

How We Help Families and Advisors Address Addiction in Family Members

*Based On Highly Successful Recovery Programs
For Pilots and Physicians*

Article 5

The New Treatment Model and Family Systems Transformations to Improve Recovery Outcomes

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Article Five

The New Treatment Model and Family Systems Transformations to Improve Recovery Outcomes

Overview

Article Five explains why current treatment is ineffective and describes a new treatment model for affluent addicts derived from the success of the pilot/physician programs. We then discuss how family relationships are impacted by addiction and conclude with a review of twelve family systems components to consider when addressing addiction in affluent families.

High Recovery Rates for Pilots and Physicians

This Article is the fifth in a series of twenty articles on improving recovery outcomes for affluent addicts.¹ These articles describe our experience in using the pilot/physician programs² as models for our work with our client families and their advisors facing addiction in a family member.

- The pilot and physician programs have proven recovery outcomes ranging from eighty-five to ninety-two percent (85% to 92%), outcomes achieved by no other treatment program.

Such high success rates set a new standard for treatment results and provided us with the inspiration to improve recovery outcomes for other groups.³ That is why, after eight years of assisting clients, we now write these series of articles so families, their advisors and professionals in the field can benefit from our work in applying the pilot/physician model to affluent family members suffering from alcoholism, drug dependence and other addictions.

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

Alcoholism, drug dependence, other addictions and significant mental health disorders are statistically probable and will occur in affluent families at an estimated minimum rate of 20%; often much higher.⁴

- These disorders will undermine the best family mission statements and succession plans and result in both the loss of wealth and cohesiveness⁵.

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

Cancer Comparison

In our way of thinking, if similar statistics applied to cure rates for pilots and physicians with cancer or diabetes, families would be beating down the doors of hospitals and doctors’ offices demanding the same programs for their relatives. *But not the families of alcoholics!*

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

Families must insist that treatment centers provide the same programs for their addicted loved ones as are provided physicians and pilots. Addiction is one disease where many family members have different opinions - whether it exists in a loved one, and if so, what to do about it.

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

Improving Recovery Outcomes from a Systems Perspective

Changing the low outcome figures for treatment (10% or less⁶) requires not only an effective protocol to end active addiction by encouraging the addict to enter treatment, but also an understanding of the role systems play in the addiction and recovery process. For the clients under discussion in this article, these systems are often complex, particularly as affluence increases. Many people wonder why current treatment does not work and their addicted friends and relatives struggle with cycles of abstinence and relapse. We answer these questions by describing in:

- Section A, the new model of treatment based on the pilot/physician program, contrasting current treatment with our new model based on the pilot/physician programs
- Section B, family roles and relationships influenced by addiction (including business, trust, family office, advisors and support staff relationships), and
- Section C, twelve (12) core areas to review when thinking about how to modify the affluent family system to support recovery for the addicted family member.

Our recovery model using leverage/change strategies and clinically appropriate treatment must occur within the context of modifications in these three “systems” in order to support long-term sobriety. The information presented is derived from our real world experience in working with families, their advisors and addicted loved ones, versus an academic study of family systems.

Entropy

Families may not be aware of the concept of “entropy” and its application to extended family systems. Entropy is the term used to describe the inevitable and steady deterioration of a system or society over time.

- Left alone, affluent family systems disintegrate – they lose the ‘energy’ to sustain their well being - unless positive steps are taken to counteract this natural tendency to return to a normative state.

Addicted family members accelerate this disintegration process. This is particularly so when family leaders and their advisors adopt a passive approach or the belief that treatment will not be successful for their problem family members. Since addiction is a disease, it “infects” the family system and brings down not only the active users, but also others in the family, as well.

One of our goals, then, is to change family attitudes about recovery from a passive or resigned attitude to one of enthusiasm and commitment to a credible program for improving outcomes. This process occurs on several fronts, including a look at how “systems” support addiction and how they need to be transformed to support recovery. Because the reader may be unfamiliar with a systems approach to problem solving a behavioral issue like addiction or the concept seems vague, the introductions to each section will provide a brief overview and example of the topics addressed in the respective sections.

New Treatment Model Treatment and Systems Transformation: Keys to Improving Outcomes

The four previous articles discussed the high recovery rates for pilots and physicians (*Article One*) and change strategies and techniques to encourage affluent addicts to enter treatment and adhere to their recommended post-treatment plans (*Articles Two through Four*).

- Improving the low-outcome figures for treatment requires not only an understanding of how to encourage and induce change, but also an understanding of the role relationships play in the addiction and recovery process for the affluent.

This article is more global and is intended to provide the reader with our understanding of how “systems” impact treatment and recovery for the affluent addict in contrast to discussions on change strategies.

Articles One Through Seven Constitute a Comprehensive Approach to Improve Outcomes

Of our twenty articles, the first seven cover core components of a comprehensive program to improve recovery rates. Because *Article Five* on Transformation is part of this comprehensive approach, it may be helpful to the reader to briefly describe the other six articles to so as to put this discussion on the importance of creating leverage in governance documents in proper perspective:

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

1. The Pilot/Physician Programs have 85% to 95% Success Rates –The “Gold Standard”

- Overall discussion on applying the ideas underlying the pilot/physician programs to other groups, with an emphasis on affluent addicts and reducing risk due to addiction. Proposes that families view and plan for addiction as a predictable and treatable disease.

B. Encouraging and Inducing Change

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

- Discusses 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 to address difficult problems in their families. Ranging from educational and risk protection to using family momentum or 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 for family documents 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 from the pilot/physician programs. Looks at family relationships in affluent family systems. Describes 12 Core Concepts to think about regarding 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.

7. Families, Wealth and Addiction

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

Leverage, Quality Treatment, Systems Transformation and Change Strategies

These topic areas comprise a comprehensive, innovative and effective treatment model for affluent addicts, their families, advisors and trustees. While these topics are discussed in separate articles, it is their integration, individualized for each family and their addicted loved ones, which lead to improved outcomes.

