STATE OF NEW YORK
COURT OF APPEALS

----------x		Appellate Division
	:	Docket No. 2005-11405
In the Matter of Simone D.	:	
	:	Queens County
----------x		Index No. 501166/2005

NOTICE OF MOTION FOR *AMICUS* RELIEF

PLEASE TAKE NOTICE that on the 30th day of April, 2007, the undersigned will move the court at the Court of Appeals, 20 Eagle St., Albany, NY 12207-1095, pursuant to 22 NYCRR sec. 500.23, based upon the attached affirmation in support, for leave to file the attached brief on behalf of proposed *amici curiae* Disability Advocates, Inc., Judge David L. Bazelon Center for Mental Health Law, Law Project for Psychiatric Rights (PsychRights), the Mental Disability Law Clinic of Touro College, Jacob D. Fuchsberg Law Center, Mental Health America (formerly National Mental Health Association), National Association of Rights Protection and Advocacy, National Disability Rights Network, New York Association of Psychiatric Rehabilitation Services and New York Lawyers for the Public Interest.

Pursuant to 22 NYCRR ş 130-1.1-a, I certify that to the best of my knowledge, information and belief, formed after inquiry reasonable under the circumstances, the presentation of this notice of motion and all the other

papers I have presented in this appeal and the contentions therein are not frivolous as defined in 22 NYCRR § 130-1.1(c).

New York, NY
April 20, 2007

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AFFIRMATION IN SUPPORT OF
MOTION FOR *AMICUS* RELIEF

1. I am an attorney admitted to practice before this Court. I am familiar with the course of these proceedings.

2. Proposed *amici curiae* Disability Advocates, Inc., Judge David L. Bazelon Center for Mental Health Law, Law Project for Psychiatric Rights, Mental Disabilities Law Clinic of Touro College, Jacob D. Fuchsberg Law Center, Mental Health America (formerly National Mental Health Association), National Association of Rights Protection and Advocacy, National Disability Rights Network, New York Association of Psychiatric Rehabilitation Services and New York Lawyers for the Public Interest respectfully move for leave to file the attached brief in support of Respondent-Appellant Simone D. The statements of interest of proposed *amici* are collected in an appendix to the brief. They are, broadly speaking, advocacy, professional and legal organizations concerned with the rights of people with psychiatric disabilities.

3. Ms. D. is involuntarily confined in Creedmoor Psychiatric Center, a state hospital in Queens, NY, where she has been continuously hospitalized since 1994. This appeal, calendared for argument May 31, 2007, is from an order of the Supreme Court, Queens County, authorizing Creedmoor to administer 30 more electroconvulsive therapy procedures to Ms. D. over her objection. She has already had at least 148 such procedures. The Appellate Division, Second Department, affirmed the order with two judges dissenting on the grounds that the trial judge unduly limited cross examination on the risks and benefits of such treatment and on less intrusive alternatives, and improperly relied on his own supposed knowledge about ECT. This is an appeal as of right based on the two dissenting votes. A copy of the Appellate Division's decision is attached.

4. In addition to the extraordinary number of ECTs Ms. D. has already had, the salient facts include –

- that she already has long-standing cognitive damage of the sorts associated with ECT;
- that ECT has little benefit for her;
- that no one contends that ECT will break her depression or restore her competence or render her well enough to leave the hospital; and
- that she is primarily Spanish-speaking, notwithstanding which Creedmoor has made no serious effort to provide her the less intrusive alternative of prescribed verbal therapies in her language.

5. The heart of the contribution proposed *amici* wish to make to this Court's consideration of the appeal is their review of the relevant professional and scientific literature. Among other things, this review shows

- that it is generally agreed there are no controlled studies on the safety or efficacy of such an extended course of ECT;
- that new evidence shows there is a significant chance of persistent memory loss from even short courses of ECT, especially with the method of ECT administration used for years on Ms. D., and that the amount of memory loss is proportional to the number of ECT procedures;
- that the involuntary use of ECT on one who benefits so little appears to be outside accepted professional judgment, practice and standards; and
- that the pronouncements of professional organizations support the common-sense notion that language and cultural barriers can significantly detract from effective treatment for mental illness.

6. Proposed *amici* also offer a thorough analysis of the record, especially the medical record in evidence, in light of the scientific and professional literature and the governing legal standard, which they briefly summarize.

7. Proposed *amici* submit that the facts in the record and the scientific and professional literature underscore the particular importance of full cross examination and a full record, in a case such as this where authority is sought to impose an *unproven* treatment regime over objection. The questions excluded went to the heart of the risk-benefit analysis and "narrow

tailoring" required under the governing legal standard, and were fully justified by the record and the scientific and professional literature. In addition, it is clear that the judge's reliance on his own supposed knowledge about ECT led him away from hearing critical facts, and was in at least one respect simply wrong – when he assumed that Ms. D.'s past experience of adverse effects from ECT was not relevant to deciding her case.

8. I have contacted Assistant Attorney General Patrick Walsh, counsel for Creedmoor Psychiatric Center, the petitioner-respondent, but I do not yet know his position on this motion. Ms. D.'s counsel advises that he assents to the filing of this brief.

9. Pursuant to CPLR 2106 and subject to the penalties for perjury, I affirm that the foregoing is true and correct of my own knowledge, except that I make statements as to the facts and procedural history of this case on information and belief. Pursuant to 22 NYCRR § 130-1.1-a, I certify that to the best of my knowledge, information and belief, formed after inquiry reasonable under the circumstances, the presentation of this affirmation and all the other papers I have presented in this appeal and the contentions therein are not frivolous as defined in 22 NYCRR § 130-1.1(c).

New York, NY
April 20, 2007

_____
John A. Gresham

STATE OF NEW YORK
COURT OF APPEALS

No argument requested

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BRIEF FOR *AMICI CURIAE*

Disability Advocates, Inc.

Judge David L. Bazelon Center for Mental Health Law

Law Project for Psychiatric Rights (PsychRights)

Mental Disability Law Clinic of Touro College,
Jacob D. Fuchsberg Law Center

Mental Health America (formerly National Mental Health Association)

National Association of Rights Protection and Advocacy

National Disability Rights Network

New York Association of Psychiatric Rehabilitation Services and

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April 20, 2007

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

State Office of Mental Health Documents

Scientific and Professional Literature

Introduction: Position of *Amici Curiae*

Amici curiae Disability Advocates, Inc., Judge David L. Bazelon Center for Mental Health Law, Law Project for Psychiatric Rights (PsychRights), **the Mental Disability Law Clinic of Touro College, Jacob D. Fuchsberg Law Center**, Mental Health America (formerly National Mental Health Association), National Association of Rights Protection and Advocacy, National Disability Rights Network, New York Association of Psychiatric Rehabilitation Services and New York Lawyers for the Public Interest respectfully urge this Court to adopt Simone D.'s position and overturn the Appellate Division's and trial court's decisions to authorize 30 more sessions of electroconvulsive treatment (ECT) over her objection. She is confined in Creedmoor, a state psychiatric hospital, and strenuously objects to more ECT.

She has had more than 148 ECT procedures already, an extraordinary number. Their benefit for her is limited at best, ECT will not break her depression or get her out of the hospital, and she already has significant cognitive damage of kinds associated with ECT.

Creedmoor seeks more ECT before making any serious attempt to provide prescribed verbal therapies in her primary language, Spanish.

The Appellate Division affirmed the trial court's order authorizing 30 more ECT procedures, *Matter of Simone D*, 32 A. D. 3d 931 (2nd Dept. 2006), with two judges dissenting on the grounds that the trial judge unduly limited her counsel's cross-examination of the psychiatrist urging more ECT, the only witness at the hearing, and improperly relied on his own unspecified, untested, unreviewable knowledge about ECT. The dissenters, Crane, JP and Goldstein, J, would have remanded to a different judge to hold a hearing after appointment of an independent expert, if deemed appropriate, *id.* at 934-36.

Not only the facts of the case, but also the present state of scientific research underscore the importance of Ms. D.'s counsel's thwarted attempts to cross examine and the impropriety of the trial judge's reliance on his own knowledge. *Amici* will analyze the facts in light of the relevant scientific and professional literature and the governing legal standard, showing that there was compelling reason for the cross-examination on risks and benefits and a less intrusive alternative that the trial judge excluded.

In Point II *amici* will call to this Court's attention that there are no controlled studies on the safety and efficacy of such an extended course of ECT. The lack of research emphasizes the necessity of a full hearing. The proponent of an order for involuntary treatment must always be put to its

proof, and the individual must always have a full opportunity to contest on risks and benefits, *especially* when authority is sought to impose *unproven* treatment over the individual's objection. In such a case, the individual must have a full opportunity to contest whether there is a life-or-death situation, the only circumstance where the benefits of an unproven treatment could possibly be shown to clearly outweigh the risks. Ms. D. did not have that opportunity, and hers is very far indeed from such a case.

In addition, *amici* will point out that recent, very sophisticated research shows that the cognitive damage from even short courses of ECT is cumulative, and that the method of administering ECT used for years on Simone D. presents particular risks. The trial judge was simply wrong in believing – as he explicitly stated in limiting cross examination – that Simone D.'s history with ECT was not of interest. The judge further isolated himself from knowledge by failing to examine the hospital record and declining to appoint an independent expert.

Involuntary use of years of ECT with so little benefit that the individual cannot leave the hospital appears to be outside accepted professional judgment, practice and standards, and there is certainly no clear and convincing evidence on this point, a required part of Creedmoor's burden under the governing legal standard.

Further, Simone D. is primarily Spanish-speaking. The main symptom of her depressive mental illness is extreme withdrawal from other people. Her treating psychiatrist and several other professionals had recognized for a decade that she would be better treated in a Spanish-speaking environment. It would have been possible to transfer her to a Spanish-speaking inpatient ward. As *amici* will urge in Point III, not only common sense, but also the pronouncements of mental health professional groups support the notion that a language barrier and other cultural factors can be very significant impediments to effective treatment. Since this record carries no good explanation for failure to take this obvious, less intrusive step, *amici* urge that it cannot support an order for more ECT over Simone D.'s objection.

The statements of interest of individual *amici* are collected in an appendix to this brief.

FACTS

A. The Facts Are Far from "Crystal Clear" in Favor of ECT, as the Appellate Division Believed

Amici submit that knowledge of the following facts is necessary to fully understand the importance of Simone D.'s counsel's thwarted cross-examination and the impropriety of the trial judge's reliance on his own knowledge. The facts also demonstrate the error in the Appellate Division

majority's conclusion that neither of these matters because the benefits of ECT for Simone D. were "crystal clear," 32 A.D. 3d at 934. The notion of "crystal clarity" is demolished by examination of the whole record.

Under the applicable legal standard (see Point I, below), the balancing of risks and benefits is at the heart of a judge's duty on a petition for psychiatric treatment over objection. So also is consideration of less intrusive alternatives and accepted professional standards, as part of the "narrow tailoring" which is required when an order is issued. The facts recited below relate to these issues.

The hospital record is of particular importance. Unfortunately, the trial judge did not consult it before announcing his decision from the bench, Tr R 37-40, 81, 90-91. As will appear below, the testifying psychiatrist – the only witness - displayed substantial ignorance of the hospital record and often and obviously exaggerated the justifications for ECT. The Appellate Division made no reference to the hospital record. Similarly, in its brief to this Court Creedmoor makes no reference whatsoever to the 600-odd pages of the hospital record that it put in evidence, except an evaluation prepared specifically to support the application that is the subject of this appeal.

Creedmoor maintains that the facts are "undisputed," Brief for Petitioner-Respondent at 36, 37, which is far from the case; in fact, as will

appear below, the written material supporting the application and the testimony of Creedmoor's ECT psychiatrist were often contradicted and undermined by its own records, which amply support the cross-examination that was excluded. Indeed, a look at the whole record compels rejection of the notion that the essential balance of risks and benefits is even close to "clear and convincing" in favor of ECT, as required by the governing legal standard.

Except as otherwise noted, the facts are from the trial court transcript (Tr R__) or the portion of the hospital record in evidence (Hosp Rec R__).[1]

B. Simone D. Was Hospitalized over a Decade at the Time of the Hearing, and ECT Held No Promise of Her Release from the Hospital

Simone D. was born in a Spanish-speaking country in the late 1940s. She came to the United States around 1984 and has been naturalized, Hosp Rec R 116, 119, 130. She went through two years of high school, and when she was younger she worked steadily at factory jobs, Hosp Rec R126. She was married and had children, Hosp Rec R126, 157. She was first hospitalized for mental illness in Queens, NY approximately 1984, then two or more times when she had returned to her native country in the 1980s, then

[1] The portion of the hospital record that Creedmoor put into evidence includes day-by-day progress notes for February 1 - November 29, 2005, and some other materials back to 1994. Among other things, it does not contain records of ECT prior to 2005 or important progress notes from 2004, *see infra,* 10-11, 32, note 45, 35. Simone D.'s counsel objected to its incompleteness but was overruled, Tr R39-40.

a few times in Queens. Her present hospitalization at Creedmoor Psychiatric Center in Queens began in 1994, two months after her father died, when she was in her mid-forties. At that time she was not only very depressed and withdrawn, but also nearly mute and not eating, drinking or sleeping. Before her admission she was separated from her husband, her younger children lived with their father, and she lived with other relatives, Hosp Rec R116-119, 124,126, 157.

