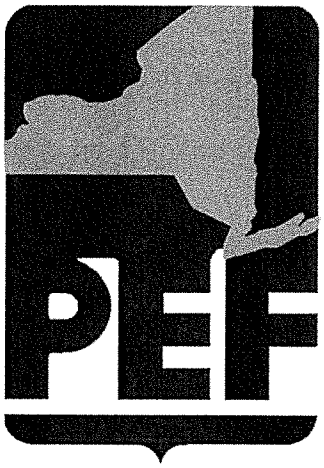

Workforce Development Joint Legislative Budget Hearing

2019-2020 Executive Budget Proposal

February 4, 2019

Randi DiAntonio, Vice President

Good evening Chairs Krueger, Weinstein, Gounardes, Abbate and other committee members. My name is Randi DiAntonio and I am a Vice President of the Public Employees Federation (PEF). I am a Licensed Master Social Worker and have been employed by OPWDD since 1999. I want to thank you for allowing me the time to speak to you on behalf of our 54,000 members. Our union is made up of professional, scientific and technical experts who provide critical services to the residents of New York State. We have a lot of pride in the work that we do, because we know we are the best qualified people to do the job.

STAFFING LEVELS

Unfortunately, while our members are dedicated professionals who love their jobs, they are suffering from chronic understaffing and low morale in virtually all agencies and all fields. We believe this is a result of the state's continued reliance on expensive consultants to do the work our highly trained and qualified members should be doing and the continued erosion of the civil service system under which we are supposed to be operating.

This budget continues the disturbing trend of using private for- and not-for-profit entities to do the work once done by state employees. Whether it is OITS, OMH, OPWDD, DOT or one of the many other State agencies doing the outsourcing, we believe that PEF members are best suited to deliver the public services that the State provides. Continuing to divert services and resources to private entities at the expense of individuals, dependent upon State services, is detrimental to clients, state workers and taxpayers.

The Executive budget proposes a small increase in the number of State workers. 678 new positions under the control of the Governor would be filled in the upcoming year. This is out of a staff of over 120,000 (see Appendix A). While an increase of less than 1 percent (0.56%) is a

good first step, much more needs to be done across the board to make up for the losses that have been experienced over the last 15 years. More than 60 percent of the new positions are for three agencies (DOCCS, Health and Tax and Finance) for specific programs. The majority of State agencies contain no or very modest increases.

The use of costly consultants is also proposed to increase in the 2019-20 budget. The Governor recommends 169 additional FTEs in the consultant service contracts (see Appendix B). Nearly $1 Billion will be spent on nearly 8,300 consultants, with an average annual salary of over $112,000. We believe that money should be invested in the State workforce. We would be thrilled to receive even half of what has been earmarked for consultants.

We ask that you use the Governor's modest proposal to invest in the State workforce as a starting point and build from there. PEF members can and do provide the professional services needed by New Yorkers at a more reasonable cost than independent for-profit corporate employees.

CLOSURE OF FACILITIES

We are happy to see that the Governor did not propose any closures as part of this year's budget. Last year, the Governor sought to close the Ella McQueen Reception Center for Boys and Girls in Brooklyn (an OCFS facility) within 30 days, circumventing the 12-month notice that is required by law. We thank you for helping us keep centers like Ella McQueen and the Institute for Basic Research (IBR), which conducts research for OPWDD, open. Unfortunately we have just learned that Ella McQueen, outside of the budget process, has been targeted for closure. We will be asking for your support in the coming weeks and months to help keep this important facility open.

We also want to thank you for your assistance in keeping the Western New York Children's Psychiatric Center (WNYCPC) open. The Governor had sought to close it a few years ago. Advocates worked hard to get the Governor to change his mind and the Legislature passed a bill to keep the Center open. While the bill was ultimately vetoed, the Governor did, in fact, change his mind and we were happy to learn recently that the Center will be getting $30 Million in renovations soon.

