DANCING WITH THE GORILLA

Resolving the Dilemma of Chemically-Dependent Beneficiaries

Cuddy & McCarthy, LLP

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Providing good resources is the focus for this subject. Hopefully, this paper will provide a viable introductory tool for an estate planner or trustee ("practitioner") who is facing the challenge of how to manage matters with clients who have beneficiaries afflicted with substance abuse disorder.[i]

In other words, we as practitioners also have our own dance with the gorilla. While there are apparently many models of treatment for substance abuse, the disease model will be relied upon in this paper; it's also the model relied upon by legislatures and many government agencies at this point in time. The terms, "substance abuse," "chemically dependent," "addict," "alcoholic" and "substance abuser" include for the purposes of this paper both alcoholism and addiction in its many forms.

Just a bit of housekeeping…. The reference tools are cited differently, depending on what is being referenced. If it is a government website, then it will be provided in an end note (unless it is an "*id.*"); if it's an additional note, then it will be a footnote; and if it's a legal citation, it will appear next to the referenced language or quote. After trying different approaches, that seemed to make it the most easily-reviewable. Hope this author is right….

[i] This author thanks The Honorable Cassandra Williams, Special District Judge, Oklahoma County OK, for her contributions to the practical aspects of substance testing. Thanks to Maire Claire Voorhees (deceased), former Communications Director at Santa Fe Prevention Alliance and former Board Member at Santa Fe Recovery Center; she provided many of the nonlegal resources initially used in this paper. Any errors are completely this author's.

I. THE WHY

A. Federal Statistics

According to the Centers for Disease Control and Prevention ("CDC"), drug overdose deaths have risen fivefold over the past two decades in the United States.[1] The most recent long-term report available on the CDC website's data is from 2021. From 2015 through 2021, synthetic opioid drug overdoses skyrocketed (this includes fentanyl). *Id.* From this same report one of the key findings is that adults aged 65 and over had the largest percentage of increase in rates of overdose deaths from 2020 – 2021. *Id.*

Approximately 105,000 people died from drug overdose in 2023 with nearly 80,000 of them involving opioids.[2] Essentially, 217 people a day in 2023 died of opioid overdose. *Id.* The good news is that 2023 was the first year there was a decline since 2018 – and that includes fentanyl. *Id.* There was a 10-year battle with the substantial increase of fentanyl-related deaths starting in 2013. *Id.*

B. Oklahoma Statistics

Oklahoma's own statistics are not good (but not as bad as other states in some respects). According to Oklahoma's Department of Health covering a period from 2019-2023, 4,812 people died due to drug overdose.[3] For 2024 alone, over 1,217 people died of drug overdose in Oklahoma.[4] As for "nonfatal" drug overdoses, from 2019-2023, there were 21,406 people at a cost of hospitalization at $867 million. *Id.* As for Oklahoma's 2024 annual rate for Substance Use Disorder ("SUD") among those 18 years or older, it sits at nearly 20%.[5]

Alcohol use disorder ("AUD") affects approximately 15 million adults in the US, with approximately 140,000 deaths per year.[6] Alcohol is deemed the "primary drug of choice"

in Oklahoma.[7] Surprisingly, "alcohol outpaced methamphetamine as the primary drug of choice" since 2015. *Id.* *The Journal Record* reported that Oklahoma was ranked in the top 10 for alcohol-related deaths in 2021. Francis-Smith, Janice, "Oklahoma in top 10 states for alcohol-related deaths" [sic], *The Journal Record* (December 5, 2022).

In Oklahoma the average illicit drug use among people aged 26 and older is 20.84%. This is based upon 2022 and 2023 data (annual average percentages) collected through National Survey on Drug Use and Health.[8] When it comes to pain reliever[ii] misuse Oklahoma is in the nation's highest percentage overall based upon 2022-2023 data.[9]

These sobering statistics (yes, pun intended) inform us practitioners that indeed a higher incidence of our families[10] coming into create or amend estate plans will expect us estate planners (think malpractice here) to ask questions and aid them in formulating plans to take care of those chemically-dependent beneficiaries they love. Trustees aren't off the hook either, because they have to implement whatever the Trust terms are – for good or ill. Trustees end up in the crosshairs of a dancing gorilla and must learn about the tools and resources necessary to assure their meeting their legal duties. We practitioners can't fix the problem, of course, but we can try to avoid making it worse.

II. THE WHAT: SUBSTANCE USE DISORDER

So let's start with the question of what *is* substance abuse?[iii] SAMSHA simply

[ii] In this instance, it's referring to opioids. *See* *https://www.samhsa.gov/substance-use/learn/prescriptions-opioids*.

[iii] The Substance Abuse and Mental Health Services Administration ("SAMHSA") is an agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMSHA has completed a myriad of initiatives and research related to substance abuse and mental illness.

defines drug addiction as a "chronic disease where people compulsively seek and use drugs despite harmful consequences."[11] Alcohol use disorder is the most common type of SUD ("substance use disorder") in the U.S.[12]

A. DSM-5's TAKE ON SUD

SUD risk rests on three key factors: biology (about 50%, including gender, ethnicity and mental health), environment (family, friends, economics, life experiences, and early exposure to substances), and development (typically use during adolescence).[13] The DSM-5 apparently no longer uses the terms, "addiction", "substance abuse" and "substance dependence" but instead the more "neutral term" of "substance use disorder," whether mild, moderate or severe; the "substance use disorder" covers a broader range of substances and avoids the "potentially negative connotation" of "addiction." "Substance-Related and Addictive Disorders," *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed: DSM-5 (2017), at p. 485 ("DSM-5"). The DSM-5 now refers to "substance use disorders," which are defined by level of severity: mild, moderate, or severe, which is determined by the number of diagnostic criteria met by an individual. *Id.* at pp. 484-485. Substance use disorders arise when the "individual continues using the substance despite significant substance-related problems." *Id.* at p. 483. In other words, the continued use of an addictive substance causes "impaired control, social impairment, risky use and pharmacological criteria." *Id.* Hence, the substance use disorder diagnosis is based on evidence of those four criteria. Here is a brief synopsis of what those four criteria mean:

