To:
Representative Kelly Keisling (rep.kelly.keisling@capitol.tn.gov)
Senator Todd Gardenhire (sen.todd.gardenhire@capitol.tn.gov)
District Attorney General Lisa S Zavogiannis, District 31(Lszavogiannis@tndagc.org)
District Attorney General Matthew F Stowe, District 24 (mfstowe@tndagc.org)
From:
Sean P. Smith (TheLastQuery@gmail.com), Bartlett TN, 38135
Date: 8.19.20

A Medically Disabled Adults Perspective on Some Needed Amendments to Tennessee Code:

Hello,

I am directing this letter primarily to Rep. Kelly Keisling. However, I was advised that it would be wise to direct it to others who might wish to become involved. Due to their involvement in the Elderly and Vulnerable Adult Protection Act of 2019, I have sent a copy to Sen. Todd Gardenhire, DAG Lisa Zavogiannis, and DAG Mathew Stowe.

As a medically disabled adult attempting to meet my basic needs I have encountered many problems which have placed my health, safety, and well-being in jeopardy. I believe legislation has a significant role to play as part of solving many of these problems. In this email and in my letter of proposed amendments I do not intend to be comprehensive in my disclosures regarding the problems I have encountered nor in my recommendations regarding proposed legislation. I intend to provide some basic information on who I am, why I have reached out, and the rationale for amending some Tennessee statutes.

In the State of Tennessee I have encountered a wide-spread societal neglect of the rights of vulnerable adults, particularly those with disabilities, and heard similar accounts from persons in other States indicating the problem is not isolated. I have experienced discrimination, neglect, exploitation, and abuse. I have been subjected to the illegal activities of others for a number of years and the impact this has had on my life is substantial. I eventually learned that I had ‘rights’ and was considered a protected class of individual. Having been made aware of this I began reading the many State and Federal laws pertinent to my circumstances. It is then that I began to comprehend the full scope of what I was encountering. A great deal of my time has been spent on tasks I never should have had to perform; tasks completed at the expense of seeking and receiving needed medical assistance to treat my medical disabilities.

It has been disturbing to understand that I have rights and that not only were those rights violated, but that I can expect those rights to continue to be trampled upon despite my very vocal protestations and requests for assistance.

In example, I attended the TennCare Block Grant Public Meetings occurring in 2019 at Jackson and Memphis. I spoke at each meeting and submitted my talk in writing, disclosing many of the problems I and other vulnerable persons are confronted with and the grand fraud being committed against taxpayers. I touched upon how the problems I described exist largely because of the illegal activities of many persons and organizations throughout Tennessee, the inaction of regulators, and the general complacency society has to these matters. I very specifically criticized the policies of TennCare and it's Managed Care Organization's and admonished them for their misconduct. TennCare has proved unreceptive to my message. Neither did news outlets show interest nor the state representatives who attended and spoke. Limited interest was there among some medical professionals and disabled persons who spoke. But I gather that they, like I, are too consumed by our problems to directly take upon another's. It was, however, reassuring to see I was not at all alone in my observations.

With better laws I hope that the enforcement of violations might be possible and it will no longer be perceived as permissible to disregard our grievances whether they are voiced privately or publicly. It is my hope that one day vulnerable adults in the State of Tennessee will, truly, have rights; have "equal protection of the laws". That day is not today.

Of particular interest in my studies of the law have been understanding T.C.A. Title 71 Chapter 6 and related statutes. Recently I performed a limited investigation regarding in which direction this type of legislation has headed and who has been involved. In understanding that I formed the belief that future legislation can benefit from my input and even direct involvement.

Afterall, I have lived through things that few encounter, fewer still survive, and even less find themselves able to describe while trying to survive or having survived. I continue to be subjected to the illegal activities of others and I learn new lessons day-by-day. I would hope the lessons I have learned will allow me to provide insights which are otherwise difficult to acquire. I hope my suffering can be made into something useful, even an instrument of Justice.

I am forced to admit, however, that the collective weight of the abuses I've suffered greatly impairs my ability to function cognitively, emotionally, and physically. I am less able than I was not but a year ago. The person who attended the TennCare Block Grants no longer exists, having been destroyed due to the continued misconduct I was and am subjected to. What I am able to provide to myself and others is impaired by my impairments.

