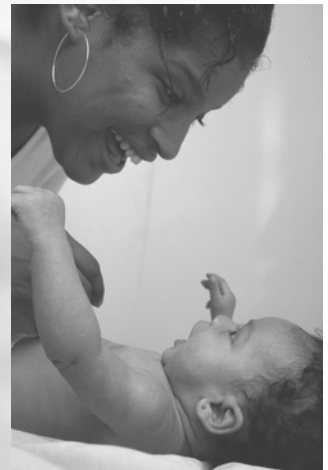




# Preparing for Conflict and Negotiation: A Case Study on Perinatal Depression

Women's and Children's Health Policy Center  
Johns Hopkins Bloomberg School of Public Health



Prepared by

Treeby Brown

For

The Women's and Children's Health Policy Center  
Department of Population, Family and Reproductive Health  
Johns Hopkins Bloomberg School of Public Health  
615 N. Wolfe Street  
Baltimore, MD 21205  
Tel: 410-502-5450  
Fax: 410-502-5831  
[www.jhsph.edu/wchpc](http://www.jhsph.edu/wchpc)

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**PREPARING FOR CONFLICT AND NEGOTIATION:  
A CASE STUDY ON PERINATAL DEPRESSION**

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## INSTRUCTOR GUIDANCE

The following case is designed to help practicing professionals and trainees in maternal and child health think strategically about how to address difficult issues related to conflict and negotiation. The case study centers on the issue of perinatal depression, a high-profile public health and mental health issue that requires comprehensive approaches and partnerships between groups that do not always have meaningful collaboration and are sometimes in conflict. Moreover, discussions about perinatal depression are sometimes characterized by vastly different opinions about mothers, parenting, and appropriate interventions. While the public health community may focus

primarily on prevention and intervention, the mental health community often shares legitimate concerns about patient rights and privacy.

The protagonist in this case study, Pam Albright, must challenge herself to be a tough negotiator, hold her cards close, and remain firm in the face of conflict and organizational differences—actions that go against her natural personality as a consensus builder and a straight talker as well as her training in public health. She must navigate two major negotiations—one within her agency and then one as a representative of her agency--with strength and finesse.

### LEARNING OBJECTIVES

As a result of this exercise, participants will be able to:

Apply negotiation and conflict resolution techniques to a public health scenarios by breaking the task into discrete steps and

- 1) Clarifying the role of the primary negotiator
- 2) Demonstrating how to prepare for negotiations by thinking strategically and tactically
- 3) Applying negotiation techniques to an actual public health issue.

### List of Key Characters (as they appear)<sup>1</sup>

Shannon Green.....	Mother suffering from postpartum depression
Jane Dixon.....	State Representative and Chair of the Committee on Children and Families
Jay Hastings.....	Governor
Pam Albright.....	Director, Women's and Maternal Health Section
Steven Alvarez.....	Director, Division of Family Health
Dr. Anne Siders.....	Commissioner of Public Health
Eric Benjamin.....	Director, Child Health Section
Judith Stevens.....	Deputy Director, Division of Medicaid and SCHIP
Jim Kennan.....	Health Director, Capital City Health Department
Dawn Minton.....	Health Director, Starmount Health Department
Stu Weisman.....	State Mental Health Director
Ned Ritchie.....	State Chapter President, ACOG
Lisa Knowles.....	State Chapter President, AAP
Jeanne Tillman.....	State Chapter President Alliance for the Mentally Ill
Anthony Bowden.....	State Director of Child Abuse and Neglect

<sup>1</sup> Names of characters and their descriptions as they appear in this case study are purely fictional. Any resemblance to actual people is purely coincidental.

## **CASE STUDY: PERINATAL DEPRESSION**

### **Background**

Perinatal depression (depression during pregnancy and postpartum depression) occurs in approximately 10 percent of pregnancies. It is characterized by persistent symptoms including strong feelings of anxiety and despair. Women experiencing perinatal depression may have trouble taking care of themselves, their infants, and other family members.<sup>2</sup> Women who have a history of depression or a family history of depression as well as a lack of social and/or financial supports are at greater risk for perinatal depression.

