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Mediators have a responsibility to maximise an individual's ability to effectively participate in the decision-making process, including supporting procedural fairness where equality and balance in the parties' contributions to the process is expected. Capacity to participate effectively is affected by the presence of mental health concerns. Various means of screening for psychological distress in mediation participants have been discussed, however, there is limited training available to mediators from non-clinical professions in evaluating mental health issues. An alternative approach is to consider ways in which the mediation process could be modified to enhance an individual's capacity to effectively participate, especially when the mental disorder is not chronic, stable, or severe, but is a temporary incapacity. This article will consider commonly occurring mental health concerns in Australia and will explore ways in which mediators might seek to support parties effectively under such conditions.

Mediation requires the parties to be able to identify issues, develop options, consider alternatives and make decisions.[1] Social and communication skills are essential to this process of conflict management and effective dispute resolution. The mediator's role is to facilitate a process of parties being able to make decisions that support effective resolution of the matters at hand. Associated with that role is a responsibility to maximise a participant's ability to participate effectively in the decision making process. This includes supporting procedural fairness that is concerned with equity and balance in the process. Australian standards for mediators specify that if a mediator considers a party "unable or unwilling to participate in the process, the

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[1] Queensland Law Society, *Australian National Mediator Standards: Approval standards 2007a* (1 July 2015) <http://www.qls.com.au/For_the_community/Dispute_resolution_services/Mediation/National_mediator_standards>.[If you are referring to the *National Mediator Accreditation System Approval and Practice Standards,* which are available for download from this link, they do not contain a "2007a". Is there another link you could provide?]

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mediator may suspend or terminate the mediation process" [Is this where the quotation ends?].[2] Upholding this standard requires the mediator to have the knowledge and skill to informally assess an individual's capacity for effective participation.

Attention has been given in the literature to various means of screening for psychological distress in mediation participants.[3] Others have advocated for the mediation process to be modified to enhance an individual's capacity to effectively participate.[4] This is particularly relevant where the mental disorder is a temporary incapacity, such as heightened psychological distress following major life change (eg, divorce). This article aims to provide mediators with a brief overview of four common mental disorders prevalent in our general community. Furthermore, the heightened emotional context disputants find themselves in may bring to the fore mental health concerns that had previously gone hidden, and therefore undiagnosed.

The following discussion will consider the extent to which the mediator has a role in determining capacity, before providing an overview of mental health in Australia, particularly in relation to anxiety, depression and stress. Following a condensed account of each of these three disorders, practical strategies for mediators managing an individual's functional impairments arising from these mental health conditions are suggested.

<DIV>CAPACITY TO MEDIATE

There appears to be no dispute in the literature that one of the responsibilities of a mediator is to ensure both parties' capacity to participate effectively in the dispute resolution process. Boulle notes that such capacity "is axiomatic in a process based on the principle of self-determination which requires parties to make their own informed choices on settlement options".[5] Clearly, where a party lacks such capacity the

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[2] Queensland Law Society, *Australian National Mediator Standards: Practice standards 2007b* (1 July 2015) <http://www.qls.com.au/For_the_community/Dispute_resolution_services/Mediation/National_mediator_standards>. [If you are referring to the *National Mediator Accreditation System Approval and Practice Standards,* which are available for download from this link, they do not contain a "2007b". Is there another link you could provide?]as above – exclude the a

[3] Australian Institute of Social Relations, *Identifying Mental Health Risks During Separation* (28 August 2014) <http://www.socialrelations.edu.au/identifying-mental-health-risks-during-separation/>; CJA Beck and LE Frost, "Competence as an Element of Mediation Readiness" (2007) 25 *Conflict Resolution Quarterly* 255.

[4] T Hedeen, "Ensuring Self-Determination through Mediation Readiness: Ethical Considerations", *Mediate.com*, (2003) <http://www.mediate.com/articles/hedeent1.cfm>.

[5] L Boulle, Mediation: Principles, Process and Practice (LexisNexis, 2005) 262.

mediation should not proceed unless there is a representative who can negotiate on their behalf.

