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Therapeutic jurisprudence: A framework for evidence-informed health care policymaking☆

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ABSTRACT

Translation of evidence-based practice (EBP) into health care policy is of growing importance, with discussions most often focused on how to fund and otherwise promote EBP through policy (i.e., at system level, beyond the bedside). Less attention has been focused on how to ensure that such policies — as enacted and implemented, and as distinguished from the practices underlying policies — do not themselves cause harm, or at least frustrate accomplishment of "therapeutic" goals of EBP. On a different front, principles of therapeutic jurisprudence (TJ) in law have been developed, most prominently in certain areas of law (e.g., mental health and family law), to support more collaborative, less traumatic advocacy and conflict resolution. This paper draws on current applications of TJ and translates such into a therapeutic approach to health care policymaking that moves beyond promotion of EBP in policy. Health care policy itself may be viewed as an intervention that impacts health, positively or not. The goal is to offer a framework for health care policymaking grounded in TJ principles that does not focus on which evidence is "right" for policy use, but rather how we can better understand how consequences of policy, intended or not, affect the well-being of populations. Such framework thus moves policymaking from an either/or debate to a data- *and* human-driven process. Utilizing TJ framing questions, policies can be developed and evaluated through open dialogue among diverse voices at the table, including — like interventions — the "patients" or, here, targets of such policies. Collectively, they clarify how ends sought — to enhance (or at least not impair) health — can best be achieved through policy when needed, recognizing that as an intervention, there are limits to and boundaries on the usefulness of policy.

1. Introduction

Evidence based practice (EBP) has been trumpeted as a way to promote the effectiveness, including the cost-effectiveness, of our health care interventions. While seeming to hold much promise, a central concern has been the difficulty in achieving widespread diffusion and adoption of evidence-based practices. Proponents of EBP see policy as a vehicle to enhance adoption. Moreover, it is increasingly recognized that health care policy itself is an intervention capable of advancing health-related goals, but by equal measure, impeding such goals. Thus do we now hear calls that health policymaking itself be "evidence based."

At the same time, law is also re-visioning its goals and the most effective and appropriate methods to achieve those goals. In the past decade or two, therapeutic jurisprudence (TJ) has emerged as a major rallying point for a comprehensive law movement that sees law as a healing agent, and not simply a formalistic endeavor. TJ offers a "therapeutic lens"[1] through which to examine the health-promoting (or –impeding) consequences of not just our laws but also our legal procedures and lawyering processes. This movement parallels a rise in several other "law and" areas (e.g., law and economics, law and psychology, law and humanities), recognizing the importance of an interdisciplinary approach for more effective and realistic development, implementation, and evaluation of our laws.

This paper seeks to marry these two parallel developments in health policy and in law, with a focus on how TJ could contribute to a

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[1] Bruce J. Winick, *The jurisprudence of therapeutic jurisprudence,* 3 PSYCHOL., PUB. POL., AND L. 184 (1997).

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more meaningful analysis of policy's "effectiveness" by attuning us to the human side of health policy. Moreover, while an "evidence based" approach to health policymaking might prioritize purely scientific (technical) over contextual (sociopolitical, cultural, and ethical) evidence, it is hoped that a *therapeutic*-oriented framework would serve to humanize policies and policymaking with its systematic attention to emotion and recognition of the moral and political nature of the policymaking process.

A policy case example (school based mental health screening) is offered as a way to apply the type of issue spotting and discussion called for by a therapeutic-oriented framework. The discussion travels from evidence-based practice, to an evidence-based and evidence-informed approach to policymaking, to a TJ framework for evidence-informed health policymaking. Each of these discussions, in turn, harkens back to the case example for explanatory context. The paper ends by identifying next steps, in recognition of the ground-laying nature of this paper and the need for additional analysis of each of its parts with a fuller investigation of its contextual utility. Issues raised and recommendations offered have potential international scope and utility, especially given the global expansion of evidence-based/informed policymaking *and* TJ.

The overarching intent is to offer TJ as a new framework on which to develop and test *evidence-informed* and *guided* health policy (i.e., policy that implements evidence-based practices via an evidence-informed process). Rather than preference a different type of evidence and offer a new answer for the "right" policy approach, TJ is envisioned as a framing tool for a more contextual, behaviorally sensitive analysis of health policy and policymaking.

1.1. The case example: a school's desire to address mental health issues

Last winter, JFK High School in Illinois experienced an outbreak of fights related to bullying.[2] Nearby, RFK High School faced a rash of teen suicides. In response, JFK High School presented a series of sessions on mental health, bringing in local experts to discuss signs and symptoms. However, spurred by the recent suicides and violence, JFK High School has decided it wants to do more than offer education. JFK administrators are working with academic psychology researchers at the local university to determine appropriate next steps, including who to target and how.

Keep this example in mind, we will return to it throughout the course of the following sections.

2. Setting the context: the clinical encounter

2.1. Evidence-based practice

"Demonstration of pervasive and persistent unexplained variability in clinical practice and high rates of inappropriate care, combined with increased expenditures, have fueled a steadily increasing demand for evidence of clinical effectiveness."[3] Joining calls for greater consistency and clinical effectiveness in treatment with concerns over the runaway costs of health care spending, we have seen a rise in the prominence of *evidence-based practice* (EBP). EBP has been defined as "the judicious application of best current knowledge to the condition and values of the individual patient."[4] The hope is that greater adherence to evidence in practice will result in higher quality and more effective, including cost-effective, care.[5]

2.2. EBP influence on clinical policy

Proponents of EBP, in addition to addressing quality and cost-effectiveness of care, highlight the role of EBP as creating a culture of accountability in clinical decision- making vs. reliance on an "uninformed authority."[6] Such accountability is enhanced by utilization of systematic reviews to analyze and distill evidence from an array of studies on a given issue to determine the level and strength of an evidence base. These reviews are increasingly used to guide clinical decision-making through guideline development and even health policy.[7] Viewed positively, these reviews cut down on individual practitioner discretion; alternatively, critics maintain reviews come between the individual patient and clinician while ignoring contextual needs.[8]

Notwithstanding the criticisms, EBP continues to gain influence across clinical settings, and has also emerged as a powerful force in public health due to increasing calls for earlier intervention and prevention. We see more attention being paid at a national, state, and insurer level to the promise of preventive medicine, and a corresponding interest in promoting public health interventions to drive down more costly, emergency-related visits. At the individual level, preventive approaches advance the use of a medical "check-up" (well-visits, checklists) to focus the clinical encounter on spotting any "risk" factors. Also emerging are evidence-based practices to educate patients on how to avoid negative behaviors and promote positive ones.[9] At a population level, evidence highlights what should be part of screening protocols and other public health surveillance tools for health promotion and disease prevention.[10] Here too, behavioral adaptations through education,

[2] This is a hypothetical example with made-up names and tools; however, the discussion draws on real-world examples and existing tools, evidence, and legislation.

[3] Sean R. Tunis, Daniel B. Stryer & Carolyn M. Clancy, *Practical clinical trials: increasing the value of clinical research for decision making in clinical and health policy,* 290 JAMA 1624 (2003).

[4] J.A. Muir Gray, *Evidence based policy making,* 329 BMJ 988 (2004).

[5] Defining "evidence" and determining the quality of "evidence" raises its own host of concerns: What is an adequate "evidence base"? Who decides the needed quality/quantity of evidence? What of individualized needs and differences among populations? What of issues difficult to study empirically? These sorts of issues are beyond the scope of this paper, but are recognized as critical to ethical adoption of EBP, and the movement toward evidence-based health-policymaking. *See* Ian Sanderson, *Is it 'what works' that matters? Evaluation and evidence-based policy-making,* 18 RESEARCH PAPERS IN EDUCATION 331 (2003); Ian Sanderson, *Evaluation, policy learning and evidence-based policy making,* 80 PUB. ADMIN. 1 (2002); Carol H. Weiss, *What kind of evidence in evidence-based policy?* 288-290 (July 2001) (unpublished manuscript presented at the Third International, Inter-disciplinary Evidence-Based Policies and Indicator Systems Conference), *available at* http://www.cemcentre.org/Documents/CEM%20Extra/EBE/EBE2001/P284-291%20Carol%20Weiss.pdf.

[6] Anna Donald, *Commentary: research must be taken seriously*, 323 BMJ 278, 279 (2001).

[7] Deborah J. Cook, Nancy L. Greengold, A. Gray Ellrodt & Scott R. Weingarten, *The Relation between Systematic Reviews and Practice Guidelines,* 127 ANNALS INTERNAL MED. 210 (1997). The Cochrane Collaboration, based in the UK, is a leading organization used to promote the use of evidence in health care. *See* http://www.cochrane.org/ (last visited Aug. 21, 2009). More recently the Campbell Collaboration was also created to promote similar use in education and social welfare policy. *See* http://www.campbellcollaboration.org/ (last visited Aug. 21, 2009).

[8] A comprehensive examination of the use of clinical guidelines and criticisms of such use (e.g., "cookbook medicine") is beyond the scope of this paper. For a fuller discussion, *see* Doris Grinspun, Tazim Virani & Irmajean Bajnok, *Nursing best practice guidelines: The RNAO Project,* 5 HOSP. Q. 56 (2001); Edward J. Mullen & David L. Streiner, *The evidence for and against evidence-based practice,* 4 BRIEF TREATMENT CRISIS INTERVENTION 111 (2004). For a response to charges of inflexibility with manual-based treatments, *see*, *e.g.*, Philip C. Kendall, Elizabeth Gosch, Jami M. Furr & Erica Sood, *Flexibility within fidelity,* 47 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 987 (2008).

[9] For example, re: healthy eating/weight management, *see* National Collaborating Centre for Primary Care, *Obesity: The Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children*, NAT'L INST. HEALTH CLINICAL EXCELLENCE (2006).