We will need your help with Ella McQueen and your continued vigilance to stave off other closures. Sadly, agencies manipulate numbers to keep clients out of certain facilities and justify their closure based upon the artificially low numbers. The truth is that beds could easily be filled if the agencies chose to do so. This type of gamesmanship happens too often and our most vulnerable citizens are the ones who pay the price.

DESIGN-BUILD

Once again, the Executive Budget includes a proposal to expand design-build in New York State, a process that PEF opposes for several reasons. The design-build project delivery system allows a single entity to be responsible for the design, construction and inspection of a single project. The design-build delivery system is a dangerous concept where time is money. PEF represents some of the best transportation engineers in the State. As a result of the extensive use of consultants, their skills and talents are underutilized and the State is losing its ability to provide these services in-house. Having an owner retain a single entity that is responsible for providing both the design and construction of a project is risky as demonstrated by the "Big Dig" disaster in Massachusetts.

While it has been alleged that the design-build process allows projects to happen faster and cheaper, there is no evidence to back these claims. The professional staff employed by State agencies are the most competent and cost-effective solution to most of the State's needs. This remains true in spite of the loss of several hundred State engineers over the last decade.

At this hearing last year, we testified that without proper state oversight the opportunity exists to skimp on critical component materials. We did not know at the time how right we were. This past December, New York City news outlets reported that the brand new bolts on the Tappan Zee (Mario Cuomo) Bridge were breaking. The Attorney General is now investigating a potential cover up by the contractors to ensure construction was not delayed even though new bolts were potentially flawed. This information only came about as the result of a whistleblower. However, if state employees were inspecting the work, we believe that a potential cover up and the push for an on-time completion would not have happened.

Any implied advantage realized by the design-build process will quickly be offset by costly procurement processes, increased need for upfront owner input, decreased owner control and increased construction risk. The lack of control and increased risk show how design-build is not appropriate for New York. The Tappan Zee issue shows a glimpse of the disaster in waiting that is design-build.

We ask that you please say no to this expansion of design-build and recognize that your state workforce already includes some of the best transportation engineers around – PEF members – whose engineering skills and talents are being under-utilized by New York State. This program should be allowed to expire at the end of March.

SUNY HOSPITALS

When it comes to health care, our public teaching hospitals are vital resources for the community. The three SUNY hospitals (Downstate, Upstate, Stony Brook) provide vital medical education, research and essential health care services to their communities and specialty care services such as burn and trauma care units and stroke centers. They are especially important to the underserved populations in the communities where they are located.

We thank you for your support in the past by restoring cuts to SUNY hospitals and rejecting language that would have opened the door to private investments in public hospitals. Last year, you not only brought back the SUNY hospital subsidy that the Governor tried to eliminate, but you increased it to $92 Million.

The Governor has once again proposed to eliminate the subsidy for the hospitals. We are asking that the $78.6 million dollar subsidy, which had been in place for several years, be restored. This funding is especially needed in light of the shortfalls they face due to lack of adequate federal Disproportionate Share Hospital (DSH) resources.

OFFICE OF MENTAL HEALTH AND OFFICE FOR THE PEOPLE WITH DEVELOPMENTAL DISABILITIES DOWNSIZING

New York State's behavioral health care services have been facing mandated community-based transitions that PEF continues to believe lack clarity. This transition has been set into motion without the necessary resources in place to ensure that individuals released into these new settings will receive the same or higher level of care and treatment that the State has historically provided. We are concerned with the adverse impact on continuity of care for those served every day by our members. Currently, PEF represents thousands of members working at

OPWDD and OMH. Unfortunately, the State continues to push services for these individuals out into the community. The Bernard Fineson Developmental Center was slated for closure on March 31, 2017, but remains open due to the difficulty the State is having in finding private contractors to make more beds available.

PEF asks the Legislature to delay any further outsourcing of these services until a more comprehensive plan is developed that ensures that all individuals will have access to the appropriate quality of care and services needed. This would include ending diminishing clinical resources and unsafe placements and discharges of those who are in the greatest need of our State services. (Appendix C)

JUSTICE CENTER

The Justice Center oversees cases of abuse and neglect in state operated, licensed or certified programs and facilities in agencies that care for individuals with developmental disabilities, mental illness, substance abuse disorders and children in residential facilities.