Capacity for mediation can be influenced by physical or psychological disability, or cognitive deficits arising from illness or distress. Equally, a person's natural style may also impact negatively on their ability to take advantage of the opportunities mediation offers for successful dispute resolution. Eddy [Who is Eddy?] identifies personality disorders, including psychopathy and antisocial behavior, as offering distinct clusters of problematic behaviours for dispute resolution contexts.[6] Brandon and Robertson also acknowledge the challenges of certain problematic behaviours and personality types. With a nod to the limitations of mental health diagnosis by non-clinicians, these authors highlight the need for mediators to recognise certain patterns of behavior and to manage these appropriately. Somewhat optimistically, Brandon and Robertson advise that "it is important that someone with a disorder is not judged but managed in a way that focuses on the person's abilities and strengths without getting hooked into their emotional crisis or trying to change their traits".[9]

Indeed Moss et al warn that people with mental disorders may be unnecessarily excluded from mediation due to erroneous assumptions about the individual's ability to effectively engage in the process.[10] These authors examined 23,759 employment discrimination disputes involving people with recognised disabilities in America from 1 January 1999 through to 30 June 2000. Disabilities were classified into psychiatric (ie. anxiety, depression, bipolar, schizophrenia, and "other emotional impairments"), substance use (alcohol or chemical) or "other". The researchers found that people with psychiatric disabilities were given less opportunities to mediate. Moreover, there was a statistically significant difference in opportunities offered by employers when the nature of psychiatric disability was examined. Employers were less willing to mediate with individuals with psychiatric or substance abuse issues than with individuals with other types of disabilities.

One of the key findings in this study was that outcomes of mediation for those who were given the opportunity to participate were similar to those disputants with no psychiatric disorder.[11] Further, participants with substance use disorders were

[6] M Brandon and L Robertson, Conflict and Dispute Resolution: A Guide for Practice (Oxford, 2007).

[9] Brandon and Robertson, n 6, 32-33.

[10] K Moss et al, "Mediation of Employment Discrimination Disputes Involving Persons with Psychiatric Disabilities" (2002) 53 *Psychiatric Services* 988.

[11] Moss et al, n 8.

more likely than others to resolve the matter in mediation. These findings highlight the relevance of pursuing functional models to assist mediators in managing the process when participants may have a mental health concern. Based on Moss et al's findings, it appears that the opportunity for a settled dispute is just as available to this group of participants as it might be for any other disputant.

Capacity considerations extend beyond mental health issues. The potential for parties in mediation to display challenging behaviours that, if left unmanaged, threaten to derail the collaborative process, has been identified in the literature.[12] These discussions have tended to focus on individual conflict styles. According to Boulle, Colatrella, and Picchioni "conflict style is an overarching strategy that a person has for dealing with the conflicts that life presents".[13] With assertiveness and cooperativeness as characteristics at the cornerstone of conflict style, these authors note five main styles, with most people relying on one or two of these approaches as their predominant conflict style. Naturally, conflict style is partially determined by personality (nature) and is influenced by an individual's experiences throughout their life (nurture). Each style has advantages and disadvantages in various conflict situations. The mediator's job is to be able to recognize the style and to be able to help an individual apply the most effective approach available to them in order to productively engage in the conflict situation. Boulle Colatrella and Picchioni note "proper management of conflict style by the mediator leads to an increased chance of the parties communicating more effectively and making good decisions about the dispute".[14]

Waldman highlights the effect of heightened emotion on a disputant's cognitive abilities.[15] In relation to an angry party, for example, Waldman notes "people prone to anger are likely to cycle into a series of cognitive biases that free their ire and propel them to rage".[16] Some of the more common cognitive distortions include assuming hostile motives from the behavior of others, assuming things will become much worse than they already are, and seeing only polar extremes when considering options. Such distortions are likely to impede the mediation process, as the angry individual will tend

[12] L Boulle, M Colatrella and A Picchioni, *Mediation: Skills and Techniques* (LexisNexis, 2008).

[13] Boulle, Colatrella and Picchioni, n 12, 150.

[14] Boulle, Colatrella and Picchioni, n 12, 152.

[15] E Waldman (ed), Mediation Ethics: Cases and Commentaries (Jossey-Bass, 2011).

