THE SOCIAL SECURITY COMMISSIONERS

SOCIAL SECURITY ADMINISTRATION ACT 1992
SOCIAL SECURITY CONTRIBUTIONS AND BENEFITS ACT 1992
SOCIAL SECURITY ACT 1998

Commissioners' Case No.: CDLA/1365/2005

APPEAL FROM A DECISION OF AN APPEAL TRIBUNAL
ON A QUESTION OF LAW

DECISION OF A TRIBUNAL OF SOCIAL SECURITY COMMISSIONERS

HIS HONOUR JUDGE HICKINBOTTOM, CHIEF COMMISSIONER
MR COMMISSIONER ROWLAND
MR COMMISSIONER JACOBS

Appellant:	**Ian Barr**
Respondent:	**The Secretary of State for Work & Pensions**
Tribunal:	**Manchester**
Tribunal Date:	**7 March 2005**
Tribunal Register No:	**U/06/929/2004/01773**

DECISION OF A TRIBUNAL OF SOCIAL SECURITY COMMISSIONERS

Decision

1. The decision of the Manchester appeal tribunal of 7 March 2005 is erroneous in law. We allow the claimant's appeal, set aside the decision and refer the case for re-hearing before a differently constituted tribunal in accordance with the law and directions set out below.

The Issue

2. This case raises issues in respect of whether and the extent to which the effects of alcohol consumption are relevant in determining entitlement to disability living allowance ("DLA"), particularly where the relevant effects are the immediate and transient consequences of that consumption.

The Facts

3. The claimant is now 55. His current problems appear to stem from 1979, when he fell from a roof, injuring his back and left arm. He claims to have suffered back pain (and has not worked) since, and to suffer from depression as the result of his injuries and consequent inability to work and lead a normal life. He has consumed large quantities of alcohol over an extensive period. He has said that he drinks more than 15 cans of lager a day, starting in the early morning and continuing throughout the day.

4. He first claimed DLA in 2002. The claim pack referred to problems with back pain, depression and anxiety; but the report from the claimant's general practitioner indicated that the claimant's main problem was "on-going chronic alcoholism. This would cause difficulty in all the areas questioned if he were intoxicated at the time". The Secretary of State obtained a report from an examining medical practitioner ("EMP"), who found the claimant intoxicated at the time of the examination. He was unable to examine the claimant's back properly, but took the view that "he certainly appears to need supervision for all aspects of personal hygiene and nutrition." On the basis of that report, the decision maker awarded DLA consisting of the mobility component at the higher rate and the care component at the middle rate, for two years.

5. In April 2004, the claimant submitted a renewal claim, which did refer to an alcohol problem, the claimant indicating that he drank because of his pain and depression. The Secretary of State again obtained a report from an EMP. This time the claimant was sober when examined and the report (which made no reference to alcohol) gave a very positive picture of the claimant's abilities. It found the claimant fully functional, and indicated that, by the claimant's own statement, this was his usual functional ability. No doubt relying on that report, the decision maker refused the claim from 2 October 2004, the renewal date. The refusal again made no reference to any alcohol problems.

6. With the assistance of a welfare benefits adviser from the local citizens' advice bureau, the claimant appealed to an appeal tribunal. In addition to the evidence mentioned above, the tribunal heard oral evidence from the claimant at the hearing, and had a letter from the claimant's doctor. That letter referred to the claimant's back condition, and continued:

"He also suffers from alcohol dependency syndrome and this has been a problem throughout the time that I have had any contact with him and has resulted in a number of attendances at hospital and admissions with complications of that alcohol problem including in 1996, haematosis, that is the vomiting of blood, and problems of acute pancreatitis in 2001. He has had several attendances at casualty as a consequence of falls which generally speaking appear to have occurred whilst under the influence of alcohol."

7. The tribunal dismissed the appeal. Given the legal and factual issues involved, the statement of the reasons is extremely brief, the essence of the reasoning being that "the problems complained of were related directly to too much alcohol, e.g., falling over when drunk rather than the conditions which may well have been the result of too much alcohol, i.e., pancreatitis and depression".

