

Addiction's Effect on Staff Morale and
Fiduciary Responsibilities in the Family and
Wealth Management Office

**Financial Managers
and
Dysfunctional Clients**

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RESTORING LIVES, FAMILIES AND CAREERS

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Bill Messinger started Aureus (formerly Addiction Recovery Professionals) to improve recovery rates for functional alcoholics and addicts. Inspired by highly successful programs for physicians and pilots, Bill developed similar approaches for complex family systems. His legal training and experience are invaluable assets when addressing the needs of Aureus' clients regarding trusts and estates as well as when working with lawyers on addiction-related concerns.

Aureus, Inc. - Formerly Addiction Recovery professionals (ARP)

Established by William Messinger, Aureus specializes in working with 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. Our extensive experience and training translate into unique and individualized consulting and case management services that ensure our client families receive the highest standard of care available and have the best opportunity for positive change.

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 law firms, family businesses, family business advisors, and family offices. We are available 24 hours a day to respond to your questions. Please visit our web address to review our articles for family advisors, trustees, attorneys and family leaders.

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The Dark Side of Family and Wealth Management Client Relations

Working in a family office or wealth management office may seem like a “dream job” for financial and legal professionals. Yet there is a downside, and that is working with difficult or unresponsive clients. Over the years, we have witnessed the toil exacted on client managers when families have loved ones suffering from alcoholism, drug dependence, and other addictions and dysfunctions. These managers are the direct service personnel assigned to interact with family office clients on a day-to-day basis regarding financial matters. They are the people family members turn to when they need money, pay bills, donate to charity, or generally manage day-to-day financial transactions and accounting.

As the primary contact for family members, these managers are usually the first to sense that something is wrong with a client. Then, as problems increase, they subsequently experience the client's downhill slide to more serious dysfunctions. The client may have addiction problems, be in treatment or an early recovery program, or have other significant impairments such as depression or an anxiety disorder. Through our experience with individual cases and systematic interviews with wealth managers, we find that significant problems develop in the relationship between the financial manager and dysfunctional client.

Our over-arching conclusion is that while the job description is about numbers, clients' personal issues (stemming from addiction and recovery) impact the well-being and job performance of financial managers. Managers are only human and are not always able to leave their clients' issues at the office. Their clients' circumstances affect them at a personal level. Most financial managers have a background in finance and a corresponding personality that is at ease with numbers and rational thought. They are professionally and personally unprepared to deal with addiction and other disorders.

Leadership Role For Executives And Family Leaders

Family office executives and family leaders need to understand the impact dysfunctions have on direct line staff. Confusing and erratic client behavior impairs employee efficiency, can lead to unsound financial decisions, and is very stressful for the employee. The end result is an unhappy employee who may be neglecting other clients in an attempt to resolve or limit negative consequences created by an out-of-control client. Yet the employee may continue to try and help because they fear they may lose their job if they

are viewed as unsuccessful, or violating confidentiality if they talk to senior staff or family leaders.

In our experience, family leadership must take the initiative to oversee on-line staff when a client is suspected of, or identified as having addictions or other dysfunctions. While there may be some discussion of a problematic client at the oversight level, the actual impact on the client manager usually flies under the radar screen. Our purpose in writing this article is to describe in detail various scenarios encountered by managers so that family leaders and office executives are aware of the pressures and stresses created by the relationship and can respond with better supervision and support for their employees.

In this report, we will deal with four main issues:

A) The Problematic and Dysfunctional Client

1. Addicted clients create high levels of personal stress
2. Managing multiple family secrets
3. Passivity in dysfunctional/addicted clients and the effect on managers
4. Managers' personal views about addiction can color judgments and advice
5. Managers know little about addiction
6. Traditional helping roles become counterproductive
7. Managers minimize, excuse, or become part of "the problem"
8. What to do if the manager suspects something is wrong

B) Resistance or Refusal to Get Help

9. Calls from family members create stress
10. Unstable client-manager interactions
11. Manager relationship with a non-family spouse

C) Treatment

12. Managers play no role in the assessment, treatment, or recovery plan process
13. Managers lack meaningful information as to what is occurring in treatment
14. Family members and spouse of the addict take over communications

D) Post-Treatment

15. Managers have unclear expectations regarding post-recovery activities
16. The relationship between the manager and the client will change
17. Behavior expectations for clients in recovery

Conclusion

18. Managers are being asked directly or indirectly by clients to provide emotional support

A. The Problematic And Dysfunctional Client

1. Addicted clients create high levels of personal stress

The financial manager has to deal with demands from the addicted client, their spouse, and family members. However, they are not supposed to disclose these conversations to anyone, including co-workers. Informal or formal confidentiality policies, including “Chinese Walls”, prevent managers from discussing these demands and conflicts with others. The manager may also believe that if concerns about a client are discussed with an office executive or senior family member, it will be viewed as an indication of incompetence or inability to adequately interact with the client.

