
Daniel A. Rosen

Recommended Citation

This document is brought to you for free and open access by Scholarship @ Hofstra Law. It has been accepted for inclusion in Hofstra Law Review by an authorized administrator of Scholarship @ Hofstra Law. For more information, please contact lawscholarlycommons@hofstra.edu.
I. INTRODUCTION

Three involuntarily committed patients were to be transferred from Queens Hospital Center, a general hospital containing acute care psychiatric facilities, to Creedmoor Psychiatric Center, a state-operated psychiatric hospital. Dr. H. George Nurnberg, director of the Department of Psychiatry at Queens Hospital Center, determined at a hearing that the patients satisfied the administrative criteria for transfer to a long-term ward at Creedmoor.

The patients objected to this transfer. They alleged that this decision violated their constitutionally protected liberty interest in avoiding transfer to a long-term psychiatric hospital, and that the aforementioned administrative hearing denied them due process of law.
in violation of State and Federal Constitutions. The New York Supreme Court of Queens County concluded that the statutory and administrative authority under which the patients were to be transferred violated the Due Process Clauses of the State and Federal Constitutions.

Dr. Nurnberg appealed to the Appellate Division, Second Department. The Second Department reversed the judgment and dismissed the action, holding that the aforementioned authority did not violate the Due Process provisions of the State and Federal Constitutions.

The New York Court of Appeals affirmed. The court, which assumed, arguendo, that such a transfer implicated a constitutionally protected liberty interest, held that the administrative hearing prior to transfer satisfied the requirements of procedural due process. However, the court also held that the patient could have judicial recourse by instituting an article 78 proceeding prior to transfer, which offers the possibility of injunctive relief.

This Comment argues that transfer from a short-term, acute care hospital to a long-term psychiatric facility implicates a constitutionally protected liberty interest, and that the aforementioned statutory and regulatory scheme provides inadequate procedural protection for the opposing patient. No de jure negation of this liberty interest exists upon confinement in a psychiatric hospital. Additionally, this Comment argues that the holding in Savastano in no way serves the constitutional interest in judicial economy and efficiency and often has the de facto effect of actually hampering these goals.

Part II establishes that, through the creation of an elaborate

---

6. Id. at 404.
7. Id. at 410.
9. Id. at 556.
11. Id. at 424.
13. Although the New York Mental Hygiene Law technically allows commitment directly into long-term psychiatric facilities, in practice this is the clear exception rather than the rule. See, e.g., N.Y. MENTAL HYG. LAW § 9.37 (McKinney 1988). In New York City, for example, the vast majority of all initial commitments are made into short-term city hospitals. Telephone Interview with Elliott Raines, Esq., Law Secretary to Hon. Maxine K. Duberstein, Supreme Court, Kings County, N.Y. (Oct. 25, 1995).
14. See infra parts II-IV.
15. See infra parts II-IV.
16. See infra part V.
mandatory statutory and regulatory scheme, New York has created a constitutionally protected liberty interest for a patient who opposes transfer. Although a patient surrenders some rights when involuntarily hospitalized, Part III maintains that no general de jure negation of liberty interests exists upon confinement.

Part IV documents the markedly increased stigma and “transfer trauma” associated with a transfer from a short-term general care facility to a long-term psychiatric hospital. Although such stigma alone does not create a liberty interest, this Part reveals that the law mandates adequate procedural protection when stigma is a factor.

Having established that transfer implicates a constitutionally protected liberty interest, or at the least, the need for adequate procedural protection, Part V argues that the administrative hearing currently in use is violative of procedural due process. Additionally, regardless of the constitutional arguments, the de facto result of Savastano has created the potential for additional fiscal and administrative burdens. Finally, the transfer regulations implemented by the New York Office of Mental Health are ultra vires, in that they serve to abrogate psychiatric patients’ rights when its enabling statutes were promulgated with the express purpose of increasing patients’ rights. Part VI concludes by offering two possible solutions to these infirmities.

II. STATE-CREATED LIBERTY INTEREST

By requiring specific substantive predicates prior to transfer through mandatory language in the relevant statutes and regulations, New York has created a protected liberty interest in avoiding transfer to a

17. In Savastano, the court of appeals did not even consider whether or not transfer implicates a constitutionally protected liberty interest. The court assumed, in arguendo, that such an interest was implicated and proceeded to the procedural due process analysis. Savastano v. Nurnberg, 569 N.E.2d 421, 424 (N.Y. 1990).

Liberty interests have been found, independent of state law, regarding both the inter-hospital and intra-hospital transfer of civil committees in certain circumstances. See, e.g., Eubanks v. Clarke, 434 F. Supp. 1022, 1029 (E.D. Pa. 1977) (holding that transfer to a more secure hospital implicates a patient’s liberty interest and invokes procedural due process protections); see also Christy v. Hammel, 87 F.R.D. 381, 390 (M.D. Pa. 1980) (holding that transfer to a secure section of the same hospital “triggered the plaintiff’s liberty interest under the Due Process Clause”).

