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TRUSTS FOR BENEFICIARIES WITH ADDICTION AND MENTAL ILLNESS ISSUES (WITH SAMPLE PROVISIONS)

WENDY S. GOFFE is a partner with the law firm of Stoel Rives LLP, in Seattle, Washington. She is a Fellow of the American College of Trust and Estate Counsel (ACTEC), a member of the ACTEC Digital Property Committee, and vice-chair of the Family Law Task Force. Wendy is co-author with Kim Kamin of The Tools & Techniques of Estate Planning for Modern Families (3rd ed.). She has a comprehensive estate planning practice that involves all aspects of estate planning for high-net-worth individuals and families, advising both individuals and charitable organizations concerning planned giving, probate, and trust administration. She is a member of the Seattle Foundation Professional Advisors Committee, a past member of the Executive Committee of the Estate Planning Council of Seattle, the Acquisition Committee of the Tacoma Art Museum, the Executive Committee of the WSBA Real Property, Probate and Trust Section, and the Ethics Committee of Valley Medical Center. She is also a past member of the Board of Directors and Grants Committee of The Women's Endowment Foundation, a supporting foundation of the Jewish Community Endowment Fund, in Seattle, Washington. In her spare time she is a volunteer coach with Girls on the Run.

G. ANDREW H. BENJAMIN has worked with families and lawyers suffering from various mental health and drug abuse problems throughout his 40-year professional life. He has served in various governance and leadership positions, and has received multiple awards from such groups as the Puyallup Nation, Washington State Bar Association, the Washington State Psychological Association, the American Psychological Association (APA), and the American Board of Professional Psychology. A clinical professor of psychology and affiliate professor of law at the University of Washington, he has published 74 peer-reviewed articles in psychology, law, and psychiatry journals. He is the author of five books published by the APA, and one book published by Sage entitled Family Evaluation in Custody Litigation: Promoting Optimal Outcomes and Reducing Ethical Risks (1st and 2nd eds.). His article, entitled, Ethical Wills: The Positives and the Perils for the Family can be viewed at https://washington.academia.edu/GAndrewHBenjamin

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When thinking about their estate plans, parents typically want to treat their children equally. This is true even when a beneficiary is struggling with addiction or mental illness issues. Of concern are beneficiaries who suffer from addictive or mental illness disorders that are likely to recur and result in a long-enduring pattern of impaired judgments which involve repeated and significant adverse life consequences. In addition, compromised self-regulation and little self-control will result in mood shifts and instability that also contribute to impaired judgment.

HOW ARE ADDICTION AND MENTAL ILLNESS DEFINED?

When asked, a client may not disclose the subject of addiction or mental illness in their family. However, when followed up with an inquiry about whether any of the beneficiaries have shared concerns about another beneficiary because that person's behaviors would affect ongoing family relationships, clients will more readily express the views that others have shared. Any concerns expressed are likely to indicate that further inquiry should occur in order to avoid the dissipation of family wealth without adequate assessment and interventions.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) horrible statistics exist for the following disorders within the United States: [1]

- More than 10 million suffering from opioid addiction;
- More than 2 million suffering from methamphetamine addiction;

- More than 14 million suffering from alcohol dependency;
- More than 51 million suffering from a serious mental disorder (psychosis, bi-polar disorder, major depression, etc.).

Three out of four people with a substance use disorder struggled with both alcohol and drug use disorders simultaneously, and four percent of American adults (9.5 million) suffered from both a mental health disorder and a substance use disorder.[2] In summary, in 2019 more than 61 million American adults suffered from either a mental illness and/or a substance use disorder, which was an increase of six percent from the prior year.[3] The more recent estimates due to the COVID-19 pandemic suggest that a much larger significant increase in the prevalence of these disorders will occur for 2020 and beyond.

The American Society of Addiction Medicine (ASAM) defines addiction as "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences."[4] The definition of addiction often includes other behaviors that have an equally significant impact on a person's health and well-being. A recent definition of "[a]ddiction [includes] several defining components: (1) continued engagement in a behavior despite adverse consequences, (2) diminished self-control over engagement in the behavior, (3) compulsive engagement in the behavior, and (4) an appetitive urge or craving state prior to engaging in the behavior."[5]

Addiction, therefore, may take many forms. It may involve legal substances like alcohol or marijuana as well as prescription drugs, illegal drugs, and other substances. Excessive engagement in behaviors such as gambling, Internet use, video-game playing, sex, eating, and shopping may also represent addictions. Although this concept remains controversial,[6] growing evidence suggests that certain habits warrant consideration as nonsubstance or "behavioral" addictions and may result in an obsessive-compulsive diagnosis, at this point, through the WHO's International Classification of Mental and Behavioral Health Disorders (ICD).[7] At present, only gambling disorder has been placed in its own diagnostic category. Still, the building consensus is that addiction is not limited to substance abuse.

