

Steve Leimberg's Estate Planning Email Newsletter - Archive Message #3176

Date: 03-Feb-25

From: Steve Leimberg's Estate Planning Newsletter

Subject: [Amanda Koplin, Martin M. Shenkman & Richard Trumpler - Working with Beneficiaries with Mental Health Challenges, An Action Plan for Estate Planners and Trustees](#)

“Trustees will commonly encounter beneficiaries with mental health and related challenges. These situations may be difficult, but with proactive planning and effort, trustees may be able to provide better help to these beneficiaries and protect themselves from liability while doing so. Information gathering and embracing proactive planning with beneficiaries is important in such situations. Avoiding discussions with beneficiaries with mental health struggles about their potential challenges may only postpone inevitable issues, leaving both trustees and beneficiaries vulnerable in the long term. The approach suggested mirrors the paradigm of a good Samaritan recognizing someone in medical distress and calling 911, where asking pertinent questions and facilitating appropriate responses can mitigate risks without assuming roles beyond one's expertise.”

Advisors educating themselves on beneficiary mental health and related needs may facilitate proactive creation of effective boundaries and procedures, co-designed with the beneficiary, to safeguard beneficiary assets and enhance quality of life for the beneficiary. This proactive stance not only may strengthen the relationship between the beneficiary and the trustee, but it may also mitigate potential liabilities, ensuring a more secure and supportive environment for all parties involved.”

Amanda Koplin, Martin M. Shenkman and **Richard Trumpler** provide members with commentary that examines the issues that can arise from working with beneficiaries that have mental health challenges.

Amanda Koplin, LPC is a mental health counselor, entrepreneur and thought leader who creates innovative solutions to fill gaps in the mental healthcare system. In 2014, she created and developed an idea for a mental health urgent care clinic and sold it in 2016 to create Koplin Consulting, a nationwide concierge mental health treatment team service. Amanda is passionate about helping people achieve mental wellness and creating sustainable support systems and solutions which integrate seamlessly into real life. She is a speaker and a nationally sought after consultant who specializes in creating unique treatment plans and recommendations for

individuals struggling with psychological concerns such as addictions, eating disorders, lack of motivation, and other issues impacting mental wellness. She is particularly adept at involving trusted advisors and family members in order to create the greatest impact.

Martin M. Shenkman is an attorney in private practice in New Jersey and New York who concentrates on estate and closely held business planning, tax planning, and estate administration. He is the author of dozens of books and hundreds of articles and has won many professional awards.

Richard Trumpler is a former US Navy pilot and retired Navy Captain who has spent over 50 years in the personal trust business. He has managed trust companies from Maine to Florida, from large (Citibank) to startups, and with a wide range of business models including traditional, directed trustee and brokerage affiliated trust companies. After “retiring” from the corporate world, he started Trumpler Wealth Consulting LLC, an international trust consulting firm, and for the past eight years has been advising and coaching executives of banks, trust companies, law firms, family offices and investment advisory firms.

Here is their commentary:

COMMENT:

Introduction

As an estate planner or trustee, encountering clients with mental health challenges is as inevitable as encountering clients navigating the effects of aging. While many advisors have protocols and referral sources for assisting clients with physical and cognitive aging issues, few are equipped with policies, procedures, and referral sources geared toward protecting and assisting beneficiaries addressing mental health and addiction concerns. Often, advisors struggle to know where to begin. Some advisors are simply uncomfortable with addressing these issues.

Estate planners, in all disciplines, and trustees need an actionable plan to effectively support and protect the best interest of beneficiaries facing mental health challenges. This is true whether these issues are known from the outset, or whether they emerge later in their working relationship. Having a checklist of the necessary steps to take

within the context of each role will empower advisors to integrate comprehensive strategies to address mental health issues alongside physical health and aging issues in their practices. This proactive approach ensures holistic support for those that they are advising (e.g., if advising a trustee as to how to address beneficiaries with mental health challenges) across all facets of their well-being.

These Issues are Common and Affect All Advisors

Many advisors assume that mental health scenarios are uncommon. The opposite is true. The misconception may be due, in part, to the societal discomfort with addressing the realities of mental health. For a lot of people these conversations remain awkward, and that is unfortunate.

More than twenty percent of people struggle with some degree of mental illness. In any given year, about one in five adults in the United States has a diagnosable mental health disorder^[1]. One in twenty adults has a serious mental illness^[2] and one in six adults has a substance use disorder^[3]. Half of all chronic mental health disorders begin by age 14 and three quarters of all mental illnesses begin before age 24^[4].