Be Persistent, Be Pro-Active

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

*The New Treatment Model and Family Systems Transformations to
Improve Recovery Outcomes*

Article Five

SECTION A:

Our Model Compared to Existing Treatment from a Systems Perspective

In Section A, we first compare our model to existing treatment from a systems perspective. In doing so, credit must first be given to the medical boards that set the recovery standards for addicted physicians and the FAA/Airlines who similarly establish the standards for pilots. Since these programs are designed to assure the safety of patients and passengers, they provide the basis for our new treatment model. As with use of leverage, the pilot/physician programs are modified to account for the fact that there is less control over affluent addicts and thus they need a more supportive recovery environment and validating interactions with their families and advisors.

Systems Example: Confidentiality

An example of a systems issue is confidentiality of information concerning the patient in treatment. Pilots and physician must agree to sign releases to their oversight boards so there is complete transparency regarding treatment, including assessments, program plans and post-treatment recommendations. However, many affluent addicts refuse to sign releases even though they are being supported by family money and may have access to other resources. Many treatment centers support their patients in refusing to sign releases.

From a systems perspective, we look for treatment centers that can establish trust with patients so they are willing to sign releases or will work with us in our use of leverage to encourage signing full releases.

- By examining these radically different approaches to conceptualizing treatment from a systems vantage point, we hope the reader will understand why the pilot/physician model is so successful in contrast to existing treatment.

From the comparison of the two models, the reader should have a good understanding of the flaws in current treatment and what to look for to improve outcomes from a treatment systems perspective.

Following the discussion of the two models, we address five topics related to implementation of the new model.

- Avoid Using Insurance (If Economically Feasible)
- Stay Engaged
- Addiction is a Chronic Disease, Managed Over the Long-Term
- Family Consensus Helpful
- Divergence Between Family and Advisors/Trustees Exercising Legal Authority

While several of these topics are touched on elsewhere in our other articles, it is important to review them since they have a direct bearing on the success of the new treatment model.

Why Don't Treatment Centers Follow the Pilot Physician Model?

One might ask,

If the two pilot/programs are so successful, why don't treatment centers adopt similar programs for other population groups?

This is indeed a very good question. The answer seems to be that treatment centers provide treatment, not long-term recovery. They are reimbursed for services, not outcomes. Also the pilot/physician model is more expensive and requires treatment center personnel to spend a great deal of time interacting with family and advisors outside the treatment center. It also requires a comprehensive and expanded definition of "treatment" to include pre-treatment and post-treatment activities.

To be fair, treatment centers are under the same pressures as other health care providers to provide more services at less cost and be accountable to the insurance company—not the patient, family or others. However, these rationalizations are of no help to family members trying to cope with a relapsing loved one. *All families, including affluent ones, need to understand why treatment does not work for them and how to improve outcomes from a systems perspective.*

Drug dependence and alcoholism are highly stigmatized diseases in our society. As a result many families internalize the message that it is shameful to talk about individuals currently actively using, struggling with relapse or even those with long-term, stable sobriety.

- A systems approach includes looking at statistical information or genetic history as information that helps a family understand vulnerabilities to addiction and prevention as health concerns, not moral or social issues.

This approach helps move the discussion from "who" has a problem to what "we" as an extended family (including advisors and professionals) can do to help improve the situation. These changes in attitude about addiction parallel the transformational thinking needed to improve treatment.

1. Recovery Systems Models – New and Existing Compared

For outcomes to improve we need to move beyond the status quo and think about how to better address addiction and other behavioral disorders. The current system is focused on in-patient treatment for the individual addict. *This system is not working.*

The model we use, and advocate others adopt, is derived both from the success of the pilot and physician programs and the fact that addiction is a chronic disease needing ongoing management. It is also based on long-standing experience that addiction is a family disease. For those with money, the definition of family extends to advisors, business entities, trustees, managers and anyone else who has regular contact with the addict, such as household help.

Treatment Systems for the Disease: New Model Compared to Existing Treatment

<u>New (Pilot/Physician)</u>		<u>Existing</u>
Disease	vs.	Individual Flaw or Moral Failing
Chronic	vs.	Episodic
Managed	vs.	Emergency
Family	vs.	Individual
Predictable	vs.	Surprise
Discussed	vs.	Secret

Private Pay	vs.	Insurance
Engagement	vs.	Abandonment
Prevention	vs.	Chance
Individualized	vs.	Generic
Therapeutic	vs.	Educational

Almost all treatment centers and most families are on the right side of this diagram. One of the counseling tasks is to work with families to move them to the left side of the diagram so they can understand what factors tend to lead to successful outcomes. Also, very few treatment centers are willing to adjust their process or services to accommodate the left side approach to addiction and recovery.

- This is most unfortunate because the end result is relapse and a sense of failure on the part of many patients, when in reality treatment is inadequate.

While our purpose here is not to describe appropriate treatment for affluent addicts (See *Articles Six, Seven and Eight*), let's look at four areas so the reader has a better understanding of the new model.

First, the list of the left describes a much more open approach to addiction. It is anticipated as a predictable disease. For example, as part of an educational process, families might discuss members of older generations who may have abused alcohol or drugs, and also review the indicators of addiction and potential patterns of overuse that define dependency.

Second, the new model stresses family engagement in productive conversations with a problematic family member when concerns arise around misuse of alcohol, drugs and other dysfunctional behaviors. These conversations are often best led by a qualified professional due to the volatile nature of the topic and because of the dramatically different perceptions of the behavioral impact of use by the abuser and family members. We find that supportive dialogue is often preferable to the surprise intervention model even when effective leverage is present because it leads to more buy-in by the addict to the recovery process.

