COMMITTEE REPORT:
HIGH-NET-WORTH FAMILIES & FAMILY OFFICES

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When Addiction Surfaces in Beneficiaries and Client Offspring

A new approach based on highly successful programs for physicians

Attorneys and trustees frequently overlook clients engaging in addictive behavior because they're unaware of the symptoms of the disease, don't know what to do or don't believe it's their role to become involved. The wealthy client is very important to the advisor, and the advisor's relationship with that client shouldn't be jeopardized—making the decision to do nothing is a very tempting approach; albeit sometimes, a tragic one. Nevertheless, to fully meet client expectations, practitioners are increasingly required to be skilled drafters and think like therapists.

Three Scenarios

Let's take the case of trusts and estates attorney John. John is serving as trustee for a beneficiary with attention-deficit/hyperactivity disorder, who may be abusing his medication. He's also a trustee's counsel for a "failed to launch" beneficiary who moved to Colorado when the state legalized marijuana. Additionally, John recently met with a former client and his wife to discuss succession planning for their family business. The couple expressed concern about their son, Mark, who's been to rehab twice but now just drinks beer. In each scenario, John must decide whether to be a transactional attorney or an advisor and counselor to the client and family.

A Holistic Approach

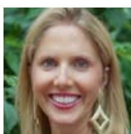
If estate planning involves a client's goals, family and assets, addiction will undermine the best plans and grantor's intent in all three domains. The problem is that if John tries to proceed on his own, he'll very likely fail, because the most common outcome of treatment is relapse, and John isn't an addiction specialist. To feel more confident in raising the topic and in selecting an expert, John needs to know how these disorders impact affluent clients. He can also help clients understand a new approach to addressing substance use disorders based on the highly successful programs for addicted physicians.

When faced with a client's addiction, we hope John will opt for the more holistic approach. To do so, John must broaden his focus, learn new skills and hire an expert to advise him on substance use issues—the same as he would when collaborating with family business advisors to help analyze options for the business. If he's successful in resolving the three scenarios, the families of the addicts will be very grateful—clients for life—and his reputation enhanced in the very private word-of-mouth world of affluence and addiction.

The Physician Treatment Program

Physicians receive a different form of addiction treatment from the general population, with their recovery programs overseen by medical boards. The boards use the threat of license revocation as leverage to obtain compliance with treatment recommendations and then manage the process for at least two years. The end result: Verified continuous abstinence rates of 78 percent for doctors at five years.[1] (Airlines run a similar program for pilots with success rate of 92 percent at two years.)

These are far superior outcomes compared to other population groups. Unlike other programs, medical boards select the treatment center; require full



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information releases; approve of treating psychiatrists, therapists and medications; and mandate regular random drug testing. A post-treatment recovery contract also sets forth recovery activities and a plan in the event of relapse.[2]

The idea, then, is to apply the physician model to beneficiaries and family business members using access to resources (primarily money) as leverage to obtain compliance with similar protocols. Without leverage, few people will agree to these requirements, even when informed about the success rates. It's striking that cancer patients, who have a fatal, chronic disease, would immediately agree to the doctor protocol to improve their chances of recovery, yet addicts will only do so when pressured.

While we discuss the physician model in more detail below, we introduce it now so John can think about sources of pressure to encourage long-term change as he considers how to proceed in his three roles.

Incidence Rates

Advisors and family members will often ask whether substance abuse and addiction are more common problems among high-net-worth (HNW) families. One family business consultant reports that 54 percent of family business clients identified a substance use disorder as a significant impairment for members in major ownership or management positions.[3] Over 20 percent of affluent young adults meet substance abuse or dependence criterion, confirming our estimate that these disorders are present at double the 10 percent rate for the general population.[4]

From incidence rates alone, addiction jeopardizes HNW family wealth preservation and is the major underlying cause of the "shirt sleeves to shirt sleeves in three generations" phenomenon. For this reason, John should advise his clients to insert clauses in documents to address potential behavioral health concerns. Approaching the issue from the point of "probability" takes the focus off any individual and places it on the "good planning" category.

Signs and Symptoms

For John to proceed, he'll need facts as a basis for taking action. Let's start with a basic understanding of behavioral health disorders.

The primary symptom of addiction is loss of control. This symptom indicates that a physical change has occurred in the brain due to drinking, drug use or any other repetitive behavior that serves as an addictive function. Aside from obvious examples, such as hangovers and inebriation at inopportune times, indirect indications of dependence are:

- Absence from social gatherings, business meetings, philanthropic discussions and other family events
- Isolation and disconnection
- Overspending or hidden debt
- Inability to commit to completing any activity
- Legal issues
- Medical problems
- Job or school suspensions
- Overreaction to challenges and lack of coping skills
- A pattern of poor decision making
- Contradictory or unpredictable directives
- Forgetting conversations and decisions
- Complaints and concerns expressed by family members and friends

> Simply because evidence indicates a problem may exist doesn't mean it's time to intervene.