Every estate planning professional has a role to play in serving their clients and families or beneficiaries with these challenges. Attorneys should address mental health provisions in drafting wills, trusts and other estate planning documents, perhaps tailoring the documents when there is a known issue. CPAs can serve as monitors or evaluate financial data to identify spending issues indicative of an issue. Financial advisors can create budgets to incorporate medical needs, and much more. Trustees have the administrative power and oversight to fund or limit distributions which could help or hurt a beneficiary. Given the common occurrence of these issues, all advisors should be attuned to them to better help clients.

What Would You Do? Where Do You Start?

Trustees could end up compromising situations where beneficiaries become symptomatic with their mental health challenges. If unprepared, trustees could be forced into action but unsure what they should and shouldn't do. More times than not, they are brought into the situation by the beneficiary because of the nature of their relationship and the trust built between the two parties. Outlined below are three common scenarios trustees encounter. Ask yourself: "If this were a beneficiary of a trust I was fiduciary for, would I be able to handle this reasonably to protect the beneficiary?" Or, as a lawyer, "If the trustee (or beneficiary) was my client, would I be

prepared to handle this situation and guide the trustee (or beneficiary) appropriately?”

Case Study 1:

“Janice” is a single woman in her 60’s, estranged from any living family members. She has a diagnosis of Schizoaffective Disorder, a psychiatric condition marked by psychotic symptoms, such as hallucinations and delusions, and symptoms of a mood disorder, meaning there are bouts of mania and sometimes depression. She also has a history of addiction but reports not drinking or using substances for the last year. She tells you that she sees a psychiatrist for medication management and receives counseling services.

When you first met Janice after her trust was transferred from another trustee to you, she appeared well dressed, groomed, and appropriately engaging. She was open about some of her struggles in life, including having some mental health issues, and where she needs help. She presented her difficulties with the former trustee in a way which made her appear to be the victim of his lack of caring or appropriate level of engagement to meet her needs. She seems reasonable and her thoughts are logical and linear, though she can tend to go off on tangents at times.

Within the first month of working with Janice, you begin to get more emails, texts, and calls which are fragmented and carry a panicked tone. Some of these messages are hard to decipher and are time stamped in your inbox for early hours of the morning like 3 am. Despite calling back, the issues never seem to resolve. In fact, the issues seem to increase and become more intense. Eventually, you get a voicemail in the morning that came in at midnight from Janice saying she was feeling suicidal and wanting to end her life. You realize, at this point, the situation requires more than you’re capable of giving or understanding. What do you do? Where do you start?

Case Study 2:

You are the trustee of a trust for the benefit of “Tina”, a young adult female in her late 20’s. Her parents set up a trust for her prior to their deaths. Her mother died a few years prior and then her dad recently passed. She is a pleasant person to talk to but seems filled with worry and grief. She expresses that it feels like the world is caving in on her, she is paralyzed by fear and not sure what to do next. You sympathize with her and lend a listening ear and some reassurance that she’ll get through this and you’ll help her.

In the beginning, you continue to pick up her calls, listen, and try to reassure her that she'll be "OK," and you'll help her figure out the logistics of paying for things. As the weeks pass, you're starting to feel more like a crisis hotline than a trust officer who's working with more than one client. She's becoming more needy and demanding of your time and tells you that you're the only person she can trust and count on. She's asking your advice for every decision and constantly seeking reassurance. You've reached a point of compassion fatigue and realize she needs more than what you're able to give her right now. What do you do? Where do you start?

Case Study 3:

You are the trustee of a sprinkle trust for the benefit of three siblings. The parents wanted a relationship with their adult children independent of their wealth because the money demands from their children was putting too much strain on their relationships. They decided to shift that responsibility to a trustee.

One of the reasons that relationships are strained is because one of the siblings, "Josh" received many hundreds of thousands of dollars for multiple rehab stays due to his drug and alcohol addiction throughout his late teens and 20's. He's been sober for the past 5 years and is now asking for money to buy a bigger house. Asking for large sums of money has been an annual event for Josh. The other siblings are resentful of Josh receiving so much more money than they have, and more so his attitude of entitlement. They feel this is unfair and everyone is expressing their resentments about it. They feel like Josh is getting the better end of the deal even though they've worked hard to stay on the "right path."

In the midst of figuring out how to navigate these family dynamics, one day you get a call from one of Josh's siblings who reports to you that Josh is using substances again. They tell you that if you distribute any money to Josh, it could take away any leverage they have to get him back to rehab and ask you to withhold distributions and deny any of his requests. They tell you that Josh is refusing their initial requests to go back to rehab and the money given to him could buy enough drugs to kill him. What do you do? Where do you start?

Defining Mental Illness:

Fundamentally, mental health underpins everything in our lives related to quality of life and well-being. In order to be diagnosed with a mental illness, the official book of different diagnosable mental health conditions states that there must be significant

changes in thinking, emotions, and behavior along with impairment in ongoing social, cognitive, occupational, and developmentally appropriate functioning^[5].

