Model Language for Addressing Substance Use Disorders (Addiction) in Trust Documents

Best Practices for Treating Substance and Other Behavioral Disorders

Second Edition (2017)

William F. Messinger, JD, LADC

Aureus, Inc.
332 Minnesota St., Suite W1360
Saint Paul, MN 55101
Phone: 651-335-2410
www.billmessinger.com

Arden O'Connor, MBA

O'Connor Professional Group
65 Sprague St., West Lobby Building
Hyde Park, MA 02136
Phone: 617-910-3940
www.oconnorprofessionalgroup.com

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Author Information

William F. Messinger, JD, LADC

Bill partners with clients facing addiction in family members to find effective treatment and stable recovery for their loved ones. His goal is to improve recovery rates for functional alcoholics and addicts, including beneficiaries. 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, their advisors and trustees. He is a member of AFHE, FFI and CFF. Bill is a graduate of Yale College, University of Minnesota Law School and the Hazelden School of Addiction Studies.

Arden O'Connor, MBA

Arden established O'Connor Professional Group to provide families with the resources to navigate through the behavioral health systems. From consultations to ongoing, intensive, individualized services, O'Connor Professional Group works with families struggling with addiction, eating disorders and chronic mental illness. Arden is a member of FFI and serves on several boards, including Harvard Business School Alumni Board of Boston; Massachusetts Association of Mental Health; and Victory Programs. Arden is a graduate of Harvard College and Harvard Business School.

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Introduction

With addiction and behavioral health disorders increasingly recognized as major threats to family well-being and wealth preservation, trustees, as well as advisors, family leaders and professionals, are looking for solutions when problems arise in beneficiaries, relatives and clients. Expectations of trustee performance are higher than ever, as families press for a response when their beneficiary/relative shows signs of dysfunctional behavior.

But where to find solutions in an industry whose claims of treatment success are unregulated by the FTC or FDA and are based on misleading or falsified data? And where to find sound, expert advice in a field where many "helpers" benefit from referrals; are unlicensed; and lack credible credentials from accredited professional schools?

- In asking this same question over 20 years ago, we fortunately found two groups with extremely high recovery rates – doctors and pilots.

Medical boards and airlines run very successful recovery programs for doctors and pilots!

We then began applying their model to other population groups, including beneficiaries and family business employees, in an effort to improve outcomes. This article describes:

- why the doctor/pilot programs work so well;
- how we use their concepts in our work with trustees facing addiction in beneficiaries;
- the technical standards applicable to addiction diagnosis; and
- model language for use in trusts to effectively address substance use and behavioral health disorders in beneficiaries.

Reasons for Increased Expectations

From a social perspective, trustees can no longer take a hands-off approach, hoping their beneficiary will seek treatment *sua sponte*.

- The virulence and destructiveness of addictive substances generated by the abuse of narcotic prescriptions (pain pills) and ready availability of heroin too often leads to fatal overdoses.

Inaction is no longer conscionable nor acceptable, even if legally defensible.

For intergenerational trusts, an additional consideration is the harm inflicted on the next generations. For trustees who are hesitant to act, reflect on this quote from Sigrid Rausing:

> *You can walk away from the addict - <u>other people's lives</u>. But you can't walk away from their children.*

This statement comes from Rausing's memoir *Mayhem*, in which she describes her sense of responsibility to her nephews and nieces as motivating her to encourage her brother and sister-in-law to seek help.

While many existing trusts grant trustees full discretion or contain specific addiction clauses, we find these clauses to be ineffective and difficult to administer, with trustees unwilling to act decisively until the beneficiary is so clearly ill that recovery is nearly impossible.

- For examples of our experience with these clauses, see "Addicted Beneficiaries; Overwhelmed Trustees[1]" referenced in the endnotes of this article.

And regardless of their efficacy, these provisions do not promote a proactive, early-intervention approach when addiction and other behavioral and mental health concerns first surface. Our model is operational at the first signs of a problem – which reflects the intent of most grantors.

Counter-considerations

In the course of our work, we encounter several legitimate reasons for trustee inaction. First, the most common outcome of treatment is relapse:

- Taking action not only creates conflict within the family but when the beneficiary returns home and resumes old behaviors, s/he becomes an adversary.

Second, the fee structure:

- The usual fixed-fee structure is disincentive to be involved in what is inevitably a time- (and energy-) consuming process.

Third, lack of expertise:

- Perhaps the most important consideration is that trustees are not trained in these disorders and realize they can easily get in way over their heads, worsening the problem.

Our model language addresses these considerations by using an approach with improved outcomes and by authorizing hourly fees and hiring experts to advise the trustee.

Opportunity to Enhance Practice and Reputation

Because behavioral health disorders usually impact entire families, leaning how to steer a beneficiary on the path to recovery will enhance reputations and lead to word-of-mouth referrals from this hard-to-reach clientele. And perhaps, as trustee, you are are tired of approving distributions to demanding, dysfunctional beneficiaries and want to adopt a new approach. Recent case law and statutory changes grant more authority to trustees to act in the best interests of beneficiaries. What can be more reason to do so than an active substance use or behavioral health disorder?

A New Recovery Model

One of the best-kept secrets in the treatment community are the very high long-term recovery rates for physicians and pilots compared to the rest of the population. These programs constitute "best practices" in the treatment field. As mentioned, we use their basic protocols as models for improving outcomes for addicted family members (beneficiaries). Therefore, our goals in writing this article are as follows:

Section 1: Applying the Physician/Pilot Program for Beneficiaries:

- Present an overview as to how we adapt the pilot/physician programs to our clients so the reader understands the basic concepts leading to improved outcomes, including incentive-based behavior modification and recovery management.

Section II: Review of Key Concepts and Specific Provisions in Model Language

- Discuss specific provisions in plain English to insert or use in trust and governance documents in order to replicate the pilot/physician protocols.

Section III: Definition of Substance-Related Disorders (SUDs) in DSM V

- Review of key technical concepts regarding SUDs and the medical criteria for defining SUDs used by professionals – one of the behaviors addressed in our model language. Because these terms are used in the model language, grantors, professionals and trustees need a working understanding of SUDs

Appendix A: Model Language

- Sets forth suggested model language for use in trusts or family business documents (after review by the family attorney).

Appendix B: Substance Use Disorders – DSM-V

- The definition and diagnostic criteria for substance use disorders (addiction) from the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

Appendix C: Case Management and Personal Recovery Support Services

- Describes what services a family or trustee should expect from the addiction expert hired to provide case management and support to the trustee, family and beneficiary/addict.

The trustee/professional must understand how we combine concepts relating to trust law, behavior modification, treatment and addiction in order to encourage beneficiaries to seek help and comply with treatment recommendations.

We decided to write this second edition because we found that readers wanted more information about our reasoning in writing some sections of our model language. The article also cites additional references to support our position that leverage is an effective tool to encourage treatment compliance, as several trustees asked for more ammunition to fend off disgruntled beneficiaries and their allies. Several readers also pointed out omissions or language needing clarification. We also address issues raised by medication-assisted treatment (MAT).

In concluding this introduction, the No. 1 outcome of treatment is relapse – the existing system is not working. As mentioned, over 20 years ago we were fortunate to learn about the unique and successful programs for pilots and doctors and began applying their protocols in our work with clients. Our model language is unique in supporting this approach and is designed to encourage addicts to comply with treatment recommendations over the many months needed to achieve stable recovery.

I. Applying the Physician/Pilot Programs to Beneficiaries

In this section, we review information regarding the highly successful physician/pilot program and other incentive-based programs and discuss using leverage and recovery management to encourage beneficiaries to seek help and comply with treatment recommendations.

A. The Remarkable Success Rates of the Physician and Pilot Programs

Medical boards and airlines administer recovery programs for physicians and pilots with very high first-time recovery rates; they are the only groups that have validated, high abstinence rates. Let's start with these facts:

- ***Doctors have first-time continuous abstinence rates of 78% at five years!***
- ***92% of airline pilots are continuously abstinent at two years![2]***

No other programs approach these recovery rates, as studies show most programs with one-year continuous abstention rates of less than 25%.

