How We Help Families and Advisors Address Addiction in Affluent Families

Tips and Tools for Trustees and Parents Dealing with Dysfunctional Beneficiaries

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Overview: Five Topics on Governance

In this article we discuss reasons for addressing addiction and other dysfunctions in governance documents and describe our suggested provisions to include in these documents.

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

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

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

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

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

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

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

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

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

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

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

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

Building Leverage: Part of a Comprehensive Program to Combat Addiction
The first 10 articles listed in the appendix discuss why the physician's program (PHP) is so successful, how we apply its concepts, including leverage, to affluent substance users, and what factors lead to quality treatment and improved outcomes. We do compare the PHP model and approach to recovery with current treatment in our efforts to educate family members and advisors on the "best evidence-based practices" in the field, as many are not only paying for treatment, but in more importantly affected by relapses.

Leverage, Quality Treatment, Systems Transformation and Change Strategies
These topic areas comprise a comprehensive, innovative and effective treatment model for affluent addicts, their families, advisors and trustees. While the topics are discussed in separate articles, it is their integration – individualized for each family and their addicted loved ones – which lead to improved recovery rates. Our intention is to share our knowledge with concerned family members and their advisors/trustees about what we know about addiction and recovery for the affluent, prominent and wealthy. Too many of our family members, friends and acquaintances have died from this disease and you, the reader, must take the time to become educated and advocate for quality services for your loved one.

Be Persistent, Be Proactive

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

SECTION A:
How Leverage Relates to Treatment and Recovery

1. High Recovery Rates for Pilots and Physicians: Risk Reduction

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

- The physician programs have proven recovery outcomes of complete abstention at the five-year mark of 78%.[3]

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

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

That is why, after 15 years of assisting clients, we now write our series of articles: so families, their advisors and professionals in the field can benefit from our work in applying the pilot/physician model to affluent family members suffering from alcoholism, drug dependence and other addictions.

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

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

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

Cancer Comparison

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

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

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

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

> *Research has shown that physicians' health programs achieve extraordinary outcomes in substance use disorders (SUDs). One recent study demonstrated nearly 80 percent abstinence at five years. The success of physicians' health programs (PHP) in driving superior outcomes in addiction treatment raises critical questions about how treatment can be improved for all with SUDs. ...* ***Why pay for multiple detoxes and no follow-up, indeed?***[5]

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

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

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

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

Reducing Risk to Family Well-Being from the Predictable Disease of Addiction
Alcoholism, drug dependence, other addictions and significant mental health disorders are statistically probable and will occur in affluent families at an estimated minimum rate of 20%, often much higher.[6]

- As one of our advisor friends writes, *"Culture eats structure for breakfast,"*[7] meaning these disorders will undermine the best family mission statements and succession plans and result in both the loss of wealth and cohesiveness[8].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The PHP model: Building Consensus Among Family Members

Addiction is one disease where many family members have different opinions – whether it exists in a loved one, and if so, what to do about it.

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

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

Some family members object to using leverage to encourage a loved one to seek professional assistance and comply with treatment recommendations. Three comments:

1. The addict always can refuse. He/she always has the option of living without the financial or other access to support provide by the family, trust or business.
2. In all my years of volunteering in the Means and Prominence Program at Hazelden, I never met a beneficiary who said he/she was cut off too early. Many said just the opposite:
   Why didn't they step in sooner? They could see I was addicted! Didn't they care about me?
3. Here is what Sally Satel, a noted addiction psychiatrist, said about waiting for your loved one to want to go to treatment:
   A myth is that the addict must be motivated to quit – that, as it is often put, "You have to do it yourself."
   Not so. Volumes of data attest to the power of coercion in shaping behavior. With a threat hanging over their heads, patients often test clean.[9]

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

Also remember that the PHP model we adapt to use with affluent families is an early intervention model – we don't want to wait for the addict to decide on his/her own to go

to treatment because by that time the disease has progressed to the point where recovery is much more difficult and the damage is greater. Yes, your addict may become very emotional and often threatening when leverage is brought into the picture, but this is temporary and an expected part of the process.