Unlike other depressions, perinatal depression is often characterized by overwhelming anxiety on the part of the mother or expectant mother. The patients may feel that they are terrible mothers, are afraid that they will somehow hurt their child, and that their child will be taken from them. For postpartum depression, experts believe that the best time for screening is sometime between 4 and 8 weeks after birth. Ideally, the six-week postpartum check would represent an opportunity for intervention. However, according to experts at the American College of Obstetricians and Gynecologists (ACOG), a recent study found that of women on Medicaid, only 50% actually attended their six-week postpartum check with their OB-GYN. Even among non-Medicaid women, there is a high no-show rate for their six-week postpartum appointment.<sup>3</sup>

On a positive note, recent research has pointed to the effectiveness of short, simple screening tools in identifying women with perinatal depression, such as the Edinburgh Postnatal Depression Scale and a shorter, two-question screen which asks: 1) Over the past two weeks, have you felt down, depressed or hopeless? 2) Over the past two weeks, have you felt little interest or pleasure in doing things?<sup>4</sup>

Some states are taking steps to address perinatal depression in a comprehensive manner. The state of Illinois recently passed legislation that directs licensed health care professionals providing prenatal care, postnatal care, and care to the infant, to administer a questionnaire to screen mothers for perinatal mental health disorders. In addition, Illinois now provides several resources for providers, including training sessions, screening, assessment and treatment tools and guidelines, and free telephone and online consultation with perinatal mental health experts.<sup>5</sup>

### **The Problem**

On May 9, on a busy suburban beltway east of the state Capital, Shannon Green is driving her three small children (all under age 4, including a 2 month-old infant) home from a shopping trip when she falls asleep at the wheel of her minivan and crashes her car into a guard rail. Paramedics who arrive on the scene find that the mother was not wearing her seatbelt, and discover that, while the car was equipped with child safety seats, none of the children was strapped in. The mother survives the crash but has no memory of the accident or the events preceding it. Her sons, two-year-old Colby and four-year-old Kyle, survive despite multiple broken bones, but her infant daughter, Taylor, sustains major head injuries and eventually dies after three days on life support. The surviving children are currently in the custody of their grandparents, while Shannon Green awaits the findings of an investigation by Child Protective Services.

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<sup>2</sup> American College of Obstetricians and Gynecologists Letter in Support of H.R. 20, the Melanie Blocker Stokes Postpartum Depression Research and Care Act, 10/15/2007

<sup>3</sup> Staff Interview, American College of Obstetricians and Gynecologists, April 2008;

<sup>4</sup> Barson, R. 2006. Considering Interventions for Depression in Reproductive Age Women in Family Planning Programs. Baltimore, MD. Women's and Children's Health Policy Center. Johns Hopkins Bloomberg School of Public Health.

<sup>5</sup> Blagojevich, R. Letter about Perinatal Depression from the Governor. 12/12/2007. Office of the Governor. , Chicago, Illinois.

After the initial outrage from the public about the mother's negligence in not strapping in the children, family members come forward to provide more details. According to them, Shannon Green has had a particularly hard time since giving birth to her third child two months ago. Mrs. Green's husband has been working on construction jobs out-of-state and was able to visit only sporadically during Mrs. Green's pregnancy; he was unable to be present at the birth. Mrs. Green's family lives out-of-state, but her mother and sister have visited twice since Taylor was born. Both noted concern about Mrs. Green's general fatigue, lack of connection to her newborn and overall stress. They described Ms. Green as "going through the motions as if she were in a fog." While the children were basically fed and diapers were changed, if only sporadically, "something was definitely off."

Because Shannon Green's husband's job does not provide health insurance, the children have been covered under the State Child Health Insurance Program (CHIPKIDS). They were enrolled at the clinic in their hometown, Starmount Community Health Clinic, about one hour east of the state capitol. When Shannon took Taylor (and the other two children) to the pediatrician for Taylor's two-month well-child visit, the doctor noticed how tired and addled the mother seemed. The doctor gently referred Shannon to the local mental health center as well as a community support center staffed by volunteers, in addition to providing the number for the state child development hotline.

Mrs. Green's mother, who accompanied her daughter on this doctor's visit, said that she had called the local mental health center herself trying to get services for her daughter, but had been told that her daughter must call to make the appointment. Mrs. Green's mother returned home a week later and was still trying to get her daughter to make the call when the car accident occurred.

### **The Reaction**

News coverage all over the state as well as successive editorials put pressure on state and local authorities to answer the basic question: "Who missed this?" Medical experts called to comment on the incident in the media said the accident was an unfortunate result of untreated postpartum depression. While mental health experts interviewed by the media noted that Mrs. Green was clearly not experiencing a psychotic break like that experienced by Andrea Yates who drowned her children, they noted that the disastrous results were similar: "A child is dead and a family is grieving."

State Representative Jane Dixon, Chair of the Committee on Children and Families, has been especially vocal in her outrage and has used the incident as an opportunity to reintroduce state legislation to provide more funds for perinatal depression and revamp the mental health referral and treatment system for mothers and children. The \$20 million legislation, which could mean as much as a 10% increase to the state mental health and public health budgets, had been previously introduced in the last two sessions of the legislature. Unfortunately, the bill never moved beyond the committee due to funding concerns and the absence of broad support from her colleagues. But with the Shannon Green tragedy, support seems to be moving her way, setting the stage for major reform. Senator Dixon has been given the green light by the House leadership to hold a hearing on the legislation in a little over a month. The hearing will feature testimony from the State Perinatal Task Force. At the other end of the political spectrum, some legislators who fault the mother are developing punitive measures to remove children from the home when a mother is diagnosed with postpartum depression.