I think the violations of the rights of vulnerable persons is a story that is largely unacknowledged in public and in court. I think more lies than truth get told on this matter. I could not tell my story of being subjected to rights violations until I understood my rights. I could not advocate how what was occurring to me was wrong, was illegal, until I knew the law well enough to stand adamantly against persons who readily seek to dismiss my complaints.

Given my disabilities and impairments it was very difficult to become aware that I should apply myself to study the law. After all of my studies and experiences I now understand that the extent to which violations are occurring surpasses what most legal professionals and legislators seem aware of it. Most people I communicate matters to flatly refuse to believe things are as I describe them to be. Ironically, it is this doubting which is part of why things are as bad as they are. There is a terrible rot in the State of Tennessee undermining the rights of vulnerable adults.

My Observations and Ideas for Amending Tennessee Code to better protect vulnerable adults are attached to this email as, "Sean Smith's Proposed T.C.A. Amendments for Vulnerable Adults.pdf". The contents of this email will also be attached as a pdf file.

Please reply to this email acknowledging receipt of it's contents.

Sincerely,
Sean Smith

To:
Representative Kelly Keisling (rep.kelly.keisling@capitol.tn.gov)
Senator Todd Gardenhire (sen.todd.gardenhire@capitol.tn.gov)
District Attorney General Lisa S Zavogiannis, District 31(Lszavogiannis@tndagc.org)
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From:
Sean P. Smith (TheLastQuery@gmail.com)
Bartlett TN, 38135
Date: 8.19.20

Sean Smith's Proposed T.C.A. Amendments for Vulnerable Adults:

Contents:

The following are some observations and ideas I had while reviewing HB909's legislation and the proceedings taking place during its enactment:

(1) The need to revise the definition of "Serious Psychological Injury" alongside enacting more comprehensive protections.

T.C.A. § 39-15-501(12):
(12) "Serious psychological injury" means any mental harm that would normally require extended medical treatment, including hospitalization or institutionalization, or mental harm involving any degree of prolonged incapacity;

Section 2 of HB909, which amended T.C.A. § 39-15-501, defines "Abuse" as being "the infliction of physical harm", whereas T.C.A. § 71-6-102(1) defines abuse or neglect as being "the infliction of physical pain, injury, or mental anguish". An amendment to section 2 was later added to include "serious psychological injury". While at first glance it seems logical to define these things separately, this change has unintended consequences and seems unfavorably divergent from that premised in T.C.A. § 71-6-102.

Pursuant to T.C.A. § 39-15-510 abuse of an elderly or vulnerable adult would not, per the reading of the law, include psychological injury, nor would it seem to include “mental anguish” nor the more broadly asserted “injury” which can be inferred to mean both physical and psychological injuries. This means that an offense would have to be considered Aggravated Abuse pursuant to T.C.A. § 39-15-511 in order for there to be grounds to bring formal criminal charges. That then makes it harder for a vulnerable adult to be protected from psychological abuse. Given the severity of the penalties in T.C.A. § 39-15-511 it would be difficult to bring any charges against a person or facility for anything but the most egregious and clear offenses. In addition, having such severe penalties also incentivizes a person or a facility to double-down on further misconduct in an attempt to avoid getting ‘caught’. In short, these laws seem suited to dealing with only the absolute worst type of offenses, and all lesser stages of offense would be ignored - nay, one could even say that pursuant to the law lesser offenses could be interpreted as permitted.

If we compared this matter to physical abuse, it would not be a crime to physically abuse someone unless one is caused injury such that a doctor will acknowledge the person requires substantial medical intervention. Which, would mean, one could close a person's nostrils, cover their mouth, and laugh as the vulnerable person's eyes are full of panic and terror as their nervous system screams at them to breathe. They could repeat this, over and over. Pursuant to the law vulernable adults could be tortured, so long as that torture doesn’t then necessitate that the subject of it requires substantive medical intervention or experiences prolonged incapacitation. If one makes certain that oxygen saturation does not reduce to levels at which medicaid/medicare guidelines acknowledge treatment is covered, then physicians would have no cause to acknowledge any need for treatment, let alone would they supply treatment. Just to be clear, this type of torture actually does occur - this is not hypothetical, although the exact context of it’s occurrence is quite different.