Regarding the outstanding outcomes for Physician Health Programs (PHP) run by medical boards, two commentators, Dr. David Carr and Dr. Robert DuPont, state:

> *Those are just over-the-top numbers for a chronic, progressive disease that kills people.*[3]
>
> *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.*[4]

These success rates will impress any family leader, trustee (or attorney advising a trustee) who is familiar with addiction.

The physician model is different from typical addiction treatment in that it is both better in quality and longer in duration – much better treatment over many months! It is also different because medical boards oversee and dictate the terms of the recovery program for doctors.

- ***Note also that addiction treatment is the only field of medicine where physicians receive different treatment than other population groups.***

If cancer treatment had similar differential outcomes, the public would insist on receiving the physicians' program.

The concepts in this article were initially developed by one of the authors, Bill Messinger, in 1998 after seeing this headline in the Hazelden Bulletin: *"Airline pilots soar to success in recovery*[5]*"*.

- Airlines required pilots to participate in a Human Intervention and Motivation System (HIMS) program – the reason for their 92% success rate.

Bill subsequently learned about similar success for physicians and began adapting the physician/pilot model in his work with affluent families, including trustees. Up until then, addicted beneficiaries he knew went through multiple treatments with high relapse rates, even while attending the best centers in the country.

- PHPs are now the gold standard for addiction treatment.

The reader must understand why they are so effective and how to apply their ideas to addicted family members, including beneficiaries.

As mentioned, this article focuses on the language family offices, their advisors and attorneys can insert in governance documents or otherwise use to address substance abuse and other behavioral disorders. The essential concepts are to:

- use family resources and relationships as leverage or pressure to encourage treatment compliance, and
- manage the recovery process to support compliance over many months, if not years.

Our suggested trust provisions are worded to support these two purposes.

This model also requires a paradigm shift – a new way of thinking about and addressing addiction – as an intensive process contrasting sharply with the current practice advocated by treatment centers, interventionists and Al-Anon.

- Phrases such as "letting go" or letting a client "hit bottom" require families to remain passive and hope the addict suffers enough consequences from using alcohol and drugs to want to go to treatment on their own.

And when they do go to rehab, they often leave early, decide they have their addiction under control and return to their using environments – a recipe for relapse.

Some parents, professionals and treatment centers oppose this new approach – the use of leverage and imposed recovery management – often on the grounds that it interferes with personal autonomy. But then consider this definition of addiction as the

> *"compulsive repetition of an activity despite life damaging consequences*[6]*"*

from a recent article in *National Geographic*, titled "The Science of Addiction[7]." This article shows in living color where and how mood-altering substances modify brain structure and cells, based on scans.

Brain scans also show how these substances diminish the brain's executive or decision function capacity. In short, the addict not only can't control his/her behavior, but also has diminished capacity to be aware of the need to do so. When you add trust distributions into this equation, ask yourself: Can you in good conscious wait for a beneficiary to see the light and trundle off to treatment?

Money allows addicted beneficiaries to avoid the consequences of their use. Therefore, without pressure from outside sources, their disease progresses to the point where they suffer significant physical deterioration; harm their families; and damage their financial well-being. We reject this do-nothing, head-in-the-sand approach as outdated and dangerous, particularly given the success rates for the physician/pilot programs.

As our approach is different than the one advocated by most treatment centers and their interventionists, we will discuss how trustees can use leverage and contingency management to encourage beneficiaries to recover.

B. Use Leverage to Obtain Treatment Compliance

Medical boards use the license to practice medicine as leverage or pressure to assure that physicians comply with treatment recommendations, including post-treatment plans and reliable drug testing for two or more years. Either comply or do not practice medicine! A treatment plan is outlined that includes consequences for relapse or non-compliance. Pressure is maintained over many months to assure that doctors are well on their way to recovery.

For the beneficiary or family business member, money and access to other resources is the leverage used by trustees and senior family members to encourage treatment compliance. <u>This type of leverage can be very effective!</u>

- ***Without leverage, any intervention strategy has little chance of succeeding.***

The fundamental idea is for the family/trustee to exert leverage on their loved one to remain in treatment and follow post-treatment recommendations, just as medical boards do for physicians and airlines do for pilots.

<u>Explicit Leverage</u>

In order to exert leverage on beneficiaries, language must be included in trusts and estate plans modeled after the process used by medical boards for their addicted physicians. We refer to this as **explicit leverage**. Without such explicit language, finding sources of pressure to encourage treatment compliance is often difficult; usually takes several tries; and occurs later in the progression of the disease.

- This is why some families "decant" or change trust agreements to insert versions of our model language; change distribution dates; "pour over" into new trusts; or modify succession and other business agreements.

They do what is necessary to keep money out of the hands of an active addict, as money fuels the fire of addiction. $500,000 in the hands of a 21-year-old addict is a disaster.

<u>Non-Explicit Leverage</u>

In the absence of such language, families and trustees will need to find other forms of pressure to assure treatment compliance by beneficiaries (**non-explicit leverage**). We've identified many different forms of encouragement to seek help too numerous to include in this article. In our experience, there are three types of non-explicit leverage:

- Soft pressure: personal, relationship-based (using emotion) – "Please go to treatment, your alcohol and drug use scares me."
- Externalized pressure: opportunistic pressure (e.g., passing out at weddings, DUI) – "It's clear you now have a problem."
- Action-based: creating consequences (setting limits and making agreements) – "OK, now let's see if you can not use for a month if you want money to pay off your debts."

To emphasize, this type of leverage is far less effective than document-based leverage because of the inability to maintain pressure to encourage sustained recovery over several months. The addict figures out how to avoid the pressure or decides to ignore it because the consequences are not significant enough to counter the desire to use.

Non-Explicit Example: Jane
Consider this example: A young adult "Jane" is arrested for stealing purses and credit card fraud to obtain money to buy heroin and Suboxone. The judge sends Jane to a diversion program with no requirement to stay "clean" or successfully complete treatment. However, to pacify her parents, she says she will go to treatment chosen by the addiction expert advising her mother, if her mother covers her credit card bills (which are overdue because Jane is broke).

Jane goes to a treatment center in a remote location in the U.S. but bails after attending only half the program, using frequent flier miles to return home, and then relapses. Her mother wisely only paid the minimum due on Jane's cards so now Jane is being hounded by the credit card companies and has trouble maintaining employment at fast-food establishments. She now is considering outpatient treatment.

This is an example of a failed opportunity to effectively use external, opportunistic pressure because the court system did not require Jane to be clean or attend treatment as a condition for diversion, so she left treatment early. Her financial situation is again leading her to consider outpatient treatment as an option (another example of non-explicit leverage). However, Jane has little incentive to remain in outpatient and will likely quit when she feels more stable and can obtain improved employment. She will then once again soon return to her old using pattern.

Add Distribution Standards or Modify the Trust, Rather than Risk Failure Using Non-Explicit Leverage
Non-explicit leverage has signification limitations. Opportunities for intervening in the addiction cycle are infrequent and they must be used for maximum effectiveness. After one or two treatments, the beneficiary becomes treatment resistant and better at hiding his/her addiction. Rather than attempt to use non-explicit leverage and risk failure, we recommend that the trustee or trustee's counsel be creative in working with family members in establishing new trusts and other governance documents that include explicit language similar to our model language.

Recent case law and statutory changes grant trustees a great deal of discretion to modify trusts in the best interests of the beneficiary. When behavior indicative of addiction surfaces, what more compelling justification can there be for the trustee to act in the best interests of the beneficiary than to adopt distribution standards based on our model language? This includes, if necessary, decanting into a new trust with the model language or relocating the trust to a state with liberal decantation and amendment laws.

In concluding this part, keep in mind that leverage is a tool to obtain treatment compliance; it is not treatment in and of itself. If treatment is ineffective, leverage is wasted. (Treatment quality issues are not covered in this article.[8])

For more information on leverage, download these articles at www.billmessinger.com:
- *Leverage First: Using Family Resources As A Positive Influence For Recovery*
- *Using Leverage to Support Long Term Recovery*

C. The Rationale for Contingency Management (Leverage)

Contingency management is a fancy way of describing behavior modification – an effective tool to encourage addicts to enter treatment and comply with treatment recommendations for the many months necessary to sustain stable recovery. The core concept is using external pressure for compliance until such time as the substance user develops sufficient internal motivation to stay clean and participate in recovery activities. At this point, the trustee or designated recovery manager can adopt a "trust but verify" mode, relying on reduced drug tests and reports from therapists.