- Impaired control means that while the individual may express a "persistent desire to cut down or regular substance use" but have been unsuccessful; also, the individual may use the substance in larger amounts or over a longer period of time than what was originally intended. *Id.* at 483. The individual's daily activities

usually revolve around the substance and may "spend a great deal of time obtaining the substance, using the substance or recovering from its effects. *Id.* Craving of the substance is a driving component as well. *Id.*

- Social impairment expresses itself by the individual's "failure to full major role obligations at work, school or home" and will continue using the substance "despite having persistent or recurrent social or interpersonal problems" relating to the substance use. *Id.* The individual may withdraw from important family activities and hobbies to use the substance.
- Risky use of the substance is the individual's choice to use the substance when it is physically hazardous – in other words, the individual's inability or "failure to abstain from using the substance despite the difficulty it is causing." *Id.*
- Pharmacological criteria relates to tolerance, which is a "markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed." *Id.* at 484. When an individual who has maintained a prolonged heavy use of the substance, then s/he feels withdrawal symptoms and needs to consume more of the substance to relieve the symptoms. *Id.* FYI: this last criteria is not "necessary for a diagnosis of a substance use disorder." *Id.*

Inappropriate use of prescription medications, of course, can result in a substance use disorder. *Id.* "Mild substance use disorder" is when there are 2-3 symptoms. *Id.* "Moderate substance use disorder" is when there are 4-5 symptoms. *Id.* "Severe" substance use disorder is when there are 6 or more symptoms. *Id.*

B. ALCOHOL USE DISORDER (AUD)

While a complete litany of disorders won't be addressed here, the more commonly-known will be briefly addressed, mainly alcoholism and in more recent times, cannabis use disorder. There will be certain references to fentanyl in this paper; however, addiction generally is the focus. According to the CDC, Alcohol Use Disorder ("AUD" or alcoholism), and its excessive alcohol use causes approximately 178,000 deaths a year.[14] In 2020, nearly 12,000 adults over 65 years of age died of alcohol-induced causes and the death rates continue to rise for this demographic.[15] The U.S. Centers for Disease Control and Prevention (CDC) report that in 2022 and 2023, 40.9% of all alcohol-attributable deaths occurred among people ages 65+. *Id.* In 2024, the CDC reports that

11.4% of older adults (ages 65+) engage in binge drinking. *Id.*

"AUD is characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences. It is a spectrum disorder and can be mild, moderate, or severe and encompasses the conditions that some people refer to as "alcohol abuse," "alcohol dependence," or the colloquial term "alcoholism." [16]

C. CANNABIS USE DISORDER (CUD)

Not far behind AUD is Cannabis Use Disorder ("CUD"); studies estimate that 22% to 30% of people who use cannabis have the disorder.[17] Relying on DSM-5, NIH defines cannabis use disorder "as a pattern of use that leads to clinically significant impairment or distress."[18]

III. THE WHAT – SOME HELPFUL IDENTIFIERS FOR PRACTITIONERS

A. AUD IDENTIFIERS

Some of the terms such as moderate and heavy drinking as well as binge drinking should probably be defined. According to the CDC, the definitions for the different levels of drinking include the following:

> •Moderate Drinking—Relying on Dietary Guidelines for Americans, moderate drinking is one drink per day for women and up to two drinks per day for men.[19]
>
> •Binge Drinking—Drinking 5 or more alcoholic drinks on the same occasion. *Id.*
>
> •Heavy Drinking—Drinking 8 or more drinks for women and 15 or more drinks during a week. *Id.*

When assessing AUD, the factors include:

- Had times when you ended up drinking more, or longer, than you intended?
- More than once wanted to cut down or stop drinking, or tried to, but couldn't?

- Spent a lot of time drinking, being sick from drinking, or getting over
- other aftereffects?
- Wanted a drink so badly you couldn't think of anything else?
- Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
- Continued to drink even though it was causing trouble with your family or friends?
- Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
- More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or engaging in unsafe sexual behavior)?
- Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had an alcohol-related memory blackout?
- Had to drink much more than you once did to get the effect you want? Or found
- that your usual number of drinks had much less effect than before?
- Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, dysphoria (feeling uneasy or unhappy), malaise (general sense of being unwell), feeling low, or a seizure? Or sensed things that were not there?[20]

The more criteria checked define the severity of the dependency: mild, moderate, or severe; *see also,* the explanation outlined for the DSM criteria for SUD. *Supra* at Provision II.(A) at p. 4.

B. CUD IDENTIFIERS

If a person has two or more of the following in a period of 12 months:

- Using cannabis in larger amounts or over a longer period than was intended.
- Persistent desire or unsuccessful efforts to cut down or control cannabis use.
- Spending a lot of time getting, using, or recovering from the effects of cannabis.
- Craving, or a strong desire or urge to use cannabis.
- Using cannabis even though it causes problems at work, school, or home.

- Continuing to use cannabis despite social or relationship problems.
- Giving up important hobbies, or activities with friends and family, or in the workplace to use cannabis.
- Using cannabis in situations with risk of injury.
- Continued use despite knowing that ongoing physical or psychological problems have been caused or worsened by cannabis use.
- Cannabis tolerance, which is a need for increased amounts of cannabis to achieve the desired effect.
- Withdrawal symptoms after stopping cannabis use.
- Cannabis use disorder can be diagnosed as mild (when a person has two or three of these symptoms), moderate (four or five of these symptoms), or severe (six or more of these symptoms).

Id.

IV. THE HOW: THE ESTATE PLANNER'S INTAKE

We are not in the business of diagnosis. On the other hand, as has been famously stated by Justice Stewart , "I know obscenity when I see it." *Jacobellis v. Ohio,* 378 U.S. 184, 197 (1964)(Stewart, J., concurring). In the same way, a practitioner who educates herself will be able to begin spotting the "ism" of alcoholism (or addiction) when making inquiry and hearing about family dynamics.

