COUNTY OF MILWAUKEE
Inter-Office Communication

Date: September 8, 2003

To: Supervisor Richard D. Nyklewicz, Jr., Chairman, Finance and Audit Committee
Supervisor T. Anthony Zielinski, Chairman, Judiciary, Safety and General Services Committee

From: Jerome J. Heer, Director of Audits

Subject: Review of Sheriff's Department's Request to Abolish and Create Selected Mental Health Care Positions at the Criminal Justice Facility and House of Correction (File No. 03-353)

Background
On May 30, 2003, the Sheriff's Department requested County Board authorization to abolish four health care (unfilled) and six mental health care (filled) positions at the Criminal Justice Facility (CJF) and House of Correction (HOC), and to create two other positions to serve the population in need of mental health services. Considerable discussion of the proposed changes ensued at the Judiciary, Safety and General Services Committee on July 10, 2003. The committee directed the Audit Department to report in detail on the projected impact of the proposed changes in treatment, and on staffing needs relating to their care prior to the implementation of the staffing changes. In addition, the Audit Department was asked to examine the mental health formulary and provide a report outlining in detail the implications of these changes in the formulary. Corporation Counsel was also directed to report on the legal impact of the proposed changes.

At the County Board meeting to discuss the Sheriff's Department requests, the County Board voted to abolish the four unfilled health care positions, and laid over until September 2003 the mental health abolishments and creations.

Steps Performed
Standard auditing procedures would have involved substantive testing of procedures and controls in place to provide assurance that they were operating as intended. However, due to the time constraints in issuing a report for the September committee cycle, our tests were limited in some cases to testimony provided by persons with first-hand knowledge of policies and procedures and how they have been implemented. To help answer the questions raised we:

- Reviewed policies and procedures relating to the screening, treatment and release of inmates with mental health disorders;
- Interviewed key players involved and affected by the proposed changes;
- Reviewed written correspondence by staff voicing concerns over the manner in which care was being provided;
- Interviewed a pharmaceutical professional concerning the use of formularies and the effects of atypical versus typical psychotropic medications;
- Researched resources relating to the administering of psychotropic medications and standards for the administering of mental health care;
- Surveyed other jail and correctional facilities to determine how their mental health programs are staffed;
- Reviewed literature from Policy Research Associates, a well known organization that is involved with addressing the needs of inmates with mental health and other health problems; and
- Reviewed financial information for purposes of calculating net cost savings.

Christiansen Consent Decree
An important court order plays a critical role in the manner in which health and mental health care is administered by the Sheriff's Department. In 1996, a lawsuit was filed by the Legal Aid Society and

the American Civil Liberties Union against Milwaukee County over conditions at the CJF. The element of that lawsuit germane to this discussion was the concern that inmates had been deprived of the constitutionally required basic necessities of life, including access to care for serious medical and mental health needs. Five years later, in 2001, the parties to the lawsuit entered into a settlement agreement that became known as the court-ordered Christiansen consent decree.

Under the terms of the consent decree, the County is required to provide certain specific key personnel to staff the health and mental health programs. For example, it requires that the Sheriff's Department provide a program administrator, medical director, physicians, psychiatrists, etc. It does not identify specific staffing levels (i.e., four nurse practitioners), but does in some instances identify the coverage required (i.e., 16 hours a day, seven days a week). According to Corporation Counsel, this general absence of specifically mandated staffing levels was deliberate, allowing Milwaukee County the right to marshal and deploy its resources in a manner that will most efficiently and effectively address medical and mental health needs of the inmates.

Court Monitor
A court monitor has been assigned the responsibility for ensuring that the provisions of the consent decree are being met by the County. The court monitor performs a wide variety of tasks during his periodic visits to the CJF and HOC. He performs site visits, reviews minutes of the Quality Improvement Committee, reviews selected records and reports from both locations and performs audits of their records, and meets with interested parties to resolve questions and concerns posed by these individuals. He has also been involved with the creation and ongoing implementation of polices and procedures relating to how health and mental health care is provided by reviewing and approving them before they are implemented.