Creedmoor is a state psychiatric center. Simone D., now in her late fifties, is still hospitalized there. From the very beginning of her hospitalization, psychiatrists, social workers, nurses and others have recognized that she is primarily Spanish-speaking, *e.g.* Hosp Rec R103, and at the same time have recommended verbal therapy for her, among other things.[2]

Also from the beginning, her prognosis was "guarded," Hosp Rec R129. Based on the testimony of Dr. Brodsky, Creedmoor's ECT psychiatrist, the only witness in this case, there is no reason to believe she will be released in the foreseeable future, even with the extended course of ECT Creedmoor seeks to impose. The justification offered for continuing ECT in spite of her objection is essentially that it will improve her "quality

[2] See below at 29.

of life" in the hospital, Tr R75. Dr. Brodsky opined that with ECT Simone D.'s withdrawal is decreased, that she is less prone to be aggressive, and that she eats better, *e.g.* Tr R44.[3] The doctor's assertions contrast sharply with the recent specific facts in her hospital record.

Dr. Brodsky acknowledged that years of court-ordered ECT had not achieved remission of Simone D.'s depression, or rendered her competent to make rational decisions on her treatment, or led to her being well enough to leave the hospital, Tr R74-75, 90. At the end of her testimony, Dr. Brodsky conceded that she did not have "any hope to offer Simone [D.] anything other than a lifetime of court ordered electroshock treatment and depression at ... Creedmoor Psychiatric Center," Tr R91.[4]

One of Creedmoor's stated objectives to be achieved by ECT is to get Ms. D. to "understand the beneficial effects that ECT has had on her behavior," given that "[Simone] has been very uncooperative and has been refusing to sign for ECT treatments," Hosp Rec R237.[5]

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[3] There are many similar generalities in the hospital record – for example Hosp Rec R107, 118.

[4] As will appear in Point II(A), below, these circumstances appear to take Creedmoor's treatment of Ms. D. outside accepted professional judgment, practice and standards. Creedmoor put in no evidence on whether the proposed treatment is within such judgment, etc., which is part of its burden under the governing legal standard.

[5] Since Creedmoor maintained that Simone D. lacked capacity to make a rational decision about ECT, Petition, R17, it is unclear how it could virtually at the same time have taken the position that her consent would be valid.

Simone D. sees ECT differently from the way Creedmoor does. When interviewed with the aid of an interpreter, she unequivocally stated her objection to receiving more ECT: "I don't need this shock treatment." "It causes more pain. I suffer more from shock treatment." Evaluation of Treatment over Objection, attached to Application for the Involuntary Administration of Electroconvulsive Therapy, R26.[6] Her treatment plan dated the month of the hearing noted that Ms. D. "periodically gets agitated, especially when she knows she is scheduled for ECT," Hosp Rec R 237, 248. Dr. Brodsky was not prepared to believe that Ms. D. suffered from ECT, other than the needle-prick for an IV, Tr R87-88, but see 24-27 and 51 below on the process of undergoing ECT and the experience of damage from memory loss.

Simone D. is largely isolated from the outside world, and except for her access to the courts, she is powerless. She has sporadic visits from her older son, Hosp Rec R108, 118, 131, 134, 145, but the record shows he is highly unreliable and at times cannot be reached, Hosp Rec 130, 136, 143, 531.[7]

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[6] These statements come from an interview conducted with the aid of an interpreter, Hosp Rec R504. At another point she is recorded as saying, "I don't feel well on this shock treatment," Hosp Rec R507. *See also* Hosp Rec R511 (same).

[7] She has very occasional visits from others, *e.g.* Hosp Rec R131, 538.

C. Simone D. Has Had Very Extensive ECT Already, with Ever-Decreasing Value

Simone D. has already had at least 148 ECTs since the end of 1999, Tr R71-72,[8] plus an unknown additional number earlier in this hospitalization and during prior hospitalizations.[9] She had ECT during this admission in 1995, 1996, 1998, from Decemher, 1999 to April or May, 2003, and from February to July, 2005, Hosp Rec R569-82, 696, 700, Tr R71-72.

Although the hospital record recites that Simone D. had "good" results from ECT in her native country about two decades prior to the hearing[10] and in 1995, in recent years – as recently as five weeks before the end of her last series of ECT - her response has been recorded as only "moderate" or "fair," Hosp Rec R105, 107,116, 696, 719. A psychologist's report clearly describes a major worsening of her psychiatric symptoms in 1996 *while she was receiving ECT*, which was very similar to the deterioration Creedmoor claimed has occurred when ECT is *not* used. ECT

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[8] The number may be greater, as her hospital record is very voluminous, and her counsel may have missed some in his effort to count them, Tr R37-38. In addition, it is clear she had ECT before 1999 as well as during prior hospitalizations.

[9] *Amici* will show in Point II, below, that 148 is far, far in excess of the typical course of ECT, and so large a number that it is, by general agreement, beyond any controlled studies on the safety or efficacy of extended courses of ECT.

[10] The source for this claim is not clear from the hospital record.

was stopped at this point in 1996, Hosp Rec R158.[11] Simone D. also had "a major cognitive decline" at this time, see below at 21. But in the present application to the court, Dr. Zhang, her treating psychiatrist, who wrote some of these earlier descriptions of the effects of ECT, bumped the value of ECT up to "good" and failed to mention the 1996 experience, R24, 28.[12] Dr. Brodsky testified the 1996 history could not be relevant, Tr R58, and that Ms. D.'s response to ECT was "very good," Tr R 44.

1. ECT Was Not Effective for Simone D.'s Depression and Withdrawal

Simone D.'s primary psychiatric diagnosis has been "major depression severe with psychotic features 296.33," or something very similar, and she has a secondary diagnosis of "dependent personality disorder 301.60," Hosp Rec R111, 129. The primary symptoms of her illness are withdrawal from other people, apathy and inability to care for herself.

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[11] This description of deterioration during ECT reads,

> [D]uring the fall of 1996 [Simone] started to decompensate again. She would not eat, sleep, drink, shower, and would disrobe, refusing to put on her clothing. She started to stare into space, would not answer when greeted and was quite withdrawn. When spoon fed she would not open her mouth or would refuse to swallow. She was constantly whining, crying, confused, disorganized and non-communicative. ECT was stopped ....

[12] He also signed treatment plans written while court petitions were pending which failed to mention the 1996 experience and said Ms. D. "has done very well in the past with ECT," Hosp Rec R237, 248, 262, 272A.

Contrary to the picture of improvement painted by Dr. Brodsky, Tr R44, accepted as obvious by the Appellate Division majority, 32 A.D. 3d at 934, and urged upon this Court by Creedmoor's brief, *e.g.,* Brief for Petitioner-Respondent at 36 ("marked improvement"), Simone D.'s depression remained quite bleak even when she was receiving ECT.

For example, in June, 2005, when she had been receiving ECT more than weekly for over four months and was said to be benefiting, Hosp Rec R106-07, Dr. Zhang summarized her condition thus:

> She is still very depressed, regressed and withdrawn. She also shows psychotic symptoms. She shows impaired insight into her illness and treatment. Her judgment is also impaired. She is unable to take care of herself.

Hosp Rec R105. This was during her most recent period of ECT. At the same time he wrote,

> She remains regressed, withdrawn and poorly motivated. She is still depressed. She neglects personal care and she still requires close supervision for food intake and [activities of daily living]. She is still very isolated. ... She shows impaired cognitive functioning while she receives ECT.[13] ...
>
> ...
>
> She remains very regressed and withdrawn. She does not actively participate in structured activities. She has Level 1a privileges she handles it fairly well after ECT was restarted. ...

[13] In fact, in 1997 and 2004, she showed cognitive impairments when she had been *off* ECT for eight and 14 months. See below at 21-24.

...

She is still depressed and apathetic.

...

She still feels helpless and hopeless.

Hosp Rec R107-09.

Simone D. has been tried on many medications, but although her condition is better than it was when she was first admitted in 1994 – *e.g.,* she weighed only 93 lbs. then but was up to 124 lbs. on the day of the hearing, Hosp Rec R197, 226, 706 - the medications have had at best limited effect, *e.g.,* Hosp Rec R105, 106, 116, 118, Tr R44.

2. ECT Was Not Needed for Nutrition: Simone D. Was Far From Underweight, and ECT Was Not the Only Approach to Improving Her Eating Habits

Dr. Brodsky testified that Simone D,"is not eating properly," Tr R48, *see also* Tr R44 (same), Tr R46 ("she was eating better" during ECT, "now she refuses to eat"). Nutrition seemed to be the main issue to the doctor – "the main thing when – which is help her with..." - Tr R74. Creedmoor tells this Court in its brief that at the time of the hearing, Ms. D. was "currently losing weight," Brief for Petitioner-Respondent at 13.

Maintaining enough weight has not been a problem with Simone D. in recent years. It is true that she gained from 105 to 124 lbs. during her last

course of ECT, Hosp Rec R342, 757, 760. However, she is only five feet, three or four inches tall, Hosp Rec R169, 197, 226, 535, and her ideal body weight is 104-127 lbs., Hosp Rec R212-13, 267, 414, 549. During her hospitalization she has been as much as 35 lbs. *over* her ideal body weight, Hosp Rec R247, 272; *see also* Hosp Rec R202 (12 lbs. over).

And notwithstanding her continuing depression, during 2005 she maintained at 124 lbs. four and a half months after her last ECT, on the very day of the hearing, Hosp Rec R706.[14] *This is a full third more than she weighed when admitted to the hospital in 1994, and toward the upper end of her ideal body weight range.* As far as nutrition is concerned, Creedmoor's brief grossly exaggerates when it claims there is "undisputed proof that Simone D.'s condition deteriorates dramatically without ECT," Brief for Petitioner-Respondent at 36.

Also, during the period in 2005 when she was gaining, and afterward while she maintained her weight, she was getting close staff attention during meals – a far less drastic measure than ECT - Hosp Rec. R107, 190, 213, 274, 276, 353, 358, 365, 371, 385, 395, 400, 414, 437, 448, 457, 463, 490, 496, 506, 513, 515, 525, 535.

[14] The high point during this period was 125 lbs., *e.g.* Hosp Rec R169, 213, 450. Similarly, she weighed 110 lbs. (six pounds over the low end of her ideal body weight) in December, 2004, when she had been off ECT for over a year, Hosp Rec R697. Dr. Brodsky testified Ms. D. had lost weight as a result of not being on ECT, but did not say when, Tr R47.

Nutrition is simply not a life-or-death matter in this case. While in the distant past Ms. D. had refused to eat and drink to the point of requiring a nasogastric feeding tube, those episodes were *a decade or more* before the hearing, Assessment R30, Hosp Rec R147, 158, 696. Dr. Brodsky testified, "when she decompensates she is a danger to herself, she stops eating and drinking," and if that continues "she'll be placed on tube or she'll die," Tr R74, but she did not mention how far in the past the tube feeding had occurred; Creedmoor's counsel had redirected her earlier when she apparently offered to do so, Tr R45-46.

The hospital record reflects many times that Simone D. preferred fluids and soft, sweet foods or "junk foods,"[15] both during ECT and after – *e.g.,* Hosp Rec R213, 278, 288, 325, 438, 478, 478, 490. During 2005 a psychiatrist noted that she "eats well when she likes the food," Hosp Rec R459, and a physician specifically ordered noodles for her, Hosp Rec R591, 592, 611, 616, 624, 635, 639, as well as Ensure, Hosp Rec R617, 635, 646, 664, 674, 682.

It is not surprising that she preferred soft foods. She was missing her upper teeth in 1994, and by 2005 she had exactly two teeth left, but no

[15] Soft, sweet food came from vending machines, where food was bought for Ms. D. by staff, and from the "token store," part of a system to reward desirable behavior, Hosp Rec R206, 208, 231-47, 272, 549.

dentures.[16] The record contains no explanation why she did not have dentures, an obvious, less drastic way to improve her eating habits. Instead, she was to be "encouraged to chew her food completely before swallowing ...," Hosp Rec R234, 242, 268. The record refers to a "soft," "chopped soft" or "mechanically texturized" diet or diet with "choking precautions," which is surely rather tiresome, *e.g.*, Hosp Rec R189, 197, 213, 218, 224, 234, 268, 272, 274, 276, 446, 583 *et seq.*, 605.[17] So far as eating is concerned, the record is hardly "crystal clear" that, as Dr. Brodsky said of ECT, "We don't have any other choice," Tr R48.

3. Creedmoor Did Not Treat Simone D.'s "Aggressiveness" as a Major Problem

As just noted, Simone D. is not large, nor is she young. Already in 1994 a psychiatrist had described her as "frail-looking...," Hosp Rec R127.[18] In the month of the hearing, Creedmoor's tentative plan was that,

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[16] She has been described as "edentulous" since 1994, Hosp Rec R117, 125, 144, 225, 241, 267,272, 697. In 1994 she was described specifically as "missing upper teeth," Hosp Rec R197, 199. In 2005 she was specifically noted to have but two lower teeth left, Hosp Rec R220, 706, 723. Those teeth were unstable, with exposed roots, Hosp Rec R 713. When admitted in 1994 she may have used dentures, *compare* Hosp Rec R197 & 225, but she was without dentures in 2005, Hosp Rec R169, 180, 722, 723, 726, 729, 731, 734, 736, 74e0, 742, 752, 753, 757, 763, 775.

[17] She also has a poor gag reflex, Hosp Rec R247, 267, 272.