The Governor, Jay Hastings, in office for nearly a year, has not taken a leadership position on any type of health care legislation or issue to date. Not wanting to be overshadowed by his political rival but fellow party member, Jane Dixon, he insists that the already existing State Perinatal task force (staffed within the Health Department by Pam Albright, Director of Women's and Maternal Health) step up to the plate to react to the legislation and draft a more comprehensive plan. Current membership on the task force includes the Commissioner of Health, the Director of the Division of Family Services as well

as state chapter presidents for the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG). At the urging of his senior advisers, Governor Hastings adds the Directors of the State Mental Health Department and State Child Protective Services as well as the State President of the Alliance of the Mentally Ill to the task force negotiations.

At the same time that the legislative negotiations are taking place, a local Child Fatality Review investigation is being led by the Capital County District Attorney.<sup>6</sup> This process usually takes from two to three months. This system investigation will hopefully lead to recommendations about how to improve the system of care, but few are aware of the process. Senator Jane Dixon doesn't want to wait until the process is complete because she feels she has the momentum now to get the legislation passed.

### **State Health Care System**

The Midwestern state where this scenario takes place is a reasonably affluent state with a State Child Health Insurance Program (SCHIP) whose benefits are rated in the moderate range. There are two major cities: the Capital City (the capital) and Brownville to the south. Families enroll in Medicaid and SCHIP through community health centers and public health centers. Pregnant women with children eligible for SCHIP, such as Shannon Green, can receive additional services, such as home visiting and parent support, through these centers. Mental health services are provided through community mental health centers located across the state. In areas outside the capital city, where it is hard to attract mental health professionals, local mental health clinics have long waiting lists and personnel openings. The recent downturn in the economy has stressed these public health and mental health clinics even more, stretching the dedicated staff to capacity.

The State Health Department has tried to have meaningful collaboration with the State Mental Health Department on a number of initiatives to forge stronger ties, but has found the staff at the state and local level well-meaning but overworked, and, because of scarce resources, only able to address the most serious cases of mental illness. Until now, perinatal depression has not been at the top of their list of priorities.

### **The Role of Public Health**

Pam Albright is the director of the Women's and Maternal Health Section, which is located in the Family Health Division of the State Health Department. She has a degree in social work and has been employed with the department for five years. Prior to her work with the State Health Department, she ran a perinatal outreach program at the State University Hospital. She has a solid relationship with public health nurses and social workers working in the local health departments and is known for her flexibility and creativity in designing programs and funding methods. She has long been an advocate for addressing women's health across the lifespan, not just during pregnancy, but fragmented federal funding streams have made comprehensive approaches difficult. While distressed at the breakdown of a system that resulted in an infant's death, she is grateful for the spotlight on perinatal depression and wants to make the most of this opportunity.

Her boss, the head of the Division of Family Health, is Dr. Steven Alvarez, trained as a pediatrician. He is supportive of addressing perinatal depression, although his primary focus has been on child health.

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<sup>6</sup> Child Fatality Review (CFR) is the process of reviewing all unexpected and unexplained child deaths. The process for conducting a child death review often includes the following: 1) gathering and presenting information, 2) identifying contributing factors, and 3) formulating data-driven recommendations to prevent future child deaths.

A local child fatality review team is often composed of representatives of agencies, offices, and institutions that investigate child deaths, including but not limited to, coroners, family service workers, medical professionals, law enforcement officials, and prosecutors. (Source: Ohio and Kentucky Child Fatality Review Web Pages)

Above Dr. Alvarez, as Commissioner of Public Health, is Dr. Anne Siders, a primary care doctor who has been with the department for 20 years. She is supportive of maternal and child health issues but is not an expert, and has been occupied in recent years with disaster planning (the state hosts a large nuclear facility) and with revamping the state laboratories.

Ms. Albright's superiors have tasked her with the goal of deciding what the Department (including local health departments) wants and needs from the new legislation and then negotiating these needs through the Perinatal Commission, with funding for public health at the top of the list.

Ms. Albright, while confident of her knowledge and ideas, is extremely nervous about these negotiations because of the media coverage they will receive in this high profile situation and because she is not completely sure how much public health really wants to take on in terms of revamping the existing system of care. She has a reputation more as a consensus builder than as a tough negotiator and is often unsure how much information to share in negotiations.

