



**Managing Conflict Cooperatively:
Making a Commitment to
Nonviolence and Recovery in
Mental Health Treatment Settings**

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**Report from the National Experts Meeting on
Conflict Management and Alternative Dispute Resolution
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Dedication

This report is dedicated to the memory of Justin Dart, disability rights activist, major contributor to the development and passage of the Americans with Disabilities Act (ADA), and longtime friend and supporter of the mental health consumer/survivor movement. Justin's personal courage and integrity and his unwavering support for disability rights and for a mental health system based on respect and dignity have been an inspiration to us all.

"We must invest in a continuum of new and strengthened programs to liberate people with disabilities from dependency, and empower them to be equal and productive participants in the mainstream."

—Justin Dart, July 26, 1990, during the signing of the ADA.

Acknowledgements

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In particular, deep appreciation goes to the consumer/survivor participants who were willing to share their personal experiences in the hopes of making a difference to the mental health system of the future. It takes extraordinary courage and commitment to relive the personal pain and heartbreak of one's own experiences of coercion and those of one's friends, and to do so in a public forum. There is often a high personal cost to this action, and we owe them a debt of gratitude.

Special thanks are also due to the meeting participants who represented the conflict management community, many of whom had no previous experience with the mental health system. It was a new frontier for them, and they rose to the occasion. Their subsequent commitment to working in the mental health field is a testimony to the power of the group process and to their belief in non-coercive alternatives.

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Note on Language:

People often feel strongly about the terms used to describe them. In this report, we have generally used the term “consumer/survivor” to describe people who have been diagnosed with a mental illness and/or have used mental health services, voluntarily or involuntarily. This term is widely accepted by the disability rights community and by former service recipients. We apologize in advance to any individuals who prefer other terminology.

Background and Purpose of Meeting

The National Experts Meeting on Conflict Management and Alternative Dispute Resolution was convened by the National Technical Assistance Center (NTAC) of the National Association of State Mental Health Program Directors (NASMHPD) in partnership with the Collaborative for Conflict Management in Mental Health (CCMMH) at the Louis de la Parte Florida Mental Health Institute at the University of South Florida. CCMMH is the only national center dedicated to introducing the principles and techniques of conflict management to the mental health system.

NASMHPD has long represented the interests of state mental health authorities in creating responsive, effective, and accessible public mental health systems, and is continuing these efforts through its *National Initiative on Creating Violence- and Coercion-Free Treatment Environments*. This effort is designed to help support state mental health systems in their efforts to: 1) create and maintain behavioral health treatment environments with zero tolerance for violence, and 2) minimize the use of overt and subtle forms of coercion. The NASMHPD Initiative is focusing first on the topic of seclusion and restraint. Reducing the use of these interventions has been shown to increase individual and systemic safety, promote recovery, decrease risk, and prevent traumatization and retraumatization. As part of this initiative, a series of national experts meetings has been held to identify and describe promising practices, and a comprehensive training program has been developed.

The experts meeting that resulted in this report was designed to: 1) introduce basic concepts of conflict management and alternative dispute resolution (ADR) to the mental health field; 2) explore the potential application of these techniques to specific mental health settings and as part of an overall systems change process; and 3) describe how this approach can provide concrete tools and assistance to states in their efforts to reduce the use of seclusion and restraint. Participants included individuals with extensive experience in conflict management as well as key leaders from the state mental health system, including commissioners, program administrators, medical directors and consumer/survivors. A list of meeting participants is included in Appendix B.

The field of conflict management provides concrete, well-tested tools to identify and manage conflict constructively and to create a climate of respect and empowerment. Over the past two decades, conflict management techniques have been applied in educational and employment settings, to settle labor disputes and conflicts regarding environmental regulation, and in just about every conceivable setting. Many states require mediation in child custody, divorce, and other types of family disputes. Training in conflict management has turned around troubled organizations in both the public and private sectors. Conflict management processes are attractive to consumers, effective in achieving resolution, and far less costly than litigation.

Conflict management techniques help staff, consumers and administrators to operationalize the principles of consumer empowerment, recovery, and continuous

quality improvement. Specific ADR programs can also provide ways of handling complaints and grievances that give all parties a voice in developing a solution.

The Americans with Disabilities Act requires that mediation be available for individuals with disabilities filing a complaint. In their “Strategic Plan,” the National Council on Disability (NCD)¹ explicitly recommends the use of voluntary settlement mechanisms including all forms of ADR (Action Step 7). They also recommend that all ADR processes operate on a level playing field, that practitioners be familiar with the specific issues raised by the cases in which they participate, and that people with disabilities be recruited and trained as ADR practitioners. This report is consistent with the NCD recommendations.

Organization of This Report

Most people have heard references to “mediation” or “arbitration” in the context of political or organizational disputes, and an increasing number may have experienced some form of ADR in their own lives. However, many readers may not be familiar with the array of different forms and applications of conflict management. It is beyond the scope of this report to provide a comprehensive introduction to the field. A list of references and available training tools are included in the appendix for those interested in pursuing the topic further. However, a basic understanding of conflict management may be helpful. We have therefore organized this report into sections.

The first section is designed to provide information for readers who want to become familiar with the concepts and principles of conflict management and alternative dispute resolution. The reader who already has a basic understanding of the field and its potential can skip over this section.

The second section describes the potential application of conflict management and ADR in the mental health field and in specific mental health treatment environments.

The third section describes how conflict management can provide tools for changing institutional culture and reducing the use of seclusion and restraint.

The final section presents recommendations from the experts meeting participants to NASMHPD concerning ways to support and enhance the capacity of states to use conflict management tools as part of their systems change and improvement strategies.

¹ National Council on Disability. (2000). *Closing the gap: A ten point strategy for the next decade*. (August 10, 2000).