18. See Logan v. Zimmerman Brush Co., 455 U.S. 422, 432 (1982) (holding that since “minimum procedural requirements [are] a matter of federal law, they are not diminished by the fact that the State may have specified its own procedures that it may deem adequate for determining the preconditions to adverse official action” (alterations in original) (quoting Vitek v. Jones, 445 U.S. 480, 491 (1980))).
state-operated psychiatric hospital. For example, the Office of Mental Health uses the following mandatory language in its regulation regarding transfer: "No request for the transfer of an objecting patient shall be made by the sending hospital until such patient has been given an opportunity to appeal such request to the sending hospital’s director."20 Additionally, the regulation requires that the director or his designee shall consider numerous criteria when deciding on the issue of transfer, the requisite legal standard being the best interests of the patient.21

Although this director or his designee has a waiver right in regard to this regulatory criteria,22 this waiver is limited in nature and has no impact upon the mandatory effect of the regulation.23 Additionally, while the director or his designee has the right to waive consideration of two enumerated criteria, these criteria relate solely to jurisdictional issues and are in addition to the elements regarding the “best interests” standard.24

Another method by which New York has created a liberty interest

19. N.Y. MENTAL HYG. LAW § 29.11 (McKinney 1988); N.Y. COMP. CODES R. & REGS. tit. 14, § 517.4 (1995); see Hewitt v. Helms, 459 U.S. 460, 472 (1983) (holding “that the repeated use of explicitly mandatory language in connection with requiring specific substantive predicates demands a conclusion that the State has created a protected liberty interest”); see also Joseph P. Messina, Comment, Kentucky Department of Corrections v. Thompson: The Demise of Protected Liberty Interests Under the Due Process Clause, 17 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 233, 252 (1991) (stating that “a statute . . . using what the Court recognizes as mandatory language (such as ‘shall’ or ‘must’) would almost certainly, in light of precedent, create a protected liberty interest’”); Leon Friedman, New Developments in Civil Rights Litigation and Trends in Section 1983 Actions, in 1 SECTION 1983 CIVIL RIGHTS LITIGATION AND ATTORNEYS’ FEES 317, 396 (Practicing Law Institute ed., 1995) (noting that “shall” or “will” language in rules regarding hearings has the effect of creating a liberty interest).

It is of no significance that the mandatory language “alleged” to create a liberty interest in Savastano is in a regulation, as opposed to a statute. In Hewitt, it was mandatory regulatory language, not statutory language, that the United States Supreme Court held created a liberty interest regarding an administrative hearing. 459 U.S. at 472 (holding that the mandatory language contained in regulations promulgated by the State Bureau of Corrections created a constitutionally protected liberty interest).


21. Id. § 517.4(c)(3)(i), (d)(1) (stating, inter alia, that the following factors shall be considered in order to serve the best interests of the patient, prior to transfer: (a) the proximity of the hospital to the patient’s significant others and (b) the ability of the sending and/or the receiving hospital to provide adequate treatment by evaluating such factors as bed capacity and overcrowding).

22. See id. § 517.4(d)(2)(ii) (stating that “a patient to be transferred from a municipal or general hospital in New York City to a hospital operated by the Office of Mental Health must satisfy [additional] requirements, unless waived by the commissioner or a designee thereof”).

23. Id.

24. Id. § 517.4(c)(3), (d)(1) (discussing a number of the mandatory best interests elements); id. § 517.4(d)(2)(ii) (dealing only with the transfer of New York City patients to state hospitals).
is by instilling in the civilly committed psychiatric patient a reasonable "expectation that adverse action[s] will not be taken . . . except upon the occurrence of specified behavior." The New York Mental Hygiene Law requires that a patient receive care suited to his needs and with respect for "dignity and personal integrity."

Additionally, a civilly committed patient has a right to an individualized treatment plan, as well as the right to participate in its creation and implementation. It is unlikely that such an administrative transfer can be argued as being outside the bounds of such a treatment plan. Therefore, the decision to transfer is clearly subsumed within the aforementioned liberty interest in treatment participation guaranteed by the Mental Hygiene Law. Commitment itself is the strongest example of an impact upon a treatment plan, and clearly implicates a patient's liberty interest. In addition to commitment, other areas of the Mental Hygiene Law relating to a course of treatment have been held to implicate a patient's liberty interest.

III. NO DE JURE NEGATION OF LIBERTY INTERESTS

The decision of the New York Court of Appeals in Savastano implies that the involuntary psychiatric patient surrenders a multitude of rights when committed. This loss of rights is said to come under the "penumbra of commitment," which does require procedural due process. Such a holding ignores the authority under which such commitments may be carried out, and discards the "best interests" analysis found throughout the Mental Hygiene Law.

"Involuntary confinement deprives a person of physical liberty to the extent necessary to carry out a prescribed function of the parens patriae or police power. It does not have the legal effect of taking away any

26. N.Y. MENTAL HYG. LAW § 33.03(a) (McKinney 1988).
27. Id. § 33.02(a)(11).
28. See, e.g., In re K.K.B., 609 P.2d 747, 752 (Okla. 1980) ("If the law recognizes the right of an individual to make decisions about . . . life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally or physically ill.").
33. Id.
other rights." A patient may not be committed to the hospital solely for the purpose of treatment. In addition to the "need of treatment" requirement, there must be a showing that the patient poses a danger to himself, society, or both. In this context, the *parens patriae* power is concerned with protecting the patient from himself and the police power is concerned with protecting society from the patient. Once this patient has been committed to a psychiatric hospital, both of these powers have effectively been carried out. Any further action on the part of the hospital is beyond this immediate power of commitment.

New York has long recognized a patient's right to self-determination—including involuntary psychiatric care—and the New York Court of Appeals has held that this self-determination must be adequately protected by procedural due process. In *Rivers v. Katz*, the court of appeals found that the due process clause of the state constitution provides involuntarily committed patients a fundamental right to refuse medication. Although the *Rivers* case dealt with involuntary medica-

34. Appellant's Reply Brief at 8, Savastano v. Nurnberg, 569 N.E.2d 421 (N.Y. 1990) (No. 2771/87); see, e.g., N.Y. MENTAL HYG. LAW § 29.03 (McKinney 1988) (stating that commitment shall not "be construed or deemed to be a determination or finding that such person is incompetent or is unable adequately to conduct his personal or business affairs").