**PREVIOUS NEGOTIATING EXPERIENCE:** Four years ago, when Ms. Albright was new to her position as women's health director, she was assigned to represent the Family Health Division on an ad hoc group convened by Representative Jane Dixon to address perinatal depression as part of a larger women's health initiative. In addition to the Family Health Division, the group included staff from the State Mental Health agency and key advocacy groups, including the state chapters of ACOG and AAP and the State Alliance for the Mentally Ill. Although the group met several times, little progress was made. Rep. Dixon was not able to attend all the meetings, assigning a junior staffer to develop the agendas for the group and moderate in her absence. The discussions were characterized by misunderstandings and misinformation about group members' priorities and goals. Pam Albright, fresh from her hospital position, was a strong advocate of promoting the use of perinatal depression screening tools. Unfortunately, someone from the group leaked information to the press and conservative legislators, who characterized Ms. Albright's views as "the Health Department trying to shove yet another regulation, that violates the privacy of mothers, on already beleaguered obstetricians." This unwanted press essentially dealt the fatal blow to an already compromised negotiation.

## The Legislation

At issue in Ms. Dixon's draft legislation is sorting out appropriate roles for mental health versus public health. For many at-risk families eligible for Medicaid or the State Child Health Insurance Program, local health departments provide a key entry to the health care system even though eventual treatment for mental illnesses, especially in complex cases, requires the mental health system. In the context of revamping the system of care to better identify and treat women with or at risk of perinatal depression, six key issues must be resolved.<sup>7</sup> *For each of the following issues, the legislation will need to delineate which agency (the State Mental Health Agency or the Health Department) will have primary responsibility and funding for implementation. These issues will form the basis of Pam Albright's negotiating points.*

- 1) **REFERRAL AND TREATMENT:** Developing more effective referral mechanisms (including identifying points of entry) and treatment options to ensure that women with or at-risk of perinatal depression receive the mental health services they need in a timely and effective manner.

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<sup>7</sup> The issues listed below are not meant to encompass all the policy issues related to perinatal depression, but rather provide a sampling of key issues that may contribute to conflict during a negotiation. More information on the public health response to perinatal depression can be found in the following fact sheets: <http://www.jhsph.edu/wchpc/publications/ConsiderIntervenDepressionWomenFPP2.pdf> <http://www.astho.org/pubs/PerinatalDepressionFS.pdf>

- 2) **RESOURCES AND TRAINING:** Providing resources and training to assist pediatricians, obstetricians and gynecologists, nurse midwives, and other practitioners in identifying, diagnosing, treating and following women with perinatal depression, including information on evidence-based screening tools.
- 3) **STANDARDS AND GUIDELINES:** Developing guidelines and protocols for referrals and follow up for practitioners and lay health workers when perinatal depression is suspected.
- 4) **CONFIDENTIALITY:** Addressing privacy and reporting issues while ensuring the safety of the mother and children.
- 5) **FINANCING:** Securing coverage from state Medicaid and third party insurers for services performed by all providers for screening and intervention for perinatal depression.
- 6) **OUTREACH:** Developing a public awareness campaign for perinatal depression.

### **Negotiation #1: Intra-agency—The Department of Health**

Ms. Albright's first levels of negotiation will be internal, within the Department of Health. In the next five days, she needs to talk to key players individually within the Department to see what issues are most important to them, and also bring all the key players together for a consensus meeting (Negotiation #1). While Albright understands that the primary concern is ensuring adequate funding for referral and treatment for local health centers, she personally would like the legislation to include specific language encouraging the use of evidence-based screening tools during and after pregnancy by key health care professionals.

Pam recognizes that she may have to reign in some of her departmental colleagues who would like to take the lead in every aspect of the legislation—an unrealistic and potentially ineffective position. She must somehow convince her colleagues that it is in the best interest of all parties if the legislation results in more meaningful collaboration between the two agencies. Colleagues with whom she will be negotiating individually and then as part of a group include the following:

- 1) **DIRECTOR OF CHILD HEALTH:**  
Eric Benjamin is a pediatrician and the Director of Child Health. He is a close colleague of Pam Albright's and is very supportive of any extra funding going to perinatal depression, having seen firsthand the negative effects of maternal depression on infants. He would like to see a stronger role for public health in assuring that mothers are treated for perinatal depression, beyond simply referring them to mental health services. Dr. Benjamin has a good relationship with the state AAP but is concerned about placing any further mandates, or even recommendations, on pediatricians in the state since many already seemed overburdened by existing pediatric care guidelines. While some pediatricians, particularly the younger ones, would welcome having a clearer role and guidelines to refer mothers to mental health services, and even to prescribe medications, others see these activities as significantly beyond their role. Nevertheless, Dr. Benjamin's primary concern is funding for public health.
- 2) **DEPUTY DIRECTOR, MEDICAID/SCHIP:**  
Judith Stevens has been Deputy Director of Medicaid and SCHIP for four years. Before her current position was created, she was Director of the Women's and Maternal Health Section. She is regarded as extremely bright, but a far better manager of finances than people. Her tenure as Director of the Women's and Maternal Health Section was marked by rocky relations with local health departments, which her successor, Pam Albright, has worked hard to repair. Judith Stevens continues to give Pam Albright unsolicited advice on a regular basis about how to run the women's health section. As Deputy Director and lead negotiator for the State

