Family Support and Addiction Management for Long-Term Success

Leverage First:

Using Family Resources as a Positive

Influence for Recovery

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Introduction

Why another article on addiction? There are many articles about intervention, treatment, and personal stories, **but none on what is proven to work for successful recovery.** Physicians and pilots have very high first time recovery rates – the only groups with excellent out comes.

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

This article is an overview of the basic concepts on how to apply these two programs to improve recovery rates for other addicts, including the affluent, prominent and powerful. In addition, suggested provisions for use in trusts and other governance documents to replicate the physicians/pilots model are included as appendices.

Airline Pilots Soar To Success

My interest in developing and using the ideas presented in this article and in working with families began when 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 I began asking treatment centers why other groups were not offered similar programs – receiving no coherent answer. The standard response on relapses is that the patients did not follow their aftercare plan or get the miracle of recovery. This is the "blame the alcoholic/addict" school of treatment.

28 Days – Not Long Enough to Recover

As is discussed in later sections, 28 days is insufficient time to develop stable recovery – the disease of addiction is still very active and, therefore, relapse is to be expected!

- Current treatment promotes the merry-go-round of treatment: efforts at abstention, relapse and then more treatment.
- In contrast, the pilot/physician model is designed to encourage participation in recovery activities for two years or more – one of the reasons for their very high success rates.

Because addiction causes so much damage, it is critical for family members and friends to understand why the pilot/physician programs are successful, in order to be more effective in addressing addiction in their loved ones. They also need to understand how physician/pilot program concepts can be modified and used to improve outcomes for their loved ones.

Medical Boards and Airlines Recovery Management Programs

These programs could be called the *medical boards and airline recovery programs*, because these organizations manage and direct the recovery programs for doctors and

physicians, with boards and airlines requiring accountability and compliance with all treatment recommendations. Families, working with qualified addiction professionals providing their guidance and expertise, must also find ways to manage and direct their addicts' recovery program over the long term, just as the medical boards and airlines do for their doctors and pilots.

- ***This is a much different approach than the current interventionist and treatment center practice familiar to many readers.***

Due to the dissimilarities between current practice and the doctor's program, it is important for readers to understand how we apply the medical board program to other groups in what we call our **Family Recovery Management Program for Addicts and Alcoholics.**

Recovery Management

Two quotes from the addiction literature on recovery management:

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

Think of recovery management and accountability as "evidence based best practices" in the field of addiction, due to the high success rates of the doctor and pilots compared to other groups.

Throughout this article, keep three core ideas in mind:

- **Supportive and knowledgeable family members can be very influential in supporting their loved one's recovery.**

This is contrary to the advice given family members by treatment centers, Al-Anon, and surprise interventionists. However, the new thinking is that families, with the help of a qualified professional, can be "positive enablers."
(Be aware that when calling a treatment center for help, almost all the interventionists that families are referred to by the treatment center are part of marketing, and not interested in or qualified to help families perform this role.)

- **Understand treatment and recovery: Become informed consumers of addiction services.**

Families are told not to "meddle" in their loved one's treatment. This is nonsense. Not only are many families paying privately or often using their insurance to pay for treatment, but also your addicted family member is by definition a vulnerable adult because of the need for inpatient treatment.

- **Addiction creates trauma in families and this trauma continues on in recovery.**

Family programs are inadequate to address this trauma and treatment centers do not refer families to qualified professionals to provide counseling to help resolve addiction-related trauma.

Now let's look into how to improve success rates for addiction treatment and also improve family well-being, beginning with learning about the physician programs.

1. Understanding the Program Concepts of the Highly Successful Physician Programs

The only treatment programs with good success rates for continuous abstention over several years are the programs run by medical boards for doctors and by airlines for pilots. You, as a parent, advisor, or other concerned family member, need to be familiar with their outcomes and know why they are so successful.

While pilots do have high recovery rates, most of the literature now focuses on the success rates of the medical boards' physician health programs (PHP) for addicted doctors in each state. These programs present reliable data because of the rigorous and continuous oversight by state regulators.

High Long-Term Recovery Rates for Physician and Pilots

Let's start with these facts:

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

No other group approaches these recovery rates, and in fact, studies show one-year continuous abstinent rates at less than 25%.[ii]

Let's add this fact:

- **Treatment is not recovery. The most common outcome of treatment is relapse.**

Despite what treatment centers and their interventionists want families to believe, going to treatment does not mean the problem is solved.

Let's end with this fact:

- **Addiction treatment is the only field of medicine where physicians receive different treatment than other population groups.**

It's different because medical boards oversee and dictate the terms of the recovery program for doctors. Their program is also different in that it is both better in quality and longer in duration – much better treatment over many months!

Read what physicians in the field have to say about the programs for doctors:

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

> *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.*

For those of you like me - seeing family members, friends, and clients go to treatment and relapse – the physicians program is fantastic news.

The Medical Director at Hazelden in an article, *Redefining Addiction Treatment*, wrote the following:

> *Research has shown that physicians' health programs achieve extraordinary outcomes in substance use disorders (SUDs).* ***<u>One recent study demonstrated nearly 80 percent abstinence at five years.</u>*** *……*
> *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?***[iii]

Many families have been asking the very same question for a long time – *why pay for multiple detoxes and no follow-up?* I continue to hear form parents after their child has attended the "best" treatment centers and suffered multiple relapses. Parents are not informed about these very effective programs and therefore know nothing about them.

Also, I consider it astonishing – nearly 80% abstinence rates over 5 years for doctors. Remember this headline I saw 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*

It took 13 years – the time between this headline in 1998 and the time when the Medical Director at Hazelden wrote his article in 2011 – for a major treatment center to discuss the PHP program as a way to reduce multiple relapses and a model for effective continuity of care. During these 13 years thousands of addicts have suffered, many dying, who could have benefited from PHP type services.