[18] Her gait was at least once described as unsteady, *compare* Hosp Rec R194 with Hosp Rec R181, 221, and she has fallen at least three times, Hosp Rec R192, 210-13.

were she ever to become psychiatrically stable enough to be discharged, she would go to a nursing home, Hosp Rec R236.[19]

It is therefore not surprising that such incidents as occurred sometimes led to *no* specific action recorded by hospital staff, *e.g.,* Hosp Rec R279, 312, 496, 503, 521. On one occasion staff recorded that they employed verbal counseling and offered food and a trip to the bathroom, Hosp Rec R277. Other times Simone D. was *offered* the chance to go into the "quiet room," Hosp Rec 305, 362, 533, 543, and/or to have extra medication or her regular medication which she had not yet taken, Hosp Rec R362, 522, 531. There is only one instance in the record where an injection was noted in connection with an incident which was not characterized as voluntary; this was the only incident in the record where she actually hit anyone, Hosp Rec R304-06, 604, and there was no reported injury.[20] Dr. Brodsky never mentioned Simone D. causing any harm to anyone.[21]

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[19] Such tentative plans are routine, even when there is no real prospect of discharge. They are found throughout Ms. D.'s record, back to 1995, see below at 28. The latest one reads, "When [Simone] is able to interact with others in an appropriate manner and accepts that she needs to have continued ECT treatments, discharge to a nursing home will be considered," Hosp Rec R247, *see also* Hosp Rec R272.

[20] This episode was in February, 2005, within three hours of an ECT. The record says Ms. D. hit another patient in the back of the head. Dr. Zhang wrote, "She mentions her son's name, but she doesn't explain," Hosp Rec R304-05.

[21] The hospital record refers to only one specific injury to someone else attributed to Simone D. - another patient with scratches on her face said Simone D. caused them, Hosp Rec R538.

Although much was made of Simone D.'s having been on 1:1 staff observation a great deal for "aggressive" or "unpredictable" behavior, *e.g.*, Tr R41, Hosp Rec R699, use of 1:1 for that reason was almost completely absent by the time of the hearing.[22] During four and a half months she was *off* ECT immediately prior to the hearing, she was on 1:1 for aggressive or unpredictable behavior *for only one day*, Hosp Rec R471. This contrasts very sharply with Dr. Brodsky's testimony that "almost every day she assaulted somebody," Tr R44. The record contains only one reference to staff putting hands on Simone D. in response to her actions - a staff member taking hold of her hands, Hosp Rec R538.[23]

Simone D. has no criminal or "legal" history, Hosp Rec R 105, 151, 155, 156. She does not have a history of substance abuse, Hosp Rec R106. And as noted below, there have been long periods when Creedmoor did not seek authority for further ECT. Clearly, she has presented some management

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[22] Often 1:1 or other heightened staff observation (*e.g.*," Q 15," meaning observation at least every 15 minutes) was ordered for other purposes – to assist Simone D. at meals, including to avoid choking, to ensure that she did *not* eat after midnight on days when she would have anesthesia for ECT, or to prevent her vomiting up an osteoporosis medication, *e.g.* Hosp Rec R 573 *et seq.*, 581, 583.

[23] The hospital record notes that Simone D. had a fracture of her right upper arm during an incident in July, 2004, but there are no details at all, R107, 696, and the incident was not mentioned at the hearing. There is no way to know how the fracture occurred, whether it involved a fall, whether staff acted properly, etc.

problems in the hospital,[24] but their recent seriousness was greatly overblown. Again, the facts in the record contrast sharply with the clear picture the Appellate Division majority assumed would justify denying Simone D.'s appeal. [25]

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[24] Dr. Zhang refers to "periods of high agitation/shouting, currently in abaience [*sic*]," Hosp Rec. 276 (May 4, 2005), *see also* Hosp Rec R274. One of Creedmoor's claims for ECT is that Ms. D. "is not a management problem when receiving ECT," Hosp Rec R, 247, 272.

[25] Although Dr. Zhang often credited ECT with reducing Ms. D.'s "aggressive" behavior and the need for 1:1 observation in early 2005, *e.g.*, Hosp Rec R107, both he and the ward social worker had an additional theory – that her condition and behavior were strongly related to how often her son visited. He wrote,

> She has met her son ... twice and other relatives. She is happy to see them, especially [her son]. This could be another important factor for the patient's progress.

Hosp Rec R436. The social worker wrote:

> When Ms. [D.] does not see her son for awhile she becomes delusional and believes that she has seen something bad happening to him on the T.V. set, and sometimes believes that the staff has harmed or killed [him].

Hosp Rec R 134.

> During the past year patient's family has intermittently been involved. ...[P]atient had been getting more and more agitated around not seeing her son .... [Her son] called Ms. [D.] in November, 2004 but did not visit her as he had said he would. [He] did visit his mother on the ward in March, 2005, and in May, 2005. ...
>
> ....
>
> [She] may have been depressed and agitated because for a very long period of time she had not heard from or seen her son .... Patient's behavior started to improve around March , 2005, after she started to receive ECT (Feb. 2005).

Hosp Rec R131, 133; *see also* Hosp Rec R487. Dr. Zhang had a similar theory about Ms. D.'s eating:

4. Suicide Prevention Was Not an Issue Here

Simone D. expressed suicidal thoughts from time to time, but her only reported act of even *attempted* self-harm - beyond not eating and drinking to a serious extent in the distant past - was allegedly jumping into a construction hole while she was in her native country *in the 1980s*, Hosp Rec R105, 114, 144. There is absolutely no claim here that ECT is necessary to save her from suicide, Application, R25, Hosp Rec R719, 755.

5. Creedmoor Has Not Treated ECT for Simone D. as an Urgent Matter

Creedmoor has not treated ECT for Simone D. as an urgent matter. For example, after the 2003 *Rivers* ECT hearing mentioned below at 34-35 resulted in a defeat for Creedmoor, the hospital did not act *for 13 months* to deal with the reason for the denial – its failure to try treatment in Spanish first. Only 13 months later did it even make a pretense to follow the recommendation of the independent psychiatrist in that proceeding to move Ms. D. to another ward with a Spanish-speaking psychiatrist. The next order for involuntary ECT was not secured until three months after that effort at

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> This patient has often in the past stated she wants to die if she cannot have her needs gratified. At times in the past she has gone on hunger strikes in the hope of forcing her family members to visit [or] show interest in her. ...

Hosp Rec R274, 276. These passages raise serious questions about whether ECT can be credited with any improvements that may have occurred.

therapy in Spanish ended – quite a feeble effort, as recounted below at 32-33.

The next order, the one now under appeal, was entered November 29, 2005. Simone D.'s counsel obtained a stay shortly afterward, which Creedmoor has never moved to vacate, apparently because nothing of sufficient urgency has occurred in the last year and a half.

D. ECT Presented Very Significant Drawbacks for Simone D.

The record amply supports Ms. D.'s counsel's attempts to cross examine on cognitive risks and negative "quality of life" consequences of ECT, both highly relevant to the risk-benefit analysis, and the record shows that the trial judge's reliance on his own "knowledge" led him away from hearing about vitally important facts.

1. Simone D. Already Had Lasting Cognitive Deficits of the Sorts Associated with ECT

Simone D. has well-documented, longstanding memory and other cognitive deficits.[26] ECT was discontinued for her in late 1996 because of a worsening in her condition – see above at 10-11. At that time, a neurological consultation indicated that she had "organic brain syndrome secondary to ECT," which Dr. Brodsky described as "a major cognitive decline," and a

[26] See Point II, below concerning the very current research connecting ECT and cognitive deficits.

"frontal lobe syndrome secondary to ECT" that dissipated over time, which Dr. Brodsky thought might have resulted in changes in her behavior, Tr R58-60. Dr. Brodsky also testified, "It comes back most of the time," but acknowledged, "Sometimes it doesn't come back completely," Tr R 60-61.

It is hardly "crystal clear" that "it came back" in Simone D.'s case. A psychological assessment in mid-1997 – almost eight months after ECT was stopped – revealed, among other things,

> [She] was able to recall only one out of the 9 configurations which indicates a very strong short term visual memory loss which may or may not have been due to ECT treatments because no previous psychological testings are available.

Hosp Rec R160.[27] Yet Dr. Brodsky thought the 1996 experience could not be relevant, Tr R58. And the 1996 discontinuation of ECT was not even mentioned in the clinical summaries Dr. Zhang wrote to justify the present application and an earlier application that resulted in her most recent course of ECT in 2005, R29-32, Hosp Rec R695-98.

In June, 2005, in the midst of Simone D.'s most recent course of ECT, Hosp Rec R107, which was justified by one of the summaries just mentioned, Dr. Zhang noted -

- that her thought process was "perseverative",

[27] Of course, in a *Rivers* hearing, it is the hospital's burden to prove that benefits clearly outweigh risks, see Point I(B), below, so the absence of "baseline" psychological testing should fall on the hospital, not on Simone D, who had no power to secure testing.

- that she displayed "thought blocking" and "poverty of thought content",
- that her ability to repeat digits forward was "fair" and backward "impaired",
- that she could recall only one of three objects after five minutes,
- that her remote memory was "impaired," and
- that she was unable to do serial 3's and 7's.

Hosp Rec R109-10.[28] At the same time, he wrote, "She shows impaired cognitive functioning *while she receives ECT*," Hosp Rec R107 (italics added).[29]

But Simone D. had such deficits on an ongoing basis, not just during and shortly after receiving ECT. The 1997 psychological testing just described was done almost eight months after her then-last ECT. And in

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[28] For more on Simone D.'s cognitive state during this period, see Hosp Rec R709-718, 720-721. Her repeated inability to copy a figure made up of two pentagons is particularly striking. *See also* June, 2005 nursing plan, Hosp Rec 196 ("self-care deficit related to ... inability to concentrate or complete a task; confusion [and] attention deficits"). She also showed thought blocking and poverty of thought content on September 6, 2005, seven weeks after her last ECT, Hosp Rec R504; *see also* Hosp Rec R511 ("impaired thought process and poverty of thought content" two months after last ECT).

[29] Likewise, Creedmoor's application to the trial court stated that the anticipated risks from more ECT included "*short term* memory deficit," R25 (italics added). Even if these deficits actually had been confined to periods when Simone D. was receiving ECT, they would have been steadily present during such periods. She was getting ECT on average more often than weekly (see below at 24-25). This 2005 evaluation was written June 9, six days after her then-last ECT and one day before the next, Hosp Rec R113, 725, 726. It describes what her life was like while she was receiving ECT. Her comment was, "I don't feel well on this shock treatment," Hosp Rec R507. There is every reason to expect the same in the future.

June, 2004, 14 months after her then most recent ECT, Dr. Zhang himself had noted -

- that her thought process was perseverative,
- that she displayed thought blocking,
- that she thought the year was 2000,
- that her ability to repeat digits forward was "fair" and backward "poor",
- that she could recall none of three objects after five minutes,
- that she was unable to spell a word backward,
- that she was unable to do serial 7's,

and that all this was determined with the aid of an interpreter, Hosp Rec. R119-120. Since her last ECT had been in April, 2003, Hosp Rec R118, these June, 2004 cognitive deficits cannot be dismissed as short-term consequences of recent ECT. In its brief to this Court, Creedmoor claims Simone D. has no "permanent side-effects" from ECT, Brief for Petitioner-Respondent at 36. This contention simply ignores very serious issues raised by Creedmoor's own records.

2. Undergoing ECT Had an Immediate Negative Effect on Her "Quality of Life"

When Creedmoor has had judicial authority to administer ECT over Simone D.'s objection, it has done so weekly or more often, Hosp Rec R107,

756.[30] In many ways, the experience was similar to being prepared for surgery.

Each session involved her being denied breakfast, *see, e.g.*,Hosp Rec R725-27, and ushered into a treatment area that was equipped to deal with many medical emergencies, including cardiac arrest from anesthesia, Tr R70.[31] The nursing plan recognized the possibility of "anxiety related to impending therapy," Hosp Rec R187. Typical descriptions of her mental state on these occasions include "silent, averts gaze" and "cooperative," Hosp Rec R722, 728, 739.

A blood pressure cuff and EEG leads were attached to her, Tr R64. She was administered oxygen, Hosp Rec R725, 731, 736, 742, 754, 759. Through an IV line, she was administered the muscle relaxant succinylcholine and placed under general anesthesia, *see, e.g.,* Hosp Rec R722, 724, 728, 735, Tr R64, 69-70.

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[30] The order under appeal authorizes the same frequency, R13.

[31] The court sustained an objection to where ECT is performed, Tr R89. But OMH acknowledges the significant medical risks inherent in ECT. Its guidelines require that the treatment location contain equipment to provide suction, oxygen, airway intubation, EEG monitoring, and various medications including those to manage arrhythmias, hyper- or hypotension and cardiac arrest, with a defibrillator readily available. New York State Office of Mental Health Electroconvulsive Therapy Review Guidelines (2003), Guidelines 3b and 3c, http://www.omh.state.ny.us/omhweb/ect/guidelines.htm#section3. See also Hosp Rec R238 ("Side rails will be in raised position and emergency equipment will be made available due to any cardio-vascular, respiratory, muscular, skeletal or nervous system complications or side effects.").