While progress has been made, the Justice Center continues to be a source of concern for health care professionals in this field. Clients use the threat of the Justice Center to manipulate their caregivers. Nurses who become subjects of Justice Center investigations often leave for nursing positions outside of State service. They fear that if they are found guilty, their licenses will be in jeopardy and their names will be on the list prohibiting them from working with children or vulnerable clients.

We believe more training is needed, both by Justice Center staff – some of whom are represented by PEF – and to the agencies so that my members can continue to meet the needs of individuals in the care of these agencies without running afoul of the Justice Center.

DOCCS

The Department of Corrections and Community Supervision (DOCCS) operates 54 facilities that house 47,400 inmates and is responsible for more than 35,000 parolees. The Executive Budget calls for an increase of 153 full time employees, which is attributable to an increase in program services and supervision of inmates staff related to the NYCLU SHU agreement and the DOCCS solitary confinement reform bill.

Despite the fact that over the past 15 years the staffing ratio of inmates to uniformed staff within facilities has been reduced consistently with the decline of the inmate population, there has been an increase in violence within the facilities. Since 2013, there has been an approximately 51 percent increase statewide in assaults on staff in State prisons and an increase of 52 percent in assaults on inmates (DOCCS Fact Sheet, Jan. 1, 2019). This trend in more violence clearly indicates the need for additional highly trained staff.

We ask that you continue to provide additional resources for staff and training necessary to improve safety for inmates and staff alike.

DOCCS, as with every other State agency, suffers from recruitment and retention problems for licensed professionals such as nurses, doctors, pharmacists and nurse practitioners, within its facilities. A DOCCS staffing report from October 2017 shows the average nursing vacancy rate is now nearly 20% statewide. Individually, Sing Sing is facing a 75% vacancy rate.

The DOCCS report goes on to say that though recruitment is ongoing, the continuing and widening gap between DOCCS nursing salaries and community salaries continues to make recruiting and retaining quality nurses nearly impossible. This results in frequent scheduling and assignment changes, as well as a high volume of voluntary and mandatory overtime (DOCCS is the worst violator of the "No Mandatory Overtime" law). Low salaries coupled with Tier 6

retirement makes it very difficult to incentivize nurses to come to, or remain in state employment. Contracting out for these services is a very costly short-term solution that is not sustainable.

It's time that we invest in nursing titles in New York State and begin to look at increasing the base pay of a nurse from a Grade 16 to a Grade 18 to help in the recruitment and retention of qualified nurses.

While we were successful in getting some geographic pay increases where the shortages are considered critical, we need to do more to solve the problem. Let's invest in our nurses!

Parole Officers are also an understaffed area within DOCCS. We believe that this problem will be exacerbated in the coming years, especially if programs such as the Geriatric Parole reform are put into place. We simply cannot ask our overworked and short-staffed Parole Officers to continue to accept increases in their caseloads. We need to make an investment in more Parole Officers, especially if we expect to have more parolees. It just makes good sense from a planning perspective.

RETIREES

The Governor has once again proposed to balance the budget, in part, on the backs of state retirees. Specifically, he wants to cap the Medicare Part B reimbursements at the current rate and make any future increases subject to budget negotiations, making it much less likely to happen. He has also proposed to end the Income Related Monthly Adjustment Amounts (IRMAA) completely for higher income retirees.

The most troubling retiree proposal is to create a new sliding scale of retiree health care costs for any new state employees hired after April 1, 2019. This, compounded with the Tier 6 retirement benefits, will only further harm recruitment efforts for State workers. All three of these bad proposals need to be rejected.

PROTECTION OF PRIVATE INFORMATION

We would like to applaud the Governor's proposal to keep the personal information of all state employees private. In light of the recent *Janus* Supreme Court decision, our members have been contacted on work emails, at their homes and through other venues in a supposed "information campaign" to encourage them to stop paying union dues. This proposal would codify Executive Order #183 to prohibit the dissemination of personal home address, personal home phone number, personal cellular phone number or personal email address of any state or local government employee. We wholeheartedly support this proposal.