Mental illnesses, a variety of mental health disorders causing impairment and disruption, vary widely in severity and impact. Symptoms can range from mild and minimally disruptive (such as a constant low level of generalized anxiety) to chronic, debilitating, and severe enough to necessitate hospitalization (such as paranoid hallucinations or delusions, substance induced or a feature of another mental illness). The appropriate guardrails and methods of care are dependent on the specific illness and severity.

Mental illness affects individuals regardless of age, gender, income, or cultural background, and its severity varies widely. Some conditions necessitate intensive care while others can be managed on an outpatient basis, mirroring the approach to managing other medical illnesses.

The category of “serious mental illness” (“SMI”) refers to a range of mental, behavioral, or emotional disorders which significantly impact a person's thinking, mood, and behavior, often resulting in severe functional impairment. Common examples of SMI include:

- Bipolar disorder, characterized by intense mood swings; severe major depressive disorder marked by persistent feelings of sadness and hopelessness;
- Schizophrenia, which distorts perception of reality; and various anxiety disorders, involving excessive fear and behavioral disturbances.
- Major Depressive Disorder with Psychotic Features, a disorder characterized by the typical symptoms of depression such as “...fatigue (exhaustion), disturbed sleep, changes in appetite, feeling worthless and guilty, being unable to concentrate or being indecisive, thoughts of death or [suicide](#)...” with the addition of psychotic features marked by “...moments of psychosis (when people lose some contact with reality).” This “...means experiencing: delusions – thoughts or beliefs that are unlikely to be true, [hallucinations](#) – hearing and, in some cases, feeling, smelling, seeing or tasting things that are not there; hearing voices is a common hallucination.” The content of these delusions and hallucinations most typically reflect the person’s deeply depressed mood. These individuals can also struggle with psychomotor agitation (the inability to sit still or constantly fidgeting or psychomotor retardation (both their thoughts and physical movements are extensively slowed down). Additionally, people with this type of disorder are at a heightened risk of thinking about suicide.^[6]

Serious mental illness can lead to numerous adverse outcomes such as difficulty maintaining employment, limited social support, frequent hospitalizations, homelessness, incarceration, substance use disorders, lack of awareness about one's condition (anosognosia), criminalization, and tragically, incidents like victimization or suicide. These consequences highlight the critical need for comprehensive support and intervention strategies to improve outcomes for individuals affected by serious mental illness. It also emphasizes the vital importance of clients making gifts or leaving inheritance in trust and not outright. Trusts can protect a beneficiary living with mental health challenges, protect the assets from claims from the beneficiaries' inappropriate activities, have a proactive trustee use funds to constructively try to help the beneficiary, and more.

The objective of these case studies and illustrative action plans presented below is to guide advisors as to how to integrate comprehensive strategies to address client and client family mental health challenges. This proactive approach ensures holistic support for clients across all facets of their well-being without forcing estate planners and trustees outside the scope of their own role.

The Role and Responsibilities of a Modern Trustee

The traditional role of a trustee is to carry out the written provisions of the trust instrument, and where silent, to divine the intent of the Settlor/Grantor, etc. The nature or relationship of the trustee can come in many variations: family trustees, individual professional trustees, directed trustees (some refer to these as administrative trustees), traditional bank trust departments, and private trust companies. Family offices can also serve an important role in this process.

Many trustees polled today would say that their job is to administer each trust according to the terms of the trust, to keep proper records, to document decisions, and to ensure that required distributions and taxes are timely paid.

There are many different standards for discretionary distributions that a trust document may include. Seldom would they suggest that the role includes any type of mental health intervention, rather making payments to third parties to benefit a beneficiary with mental health issues is often subsumed under a discretionary or HEMS standard:

- Many trust documents give the trustee discretion over the trust's income and/or principle. Some trusts give the trustee broad latitude, with no guidance or

framework (e.g., “My trustee may distribute as much of the principle of my trust as my trustee in its absolute and sole discretion may deem appropriate”). This is common in many modern trusts as it may provide broader flexibility to address unforeseen circumstances. It may also provide asset protection benefits as there is no fixed standard for distributions that a creditor may try to use to force a distribution. That may be particularly important to protect a beneficiary struggling with mental health challenges.

- However, if a trustee is also a beneficiary, their right to make distributions to themselves must be limited to a specified standard. If that is not done, the beneficiary/trustee’s estate will include the trust assets and their creditors can reach trust assets. As a result, if a trustee could also be a beneficiary the trust will incorporate a standard for distributions that limits distributions to the beneficiary’s health, education, maintenance and support (referred to by the acronym “HEMS.”). Many trust forms default to a HEMS standard more generally. Each of these terms has been well-defined by statute and case law.