Keep in mind that alcohol isn't the only offender. Be on the lookout for overuse of pain pills (for example, OxyContin and Vicodin, Percocet), anti-anxiety medications (for example, Xanax, Librium, Valium, Klonopin, Serax and Ativan), stimulants (for example, Ritalin, Adderall and Vyvanse) and sleep aids (for example, Ambien and Lunesta), which often fly under the radar because they are doctor-prescribed.

Don't be deceived by high functioning alcohol or drug abusers who are skilled at leading double lives and appear to the outside world to be managing life well.

Many are fashionable, physically attractive and able to maintain respectable—even high profile—lives.

Taking Action

Simply because evidence indicates a problem may exist doesn't mean it's time to intervene. Too many times, people jump the gun, and the person with the problem (PWP) either rejects help or goes to treatment and is so resentful, relapse is inevitable. And, family members may be divided on what to do or even on the underlying concern ("Is it addiction or a mental illness?").

In the three scenarios, John needs more information to support a plan of action to encourage the PWP to seek help. Depending on the symptoms, a first step might be developing plans or agreements regarding education, financial decisions, spending limits, therapy and evaluations for learning issues or vocational interests with specific, measureable goals. This requires no mention of addiction, but failure to adhere to these plans is usually indicative of a larger underlying problem, such as an addiction or mental health disorder.

> The key to successful treatment outcomes is leverage.

John may need to create leverage or wait for a crisis to proceed (more on this topic below), as well as assess the willingness of other professionals and family members to become involved. He also needs to decide whether to have a direct discussion of addiction concerns with other professionals or family members to see if they share the same outlook. We recommend using open-ended or vague questions to test the waters if anticipating an adverse response. Reports from anonymous third parties can be useful.

We advise John against raising the concern directly with the PWP unless there's an identifiable source of leverage and support from influential family members or professionals. Otherwise, the PWP will simply deny having a problem and do a hatchet job on John with relatives. Remember, the PWP sees any threat to accessing money for alcohol or drugs as a life-or-death matter.

Experts

At this point, it's time for John to say, "Let's bring in an expert in addiction." Unfortunately, this is easier said than done. Most experts are aligned with treatment centers and push for interventions. Also, many people in the addiction field resent the affluent (including lawyers) and therefore lack the sound judgment needed to navigate wealthy culture. John's challenge is to find an expert comfortable with HNW clients, who'll provide him with independent advice regarding treatment resources.

Having the Conversation

If an expert is involved, he might take the lead, but with coaching and in the expert's presence, John could start the conversation. The message is much more powerful if it comes from the attorney or advisor. Regardless of how the conversation gets started, there are some general guidelines around language and tone to maximize the chances for a productive discussion.

- Use observed behaviors (for example, non-engagement in a family meeting, number of drinks over a specific timeframe).
- Avoid speculation ("You're clearly back to your old tricks.")
- Express compassion and the hope to see that the family member become healthy so he can participate in family endeavors.
- Avoid shaming language ("Why would you do this to your mother?")
- Normalize the problem ("Many people struggle with this issue; the important piece is for you to get help.")
- Use crisis as an opportunity. Helping an individual get out of a crisis is fine, but it should serve as an opportunity to insist on that person seeking help.
- Offer independent, professional support ("You don't have to share all of the details here; we've scheduled a placement for you at this treatment center that we hope you'll accept.")
- Be clear about your own boundaries, without threatening the individual ("If you choose not to accept the help we're offering, please know that we can't continue to support your current lifestyle, as we know it's harming you.")

These language suggestions need to be tailored to

the specific situation. The tone and content will depend on who's delivering the message, what his relationship is to the individual with the issue and how much leverage exists. Keep in mind that if the leverage is weak or non-existent, you can expect a negative reaction; it may not even be worth having the conversation.

More on Leverage

As mentioned several times already, the key to successful treatment outcomes is leverage. This means maintaining external pressure on the addict to comply with treatment recommendations until he develops the internal motivation to abstain and seek sobriety. The failure to use and maintain leverage is a major reason for high relapse rates and tragic deaths among the affluent and prominent. There are two forms of leverage: explicit and non-explicit.[5]

Explicit leverage is language replicating the process used by medical boards for their addicted physicians, inserted in trusts and estate plans allowing for termination of funding in the event of noncompliance with treatment recommendations. The language (1) is detailed; (2) allows for the appointment of experts to advise; and (3) allows the experts to manage the recovery process for at least two years.[6] 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.

John would advise his succession-planning client to adopt this language in the event a child or grandchild might have a problem with drugs or alcohol. In his capacity as trustee, he may decide to decant the existing trust into a new agreement with the addiction language and change distribution dates to better address addiction concerns in the beneficiary.

Non-explicit leverage includes other sources of pressure to encourage the PWP to seek help. 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 (passing out at weddings, DUI)—"It's clear you now have a problem."
- **Action-based pressure:** creating consequences (setting limits and making agreements)—"OK, if you want money to pay off your debts, let's see if you can abstain for a month."

Non-explicit leverage is far less effective than document-based leverage because of the inability to maintain pressure to encourage sustained recovery over several months.