CONCLUSION

In closing, I hope you will agree that we need, and the citizens of New York State deserve, an investment in the professionals that serve our state.

We ask that there be an investment in a fully staffed and fully trained state workforce and a decreased reliance on costly consultant employees.

We ask that recruitment and retention issues are properly addressed so that the hard working members I represent are relieved of the stress of mandatory overtime and the scheduling issues that cause havoc in their lives.

We believe, and I think you share this belief, that abolishing qualified public service is not the solution.

The public interest is best served by state agencies that are fully staffed with public servants. So, we are asking that public interest be served by public workers… not those committed solely to private profit.

I appreciate your time and the opportunity to address you today. Thank you.

A

Workforce Impact Summary

All Funds
FY 2018 Through FY 2020

	FY 2018 Actuals (03/31/18)	Starting Estimate (03/31/19)	Attritions	New Fills	Fund Shifts	Mergers	Net Change	Ending Estimate (03/31/20)
Major Agencies								
Children and Family Services, Office of	2,887	2,964	(468)	468	0	0	0	2,964
Corrections and Community Supervision, Department of	29,351	29,175	(614)	767	0	0	153	29,328
Education Department, State	2,575	2,692	(269)	269	0	0	0	2,692
Environmental Conservation, Department of	2,887	3,110	(234)	239	0	0	5	3,115
Financial Services, Department of	1,356	1,381	(55)	55	0	0	0	1,381
General Services, Office of	1,811	1,931	(323)	323	0	0	0	1,931
Health, Department of	4,690	5,462	(718)	872	0	0	154	5,616
Information Technology Services, Office of	3,471	3,489	(130)	130	0	0	0	3,489
Labor, Department of	2,935	2,987	(285)	285	0	0	0	2,987
Mental Health, Office of	13,911	13,677	(1,455)	1,495	0	0	40	13,717
Motor Vehicles, Department of	2,301	2,344	(266)	266	0	0	0	2,344
Parks, Recreation and Historic Preservation, Office of	1,751	2,024	(152)	169	0	0	17	2,041
People with Developmental Disabilities, Office for	18,867	18,590	(1,078)	1,078	0	0	0	18,590
State Police, Division of	5,609	5,741	(311)	311	0	0	0	5,741
Taxation and Finance, Department of	3,898	3,975	(142)	252	0	0	110	4,085
Temporary and Disability Assistance, Office of	1,923	1,989	(234)	234	0	0	0	1,989
Transportation, Department of	8,501	8,520	(383)	383	0	0	0	8,520
Workers' Compensation Board	1,082	1,109	(89)	89	0	0	0	1,109
Subtotal - Major Agencies	**109,806**	**111,160**	**(7,206)**	**7,685**	**0**	**0**	**479**	**111,639**
Minor Agencies	**7,591**	**8,167**	**(852)**	**1,051**	**0**	**0**	**199**	**8,366**
Subtotal - Subject to Direct Executive Control	**117,397**	**119,327**	**(8,058)**	**8,736**	**0**	**0**	**678**	**120,005**
University Systems								
City University of New York	13,726	13,632	0	0	0	0	0	13,632
State University Construction Fund	142	152	0	0	0	0	0	152
State University of New York	45,882	46,092	0	0	0	0	0	46,092
Subtotal - University Systems	**59,750**	**59,876**	**0**	**0**	**0**	**0**	**0**	**59,876**
Independently Elected Agencies								
Audit and Control, Department of	2,630	2,663	(212)	212	0	0	0	2,663
Law, Department of	1,822	1,839	(139)	139	0	0	0	1,839
Subtotal - Independently Elected Agencies	**4,452**	**4,502**	**(351)**	**351**	**0**	**0**	**0**	**4,502**
Grand Total	**181,599**	**183,705**	**(8,409)**	**9,087**	**0**	**0**	**678**	**184,383**

B

Consulting Service Contracts

The Division of the Budget (DOB) annually collects and reports information related to employees working under State agency consulting service contracts. Estimated consultant spending includes labor-related contract costs such as overhead, travel and fringe benefits, and in some cases, other non-personal service expenses. Accordingly, contract costs cannot be interpreted as representing only the compensation paid to contract employees. The Executive Budget Consulting Service Contracts Report is presented in the following tables.