As discussed above, there is no universal and agreed upon definition of addiction. The following is a nonscientific definition:

> Definition of Addiction. The terms "addiction" and "mental illness" shall include, but not be limited to, a substance abuse problem with alcohol, drugs, prescription medications, or other harmful substances, as well as any behavior that is destructive to the Beneficiary's emotional, physical, or financial health and well-being.

The following is a scientific definition, which is a work in progress:

> 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 ICD defining alcohol and drug dependence and abuse. Other addictions, compulsive behaviors, or mental illness shall be identified as defined in the ICD, and as updated by current medical information and/or credible research.

While the second definition is more precise in its reference to the beneficiary's behavior, the first definition focuses on the beneficiary's quality of life. A grantor may wish to use one or both definitions, depending upon their concerns.

THE TEAM AND THE TRUST

Often, a family comes to the estate planner without a plan to help an addicted or mentally ill beneficiary. Thus, the estate planner is in the position to play a critical role in a possible intervention and recovery, and help change how the family transfers a future inheritance while providing current support. Drafting a trust for this purpose is not formulaic and may

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quickly become emotionally fraught for the family. It is highly recommended that the lawyer obtain permission of the family to consult with outside care professionals as early in the process as possible.

In some cases, the family may have been dealing with addiction or mental illness issues for so long that they may have lost sight of how complicated the situation has become as well as their need for outside help. Or they may have reached complete emotional exhaustion and want to ignore the problem in the hope that it will go away on its own. In addition, it is common that conflict has arisen among family members about the afflicted beneficiary. Some may have enabled the disorder; others may have ignored it; some may want to discontinue support or even contact because of resentment or fear that the afflicted individual may continue to disrupt family relations. As a result, discussions will range from conferring the bequest to "keep the peace" to cutting off the disordered beneficiary entirely.

The estate plan is part of a puzzle and the lawyer needs to recruit a larger team of professionals to help the family understand all of the pieces of the puzzle, including how to support the disordered beneficiary without disrupting the family's health. That assistance may take many forms. Discussed below are the issues for a client to consider and suggested trust drafting solutions to address both the needs of the beneficiary and the client's wishes.

Identify the purpose of the trust

It is important that the grantor is clear about the purposes that a trust may serve, and that the trustee will have sufficient flexibility to meet a beneficiary's needs to fulfill that purpose. A typical trust for health, education, maintenance, and support (HEMS) will not give a trustee the guidance needed to make appropriate distributions to a beneficiary dealing with addiction.

Financial support has the potential to promote a beneficiary's recovery or interfere with it. An unfettered windfall may enable self-destructive behavior and inhibit any path to recovery. In most circumstances, recovery requires firm boundaries. A well-drafted trust, therefore, will provide tactical guidance goals to be met before money is conferred as well as methods for verifying that the goals are sustained.

In addition, until a beneficiary is able to manage funds responsibly, any distributions should be made on their behalf to support recovery rather than directly in an unfettered manner. Many disordered beneficiaries, even those in recovery, lack the skills to handle money responsibly. Recovery may involve counseling about financial management skills and ongoing verification which will enable the disordered beneficiary to take on increasing responsibility as the recovery is sustained.

Similarly, a special needs trust is unlikely to meet the needs of a disordered beneficiary. Eligibility for public assistance benefits is based on whether the beneficiary has a "disability," which under the Social Security Act means a serious, medically determinable physical or mental impairment that renders the beneficiary unable to engage in any substantial gainful activity.[8] Moreover, the disability must have lasted, or be expected to last, for at least one year, or result in death.[9] A beneficiary suffering from addiction may not meet these criteria. First, substance use disorder itself is not considered an impairment that may serve as the basis for a finding of disability. Second, even if the beneficiary has a separate mental health-based impairment that is recognized as a disability (e.g., bipolar disorder, major depression, or anxiety), the beneficiary's eligibility will be denied if their substance abuse is found to be a material contributing factor to the impairment. The key question will be whether the beneficiary would still be disabled if they stopped using drugs or alcohol.

Finally, a trust should not be limited to distributions to further recovery. Such an option may not be viable for every beneficiary, and the beneficiary is likely to have greater needs than simply funds for recovery-related expenses.

Clarity of purpose is critical. Will this trust be used to support the beneficiary whether or not they are on a track toward recovery? Will it cover basic

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expenses or only recovery-related expenses? The purpose may be defined, in part, by the extent of the resources that are available.