One might contest my analogy saying “torture is torture and the law does not allow it”. But vulnerable persons are vulnerable and as such a vulnerable person I can tell the reader with certitude that people don’t do much about the harms we suffer. One of the reasons that they don’t is because the laws make it difficult for them to understand that disabled adults have rights and these should be respected. When the law is unclear or difficult to study and understand people are less inclined to believe an offense of that law has occurred. And when people do not believe an offense has occurred, they tend to act such that the law is not enforced, and as a result the law then affords little to no protection.

As currently worded, the laws protecting vulnerable adults will require that an elderly or vulnerable person will have to get hurt so badly that they are substantially damaged before anyone is ‘required’ or incentivized by threat of enforcement of the law to intervene and provide protections. By then there is not much to protect from, as the damage will have been done. The damage a vulnerable adult sustains is unlikely to be treated appropriately because, again as a vulnerable adult, I can attest that the care made available to us is often quite deficit and does not seek to truly meet one's needs. Oftentimes, those supplying care do not even comprehend the real needs of the person nor do they seek to comprehend. They merely supply what they think ought to occur, or which ‘insurance will cover’, sometimes then causing more damage than if they had provided no assistance whatsoever.

Additionally, it is already difficult to ‘prove’ mental anguish and psychological injury in court. Assuming one can even find an attorney willing to try. And furthermore, the definition of “serious psychological injury” leaves much to be desired. Whereas “Mental Anguish” as specified in T.C.A. § 71-6-102(1) leaves the matter more open to the court to interpret.

The wording of the definition of “Serious Psychological Injury” in T.C.A. § 39-15-501(12) is not wholly respectful of the medical science regarding at what point psychological insults cause neurobiological damage or unfavorable changes in a persons health and well-being.

There can be significant physical detriment occurring from psychological injury, as the works of Stanford professor of biology, neurology, and neurological sciences Robert Sapolsky has attested to for many years. In effect, the psychological injury becomes a physical injury. And those injuries can be expected to go unacknowledged by a great many physicians.

Recognizing such injuries to have occurred can require that one is quite studied in these matters while also being exceptionally attentive to the patients overall health status. Many clinicians do not possess such specialized knowledge and even were they to possess that knowledge the clinical practice of medicine for doctors in-network to medicaid/medicare does not afford them much of any opportunity to apply that knowledge. Sometimes, in fact, coverage policy fully disallows it. Some very interesting things can be observed regarding the mental health parity laws and how coverage policies prevent people from receiving the care that they really need.

Of those physicians that do possess sufficient knowledge and would exert the attention required to apply it, quite often an elderly or vulnerable adult will find they do not have access to these physicians. A dysfunctional health system and the vulnerable persons indigence and/or incapacity - and more broadly the almost total reliance upon the wims of third party payers such as medical insurers - stands as a barrier between vulnerable adults receiving Justice against, and safety from, offenders.

Neither does this definition of “Serious Psychological Injury” respect at what point psychological injury has an unfavorable impact upon “the pursuit of happiness” or the exercise of one’s “Liberty”. Moreover, many vulnerable adults are already so incapicated that they are medically disabled; they have already been experiencing psychological injury such that it has been causing them to experience “prolonged incapacity”.

Some of those medical disabilities undermine a person’s ability to exercise their independence in any meaningful way. I believe that permitting such individuals to be subjected to psychological abuses such that it may undermine what capacity they yet retain to pursue happiness and exercise their Liberty is ethically problematic and legally not in standing with the intent of the legislation protecting the elderly and vulnerable adults, nor of the U.S. or TN Constitution, or the Declaration of Independence.

Furthermore, people with disabilities are often already experiencing intense psychological struggles. Some are disabled by those psychological or psychiatric struggles. If someone disabled by a psychiatric condition is psychologically abused, how can you tell it was abuse that caused them to need “extended treatment” when treatment has been ongoing the majority of their life? How can you tell abuse caused incapacitation when they were already incapacitated? I believe the truth of the matter is that the effort required to figure out the difference does not get expended.

Indeed, of those vulnerable persons who are medically disabled I would say those with psychiatric disability are amongst the most exploited and preyed upon. They experience some of the worst discrimination and are regularly subjected to extreme prejudice. Even the field of psychiatry perpetuates that prejudice, such that treating facilities and many clinicians are not trustworthy and will either knowingly or unknowingly act against their patients best interests. Thereby there are inherent problems with relying upon the notion that psychological injury is only serious if validated by mental health clinicians as something that they can treat.

