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USING THERAPEUTIC JURISPRUDENCE TO FRAME THE ROLE OF EMOTION IN HEALTH POLICYMAKING*

Amy T. Campbell**

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** Assistant Professor, Center for Bioethics and Humanities, SUNY Upstate Medical University and Syracuse University College of Law (courtesy) (Syracuse, NY). I would like to thank participants in the panel session on the theme of emotion's role in law at the 13th Annual Meeting of the Association for the Study of Law, Culture & the Humanities in Providence, Rhode Island for helpful feedback during presentation of the themes outlined in this article. I also thank Nick Moore and Robert Webb for excellent research assistance. Special thanks, as always, to David Wexler for his support of my on-going work in the field of therapeutic jurisprudence.

I. INTRODUCTION

Therapeutic jurisprudence ("TJ") is growing in prominence as a reappraisal of law and the legal process. It seeks to reframe law by offering a prism through which it can be viewed as a healing agent, to enhance the positive consequences of legal intervention, or at least to mitigate its more harmful effects.[1] The aim of this article is twofold: (1) to briefly outline the evolution of therapeutic jurisprudence, and discuss the prominence of evidence-based/ evidence-informed healthcare policymaking; and, more specifically, (2) to use a TJ-informed framework to investigate the role of *emotion* (as evidence, or impact on evidence) in the development, implementation, and evaluation of health policy. The intent is not to identify the right policy in any given case; rather, it is to utilize framing questions to better understand how emotion impacts policy and policymaking with an eye toward enhancing therapeutic consequences.

Part II provides a background on the evolution of therapeutic jurisprudence in the law and discusses differing conceptions of health policymaking as either a linear or a more complex process, suggesting the latter could benefit from TJ's re-visioning influence. Part III goes into more detail about how emotions are raised by and also have an impact on health policymaking. Specific case examples are given to illustrate the myriad of ways emotions are triggered in this process. Part IV lays out a TJ-informed framework that could help channel emotions in health policymaking in therapeutic ways. The framework (i.e., framing questions) is applied to each of the case studies to enhance understanding of how TJ might inform this process to the benefit of the policymaking experience as well as resulting policies. In this way, TJ offers a means to systematically address emotional consequences. The article concludes with lessons learned through this framing process and recommends next steps to test the value of TJ to frame the role of emotion in health policymaking.

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[1] *See generally* Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCHOL. PUB. POL'Y & L. 184 (1997).

II. BACKGROUND

A. *Therapeutic Jurisprudence in Brief*

TJ offers a new perspective on law and lawyering—a therapeutic lens through which to view the law,[2] fleshing out the therapeutic and anti-therapeutic consequences of our laws and law-making processes. It asks that lawmakers consider these consequences, and search for ways to enhance therapeutic outcomes, or at the very least, lessen or mitigate the anti-therapeutic ones.[3] If considered from an ethics perspective, one could say TJ has a utilitarian flavor to maximize good consequences over bad ones. Inasmuch as it is a contextual endeavor that looks to relationships affected by the law,[4] it could also be said to promote an ethic of care asking that actors in the process tend to those relationships in therapeutic ways.[5]

Given its illumination of psychological consequences, TJ unsurprisingly emerged first in mental health law.[6] Earliest developers recognized flaws in the law's treatment of persons with mental health disorders and sought a more therapeutic relationship between lawyer and client.[7] As it evolved, however, it quickly became attractive to other areas more intensely *personal* in the law,

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[2] *Id.* at 200-201, 206.

[3] *Id.* at 185.

[4] Susan Daicoff, *Law as a Healing Agent: The "Comprehensive Law Movement"*, 6 PEPP. DISP. RESOL. L.J. 1, 9 (2006). *See generally* Susan Daicoff, *Making Law Therapeutic for Lawyers: Therapeutic Jurisprudence, Preventive Law, and the Psychology of Lawyers*, 5 PSYCHOL. PUB. POL'Y & L. 811 (1999) [hereinafter *Making Law Therapeutic*].

[5] 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).

[6] *See, e.g.,* ESSAYS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick, eds., 1991); THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (David B. Wexler ed., 1990); David B. Wexler, *New Directions in Therapeutic Jurisprudence: Breaking the Bounds of Conventional Mental Health Scholarship*, 10 N.Y.L. SCH. J. HUM. RTS. 759, 770-772 (1993); David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 PSYCHOL. PUB. POL'Y & L. 220, 228-231 (1995). *See generally* Symposium, *Therapeutic Jurisprudence: Restructuring Mental Disability Law*, 10 N.Y.L. SCH. J. HUM. RTS. 623 (1993).

[7] *See* sources cited *supra* note 6; *see also* Michael L. Perlin, *The Jurisprudence of the Insanity Defense*, *in* LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE 59–75 (David B. Wexler & Bruce J. Winick eds., 1997); Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183 (2003); Bruce J. Winick, *A Therapeutic Jurisprudence Approach to Dealing with Coercion in the Mental Health System*, 15 PSYCHIATRY, PSYCHOL. & L. 25 (2008); Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37 (1999).

e.g., family,[8] trust and estates,[9] and elder law.[10] In turn, it became a considered approach to lawyering beyond substantive areas of the law, blending with relationship-centered lawyering and preventive law to endorse a set of skills that would enhance the experience of the law for the client and the legal actor.[11] Today, we see TJ applied to a range of substantive areas perhaps inconceivable when first developed, such as military law,[12] bankruptcy law,[13] and worker's compensation law.[14]

What has TJ to offer the law and legal process? Some question whether a positivist approach to law ignores the context within which law occurs and how that context may—and likely does—influence the law. Inasmuch as context matters, TJ offers a new framework to approach how we describe, develop, and interact within the law. And inasmuch as relationships can affect law's experience and even effectiveness, an approach such as TJ that seeks to enhance relationships is seen as holding merit. Calling forth the *counsel* vision of the lawyer, TJ in its more practical iterations equips legal actors with tools to be more effective counselors within their own practices by taking a preventive approach to client relations.[15] The goal is not lawyer-as-psychologist; rather, what is sought is a lawyer who can use psychological insights to be a more effective advocate and representative of the law.[16]

Thus, TJ has found a home in many facets of the law, including law-making in a traditional sense. But what of larger policymaking endeavors? Specifically, consider health policy, a natural basis for consideration of therapeutic

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[8] *See, e.g.*, Stephen J. Anderer & David J. Glass, *A Therapeutic Jurisprudence and Preventive Law Approach to Family Law*, *in* PRACTICING THERAPEUTIC JURISPRUDENCE 207-234 (Dennis P. Stolle et al. eds., 2000).

[9] *See, e.g.*, Patricia M. Wisnom, *Probate Law and Mediation: A Therapeutic Perspective*, 37 ARIZ. L. REV. 1345 (1995).

[10] *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).

[11] *See* Diacoff, *supra* note 4; Dennis P. Stolle et al., *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering*, 34 CAL. W.L. REV. 15, 19 (1997).

[12] Evan R. Seamone, *The Veterans' Lawyer as Counselor: Using Therapeutic Jurisprudence to Enhance Counseling for Combat Veterans with Posttrautmatic Stress Disorder*, 202 MIL. L. REV. 185, 188-190 (2009).

[13] *See generally* Michael L. Stines, *Must We Bankrupt the Spirit Also?: The Benefits of Incorporating Therapeutic Jurisprudence into Law School Bankruptcy Assistance Programs*, 17 ST. THOMAS L. REV. 855 (2005).

[14] *See generally* Katherine Lippel, *Therapeutic and Anti-Therapeutic Consequences of Workers' Compensation Systems*, 22 INT'L J.L. & PSYCHIATRY 521 (1999).

[15] Diacoff, *supra* note 4; *Making Law Therapeutic*, *supra* note 4; *supra* note 11, at 15; Bruce J. Winick, *The Expanding Scope of Preventive Law*, 3 FLA. COASTAL L.J. 189 (2002).

[16] Amy T. Campbell, *Therapeutic Jurisprudence: A Framework for Evidence-Informed Health Care Policymaking*, 33 INT'L J.L. & PSYCHIATRY 281, 288 (2010).

consequences: would health policymaking not benefit from being seen through a therapeutic lens? First, it is critical to reflect on the traditional and emerging prisms through which we envision health policymaking.

B. Envisioning the Health Policymaking Process and the Use/Impact of Evidence

Health policymaking within the United States, let alone around the world, is a complex undertaking. Others have explained how it is made and evaluated;[17] the area of interest for purposes of this article, however, is the use of evidence in this process. Historically, a linear model has been applied to the policymaking process wherein evidence is plugged into the policymaking and implementing process to reach a desired goal, with the process occurring in a stepwise fashion—a rationalist vision.[18] The benefit of such model is the ease of evaluating the effectiveness of a given policy towards reaching the desired end-goal. It also allows for ready use of scientific evidence wherein supporting evidence can be conveniently plugged in during the policy development process to effectuate the desired goal.[19] In countries around the globe we have seen such evidence-based policymaking trumpeted.[20]

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[17] *See generally* THOMAS BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY (5th ed. 2008); BEAUFORT B. LONGEST, HEALTH POLICYMAKING IN THE UNITED STATES (5th ed. 2010).

[18] Harold D. Lasswell, *The Policy Orientation*, *in* THE POLICY SCIENCES: RECENT DEVELOPMENTS IN SCOPE AND METHODS 3-15 (Daniel Lerner & Harold D. Lasswell eds., 1951); 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 et al. eds., 2000) [hereinafter *Evidence and the Policy Process*].

[19] *Evidence and the Policy Process*, *supra* note 18.

