extending beyond that of being a conduit to information and evidence as regards their poor health. In this respect, applicants were typically asked to complete the medical assessment form, but few attempts were made to glean additional information about their personal biographies or circumstances and their own views of the impact of their ill-health or disability on their homelessness:

[I] give it out to them and then while I go away to take the copies I come back and it's completed and then pass it on for, to get an opinion on it...So...generally I never actually question them about the stuff they write in the medical assessment form, especially during the interview.

...I generally just go with enquiries and, it's just the standard stuff that we do, don't get sucked in with their personal circumstances.

A number of homelessness officers noted that they sometimes mistrusted the information the applicant had revealed in relation to their medical issues, referring to 'anomalies' that would be 'found out' during the medical evidence collection process:

... from our point of view, to see that medical [evidence]...'cos some people may just take a walking stick, not necessarily need it but just have it. I mean I've come across clients that say they need wheelchairs and stuff like that and don't necessarily need them...

¹⁰ See <https://www.gov.uk/dla-disability-living-allowance-benefit/overview>

Conclusions

Earlier research in the UK, including that by Halliday (2004) and other studies of homelessness services such as that conducted by Cramer (2005), has indicated that frontline workers in the homelessness sector commonly refer to a social construct of the 'service worthy' homeless person when making their decisions. Similar conclusions have been drawn elsewhere, as US and Canadian research has found that even when someone has been accepted by a homelessness service, the operation of that service and the outcomes it delivers are heavily influenced by constructs of who is 'service worthy' and who is not (Lyon-Callo, 2000; Dordick, 2002; Schneider, 2010). The findings of this study show clear parallels, in that the social constructs developed by homelessness officers in England were derived from their own experiences, but also shaped by professional, administrative and legal norms in the UK (see also Hutson and Liddiard, 1994).

The process of social construction clearly begins at the point of initial interview, which, as the quotation in the title of this paper suggests, can set the impression with the decision-maker as to the nature of the applicant and the 'legitimacy' of his/her case. However, as the evidence presented has suggested, this is only the start of a highly complex process, where initial views are revised, often substantially, in light of the evidence that emerges. However, unlike the decision-making in ESA decisions, reported by Gulland (2011), a much more uneven and differentiated process emerges, involving a range of 'experts' and other sources of information which are accorded different weightings.

Across all three local authorities, the views of 'experts' were highly influential, but some 'expert' opinion was more influential than others. It was certainly not the assessment of the applicant's own doctor, which was often regarded with ambivalence, but rather that of the medical experts employed by the local authority that carried most weight. In so doing it would seem that homelessness officers were trying, very much like the JobCentre Plus staff in ESA cases, to construct an 'objective' assessment of an applicant's medical condition. Furthermore, and notably, it was clear that those persons who might understand such medical issues best (that is, the medical professionals treating the applicant) were generally regarded as being too subjective in their views.

It is interesting that different weightings were also accorded to avowedly 'objective' external sources of information. The lack of trust in MedicReview, for example, stemmed from the fact that the organisation's staff were perceived as being generally negative in their views and thus not objective. They were also considered to know too little of the applicants because they did not meet or interview them. There seemed to be a mid-point between being too much on the side of the applicant (GPs) and not knowing them well enough (MedicReview). In those authori-

ties where an internal medical assessor was present, these internal experts were perceived to be at this mid-point which enabled the homelessness officer to consider that an objective view of the medical condition was being made.

It seems that the Internet was also seen as providing 'objective' sources of information, and this might explain the confident reliance on information obtained this way. It has been said that the Internet exposes the health professional's knowledge to the public gaze and challenges previously hierarchical models of information giving and receiving. This shift in control, Hardey notes, is 'centre to the de-professionalization thesis and could be seen as contributing to the decline in trust in doctors' (1999, p.832). Given this emphasis of objective assessment, it is not surprising that the applicants' views of their situation were accorded so little importance. In creating an objective assessment medication, dosage and the officers' own professional 'gut feeling' or instincts were more fundamental.

Taking these different facets into account it seems that the picture painted by the Housing Law Practitioners Association in their evidence to the ODPM Select Committee (ODPM Select Committee 2005) is to some extent true of cases involving medical evidence today. That said these cases do not simply involve the utilisation of in-house or external medical experts with little or no knowledge of the applicant seeking to give negative decisions. On the contrary, homelessness officers weigh up a range of complex (and sometimes contradictory) forms of evidence, which they seek to assess in terms of the authority and objectivity of the sources, when endeavouring to come to a defensible decision under the legislation.

It has been suggested that the homelessness provisions in England (and their equivalents in the other parts of the UK) avoid the room for inconsistency and barriers to implementation that have emerged in relation to France's right to housing for example (Loison-Leruste and Quilgars, 2009; Ball, 2012). This study has however shown that one should not assume that decision-making is consistently implemented within the English legislative framework.

This is not to argue that we should move away from a rights-based approach. Despite the limitations of rights-based models (see Fitzpatrick and Watts, 2010 and Fitzpatrick and Pleace, 2012), it is not suggested that an alternative of giving more discretion back to public administrators would be an effective response to the problems that are outlined in this paper. Nor is it suggested that moving to a more standardised 'tick-box' model of decision-making as has happened in the case of ESA assessments would necessarily make for better decision-making. As this has not been a study directly involving applicants or indeed their advisers and their views of the process we cannot suggest what, if any, bottom-up reforms might help in avoiding these problems from their point of view.

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This research is indicative of the real world problems that can arise even when seeking to guarantee rights to housing for vulnerable homeless people through law. The most obvious change that would end any need for decision-making regarding priority need based around medical evidence would be to follow the move in Scotland to dispense with differentiation based on priority need categories (Anderson, 2009). However, in considering the use of 'housing rights' responses to homelessness, the potential complexities and inconsistencies of bureaucratic process have to be taken into account.

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