Third, the focal point of the change process is on the relationship between the counselor and patient in the New Model. For an example of elements of that relationship, a recent article in *Counselor* magazine identified five aspects of the therapeutic relationship that led a patient to a sudden breakthrough to new determination and motivation to recover.⁷ These five components are:

- *The therapeutic contract*, or roles played by client and counselor, whether treatment is conducted individually or in a group, as well as treatment model and session schedule, among others.
- *Therapeutic bond*, or the quality of involvement and rapport between client and counselor.
- *In-session impacts*, or therapeutic realizations, such as insights vs. confusion, relief vs. distress, as well as the counselor impact, such as frustration vs. feeling good about a session.
- *Temporal patterns*, or distinctive moments of facilitation as well as total number of sessions.⁸
- *Therapeutic operations*, which include how the client presents his complaints and problems; how he thinks; how the counselor understands the client (e.g., diagnosis, case formulation); the strategy used (e.g. 12-step model); and how the client responds or cooperates with the interventions.

Existing treatment deemphasizes the counselor/patient relationship and uses educational material as the means to promote change.

Fourth, the number of key participants in the new model is far greater than the just the patient-counselor relationship in current treatment. In moving to the new model of family engagement, the number of people involved increases from two to at least four and often more. It is common for us to work with parents, siblings, key family advisors or trustees, and the treatment center counselor when the patient enters treatment. The professional assisting such an extensive relationship constellation needs to be aware of the feelings and attitudes of each individual as well as group and subgroup interactions and relationships.

2. Key Considerations in Implementing the New Model

Rarely Use Insurance

If possible, avoid using insurance to pay for services. Insurance companies control costs by usually only approving outpatient treatment for the first and second treatments. They use an evaluation process that often leads the addict to minimize his/her problems and resist in-patient recommendations by addiction professionals.

- We advocate using the best in-patient program and services the first time because it is hard to get an addict to agree to treatment after a relapse and, of course, relapses can lead to significant harm.

Apply for insurance reimbursement after services are provided, if you choose to do so. *(Remember, once an insurance company has a record of addiction treatment, it is permanent and will be part of your loved one's record, thereby jeopardizing future coverage. In our experience, privacy assurances have little value - another reason not to use insurance.)*

Stay Engaged

Families and advisors need to stay engaged with the addict, contrary to Al-Anon and family program messages. Letting go is abandonment, which is not a successful strategy. The successful strategy is to be engaged but not enmeshed, a difficult distinction for many families to make without the support of a counselor. Treatment outcomes are improved when counselors create therapeutic alliances with their clients and respond with empathy, and the addict's social network supports changes needed for recovery. We find families and their advisors have trouble understanding and implementing these concepts when their loved ones are in early recovery – another reason for seeking professional help.

Addiction is a Chronic Disease, Managed Over the Long-Term.

Addiction is predictable and chronic – a disease best managed by anticipating its presence in family members and managed through written policies and procedures. The treatment focus is long-term, incorporating the family “system” (including their enterprises and family affluence transfer instruments) and on changing behaviors that support addiction. *For teenagers and young adults, early onset is usually a sign of a significant co-occurring disorder that must be addressed and included in the management plan.*

Family Consensus is Helpful

Family leaders and advisors need to buy into the physician/pilot model to make it work. You can't have half the family thinking “new” and the other thinking “existing.” Building consensus requires tact and negotiation because family members may be invested in the problem and have

their own ideas as to how to proceed. As relapse is common, working on consensus will allow family and advisors to respond effectively, rather than argue about who is right and who is wrong. Consensus is not necessary to begin the process, but it is helpful in working toward a common understanding over time.

Divergence Between Family and Advisors/Trustees Exercising Legal Authority

In some cases family members will want to act, but trustees or advisors exercising legal authority over assets or an income stream to the addicted family member refuse to take action to cut off funds or otherwise ask the addict to get help and stay in recovery. This situation is extremely frustrating to family members. Trustees and their legal advisors don't have to live with the consequences of their failure to act – the family does – so leave no stone unturned in bringing pressure on the trustees. In our article, the *Demise of Trustee Discretion* we advocate taking an aggressive approach towards intractable trustees.

Summary

Over the past few years, as we continued to experience gaps in service and flaws in the current treatment for affluent families, we developed a new treatment model that builds on the successful pilot/physician programs. Spurred on by a recent focus on the low outcome rates for treatment, professional chemical dependency literature is now replete with programs and ideas for improving recovery rates. Many of these ideas corroborate our views on the importance of post-treatment support services and long-term management of addiction as a chronic disease. We are pleased to see these recent trends in the recovery field.

SECTION B: Family Roles and Relationships

Relationships and roles between the family members are part of the “systems” affecting use and recovery. In this section, we discuss:

- Areas of focus when first working with a family, including our initial analysis of the current system
- Informal relationships, roles and attitudes within the family and their advisors
- The more formal roles and relationships defined by legal documents, longstanding custom or family entity operations

Many of these types of relationships may be unintentionally supporting addictive behavior. By discussing and identifying them, efforts can be made to change them to enhance opportunities for recovery.

Trustee Example

For affluent families, the definition of family extends to include, the family business, trustees, advisor and the family office.

- An example of this type of systems issue is the situation that occurs when family members ask the trustee for an addicted relative’s trust to cut off funds, but the trustee refuses to do so.

In this instance, the goal would be to develop an understanding of the scope of the trustee’s legal authority, the grantor’s intention in creating the trust, the attitude and knowledge of the trustee regarding addiction, and ways to pressure the trustee to support recovery-related activities and implement the ideas in our articles.

1. Our Initial Analysis of the Family System:

What is the Current Structure?

We try to determine how the family system impacts the addiction. Are family members or entities providing money and support to the addict? Who supports recovery and who is currently supporting addictive behavior? Often times this process is ongoing, as family members initially may be reluctant to discuss significant relationships due to privacy and trust concerns or do not believe the information has any bearing on the addiction problem.

Who is the Client?

We identify the client. Sometimes the person who contacts us is not the one with the most leverage or power in the family. We usually prefer our client to be the person with the most power and authority within the family. One reason we like to align with the most powerful person in the family is that the addict will try to enlist that person’s support to ward off recovery efforts if he/she is not clearly behind us. If our client is not this person, or if power is shared among several clients, we then try to identify the strength relationships and where there might be weak points in family unity and response to the addict.