[20] *See, e.g.*, GARY BANKS, EVIDENCE-BASED POLICY MAKING (2009), http://www.pc.gov.au/__data/assets/pdf_file/0003/85836/20090204-evidence-based-policy.pdf (providing an example from Australia); WORLD HEALTH ORG., PROMOTING HEALTH AND EQUITY: EVIDENCE, POLICY AND ACTION (2009), http://www.wpro.who.int/publications/docs/PromotingHealthEquitysmallV3.pdf (providing an example for the Pacific region); EPPI CENTRE, http://eppi.ioe.ac.uk/cms/ (last visited Apr. 18, 2012) (providing an example from the United Kingdom and promoting systematic reviews in non-clinical health issues, education, and social care); *Evidence Based Policy Making*, DEP'T ENVTL. FOOD & RURAL AFF. (Sept. 21, 2006), http://archive.defra.gov.uk/corporate/policy/evidence/ (providing another example from developing countries and providing an overview of evidence policy-making); *Evidence-Informed Policy Network*, WORLD HEALTH ORG., http://www.who.int/rpc/evipnet/en/ (last visited Apr. 18, 2012) (providing an example from developing countries and encouraging policy-makers in low and middle-income countries to use evidence generated by research).

Some increasingly question the linear evidence-use policymaking model[21]—and related uncritical heralding of the value of evidence in health policymaking[22]—and have sought other policymaking visions[23] and uses of evidence.[24] Policy development and implementation does not occur in a vacuum or a laboratory. In reality, policy is affected by a range of factors beyond scientific evidence, such as politics, religious values, economics, relationships, and timing.[25] The list of factors is as long as the interested party is ready to intervene when her interests are affected. Might considering this range of factors and being open to the realities in which policy is based help the long-run effectiveness of actual and developing policies?

This complexity of policymaking has begun to be more fully fleshed out. Shelley Bowen and Anthony Zwi, for example, have offered a model of policymaking that moves policy development through stages, recognizing the myriad of influences at each stage and the back-and-forth (versus stepwise) nature of much of what goes on within this process.[26] Too, our understanding of evidence has moved beyond the purely scientific to a range of values and experiences we may count toward how we develop, implement, and evaluate policy.[27] Examples of other sorts of evidence, noted above, include political

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[21] *See* Campbell, *supra* note 16, at 286 (providing further discussion). *See generally* Rebecca Sutton, *The Policy Process: An Overview* (Overseas Development Inst., Working Paper No. 118, 1999), http://www.odi.org.uk/resources/docs/2535.pdf.

[22] *See generally* Nick Black, *Evidence Based Policy: Proceed with Care*, 323 BMJ 275 (2001); Ian Sanderson, *Is It 'What Works' That Matters? Evaluation and Evidence-Based Policy-Making*, 18 RESEARCH PAPERS IN EDUCATION 331 (2003).

[23] Shelley Bowen & Anthony B. Zwi, *Pathways to "Evidence-Informed" Policy and Practice: A Framework for Action*, *2* PLoS. MED. e166, 0600 (2005); *see* Peter Davis & Philippa Howden-Chapman, *Translating Research Findings into Health Policy*, 43 SOC. SCI. MED. 865 (1996) (providing a discussion of the researcher role in enhancing evidence use in a complex policy system); Stephen R. Hanney et al, *The Utilisation of Health Research in Policy-Making: Concepts, Examples and Methods of Assessment*, 1 HEALTH RES. POL'Y & SYSTEMS 2 (2003).

[24] J.A. Muir Gray, *Evidence Based Policy Making*, 329 BMJ 988 (2004); Ian Sanderson, *Intelligent Policy Making for a Complex World: Pragmatism, Evidence and Learning*, 57 POL. STUD. 699 (2009); Inger B. Scheel et al., *The Unbearable Lightness of Healthcare Policy Making: A Description of a Process Aimed at Giving It Some Weight*, 57 J. EPIDEMIOLOGY & CMTY. HEALTH 483 (2003); Carol H. Weiss, *The Many Meanings of Research Utilization*, PUB. ADMIN. REV., Sept.-Oct. 1979, at 426-431.

[25] CAROL H. WEISS, WHAT KIND OF EVIDENCE IN EVIDENCE-BASED POLICY? 286-290 (2001), http://www.cemcentre.org/attachments/ebe/P284-291%20carol%20Weiss.pdf; *see also* Gray, *supra* note 24; Carol H. Weiss et al., *The Fairy Godmother and Her Warts: Making the Dream of Evidence-Based Policy Come True*, 29 AM. J. EVAL. 29, 31-34 (2008).

[26] Bowen & Zwi, *supra* note 23, at Fig. 1.

[27] *See* Campbell, *supra* note 16, at 286-287; *see also* Nikola Biller-Andorno et al., *Evidence-Based Medicine as an Instrument for Rational Health Policy*, 10 HEALTH CARE ANALYSIS 261 (2002) (arguing against over-reliance (exclusive) on economic and scientific research evidence in health policymaking, and endorsing explicit address of social values and patient preferences);

philosophy, economics, ethics, and religious values. And yet, whether a rational, evidence-based or complex vision of the policymaking process is applied, less explored are the specifically emotional aspects of this process—at a broader policymaking level or simply as a type of evidence to consider—aspects to which this article now turns.

III. Emotion in Health Policymaking

Emotions may drive policy, through manipulation by advocates to control the news cycle and to command policymaking attention.[28] Too, however, emotions may be by-products of heath policy initiatives, intended or not. Unintended consequences can frustrate the short and long-term policy goals; intended emotional responses are often manipulated when advancing one's cause (be it to pass or to bury a certain policy). Rather than speak in generalities, however, case examples would help illustrate these dynamics. A few examples follow; many more could be offered, including from international sources. The goal here is not to be all encompassing but to highlight the different ways emotions are triggered by, used in, impacted by, or impact on health policy.

A. Case Examples

1. Emotion Generally: Health Care Reform—Malpractice Reform

With health reform at the forefront of the news cycle in the United States lately, there are any number of emotional appeals from which to draw: consider, for example, the debate around medical malpractice reform (tort reform). For years, physicians and others have decried a malpractice system that they see as unfairly impinging on their expertise[29] and negatively impacting the physician-patient relationship.[30] Backers of malpractice reform claim that liability fears drive defensive medicine, which in turn costs the health care system

Mark J. Dobrow et al., *Evidence-Based Health Policy: Context and Utilization*, 58 Soc. Sci. & Med. 207 (offering a conceptual framework for context-based evidence-based decision-making).

[28] The media uses emotion to frame a story, as do policy advocates. Narrative plays a powerful role in policymaking, which joins data and the story. My focus, however, is on the aggregate *emotions* from these narratives that weave their own story, one of policymaking-as-emotion.

[29] Catherine T. Struve, *Improving the Medical Malpractice Litigation Process*, Health Affairs, July 2004, at 33.

[30] Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, Health Aff., July-Aug. 2004, at 42-43 (study of negative effects of tort liability system on relationships with patients among physicians in Pennsylvania, noting perceptions matter); *see also* Kristin E. Schleiter, *Difficult Patient-Physician Relationships and the Risk of Medical Malpractice Litigation*, 11 Virtual Mentor: Am. Med. Ass'n J. Ethics 242 (2009) (discusses how malpractice rates fueled by impaired patient-physician relationships).

billions of dollars each year.[31] A Massachusetts study found that eighty-three percent of physicians practiced defensive medicine and that in this environment, thirty-eight percent of physicians limited providing high risk services and procedures while twenty-eight percent reduced the number of high-risk patients seen.[32] For purposes of this discussion, however, consider also the emotional appeals: the current system negatively impacts physician relationships with patients and limits patients' access to care.[33] Physician perception—based in reality or not—of litigation risks and insurance costs are causing them to leave specialty areas or particular states altogether because of the broken system.[34] Faced with the status quo, the patient experiences a lesser standard of care, pays more, and may not even be able to find a needed doctor. Patients should be afraid and angry with this; besides, who wants to side with a bunch of greedy trial lawyers?

An alternative view may counter that the costs are much lower than described.[35] This reliance on data, however, only goes so far in the face of emotion. And so we see different emotional appeals: during a White House-convened briefing with key leaders on healthcare reform, Senator Durbin (D-IL), in dramatic fashion, told the story of one woman grievously injured during a medical procedure.[36] Would a capped (i.e., too small) award be sufficient for her pain and suffering? Clearly, both sides are not without their narrative to seize the emotional impact prize.

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[31] AM. MED. ASS'N, THE CASE FOR MEDICAL LIABILITY REFORM (2009), www.ama-assn.org/ama1/pub/upload/mm/-1/case-for-mlr.pdf; *cf.* TOM BAKER, THE MEDICAL MALPRACTICE MYTH 1-14 (2005); CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 1 (2004) ("malpractice costs account for less than 2 percent of that [health care] spending") [hereinafter LIMITING TORT LIABILITY]. *See generally* Letter from Douglas W. Elmendorf, Dir. Cong. Budget Office, to Hon. Orrin G. Hatch, U.S. Sen. (Oct. 9, 2009) (analysis of tort reform proposals).

[32] MASS. MED. SOC'Y, INVESTIGATION OF DEFENSIVE MEDICINE IN MASSACHUSETTS 3, 5 (2008), http://www.massmed.org/AM/Template.cfm?Section=Advocacy_and_Policy&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=23557.

[33] AM. MED. ASS'N, MEDICAL LIABILITY REFORM–NOW! 3 (2012), http://www.ama-assn.org/resources/doc/arc/mlr-now.pdf.

[34] *Id.* at 4.

