

STATE OF MINNESOTA
COUNTY OF DAKOTA

DISTRICT COURT
FIRST JUDICIAL DISTRICT
PROBATE DIVISION

In the Matter of the Civil Commitment of:
Charles Helmer,
Respondent

**PETITION FOR AUTHORIZATION
TO IMPOSE TREATMENT
ELECTROCONVULSIVE THERAPY**
Court File No. P19HA-PR-20-939

I Alexandra Hartley, DO, MD, with offices at M Health Fairview Riverside Hospital, Minneapolis (city), Hennepin County, Minnesota, respectfully represent, to the best of my knowledge, information and belief, as follows:

1. That I am a staff psychiatrist at M Health Fairview Riverside Hospital. That I am trained and experienced in the administration of Electroconvulsive Therapy.
2. That the Respondent Charles Helmer was born on 6/4/1998 and is a resident of Dakota County, Minnesota.
3. That a Petition for commitment of the Respondent as mentally ill has been initiated in Dakota County Probate Court.
4. That the Respondent carries the following diagnosis: Schizophrenia, Autism Spectrum Disorder
5. That the Respondent is presently receiving care and treatment from Alexandra Hartley, DO who has requested an opinion with regard to the appropriateness of electroconvulsive therapy for the Respondent.
6. That the following procedures are medically and psychiatrically necessary, based on my review of the Respondent's condition: Electroconvulsive therapy, including both an acute phase consisting of 3 treatments per week to a maximum of 12 treatments, and if the acute phase is successful, a maintenance phase consisting of 1 (or fewer) treatments per week for the duration of the requested Order. The exact number of treatments would be determined based on the patient's response to treatment.
7. The administration of electroconvulsive therapy is reasonable and the likely benefits thereof outweigh the potential risks and side effects of said treatment. The procedure is administered under general anesthesia and monitored closely by medical personnel. The usual safety precautions associated with general anesthetic are carried out, including but not limited to: administration of oxygen; placement of an intravenous needle for medication administration; and close monitoring of vital signs, oxygen saturation, seizure duration, and cardiac status. The usual side effects of electroconvulsive therapy include headache and memory loss (the amount of memory loss is extremely variable from one person to the next). The risks of electroconvulsive therapy are extremely rare and include death (1 in

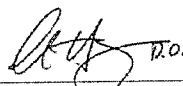
10,000). A copy of the consent form and the information form used with voluntary patients are attached hereto as Exhibits A and B and made a part hereof, including a more detailed description of the procedure and providing a more detailed list of the potential side effects and risks.

8. Respondent has/ has not received ECT in the past. Was it beneficial? Yes/ No
9. The objective of electroconvulsive therapy in this instance is to reduce and/or relieve the symptoms of mental illness which are currently afflicting the Respondent.
10. The Respondent's written consent to the administration of this procedure has not been obtained because of lack of insight which prevents recognition of psychiatric condition which requires treatment, and inability to understand the risks, benefits and side effects of treatment.
11. Judicial authorization is a prerequisite to the administration of the above-described procedure in the absence of Respondent's consent under the requirements of Price v. Sheppard, 307 Minn. 250, 239, NW2d 905 (1976) and Minn. Rule DPW 20.

Wherefore, Petitioner asks the court for an order authorizing the use of ECT for Respondent as set forth herein.

I declare under penalty of perjury that everything I have stated in this document is true and correct.
Minn. Stat. § 358.116.

Date: 12/21/2020



Alexandra Hartley DO, Petitioner
Signed in Hennepin County, Minnesota

STATE OF MINNESOTA
COUNTY OF DAKOTA

DISTRICT COURT
FIRST JUDICIAL DISTRICT
PROBATE DIVISION

In Re:

Charles Helmer
Respondent

AFFIDAVIT
Court File No. P **19HA-PR-20-939**

STATE OF MINNESOTA)
COUNTY OF Dakota)

Alexandra Hartley, DO, being duly sworn under oath, states the following:

1. My educational background, training and experience include the following: See Exhibit A hereby incorporated by reference.
2. I am qualified to give background information about the effectiveness and usage of electroconvulsive therapy (ECT).
3. ECT was introduced in the late 1930's by Cerletti and Bini and became the preferred therapy for severe psychiatric illnesses. In effect, it was the first somatic (of the body) treatment other than simply restraining, sedating, and secluding people with major thought disorder problems. Although definitive research designs were not employed during the initial popular use of ECT, many subsequent studies comparing its efficacy to medications and placebo therapies have shown it to be an effective treatment in psychiatry.
4. ECT is the preferred treatment for several conditions, including but not limited to: severe Major Depressive Disorder; and severe episodes of Mania or Depression in Bipolar Affective Disorder. It may also be used in Schizophrenia, Acute Psychosis and Schizoaffective Disorder.
5. The purpose of ECT is to reduce and treat the symptoms of mental illness, including but not limited to: In the affective disorders, to end hyperactivity and the rapid thought process of mania; in depression, to reduce vegetative signs such as insomnia, anorexia, weight loss, irritability, and loss of libido and to reduce depressive mood and suicidal preoccupation; and, in schizophrenia, to reduce delusional thinking.
6. ECT is indicated for treatment of several conditions. It is primarily indicated in severe depressions such as endogenous depression (unrelated to external life events) or melancholic depression (loss of interest or pleasure in all, or almost all, activities). It is also primarily indicated in depression with imminent suicide potential where the delayed effect of a tricyclic antidepressant might occur too late in therapy to prevent serious injury. ECT is indicated in uncontrollable mania, that is, mania not responsive to mood stabilizers and neuroleptic medication, and especially mania where serious injury or death by exhaustion may occur. ECT is considered a secondary indication in

the following: depressions that fail to respond to antidepressant medication; manias that fail to respond to antimanic medications; and schizophrenia that does not seem to respond to neuroleptic medication.

There is no definitive theory as to why ECT is effective for certain psychiatric conditions. However, it has been shown that the production of a seizure (convulsion) is necessary for the therapeutic response. When sham ECT is administered (whole procedure takes place but the electric current is not strong enough to produce a seizure), then there is no therapeutic response. Historically, seizures were produced by the use of intravenous drugs and hormones such as use of insulin to produce a convulsion. All of these methods are therapeutically effective as long as they produce the central nervous system convulsion. It is not understood why a central nervous system seizure is effective in treating depression and thought disorders. The basic neurophysiologic changes that are produced by a seizure have not been delineated.

7. The clinical procedure followed in the administration of ECT, as currently recommended by the American Psychiatric Association Task Force on electroconvulsive therapy, is described as follows: the patient refrains from eating prior to treatment, all dental appliances are removed, and then an anticholinergic agent such as Atropine is injected to prevent the slowing of the heart during the procedure and also to dry up secretions in the nasal/pharyngeal passageways. An anesthetic agent is administered intravenously; this is usually a quick-acting barbiturate. When the patient is under the influence of the anesthesia, a face mask with oxygen is used to ventilate the patient. A muscle paralyzing agent is injected to protect the patient from sustaining powerful muscle contractions during the convulsion. A mouthpiece is inserted. Electrodes are placed on the forehead. A pulse of electric current is passed through the patient's head. This generally produces a convulsion which lasts thirty to sixty seconds. The convulsion is monitored by excluding the muscle relaxant from one extremity to which a tourniquet has been applied prior to administering the muscle relaxant and watching the tonic/clonic muscle action. In some cases, an EEG monitor is used. At the conclusion of the seizure, the protective mouthpiece is removed, oxygen is administered to the patient through the face mask, and suction is used as necessary to remove any secretions accumulating in the hypopharynx. The patient will then spontaneously resume breathing within a few minutes, at which time the patient is turned on his or her side and allowed to fully recover from the anesthetic effect. Patients are observed for approximately thirty minutes after the procedure to make sure they are fully awake and steady on their feet before being returned to the ward.
8. The effect of ECT on behavior patterns and the length of its effect vary with the condition and number of treatments administered. There is no way to predict in an individual treatment the exact number of treatments required.

Generally, in the case of an affective disorder, depressed type (severe mental disorder marked by periods of extreme depression dominating the mental life of the subject resulting in loss of contact with the environment), the administration of six to twelve treatments is generally sufficient to return the patient to a state of normal mood with amelioration of the symptoms. Suicidal ideation (formation of mental concepts or ideas of suicide) generally subsides. However, the recurrent nature of the illness may lead to

relapse at some time in the future – sometimes within a few months – requiring another series of treatments.