[16] Waldman, n 15, 58.

to view all propositions from the other party as malevolently motivated. Waldman provides a succinct account of how these cognitions can derail productive mediation.[17]

One of the unresolved questions in the mediation field is the degree to which a mediator has a responsibility to determine capacity. In consideration of this issue, Crawford et al recognise the challenges for mediators in determining capacity when some have limited understanding of mental health issues.[18] These authors argue for mediators to focus not on judging capacity, but on facilitating the party's competencies to participate effectively in the mediation process. More recently, Petch et al, have reinforced this point by noting it is not the role of the mediator to diagnose, but some assessment of capacity to engage in a meaningful way is important.[19] They add that the mediator needs to consider what accommodations could be made to the mediation process to enable a person struggling with a mental disorder to participate effectively in the mediation process.

<DIV>MENTAL HEALTH IN AUSTRALIA

Latest statistics indicate that common mental health concerns, such as stress, depression and anxiety, will be experienced by nearly half of all Australians at some point in their lifetime.[20] According to the National Survey of Mental Health and Wellbeing, every year 1 in 5 adults (aged 16 to 85 years) and 1 in 7 children or adolescents (4 to 17 years) will experience a mental health condition.[21] The cost of untreated mental health disorders in terms of diminished employee productivity is estimated at $5.9 billion per annum.[22] In addition, commentators have highlighted the

[17] Waldman, n 15, 58.

[18] S Crawford et al, "From Determining Capacity to Facilitating Competencies: A New Mediation Framework" (2003) 20 *Conflict Resolution Quarterly* 385.

[19] J Petch et al, "Psychological Distress in Australian Clients Seeking Family and Relationship Counselling and Mediation Services" (2014) 49 *Australian Psychologist* 28.

[20] Australian Institute of Health and Welfare, *Mental Health Services: In Brief 2014* (AIHW, 2013) 141 <http://www.aihw.gov.au/publication-detail/?id=60129549463>.

[21] Australian Institute of Health and Welfare, n 20.

[22] Department of Health, *National Mental Health Report* (2010) <http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-report10-toc~mental-pubs-n-report10-c~mental-pubs-n-report10-c-5~mental-pubs-n-report10-c-5-9>[This link no longer appears to be working. Is there another link you can provide?]. The document appears to be archived – the new link is here: http://apo.org.au/resource/national-mental-health-report-2010

intangible costs of individual suffering to the community including impact on relationships as well as on individual education and work achievements.[23]

Given the high prevalence of mental health disorders in our community, there is likelihood that at some time a mediator will need to work with parties who may be suffering a psychological disorder. In fact, Petch et al reports on an Australian study of 319 females and 289 males appearing for Family Dispute Resolution. Petch et al used scores from the K-10, which is a brief screener of psychological distress with high scores predictive of anxiety and depression.[25] Petch et al found almost 20% of participants' evidenced scores in the "high" range (raw scores between 22-29) and around 9% were in the "very high" range (scores of 30 or over; where scores over 30 are indicative that clinical intervention is required). There was no statistically significant difference in scores of psychological distress between male and female participants. Clearly, symptoms of psychological distress are likely to be exacerbated by the emotionally charged situations that often accompany parties to mediation, and thus may influence negatively an individual's capacity to mediate. Petch et al support this assumption by noting the high rates of elevated psychological distress in clients accessing mediation services in their study and suggesting that screening for severe distress may be useful.[26] The implication of their findings is that mental health issues are likely to require assessment as part of the mediation process.

An earlier account provides a review of relevant literature and guidelines for screening mediation candidates in terms of the individual's ability to communicate and negotiate effectively.[27] Here the authors argued for a "minimalist" approach which is more about screening out, than screening in. Yet screening for psychological issues is only one response to this issue. Indeed, some argue that most mediators do not have the professional background to support such clinical judgments.[28]

A more accessible option may be to assist mediators to develop the knowledge and skills to be able to make the necessary adjustments to the mediation process to accommodate certain mental health issues, in a similar way to the adjustments made to account for individual conflict styles. For instance, Coy and Hedeen advocate for a

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[23] Australian Psychological Society, *Stress and Wellbeing in Australia Survey 2014* (APS, 2014) 7 <https://www.psychology.org.au/Assets/Files/2014-APS-NPW-Survey-WEB-reduced.pdf>.