35. Zinermon v. Burch, 494 U.S. 113, 134 (1990); O'Connor v. Donaldson, 422 U.S. 563, 574 (1975); see John Parry, *Involuntary Civil Commitment in the 90s: A Constitutional Perspective*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 320, 324 (1994) ("The first Supreme Court decision to address dangerousness was *O'Connor v. Donaldson*, which introduced the notion that dangerousness is a major justification for civil commitment. Later, in *Zinermon v. Burch*, a majority of the justices agreed that dangerousness is a constitutional requirement for civil commitment." (footnotes omitted)).

36. Many members of the medical and legal community believe that need of treatment alone is, or should be, the requisite standard for the establishment or maintenance of involuntary commitment. The following is a statement by the chairman of psychiatry and psychology at a Long Island hospital: "It's not a question of civil liberties, unless you are talking about the liberty to be psychotic, and that is not among one's basic rights . . . ." David Firestone, *For Their Own Good? With Public Pressure Mounting to Get the Mentally Ill Off the Streets, Lawyers Say They Don't Always Get a Fair Hearing*, NEWSDAY, May 31, 1989 at 8. Yet, the decisions in *Zinermon* and *O'Connor* do just this; psychosis without dangerousness is constitutionally insufficient for involuntary civil commitment.


38. *See, e.g.*, N.Y. MENTAL HYG. LAW § 33.02(a)(11) (McKinney 1988) (providing that patients have a right to participate in the creation of the treatment plan); Fosmire v. Nicoleti, 551 N.E.2d 77, 80-81 (N.Y. 1990); Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986).

tion—as opposed to involuntary transfer in Savastano—both decisions implicate the due process guarantee of a patient’s self-determination in the course of a treatment plan. Additionally, the regulations regarding both involuntary medication and transfer use similar language in regard to noncompliance.

New York has defended its administrative procedures by analogizing civilly committed patients to prisoners, who have no liberty interests. Although prisoners have no “liberty interest is [sic] choosing the place of his or her confinement,” any comparison between prisoners’ rights and the rights of the civilly committed is bound to be faulty. “[T]he considerations underlying our penal system are vastly different from those regarding our responsibility, care and concern for the mentally ill.” The language of United States Supreme Court decisions speaks in terms of convictions, not civil commitments, as removing the liberty interest of a prisoner regarding transfer from one facility to another.

For civil commitment of psychiatric patients to be constitutional, treatment must be the goal of such commitment, not mere custodial confinement. Commitment must not be punitive in nature, and any deprivation in liberty must be narrowly tailored to the purpose of

41. See N.Y. COMP. CODES C. & REGS. tit. 14, § 517.4(c)(1) (transfer); id. § 527.8(c)(3) (psychotropic medication).
44. See, e.g., Meachum v. Fano, 427 U.S. 215, 224 (1976) (holding that a “conviction[, not an involuntary commitment,] has sufficiently extinguished the defendant’s liberty interest to empower the State to confine him in any of its prisons”). But cf. Eubanks v. Clarke, 434 F. Supp 1022, 1029 (E.D. Pa. 1977) (holding that transfer of a civil committee to a more secure hospital does invoke a patient’s liberty interest).

“One student author has suggested that, in cases involving mental patients, the Eubanks approach ‘seems more appropriate than that in Meachum and Montayne.’” 1 PERLIN, supra note 2, at 403 n.1107 (quoting Note, 51 TEMP. L.Q. 357, 371 (1978)).
confinement.\textsuperscript{46} Wholesale derogation of fundamental constitutional rights is permissible only if such derogation is related to therapeutic, not punitive goals.\textsuperscript{47}

IV. STIGMA REQUIRE PROCEDURAL PROTECTION\textsuperscript{48}

Although not necessarily implicating a liberty interest by itself, the increased stigma associated with a transfer from a general hospital to a state psychiatric hospital requires adequate procedural protection.\textsuperscript{49} The stigma associated with treatment in a psychiatric hospital is not open to dispute and courts readily take judicial notice of its existence.\textsuperscript{50}

In Savastano, the court of appeals entirely failed to discuss stigma. The appellate division recognized that stigma was inherent in an involuntary commitment, but failed to acknowledge any increase in stigma resulting from a transfer to a chronic-care state psychiatric facility.\textsuperscript{51} Although the Mental Hygiene Law explicitly requires patients’

\textsuperscript{46} See Washington v. Harper, 494 U.S. 210, 223 (1990); see also Kesselbrenner v. Anonymous, 305 N.E.2d 903, 905 (N.Y. 1973) (holding that "[t]o subject a person to a greater deprivation of personal liberty than necessary to achieve the purpose for which he is being confined [for psychiatric purposes] is, it is clear, violative of due process").

\textsuperscript{47} See Harper, 494 U.S. at 223 (stating that civil commitment must be viewed as presenting "other circumstances" and cannot be permitted to have the same adverse impact on a person’s liberty interests as a criminal conviction).

\textsuperscript{48} See, e.g., Parham v. J.R., 442 U.S. 584, 631 (1979) (stating that "[t]he right to be free from wrongful incarceration, physical intrusion, and stigmatization has significance for the individual surely as great as the right to an abortion" (Brennan, J., concurring in part and dissenting in part)).

\textsuperscript{49} Vitek v. Jones, 445 U.S. 480, 494 (1980) (stating that "the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment . . . constitute the kind of deprivations of liberty that requires procedural protections").


