Methods for Managing Difficult Beneficiaries

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TABLE OF CONTENTS

I. Introduction 1
II. Substance Use Disorders 2
A. Methods for Raising the Issue With Clients in the Planning Phase 2
B. Drafting for Substance Use Disorders 3
III. Mental Health 6
A. Methods for Raising the Issue With Clients in the Planning Phase 6
B. Drafting for Mental Health Issues 7
C. Personality Disorders 9
IV. Autism Spectrum Disorder and Other Special Needs 11
A. Impact and Implications of ASD and Special Needs in the Planning Context 11
B. Spotting Beneficiaries With ASD 12
C. Drafting for Autism Spectrum Disorder and Other Special Needs 13
V. Protecting Beneficiaries Who Cannot Protect Themselves 15
A. The Professional Trustee 15
B. The Corporate Trustee 16
C. The Observer 17
VI. Absolute Discretion and Fiduciary Liability 18
VII. The Important Role For Attorneys In Addressing Behavioral Health 19
VIII. Attorney Ethics Issues and Liability Concerns 20

I. Introduction

What is behavioral health and why does it matter to me? I'm a lawyer.

The definition of behavioral health is not completely consistent in the pedagogical literature on the subject, however, it is generally considered to cover the full range of mental and emotional well-being. This includes, among other items: How we cope with day-to-day challenges of life, mental illnesses such as depression or personality disorder, and substance use disorders and other addictive behaviors.

Study after study has shown that the behavioral health of attorneys ranks poorly as compared even to general societal norms. In 2018, the Harvard Business Review published the results of a study that determined legal practice to be "the loneliest kind of work".[1] However, jobs involving a high degree of social interaction seemed to result in happier people. "At the other end of the spectrum were occupations involving high degrees of social interaction: social work, marketing, and sales."[2]

According to a study co-funded by the American Bar Association and the Hazelden Betty Ford Foundation, the results of which were released in 2016, attorneys have alcohol use problems at almost twice the rate of highly educated workers across other professions.[3] Nearly 1/3 of attorneys struggle with depression, and almost 1/5 of attorneys show symptoms of anxiety.[4]

In the context of estate planning, which often includes helping families through business transitions and resolving family strife (both in and out of court), that means that some of the people with the poorest behavioral health are being asked to assist others in managing situations that often involve working with individuals who have mental health issues or addiction. It's like asking a person with impaired vision to guide you through a dark cave.

Other studies show that attorneys have a much lower emotional intelligence than the general population, meaning they generally are less empathetic, less perceptive to non-verbal cues, and less likely to understand how to help calm the waters when the communication among family members becomes complex. George Bernard Shaw once said, "The single biggest problem in communication is the illusion that it has taken place." As attorneys, we may believe that a meeting among family members will solve all problems; however, if true communication does not occur at a meeting, then issues will not be resolved. Setting the right environment for

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[1] Shawn Achor et al., *America's Loneliest Workers, According to Research*, HARVARD BUSINESS REVIEW, March 19, 2018, available at https://hbr.org/2018/03/americas-loneliest-workers-according-to-research (last visited October 7, 2018).

[2] *Id.*

[3] Patrick R. Krill et al., *The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys*, JOURNAL OF ADDICTION MEDICINE, January/February 2016, Volume 10, Issue 1.

[4] *Id.*

communication is important. The practical reality for estate planners, however, is that we are part of a profession full of people less likely to perceive how to facilitate communication, yet we are often asked to fix things with a family's squeaky wheel.

Not only for our own behavioral health, but also for the behavioral health of our clients, it is important for estate planning attorneys to consider their own skills and capabilities in this arena. While we can take efforts to improve our own behavioral health and emotional intelligence, it is important to keep in mind other behavioral health resources that can support our efforts in assisting families. Mark Twain wittily noted, "The difference between the right word and the almost right word is the difference between lightning and a lightning bug." While we may get close to being just what the family needs, if we do not possess the skill set to implement a solution, that gap may be more significant than we realize.

II. Substance Use Disorders

It is not unusual for a client to confide that a child or grandchild has a substance use disorder. On the flip side, clients sometimes do not reveal the substance use disorder because they are ashamed or do not want to embarrass their loved one. Sometimes, clients are in denial about the fact that substance use disorders are a forever illness and that someone who has been sober for years can always relapse.

A. Methods for Raising the Issue With Clients in the Planning Phase

"Many people don't understand why or how other people become addicted to drugs. They may mistakenly think that those who use drugs lack moral principles or willpower and that they could stop their drug use simply by choosing to. In reality, drug addiction is a complex disease, and quitting usually takes more than good intentions or a strong will. Drugs change the brain in ways that make quitting hard, even for those who want to."[5]

Because of the societal stigma attached to substance abuse, it is often difficult for clients to open up about the fact that they are asking for the attorney to create an estate plan for a beneficiary who is a recovering substance user. If the loved one has been clean for many years, it may also be difficult for the client to recognize that relapse can occur even after long periods of sobriety.

Many attorneys use an estate planning questionnaire that they provide to clients prior to the first meeting. Consider including a question that addresses substance use disorder, perhaps with other special issues that are clearly not anyone's "fault" to avoid negative connotation. For example,

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[5] Understanding Drug Use and Addiction, NIH National Institute on Drug Abuse; available at https://www.drugabuse.gov/publications/drugfacts/understanding-drug-use-addiction (last visited October 7, 2018).

"Do any of the individuals you are thinking about benefitting under your estate plan have special needs, a history of mental health issues or substance use disorder?" If the clients' answer "no", then it is unlikely they will talk about it. But if they answer "yes", that opens the door for more conversation to be had face-to-face and in a way that the attorney can be prepared to tread lightly rather than stepping on a landmine during the meeting.

