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"YOU CAN JUDGE THEM ON HOW THEY LOOK….": HOMELESSNESS OFFICERS, MEDICAL EVIDENCE AND DECISION-MAKING.

Joanne Bretherton
Centre for Housing Policy, University of York
Joanne.Bretherton@york.ac.uk

Caroline Hunter
York Law School, University of York

Sarah Johnsen
School of the Built Environment, Herriot Watt University

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Abstract

Unusually in the international context (Fitzpatrick and Stephens, 2007), the landmark Housing (Homeless *Persons) Act 1977 provided a set of justiciable 'rights' to homeless people and imposed duties on local* authorities to assist persons who met a set of criteria set out in the Act (the current legislation is contained in *the Housing Act 1996, Part 7). One of the criteria ("vulnerability") often requires co*nsideration of medical *evidence. As the individuals assessing whether or not an applicant is 'vulnerable', homelessness officers are key* actors in decision-making. Homelessness officers represent, as Bengtsson (2009) suggests of housing managers in the UK, *classic examples of Lipsky's (1980) 'street-level bureaucrats', in that they exercise discretionary power in the interpretation of legal rules. In exercising this discretion they work in an environment that "can be* characterised as a space where law and alternative normative influences co-*exist" (Halliday, 2004, p.87).*

This paper examines the evidence from early findings of an empirical study of how decisions are made by homelessness officers where medical evidence is involved. It explores how far officers *assess the "expert"* medical evidence that is put to them, how far they rely on their own intuition and judgment and the other factors which influence their ultimate decision.

Introduction

Statutory homelessness legislation represents a key mechanism for the distribution of social welfare in the UK. Significantly, and unusually in the international context (Fitzpatrick and Stephens, 2007), the landmark Housing (Homeless Persons) Act 1977 provided a set of justiciable 'rights' to homeless people and imposed duties on local authorities to assist persons who met a set of criteria set out in this Act, and expanded in subsequent Acts. Local authorities thus have to make a decision as to whether applicants are eligible and in 'priority need'. The latter is a particularly key criterion for 'single' applicants, defined under the legislation as people who are not pregnant or do not have dependent children. To qualify for assistance, a single applicant must be "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)). 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).

The 1996 Act provides no further assistance as to what is meant by "vulnerable" but there have been a number of cases where it 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 Periera 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.

Local authorities have a high degree of discretion as to their interpretation of 'vulnerability', and have been under increasing central government policy pressure to reduce the number of homeless acceptances (ODPM, 2005). The numbers of acceptances have indeed declined very dramatically, but it has been suggested that this is not necessarily simply a reflection of better preventative techniques and other policy improvements but rather that some local authorities 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 (Carlen, 1994; Lidstone, 1994; Homeless Link, 2004; Pawson, 2007).

The use of medical evidence is an important, and contentious, issue within these debates, and has been central to a number of court cases in recent years (see further the cases discussed below). 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 Sagermano (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 use of one particular private company, MedicReview, who provide services to over 50 local authorities in the UK [1]. MedicReview generally do not meet or conduct any medical examination on a particular applicant, but rather give an opinion based on the written evidence the local authority has compiled (Marshall, 2007). Their decisions have featured in a number of recent 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 further Hunter, 2007). Concerns regarding whether local authorities were being encouraged to use MedicReview, who have a reputation for denying claims of vulnerability (Marshall, 2007), were sufficient for questions to be raised about the organisation's role in Parliament in 2006 (Hansard, 2006).

The exercise of discretion by local authority homelessness officers has been the focus of a number of socio-legal studies (Loveland, 1995; Cowan, 1997; Halliday, 2000a, 2000b, 2004; Cowan & Halliday; 2003), with several commentators concluding that it is not uncommon for local authorities to make unlawful decisions, and for these to go unchallenged by applicants. Perhaps surprisingly, given its

[1] This is a pseudonym used throughout the paper.

importance in day-to-day decision-making practice, and the on-going litigation it has fuelled, the use of medical evidence in homelessness decision-making has not been the focus of explicit research attention to date. The study sought to redress this gap. It is clear from the existing socio-legal literature that, while legal norms have some purchase on decision-making by homelessness officers, there are other competing normative frameworks. In conducting a detailed examination of the use of medical evidence in local authorities' homelessness decision-making processes, the project was able to investigate the practical and theoretical intersection between law, administration, and medicine.