8. The claimant sought to appeal, directly challenging the correctness of CDLA/2408/2002, a decision of Mr Commissioner Bano which found that the immediate and transitory effects of alcohol consumption could not be taken into account in determining entitlement to DLA.

9. On 16 May 2005, the Chief Commissioner gave leave to appeal and, as the case raised a question of law of special difficulty, appointed a Tribunal of Commissioners to deal with it. There was an oral hearing of the appeal at which the claimant was represented by Mr David Forsdick (instructed by the Child Poverty Action Group) and the Secretary of State was represented by Mr James Maurici (instructed by the Solicitor to the Department for Work and Pensions). We are grateful to both Counsel for their helpful submissions.

The Law

10. DLA comprises two components (a care component and a mobility component), which are provided for by sections 72 and 73 of the Social Security Contributions and Benefits Act 1992 ("the 1992 Act") respectively. Section 72(1), so far as material, provides:

"Subject to the provisions of this Act, a person shall be entitled to the care component of a disability living allowance for any period throughout which –

(a) he is so severely disabled physically or mentally that –

(i) he requires in connection with his bodily functions attention from another person for a significant portion of the day (whether during a single period or a number of periods; or
(ii) he cannot prepare a cooked main meal for himself if he has the ingredients; or

(b) he is so severely disabled physically or mentally that, by day, he requires from another person –

(i) frequent attention throughout the day in connection with his bodily functions; or

(ii) continual supervision throughout the day in order to avoid substantial danger to himself or others; or

(c) he is so severely disabled physically or mentally that, at night, –

(i) he requires from another person prolonged or repeated attention in connection with his bodily functions; or
(ii) in order to avoid substantial danger to himself or others he requires another person to be awake for a prolonged period or at frequent intervals for the purpose of watching over him."

By virtue of section 72(4), the lowest rate is paid if one of the conditions of paragraph (a) is satisfied, the middle rate is payable if one of the conditions of either paragraph (b) or (c) is satisfied, and the highest rate is payable is one of the conditions of each of both paragraph (b) and paragraph (c) are satisfied.

11. DLA is not payable unless the overall effect of disablement is relatively long-term. Section 72(2) provides, so far as material:

"... a person shall not be entitled to the care component of a disability living allowance unless –

(a) throughout
(i) the period of three months immediately preceding the date on which the award of that component would begin; or
(ii) ...,
he has satisfied or is likely to satisfy one or other of the conditions mentioned in subsection (1)(a) to (c) above; and

(b) he is likely to continue to satisfy one or other of those conditions throughout –
(i) the period of six months beginning with that date; or
(ii) ...".

12. Although, because of the specific issues in this case, submissions concentrated upon the care component and section 72, some of the issues of principle raised also concern the mobility component. Section 73(1), so far as material, provides:

"Subject to the provisions of this Act, a person shall be entitled to the mobility component of a disability living allowance for any period in which he is over the relevant age and throughout which –

(a) he is suffering from physical disablement such that he is either unable to walk or virtually unable to do so; or
(b) ...
(c) ...
(d) he is able to walk but is so severely disabled physically or mentally that, disregarding any ability he may have to use routes which are familiar to him on his

own, he cannot take advantage of the faculty out of doors without guidance or supervision from another person most of the time."

By virtue of section 73(11), if section 73(1)(a) is satisfied there is entitlement to the higher rate and if only (d) is satisfied there is entitlement to the lower rate. Section 73(9) is almost identical to section 72(2).

The Correct Approach to the Legislation

13. The approach to "disablement" for the purposes of sections 72 and 73 was recently considered in the Tribunal of Commissioners' decision CDLA/1721/2004 (to be reported as R(DLA) 3/06), particularly at paragraphs 33 and following. In that decision, in summary, the Commissioners identified the following propositions:

(i) DLA is a benefit for people who are so disabled that they need help to cope with their disability. The purpose of the benefit is to assist with the reasonable care and mobility requirements that result from disability.

