How We Help Families and Advisors Address Addiction in Affluent Families

Based On Highly Successful Recovery Programs For Pilots and Physicians

Article 1
(Summary)

Family/Advisor Recovery Management Program For Affluent Alcoholics and Addicts

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RESTORING LIVES, FAMILIES AND CAREERS

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A Family/Advisor Recovery Management Program for Affluent Alcoholics and Addicts

Article One

Overview

This article discusses improving outcome rates for affluent addicts by modeling services after the highly successful pilot/physician programs run by airlines and medical boards. We describe a Recovery Management Program similar to the programs run by these organizations but adapted to affluent family systems. Because addiction is a leading risk to personal and financial family well being, it is important that advisors and family leaders understand these new concepts and how they can be used to be more effective in addressing addiction in family members.

Four reasons for writing this article are:

- To raise awareness of the dramatic difference in success rates of the pilot/physician program in comparison to other groups in the hope that family, friends, and advisors will begin to demand similar services for their addicted family members.
- To promote a dialogue among treatment providers and professionals in the field on improving outcome rates, while using the pilot/physician model as the standard of treatment excellence.
- To describe our experience in adapting the pilot/physician model to the affluent addicts so professionals can learn how to help their clients throughout the intervention and recovery process.
- To explain why treatment centers face institutional constraints in adopting the pilot/physician recovery model.

<u>While the focus is on adapting the pilot/physician model, there also must be equal emphasis on providing clinically appropriate programming in a supportive therapeutic environment.</u> As to the latter point, the treatment and therapeutic community have often viewed the affluent as requiring special service needs – to be catered to – rather than understanding that the affluent have psych-social vulnerabilities that need to be acknowledged and addressed as part of treatment.

Attention Grabbing Risk Data on Excessive Use of Alcohol by the Affluent
As a family leader or advisor, educational and planning activities will need to take into account the following information:

- 30% of adults drink at levels that raise the risk of alcoholism.[1]
- Half of all alcoholics are high functioning.

Based on our experience, we think that 30 percent would be a low number for affluent families, although 30 percent is high enough to undermine family unity and destroy family enterprises. Of course, a high percentage of this group is actually addicted to alcohol and/or drugs.

Affluent young adults drink and use drugs at a level that should concern all parents:

- 22.6% of young adults (18-25) with family incomes or $75,000 or more meet the criteria for dependence or abuse of alcohol and drugs.
- 93% of abusers don't see themselves as having a problem.[2]

Again, we think this number is higher for affluent families, but the point here is that as young adults begin to receive funds and participate in family activities, at least one in five will be an actual or potential addict, but will strongly resist suggestions they may have a problem.

First of Twenty Articles
As the first in a series of twenty articles on improving recovery outcomes for affluent addicts, our purpose in writing this article is to provide an overview of our ideas on helping families effectively address addiction in a loved one. The remaining nineteen articles describe our experience in using the pilot/physician programs[3] as models for our work with our clients and their advisors, including trustees, client relationship managers, family offices, and governance provisions.

- **Our goal is to provide family leaders and advisors with practical, experienced based advice on how to handle the 30 percent actual or at risk adult family members and the 23 percent abusing or dependent young adults.**

A list with a brief description of each article can be found in the Appendix. Taken as a whole, the twenty articles provide a comprehensive program for addressing addiction and other dysfunctional behavior in affluent families though a "systems" approach with the common focus on improving recovery rates. A second goal is to provide a curriculum for training clinicians, therapists, and advisors.

One of the leading causes of relapse is non-compliance 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 treatment recommendations. While medical boards and airlines use the potential loss of license as leverage to obtain such compliance, families and their advisors will need to use more sophisticated and diverse leverage to achieve treatment compliance, as are discussed in the following topics:

A. Verifiable, Successful Recovery Programs – The Pilot/Physician Programs

B. Core Concepts for the Pilot/Physician Recovery Program

C. Family/Advisor Recovery Management Programs (FRMP)

D. Addressing the Clinical Needs of the Affluent and Prominent

E. Barriers Treatment Centers Face in Offering Families "Recovery Management Programs"

One concept to keep in mind in reading this article is that we view the family and family "system" as the best way to heal addiction while treatment centers focus on healing the individual addict.[4]

A. Verifiable and Successful Recovery: The Pilot/Physician Programs

One of the daunting tasks for families and advisors seeking help for a family member with an addiction problem is sorting through all the treatment models, including claims about success rates for recovery and the benefits of specific recovery programs.

Despite all the claims and promotions on TV and websites, those searching for help should focus on the only verifiable, statistically valid, successful programs in the world **– those run by airlines for pilots and medical boards for physicians.**

The Physician Program
Here is what Dr. Robert DuPont, former Director of the National Institute on Drug Abuse said about a nationwide review of outcomes for physicians' programs:

> *The results: **78 percent** of the physicians did not have a single positive test for any drug or alcohol use over **five years** of testing. Of the 22 percent who did have at least one positive test, **65 percent** did not have a second positive test.*
>
> ***Where else in the addiction treatment field can you find results like that? Those results set an entirely new standard for recovery outcomes, one that every treatment program should aspire to.***[5] (Emphasis added.)

These reported success rates are reliable because they are measured by State Health Boards who are charged with protecting the public safety by making sure pilots and physicians with addictions are fully recovered before returning to their professions.