B. Drafting for Substance Use Disorders

Beneficiaries with substance use disorders are often highly intelligent, well-educated, high-functioning and uniquely clever. Although substance use can cloud certain aspects of mental acuity, the chemical need inspired by alcohol and drugs impact the brain to reduce the user's self control. Long-term drug use causes changes in the brain and other chemical systems of the body and can affect functions such as judgment, decision-making, stress, memory and behavior.[6] In short, the drugs push good people to lie to and manipulate loved ones and those possessing something the substance user needs to feed the addiction. The fact that substance users are often good at hiding in plain sight and may be otherwise unimpaired, makes estate planning around substance use disorder particularly challenging.

In the trust scenario, a substance abuser will often attempt to skirt "support" language or other restrictions by complying with the rules set forth. For example, the beneficiary might ask the trustee to pay for necessities such as health insurance, medical bills, rent, food and clothing so that the beneficiary can use his other income to pay for drugs or alcohol.

Across U.S. jurisdictions, the law typically provides that as long as a trustee administers the trust in good faith and within the limits of sound discretion, a court will not interfere with that discretion or undertake to substitute its discretion for that of the trustee.[7] Beneficiaries may seek relief from the court for a breach of the duty of loyalty, however, the court generally cannot interfere with a trustee's actions taken pursuant to the provisions of a trust instrument unless the actions were arbitrary, in bad faith, or outside of the trust's authority.[8] Consistent with a

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[6] *See id.*

[7] *See Rock Springs Land and Timber, Inc. v. Lore*, 75 P.3d 614 (Wyo. 2003) ("To the extent to which the trustee has discretion, the court will not control his exercise of it as long as he does not exceed the limits of the discretion conferred upon him, *citing* AUSTIN W. SCOTT & WILLIAM F. FRATCHER, THE LAW OF TRUSTS §187 [2d ed. (1956) at 1374]. *U.S. v. O'Shaughnessy*, 517 N.W.2d 574, 577 (Minn. 1994) ("So long as the trustees act in good faith, from proper motives, and within the bounds of reasonable judgment, the court will not interfere with their decisions"); *Hopkins v. Cleveland Trust Co.*, 127 N.E.2d 385, 390 (Ohio 1955); Restatement (Second) of Trusts §187 (1959) ("Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion").

[8] *Kloha v. Duda*, 246 F. Supp.2d 1237, 1241 (M.D. Fla. 2003), *citing In re Moir Hotel. Co.*, 186 F.2d 377, 382 (7th Cir. 1950) ("So long as a trustee is exercising discretionary powers conferred upon him, honestly and reasonably, a

fundamental principle of trust law that the grantor's intent controls, the court should abide by the plain terms of the trust instrument.[9] Because full discretion is such a powerful tool that virtually permits a trustee to be able to say no for any good faith reason, it can be argued that full discretion without further mention of substance abuse is the best route to avoid having the beneficiary be able to force distributions.

On the other hand, if the trustee is not familiar with the beneficiary or may not have the physical proximity or perception to be aware of the beneficiary's drug-seeking behaviors, giving the trustee a "heads up" may be a good idea. The question then becomes, "how far do I go?"

A knee-jerk reaction is to include a provision that limits distributions without proof that the beneficiary is substance-free. With marijuana for medicinal purposes or without restriction legal in many states, with alcohol being legal if an individual is over 21 and with legal medicinal purposes for other substances, how does one define "substance-free"? And even if the attorney and client are able to agree on an appropriate definition for that phrase, what proof is required? Most trustees do not want to be placed in a position where they have to demand a drug test on a regular basis. And if a beneficiary refuses to take a drug test and then sues the trustee for violating the beneficiary's rights, that scenario will not be fun or economically prudent for either the beneficiary or the trustee.

Corporate fiduciaries, in particular, hate clauses that require drug tests because they are educated trustees and know the problems these provisions create. One trust officer recounted an experience where his employer institution was serving as trustee of a trust that required cessation of distributions if the trustee had "reason to believe the beneficiary was using illegal substances." The beneficiary and her spouse went through a bitter divorce, and the former spouse was aware of the provision. He began calling the institution to report that the beneficiary was abusing drugs. The trust officer avoided the calls for several months because he did not want to have "actual knowledge" that would require him under the terms of the trust to force the beneficiary to submit to drug testing, particularly when the trust officer suspected the call was being made out of spite and not due to real drug issues.

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court … has no right to interfere"). *See Scott v. Arden Farms Co.*, 28 A.2d 81 (Del. Ch. 1942) (holding that voting trust certificate holders were bound by the voting trustees' acts if those acts were done in good faith and within the scope of their authority); *Warehime v. Warehime*, 761 A.2d 1138 (Pa. 2000) (noting that, because the trustee had acted in good faith and did not act for his own personal benefit, the trial court found he did not violate his fiduciary duties as voting trustee).

[9] *Warehime v. Warehime*, 761 A.2d 1138 (Pa. 2000) (reversing the decision of the appellate court for straying from the plain terms of the trust agreement, which required only that the trustee exercise his best judgment and act in good faith).