In manic disorders, the use of ECT usually brings the patient out of the manic state in eight to twelve treatments. In general, the adjunctive use of neuroleptic medications and mood stabilizing medications, is sufficient to sustain remission.

In the case of schizophrenia, as many as 30 treatments may be necessary, and the behavioral changes are somewhat more difficult to ascertain. A reduction in thought disorder symptoms such as hallucinatory experiences and overt delusional production is expected. However, frequently, only partial responses and reductions are achieved. Thus, the patient is given a period free of ECT treatments to ascertain the degree and time of relapse. If the patient is somewhat improved over the course of 30 ECT treatments, generally given about three times a week over a period of 10 weeks, use of maintenance ECT would be clinically considered. Maintenance ECT is administered every week to two weeks on a permanent basis to maintain the clinical response that was achieved during the initial series of treatments.

9. The probability of success with the use of ECT also depends on the category of illness being treated. The probability of success in the treatment of profound depression is quite high, approximately 90 percent. The likelihood of success in treating mania is also quite high, approximately 80 percent. The probability of success in treating schizophrenia is somewhat lower but possibly as high as 50 percent. In most cases, other therapeutic approaches are tried before using ECT to treat schizophrenia. Thus, it is possible that the success rate is artificially lowered and that if ECT were used as the first treatment in schizophrenia its success rate might be quite high.
10. "Success" in the use of ECT treatment is defined as a therapeutic response in a positive direction, a diminution in symptoms and degree of dysfunction produced by the underlying illness. Success in the treatment of disorders of the depressive type is a return of the patient's mood to a normal state, elimination of suicidal ideation, and amelioration of symptoms of the depressive syndrome to some degree or even totally. The duration of success depends on the frequency of relapse in the underlying illness. Some patients experience depressive episodes on a monthly basis, while others only experience such episodes every few years. Success in the treatment of schizophrenia is assessed differently because a certain percentage of schizophrenics show a downward deteriorating course through their life that is unaffected by various treatment intervention strategies. Success would be measured by the amount of social, vocational, and personal care functioning that the patient was able to achieve after introduction of ECT and completion of treatment as compared to levels of achievement in those areas before treatment. For example, a schizophrenic who is actively hallucinating and delusional to the point where personal hygiene was poor or nonexistent, ability to socially interact in a coherent manner was severely impaired, and ability to pursue any vocational endeavor or stick with minimal tasks for any time would improve to the point where the person could meet minimal hygiene standards, be able to interact socially in appropriate ways with hospital staff, patients, and relatives, and would be able to perform certain tasks. The duration of success is highly variable in

schizophrenia. In some patients, 30 treatments may produce quite long-lived success. In other cases, use of maintenance ECT may be required.

11. Perhaps the most prominent adverse side effect of ECT is memory impairment. Initially, it was believed that memory impairment might be part of the therapeutic efficacy of the treatment, but this is no longer generally accepted. The memory loss is both anterograde and retrograde, that is, it affects both memories for events prior to the initiation of each seizure, and there is also some difficulty committing new events to memory following the seizure. The impairment in learning new material diminishes gradually following each seizure but may be cumulative with successive treatments. Memory for events in the remote past may be affected and persist for approximately two weeks after the course of ECT has ended. The administration of unilateral current (on one side of the head rather than on both sides) causes less memory loss, but is not as reliably effective as bilateral treatment.

According to the American Psychiatric Association Task Force's Report XIV, the following statements can be made about ECT's effect on memory:

1. ECT can affect memories acquired many years prior to treatment;
2. The effect on memory is greater for recent memories and less for more remote memories;
3. Very remote memories appear to recover fully following ECT in a manner that suggests that recovery is spontaneous and does not require relearning;
4. Memories acquired during the days prior to a course of ECT may be permanently lost;
5. There is, as yet, no evidence to suggest that ECT produces permanent loss of memory for events occurring the one or two years preceding ECT; indeed, there is some evidence to indicate that memories acquired during this period do recover. Nevertheless, a fully satisfactory study of these issues with maximally sensitive tests has not yet been accomplished.