[35] LIMITING TORT LIABILITY, *supra* note 31; U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 5-6, 9-10 (2003), http://www.gao.gov/new.items/d03836.pdf (noting the rise in malpractice premiums, but concluding that research attributing the rise to defense medicine practices (due to fear of litigation) and malpractice lawsuits are unreliable; instead, the rise was attributed to changing insurance market conditions).

[36] *Sen. Dick Durbin on Medical Malpractice Reform at White House Health Summit*, WASH. POST, Feb. 25, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/02/25/AR2010022504290.html (publishing the transcript from Sen. Durbin).

2. Emotion of a Tragic Event and Policy Response: Virginia Tech Shootings

Another way emotions are raised, and manipulated, in policy is when a tragic event occurs and policymakers demand a policy response on behalf of the public so the event will never happen again. One need only look at all the named laws to see how this occurs (e.g., Kendra's Law[37], Megan's Law[38], Timothy's Law[39]). In April 2007, a tragedy of wide impact occurred at Virginia Tech University when a shooting rampage on campus left thirty-three individuals dead, with many more physically and emotionally impacted.[40] The immediate impulse was two-fold: why are persons with serious mental disorders walking the streets, and why can they access guns? Going further, why can mentally healthy people not carry guns in more places?

Virginia, perhaps not unsurprisingly, used the emotion of the day and ensuing weeks and months to pass gun legislation.[41] States and campuses around the country focused on their own gun control laws, appealing to fear by advocating that more guns be allowed on campuses[42] (or not)—the same emotions driving opposite sides of the argument—or at the very least calling for more rigorous background checks of persons with mental illness.[43] Fear, it seems, is a very powerful emotion and can do funny things to how we see the evidence.

An interesting thing happened in Virginia however, giving a bit of hope to how fear might be channeled into enhanced dialogue and an attitude of thoughtful, multi-stakeholder-informed policy change. Virginia moved along the emotion continuum from the immediate fear response to that of a more therapeutic

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[37] N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2010).

[38] N.J. STAT. ANN. § 2C:7-1 to 7-23 (West, Westlaw through 2012 legislation); 42 PA. CONS. STAT. § 9791 (2010).

[39] N.Y. INS. LAW § 3231 (McKinney 2010).

[40] Christine Hauser & Anahad O'Connor, *Virginia Tech Shooting Leaves 33 Dead*, N.Y. TIMES, Apr. 16, 2007, http://www.nytimes.com/2007/04/16/us/16cnd-shooting.html.

[41] Va. Exec. Order No. 50, Apr. 30, 2007, http://www.lva.virginia.gov/public/EO/eo50(2007).pdf.

[42] *See generally* Lisa Kocian, *Arming Police on Campus*, BAY LEDGER NEWS ZONE (Apr. 30, 2008), http://www.blnz.com/news/2008/05/01/Arming_police_campus_5254.html; Brigid Schulte, *Students Aim for Gun Rights on Campus*, WASH. POST, Feb. 15, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/02/14/AR2009021401668.html.

[43] Rich Daly, *People with Mental Illness Target of New Gun Law*, PSYCHIATRIC NEWS NO., Feb. 2008, at 1; Michael Luo, *Mental Health and Guns: Do Background Checks Do Enough?*, N.Y. TIMES, Apr. 19, 2007, http://www.nytimes.com/2007/04/19/us/19weapons.html; Chuck Todd & Ali Weinberg, *Slipping Through the Cracks, One Background Check at a Time*, MSNBC.COM, Jan. 18, 2011, http://www.msnbc.msn.com/id/41131860/ns/politics-more_politics/t/slipping-through-cracks-one-background-check-time/; *see* JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH, STATES MAY ALTER POLICIES ON BACKGROUND CHECKS FOR GUN PURCHASES (2007), http://bazelon.org.gravitatehosting.com/LinkClick.aspx?fileticket=iTPdjaurtqs%3d&tabid=250 (discussing concerns about the trend).

bent, looking at those who are falling through the cracks. Safety, in part, energized initial responses—e.g., legislation reforming civil commitment laws for persons with serious mental health disorders, altering the commitment standard from "imminent risk" to "substantial likelihood."[44] However, after its first wave of policy responses, Virginia acted again in 2009, after dialogue through a statewide, court-led process which included a range of stakeholders. In amending its advance care planning statutes, Virginia lawmakers created a mechanism allowing persons with mental health disorders to plan, in advance and through dialogue with physicians and loved ones, what sort of mental health care they would or would not want in the event of a crisis, and even more important, how such crisis might be adverted.[45] The evidence base is growing on the potential positive impact of psychiatric advance directives.[46] Thus, Virginia connected emotion to policy action in what appears to be a positive fashion. An important follow-up is the awarding of a grant to a leading member of the statewide commission to enhance implementation of the act's provisions and to study their effectiveness.[47] The power of fear it seems can be channeled in interesting—and therapeutic—ways.

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[44] VA. CODE ANN. § 37.2-817C (LEXIS through 2012 Legis. Sess.); BRUCE J. COHEN ET AL., UNDERSTANDING AND APPLYING VIRGINIA'S NEW STATUTORY CIVIL COMMITMENT CRITERIA, 1-4, 7-8 (2008), http://www.dbhds.virginia.gov/OMH-MHReform/080603Criteria.pdf; Aaron Levin, *Virginia's Commitment Law Raises Many Questions*, 43 PSYCHIATRIC NEWS 21 (2008).

[45] VA. CODE ANN. § 54.1-2983 to 2996 (LEXIS through 2012 Legis. Sess.) ("Health Care Decisions Act"). The changes are discussed in Nathan A. Kottkamp et al., *Law Revised to Enhance Health Care Decision-Making*, VA. LAWYERS WEEKLY, June 2009, http://www.vsb.org/site/members/vlw-advance-directives-article-june-2009/.

[46] *See* Mimi M. Kim, et al., *Understanding the Personal and Clinical Utility of Psychiatric Advance Directives: A Qualitative Perspective*, 70 PSYCHIATRY 19 (2007); *Making the Most of Psychiatric Advance Directives*, 24 HARV. MENTAL HEALTH LETTER 1 (2007) (discussing benefits of PADs and how to make them more effective); A.M. Scheyett et al., *Psychiatric Advance Directives: A Tool for Consumer Empowerment and Recovery*, 31 PSYCH. REHABILITATION J. 70 (2007); Jeffrey W. Swanson et al., *Facilitated Psychiatric Advance Directives: A Randomized Trial of an Intervention to Foster Advance Treatment Planning Among Persons with Severe Mental Illness*, 163 AMER. J. PSYCH. 1943 (2006); Jeffrey W. Swanson et al., *Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions*, 17 J. MENT. HEALTH 255 (2008); Marvin S. Swartz et al., *Psychiatric Advance Directives: Practical, Legal, and Ethical Issues*, 4 J. FORENSIC PSYCHOL. PRAC. 97, 99 (2004) (discussing the potential barriers to their use, how to address those barriers, and discussing issues to address for more effective use of PADs). *See generally* NAT'L RESOURCE CENTER ON PSYCHIATRIC ADVANCE DIRECTIVES, http://www.nrc-pad.org/ (last visited Apr. 18, 2012).

[47] *Law School Receives Grant to Study Health Law Changes*, VA. LAW (Dec. 8, 2009), http://www.law.virginia.edu/html/news/2009_fall/health_grant.htm.

3. Emotion of a Public Health 'Crisis': New York State's Vaccine Mandate

Another time when emotions come to the fore is when there are cries of an epidemic. Consider recent experiences with the H1N1 influenza and the range of regulatory responses—and use of media to trumpet those responses—to a pandemic that was seen as targeting younger populations and pregnant women.[48] Emotionalism here does not lessen the very real threat of pandemic influenza strains such as H1N1 or the need for sensible precautions building on years of public health evidence.[49] The concern, rather, is that emotional appeals lessen clarity around the public health impact and needed response. New York State's ("NYS") experience with a vaccine mandate for health care workers is an excellent case in point.

In August 2009, at the height of fears that a flu pandemic could overwhelm the health system, not to mention take many lives, the NYS Department of Health ("DOH") passed an emergency regulation mandating that most health care workers and volunteers be vaccinated for seasonal and H1N1 influenza.[50] The *or else*, you can imagine, raised fear in affected health care workers' minds. Would a nurse who did not want to get an H1N1 vaccine because of safety concerns[51] lose her job if she declined the vaccination? This fear then turned to anger that the administration would rush through a regulation affecting individual liberty without public comment or traditional regulatory processes.[52]

The NYS DOH responded to emotion with an appeal to ethics: "Knowing that our privileged access to the new vaccine is earned not by our personal risk factors but by the special trust society places in us, then how can we as health care workers maintain that our cooperation in protecting the most vulnerable

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[48] *Doctors: Parents Should Heed Warnings on H1N1 and Children*, FOXNEWS.COM (Oct. 13, 2009), http://www.foxnews.com/story/0,2933,564928,00.html; Rita Rubin, *Pregnant Women Bare Arms for H1N1 Vaccine*, USA TODAY (Sept. 21, 2009), http://www.usatoday.com/news/health/2009-09-21-swine-h1n1-pregnant_N.htm; Tom Watkins, *Study: H1N1 Virus More Severely Affects Pregnant Women*, CNN HEALTH.COM (July 28, 2009), http://www.cnn.com/2009/HEALTH/07/28/swine.flu.pregnant/index.html.

[49] For example, the importance of vaccines has been extensively studied and promoted. *See generally Strategies for the 'Decade of Vaccines'*, 30 HEALTH AFF., June 2011; *Basics and Common Questions: Why Immunize?*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/vaccines/vac-gen/why.htm (last visited Apr. 18, 2012).

