COOK COUNTY HEALTH

2024 COOK COUNTY BEHAVIORAL HEALTH NEEDS ASSESSMENT REPORT

Acknowledgements

This 2024 Cook County Behavioral Health Needs Assessment Report was completed by JSI on behalf of the Cook County Health Office of Behavioral Health (OBH).[1] The report is a culmination of a collaborative process that sought to meaningfully engage and gather critical input from Cook County residents, community-based organizations, clinical service providers, public health officials, Cook County Health clinical and administrative leadership, and other key partners.

Throughout this project, more than 400 people who live or work in Cook County were engaged in this effort. These individuals participated in meetings, interviews, focus groups, Partners In Action (PIA) committees, and survey efforts. These voices are honored and incorporated in this report's findings. We are especially grateful to the several dozen Cook County community members with lived experience who participated in this project. Without you, the stories, struggles, and courage of Cook County residents would not be visible, and the breadth and impact of this needs assessment would not be possible. Thank you for being an advocate for so many.

Executive Summary

The 2024 Cook County Behavioral Health Needs Assessment (BHNA) was conducted by JSI Research and Training Institute, Inc. on behalf of the Cook County Health Office of Behavioral Health (OBH). This report represents a comprehensive effort to analyze and understand behavioral health needs across Cook County, utilizing both existing data and new insights gathered from various community stakeholders. Over 400 residents, service providers, public health officials, and other key partners contributed through interviews, focus groups, surveys, and meetings. Their voices and experiences are embedded in the findings and recommendations presented in this report.

Background and Introduction

This BHNA was funded by the federal American Rescue Plan Act (ARPA), through an award provided to Cook County Health by the U.S. Department of Treasury (Award No. ALN 21.027). The primary goal of the assessment is to ensure that the efforts of OBH and its partners are focused on building an equitable, integrated and coordinated behavioral health system that is both community-informed and data-driven. The BHNA is a cornerstone of OBH's Stronger Together initiative, which seeks to address regional behavioral health inequities by improving system alignment, enhancing care quality, and expanding access to prevention, treatment, crisis care, and long-term recovery services.

Approach and Methods

The methodology for the BHNA combined both quantitative and qualitative data collection to offer a detailed view of the behavioral health landscape in Cook County. Quantitative data was sourced from federal, state, and local health databases, along with surveys of behavioral health providers. Qualitative insights were drawn from focus groups, key informant interviews, and community meetings with stakeholders that included individuals with lived behavioral health experience, policy makers, providers, advocacy organizations, and public health officials. This combined approach revealed significant trends and service gaps in the County's behavioral health system, forming the basis for the recommendations and action steps outlined in the report.

Community Need and Behavioral Health Status Data

The report provides a comprehensive analysis of quantitative data that elucidates the social factors contributing to Cook County's behavioral health challenges. This data helps clarify the impact of behavioral health issues on the County and highlights the communities most affected by the crisis. OBH aims for this data to be a valuable resource for its partners across Cook County in their ongoing efforts to address behavioral health needs.

Key Findings

A. Priorities from Existing Community Health Needs Assessments (CHNAs) The report highlights priorities identified in 14 recent CHNAs conducted by various agencies in Cook County, providing a clear view of the most critical behavioral health issues facing the region. Priorities included enhancing access to behavioral health services, addressing social determinants of health, improving behavioral health awareness and education, decreasing stigma, implementing violence prevention, strengthening and expanding substance use disorder resources, promoting system integration, and increasing culturally and linguistically responsive care.

B. Behavioral Health System Strengths Cook County boasts a robust and diverse network of behavioral health service providers, supported by a strong infrastructure of community health centers and hospitals, including Cook County Health (CCH). The County and the City of Chicago are known for progressive approaches to behavioral health and a commitment to health equity and social justice. Federal, state, and local partnerships further strengthen the region's behavioral health system.

C. Behavioral Health System Gaps, Challenges, and Needs The report identifies significant gaps in behavioral health services across the county, using OBH's Behavioral Health Framework. These gaps include housing instability, public safety concerns, behavioral health stigma, economic insecurity, and challenges related to insurance coverage and access to care. Additional needs highlighted in the report include expanded access to crisis services, prevention and early intervention, and culturally responsive care.

Recommendations and Strategic Opportunities

The report outlines key recommendations for addressing the identified gaps, challenges, and opportunities, aligned with OBH's Behavioral Health System Framework. These include:

Priority Area 1: Prevention and Early Intervention for Children and Adults

- Implement county-wide campaigns to reduce behavioral health stigma.
- Invest in prevention and early intervention programs for those experiencing the greatest challenges and disparities.
- Support the development of harm-reduction programs focused on lowering risks and supporting long-term recovery.

Priority Area 2: Access to Crisis, Assessment, Treatment, and Care

- Expand and enhance crisis support and early intervention efforts.
- Strengthen the integration of behavioral health services in clinical and community settings.
- Support programs that enhance screening, assessment, and referrals related to health-related social needs.

Priority Area 3: Care, Treatment, Support, Recovery, and Sustainability

- Expand access to behavioral health services, particularly in underserved communities.
- Address workforce shortages to ensure sustainable access to high-quality, person-centered care.

Priority 4: Health-Related Social Needs

- Continue efforts to address the social determinants of health, such as housing, employment, and community safety, for individuals with behavioral health conditions.

Priority 5: Cross-Cutting Structures

- Focus on workforce development and retention strategies.
- Promote value-based payment models and enhance data analysis capabilities to support informed decision-making and system transparency.
- Expand engagement and the effective application of Cook County's health information exchange (HIE) resources.

Contents

Glossary of Terms

Access to Care: the ability of individuals to obtain the necessary health services they need. This includes receiving care that is affordable, high quality, and culturally humble.[2]

Affordable Housing: housing costs that do not exceed 30% of a household's gross income, including utilities. The goal of affordable housing is to ensure that individuals can find safe, stable living conditions without being burdened by excessive housing costs that would otherwise limit their ability to cover other essential needs, such as food, healthcare, and education.[3]

Behavioral Health: emotional, psychological, and social aspects of health or well-being, including mental health and substance use.[4]

Community-Based Organization (CBO): non-profit organizations that provide services to address the needs of their community, including public health, social services, and healthcare.[5]

Community Engagement: the process by which individuals or organizations actively collaborate with members of a community to address issues, solve problems, and achieve common goals. This is done by ensuring that community members have a voice and that their perspectives are considered in shaping initiatives and policies that affect their lives.

Co-Occurring Disorders: a combination of two or more substance use disorders and mental health disorders as identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR).[6]

CountyCare: a provider-led, public Medicaid managed care health plan in Illinois, owned and operated by Cook County Health. CountyCare is a choice for all Cook County residents enrolled through HealthChoice Illinois which is the statewide Medicaid managed care program.[7]

Crisis Care: care that addresses critical needs during emergencies such as behavioral health or psychiatric crisis.[8]

Cultural Competency: ability to understand and respect values, attitudes, and beliefs, that differ across communities and cultures to respond appropriately to these differences when providing care or designing programs.[9]

Cultural Humility: a lifelong process of self-reflection where individuals assess their knowledge, biases, assumptions, and limitations.[10]

Downstream Factors: issues that affect people when they become ill, such as access to health care, behavioral risk factors, and living conditions. Downstream interventions such as counseling and medication focus on changing the effects of the causes identified by upstream interventions, which focus on the social factors that contribute to health and prevent illness.[11]

Evidence-Based Practices: skills, techniques, and strategies that have been proven to be successful through experimental research.[12]

Federal Poverty Level (FPL): The Federal Poverty Level (FPL) is a set income threshold determined annually by the U.S. Department of Health and Human Services, used to assess eligibility for various government assistance programs. It varies based on household size and location, helping determine access to programs like Medicaid and Affordable Care Act (ACA) subsidies.[13]

Fee for Service (FFS): a payment model where clients or patients are charged separately for each individual service or procedure they receive. The provider is paid a specific fee for each service performed, rather than receiving a lump sum payment.[14]

Harm Reduction: an evidence-based approach that aims to meet people where they are to minimize the negative impacts associated with substance use, mental health, and medical conditions.[15,16]

Health Equity: work to identify, dismantle, and reimagine systems of power ingrained with racism, discrimination, neglect, disrespect, and dehumanization. This work contributes to the evolution of society in offering all individuals opportunities, security, power, resources, and information to live their full potential for health and well-being.[17]

Health Information Exchange (HIE): refers to sharing of information through electronic platforms. HIEs allow health care professionals and patients to access a patient's medical information among different healthcare organizations and providers.[18]

Health Literacy: the ability to which individuals understand, find, and use information and services to inform health-related decisions and actions for themselves and others. Limited health literacy can contribute to health inequities by hindering access to healthcare and understanding of health information.[19]

Historical Trauma: the collection of emotional and psychological pain over an individual's lifetime and across generations.[20]

Housing First: an approach that prioritizes providing permanent housing to people experiencing homelessness.[21]

Implicit Bias: the attitude or internalized stereotypes that unconsciously affect an individual's perceptions, actions, and decisions.[22]

Inpatient Care: care provided in a hospital or residential medical facility. The patient is admitted and spends one or more nights at the facility to ensure around-the-clock care.

Interpersonal Racism: a person's conscious or subconscious bias that influences their interactions and perceptions of other people.[23]

Key Informant Interview: a qualitative research method used to gather in-depth insights from individuals who have specialized knowledge or expertise about a specific issue, topic, or community.

Linkage to Care: the process of connecting individuals with the appropriate healthcare services and resources they need for effective management and treatment of their health conditions. The goal is to ensure continuity of care and improve health outcomes by bridging gaps between individuals and the healthcare system.

Lived Experience: knowledge based on personal perspective, identities, and history beyond professional or educational experience. Lived experience gives people insights that can inform and improve systems, research, policies, practices, and programs.

Living Room Model: an alternative to emergency rooms that are designed to divert crisis and break the cycle of psychiatric hospitalization. These are spaces where individuals having suicidal or homicidal thoughts, panic attacks, severe depression, or struggling with substance use can easily find help. Living rooms are aimed to give individuals in a crisis a safe, comfortable place to go.[24]

Managed Care: prepaid health plans such as health maintenance organizations (HMOs) that are designed to manage cost, utilization, and quality of care. It involves a network of providers that work together to provide comprehensive care at a lower cost than fee-for-service. Managed care also includes preferred provider organizations (PPOs).[25]

Mandated Care: healthcare services or treatments that are required by a court order or legal mandate. This often occurs in instances where an individual is involved in a legal case or judicial process and the court determines that specific medical or psychological care is necessary for their well-being or to meet legal obligations.[26]

Medication for Opioid Use Disorder (MOUD): medications used to help individuals with opioid use disorder. MOUDs can help reduce or eliminate withdrawal symptoms, cravings, and block the effects of illicit opioids.[27]

Mental Health: includes an individual's emotional, psychological, and social well-being. Mental health can affect how an individual thinks, feels, acts, and can determine how someone handles stress, relates to others, and makes choices. [28]

MySidewalk: an online data visualization platform. The platform contains large "live" datasets containing thousands of variables from sources such as the United States Census, the Environmental Protection Agency, the Centers for Disease Control and Prevention, and the United States Department of Housing and Urban Development, among others.

Naloxone: an opioid antagonist that rapidly reverses an opioid overdose by attaching to opioid receptors and reversing and blocking the opioid's effects.[29]

Needs Assessment: a process and resulting resource used to understand the qualities of a given community including its strengths and opportunities for growth. Needs Assessments often use both quantitative and qualitative data to gain a representative depiction of a community.

Opioid Use Disorder (OUD): the chronic use of opioids (a class of drugs that include fentanyl and pain relievers) that result in an individual becoming dependent on them.[30]

Outpatient Care: also called ambulatory or day patient care, does not require hospitalization or an overnight stay. This includes visits to a hospital, clinic, or similar facility for diagnosis, treatment, or a procedure, where the patient is free to leave upon completion of service.[31]

Partners in Action (PIA) Committees: groups of subject matter experts comprised of 1) staff providing mental health and substance use services from key behavioral health organizations throughout Cook County and 2) individuals living with a mental health and/or substance use diagnosis, have lived experience accessing mental health services in Cook County, or are loved ones of individuals living with a mental health and/or substance use diagnosis.

Patient Advocacy: the act of helping patients navigate the healthcare system to protect patients' rights, needs, and overall well-being with the goal of receiving the best treatment and services possible.

Peer Support: a form of support from people who have been through similar experiences provide guidance. These experiences usually include providing support to individuals who have been diagnosed with a mental health disorder or a substance use disorder.[32]

Person-Centered Care: iintegrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values, and preferences. Person-centered care empowers individuals and providers to make effective care plans together.[33,34]

Primary Prevention: measures or strategies to prevent a disease or illness from occurring.

People Who Use Drugs (PWUD): individuals who use drugs for any purpose whether that is for recreational, medicinal, or other uses.[35]

Quantitative Data: can be counted, measured, or given a numerical value. Quantitative data can include demographic information such as race, ethnicity, age, income, employment, marriage status, etc.

Qualitative Data: typically collected through focus groups, interviews, and conversations. These data are not numerical. Qualitative data collection methods allow community members to share their experiences and deep insights that are more difficult to capture quantitatively/numerically.

Quality of Care: how well healthcare services meet the needs of patients to improve health outcomes and well-being.[36]

Recovery: a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. This process may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other methods.[37]

Recovery Housing: an intervention that is specifically designed to address a person who uses drug's need for a safe and healthy living environment, while supplying requisite recovery and peer support.[38]

Screening: observations and tests used to identify health concerns, substance use disorders, and other potential health issues early in their development.

Secondary Prevention: strategies aimed at early detection and intervention. The goal is to catch a health issue at an early stage in order to reduce the impact of adverse health outcomes.[39]

Social and Structural Determinants of Health (SDOHs)/Health Related Social Needs: the non-medical factors that influence health outcomes, including the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. They include economic and social policies, political systems, and social norms.

Stakeholder: behavioral health providers, community-based leaders, patients, community members, and others that are part of the Cook County Behavioral Health System that are involved and invested in the design, implementation, and results of the Cook County Health Behavioral Health Needs Assessment.

Stigma: the negative attitudes, beliefs, and behaviors that lead to the marginalization or discrimination of individuals or groups based on certain attributes, such as health conditions, behaviors, or identities. Stigma can be associated with various health issues, including mental illness, substance abuse, and infectious diseases. Stigma also perpetuates barriers to seeking care and adhering to treatment.[40]

Street Outreach: a service design used to meet the immediate needs of people, such as those experiencing homelessness. This approach aims to meet people where they are at and not expect individuals to actively seek care, such as at a brick-and-mortar medical clinic.[41]

Substance Use: the use of illegal drugs or prescription or over-the-counter drugs or alcohol for purposes other than those for which are meant to be used, or in excessive amounts. Substance use may lead to social, physical, emotional, and job-related problems.[42]

Substance Use Disorder (SUD): occurs when the use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[43]

System Integration: the process of connecting and coordinating different systems into a cohesive unit to improve efficiencies. For example, creating systems that share data across platforms to ensure data is accurate and timely.

Systemic Racism: includes the multitude of ways that racial discrimination is deeply embedded in systems and structures such as laws, written or unwritten policies, and widespread, deeply rooted, established practices, beliefs, and attitudes that perpetuate widespread unfair treatment of people of color.[44]

Telehealth: the use of digital communication technologies to provide and manage healthcare services remotely.

Tertiary Prevention: strategies aimed at managing and reducing the impact of an existing health issue.[45]

Trauma: an emotional response resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.[46]

Trauma Informed, Trauma-Responsive, or Trauma-Competent Care: an approach to providing support and services that recognizes and responds to the widespread impact of trauma on individuals. It involves understanding, recognizing, and addressing the effects of trauma in all aspects of service delivery.[46]

Treatment Plan: a structured, personalized strategy developed to address an individual's specific health needs or conditions. It outlines the goals, methods, and steps for managing and treating a health issue.

Upstream Factors: conditions that can affect health outcomes outside of the healthcare system and beyond individual characteristics. This is also known as social determinants of health (SDOH). Upstream factors can include living conditions such as access to healthy food, built environment, and laws and regulations.[47]

Value-Based Payment (VBP): a healthcare payment model that focuses on compensating providers based on the quality and efficiency of care they deliver, rather than the volume of services provided. The goal of value-based payment is to improve patient outcomes, enhance the quality of care, and reduce overall healthcare costs by aligning financial incentives with the value of care.[48]

Wrap-Around Services: a holistic approach to providing care. Wrap-around services are designed to address a wide range of needs that can include addressing social determinants of health and/or medical needs.

Youth: individuals who are in the transitional stage between childhood and adulthood. This period typically encompasses the ages from early adolescence to young adulthood.[49]

Background, Introduction, and Report Considerations

Background

The Cook County Behavioral Health Needs Assessment (BHNA) was funded by the federal American Rescue Plan Act (ARPA), and awarded to the Office of Behavioral Health (OBH) at Cook County Health by the U.S. Department of Treasury. This assessment is a critical component of their mission to establish a more equitable behavioral health system in Cook County. OBH advocates for a system that provides equitable services and support to all residents, irrespective of their ability to pay, to promote mental well-being, facilitate prevention and early intervention, and promote effective treatment, support, and recovery for mental health and substance use conditions. While resource allocation and investment are critical needs, collaboration across the County is essential to strengthening efforts.

Introduction

The purpose of the Cook County BHNA is to ensure that behavioral health strategic efforts aimed at building and sustaining an equitable, integrated, and well-coordinated behavioral health system across the County are community-informed and data-driven. This BHNA report provides a roadmap for initiatives, detailing the development of a comprehensive, accessible, and equitable behavioral health care system strategy capable of delivering high-quality, patient-centered services. Specifically, this report elucidates community needs and barriers to care, service capacity and gaps, and workforce shortages, as well as strengths and weaknesses within the system.

The Cook County BHNA engaged a diverse range of stakeholders, including residents with lived experience, community-based organizations, clinical service providers, public health officials, Cook County Health (CCH) clinical and administrative leadership, first responders (e.g., police, fire department, and ambulance officials), faith-based leaders, advocacy organizations, and various other key stakeholders.

The findings of the Cook County BHNA will guide OBH's commitment to promoting health and well-being, addressing health disparities, and achieving health equity, particularly in the realm of behavioral health. Health equity - the attainment of the highest level of health for all people - necessitates focused and ongoing efforts to address disparities and socioeconomic barriers, including current and historical discrimination and injustices that underpin existing inequities. This assessment endeavored to thoroughly understand the behavioral health needs of communities across the county, as well as individuals living and working in Cook County, especially those who are marginalized, face disparities in health-related outcomes, and are historically excluded from such assessments, including individuals with mental health and substance use diagnoses and their families.

Report Considerations

This report commences with a comprehensive discussion of the principles and framework that guided the Cook County BHNA process to ensure the implementation of a robust, equitable, and aligned system of behavioral health care. These principles highlight the importance of community and consumer engagement in assessing need, developing strategic plans, and implementing programs. They also emphasize the necessity of power-sharing, particularly with those who are most impacted, (i.e., "Nothing about us, without us!"), when assessing need, developing strategic priorities, and implementing strategies. Furthermore, the principles underscore a focus on equity, particularly health and racial equity, and the need to address existing disparities in access and health outcomes, including the social, environmental, and economic inequities that have contributed to these disparities.

Additionally, this report discusses OBH's Behavioral Health Care Continuum Framework, which will structure OBH's priorities and initiatives. This framework emphasizes a holistic approach to care, incorporating innovative and strategic initiatives that address health-related social factors, as well as prevention, early intervention, crisis support, assessment, treatment, and recovery services. It provides a structure for understanding and assessing the strength of Cook County's behavioral health system, implementing strategies that support aligning resources, maximizing access to and quality of care, and evaluating the impact of these efforts.

This report documents the approach and methods to conduct the Cook County BHNA, reviews quantitative data and other information gathered throughout the process, provides a detailed narrative of key findings, and presents emerging opportunities and recommendations.

Conducting a BHNA presents an opportunity to identify and elevate the behavioral health strengths and needs of communities, individual residents, nonprofit organizations, and direct service providers. This assessment was intentionally designed to give voice to those most impacted by the policies and programs developed from the data collected.

While various methods to ensure representation across the County, limitations exist due to data constraints. Some presented data may reflect a single voice representing a broader community. For example, during a Spanish-speaking focus group, a participant articulated the challenges faced in seeking domestic violence support as an undocumented Cook County resident. This individual's perspective aligns with local and national reports indicating a critical need among undocumented community members.

Special care has been taken to ensure that quotes and data included in this report align with quantitative data, Community Health Needs Assessment (CHNA) findings, or statements from other stakeholders. However, it is important to note that some reflect individual opinions and are not intended to be interpreted beyond the statement.

Many of the challenges identified in this report stem from upstream or systemic factors that fall outside the scope of the traditional behavioral health system. Therefore, the BHNA can also be used to support efforts that address these upstream factors, which may, in turn, mitigate many of the highlighted challenges.

Guiding Principles and Frameworks

Guiding Principles

Individualized Pathways to Support, Treatment, and Sustainability

Individuals living with mental health and substance use diagnosis, and those without a diagnosis who may be struggling with their mental wellness, have diverse pathways for identifying their support and treatment needs. The BHNA revealed that access resources and decisions to seek treatment vary widely. Consequently, the BHNA focused on both recovery frameworks and the pathways through which individuals seek support and treatment (e.g., prevention, harm reduction, stabilization, contingency[59] management, crisis response models, medications, trauma-informed therapeutic models).

The BHNA data also emphasizes that the ability to sustain, adapt, and grow services and supports based on individual and community needs is critical for long-term health. This includes ensuring ongoing system funding, accessible and adaptable, insurance coverage for existing and new treatment and recovery options, meeting health-related social needs, and advancing policies that reduce stigma and coordinate care for those in need.

Further details and examples of these individualized pathways can be found in the findings section of this report, which presents key themes and narratives from focus groups and interviews with service providers and individuals with lived experience.

Community Engagement, Power-Sharing, and Capacity Building

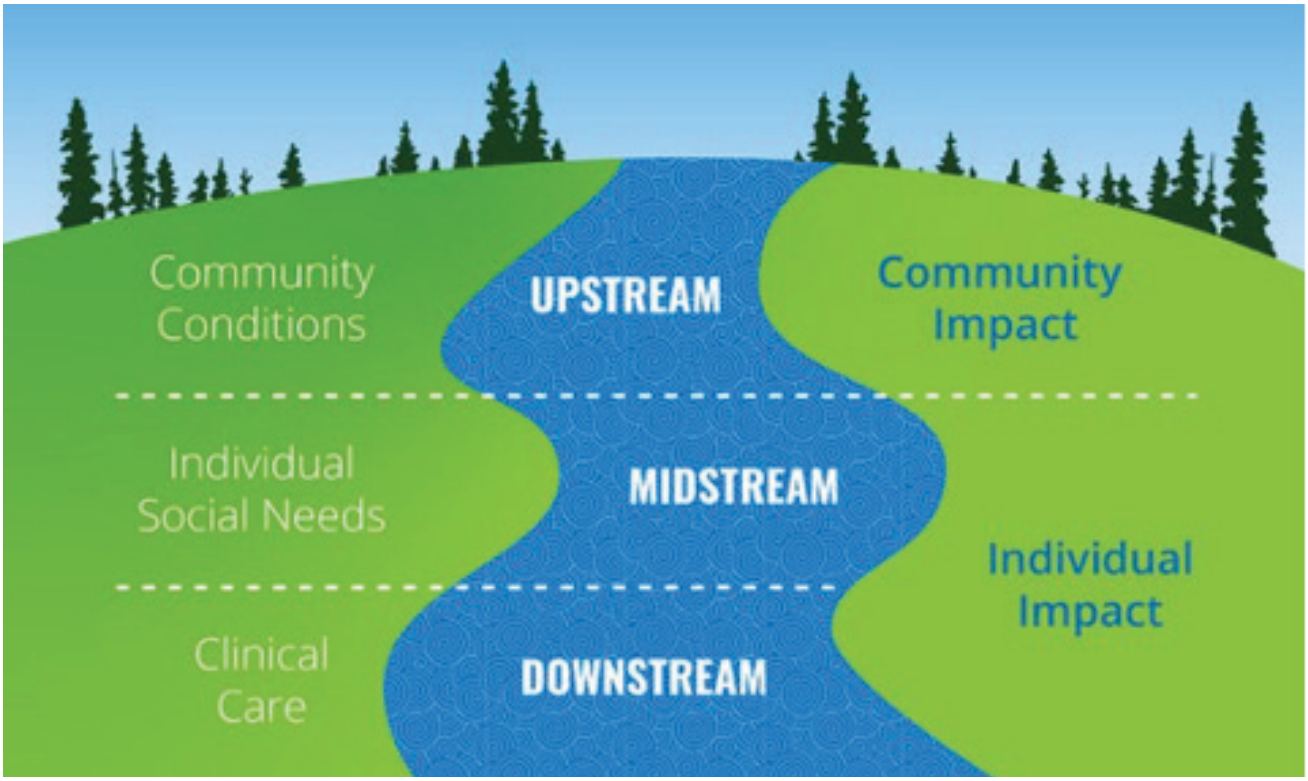
To ensure an inclusive, unbiased, and equitable process, the assessment prioritized individuals with lived experience, applied equitable data practices, utilized a strengths-based approach, and aimed to build the capacity of Cook County residents and workers. These efforts promoted engagement, reduced bias, and maximized benefits for participation in the process.

- **Centering Lived Experiences:** The BHNA process focused on community voices through the establishment of two Power In Action (PIA) committees: 1) Cook County community members with lived experience navigating the behavioral health system; 2) staff members of behavioral health organizations serving Cook County. To accommodate community members' capacities and experiences and to reduce participant burden, multiple avenues were provided for them to share their voices (e.g., surveys, virtual and in-person focus groups, and individual interviews).
- **Strengths-Based Approach:** While needs assessments typically identify gaps and challenges, acknowledging the community's strengths and assets is equally important. Participants in focus groups, survey respondents, and key informant interview participants were specifically asked, "What is going well/are the current assets or strengths of Cook County when it comes to mental health and substance use services?" Emphasizing only deficits can be disempowering and overlooks communities' sources of strength and resilience. Therefore, this report highlights the existing hard work and resilience in Cook County.
- **Community Capacity Building:** To mitigate the extractive nature of needs assessments, the assessment intentionally shifted power and created opportunities for community involvement in data collection and analysis. PIA committee members informed the recruitment processes and data analysis procedures to ensure community members' inclusion in the BHNA. The assessment process also supported understanding the needs assessment processes to ensure PIA members felt prepared to fully participate. Additionally, findings were presented to PIA committee members in accessible formats, and terms were clarified as necessary.

Upstream and Downstream Factors

Needs assessments illustrate the challenges that communities face, but these challenges often represent "downstream" factors resulting from unaddressed "upstream" systematic and structural inequities. For example, addressing the behavioral health needs of an individual might involve ensuring access to counseling and medication while upstream strategies would focus on preventing or reducing systemic and structural factors that may be the cause or exacerbate the development of a behavioral health issue (e.g., economic insecurity and unsafe, expensive housing). Upstream and midstream approaches focus on factors in place that can influence an individual's ability to lead a healthy life–often referred to as the social determinants or drivers of health (SDOH). These concepts are illustrated in Figures 1 and 2 below.[51]

Figure 1: Upstream/Downstream Analogy

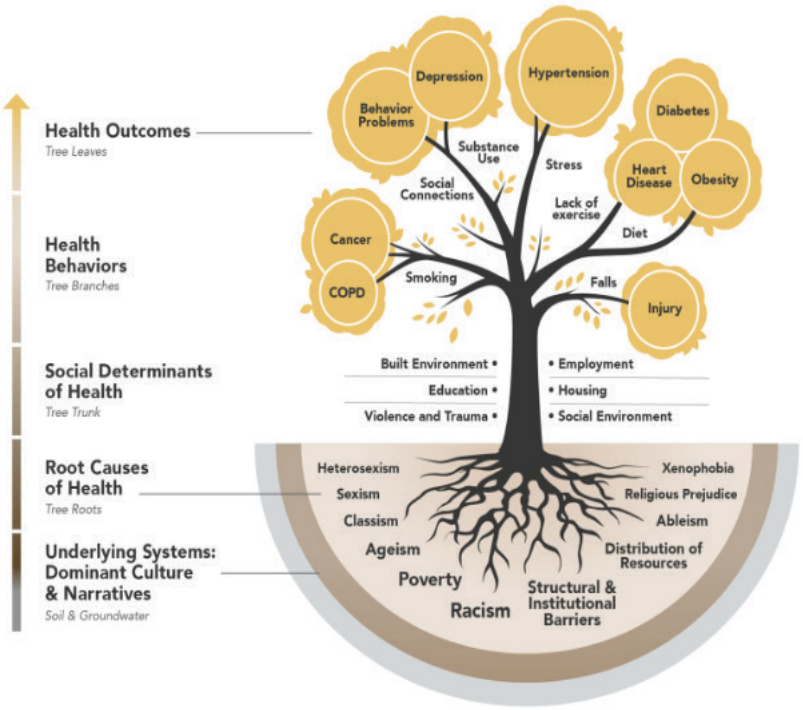


Most non-profit and service providers address downstream consequences; however, there is a need to focus on midstream and upstream factors. This needs assessment underscored the need for prevention efforts. By focusing on prevention strategies and tailoring programs to youth, Cook County can tackle the upstream factors affecting behavioral health. Without incorporating upstream approaches, root causes cannot be fully addressed.

Social Needs and the Root Causes of Inequities and Illness

Midstream and upstream factors include SDOH, defined as *"...the environments in which people are born, grow, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks."* (Healthy People 2023). Many BHNA participants cited interpersonal and systemic racism as key forces impacting Cook County residents' ability to access health-related services and healthy living. Participants noted that racism influences the geographical distribution of services throughout the County, as how they are provided, and their overall impact.

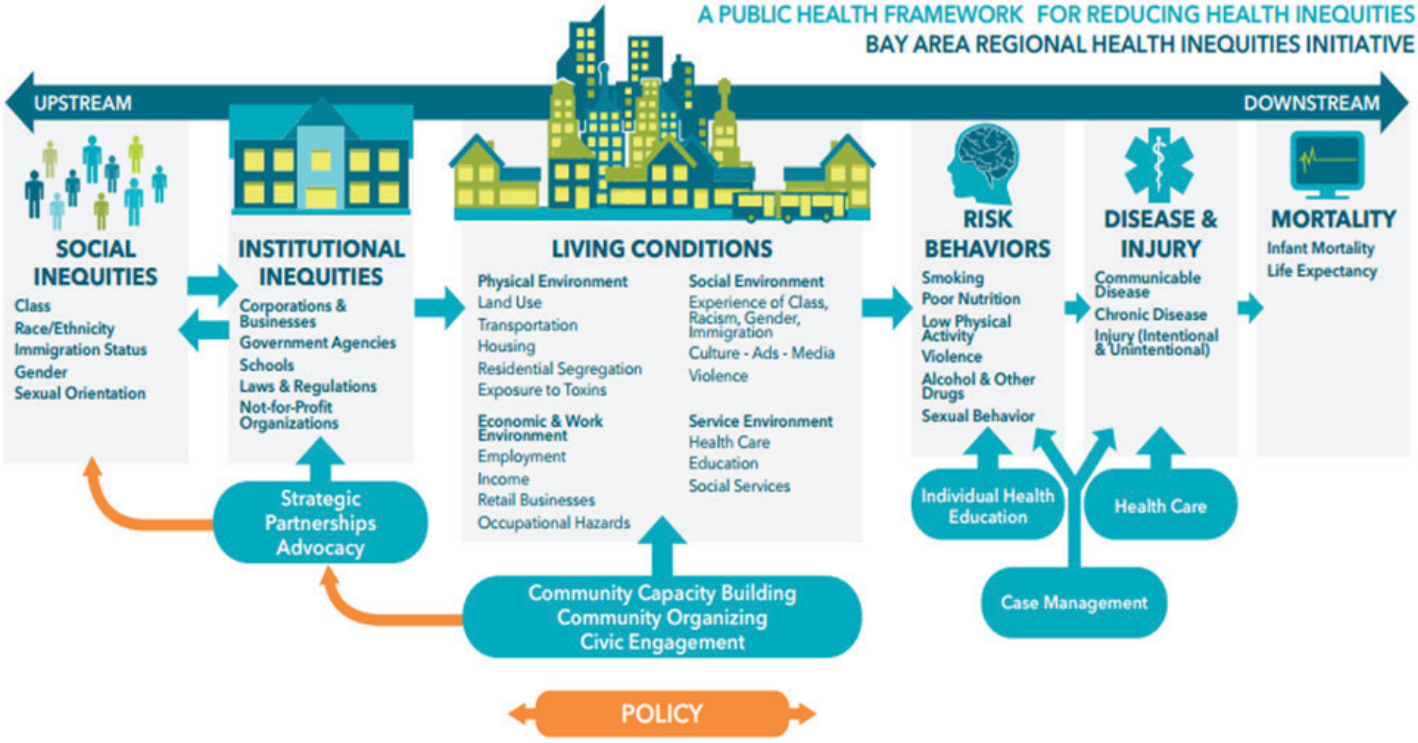
Figure 2: Health Tree Model[52]



BHNA participants identified additional root causes contributing to current issues within the behavioral health system, including stigma, individual and systemic racism and discrimination, housing policies, funding streams, and other structural barriers. Figure 2, developed by Health Resources in Action (HRiA) illustrates the important connections between health outcomes and the associated risk and protective factors.[52] Most importantly, it connects the social determinants, root causes, and underlying systems at the core of existing inequities and disparities. This framework is vital for reflecting on existing health outcomes, community needs, and strategic opportunities to support health improvement or system strengthening.

A framework from the Bay Area Regional Health Inequities Initiative (Figure 3)[53] reinforces similar concepts with a greater focus on connections between health outcomes, SDOH, inequities, and racism/discrimination. For many, racism underlies the social and institutional inequities impacting living conditions and their upstream health consequences. Therefore, addressing inequitable SDOH necessitates confronting the roots of structural racism.

Figure 3: A Public Health Framework for Reducing Health Inequities



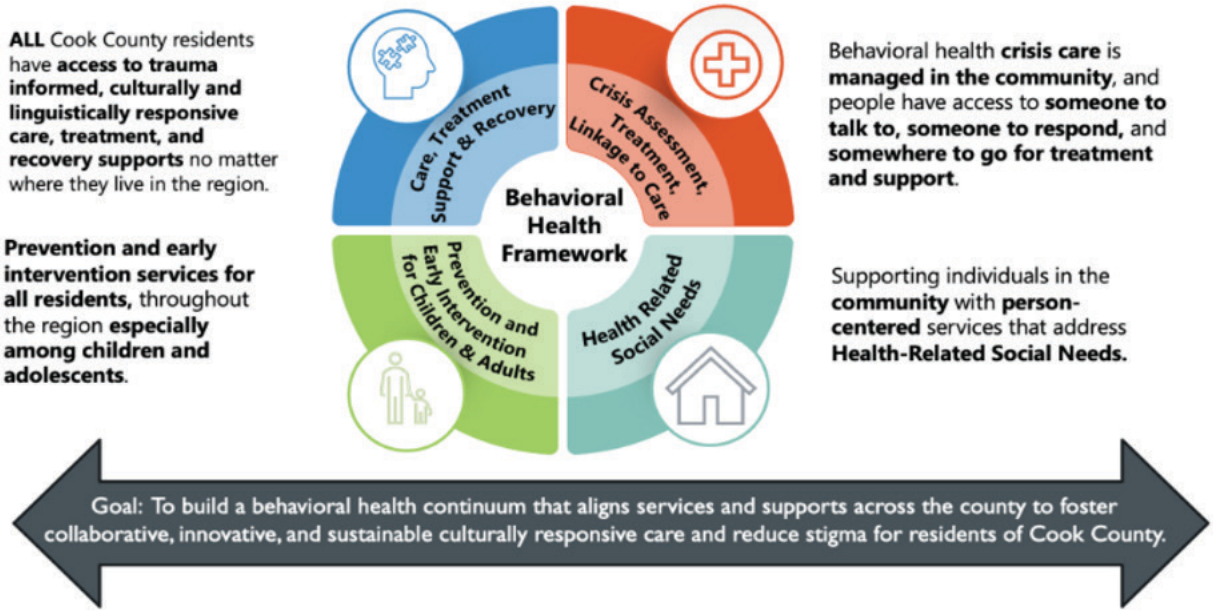
Frameworks

OBH advocates for a behavioral health system that provides services and support for promoting mental health well-being, early intervention, and prevention and treatment of mental health and substance use conditions--ensuring parity in access to health-related social needs. In this context, OBH is committed to establishing a more equitable behavioral health system in Cook County. This commitment involves taking proactive steps to resolve behavioral health inequities through increased systems alignment, enhanced system quality, and the development of a robust, comprehensive behavioral health service framework. This framework is designed to deliver a full spectrum of person-centered, linguistically accessible, culturally appropriate services, characterized by compassion, humility, and understanding.

To support and guide its efforts, OBH developed a Behavioral Health System Framework (See Figure 4 below) intended to inform its visioning, assessment, and planning processes. The framework is segmented into four core service system elements, aimed at assuring that all Cook County residents have access to the services needed to thrive and live healthy, happy, and fulfilling lives.

As stated above, the findings and recommendations are organized utilizing OBH's Behavioral Health System Framework.

Figure 4: Cook County Health Behavioral Health System Framework



The framework includes:

Prevention and Early Intervention for Children and Adults: Prevention and early intervention services, are readily available, especially among children and adolescents.

Care, Treatment, Support & Recovery: Access to culturally and linguistically responsive care, treatment, and recovery support is accessible when care is needed and no matter where they live in the region.

Crisis Assessment, Treatment Linkage to Care: Behavioral health crisis care is available in all communities, and people have access to someone to call, someone to respond, and somewhere to go for treatment and support.

Health-Related Social Needs: Community members are supported by person-centered services and resources.

Each of the four elements of this framework are discussed in greater detail in the findings section.

Approach and Methods

The purpose of the BHNA was to ensure that behavioral health strategic efforts to build and sustain an equitable, integrated, and well-coordinated behavioral health system across the County are community-informed and data driven. The goal of this report is to provide a roadmap for behavioral health work across the County by clarifying community needs and barriers to care, as well as service capacity and gaps, workforce shortages, and overall system strengths and weaknesses.

To achieve this goal, the assessment gathered an extensive amount of existing quantitative data to clarify and confirm community characteristics, the impact of health-related social factors and health-related behaviors, and the health status of Cook County residents, with a particular focus on behavioral health. Many health-related variables were compiled and are presented below in the findings section (A: Community Need and Behavioral Health Status).

The assessment also compiled and summarized information from many recent CHNAs conducted by hospitals and organizations in Cook County. This activity helped to ensure that BHNA efforts and findings were appropriately leveraged and applied to support the assessment.

Perhaps most importantly, the assessment implemented a comprehensive community engagement strategy that engaged hundreds of people from the community, including CCH representatives, key behavioral health service providers, public health officials, representatives from community-based and advocacy organizations, and community residents. Community engagement activities included conducting interviews, focus groups, and a behavioral health survey, as well as forming and facilitating conversations with two PIA committees.

Finally, it is important to note that in February 2024, OBH held a Cook County Behavioral Health Summit, which brought together approximately 800 people from Cook County to discuss the impacts, implications, and needs related to behavioral health. The information from the summit was analyzed separately from this assessment, but key findings from this analysis were incorporated where appropriate.

Below are brief descriptions of each of the methods discussed above.

Community Need and Behavioral Health Status

To assess community characteristics and health status, a data visualization and analysis tool called MySidewalk - a platform designed to facilitate the collection and interpretation of complex community data was used. MySidewalk allowed for the integration and analysis of a wide range of demographic, socioeconomic, and health-related indicators and served as a host for this assessment's final report. More information is included below.

How the MySidewalk Data Tool Works

MySidewalk is designed to support community planning, public health analysis, and policy development. It operates by aggregating a vast array of public data sources, allowing users to explore and analyze community characteristics with precision. The platform's key functionalities include data integration, visualization, and reporting, which work together to provide actionable insights.

1. *Data Integration and Aggregation:* MySidewalk compiles data from a variety of trusted public sources, including the U.S. Census Bureau, the Centers for Disease Control and Prevention (CDC), and other local and national databases. This integration enables users to explore various indicators such as demographics, economic conditions, housing, and health outcomes.

2. *Interactive Data Exploration:* Users can interact with the data through a user-friendly interface that supports dynamic exploration. MySidewalk provides filtering options, enabling users to focus on specific populations, geographic areas, or variables of interest. This flexibility allows for tailored analysis, ensuring that the data examined is relevant to the specific goals of the project.

3. *Data Visualization:* One of the strengths of MySidewalk is its ability to convert complex datasets into clear, visual representations. The tool offers a range of visualization options, including maps, graphs, and charts, which help to illustrate patterns, trends, and disparities within communities. These visualizations make it easier to communicate findings and to highlight areas that require attention.

4. *Custom Reporting:* MySidewalk also facilitates the creation of custom reports, allowing users to compile their findings into a cohesive narrative. Reports can be tailored to include specific data points, visualizations, and interpretations, making them a valuable resource for decision-makers. The platform's reporting features ensure that data-driven insights are effectively communicated, supporting evidence-based planning and policy development.

Quantitative data findings were organized into distinct categories:

- Demographics and Socioeconomics
- Social Determinants of Health
- Health Access and Preventative Care
- Behavioral Health Outcomes

It should be noted that not all sources of data are able to be stratified beyond the County or Municipal level. Whenever possible, data is shown in the following configurations:

- **State of Illinois, Cook County, City of Chicago, Suburban Cook County.** Suburban Cook County includes zip codes in Cook County, with the City of Chicago removed. Data for suburban Cook County is largely drawn from the Cook County Health Atlas.
- **Cook County Department of Public Health Districts (CCDPH Districts).** CCDPH serves five distinct public health districts, organized by zip code: South District, Southwest District, North District, Northwest District, and West District.
- **City of Chicago Health Equity Zones (HEZs).** The Healthy Chicago Equity Zones (HCEZ) initiative is a network of hyper-local partnerships established to achieve Healthy Chicago's[54] goal of closing Chicago's racial life expectancy gap.

Additionally, when relevant data were not available through MySidewalk's searchable data sets, two existing data portals were utilized:

- **The Cook County Health Atlas**. The atlas is an information sharing platform co-designed by Cook County Department of Public Health, along with multiple stakeholders to increase public health awareness and improve health equity. Data shared on the platform are regularly updated.
- **Chicago Health Atlas**. The Chicago Health Atlas was created to review, explore and compare health-related data over time and across communities. In addition, the Chicago Health Atlas provides a place for residents to see progress implementing Healthy Chicago, the citywide plan to improve health equity.

Summary of Recent Community Health Needs Assessments

To inform the BHNA process and ensure that work of other organizations was applied and leveraged, 14 CHNAs from various hospitals were analyzed to better understand community need, particularly with respect to behavioral health, and understand how the findings and recommendations from these assessments aligned with the findings from the BHNA. A full listing of the CHNAs reviewed for this report can be found in Appendix C.

Twenty-five (25) Cook County-based hospital CHNAs were reviewed and analyzed from 2019 until 2024 using an extraction method via Excel. Ultimately, 14 CHNAs were selected from this list; those hospitals excluded were determined to not have conducted CHNAs recently enough to be beneficial to this BHNA. Each CHNA chosen provided a comprehensive understanding of the current landscape of behavioral health in Cook County and identified community needs to improve mental health and substance use services. Next, each of the 14 CHNAs was summarized by researching the main priorities, summary of methods, affinity groups identified as most at risk, recommendations, trends in findings, barriers to behavioral health, gaps and needs from the community perspective, and strengths of the community. From this, seven major health priorities were identified and the number of times these priorities were referenced in each CHNA was documented. See below table for details.

Community Engagement

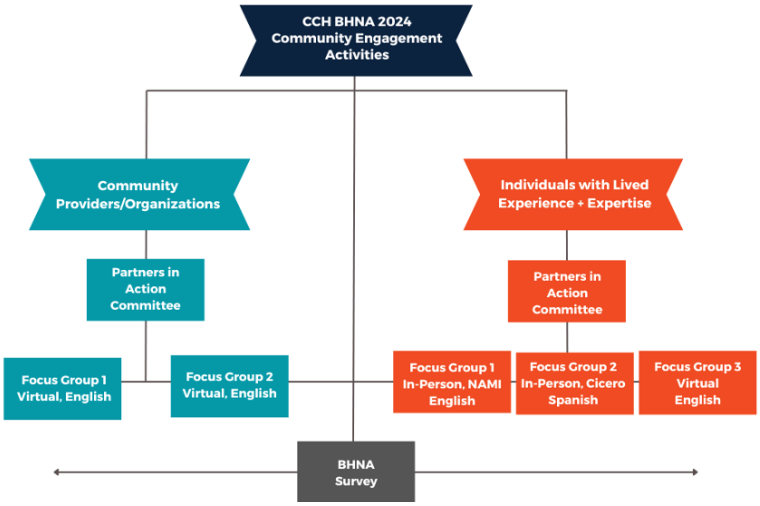
The World Health Organization defines community engagement as "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes."[55] In 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a report describing community engagement as "An Essential Component of an Effective and Equitable Substance Use Prevention System."[56]

These are only a sample of the multitude of organizations, publications, leaders, advocates, and researchers emphasizing the importance of collaborating with communities to represent their lived experience, understand impact and barriers, and develop programs and outreach for the populations of greatest need.

Utilizing these examples and the guiding principles and framework listed above, the assessment incorporated community voices in all aspects of the BHNA, from the project kick-off to data analysis, to reporting with the ultimate goal of, amplifying community voice.

As shown in Figure 5 below and described in this section, community voice was gathered through interviews, focus groups, a survey, and discussions with two PIA committees.

Figure 5: Cook County Behavioral Health Needs Assessment Community Engagement Activities



Key Informant Interviews

To gain a deeper understanding of priority issues facing the behavioral health system, 50 key informant interviews were conducted with county and state policy and community leadership, current and past CCH service providers, community-based organization staff, and other CCH behavioral health partners. Questions included topics related to strengths, areas for improvement, service gaps, priority populations, and recommendations. Recommendations for people to interview came from OBH staff, key informant interview participants, PIA committee members, and consultants. The interviews lasted approximately 30 minutes to 1 hour and took place via Zoom. The interviews were not recorded to ensure privacy and confidentiality. Extensive notes were drafted to identify key themes and uploaded them into Dedoose, a qualitative software, for coding. This same software and coding process were used throughout the BHNA to be consistent with other qualitative data analysis efforts.