Medicaid/SCHIP plan, Pam absolutely needs Judith's input into and support of the Medicaid reimbursement and financing piece of the legislation.

- 3) **HEALTH DIRECTOR FOR CAPITAL CITY:** Jim Kennan is the Health Director for the Capital City Health Department. The Capital City health department has a reputation as an incubator for promising practices and new approaches as well as a well-regarded lay health visitor program. Dr. Kennan is known as an extremely bright but impatient man, whose self-confidence and brash style can rub people the wrong way. Dr. Kennan would like to see a larger role for lay health visitors in identifying and making an initial screen for prenatal depression, as well as more funding to the local health department to ensure that the mothers receive the mental health services they need. He has been particularly frustrated in his workings with the local mental health agency. While recognizing that the local mental health services agency across is underfunded and capable of handling only the most severe cases, he feels that the agency has been less than collaborative when the health department has tried to reach out and develop more effective referral mechanisms, including the use of lay health visitors: "These folks are on the front lines, with a good sense of the mothers that need help. Yet, they are frustrated by the local mental health agencies' lack of response to their referrals." He is pushing Pam Albright to be a tough negotiator with mental health, if not downright adversarial.
- 4) **HEALTH DIRECTOR FOR STARMOUNT:** Dawn Minton is the long-time director of the Starmount Health Department and is considered a leader in public health in more rural areas. She has taken the Shannon Green tragedy very hard and wonders if her hands-off management style played some role. She was aware of the lack of comprehensive mental health services and the "disconnect" between public health and mental health, and she wonders if she has done enough to bridge the gap. At the same time, she is somewhat conflicted about the role of the local health department in assuring these women receive services. Ms. Minton has close colleagues at the local mental health agency that she is reluctant to criticize. In addition, she is frustrated at Jim Kennan's vocal criticism of the whole system—which she is taking personally.

## **Negotiation #2: Task Force Level**

The State Task Force on Perinatal Health will meet one week after Pam Albright's consensus meeting with her Department of Health colleagues (Negotiation #1) and one week prior to Rep. Dixon's hearing. Ms. Albright must work with persons outside her agency, with whom she is not as familiar and may very well come into conflict. She will be negotiating with larger and more established political constituencies (such as the AAP and the National Alliance for the Mentally Ill) with personal and professional motivations, and the negotiations will certainly garner more attention and more publicity. There may be more pressure on Pam Albright to compromise at this level of negotiation. While the backgrounds of the task force members are provided below, Ms. Albright is not necessarily aware of all these connections.

- 1) **STATE MENTAL HEALTH DIRECTOR**  
Stu Weisman is the director of the State Department of Mental Health. He has a degree in social work and worked as a therapist in a variety of local health departments before taking on more administrative roles. He is an effective speaker in meetings promising collaboration and more attention to prevention, but rarely follows through. Local mental health directors like Mr. Weisman on a personal level, but are frustrated that he has not secured the additional funding that they desperately need. He has had little contact with the Governor or his office because, until now, mental health issues were not on the Governor's agenda. In this negotiation, Mr. Weisman desperately wants to prove himself to the new governor and the mental health

community by ensuring that the bulk of the new funding goes to mental health and not to the health department.

2) **STATE CHAPTER OF ACOG**

Ned Ritchie is the chair of the state section of the American College of Obstetricians and Gynecologists (ACOG). He is in his late 50s and runs a thriving practice in the southern part of the state. He has been an active member of the State ACOG section on issues such as professional liability, early postpartum discharge, and other issues. His practice is open to a Medicaid clientele. He is aware of new prenatal depression guidance and is starting to employ this in his practice; however, he is not sure how much his other colleagues are using the tools. He is comfortable prescribing medication for depression, if necessary, but thinks OB-GYNs need more training in this area. He also has major concerns about the effectiveness of the referral process to mental health agencies when he suspects perinatal depression. Dr. Ritchie has a close relationship with his county health director, but has had few dealings with the county mental health director.