Some drafters have suggested taking a softer approach. For example, placing a more elaborate qualifier on discretionary distribution authority, such as:

> *In determining whether a discretionary distribution to a beneficiary should be made, the trustee may consider whether the beneficiary is under the influence of drugs or alcohol such that the beneficiary's ability to manage financial affairs is impaired.*

That type of language also places the trustee in a conundrum and subjects the trustee to possible liability. If we apply this standard to a hypothetical situation where a beneficiary is clearly using drugs in a manner that is apparent to those who know him well, the issues with this approach become apparent. As with many substance abusers, the beneficiary is smart and clever, and uses those skills to his advantage in dealing with people to obtain the funds he needs to feed his addiction. The trustee and the beneficiary speak on the phone periodically, and the trustee is completely fooled by the beneficiary's appearance of perfect sobriety on their calls. The trustee writes the beneficiary a $10,000 check for beneficiary's vacation, but it turns out that beneficiary actually uses that money to buy drugs, then gets behind the wheel and seriously injures several people in a crosswalk when the beneficiary runs a red light because he was driving while under the influence. When the individuals sue to recover for their injuries, they include claims against trustee, who enabled beneficiary to have the funds to get high and should have known better. More than half the states have social host liability statutes. It is not impossible to envision an effort to expand the concept in the scenario above.

The concept of requiring a beneficiary to have regular drug tests is generally recognized as a recipe for litigation, and so options that produce less friction should be considered. For example, consider having distributions made directly to service providers or to have the trustee require receipts or other proof of payment in order for the beneficiary to receive cash. Although a clever beneficiary could find a way to game this system as well, it at least provides some reasonable formal proof that a trustee can rely on regarding the legitimacy of an expenditure.

While mandatory distributions generally may be less preferable for beneficiaries known to have substance abuse disorder, there are circumstances where mandatory distributions may be what the client decides are appropriate. Trusts that require mandatory distributions may warrant special consideration to give the trustee extra flexibility to hold back distributions if the trustee feels the funds will endanger the beneficiary or others. Rather than hinge the holdback on drug testing or relapse, consider giving the trustee discretion such as:

> *In the event that a beneficiary shall become entitled to a distribution of income or principal, but that beneficiary by reason of illness (including substance abuse disorder) or mental or physical disability, is, in the sole discretion of the Trustee, unable properly to administer such amounts, then such amounts may be retained*

in trust for the benefit of the beneficiary and used by the Trustee directly for the best interests of said beneficiary.

This provision allows the trustee to withhold the distribution, but also requires the trustee to have a reasonable belief that withholding is necessary. This standard may be more subject to court interference, however, it at least provides the trustee with the ability to act in the beneficiary's best interests when a mandatory distribution might do more harm than good.

Drafting with knowledge of an addicted beneficiary allows for consideration of appropriate options given the circumstances of the actual people involved. Many trusts drafted today as generation-skipping trusts, however, may continue for generations. The beneficiary who has a substance abuse problem 75 years from now probably is not born yet and may be addicted to a substance that does not even exist on the market today. A provision like the one above included in boilerplate of trust agreements is one idea to consider affording trustees flexibility to deal with unforeseen substance use disorder among trust beneficiaries.

III. Mental Health

A. Methods for Raising the Issue With Clients in the Planning Phase

Mental health conditions are incredibly prevalent in the United States. According the National Institute of Mental Health, it is estimated that only half of people with mental illnesses in the U.S. receive treatment.[10] Nearly one in five U.S. adults lives with a mental illness,[11] which includes mental, behavioral or emotional disorders ranging from mild to severe. Approximately 4.2% of all U.S. adults are estimated to have a serious mental illness.[12]

Individuals who suffer from mental illness and their families often struggle with the societal stigma placed on such disorders. Families sometimes try to hide the diagnosis from the outside world and are ashamed that they have a family member with a mental illness.

Having a full discussion about mental illness, therefore, may not be something clients are willing to do. In addition to the technique of including a soft question about mental illness on an intake

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[10] Statistics, NIH National Institute of Mental Health, *available at* https://www.nimh.nih.gov/health/statistics/index.shtml (last visited October 13, 2018).

[11] *See id.*

[12] *See id.*

questionnaire, it may be a good idea to ask clients during a meeting, as a matter of course, if any of the potential beneficiaries of their estate plan have special considerations.

In any event, adding a catch-all like the one provided in the section of this outline on substance abuse will provide a bit of a safety net in situations where clients are not forthcoming about the beneficiary's mental illness. Such a clause may also be helpful in situations where the mental illness has not surfaced prior to the drafting of the document or during a period when it is easily modified.

B. Drafting for Mental Health Issues

An attorney who is alerted to the fact that a potential beneficiary suffers from mental illness needs to gather as much information about the individual's condition as possible in order to consider what tools in the drafting toolbox will be appropriate to ensure the safety and well-being of the beneficiary. Considerations include:

- Whether the beneficiary has a formal diagnosis and is under regular treatment
- What the prescribed course of treatment is and whether it is anticipated to continue or need periodic modification
- Whether the beneficiary will be able to live alone and/or will need supportive services
    - For example, can the beneficiary drive, or is he directed not to do so because of his medication?
    - Does the beneficiary have anxiety leaving the house such that someone may need to run errands?
    - Is there anyone to visit the beneficiary regularly to do well-being checks and to ensure the beneficiary stays on his treatment plan?
- The presence of family or friends to provide support to the beneficiary if the current support network passes away (particularly relevant for parents of an adult child with mental illness)

Unless the estate planner takes time to become educated about the beneficiary's condition and needs, it will be difficult to craft the proper trust to support the beneficiary without unnecessarily restricting independence and participation. There is substantial information available on the internet from reliable sources such as the National Institute of Mental Health and Psychology Today (www.psychologytoday.com), meaning there is no need for planners to enter blindly into drafting for a condition with which they are not familiar. Deploying emotional intelligence and making an effort to have a full understanding of the situation may save the trustee headaches down the line when he or she is trying to administer what the estate planner has drafted.