Substance abuse can hide in plain sight. For example, alcoholics switch to vodka, which can be a little harder to detect by smell. IV drug users don't necessarily have track marks on their arms, because they inject in areas that are easily hidden by clothing (even injecting between their toes – eeesh!). The family may be in denial *even as the couple*[iv] *is describing their concerns.*[21]

A. AUD INQUIRY

Some ideas of what to listen for while meeting with the couple might be:

- ·Joe might have been to treatment "and is all better now."
- ·Joe used to smoke pot a lot but he doesn't anymore (inquiry suggestion: how long

[iv] While clearly individuals with children etc. obtain estate plans, for the purposes of this paper, the author has chosen "couple."

ago was it? How old was Joe? Ask about current versus past lifestyles, Joe has had. Some people, after all, aren't addicts but just party animals in their teens and twenties.)

- ·Joe doesn't need AA (or some other 12-step program). He went to a few meetings and "he is over that."
- ·Joe has had one or more DUIs or related arrests (not necessarily convictions)
- ·Joe has had multiple jobs and possibly multiple wives
- ·Joe has moved around a lot
- ·At meals involving alcohol, Joe drinks instead of eats
- ·Joe's behavior changes significantly while drinking/using, e.g., a calm person becomes outgoing, aggressive or even impulsive while consuming alcohol
- ·Joe gets thrown out of drinking establishments or restaurants
- ·Joe can't have one drink (and the family makes excuses, "well, he was going through a hard time...")
- ·Joe's promised to cut down, drink less etc.
- ·If Joe has progressed in his alcoholism, he may have blackouts. The family members might note that he didn't seem all that drunk but Joe couldn't remember what happened when asked the next day.
- ·Joe makes excuses about why he drinks (and becomes angry when gently confronted about his drinking)
- ·A family member has noticed that Joe sneaks drinks or has hidden bottles
- ·Joe is not forthcoming about his life with his family
- ·Joe's quit but starts drinking again
- ·Joe doesn't have a problem, because he's told me he doesn't get hangovers even though he drinks a lot
- ·Joe becomes irritable, nervous, or uncomfortable later in the day when he doesn't get to drink (can't miss happy hour or the lunch cocktail etc.)
- ·Joe's not interested in things that he used to really enjoy

The above does *not* mean the reader should ask direct questions; the above is a guideline for red flags. When questioning a client a little more finesse is required – it involves paying attention and using opportunities to ask questions "around the edges". There is usually a lot of shame around addiction and alcoholism in the family. The parents feel guilty that somehow they caused the loved one's affliction. They may try to protect Joe.

Of course, it could be that Joe is the in-law and the daughter is the long-suffering enabler. The enabler is the one who may protect the loved on from the consequences of addiction, keep secrets about the loved one's addiction, refuse to follow through with

boundaries and expectations and make excuses for the loved one's behavior.[22] Think of being in the room with someone choosing to dance with a gorilla. *Anyone in that room is at risk of harm.*

B. OTHER FORMS OF SUD

The discussion above deals with considerations when dealing with alcoholism. Additional considerations for drug addiction (and not necessarily ruled out for alcoholism) might be (and of course depending on the drug of choice, there might be many other descriptors):

- ·When using or addicted there is increased aggression or irritability
- ·The couple talks about Joe having a change in attitude/personality and that's when they can tell he is using
- ·Joe sleeps all the time (or during the day and is out all night)
- ·Joe is just "depressed"
- ·Joe doesn't hang around with a very nice group of people
- ·Noticed that Joe's priorities are different (not family for example and before he was the baseball coach for Little Joe's team)
- ·Joe never has money to pay rent
- ·Joe was involved in some sort of criminal activity and it was all a big mixup
- ·Grooming has declined
- ·Joe shows signs of paranoia
- ·Joe gets confused easily
- ·Joe has big highs and lows
- ·Joe's pupils are dilated (or constricted) and he hasn't been to the eye doctor
- ·Joe just uses poor judgment
- ·Joe is impulsive sometimes (and it makes no sense)
- ·Joe talks really fast sometimes
- ·Joe gets drug tested at work and has had problems, because "something was wrong with the test"

V. THE HOW: DESIGNING THE ESTATE PLAN

If the grantors are up to the task, language can be formulated to make the trustee's job easier in administering a trust crafted for a chemically-dependent beneficiary. Basic terms are attached here as Exhibit "A".

In Oklahoma,

> [i]t is hereby declared to be the public policy of this state to recognize alcoholism and drug abuse as illnesses and public health problems affecting the health, safety, morals, economy and general welfare of the state; to recognize alcoholism and drug abuse as illnesses subject to medical treatment and other therapeutic intervention and abatement; and to recognize that the sufferer of alcoholism and drug abuse is entitled to treatment and rehabilitation. The purpose of [the "Oklahoma Alcohol and Drug Abuse Services Act"] is to establish means whereby the appropriate resources of this state may be most fully and effectively focused upon the problems of alcoholism and drug abuse and utilized in implementing programs for the control and treatment of these illnesses.

43A OS § 3-402. As used in the Oklahoma Alcohol and Drug Abuse Services Act, there are certain definitions that might prove helpful here:

> 2. An "alcohol-dependent person" is one who uses alcoholic beverages to such an extent that it impairs the health, family life, or occupation of the person and compromises the health and safety of the community;
> 3. A "drug-dependent person" means a person who is using a controlled substance as presently defined in Section 102 of the Federal Controlled Substances Act and who is in a state of psychic or physical dependence, or both, arising from administration of that controlled substance on an intermittent or continuous basis. Drug dependence is characterized by behavioral and other responses which include a strong compulsion to take the substance on a continuous basis in order to experience its psychic effects, or to avoid the discomfort of its absence;
> 4. "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as the direct result of the consumption of alcohol or drugs;
> 11. "Treatment" means the broad range of emergency, inpatient, intermediate and outpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological and social service care, vocational rehabilitation and career counseling, which may be extended to alcohol-dependent, intoxicated and drug_dependent person….