Partners in Action (PIA) Committees

To center community voice throughout the BHNA process, the assessment developed two PIA committees that helped inform data collection efforts and analysis. Flyers and a one-pager outlining the purpose and roles of PIA committee members were created (Appendix A). An outreach plan to ensure accurate representation on the committees was designed.

The Community Organizations PIA Committee comprised staff providing mental health and substance use services from key behavioral health organizations throughout Cook County, which included groups as outlined Appendix A. The Lived Experience PIA Committee consisted of members who were living with a mental health and/or substance use diagnosis, have lived experience accessing mental health services in Cook County, or are loved ones of individuals living with a mental health and/or substance use diagnosis.

PIA committee members were involved in developing ways to capture the voices of those living with a mental health and/or substance use diagnosis. This committee helped with multiple activities, including creating strong local connections for focus group outreach; supporting the development of focus group guides; reviewing data; and providing insights on the experience of providing mental health/substance use care in Cook County or living with a mental health/substance use disorder.

Each PIA committee met three times throughout the BHNA process. The first meeting oriented the committee members to the purpose of the BHNA and their role. The second meeting provided space for members to guide the development of survey and focus group questions and recruitment strategies. At the final meeting, preliminary findings were provided to members and solicited their feedback to ensure the data gathered were representative of the community. It is important

to note that the PIA committees were forthcoming, engaged, and deeply passionate from the outset. The input provided by these groups greatly informed JSI's approach and the project's findings, as well as the recommendations that were derived from this work.

Focus Groups

With the help of the PIA committee members and Cook County-based project consultants (SASU Project Management and Luna Consulting), physical and electronic flyers were developed (available in both English and Spanish) and email communications to support the recruitment of focus group participants of both those with lived experience and those who identified as behavioral health community providers/staff (Appendix B).

Recruitment was based on convenience sampling, and all interested individuals were screened and confirmed eligible via email or telephone. To be eligible for participation in a focus group, individuals must have identified as the following:

- 18 years of age or older
- Speak English or Spanish, and either
  - Currently living with a mental health and/or substance use diagnosis in Cook County
  - Have lived experience accessing mental health services in Cook County
  - Are a loved one of someone living with a mental health and/or substance use diagnosis in Cook County
  - Provide behavioral health services in Cook County

A total of 40 individuals participated in one of five focus groups as described below in Table 1.

Table 1: Focus Groups by Modality, Language, and Participant Representation

Focus Group	Participant Representation	Modality	Language
1	Persons with Lived Experience	Virtual	English
2	Persons with Lived Experience	In-Person	English
3	Persons with Lived Experience	In-Person	Spanish
4	Behavioral Health Community Providers/Staff	Virtual	English
5	Behavioral Health Community Providers/Staff	Virtual	English

To limit implicit bias and potential stigma and/or power dynamics, those who identified as persons with lived experience and behavioral health community providers/staff were separated into similarly-focused groups, as noted in the above table. It is important to note, however, that many behavioral health community providers/staff also identified as persons with lived experience.

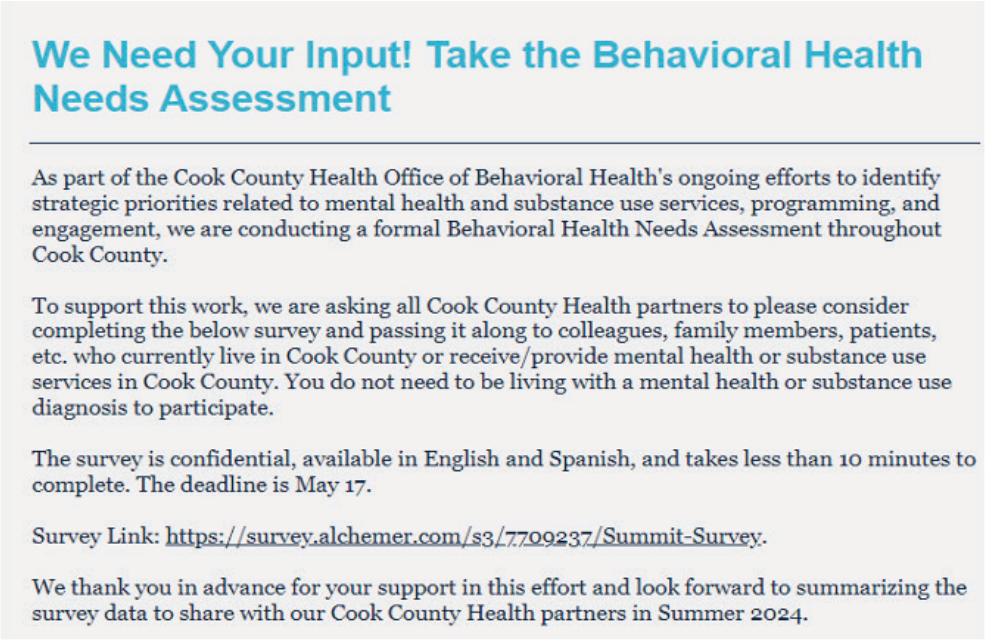
All focus groups were 90 minutes in length and held either virtually via Zoom or in-person at a community location that was familiar and easily accessible to participants (i.e., NAMI Chicago, Family Service and Mental Health Center of Cicero). Facilitators (Sarah Rittner of SASU Project Management, David Luna of Luna Consulting, and Mauricio Cifuentes of Family Service and Mental Health Center of Cicero) utilized a facilitator's guide to follow the same focus group structure and ask the same questions of each participant (questions developed with the guidance of PIA committee members). Focus group participants were compensated $50 (via Visa Gift Card) for their time. If the focus group was held in-person, participants also were provided with lunch.

With participants' verbal approval, all focus groups were recorded for note-taking purposes. No identifiable information was collected, and recordings were transcribed utilizing Zoom or manually. Transcriptions were uploaded to Dedoose for thematic coding and analyzed by the assessment. Focus group members were also asked to complete an anonymous demographics form so that the assessment could continue to assure representation throughout community engagement activities (Appendix B).

Behavioral Health Needs Assessment Survey

A short BHNA survey (available in English and Spanish) was launched from February 15 to June 13, 2024. This survey was used to provide diverse and accessible options for providing feedback in addition to capturing the community voice via key informant interviews, PIA committees, and focus groups. Survey questions closely aligned with focus group questions to assure the same data points were captured for analysis purposes (Appendix B).

Figure 6: BHNA Survey Excerpt from CCH OBH Monthly Newsletter



We Need Your Input! Take the Behavioral Health Needs Assessment

As part of the Cook County Health Office of Behavioral Health's ongoing efforts to identify strategic priorities related to mental health and substance use services, programming, and engagement, we are conducting a formal Behavioral Health Needs Assessment throughout Cook County.

To support this work, we are asking all Cook County Health partners to please consider completing the below survey and passing it along to colleagues, family members, patients, etc. who currently live in Cook County or receive/provide mental health or substance use services in Cook County. You do not need to be living with a mental health or substance use diagnosis to participate.

The survey is confidential, available in English and Spanish, and takes less than 10 minutes to complete. The deadline is May 17.

Survey Link: https://survey.alchemer.com/s3/7709237/Summit-Survey.

We thank you in advance for your support in this effort and look forward to summarizing the survey data to share with our Cook County Health partners in Summer 2024.

Marketing and dissemination of the BHNA survey was vast, including the CCH newsletter (see Figure 6), outreach by the PIA committee members' community organizations and focus group members, individual emails, social media posts, and flyers. Over 200 (N=229) individuals completed the survey, most of whom identified as a Cook County Resident (83.8%), Staff Member at a Mental Health or Substance Use Service Organization (30.6%), and/or a Person with a Mental Health Diagnosis (23.6%) or Substance Use Diagnosis (11.4%). Nearly 9% completed the survey in Spanish.

Data from the survey were analyzed using the Alchemer survey platform, which was used to collect survey responses. A detailed report of findings from the BHNA survey are available in Appendix B.

Cook County Health Behavioral Health Summit

On February 15, 2024, OBH hosted an inaugural Behavioral Health Summit[57] in Chicago to lay a foundation in which to improve access, quality, and care in mental health and substance use services across Cook County. This summit included approximately 800 attendees from nearly 300 organizations, including those represented by PIA committee members. Attendees included behavioral health clinical and service providers, advocates, community leaders, persons with lived experience, and elected officials. The assessment supported the summit's activities by planning meetings, presenting on the importance of community voice and representation in behavioral health strategic planning and programming, and conducting data collection and analysis.

Data from the summit was reviewed and considered in the development of this report to align ideas, identify or amplify key themes, and foster recommendations for next steps.

Photos from CCH Behavioral Health Summit[57]

Community Characteristics and Quantitative Data Findings

The following sections contain quantitative data related to findings in four categories:

- Demographics and Socioeconomics
- Social Determinants of Health
- Health Access and Preventative Care
- Behavioral Health Outcomes

It should be noted that not all sources of data are able to be stratified beyond the County or Municipal level. Whenever possible, data is shown in the following configurations:

- **State of Illinois, Cook County, City of Chicago**. In some instances, data is also available for Suburban Cook County, which includes zip codes in Cook County with the City of Chicago removed (data extracted from the Cook County Health Atlas).
- **Cook County Department of Public Health Districts (CCDPH Districts).** CCDPH serves five distinct public health districts, organized by zip code: South District, Southwest District, North District, Northwest District, and West District.
- **City of Chicago Health Equity Zones (HEZs).** The Healthy Chicago Equity Zones (HCEZ) initiative is a network of hyper-local partnerships established to achieve the Healthy Chicagogoal of closing Chicago's racial life expectancy gap.

Demographics and Socioeconomics

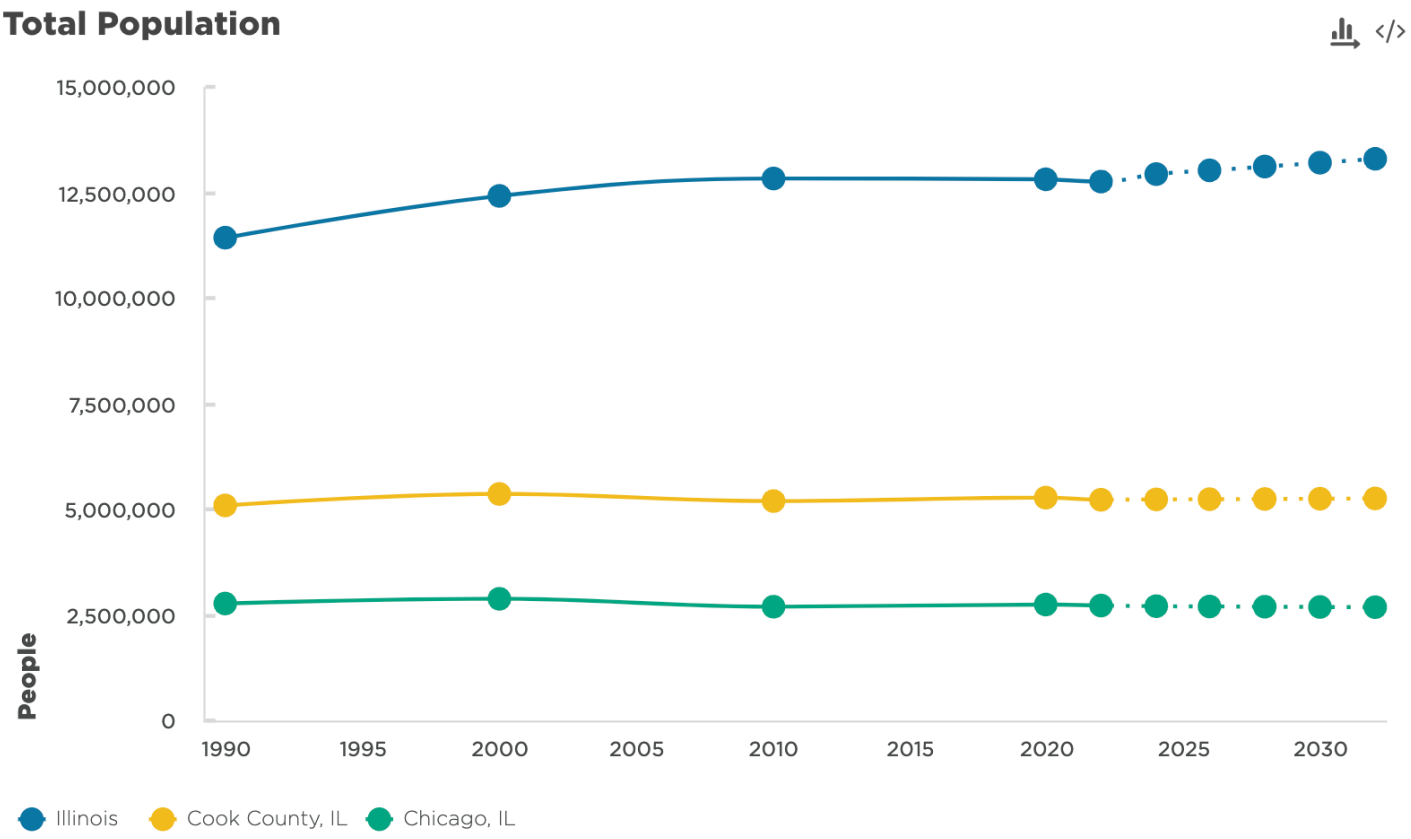
Demographic data is a cornerstone in conducting comprehensive behavioral health assessments, as it provides crucial insights into the unique needs and challenges faced by different population groups. Age, gender, race, ethnicity, socioeconomic status, and geographic location significantly influence the prevalence and types of behavioral health issues. By examining these demographic characteristics, health professionals can identify which groups are most at risk, allowing for the development of tailored interventions. This targeted approach not only addresses the specific needs of diverse populations but also helps in identifying and reducing health disparities. Understanding the cultural backgrounds and specific needs of various demographic groups enhances cultural competence in healthcare, leading to better engagement, adherence to treatment, and overall satisfaction with care.

Moreover, demographic data informs effective resource allocation and guides policymakers and program developers in creating evidence-based initiatives. It highlights where the greatest needs lie, ensuring that resources are directed to the most vulnerable populations. Analyzing demographic trends over time allows for the monitoring of shifts in behavioral health patterns, enabling timely adjustments to policies and programs.

Population Trends

Examining population trends in behavioral health assessments is essential for identifying emerging issues and changes in mental health patterns over time

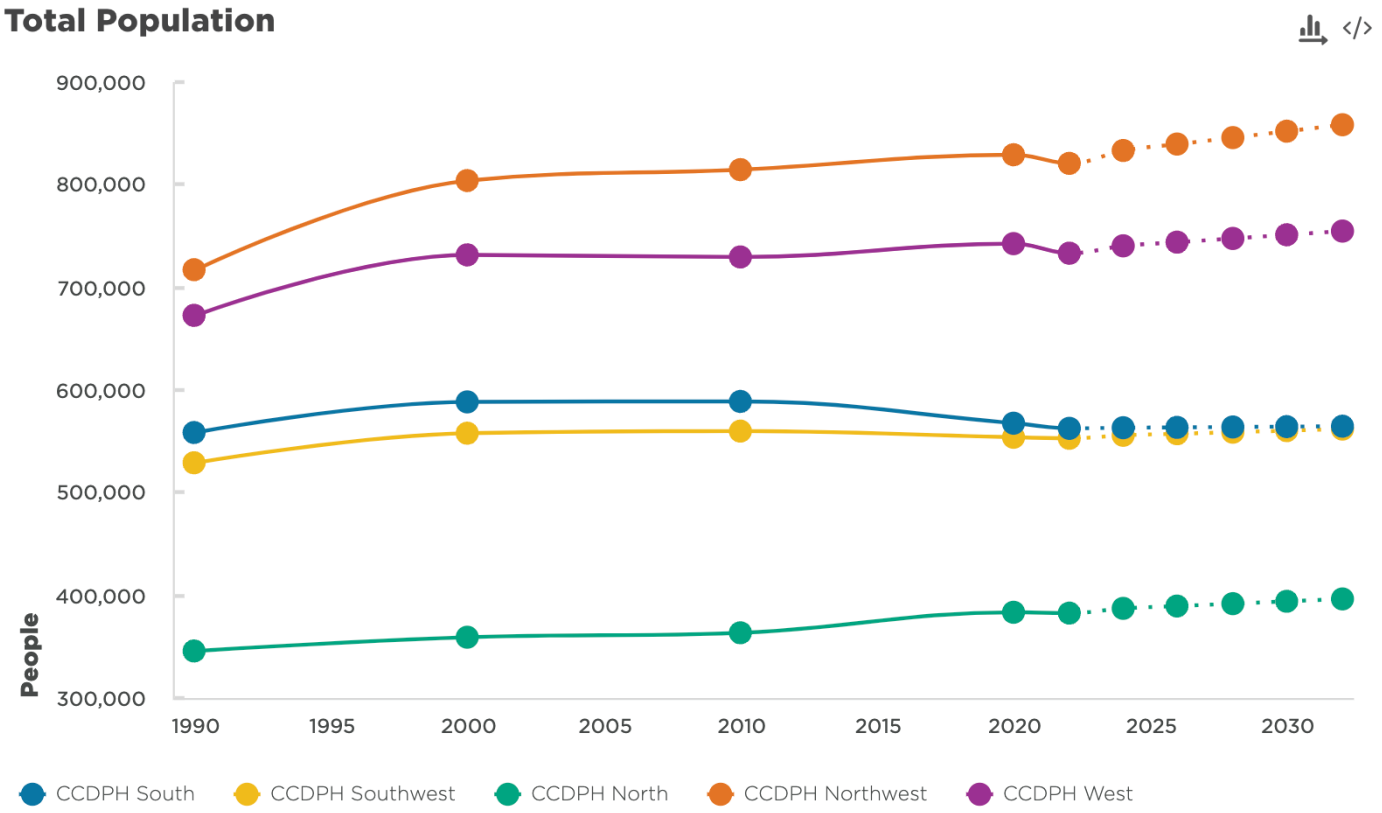
The data on total population shows growth from 1990 to 2000 for the state, Cook County, and the City of Chicago, with steady numbers since then.



Sources: US Census Bureau; US Census Bureau ACS 5-year

The graph below shows changes in total population since 1990 in Cook County Department of Public Health's (CCDPH's) Planning Districts.

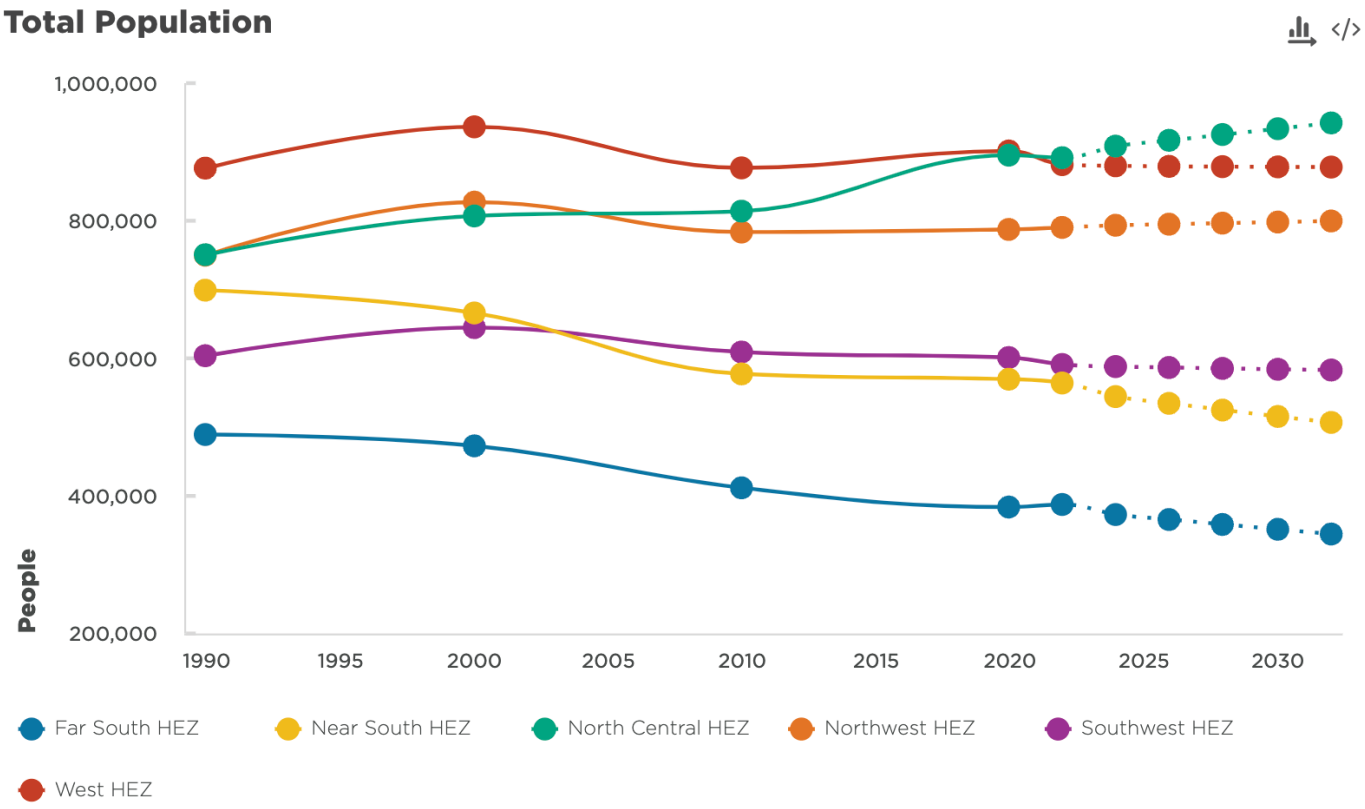
- In comparing the smallest geography, CCDPH North, with the larger ones such as CCDPH Southwest, CCDPH North consistently has a lower total population over the years. For example, in 2020, CCDPH North had 383,541 people, while CCDPH Southwest had 554,032 people. This trend is projected to continue through 2031.
- CCDPH Northwest has the highest total population among all the geographies throughout the years. In 2020, CCDPH Northwest had 829,241 people, significantly more than CCDPH North with 383,541 people.



Sources: US Census Bureau; US Census Bureau ACS 5-year

When looking at the total population in Chicago's Health Equity Zones (HEZs) over time, you can see interesting similarities and differences.

- The Far South HEZ has shown a gradual decrease in population over time
- In contrast, the North Central HEZ has experienced steady growth over the years.
- The Near South HEZ, Northwest HEZ, Southwest HEZ, and West HEZ have had fluctuations in their population numbers but have generally maintained their populations over the years without significant decreases or increases.



Sources: US Census Bureau; US Census Bureau ACS 5-year

Aging Trends

Age plays a significant role in behavioral health, with distinct challenges and vulnerabilities emerging at different stages of life. Adolescence and young adulthood often coincide with the onset of mental health disorders such as anxiety and depression, influenced by factors like academic pressures, social relationships, and identity formation. In middle age, stressors related to career, finances, and family responsibilities can contribute to conditions like burnout and substance abuse. Later in life, older adults may grapple with loneliness, chronic illness, and grief, predisposing them to conditions like depression and cognitive decline. Understanding these age-related dynamics is essential for designing targeted interventions and support systems that address the unique needs of individuals at different life stages, promoting lifelong mental well-being.

In both Cook County and Chicago, the median age is lower compared to the overall state of Illinois. This suggests a relatively younger population in these urban areas. Additionally, the data shows that the largest age group in these areas is the 25 to 34-year-olds, followed by the 35 to 44-year-olds. This indicates the presence of a significant working-age population.

However, it's important to note that there are differences in the population distribution among different age groups between these areas. Chicago, in particular, has a higher concentration of young adults aged 20 to 24 years compared to Cook County and the state of Illinois.

Age Distribution (2018-2022)

Data Sources	Illinois	Cook County, IL	Chicago, IL
Median Age	38.7	37.5	35.3
Population Age Under 5 per capita	5.7%	5.7%	5.7%
Population Age 5 to 9 per capita	6%	5.8%	5.2%
Population Age 10 to 14 per capita	6.5%	6.2%	5.7%
Population Age 15 to 19 per capita	6.7%	6.1%	5.7%
Population Age 20 to 24 per capita	6.7%	6.4%	7.4%
Population Age 25 to 34 per capita	13.6%	15.9%	19.7%
Population Age 35 to 44 per capita	13.1%	13.8%	14.3%
Population Age 45 to 54 per capita	12.6%	12.4%	11.8%
Population Age 55 to 59 per capita	6.6%	6.2%	5.7%
Population Age 60 to 64 per capita	6.4%	6.1%	5.4%
Population Age 65 to 74 per capita	9.5%	8.9%	7.8%
Population Age 75 to 84 per capita	4.7%	4.3%	3.8%
Population Age Over 85 per capita	2.1%	2%	1.7%
Population Under Age 18 (Children) per capita	22.1%	21.5%	20%

Sources: US Census Bureau ACS 5-year 2018-2022

The data table below shows the age distribution among CCDPH Districts.

- In CCDPH North, the median age is 45.5, which is the highest among the regions.
- CCDPH West, CCDPH Northwest, and CCDPH Southwest have similar median ages, around 41-42.
- CCDPH South has the lowest median age at 40.1
- Across all regions, the highest population per capita is in the age group 25 to 34, followed by 45 to 54.
- CCDPH South has the highest percentage of population under age 18 per capita at 24%
- The regions have varying proportions of children under 5 and over 85, with CCDPH North having the highest proportion of children under 5 and CCDPH West having the highest proportion of people over 85.

Age Distribution (2018-2022)

Data Sources	CCDPH West	CCDPH Northwest	CCDPH North	CCDPH Southwest	CCDPH South
Median Age	40.7	41.5	45.5	41.9	40.1
Population Age Under 5 per capita	5.6%	6%	5.6%	5.9%	5.6%
Population Age 5 to 9 per capita	6.3%	6.2%	6.9%	6.2%	6.4%
Population Age 10 to 14 per capita	7.1%	6.7%	6.4%	6.7%	7.4%
Population Age 15 to 19 per capita	6.9%	6%	6.2%	6.5%	7.5%
Population Age 20 to 24 per capita	5.9%	5%	3.9%	5.7%	6%
Population Age 25 to 34 per capita	11.9%	12.6%	8.4%	12.2%	12.7%
Population Age 35 to 44 per capita	13.6%	13.9%	12.8%	12.7%	12.1%
Population Age 45 to 54 per capita	13.5%	13.5%	14.1%	12.2%	13%
Population Age 55 to 59 per capita	7%	7%	7.2%	7.1%	6.8%
Population Age 60 to 64 per capita	6.5%	6.8%	6.8%	7%	6.7%
Population Age 65 to 74 per capita	9.2%	9.5%	11.5%	10.5%	9.5%
Population Age 75 to 84 per capita	4.3%	4.7%	6.2%	5.2%	4.5%
Population Age Over 85 per capita	2.1%	2%	3.9%	2.2%	1.8%
Population Under Age 18 (Children) per capita	23.3%	22.9%	23.2%	22.8%	24%

Sources: US Census Bureau ACS 5-year 2018-2022

The data table below shows the age distribution in different Health Equity Zones (HEZs) from 2018 to 2022. Overall, the data indicates variations in age distribution among different HEZs, with some zones having more younger adults and others having a higher percentage of older adults.

- In the North Central HEZ, the median age is 35.9 years, with a high percentage of people aged 25 to 34 and 35 to 44. This HEZ has a lower percentage of children under 18 compared to other zones.
- The Near South HEZ has a slightly lower median age of 39.3 years, with a higher percentage of people aged 20 to 24 and 25 to 34. Children under 18 make up about 21.6% of the population in this zone.

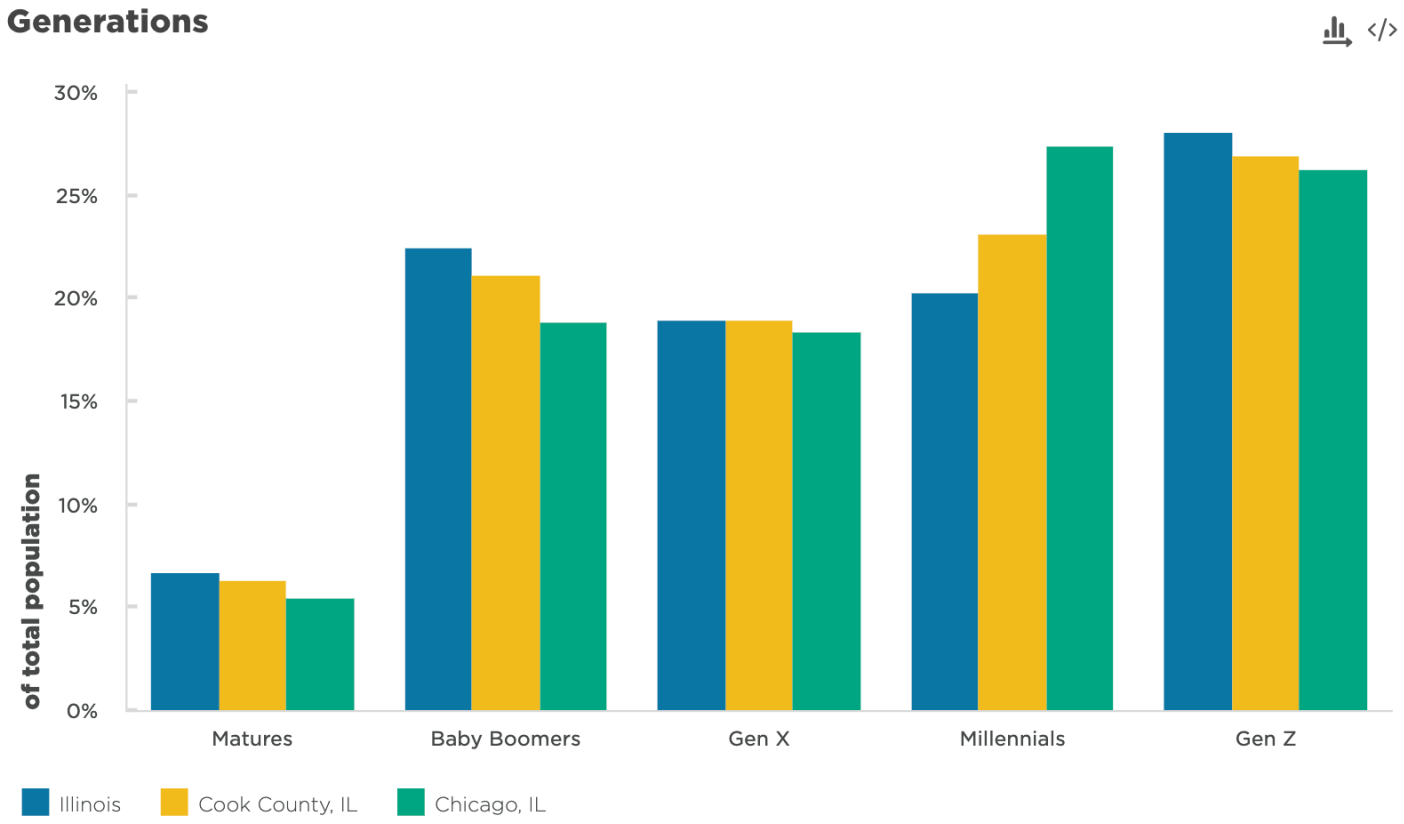
Age Distribution (2018-2022)

Data Sources	Far South	Near South	North Central	Northwest	Southwest	West
Median Age	41	39.3	35.9	37.7	36.9	35.5
Population Age Under 5 per capita	5.9%	5.7%	5.1%	6.2%	6%	5.6%
Population Age 5 to 9 per capita	6.1%	5.6%	3.9%	5.4%	5.7%	5%
Population Age 10 to 14 per capita	7.3%	6.5%	3.7%	5.6%	7%	5.8%
Population Age 15 to 19 per capita	6.5%	6.5%	4.4%	5.5%	6.4%	5.6%
Population Age 20 to 24 per capita	6.3%	7.3%	8.2%	6%	7.5%	7.5%
Population Age 25 to 34 per capita	12.7%	15.6%	26.6%	19.4%	16.4%	22.9%
Population Age 35 to 44 per capita	12.3%	12.6%	15.5%	16.3%	13.3%	14.7%
Population Age 45 to 54 per capita	12%	11.5%	11.2%	12.6%	12.6%	11.2%
Population Age 55 to 59 per capita	7%	6.4%	5.2%	5.7%	5.9%	5.2%
Population Age 60 to 64 per capita	6.5%	6.2%	4.7%	5.4%	5.2%	4.8%
Population Age 65 to 74 per capita	9.4%	9.3%	6.7%	7.3%	7.9%	7.1%
Population Age 75 to 84 per capita	5.3%	4.7%	3.3%	3.3%	4.5%	3.1%
Population Age Over 85 per capita	2.6%	2.2%	1.4%	1.6%	1.7%	1.4%
Population Under Age 18 (Children) per capita	23.5%	21.6%	14.7%	20.6%	22.5%	19.5%

Sources: US Census Bureau ACS 5-year 2018-2022

Generations thrive side by side, each bringing unique perspectives and experiences. From the wise Matures to the trailblazing Gen Z, every generation plays a vital role in shaping the community. As Baby Boomers embrace their golden years and Gen Z comes into its own, it's important to recognize the contributions and needs of each generation. Understanding these dynamics can foster intergenerational connections, support inclusion, and build a thriving community for all.

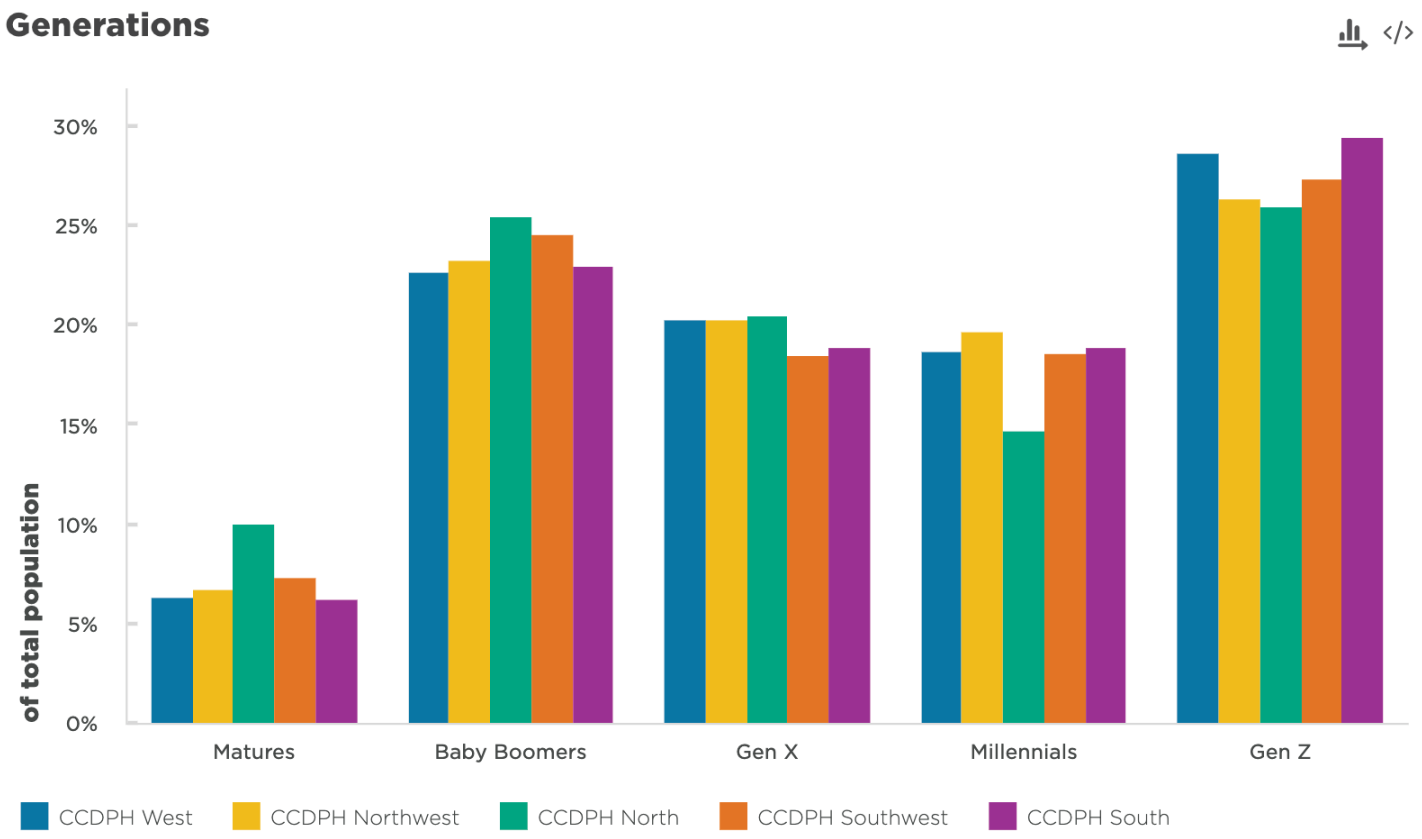
The data reveals that in Cook County, the largest generation is Gen Z, followed closely by Millennials. Baby Boomers and Gen X make up a significant portion of the population as well. In Chicago, the pattern is similar, with Gen Z and Millennials being the largest generations. Illinois as a whole has a higher percentage of Gen Z than any other generation.



Sources: US Census Bureau ACS 5-year 2018-2022

The chart below compares different generations in CCDPH Districts.

- In all areas, Baby Boomers make up the largest proportion of the population, followed by Gen Z. Gen X is also fairly consistent across geographies.
- When comparing the areas, you can see that the North area has the highest percentage of Matures at 10%, while the Southwest has the highest percentage of Baby Boomers at 25%.
- Millennials are consistent across regions, making up around 19-20% of the popuation. Gen Z varies slightly, with the highest percentage in the Northwest at 26%.

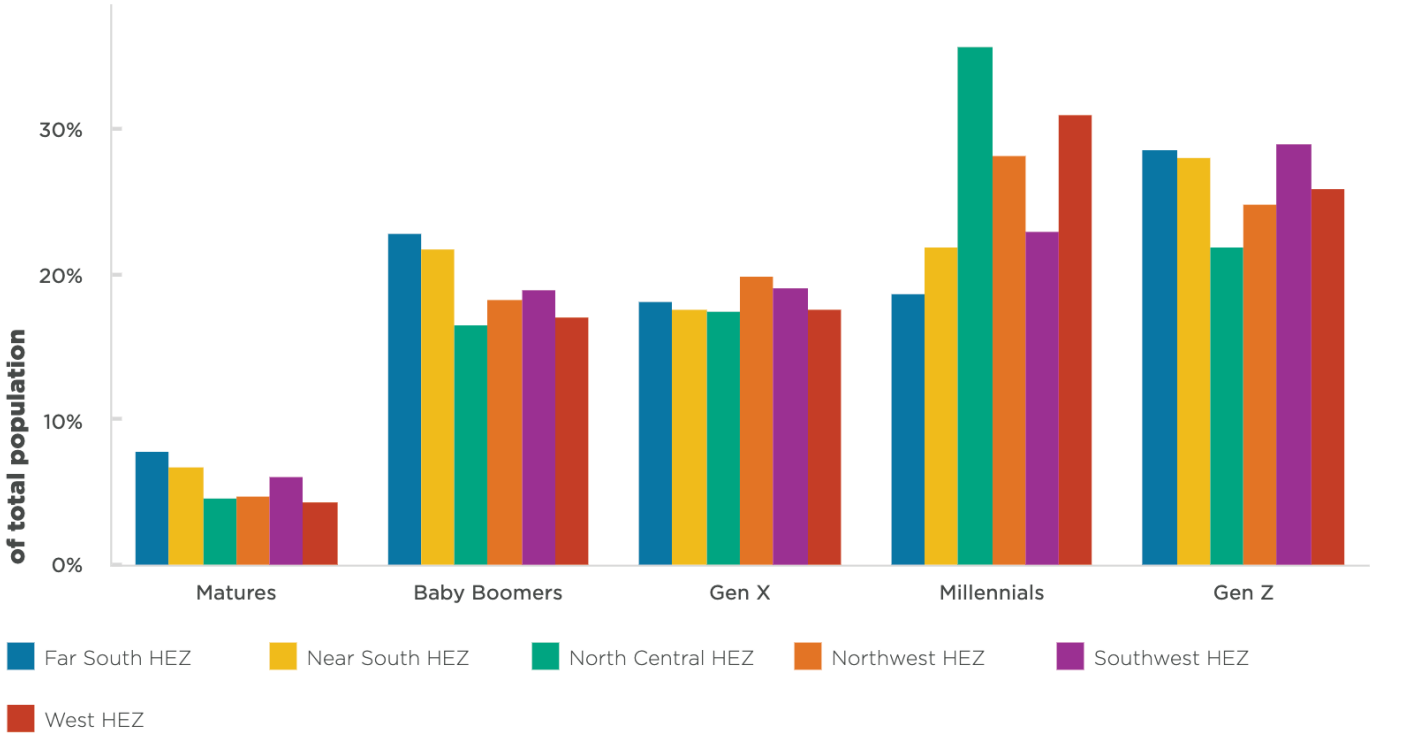


Sources: US Census Bureau ACS 5-year 2018-2022

The chart compares the distribution of different generations in Chicago HEZs. Across all regions, Baby Boomers have the highest percentage of the total population, followed by Gen Z. Millennials have a significant presence as well.

- The West HEZ has the smallest percentage of Matures compared to other regions.
- In the North Central HEZ, Millennials represent the highest percentage of the population.
- In the Far South HEZ, Gen Z makes up the largest portion compared to other regions.

Generations

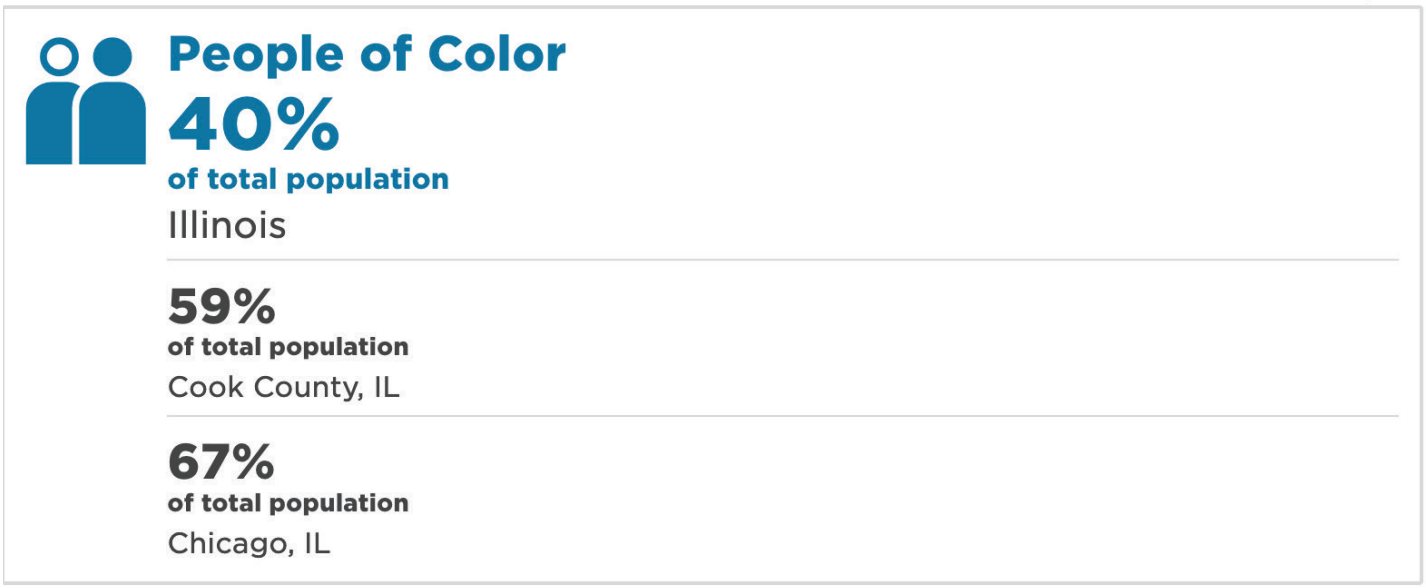


Sources: US Census Bureau ACS 5-year 2018-2022

Race & Ethnicity

Race and ethnicity intersect with behavioral health in complex ways, influencing access to care, treatment outcomes, and the prevalence of mental health conditions. Structural inequities, including systemic racism and discrimination, can contribute to disparities in mental health outcomes among racial and ethnic minority groups. Historical trauma, socioeconomic factors, cultural stigma, and limited access to culturally competent care further exacerbate these disparities. It's crucial to recognize and address these disparities through culturally sensitive interventions, community-based support networks, and policy initiatives aimed at promoting equity and improving mental health outcomes for all racial and ethnic groups.

In Cook County, 59% of the population are people of color, while in the city of Chicago, it rises to 67%. In comparison, the state of Illinois has a lower percentage with 40% people of color. This data demonstrates the rich diversity found within these regions, highlighting the vibrant and multicultural nature of Cook County and Chicago.