What is Conflict Management? A Brief Introduction

Definitions, Practices, and Principles of Conflict Management and ADR

Definitions. *Conflict management* is a broad term that refers to the many different ways in which individuals and groups can identify and address differences between them. This term is often preferred to others because it implicitly acknowledges that conflict involves energy that can be utilized to produce positive change. *Conflict resolution* is a slightly more narrow term, referring to methods for handling differences that have risen to the level of an identifiable problem requiring resolution. *Alternative dispute resolution (ADR)* refers to specific approaches to conflict resolution, often formalized into discrete programs. The “alternative” in ADR refers to the fact that ADR is often seen as a way to divert cases from expensive and adversarial court procedures to more informal approaches. ADR includes a variety of specific approaches, including negotiation, binding and non-binding arbitration, mediation, and so forth.

In this report, the term conflict management refers to any overall strategy for identifying and using conflict constructively. The term ADR refers to specialized programs dealing with identified disputes, whether or not they are tied to legal or quasi-legal procedures. Mediation receives special attention as a form of ADR that has particular utility in the mental health system.

A continuum of actions and approaches. People can respond to differences between them in a variety of manners, from avoidance and withdrawal, to cooperation and dialogue, to litigation or fighting. Conflict management entails a continuum of possible actions beginning at the point when a potential difference is identified and extending through reconciliation between parties with long-standing and deep-seated differences. This continuum includes the following actions:

- ◆ identifying and analyzing conflict, emerging conflict, or different perspectives between individuals or groups;
- ◆ conflict diagnosis (kind, parties involved, level of intensity, history, dimensions);
- ◆ bringing parties to the table, empowering parties to work together on the issues;
- ◆ communication about what’s going on between involved parties;
- ◆ facilitated discussion, dialogue, and/or study circles;
- ◆ negotiation (includes different approaches such as interest-based and rights-based negotiation);
- ◆ advocacy (includes a variety of formal and informal approaches);
- ◆ informal mediation (assisted negotiation);
- ◆ formal mediation (includes a variety of directive, non-directive and transformative approaches);
- ◆ non-binding arbitration;
- ◆ binding arbitration; and
- ◆ restorative justice and reconciliation processes.

Different forms of conflict management are useful in different settings, and the use of one form does not preclude the use of another. In general, the conscious, strategic use of conflict management and ADR techniques can facilitate early identification of environmental and individual tensions; offer concrete tools to limit the destructive effects of conflict and facilitate transformative change; and help to maintain ongoing relationships between disputing parties.

Guiding assumptions. Conflict management practitioners are guided by certain assumptions about conflict and communication. Guiding assumptions are listed below.

- ◆ Conflict is an unavoidable fact of life. However, people can learn to manage conflict constructively; destructive consequences are not inevitable.
- ◆ Conflict can stimulate creative change and encourage an examination of values.
- ◆ Increased self-awareness (understanding personal biases and reactions to conflict) is key to better conflict management.
- ◆ Communication is key to the process. Examining individual assumptions, asking questions, and careful listening all lead to improved communication, which helps parties resolve conflict without destroying their relationship.
- ◆ The use of conflict management improves decision-making skills, enhances self-determination, and constructs a healing process for self and community.
- ◆ Win-win solutions are always possible.
- ◆ Power differences between parties to a conflict must be acknowledged and efforts must be made to “level the playing field.”

Conflict Management and Communication Skills

Communication skills are basic to all forms of conflict management, whether formal or informal. Conflict can be avoided or resolved and many potentially destructive situations transformed through improved communications. Conflict management almost always entails some combination of improving communication and developing creative solutions to differences. In disputes involving high levels of tension and emotion, special attention needs to be paid to communication issues. Some of the specific communication tools that can help diffuse highly charged environments are:

- ◆ techniques for reframing emotionally charged language;
- ◆ strategic use of open-ended and closed questions;
- ◆ an analysis of non-verbal and metaphoric communications;
- ◆ practice in using “I” statements to address an issue without blaming the other party;
- ◆ distinguishing wants from needs;
- ◆ distinguishing concrete and structural issues from relationship issues;
- ◆ determining underlying interests from stated positions;
- ◆ using language that will be acceptable to all parties; avoiding “loaded” words and phrases; and
- ◆ remembering cultural components to communication.

Cultural Competence and Conflict Management

Culture plays a critical role in both verbal and nonverbal communication and in the effective identification and management of conflict. The following items should be considered when addressing cultural competence within conflict management.

- ◆ Language barriers *must* be adequately addressed.
- ◆ Cultural differences in communication patterns must be considered.
- ◆ Don't assume that communication patterns and styles are necessarily uniform within racial or ethnic groups—much variability does exist.
- ◆ Recognize that forms of expressing opinion, emotion and conflict vary; some groups are more comfortable expressing high levels of conflict than others.
- ◆ Unless discussed, most people will judge conflict according to the norms of their own family or peer group, and may, as a result, seriously misjudge the situation.
- ◆ Withdrawal from activities or interactions that are culturally irrelevant may easily be misinterpreted (i.e. as a symptom of depression).

Conflict management practitioners must also be especially sensitive to cultural issues.

- ◆ Practitioners must be sensitive to cultural differences without losing their personal sense of identity (for an example of what *not* to do, a mediator who adopts ethnic slang in order to show empathy may just end up looking foolish).
- ◆ Conflict management is intended to open up dialogue, create more responsive services, and reduce coercion through creation of new options. As facilitator of the process, the practitioner is responsible for bringing up cultural issues as the process unfolds, whether or not they prove to be relevant to the situation.
- ◆ *Don't* assume that having a mediator of the same racial/ethnic/gender/cultural background as the parties will necessarily make it a better mediation. But *do* respect the parties' preferences on this topic.