The stigmatization associated with mental illness is not limited solely to the need for psychiatric treatment. Societal perception of "stand alone" psychiatric facilities carries with it a unique, additional brand of stigma. See Ed Struzik, MDS Buys Grey Nuns Supporters, EDMONTON J., Apr. 18, 1994, at B1 ("Dr. Lorne Warneke, head of psychiatry for the Grey Nuns, said the trend in psychiatry is to move away from the kind of large institution that is being proposed for Mill Woods . . . [T]he large institution enhances the stigma associated with psychiatric illness."); Marybeth Burke, Hospitals Seize New Opportunities in State Privatization Efforts, HOSPITALS, Apr. 5, 1992, at 50, 51 ("[T]he privatization process will allow clients to be treated in their own communities in normal settings, offsetting the stigma that is often associated with facilities geared
clinical records to remain confidential, the appellate division ignored the *de facto* realities regarding this confidentiality in dismissing its relevance to an increase in stigma upon involuntary transfer. While "stigma is . . . absent when confidentiality is maintained," true confidentiality regarding the location of a psychiatric patient is not adequately protected.

The increase in stigma regarding the location of the patient is not difficult to identify. If a patient were in the psychiatric ward of a general hospital, this hospitalization does not carry the inference that treatment is for a psychiatric illness. This is not generally the case when a patient is transferred to a state psychiatric hospital:

The cases of the patient-plaintiffs herein are illustrative. All were patients at Queens Hospital Center, a general hospital providing general inpatient medical services not limited to psychiatric care. . . . Relation of the fact that they were patients [there] does not, by itself, convey the information that they were confined for treatment of mental illness. However, Queens Hospital Center sought to transfer them to Creedmoor Psychiatric Center, a State facility operated . . . exclusively for the treatment of mental illness. Had the transfers to Creedmoor been carried out, anyone informed that the individuals were Creedmoor Psychiatric Center patients would know that they were treated for mental illness. The name alone broadcasts that information . . . .

The court of appeals in *Savastano* failed to consider the trauma


solely to the mentally ill.").

52. See, *e.g.*, N.Y. MENTAL HYG. LAW § 33.13(c) (McKinney 1988) (mandating that patients' psychiatric records are not public records).

53. See *Savastano*, 548 N.Y.S.2d at 561.


55. See N.Y. MENTAL HYG. LAW § 33.02 (McKinney 1988) (providing that contacts with outsiders such as friends and employers must be maintained, without stating that they are subject to the confidentiality requirements of the Mental Hygiene Law).

56. Appellant's Brief at 17, *Savastano* v. Nurnberg, 569 N.E.2d 421 (N.Y. 1990) (No. 2771/87). The stigmatization associated with institutions such as Creedmoor has found description outside of the arguments proffered by appellants in *Savastano*. See, *e.g.*, The Creedmoor Experiment: *Vacation as Therapy*, *Newsday*, Feb. 6, 1983, at 11 (stating that "[the] physical image of Creedmoor itself is ominous—a towering medical building of dreary beige brick and wire enclosed windows looming near the Grand Central Parkway in Queens Village, like everyone’s nightmare of what a mental hospital looks like"); *see also* Outdoor Sculptures to Soften Creedmoor’s Image, *New York Daily News*, Nov. 7, 1979, at 14-15 (describing that "[f]or generations of Queens residents, the Creedmoor Psychiatric Center in Queens Village has been a place of mysterious foreboding").
associated with a transfer from one psychiatric hospital to another. 57
"While transfer may be viewed by professionals as a routine procedure, the patient and his family often experience transfer as a stressful and intimidating event and as an ongoing crisis that may take weeks or even months to resolve. The transfer process requires special understanding and special management." 58 At the very least, this trauma requires that patients receive procedural protection against the concomitant stigma upon transfer.

V. HEARING IS CONSTITUTIONALLY INADEQUATE

Thus, a constitutionally protected liberty interest exists on the issue of transfer from a short-term general hospital to a long-term psychiatric hospital. 59 Additionally, the stigmatizing consequences of such a transfer mandate adequate procedural protection, regardless of whether or not a liberty interest is implicated. 60 This Part argues that the administrative framework, which must be followed prior to such a transfer, is constitutionally inadequate and procedurally unfair. 61

An objecting patient is entitled to an appeal of the decision to transfer him or her to a long-term care psychiatric facility. 62 This appeal is heard by the director of the sending hospital or his designee. 63 Thus, the person conducting the hearing and the person seeking the transfer are


Avoidance of transfer trauma may be subject to greater procedural protection than stigma upon transfer requires; the issue of whether or not transfer trauma may give rise to a constitutionally protected liberty interest was answered in the affirmative by the Second Circuit. Yaretsky v. Blum, 629 F.2d 817 (2d Cir. 1980), rev’d on other grounds, 457 U.S. 991 (1982) (reversing based on the issue of state action, and never reaching the liberty interest issue of transfer trauma).

59. See supra notes 17-58 and accompanying text.
60. See supra notes 48-58 and accompanying text.
61. See Henry J. Friendly, Some Kind of Hearing, 123 U. PA. L. REV. 1267, 1278-94 (1975) (enumerating the following factors, "roughly in the order of priority," that have been considered to be elements of a fair hearing: (1) an unbiased tribunal; (2) notice of the proposed action and the grounds asserted for it; (3) an opportunity to propose reasons why the proposed action should not be taken; (4) the right to call witnesses; (5) to know the evidence against one; (6) to have decision based only on the evidence presented; (7) counsel; (8) the making of a record; (9) a statement of reasons; (10) public attendance; and (11) judicial review).
62. N.Y. COMP. CODES R. AND REGS. tit. 14, § 517.4(c)(3) (1995) (providing that "[n]o request for the transfer of an objecting patient shall be made by the sending hospital until such patient has been given an opportunity to appeal such request to the sending hospital’s director").
63. Id. § 517.4(c)(3)(i).
likely to be either the same person or co-workers. In fact, this was the situation in Savastano. This hearing may be conducted without regard to the rules of evidence, the ability of the patient to cross-examine witnesses, and without the necessity of keeping a record. The hearing officer must review the patient's clinical history, give the opportunity for the patient to voice objection, and consider enumerated criteria for transfer.