The monitor has been kept apprised of the request by the Sheriff's Department for position changes. In a letter dated May 18, 2003, he reported that he had reviewed the proposed changes to the staffing and opined that the new plan should allow for achieving compliance with the Christiansen consent decree.

In his most recent report, following his seventh site visit on July 28–30, 2003, he has responded very favorably in general to the direction the health and mental health care program has taken since the hiring of the program administrator and medical director. His official report, dated August 11, 2003, noted that he was "extremely impressed with the extraordinary efforts" in the implementation of the policies and procedures. Much of his report addressed issues relating to how medical services were provided and where improvements could be made. His comments relating to the two general areas that follow are included in those sections.

Issues Relating to the Request to Create and Abolish Positions

The Sheriff's Department has asked the County Board for the following authorization:

Health Care:
- Abolish two unfilled Shift Supervisor positions.
- Abolish two unfilled Nurse Practitioner positions.

Mental Health Care:

- Abolish one filled Mental Health Service Manager position.
- Abolish five filled Psychiatric Social Worker positions (reduced the number of authorized and filled full time equivalent positions from 16 to 11).
- Create one Psychiatric Social Worker Supervisor position.
- Create one Mental Health Case Management Specialist (Sheriff) position for the CJF.

In addition to supervisory duties (25% of time), the psychiatric social worker supervisor also will be required to spend the remaining 75% of the position's time screening inmates for mental health illnesses, performing assessments, participating in crisis interventions, and coordinating jail mental health and substance abuse services. The case management specialist will act as liaison between the County's mental health staff and community providers to ensure continuity of care for inmates that have been released, and assist with release plans in attempts to divert inmates with severe and persistent mental illness and/or developmental disabilities from the jail. Initially the work for the case management specialist will come from the CJF population, but may extend to the HOC depending upon workload.

The stated purpose of these changes is to provide more effective mental health services and to allow for better integration of services with the community as inmates are released. To accomplish that goal, the program director intends to have the work of the psychiatric social workers (PSWs) directed by the chief psychiatrist of the CJF. Prior to this, the PSWs reported to the mental health service manager, who reported directly to the program administrator. According to the program director and the court monitor, the proposed change is the model used in other correctional mental health programs throughout the country. The court monitor's vision is to see closer integration of activities performed by the psychiatrists and PSWs, and for the mental health program as a whole to be better integrated with the medical program. According to the court monitor, such an integration is a prerequisite to the successful implementation of program policies.

The realigning of staff could have been accomplished simply by having the PSWs reporting directly to the chief psychiatrist. However, the program administrator also reported low productivity on the part of PSWs in terms of documented contacts with inmates, thus the request to abolish the five filled PSW positions and mental health service manager. Questions have been raised about the accuracy of the numbers compiled by the program administrator, and concerns have been raised that the numbers don't fully show the extent of the work actually performed by PSWs.

There appears to be merit to a related concern on the part of program administration regarding the necessity of the types of contacts that the PSWs have been performing. In particular is the question of whether or not one-on-one counseling is appropriate for inmates with Axis II mental health issues (for example, behavioral disorders), given the relative short-term basis in which they are incarcerated, particularly at the CJF.

What became apparent during our interviews was the 'turf battle' between the PSWs and the mental health service manager and program administration. According to the court monitor, such resistance to change is predictable. He was not as concerned over the number of staff providing care as the he was with the program's responsiveness to the needs of the inmates. As a result, he will be assessing the changes and will review the timeliness of care provided as part of his monitoring visits.