Electrodes were placed on both her temples, *id.*, and she was given an electric shock to induce a grand mal seizure, Tr R64-65, which for her lasted between half a minute and a minute, Hosp Rec R 720, 725, 731, 742, 747, 751, 754, 756.[32] Succinylcholine caused temporary "respiratory paralysis," *i.e.* a cessation of breathing, American Psychiatric Association, *The Practice of Electroconvulsive Therapy*, 134 (2001). Her blood pressure spiked, *see, e.g.,* Hosp Rec R725 (to 201/90).

When she woke up in the recovery room, she was completely disoriented, Hosp Rec R727, 733, 738, 744, 749, 761. Her nursing plan recognized the possibility of post-treatment headache and "need to rest," Hosp Rec R187. Her most recent treatment plan recited, "she is often in a confused state after ECT," Hosp Rec R247, 272; see also Dr. Zhang's description of her cognitive state six days after an ECT, above at 22-23. ECT at least temporarily increased her risk of falling, Hosp Rec R163, 164, 168, 179, 182, 230, 244, 269.

The whole process was repeated on average every five to six days.

Contrary to Dr. Brodsky's bland dismissal, the uncontested facts show that the mere administration of ECT had an obvious negative effect on Simone D.'s "quality of life." Given the logic of Creedmoor's position, the

[32] As will become apparent in Point II(C), below, the fact that bilateral electrode placement was used on Simone D., Tr R59, increases the risk of persistent memory loss.

hospital may come back again and again to seek judicial authority for more ECT.

E. Creedmoor Left Simone D. Linguistically Isolated for a Decade, and Never Seriously Explored Ending Her Isolation as a Way to Treat Her Depression

Simone D.'s primary language is Spanish, and her primary diagnosis is a severe form of depression. The most salient symptom of her illness is withdrawal from others. She has been prescribed verbal therapies, rehabilitative teaching and opportunities to interact with others hospitalized with her, to deal with her mood, her eating and her behavior, since the very beginning of her hospitalization. But there have been virtually no efforts to deliver them in her language, despite clear recognition that she would benefit more from a Spanish-speaking environment. It is abundantly clear that this less drastic alternative to ECT has not been adequately explored.

Ms D.'s initial nursing assessment in 1994 recited that she "understands and speaks little English," Hosp Rec R200. A 1995 assessment recited, "Pt has language barrier, doesn't express well in English ...," and listed "poor English" as a problem, Hosp Rec R146.[33] In 2004, Dr. Zhang wrote, "She understands some English but speaks very little English," Hosp

[33] *See also* 1996 social work note, Hosp Rec R146 ("Poor use of English language"), and 1996 activities assessment, Hosp Rec R209 ("She has problems communicating (Spanish-speaking)").

Rec R119. A 2005 note says, "Sometimes she will speak in English, but usually it's a mixture of Spanish, English and gestures," Hosp Rec R443. Her latest treatment plan described her as "Spanish-speaking," Hosp Rec. R237. A month before the hearing under review here, a nurse noted, "Pt. always shows negative feelings about body but unable to express feelings in English," Hosp Rec R537. She was appointed an interpreter at the hearing before the trial court, Tr R35, 81.[34]

For a decade, in tentative plans for Ms. D.'s follow-up care, should she recover enough to leave the hospital, Creedmoor consistently specified that those taking care of her after her discharge should do so in Spanish.[35]

Modern psychiatric hospital treatment is based on a therapeutic "milieu" consisting in part of continuous interactions with staff of many

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[34] *But see* psychologist's note, Hosp Rec 413 ("Although she can speak/understand English, she prefers to communicate in Spanish."). If this note means more than that Ms. D. can speak and understand a little English, it is at variance with many others. In sharp contrast to very numerous record entries made over a decade by many hospital staff who dealt with Simone D. on a day-to-day basis, Dr. Brodsky testified that when Ms. D. was "in a better state of mind, she responds pretty well and understands English when she improves," Tr R52. Dr. Brodsky had seen Ms. D. to give her ECT, Tr R40, 49-50, when, as noted above, Ms. D. was generally uncommunicative, and to evaluate her, when she was also uncommunicative, Tr R50-52, so the soundness of the doctor's view is dubious.

[35] A 1995 tentative plan was to have her move back with a relative or to an adult home with "Spanish setting," Hosp Rec R145. Another version of such a plan called for aftercare "at Spanish-speaking OPD," Hosp Rec R150. Yet another was to discharge her to Family Care with "a Spanish-speaking family," Hosp Rec R159. The latest tentative discharge plan provided, "Ms. [D.] would benefit from Spanish-speaking staff at nursing home. Nursing home will provide Spanish-speaking personnel for patient," Hosp Rec R260

disciplines as well as others who are hospitalized.[36] This approach is illustrated in great detail in Ms. D.'s latest treatment plan, written the same month as the hearing, Hosp Rec R230-247, which is filled with prescriptions for many kinds of verbal therapy and rehabilitative teaching by many kinds of staff, designed to deal with all her problems. It also called for interactions with others hospitalized with her. Earlier treatment plans were very similar, Hosp Rec R248-272A. In his most recent annual review of Ms. D.'s treatment, written in June, 2005, Dr. Zhang recommended continuation not only of ECT and medications but also of "[s]upportive, recreational, rehab and group therapies," Hosp Rec R113.[37]

Ms. D.'s record is full of references to her not participating much in the sessions and groups prescribed for her, *e.g.*, Hosp Rec R237 ("She has been refusing to attend activities which are not held in the day hall."), but that is not surprising, since they are not conducted in her language. The New York state hospital system that runs Creedmoor has Spanish-speaking wards

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[36] For example, in Creedmoor's inpatient service, "Treatment is provided by multi-disciplinary teams of professional and para-professional staff," New York State Office of Mental Health, Creedmoor Psychiatric Center Inpatient Services, http://www.omh.state.ny.us/omhweb/facilities/crpc/inpatient%5Fservices.htm.

[37] At the same point the ward social worker recommended group therapy "to decrease Ms. [D.'s] unpredictable and aggressive behavior and to help her to interact more in a positive manner with others, ... to decrease patient's depression and anger, [and] ... to increase patient's involvement in her environment," Hosp Rec R135. *See also* June, 2005 nursing plan, Hosp Rec R192-93 ("RN 1:1 with patient to discuss patient's feelings, concerns or fears that may have contributed to depression," etc.) and Rehabilitation Assessment, Hosp Rec R204-206. Recommendations for verbal therapy go back to the day after Ms. D.'s admission to Creedmoor in 1994, Hosp Rec R129, 146.

in the Bronx and Manhattan, boroughs of New York City adjacent to Queens,[38] but Simone D. has never been transferred to one of them.

The potential benefit of her being with many other people who are also being treated and who speak her language is suggested by this passage from her record:

> During 4/97 another Spanish-speaking patient was admitted to the ward and [Ms. D.] became very motherly towards her; holding her hand, telling staff what it was that her new friend wanted.

Hosp Rec R159.[39] Further, her latest treatment plan notes that "she only responds at times when spoken to by select staff," Hosp Rec R237, *see also* Hosp Rec R261 (same). Apparently some staff have had some success in reaching Ms. D. Common sense indicates that speaking her language would be an advantage in doing so.

In June, 2004 Dr. Zhang noted,

> ... There is a language barrier. We have been getting translators to help out with communication on a regular basis. She would benefit more if she were in a Spanish unit (Spanish-speaking).

Hosp Rec R119.

> The [treatment] team has made [sic] to contact and her family (her son) regarding to transfer the patient to a Spanish-speaking inpt unit at another facility. However, her son has not got back to the team.

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[38] See Point III, below.

[39] The same report notes that she communicates at some level by gestures, *id.*

Hosp Rec R118.[40] Waiting for Ms. D.'s son was like waiting for Godot,[41] and his permission was not required. Although it would be very desirable to talk with him about a major change, so long as Simone D. agrees, securing his cooperation appears to have been totally and obviously impractical.

In June, 2005, a year after the first recommendation by Dr. Zhang for a Spanish-speaking ward that is in evidence, there had been no movement on this front. Dr. Zhang again recommended a Spanish-speaking ward:

> … She understands and speaks some English. There is a language barrier. There are Spanish-speaking staff members on the ward, but she would benefit more from the treatment if she were in Spanish ward.

Hosp Rec R108. There is no further mention of moving her to such a ward, or any explanation why this obvious recommendation by her treating doctor

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[40] This passage also states that "[s]he refuses to talk to a Spanish-speaking psychiatrist for therapy/treatment." It appears this refers to a doctor in another ward to which Simone D. was later briefly transferred, Hosp Rec R 697. The record does not reveal what attempts were made prior to the transfer, which is discussed three paragraphs below.

[41] As noted above, his contacts have been quite sporadic. The hospital record indicates also that staff understood he was a drug-user, was often "in trouble," was "in and out of jail," moved frequently, and at times refused or neglected to give the hospital his contact information, Hosp Rec R126, 136,143, 145, 157, 377, 420, 544. He finally visited in March, 2005, when he had been absent almost a year, *e.g.,* Hosp Rec R400, and it had been at least 10 months since hospital staff had started to try to contact him to discuss a transfer to a Spanish-speaking ward. At first he refused to give his new contact information. He was upset that his mother had had a broken arm, which had happened at least by June, 2004, Hosp Rec R216-17, 426, 544. In May, 2005, he agreed to meet with his mother's treatment team to discuss her care, but "he did not show up and has not returned [social] worker's phone calls," and he continued not to return calls or visit for months, Hosp Rec R426, 437, 450, 466, 487, 489, 505, 510, 511. In fact there is no indication he had contacted the staff or his mother even by the date of the hearing at the end of November, 2005.

was not followed. Here too, it is far from "crystal clear" that Creedmoor does not "have any other choice."

In the fall of 2004, nine months prior to this second recommendation of a Spanish-speaking ward, Ms. D. had been transferred briefly to a different ward in Creedmoor which had a purportedly Spanish-speaking psychiatrist, Dr. Rousseau.[42] Contrary to Creedmoor's suggestion, Brief for Petitioner-Respondent at 42, this was not generally a "Spanish-speaking ward."[43] She remained there only about six weeks, Hosp Rec R107.[44] In a progress note written just 16 days after she arrived, Dr. Rousseau expressed defeat ("All attempts to reach out to her failed"), Tr R84,[45] *see also* Hosp Rec R697, giving up that quickly although Ms. D. had been largely

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[42] Dr. Rousseau's Spanish proficiency was apparently an issue to Ms. D.'s counsel, who asked about it. Dr. Brodsky testified that Dr. Rousseau speaks Spanish "perfectly," even though she had already acknowledged that she does not herself speak Spanish and could not tell whether Simone D. speaks fluent Spanish, Tr R51-52, 82. The judge sustained an objection to a question on how Dr. Brodsky knew Dr. Rousseau's proficiency, Tr R83.

[43] Creedmoor has no generally Spanish-speaking ward. As noted above at 30, Dr. Zhang recommended a Spanish-speaking unit "at another facility." Similarly, the ward social worker recorded attempts to talk to Ms. D's family about a transfer "to the Spanish Unit at Bronx Psychiatric," Hosp Rec R137. Although OMH's website clearly describes entirely Spanish-speaking wards at Bronx and Manhattan Psychiatric Centers, see below at 60-61, footnote 69, its description of Creedmoor mentions only a unit that offers *translation* "as needed," which Simone D. was supposedly already getting, see 30 above, New York State Office of Mental Health, Creedmoor Psychiatric Center Inpatient Services, http://www.omh.state.ny.us/omhweb/facilities/crpc/inpatient%5Fservices.htm. There is no indication that Simone D. was transferred even to the Spanish "translation" ward at Creedmoor.

[44] Dr. Brodsky testified that she recalled the transfer was for at least six *months*, Tr R80.

[45] Although Creedmoor relied on this brief transfer in the assessment attached to its application for an order, R31, it did not produce progress notes from the transfer in court. When questioned, Dr. Brodsky did not dispute the above text of the note, but technically we have only the word of Ms. D.'s counsel for it.

linguistically isolated for over a decade.[46] She was transferred back to her former ward, and, as just noted, the following June Dr. Zhang again recommended moving her to a Spanish-speaking ward. However, she was not transferred but remained in the same ward with Dr. Zhang at the time of the hearing, Hosp Rec R105, 550A

F. Many New York State Psychiatric Centers Do Not Use ECT

Whether an individual confined in an OMH institution receives ECT depends at least in part on which institution the individual is in. This casts doubt on whether ECT is the "only choice" for Simone D. The most current version of an OMH pamphlet recites:

> Five of OMH's 27 psychiatric centers currently provide on-site ECT (Creedmoor, Manhattan, Pilgrim and Rockland PCs, and NYS Psychiatric Institute). Twelve psychiatric centers reported ECT treatment using community hospitals during calendar year 2000. Ten psychiatric centers report no ECT procedures during the year 2000.

New York State Office of Mental Health, Information about ECT, 2 (2001), http://www.omh.state.ny.us/omhweb/ect/index.htm.