An example of a commonly encountered problem is when a manager notices that a client has a substantial increase in cash flow, often indicating a drug or other cash-needy problem. However, the client will provide their manager with legitimate reasons for the increase when questioned, which puts the manager in a bind. Should the manager keep quiet, continue to question the client or report the cash flow increase to the office executive or trustee, thereby potentially angering the client? These options are not often spelled out in the office procedures manual.

Since some wealthy clients continue in an addicted or dysfunctional state for many years, the manager’s inability to talk about the situation can lead to physical and emotional stress-related disorders. The manager may also begin to adopt some of the thinking and attitudes of the sick client. This is especially true if the manager is working with several dysfunctional family members (the cucumber in a pickle jar syndrome). But despite the stress and difficulties, managers remain in their jobs because the pay and benefits are too good to leave.

2. Managing multiple family member secrets

A manager may know the secrets of each family member, but cannot share them with other members. Managers report that holding on to these collective secrets is very stressful. Managers are not therapists. Rather, they are trained in finance or law and do not know how to get help to reduce their stress or change the position they find themselves in (poor at self-efficacy). As family members become alienated from each other over time, it may be impossible for the manager to keep working with the same client group, creating a staff allocation problem for office executives. However, the usual solution is for the manager to remain with the same clients and keep quiet, hoping problems will go away or never escalate to the level of open warfare.

A second area where secrets become a problem is when family staff members go to the manager with their concerns about the client’s behavior. These reports often happen when staff are concerned about the welfare of children, they find the client passed out in the house, or extremely inebriated and vulnerable to injury. When the information

reported concerns the well-being and safety of another family member or client, stress can become almost unbearable for the manager

Staff calling to express their concern is a sign that the disease has progressed to the point where recovery will be a long process. Therefore, it is important to carefully plan and strategize with all significant players on board as to the process and proposed actions, while at the same time educating staff about addiction and how it plays out for their employer. One element of the plan is to be able to assure staff that they will be protected for their candor and that, if fired, their economic status will be secure for the near term.

In instances where the addict is using regularly and engaging in behavior that might be self-destructive or harmful to others, one tactic is for family members to assume responsibility for paying the addict's staff. This burden often falls on the grandparents or siblings and is directed at assuring that staff members reveal any information about the addict's behavior both candidly and in a timely manner. Also, the active addict will be an erratic employer, sometimes firing help in a fit of anger, blackout or hangover, but after a day or two of abstaining rehiring the previously fired staff. If staff is paid by the addict's family, they can ignore their firing and continue to work for the at-risk family addict as if nothing has happened. Remember that we are dealing with a diseased person here, not an unkind or evil person, and it is important to maintain a zone of safety until the addict goes to treatment.

3. Passivity in addicted/dysfunctional clients and the effect on managers

The dysfunctional client is often passive in his/her relationship with the manager. When the client does give direction, the direction may be changed soon afterwards. This client may be unresponsive to calls, inquiries, or requests to sign important documents such as tax returns or investment authorizations. If a meeting is set, the client may not attend or call with a last minute excuse to postpone the meeting. Delays resulting in missed deadlines and investment opportunities bring added pressure when client advisors, trustees, and attorneys are waiting for action by the client.

The passive, or unresponsive client creates considerable consternation when other family members or their advisors are dependent on decisions made by the client in order for them to act. These relatives and their professionals need to be able to move forward on commonly owned assets such as family property, investments or the office. The simplest matter, as to when and where to hold a meeting, may hinge on this client deciding on a date. Even when the day is set, the client may not attend the meeting and call with a last-minute cancellation, or claim that there was improper notice and therefore participation is impossible. This type of behavior exposes the client to the scrutiny of the larger family and their advisors, and also brings unwanted attention on the client's manager.

