How We Help Families and Advisors Address Addiction in Affluent Families

Building Leverage into Governance Documents for Earlier Intervention and Stable Recovery

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- Explains how therapeutic leverage (pressure) is used to encourage compliance with treatment recommendations.

Section B: Governance Recommendations

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Section D: Managing Problem Family Members

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- Suggested language for family control and governance documents for business, trusts, office, shared properties, and other family enterprises, as well as dispute resolution procedures.

Overview

In Article Four we discuss the importance of addressing addiction and other dysfunctions in governance documents and describe our suggested provisions to include in such documents.

- Examples of governance documents include trusts, wills, partnerships, limited liability, non-profit and other corporations, and real estate ownership agreements – anything regarding how family members relate to each other or to their assets and income.

Examples of problem beneficiaries and our advice on dealing with them are provided in Section B, with our Model Language for governance documents in Section E. This is by necessity a lengthy article because are discussing both treatment and trust/governance concepts that are unfamiliar to most readers, but vital to the well-being of your loved ones (aka beneficiaries) behavioral health disorders.

The core concept is to use access to funds and other family resources as leverage similar to the potential loss of license by pilots and physicians.

- The goal is to use this leverage to encourage the problem family member to seek help and follow treatment recommendations.

We call this **explicit leverage** because the suggested provisions specifically allow for terminating trust distributions, employment in the family business or access to other resources when problematic behavior first surfaces.

In addition, *Article Four* explains from the stages of recovery perspective the benefits of following our proposed process for managing addictive or other dysfunctional behavior – the clinical rationale for using leverage. Addiction is a very difficult disease to recover from. It takes much longer than 28 days in treatment, as you will see from reading Section C.

- It is the failure to continue on with recovery after treatment that leads to so many relapses and that is why leverage is needed - to assure compliance with post-treatment recommendations.

This is why before a family considers intervening strategies, they must first identify available leverage. Without leverage the addict may agree to go to treatment due to expressed "love" during an intervention, but fail to follow through on professional recommendations. Therefore, we believe in *Leverage First,* and managing the recovery process, as explained in Section D.

To be blunt, effective governance provisions are a key factor in winning the fight against addiction.

Principles Underlying Governance Provisions Leading Effective Outcomes

Before discussing our ideas and reasons for our suggested model language, we want to remind the reader of the principles that lead to effective outcomes for affluent families and their advisors. Governance leverage is not a strictly legal concept, but fits into an overall recovery process or model that is a combination of both structure and positive intentions, i.e.:

- Leadership at the top for addressing the problem
- Establishing a process for assessing or evaluating the problem
- Understand the reasoning behind the procedure for resolving the problem
- Commit to the goal of containing, managing and successfully resolving a chronic disease
- Be willing to incorporate leverage or pressure to encourage change
- Use licensed CD professionals to advise and support the family and their advisor
- Understand that effectiveness is dependent on early identification of problems
- Know that resolving addiction must be a primary focus of the family
- Act to align advisors and family with professional advice
- Be willing to fully fund the investment in recovery
- Above all, be fully candid as to issues and facts that might impair recovery

These are also excellent topics for family leaders to discuss when considering action to address dysfunctional family members. It is also a good checklist to review with their CD professional.

Building Leverage: Part of a Comprehensive Program to Combat Addiction

- *Leverage First,* discusses in detail why the PHP program is so successful, what elements we use with our clients and an overview of addiction and recovery. (Love may get the addict to treatment, but that does not lead to recovery!)
- *How To Implement Leverage*
- *Building Leverage Into Governance Documents*
- *Model Language*
- *Individual Change Strategies in the Absence of Explicit Leverage*
- Family/Group Strategies to Encourage Change
- *System Transformations To Support Recovery, Including Both Treatment And Affluent Family Systems*
- *Effective Treatment for Affluent Addicts*
- *Families, Wealth and Addiction Treatment.*

These articles are detailed, but designed to inform family members of what we have learned about addiction and recovery for the affluent, prominent and wealthy. Too many of our family members, friends and acquaintances have died from this disease and you, the reader, must take the time to become educated and advocate for quality services for your loved one.

Leverage, Quality Treatment, Systems Transformation and Change Strategies

These topic areas comprise a comprehensive, innovative and effective treatment model for affluent addicts, their families, advisors and trustees. While these topics are discussed in separate articles, it is their integration - individualized for each family and their addicted loved ones - which lead to improved recovery rates.

Be Persistent, Be Pro-Active

We hope our ideas about improving outcomes will encourage advisors to take a pro-active approach in addressing addiction in their client families, knowing that successful outcomes can occur for the affluent. In cases where addiction is not currently present in families or is too difficult to confront or arrest, our additional hope is that our articles will provide a platform for advisors to help their clients adopt measures to effectively address dysfunctions in future generations.

Section A: How Leverage Relates to Treatment and Recovery

High Recovery Rates for Pilots and Physicians

This article is the fourth in a series of articles on improving recovery outcomes for affluent addicts.[1] These articles describe our experience in using the physician programs (PHP)[2] as models for our work with our client families and their advisors facing addiction in a family member.

- The physician programs have proven recovery outcomes of complete abstention at the five (5) year mark of seventy-eight percent (78%).[3]

With the exception of airline pilots, no other group comes close to these outcomes. Such high success rates set a new standard for treatment results and provided us with the inspiration to improve recovery outcomes for other groups.[4]

- Addiction is the only field of medicine where physicians receive different treatment than other groups. (It is qualitatively and quantitatively better.)

That is why, after fifteen years of assisting clients, we now write our series of articles: so families, their advisors and professionals in the field can benefit from our work in applying the pilot/physician model to affluent family members suffering from alcoholism, drug dependence and other addictions.

We are pleased to find that our views are confirmed by a recent report discussing the excellent outcomes for doctors and efforts, including ours, in applying the model to other groups. This report, from the John B. McGovern Symposium, is entitled,

> *The New Paradigm for Recovery: Making Recovery – and Not Relapse – The Expected Outcome of Addiction Treatment* (Available on our website.)

We are proud to be part of an evidence based, best practices effort at improving treatment outcomes.

Effective Governance Provisions Critical in Supporting Long-Term Recovery

In our personal experience and professional practice, we observe that almost all affluent families lack effective means of addressing addiction in their loved ones. It is all well and good to discuss highly successful recovery programs, systems transformation and clinically appropriate and respectful treatment to improve outcomes, as we do in our other articles.

- **However, before these concepts come into play, the family must first overcome the problem of how to encourage the addict to enter treatment and remain active in a post-treatment program.**

One purpose in writing this article is to explain to the reader why governance provisions are critical to supporting long-term stable recovery for affluent addicts.

- Without such provisions, most addicts will continue to drink, use drugs and engage in similar addictive behavior because their money and other resources buffer them from the consequences of their addiction.

To be specific, we know people in these situations who stop only when they are so disabled they are institutionalized or dead. Unfortunately, their relatives and advisors lacked the legal tools to cut them off from their resources early on in their addictive careers. *These devastating losses must end now*!

Reducing Risk to Family Well-Being from the Predictable Disease of Addiction
Alcoholism, drug dependence, other addictions and significant mental health disorders are statistically probable and will occur in affluent families at an estimated minimum rate of 20%; often much higher.[5]

- As one of our advisor friends writes *"Culture Eats Structure for Breakfast"*[6], meaning these disorders will undermine the best family mission statements and succession plans and result in both the loss of wealth and cohesiveness[7].

Family leaders and their advisors need an effective **"game plan"** for addressing these diseases. We offer not only that "game plan", but also the reasoning underlying our recommendations. In our experience, addiction and mental health disorders are the leading cause of harm to families due to the combined monetary, personal and inter-generational damage generated by these diseases.

- To repeat, addiction and other behavioral disorders will be present in a significant number of your family members

The **only way** to improve outcomes is to use the medical board programs for physicians (called PHP).

Cancer Comparison
If similar statistics applied to cure rates for pilots and physicians with cancer or diabetes, families would be beating down the doors of hospitals and doctors' offices demanding the same programs for their relatives. *But most families and advisor have never heard of the PHP or pilot programs!* Treatment centers do not tell them about these programs. Success is not newsworthy, only tragic failures.

My interest in developing and using the ideas presented in this article and in working with families began after leaving treatment in 1995 and seeing so much relapse in the St. Paul recovery community. Then I saw this headline in the Hazelden Voice in **1998**:

> ***Airline Pilots Soar to Success in Recovery***
> ***92% of airline pilots in the Hazelden program were 100% abstinent for TWO years***

I then found out that doctors also had high recovery rates and began asking why other groups were not offered similar programs – receiving no coherent response. Then, in **2011**, the Medical Director at Hazelden wrote Redefining Addiction Treatment:

*Research has shown that physicians' health programs achieve extraordinary outcomes in substance use disorders (SUDs). One recent study demonstrated nearly 80 percent abstinence at five years. The success of physicians' health programs (PHP) in driving superior outcomes in addiction treatment raises critical questions about how treatment can be improved for all with SUDs. …**Why pay for multiple detoxes and no follow-up, indeed?**[8]*

Is this not amazing? It took 14 years for a major treatment center to make that statement. During this time thousands of addicts have suffered, many dying who could have benefited from PHP-type services.

This information is offered as an example of how indifferent treatment centers are to improving outcome rates. They provide treatment, not recovery. Unfortunately, there is still so much shame about addiction that few family members discuss their problems with family and friends, let alone advocate for better treatment.

- Addicts and alcoholics are sick people. They need educated, active family members to help them find effective treatment and encourage them to engage in post-treatment recovery activities, just like relatives who are sick with other chronic, life-threatening diseases.

Treat addiction like cancer – ask for help and talk about it. Become advocates for quality treatment. Families and their advisors must insist that treatment centers provide the same programs for their addicted loved ones as are provided physicians and pilots.

Creating Consequences

We are firm believers in *creating consequences* for active or potential users in affluent families.