43A OS § 3-403. The reader might notice that the definitions discussed in the mental health milieu (government websites and DSM-5) are different than what Oklahoma law has used in its statutes. Oklahoma law seems to use "drug-dependent" or "alcohol-dependent" (as well as "intoxicated person") in its statutory and case law. As the reader can see above, the use of "alcoholism" and "drug addiction" is also used in the purpose

clause of the Act. Oklahoma law includes gambling addiction treatment. *See* 43A OS §3-322. Oklahoma law also refers to a behavioral addiction (gambling is acknowledged in the DSM-5 but other behavior addictions are not). *See* 43A OS §3-320 (eating disorder treatment) and DSM-5 at p. 481.

The differences in the definitions for the legal aspects as well as mental-health-based can be difficult to navigate – and worse a challenge when statutes contain inconsistencies. Referencing in the estate-planning documents the actual statutory citations above probably would be less than optimal in case the Legislature repeals those definitions and/or moves them. Because trusts can remain in place for decades, there could be difficulties when the definitions either through the DSM, government websites or Oklahoma statutes become more nuanced in addressing the chemically-dependent.[v] The more hazardous problem is this. Remember at the beginning of this paper, this author said she would use the disease model? What if the relied-upon model upon which the estate planner relied in crafting the language has changed?

There is really no easy solution, except choosing to provide the definitions in your trust for the term usage. Fashioning what an estate planner believes will aid in the administration of the trust (and for which a trustee will later thank you) in light of the circumstances known (and presently unknown but predictable when addiction takes its course) is the best that can be done.

While Oklahoma allows a trustee to determine incapacity under the standard of "reasonable belief," it might be helpful to give the trustee the discretion *and also* provide some guidance in light of chemical dependency. *See* 60 OS §1608.15(21)(eff.

[v] Throughout this paper the use of the phrase "chemically dependent" may be used as a broader term than alcohol- or drug-dependent.

11/1/2025).

For guidance in constructing trust language with addiction protocols, case law addressing drug addiction and supervision of professionals who have been faced with the same challenges might prove invaluable. Guidance in Oklahoma law was sparse; there was only one case that provided some direction, which will be discussed below. Because a New Mexico case involving a chemically dependent lawyer is instructive, this author is first discussing the case of *In re Zamora,* 2001-NMSC-011, 21 P.3d 30:

> The ABA Standards also suggest that mental disability or chemical dependency, including alcoholism or drug abuse, may be considered in mitigation of misconduct if (1) there is medical evidence that a respondent is affected by a chemical dependency or mental disability, (2) the chemical dependency or mental disability caused the misconduct, (3) the respondent's recovery from the chemical dependency or mental disability is demonstrated by a meaningful and sustained period of successful rehabilitation, and (4) the recovery arrested the misconduct and recurrence of that misconduct is unlikely. See ABA Standards 9.32(i)(1991)(amended 1992)."

In re Zamora, 2001-NMSC-011 at ¶7. Paying special attention to provisions three and four, the formerly chemically-dependent beneficiary who has some years of being clean and sober under his belt could demonstrate to the well-informed Trustee "meaningful and sustained" recovery. Such could be done by the beneficiary showing his involvement in a twelve-step group, faith-based group that focuses on recovery (which is allowable under Oklahoma law, *see* 43A OS § 3-403(12)) as well as a brief conversation with the fellow's sponsor. As for provision four, the beneficiary could show proof of how recurrence would be unlikely by virtue of showing a sustained, stable lifestyle.

The *Zamora* court discussed New Mexico's physician's assistance program, which has a high success rate:

> The New Mexico Physicians' Assistance Program ... has a recovery

> program success rate of over ninety percent. The assistance program has demonstrated that following appropriate inpatient treatment and a return to work (emphasis added) the elements to a successful recovery from addiction consist of a program that (1) is mandatory, (2) requires regular participation in a twelve step recovery program, (3) incorporates random drug testing and/or screening, and (4) requires participation for five years. The random drug testing and screening is believed to be the key to the protection of the public that the professional serves. Because of the nature of chemical dependency, the random testing/screening is essential to assure that an individual will not escape detection in the event of a relapse.

Id. at ¶8. While it's a given that physicians have learned by their very training how to use protocols and be disciplined, it seems that a motivated beneficiary might do well under the same protocol as above-outlined. It also brings up, how long is long enough in requiring the beneficiary and the trustee to engage in the monitoring dance? Should that also be defined in the trust agreement? The trustee should probably be given discretion and then be required to take into consideration other income and property available to beneficiary. As is always true with estate planning, the tension is between allowing flexibility and specificity. Testing will be briefly addressed below. The *Zamora* court required the bar member to:

> ... (1) report to an appointed attorney monitor on a regular basis, (2) abstain totally from the use of any mind-altering substances and have the use of any prescribed medications monitored by a physician trained in the field of addiction, (3) attend twelve step meetings at least three to five times weekly and accompany his attorney monitor to at least two such meetings each month, and (4) submit to random drug screening.

Id. at ¶10. In a disciplinary action by the Oklahoma Bar Association, the Oklahoma Supreme Court opined:

> Carpenter must (a) sign a "contract" with the Lawyers Helping Lawyers Committee, (b) be supervised by a designated member of the Committee throughout the term of his probation, as well as participate for that length of time in the Alcoholics Anonymous program or in some other recognized organization in conformity to his agreement with the Lawyers–Helping–Lawyers program, (c) report his attendance and status to the designated

> member-sponsor of the Lawyers–Helping–Lawyers group, and (d) cooperate with the General Counsel of the Bar in any investigation of an alleged unprofessional conduct which has or may come to the Bar's attention. If he fails to comply with the terms of his probation, his Lawyers–Helping–Lawyers sponsor shall be required to report immediately to the General Counsel any violations with a view to pressing for additional disciplinary measures.

OBA v. Carpenter, 1993 OK 86, ¶18, 863 P.2d 1123.

Ultimately, the onus should be placed on the beneficiary to demonstrate a consistent and prolonged period of rehabilitation. *See, eg, OBA v. Carpenter*, 1993 OK 86 at ¶17 ("Although alcoholism is not in itself enough to mitigate discipline, the fact that Carpenter recognized his problem, sought and cooperated in treatment, and is now willing to undergo supervision, convinces us that severe discipline need not be imposed.")