As the individuals assessing whether or not an applicant is 'vulnerable', homelessness officers are key actors in the welfare system. Homelessness officers represent, as Bengtsson (2009) suggests of housing managers in the UK, classic examples of Lipsky's (1980) 'street-level bureaucrats', in that they exercise discretionary power in the interpretation of legal rules. In exercising this discretion they work 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. 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).

In cases involving medical evidence there is added to this a further set of norms, which may be derived from the use of medical experts. In other areas of decision-making, such as mental health tribunals, decisions are also made "on the fraught borderland between law and medicine" (Richardson and Machin, 2000, p.110). Evidence from mental health tribunals suggests that members may be over-influenced by the views of the 'expert' medical member in reaching their legal conclusions (Richardson and Machin, 2000). Also in the context of Mental Health Review Tribunals, Campbell (2008) notes the difficulties in challenging medical evidence and in finding independent medical experts. These findings raise issues which are also relevant to the medical experts used by local authorities, as it is similarly a "legal exercise concerned to apply statutory criteria to an existing set of circumstances, those statutory criteria are highly dependent for their application on clinical judgment" (Richardson and Machin, 2000, p.113).

It has been said that the housing profession as such is relatively under-professionalised (see Franklin and Clapham, 1997; Franklin, 2000; Clapham, Franklin and Saugeres, 2000; Furbey et al, 2001; Casey and Allen, 2004) – and whilst none of these studies have looked directly at homelessness officers (focussing, rather, on housing management functions of local authority housing departments), there is nothing to suggest that the same may not be true of homelessness cases, and indeed the evidence from Halliday's work would seem to confirm this. Given this relative lack of "professionalisation" of housing work, it may be expected that homelessness officers might be strongly influenced by medical views (Richardson and Machin, 2000; Peay (2003) on the complex relationship between social workers and lawyers when making decisions under the Mental Health Act 1993).

On the other hand, homelessness decision-making could be characterised as an area where the norms of law and medicine may be weaker than in mental health decision-making and find it more difficult to penetrate the administrative norms identified by Halliday. 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 that source. The legitimacy or significance accorded to various forms of evidence may thus differ depending on its source (e.g. the applicant 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 the written evidence).

The study explored the full range of norms drawn upon by homelessness officers in making decisions on homelessness applications including, importantly, the 'intuitive ethics' deployed and their rationalisation/ justification of these. In so doing, it explicitly considers where medical norms 'fit' in relation to other norms drawn upon, and the relative weighting of importance or value accorded to each.

The Study

This paper reports some early results from an ESRC funded study of the use of medical evidence in local authorities' homelessness decision-making processes. 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 Town were 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 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 comprised:

- A semi-structured in-depth interview with the local authority Housing Options 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 explore the rationale behind the different approaches adopted.

- A focus group 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 (Barter and Renold, 1999; Rahman, 1996; Schoenberg and Ravdal, 2000), vignettes – short written scenarios intended to illicit 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 to ensure they appear plausible. The utilisation of uniform scenarios in all the case studies enabled a degree of comparison of different organisational cultures. These vignettes of hypothetical cases provided an understanding of the day-to-day practices in the department.

- Examination of individual homelessness application case files. The fifteen most recent decisions (including both cases that were accepted and rejected) in each local authority where a decision on vulnerability involved taking into account applicants' medical issues were examined in detail. In addition, up to five cases of this type that proceeded to internal review (the first stage in any challenge to the decision) were examined[2]. This enabled us to consider "real" cases and assess the actual medical evidence that was provided in the case and what was used as a basis for the decision.

- Semi-structured in-depth interviews with the officer(s) handling each individual case. We conducted interviews with decision-making officers regarding the individual decisions on each of the case files that we had analysed. With reference to each case, interviews explored officers' understanding of and response to their 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 that particular case.

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

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, forty-six in-depth interviews with homelessness and review officers and detailed analyses of forty-six homeless applicants' case files including twelve cases that went to review.

Emerging Findings

At the point of writing, data has been gathered from all of our three case study areas but analysed from only one. Consequently the findings presented here are interim findings from that case study and thus one-third of our data. This is a London Borough that on average accepts forty applicants as homeless per quarter. It also rejects approximately just over a hundred applicants per quarter on the basis that they do not have a priority need. The senior manager interviewee noted that this particular borough does have a reputation for rejecting a greater proportion than is typical.