Mediation: ADR for Empowerment

Although mediation is only one of the approaches offered by ADR, it is particularly useful in areas with structural conflicts (like the mental health field) because it uses a neutral third party, making it possible to balance uneven relationships and step out of locked positions, and because it empowers participants to develop their own solutions. Some relevant characteristics of mediation are listed below.

- ◆ Mediation begins and ends with a dialogue generated by conflicting positions.
- ◆ Every attempt is made for parties to meet as equals on neutral ground.
- ◆ Every effort is made to empower individuals to explain their perspectives and to generate and design their own options for resolution.

- ◆ Mediation is voluntary; at any point in the process individuals can decide not to go further—a particularly important factor for those with histories of being coerced and/or threatened.

Figure 1: Stages of Mediation

Stages of Mediation ²	Process
Setting the Stage	Mediator builds relationship with parties. Mediator establishes neutrality. Mediator explains confidentiality and establishes ground rules with help of parties.
Fact Gathering/Storytelling	Each party thoroughly explains viewpoint in own words. Perspectives are restated, clarified, considered, reviewed. Parties listen actively.
Framing the Issues/Defining the Problem	Positions and wants are reframed as interests and needs.
Seeking Options	Multiple options are considered. Creativity in thinking through options is encouraged.
Negotiation	Options are selected and modified for their workability.
Final Bargaining	Plans are made. Agreements are written and discussed regarding enforceability. Relationships are nurtured.

Some of the factors that affect the implementation of formal mediation include deciding when and how to use formal mediation; establishing balance and neutrality; responding to inequalities in power and ensuring that the process is voluntary; monitoring agreements; ensuring that there are no repercussions or retaliation; and establishing rules and procedures for confidentiality.

² [Source: Clark & Mattson. Mediation & Facilitation Resources.]

Conflict Management in Mental Health

How Conflict Management Fits in the Mental Health Field

There are strong historical relationships between the field of conflict management and the “helping professions.” There are also significant areas of overlap between the roles of mediator or facilitator and traditional mental health roles such as healer, therapist, buffer, coalition-builder, social supporter, consultant, and problem-solver, and all helping professionals routinely resolve conflict as part of their work. However, most mental health practitioners can benefit from explicit training in conflict management and in clarification of their own roles. In addition, it is often beneficial for mental health practitioners to have access to formal conflict management options such as mediation when an external, neutral process might help to break through an impasse.

Conflict management and ADR techniques are a natural fit in the mental health field for several reasons. First, the conflict management model in general, and the techniques of nondirective and transformative mediation in particular, are clearly consistent with the principles of recovery. Introducing this model in mental health settings reaffirms a commitment to recovery and empowerment. Second, conflict management offers a neutral alternative conceptual framework to the prevailing medical and legal models. Conflict management encourages a questioning attitude; it trains people in how *not* to be experts. By utilizing conflict management, practitioners also learn to examine assumptions (their own and others’) in an ongoing process designed to uncover different ways of seeing reality. Finally, conflict management practitioners have expertise in maintaining neutrality and optimism even when working in crisis environments, with individuals who have experienced severe trauma, and in situations with very high stakes. Each of these dimensions of conflict management is explored below.

Conflict management provides a model that is consistent with recovery. The table below shows the relationship between recovery and empowerment³ as understood in the mental health field and transformative models of conflict management. These models focus explicitly on “the restoration to individuals of a sense of their own value and strength and their own capacity to handle life’s problems.”⁴ The goal of transformative conflict management is *not* to reach a settlement or solution (although an agreement is often reached), but to promote self-determination, choice and autonomy for all parties and to enhance interpersonal communication and empathic understanding. When successful, transformative mediation strengthens relationships and promotes systemic change.

³ Blanch, A., Fisher, D., Tucker, W., Walsh, D., & Chassman, J. (1993). Consumer-practitioners and psychiatrists share insights about recovery and coping. *Disability Studies Quarterly*, 13, 17-20.

⁴ Barsky, A. E. (2000). *Conflict resolution for the helping professions*. Belmont, CA: Brooks-Cole.

Figure 2: Relationship Between Recovery and Empowerment and ADR

Factors that Facilitate Recovery and Empowerment	Characteristics of Conflict Management and ADR
Hopeful orientation to the future; seeing others who have recovered; believing that recovery is possible	Looking for win-win solutions; believing that solutions are always possible
Self-efficacy and sense of control ; people make their own choices and determine their own futures	Parties to the dispute control the outcome and come up with their own solutions
Basic needs as defined by person are met; focus on human needs rather than on clinical problems	Focus is on underlying issues and needs as identified by parties
Voice ; being heard; people describe and define their own experiences	Parties tell their own stories about the dispute or conflict in their own words
Finding meaning in one's experience ; people talk about what has been meaningful and what they have learned	Looks to lessons learned from conflict
Relationships ; making friends, maintaining connections with others	Builds and/or preserves relationships among parties
Skills ; people develop skills necessary to cope with life	Parties develop skills in handling conflict that arises in a variety of settings
Helping others ; mutual support is key element	Focus is on meeting needs of all parties not just on one's own needs

Conflict management provides a neutral model for decision-making. The following table highlights different approaches to decision-making offered by clinical, legal, and ADR models.⁵ In the clinical paradigm, individuals coming for services are viewed as patients with symptoms to be assessed, treated, and diagnosed according to the clinical judgment of the experts involved. The legal approach views individuals as clients in need of protection against rights violations or harmful actions through the actions of legal decision-making entities. In contrast, the ADR model approaches individuals as key stakeholders and decision-makers. All three approaches are necessary in certain circumstances, and an effective mental health system will have access to all three.

⁵ Mazade, N., Blanch, A., & Petrila, J. (1994). Mediation as a new technique for resolving disputes in the mental health system. *Administration and Policy in Mental Health, 21*(5), 431-445.