When drafting for individuals with mental health issues, clients may want to consider making distributions (or broader distributions beyond basic support) contingent on ongoing compliance

with a treatment program. Such restrictions should be permissible. *Claflin v. Claflin*. *Claflin*, an 1889 Massachusetts case, established the principle that trust restrictions cannot be set aside simply because a property interest exists. The testator, Wilbur F. Claflin included an article in his will that required his trustees to sell his personal estate and to then divide it into thirds to support his wife and children.[13] The proceeds for his son, Adelbert, were to be held in trust and distributed at age twenty-one, twenty-five, and the remainder at thirty.[14]

Following Adelbert's twenty-first birthday, but prior to his twenty-fifth birthday, he brought suit to compel the trustees to pay him the remainder of his trust.[15] Adelbert argued that the provisions of the will postponing payment were void because his interest in the trust was vested and absolute.[16] The Massachusetts Supreme Court agreed that Adelbert's interest was vested and absolute, but also found that the directions of the testator to his trustees were not against public policy or so inconsistent with Adelbert's property rights that the provisions should be given immediate effect.[17]

The focus on trust restrictions has shifted away from a purpose analysis to a public policy analysis. Case law across the U.S. has reached a point where today a settlor may condition receipt of the trust income or corpus as long as the conditions are not ambiguous, illegal, against public policy, or impossible to satisfy.

While legality of the provision is unlikely to fall into any of the categories that would invalidate a condition of a trust, thought should be given to practical enforceability. Unless the beneficiary signs a HIPAA release or instructs their psychologist or other medical or behavioral health providers to notify the trustee that the beneficiary is making his appointments, the trustee may not be able to gather such information. Absent clear indicators that the beneficiary is not taking his medication or cooperation with blood tests to confirm the presence of medication, again, the trustee will not be able to gather information about medication compliance. Therefore, a client may need to be willing to condition receipt of funds on voluntary compliance with reporting by the beneficiary if the restrictions are going to work in real life.

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[13] *Claflin v. Claflin*, 20 N.E. 454, 455 (Mass. 1889).

[14] *Claflin*, 20 N.E. at 455.

[15] *Id.*

[16] *Id.*

[17] *Id.* at 456.

C. Personality Disorders

According to statistics from the National Institute of Mental Health ("NIMH"), approximately 9% of adults in the United States have personality disorders, including anxiety, mood, impulse control and other disorders.[18] Almost 2% of adults in the United States suffer from borderline personality disorder, which is in the class of personality disorders, but is often addressed separately in the literature.[19]

NIMH explains the distinction:

> *Personality disorders represent "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture" per the Diagnostic and Statistical Manual on Mental Disorders, Fifth Edition (DSM-5). These patterns tend to be fixed and consistent across situations and leads to distress or impairment.*
>
> *Borderline personality disorder is a serious mental disorder marked by a pattern of instability in moods, behavior, self-image, and functioning. These experiences often result in impulsive actions and unstable relationships. A person with borderline personality disorder may experience intense episodes of anger, depression, and anxiety that may last from only a few hours to days.*

With only around 40% of individuals with personality disorders and borderline personality disorder receiving treatment, the odds of an individual with an untreated personality disorder becoming a client or a beneficiary under an estate plan are fairly high. In borderline personality numbers alone, that is approximately 14 million people in the United States with this mental health issue, and nearly 8.4 million of them are not receiving treatment.

Those difficult beneficiaries who love someone one day and then turn on a dime to strong dislike and mistrust may be suffering from a mental health issue that necessitates compassion and an understanding to attempt to have them seek help. There generally are considered to be 10 main types of personality disorders.[20] They are subdivided into three groups, and classified as follows:

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[18] Personality Disorders, NIH National Institute of Mental Health, *available at* https://www.nimh.nih.gov/health/statistics/personality-disorders.shtml (last visited November 18, 2018).

[19] *Id.*

[20] The 10 Personality Disorders: A Short, Sharp Look Into the 10 Personality Disorders, PSYCHOLOGY TODAY, available at https://www.psychologytoday.com/us/blog/hide-and-seek/201205/the-10-personality-disorders (last visited November 18, 2018).

Cluster A (Odd, bizarre, eccentric) - Paranoid, Schizoid, Schizotypal; Cluster B (Dramatic, erratic) - Antisocial, Borderline, Histrionic, Narcissistic; Cluster C (Anxious, fearful) - Avoidant, Dependent, Obsessive-compulsive. While all of these personality disorders can cause a beneficiary to create problems within the family dynamic, borderline personality disorder causes particular turbulence.

People with borderline personality disorder feel very uncertain about themselves, and so their opinions and values can quickly change. They tend to view things in extremes, such as all good or all bad. The NIMH describes the following additional signs or symptoms that may indicate borderline personality disorder:

- Efforts to avoid real or imagined abandonment, such as rapidly initiating intimate (physical or emotional) relationships or cutting off communication with someone in anticipation of being abandoned
- A pattern of intense and unstable relationships with family, friends, and loved ones, often swinging from extreme closeness and love (idealization) to extreme dislike or anger (devaluation)
- Distorted and unstable self-image or sense of self
- Impulsive and often dangerous behaviors, such as spending sprees, unsafe sex, substance abuse, reckless driving, and binge eating. Please note: If these behaviors occur primarily during a period of elevated mood or energy, they may be signs of a mood disorder—not borderline personality disorder
- Self-harming behavior, such as cutting
- Recurring thoughts of suicidal behaviors or threats
- Intense and highly changeable moods, with each episode lasting from a few hours to a few days
- Chronic feelings of emptiness
- Inappropriate, intense anger or problems controlling anger
- Difficulty trusting, which is sometimes accompanied by irrational fear of other people's intentions
- Feelings of dissociation, such as feeling cut off from oneself, seeing oneself from outside one's body, or feelings of unreality[21]

People with borderline personality disorder have been described as "interpersonal tornadoes", and the literature acknowledges that even psychiatrists dislike dealing with such patients, in part because they are so difficult to help.[22]

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[21] Borderline Personality Disorder, NIH National Institute of Mental Health, available at https://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml (last visited November 18, 2018).