The overriding concern with the implementation of the proposed position changes seems to be whether or not inmates with mental health disorders, in particular inmates with Axis II disorders, will be identified and provided proper levels of treatment. However, such a discussion must first describe the types of mental health issues that are routinely encountered in correctional facilities. The most serious mental health illnesses are categorized as Axis I disorders. These inmates have severe and persistent mental illnesses, such as schizophrenia and bi-polar disorders (manic depressant), which significantly affects the thought process and prevents them from controlling their actions. Treatment includes the use of psychotropic medications to help stabilize the individual. Their treatment is addressed primarily by psychiatrists. It is estimated that about 10 – 15% of all inmates have Axis I disorders.

Inmates are more likely to have Axis II disorders. These inmates generally have personality or behavioral disorders and, as opposed to Axis I illnesses, the inmate can be held responsible for his or her actions. Symptoms can range from being severely withdrawn to very aggressive. Estimates as high as 80% of inmates have Axis II mental health disorders. Treatment for inmates with Axis II disorders who act out can include some medications, but often will involve counseling by PSWs. According to the HOC psychiatrist, PSWs do a good job of working with inmates with behavioral disorders.

Process for Identifying Inmates with Mental Health Disorders

Identifying inmates with either Axis I or Axis II mental health disorders is done at several points while in the CJF. First, each inmate receives a medical assessment upon entry to the facility. Each inmate is also subject to a 14-day evaluation if still incarcerated. We noted that only 12% of all inmates entering and leaving the jail between January 2003 and June 2003 remain at least 14 days.

The initial screening does not always identify persons with mental health disorders. Inmates under the effect of drugs or alcohol may have their illnesses masked by these agents. After the initial screening, inmates are monitored by deputies that have received 44 hours of training relating to mental health issues. At HOC, correctional officers receive 20 hours of training. They report any unusual behavior to the PSWs. PSWs can also identify inmates with mental health problems while in the prisoner area. Inmates also have the ability to refer themselves for an evaluation. Under the new model, all parties will continue to be involved in the identification of inmates with mental health disorders.

Care for Inmates With Axis II Mental Health Illnesses

In the past, PSWs provided counseling, both individual and group sessions, to those inmates displaying Axis II symptoms. This level of care is questioned in some quarters. According to the court monitor, the only data he is aware of with regards to the most effective treatment of inmates with Axis II disorders was disciplining them. He stated that group counseling can be effective when the principles of right and wrong are emphasized, though he said that Milwaukee County's documentation of group sessions was lacking.

According to the program administrator and Behavioral Health Division (BHD) administrators, counseling is most effective when provided over a sustained period of time. As previously noted, only 12% of inmates during the first half of 2003 remained in the CJF 14 days or longer. This is not to say that all such interventions are inappropriate, but that the decisions on when they need to be performed, as well as when to conduct group counseling, need to come from the psychiatrist.

Survey of Other Jurisdictions

Our research did not identify any staffing level standards for health or mental health care for a given size prison or jail population. The health and mental health programs administrator for the Sheriff's Department conducted a survey of selected jurisdictions to show how Milwaukee County's staffing for its mental health program compared with others. The results, shared with several County Board supervisors at three committees during the July 2003 cycle, generated considerable discussion. One of the concerns with the data was that none of the compared jurisdictions were located in the Midwest.

We attempted to address those concerns by contacting correctional facilities from the Midwest. Responses were received from four jurisdictions, including Hennepin County (Minneapolis, MN), Franklin County (Columbus, OH), Du Page County (Wheaton, IL) and Lake County (Waukegan, IL). The results obtained from these criminal justice facilities, shown in Exhibit 1, indicate that the mental health staff for Milwaukee County, at 6.6 to one under the proposed plan, is within the ranges reported. On the low end is Lake County, with a reported mental health staff of 3.2 per 1,000 inmates. The highest is Hennepin County, with a reported 7.9 staff per 1,000 inmates.

Transition Planning

One of the positions that the Sheriff's Department has asked to be created is a case manager to help the transition from the CJF and HOC into the community. This effort has been applauded by management of the BHD, which stated that in the past there has not been an effective focus on transitioning inmates leaving the judicial system.