VI. THE WHO: TRUST ADMINISTRATION

The case has landed in the reader's lap and both parents have died, the chemically-addicted beneficiary has been a pain after the first death and, without the eagle eye of the other siblings, would have been successful in stripping accounts. There's now a new sheriff in town and it's the reader's job to counsel the trustee. A Trustee with a chemically-dependent beneficiary has his hands full. The Trustee has a difficult line to walk to assure that the trust is administered in "good faith, in accordance with [the trust's] terms and purposes and the interests of the beneficiaries...." 60 OS §1608.1 (eff. 11/1/2025). The Trustee is commanded to "administer the trust as a prudent person would, by considering the purposes, terms, distributional requirements and other circumstances of the trust. In satisfying this standard, the trustee shall exercise reasonable care, skill and caution." 60 OS §1608.4 (eff. 11/1/2025). When dancing with the gorilla, prudence seems a far off virtue and requires exceptional courage, wisdom

and emotional detachment.

Presuming the trust's terms define incapacity well, then the Trustee might be able to deem the beneficiary incapacitated and make distributions in accordance with Oklahoma law's directives. *See* 60 OS §1608.15(21)(eff. 11/1/2025). If there is no provision in the trust that's helpful, Oklahoma's new law helps out the trustee with this language: "who the trustee *reasonably believes is incapacitated*." *Id. (emphasis added).* Relying upon Oklahoma's guardianship statutes, the definitions provision provides some guidelines for the Trustee:

> "Incapacitated person" means a person eighteen (18) years of age or older:
> a. who is impaired by reason of:
> (1) mental illness as defined by [43A §1-103],
> (2) intellectual or developmental disability as defined by [10 OS §1430.2],
> (4) *drug or alcohol dependency* as defined by [43A OS §3-403], and
> b. whose ability to receive and evaluate information effectively or to make and to communicate responsible decisions is impaired to such an extent that the person:
> (1) lacks the capacity to meet essential requirements for physical health or safety, or
> (2) is unable to manage financial resources.

30 OS §1-111(A)(12)(emphasis added).

If the chemically-dependent beneficiary engages in aggressive and accusatory behavior with repeated threats of "going to court," then the Trustee may actually need to do just that to avoid more difficult problems later. *See* 60 OS §1602.01 (eff. 11/1/2025); *see also,* breach of trust at 60 OS §1609.3 (eff. 11/1/2025) (*but see,* 60 OS §1609.5 (eff. 11/1/2025) and 60 OS §175.57).

A. WHO GETS THE MONEY?

A dilemma exists – a trust "must be for the benefit of its beneficiaries." 60 OS

§1604.4 (eff. 11/1/2025). So how does this work when there are remainder beneficiaries, eg, the children of the beneficiary? Court oversight might avoid difficulties in making the hard decisions of whether to pay for treatment, the beneficiary's defense in a parental-rights-termination case or drug-or-alcohol-related criminal actions. After all, is that in furtherance of the commonly used HEMS standard?[vi] If the trust would result in not benefitting the current income beneficiary, then it may be necessary to modify the trust (and what is the benefit anyway when dealing with a drug-addled beneficiary?). *See* 60 OS §1604.11(A or B) (eff. 11/1/2025). For example, it is quite likely the settlor did not contemplate the drug dependent beneficiary when the documents were created. Of course, court intervention costs money. Unless the trust can afford what will most likely be a nasty little bit of court business, the Trustee may have to employ other, more practical means, such as the use of an experienced chemical-dependency counselor to consult on options. 60 OS §1608.7(A) (eff. 11/1/2025).

1. Parental Rights Termination

How far can a trustee go in using the HEMS standard and expending funds for the benefit of the chemically-addicted beneficiary? For example, it is not uncommon that a chemically-dependent beneficiary is an abusive and neglectful parent. Oklahoma law provides that if

> 13. A finding that all of the following exist:
>
> a. the parent has a diagnosed cognitive disorder, an extreme physical incapacity, or a medical condition, including behavioral health, which renders the parent incapable of adequately and appropriately exercising parental rights, duties, and responsibilities within a reasonable time considering the age of the child, and
> b. allowing the parent to have custody would cause the child actual harm or

[vi] HEMS is "health, education, maintenance and support." IRS Code § 2041(b)(1)(A).

> harm in the near future.
> A parent's refusal or pattern of noncompliance with treatment, therapy, medication, or assistance from outside the home can be used as evidence that the parent is incapable of adequately and appropriately exercising parental rights, duties, and responsibilities.
> A finding that a parent has a diagnosed cognitive disorder, an extreme physical incapacity, or a medical condition, including behavioral health or substance dependency, shall not in and of itself deprive the parent of parental rights;
> [but]
> 14. A finding that:
> a. the condition that led to the deprived adjudication has been the subject of a previous deprived adjudication of this child or a sibling of this child, and
> b. the parent has been given an opportunity to correct the conditions which led to the determination of the initial deprived child.

10A OS §1-4-904 (eff.11/1/2025). A fact pattern where repeated drug use was the reason for termination of the parental rights of the chemically-dependent parent is not rare. *See Matter of CKT,* 2024 OK CIV APP 23, ¶¶49-50, 558 P.3d 1254; *see also, Matter of AB,* 2024 OK CIV APP 1, 542 P.3d 872, generally. As noted in the Child Welfare Information Gateway,

> Families with alcohol and drug problems usually have high levels of stress and confusion. High stress family environments are a risk factor for early dangerous substance use, as well as mental and physical health problems.[23]

Besides the untenable position of having to call the State if neglect or abuse is evident, the Trustee must decide whether it is appropriate to use the trust to defend the beneficiary's actions. How does that work when the children are the remainder beneficiaries? How does that work when terminating the parent's rights to the children *who are the remainder beneficiaries?*

2. Treatment

It becomes apparent that the beneficiary needs treatment NOW. What to do? Is

this the first time…. or the fifth time? Clearly, it would be appropriate to have the trust pay for that, but what about shipping the recalcitrant beneficiary off to Betty Ford? The general rule is that constitutional guarantees of individual liberty apply to the actions undertaken by the state (a person acting under color of state law, see 42 U.S.C. § 1983), and not to the actions undertaken by private persons and entities. See *Edmonson v. Leesville Concrete Co., Inc.*, 500 U.S. 614, 619-620, 111 S.Ct. 2077, 2082, 114 L.Ed.2d 660 (1991).