To better understand this approach, let's explore the disease concept of addiction as it relates to addict decision-making. Yes, addiction is disease of the brain, as *National Geographic* describes in detail in the above-referenced article. But as Dr. Sally Satel points out:

> *"[The] critical question is not whether brain changes occur – they do – but whether these changes block the factors that sustain self-control for people. ...*
> ***The point is that addicts do respond to consequences and rewards routinely.*** *....*
> *It is far more productive, in my view, to view addiction as a behavior that operates on several levels, ranging from molecular function and structure and brain physiology to psychology, psychosocial environment and social relations."*[9]

The disease of addiction does "hijack" the user's brain, strongly influencing behaviors, but that does not mean the users are helpless and unable to respond once detoxed or confronted with external negative consequences. Let's look at the following examples of clinical studies of improved recovery rates through incentives:

- Physicians/pilots: Job is dependent on treatment compliance
- Workers submitting clean urine samples for $10-per-hour jobs
- Patients at outpatient centers receiving food vouchers for compliance
- Offenders in drug courts with sanctions for non-compliance

(Judges in these courts are said to have better recovery outcomes than treatment centers.)

And consider the opinion of professionals on the benefits of leverage-based incentives to comply with treatment:

Chemically dependent patients, free of co-existing mental illness, with intact jobs and family, tended to do well in rehabilitation programs if families and ***employers applied therapeutic leverage and support.***

Goodman and Levy. Biopsychosocial Model Revisited. p. 3.

Internal motivation is a more powerful predictor of recovery than external motivation. Moving from external motivation to internal motivation is a long process. Therefore ***it is critical for external pressure to continue*** *until this transition is fully underway, if not complete. The failure to follow this advice is a major cause of relapse (paraphrased).*

Susan Merle Gordon. Relapse & Recovery: Behavioral Strategies for Change. Caron Foundation. Rept. 2003: p. 18.

My experience with attorneys tells me that long-term outcomes are dramatically improved when lawyers ***can be monitored and when there is an accountability system with a fair amount of external support.***

> Chuck Rice. Impaired Lawyers Overcome Denial, Stigma to Achieve Road to Recovery. Hazelden Voice. Vol. 9, No. 2. Summer, 2004.

Treatment compliance is the biggest cause of relapses *for all chronic illnesses, including asthma, diabetes, hypertension, and addiction.*

> Alan I. Leshner, Former Director, National Institute on Drug Abuse. National Institute for Mental Health. Science and Technology. Spring, 2001: p. 2.

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.***

> Satel, M.D., Sally. 2006. "For Addicts, Firm Hand Can Be the Best Medicine." *The New York Times*, Aug.15.

Treatment that works best […] relies on improving patient choice-making and self-control and that ***leverages the power of incentives and sanctions.***

> Satel, M.D., Sally. 2016. "Is Addiction a Brain Disease?" The Conversation.

These examples and experts are provided as support for when, as counsel to the grantor or trustee, you are asked for your reasons for incorporating our suggested or similar language in a trust or as a distribution standard.

It stands to reason that for treatment to be successful there must be sufficient time for the addict to work on the psychological, psychosocial, environment and social relations aspects of addiction (including money as a trigger or facilitator for using).

- These are uncomfortable topics for many and are often the underlying reason for relapses.

Leverage is then a tool to encourage longer engagement in treatment so these issues can be addressed. And it is a tool to provide the addict time to learn different responses to cravings or using impulses. In inpatient treatment, lack of access to substances lays the foundation for a post-treatment program of incentives and deterrents to promote these new, healthier responses. (To understand how treatment works to develop positive responses to using urges, see *The Power of Habit,* by Charles Duhigg.)

Another reason for leverage-based accountability stems from studies correlating willingness to participate in treatment with severity of using consequences. Because affluent, trust-funded or family-supported addicts face far fewer consequences, they are much less likely to commit to treatment. Therefore, the model language and similarly imposed restrictions on access to funds or other resources are, in effect, consequences imposed by family "rules" incorporated in trusts or family policy. We call it "creating consequences" in order to make the disease real.

It is far easier to create these rules or standards in trusts in advance of a crisis than to do so after the crisis. Family businesses have been sold due to the inability to effectively

rein in family members working in the business. And, of course, trustees are reluctant to adopt effective distribution standards for reasons discussed earlier in the article.

The critical takeaway is that pressure is a well-documented method to support improved recovery outcomes based on treatment compliance. It is not punishment! We say this because the objects of the pressure – addicts – will complain that they are being punished for having a disease, particularly when they are 20 days into treatment, are "recovered" and want their distributions.

D. Manage the Recovery Program with the Help of Addiction Experts

The physician/pilot programs could be called *the medical boards and airline recovery programs* because these organizations manage and direct the recovery programs for doctors and physicians. Family leaders and trustees, working with qualified addiction professionals providing guidance and expertise, must also find ways to manage and direct their addicted beneficiary's recovery program over the long term, just as the medical boards and airlines do for their doctors and pilots.

Examples of post-treatment case management and personal recovery support services are in Appendix C and include activities from recovery coaching to support for attending meetings. See the O'Connor Professional Group website (www.oconnorprofessionalgroup.com) for a more detailed description of these services.

Think of this concept as a *recovery management program* for substance-abusing beneficiaries. Two quotes on the topic of recovery management from recent articles in the addiction field:

> ***Recovery management*** *is an emerging model geared toward treating addiction similar to how other chronic and progressive illnesses, such as diabetes and cancer, are treated.*[10]
>
> *Some clinical people are uncomfortable with this idea, but* ***the research shows that some accountability in the environment is very good for people****. That includes, for example, drug testing with immediate, certain consequences such as you see in drug courts.*[11]

(For more references on recovery management, see the endnote[11].)

The goal is to use leverage (external pressure) on the addict until s/he develops the internal motivation to recover – a process that often takes several months of quality inpatient and outpatient treatment. Recovery management helps develop that internal motivation.

- Addiction is an extremely difficult behavioral disorder to put into remission because it is lodged in the autonomic part of the brain and is triggered by so many "cues" associated with past use.

This is another reason why the most common outcome of 28-day treatment is relapse and why we emphasize the need for a long-term *recovery management strategy*.

Family Case Management Program

As mentioned, for nearly 20 years we have used the concepts of the Physicians Health Program (PHP) in our work with families, now formalized in what we call our ***Family Recovery Management Program.***

- This title is used because families *can learn* to play the same role as medical boards in using leverage with their addicted loved ones to encourage them to enter treatment and comply with post-treatment recommendations (i.e., to manage their family member with the chronic disease of addiction).

The phrase **"can learn**" is emphasized because while medical boards use qualified, licensed professionals to guide them, most families are unfamiliar with the concept. They must use similar assistance to effectively implement and convert the PHP concepts to their individual circumstances for loved ones with behavioral disorders.

As the PHP model is unfamiliar to many readers, a conceptual overview of the PHP program might be helpful. Without going into detail, the most important part of the PHP program is that it is a two-track system. When adopted by families and their addicted loved ones, the system is outlined as follows:

Family/Addict Two-Track System

• ***Family Track*** *Uses Leverage*

– Professionals working with families dictate recovery activities and receive progress reports from treatment centers. Professionals oversee this process.

• ***Addict Track*** *Complies With Leverage*

– Family addict has his/her own recovery: treatment, aftercare, 12-step meeting, therapy – a two-to-three-year process.

As we emphasize, this model is conceptually and in practice very different from what is promoted by treatment centers, Al-Anon and interventionists. But the model results in much better outcomes than current practice.

Note that the family can't merely use leverage to get their addict into treatment and then ease off, thinking that the addict will engage in recovery. Leverage or pressure needs to be continued in place over time, as treatment is only the beginning of the recovery process. Stabilization of urges and emotions occurs well after 28 days. (Keep repeating: "Inpatient treatment is not recovery!")

Implementing Recovery Management

The common elements of the successful PHP/pilot programs, as applied to affluent family systems are:

- Emphasis on open communication among all parties (This means signing full or complete releases)
- Immediate response if relapse
- Leverage used to assist in implementing a structured recovery program
- Drug testing
- Proactive therapeutic "community" (counselors, sponsor, meetings, etc.)
- Contract signed by the addict – specifying recovery activities and relapse plan

All of these elements are part of a recovery management strategy supported by the family and implemented collaboratively with their addiction counselor.