Studies have shown that discharge planning is the least frequently provided mental health service within jail settings. This occurs despite of the fact that discharge planning has long been viewed as an essential part of psychiatric care in the community. Inadequate transition planning puts people with mental health and other disorders (predominantly alcohol and drug addiction) who entered the jail in a state of crisis, back in the middle of the same crisis. This practice results in compromised public safety, an increase in psychiatric symptoms, hospitalization, relapse to substance abuse, suicide, homelessness and re-arrest.

Diversion to Community Programs

Persons with mental health illnesses often are arrested for less serious, non-violent crimes. According to experts in the inmate mental health field, these types of individuals are better served by diverting them from the jail population and providing them treatment in community based programs. People who receive appropriate mental health treatment in the community usually have a better long-term prognosis and less chance of returning to jail for a similar offense. Keeping such individuals out of jail also helps to promote smoother jail operations.

Milwaukee County has two mechanisms to help divert inmates with mental illnesses from the criminal justice system. One is called Project AIM, and is designed to divert individuals prior to their being charged. The other, administered by Justice 2000, is designed to divert inmates after charging but before being adjudicated. It is planned that the mental health case management specialist will be working with the parties involved in the diversion process to help transition inmates into mental health programs in the community.

Projected Savings
According to the fiscal note on the resolution, gross savings of $324,226 were calculated for 2003. Of this amount, $182,845 is attributable to the reduction of the six filled mental health positions. The remaining $141,381 is for the funded but unfilled health care positions, which represents a reduction in the Sheriff's Department's spending authority for the rest of the year. Offsetting these savings is the cost for created positions, totaling $52,314 These amounts were predicated on taking necessary personnel actions (the six layoffs and two hires) as of August 10, 2003. These amounts will change based on the actual date that staff are laid off and new staff are hired.

We noted the savings for 2003 related to the six layoffs did not take into consideration the cost of accrued vacation and sick pay, and the potential cost of unemployment compensation for the remainder of the year. Thus, the reported savings need to be reduced by these costs, estimated at $27,533 based on a final day of work of October 11, 2003 (assuming a two week layoff notice given effective September 27th).

For subsequent years, savings of $846,230 were calculated, offset by salary costs of $136,540, with a net savings of $709,690. However, our estimates of savings vary somewhat from the fiscal note, again due primarily to the effect of any unemployment compensation payments that carry into 2004. We estimate that the maximum potential payments in 2004 is $34,623. However, it should be expected that some of these individuals will obtain employment elsewhere before receiving the maximum unemployment compensation benefits.

Summary
It is important to note that there will still be PSWs at both the CJF and HOC to perform duties that have not changed. They will still have to monitor inmate behavior, both through communication with jailers and corrections officers and through personal observation. This will continue under the new model, though the frequency of the personal observations may diminish. However, since less time will be spent on self-directed individual counseling, that may not be as great of a concern. The PSWs will still be the eyes and ears for the psychiatrists, but their individual and group counseling will be at the doctor's direction rather than their own.

With the reduced number of PSWs, the court monitor wanted to make sure that systems were in place to monitor whether inmates were able to make timely contact with PSWs or the psychiatrists. This would require a system for tracking time between receipt of a referral for care and the time the inmate is actually seen by either a PSW or psychiatrist. He also wanted a system to monitor time spent between a referral by a PSW and getting seen by a psychiatrist. Program administration has agreed to establish the requested monitoring systems. We concur with the need to implement the court monitor's request.

According to the court monitor, a system does not need intense monitoring once it can begin to monitor itself. We concur with that assessment, and with the measurement plans he has suggested. In addition, we believe another monitoring system could help measure the effect of program changes. We have heard allegations of rising frequency and severity of instances of inmates with mental health disorders that have been acting out since the new plan has been implemented. Such occurrences could indicate that inmates with mental health disorders are not getting necessary treatment because their conditions have not been identified earlier on, with the inmate improperly placed in the general population. For those with known mental health disorders, it could indicate a problem with getting timely treatment. We believe that documenting and analyzing the circumstances surrounding these crises, noting the frequency and severity of the

crises, may also be a way of measuring the effect that the staffing changes have had on the program's ability to identify and stabilize inmates with mental health disorders.

