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

Best Practices for Treating Substance and Other Behavioral Disorders

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Introduction

With addiction and behavioral health disorders increasingly recognized as major threats to family well-being and wealth preservation, family leaders, trustees and advisors are looking for solutions when problems arise in relatives, beneficiaries and clients.

- Delayed identification of serious conditions, refusal to accept help and failed treatments are common experiences in far too many instances.

Motivated by similar personal experiences with relatives, our professional lives are focused on improving treatment outcomes for individuals suffering from these devastating diseases.

One of the best-kept secrets in the treatment community is 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. Accordingly, we use their basic protocols as models for improving outcomes for addicted family members (beneficiaries).

Our goals in writing this article are to:

- Present an overview as to how we adopt the pilot/physicians programs to our clients so the reader understands the basic concepts leading to improved outcomes,
- Discuss specific provisions to insert or use in trust and governance documents in order to replicate the pilot/physician protocols, and
- Review the criteria for defining substance abuse used by professionals – one of the behaviors addressed in our model language.

As you can imagine, the latter two topics are technical by necessity and so our fourth goal is to explain our suggested provisions to non-lawyers in understandable language.

Discretionary and Ascertainable Standards Ineffective in Addressing Addiction

We know that many existing trusts and other governance documents grant trustees full discretion or contain specific addiction clauses. However, 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.[1] And regardless of their efficacy, those clauses do not promote a proactive, early-intervention approach when addiction and other behavioral and mental health concerns first surface.

- Our model language is unique in supporting this approach and is designed to encourage addicts to comply with treatment recommendations over many months.

As the reader may know, the number one outcome of treatment is relapse – the existing system is not working. Therefore, we will turn to the programs with proven high outcomes.

I. Applying the Physician/Pilot Programs to Beneficiaries

In this section, we review information regarding the highly successful physician/pilot programs, and then 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!***

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 Recovery 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.*[2]
> *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.*[3]

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

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

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

After reading about the high success rates for pilots in 1998, Bill Messinger 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, while attending the best centers in the country.

- The PHP programs are now the state-of-the-art approach for addiction treatment and the reader should understand why they are so effective and how to apply their ideas to addicted family members.

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 over many months.

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 – 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.

Since money helps addicts avoid the consequences of their use, their disease progresses to the point where they suffer significant physical damage and damage their families and financial well-being. We reject this head-in-the-sand approach as outdated and dangerous.

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 recovery management 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 is 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.

Explicit Leverage

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 21-year-old addict is a disaster.

Non-Explicit Leverage

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."

As mentioned, 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.

Because non-explicit leverage has its limitations, rather than attempt to use it and risk failure, as mentioned, 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 do have explicit language, including if necessary, relocating the trust to a state with liberal decantation and amendment laws.

For more detailed information on using leverage, see our companion article:
Leverage First: Using Family Resources As A Positive Influence For Recovery

C. 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.

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.*[4]
> *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.*[5]

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.

- 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.

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*.

<u>Family Case Management Program</u>

As mentioned, for more than 15 years the concepts of the PHP program have been used 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 medical boards use qualified, licensed professionals to guide them. Families 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: "In-patient 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 (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.

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.

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. Specific Provisions to Replicate the Pilot/Physician Protocols

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

A. Key Concepts

Problem-Solving 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 (failing grades, showing up late for family activities) and direct (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, and will 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.

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

While a discretionary clause or an ascertainable standard ("no distributions to addicted beneficiaries") does provide authority for a trustee to cut off funds, such 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 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.

New Definition of Addiction and Alcoholism

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 criterion.

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 at the end of Appendix A for reference purposes.

The Professional Works for the Trustee – not the Beneficiary

Keep in mind that under our Dual-Track System, the professional works for the trustee and not 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.

B. Plain English Summary of Appendix A Model Language

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

Comment: If there are indications of problematic behavior, the trustee can make a referral to a professional for an assessment or other evaluations to clarify underlying issues. There is no need for an actual determination that a substance use disorder or mental health condition is present to trigger a request for an evaluation. Early intervention is the key to success.

a. Scope of behavior by Beneficiary triggering withholding:

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

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

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

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

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

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

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

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

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

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

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

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

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

Comment: One major problem is that beneficiaries do not want their trustees to find out their diagnosis, if they are making progress in treatment, or their post-treatment recommendations.

As beneficiaries lie about their behaviors and activities, it is important to establish the expectation early on that recovery is about openness and honesty.

Also, usually the trustee is paying for treatment and otherwise supporting the beneficiary and it is reasonable to ask for a full and complete release of information in exchange for such support.

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

5. Alcohol and Drug Testing – Observed Tests

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

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

6. Recovery – Two-Year Minimum

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

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

7. Date when Recovery Begins

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

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

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

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

Comment: This provision is intended to prevent the addicted spouse or parent who controls the money from threatening to cut off non-using family members if they report the addict has relapsed or is otherwise engaged in unhealthy behavior. Support the healthy spouse (even if a non-family member), particularly if children are involved.