What Additional Help, if any, Does the Family Need?

Are additional professionals needed for mental health assessments, review of prescription medicines, psychotherapy, or to help with multiple-addicted family members or other problems? Our expertise is addiction and its relationship to affluent families. Many addicts have co-occurring conditions, such as depression or abuse histories, which need to be addressed by psychologists working together with the chemical dependency counselor. Too often, we see experts in one area try to address issues outside their scope of expertise rather than collaborate with other specialists.

What is the Initial Assessment of Capacity for Change?

Is the family really willing to take the steps necessary to help their loved one to get into treatment? Are they only interested in help so their addicted family member enters treatment or are they open to assistance for the on-going recovery process? Do they seem committed to listening to the expert or are they going to make decisions on their own? Are other professionals and advisors involved who may want to control or interfere with the family commitment to address and resolve the addiction?

Is There an Efficient Decision-Making Process in Place?

Is there an efficient decision-making process or does a committee make decisions? Are there unknown advisors, lawyers or trustees who seem to be influential or have veto power that the client is reluctant to fully disclose? We find that the more people involved in making decisions, the greater the opportunity for the addict to divide the decision-makers to delay or avoid action.

Is There Willingness to Fund Services Under the New Model?

Is the family leader committed to funding the professional and treatment services necessary to implement the new model? With most of our clients, achieving recovery will prevent further loss of funds, premature death or disability, and improve outcomes for the next generations. However, sometimes families decide not to keep spending money for another treatment or professional addiction service, thinking additional efforts will not be successful – a decision we urge families to reconsider, based on the information in this article.

Summary: Initial Analysis

Answering these questions inevitably involves face-to-face client contact, which is why an initial meeting to see if there is a fit with the client is in order. If you are a parent, a family leader, advisor to the family or family office executive, the above topics are good ones to discuss with the addiction professional before deciding on whether to proceed. If it appears the answers to the questions are negative, see *Article 3* with suggestions on change strategies to help move hesitant families forward.

2. Informal Roles and Relationships

The family systems model with the various roles of siblings in an addictive or dysfunctional family is well known to many readers. In particular “the difficult one” or family scapegoat may also be the actual or potential addict.⁹ However, the roles and players in affluent families can expand to include advisors, lawyers, stepparents, trusts, trustees, the family founder, the office, business, important historical family figures or even ethical norms or slogans (“to whom much is given, much is expected”) – all may be a part of the family system. For the media and sports affluent, there are often managers, producers, assistants, friends, and relatives invested in

continuing the addiction because they benefit economically. Disentangling this “entourage” is often a difficult and time-consuming process.

Examples:

- In multi-generational families, the family office, lawyer, trust, or business can be more influential than relationships with spouses and children.
- Following in the family footsteps takes precedence over healthy parenting.
- Preserving the family name and reputation takes precedence over acknowledging problems in any individual member.
- The goal of treatment is to manage a problem or dry out, so the addict can return to business as usual and continue his/her role as a source of funds and high status.

These types of barriers occur at great expense to the addict’s recovery and health. For those in arts, entertainment and sports, it takes the entity with the power of the purse to get behind recovery or extremely energetic and persistent family members to break through the addict’s protection.

Advisors Lack the Training and Emotional Demeanor to Deal with Addiction

Addiction leads to high emotional content in relationships. Feelings can range from anger to tears to despair in a few minutes. Lawyers and financial advisors have low tolerance for the addict’s volatility and intensity. They have a great deal of difficulty responding to emotional outbursts and charged disagreements.

- Pressure to change generates resistance and the resistance takes many different forms depending on how the addict perceives the most effective means to counter the family’s efforts at pressuring the addict to seek help.

This disconnection between advisor and addict often leads to a breakdown in the relationship and lack of long-term resolution of problems. Addiction professionals are much more experienced at handling emotions and understanding an addict’s game-playing. One of the roles of this professional is to absorb some of the extreme emotions generated so as to reduce family stress.

Other Advisors Threatened

The addiction professional’s relationship with the client is often threatening to existing advisors. The counselor/professional and family leaders develop a very close relationship. During the course of the relationship family secrets and conflicts often surface. This closeness can be a challenge to existing family advisors who are left out or want to preserve their status as top counselor to the family.

- A particularly dicey situation arises when the advisor has not been successful in solving the problem and the addiction professional enters the scene, with credible advice and support.

The threatened advisor can withhold important information from the addiction professional; undermine the client relationship; or advocate early termination of the relationship because the problem is “solved.” The family leader must unequivocally endorse and support the role of the addiction professional by sending clear messages that cooperating and assisting is important to the family.

Delayed Development and Learning Problems Not Understood or Accepted by Family

Delayed development caused by use of alcohol and drugs as a teenager is often not recognized or fully accepted by advisors or family members.

- A middle-aged adult can actually have the emotional age of an adolescent due to early onset of use. Similarly, the family and advisors can overlook learning issues.

Family members can be so invested in producing accomplished offspring that the pressure to perform becomes overwhelming and addictive substances are used to numb the pain of failure. In both instances, families will underestimate the time it takes for their loved one to recover and may become frustrated with the process or blame the addict for not recovering sooner.

Identify All Players

Identifying all the players in the family system is one key to changing from a system that supports addiction (actively or passively) to one that supports recovery. These players can include pilots, accountants, housekeepers, family office personnel, relatives, gardeners, and drivers – anyone who has enabled the addict to abuse the substance of choice or assisted him/her in avoiding consequences. They may be economically dependent on the addict, nominally employed by the addict or have received past gifts (with promises of more in the future) from the addict. For example, an alcohol provider might say

“She paid for my daughter’s college, how could I refuse to buy wine for her?”

This type of thinking needs to be teased out, confronted, and ended with education about the disease concept and clear communication that the family wants the drinking to stop.