(ii) "Disability" is distinct from "medical condition", "disability" being entirely concerned with a deficiency in functional ability, i.e. a physical or mental ability to do things. Whilst a medical condition may give rise to a disability (e.g. a condition that involves the loss of a limb would give rise to an obvious diminution in functional capacity), it may not do so (e.g. a life threatening but asymptomatic heart condition may not have any adverse impact on one's ability to care for oneself or be mobile without assistance). Sections 72 and 73 are entirely focused on disability.

(iii) However, the statutory provisions impose a number of limitations. First, the claimant must be disabled, i.e. have some functional incapacity or impairment. He must lack the physical or mental power to perform or control the relevant function. Second, even where there is a functional incapacity, that alone is insufficient for entitlement to benefit - for the purposes of sections 72 and 73(1)(d), the disability must be *severe* i.e. the disability must be such that it results in the claimant requiring the degree of assistance identified in the legislation (e.g., under section 72(1)(a)(i), the claimant must require attention for a significant part of the day).

(iv) The Commissioners conclude (at paragraph 42) that sections 72(1) and 73(1)(d) give rise to two issues. (i) Does the claimant have a disability, i.e. does he have a functional deficiency? (ii) If so, do the care or mobility needs to which that functional deficiency give rise satisfy any of paragraphs (i) or (ii) of section 72(1)(a) to (c) (and, if so, which) or (for the lower rate of the mobility component) section 73(1)(d)?

14. For the reasons set out in another recent Tribunal of Commissioners' decision (CDLA/2879/2004, to be reported as R(DLA) 4/06), section 73(1)(a) gives rise to some different issues. To satisfy the requirements for higher rate mobility component, it is necessary for a claimant to show that his symptoms or manifestations (even if physical themselves) have an identifiable physical cause. This is the only exception to the principle that the focus of the relevant statutory provisions is upon the *consequences* of a condition, not

its *cause*, this exception resulting from the binding effect of the Court of Appeal decision in *Harrison v Secretary of State for Social Services* (reported as an Appendix to R(M) 1/88).

15. In our view, these principles are the starting point for a consideration of the issue of the extent to which the effects of alcohol consumption are relevant in determining entitlement to DLA.

Alcohol Dependence

16. We had the benefit of written and oral evidence from Dr Helen Watts of the Central Medical Group of the Department for Work and Pensions. Dr Watts is not of course independent, but her expert evidence in respect of the effects of alcohol consumption and the nature of alcohol dependence was uncontroversial, compelling and extremely useful. We accept it.

17. She said that the long-term ingestion of significant quantities of alcohol may result in a wide variety of medical conditions, with mental and/or physical manifestations. Those with primarily mental symptoms include dementia and other cognitive impairments, psychoses (including Korsakoff's Psychosis), amnesia, depression and anxiety states. Those with primarily physical symptoms include cirrhosis (with associated encephalopathy, ascites or oesophageal varices), cerebellar degeneration, peripheral neuropathy, fits, pancreatitis, anaemia, and atrial fibrillation, cardiomyopathy and other heart conditions. Some conditions may have both mental and physical manifestations.

18. Alcohol dependence is a discrete illness, well recognised by the medical professions and manuals of diagnostic criteria. Alcohol dependence falls within the category of Substance Dependence in the current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association ("DSM IV"). The illness is diagnosed on the basis of a constellation of markers, as follows:

> "A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period
>
> (1) tolerance, as defined by either of the following:
> (a) a need for markedly increased amounts of the substance to achieve intoxication or desire effect
> (b) markedly diminished effect with continued use of the same amount of the substance
>
> (2) withdrawal, as manifested by either of the following:
> (a) the characteristic withdrawal syndrome for the substance ...
> (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
>
> (3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)."

The definition of Dependence Syndrome in the current equivalent World Health Organisation manual ("ICD10") largely corresponds.