- It is also common to name both an independent trustee and a beneficiary/trustee and many trusts will apply the discretionary standard to the independent trustee and the HEMS standard to the beneficiary/trustee.

- Some trusts include mandatory income distributions. If the trust is a spousal trust that was intended to be a qualified terminable interest property (“QTIP”) marital trust for tax purposes it must distribute all income annually. Other trusts, even if not required for tax law purposes, may mandate that income be distributed at certain intervals.

These nuances are important to consider when drafting a trust at inception, or in evaluating the terms of a trust when it is learned that a beneficiary has mental health, addiction or other challenges. If in the latter case, where a beneficiary has a mental health, addiction, or other challenge, and if the distribution standard is not conducive to dealing with the beneficiary’s challenges, it may be possible depending on the terms of the trust and state law to modify the trust to improve the standards. For example, it may be feasible to decant a trust into a new trust that has different distribution standards. If state law does not permit changing distribution standards it may be feasible to move the trust to a different state whose laws permit that type of change and thereafter decant the trust under that new state’s statutes. If a mandatory distribution standard cannot be changed as above, other actions may be feasible to control distributions to protect a beneficiary. For example, the trust may permit payments for the benefit of the beneficiary. So, instead of making direct distributions to a beneficiary who may be manic, the trustee could pay third parties

for services provided to the beneficiary. Investment decisions and perhaps holding certain assets inside an entity to impact the definition of fiduciary accounting income under state law might also be useful to evaluate if permissible.

Some trusts also specify, or prudence would dictate, that the trustee take into consideration other resources available to the beneficiary and may require the beneficiary to submit an asset statement and/or budget to demonstrate that no other resources are available. This is particularly true in the case of Special Needs Trusts, where various government benefits may depend upon an assessment of all available resources in order to qualify. This might also be done for a beneficiary with mental health challenges so that guardrails for trust distributions (and payments to third parties) can be created that work for, but protect, the beneficiary.

The trustee's duties do not bridge the gap to the personal care of a beneficiary, which would fall under the domain of a parent or possibly a court-appointed guardian. Few corporate trustees (e.g., trust companies and trust departments of banks) will accept the role of a guardian of the person, nor appointment as a Health Care Surrogate or Agent with a General Durable Power of Appointment. Some professionals (e.g., social workers who may serve as professional health proxies if state law permits or individual trustees) will take on these roles and can coordinate with the trustee. Also, a trustee may be able to fund a periodic independent assessment by an appropriate health care professional so that objective information can be used as the basis of distribution and other trustee decisions. It may be helpful if the trust instrument expressly provided for this power. But regardless of trust terms a mechanism may be necessary or advisable to encourage the beneficiary to cooperate with such an evaluation.

What is a trustee to do when determining whether a beneficiary has some level of mental health issues? While professional trustees have a great deal of knowledge about finance, law, real estate, business and even some psychological issues regarding family dynamics, trustees (and their employees) are not as likely, or required, to have any training on mental health. Although some large institutional trustees have care managers and other professionals on staff or under contract to provide these types of services, and hence the information and guidance to the trustee as to how to act, not every advisor has access to the same type of immediate guidance.

So, what is a trustee to do when identifying what they might consider to be a mental health issue (because their lack of training means that they don't even know what is and is not a mental health issue, nor would they know about the severity or diagnosis thereof).

There are a number of possibilities for how a trustee might respond to this while staying within the scope of their role and training. Is there an obligation for a trustee to be able to identify the correct issues, and take reasonable action, when a beneficiary exhibits unusual behavior? Some might suggest that is not within the scope of the trustee's responsibilities, as they are not trained to address such matters. But the trustee is charged with making distributions to or for the benefit of the beneficiary in accordance with the terms of the trust. Most important, not addressing the realities of the beneficiary's situation is clearly not the approach to protect the beneficiary facing challenges. Lack of training does not absolve trustees of a moral (if not legal) responsibility to identify and help beneficiaries in need of mental health support.

To help the trustees meet the needs of these clients, creating awareness and action steps discussed below might be helpful.

Next steps:

1. Professional trustees could develop policies and procedures surrounding the issue of mental health issues among beneficiaries, other fiduciaries and powerholders. For example, settlors should be asked whether there are any known or suspected mental health, addiction or other considerations affecting beneficiaries. Periodic information gathering from beneficiaries may include questions to identify such considerations. If the trustee pays expenses directly rather than merely provide a distribution to the beneficiary, information may be gleaned from those payments. Consideration might be given to confidentiality and sensitivities of the beneficiaries. It might be helpful if the draftsman included provisions in the trust document establishing or granting the trustee the right to withhold distributions if certain specified information is not provided by beneficiaries.
2. Those involved in trust administration should be required to attain a minimal level of knowledge and awareness of mental health issues through training. This may require the development of additional training resources.