Let's look at what another PHP program doctor says about the high outcomes for physicians:

> *The research showed that 78 percent of 904 doctors in the studied programs completed an average of 7.2 years of monitoring without relapse. …*
> ***Those are just over-the-top numbers for a chronic, progressive disease that kills people.***
>
> -Dr. David Carr, Director, Mississippi Physicians Health Program

<u>78% percent rate of continuous abstinence at seven years!!!!</u>

Think carefully – would you rather have your family member, client, beneficiary, celebrity, athlete, or friend follow the medical board program for physicians with a 78% continuously abstinent rate at five years (Option 1), or enter a traditional program with a continuously abstinent rate of 25% (or lower) at one year (Option 2)?

- The answer is obvious, yet the problem is finding a treatment center that uses the doctors' model with other patients or interventionist who understand the model.

As to former there are a handful of centers that follow the PHP program. Regarding the latter, I am establishing a network of professionals around the country who can properly assist families and advisors.

Therapeutic Leverage

One reason for their very good outcomes is that medical boards use the license to practice medicine as leverage or pressure to assure that physicians comply with treatment

recommendations, including post-treatment plans and reliable drug testing for two or more years.

- Either comply or do not practice medicine.

In the next five chapters, I will discuss why leverage is so important to use when treating addictive disorders, and describe the goals sought to be accomplished through the use of leverage. As mentioned, this article is overview on basic information about Option 1 – the Physicians' Recovery Program (PHP) and how we have applied their program concepts to affluent and prominent addicts.

Remember, the only way to significantly improve outcome rates is by using the PHP model, and that model is a long-term one, managing recovery for at least one year and often much longer.

2. Therapeutic Leverage or Pressure

Medical boards use the threat of license revocation as **"leverage,"** or pressure to obtain compliance by physicians with their program requirements.

- Pressure is maintained for up to two years to assure that doctors are well on their way to recovery.

This type of leverage is very effective and we have been helping our clients – parents, family leaders, trustees, and business owners – find similar pressure points to encourage their addicts to enter treatment and comply with post-treatment recommendations.

Our article is called ***Leverage First*** because without leverage, any intervention strategy has little chance of succeeding. Love and the emotional flooding of the traditional surprise, quickie letter-reading meeting with the addict may result in entering treatment *but it is absolutely no guarantee as to successful long-term recovery. In many cases, it is counterproductive and almost always increases family trauma.*

It is fine to use leverage or the implied threat of leverage in a respectful and loving manner, but without leverage, all the love in the world will not sustain recovery. So throw that book away.

Insert Our Suggested Model Leverage Language into Governance Documents

The first thing we recommend to our clients is that they put language that addresses suspected addiction or other behavioral disorders into all of their legal documents (trusts, business control, financial and real estate agreements, and contracts for key employees).

- Our suggested model language is at the end of this article (preceded by a "plain language" summary of the model language).

Adapt the model language to your particular circumstances (and consult with a lawyer when doing so, as we are not offering legal advice, just general ideas for discussion).

Because trustees do not have the time or expertise to act as "guardians", one key concept is to hire an expert to advise the trustee, find resources to evaluate and treat the beneficiary and then manage the recovery process. (For more information on the suggested language, how addiction impacts trustees and family offices, and managing the recovery process, see articles listed in the appendix or on my website.)

Without such explicit language, finding sources of pressure to encourage treatment compliance is often difficult, usually takes several tries, and occurs later in the progression of the disease.

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

"Decant" is a trust term and there is a growing body of legal decisions and state statutes that allow an "unamendable trust" to be amended by the trustee using decanting concepts if acting in the best interests of the beneficiary. Because money is the fuel that fires the addiction, family members need to explore all avenues to avoid giving money to their loved one with a problem.

For celebrities, athletes, the media, executives, and the like, the people or entity controlling their pay need to insert our model language or similar language in their contracts. For example, comedy clubs could insert language that addresses addiction in their contracts with comedians to prevent the continued tragedies occurring in their field.

Non-Explicit Leverage

In the absence of such explicit leverage, families will need to find other sources of pressure to encourage the person with the problem to seek help and comply with treatment recommendations. To distinguish this type of pressure from the written provisions in trusts and other governance documents, it is called "Non Explicit Leverage". It can be divided into three different categories:

- Soft Pressure – Personal
- Externalized (*it's not me, it's you*) – Opportunistic Pressure
- Action-Based – Creating Consequences

For examples of non-explicit leverage in these three different categories see pending articles available on www.BillMessinger.com.

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

Five Key Points on Using Leverage:

- **Leverage is an early intervention strategy**

Using leverage is an early intervention strategy – you wait too long and, many people have so much money they are immune to pressure, they can be treatment-savvy, or their disease has progressed to the point where their ability to recovery is limited (or they are dead).

- **Leverage is maintained over many months**

Pressure to remain compliant with treatment and post-treatment recommendations must remain in place for many months. The goal is for the external motivation to remain compliant with recommendations to be replaced by internal or self-generated motivation to lead a sober life.

- **Leverage is a strategy to obtain compliance – it is not treatment.**

Leverage is not treatment. It is a technique to get the addict to enter treatment and stay in recovery. So you have to find a treatment center with a traditional 12-step based program that respects and treats the clinical needs of the affluent and prominent.

- **Find and use qualified, licensed help.**

Use professional, licensed, and degreed help to implement the ideas in this article. Do not call a treatment center for help; you will be referred to their marketing department (aka interventionist).

- **Never cut off an addict without a support system in place.**

If an addict refuses to comply with treatment requirements, never cut him/her off without a support system in place. This support system can range from hiring private investigators that can monitor the addict, to working with a local counselor, to housing him in a sober house or a minimal living environment.