4. Governance Leverage: Part of a Comprehensive Approach to Improve Outcomes
As mentioned in the Overview, the first 10 articles listed in the appendix cover core components of our comprehensive program to improve recovery rates by using the PHP program as a model in our work with families. This article focuses on inserting provisions into governance documents to use access to resources as leverage (and the clinical/treatment reasons for doing so). Similar language can be used in other situations such as employment agreements or entertainment contracts.

Some clients ask what to do when explicit leverage is lacking in trusts or business documents or if they prefer to use alternative techniques, knowing that they can ultimately rely on limiting access to resources. That's why we wrote the two articles on leverage (Section B on the list of articles), which describe a range of approaches that may motivate a loved to seek help. The problem, of course, is that these strategies are often inadequate to sustain recovery over the long term.

Cautions on Using Leverage
Please read our articles on leverage and implementing leverage. In our view, leverage is best used with a velvet hand rather than a hammer, with the goal of engaging, rather than forcing, the addict in the recovery process.

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

Using Leverage Never Means Cutting Off an Addict from a Support Structure or Contact

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

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

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

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

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

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

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

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

We have written at length in the *Trustee's Handbook* on the tactics used by dysfunctional or underperforming trust fund beneficiaries to crack open discretionary and restrictive trusts. And *Solutions for Dealing with Alcoholism and Drug Addiction in Affluent Families*, referenced in the article list, is directed at helping trustees and family advisors identify addictive behavior and appropriately interact with the addict. Our intention is not to duplicate the information in these articles, but simply to provide on overview of our thinking as it applies to problem-solving, based on our positive experiences in helping clients find solutions for their dysfunctional and/or addicted family members.

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

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

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

1. Problem Family Members – Who Are They?

a) The Dysfunctional Family Member

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

b) The Underperforming Family Member

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

c) The Economically-Challenged or Contentious Family Member

Some family members, whether they are beneficiaries, shareholders, employees or simply offspring, will make extraordinary requests for funds. Regardless of whether these requests are permitted by trust language, family business policy or equity, these claims are pursued by putting pressure on parents, other relatives or advisors through a variety of methods too numerous to mention here. (For 10 pages of specific examples on this topic see *The Trustee's Handbook for Addressing Addiction in Beneficiaries*, pages 50-61.)

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

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

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

The procedure suggested here – appointing an expert to make recommendations – reduces pressure on a parent or trustee by diverting the decision focal point to an independent third party who absorbs the emotions often generated by such requests. For example, if there is a history of overspending, an expert could be asked to help with review of the financial situation, budgeting and monitoring of ongoing expenditures, as a condition of receiving measured assistance to cover deficits.

3. The Value of Professional Assessments and Recommendations

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

- First, as embodied in the writings of James (Jay) Hughes Jr., that wealth preservation in families results from shared expectations regarding behavior, is a dynamic process, and is dependent on the human and intellectual capital of its members.[12]
- Second, that adverse decisions regarding suspected addictive or non-functional behavior be grounded in the recommendations of qualified experts.[13]
- Third, recognizing that the concept of "entropy" applies to family systems and active attention to family well-being is needed to offset the momentum for disintegration and self-destruction.
- Fourth, the vast majority of people with seriously dysfunctional behavior as seen by outsiders do not perceive themselves in the same light.[14]

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

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

4. The Courts of Family Opinion and Law

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

a) Family Opinion

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

b) Law

A final and very important reason for using licensed professional experts to help resolve problems is that judges rely on their expertise: not only as expert witnesses, but also as key players in settlement discussions. Judges now are much more knowledgeable about addiction since so many criminal cases are drug – or alcohol – driven. When a civil case involving addiction comes before them, they will use their best efforts to force the parties to reach an agreement that addresses the underlying addictive behavior. As a family, you want your expert on your side from day one so the expert is familiar with the history and source of the dispute.