3. All advisors should encourage educational providers and continuing professional education providers to increase coursework and training regarding mental health issues.
4. Identify professional resources available to estate planners generally, and trustees and trust officers in particular, such as community health services and national consultants who are experts in dealing with mental illness.

Mental Health Issues, Capacity, and the Trustee's Role

A trustee may have to address a beneficiary who is actively intoxicated, experiencing a psychotic episode, in a manic episode, or a myriad other situations. In any of those states of being, the beneficiary may not have legal capacity to act and the trustee might consider taking more protective actions. This might take the form of the trustee paying third parties directly for goods or services provided to the beneficiary, rather than making a distribution directly to the beneficiary who under other circumstances could arrange on their own to receive necessary goods and services. With more severe symptoms, more extreme circumstances might arise. For example, a beneficiary may decide to get off their psychiatric medications and become so severe in their symptomology that they may even be held in a psychiatric hospital for a 72-hour hospitalization and given medication, even without consent, for the sake of stabilization. If a trustee can ascertain in advance that a beneficiary has a higher likelihood of experiencing this level of symptomology, they could help guard against some of the potential damage and be an ally for the beneficiary through a process of creating mutual agreements if they discussed these things in advance of the above events. For trustees with limited knowledge of such situations, involving or consulting with a mental health professional may be advisable, or essential.

It may be helpful to differentiate mental health issues and capacity. The discussion of "capacity" has specific legal connotations and definitions, which determination is within the purview of legal counsel. Capacity is not a static condition but varies based on the individual's mental state and the decisions they are required to make. It encompasses the ability to comprehend relevant information, appreciate the consequences of decisions, and communicate choices effectively. It refers to the ability of an individual to understand and make informed decisions about their personal and financial affairs. In the legal context, mental capacity is assumed to exist for all persons of adult age, unless demonstrated otherwise. So, a trustee may assume that a beneficiary is capable of making their own decisions unless there is sufficient evidence to confirm otherwise. The burden of proof lies with the party challenging the person's capacity.

The concept of supported decision-making is also important. It focuses on providing the necessary support to help individuals with mental health issues make their own decisions rather than limiting or eliminating their involvement in decision-making. A beneficiary with mental health challenges is not necessarily legally, or even functionally, incapacitated. Although they may have points in time where they are in and out of legal capacity depending on their level of symptomology. Whether or not a particular beneficiary meets the legal definition of being incapacitated may be secondary to the reality that the beneficiary may be struggling, and the trustee may have to evaluate when to make a distribution, or to instead to pay a third party, or to make no payment or distribution. It may also affect the type of distributions made, e.g., to a residential care facility to aid the beneficiary at that particular time.

Identifying, understanding, and addressing mental illness issues and issues of capacity may be important to the trustee-beneficiary relationship. When identifying possible incapacity, a critical question often arises, when does someone with a mental illness become incapacitated, unable to make informed decisions, and how might that affect trustee actions? This determination may require assessment by qualified mental health professionals, considering factors such as cognitive functioning, judgment, and the impact of the mental illness and medications on decision-making abilities. As for legal purposes, the determination is a legal one, not a medical one. For the trustee's role, it may be important to understand the beneficiary's capacity from a mental health perspective as much as from a legal perspective. One of the challenges with mental illness is that capacity can fluctuate. A person may be capable of making decisions at certain times but may lack capacity during periods of acute symptoms or crisis. This variability underscores the need for dynamic strategies in trustee-beneficiary relationships.

Depending on the terms of the trust agreement, a trustee, trust protector or other person can retain or appoint a care manager or other mental health professional to advise. This individual could provide services, make recommendations, or even provide mental health professionals who can assess the beneficiary's current capacity, and mental health challenges, if the beneficiary is willing to cooperate. This approach ensures decisions are grounded in professional expertise and sensitive to the beneficiary's condition. To provide stability and support during periods of incapacity, trustees and beneficiaries might establish guardrails. These could be predetermined guidelines and directives crafted through mutual agreements. They outline specific actions and decisions to be implemented when the beneficiary is deemed incapacitated or when the beneficiary identifies in advance the recognizable

symptoms indicating a lack of stability, ensuring continuity and protection of their interests.

Mutual agreements between trustees and beneficiaries may be pivotal. They may outline expectations, preferences, and contingencies tailored to the beneficiary's needs and circumstances. These agreements may foster transparency, trust, and proactive decision-making, enhancing the relationship's resilience in the face of capacity challenges.