[10] *See*, *e.g.*, U.S. Preventative Services Task Force, *Screening for family and intimate partner violence: recommendation statement,* 140 ANN. INTERNAL MED. 382 (2004); Centers for Disease Control and Prevention, *Preventing Lead Poisoning in Young Children*, U.S. DEP'T OF HEALTH AND HUM. SERVICES (2005); *Identification of Common Mental Disorders and Management of Depression in Primary Care,* N.Z. GUIDELINE GROUP (2008) (international example).

altered incentives, and similar strategies hold great power. And, this shift in application of EBP from an individual to a population level presages the shift in attention from an evidence-based clinical policy to an evidence-based health policy.

2.3. Back to the screening example: EBP implementation

At any one time, twenty percent of adolescents have a diagnosable emotional disorder,[11] up to thirty percent of adolescents experience a major depressive disorder before reaching legal adulthood,[12] and twenty-five percent of mood disorders (e.g., depression) emerge during adolescence.[13] Suicide is the third leading cause of death for children, adolescents, and young adults ages 10–24.[14] Given the prevalence of mental health issues among adolescents and the recognition that many adult mental health problems are influenced by early life experiences,[15] there has been a greater push for early intervention to prevent or halt the progression of mental illness. While primary care settings have been a natural site for intervention,[16] schools have also been identified as optimal spots to address the emotional health of youth because that is where our youth spend so many hours each day.[17]

So, we have a concern — the emotional well-being of youth and prevention of suicide and other serious emotional disorders, and a location — schools. Now we need an intervention, and screening has been advanced as just such a response.[18] The hope behind mental health screening in schools is two-fold: for youth, that we can address potential problems before they emerge or at least intervene early in their course for more preventive "treatment"; and for schools, that mental health promotion and earlier recognition of mental health issues will positively impact academic progress.

ScreenRTeens is a leading evidence-based screening protocol for youth. Over 500 school districts across the US have adopted it in some format for use over the past five years, primarily at the secondary school level. JFK became one such school. It has seen the numbers, and intimately "knows" the numbers from its experiences and that of RFK High School. The environment, plus the evidence, has led it to ScreenRTeens, a tool it discovered while meeting with academic psychology researchers at the local university.

JFK administrators decide on using the screening instrument on all entering tenth graders, but only after requiring parental consent and adolescent assent. They send a letter to each student's parents prior to the start of the academic year, describing the nature of the screening protocol, its purpose, and the implementation process. Parents are requested to send back a signed form if they do *not* wish their child to be screened. Very few parents responded, and most adolescents assented, so 90% of the tenth graders go through the screening in its first year of use. Of this, 32% display signs of sufficient mental health distress to merit moving to the second phase of the protocol: a diagnostic interview with an on-site mental health clinician.

JFK's use of ScreenRTeens exemplifies the development of an EBP and its adoption in a certain tested setting, with the latter's adoption premised, at least in part, on an expectation that the EBP will meet a clinical (early intervention) and developmental (academic progress) goal. The next step is considering the policy implications for adoption, dissemination, and evaluation.

2.4. The next horizon

Building an evidence base in clinical and population-level practice, however, has not been the hoped-for panacea in driving down costs and enhancing quality of care. Over the past two decades, the costs of health care as a percentage of GDP and as a portion of personal spending have dramatically risen. In 2007, 16.2% of the US GDP was health care-related spending, up from 7.2% in 1970.[19] Individuals are also feeling the pinch with health insurance premiums in the US cumulatively growing 78% between 2002 and 2007, a much higher growth rate than wages.[20] At the same time, studies have revealed great heterogeneity in treatment for similar conditions across the country, altering cost and outcomes.[21]

Studies have led to more questioning of the divergence between what science demonstrates works, what we do, and what policy supports. With a greater understanding of what works — and does not — for a host of conditions, coupled with studies showing that treatment may depend more on where it is sought than what the evidence says, more stakeholders have demanded that policy support EBP. At a clinical policy level (e.g., development of practice guidelines), research evidence has had a greater influence on policy, especially in the development and application of systematic reviews. Yet, as evidenced by data on disparate and haphazard use of EBPs, our focus has shifted: from the clinical practice to the clinical policy level, and even to general health policy. What role might policy play in enhancing uptake of EBPs, and can/should policy itself be evidence-based? To understand the emerging focus on how evidence can be supported by and also influence health policy, first we must understand the nature of health policy.

3. Expanding the context: health policy

While health care is affected by a host of individual factors, the environment is increasingly recognized as having an impact on health. Beyond the physical or built environment, initiatives at the policy

[11] R.C. Kessler, P. Berglund, O. Demler, R. Jin, & E. E. Walters, *Life-Time prevalence and age-of-onset distribution of DSM-IV disorders in the national co-morbidity survey replication,* 62 ARCHIVES OF GEN. PSYCHIATRY 593 (2005).

[12] J.L. Rushton, M. Forcier & R.M. Schectman, *Epidemiology of depressive symptoms in the national longitudinal study of adolescent health,* 4 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 199 (2002).

[13] *Id.*

[14] National Institute of Mental Health, Suicide in the U.S.: Statistics and Prevention (2009) *available at* http://nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml (last visited July 30, 2009).

[15] Nat'l Scientific Council on the Developing Child, *Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life* (Center on the Developing Child at Harvard Univ., Working Paper No. 6, 2008); Katja Weber, Brigitte Rockstroh, Jens Borgelt, Barbara Awisus, Tzvetan Popov, Klaus Hoffmann, Klaus Schonauer, Hans Watzl & Karl Pröpster, *Stress load during childhood affects psychopathology in psychiatric patients,* 8 BMC PSYCHIATRY 63 (2008); Bruce S. McEwen, *Early life influences on life-long patterns of behavior and health,* 9 MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES RES. REV. 149, 149-154 (2003).

[16] Elizabeth M. Ozer, Elaine G. Zahnd, Sally H. Adams, Sheila R. Husting, Charles J. Wibbelsman, Kim P. Norman & Susan M. Smiga, *Are adolescents being screened for emotional distress in primary care?* 44 J. ADOLESCENT HEALTH 520 (2009).

[17] ILL. CHILD. MENTAL HEALTH PARTNERSHIP, GUIDELINES FOR SCHOOL-COMMUNITY PARTNERSHIPS – ADDRESSING THE UNMET MENTAL HEALTH NEEDS OF SCHOOL AGE CHILDREN, 2007.

[18] U.S. Preventive Services Task Force, *Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force Recommendation Statement,* 123 PEDIATRICS 1223 (2009) (recommending screening of adolescents (ages 12–18) for major depressive disorder if systems in place for diagnosis and to offer follow-up services; note, evidence not supporting such for youth ages 7–11). A presidential commission also called for earlier intervention and prevention of mental health disorders through such screening practices. New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003 (Goal 4 specifically addressing early mental health screening and assessment, and discussing schools' role in mental health issue identification). Mental health screening of youth is not without controversy. Critics raise fears of mandatory screening and usurpation of parental rights, potential conflicts of interest among developers and promoters of screening, and lack of community resources to which to refer identified adolescents. *See, e.g.,* Charles Q. Choi, *National screening for mental health in teens inspires controversy,* SCIENTIFIC AMERICAN, Jan. 23, 2007, *available at* http://www.scientificamerican.com/article.cfm?id=national-screening-for-me (last visited Aug. 21, 2009).

[19] Andrea Sisko et al., *Health spending projections through 2018: recession effects add uncertainty to the outlook,* 28 HEALTH AFFAIRS W346, n.2 (2009); Kaiser Family Foundation, Trends in Health Care Costs and Spending (September 2007) *available at* http://www.kff.org/insurance/upload/7692.pdf (last visited July 30, 2009).

[20] *See Kaiser Family Foundation, supra* note 19.

[21] *See* Elliott Fisher, David Goodman, Jonathan Skinner & Kristen Bronner, *Health Care Spending, Quality, and Outcomes: More Isn't Always Better*, THE DARTMOUTH ATLAS, Feb. 27, 2009.

level create an "environment" that is more or less conducive to health. Health care policy[22] encompasses more than just legal or regulatory pronouncements; rather, it represents a broader schema for addressing the costs, quality, expectations, and experience of health care.[23]

Policy also exists at many levels: international, federal, state, local, and organizational. In the US, federal health care reform has taken center stage again,[24] in recognition that the federal government is an important shaper of the health care system and payer of treatments within that system. Yet, much of health care in the US is governed at the state level. For example, state laws: (1) impact who can consent for care and how; (2) determine who may offer what care, when, and how; and (3) affect an increasing number of patients through Medicaid and other state-run programs. Local (e.g., county support of nurse–family partnerships (nurse home visitation programs)) or institutional (e.g., hospital patient visitor rules) policy may also affect the "experience" of health care, individually and collectively. No matter the level, policy matters, for better or worse.

Consider for example a federal policy decision to expand the reach of the Children's Health Insurance Program to include more children from low-income families.[25] While this may have the intended effect of insuring more children (i.e., addressing gaps in coverage), it may also have an unintended effect of moving some children from private plans to public ones, and causing more confusion for families about paperwork involved in enrolling children in newly available plans. Some issues may be addressed by implementation; others may be much more structural, or theoretical, in nature and require a broader conversation about the goals of policy. Either way, policy may unintentionally result in administrative delays in coverage for some children and/or a greater number of children being publicly covered. The latter result might alternatively be intentional, but not transparently so — and thus necessitate the suggested discussion about policy goals.

This example illustrates a positive intent with, at least in part, unintended negative consequences; such negative consequences do not necessarily trump the original intent or policy implementation, but are deserving of recognition and due consideration. Unfortunately, much of this consideration takes place after the fact. Adding these negative consequences to the seeming "waste" of the uninformed use of limited health care resources and to the faith in science as the key font of knowledge, we see advocated scientific approaches to not simply clinical but also clinically-relevant health policy decisions. A more scientific approach, as used in clinical policy, is seen as rationalizing and making more transparent the health policy process.