Individuals with borderline personality disorder are much more likely to hurt themselves or to commit suicide. Helping families to have a conversation with their interpersonal tornado can be a great service to clients. There are many resources to help with initiating these conversations. Beginning the conversation with an expression of concern about a particular behavior or emotion, and then offering to help, seems to be the general recommendation. The government's mental health resource site offers specific suggestions on questions to initiate the discussion.[23]

Helping clients to find the proper support structure is a tremendous service to them. There are many organizations that provide assistance and information to family members of individuals suffering from mental illness. NAMI is a nationally known organization that provides significant resources for family members and caregivers.[24]

IV. Autism Spectrum Disorder and Other Special Needs

A. Impact and Implications of ASD and Special Needs in the Planning Context

Clients tend not to be forthcoming about special needs of a potential beneficiary. When a child has ASD or other special needs, parents may be in denial about their child's special needs, which can make conversation about safeguards within an estate plan structure difficult to discuss effectively. Parents of a child with special needs also often are hesitant to define "limitations" on what their child may or may not be able to do as an adult. Having a frank but gentle discussion about best case scenario and worst case scenario can facilitate a discussion about reasonable restrictions and mechanisms to expand or retract those restrictions with a trust that is or becomes irrevocable.

Family members with special needs can impact the entire family system and cause a reorganization of that system. Members of the family can become protective or resentful. The family may revolve around the needs of the individual requiring special care. Primary caretakers may exhibit depression and stress from the added duties involving the special needs individual, and the results of that behavioral health situation may impact the family as well.

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[22] Elizabeth Svoboda, *The Chaos Borderline Personality Disorder Can Cause*, PSYCHOLOGY TODAY, *available at* https://www.psychologytoday.com/us/articles/201309/the-chaos-borderline-personality-disorder-can-cause (last visited November 18, 2018).

[23] Mentalhealth.gov, Let's Talk About It, Friends and Family Members, *available at* https://www.mentalhealth.gov/talk/friends-family-members (last visited November 18, 2018).

[24] *See* https://www.nami.org/Find-Support/Family-Members-and-Caregivers (last visited November 18, 2018).

Siblings of special needs individuals may feel less important and resent the increased attention afforded to the special needs sibling. As siblings age, they may also resent the amount of resources being spent on the special needs family member, particularly if they feel as though they are being deprived of things they want because the resources are diverted to the special needs person. This emotional history may surface when parents are gone, particularly if the special needs beneficiary and the other sibling are beneficiaries of the same trust, creating an ongoing financial interdependence.

Being aware of the emotional and psychological effects that ASD and other special needs can have on a family may allow the structuring of a trust in a way that reduces the likelihood of litigation. Hoping for the best but not planning for the worst may exacerbate the very real impact that living with special needs may have on individuals without special needs.

B. Spotting Beneficiaries With ASD

While severe autism and many other special needs usually will be easy to spot, autism is a spectrum disorder, and some individuals on the autism spectrum are high functioning. They may seem just quirky or eccentric, and so being aware of the signs that may indicate someone has Autism spectrum disorder (ASD) can be helpful in working with beneficiaries. ASD is what is called a "developmental disorder" because symptoms generally appear within the first two years of life.[25] ASD affects communication and behavior, and people with ASD generally have difficulty communicating and interacting with others and often exhibit repetitive behaviors. Some of the common behaviors of individuals with ASD include:

- Making little or inconsistent eye contact
- Tending not to look at or listen to people
- Rarely sharing enjoyment of objects or activities by pointing or showing things to others
- Failing to, or being slow to, respond to someone calling their name or to other verbal attempts to gain attention
- Having difficulties with the back and forth of conversation
- Often talking at length about a favorite subject without noticing that others are not interested or without giving others a chance to respond
- Having facial expressions, movements, and gestures that do not match what is being said
- Having an unusual tone of voice that may sound sing-song or flat and robot-like

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[25] Autism Spectrum Disorder, NIH National Institute of Mental Health, *available at* https://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd/index.shtml (last visited October 13, 2018).

- Having trouble understanding another person's point of view or being unable to predict or understand other people's actions
- Repeating certain behaviors or having unusual behaviors. For example, repeating words or phrases, a behavior called *echolalia*
- Having a lasting intense interest in certain topics, such as numbers, details, or facts
- Having overly focused interests, such as with moving objects or parts of objects
- Getting upset by slight changes in a routine
- Being more or less sensitive than other people to sensory input, such as light, noise, clothing, or temperature[26]

The recommended tips for working with individuals who have ASD may be helpful communicating with beneficiaries who exhibit the characteristics on the list above, even if the beneficiary does not actually have ASD. There are many resources publicly available to learn about working with individuals with ASD.[27] For example, organizations skills are often a challenge for individuals with ASD, so providing written checklists and reminders may facilitate the trustee receiving information he needs to approve or deny distributions. Sensory input can be a challenge for individuals with ASD, so keeping the number of people in the room to a minimum and finding a quiet place to meet may help with interactions. Lack of structure can be difficult for ASD individuals, so providing an agenda and then sticking to that agenda may facilitate a better meeting as well.

C. Drafting for Autism Spectrum Disorder and Other Special Needs

Particularly with ASD, it can be difficult to know whether a beneficiary will be able to live independently until the beneficiary is an adult. Drafting with flexibility in mind, therefore, is particularly important in such situations.