[25] Petch et al, n 19.

[26] Petch et al, n 19, 33.

[27] P Coy and T Hedeen, "Disabilities and Mediation Readiness in Court- Referred Cases: Developing Screening Criteria and Service Networks" (1998) 16 *Mediation Quarterly* 113.

[28] Petch et al, n 19.

stronger focus on adjusting the process to suit disputant capabilities, rather than setting the benchmark for entry into mediation too high.[29]

In her commentary around a series of case vignettes concerning issues of autonomy and diminished capacity, Liebman highlights the need for a mediator to consider a number of questions in this scenario.[30] These include:

- What should the mediator do to develop this case before the mediation begins?
- Who should be at the table?
- What decisions is (the party) capable of understanding and participating in, and what decisions should be made by others in (his or her) best interest?
- Does the mediator need special knowledge or skills to handle this case?
- How should mediation be structured to best support (the party's) participation?[31]

Many of these queries are raised in the context of severe mental illness or cognitive dysfunction, yet sub-clinical levels of anxiety, depression or stress while not diagnostically significant, may still result in heightened emotionality, impaired concentration, poorer decision-making, and lower frustration tolerance. In a heightened emotional state, whether distressed, grieving or angry, an individual experiences physiological changes that can undermine their ability to think creatively and to regulate their behavior. This sometimes results in disruptive or impulsive reactions under heightened emotional arousal.

<DIV>DIAGNOSING MENTAL HEALTH CONCERNS

Any discussion of the impact of mental illness needs to start with acknowledgement of the prejudice that often accompanies stereotyping associated with psychiatric labels. Such stigma is experienced by 75% of individuals with a mental illness.[32] Often a discussion of mental health symptoms is viewed as threatening and uncomfortable. Commonly occurring mental disorders of depression, anxiety and stress are conditions likely to be associated with experiencing high conflict situations, that is, the type of circumstance that leads to mediation being required. These are disorders likely to

[29] Coy and Heeden, n 27.

[30] C Liebman and M Murray, "Autonomy and Diminished Capacity" in E Waldman (ed), *Mediation Ethics: Cases and Commentaries* (Jossey-Bass, 2011) 27.

[31] Liebman and Murray, n 30, 37.

[32] Government of Western Australia Mental Health Commission, *What is Stigma* (2010) <http://www.mentalhealth.wa.gov.au/mental_illness_and_health/mh_stigma.aspx>.

impact an individual's functioning, but may not have reached a point that the individual has been diagnosed or sought treatment. In fact, while effective evidence-based treatments exist for these commonly occurring disorders, 50% of Australians with a common mental disorder are not accessing treatment, despite recent reforms in Australian primary health care services.[33]

Mental health professionals communicate about mental health conditions using a common language that relates to labels assigned to clusters of symptoms. The diagnostic system used by mental health professionals in Australia is the *Diagnostic and Statistical Manual of Mental Disorders* – Fifth Edition (DSM-5)[34] or the classification system described in the *International Statistical Classification of Diseases and Related Health Problems* – 10th Revision (ICD-10).[35] Some authors argue against the ethics of utilising such diagnostic labels, claiming these marginalise sufferers and reduce an individual's experience to component parts that do not adequately represent the whole.[36] Others argue that diagnostic systems for mental disorders are no different to those available for physical disorders and are a means of providing a unified description of a condition requiring treatment.[37] This paper will refer to criteria listed in the DSM-5 as this is the classification approach used by the majority of private practitioners in Australia.

For each disorder a brief overview of the cluster of symptoms will be provided, followed by a short discussion of how these symptoms might influence relevant cognitive capabilities in a mediation setting. To conclude, practical strategies for a mediator to consider will be suggested. At times, providing referral details of more than one mental health professional and encouraging the incapacitated party to seek professional support is often a helpful option. If the individual is already engaged in support services, it may be appropriate for mediation to be part of a coordinated approach with other helping professionals.

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[33] Department of Health and Ageing, National Mental Health Report: Tracking Progress of Mental Health Reform in Australia 1993-2011 (Commonwealth of Australia, 2013).