Figure 3: Comparison of Clinical, Legal, and ADR Models of Decision-Making

	Medical Model	Legal model	ADR Model
People referred to as:	Patients	Clients	Parties
Problems to be solved seen as:	Symptoms	Rights violations	Conflicts or disagreements
Practitioners are trained to:	Assess, diagnose, treat	Represent & advocate for client	Facilitate discussion
Bottom-line decision based on:	Clinical judgment	Legal decision	Collaborative solution

Conflict management can be effective in complex crisis situations. Conflicts are, by nature, emotionally charged events. Emotions can run especially high when conflicts involve multiple parties, when some or all of the parties have experienced severe trauma, and/or when there are historical tensions or power imbalances among various stakeholders—all of which are often true in the mental health system. Conflict management and ADR practitioners are not automatically capable of handling complicated and difficult problems in the mental health system. However, conflict management is in essence a psychologically informed process designed to improve communication, and it offers tools to facilitate dialogue with polarized groups. As a result, people trained and experienced in conflict management (whether mental health or ADR practitioners) can be particularly effective in handling the high level of emotion often present in mental health disputes.

Conflict management contributes to cultural competence in mental health settings. Cultural competence is now a general expectation of quality mental health systems.⁶ Principles and standards for culturally competent mental health services have been developed; requisite knowledge, attitudes and skills for staff have been identified; and a continuum for assessing the development stage of an organization has been designed.⁷

Culture also plays a critical role in both prevention and effective management of conflict in mental health settings. Sources of conflict may differ between racial, ethnic, and/or religious groups. For example, there are clear racial and ethnic disparities in access and availability of services, a primary source of conflict in mental health systems. In addition, cultural differences may influence the thoughts, behaviors and feelings of individuals and groups in ways that may be overlooked if an environment is not culturally proficient, and in ways that may lead to tension or conflict. For example, mental health practitioners routinely expect stress levels to escalate at Christmas, but may be unaware of similar effects occurring around Jewish, Muslim or Hindu holy days. Specific experiences

⁶ U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity – A supplement to Mental health: A report of the surgeon general – executive summary*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

⁷ The Santa Fe Summit on Behavioral Health, March 14 –16, 2002, sections II and III.

related to cultural background may also contribute to conflict. For example, immigrants who have recently come from countries where there is a high level of oppression and violence are likely to be seriously traumatized as well as disoriented, and may show behaviors that reflect both conditions.

Cultural factors may also directly influence reactions to conflict. For example, the behavior of some groups may receive a higher level of scrutiny than others—the equivalent of racial profiling. Similarly, cultural cues may at times be misinterpreted, leading to coercive interventions like seclusion and restraint being used at a higher rate with people of color, people who are deaf or hard of hearing, or people who express emotion differently than the dominant culture.

Therefore, one of the most effective conflict prevention strategies is to develop a culturally competent and respectful organizational climate. Any consideration of conflict in a mental health setting should *first* address the question: Is the environment *respectful and knowledgeable* about the individuals being served here, including their cultural backgrounds? If the answer is “no,” the environment should become the first line of intervention. Strategies for ensuring culturally competent alternative dispute resolution are outlined in the first section of this report.

Understanding Trauma: The Roots of Conflict

The first step in effective conflict management is to ensure the immediate safety of all involved individuals. Effective introduction of conflict management techniques is best framed as part of a commitment to nonviolence for *all*.

Once safety has been assured, it is critical to unravel the present and past roots of the conflict. In mental health, this almost always involves understanding the role of trauma. The relationship between physical and sexual abuse and severe mental health and substance abuse problems has now been extremely well documented.⁸ In mental health treatment settings, it is highly likely that a majority of staff as well as clients will have experienced some form of severe trauma in their lives. When conflict occurs, it is almost always helpful to look at what’s happening through the lens of a trauma model. Even if there are other precipitating factors, peoples’ response to conflict is often colored by their previous experiences. A clear and unbiased focus on trauma can be extremely helpful in efforts to reduce conflict and violence in all mental health treatment settings, including state hospital cultures.⁹

⁸ Jennings, A. (in press). *The Damaging Consequences of Violence and Trauma: A Two-Part Report on a Key Public Health Issue*. Report prepared for the Substance Abuse and Mental Health Services Administration by NTAC/NASMHPD.

⁹ Bills & Bloom. (1998). From chaos to sanctuary: Trauma-based treatment for women in a state hospital. In B. L. Levin, A. K. Blanch, & A. Jennings (Eds.), *Women’s Mental Health Services. A Public Health Perspective*. Thousand Oaks, CA: Sage.

Applications of Conflict Management and ADR

Community Mental Health Settings

Community dispute resolution and mediation programs exist in a growing number of communities across the country. Some of these organizations employ professional mediators; others use community volunteers. Partnerships, cross-referrals, and cross-training between the mental health system and community dispute resolution centers benefit both.

Several examples of such partnerships currently exist. Maine has developed an external statewide community mediation program serving all clients of the Department of Developmental and Behavioral Services; Vermont has trained a statewide panel of professional mediators to resolve disputes arising as part of the grievance process at the state hospital and in the mental retardation/developmental disabilities system. Several other states including Ohio and Arizona require that all community mental health programs make mediation available to their clients, and other states are currently considering strategies for using ADR in their service systems. Many local programs also effectively link the mental health and conflict resolution systems to meet a variety of specific and general needs.

Most ADR practitioners believe that in order to ensure neutrality, mediation programs should be externally funded and administratively independent from the service system. However, there are pros and cons of internal and external models. The following characteristics are important regardless of organizational model:

- ◆ capacity to decide at intake what parties need to be at the table, including disputants, resource people, decision-makers, support people, advocates, etc., and the necessary authority to get them there;
- ◆ strong support for participation without making participation mandatory;
- ◆ independence/neutrality of program and personnel;
- ◆ legal or regulatory framework defining and supporting program;
- ◆ political and financial sustainability; and
- ◆ context that understands and values ADR—that sees the use of mediation as a sign of a healthy mental health system, rather than a sign of failure.