To determine whether or not this procedural framework meets the requirements of procedural due process, the appropriate inquiry is into the private interest that will be affected, the risk of erroneous deprivation of that interest, and the government's interest in the proceeding. This "accuracy-oriented" approach is known as the three part Mathews analysis, and is the current model employed by the United States Supreme Court in determining "what process is due."

---

64. See id.
68. Mathews v. Eldridge, 424 U.S. 319, 335 (1976). The "Mathews approach," employed by the New York Court of Appeals in Savastano, received much academic criticism. See, e.g., LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 718 (2d ed. 1988). The Eldridge Court's unwillingness to consider values beyond accuracy of result in the context of a utilitarian balancing test when deciding what process is due, and the Court's grant of a strong presumption of constitutionality to statutory procedural provisions, amount to a serious abdication of traditional notions of judicial responsibility under the due process clauses.

Id.
[A]t a minimum, procedural due process contemplates some kind of hearing—an opportunity to join issue, through the presentation of evidence to a decision maker who is then obliged to reach a reasoned determination on the basis of the submissions. Underlying this conception [in Mathews] is the vital interest in promoting an accurate decision, in assuring that facts have been correctly established and properly characterized in conformity with the applicable legal standard . . . .

[Yet, f]undamental to the concept of procedural due process is the right to a reasoned explanation of government conduct . . . . It is crucial that this value be seen as distinct from the concern about administrative accuracy—the interest in correcting wrong decisions. Obviously, the two are related . . . . I would insist that the respect for individual autonomy that is at the foundation of procedural due process imposes a distinct obligation upon the government to explain fully its adverse status decision.

69. Mathews, 424 U.S. at 335; see Cleveland Bd. of Educ. v. Loudermill, 470 U.S. 532, 541 (1985) (stating that "[t]he right to due process 'is conferred, not by legislative grace, but by
The private interest affected has been established as a liberty interest. At the very least, the stigma and "transfer trauma" associated with such a transfer also mandates adequate procedural protection. At most, New York has created a constitutionally protected liberty interest regarding such a transfer.

The court of appeals in Savastano downplayed the risk of erroneous deprivation. The court characterized the decision regarding transfer as being primarily medical in nature, and thus better left to medical professionals.

There are numerous problems with this characterization. A cursory analysis of the elements, which merit consideration prior to transfer, reveals that they are essentially non-clinical in nature. Examples of some of these factors are proximity of family and friends to the sending hospital, availability of services, and bed capacity. These criteria require no clinical expertise or skill and do not need to be "left to those who have expertise in that field." Even if one accepted the court of appeals' characterization of the transfer decision as being primarily medical in nature, the regulation in question in no way guarantees that the person hearing the appeal will be constitutional guarantee'... once it is determined that the due process clause applies, "the question remains what process is due" (quoting Arnett v. Kennedy, 416 U.S. 134, 167 (1974), and Morrissey v. Brewer, 408 U.S. 471, 481 (1972), respectively).

70. See supra notes 17-58 and accompanying text.
71. See supra notes 48-58 and accompanying text.
72. See supra notes 17-30 and accompanying text.
74. Id.
76. Id.
77. Savastano, 569 N.E.2d at 424 (citing Parham v. J.R., 442 U.S. 584, 607 (1979)). The patient's right to a judicial hearing regarding the initial transfer determination has found support in recent decisions. See, e.g., In re Jerome G., 607 N.Y.S.2d 709, 710 (App. Div. 1994).

The "so-called" medical-legal distinction has been the subject of much academic criticism. See, e.g., JERRY L. MASHAW, DUE PROCESS IN THE ADMINISTRATIVE STATE 111 (1985). Mashaw argues that the Parham court did not believe that a minor needed a hearing prior to commitment to a mental institution, apparently in substantial part, because a hearing would provide little additional protection from error... Yet, somehow, when in Vitek the question was whether a prisoner should have a hearing prior to being transferred to a mental hospital, the suggestion that psychiatric judgment was involved elicited the following judicial response: "The medical nature of the inquiry... does not justify dispensing with due process requirements. It is precisely [t]he subtleties and nuances of psychiatric diagnoses that justify the requirement of adversary hearings."

Id. (quoting Vitek v. Jones, 445 U.S. 480, 495 (1980)).
a medical professional.\textsuperscript{78} Not only does the statute speak of a designee of the hospital director—who may or may not be a medical professional—but it also fails to specify whether the director himself need be medically trained.\textsuperscript{79}

The question arises as to the impartiality of the factfinder in such a proceeding. The United States Supreme Court has generally required such impartiality.\textsuperscript{80} An impartial factfinder “helps to guarantee that life, liberty, or property will not be taken on the basis of an erroneous or distorted conception of the facts or the law.”\textsuperscript{81} As stated previously, the factfinder in such a hearing may be party to the dispute, and as such, may have a constitutionally impermissible conflict of interest.\textsuperscript{82} Additionally, as stated by the trial court in \textit{Savastano}, the pressure to relieve overcrowding in city and municipal hospitals may also adversely affect the impartiality of the factfinder:

The mere fact that the transfer might be motivated by the desire or necessity to alleviate overcrowding to meet the demand for inpatient treatment in acute-care psychiatric facilities is a conflict which prevents the director of the transferring facility from deciding the issues in an unbiased and impartial manner. Under present rules, this same director may apply for an order of transfer and thereafter may be called upon to review his own decision should objection be raised.\textsuperscript{83}

As part of the \textit{Mathews} analysis regarding erroneous deprivation of liberty,\textsuperscript{84} the court of appeals in \textit{Savastano} opined that “any potential for undue influence [regarding the transfer decision] is offset by the \textit{receiving} facility’s right to refuse any transfer [that] it finds inappropriate.”\textsuperscript{85} Yet, this right of refusal does not carry with it the right of the

\textsuperscript{78} N.Y. COMP. CODES R. \& REGS. tit. 14, § 517.4(c)(3)(i) (1995) (providing that the hospital’s director, unit chiefs, supervisors or psychiatrists are appropriate parties to hear the appeal).