[50] N.Y. COMP. CODES R. & REGS. tit. 10, § 66-3.2 (2009). For additional information on New York's efforts and more generally, see KATHLEEN S. SWENDIMAN, CONG. RESEARCH SERV., RS21414, MANDATORY VACCINATIONS: PRECEDENT AND CURRENT LAWS (2011).

[51] *GBS a Side Effect of H1N1 Vaccine?*, CBS NEWS (Nov. 21, 2009), http://www.cbsnews.com/stories/2009/11/20/earlyshow/health/main5723397.shtml.

[52] Anemona Hartocollis & Sewell Chan, *Albany Judge Blocks Vaccination Rule*, N.Y. TIMES, Oct. 17, 2009, at A17, *available at* http://www.nytimes.com/2009/10/17/nyregion/17vaccine.html.

members of society is nevertheless optional?"[53] Not unsurprisingly, many healthcare workers had their own spin on ethics: a vision of individual liberty[54] that should not force them to be vaccinated with a rushed vaccine.[55] Too, where was the sense of solidarity, prominent in other countries, which would support healthcare workers with more safety procedures and training and take care of any injured workers?[56] Rather, it seemed professional obligations were called on without consideration of the consequences to healthcare workers or the obligations of the system in caring for affected workers. Further, the policymaking process itself—through rushed emergency regulation rather than public deliberation—left out key voices in the discussion, understandably upsetting to those most affected.

In this case, fear of a pandemic was matched by anger among healthcare workers over their treatment, the latter—perhaps as H1N1 fears quieted down as the fall of 2009 wore on—gaining particular traction in the media.[57] A powerful argument was made against a mandate and in favor of voluntary inoculation, powerful enough to have a State court temporarily suspend the regulation for full consideration of its merits.[58] Interestingly, a week later the government backed off of the mandate, suspending it due to H1N1 vaccine supply issues.[59]

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[53] Press Release from Richard F. Daines, N.Y. State Health Comm'r, to health care workers (Sept. 24, 2009), *available at* http://www.health.ny.gov/press/releases/2009/2009-09-24_health_care_worker_vaccine_daines_oped.htm (telling health care workers that mandatory flu-vaccine is in their best interest).

[54] *Dutchess County Nurse Sues to Block Mandatory Flu Vaccine*, SYRACUSE.COM (Oct. 10, 2009), http://www.syracuse.com/news/index.ssf/2009/10/dutchess_county_nurse_sues_to.html (quoting Barbara Crane, president of the National Federation of Nurses, "We're against our civil liberties being stepped on").

[55] Paul Harasim, *No Rush for H1N1 Vaccine*, LAS VEGAS REVIEW-JOURNAL (Oct. 13, 2009), http://www.lvrj.com/news/no-rush-for-h1n1-vaccine-64067397.html.

[56] *See generally* CANADIAN PROGRAM OF RES. ON ETHICS IN A PANDEMIC, http://www.canprep.ca/ (last visited Apr. 18, 2012) (information on Canada's effort around pandemic preparedness and ethics); *The New York State Mandate*, UPSTATE MED. UNIV. CENTER FOR BIOETHICS AND HUMANITIES: BIOETHICS IN BRIEF (Jan. 2010), http://www.upstate.edu/bioethics/bnb_1_10_web.pdf.

[57] Cara Matthews, *N.Y. Health Care Workers Protest Mandatory H1N1 Flu Shots*, USA TODAY (Sept. 29, 2009), http://www.usatoday.com/news/health/2009-09-29-swine-flu-mandatory_N.htm; *Health Workers Protest Flu Vaccine Mandate*, CBS NEWS (Oct. 4, 2009), http://www.cbsnews.com/stories/2009/10/04/eveningnews/main5362636.shtml.

[58] Anemona Hartocollis & Sewell Chan, *Albany Judge Blocks Vaccination Rule*, N.Y. TIMES, Oct. 17, 2009, at A17, *available at* http://www.nytimes.com/2009/10/17/nyregion/17vaccine.html.

[59] Press Release, Office of Governor David A. Paterson, Governor David A. Paterson Announces Suspension of Flu Shot Mandate for Health Care Employees Due to Shortage of Vaccine (Oct. 22, 2009); *see also* Letter from Richard F. Daines, N.Y. Comm'r of Health, to Adm'r, Suspension of Flu Vaccine Mandate for Health Care Workers, (August 2009), *available at* http://www.health.ny.gov/diseases/communicable/influenza/seasonal/providers/2009-10-23_suspension_of_mandatory_influenza_immunization.htm.

True rationale or not, it appeared that emotional response to a mandated action won the day. One might wonder what would have happened had evidence more clearly shown healthcare worker vaccination is effective[60] and/or if the H1N1 had truly reached crisis levels.[61]

4. Emotion of Spiraling Costs: Obesity Regulation by States

Finally, consider a different sort of public health emergency: what are we to do with the large number of overweight and obese children and adults in our country who strain our health care system in current and potentially dramatic future ways? Numerous reports offer a snapshot on the current situation: in 2006, almost 73% of U.S. adults were overweight or obese,[62] and spending on adult obesity was $1,429 more per person versus a normal weight individual (a 41.5% difference).[63] Given the myriad of obesity's health consequences, e.g., type 2 diabetes, hypertension, coronary artery disease, and certain cancers,[64] not surprisingly its growth has led to a growth in healthcare costs. As of 2008, obesity cost the United States as much as $147 billion per year in health-related

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[60] Akiko C. Kimura et al., *The Effectiveness of Vaccine Day and Educational Interventions on Influenza Vaccine Coverage Among Health Care Workers at Long-Term Care Facilities*, 97 AM. J. PUB. HEALTH 684, 689 (2007); James A. Wilde et al., *Effectiveness of Influenza Vaccine in Health Care Professionals: A Randomized Trial*, 281 JAMA 911-12 (1999).

[61] For an interesting discussion of how data could help inform a less emotional process, see Steven Black et al., *Importance of Background Rates of Disease in Assessment of Vaccine Safety During Mass Immunization with Pandemic H1N1 Influenza Vaccines*, 374 LANCET 2115 (2009).

[62] NAT'L CTR. FOR HEALTH STATISTICS, PREVALENCE OF OVERWEIGHT, OBESITY AND EXTREME OBESITY AMONG ADULTS: UNITED STATES, TRENDS 1976-80 THROUGH 2005-2006 (2008), http://www.cdc.gov/nchs/data/hestat/overweight/overweight_adult.pdf (sharing results from 2005-06 National Health and Nutrition Examination Survey (NHANES)); *see* Katherine M. Flegal et al., *Prevalence and Trends in Obesity Among US Adults*, *1999-2008*, 303(3) JAMA 235 (2010), http://jama.ama-assn.org/content/303/3/235.full.pdf+html; Cynthia L. Ogden et al., *Prevalence of Overweight and Obesity in the United States*, *1999-2004*, 295 JAMA 1549, Table 4 (2006) (as of 2004, 71% of adults were overweight or obese, evidencing similar trend lines as the NHANES survey); *Defining Overweight and Obesity*, CTR. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/defining.html (last updated June 21, 2010) (a BMI of 25-29.9 is considered overweight; 30+ is considered obese).

[63] Eric A. Finkelstein et al., *Annual Spending Attributable to Obesity: Payer- And Service-Specific Estimates*, 28 HEALTH AFF. w822, w826 and Exhibit 1 (2009).

[64] NAT'L HEART LUNG & BLOOD INST., NAT'L INSTS. OF HEALTH, THE EVIDENCE REPORT: CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS NO. 98-4083 (1998) *available at* http://www.ncbi.nlm.nih.gov/books/n/obesity/pdf/; U.S. DEPT. OF HEALTH & HUMAN SVCS., PREVENTION MAKES COMMON "CENTS" (2003), http://aspe.hhs.gov/health/prevention/prevention.pdf.

spending, or 9.1% of healthcare expenditures,[65] with projected spending in excess of $300 billion by 2018.[66]

This has not gone unnoticed by employers: it has been estimated that obesity costs each large company in the United States (1000+ full-time employees) $285,000/year (medical and absenteeism costs).[67] Another report tallies the costs to employers in the billions, in direct health insurance expenditures but also in indirect costs such as sick leave, absenteeism, and lower worker productivity.[68] With obesity's impact felt by state government coffers around the nation, many are looking for ways to limit this cost outlay. For many years, companies have incentivized covered individuals to lose weight through sponsored health club memberships and other weight loss programs.[69] States are increasingly entering the fray as well, considering sin taxes—taxes on certain foods or drinks, akin to taxes on tobacco and alcohol.[70] Anxiety over cost overruns in an already economically perilous time has some states looking for solutions beyond this approach.

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[65] Finkelstein et al., *supra* note 63, at w828.

[66] Nanci Hellmich, *Rising Obesity Will Cost U.S. Health Care $344 Billion a Year*, USA TODAY, Nov. 17, 2009, http://www.usatoday.com/news/health/weightloss/2009-11-17-future-obesity-costs_N.htm.

[67] Eric Finkelstein et al., *The Costs of Obesity Among Full-Time Employees*, 20 AM. J. HEALTH PROMOTION 45 (2005).

[68] U.S. DEPT. OF HEALTH & HUMAN SVCS., *supra* note 64; J.G. Trogdon et al., *Indirect Costs of Obesity: A Review of the Current Literature*, 9 OBESITY REV. 489 (2008).