When decisions are made, the client may forget about the decision and become upset when he/she finds out about it. He or she may blame the manager for failing to communicate adequately. Another commonly reported behavior is for the client to change a decision without any clear rationale. This leaves the manager in the position of

never really knowing if a course of action is to be pursued or if others can be told to rely upon the decision.

4. Managers' personal views about addiction can color judgments and advice

Managers bring their own personal bias into play and may judge a spouse, child or non-addicted family member without fully understanding the disease. These personal views can prevent managers from being a positive force in supporting the client to seek help. The manager's views can even reinforce the client's perspective around addiction:

"If she was nicer to him, he wouldn't drink." "Just try harder to quit."

Managers may talk with the client about trying to control his/her alcohol or prescription drug use, thinking that reviewing scenarios where the client was out of control will prevent reoccurrences. These examples reflect a commonly held erroneous belief about alcoholics – that they can use "willpower" to stop.

A manager may also be drinking regularly, causing the manager to be conflicted about bringing the issue to the attention of the office executive. The manager may be thinking,

"Well, if he has a problem, then I may have a problem. I don't want to quit."

Regular client meetings over lunch or dinner where wine is served can lead to an abusive pattern of drinking detrimental to the manager's long-term health. Family offices are one of the few institutions where alcohol with lunch is permitted, because the client sets the tone. (Most financial institutions have policies regarding employees drinking with clients.) In short, managers may not want to acknowledge their own possible abuse and will therefore keep quiet about their clients' alcohol use.

5. Managers know little about addiction

Managers often lack basic information about addiction as a disease. They do not understand that once a person is addicted to one substance, that person cannot use other addictive substances. This is because the brain receptors view all such substance as having the same chemical make-up. Comments by managers to us include the following flawed beliefs:

- It's fine for a client to have a glass of wine, since wine is not a hard liquor, and different than drugs such as cocaine.
- Clients can take Xanax, Klonopin or other Benzodiazepines for relaxation, anxiety or other reasons, as prescribed by physicians.
- Ambien and similar sleep aids are non-addictive and therefore safe to take.
- Marijuana is not an addictive drug and creates few problem users.

It is common for wealthy clients to be treated for cocaine, painkillers, or alcohol in treatment. Then upon their return home, they obtain Xanax, Klonopin or other Benzo prescriptions from their physicians (often supplemented with internet purchases) – all substances not to be used by a person in recovery.

Managers sometimes order wine when socializing with a client in early recovery or engage in other activities with a client that trigger using urges or high anxiety. Recent

brain research shows that brain receptors hold on to memories of use long after an addict stops active drinking or drugging.

- This new research on the brain is showing that addiction is a matter of “receptor brain change”, and recovery is a slow and hesitant process in which the influence of those memories is diminished over months.

Essentially, the brain receptors must be reprogrammed to react differently to physical places and emotional experiences. Therefore, in early recovery, it is important for the client to stay away from places where alcohol is served and to limit stressful events and conversations, thereby reducing opportunities for environmental or behavioral triggers in the brain.

6. Traditional helping roles become counterproductive

Managers are supposed to be helpful to their clients. Therefore, when clients discuss a problem or ask for help to resolve a problem, the manager will offer suggestions and look for resources for the client. Managers are trained to be good listeners and will tolerate lengthy conversations in order to be responsive to their clients’ needs. Over time, as a client’s dysfunctions increase, friends will fall away and the manager may be one of the client’s primary relationships.

In addition, managers are problem solvers for their clients. If a client is too ill to come to the office to sign documents, the manager will go to the client’s residence or use a messenger service. If a client has an automobile accident, the manager will make sure the family lawyer is immediately called to begin damage control. The manager’s role is “to protect and serve” the client.

Unfortunately, for wealthy alcoholics and addicts, often the reverse of the traditional helping role is needed to promote recovery. Most of us, particularly women, are trained to help people in need or ask for help. However, for the addict, acting on this urge can protect the addict from the consequences of his or her behavior. In fulfilling their role as client helpers, managers actually do a disservice to their addicted clients because they are keeping their clients from recognizing the effects of their use or mental health issues.

In addition, although managers may think they are helping their client by spending excessive time with them, they do so at the expense of their career. Other clients will start to complain about lack of attention to their needs. We know of one manager who was discharged because of the time spent with three needy clients at the expense of the rest of the family. This scenario may also lead to manager burnout, with the manager unable to effectively serve any clients.

