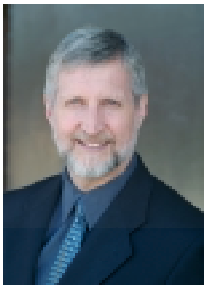
"ON THE LINE" WITH BOB FINLAY:

Accommodating Mediation Participants with Mental Health and Addiction Issues



The Society's best practice teleconference of October 2006 saw board member, Bob Finlay, bring his expertise to a discussion about mediating with participants who have mental health and addiction issues. In the following article, Bob delves into the topic further, focusing on how mediators can accommodate participants with these problems:

Consider the following scenarios: A mediation participant discloses during a private pre-mediation session that they believe that their child protection social worker has set up cameras in their apartment to watch them. During a mediation, a participant appears to be having difficulty following the conversation and often asks for information to be repeated. A participant shows up at a mediation, smelling of alcohol. An hour into a mediation, the mediator notices that one of the participants has fallen asleep. A participant discloses during a private pre-mediation session that they are unsure if they can make it through the mediation because of their feelings of anxiety.

These are only some of the situations that mediation participants with mental health and addiction problems may present to the mediator. Although they do not necessarily indicate such problems, as there may be other explanations for the behavior, they are examples of situations where the capacity of the participants to participate in mediation may well be compromised because of mental health and addictions problems. By capacity, I mean the ability of the participants to follow the conversation, articulate their opinions clearly, concentrate on and understand the issues at hand, understand clearly what is being agreed to and be able to follow through on their obligations and responsibilities in good faith, as outlined in the agreement.

While it is not the mediator's job to diagnose a participant as having a mental health or addictions problem, it *is* the role of the mediator to assess and evaluate the ability of the participant to engage in the mediation in a meaningful way. Sometimes this requires that the mediator work with a participant with compromised capacity to set up accommodations to the mediation process so that the person can still participate. This is especially important for the participant who is struggling with the symptoms of a mental health and/or addictions disorder. The willingness to be creative in developing these accommodations for the participant with compromised capacity is based on two core values: self-determination and inclusiveness. As mediators, we want to be able to assist participants, wherever possible, to feel empowered in making their own decisions about issues that affect them directly. Secondly, the value of inclusiveness means that all participants who can add value to the mediation process through their involvement or who are parties in the negotiation should, wherever possible, be included regardless of the presence of a disorder.

Mental health and addictions issues tend to be hidden unless the participant identifies themselves as having a problem. For this reason, I believe mediators should be proactive in asking participants questions about their general emotional and behavioral functioning and any barriers that may impede their ability to participate in the mediation. This may include asking questions about the participant's ability to concentrate and process information, and their ability to cope with stress, particularly during the mediation. General questions about ability to function in mediation often lead to disclosures about symptoms that point to the existence of a mental health, and/or addictions problem. I find it helps to use neutral language when asking such questions; for example, "Have you been feeling low?" "Have you been stressed lately?" "What is helping and not helping you to cope with these feelings?"

It is helpful for mediators to have a basic knowledge of mental health and addictions problems and to be familiar with the types of symptoms that participants may talk about or present in the pre-mediation and mediation sessions. This knowledge is not for the purpose of providing a clinical diagnosis, as this is outside the realm of the role of the mediator, but rather to assist the mediator and the participant to plan together how best to structure the mediation to accommodate their needs. A good resource for non-clinicians to consult is *The DSM-IV Made Easy*. This book is easy to follow, and clearly lays out all of the necessary information for understanding psychiatric and addictions disorders.

Our willingness or unwillingness as mediators to make accommodations for the participant who has mental health and addictions problems often reflects our own attitudes and values about these conditions.

Research conducted in the United States indicates that participants with mental health and addictions problems are not referred to mediation as frequently as others, including people with physical disabilities. This research also shows that people with mental health and addictions disorders who do participate in mediation tend to be compensated at a lower level as part of their settlement, compared to people with other disorders. These results suggest that various forms of discrimination relating to people with mental health and addictions disorders still do exist. As mediators, I believe we need to reflect on our own biases and assumptions about mental health and addictions issues as this will directly affect how we manage the mediation process.

Experience has shown that most individuals with mental health and addictions issues can successfully participate in mediation. Even people with severe psychiatric disorders can participate in mediation as long as they are receiving treatment and appropriate accommodations are set up by the mediator. The following are examples of accommodations that have been successfully used in supporting participants with mental health and addictions problems to participate in mediation:

- A participant with cognitive deficits, resulting from a brain injury, is assisted by visual aids as well as frequent summarizing and repetition of points made during the mediation.
- A person with an anxiety disorder is given frequent breaks in order to calm down and is allowed to sit close to the door so as not to feel trapped.
- A participant with paranoid delusions is granted a request to have all electronic equipment removed from the room.
- A person with Tourette's syndrome is asked to signal the mediator when their impulses have built up to the point that they need to take a break so they can release their impulses in a private room.
- A participant who has difficulty managing their emotions attends the mediation with an advocate or other support person.

A key point here is that, in order to make these types of accommodations, the mediator needs – prior to the mediation - to gather detailed information about what would help these particular individuals to participate fully in the mediation. Our willingness to make accommodations, combined with a creative approach, is often what is needed in assisting participants with mental health and addictions problems to benefit from mediation.

Accommodations may be made in many different areas. I find it very helpful to ask participants who disclose that they are being treated for a mental health and/or addictions problem whether they are currently using any medications with side effects which might affect their ability to participate in the mediation. Participants, for example, who suffer from depression and are being treated with medication may find that they tend to be drowsy in the morning; therefore, scheduling the mediation in the afternoon may assist them to participate more fully. I ask participants who self-identify with a diagnosis how they would like that information to be utilized in the mediation, particularly if it is relevant to the issues at hand. I find it important to review with these participants how confidentiality will be managed and, if their diagnosis is likely to be discussed during mediation, how they might want me to handle this. I also find it helpful to discuss some ground rules pertaining to how the problem will be dealt with during the mediation. For example, in the case of psychiatric conditions, I discuss what language will be used when referring to the condition, what kinds of information about the psychiatric condition will be open for discussion in the mediation and what kinds of information will be kept confidential.

Our willingness or unwillingness as mediators to make accommodations for the participant who has mental health and addictions problems often reflects our own attitudes and values about these conditions.

Mediation with participants who are challenged by mental health and addictions problems is no doubt a challenge for the mediator. However, in my experience, it is extremely rewarding to see such participants become empowered during the process and have their voice heard at the table. I encourage all mediators to acquire knowledge and develop awareness of these issues. It is well worth your time and interest and ultimately will make you more effective as a mediator.

***Bob Finlay** has a Masters Degree in Psychology and is a Registered Clinical Counsellor and Registered Marriage and Family Therapist. In addition to his clinical work, he mediates in the areas of separation and divorce, child protection, extended family, family business and workplace contexts.*