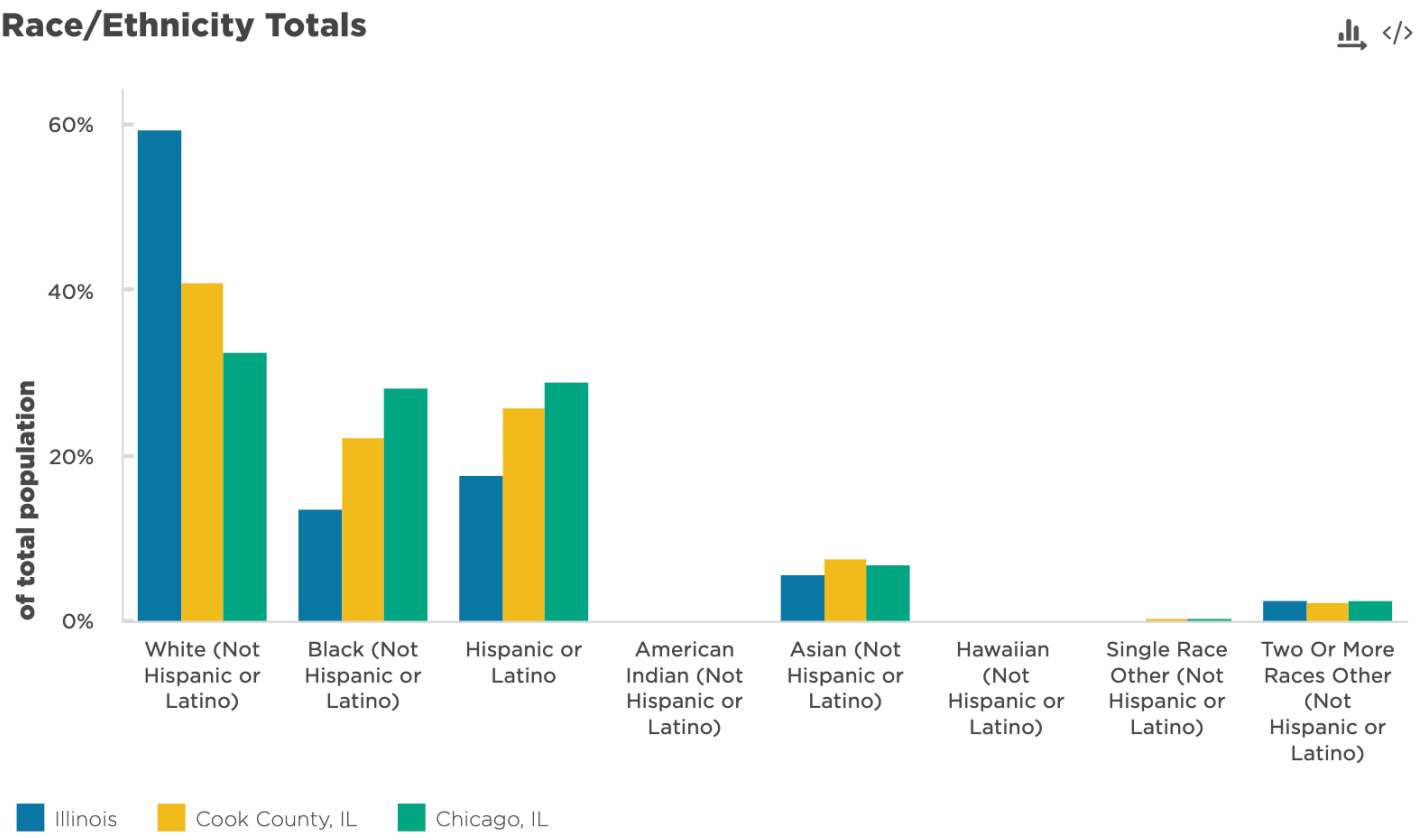
Sources: US Census Bureau ACS 5-year 2018-2022

When looking at the race and ethnicity totals for Cook County, IL, Chicago, IL, and Illinois, there are some notable differences.

In Cook County, the largest racial or ethnic group is White (Not Hispanic or Latino), making up around 41% of the population. Black (Not Hispanic or Latino) and Hispanic or Latino populations follow at 22% and 26% respectively.

In comparison, Chicago has a more diverse population with White (Not Hispanic or Latino) representing around 33%, Black (Not Hispanic or Latino) at 28%, and Hispanic or Latino at 29%.

Looking at the state of Illinois as a whole, the majority of the population is White (Not Hispanic or Latino) at around 60%, followed by Hispanic or Latino at 18% and Black (Not Hispanic or Latino) at 14%.

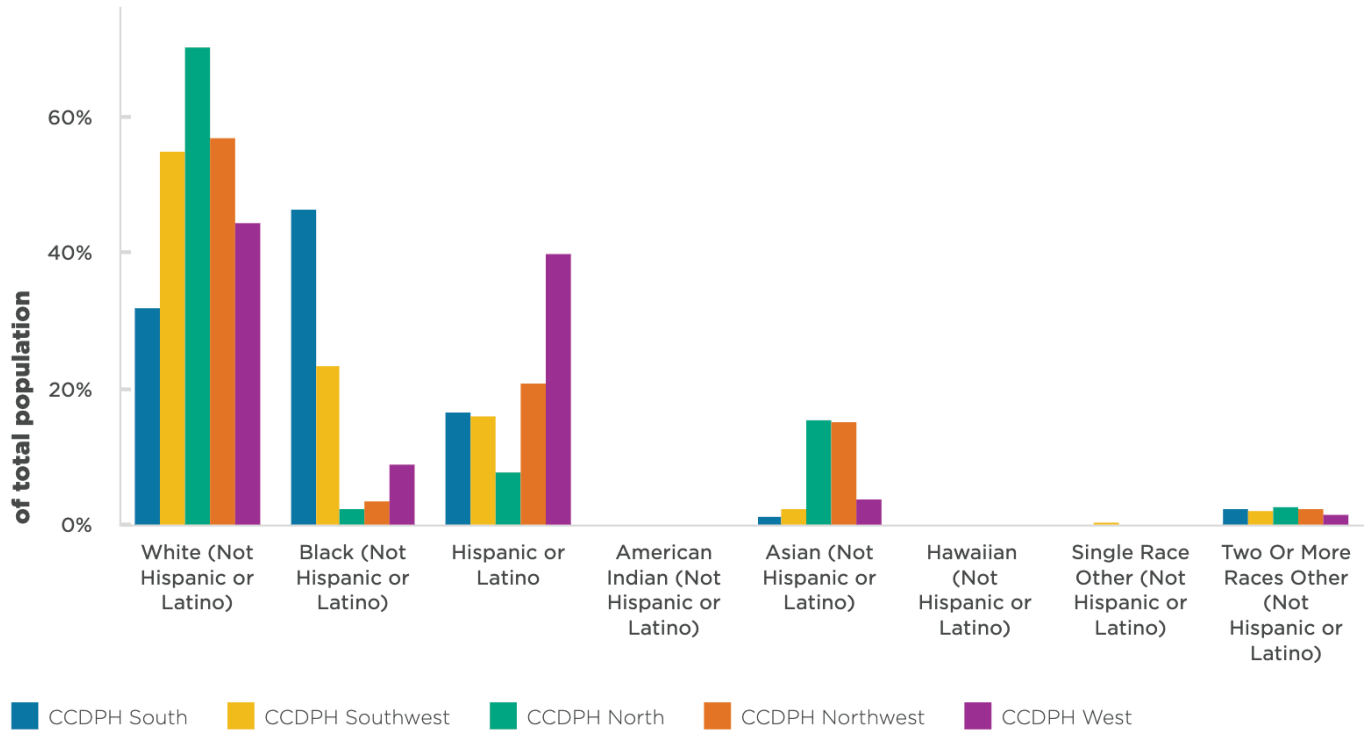


Sources: US Census Bureau ACS 5-year 2018-2022

The chart below compares race and ethnicity totals in CCDPH Districts. Overall, there are significant variations in racial and ethnic demographics among the areas, with disparities in the distribution of different groups.

- In CCDPH South, 47% of the population is Black, while in CCDPH North, only 2% are Black. CCDPH North has the highest percentage of white people at 71%, compared to other areas.
- Hispanic or Latino populations range from 8% in CCDPH North to 40% in CCDPH West. CCDPH South has the lowest percentage of white individuals at 32%.
- Asian representation is highest in CCDPH North at 16% and lowest in CCDPH South at 1%. CCDPH Northwest stands out with 15% of the population being Asian.

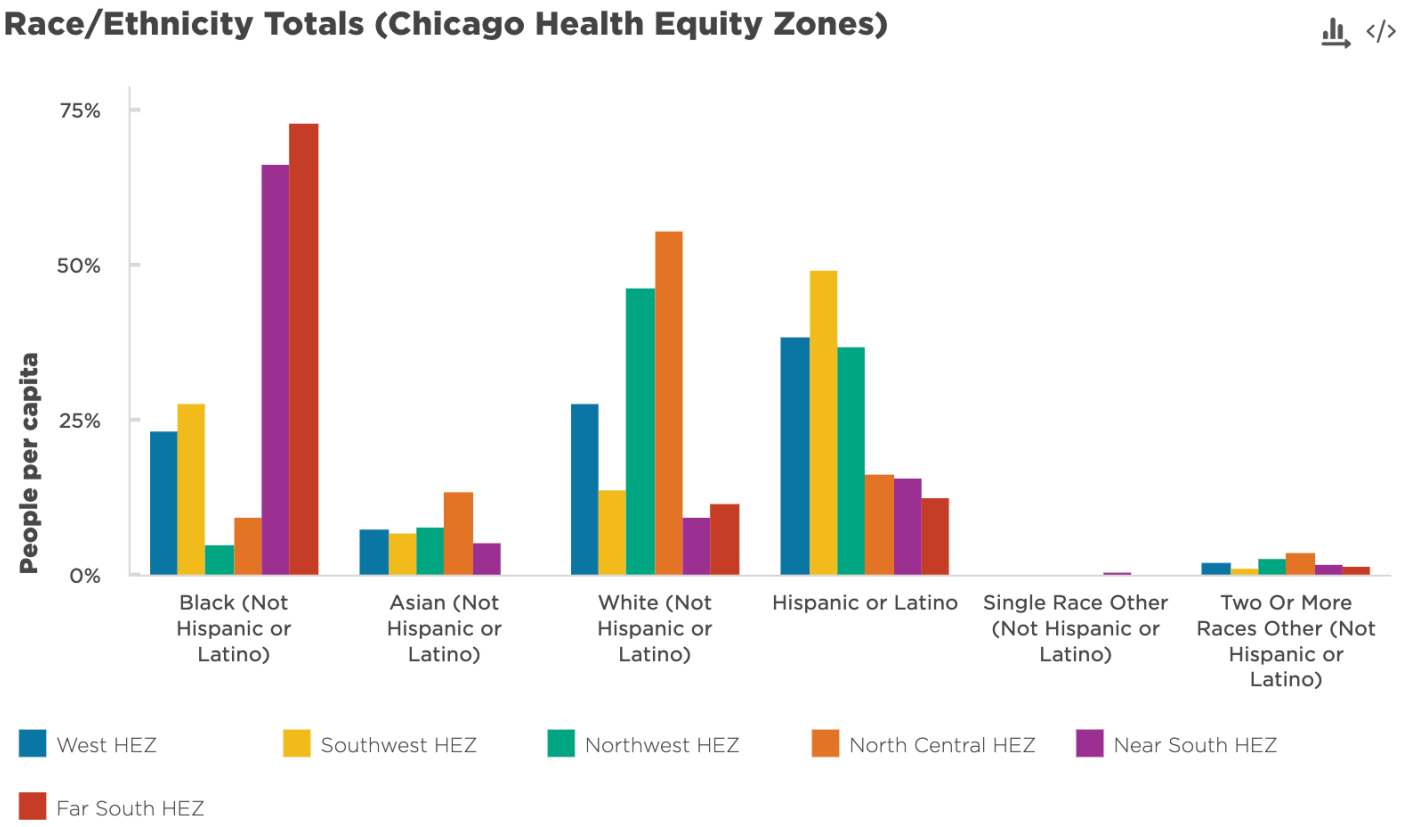
Race/Ethnicity Totals



Sources: US Census Bureau ACS 5-year 2018-2022

The chart below shows the racial/ethnic breakdown by Health Equity Zones.

- In the West and Southwest HEZs, Black and Hispanic or Latino populations are higher compared to White and other groups.
- The North Central HEZ has a significant White population. In contrast, the Far South and Near South HEZs have predominantly Black populations.
- Across all zones, the Asian population is relatively small.



Sources: US Census Bureau ACS 5-year 2018-2022

Place of Birth

Foreign-born status can significantly impact behavioral health outcomes due to various factors such as migration-related stressors, acculturation challenges, and barriers to accessing culturally appropriate care. Immigrants and refugees may face language barriers, discrimination, and social isolation, which can exacerbate mental health issues. Additionally, pre-migration trauma, including experiences of violence, persecution, or displacement, may contribute to higher rates of post-traumatic stress disorder (PTSD) and other mental health conditions.

Foreign Born - Naturalized US Citizen per capita

7.5%
Illinois

11.2%
Cook County, IL

9.8%
Chicago, IL

Foreign Born - Not US Citizen per capita

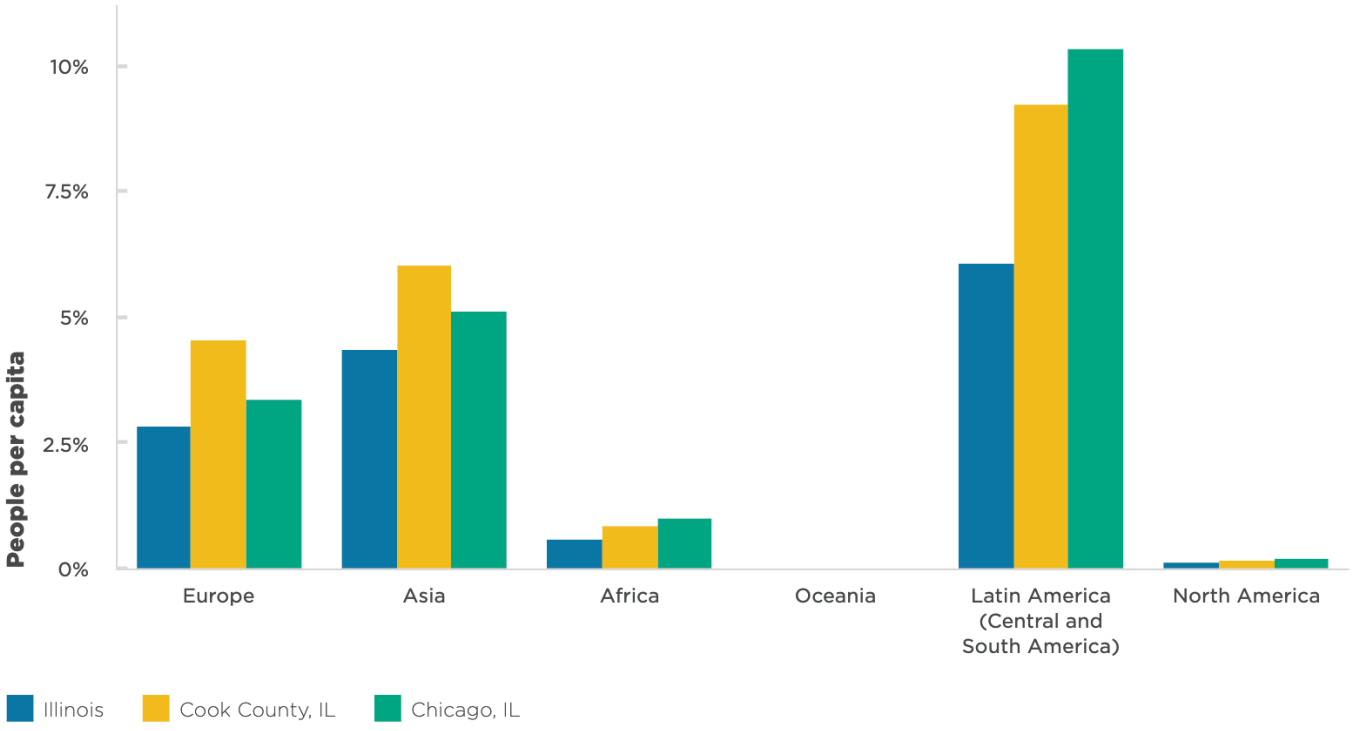
6.6%
Illinois

9.8%
Cook County, IL

10.4%
Chicago, IL

Sources: US Census Bureau ACS 5-year 2018-2022

Foreign Born by Continental Region

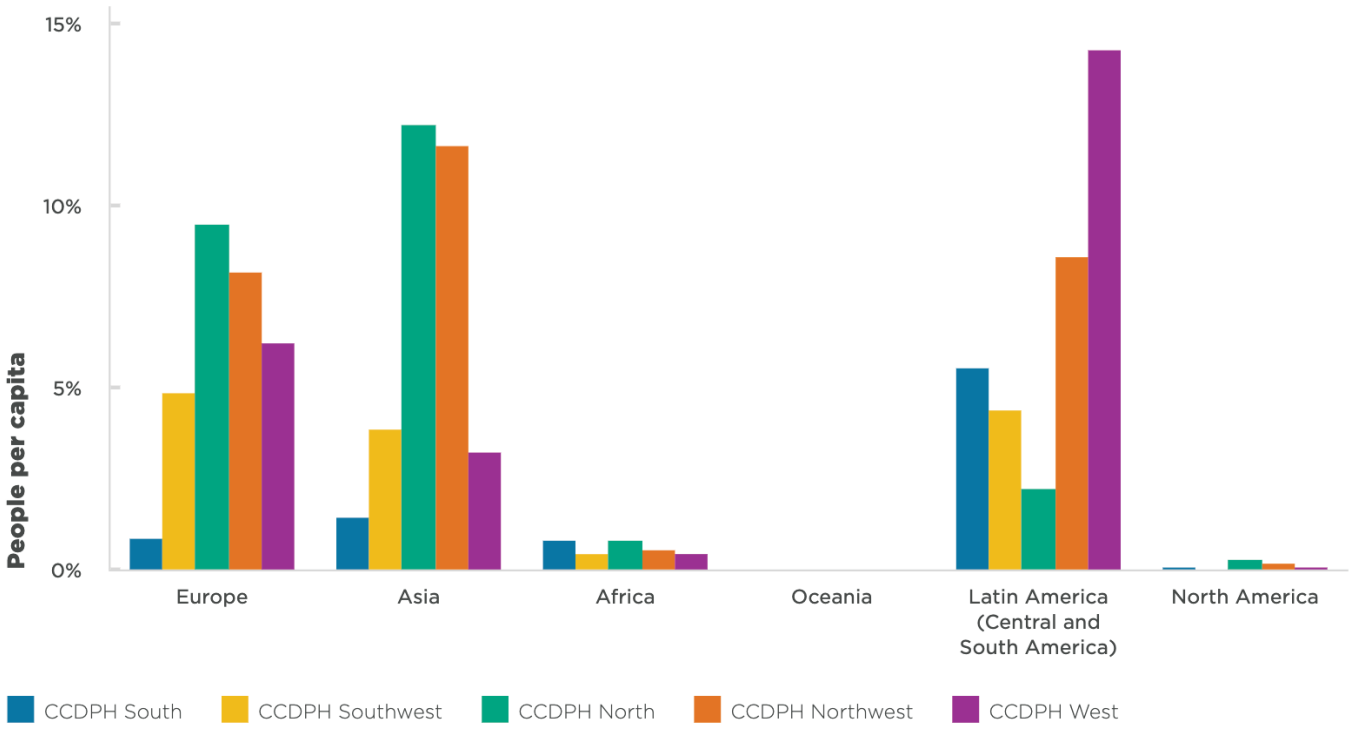


Sources: US Census Bureau ACS 5-year 2018-2022

The data shows differences in the foreign-born population by CCDPH Districts.

- In CCDPH South, the majority of foreign-born individuals are from Latin America, particularly Central and South America, while in CCDPH Northwest, there are significant numbers from Europe and Latin America.
- Across all regions, the presence of foreign-born individuals from North America is limited, with the highest percentage in CCDPH North.
- Asia has a notable presence in all regions, with higher concentrations in the northern areas like CCDPH North and CCDPH Northwest.
- Oceania has the least representation across all regions, with minimal or no presence in most areas.

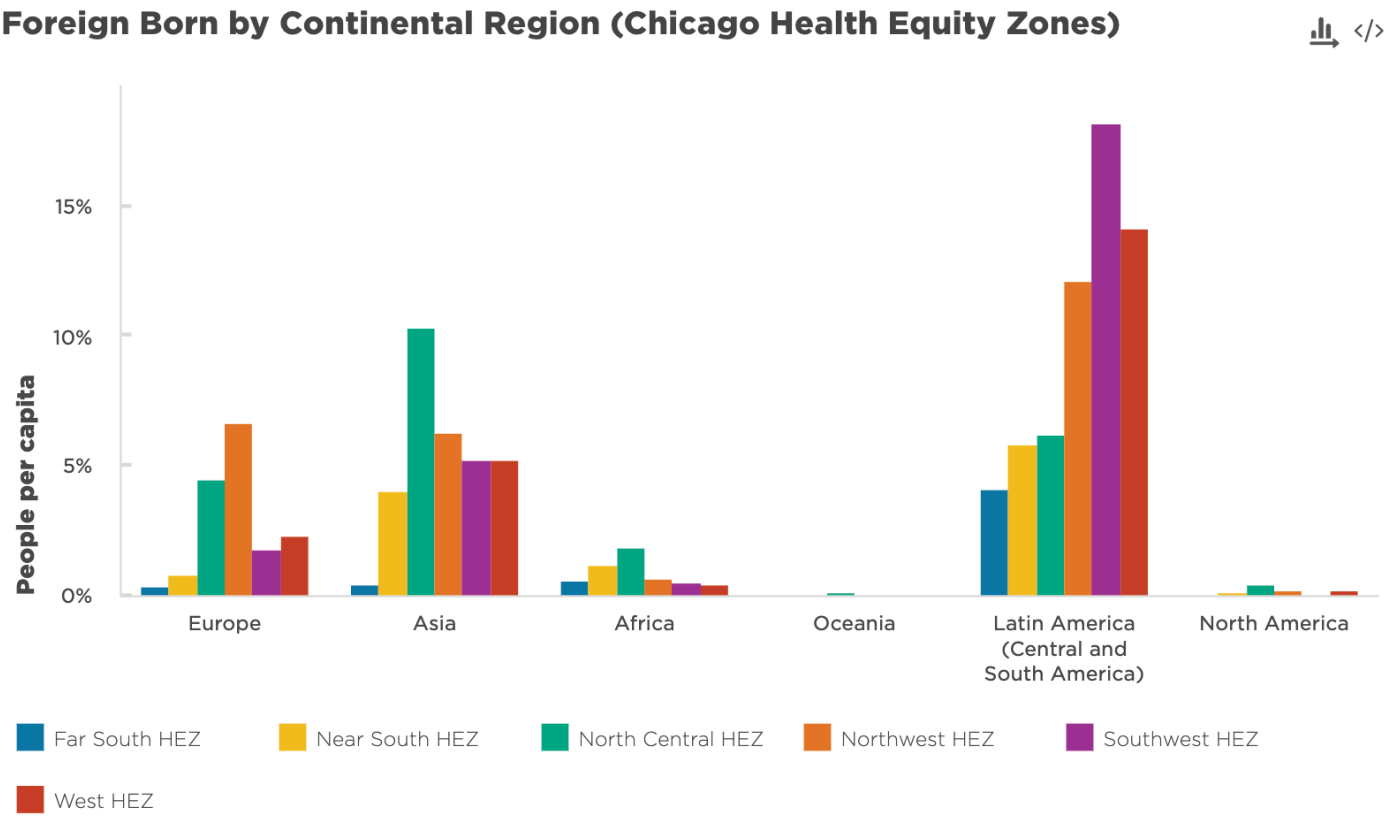
Foreign Born by Continental Region



Sources: US Census Bureau ACS 5-year 2018-2022

The graph below includes the percentage of foreign-born people from different continental regions in various Health Equity Zones in Chicago.

- Across the HEZs, the highest percentages of foreign-born individuals are from Latin America (Central and South America) and Asia.
- In the North Central HEZ, the highest percentage of foreign-born individuals are from Asia, while in the Northwest HEZ, the highest percentage are from Europe.



Sources: US Census Bureau ACS 5-year 2018-2022

Language

Spoken language and English proficiency are crucial factors in accessing behavioral health services and achieving positive outcomes. Limited English proficiency can create significant barriers to communication with healthcare providers, leading to misunderstandings, misdiagnoses, and inadequate treatment. Moreover, language barriers may exacerbate feelings of isolation, cultural disconnect, and stigma surrounding mental health issues within immigrant and non-English-speaking communities.

Language Spoken at Home by Population 5 Years of Age and Older

Geography	Language Spoken at Home - English Only per capita over 5	Language Spoken at Home - Spanish per capita over 5	Language Spoken at Home - Other Indo-European per capita over 5	Language Spoken at Home - Asian-Pacific Islander per capita over 5	Language Spoken at Home - Other per capita over 5
Illinois	76.6%	13.6%	5.6%	3%	1.1%
Cook County, IL	64.8%	20.7%	8.4%	4.2%	1.9%
Chicago, IL	64.8%	23.5%	6%	4.2%	1.5%

Sources: US Census Bureau ACS 5-year 2018-2022

The chart below includes languages spoken by CCDPH Districts.

- Overall, CCDPH South has the highest percentage of people speaking only English at home, while CCDPH West has the highest percentage of Spanish speakers. CCDPH Northwest stands out with a more even distribution of different language speakers compared to the other areas.

- In terms of diversity of languages spoken, CCDPH South has the least variety, with a high concentration on English speakers. CCDPH Northwest has a more diverse language profile with significant numbers of Indo-European, Asian-Pacific Islander, and other language speakers.

Geography	Language Spoken at Home - English Only per capita over 5	Language Spoken at Home - Spanish per capita over 5	Language Spoken at Home - Other Indo-European per capita over 5	Language Spoken at Home - Asian-Pacific Islander per capita over 5	Language Spoken at Home - Other per capita over 5
CCDPH South	83.7%	12%	1.9%	0.8%	1.6%
CCDPH South-west	76.3%	10.5%	7.8%	1.2%	4.2%
CCDPH North	66.5%	5.1%	17.1%	8.3%	3%
CCDPH North-west	57.6%	16.8%	16.8%	7.5%	1.3%
CCDPH West	54.7%	32.6%	9.5%	2.3%	0.9%

Sources: US Census Bureau ACS 5-year 2018-2022

Language Spoken at Home by Population 5 Years of Age and Older (Chicago Health Equity Zones)

When looking at the language spoken at home in different Health Equity Zones, you can see variations in the percentages of languages spoken.

- In the Far South HEZ, the majority of people speak English only, with a high percentage of 88% compared to other languages.
- Meanwhile, in the Southwest HEZ, there is a more even distribution between English and Spanish spoken at home, with 48% and 42% respectively.
- In the North Central HEZ, English is predominantly spoken at 68%, but there is a lower percentage of Spanish speakers at 13%.

Geography	Language Spoken at Home - English Only per capita over 5	Language Spoken at Home - Spanish per capita over 5	Language Spoken at Home - Other Indo-European per capita over 5	Language Spoken at Home - Asian-Pacific Islander per capita over 5	Language Spoken at Home - Other per capita over 5
West HEZ	57.9%	32.2%	4%	5.1%	0.7%
Southwest HEZ	48.2%	42%	3%	6%	0.8%
Northwest HEZ	54.2%	28.9%	10.5%	4.7%	1.6%
North Central HEZ	68.1%	12.5%	9.2%	7.6%	2.7%
Near South HEZ	78.8%	13.3%	2.4%	4.2%	1.3%
Far South HEZ	88%	9.6%	1.2%	0.4%	0.8%

Sources: US Census Bureau ACS 5-year 2018-2022

Education

Education is a fundamental pillar of society, empowering individuals and fostering social and economic development. Educational attainment also plays a vital role in behavioral health outcomes, with higher levels of education often associated with better mental well-being. Education provides individuals with valuable resources and coping skills to navigate life stressors effectively, fostering resilience and psychological empowerment. Conversely, lower educational attainment can be linked to increased susceptibility to mental health challenges due to limited access to opportunities, socioeconomic disadvantages, and reduced health literacy.

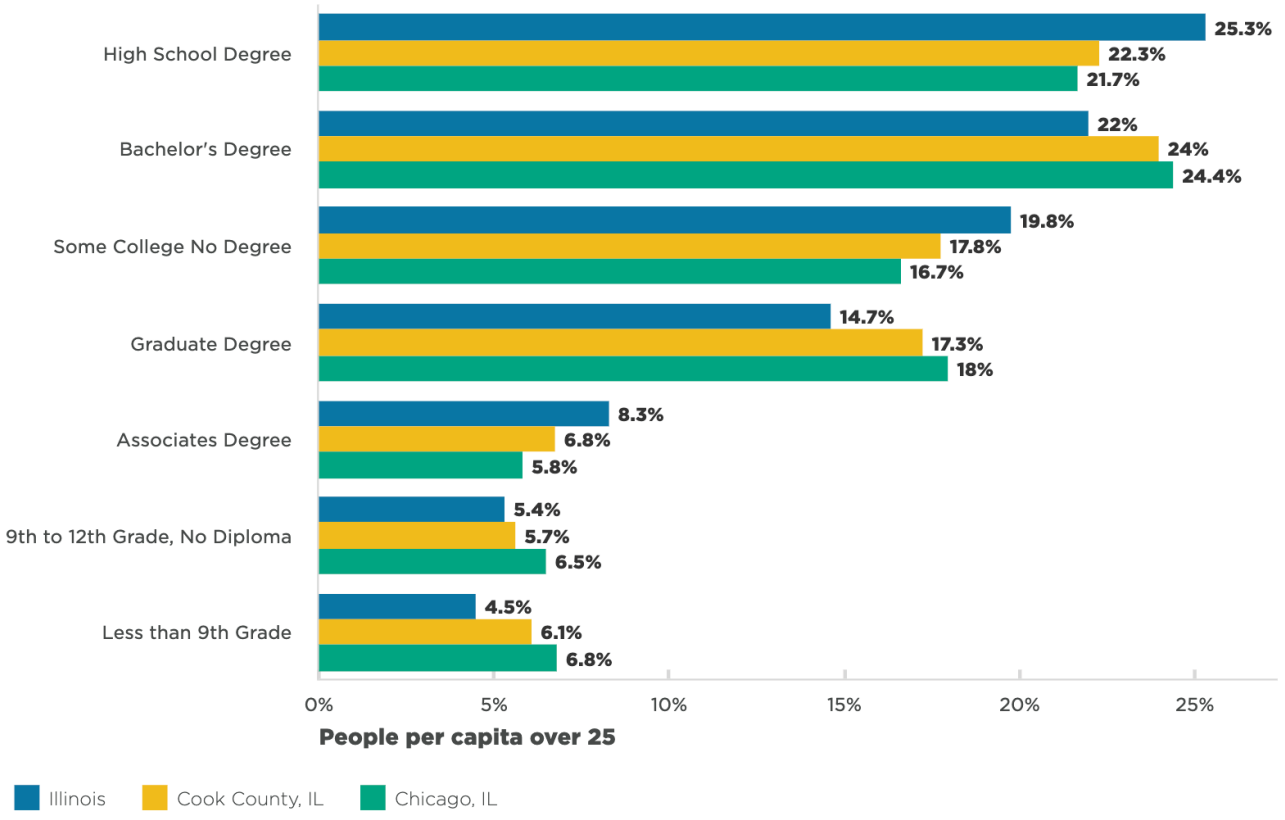
Looking at the data on educational attainment in Illinois, Cook County, and Chicago, we can gain valuable insights into how these communities are meeting this vital need.

In Illinois, there is a diverse range of educational attainment levels, with a significant percentage of people holding high school degrees and some college education. However, there are also notable gaps, with a portion of the population not completing high school or having advanced degrees.

When we narrow our focus to Cook County, we see a similar trend, with a higher percentage of individuals holding high school degrees compared to the state average. However, there is still room for improvement, as there is a significant portion of the population who have not completed high school or have advanced degrees.

In Chicago, while there has been progress in educational attainment, there are still pockets of inequity. A higher percentage of the population has not completed high school compared to the county and state averages. However, there are also relatively higher percentages of individuals with bachelor's and graduate degrees.

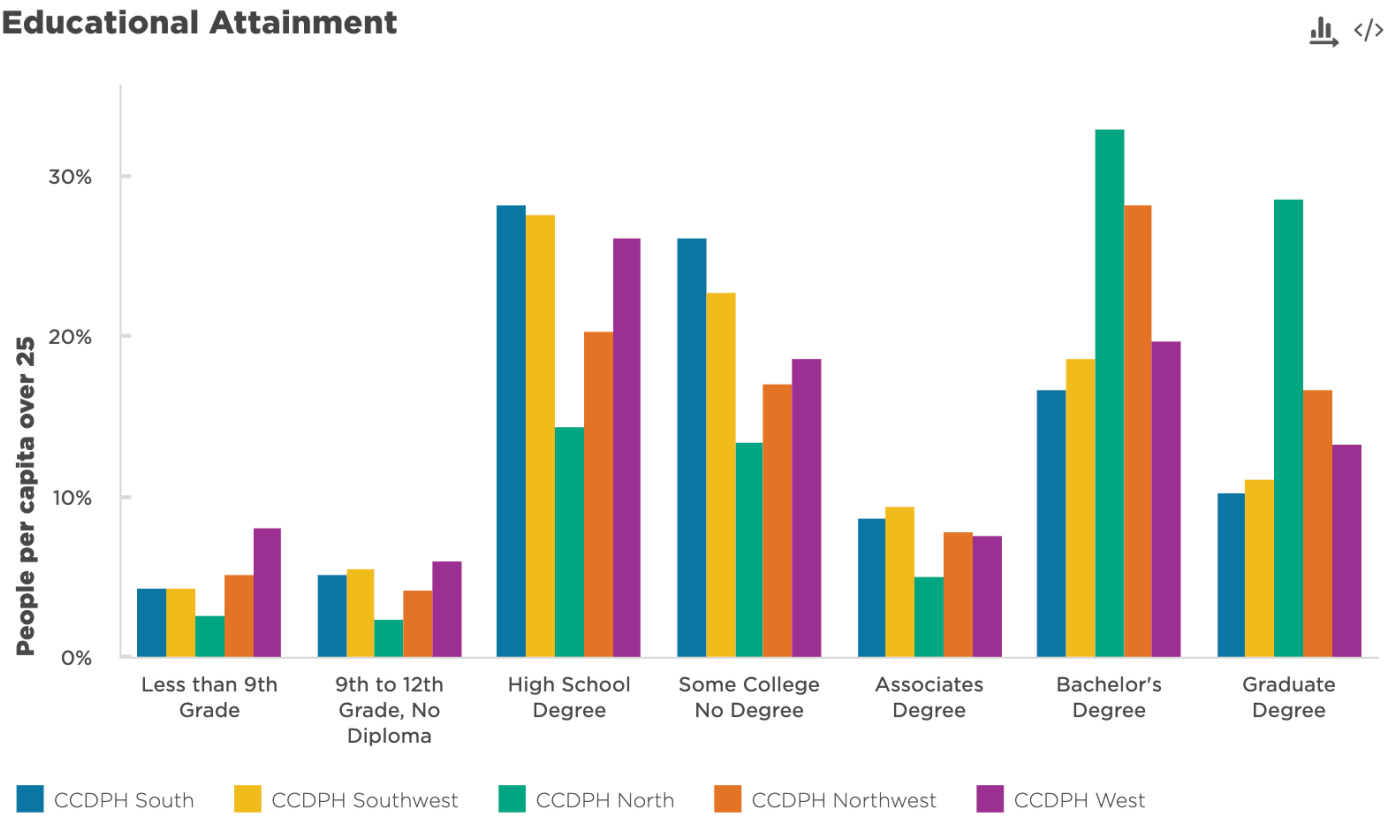
Educational Attainment



Sources: US Census Bureau ACS 5-year 2018-2022

The chart below compares the educational attainment of people over 25 in the various CCDPH regions.

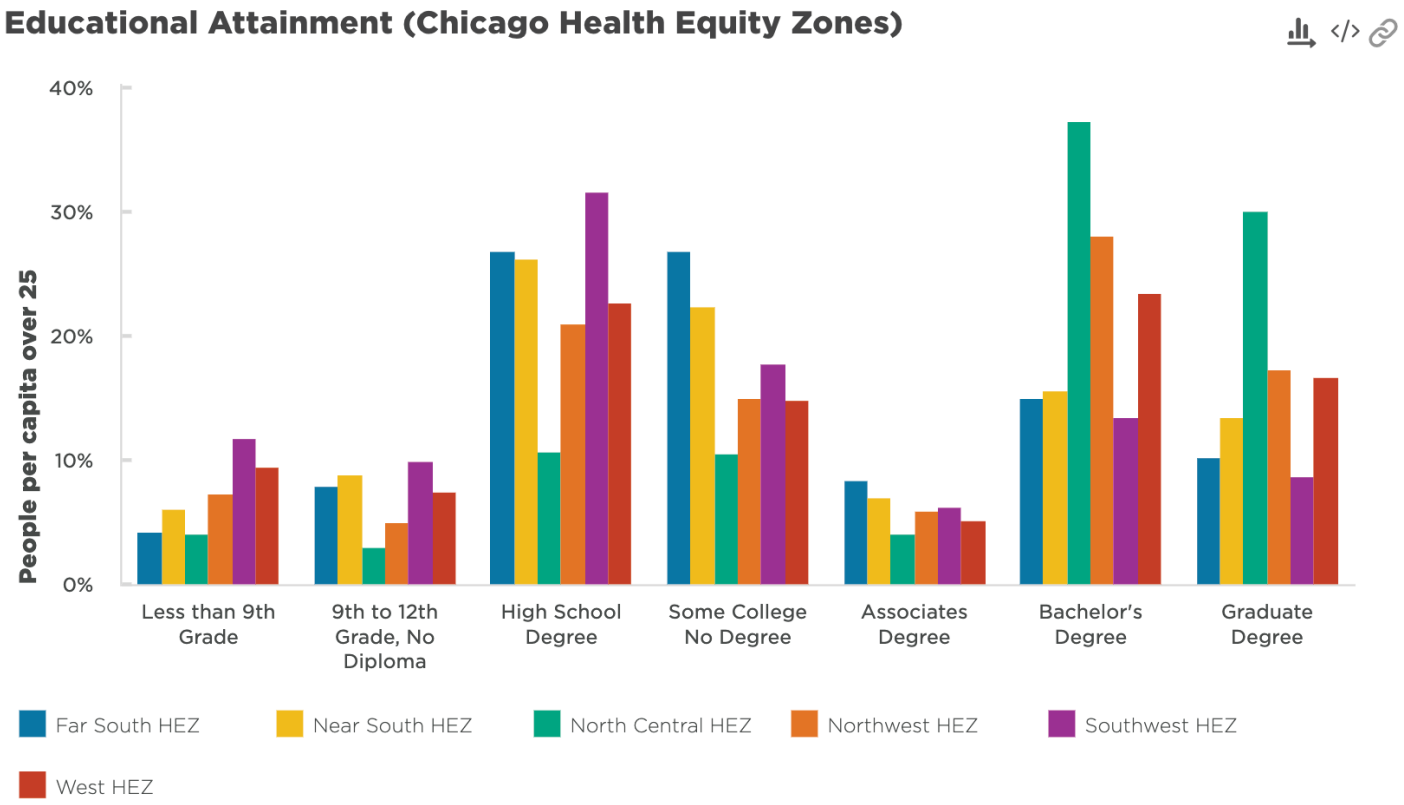
- In the CCDPH North region, a smaller percentage of people have less than a 9th-grade education compared to other regions. The CCDPH West region has the highest percentage of people with less than a 9th-grade education.
- When it comes to “Bachelor’s Degree” and “Graduate Degree” attainment, the CCDPH North region stands out with the highest percentages, showing a higher rate of higher education compared to other regions. In contrast, the CCDPH Southwest region has lower percentages of people with Bachelor’s and Graduate Degrees.



Sources: US Census Bureau ACS 5-year 2018-2022

The data from the chart shows the educational attainment of people over 25 in different Health Equity Zones in Chicago.

- The North Central HEZ has the lowest percentage of people with less than a high school diploma (7.3%), while the Southwest HEZ has the highest percentage (21.8%).
- The North Central HEZ also has the highest percentage of people with a graduate degree (30.0%), while the Far South HEZ has the lowest percentage (10.3%)



Sources: US Census Bureau ACS 5-year 2018-2022

Employment

Employment status is intricately linked to behavioral health, serving as both a determinant and an outcome of mental well-being. Meaningful employment can provide individuals with a sense of purpose, financial stability, and social connections, which are protective factors against mental health issues such as depression and anxiety. Conversely, unemployment or precarious employment situations can lead to increased stress, low self-esteem, and feelings of isolation, contributing to the onset or exacerbation of mental health conditions. Recognizing the bidirectional relationship between employment and behavioral health highlights the importance of supportive workplace environments, job training programs, and policies aimed at reducing unemployment and promoting mental well-being in the workforce.

Labor Market Engagement

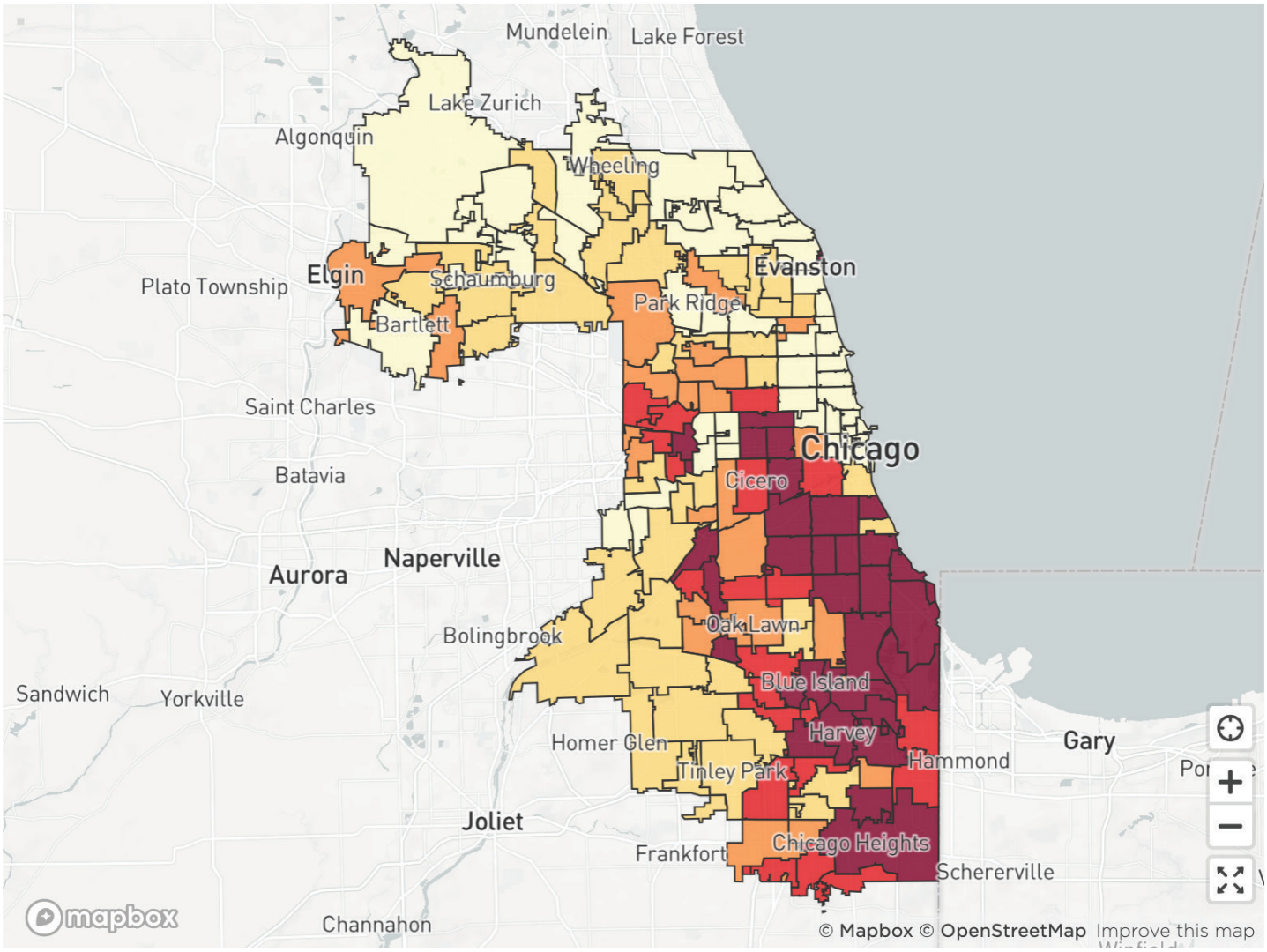
The labor market engagement index (LMEI) measures how engaged residents are in the local labor market. The LMEI is calculated using a formula provided by U.S. Department of Housing and Urban Development, and is based on the level of employment, labor force participation, and educational attainment (percent with a bachelor's degree or higher) in a geography. The value displayed is the national percentile ranking, higher scores are better.

A higher labor market engagement score (closer to 100) indicates a strong level of participation in the labor market, with high employment rates and workforce engagement. Lower market engagement scores indicate that individuals in these areas may be experiencing barriers to employment, such as limited job opportunities, skills gaps, or other socioeconomic factors that hinder labor market engagement. Disparities in labor market engagement have important implications. Areas with high labor market engagement likely benefit from a strong economy, job availability, and greater access to opportunity. On the other hand, communities with low labor market engagement may face challenges related to poverty, limited economic mobility, and inequality.

The data reveals significant disparities in labor market engagement across different areas. Some areas, represented by ZIP codes like 60601, 60603, 60606, 60613, and 60622, have a Labor Market Engagement Index of 100, indicating high levels of labor market participation and engagement.

However, there are areas with much lower labor market engagement. ZIP codes like 60208, 60636, 60621, 60624, and 60644 have indexes as low as 1, 3, 4, 4, and 5 respectively, indicating limited access to employment and economic opportunities.

Labor Market Engagement Index



Labor Market Engagement Index

- 1 – <27
- 27 – <49
- 49 – <71
- 71 – <89
- 89 – 100

Sources: US Census Bureau ACS 5-year 2018-2022

Labor Force

Labor force participation displays the number of residents over 16 who are either employed or unemployed and have been actively looking for a job in the past 4 weeks at the time of the survey (the reference week). Labor force participation is often used as a local labor market and economic health indicator. It helps us understand if there are adequate employment opportunities for residents.