3.1. Growth in calls for use of science in policy

As indicated above, the policy realm is increasingly seen as a critical link in the broader uptake of existing EBPs as well as supporter of EBP generally. This connection builds on a vision of policy being more scientifically informed and based. This is not a new phenomenon, or one unique to health policy. The Age of Enlightenment ushered in a view of scientific knowledge as holding the promise to make rational our policies and guide our policy-related behaviors.[26] Since the time of President Lincoln, the National Academies of Science has existed to promote the role of science in informing US federal policy.[27] More recent examples of this belief in action can be found in the UK New Labour's focus on "what works" to modernize government in the late 1990s,[28] Israel's passage of legislation to, in part, gather data to guide health care policy decisions,[29] Australia's New Public Management emphasis on effectiveness and efficiency,[30] the US government's push in the 1990s to "reinvent government,"[31] and the current US federal administration's trumpeting of science over partisan ideology to guide policy.[32]

Each of these recent calls for use of scientific evidence to guide policy development and implementation builds on the aforementioned movement in medicine. Not only do they recognize that while policy could help support adoption of EBPs more consistently and broadly, they also herald that an evidence-based approach to policymaking is possible and preferable.

[22] Longest defines health policies as "authoritative decisions made within government that are intended to direct or influence the actions, behaviors, or decisions of others pertaining to health and its determinants." They are how government "helps shape the pursuit of health by its members," be it via laws, regulations, rules, operational decisions, or judicial decisions and via an allocative or regulatory method. BEAUFORD B. LONGEST, HEALTH POLICYMAKING IN THE UNITED STATES, 30 (4th ed., Health Administration Press 2006).

[23] Of course, non-health policies may also affect care. For example, consider a local county's transportation policy decision to end certain bus routes and raise prices: this may impact the ability of families without their own transportation to readily make appointments at a health system outside the urban core due to the greater time and cost in traveling. While also deserving attention, this paper will be limited to health care-specific policy proposals to maintain a narrower scope; however, the framework and discussion, *infra*, will also have relevance to other policy settings (e.g., education).

[24] Jay Newton-Small, *The Five Biggest Hurdles to Health-Care Reform,* TIME MAGAZINE, Jul. 27, 2009, *available at* http://www.time.com/time/politics/article/0,8599,1912920,00.html (last visited Aug. 26, 2009); Anne E. Kornblut, *Obama to Take On Health-Care Critics,* WASH. POST, Aug. 14, 2009, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2009/08/13/AR2009081301914.html (last visited Aug. 26, 2009); *See also* Robert H. Brook, *The science of health care reform,* 301 JAMA 2486, 2487 (2009) (offering recommendations for health reform that build on a science base and comparative effectiveness research to "determine whether what can be done less expensively will improve health or, at least, not harm patients").

[25] *See* Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 8 (2009) (CHIPRA). CHIPRA, Title XXI of the Social Security Act and formerly known as the State Children's Health Insurance Program (SCHIP), was renewed and expanded by President Obama in February of 2009. CHIPRA is a "state and federal partnership that targets uninsured children and pregnant women in families with incomes too high to qualify for most state Medicaid programs, but often too low to afford private coverage. Within Federal guidelines, each State determines the design of its individual CHIPRA program, including eligibility parameters, benefit packages, payment levels for coverage, and administrative procedures. In addition to renewing the CHIPRA program, the new legislation makes it easier for certain groups to access CHIPRA health care, including uninsured children from families with higher incomes and uninsured low-income pregnant women." *See* http://www.cms.hhs.gov/LowCostHealthInsFamChild/ (last visited June 25, 2009).

[26] Sanderson 2003, *supra* note 5, at 333.

[27] History of the National Academies, *available at* http://www.nationalacademies.org/about/history.html (last visited June 25, 2009).

[28] Sanderson 2003, *supra* note 5; *see also* Sanderson 2002, *supra* note 5; Steve Martin & Ian Sanderson, *Evaluating public policy experiments: measuring outcomes, monitoring processes or managing pilots?* 5 EVALUATION 245 (1999).

[29] Robert Schwartz & Bruce Rosen, *The politics of evidence-based health policy-making,* 24 PUB. MONEY & MGMT. 121 (2004).

[30] Brian W. Head, *The lenses of evidence-based policy,* 67 AUSTL. J. PUB. ADMIN. 1 (2008).

[31] In 1993, President Clinton created the National Partnership for Reinventing Government (begun as the National Performance Review) whose mission was "to create a government that 'works better, costs less, and gets results Americans care about'." *See* http://govinfo.library.unt.edu/npr/whoweare/history2.html (last visited June 25, 2009).

[32] On March 9, 2009, President Obama signed a Presidential Memorandum on scientific integrity, stating intent to "ensure that in this new Administration, we base our public policies on the soundest science; …that we are open and honest with the American people about the science behind our decisions." Signing of Stem Cell Executive Order and Scientific Integrity Presidential Memorandum, from Barack Obama, President, United States of America (March 9, 2009), *available at* http://www.whitehouse.gov/the_press_office/remarks-of-the-president-as-prepared-for-delivery-signing-of-stem-cell-executive-order-and-scientific-integrity-presidential-memorandum/ (last visited Aug. 11, 2009). As stated by Peter Orszag, Director of the U.S. Office of Management and Budget: [I]n making new investments, the emphasis has to be on "smarter." …Wherever possible, we should design new initiatives to build rigorous data about what works and then act on evidence that emerges. …By instilling a culture of learning into federal programs, we can build knowledge so that spending decisions are based not only on good intentions, but also on strong evidence that carefully targeted investments will produce results. Press Release, Peter R. Orszag, Director, Office of Management and Budget (June 8, 2009) (emphasis in original), *available at* http://www.whitehouse.gov/omb/blog/09/06/08/BuildingRigorousEvidencetoDrivePolicy/ (last visited Aug. 11, 2009).

3.2. Defining "evidence" as used in health policy

For purposes of this discussion, how one defines health policy (a tricky proposition at best) is less critical than how one views the policymaking process, and the role of research evidence within and having influence on that process and resulting policy. How one defines "evidence" is important inasmuch as evidence is not objective fact; rather, evidence obtains meaning based on context, purpose for use, user or creator beliefs and interests, and theories of policymaking.[33] In policy, evidence is not simply introduced and applied; it is interpreted.[34]

While adherents of EBP may view evidence as scientific knowledge ordered according to a hierarchy of study validity, quality, and replicability,[35] say, at a policy level, we traditionally accept a broader range of evidence and more horizontal vision of its use, or at least a shifting of the hierarchy ordering to privilege ideology and interests. Policymakers typically include other sources of information, including: values/beliefs, personal experiences, political judgments and the political climate, interest group arguments, economics, etc. Weiss summarizes this broader policy-level use as including four types of evidence: (1) descriptive data (including economic analyses, trend and incidence numbers), (2) analytic findings (showing associations), (3) evaluation evidence (of existing programs and policies), and (4) policy analytic forecasts (determining which policy alternative will likely have the best outcome).[36] Critical to defining what "counts" as evidence, and the role of evidence in influencing policymaking and resulting policies, is how the process of policymaking itself is viewed — be it linear, iterative, or more complex.

3.3. Using evidence within a policymaking model: a linear model — a direct use

One view of the influence of research attaches to a linear (stepwise) model of policymaking, whereby a policy goal (outcome) is identified and a policy developed and implemented (strategy) to achieve such goal.[37] Where the latter is not clear, research facilitates the process by filling knowledge gaps.[38] The model might also have a cyclical component, whereby after achieving certain outcomes we revisit strategies.[39] Either way, however, this process is mechanistic: a rational approach to policymaking wherein scientific knowledge has *direct* influence on linking a policy tool/approach with a sought policy outcome.[40] Research evidence is valued for its ability to impact the policy process positively and answer policy questions. With greater policymaker awareness of the value of scientific evidence in advancing policy, we also see selective use of evidence, i.e., the use of evidence in a limited way to justify policy objectives, where and when evidence is supportive.[41]

Both direct and selective uses contribute to an *evidence-based health policy* (EBHP). EBHP has been defined as "an *approach* to policy development and implementation which uses rigorous techniques to develop and maintain a robust evidence base from which to develop policy options. All policies are based on evidence — the question is more whether the evidence itself, and the processes through which this evidence is put to turn it into policy options, are of sufficiently high quality."[42] It is a data-driven endeavor, and a systematic approach to applying evidence to policies and policymaking to ensure that policies promote what works over ideology or blind faith. Nations across the globe increasingly support this policymaking approach. Their efforts are supported by the rising number of academic, government, and other centers devoted to advancing in some fashion evidence use in policy.[43]

3.4. Mental health screening as evidence-based policy

Earlier, I discussed JFK's organizational policy goals to adopt screening. Now, let's shift to a government level where a federal and state policy goal (enhance mental well-being of youth) and a secondary objective (enhance academic performance) might utilize an evidence-based approach (screening in schools).

One state seizing the momentum behind the evidence is Illinois, which in 2003 passed the Children's Mental Health Act,[44] which created the Illinois Children's Mental Health Partnership to oversee implementation of a children's mental health plan. The Partnership's strategic vision endorsed voluntary mental health screening as "a core component of an effective and comprehensive children's mental health system, and of an overall approach to promoting health and wellness in children."[45]

JFK administrators cite the Illinois action and other state and federal recommendations, as validating their endorsement of screening as a clinically *and* politically valid action. This endorsement also reflects a belief that — from a scientific research and policymaker perspective — the outcome (earlier intervention of emotional disorders in youth) is the right one on which to focus, and a science-based approach (use of evidence based screening tool) is the best way to reach that goal.

