International Journal of Law and Psychiatry 33 (2010) 281–292

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

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

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ARTICLE INFO

Keywords:
Therapeutic jurisprudence
Evidence-based health policy

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.

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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

☆ The author wishes to thank Nick Moore for his assistance with references, Andrea Asprelli for final editing assistance, the anonymous reviewers for their invaluable editorial suggestions, and, most of all, Professors Bruce Winick and David Wexler for their on-going encouragement and support and for their contributions in developing the field of therapeutic jurisprudence. This paper was initially prepared for presentation at the 31st Congress of the International Academy of Law and Mental Health in July of 2009.

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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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doi:10.1016/j.ijlp.2010.09.001

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).

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