Resolving Voluntary Mental Health Treatment Disputes in the Community Setting: Benefits of and Barriers to Effective Mediation

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I. INTRODUCTION

Nora is a forty-three year-old woman diagnosed with bipolar disorder and moderate mental retardation.[1] She is a resident of Harmony House, a group home maintained by a community-based voluntary treatment program for individuals with mental disabilities. Yesterday, Harmony House staff called an emergency meeting to address Nora's refusal to take Thorazine, a psychotropic medication prescribed by the program's physician to control the symptoms of her disorder.[2] The staff asked Nora why she refused to take her medication. Nora responded that the medication made her too sleepy to work.

Dana, a Harmony House staff member, questioned Nora's reason for refusing her medication. She noted that Nora routinely stays up watching television until midnight and gets up for work each morning at 5:30 a.m. Dana speculated that Nora's lack of sleep, and not the Thorazine, was to blame for Nora's lethargy. Dana reminded Nora in front of the other staff members that she ought to go to bed by 10:00 p.m. She also noted that the staff has repeatedly asked Nora to wait until 7:30 a.m. to rise for her job. Dana's comments angered Nora, who disliked being told what to do. "I know my rights," Nora shouted. "I can get up when I want to and I don't have to take my medicine."

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[1] The situation discussed here is hypothetical and is based on the Author's experience working with mentally disabled adults. Any similarities to actual persons or programs are purely coincidental.

[2] Thorazine is a major tranquilizer most commonly used to treat patients suffering from schizophrenia. *See* 2 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL & CRIMINAL § 5.02, at 218 n.5 (1989) (citing G.E. Crane, *Two Decades of Psychopharmacology and Community Mental Health: Old and New Problems of the Schizophrenic Patient*, 36 TRANSACTIONS N.Y. ACAD. SCI. 644, 656 (1974); H.C. Denber, *Tranquilizers in Psychiatry*, *in* COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1251 (A.M. Freedman & H.I. Kaplan eds., 1st ed. 1967)). Thorazine is prescribed for "the management of manifestations of psychotic disorders" in doses large enough to control the patient's symptoms for a "reasonable period." PHYSICIANS' DESK REFERENCE 2701, 2703 (1997). For a concise introduction to psychotropic drugs, see BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 62-63 (1997).

The staff attempted to calm Nora down but feared that her disorder would prevent any further attempts at reasonable conversation. This open condescension frustrated Nora, who abruptly stormed out of the meeting.

Twenty-four hours have now passed with no discussion between Nora and Harmony House staff. The director of the program worries about what to do. As a voluntary program, Harmony House cannot force Nora to take her medication.[3] On the other hand, Harmony House cannot allow Nora's behavior to disrupt the entire house either.

Currently, programs like Harmony House have two options to resolve the dispute. They may discharge noncompliant consumers like Nora, leaving their care to other community agencies or family and friends.[4] Or they may seek to have the consumers involuntarily committed to a state psychiatric hospital in order to force them back on their medication.[5] Neither of these options, however, provides a meaningful, long-term solution. This is because discharge and involuntary commitment only address *who* should be responsible for seeing that Nora is taken care of. They do not address *why* Nora refuses to take Thorazine, *why* the staff

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[3] *See* Ronald J. Diamond, *Coercion and Tenacious Treatment in the Community: Applications to the Real World, in* COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW 51, 61 (Deborah L. Dennis & John Monahan eds., 1996). Diamond notes, however, that community treatment programs have other practical means of controlling consumer behavior. This includes program ability to limit money available to consumers whose funds are managed by program staff and control over housing through group home arrangements. *See id.* at 55-58.

[4] *See id.* at 56.

[5] *See id.* at 62. Diamond notes, however, that:

> Coercion is often a short-term solution to a long-term problem. . . . Most episodes involving coercion involve clients with a chronic illness. [However,] [t]hese clients require an ongoing rather than an episodic approach to treatment . . . [rather than a more immediate one which focuses on getting] the client to take the medication as soon as possible.

Id. Other scholars agree. "Coercion may sometimes be necessary, particularly in the treatment of severely ill patients. However, in light of the potential antitherapeutic consequences of coercion, clinicians should resort to it only when truly necessary and should involve the patient in the . . . treatment decision-making processes to the greatest extent possible." Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENV. U. L. REV. 1145, 1167 (1997). For a more complete discussion of the impact of involuntary medication on individuals with mental illnesses, see Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication, in* THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT 189 (David B. Wexler ed., 1990).

believes it is necessary, or *how* to establish improved communication between them to prevent future disagreements from occurring.

In an attempt to find an alternative means of resolving treatment disputes that arise in the voluntary community treatment setting, many scholars and practitioners have begun to explore the use of mediation.[6] Unlike discharge or involuntary commitment,[7] mediation allows for discussion of the root of the consumer's behavior and his or her reasons for refusing a prescribed treatment.[8] Rather than enforcing a unilateral decision by the health care provider, mediation encourages discussion between the provider and consumer on how to best resolve the impasse.[9] Through mutual brainstorming, each party will come to better understand the other's point of view and hopefully reach a resolution that suits both parties' needs.

If these are the benefits of using mediation to resolve disputes between mental health consumers and providers, then why are most voluntary community-based programs not utilizing it? This Note will explore the benefits of integrating mediation into the delivery of community mental health care while addressing some of the criticisms that have arisen to create barriers to its use. Part II will begin with an overview of the

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[6] *See, e.g.*, Janet B. Abisch, *Mediational Lawyering in the Civil Commitment Context: A Therapeutic Jurisprudence Solution to the Counsel Role Dilemma*, 1 PSYCHOL. PUB. POL'Y & L. 120 (1995); Jeanne A. Clement & Andrew I. Schwebel, *Mediation: An Intervention to Facilitate the Empowerment of Mental Health Consumers*, *in* MEDIATION AND CONFLICT RESOLUTION IN SOCIAL WORK AND THE HUMAN SERVICES 195 (Edward Kruk ed., 1997); Joel Haycock et al., *Mediating the Gap: Thinking About Alternatives to the Current Practice of Civil Commitment*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 265 (1994); Noel Mazade et al., *Mediation as a New Technique for Resolving Disputes in the Mental Health System*, 21 ADMIN. & POL'Y MENTAL HEALTH 431 (1994).

[7] For a brief overview of the failings of the civil commitment process generally, and Massachusetts's civil commitment laws specifically, see Haycock et al., *supra* note 6, at 267–269.

[8] *See* Clement & Schwebel, *supra* note 6, at 199; Haycock et al., *supra* note 6, at 281–282; Mazade et al., *supra* note 6, at 437.