As Dr. David Carr, a physician involved in examining 36 physician health programs (PHP's)[6], states:

> ***Those are just over-the-top numbers for a chronic, progressive disease that kills people…***

Why does Dr. Carr say these are "over-the-top numbers" and Dr. DuPont say it sets a "new standard for recovery outcomes"? Because, as professionals, we must confront the reality that…

> *the most frequent outcome of these treatment programs is relapse*[7].
>
> *A 2001 review of the largest and methodically rigorous alcoholism treatment outcome study…reported an average **one-year** continuous abstinence rate of **<u>24 percent</u>**.*[8]

So there you have it: Physicians have **78 percent** continuous abstinence at **5 years** versus 24 percent at one year for other population groups. (Pilots have high first time recovery rates, as well. Judges overseeing DUI and Drug Courts also are said to obtain better outcomes than treatment centers.[9])

PHP physicians have been advocating for treatment centers to apply the PHP model to all their patients, with no takers to date. However, the Medical Director at Hazelden recently wrote the following in an article touting the benefits of the PHP program:

> *Research has shown that physicians' health programs achieve extraordinary outcomes in substance use disorders (SUDs).* ***One recent study demonstrated nearly***

> ***80 percent abstinence at five years****. The success of physicians' health programs (PHP) in driving superior outcomes in addiction treatment raises critical questions about how treatment can be improved for all with SUDs. …***Why pay for multiple detoxes and no follow-up, indeed?**
> Omar S. Manejwala, MD, Medical Director at Hazelden[10]

Now, let's explore the basic concepts behind the pilot/physician program and how these concepts can be applied to support recovery for affluent addicts.

B. Core Concepts for the Pilot/Physician Recovery Program

1. Employer-Run Recovery Management Program

The pilot/physician recovery programs are *Recovery Management Programs* run by their employers and oversight boards. In essence, *Recovery Management is a Two-Track System:*

Airline/FAA/Medical Board Track (Employer Track)

- On behalf of these employers and agencies, licensed professionals (PHP's, for example) manage and oversee the recovery programs for pilots and physicians.

Pilot/Physician Track (Employee Track)

- Doctor and pilots have their own recovery program such as in-patient treatment, counselors, therapists, drug testing, A.A. meetings, and similar activities (although specified by the employer).

These two tracks are separate, but do interact, because employees are accountable to their employers for complying with their employer's recovery requirements.

What exactly are some activities that constitute "managing recovery" by the pilot and physician oversight boards? In an article entitled, *U.S. Physicians Health Program: A Model of Successful Treatment of Addiction*, Drs. Skipper and DuPont describe the *PHP* goals:

> *All responding PHP's shared the common goals of* ***early detection of substance use disorder****s; rapid intervention, thorough assessment and evaluation of potential cases; referral to abstinence-based treatment; long-term contingency monitoring; and reporting monitoring results to credentialing agencies (i.e. medical groups, hospitals, malpractice companies, etc.) concerned with assuring that physicians are able to practice with reasonable skill and safety. There was essentially complete uniformity of these goals across all surveyed programs.*[11]

The article describes in detail how these goals are implemented, including long-term post-inpatient treatment support and monitoring. Improving treatment outcomes for the affluent require similar monitoring activities.

2. The Contract Between the Employer and Oversight Entity

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 include and what constitutes compliance. 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 (see below).)* [12]
> (The Post-Treatment Supervision Agreement is one such document, See p. 15 below)

For the affluent, this written agreement takes different forms, individualized for each family situation.

3. Sanctions are Suspended or Postponed During Treatment – Creating Leverage
Deferring pending legal, employment or family sanctions during treatment creates leverage or pressure on the employee to comply with PHP and airline requirements. For families, similar leverage takes different forms and is often lacking in trusts, family businesses, foundations and other family entities.

Qualitatively and Quantitatively Better Treatment
Drs. Skipper and DuPont summarize the contrast between the PHP program and chemical dependency services for other groups (excluding pilots):

> *…it appears that the care and management of addicted physicians, as coordinated by PHP's is qualitatively and quantitatively different from the care received by the public.*[13]

This is an accurate statement and the challenge for affluent families and their advisors is to figure out how to find similar services for affluent addicts. Unfortunately, no treatment center offers services to families incorporating the three program elements discussed in this section. Until they do, recovery rates are not going to improve significantly from the 24 percent rate at the one-year mark. Accordingly, families and their advisors must create their own Recovery Management Program, as we discuss in the next section.

C. Family/Advisor Recovery Management Programs (FRMP)

In this section, we present an overview of our ideas on how families and their advisors, working with professionals, can emulate the airline/medical board programs to encourage and support their family member's recovery efforts.

As an overriding principle, when we talk about "managing recovery," we mean the family supports recovery under the guidance of a professional. The professional(s) collaborate with family members and their advisors in this process.

- An example of a collaborative "team" is the following: An addicted young male adult living at a sober house, with the team members being his father, aunt, family professional, sober house executive and sober house therapist.

Without going into detail, this group communicated at least two hours each week and more often as crises occurred concerning the young man. It was also a learning experience for all participants.

1. Recovery Management for Families
As with the pilots and physicians*, Recovery Management is a two-track system:*

Family Track

- Families are helped by professionals to collaborate in order to encourage and support their addicted loved one's recovery.

Addict Track

- Addicts have their own resources for treatment, including counselors, support groups, therapists and psychiatrists, as needed.