9. Definition of Alcohol/Drug Dependence or Abuse

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

10. Indemnifications, Exoneration Provisions, and Dual Capacity

a. Indemnification of Trustees (and any professional, advisor, assistant, or other person including their business entities, hired and/or retained by the Trustees)
b. The Trustees (and persons hired by the Trustees) have no liability for the actions or welfare of the Beneficiary.
c. Trustees have no duty to inquire whether a Beneficiary uses drugs or other substance, but are expected to initiate the process specified in this Appendix if circumstantial or direct evidence comes to their attention that the Beneficiary is engaging in conduct specified in Paragraph 1.
d. Authorizes Trustees acting in the dual capacity as Trustee and family member to disclose information to family members.

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

11. Other Prohibitions During Suspension or Withholding of Distributions

a. Disqualification of beneficiary to remove or replace Trustee or act as Trustee or Trust Protector.
b. Suspension or withholding of distributions is *prima facie* evidence for removal or suspension of the Beneficiary from other family positions or activities.

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

Trust Protector Provision

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

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

III. 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 – the topic covered in this section.

To begin with, 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 categories of substance use disorders. We will be discussing their common criteria later on, as well as the criteria for one of the categories – alcohol use disorder – 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 attributes.

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.

2. Activating the reward system

All drugs taken in excess have in common the direct activation of the brain 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 of abuse 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 using substances begin to take over a person's life. When the brain circuits are becoming rewired, then it's not so pleasant, because one begins to lose control over how much and when to drink or take a drug. 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.

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 its 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 that the treatment center said, "I only had a problem with cocaine, the treatment center said 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 defined 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 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. Behavioral 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, without a reliable brain scan to prove 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

<u>Impaired Control</u>
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 Palov's dog.) (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. (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 cause or exacerbated by the substance. (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).

Alcohol Use Disorder - Diagnostic Criteria
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.

C. 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 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 dispensers 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.

D. 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.

E. 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 three months after last meeting any of the criteria.

- 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:
In early remission: 3 to 12 Months
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 recent 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 his clean and sober, his old self," said David Bar Katz, a play-write, and the friend who found Mr. Hoffman and called 911. "I really thought this chapter was over.*[6]

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 in-patient, 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 pilot/physician 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*. 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Alcohol and Drug Testing

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

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

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

6. Recovery – Two-Year Minimum

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

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

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

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

7. Date When Recovery Begins

The commencement of any time period of recovery begins after the Beneficiary has successfully completed chemical dependency inpatient primary treatment (or other addiction or mental health related treatment) and any subsequent long-term, halfway, sober house or wilderness program.

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

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

In the event of withholding of or restriction on distributions to the Beneficiary, the Trustee is authorized to make distributions for the benefit of the Beneficiary, including those owed a duty of support by the Beneficiary, such as the Beneficiary's spouse, ex-spouse, children or other family members.

The Trustee is authorized to make arrangements for the support of such individuals through distributions by alternative means, as the Trustee determines in his/her sole discretion, with the intent to maintain such individuals' lifestyle, including paying support staff and third party vendors.

In the event any such individual meets the definition in paragraph 9, the trustee is authorized to provide services as set forth in this Appendix herein.

In the event any such individuals are in need of therapy, treatment or other forms of assistance due to the conduct of a beneficiary meeting the definition in paragraph 9, the trustees is authorized to provide services as set forth in this Appendix

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

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

10. Indemnifications, Exoneration Provision, and Dual Capacity

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

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

c. The Trustee has no duty to inquire whether a Beneficiary uses drugs or other substance, but is expected to initiate the process specified in this Appendix if circumstantial or direct evidence comes to the Trustee's attention that the Beneficiary is engaging in conduct

specified in Paragraph 1, to wit: the beneficiary has a substance use disorder or may have other use disorders (addictions), compulsive or destructive behaviors, other disorders or mental health concerns or any combination of the above mentioned disorders, as defined above in 9.

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

11. Other Prohibitions During Withholding of Distributions

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

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

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

Trust Protector Provision

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

Alcohol Use Disorder DSM-V

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

Diagnostic Criteria

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

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

Specify if:

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

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

Specify if:

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

Specify if:

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

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

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

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

Footnotes

[1] See the article *"Demise of Trustee Discretion and Ascertainable Standards*" for a detailed discussion of these clause sand their defects, soon to be available on the resources page at BillMessinger.com

[2] Dr. David Carr, Director, Mississippi Physicians Health Program

[3] Dr. Robert DuPont, former Director of the National Institute on Drug Abuse:

[4] ***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, twenty-one 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 ninety 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

[5] **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, PhD **By William L. White, MA Counselor Magazine, December 2011**

[6] (New York Times, p.1, 2/3/14)