The following is a purpose provision that may be used:

> Purpose. The following provisions shall apply to any trust created herein for a Beneficiary who is impaired by an addiction, as defined herein. My intent is to allow the trust to be used to support such Beneficiary in his or her evaluation, treatment, and recovery, prevent such Beneficiary from dissipating financial resources from such trust due to his or her addiction and mental illness, and to prevent the management or ownership of trust property from being jeopardized by legal seizure or other issues, including incarceration, that may arise from his or her addiction and to support his or her successful efforts toward rehabilitation to be a productive, healthy individual, and to otherwise provide for his or her general health and support.

Authorization to hire and rely on professional expertise

The trustee cannot reasonably be expected to be an expert on addiction, mental illness, or the recovery process. The trust agreement should permit the trustee to employ and consult with professionals.

The following is a provision that would allow the trustee to engage professionals. It would need to be modified to fit the situation:

> Authorization to Employ Experts. The Trustee is authorized to employ and retain experts on alcohol and drug addiction, other addictions, mental illness, and family conflict to advise him or her regarding any matters, issues, or determinations provided for herein. The Trustee has sole discretion regarding the employment and use of any such experts, treatment centers, or other resources as needed; however, all such experts shall be licensed or credentialed pursuant to applicable state guidelines and standards.
>
> Before distribution, the Beneficiary shall be evaluated for addiction and mental illness by such experts, who, after that evaluation, can recommend comprehensive treatment and post-treatment recovery programs and oversee and implement such programs, and the Beneficiary must consent to the disclosure to the Trustee of such treatment plan.
>
> The Trustee may accept the recommendations of such persons to determine appropriate treatment requirements and compliance, and to determine conditions for trust distributions based upon compliance with treatment. Such authority includes expending funds for safe housing, evaluations, treatment and all related costs, for post-treatment recovery programs, and any and all related matters deemed appropriate by the Trustee in his or her sole discretion. This paragraph is fully applicable to other addictions, compulsive behaviors, or mental health concerns regarding the Beneficiary.

DISTRIBUTION PROVISIONS — DISTRIBUTIONS COORDINATED WITH THE STATES OF RECOVERY

Current thinking is that the distribution provisions of a trust must work in tandem with the recommendations and treatment plan provided by a treatment specialist or treatment team. The team may take many different forms based on the beneficiary's needs and the resources available. For example, a team may include a case manager who has expertise in the protective payee process, a psychotherapist, a physician, a psychiatrist, a vocational specialist, and even a nutritionist as active participants in a treatment plan. Such a plan would depend on the beneficiary actively pursuing treatment and recovery through a series of treatment and recovery stages.

Stages of behavioral change

One compelling description of the process of behavioral change is the Transtheoretical Model of Behavioral Change, developed by James Prochaska and Carlo DiClemente. It describes the process of behavioral change for addictive behaviors and provides a

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useful framework for understanding the recovery process for mental illness, too:[10]

> [I]ndividuals pass through a series of five stages when attempting to change their behaviour, the first three of which are motivational and the remaining two actional stages. The first stage is referred to as the *precontemplation* stage, where the individual does not intend to change his or her behaviour in the foreseeable future. It is suggested that many people at this stage are unaware, or under-aware, of their problems. Next is the *contemplation* stage, where the individual is aware that a problem exists in relation to that behaviour and is seriously thinking of overcoming it, but has not yet taken action or made any preparations. The third stage is the *preparation* stage, where individuals have decided to take action in the next month and have been unsuccessful in taking action in the past year. Then comes the *action* stage, where the individual actually changes his/her behaviour. The final stage is the *maintenance* stage, where the individual is attempting to maintain the behaviour change by working to prevent relapse. In addition, the action and maintenance stages have strict time frames, in that people are described as being in the action stage if they have changed their behaviour for a period of 1 day to 6 months and as being in the maintenance stage if they have changed their behaviour for more than 6 months.[11]

Some beneficiaries may not work with treatment professionals and may choose a 12-step or similar program instead. In that case, the trustee and assessment team will need to devise a method (e.g., written agreements, random drug testing, etc.) for reporting necessary benchmarks to move to the next level of distributions. The beneficiary's refusal to work with professionals should not limit the trustee's right to consult with professionals.

Whether the recovery plan involves treatment professionals or a 12-step-type program, a traditional trust based on the HEMS standard is inappropriate. Instead, distributions should be based on stages of recovery, and should adjust as an engaged beneficiary moves through such stages. The trust should also account for the risk that a beneficiary may never engage with the recovery process, or that an engaged beneficiary may relapse.