G. Fact-Finding by the Trial Court Was Woefully Deficient

Dr. Brodsky, Creedmoor's ECT psychiatrist and the only witness at the hearing, showed lack of familiarity with Simone D.'s relevant hospital

[46] There is no indication in the record how often Dr. Rousseau spoke with Ms. D., but when she was supposed to be seen individually by Dr. Zhang starting in November, 2004, the treatment plan called for him to speak with her individually just 15 minutes per week, Hosp Rec R264. The judge sustained an objection to a question on how many progress notes Dr. Rousseau wrote, see below at 37.

record in other ways, and had not even reviewed her entire record, Tr R55. For example, until reminded she did not recall whether Ms. D. had ever received unilateral as opposed to bilateral ECT, Tr R58, which is highly relevant to risk of cognitive damage (see Point II(C), below); even Dr. Brodsky acknowledged that unilateral "gives less side effects," although bilateral is preferable for greater effectiveness, Tr R62-63. She had not read the reports of unilateral ECT which Simone D. had received in 1996, Tr R63. She did not know until prompted that Simone D. had received ECT prior to being at Creedmoor, Tr R61-62.

The record put into evidence was only a fraction of the total hospital record, Tr R37-40, and it is apparent that the trial judge did not review it before announcing his decision from the bench, Tr R37-40, 81, 90-91 .

The trial judge declined to appoint an independent psychiatrist to act as the court's expert, Tr R92. His severe limitations on Simone D.'s counsel's attempts to cross examine Dr. Brodsky (see next section) further isolated him from facts bearing on the constitutionally-mandated balancing of risks and benefits and "narrow tailoring" (see Point I(B), below). He explained that he already knew about ECT. When another judge had appointed an independent expert in an earlier proceeding in 2003, the independent expert had recommended *against* further ECT and in favor of

placing Simone D. with a Spanish-speaking psychiatrist or other therapist for intensive therapy, and that judge had denied an order for more ECT over objection, Hosp Rec R696.

The Trial Court Severely Curtailed Cross Examination and Relied on its Own Unspecified, Untested, Unreviewable "Knowledge"

The record speaks for itself. The trial court cut off the following important lines of cross-examination during the proceeding in which it took the very serious step of authorizing 30 more ECT sessions over Simone D.'s objection. In doing so it announced its reasons and its reliance on its own "knowledge," as indicated below:

- The total number of ECT procedures Simone D. had had at Creedmoor, Tr R71. This goes fundamentally to risks and benefits and consistency with accepted professional judgment, practice and standards.

- How far back Dr. Brodsky had reviewed progress notes in Simone D.'s hospital record, Tr R56. This went to benefits achieved, cognitive damage already suffered, and the doctor's competence to opine on risks and benefits. The trial judge commented, "It is the present condition that we're interested in," *id.*

- Whether the ECT Simone D. received in 1996 (when ECT was stopped for bad results – see above at 10-11, 21-22) was unilateral or bilateral, Tr R58. This went to a distinction highly relevant to risks of cognitive damage (see Point II(C), below) and thus to Dr. Brodsky's competence to opine on risks and benefits, and consistency with accepted professional judgment, practice and standards.

- The facts noted by the hospital social worker on Simone D.'s depressed and withdrawn condition in 2003, when she had received over three years of continuous ECT, Tr R72-73. This went to the heart

of the "benefits" of ECT for the central symptoms of her illness and consistency with accepted professional judgment, practice and standards. The trial judge asked, "Hold it, counselor, you going to be much longer? We are going to go over everything that's ever happened to this patient? ... Next question," Tr R73.

- How ECT "is done" (the judge's words), Tr R63-64. This went potentially to many issues, including how receiving ECT would affect one's "quality of life." The judge said, "The court is familiar with how it is done, sir. … The court is familiar with how it is done, sir. Go on to something else," *id.*

- The machine Dr. Brodsky used to administer ECT, and the Food and Drug Administration's classification system for such machines, Tr R69. These questions went to risks and benefits.

- What a grand mal seizure is – which is induced by ECT – Tr R65. This went at least to the risks of brain damage, other physical risks and "quality of life." The trial judge said, "The court is familiar with that, sir," *id.*

- What succinylcholine[47] is and whether a medication is used to paralyze muscles during ECT, Tr R70. These questions went at least to medical risks and unpleasant side effects. The trial judge sustained an objection after being reminded by Creedmoor's counsel that "the court has said it is familiar with ECT," Tr 70-71.

- Whether oxygen is administered during ECT, Tr R71. This went to medical risks and "quality of life."

- Whether Creedmoor has a protocol to assess a patient's memory before and after ECT, Tr R77-78. This went to precautions against cognitive damage. The judge sustained the objection after Creedmoor's counsel pointed out that Dr. Brodsky had testified the benefits outweighed the risks, *id.*

[47] One of the drugs administered to Simone D. during ECT, *e.g.* Hosp Rec R724, 730, 735, 741, 753, 758.

- Whether through 2003 Ms. D. had a psychiatrist or social worker at Creedmoor who could speak Spanish fluently, Tr R78. This went to a less intrusive alternative.

- Whether a prior application for ECT over objection was denied in 2003, and when the independent psychiatrist in that proceeding recommended that Ms. D. be provided a Spanish-speaking psychiatrist or social worker, Tr 79-80. These questions went at least to a less intrusive alternative (see above, 27-33) and the urgency of resuming ECT. The judge said, "We're now in November of 2005, sir," Tr R80.

- Whether anything was done on that recommendation for the following 13 months, Tr R80. This went to a less intrusive alternative and the urgency of resuming ECT.

- The basis for Dr. Brodsky's assertion that Dr. Rousseau speaks Spanish "perfectly," given that Dr. Brodsky does not speak Spanish, Tr R81-82. This went to a less intrusive alternative.[48]

- Whether Dr. Brodsky knew how many progress notes Dr. Rousseau wrote while Simone D. was briefly transferred to her ward, whether that number was just three, and whether Dr. Brodsky recalled reading those notes, Tr. R83-84. These questions went to a less intrusive alternative. The judge demanded, "Do you expect this doctor to know every detail of every day of everything that's happened to this patient?", and indicated the doctor was before the court to testify about "[w]hat the patient needs at the present time," *id.*

- Whether after 10 years of linguistically isolating Simone D., Creedmoor gave up on Spanish-language therapy in six weeks, Tr 85. This went to a less intrusive alternative.

[48] Ms. D. was transferred briefly to Dr. Rousseau's ward for psychotherapy by Dr. Rousseau, supposedly in Spanish – see above at 32-33.

ARGUMENT

I. Due Process Requires Effective Assistance of Counsel prior to Forced ECT, including the Opportunity to Cross Examine Fully, and Clear and Convincing Evidence on the Record

A. *Rivers v. Katz* Applies to Forced ECT

The same requirements imposed by the State's Due Process Clause for overriding the objection to psychotropic mediation raised by a person involuntarily committed to a psychiatric hospital apply to overriding his or her objection to ECT. *In re: Adam S.*,285 A.D. 2d 175 (2nd Dept. 2001), *lv. den. sub nom. Adam S. v. Weinberg*, 97 N.Y. 2d 603; *Matter of Pamela S.*, 286 A.D. 2d 504 (2nd Dept. 2001); *Matter of Harvey S.*, 2007 WL 926467 (2nd Dept. March 27, 2007); *Matter of Rosa M.*, 155 M. 2d 103 (Supreme Court, New York County 1991). Creedmoor does not dispute this proposition, *see* Brief for Petitioner-Respondent at 28, note 6.

This is entirely logical. The due process requirements concerning medication over objection are founded on the physical intrusiveness of the treatment, *Rivers v. Katz*, 67 N.Y. 2d 485, 493 (1986), *reargument den.* 68 N. Y. 2d 808.[49] ECT is enormously intrusive, involving the use of medication to paralyze muscles and breathing and anesthetize the individual,

[49] "It is a firmly established principle of the common law of New York that every individual 'of adult years and sound mind has a right to determine what shall be done with his own body' *(Schloendorff v Society of N. Y. Hosp.*,211 NY 125, 129 [Cardozo, J.]) and to control the course of his medical treatment *(see, Matter of Storar*...." This common-law principle is also embodied in the Due Process Clause, *id.*

then the use of a strong electric current through his or her brain to deliberately induce a grand mal seizure, which causes blood pressure to spike, etc. See 25-26, above.

There is also statutory support for the seriousness of ECT and therefore affording Constitutional protection with respect to its involuntary use. The Legislature has recognized that administration of ECT requires informed consent of the individual, Mental Hygiene Law sec. 33.03(b)(8), Public Health Law sec. 2504(1), or of someone traditionally empowered to consent to major medical treatment - minor's parent, adult's guardian, Public Health Law sec. 2504(2), Mental Hygiene Law secs. 81.03(i) & 81.22(8), or a judicial order. On the other hand, surrogate decision-making panels and individuals in parental relation to a child under the General Obligations Law may not consent to ECT, as they may not consent to withdrawal of life-sustaining treatment.[50]

[50] ECT is exempted from the jurisdiction of statutorily-created surrogate decision-making committees, which are authorized to consent to most other major medical treatments for certain individuals with mental disabilities, Mental Hygiene Law sec. 80.3(a), and the power to consent on behalf of a child which is conferred on an individual who has been determined to be in parental relation to the child pursuant to the General Obligations Law, Public Health Law sec. 2504(2). In both situations the Legislature has limited the authority conferred so as to exclude also consent to withdrawal of life-sustaining treatments. ECT is not justified here as a life-sustaining treatment – far from it – but the seriousness with which the Legislature has treated it in these statutes is worthy of note.

B. Due Process Requires a Balancing of Risks and Benefits and Consideration of Less Intrusive Alternatives, and a Forced ECT Order Must be Narrowly Tailored

In *Rivers*, this Court held that there is a fundamental State Due Process right to refuse antipsychotic medication, even for one involuntarily committed to a hospital, which can be overcome only by a compelling State interest, *Rivers* at 493, 495. It held also that due process requires that, when deciding whether to order medication over the objection of such an individual who lacks capacity to make a rational decision on the subject,

> a court [must] balance the individual's liberty interest against the State's asserted compelling need on the facts of each case to determine whether such medication may be forcibly administered.

Id. at at 498. Further,

> the court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments.

Id. at 497-98. Here, many factors bring into question whether the benefits could possibly outweigh the risks, and ending Simone D.'s linguistic isolation constitutes a less intrusive alternative, see above at 37-33 and Point III, below.

The judge in a *Rivers* hearing must also consider "whether a particular drug is the least intrusive, whether it is capable of producing the least serious

side effects, *and the proper length of its use*," *id* (italics added). Here the extent of ECT use is a critical factor in the risk-benefit analysis.

This Court further held,

> [M]edical determinations as to the need to administer antipsychotic drugs must ... be made in accordance with accepted professional judgment, practice and standards.

Id. at 498-99. There is no evidence on this point in the record, and as will be shown below in Point II(A), involuntary use of ECT on one who benefits as little as Simone D. appears to be outside accepted professional judgment, practice and standards.

C. Due Process Requires Effective Assistance of Counsel, including Cross Examination, and Clear and Convincing Evidence on the Record

In the course of the Constitutionally-required hearing, the individual who objects to treatment has the right to assistance of counsel, *Rivers* at 498. Again, this is entirely logical. The court hearing the case needs a thorough presentation to make the necessary determinations about complex and vital matters. The right to cross examination is "basic to our judicial system," *People v. Ramistella*, 306 N.Y. 2d 379, 384 (1954), and must extend to all the relevant considerations before the court. Creedmoor does not dispute these propositions, either, only whether adequate cross examination was allowed, Brief for Petitioner-Respondent at 36-46.

Further, "[t]he State would bear the burden to establish by clear and convincing evidence that the proposed treatment meets these criteria" concerning narrow tailoring, etc., *Rivers* at 498. A judge may not without the parties' consent rely on evidence outside the record or become an unsworn, un-examined witness, and since there is a right to appeal, the record must contain all the information relied upon, so a proper appellate review can occur, *Matter of Simone D.* at 935-36 (dissent) and cases cited. Creedmoor does not contend that a judge may properly rely on his own knowledge – the only dispute on this point is whether the trial judge in Simone D.'s case did so, Brief for Petitioner-Respondent at 48-50.

II: There Are No Controlled Studies on the Safety or Efficacy of Long-Term "Maintenance" ECT, Such as That Sought over Simone D.'s Objection, but There Is Ample Evidence Supporting Alarm about Persistent Memory Loss

It is critical to focus on the fact that Creedmoor seeks – over Simone D.'s objection - to extend the number of ECTs for her to at least 178. This number is many times greater than the usual course of ECT. It takes Creedmoor's proposed treatment over her objection far beyond any controlled studies on the *safety and efficacy* of ECT. The lack of systematic evidence on risks and benefits of long-term ECT is generally acknowledged by the relevant authorities, and it persists to this day. Risks and benefits are

at the heart of the *Rivers* test, and without good science, it is especially critical to have a full inquiry into risks and benefits in the individual case. Full cross examination and a complete record are especially vital here.

In addition, sophisticated new research just published shows that *persistent* cognitive damage can result from even short-term ECT, especially with bilateral electrode placement like that used for years on Simone D. This new research flatly contradicts Dr. Brodsky's assertion that cognitive damage from ECT is almost always transitory. It also shows that the amount of damage is *proportional* to the number of ECT procedures. Thus, a number as large as 178 would be considerable cause for alarm even if Simone D. did not already have persistent cognitive deficits.

"Maintenance ECT" – generally defined as a course of ECT lasting over six months beyond treatment for the acute phase of illness – has traditionally been reserved primarily for individuals who are much improved, are able to leave the hospital, and consent – hardly Simone D's situation. Yet she has already had *years* of ECT. Creedmoor appears to be outside accepted professional judgment, practice and standards, and it has put nothing in the record on this point.

