UNCOVERING AND ADDRESSING MENTAL HEALTH BIAS IN DISPUTE RESOLUTION: SOME OBSERVATIONS

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Explicit and implicit biases about mental health can impede impartiality. This article will share evidence of biases about mental health in dispute resolution practice, make a case for why dispute resolvers should address these biases, and shed light on the prevalence and relevance of mental health conditions. It will also provide an overview of tools practitioners can use to counteract biases related to mental health, including resources developed for a groundbreaking AAA-ICDR Foundation-funded initiative spear-headed by the CUNY Dispute Resolution Center and MH Mediate.

I. MENTAL HEALTH BIAS IN DISPUTE RESOLUTION

The genesis of our work on mental health in the dispute resolution context began with one of the authors, Dan Berstein's firsthand experience as a mediator living with bipolar disorder. Once trained as a mediator, Dan noticed biases affecting how practitioners responded to parties with disclosed or suspected mental illness histories. He found that both basic and advanced mediation trainings noted that the mere presence of a mental illness diagnosis or substance use history has been used as a basis to end a mediation due to widely cited thinking that these parties lacked capacity to engage in the process. Additionally, he experienced both structural and procedural challenges as well as face-to-face insensitivities. For instance, some mediation programs listed mental illness as a criterion to screen out prospective cases. Some mediation trainings that focused on "difficult" clients presented a taxonomy of personality-disorder-inspired categories and recommended surreptitiously placing people into these categories and adjusting

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practices so that these labeled people received differential treatment. Some mediators made comments questioning if parties in their sessions might have mental illness and judging them for potentially being "off their medications." Some practitioners were openly paternalistic to Dan upon learning that he lives with a mental health condition.

Beyond these anecdotal experiences, a literature search provides additional evidence of these disparate practices in the field. Historically, many dispute resolution professionals have been challenged by how to respond to a variety of mental health concerns.[1] For instance, they are often reluctant to proceed with specific cases and some mediation centers have even gone as far as suggesting that participants with mental illness lack the capacity for participating in a session at all. In their 2010 review of books about collaborative law dispute resolution processes, Lande and Mosten found that over half of the books suggested that mental illness and substance abuse raise questions when screening for case appropriateness.[2] For instance, Cameron suggested cases be screened out of the collaborative dispute resolution process if a party has a history of mental health problems, is currently on medication for mental health reasons, is currently receiving disability benefits, has a history of psychiatric hospitalizations, or has a history of suicide attempts.[3] Tesler mentioned specific disorders to consider screening out, such as bipolar disorder and depression.[4] Abney warned against allowing cases to proceed if there is serious mental illness.[5] Shields suggested additional scrutiny for parties with clinical mental health histories.[6] Lande and Mosten also found websites discouraging cases

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[1] *See* Rutter, Mandy, "Mental Health and Mediation: Is Mediation Always the Right Process?", *Mediate.com* (2014), retrieved from http://www.mediate.com/articles/Rutter Mbl20140603.cfm. *Also see* Cleary, J., "On the Question of a Party's Capacity to Use Mediation", *Mediate.com* (2015), retrieved from http://www.mediate.com/articles/ ClearyJ2.cfm; and Crawford, S. H., Dabney, L., Filner, M. and P. Maida, "From determining capacity to facilitating competencies: A new mediation framework", *Conflict Resolution Quarterly,* 20(4), 385 – 401 (2003).

[2] Lande, J., & Mosten, F. S., "Collaborative Lawyers' Duties to Screen the Appropriateness of Collaborative Law and Obtain Clients' Informed Consent to Use Collaborative Law", *Ohio State Journal on Dispute Resolution*, *25*, 347 (2010).

[3] Cameron, N. et al, *Collaborative practice: Deepening the dialogue*, BookBaby (2004).

[4] Tesler, P. H., *Collaborative law: Achieving effective resolution in divorce without litigation*, American Bar Association (2001).