[34] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (APS, 5th ed, 2013).

[35] World Health Organisation, *International Statistical Classification of Diseased and Related Health Problems*, 10th Revision (WHO, 2015) <http://apps.who.int/classifications/icd10/browse/2015/en#/IX>.

[36] A Frances, "DSM 5 Is Guide Not Bible – Ignore Its Ten Worst Changes" (2012) *Psychology Today* <http://www.psychologytoday.com/blog/dsm5-in-distress/201212/dsm-5-is-guide-not-bible-ignore-its-ten-worst-changes>; A Frances and T Widiger, "Psychiatric Diagnosis: Lessons from DSM-IV Past and Cautions for the DSM-5 Future" (2012) 8 *Annual Review of Clinical Psychology* 109; M Zimmerman, "A Critique of Proposed Prototype Rating System for Personality Disorders in DSM-5" (2011) 25 *Journal of Personality Disorders* 206.

[37] A Barsky, Ethics and Values in Social Work: An Integrated Approach for a Comprehensive Curriculum (Oxford University Press, 2010).

At the outset, it is important to acknowledge that the mediator's role is not to become proficient in mental health assessment and diagnosis. Rather, as with other challenging behaviours, recognising the impact of mental health issues on conflict resolution styles and decision-making capacities is an important skill for successful dispute resolution practitioners. Understanding the particular needs of the individuals involved, whether due to mental health issues, emotional distress, or personality style, is part of the suite of competencies that assist practitioners to manage mediation effectively.

<subdiv>Depressive disorders

Depression is arguably an over-used term in common parlance.[38] In a clinical context it refers to a cluster of symptoms such as loss of interest in pleasurable activities, feelings of worthlessness, low energy, social withdrawal, unresolved grief issues, loss of energy, sleep disturbances and often thoughts of suicide or death. In the Australian community, prevalence rates are estimated at around 3% for men and 5% for women.[39] The widespread impact of this disorder on the community is evident from estimates of 1 in 10 Australians being affected by depression.[40] Manicavasagar provides a brief summary of current best practice in clinical assessment and treatment for depressive disorders.[41]

Functional impairments arising from the disorder include poor concentration and indecisiveness, irritable mood, distractibility and low frustration tolerance, tearfulness, fatigue, decreased energy and tiredness resulting in significant difficulties accomplishing even the most basic of daily tasks, such as washing and dressing. Impairment can be quite mild, such as when symptoms are not noticeable to others who interact with the individual. It may be, however, associated with complete incapacity, where the individual is unable to manage basic tasks or is catatonic.[42] Obviously, in a mediation setting this more severe end of the symptom spectrum is less

[38] H Grossman, "Misplacing Empathy and Misdiagnosing Depression: How to Differentiate Among Depression's Many Faces" (2004) 59 *Geriatrics* 39; J Jureidini and A Tonkin, "Overuse of Antidepressant Drugs for the Treatment of Depression" (2006) 20 *CNS Drugs* 623.

[39] Australian Bureau of Statistics, *National Survey of Mental Health and Well-being: Summary of Results*, (ABS, 2007) <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0>.

[40] Australian Institute of Health and Welfare, *Australia's Welfare 1999: Services and Assistance* (AIWH, 1999) <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442453040>.

[41] V Manicavasagar, "Depressive Disorders" (2014) 36 *InPsych* 8.

[42] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, n 34, 167.

likely to be seen, however, given the emotional investment many disputing parties have in the issue at hand, it is possible that some impairment due to depressive symptoms may be apparent.

Wang et al note the impact of major depression on the social decision making capacities of people with major depressive disorder and finds these deficits influence both the self-interests of the individual as well as those of others in the process.[43] These researchers highlight deficits in bargaining behaviours, decreased reward sensitivity (meaning limitations in their ability to recognize opportunities in mediation), limited capacity for reciprocity, and selective attention to negative stimuli. These cognitive dysfunctions are likely to result in shortfalls in the impaired individual's ability to respond to the thoughts and feelings of the other disputant in a mediation, to accurately assess the fairness and benefits of a proposal, and to provide creative alternatives when in negotiation.