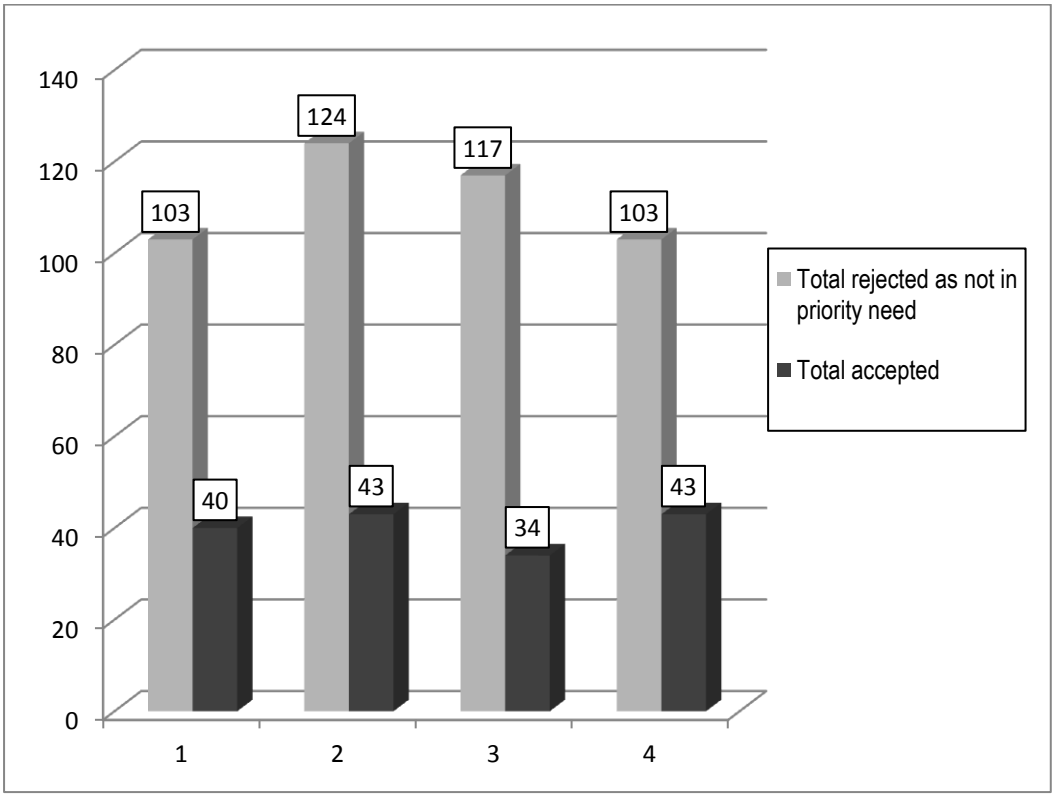

Figure 1: Homelessness Acceptances in the London Borough for Each Quarter of 2010

Application process in cases of *'vulnerability'*

In brief, the decision making at the London Borough starts with an initial assessment of criteria and eligibility whereby cases may be diverted away at this stage, but if they are strong enough they are passed on to a caseworker for enquiries and possibly a decision. Decisions are made in consultation with the homelessness manager, although it was evident that the manager, who in most cases has had little or no contact with the applicant, has priority of decision where there is any conflicting assessment.

There are three distinct sources of assistance in decision-making which may be used. There is an internal medical assessment officer, who has some medical qualifications, where cases would usually

go to in the first instance. Cases can also be referred to a third-party private service (MedicReview) which has been in operation since the mid-1990s and offers services to a large number of local authorities. The service is staffed by three general practitioners (GP's). The procedure is generally to have all the documents that have been collected and held by the local authority faxed to them, on which they respond with an assessment of vulnerability. They do not meet with the applicant at all during their assessment. Finally, if MedicReview do provide an assessment of 'vulnerability' the case has to then be referred to the Joint Assessment Service (JAS) whereby the applicant is interviewed again by JAS in person and a detailed assessment of support needs carried out with a decision given within thirty-five days.

Decision-making

First Impressions

The initial staff focus group and interview with senior management gave some indication that initial impressions of the applicants were important.