See Article 2, *Using Leverage to Support Sustained Recovery*, which explains how we modify the pilot/physician program when applying leverage to affluent alcoholics and addicts to improve outcomes. It describes fifteen differences between programs for pilots/physicians and programs for the affluent.

3. Leverage or Neglect: More on the "Why" Behind Using Leverage

Many families prefer not to use leverage because they fear a negative response from the addict or want recovery to be the addict's "choice." Aside from the fact that the only successful models of recovery – the pilot and physicians models – use leverage, and every other model is a failure, families still decline to use pressure because they want their addict to make the decision to enter treatment.

- Because the addict has a disease that results in the compulsive and harmful use of alcohol or drugs, this reluctance to act is actually neglect.

Without the help of family and friends, the addict will continue to suffer as the disease progresses. **For families the options are not leverage or choice, they are leverage or neglect.** You need to take steps to help your addict get into recovery and this requires counseling and an intervention strategy (more on these topics below).

Expert Opinions

For more from professional on the benefits of coercion in supporting recovery, I offer the following quotes from experts:

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

Chemically dependent patients, free of co-existing mental illness, with intact jobs and family, tended to do well in rehabilitation programs if ***families and employers applied therapeutic leverage and support.***
Goodman and Levy. Biopsychosocial Model Revisited. p. 3.

Internal motivation is a more powerful predictor of recovery than external motivation. Moving from external motivation to internal motivation is a long process. Therefore it is ***critical for external pressure to continue until this transition is fully underway, if not complete. The failure to follow this advice is a major cause of relapse.*** (Paraphrased from report.)
Susan Merle Gordon. *Relapse and Recovery*. Caron Foundation Report. 2003.

My experience with attorneys tells me that long-term outcomes are dramatically improved when lawyers can be monitored and when there is an ***accountability system with a fair amount of external support.***
Chuck Rice. *Impaired Lawyers Overcome Denial, Stigma to Achieve Road to Recovery*. Hazelden Voice. Vol. 9, No. 2. Summer, 2004

Treatment compliance is the biggest cause of relapses for all chronic illnesses, *including asthma, diabetes, hypertension, and addiction.*
Alan I. Leshner, Former Director, NIDA. Science and Technology. Spring, 2001.

This expert advice needs to be followed by families. In all of my interactions with beneficiaries, none ever told me they were cut off too soon. Some wondered why their families did not act more promptly – if they really cared about them – when they were unable to stop due to their disease.

- These quotes are intended to reinforce the message regarding the need to use leverage despite the often-dramatic responses of the beneficiaries.

And there are treatment centers that view using pressure as anti-recovery because it upsets and disempowers the patient. Their advice is to give the patient control over his/her money so the patient can focus on the recovery process. Giving someone 20 days into treatment control over their money is insane and any treatment center that advises families or trustee to do so is engaging in malpractice.

In closing this discussion, remember that you will never be told to use leverage by a treatment center, as they represent the patient and what the patient wants – their loyalty is to the patient, not to the family.

- In fact, the treatment center will support your addict in resisting leverage regarding implementation of post-treatment recommendations.

So you will need to find your own professional help and advocate. Do not rely on the treatment center to do what is best for your family member – you live with the consequences of relapse. They take no responsibility for their patient when treatment fails.

4. Family Recovery Management Program

For more than ten years we have applied the concepts of the PHP program in our work with families and are now formalizing our experience in what we call our ***Family Recovery Management Program.***

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

- The phrase "can learn" is emphasized because medical boards use qualified, licensed professionals to guide them.

Families must use similar assistance to effectively implement and convert the PHP concepts to their individual circumstances.

Two Track System of Services

Because the PHP model is unfamiliar to many readers, a conceptual overview of the PHP Program might be helpful. It is a "Two-Track System" in that there are set of activities for the medical board and a set of activities for the doctors

MEDICAL BOARD (PHP) TRACK – PATIENT TRACK

The most important part of the PHP program is that it is a TWO-TRACK system:

- **Employer Track** USES LEVERAGE

-Medical boards dictate recovery activities and receive progress reports.

- **Employee Track** COMPLIES WITH LEVERAGE

-Physicians have their own recovery: treatment, aftercare, 12-step meeting, therapy, 2-3 year process.

This approach is the primary reason why physicians have such high recovery rates.

When adopted by families and their addicted loved ones, the system is outlined as follows:

FAMILY/ADDICT TWO-TRACK SYSTEM

It is a "Two-Track System" in that there are set of activities for the family and a set of activities for their loved ones with the problem

- **Family Track** USES LEVERAGE

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

- **Addict Track** COMPLIES WITH LEVERAGE

-Family addict has his/her own recovery: treatment, aftercare, 12-step meeting, therapy, 2-3 year process.

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

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

- Emphasis on open communication among all parties (complete releases)
- Immediate response if relapse
- Leverage used to assist in implementing a structured recovery program
- Drug-testing
- Proactive therapeutic "community" (counselors, sponsor, meetings, etc.)
- Contract – specified recovery activities and relapse plan

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

You may have heard the slogan, ***Recovery Begins After Treatment***. For both the pilot/physician and family recovery management programs, the emphasis is on recovery activities occurring after inpatient treatment.

- As emphasized throughout this article, one of the leading causes of relapse is noncompliance with treatment recommendations.

Accordingly, the Family Recovery Management Program (FRMP) should **first be thought of as a means to encourage the family addict to comply with post-treatment recommendations.**

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

This contract between the medical board and the doctor describes in detail the recovery activities the doctor is required to engage in so they can practice medicine. It specifies in detail such items as drug testing requirements, releases of information, meetings, use of medication.

Again, Drs. Skipper and DuPont:

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

This agreement is another reason for the high success rates because it leaves no room for debate as to what the physician's recovery activities are and what constitutes compliance.