Next to providing flexibility to adapt to changes in circumstances with respect to the special needs beneficiary, choice of trustee is paramount. The Rhode Island case *Sargent v. Sargent*[28] is instructive of the issues that can result to all involved when there is a poor choice of trustee.

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[26] *See id.*

[27] *See, e.g., Autism Awareness Month: Tips for Working with Individuals on the Autism Spectrum*, Indiana Resource Center for Autism, *available at* https://www.iidc.indiana.edu/pages/autism-awareness-month-a-facts-andtips-for-working-with-individuals-on-the-autism-spectrum (last visited October 13, 2018).

[28] *Sargent v. Sargent*, C.A. No PC08-1429, *available at* https://www.courts.ri.gov/Courts/DecisionsOrders/08-1429.pdf (last visited October 14, 2018).

Diane Sargent was survived by four adult children, Kennett, Jeffrey, Lisa and Pamela. Pamela was named as successor trustee under Diane's revocable trust, which included provisions establishing a special needs trust for Kennett. From 1999 through December 2004, Pamela had made no distributions to or for Kennett. Kennett and Jeffrey filed a lawsuit against Pamela in 2004, and renewed their petition to remove Pamela as trustee in 2007. The court appointed a GAL for Kennett in 2007, and the GAL concluded that Pamela had "act[ed] arbitrarily in denying distributions to Kennett for his health, maintenance and support."[29]

The terms of the trust for Kennett directed the trust to use her "best judgment and fiduciary duty" to maintain available public resources for Kennett and to provide for Kennett so that he was "maintained at a level of human dignity". Pamela was advised by both her own attorney and Kennett's attorney that purchasing a condominium for Kennett would not impact his social security benefits. Kennett, who had bipolar disorder and was a recovering substance user who had been clean and sober for some time, was living in Boston, had found a position doing volunteer work at a charity, and had made friends and was happy. The building where Kennett resided was being sold and his SSDI did not provide enough funds for him to put a deposit on another apartment in Boston. Without money from his trust, Kennett was forced to move to Providence to live with Lisa, where he became depressed about losing his volunteer work and friends in Boston, relapsed into alcohol use, and attempted suicide.

Pamela admitted that she was never "terribly close" with Kennett, was not in regular contact with him, and knew nothing about his life. She had insisted he provide correspondence from the Social Security Administration about the benefits he was receiving and that a distribution from the trust would not disqualify Kennett from receiving benefits. In short, rather than put any effort into learning about Kennett's needs, public benefits or the applicable rules, she transferred to the special needs trust beneficiary the burden of proof. In fact, Kennett testified that Pamela never spoke with him, called or visited him after their mother's death.

Not surprisingly, the court found that Pamela "did not perform even the most basic duties of a special needs trustee, i.e., educating herself as to the type of benefits Kennett was receiving." The court held that Pamela "breached her duty to administer Kennett's special needs trust in accordance with its terms by acting arbitrarily and without knowledge of, or inquiry into, Kennett's basic life circumstances".[30]

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[29] *Id.* at p. 5.

[30] *Id.* at p. 19.

V. Protecting Beneficiaries Who Cannot Protect Themselves

Kennett Sargent, despite his tough times, was relatively fortunate. He had his sister Lisa who cared about him and who provided a place for him to live when his trustee did not expend his trust funds to provide for him as intended by his mother and as specified in the trust agreement. He had the ability to find a lawyer and to challenge what was being done (or not done) by his trustee, ultimately being successful in protecting his own interests.

Cases like Sargent might lead to the conclusion that choosing a professional trustee is all that is needed. As the following two cases, demonstrate, however, unsupervised professionals can be as imperfect a choice as indifferent family members.

A. The Professional Trustee

The matter of A'Yana McDonald involves a "professional" special needs trustee, Melodie Scott.[31] A'Yana had been diagnosed with mild-moderate cerebral palsy, ADHD and seizures. She received a settlement from a lawsuit against a medical provider, and a special needs trust was established with approximately $220,000 in 2004. Although the trustee was required to file reports with court, she did not do so until July 2012, by which time she had expended all of the trust's funds, including a $15,000 "terminating" payment to A'Yana's mother.

A'Yana's court-appointed attorney filed objections. Among the objectionable items were $34,000 in trustee fees, payments for living expenses such as rent, phone bills, and vacations to Hawaii, London and Jamaica that included A'Yana's mother and other family members to the tune of $24,000, a car for A'Yana's mother, insurance and repairs on the car totaling approximately $25,000.

A'Yana's mother, who had benefited greatly from the trust distributions, testified in support of the trustee. The Trustee, however, was surcharged $95,000, which included repayment of her fees in full.

Trustee Scott argued on appeal that the lower court could not challenge her exercise of discretion unless there had been "an abuse of discretion". The appellate court, noted, "However, 'abuse of discretion' can also be defined as acting in an irrational manner…".[32] Rejecting Scott's arguments, the appellate court reversed only $1,000 of the surcharge.

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[31] *See Scott v. McDonald*, 237 Cal.Rptr.3d 137 (Cal. App. 4th Dist. 2018) (*review denied and ordered not officially published*).

[32] *Id.* (*citing Ajamian v. CantorCO2e, L.P.*, 203 Cal.App.4th 771, 804 (2012)).

In this instance, the trustee chosen, presumably during the course of the settlement of the case that led to the funding of the trust, purportedly was a professional specializing in special needs trusts. She was licensed, but not during 2 years of her trusteeship for A'Yana. Despite the trustee's experience that 75 percent of special needs trusts are court supervised, she never realized that she was supposed to be filing annual reports. In addition, she admitted in her testimony that she never looked at the trust instrument with regard to what authority she was granted because it was "a cookie-cutter special needs trust". Had the trustee not filed a final report to discharge herself for terminating the trust, the misapplication of A'Yana's funds might have gone unnoticed.