[69] U.S. DEPT. OF HEALTH & HUMAN SVCS., *supra* note 64; Larry Hand, *Employer Health Incentives*, HARV. PUB. HEALTH REV., Winter 2009, http://www.hsph.harvard.edu/news/hphr/winter-2009/winter09healthincentives.html; Laura Linnan et al, *Results of the 2004 National Worksite Health Promotion Survey*, 98 AM. J. PUB. HEALTH 1503 (2008). For specific insurer programs, see, e.g., *Fit Choices℠ by Medica*, MEDICA, http://member.medica.com/C9/FitHealth/default.aspx (last visited Apr. 18, 2012); *Rewards*, BLUE CAL., https://www.blueshieldca.com/bsc/hlr/home.jhtml (last visited Apr. 18, 2012). For a discussion of benefits of these programs at the work site, see Ron Z. Goetzel & Ronald J. Ozminkowski, *The Health and Costs Benefits of Work Site Health-Promotion Programs*, 29 ANN. REV. PUB. HEALTH 303 (2008); Alison Harding, *Company Wellness Programs Improve Health, Cut Costs*, CNN (Sept. 1, 2009), http://www.cnn.com/2009/HEALTH/09/01/hcif.healthy.living/. *But cf.* Eric A. Finkelstein et al., *A Longitudinal Study on the Relationship between Weight Loss, Medical Expenditures, and Absenteeism among Overweight Employees in the WAY to Health Study*, 51 J. OCCUP. & ENVTL. MED. 1367 (2009) (limited data to support quick return on investment from weight loss programs, but may be other benefits from programs). For a different corporate approach, see Stephanie Volkoff Green, *Whole Foods to Employees: Lose Weight*, MOTHER JONES (Jan. 28, 2010, 4:30 PM), http://motherjones.com/blue-marble/2010/01/whole-foods-employees-lose-weight (discussing how BMI level, among other things, may impact level of in-store discount employees receive).

[70] Jonathan Gruber, *Taxing Sin to Modify Behavior and Raise Revenue*, EXPERT VOICES, Apr. 2010, http://www.nihcm.org/pdf/ExpertVoices_Gruber_April2010.pdf; Barbara Kiviat, *Tax and Sip. Legislators are Floating Soda Taxes to Raise Revenue and Fight Obesity. But Most of the Time, Their Proposals Fall Flat*, TIME, July 12, 2010, at 51-52.

Recently, Alabama became the first state to impose a surcharge on overweight state workers covered by the state's insurance plan who did not lose weight, choosing a weight-based penalty over a more traditional approach of rewarding desired behavior change (e.g., paying gym membership costs).[71] Starting January 1, 2010, overweight Alabama state workers had one year to try to lose weight or face an additional $25/month surcharge.[72] Building on its current approach with workers who smoke, Alabama hopes new surcharges will incentivize workers to join a weight loss program or take other steps to lose weight. The upshot: the state (hopefully) saves money, has less worker absenteeism, and has workers who (hopefully) lead healthier lives.

North Carolina became the second state to use a surcharge approach, tying financial incentives to its state insurance health plan through a Comprehensive Wellness Initiative.[73] Armed with evidence of high obesity rates in the state and the impact of such on overall healthcare costs,[74] effective July 1, 2011, the default plan for North Carolina state workers is a 70/30 plan; only those workers who do not smoke and have a BMI under 40 or participate in a weight management program (or have a medical exemption) may enter an 80/20 plan.[75] Interestingly, their dependents must also qualify.[76] As of July 1, 2012, the BMI cut-off will lower to 35. The federal government, too, has gotten in on the act, supporting the approach through the recent healthcare reform legislation.[77] This reform includes an exemption that would raise the cap (from 20% to 30%, and possibly 50%) allowing insurers more latitude to set differential rates for enrollees based on behaviors, e.g., maintaining a healthy weight.[78]

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[71] ALA. CODE §§ 36-29-1 to -22 (Westlaw through 2012 legislation).

[72] STATE OF ALA., WELLNESS PREMIUM DISCOUNT PROGRAM (2010), http://www.alseib.org/PDF/SEHIP/SEHIPWellnessPremiumDiscount.pdf; *see also*, ALA. CODE §§ 36-29-1 to -22 (Westlaw through 2012 legislation); *Alabama Workers to Pay for Extra Pounds*, MSNBC.COM (Aug. 21, 2008, 7:36 PM), http://www.msnbc.msn.com/id/26337794/.

[73] *See generally State Health Plan's Wellness Initiative*, MISSION HOSP., http://www.missionhospitals.org/statehealthplanswellnessinitiative. Note this initiative was subsequently repealed in 2011, shortly before the new BMI provisions were to become effective. 2011 N.C. Sess. Laws 2011-85 (S.B. 323).

[74] N.C. INST. OF MED., PREVENTION FOR THE HEALTH OF NORTH CAROLINA: PREVENTION ACTION PLAN (2009).

[75] 2009 N.C. Sess. Laws 2009-16 (S.B. 287).

[76] *Id.*

[77] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

[78] *Id.* at § 2705. For a discussion of this issue, see Mercedes Varasteh Dordeski et al., *An Ounce of Prevention Saves a Pound of Cure: A Summary of PPACA's Wellness and Prevention Reforms*, 6 ABA HEALTH ESOURCE NO. 9 (2010), http://www.americanbar.org/content/newsletter/publications/aba_health_esource_home/Dordeski.html.

While an evolving concept and approach, the evidence to support the use of financial incentives is mixed.[79] There is, however, a body of evidence showing negative effects of stigma on overweight individuals;[80] such negative consequences include psychological impacts, e.g., depression, lower self-esteem, and body dissatisfaction.[81] Of note, chronic stress may in fact exacerbate negative physical effects.[82]

With policy action here, we see two sides of the 'emotion' coin. On the one hand, there exists a socially constructed vision of obesity that places blame on individuals who are seen as lacking personal responsibility[83] versus obese individuals being seen as victims of a social and environmental context that impacts behavior, e.g., a lack of access to healthy foods. Attached to that vision are the emotions of disgust, pity, or anger: "Not only is weight stigma viewed as a beneficial incentive for weight loss, but it is also assumed that the condition of obesity is under personal control, implying that the social influence of weight stigma will be sufficient to produce change."[84] And so the public at large seeks to use stigma and accompanying shame to motivate the desired response, where policy is a tool in this process.

On the other hand, the focus could be on the concerns of individuals affected by these policies, who may need to alter behaviors for health reasons but who may also face genetic and biological—as well as social and environmental—causes creating a much more complex picture than a single policy incentive could address.[85] In fact, studies show that most individuals lose no

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[79] *See* Eric A. Finkelstein et al., *A Pilot Study Testing the Effect of Different Levels of Financial Incentives on Weight Loss Among Overweight Employees*, 49 J. OCCUP. ENVIRON. MED. 981 (2007) (small financial incentives may have some short-term benefits); Robert W. Jeffery et al., *Use of Personal Trainers and Financial Incentives to Increase Exercise in a Behavioral Weight-Loss Program*, 66 J. CONSULTING & CLIN. PSYCHOL. 777 (1998) (combining personal trainers and financial incentives has most benefit but did not improve long-term weight loss); Kevin G. Volpp et al., *Financial Incentive Based Approaches for Weight Loss: A Randomized Trial*, 300 JAMA 2631, 2636 (2008) (positive findings, but use of behavioral economics approach suggests that desired changes may be more difficult to maintain long-term, with a need for more relative cost-effectiveness data for a variety of weight loss approaches).

[80] Rebecca M. Puhl & Kelly D. Brownell, *Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults*, 14 OBESITY 1803 (2006) [hereinafter Puhl 2006]; Rebecca M. Puhl & Chelsea A. Heuer, *The Stigma of Obesity: A Review and Update*, 17 OBESITY 941 (2009) [hereinafter Puhl 2009].

[81] Puhl 2009, *supra* note 80, at 953-54. *See also* Rebecca M. Puhl & Chelsea A. Heuer, *Obesity Stigma: Important Considerations for Public Health*, 100 AM. J. PUB. HEALTH 1019, 1023 (2010) (references omitted) [hereinafter Puhl 2010].

[82] Puhl 2010, *supra* note 81, at 1023.

[83] *Id.* at 1024.

[84] *Id.* at 1020 (references omitted).

[85] *Id*. at 1024 ("[L]arger-scale efforts are needed. To address obesity commensurate to its impact, a coordinated and well-funded response is critical."). Additionally, other authors have

more than 10% of body weight and that gaining back weight is a common phenomenon.[86] In this instance, there are similar emotions as among those challenging obesity—e.g., disgust, pity, and frustration—but now directed inward by targeted individuals. Ironically, but perhaps unsurprisingly, obese individuals faced with such difficult barriers,[87] marginalization,[88] and experiencing such natural emotional responses, react to policy responses that increase stigma in a way that may lead to more disordered eating.[89]

Thus, utilizing emotions in this instance can have many unintended emotional consequences, potentially negating the policy's effectiveness. In public health policy, emotions and behavioral responses are often complex and there is difficulty with maintaining a desired state. The search for an individual cause and singular solution in these cases may fail to accomplish desired goals. Alternatively, these solutions may reach desired goals, but through a process that may cause alarming side effects, e.g., more stigma and depression. Considering this example and those that precede it—where emotion plays a variety of roles in policymaking—is there a way to channel emotions so that they are recognized, respected, and supported in therapeutic ways to enhance policy's effectiveness? This article suggests that TJ may play such a framing role.

IV. USING TJ TO FRAME EMOTION IN POLICYMAKING

A. Utilizing a TJ Framework (Framing Questions)

As noted earlier, TJ offers a new prism through which to view the law wherein we focus on the law's psychological impacts. In this fashion, we are encouraged to enhance therapeutic consequences and mitigate anti-therapeutic ones. This consequentialist vision, and psychological focus, suggest a potential prism through which to view the emotional side of health policymaking—a broader application of law with particular relevance for consideration of how

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provided an interesting discussion of weight bias legislation. *See* Jennifer L. Pomeranz & Lawrence O. Gostin, *Improving Laws and Legal Authorities for Obesity Prevention and Control*, 37 J. L., MED., & ETHICS 52 (2009) (regarding how laws regulating obesity have positive and negative consequences); Jennifer L. Pomeranz et al., *Innovative Legal Approaches to Address Obesity*, 87 MILBANK Q. 185 (2009); Puhl 2009, *supra* note 80.