Acknowledge Use of Money as Leverage

In affluent families money is part of the relationship. Usually there is a long history of how money has flowed from the family to the addict with conditions on receiving or use of the funds. The addict invariably is upset about how money has been used to manipulate his or her behavior.

- Rather than dismiss these feelings as “addict talk,” we find that it is helpful to listen to what the addict is saying to try to find out what the truth is, what is real and what is not, regarding family money.

Identifying and acknowledging the role of money as an agent of manipulation is a step towards encouraging the addict to self-actualize independently from money. (*“You are not your money and you don’t need it to feel good about yourself.”*)

Black and White Thinking

Usually when we are called onto the scene, the situation has deteriorated to the point where attitudes and feelings are well formed and the participants are in highly defensive modes. The addict and family/advisors are at polar opposites, with extreme views of each other. The mentality is all or nothing, with a vow to never again give the addict any money. An opposing scenario begins with the addict being promised restoration of funds or a new car upon completion of treatment. These are unsuccessful strategies.

In our work with families, one goal is to help them move away from a polarized view of the addict to one that is focused on incremental performance, where improved behavior is responded to with corresponding incremental monetary or other rewards. The longer the recovery processes, the slower the increase in rewards. *For example, don’t take an adult child living in a group home in a chauffeured car to shop on Worth Avenue in Palm Beach. Drive her/him to Target in a rental car.*

Stylistic Differences Between Advisors and Addiction Professionals

The addiction counselor must be a very good listener, as opposed to someone who talks at, or instructs, family members. Lawyers, in particular, talk too much and lack the training to be skilled at encouraging people to talk about themselves. The goal is to develop ideas on how to address addiction in a cooperative manner because families must be involved in decisions when addressing a life-threatening disease. The stakes are too high to simply dictate a course of action. In meetings with advisors and families, encourage attendees to present their views and express their feelings and concerns before focusing on addiction as the primary issue. The professional is providing a life-changing service, not selling a program or process.

Standards for Family Performance or Values Expectations

Ask question regarding the family's values. Are there any standards for performance in the family, such as healthy living with money or beneficiary performance expectations? Are there unwritten or common sense value-standards violations by the addict in which the family acquiesces or feels they can do nothing about? Examples of this kind of behavior are the out-of-control family owner who acts with impunity or the middle generation, using son who bans grandparents from seeing their grandchildren and threatens to leave his wife penniless if she tells the truth about his drinking and drugging.

Summary: Roles and Relationships

These relationship and roles can be seen as barriers to a successful engagement or opportunities to create a successful engagement. This is where experience comes into play. The expert should expect to see many of these role and relationship problems in affluent families where addiction is present and respond with tact, skill, compassion, and patience.

3. Formal Roles and Relationships

More formal roles and relationships are those between an addicted family member and the family office or an addicted beneficiary and trustee. While the information presented in this section does include informal roles, the main focus is on the more formal relationships.

Draft CFF Domain Map of Roles and Relationships

The Collaboration for Family Flourishing is developing a model of the many relationships that often exist in affluent families (see Draft Diagram, Appendix A). We modified the diagram by placing the word "addiction" in the center of the diagram for the word "person" because when that person is an addict, in the end, the disease calls the tune.

- This is true no matter how successful or seemingly healthy the addict seems when abstinent or is limiting substance use.

In our work with families, we think about both the specific problem of how to encourage the addict to recover and all the roles and relationships in the family system as they relate to the addictive process.

The diagram draws distinctions between four categories of roles (Legacy, Self, Stewardship and Relationships) and includes many sub-roles in each category.

- In addictive family systems, these categories are blurred and roles are confused or misinterpreted.

One of the recovery tasks for families is to examine these roles and relationships with the goal of establishing distinct boundaries and common understandings as to what is healthy and appropriate.

b) Larry Hause – Multiple Roles Played by One Person

Our Attorneys for Family-Held Enterprises (AFHE) colleague and collaborator, Larry Hause¹⁰ has identified multiple roles played by a family member in affluent families. He lists: Self, Couples, Family, Owner, Board, Manager, and Enterprise, to which we added Beneficiary, Trustee and Partner (see Diagram Appendix B). When he works with family members on their Values, Needs and Goals in succession planning, Larry finds these roles are very often mixed together with few distinctions made by the family. Also, as most family wealth practitioners know, the driving forces behind family disputes are the childhood experiences and relationships of each member.

When addiction is present, the various roles become even more confused and much more difficult to untangle, particularly when driven by childhood hurts and perceived injustices. Often imbalances exist in terms of access to resources or funds due to dependencies in one or more family members, creating additional resentments above and beyond childhood-based and role confusion conflict. It is not uncommon for the son or daughter with the addiction to absorb more attention and money than siblings engaging in positive behaviors, with the addict being placed in positions of responsibility.

c) Our Articles on Beneficiaries, Family Offices and Trustees

We have written several articles discussing these relationships at length:

- *Solutions for Dealing with Alcoholism and Drug Addiction in Affluent Families: What Advisors, Account Managers, Trustees and Family Offices Need to Know*
- *Financial Managers and Dysfunctional Clients: Addiction's Effect on Staff Morale and Fiduciary Responsibilities in the Family and Wealth Management Office*
- *The Demise of Trustee Discretion and Ascertainable Standards as Effective Controls on Dysfunctional and Underperforming Beneficiaries*¹¹

The ideas and concepts described in these articles are easily transferable to family businesses or other family environments.

- All three cover some of the basic principles of the pilot/physician model and our advice that families and their advisors need to be more pro-active regarding a loved one's recovery.

However, the focus of these articles is on identifying problems created by addiction in the family system and encouraging families and their advisors to take action rather than ignore or discount the signs and symptoms of alcoholism, drug use, or other dysfunctions. As mentioned, many readers have asked us for information about how we work with our clients, which is one reason for writing this article.

d) Family Enterprise Documents

We advocate addressing potential addictive or other dysfunctional behavior in all documents governing ownership of property, business or assets. (See *Article Four* on Governance.) Depending on the circumstances of each family, additional documents establishing a formal relationship between the addict and his or her family might include:

- Uniform standards for participation in family enterprises (such as job descriptions or educational requirements).
- Written alcohol and drug use policies (published in the employee handbook or elsewhere).
- Expectations for beneficiaries or shareholders regarding education, training and other self-development activities as a condition for trust fund or dividend distributions.