So perhaps the solution is to choose instead a more closely regulated and supervised trustee like a bank? That is often a good solution…but not always.

B. The Corporate Trustee

In the Matter of JP Morgan Chase Bank, N.A. (Marie H.)[33], the corporate trustee demonstrated that corporate fiduciaries are not always the perfect solution either for those who cannot protect themselves. Marie H. had adopted two children during her lifetime, Charles and Mark. Mark was severely disabled, so when Marie learned she had terminal cancer, she placed Mark in the Anderson School, which she felt was an appropriate residential placement for Mark. She left half of her estate, or nearly $3 million, in trust for Mark. She named her attorney, who held himself out as an expert in estate planning for children with intellectual disabilities, as co-trustee with the bank.

The court, by its own monitoring of Mark's situation, intervened and encouraged the co-trustees to retain the services of a care manager. During the nearly 4-year period between Marie's death and the retention of the care manager, only $3,525 of the nearly $3 million was spent on Mark's care. The bank and the lawyer, however, had received almost $50,000 during that same time period.

Prior to the judge's prompting, neither of the trustees had been to visit Mark. The trustees "left Mark to languish for several years with inadequate care, despite the fact that the Mark Trust had abundant assets."[34] The happy note to this case is that, with proper care and use of his resources, Mark made tremendous improvement. He went from being nonverbal and needing help with all basic life activities to helping with his own laundry, clearing his plate and loading it into the

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[33] 38 Misc.3d 363 (Surr. Ct. 2012).

[34] *Id.* at 376.

dishwasher after meals, and waving goodbye. His brother, Charles, was able to begin having visits with Mark as well.

Although it was pleased with the action of the co-trustees once they were prompted into action, the court still noted that the failure of the trustees to fulfill their fiduciary obligations "should result in denial or reduction of their commissions for the period of their inaction."[35] Apparently, the bank's assertion that it lacked "institutional capacity to ascertain or meet the needs of [a] severely disabled, institutionalized young man"[36] was not convincing.

The court also summarized the dilemma of choosing and acting as a trustee for a beneficiary with special needs, whether substance use disorder, mental illness, or physical or mental disability. "The history brings into sharp focus the obligations of trustees, both individual and institutional, to the beneficiaries of trusts they administer when they know, or should know, that those beneficiaries have disabilities, and have medical, educational or quality of life needs that can and should be met from trust income."[37]

C. The Observer

As the cases discuss above reflect, failures of the system can occur even where they are least expected. With a beneficiary like Mark, who had no ability to call his co-trustees to task, he would have continued to languish had the court not performed its role with diligence. Unfortunately, failures occur in the judicial system as well.

And we have seen these failures occur even where famous figures are involved. Consider the cases of Mickey Rooney and Huguette Clark. So, how can we build systems that create a series of multiple checks and balances?

The biggest challenge with individuals who lack full capacity is their inability to raise the red flag when it is needed. Consider requiring reporting to someone other than the trustee on an annual basis. Or consider involving a care manager currently and pay them on an annual basis to check in on the beneficiary even while the parents or other family members providing care are living. If one or more people are asked to do the job of checking on the beneficiary and/or checking on the trustee, then there is an increased chance that inaction or neglect can be turned into action more quickly. Creating an advocate to fill the role that the beneficiary can usually fill for himself normalizes the balance of power usually seen with beneficiaries and trustees.

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[35] *Id.* at 379.

[36] *Id.* at 370.

[37] *Id.* at 377.

VI. Absolute Discretion and Fiduciary Liability

When a trustee is asked to serve under a trust instrument and is given absolute discretion to distribute funds or not to a beneficiary, that grant of power places a tremendous burden on the trustee. Where the beneficiaries are reasonable people without some of the challenges discussed above, this burden often is not onerous. For beneficiaries with challenges such as mental illness or substance abuse disorder, the trustee's job can make walking on a tightrope sound easy.

Historically, fiduciaries (and sometimes their counsel) have viewed trustee discretion as absolute and not subject to question by beneficiaries or by the courts. That is not the world we live in today. Statistics on malpractice claims against trusts and estates attorneys, as well as trends in fiduciary litigation, bear out that beneficiaries are more willing to sue than they were in "the good old days".

Trustees who choose to exercise their discretion to say "no" to a beneficiary, therefore, should be thinking about creating the record for a lawsuit. The trustee should consider putting in writing to the beneficiary the reasons for the denial of a beneficiary's request for funds. That written correspondence likely will want to touch on some or all of the following points:

- How the requested distribution does not fall within the terms and purposes of the trust
- That the trustee does not believe the distribution is in the best interests of the beneficiary because [insert reason].
- What information the trustee has to believe the beneficiary has a substance use disorder, mental illness or special needs.
- What steps the trustee is willing to take to help the beneficiary seek treatment, or the steps the beneficiary would need to take to give the trustee comfort about making some or all of the requested distribution.

Trustees are permitted to be incorrect, but they are not permitted to be negligent or hostile. Creating a record that the trustee had a reasonable belief and that the trustee communicated this belief and presented the beneficiary with steps to disprove the belief or to remedy the concern, can facilitate a more prompt resolution of litigation.

Hostility is a reason beneficiaries afflicted with substance abuse disorder or mental illness may allege to have a trustee removed from the scenario. Most courts will look at this hostility and will analyze whether it is actually or potentially (depending on the state) impairing the administration of the trust. In the end, the decision to remove a trustee usually turns on the behavior of the trustee. Are the beneficiaries just angry, or is the trustee actually neglecting or breaching its duties? Being able to demonstrate a reasonable approach by the trustee can combat allegations of hostility and may create leverage to push the beneficiary toward treatment.