Even if you are only partially successful in having your beneficiary agree to some of these elements, they can be useful in other settings. For example, trustees like to see hard evidence of addiction before they take action. Often, the only information they receive are verbal reports, including treatment center attendance.

Remember the example of Jane? She did sign a release for her mother's treatment advisor, who obtained a copy of Jane's treatment plan. When Jane decided to leave she revoked her release, so other documents were not available, including her leaving against medical advice. But if necessary, treatment plan information can be submitted to the trustee as evidence to prove her addiction history and the fact that she left earlier than recommended by the treatment center.

The Contract Between the Employee (Doctor) and Oversight Entity (Medical Board Designee)

This contract physicians sign with the medical boards also contributes to the high success rates of the PHP model because the contract leaves no room for debate as to what the physician's recovery activities are and what constitutes compliance. Again, the PHP experts Drs. Greg Skipper and Robert DuPont point out:

> *Regardless of referral source or condition, all physician participants were required to sign a contract specifying the nature and duration of their treatment and monitoring, as well as the consequences for failing to abide by the contract.*

All contracts also contain clauses requiring random drug testing.

Therefore, an important component of recovery management is the agreement between the addict in early recovery and the family or trustee.

- This document identifies recovery activites to be engaged in by the addict in exchange for family financial support and progress reports sent to a case manager acting on behalf of the family.

For the affluent, this written agreement takes different forms; is individualized for each family situation; often incorporates as an addendum the key points of our model language; and includes a plan in the event of relapse.

In conclusion, the Family Recovery Management Program may be thought of as one end result of the use of leverage – compliance with high-quality and effective post-treatment recommendations and activities with management oversight on behalf of the trustee. It is now being replicated in many other settings, including hospitals and clinics to wean patients off pain pills.

For more information on recovery management, see our companion article:

- *Dual Track Family Case Management and Monitoring: The Key to Recovery from Addiction and Other Behavioral Disorders*

II. Replicating the Pilot/Physician Protocols

This section is intended to provide the reader with an overview of our model language in Appendix A, first beginning with an explication of key underlying concepts in Part A and then in Part B, discussing each section of the model language in the Appendix in a "plain English" summary.

A. Key Concepts

1. A Problem-Solving, Early-Intervention Approach

Our goal is for families and their trustees to use a problem-solving approach with dysfunctional family members.

- Our clauses authorize the appointment of experts to evaluate the presenting issues, make recommendations and generally manage the situation on behalf of the trustees.

Therefore, when concerns arise regarding questionable behavior, the person with the problem is referred to a competent, licensed professional for an evaluation and alterative options going forward.

Evaluating Problematic Behavior Promotes Early Intervention

Problematic behavior is both circumstantial (e.g., failing grades, showing up late for family activities) and direct (e.g., drinking too much, smelling of alcohol, hangovers).

- Trustees do not have the time or expertise to accumulate information or understand its implications regarding such behavior.

They often avoid taking action until the disease progresses to the point the beneficiary is unable to recover. Professional evaluations are, therefore, the foundation of an early intervention strategy.

2. Role and Value of the Professional Expert

The Professional Works for the Trustee – Not for the Beneficiary

Keep in mind that under our dual-track system, the professional works for the trustee and not for the beneficiary.

- This relationship must be made clear to the beneficiary so s/he does not try to invoke a privileged or therapeutic relationship with the professional to prevent communication with the trustee.

The beneficiary should be reminded that s/he has her own therapist and asked to acknowledge this distinction in writing.

Trustee vs. Guardian

Trustees do not consider their role to be overseers of problem beneficiaries. They consider these types of activities as more properly performed by guardians.

- Therefore Appendix A provides for the trust to pay for professional assistance as well as direct services for the beneficiary.

If necessary, the professional can be asked to assist the trustee in communicating with the beneficiary, organize treatment resources, review budgets and expenditures and generally manage the recovery process – essentially acting as "guardian" on the trustee's behalf.

The Court of Family Opinion and Law – The Value of Professionals

While a discretionary clause or an ascertainable standard ("no distributions to addicted beneficiaries") does provide authority for a trustee to cut off funds, this action can be perceived as arbitrary if not supported by the opinion of a professional.

- Such opinions are very helpful in persuading family members to encourage beneficiaries to seek help, rather than undermining the process.

Also, in the event there is the threat of litigation, professional opinions can be persuasive with opposing counsel and the court. Far better to submit an expert's report than the statement of a trustee that the beneficiary was cut off, because s/he heard there was a problem with drugs or drinking. (Be sure the professional is accredited and holds a state license or the court or opposing counsel will reject his/her advice due to lack of qualifications.)

Reducing Tension Between the Trustee and Beneficiary

Saying "no" or placing other restrictions usually results in an emotional response from the beneficiary. This can be difficult for trustees who are not trained to deal with anger, tears or other forms of intensity designed to influence the trustee to back off. Using a professional helps defuse the trustee-beneficiary interaction, as it is the professional who is advising the trustee.

- The trustee can rightfully say s/he is simply adhering to expert opinion.

Also, beneficiaries like to argue justifications, intentions and make promises when confronted with their actions or inactions. Professionals are excellent resources to assist trustees in sorting through the rhetoric and focusing on behaviors.

3. New Definition of Addiction and Alcoholism – Substance Use Disorder

The American Psychiatric Association no longer uses the terms "addiction" or "alcohol use and dependence." Rather, the new phrase is "substance use disorder." There are separate diagnostic categories for 10 different classes of substances, such as alcohol, opioids, sedatives and caffeine. For example, there are 11 criteria for diagnosing the class called "Alcohol Use Disorder." The disorder is then defined as:

- **Mild:** Presence of 2-3 symptoms
- **Moderate:** Presence of 4-5 symptoms
- **Severe:** Presence of 6 or more symptoms

As noted, the former classifications were alcohol abuse or alcohol dependence – not mild, moderate or severe. The other classes of substances also have their own set of criteria.

The noteworthy point here is that a mild substance use disorder results from matching 2-3 out of 11 criteria and so allows for earlier identification of potentially serious problems. It is also reflects the fact that substance use disorders are progressive (i.e., they get worse over time).

The Alcohol Use Disorder criteria are included in Appendix B for reference purposes.

4. Understanding the Stages of Treatment

In the previous section, we noted that leverage is a means to encourage the beneficiary to remain in treatment until the recovery process is complete, but we did not discuss

treatment itself. Regardless of what type of treatment the addict receives, there are well-defined stages of recovery that the trustee needs to be aware of in order to understand the treatment process and the justification for maintaining leverage for at least two years.

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. An article in a professional addiction journal discusses the developmental approach to recovery and the six stages to achieving stable remission[12]:

- 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*

These stages occur over years, which is why we use a two-year minimum time in our model language.

Lawyers and others advising families or serving as trustees do not have the time or skills to oversee these stages, nor do family members – no matter how dedicated or devoted to their addicted loved one. In working with clients and reviewing circumstances leading to relapse, failure to recognize these limitations is often a major contributor to post-treatment failures.

Stabilization – Recuperation

Treatment can be a mystery to outsiders, but there are recognized tasks to be accomplished in a 28-day program and the weeks following. The referenced article discusses Stage Two – Stabilization – as including five tasks[13]:

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

It is no wonder that inpatient treatment is insufficient to assure abstention from use because the stabilization process – Stage Two – takes much longer than 28 days. For some drugs, it takes two to three weeks just complete active withdrawal. Learning new ways of socializing and healthy responses to stress can take many weeks for most people.

Most parents and any trustees receiving information from treatment centers are simply told that the patient is "making progress," not the task the patient is working on in this stabilization process. (Why? That's a topic for a different article.) Experts are more able to communicate with treatment personnel to obtain this information because they know what questions to ask and tend to be viewed as peers.

In concluding Part A, we hope the reader now understands our reasoning and objectives in developing the various provisions of our model language, as well as some of the practical considerations for implementation.

