

Testimony of Kirk W. Lowry
Before the Public Health Committee
Proposed Bill No. 5298 – Prohibiting Involuntary Shock Therapy

The Connecticut Legal Rights Project is a private, non-profit, state-wide legal services organization which represents low-income people with psychiatric disabilities. CLRP's main office is at Connecticut Valley Hospital (CVH) in Middletown. We have satellite offices in all of the DMHAS inpatient psychiatric hospitals in the state: Capitol Region Community Mental Health Center, Connecticut Mental Health Center, and Greater Bridgeport Community Mental Health Center. I am the legal director for CLRP. I attend probate court at CVH almost every Friday morning. CVH averages about 1 involuntary ECT hearing every two weeks, or about 25 - 30 a year. I have been present for about 150 forced ECT hearings in probate court. Since CVH patients get court-appointed counsel, we do not represent them at the hearing. We do represent patients with ECT orders and work with court-appointed counsel.

Connecticut General Statutes §17a-543(c) prohibits "shock therapy" without the written informed consent of the party or a probate court order after a hearing. The probate court may order shock therapy for 45 days if the "court finds that the patient is incapable of informed consent and there is no other, less intrusive beneficial treatment." Commitment and forced medication decisions require clear and convincing evidence. Shock therapy only requires a preponderance of the evidence. Probate hearings for commitment and forced medication require an independent psychiatrist to interview and report to the probate court. In forced shock treatment hearings there is no independent psychiatrist to review the treating psychiatrist's recommendation for shock therapy. The treating physician petitions the probate court for an order and is usually the only person to testify. Sometimes the patient does not attend the hearing. The physician who administers the ECT is not present. At CVH, the treating physician testifies that the person is not able to give informed consent to shock therapy and that there is no other, less intrusive beneficial treatment. There is no testimony about the procedure or details of the shock therapy because it is done at the Institute of Living in Hartford by Dr. Joanna H. Fogg-Waberski. Ninety-eight to ninety-nine percent of the petitions are granted.

In my experience, a substantial majority of patients testify that they do not want shock therapy.

The process we are left with is one in which the treating psychiatrist, who does not administer the shock therapy, is the only witness and the only source of information. The treating psychiatrist is unable to testify about more than the number of shock treatments this patient has been given, how the patient has reacted, the general side-effects of shock therapy, and how the patient does when shock therapy is reduced or eliminated. There is little or no cross-examination, little information from peer-reviewed literature or about randomized-controlled studies of effectiveness of ECT. There are approximately ten to fifteen patients at CVH who regularly receive ECT. One patient has had more than 190 treatments over a three year period. Another patient has had over 150 treatments over a three year period.

No one knows how or why shock therapy works on the brain. Electrodes are attached to the brain, bilaterally, bi-frontally, or uni-polar. The person is prepared with general anesthesia and muscle relaxer. The current is run through the brain to induce a seizure. Common and/or severe side effects include cardiovascular, pulmonary and anesthetic risks of stroke, death, irregular heartbeat, and high blood pressure. Universally, patients suffer from initial cognitive dysfunction and disorientation, which usually resolves. Many patients also suffer from memory loss, which usually resolves after six months. More seriously, some patients suffer loss of past memories. This past memory loss, or retrograde autobiographical memory loss, may persist. Other serious side effects include prolonged seizures and pain, headache and discomfort from the procedure. (FDA Executive Summary for the Neurological Devices Panel, On the Classification of ECT, January 27-28, 2011, pages 45-50.)

The electroconvulsive therapy device is classified by the FDA as Class III, the highest risk category. 21 C.F.R. §882.5940 and FDA Executive Summary, pages 7-9. On April 9, 2009, the FDA issued a notice requesting safety and effectiveness information from manufacturers to determine whether the ECT device should remain Class III devices or be reclassified as Class I or II. After it received information from two manufacturers and 3,045 public comments, the FDA met on January 27-28, 2011 and decided to keep ECT devices in Class III, the highest risk category.

The FDA reviewed 17 published review articles examining the effectiveness of ECT, including ten systemic reviews, seven meta-analyses and three practice guidelines (American Psychiatric Association, National Institute for Clinical Excellence and Royal College of Psychiatrists). The FDA's Executive Summary of the effectiveness of ECT for depression includes these findings:

1. Evidence for the effectiveness of ECT exists only for acute effects (ECT plus one month).
2. Increased electrical stimulus above seizure threshold increases efficacy of unilateral ECT at the expense of increased memory and cognitive impairment.
3. There is limited evidence to support the effectiveness of ECT for elderly patients.
4. Little evidence exists supporting the long-term effectiveness of ECT.
5. Gains in efficacy are achieved only at the expense of increased risk of cognitive side effects.
6. There is no evidence to suggest that ECT causes brain damage.

The FDA's effectiveness review for Schizophrenia found:

1. Evidence for the effectiveness of ECT for schizophrenia exists only for acute effects; there is no evidence of effectiveness beyond the acute phase.

FDA Executive Summary, pages 36 and 37.

CLRP supports proposed bill 5298 prohibiting involuntary shock therapy. CLRP also has concerns about due process, burden of proof, effective assistance of counsel, access to and opportunity to present effectiveness evidence, full written standards for the risks and benefits of ECT for each specific patient, access to independent psychiatrists knowledgeable in ECT procedures and the detailed risks and benefits of ECT, access to cognitive functioning and/or neuropsychological reports for each patient establishing a baseline and cognitive deficits after ECT, and whether a special conservator with knowledge of ECT should be appointed as a surrogate decision-maker instead of by court order alone.