VII. The Important Role For Attorneys In Addressing Behavioral Health

Society continues to stigmatize the concept of receiving behavioral health services. It can be difficult for a client or beneficiary to hear that you think they need to seek additional help. Behavioral health professionals, however, stress the importance of attorneys in a position of trust and confidence helping to resolve situations that need intervention. Often, individuals suffering from behavioral health issues struggle with secrecy and shame regarding their challenges, and may welcome an offer of assistance. Family members of individuals with substance use and other behavioral health challenges may need therapy themselves to learn how to best handle situations with their loved ones.

By talking about these issues, legal professionals can help to normalize these behavioral health difficulties, and by doing so, lessen the stigma. Many clients may not realize the high percentage of the overall population impacted by behavioral health challenges, and by discussing this reality, we may empower clients to seek the help they need to address their own issues or to learn the skills to manage the difficult behaviors of a loved one.

Behavioral health professionals advise that the approach taken in raising the topic is critical. Attorneys should do their best to raise the topic from the perspective of support and personal effectiveness. Equating behavioral health professionals to lawyers – people who help deal with a different subset of problems to make you feel better and be more effective in life – can be a useful approach.

There generally are three main types of outpatient behavioral health care. The first is psychological testing from a clinical psychologist. These professionals perform assessments and diagnostic work-ups to help determine a diagnosis and to recommend the next steps for treatment. This type of testing may be a good starting point when the difficult party seems to have complex or unclear issues.

Psychiatrists are the second type of outpatient care. They generally supervise a patient's medication, but most do not provide therapy or assistance with broader family impact issues.

The third type of outpatient care is available through behavioral health counselors and psychotherapists. There are different types of psychotherapy and different certifications among psychotherapists, so finding the right treating professional for a particular condition can increase the effectiveness of the treatment. Psychotherapists and counselors may also help families work through complex family dynamics that are impacted by the behavioral health issue.

Understanding what services are available in the local community is important. Some primary care physicians are helpful in finding behavioral health professionals, but most are not. Health insurance companies often have listings of local providers within a client's insurance network. Psychology Today offers a provider resource guide with photos and profiles. Your home state's psychological association may offer resources, and there may be a hospital in the region that has a behavioral health center. Spending some time to become familiar with options in the area where you practice is a worthwhile endeavor.

VIII. Attorney Ethics Issues and Liability Concerns

Dealing with beneficiaries who may have compromised ability to analyze, rationalize or make decisions can pose ethical concerns for attorneys. And, as any attorney who has been practicing long enough knows, where there are ethics issues, there can be liability pitfalls.

American Bar Association ("ABA") Model Rules of Professional Conduct ("MRPC") specifically addresses dealing with clients who have diminished capacity.

> *Rule 1.14 Client With Diminished Capacity*
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> *(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.*
>
> *(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.*
>
> *(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.*

As with most of the MRPC governing the attorney-client relationship, the first determination to be made is who the attorney represents. Although not precisely on point because they approach the MRPC from the perspective of representing a client with respect to their estate plan, The American College of Trust and Estate Counsel Commentaries on the Model Rules of

Professional Conduct[38] (the "ACTEC Commentaries") offer some guidance to the lawyer representing the trustee of a trust that has a beneficiary with diminished capacity.

> *The lawyer retained by a person seeking appointment as a fiduciary or retained by a fiduciary for a person with diminished capacity, including a guardian, conservator or attorney-in-fact, stands in a lawyer-client relationship with respect to the prospective or appointed fiduciary. A lawyer who is retained by a fiduciary for a person with diminished capacity, but who did not previously represent the person with diminished capacity, represents only the fiduciary. Nevertheless, in such a case the lawyer for the fiduciary owes some duties to the person with diminished capacity. See ACTEC Commentary on MRPC 1.2 (Scope of Representation and Allocation of Authority Between Client and Lawyer). If the lawyer represents the fiduciary, as distinct from the person with diminished capacity, and is aware that the fiduciary is improperly acting adversely to the person's interests, the lawyer may have an obligation to disclose, to prevent or to rectify the fiduciary's misconduct. See MRPC 1.2(d) (Scope of Representation and Allocation of Authority Between Client and Lawyer) (providing that a lawyer shall not counsel a client to engage, or assist a client, in conduct that the lawyer knows is criminal or fraudulent).*

But the rules are not always as clear as the ACTEC Commentaries would indicate. In a litigious society, considering risk management both for the trustee and the attorney herself is advisable. It is not difficult to imagine situations where a tort plaintiff might sue the trustee and the trustee's lawyer for what the plaintiff views as failure to prevent a foreseeable injury or death.

If a beneficiary who is under the influence shows up at the trustee's house with a gun, does the lawyer have a duty to report that behavior to the authorities even if the trustee chooses not to do so?

What if the lawyer has been having conversations with the trustee about the beneficiary's drug use relapse, but the trustee distributes money anyway and the beneficiary gets high and kills someone while driving under the influence?

Attorneys advising trustees of trusts with beneficiaries under impairment may have a duty under their local ethics rules to report conduct that could be dangerous to others, but they may also have to reconcile duty of confidentiality in certain jurisdictions that do not view the attorney-client relationship in the same way as the ACTEC Commentaries. Some jurisdictions provide that the attorney representing a fiduciary estate also owes attorney-client duties to the trust

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[38] ACTEC, Commentaries on the Model Rules of Professional Conduct (5th Ed., 2016).

beneficiaries. It is important, therefore, to understand the applicable ethics rules, because what an attorney may want to do and what she can or must do may be very different under the jurisdiction's ethics rules than what common sense might dictate.