Few families have these documents in place or, if they do, they allow for “blood” exception. Often families consider implementing these types of standards after a problem arises, a far more difficult process than if done in advance.

Summary: Formal Roles and Relationships

Written standards and procedures such as the ones identified in the previous paragraph can be very helpful to families by encouraging positive behavior among members. Without such documents, some relatives believe there are no shared values or expectations and anything goes in terms of conduct or performance. Remember that the law of entropy applies to families and negative behavior is very likely to occur in the absence of positive standards and role models, particularly when there is a history of addiction in the family.

SECTION C:

Twelve Core Recovery Concepts for the Affluent Family Addictive System

Twelve Core Concepts for Analyzing Addictive Affluent Family Systems

In this final section, we explain how we conceptualize our work with families by identifying twelve areas to consider when thinking about affluent addicts, their families and their relationship to money and other resources, including how these systems evolve, from sustaining addiction to supporting recovery and long-term sobriety.

Example: Money

An example of a “core concept” is the role of money or other resources in supporting addiction in the family member of concern. In thinking about this topic, we look at the family system, including related enterprises, to see how money is used in a negative manner, how to limit access to such resources and how to make money a positive force for recovery.

- The information presented in this section is derived from our experience in working with families, their advisors and addicted loved ones, versus an academic study of family systems.

Using money as the example, in extensive interactions with treatment personnel regarding affluent patients, we have been told repeatedly that, “we don’t talk about money in treatment”. This is, of course, absurd, because money fuels addictive behavior and it needs to be addressed because it is so integral to addiction and recovery.

Clinical Needs

These concepts identify **clinical needs**. A common belief at many treatment centers and among many counselors is that the affluent have no unique clinical issues, a significant reason for high relapse rates.

- We disagree and find there are many childhood issues as well as complex relationships that need to be considered in any comprehensive treatment and recovery program for well-off and well-connected addicts and alcoholics.

The twelve concepts, goals and action steps discussed here were developed from numerous interactions with affluent addicts, their families and advisors and treatment center personnel.

Clinical needs include the counseling and support for the addict’s family and extended system. One of the ways treatment center personnel avoid including family as part of the recovery process for patients is to paint family members as either “toxic” to the patient or “enabling” the patient. Not only does this type of attitude ignore the fact that almost all affluent patients return to their family environment, but it also prevents the patient from developing a more nuanced picture of strengths and weaknesses of individual members and the family as a whole.

1. Addiction, Treatment and Recovery Occur within the Larger Family Environment

Goal: Engage the family in positive change activities and ongoing support for recovery.

- Focus on returning the client to his/her environment – not just intervening
- Treatment differentiated to address individual circumstances of clients
- Ongoing professional counseling relationship (not intermittent)
- Success in dealing with a chronic disease through monitoring, support and coaching, including return to treatment when needed

- Emphasis on addiction as a primary disease (versus insurance companies – addiction is a short-term problem to be medicated, and versus psychiatrists – view of symptoms as manifestations of underlying psychiatric problems)
- Active, interventionist recovery model (open)

2. Money and Status – An Addictive Dynamic

Goal: Identifying money/status as an integral part of the problem-like drugs, alcohol, or other addictions. The following are problematic:

- “I will because I can”
- Money is the tie that binds
- Primary component – not to be ignored or discounted
- Mental and emotional attachment to money (gone, delayed or existing)
- Idea that they are different/special
- Identifiable populations group (specific social and psychological markers)¹²
- Image driven – protect at all costs (save face vs. save ass dilemma)

3. Assessment: Individual and Family to Identify the Addictive “Drivers”

Goal: Look at the role of money/prominence (along with biological, spiritual, social, emotional factors) for an accurate assessment.

Money/Status Issues

- Identification process – the dynamics of money and status
- Is the situation right for change to occur? What is the barometer for change?
- Client insight into the problem (enabling effects of money/prominence)
- Willingness and awareness of what to do about it
- Spiritual vs. material
- Wellness component

Biological/Spiritual/Social/Emotional Assessment

- Identify what is driving the addiction
- Identify specifics of culture and the family system abetting addiction
- Look at all problematic behavior

4. Creating the Crisis: Breaking the Connection to Money/Prominence

Goal: Turning off the flow of funds and access to prominence to encourage the addict to seek help (otherwise the addict will continue to use until physical limits are reached).

- Helping family members see the connection to problematic behavior
- Knowing verbal messages contradict actions (money, etc. is a reinforcement)
- Turning off the spigot
- Selecting intervention options and cooperative treatment facilities
- Managing any interim negative reaction by the addict

5. Providing Input to the Treatment Center

Goal: Help treatment center staff develop an accurate picture of the individual, including how money/prominence impacts his/her disease and important considerations for treatment planning.

- Creating a trusted counselor relationship
- Understanding and empathy
- Embracing honesty – making the connection to other addicts/alcoholics
- Helping with boundary-setting

- Developing insight into self-will
- Identifying lifestyle changes
- Goal: Integration into the recovery community

6. Supporting the Family While Their Addicted Family Member is in Treatment

Goal: Be the resource for family members regarding the treatment process; help counsel and support them in their recovery process.

- Facilitating insight into family systems issues
- Education regarding disease
- Establishing communication between family members and identified patient
- Information about recovery
- De-emphasizing secrecy
- Exploring the “ties that bind”

7. Pro-Active in Planning for Post-Treatment

Goal: Help the family actively participate in post-treatment planning and assist them in suggesting post-treatment options.