[86] Puhl 2010, *supra* note 81, at 1021. For a review of weight loss maintenance strategies, see Robert W. Jeffery et al., *Long-Term Maintenance of Weight Loss: Current Status*, 19 HEALTH PSYCHOL. 5 (2000).

[87] For an interesting review of barriers in health, employment, and education settings and within relationships, see Puhl 2009, *supra* note 80.

[88] Jennifer L. Pomeranz, *A Historical Analysis of Public Health Law, the Law, and Stigmatized Social Groups: The Need for Both Obesity and Weight Bias Legislation*, 16 OBESITY S93 (2008) (discussing a history of stigmatization of "socially undesirable groups" via law); Puhl 2010, *supra* note 81.

[89] Puhl 2009, *supra* note 80, at 955-56; Puhl 2006, *supra* note 80, at 1811.

emotions impact, and are impacted by, policy and policymaking. TJ, however, offers more than simply a new perspective. Its partnership with preventive lawyering offers a pragmatic and systematic approach to consideration of consequences proactively and prospectively, with wide stakeholder input and relationship-centered dialogue.[90]

In the law context, we have a process for identifying psycholegal soft spots[91] where legal actors and clients can consider potential psychological ramifications of legal decisions and seek to promote positive, or at least mitigate negative, effects. In moving beyond the individual legal context, how might this apply at a broader policy level? An earlier work suggests a potential framework,[92] rather than a cookbook with specific rules. The proffered framework envisions a question-generating exercise through which to proactively identify "psycho-policy soft spots"[93] in an effort to, on balance, end up with a more therapeutic outcome than not. This earlier conceptual work contemplated the use of TJ to frame a more systematic and proactive consideration of the therapeutic (i.e., health) consequences of health policymaking and health policies (i.e., policy as an intervention[94]). The discussion herein applies the framework (set of framing questions) to a more specific scenario: the role of emotion as having an influence on and as being impacted by policymaking, and emotion's potential role as evidence. Table 1 lays out the general process envisioned, building on earlier work but reformatted to fit the specific purpose herein; emotion-focused areas are highlighted with italics.[95] This article's case examples that dwell on the emotional aspects of policymaking are ripe for application of this framework.

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[90] Stolle et al., *supra* note 11; *Making Law Therapeutic*, *supra* note 4.

[91] David B. Wexler, *Practicing Therapeutic Jurisprudence: Psycholegal Soft Spots and Strategies*, *in* PRACTICING THERAPEUTIC JURISPRUDENCE 45, 48 (Dennis P. Stolle et al. eds., 2000).

[92] Campbell, *supra* note 16, at 289-291 and fig. 1.

[93] *Id.* at 289.

[94] *Id.* at 281.

[95] Applied herein, I use a table format (similar to a rational or evidence-based model) for convenience; recognizing, however, the cyclical and complex nature of the context within which this TJ-informed vision exists.

TABLE 1
TJ FRAMING PROCESS: ADDRESSING THE ROLE OF EMOTIONS IN HEALTH POLICYMAKING[96]

TJ-Informed Question	*Emotional* Consequences Viewed through TJ Prism	Proceed On?
What is the problem?	Define problem. Consider emotional nature of such.	Yes
Is the problem influenced by (or an influence on) emotions *or* is it informed by emotions as *evidence* (focus on stakeholder emotional reactions)?	Stakeholder by stakeholder reactions. (*Note if use of evidence to sway opinion or if emotions = *evidence*)	Yes
Can policy address the problem in psychological health-promoting ways?	Consider if a problem to address by policy.	Yes
What are the therapeutic consequences of policy action?	Consider policy options through therapeutic lens.	Yes
Does policymaking or implementation create psycho-policy soft spots, e.g., what are potential anti-therapeutic consequences? [Gets to: Should policy address problem?]	Consider potential anti-therapeutic consequences of proposed options.	Yes
Do positives sufficiently outweigh negatives (or are so preferred) to justify policy?	Look to values (therapeutic) trying to promote.	Maybe
Can we adequately address anti-therapeutic consequences?	Consider how (*mitigate negative emotions*).	Maybe
Do other values trump therapeutic considerations (so proceed with preferred policy solution notwithstanding therapeutic consequences)?	Look to other critical values (e.g., justice, individual liberty, economics).	Maybe
Action: *Act with policy solution. *Act but tweak policy solution. *Don't act (yet).	State each.	Yes
Evaluation	*For whatever *action* (including no change at this time), evaluate consequences, including psychological ones (e.g., account for anxiety, fear, anger, confusion, satisfaction). See how to channel emotions therapeutically.	Cycle

B. TJ Framing of Case Examples

1. Malpractice Reform

Turning to the first example, recall the emotions raised by the malpractice reform debate in reaction to issues real and perceived. A great many emotions

[96] Adapted from Amy T. Campbell, *Therapeutic Jurisprudence: A Framework for Evidence-Informed Health Care Policymaking*, 33 INT'L J.L. & PSYCH. 281, fig. 1 (2010). Reproduced (with slight amendment) with permission of PERGAMON via Copyright Clearance Center (permission granted Nov. 2011).

are triggered, including: anger at intrusion in the medical sphere of authority and the physician-patient relationship, anger at mistakes, fear about mistakes, anxiety over malpractice suits, frustration with malpractice costs, and frustration with defensive medicine and spiraling costs. These are expected emotions, and at times their arousal is an intended consequence of policymaking. How might a TJ-influenced framework channel these emotions in therapeutic ways?[97]

2. Virginia Tech Shootings

And what of policy-by-tragic-event? Emotions in Virginia understandably first centered on fear, i.e., fear of whom else with access to guns might lurk on school grounds. The fear turned to anger as more facts came to light about the number of contacts the shooter had with mental health authorities.[98] This fear and anger spread to campuses and communities nationwide and was only further inflamed by other events, such as in Binghamton, New York in April 2009;[99] at Ft. Hood, Texas in November 2009;[100] and in Tucson, Arizona in January 2011.[101] Media accounts of violence by persons with mental health disorders further fanned the flames. In this environment, is it any wonder that policies often slant towards the coercive, punitive, or public safety expanding rather than slanting towards promotion of individual liberty or mental health? Less considered are the negative consequences of the resulting policies, and whether they best address the emotional needs of the targeted group and the public at large in an evidence-based way. Virginia's policy response followed a continuum of emotions, which could be considered through a TJ frame.[102]

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[97] *See* Appendix, Table A1 (providing a full framing process). Given the size of the tables and space limitations, the table accompanying this part, as well as the following two parts, may be found in the Appendix. Readers are encouraged to go there for a fuller picture of the process envisioned. Note, however, the tables provide a snapshot of the process for rendering transparent and addressing emotions in health policymaking; they are not intended to provide a full discussion of what such a process would entail.

[98] VIRGINIA TECH REVIEW PANEL, MASS SHOOTINGS AT VIRGINIA TECH: ADDENDUM TO THE REPORT OF THE REVIEW PANEL, 1-5 (2009), http://www.governor.virginia.gov/tempcontent/techPanelReport-docs/FullReport.pdf.

[99] Robert D. McFadden, *Upstate Gunman Kills 13 at Citizenship Class*, N.Y. TIMES, Apr. 4, 2009, at A1, *available at* http://www.nytimes.com/2009/04/04/nyregion/04hostage.html.

[100] *Gunman Kills 12, Wounds 31 at Fort Hood*, MSNBC.COM (Nov. 5, 2009, 10:48 PM), http://www.msnbc.msn.com/id/33678801/ns/us_news-crime_and_courts/.

[101] Shailagh Murray & Sari Horwitz, *Rep. Gabrielle Giffords Shot in Tucson Rampage; Federal Judge Killed*, WASH. POST, Jan. 9, 2011, http://www.washingtonpost.com/wp-dyn/content/article/2011/01/08/AR2011010802422.html. Of note, early discussion of this shooting focused on the negative emotional nature in our political debates. *See* Liz Halloran, *'Vitriol' Cited as Possible Factor in Arizona Tragedy*, NPR (Jan. 8, 2011), http://www.npr.org/2011/01/10/132764367/congresswoman-shot-in-arizona.

[102] *See* Appendix, Table A2 (providing a full framing process).

3. New York State's Vaccine Mandate

Next, consider our public health system and emergency preparedness efforts. When we find ourselves a bit flat-footed in the area of preventive planning, it is not surprising that emotions may drive responses to a seeming pandemic. In NYS, this led to emergency regulation that raised fear, anxiety, and anger much more than it seemed to assure the public of ready availability to safe and adequately staffed health systems. If a TJ frame had been applied during the summer before the emergency regulation came to be, perhaps NYS leaders in partnership with key stakeholders could have fostered the more positive emotions (and results) envisioned.[103]

4. Obesity Regulation by States

And finally, what about when states preemptively act to control costs via behavioral interventions with financial teeth? Do behavioral economics help generate effective regulation? Are the consequences of using behavioral techniques considered for their emotional side effects? It is too early to determine the impact in Alabama and North Carolina, but literature suggests that efforts increasing weight stigma—intentionally or not—may result in psychological and potentially physical harm to individuals. There is a fine line between encouraging healthy behaviors and penalizing individuals for being obese, especially when there may be inadequate resources for obese individuals to effectively change and sustain that change. So what might a policymaker in Alabama or North Carolina add to the evidence collection process in their respective evaluation processes of the policies' effects? Consider potential TJ framing questions.