In navigating issues of capacity, trustees play a crucial role in safeguarding the well-being and interests of beneficiaries with mental illness. By understanding the unique situation of each beneficiary with mental health challenges, nuances of capacity, implementing robust strategies, and fostering collaborative agreements, trustees may more effectively navigate the complexities inherent in managing trusts for individuals facing mental health challenges.

Company Policies and Procedures:

Trustees might consider developing overarching policies and procedures to address situations where a beneficiary may be rash, impulsive, intoxicated, or exhibits erratic behavior. For example, a policy might be that no trustee makes distributions over the allotted budget without first talking to the beneficiary and being given 72 business hour notice before a decision is reached by the trustee. For professional or institutional trustees who serve on many trusts, this might be advantageous to do generally. For individual trustees, they might consider this proactively if they know or even suspect a beneficiary has mental health issues. Having a policy established and informing affected beneficiaries may allow the trustee to reference these policies and procedures when and as needed. Here are some examples:

Policies:

1. Every beneficiary might have an introductory meeting with the trustee to review terms of the trust as well as trust company policies and procedures during the trustee and beneficiary check-in related to health and capacity. These are reviewed annually.
2. Every beneficiary is asked about mental and physical health concerns the beneficiary experiences or anticipates, and any support they might need in finding or hiring the appropriate professionals. These might be reviewed and updated annually as appropriate in the trustee's discretion.

3. When called for, no distributions over “X” amount will be distributed without review and a meeting. These meetings and reviews will occur within 3 business days. The policy would ideally specify or might specify that the meetings must be in person so that the trustee can be afforded a better opportunity to assess the status of the beneficiary. This gives the trustee an opportunity to investigate further whether this is a legitimate decision or whether the beneficiary is experiencing cognitive impairment related to mental health challenges, intoxication, or other factors. Tactical patience often gives people the opportunity to change their mind, regain clarity, or for more relevant information to come to light.
4. Trustees might endeavor to compile contacts of business, aging, legal, medical, and mental health professionals that are made available to clients upon onboarding and resent upon request.
5. Trustees may limit the time periods for communication. For example, the trustee will not accept calls between the hours of 5 pm and 9 am. If there is a medical or mental health emergency, the beneficiary should call 911 to access immediate help and inform the trustee to handle all financially related matters as soon as possible.

Procedures:

1. First meeting: Trustees might insist on having a first meeting, in person, with the beneficiaries enabling the trustee to get to know the beneficiary beyond whatever the trust document or other formal communications the trustee may have received.
 - a. The trustee may formally inform the beneficiary of trustee policies and an overview of the trustee’s role, especially limitations on what the trustee can do, as well as communication guidelines.
 - b. Ask predetermined questions which may give the trustee more insight into who the beneficiary is, as well as their history.
 - c. Ask predetermined questions about the beneficiary’s level of functioning, as well as strengths and struggles they encounter where they can use more assistance
 - d. Inform them of the limits of your role as trustee and the possible benefits of your role as trustee to them as beneficiary.
 - e. Ask the beneficiary how the trustee can best support them and be upfront about whether the trustee can do whatever they may request, whether the trustee might be able to instead identify another service provider who may be able to address their request, and whether that could be at the expense of the trust.
 - f. Inform the beneficiary of the terms of the trust in simple language. Ask if they have questions.

g. Ask the beneficiary what resources they might need now or in the near future so that the trustee can assist and plan if needed.

h. If it comes to light that the client is experiencing or has a history of mental health challenges, let them know that part of the policies in place for the trust are that the trustee set up a second meeting to create financial safeguards if needed, work with them to understand their specific diagnoses, symptoms, needs, and how the trustee can be an ally in this role.

2. Second Meeting

a. Ask the beneficiary whether they have had a formal medical diagnosis of their condition. If not, perhaps an appropriate evaluation should be encouraged. If they have had a formal diagnosis inquire what they know about their diagnosis, what they feel comfortable sharing, if they have a support system in place, and what some of their red flags might be when they're symptomatic.

b. Ask the beneficiary at what point they believe they have or might in the future lack adequate ability to make sound financial decisions. Write down their definition and listed symptoms. This is important to address whether or not the beneficiary's inability to make decisions rises to the level of legal incapacity.

i. Ask the beneficiary what they would like the trustee to do when they are exhibiting the symptoms they indicated might impair their decision making, or even more so, legal incapacity. Make a safety plan together that defines who the trustee should inform if the trustee is concerned about their symptoms, what financial safeguards are further implemented and strengthened, and what steps the beneficiary may want to go through to prove they've regained capacity.

ii. In the world of mental health, capacity is a thing that can come and go depending on levels of intoxication, intensity of symptoms, and medication compliance/ stabilization. The same person can have moments of lucidity or lose and regain capacity within the span of a day or week depending on many factors. Other people take longer to stabilize and regain capacity. In this context the person may, or may not retain legal capacity throughout these events, but nonetheless may lack sufficient ability to make good decisions for themselves. This might sometimes be viewed as more about practical or functional capacity than the technical definition of legal capacity.

