

THE USE OF MEDICAL EVIDENCE IN HOMELESSNESS CASES

This study examines the use of medical evidence in homelessness applications in England. It does so by examining the decision-making practices in three different local authorities: London Borough, Northern City and Eastern Town.

Background to the study

The safety-net for assistance for homeless persons in the UK is highly legalised. In England and Wales it is governed by the Housing Act 1996, part 7. In order to qualify for assistance homeless applicants must satisfy the local authority that they fall within a number of criteria. One of these is that the applicant is in “priority need”. This is a particularly key criterion for single applicants (i.e. those who are not pregnant or with dependent children). This is set out in s.189(1) of the Housing Act 1996. The 1996 Act provides no further assistance as to what is meant by “vulnerable” but there has been a number of cases where it has been considered by the courts.

The legal test - Housing Act 1996, s.189(1)

To qualify for assistance a single applicant will be in priority need if he or she is:

“(c) a person who is vulnerable as a result of old age, mental illness or handicap 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)).

Key cases

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.”

The starting position therefore is that the applicant has become or will become street homeless, it does not turn (as had been suggested in some earlier cases) on his/her ability to fend for him/herself while still housed: *Osmani v. Camden L.B.C.* [2004] EWCA Civ 1775; [2005] HLR 22.

Decisions on vulnerability often turn on the use of medical evidence, as demonstrated by the significant amount of litigation on this issue. A number of cases have been critical of the way that local authorities use medical evidence, particularly when referring to external advisors such as a company called NowMedical (see e.g. *Shala v. Birmingham C.C.* [2007] EWCA Civ 62; [2008] HLR 8), although in others

the courts have refused to intervene in the decision-making of authorities. The use of external advisors has been criticised in the housing press (see Marshall, 2007).

The existing evidence on decision-making by local authorities on homelessness suggests that there are competing priorities and normative systems including the administrative, financial and the political as well as the legal (Loveland, 1995; Cowan, 1997; Halliday, 2000a, 2000b, 2004). However, there have been no studies to date which looked at how medical evidence is used in decisions on vulnerability and the effect of how such evidence weighs in the decision-making processes of homelessness officers.

Aims of the study

This study sought to provide a rigorous, theoretically informed account of the basis on which homelessness officers make decisions on vulnerability of applicants where medical evidence is involved. The specific objectives underpinning this aim were:

1. documentation of the types and sources of medical evidence used in local authority assessments of whether (single) homeless applicants are 'vulnerable';
2. identification of the full range of normative influences shaping homelessness officers' decisions on homelessness applications;
3. assessment of the relative weighting attached to each of these, and medical evidence/norms in particular, by homelessness officers when making decisions; and
4. development of recommendations as to appropriate policy and practice responses by both central government and local authorities.

Methods

In addition to a literature review, in order to understand the day-to-day decision-making process the research used multi-method case study methodology. This was based in 3 local authorities purposively sampled to include insofar as possible 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 each of the three case studies, the following fieldwork was conducted:

- A semi-structured in-depth interview with the relevant service manager.
- A focus group with frontline homelessness officers who have handled applications and/or reviews involving medical evidence. Vignettes – short written scenarios intended to elicit responses to typical situations – were used to explore how officers would deal with particular cases.
- Data was collected from 41 case files which involved decisions on vulnerability from across the three case study authorities. Of these, 8 cases also went on to internal review following a negative decision. Semi-structured in-depth interviews were conducted with the officer(s) handling each case. The 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; other factors taken into account (e.g. council policy, targets, 'intuition' etc.); and their understanding of the application of the law to the particular case. Interviews were also conducted with the reviewing officer in 5 of the cases.

Decision-making in each authority

The decision-making processes in each of the local authorities varied. These brief outlines illustrate the key differences.

London Borough:

- An initial interview was undertaken by a customer services officer who dealt with housing options.
- The case was then handed on for investigation by one of 8 caseworkers who issued letters.
- An initial form was completed with the applicant by the caseworker.