\textsuperscript{79} Id.


\textsuperscript{81} Id.

\textsuperscript{82} United Retail & Wholesale Employees Teamsters Union Local Union No. 115 v. Yahn & Mc Donnell, Inc., 787 F.2d 128, 138 (1986), \textit{aff’d} \textit{per curiam}, 481 U.S. 735 (1987) (stating that although there is a presumption of factfinder impartiality, all that need be shown to rebut the presumption is a “possible temptation” or an “underlying incentive” to manifest bias). The temptation is evident in this situation. \textit{See supra} notes 62-67 and accompanying text.


\textsuperscript{84} Mathews v. Eldridge, 424 U.S. 319, 335 (1976).

objecting patient to be heard, and thus fails to ameliorate the constitutional infirmities of the initial transfer hearing.\textsuperscript{86} The United States Supreme Court has stated that even when the interest under consideration is "not one of great consequence,"\textsuperscript{87} minimal due process requires some right to be heard.\textsuperscript{88}

In addition to this "right of refusal" vested in the receiving hospital, the court of appeals stated that any possibility of erroneous liberty deprivation would be offset by the availability of an article 78 proceeding subsequent to the transfer.\textsuperscript{89} Yet, this so-called remedy also fails to cure the constitutional infirmities of the administrative transfer hearing. An article 78 proceeding is essentially a writ of mandamus to review, which places the burden on the patient to show that the administrative determination was arbitrary and capricious.\textsuperscript{90} This procedure falls short of the constitutional guarantee of an impartial factfinder determining whether or not transfer to a long-term state psychiatric center is appropriate.\textsuperscript{91}

The court of appeals summarily dismissed the due process importance of a patient's ability to cross-examine witnesses.\textsuperscript{92} In support of this position, the court quoted \textit{Basciano v. Herkimer}.\textsuperscript{93} "[T]he value of cross-examination to discredit a professional medical opinion at best is limited."\textsuperscript{94} Yet, as stated previously, the enumerated factors considered concerning transfer contain mostly non-clinical components.\textsuperscript{95} Absent the medical characterization espoused in \textit{Basciano}, this transfer determination falls short of due process requirements. When decisions involve questions of fact, due process requires an opportunity

\textsuperscript{86} N.Y. COMP. CODES R. & REGS. tit. 14, § 517.A(g)(iv) (1995) (providing that "[i]f the receiving hospital determines that the patient is not appropriate for admission, the order of transfer . . . may be canceled"). The regulation fails to provide for any patient input into the decision.


\textsuperscript{88} Id. at 472 (stating that in order to satisfy procedural due process, respondent was entitled to offer any "statement respondent wished to submit").

\textsuperscript{89} Savastano, 569 N.E.2d at 423-24 (stating that "a patient who is dissatisfied with a transfer determination may challenge it by commencing an article 78 proceeding").


\textsuperscript{91} See supra notes 80-81 and accompanying text.

\textsuperscript{92} See Savastano, 569 N.E.2d at 425.

\textsuperscript{93} 605 F.2d 605 (2d Cir. 1978), cert. denied, 442 U.S. 929 (1979).

\textsuperscript{94} Id. at 611.

\textsuperscript{95} See supra notes 75-77 and accompanying text.
to confront and cross-examine witnesses. 96

The inability to cross-examine the facility’s witnesses prevents a patient’s attorney from eliciting such pertinent information as the witnesses’ familiarity with the patient, what information the witnesses relied upon in forming their opinions, and the extent to which any administrative considerations such as bed space or budgetary concerns may have influenced a decision to recommend transfer, all of which touch upon the reliability of the testimony of any witness in the administrative proceeding. 97

The final element of the Mathews analysis involves the state’s interest in the transfer, taking into account the requisite “fiscal and administrative burdens that [a judicial hearing] would entail.” 98 The court of appeals in Savastano concluded that “significant administrative and fiscal burdens . . . would result from the necessity of holding a prior judicial hearing each time an involuntary patient objects to being transferred to a State institution.” 99 This conclusion is empirically wrong. The effect of denying the right to a judicial hearing has been to hamper, not help, the goals of economy and efficiency.

In order to meet the current requirements for the administrative hearing, the hospital must produce a physician as a witness. 100 This would not change if the hearings were conducted in front of a judge. 101 The hospital director or his designee already must sacrifice his or her time to conduct such a hearing. 102 Therefore, it is unlikely that the fiscal and administrative cost will increase much, if at all, if the hearing

96. See, e.g., Vitek v. Jones, 445 U.S. 480, 494-95 (1980) (holding that there is a right to confront and cross-examine witnesses prior to a transfer from a penitentiary to a psychiatric institution).

97. Appellant’s Brief at 34, Savastano v. Nurnberg, 569 N.E.2d 421 (N.Y. 1990) (No. 2771/87). In Savastano, the court of appeals downplayed the impact of institutional pressures such as overcrowding on the proceeding’s impartiality. The court stated that “such concerns are relevant to decisions regarding treatment, inasmuch as overcrowding has a direct impact on the level and quality of hospital services.” 569 N.E.2d at 425. Yet, as stated previously, overcrowding is but one of many factors which must be considered in a transfer proceeding.


99. Savastano v. Nurnberg, 569 N.E.2d 421, 425 (N.Y. 1990) (concluding from the holding in Parham that permitting such a judicial hearing would “accomplish little else than the diversion of scarce resources from the care and treatment of mentally ill patients”).