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

There was some support from this during the interviews with the officers when looking retrospectively at some of their cases. This is particularly acute where presentation might indicate that an applicant was appropriately vulnerable.

> "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."

> "…but I didn't think that it made him vulnerable because, 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, you know what I mean, 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."

Certainly physical infirmity (walking with a stick, shortness of breath, amputated limbs) was a strong indicator of vulnerability even before any information had been collected. On the other hand an applicant might appear too clever and tuned in to council procedures to be vulnerable. Suspicions were always raised when an applicant seemed to 'know the system' a little too well.

> "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."

> "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."

Nonetheless such initial impressions were by no means determinative and officers would admit that sometimes the way an applicant presented at interview didn't 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."

> "...with clients who have mental health issues, I never try and like assume anything. I'm not like qualified, or a medical professional and not qualified in assessing people's mental health issues.... if we're interviewing clients who were deemed as mentally vulnerable or who we have reason to believe that they're mentally vulnerable, I tend to go into the interview with an open mind."

Medical Knowledge

The officers in the London Borough were absolutely clear that they did not have sufficient medical expertise to make decisions.

> "....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"

> "Ultimately most of us are not medically trained. So when you're looking at information you may think 'wow, it looks really bad for this person' and then the medical professional will say 'well no, this is what we're seeing...″

Although, the speed at which MedicReview conducts an assessment and provides an opinion seemed to cause a little concern amongst officers.

> "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.

> "…and they have their own deadline of 24 hours. So they have to give us their decision within a day, so they can only base it on what they have."

Given this accepted lack of medical knowledge, the homelessness officers were generally very clear that they would not deviate from the advice given by their advisors, particular the medical advisor and JAS. There was occasionally a little more scepticism expressed of MedicReview.

> "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."

This scepticism extended to those cases that reached review stage. It was mentioned that while generally MedicReview had made an assessment of no 'vulnerability' and therefore non-priority need in the initial application; this would almost always be overturned by the same organisation if the case went to a review.

> "…having looked at the recommend, the recommendation they sent to me, and then the additional recommendation they sent to (review officer) there wasn't really that much additional information that they, 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, don't really know why. But they, they will tell the caseworker that they don't feel, you know, that, that, 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, it's a pattern that, that we, we do see…"

Nevertheless, the general following of the advice given by the medical advisor or MedicReview could also be said of the senior staff in instances when officers pass on cases where they may be 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 medical expertise of those who actually might know the client quite well, their own GP. The following interaction during an interview about an officer's particular case describes the slightly ambivalent view taken of evidence from the applicant's GP. It was generally felt they were always on the side of the applicant.

> Q: "The GP set out details of his traumatic childhood and numerous admissions to psychiatric departments and he stated that if he was to remain homeless he would, from the GP's point of view, his physical and mental health would deteriorate, and he was perceived to be quite likely to self-harm and attempt suicide…"
>
> A: "Right."
>
> Q: "…and I'm just wondering what your view of that GP opinion was, at that time, if you remember?"
>
> A: "I mean they're quite serious allegations. ....you'd, you'd have to sort of consider it very carefully. But, at the same time, the GP would always want to do their best for their patients, OK, so you'd have to look at sort of how did he qualify those statements. It's not enough to say he is X, Y, Z ... the GP would have to say, well he's X, Y, Z for these reasons. But, you know, having said that, if the GP has sort of raised it as an issue, then I suppose we'd have to sort of look at it quite carefully....you'd put it to MedicReview or the JAS team…I mean if the GP had such concerns…then you'd expect that GP to make an urgent referral to local Health Services in order for them to provide an appropriate level of care. And if the GP has sort of said that in a letter, but then not followed that up by making a referral, he's sort of kind of undermining his own argument really.

There was also a perception of GP's simply exaggerating their patients' conditions so as to enable an assessment of vulnerability and within this to not really understand vulnerability in terms of the homelessness legislation. Therefore, an assessment undertaken by internal medical assessors or MedicReview will be more objective and accurate. One officer commented:

> "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. 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."

One of the vignettes used during the homelessness officer focus group contained a letter from the GP stating the applicant was vulnerable, eliciting the following response:

> "Yeh, this is not enough. Coz the GP and the counsellor, they... they exaggerate in my eyes. I would want to get further information before I made my decision."