7. Managers minimize, excuse, or become a part of “the problem”

Managers feel it is their role to serve their clients regardless of personal quirks or expenditure preferences. They are not supposed to judge their clients’ behaviors. Over

time, as a client's behavior deteriorates, the manager can lose perspective as to what is normal. They can begin to adopt the client's increasingly distorted view of relationships and health. The manager's role, plus client confidentiality, can lead to client dysfunctions becoming worse over time until something serious happens – injury to self or others, health problems, or public embarrassment.

When questioned by superiors or those in authority (trustees/lawyers), the manager may give excuses or cover up negative behavior. The manager may do this in order to protect the client or out of fear being terminated. If relatives ask questions, the manager may admit to knowing problems but express helplessness as to what action to take. The manager may explain what he/she has tried and failed. Furthermore, the manager may tell the client that family members are asking questions, resulting in strained or terminated relationships.

As problems continue, the manager may feel increasingly guilty or alternatively become “numb” to the issue by letting the problem go on for so long without talking about it to other staff or family members. Either situation – guilt or numbed indifference – prevents the manager from being an effective resource in getting help. We observe managers adopting two coping strategies:

- Hoping the problem will go away, that the client decides to get help, or that someone else intervenes.
- Strictly following the advice of lawyers to avoid the issue or feelings about the issue, *i.e.* “*I am following the rules.*”

The office executive of a family leader needs to tell the manager to focus on client behavior and then document and report issues when they come up. This is one strategy for taking the pressure off the manager because it is fact-based. Another approach is to bring in a counselor to start a family discussion as to what to do, with the ultimate goal of bringing the dysfunctional family member into the conversation.

8. What to do if the manager suspects something is wrong

As mentioned, the manager should focus on behaviors that indicate a problem. In assessing addiction and other dysfunctions, actions (or inactions) count. There is the therapeutic phrase “trying is lying”, *i.e.*, the client either did or did not show up for the meeting. Buying into client excuses can easily result in the manager becoming more of an advocate for the client than for the office and family standards (assuming there are standards).

One of the signs of a deteriorating family system is the emphasis on intent, excuses, and rhetoric versus facts and adequate documentation of interactions and events. Standard practice is the “who, what, when and where” type of reporting, including verbatim comments of the client. For example, rather than saying the client was “drunk,” report facts relating to why you drew this conclusion (slurred words, language used, number of drinks ordered).

Fact-based documentation is critical when lawyers and senior family members become involved in assessing if there is sufficient information to take action. In many families, lack of documentation means that efforts to help are postponed until there are public incidences resulting in arrests. Police reports will then provide the factual basis for confronting the addict with the reality of his/her disease. Even then, the addict may say that the police got it wrong, a common assertion when the events occurred during a blackout.

In an ideal world, the office would have a set of policies and procedures to help guide the client manager. Most do not. Executives assume that the manager can handle any problem, and will report any significant concerns to the office executive. As mentioned before, seeking help from the executive is unlikely to happen until an event brings the problem to his or her attention or relatives start complaining.

We find that the manager's willingness to initiate conversations with superiors about their concerns regarding their clients depends on several factors:

- The length of the relationship. The longer the relationship, the more likely the manager is to express concerns, unless previous efforts have failed or been discouraged, *i.e.* *"It's not your place to be concerned about such matters."*
- Intimacy in the relationship. How much information has the client shared with the manager regarding his/her life on such issues as relationships with siblings or concerns regarding children?
- What has the client discussed or revealed in the past to the manager regarding his or her efforts to address problems?
- The degree of trust. Does the client believe the manager can work for his/her best interests, or will there be a sense of betrayal if the manager suggests the client needs help or talks to the office executive?

In our experience, the preferred method for managers is to avoid dealing with the problem, wait for a revealing event to occur, and then shift decisions about what to do to a lawyer or office head.

B. Resistance Or Refusal to Get Help

9. Calls from family members create stress

The spouse and other non-addicted family members will often attempt to give directives or express concerns regarding the conduct of the client using alcohol or drugs. These calls also occur when the client is suspected of relapsing. If the manager also provides services to siblings, cousins and other relatives, they will communicate their concerns when dealing with the manager.

"Do something!" That is what everyone says, but without the active support of trustees or family leaders, in reality nothing much is likely to succeed in the long run. Persuasion and family meetings can be successful in the early stages of addiction, but in most cases, once the disease progresses, outside leverage is needed to move the client into treatment.