101. See, e.g., In re Jerome G., 607 N.Y.S.2d 709, 710-11 (App. Div. 1994) (stating that when a judge entertains a transfer hearing, the same requisite elements must be established).

102. N.Y. COMP. CODES R. & REGS. tit. 14, § 517.4(e)(3) (1995) (providing that “[n]o request for the transfer of an objecting patient shall be made by the sending hospital until such patient has been given an opportunity to appeal such request to the sending hospital’s director”).

Published by Scholarship @ Hofstra Law, 1996
is instead conducted by a judge.

This argument is bolstered by the fact that "special terms" are in place which hold weekly calendars to review cases involving the Mental Hygiene Law. These "special terms" consist of judges and clerks who are thoroughly familiar with this area of the law and are able to move cases through quickly and efficiently. Therefore, they provide a "ready solution" to the constitutional infirmities inherent in the current administrative transfer framework.

Arguing in support of this premise, the appellant in Savastano stated that "[s]ince the special terms presently hold and historically have held regular weekly calendars to deal with mental health matters such as commitment and medication hearings, transfer hearings can continue to be incorporated into said calendars (as is presently the case)." Although judges had long incorporated transfer hearings into the Mental Hygiene calendar, the "unfortunate effect" of Savastano has been to bifurcate this hearing, even when it would clearly be in the interest of judicial economy and efficiency to incorporate.

Historically, hospitals have sought transfer in concert with receiving a court-ordered, six-month retention. A patient is guaranteed the right

103. For example, the New York Supreme Court of Kings County utilizes a fixed staff of clerks and a judge who has expertise in the Mental Hygiene Law and criminal commitments. This part of the court is extremely specialized and efficient, issuing on average one thousand mental hygiene warrants, inter alia, per annum. Telephone Interview with Elliott Raines, Law Secretary to Hon. Maxine K. Duberstein, Supreme Court, Kings County (Oct. 25, 1995).


105. Although Savastano does not prevent a judge from entertaining a hearing on transfer if he or she so wishes, the personal experience of this author with the Mental Hygiene Part is that judges generally refuse to do so when the issue is presented, even when economy and efficiency would clearly be the result. It should be noted that the New York Court of Appeals has emphasized that a central aim of judicial discretion is the promotion of economy and efficiency. See, e.g., Kane v. Parry, 364 N.E.2d 846 (N.Y. 1977). For a defense of the "judge's position," see infra note 108.

Even for those judges who do not explicitly refuse to entertain transfer hearings, the current practice is that the transfer issue is rarely, if ever, raised by the hospital at a commitment hearing subsequent to Savastano. Westchester County is the only jurisdiction in which transfer hearings are currently tried in court. Telephone Interview with Dennis B. Feld, Assistant Director of Mental Hygiene Legal Service, 2d Dep't. (Jan. 23, 1995).

106. See N.Y. MENTAL HYG. LAW § 9.33(b) (McKinney 1988) (providing that the first period of retention requiring court authorization not to exceed six months); Interview with Elliott Raines, Law Secretary to Hon. Maxine K. Duberstein, Supreme Court, Kings County (Jan. 22, 1994) ("Hospitals, prior to the Savastano decision, traditionally sought, and continue to administratively seek, transfer orders in concert with their six-month orders of retention. This is so because this was now for the 'long haul,' and the city hospitals want to free up beds.")
to a judicial hearing when such a commitment is sought.\textsuperscript{107} Although prior to \textit{Savastano} the hearings on commitment and transfer would have been condensed into one judicial proceeding, this does not represent current practice.\textsuperscript{108} After the retention hearing, the relevant parties must return to the hospital for a transfer hearing. The expenditure of legal and medical professional time is greatly increased under such a scenario, and defeats the underlying purpose of the third part of the \textit{Mathews} analysis.

The final consideration which must be given to New York’s interest in economy and efficiency concerns the aforementioned “remedy” of an article 78 proceeding.\textsuperscript{109} The substitution of an article 78 proceeding for a Mental Hygiene Law article 9 hearing has the effect of hampering the goals of economy and efficiency, as does the failure to condense commitment and transfer hearings into one proceeding.\textsuperscript{110} The amount of paperwork and pre-hearing court involvement in an article 9 hearing is minimal.\textsuperscript{111} An article 78 proceeding, on the other hand, is much more complex. It involves, \textit{inter alia}, notice of petition, supporting affidavits, and motion papers.\textsuperscript{112} Most importantly, the date for such a hearing “cannot be set for earlier than the 20th day after service.”\textsuperscript{113} It is questionable that the use of a relatively complex article 78 proceeding in lieu of a relatively simple article 9 hearing on the issue of transfer will advance an economy-efficiency objective.

Consideration also must be given to the scope of the Office of Mental Health regulations for administrative psychiatric transfer. These

\begin{flushleft}
\textsuperscript{107} N.Y. MENTAL HYG. LAW § 9.33(c) (McKinney 1988) (“Upon the demand of the patient or of anyone on his behalf . . . the court shall, or may on its own motion, fix a date for the hearing . . .”).
\textsuperscript{108} See supra note 105. An additional point should be made: judges who refuse to entertain transfer hearings have legitimate reasons for doing so. Prior to the decision in \textit{Savastano}, transfer hearings were regularly heard in the courts. It was the Office of Mental Health that chose to appeal the Supreme Court, Queens County’s ruling to the New York Court of Appeals to ensure that the administrative hearing be declared constitutional. Now, after all the time and expense that went into the appeals process, the feeling is that it is inappropriate for the same agency to attempt to bifurcate the transfer issue in court. The sentiment is “be careful what you ask for, because you may just get it.” Telephone Interview with Elliott Raines, Law Secretary to Hon. Maxine K. Duberstein, Supreme Court, Kings County (Oct. 25, 1995).
\textsuperscript{109} See supra notes 89-91 and accompanying text.
\textsuperscript{110} Id.
\textsuperscript{111} See, e.g., N.Y. MENTAL HYG. LAW § 9.31(c) (McKinney 1988) (mandating that the court must “fix the date of such hearing at a time not later than five days from the date such notice is received by the court”).
\textsuperscript{112} See SIEGEL, supra note 90, at 890-92.
\textsuperscript{113} Id. at 890.
\end{flushleft}
regulations—in particular 29 NYCRR 517.4—are *ultra vires* because they go beyond the legislature’s declared purpose of article 9 to bolster the rights of psychiatric patients, not further abrogation of these rights.