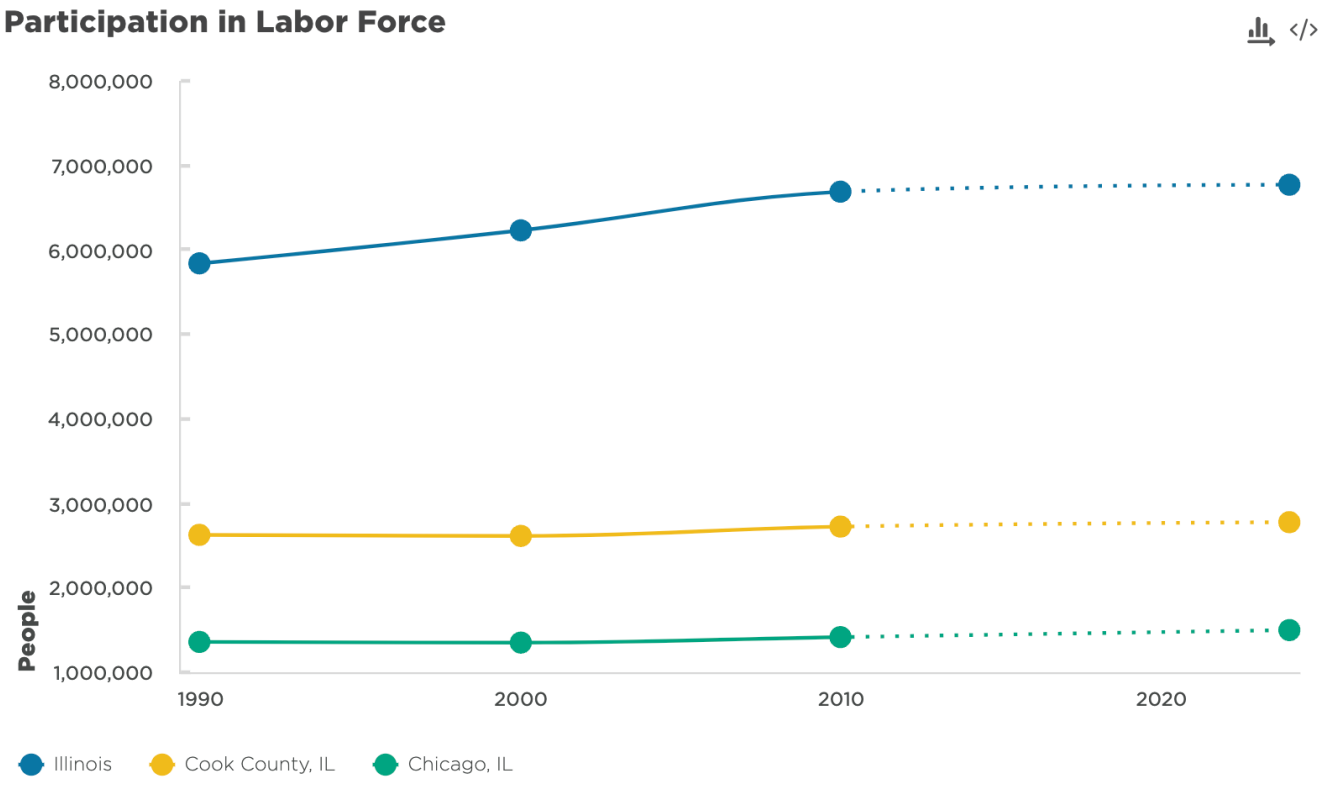
This section also shows the total number of unemployed and employed persons 16 and over. This information is useful for understanding the overall employment status of an area.

The Census Bureau provides a definition for unemployed persons:

> Civilians 16 years old and over are classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to accept a job.

The data on labor force participation reveals some interesting trends. From 1990 to 2010, there was an overall increase in the number of people in the labor force in Illinois, Cook County, and Chicago. However, starting from 2018, the data shows a more steady and incremental growth in the labor force across these areas.

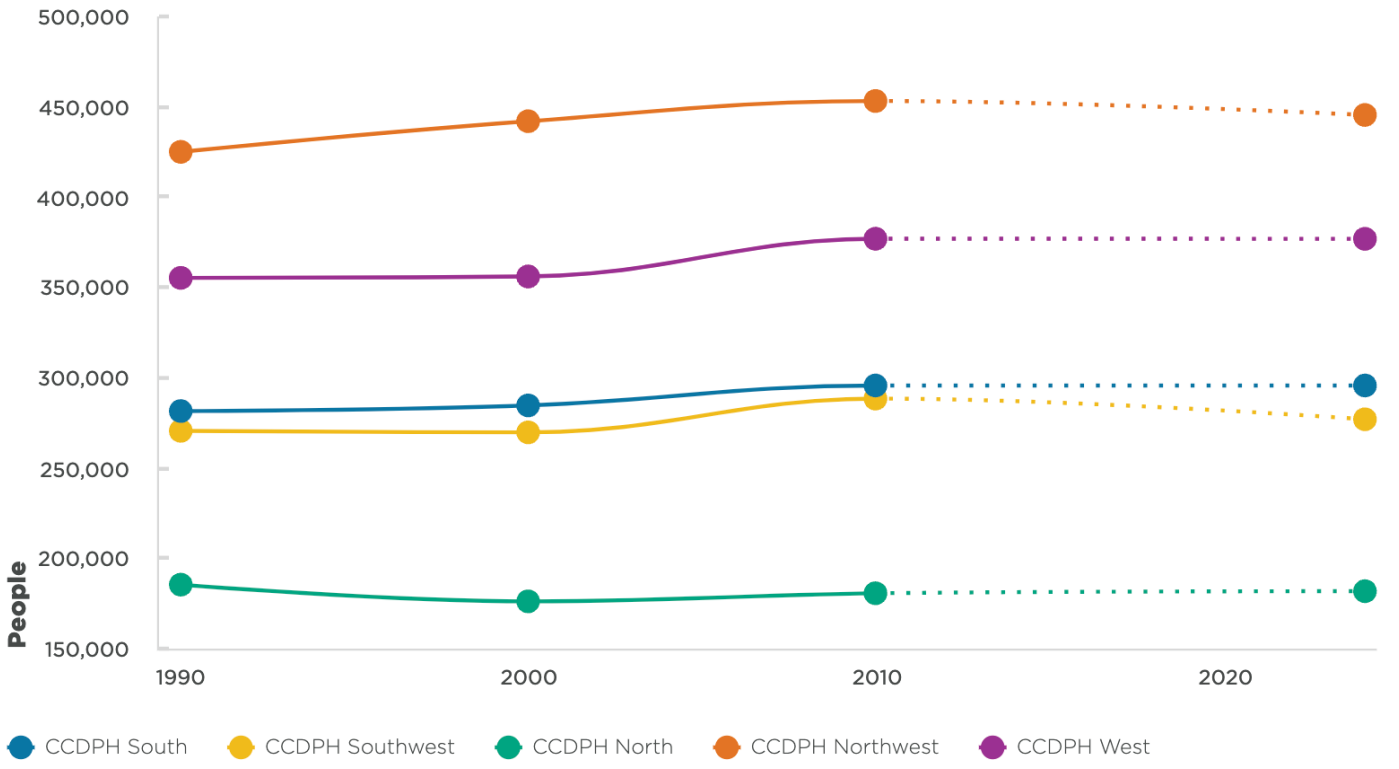
This suggests that while there was significant growth in the labor force in the past, the rate of growth has slowed down in recent years. This may have implications for job opportunities and economic development in the future. It's important to note that this data does not explain the reasons behind these trends, but it does provide a starting point for further investigation and discussion.



Sources: US Census Bureau; US Census Bureau ACS 5-year

The data shows the number of people in the labor force for different CCDPH regions at various points in time. Over the years, there has been a general increase in the number of people in the labor force across all regions, with some fluctuations. Over time, the gap between the regions with the highest and lowest numbers of people in the labor force has narrowed, but CCDPH Northwest still has the highest number while CCDPH North remains the lowest.

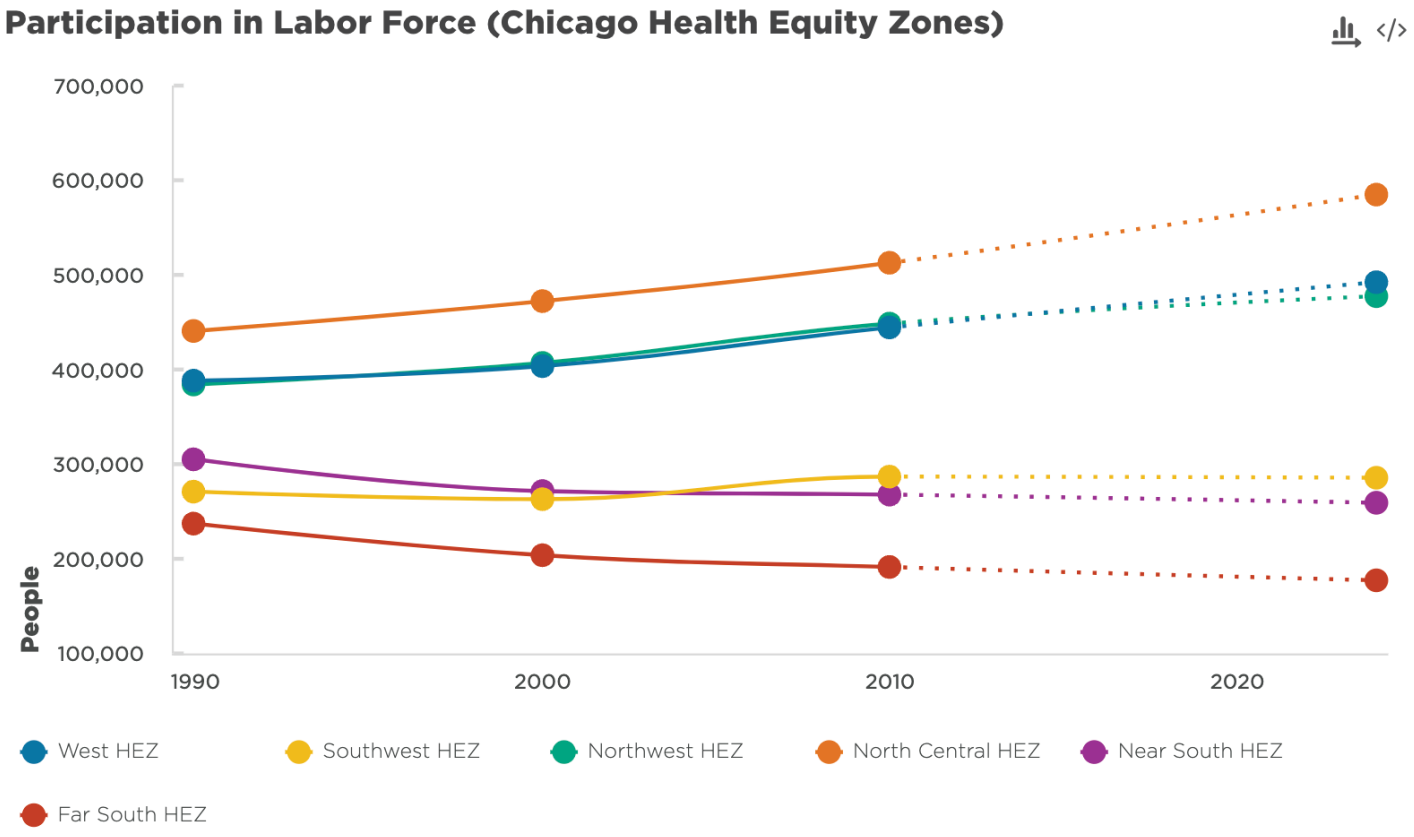
Participation in Labor Force



Sources: US Census Bureau; US Census Bureau ACS 5-year

The chart below shows the number of people in the labor force in different Chicago Health Equity Zones over the years.

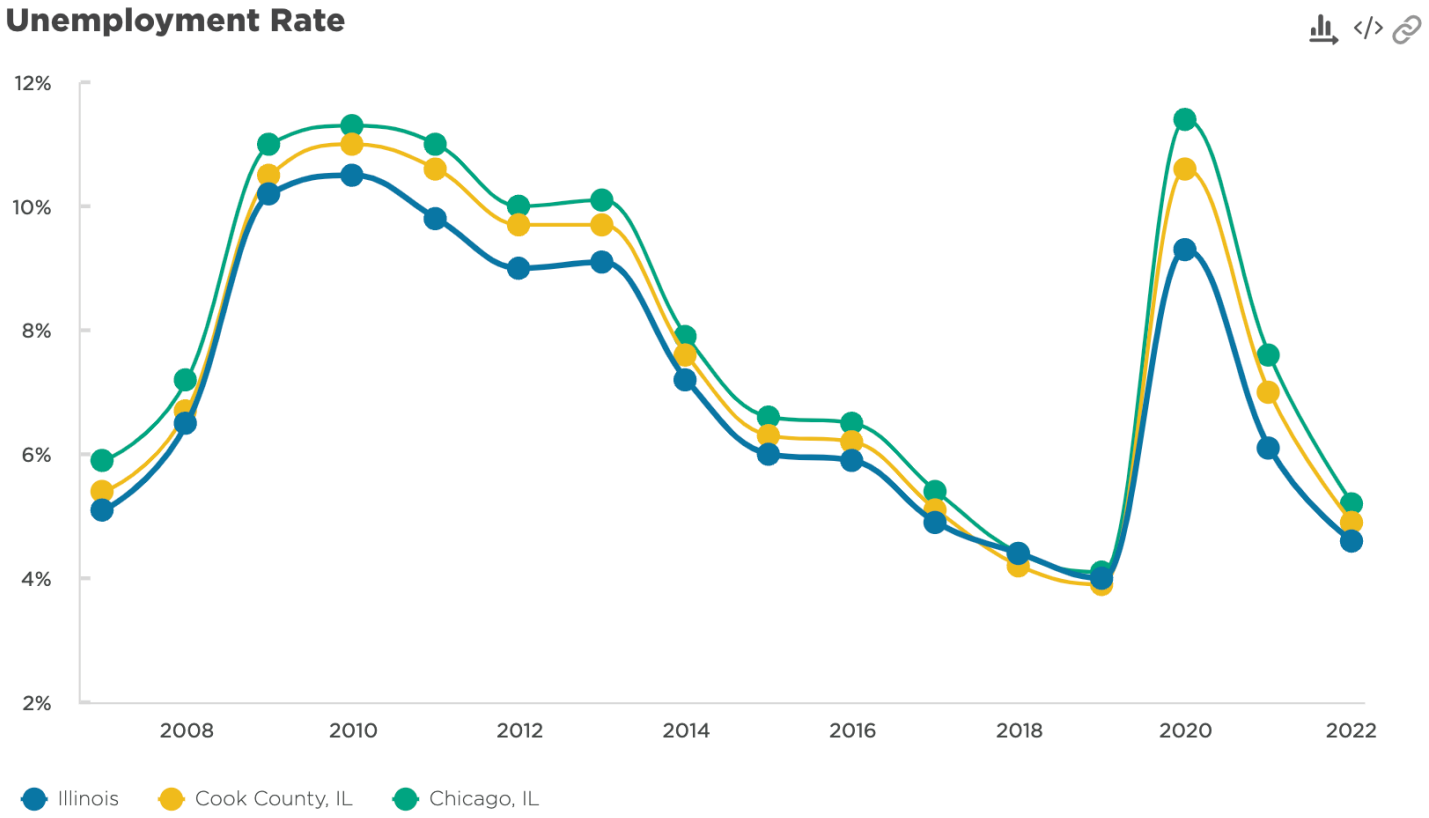
- In the West HEZ, the number of people in the labor force has been consistently increasing since 1990, with the highest numbers in all years compared to other zones.
- The Far South HEZ has had the lowest number of people in the labor force across all years, showing a general decline over time.
- The North Central HEZ has experienced significant growth in labor force participation, surpassing all other zones in numbers in recent years.



Sources: US Census Bureau; US Census Bureau ACS 5-year

Unemployment

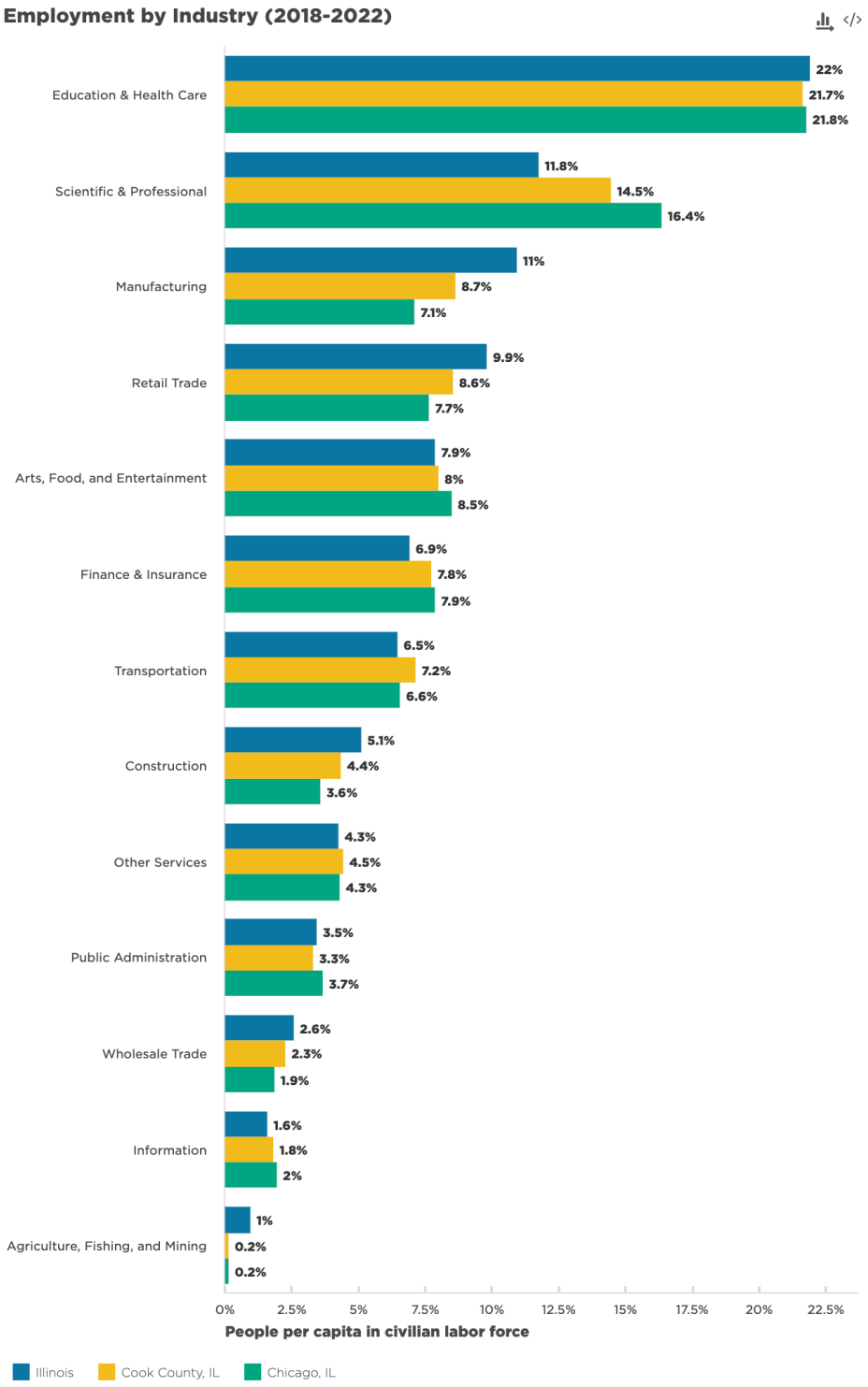
The data on unemployment rates from 2007 to 2022 shows fluctuations over time in different areas. In Illinois, Cook County, and Chicago, the rates vary but follow a similar trend overall.



Sources: BLS LAUS

Employment Types

The data shows the distribution of employment industries in Cook County, IL from 2018-2022. The industries with the highest number of people employed are Education & Health Care, Arts, Food, and Entertainment, and Public Administration. On the other hand, Agriculture, Fishing, and Mining have the lowest number of people employed.



Sources: US Census Bureau ACS 5-year 2018-2022

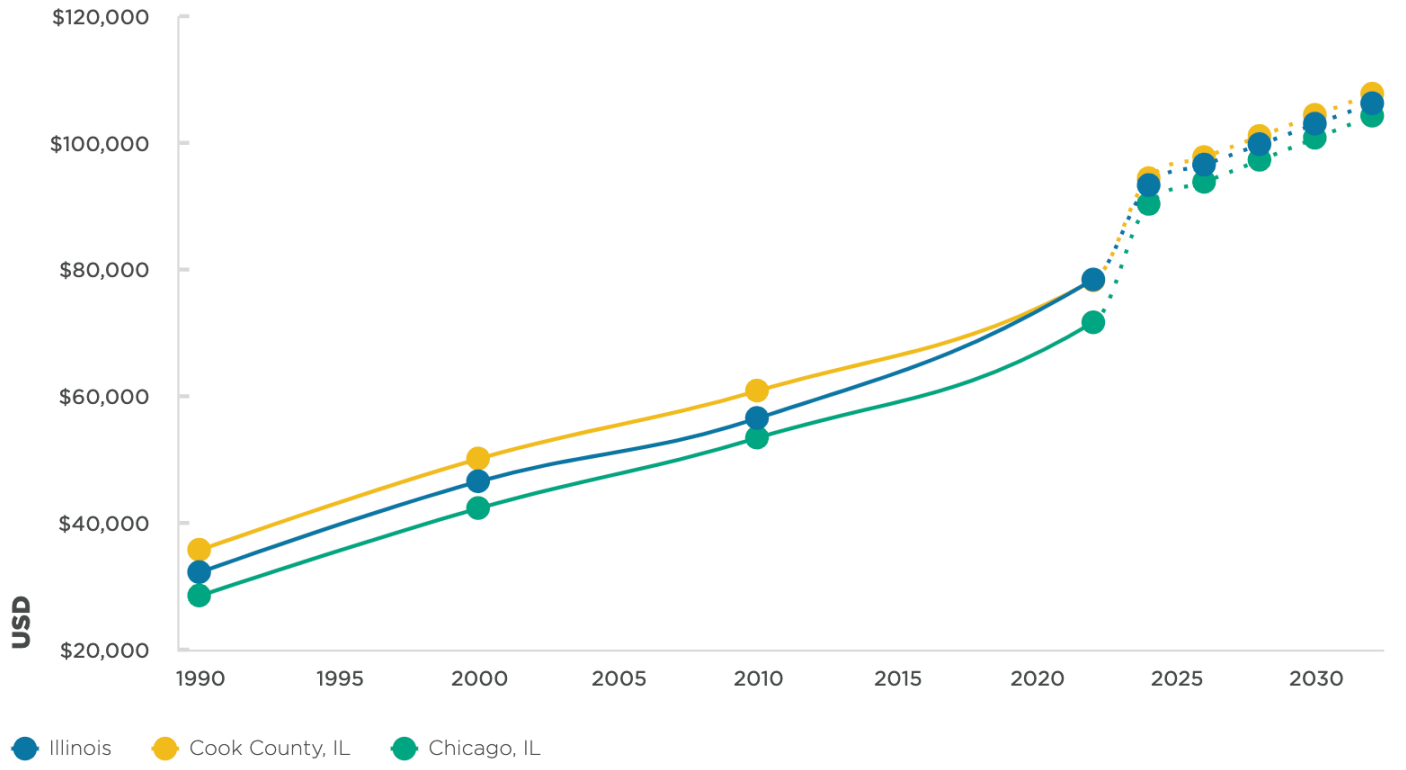
Income and Poverty

Income is closely tied to behavioral health, with socioeconomic status serving as a significant determinant of mental well-being. Higher income levels often provide individuals with greater access to resources such as healthcare, education, and housing, which can buffer against stressors and promote resilience. Conversely, lower income or economic instability can contribute to chronic stress, material deprivation, and limited access to mental health services, increasing the risk of conditions like depression, substance abuse, and anxiety disorders.

The data on median household income shows a clear upward trend over the years for different geographies within Illinois. In 1990, Chicago had the lowest median household income at $28,416. By 2031, Chicago's median household income increased to $95,046, narrowing the gap with other areas.

Cook County and Illinois followed similar trajectories, with Cook County consistently higher, reflecting urban and suburban differences.

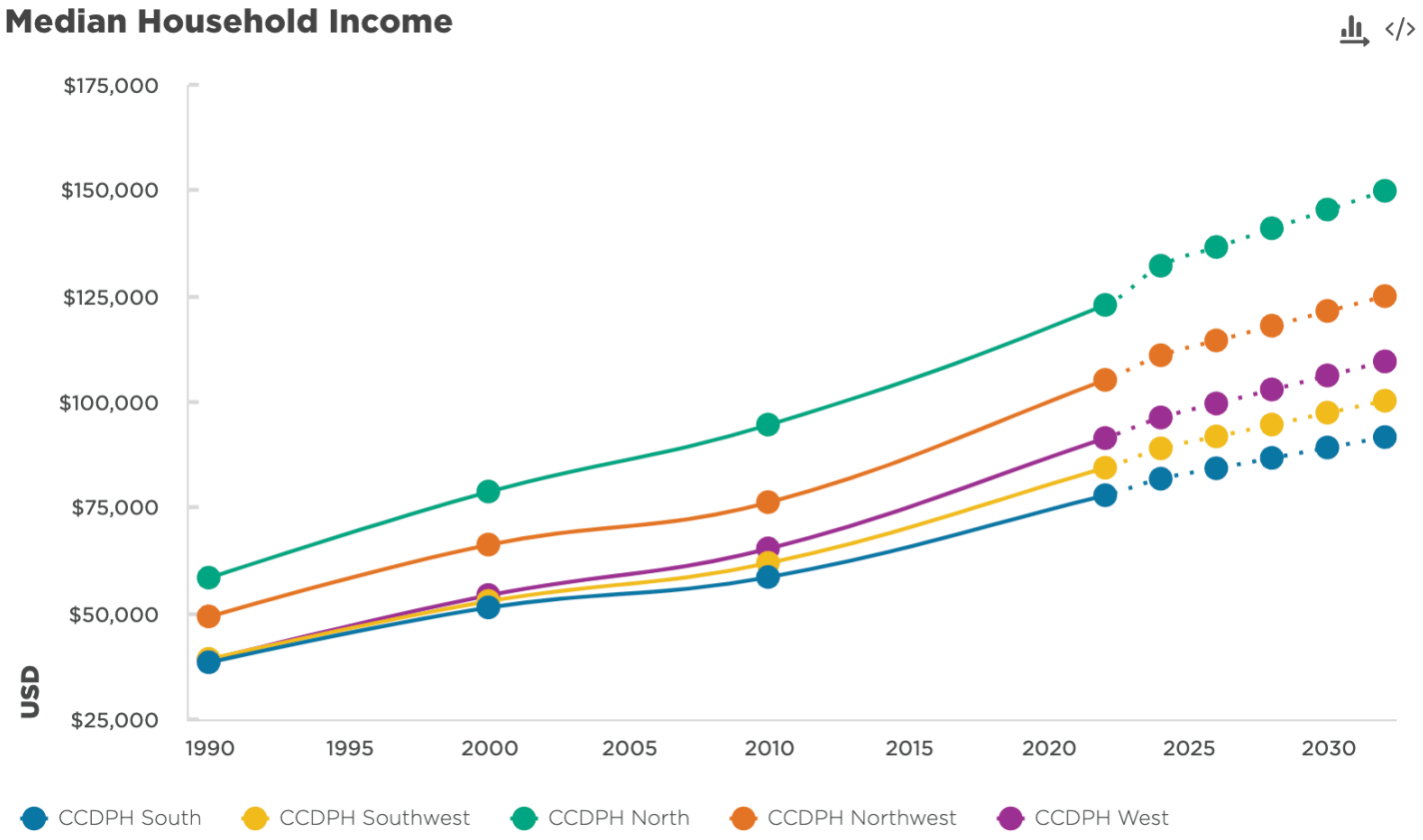
Median Household Income



Sources: US Census Bureau; US Census Bureau ACS 5-year

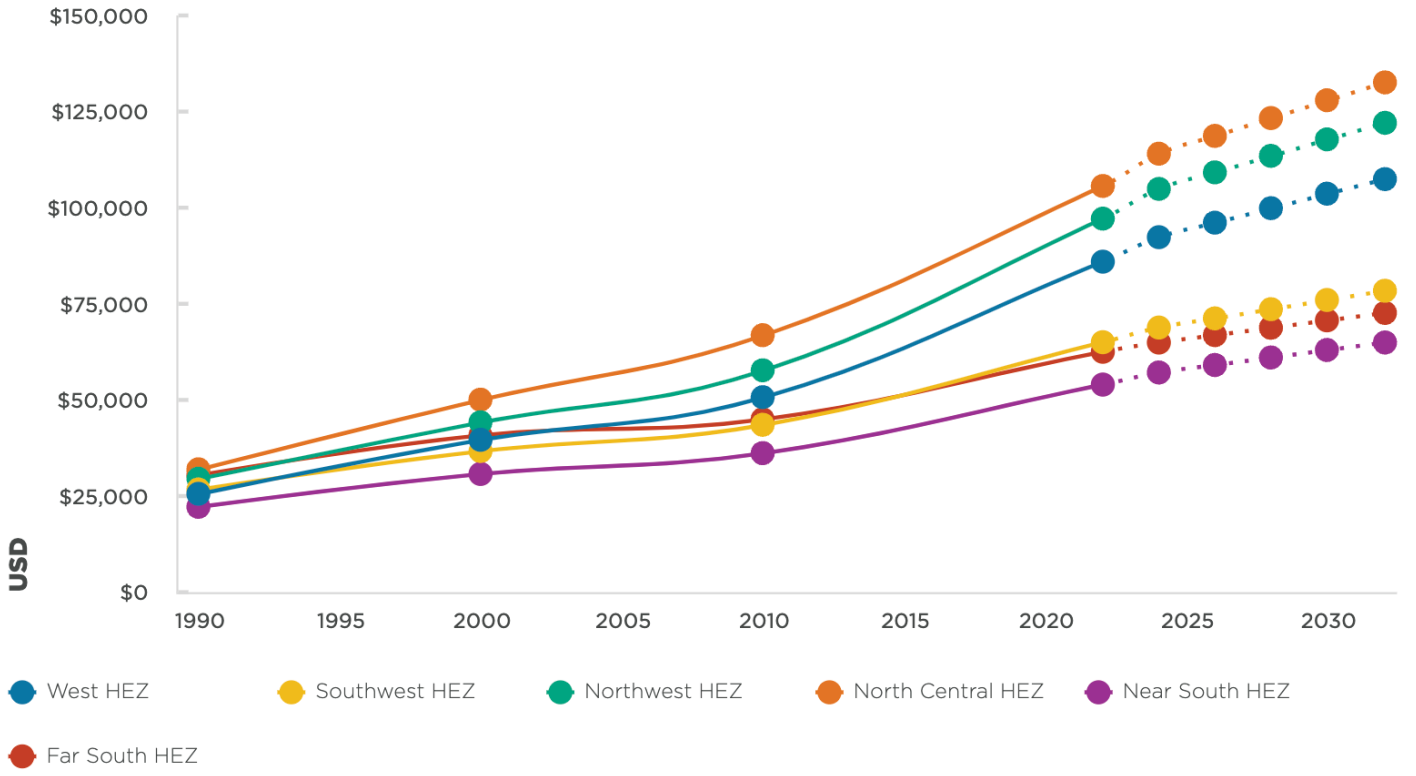
The chart below shows median household income by CCDPH Planning District.

- In 1990, CCDPH North had the highest median household income at $58,498, while CCDPH South had the lowest at $38,495. By 2010, the income for all areas had increased, with CCDPH North still leading at $94,673 and CCDPH South showing growth to $58,643.
- From 2018 to the 2031 projection, we observe a continuing increase in median household incomes for all areas. CCDPH North consistently maintains the highest income, reaching an estimated $139,302 in 2031. On the other hand, CCDPH South consistently has the lowest income, increasing to $83,475 by 2031.



Sources: US Census Bureau; US Census Bureau ACS 5-year

Median Household Income (Chicago Health Equity Zones)



Sources: US Census Bureau; US Census Bureau ACS 5-year

Poverty

In Chicago, 16.6% of households are below the poverty level, with 24.1% of young people under 18 in poverty. Among those 65 and older, 16.6% live in poverty. Families with children experience poverty at a rate of 22.6%. Foreign-born individuals in poverty make up 16% of the population, while 4.2% of those below the poverty line are employed. Percentages are higher than the state in both Cook County and the City of Chicago.

Geography	Total Households Below Poverty Level	People Below Poverty Level - Age Under 18	People Below Poverty Level - Age 65 and Over	Family Below Poverty Level - with Children	Below Poverty Level and Foreign Born	Below Poverty Level and Employed
Illinois	12%	15.6%	9.4%	14%	11.9%	3.2%
Cook County, IL	13.5%	18.3%	12.1%	16.7%	12.9%	3.3%
Chicago, IL	16.6%	24.1%	16.6%	22.6%	16%	4.2%

Sources: US Census Bureau ACS 5-year 2018-2022

Across CCDPH Districts, you can see variations in poverty levels.

- In CCDPH South and CCDPH Southwest, the percent of total households living below the poverty level are higher compared to CCDPH North and CCDPH Northwest.
- The percentage of people under 18 living in poverty are highest in CCDPH South, while CCDPH North has the lowest percentage.
- The percentage of older adults living in poverty is more prominent in CCDPH South.
- The percentage of families with children below the poverty level are highest in CCDPH South and CCDPH Southwest.
- The percentage of foreign-born people living in poverty is similar across regions, with a slightly higher percentage in CCDPH South.

Geography	Total House-holds Below Poverty Level	People Below Poverty Level - Age Under 18	People Below Poverty Level - Age 65 and Over	Family Below Poverty Level - with Children	Below Poverty Level and Foreign Born	Below Poverty Level and Employed
CCDPH South	14.1%	21.6%	11.1%	19.9%	13.7%	3.2%
CCDPH South-west	12.1%	17%	9.9%	16.2%	12.3%	2.7%
CCDPH North	6.8%	6.8%	6.7%	6%	8.2%	1.5%
CCDPH North-west	7.4%	10.1%	7.1%	8.6%	8.8%	2.1%
CCDPH West	9.2%	11.1%	8.6%	10.8%	9.8%	2.3%

Sources: US Census Bureau ACS 5-year 2018-2022

Poverty by Population Characteristics (Chicago Health Equity Zones)

Between 2018-2022, there were similarities and differences in the percent of populations living in poverty among Chicago Health Equity Zones.

- The Near South HEZ has the highest percentage of total households living below the poverty level at 26%, compared to Northwest HEZ with the lowest percentage at 11%.
- The rates for people over 65 in poverty are similar across areas, with the North Central HEZ at 15.5% and the Southwest HEZ at 16.9%.
- When it comes to families with children living in poverty, the Near South HEZ has the highest rate at 35.6%, while the Northwest HEZ has the lowest at 13.0%.

Geography	Total Households Below Poverty Level	People Below Poverty Level - Age Under 18	People Below Poverty Level - Age 65 and Over	Family Below Poverty Level - with Children	Below Poverty Level and Foreign Born	Below Poverty Level and Employed
Far South HEZ	21%	29.9%	15.1%	31.4%	17.5%	4.1%
Near South HEZ	26.3%	36.2%	22%	35.6%	23.2%	5.6%
North Central HEZ	11.8%	15.2%	15.5%	12.6%	17.2%	3.7%
Northwest HEZ	11%	14.6%	12.7%	13%	13.2%	3.1%
Southwest HEZ	18%	25%	16.9%	25.2%	16.2%	4.1%
West HEZ	17.2%	26.3%	17.5%	25.4%	16.2%	4.3%

Sources: US Census Bureau ACS 5-year 2018-2022

Social Determinants of Health

The link between social determinants of health and behavioral health outcomes is intrinsic and profound, shaping individuals' mental well-being and behavioral patterns in many ways. Factors such as socioeconomic status, education, employment, housing, social support networks, and access to healthcare services exert significant influence on behavioral health. Lower socioeconomic status often correlates with higher levels of stress due to financial strain and limited resources, fostering conditions that create or exacerbate mental health challenges like depression and anxiety, as well as maladaptive coping mechanisms such as substance abuse. Education plays a pivotal role in mental well-being, offering avenues for employment, higher income, and access to resources. Employment status and working conditions can significantly impact mental health, with unemployment or stressful jobs contributing to negative outcomes. Moreover, living in disadvantaged neighborhoods with inadequate housing and limited access to healthcare exacerbates behavioral health challenges. Recognizing and addressing these social determinants is essential for fostering healthier communities and reducing health disparities.

Household and Family Composition

Household and family composition can significantly influence behavioral health outcomes, as the dynamics within a household shape individuals' experiences and support systems. Stable and supportive family structures can provide a buffer against stressors and promote mental well-being, fostering resilience and emotional security. Conversely, households characterized by instability, conflict, or lack of support may increase the risk of adverse mental health outcomes, particularly among vulnerable populations such as children and older adults.

Parenting is a difficult task for anyone, and even more so for a single parent or grandparent raising a child. The health of caregivers and children can suffer because of the stress, increasing the risk for some chronic diseases or mental health issues. Single parents struggle more financially than families with more than one parent, affecting every area of life including health. Supporting caregivers in the important task of providing for children helps our entire community thrive.

Household Composition

Illinois, Cook County, and Chicago have varying percentages of family households, households with children, single householder families with and without children, and households with people age 65 and over.

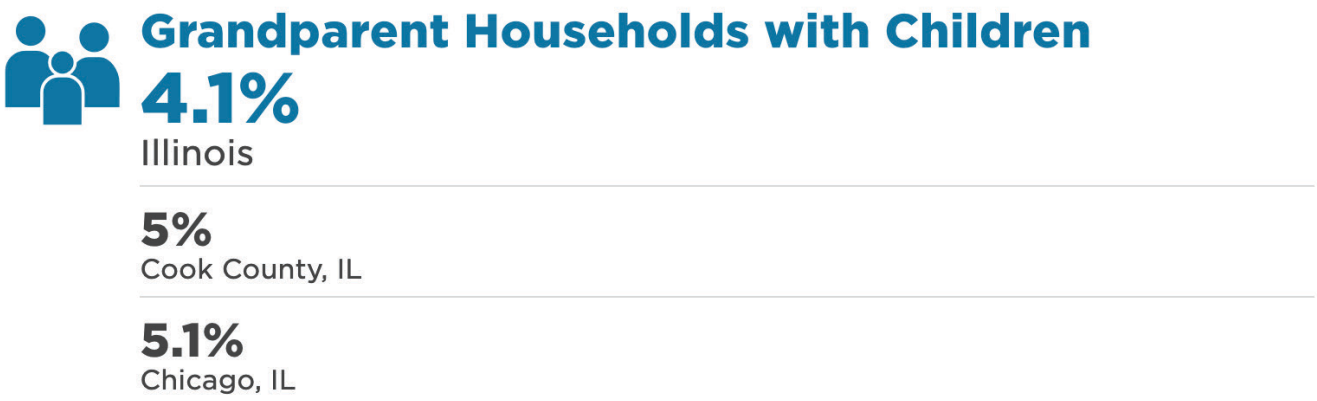
The City of Chicago has the lowest percentage of family households at 51.1%, while the other areas range from 58.6% to 63.7%. Chicago also has the lowest percentage of households with children, at 24.7%. The percentage of single householder families with children are similar across the areas, with percentages ranging from 7.9% to 8.6%.

The percentage of single householder families without children is highest in Cook County at 10.6%, while Chicago has the lowest percentage at 10.9%. Households with people age 65 and over are most prevalent in Illinois at 29.9%. Cook County and Chicago have slightly lower percentages for this category.

Geography	Family House-holds	Households with Children	Single House-holder Families with Children	Single House-holder Families without Children	Households with People Age 65 and Over
Illinois	63.1%	29.5%	8.2%	8.5%	29.9%
Cook County, IL	58.6%	27.8%	8.3%	10.6%	28.5%
Chicago, IL	51.1%	24.7%	8.6%	10.9%	24.7%

Sources: US Census Bureau ACS 5-year 2018-2022

In Illinois, around 4.1% of households have grandparents taking care of children. The percentage is slightly higher in Cook County and the City of Chicago overall (5%).



Sources: US Census Bureau ACS 5-year 2018-2022

By CCDPH Districts, household composition varies.

- In areas like CCDPH North and CCDPH Northwest, a higher percentage of households are family households compared to regions like CCDPH South and CCDPH Southwest. These regions also have a higher percentage of households with children.
- Single householder families with children are more prevalent in CCDPH South and CCDPH Southwest, while CCDPH North and CCDPH Northwest have a lower percentage of these types of households.
- CCDPH North has the highest percentage of households with people over 65 compared to the other regions.

Geography	Family House-holds	Households with Children	Single House-holder Families with Children	Single House-holder Families without Children	Households with People Age 65 and Over
CCDPH South	65.9%	31.8%	12.4%	13.8%	31.9%
CCDPH South-west	66%	30.1%	8.9%	11.7%	34.3%
CCDPH North	71.9%	32.2%	4.9%	6.8%	38.5%
CCDPH North-west	70.4%	32.5%	6.4%	8.1%	30.4%
CCDPH West	69.1%	33.5%	8.7%	11%	31.8%

Household Composition (Chicago Health Equity Zones)

The data from 2018 to 2022 shows differences and similarities in family households among the Chicago Health Equity Zones.

- In the North Central HEZ, only 39.5% of households are family households, the lowest among the regions mentioned. This region also has the lowest percentage of households with children at 16.5%.
- Across all regions, households with people aged 65 and over are quite common, ranging from 17.6% in the North Central HEZ to 35.0% in the Far South HEZ.

Geography	Family House-holds	Households with Children	Single House-holder Families with Children	Single House-holder Families without Children	Households with People Age 65 and Over
West HEZ	51.1%	24.4%	9%	11.1%	22.2%
Southwest HEZ	62.7%	32.5%	11.2%	14.8%	31.2%
Northwest HEZ	58.7%	28.2%	7%	9.9%	23.2%
North Central HEZ	39.5%	16.5%	3.9%	5.1%	17.6%
Near South HEZ	50%	26.1%	13.6%	15.4%	30.6%
Far South HEZ	59.3%	29.2%	14.2%	19.5%	35%

Sources: US Census Bureau ACS 5-year 2018-2022

Housing Trends

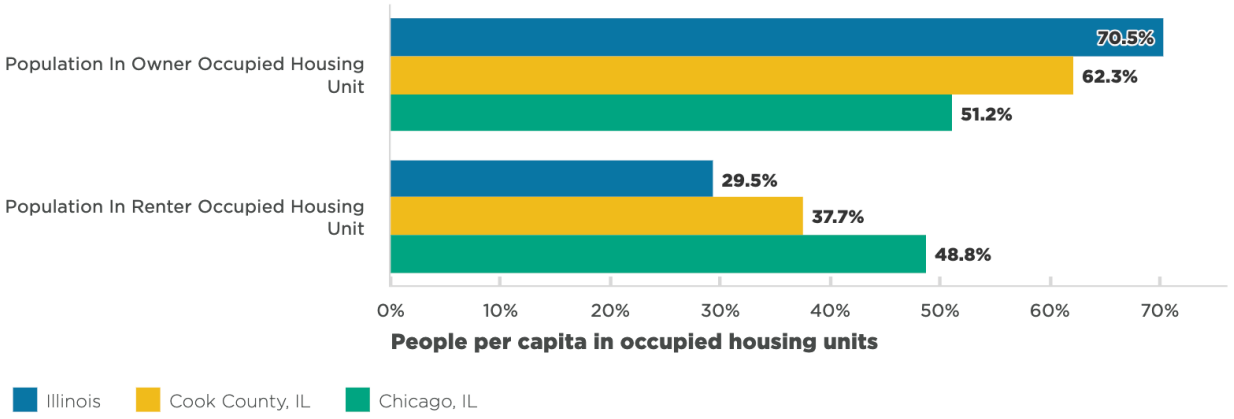
Housing stability is closely intertwined with behavioral health, serving as a fundamental determinant of mental well-being. Secure and stable housing provides individuals with a sense of safety, stability, and control over their environment, which are essential for maintaining positive mental health. Conversely, housing instability, including homelessness, overcrowding, and precarious housing arrangements, can contribute to chronic stress, anxiety, and depression. Inadequate housing conditions may also exacerbate existing mental health conditions or lead to their onset, particularly among vulnerable populations.

Homeowners vs Renters

In the City of Chicago, nearly half of residents live in renter occupied housing units compared to owner-occupied ones. In comparison, at the state level, almost three quarters of Illinois live in owner occupied units.

Cook County also has a higher percentage of people living in renter-occupied housing units compared to the state average.

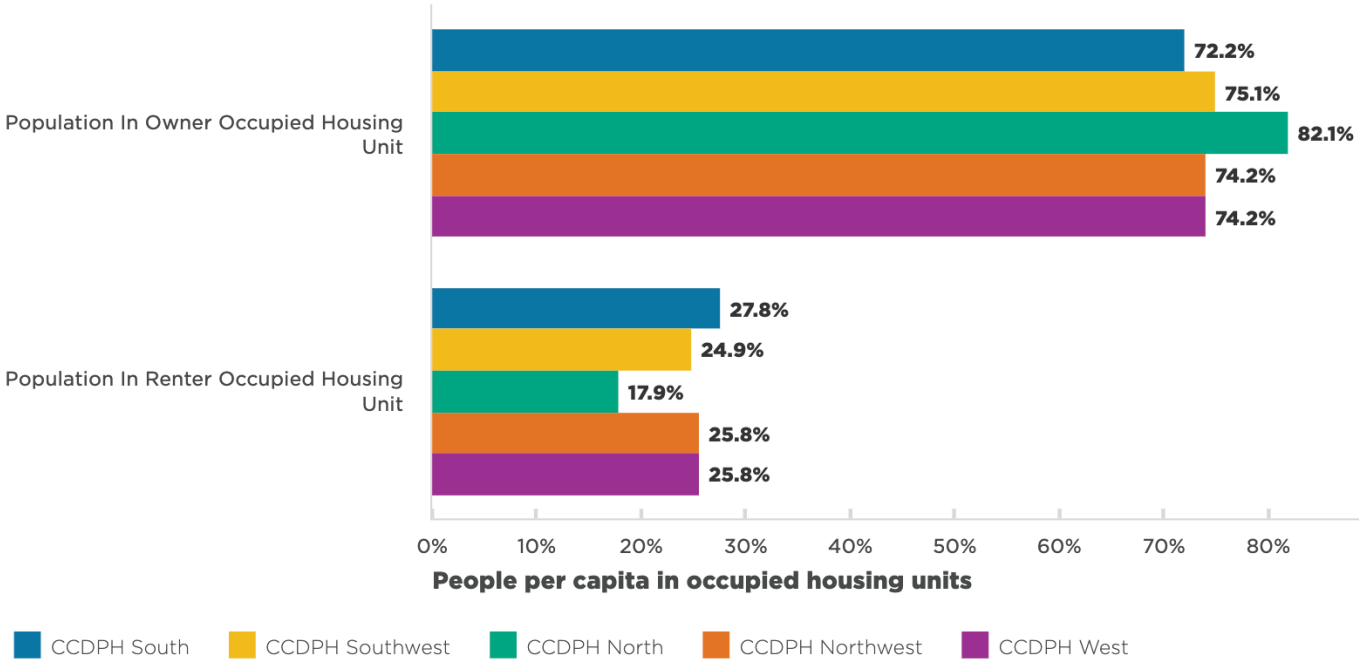
Population in Renter vs Owner Occupied Housing Units (Chicago Health Equity Zones)



Sources: US Census Bureau ACS 5-year 2018-2022

Across all Chicago Health Equity zones, a high percentage of residents live in owner-occupied housing units than renter-occupied units.