Given the generally acknowledged lack of systematic research,[51] a court should not – as a matter of law - compel such an extended course of ECT over an individual's objection absent extraordinarily compelling individual circumstances, and the individual's counsel should be given broad latitude to develop the record. Here, Simone D.'s attorney was denied important cross-examination going in many ways to the extent of risks and benefits, as well as to a less intrusive alternative. In addition, the lack of good science illustrates that the trial judge could not possibly have had accurate personal knowledge on the general level of long-term risks and benefits, *since no one does*.

A. The Extended Maintenance ECT Creedmoor Seeks is Far, Far Longer than the Typical Acute Course of ECT, and Outside the Usual Parameters Even for Maintenance ECT

The number of ECT procedures Creedmoor seeks for Simone D. is far beyond the usual course, and her circumstances are vastly different from those in which maintenance ECT is generally accepted in the medical profession.

The typical acute course of ECT is quite brief. The State Office of Mental Health has published guidelines for ECT in psychiatric facilities it licenses, New York State Office of Mental Health, Electroconvulsive

[51] State regulations preclude "emergency" ECT without consent or a court order, 14 NYCRR secs. 27.8(b), 27.9 & 527.8(c)(1). Here there is no emergency.

Therapy Review Guidelines (2003).[52] While acknowledging that repeated courses of treatment are sometimes necessary, the guidelines suggest that 6-12 are appropriate numbers of ECT procedures for major depression, Guideline 6k.[53] Creedmoor's proposed treatment over objection for Simone D. extends to at least *15 times* the typical acute course of ECT.

In its book on ECT, which OMH endorses and incorporates into its guidelines,[54] the American Psychiatric Association employs the concept of maintenance therapy, which it defines as ECT and/or medication that goes on longer than six months after treatment for the acute phase of illness. It also uses the concept of continuation therapy, which lasts up to six months beyond the acute phase, American Psychiatric Association, *The Practice of Electroconvulsive Therapy*, 206 (2001). These definitions are generally followed in the literature. Simone D. has long since passed into the realm of "maintenance ECT."

The APA considers maintenance ECT most justified when it can keep an individual *free of symptoms*[55] – hardly Simone D.'s situation.

> Maintenance therapy is defined as the prophylactic use of psychotropics or ECT longer than 6 months after the end of the index

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[52] http://www.omh.state.ny.us/omhweb/ect/guidelines.pdf.
[53] Similarly OMH's pamphlet Information About ECT states, "The course of treatment is 2 to 3 ECT procedures per week, over several weeks...," *id.* at 1.
[54] *ECT Guidelines, suprai* at 1, Information About ECT, *supra*, at 1-2.
[55] In Britain even this use of maintenance ECT for people with major depression would contravene National Health Service guidelines – see below at 51.

episode. Conceptually, maintenance therapy aims to protect against *recurrence*....[56]

Maintenance treatment is most strongly indicated when the patient has a strong history of recurrent illness or when present or past attempts to stop or taper continuation therapy have been associated with *return* of symptoms. ...

...

... The frequency of maintenance ECT should be kept to the minimum compatible with sustained *remission*. ...

Id., 210-11 (citations omitted, italics added).

And the APA assumes that someone receiving continuation or maintenance ECT will be able to and will consent.[57] It is entirely logical to reserve longer-term ECT for people who consent and benefit greatly, since there are no controlled studies on the safety and efficacy of longer-term use of ECT – see next section.

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[56] A medical definition of *recurrence* is

> (1) A return of the symptoms occurring as a phenomenon in the natural history of the disease, as seen in recurrent fever; (2) Relapse.

Steadman's Medical Dictionary, 24th edition 1208 (Williams & Wilkins, 1982).

[57]

> Continuation/maintenance ECT ... differs from a course of [acute] ECT in that 1) its purpose is the prevention of relapse or recurrence; [and] 2) the patient's clinical condition is improved .... Because the purpose of continuation/ maintenance treatment differs from that of an acute course of ECT, a new informed consent process should be initiated .... Because a continuation ECT series often lasts at least 6 months, and because continuation/maintenance ECT is provided to individuals who are clinically improved and already knowledgeable about the treatment, a 6-month interval is suggested before readministration of the formal consent document ....

Id. at 99.

Similarly, in 1999, one of the leading authors on ECT remarked on the improved state of individuals who are administered ECT beyond the acute stage, the brevity of the typical course of treatment even after the acute stage, and the fact that maintenance ECT is based on agreement between the individual and the physician.[58]

Finally, the author of a well-known text on ECT observed:

> Maintenance ECT is an outpatient procedure for patients who have already exhibited satisfactory improvement with a conventional course of ECT and who have previously failed or do not tolerate maintenance drug therapy (Fink *.et al.* 1996).

Richard Abrams, Electroconvulsive Therapy (4th edition), 160 (2002).

Simone D.'s ECT history is already vastly longer than even the usual course of maintenance ECT. She has not improved to the point of being able to be treated as an outpatient, much less achieved remission of her symptoms, or become able to give informed consent. She vehemently objects to more ECT. Her situation is clearly outside the usual professional parameters even for maintenance ECT.

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[58] It is difficult to predict the number of treatments required after the initial course of ECT, but it is *rarely fewer than six*. Follow-up office visits with the patient and discussions with the family will determine the number. If a patient has experienced no symptoms for several months, treatment can be stopped.

Usually, depressed patients need between three and nine treatments after the successful initial course. Some may need years of weekly treatments. ... *Such courses are unusual*....

Max Fink, Electroshock 14 (1999) (citations omitted, italics added).

B. There Is a Generally Acknowledged Evidence Gap on Risks and Benefits of Maintenance ECT

In 2001, the American Psychiatric Association noted the "absence of controlled studies of the efficacy or safety of long-term maintenance ECT," American Psychiatric Association, *The Practice of Electroconvulsive Therapy* 212 (2001). The State Office of Mental Health endorses the APA manual and incorporates it into its guidelines, *supra* at 45, note 54.

The same absence of systematic studies was noted a few years earlier by Canadian authors who surveyed the literature. The summary of their results includes this observation: "Cognitive risks of C/MECT [continuation and maintenance ECT] need to be further studied because the literature to date consists mostly of case reports and anecdotal evidence. Controlled studies with well-defined outcome measures are needed," Kiran Rabheru and Emmanuel Persad, *A Reviw of Continuation and Maintenance Electroconvulsive Therapy*, 42 Canadian Journal of Psychiatry 476 (1997).

> [N]o objective data are available on the effects of serial ECT on cognition, and some negative consequences, particularly involving autobiographical data processing, should be suspected until definitive studies are concluded.

Id. at 481. And the authors noted that Harold Sackeim, a leading figure in ECT research who works for the New York State Office of Mental Health,[59] listed among the questions for further research, "How severe are adverse effects of C/MECT compared with other treatments?",[60] and "How long should C/MECT be given?", *id.* at 482.

The gap in research with respect to prolonged ECT has not narrowed since the APA's book was published in 2001. The following year, a review of the literature published by the Association for Convulsive Therapy concluded that,

> One concern about maintenance ECT is that the treatment may compromise cognition to an unacceptable extent. This concern was addressed in two case reports and one small study, but in no systematic investigation.

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[59] Dr. Sackeim, a neuropsychologist, is a member of the American Psychiatric Association's Committee on Electroconvulsive Therapy, which prepared the APA's 2001 book, *The Practice of Electroconvulsive Therapy, supra*; Chief of the Department of Biological Psychiatry at the New York State Psychiatric Institute; and a professor of psychiatry and radiology at Columbia University, APA, *supra*, viii. The New York Psychiatric Institute, like Creedmoor, is operated by the New York State Office of Mental Health, *see* http://www.omh.state.ny.us/omhweb/aboutomh/omh_facility.html. See also Columbia University website, http://asp.cumc.columbia.edu/facdb/profile_list.asp?uni=has1&DepAffil=Psychiatry.

[60] The authors note that such research will be challenging because of "biased baselines" – *i.e.,* situations in which it is "difficult to tease apart the various components contributing to an individual's cognitive impairment … [-] the effects of age, the psychiatric disorder, the use of concurrent medications, and the effect of previous ECT," *id.* at 481-482. Simone D. presents just such a puzzle: She is well into her sixth decade, she has severe mental illness, she has been taking medications for years, and she has had at least 148 ECT procedures already. It is therefore impossible to sort out how much of her impairment is due to which factor(s). *But the absence of data on the risks and benefits of long-term maintenance ECT still matters greatly for her. The new research on acute ECT discussed in the next section suggests there is a significant chance that the damage she has already suffered is from ECT, and she can ill afford to lose more cognitive ability.*

Chittaranjan Andrade and S. Kurinji, Continuation and Maintenance ECT: A Review of Recent Research, 18 Journal of ECT 149, 155 (2002).

In 2003, the same association published an article by ECT practitioners at the Mayo Clinic in Minnesota, who observed, "Little is known about the outcomes of long-term use (> 1 year) of maintenance ECT." The article reviewed charts of 43 individuals who received maintenance ECT in the authors' practice, and was the largest series of published case reviews on maintenance ECT to that date. Their review of the prior literature had turned up references of any sort to just 72 individuals who had received a year or more of maintenance ECT. The people in their own practice on whom they reported had had an average of 50.4 ECT procedures, a third or less of what Simone D. has had already. They reviewed only people who "succeeded" in staying in maintenance ECT at least a year, and did not monitor retrograde amnesia, impairment of the ability to recall past events.[61] They concluded by saying,

> Finally, emphasis should be placed on the need for more data on ongoing memory function of long-term M-ECT patients. In particular, attempts should be made to assess retrograde memory function, because this is the type of memory dysfunction most

[61] The individuals whose charts were reviewed showed various benefits, and none showed cognitive impairment of the kinds measured. But the authors had no data for others at their clinic for whom physicians had stopped maintenance ECT sooner than a year, so this small study stands at most for the proposition that *some* people can benefit without *certain* side effects, not that the procedure is generally free of side effects.

> troublesome to patients. Furthermore, for those patients on schedules of treatment more frequent than monthly, there may be ongoing disturbance in anterograde[[62]] memory function, so this should be assessed as well.

J. Calvin Russell, Keith G. Rasmussen, M. Kevin O'Connor *et al.*, *Long-Term Maintenance ECT: A Retrospective Review of Efficacy and Cognitive Outcome.* 19 Journal of ECT 4-8 (2003).

Also in 2003, the National Institute for Clinical Excellence, the standard-setting body for the National Health Service in England and Wales, reacted to the lack of research by publishing guidelines which include the following:

> As the longer-term benefits and risks of ECT have not been clearly established, it is not recommended as a maintenance therapy in depressive illness.

National Institute for Clinical Excellence, Guidelines on the Use of Electroconvulsive Therapy: Technology Appraisal 59 (2003), guideline 1.8 at 6. NICE explained,

> ECT may cause short- or long-term memory impairment for past events (retrograde amnesia) and current events (anterograde amnesia). ... [A] number of individuals find their memory loss extremely damaging and for them this negates any benefit from ECT.

Id., 9-10.

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[62] Anterograde memory is memory for new information, and it is obviously basic to learning and adaptation.

> Further research is urgently required to examine the long-term efficacy and safety of ECT, including its use as a maintenance therapy .... [O]utcome measures should include users' perspectives on the impact of ECT, the incidence and impact of important side effects such as cognitive functioning, and mortality.

Id., 18.

Two years after publication of the NICE guidelines, Britain's Royal College of Psychiatrists revised its ECT Handbook. The new edition contains the following comment on maintenance ECT:

> [T]here are as yet no data from a randomized controlled trial of continuation or maintenance ECT to support or refute its efficacy. *This evidence gap* was the major reason that the National Institute for Clinical Excellence (NICE) recommended that ECT should not be used as a long-term treatment to prevent recurrence of depressive illness ....

Richard Barnes, *The Use of ECT as a Continuation or Maintenance Treatment*, *in* Allan I. F. Scott, ed., ECT Handbook (2nd edition): The Third Report of the Royal College of Psychiatrists' Special Committee on ECT, 78, 80 (2005) (citations omitted, italics supplied).

The response to NICE's guidelines published by the Association for Convulsive Therapy tried to point to studies not previously considered in reviews of the literature. However, it referred to only one prospective controlled study involving *just 13 people with depression.*[63] Melissa

[63] These 13 individuals received a year of continuation and maintenance ECT and in most cases medication as well. They were found to have more favorable outcomes on re-

Frederikse, Georgios Petrides and Charles Kellner, *Continuation and Maintenance Electroconvulsive Therapy for the Treatment of Depressive Illness: A Response to the National Institute for Clinical Excellence Report*, 22 Journal of ECT 13, 14 (2006).[64]

The evidence gap was confirmed in an article published just four months ago by the Association for Convulsive Therapy, which was written by a group including two of the three authors of the article cited in the last paragraph. This new article presented the first systematic study comparing the effectiveness of continuation ECT (10 treatments over six months after the end of acute treatment) with that of continuation antidepressant treatment. Its authors commented,

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hospitalization than 13 others receiving just medications. Even this small study is beside the point for Simone D, who has been subjected already to *several* years of ECT, and who no one claims will be able to leave the hospital, even with ECT. The study, conducted in Austria, is reported in E. Swoboda, A. Conca, P. Konig *et al.*, *Maintenance Electroconvulsive Therapy in Affective and Schizoaffective Disorder*, 43 Neuropsychobiology 23 (2001).