Emergency Rooms

Emergency rooms are a key part of the mental health service system and a critical point of intervention in any systemic effort to reduce the use of coercive practices. Many people who are ultimately admitted to state hospitals begin their journeys in an emergency room, where it is quite possible to be restrained to a gurney for a very long period of time. When this happens, the individual may arrive many hours later at a psychiatric inpatient unit filled with confusion, rage and/or despair from treatment received prior to arrival. Inpatient staff then must respond to an escalated situation with an individual who has likely experienced severe traumatization or retraumatization.

The fast pace of emergency room settings provide unique challenges. Clearly, a balance must be maintained between keeping the environment calm at all costs and maintaining clinical best practices. One potential approach would be to institute a peer support program, perhaps modeled after rape crisis programs, where trained volunteers would be called in to sit with the individual and facilitate dialogue with treatment personnel. An individual who is trained in conflict management and is familiar with the mental health system could potentially avert some of the more damaging consequences of emergency room visits. A model along these lines is currently being explored at the Eastern Maine Medical Center Emergency Room in Bangor, Maine.

State Hospital Admissions

The introduction of conflict management and ADR to the hospital admissions process can make significant improvements to patient satisfaction and to quality of care. As in any organizational change, many interrelated factors need to be considered. Training in conflict management techniques can encourage a helpful questioning process—for example, asking, “What do I need to know about you,” before, “I also need to know the following information.” An effective change strategy would combine training for both staff and advocates with structural changes (e.g., consideration of direct admissions to units to reduce the trauma that occurs when patients are transferred between wards), procedural changes (e.g., required debriefing of all admissions as well as all critical incidents), and new program approaches. The program model described above for ER settings could also potentially function effectively on hospital admissions units.

Debriefing of hospital admissions could include a mediator from a local community dispute resolution center, a self-identified consumer/survivor or peer advocate trained and experienced in conflict management, and hospital staff and advocates directly involved in the admission. In order to successfully institute such a procedure, it would be helpful first to train all participating staff in basic conflict management skills.

Inpatient Wards

People sometimes have difficulty envisioning the use of conflict management in inpatient settings because they imagine that conflict in hospitals always involves highly agitated or symptomatic behavior. In addition, it may be difficult to make changes in settings where there are hardened positions, strong emotions, and/or overt violence, even though these situations might be most in need of an alternative approach. For example, a hospital ward with a high rate of staff and client injuries, a heavy reliance on seclusion and restraint, or a recent patient death might be in too much turmoil to see the potential merit or relevance of mediation. Nonetheless, the field of ADR has significant expertise in working in environments and among groups with open hostilities, and can bring much to the discussion in these circumstances.

ADR techniques also have the potential to prevent the escalation of less serious conflicts. For example, two hospital patients are arguing over what to watch on television. A staff

person gives them an ultimatum: either come to an agreement or the television gets shut off. They can't agree, and the television is turned off, leaving them still angry at each other and now also at the staff person. In this situation, another event could easily escalate the situation and result in one or more individuals being secluded or restrained. If, instead, ward staff and individuals with psychiatric diagnoses had been trained in ADR, an impromptu "mediation" might have been conducted and the dispute might have been resolved.

The human rights program at Arizona State Hospital has been running an inpatient mediation program for the past five years. Mediation training is provided several times a year to mental health technicians, psychologists, nurses, social workers, and peers (consumer/survivors) from the community. Trainees use their new skills immediately in their day-to-day activities and are available to conduct formal mediations on an as-needed basis (never on their own unit). This program has successfully resolved a wide variety of complaints, grievances and conflicts, including disagreements over medications.

Conflict management can also be useful in structuring discussions about volatile issues. For example, a major staff concern in state psychiatric centers today is the increase in admissions of individuals with criminally violent histories, especially histories of physical or sexual violence, which may put both staff and patients at risk if precautions are not taken. This situation engenders fear in both staff and patients and may lead to a rejection of any change that appears to diminish staff control. In circumstances like this, a conflict management approach can be used to reinforce an organizational commitment to nonviolence and to structure a process to engage both staff and patients in operationalizing that commitment.

Hospital Treatment and Discharge Planning

Effective treatment and discharge planning are essential elements in hospital-based rehabilitation and treatment, and are also key to compliance with the Olmstead decision and the Americans with Disabilities Act. Interdisciplinary teams skilled in conflict management are more likely to work together effectively and to negotiate acceptable plans with their patients, thereby increasing success in the community and decreasing recidivism. In those instances where an impasse is reached, the assistance of a neutral third party can often help to resolve the disagreement.

The introduction of conflict management principles and techniques to a mental health treatment team is consistent with best practices in all disciplines and also with an orientation to rehabilitation and recovery. The notion of recovery is often based on principles of self-determination and autonomy; healing within this context can be understood as a process of uncovering and discovering self-knowledge rather than symptom management and compliance with treatment regimes. There is evidence to suggest that individuals who are involved and/or become the directors of their own treatment can recover in ways that others didn't think possible. However, conflict can arise when an individual's desire to determine what is in his own best interest and to exercise his right to take risks and learn from his mistakes comes into conflict with the

hospital's need to minimize potential risk and future liability. ADR can be useful in explicating these distinct interests and positions and mediating between them.

Using Conflict Management to Change Organizational Culture: Seclusion and Restraint Reduction as a Specific Application

Conflict Management and the Commitment to Quality Improvement

Behavioral health systems across the country are currently facing major challenges in implementing quality systems of care with limited fiscal resources. Some of the problems and needed changes have been forcefully articulated in the most recent report from the Institute of Medicine (IOM), *Crossing the Quality Chasm: A New Healthcare System for the 21st Century*.

