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Clinically Sensitive Peer-Assisted Mediation in Mental Health Settings

Mediation has been increasingly recognized by social workers as a valuable practice tool in resolving interpersonal, organizational, and other human services system conflicts. Traditional mediation has been defined as a process by which a neutral third party, without a vested interest in any specific outcome, assists parties in a dispute to reach a mutually agreeable resolution (Center for Dispute Settlement, 1980). Child welfare organizations, schools, criminal justice systems, divorce proceedings, and domestic violence programs are currently using mediation techniques to help reduce conflict between individuals, families, and service systems (Barsky, 1997; Etter, 1988; Kurtz, 1988, 1999; Maxwell, 1989; Severson & Bankston, 1995; Umbreit, 1993; Wilhelmus, 1998).

Although mediation practices have become increasingly commonplace in many human service settings, the value of mediation in mental health settings is only beginning to be recognized. This lack of recognition is in part a result of the negative stereotypes surrounding the capacity of people with mental illness to engage meaningfully in the mediation process (Mazade, Blanch, & Petril, 1994; Retzinger, 1990).

There is, however, increasing evidence that people with mental illness are capable of benefiting from mediation (Banyon & Antes, 1992; Clement & Schwebel, 1996). Blanch and Parrish (1994) found that patients "can often discuss and negotiate about aspects of their lives that are unrelated to their specific psychotic thought content" (p. 437). Consumers surveyed felt they could adhere to most mediated agreements when their illness was under control and that mediation offered a way of reducing stress through problem prevention. Mediation also offered mental health consumers a sense of em-

powerment and greater control over their lives. (Clement & Schwebel).

This article describes a pilot mediation program for use by mental health consumers developed at the Rochester Psychiatric Center, an inpatient psychiatric hospital operated by the New York State Office of Mental Health which provides treatment to individuals with severe and persistent mental illness. The mediation program uses mental health clinicians and consumers (peer advocates) to act as mediators or assistants in mediating disputes between consumers and between consumers and staff.

PROGRAM DESCRIPTION

In May 2000, with the help of six peer advocates, the authors designed a mediation program for use on the adult and adolescent inpatient programs at the psychiatric center. A training program for mediators was developed that addressed mediation concepts, values, and conflict resolution skills. The curriculum consists of the following sessions:

1. Understanding Conflict in Mental Health Systems
2. Balancing Power/Empowerment
3. Conflict Styles
4. Values/Feelings Clarification
5. Identifying and Clarifying Interests
6. Communication Skills
7. Problem-Solving Skills
8. Mediation Process
9. Developing Agreements
10. Monitoring Outcome

From the authors' experience with both clinician-mediators and peer mediators, some general principles were developed to guide the phases of clinically sensitive mediation in this mental health setting.

Phases of Clinically Sensitive Mediation

Phase 1: Assessment. In the traditional clinical assessment process, the definition of the problem or proper diagnosis is generally the exclusive domain of the clinician. In contrast, the clinically sensitive mediator or peer assistant helps the individual parties define the problem in terms amenable to the mediation process. The assessment process for mediation focuses on the following questions:

1. Is the consumer a voluntary, willing participant?
2. Can some minimal level of trust be established between the mediator/peer assistant and the individuals in conflict?
3. Can existing power imbalances between the parties, or between the parties and the mediator, be minimized to permit the possibility of a fair and balanced process?
4. Can the consumer state the conflict in a way that is understandable to other parties and engage in a good faith effort to resolve the problem?

Because the final choice to proceed is made by the participants in conjunction with the mediator, the consumer's sense of control over the mediation process and responsibility for the outcome is greatly enhanced during the assessment/orientation phase. In some cases, mediation may have to await symptom reduction.

Phase 2: Orientation. If the assessment phase indicates that the consumer is able to participate in mediation (either with or without peer assistance), an orientation session is provided. The orientation includes explanations of mediator neutrality, the importance of consumers speaking for themselves, assurances regarding the confidentiality of the process, and ground rules for the process. A discussion of the differences between mediation and traditional therapy is provided to consumers.

As the concept of professional mediator neutrality may not be familiar to most consumers (Schwebel & Clement, 1996), it is important that participants understand that the mediator has no power or authority to make decisions on their behalf. A similar explanation is necessary for the role of the peer advocate as mediator, whose job is not to advocate on behalf of the consumers, but rather to advocate for a mutually acceptable solution.

As mental health consumers may have learned that submission to psychiatric authority

is necessary if they are to get along in the hospital, earn "privileges," and return to the community, they may be reluctant to state their interests plainly and assertively. Moreover, individuals with serious mental illness may also be accustomed to others speaking on their behalf (for example, family members, therapists, and consumer advocates) and may lack experience in speaking for themselves. During the orientation process, individuals are coached to be assertive and taught how to problem solve. Responsibility for actual problem solving is, however, clearly assigned to the disputing parties.

Consumers may need to be reassured that by expressing their concerns or complaints openly they will not be subject to reprisals by staff or other consumers. Confidentiality of the process is clearly defined, including those situations in which confidentiality cannot be maintained, such as threats of violence, self-harm, or illegal acts. In a hospital setting, some consumer complaints may meet the criteria of a policy/procedure violation by staff and must be reported as an "incident" requiring formal investigation, including allegations of verbal or psychological abuse, physical abuse, assault, or harassment. The consumer is informed that if such information is revealed, mediation is not the appropriate venue for resolution. In these instances a formal investigation is completed by designated facility staff other than the mediator to preserve neutrality. This prevents the mediation process from becoming a tool of the hospital administration or a consumer vehicle for false allegations against staff.