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

- Emphasis on open communication between all parties
- Immediate response if relapse
- Leverage used to assist in implementing a structured recovery program
- Drug testing
- Pro-active therapeutic "community"
- 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.

2. Accountability for Recovery Between the Family and Addict

Families may be told by treatment counselors that addicts are responsible for their own recovery and families should not ask too many questions about diagnosis, progress, or post-treatment recommendations. This information is in direct opposition to the pilot/physician programs that require full disclosure of all treatment information and approval or post-treatment plans – which are in writing.

Accountability helps addicts recover because they know if they fail to keep commitments there will be consequences.

- Therefore, we look for treatment centers that encourage family input in post-treatment planning, prepare written plans, including what the patient agrees to do in the event of relapse.

We also advocate creating a written agreement by the addict where the addict specifies his/her recovery activities and relapse plan in exchange for continued support by the family for his/her recovery and, as needed, living expenses. This agreement can be directed to family members, trustees, and the family business (as employer), depending on the circumstances.

3. Family Leverage Alternatives to Licensing Sanctions

Affluent families do not have the power of licensing sanctions to encourage compliance with assessment and treatment recommendations. However, they can build leverage into governance documents, as we describe in Article Four (See Appendix C to this article for Model Trust Language.) Absent such explicit provisions, families do have different sources of leverage, based on the ties between family members and the addict.

- These ties include the following: emotional, relationship, values, financial, interactive dialogue, status, and access to resources.

- In addition, families can find useful pressure points in third party actions, such as criminal proceedings, school failures, medical crises, and economic loss.

We emphasize that these leverage points are much more successful when used early on in the addiction process and before multiple treatments cause the addict to be treatment resistant. Despite behavior that indicates otherwise, many addicts look to their families for continued emotional support and these relationships can be important enough to encourage the addict to seek help. Accordingly, we tend to favor intervention strategies that build off the strength of these relationships, rather than surprise interventions, because, in our view, the former lead to better outcomes.[14]

Delusional Versus Denial

Because most addicts do not perceive themselves as having a problem with drugs or alcohol, different leverage concepts can be used to help to bring them more in contact with the reality of their disease. While "denial" is a familiar concept, it fails to adequately describe this self-perception problem.[15] Denial would imply that that the addict knows facts but chooses to say they do not exist.

- "Delusional" is a better word, as the addict is not even aware of the facts of her/his use or how it impacts others.

Therefore, a leverage technique such as "interactive dialogue" between the addict and a counselor can, over time, help break through the addict's delusions and change his/her perceptions as to the need for treatment.

Leverage is a Technique to Achieve a Goal

One final thought on leverage. Leverage is a technique to encourage a family member to enter and remain in recovery. It is a means to an end, not the end. If the family member goes to a bad treatment center, leverage is used to no avail (and there is a limited supply!). Good treatment is the key factor, as we discuss in the next section.

Professional Help

One significant difference between the pilot/physician programs and the family model is that families and advisors need intensive support and education from their counselor (much more than one hour a week in a therapists office).

- These activities include advice on how to communicate with their addict, particularly over money and recovery issues.

The family counselor works for the family and is independent of the addict. The counselor seeks to obtain compliance from the addict through agreements made with the family and treatment recommendations, by using various forms of leverage to encourage behavior change.

"Management vs. Letting Go"

The family recovery management program on the surface contradicts Al-Anon and Family Program messages about detaching from the addict and letting him/her suffer the consequences from addiction.

- However, the concept is to detach emotionally, not abandon the use of resources and relationships within family systems to support and encourage recovery.

In addition, contemporary addiction literature now supports assisting families in learning how to encourage their loved one's recovery.[16]

Finally, Al-Anon and Family Programs provide little guidance for the complex relationships in affluent family systems where access to funds and other resources allow the addict to continue to use and avoid consequences. **Letting go is not a viable option. Waiting for consequences allows the disease to progress to the point where recovery is much more difficult and increases harm to the addict, children and spouse.**

We conclude this section on the Family/Advisor Recovery Management Programs (FRMP) with a message from Dr. Gary Carr, from the Mississippi PHP who advocates, as we do, applying the PHP program philosophy to other groups. He believes most everyone has something similar to physicians in their lives that they value, and that is what the treatment system must identify and tap into.

> *"The plumber has a good job and doesn't want to lose it," he says. "Or he's got a great wife."*

Carr says the field needs to analyze what it is providing to some groups, such as physicians and airline pilots, but not to others. Then it can determine how to overcome barriers to a more widespread application of a treatment model that is based on accountability.
We hope this article, as well as our other articles, provide a sound foundation for such analysis.

D. Addressing the Clinical Needs of the Affluent in Treatment

As mentioned, an effective management plan is only half the battle. Finding treatment centers that understand affluent clients' emotional vulnerabilities unique to the experiences of growing up with or creating wealth is not easy, but necessary for successful outcomes. This section identifies seven areas for clinically sound treatment.

Creating Safe Environments

One challenge is for chemical dependency counselors, in particular, and treatment center staff in general, to approach affluent patients in a bias-free, non-exploitive and empathetic manner. Prejudicial views toward the well off, or "wealthism", as Joanie Bronfman, PhD calls it, are common among treatment center staff. Bias is a recovery barrier for the affluent, as is explained further in Article 7, Section 4.

- The first clinical need is to create a safe environment so patients can begin to make the emotional and behavioral changes to move from addiction to recovery.