All Funds Comparison

	FY 2019	FY 2020	Amount Change	Percent Change
Est. Appropriations	$920,199,185	$929,543,078	$9,343,893	1.02%
Est. Reappropriations	$892,428,386	$975,377,104	$82,948,718	9.29%
Est. Disbursements	$959,332,045	$976,483,107	$17,151,062	1.79%
Est. Consultant FTEs	8,130	8,299	169	2.08%

According to data reported by State agencies, consultant spending is estimated to increase slightly by approximately $17.2 million (1.79%) in FY 2020. This growth is primarily attributable to inflationary costs and is below the 2% spending cap. Those agencies projected to have the largest growth in FY 2020 include:

- The Department of Transportation's FY 2020 increase is the result of planned disbursements based on obligations included in DOT's 5-year capital plan (142 FTE / $24 million);
- The Department of Labor's FY 2020 increase is largely due to modernization of the Unemployment Insurance System (87 FTE / $10.4 million);

The year-to-year increase in reappropriations ($82.9 million) is primarily attributable to a multi-year spend out of appropriations within the Department of Transportation's five-year capital plan.

C

cnn.com

ERs 'flooded' with mentally ill patients with no place else to turn

By Susan Scutti, CNN
Updated 9:45 PM ET, Fri January 4, 2019

(CNN)A "huge and largely unreported problem" is happening in ERs across the nation, one expert says.

"The extent to which ERs are now flooded with patients with mental illness is unprecedented," said Dr. David R. Rubinow, chairman of the Department of Psychiatry at the School of Medicine at University of North Carolina, Chapel Hill.

And this overflow is "having a really destructive effect on health care delivery in general," he added. "There are ERs now that are repeatedly on diversion -- which means they can't see any more patients -- because there are so many patients with mental illness or behavioral problems that are populating the ER."

A 2017 government report found that the overall number of emergency department visits increased nearly 15% from 2006 to 2014, yet ER visits by patients with mental or substance use disorders increased about 44% in the same period.

This supports Rubinow's belief that ERs are a major provider of mental health care for a "very, very sizable percentage of patients" these days.

Dr. Catherine A. Marco, from her vantage point as an emergency physician professor at Wright State University in Dayton, Ohio, said, "we commonly see depression, anxiety, substance-related conditions and suicidal behavior."

Firsthand experience suggests to Dr. Mark Pearlmutter, an emergency physician in Boston, that the most common mental health problems in emergency rooms are dual diagnoses, such as "substance abuse and depression, for example." He's also seen cases combining acute psychosis, bipolar disorder, suicidality, aggression and (mal) adjustment disorders.

"We're the safety net," he said.

On the opposite coast, Dr. Renee Y. Hsia, an attending physician at Zuckerberg San Francisco General Hospital and Trauma Center, also finds that the most prevalent psychiatric diagnoses among adults in the ER are alcohol-related disorders, anxiety disorders and suicide or intentional self-harm. Based on her own research of "avoidable" ER visits, she found that two of the top three discharge diagnoses were alcohol abuse and depressive disorder.

"There are very real spillover effects from this phenomenon, which affects not only our ability to care for these patients with psychiatric needs but all patients seeking care in the ER," she said.

In addition to longer wait times for everyone, "spillover effects" include dissatisfied mental health patients and an assumption of potential violence in the ER, according to these doctors.

How one psychiatric patient sees the ER

Sharon Marshall, 43, says her multiple experiences in the ER as a psychiatric patient were "very upsetting."

"They took your phone away, and you couldn't communicate with anybody else in the world," said Marshall, who has been diagnosed with schizophrenia. Being held in the ER for "hours and hours and hours," during which time "you couldn't get your questions answered," means "you have very little control over your circumstances" and "you're at their mercy," she said. "Anybody would be upset."