B. Plain English Summary of Appendix A Model Language

Because legal writing for trusts can be confusing, in this section we explain the model language in plain English so the reader understands the purpose of each paragraph. Trust creators must use precise and detailed language to effectively address SUDs and other disorders in beneficiaries. Leave no room for dispute, as addicts (and their attorneys) will exploit any opening.

We suggest you print out the model language and do a paragraph-by-paragraph comparison between our plain English section and the model language.

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

(**Introduction - Substance Use Disorders - Behavioral Health Disorders)**

Note: The model language covers not only Substance Use Disorders, but a broad range of disorders, including mental illness and other compulsive behaviors that may affect a beneficiary, as defined in the DSM-V. While the focus in this article and discussion is on alcohol and drug addiction (SUDs), a higher percentage of addicts also suffer from clinically diagnosable significant abuse and trauma or other mental health conditions. Or the beneficiary may only have a mental health issue – acute anxiety or depression. In either case – dual diagnosis or standalone problem – the model language authorizes the hiring of experts and the funding of treatment to assist the beneficiary and encourage him/her to seek help and sustain recovery.

Statement of Purpose

The Statement of Purpose is an opportunity to express your intentions and goals in including this language in your trust or estate plan. The statement may be used by the trustee in the event of the need for clarifications regarding interpretation or implementation.

Subjects addressed include:

- Stating your opinions on your view on addiction, treatment and recovery due to the many different, and often conflicting, ideas on these topics.
- Describe your thought process or outline your intentions in incorporating this language into to your estate plan or trust to help both the trustee and beneficiary understand expectations and better execute the directives in the language.
- You may also wish to discuss what actions the trustee may and should take in the event of non-compliance (i.e., the beneficiary continues to use) and any minimal levels of support.
- Finally, as this model language is new to many trustees and courts, it may be helpful to confirm that you intend for Appendix A to be enforced quickly and completely, including funding of experts and services from the trust.

This section will be unique for each trust. Sample language is provided in Appendix A.

1. Sole Discretion of Trustee to Withhold Income or Principal, Notwithstanding Any Other Provision of this Trust Agreement, When SUD or Behavioral Health Disorder Indicated

a. Defining the scope of behavior by a beneficiary that would trigger withholding:
   Any Beneficiary who has or may have: substance use disorder(s), (addiction), other disorders, compulsive or destructive behaviors, mental health conditions or concerns or any combination of the foregoing (described hereafter as SUDs and other behavioral health disorders)

Comment: If there are indications of problematic behavior, the trustee can make a referral to a professional for an assessment or other evaluation 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.

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 Appendix A, such as hiring experts or treatment costs.

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.

c. In the event the beneficiary dies before rights of withdrawal from the trust are reinstated, resume distributions to the alternate or secondary beneficiaries of the beneficiary's share.
d. While the provisions of Appendix A or a recovery program are in effect, the trust will be administered as a discretionary trust to provide for the beneficiary according to the provisions of the trust and in the trustee's sole and absolute discretion.

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

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

a. Authorization to hire experts; describes their general area of expertise and the general scope of their activities; can help determine what recovery-related activities should be funded by the trust.
b. Authorizes inpatient evaluations, recommendations and treatment as defined.

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.

c. Requires experts and treatment facilities/programs to be licensed and meet standards for Society of Addiction Medicine if prescribing medications.

Comment: Many interventionists and other people "treating" or otherwise 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 the Expenditure of Funds for Intervention, Treatment and Recovery Activities

Trustee (or trustee's designee) has full authority to initiate and implement plans for recovery, including expending funds to implement Appendix A (e.g., paying for evaluations; treatment and all related costs; post-treatment recovery programs; and any and all related matters deemed appropriate by the trustee in his/her sole discretion).

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

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 treatment and recovery recommendations, as approved by the trustee or his/her designee.

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.

5. Alcohol and Drug Testing – Observed Tests

a. Requires drug tests by a reliable, comprehensive testing service to verify drug-free status.
b. Method of testing could be hair, tissue, bodily fluid, etc., and must be conducted under observation of personnel from the drug testing service or their designee. Preferred choice is the testing service used by and for health care professionals.
c. Specific authorization to withhold distributions for non-compliance with drug testing requirements.

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.

6. Recovery – Two-Year Minimum

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 if 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.
c. If the beneficiary has not completed the recovery program, the trustee can make distributions to continue supporting the recovery program but is not authorized to make any distribution that might lead to relapse.
d. If the beneficiary continues to use and fails to attempt or achieve recovery, the trustee may still make distributions to support the beneficiary's basic needs (i.e., food, shelter, medical care, etc.). However, the trustee's authorization to do so is not a requirement; it is entirely up to the trustee's sole and absolute discretion to fund a non-compliant beneficiary.

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

7. Date when Recovery Begins

a. Time in recovery begins after the beneficiary leaves treatment, halfway house, sober house or other inpatient environment.

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.

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) definitions of 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). Clause includes indemnification from 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 for his/her defense.
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 Appendix A if

circumstantial or direct evidence comes to their attention that the beneficiary is engaging in conduct specified in Section 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.

e. When administering the program as specified in Appendix A, the trustee has the option to be compensated from the trust at a competitive hourly rate. In the event trustee compensation is contested, the trust protector will be responsible for settling any disputes.

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.

12. Prohibition on Payment of Beneficiary's Litigation Expenses

The trust will not fund a beneficiary's legal action taken against a trustee but will pay for the trustee's defense of such action brought by the beneficiary.

13. 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 Appendix A.

III. Brain Changes and Substance-Related Disorders DSM-V

Many people use words like "alcoholism," "drug dependence" and "addiction" as general descriptive terms without a clear understanding of their meaning.

What does it really mean to think of someone as a "drunk," "junkie" or "smoker"?

- Well, we can all have our own views and definitions, until we become family leaders, advisors and trustees and are confronted with problematic behavior that may be related to alcohol, drug use or other disorders.

Then we must become familiar with standards used by professionals to assess and categorize these behaviors in the DSM-V – the topic covered in this section.

You may recall the general definition from the *National Geographic* excerpt earlier in this article:

- *Addiction is characterized by the compulsive repetition of an activity despite life-damaging consequences. Addiction is possible without drugs.*

Addiction is no longer characterized only by withdrawal symptoms or physical dependence – these are two of **11 evaluation criteria**. (Discussed below.)

- It is the behavior that counts.

That is why the DSM-V includes Internet gaming, compulsive shopping, sex, food addiction and gambling, as well mental health disorders. But for the purposes of this discussion, the focus is on alcohol and drug addiction.

Alcoholism/Addiction Now Called 'Substance Use Disorder'

As mentioned, the experts – the American Society of Addiction Medicine – in their latest edition of the DSM-V, changed the name from alcohol and drug dependence to "substance use disorder."

There are now 10 separate classes of drugs that fall under the umbrella of substance use disorders:

- Alcohol, Caffeine, Cannabis, Hallucinogens (phencyclidine and other), Inhalants, Opioids, Sedatives (hypnotics or anxiolytics), Stimulants, Tobacco and Other (or unknown).

We will be discussing their common criteria later on, as well as the criteria for one of the categories – **alcohol use disorder (alcoholism)** – as an example of how the general criteria are applied to one of the 10 categories. However, before we examine these criteria, it is helpful to understand several common overarching concepts or definitions.

A. Brain Changes Due to Substance Use

1. Autonomic/Limbic System Responses

An important characteristic of substance use disorders are ***underlying changes in brain circuits*** that often persist beyond detoxification (meaning after the substance is no longer in the body).

- These changes are prominent in individuals with severe disorders, but also occur at the mild or moderate level.

One set of critical circuits modified are in the limbic system – the fight-or-flight response area – a primitive section of the brain. Another significant change is that using the substance or engaging in a negative behavior becomes a learned autonomic (automatic) action beyond the control of the executive control or frontal area of the brain. Addiction becomes habit.

2. Activating the Reward System

All drugs taken in excess have in common the direct activation of the brain's reward system. This system is involved in the reinforcement of behaviors and the production of memories.

- Drugs produce such an intense activation of the reward system that normal activities may be neglected.

Instead of achieving normal reward activation by engaging in pursuits such as exercise, reading or interesting conversations with friends, drugs directly activate the reward pathways and produce feelings of pleasure, often referred to as a "high."