With this "direct" approach, we may have implementation issues or a mismatch between a selected EBP and the sought policy goal. Critically, however, such *implementation* concerns do not affect the *policy goals* of *promoting evidence-based* clinical practice *through health*

[33] *See* Martin Rein, Value-Critical Policy Analysis 83-111, 88-90, in ETHICS, THE SOCIAL SCIENCES, AND POLICY ANALYSIS (Daniel Callahan & Bruce Jennings eds., Plenum Press) (1983) (discussing the "value aspects of facts"); Julian Neylan, *Social policy and the authority of evidence,* 67 AUSTRAIL. J. PUB. ADMIN. 12 (2008) (discussing the historical evolution of reliance on statistical knowledge as evidence base for social policy); Carol H. Weiss, *The many meanings of research utilization,* PUB. ADMIN. REV., 426-431 (1979).

[34] Shelley Bowen & Anthony B. Zwi, *Pathways to "evidence-informed" policy and practice: a framework for action, 2* PLOS MED. E166, 0600 (2005).

[35] Sandra Nutley, Huw Davies & Isabel Walter, *Evidence-based policy and practice: cross-sector lessons from the United Kingdom,* 20 SOC. POL'Y J. OF N.Z. 29, 31 (June 2003) (explaining nature of evidence, and how in health care, hierarchy is preferred over "egalitarianism in sources of evidence").

[36] Weiss, *supra* note 5, at 288–290.

[37] SANDRA NUTLEY & JEFF WEBB, *EVIDENCE AND THE POLICY PROCESS,* IN WHAT WORKS? EVIDENCE-BASED POLICY AND PRACTICE IN PUBLIC SERVICES, 25-27 (Huw T.O. Davies, Sandra M. Nutley & Peter C. Smith eds., The Policy Press 2000).

[38] Nick Black, *Evidence based policy: proceed with care,* 323 BMJ 275, 275 (2001).

[39] *See* Nutley, *supra* note 37, at 26 fig. 2.1.

[40] I.B. Scheel, K.B. Hagen & A.D. Oxman, *The unbearable lightness of healthcare policy making: a description of a process aimed at giving it some weight,* 57 J. EPIDEMIOLOGY AND CMTY. HEALTH 483 (2003). For the original enunciation of uses of research evidence, *see* Weiss, *supra* note 33.

[41] Scheel, *supra* note 40; Weiss *supra* note 33, at 429 (referring to this use as the "political model").

[42] Department for Environment Food and Rural Affairs, Evidence Based Policy Making, http://www.defra.gov.uk/science/how/evidence.htm (emphasis in original) (last visited July 31, 2009).

[43] Non-US based examples include: *EVIPNET: Evidence-Informed Policy Network for Better Decision Making,* WORLD HEALTH ORG., *available at* http://www.who.int/rpc/evipnet/en/ (last visited Aug. 11, 2009) ("encourages policy-makers in low and middle-income countries to use evidence generated by research"); UNITED NATIONS EDUC. SCI. CULTURAL ORG., *available at* http://www.unesco.org/most/weiss.htm (last visited Aug. 11, 2009) (discussing factors improving use of research in social policy via case studies); *Evidence Based Policy Making,* DEP'T ENVTL. FOOD AND RURAL AFF., Sept. 21, 2006, *available at* http://www.defra.gov.uk/science/how/evidence.htm (last visited Aug. 11, 2009; *EPPI-Centre for Social Science Research Unit*, THE EVIDENCE FOR POL. AND PRAC. INFO. AND CO-ORDINATING CEN., *available at* http://eppi.ioe.ac.uk/cms/ (last visited Aug. 11, 2009) (promoting systematic reviews in non-clinical health issues, education, social care). U.S.-based examples include: *Division of Behavioral and Social Sciences and Education Standing Committee on Social Science Evidence for Use,* THE NAT'L ACAD. NAT'L RES. COUNCIL (2008) (to build bridges between high quality research (the supply side) and the appropriate and realistic uses of research evidence to guide decision making (the demand side)); COALITION FOR EVIDENCE-BASED POL. (2009) (a Washington D.C.-based nonprofit "to increase government effectiveness through rigorous evidence about 'what works'"); Drug Effectiveness Review Project, *available at* http://www.ohsu.edu/ohsuedu/research/policycenter/DERP/ (last visited Aug. 21, 2009) (a collaboration of public entities in the US and Canada to produce systematic reviews of the comparative effectiveness and safety of drugs and use to inform local public policy).

[44] Children's Mental Health Act of 2003, 405 ILL. COMP. STAT. 49/1-99 (2003).

[45] ILL. CHILD. MENTAL HEALTH P'SHIP, STRATEGIC PLAN FOR BUILDING A COMPREHENSIVE CHILDREN'S MENTAL HEALTH SYSTEM IN ILLINOIS, EXECUTIVE SUMMARY, 33 (June 30, 2005).

policy. A focus on policy goals seems to take as a given that making health policy evidence-*based* is the most effective, feasible, and appropriate approach. But is it?

3.5. A critique of EBHP: limits on research influence on health policy

In health care as in other social welfare contexts, it is increasingly recognized that the policymaking process is not so linear, and hence the use — and usefulness — of research evidence in this process not so clear. Social interventions are necessarily complex, acted out in an environment of ever-changing people, politics, and value-laden priorities.[46] Directly verifying that outcomes are caused by identifiable policies is quite tricky in such a complex environment. A key criticism of the direct model of influence is that it does not accord with a real-world context in which policy is developed, implemented, and evaluated — a world where multiple influences over time may synergistically or indirectly influence outcomes. A selective use of evidence is also criticized inasmuch as, here, policy goals are more hardened and policies to reach goals predetermined. Instead of traveling from research to policy to end goal, the risk in a selective approach is that we have beliefs in search of evidence to support existing (or desired) policies — a policymaker-driven top-down policymaking process. And, by privileging certain sorts of evidence, we may have researchers creating data in search of policy problems where this data could be used — a researcher-driven top-down policymaking process.[47]

There are a number of reasons why this direct evidence use loses steam as it moves from application at a clinical to a population, and ultimately to a policy level. For example: there are goals other than maximizing clinical effectiveness; evidence too often disregards tacit knowledge; many issues are so complex and/or controversial, there is disagreement about what (if) evidence matters; research evidence is seen as excluding other evidence like personal experience and professional opinions; and the current environment cannot support policy change.[48] Further, researchers and policymakers are viewed as coming from different cultures, resulting in communication and understanding issues you might expect in cross-cultural endeavors.[49]

Moreover, it has been argued that even were we able to accurately test policy-level assumptions through social science research tools, this mechanistic/rational pursuit to policy making unduly devalues the deliberative and communicative nature of the policymaking process and the context in which this process unfolds.[50] Instead of looking for objective (context-free) outcomes, we should seek *appropriate* ones — admittedly subjective, but more practical, given our complex policy context.[51] Unlike the direct or selective uses of evidence, in this model of policymaking, evidence influence is subtler: research enriches our understanding of the context and suggests that certain assumptions are more or less tenable.[52]

3.6. Health policymaking process: a contextual and evidence-informed model

All hope of applying evidence in health policymaking is not lost: if we shift to a different vision of the policymaking process, evidence may be seen as having more influence, albeit in a different fashion. In an *enlightenment model*, research "helps to enrich and deepen understanding of the complexity of problems and unintended consequences of action."[53] In an *interactive model*, we see a back and forth between policy and research communities, addressing the cultural divide criticism of direct use models. Research generation and use does not take place in a vacuum with a one-way dialogue; rather, researchers and policymakers are to build relationships, and also include other stakeholders in the dialogue, wherein "a focus on human interactions is essential."[54]

With this negotiated evidence use, policy is not based on evidence but rather uses evidence to inform the policymaking process and resulting policies. For *evidence- informed health policy* (EIHP), the process is interactive vs. linear, embraces the uncertain and long term over the objective and immediate, and is more humble in its reliance on scientific evidence. This humility, in turn, opens up for research evidence a new way to have influence, by having us question the "certainty" of our beliefs concerning how policy can achieve certain goals, and be open to other influences on this policymaking process.

> Research is seen as one of several knowledge sources and cannot speak for itself in policy terms. Evidence based policy is not simply an extension of evidence-based medicine: it is qualitatively different. Research is considered less as problem solving than as a process of argument or debate to create concern and set the agenda.[55]

The benefit of such a model is its embrace of the complexity of issues health policy seeks to address. Moreover, it places this process in a context vs. a "lab-like" setting of the linear, the objective, and the clearly causal. Research evidence is not sought out to directly solve problems or justify policy decisions; rather, it helps policymakers debate where they should be concerned and how they should proceed.[56] Our new challenges are to figure out how to: (1) support a more limited role for "scientific knowledge" in the evidence gathering process, and (2) place scientific evidence alongside and be complementary to the range of other policy influences, (e.g., sociopolitical, ethical and moral, cultural, and financial).[57] Here we allow — and expect — a fuller range of evidence, including the psychological impacts from and behavioral resistance to change.

As envisioned by Bowen and Zwi,[58] a complex, multi-layered model would include a range of influences beyond scientific evidence to include, for example, "tacit" (experiential) knowledge,[59] cultural

[46] The criticisms that follow mirror criticisms of a view of law as purely rational, objective, and mechanistic in application vs. contextually defined and applied. For the law side, *see* discussion *infra* Part 4.1 and accompanying notes 62–65.

[47] For a different way to view a "political" use, *see* Weiss, *supra* note 33, at 429.

[48] Black, *supra* note 38, at 276 (*see* Box and accompanying discussion). Moreover, "policies are driven by ideology, value judgments, financial stringency, economic theory, political expediency, and intellectual fashion." *Id.*

[49] For an interesting discussion of the hindrances to evidence use in policy (at the state government level) and potential facilitators of evidence use, from an empirical study, *see* Christopher J. Jewell & Lisa A. Bero, *"Developing good taste in evidence:" facilitators of and hindrances to evidence-informed health policymaking in state government,* 86 THE MILBANK Q. 177 (2008).