- Recognizing the need “to bring the bottom up”, creating consequences¹³
- Continuing to focus on limits regarding money and prominence issues
- Maintaining a structured environment
- Fostering a family process
- Keeping a positive dynamic for recovery
- Identifying environmental “cues”, social expectations, and family rituals
- Using resources for recovery – a wellness program

8. The Spiritual–Money/Prominence Conflict

Goal: Help identify material-spiritual tensions and facilitate ways to place money/prominence in a subordinate role in recovery.

- Addressing it head on
- Learning how money inhibits the process of transformation
- Performing service work
- Practicing attitudinal shifts
- Developing positivity and creativity
- Learning to have fun
- Developing relationships

9. Counseling, Supporting, Coaching, and Mentoring for the Addict & Family

Goal: Assist in building a healthy recovery with money and prominence in proper perspective by looking at what “works” for recovery within the specific family system.

- Developing and following a program of recovery (addict & family)
- Addressing boundary, relationship and family issues
- Addressing underlying issues driving the addiction
- Re-defining of self
- Doing group work
- Identifying stress factors
- Becoming aware of environmental “cue” issues
- Establishing recovery tools

10. Identifying and Supporting Deeper Emotional and Healing Work

Goal: Address childhood, trauma and relationship issues.

- Attending intensive workshops
- Addressing trauma recovery
- Emotional healing for ACOA (Adult Children) experiences
- Dealing with addiction and money/prominence
- Examining childhood experiences (including abuse and neglect)¹⁴
- Exploring relationships

11. Affluent Dynamics Issues - Building Healthy Families

Goal: Support for exploring money/prominence and addiction factors within the family.

- Exploring family dynamics in regard to money/status and addiction
- Examining inter-generational issues
- Establishing a family advisor
- Offering guidance and prevention for future generations
- Educating re: the disease
- Creating roles for family leaders
- Communicating with family advisors, wealth managers, trustees, accountants

12. A Structured Recovery Program with Chemical Dependency Experts in Charge

Goal: Family commitment to listening to alcohol and drug experts as the source for primary guidance on issues of money, prominence & recovery.

- Coaching the family through the recovery process
- Honoring the commitment and time required
- Respecting that addiction is a life-threatening disease – taking the advice of **CD** experts seriously
- Acknowledging the core concepts, customized for each family
- Establishing parental control and connections as levers to be used when needed
- Being open to counseling interactions and suggestions regarding money/prominence issues and the recovery process as a whole

Summary

This “Core Concept” outline list encompasses concepts about recovery; specific tasks that support recovery, and ongoing recovery activities.

- The intention is to provide a “holistic” view of what we have learned about improving recovery rates for affluent addicts, a group whose clinical needs have been ignored and service needs catered to for far too long by treatment centers and exploitative therapists.

In our experience, the addict is blamed when relapse occurs when in reality, treatment is often the problem or family members and their advisors are not encouraged to examine how they may be unknowingly supporting addiction. In developing, these concepts, we want to acknowledge the importance of articles by Joanie Bronfman and Tian Dayton, whose work helped enhance our understanding of affluent families’ psycho/social development and impairment.¹⁵

CONCLUSION

While this article is about a new recovery model, relationships and systems transformations, it is important to keep several key concepts in mind when reading all our articles:

Family Support and Education are Critical to Improve Outcomes

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

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

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

Most families know little about what constitutes effective treatment even though they are often paying the bill and locating the treatment center to help their loved ones. In writing this article, one goal is for families to understand factors leading to effective treatment, while a second goal is to develop awareness of the multiple roles and relationships affecting recovery in the post-treatment environment.

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

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

While this article is not about using leverage, we do want to remind the reader to always stay engaged with the addict, particularly for the out-of-control addict who is on the loose or overdosing. (See this footnote¹⁶, and *Article Two* for more information on remaining engaged with an addict when funds or other direct support is cut off.)

You can make the difference

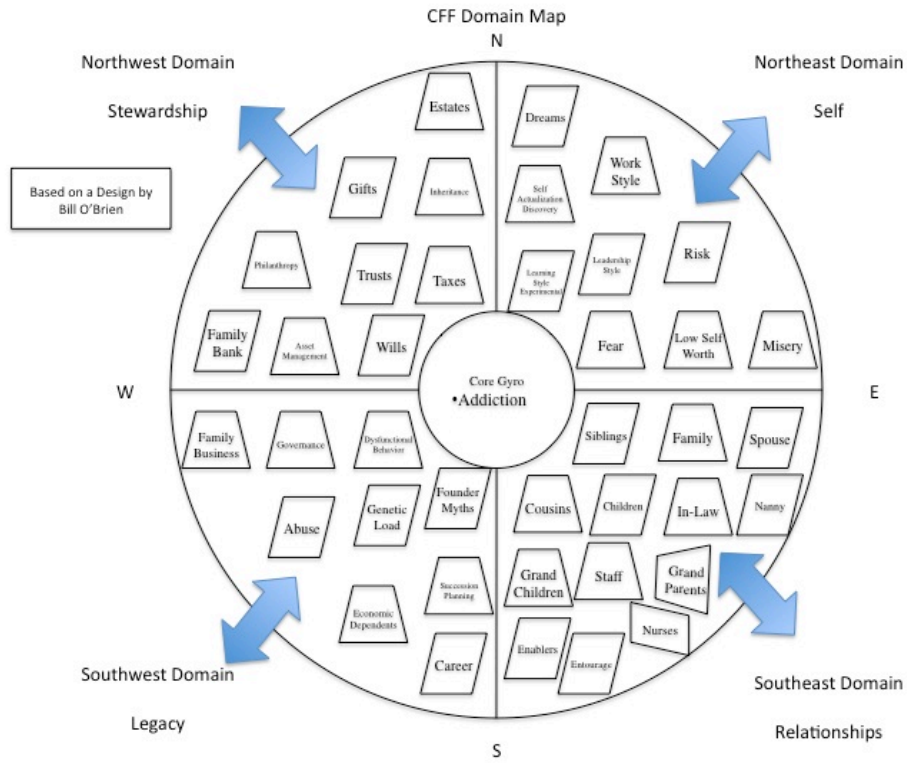
Through our professional, recovery and personal lives we know many members of affluent families who struggle to abstain and find meaningful lives without alcohol and drugs. You, as parent, sibling, advisor, trustee, family leader or business owner have the power to collaborate with professionals to insist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

Concepts Apply to Other Groups

Many of the ideas discussed in this part apply to small business owners, professional groups, non-profits and similar entities. And, although governance practices might seem to be a topic suited only for the affluent, our discussion of the recovery process applies to all families with an addicted loved one, regardless of economic status.