Concerning an extended series of ECT, such as 50 or more treatments, the Task Force states:

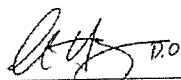
1. Bilateral ECT is associated with greater anterograde amnesia than right unilateral ECT;
2. Bilateral ECT also produces more extensive retrograde amnesia for remote events than right unilateral ECT;
3. Extensive ECT (e.g., more than 50 treatments) may lead to long-lasting or permanent impairment in memory capacity or cognitive function, but a definitive conclusion is not yet possible;
4. The activation of previously learned material just prior to ECT does not cause amnesia for that material;
5. New learning capacity substantially recovers by six to nine months after the completion of bilateral or right unilateral ECT, but persisting memory complaints are common in individuals who receive bilateral treatment;

6. Memory for events that occurred long prior to ECT substantially recovers by six to nine months after ECT; memory for events that occurred days prior to ECT may be permanently lost.
12. As outlined above, the current actual clinical procedure for the administration of ECT involves the use of general anesthesia, and hence there is no pain associated with the actual treatment. The only pain that would be experienced by the patient would be the placing of the intravenous needle prior to the administration of the anesthesia. There is commonly headache pain, and occasionally muscle pain or throat pain after the treatment.
13. At this point, the use and clinical effectiveness of ECT are well-documented in professional literature, and there is no individual professionally trained who would consider ECT experimental at this time. Nevertheless, there are some individuals who advocate that the treatment is barbaric, not useful, and articles have been published by these individuals. However, most scientific and medical literature seems to support the view that ECT is more effective than placebo treatment for the conditions which are responsive to it. It is the position of the medical and psychiatric community that the use of ECT for other than clinical conditions responsive to it would not be justified. It should not be used as an aversive or punishment-type treatment.
14. ECT is accepted as an appropriate treatment in the medical and psychiatric community in Minnesota. The American Psychiatric Association questionnaire, designed to sample psychiatrists' attitudes on the use of ECT, found that only two percent of the samples were totally opposed to its use.
15. Certain pretreatment measures are recommended before the administration of ECT. These include a general medical history to delineate the existence of pulmonary, coronary, vascular, neurological, and orthopedic disease as well as any untoward responses to the medications that might be administered during the anesthesia. A physical examination is conducted. Laboratory investigation including routine blood counts and blood and urine chemistries would be conducted to determine if the patient were generally suitable for undergoing anesthetic procedures. Additional testing such as electrocardiograms (EKG); CT or MRI scans of the brain or X-rays of spine or lungs may be done depending on the results of physical examination and hospital policies.
16. There is some risk of complications or long-term care risks of treatment. The issue of impairment of memory has been addressed above. Another reported adverse effect is the production of organic psychosis, that is a period characterized by memory loss, confusion, disorientation, dysarthric speech, lack of verbal spontaneity, and apathy. These conditions generally subside after ECT is discontinued and are mostly associated with the use of multiple treatments (up to six) each day. This confusional state is believed to be rare. There is no biochemical evidence that there is actual brain damage due to ECT. There have been rare reports of individuals dying close to the time of administration of ECT, but the risk of death appears to be extremely low, and with the use of precautions and treatment with general anesthesia and oxygenations the rate has become extremely low. According to the survey done by the American Psychiatric

Association Task Force prior to its 1978 report, 97 percent of the responders said that among their patients receiving ECT in a period of five years no deaths had occurred among their patients during or within 24 hours of the administration of ECT. Although the use of oxygenation and the advent of unilateral ECT have greatly reduced the incidence of impairment, there is some clinical evidence that unilateral ECT requires one or two more treatments than bilateral ECT to achieve the same effect. The American Psychiatric Association has no particular recommendation as to whether or not the decrease in memory problems is sufficient to outweigh the risk of having to administer one or two additional treatments to achieve the same clinical effect and should be weighed by the clinician in each particular case.

I declare under penalty of perjury that everything I have stated in this document is true and correct.
Minn. Stat. § 358.116.

Date: 12/21/2020



Alexandra Hartley, DO, Petitioner
Signed in Hennepin County, Minnesota