Common Ground

19. The diagnostic definition is expressed in terms of manifestations rather than causes. However, Dr Watts' evidence was that alcohol dependence had a mental cause, in that it had a psychological or psychiatric cause which, insofar as science currently understands the conditions, may result from some activity at receptor level in the brain. On the basis of this evidence it was common ground (with which we agree) that physical symptoms or manifestations flowing from alcohol dependence alone do not result from an identifiable physical cause. In the light of *Harrison* and CDLA/2879/2004, it follows that a claimant is not entitled to higher rate mobility component if the only disability on which his claim is based flows from only such a cause.

20. Two further matters were common ground.

21. First, if a separate medical condition arises from the excessive consumption of alcohol, then any disabling manifestations of such a condition can be taken into account in assessing entitlement to the care component and the lower rate of the mobility component of DLA, whether or not the ingestion is related to alcohol dependence. If the disabling manifestations also have a physical cause, they can also be taken into account in assessing entitlement to the higher rate of the mobility component.

22. We agree with these propositions because DLA is focused on needs resulting from disability, rather than the cause of disability, and therefore a claimant is not deprived of the benefit simply because the condition from which the disability arises may have been self-induced or the result of a negligent or reckless or morally reprehensible or even criminal course of conduct on his part. As indicated above, long-term ingestion of significant amounts of alcohol (whether or not this consumption results from dependence or voluntary abuse) may result in cirrhosis, or pulmonary or neurological conditions, or any of the other medical conditions identified by Dr Watts and those medical conditions might give rise to their own

consequences in terms of disablement. Simple drunkenness can also give rise to a separate medical condition. A claimant may fall down a flight of stairs because he is intoxicated, breaking a leg. The functional deficiency resulting from the broken leg would be a disablement relevant to DLA (although probably too short-term to result in an award unless there were medical complications).

23. Second, the transient and immediate effects consequent upon a person *choosing* to consume too much alcohol are *not* to be taken into account in determining entitlement to DLA. Bearing in mind the purpose of the statutory provisions, this would appear obvious; but, as a matter of statutory interpretation, why?

24. Both parties submitted that it was because the effects could not be regarded as the result of disablement if they were the result of choice; but choice alone cannot be determinative. If the long-term conditions arising from alcohol ingestion referred to above occur, then their consequences will be taken into account in assessing entitlement to DLA whether the ingestion of alcohol resulted from dependence or was by way of free choice. However, not every restriction of action is a "disability" (see paragraph 39 of CDLA/1721/2004). Just as someone who agrees to have their legs temporarily bound might not properly be described as "disabled" (because the functional incapacity is both transient and by choice), so it might be that the transient effects of the voluntary consumption of alcohol also cannot properly amount to disablement.

25. However, even if, given the breadth of "disablement" in terms of functional incapacity or impairment after CDLA/1721/2004, such effects can properly be said to result in a disability, there is no entitlement to DLA unless the disability is so "severe" that one of the statutory conditions for entitlement to benefit is satisfied. Thus, where section 72(1)(a)(i), (b)(i) or (ii) or (c)(i) or (ii) is in issue, attention, supervision or watching over is not *required* if the claimant can reasonably be expected to avoid the need for attention or supervision by controlling the consumption of alcohol. Where the "cooking test" for the care component or the mobility component is in issue, the legislation does not expressly refer to a requirement for help; it refers simply to an inability to prepare a cooked main meal, an inability to take advantage of the faculty of walking without guidance or supervision or an inability, or virtual inability, to walk. However, it is implicit in the scheme of the legislation that, where the "cooking test" is satisfied, the claimant is to be taken to require another person to prepare or help prepare a cooked main meal and that, where either of the relevant conditions for entitlement to the mobility component is satisfied, the claimant is to be taken to require help with mobility (although not necessarily from another person in the case of the higher rate of the mobility component). Looked at from that perspective, it is quite clear that those conditions for entitlement should be approached in the same way as those where there is an express condition that attention, supervision or watching over be required. The conditions are not satisfied where the claimant does not *require* the help contemplated by the legislation because he or she can simply avoid getting drunk.