While the financial manager's relationship is with the client, many times a spouse is accustomed to communicating with the manager. In fact, an addicted client in the early stages of use may prefer their spouse to be the primary contact with the family office because it is more convenient. However, when the relationship between the addicted client and his/her spouse starts to deteriorate due to use, then the client begins to reassert control over communications between the spouse and manager. The spouse may realize that the manager is less available and no longer as responsive to requests, leading to conversations marked by increasing fear and anxiety regarding financial security.

In circumstances where family members know the manager, they will see the dysfunction and poor decision-making and will contact the manager to "diagnose" the problem, suggest treatment centers/therapists, discuss intervention, and figure out who is enabling the problem. They are not the "client" and, while acting according to their advice may be the right course of action, the resistant and addicted client wants nothing to do with his/her intrusive relatives. This leads to additional stress on the part of the financial manager, *i.e.* ("I told you not to talk to them.")

Some family members will by-pass the manager and present their concerns to senior family members, trustees and counsel. The common response by those in senior positions is to ask the manager to "control" these family members. This leads to additional pressure on the manager. This is a particular problem when the manager has told the relatives he/she lacks the power to take action, and they must talk to the people who have the authority to take action. The manager is in the middle of a power struggle between rightfully upset and concerned relatives and unresponsive fiduciary and family leadership.

10. Unstable client-manager interactions

One of the major sources of stress for the manager is the client who is active in his or her addiction and/or mental health problems. This leads to unpredictable behavior and contradictory messages. This situation is different from the passive client who is indecisive due to depression from alcohol, drug use or mental illness. Rather, this is the client who is on the active side of use, either from stimulants, such as cocaine, or alcohol. Behaviors will fluctuate between angry directives and ingratiating conversations. The latter occurs when the client realizes he/she has been rude or that bullying has not been successful and decides to change tactics by attempting to befriend the manager.

This client may also be difficult to reach, but usually because of active use. The client may be holed up doing drugs and sending out nasty emails or text messages. The client may have associates (drug dealers, assistants, attorneys) protecting him or her and holding off relatives. This client usually has a history of breaking off relationships with friends and advisors – even childhood schoolmates – although treatment or AA buddies may remain in contact. These severed relationships include family members, advisors, and the family office.

The use of intimidation and other scare tactics is very disturbing for managers and advisors. Their natural reaction to this addicted client is to respond either directly or indirectly (“*I don’t get mad, I get even!*”). However, being employees, managers have to accept the unpleasant situation because there is nothing they can do to improve it. Managers end up stuffing their emotions; pretending everything is okay.

A common tactic for male clients is to express their anger by moving into the personal space of the person they seek to intimidate. The client will yell and make threatening gestures, being careful to avoid touching the person. Often the manager agrees to the requests of this intimidating client, hoping to reverse the decision when the client leaves. (We see similar tactics used on family members and professionals such as lawyers and accountants.) Few managers and advisors are schooled in anger management or conflict resolutions. Therefore, this intimidating client maintains fear-based relationships until those in power put their foot down and enforce improved conduct.

11. Manager relationship with a non-family spouse

Managers find it difficult to support the clean spouse when the manager is associated with (and has a long-term relationship with) the addicted spouse. Feelings of disloyalty start to build in the manager if and when they support the clean spouse. This is true even though the client’s conduct has been outrageous.

Under these circumstances, the conflict of interest between the family member and non-family member inherent in the manager working with both husband and wife comes to the surface. Few family offices handle this situation well. They often down play adverse facts and undercut efforts by the non-addicted/non-family spouse to get help for the addicted family member. Managers and executive officers will side with their client when there is dispute about treatment options, leaving his/her spouse with little support and few alternatives but to agree with the family office.

We see situations where the actively addicted client has minor children adversely affected by the addictive behavior. Yet the family office is unable to support the non-addicted spouse in taking a stand for treatment. This unwillingness to take action reflects both lack of support from family leadership, trustees, and advisors and failure to exercise duties owed to the minor children. In an ideal world, trust and other documents would allow trustees and family office personnel to direct funds to the healthy, non-client spouse. However, such provisions are not common. In the absence of specific legal authorization, family leadership will have to coalesce around a strategy founded on child welfare as well as family and general trust law in order to protect the children.

When addiction-related events indicate a separation is likely, the family office often will string the non-client spouse along with palliatives until their client’s situation improves or the healthy spouse’s resources are exhausted. Unfortunately, this conduct is usually promoted and led by lawyers for the family. This leaves managers feeling very conflicted about misleading the non-addicted spouse, particularly when she or he is the responsible parent.