Stage 1: Precontemplation[12]

Distribution provisions for a trust based on stages of recovery may look something like the following, with modifications depending on the treatment plan and the type of addiction:

> Distribution of Income and Principal. The Trustee is under no obligation to distribute income or principal to an addicted or mentally ill Beneficiary of any trust created hereunder who is or may be using or consuming any illegal drug or other illegal substance or who is clinically dependent upon the use or consumption of alcohol or any other legal drug or chemical substance that is not prescribed by a board-certified medical doctor or psychiatrist in a current program of treatment supervised by such doctor or psychiatrist, or is engaging in behavior determined by said doctor or psychiatrist to be harmful.
>
> If the Trustee has reason to believe that as a result of such use or consumption or behavior, the addicted or mentally ill Beneficiary is incapable of caring for himself or herself or is likely to dissipate his or her financial resources, the Trustee may request the Beneficiary to submit to one or more examinations determined to be appropriate by a qualified health care provider, board-certified medical doctor, psychiatrist or psychologist, or other licensed health care professional selected by the Trustee.
>
> The Trustee, in the exercise of his or her sole and absolute discretion, may totally or partially suspend all distributions otherwise required or permitted to be made to that Beneficiary until the Beneficiary or the parent or legal guardian of a minor Beneficiary consents to the prompt examination and complete disclosure of all information derived from such test(s) or from

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information held by a state agency, local health authority, insurance company, health maintenance organization, or employer to the Trustee.

Alternate provision for gambling or other behavior:

Gambling and Other Addictive Behavior. The Trustee, in the exercise of his or her sole and absolute discretion, may totally or partially suspend all distributions otherwise required or permitted to be made to the Beneficiary, until the consulting expert chosen by the Trustee indicates a belief that the Beneficiary's financial well-being is no longer endangered as a result of the Beneficiary's [gambling] [or other nonsubstance addictive behavior] behavior and when the Trustee in his or her sole discretion determines that the Beneficiary is able to care for himself or herself and to manage his or her financial affairs.

Stage 2: Contemplation

If the beneficiary completes an initial program as prescribed by the treatment professionals (often a 30- or 90-day full-time, residential addiction treatment program) in a manner deemed satisfactory by the treatment center, the trustee may be directed to make a distribution to recognize such accomplishment:

Recognition of Accomplishments. Upon completion of the first phase of the Beneficiary's treatment plan, the Beneficiary shall be entitled to receive an amount to recognize such accomplishment, in the discretion of the Trustee, in addition to weekly cash distributions, in an amount in the discretion of the Trustee, for each week that the Beneficiary's treatment professional(s)/team verify that the Beneficiary has successfully completed the activities and has demonstrated that he or she is following the parameters set forth by them each week.

Receiving benefits under this provision is contingent on the beneficiary's continued participation in a "recovery program," as determined by the trustee in consultation with the treatment team.

Equivalent provisions could be adapted for the beneficiary who has a gambling addition, other nonsubstance addictive behaviors, or mental illness to address concerns regarding the beneficiary's impaired judgment regarding financial expenditures. Money often serves as a trigger for anyone struggling with an addiction; it is even more so a trigger for people with a gambling addiction. A beneficiary's treatment team will need to carefully devise a plan for distributions of money directly to a beneficiary with such an addiction. Gambling-addicted individuals may need to provide case managers or trustees with financial records and budgets for a period to demonstrate the absence of gambling and to hinder relapse.

Stages 3 through 5: Preparation, action, and maintenance

The trust should describe what "recovery" benchmarks will look like through preparation for, active participation in, and maintenance of recovery. Not every beneficiary will follow the same path; some will relapse. The benchmarks will need to be broad enough to meet the realities of the beneficiary's situation:

Recovery. "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, ongoing participation in activities addressing issues related to drug addiction, alcoholism, or other compulsive behaviors, and any mental illness (i.e., participating in a "recovery program," as determined by the Trustee in consultation with the treatment team).

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 extension(s) of time determined at the sole discretion of the Trustee. 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

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> 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 may lead to relapse. The Trustee is authorized to rely on the advice of experts, as described herein, in implementing this Section and exercising discretion.

Action and maintenance may involve hospital programs, in-patient or outpatient programs, sober residential arrangements, 12-step programs, and in-home coaching and monitoring, to name only a few of the treatment modalities.

Upon accomplishment of recovery benchmarks, including year two and additional annual periods of continuous sobriety or recovery, the trustee may want to consider additional distributions to mark the accomplishment. If the trust assets permit, the trustee may also want to increase distributions to supplement a beneficiary's lifestyle, and make more distributions directly to the beneficiary rather than on the beneficiary's behalf, keeping in mind that the beneficiary may have low impulse control and poor money management skills, and plan accordingly.