[9] *See* Mazade et al., *supra* note 6, at 432–435. Power imbalances are a particular concern in mediations between mental health consumers and providers. This is because traditional mental health treatment has been delivered in a paternalistic fashion. Often, consumers believe they are powerless in making decisions regarding their own care. This idea has been reinforced through the civil commitment process and ability of community programs to control discharge policies. For this reason, mediators must be particularly sensitive to the role each party plays and must encourage participation by the consumer. *See* Clement & Schwebel, *supra* note 6, at 199; Haycock et al., *supra* note 6, at 283; Mazade et al., *supra* note 6, at 434–435.

treatment problems inherent in a voluntary community-based system of mental health care. Part III will discuss current approaches available to community-based programs to resolve the disputes that arise when consumers refuse prescribed treatment. Part IV will then examine the benefits of using mediation as an alternative means of resolving these disputes. Part V will touch upon some concerns regarding the limits of mediation in this context, both real and imagined. Part VI will offer some suggestions for adapting the mediation process to the community mental health context. This Note argues that, despite some limits on consumer participation, mediation should be utilized by voluntary community-based mental health care programs to resolve treatment disputes with consumers.

II. COMMUNITY-BASED MENTAL HEALTH CARE

Beginning in the 1960s, treatment of those with mental disabilities[10] began to shift away from large state institutions to smaller, community-based programs.[11] The following two factors were primarily responsible for this transition: the civil rights movement, which invited debate and commentary on the rights of traditionally under-represented persons, including those with mental disabilities,[12] and the advent of psychotropic

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[10] Congress, while not specifically defining what mental illnesses constitute a mental disability for purposes of the Americans with Disabilities Act of 1990, has included "mental impairment[s] that substantially limit[] one or more of the major life activities of that individual" within the parameters of that Act. 42 U.S.C. § 12102(2) (1994). The courts, however, have interpreted this to "include manic-depressive disorder, schizophrenia, personality disorder, anxiety disorder, alcoholism, post traumatic stress disorder, depression, and unspecified psychiatric problems." Janet Lowder Hamilton, *New Protections for Persons with Mental Illnesses in the Workplace Under the Americans with Disabilities Act of 1990*, 40 CLEV. ST. L. REV. 63, 75-76 (1990).

[11] In 1960, more than 2,000,000 mentally disabled adults resided in state psychiatric institutions. By 1980, the number had decreased to 1,144,785. *See* John Monahan et al., *Coercion to Inpatient Treatment: Initial Results and Implications for Assertive Treatment in the Community*, *in* COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW, *supra* note 3, at 13, 15 (citing M. ROSENSTEIN ET AL., LEGAL STATUS OF ADMISSIONS TO THREE INPATIENT PSYCHIATRIC SETTINGS, MENTAL HEALTH STATISTICAL NOTE NUMBER 178 (1986)).

[12] *See* Virginia Aldigé Hiday, *Outpatient Commitment: Official Coercion in the Community*, *in* COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW, *supra* note 3, at 29, 29.

medications, which effectively controlled many of the symptoms of debilitating mental illnesses.[13]

The civil rights movement's focus on the rights of those historically disenfranchised and neglected by society helped to generate interest in the plight of mentally disabled individuals who, up until that time, were largely committed to state institutions out of society's fear and ignorance.[14] Patients, family members, and nonprofit organizations dedicated to helping mentally disabled individuals began initiating lawsuits challenging the appropriateness of the placement and the adequacy of the care provided by these institutions.[15] These cases, heard by both federal and state courts, determined that the Constitution required states to use the least restrictive means available to treat mentally disabled individuals.[16]

One of the more influential cases in the movement for deinstitutionalization of mentally disabled individuals was the United States

[13] *See generally* 2 PERLIN, *supra* note 2, § 5.02, at 218–227 (discussing the use and effect of the development of psychotropic medication on individuals with mental illnesses and institutional roles). Perlin further notes the following "five separate forces" leading to the deinstitutionalization of mentally disabled adults: (1) recognition of state hospital deficiencies, (2) experimentation with community treatment, (3) increased federal funding available for the treatment of individuals with mental disabilities, (4) development of anti-psychotic drugs, and (5) the "due process revolution" in mental health law. 2 PERLIN, *supra* note 2, § 7.02, at 560–564.

[14] *See* JAMES A. HOLSTEIN, COURT-ORDERED INSANITY: INTERPRETIVE PRACTICE AND INVOLUNTARY COMMITMENT 19–24 (1993); ROBERT D. MILLER, INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL IN THE POST-REFORM ERA at xiii (1987).

[15] For a concise introduction to the role of the courts in the deinstitutionalization of mentally disabled individuals, see JOHN PARRY, MENTAL DISABILITY LAW: A PRIMER 87–92 (5th ed. 1995). For a more in-depth analysis of the right of mentally disabled individuals to refuse medical treatment under the Fourteenth Amendment's Due Process Clause, see Douglas S. Stransky, *Civil Commitment and the Right to Refuse Medical Treatment: Resolving Disputes from a Due Process Perspective*, 50 U. MIAMI L. REV. 413 (1996).

[16] *See* Hiday, *supra* note 12, at 29 (citing Shelton v. Tucker, 364 U.S. 479 (1960); Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Dixon v. Wineberger, 405 F. Supp. 974 (D.D.C. 1975); Lessard v. Schmidt, 379 F. Supp. 1376 (E.D. Wis. 1974); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971)). *But see* Society for Goodwill to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1247 (2d Cir. 1984) (holding that mentally retarded adults have no constitutional right to be in the community because there is no constitutional deprivation associated with being institutionalized); Doe v. Public Health Trust, 696 F.2d 901, 905 (11th Cir. 1983) (holding that minors voluntarily committed to institutions by their parents do not have a right to treatment in the least restrictive means).

Supreme Court's decision in *O'Connor v. Donaldson*.[17] In that case, the Court held that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[18] Additionally, the Court noted that "a finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement."[19] As a result, directors of state institutions were forced to justify the confinement of mentally disabled individuals beyond a simple diagnosis of mental illness or retardation. More importantly, mentally disabled individuals would now have to be provided with treatment programs that included more than the bare essentials of food, clothing, and shelter. Such treatment requires significant funding, something many of these state institutions did not have.[20] As a result, many states began to seek alternate housing and treatment options for their mentally disabled citizens.[21]

While the courts resisted mandatory deinstitutionalization as a broad policy, several required specific institutions to close for quality of care reasons and obligated those institutions to find more suitable community treatment for their former residents.[22] Some states, such as New York,

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[17] 422 U.S. 563 (1975). The respondent Donaldson was involuntarily committed to a Florida psychiatric hospital for almost 15 years. He brought this action against the hospital's superintendent alleging that the hospital had deprived him of his constitutional right to liberty after repeatedly denying requests that he be released. His complaint alleged, and the record substantiated, that "he was dangerous to no one, that he was not mentally ill, and that, at any rate, the hospital was not providing treatment for his supposed illness." *Id.* at 565. Respondent was initially committed by his father, who complained that his son was suffering from delusions. The state diagnosed him as a paranoid schizophrenic and committed him for "care, maintenance, and treatment" pursuant to a Florida statute. *Id.* at 565–566.

[18] *Id.* at 576.

[19] *Id.* at 575.

[20] *See* JOHN Q. LAFOND & MARY L. DURHAM, BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW AND POLICY IN THE UNITED STATES 166 (1992) (citing Statistical Research Branch, Division of Applied & Serv. Research, National Inst. of Health, Unpublished Estimates (Aug. 1991) (noting that more than $8 billion were spent on state hospitals in 1988 alone)).