Ground rules for the mediation session, such as courtesy, respect, and active participation are established. Commitment to working in good faith toward a resolution is established as an expectation.

Phase 3: Identifying and Defining the Issues. Separate premediation meetings with each party to explore and define the issues help the mediator to establish rapport and trust, as well as to interpret process definitions and possible solutions. These separate meetings also allow consumers to tell their stories to a sympathetic listener before discussing them in the mediation session. The mediator or peer assistant helps to clarify the issues and begins the process of reframing the perceived conflict in more neutral terms, always checking with the consumer for acceptance or validation of the introduction of

new words, redefinitions, or strong affective attachments.

In this phase, the mediator or peer assistant attempts to get past the fixed "position" of each party and begins to explore the underlying needs, concerns, and interests of the individuals in dispute. The mediator tries to determine the common ground, reframes "positions" into "interests," and helps the parties articulate the problem to be resolved in mutually acceptable terms.

Phase 4: Problem Solving. Problem solving usually begins with the process of brainstorming. All ideas are encouraged, generating multiple options without discussing the merits or demerits of each. Peer mediators or assistants can help with this by empowering consumers in separate meetings to clearly state their interests and concerns, and developing possible solutions. Options are then evaluated by the participants, identifying the pros and cons of each proposed solution. If agreement about the solution cannot be reached, both parties are informed that mediation is at an impasse and given the option of continuing or terminating the effort.

Phase 5: Developing the Agreement. After agreement on a solution is reached, participants discuss implementation issues. Participants receive congratulations for their hard work, cooperation, and creativity. Reassurance is given that in the event of any future difficulties with the solution chosen, the mediator or peer assistants are available to discuss problems and arrange for a subsequent mediation session if needed. Agreements can be verbal, although it is often beneficial to commit them to written form. The written agreement tends to carry more weight with participants, serves as a reminder of the agreement made, and can be used to track outcomes.

Phase 6: Follow Up. Use of consumer satisfaction surveys and tracking outcomes of mediated agreements provides valuable data for evaluating the mediation program. The mediator personally checks with each of the parties, usually within a day or two after the mediation session, to evaluate the effectiveness of the resolution or whether modifications or reinforcements are needed. A brief consumer satisfaction survey is then completed by each party, to evaluate levels of satisfaction with the mediation process and outcome, and to identify any problems.

Outcome

The pilot mediation program has been well-received by consumers, who have used it to resolve a variety of interpersonal conflicts, including roommate disputes over room neatness and volume of music, personal boundary issues, and misperceptions or miscommunications leading to verbal (or on occasion physical) aggression. Most of these conflicts have been resolved to the satisfaction of the participants, (as assessed by the satisfaction survey), and consumers have reported a sense of accomplishment and improved interpersonal interactions with the other party to the dispute subsequent to the mediation. Consumers who have used mediation refer their peers for this service as well. The mediators have found that many consumers, despite the presence of active psychiatric symptoms, can effectively participate in the mediation process.

MEDIATION: AN EMPOWERING ALTERNATIVE

The mediation literature overwhelmingly cites empowerment as one of the most important features of the mediation process for all types of disputes (Clement & Schwebel, 1996; Mayer, 1997; Umbreit, 1993). By assisting individuals with mental illness to engage fully in developing their own solutions to problems, the mediator sets the expectation that people are competent in addressing their own difficulties and that their choices, desires, and points of view are legitimate and valid, regardless of mental health history or setting. By teaching and modeling productive conflict resolution skills, the mediator helps individuals develop self-confidence in their own abilities and gives consumers valuable experience in handling future conflicts more effectively on their own.

Beyond personal empowerment, the mediation process focuses on interpersonal relationships for understanding our responsibilities toward others. It involves learning to give up to get back in negotiation and the importance of reciprocity in relationships. Mediation's focus on real problems in the real world helps consumers test their problem-solving skills in a protected environment and prepares them for dealing with problems effectively after discharge. Mediation teaches consumers that listening is sometimes as important as speaking, or conversely, that speaking up is necessary to get what you want. The

mediation process not only demonstrates the ground rules for successful interpersonal interactions, but also it makes conflict less frightening and more like a manageable part of everyday life. Finally, agreements that arise from the mutual efforts of two or more affected parties have a greater likelihood of adherence over time. Mediation does reduce conflict; more research is needed to determine how it is accomplished.

A cautionary note is warranted. Mediation is by definition and practice a voluntary process. Unfortunately, coercion continues to be a significant feature of many psychiatric settings (Monahan, Lidz, & Hoge, 1999). Consequently, clinically sensitive mediators must be ever vigilant to possible abuses of authority or power before, during, and after the mediation process. This is especially important when two parties in the dispute are of unequal status within a setting, for example consumer-staff disputes. Mediation cannot ethically proceed if one or both of the parties is coerced, either overtly through threats, or covertly through manipulation. The problem is that agreements attained through compromise between participants of unequal status and resources have a high risk of replicating the original conditions of inequality (Leitch, 1987). That does not mean that people from different ethnic, socioeconomic, or gender groups cannot negotiate, only that the mediator has a responsibility to keep the playing field as level as possible.

The authors believe, however, that clinically sensitive mediation can offer an empowering alternative to problem resolution in mental health settings. Moreover, the benefits resulting from this approach far outweigh the risks. **HSW**

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