[50] Sanderson 2003, *supra* note 5, at 339; Sanderson 2002, *supra* note 5.

[51] *Id.* at 332, 338–41.

[52] Scheel, *supra* note 40, at 486 (describing enriching nature of this use); *see also* Weiss, *supra* note 33.

[53] Scheel, *supra* note 40, at 486.

[54] Bowen, *supra* note 34, at 0603.

[55] Black, *supra* note 38, at 277. Stated another way: "As we move from EBM to evidence-based health policy, the decision-making context changes, shifting from the individual-clinical level to the population-policy level. Decisions are subject to greater public scrutiny and outcomes directly affect larger numbers of people, heightening the requirement for explicit justification." Mark J. Dobrow, Vivek Goel & R.E.G. Upshur, *Evidence-based health policy: context and utilisation*, 58 SOC. SCI. & MED. 207, 208 (2004).

[56] As Muir Gray has stated: The job of the professional [researcher] … is to set out all the information about the probability and size of benefits and harms, and about the opportunity costs. …This is decision making. The job of the politician is to take the decision, as opposed to making the decision, based on values. In the end values will always be more influential than evidence, and the tension between the two should be regarded as the very stuff of the relationship between expert and politician. Muir Gray, *supra* note 4, at 989. So here, "research is one part of the interconnected intellectual enterprise." Weiss, *supra* note 33, at 430.

[57] Sanderson 2003, *supra* note 5, at 339; *see generally* Black, *supra* note 38, for more complete discussion of influences; *see also* Sanderson 2002, *supra* note 5.

[58] Bowen, *supra* note 34, at 0600 fig. 1.

[59] Sanderson 2003, *supra* note 5, at 340.

beliefs, and the psychological and emotional impacts of different policy approaches on targeted members of the public. Sources of evidence are influenced by and have influence on how evidence will be used, and in turn are affected by our capacity to implement given policy options. The "what" in this process matters, wherein a hierarchy of evidence places more weight on narrative, cultural, qualitative, and relational experiences. Yet, we are informed not simply by the "what" of evidence, but also by the "who" that prioritizes it, collects it, interprets it, implements it, and is affected by it, as well as the "how" that it is prioritized, used, and evaluated.

Ultimately, evidence is seen as, *in part* and *in context*, *informing* policy. This vision of the evidence-informed policymaking process is not so much a search for "the" answer, but a process to test perceived "right" answers. It is an iterative question generating exercise valuing multiple stakeholder input. It accords with a vision of policymaking as a moral, value-laden, and not purely technical, process.[60]

3.7. Back to the case example: a more contextual examination

Consider if JFK administrators had decided to step back prior to adoption of ScreenRTeens, and had given a more critical read of mechanistic application of evidence. They may then have been prompted to ask about the policy goal of better youth mental health, and if any single evidence based approach effectively and appropriately addresses their health-related concerns. Screening itself may hold much promise, but for who, when, and how? Can an instrument given in a school setting capture the range of issues affecting youth? Does it privilege a certain type of "evidence" (i.e., what a screening test may identify) over more contextual understandings of mental health in youth? Perhaps more importantly, does it value one approach to promotion of mental health — through a medical model of identification and treatment — over potentially more effective and/or politically palatable approaches, such as better family support, promotion of resiliency, family, school, and community education, and/or redress of environmental impacts on mental health?

These questions do not suggest screening has no value; just that it is not *the* only or necessarily preeminent value. For JFK, research behind ScreenRTeens is one of many values enriching a *discussion* of effective policymaking. A focus on "the right" evidence without multi-stakeholder input or a goal that is not crafted through a participatory process may replace one unsatisfying policymaking process for another, and deal a fatal blow to the myriad of benefits of *evidence-informed* health policy.

4. Framing the Context: therapeutic jurisprudence as an organizing construct for EIHP

The complexity of a contextual vision of EIHP would benefit from a way to frame its approach to policymaking. So what organizing construct might guide this complex process? What basis is there to consider health policy consequences in a contextual, empirical, and ethically sensitive fashion? I argue that TJ may provide a useful framework, especially inasmuch as the policy sphere holds promise in promoting behavior change through its ability to push (e.g., sanctions on undesirable behaviors) and pull (e.g., incentives for desired change) "consumers" of policy (and resulting services).

Until this point, I have discussed the importance of context and relationships, the importance of consequences, the importance of who defines evidence, and how it is used in development, implementation, and analysis of policy. Next is to consider the behavioral issues behind the statistics (e.g., why are people not using EBPs, and why are policymakers not simply applying research evidence)? Couple these questions with a view of policy as an intervention influencing health, and with a need to enhance positive consequences or at least mitigate negative consequences of our policymaking processes on outcomes. This talk of consequences and behaviors parallels growth of TJ to address legal-related health consequences. [61] Might policymaking benefit from similarly being seen through a "therapeutic lens" to recast our examination of the substance (policies), processes (policymaking), and actors (policymakers/policy influencers) behind policy with a relational vs. atomistic view? Might the evidence-informed view benefit from behavioral insights into what makes people do certain things or respond in certain ways — and consideration of resulting impacts on and from policy?

4.1. The social context of law

In the US, it is still debated whether law is some external, objective "truth" to mechanistically apply, or is more contextually based and thus a more subjectively applied force in society. [62] Increasingly, the mechanistic vision is recognized as somewhat lacking: "Law is not an artifact on display in the museum: It is a living, breathing organism. Law functions within a particular society, absorbing and reflecting the culture in which it exists."[63] To be truly effective, law must learn how to engage with and best respond to a host of environmental factors impacting individuals, including poverty, violence, health status, and educational attainment. Moreover, law is not just a "thing" but also a profession made up of people who influence others and are influenced by their professional practice, and who may thus benefit from person-centered insights into how law can do more for those affected and those doing the "lawyering."

New approaches to the law recognize this "living" dynamic with the law as having influence on and being influenced by context, not separate and apart from context. These approaches require a multidisciplinary examination of the law and lawyering, drawing on the "tools" of "political science, economics, anthropology, sociology, and psychology"[64] to better understand how law is affected by its context as well as how law impacts that context and its citizens. TJ uses these social science tools to "examine law's impact on the mental

[60] Ethics-informed policymaking as part of an "evidence-informed" process is an area ripe for future research. For more information, *see* J.F. Wharam & N. Daniels, *Toward evidence-based policy making and standardized assessment in health policy reform,* 6 JAMA 676, 676-679 (2007) (providing framework for ethical evaluation of health care reform); Warren Brookbanks, *Therapeutic jurisprudence: conceiving an ethical framework,* 8 J. L. & MED. 328 (2001) (applying an ethic of care to therapeutic jurisprudence as richer framework than consequentialist vision).

[61] The language might also mirror what an ethically informed policymaking process might look like. For example, with an 'ethics-informed' perspective, we may rightly question the potential benefits and harms of policy approaches, their impacts on relationships, and the fairness of distributing benefits and burdens. *See* Brookbanks, *supra* note 60. *See also* Sanderson 2003, *supra* note 5, at 343 (urging evaluation's focus be broadened because "it must be acknowledged that the ethical and moral implications of the policies and the values and 'goods' (and 'bads') that they promote are amenable to 'rational' considerations and debate").

[62] The recent hearings over the nomination of Judge Sonia Sotomayor to the US Supreme Court made vivid the debate: whether "empathy" has any role in judging and in one's take on interpreting "the law." *See* Ari Shapiro, *Sotomayor Differs with Obama on 'Empathy' Issue*, NPR, July 14, 2009, *available at* http://www.npr.org/templates/story/story.php?storyId=106569335&refresh=true (last visited Aug. 21, 2009); Ari Shapiro, *Sotomayor: 'Fidelity To The Law' Guides Me*, NPR, July 13, 2009, *available at* http://www.npr.org/templates/story/story.php?storyId=106492900&ps=rs (last visited Aug. 21, 2009).

[63] Winick, *supra* note 1.

[64] *Id.* at 186; *see also id.* at 186–191 (discussing an interdisciplinary examination of law, and more narrowly explaining the place of therapeutic jurisprudence within this examination).

and physical health of the people it affects."[65] So what exactly is *therapeutic jurisprudence*?

4.2. Defining therapeutic jurisprudence: in theory and in practice

4.2.1. TJ

TJ has been defined as "the study of the law as a therapeutic agent,"[66] a new prism through which to study the substance of law, legal procedures and legal actors.

> TJ explores the therapeutic and countertherapeutic consequences of the law on the individuals involved … perhaps even the community. TJ recognizes that the *law is a social force* with negative and positive emotional consequences for all the people involved in a particular legal matter. …It seeks to identify those emotional consequences; assess whether they are therapeutic or countertherapeutic; and then *ask whether the law can be changed in ways that can maximize its therapeutic effects.*[67]

TJ found its initial home in mental health law over twenty years ago, but its relevance soon had it being applied in family law,[68] elder law,[69] and lawyering itself.[70] Through its growth across a range of legal disciplines, TJ has emerged as an overriding framework for a host of re-conceptions of the law and legal practice — hub of a comprehensive law movement.[71] Key to this approach is a re-visioning of what the law and its practice can be: a way to enhance the experience of clients and legal actors in the legal system. It is a less adversarial approach, where a "culture of critique"[72] is replaced with a "healing" use of the law to support rights and advance justice, but in ways that promote (to the extent possible) psychological well-being.[73] As such, it offers a top–down law reform agenda (to reshape the law by giving due consideration to its therapeutic and anti-therapeutic consequences), and also a more practical-oriented agenda (to offer new approaches to applying existing law). The latter "health-promoting" view of lawyering also drives a bottom-up approach to legal reform.