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

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

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

c) Two Cautions

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

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

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

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

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

> *We have received advice from our addiction expert that you need an inpatient evaluation to determine if you have an addiction issue. Therefore we can no longer provide you with funds until you complete the evaluation, including fully complying with all requests related to the evaluation process. We are now aware*

that we have been supporting what appears to be an addictive lifestyle and we are no longer in good conscience willing to do so.

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

The Expert's Qualifications Must Withstand Legal Scrutiny

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

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

SECTION C:
Reasons Underlying Our Approach to Process and Recovery

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

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

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

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

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

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

1. Believe in the Program and the Process

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

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

One purpose in writing this article is to help develop and sustain confidence in family members and advisors so that the substantive recovery program and process to implement the program described in this article (and as further described in *Practical Advice on Achieving High Recovery Rates*) will in fact be effective – that is, the addict will recover.

2. Stages of Recovery

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

a) Recovery Takes Much More than 28 Days

Many people view addiction as episodic and resolvable in 28-day inpatient treatment programs. That is not the case. A recent article in one of our professional addiction journals discussed the developmental approach to recovery and the six stages to achieving stable remission[15]:

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

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

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

- *"The therapeutic contract,* or roles played by client and counselor, whether treatment is conducted individually or in a group, as well as treatment model and session schedule, among others.
- *Therapeutic operations,* which include how the client presents his complaints and problems; how he thinks; how the counselor understands the client (e.g., diagnosis, case formulation); the strategy used (e.g., 12-step model); and how the client responds or cooperates with the interventions.
- *Therapeutic bond,* or the quality of involvement and rapport between client and counselor.
- *In-session impacts,* or therapeutic realizations, such as insights vs. confusion, relief vs. distress, as well as the counselor impact, such as frustration vs. feeling good about a session.
- *Temporal patterns,* or distinctive moments of facilitation as well as total number of sessions."[16]

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

b) Transition: *Recognition of Addiction*

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

board with an active recovery program.[17] In other words, the addict does not internalize the clinical data that he/she is addicted – this information is rejected. This is another reason why the emergency intervention is best used only when there is significant danger of harm to self or others.

c) Stabilization: *Recuperation*
Stage Two: Stabilization – Five Tasks to Facilitate[18]:

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

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

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

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

- Affluent addicts do not feel safe in doing so and therefore actually get stuck back at the withdrawal and preoccupation stage[19] – a recipe for relapse.

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Management Services Include:

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

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

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

Post-Treatment Counseling and Support Services include:

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

These services should be coordinated with post-treatment and continuing care recommendations and therefore require the patient to sign releases so his support

counselor can receive treatment related information and can communicate with key family members, advisors and the family professional (if there is one).

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

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

Jay Hughes

Next-generation members, regardless of whether they are productive or not, or whether they are asking for additional funds, will benefit from the ideas Jay Hughes discusses regarding the role of the trustee, the role of the beneficiary, and the trustee as "mentor" to the beneficiary in chapters 10, 11 and 19 in his *Family Wealth* book. (See Appendix A for a list of his suggested "Roles and Responsibilities for Beneficiaries and Trustees.") Similar concepts are useful for family members working in the family business, serving on boards or as preparation for future gifts or inheritances.

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

Job Qualifications and Training for Family Enterprise Positions

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

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

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

This last Section E describes our proposed language to **address alcoholism, drug addiction, other addictions, and mental health concerns in a beneficiary, employee or inheritor,** including our rationale for detailed provisions in governance documents.

Our model language for family control and governance documents (business, trusts, office, shared property and similar enterprises) is included in our article, *Model Language for Addressing Substance Use Disorders (Addiction) in Trust Documents*.

1. Reasons Why We Favor Detailed Provisions in Governance Documents

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

- We find this type of language too broad and easily manipulated, or avoided, by beneficiaries. (See *The Demise of Trustee Discretion* for examples.)