c. Create financial management safeguards, if needed. This may include oversight mechanisms to prevent financial exploitation or overspending, regular audits of trust accounts, and transparent reporting to legal guardians or designated representatives.

d. Crisis management protocols: This includes procedures for addressing situations such as financial exploitation, mental health crises, or instances where the beneficiary may pose a risk to themselves or others. These could become mutual agreements, perhaps reduced to writing in the agreement between the beneficiary and trustee, that the beneficiary may then sign and agree to.

i. Example: Requests for distributions at unusual times of the day/ night or over the amount of “X” will result in a drug test or psychiatric consult before a distribution is made (tailor it to the beneficiary’s specific issue).

ii. Example: The trustee will utilize a TrueLink Financial card to set parameters on the times of day and places where a beneficiary can spend money. For example, instead of a trustee endeavoring to grapple with small dollar daily type expenditures a determined dollar amount could be loaded on a prepaid Visa card and the trustee can limit when and where the card can be used. Those limitations might be done as part of the agreement with the beneficiary. For example, the card might be set so that it can’t be used at smoke shops or casinos. The card might be set so that it can’t be used after 11 pm at night or before 6 am. This can provide a controlled way to give the beneficiary some independence but with guardrails.

iii. Example: If the beneficiary stops taking their medications or exhibits certain identified behaviors, then that beneficiary must agree to undergo a psychiatric evaluation in order to receive further distributions.

iv. Example: The trustee will pay all necessary persons providing housing and services directly so as not to burden the beneficiary with excess amounts of money which may be a temptation when they’re symptomatic.

v. Example: The beneficiary agrees to comply with a psychiatric evaluation within a 30-day period to provide a baseline of functioning and attest to the beneficiary’s current mental status.

e. Both the trustee and beneficiary sign and notarize the document.

3. Annual review meeting.

a. Review relevant policies, procedures, the role of the trustee, trust document distribution provisions, and the mutual agreements with the beneficiary.

b. If the trustee had to implement any of the additional mutual agreements, how did the plan meet reality and does there need to be an adjustment made?

c. Does the beneficiary need any additional resources to support their mental health and well-being?

d. If any new agreements are made or old ones shifted, sign and notarize a new document memorializing what the beneficiary has agreed to do.

Creating and Tailoring Mutual Agreements With the Beneficiary:

Once a beneficiary identified themselves as an individual struggling with their own mental health, it would be appropriate, and easy, to continue forward in creating mutual agreements. In a professional context, mutual agreements are collaboratively developed plans between the trustee and beneficiary which outline actions to be taken if the beneficiary shows symptoms or exhibits previously identified warning signs. These agreements are tailored to the individual's specific needs and the mutually defined circumstances. The trustee initiates a transparent discussion with the beneficiary, clearly explaining the purpose of these inquiries and obtaining the beneficiary's consent before proceeding. Throughout the process, the beneficiary is informed of their right to question the rationale behind any queries or to decline answering them. Establishing comfort and fostering a collaborative alliance are pivotal in ensuring the effectiveness of this approach and in fortifying the relationship.

To illustrate this process, consider the initial case study above involving "Janice," who is diagnosed with Schizoaffective Disorder and is in recovery from addiction:

Trustee: "Thank you for being so open with me about your mental health. Part of my role is to protect not only your assets but your best interest. I know that sometimes when people stop taking medication or start using substances, they can act in ways that are detrimental, and I was wondering if you'd feel comfortable sharing some of the red flags I should be aware of if your mental health starts to become unstable?"

Janice: "Sometimes I get off my medication and I can start hearing things or seeing things that aren't there. I'm ok right now but I can get real paranoid sometimes. It's hard with the medication side effects. They don't feel good and I don't like being on them but I've learned that I need them. Sometimes I also get angry. My psychiatrist says that's part of the disorder and I can just explode. I don't mean to though. I just say things I don't mean. "

Trustee: "Of course. Nobody wants to feel angry and explosive. It sounds like that's one of the things I should look out for. Let me write that down. I want to remember that so I don't take it personally and can remember that's a sign you might need help."

Janice: "I don't really have anyone I can turn to; you know? It's hard. My last trustee was really mean and he didn't care about me at all. That's why I wanted a new trustee. He was abusive."

Trustee: "I'm so sorry to hear that you're alone. One of the things we ask is who we should call if you start to exhibit these red flags, but I hear you saying you don't really have anyone right now that you can turn to. It sounds like you might need some resources. Did I get that right?"

Janice: "I have a psychiatrist and everything. She's really busy but she's kind to me. Outside of that, there's nobody in my real life."