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[103] *See* Appendix, Table A3 (providing a full framing process).

TABLE 2
OBESITY INSURANCE PLAN SURCHARGES ("FAT TAX") / TJ AND EMOTIONS FRAMEWORK

TJ-Informed Question	*Emotional* Consequences Viewed through TJ Prism	Proceed On?
What is the problem?	*Health and financial costs of obesity -To patients, insurers, employers *Weight stigma, weight bias	Yes
Is the problem influenced by (or an influence on) emotions *or* is it informed by emotions as *evidence* (focus on stakeholder emotional reactions)?	Targeted individuals – Look for evidence of: *Depression, lowered self-esteem; more disordered eating; *Anger at bias against them; anger at intrusion on individual liberties; *Anxiety over own health care issues; anxiety over paying more; and *Frustration at inability to maintain weight goals. State Plans/Policymakers ("PM") – Look for evidence of: *Anxiety at rising health care costs from obese state workers. Public – Look for evidence of: *Anger at people who lack individual responsibility (weight bias); anger if sin taxes applied too broadly (e.g., soda); and *Fear of rising health care costs; fear that state plan surcharge approach will be adopted by all health insurance plans.	Yes
Can policy address the problem in psychological health-promoting ways?	*Decrease anxiety over costs (including to health) via promotion of prevention programs. -Utilize behavioral economics to inform approach. *Decrease anger among public by doing something to address issue (and potentially lessen premiums for healthy workers). *Decrease anxiety of targeted individuals by encouraging weight loss program participation or other interventions. *Decrease targeted individual anxiety if 'carrot' over 'stick' approach, and evidence behind chosen approach (or evidence-gathering process). *Decrease targeted individual anger if include in decision-making process.	Yes

What are the therapeutic consequences of policy action?	1. Additional surcharge if no weight loss: Motivate positive behavioral change among targeted individuals to be healthier; more satisfaction among targeted individuals if lose weight/ enhance health; less anxiety among state plans/PM/public if steps to lower overall plan costs; less anger among public if see individuals take proactive steps to change. 2. Kept in basic plan (higher cost-sharing) if no weight loss/ maintenance: See #1. 3. No plan surcharge but other incentive for weight loss prevention (here, 'status quo'): Decrease targeted individual anxiety and anger because 'carrot' over 'stick'; less anger among targeted, already vulnerable populations (e.g., racial, ethnic minorities); less stigma; more satisfaction among all plan members if program incentives (e.g., gym membership fee reductions) widely available.	Yes
Does policymaking or implementation create psycho-policy soft spots, e.g., what are potential anti-therapeutic consequences?	May, e.g.,: 1. Additional surcharge: Anger (treated differentially when not entirely under individual control; limited data to show if works; stigmatizes); fear (of greater costs; of bias against; of health woes); depression, harm to self-esteem, trigger more disordered eating. 2. Keep in basic plan: See #1. 3. Status quo: Health costs to individuals; anxiety not lessened among public/PM if costs stay high or go up.	Yes
Do positives sufficiently outweigh negatives (or are so preferred) to justify policy?	Values-based decision, e.g., do we emphasize individual behaviors vs. societal issues; do we focus on financial over psychological costs? *How define *harm* and where focus efforts to do no harm? What is the harm in surcharge, on whom/how?	Maybe
Can we adequately address anti-therapeutic consequences?	1. If surcharge: Ensure that phased in and not focus so much on raw weight numbers, but rather on participation in efforts to lose weight; make incentive sufficient but not overly burdensome; track effectiveness (and psychological impacts); tie-in anti-stigma education (and potentially legislation). 2. If keep in basic plan: See #1. 3. If status quo: Track changes and effectiveness; tie-in anti-stigma education (and potentially legislation).	Maybe
Do other values trump therapeutic considerations (so proceed with preferred policy solution notwithstanding therapeutic consequences)?	E.g., *Justice: Is our primary concern allocating limited resources most efficiently and targeting cost centers for change (but can we act in ways that do not unduly stigmatize)? *Justice: Is our primary concern not creating differential plans based on weight (discriminatory/bias) (but can we act in ways that help incentivize healthy behaviors)? *Public health concerns: Are we more concerned about long-term public health ramifications of overweight and obesity, justifying imposing certain costs now in effort to save costs later (but can we balance benefits and burdens of approach fairly)? *Financial concerns: Does economics trump other ethical concerns (but can we acknowledge in a meaningful way the emotions tied to economics)?	Maybe

Action: *Act with policy solution. *Act but tweak policy solution. *Don't act (yet).	*Enact surcharge. *Enact surcharge coupled with sufficient access to healthy options and anti-stigma messaging (or with smaller pool to collect evidence on effects of policy). *Public deliberation first; insufficient evidence on therapeutic (and other) costs of surcharge approach at this time.	Yes
Evaluation	*For whatever *action* (including no change at this time), evaluate consequences, including psychological ones (e.g., account for anxiety, fear, anger, confusion, satisfaction). See how to channel therapeutically.	Cycle

C. Summing Up the TJ Table Exercise

The preceding case examples with accompanying tables illustrate how a TJ-informed framing and questioning process might work. Information contained therein is not meant to be exhaustive, but to provide a model for question-generating and evidence-gathering processes—an approach to better frame the role of emotion in policymaking and systematize consideration of emotional consequences. Ideally such a process would take place before policy development and during policy implementation, but it may also have value post-hoc for policy analysis. Key to this is brainstorming the pros and cons of potential emotional consequences triggered by various alternatives and collecting psychological data on chosen approaches. Only then will the true emotional toll of health policies be uncovered. Positive emotional outcomes are not the only values, but they are *a* value and one worth spotlighting.

V. CONCLUSION

A. Lessons Learned—A New Vision

So where does this leave us? It seems no matter how hard one tries to be rational or evidence-based in health policymaking, emotions come into play. This occurs during the policymaking and policy implementation processes. Too often, however, emotions are either ignored—especially when *counting* costs of policies—or are used to inflame the populace to spur change. The latter is not necessarily a bad thing; yet, such efforts should be made more transparent and measured for their positive and negative therapeutic consequences.

It would seem that TJ, as a framing construct, has a role to play. TJ is inherently focused on therapeutic consequences, especially psychological ones. It encourages legal actors to be mindful of the therapeutic effects of their actions and seeks to—on balance—promote therapeutic over anti-therapeutic ends. At the very least, in parlance familiar to the medical world, legal actors should seek to do no harm (or be clear in defining and mitigating harm).

This article would suggest that this approach has much to offer in an emotion-laden health policymaking endeavor. By using the TJ framework, and having policymakers and all key stakeholders ask the TJ-informed questions to build a TJ-informed evidence base, the role of emotion in the policymaking process can be clarified. The intent is not to develop a new vision for policymaking; rather, it is to reframe what is currently done and to place emphasis on therapeutic consequences and systematically investigate how emotions have an impact on, and are impacted by, the process—both positively and negatively.

B. Next Steps

What is needed now is a fleshing out of how the process would flow in real-time and a visualization of the TJ-framing table approach in a more iterative format. An investigation of international initiatives may assist in such efforts, as TJ-related efforts have blossomed internationally,[104] as have evidence-based policymaking approaches.[105] The tables suggest the sort of questions to ask to generate the necessary evidence. This should be discussed with policymakers to ensure its real-world application and then tested to begin the critical evidence-gathering process. In so doing, one should begin to see that emotions truly do 'count' and force policy actors to increase the transparency of potential emotional consequences, intentional or not.

A TJ framework for health policymaking recognizes that emotions are real and should be transparently acknowledged but also that appeals to emotion without substance or consideration of negative consequences threaten the *health* of our policies. As the evidence base is built, it would be interesting to study emotion's impact on healthcare policymaking and how TJ-framing questions may reframe the process in emotional and other evidentiary (e.g., cost) terms. Ultimately, if we can channel emotions to more constructive ends by bringing them out into the open—if we can listen to emotional concerns and act on, to the extent possible, opportunities to lessen negative emotions—we may arrive at policy that achieves desired goals in a therapeutic, less politicized, and more unifying fashion.

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[104] *See* INT'L NETWORK ON THERAPEUTIC JURISPRUDENCE, http://www.law.arizona.edu/depts/upr-intj/ (last visited Apr. 18, 2012) (highlights international scope, including through a helpful bibliography).

[105] *See generally* sources cited *supra* note 20.