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

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

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

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

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

Trustee lacks expertise on mental health and addiction

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

Allows the trustee to hire qualified Professional Assistance

- Qualified, licensed professionals plan and manage the recovery process on behalf of the trustee (and family) over the time period needed to achieve stable recovery – at least six months and many times longer. This is the key element of the pilot/physician program and a distinguishing feature from standard treatment.

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

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

Helps avoid the "Dry Drunk Syndrome"

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

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

Bypass Provisions When the Heir is the Addict

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

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

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

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

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.

CONCLUSION

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

Family Support and Education are Critical to Improve Outcomes

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

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

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

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

You Can Make the Difference

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

Concepts Apply to Other Groups

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

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

Appendix A

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

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

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

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

b. Roles and Responsibilities of Trustees (page 134)

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

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

ARTICLES LIST

William F. Messinger, JD, LADC

Advice for Families, Advisors and Trustees on Improving Recovery Rates for Affluent Addicts and Alcoholics

(Available on www.BillMessinger.com or on Request)

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

Leverage First: Using Family Resources as a Positive Influence for Recovery

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

Family/Advisor Recovery Management Program for Affluent Alcoholics and Addicts

- Also focuses on applying the pilot/physician program to other groups, with an emphasis on the clinical needs of the affluent, recovery management and reasons why treatment centers fail to offer the pilot/physician program to other groups.

Airline Pilots Soar to Recovery: Headline in Hazelden Voice Winter 1998 (Copy of Hazelden Newsletter)

- Hazelden Treatment Center reports: *"92-95 % of pilots going through the "HIMS" program remain sober two years later*." HIMS stands for Human Intervention and Motivation System, only available to pilots. (Doctors have a similar program.) Thus began my quest to educate families and advisors about the HIMS treatment protocols and the benefits of applying the same concepts to other groups, including the affluent.

The New Paradigm for Recovery: Making Recovery – and Not Relapse the Expected Outcome of Addiction Treatment

- Issued by the Institute for Behavior and Health, Inc., Chair: Dr. Robert DuPont, this report reviews the decades of data from the pilot and doctors recovery programs regarding their high success rates, reason for their success and efforts to apply their model to other groups. I include the report in this list as outside evidence to verify the value of using their approach to improving recovery rates for the well off and well-known.

B. Encouraging and Inducing Change Through Explicit Leverage in Governance Documents

Model Language For Addressing Substance Use Disorders (Addiction) in Trust Documents: Best Practices for Treating Substance and other Behavioral Disorders

- The most recent revision of our model language, including an explanation of the American Psychiatric Association updated DSM V standards for assessing substance use disorders (no longer called alcoholism or addiction). These standards are incorporated by reference in our model language.

The Roles Of Trust Protectors, Trustees And Experts In Implementing Behavioral Health Trusts

- Explains the function of trust protectors in removing trustees refusing to implement substance use disorder provisions and discusses trustee and expert selection issues.

Decanting - Amending the "Unamendable Trust"

- Discusses ideas on modifying irrevocable trust provisions to insert the model language to prevent beneficiaries with behavioral health disorders from accessing funds.

Using Leverage to Support Long-Term Recovery and Improve Outcomes

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

pilots/physicians and programs for the affluent and cautions on using leverage. (Formerly labeled Article 2.)

C. Ideas on Responding to and Managing Out of Control Beneficiaries

Tips and Tools for Trustees and Parents Dealing with Dysfunctional Beneficiaries

- Discusses a problem solving approach in dealing with family members exhibiting addictive or other dysfunctional behavior. Focus is on resolving family conflict and the reasons underlying our Model Language. Also explains from a "stages of recovery" perspective why leverage must remain in place for many months. (Formerly labeled Article 4.)

Fending Off Distribution Requests from Dysfunctional and Underperforming Beneficiaries: Solutions for Trustees

- Complementing the previous article, we expand our discussion with examples of the many ways beneficiaries attempt to overcome discretionary and specific addiction prohibition clauses to fund their lifestyle or using. Addresses flaws in appointing special purpose trustees or addiction advisors. (Formerly labeled Article 16.)

