**Mental health and Homelessness**

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**Introduction**

This article was prompted by a seminar on ‘Housing, homelessness and mental health’ arranged by the Mental Diversity Law Network.[[1]](#footnote-1) The seminar included the lived experience of someone with knowledge of the links between housing and mental health services[[2]](#footnote-2) and a talk by Linda Clark of Changing Lives[[3]](#footnote-3) about the Mental Health Housing First service in York that was established in York in 2020 as a partnership between Changing Lives, City of York Council and Tees Esk and Wear Valley Mental HealthTrust. Kesia Reeves and Stephen Green from the Centre for Regional Economic and Social Research at Sheffield Hallam University talked about their research on homelessness, mental health and multiple disadvantage.[[4]](#footnote-4)

We presented some thoughts on the legal aspects of homelessness and how it intersects with people with mental health issues. Carla’s research has been on the changes to the Housing Act 1996, Part 7, made by the Homelessness Reduction Act 2017. For Caroline, this took me back firstly, to the cases on priority need and secondly, research I led 10 years ago on decision-making on priority need and in particular the use of medical evidence.

**Homelessness Law**

As noted above the statutory framework on homelessness in England, the Housing Act 1996, Part 7, was changed markedly by the Homelessness Reduction Act 2017. This added a layer of duties on local authorities that arise before the main homelessness duty. The key new duties are owed to anyone who is homeless (i.e. has no accommodation available[[5]](#footnote-5)) or is at risk of becoming homeless in 56 days, and is eligible for assistance[[6]](#footnote-6) (i.e. has recourse to public funds). Because the duties are open to anyone who is homelessness or threatened with it and eligible, the personal characteristics, such as the health of the applicant, do not matter in determining whether they are owed a duty. Local authority must take action without having to assess the medical needs of the applicant, that leads to the problems discussed below about medical evidence. This was deliberate - the 2017 Act was designed to open up assistance from local authorities to help more people than ever before.[[7]](#footnote-7)

The keys duties that we focused in the seminar were:

* The Prevention Duty - s.195
* The Relief Duty - s.189(B)
* The Duty to Assess an Applicant’s Needs and agree a Personal Housing Plan - s.189(A).

The prevention duty is focused on those at *risk* of homelessness within 56 days, while the relief duty is for those who then become homeless or who approach the local authority when already homeless. The prevention duty in HA 1996, s.195 requires the authority to ‘take *reasonable steps* *to help* the applicant to secure that accommodation does not cease to be available for the applicant's occupation.’[[8]](#footnote-8) By contrast the relief duty is to ‘take *reasonable steps* *to help* the applicant to secure that suitable accommodation becomes available for the applicant's occupation for at least 6 months.’[[9]](#footnote-9)

Key in deciding what reasonable steps to take under the prevention and relief duties is an applicant’s assessment of needs and a personal housing plan.[[10]](#footnote-10) Assessment of support is likely to be important for anyone experiencing mental health needs. But the duty is only to record support needs, not a duty to guarantee they are met. A personal housing plan is required,[[11]](#footnote-11) recording reasonable steps the local authority and the applicant are to take to find and retain accommodation.. Plans are supposed to be tailored to the applicant[[12]](#footnote-12) and so *should* take into account the effect of any mental health needs on suitability of suggested steps.

Both the prevention and relief duties can be ended due to a ‘deliberate and unreasonable refusal to cooperate’ with the plan.[[13]](#footnote-13) Little is known at the moment of the use of the ability to end duties in this way and the circumstances in which authorities will use it – but it creates a potential risk for misunderstood symptoms/behaviour (such as the symptoms of depression/anxiety) by applicants experiencing mental health need.

What is clear from these new duties is that there is still no obligation on an authority to provide temporary or settled accommodation to all who need it. Hence the full duty will remain very important for those with mental health issues. This of course means consideration of not only homelessness and eligibility, but also priority need[[14]](#footnote-14) and intentional homelessness.[[15]](#footnote-15)

If any applicant is homeless, eligible, in priority need and not intentionally homelessness the relevant authority ‘shall *secure* that accommodation is available for occupation by the applicant.’[[16]](#footnote-16) Although the duty can be discharged through a tenancy of at least 12 months,[[17]](#footnote-17) it is also the route into a social tenancy.[[18]](#footnote-18)

**Priority Need**

Turning to priority need, applicants with mental health issues may fit under any of the priority need criteria. However, most of the issues arise in cases of people without children and for that reason in the seminar we focused on whether applicants are vulnerable. No doubt readers of the Journal will be familiar with the statutory definition in s.189 of the HA 1996 :

The following have a priority need for accommodation:

(c) A person who is vulnerable as a result of old age, mental illness or disability or other special reason…

The leading case on the meaning of the section is *Hotak*.[[19]](#footnote-19) As Justin Bates wrote in 2015 the decision of the Supreme Court ‘changed long-held conceptions about what it means to be “vulnerable” for the purposes of’ the HA 1996.[[20]](#footnote-20) Out was the *Pereira[[21]](#footnote-21)* criteria that the applicant was vulnerable if when homeless she or he was ‘less able to fend for himself than an ordinary homeless person so that injury or detriment to him would have resulted when a less vulnerable man would be able to cope without harmful effect.’