(This includes not asking these patients for favors, autographs or donations for at least one year after they leave a "protective environment".)

Clinician Face Time with Patients

A second clinical need is for experienced, trained clinicians to spend time with affluent patients in order to build a trusting relationship.

- Experienced counselors understand that money and prominence often hinder recovery, and therefore are not to be envied but addressed as a recovery block.

Trained counselors will know how to engage in open-ended dialogue with patients over topics such as childhood, parenting, and self-esteem. This means higher pay and better working conditions for these therapists.

The Assessment Process

A third area of concern is the assessment process. The assessment process at some treatment centers overlooks key information regarding economic relationships, family interactions, dependencies, and upbringing. This may be the result of inadequate assessment tools, unwillingness to ask the right questions or negative counselor reaction. For example:

- When a patient raises a concern involving money, he/she may be told by the counselor not to talk about it. This not only prevents any further discussion of the topic, but it also reinforces the patient's shame about being affluent.

Aside from tailored assessments, there are "off the shelf" assessments tools, such as, *The Money Identity and Preferences Inventory: A Tool for Assessing a Client's Relationship to Wealth*.[17]

Establishing Meaningful Relationships with Key Family Members

A fourth clinical program component is to establish an ongoing relationship with key patient family members and their advisors beginning with the in-take, assessment and program plan process. As discussed above, affluent patients are very reluctant to disclose information about their childhood, economic situation or relationships involving money, position, or power.

- For example, it is common for patients to omit information regarding financial support from trust funds, parents or a family business, instead claiming they rely solely on a job for their income. Another example is reluctance to acknowledge prominent relatives.

Treatment counselors should encourage family members, therapists, and advisors to take the initiative and provide this information on intake, and as needed, throughout treatment process.

Training on Clinical Issues

A fifth clinical area to concentrate on is staff training and knowledge regarding clinical issues personal to affluent families.

> *An example of a clinical issue affecting many affluent addicts is the substitute parent – the nanny or other childcare person who takes care of the children in lieu of their mother. Ineffective substitute parenting often leads to attachment disorders or trauma due to heavy-handed discipline. Effective substitute parenting can lead to another form of severe trauma, for when Mom figures out her children prefer their nanny to her, the nanny is fired.*

This example is taken from Joanie Bronfman's chapter on childhood, referenced in the footnote[18], along with other useful articles for learning more about the clinical needs of the affluent. These articles are preferred sources for information about clinical needs of the affluent in treatment because they are based on the experiences of many families, including addicted and non-addicted members, and are authored by clinicians.

Sequencing Therapy For Underling Conditions Driving the Addiction
A sixth clinical issue concerns "sequencing" or when to address clinical issues unique to the affluent. Should these concerns be acknowledged during a 28-day treatment program and addressed after this initial stage of treatment or during the 28 days? Or should they be addressed during the initial 28 days? A similar concern is whether dual diagnosis issues are addressed in treatment or after treatment.

In selecting a treatment center, it is important to know what approach the treatment center takes. One approach is to stabilize the addiction and work on underlying conditions later on. A second approach is to work on stabilizing the addiction and gaining insight into the drivers at the same time. An article on this topic in *Counselor* magazine for addiction professions states:

> *A few wise therapists realized that once a patient developed solid recovery tools, they could safely probe more deeply into the patient's psyche. For these patients, a phased type of approach has been useful. For many other patients, the uncovering therapy and acquisition of recovery skills needs to happen simultaneously. These patients require a treatment plan that understands the underlying issues that drive the addiction. They need to understand the secondary gains represented by the addictive behaviors.*[19]

This point is not merely an argument over which approach is better. Many people struggle with abstention unless underlying conditions are addressed in treatment (since these conditions trigger relapse). If a treatment center postpones looking at underlying conditions until after treatment, a patient needing to do so will experience difficulty in recovery, particularly with a poorly written or implemented post-treatment plan.

Affluent and prominent patients can leave treatment with clinical needs overlooked and untreated. While this can happen for pilots and physicians, their clinical needs are identified and addressed in treatment and in post-treatment plans. In fact, they usually have specialized groups that meet during treatment.

One solution is to offer a 60-day program, rather than the traditional 28-day program, so there is sufficient time after stabilization to address clinical issues unique to each patient.

Family Recovery Management Programs (FRMP)
In closing this section, a seventh clinical need is the use of the Family/Advisor Recovery Management Program (FRMP) as family systems, leverage, and recovery agreements are integral components of an overall clinically based approach to improving outcomes.

E. Barriers Treatment Centers Face in Offering Families "Recovery Management Programs"

In this section, we will explain several barriers treatment centers face in providing services for families similar to those for airlines, medical boards and as we describe in this article. Treatment centers:

- Can't duplicate the leverage applied to pilots and physicians.

- Are not able to offer the same type of program as received by physicians/pilots.
- Have institutional constraints preventing implementation of similar services.

Now lets look at these barriers in more detail:

1. Using Licenses as Leverage for Compliance

As we know, if doctors and pilots do not fully comply with all treatment recommendations they lose their licenses to fly and practice medicine.

- The threat of license revocation creates the incentive to agree to initial treatment protocols; including evaluations and in-patient care (this threat is "therapeutic leverage" to encourage behavioral change) and comply with post-treatment recommendations.

Over time, as treatment continues, pilots and doctors develop the internal motivation to remain in recovery. While loss of license remains a possibility, most become less fear driven and eventually commit to a sober lifestyle and the benefits of recovery activities.