The Principal Issue

26. Therefore, much was common ground between the parties; but there was a substantial issue between them concerning the extent to which the immediate and transient effects of alcohol consumption are to be taken into account in assessing entitlement to DLA. As

indicated above, it was agreed that, if the consumption was by way of choice, then they must be left out of account. However, if the consumption resulted from alcohol dependence rather than choice, it was submitted on behalf of the claimant that they should be taken into account for all rates of both components, with the exception of higher rate mobility. For the Secretary of State it was contended that such effects ought never to be taken into account, even if resulting from dependence rather than choice.

27. Mr Maurici for the Secretary of State relied on the reasoning of Mr Commissioner Bano in paragraph 11 of CDLA/2408/2002, where the Commissioner said:

> "Section 72 of the Social Security Contributions and Benefits Act 1992 confers entitlement to the care component of disability living allowance on a person who is *so severely* disabled physically or mentally *that* he requires in connection with his bodily functions attention from another person, and in *Re H (a minor)*, reported as R(A) 1/98, the Court of Appeal accepted that the severity of a disablement is a function of the need for care. A person who is intoxicated by alcohol may require attention in connection with bodily functions such as standing and walking, but the amount of alcohol which the person has consumed, and hence the extent of the person's need for attention at any particular time, will depend on factors such as the availability of alcohol, the extent of the claimant's willingness to control his or her alcohol consumption, and the claimant's financial resources (which will of course actually be increased if benefit is awarded). (In this case the claimant's consumption varies from no alcohol on some days, to between five and fifteen cans of beer the rest of the time.) In the leading case of *Cockburn v Chief Adjudication Officer* [1997] 1 WLR 799 (reported also as R(A) 2/98) the House of Lords approved the passage from the decision of Mr Commissioner Monroe in C.A. 2/79, cited by Lord Bridge in *In re Woodling*, [1984] 1 WLR 348 (also reported as Appendix 2 to R(A) 2/80) that the provisions "are directed primarily to those functions which the fit man normally performs for himself." An inability to stand or walk unaided when intoxicated by alcohol is unrelated to any infirmity, but is a temporary effect which is a direct and natural consequence of the consumption of excessive alcohol. Since the nature and extent of the attention required by a person when intoxicated by alcohol cannot be directly related to the 'severity' of alcohol dependency (on the basis that such dependency, in itself, constitutes a physical disability), I consider that such attention needs should not be taken into account. Entitlement to lower rate mobility component and care component on the basis of supervision needs is also prescribed in terms of the severity of disablement as a function of care needs, and I therefore consider for the same reasons that the intoxicating effects of alcohol should also be excluded when considering those entitlement conditions. Similarly, the extent to which a person is prevented by intoxication from cooking a main meal is not related to the 'severity' of disablement, and I therefore consider that the intoxicating effects of alcohol should be left out of account when considering entitlement to lowest rate care component on the basis of the 'main meal' test."

28. However, this reasoning appears to be based upon a false premise, namely that alcohol dependence is a disability. It is not. It is a medical condition. Even where that condition is severe (e.g. where a withdrawal syndrome has included severe symptomatology, or cravings are still severe), the condition may not be disabling. At one end of the scale, a person may be so used to substantial ingestion that he or she tolerates alcohol, and can function in a

reasonable manner even whilst consuming large quantities. This scenario was specifically referred to by Dr Watts as a common one. On the other hand, a person with alcohol dependence syndrome may address his or her condition, and not drink alcohol. Whilst abstaining, again, he or she may be able to function perfectly well. The condition may be asymptomatic, just as a person may have a heart condition that is asymptomatic. Because of his apparent confusion between "medical condition" and "disability" (i.e. functional deficiency), we consider that the foundations of Mr Commissioner Bano's distinction between the effects of alcohol consumption and the effects of dependence are not secure.