[21] *See id.* ("[C]ommunity facilities . . . are far less expensive than hospitals. . . . Residential alternatives available on a continuous basis make sense financially and clinically for the vast majority of chronically mentally ill people who need a caring and less stressful environment.").

[22] For an example of one of the most highly litigated of such cases, see *Halderman v. Pennhurst State Sch. & Hosp.*, 446 F. Supp. 1295 (E.D. Pa. 1977), *modified* 612

enacted statutes calling for the creation of community-treatment programs to be funded by state resources generated by the closing of its larger psychiatric institutions.[23] Such legislative responses, however, are the exception rather than the rule.[24]

A second and arguably more influential factor leading to the shift in treatment of those with mental disabilities away from large state institutions to smaller, community-based programs was the discovery and widespread availability of psychotropic medications.[25] These medications significantly reduce or eliminate "hallucinations, lower[] recidivism rates, [allow for] longer intervals between psychotic relapses, . . . [and] reduc[e] [the] average hospital stay."[26] Now able to control the outward manifestations of their illnesses, mentally disabled adults were able to participate more fully in the community and no longer required the care given by larger state institutions.

As a result of increased attention to the rights of individuals with mental disabilities and the advent and availability of psychotropic medications, confinement of mentally disabled persons in large state institutions fell into disfavor and community-based mental health treatment programs flourished.[27] Within a few short years, community-based programs gained primary responsibility for the care, treatment, and training of mentally disabled individuals. More comprehensive in nature than the institutions they replaced, community-based programs seek to treat the individual's illnesses or learning disabilities with medication and training while also engaging the individual in activities designed to facilitate independent community living. Such activities include workplace orientation and job-related skill training, basic household and personal care skill training, and social and communication skill training.[28]

The most striking difference in the methods of treatment employed by these programs as compared with large state institutions, however, is their

F.2d 84 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981), *aff'd prior judgment*, 673 F.2d 647 (3d Cir. 1982), *rev'd and remanded*, 465 U.S. 89 (1984).

[23] *See* PARRY, *supra* note 15, at 91-92 (citing S. 6214 (1993); A. 8920 (1993)).

[24] *See id.* at 90-91; *cf.* LAFOND & DURHAM, *supra* note 20, at 118 (finding a "modest but discernible trend toward broadened civil commitment laws" during the latter half of the 1970s).

[25] *See* 2 PERLIN, *supra* note 2, § 5.02, at 219; WINICK, *supra* note 2, at 61-85.

[26] 2 PERLIN, *supra* note 2, § 5.02, at 219-220.

[27] *See* 2 *id.*, § 5.02, at 219; 2 *id.*, § 7.02, at 560-564.

[28] *See, e.g.*, Diamond, *supra* note 3, at 67-68.

voluntary nature.[29] While voluntary treatment has been shown to have positive therapeutic effects for consumers, it can create significant compliance issues. One of the most frequently encountered problems is a mentally disabled individual's refusal to comply with program medication and medical treatment plans.[30] The individual's need for medical therapy to control the symptoms of mental illness is thus often in tension with the individual's constitutional right to refuse medical treatment.[31] As a result, many community-based mental health treatment programs are left with few choices in how to deal with conflicts between program staff and program participants when the participants refuse to comply with medical treatment plans.

III. CURRENT APPROACHES TO RESOLVING DISPUTES BETWEEN MENTAL HEALTH CARE CONSUMERS AND PROVIDERS IN THE COMMUNITY CONTEXT

To date, voluntary community-based mental health treatment programs have few options to resolve the differences that arise between program staff and participating consumers when the consumers refuse medical treatment. Two fundamentally different approaches to these disputes exist. The first approach focuses on the mentally disabled individual's constitutional right to refuse unwanted medical treatment. The second approach focuses on the individual's best medical interests, regardless of what the individual desires. Applied to any one individual's case, the two approaches often argue conflicting ways of dealing with the individual's refusal of medical treatment.[32]

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[29] While many states employ a system of involuntary community-based mental health treatment programs as a step between involuntary institutionalization and voluntary community treatment, such treatment is outside the scope of this Note. For a discussion of involuntary community-based treatment, see LAFOND & DURHAM, *supra* note 20, at 121–122. *See also* Hiday, *supra* note 12.

[30] *See* 2 PERLIN, *supra* note 2, § 5.01, at 217. For a concise overview of a mentally disabled individual's right to refuse antipsychotic medication, see COMMISSION ON THE MENTALLY DISABLED, AMERICAN BAR ASS'N, THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION (1986) [hereinafter COMMISSION ON THE MENTALLY DISABLED].

[31] *See* discussion *infra* Part III.

[32] *See generally* Mazade et al., *supra* note 6, at 432–433.

The rights-based approach places primary emphasis on a mentally disabled individual's constitutional right to refuse medical treatment.[33] Those espousing this view therefore believe that it is their obligation to abide by the consumer's choice to refuse a particular medication or treatment, regardless of the effect it may have on the consumer's health.[34] For this reason, some scholars have criticized advocates of a rights-based approach for encouraging mentally disabled adults to "die with their rights on."[35] However, most agree that a recognition and focus on a mentally disabled individual's constitutional rights is an integral part of resolving any dispute that may arise during the course of treatment in a community-based program.

In contrast to a rights-based approach, the best interest approach places primary emphasis on the consumer's medical treatment needs.[36] Advocates of this approach believe that it is their obligation to see that the consumer's medical needs are met and are willing to deny the consumer their constitutional right to refuse the treatment if it is in their best interest.[37] The best interest approach is often deferred to by the courts, particularly in the process of involuntary commitment.[38] Consumers' lawyers often appear willing to defer to the judgment of medical experts, even when contrary to

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[33] For a discussion of this right, see COMMISSION ON THE MENTALLY DISABLED, *supra* note 30.

[34] *See* Mazade et al., *supra* note 6, at 431–432.

[35] *See id.* at 432 (citing D.A. Treffert, *Dying with Their Rights on*, AM. J. PSYCHIATRY 130, 259 (1973)).

[36] *See* Mazade et al., *supra* note 6, at 432.

[37] *See* LAFOND & DURHAM, *supra* note 20, at 117. LaFond and Durham note:

> Many court decisions are . . . limiting the rights of patients to refuse drugs and other therapies, reasoning that the law should not impede hospital staff who are trying to bring about the very aim of coercive hospitalization—treatment of people who need it. Measures to increase patient autonomy are increasingly taking a back seat to more pragmatic concerns.

Id.

[38] *See id.* at 167–168; Mary L. Durham & John Q. LaFond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 309 (1988) (discussing the recent trend in the states toward involuntary commitment of mentally ill individuals and the legal justifications for this trend); Charles D.H. Parry et al., *A Comparison of Commitment and Recommitment Hearings: Legal and Policy Implications*, 15 INT'L J. L. & PSYCHIATRY 25, 25 (1992) (discussing the ineffectiveness of the current civil commitment system which allows mentally ill individuals to be committed without the appropriate legal checks).

their clients' stated positions.[39] This is particularly troublesome given attorneys' general ignorance of medical science and methods of diagnosing and treating individuals with mental illnesses.[40] As a result, courts often find in favor of the party advocating treatment and commit the mentally disabled individual to involuntary care over the individual's objections.