Practical strategies relevant for such presentations include providing referral details of a mental health professional and encouraging the party to seek professional support. If already engaged with a support professional, the mediator may encourage the party to consent to a coordinated approach to support the incapacitated party through the mediation process. Other creative solutions include using visual aids as well as frequent summarising and repetition of points made during the mediation or, if the participant has difficulty managing their emotions, she or he may attend the mediation with an advocate or other support person.[44] Mediation may take longer and require more breaks or be reconvened to accommodate cognitive processing delays.

<subdiv>Anxiety disorders

Whereas fear is a response to real or perceived threat, anxiety is a response to anticipated threat.[45] In her summary of current clinical best-practice in relation to anxiety disorders, Kangas notes prevalence of anxiety in 1 in 8 Australians (12.8%) aged 16 to 85 years.[46] Anxiety disorders can start in childhood and tend to occur more frequently in females compared to males. The key features of generalised anxiety include persistent and excessive worry, as well as physical symptoms that the

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[43] Y Wang et al, "Impaired Social Decision Making in Patients with Major Depressive Disorder" (2014) 14 *BioMed Central* 18.

[44] B Finlay, *Accommodating Mediation Participants with Mental Health and Addiction Issues* (2006). <http://www.finlaycounselling.ca/pdfs/mediation_participants.pdf>.

[45] American Psychiatric Association, n 34, 189.

[46] M Kangas, "Anxiety Disorders" (2014) 36 *In Psych* 9.

individual finds difficult to control. These can include restlessness or feeling "keyed up", fatigue, difficulty concentrating, irritability, and sleep disturbances. A core feature of all anxiety disorders is the persistent excessive anxiety and avoidance of feared or anticipated events. Anxiety can manifest in physical symptoms such as headaches, stomach-aches, and vomiting, as well as cause impairment in social, occupational and other domains of functioning that impact an individual's ability to undertake daily activities.

Functional impairments arising from anxiety impacts an individual's ability to process information efficiently and quickly.[47] Excessive worrying creates physical and mental tension that is exhausting and time-consuming. Combine these consequences with sleeplessness and distress and the individual may be experiencing significant cognitive impairment. The anxious disputant experiences a pervasive and deep-seated sense of impending doom. Waldman provides a clear account of the core neurological changes that occur when an individual experiences anxiety, and the impact of these neural responses on our cognitive and behavioural pathways.[48]

The overly anxious disputant might find it difficult to recognise opportunities for settlement in mediation. These individuals are threat sensitive and in mediation this translates to the individual tending to:

- fix on the possibility that their adversary is not operating in good faith;
- perseverate on the uncertainty surrounding their settlement alternatives;
- see only the downsides of any offer from the other side;
- worry about buyer's remorse; or
- obsess over being perceived as weak if they make an offer themselves.[49]

Accordingly, practical strategies relevant for this presentation include providing a private space where the individual can retreat to in breaks and scheduling frequent breaks and being able to have the door open to avoid feeling "hemmed in" during the mediation process, thereby lowering arousal. As with depression, reconvening or allowing longer for processing of salient information is important for these participants. Basic anxiety management practices such as deep breathing and muscle relaxation techniques may also be useful as short-term, immediate strategies.

[47] American Psychiatric Association, n 34, 225.

[48] Waldman, n 15, 59. [As this is an edition of collected articles, could you please cite the actual article you are referring to and likewise for the footnote below]

[49] Waldman, n 15, 60.

<subdiv>Adjustment disorder

Stress is not a diagnosable disorder in either DSM-5 or ICD-10 nomenclature. Getting upset when adverse events occur is a normal reaction for most people.[50] The development of emotional and behavioural symptoms are clinically significant where these are disproportionate to the stressor event and where impairment in social, occupational and other areas of functioning is evident.[51] When such symptoms arise from a stressor within the last three months the cluster is recognised as an Adjustment Disorder. In his summary of clinical assessment and treatment options for this disorder, Kenardy notes that Adjustment Disorder is more common in clinical (medical) settings (rate is estimated at around 14%) than in the general community (rates vary between 2% and 4%).[52]

Adjustment Disorder is associated with significant life changes or stressors and, as such, impact the individual across a range of domains including social, occupational and educational. Diagnostic criteria identify that the disorder can accompany most mental disorders and many medical conditions.[53] Impairment associated with other recognised mood disorders, such as depression and anxiety, also may be evident as these conditions are often part of the presentation for an individual with adjustment disorder.