- *As we emphasize in all our writings, the Al-Anon approach advocated by many Chemical Dependency (CD) counselors and treatment centers of waiting for the addict to suffer consequences from his or her use does not work for the affluent addict (see above).*

Having effective governance language in all succession planning and estate documents is one way of making sure that consequences are in place when indications of addictive disorders appear in family members (as they will, given statistical probabilities and family predisposition, as we explain in more detail in *Leverage First*).

When such language is missing, some families transfer their trusts to jurisdictions that allow "decantation" so that their family addicts cannot gain access to income or principal. (See our article on decanting in the Trustees' Handbook, referenced in the appendix.)

- Other families use a variety of methods to keep funds out of the hands of addicts – even if not entirely "legal" – so that money will not fuel their loved one's addiction.

Addicts tend to have very short time frames, as they need their drink, drug or other "fix" in a few days. They can't wait for the months it takes to file a lawsuit and appear in court. Also, during the litigation process, an addict will usually engage in negative behavior adversely affecting his/her legal case.

Given this reality, the general rule followed by many (but certainly not all) families is that they will do whatever it takes to keep money away from their active user in order for the addict to maximize opportunities to experience consequences from their addiction.

- However, this ad hoc approach usually is only partially successful and is generally viewed by the addict as "punitive and unfair" because he/she is being treated differently from other family members (never mind the logic behind the differential treatment).

Therefore it is far better to have in place effective governance provisions in advance of addictive or other dysfunctional or problematic behavior arising in a family member: particularly so, if all members are made aware of these provisions due to review and discussion at family meetings or individual review of governance documents with a trustee, counsel or advisor.

The PHP model: Building a Common Understanding of Treatment and Recovery
Addiction is one disease where many family members have different opinions - whether it exists in a loved one, and if so, what to do about it.

- The physician model, as applied to the affluent, provides a coherent, understandable and results-oriented structure for all concerned persons to rally around.

The focus is obtaining professional assistance and evaluations to aid family members and trustees in the decision making process – not simply hustling the addict off to treatment. It is a much more respectful process.

Some family member object to using leverage to encourage a loved one to seek professional assistance and comply with treatment recommendations. Three comments:
First, the addict always can refuse. He/she always has the option of living without the financial or other access to support provide by the family, trust or business.
Second, in all my years of volunteering in the Means and Prominence Program at Hazelden, I never met a beneficiary who said she/he was cut off too early. Many said just the opposite,
Why didn't they step in sooner? They could see I was addicted! Didn't they care about me?
Third, here is what Sally Satel, a noted addiction psychiatrist, said about waiting for your loved one to want to go to treatment:

> *A myth is that the addict must be motivated to quit – that, as it is often put, "You have to do it yourself."*
> *Not so. Volumes of data attest to the power of coercion in shaping behavior. With a threat hanging over their heads, patients often test clean.*[9]

The idea is keep the pressure on for treatment compliance and until the addict in recovery develops the internal motivation to want to do what is required to become sober.

Also remember that the PHP model we adapt to use with affluent families is an early intervention model – we don't want to wait for the addict to decide on his/her own to go to treatment because by that time the disease has progressed to the point where recovery is much more difficult and the damage is greater. Yes, your addict may become very emotional and often threatening when leverage is brought into the picture, but this is temporary and an expected part of the process.

Governance Leverage: Part of A Comprehensive Approach to Improve Outcomes

Of our articles, the first seven cover core components of our comprehensive program to improve recovery rates by using the PHP program as a model for our work with families. This article, as mentioned, is about inserting provisions into governance documents to use access to resources as leverage (and the clinical/treatment reasons for doing so). Similar language can be used in other situations such as employment agreements or entertainment contracts.

As readers have asked what to do when explicit leverage is lacking, we discuss various forms of non-explicit leverage in articles identified in the list in the appendix by by e-mail request.

Leverage is a Technique – a Means to an End

Leverage is pressure to encourage the addict to get help – but it is not a substantive treatment program. What good is it to have effective leverage, but ineffective treatment? Please see our list of articles in the appendix for our views on the clinical issues to be addressed in treatment and applying the PHP/Pilot model to affluent addicts. (Note, It is difficult to find treatment centers that will cooperate with our efforts to use this model, but some do exist.)

Using Leverage <u>Never</u> Means Cutting Off an Addict from a Support Structure or Contact

- Families must always remain engaged with their addict, even when "cutting off" access to funds or other resources.

While this article is not about using leverage, we do want to remind the reader to <u>always</u> stay engaged with the addict, particularly for the out-of-control addict who is on the loose or overdosing. By engaged, we mean, at a minimum, using experts to oversee the addict or making available services accessible by the addict. (See this footnote[10], and *Article Two* for more information on remaining engaged with an addict when funds or other direct support is cut off.)

SECTION A:
Process Focused Problem-Solving for the Dysfunctional, Underperforming, Economically-Challenged or Contentious Family Member

In Section A, we discuss our process-focused problem-solving suggestions for the dysfunctional, underperforming, or economically-challenged or contentious family member, including:

1. Problem Family Members
2. Using Requests for Funds as an Opportunity for Problem Solving
3. The Value of Professional Assessments and Recommendations
4. The Courts of Family Opinion and Law

The goal is to identify the problem underlying a dispute rather than engage in contentious arguments about money or other surface issues.

- This process often involves the use of professionals to advise family decision-makers on what help a family member may need to prevent the situation from reoccurring or otherwise identify problematic behavior that needs to be addressed.

Also, by using a professional, family leaders and advisors can divert pressure exerted on them to comply with requests for funds to a third party, often a useful tactic in maintaining good relationships with all family members.

We have written *Article 13* on the subject of the dysfunctional or underperforming trust fund beneficiary tactics used to crack open discretionary and restrictive trusts. *Article 14* is written for family advisors, referenced in the appendix. Our intention is not to duplicate the information in these articles, but simply to provide on overview of our thinking as it applies to problem-solving, based on our positive experiences in helping clients find solutions for their dysfunctional and/or addicted family members.

Parents, family office personnel, advisors, and siblings are often aware that a family member may be engaging in problematic behaviors but do not know what to do about it.

- Many believe they have to wait until this member has severe enough consequences to want to ask for help. This belief is incorrect.

For the affluent, resources postpone or assist in the avoidance of consequences from self-destructive or non-productive behavior until such behavior becomes severe, makes recovery difficult and harms future generations (if children are involved). In this section we discuss why a **process-focused problem-solving approach** is an effective early intervention protocol designed to provide support for change before problems become too severe to overcome.

1. Problem Family Members – Who Are They?

a) The Dysfunctional Family Member

The family member who appears to have problems with drugs, alcohol, over-spending, eating disorders, gambling, Internet or other seemingly addictive behavior. Because parents, advisors and trustees are not experts on addiction, they often wait until the evidence of dependence is overwhelming before taking action. By then it can be too late for the beneficiary to recover.

b) The Underperforming Family Member

The family member who is underperforming or non-productive (economically, socially and personally). Families and their trustees are apt to accede to requests rather than keep meeting resistance when asking the underemployed or non-employed offspring beneficiary to get his or her act together and become a productive member of society. As Dennis Jaffe, Ph.D. and James A. Grubman, Ph.D., point out in their article, *Acquirers' and Inheritors' Dilemma: Discovering Life Purpose and Building Personal Identity in the Presence of Wealth*,[11] growing up and living with money can be a disincentive to many next-generation family members in the challenging engagement of learning productive skills.

c) The Economically-Challenged or Contentious Family Member

Some family members, whether they are beneficiaries, shareholders, employees or simply offspring, will make extraordinary requests for funds. Regardless of whether these requests are permitted by trust language, family business policy or equity, these claims are pursued by putting pressure on parents, other relatives or advisors through a variety of methods too numerous to mention here.[12]

2. Use Requests for Funds as an Opportunity for Problem-Solving

Some form of family money - direct payments, subsidized living, trust distributions or employment in a family business - almost always sustains dysfunctional and underperforming family members. Other forms of family support are either direct (gifting or employment in a family business) or indirect, using family resources (house, paid vacations, subsidized events or common properties). The withholding (or reinstatement) of these resources is useful leverage – a tool to encourage a loved one to engage in a problem-solving process intended to identify needed assistance to help resolve or manage the problem. For family members asking for extra funds, similar opportunities exist.

Our suggested provisions permit a process to be initiated for evaluating questionable behavior through the use of experts. In this way, circumstantial evidence, such as signs, symptoms or behaviors indicating addiction, can be taken into account to provide assistance before problems develop into permanent impairments, with the attendant harm to finances and relationships. In cases where apparent difficulties do not rise to the level of addiction or severe dysfunction, appointing a professional to assess, advise and coach the underperforming family member is a much better option than simply providing support for a do-nothing lifestyle.

The procedure suggested here – appointing an expert to make recommendations - reduces pressure on a parent or trustee by diverting the decision focal point to an independent third party who absorbs the emotions often generated by such requests. For example, if

there is a history of overspending, an expert could be asked to help with review of the financial situation, budgeting and monitoring of ongoing expenditures, as a condition of receiving measured assistance to cover deficits.

3. The Value of Professional Assessments and Recommendations

We view our recommendations in the context of four recent trends in the trust and disability and addiction fields:

- First, as embodied in the writings of James (Jay) Hughes Jr., that wealth preservation in families results from shared expectations regarding behavior, is a dynamic process, and is dependent on the human and intellectual capital of its members.[13]
- Second, that adverse decisions regarding suspected addictive or non-functional behavior be grounded in the recommendations of qualified experts.[14]
- Third, recognizing that the concept of "entropy" applies to family systems and active attention to family well-being is needed to offset the momentum for disintegration and self-destruction.
- Fourth, the vast majority of people with seriously dysfunctional behavior as seen by outsiders do not perceive themselves in the same light.[15]

As to the latter point, an evaluation process using experts provides good feedback to break through this self-deception or, at a minimum, provide independent evidence of an alternative view the family can point to validate their concerns about their loved one.