4.2.2. Adding preventive law to TJ

TJ is not without its critics, including those who fault its original academic orientation. TJ has benefited from alliance with its more practical allies, foremost among them preventive law (PL). PL has been described as a "proactive approach to lawyering."[74] Unlike TJ, PL is action-oriented and client focused. Critical to being a preventive lawyer is engaging in a "legal check-up" to foresee potential legal issues — so-called "legal soft spots"[75] — and avoid them, or at least mitigate their negative effects through advanced planning.

In joining TJ and PL, TJ benefits from being given a context in which to work; in turn, TJ has given PL a "human face and legitimizes (indeed, expects) the lawyer's explicit and systematic attention to the potential positive or negative psychological fallout of the law and proposed legal measures."[76] With TJ, preventive-oriented lawyers are to consider not just their technical skills at completing items on their checklist, but also are to think about the (anti-) therapeutic effects of that lawyering. This TJ-informed practice builds on the lawyer's role as counselor *at law*; note the emphasis on "law" and not the expectation that the lawyer be psychologist.[77] Yet, inasmuch as the law takes place in the context of human lives and interactions, TJ suggests that legal actors should be mindful of how their actions, including how they apply the law, therapeutically influence those lives, and how they too are shaped by their context.

Central to the work of combining the theory of TJ to the practice of PL, and moving TJ from an academic theory to a practical schematic, is identifying "*psycholegal soft spots* — ways in which certain legal procedures … or legal interventions … may expectedly produce or reduce anxiety, anger, hurt feelings, and other dimensions of law-related psychological well-being."[78] Systematically and transparently focusing on such soft spots clearly attunes the lawyer to the potential psychological impacts of his or her work on clients and families. In the legal context, examples include: a parents' decision to leave a portion of an inheritance in trust to one child with drug problems, an HIV + client drafting a will in the face of fractured family relationships, a client's declaration of bankruptcy, or a client's civil commitment hearing.[79]

Anticipating such, as psycholegal soft spots, a TJ/PL-oriented lawyer might:

- Examine the potential psychological fallout of a given legal tactic (leaving portion of inheritance in trust), and seek to limit adverse effects by perhaps having the parents include a letter explaining their action to the subject child[80];
- Examine non-legal-related stressors in a situation and see how the legal process might help by, say, seeing in end-of-life planning an opportunity for an HIV + client to reach out to family members to heal relationships and identify a health care proxy[81];
- Examine the non-legal-stress-related concerns of financial troubles aided by the legal action of filing for bankruptcy but in turn compounded by the legal stress created by this action, and work with the client on if/how to reveal this situation to others[82]; or
- Examine how a legal setting may cause stress, such as in a civil commitment hearing open to the public, but how action by a legal actor could reduce negative health effects by requesting that the judge have the public leave the courtroom during sensitive testimony.[83]

In certain identified examples, the law creates negative health consequences, either as primary stressor or secondarily in its response to other stressors. Alternatively, the law may present an opportunity

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[65] *Id.* at 187.

[66] *Id.* at 185.

[67] Susan Daicoff, *Making law therapeutic for lawyers: therapeutic jurisprudence, preventive law, and the psychology of lawyers,* 5 PSYCHOL., PUB. POL'Y, AND L. 811, 813 (1999) (emphasis added).

[68] See, *e.g.,* STEPHEN J. ANDERER AND DAVID J. GLASS, *A THERAPEUTIC JURISPRUDENCE AND PREVENTIVE LAW APPROACH TO FAMILY LAW*, IN PRACTICING THERAPEUTIC JURISPRUDENCE 207–234 (Dennis P. Stolle, David B. Wexler & Bruce J. Winick, eds., Carolina Academic Press 2000).

[69] *See, e.g.,* Dennis P. Stolle, *Professional responsibility in elder law: a synthesis of preventive law and therapeutic jurisprudence,* 14 BEHAV. SCI. L. 459 (1996).

[70] *See* DENNIS P. STOLLE, DAVID B. WEXLER, BRUCE J. WINICK & EDWARD A. DAUER, *INTEGRATING PREVENTIVE LAW AND THERAPEUTIC JURISPRUDENCE: A LAW AND PSYCHOLOGY BASED APPROACH TO LAWYERING*, IN PRACTICING THERAPEUTIC JURISPRUDENCE 7-9 (Dennis P. Stolle, David B. Wexler & Bruce J. Winick eds., Carolina Academic Press 2000); Daicoff, *supra* note 67.

[71] SUSAN DAICOFF, *THE ROLE OF THERAPEUTIC JURISPRUDENCE WITHIN THE COMPREHENSIVE LAW MOVEMENT*, IN PRACTICING THERAPEUTIC JURISPRUDENCE 465-492 (Dennis P. Stolle, David B. Wexler & Bruce J. Winick, eds., Carolina Academic Press 2000). Such a "comprehensive" reshaping would also include: preventive lawyering, creative problem solving, restorative justice, procedural justice, ADR/mediation, and collaborative law. *Id.* at 471–483.

[72] DAVID B. WEXLER, *THERAPEUTIC JURISPRUDENCE AND THE CULTURE OF CRITIQUE*, IN David B. Wexler, *Therapeutic Jurisprudence and the Culture of Critique, in* PRACTICING THERAPEUTIC JURISPRUDENCE 449–464, 449 (Dennis P. Stolle, David B. Wexler & Bruce J. Winick, eds., Carolina Academic Press 2000).

[73] Brookbanks, *supra* note 60 at 330 (TJ is a "way of viewing law which engages the possibility of genuine relational dialogue favouring [sic] legal outcomes which emphasise [sic] psychological wellness over adversarial triumphalism").

[74] Stolle, *supra* note 70, at 6.

[75] *Id.* at 35 and fn. 96 (describing rise of "legal soft spots" as relating to client affairs and potential legal issues, and drawing parallel to "psycholegal soft spots"). This preventive approach in law parallels that of a preventive approach in medicine and the use of a medical check-up, discussed *infra* text accompany p. 6.

[76] Bruce J. Winick, David B. Wexler & Edward A. Dauer, *Preface: a new model for the practice of law*, 5 PSYCHOL., PUB. POL., AND L. 795 (1999).

[77] Stolle, *supra* note 70, at 24-28.

[78] DAVID B. WEXLER, *PRACTICING THERAPEUTIC JURISPRUDENCE: PSYCHOLEGAL SOFT SPOTS AND STRATEGIES*, IN PRACTICING THERAPEUTIC JURISPRUDENCE, 48 (Dennis P. Stolle, David B. Wexler & Bruce J. Winick, eds., Carolina Academic Press 2000).

[79] Examples drawn from *id.*

[80] *Id.* at 50–51, 59–60 (discussing the "Tom's Drug Problem/Trust Example").

[81] *Id.* at 52, 61 (discussing the "HIV/Family Reconciliation Example").

[82] *Id.* at 52, 59–60 (discussing the "Bankruptcy Example").

[83] *Id.* at 54, 57-8 (discussing the "Civil Commitment Hearing/Embarrassing Material Example").

to promote psychological health. The identification exercise renders clearer such consequences, and deposits within the practice of lawyering the development of strategies to promote positive and/or mitigate negative consequences of the law as applied. It is also urged that strategies be tested and collected to build an evidence base of effective responses to psycholegal soft spots,[84] with the potential to reform law as needed to shift a preventive agenda vis-à-vis health consequences from lawyering to the law itself. Development of an evidence base of "therapeutic" approaches to lawyering and utilizing the evidence to drive "therapeutic" legal reforms begins to build a bridge to an *evidence-informed* vision of health policymaking.

4.3. Bringing TJ to health policymaking

Health policy is an area ripe for top-down and bottom-up reform. There are various theories and strategies for how best to develop, implement, or analyze health policy. Policy success is often judged by its outcomes; recently, focus has been placed on cost as well as population-level health effects, each measured in numbers or other de-personalized data. Yet, when health care policy itself (vs. an underlying program or service) is also viewed as an intervention that affects the health of individuals within its scope, viewing such policy through a therapeutic prism allows us to more clearly investigate therapeutic consequences.

Health policy, in essence, becomes a "therapeutic agent" — a systematic means of influencing the health of individuals. Now, the emphasis is not just on "quality-adjusted life years" or treatment costs, but the actual physical, psychological, and emotional impact on individuals and populations of policies whose effects are hypothesized and then empirically tested. And it is this hypothesizing and testing agenda from TJ (of psychological impacts) that complements the evidence-informed approach to health policymaking.

TJ stands to benefit from its movement from law to policy application. Health policy, with its wider scope than law, provides a rich context for applying TJ theories, a rich data set for the TJ research agenda, and perhaps most critically, an expansion of relevance of TJ values from lawyering and law implementing to law-making. And for EIHP, TJ brings to the fore the health effects on individuals and populations, inserting in any analysis of evidence use or policy consequences a consideration of these relational effects. Too, EIHP benefits by the contribution of behavioral evidence to help shape therapeutically "informed" policies, thereby addressing psychological impacts from and influences on policy. TJ, as complemented by PL, contributes a proactive agenda of bottom–up and top–down policy reform — to influence change by uncovering behavioral reasons why policy is/is not working and/or how it might work better.