After a period of time, the trustee may allow the beneficiary to become a co-trustee and eventually his or her own sole trustee. The beneficiary's history of compliance and relapse would need to be taken into consideration to reach these stages.

Relapse

Relapse is a part of the recovery process. A well-drafted trust needs to anticipate that a beneficiary may earnestly commit to a recovery plan and then relapse, often multiple times. A trust for a beneficiary who may have relapsed but is able to work could cover recovery-related expenses. In other words, it would not cover expenses under the HEMS standard such as food, housing, and utilities. The trustee will need to decide whether relapse restarts the beneficiary back at stage 1, with the requirements imposed for them to re-commit to a treatment plan described above.

If it appears that a beneficiary will not commit to further recovery plans, a grantor may want a broader distribution standard, but not one tied to the stages of recovery discussed above:

> Distributions for Basic Living Requirements. If the Trustee reasonably believes that a Beneficiary routinely or frequently engages in addictive behaviors or fails to engage in the treatment process for mental illness and if the Trustee reasonably believes that as a result the Beneficiary is incapable of caring for himself or herself or is likely to dissipate his or her financial resources, the Trustee shall limit distributions to such Beneficiary to those that the Trustee deems necessary to ensure that such Beneficiary's basic living requirements are met. Such needs may include basic housing, utilities, treatment, and maintenance needs. In making distributions for the Beneficiary, the Trustee shall, to the extent practicable, make payments directly to persons for goods and services on behalf of the Beneficiary, rather than directly to the Beneficiary. The Trustee shall have the authority to withhold all distributions to or for the benefit of the Beneficiary if the Beneficiary refuses to authorize the disclosure to the Trustee of complete information regarding the Beneficiary's course of treatment and other otherwise confidential information appropriate for the Trustee to determine the continuing behavior of the Beneficiary.

The beneficiary not in recovery

Not every beneficiary will cooperate with a recovery plan. A grantor must decide whether distributions should be made in that event or leave the decision to the trustee's discretion. Some clients will want distributions withheld entirely; others will want the trustee to make distributions that maintain the status quo, which is that the beneficiary receive distributions even when actively using drugs or alcohol or engaging in addictive behavior; others will want the trust to serve only as a safety net in the event of catastrophic need. To carry out the grantor's intent, a possible clause in the trust document could read:

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Distributions in the Sole Discretion of the Trustee. Notwithstanding any other provision herein to the contrary, the Trustee shall, in the Trustee's sole discretion, make discretionary distributions of income and principal to or for the benefit of any Beneficiary with addiction issues or mental illness. I request that the Trustee limit distributions to such Beneficiary to those that the Trustee deems necessary to avoid unusually adverse circumstances that threaten his or her safety [and to ensure that such Beneficiary's basic living requirements are met]. In making distributions for the basic health and maintenance needs of a Beneficiary under this paragraph, the Trustee is requested, to the extent practicable, to make payments directly to persons or organizations who are furnishing housing, utilities, health care (including health care insurance), and other basic goods and services to the Beneficiary, rather than directly to the Beneficiary.

GUIDANCE REGARDING WITHHELD AND POSTPONED DISTRIBUTIONS

If a trustee is directed to withhold distributions, they will need further guidance as to what to do with the withheld funds. They will also need to be indemnified if a disgruntled beneficiary tries to use the court to force a distribution. The following is a suggested way to handle withheld distributions:

Withheld and Postponed Distributions. Distributions that are withheld or postponed pursuant to this Article shall be held for the life of the Beneficiary for whom the distributions could have been made, with distributions of income and principal to be made to or for the benefit of the Beneficiary in the discretion of the Trustee pursuant to the guidelines set forth or referred to in the trust share from which the distribution was intended to be made, unless and until a distribution is deemed appropriate by the Trustee, exercising the Trustee's sole and absolute discretion. Any such withheld or postponed distributions (the undistributed portion) remaining undistributed at the death of the Beneficiary, or at any earlier time when a court of competent jurisdiction would have the authority to direct the distribution of any such undistributed portion pursuant to any statute relating to the Rule Against Perpetuities, shall be distributed pursuant to the provisions of the trust from which distributions were intended to be made directing the disposition of that property remaining at the Beneficiary's death; provided, however, that such discretion regarding the undistributed portion may only be exercised by a Trustee who is not within the permissible class of distributees of such undistributed portion.

The trust could permit distribution of the undistributed portion to a larger class of beneficiaries, as follows:

Distribution of Otherwise Withheld Distributions. 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 to 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 payments directly to persons or organizations who are furnishing housing, utilities, health care (including health care insurance), and other basic goods and services to such class of Beneficiaries, rather than directly to the Beneficiaries.