In our view, these four trends now support a more active role by family members in developing creative solutions – not solely through their own efforts or devises – but by aligning with professionals with the skill sets to assess and make recommendations so as to identify and address the presenting problems underlying the requests for funds. Simply saying "no" is not a solution in today's world, as we have found in our practice.

4. The Courts of Family Opinion and Law

Making the correct legal decision is no longer sufficient. Family leaders and trustees must also manage perceptions within the family system, and, if needed, prepare for subsequent review by opposing counsel or a judge.

a) Family Opinion

The family member (beneficiary) may reject the assessment and recommendations, but then the family leader (trustee) can rely on the advice of a professional expert to support the denial of additional funds (distributions). One benefit is that in the "court" of family opinion, (or, if it comes to it, of law) the burden of compliance is on the beneficiary to follow recommendations. A second benefit is that reliance on experts takes the focus off money as the solution to the problem and puts the focus on the core issues leading to the request for funds. Furthermore, because the expert works for the family, the expert is also a source of ongoing advice and support for the family and advisors.

b) Law

A final and very important reason for using licensed professional experts to help resolve problems is that judges rely on their expertise: not only as expert witnesses, but also as key players in settlement discussions. Judges now are much more knowledgeable about

addiction since so many criminal cases are drug - or alcohol - driven. When a civil case involving addiction comes before them, they will use their best efforts to force the parties to reach an agreement that addresses the underlying addictive behavior. As a family, you want your expert on your side from day one so the expert is familiar with the history and source of the dispute.

Many disputes do not reach the level of actual litigation, but lawyers are often involved in negotiating or acting as an advocate for the disgruntled family member after his/her request for funding is rejected.

- From the family office, trustee or family enterprise perspective, it is extremely productive to use an expert early on in the process because that expert can communicate with the unhappy family member to find out what may be underlying the request for funds.

Subsequently, if the dispute does involve lawyers and litigation, a fact affidavit or evaluation report from the expert can be a crucial element in the case. Often times, the addict will self-disclose information that meets criteria for an addiction diagnosis or provide other information helpful to resolving a case. The family professional can also act in instances where the addict is in crisis by summoning assistance and encouraging the addict to get help.

c) Two Cautions

<u>The Expert Works Only for the Family</u>

The expert must always work on behalf of the family, family enterprise or trustee and never under any circumstances for the problem family member.

- It should always be made clear to the problem family member that *the expert works for the family*.

If the family member needs professional help, the family and family expert can encourage him or her to seek help, and can provide the names of referrals and offer to pay for these services, but the family expert must never become the therapist for the problematic person.

The family expert can speak with the problem family member, make suggestions as to referrals, explain the family's position or otherwise be in dialogue but it must be clear that these activities are done on behalf of the family. In volatile situations, as a protective measure, the advice of the expert the family is relying on should be communicated by counsel, if written, or in the presence of counsel if verbal. Sample language is the following:

> *We have received advice from our addiction expert that you need an inpatient evaluation to determine if you have an addiction issue. Therefore we can no longer provide you with funds until you complete the evaluation, including fully complying with all requests related to the evaluation process. We are now aware that we have been supporting what appears to be an addictive lifestyle and we are no longer in good conscience willing to do so.*

This type of communication helps cushion the expert from a direct attack from the problem family member and sends a very clear message that the game is over. **(Caveat: Don't cut off without a support system in place. See footnote 13.)**

The Expert's Qualifications Must Withstand Legal Scrutiny

Most interventionists do not hold state licenses, nor have they earned professional degrees. Therefore, if the family hires such an interventionist to work for them and lawyers become involved or the case goes to court, the interventionist will be dismissed as unqualified by opposing counsel or impeached in litigation.

A secondary issue is that these "non-qualifying" interventionists are often clueless when it comes to affluent family systems and may do more harm than good. Also, you, as the advisor, do not want to be in the position of explaining to your family leader why the chemical dependency helper you chose does not hold a state license or a professional degree from an accredited educational institution.

SECTION B:
Reasons Underlying Our Approach to Process and Recovery

In Section B, we discuss treatment and recovery concepts underlying our proposed management tools and governance provisions so the reader understands the reasons for our advice from a recovery perspective. Family Leaders must:

- Believe in the Program and the Process
- Understand the Stages of Recovery

As with our problem-solving suggestions, our discussion here is health-oriented – recovering from addiction, often with co-occurring disorders – takes many months.

One important factor in improving recovery outcomes is that family members and other leaders believe in the actions they are taking to help their addicted loved one.

- This section is intended to provide the reader with basic recovery information in order to understand the relationship between the language we advocate using and the stages of recovery from addiction.

To be blunt, it takes a long time for an addict to recover. The family needs to understand why they need to remain committed to a long-term recovery process and why they need the ongoing support and recommendations of the addiction professional - precisely the approach used by oversight boards for doctors and pilots.

1. Believe in the Program and the Process

Before covering the stages of recovery, let's look at four basic ideas previously discussed that help develop a belief in and commitment to our recovery ideas and action steps from:

- The medical perspective – addiction is a disease.
- The practical experience of "what works" – the pilot/physician model is highly successful and worthy of emulation.
- The legal perspective – the law supports decision-making based on evaluations and professional advice.
- The family systems perspective – family members and their advisors will need to work together to support sobriety.

One purpose in writing this article is to help develop and sustain confidence in family members and advisors so that the substantive recovery program and process to implement the program described in this article (and as further described in Article 6) will in fact be effective – that is, the addict will recover.

2. Stages of Recovery

But what does it mean to "recover"? What are the elements that comprise early stages of treatment? For most people treatment is a mystery. Let's take a brief look at all the stages of recovery and then examine stabilization, an area that trips up many affluent patients in early recovery, leading to relapse.

a) Recovery Takes Much More than Twenty-Eight Days

Many people view addiction as episodic and resolvable in 28-day inpatient treatment programs. That is not the case. A recent article in one of our professional addiction journals discussed the developmental approach to recovery and the six stages to achieving stable remission[16]:

- Transition *Recognition of Addiction*
- Stabilization *Recuperation*
- Early Recovery *Changing Addictive Thoughts, Feelings and Behaviors*
- Middle Recovery *Lifestyle Balance*
- Late Recovery *Family of Origin Issues*
- Maintenance *Growth and Development*

In our experience this is a two to five-year process depending on the progression of the disease, severity of use and co-occurring conditions (trauma, abuse, learning, mental health).

For family members, the process of *Changing Addictive Thoughts, Feelings and Behaviors* is obviously a good idea, but how does that happen? In a recent article in *Counselor Magazine*, the writer noted that adhering to treatment goals and positive interactions with the therapist often set the stage for significant breakthroughs in attitudes and commitment to recovery. The writer went on to identify five components in therapeutic sessions that over time factored into the change process:

- *"The therapeutic contract,* or roles played by client and counselor, whether treatment is conducted individually or in a group, as well as treatment model and session schedule, among others.
- *Therapeutic operations,* which include how the client presents his complaints and problems; how he thinks; how the counselor understands the client (e.g., diagnosis, case formulation); the strategy used (e.g., 12-step model); and how the client responds or cooperates with the interventions.
- *Therapeutic bond,* or the quality of involvement and rapport between client and counselor.
- *In-session impacts,* or therapeutic realizations, such as insights vs. confusion, relief vs. distress, as well as the counselor impact, such as frustration vs. feeling good about a session.
- *Temporal patterns,* or distinctive moments of facilitation as well as total number of sessions."[17]

While this is one description of the conditions leading to change in attitudes of the addict from addictive and hopeless thinking to a positive mindset of recovery, most other such descriptions cover similar elements. All require time: usually months, and sometimes years, to take place.

b) Transition: *Recognition of Addiction*

Inpatient treatment includes recognition of addiction, although partial or full recognition occurs for many prior to entering treatment. The one-time surprise intervention may get the addict or alcoholic into treatment, but long-term success is problematic because the person is often so angry he/she merely complies during treatment rather than getting on

board with an active recovery program.[18] In other words, the addict does not internalize the clinical data that he/she is addicted – this information is rejected. This is another reason why the emergency intervention is best used only when there is significant danger of harm to self or others.

c) Stabilization: *Recuperation*
Stage Two: Stabilization – Five Tasks to Facilitate[19]:

- Achieving Recovery From Withdrawal
- Interrupting Active Preoccupation
- Creating Short-Term Social Stabilization
- Learning Non-Chemical Stress Management
- Developing Hope and Motivation

It is no wonder that in-patient treatment is insufficient to assure abstention from use. The stabilization process, Stage Two, takes much longer than 28 days. For some drugs, benzodiazepines (Librium, Xanax, Klonopin, Ativan, etc.) and marijuana, it may take three weeks or more just to complete active withdrawal. These patients are just finalizing their withdrawal when it becomes time to leave the inpatient setting. Also, learning new ways of socializing and healthy responses to stress takes months for most people.

d) Early Recovery: *Changing Addictive Thoughts, Feelings and Behaviors*
For more intact patients, this process can begin during inpatient treatment in conjunction with Stabilization. However, for most addicts it occurs after leaving treatment, which is one reason why it is vital for them to engage in post-treatment recovery activities.

In addition to insufficient time devoted to recovery, another very serious barrier to successful outcomes for Transition, Stabilization and Early Recovery is that the addict must feel comfortable talking about his or her personal circumstances and feelings – getting honest is key.

- Affluent addicts do not feel safe in doing so and therefore actually get stuck back at the withdrawal and preoccupation stage[20] - a recipe for relapse.

How do we know this? From our experience in treatment centers and speaking individually with hundreds of affluent addicts as part of our recovery activities. As a side note, it doesn't take much in the way of a job or money to be considered "better off" than most people in treatment – stay-at-home moms, college students and professionals can be the objects of resentment by other patients and staff. Unfortunately, very few treatment centers work well with affluent patients.