The IOM report provides a blueprint for a new healthcare system based on a vision of patient participation in treatment, organizational supports for quality (including the most recent advances in information technology) and an unwavering commitment to the highest quality of care for *every* patient. The implementation of this blueprint will require strong leadership and a change process that incorporates the principles underlying the vision. As described throughout this report, the field of conflict management has well-tested tools and techniques to assist in this process.

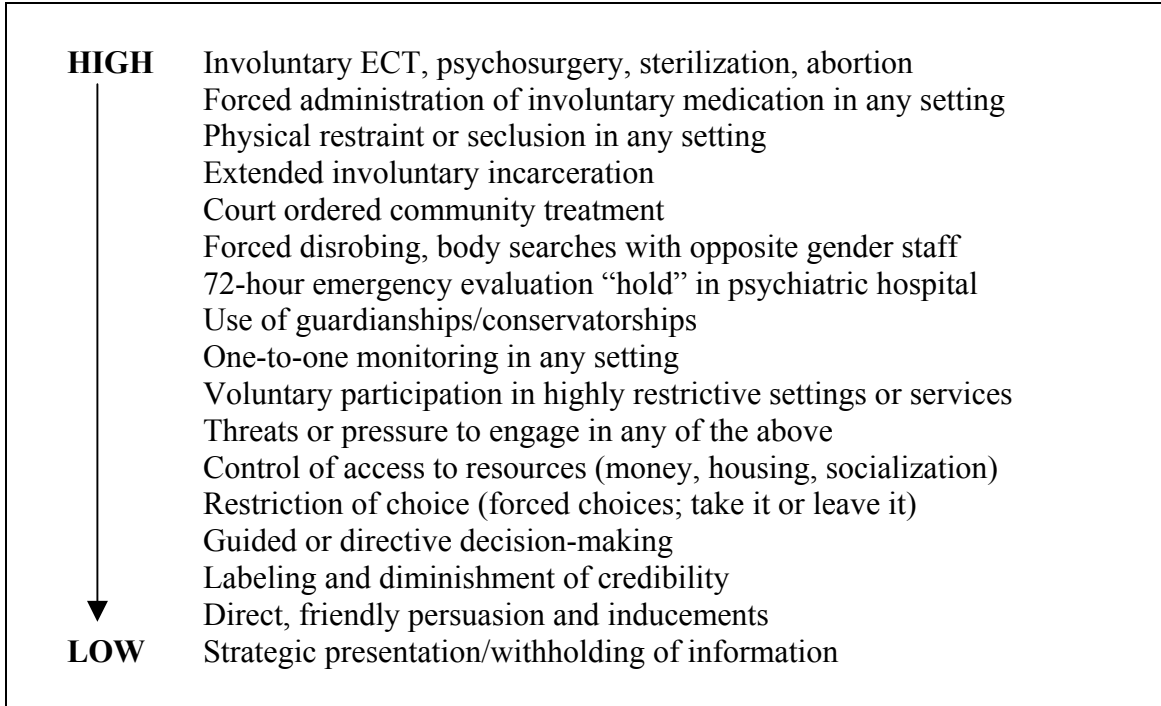
A goal of reducing or eliminating coercive practices in general, or seclusion and restraint in particular, is one aspect of an overall commitment to quality care in the mental health system. Efforts to reduce the use of seclusion and restraint are unlikely to succeed in isolation; deep and enduring changes will occur only if the hospital and the mental health system embrace a commitment to nonviolence and recovery.

One aspect of a commitment to nonviolence is the willingness to examine the ways in which covert and overt forms of violence, coercion, and control occur within the mental health system. A thorough examination would include a careful look at all forms and constellations of interpersonal violence and control, including staff-staff, patient-patient, patient-staff, staff-patient, as well as structural forms of control such as unnecessarily punitive administrative procedures.

One useful way to view coercion is to see it as a continuum of forms ranging from those that are relatively limited to activities that are highly invasive in nature. The model below illustrates the continuum of coercion developed by consumer-survivors to describe their experiences;¹⁰ a similar analysis, including all forms of institutional coercion, could be useful as a starting point in a seclusion and restraint reduction strategy.

¹⁰ Curtis, L. C., & Diamond, R. (1977). Power & coercion in mental health services. In B. Blackwell (Ed.), *Treatment Compliance and the Therapeutic Alliance* (97-122). Toronto, Canada: Harwood Academic Publishers.

Figure 4: The Continuum of Coercion



Bringing Parties to the Table: The Process of Neutrality

In any conflict management or systems change process, the first task is to “get the parties to the table” and encourage authentic communication and real investment in the outcome. When the conflicts are deep, this may be the most difficult part of the process. In situations where one party holds power over the other, particularly in restricted or locked environments, even talking in an open and honest way may not be possible. At a minimum, parties need to be assured of safety.

Creating a “neutral” space may in itself constitute a challenging intervention, because the very act acknowledges that there are different and equally valid perspectives on reality. Mediators are trained to adopt a neutral approach, to work to overcome their own biases, and to ensure that the terms and issues under discussion have meaning to all parties. However, in some circumstances, especially when conflicts are longstanding and intense, simply by choosing to participate in the discussion parties may be seen (or may see themselves) as separating themselves from their peer groups or as violating unstated norms of behavior. In these circumstances, the mediator may also face a challenge maintaining non-alignment.

The field of conflict management has a depth of experience in bringing (sometimes reluctant) disputing parties to the table and creating a process to ensure safety and perceived fairness. The importance of this part of the process cannot be overestimated.