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

- Whereas the doctors contract conditions licensing on contract compliance, for the affluent, access to funds for support, to pay for treatment or participation in family events is the "carrot".

Contracts can also be created for pre-treatment situations as a means to persuade the person with the problem to enter treatment. This is a subject for longer articles on persuasion to enter treatment and post-treatment case management. In particular, see the article, *Dual Track Family Case Management & Monitoring: The Key to Recovery from Addiction and Behavioral Disorders*, with Arden O'Connor as co-author.

5. The Predictable Risk of Addiction

Addiction is a predictable risk because it occurs within the general population at an estimated rate of 10% and at much higher rates within certain sub-groups.

- We estimate the addiction rate to be between 20% and 40% among the wealthy, although in some extended families it is much more pervasive.

The risk of addiction is said to be the leading factor in loss of wealth over generations. For readers in the celebrity managing or producing business, the risks from addiction are often more acute, with the high of success followed by destruction in one generation.

The PHP model, as adapted to the affluent and prominent in our Family Recovery Management Program, offers an effective approach to recovery that reduces risks resulting from addiction.

- Our interest in using the PHP program as a model to help others stems from high relapse rates in family members, treatment peers, and the recovering community, including many affluent and prominent people.

Traditional treatment failed all of them, always with negative results, including death. It is time for a new approach that actually works to sustain recovery.

6. Relapse (The "R" Word)

Many treatment centers do not want to create a relapse plan, asserting that talking about relapse makes it more likely to occur. This is "voodoo" treatment and counter to contemporary practice, as Dr. Gordon states in her relapse report:

> *Relapse is common following treatment for addiction and patients should understand that they are likely to be vulnerable. Discussing vulnerability to relapse during treatment is the duty of the clinician. The idea that mentioning the "R" word will give permission to relapse is simply wrong.*[iv]

I continue to be amazed that with all the current emphasis on "best practices", leading treatment centers will not urge their patients to create a written plan, nor share it with key family members. (Example father who owns a family business now run by a son who is an alcoholic and is worried about what will happen if his son relapses. No plan recommended.)

- This is an additional area where you, as the family member, advisor, etc., will need to take the initiative and insist on developing a relapse plan, even if the treatment center does not agree.

You will need to use your <u>own</u> professional counselor to make progress on this topic.

The Predictable Risk of Relapse

The Caron Foundation Report, *Relapse & Recovery: Behavioral Strategies for Change*, has 24 pages of detailed information about what leads to relapse and how to improve recovery outcomes – too many to discuss here. But six key points are:

- Broadly speaking, relapse is the inability to maintain behavioral changes over time.
- Maintaining recovery requires different skills than those needed to enter recovery.
- Ninety percent (90%) relapse rate for alcohol treatment (does not provide time frame).

- The greater the consequences from use, the greater the motivation for recovery.
- Those with fewer consequences tend not to believe they have a significant alcohol or drug problem (i.e., the affluent).
- Ninety percent (90%) of people attending AA and aftercare once a week remained abstinent.[v]

My conclusion in reading the report is that 28 days of treatment has little impact on improving recovery outcomes – it is what happens before and after treatment that counts.

Also, because most affluent people have few external consequences from drinking or using drugs, one goal of an effective intervention strategy is to "create consequences" so as to make their use more real to them.

- (See Article Six on Treatment for Affluent Addicts, listed in the Appendix).

The Family Recovery Management Program performs this role in several ways with the use of leverage, helping the addict change to a recovery lifestyle, and preventing situations that might lead to relapse.

7. Family Support for Recovery

In our Family Recovery Management Program, family members work together with their professional to proactively develop a plan to intervene in and manage their addict's disease and recovery over the long term.

- The key ideas are active, continuous engagement with the addict and family collaboration to address addiction, in conjunction with their addiction professional.

This concept is foreign to many family members, especially parents, and is directly contradicted by Al-Anon, treatment centers, and many counselors and interventionists.

- Therefore, this section will address contemporary views on the need for families to actively support their addict's recovery.

Then in the next section discuss why following the advice of "letting go" is another misguided concept and dangerous to the health of your loved one.

Families are Powerful Allies in Supporting Recovery

The idea of continuous engagement with the addict stems from the fact that families are powerful allies in fostering recovery.

- Such engagement is a significant factor in the success rates of pilots and physicians where there is the active and constructive involvement of their employers regarding treatment and post-treatment activities.

Similarly, for the affluent and prominent, effective communication by treatment personnel with key family members, advisors, and addiction professionals is critical to sustaining recovery.

In fact, as Susan Cheever observes in her book about Bill Wilson, co-founder of Alcoholics Anonymous:

> *Families neither cause nor cure addiction. However, they can be powerful allies in fostering recovery.* ***It is an essential part of the clinical mission*** *to draw these families into treatment planning and execution.*[vi]

Families and other influential people in the life of the patient can only be "powerful allies" if they are incorporated in the process. Families are resources for assessment and treatment planning, particularly as to information the patient may be reluctant to disclose. They must also be included in post-treatment planning when they are funding recovery, controlling access to resources, and/or reemployment, or in a relationship with the patient.

Successful Families: Like the Balance of a Tightrope Artist on a Bicycle

Here is how Susan Cheever describes the family's role:

> *The balance that **creates** a successful family around an alcoholic is trickier than the balance of a tightrope artist on a bicycle. Families of alcoholics must both separate themselves from the alcoholic and involve themselves intimately with the alcoholic, and they must do so at the same time.*[vii]

Substitute the words *advisor, family business,* or *trustee* for ***family*** and the same prescription applies.

- The key word here is *create*, because the sought-after balance is a learned phenomenon, ongoing and evolving.