[64] There is also at least one small study suggesting cognitive danger from moderately extended ECT. *See* L. Rami-Gonzalez, M. Salamero, T. Boget *et al.*, *Patterns of Cognitive Dysfunction in Depressive Patients during Maintenance Electroconvulsive Therapy*, 33 Psychological Medicine 345 (2003), which recounts a study of 11 individuals with major depression in Barcelona, Spain, who had had an average of 36.1 ECT sessions, less than a quarter of the number Simone D. has had. Compared with 11 matched individuals who had not received any ECT, the 11 who had received maintenance ECT had significantly lower scores on one test of encoding new information and several measuring "frontal functions," such as planning and problem-solving. By way of background, the authors stated, "the risk of cognitive dysfunction associated with [M-ECT] remains unknown," *id.* at 345 (citations omitted). They concluded, "further studies are required to establish the cognitive state in patients during M-ECT, as this will help to determine their quality of life and everyday functioning during treatment." *Id.*, 345-349.

> [ECT] has repeatedly been demonstrated as an extremely effective acute treatment for major depressive episodes [citations omitted]. It is also used clinically as a continuation and maintenance treatment, *despite a lack of well-designed trials to support such use* [italics added, citing Andrade & Kurinji, *supra*].[65]

This study was funded by the National Institute of Mental Health. It filled the gap in systematic research only to the extent of comparing the *effectiveness* of a continuation course of *10* electroconvulsive treatments with that of continuation antidepressants. Charles H. Kellner, Rebecca G. Knapp, Georgios Petrides *et al.*, *Continuation Electroconvulsive Therapy vs Pharmacotherapy for Relapse Prevention in Major Depression*, 63 Archive of General Psychiatry 1337-38 (Dec. 2006).[66]

There are no controlled studies on the safety and effectiveness of maintenance.

C. New Evidence Shows Persistent Memory Loss from Even Short-Term ECT

Persistent cognitive deficits resulting from ECT, long feared, have recently been confirmed to be a real risk for depressed individuals, even with routine acute courses of ECT, which are generally quite brief. In an article

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[65] Both forms of treatment "were shown to be superior to a historical placebo control, but both had limited efficacy, with more than half of patients either experiencing disease relapse or dropping out of the study," *id.*

[66] The persisting lack of systematic research on maintenance ECT is illustrated also by the quite recent publication of a letter to a journal recounting a chart audit of just 17 individuals who received M-ECT in Australia. L. M. Lim, *A Practice Audit of Maintenance Electroconvulsive Therapy in the Elderly* (letter), 18 International Psychogeriatrics 751 (2006).

published this year, Harold Sackeim[67] and colleagues summarized the knowledge base prior to their efforts, and their own research on acute ECT as administered in New York City-area hospitals, as follows:

> Empirical information about ECT's long-term effects derives mainly from small sample studies conducted in research settings, with follow-up intervals frequently limited to 2 months or less. By excluding individuals with significant medical and psychiatric comorbidities, use of optimized forms of ECT, and limited statistical power, these studies could not adequately assess the severity and persistence of long-term deficits, In a sample treated in community settings, we conducted the first large-scale, prospective long-term study of cognitive outcomes following ECT. We characterized the profile of cognitive change immediately and 6 months following completion of ECT, and examined the relationship of treatment technique and patient characteristics to cognitive outcomes. ...

Harold A. Sackeim, Joan Prudic, Rice Fuller *et al.*, *The Cognitive Effects of Electroconvulsive Therapy in Community Settings,* 32 Neuropsychopharmacology 244 (2007). Their work was funded by the National Institute for Mental Health, *id.*, 253.

According to Sackeim *et al.*, earlier studies had left in doubt whether more than transitory cognitive impairments result from modern ECT methods, *id.*, 244. In sharp contrast, their basic conclusion from their own new, large-scale research was:

> [T]his study provides the first evidence in a large, prospective sample that adverse cognitive effects can persist for an extended period and

[67] See above at 49, note 59, on Dr. Sackeim's various positions.

> that they characterize routine treatment with ECT in community settings.

Id., 253. For example,

> ... BL [bilateral] ECT resulted in greater retrograde amnesia than other electrode placements, and even at the 6-month time point, this effect was linearly related to the number of BL treatments administered during the acute ECT course. The average decrease in [autobiographical memory] scores in patients treated exclusively with BL ECT was 3.4 and 2.8 times the amount of forgetting seen in the healthy comparison groups at the post-ECT and 6-month time points, respectively, *suggesting that the deficits were substantial.* ...

Id., 252-253 (italics added).

Bilateral ECT is the type Creedmoor has given Simone D in recent years. Autobiographical memory, which this large, sophisticated study shows can be impacted as much as six months after the end of even an acute course of ECT, goes to the very essence of our human identities – who are we if we cannot recall our lives? Even with routine acute courses of ECT, the more bilateral ECT procedures are administered, the greater the risk of "forgetting."[68] Simone D. has had more than 148 ECT procedures already, and Creedmoor proposes to carry on over her objection with 30 more. Simone D. already has well-documented, long-standing, significant

[68] The APA recognized even in 2001 that the number of treatments and several other factors (including bilateral vs. unilateral electrode placement) are each independently associated with the intensity of cognitive side effects, APA, *supra*, 67-68

cognitive damage, and this large new study strongly suggests she is at risk for more.

D. Given the State of Research and the Record Before the Court, The Order Here Violates Due Process

Thus, it is generally acknowledged by authorities on the subject that long-term maintenance ECT remains untested and unproven by systematic studies. The general profile of its risks and benefits remains unknown. On the other hand, the systematic evidence newly available on cognitive damage from shorter-term acute ECT strongly suggests caution about maintenance ECT. While long-term M-ECT may be a course of action some people and their doctors feel is worth the risks, a court should not compel such treatment over objection absent an extraordinarily compelling individual balance of risks and benefits. Obviously, absent dire circumstances, no medication could be ordered over a person's objection which had not been proven generally safe and effective. Barring a dire situation and the lack of other choices, in the absence of scientifically valid information on safety and efficacy, as a matter of law, it is impossible for a court to determine whether the benefits of proposed involuntary treatment outweigh the risks – one of the core inquiries under *Rivers*. Especially when unproven treatment is at issue, the proponent of an order must be made to fully meet its burden, the individual must be given full latitude to explore particular circumstances

through cross-examination, and a judge should not rely on personal knowledge.

Simone D. already has very well-documented and major cognitive impairments – this is not a theoretical question for her. She has those impairments when she is receiving ECT, *and* when she has not received it for as long as 14 months, so they cannot be passed off as transitory, see above at 21-24. In recent years she also has had at best very limited benefit from ECT. And she is unequivocally opposed to receiving more ECT. The record before the court presents a compelling basis for allowing her and her lawyer a full day in court, not for the benefits to her of ECT.

In addition, the present record is devoid of clear and convincing evidence that further ECT for Simone D. is within "accepted professional judgment, practice and standards," particularly since ECT is proposed on an involuntary basis. Creedmoor put in no evidence on this point. Ms. D. has not substantially recovered. All Creedmoor has any hope of offering her is "a lifetime of court ordered electroshock treatment and depression" in a state hospital, *supra* at 8. These are vastly different from the circumstances in which the sources above indicate ECT is considered appropriate, *supra* at 45-47. Her lack of benefit goes to this *Rivers* requirement as well.

Simone D. did not have her full day in court. Her attorney's cross examination was severely limited on the degree to which she has already suffered adverse effects, the risk of more harm, the methods to be used in the proposed further ECT – which clearly affect risk of future harm, the extent or absence of benefit, the "quality of her life," as well as the exploration of a less intrusive alternative. All these matters go to the heart of the trial court's duty to assess risks and benefits and to "narrowly tailor" any order.

Not only did the trial judge decline to hear much proper cross examination, he also declined to hear from an independent expert, he failed to examine the hospital record, and he relied on his own supposed prior knowledge, whatever it may have been. If he truly knew about the generally applicable risks and benefits of such an extreme course of maintenance ECT as is proposed here, he would know what scientists in the field do not know. No one can yet generally quantify those risks and benefits, but it is already clear that the risks are substantial. He did not even permit proper inquiry into the evidence of risks and benefits from Simone D.'s own experience. And the solid evidence that cognitive damage from ECT is cumulative shows the judge was simply wrong in believing that Simone D.'s history with ECT was not a proper subject of inquiry. His errors compel reversal.

III. Ending Simone D.'s Language Isolation Would be a Far Less Intrusive Alternative to Improve Her Condition

Simone D.'s hospital record is filled with statements that she is primarily Spanish-speaking, and that she understands and speaks little English. The most notable symptom of her mental illness is extreme withdrawal from contact with others. Dr. Zhang, her treating psychiatrist, and several other professionals have recognized the obvious – that she would benefit more from being in a Spanish-speaking treatment environment. As the doctor apparently knew, OMH hospitals in the Bronx and Manhattan have such wards. It is entirely within OMH's power to comply with common sense and move Simone D. to such a ward,[69] but there is no good

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[69] OMH's description of the Bronx Psychiatric Center includes the following:

> Bilingual Services Wards 9 and 11:
>
> Wards 9 and 11 are designed to serve Spanish-speaking patients: Programs are geared to the psychiatric and cultural needs of the Hispanic patient and their families. Staff are fluent in the language and customs of the Hispanic and Latin American Countries. These variables are fully integrated in the provision of treatment and other services and closely embraces [*sic*] family and friends in programs and cultural events.

http://www.omh.state.ny.us/omhweb/facilities/brpc/facility.htm#bilingualservices. Similarly, its description of Manhattan Psychiatric Center lists the following specialized service:

> Hispanic Ward: for patients who speak only Spanish and/or whose cultural identity is primarily Hispanic. Services include treatment services provided in Spanish, culture specific events, and liaison with community based culturally appropriate resources.

explanation in the record of why this has not been explored and accomplished. Moving her to one of these hospitals would not take her far from the areas in Queens where she lived before her admission to Creedmoor and where her son lives (Hosp Rec R102, 426).

The importance of culture and language in mental health treatment is well recognized but not necessarily honored in practice. For example, the standard psychiatric diagnostic manual, in the edition published the year Simone D. entered Creedmoor, recommended the following among the factors to be studied in making a cultural formulation with respect to an individual in treatment:

> **Cultural elements of the relationship between the individual and the clinician.** Indicate differences in culture ... between the individual and the clinician and problems these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language; eliciting symptoms or understanding their cultural significance; in negotiating an appropriate relationship or level of intimacy; in determining whether a behavior is normative e or pathological)

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http://www.omh.state.ny.us/omhweb/facilities/mapc/facility.htm. OMH determines its hospitals' catchment areas and varies them as needed for specialized wards. For example, when agreeing to create the second Spanish-speaking ward at Bronx Psychiatric Center in settlement of litigation, it agreed also that Spanish-speaking patients from New York City, who would otherwise go to Rockland Psychiatric Center, should go instead to a Bronx Psychiatric Center bilingual ward. *W. G. et al. v.S tone*, 95-CIV-2106 (CLB). Stipulation of Settlement and Order, paragraph 4(b) at 2-3 (SDNY so-ordered December 14, 1995). Similarly, Creedmoor's ward with Korean- and Chinese-speaking staff is available to patients from Queens *and* other boroughs, although Creedmoor generally admits people from Queens only , New York State Office of Mental Health, Creedmoor Psychiatric Center Inpatient Services, http://www.omh.state.ny.us/omhweb/facilities/crpc/inpatient%5Fservices.htm.

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, (fourth edition) 844 (1994).

Amicus curiae Mental Health America (formerly the National Mental Health Association) has a formal policy statement which provides, in pertinent part:

> Mental Health America (MHA) believes that it is essential that all aspects of mental health systems be reflective of the diversity of the communities that they serve and that mental health agencies strive to become and remain culturally and linguistically competent. A culturally and linguistically competent mental health system incorporates skills, attitudes, and policies to ensure that it is effectively addressing the needs of consumers and families with diverse values, beliefs, and ... backgrounds that vary by race, ethnicity ... and language.
>
> ...
>
> Unfortunately, many mental health systems and agencies, including those that serve highly diverse populations, pay only lip service to these concepts, despite the significant impact that cultural and linguistic competence has on both positive outcomes and costs. ...

Mental Health American, Position 38: Cultural and Linguistic Competency in Mental Health Systems (2006),

http://www.mentalhealthamerica.net/go/about-us/what-we-believe/position-statements/p-38-cultural-and-linguistic-competency-in-mental-health-systems.

The New York State Office of Mental Health, which operates Creedmoor, recognizes the following reasons, among others, why culturally competent services matter:

- Disparities impose a greater disability burden for minority populations.
- Language barriers exist.
- Misunderstanding expressions of distress occur.

NYS OMH Fact Sheet: Cultural Competence, Evidence-Based Practices and Planning,

http://www.omh.state.ny.us/omhweb/ebp/culturalcompetence.htm.

The first recommendation of a working group of mental health professionals and government officials, which was concerned with the mental health needs of Hispanic elders in New York City, centered on language barriers.

> A large proportion of Latino elders are not proficient in English, and even those who are often can only communicate their innermost experiences in Spanish or Portuguese. Unfortunately, most mental health professionals are not fluent in these languages. As a result, non-professional staff or even family members are frequently called upon to translate. This obviously is not conducive to personal privacy, accurate diagnosis or sensitive treatment. ...