Population in Renter vs Owner Occupied Housing Units (Chicago Health Equity Zones)

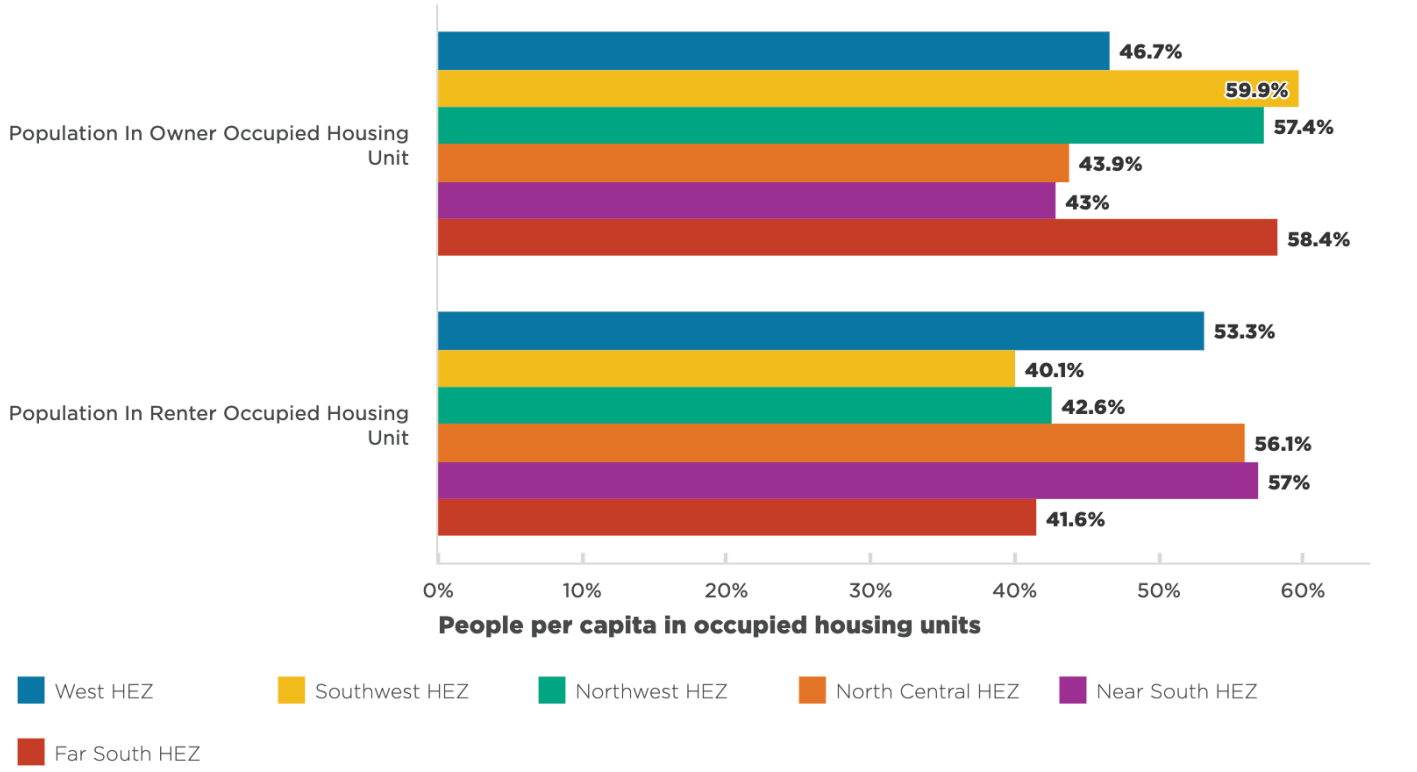


Sources: US Census Bureau ACS 5-year 2018-2022

In the Chicago Health Equity Zones, there are notable differences in the population between areas with owner-occupied housing units and areas with renter-occupied housing units.

- In the West HEZ, there are more people living in renter-occupied housing units (53.3%) compared to owner-occupied units (46.7%). Similarly, in the Southwest HEZ, Northwest HEZ, Far South HEZ, and Near South HEZ, a higher percentage of people reside in renter-occupied units.
- Conversely, in the North Central HEZ, a larger proportion of the population (56.1%) live in renter-occupied housing units, while in the North Central HEZ, there are more people in owner-occupied units (57.4%).

Population in Renter vs Owner Occupied Housing Units (Chicago Health Equity Zones)



Sources: US Census Bureau ACS 5-year 2018-2022

Homeowner Affordability

The data reveals that in Cook County and Chicago, the median income of homeowners is higher compared to the state of Illinois as a whole. However, a higher percentage of homeowners in Cook County and Chicago are cost-burdened, meaning they spend a larger proportion of their income on housing costs. This suggests that even though homeowners have higher incomes, they still face affordability challenges.

Median Income of Homeowners

$98,157
USD
Illinois

$103,319
USD
Cook County, IL

$104,025
USD
Chicago, IL

Median Percent of Income Spent on Selected Homeowner Costs

18%
of income
Illinois

20%
of income
Cook County, IL

20%
of income
Chicago, IL

Percent of Homeowners That Are Cost-Burdened

22%
of Total Homeowners
Illinois

27.7%
of Total Homeowners
Cook County, IL

29%
of Total Homeowners
Chicago, IL

There are notable differences in owner-occupied household incomes and housing costs across different regions within CCDPH.

- In CCDPH North, the median income for owner-occupied households is the highest at $139,528, while CCDPH South has the lowest at $84,250. However, despite the differences in income, CCDPH North has the lowest median monthly ownership costs as a percentage of income at 19.9%, compared to the other regions.
- When it comes to excessive housing costs per housing unit, CCDPH West has the highest value at 27.6%, indicating a potential affordability challenge for homeowners in that area. CCDPH Northwest has the lowest excessive housing costs at 23.9%.

Geography	Owner Occupied Household Median Income	Median Monthly Ownership Costs as a Percentage of Income	Home Owner Excessive Housing Costs per housing unit
CCDPH South	$84,250.00	20.7%	27.5%
CCDPH Southwest	$92,210.00	20.8%	26.7%
CCDPH North	$139,528.00	19.9%	26.8%
CCDPH Northwest	$114,699.00	19.9%	23.9%
CCDPH West	$104,837.00	21%	27.6%

Sources: US Census Bureau ACS 5-year 2018-2022

The graph below includes data from Chicago Health Equity Zones. Data shows that there are significant differences among these geographies.

- In the Owner-Occupied Household Median Income category, North Central HEZ has the highest median income at $141,893, while Far South HEZ has the lowest at $79,316.
- When looking at Median Monthly Ownership Costs as a Percentage of Income, North Central HEZ again stands out with the lowest percentage at 20.8%, indicating a lower burden compared to the other areas.
- In terms of excessive housing costs, West HEZ has the highest percentage of burdened residents (32%), and Far South HEZ has the fewest (27%).

Geography	Owner Occupied Household Median Income	Median Monthly Ownership Costs as a Percentage of Income	Home Owner Excessive Housing Costs per housing unit
Far South HEZ	$79,316.00	21.7%	27.2%
Near South HEZ	$88,996.00	22.6%	30.8%
North Central HEZ	$141,893.00	20.8%	27.5%
Northwest HEZ	$125,313.00	21.4%	28.9%
Southwest HEZ	$85,365.00	22.2%	29.6%
West HEZ	$118,737.00	22.1%	31.5%

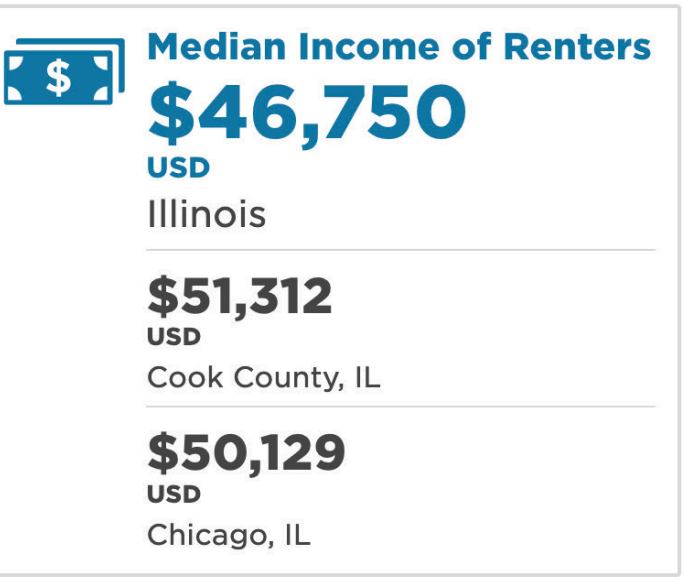
Sources: US Census Bureau ACS 5-year 2018-2022

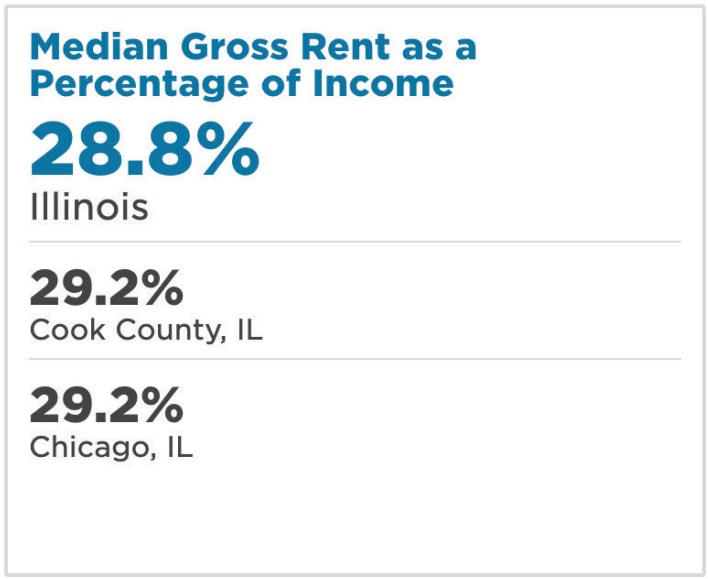
Renter Affordability

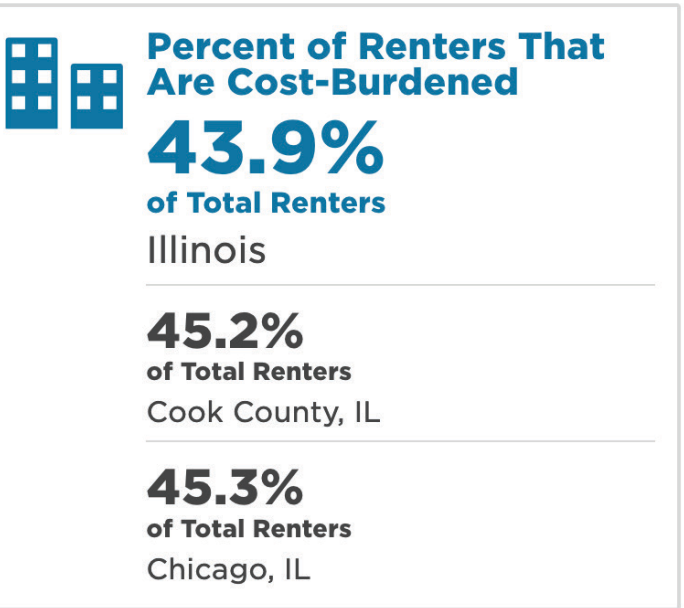
In Illinois, renters face challenges with housing costs. Looking at Cook County, including Chicago, shows similar trends. The median income for renters in these areas is around $46,750 to $63,654. Rent typically consumes nearly 29% of their income.

The data reveals a concerning statistic: about 44-45% of renters in these areas are considered cost-burdened. This means they spend 30% or more of their income on housing, leaving less for other essential needs.

Across Illinois, including Cook County and Chicago, there is a significant portion of renters struggling to afford housing. This highlights the importance of addressing affordable housing policies to ensure that all residents can access safe and stable housing without financial strain.







Sources: US Census Bureau ACS 5-year 2017-2021Note: Cost burden is defined as those that spend 30% or more of their income on housing costs.

Transportation Trends

Access to transportation is closely tied to behavioral health, as it directly impacts an individual's ability to access essential services, support networks, and opportunities for social participation. Limited transportation options can lead to social isolation, reducing opportunities for meaningful social interactions and engagement in community activities, which are crucial for mental well-being. Moreover, inadequate access to transportation may hinder individuals from accessing healthcare services, including mental health treatment, leading to delays in diagnosis and treatment and exacerbating mental health conditions. Addressing transportation barriers through improved public transportation infrastructure, affordable transportation options, and community-based transportation services can help enhance social connectivity, increase access to vital resources, and promote better mental health outcomes for individuals and communities alike.

The table below shows the percentage of income that low-income individuals spend on transportation. In the state overall, nearly 60% of low-income residents' income is spent on transportation and housing, leaving fewer resources for other necessities.

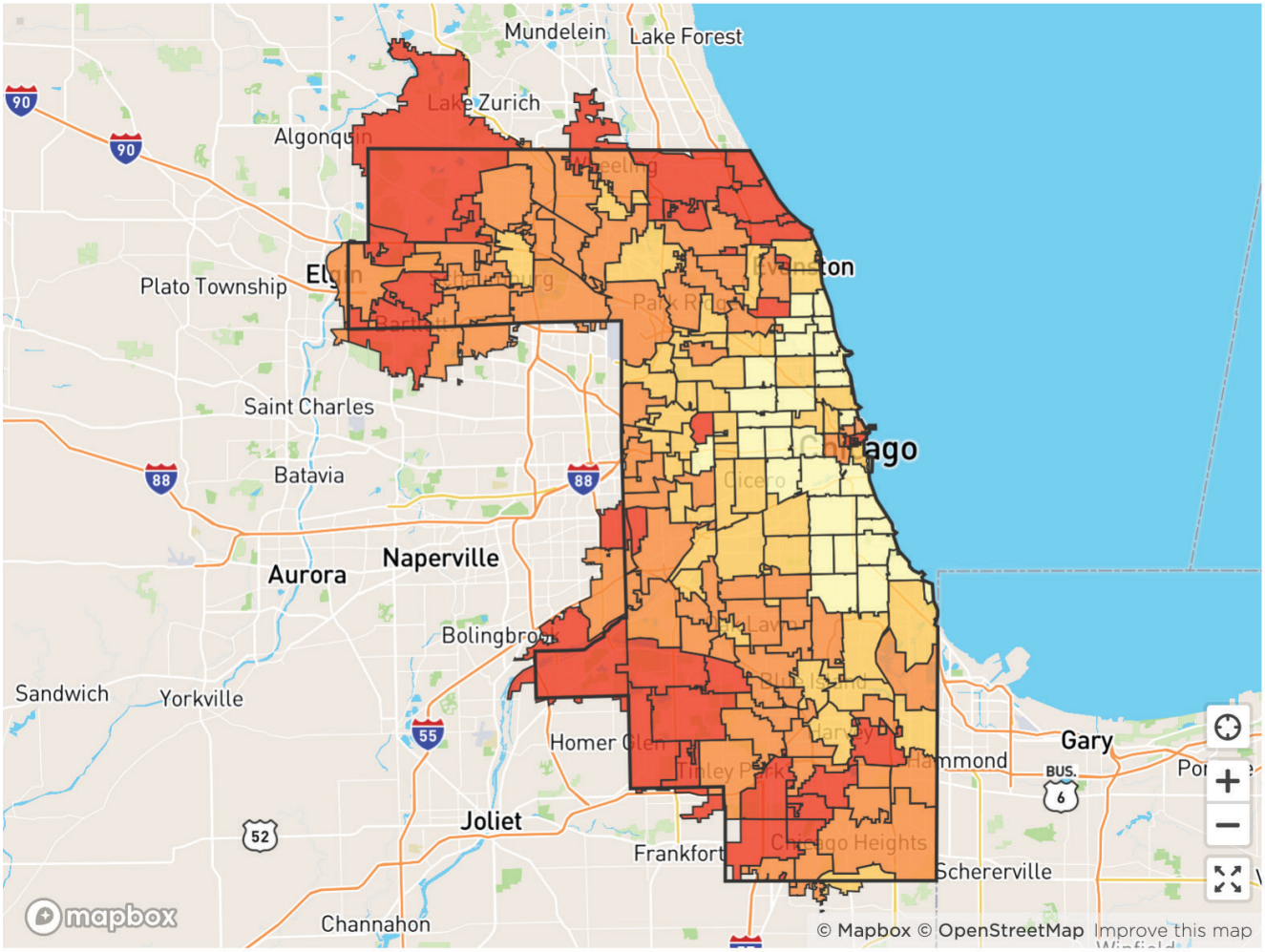
Geography	Percent of Income Spent on Housing and Transportation - Low Income Individuals
Illinois	58.3%
Cook County, IL	40.3%
Chicago, IL	30.5%

Sources: US HUD & DOT LAI V3.0 2016

The map below shows the percentage of income single-parent families in different areas spend on housing and transportation. In ZIP codes 60603 (Chicago), 60604 (Chicago), 60029 (Glenview/Golf), 60192 (Hoffman Estates), and 60010 (Barrington), single-parent families spend a higher percentage of their income on housing and transportation, which means they have less money for other necessities.

In the Chicago ZIP codes of 60660, 60653, 60626, 60640, and 60615, single-parent families spend a lower percentage of their income on housing and transportation. Looking at this data by geography can help you understand where families may be struggling to afford basic needs like housing and transportation. It can also show where families may have more financial stability and flexibility.

Percent of Income Spent on Housing and Transportation - Single Parent Family



Cook County, IL

Percent of Income Spent on Housing and Transportation - Single Parent Family

- 58.5% – <66%
- 66% – <69.9%
- 69.9% – <74.1%
- 74.1% – <85.2%
- 85.2% – 86.4%

Sources: US HUD & DOT LAI V3.0 2016

Access to Food

Chronic food insecurity can lead to increased stress, anxiety, and depression as individuals grapple with the uncertainty of not having enough food to meet their basic needs. Additionally, inadequate nutrition resulting from food insecurity can impair cognitive function and exacerbate mental health conditions, further compromising overall well-being. The psychological distress associated with food insecurity can negatively impact interpersonal relationships and increase the risk of substance abuse and other maladaptive coping mechanisms.

In 2019, over half of Illinois residents lacked access to healthy food, defined as having no healthy food options within a half mile in urban areas, and within 10 miles in rural areas. Percentages were better in Cook County (39%) and the City of Chicago (22%).

People Without Access to Healthy Food within a Half Mile

50.3%
Illinois

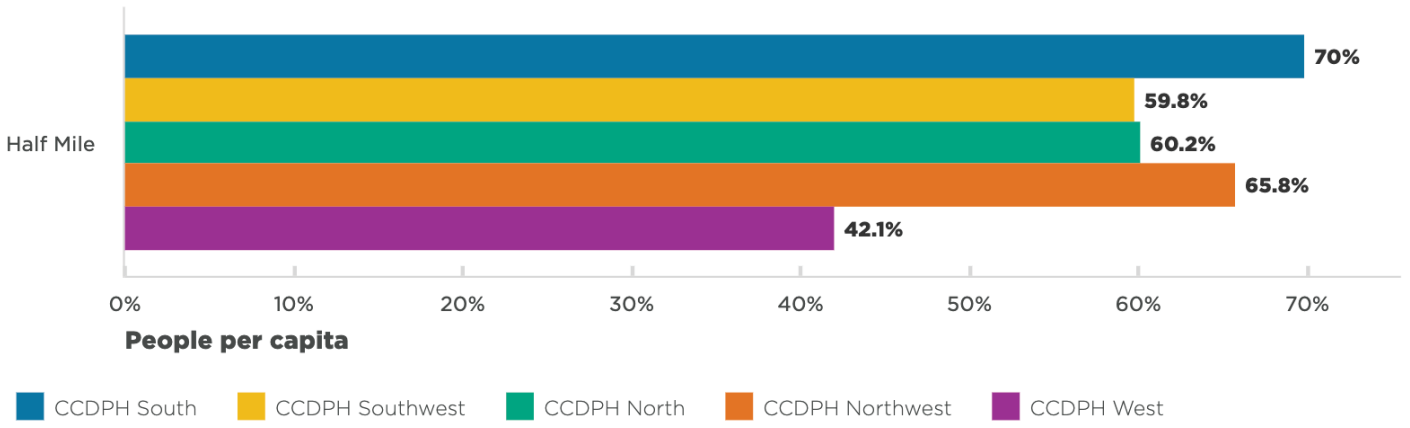
38.7%
Cook County, IL

22.1%
Chicago, IL

Sources: US Census Bureau ACS 5-year 2018-2022; USDA ERS 2019

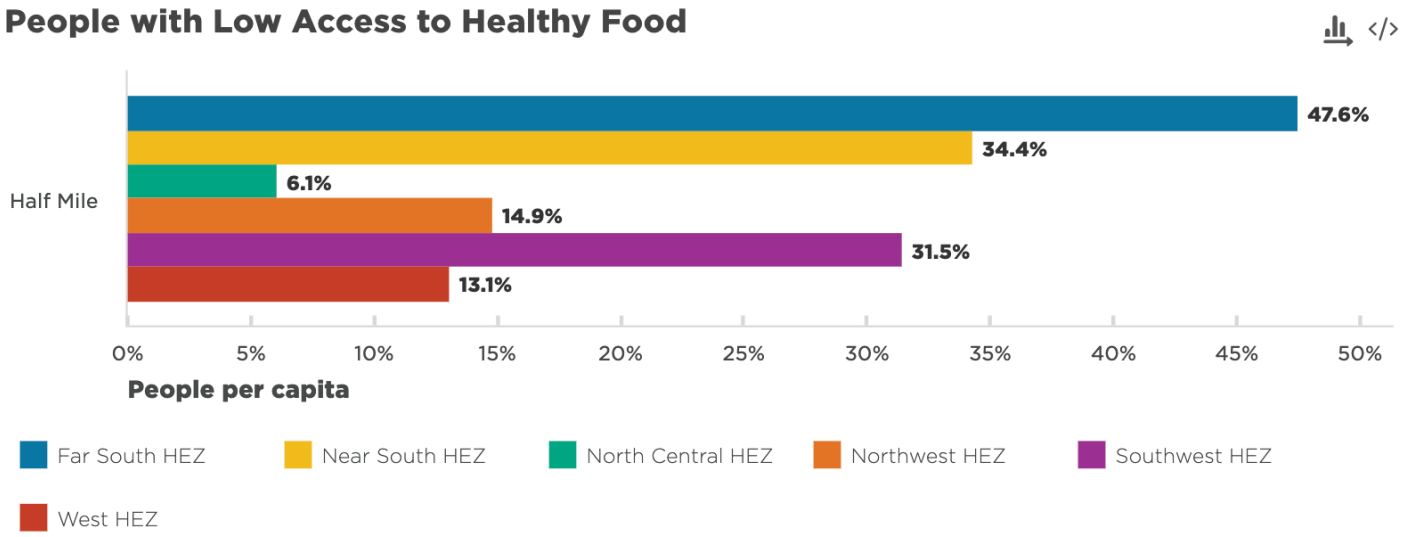
The percentage of residents with low access to health food is high across all CCDPH Districts, but is especially high in the South District (70%).

People with Low Access to Healthy Food



Sources: USDA ERS 2019

Looking at Chicago's Health Equity Zones, nearly half of residents in the Far South HEZ have poor access to healthy food. In contrast, only 6% of residents in the North Central HEZ lack these resources. Areas like the Northwest HEZ and West HEZ also had relatively low percentages.



Sources: USDA ERS 2019

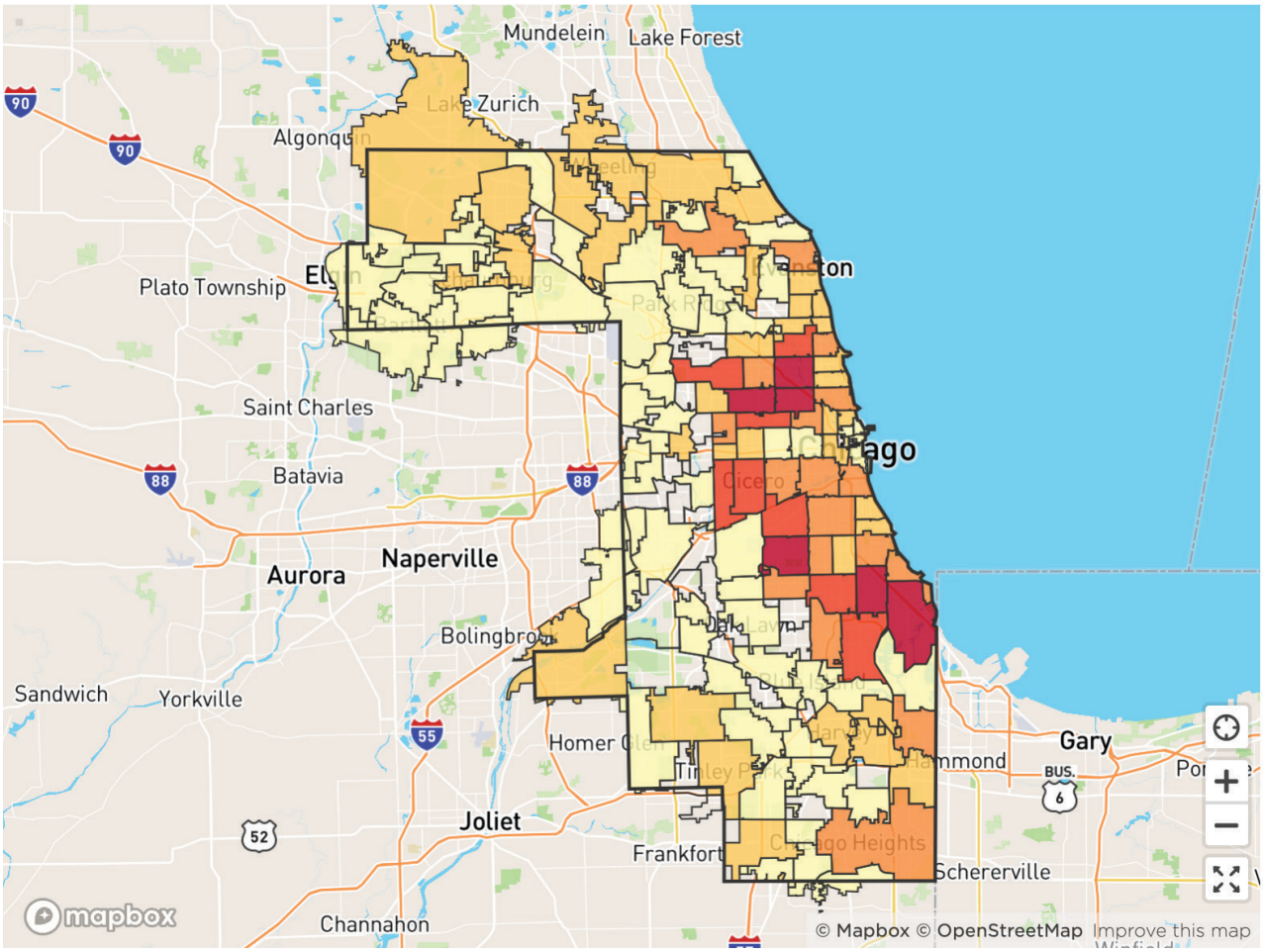
Access to Childcare

Affordable childcare options can alleviate stressors related to balancing work and caregiving responsibilities, providing parents with the support they need to maintain their mental well-being. Without access to affordable childcare, parents may experience increased levels of stress, anxiety, and burnout, which can negatively impact their mental health. Lack of access to childcare may limit parents' ability to engage in self-care activities and maintain social connections, further exacerbating feelings of isolation and strain.

In some areas, including Chicago-area ZIP codes 60647, 60629, and 60617, there are a high number of businesses offering childcare services, with 46, 44, and 42 childcare centers in these ZIP codes, respectively.

Zip codes like 60425 (Glenwood), 60154 (Westchester), 60169 (Hoffman Estates), 60176 (Schiller Park), and 60192 (Hoffman Estates) have fewer childcare centers, each with only 3 in total.

Child Care Centers



Cook County, IL

Child Care Centers

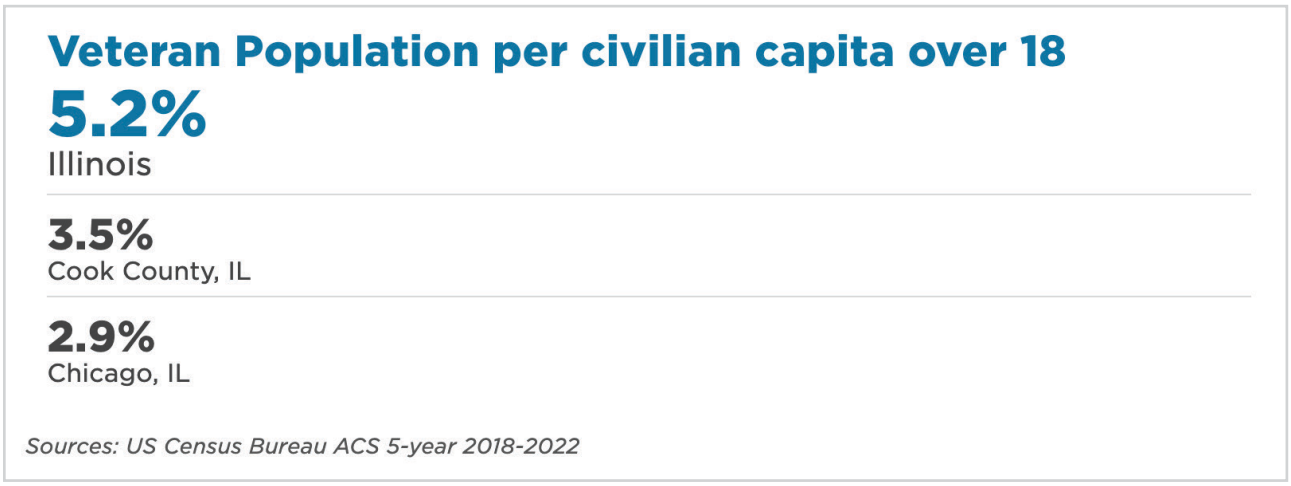
- 3 – <8
- 8 – <16
- 16 – <27
- 27 – <38
- 38 – 46

Sources: CBP 2020

Veterans Status

Veteran status is closely associated with behavioral health issues owing to the distinct stressors encountered during military service and the transition to civilian life. Veterans commonly confront mental health challenges such as post-traumatic stress disorder, depression, anxiety, and substance abuse, stemming from combat exposure and the rigors of military life. Moreover, reintegration into civilian society and accessing healthcare and employment resources present additional hurdles for veterans, contributing to the complexity of their behavioral health needs. Addressing these needs necessitates comprehensive support systems, including specialized mental health services, peer support networks, and transitional programs designed to foster resilience and facilitate successful civilian reintegration. Recognizing and addressing the unique challenges faced by veterans are imperative steps in ensuring their well-being and honoring their dedicated service.

When comparing the veteran population per civilian capita over 18, Cook County has a lower percentage (3.5%) compared to Illinois (5.2%). Chicago has a slightly lower percentage (2.9%) than Cook County overall.



The percentage of the population with veteran status varies only slightly across CCDPH Districts, ranging from 2.8% in the North, Northwest, and West Districts to approximately 4% in CCDPH South.

Veteran Population per capita	
CCDPH North	2.8%
CCDPH Northwest	2.8%
CCDPH West	2.8%
CCDPH South	3.9%
CCDPH Southwest	3.7%

Sources: US Census Bureau ACS 5-year 2018-2022

Looking across Health Equity Zones, the percentage of the population with veteran status ranges from 1.8% in the North Central, Northwest, and West Zones to approximately 4% in the Far South HEZ.

Veteran Population per capita	
Far South HEZ	3.8%
Near South HEZ	3.4%
North Central HEZ	1.8%
Northwest HEZ	1.8%
Southwest HEZ	2.3%
West HEZ	1.8%

Sources: US Census Bureau ACS 5-year 2018-2022

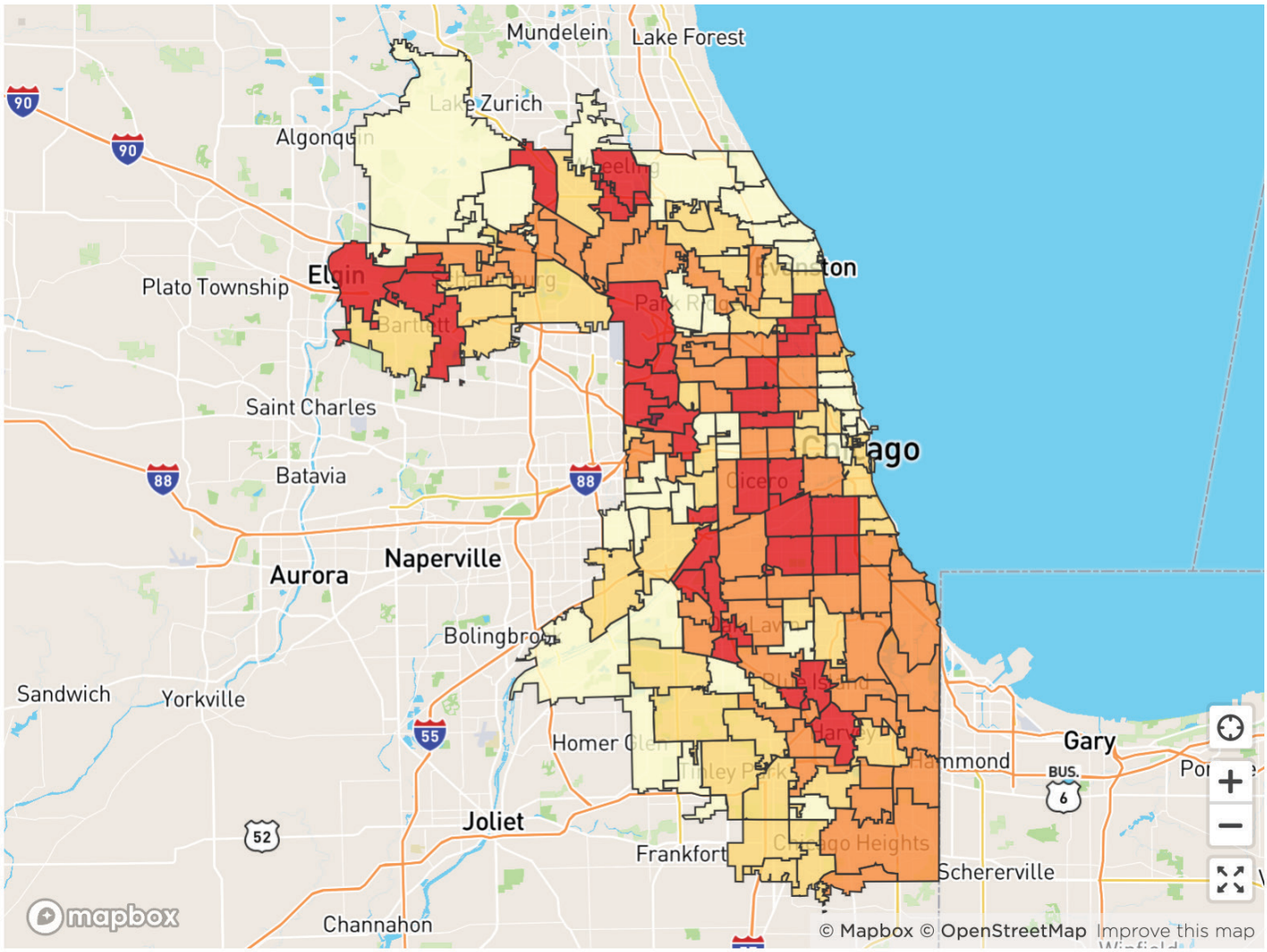
Health Access and Preventative Care

Health Care Costs

The cost of healthcare directly impacts access to behavioral health services, as high expenses can create significant barriers for individuals seeking mental health treatment. Affordability concerns may deter individuals from seeking care or limit the frequency of appointments, leading to delayed or inadequate treatment for mental health conditions. Additionally, insurance coverage limitations or high out-of-pocket costs for behavioral health services can further exacerbate disparities in access, particularly for marginalized or low-income populations. Addressing the cost of healthcare through policies that increase affordability, expand insurance coverage for mental health services, and reduce financial barriers is essential for ensuring equitable access to behavioral health care and promoting overall well-being for all individuals.

Health Insurance Coverage

The data reveals significant disparities in health insurance coverage within the County. In the ZIP codes 60629 (West Lawn/Chicago Lawn), 60804 (Cicero), 60639 (Belmont Craig - Chicago), 60623 (South Lawndale - Chicago), and 60632 (Brighton Park/Archer Heights - Chicago), a high number of people are uninsured, with the highest count being 15,319 uninsured individuals in ZIP code 60629. Conversely, ZIP codes 60602 (The Loop - Chicago), 60141 (Hines), 60208 (Evanston), 60604 (The Loop - Chicago), and 60029 (Golf) have the lowest uninsured rates, with some areas reporting zero uninsured individuals.



Health Insurance Coverage - Uninsured per capita

- 0% – <3.9%
- 3.9% – <7.3%
- 7.3% – <11.9%
- 11.9% – <28%
- 28%

Sources: US Census Bureau ACS 5-year 2018-2022

Availability and Engagement in Care

Cook County has a higher provider-to-patient ratio compared to Chicago and the state of Illinois as a whole. Specifically, Cook County has more dentists, optometrists, pediatricians, OBGYNs, mental health providers, primary care physicians, clinical social workers, midwives or doulas, and primary care nurse practitioners for every 1,000 people. This indicates that people in Cook County likely have better access to these healthcare professionals than residents of Chicago or the entire state of Illinois. However, it is important to note that these ratios do not provide information about the quality of care provided or the specific needs of individuals in each area.

Provider Ratio by Provider Type

Data Sources	Illinois	Cook County, IL	Chicago, IL
People per 1 Dentist	1,349	1,152	1,252
People per 1 Optometrist	5,070	4,676	4,977
Children per 1 Pediatrician	778	502	402
Females per 1 OBGYN	3,153	2,286	1,939
People per 1 Mental Health Provider	916	838	855
People per 1 Primary Care Physician	801	594	522
People per 1 Clinical Social Worker	1,226	917	837
Females per 1 Midwife or Doula	27,382	23,640	18,002
People per 1 Primary Care Nurse Practitioner	1,527	1,485	1,386

Sources: NPPES NPI 2022

Primary Care

The link between primary care and behavioral health is crucial for comprehensive healthcare delivery and overall well-being. Primary care providers often serve as the first point of contact for individuals seeking healthcare services, making them well-positioned to identify and address behavioral health concerns. Integration of behavioral health services within primary care settings allows for early detection, intervention, and management of mental health conditions, leading to improved outcomes and reduced stigma associated with seeking specialized mental health care. Moreover, addressing behavioral health concerns in primary care settings promotes a holistic approach to healthcare, addressing both physical and mental health needs within the same framework.

Access to primary care physicians is a crucial aspect of healthcare. In Cook County, there are 594 people per primary care physician, compared to 525 in Chicago and 813 in Illinois as a whole. This suggests that Cook County has a slightly higher demand for primary care services than Chicago and the state overall.

People per 1 Primary Care Physician

801
Illinois

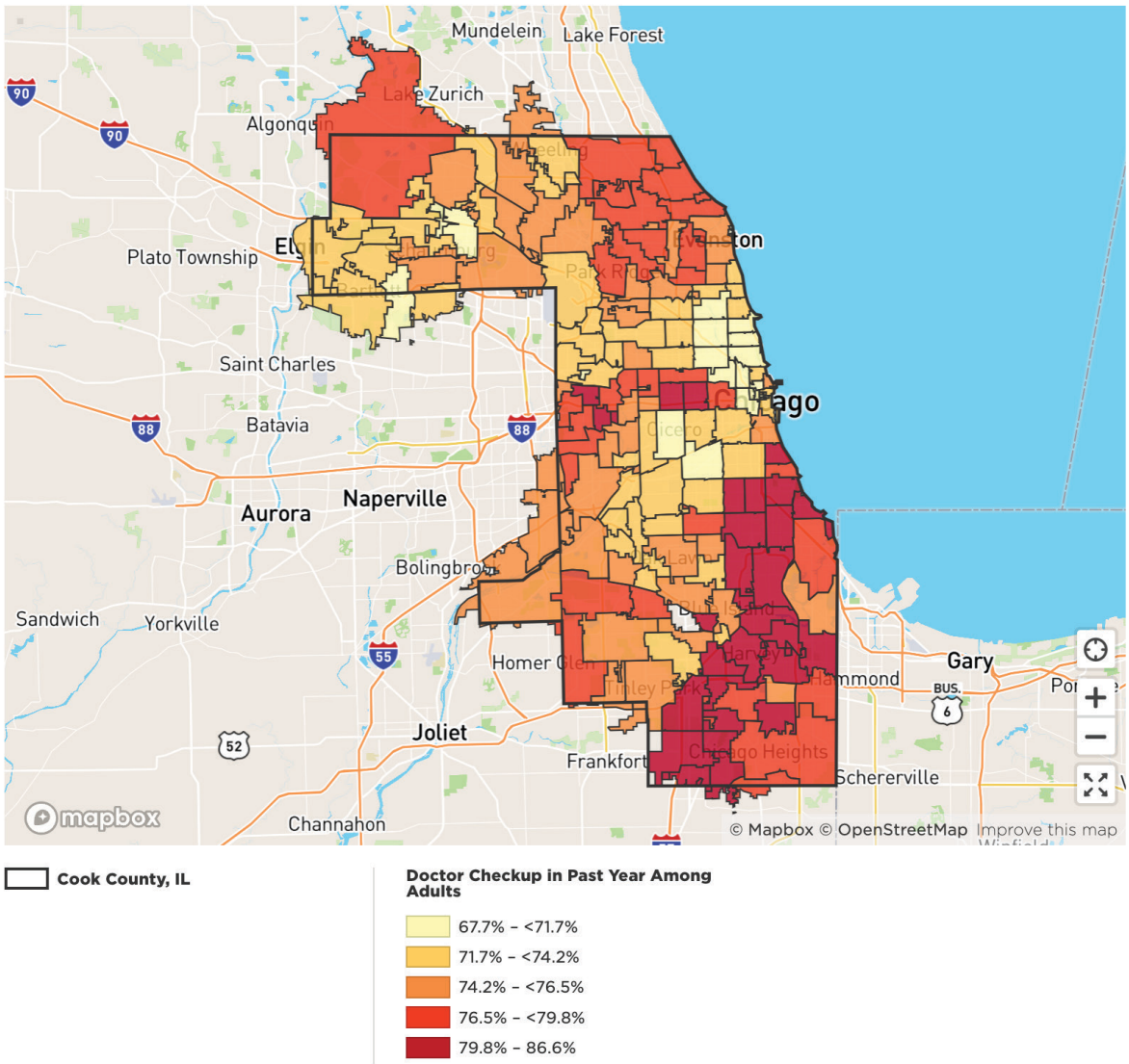
594
Cook County, IL

522
Chicago, IL

Sources: NPPES NPI 2022

In ZIP codes like 60661, 60195, 60657, 60165, and 60606, fewer people get regular checkups compared to areas like ZIP Codes 60141, 60619, 60461, 60620, and 60628. Access to healthcare is crucial for overall well-being, so it's important for the community to address these disparities. By ensuring everyone can easily see a doctor, we can improve health outcomes and quality of life for all residents.

