Bulletin 162 7

Attendance = mental or physical disability

(disagreeing with CSDLA/268/1995)

SOCIAL SECURITY AND CHILD SUPPORT COMMISSIONERS

Commissioner's File No.: CDLA/778/2000

Starred Decision No: 32/01

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32/01

CF **CDLA/778/00**

1. This appeal, brought with leave of a Commissioner, succeeds. The decision of the Disability Appeal Tribunal on 11 1 99 was erroneous in point of law, for the reasons given below, and I therefore set it aside. I had hoped to be able to give my own decision, but on further consideration of the evidence there are too many unanswered questions (see below) for me to be able to do so. I therefore remit the appeal to a differently-constituted tribunal for determination.

2. I directed an oral hearing because I wanted to know more about the mechanism, both physical and mental, of alcohol dependency, and to be brought up to date on the DSS view of the law following the conflicting decisions in CSDLA/268/95 and CSDLA/171/98. The appellant was represented by Mr Mark Stanyer of Coventry CAB. He had taken a lot of trouble to obtain the further information I had asked for: see his letter at pages 152-3 to Dr Cameron of the University of Leicester Community Alcohol Team, and Dr Cameron's detailed response at pages 154-6, for which he made no charge. He recommended a booklet called *Medical Students' Handbook: Alcohol and Health* which I found so useful that I have selfishly kept my copy rather than placing it on the file. I am afraid Mr Stanyer will have to provide another copy for the tribunal. The DSS was represented by Miss Anna Powick of the Solicitor's Branch. I am very grateful to both of them for their help.

3. The appellant, born on 30 9 55, suffers from alcoholism and anxiety/depression. I say alcoholism, but the material I have seen suggests that this is not a very useful term. Dr Cameron recommends reference to "problems related to habitual heavy use of alcohol and on occasions to dependence upon alcohol". It seems from the CAB submission to the tribunal (pages 109A-C) that the appellant had a breakdown after the death of her mother in 1991, and was admitted to a psychiatric unit. A number of other deaths of friends and family followed, and the appellant became depressed and drank, so that the more depressed she got the more she drank and the more she drank the worse the depression became. She has been detoxed both in hospital and at home, with support from her husband and a CPN, but continues to drink heavily. She attends the Alcohol Advisory Service and a programme of stress management.

4. The claim pack dated 24 3 97 stated a variety of both mobility and cae needs. The GP reported severe alcoholism and recurrent abdominal pain and attacks of vomiting and diarrhoea which were not necessarily related to excess alcohol at the time they occurred. She would need constant supervision during these attacks, which occurred from weeks to months apart. He referred to the efforts at detoxification but continued drinking and said the appellant was still under a consultant psychiatrist (he has since retired). Another GP in the same practice in October 1997 confirmed the history of treatment and said that she had been more successful "presently" in abstaining from alcohol but had relapsed frequently in the past. During relapses she had multiple symptoms, including depression and low mood and a need for help with motivation, dressing and taking her medication. She could become aggressive and confused and had difficulty in sleeping. She also had a pain in her side and attacks of vomiting, but frequent admissions to hospital and investigations had failed to find a cause.

5. An EMP visited on 11 11 97 to examine for the care component, and found the appellant (page 95) lethargic and unsteady on her feet. Her speech was alow and slurred and she claimed to be unable to do a number of physical actions, though no obvious physical disability was observed when she undressed. Peak flow (she uses an inhaler, but her doctors have not mentioned asthma) could not be properly tested. She said she fell daily and blacked out about 4 times a week. She needed prompting to get out of bed (and to go to bed at night), to wash and to eat. She often wandered out and forgot to come back. She dropped things, including cigarettes, and needed watching day and night, though she did not usually have blackouts at night. The EMP accepted a need for help (prompting) to get in and out of bed and to take a bath or shower and for observation in case she fell using the stairs or moving around indoors, and found she could only cope with hot pans with someone else's help. She needed supervision for dangerous behaviour, and there was mention of a suicide attempt.

6. However on 9 12 97 a different EMP visited to examine for the mobility component and found the appellant cheerful and chatty, lying comfortably on a settee, alert and orientated, with spontaneous speech and smiles. Rapport, eye contact, speech, mood, memory, intellect, concentration and social interaction were all normal, and there were no

obvious physical disabilities except tenderness in the epigastrium. She told this EMP that all days were bad and that day was a bad day. The doctor considered that 20% of the appellant's diminished walking ability was due to physical factors, the remainder to psychological interpretation of the physical problems. He clearly knew about the alcoholism (page 92) and about the anxiety and depression, but found no signs of the latter and seems to have found no signs of the former. This may be because, as he also recorded, the appellant had been sober for a week.

7. These two visits, less than a month apart, certainly suggest that when the appellant does abstain from alcohol her condition improves dramatically, at least to an objective observer, though she herself does not admit a difference. Her case, as I understand it, is that her needs do not vary even when she is not drinking, she still gets confused, gets panic attacks outdoors, has pain in her side and sometimes gets attacks of vomiting and diarrhoea. I do not understand her advisers to dissent from the second EMP's report, but they submit that overall her needs are more accurately reflected by the claim pack and the first EMP's observations.