29. The approach taken by Mr Commissioner Bano has not been universally followed by Commissioners. For example, in CSIB/287/2003, Mrs Commissioner Parker expressed some concern over his reasoning, indicating (in paragraph 18) that, if "the claimant has an uncontrollable physical addiction, then it is logical that the results of that addiction may be taken into account".

30. At the hearing, the following example - familiar in attendance allowance cases - was put to Mr Maurici. Suppose that a claimant is an elderly lady who has arthritis. She is not incontinent. However, when she wakes in the night to go to the toilet, she is stiff and in pain as a result of her arthritis. This impedes her in getting out of bed and making her way to the toilet. As a result, she often loses control of her bladder. These circumstances appear to us to be indistinguishable from the case of a person who is alcohol dependent and who, as a result, drinks to excess and becomes intoxicated. The claimant in the example does not have incontinence. Losing control of her bladder is the natural result of an overfull bladder and not directly the consequence of arthritis. And the loss of control may in part be attributable to other factors such as the layout of her home, the height of her bed, and the availability of aids. All of those factors may be affected by financial considerations. Subject to matters such as the use of a commode and restricting fluid intake in the evening, no one would deny that the circumstances of the claimant is this example are relevant to her entitlement to an allowance. We can see no relevant distinction between intoxication due to alcohol consumption consequent upon dependence and loss of bladder control due to loss of mobility consequent upon arthritis. The positions are in principle indistinguishable. Indeed, if anything, in our view the example would provide a stronger case for withholding benefit. The lady's overflow of urine is in no way connected by medical aetiology to her arthritis. There is a more direct causal link between dependence on alcohol and intoxication.

31. Part of the reason for the different conclusions reached by Mr Commissioner Bano and Mrs Commissioner Parker lies in the different approaches they took to the ability of a person dependent on alcohol to control his intake. Mr Commissioner Bano assumed a degree of "willingness to control his or her alcohol consumption". Mrs Commissioner Parker's approach was predicated on the consumption of alcohol being "uncontrollable". Mr Maurici and Mr Forsdick put the issue in similarly absolute and mutually exclusive terms; dependence (involving no choice) or voluntary consumption (involving an entirely free choice).

32. However, we do not see the issue in such stark terms. It is no part of a medical definition of alcoholism that the condition is "uncontrollable" in the sense that it is absolutely impossible for a person to control the condition, e.g. by becoming and remaining abstinent. We have already referred to the DSM IV diagnostic criteria for dependence (see paragraph 18 above). The definition is expressed in terms of consequences rather than causes and does not

imply a complete loss of control, although marker (2) implies that becoming abstinent may be difficult and even dangerous in the short term, markers (3) and (4) imply some loss of control and markers (5) to (7) imply at least a distortion of priorities. This definition shows that it is inappropriate to think in absolute terms of choice or no choice.

33. Rather than a clear-cut distinction between dependence and choice, in our judgment it is more helpful to think in terms of the degree of self-control that is realistically attainable in the light of all of the circumstances, including the claimant's history and steps that are available to him to address his dependence. A person who cannot realistically stop drinking to excess because of a medical condition and cannot function properly as a result can reasonably be said both to be suffering from disablement and to require any attention, supervision or other help contemplated by the legislation that is necessary as a consequence of his drinking. We can see no reason why the effects of being intoxicated should not be taken into account in determining his entitlement to the care component of DLA.

34. We find support for our conclusion in the lack of any policy rationale on which section 72(1) might distinguish between the short-term and long-term consequences of alcohol dependence. The Secretary of State was unable to suggest one, other than the point made by Mr Commissioner Bano that adjudication may in such cases be difficult because of the wide diversity of facts and circumstances that might arise. But that is true of many cases that fall within the legislation. Moreover, disentangling the effects of being drunk from the effects of medical conditions such as depression (which are often coterminous) would also be difficult if not impossible, and would always be required on the approach advocated by the Secretary of State. It is noteworthy that, in the appeal before us, the claimant contends that he began drinking to alleviate the pain from his back, and the consequences of depression and inability to work that resulted from his physical injuries. In this very case it would be an extraordinarily difficult task to tease out the effects of these various matters, which all ultimately stem from the claimant's aggregated medical conditions.