Medication-Related Issues

In addition to discussing the position requests, questions concerning the formulary medications used to treat inmates with mental health disorders were also raised at the July 10, 2003 meeting of the Judiciary, Safety and General Services Committee. The following subsections address the issues raised relating to the administering of medications to patients with mental health disorders:

Use of Formulary Medications
The use of formulary medications is a common practice used both within and outside justice system settings to help save money. The purpose is simple – to help reduce the cost of medications administered to patients by using a generic equivalent medication offering the same effect instead of a brand name medication. For example, the cost of the anti-depressant brand name medication Elavil is seven times more costly than its generic equivalent for a 30 pill prescription. With thousands of doses of various drugs being dispensed each year, the cost savings can be substantial.

The issue concerning psychotropic medications for inmates with mental health disorders is somewhat different than described above. With these medications it is not just a case of generic versus brand name. Instead, it is also a case of different classes of medications being administered. Traditional, or 'typical,' psychotropic medications were first introduced in the 1950s to help stabilize patients with mental health disorders. Like other medications, typical medications can also have brand name and generic equivalents.

Beginning in 1989, the Food and Drug Administration approved the first of five 'atypical' psychotropic medications. These medications address the same symptoms and diagnoses as typical medications, but in many cases the side effects are much less severe. In discussing these medications with the chief of the BHD pharmacy, it was noted that the difference between the two classes basically came down to quality of life issues. Atypical medications presented fewer unpleasant side effects, allowing the patient to live a more comfortable life. In some cases, the use of atypical medications also reduce the risk of developing other life-threatening medical conditions as compared to typical medications. It is also believed that with fewer and less extreme side effects, patients using atypical medications will be more likely to take the medication to keep their illness in check.

In general, physicians (both medical and psychiatric), prescribe medications based on a number of factors, such as other concurrent medical conditions, past experience with the medications, patient tolerances, etc. The issue of risk also comes into play. Physicians may lean toward prescribing medications that have less chance of causing other problems, such as heart attack. Also noteworthy is the fact that medication manufacturers invest a great deal of money trying to encourage physicians to use their products over others. For these reason, two or more physicians could make similar diagnoses but prescribe different medications. When formularies are involved, physicians are encouraged to select medications from the list of formulary medications.

Following are a series of concerns that have been raised concerning the use of psychotropic medications:

Are there formulary restrictions on the medications ordered by psychiatrists at the CJF or HOC? Psychiatrists have the ability to prescribe medications not on the formulary. The Sheriff's Department's health and mental health unit has procedures in place to address instances when psychiatrists prescribe medications not on the formulary. Psychiatrists are required to fill out a form and give it to the medical director for approval. An important key to this form is to have the psychiatrist give a written explanation as to why they are prescribing a non-formulary medication. According to the medical director, the purpose of this exercise is so psychiatrists don't simply prescribe a more expensive medication for no apparent reason. According to the medical director, he wants them to think about their choice, and if it is justified, the request is approved 99.5% of the time. However, if the request is absent or does not contain the required justification, the request is not approved.

An indicator that the formulary for psychotropic medications has not been a significantly limiting factor is the lack of substantial cost savings for psychotropic medication use. According to program administration, psychotropic medications account for 70% of medication costs, but none of the savings generated to date. Several factors could explain this, such as increased overall use of psychotropic medications, or psychotropic drug costs have substantially risen since last year.