The threat of loss of license is a very effective pressure point, not available to other groups (or if available, not used for such groups (such as lawyers, accountants, brokers, or other groups acting in fiduciary or licensed capacity). This threat originates from outside the treatment center. Treatment centers have neither the ability nor the desire to help create such threats for their patients, although some counselors are often very aware of the importance of pressure in encouraging compliance by their patients. Because they serve their patients, they cannot be effective in advising families on this topic.

A second issue is that even when families attend family programs at treatment centers, the families are not told about the benefits of leverage and the need to exert it if their family member in treatment disagrees with treatment recommendations.

2. Current Treatment Centers Do Not Offer the Pilot/Physicians Programs to Other Groups

While we agree that the pilot/physician programs set the standard for addiction treatment, there are at least four major problems regarding existing treatment centers that make it almost impossible to achieve these standards:

- No in-patient treatment center offers the general public the same quality of clinically based services as the programs for pilots and physicians.
- The pilot/physician programs last two or more years, much longer than the standard treatment, with an emphasis on post-treatment recovery compliance.
- The program content and standards for pilots and physicians are much more comprehensive and clinically driven over the long-term – particularly post-treatment.
- A major reason for the success of these programs is the oversight role played by medical boards and airlines to assure compliance with treatment recommendations.

We believe the only way to significantly improve outcomes is for treatment centers to incorporate the pilot/physician recovery management model into their treatment programs. Unfortunately, this is not going to happen in the current environment.

3. Institutional Constraints Prevent Treatment Centers from Implementing Similar Services for Families

Institutional constraints include focus on the addict, funding and confidentiality laws.

The Addict. Treatment centers treat the addict – that is their patient – not the family or family system. Counselors owe their duty of loyalty to the patient. Families may attend a family program, be sent a questionnaire or receive a call from the patient's counselor, but families are secondary to the patient.

- Counselors are overworked as it is, and adding responsibility for family interactions would detract from administrative duties and direct patient care.

Funding. Most insurance and private pay only cover in-patient treatment.

- Some fees cover family program attendance, but not comprehensive post-treatment programs for the addict in early recovery and certainly not services for family members.

Confidentiality. Confidentiality laws protecting patient privacy cause treatment centers to believe that they cannot provide comprehensive services to the patients and their families because patients object to full disclosure. Also, obtaining releases to do so is difficult and distracts from treatment.

- Even when the patient signs releases of information, if the patient revokes the release, (as is often the case when a patient perceives the family as interfering with his/her recovery plans) the treatment center will then no longer be authorized to work with his/her family.

In conclusion, one solution to these barriers would be for a treatment center to set up a separate legal entity that worked with families. This would avoid any potential conflict of interest problems. This entity might be called The Family Resource Center, or Family Business Center, or Family Recovery Management Program. It could sponsor family program activities at treatment centers. The center could then provide fee-based advice for families who want support returning home after leaving the family program. This center could also contract with therapists to work with families who wanted services described in The Family/Advisor Recovery Management Program.

Conclusion: Reducing Risk to Family Well-Being from the Predictable Disease of Addiction

Alcoholism, drug dependence, other addictions and significant mental health disorders are statistically probable and will occur in affluent families at an estimated minimum rate of 20 percent; often much higher.[20]

- In our experience, addiction and mental health disorders are the leading cause of harm to families due to the combined monetary, personal and inter-generational damage generated by these diseases.

These disorders will undermine the best family mission statements and succession plans and result in both the loss of wealth and cohesiveness[21]. Family leaders and their advisors need an effective "game plan" for addressing these diseases. We believe the Family Recovery Management Program provides a coherent, understandable, and results-oriented structure for all concerned persons to rally around.

Appendix A: Post Treatment Supervision™ Agreement

This is an agreement between Occupational Medicine Consultants (OMC) and ___________________________, participant. The participant agrees to abide by all the terms of this agreement. Any modification of this agreement must be agreed to by and the participant and specified in writing. The purpose of this agreement is to monitor and support the abstinence of chemical use. The participant agrees to abide by all terms of this agreement unless mutually agreed and reduced to writing.

PREREQUISITE AND UNDERSTANDINGS FOR ENTRY TO POST TREATMENT SUPERVISION

1. The participant must have completed a residential, inpatient or intensive outpatient treatment program for substance abuse or dependence prior to entering the OMC program.
2. Post treatment supervision is not treatment and does not replace the need for primary substance abuse treatment or ongoing medical care, psychiatric care and/or counseling.
3. The OMC post treatment program is highly structured and designed to support individuals in early recovery to significantly enhance the probability of maintaining sustained sobriety and abstinence of chemical use.

TERM

The terms of this agreement is for a minimum period of six months. This agreement may be extended in three-month to six-month increments by agreement of OMC and the participant. Recommendations for termination or extension of the agreement will be based on the participant's compliance with the agreement and progress in recovery as determined by the participant's Post Treatment Supervision staff member.

PROGRAM COMPONENTS

1. 12 Step or Self Help Group Meetings

   A. The participant shall attend 90 meetings in 90 days beginning with either the day following discharge from an approved treatment center/program or the effective date of this agreement.
   B. After completion of the 90 meetings in 90 days, the participant shall attend a minimum of three meetings per week during the term of this agreement.
   C. A meeting log will be required.
   D. The participant is required to obtain a Sponsor.
   E. Participant is required to sign a release authorizing the Sponsor to communicate with OMC, as specified further below.