D. Encouraging and Inducing Change in the Absence of Explicit Leverage

Individual Change Strategies

- In the absence of explicit leverage in trust or governance documents, this article discusses personal, opportunistic, and action based pressure points to encourage individuals to agree to engage in a change process, such as beginning therapy, entering treatment or some other positive step.

Change Strategies for Families and Groups

- Advice on change strategies for advisors facing reluctance in extended families to address difficult problems. Strategies range from education and risk management to using the momentum generated by values discussions and genograms to promote change. (Formerly labeled Article 3.)

E. Improving Treatment Outcomes for Affluent Addicts

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

- In depth review of the clinical needs of the affluent in treatment and in the context of applying the pilot/physician program model to the affluent. Explains why current treatment is inadequate and describes strategies to improve outcomes. (Formerly labeled Article 6.)

The New Treatment Model: Systems Transformation to Improve Outcomes

- Discusses why current treatment is ineffective and describes a new model derived form the pilot/physician programs. Reviews family relationships in extended family systems including advisors, household help and institutions that influence the substance user. Describes 12 Core Concepts to consider in promoting recovery in affluent families. (Formerly labeled Article 5.)

Families, Wealth and Addiction

- An overview of our new clinical approach to addiction, treatment and recovery for affluent families. Discusses barrier to finding and receiving effective treatment. At four pages, it's a quick read. (Formerly labeled Article 7.)

F. Advice for Families

Flawed Family Assumptions about Addiction and Treatment: Information for Families

- Misconceptions by parents about treatment impede recovery for their adolescents and young adults. Don't give up on your child. Instead figure out what went wrong in treatment. (Formerly labeled Article 8.)

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

- Written after a friend's child died five months after leaving treatment. This tragedy motivated the author to enroll in addiction studies school and become an advocate for improved treatment outcomes,

using the pilot/physician model as a prototype for services to other groups. (Formerly labeled Article 9.)

G. Blocks to Change and Treatment Issues

Counselor – Client Relationship and Conditions Promoting Change

- Identifies blocks to recovery for the affluent in the treatment and counseling setting and the need for creating a safe environment as a precondition for change to occur

H. For Family Office, Family Businesses, Trustees, Lawyers, Accountants and Advisors

Trustees Handbook on Addiction in Beneficiaries

- Discusses ways beneficiaries access funds despite restrictions on distributions. Suggests language to include in trusts and other governance documents to address addictive behavior in family members (see Article 4, above).

Addiction in the Family Business: Considerations and Solutions (Arden O'Connor lead author)

- Identifies considerations when family and business are intertwined. Discusses risk factors, review of signs and symptoms and how to productively raise concerns. Model Return to Work Agreement included.

It Just Got Complicated: Approaches for Advisors and Families with Addiction and Affluence (Arden O'Connor lead author)

- Similar to previous article, but uses a "case history" to take readers through deciding when problematic behavior crosses the line to addiction, raising concerns and identifying and using leverage points to encourage participation in treatment.

For Advisors, Trustees, Account Managers and Family Offices

- Encourages a pro-active stance in identifying addiction, including signs and symptoms and the role of the advisor in encouraging recovery. Includes tips on finding competent addiction professionals for collaboration or referral. (Formerly labeled article 14.)

Financial Managers and Dysfunctional Clients

- Addiction's effect on staff morale and fiduciary responsibilities in the family and wealth management office. Addresses concerns when a client enters treatment and changes in the relationship. (Formerly labeled article 15.)

Core Needs in Wealthy Families – Coauthored with Terry Hunt

- The Advisor's Role in Helping Wealthy Families Meet Their Core Needs (formerly labeled article 18.)
  Part 1: A Developmental and Experiential Model for Advisors and Consultants
  Part 2: An Alternative Model for Planners and Consultants

A contrarian view, focusing on the advisor's role in supporting next generation individuation and psychological development and the importance of childhood/family relationships. We believe "culture eats structure for breakfast" and the business/education model currently imposed on families is doomed to failure.