Doctor Checkup in Past Year Among Adults

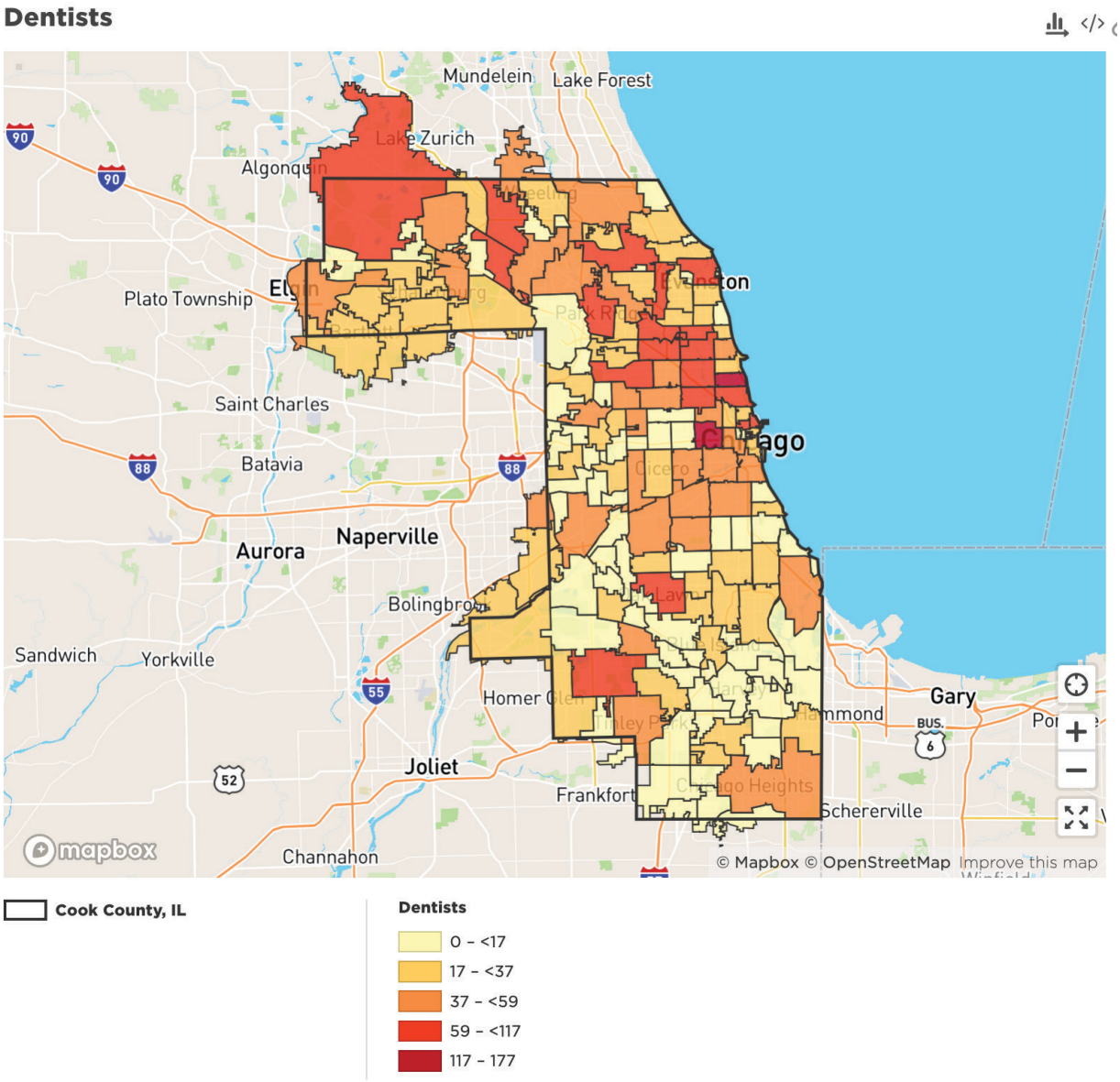


Sources: CDC BRFSS PLACES 2020

Oral Health

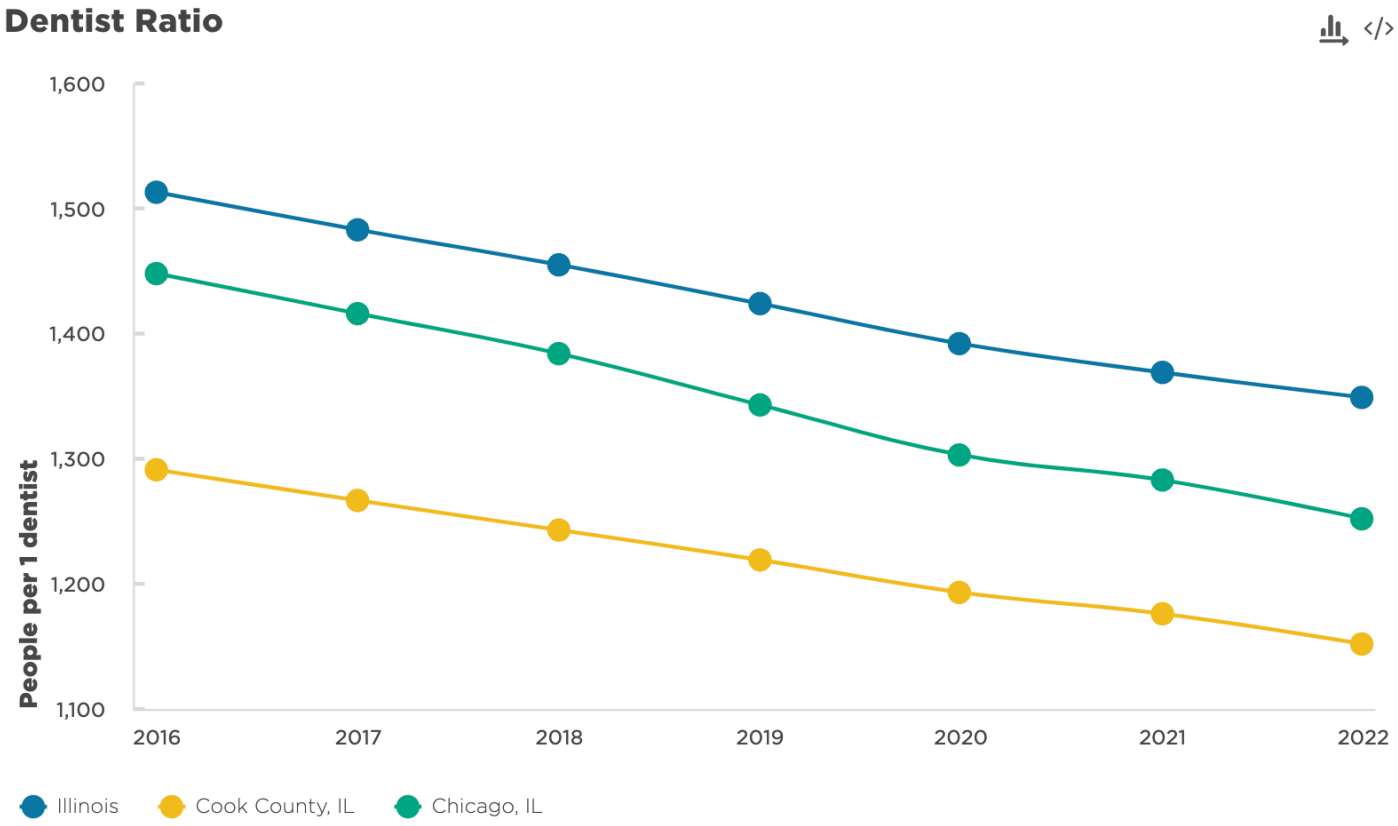
While seemingly distinct, oral health care and behavioral health are interconnected in several ways. Poor oral health can contribute to psychological distress, including feelings of embarrassment, social isolation, and low self-esteem, particularly if oral health issues lead to visible changes in appearance or difficulties with speech and eating. Moreover, individuals with mental health conditions may be more susceptible to neglecting oral hygiene practices due to factors such as lack of motivation, cognitive impairments, or medication side effects, leading to worsening oral health outcomes. Conversely, oral health problems can also impact behavioral health by causing chronic pain, discomfort, and difficulty sleeping, which may exacerbate existing mental health conditions or contribute to the onset of new ones. Recognizing these links underscores the importance of integrating oral health care into comprehensive healthcare approaches, addressing both physical and mental health needs to promote overall well-being.

Looking at the map below, you see an uneven distribution of dentists, meaning some areas have better access to dental care.



Sources: NPPES NPI 2023

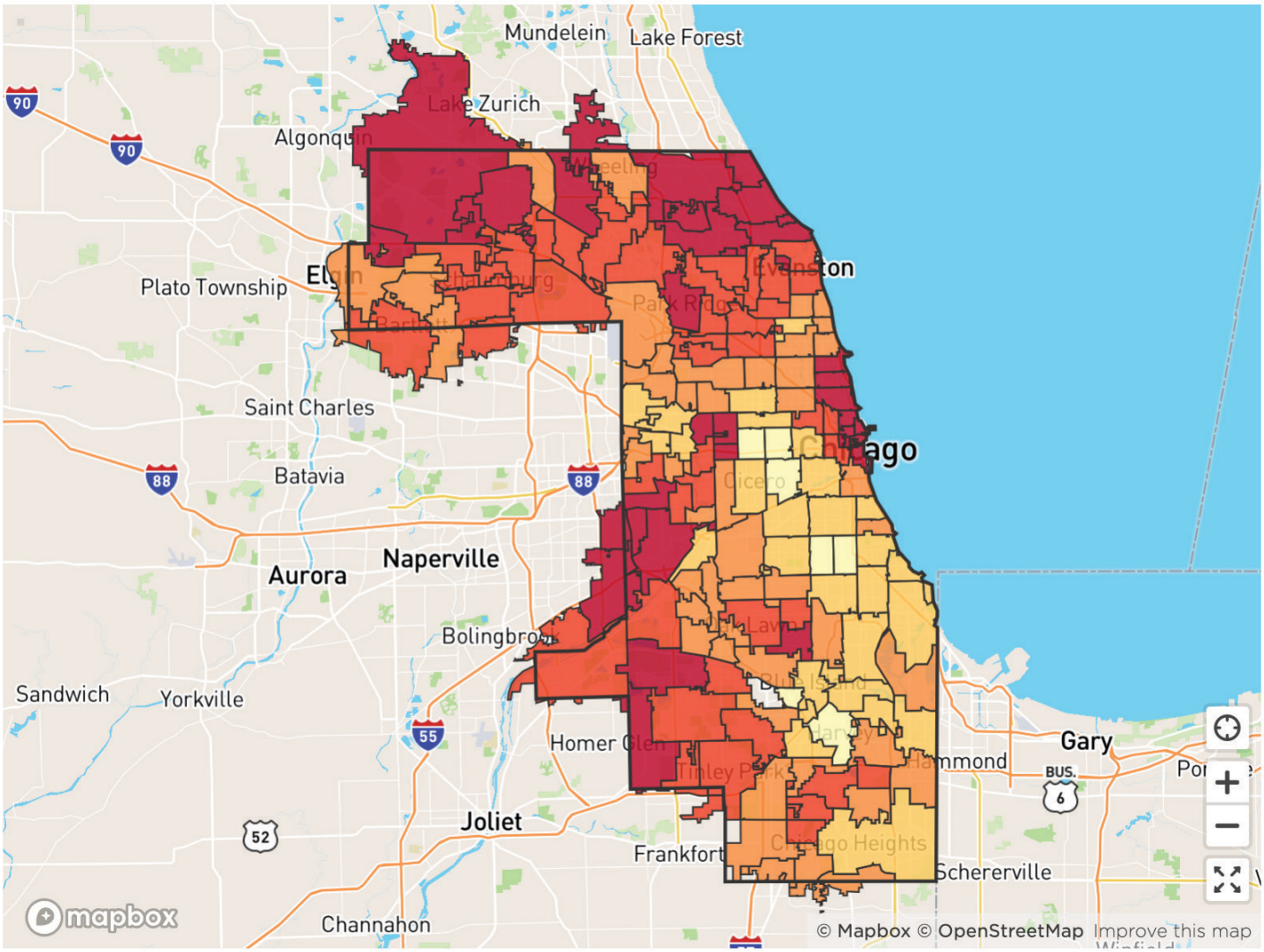
In terms of dentist availability, the data reveals that Cook County has a lower dentist-to-population ratio compared to Chicago and the state of Illinois as a whole. Over the years, the ratio has consistently decreased in all four geographies.



Sources: NPPES NPI

In the community, areas like ZIP Code 60624, 60621, 60623, 60636, and 60644 show significantly lower rates of dental visits among adults compared to areas like ZIP Code 60043, 60022, 60093, 60091, and 60521.

Dental Visit Among Adults



Cook County, IL

Dental Visit Among Adults

- 39.1% – <46.9%
- 46.9% – <56.3%
- 56.3% – <65.2%
- 65.2% – <72.2%
- 72.2% – 80.7%

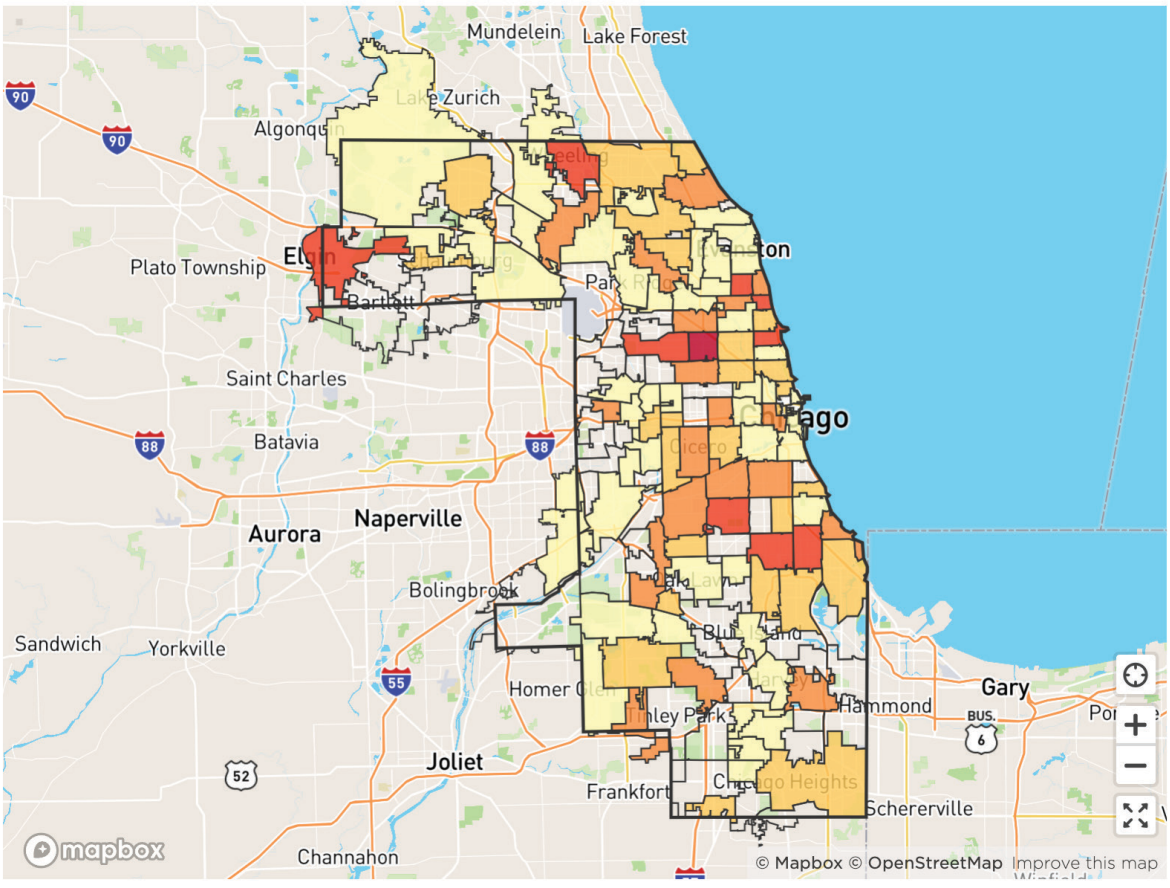
Sources: CDC BRFSS PLACES 2020

Prenatal Care

Prenatal care plays a critical role not only in ensuring the health of the mother and the developing fetus but also in laying the foundation for optimal behavioral health outcomes. Adequate prenatal care can help identify and address maternal mental health concerns such as depression and anxiety early in pregnancy, reducing the risk of adverse outcomes for both mother and child. Additionally, prenatal care offers opportunities for healthcare providers to educate expectant mothers about the importance of self-care, stress management, and healthy coping strategies, which can positively impact maternal mental well-being throughout pregnancy and beyond. Furthermore, addressing maternal mental health during prenatal care can contribute to positive birth experiences and promote healthy parent-child attachment, which are essential factors for the long-term behavioral health and development of the child. Integrating mental health screening and support services into prenatal care settings is crucial for addressing the complex interplay between maternal mental health and perinatal outcomes, ultimately promoting the well-being of both mother and child.

In areas like ZIP codes 60602, 60141, 60604, 60611, and 60612, there are very few OBGYNs available per female compared to places like ZIP Code 60641, 60613, 60120, 60645, and 60660. This means that women in the former areas may have less access to essential reproductive healthcare services.

OBGYN Ratio



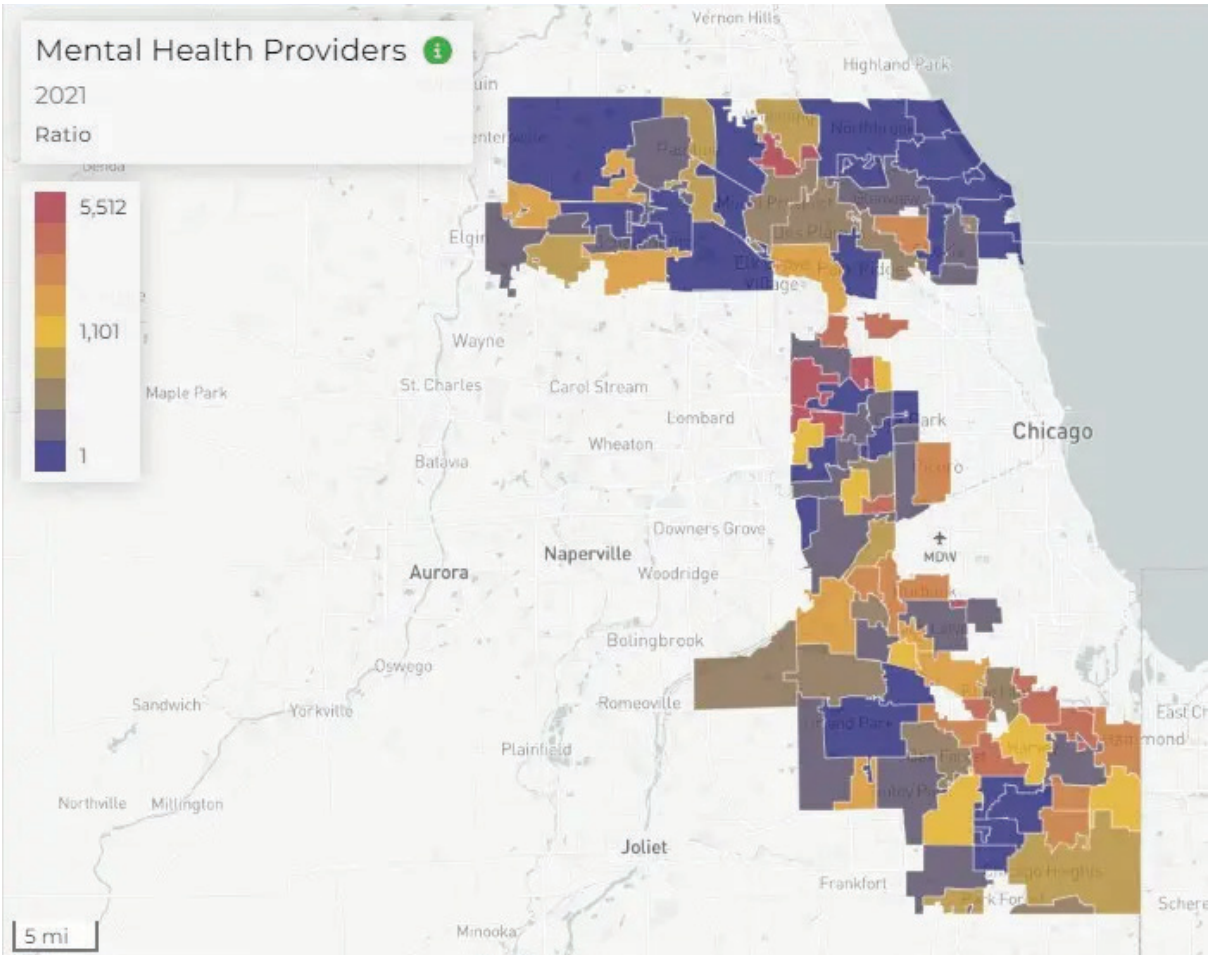
Sources: NPPES NPI 2023

Behavioral Health

Behavioral health provider availability is crucial for the well-being of a community as it ensures that individuals have access to essential mental health services. These providers offer support for various conditions, including anxiety, depression, and substance abuse, helping to alleviate suffering and improve quality of life. Moreover, their presence contributes to early intervention, reducing the likelihood of mental health crises and associated societal costs.

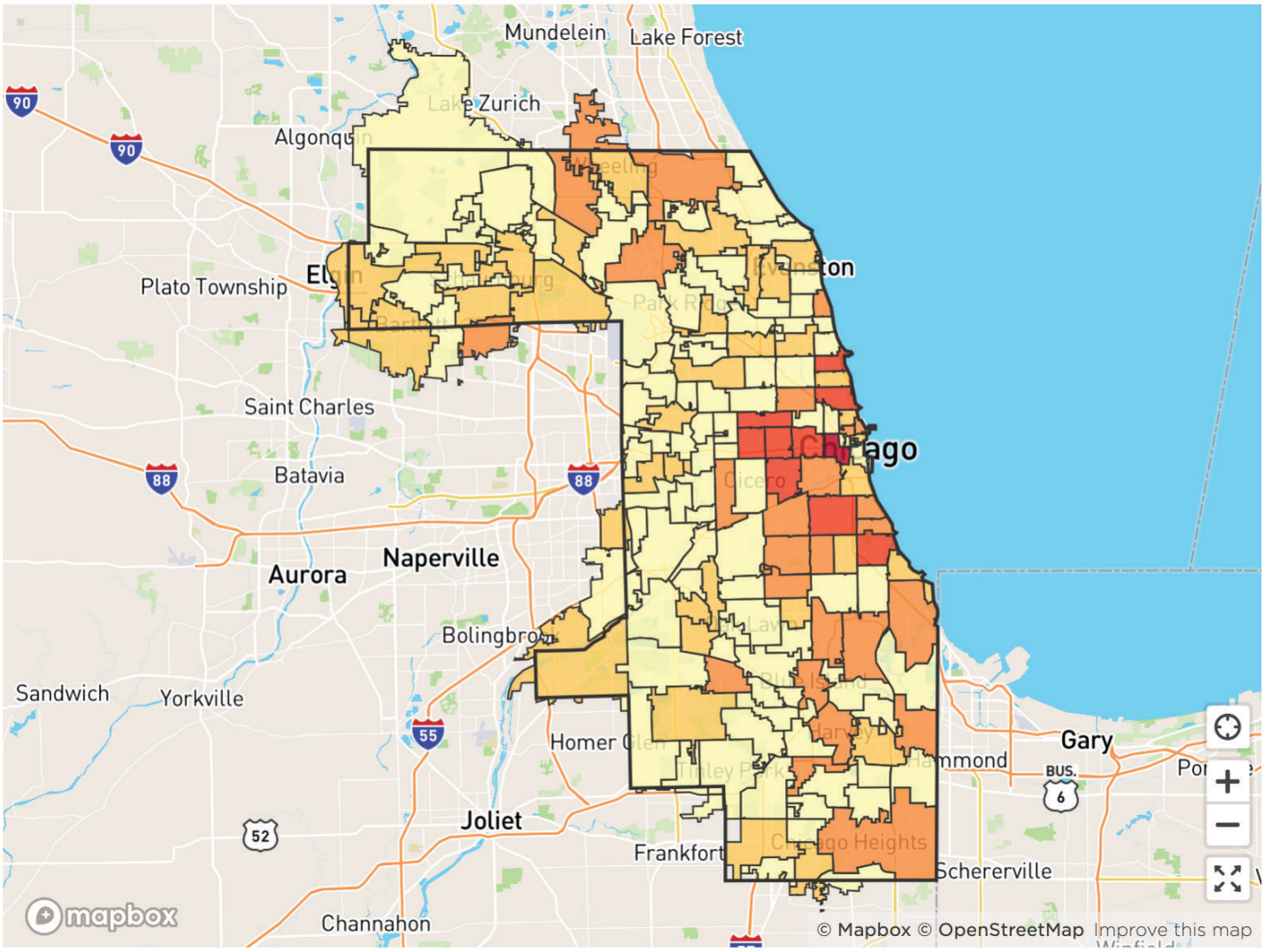
Availability

The map below, from the Cook County Health Atlas, shows the ratio of mental health providers in suburban Cook County, with areas in red showing a higher ratio, and areas in blue showing a lower ratio.



In Cook County, ZIP codes 60607, 60623, 60624, 60612, and 60651 stand out with 5-8 co-occurring substance use treatment facilities each. This indicates a higher availability of support services for people with substance use disorders in these areas.

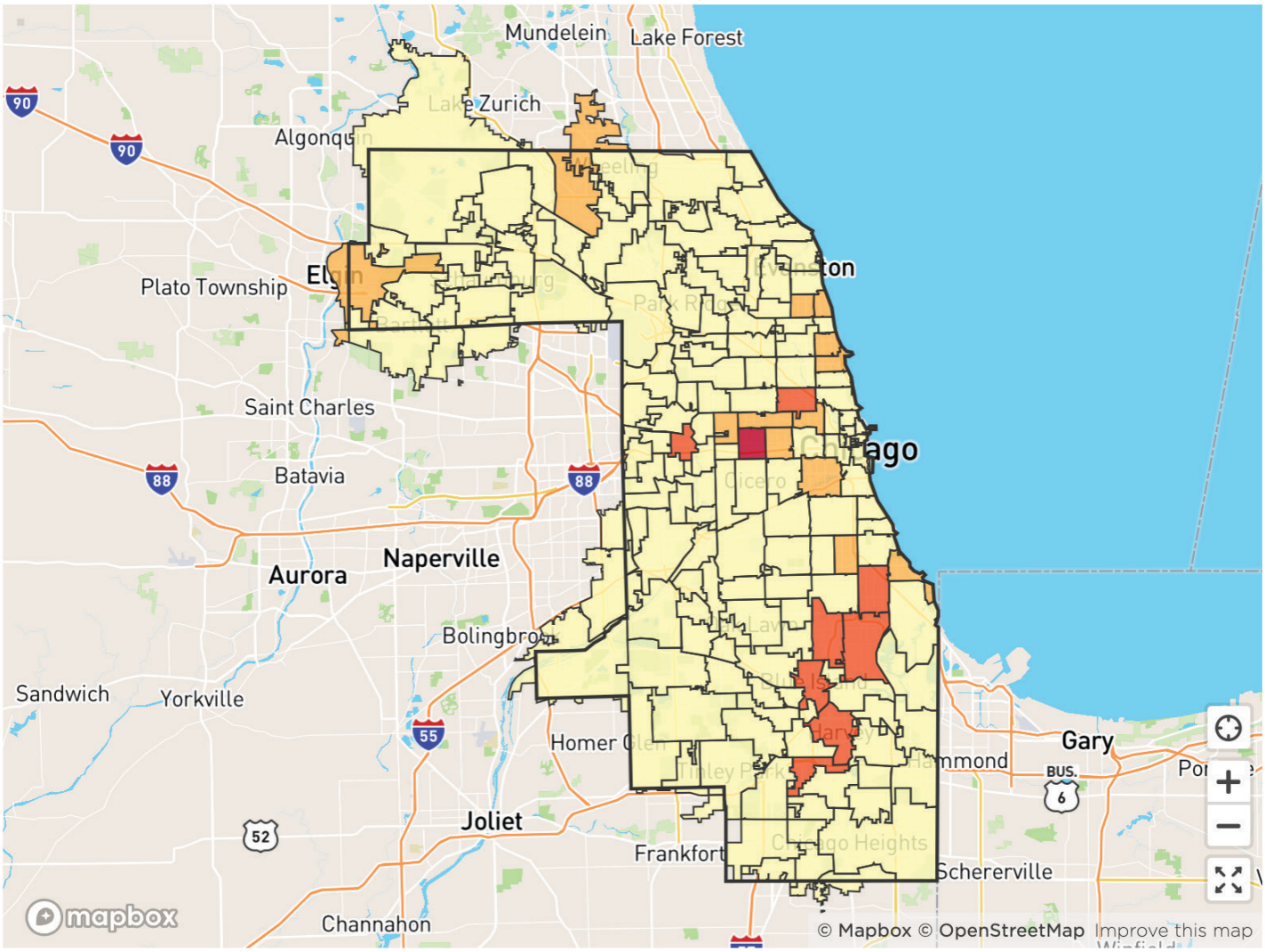
Co-occurring Substance Use Treatment Facilities



Sources: SAMHSA N-SUMHSS 2022

In Cook County ZIP codes 60644, 60406, 60153, 60426, and 60429, there are the most transitional substance use treatment facilities, with ZIP code 60644 having the highest number, at 4 facilities.

Transitional Substance Use Treatment Facilities



Cook County, IL

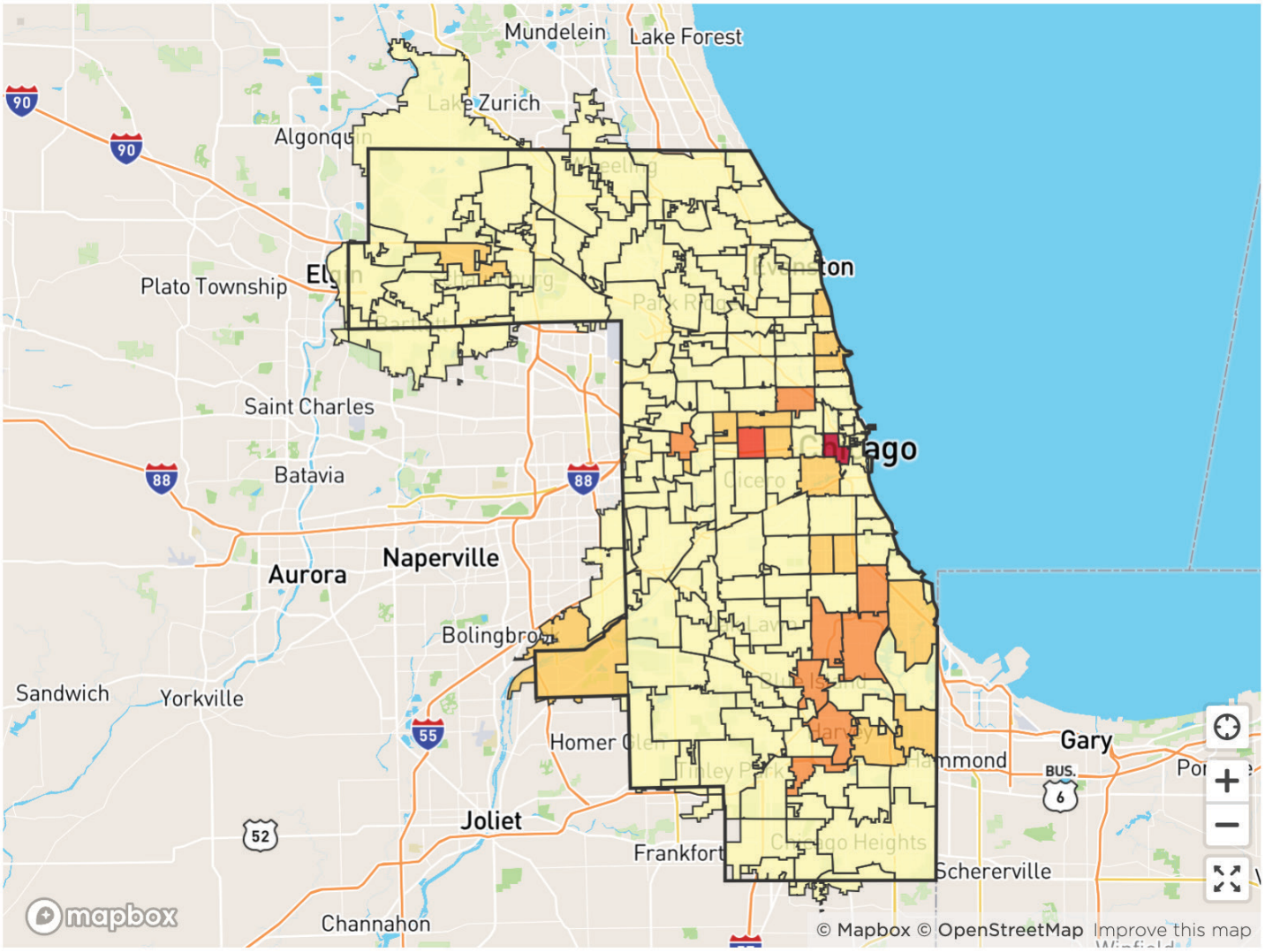
Transitional Substance Use Treatment Facilities

- 0 – <1
- 1 – <2
- 2 – <4
- 4

Sources: SAMHSA N-SUMHSS 2022

In ZIP code 60607, there are 10 residential substance use treatment facilities, while in many zip codes, there are none.

Residential Substance Use Treatment Facilities



Cook County, IL

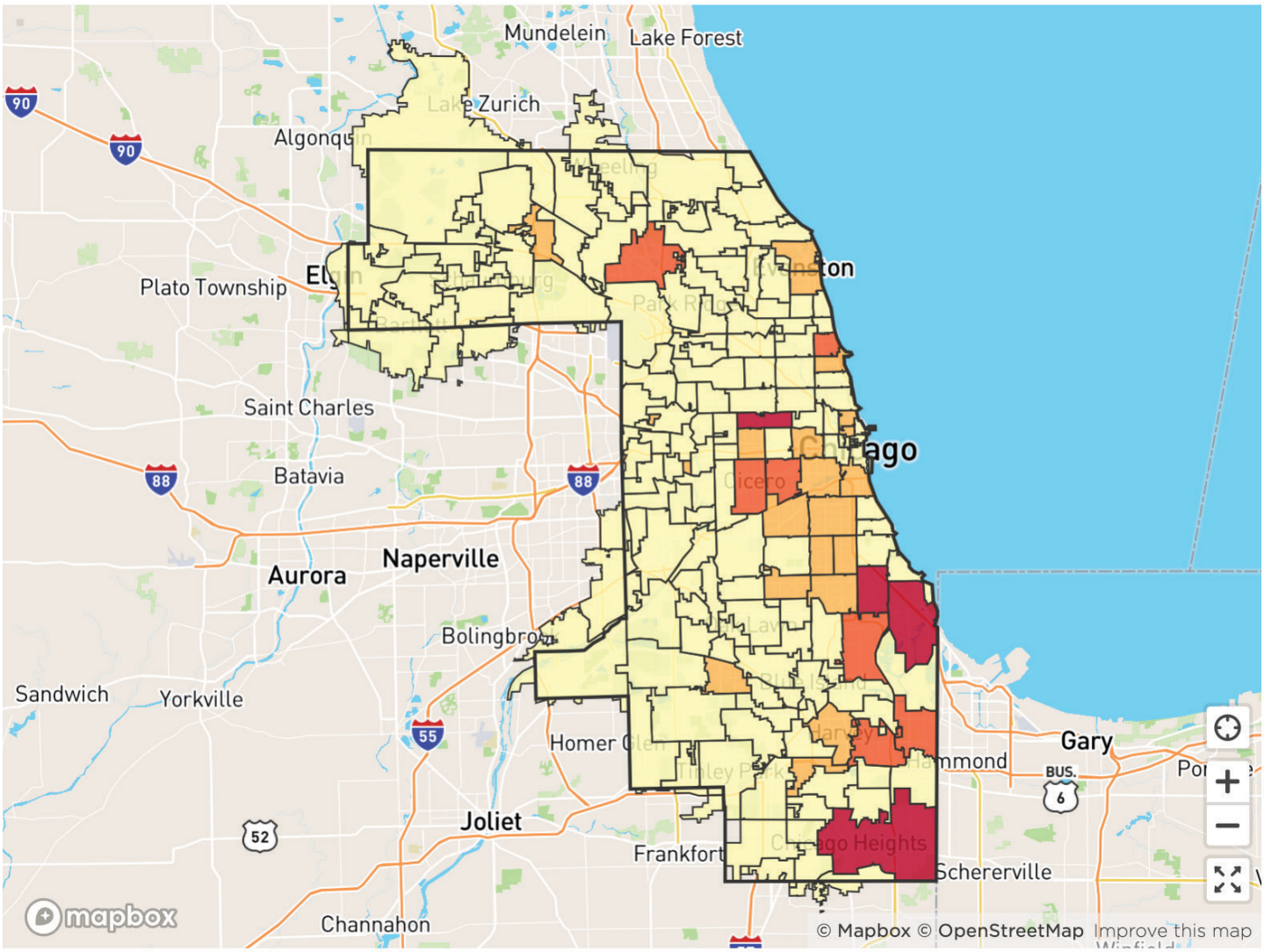
Residential Substance Use Treatment Facilities

- 0 – <1
- 1 – <2
- 2 – <5
- 5 – <10
- 10

Sources: SAMHSA N-SUMHSS 2022

In Cook County, ZIP codes 60411, 60617, 60619, 60651, and 60409 stand out with the highest number of Certified Opioid Treatment Programs.

Certified Opioid Treatment Programs



Cook County, IL

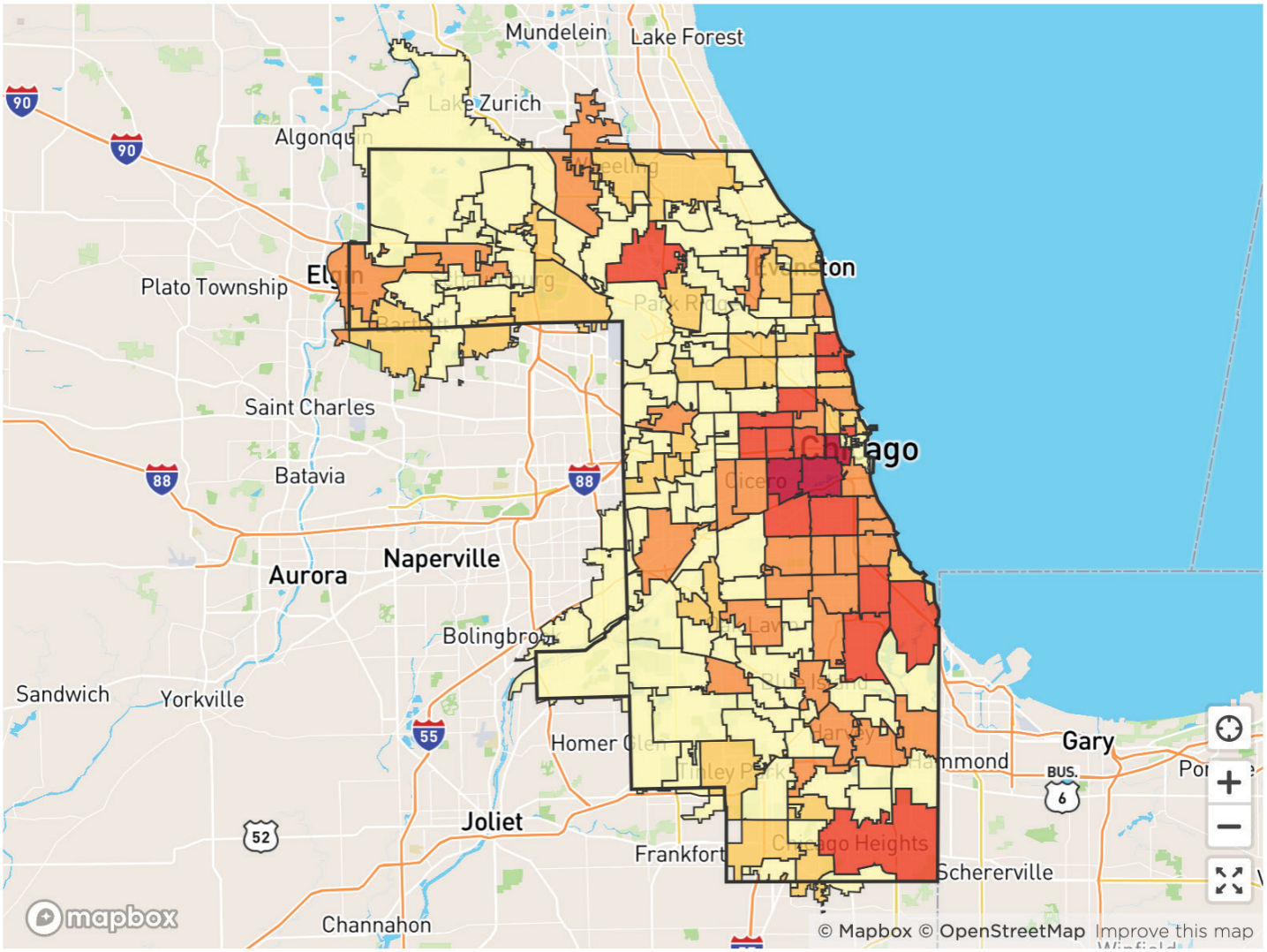
Certified Opioid Treatment Programs

- 0 – <1
- 1 – <2
- 2 – <3
- 3

Sources: SAMHSA N-SUMHSS 2022

In Cook County, ZIP codes like 60456, 60304, 60305, 60458, and 60459 have no substance use treatment facilities that accept Medicaid. This disparity means people in these areas may face barriers accessing crucial treatment for substance use issues.

Substance Use Treatment Facilities Accepting Medicaid



Cook County, IL

Substance Use Treatment Facilities Accepting Medicaid

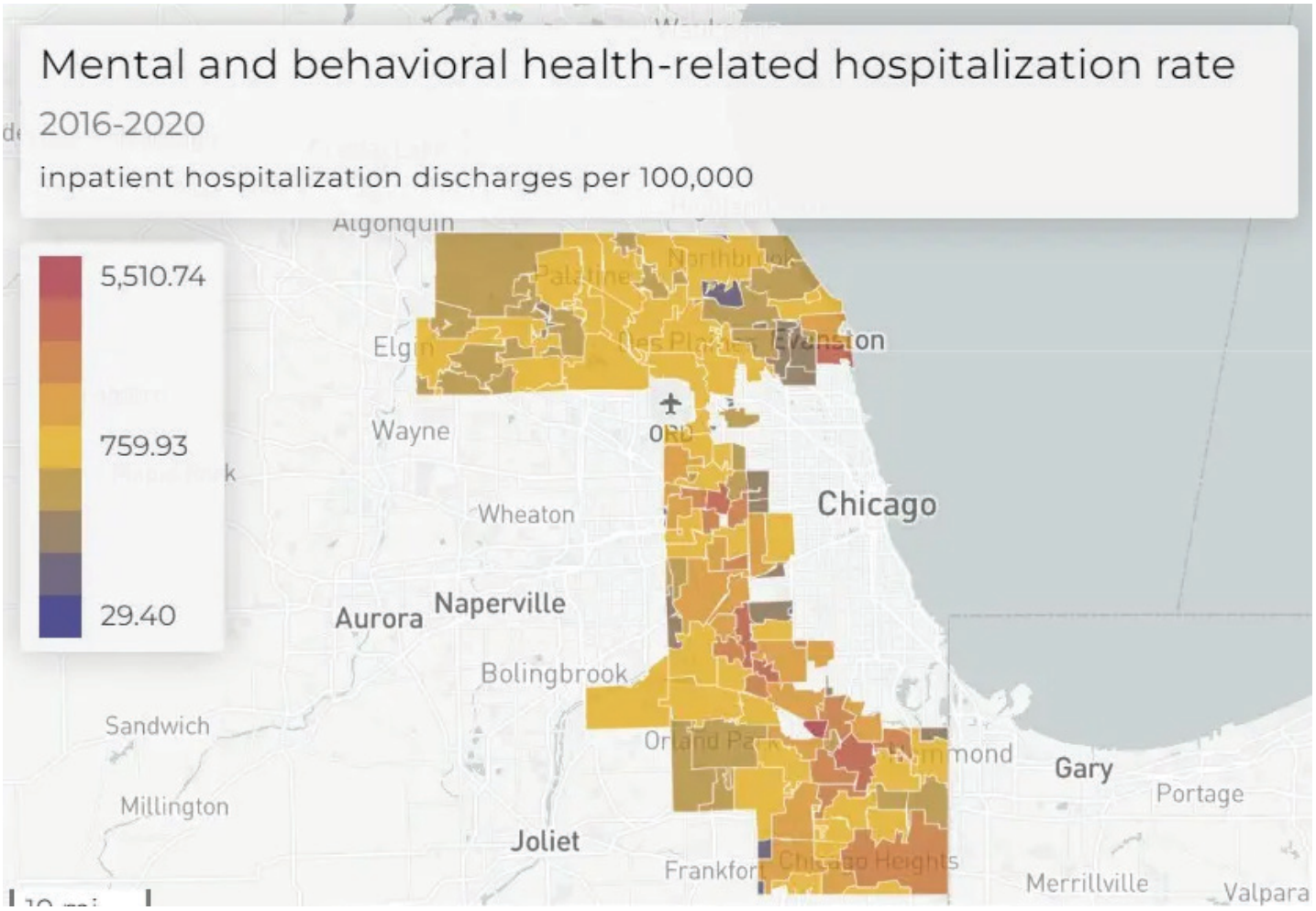
- 0 – <1
- 1 – <2
- 2 – <4
- 4 – <7
- 7 – 11

Sources: SAMHSA N-SUMHSS 2022

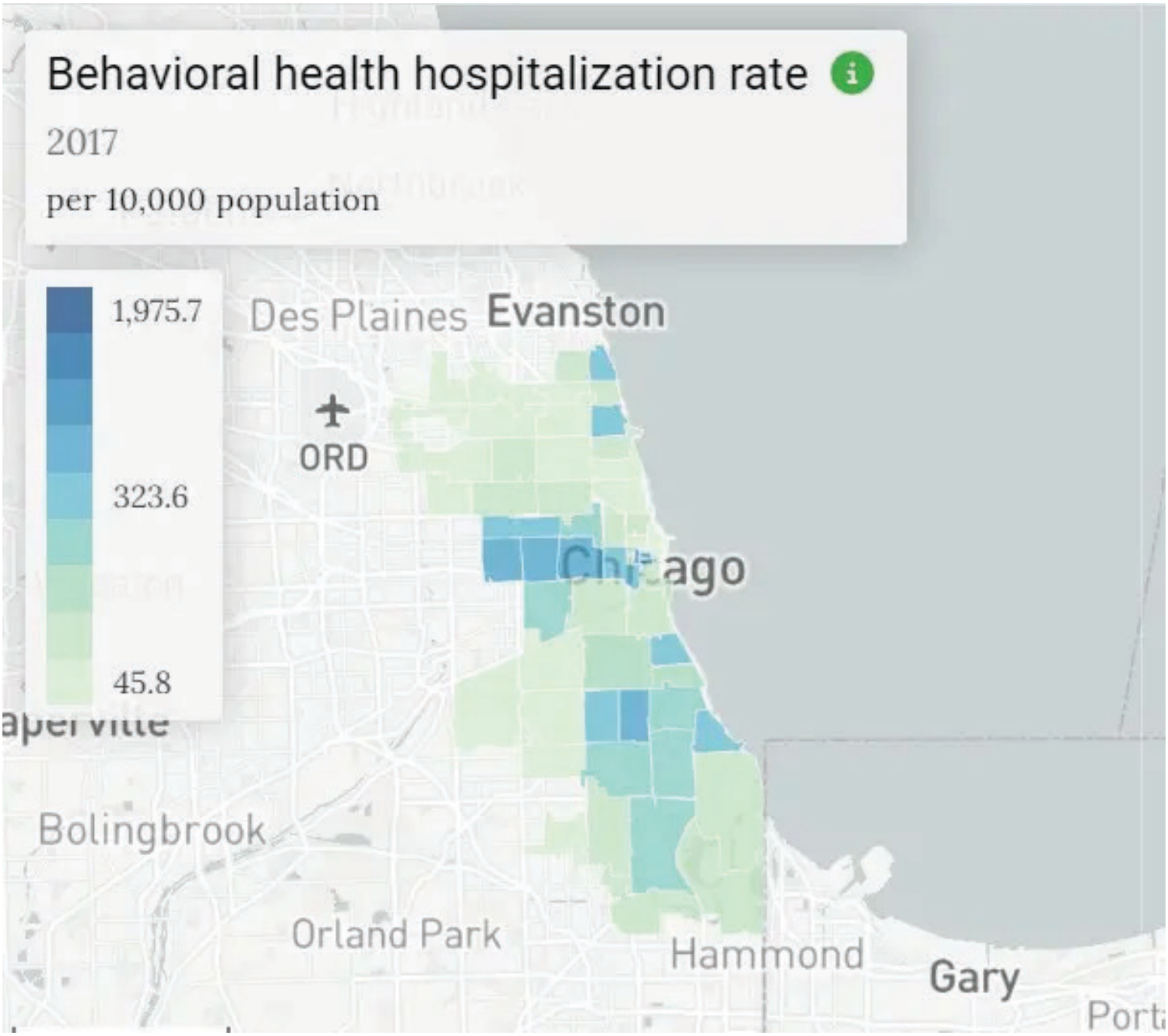
Hospitalizations

Analyzing the rate of behavioral health hospitalizations in a community can provide valuable insights into several aspects of its mental health landscape. A higher rate of hospitalizations may suggest a greater prevalence of severe mental health conditions or inadequate access to outpatient mental health services. It could also indicate potential gaps in community support systems or socioeconomic factors contributing to mental health crises. Conversely, a lower rate might suggest effective preventative measures, robust community support networks, or better access to mental health resources. Understanding these patterns can aid in the allocation of resources, development of targeted interventions, and implementation of policies aimed at improving overall mental health outcomes within the community.