What is needed at day one is different at day 10, 20, 30, 60 and so on. Ideally, learning occurs with support by a therapist specializing in addiction and with expertise in interacting with the patient's counselors.

Positive Enabling

Let's turn to another idea expressed in the article, *Erasing Misconceptions About Enabling* by James M. Pedersen:

> ***Changing "Enabling" from a Negative to a Positive Force to Support Recovery***
> *It is time for therapists who work with addicts and their families to reevaluate a concept that has existed in the addiction literature for some time. For far too long we have been careful to ensure that families (including anyone in the addict's natural support system) avoid enabling at all costs.*
>
> *It is the therapist's job to help the family move beyond the guilt and compunction so often associated with the misperception that enabling is a bad thing. Enabling is a high-energy expression of love for the addict and should be reevaluated, then redirected, toward behavior that enables recovery, not addiction.*
>
> *"The Family Factor" is based on the premise that of all the people involved with an addict, it is the natural support system that almost always constitutes the most decisive and powerful outside influence.*[viii]

Note two ideas:

- One, the importance of the therapist's role in helping the family, and
- Second, that the family is the most important outside influence in supporting recovery.

Finding competent counselors is difficult. Please read Section 10, below, for suggestions as to resources for you and your family.

Powerful Outside Influence to Encourage Recovery

Also, we are back to a familiar theme, finding a "decisive and powerful outside influence" to encourage the addict to recover – i.e., leverage as mentioned in the PHP program.

- What makes the idea of family non-involvement with the addict even more absurd is that we know a lot about what factors support recovery and what factors lead to relapse.

For example, the Caron Foundation Report, *Relapse and Recovery: Behavioral Strategies for Change*, has 23 pages of good information to be discussed with the addict, with his/her counselor, or in a family meeting with a counselor.

- Talk about it – don't ignore it.

Addiction is not going away by closing your eyes, spinning in a circle, and hoping your loved one has overcome his/her disease on their own.

Advice on Making Therapeutic Decisions vs. Personal Decisions

Under this concept of recovery management, decisions regarding access to resources are made for therapeutic purposes and under the guidance of the counselor. The intention is for the addict to understand that decisions are not punitive or personal, but treatment-based. This allows parents to be parents and the counselor to be the "addiction advisor". Let's look at the following example; deciding a young adult in treatment should be in a double rather than a single room could be:

- *Because we are tired of spending money on repeated treatments while you continue relapsing and you are going to run out of money at this pace.*

Or,

- *Our addiction advisor thinks a single room allows too much isolation and says getting to know your peers is an important part of the recovery process.*

Both are valid statements. The latter is much preferred because it is therapeutic-based and depersonalized. The former comes across as part of an ongoing family struggle over money.

Few Treatment Centers Include the Family in Treating the Addict

Another problem is that while every treatment center says it promotes family involvement and communication, few actually perform as promised. The following comment reflects contemporary practice:

> *Alcoholism/addiction has been characterized as a "family disease" since the mid-20th century.* ***That rhetoric continues today, but there is little evidence that such beliefs permeate clinical practice.***
>
> *If we really believed that addiction was a family disease, we would not assess, treat, and provide continued support services to individuals in isolation from their families, we would instead deliver family-oriented models of engagement, assessment, treatment, and continuing care.*[ix]

Communication with family members, employers, and even outside therapists is often perfunctory and when it does occur, has almost no influence on treatment planning, which happens within three or four days of entering treatment.

To address this treatment defect, one expert suggests assigning a staff member as advocate for families:

> *It is useful to consider having a skilled and sensitive staff member whose sole responsibility is to act as family advocate.*[x]

We couldn't agree more, as we have spent countless hours attempting to communicate with counselors and administrators, but it is not going happen. Treatment centers are making money and see no need to change. One would think centers would be more responsive to those paying the bill, but this is not so. Why? They are not going to change until families demand change.

Pilots and Physicians Programs' Oversight Communication

Counselors at centers treatment pilots and physicians must communicate with employers and oversight professionals.

- Families and their advisors need to be more assertive in fulfilling this role in recovery of their loved ones.

Families need to be aware of how vital it is to use treatment centers that clearly articulate their commitment to communication and are willing to set up specific times to do so, such as phone dates.

- If communication is poor, families and advisors can call marketing representatives and the administration to complain.

Do not be passive! This is one reason to use one of the PHP physicians with a private practice – because they understand the need for full communication with treatment centers.

8. "Letting Go" is NOT a Successful Recovery Strategy

Many people are told to "let go," do nothing, and simply wait for their addicted family members to suffer enough consequences from their use to seek help from counselors or go to treatment. As mentioned above, family programs at treatment centers, Al-Anon, and many counselors give this message to family and friends. However, as discussed in Sections 2 and 3 above, early intervention models and strategies prove that this message is not only incorrect, but also harmful to the addict. The correct message is that families must focus on emotional detachment, but otherwise remain engaged with their loved one and actively support his/her recovery.

Why "Letting Go" or "Doing Nothing" is a Bad Idea

In addition to being told to "let go," families and advisors are often told that they are "powerless" over their loved one's addiction and he/she must "hit bottom" before wanting to stop and enter treatment or attend AA. This advice can lead to at least three negative results:

<u>It takes too long to hit bottom and waiting is dangerous</u>

- Concerned persons do nothing in regard to their loved ones' or beneficiaries' alcohol and drug use, simply hoping for the consequences of such use to lead to the "bottom."

Waiting can take a very long time for someone with money or other resources. They continue to use when in fact an earlier intervention strategy can be successful.

Support systems continue when they should be cut off

- The passive monetary support and other resources enabling use continue to be in place with no changes.

This passive system must be terminated or the addict will use until physically unable to do so.

Harm to self and others and wasted assets

- The failure to intervene at an early stage in the disease decreases the ability to recover, hurts others (such as children), and wastes resources.