3. The Process is Too Time-Intensive for Advisors and Family Members
Lawyers and others advising families or acting as trustees, do not have the time or skills to oversee these stages. Nor do family members, no matter how dedicated or devoted they are to their addicted loved one. The early stages of recovery are fraught with multiple barriers to recovery for affluent addicts. *Articles 5, 6* and *7* referenced on page 29 discuss many of these barriers. In our experience, few clients have successfully negotiated these barriers on behalf of a loved one without good fortune or the help of a supportive and respectful professional. In working with clients and reviewing

circumstances leading to relapse, failure to recognize these limitations is another major contributor to post-treatment relapses.

We discuss this information in the hope that the reader better understands the value of collaborating with addiction professionals in managing family members with what is a chronic disease, not a personal failure. As mentioned, the services provided by this professional are time-intensive and require much more availability than an office visit each week. (For a more extensive discussion of this program, look for the article *Achieving High Recovery Rates for the Affluent and Prominent.* Also see the discussion in the next subsection for examples of the specific services that constitute "counseling support and case management and " on behalf of the family and "support services" for patients after completing in-patient treatment, designed to address the problems associated with early recovery.)

SECTION C:
Management Tools for Dysfunctional, Underperforming, Economically- Challenged or Contentious Family Members

We follow Section B with suggested **management tools** for problem family members, with an emphasis on the importance of the family hiring a professional for the following services:

- Intermediary Between Family and the Addict on Behalf of the Family
- Family Support and Case Management Services on Behalf of the Family
- Personal Counseling and Recovery Support on Behalf of the Addict in Recovery
- The Underperforming or Financially-Challenging Family Member/Beneficiary

Our suggestions are designed to provide varying degrees of oversight and professional involvement as best fits the situation, using evaluations from the problem-solving process, if relevant and available.

1. Intermediary Between Family and the Addict on Behalf of the Family

The professional expert acts as the intermediary in situations where the relationship between the family/advisors and the addict/alcoholic has broken down and is not supportive of recovery. Sometimes this relationship generates such high emotions that it is better for no conversations to occur between the addict and family until both sides receive therapeutic help and several months pass. The expert then works with the family to better understand the addictive process, stages of recovery, and how to restore access to resources in ways that support the addict in his/her journey to sobriety. In the meantime, the professional acts as the communication link between the problem family member and parents/advisors.

Where money has been a source of conflict and dishonesty, the family or trustees may say:

> *Don't talk to us about money (and assets), talk to our CD expert. We will be happy to talk to you about any other topic.*

We have performed this role very successfully on behalf of several families and trustees. To reiterate, we act on behalf of the family, not the addict, although this role obviously involves a great deal of interaction between the professional and the addict.

2. Family Support and Case Management Services on Behalf of the Family

Family Support and Case Management services are provided on behalf of the family by an addiction professional who oversees the post-treatment recovery program of the addicted family member. The professional works for the family and not the addict, which helps to avoid conflict of interest and confidentiality problems. However, the professional does meet with the addict, checking on progress and helping communication with the family on various topics that may be hurdles and challenges in early recovery.

Case Management Services Include:

- Coordination of ongoing care (continuing care group, therapists, testing facility, other support groups, sober companions)
- Communication with providers
- Weekly progress meetings (as needed)
- Support for returning to work (within or without the family business)
- Support for reintegrating with the family
- Ongoing program monitoring
- Referral as needed
- Monitoring/observed drug testing
- Advice to client (family, advisors and trustees)
- Family meetings

These services are modeled after the successful programs, which emphasize the importance of following post-treatment recommendations and addressing secondary problems. The goal is to help families heal, communicate more effectively and make the most of their new recovery journey. Advice and support for family members, family office and advisors plays an important role in the recovery process. These conversations often occur at night and on weekends when concerned family members have time to reflect on the situation.

3. Personal Counseling and Recovery Support on Behalf of the Addict in Recovery
This service is for the individual in early recovery. It is also called "mentoring" or "coaching," but it is much more than those activities because it involves learning new skills to handle emotions and relationships. This takes time, encouragement, and the skills set of licensed alcohol and drug counselors and similarly-trained licensed professionals. The counselor may interact with the family, but does so on behalf of the addict in early recovery, as the addict is the client (paid for by the family).

Post-Treatment Counseling and Support Services include:

- Individual Counseling and Mentoring:
  Promoting positive change and healthier relationships within appropriate boundaries.
- Family Meetings:
  Improving interpersonal relationships, communication, and family dynamics, particularly affected by the addict's drug or alcohol use.
- Life Management Skills:
  Smoothing transitions to home, work or school.
- Relapse Prevention:
  Sound relapse prevention plans and skills.
- Clinical Transportation:
  Supervised by trained addictions counselors.

These services should be coordinated with post-treatment and continuing care recommendations and therefore require the patient to sign releases so his support counselor can receive treatment related information and can communicate with key family members, advisors and the family professional (if there is one).

4. The Underperforming or Financially-Challenging Family Member/Beneficiary
Be pro-active rather than reactive!

A great deal has been written about incentives to encourage next-generation family members to be productive, the thinking being that idleness leads to self-destructive behavior. In our view, a positive parental role model where Mom and Dad set the standard by what they do (not just what they say) is the best inoculation against many of the problems discussed in this article. Responsible parenting means discouraging alcohol and drug use by setting limits for teenagers and a good example through reduced adult drinking.

Jay Hughes

Next-generation members, regardless of whether they are productive or not, or whether they are asking for additional funds, will benefit from the ideas Jay Hughes discusses regarding the role of the trustee, the role of the beneficiary, and the trustee as "mentor" to the beneficiary in chapters ten, eleven and nineteen in his *Family Wealth* book. (See appendix B for a list of his suggested "Roles and Responsibilities for Beneficiaries and Trustees.") Similar concepts are useful for family members working in the family business, serving on boards or as preparation for future gifts or inheritances.

For the underperforming, non-productive, financially-challenging family member, entering into a dialogue based on the Jay Hughes list might change expectations about current or future payouts. It also is an opportunity for family office personnel or family leadership to acknowledge that they could have done a better job of preparing the family member for handling money or a career. Perhaps funding an educational plan or establishing a family bank to invest in potential businesses might be a way of making amends without the drawbacks of cash disbursements.

Job Qualifications and Training for Family Enterprise Positions

Some families are now requiring minimum qualifications, job descriptions and training in order to serve on boards or be employed in the family business. Why not use a similar approach for beneficiaries? The "job description" (the conditions for receiving distributions) could be developed by looking at the intent of the grantor as stated in the trust and any related writings.

While the reader may wonder what the direct connection is between these ideas and addiction, our goal is for families, their offices and advisors to understand the importance of having structures in place that will support recovery. It is very difficult to create expectations, job descriptions, educational requirements and the like ***after*** a family member is addicted and then tell him or her to comply when they return home from treatment. Because all these ideas help prevent addiction, why not consider implementing them as a matter of policy before serious problems develop? It will make our job easier and save a lot of family anguish since the requirements and standards will already be in place.

SECTION D:
Provisions for Alcoholism, Drug Addiction, Other Addictions, and Mental Health Concerns in a Beneficiary, Employee or Inheritor

This last Section D describes our proposed language to **address alcoholism, drug addiction, other addictions, and mental health concerns in a beneficiary, employee or inheritor,** including:

- Our Rationale for Detailed Provisions in Governance Documents
- Summary of Provisions set forth in Appendix A

Our model language for family control and governance documents (business, trusts, office, shared property and similar enterprises) is in Appendix A.

1. Reasons Why We Favor Detailed Provisions in Governance Documents

Current practice commonly addresses addiction and/or mental health concerns either with a general clause permitting the trustee to withhold distributions in the event the beneficiary suffers from addiction or relies on general trustee discretion.

- We find this type of language too broad and easily manipulated, or avoided, by beneficiaries. (See Article Thirteen, listed in the Appendix for examples.)

We prefer that trust agreements address dysfunctions by granting trustees detailed authority to identify and manage the chronic diseases of addiction and mental illness over the long-term. Because addicts excel at gaming their relationships for funds to continue using and avoid accountability, the model language is intended to grant the trustee complete control over this process.

Most family enterprise documents governing non-profit corporations, the family office, and commonly owned property or businesses contain no language at all addressing addiction concerns or behavioral standards.

- Family businesses may contain general provisions regarding alcohol or drug use or even allow for drug testing, but due to family connections these provisions are usually inadequate to address addiction in a blood relative.

<u>While the remaining information in this sub-section is directed at trusts, trustees and beneficiaries, the language can be easily modified to apply to various family settings.</u>

A summary of the reasons why we favor detailed provisions follows:

Trustee lacks expertise on mental health and addiction

- The trustee is unlikely to know much about addiction or mental health and thus requires the direction and the assistance of professionals.

Allows the trustee to hire qualified Professional Assistance

- Qualified, licensed professionals plan and manage the recovery process on behalf of the trustee (and family) over the time period needed to achieve stable recovery – at

least six months and many times longer. This is the key element of the pilot/physician program and a distinguishing feature from standard treatment.

Leads to better understanding by the beneficiary of what he/she needs to do for recovery

- Detailed provisions help the beneficiary understand what he/she needs to do to resume receiving funds from the trust and the standards regarding non-use of alcohol and drugs.

Helps avoid the "Dry Drunk Syndrome"

- The language regarding recovery or recovery-related activities is directed at avoiding the dry-drunk syndrome – where the alcoholic or addict has stopped using but still exhibits all the emotions, attitudes and behaviors as if actively using – as well as to prevent relapse.

A similar approach can also be used for family businesses and other family-related economic, philanthropic, recreational enterprises, ventures etc.

Bypass Provisions When the Heir is the Addict

We frequently encounter situations where the blood heir is the addict and is intimidating his/her spouse (ex-spouse) or partner by threatening to withhold funds if the spouse or partner tells the family or family advisors about the extent of the heir's alcohol or drug use or other dysfunctional behavior.