There is some leeway in the Oklahoma statutes that seems interesting and a court might be open to it. The Trustee will have to use a bit of strategy to set itself up… Pursuant to 43A OS §109.1(A)(1) an adult who has a mental illness *as defined in 43A OS §1-103* can be informed by a mental health professional or treatment facility that the individual is entitled to designate a "family member or other concerned individual as a treatment advocate." The treatment advocate must act in the best interests of the individual. 43A OS §109.1(A)(2). This is the great part:

> [t]he treatment advocate may participate in the treatment planning and discharge planning of the [beneficiary] to the extent consented to by the [beneficiary] and as permitted by law.

43A OS §109.1(A)(4). This is a bit of a challenge. However, it aids in empowering the trustee to file a Petition concerning a person "requiring treatment." 43A OS §5-410(A)(1). Of course, the trustee would have to obtain the trust of the beneficiary and then be designated as the treatment advocate. Because the petition allows for an assessment or evaluation concerning *mental health* that seems a tough sell. *However,* 43A OS §5-206(1) *defines* "mental health evaluation" as follows: "Mental health evaluation" means the examination of a person, either in person or via telemedicine, who appears to have a

mental illness *or be alcohol- or drug-dependent* by two licensed mental health professionals…." (emphasis added). In the long run, this may be a strategy for the trustee to assure treatment can occur. Also, the in-need-of-treatment individual is also defined under "mental illness" definitions at 43A OS §1-103(13) and the definition *includes drug or alcohol dependency.* At §1-103(13), the Trustee will also find the criteria for whether the addicted beneficiary needs treatment. In other words, with a little creativity, the trustee may be able to use the court to assure treatment occurs for the SUD beneficiary.

Keep in mind that treatment can happen in a variety of settings, in different forms and for different lengths of time.[24] Of course, the beneficiary has to stop using chemicals and most need help to stop. *Id.* An addiction specialist can guide the trustee in the best approach for the circumstances. The infamous intervention may work but only if carefully prepared and handled with the guidance of a competent, trained specialist. *Id.*

In the last few years through its State Department of Health, Oklahoma has created a task force that addresses SUD issues. An OK State Health Improvement Plan ("SHIP") has been implemented and among other resources, provide "medication lockboxes" and distribution of fentanyl test strips as well as overdose reversal medication (Naloxone/Narcan).[25] It would behoove the trustee to be aware of these resources. For more information, go to www.Oklahoma.gov/health/ship.

3. Monitoring

Monitoring can be an integral part of the administration of the chemically-addicted beneficiary's trust. Lack-of-compliance language in the trust can provide back-up for the trustee. Here's a basic primer on testing.

a. Alcohol Testing

There are essentially three types of alcohol testing: breath, blood, and urine (and a fourth to be discussed). For alcohol testing, the breathalyzer is the most commonly known. It can be placed on the beneficiary's car and a report sent to the trustee. Generally, breath tests are not as accurate as blood tests. *See Mitchell v. Wisconsin,* 588 US 840, 852, 139 S.Ct. 2525, 2536, 204 L.Ed.2d 1040 (USSC 2019). However, the breath test is deemed accurate enough for Court purposes. *Id.* (blood tests are used when the implied-consent law cannot be used, such as when the driver is unconscious or cannot blow into a breathalyzer).

The blood test is of course the most accurate but has a short time window, like the breathalyzer. Even less accurate are urine tests and for purposes of gauging alcohol in the system is not recommended. There is now testing available through breathalyzer testing kits at Amazon, Wal-Mart or Walgreens. That will provide a recent point in time.

There is one test that has come into more popular use called the EtG (ethyl glucuronide) test; it's available on Amazon! EtG is a byproduct of ethanol.[26] EtG is present in urine longer than in blood or breath. *Id.* EtG is present in urine for up to 48 hours, and "sometimes up to 72 hours or longer if the drinking is heavier." *Id.* EtG can also be tested by testing nails or hair (keratin based).[27] Under certain circumstances using a keratin-based testing might prove more accurate. *Id.* The NIH notes that "… in addition to a good sensitivity and specificity, a great advantage of this [EtG] marker is that it detects chronic alcohol intake over a long period of time, which can range from months to years, depending on sample length, through its quantification in keratin matrices (mostly hair). *Id.*

b. Drug Testing

Drug testing now can be done through saliva, urine or blood. Again, tests are available through Walgreens, Walmart and Amazon. For $39.99 a trustee can pick up a 14-panel drug test that tests urine for amphetamine, barbiturates, benzodiazepines, buprenorphine (Suboxone), cocaine, ecstasy, marijuana, opiates (including heroin, morphine, codeine and hydrocodone), oxycodone, phycyclidine, propoxyphene and tricyclic antidepressants. If the trustee is checking for fentanyl[vii] that's a separate test (for as little as $16.99).

In discussion with The Honorable Cassandra Williams, Special District Judge, Oklahoma County (criminal docket), the various methods of testing used depend upon, of course, what the substance the defendant is suspected of using. Williams, Cassandra, J., September 7, 2025. The first tip she provided is that it is imperative to use testing companies that have good protocols, such as observing closely the "deposit." *Id.* Overall, hair provides information about cumulative use. *Id.* Whereas, a urine test provides about a 3-day range, depending on the test and what drug it is. *Id.* For example, meth and cocaine are out of the system in about 3 days. *Id.* Using OTC tests can be helpful and can always then be confirmed by a drug lab. *Id.* Urinalysis is usually cheaper. *Id.* Blood is usually the most expensive. *Id.* Of some interest is the use of a sweat patch; Cleveland County apparently is using this. *Id.*

Further research on the sweat patch revealed that this testing method has been around for approximately 25 years (there are Dept of Justice articles on it). Apparently when a person uses drugs, trace amounts of the parent drug and its metabolites are

[vii] Fentanyl is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. https://www.hhs.gov/opioids/prevention/index.html.

excreted through sweat and are trapped in the patch's absorbent pad. A sweat patch consists of an absorbent pad held against the skin by a water-resistant, adhesive membrane. A semi-permeable film allows the skin to breathe but prevents outside contaminants, like water and dirt, from entering the patch; it can be placed on someone for up to 14 days.[28] The longer testing window helps with determining the use of more common drugs like marijuana, cocaine, methamphetamines, LSD, and heroin. *Id.* A trained observer removes the patch and sends the pad to a lab for forensic analysis. Apparently, the patch is designed to be tamper-resistent and a trained professional can easily spot any attempts to remove, alter, or dilute the sample.