Take action before the progression leads to economic and personal harm and decreased ability to grasp the emotional and spiritual elements of recovery. Waiting for your loved one to experience the consequences of his/her disease has been lethal, particularly for addicts with money or other resources. It is far better to come up with a recovery plan and well-thought-out intervention strategy, even if your addict becomes angry, than to go through the immense and on-going agony of regret and remorse.

Example of Bad Counseling for an Addict who Continues to Use

Let's look at this example of counseling incompetence regarding "letting go":

> A therapist tells her client who has just returned from another treatment, *"If you relapse, I will terminate my relationship with you."*
>
> The client relapses and the relationship is ended, leaving the relapsing addict with no support system. The therapist also advises the family to "do nothing."

This is like a heart doctor firing a patient for having a heart attack. It also leads to an increase in trauma to the family and the addict, when our goal is to decrease trauma (more on this below).

Addiction is a chronic disease and relapse is to be expected. The Caron Foundation Report states:

> ***The earlier one intervenes in the relapse process the better the prognosis.***

This counselor should not have fired the patient; she should have helped him or her get back into recovery and worked with the family to do so. If the counselor was concerned about her client using drugs again, she should have had her client drug tested. Everyone knows this is standard practice these days. In my view, her actions constitute malpractice. With a chronic disease, we expect setbacks, so remain focused on the ultimate goal.

In concluding these two sections, I have deliberately written at length on the need for supported family involvement with the addict because, aside from the failure to use leverage, adopting the approach of letting go and hoping the addict reaches a bottom or wants to enter recovery, has harmed and killed many people – it is lethal. This passive approach is no longer accepted practice in the addiction field. So get on board with our advice and hire a qualified family addiction counselor to assist you and your family.

9. Intervention Strategies to Improve Outcomes and Reduce Trauma

Family members facing addiction in a loved one must consider intervention strategies that will maximize the opportunity for long-term recovery while at the same time healing family trauma caused by addiction.

- Admittedly, these are extremely difficult tasks to attempt simultaneously because the trauma increases emotions – pain, anger, alienation and fear – while strategies on what might work for recovery require a dispassionate and rational analysis.

Holding these two contradictory states is almost impossible without the help of experienced addiction counselors.

The Predominant and Popularized Intervention Method Increases Trauma

I am not going to discuss trauma in this article except to say that the current system of calling treatment centers for help and being referred to their interventionist who conduct the surprise letter-reading intervention increases family trauma. When you call a treatment center for help, you are sent to their marketing department and usually referred to an interventionist.

- Their job is to get your addict into treatment as soon as possible in order to capitalize on the crisis that prompted the call.

Some of these interventionists run "boiler rooms" where the salespeople are taught to increase the caller's fears in order to sell the intervention ("the last person who turned down our services had their son die"). They are not interested, trained, skilled or licensed to help your family heal from trauma. So forget the standard model and these "interventionists" and start thinking about what is best for your family over the long run.

Alternative Intervention Strategies

Presenters at many addiction conferences are now advocating for different intervention methods, recognizing that the current system not only makes matters worse for family members, but as all the data shows, does not lead to sustained recovery.

<u>These alternative methods include family counseling, weekend educational workshops, invitational interventions, the ARISE model, family educational meetings, and other forms of interactive engagement with the family that may or may not include the addict.</u>

- All are designed to change the family dynamic concerning the addict so that his/her using life becomes more uncomfortable or difficult, and to provide the addict with direct or indirect feedback about his using.

They require an investment of time and money at the front end to make treatment a worthwhile experience and improve outcomes in the post-treatment world.

Before turning to a discussion of how to find a qualified addiction counselor, let's take a moment to think about what families are trying to accomplish when they decide to become proactive in addressing addiction in a family member. There may be a crisis to deal with immediately, and if not, then the concern is how to break the addict's delusional perception that he/she does not have a problem with alcohol or drugs. The concern is not how fast the family can get the addict into treatment – that is a losing proposition in terms of recovery and maintaining a relationship with the addict.

Crisis Intervention

There may be a crisis. Your loved one may have passed out, been arrested, become belligerent, threatening, or otherwise out of control. Here is my advice:

- If your addict has a serious health problem, is passed out, incoherent, is otherwise out of it or you think there is risk to his/her own safety, call an ambulance or take him/her to the ER or detox.
- If your addict is belligerent, threatening, or a danger to others, call the police.

Do not be passive. Take action.

If you think your addict will be angry at you for calling an ambulance or the police, tell him/her you did it because you were afraid for his life, afraid he would hurt someone, or your family counselor advised you to do so. Addicts may be in a blackout and not remember what they did or said – so you can tell them what they said. Or better yet, video them and replay the video.

The main point here is to call 911, not a treatment center, for help. Real emergencies require immediate help from professionals (EMTs and the police). Once these crises pass, they can be used as part of an overall intervention strategy.

10. Finding and Using Qualified Counselors

Finding Qualified Counselors

As stressed throughout this article families and trustee need to find qualified, licensed counselors with expertise in different intervention models and who is familiar with using leverage.

Why do I keep saying this? Let's look at another example of really bad advice from an unlicensed interventionist referred to parents by a well-known treatment center. He advised parents to tell their young adult child that unless the child went to treatment, they would never speak to the child again. The child had several hundred thousand dollars in the bank. The child went to treatment, left after five days and has not spoken to the parents in two years.

- First, there was absolutely no leverage due to the money in the bank.
- Second, even worse, as with the example given earlier, do not cut off communication with an addict – stay engaged.

So not only is it a question of what is a good intervention strategy, but also a question of understanding what is therapeutically beneficial for the family. Did this cause more trauma for the family? Of course!