8. The evidence the appellant gave the tribunal was somewhat contradictory, as can be seen from the record of proceedings. She stated variously that she had no physical disabilities, that she had started drinking to ease the pain in her side, that she drank to calm the panic, that alcohol was her main problem, that her condition varied, that she had recently cut down on drinking, that she never went out alone and that her husband went out to buy her drink to stop her going out on her own. She had additionally begun to suffer from a degree of stress incontinence over the last 10 weeks. She was drinking 2-3 bottles of cider a day and sometimes vodka. She drank at home when on her own and hid the drink from her family. She had stopped taking the Antabuse she had been prescribed. The tribunal recorded much of this evidence in its full statement It noted that her history of abstention was that she drank more than she abstained, but she had been able to stop drinking to attend her daughter's wedding.

9. The tribunal relied on CSDLA/268/95 in finding that it was not obvious that chronic alcoholism could properly be described as a physical or mental disability. The appellant could control her drinking if she had the self-control, and indeed had done so in the past, and particularly the previous

year when she had stayed dry to be able to attend her daughter's wedding. It attributed the more severe of her problems to alcoholism, which caused her anxiety and depression, and therefore declined to take them into account. Her various other physical problems were not sufficient for her to fulfil the criteria for DLA.

10. I find two difficulties with this otherwise very careful decision: CSDLA/171/98, which expressed a different view of alcoholism, was not cited to the tribunal, and there was evidence (apart from the appellant's own contradictory oral evidencel) that her anxiety/depression preceded her drinking, which even CSDLA/268/95 accepted as in principle allowing the effects of alcoholism to be taken into account. I must therefore set the decision aside.

11. However, there is a vast amount of evidence and, as I have tried to highlight above, some of it is contradictory. I am not clear, for example, why on the days when the appellant is not drinking her problems should continue to be as bad as on the days when she is. Nor am I clear how she manages to avoid being a danger to herself when, according to her evidence, she is left alone at home during the day. She says she never goes out alone (and her husband buys drink for her to avoid this), yet told the first EMP that she wandered off alone. The EMP who saw her when she had been sober for a week found a very different woman from the EMP who saw her when she had been drinking. Physical withdrawal symptoms, according to Dr Cameron, take some hours to come on, and if the appellant has a pattern of drinking on some days but not on others there are likely to be at least some nights when she would not be troubled with them to the extent described. Her giving up of Antabuse, which induces unpleasant physical reactions if alcohol is drunk while it is being taken (page 43 of the*Handbook*) reflects adversely on her determination, though Mr Stanyer sought to attribute this to her overall mental state. On the other hand, many of the features of her condition as described do accord with the medical evidence I refer to below. I consequently find it impossible to make the decision myself on the evidence I have and must regretfully remit the case for further investigation. It occurs to me that the records from the appellant's consultant psychiatrist, Dr Rogers (now retired) might be useful.

The law

12. In CSDLA/268/95, Mr Deputy Commissioner Mitchell's view was that *except* where the alcoholism was attributable to some pre-existing recognisable and serious psychological disorder of which alcohol or other substance abuse was a symptom, ongoing alcoholism was a matter of weakness of character or lack of self control and was not a disability. Mental symptoms resulting from it would not fall to be taken into account. He cited R(A)2/92, where the Commissioner held that unsocial behaviour (aggression and irresponsible conduct) not attributable to a recognised disorder or mental condition could not be considered a disability. The disabilities asserted in CSDLA/268/95 were rather similar to those in the present case in so far as they consisted of a need for help in and out of the bath, danger in coping with hot pans, and panic attacks and aggression outdoors.

13. In CSDLA/171/98 Mr Commissioner Walker was dealing with a claimant whose primary disability was epilepsy, which the tribunal had associated entirely with his alcoholism. The Commissioner found that the tribunal had not adequately considered whether the epilepsy might have had some other, at least contributory, cause. He expressly dissented from the view of alcoholism given in CSDLA/268/95. The proper course was to assess whatever disabilities a claimant might have, physical or mental, irrespective of what caused them.

14 Miss Powick's reconciliation of these decisions, echoing the written submission of the Secretary of State's officer, was that adjudicating authorities must consider, in cases citing alcoholism as a disability, whether there is some pre-existing, underlying or resulting identifiable physical or mental condition and assess the effects of that condition - in the present case, the appellant's attested anxiety/depression.

15. Mr Stanyer cited the Tribunal of Commissioners decision in R(A)4/90, where a claimant persisted against all medical advice in overdosing herself with laxatives and as a consequence suffered from iatrogenic (induced by self-medication) irritable bowel syndrome. The Tribunal, with some hesitation, remitted the case for reconsideration of whether the claimant's attested psychiatric conditions meant that she no longer had any effective control over this otherwise foolish habit. Mr

Stanyer also relied on R(A)2/74 in arguing that just as other conditions can require consideration of the ratio of good days to bad days by reference to a week, it was permissible in his client's case to look at the ratio of good spells to bad spells over a period of years. I did not understand Miss Powick to dissent from this, though she stressed that each case must be looked at on its own individual circumstances.