How can we protect vulnerable persons from this? I believe such questions require thoughtful contemplation while working on future legislation. It may also require involving persons who have lived through those abuses to offer their opinions. I have had to learn the hard and slow way that few professionals in the field of mental health are truly attending to the needs of their patients. Understanding the cause of a patient's distress is rarely a priority.

The current mental health system does not actively seek to determine why a person has symptoms, but will instead play a game of talk therapy and chemical-roulette year after year after year while the patient experiences a lifetime of suffering and disability. For vulnerable adults, it is a process largely funded by taxpayers. The social and economic impact on communities is significant. This suffering can be curtailed if one but seeks to determine the cause of those symptoms.

In short, the clinical practice of psychiatry as it is typically applied aims to alter the function of the central nervous system such that a person is made more ‘comfortable’ with the insults that cause them to experience distress, develop symptoms, and to be disabled.

Put in a way that is more direct: If someone with a psychiatric condition becomes exceedingly upset due to having their rights violated, medical professionals will predominantly ignore the legal side of it and merely insist the person needs medication and/or talk therapy. Even to the point of seeking to involuntarily commit them when there is no legal basis to do so.

I know because I’ve had that occur to me on a repeated basis, and so have other patients I have spoken with, and accounts of such illegal activity can be found in places as public as the Google and Yelp Reviews of treating facilities. Yet illegal involuntary commitment is but one of many offenses occurring and being ignored.

While having been illegally detained and presented to a psychiatric facility for evaluation I was witness to abuses perpetrated against one woman who was in a state of acute psychosis. The woman remained relatively calm while babbling out loud in apparent response to either hallucinations or merely an internal dialogue. She would occasionally grow agitated and then settle down. The healthcare worker that was present to monitor patients - those patients consisting only of myself and the woman - would try to verbally engage with her. His amicable attempts to interact with her would only provoke further agitation in the woman. Between the women’s ravings, particularly her comments about how “men can’t be trusted”, it seemed quite likely she had been traumatized by a large adult male in the past. The male staff member seemed to recognize this, and left her to herself, instead electing to hold a conversation with me.

There was a shift change and with it came a different healthcare worker acting in the role of a monitor. This man was larger in his bodily frame and stature and of the same race as the women and he did repeatedly provoke the woman and escalate her state of psychological distress. He made demands of this woman to be quiet and calm while simultaneously acting to provoke her. I tried to communicate what I had observed regarding the woman's past behaviors to this healthcare worker; that if left alone she would settle down and her ramblings presented no burden to myself, still yet having been the only other person in the room. My input was ignored.

The man got one of his co-workers to assist him in forcibly restraining the women and then injecting her with a powerful sedative. After which I then witnessed the woman drowse off to sleep in an upright position, her body slumping upon itself, her breathing stopping during her sleep multiple times within a five minute period of time. This indicated to me that this women had severe obstructive sleep apnea.

Which by her facial anatomy, obesity, and apparent mental health issues was to be expected even prior to making any direct observations of a cessation of breathing during sleep. Facial anatomy alone is able to predict Obstructive Sleep Apnea with 91% accuracy per the published medical literature. Sleep and Mood have long been understood to be intertwined. Dr. Matthew Walker, a PhD sleep scientist and psychiatric specialist, refers to good sleep as “mental health first-aid”.

Not only was such first-aid deprived to this women on a regular basis by her unmet - and likely undiagnosed - medical conditions, but the treating facility acted to cause her even further deprivation of this most basic of interventions which facilitate one’s physical and mental health: a good night’s rest. Sedatives and other sleep medications are known to impair the patency of the airway both by how they alter the tone of the muscles and soft tissues of the airway and how they inhibit the autonomic nervous systems ability to control the airway.

That is our mental health system. I made no exaggeration when I asserted there is a terrible rot in Tennessee. The above example is inconsequential compared to other matters. It barely merits observance. Tiny. Small. It would be unimportant if not that it was so clearly wrong.

The way people in these circumstances are treated is akin to having someone walk into a room and see someone being physically tortured screaming “kill me now” and suggesting that they shouldn’t be so loud and just need some pills and talk therapy. It’s absurd what is occurring. And part of why this is allowed to occur is because these individuals are not being protected. And worse, facilities and physicians are being monetarily reimbursed for operating in this manner. In fact, the current reimbursement models encourage this type of misconduct; these actions that per the scientific literature and laws can be asserted as abuse and neglect, but due to such affronts being common in clinical practice they are somehow rationalized as being okay.