- This is often the case when the heir has been through treatment and has relapsed or is not following treatment recommendations.

In addition, the blood heir may be withholding money needed for support of his/her offspring in order to maintain control over the children if they are old enough to communicate with their grandparents or to intimidate their parent, if too young to speak out on their own. In order to counteract this controlling and coercive behavior, we highly recommend including provisions in governance documents to allow funds to be sent directly to the spouse or children or otherwise spent on their behalf.

Lawyers have commented that for this provision to be effective the disbursement clause must be "to or for the benefit" of the beneficiary. Others have suggested using a "sprinkle trust" to by-pass the beneficiary, but in my experience the option of "sprinkling" can lead to unanticipated problems with the next generation demanding annual sprinkling as a matter of right, not discretion.

Plain English Summary of Appendix A Model Language

1. Sole Discretion of Trustee to Withhold Income or Principal, Notwithstanding Any Other Provision of The Trust Agreement

Comment: If there are indications of problematic behavior, the trustee can make a referral to a professional for an assessment or other evaluations to clarify underlying issues. There is no need for an actual determination that a substance use disorder or

mental health condition is present to trigger a request for an evaluation. Early intervention is the key to success.

a. Scope of behavior by Beneficiary triggering withholding:

> **A Beneficiary who has or may have: a substance use disorder(s), (addiction), other disorders, compulsive or destructive behaviors, mental health conditions, or concerns or any combination of the foregoing.**

Comment: This definition includes mental illness and mental disorders as well as behavioral disorders such as eating, gambling, spending, Internet – the whole range of compulsive activities.

b. Funds are withheld until the Beneficiary is in recovery (as defined in 6, below). Also authorizes the expenditure of funds for the purposes set forth in this Appendix A, such as hiring experts or treatment costs.

Comment: It is permitted to provide financial support for a beneficiary for living expenses, as agreed to as part of post-treatment recovery plan or agreement.

c./d. Provisions addressing disposition of withheld distributions in the event of death and converting any non-discretionary trust to a discretionary trust during the withholding period.

2. Authorization to Hire and Rely on Professional Expertise to Implement Appendix A

Comment: The trustee hires the expert, not the beneficiary, because in our experience the beneficiary will find someone who will support his/her position regarding problematic behavior. The beneficiary will also try to limit the information given to the evaluating professional and control release of information to the trustee and family members. Similarly, the trustee selects the treatment center options, not the beneficiary.

a. Authorization to hire experts, describes their general area of expertise and the general scope of their activities
b. Authorizes inpatient evaluations, recommendations and treatment as defined
c. Requires experts to be licensed and meet standards for Society of Addiction Medicine if prescribing medications

Comment: Many interventionists and other people "treating" or other helping addicts and their families do not hold state licenses or credentials appropriate for their claimed area of expertise. Many belong to organizations that "self certify", but are not in reality academic or state-certified. Referral fees or other financial relationships are commonplace.

Comment: No physicians or others prescribing medications should do so unless they are a member of the American Society of Addiction Medicine (ASAM) or under the supervision of an ASAM member.

3. Authorization Regarding Intervention, Evaluation, Treatment, and Recovery

Trustee (or Trustee's designee) has full authority to initiate and implement plans for recovery, including the expenditure of funds to implement Appendix A.

4. Beneficiary's Consent to Release Information and Compliance Requirement

Comment: One major problem is that beneficiaries do not want their trustees to find out

their diagnosis, if they are making progress in treatment, or their post-treatment recommendations.
As beneficiaries lie about their behaviors and activities, it is important to establish the expectation early on that recovery is about openness and honesty.
Also, usually the trustee is paying for treatment and otherwise supporting the beneficiary and it is reasonable to ask for a full and complete release of information in exchange for such support.

a. Allows Trustee to receive reports and requires Beneficiary to sign information releases so Trustee (or professional hired on Trustee's behalf) has access to treatment records and can speak directly with counseling staff.
b. Requires Beneficiary to fully comply with all recommendations, as approved by the Trustee or his/her designee.

5. Alcohol and Drug Testing – Observed Tests

Comment: Again the trustee (or professional hired by the trustee) selects the drug testing facility and the scope of the tests. Addicts are very good at finding ways to beat the system and so the trustee needs to control all elements of the testing process.

a. Requires drug tests by a reliable testing service to verify drug-free status
b. Scope of test, including requirement for observation (Preferred choice is the testing service for health care professionals.)
c. Specific authorization to withhold distributions for noncompliance with drug testing requirements

6. Recovery – Two-Year Minimum

Comment: It takes a long time for the brain to stabilize and the addict to learn new behaviors and responses to using urges.

a. Minimum of two years of continuous sobriety as defined and active participation in a "recovery program" as determined by the Trustee or his designee. Two-year minimum may be extended if relapse occurs or Beneficiary is not actively engaged in a recovery program.
b. Trustee can distribute funds to support Beneficiary's recovery program, even when the Beneficiary is in relapse.

7. Date when Recovery Begins

Comment: It is easy to stay off drugs and alcohol when in a protective environment, so the time begins after returning to a normal living arrangement.

a. Time begins after the Beneficiary leaves treatment, halfway house, sober house, or other inpatient environment).

8. Distribution to Spouse, Children, or Other Family Members

Authorization to make distributions on behalf of Beneficiary to his/her spouse, children, other family members, or others dependent on the Beneficiary

Comment: This provision is intended to prevent the addicted spouse or parent who controls the money from threatening to cut off non-using family members if they report

the addict has relapsed or is otherwise engaged in unhealthy behavior. Support the healthy spouse (even if a non-family member), particularly if children are involved.

9. Definition of Alcohol/Drug Dependence or Abuse

DSM-V-TR (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) defining substance use disorders (and other mental health or behavioral concerns) and as updated by current medical information or credible research on addictive behaviors

10. Indemnifications, Exoneration Provisions, and Dual Capacity

a. Indemnification of Trustees (and any professional, advisor, assistant, or other person including their business entities, hired and/or retained by the Trustees)

b. The Trustees (and persons hired by the Trustees) have no liability for the actions or welfare of the Beneficiary.

c. Trustees have no duty to inquire whether a Beneficiary uses drugs or other substance, but are expected to initiate the process specified in this Appendix if circumstantial or direct evidence comes to their attention that the Beneficiary is engaging in conduct specified in Paragraph 1.

d. Authorizes Trustees acting in the dual capacity as Trustee and family member to disclose information to family members.

Comment: This ends the secrecy used by the person with the problem to hide his/her negative behaviors.

11. Other Prohibitions During Suspension or Withholding of Distributions

a. Disqualification of beneficiary to remove or replace Trustee or act as Trustee or Trust Protector.

b. Suspension or withholding of distributions is *prima facie* evidence for removal or suspension of the Beneficiary from other family positions or activities.

Comment: When Uncle Snuffy shows up intoxicated for meetings with professionals or other family enterprises, it sends the message that the family has no standards and sets a bad example for the next generation.

Trust Protector Provision

It is advised to use a Trust Protector to permit Appendix A to be modified due to changes in addiction treatment or as other conditions warrant.

Comment: Since the trust is intended to last many years, there needs to be a method to revise the language to account for changes in treatment or in the event the appointed trustees are not complying with the intent of this Appendix.

CONCLUSION

While this article is about governance provisions, it is important to keep several key concepts in mind when reading all our articles:

Family Support and Education are Critical to Improve Outcomes

- The focus of all our articles is on helping families and their advisors.

Competent, professional and ongoing help for families is one of the missing pieces in a successful recovery strategy for an addicted family member.

- One goal is for families to become knowledgeable buyers of treatment services.

Most families know little about what constitutes effective treatment even though they are often paying the bill and locating the treatment centers to help their loved ones.

You Can Make the Difference

Through our professional, recovery and personal lives we know many members of affluent families who struggle to abstain and find meaningful lives without alcohol and drugs. You, as parent, sibling, advisor, trustee, family leader or business owner have the power to collaborate with professionals to assist your family members afflicted with alcoholism and drug addiction start down the path to recovery. You can make the difference.

Concepts Apply to Other Groups

Many of the ideas discussed in this part apply to small business owners, professional groups, non-profits and similar entities. In addition to inclusion in ownership documents, our model language in Appendix A should also be incorporated into any dispute resolution procedures. And, although governance practices might seem to be a topic suited only for the affluent, our discussion of the recovery process applies to all families with an addicted loved one regardless of economic status.

In ending this article on governance, we do recognize that written procedures are not a panacea. However, at a minimum, they do provide a platform to move discussions about problematic behavior beyond the talking stage to the action phase. Without leverage in documents, the addict will always quit "tomorrow", as pointed out in Vern Johnson's book "I'll Quit Tomorrow".

Appendix A

Model Language for Family Governance Documents For Substance Use Disorders and/or Mental Health Concerns

Suggested Language Restricting Access To Principal And Income When A Beneficiary Or Family Member May Have Problems With Alcohol, Drugs, Other Behaviors and Activities Or Mental Health Concerns.