A Critical Step: Seeing Different Perspectives

Once parties are at the table, it is absolutely critical that all parties are given voice. The most fundamental premise of conflict management is that different people and groups may see the world from different perspectives, and that all perspectives may contain some truth. Often, the most effective programs and the most enduring relationships are those in which different points of view are expressed and validated.

In mental health treatment settings, it is very common for service recipients and providers to see the world through different lenses and to have different meanings for common words. Much of the conflict that arises in these settings results from people operating from their own worldview without acknowledging that of another. The chart below illustrates how the word “safety,” which is often used in hospitals to justify the use of procedures such as seclusion and restraint, may mean very different things to patients and staff. Understanding these different definitions is critical to seclusion and restraint reduction.

Figure 5: Conflicting Definitions of Safety

Conflicting Definitions of “Safety”¹¹	
Service Recipients	Service Providers
Safety = minimizing loss of control <i>over their lives.</i>	Safety = minimizing loss of control <i>over the environment and risk.</i>
Safety means: <ul style="list-style-type: none"> ◆ Maximizing choice ◆ Authentic relationships ◆ Exploring limits ◆ Defining self ◆ Defining experiences without judgment ◆ Receiving consistent information ahead of time ◆ Freedom from force, coercion, threats, and punishment ◆ Owning and expressing feelings without fear 	Safety means: <ul style="list-style-type: none"> ◆ Maximizing routine and predictability ◆ Assigning staff based on availability ◆ Setting limits ◆ Designating diagnoses ◆ Judging experiences to determine competence ◆ Rotating staff and providing information as time allows ◆ Use of control (medication, restraint, seclusion) to prevent potentially dangerous behavior ◆ Reducing expressions of strong emotion

¹¹ Adapted from Laura Prescott. (1998). *A life of my own*. Used with permission.

Summary: Conflict Management and Seclusion and Restraint Reduction

A successful effort to reduce or eliminate seclusion and restraint, like any other major systems change initiative, will require strong leadership and a systemic approach. Introducing a conflict management approach can be very helpful as part of such an effort because it reframes the initiative in positive terms. Staff may resist giving up the use of techniques that they *feel* ensure safety unless they are given alternative techniques; conflict management provides both a non-blaming conceptual lens and a concrete, easily exportable set of skills that can assist in the necessary culture change.

A summary table on the next page shows the key factors associated with successful reduction of seclusion and restraint in state hospital settings and the ways in which introducing conflict management can assist with this process.

Final Note: Evidence-based Practices: Balancing Experiential and Empirical Data

There has been a growing national emphasis on “science-based” or “evidence-based” practices in mental health.^{12,13} An effort to focus on what *works* rather than on what is expedient or what has historically been done is clearly needed. However, this emphasis on empirical research has several built-in limitations. First, as the experts on evidence-based medicine are quick to point out, ultimately the “answers” provided by these techniques depend on the questions asked, which in turn reflect the worldview of the people asking them.⁷ This has led to larger tensions between the consumer/survivor and research/policy communities over the questions, “Who are the ‘experts’ with power/authority to name the problem?” and, “Who are the ‘experts’ to frame what constitutes successful outcomes?” Consumer/survivors and other advocates insist that experiential knowledge be given equal attention and weight in determining new program approaches.

While the lives of consumer/survivors have often been the objects of study (constituting the body of evidence for future practice), they have rarely been considered the active subjects or key stakeholders in research design or in service delivery. As a result, the body of recorded research evidence is largely a record of dominant cultural narratives, which many consumer/survivors feel misrepresents their reality. Mediators and others involved in ADR offer important opportunities to open up dialogue between researchers, policymakers and consumer/survivors, allowing lost narratives to be reclaimed and experience to be valued and recorded as part of the larger evidence base. When discussions like this have occurred, results have been powerful.

¹² Donald, A. (2002). Evidence-based medicine: Key concepts. *Medscape Psychiatry and Mental Health eJournal*, 7(2).

¹³ Carpinello, S. E. et al. (2002). New York State’s campaign to implement evidence-based practices for people with serious mental disorders. *Psychiatric Services*, 53(2), 153-155.

Figure 6: Conflict Management and Seclusion and Restraint Reduction

Factors Leading to Successful Reduction in S&R	How Conflict Management and ADR Can Help
Leadership. Top administration and leaders from all levels of organization make highly visible statement and actions in support of change.	Introducing throughout institution makes clear statement and provides context and tools for assessing and examining conflict in a non-judgmental way.
Vision. Zero tolerance for violence; unequivocal statement of S&R as treatment failure, and of rights, recovery, cultural and clinical competence, trauma-sensitive services and safety as <i>mutually reinforcing</i> .	Provides model of collaboration and partnership; doesn't polarize groups or positions; demonstrates relationship between empowerment and nonviolent solutions.
Stakeholder involvement. All perspectives included, especially c/s/x and direct care staff. All stakeholders "own" initiative and feel respected.	Dialogues, facilitated discussion, reconciliation processes helpful in "getting people to the table," making amends, ¹⁴ healing old wounds and underlying conflicts that can undermine initiative.
Alternatives available. Concrete options available and tools to handle situations differently placed into peoples' hands.	Encourages examination of negative events and painful situations without blame or recrimination; tolerates high levels of emotion; validates consumer participation.
Staff training. People receive adequate training and ongoing feedback to ensure effective use of alternatives.	Training is skills and performance-based; provides concrete tools and strategies for dealing with people and situations.
Data and monitoring. Measures reflecting multiple perspectives publicly available; each S&R incident requires approval and subsequent debriefing.	Provides tools for witnessing and recording narratives; supports parties to suggest changes to an effort not working.
Prevention. Entire organization makes commitment to preventing problems that could eventually rise to level of S&R.	Provides conceptual lens to view conflict as part of everyday life and to identify and use it creatively; provides concrete tools for use in all areas of hospital operations.
Policies, procedures, and staff support. Organizational rules reflect new vision; staff supported for accepting responsibility and exercising personal judgment.	Can structure safe forum for staff concerns to be heard, especially regarding high-risk situations; support staff in adapting rules when necessary to achieve goals.
Advocacy and grievance process. Disagreements anticipated; complaint process perceived as fair and effective.	Advocates trained in conflict management; mediation available as alternative to formal grievance process.