We have seen family offices and related professionals deliberately put economic pressure on the healthy parent, to the detriment of the children, in order to promote the interests of the family client. The task for ethical office executives and advisors is to find effective, competent support for the healthy spouse, regardless of the reaction of the client. In many circumstances, parents will back the client, putting a lot pressure on office personnel and advisors to prove their loyalty by ostracizing the non-family spouse. In these instances, it will be up to senior family members to step in and do the right thing.

C. Treatment

12. Managers play no role in the assessment, treatment, or recovery plan process

After experiencing the effects of addiction, supplying the funds for use, and often being the confidant of addicted clients, managers usually know little or nothing about their client's treatment.

Treatment centers focus on their "28" days of treatment and rarely have the time or desire to inquire about outside factors or relationships that weigh on a patient's addiction and recovery. Wealthy patients are very reluctant to discuss family offices and their relationships with client managers. The result is that the manager and family office executive are excluded from any meaningful participation in treatment and post-treatment assessment and planning. This exclusion occurs routinely, even though they have valuable information to contribute in all areas mentioned.

This limited or non-existent communication with treatment professionals can be another area of frustration for the manager, as he/she will know specific situations evidencing addictive behavior and how money supports the behavior. Managers uniformly have an emotional and professional investment in a positive outcome, given their long-standing relationships with clients. This is another area that office executives need to be aware of when supervising employees with a client in treatment.

In our experience, the client manager/family office is part of the "family system" that is involved in the addictive process and therefore needs to be included in the client's recovery process. As we discuss in other articles, the pilot/ physician models have very high first-time recovery rates. This model mandates free flow of information between all elements of the "system" including family, employer, regulatory board, and pilot or physician support groups. Following this model means that the family office is an important resource as to the assessment of the addiction as well as a significant participant in a well-thought-out recovery plan. However, the manager and family office will need the help of the professional counselor assisting the family (assuming there is one) to successfully perform this role.

13. Managers lack meaningful information as to what is occurring in treatment

Confidentiality rules combine with family shame to keep managers out of the information loop. Treatment centers are required to keep patient information confidential. This means that their patient (family office client) must sign a release of information. This authorizes the treatment center to send information to the manager as to progress and post-treatment plans. It is highly unusual for clients to sign these releases; or if they do, there are severe restrictions on the type of data that can be released. Therefore, any information the manager obtains is from family members who usually do not see specific documents from the treatment center, but are informed through verbal reports. Due to shame and the perceived need to protect the addict's privacy, family members rarely share this information with their family office. If they do decide to do so, it is usually a vague statement like, "Everything is fine."

We strongly advocate for the family office and manager to be viewed as part of the addict's addiction and recovery system. We also believe that managers should be authorized to communicate with treatment centers and that patients (clients) should authorize treatment centers to speak with family offices/managers. However, there are three caveats to our advice:

- First, most treatment centers will not send diagnostic or sensitive information to lay persons, even with a signed release. This is because they are concerned about how the information will be interpreted by the recipient. They will only do so to licensed professionals who are expected to use their discretion in sharing information with non-professionals.
- Second, managers only need selective information, such as a copy of the post-treatment plan and how treatment is proceeding. A lot of the information is unique to the field and is in treatment jargon - best understood and interpreted by a licensed professional.
- Third, if family offices work with a licensed advisor and this advisor is unknown to the client in treatment, the client will likely refuse to sign a release. This is because the client in treatment does not want to give out personal information to someone they do not know. The family offices/manager will likely have to explain whom this new person is before the client will sign a release of information to the new licensed advisor.

In short, allowing financial managers and family offices to receive selected information as to treatment progress and recovery planning conforms to the pilot/physician models – the gold standard for treatment and long-term success.

14. The family members and spouse of the addict take over communications

When the client family member is in treatment, the spouse and non-addicted family members may call with directives as to what to do with the client's assets, properties, possessions or income distributions. A client in treatment is often difficult to reach due to restrictions on cell phone and email use. In addition, the client may want to focus on treatment and recovery and prefer not to be distracted by outside matters. This situation

presents a ripe opportunity to put pressure on the manager, particularly when a family member purports to be relaying decisions made by the client to the manager. “I just talked to him and he said you are supposed to do X” is a common request heard by managers. Unfortunately, when the manager tries to call the client to verify, the client is invariably unavailable.