[5] Abney, S. R., *Avoiding Litigation: A Guide to Civil Collaborative Law*, Trafford (2005).

[6] Shields, R. W., Ryan, J. P., & Smith, V. L., *Collaborative family law: another way to resolve family disputes*, Thomson Carswell (2003).

when parties have past mental health histories.[7] These warnings are examples of implicit biases about mental health getting codified into explicit policies and practices.

II. WHY ADDRESSING MENTAL HEALTH BIASES MATTERS

Central to third-party dispute resolution processes is the notion of impartiality. According to the Model Standards of Conduct for Mediators, mediators have an ethical obligation to act free from favoritism, bias or prejudice and to avoid conduct that gives the appearance of partiality.[8] The Standards state that "a mediator should not act with partiality or prejudice based on any participant's personal characteristics, background, values and beliefs, or performance at a mediation, or any other reason." The message is clear that it is inappropriate to treat one party different from another. People should not receive disparate treatment based on a variety of different identity characteristics, including disabilities and mental health conditions. Yet, as noted earlier, evidence exists that preset views about mental health contribute to the disconnect between the ideals espoused by the Standards and the reality of everyday mediation practice. Moreover, important ideal principles like impartiality are forgotten when practitioners rely on their intuition[9] or their own implicit personal biases.[10]

Another key dispute resolution principle for mediators is self-determination. The Model Standards of Conduct for Mediators states that "self-determination is the act of coming to a voluntary, uncoerced decision in which each party makes free and informed choices as to process and outcome." Just as mediation practitioners attempt to refrain from interfering with party choices available to them when conducting a routine mediation, practitioners should also refrain from becoming paternalistic with respect to mental health choices. Parties who identify

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[7] *See* Lande & Mosten, *supra* fn. 2.

[8] American Bar Association, American Arbitration Association, and the Association for Conflict Resolution, *Model Standards of Conduct for Mediators* (2005). *See* https://www.americanbar.org/content/dam/aba/migrated/2011_build/dispute_resolution/model_standards_conduct_april2007.authcheckdam.pdf.

[9] Kressel, K., "How do mediators decide what to do? Implicit Schemas of Practice and Mediator Decisionmaking," *Ohio State Journal on Dispute Resolution*, *28*, 709-735 (2013).

[10] Izumi, C., "Implicit Bias and the Illusion of Mediator Neutrality," 34 *Washington University Journal of Law and Policy*, 71-155 (2010). *See* https://openscholarship.wustl.edu/law_journal_law_policy/vol34/iss1/4.

as having a mental health condition or are suspected of having a mental health condition should not be compelled, in any way, to have a discussion about their mental health that they themselves did not choose to initiate just because the mediator or another party thinks it is important. They should not receive any different treatment from the mediator that is tailored to their mental health condition unless they requested it. Put another way, parties who choose to seek dispute resolution typically have not done so expecting to receive tailored treatment based on their perceived mental health conditions; they should not be provided something they did not choose. Those parties who are seeking to find a safe space to address their beliefs about causes, labels, and treatments for their mental health situations should be encouraged to sort through the variety of available options and not be judged, much like any party would not want to be judged for his/her religious beliefs, lifestyle choices, or decision-making about any other values s/he believes in.

It is crucial that dispute resolvers remain vigilant in recognizing and counteracting biases regarding mental health, operationalizing fundamental dispute resolution values, providing quality service to clients, and respecting settled law about discrimination due to disabilities. Instead of approaching parties living with mental health conditions with a different process, it is imperative for practitioners to treat all parties the same and address whatever challenging behaviors that occur rather than rely on mental health labels to screen out cases or make service adjustments. Anyone can exhibit a variety of challenging behaviors when experiencing conflict. Practitioners should react to these behaviors instead of discriminating based on mental health labels. Succumbing to biased stereotypes often inappropriately, unfairly and sometimes, unknowingly discriminates against selected individuals.