AUTHORIZATION FOR ONGOING TESTING AND RECEIPT OF TESTING RESULTS

In order to implement the treatment plan, a trustee may need the authority to have the beneficiary periodically tested. Testing may take many forms, some more invasive than others. And technology continues to evolve. Testing provisions should be drafted with both of these facts in mind. Furthermore, the Health Insurance Portability and Accountability Act (HIPAA) protects a patient's privacy and confidentiality. A mechanism will need to be provided for the testing agency to provide the results to the trustee.

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Testing. The Trustee in consultation with the treatment team shall engage a reliable and licensed drug testing company to randomly drug test the Beneficiary [during the first ______ years of Recovery (as defined above)]. The Trustee in consultation with the treatment team is authorized to require continued testing for so long as the Trustee deems such testing to be advisable, regardless of any other provision herein. Full disclosure of results from such tests shall be made in a timely manner to the Trustee [in consultation with the treatment team].

In the case of suspected gambling abuse, other nonsubstance addictive behavior or mental illness, the Trustee will request the Beneficiary to submit to examination by a qualified health care provider, board-certified medical doctor, psychiatrist, psychologist, or other licensed health care professional chosen by the Trustee, with expertise in addictive behavior and mental illness, and to consent to disclosure to the Trustee of the diagnostic results and if applicable, any therapeutic recommendations.

Authorization to receive reports/beneficiary's consent to release information

The trustee must be authorized to receive protected health information and should be required to protect it as confidential to the maximum extent possible:

Release of Treatment Information. In determining whether the Beneficiary is participating in and/or has successfully completed an approved and applicable treatment and recovery program, the Trustee [in consultation with the treatment team] must be permitted to receive reports from the case manager, staff from treatment programs of any kind, sponsors, and all health care professionals or others providing assistance to the Beneficiary, and share such information among the members of the treatment team.

The Beneficiary must sign consents for full release of information to the Trustee in consultation with the treatment team in order to be in compliance with this Section. Failure to sign all requested authorizations means the Beneficiary is not in Recovery as that term is defined herein. The Trustee must maintain strict confidentiality of all information disclosed to him or her, and cannot disclose that information to anyone other than the Beneficiary, and care team, unless required by law.

SELECTING THE TRUSTEE

The success of a trust in dealing with addiction issues or mental illness is dependent on the engagement of the trustee. Choosing a trustee should begin with a clear understanding of what the grantors will be asking the trustee to carry out. Selecting a trustee may be the final drafting step. It is important that a trustee is willing and qualified to perform their duties, which will involve a broad degree of discretion and many decision points along the recovery continuum.

Trustee duties

Family members often have the best understanding of a grantor's intent. We recommend that the grantor increase the transparency of their intentions by writing to and discussing with all of the beneficiaries the contents of what is called an "ethical will."[13] An ethical will may avert surprises and continue to remind the beneficiaries of the testator's values, beliefs, and lessons that led to the bequest. Transparency will also help to guard against the negative consequences of family members turning against one another. However, even with increased transparency regarding the grantor's intentions, appointing a family member to serve as a trustee of an addicted or mental ill beneficiary may create a conflict between the fiduciary duties of a trustee and ongoing family relations. Furthermore, a family member may grow weary from the burdens placed on him or her or become embittered that the family's wealth is being spent down or even depleted entirely.

A corporate or professional trustee may help preserve those family relationships that are important

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to the beneficiary and may have an easier time setting boundaries. But the trustee should have special training to work with a beneficiary grappling with addiction and mental illness. The corporate or professional trustee will also need to be reimbursed for the additional time to form a treatment team, implement a treatment plan, consult with treatment professionals, and meet the additional needs of the beneficiary. There are trustees who specialize in handling beneficiaries with special needs. Ideally they would have case managers and treatment provider on staff, or with whom they work, to handle the needs of beneficiaries.

Another alternative is a co-trustee relationship between a family member and a professional trustee. The individual trustee could focus on the beneficiary and their needs for recovery, while the institutional trustee would handle the investment of the trust property. However, both trustees should be equally involved in making distribution decisions.

Trust protectors

In addition to a trustee, the grantor should consider naming a trust protector (sometimes called a "trust advisor") to serve in a supervisory role. Whether the trust protector will serve in a fiduciary or nonfiduciary capacity may be subject to state law and should be taken into consideration.[14] The trust protector could be given the power: (i) to direct that the trust be modified or terminated (if, for example, the definition or diagnostic criteria for the addictions or mental illnesses are updated in the newest edition of the ICD[15]); (ii) to remove and replace a trustee if they fail to perform their duties; (iii) to direct the investment of trust assets; and (iv) approve or veto any proposed trust distributions. Additionally, in the context of the addicted beneficiary, a trust protector could be charged with actively monitoring the progress of the beneficiary's recovery and, if necessary, directing the trustee to hire or remove treatment professionals on the treatment team. The trustee would be obligated to comply with the trust protector's directions, unless they violate the trust terms, the trust protector's duties, or the trustee's fiduciary duties.