35. We record that neither Mr Maurici nor Mr Forsdick suggested that the fact that a claimant suffering from alcohol dependence might spend DLA on drink rather than the care he needs - a point alluded to by both Miss Commissioner Fellner in CDLA/788/2000 and Mr Commissioner Bano in CDLA/2408/2002 - is a material consideration. We agree that it is not. If it were, it would apply as much to those suffering the long-term effects of alcohol dependence as to those suffering the transitory effects. However, it does seem to us to be desirable that a claim for DLA by a person who is suffering from alcohol dependence should at least raise the question whether the assistance the claimant needs is help to stop drinking rather than help to deal with the consequences of drinking. Our approach does that. It requires the decision-maker or tribunal to consider whether the claimant could realistically be expected to reduce his or her consumption of alcohol so as to avoid the requirement for attention, supervision or other help upon which the claim for DLA is based.

36. A person who is properly regarded as dependent on alcohol may well have some ability to control his alcohol consumption without professional assistance. However, there is no reason why the possibility of the claimant's taking advantage of such assistance should not be taken into account in assessing the attention, supervision or other help that is required by a person who is claiming DLA. Dr Watts said that such professional assistance is widely available through the National Health Service, and that a detoxification course takes four to

six weeks. There would, of course, be a waiting period between referral and a course becoming available during which a claimant would still be drinking but, even so, we were told that, if successful, a programme of rehabilitation is likely to result in a claimant losing his dependence within the six month minimum period of entitlement laid down by section 72(2)(b) or section 73(9)(b) of the 1992 Act.

37. However, Dr Watts also said that, in a significant proportion of cases, programmes of rehabilitation are not permanently successful and patients relapse. Indeed, we observe that one of the diagnostic criteria for dependence is that the patient has failed to give up alcohol. For a particular claimant, rehabilitation may, therefore, not be a realistic possibility. It may have previously been tried with little or no effect; or the claimant may lack insight or motivation to such an extent that rehabilitation at that stage is not feasible. If rehabilitation is not currently feasible, we agree with Miss Commissioner Fellner who said in CDLA/778/2000 that the tribunal should recognise that this may change and fix the period of any award appropriately.

38. Therefore, a decision maker or tribunal considering a claim for DLA based on the short-term effects of alcohol dependence will wish to know whether the claimant has ever been referred for rehabilitation and, if so, the outcome; the reason why other possible courses of intervention have not been considered or considered but rejected; and what the prospects would be for a future referral or a further referral. The claimant's medical records will often answer at least the first of those questions. It is to be noted that a referral may have an effect not only on the transient effects of intoxication, but also on other adverse effects such as depression which, as we have indicated, may interact.

39. Where rehabilitation is not a realistic possibility, the transient effects of being drunk must be taken into account but will seldom, if ever, entitle a person to DLA by themselves. Significant consumption of alcohol alone will certainly not imply satisfaction of any conditions of entitlement. As we have indicated, Dr Watts said that one result of the significant consumption of alcohol is toleration, so that the same amount of alcohol has less effect. This is why many people who abuse alcohol nevertheless hold down jobs. It also has important implications for the proportion of time that a person who consumes too much alcohol is so drunk as to require attention or supervision. There is a spectrum of degrees of drunkenness and for only a small part is it likely that attention or supervision from another person will be both required and potentially effective. Quoting Dr Watts' evidence, someone who is intoxicated "will retain an awareness of surroundings and be able to relate to them until very late in the process. There would normally be complete recovery within about 6 hours of stopping consumption of alcohol." A regular drinker may therefore be rather less drunk in the morning than in the evening. The pattern of drunkenness during a day of drinking is material because entitlement under section 72(1)(b) depends on frequent attention or supervision being required "throughout the day". Attention, supervision or watching over may be required, but usually only when the claimant is most intoxicated. It is only the most seriously drunk people who require care on that ground alone. Such a claimant who vomits or is incontinent may need attention to clean himself and change the bedding. There may also be a risk of choking on vomit, which might require that the claimant be supervised or watched over. But we agree with Miss Deputy Commissioner Ovey's comment in CDLA/3542/2002 (with which Mr Commissioner Bano agreed in CDLA/2408/2002) that attention or supervision can reasonably be required only if something useful can be expected to result.