4.4. Psycho-policy soft spots

As with a TJ/PL orientation, in TJ/EIHP policymakers are to develop strategies to deal with what I deem *psycho-policy soft spots*.[85] A TJ lens through which to view health policy utilizes the identification of psycho-policy soft spots to develop, test out, and revise as needed strategies to proactively address potential impacts of various policies on emotional health. For example, imagine a set of policies distinguishing between mental and physical health that places obstacles before parents seeking mental health care for their children, or policies limiting the ability of families to assist in end-of-life decision-making. Or consider policies mandating vaccination for certain populations. Identification of potential soft spots in such examples would require that we:

- Examine the psychological stress placed on families by disparate policies governing mental vs. physical health coverage and the range of access issues in seeking mental health care for one's children (e.g., costs, limited number of providers, socially-accepted stigma through disparate laws), and consider the psychological consequences of potential policy options. For example, might a potential policy "fix" that incentivizes parents to place their children in state custody to receive needed treatment create heavy burdens on such families, and potentially more stress than no policy action? Could the policy instead be more therapeutic, e.g., via mental health parity legislation or legislation appropriating additional funding to grow/enhance mental health resources in the community? Or, at the very least, could the policy be crafted and/or implemented to mitigate anti-therapeutic consequences, for example by allowing families to apply unused parental or other child benefits to coverage of mental health needs without breaking up families?
- Examine the non-policy-driven psychological stress of end-of-life decision-making, and how a potential policy "fix" to facilitate surrogate decision-making through proxy selection might compound stress. What if policy recognizes proxies but such designations have not been made, for example by a woman in her mid-20 s who is left in a persistent vegetative state after a car crash leaving no proxy or advance directive document behind. What of the policy-related negative consequences? In our example, the policy fix does not help if no designations have been made; in fact, such absence might be seen as disempowering alternative decision-makers rather than as mere silence. While the benefits of proxy laws arguably outweigh non-policy action, we could at least consider how anti-therapeutic consequences could be ameliorated by expansion of decision-making authority to a list of family members beyond a designated proxy. Or, consider how policy might promote long-term goals of proxy selection via education and incentives to primary care providers for proxy-related discussions and completion.
- Examine how bringing public health preventive measures into the realm of legal mandate might create psychological stress. How best can a policy that mandates influenza vaccination, say, balance between appeals to individual liberty, the "solidarity" (collective responsibility) of populations, and a state's interest in safeguarding the public's health? As a preliminary matter, how might evidence of effectiveness of widespread vaccination, and frank discussion of any potential risks, be shared in a "healing" way? Moreover, are there incremental steps short of a mandate that might work, at least initially? Additionally, rather than focus solely on the policies (and their consequences), perhaps here attention to the policymaking process itself might ameliorate stress. If evidence suggests a mandate is critical, how might incorporating greater public input into policy level decision-making, and involving affected populations in implementation processes, de-escalate fearful and/or angry responses to mandates?

These examples begin to sketch out a policy research strategy framed by TJ principles and to make the exercise of evidence informed policymaking and policy implementation proactively focus on health-affecting consequences. It also forces consideration of policy or policymaker strategies to promote positive or mitigate negative health consequences. In the process of identification and strategizing, a research base is developed on which to ground TJ/EIHP.

5. The new context: TJ/EIHP framework

And so this discussion leads to what a TJ framework for EIHP might look like. Fig. 1 illustrates the sort of question generating process envisioned. Critically, the frame is about evidence gathering and

[84] *See infra* Part 4.5 for more discussion of the empirical push in TJ — in law and, as suggested, in policy.

[85] This builds on Wexler's model of psycholegal soft spots, discussed at Wexler, *supra* note 78, and accompanying text.

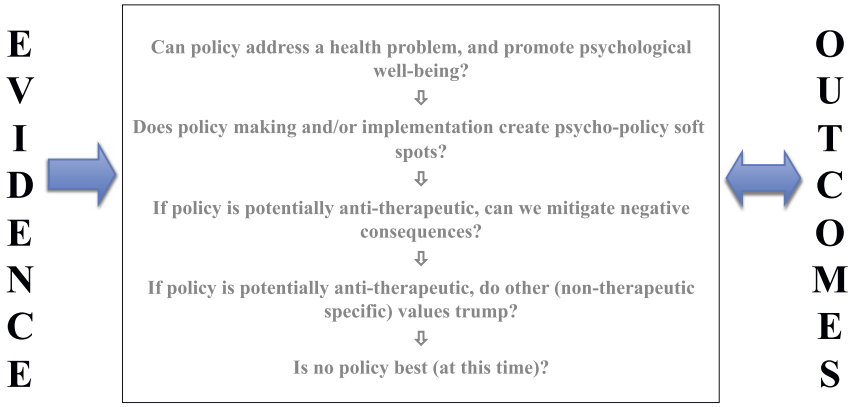

Fig. 1. TJ/EIHP framing questions.

hypothesis testing, and should be understood as framing an iterative vs. linear process.

5.1. Tying it all together: returning to mental health screening case example

How does this all work together in practice? Filtering health policy through a TJ prism pushes us to ask the questions noted in the framework (Fig. 1) when considering our development (ideally) or implementation and evaluation of the ScreenRTeens program at JKF. The process might look something like this:

1. *Can policy address a health problem, and promote psychological well-being?* JFK's policy on mental health screening may help advance the preventive and early intervention goals inherent in a public health approach to youth mental health, and recognize the importance of emotional health as part of healthy development and academic advancement. It may also "normalize" consideration of mental health issues alongside physical health ones.
2. *Does policymaking and/or implementation create psycho-policy soft spots?* Preventive planning by JFK administrators may assist "health-advancing" implementation. For example, they may consider effects on student–parent relationships and alter policy guidelines to call for voluntary vs. mandatory screening, requiring active (vs. passive/opt-out) parental consent. They may anticipate the potential for increased numbers of referrals and have clear guidelines governing the referral process, doing legwork in advance to secure necessary community resources. Potentially they could delay implementation until resources are better available and equipped to meet demand.
3. *If policy is potentially anti-therapeutic, can we mitigate negative consequences?* Students who are going through normal developmental changes, or who have "typical" adolescent experiences such as a first break-up, may be falsely identified as having disorders and feel stigmatized by the process, and perhaps more fearful of the mental health system frustrating future treatment if/when actually needed. JFK administrators could work with expert social scientists to examine the issue of "false positives" and alter questions as needed to more carefully distinguish typical "angst" from issues rising to clinical significance. Alternatively or in addition, policy could address identified "angst" as deserving attention even if normal developmentally or a subthreshold disorder, through education and other measures that promote resiliency when confronting stress or times of transition.
4. *If policy is potentially anti-therapeutic, do other (non-therapeutic specific) values trump?* JFK may decide to implement its mental health screening policy despite concerns based on the value it places on identifying any potential emotional disorders and its view that ScreenRTeens is a cost-effective way to promote prevention and early intervention. Values of justice between mental and physical health, benefiting even a few teens, and cost-efficiencies may supersede other values; however, steps identified in numbers 2 and 3 may still be in order to lessen any anti-therapeutic consequences to the extent possible.
5. *Is no policy best (at this time)?* Finally, ethical considerations (e.g., concerns over effects on relationships or cultural sensitivity of tools) or clinical/pragmatic considerations (e.g., lack of adequate mental health resources in the community) may lead to delay of implementation of a screening policy until such considerations can be adequately addressed. It may also be decided that there is a better way to address policy goals, e.g., focus on mental health as part of annual pediatrician visits, more limited screening with at-risk populations, or mental health/resiliency/healthy behavior education in schools.

Use of this example with these framing questions illustrates how to crosswalk TJ principles and approaches to EIHP in order to analyze policies and policy processes through a "therapeutic lens." The focus is on guiding and analyzing action and results, in relational and human terms, and not just adding a new theoretical gloss to the discussion (or providing *the* answer vs. a hopeful better process). Thus is the frame written in terms of questions meant to stimulate broader consideration of relational and emotional consequences, which seek to be answered by building an evidence base.

5.2. The TJ/EIHP research agenda

5.2.1. Descriptive + empirical focus

TJ is recognized as having a normative orientation, i.e., enhancing, or at least not harming, the physical and psychological or emotional health of clients is a good thing to seek. Similarly, in this reframing of policy, it is contended that enhancing, or at least not harming, health through our policies is a good thing. A goal is to humanize the EIHP process and resulting policies. Yet, notwithstanding this normative basis, the policy focus is a descriptive and empirical one[86]: What effects are our policies actually having? Where there is a mismatch between intent and result, is the balance more positive or negative on health? Are policies aiding or obstructing individuals' construction of their own life stories?[87]

[86] Robert F. Schopp, *Therapeutic jurisprudence: integrated inquiry and instrumental prescriptions*, 17 BEHAV. SCI. L. 589 (1999) (describes TJ as not adding normative but rather instrumental prescriptions, wherein TJ's value is in promoting integrated interdisciplinary scholarship).

[87] For a more thorough discussion applying a relational model (drawing on an ethic of care) to TJ, *see* Brookbanks, *supra* note 60, at 339: "The challenge, for lawyers as for physicians, is to be able to assist their clients integrate the narrative of their life's experiences into an ongoing experience of life within which specific incidents of legal 'trauma' may be located and understood in such a way that the client is not destroyed by the shock of legal conflict and is able to process it as an aspect, and incident, in a life well lived."

Key issues for any research agenda should include: what do and should we hope to achieve? Does reality (outcomes) match our hopes? Should we care about any mismatch? Can we do anything about the mismatch? How can we achieve better outcomes? What a therapeutic prism adds to this agenda is the recognition that theories, principles, and goals of EIHP have an effect on the emotional health of individuals and populations as policy is made, implemented, and evaluated. Data should matter, but it should also include behavioral, in addition to social science understandings, of these health effects.

Ultimately, this places the pursuit in a social context, and requires an interdisciplinary and collaborative process to gather evidence to help inform policymaking. Critically, affected parties are understood as holding a preeminent position in determining and relaying information about desired, actual, and unacceptable psychological health consequences, just as they are in the person-centered medical encounter. Recall the view in EIHP that "evidence" is socially constructed, deriving meaning and import through negotiation among various power structures. In this construction, TJ would broaden who is involved in the negotiation (and holds power) to a broader range of stakeholders and posit more power with end users,[88] bringing a "self" (vs. abstract)-defined therapeutic dimension to the outcomes comprising evidence.