The following provision may be used to address the appointment of a trust protector:

> Appointment of Trust Protector. The Grantors appoint __________ and __________ as Trust Protectors hereunder, provided that if one of them is unable or unwilling to serve, then __________ shall serve. If no two of them can serve as Trust Protector, then the remaining Trust Protector shall select one or more licensed addiction counselors with at least a master's degree in Psychology or Counseling who is engaged in the full-time practice of addiction counseling or working as an addiction counselor and/or manager in an addiction treatment facility. If there are only two or fewer Trust Protectors serving, then the remaining Trust Protector or Trust Protectors may choose a new additional Trust Protector meeting the above requirements.

Trust advisory committee

Rather than relying on an individual trust protector, the grantor could form a trust advisory committee to advise the trust protector or the trustee. This would relieve any one individual from shouldering the entire burden, and also would allow individuals from different backgrounds and disciplines to be involved in the decision-making process. The following clause allows trust protectors to appoint a trust advisory committee:

> Trust Advisory Committee. The Trust Protectors may appoint a Trust Advisory Committee to provide advice and guidelines to be followed with reference to addiction and related issues concerning any Beneficiary of this trust with an addiction disorder. At all times, there shall be three members, and if one individual cannot serve, then the remaining individuals shall appoint an alternate so as to maintain three members. Each member of the Trust Advisory Committee may be compensated based upon time reasonably spent, reasonable hourly rates, and reimbursement of reasonable expenses, and shall be indemnified and held harmless for

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any liability, obligation, or reasonable expense incurred as a result of serving under this Agreement or providing any services to or for the benefit of the Beneficiary or the Committee. The Trust Advisory Committee may communicate with family members and other individuals who may have useful information about the Beneficiary's addiction or mental illness. The Trust Advisory Committee may require that the Beneficiary agree to open communication, including the release of protected health information, meetings, and other conduct required in his or her treatment plan. Any Trustee serving hereunder shall cooperate with the Trust Advisory Committee and shall be indemnified and held harmless for following the advice of the Trust Advisory Committee.

COORDINATING TRUST DISTRIBUTIONS WITH SSI, MEDICAID, AND SSDI BENEFITS

Public benefits and special needs trusts are beyond the scope of this article. But, in general, when drafting a trust for a beneficiary with an addiction disorder, the grantor should anticipate that at some point the beneficiary may be eligible for public benefits such as Supplemental Security Income (SSI), Medicaid, and possibly Social Security Disability Income (SSDI). Unless there are sufficient funds to cover the needs of the beneficiary without having to resort to public benefits, the trust should be drafted so that the public benefits, rather than trust assets, will have primary responsibility to pay for the beneficiary's needs.[16]

As discussed above, there may be times when a special needs trust will not serve the needs of a beneficiary with addiction issues. In that case, it may be necessary for the trustee to use the trust in such a way that the beneficiary would not be eligible for public support (but may be able to take advantage of other programs or interventions that the trust would pay for). In that case, the following provision should be included in the trust agreement, if the corpus will be sufficient to support the beneficiary even without eligibility for public support:

Distributions That May Disqualify Entitlement Eligibility. The Trustee may also make one-time or short-term distributions to the Beneficiary even though it will result in disqualifying the Beneficiary from government assistance in the month or months of distribution if the Trustee determines, in the Trustee's sole discretion, that the benefits of the temporary or one-time distribution outweigh the temporary loss of government assistance.

INDEMNIFICATION

Indemnification of the trustee and others hired by the trustee will permit the trustee to act without fear of retaliation by the beneficiary or other family members who might be frustrated with the progress, actions, or inactions of a beneficiary. The following is a suggested provision:

Indemnification. All decisions made by the Trustee are to be made upon information and investigation deemed appropriate by and to the Trustee. Any such decision(s) made by the Trustee shall be binding upon all parties. Nothing contained herein shall be construed to provide the Beneficiary with a right of action nor to any right of recovery, legal obligation, trust or will reformation, monetary damages, injunction, attorneys' fees, or other relief.