Drugs are attractive because they work to change mood every time. Unlike interactions with friends, books or a game of tennis, the outcome is predictable and reliable. Problems begin when mood-altering substances begin to take over a person's life.

- As the brain circuits become rewired, the pleasant reward changes to compulsive need when one begins to lose control over how much and when to drink or use.

For the reader who has trouble understanding this concept, try not drinking or using Ambien or Xanax for a month. Record your reactions in a diary, particularly when there is a regular time of day when you are accustomed to pouring that glass of wine or taking your prescription. (See the September 2017 *National Geographic* article for detailed information on brain changes and the dopamine transmission within the brain.)

3. Cross-Addiction (Cross-Substance Use Disorders)

With 10 categories of substance use disorders, a person's behavior might meet the criteria for a category for one or two – say alcohol and cocaine, but not marijuana. Therefore, this person could argue that it is fine to use marijuana due to lack of a finding regarding that substance. But this argument fails to consider the fact that the both the brain reward system and limbic/autonomic area respond to all substances in much the same way, regardless of their category.

- Essentially, it makes no difference whether the substance is alcohol, cocaine, Xanax, Ritalin, heroin, marijuana or an herb-based stimulant – to the brain it's all the same.

This used to be called "cross-addiction," in that a person who is addicted to one substance will also have symptoms indicating an addictive relationship with other substances. So don't buy the argument when a beneficiary claims the treatment center said, "I only had a problem with cocaine, they told me it is fine to drink beer."

One reason for emphasizing this fact is that medical marijuana and narcotic prescriptions are taken by people with defined substance use disorders in other categories, such as alcohol, cocaine and pain medications. This "medication management" of substance use disorders is not "recovery" as we define the term in Appendix A.

- The DSM describes prescribing medications to help someone stop using one substance as "on maintenance therapy" to indicate recovery is conditional and not complete.

This is also one important reason why our model language requires all prescribed medications to be approved by an ASAM-certified prescriber.

We do not subscribe to the view that it is OK to use other medications fitting into DSM-V categories and also meet our definition of recovery.

B. Medication-Assisted Treatment (MAT)

In addition to cross-addiction as a concern, medication-assisted treatment (MAT) involves the use of substitute medications for heroin or pain medication such as methadone or Suboxone. These medications have a longer half-life, but still are mood-altering and, when abused, can lead to a significant high. Currently (October 2017), there are two camps regarding MAT:

Camp One believes that remission lies in fixing the faulty chemistry or wiring of the addicted brain through medication with psychosocial support as an adjunct.

- This approach means that the addict can be on medication for a long time, including mood-altering drugs (Suboxone, methadone, Klonopin) – popular in Europe and some U.S. treatment centers.

The concern for all substitutes is the danger of abuse and never achieving "true" recovery as we aspire to in our model language.

Camp Two views medication as an adjunct to treatment as a way to reduce craving and the agony of withdrawal while people do the psychological work essential to addiction recovery.

- Medication is reduced over time per withdrawal protocols or to help those in early recovery experience reduced cravings when the patient leaves inpatient treatment.

Camp Two is an abstinence-based approach, with the ultimate goal of full remission, as defined in the DSM-V and discussed below.

Model Language – Camp Two – Abstinence Ultimate Goal

To be clear, the model language in Appendix A reflects Camp Two's abstinence goal. If a beneficiary is on a mood-altering chemical or other substance used to control or block more addictive substances, the beneficiary cannot meet the definition of remission used in the model language.

- One reason is due to the need for continual monitoring for levels of medication to assure the dose is therapeutic or not misused.
- A second is that many people on maintenance drugs like Suboxone or methadone abuse these drugs and mix them or relapse with other drugs.
- The third is that, in our experience, in a monitored, comprehensive recovery program, abstinence is achievable and often leads to the desired personality change reflective of a sober person.

Further on in this article, we review the DSM-V discussion on the use of appropriate prescribed medications for addiction treatment. But we raise this issue here, because many treatment centers are vocal advocates for permanent MAT. But in our view, this may be because they are not willing to spend the time or provide the professionals for a comprehensive treatment program necessary to achieve abstinence.

C. Behavioral Standards Based on Effects of Substance Use Disorders Due to Brain Changes

The **behavioral effects** of brain changes due to substance use may be exhibited in repeated relapses and intense drug craving. In other words, until brain scans are accepted as proof that someone's circuits are altered by use, we need to examine observable symptoms. The essential features are a group of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

- Overall, the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance.

These behaviors fall into 11 criteria with overall groupings of *impaired control, social impairment, risky use* and *pharmacological criteria.* For some substances, symptoms are

less prominent, and in a few instances not all symptoms apply. We will now look at the criteria in these groupings, as discussed in the DSM-V.

Impaired Control

Impaired Control over substance use is the first criteria grouping (Criteria 1-4).

1. The individual may take the substance in larger amounts or over a longer period than was originally intended.
2. The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use.
3. The individual may spend a great deal of time obtaining the substance, using the substance or recovering from its effects. In some instances of more severe substance use disorders, virtually all of the individual's daily activities revolve around the substance. In other instances, use is confined to limited time periods – a few hours per day, or a day or two per week or a weekend every few weeks.
4. Craving is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used. Craving has also been shown to involve classical conditioning and is associated with activation of specific reward structures in the brain – think Pavlov's dog and read *The Power of Habit.* (Current craving is often used as a treatment outcome measure because it may be a signal of impending relapse.)

Social Impairment

Social Impairment is the second grouping of criteria (Criteria 5-7).

5. Recurrent substance use may result in a failure to fulfill major role obligations at work, school or home.
6. The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
7. Important social, occupational or recreational activities may be given up or reduced because of substance use. The individual may withdraw from family activities and hobbies in order to use the substance.

Risky Use

Risky Use of the substance is the third grouping of criteria (Criteria 8-9).

8. This may take the form of recurrent substance use in situations in which it is physically hazardous (e.g., driving while intoxicated).
9. The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., anger issue or liver damage). The key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite the difficulty it is causing.

Tolerance and Withdrawal

Tolerance and Withdrawal are the final grouping (Criteria 10-11).

10. Tolerance is signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed.

- The degree to which tolerance develops varies greatly across different individuals as well as across substances and may involve a variety of central nervous system effects (such as coordination and passing out).

Tolerance may be difficult to determine by history alone, and laboratory tests may be helpful (e.g., high blood levels of the substance coupled with little evidence of intoxication suggest that tolerance is likely).

11. Withdrawal is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance. After developing withdrawal symptoms, the individual is likely to consume the substance to relieve the symptoms.

- Withdrawal symptoms vary greatly across the classes of substances, and separate criteria sets for withdrawal are provided for the drug classes.

Marked and generally easily measured physiological signs of withdrawal are common with alcohol, opioids, sedatives, hypnotics and anxiolytics. Withdrawal signs and symptoms with stimulants (amphetamines and cocaine), as well as tobacco and cannabis, are often present but may be less apparent.

Note that neither tolerance nor withdrawal is necessary for a diagnosis of a substance use disorder.

However, for most classes of substances, a past history of withdrawal is associated with a more severe clinical course (i.e., an earlier onset of a substance use disorder, higher levels of substance intake and a greater number of substance-related problems).

<u>Alcohol Use Disorder – Diagnostic Criteria</u>

As mentioned, there are 11 criteria for determining an alcohol use disorder (formerly alcohol abuse or dependence). See the end of Appendix A for these criteria.

D. Medications Prescribed for Pain Reduction or Other Conditions

This part covers the problem that occurs when patients are prescribed painkillers for injuries or surgeries and when young adults are prescribed medications for ADD and other learning disorders. **When does use "as prescribed" cross over to "substance use disorder"?**

The DSM states the following:

The appearance of normal, expected pharmacological tolerance and withdrawal during the course of medical treatment has been known to lead to an erroneous diagnosis of "addiction," even when these were the only symptoms present.

Symptoms of tolerance and withdrawal occurring during appropriate medical treatment with prescribed medications (e.g., opioid analgesics, sedatives, stimulants) are specifically *not* counted when diagnosing a substance use disorder.

- Individuals whose *only* symptoms are those that occur as a result of medical treatment (i.e., tolerance and withdrawal as part of medical care when the medications are taken as prescribed) should not receive a diagnosis solely on the basis of these symptoms.