An in-house medical advisor was used particularly for physical illness. Mental illness cases were sometimes referred to a team who also assessed for support needs. Cases could also be referred to an external medical advice service.

Northern City:

- A large team of case workers split into five teams undertook both housing options advice and homelessness case work.
- A standard form was completed by applicants as part of the interview process.
- A standard letter was sent routinely to GPs.
- There was no in-house medical advice provided.
- Cases were very occasionally sent to an external medical advice service.

Eastern Town:

- A small team of officers are split between housing options advice initially and then homelessness case work.
- The officers are split over two quite geographically distant sites.
- A standard form is completed by applicants as part of the interview process.
- There is no in-house medical advice but an intensive support worker who works with applicants is often called upon for her advice and opinion.
- Negative decisions very rarely occur on the question of vulnerability because applicants are also offered support into the private rented sector and many applicants who would potentially receive a negative decision are diverted into the private sector and do not pursue an application.

Findings

- The open textured nature of the law means that although some cases were clearly not open to dispute as to whether an applicant was vulnerable or not, in many the decision was much more open and an authority could legally decide the issue either way. This means that there is potentially a lack of consistency both within and between authorities as to the outcomes of cases. Accordingly the view of the case taken by the individual officer deciding has a significant influence on the decision made.

- Homelessness officers acted as street-level bureaucrats where “professional intuition” played an influential role in the decision-making. This manifested itself in the way that applicants were “constructed” as potentially vulnerable or not. In particular applicants who seemed knowledgeable about the process and able to take control of the cases were less likely to be viewed as vulnerable. Generally this intuition impacted at an initial stage of decision-making – i.e. whether detailed investigations were required, but such initial impressions were generally not determinative of the final outcome. The individual applicants had very little voice in this process.
- This intuition was also tempered by a high-level of legal consciousness and conscientiousness – officers were well-versed in the tests arising from the relevant case law. They were also aware that the legal consequences of getting a decision wrong were that it could be reviewed and potentially then appealed. It was generally considered better to avoid these consequences by applying the law correctly first time.
- A variety of sources of information was used by officers in decision-making, this included evidence from an applicant’s own doctor (particularly GPs), in-house and external advice, information from the internet and some decisions relating to benefits (e.g. when applicants were on higher rate Disability Living Allowance). There was not, as expected, a perceived hierarchy of expertise, but rather a search for an objective view of the evidence which could most readily come from those who were trusted as objective sources. This was most obvious in the two boroughs with in-house advice which was particularly valued not because of the status of the medical qualifications but because of the advisors’ ability to get to know the applicant or understand the case and be seen to provide an objective view.
- Accordingly there was little deference to the medical profession – the opinions of the applicants’ GPs were viewed with some scepticism. In one authority this was the main source of information, as no in-house service was available, yet the officers tended to revert to their professional intuition about the case rather than rely on what GPs said in response as it was felt they were often “on the side” of the applicant.
- The internet was relied upon to a surprising degree particularly to assess types and levels of prescribed medication as indicators of the severity and/or likely duration of applicants’ health problems. Awareness as to the reliability of different sites varied. Such information was perceived to be objective and where used it was often an important part of the decision-making process.
- Although an external agency was used by two of the authorities, in one authority this use was very limited and inconsistent. In the other there was a preference for in-house medical expertise (of varying types) where, as noted, officers had trust in the individuals and systems concerned, particularly as the external agency had been known to give different views about the same case when the matter went to review.

Key Recommendations

The following recommendations emerged from the study:

- Steps need to be taken to provide more consistency of process across and within authorities. This could be achieved through more detailed guidance in the Homelessness Code of Guidance covering issues such as:

- How requests for information are made to GPs and other medical professionals:
 - These should avoid seeking comments on “vulnerability”, but ask for clear factual and medical information and opinion.
- When and how internet information can be used reliably.
- Difficulties emerged with GPs who failed to respond to inquiries or who did so inappropriately. Training needs to be provided for GPs as to how to respond to requests for information.

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