The Trustee (and any professional, advisor, assistant, or other person, including their business entities and affiliates, hired and/or retained by the Trustee or encountered during the performance of the Trustee's duties) will be indemnified from the trust estate for any liability in exercising the Trustee's judgment and authority granted herein, including any failure to request the Beneficiary to submit to medical examination and including a decision to distribute undistributed amounts to the Beneficiary, unless a court of competent jurisdiction determines said Trustee acted in bad faith with intentional disregard of his or her duties hereunder. This indemnification clause includes any allegations of any kind brought by the Beneficiary, or on behalf of the Beneficiary, directly or indirectly, against the

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Trustee and those hired and/or retained by the Trustee. If such allegations occur, the respondent has the option of requesting the Trustee to provide the defense or to pay to the respondent funds for his or her defense.

SAVINGS CLAUSE

Finally, the trust should contain a savings clause to avoid disqualifying the trust from any tax provisions under which it is qualified:

> Savings Clause. Despite the distribution provisions above, the Trustee may not suspend any mandatory distributions to or for the benefit of a Beneficiary that are required in order for the trust to qualify for any federal transfer tax exemption, deduction, or exclusion available with respect to the trust, or that are required to qualify the trust as a qualified subchapter S trust or electing small business trust.

CONCLUSION

A well-drafted trust may prove to be a valuable tool in helping a family and an addicted or mentally ill beneficiary through a drawn-out and difficult process. The estate planner cannot solve all of the problems that the family and beneficiary will face throughout this process. But the estate planner can help to minimize some of the more serious problems by assembling a team of professionals and creating a trust agreement that will aid those professionals in making the right choices for both the beneficiary and the family.

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Notes

1 Substance Abuse and Mental Health Servs. Admin., Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (2019), https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases (2019 NSDUH Annual National Report).

2 2019 NSDUH Annual National Report.

3 Id.

4 Adopted by the ASAM Board of Directors September 15, 2019, https://www.asam.org/Quality-Science/definition-of-addiction.

5 Yvonne H.C. Yau & Marc N. Potenza, Gambling Disorder and Other Behavioral Addictions: Recognition and Treatment, available at Harv. Rev. Psychiatry. 2015 Mar-Apr; 23(2): 134–146.

6 Justin D. Wareham & Marc N. Potenza, Pathological Gambling and Substance Use Disorders, Am. J. Drug Alcohol Abuse. 2010 Sep; 36(5): 242-7.

7 World Health Organization, ICD-10: Clinical descriptions and diagnostic guidelines, available at https://www.who.int/classifications/icd/en/bluebook.pdf.

8 Social Security Act section 216(i)(1), 42 U.S.C. § 416(i)(1) (Other definitions—Disability; period of disability). See also 20 C.F.R § 404.1505 (Basic definition of disability).

9 Id.

10 James O. Prochaska, Carlo C. DiClemente, and J.C. Norcross, In Search of How People Change: Applications to Addictive Behaviors, 47 Am. Psych.at 1102-14 (Sept. 1992). See also Substance Abuse and Mental Health Servs. Admin., Treatment Improvement Protocol: Enhancing Motivation for Change in Substance Use Disorder Treatment (2019), available at: https://store.samhsa.gov/sites/default/files/d7/priv/tip35_final_508_compliant_-_02252020_0.pdf.

11 R. Povey, M. Conner, P. Sparks, R. James, & R. Shepherd, A Critical Examination of the Application of the Transtheoretical Model Stages of Change to Dietary Behaviours, 14 Health Educ. Res. 581, 641-51 (Oct. 1999)

12 Some of the forms included herein have been excerpted and adapted from the American College of Trust and Estate Counsel (ACTEC) materials prepared by Jon J. Gallo and Anne K. Hilker entitled What They Don't Teach You In Form Books (1993, 1994) available on the ACTEC web site at: https://www.actec.org/assets/1/6/Non-Tax_Drafting_Issues_(Part_1).pdf. The author is grateful to the late Jon Gallo, Anne Hilker, and all of the contributors to that publication.

13 F. Kaslow and G.A.H. Benjamin, Ethical Wills: The Positives and the Perils for the Family, 26 Journal of Family Psychotherapy, 163–177 (2015).

14 For an in-depth analysis of the various roles that a trust protector may play, see Alexander Bove, Jr., A Protector by Any Other Name..., 8 Tex. Tech. Est. Plan. & Comty. L. J 1 (2016), and Lawrence A. Frolik, Trust Protectors: Why They Have Become "The Next Big Thing," 50 Real Prop., Probate & Tr. L. J. 267 (2015), for an in-depth analysis of the various roles that a trust protector may play.

15 World Health Organization, ICD-10: Clinical descriptions and diagnostic guidelines. Available on the WHO web site at https://www.who.int/classifications/icd/en/bluebook.pdf.

16 For additional information on drafting where public benefits are involved, see Substance Abuse Trust for a Child Or Grandchild, Martin Hagan's Estate Planning Resource Center, http://haganlaw.net/?page_id=3340#.