2. Biological Fluid Testing

   A. Participant agrees to participate in the random biological fluid testing program.
   B. Participant will be required to maintain via cellular phone/pager which is available 24 hours/day for notification of random testing. If called to provide a random sample, the participant must provide the sample by the end of the business day or it will be considered "refusal to test".
   C. Additional biological fluid specimens (including hair testing) may be requested by OMC.
   D. Participant shall cooperate with collection personnel at all times and shall behave in a courteous and professional manner.

3. Psychiatric and Psychological Monitoring

   A. In the event Participant has or may have a psychiatric condition appropriately treated by a psychiatrist, the Participant will obtain a psychiatrist who will treat and monitor such psychiatric conditions.
   B. Participant agrees to obtain counseling from a licensed professional appropriate for the presenting conditions as indicated on discharge summaries or other information from participants treatment facility or as may be indicated by other sources or Participants current conditions.
   C. OMC retains the right to approve any such psychiatrist or other licensed professional.
   D. OMC will assist Participant with referral if Participant is unable to locate a psychiatrist or psychologist, as the case may be, within 30 days.
   E. Participant may be required to obtain counseling from additional professionals depending on assessment, treatment planning or additional information received by OMC.
   F. Participant agrees to have psychiatrist provide OMC with monthly progress reports for the first six months, regarding treatment and compliance, quarterly progress reports thereafter, if in compliance
   G. Participant agrees to sign a release authorizing OMC to communicate with any psychologist or psychiatrist or counselor.

4. Chemical Dependency Continuing Care Group

   A. Participant is required to attend a weekly chemical dependency continuing care group session or post-treatment care group session.
   B. Any such group must be approved by OMC.
   C. Minimum time is six months and may be longer as directed by OMC.
   D. Participant agrees to sign a release so OMC can communicate with the counselor facilitating the post-treatment group.

5. Monthly Evaluations

   A. Participants agrees to meet with their primary OMC staff member one a month for a progressive evaluation.

PROHIBITED SUBSTANCES

A. Abstinence from alcohol and all mood-altering drugs unless prescribed for a proper therapeutic purpose, as approved by OMC.
B. No use of alcohol or foodstuff or beverages or toiletries containing alcohol
C. No use of foodstuffs containing poppy seeds
D. No use of foodstuffs containing hemp products
E. No herbal or health preparations containing derivative of controlled substances
F. The participant is fully responsible for any and all ingested materials and their contents.

MEDICATIONS

A. Each participant is required to have a primary care physician who has been notified of the participant's addiction issues and must prescribe all medications except plain aspirin, acetaminophen or ibuprofen. All medications must be documented in the participant's medical records.
B. If a controlled substance is prescribed, dispensed, or administered to the participant, the OMC staff member must be notified in advance, and in the case of an emergency, within 48 hours of such medication use.
C. Participant shall maintain a medication log of all medications taken and shall make the log available to OMC upon request. The log, at a minimum, shall contain the name and

dosage of medication used, date taken or administered, name of prescribing or administering physician and the reason the medication was given.

OUT OF TOWN AND OUT OF STATE TRAVEL

A. Participant agrees to provide three days advance notice of all out of town or out of state travel.
B. Notification of travel must be made by fax, phone, or e-mail to PTS staff member.
C. Participants are still subject to the biological fluid collections.

MOVE OUT OF STATE

A. If the participant moves out of the state, he/she shall provide 30 days advance notice of planned move.

RELAPSE AND NON-COMPLIANCE

A. In the event of chemical dependency relapse as determined by positive biological fluid testing or documented relapse behavior, participant agrees to immediately meet with their primary OMC staff member to discuss the relapse and help reach a plan for additional treatment or monitoring.
B. In the event of other non-compliance with any term of this agreement, participant agrees to meet with their primary OMC staff member and resolve any issues of noncompliance. (Definitions of non-compliance shall be provided as an addendum to this agreement.)

RELEASES

A. Participant authorizes OMC to discuss his/her chemical dependency recovery monitoring and any other issue or related issues with the Participant's psychologist, psychiatrist, chemical dependency counselors, Sponsors, such family members and other persons as may be designated below. Participant agrees to sigh such authorizations as may be necessary for OMC to implement this release provision.
B. In the event, in OMC's opinion, there is significant uncorrected non-compliance relapse or relapse behavior or other concerns on the part of the Participant, the Participant authorizes OMC to notify designated family members or other persons set forth below, of such behavior.
C. In the event of chemical dependency relapse as defined by OMC, Participant authorizes OMC to inform the persons previously specified in this paragraph or as specified below.
D. The Participant authorizes OMC to receive information from any and all treatment centers, treatment resources or other health care professionals treating Participant. Participant agrees to sign authorizations for OMC to obtain such records.
E. Persons designated to receive information and reports from XXXXXX would be as follows:

____

____

____

____

____

____

REPORTS

A. OMC agrees to provide progress reports to any healthcare institution, provider group, employer, payer, liability insurer, disability of life insurer or any other party at the request of the participant.

PAYMENT FOR SERVICES

A. Advance payment is required for all program costs.
B. In the event program costs are paid by someone other than the Participant, such payment shall not create any potential conflict of interest, and in the event such conflict of interest exists, Participant specifically agrees to waive any and all conflict of interest that may be created by such payments.