Returning to the example in Part I, one may see why neither of the above approaches can completely or satisfactorily resolve disputes between mental health care consumers and providers in the voluntary treatment setting. If Harmony House staff assume a rights-based approach to resolving the dispute, they will respect Nora's decision to discontinue taking Thorazine as an exercise of her constitutional right to refuse medical treatment. While it is important that the staff acknowledge her constitutional rights, such recognition will leave them with few options for resolving the dispute. Harmony House staff may decide to continue to work with Nora, searching for alternate means of controlling the symptoms of her illness. This will be difficult, however, given the fact that Nora must continue to function in this communal setting. Her mood swings and inability to control her anger will doubtless cause a good deal of friction between Nora and her housemates. As a result, it is more likely that Harmony House will decide that Nora's refusal to comply with the program's recommendations warrants discharge from the program. Nora will thus be compelled to find alternative housing and assistance with daily living tasks. If she has family or friends in the community, this may be possible. However, for most individuals like Nora, discharge from a program like Harmony House will result in their homelessness or hospitalization if their symptoms exacerbate.

On the other hand, if Harmony House staff choose a best-interest approach to resolving the dispute, they may decide that Nora's well-being demands that she be forced to continue taking Thorazine despite her refusal

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[39] *See* Haycock et al., *supra* note 6, at 272–274 (noting the failures of the current civil commitment process to promote effective advocacy for patients facing involuntary hospitalization); Virginia Aldigé Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C. L. REV. 1027, 1030 (1982) (summarizing surveys of attorneys' performance in the representation of mentally ill clients, in which observers described them as "reticent, ineffective, ill-prepared, mostly silent, lacking interest, rarely extending any effort, giving only perfunctory representation, doing little to obtain a client's release, and seldom challenging adverse statements by witnesses or adverse psychiatric testimony").

[40] *See* Hiday, *supra* note 39, at 1030 (noting that attorneys' "lack of medical expertise" encourages them to "rely on psychiatric reports that recommend involuntary hospitalization").

to do so. Thus, the staff may attempt to coerce Nora to comply by taking away program benefits.[41] For example, Harmony House may inform Nora that they will no longer provide free transportation to activities that she enjoys, like shopping trips at the local mall. Staff may place additional pressure on Nora to comply by constantly cajoling her to take her medicine. If they are unable to make Nora take her medication after all of the above methods are exhausted, Harmony House staff may have to have Nora involuntarily committed to a state institution.

Unfortunately, neither a rights-based nor best-interest approach gets at the heart of the disagreement between Nora and Harmony House staff. This is because neither approach seeks to address the reasons behind Nora's refusal to take Thorazine. More importantly, neither looks to how *Nora* feels about the situation or gives her any power or control over its resolution. The following Part will examine mediation as an alternative method of resolving this dispute that both empowers the consumer and provides for valuable communication and exchange between the parties to the dispute in order to come to a meaningful resolution.

IV. MEDIATION AS AN ALTERNATIVE MEANS OF RESOLVING DISPUTES BETWEEN MENTAL HEALTH CONSUMERS AND PROVIDERS IN THE COMMUNITY TREATMENT SETTING

Because of the flaws inherent to both a rights-based and best-interest approach to resolving mental health disputes in the community treatment setting, legal and social science scholars have begun to explore alternative methods. Many have turned to the idea of mediation as a valid and useful tool.[42]

Mediation is the process in which a neutral third person assists the parties in resolving their dispute.[43] The neutral person, or mediator, does not act as a fact-finder or adjudicate the dispute as would a judge or arbitrator.[44] Rather, the mediator's role is to facilitate the communication between the parties and to encourage creative problem-solving so that they

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[41] *See* Diamond, *supra* note 3, at 55–58.

[42] *See* sources cited *supra* note 6.

[43] For a concise introduction to the process of mediation, see 1 NANCY H. ROGERS & CRAIG A. MCEWEN, MEDIATION: LAW, POLICY & PRACTICE §§ 1:01–1:04 (2d ed. 1994 & Supp. 1997).

[44] *See* Abisch, *supra* note 6, at 134 (citing Joshua D. Rosenberg, *In Defense of Mediation*, 33 ARIZ. L. REV. 467, 471 (1991)).

may arrive at some mutually acceptable agreement.[45] The process is characterized by joint sessions, in which all parties participate, and individual caucuses, in which the mediator speaks with each party separately.[46] Although the mediator establishes ground rules[47] for the mediation and helps guide the process by framing the issues in dispute, the parties themselves are largely responsible for directing the process and outcome of mediation.[48]

Many advocates of expanded mediation use argue that party participation is the most valuable aspect of mediation as it allows the parties an opportunity to develop their problem-solving[49] and communication[50] skills, which will in turn enable them to better resolve future disputes between the parties. This is especially important for parties to mental health treatment disputes who will likely have a continuing relationship.[51] Moreover, supporters of mediation argue that because the parties play such

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[45] *See* 1 ROGERS & MCEWEN, *supra* note 43, at § 1:02; Haycock et al., *supra* note 6, at 280 (citing H. Jay Folberg, *Divorce Mediation—A Workable Alternative*, *in* ALTERNATIVE MEANS OF FAMILY DISPUTE RESOLUTION 12, 16 (Howard Davidson et al. eds., 1982)).

[46] *See* 1 ROGERS & MCEWEN, *supra* note 43, at § 3:02. Researchers on the use and application of traditional mediation processes to mental health disputes note, however, that caucusing may be ill-advised "if the mental health consumer comes to believe that there is collusion between the mediator and the other party, or the consumer is not able to tolerate being alone while the other party is caucusing." Clement & Schwebel, *supra* note 6, at 204.

[47] Clement and Schwebel stress the importance of explaining the process of mediation to the mental health consumer in a way that the consumer will understand. This includes ensuring that:

> [C]lients have a clear picture of the overall goals of mediation, the role of the mediator, and the nature of the interventions used. . . . Fully orienting mental health consumers to the mediation process may require a unique blend of approaches, an expanded time frame, and frequent repetition of the material covered.

Clement & Schwebel, *supra* note 6, at 202.

[48] *See id*; *see also* Abisch, *supra* note 6, at 134 (citing Rosenberg, *supra* note 44, at 471, 476–477).

[49] *See* Clement & Schwebel, *supra* note 6, at 199.

[50] *See* Haycock et al., *supra* note 6, at 281.