The map below, taken from the Cook County Health Atlas, shows the mental and behavioral health-related hospitalization rates, based on inpatient hospitalization discharges per 100,000 population. ZIP codes 60411, 60804, and and 60402 have a rate over 3,000 per 100,000. Rates are lowest in ZIP codes 60029, 60141, and 60301, which all have fewer than 50 discharges per 100,000.



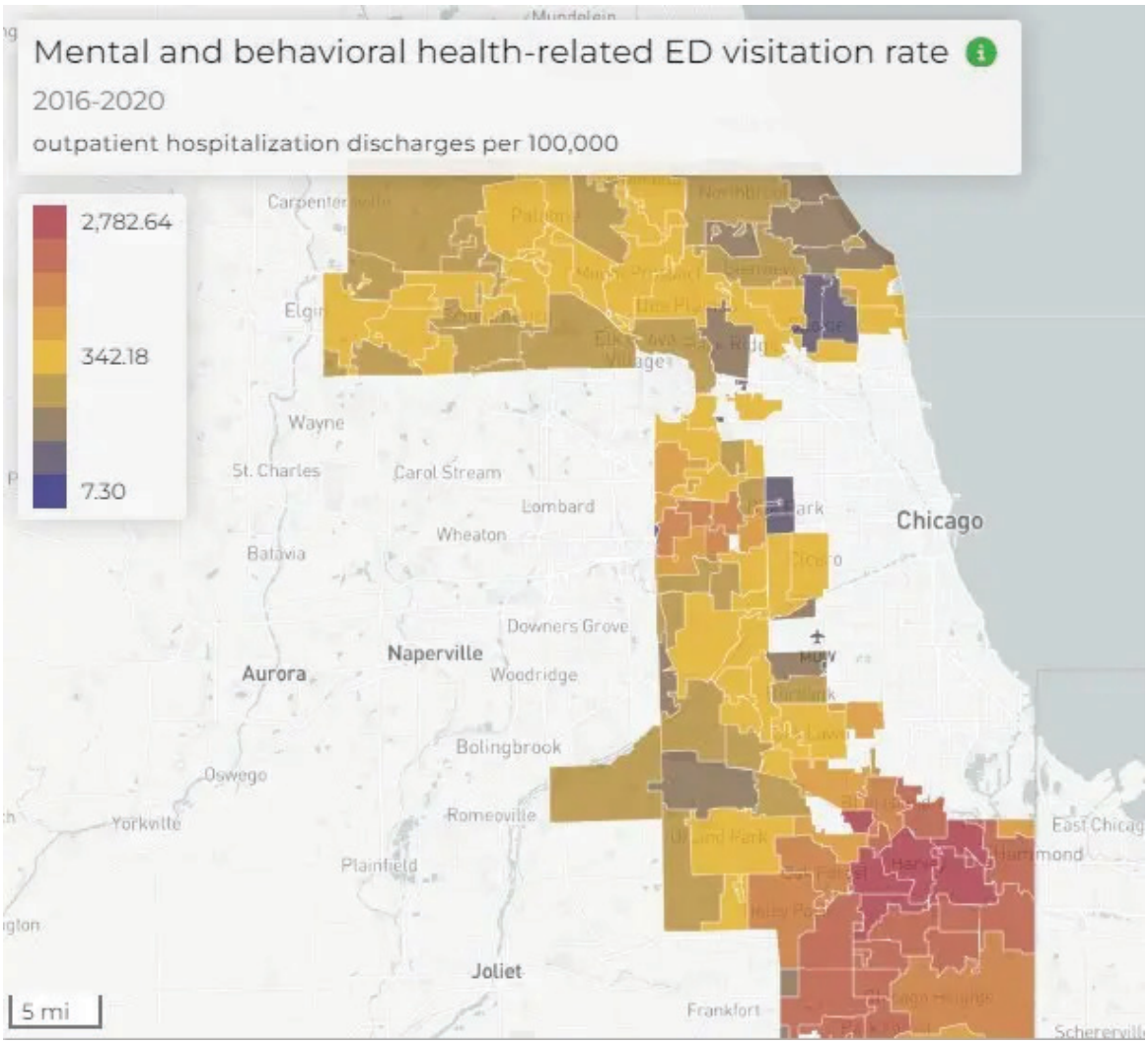
The map below, from the Chicago Health Atlas, shows the behavioral health hospitalization rate per 10,000 population. Rates were highest in ZIP codes 60604, 60602, and 60644, and were lowest in 60661, 60632, and 60646.



Emergency Department Use

Emergency department rates for behavioral health conditions can offer insights into the accessibility and effectiveness of mental health services. Higher rates of emergency department visits for such conditions may indicate barriers to accessing timely care, gaps in community-based mental health support, or insufficient resources for managing mental health crises outside of hospital settings. Additionally, frequent emergency department utilization for behavioral health concerns could suggest a lack of preventative care or early intervention programs. Conversely, lower rates may suggest effective community-based mental health services, robust crisis intervention strategies, or proactive efforts to address mental health needs before they escalate to emergency situations.

The map below, from the Cook County Health Atlas, shows the mental and behavioral health related emergency department visitation rate, per 100,000 population. Rates were highest in ZIP codes 60411, 60804, and 60402, and lowest in 60029, 60141, and 60301.



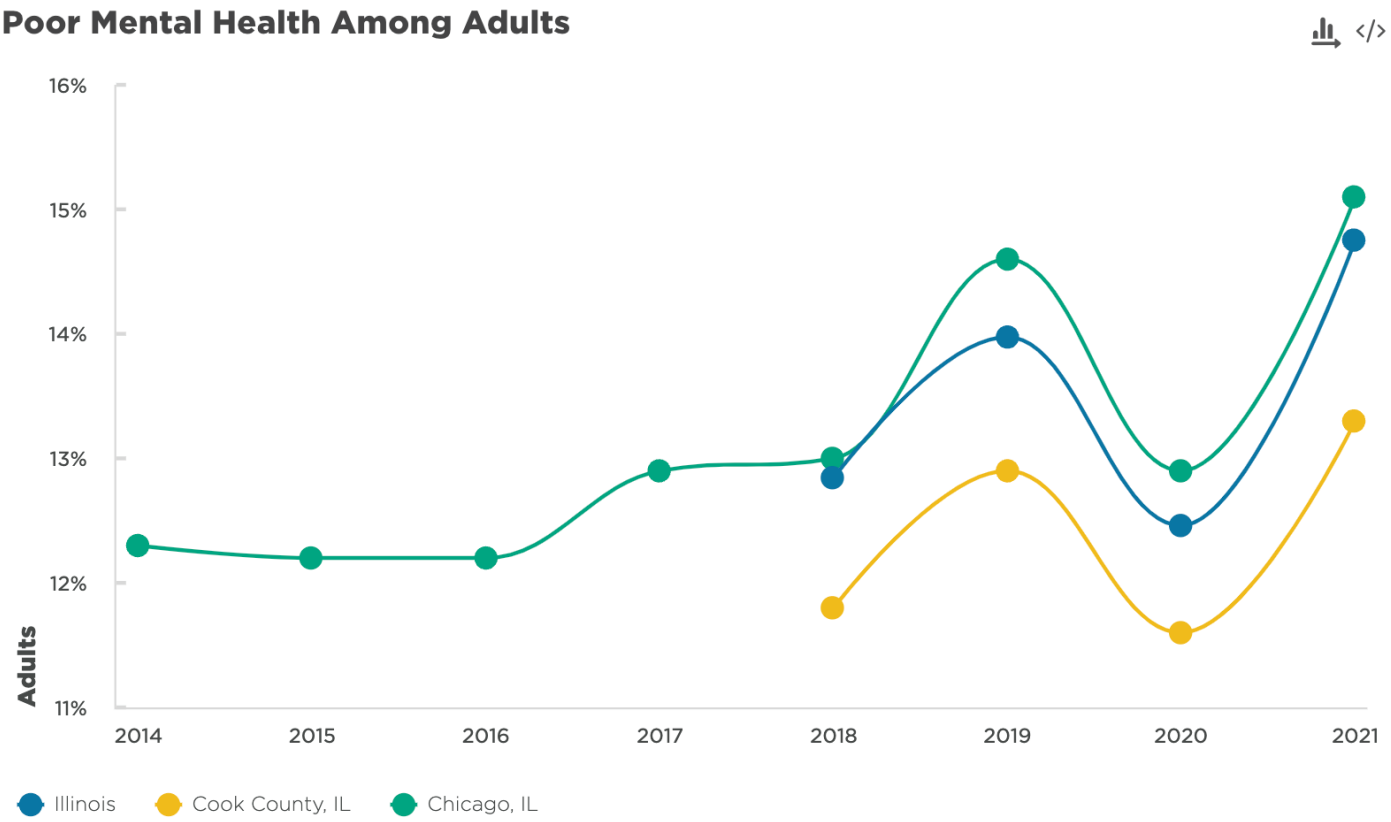
Behavioral Health Outcomes

Mental Health: Morbidity, Behaviors, and Outcomes

Depression and Isolation

When looking at poor mental health among adults, Chicago consistently shows higher rates compared to the comparison regions. Data reported in 2019 showed an increase in the percentage of older adults with poor mental health. The decrease in 2020 percentages is likely due to surveillance limitations of the 2020 pandemic. The data shows another increase from 2020 to 2021.

Poor Mental Health Among Adults

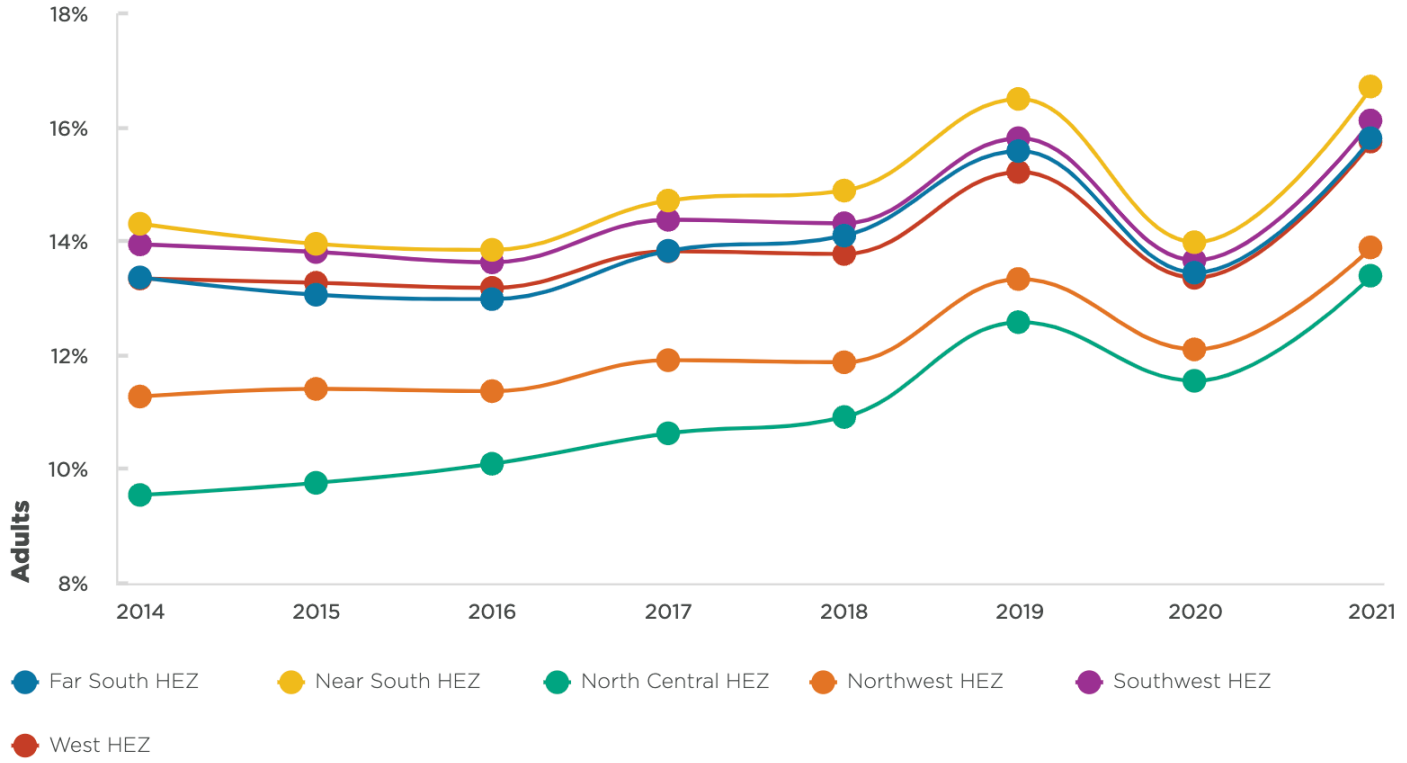


Sources: CDC BRFSS 500 Cities; CDC BRFSS PLACES

Note: This data shows the percent of adults who indicated their mental health was not good for at least 14 of the past 30 days at the time the survey was taken.

Among the 6 Chicago Health Equity Zones, Near South has consistently shown the highest percentage of adults with poor mental health, while North Central has consistently had the lowest percentages.

Poor Mental Health Among Adults (Chicago Health Equity Zones)

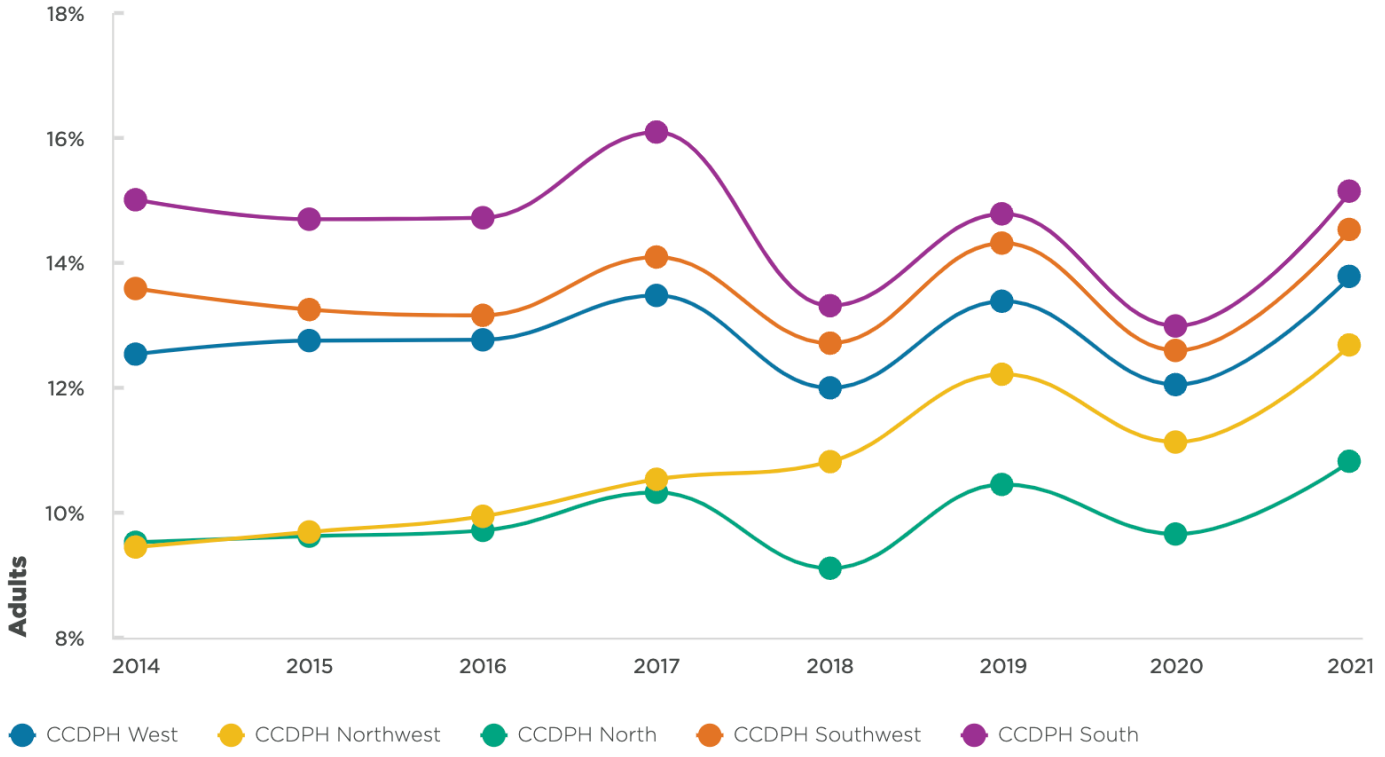


Sources: CDC BRFSS 500 Cities; CDC BRFSS PLACES

Note: This data shows the percent of adults who indicated their mental health was not good for at least 14 of the past 30 days at the time the survey was taken.

Looking across CCDPH Planning Zones, South has consistently had the highest percentages of adults with poor mental health, while North has had the lowest.

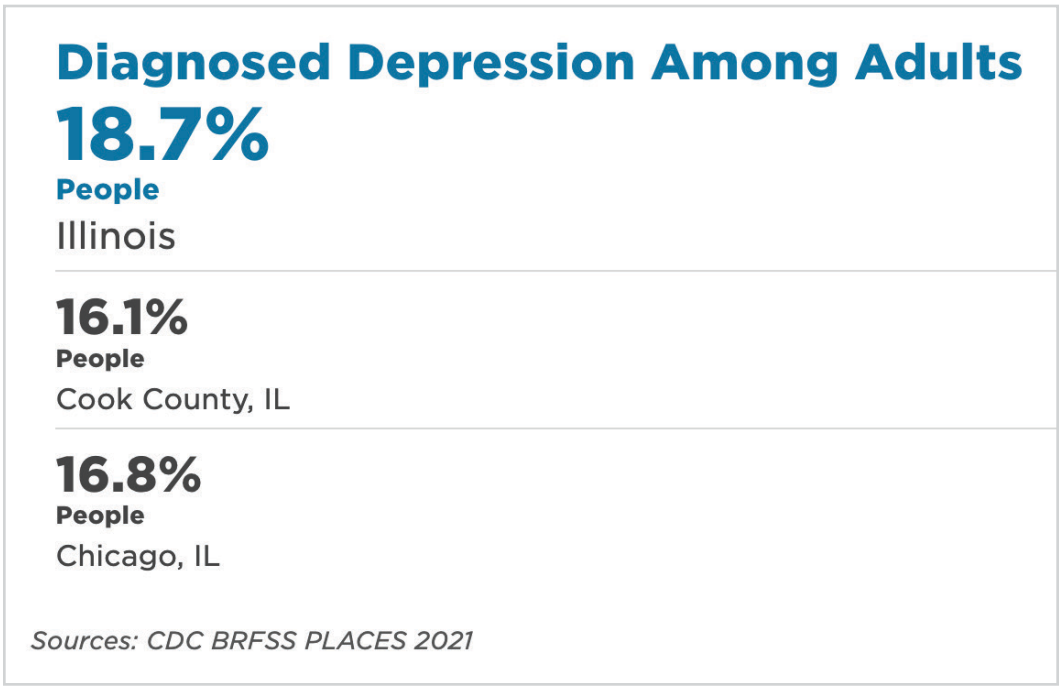
Poor Mental Health Among Adults (Planning Zones)



Sources: CDC BRFSS 500 Cities; CDC BRFSS PLACES

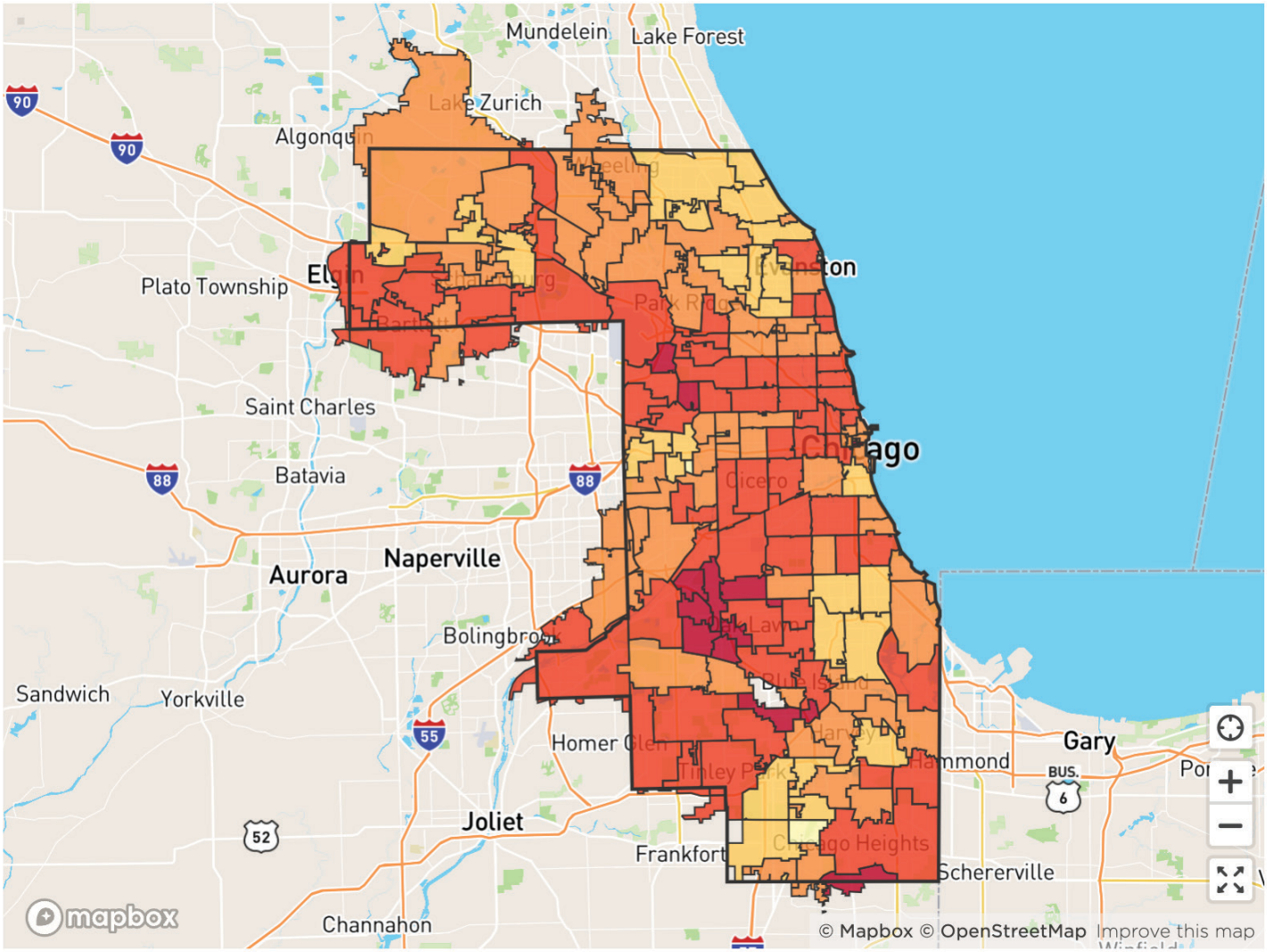
Note: This data shows the percent of adults who indicated their mental health was not good for at least 14 of the past 30 days at the time the survey was taken.

In 2021, data shows that the percentage of adults diagnosed with depression was higher for the state of Illinois overall, compared to Cook County and Chicago.



The diagnosed depression rate among adults is highest in Chicago Ridge (60415) at 20.3%, and lowest in Hines (60141), at 9.8%. The map of diagnosed depression by zip code shows that depression rates are close to 20% in many areas of the County.

Diagnosed Depression Among Adults



Cook County, IL

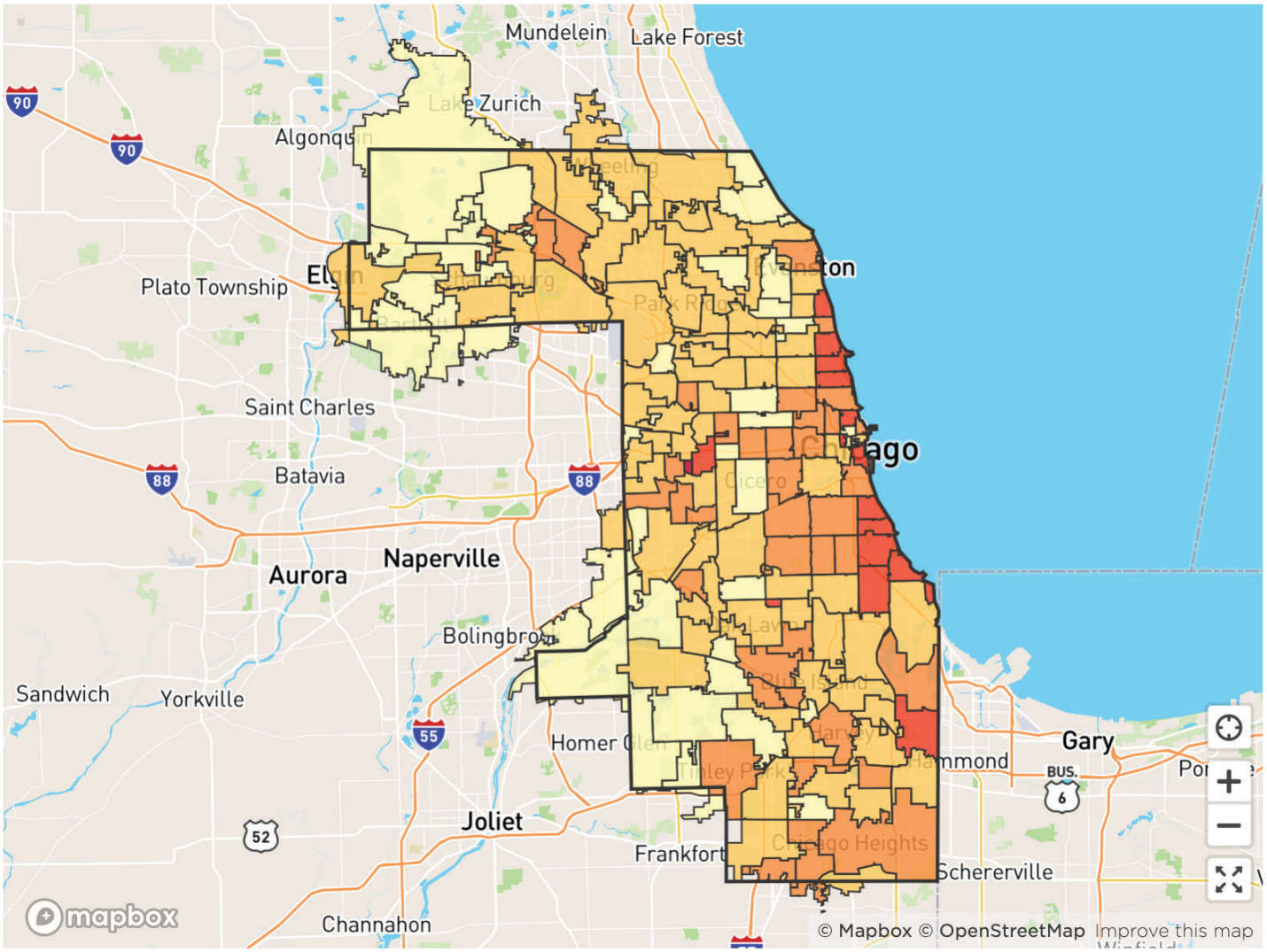
Diagnosed Depression Among Adults

- 9.8% – <14.1%
- 14.1% – <15.6%
- 15.6% – <17%
- 17% – <18.6%
- 18.6% – 20.3%

Sources: CDC BRFSS PLACES 2021

Research has shown that there is a significant link between social isolation and depression. The map below shows the percentage of older adults (age 65 and older) that live alone. The National Institute on Aging reports that older adults are at an increased risk for social isolation due to changes in vision and hearing, higher rates of memory loss, mobility issues, and the loss of family or friends. In Cook County, there are several communities where more than half of adults over the age of 65 are living alone.

Seniors Living Alone normalized by People in Household Age 65 and Over (Seniors)



Cook County, IL

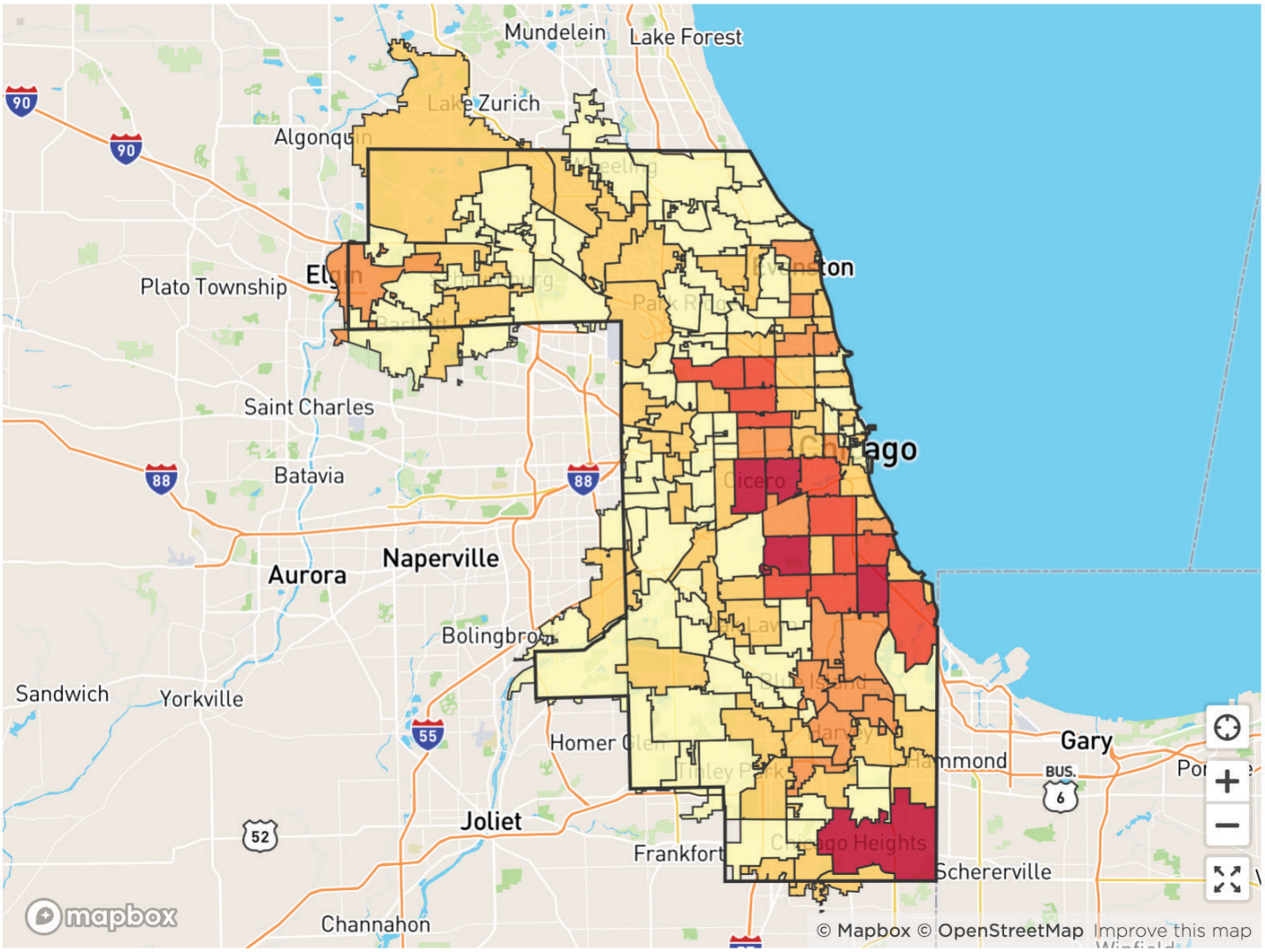
Seniors Living Alone normalized by People in Household Age 65 and Over (Seniors)

- 0% – <24%
- 24% – <33.8%
- 33.8% – <47%
- 47% – <100%
- 100%

Sources: US Census Bureau ACS 5-year 2018-2022

Access to education and employment is crucial for young people's future. The data on disconnected youth aged 16 to 19 not enrolled in school and unemployed or not in the labor force between 2018-2022 across different ZIP codes reveals disparities in opportunities.

Disconnected Youth - Age 16 to 19 Not Enrolled in School and Unemployed or Not in Labor Force



Cook County, IL

Disconnected Youth - Age 16 to 19 Not Enrolled in School and Unemployed or Not in Labor Force

- 0 – <69
- 69 – <176
- 176 – <308
- 308 – <542
- 542 – 765

Sources: US Census Bureau ACS 5-year 2018-2022

According to the 2020 Youth Risk Behavior Survey of suburban Cook County high school students, approximately 32% have felt sad or hopeless almost every day for over 2 weeks in a row, to the point where they stopped doing some of their usual activities.

32.3%
of Suburban Cook County High School Students
Have Had Periods of Depression (2020)

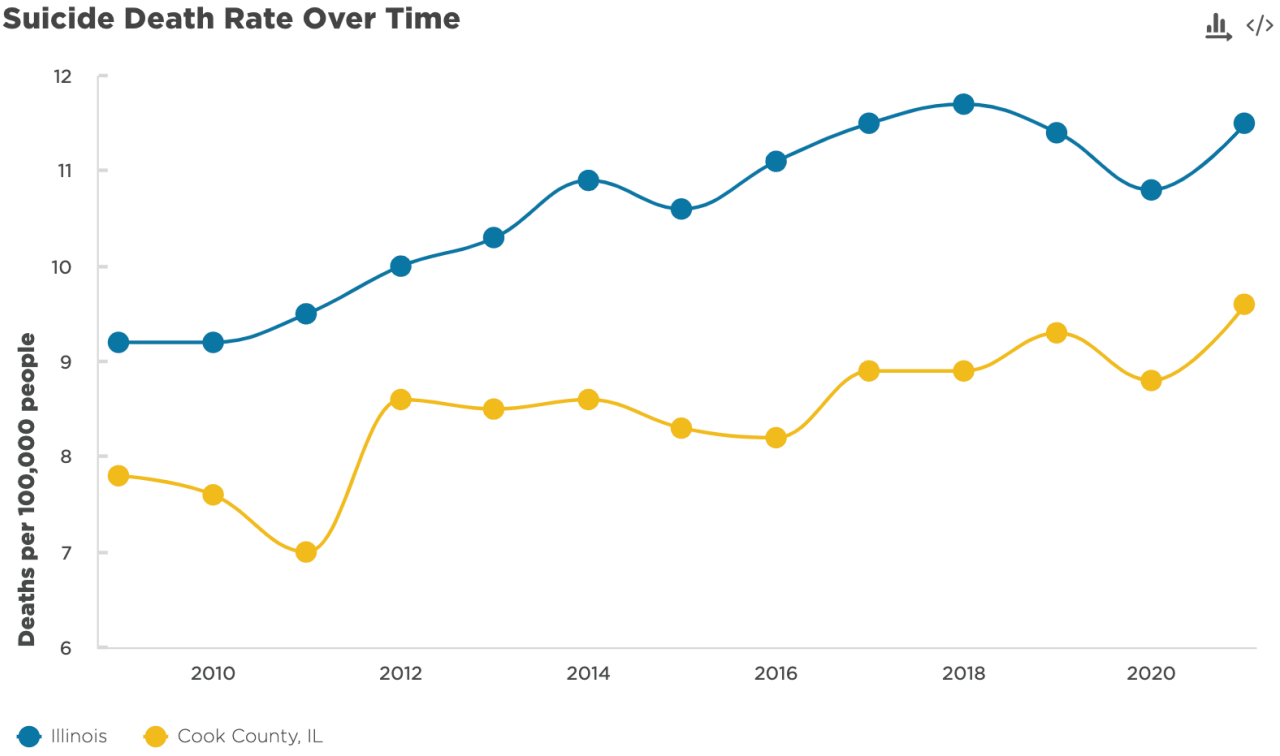
Self Harm

The suicide death rate is lower in Cook County compared to the state of Illinois - both overall and broken out by gender.

Data Sources	Illinois	Cook County, IL
Suicide Death Rate	11.5	9.6
Suicide Death Rate - Male	44.2	15.1
Suicide Death Rate - Female	14.3	4.3

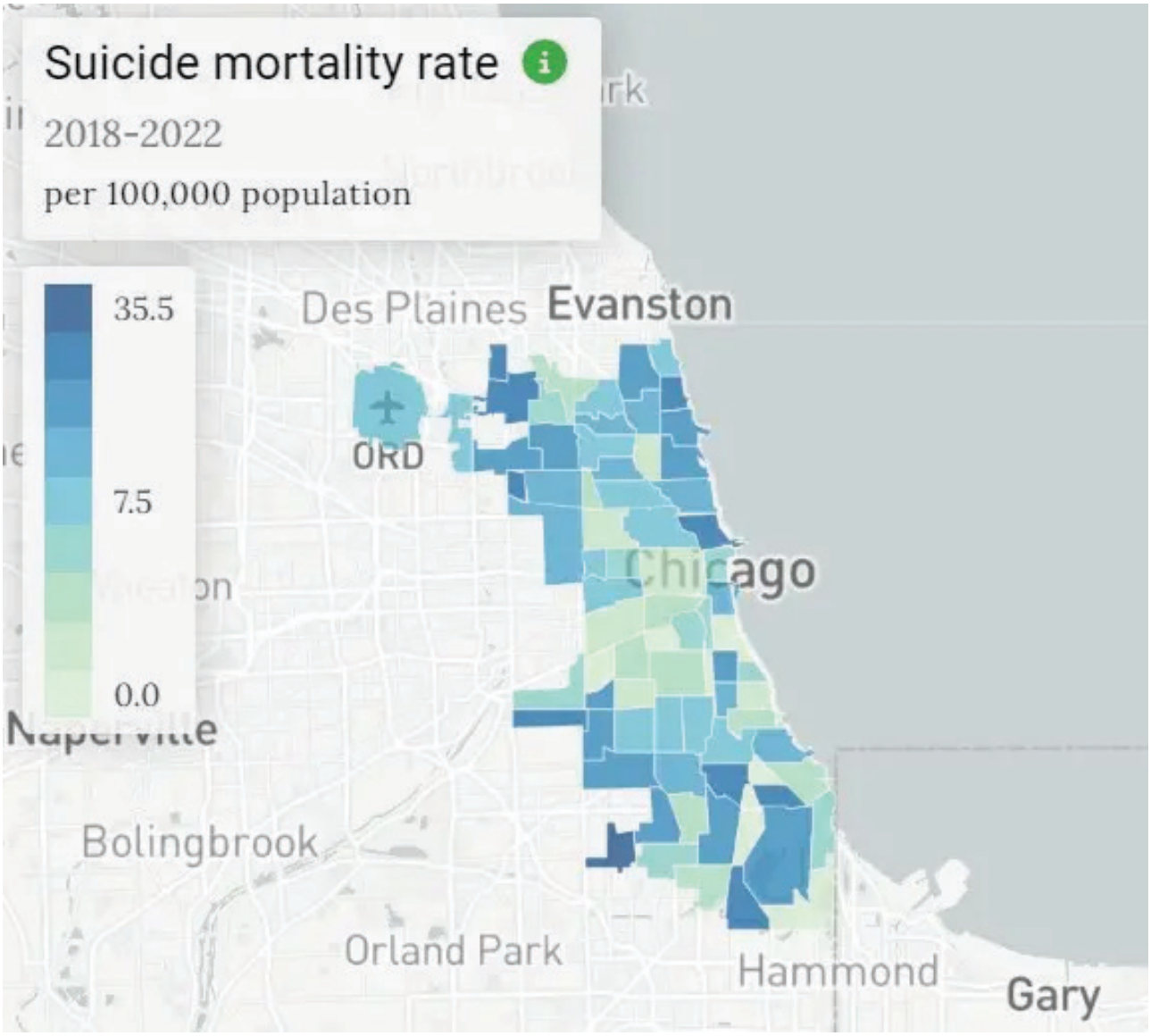
Sources: CDC WONDER Cause of Death 2021

In Illinois and in Cook County, the suicide death rate has increased over time, with recent upswings from 2020 to 2022 in both the state and the County.



Sources: CDC WONDER Cause of Death

The map below, from the Chicago Health Atlas, includes the suicide mortality rate for the City of Chicago. The highest rate was in Mount Greenwood (28.4 per 100,000).



As reported in the 2020 Youth Risk Behavior Survey of suburban Cook County high school students, approximately 6% have attempted to take their own life at least once in their lifetime. Of those, 1.6% have attempted to take their life 2 or 3 times.

6%
of Suburban Cook County High School Students
Have Attempted to Take Their Own Life

Substance Use: Behaviors, Morbidity, and Outcomes

Tobacco Use

In 2021, data shows only very slight differences in regular smoking rates among adults in Illinois, Cook County, and the city of Chicago.

Regular Smoking Among Adults

14.9%
People
Illinois

13.1%
People
Cook County, IL

14.9%
People
Chicago, IL

Sources: CDC BRFSS PLACES 2021

Data from the 2020 Youth Risk Behavior Survey shows that 3.3% of high school students in suburban Cook County smoke cigarettes, compared to approximately 6% of high school students nationally. In 2020, 35.4% of high school students reported that they had ever used an electronic vapor product, which is higher than the national average (33%).

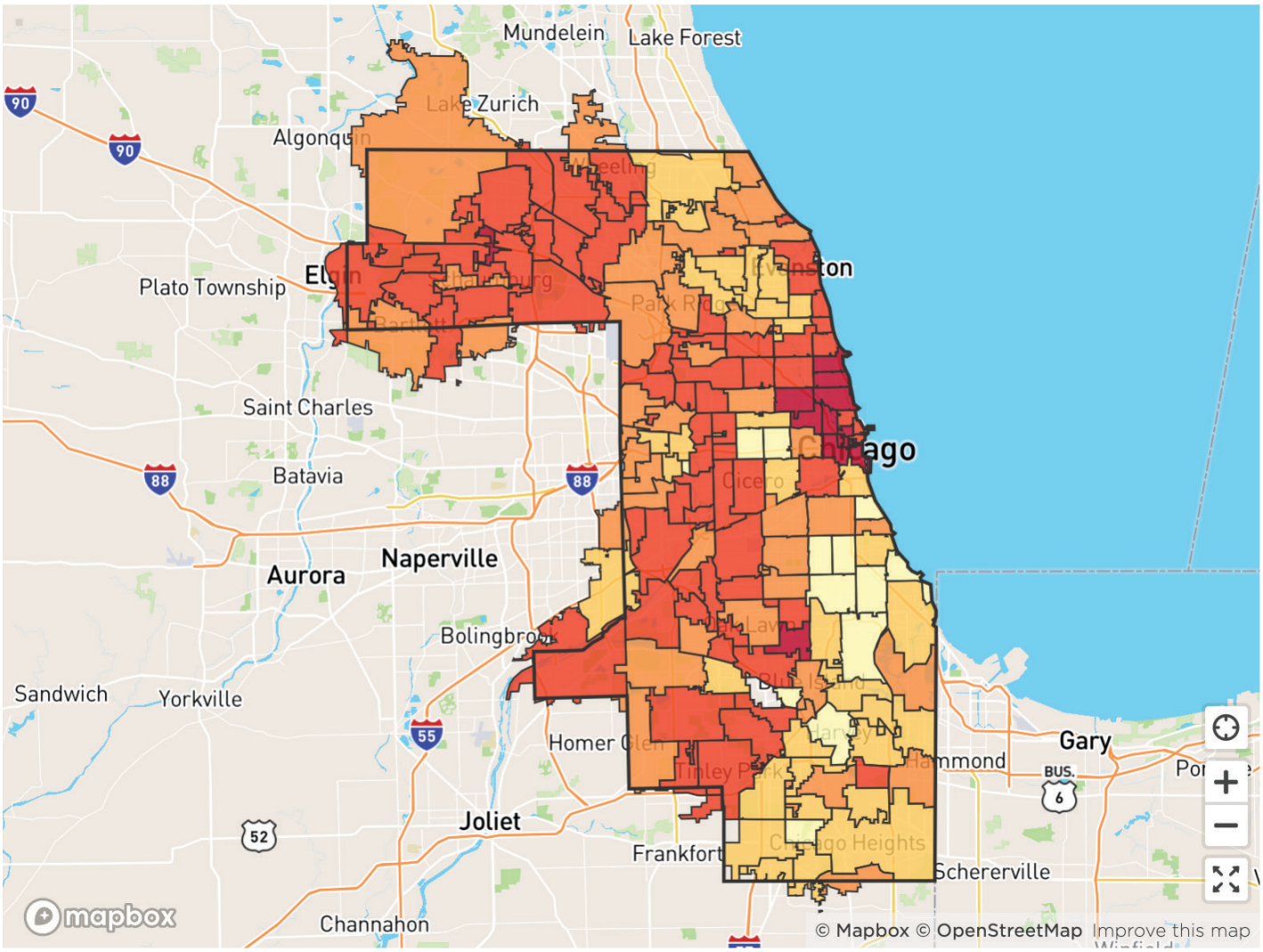
3.3%
of Suburban Cook County High School Students
Currently smoke cigarettes (2020)

35.4%
of Suburban Cook County High School Students
Have Ever Used an Electronic Vapor Product (2020)

Alcohol Use

In the Cook County, Hines (ZIP Code 60141) has the lowest rate of binge drinking among adults at 8.5%, while Chicago's Lakeview neighborhood (ZIP Code 60657) has the highest at 24.4%. Binge drinking is defined as having five or more drinks on one occasion for males, and four or more drinks on one occasion for females.