Another version of this problem is that the client is often asking for “space” to recover, leaving the manager to run his or her affairs without real direction. This situation is exacerbated when the client is in long-term treatment (more than 28 days) and communication is deliberately limited. There is often nothing that can be done except to wait for the client to return. In most instances, a client will not sign a power of attorney or otherwise authorize anyone to act on his behalf due to fear of misuse of the power while he/she is absent.

D. Post-Treatment

15. Managers have unclear expectations regarding post-recovery activities

The client leaves treatment and the manager is expected to resume the relationship with little knowledge as to “normal” post-treatment expectations. This is a common problem for managers because what their client tells them about treatment is minimal.

- Many treatment centers are now preparing written post-treatment plans in conjunction with their patients, but most patients do not give a copy of these plans to their family members and certainly not to their financial managers.

If the family has tied financial support to adherence to abstinence, compliance with the post-treatment plan, or passing drug/alcohol screens, then the manager would certainly need to know about these conditions.

Managers ask us how they will know if clients are doing well. Our answer is that the manager may not be in a very good position to evaluate progress. Clients usually maintain abstinence in early recovery by following their post-treatment plan, living within any financial or other agreed upon or imposed guidelines, and increasing their emotional stability. Avoiding past relationships or locations where drugs or alcohol were used is also another good indicator that they are doing well. Verbal interactions can be misleading. We prefer reports from counselors leading post-treatment recovery groups, therapists and supervised drug tests, rather than self-reporting from clients as measures of progress.

16. The relationship between the manager and the client will change

The client is used to the intimacy of treatment and will often not know what is appropriate or not appropriate to say. What the client previously held back as shameful or too painful to talk about is now easier for the client to express freely. As they say in treatment, “You are only as sick as your secrets!” One manager told us,

“You will learn a lot more than you want to know or thought you knew about your client.”

The problem the manager faces is the fear that if he or she is not a good listener, the client will become upset, given the emotional volatility of clients in early recovery (including post-withdrawal syndrome), and may arbitrarily ask for a change in managers.

The manager is one of the client’s few trusted people, and the client will feel free to share his or her feelings with them. Asking, “How are you?” can result in a 10-minute response. Not only is this more than you want to hear, but it cuts into time needed for a more productive conversation related to financial work. This type of long response can also limit the time for other clients, who then feel underserved. For offices where the fee is based on a percentage of assets, this type of client can be very expensive. For hourly-based services, the manager may simply not charge for these types of unrelated discussions. He/she may do this so as to not upset the client by sending a large bill for actual time incurred in conversations.

While family offices typically tolerate chatty clients talking about non-business related topics in order to maintain and solidify their client relationships, in this instance, the length or inappropriateness of the content indicates a need for professional help. Our colleague Terry Hunt, writes in his book *“Secrets to Keep, Secrets to Tell”* about the problem of people in recovery understanding appropriate “boundaries” regarding information-sharing and ability to discern interest in the listener. The manager will experience this problem firsthand. It is up to the office executive and family leadership to provide guidance and assistance to the manager.

Our advice is for the family office executive to hold a meeting with the client and manager in order to discuss how the family office can be supportive of recovery for the client. One purpose of the meeting would be to find out what therapeutic help the client is receiving (or is supposed to receive). Roles would then be clarified between the manager/family office and therapist(s). Then the manager can gently suggest that the client discuss some issues with the therapist rather than continue on with the manager. Finding out what medications the client is on and who is prescribing the medications (General Practitioner, Psychiatrist, or Psychiatrist who is a Certified Addiction Specialist) is also important information to know.

Do not assume the financial manager will ask for help in discussing these problems or think that once the client leaves treatment, the demands on the manager will decrease and return to normal.

17. Behavior expectations for clients in recovery

As we discussed above, there will be a post-treatment plan with specific performance expectations. In this regard, it is compliance that counts, not intentions (*“I was going to go the meeting, but Mom called and I needed to talk to her.”*) This is not acceptable.

However, the manager may have no idea as to the contents of this post-treatment plan. There will be an expected change in communication content and style between the client and office personnel. But what about the actual day-to-day activities of the client? What changes can be hoped for?

First, the addict is to avoid usual and customary environments where past use of drugs and alcohol occurred, including friends and colleagues who are drinkers, users or partiers. Cocktail parties, country clubs, bars and friends are to be avoided early on. Examples of situations leading to relapse include:

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

For colleagues in a family business, it is advised to have a private side conversation about repercussions (job loss) if colleagues are found drinking, using, or distracting the client from recovery activities.