When I describe the harm I and others are subjected to and highlight how illegal this is, people most often refuse to believe my account and refuse to invest their energy in investigation. The type of retort I usually hear is that if what I was saying was true somebody would help me; somebody would defend me. What ends up happening is that there are countless people all claiming that same premise - if it was really wrong, then someone would do something about it. That somebody is them and all the others I described the matter to. And it is that rationalization and refusal to act which is what allows the misconduct to continue unabated. It is by their omission to act that they provide their consent, or to use the words of Dr. Martin Luther King Jr. “To ignore evil is to become accomplice to it.”

I believe Stanely Milgram's famous experiments at Yale in the 1960s provides an ample framework to understand the societal neglect that I describe. Milgrim's experiment demonstrated how common it is for people to disbelieve the objective evidences presented to them which did indicate their actions would cause or are causing harm so long as what they perceived as being an authority did absolve them of their perceived responsibility. Similarly, people will engage in disbelief that their actions or inaction leads to harm so long as they receive assurances this is okay by sources of information that they consider authoritative.

Do not believe the patients report of harm if the Doctor asserts such harm did not occur. Do not believe a person is the victim of a crime if an Officer of the Court asserts no such crime occurred. Do not believe the referenced materials and evidence if an 'expert' claims they are invalid. People allow such beliefs to form and rule them and dictate their ethics and morals, and quite often do so while claiming possession of "The Truth". So much harm occurs from this common behavior.

I reached out to the Memphis chapter of the National Alliance on Mental Illness and inquired what they were doing to try to hold treating facilities responsible for violating the rights of the vulnerable individuals presented to these facilities. They are doing nothing. They do not pay attention to it. Indeed, to me, they seemed almost oblivious to things like this occurring.

I made similar inquiries to Adult Protective Services, asking that when disabled adults are being psychologically tortured by others what do they do? I was told, "We do not investigate".

As far as I can tell, no one has championed trying to make organizations acting as caregivers compliant with existing laws; in fact, those laws are often weaponized against these vulnerable individuals.

I believe if the Certificates of Need for involuntary commitment which are submitted to courts underwent extensive scrutiny, such scrutiny as a person like I would exercise, one would find a fraud is being committed upon the courts of Tennessee by treating facilities, and thereby the TennCare program. I would in fact expect many forms of fraud are being committed across multiple agencies receiving federal funding. If one of the District Attorney Generals wishes to follow through and investigate this matter, I insist that they apprise me of such so that I may be involved in the matter as a Whistleblower under the False Claims Act.

(2) Proposed Changes to the definition of "Caregiver" within T.C.A. § 39-15-501(4), AND, "Caretaker" in T.C.A. § 71-6-501(5)

I believe that the persons who are legally defined as caregivers/caretakers requires some revision. Many people and groups are excluded by the current definition, even though they hold positions of stewardship in which they act in a capacity which is or is similar to those definitions already provided within Title 71 Chapter 6 Part 5. This has led to much abuse and suffering of both vulnerable adults and those caregivers who act in good faith. I believe expanding the definition of caregiver is warranted to curtail that misconduct. However, I recognize that expanding the definition as I believe it needs to be expanded would provoke much discussion and debate. In the interim, and as a starting point, I believe there is a simple and easy solution to improve the protections afforded to vulnerable adults.

Proposed changes to T.C.A. § 71-6-501(5)(C):
From:

> C) Does not mean a financial institution as a caretaker of funds or other assets unless such financial institution has entered into an agreement to act as a trustee of such property or has been appointed by a court of competent jurisdiction to act as a trustee with regard to the property of the adult;

To:

> C) Does not mean **an** institution as a caretaker of funds or other assets unless such institution has entered into an agreement to act as a trustee of such property or has been appointed by a court of competent jurisdiction to act as a trustee with regard to the property of the adult;

Propose Changes to T.C.A. § 39-15-501(4)(B)
From:

> (4) “Caregiver”:
>
> > (B) Does not include a financial institution as a caregiver of property, funds, or other assets unless the financial institution has entered into an agreement, or has been appointed by a court of competent jurisdiction, to act as a trustee with regard to the property of the adult;

To:

> (4) “Caregiver”:
>
> > (B) Does not include **an** institution as a caregiver of property, funds, or other assets unless the institution has entered into an agreement, or has been appointed by a court of competent jurisdiction, to act as a trustee with regard to the property of the adult;

(3) What is “effective consent” and can vulnerable persons provide it while under the duress of unmet physical and psychological needs?