¹⁴ Alcoholics Anonymous World Services. (1996). *Twelve Steps and Twelve Traditions*.

Future Directions: Recommendations to NASMHPD

1. Develop training materials and programs to assist states in using the principles and techniques of conflict management as part of their systems change and improvement efforts. Training programs shall include the following:

- ◆ a training module on conflict management taught by a team of ADR practitioners and consumers/survivors as part of seclusion and restraint reduction training;
- ◆ a 40-hour mediation training program for mental health consumers and providers; and,
- ◆ a 3-hour workshop on conflict management taught by a team of ADR practitioners and consumer/survivors for staff and clinicians who want to understand how this approach can complement their existing skills and help them in their day-to-day work.

2. Work with all sections and divisions (Children, Adult Services, Forensics, Medical Directors, etc.) to explore applications of conflict management and ADR to their constituencies, and to include relevant discussions and/or presentations at their annual meetings. Potential applications include:

- ◆ the use of ADR as part of complaint and grievance procedures in the Legal Division;
- ◆ the use of ADR in disputes involving child custody and between systems of care (e.g., education, mental health, juvenile justice) in the Children's Division;
- ◆ issues of reconciliation between victims and offenders in the Forensic Division; and
- ◆ in the Medical Directors Council, the use of conflict management training and/or ADR programs to assist in the development of full consumer participation in treatment and discharge planning.

3. Work with NAC/SMA and other stakeholders to design and implement a study of the nature, extent, and costs of unmanaged conflict and coercion within the mental health system.

4. Explore the possibility of co-sponsoring a national conference bringing together various stakeholders from the fields of mental health and ADR.

5. Where the interface is not otherwise developed, NASMHPD should encourage and facilitate the development of partnerships between mental health systems and community dispute resolution centers.

6. Explore the ways in which community mental health programs can make ADR services available to consumers.

7. Explore working with federal and state Protection and Advocacy organizations to develop a mutual understanding of the uses and benefits of conflict management and ADR to resolve individual and systemic issues.

Appendices

Appendix A: Selected References/Toolkit

**Appendix B: National Experts Meeting on Conflict Management and Alternative
Dispute Resolution Participants List**

Appendix C: Recommendations for ADR Training Manual

Appendix A: Selected References/Toolkit

Guidelines, Policies, and Regulations

ADA Mediation Guidelines. Available from Judith Cohen, Project Coordinator, The Kukin Program for Conflict Resolution, Benjamin N. Cardozo School of Law. Online version available at Web site: www.cardozo.yu.edu/cojcr/

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Other Resources

ABA Section on Dispute Resolution: www.abanet.org/dispute

ADA Mediation Program at Key Bridge Foundation for Education and Research: www.keybridge.org

Center for Social Gerontology: www.tcsf.org

Collaborative for Conflict Management in Mental Health (CCMMH): www.fmhi.usf.edu/mediation/

Consortium for Appropriate Dispute Resolution in Special Education (CADRE):
www.directionservice.org/cadre/

CRInfo, a cooperative effort to strengthen the infrastructure of the field of conflict resolution: www.crinfo.org/

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Special Education Conflict Resolution/Peer Mediation Research Project:
www.coe.ufl.edu/crpm/crpmhome.html

Victim-Offender Mediation Association: www.voma.org

Videotapes on Recovery Dialogues – available from CCMMH

Dialogue on Recovery (New York State Office of Mental Health)

Dialogue on Recovery II: Coping (New York State Office of Mental Health)

Dialogue on Recovery Revisited (National Empowerment Center)

Recovery: Implications for Psychiatric Research and Practice (New York State Office of Mental Health)

**Appendix B: National Experts Meeting on Conflict Management and Alternative
Dispute Resolution Participant List**

Appendix C: Recommendations for ADR Training Module

A training program for inpatient staff is currently being developed by NTAC to help states reduce their use of seclusion and restraint. A 90-minute module on ADR is envisioned as part of this training. The major goals of this module should be to:

1. demonstrate how ADR can solve common conflicts that occur on inpatient wards;
2. make staff aware of the range of conflict management strategies and techniques that are available and where they can go for further information or training; and
3. help staff understand their own conflict management styles and recognize the role that they can play in conflict management.

Trainers, Training Strategies, and Techniques

Should include an experienced mediator-trainer and a consumer/survivor who is also experienced in the ADR field. The training should be built around a role-play (with audience participation if size allows) that can convey to staff the potential of creating win-win solutions to common ward conflicts. Training should also include experiential learning (self-assessment and analysis), and didactic presentation designed to give a very basic overview of the field.

Potential Topics to be covered:

1. Introduction
 - The continuum of ADR techniques
 - The conflict management pyramid
 - How ADR differs from what currently happens in the mental health system
2. Self-awareness and conscious use of self
 - Identifying one's own experience with being coerced or controlled
 - Understanding one's own biases
 - Learning one's own conflict management style
3. Understanding conflict on the ward from different perspectives
 - The tautology of diagnosis
 - The continuum of coercion
 - Cultural competence and conflict (i.e. misconstruing passion for anger)
4. Envisioning the role of staff in conflict management
 - What escalates and de-escalates conflict?
 - What specific phrases or actions to use or avoid (e.g., "calm down")
 - Building on existing tools (e.g., proactive crisis planning, advanced directives)
 - Key communication skills