3) **STATE CHAPTER OF AAP**

Lisa Knowles, in her early 40s, is the president of the state chapter of the AAP. She has enjoyed a close working relationship with Dr. Alvarez, the director of the Division of Family Health, and considers him a mentor. As a pediatrician, she has observed suspected cases of perinatal depression and has sought to be proactive in asking the mothers key questions and occasionally referring them for services. She herself would not be opposed even to writing a prescription for the mother, but is not sure if that would be overstepping bounds. Above all, she wants clearer guidelines about what to do if a pediatrician suspects maternal depression, and more available services to refer to. She has worked with the local mental health department on mental health campaigns as well as child mental health issues and is open to a stronger relationship.

4) **STATE CHAPTER OF ALLIANCE FOR THE MENTALLY ILL**

Jeanne Tillman, President of the State Alliance for the Mentally Ill and the mother of a grown son with schizophrenia, is coming to the task force meeting intent on putting a lot of pressure on Stu Weisman, the state mental health director. She is excited at the opportunity for any kind of new funding for mental health, even if she is not well versed in perinatal depression issues. She has been frustrated that Stu Weisman has not been able to garner more funds for mental health and that he has not always followed through on funding opportunities (e.g. pilot projects, grant opportunities) to strengthen the mental health system. She understands the constant pressure between prevention and crisis in mental health, having gone through so much with her son. She is wary of public health taking too much of a role in this issue, when she feels that mental health badly needs additional funding.

5) **STATE DIRECTOR OF CHILD ABUSE AND NEGLECT**

Anthony Bowden, newly appointed Director of the State Department of Child Abuse and Neglect, is primarily concerned about keeping children alive on his watch as state director. The death of a child who is in foster care or who has been reported to Child Protective Services is a director's ultimate failure. Mr. Bowden is extremely supportive of any efforts to address perinatal depression in mothers but wants to include measures in the legislation that would somehow ensure the safety of the children if the parent has been referred to mental health services. Mr. Bowden is pressing for a delay in discussion of legislative specifics until the findings of the Child Fatality Review Team, of which he is a member, are released. Conservative legislators have consulted him on various parts of the proposed legislation.

## The Hearing

All the negotiations are in preparation for the upcoming hearing chaired by Rep. Jane Dixon. Pam Albright must therefore keep Rep. Dixon's legislative perspective in mind as she prepares. Rep. Dixon is mainly concerned with getting the legislation passed. She has a cordial but not close relationship with the Governor, and she is considering challenging him for the nomination when he runs for re-election. She has a reputation as a knowledgeable legislator but has sponsored no major legislation, so she really wants a bill that will pass.

## What's Next?

In the next two weeks, Pam Albright must handle two major negotiations to address which agency takes the primary lead and funding in addressing the six key issues of the legislation: referral and treatment, resources and training, standards and guidelines, confidentiality, financing of care, and outreach. For the first negotiation, Pam Albright must work within her department to determine where the Health Department (including the two local health directors) feels most strongly about taking the lead in terms of their expertise, their effectiveness and their need for funding. To be effective and successful, her negotiating position must make room for meaningful roles for the Department of Mental Health. For the second negotiation, the stakes are even higher. With more players and more established political constituencies, the potential for failure is even greater. Her agency and her own reputation are on the line.

## Timeline

Date	Activity	Participants
<b>Week 1:</b>	Shannon Green Accident Takes Place	
<b>Week 2:</b>	Pam Albright's first meeting with the Director of the Division of Family Health and the Commissioner of Health regarding her role on the Perinatal Task Force	Pam Albright, Steven Alvarez, Anne Siders
<b>Week 2:</b>	Pam Albright conducts pre-meetings with colleagues from Department of Health	Pam Albright, Eric Benjamin, Judith Stevens, Jim Kennan, Dawn Minton
<b>Week 3:</b>	Negotiation #1: Department of Health (Intra-agency)	Pam Albright, Steven Alvarez, Anne Siders, Eric Benjamin, Judith Stevens, Jim Kennan, Dawn Minton
<b>Week 4:</b>	Negotiation #2: Perinatal Task Force	Pam Albright, Steven Alvarez, Anne Siders, Stu Weisman, Ned Ritchie, Lisa Knowles, Jane Tillman, Anthony Bowden
<b>Week 5:</b>	First Hearing on Perinatal Health Legislation, Committee on Children and Families	Jane Dixon, State Perinatal Task Force
<b>Two to Three Months Later</b>	Findings from Child Fatality Review Released	District Attorney, Capital County

## **DISCUSSION QUESTIONS AND GROUP EXERCISES**

The discussion questions and group exercises that follow are intended to help participants connect the scenario to their own experience and to reinforce the concepts explored in Module 4, *Managing Conflict Effectively*, of the MCH Leadership Skills Development Series. The following exercises will be most effective after studying Module 4. The exercises may also be used as a stand-alone instrument with the case study. While it is recommended that participants discuss the initial set of general discussion questions and complete Exercise A, only one mock negotiation (Exercise B or C) needs to be completed if time is limited.