Trustee: "One of the things we do as a trustee is make sure our beneficiaries have access to resources they might need to help them move forward in life. Are you open to me sharing some of those with you?"

Janice: "Sure. Do you think they can help?"

Trustee: "I think so but that's something you can talk to them about when you call. I want to make sure we can find someone who can be your emergency contact, because everyone needs someone in their corner if something goes wrong. What about if you're drinking or using drugs?"

Janice: "That's hard to say. I love spending money and having a good time without drugs and drinking now but it's hard to tell."

Trustee: "Good to know! What do you think we can do to differentiate between times when you want to spend money and thought it out and times when you might be exhibiting some symptoms of your mental illness or intoxication?"

Janice: "You can drug test me if you want. They did that all the time after rehab."

Trustee: "That's a great idea! I'm going to write that down. So, let's agree that if you ask for money beyond the distributions over "X" amount, you will agree to have a medical provider the trust hires do a quick drug test and breathalyzer? Is that something you would be willing to agree to?"

Janice: "Sure. But sometimes I can be really impulsive and my psychiatrist says I have bad judgment."

Trustee: "That's very common for a lot of people struggling with mental health challenges. That's part of the reason why we built in a 3-business day delay for review of any major distributions over X amount. "

Janice: "That's a good idea! I have tons of stuff I buy in the moment and then don't need it or want it at all when I get home or the next day."

Trustee: "Maybe one of the things you can do is save the receipts in case you decide to return it later and spend your money on things you do want. We can also implement a financial guardrail with a credit card that allows you to set parameters on your spending. Is that something you'd be interested in implementing?"

Janice: "Forever?"

Trustee: "No, you can change the parameters at any time so long as we can confirm that the parameters are within the range of what the trust can permit you to spend. What I'd ask is you think it out for 3-4 days before changing the parameters. That way the tool can be in place to help you guardrail against your impulses. "

Janice: "Ok. But I can change it any time, right?"

Trustee: "Exactly! So, what I wrote down from our conversation is that sometimes you struggle to stay on your meds and it can result in you ending up feeling paranoid, seeing and hearing things that aren't there, getting explosive with your anger, and lower impulse control? In order to protect against some of these symptoms that can derail your wellbeing, we're putting in place a credit card with guardrails, drug tests to make sure you're not using substances when making big decisions, and referrals for some more help in finding a trusted person who can be your emergency contact. I'm wondering if we can also ask your psychiatrist to verify that you're making decisions from a stable place if you want a distribution above X amount?"

Janice: "She's a really busy doctor, you know? She's very popular but I can do that."

Trustee: "I'm glad you like her! Our next step is me typing this up and then, after it is approved by the [co-Trustee, Trust officer, etc.] we can sign and notarize it. We'll

review it every year during our annual meeting so that we can adjust it as needed. I appreciate you being so open with me today. Is there anything else I can do to help you or anything else I missed?"

Janice: "Not really. I'll email you if I think of anything. Sometimes I can remember things later but not in the moment."

Trustee: "That happens to me too! And I'll email you too if I have any other ideas."

Janice: "Sounds good!"

Trustee: "Bye, Janice!"

Conclusion

Trustees will commonly encounter beneficiaries with mental health and related challenges. These situations may be difficult, but with proactive planning and effort, trustees may be able to provide better help to these beneficiaries and protect themselves from liability while doing so. Information gathering and embracing proactive planning with beneficiaries is important in such situations. Avoiding discussions with beneficiaries with mental health struggles about their potential challenges may only postpone inevitable issues, leaving both trustees and beneficiaries vulnerable in the long term. The approach suggested mirrors the paradigm of a good Samaritan recognizing someone in medical distress and calling 911, where asking pertinent questions and facilitating appropriate responses can mitigate risks without assuming roles beyond one's expertise.

Advisors educating themselves on beneficiary mental health and related needs may facilitate proactive creation of effective boundaries and procedures, co-designed with the beneficiary, to safeguard beneficiary assets and enhance quality of life for the beneficiary. This proactive stance not only may strengthen the relationship between the beneficiary and the trustee, but it may also mitigate potential liabilities, ensuring a more secure and supportive environment for all parties involved.

HOPE THIS HELPS YOU HELP OTHERS MAKE A *POSITIVE* DIFFERENCE!

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CITATIONS:

^[1] <https://www.nami.org/About-Mental-Illness/Mental-Health-By-the-Numbers/>

^[2] <https://www.samhsa.gov/mental-health/myths-and-facts>

^[3] <https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html>

^[4] <https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf>

^[5] 5th edition of the Diagnostic Statistical Manual Text Revision (DSM-V TR)

^[6] <https://www.nhs.uk/mental-health/conditions/psychotic-depression/>