[51] *See id.* (citing Marilyn Park et al., *Developing a Legal Services Program Policy on Alternative Dispute Resolution: Important Considerations for Older Clients and Clients with Disabilities*, 26 CLEARINGHOUSE REV. 635, 636 (1992)); Mazade et al., *supra* note 6, at 435.

a significant role in shaping their agreement, they are more likely to be satisfied with it and comply with its terms.[52]

Advocates of the integration of mediation into the delivery of community-based mental health treatment focus primarily on its consumer-centered approach and its flexibility.[53] In contrast to the rights-based and best-interest approaches to resolving voluntary treatment disputes, mediation allows for an examination of the consumer's feelings underlying the dispute.[54] This is particularly important in the mental health care context, where consumers often feel that their feelings are ignored in favor of the opinions of doctors and mental health advocates.[55] Additionally, mediation allows for creative problem-solving and the establishment of agreements that are unique to the parties.[56] This flexibility is not characteristic of more traditional legal approaches[57] and is particularly desirable in the resolution of mental health disputes, where the individuals may not be able to abide by more rigid, court-ordered requirements.[58] Through mediation, the parties may arrive at an agreement that is tailor-made to accommodate the needs of the consumer while taking into account the resources of the community provider.

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[52] *See* Haycock et al., *supra* note 6, at 281 (citing Craig A. McEwen & Richard J. Maiman, *Small Claims Mediation in Maine: An Empirical Assessment*, 33 ME. L. REV. 237, 257, 260–264 (1981); Jessica Pearson & Nancy Thoennes, *Mediating and Litigating Custody Disputes: A Longitudinal Evaluation*, 17 FAM. L.Q. 497, 504–510 (1984)); Mazade et al., *supra* note 6, at 441 (citing S. Eisenthal et al., *Adherence and the Negotiated Approach to Patienthood*, 36 ARCHIVES GEN. PSYCHIATRY 393–398 (1979)).

[53] *See* Haycock et al., *supra* note 6, at 280; Mazade et al., *supra* note 6, at 435; Andrew I. Schwebel & Jeanne A. Clement, *Mediation as a Mental Health Service: Consumer's and Family Members' Perceptions*, 20 PSYCHIATRIC REHABILITATION J., Summer 1996, at 55, 56.

[54] *See* Clement & Schwebel, *supra* note 6, at 198–199.

[55] *See* Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 17 (1991). Indeed, research suggests that getting mental health consumers to participate in mediation may be a mediator's greatest challenge. This is because most individuals having long-term involvement with mental health care and legal and clinical advocates are used to being spoken for instead of asserting their interests and opinions themselves. *See* Clement & Schwebel, *supra* note 6, at 203; Mazade et al., *supra* note 6, at 434–435.

[56] *See* Haycock et al., *supra* note 6, at 280; Mazade et al., *supra* note 6, at 435.

[57] This is particularly true of the civil commitment process, where the only options are to commit or not. *See* Haycock et al., *supra* note 6, at 280.

[58] *See generally* Clement & Schwebel, *supra* note 6.

In Nora's situation, for example, mediation might be employed to resolve the dispute regarding her treatment. The mediator's role would be to facilitate communication between Nora and Harmony House staff in order to uncover the issues underlying her refusal to take her prescribed medication. The mediator would begin by explaining the mediation process in a way that is meaningful to both Nora and the staff.[59] The mediator would then encourage Nora to explore why she dislikes taking Thorazine. For the first time, staff may hear that Nora is afraid that she will be fired from her job at the local sandwich shop as a result of her constant catnapping, which she attributes to her medication. During this discussion, Nora might also inform staff that the sandwich shop has emphasized the need for a tidy and well-groomed appearance. This, she explains, is why she rises so early each morning to prepare for work.

The mediator might then ask Harmony House staff to discuss why they believe Thorazine is the appropriate medication for Nora. Staff will relate instances of aggressive and disruptive behavior by Nora, particularly toward her roommate, Betty. Because Betty dislikes having the light on in their room so early in the morning and is upset by the noise created by Nora's grooming, Betty and Nora frequently engaged in loud shouting matches. The staff attributed these outbursts to Nora's mental illness and relayed them to the program physician. As a result, the physician has recently increased Nora's Thorazine dosage. Nora's recent catnapping at the sandwich shop is one apparent side effect.

Upon further discussion, Harmony House staff will reassess whether or not medication is the best answer to Nora's problems. They may now understand that Nora's outbursts may be attributable to her fear of losing her job, rather than her illness. However, if they still believe that taking Thorazine will help Nora, they will have the opportunity to explain this to her. Moreover, because Nora has had the opportunity to talk out her concerns, she may be more willing to listen to Harmony House staff. Once Nora feels heard and understood, she may be more amenable to discussing her medication.

The mediator might then excuse program staff and spend some time talking with Nora individually.[60] During this session, the mediator will encourage Nora to brainstorm about some possible solutions to the

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[59] *See* discussion *supra* note 47. Clement and Schwebel suggest that the mediator use visual aids where possible and use short, simple, concrete ideas when explaining the process. *See* Clement & Schwebel, *supra* note 6, at 202-204; Schwebel & Clement, *supra* note 53, at 58.

[60] *But see* LAFOND & DURHAM, *supra* note 20.

problem. Would she consider exchanging roommates with another resident? Is there some place or someone that she could talk to when she felt her anger rising in order to prevent explosive outbursts? Could she adjust her work schedule so that she would have adequate time to get ready in the morning and thus avoid the cause of the disruption? Lastly, the mediator might prompt Nora to consider the staff's position regarding continued medication. Might she consider resuming the medication at the previously lower dose, with adjustments to follow if needed once her home and work schedules have been adjusted to compensate for her difficulties?

Likewise, the mediator would meet separately with the staff. Is it possible to switch Nora and another resident so that she and Betty no longer have to share a room? Is there some place Nora can go or someone available to Nora who can listen to her and help her to vent her emotions before they develop into an explosive episode? With these adjustments at home, and perhaps a few at work, might it be appropriate to lower Nora's dose of medication or change it entirely so that she will be better able to perform at work?

Bringing Nora and the staff back together for a joint session, the mediator would then explore the options discussed during the caucuses with Nora and Harmony House staff. The mediator will attempt to find a middle ground that is acceptable to both parties. Once this is established, the mediator will draft an agreement that incorporates the compromise reached. The agreement must be drafted in such a way that Nora will comprehend it. This problem might be overcome by some picture cards designed to remind Nora of the agreement and to prompt her to talk with staff or relax in her special place when she feels the need to release anger. Alternatively, the mediator might make an audio or video recording of the agreement to remind Nora of the settlement and her responsibilities under it.[61]

In the end, such a process will likely leave Nora feeling less angry, less frustrated, and less anxious about both her home and work situations. The staff, too, will be more sympathetic to the stresses in Nora's daily life. Having brought both parties to a new understanding of the conflict and the reasons behind it, mediation will strengthen rather than harm their relationship.

Improved communication, party-directed settlement, and the opportunity for consumer expression and empowerment through participation in the decisionmaking process make mediation a very

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[61] *See* Clement & Schwebel, *supra* note 6, at 204; Schwebel & Clement, *supra* note 53, at 58.

attractive alternative to the current approaches available to resolving disputes that arise in the community treatment context.