The Supreme Court found this formulation was not helpful. The comparator should be someone not homeless. Justin Bates’ article provided an excellent analysis of the decision.[[22]](#footnote-22)

In identifying the comparator, it may be that the easiest approach is to identify what factors cannot be taken into account:

* we know from the decision that an authority cannot take into account statistical evidence, whether as to the population as a whole or homeless persons. As the Supreme Court held "the use of statistics to determine whether someone is vulnerable is a very dangerous exercise whatever the correct test of vulnerability"[[23]](#footnote-23);
* furthermore, we know that an authority cannot take into account its knowledge (or, more accurately, the knowledge of its officers) as to the nature of the homeless population in its area. Not only is that now the wrong test, but the Supreme Court has rejected this approach as "likely to lead to arbitrary and unpredictable outcomes"[[24]](#footnote-24); and
* finally, we also know that the factors listed in s.189 do not, of themselves, make someone vulnerable, i.e. someone cannot be vulnerable simply on account of their age, mental health, etc. There must be something more.[[25]](#footnote-25)

But does this take matters very much further? If anything, it seems likely that this just makes the comparison more difficult by excluding from consideration information which might have been used to assess the traits of the ordinary person.

We are told, however, that the ordinary person is "robust and healthy".[[26]](#footnote-26) We also know that authorities are entitled to take into account support provided by third parties (whether family or statutory), so long as that support is provided on a "consistent and predictable basis."[[27]](#footnote-27) But that does not assist with the comparison between the applicant and the ordinary person, rather, it is a reason why an applicant who is prima facie vulnerable may nonetheless not be held to be vulnerable in any given factual scenario.

So the key issue is the particular circumstances of the applicant – their individual mental health. But how will local authorities make this decision? Homelessness officers are not medical experts – see below. Some may seek information from the applicants doctors, some have in-house expertise but many use medical external assessors – the most well-known one is NowMedical. In 2007, in the *Shala* case, Birmingham decided that a refugee couple were not in priority need based on the decision of NowMedical.[[28]](#footnote-28) The evidence from one the applicant’s own doctors was that she had PTSD and depression as well hypertension and osteoarthritis.

The Court of Appeal noted that the doctor at NowMedical had not examined the applicant and was not a psychiatrist – unlike the evidence provided by the applicant. The view of NowMedical taken by the Court was that they did not provide ‘medical evidence.’ Rather the role of the external advisor is to enable the authority to understand the medical issues, but no more that.

*Shala* was decided 15 years ago. However, it is clear that the issue has not gone away. Two recent cases in the county courts from 2021 and 2018 demonstrate this. The first one involved a 23 year-old woman with a learning disability.[[29]](#footnote-29) The local authority preferred the views of NowMedical to the applicant’s own psychiatrist and social worker. The decision was varied to priority need.

In the second the applicant was a 40 year-old man.[[30]](#footnote-30) He had been homeless for 4 years and had been the victim of a serious assault 2 years before he became homeless. The evidence from his doctors was that he had PTSD which was continuing and of depression of a moderate severity as well as cannabis dependence and a concern with a risk of suicide. NowMedical did not meet or examine the applicant but advised that the applicant was not in priority need. Again, the court varied the decision.

**Decision-making in local authorities**

Turning to the research on decision-making,[[31]](#footnote-31) homeless officer are very aware that they do not have medical training and advice from professionals is needed to make a decision.

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…’ (Homelessness Officer)

They are also quite sceptical of the external advice they might receive.

[External advisor] 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. (Homelessness Officer)

However, they are also ambivalent towards medical evidence from the applicant’s GP. There was a consensus amongst officers that GP’s exaggerated their patients conditions and that they did not understand what ‘vulnerability’ meant in the context of the 1996 Act.

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. (Homelessness Officer)

Perhaps the most surprising founding from the research was that for officers medication an important proxy for vulnerability. Dosage was especially important and the Internet was used to check dosages and other medical queries where the officers lacked knowledge.

....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. (Homelessness Officer)

**Conclusions**

This seminar gave us an opportunity to return to these important issues and reflect on recent legal developments. It is clear that prevention and relief duties discussed above make desirable developments to the law in removing previous barriers to assistance, and any actions taken by the local authority in assisting applicants in these early stages should be more sensitive to, and inclusive of, any mental health needs.

However, these duties are ultimately limited in scope, meaning many applicants will still filter through to consideration of priority need, where non-expert housing officers will make decisions as to whether an applicant’s medical needs make them vulnerable enough for the provision of accommodation.