However, prescription medications can be used inappropriately, and a substance use disorder can be correctly diagnosed when there are other symptoms of compulsive, drug-seeking behavior. Users substitute one drug for another, trying to regulate their use by finding a new substance that allows for better control: Xanax for alcohol, Ritalin for cocaine, methadone for heroin. However, often these are temporary, with the user returning to the favorite drug.

Three comments:

- We find that many people who assert they are using medications as prescribed and exhibiting questionable behavioral symptoms are in fact obtaining medications from multiple doctors, over the Internet or from dealers.
- There is more misuse and overuse of prescription medications than illegal drugs.
- Spiritual healers, medical marijuana dispensaries and shamans are increasingly promoting use of curative and mood-altering herbs and remedies that do in fact lead to behavior that fits substance use disorder criteria.

Family leaders and trustees will find themselves with increasing numbers of next-generation members exhibiting suspect behaviors and being blissfully unaware of how their actions might be connected to drug use.

E. Severity of the Substance Disorders

Substance use disorders are described as:

- **Mild:** Presence of 2-3 symptoms
- **Moderate:** Presence of 4-5 symptoms
- **Severe:** Presence of 6 or more symptoms

Substance use disorders occur in a broad range of severity, from mild to severe, with severity based on the number of symptom criteria, as assessed by the individual's own report, report of knowledgeable others, clinician's observations and biological testing. The important point here is that evaluating problematic behavior when it first comes to the attention of parents, family members and trustees promotes an early intervention strategy if there is a finding of a mild substance disorder. Similar standards apply to other behavioral disorders and mental health conditions.

F. Definitions of Remission and Controlled Environment

Once a substance use has been determined, what about recovery? The DSM uses the term "remission." Remission means the person with the disorder meets *none* of the 11 criteria <u>three months after last meeting any of the criteria.</u>

- Therefore recovery or remission does not even begin until three months after last use of the substance.

Because relapse is so common, the DSM considers the first three months as a period when an attempt is made at abstaining.

Additional qualifications are:

<u>In early remission: 3 to 12 Months</u>

After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least three 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). This early stage reflects the unstable nature of recovery – relapse is common during the first year.

In sustained remission: After 12 Months

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).

In a controlled environment

This additional qualification is used if the individual is an environment where access to alcohol is restricted. In other words, in a treatment center, halfway house, sober home, wilderness or similar supervised residential setting. This is why in our model language we state that the time period for recovery begins when the beneficiary leaves a controlled environment.

Philip Seymour Hoffman

A good example is the 2014 death of Philip Seymour Hoffman from an apparent heroin overdose. He was reported to have gone to treatment for about 10 days after a reliance on prescription pills led him to briefly return to using heroin.

> *"I saw him last week, and he was clean and sober, his old self," said David Bar Katz, a playwright, and the friend who found Mr. Hoffman and called 911. "I really thought this chapter was over.*[14]*"*

Assuming this information is correct, three comments:

- "Clean" is a phrase used when a person has 12 months of no use of alcohol or drugs, including narcotic prescription medications. So don't think of someone as being "clean" until after 12 months. The better thought is "S/he is trying to abstain."
- Sober is a phrase used to describe someone who has 12 months of non-use and is actively engaged in a program of recovery.
- Hoffman "was long known to struggle with addiction." Therefore, a 10-day program was wholly inadequate. A minimum of 60 to 90 days inpatient, depending on his use history and prior treatments, is the recommended treatment.

As we discuss earlier in this article, finding and using leverage to encourage treatment compliance is a key consideration. Was there a source of leverage? Or was he so far into his disease and so wealthy, no leverage was available? Well, it is reported that he was found with 50 envelopes of heroin, so that is an answer.

In concluding this section, we now hope the reader has a thorough understanding of how professionals determine that someone with alcohol or drug problems meets the definition of a substance use disorder and how easy it is to misperceive the perniciousness of the disease – both by the user and family/friends.

Conclusion

This article reviews the reasons why the recovery programs for physicians and airlines are so successful and describes how their concepts are implemented for trustees concerned about beneficiaries with addiction or other behavioral disorders. As co-authors, we have extensive experience in creating and using leverage and arranging for and implementing a full range of recovery management contracts and services, as discussed at length in our two companion articles. It is our hope that the reader will have a thorough understanding of our model language and the standards for diagnosing problematic behavior used by professionals.

Also, in our experience, trustees are not interested in being guardians or spending the time necessary to administer the procedures we recommend for dealing with dysfunctional beneficiaries. However, we do find that trustees are now more willing to hire addiction experts and use pressure to obtain treatment compliance, as they become familiar with physician/pilot model and its application to beneficiaries.

One key idea to remember is the fact that *addiction is the only field of medicine where physicians receive different (and better) treatment than the rest of the population*. Treatment centers remain focused on treating the individual addict and are reluctant or unable to include the family system in the recovery process. You, as trustee, are part of the broader family system because the trust is supporting the addict and sometimes paying for treatment. The trust is, in essence, a consumer or "customer" of the treatment center. As such, the trustee and trustee advisory community should insist that their beneficiaries receive the highest quality services – the programs for doctors and pilots!

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.

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Sample Statement of Purpose

It is my intention that any beneficiary who may have or does have a substance use disorder, behavioral health disorder or other mental health concern be governed by the processes and procedures set forth in this Appendix A. To beneficiaries who have achieved stable recovery, congratulations! It can be a difficult journey and I hope you will experience the benefits of living in sobriety with a good understanding as to how money can support a healthy lifestyle.

To those of you still challenged by substance use or other behavioral disorders, Appendix A is based on the highly successful program for pilots and doctors. These are the only programs with proven, drug-tested outcomes and so while you may not like having access to distributions dependent on adhering to Appendix A, it offers the best path to sobriety. Therefore, in the event the Trustee does not implement these provisions or otherwise fulfill their intent, the Trust Protector is authorized, as specified in the Trust Protector section below, to replace the Trustee.

In my view, giving money to someone with an active disorder only perpetuates the problem. I do not want my gift to be used to support negative behavior, particularly when other family members or spouses are impacted. Therefore, I direct my Trustee to fully implement the provisions of this Appendix, including using trust funds to support these relatives when the Beneficiary is active in his/her disorder. Therefore there is a section in this Appendix that allows the Trustee to bypass the Beneficiary and preserve or distribute funds to the secondary beneficiaries.

I understand that dealing with any such disorder or concern is often time intensive, requiring the advice and assistance of professionals and costs for treatment. I authorize such expenditures, as recommended by the expert or experts advising the Trustee and approved by the Trustee, with such expenditures fully paid for by the trust. I realize that such expenditures will likely diminish trust assets as well as use up trust income. However, it is more important that the Beneficiary attain recovery, as defined herein, than trust assets be preserved.

Of course, the Beneficiary always has the option of choosing to recover, if s/he is worried about asset depletion. The process, as I envision, is that once the Beneficiary is in remission, as defined herein, the Trustee and expert will assume an oversight/monitoring role, which will reduce costs significantly. For example, simply receiving reports on drug testing or from counselors on a periodic basis.

Because the disorders covered by this section are chronic, it is my intention that the principal be retained in the trust for the lifetime of the Beneficiary, with Trustee discretion to disburse principal to the Beneficiary for specific requests or needs, assuming that the Beneficiary is in stable remission.

People with active substance use disorders sometimes engage in litigation to obtain funds from trusts. In the event of beneficiary litigation, I include language in Appendix A as follows:

1. That the Trustee, experts, professional or other resources assisting the Trustee be indemnified out of trust assets and that they be held harmless in connection with any and all acts or omissions undertaken in good faith.
2. That the Trustee's attorney's fees and associated expenses incurred in defending Beneficiary-initiated litigation against the Trustee shall be fully paid from trust property.
3. That the Beneficiary's attorney's fees and expenses incurred in bringing and prosecuting an action against the Trustee shall not be paid to any extent from trust property.

While this may seem harsh, I fully intend that the Trustee and anyone assisting the Trustee be completely protected from claims by the Beneficiary and that the Beneficiary expenses and fees to pursue such claims never be paid by trust assets.