V. BARRIERS TO EFFECTIVE MEDIATION OF DISPUTES IN THE COMMUNITY TREATMENT CONTEXT: THE QUESTION OF COMPETENCY

Despite its apparent benefits, mediation has yet to be integrated into the community mental health care delivery system.[62] This is primarily due to the belief that mentally disabled individuals are incompetent to negotiate effectively or to abide by mediated agreements.[63] However, recent studies indicate that mentally disabled adults can participate in their own treatment decisions and welcome the opportunity to do so.[64] Moreover, they show that consumers who participate in mediation are more likely to abide by the agreements reached than with treatment decisions made unilaterally by the program or legal system.[65] This Part will address the conventional wisdom regarding mental disabilities and competency as well as research suggesting that just the opposite may be true.

The legal community has long wrestled with the question of how much input and autonomy mentally disabled individuals should be given in representing their interests.[66] Conventional wisdom suggests that individuals who are mentally retarded or who suffer from mental illnesses are unable to make decisions, particularly with regard to their medical treatment, that are both well reasoned and in their best interest.[67] As a result, these individuals have been shut out of the decisionmaking process. When able, doctors, therapists, social workers, and others attempt to exert influence over mentally disabled individuals in order to assure that their best interests are looked after. Where this is not possible, or where the individual refuses to comply, the legal system often assumes the role of

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[62] *See* Mazade et al., *supra* note 6, at 434, 436, 441.

[63] *See* Haycock et al., *supra* note 6, at 284; Mazade et al., *supra* note 6, at 436-437; Schwebel & Clement, *supra* note 53, at 55-56.

[64] *See* Mazade et al., *supra* note 6, at 437; Schwebel & Clement, *supra* note 53, at 57.

[65] *See supra* note 58 and accompanying text.

[66] For a discussion of competency and mental health law, see Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625 (1993) (addressing the presumption that mentally disabled individuals are incompetent to make treatment decisions as played out in the civil commitment process and the legal system's reliance on expert medical testimony).

[67] *See id.* at 627-630; Schwebel & Clement, *supra* note 53, at 55.

care-giver and guardian. Unfortunately, research shows that such arguably altruistic actions may actually undermine, rather than contribute to, a patient's therapy.[68]

The problems inherent in both our medical and legal communities regarding the treatment of mentally disabled individuals is the subject of much discussion among therapeutic jurisprudence scholars.[69] They note that societal prejudices towards mentally disabled adults have prevented the development of a legal system that values their abilities and contributions.[70]

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[68] Winick notes that "[t]reating patients as incompetent to make . . . treatment decisions for themselves . . . actually may promote psychological dysfunction. Exercising self-determination is a basic human need. Studies show that allowing individuals to make decisions for themselves is intrinsically motivating." Winick, *supra* note 5, at 1162.

[69] "Therapeutic jurisprudence" is "the study of the role of the law as a therapeutic agent." David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 PSYCHOL. PUB. POL'Y & L. 220, 220 (1995). For a complete discussion of therapeutic jurisprudence and its arguments for the empowerment and treatment of mentally disabled adults through the law, see DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (1990); ESSAYS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1991); Janet B. Abisch, *supra* note 6, at 120 (arguing that mediation techniques should be incorporated in the current civil commitment process to empower mentally disabled clients and allow for meaningful representation by counsel); Michael L. Perlin, *On "Sanism,"* 46 SMU L. REV. 373 (1992) (arguing that societal prejudices towards mentally disabled individuals have shaped our law to limit their rights and impair their participation); Perlin, *supra* note 66 (discussing the use of competency to limit the rights of mentally disabled adults); Winick, *supra* note 5.

[70] In his article, *On "Sanism,"* Michael Perlin describes the following ten most common myths held applicable to individuals with mental illnesses: (1) they are "different" from others in that they are unable to control their moral, emotional, and sexual selves; (2) they are dangerous at worst, simple-minded at best, and thus the state's institutionalization of them is justified under its police or *parens patriae* power; (3) they are incompetent to make well-informed decisions regarding their own well-being; (4) those individuals who refuse to take antipsychotic medication are likely to become violent and therefore should be institutionalized; (5) they are easily identifiable; (6) labeling individuals who are mentally ill as suffering from particular maladies is acceptable, and in fact proper; (7) they should not be integrated into the community due to their economic and social instability; (8) those individuals suffering from mental illnesses who are convicted criminals are incapable of reform and are thus the most dangerous kind of criminals—yet they too often are allowed to plead insanity and therefore "beat the rap"; (9) they are the way they are because they lack the ability to control themselves, or simply choose not to; and (10) they are best left in institutions, where neither they nor society will be harmed. *See* Perlin, *supra* note 69, at 393-397; *see also* ROBERT M. LEVY & LEONARD S. RUBENSTEIN, THE RIGHTS OF PEOPLE WITH

As a result, mentally disabled individuals have been left out of the decisionmaking processes that most affect them. This includes civil commitment hearings, medication reviews, and other issues in treatment planning.

Contrary to the conventional wisdom that mentally disabled individuals are unable to make reasoned decisions regarding their medical treatment, recent studies suggest that the opposite is true.[71] Relying on data and feedback generated by five consumer focus groups,[72] researchers Andrew Schwebel and Jeanne Clement found that consumers favored the use of mediation to resolve mental health care disputes.[73] Furthermore, most stated that they believed they would be able to comply with mediated agreements so long as their illnesses remained asymptomatic.[74] Other researchers, such as Blanch and Parrish, found that consumers believed they could participate in mediation "even when holding psychotic beliefs" or when hospitalized as a result of acute illness.[75]

MENTAL DISABILITIES 1-2 (1996) (describing early Supreme Court case law and state statutory law finding mentally retarded adults to be a "blight on mankind" and "a danger to the race"). Justice Holmes, writing for a unanimous United States Supreme Court in *Buck v. Bell*, commented that "[i]t is better for all the world, if instead of waiting to execute the degenerate offspring for crime, or let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind [through compulsory sterilization] . . . . Three generations of imbeciles are enough." 274 U.S. 200, 207 (1927).

[71] *See* Schwebel & Clement, *supra* note 53, at 56.

[72] Fifty consumers of differing ages, gender, ethnicity, social class, and level of disability participated in ten meetings which were held in urban, suburban, and rural areas. Each had been hospitalized at least once in the recent past. Consumers were introduced to mediation through a brief film, after which they were encouraged to participate in a two hour discussion regarding the use of mediation to help them in resolving disputes with mental health care providers over issues of treatment. *See id.*

[73] *See id.* at 55-57.

[74] *See id.* at 57.

[75] *Id.* at 56 (citing Andrea K. Blanch and Jacqueline Parrish, *Reports of Three Roundtable Discussions on Involuntary Interventions*, *in* PSYCHIATRIC REHABILITATION AND COMMUNITY SUPPORT MONOGRAPH SERIES 1 (1994)); *see also* Mazade et al., *supra* note 6, at 437 (citing Andrea Blanch et al., *Consumers, Practitioners, and Psychiatrists Share Insights About Recovery and Coping*, 13 DISABILITY STUD. Q. 17-20 (1993) ("[D]ata . . . suggest[s] that even persons in a mental health crisis are often willing and capable of talking with others about the precipitating events that have led to the crisis, and about potential resolution of their problems.")).