In ending this article on treatment and family roles, relationships and systems, we do recognize that without the means to persuade the addict to enter treatment and engage in recovery, all the suggested treatment improvements and insights into what “works for recovery” may be for naught. However, we do hope that once the addict is in a new model-type treatment program, there will be a much greater chance that treatment and recovery will take hold over the long run, and relapses, if they occur, will be immediately addressed.

Appendix A



Appendix B

Allocation of Values, Needs and Goals

Self	Owner	Couples	Partner	Managers	Beneficiary	Enterprises	Trustees	Board	Family



Based on a Design
By Larry Hause

Improving Recovery Rates for Affluent Addicts and Alcoholics

TWENTY ARTICLES

Introduction

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

1. The Pilot/Physician Programs have 85% to 95% Success Rates – The “Gold Standard”

- 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 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*¹⁷. 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

Author Information

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Aureus, Inc.

Established by William Messinger, Aureus specializes in helping families and their advisors facing alcohol, drug and other addictions in loved ones. We model our program after highly successful programs for pilots and physicians. We provide our clients with comprehensive support, thorough assessment services, selecting and utilizing the right interventions, referral and placement with the treatment providers, and post-treatment care and monitoring. Our clients include family businesses, family business advisors, family offices, and law firms.
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Footnotes

¹ Some readers may know that I have written several lengthy articles on affluence and addiction, often combing several concepts in one article. Feedback from professionals and advisors is that these lengthy articles can be confusing to those unfamiliar with addiction terminology. They have asked that I “unbundle” these articles and address one topic per article. This is the second one in a series on affluence and addiction, with an emphasis on improving recovery rates.

² 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”.

³ 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. (Emphasis added.)

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

95% success rate for NWA pilots. *Pilots Soar to Success in Recovery*. Hazelden Voice Vol. 3, Issue 1.

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

⁴ In our year of living and working with affluent families, we know of no extended family system (including in-laws) with addiction and significant mental health problems at rates of less than 20%. Many families have rates exceeding 30% to as high as 70%. However, these numbers are based on anecdotal and personal experience. The overall addiction rate is said to be 10% of the population.

⁵ 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”

⁶ See Footnote 1

⁷ Taleff, Michael J., Ph.D. *Dawn of a New Era (Part II)*. Counselor Magazine. February 2010.

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

⁹ For example, Tian Dayton, Ph.D. “*High-End Deprivation, the Dark Side of Wealth: Understanding Children of Wealth,*” <http://tiandayton.com/wpcontent/uploads/pdf/HighEndDeprivation.pdf>

¹⁰ Larry Hause is an attorney in Minneapolis and co-author of the book, *The Balance Point, New Ways Business Owners Can Use Boards*, Famille Press, 2008

¹¹ Available on our website, at www.AureusInc.com)

¹² Joanie Bronfman. “*The Experience of Inherited Wealth: A Social-Psychological Perspective*” Ph.D. Dissertation, Brandeis University, 1987. Her outline of her dissertation is also an excellent resource.

¹³ “*THEY STOPPED IN TIME*”.

These words introduce the second set of stories in the Big Book of Alcoholics Anonymous. The introduction goes on to tell us:

Among today’s incoming AA members, many have never reached advanced stages of alcoholism, though given time, all might have....Why do men and women like these join A.A.?.... They saw that they had become actual or potential alcoholics, even though no serious harm had yet been done. They realized that repeated lack of drinking control when they really wanted control was the fatal symptom that spelled problem drinking. This, plus mounting emotional disturbances, convinced them that compulsive alcoholism already had them; that complete ruin would only be a matter of time. Seeing this danger, they came to A.A. They realized that in the end alcoholism could be as mortal as cancer; certainly no sane man would wait for a malignant growth to become fatal before seeking help. Therefore, these seventeen AA’s and hundreds of thousands like them have been saved years of infinite suffering. They sum it up like this: “We didn’t wait to hit bottom because, thank God, we could see the bottom. Actually, the bottom came up and hit us.

¹⁴ 1 in 4 girls is sexually abused before the age of 18. (96): 1 in 6 boys is sexually abused before the age of 18. (96): 30-40% of victims are abused by a family member. Another 50% are abused by someone outside of the family whom they know and trust. Approximately 40% are abused by older or larger children whom they know. Therefore, only 10% are abused by strangers. See: www.darkness2light.org/KnowAbout/statistics

¹⁵ cite to jb td articles/.

¹⁶ For out of control addicts on the loose, families must stay engaged with these addicts and not wait for them to “hit bottom” on their own (the latter advice given by many interventionists, family programs and AI-Anon, is not a successful strategy). Instead,

families must do what is necessary to remain in contact and finding ways to encourage the addict to get help. For affluent families, this may mean assembling a group that includes a knowledgeable addiction professional, private detectives, lawyers (to use the legal system, if feasible), sober companions and a “go to person” in the family who can authorize expenditures and actions. If the addict is holed up in a hotel room or resort drinking and using, living or driving around town with her dealer, smoking crack at the crack house, or wandering the streets, using heavily, overdosing or otherwise at risk, **the family must go after the addict** (or hire professionals to do so). We emphasize this point in every article because too many families are being given misinformation about what to do under the circumstances described in this footnote. No family has regretted doing too much when a loved one dies from addiction or addiction- related complications. Many regret doing too little.

¹⁷ Available on our website, at www.AureusInc.com)