In regards to medication-assisted treatment (MAT), such as Suboxone, methadone or other mood-altering medications, it is my specific intention that beneficiaries using such medications do *not* meet the definition of recovery as set forth in the section on recovery (Section 6, in this document). I am not opposed to the use of such substances for detoxing purposes under the supervision of a qualified professional as part of a recovery program, but of course this would mean that time for recovery would not commence until such use ended.

In addition, I want to emphasize that the two-year time period does not begin until there is remission of all behavioral health disorders, including any co-occurring conditions for substance users.

Finally for the Beneficiary who continues to be non-compliant with this addendum, I have authorized the Trustee to provide minimal levels of support (Section 6-D) in the Trustee's sole discretion. I suggest in this situation that Trustee's expert would hire someone to stay in contact with the Beneficiary to encourage him/her to seek help or otherwise check on or oversee his/her safety.

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: substance use disorder(s), (addiction), other disorders, compulsive or destructive behaviors, mental health conditions or concerns or any combination of the foregoing (described hereafter as behavioral health disorders) as defined in Section 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 Section 6) from substance use disorders (addictions) and behavioral health disorders, as defined in Section 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 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 disorders, behavioral health disorders and resultant family conflict or any combination of the foregoing, as defined in Section 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 subsections 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 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 Section 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, halfway 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 section. Any experts utilized by the Trustee shall be licensed and credentialed 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 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; post-treatment recovery programs; and any and all related matters deemed appropriate by the Trustee in his/her sole discretion.

This section (3) is fully applicable to behavioral health disorders, including non-compliant behavior with treatment plans and behavioral relapses. The Trustee is similarly authorized to expend funds to provide such services for family members of the Beneficiary.

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 section (4). Failure to sign all requested authorizations means the Beneficiary is not in "recovery" as that term is used in Section 6, below.

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 Section 6, below), and/or if the Beneficiary may be disputing whether s/he 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. Definition of 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 behavioral health disorders) and/or two years of 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 Beneficiary's **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) and behavioral health disorders, as defined in Section 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.

d. In the event the Beneficiary is non-compliant (continues to use, unwilling to follow treatment recommendations or otherwise follow the requirements herein), the Trustee may choose to expend funds to minimally support the Beneficiary's basic needs, in the Trustee's sole and absolute discretion. However, this provision creates no duty or obligation to make such distributions.

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 outpatient 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 of 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 Section 9, and/or 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 Section 9, the Trustee is authorized to provide services paid for from trust assets, 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, including any behavioral disorder 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 Section 2. (Examples: gambling, internet gaming, internet addiction, compulsive shopping, compulsive sex, food addiction and kleptomania.)

10. Indemnifications, Exoneration Provision, Dual Capacity and Compensation

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 or claim of 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 Section 1, to wit: the Beneficiary has a substance use disorder or behavioral health disorder, as defined above in Section 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.

e. When the Beneficiary is subject to the provisions of this Appendix A, the Trustee has the option to be compensated from the Trust at an hourly rate commensurate with standard rates in his/her profession. Any disputes concerning Trustee compensation shall be referred to the Trust Protector for resolution.

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 substance use disorders, behavioral health disorders or other disorders described in Section 9 to the appropriate family governing body or authority.

12. Prohibition on Payment of Beneficiary's Litigation Expenses

The Beneficiary's attorney's fees and expenses incurred in bringing and prosecuting an action against the Trustee shall not be paid to any extent from trust property.

13. Trust Protector Provision

I designate _____ as Trust Protector. The Trust Protector has the power to:

1. Resolve disputes regarding compensation of the Trustee.
2. Replace the Trustee and Expert, after consultation to resolve any disputes or concerns, for failure to implement the provisions of this Appendix and the intent of the Grantor.
3. In conjunction with the Trustee, decide to bypass the Beneficiary due to the Beneficiary's persistent non-compliance with this Appendix, thereby making contingent or secondary beneficiaries primary beneficiaries.

The Trust Protector shall be advised by the following members of my family: _____ and may be replaced by a majority vote of such family members or as otherwise provided in MS 501C.0704, in the event there is vacancy. I hereby direct that the successor Trust Protector be _____ or _____.

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

(End of Appendix A)

Appendix B

Substance Use Disorder – DSM-V

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.*

(End of Appendix B)

Appendix C

Case Management and Personal Recovery Support Services

1. Case management services

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 (avoiding 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 of early recovery.

These services include:

- Coordination of ongoing care
- Communication with providers
- Weekly progress meetings
- Aid in returning to work and family
- Ongoing program monitoring
- Referral as needed
- Monitoring/observed drug testing
- Advice to client
- Family meetings

These services are modeled after 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.

2. Personal counseling and recovery support

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 the skills set of licensed alcohol and drug counselors and similarly trained licensed professionals.

Learning new skills to handle emotions and relationships takes time and encouragement. The counselor may interact with the family, but does so on behalf of the addict in early recovery, as the addict is the client.

These services include:

- Post-treatment counseling and support services
- 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 addicts 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 are coordinated with post-treatment and continuing care recommendations.

(End of Appendix C)

Endnotes

[1] See the article "Addicted Beneficiaries, Overwhelmed Trustees: The Pitfalls of Absolute Discretion, Ascertainable Standards and Doing Nothing in the Face of Addiction" on www.billmessinger.com.
[2] For data supporting these outcomes, see *The New Paradigm for Recovery*: *Making Recovery – and Not Relapse – the Expected Outcome of Addiction Treatment*, A Report of the John P. McGovern Symposium Hosted by the Institute for Behavior and Health, Inc. November 18, 2013, Washington, D.C., March 2014 (available at www.billmessinger.com)
[3] Dr. David Carr, Director, Mississippi Physicians Health Program
[4] Dr. Robert DuPont, former Director of the National Institute on Drug Abuse:
[5] Hazelden *Voice*, Vol. 3, Issue 1, Winter 1998
[6] "The Science of Addiction." National Geographic. September 2017, p. 37
[7] "The Science of Addiction." National Geographic. September 2017
[8] For treatment-related topics, see: *Practical Advice on Achieving High Recovery Rates for Affluent/Prominent Alcoholics and Addicts* at www.billmessinger.com.
[9] "Is Addiction a Brain Disease?" Satel, M.D., Sally. The Conversation. May 10, 2016.
[10] *Recovery management is an emerging model geared toward treating addiction similar to how other chronic and progressive illnesses, such as diabetes and cancer, are treated (White, Kurtz & Sanders, 2006). Beginning with the writings of Benjamin Rush, our nation's first surgeon general, for more than a century the field of addictions treatment has argued that addiction was a chronic illness (Kinney, 2006), yet we have treated it more like an emergency room hospital visit – i.e., three days of detox, three weeks of intensive outpatient, 21 days of inpatient, etc. (White, 2005). The end result of this acute care approach has been continuous relapse. Research reveals that the great majority of chemically dependent clients do not receive an adequate service dose of treatment to launch them on a path toward recovery – that dose of treatment being 90 days of continuous recovery support (White, 2005). If the addiction field truly believed that addiction was a chronic disease, like cancer, treatment would be longer. There is no cancer detox. Cancer patients are monitored for five years following their acute care treatment.*
"Recovery Management in the Hispanic and Latino Community" by Jose Tovar, Jr. and Mark Sanders, LCSW, CADC Counselor Magazine, December 2011.
[11] Addiction Treatment
Bill White: You have been involved in many addiction treatment outcome studies. What conclusions have you drawn about the degree of effectiveness of various approaches to addiction treatment?
Dr. Humphrys: To my mind, the research shows that the things most researchers obsess about – e.g., is cognitive-behavioral therapy better than purely behavioral therapy versus purely cognitive therapy – are not where the action is.
Good treatments have common elements, including a relationship with someone who cares about you, some persistence of the treatment over time and some changes in your environment such that abstinence becomes easier and more rewarding than continued use. Some clinical people are uncomfortable with this idea, but the research shows that some accountability in the environment is very good for people. That includes, for example, drug testing with immediate, certain consequences such as you see in drug courts.
"Circles of Recovery: An Interview with Keith Humphreys, Ph.D." by William L. White, MA, Counselor Magazine, December 2011.
[12] "Recovery From Addiction, A Developmental Model, Part One." It's All in the Journey. September 2008, p. 8.
[13] Ibid, p. 12
[14] *The New York Times*, p.1, February 3, 2014.