Resulting data does not make the decision for what to do, i.e., a TJ framework does not solve policy problems. Rather, from this data we have a greater range of information on which to make a decision, the latter encompassing a range of values beyond therapeutic ones, such as economics and justice. Yet, why should emotional health effects matter any less than costs or other considerations, even if not decisive? Moreover, a therapeutic prism ensures a focus on the *health* outcomes of health policymaking and implementation, and thus seems a positive framework for evaluating health policies and processes.

In practice, a TJ framework for EIHP illuminates through contribution of a human dimension looking to psychological impact on and from policies and policymaking as the framework's guiding light. It serves to generate hypotheses building on an enlightened view of evidence use in health policy wherein evidence helps us more critically examine our ideological positions and interests vis-à-vis policy action. A TJ frame expands the range of questions to ask, with an eye toward health-promoting (or not) consequences.[89] Results may help inform new approaches not only to health policymaking, but also to health policy implementation, evaluation, and diffusion.

To summarize, what is advanced is a "generous" framework, i.e., one that does not restrict what sorts of evidence or other values go within it, but simply recasts consideration of such evidentiary values with a therapeutic eye. While grounded in theory, TJ's influence on health policy would be more pragmatic: (1) descriptive — offering a new prism through which to view evidence of our health policy's *therapeutic* effectiveness, and (2) empirical — crafting a research agenda building on behavioral, end-user informed, data.

5.3. Limits of TJ/EIHP framework

The framework — and endeavor of therapeutic and evidence-informed policymaking — is not without their challengers or limitations. First, what of "empirical uncertainty," i.e., the difficulty in crafting "gold standard" (i.e., blinded, placebo-controlled) studies to test TJ-related hypotheses, a common complaint about research in the social sciences generally?[90] In policy it is tricky to conduct controlled studies, difficult to foresee all consequences of sweeping policy, and challenging politically to determine which values to preference in application of policy. Yet, in the face of uncertainty, seeking out therapeutic-minded consequences is an approach with merit.

And, importantly, lest one think this is too "fuzzy" an experiment to take on when policy implementation and changes have population-level consequences, we must remember the empirical basis to this endeavor. In having us ask more questions, and in partnering with clinicians, social scientists, and affected populations to consider therapeutic consequences, the next step is to allow stakeholders to gather evidence about our assumptions. Proactive consideration of therapeutic consequences, and a view of health policy-as-intervention needing similar testing (including via pilot, or smaller-scale, studies), can contribute a richer evidence base to the policy landscape.

Next, what of a conflict in values about what information to privilege: rather than solve any conflicts or give answers, TJ-framing-EIHP seems to simply add more "noise." This, however, is a criticism of any sort of evidence influence on health policy, and requires recognition of the limits of evidence use in policy, where policymakers take what is developed and then must apply such in light of a range of other interests, a limitation addressed in the shift from an EBHP to an EIHP approach.[91] TJ, however, does offer a foundation for this discussion, and a way to "maximize balancing" to go from a zero-sum view of policymaking to a diplomatic view that seeks mutually acceptable results.[92] Here, our common ground is advancement of therapeutic values *to the extent we can*, and re-visioning of other values (e.g., justice) with a therapeutic eye to where they might lead (e.g., what fears arise among segments of the population from a discussion about expanding the health insurance safety net and how might we mitigate fears/anxiety).[93]

Finally, at a broader level, what of the limits of what policy can be reasonably expected to accomplish: can policy be a healing agent? Policy may not be the best means to ensure certain therapeutic outcomes, or may not be able to prospectively address potential anti-therapeutic ones. It is imperative that a TJ framework recognizes the limits of policy. Policy action may not always be the best answer, i.e., there may be other means to address an issue, or policy development may be premature.[94] Again, however, having therapeutic consequences in mind and reflecting on related evidence may be our best hope — where policy is possibly helpful or necessarily implemented — of enhancing therapeutic outcomes. Too, policymakers can maintain an approach to various policy issues from a *carer* vs. a partisan or overly "detached" bureaucratic perspective.

[88] This accords with an *interactive* view of policymaking, discussed *infra* Part 3.6.

[89] For example, see *infra* Part 3 (discussing CHIPRA and its potential consequences).

[90] Winick, *supra* note 1, at 196–197 (discussing difficulties with experimentation in the law).

[91] *See* discussion *infra* Part 3.6.

[92] Ken Kress, *Therapeutic jurisprudence and the resolution of value conflicts: what we can expect, in practice, from theory,* 17 BEHAV. SCI. L. 555, 585 (1999) (refuting arguments against TJ as unable to resolve value conflicts).

[93] This goes to the point that what science tells us is working might not always accord with our view of what is just, fair, etc. For example, new reports suggest that assisted outpatient treatment programs, which provide a process for judicial order of outpatient treatment of certain individuals with mental disorders, are effective. *See* MARVIN S. SWARTZ ET AL., NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION, DUKE UNIV. SCH. MED. (2009) *available at* http://www.omh.state.ny.us/omhweb/resources/publications/aot_program_evaluation/ (last visited Aug. 21, 2009). However, some mental health advocates decry efforts mandating treatment and bringing treatment into the judicial realm, instead preferring less coercive means. In balancing alternatives, it is conceivable that the arguments against what is seen as an evidence-based practice potentially could hold sway in a policy sphere where values such as fairness and justice in treatment of persons with mental health disorders is a weighted consideration.

[94] Sometimes it is best, say, for the US federal government to leave policymaking to the natural experiment of the states, or at the very least to let the states try various options before supporting through federal means any single approach. *See, e.g.,* Frank J. Thompson, *New federalism and health care policy: states and the old questions,* 11 J. HEALTH POL. L. 647 (1986); James W. Fossett, Alicia R. Ouellette, Sean Philpott, David Magnus & Glenn McGee, *Federalism and Bioethics: States and Moral Pluralism*, 37 THE HASTINGS CENTER 24 (2007).

6. Conclusion

6.1. Implications

This paper endeavored to set out a basic framework for how therapeutic jurisprudence might enhance the crafting, implementing, and analyzing of EIHP to be more therapeutically oriented. An evidentiary base is valued, especially behavioral knowledge, and is now filtered through a framing tool that casts evidence and its prioritization, collection, and analysis in a psychological health promotion light.

6.2. Next steps

I have set out general connectors between TJ/PL, EBP, and EIHP, with the hope of beginning to lay the groundwork for how TJ might frame evidence informed policy and policymaking with its health-specific, contextual, and interdisciplinary insights. At a theoretical level, further analysis of how TJ enhances an evidence informed approach to health policymaking, as well as an ethically informed one, is needed.

At the practice level, still to do is more fully flesh out the basic framework, and test it in real-world settings to gauge its usefulness and identify further areas in need of theoretical and empirical analysis. This would also begin to build the critical TJ/EIHP research agenda. School-based mental health screening is but one example for cross-walking principles of TJ to EIHP, but many more could and should be considered as should a range of issues raised by this preliminary work. [95] Finally, also helpful would be building a coalition of support to enhance the framework's real-world application and relevance through greater dialogue with TJ experts, researchers, policymakers, clinicians, and affected populations, among others.

In the end, my intent is to move TJ from a study of the law to a broader health policy application, with the hope that a therapeutically oriented examination of the policy process will lead to better public health effects just as therapeutically oriented lawyering seeks better client health effects. The immediate goal was to generate discussion of the applicability and utility of TJ-framed EIHP, with a belief that such re-visioning of policy would prove beneficial to the health-advancing goals of health policy. Just as TJ has helped lead an agenda of reform of law, legal processes, and lawyering to promote health of clients and legal actors, so too is it hoped that what is started here could lead to reform of policy and policy processes to advance the public's holistic health in a democratic and evidence-informed while person-centered process.

[95] A host of other examples could be given. A few I intend to examine include: state support of inclusion of BMI reporting to parents through schools (e.g., Arkansas Act 1220 of 2003, ARK. DEP'T EDUC., *available at* http://cnn.k12.ar.us/Healthy%20Schools%20Initiative/Information%20About%20Act%201220%20of%202003.htm (last visited Aug. 21, 2009) (annual (since modified) BMI screening of public school children, and reporting of the BMI and associated health risks to parents)); state safe haven laws (e.g., Nebraska Legislative Bill 157 (Feb. 13, 2008) (allowed a person to drop off a child at hospital without prosecution but did not set age limit for how old child could be, leading to several instances of older children/teens being left, including by persons residing outside Nebraska, *see* Safe Haven Law, NEB. DEP'T HEALTH & HUM. SERVICES, *available at* http://www.hhs.state.ne.us/SafeHaven/ (last visited Aug. 26, 2009) (describing law)); child and adolescent vaccine policy (*see* R. Alta Charo, *Politics, Parents, and Prophylaxis – Mandating HPV Vaccination in the United States,* 356 NEW ENG. J. MED. 1905 (2007)); and state newborn screening policy (*see* THE PRESIDENT'S COUNCIL ON BIOETHICS, THE CHANGING MORAL FOCUS OF NEWBORN SCREENING: AN ETHICAL INQUIRY BY THE PRESIDENT'S COUNCIL ON BIOETHICS (2008). Another area of interest for future examination includes the rise in medical legal partnerships (MLPs) to address legal issues as part of "medical" treatment. *See* NAT'L CENTER MED. L. PARTNERSHIP, *available at* http://www.medical-legalpartnership.org (last visited Aug. 11, 2009). MLPs recognize that legal barriers (or legal applications) could enhance health and move that knowledge into an interdisciplinary clinic-based, holistic approach to practice. Of note for purposes here, MLPs are identifying that individual cases may bring up the same legal issues, requiring a larger policy (legal reform) change – wherein the TJ/EIHP framework might be of use.