I. Lawyers and Law Firms

Achieving High Recovery Rates for Addicted Attorneys; What Every Law Firm and Lawyer Needs to Know Based on the highly successful recovery programs for physicians and airline pilots. (formerly 19.)

Bench and Bar Article

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

BLOGS

Topics range from discussions on current drug trends, treatment and cultural news to my views on best practices for treatment, particularly for substance user with the additional challenge of significant incomes and high profiles.

Author Information

William F. Messinger, JD, LADC

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

Footnotes

[i] Readers of previous articles combining several topics on how we apply the pilot physician model to affluent addicts have asked me to "unbundle" these articles and address one topic per article.

[2] Since pilots and doctors are required to follow all the recovery program mandates of their oversight boards, their programs can also be described as "airline and medical board recovery programs".

[3] See 4

[4] Here is what Dr. Robert DuPont, former Director of the National Institute on Drug Abuse said about a nation wide review of outcomes for physicians' programs:

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

Why does the doctor say it sets a "new standard for recovery outcomes"? Because all other programs have long-term recovery rates at thirty percent (30%) and below. *(See Dirty Little Secrets: Why Rehab Programs Must Come Clean*, Consumers Digest, p. 20-24, May/June 2008)

95% success rate for NWA pilots Airline pilots soar to success in recovery. Hazelden Voice Vol. 3, Issue 1.

78% continuous abstinence rate at **7.2 years** for 904 doctors in Physicians Recovery Programs, Addiction Professional, online, 8/24/10)

[5] By: Omar S. Manejwala, MD, MBA, FAPA, CPE

Behavioral Healthcare, April 2011

[6] In our year of living and working with affluent families, we know of no extended family system (including in-laws) with addiction and significant mental health problems at rates of less than 20%. Many families have rates exceeding 30% to as high as 70%. However, these numbers are based on anecdotal and personal experience. The overall addiction rate is said to be 10% of the population.

[7] Mathew Wesley, www.mathewwesley.com

[8] Family Firm Institute Brochure excerpt for 2010 Annual Conference

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

[9] Satel, M.D., Sally. 2006. For Addicts, Firm Hand Can Be the Best Medicine. The New York Times, August 15.

[10] For out of control addicts on the loose, families must stay engaged with these addicts and not wait for them to "hit bottom" on their own (the latter advice given by many interventionists, family programs and Al-Anon, is not a successful strategy). Instead, families must do what is necessary to remain in contact and finding ways to encourage the addict to get help. For affluent families, this may mean assembling a group that includes a knowledgeable addiction professional, private detectives, lawyers (to use the legal system, if feasible), sober companions and a "go to person" in the family who can authorize expenditures and actions. If the addict is holed up in a hotel room or resort drinking and using, living or driving around town with her dealer, smoking crack at the crack house, or wandering the streets, using heavily, overdosing or otherwise at risk, **the family must go after the addict** (or hire professionals to do so). We emphasize this point in every article because too many families are being given misinformation about what to do under the circumstances described in this footnote. No family has regretted doing too much when a loved one dies from addiction or addiction related complications. Many regret doing too little.

[11] Dennis Jaffe, P., & James A. Grubman, P. (2007). Acquirers' and Inheritors' Dilemma: Discovering Life Purpose and Building Personal Identity in the Presence of Wealth. *Journal of Wealth Management*.

[12] James E Hughes, Jr (2004). *Family Wealth Keeping It in the Family* New York: Bloomberg Pr.. P 14-23

[13] Kozisek v County of Seward, 07-3692 (Eight Circuit Court 08 27, 2008). In this case the Court upheld the firing of county worker who claimed a disability due to alcoholism but refused inpatient treatment, stating:

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

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

[14] There is a huge disparity between an addict's self-perception vs. his/her perception by friends and family

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

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

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

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

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

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

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

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

[18] Ibid, p 12

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

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