What the GP was viewed as important for, was to obtain information which verified what the client had said during the application and interview. There was a great deal of frustration if the medical evidence that had been requested did not come in, perhaps evidence of the performance and audit pressures on the Borough to make decisions.

> "But we've, actually have nothing besides his words, obviously, so he's saying this is in, and, and this is what's happening. But yeah, just got absolutely no information from, from his GP, from the hospital, don't know…Nothing, absolutely nothing on that one…Just keep chasing them and just hound them into the ground because I'm going to get hounded into the ground there…I need to chase them up…The, the thing is I've, see we've, we've got to, I suppose, decide if he's in a priority need…and if I don't get a response in like two weeks then we'll just have to go ahead with what we have and make a decision."

> "And that's after waiting, you know, between two and four weeks just, just to get a limited response from, from the GP or from, from the consultant. So time was also a factor in this as well."

Medication and the Internet

Despite many protestations as to not being medical professionals one striking feature was the regular referral to levels of dosage of medication. Medication seemed a very important proxy of vulnerability. However, it was not sufficient for applicants to be simply taking medication, what was important was the dosage of that medication.

> "....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, that basically gives an idea, well if he's on that sort of heavy medication then obviously he may have mental health issues that, that would impede his daily activity."

Frequently it was found that officers didn't have enough knowledge of medication, types or dosage, and when they were uncertain about a particular illness and the associated medication, the internet was used as a source of information. Officers would check information about an illness and what medication is for and the effects this could have on the client.

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

Role of the Applicant?

One question that kept springing to mind during the course of the research was where then is the voice of the applicant in all of this? The answer is that it is very little heard and could be perceived as relatively unimportant. Applicants are simply a conduit for giving access to information. Thus they are asked to complete the medical assessment form but:

> "[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."

Furthermore, following an interview and the completion of an application, sometimes there was a suggestion that officers held a level of mistrust about the information the applicant had revealed in relation to their medical issues and any anomalies would be 'found out' during the medical evidence collection process.

> "…from our point of view, to see that medical…, 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… well I'm not trying to…you know, I think that the clients would lie about this and that, it's not, but sometimes when they use it and they don't really need to use it. So it's not that, they, maybe they just feel that they need to use it without having a physical actual need to use it…"

'Gut Feeling'

While medical evidence and advice of medical professionals is no doubt important in assessing vulnerability, a substantial element of the decision-making process rests upon 'gut feeling' and what officers attributed to professional intuition.

> "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."

Conclusions

It has to be made clear that these are early findings, however, what we see here is perhaps an initial construction of the client taken from how they present that is somewhat similar to findings from Schneider (2010) who explored the work of supported housing representatives in Canada and how they categorise clients (with mental illness) as appropriate for housing. Determining eligibility in allocation of scarce resources (and the clear parallels here for homelessness officers in our London Borough), 'versions' of clients were constructed and utilised in decisions.

However, in the analysis of this first case study, essentially it was the view of the "experts" that appeared to be the most influential. It was certainly not the expertise of the applicant's own Doctor, which was often greeted with cynicism, but rather, that of the experts employed by the local authority. Having said this it was clear that types of illness, medication and dosage were important triggers in seeking the view of these experts.

Usage of the internet was found to be a common method of sourcing information on medical issues, medication and dosage where there existed gaps in the homelessness officer's knowledge. Whether or not on occasion this occurred as a reaction to the ambivalence of the assessments made by applicants' GP's is an issue to be explored further in the additional case study analysis. 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 deprofessionalisation thesis and could be seen as contributing to the decline in trust in doctors" (Hardey, 1999: 832). Hardey concludes that the internet forms the site of a new struggle over expertise in health that will transform the relationships between health professionals and their clients

and, one might argue, street-level bureaucrats such as homelessness officers, medical professionals, and applicants.

It became apparent during the course of the research that the voice of the applicant is unimportant. The homelessness officers felt they were constructing an objective reality and this is perhaps why medication and dosage was so fundamental in decision-making.

While the findings are currently inconclusive and we are awaiting data analysis of our other two case studies, it is evident that the officers here were relying heavily on, particularly internal, medical professionals as was found in the earlier cited work by Richardson and Machin (2000). Furthermore, the homeless applications are viewed with what Halliday (2000b) referred to as a professionally intuitive sense. Where analysis of medical evidence is a requirement these are the norms that are influencing their ultimate decision.

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