III. THE PREVALENCE AND RELEVANCE OF MENTAL HEALTH CONDITIONS

The prevalence of mental health conditions in the general population is well documented. An estimated 44.7 million American adults, or one in five, experience a mental health problem each year.[11] On a daily basis, this population encounters a wide array of different conflicts and finds its way to conflict resolution processes like any other party.

[11] National Institute of Mental Health, "Transforming the understanding and treatment of mental illnesses," (2017). *See* https://www.nimh.nih.gov/health/statistics/mental-illness.shtml.

Given the aforementioned reality that mental health conditions are widespread, it is fair to assume that many parties in dispute resolution cases are living with mental health conditions.

These parties may not disclose their mental health problems because doing so can be disempowering in a society where stigma toward mental health still runs rampant. A 2007 survey of 35 states, Puerto Rico, and the District of Columbia found that only 57.3% of the general public felt that people were caring to people with mental illness while only 24.6% of people with mental health symptoms felt people were caring to them.[12]

IV. TOOLS FOR MITIGATING BIAS AND FOSTERING EMPOWERMENT IN MENTAL HEALTH CONFLICTS

Mental health biases can be reduced and their impact minimized by raising awareness to counteract misconceptions, empowering party choices to overcome paternalism, and creating robust processes resilient to any unconscious prejudices. The CUNY Dispute Resolution Center and MH Mediate have been partners in this work since 2012. In 2017, we launched the Dispute Resolution in Mental Health Initiative (DRMH Initiative), a project generously funded by the AAA-ICDR Foundation with the goal of developing resources to make a scalable impact. To our knowledge, it is the first high profile undertaking related to mediation training involving people with mental illness since the University of South Florida was funded by the Hewlett Foundation to work on similar issues in 2000.[13] Additionally, our development of extensive online resources promises to be one of the most comprehensive clearinghouses for information on dispute resolution in the mental health context.

Highlights of our efforts leading up to the DRMH Initiative and of our more recent undertakings include:

- **The National Dialogue on Mental Health.** We hosted the first New-York-City-based event in 2013 as part of Barack Obama's White House Initiative to host community mental health

[12] Centers for Disease Control and Prevention, "Attitudes toward mental illness-35 states, District of Columbia, and Puerto Rico, 2007", *MMWR - Morbidity and mortality weekly report*, 59(20), 619 (2010).

[13] Kovick, D., "The Hewlett Foundation's Conflict Resolution Program: Twenty Years of Field-Building" (2005), retrieved from http://www.hewlett.org/wpcontent/uploads/2016/08/HewlettConflictResolutionProgram.pdf.

conversations around the country. Ours was the first to be inclusive of diverse mental health perspectives. As a follow-up, we hosted a training for future organizers to follow this model.

- **The Talking Mental Health Toolkit**. With funding from the NY State Office of Mental Health's Mental Illness Anti-Stigma Fund, we developed a set of three action guides as well as a companion webinar designed to help people have empowering conversations about mental health through the use of conflict resolution practices.
- **Basic Mediation Training for Peer Specialists.** With funding from the AAA-ICDR Foundation, we hosted a Part-146-approved 5-day basic mediation skills training for peer specialists living with mental health conditions. Certified peer specialists use their lived experience of mental illness to help others struggling through similar problems. They receive extensive training and, along with social workers, psychiatrists, psychologists, and other mental health professionals, are part of the treatment teams in outpatient clinics and inpatient settings. Their responsibilities often include program outreach, supporting clients, acting as treatment team liaisons, and motivating clients toward recovery. The peers they support are involved in conflicts with their families, clinicians, and fellow service users. Peer specialists represent a bourgeoning field, and with recent approvals for reimbursement by Medicare, it has become a fast-growing one reaching many diverse mental health contexts (2014; Vestal 2013).[14] There are at least 37 states, as well as D.C., which train and certify peer specialists to work at inpatient or outpatient sites.[15]
- **Online Toolkit to Welcome Mental Health Peers to Conflict Resolution Services.** With funding from the AAA-ICDR Foundation, we developed online resources to help conflict resolvers become accessible to parties with mental health histories.
- **Online Hub for Family Mental Health Conflicts.** With funding from the AAA-ICDR Foundation, we developed an online hub