The claimant may be so intoxicated that any intervention would be either impossible or impractical. In those circumstances, the assistance would not reasonably be required.

40. Moreover, a claimant's own evidence on consumption and its effects may require some scrutiny and testing against other known facts. For instance, in the present case, the claimant said to the examining medical practitioner who saw him in 2002 that he drank 15 cans of strong lager a day. His representative's submission to the tribunal in 2005 said that he reported drinking "up to 12 cans of beer most days", which suggests that he does not drink 12 cans every day. If he claims to do so, he might reasonably be asked how he manages to pay for the drink he consumes. Realistically, his average consumption may be lower, although he may well drink 12 or 15 cans on some days. Therefore, although he appears to have drunk to excess over a sufficient period of time to have caused haematemesis and acute pancreatitis and frequent injuries due to falling, there may be very substantial periods when he is not so drunk as to require attention or supervision. Entitlement to DLA does not depend on satisfying the criteria on every day, but it does depend on being likely to satisfy them for a substantial proportion of the period for which benefit is claimed (R(A) 2/74, R(IB) 2/99 and *Secretary of State for Work and Pensions v Moyna* [2003] UKHL 44; [2003] 1 WLR 1929 (also reported as R(DLA) 7/03)). The words "most of the time" appear on the face of the legislation in section 73(1)(d) and it is without surprise that we note that the claimant in the present case does not seek the lower rate of the mobility component.

41. We also note that he claims the higher rate of the mobility component on the ground that his mobility is limited by his back pain, without drunkenness being prayed in aid at all. We have already explained that the effect of *Harrison* and CDLA/2879/2004 is that, as a matter of law, a claimant cannot base a claim to the higher rate of the mobility component on the effects of alcohol dependence unless the effects include a discrete medical condition with another cause that is physical. However, even if that were not so, it would be unlikely that the transient and immediate effects of alcohol consumption would advance a claim for the higher rate of mobility component very far, unless the claimant were suffering from some other serious disablement affecting his mobility, because it would be unusual for a person to be so drunk as to be virtually unable to walk for the greater part of most days and, if a claimant were, it might be difficult to satisfy the requirement imposed by section 73(8) that he or she be capable of benefiting from enhanced facilities for locomotion for most of the period of the award.

42. In reality, a person who is drunk severely enough and often enough to raise the possibility of entitlement to DLA on that ground alone is likely to be seeking the care component and have other serious problems that may themselves independently give rise to care needs. In such cases, the practical significance of our decision is that requirements for attention or supervision as a result of intoxication can be taken into account and aggregated with a claimant's other requirements, which makes it unnecessary to draw artificial distinctions between the causes of the various problems afflicting a person who is seriously disabled as a consequence of alcohol dependence.

Disposal and Directions

43. For the above reasons, the tribunal in this case was wrong simply to exclude from all consideration the effects of the claimant being drunk. We allow the appeal, set aside the tribunal's decision and remit the case for rehearing in accordance with our analysis of the law.

44. Mr Forsdick invited us to direct the tribunal to approach the case by going through specific questions he proposed, in turn. We decline to give that direction. The tribunal should be free to deal with the case in the way that it considers most efficient and effective given the evidence before it and the arguments presented to it. Tribunals are experienced at judging how best to conduct their proceedings and it is not for us to hamper them by imposing a rigid approach.

His Honour Judge Gary Hickinbottom
Chief Commissioner

Mark Rowland
Commissioner

Edward Jacobs
Commissioner

22 March 2006