HB909 made the following amendment which is in bold:
“SECTION 3. Tennessee Code Annotated, Section 39-15-501(6)(C),is amended by deleting the subdivision and substituting instead the following: The act of obtaining or exercising control over an elderly or vulnerable adult's property, **without receiving the elderly or vulnerable adult's effective consent**, by a caregiver committed with the intent to benefit the caregiver or other third party;”

Many vulnerable adults and elderly individuals are cognitively or emotionally impaired and some may be developmentally impaired. They may thereby possess a limited ability to provide effective consent which is informed. Indeed, these individuals have been known to give consent in matters that they did not fully understand. This is one of the reasons these individuals need protection; they can be more easily taken advantage of.

Consider as an example a vulnerable adult who has been medically disabled by Major Depressive Disorder (MDD) nearly their entire life. Such a person is presented with a contract or agreement to sign by a caregiver or by an institution which should be considered as a caregiver despite the law currently making it difficult to define them as such.

Due to long-standing and severe depression their fear of mortality is muted and this person is less motivated to review the contract or agreement and thereby fully understand what one is agreeing to in an effort to avoid being taken advantage of. And even if this person were to attempt to exercise prudence and review the information presented before them and then seek out what information may have been withheld or required to understand that which was presented before them, their ability to do so would be impaired by their depression and likely also comorbid medical conditions. A person so impaired would be disposed to making mistakes or could altogether fail to understand the information one was attempting to review.

In addition, one of the things that occurs in depression and severe mental illness is it becomes difficult to fully appreciate long-term consequences. This often being so because one's present circumstances are often so terrible that what occurs at a later date seems unimportant, or it is merely accepted that the future can be expected to be as terrible as the present and thereby 'so what if it I get taken advantage of; terrible is terrible; the sum will be the same'. In short, this person may rationalize that the need to perform risk-assessment of the agreement's terms is unwarranted, when, in fact, it is quite warranted.

Consider also another form of psychiatric illness: Bipolar Disorder. While experiencing a manic or hypomanic episode, people with Bipolar Disorder are known to make unsound decisions. Indeed, part of the diagnosis of hypomania is to note such unsound decision-making to have been present. One could conspire to subject such a person to conditions that are likely to provoke mood instability or further aggravate an already ongoing mood episode. When so provoked they may then present that person with agreements requiring their effective consent.

Also keep in mind that while the nature of Bipolar Disorders is often perceived as being hallmarked by Highs and Lows in mood, a cycle between extremes, the reality is that people can present with very different symptoms and those symptoms may be rather homogenous. Some persons spend very little time with hypomania, and are predominantly experiencing depression. As such, a person experiencing MDD experiences impairments both cognitively and emotionally which will be similar to those of some persons with Bipolar Disorder. A person may in fact have both diagnoses. Such people may provide 'consent' to an agreement because, 'you know, whatever', 'nothing matters', 'better off dead', 'what have I got to lose', etc, etc.

Subsequent to providing one's 'consent' the restrictions or limitations posited by the agreement one entered into may cause one's circumstances to become more difficult. One who is already substantially burdened is now further burdened and can be pushed past their capacity to cope. As a result one experiences psychological injury, but that injury doesn't appear to require 'treatment' because the person has already been receiving treatment for refractory medical conditions; conditions so refractory they have been disabled by them their entire life. The tendency to attribute a psychological injury as being merely part of the pathology of a pre-existing psychiatric disorder is, I should add, a primary mechanism by which misconduct and psychological abuses are able to occur and offenders are not penalized.

Is what happened abuse? Whose fault is it that the vulnerable person has been injured? Did this person provide their “effective consent” to be subjected to conditions which can be understood to cause injury to them? Who is the responsibility party?

What I have found is that society likes to burden disabled adults with things that it is absurd to ask these vulnerable persons to deal with given that what they are already dealing with has disabled them. Society often requires the cripples to fix a problem that the able-bodied people find ‘too hard’ to attend to.