Trustee Authority Regarding Substance Use Disorders, Other Disorders and Mental Health Concerns in a Beneficiary

1. Sole Discretion of Trustee to Withhold Income or Principal, Notwithstanding Any Other Provision of this Trust Agreement

a. Notwithstanding the foregoing as to distributions of income and principal, the Trustee in his/her sole discretion, shall withhold distributions of principal, income or other withdrawals from any Beneficiary who has or may have: a substance use disorder(s), (addiction), other disorders, compulsive or destructive behaviors, mental health conditions or concerns or any combination of the foregoing, as defined in paragraph 9, below.

b. Such principal, income or specified withdrawals shall be retained and held by the Trustee until such time as the Trustee determines, in his or her sole discretion, that the Beneficiary is in recovery (as defined below in paragraph 6) from a substance use disorder (s), (addictions), other disorders, compulsive or destructive behaviors, mental health conditions or concerns or any combination of the foregoing, as defined in paragraph 9, below. Any amounts so withheld and accumulated may be retained in the Trust rather than distributed, at the Trustee's sole discretion. However, the Trustee is authorized to expend income and principal for the purposes set forth in this Appendix A.

c. If the Beneficiary dies before mandatory distributions or rights of withdrawal are resumed, the remaining balance of the mandatory distributions that were suspended will be distributed to the alternate beneficiaries of the Beneficiary's share as provided herein.

d. While mandatory distributions are suspended, the trust will be administered as a discretionary trust to provide for the Beneficiary according to the provisions of the trust providing for discretionary distributions in the Independent Trustee's sole and absolute discretion and as mandated by the Appendix

2. Authorization to Hire and Rely on Professional Expertise to Implement this Appendix

a. The Trustee is authorized to employ and retain experts on: substance use disorder (addictions), other disorders, compulsive or destructive behaviors, mental health conditions or concerns and resultant family conflict or any combination of the foregoing, as defined in paragraph 9, below to advise him/her regarding any matters, issues or determinations in this Appendix A. The Trustee may designate such experts to receive information or perform tasks on his/her behalf in order to implement Appendix A.

Further, the Trustee may employ experts to recommend comprehensive treatment and post-treatment recovery programs (meeting the standards in subparagraphs b and c, below) and to oversee and implement such programs. The Trustee is also authorized to use the recovery programs for addicted pilots and physicians as part of an oversight program for the Beneficiary (or similar programs in the event the pilot or physician program is unavailable).

In addition, the Trustee is authorized to employ and be advised by experts regarding entering into and preparing agreements (Recovery Contracts) between the Beneficiary and Trustee specifying recovery activities by the Beneficiary, including such activities that are funded directly or indirectly by the trust.

b. The Trustee is further authorized to utilize and rely on the professional judgment of a reputable treatment center, utilizing an abstinence-based chemical dependency treatment model and recognized by the Joint Commission on Accreditation of Health Care Organizations, for evaluations, recommendations and treatment regarding the Beneficiary's suspected or actual substance use disorders (alcohol/drug dependence and abuse). The Trustee is similarly authorized regarding any other disorders, compulsive or destructive behaviors, mental health conditions or concerns or any combination of the foregoing, as defined in paragraph 9, below.

c. The Trustee has sole discretion regarding the employ and use of any such treatment centers or other resources such as supervised living facilities, half-way houses, sober homes and wilderness programs as needed; however, all such resources shall be licensed or credentialed as per applicable state guidelines and standards described in the preceding paragraph. Any experts utilized by the trustee shall be licensed and credential as per applicable state standards and guidelines, with any professional authorized to prescribe medications certified by ASAM (Society of Addiction Medicine) or under the direct supervision and direction of an ASAM certified professional.

3. Authorization Regarding the Expenditure of Funds for Intervention, Treatment, and Recovery Activities

The Trustee has full authority and discretion to expend funds for advice regarding implementation of this Appendix, to develop and implement plans for intervention in the event the Beneficiary may have a substance use disorder (dependent on or abusing alcohol or drugs) or may be actively using alcohol or drugs after treatment (relapse). Such authority includes expending funds for evaluations, treatment and all related costs, for post-treatment recovery programs, and any and all related matters deemed appropriate by the Trustee in his/her sole discretion. This paragraph (3) is fully applicable to other disorders, compulsive or destructive behaviors, mental health conditions or concerns or any combination of the foregoing, as defined in paragraph 9, below, including non-compliant behavior with treatment plans and behavioral relapses.

4. Authorization to Receive Reports/Beneficiary's Consent to Release Information

a. In making determinations as to whether the Beneficiary is participating in, has successfully completed an approved and applicable treatment program and/or is engaged in an active recovery program, the Trustee (and/or her/his designee) is authorized to receive reports from counselors and staff from treatment programs of any kind, sponsors and all health care professionals or others providing assistance to the Beneficiary.

b. In addition, the Beneficiary must fully comply with all recommendations of treatment programs and health care professionals, as approved by the Trustee (and/or his/her designee. The Beneficiary must sign consents for full release of information to the Trustee (and/or his/her designee) in order to be in compliance with this paragraph (4). Failure to sign all requested authorizations means the Beneficiary is not in "recovery" as that term is used in Paragraph 6.

5. Alcohol and Drug Testing

a. The Trustee (and/or her/his designee) shall utilize the services of a reliable and licensed drug testing company to randomly drug test the Beneficiary during the first two years of recovery (as defined in Paragraph 6, above), and/or if the Beneficiary may be disputing whether he/she is using alcohol or drugs. The Trustee (and her/his designee) is authorized to require continued drug testing for so long as the Trustee deems such testing to be advisable, regardless of any other provision in this Appendix. Full disclosure of results from such tests shall be made in a timely manner to the Trustee (and/or her/his designee).

b. Such tests must be conducted under the observation of personnel from the drug testing service or their designee, and may include but not be limited to laboratory tests of hair, tissue, or bodily fluids. The physician in charge of the Physician's Health Program is the preferred resource for such testing.

c. The Trustee, in the exercise of sole and absolute discretion, may totally or partially suspend all distributions otherwise required or permitted to be made to the Beneficiary until the Beneficiary consents to the examination and complies with full disclosure of the results to the Trustee.

6. Recovery – Two-Year Minimum

a. **Recovery,** as used herein, is defined as no less than a minimum of two years of continuous sobriety (including abstention from narcotic prescription medicine, drugs, alcohol or other addictive or compulsive behaviors or use disorders) and/or two years continuous adherence to treatment plans in the case of mental health conditions. Only medications prescribed and approved by ASAM certified prescribers and consistent with the beneficiaries **Recovery Program** will be considered as meeting the foregoing definition.

The definition of **Recovery** also includes, but is not limited to ongoing participation in a **Recovery Program**, as determined by the Trustee or his designee: Activities addressing issues relating to substance use disorders, (addiction), other disorders, compulsive or destructive behaviors, mental health conditions or concerns or any combination of the foregoing, as defined in paragraph 9, below. (Examples: attending 12 step or other self help groups, therapy, case management meetings, avoiding high risk relapse environments and adhering to recovery plans, recommendations or agreements.

b. The two-year minimum shall be extended if the Beneficiary has a history of relapse, is not compliant with treatment plans or fails to actively engaged in a Recovery Program, with such time extension(s) determined at the sole discretion of the Trustee.

c. In the event the Beneficiary has not completed the two-year minimum of recovery or extensions thereof, the Trustee has the discretion to disburse income and/or principal on behalf of the Beneficiary in amounts to support the Beneficiary's recovery program. Conversely, the Trustee shall not disburse funds for activities that might lead to relapse. The Trustee is authorized to rely on the advice of experts in implementing this Section 6 and otherwise exercising discretion as permitted in this appendix.

7. Date When Recovery Begins

The commencement of any time period of recovery begins after the Beneficiary has successfully completed chemical dependency inpatient primary treatment (or other addiction

or mental health related treatment) and any subsequent long-term, halfway, sober house or wilderness program.
(Such time does not commence upon entering treatment, but when successfully completing out-patient treatment or leaving a supervised or otherwise restrictive environment.)
Successful completion of any such program is determined by the treatment provider and as approved by the trustee, who may rely on the advice and opinion or experts independent of any treatment center.

8. Distribution to Spouse, Children, or Other Family Members

In the event of withholding of or restriction on distributions to the Beneficiary, the Trustee is authorized to make distributions for the benefit of the Beneficiary, including those owed a duty of support by the Beneficiary, such as the Beneficiary's spouse, ex-spouse, children or other family members.
The Trustee is authorized to make arrangements for the support of such individuals through distributions by alternative means, as the Trustee determines in his/her sole discretion, with the intent to maintain such individuals' lifestyle, including paying support staff and third party vendors.
In the event any such individual meets the definition in paragraph 9, the trustee is authorized to provide services as set forth in this Appendix herein.
In the event any such individuals are in need of therapy, treatment or other forms of assistance due to the conduct of a beneficiary meeting the definition in paragraph 9, the trustees is authorized to provide services as set forth in this Appendix

9. Definition of Substance Use Disorder or Abuse and Other Addictions/Disorders

The phrase, "Beneficiary who has or may have a ***substance use disorder*** **(**formerly dependent on and/or abusing drugs or alcohol), other disorders, compulsive or destructive behaviors, mental health conditions or concerns (including mental illness and mental disorders) or any combination of the foregoing, shall have meaning as defined in the DSM-V-TR (Diagnostic and Statistical Manual of Mental Disorders. The DSM-V criteria for "Alcohol Use Disorder" are at the end of this Appendix A. These definitions may be revised to reflect new medical information and/or credible research by recognized professionals, as defined in paragraph 2.

10. Indemnifications, Exoneration Provision, and Dual Capacity

a. The Trustee (and any professional, advisor, assistant, or other person including their business entities, hired and/or retained by the Trustees) will be indemnified from the Trust Estate for any liability in exercising the Trustee's judgment and authority in this Appendix A, including any failure to request a Beneficiary to submit to medical examination and including a decision to distribute suspended amounts to a Beneficiary. This indemnification clause includes any allegations of any kind brought by the Beneficiary, or on behalf of the Beneficiary, directly or indirectly against the Trustee and those hired and/or retained by the Trustee. If such allegations occur, the respondent has the option of requesting the trust to provide the defense or asking the trust to pay to the respondent funds for his/her defense.

b. It is not the Grantor's intention to make the Trustee (or any professional, advisor, assistant, or other person including their business entities, hired and/or retained by the Trustees) responsible or liable to anyone for a Beneficiary's actions or welfare.

c. The Trustee has no duty to inquire whether a Beneficiary uses drugs or other substance, but is expected to initiate the process specified in this Appendix if circumstantial or direct evidence comes to the Trustee's attention that the Beneficiary is engaging in conduct specified in Paragraph 1, to wit: the beneficiary has a substance use disorder or may have other use disorders (addictions), compulsive or destructive behaviors, other disorders or mental health concerns or any combination of the above mentioned disorders, as defined above in 9.

d. A Trustee acting in the dual capacity as Trustee and family member is authorized to discuss with the Beneficiary and the Beneficiary's relatives, information the family member obtains in his capacity as Trustee, for the purpose of furthering the welfare of the Beneficiary.