Most scholars agree, however, that there are limits to consumer participation in mediation.[76] Some suggest that mediation should not be used to resolve conflicts where competency of the consumer is the central issue[77] or where the individual is unable to effectively communicate wants and needs.[78] Many others want to preclude participation to consumers experiencing full blown psychotic episodes. However, making participation in mediation contingent upon the consumer's psychiatric state begs the question of who is to make that determination.[79] A mediation system that hinges on a finding of competency by either the mediator or counsel would appear to have the same problems as the current approaches to resolving mental health disputes.[80]

Unfortunately, there simply is not enough data to date to overcome societal prejudices that color our beliefs regarding the competency of mentally disabled individuals, particularly as it is required to participate in the legal system. The debate over competency will thus continue to be an effective barrier to the integration of mediation into the mental health system until further research can be completed.

VI. ADAPTING MEDIATION TO SUIT THE MENTAL HEALTH CONTEXT

Those willing to accept that mentally disabled adults are competent to participate meaningfully in the mediation process do, however, advocate for systematic changes to accommodate for the special needs of mental health care consumers.[81] This includes establishing specific mediator qualifications to limit the practice of mediation to mental health professionals or those educated in topics of mental health. Advocates also

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[76] *See* Mazade et al., *supra* note 6, at 441.

[77] *See* Haycock et al., *supra* note 6, at 284 (citing AMERICAN BAR ASS'N, ALTERNATIVE DISPUTE RESOLUTION: AN ADR PRIMER (3d ed. 1989)). This does not accord with the authors' view, which is that competency is almost always the issue in disputes between mental health care consumers and providers. *See id.*

[78] *See* Mazade et al., *supra* note 6, at 441.

[79] *See* Abisch, *supra* note 6, at 136 (arguing that lawyers trained in mental health law and mediation techniques might be the best decisionmakers); Haycock et al., *supra* note 6, at 285 (arguing that this power should be invested in the mediator).

[80] *See* Haycock et al., *supra* note 6, at 284–285. The authors note that "to achieve its goals and to represent an alternative approach to involuntary civil commitment, mediation cannot simply be for the already compliant patient, but must also involve some of those who have weak relationships with mental health providers or are otherwise somewhat treatment resistant." *Id.*

[81] *See, e.g.*, Clement & Schwebel, *supra* note 6, at 202–204.

address issues of appropriate settings in which to hold mediations involving mental health consumers, whether or not to limit the use of caucuses, and the need to create visual or audio aids to assist the consumer in an understanding of the process and the agreement. Finally, those seeking to integrate mediation into the current system of mental health delivery must determine whether the parties' counsel should attend the mediation.[82]

A. *Who Should Mediate?*

Although scholars disagree as to whether mediator qualifications are a necessary means of ensuring quality mediation,[83] most recognize that in specific areas of conflict additional training or education may be needed.[84]

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[82] For a brief overview of this debate, see Haycock et al., *supra* note 6, at 284–287.

[83] Mediator qualifications and training are areas of considerable debate among legal scholars. *See* W. Lee Dobbins, *The Debate over Mediator Qualifications: Can They Satisfy the Growing Need to Measure Competence Without Barring Entry into the Market?*, 7 U. FLA. J.L. & PUB. POL'Y 95, 96 (1995); Norma Jeanne Hill, *Qualification Requirements of Mediators*, 1998 J. DISP. RESOL. 37, 37. Many argue that mediators should be required to meet a minimum level of education and training in the process and techniques of mediation in order to be licensed as a mediator. *See* Dobbins, *supra*, at 96–97; Bobby Marzine Harges, *Mediator Qualifications: The Trend Toward Professionalization*, 1997 BYU L. REV. 687, 688. Some, however, maintain that such requirements unnecessarily limit the number of mediators available to the public and create a private system of mediation that precludes its use to those who cannot afford it. *See* 1 ROGERS & MCEWEN, *supra* note 43, § 2:04 (citing NEW S. WALES LAW COMM'N, TRAINING AND ACCREDITATION OF MEDIATORS, REPORT 47 (1991)); *id.* at § 2:08; Dobbins, *supra*, at 97–98. They would not limit mediator licensing to particular professions, such as lawyers, but rather would simply require some basic training in mediation techniques. *See* Dobbins, *supra*, at 110, 111.

[84] This is most often the case with mediation involving the family issues, including divorce and child custody arrangements. *See* Dobbins, *supra* note 83, at 101 ("The Academy of Family Mediators requires its members to hold a law degree, a master's degree, or a bachelor's degree in addition to having several years experience."); Dobbins, *supra* note 83, at 105 ("In Michigan, an individual cannot become a domestic relations mediator unless he has been practicing law for five years and has actively practiced in domestic relations for three of the past five years."); Harges, *supra* note 83, at 694–699 (providing a table of state qualifications for domestic case mediators). *But see* Nichol M. Schoenfield, Note, *Turf Battles and Professional Biases: An Analysis of Mediator Qualifications in Child Custody Disputes*, 11 OHIO ST. J. ON DISP. RESOL. 469, 486 (1996) (noting that some studies cast a doubt on "whether mediator qualifications, particularly those requiring educational degrees, make a substantial contribution to the fairness of the process") (quoting Craig A. McEwen et al., *Bring in*

This is particularly true in mental health law, where issues of diagnosis, treatment, and community resources and services are almost always intertwined with the discussion of the individual's legal rights. For this reason, most commentators argue that mediators employed in the mental health context should have a thorough knowledge of mental health law and related mental health concepts in addition to available community resources.[85]

Some have suggested that mediation teams be employed rather than individual mediators.[86] Their assumption is that a team would be less likely to slip into the role of legal advocate for the consumer or, alternatively, a clinician seeking to advance the best medical interests of the consumer.[87] Whether a team or individual is ultimately employed, however, the mediator's appearance of fairness and ability to facilitate communication between the parties without appearing coercive to the consumer is crucial to successful mediation of mental health disputes.[88]

B. *Where Should Mediations Be Held and How Should Mediators Accommodate for Consumers' Special Needs?*

Because individuals with mental disabilities are often unable to process large amounts of information over an extended period of time, advocates of the use of mediation to resolve disputes between mental health consumers and providers suggest that mediation be conducted in a setting in which there are few disturbances[89] and that the mediator allow for frequent breaks and repetition of information and instructions.[90] Additionally, scholars note that mediators will have to be more sensitive to how consumers are

the Lawyers: Challenging the Dominant Approaches to Ensuring Fairness in Divorce Mediation, 79 MINN. L. REV. 1317, 1344 (1995)).

[85] *See* Clement & Schwebel, *supra* note 6, at 203; Haycock et al., *supra* note 6, at 286 (arguing that familiarity with mental health issues and the law is the key requirement).

[86] *See* Haycock et al., *supra* note 6, at 286 (citing Russell M. Coombs, *Noncourt-Connected Mediation and Counseling in Child Custody Disputes*, 17 FAM. L.Q. 469, 470 (1984)).

[87] *See id.* at 287.

[88] *See* Clement & Schwebel, *supra* note 6, at 203, 207.