When considering the impact of sadness and grief on the dispute resolution process, Waldman highlights the slowing down of our physiology in response to the neurological changes that take place while processing these similar, but distinct, emotions.[54] The symptoms of Adjustment Disorder usually abate within six months of the removal of the stressor or its consequences. Waldman reminds mediators to assess whether the degree of emotionality experienced by the disputant is likely to preclude an effective process occurring, and the likely risk of harm to the other party should mediation proceed. In addition to the general strategies considered above, the highly anxious disputant may benefit from postponing the mediation session. This can provide the distraught disputant with an opportunity to calm physiological symptoms associated with heightened arousal and restore optimum cognitive functioning.

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[50] American Psychiatric Association, n 34, 289.

[51] American Psychiatric Association, n 34, 286.

[52] J Kenardy, "Adjustment Disorder" (2014) 36 *InPsych* 12.

[53] American Psychiatric Association, n 34, 289.

[54] Waldman, n 15. [If this refers to a specific article within the book, please advise which one and likewise for the footnote below.]

The individual experiencing reduced cognitive capacity may also benefit from more time taken in intake and coaching around essential social and problem solving skills fundamental to successful mediation. With this strategy in particular, it is important to acknowledge that procedural fairness applies to both parties in the mediation. Once a determination has been made that both parties have the capacity to participate, then the mediator needs to decide on the nature and extent of support to provide the party who he or she has assessed as being of lower capacity. However, once mediation begins the mediator must not act as an advocate for either party, but rather function in a place of neutrality and impartiality.[55]

<subdiv>Substance use disorders

Substance use disorders are characterised by changes in the brain's structure that persist beyond intoxication. These changes are associated with intense cravings and subsequent repeated relapse when the individual is seeking to cease substance use. Consequently, individuals with a substance use disorder continue to use substances (alcohol, prescription medication, non-prescription drugs) despite significant substance-related problems.[56] The desire to use substances overwhelms and comes at the expense of other goal directed behaviours. Prevalence of substance use disorders varies according to the specific disorder. For many, such as cannabis use and hypnotics or sedative use, rates are unclear. On the other hand, alcohol use disorder is a common difficulty, estimated around 12% for adult men and 5% for adult women in a 12-month period.[57] Kavanagh notes that 25% of Australians will have a substance use disorder in their lifetime, with one in five consuming alcohol at high-risk levels at some stage in their lifetime.[58] Men are twice as likely as women to have a substance use disorder.[59] Kavanagh provides a summary of current best practice in assessment and treatment approaches for substance use in Australia.[60]

As identified in the clinical criterion (singular or plural) listed in DSM-5, the pathological behaviours common to all substance use disorders include impaired

[55] Waldman, n 15, 53.

[56] American Psychiatric Association, n 34, 483.

[57] American Psychiatric Association, n 34, 493.

[58] D Kavanagh, "Substance use Disorders" (2014) 36 *InPsych* 13.

[59] Australian Bureau of Statistics, n 39.

[60] Kavanagh, n 58.

control, social impairment, risky use and pharmacological criteria.[61] The individual may take substances for longer or in larger quantities than planned, despite expressing a desire to cut down or discontinue use. Significant time is spent in acquiring and consuming substances, as well as recovering from substance use effects. To meet the clinical criteria for a substance use disorder there also needs to be evidence of risky use of substances. This refers to an individual's persistent use of substances despite the negative consequences to them physically, psychologically and socially. The final criterion is the presence of tolerance, whereby over time increased doses of the substance are required to achieve the desired effect.

The severity of substance use disorder varies according to the number of symptoms evident and ranges from mild to severe. Functional impairments associated with substance use disorders appear in social functioning, with individuals failing to fulfill obligations associated with work, school or home. Cognitive deficits may be apparent and persist for up to 12 months post detoxification.[62] In addition, substance use disorders frequently co-occur with mood disorders, such as depression and anxiety, with the attendant impairments associated with these illnesses.