Prior to 1964, the only way that an involuntary psychiatric patient could be transferred against his will was by certification from the court. Article 9 was created with the express purpose of increasing patients’ rights, and statements concurrent with its passage reinforce this notion. It is clear that the passage of article 9 was understood to be a step in the right direction for increasing the rights of psychiatric patients.

VI. CONCLUSION

The opinion of the New York Court of Appeals in *Savastano* provides inadequate procedural protection for a patient contesting transfer. Additionally, it fails to prevent the diversion of scarce resources from the care and treatment of mentally ill patients.

The New York Legislature should mandate a judicial determination on the issue of transfer. The sending hospital should be required to prove, by clear and convincing evidence, that transfer is in the best

---

114. See BLACK’S LAW DICTIONARY 1522 (6th ed. 1990) (defining *ultra vires* as an “act . . . which is beyond powers conferred . . . by law”).

115. See infra notes 116-18 and accompanying text.


117. The revamping of the Mental Hygiene Law was the work of the Special Committee of the Bar of the City of New York. See, e.g., Special Committee to Study Commitment Procedures of the Association of the Bar of the City of New York & Cornell Law School, Mental Illness and Due Process: Report and Recommendations on Admission to Mental Hospitals Under New York Law, at 14 (1962) (stating that the purpose of revamping this area of the law is to ensure that “[a]ny person hospitalized against his will is entitled to watchful protection of his rights, because he is a citizen first and a mental patient second”).

118. The revamped statutory scheme “preserves due process safeguards of every person who is admitted to a psychiatric facility for care and treatment.” 1964 N.Y. Rules 1968 (statement of Governor Nelson A. Rockefeller, upon approving the statutory change).

Executive statements and those of the drafters are not the only evidence of the “rights bolstering purpose” in the revamping. See, e.g., Proceedings of the Seminar of Supreme Court Justices on the Subject of Hospitalization of the Mentally Ill, 1965, at 37 (stating that the Justices were “firmly convinced” that patients should continue to enjoy judicial transfer determinations).


121. See, e.g., N.Y. MENTAL HYG. LAW § 9.31 (McKinney 1988) (mandating the clear and convincing standard of proof for involuntary commitment); Addington v. Texas, 441 U.S. 418, 433 (1979); Rivers v. Katz, 495 N.E.2d 337, 344 (N.Y. 1986) (mandating the same standard for the
interests of the patient. Despite the court’s characterization, the special terms created to deal solely with the Mental Hygiene Law are more than able to condense transfer proceedings into current calendars economically,\textsuperscript{122} while at the same time ensuring the procedural due process denied to patients by the current administrative proceeding.

Although judicial determination on the issue of transfer would be the most economical solution to the current regulatory infirmities, another option would be to amend 14 NYCRR 517.4 to provide for a hearing before an impartial administrative officer.\textsuperscript{123} “A hearing officer who is employed by the institution or the Office of Mental Health cannot but feel, rightly or wrongly, that his/her career might be affected by decisions which overturn administrative decisions in a situation of overcrowded short-term facilities.”\textsuperscript{124} The right to present evidence, cross-examine witnesses, and have a record made of the proceedings should also be required.\textsuperscript{125} As with other administrative proceedings,\textsuperscript{126} strict conformity to the rules of evidence would not be required. This “administrative

\textsuperscript{122} A hospital within the jurisdiction of a particular special term is given a weekly calendar day on which the patients requiring hearings on commitment and/or involuntary medication are “bussed in,” or judges travel to the institution for in-hospital proceedings. These hearings tend to be brief, and most judges require that retention and medication hearings be condensed for a particular patient. Condensing transfer poses little additional burden on this procedure.

It is interesting to note that when the issue concerns further abrogation of patients’ rights, hospitals advance similar “condensation arguments” regarding economy and efficiency. See, e.g., \textit{In re Lesley B.}, 567 N.Y.S.2d 999, 1000 (Sup. Ct. 1991) (“The hospital maintains that the proceedings pursuant to § 9.13 [conversion from voluntary to involuntary status] and § 9.33 [involuntary retention] should be consolidated and such consolidation is not prohibited by statute. Furthermore, the hospital argues that such consolidation is in the interest of judicial economy . . . .”).

\textsuperscript{123} It must be remembered that the fear of the “courts being flooded with transfer determinations” is unfounded. It is in a relatively small number of cases that the decision to transfer is contested.


\textsuperscript{125} \textit{See supra} note 61 and accompanying text.

solution" would solve the infirmities of the present system without "unduly burdening the transfer process."\textsuperscript{127}

\textit{Daniel A. Rosen}\textsuperscript{*}

\begin{itemize}
\item \textsuperscript{127} \textit{See supra} note 123. \textit{But see supra} note 121.
\item \textsuperscript{*} I wish to thank Professor Michael L. Perlin of New York Law School, Dennis Feld, Esq., and Elliott Raines, Esq., for their constructive criticism, abundant resources, and advice. Deepest appreciation to Hon. Maxine K. Duberstein, who gave me the opportunity to see the "special term" at work. Finally, thank you to Christine A. Cirillo, whose patience, assistance, and understanding have been a constant source of strength.
\end{itemize}