The medical evidence as to alcohol misuse

16 Both Dr Cameron's advice and the *Medical Students' Handbook* set out the physical and psychological effects of long-term heavy use of alcohol. The former tend to occur with greater and more regular exposure. They can include memory impairment and incoordination and difficulty in walking (as claimed by this appellant). Chapter 4 of the *Handbook* sets them out in more detail. Withdrawal symptoms include sweating, shaking, insomnia, over-arousal, and restlessness (all claimed by this appellant), and possibly confusion and hallucinatory phenomena. The chances of these are minimised if consumption is tailed off rather than cut off. They occur within a few hours of cessation and can go on for up to two weeks - or more if there has been severe and irreparable brain damage.

17. Psychological dependency can develop quite quickly, leading to anxiety if alcohol is not readily available. Chapter 5 of the *Handbook* explains how underlying depression or anxiety can both lead to alcoholism and be induced by it; and this association is more prevalent in women (page 9). The sometimes damaging interactions between alcohol and other drugs are set out at pages 42-43, and perhaps the rehearing tribunal could explore whether, given the medication the appellant is taking, this is likely to be occurring in her case.

18. Mr Stanyer urged me to have regard to the characteristics of alcohol dependency as a syndrome, as set out at page 1 of the *Handbook*, including persistence in drinking despite clear evidence and knowledge of the harm it is doing. Dr Cameron makes the same point in his paragraph C, where he says that one definition of dependency is an impaired ability to stop drinking despite manifest and obvious physical or social damage. He makes the further point that past behaviour is probably a better predictor of future behaviour than any other.

My conclusion

19. I do not think I have any choice, on the evidence before me, but to accept that alcohol dependency is *capable* in itself of being a physical or a mental disability, or both, and that to dismiss it as merely the result of weak will or a defective character is too summary. It is clear that the matter is far more complicated than this. As a matter of practicality, evidence of some other condition (be it epilepsy or anxiety/depression, and whether pre-existing or resulting from the alcohol dependency) will be looked for as an indicator of the severity of the dependency. I do not accept Mr Commissioner Mitchell's view that in the absence of an identifiable pre-existing condition nothing that results from alcoholism can be taken into account, and I prefer the view of Mr Commissioner Walker. This was, it seems to me, already established by the Tribunal of Commissioners in R(A)4/90, where an apparently much more readily-controlled condition, with no likelihood of physically harmful withdrawal symptoms, was held to be at least conceivably attributable to a purely psychological condition.

20. But I also endorse Mr Commissioner Walker's (and Miss Powick's) view that misuse of alcohol is a condition where medical evidence is of crucial importance. Each case must be looked at individually, and in the absence of convincing medical evidence adjudicating authorities should be slow to accept a claimant's unsupported assertion (or an assertion supported only by members of his immediate circle) that there is alcohol dependency requiring some level or another of DLA. It is not impossible, and the evidence does not require me to accept, that everyone who drinks to excess, so as to cause embarrassment and inconvenience to themselves and those around them, should be unable to stop. I appreciate that there will be some instances where a person has fallen through the net of support services; but if he has managed to claim DLA, he is to be expected, like every other claimant, to acquire the evidence to make out his case.

21. Where I do part company with Mr Commissioner Walker is in his view that no account should be taken of possible treatment in deciding on the length of an award. This stemmed from his concentration purely on the effects of drinking as opposed to a claimant's ability to control it, a conclusion with which I disagree. I take Mr Stanyer's point that past behaviour is an indicator of future conduct; but I also note with the present

appellant that when sufficiently motivated, as by her daughter's wedding, she was able to keep off alcohol so as to avoid embarrassment and enjoy herself. Motivation, and thus responsiveness to treatment, is something that can change with changing circumstances. Improved motivation and consequent abstention may also improve whatever physical or mental effects the drinking may cause. It should not be left to claimants to report improvements which would deprive them of benefit, only perhaps at some later date to be faced with repaying large amounts of overpaid benefit. Alcohol dependency is not a hopeless condition, and the benefit system should not contribute to a belief that it is. Awards should normally be made for a limited period, so as to allow an automatic review.

22. Whether in a rational society the law should require the payment of money to people who may simply spend it on more of what is doing them, and those with whom they come in contact, such terrible harm is not for me to say. The *Handbook* at page 45 observes that restricting the availability of alcohol, whether through taxation or limited licensing hours, though politically unpopular, is probably the most potent way of affecting the overall level of alcohol-related harm. But these are matters of policy.

23. The rehearing tribunal will investigate the matter afresh, and will bear in mind that because this is a pre-21 5 98 appeal, it will be able to carry its decision down to the date of its hearing. If it considers, having regard to the history, to any developments since the last hearing, and to any further evidence that may be produced that, overall and over time, the appellant satisfies the criteria for some level of DLA, it will so decide - making a staged award if appropriate. If it does not, it will explain why it so concludes.

(signed) Christine Fellner
Commissioner

26 February 2001