ACCEPTED

______________________________	________________________________
Participant	XXXXXXXXXX
_________________	________________
Date	Date

POST TRESTMENT SUPERVISION
2005 FEES

Six Month Monitoring Fee $ ______

Drug Tests (average two per month) $ _______each

Additional Six months $ ______

Consultation Outside regular Program Activities $ ______ per hour

Post Treatment Supervision does not accept insurance, however, we will assist you in obtaining reimbursement from your insurance company at your request. Insurance companies may or may not partially reimburse OCM Participants or their payers.

Appendix B: Summary of Provisions

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

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

   a. Scope of behavior by 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 IV).*

   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).

   c. Specific authorization to withhold distributions for non-compliance with drug testing requirements.

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-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, 4th 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 Trustee) have no liability for the actions or welfare of the Beneficiary.

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

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

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 A to be modified due to changes in addiction treatment or as other conditions warrant.**

Appendix C:
Model Language for Family Governance Documents for Addictions and Other Mental Health Concerns

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

Trustee Authority Regarding Alcoholism, Drug Addiction, Other Addictions, and/or 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 is or may be actively dependent on and/or abusing drugs or alcohol or may have other addictions, compulsive behaviors or mental health concerns (as defined below in 9).

   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) from such drug and or alcohol addiction other addictions, compulsive behaviors or mental health concerns, or any combination of above mentioned disorders. 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.

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

   a. The Trustee is authorized to employ and retain experts on alcohol and drug addiction, other addictions, mental health issues and family conflict 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 subparagraph b, 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 alcohol/drug

dependence and abuse. The Trustee is similarly authorized regarding any other suspected or actual addictions, compulsive or destructive behaviors, and/or mental health concerns.

c. The Trustee has sole discretion regarding the employ and use of any such experts, treatment centers or other resources, as needed, however, all such experts shall be licensed or credentialed as per applicable state guidelines and standards described in the preceding paragraph.

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 be 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 addictions, compulsive behaviors or mental health concerns regarding the beneficiary.

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

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

b. In addition, the Beneficiary must fully comply with all recommendations of treatment programs and health care professionals, as approved by the Trustee (and/or his/her designee. The Beneficiary must sign consents for full release of information to the Trustee (and/or his/her designee) in order to be in compliance with this 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 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 addictive prescription medicine, drugs, alcohol or other addictive or compulsive behaviors). Recovery includes, but is not limited to, on-going

participation in activities addressing issues relating to addiction, alcoholism or other compulsive behavior, and any co-existing mental health problems (i.e. participating in a "recovery program", as determined by the trustee or his designee). The two-year minimum shall be extended if the Beneficiary has a history of relapse or is not actively engaged in a recovery program, with such time extension(s) determined at the sole discretion of the Trustee.

b. 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, as specified in the preceding paragraph in implementing this Section and exercising discretion.

7. Date When Recovery Begins

The commencement of any time period of recovery begins after the Beneficiary has successfully completed chemical dependency in-patient primary treatment (or other addiction or mental health related treatment) and/or any long-term, halfway or sober house. (Such time does not commence upon entering treatment.)

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, 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 support staff and third party vendors. In no event shall any such distributions be made to anyone who may be dependent on or abusing alcohol or drugs, as defined herein in paragraph 9.

9. Definition of Alcohol/Drug Dependence or Abuse and Other Addictions/Disorders

The phrase, **actively dependent on and/or abusing drugs or alcohol**, has the meaning set forth in DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition) defining alcohol and drug dependence and abuse. Other addictions, compulsive behaviors or mental health concerns shall be identified as defined in the DSM-IV-TR, and as updated by current medical information and/ or credible research on addictive behaviors.

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 are expected to initiate the process specified in this Appendix if circumstantial or direct evidence comes to their attention that the beneficiary is engaging in conduct specified in paragraph 1, to wit: "is or may be actively dependent on and/or abusing drugs or alcohol or may have other addictions, compulsive behaviors or mental health concerns (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.)

Diagnostic and Statistical Manual of Mental Disorders (DSM IV)

Criteria for Substance Dependence (p.197)

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following
- (a) a need for markedly increased amounts of the substance to achieve
- (b) intoxication or desired effect

(2) withdrawal, as manifested by either of the following:
- (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance abuse

(7) the substance 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 the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Criteria for Substance Abuse (p. 199)
A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving and automobile or operating a machine when impaired by substance use)
(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

The symptoms have never met the criteria for Substance Dependence for this class of substance.

Improving Recovery Rates for Affluent Addicts and Alcoholics
TWENTY ARTICLES

Introduction

A. _Our Family/Advisor Recovery Management Program For Affluent Alcoholics and Addicts_

1. The Pilot/Physician Programs have 85% to 95% Success Rates – Rates Far Superior to Other Groups

- Describes our Recovery Management Program, based on the medical board and airline programs. 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. General overview of our ideas.