11. Other Prohibitions During Withholding of Distributions

a. If distributions to a Beneficiary are suspended or withheld as provided above in this Appendix, then the Beneficiary shall automatically be disqualified from serving, and if applicable, shall immediately cease serving, as a Trustee, Trust Protector, or in any other capacity in which the Beneficiary would serve as, or participate in, the removal or appointment of any Trustee or Trust Protector hereunder.

b. The withholding or suspension of benefits to the Beneficiary is sufficient evidence to suspend or terminate the Beneficiary's role in other family positions or activities. If the Beneficiary contests such suspension or termination, the Trustee is authorized to release information relating to the Beneficiary's addiction to the appropriate family governing body or authority.

(This language can be modified for use in business, succession, management, real estate ownership, family office and philanthropy governing documents.)

Trust Protector Provision

- **It is advised to use a Trust Protector to permit Appendix A to be modified due to changes in addiction treatment or as other conditions warrant.**

Alcohol Use Disorder DSM-V

As defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – DSM 5 (p. 490)

Diagnostic Criteria

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol 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 alcohol.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal, pp. 499-500).
    b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Specify if:

In early remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use alcohol," may be met).

In sustained remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use alcohol," may be met).

Specify if:

In a controlled environment: This additional specifier is used if the individual is an environment where access to alcohol is restricted.

Specify if:

305.00 (F10.10) Mild: Presence of 2-3 symptoms

303.90 (F10.20) Moderate: Presence of 4-5 symptoms

303.90 (F10.20) Severe: Presence of 6 or more symptoms

*Because the first **12 months** following a Substance Use determination is a time of particularly high risk for relapse, this period is designated Early Remission*

Appendix B Family Wealth – Keeping It in the Family (James E. Hughes, Jr.) [31]

a.) Roles and Responsibilities of Beneficiaries (page 108)

Each beneficiary has an obligation to educate himself or herself about the duties of a beneficiary, as well as the duties of the family trustees. Here are specific responsibilities of beneficiaries:

- To gain a clear comprehension of each trust in which the beneficiary has an interest and a specific understanding of the mission statement for each trust as prepared by the trustee
- To educate himself or herself about all trustee responsibilities
- To understand the trustee's responsibility to maintain the purchasing power of the trust's capital while maintaining a reasonable distribution rate for the income beneficiaries
- To have a general understanding of modern portfolio theory and the formation and process of asset allocation
- To recognize and look for proof that each trustee represents all beneficiaries
- To meet with each trustee once each year to discuss his or her personal financial circumstances and personal goals and to advise the trustee of his or her assessment of the trustee's performance of the trustee roles and responsibilities to the trust, to the beneficiary, and to the family governance
- To become knowledgeable about the functions and importance of each element of the family's trust governance structure
- To attend the annual family business meeting and to accept responsible roles within the family governance structure, base on his or her qualifications for such roles
- To develop a general capacity to understand fiduciary accounting
- To demonstrate a willingness to participate in educational sessions and to become financially literate (through family seminars and family-funded educational programs)
- To know how and in what amount trustees and other professionals are compensated and to obtain a general understanding of the budgets for the trust and investment entities in which the trust will be invested

b. Roles and Responsibilities of Trustees (page 134)

Each trustee has an obligation to educate himself or herself on the duties of a trustee, as well as on the duties of the trust beneficiaries. The trustee's specific duties are as follows:

- To be fully aware of the grantor's original purposes in creating the trust and the current purposes of the trust, if these have changed over time
- To guide his or her decisions by these purposes
- To act so that the actual operation of the trust is empowering to the beneficiaries, within the provisions of the trust
- To put mechanisms in place to increase the level of financial awareness of the beneficiaries, and to see that such financial education of the beneficiaries is carried out effectively
- To meet at least annually with each beneficiary in order to renew the beneficiary's understanding of the trust, as well as to obtain from each beneficiary full information, financial and otherwise, about his or her personal situation
- To educate himself or herself about all beneficiary responsibilities
- To evaluate and advise each beneficiary on how well he or she is meeting the roles and responsibilities of a beneficiary
- To implement effectively the trust's general policies and procedures as they relate to the following:
    1) The trust's investment goals and acceptable risks
    2) The selection and/or provision of investment advice and management to accomplish such investment goals within the given risks
    3) The trust's tax position and the selection of tax services
    4) The trust's legal position and the selection of legal services

Appendix C: Hennepin County Terms and Conditions of Sentence

STATE OF MINNESOTA
COUNTY OF HENNEPIN

DISTRICT COURT
FOURTH JUDICIAL DISTRICT COURT

STATE OF MINNESOTA, Plaintiff

vs.

_____, Defendant

TERMS AND CONDITIONS SENTENCE
CASE TYPE: DWI COURT

Court Case # __27 – CR - _____

Charge _____

☑ You are sentenced to _____ days in the workhouse and a fine of $_____ (plus surcharges and assessments). This sentence is consecutive to file(s) No. _____. Credit given for _____ days. Of this sentence, $_____ of the fine and _____ days are stayed for _____ year(s) on the following marked conditions:

☐ 1. Serve all workhouse time as ordered and, if eligible, with:
☐ work/school release ☐ a furlough to _____
☐ Electronic home monitoring (after _____ days)

☑ 2. Have no arrest supported by probable cause for any new offense.

☐ 3. Satisfactorily perform _____ days of Sentence to Service within _____ days. This is in place of workhouse and/or fine or as a condition of probation.

PROBATION CONDITIONS

☑ 4. Complete the DWI Court program. Obey all rules of DWI Court. You cannot opt out.

☑ 5. Complete a Victim Impact Panel.

☑ 6. Do not use alcoholic beverages, non-prescribed drugs, or substance(s) listed on the ETG Agreement you signed. You must submit to random testing by Probation and/or law enforcement.

☑ 7. Complete a chemical health evaluation through Rule 25 or private insurance. Follow all recommendations for treatment and aftercare. You must attend at least three treament, aftercare or twelve step meetings per week.

☑ 8. Do not drive a vehicle unless it has an ignition interlock device installed for one calendar year.

☐ 9. Make restitution of $ _____ or as determined by the probation department within _____ days.

☐ 10. Pay $ _____ to the DWI Court Training and Employment Fund within _____ days.

☑ 11. Curfew: You must be home and available for a visit and random testing by Probation and/or law enforcement between _____ p.m. and _____ a.m. You must also allow a cursory search to confirm that you do not have alcohol and prohibited substances in your home. You may not be absent from your home during curfew hours without permission of your Probation Officer or the Court.

☑ 12. Appear for weekly judicial review every _____ at _____ a.m. You must be on time.

☑ 13. You are warned that if you drink and drive again, all stayed time will be revoked; no EHM or Work Release.

☐ 14. Other _____

_____

_____

THE COURT FINDS THAT:

☐ The mandatory minimum fine and surcharge is reduced based upon (indigency) (hardship).

Date _____

_____
District Court Judge Signature

I have read the checked paragraphs and I understand the conditions of my sentence. I understand that failure to obey all the conditions may result in the Court imposing the entire sentence and issuance of a warrant for my arrest without further notice to me or my attorney.

_____
Defendant's signature

Improving Recovery Rates for Affluent Addicts and Alcoholics

TWENTY ARTICLES

Introduction

A. *The Successful Pilot/Physician Programs: Proven Standards for Recovery Outcomes*

1. The Pilot/Physician Programs have 85% to 95% Success Rates – The "Gold Standard"

- Contrasts the high success rates for pilots/physicians with the low (and misleading) outcomes rates promoted by treatment centers. Discusses addiction as a statistically probable disease to be anticipated and planned for by families, as well as different intervention strategies and an overview on improving recovery rates by adopting the pilot /physician model to other groups.

B. *Encouraging and Inducing Change*

2. Use Leverage to Support Long Term Recovery and Improve Outcomes

- Explains how we modify the pilot/physician program when applying leverage to affluent alcoholics and addicts to improve outcomes. Describes fifteen differences between programs for pilots/physicians and programs for the affluent.

3. Change Strategies For Advisors with Low Leverage or Low Interest Families

- Advice on change strategies for advisors facing reluctance in client families to address difficult problems. Strategies range from education and risk protection to using the momentum generated by addiction related incidents to promote change.

4. Creating Leverage in Governance Documents to Support Early Intervention and Stable Recovery

- Discusses a problem solving approach in dealing with family members exhibiting addictive or other dysfunctional behavior. Suggests language to include in family documents, the reasons underlying these suggestions and explains from a "stages of recovery" perspective why leverage must remain in place for many months.

C. *Systems Transformation to Improve Outcomes*

5. The New Treatment Model: Systems Transformation to Improve Outcomes

- Discusses why current treatment is ineffective and describes a new model derived from the pilot/physician programs. Reviews family relationships in affluent family systems. Describes 12 Core Concepts to consider in promoting recovery in affluent families.

D. *Improving Treatment for the Affluent:* ***Substantive Program and Clinical Issues***

6. Practical Advice on Achieving High Recovery Rates for Affluent Alcoholics and Addicts,

- In depth review of the clinical needs of the affluent in treatment and in the context of applying the pilot/physician program model to the affluent. Explains why current treatment is inadequate and describes strategies to improve outcomes.

7. Families, Wealth and Addiction

- A new clinical approach to addiction, treatment and recovery for affluent families. Discusses barriers to finding and receiving effective treatment (four page overview).

E. *Advice for Families*

8. Flawed Family Assumptions about Addiction and Treatment: Information for Families

- Misconceptions by parents about treatment impede recovery for their adolescents and young adults.