VI. APPENDIX

A. Table A1: Malpractice Reform / TJ and Emotions Framework

TJ-Informed Question	*Emotional* Consequences Viewed through TJ Prism	Proceed On?
What is the problem?	*Malpractice insurance costs (pushing some physicians ("drs") from regions, specialties). *Defensive medicine and increased health care costs. *Patient ("pt") injuries (mistakes, negligence).	Yes
Is the problem influenced by (or an influence on) emotions *or* is it informed by emotions as *evidence* (focus on stakeholder emotional reactions)?	Drs – Look for evidence of: *Anxiety from perceived threat of suit. *Behavior change because of fears. *Anger over intrusion in physician decision-making. Pt – Look for evidence of: *Fear of potential injury and harm; fear of limited access to drs. Pt/Policymaker/Public – Look for evidence of: *Anxiety over rising health care costs.	Yes
Can policy address the problem in psychological health-promoting ways?	*Decrease (perception of) anxiety among drs over lawsuits. *Enhance dr-pt trust. *Confront emotions generated by cost (e.g., defensive medicine) concerns.	Yes
What are the therapeutic consequences of policy action?	1. Cap on awards: Decreased dr anxiety; greater ability to estimate costs (and control); fewer *unnecessary* lawsuits; less defensive medicine. 2. No cap: Ability of patients to get recompense they feel adequately meets needs. Pt satisfaction.	Yes
Does policymaking or implementation create psycho-policy soft spots, e.g., what are potential anti-therapeutic consequences?	May, e.g.,: 1. Cap on awards: Fear (sufficient to cover pt costs from tragic outcomes?). 2. No cap: Anxiety (among drs); fear (among pts, at loss of specialists in some areas); frustration (continued defensive medicine/costs of).	Yes
Do positives sufficiently outweigh negatives (or are so preferred) to justify policy?	Values-based decision, e.g., what weight do we put on dr anxiety and anger vs. how pts feel about system? *How do we define 'harm' of current system and where can we focus efforts to 'do no harm'?	Maybe
Can we adequately address anti-therapeutic consequences?	1. If cap: Cap but allow for process for additional compensation for severe harms. Develop better system to track reasons behind and costs of defensive medicine. 2. If no cap: Alter lawsuit incentive system to rationalize when suits are brought and how.	Maybe
Do other values trump therapeutic considerations (so proceed with preferred policy solution notwithstanding therapeutic consequences)?	E.g., *Economic costs related to caps or no caps. *Justice, e.g., prefer to keep burden with drs over *vulnerable* pts (but could still consider how to make less litigious; allow for more mistake disclosure and healing avoiding dr vs. pt).	Maybe

Action: *Act with policy solution. *Act but tweak policy solution. *Don't act (yet)	*Cap awards. *Cap with appeals process and better data collection. Or propose cap but then public deliberation process to refine. *Public deliberation first; insufficient evidence on costs of action at this time.	Yes
Evaluation	*For whatever *action* (including no change at this time), evaluate consequences, including psychological ones (e.g., account for anxiety, fear, anger, satisfaction). See how to channel emotions therapeutically.	Cycle

B. *Table A2: Guns, Violence, and Mental Health / TJ and Emotions Framework*

TJ-Informed Question	*Emotional* Consequences Viewed through TJ Prism	Proceed On?
What is the problem?	*Violence on campus (and communities). *Access to guns. *Inadequate care (control?) of persons with serious mental illness.	Yes
Is the problem influenced by (or influence on) emotions *or* is it informed by emotions as *evidence* (focus on stakeholder emotional reactions)?	Campus students, faculty, staff – Look for evidence of: *Fear of those with mental health ("MH") issues. *Anger if known 'person of interest' on campus Person with serious mental illness ("PSMI") – Look for evidence of: *Anxiety because may increase stigma on campuses (and perhaps not welcome?). *Anger at loss of own individual liberties (e.g., gun control, coercive commitment). Policymakers/Public – Look for evidence of: *How to protect public safety while being sensitive to individual rights and interests?	Yes
Can policy address the problem in psychological health-promoting ways?	*Decrease fear on campuses through more focus on safety and coercive measures. *Decrease anxiety of PSMI with better access to community resources.	Yes
What are the therapeutic consequences of policy action?	1. Gun control: Less anxiety because feel harder for persons with history of mental illness to get guns; feel more safe with armed campus security and/or if concealed weapons ok (for self). 2. Easier civil commitment: Less fear because feel easier to admit PSMI to MH facilities when concerns of violence; less anxiety among families because feel can get care needed for loved one. 3. MH advance care planning: Less anxiety among public and PSMI where enhanced community-based services head off crises; enhance PSMI sense of self-control if allowed to be part of advance care planning.	Yes

Does policymaking or implementation create psycho-policy soft spots, e.g., what are potential anti-therapeutic consequences?	May, e.g.,: 1. Gun control: Anxiety (if more weapons on campus (e.g., concealed guns, armed security); anger (among PSMI for climate of fear directed at them). 2. Easier civil commitment: Anxiety (among PSMI because more stigma on campus, in communities); anger (among PSMI because perceived loss of liberties). 3. MH advance care planning: Frustration (if feel pendulum swing too far towards rights of PSMI); anger and fear (if feel PSMI decision-making seen as trumping doctor and family role in decision-making).	Yes
Do positives sufficiently outweigh negatives (or are so preferred) to justify policy?	Values-based decision, e.g., what weight do we put on public anxiety vs. fears and concerns of PSMI? *How do we define 'harm' in current climate and with proposed solutions, and where do we focus efforts to 'do no harm'?	Maybe
Can we adequately address anti-therapeutic consequences?	1. If gun control: Make it harder for PSMI and system involvement to have access to guns (but not just for having a diagnosis); control concealed weapons on campuses to limit fears of who has access and when. 2. If easier civil commitment: Alter civil commitment standards with education about how to prevent a crisis and tie in anti-stigma activities around MH issues. Include adequate appeals processes for PSMI voice. 3. If MH advance care planning: Enhance community services while also creating process for PSMI to decide in advance what sorts of treatment would want in future if decompensate; include process where can commit over objection (to lessen family and public anxiety).	Maybe
Do other values trump therapeutic considerations (so proceed with preferred policy solution notwithstanding therapeutic consequences)?	E.g., *Justice, e.g., prefer to look to individual needs and rights of PSMI (but could also use education and wider/deeper dialogue to enhance public understanding to mitigate their concerns).	Maybe
Action: *Act with policy solution. *Act but tweak policy solution. *Don't act (yet)	For MH advance care planning option – *Pass amendments to existing advance care planning law explicitly to address mental health advance planning. *Pass amendments, but also address civil commitment issues within same package of MH reforms to address crisis concerns should they arise (and unplanned for). *Public deliberation first; insufficient evidence on therapeutic (and other) costs of action at this time.	Yes
Evaluation	*For whatever *action* (including no change at this time), evaluate consequences, including psychological ones (e.g., account for anxiety, fear, anger, satisfaction). See how to channel emotions therapeutically.	Cycle

C. *Table A3: NYS Influenza Vaccine Mandate / TJ and Emotions Framework*

TJ-Informed Question	*Emotional* Consequences Viewed through TJ Prism	Proceed On?
What is the problem?	*Potential overwhelming of health care system, including hospitals emergency rooms if H1N1 pandemic. *Potential health care worker ("HCW") absenteeism. *Patient ("pt") well-being.	Yes
Is the problem influenced by (or an influence on) emotions *or* is it informed by emotions as *evidence* (focus on stakeholder emotional reactions)?	HCW – Look for evidence of: *Fear of unsafe vaccine, of losing job if not comply. *Anger at intrusion on individual liberties. Health care institutions – Look for evidence of: *Confusion over what do if not comply. *Anxiety over flood of pts and potential HCW absenteeism. *Fear of union/HCW backlash; fear of pt lawsuits if sickened by staff. Pt/Public – Look for evidence of: *Fear of safety within hospital; fear of vaccine safety. *Anger if inadequate hospital resources to address flood of pts; anger if limited access to vaccine b/c supply used on HCWs. Policymaker – Look for evidence of: *How protect public safety while being sensitive to individual rights and interests?	Yes
Can policy address the problem in psychological health-promoting ways?	*Decrease fear among public with HCW mandate. *Decrease anger among HCWs if voluntary approach (carrots) over mandate (sticks). *Decrease anger with public process of decision-making. *Decrease fear with guarantees of support for any HCWs who are harmed.	Yes
What are the therapeutic consequences of policy action?	1. Mandate: Less anxiety among public because perceive less risk from HCWs; less anxiety among hospital admin of HCW absenteeism; more satisfaction among some HCWs who believe in vaccine. 2. No Mandate: Less fear over vaccine safety (because need not get); less anger because individual decision allowed; less anger among public if more available vaccine supply.	Yes
Does policymaking or implementation create psycho-policy soft spots, e.g., what are potential anti-therapeutic consequences?	May, e.g.,: 1. Mandate: Anger (take away individual liberties; mandate action without adequate attention to potential risks and how will support if harmed; mandate without public debate); fear (of vaccine safety; of losing job). Confusion (if truly are transmission risks). 2. No mandate: Fear (if HCWs not getting vaccine, is it not safe for me (pt)?; will HCW absenteeism negatively impact public health preparedness); anger (put HCW interests before pt best interests).	Yes

Do positives sufficiently outweigh negatives (or are so preferred) to justify policy?	Values-based decision, e.g., what weight do we put on public anxiety and pt well-being versus concerns of HCWs? *How define 'harm' and where focus efforts to 'do no harm'? What is the harm in mandate—to whom/how?	Maybe
Can we adequately address anti-therapeutic consequences?	1. If mandate: Ensure that HCWs will be supported in event of harm from vaccine; involve union leaders in discussions. 2. If no mandate: Focus on education of HCW and public about vaccine and continue safety testing and tracking to build evidence-base for future situations.	Maybe
Do other values trump therapeutic considerations (so proceed with preferred policy solution notwithstanding therapeutic consequences)?	E.g., *Professional autonomy, e.g., place rights of individuals not to receive vaccine above other interests in certain cases (but could also collaborate with HCW unions to promote vaccination). *Public health preparedness, e.g., prefer coercive power of state in pandemic over individual rights argument (but could also consider a public vs. emergency regulation process). *Employer right to impose certain mandates on HCWs, e.g., influenza just another required shot for protection of pt health like any other (but could also use education to explain vaccine safety and mitigate fears).	Maybe
Action: *Act with policy solution. *Act but tweak policy solution. *Don't act (yet).	 *Mandate. *Mandate, but set aside resources for HCW support if harmed; more education. *Public deliberation first; insufficient evidence on therapeutic (and other) costs of mandatory action at this time.	Yes
Evaluation	*For whatever *action* (including no change at this time), evaluate consequences, including psychological ones (e.g., account for anxiety, fear, anger, satisfaction). See how to channel emotions therapeutically.	Cycle