[89] Clement and Schwebel suggest holding mediations in locations other than those usually used by mental health professionals, such as a church or local library. This way, both the consumer and the provider are able to feel at ease in a setting that is quiet and disconnected to the dispute, thus avoiding the possibility for "negative cues." *Id.* at 206.

[90] *See id.* at 207.

processing information regarding mediation procedure.[91] They suggest that mediators use flip charts or other visual and audio aids to stimulate and engage the consumer during mediation.[92] Likewise, similar cues may be employed by the mediator to remind the consumer of the agreement reached so that the consumer may be better able to comply with its provisions.[93]

C. *Should the Parties' Counsel Attend the Mediation?*

As stated above, lawyers and the courts must recognize the consumer's constitutional right to refuse treatment when engaging in any legal proceeding.[94] Those who advocate counsel attendance argue that lawyers are needed to provide a check on the paternalistic influence and pressure exerted by mental health care providers.[95] They believe that lawyers will be better able to balance the needs of the consumer with the consumer's legal rights than would a mediator whose training would prejudice the mediator toward a clinical approach.[96]

However, as previously noted, lawyers are rarely able to strike that balance.[97] Professional guidelines, moreover, do little toward assisting

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[91] *See* Schwebel & Clement, *supra* note 53, at 58.

[92] *See* Clement & Schwebel, *supra* note 6, at 204–207; Schwebel & Clement, *supra* note 53, at 58.

[93] *See* Schwebel & Clement, *supra* note 53, at 58.

[94] For a discussion of the legal rights of mentally disabled adults, see *supra* Part III and accompanying notes.

[95] *See* Abisch, *supra* note 6, at 133–137 (discussing the role of the lawyer generally); Haycock et al., *supra* note 6, at 287 (discussing the role of the lawyer as one who focuses on the legal aspects of the consumer where the mediator might be less inclined to do so because of the mediator's mental health orientation).

[96] *See* Abisch, *supra* note 6, at 133–137; Haycock et al., *supra* note 6, at 287.

[97] *See supra* notes 39–40 and accompanying text. For a more in-depth discussion of the lawyer's difficult role in representing clients with mental disabilities, see Elliot Andalman & David L. Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L.J. 43 (1974); Stanley S. Herr, *Representation of Clients with Mental Disabilities: Issues of Ethics and Control*, 17 N.Y.U. REV. L. & SOC. CHANGE 609 (1990); Stanley S. Herr, *The Future of Advocacy for Persons with Mental Disabilities*, 39 RUTGERS L. REV. 443 (1987); Hiday, *supra* note 39; Steven J. Schwartz et al., *Protecting the Rights and Enhancing the Dignity of People with Mental Disabilities: Standards for Effective Legal Advocacy*, 14 RUTGERS L.J. 541 (1983); Paul R. Trembley, *On Persuasion and Paternalism: Lawyer Decisionmaking and the Questionably Competent Client*, 1987 UTAH L. REV. 515;

lawyers in this role.[98] The complete discretion given lawyers in their relationship and representation of mentally disabled individuals leaves them as vulnerable to the influences and professional judgment of clinicians as are their clients.

Moreover, including lawyers in mental health mediation makes it more likely that the proceedings will be adversarial rather than cooperative in

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Steven J. Goode, Note, *The Role of Counsel in the Civil Commitment Processes: A Theoretical Framework*, 84 YALE L.J. 1540 (1984).

[98] *See* Haycock et al., *supra* note 6, at 287. The legal system's ambivalence is evidenced in the inability of drafters to agree on the lawyer's role in representing clients with mental disabilities. The most recent statement on this issue can be found in the American Law Institute's Proposed Final Draft Number One of Restatement of the Law: The Law Governing Lawyers:

> § 35. Client Under Disability
>
> (1) When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of minority, physical illness, mental disability, or other cause, the lawyer must, as far as reasonably possible, maintain a normal client-lawyer relationship with the client and act in the best interests of the client as stated in Subsection (2).
>
> (2) A lawyer representing a client impaired as described in Subsection (1) and for whom no guardian or other representative is available to act, must, with respect to a matter within the scope of the representation, pursue the lawyer's reasonable view of the client's objectives or interests as the client would define them if able to make adequately considered decisions on the matter, even if the client expresses no wishes or gives contrary instructions.
>
> . . . .
>
> (4) A lawyer representing a client impaired as described in Subsection (1) may seek the appointment of a guardian or take other protective action within the scope of the representation when doing so is practical and will advance the client's objectives or interests, determined as stated in Subsection (2).

RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 35 (Proposed Final Draft No. 1, 1996). The comments to § 35 note that:

> Clients should not be unnecessarily deprived of their right to control their own affairs on account of such disabilities. Lawyers, moreover, should be careful not to construe as proof of disability a client's insistence on a view of the client's welfare that a lawyer considers unwise or otherwise at variance with the lawyer's own views.

Id. at § 35 cmt. c. This unfortunately adds little to previous statements of a lawyer's responsibility in representing mentally disabled clients as embodied in the American Bar Association Model Code of Professional Responsibility and American Bar Association Model Rules of Professional Conduct. *See* Abisch, *supra* note 6, at 138-139.

nature.[99] Critics of representation during mediation, particularly in the mental health care context, worry that the adversarial climate will ultimately do more harm than good to the consumer and the consumer's treatment.[100]

Most importantly, critics of including lawyers note that, if counsel are present at mediations between mental health consumers and providers, consumers are less likely to participate.[101] Because mental health consumers have traditionally been left out of the decisionmaking processes that most effect them, few would feel empowered to take an active role with counsel representing them. As one commentator put it, including counsel in mental health mediation may in fact "defeat the purpose of mediation, namely to let the parties speak for themselves."[102] Because the inclusion of counsel threatens to jeopardize the therapeutic effects of mediation, lawyers should rarely be included in mental health mediation.

VII. CONCLUSION

Despite the conventional wisdom which suggests that mentally disabled individuals cannot participate meaningfully in mediation to resolve mental health treatment disputes with community providers, initial research has proven that mediation is an effective and therapeutic alternative to the current rights-based and best-interest approaches. Further research and study regarding the ability of mentally disabled individuals to participate in mediation is needed in order to better define adaptations to the process and limits to its use. With increased data and scholarship on the use of mediation to resolve mental health disputes in the community treatment setting, the clinical and legal communities might come to value the

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[99] *Cf.* Alison Smiley, *Professional Codes and Neutral Lawyering: An Emerging Standard Governing Nonrepresentational Attorney Mediation*, 7 GEO. J. LEGAL ETHICS 213, 214–215 (1993).

[100] *See* Abish, *supra* note 6, at 141.

> The adversarial role enables the lawyer to represent a client zealously and defer to the client's wishes, but it also simply takes the client's decision at face value and ignores the fact that a client may need to be educated in order to "understand, deliberate upon, and reach conclusions about the matters affecting [the client's] own well-being."

Id. (alteration in original) (citing MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.14 cmt. (1990)).

[101] *See* Haycock et al., *supra* note 6, at 287.

[102] *Id.*

participation of mental health consumers and understand the role they can play in resolving their own disputes and formulating reasoned treatment plans.