She believes that her family should have requested outpatient services with her psychiatrist instead of authorizing an emergency psychiatric evaluation that was not voluntary on her part. It was not an arrest; it was a psychiatric hold, she explains.

"If you just play the game and you're quiet and don't pose any problems to them, they'll let you go," she said. "If you questioned being held or resisted ... you'd likely go to a psychiatric facility. The process was so very arbitrary."

Later, a car wreck gave Marshall greater perspective on her experiences as a mental health patient. Arriving in the ER with an arm injury "was like a dream," said Marshall, who works as a certified peer specialist for the Georgia Mental Health Consumer Network, a nonprofit advocacy and education organization. "I was definitely taken seriously when I was in there for a car accident."

David Morris, a psychologist at UT Southwestern's O'Donnell Brain Institute in Dallas, said, "the ER is not a great place if you're a mental health patient; the cardiac patients get put in front of you, and you could end up being there for a really long time." Worse still, a mental health patient could be feeling extreme distress the whole time they wait.

"It's a real ineffective and inefficient place for them to get care," Morris said. "People who need to be seen for other maladies that might be life-threatening, it slows them down as well."

Why is it happening?

A psychiatric bed shortage is one cause of overcrowded ERs

Hsia points to "a shortage of psychiatric inpatient beds" as a "key contributing factor" to overcrowded ERs across the nation.

"Between 1970 and 2006, state and county psychiatric inpatient facilities in the country cut capacity from about 400,000 beds to fewer than 50,000," Hsia said.

A 2012 Wake Forest University Health Sciences study also showed that psychiatric patients who are waiting in ERs remain there 3.2 times longer than nonpsychiatric patients. These longer stays mean that for every psychiatric patient idling in the ER, there are two other

patients not being helped, according to the study authors. Patient "boarding" -- holding of a patient in an ER bed while waiting for an inpatient mental health bed -- occurs frequently, the study indicates.

"We've also seen shortages in outpatient mental health facilities and substance abuse treatment programs," Hsia said. Many psychiatric patients who would otherwise receive long-term care are going "relatively untreated" and so end up in ERs, she says. "Patients may come to the emergency department when they cannot find help elsewhere."

One such patient is Karen Taylor, 46, diagnosed with post-traumatic stress disorder and depression. Taylor, who has had suicidal thoughts, says she visited ERs in her home state of Georgia multiple times because she "didn't want [the symptoms] to get so bad that I would actually go so far as to try to attempt suicide."

She was insured and routinely seeing a therapist, and Taylor's various trips to the ER were made out of necessity, she says, because her therapist does not offer after-hours services.

Driven by thoughts of self-harm, she had originally taken herself to a psychiatric hospital, but it would not admit her without the ER referral, she explained in a pained voice.

Emergency departments do not welcome patients like her, says Taylor, who described the ER as "a bad place for a mental health patient."

"They strip away your dignity, your clothes, everything, and the doctor comes in and treats you like dirt because you're taking up a bed," Taylor said. "I was told several times that I was just physically wasting space and I wasn't really sick like the medical patients were.

"They put me in a room where I stayed for hours on end. I've stayed in the ER for up to three days prior to going to a psychiatric hospital."

Mental disorder makes it difficult to access care

UT Southwestern's Morris co-wrote a study that examined psychiatric readmissions at one of the largest public hospitals in the nation, Parkland Hospital in Dallas, with more than 1 million patient visits annually. Nearly three-quarters of mental health patients there were readmitted for the same problem, the study found.

"Most of the patients simply were not able to follow up with their care," said Morris, explaining that the reason for this might be patient confusion about how to access follow-up care or a problem with transportation.

"Organizing the community resources that are out there, they cannot do it themselves," Morris said. "They need the help of a more structured environment. But the more structured environments that used to be available are no longer available."

Asking for help
The suicide rate in the United States has seen sharp increases in recent years. Studies have shown that the risk of suicide declines sharply when people call the national suicide hotline: **1-800-273-TALK.**

There is also a crisis text line. For crisis support in Spanish, call 1-888-628-9454.