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[14] *See* Kaufman, L., Brooks, W., Bellinger, J., Steinley-Bumgarner, M., & Stevens-Manser, S., "Peer Specialist Training and Certification Programs: A National Overview", *Texas Institute for Excellence in Mental Health*, School of Social Work, University of Texas at Austin (2014). *See also* Vestal, C., "'Peers' Seen Easing Mental Health Worker Shortage", *The Pew Charitable Trusts* (2013), retrieved from http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage.

[15] *See* Kaufman et al, *supra* fn. 14.

with trainings, tools, and referral resources designed to help organizations and families navigate family mental health conflicts.

All of our resources were developed based on the following key conflict resolution principles, adapted for mental health contexts:

- **Appreciation of Diverse Mental Health Perspectives.** Inherent in all conflict resolution practices, we begin with an appreciation that there are a variety of personal perspectives surrounding conflicts instead of looking for definitive right answers. Too often, even conflict resolvers neglect this fundamental truth when the subject becomes mental-health-related – assumptions, paternalism, and stigma lead them to form more rigid views of appropriate decisions and beliefs. We teach people to respect a diversity of mental health viewpoints, ranging from mainstream medical model perspectives to alternative approaches. We explain the reasons different people may form different views, including such aspects as their roles, experiences, cultures, and personal beliefs about causes, labels, and treatment. We share tools designed specifically to assist people in validating a wide range of views in mental health.
- **Impartiality Across Diverse Mental Health Perspectives.** After respecting that there are diverse views about mental health, it is imperative to treat all of these different views fairly and impartially. We share information about debates within the scientific community regarding best practices in mental health treatment, to underscore the reality that mental health is complicated with even experts disagreeing about best practices. Then we provide tools that help people to remain impartial when encountering diverse mental health perspectives and terminologies. This impartiality is extremely important to support a community that is used to being disempowered by receiving biased treatment.
- **Emphasis on Mental Health Choices.** Frequently, mental health stakeholders defer to expert advice without remembering that they have decisions about how they want to communicate about mental health, which treatment professionals to see and what advice to follow, and what lifestyle choices they feel are best for them. All of our resources highlight the plethora of decisions people face when managing their mental health. They provide tools to help stakeholders collaborate as they make these decisions. These tools for self-determination help to empower people who

have previously had their voices ignored, and who had previously been unaware they had choices.

- **Sensitivity to Mental Health Experiences and Related Traumas.** People who have lived experience of mental health conditions may have experienced symptoms, side effects, life interruptions, social prejudices, and other events. Some of our resources help increase sensitivity to these kinds of experiences while teaching trauma-informed approaches to develop more comfortable practices. All of our resources emphasize becoming accessible and sensitive to all parties, as opposed to profiling certain individuals with special treatment based on asking questions about their mental health histories. Accessibility helps people form better practices for all without making any individuals feel singled out.

V. CONCLUSION

Practitioners can manage their biases about mental health by reminding themselves of core conflict resolution values and applying them to mental health. By remaining aware of diverse mental health perspectives, being impartial across them, and emphasizing mental health choices, they can provide all parties with the same quality service. Mediators can also become more accessible to all parties by becoming trauma-informed and sensitive to mental health experiences, without singling anyone out. By practicing these skills, practitioners can improve how they handle cases related to mental health and they will also be better at operationalizing core dispute resolution values more broadly in all of their cases.

The online materials developed by CUNY Dispute Resolution Center and MH Mediate to help practitioners and laypeople understand and apply dispute resolution in the mental health context are posted online at www.mhmediate.com/drmh.