As a result of new duties to assess an applicant’s needs, there is now more available data on the characteristics of applicants, which tells us that the most common support need reported for single households is a history of mental health problems.[[32]](#footnote-32) This simply highlights the urgent need for further research on the extent to which mental health problems reported by applicants are adequately met under the homelessness statutory framework. Further, exploration of recent case law above suggests people with mental health needs still struggle to be recognised as in priority need. There is, again, need for further research on whether developments under *Hotak* have made any difference to assessments of vulnerability, and the remaining barriers faced by applicants in asserting their case. We are left questioning whether the statutory homelessness route remains the best way into stable housing.

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   The Mental Diversity Law Network (MDLN) is an interdisciplinary network of approximately 200 people with academic, professional and/or lived experience of mental differences or difficulties, care givers, and other stakeholders with an interest in the law as it relates to mental diversity. The network hosts a biennial conference (the next in the early summer of 2023), plus a selection of smaller online and in person events. Our web site is at https://institutemh.org.uk/mentaldiversitylawnetwork. [↑](#footnote-ref-1)
2. You might think this is virtually every user! [↑](#footnote-ref-2)
3. https://www.changing-lives.org.uk/about. [↑](#footnote-ref-3)
4. See: Reeve, K. and others (2018), *The mental health needs of Nottingham's homeless population: an exploratory research study*, Sheffield: Sheffield Hallam University and Fulfilling Lives LSL and others, (2021) *Re-thinking Outcomes: A guide for commissioners of services designed for people experiencing multiple disadvantage*, https://www.thinknpc.org/wp-content/uploads/2022/02/Re-thinking-Outcomes-Guide-for-Commissioners.pdf [↑](#footnote-ref-4)
5. See the Housing Act (HA) 1996, s.175. [↑](#footnote-ref-5)
6. See HA 1996, s.185 and Allocation of Housing and Homelessness (Eligibility) (England) Regulations 2006 (SI2006/1294, as amended). [↑](#footnote-ref-6)
7. Foreword to Sutton-Hamilton, C., Allard, M., Stroud, R., and Albanese, F. (2022) “I hoped there’d be more options:” Experiences of the Homelessness Reduction Act, 2018-2021. London: Crisis. [↑](#footnote-ref-7)
8. HA 1996, s.195(2). [↑](#footnote-ref-8)
9. HA 1996, s.189B(2). [↑](#footnote-ref-9)
10. HA 1996, ss.189A. [↑](#footnote-ref-10)
11. HA 1996, ss.189A(4). [↑](#footnote-ref-11)
12. See the Homelessness code of guidance for local authorities, para.11.18, https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/chapter-11-assessments-and-personalised-plans. [↑](#footnote-ref-12)
13. HA 1996, ss.193B, 193C. [↑](#footnote-ref-13)
14. HA 1996, s.189. [↑](#footnote-ref-14)
15. HA 1996, s.191. [↑](#footnote-ref-15)
16. HA 1996, s.192(3). [↑](#footnote-ref-16)
17. HA 1996, s.192(7AA). [↑](#footnote-ref-17)
18. HA 1996, s.166A(3). [↑](#footnote-ref-18)
19. *Hotak v Southwark LBC; Kanu v Southwark LBC; Johnson v Solihull MBC* [2015] UKSC 30. [↑](#footnote-ref-19)
20. J. Bates ‘The Ordinary Person’ [2015] JHL 63, p.63. [↑](#footnote-ref-20)
21. *R. v. Camden LBC, ex p. Pereira* (1998) 31 HLR 317. [↑](#footnote-ref-21)
22. J. Bates ‘The Ordinary Person’ [2015] JHL 63, pp.65-6. [↑](#footnote-ref-22)
23. *Hotak* at [43]. [↑](#footnote-ref-23)
24. *Hotak* at [56]. [↑](#footnote-ref-24)
25. *Hotak* at [92]. [↑](#footnote-ref-25)
26. *Hotak* at [71]. [↑](#footnote-ref-26)
27. *Hotak* at [95]. [↑](#footnote-ref-27)
28. *Shala v. Birmingham C.C.* [2007] EWCA Civ 62. [↑](#footnote-ref-28)
29. *SR v Lambeth London Borough Council,*County Court at Central London, 21October 2021,  [↑](#footnote-ref-29)
30. *Cherry v LB Tower Hamlets*. County Court at Central London, 11 January 2018, https://nearlylegal.co.uk/2021/11/recitation-is-not-application/https://nearlylegal.co.uk/2018/01/failure-engage-medical-advisors-homeless-vulnerability/ [↑](#footnote-ref-30)
31. For more on the research see: Bretherton J., Hunter C and Johnsen S. (2013) “‘You can judge them on how they look…’: Homelessness Officers, Medical Evidence and Decision-Making in England” *European Journal of Homelessness* 7(1), pp. 69-92. [↑](#footnote-ref-31)
32. DLUHC, Statutory Homelessness Annual Report 2021-22, England, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1105577/Annual_Statutory_Homelessness_release_2021-22.pdf> page 15. [↑](#footnote-ref-32)