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

- Parents believing son was told at treatment that he should stop using cocaine, but it was OK to drink beer
- Wife was told marijuana was permissible because it is non-addictive
- *"I will have Diet Coke at the bar after playing golf with my buddies and have no problem with not drinking."*

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

If there is any question about these assertions, speak with a licensed alcohol and drug counselor. Also, some alcoholics will drink "non-alcoholic" beer, which has a .005 alcohol content (and may drink a lot of it). Unfortunately, even a small amount of alcohol triggers the addictive brain receptors and can lead to the emotional responses reflective of the controlled drinker or dry drunk syndrome.

Conclusion

18. Managers are being asked directly or indirectly by their clients to provide emotional support

The client-manager relationship can develop into a very personalized helping process. As conversations initiated by the client become more detailed as to the problems the client or immediate family members face, the personal information shared is much more appropriate for a therapist rather than a financial manager. Yet managers feel obligated to listen, even when there is no hourly fee, causing the manager to take time away from other clients.

Managers often have the longest standing, non-blood relationships with the client and are trusted because of their history with the client (more than spouses, who turn over and are often marginalized by their in-laws). However, few are adept at directing their clients to use other, more appropriate resources or know how to divert or avoid personal topics with clients. In reviewing the role of the manager as “helper and personal problem solver,” managers are operating outside the scope of their expertise and training, resulting in ineffective help for clients and personal and financial cost to family and wealth management offices.

Financial and legal backgrounds are poor preparation for being effective in dealing with health and addiction related problems of clients. The client may ask the manager to research places to obtain help, find information about a health problem, or the best therapies or treatments for a specific problem or disease. Even such important decisions, as locating a good treatment center, are given over to the manager. Responding to the client request, with little thought to the significance of the choice and lack of expertise by the manager, is a recipe for a disaster, as it sets up a relapse scenario all too common for wealthy families. As we have emphasized throughout this article, if managers keep these requests to themselves, the problems generated by their dysfunctional clients can be so great that they are unable to do their jobs effectively.

By discussing these issues, managers are able to bring a more open and objective perspective to their client relationships. Viewing addiction and mental health problems as statistically probable and, therefore, likely to exist in each manager’s client base, allows office executives and family leaders to create an atmosphere where managers are expected to identify and report on these matters as soon as they suspect a problem. If a manager has a caseload of ten or more clients, it would be expected that at least 20% would have significant enough problems to warrant ongoing supervision from the office executive and therefore, ongoing information sharing with the executive by the manager.

Harm Prevention

Our advice to office executives and family leaders is to not expect financial managers to respond effectively to clients with addictions or other dysfunctions or to take responsibility for managing problem clients. Managers are not in a position to be effective in these roles in terms of authority or job security. They lack the skills or training to be responsive to client needs. After a 30-year-old client died from a drug overdose, his financial manager said,

“I wish something had been done sooner to help him. He had been in trouble for a long time.”

This client had his first alcohol-related driving accident at 15, which was before it was even legal for him to drive. The manager had 15 years of information about this young man’s decline, yet was unable to interact with family leaders or his office executive so the client could get the help he needed to recover.

Family offices, whether separate or in the family business, are replete with similar examples of next generation young adults whose serious problems are left unattended because they are expected to be managed by low authority, untrained personnel. Clients with behavioral problems must be attended to by the office executive and family leadership, working together and advised by a seasoned professional. These clients take office and family time. Hiring skilled counselors is expensive. However, when problems first surface, it is far better to invest early on, in both time and professional advice.

In our experience, waiting for the client to seek help allows the disease to progress, may make recovery nearly impossible, and increases time and expense. Addiction and related behavioral disorders are not “straight line” illnesses. They are more like a roller coaster where the ride slowly climbs to an apex and then accelerates to the bottom. The goal of the family is to catch the illness on its way up. This is because people with money have a rough time on the ride down, which is very difficult to stop. Early intervention requires a proactive mindset by family leaders, purposeful governance documents, and positive expectations that family members will receive the benefits of monetary and non-monetary legacies. It also require a willingness to find and use qualified, licensed help.

In our other articles and on our website, we present detailed information about how to effectively combat addiction, including our discussion of highly successful recovery models that can be applied to family businesses and related enterprises.

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