Among the groups convening the workgroup were the Association of Hispanic Mental Health Professionals,[70] the Geriatric Mental Health

[70] AHMHP lists first among its accomplishments –

Alliance of New York, the New York City Department of Aging, and the New York City Department of Health and Mental Hygiene. Latino Geriatric Mental Health Workgroup of New York City, Meeting the Mental Health Needs of Hispanic Elders, 2 & 4 (2006), http://www.mhawestchester.org/advocates/platino110206.asp.

The social work profession, which provides many of the therapists in psychiatric hospitals and makes up part of the membership of the workgroup just mentioned, has through its national organization adopted standards for cultural competence which include the following:

> Agencies and providers of services are expected to take reasonable steps to provide services and information in appropriate languages other than English to ensure that people with limited English proficiency are effectively informed and can effectively participate in and benefit from its programs.

National Association of Social Workers, Standards for Cultural Competence, Interpretation of Standard 9 (2001), http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf.

Simone D.'s attorney's attempts to cross-examine Dr. Brodsky on Creedmoor's feeble attempt to relieve Simone D.'s language isolation were

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Taking part in testifying before the Governor's Commission on Hispanic Affairs leading to the development of the first bilingual/bicultural inpatient and out-patient units in the City of New York.

http://www.ahmhp.org/accomplishments/index.php.

thwarted, and this record is devoid of an explanation of why she has never been moved for a substantial period to a ward where all those around her – all the staff and all those hospitalized – speak her language. Certainly the idea of ending linguistic isolation deserves more than a six-week trial in a ward with a Spanish-speaking psychiatrist who obviously had little contact with Simone D. After the institution has confined her for over a decade, largely isolated her from people who speak her language, and subjected her more than 148 times to a procedure she fears and hates, it may take a sustained effort to gain her trust and cooperation.

Failing to put Simone D. in a Spanish-speaking treatment environment, when she admittedly needs one and one is available, constitutes a failure to explore a less intrusive alternative to ECT, as required by *Rivers, supra.* Given these circumstances, there is no clear and convincing evidence that more ECT is the least intrusive alternative, or that the order is narrowly tailored.

Conclusion

Amici support Simone D's request for relief – remand for a full hearing - and they reiterate the Appellate Division dissenters' suggestion of the appointment of an independent psychiatrist - although given the nature of the order sought, the state of the relevant science, the lack of urgency, and

the hospital's failure to explore the less drastic alternative of ending Simone D's linguistic isolation, outright dismissal would be warranted as a matter of law.[71]

New York, NY
April 20, 2007

Respectfully submitted,
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CERTIFICATION

Pursuant to 22 NYCRR § 130-1.1-a, I certify that to the best of my knowledge, information and belief, formed after inquiry reasonable under the circumstances, the presentation of this brief and all the other papers I have presented in this appeal and the contentions therein are not frivolous as defined in 22 NYCRR § 130-1.1(c).

_____
John A. Gresham

[71] *See* Simone D.'s similar suggestion, Appellant's Brief at 35, note 8.
[72] Counsel gratefully acknowledges the assistance of Ian Vandewalker, New York University School of Law 2L, and Rebekah Pazmino, legal assistant.

APPENDIX: Statements of Interest of *Amici Curiae*, including Disclosure Statements

The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advocate for the rights of individuals with mental disabilities. The Center has engaged in litigation, policy advocacy, and public education to preserve the civil rights of and promote equal opportunities for individuals with mental disabilities in institutional as well as community settings. It has litigated numerous cases concerning the rights of people with mental illness or mental retardation, including the right to refuse treatment. The Bazelon Center has been an *amicus curiae* for this Court in *T.D. v. New York State Office of Mental Health*, 91 N.Y.2d 860 (1997), concerning research on subjects incapable of consenting, and *In re: K.L.*, 1 N.Y. 3d 362 (2004) on Kendra's Law. The Bazelon Center is a District of Columbia not-for-profit corporation; it has no parent, subsidiary or affiliated organizations.

Disability Advocates, Inc. is authorized by federal law to provide protection and advocacy to persons with mental illness in New York State pursuant to the federal Protection and Advocacy for Mentally Ill Individuals Act, 42 U.S.C. § 10801 *et. seq*. Personal autonomy is a major concern of

persons with mental disabilities who have often been deprived of control over their psychiatric care based upon paternalism and without due process. Since 1989, Disability Advocates has opposed laws and practices which deprive individuals with mental illness of the rights enjoyed by other persons without due process. We have raised such issues before this Court. *See Matter of St. Luke's-Roosevelt Hospital Center, Marie H., City of New York, State of New York*, 89 N.Y.2d 889 (1996) (indigent persons in guardianship proceedings have the right to counsel at public expense, and the county government must pay for counsel); *T.D. v. New York State Office of Mental Health*, 650 N.Y.S.2d 173, 65 USLW 2439 (1st Dept. 1996), appeal dismissed, 91 N.Y.2d 860 (1997) (invalidated the regulations of the New York State Office of Mental Health which authorized non-therapeutic experiments on incapable children and adults); *Matter of Grinker (Rose)*, 77 N.Y.2d 703, 573 N.E.2d 536, 570 N.Y.S.2d 448 (1991) (Disability Advocates represented *amici* in *Rose*, which prohibited conservators from involuntarily placing subjects of conservatorship proceedings in nursing homes). In the present case the court below ordered involuntary ECT, a procedure which can destroy memories of one's personal history and thus permanently alter one's self awareness. A*mici* urge this Court to find that due process was not provided and remand this matter for a full and fair

hearing. Disability Advocates, Inc., is a not-for-profit corporation; it has no parent, subsidiary or affiliated organizations.

The Mental Disability Law Clinic of Touro College, Jacob D. Fuchsberg Law Center is funded pursuant to Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. 10801 *et seq.* Pursuant to this legislaiton the Clinic is charged with protecting, advocating for, and enforcing the rights of individuals who suffer from mental illness. Electroconvulsive treatment can be a highly intrusive form of coercive treatment with many debilitating side effects. The Clinic seeks to ensure that individuals who receive ECT over objection do so only under proper scrutiny from the judicial system.

The Law Project for Psychiatric Rights (PsychRights) is a tax exempt public interest law firm whose mission is to mount a strategic litigation campaign against unwarranted court ordered medication and electroshock akin to the campaign to end racial segregation in the 1950's and 60's. A key component of this is seeking to have courts honor the rights people have. This case presents an extreme example where someone's rights were disregarded by the trial court, resulting in an order that would cause great

harm. In furtherance of its mission, PsychRights has assembled scientific research showing the benefits of psychiatric drugs and electroshock are greatly exaggerated and their harm greatly underestimated by their proponents. Some of this research is included in this *amicus* brief. PsychRights is an Alaska not-for-profit corporation; it has no parent, subsidiary or affiliated organizations.

Mental Health America (MHA), formerly the National Mental Health Association, is the nation's oldest and largest organization dedicated to all aspects of mental health and mental illness. In partnership with more than 320 state and local Mental Health Association affiliates nationwide, MHA works to improve policies, understanding, and services for individuals with mental illnesses and substance use disorders. Through advocacy, education, and service, MHA works to ensure that people with mental illnesses are accorded dignity, respect, and the opportunity to achieve their full potential.

MHA has elected to join in this amicus brief because of the importance of the issues raised, which touch on three key MHA policies: Policy 36: Involuntary Mental Health Treatment, Policy 31, Electro-convulsive Therapy, and Policy 38, Cultural and Linguistic Competency. The issues --

of the trial judge's prejudging the appropriateness of ECT, refusing to hear evidence concerning ECT, frustrating cross-examination, and refusing to appoint an independent expert -- are all of great concern. Of even greater concern is the imposition of more than five years of ongoing maintenance ECT without any scientific proof of the safety and efficacy of such prolonged treatment or any likelihood of success in treating this person. And the linguistic and cultural isolation of this Spanish-speaking person for ten years in the New York State mental health system is inappropriate and inexcusable.

MHA has recognized a high burden of proof for involuntary imposition of ECT, a standard definitely not met by the proceedings in this case. MHA's ECT policy requires vigilance to find alternatives to use of ECT and reserves its use for emergencies:

> Mental Health America acknowledges that many consumers are opposed to any involuntary imposition of ECT. This is a controversial subject, since there is evidence that for some extremely depressed and catatonic individuals who are refusing food, or for persons with mania-induced, fluctuating, very high fever with no infection, involuntary ECT can be a life-saving intervention. Accordingly, Mental Health America cannot preclude involuntary use of ECT but supports it only with appropriate procedural protections that recognize the substantial cognitive side effects of ECT, a finding of an emergency that cannot be met by any other treatment, and a high threshold of proof.

There was no documented emergency within the meaning of MHA's Policy 31, cognitive side effects were ignored, no significant effort was made to deal with Simone D.'s cultural and linguistic isolation, and the procedural flaws in this record require reversal. Therefore, Mental Health America enthusiastically supports this *amicus* brief. MHA is a New York not-for-profit corporation; other than its state and local affiliate Mental Health Associations, it has no parent, subsidiary or affiliated organizations.

The National Association of Rights Protection and Advocacy (NARPA) was formed in 1981 to provide support and education for advocates working in the mental health arena. It monitors developing trends in mental health law and identifies systemic issues and alternative strategies in mental health service delivery on a national scale. Members are attorneys, people with psychiatric histories, mental health professionals and administrators, academics, and non-legal advocates -- with many people in roles that overlap. Central to NARPA's mission is the promotion of those policies and strategies that represent the preferred options of people who have been diagnosed with mental disabilities. Approximately 40% of NARPA's members are current or former patients of the mental health system.

NARPA has submitted amicus briefs in many cases in federal and state courts affecting the lives of persons with psychiatric disabilities, including *Tennessee v. Lane*, 541 U.S. 509, 124 S.Ct. 1978 (2004); *Olmstead v. L. C.*, 527 U.S. 581, 144 L. Ed. 2d 540, 119 S. Ct. 2176 (1999); *Godinez v. Moran*, 509 U.S. 389, 125 L. Ed. 2d 321, 113 S. Ct. 2680 (1993); *Washington v. Harper*, 494 U.S. 210, 108 L. Ed. 2d 178, 110 S. Ct. 1028 (1990); *T.D. v. New York State Office of Mental Health*, 91 N.Y.2d 860 (1997); and *Phoebe G. v. Solnit*, 252 Conn. 68, 743 A.2d 606 (1999). NARPA members were key advocates for the passage of Federal legislation such as the Americans with Disabilities Act (42 U.S.C. §§ 12101 et seq.) and the Protection and Advocacy for Individuals with Mental Illness Act of 1986 (42 U.S.C. §§ 10801-51). NARPA is a not-for-profit corporation; it has no parent, subsidiary or affiliated organizations except for a state NARPA affiliate in Kansas.

The National Disability Rights Network ("NDRN") is the membership association of protection and advocacy ("P&A") agencies that are located in all 50 states, the District of Columbia, Native American community, Puerto Rico, and the territories (the Virgin Islands, Guam, American Samoa and the Northern Marianas Islands). P&As are authorized under various federal statutes to provide legal representation and related advocacy services on

behalf of persons with all types of disabilities in a variety of settings. In fiscal year 2005, P&As served over 73,000 persons with disabilities through individual case representation and systemic advocacy. The P&A system comprises the nation's largest provider of legally based advocacy services for persons with disabilities.

This case is of particular interest to NDRN because involuntary administration of ECT is an issue of national interest to persons with disabilities.

NDRN has no parent or subsidiary or affiliated organizations other than its members mentioned above.

The New York Association of Psychiatric Rehabilitation Services (NYAPRS) is a statewide coalition of New Yorkers who use and/or provide community-based mental health services. It is dedicated to improving services and social conditions for people with psychiatric disabilities by promoting their recovery, rehabilitation and rights. NYAPRS regularly conducts and supports local, state and national advocacy efforts, provides a broad range of training and technical assistance for recipients and providers at over 100 of the state's community based rehabilitation and peer-run

agencies, and serves to inform the larger mental health community through its daily 'mental health e-news' and weekly 'Recovery Report' services. NYAPRS has worked closely with the NYS Commission on Quality of Care to successfully press for decreases in seclusion and restraint practices. NYAPRS members have a longstanding concern that ECT be administered as much as possible in a voluntary and informed way, with appropriate oversight by governmental bodies and the courts. NYAPRS also has a deep concern that people receive culturally and linguistically appropriate treatment, and has serious questions whether that has occurred in this case. NYAPRS is a not-for-profit corporation; it has no parent, subsidiary or affiliated organizations.

New York Lawyers for the Public Interest is a not-for-profit law office specializing in disability rights, access to health care and environmental justice. NYLPI has a long history of advocating for the dignity and self-determination of people with disabilities, including mental disabilities. NYLPI has served before as *amicus curiae* for this Court, in *Katherine F. ex rel. Perez v. State*, 94 N.Y. 2d 200 (1999), concerning discovery in psychiatric hospital abuse cases, and *In re: K.L.*, 1 N.Y. 3d 362 (2004) concerning Kendra's Law. NYLPI is the New York City subcontractor for

the federally-funded program, Protection and Advocacy for Individuals with Mental Illness, 42 U.S.C. sec. 120801 *et seq.* NYLPI is a not-for-profit corporation. Its board of directors includes members of many law firms and corporate legal departments. It has no parent, subsidiary or affiliated organizations.