The lines are staffed by a mix of paid professionals and unpaid volunteers trained in crisis and suicide intervention. The confidential environment, the 24-hour accessibility, a caller's ability to hang up at any time and the person-centered care have helped its success, advocates say.

The International Association for Suicide Prevention and Befrienders Worldwide also provide contact information for crisis centers around the world.

As Morris sees it, if someone had diabetes and ended up in the ER, it would be clear that something's wrong with their ability to handle their condition and care. "That's the issue," he said. "Why are these folks having to do that? Do they need additional management and additional help to maintain the continuity of care?"

Marco, a spokeswoman for the American College of Emergency Physicians, says psychiatrists, psychologists or other licensed therapists are often backlogged; this is why so many mental health patients show up in ERs.

Pearlmutter, the Boston emergency physician, agrees. The reason mental health patients end up in ERs, he says, is due to a lack of "resources within the community and the closure many years ago (20, 30 years ago) of state facilities and, frankly, the fact that mental health is underfunded." Overcrowded outpatient facilities and services mean "patients might call and not be able to be seen for two or three weeks," he added.

"And a lot of this transcends insurance," Pearlmutter said.

In certain regions, patients may call and ask to see a counselor, and the response is that they're not taking new patients, or they don't take insurance and only take cash. "And if they do take insurance, the patient's got to wait," he said. "If the patient's feeling like they're in a crisis, what options do they have? The only place to go is to the ER."

The ER may be the only place to go even for patients receiving routine care.

Assumptions in the ER

Dan Stephens, whose diagnosis is major depressive disorder with psychotic features, sees a therapist once a week and a doctor every three months. Still, on two occasions, suicidal thoughts drove him to the ER.

"I had zero wait time at the desk. They took me straight back to the mental health section" of the ER, says Stephens, a 39-year-old warehouse worker. Delays occurred as he waited for an evaluation, he says. "The first time, it took me four hours to speak to somebody, the second time about six or seven. They had given me something to calm down, so I had relaxed a little bit instead of being uptight and ready to do harm to myself."

Stephens believes that the ER was necessary given his condition. He accepts longer wait times because, as he understands it, multiple types of doctors are able to care for a patient with a broken bone, but only specialists can treat someone experiencing mental health problems.

Still, one aspect of his two ER experiences was "very humiliating," Stephens said: "The worst part is being escorted to the back by a police officer."

Leaving an ER can also be problematic for mental health patients, according to Stephens: "Usually, you leave in a cop car in handcuffs." A 2016 national survey found that handcuffs were one of the "available tools" used by security personnel in 96% of the hospitals surveyed.

Though he understands why security escorts and restraints might be necessary for some patients, he believes that these measures weren't needed in his case, and he resents their use.

"If I come in of my own volition and say 'Look, I need help,' they should just walk me back there without having to get a cop or security guard," says Stephens, who lives in a small town in Georgia. "People look at you funny, that's what happens."

When he was treated like a criminal, the whole process made him feel worse about himself, he says.

Pearlmutter suggests that doctors may automatically call in help to restrain a patient experiencing a mental health crisis. With overcrowding and more mental health patients, "there's an increase in violence in the emergency department -- absolutely," he said.

What can be done?

One solution to ERs crowded with mental health patients is to do a better job at integrating mental health into medical practice, Pearlmutter says. It's helpful that family medicine and primary care physicians are increasingly providing mental health care, he says, but "we still have a long way to go."

"Payors, by the way, play a role in this," Pearlmutter said. Health care is funded in a manner that promotes a "siloing" of mental health versus physical health. Insured patients, for example, have certain benefits provided for their physical health and separate benefits offered for mental health.

Marco said, "we need more resources, both inpatient and outpatient, for mental health and substance-related disorders. We should advocate for increased funding for treatment of these conditions."

Rubinow says he first wrote about ERs crowded with mental health patients years ago.

"At that time, it was a tsunami on the way," he said. "That tsunami has hit."

Correction: *A previous version of this story misstated the employer of Dr. Catherine Marco.*