Counseling Role: Advisor to Family or Manager of Addict

There are two distinct roles to consider when looking for counseling support

- Advising the family, trustee, family office, etc. regarding an addicted family member and devising strategies to address and manage that member over the long-term.
- Directly interacting with the addict and identifying resources for the addict and overseeing and implementing the recovery plan.

One counselor can provide both services, but for more complex families, it is preferable for one expert to work with the family and another to be more involved with managing the addict.

Due to bias against the affluent by counselors, I have had difficulty in referring callers to competent professionals. Fortunately, there are an increasing number of counselors in their late 20's and early 30's who come from business or trust fund backgrounds and are in recovery or have relatives who struggled with addiction. These counselors work well with families because they respect their clients and understand affluent culture

Independent, Licensed Counselors
Work with addiction counselors with degrees from accredited addiction schools (sometimes Masters degrees) and hold state licenses and who also do not take kickbacks or referral fees from treatment centers and are not affiliated with any treatment center. The following website lists therapists with an addiction degree who believes that addiction needs to be addressed as a primary disease in the context of family

- See www.independentinterventionists.com for a list of competent chemical dependency counselors.

I am actively building a network of addiction professionals who meet these qualifications as well and, can fulfill the two roles describe above as well as implement the ideas presented in this article. See my website for more information.
You will, of course, have to make your own decision as to whom to hire.

Because many people believe finding help for an addict means the traditional intervention shown on TV, we offer two examples as to how a counselor can assist families in encouraging their loved ones to seek help in ways that can lead more stable recovery.

Breaking Through the Addict's Faulty Self-Perception – Delusional Thinking
Very few alcoholics and addicts perceive themselves as having a problem with alcohol or drugs, although everyone around would say they do. This self-perception problem often continues even after leaving treatment.

- While *denial* is a familiar concept, it fails to adequately describe this self-perception problem.[xi]

Denial would imply that the addict knows facts but chooses to say they do not exist. Delusional is a more appropriate word, as the addict is often not even aware of the facts of her/his use or how it impacts others (particularly so if blackouts occur).

An important goal then, when facing addiction, is to try to penetrate this delusional state by exploring different intervention strategies (except, of course, surprise interventions). This is one reason why the suggested intervention models take place over time so there is a slow awakening to reality by the addict. I tend to favor tailoring the intervention strategy to the individual situation rather than using a set formula, but structured intervention models, such as Arise, are also worthwhile in accomplishing this goal.

Hey! What Problem? Talking to the Addict about Concerns as to Use
One concern is how to introduce addiction to the addict as an issue others perceive as a problem. While this topic is too complex to address at length in this article. Our thinking on different approaches can be summarized under three overall headings previously discussed in the context of leverage. In this context, the focus is on the role of the counselor

- Document Driven Language (AKA, Explicit Leverage)

Appendix B language, suggested for trust documents, provides a "problem solving process" designed to encourage the addict to agree to meet with a counselor or to undergo an addiction evaluation.

- Non-Explicit Leverage or Pressure

Absent explicit language, our ideas on finding sources of pressure to encourage an addict to get help can also be used to initiate a counselor led discussion on the use of alcohol and drugs. This can lead to an evaluation or lesser measures such as drug-testing or behavior expectations in a written contract. Or the family could decide to start a formal intervention process such as the invitational or ARISE model.

- Indirect Methods

Under this heading, there is no talk about addiction. Rather the emphasis by the counselor is on other manifestations of problems such as failure to launch, educational or learning concerns or inability to manage finances. Indirect methods are sometimes helpful when families don't want to confront problematic behavior.

Conclusion

Keep in mind that we view the family and family "system" as the best way to heal addiction, while treatment centers focus on healing the individual addict.[xii]

- This fundamental distinction is key to understanding why current treatment does not work.

It is not simply the failure of treatment centers to advocate using leverage, it is that they address addiction as an episodic, emergency, short-term problem resolved with inpatient treatment, whereas we view addiction as a chronic disease to be managed over the long-term with a continued family based recovery strategy and varied intervention techniques designed to support sobriety.

To summarize key points to improve outcomes:

- Develop a long-term recovery management plan,
- Look for effective treatment,
- Identify sources of leverage for treatment compliance, and
- Do all this with the help of a trusted addiction counselor.
- Use a family systems approach

The physicians program is a wonderful model to work from. Keep their success rates in mind and don't settle for less than optimal recovery services for your loved one.

Appendix A
Summary of Model Language

(See Appendix B for the full text of our model language.)

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

a. Scope of behavior by the Beneficiary triggering withholding:

The Beneficiary *is or may be actively dependent on and/or abusing drugs or alcohol or may have other addictions, compulsive or destructive behaviors or mental health concerns as defined in 9 below (i.e., DSM V).*

b. Withheld until the Beneficiary is in recovery (as defined in 6, below), authorizes expenditure funds for the purposes set forth in this Appendix A.

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

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

a. Authorization to hire experts, describes their general area of expertise and the general scope of their activities.

b. Authorizes inpatient evaluations, recommendations and treatment as defined.

c. Requires experts to be licensed.

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

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

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

a. Allows Trustee to receive reports and requires Beneficiary to sign information releases so Trustee (or professional hired on Trustee's behalf) has access to treatment records and can speak directly with counseling staff.

b. Requires Beneficiary to fully comply with all recommendations, as approved by the Trustee or his/her designee.

5. Alcohol and Drug Testing – Observed Tests

a. Requires drug tests by a reliable testing service to verify drug-free status.

b. Scope of test, including requirement for observation (preferred choice is the testing service for health care professionals).

6. Recovery – Two-Year Minimum

a. Minimum of two years of continuous sobriety as defined and active participation in a "recovery program" as determined by the Trustee or his designee. Two-year minimum may be extended if relapse occurs or Beneficiary is not actively engaged in a recovery program.

b. Trustee can distribute funds to support Beneficiary's recovery program, even when the Beneficiary is in relapse.