I believe the previous wording of T.C.A. § 39-15-501 acknowledged these matters by not providing this exemption of “effective consent”. With the wording as it currently is in 2020, a carefully worded and protective definition of what is considered “effective consent” would need to be added. And as my criticism of the definition of “psychological injury” illustrated, this could prove difficult to accomplish. I believe it would be better to remove this exemption regarding “effective consent” until more comprehensive legislative efforts can be performed such that the enacted law would not disadvantage vulnerable adults.

It should be noted that “effective consent” bears similarities to the definition of “capacity to consent” found in T.C.A. § 71-6-101(4). However, I observe the issues I raise remain largely unacknowledged by either T.C.A. Title 71 Chapter 6 or Title 39 Chapter 15.

What I would like to see is that “effective consent” must revolve around the idea that the Vulnerable Adult is verified to have their basic needs met. That they are not under any form of undue duress that compromises their decision-making. That their health and well-being is not undermined by the misconduct of others, or circumstances beyond the vulnerable adults control. That they are in a state of being which will allow them to make informed decisions, and are made aware of the consequences of their consent in a manner that they can be expected to understand.

I believe it is necessary to explicitly define matters. I would remind the reader of past history with regard to our court systems misinterpreting the intent of legislation and causing harm to vulnerable persons. Senator Tom Harkin was instrumental in the passage of the Americans With Disabilities Act of 1990 (ADA). However, despite the clear intent of the legislation, what occurred in the courts “severely limited the scope of the legislation’s effectiveness”[1]. “The more successful a person is at coping with a disability, the more likely it is for a court to find that he or she is no longer sufficiently disabled to be protected by the ADA”[1]. This prompted Sen. Harkin and others to amend the ADA in 2008 in order to “restore the proper balance and application of the ADA by clarifying and broadening the definition of disability, while increasing eligibility for ADA protections."[1].

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[1] .https://en.wikipedia.org/wiki/Tom_Harkin

(4) Expanding the definition of “Confinement” to include circumstances that cause a vulnerable adult to be forced into seclusion or otherwise deprived of autonomy and socialization.

“Confinement” as defined by TCA § 39-15-501(5) is limited to the concept of physical restriction of movement. It does not deal with what happens when vulnerable adults who have been subjected to repeated neglect and abuse are so overwhelmed with trying to defend themselves that they become socially isolated and experience physical and mental deterioration that then limits their ability to participate in their “living area”.

I note that it is well-known that when attacking another person one should seek to limit the ability of the other to respond in either defense or offense. I propose that the misconduct of some institutions and persons illustrates that they apply this principle knowing that it causes a type of confinement. As one’s ability to function, to interact with their environment, is being constrained by the actions of another and the outcome of this is that the subject is then confined to conditions which limit their autonomy, this then limiting the subject’s capacity to respond in either defense or offense.

I would suggest that one’s environment is one’s “living area” and that area of living most directly includes one’s community, even though I would expect any court to interpret “living area” as it is used in T.C.A. § 39-15-501(5) to mean that of one’s place of residence. However, I contest such a limited view because I note that in both the fields of psychology and medicine one will find substantial evidence in support of the notion that one’s area of living is their community.

One can look to studies of human longevity and note the observations made regarding the importance of strong social bonds to one’s health and well-being. One can also examine psychology’s various theories regarding Universal Human Needs and will find social relationships to be among those needs. The Covid-19 pandemic which has occurred throughout 2020 has led to restrictions on social gatherings and undermined our economic well-being. An economy occurs secondary to human interactions, and economics is noted to be a social science studying those interactions. I find the subsequent rise in mental health struggles as part of Covid’s disruptions to our social interactions attests to these matters.

Humanity’s origins, our histories of civilizations, and our observations of our immediate society make it clear that human beings function as a group and depend upon one another for our safety and well-being. We are social organisms and fair poorly when prevented from forming and maintaining social relationships. This being so irrespective of how sociable an individual appears to be or not to be.

When the misconduct of others requires a person to form a defense of their person which is so demanding of one’s time and energies that it confines one to social seclusion, I believe there should be consequences to the offenders. I believe expanding the definition of confinement can achieve this. This topic is particularly applicable to what has happened to myself. It’s very much a part of why I’ve written this letter.

I have become increasingly secluded while engaged in my efforts to find a way to survive and my mental health, particularly my cognitive ability, has been adversely affected because of this. In addition to which the toll of sitting at a computer nearly all day aggravates my musculoskeletal disorder, chronic pain, mood disorder, and other medical conditions which contribute to and cause my medical disability.