The impairment issues in this case require similar considerations to those raised for individuals suffering anxiety, depression, acute emotional arousal, or adjustment disorder. Capacity can be enhanced through strategies designed to slow down the mediation process to take into account the delayed processing issues faced by individuals experiencing these types of disorders. Steps such as taking extra time to provide coaching prior to mediation commencing, involving support workers, allowing frequent breaks to help the individual lower their emotional arousal during the negotiation may be appropriate. However, if an individual is under the influence of substances on attendance at mediation the mediator is advised not to proceed with the session as it is unlikely the individual, even if high functioning, is in a fit state to make important decisions.

<DIV>SUMMARY AND CONCLUSION

One of the core considerations is a definition of "capacity to mediate". Capacity implies an ability to be self-determining, yet what that means can vary between mediation contexts.[63] Ethically, exploring a participant's mental health poses challenges. Disputants with disabilities have confidentiality rights that must be balanced with the

[61] American Psychiatric Association, n 34.

[62] Kavanagh, n 58.

[63] Hedeen, n 4.

mediators "need to know" position.[64] Waldman highlights several core questions for mediators when considering an emotionally upset disputant's capacity:

- Does the disputant have the ability to understand the information being presented?
- Can she appreciate the significance of that information for her own life?
- Can she consider her options in light of her long-standing needs and interests?[65]

Liebman provides an anecdote that offers a poignant reflection relevant to this discussion.[66] Liebman's client (Liebman was acting as a legal advisor at the time) was a woman who suffered hallucinations and psychosis had been involuntarily committed to a mental hospital following an assault on a family member. Heavily pregnant, the woman had decided, after appropriate consultation and deliberation supported by a range of health care professionals, to give her unborn child up for adoption, as she believed she would be unable to care for the child appropriately. On the day the adoption papers were to be signed, the client handed Liebman a letter she had drafted for her child and requested Liebman review the letter to ascertain it's suitability to pass onto her child when the time came. After reading this letter, Liebman found she could not have contemplated a more eloquent letter from a birth mother to a child being given up for adoption. She notes

> <blockquote>
>
> my client taught me that regardless of the labels society puts on people or our conventional views of their ability to make hard, important, meaningful decisions, there is often a core of competence that is too easily overlooked, ignored, or devalued by those in authority.[67]</blockquote>

Indeed, research has indicated that people with psychiatric disabilities, including substance use problems, are as likely to reach settlement in a mediation context as are those with no such mental health challenges.[68]

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[64] Coy and Hedeen, n 27.

[65] Waldman, n 15, 56. [If this refers to a specific article within the book, please advise which one and likewise for the footnote below.]

[66] Liebman and Murray, n 30.

[67] Liebman and Murray, n 30, 43.

[68] Moss et al, n 10.

This discussion has provided clear grounds for a mediator to understand the complexities of commonly occurring mental health disorders in our community today. Aside from a person's fundamental conflict management skills, any mental health concerns that are present will also impact a person's style in mediation. Coy and Hedeen note that many cognitive and psychiatric disabilities are relatively hidden and far from immediately obvious, yet they may interfere to varying degrees with a disputants ability to communicate and negotiate effectively.[69] For those suffering acute but temporary incapacity, mediation may be possible with adjustments to the process to accommodate the functional requirements of the individual. However, for people with chronic, severe or stable presentations of mental health concerns, effective mediation may not be appropriate or, at the very least, is likely to require the involvement of the individual's health professional to support them during the process.

An important codicil to this work is that the burden of diagnosis should not fall to the mediator. Our argument is for conscious consideration to be given to the potential impact of such high prevalence disorders on a party's capacity to effectively mediate. We have provided some preliminary recommendations with practical considerations for mediators, with the premise that people experiencing substance use, depression, anxiety, and/or stress may well be able to mediate effectively given appropriate support. The mediator's role, as for any individual attending mediation, is to provide the optimum context for such dispute resolution to occur. Practicing in this context requires reflection, constant attention to the fundamental requirements of mediation, a deliberate approach, along with skillful practice. In providing these practical suggestions, we aim to support mediators' decision making in managing the dispute resolution process.

[69] Coy and Heeden, n 27, 119.