After deciding the optimal type of test to use for the type of suspected drug in the beneficiary's system, then the timing (random or regularly-scheduled) and levels to test for become important. SAMHSA provides a cornucopia of information about work-place testing that will prove useful.[29] A practitioner can also pick up the phone and talk with an experienced criminal or family-law attorney since it is common practice to have drug testing performed in those types of cases.

Additionally, if the addiction is a prescription drug(s), then the trustee might want to familiarize himself with something called "Prescription Drug Monitoring Programs" (PDMPs). Usually these are located within a state agency, such as a health department. There, one can find a list of all controlled substance prescription drugs prescribed to the patient, the name of the prescriber issuing the prescription and the pharmacy where it was filled. Since a trustee could not usually get this information, it is suggested that the trustee require the beneficiary to sign a release so that an authorized medical professional can obtain the information from the PDMP. However, it could be that a state handles the

data distribution more proactively. More can be found about this resource at http://www.pdmpassist.org/content/state-profiles.

CONCLUSION

Family dynamics always adds complexity and texture to an estate planner's job. Unfortunately, the estate planning professional will find him- or herself sucked into the perilous dance with the gorilla unwittingly if care is not taken.

EXHIBIT “A”

This is a starting point for language in the trust….

ARTICLE __ : Substance Abuse

The following provisions apply to all trusts created under this <Will/Trust Agreement>, except as expressly provided to the contrary in this Article entitled "Substance Abuse:"

A. **Dependence.** If the Trustee reasonably believes that: (1) a beneficiary of any trust created under this <Will/Trust Agreement> (i) routinely or frequently uses or consumes any illegal drugs or other illegal chemical substance so as to be physically or psychologically dependent upon that drug or substance, or (ii) is clinically dependent upon the use or consumption of alcohol or any other legal drug or chemical substance that is not prescribed by a licensed medical doctor or psychiatrist in a current program of treatment supervised by that doctor or psychiatrist; and (2) as a result of such use or consumption, the Beneficiary is incapable of caring for himself or herself or is likely to dissipate the Beneficiary's financial resources; then the Trustee must follow the procedures set forth below.

B**.** **Testing.** The Trustee will request the Beneficiary to submit to one or more examinations (including over-the-counter testing and/or laboratory tests of hair, tissue, or bodily fluids) determined to be appropriate by a licensed addiction specialist selected by the Trustee. The Trustee will request the Beneficiary to consent both to (i) full disclosure by the examining doctor or facility to the Trustee of the results of all the examinations; and (2) the delivery of a written summary (the “Summary”) of the results of all of such examinations to the trustee, if any. Other than the delivery of the Summary to a trustee, the Trustee will maintain strict confidentiality of those results and will not disclose those results to any person other than the Beneficiary without the Beneficiary's written permission, subject to court proceedings. The Trustee may totally or partially suspend all distributions otherwise required or permitted to be made to that Beneficiary until the Beneficiary consents to the examination and disclosure to the Trustee. In furtherance of the foregoing, the Grantor authorizes and directs the trustee who receives the Summary to rely on the matters and conclusions set forth in the Summary without undertaking any independent research, examination or analysis of such matters or the conclusions set forth therein. The trustee which receives the Summary will (and will direct and cause all of its employees and agents to) maintain strict confidentiality of the Summary and will not disclose the Summary to any person other than the Beneficiary (or as needed to the court) without the Beneficiary’s written permission.

C. **Treatment.** If, in the examining doctor, mental health-care professional, addiction specialist’s or psychiatrist's (‘professionals”) opinion, the examination indicates current or recent use of a drug or substance as described above, the Beneficiary will consult with the professionals to determine an appropriate method of treatment for the Beneficiary. The Beneficiary will sign a HIPAA release form so that limited information may be provided to the trustee for purposes of discerning appropriate treatment to be

paid for by the trust. The professional treatment may include counseling or treatment on an in-patient basis in a rehabilitation facility. If the Beneficiary consents to the treatment, the Trustee may pay the costs of treatment directly to the provider of those services from the income or principal otherwise authorized or required to be distributed to the Beneficiary, if the Trustee otherwise determines that the funds are available to do so and it is in the best interests of the Beneficiary to do so.

D. **Mandatory Distributions Suspended.** If the examination indicates current or recent use of a drug or substance as described above, all mandatory distributions and all withdrawal rights from the trust estate with respect to the Beneficiary during the Beneficiary's lifetime (including distributions upon termination of the trust for reasons other than the death of the Beneficiary) will be suspended until:

1. in the case of use or consumption of an illegal drug or illegal substance, examinations indicate no such use; and

2. in all cases of dependence, until the Trustee, in the Trustee's judgment, determines that the Beneficiary is fully capable of caring for himself or herself and is no longer likely to dissipate his or her financial resources.

E. **Discretionary Distributions.** While mandatory distributions are suspended, the trust will be administered as a discretionary trust to provide for the Beneficiary according to the provisions of the trust providing for discretionary distributions in the Trustee's absolute discretion (other than an Interested Trustee) and any provisions of the trust relating to distributions for the Beneficiary's health, education, maintenance and support.