I have made an effort to force myself to go on walks as part of managing the damage this does to me. Even when my disabilities are so impairing that I find ambulation a struggle; on those days my body tells my brain it just wants to curl into a ball on the floor. And to be honest, some days I have had to.

On my walks I used to see people, say hi, sometimes have a conversation, even get exposed to new ideas and useful information from time to time. I even regularly walked with a group of people who conglomerated with their dogs for conversation and company.

As the misconduct of others continued to demand more and more of my time, I had less time to try to do things that helped take care of myself, including my walks. I had been so absent that the group of persons I walked with had worried that something had happened to me. They're good people. They even took the time to get together, sign a Christmas card, and drop it by my house in-person as part of trying to check that I was okay. I wasn't present to receive that card as I was away from my home on errands directly or indirectly related to responding to the misconduct of others that grips my life.

One of these people that I had walked beside for years grew suddenly ill, got diagnosed with late-stage cancer, and then died not long after. I only learned of this having occurred much later. I felt robbed that the time I was able to spend with this person had been limited because of the misconduct I was being subjected to, and thereby, my capacity to better know him was similarly constrained. My circumstances even prevented me from being made aware of the memorial service. The last form of interaction I had with this person is that Christmas card. Yet, this is but one of the many things I have had to endure. It is just that this event was momentous, making it very clear to me that I am being robbed of living life; what is happening to me is very wrong; it is unacceptable.

The misconduct of others over the last six years has led to a continual decline of my physical and mental health. For the past two years responding to this has confined me to my room and my computer and to studying law and medicine in an effort to find a way to defend myself and survive. Before I had discovered and developed ways to self-manage my medical conditions I had been incapacitated by pain and dysfunction. Doctors were unhelpful, even making matters worse. I had to figure my way out of that incapacity largely by myself while nearly bed bound with little more than my phone, my mind, and the internet - thankfully other patients and some physicians were making helpful educational resources available online.

While I managed to improve my situation significantly, I have continued to experience complications that have further limited my ability to function, and thus demanded that more of my time be expended in managing my conditions so as to help me function well enough that I can defend myself from the misconduct of others. It is a scenario of diminishing returns and increasing impairment. It is a difficult task to attend to and to some extent arguably impossible to succeed in. It is a situation that has, for years, caused me to entertain that my premature death or suicide is an inevitability.

One way that I compensate for my deficits is by creating my own assistive devices. The time invested in creating those assistive devices ironically further limits my ability to attend to my own health and well-being. In example, due to my cognitive deficits I began making “To Do” lists. Which are somewhat helpful, but have become so voluminous that they’re more of a historical record of the things I managed to recognize that I should attend to, rather than a list that facilitates my productivity. I wonder what one is ‘to do’ with a “To Do” list that is over 20 pages long and only grows longer despite one’s best efforts?

The most social engagement I get on a regular basis is at doctors appointments, interacting with staff at grocery stores, or on those rare days I can go for a walk around the neighborhood and someone says “hi”.

Quite often though, interactions with healthcare professionals can lead to confrontation, as the clinical practice of medicine has conformed to accommodate the misconduct of medical insurance health plans. I would go so far as to say that the manner in which many physicians let insurers dictate what occurs in medical practice allows coverage policies to function as automated death panels. There is also a curious obstinance on the part of clinicians refusing to seek continuing education so as to be able to understand a patient's medical conditions and meet their real medical needs.

Needless to say, I am trying not to die, so when a physician attempts to set out upon a path which works against my best interests as a patient I become quite agitated and attempt to advocate for myself. As a result, I have found few opportunities to form meaningful relationships amongst those who work in the medical field, but I have found some. There are good people; they are just hard to find, and sometimes harder still to get access to or maintain access to, largely, again, because of the misconduct of others.

Yet the good that I can find has been a poor substitute for “having rights”. I hope I’ve made it clear what I have, what some vulnerable adults are limited to, really isn’t living. I don’t see why it is that people in positions of trust and stewardship should be allowed to subject vulnerable adults to circumstances such as these without penalty. They most certainly shouldn’t be awarded monetary compensation for their contributions. And to be frank, I think it long past time I and others were provided a means to be compensated for our suffering.

Sincerely,
Sean Smith