### **General Discussion Questions**

- 1) Is this a familiar scenario?
- 2) What are Pam Albright's policy priorities?
- 3) How do you think Pam Albright views conflict? What are the strengths and weaknesses she may bring to the negotiating table?
- 4) Where do think Ms. Albright will face her greatest challenges?
- 5) What negotiation strategies Ms. Albright could use?
- 6) Based on the information provided, please characterize the likely negotiating style of the characters in the case study based on the five approaches to handling conflict (competing, accommodating, avoiding, collaboration, and compromising).

### ***CASE STUDY EXERCISE A: PREPARING FOR NEGOTIATION #1***

**The following questions are intended to help Pam Albright prepare for Negotiation #1, primarily through individual meetings with members of her own department.**

- 1) What disagreements with colleagues in the health department can Pam Albright anticipate? Use the Diagnosing Disagreements worksheet (Appendix A) to analyze the intra-agency conflicts.
- 2) What conflicts should/could be resolved one-on-one prior to the first negotiation?
- 3) With whom would you anticipate Pam Albright forming an alliance? How might that alliance help or hinder her negotiations?
- 4) Based on her approach to conflict, what specific techniques and considerations should Pam Albright keep in mind as she enters the intra-departmental negotiations?
- 5) How much information should Pam Albright reveal about her own priorities for the negotiation and at what point in the negotiation? Should she have a set of minimum acceptable outcomes in mind in advance?
- 6) **OPTIONAL:** Draft a set of talking points and negotiating strategy for Pam Albright to take for her first (intra-agency) negotiation.

### **CASE STUDY EXERCISE B: NEGOTIATION #1 ROLE PLAY**

In this exercise, participants will have the opportunity to conduct a mock negotiation. Each will be assigned a character for the role-play of the first negotiation. Characters include: Pam Albright, Steven Alvarez, Dr. Anne Siders, Eric Benjamin, Judith Stevens, Jim Kennan, and Dawn Minton.

#### **Getting in Character:**

Each participant is given a set of six index cards with the headings of the six legislative negotiating points listed on the cards: 1) Referral and Treatment; 2) Resources and Training; 3) Standards and Guidelines; 4) Confidentiality; 5) Financing; and 6) Outreach. Each participant also receives one blank index card.

- Participants decide, based on their assigned character's point of view, which agency should take the lead in management/funding for each of the six legislative areas. Write down the lead agency for each area, including a brief justification as well as any areas of compromise. Then, each participant ranks the six legislative points in order of priority.
- On the blank card, participants write down how they view their character's general motivations. Be sure to include information about with whom your character could forge an alliance and where you might anticipate conflict.
- Do not share the priorities with your colleagues; rather, use this information to inform you as you negotiate for the legislation.

#### **The Negotiation:**

The goal of the negotiation is for the group to collectively prioritize the six legislative negotiating points (in numerical order) in a process where no one person *appears* to dominate the negotiation. A successful negotiation will ensure that everyone feels ownership of the final product and that all perspectives were heard if not adopted.

Participants gather in a circle. The Pam Albright character will lead the negotiation by stating her goals for the meeting and starting the discussion. During the negotiation, try at least one of the following techniques:

- 1) Use some of the conflict resolution techniques addressed in the Module 4 lecture (e.g. how to start the meeting, using open-ended questions, taking a time out).
- 2) Alter your character's approach to conflict during the negotiating so that at one point you are competing and another accommodating.
- 3) Test out the effect of simply being unpredictable and see if that works to everyone's advantage or not.

Note that depending on the amount of time allotted for this exercise, the mock negotiation may not address all of the potential complexities involved in making comprehensive policy recommendations.

#### **Post-Negotiation:**

After the group has completed the collective ranking of the priorities, participants share how they individually ranked the negotiating points as well as their interpretation of their assigned character. If time allows, participants should discuss the following:

- 1) How effective was the negotiation in gaining a workable outcome?
- 2) How would you diagnose the sources of conflicts? Were they the ones you would have anticipated? Explain your answer.
- 3) What could Pam Albright have done to facilitate a better negotiation?

- 4) What could the other participants have done differently?
- 5) How will Pam Albright need to do differently to prepare for the next level of negotiation?