9. Fifty Seven (57) Things I Wish I Had Told You When First Becoming Aware Your Loved One Has "A Problem"

- Written after a friend's child died five months after leaving treatment. This tragedy motivated the author to enroll in addiction studies school and become an advocate for improved treatment outcomes, using the pilot/physician model as a prototype for services to other groups*.

10. Advice for Parents of Adolescents and Young Adults

- A parent's perspective on the developmental impact of addiction and recovery issues*.

F. *Individual Blocks to Change: Childhood Experiences and Counseling Inadequacies*

11. How Childhood Experiences in Affluent Families Impede Change as Adults

- Counselors and family members must understand how these experiences negatively influence the addict's ability to benefit from treatment, including lack of trust and inability to connect with peers*.

12. Counselor - Client Relationship and Conditions Promoting Change

- Identifies blocks to recovery for the affluent in the treatment and counseling setting*.

G. *For Family Offices, Family Businesses, Trustees, Lawyers, Accountants and Advisors*

13. Trustees and Beneficiaries*

- *The Demise of Trustee Discretion and Ascertainable Standards as Effective Controls on Dysfunctional and Underperforming Beneficiaries"*[21]. Discusses ways beneficiaries access funds despite restrictions on distributions. Suggests language to include in trusts and other governance documents to address addictive behavior in family members (See Article 4, above).

14. Advisors, Trustees, Account Managers and Family Offices

- *Solutions for Dealing with Alcoholism and Drug Addiction in Affluent Families: What Advisors, Account Managers, Trustees and Family Offices Need to Know*

15. Financial Managers and Dysfunctional Clients

- *Financial Managers and Dysfunctional Clients: Addiction's Effect on Staff Morale and Fiduciary Responsibilities in the Family and Wealth Management Office*

16. Family Integration Services; the Key to Successful Succession Planning for the Family Business, Foundation and other Enterprises (with Larry Hause)*

- Families need much than sound legal and financial planning; they also need to make sure their relationships and roles are on a sound footing for the business to survive.

17. Functional Alcoholism Distinguishing Between Safe and Potentially Dependent use of Alcohol and Drugs*

- Reducing risk to family wealth and well-being by understanding contemporary medical definitions of safe drinking, at risk drinking and prescription medicine use, and definitions of abuse of and dependence on addictive substances.

18. Core Needs in Wealthy Families

- *The Advisor's Role in Helping Wealthy Families Meet Their Core Needs*
  Part 1: A Developmental and Experiential Model for Advisors and Consultants
  Part 2: An Alternative Model for Planners and Consultants

H. *Lawyers and Law Firms*

19. Law Firms

- *Achieving High Recovery Rates for Addicted Attorneys, What Every Law Firm and Lawyer Needs to Know (Based on the Highly Successful Recovery Programs for Physicians and Airline Pilots)*

20. Bench and Bar Article

- *Lawyer Seeks Treatment, Boss Seeks Assurance* by Todd Scott, GPSolo Magazine October/November 2009

* Articles marked with an asterisk are in progress or being revised

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Author Information

William F. Messinger, JD, LADC

Bill founded Aureus to improve recovery rates for functional alcoholics and addicts. Inspired by highly successful programs for physicians and pilots, Bill developed similar approaches for complex family systems. He writes articles on topics relating to addiction and recovery for families and their advisors, and is a member of AFHE, FOX, FFI, and CFF. Bill is a graduate of Yale College, University of Minnesota Law School, and the Hazelden School of Addiction Studies

Footnotes

[1] Readers of previous articles combining several topics on how we apply the pilot physician model to affluent addicts have asked me to "unbundle" these articles and address one topic per article.
[2] Since pilots and doctors are required to follow all the recovery program mandates of their oversight boards, their programs can also be described as "airline and medical board recovery programs".
[3] See 4
[4] Here is what Dr. Robert DuPont, former Director of the National Institute on Drug Abuse said about a nation wide review of outcomes for physicians' programs:

> *The results: 78 percent of the physicians did not have a single positive test for any drug or alcohol use over five years of testing. Of the 22 percent who did have at least one positive test, 65 percent did not have a second positive test.* ***Where else in the addiction treatment field can you find results like that? Those results set an entirely new standard for recovery outcomes, one that every treatment program should aspire to."*** (Emphasis added.)

Why does the doctor say it sets a "new standard for recovery outcomes"? Because all other programs have long-term recovery rates at thirty percent (30%) and below. *(See Dirty Little Secrets: Why Rehab Programs Must Come Clean*, Consumers Digest, p. 20-24, May/June 2008)
95% success rate for NWA pilots Airline pilots soar to success in recovery. Hazelden Voice Vol. 3, Issue 1.
78% continuous abstinence rate at **7.2 years** for 904 doctors in Physicians Recovery Programs, Addiction Professional, online, 8/24/10)
[5] In our year of living and working with affluent families, we know of no extended family system (including in-laws) with addiction and significant mental health problems at rates of less than 20%. Many families have rates exceeding 30% to as high as 70%. However, these numbers are based on anecdotal and personal experience. The overall addiction rate is said to be 10% of the population.
[6] Mathew Wesley, www.mathewwesley.com
[7] Family Firm Institute Brochure excerpt for 2010 Annual Conference

"Addiction: the Achilles Heel. Preliminary research indicates that 52% of family businesses utilizing business consultants have an acute addiction issue embedded in the family business system"

[8] By: Omar S. Manejwala, MD, MBA, FAPA, CPE
Behavioral Healthcare, April 2011
[9] Satel, M.D., Sally. 2006. For Addicts, Firm Hand Can Be the Best Medicine. The New York Times, August 15.

[10] For out of control addicts on the loose, families must stay engaged with these addicts and not wait for them to "hit bottom" on their own (the latter advice given by many interventionists, family programs and Al-Anon, is not a successful strategy). Instead, families must do what is necessary to remain in contact and finding ways to encourage the addict to get help. For affluent families, this may mean assembling a group that includes a knowledgeable addiction professional, private detectives, lawyers (to use the legal system, if feasible), sober companions and a "go to person" in the family who can authorize expenditures and actions. If the addict is holed up in a hotel room or resort drinking and using, living or driving around town with her dealer, smoking crack at the crack house, or wandering the streets, using heavily, overdosing or otherwise at risk, **the family must go after the addict** (or hire professionals to do so). We emphasize this point in every article because too many families are being given misinformation about what to do under the circumstances described in this footnote. No family has regretted doing too much when a loved one dies from addiction or addiction related complications. Many regret doing too little.
[11] Dennis Jaffe, P., & James A. Grubman, P. (2007). Acquirers' and Inheritors' Dilemma: Discovering Life Purpose and Building Personal Identity in the Presence of Wealth. *Journal of Wealth Management*.
[12] See, *The Demise of Trustee for Trustees*, Messinger.
[13] James E Hughes, Jr (2004). *Family Wealth Keeping It in the Family* New York: Bloomberg Pr.. P 14-23
[14] Kozisek v County of Seward, 07-3692 (Eight Circuit Court 08 27, 2008). In this case the Court upheld the firing of county worker who claimed a disability due to alcoholism but refused inpatient treatment, stating:

> *The fact remains that the county based it decision about Kozisek's "restriction" – complete impatient treatment before returning to his important public job of assisting veterans – upon the recommendation of a professional substance abuse counselor.*

It is the recommendation of the professional counselor that persuaded the Court to uphold the dismissal of the worker by the County. (Kozisek v County of Seward, 8th Cir., 8/27/08). Note that in the Chemical Dependency field many people offering help to families neither hold degrees from accredited institutions nor are licensed by State or local agencies. These "helpers" would not qualify as expert witnesses in Court and are vulnerable to attack by opposing counsel. Also, some therapists do not believe addiction is a disease and do not believe in abstinence from mood altering chemicals.
[15] There is a huge disparity between an addict's self-perception vs. his/her perception by friends and family

Even when an incident occurs that is used to persuade the family member to obtain help and enter treatment, many times treatment is not successful over the long term. This is because there is a vast difference between the addict's perception of his or problem versus the perception of outside observers.

- For example, 22.5% of adults between the ages of 18-25 from families with an income exceeding $80,000 are either abusing or dependent on alcohol.
- However, 97% of this group do not perceive themselves as having a problem.

Therefore, simply forcing a member of this 97% group into treatment does not lead to long-term recovery because they tell themselves they are OK and everyone else is overreacting or does not understand their situation. Similar numbers occur for older population groups.

[16] Recovery From Addiction, A Developmental Model, Part One, *It's All in the Journey,* Sept. 2008, p 8.

[17] Have you ever noticed how one client session can produce sudden – and sometimes noticeably more significant – changes in a client? Furthermore, these changes don't die out in a week, but seem to continue. Some data indicates that just prior to these sudden changes, certain clients began to process what is going on in therapy better. Often good adherence to treatment goals and good alliance in early sessions set the stage for these sudden breakthroughs. In addition, key mediators, such as increase in self-efficacy (e.g., thinking "I can do this"), or the ability to better handle a craving, may lay the groundwork for a sudden gain. Basically, critical session models point toward finding subgroups of clients who respond well to specific treatments. Instead of applying one treatment, such as CBT, to all your clients, you may want to apply parts of the treatment to selected clients. The idea is to find who responds to what and use more of the application on this subgroup. **(p. 16)**

From this perspective, you are to pay attention to critical components of treatment that include what's inside a session and what happens across many sessions. There are five components.

Taleff, Michael J., PhD. *Dawn of a New Era (Part II).* Counselor Magazine. February 2010. (p.17)

[18] See above on the self-perception problem.

[19] Ibid, p 12

[20] For more on this topic and other barriers, see *Achieving High Recovery Rates for Addicts* and *Flawed Family Assumptions About Addiction*

[20] Available on our website, at www.BillMessinger.com

[21] Available on our website, at www.BillMessinger.com)