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. Building Leverage into Governance Documents for Earlier 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 and Family Systems Transformations to Improve Outcomes

- Discusses why current treatment is ineffective and describes a new model derived from 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 barriers 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 impede 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 parent's 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 Offices, 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"*[22]. 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, Boss Seeks Assurance* by Todd Scott, GPSolo Magazine October/November 2009

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

Footnotes

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[1] Brody, Jane. NYT 5/5/09 and 5/12/09
[2] 2007 SAMHSA, NSDUH Report from article dated June 25, 2009.
[3] Since pilots and doctors are required to follow all the recovery program mandates of their oversight boards, their programs should be called "airline and medical board recovery programs".
[4] (For more on this comparison, see Article Five).
[5] Interview with former NIDA (National Institute on Drug Abuse) Director, Dr. Robert DuPont, *What lessons can be drawn from the PHPs (Physician Health Programs) for the addictions field and for frontline addiction professionals? There, I observed their experiences in their state PHPs. Although these programs had excellent results, there had been no national study to validate these outcomes. For help, I turned to two long-time colleagues. Tom McLellan was the inventor of the Addiction Severity Index and the dean of treatment evaluation studies in the country through his role as Director of the Treatment Research Institute at the University of Pennsylvania. Greg Skipper was the distinguished head of the Alabama PHP and a leader in the PHP movement. Tom got funding for the study from the Robert Wood Johnson Foundation. Our biggest challenge was convincing the state PHPs that it was safe to collaborate with our group of outsiders to do this sensitive independent evaluation of their outcomes. Together, we achieved our goals, publishing a continuing series of papers documenting the outcomes of these programs. The most remarkable single statistic from this study came from the drug testing, which for these physicians was random, extensive and intensive. These addicted physicians were held to a standard of no use of any drug and no use of alcohol for five years or longer. That meant that each workday they called a phone number to see if they needed to submit a sample for testing that day. The tests were not the common five-drug screen but a 2-=drug screen, including alcohol testing using EtG to identify alcohol use in the prior five to seven days. The results: 78 percent of the physicians did not have a single positive test for any drug or alcohol use over five years of testing. Of the 22 percent who did have at least one positive test, 65 percent did not have a second positive test.* ***Where else in the addiction treatment field can you find results like that? Those results set an entirely new standard for recovery outcomes, one that every treatment program should aspire to.*** **(White, William L., MA. *Interviews with Pioneers.* Counselor Magazine. February 2010.)**
[6] Dr. David Carr helped oversee research data from Project Blue Print, involving an examination of 36 state "physician health programs" in which physicians receive treatment and ongoing monitoring that allows them to resume practice safely. The research showed that 78 percent of 904 doctors in the studied programs completed an average of 7.2 years of monitoring without relapse.
[7] Judges overseeing DUI Courts are also reported to have high outcomes in comparison to non-pilot/physician programs.
[8] Ibid. 62. An abstract of the White and Godley article is at our website: wwwAureusInc.com
[9] 92 % for pilots, Airline Pilots Soar to Success in Recovery, Hazelden Voice, Vol. 3, #1, Winter 1998, 73% reunification rate vs. 17% for child protection cases, Dakota County Court, "Where Sobriety Leads to Success", St. Paul Pioneer Press, 4/8/11, Local Section, p.1
[10] Redefining Addiction TreatmentBy: Omar S. Manejwala, MD, MBA, FAPA, CPE Behavioral Healthcare, April 2011
[11] *(p.23)* U.S. Physician Health Programs: A Model of Successful Treatment of Addictions
By Gregory E. Skipper, MD and Robert L. DuPont, MD
Counselor, December 2010
[12] Ibid, p. 24
[13] Ibid,. p. 22
[14] There are many other forms of intervention than the "surprise" model. Intervention techniques need to fit into an overall recovery strategy that includes what happens after in-patient treatment.
[15] Carr, Gary, MD Denial vs. Delusion www.professionalshealthnetwork.com, 2009
[16] The Family Factor, James M. Peterson, Addiction Professional, Sept/Oct 2006, A Protocol to Empower Family Members, Addiction Professional, Sept./Oct 2007, William White, generally.

[17] Goldbart, Stephen, Dennis T. Jaffe, and Joan DiFuria. CCH Incorporated, 2003. The Money Identity and Preferences Inventory: A Tool for Assessing a Client's Relationship to Wealth.

[18] *1. The Experience of Inherited Wealth: A Social - Psychological Perspective; Dissertation Outline* by Joanie Bronfman, PhD This 25-page outline provides of good overview of the many clinical issues affecting the affluent. It is divided into twelve topics heading, beginning with childhood.[18]

2. *Fame: The Power and Cost of a Fantasy* by Sue Erickson Boland.[18]
3. *The Caron Program for Professionals and Business Types.*[18]
4. *The Dark Side of Wealth*[18] by Tian Dayton
5. *High End Deprivation: Treating the Wealthy Client*[18] by Tian Dayton
6. *The Black and White World of the Addicted Family: A Model of the Addicted/Traumatized Family System* by Tian Dayton
7. *Forgiving Parents: Breaking the Chain of Anger, Resentment and Pain* by Tian Dayton
8. *Acquirers' and Inheritors' Dilemma: Discovering Life Purpose and Building Personal Identity in the Presence of Wealth* by Dennis T. Jaffe and James A. Grubman[18]
9. *Practical Advice on Achieving High Recovery Rates for Affluent Alcoholics and Addicts* by William Messinger, JD, LADC See Sections B-D
10. *The Biopsychosocial Model Revisited: A Psychodynamic View of Addiction* by Goodman and Levy.[18]

[18]. Ibid, p. 6

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

[21] Family Firm Institute Brochure excerpt for 2010 Annual Conference. "Addiction: the Achilles Heel. Preliminary research indicates that 52% of family businesses utilizing business consultants have an acute addiction issue embedded in the family business system."

[22] Available on our website, at www.AureusInc.com)