Are all CJF and HOC psychiatrists required to follow the requirement to complete a form in order to obtain a formulary exception? The psychiatrist assigned to the HOC has voiced concerns that the chief psychiatrist assigned to the CJF did not have to follow the prescribed procedures for deviating from the formulary medication list. That is, he didn't have to fill out the required form or otherwise get approval from the medical director for non-formulary prescriptions. The medical director verified this concern, stating that his reasoning for allowing this deviation was that the chief psychiatrist had demonstrated a willingness to consider formulary medications first before making non-formulary prescriptions.

If an inmate is already being prescribed medications before coming into the criminal justice system, is that prescription automatically changed to a medication contained in the formulary before the inmate is seen by a psychiatrist? The first order of business is to obtain as much medical information on the inmate's medical history as possible before making any changes. If a prescription can be verified, inmates are allowed to keep taking prescriptions that they bring into the criminal justice system. Once those run out, then a medical evaluation is performed to determine the inmate's continued needs. If the evaluation cannot be performed before the prescription runs out, the original prescription is extended for 14 days.

However, there are certain exceptions that will result in automatic prescription changes. One is relating to prescriptions for controlled substances. This includes a class of sedatives called benzodiazepines (such as Valium), which are generally changed to librium with the intent to taper the dosage to avoid possible withdrawal.

Another example is a class of anti-depressants known as SSRI, such as Prozak. The program administrator noted that it was too costly to maintain a supply of the many types of brand name SSRIs for which inmates have prescriptions, and the use of a generic equivalent is much less costly and just as effective.

One other exception is the change of prescriptions for the brand name Depakote to the generic valproic acid, again for cost saving reasons. Depakote is a medication used to treat persons with bi-polar (manic depressive) disorders. There are differences of opinion concerning whether or not

the generic equivalent works as well as the brand name in this case. Depakote is released into the system more slowly and has less gastric problems, though studies have shown that the generic equivalent medication has fewer gastric problems when taken with food. Medications are generally administered around meal time at the CJF and HOC.

It should be noted that according to program administration, these changes are not made if there is a documented reason for continuing the original medication.

It appears that the above exceptions were made without input of the psychiatrists who are closely involved with implementing those policies. There also appears to be a lack of communication over what the specific policy is concerning how prescriptions held by incoming inmates are to be handled.

Are psychiatrists limited to prescribing inmates no more than one psychotropic medication? Psychiatrists both within and outside criminal justice settings will at times prescribe more than one psychotropic medication to an individual to help stabilize a patient. As a result, inmates often come into the CJF on multiple medications.

We found no written policy that precludes psychiatrists from prescribing more than one psychotropic medication. However, the chief psychiatrist at the CJF believes that it is best to prescribe the least amount of medication to get the job done. This philosophy is consistent with generally accepted practices in the medical profession. For example, the Texas Algorhythms, a decision-making model for indicating how to increase, decrease and switch medications followed by many institutions, generally uses only one atypical medication and then it uses typical medications. However, this belief does not preclude psychiatrists from using their own judgment and prescribing more than one medication if that is in fact what an inmate requires.

Program management noted that incoming inmates will at times have obtained prescriptions from more than one psychiatrist without the knowledge of the others. Thus, the inmate may be using several medications, without a clear goal of what the different medications are designed to achieve, and counterproductive to the inmate's mental health. When this is the case, the CJF or HOC physician must perform an evaluation to determine the best medical course of action, which often will result in taking the inmate off one or more of the medications, or tapering them off of benzodiazepines.

Does it take 4-10 days to obtain prescribed medications? Review of current procedures indicate that it should take no more than two days to obtain medications. A supply of all formulary medications is maintained in the CJF and HOC. If these run out, or if a non-formulary medication is requested, the medication can be received the next day via Federal Express, depending upon what time of day the order is made. If a medication is needed immediately, procedures are in place to obtain the medication from a local 24-hour pharmacy. However, purchase records indicate this route is rarely used. It is unknown if the reason for its limited use is due to poor communication of its availability to the prescribing physicians.