F. **Resumption of Mandatory Distributions and Withdrawals.** When mandatory distributions to and withdrawals by the Beneficiary are resumed, the remaining balance, if any, of the mandatory distributions that were suspended may be distributed to the Beneficiary at that time and the balance of any rights of withdrawal by the Beneficiary shall be immediately exercisable by the Beneficiary. If the Beneficiary dies before mandatory distributions or rights of withdrawal are resumed, the remaining balance of the mandatory distributions that were suspended will be distributed to [the alternate beneficiaries of the Beneficiary's share] as provided herein.

G. **Other Prohibitions During Mandatory Suspension of Benefits.** If mandatory distributions to a Beneficiary are suspended as provided above in this Article, then as of such suspension, the Beneficiary shall automatically be disqualified from serving, and if applicable shall immediately cease serving, as a Trustee, Trust Protector, or in any other capacity in which the Beneficiary would serve as, or participate in the removal or appointment of any Trustee or Trust Protector hereunder.

H. **Exoneration Provision.** It is not the Grantor's intention to make the Trustee (or any of the professionals retained by the Trustee) responsible or liable to anyone for a Beneficiary's actions or welfare. The Trustee has no duty to inquire whether a Beneficiary uses drugs or other substances. The Trustee (and any of the professionals retained by

the Trustee) will be indemnified from the trust estate for any liability in exercising the Trustee's judgment and authority under this Article, including any failure to request a Beneficiary to submit to medical examination and including a decision to distribute suspended amounts to a Beneficiary.

I. **Tax Savings Provisions.** Notwithstanding the provisions of the preceding subparagraphs or any other provision of this <Will/Trust Agreement>, the Trustee shall not suspend any mandatory distributions required for a trust to qualify, in whole or in part, for any Federal or state marital deduction or charitable deduction or as a qualified subchapter S trust, nor shall the Trustee suspend any rights of withdrawal necessary for qualification of a gift as a gift of a present interest. Additionally, nothing herein shall prevent or suspend a distribution mandated by the provisions of any trust created hereunder to which Retirement Benefits are payable. Finally, nothing herein shall prevent a distribution mandated by the provisions hereof relating to the Maximum Duration of Trusts.

J. **Beneficiary Shall Not Participate.** A Trustee who is a mandatory or discretionary income beneficiary shall not serve as a Trustee and shall not participate in any decisions made or to be made under this Article.

Endnotes

[1] https://www.cdc.gov/nchs/data/databriefs/db457.pdf.

[2] https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html.

[3] https://oklahoma.gov/health/health-education/injury-prevention-service/drug-overdose/data/drug-overdose-data-dashboard.html.

[4] https://oklahoma.gov/health/health-education/data-and-statistics/oklahoma-state-health-improvement-plan/su-dashboard.html.

[5] https://oklahoma.gov/health/health-education/data-and-statistics/oklahoma-state-health-improvement-plan/su-dashboard.html.

[6] https://oklahoma.gov/odmhsas/about/blog/2024/alcohol-awareness-month.html.

[7] https://oklahoma.gov/odmhsas/about/public-information/press-releases-and-other-news/2025/alcohol-awareness-month--addressing-alcohol-misuse-and-its-impac.html.

[8] https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.pdf.

[9] https://datatools.samhsa.gov/saes/state.

[10] Substance-abuse problems cut across all demographics. *Alcohol and Drug Addiction Happens in the Best of Families,* https://cwlibrary.childwelfare.gov/discovery/delivery/01CWIG_INST:01CWIG/1218267550007651; *see also,* https://www.drugabuse.gov/publications/drugfacts/treatment-statistics

[11] https://www.samhsa.gov/substance-use/what-is-sud.

[12] https://my.clevelandclinic.org/health/diseases/16652-drug-addiction-substance-use-disorder-sud; *see also,* https://oklahoma.gov/odmhsas/about/blog/2024/alcohol-awareness-month.html.

[13] https://www.samhsa.gov/substance-use/what-is-sud.

[14] https://www.cdc.gov/alcohol/about-alcohol-use/ relying on Esser MB, Sherk A, Liu Y, Naimi TS. Deaths from excessive alcohol use — United States, 2016-2021. *MMWR Morb Mortal Wkly Rep.* 2024;73:154–161. doi: 10.15585/mmwr.mm7308a1.

[15] https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics-z/alcohol-facts-and-statistics/alcohol-and-older-adults-ages-65#:~:text=According%20to%20the%20U.S.%20Centers,8.

[16] https://www.niaaa.nih.gov/sites/default/files/publications/NIAAA_RethinkingDrinking.pdf.

[17] https://nida.nih.gov/research-topics/cannabis-marijuana#cannabis-addictive.

[18] https://nida.nih.gov/research-topics/cannabis-marijuana#cannabis-addictive.

[19] https://www.cdc.gov/alcohol/about-alcohol-use/.

[20] https://www.niaaa.nih.gov/sites/default/files/publications/NIAAA_RethinkingDrinking.pdf.

[21] *Alcohol and Drug Addiction Happens in the Best of Families,* https://cwlibrary.childwelfare.gov/discovery/delivery/01CWIG_INST:01CWIG/1218267550007651.

[22] https://www.hazeldenbettyford.org/articles/enabling-fact-sheet.

[23] *Alcohol and Drug Addiction Happens in the Best of Families,* https://cwlibrary.childwelfare.gov/discovery/delivery/01CWIG_INST:01CWIG/1218267550007651.

[24] *Alcohol and Drug Addiction Happens in the Best of Families,* https://cwlibrary.childwelfare.gov/discovery/delivery/01CWIG_INST:01CWIG/1218267550007651.

[25] https://oklahoma.gov/health/health-education/data-and-statistics/oklahoma-state-health-improvement-plan/su-dashboard.html.

[26] https://medicine.musc.edu/departments/psychiatry/divisions-and-programs/programs/clinical-neurobiology-lab/services/etg (Medical University of South Carolina).

[27] https://pmc.ncbi.nlm.nih.gov/articles/PMC9696213/.

[28] https://www.beaumontoccupational.com/6-advantages-sweat-patch-testing-urine-testing/.

[29] https://www.samhsa.gov/substance-use/drug-free-workplace/drug-testing-resources.