7. Date When Recovery Begins

Begins after the Beneficiary leaves treatment, halfway house, sober house, or other inpatient environment.

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

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

9. Definition of Alcohol/Drug Dependence or Abuse

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

10. Indemnifications, Exoneration Provisions, & Dual Capacity

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

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

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

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

11. Other Prohibitions During Suspension or Withholding of Distributions

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

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

Trust Protector Provision

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

Appendix B

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Alcohol and Drug Testing

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

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

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

6. Recovery – Two-Year Minimum

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

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

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

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

7. Date When Recovery Begins

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

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

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

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

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

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

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

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

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

10. Indemnifications, Exoneration Provision, and Dual Capacity

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

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

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

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

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

11. Other Prohibitions During Withholding of Distributions

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

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

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

Trust Protector Provision

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

Alcohol Use Disorder DSM V

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

Diagnostic Criteria

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

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

Specify if:

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

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

Specify if:

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

Specify if:

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

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

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

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

Appendix C
Improving Recovery Rates for Affluent Addicts and Alcoholics

TWENTY ARTICLES

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

1. 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 adopting the pilot/physician model to other groups.

B. *Encouraging and Inducing Change*

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

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

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

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

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

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

C. *Systems Transformation to Improve Outcomes*

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

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

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

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

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

7. Families, Wealth and Addiction

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

E. *Advice for Families*

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

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

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

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

10. Advice for Parents of Adolescents and Young Adults

- A parents perspective on the developmental impact of addiction and recovery issues*.

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

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

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

12. Counselor – Client Relationship and Conditions Promoting Change

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

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

13. Trustees and Beneficiaries*

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

14. Advisors, Trustees, Account Managers and Family Offices

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

15. Financial Managers and Dysfunctional Clients

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

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

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

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

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

18. Core Needs in Wealthy Families

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

H. *Lawyers and Law Firms*

19. Law Firms

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

20. Bench and Bar Article

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

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

Footnotes

[i] ***Recovery management is an emerging model geared toward treating addiction similar to how other chronic and progressive illnesses, such as diabetes and cancer, are treated (White, Kurtz, & Sanders, 2006).*** *Beginning with the writings of Benjamin Rush, our nation's first surgeon general, for more than a century the field of addiction treatment has argued that addiction was a chronic illness (Kinney, 2006), yet, we have treated it more like an emergency room hospital visit – i.e., three days of detox, three weeks of intensive outpatient, twenty-one days of inpatient, etc. (White, 2005). The end result of this acute care approach has been continuous relapse. Research revels that the great majority of chemically dependent clients do not receive an adequate service dose of treatment to launch them on a path toward recovery – that dose of treatment being ninety days of continuous recovery support (White, 2005). If the addiction field truly believed that addiction was a chronic disease, like cancer, treatment would be longer. There is no cancer detox. Cancer patients are monitored for five years following their acute care treatment.*

Recovery Management in the Hispanic Latino Community by Jose Tovar, Jr. and Mark Sanders, LCSW, CADC Counselor Magazine, December 2011

Bill White: You have been involved in many addiction treatment outcome studies. What conclusions have you drawn about the degree of effectiveness of various approaches to addiction?

Dr. Humphreys: To my mind, the research shows that the things most researchers obsess about – e.g., is cognitive-behavioral therapy better than purely behavioral therapy versus purely cognitive therapy – are not where the action is.

Good treatments have common elements, including a relationship with someone who cares about you, some persistence of the treatment over time and some changes in your environment such that abstinence becomes easier and more regarding than continued use. Some clinical people are uncomfortable with this idea, but the research shows that some accountability in the environment is very good for people. That includes, for example, drug testing with immediate, certain consequences such as you see in drug courts.

Circles of Recovery: An Interview with Keith Humphrys, PhD by William L. White, MA, Counselor Magazine, December 2011.

[ii] White, William on outcome rates, Counselor Magazine, June 2005, p. 5. Many asserted high outcomes by treatment centers are simply false or don't treat relapse as a negative outcome. Others use databases that exclude patients that cannot be reached or do not respond to inquiries. These non-responders are treated as neutral, when in reality those of us who have been through treatment know that peers who cut off communication have in fact relapsed. Hazelden at one year, low to mid 50s during the 12 month follow up period for those reached by telephone attending residential treatment at Center City, Feb. 2011 Butler Center, The Retreat in Wayzata, 61% continuous abstinence at one year, with 61% percent response rate to the survey (39% did not respond to the survey). Confidential information from Betty Ford – 30% continuously abstinent at one year, when non-responders tracked down. Other data distortions stem from the fact that databases exclude patients who entered but didn't not complete treatment (bolters) and that self-reporting patients will affirm non-use when they in fact have used or are using – they lie. The only way to verify continuous sobriety is by drug testing all patients as the PHP and airline programs do.

[iii] Manejwala, Omar S. MD, MBA, FAPA, CPE Behavioral Healthcare, April 2011.

[iv] Gordon, Susan Merle. *Relapse & Recovery: Behavioral Strategies for Change.* Caron Foundation Report. 2003: p. 3.

[v] Caron Report, p. 18.

[vi] Ibid.

[vii] Cheever, Susan. *My Name is Bill.* Simon and Schuster. 2004: p. 236.

[viii] Pederson, James M. *Erasing Misconceptions About Enabling*. Addiction Professional Magazine. January/February 2007.

[ix] Davis. *What I Learned About Recovery.*

[x] Goodman, p. 15.

[xi] Carr, David MD *Denial vs. Delusion* www.professionalshealthnetwork.com, 2009.

[xii] For more on this comparison, see Article 5.