Comments By Court Monitor

The court monitor's report dated August 11, 2003, also discussed the issue of psychotropic medications being changed without an inmate first being seen by a psychiatrist. He indicated that an agreement was reached with the medical director to have him modify current procedures so that

proposed changes to inmate prescriptions are first discussed with the inmate by a nurse, and if the inmate identifies a problem with the change, the matter will be discussed with a physician. He also noted the environment created by the for-profit pharmaceutical companies is a major factor in how medications are prescribed. He noted that

> "medical doctors as well as psychiatrists have been destructively influenced by the pharmaceutical industry, and thus prescribing patterns have no relationship to cost effectiveness, either in the free world or in corrections. Thus an effort to create a more cost-effective approach by the Jail certainly meets with my approval. For those who would spread the word the sky is falling with regard to the mental health program, I would indicate there is no data I have seen that would in any way support such a conclusion."

Summary
The psychiatrists assigned to the CJF and HOC normally work for the BHD, which has an open formulary for psychotropic medications. Thus, whatever the psychiatrists prescribe is filled without question or the need to justify the request. However, efforts are being made by the Sheriff's Department to control medical costs which have been spiraling out of control in recent years, including the establishment of formulary medications. By assigning those same psychiatrists to work in a more restrictive environment at the CJF and HOC, a certain level of resistance can be expected. To help ensure all doctors are aware of the policies and procedures in use, we recommend that the Sheriff's Department improve the communication process between health and mental health care administration and physicians and psychiatrists so that all parties are familiar with policies and procedures and how they are to be implemented.

We will be present at your September committee meetings to discuss this report further.

Jerome J. Heer, Director of Audits

JJH/cah

cc: David A. Clarke, Jr., Milwaukee County Sheriff
Milwaukee County Board of Supervisors
Scott Walker, Milwaukee County Executive
Linda J. Seemeyer, Director, Department of Administrative Services
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Exhibit 1

Survey by Sheriff's Department — **Audit Survey**

Mental Health Staffing in Various Jurisdictions

Title	**Orange County Florida** (Orlando)	**Broward County Florida** (Ft. Lauderdale)	**Dekalb County Georgia**	**Allegheny County Pennsylvania** (Pittsburgh)	**Milwaukee County Wisconsin** (Jail & HOC) Current Staffing	**Milwaukee County Wisconsin** (Jail & HOC) Resolution Staffing	**Hennipin County** (Minnesota)	**Franklin County Ohio** (Columbus)	**DuPage County Illinois** (Wheaton)	**Lake County Illinois** (Waukegan)
Psychiatrist	1	2	1.7	1.3	1.5	1.5	.2	1.2	.5	1
Psychologist	1	1	0	0	0	0	1.2		2.5	.1
Administrator	1	1	1	1	1	0				
ARNP	1	1	0	0	0	0				
MH Specialist (MA Psychology)	8	1.2	0	0	0	0				
PSW**		1	5.6	3	16	11.75	1.3	7	.5	.6
M.H. Liaison								4		
Nursing Positions	2	5.6	11.0	7	2	2	1		1.85	
Case Manager	0	0	0	0	1	2				
Psych. Aides	0	0	0	3	0	0				
Total	14	12.8	19.3	15.3	21.5	17.25	3.7	12.20	5.35	1.70
Ave. Daily Pop	3800	4500	3000	2400	2600*	2600*	470	2,532	750	526
Total Staff/1000 Inmates	**3.7**	**2.8**	**6.4**	**6.4**	**8.3**	**6.6**	**7.9**	**4.8**	**7.1**	**3.2**

* Data does not include the Community Corrections Center (CCC) population because no services are provided to these inmates. Adding CCC population yields a ratio of 5.5 mental health workers/1000 inmates.

** Total includes 75% clinical duties of the PSW Coordinator.

Note: Broward County has a Mental Health Court and an active diversion program to provide persons with severe and persistent mental illness with non-jail treatment for minor crimes.