### **EXERCISE C: NEGOTIATION #2 ROLE PLAY**

**Assign new characters (including a new Pam Albright) for the second negotiation. Characters include Anne Siders, Steven Alvarez, Stu Weisman, Ned Ritchie, Lisa Knowles, Jeanne Tillman, and Anthony Bowden. Think about how this Task Force negotiation may be different from the interagency negotiation.**

Participants may want to consider the following as they prepare for this second negotiation: 1) The sources of the conflicts may be more difficult to diagnose. 2) The pressure to compromise rather than collaborate may be greater. 3) The personal motivations and egos of the characters may come into play more at this higher level of negotiation.

As in the first negotiation, each participant is given a set of six index cards with the headings of the six legislative negotiating points listed on the cards: 1) Referral and Treatment; 2) Resources and Training; 3) Standards and Guidelines; 4) Confidentiality; and 5) Financing; and 6) Outreach.

- Participants decide, based on their assigned character's point of view, which agency should take the lead in management/funding for each of the six legislative areas. Write down the lead agency for each area, including a brief justification as well as any areas of compromise. Then, each participant ranks the six legislative points in order of priority.
- On the blank card, participants write down how they view their character's general motivations. Be sure to include information about with whom your character could forge an alliance and where you might anticipate conflict.
- Do not share the priorities with your colleagues; rather, use this information to inform you as you negotiate for the legislation.

#### **The Negotiation:**

The goal of the negotiation is for the group to collectively prioritize the six legislative negotiating points (in numerical order) in a process where no one person *appears* to dominate the negotiation. A successful negotiation will ensure that everyone feels ownership of the final product and that all perspectives were heard if not adopted.

Participants gather in a circle, and the *new* Pam Albright begins the meeting. During the negotiation, again try at least one of the following techniques:

- Use some of the conflict resolution techniques addressed in the Module 4 lecture (e.g. how to start the meeting, using open-ended questions, taking a time out).
- Alter your character's approach to conflict during the negotiating so that at one point you are competing and another accommodating.
- Test out the effect of simply being unpredictable and see if that works to everyone's advantage or not.

Note that depending on the amount of time allotted for this exercise, the mock negotiation may not address all of the potential complexities involved in making comprehensive policy recommendations.

**Post-Negotiation:**

After collectively ranking of the priorities, participants share how they individually ranked the negotiating points as well as their interpretation of their assigned character. If time allows, participants should discuss the following:

- 1) How effective was the negotiation in gaining a workable outcome?
- 2) How would you diagnose the sources of conflicts? Were they easier to anticipate or more difficult than the intra-agency negotiations?
- 3) Is there more pressure to compromise rather than collaborate at this level of negotiation?
- 4) Were the major players more concerned about their departments or themselves? Could you distinguish between the two?
- 5) What could Pam Albright have done differently to facilitate a better negotiation?
- 6) How did the second Pam Albright negotiate differently from the first one?
- 7) How do you envision the eventual policy outcome of these and future negotiations on the perinatal depression legislation? Will the legislation pass? Will it include meaningful policy and system changes?

**CONCLUDING QUESTIONS AND SELF-REFLECTION**

- 1) How would you characterize your own negotiating style?
- 2) Do you enter negotiations or potential conflict situations with the level of preparation used in the preceding exercises?
- 3) Which of the skills addressed in this case study and Module 4 would most help you in your own negotiating situations?
- 4) Based on your participation in these negotiating exercises, will you do anything differently the next time you are facing conflict?

## APPENDIX 1: DIAGNOSING DISAGREEMENT

Understanding how to manage disagreement involves analyzing the kind of issues on which people disagree. Think about a situation in which you had to address a disagreement with another person or persons. With that situation in mind, answer the following questions.

### A. Individual Work

**Briefly state the disagreement you want to diagnose:**

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1. **Facts.** Is the disagreement about FACTS? Are there different definitions of the problem? Are conflicting parties coming at the problem with different pieces of relevant information? If “yes,” describe the situation below:
  
  
  
  
  
  
  
  
  
  
2. **Goals.** Is the disagreement about GOALS? Are there different views about **what** is to be accomplished? If “yes,” describe the situation below:
  
  
  
  
  
  
  
  
  
  
3. **Methods.** Is the disagreement about METHODS? Are persons disagreeing about tactics, strategies, how to get it done? If “yes,” describe the situation below:
  
  
  
  
  
  
  
  
  
  
4. **Values.** Is the disagreement about VALUES? Are persons disagreeing about the way power should be exercised, about what is “good” or “moral” or “ethical?” If “yes,” describe the situation below:

## **B. Underlying Factors**

1. Do the disputing parties have access to the same information? If not, describe what you know about the information each is working with.
2. Do you think there a difference in the way each party perceives the information they have. Describe the difference(s).
3. Describe how you think the role or job of the other party may influence her/his attitude toward the disagreement.
4. Given this brief analysis, how would you now approach resolving this disagreement?
5. List the steps you will consider taking to tackle the situation.