Because non-explicit leverage has its limitations, rather than attempt to use it and risk failure, we recommend that the trustee or trustee's counsel be creative in working with family members in establishing new trusts and other governance documents that have explicit language, including, if necessary, relocating the trust to a state with liberal decantation and amendment laws.

> The affluent lifestyle is a breeding ground for addiction for many reasons, including lack of consequences from use.

Managing the Recovery Process

The goal of leverage is treatment compliance over many months, with protocols similar to the physician model. These protocols include: treatment center selection; information releases; approval of psychiatrists, therapists and medications; drug testing and preparation and implementation of the recovery agreement. It's the job of the expert to manage the recovery process, working on behalf of the trustee or family—not the PWP. We refer to this concept as "dual-track case management," with one manager for the family (the medical board model) and one for the PWP.[7]

What to Expect During Treatment

Treatment centers encourage patients to focus on their recovery and refrain from conversations with advisors and family offices. John's role is to reinforce this advice and similarly urge his client or beneficiary to take care of first things first (recovery). In his absence, the spouse and blood family members sometimes present

conflicting views as to what to do with the client's assets, properties and/or possessions. Longstanding feuds may resurface. We recommend working on a strategy with your addiction expert ahead of time as to how to best communicate with the family as a whole to minimize distractions that draw the patient's attention away from recovery.

The treatment environment encourages open and honest communication about feelings as part of the recovery process. The advisor may be one of few trusted people in the recovering addict's life, and the client may want to disclose a lot more than the advisor wants to know. Even asking the simple question, "How are you?" can result in a 10-minute response. Our advice is to be a good listener and suggest that the client talk to his counselor about recovery concerns.

If possible, obtain a copy of the post-treatment plan that outlines recovery activities and identifies counselors so the client can be encouraged to follow the plan. Recovery progress and success are directly correlated to the degree of compliance with these post-treatment recommendations.

Behavior Expectations During Recovery

As we discussed, there will be a post-treatment plan with specific performance expectations. In this regard, it's compliance that counts, not intent. Let's consider the actual day-to-day activities of the client. What changes can be hoped for?

First, the addict is to avoid usual and customary environments where past use of drugs and alcohol occurred. Examples of situations leading to relapse include:

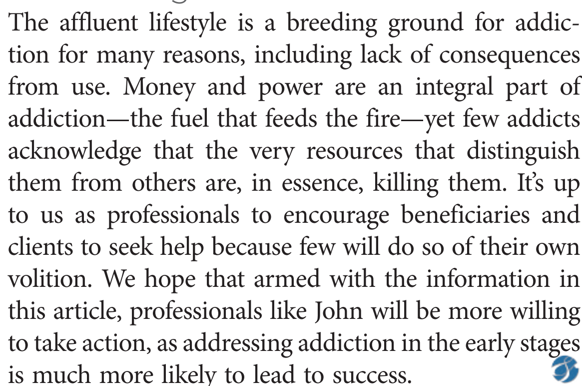
- Weekly lunch at the country club where wine is served
- Planning to drink only Diet Coke with golfing buddies at 19th hole
- Visiting friends at bars to have a good time without drinking
- Taking a vacation or visit to one's cabin to recover from treatment

Second, the client may try to convince the manager or family members that limited use of some addictive substances is perfectly fine. Examples:

- Parents believing son was told at treatment that he should stop using cocaine, but it was OK to drink beer.
- Wife was told marijuana was permissible because it's non-addictive.

No, it's not normal to drink beer after treatment, not even just one or two. Prescribed medications are another source for abusive substances that the client may claim are permissible to use due to "doctor's orders."

A Breeding Ground



The affluent lifestyle is a breeding ground for addiction for many reasons, including lack of consequences from use. Money and power are an integral part of addiction—the fuel that feeds the fire—yet few addicts acknowledge that the very resources that distinguish them from others are, in essence, killing them. It's up to us as professionals to encourage beneficiaries and clients to seek help because few will do so of their own volition. We hope that armed with the information in this article, professionals like John will be more willing to take action, as addressing addiction in the early stages is much more likely to lead to success.

Endnotes

1. "Airline Pilots Soar to Success in Recovery," *Hazelden Voice* (Winter 1998).
2. "The New Paradigm for Recovery: Making Recovery —and Not Relapse— the Expected Outcome of Addiction Treatment," Report of the John P. McGovern Symposium hosted by the Institute for Behavioral Health, Inc. (Nov. 18, 2013).
3. Ned Smith, "The Hidden Secret That's Destroying Many Family Businesses," *Business News Daily* (Dec. 21, 2012).
4. 2007 SAMHSA NSDUH Report, dated June 25, 2009.
5. For more information on leverage and the pilot/physician model, *see http://billmessinger.com/downloads/Leverage-First.pdf.*
6. For model language replicating the physicians program for use in trusts and governance documents, *see http://billmessinger.com/downloads/Model-Language.pdf.*
7. For more on recovery management, *see http://billmessinger.com/downloads/Dual-Track.pdf.*