Binge Drinking Among Adults



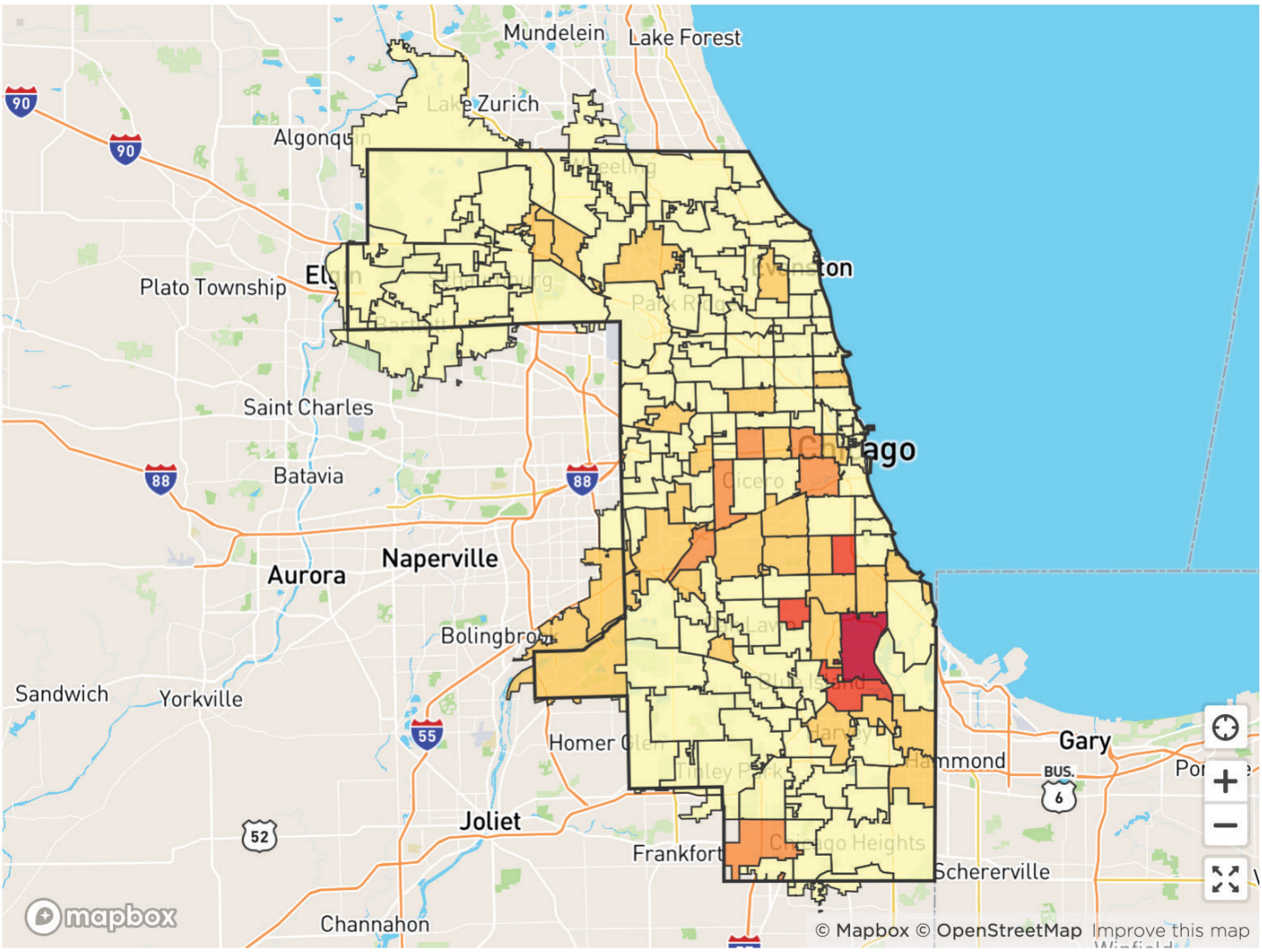
Cook County, IL

Binge Drinking Among Adults

- 8.5% – <13.6%
- 13.6% – <15.9%
- 15.9% – <17.8%
- 17.8% – <20.8%
- 20.8% – 24.4%

Sources: CDC BRFSS PLACES 2021

Motor Vehicle Fatal Crash Involving Drunk Driver



Cook County, IL

Motor Vehicle Fatal Crash Involving Drunk Driver

- 0 – <1
- 1 – <2
- 2 – <3
- 3 – <4
- 4

Sources: NHTSA FARS 2021

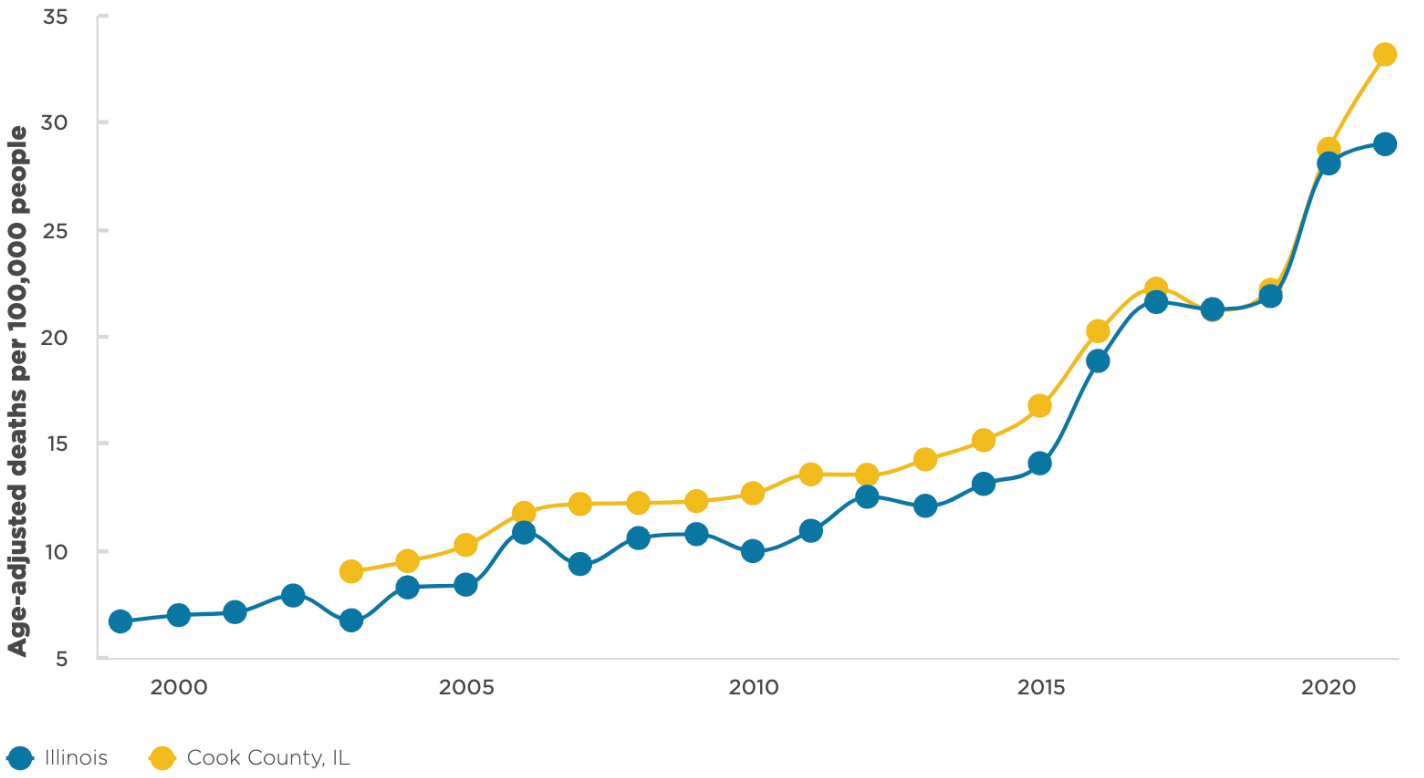
According to the 2020 Youth Risk Behavior Survey (YRBS), approximately 20% of high school students in suburban Cook County had consumed alcohol in the past 30 days. Additionally, in the same year, 11% reported binge drinking in the past 30 days. Of the students who reported ever having drank alcohol, 23.5% had their first drink before the age of 14.

19.9%
of high schoolers in Suburban Cook County
Consumed Alcohol in the Past 30 Days (2020)

Substance Use Mortality

The drug overdose death rate in Cook County has gradually increased over the years, with higher rates compared to the overall state of Illinois since 2000. Looking at the chart below, there has been a significant increase in the overdose death rate in both the state and Cook County since 2019.

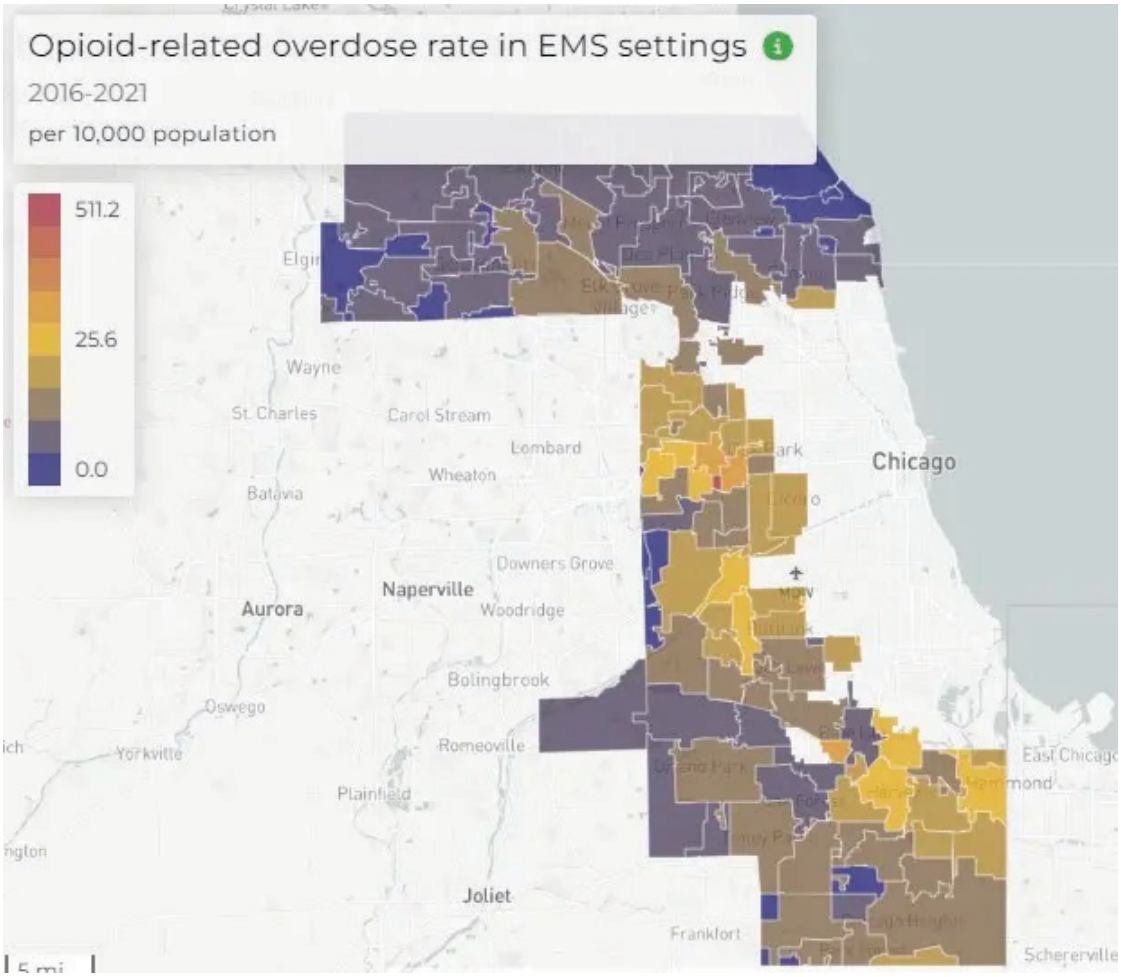
Drug Overdose Death Rate



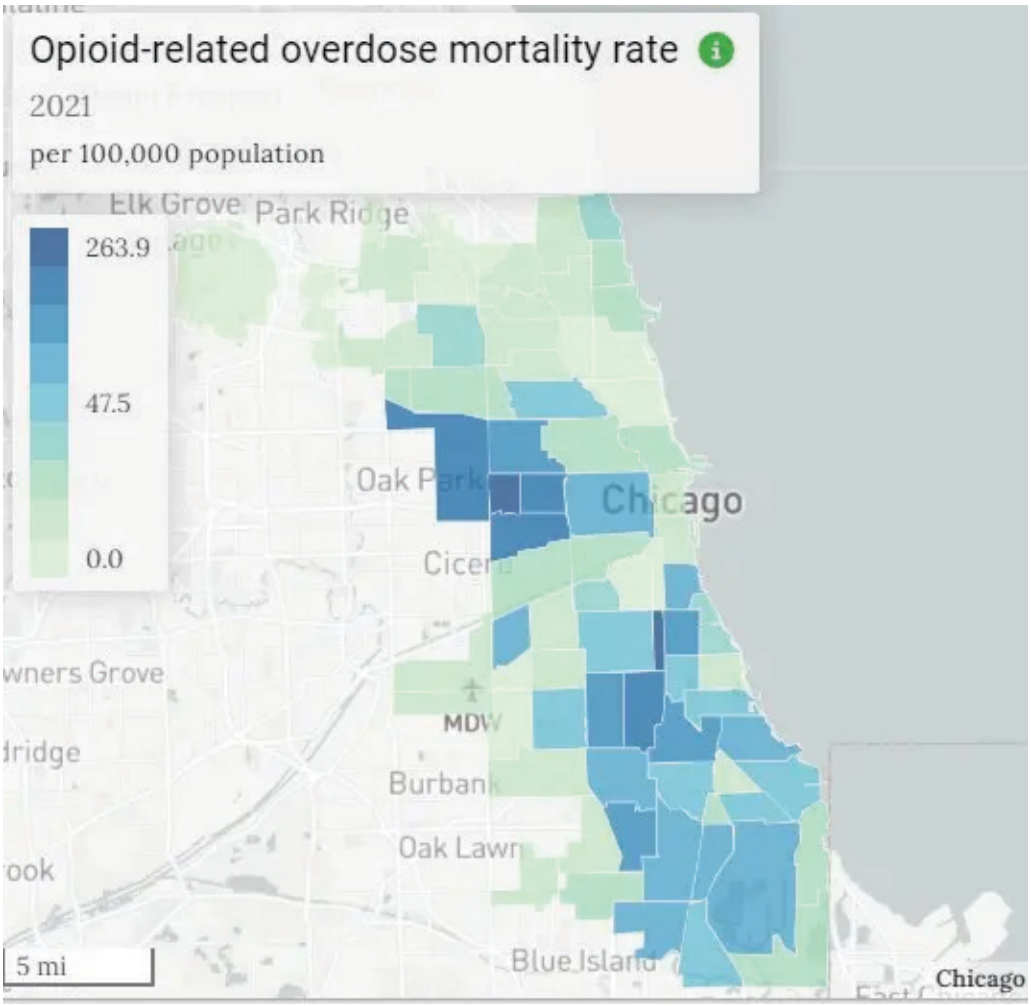
Sources: CDC

Opioid Overdoses

The map below, taken from the Cook County Health Atlas, shows the rate per 10,000 population of opioid-related overdose deaths in EMS settings. Rates were highest in zip code 60624 (West Garfield Park, Chicago) and 60141 (Hines, IL), each with a rate of over 400 per 10,000 population.



The map below, from the Chicago Health Atlas, includes opioid-related overdose mortality rates for Chicago neighborhoods. Rates are highest in Fuller Park (263.9 per 100,000), and West Garfield Park (225.6 per 100,000).

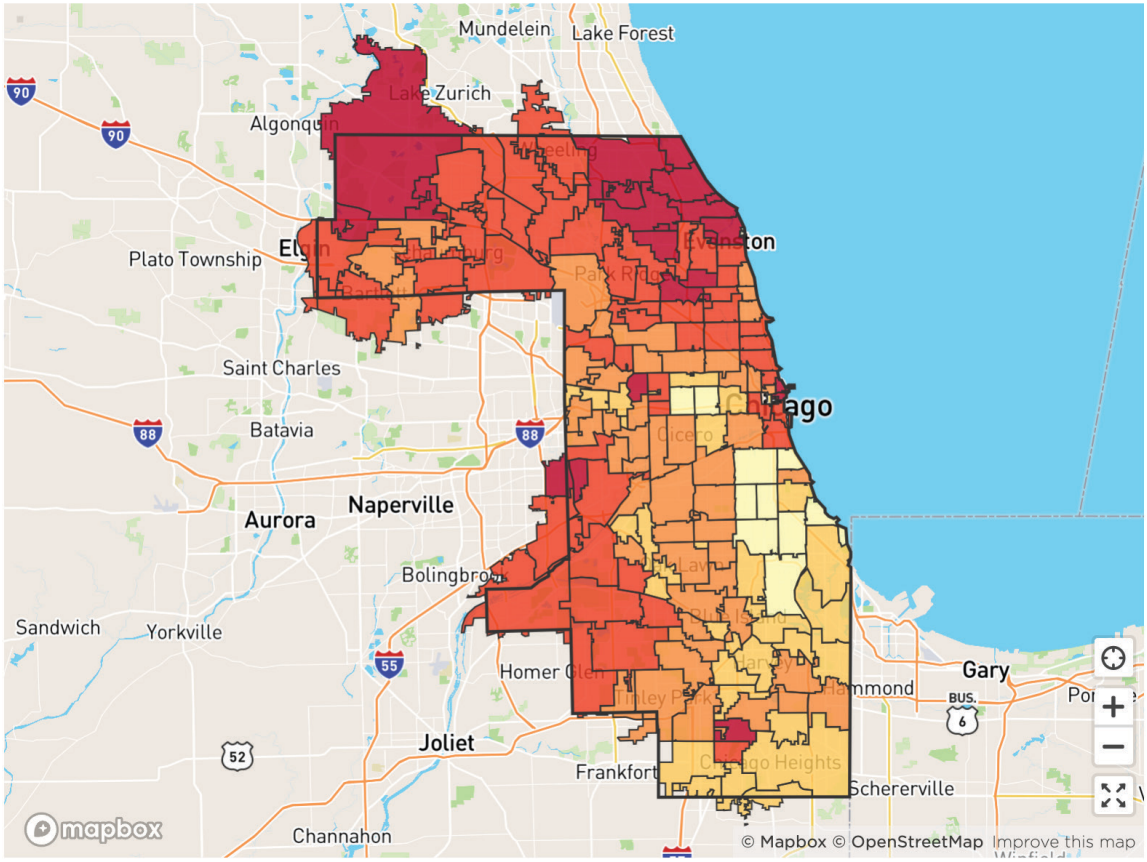


Life Expectancy

The link between life expectancy and behavioral health is profound, as mental health and well-being play a significant role in overall longevity and quality of life. Numerous studies have demonstrated that individuals with untreated mental health conditions, such as depression, anxiety, or substance abuse disorders, often have reduced life expectancy compared to those without these conditions. Behavioral health issues can contribute to a range of negative health outcomes, including increased risk of chronic diseases such as cardiovascular disease, diabetes, and certain cancers, as well as higher rates of mortality from preventable causes such as suicide and accidental drug overdoses. Furthermore, behavioral health concerns can impact health behaviors and access to healthcare, leading to disparities in health outcomes and exacerbating existing health conditions.

Englewood (ZIP code 60621) has the lowest life expectancy at birth of 68.2 years, while Kenilworth (ZIP code 60043) has the highest at 87.7 years - despite only 30 miles between the two neighborhoods. Understanding these disparities is crucial for the community to address unequal access to healthcare, social services, and resources.

Life Expectancy at Birth



Cook County, IL

Life Expectancy at Birth

- 68.2 – <73.4
- 73.4 – <76.9
- 76.9 – <79.6
- 79.6 – <82.6
- 82.6 – 87.7

Sources: CDC NCHS USALEEP 2010-2015

Key Findings

Summary Findings from Cook County's Existing Community Health Needs Assessments

After thorough research and analysis of the previously mentioned 14 CHNAs, key themes and patterns were identified in each, providing additional insights on the issues that are most important to the health and well-being of those who live in Cook County and that may impact behavioral health. A review of these CHNAs also helped to ensure that the extent to which behavioral health issues were identified as leading priorities was understood, and explored the extent to which there was alignment of ideas across the CHNAs and with respect to the BHNA findings. The review of these CHNAs also offered important insights on how other organizations articulated the strategic opportunities with respect to improving community health, including improvements to the county's behavioral health system. This information also informed this assessment's recommendations and priorities with respect to mental health and substance use, as well as health risk-factors, physical health, and access to care.

First, Table 2 provides a summary of findings, and the priorities articulated in each of the 14 CHNAs and indicates how often the same priorities were identified across the CHNAs. Not surprisingly, based on the findings from the BHNA, access to behavioral health services was the most commonly identified priority across the 14 CHNAs analyzed. It was identified as a priority issue in 11 out of 14 CHNA reports reviewed. Social determinants of health (e.g., housing, economic insecurity, food insecurity, transportation, education) was the second most common priority identified (10 out of 14), followed by behavioral health awareness, education, and stigma (8 of 14), violence (gun-violence, crime) (7 out of 14), substance use (6 out of 14), lack of system integration (5 out of 14), and lack of diverse, culturally responsive/humble service providers (5 out of 14).

Table 2: Overall Top Priorities of Cook County-Based Community Health Needs Assessments

Overall Top CHNA Priorities	Counts Referenced
Access to Behavioral Health Services	11/14
Social Determinants of Health (housing, food, transportation, etc.)	10/14
Behavioral Health Awareness, Education, and Stigma (from both community and providers)	8/14
Violence (crime, shootings, etc.)	7/14
Substance Use Diagnosis/Disorder (SUD)	6/14
Lack of System Integration	5/14
Lack of Culturally Competent/Humble Providers or Providers who Reflect Community Identity	5/14

The following are brief descriptions of each of these 7 leading areas of priority.

Access to Behavioral Health Services (e.g., mental and substance use disorder (SUD))

Behavioral health issues, and in particular access to behavioral health services, emerged as the most prominent theme across the CHNAs analyzed, with 11 out of 14 assessments highlighting this issue. Substance use diagnosis/disorder, on its own, separate from mental health, was noted in six CHNAs. Access to care for behavioral health was identified as a challenge across all segments of the population but was identified as a particular challenge for those who are Medicaid-insured or uninsured, individuals/families who are economically insecure, non-English speakers, those with intellectual or developmental disabilities, those who are justice involved or recently incarcerated, and those who identify as Black/African American or Hispanic, to name just a few.

As will be discussed in even greater detail below, with respect to access the hospital CHNAs cited challenges related to:

- **Gaps in services and shortages of mental health providers,** leading to substantial delays in accessing care or preventing individuals from accessing care all together,
- **Stigma and the lack of awareness or understanding of mental health and substance use,** leading to isolation, marginalization or discrimination towards those with behavioral health issues,
- **Financial and insurance-related barriers** that limit access due to the high cost of care,
- **Over-reliance on hospital emergency departments and medication for care,** leading to poor quality of care, high costs of care, and major burdens on hospital emergency department operations,
- **Lack of transportation,** leading to missed appointments, poor follow-up care, and limited engagement in care, and
- **Language and cultural barriers,** limiting the quality of the care provided and preventing many from engaging in care all together.

A number of the CHNAs also discussed the need for a broader array of high-quality, person-centered, individualized services that would more effectively promote engagement in care and long-term recovery, including trauma-informed care and specialized programs for young children, those who are unstably housed, formerly incarcerated and justice-involved individuals, and active users of drugs. Finally, with respect to addressing issues of access and quality, several of the CHNAs referenced the need for workforce training and technical assistance to reduce stigma, address implicit bias towards those with mental health and substance use issues, and promote harm-reduction strategies.

Health Related Social Needs

Health Related Social Needs (HRSN) are the social and economic conditions that can affect a person's ability to maintain their health and well-being. There is ample research and experience that illustrate the extent to which these issues impact health and are the root of the health disparities and inequities that exist across the nation and certainly in Cook County. The quantitative data provided above in the community need and behavioral health status section and the qualitative information provided below in the behavioral health system gaps, challenges, and needs section provide ample evidence of the impacts and the importance of prioritizing HRSN issues when it comes to strengthening the health system, especially in the context of behavioral health.

As stated above, 10 out of the 14 CHNAs that were reviewed for this BHNA, highlighted HRSN as a leading finding and priority in their assessments. These assessments highlighted and spoke of a range of issues, including housing, economic insecurity, jobs and employment, food insecurity, and transportation. The detail provided in the CHNAs reviewed reflects on the impacts that these issues have on residents in every community but, it is important to note that these issues have a particular impact on those living in Chicago's Southside and Westside communities as well as South-Suburban neighborhood of Cook County. These communities and other communities in Cook County experience high rates of poverty, unemployment, violence, incarceration, and other health-related inequalities that underlie the health and well-being of the population.

- Housing was one of the leading HSRN issues identified in the CHNAs. This issue was mentioned as a leading priority in six of the fourteen CHNAs. Issues of racism and discrimination were also highlighted specifically in the context of housing with several of the CHNAs emphasizing the disparities and inequities that Black/African American and Hispanic/Latinx communities face with respect to housing. Housing cost burdens were also referenced in many the CHNAs, particularly in Chicago's, West Garfield Park, North Lawndale, East Garfield Park, and Austin, where at least 50% of residents are reported to be cost-burdened due to their housing costs. One of the hospital CHNAs also highlighted the negative impacts of gentrification, including rising housing costs and displacement, leading to diminished community investment and resources especially in the West Side of the City.

The need for transitional housing and safe, affordable housing more generally was also referenced in several of the CHNAs, particularly for those with substance use disorders. Transitional housing and Recovery Homes play a crucial role in the continuum of care since housing is a large part of an individual's recovery.

- Transportation was another leading HRSN issue identified in the Hospital CHNAs with eight of the fourteen CHNAs highlighting this issue as a leading priority. Lack of access to safe, reliable, affordable transportation is known to be a leading barrier to access, engagement, and care continuity. Reliable transportation is essential for promoting employment, social connections, and food security, as well as promoting engagement in needed health care services. Transportation was also identified as critical to those living with a disability.

Behavioral Health Awareness, Education, and Stigma

Stigma is defined as the negative attitudes, beliefs, and behaviors that lead to the marginalization or discrimination of individuals or groups based on certain attributes, such as health conditions, behaviors, or identities. Stigma can be associated with various health issues but is a particularly important issue with respect to mental illness and substance use as it perpetuates barriers to access and prevents people from seeking and engaging in the care they need. Stigma and the need for investment in health education and awareness programs and campaigns was identified as a leading priority in 8 of the 14 assessments reviewed.

As discussed above, 11 of the 14 CHNAs identified behavioral and specifically access to behavioral health services as a leading priority. These CHNAs identified gaps in specific services, workforce shortages, language/culture barriers to care and a wide range of issues that are central to these issues. However, taking steps to reduce behavioral health stigma and the need for both broadly and more narrowly focused education campaigns was identified as a leading priority with respect to addressing the behavioral health challenges facing the County. Numerous CHNAs emphasized the importance of targeting efforts on youth, others referenced the importance of focusing on those facing economic insecurity, and others highlighted the need to focus on cultural stigma against seeking treatment that is experienced by those in many cultural/ethnic groups. Additionally, several CHNAs highlighted the need for education with respect to substance use and the critical need to address the stigma and negative beliefs about those with SUD and who are impacted by addiction.

Investing in community-based education and outreach is vital to increase mental health awareness, education, and access to resources in the community. Many of the hospitals that conducted the CHNAs expressed a need for additional resources and programmatic investment in efforts to raise awareness and facilitate a better understanding of the signs, symptoms, and risk factors of mental health and substance use issues, as well as provide guidance on what to do or where to go if you, a family member, a friend or someone in your community seems to be in behavioral health distress.

Violence (crime, shootings, etc.)

Violence was noted in 7 out of the 14 CHNAs reviewed as part of the BHNA. This issue was also elevated by many of the people that were interviewed and who participated in the BHNAs focus groups. Community violence, particularly gun violence, is a leading issue in the County and poses a wide range of challenges in Cook County. The leading challenge is of course the impact that violence has on its victims, their families, friends, and caregivers, as well as the communities that are

witness to and indirectly impacted. Violence also has an impact on the health system as resources are diverted away from other essential services to those who are experiencing trauma associated with violence.

Several of the CHNAs discussed the need for a multifaceted approach that goes beyond treating the immediate injuries or trauma. Health Related Social Needs, including poverty, unemployment, lack of education, and insufficient housing, often create environments where violence thrives. To address violence and improve community health status, initiatives must focus on prevention through community-based interventions, such as violence interruption programs, neighborhood safety improvements, and access to mental health services. Additionally, investing in educational and economic opportunities can provide alternatives to violent behavior, while fostering community resilience and improving overall health outcomes. Without addressing these systemic issues, violence will continue to perpetuate cycles of poor health and hinder efforts to achieve sustainable community wellness.

Lack of System Integration

The need for system integration was noted in 5 out of the 14 CHNAs reviewed as part of the BHNA. Limited health system integration was a common explanation for the challenges that community residents faced with respect to accessing and engaging in the care they needed. Limited care coordination, challenging transitions from care setting to another, and the inability to navigate the system and nowhere to go was a major finding in the BHNA and was also highlighted in many of the CHNAs. This was cited as an issue for the community at-large regardless of the health condition you might be experiencing but is particularly challenging for those with chronic, severe and persistent behavioral health challenges who often must shift from one care setting to another as they step-up or down to different types of treatment on their road to recovery or sustainability.

Lack of health system integration, stemming from the siloed structure of the treatment system, was cited by many of the CHNAs. For example, one of the CHNAs highlighted the challenge for those who are homeless or unstably housed, particularly if they are also impacted by a mental health issue and are also active drug users. The breadth of needs with respect to HRSNs, mental health, and substance use are tremendous, and care is often challenging to navigate and coordinate, if it is not well-integrated.

Lack of Culturally Humble Providers or Providers who reflect Community Identity

As will be discussed below, a common theme from the BHNAs interviews and focus groups was the need to enhance the behavioral health system's ability to provide linguistically and culturally responsive services. Cook County is racially, ethnically, and linguistically very diverse. There are more than 40 languages spoken by those who live in Cook County, with Spanish being the most spoken language other than English. This is followed by Chinese (Mandarin and Cantonese), Polish, Tagalog, Urdu, and Arabic. According to data from the community need and behavioral health status section of this report, 20.7% of Cook County households speak Spanish at home and 8.4% of Cook County households speak an Indo-European language at home. Furthermore, 59% of Cook County's population identifies as a person of color, jumping to 67% in Chicago. Five of the 14 CHNAs reviewed highlighted the importance of ensuring that the Cook County's diverse, multicultural, non-English speaking population received care and support that was linguistically and culturally responsive and provided with humility and respect. The importance of providing services that are culturally and linguistically responsive is widely understood and discussed in the academic literature. Nonetheless, there are major shortages of non-English speaking service providers, as well as service providers who are from different cultures or who have expertise serving specific populations by age, race, ethnicity, religion, and other identities.

Given this challenge and the literature, many of the CHNAs reflected on the importance of a diverse workforce and the importance of ensuring that the existing service providers were appropriately trained to provide culturally sensitive and responsive services. The need for cultural sensitivity and humility spans beyond ethnicity and language. Many talked about the need for providers to be better trained and aware of the importance of person-centered, culturally responsive and humble care, especially given the judgment and stigma that is often associated with those with mental health and substance use issues.

Behavioral Health System Strengths

Too often, assessments of this nature put too much emphasis on assessing gaps, challenges, and needs and not enough on identifying a community's or a health system's strengths or assets. It is critical that strategic responses take care to elevate, support, leverage, and expand on these strengths and assets along with efforts to fill gaps and address identified challenges. With this in mind, the following discusses key findings with respect to Cook County's strengths as drawn from various data and information sources, including the quantitative data shared above and information gathered through this project's community engagement efforts (i.e., key informant interviews, the BHNA Survey, focus groups, and the PIA Committees).

Strong, diverse, well-distributed, and well-supported network of behavioral health service providers across Cook County

The BHNA was not designed to gather numerical data on the actual clinical and programmatic staffing capacity of Cook County's behavioral health service network. However, the behavioral health service providers, public health officials, behavioral health advocates, and PIA committee representatives, and community residents who participated in the BHNA, consistently shared that Cook County had a strong, diverse, and geographically well-distributed network of behavioral health service provider organizations that were dedicated to their communities and provided a broad array of quality services to Cook County residents.

It should be noted that this does not mean that everyone can access and engage in needed services when and where they want them. In fact, one of the most common themes from the assessment was the extreme challenges that Cook County residents face accessing and consistently engaging in the care they need; this is particularly true for those who are Medicaid-insured, uninsured, non-English speakers, economically insecure and/or who identify with a range of other, often marginalized population groups. These issues are not necessarily due to a lack of an adequate network of behavioral health providers, but rather to issues of workforce and organizational capacity, the need to address consumer barriers to care, health-related social needs, and other factors impacting engagement in care. The need for additional training and technical assistance also are major challenges that impact access to care. The simple fact is that the needs and demands for behavioral health services across Cook County's population far exceed the region's supply of services. Cook County is not alone in this regard. This is an issue in nearly every community in the nation. However, what was noticeable and unique was how often those who participated in the BHNA reflected positively, and with a sense of pride, when asked about Cook County's network of behavioral health providers.

Half (50%) of the people who participated in the BHNA Survey stated that community-based organizations are a top current asset of Cook County when it comes to behavioral health services. Nearly 30% of survey respondents identified access to behavioral health care as a strength.

One survey respondent said:

> *"Although funding is often a struggle, I believe that community-based/nonprofit organizations in Cook County are providing accessible mental health care services and have been a huge part of forward progress in increasing equity of mental health care in Cook County. I believe that the breadth of programs and services available is a huge asset, albeit often with limited capacity or long wait times for specialty programming."*

Another shared:

> *"Cook County offers a large variety of services and programs across the county, and there is a major focus on equity. While services may not always be available and/or there may be limited resources, the efforts to move these programs along are there. Many organizations offer great tools and resources."*

Similarly, a focus group participant with lived experience with behavioral health conditions who also worked for a community-based behavioral health organization spoke very supportively of the services available in Cook County:

> *"Supportive community agencies are out there, they don't always have the capacity to serve everyone because the demand is too high or the person's needs require more intensive care, but there are quite a few agencies out there that are, you know, pillars in the community."*

Strong network of community health centers and other organizations who provide care regardless of an individual's ability to pay

Cook County has a strong, well-dispersed network of community health centers, including 22 Federally Qualified Community Health Center (FQHCs) and Look-Alike organizations (comprising over 200 locations) along with a network of health center sites (Ambulatory and Community Health Network) operated by Cook County Health that provide comprehensive, quality, person-centered care regardless of a person's insurance status or ability to pay. These health center sites are well-supported through federal, state, local public sector and other private sector funding.[58,59] These organizations are dedicated to providing access to those who struggle to access or engage in the care they need, typically due to the acuity and complexity of their conditions, the intense health-related social factors they face, or a lack of insurance or documentation. Cook County is not entirely unique in this regard, as Health Resources and Services Administration's (HRSA's) Bureau of Primary Health Care[58] funds more than 1,500 organizations across the country. However, the network of community health centers in Cook County is particularly strong and well-distributed. Cook County Health is equally dedicated to ensuring that everyone has access to the care they need when and where they want it and since its inception has operated health care organizations throughout the County.

These organizations provide comprehensive primary care preventive, acute, and chronic disease management services, with an emphasis on physical, behavioral, and oral health. They also provide enabling and supportive services to address barriers to care, including addressing health-related social factors and supporting care management and care coordination. From a behavioral health perspective, these organizations are committed to integrating behavioral health into their operations either on-site or through enhanced referral relationships with community partners.

In 2023, the network of Federally Qualified Health Center in Cook County served nearly 900,000 (893,429) patients, 94.3% of whom live in households earning less than 200% of the federal poverty level. Of these patients, 83,583 sought behavioral health care services directly from behavioral health providers. Cook County Health's facilities serve an additional 300,000 patients annually.

Strong network of hospitals and health systems in Cook County with Cook County Health (CCH) at its foundation

Cook County and the City of Chicago have a strong, nationally recognized networks of hospitals and health systems, many of which are affiliated with academic institutions that are well-distributed and provide high-quality, technologically advanced services. While this is not uncommon for large cities in the nation, the health care network in Cook County is a clear and leading asset. What is particularly notable is the strength, commitment, overall approach, and presence of CCH, one of the few remaining large, urban, public safety-net hospital systems in the United States. It provides a strong foundation for the health system in Cook County, particularly with respect to CCH's ongoing commitment to serving underserved, marginalized, and at-risk communities. CCH is nationally recognized for its commitment to excellence and its broad array of specialized clinical services, as well as for its commitment to health equity, addressing disparities in access and health outcomes, and to serving all Cook County residents, regardless of their ability to pay. The fact that CCH is linked to and integrated with Cook County's other public health and health-related agencies, such as those responsible for housing, transportation, employment assistance, public safety and jails, social justice advocacy, family supports, and veterans' affairs, just to name a few, also is a major asset.

Cook County, the City of Chicago, and the network of service providers that operate in the County are progressive and innovative in their approach to providing services

Based on input gathered by the assessment, there was a clear appreciation that the Cook County and City of Chicago governments, along with the County's network of behavioral health providers, were progressive and innovative in their perspectives and their approaches to care delivery. The government agency programs and the core providers in the network seem to fully embrace the ideas that are considered to be "best practice", and many champion these ideas. Through the assessment's interviews and meetings, there were frequent references to many of the ideas, programs and services that are considered best practice, including:

- Addressing the health-related social needs
- Developing low-barrier, easy-entry programs
- Applying community health workers, peer-recovery coaches, and other peer-support staff
- Implementing and supporting harm reduction strategies (including Narcan/Naloxone distribution, supervised injection sites)
- Applying trauma-informed approaches
- Developing programming for recently incarcerated and justice-involved individuals
- Developing safe spaces to support recovery, such as "clubhouses" and "living room" models
- Expanding and enhance behavioral health integration into primary care and other clinical and nonclinical settings
- Applying value-based payment models to support outreach and engagement in care
- Developing specialized programs for those impacted by gun violence
- Developing street outreach programs that support those with mental health and substance use conditionsCook County and the City of Chicago are broadly recognized for their focus on equity, health equity, and social justice

Cook County and the City of Chicago are broadly recognized for their focus on equity, health equity, and social justice

Cook County and the City of Chicago's focus on equity, health equity, and social justice is highly recognized and considered of paramount importance. The partnerships and programming that the governments of Cook County (including CCH) and the City of Chicago have developed, show a clear commitment to addressing the deep-rooted disparities that have long affected marginalized communities in Cook County. By prioritizing these values, Cook County and CCH aim to ensure that all residents, regardless of their socioeconomic status, race, or background, have equal access to healthcare services and opportunities for a healthy life. Initiatives to expand access to quality health care, invest in neighborhoods that have faced historical inequities for decades, and implement policies that address SDOH demonstrate a commitment to creating a more equitable and just society. These efforts improve individual health outcomes and strengthen the overall well-being of the community, fostering a healthier, more inclusive environment for everyone.

Programs like CountyCare (CCH's Managed Care Health Plan), which provides Medicaid coverage to low-income residents, the Healthy Chicago 2025 initiative, focused on reducing the life expectancy gap between different communities, and the Stronger Together initiative, discussed above is working to address the behavioral health crisis, highlight Cook County's dedication to health equity. Moreover, their emphasis on social justice is evident in policies that address systemic issues such as affordable housing, education, and employment opportunities, which are crucial for achieving long-term health equity.

Strong federal, state, county, and local (Chicago) public sector partnerships

When it comes to behavioral health services and programming, entities in Cook County are well-supported by the federal government, the State of Illinois, and the City of Chicago. With this support and comes tremendous opportunities for partnership and alignment of public sector policies. The US Department of Health and Human Services through SAMHSA and HRSA funding continues to make substantial investments to support prevention in strengthening behavioral and physical health systems of care, particularly for those segments of the population that face barriers to access and disparities in health outcomes. Both agencies have recently completed strategic plans that are well-aligned with the findings from this assessment.[60,61] The State of Illinois has been recognized for the breadth and depth of its Opioid Action/Remediation Plan, its rollout of federally supported Certified Community Behavioral Health Clinics (CCBHCs), and its efforts to care for those in behavioral health crisis (e.g., 590 Crisis Care System).[62] The City of Chicago recently completed its Healthy Chicago 2025 initiative, which invested heavily in addressing behavioral health, including efforts to reduce opioid overdoses, promote access to affordable, accessible, high-quality, culturally responsive health and human services, and address systemic and institutional racism by reshaping Chicago's social, economic, and physical environments.[63] It should be noted that while the federal government, the State of Illinois, Cook County, and the City of Chicago provide a tremendous amount of resources and support related to behavioral health, it does not mean that everyone in the County receives the care they need when and where they need it. The BHNA provided ample evidence that the behavioral health needs of the County far outstrip the supply of services. Nonetheless, the mutual commitment of these governmental agencies is a huge asset.

Born out of the BHNA interviews and discussions with partners at the Cook County Behavioral Health Summit, there is a true commitment from public sectors to align policies and respective investments to strengthen the behavioral health system. The following are web links to resources that illustrate this commitment, and the opportunities that exist at the federal, state, county, and municipality levels.

- Substance Abuse Mental Health Services Administration Strategic Plan[60]
- Illinois Behavioral Health Initiatives in Crisis Continuum[64]
- Cook County Office of Behavioral Health Initiatives
- City of Chicago Behavioral Health Agenda[65]

The perception that the public sector is fully committed to behavioral health was also reflected in many BHNA conversations:

One service provider interview participant provided the following reflection:

> *"...at every level of government [in Illinois, Cook County, and the City of Chicago] we seem to be action-oriented, and I just don't want to take that for granted. Coming from Louisiana where they did not expand Medicaid, or talking to another partner agency in Texas where they didn't expand Medicaid, [behavioral health organizations are] so limited in what they can do because of that. And so, the fact that we're finally putting our money where our mouth is. We say it's important, but these words are backed up with action, which is positive and reassuring. Reimbursement rates, programmatic and grant support, training and technical assistance, all of this allows us to do more, as opposed to the possibility that they would just tell us we have to do more with less."*

Collectively, those engaged in the assessment also shared a great sense of urgency and the desire for immediate action, making coordinated public sector investments clear and intense. One BHNA survey respondent provided the following feedback:

> *"To be frank...we must improve all of these areas and more as a county, a state, a nation, and as a global community. We need a systematic overhaul of all mental health, substance use disorder, and gambling disorder service models. While [behavioral health service] organizations are all doing their utmost to help as many people as possible, insurance and financial coverage/reimbursement/pay is unrealistic, and people are unable to obtain help and attain long-lasting sobriety as a result. We are also unable to retain staff. Until nonprofits and organizations receive enough financial support for not only staff and programming (for which we do not receive enough), but also for individuals who have lost close-to-if-not-everything as a result of their addiction who do not have insurance and cannot afford housing, food, medicine, and treatment, we will continue to lose lives. We need to do better and change the models that exist, even if it means revamping entire systems at both the micro and macro levels. We need change now."*

Behavioral Health System Gaps, Challenges and Needs

The BHNA's leading findings with respect to behavioral health system gaps, challenges, and needs are discussed in detail below. These findings are drawn from the BHNA's various data and information sources, including the quantitative data shared above and qualitative data gathered through community engagement efforts. This mixed-methods approach was designed specifically to ensure that this report includes the voices of all Cook County stakeholders.

As mentioned earlier, the below BHNA findings are broken out by each of the four components in OBH's Behavioral Health Framework. They are:

1. Health-Related Social Needs
2. Prevention and Early Intervention
3. Crisis Assessment, Treatment, and Linkages to Care
4. Care, Treatment, Support and Recovery

Each of the four sections begins with a brief description of that segment of the framework, followed by a discussion of the gaps, challenges, and needs relative to that segment. It is important to note that there is a great deal of overlap across each segment; to reduce redundancy, the Assessment limited the number of times it included key themes in more than one area of the framework. With this in mind, it is important to consider the findings of this report in totality and appreciate the overlap. For example, the need to strengthen the behavioral health system capacity to provide linguistically and culturally responsive care is cross-cutting and relevant to each component of the OBH Behavioral Health Framework. This issue is mentioned in several different sections, but not as often as it could have been to limit redundancy.

Health-Related Social Needs

Overview

Health-Related Social Needs (HSRNs) refer to the social, economic, and environmental conditions that affect the ability of individuals, families, or communities to access needed health services and live happy, productive, fulfilling lives. The list of possible HRSNs is lengthy and varied, and the issues that may impact a given individual, family, or community depend entirely on the social and environmental context in which they live. The most common and influential HRSNs are listed below:

- ***Housing Instability:*** Safe, affordable, and stable housing is critical for mental health and overall well-being.
- ***Community/Workplace Violence:*** Community/workplace violence affects stress levels and the mental health status of those who are direct victims of violence. It also affects those who are indirectly impacted because they are either a witness to violence or are the parents, friends, or caregivers of those directly impacted. Community/workplace violence also impacts people's ability to access and engage in care. Finally, workplace violence has a major and increasing impact on the healthcare workforce.
- ***Behavioral Health Stigma, Discrimination, and Racism:*** Addressing behavioral health stigma, discrimination, and systemic and interpersonal racism is crucial for ensuring equitable access to mental health services and improving overall health outcomes for marginalized communities.
- ***Insurance Coverage and the Cost of Health care:*** Insurance coverage and/or the ability to afford essential health care services is essential for ensuring individuals can access necessary health services, leading to better health outcomes and overall well-being.

- ***Transportation:*** Reliable transportation is necessary for accessing health care services, employment, and social support.
- ***Economic Insecurity and Employment:*** Financial stability, including the ability to pay for safe housing, nutritious food, transportation, and other basic items is critical to health and well-being. Stable employment that pays a livable wage is at the heart of one's financial steadiness and is crucial to fostering a sense of purpose.
- ***Social Support:*** Strong social networks and support systems are essential for emotional and psychological health.
- ***Health Education:*** Access to education and educational resources influences long-term health outcomes.

Recognizing these HRSNs is paramount to developing a strong, equitable behavioral health system, as they significantly influence individuals' overall well-being and mental health outcomes. By identifying and addressing a person's need for nutritious food, stable housing, safe neighborhoods, accessible transportation, employment, and social supports, a behavioral health system can move beyond traditional clinical interventions to incorporate a more holistic approach that considers the broader context of individuals' lives.

By incorporating HRSNs into the Behavioral Health System Framework, OBH can reinforce the importance and help to mitigate the impact of SDOH that often create barriers to accessing care and achieving positive health outcomes. For instance, individuals facing housing instability or food insecurity may struggle to cope with the stress that this challenge creates, to prioritize necessary mental health treatment, or to adhere to prescribed counseling or medication regimens. By addressing underlying HRSNs, the behavioral health system can prevent the onset of behavioral health issues, reduce disparities, enhance the effectiveness of behavioral health services, and support those in recovery. Given the close linkage between the health-related social factors and health equity, this approach not only improves individual health outcomes but also fosters greater equity within the community, ensuring that all individuals, regardless of their socioeconomic status, can achieve optimal mental health.

Gaps, Challenges, and Needs

The following is a discussion of the leading needs and challenges relative to the HRSN component of the OBH Behavioral Health System Framework, including quantitative data drawn from the community need and behavioral health status section of this report and other more qualitative information drawn from BHNA community engagement activities. Where possible and appropriate, the discussion below also cites national research that supports this report's findings.

Throughout the BHNA, there was an overwhelming sentiment that success with respect to addressing the behavioral health crisis is tied to addressing the health-related social factors that underlie people's behavioral conditions and people's ability to access and engage in needed services.

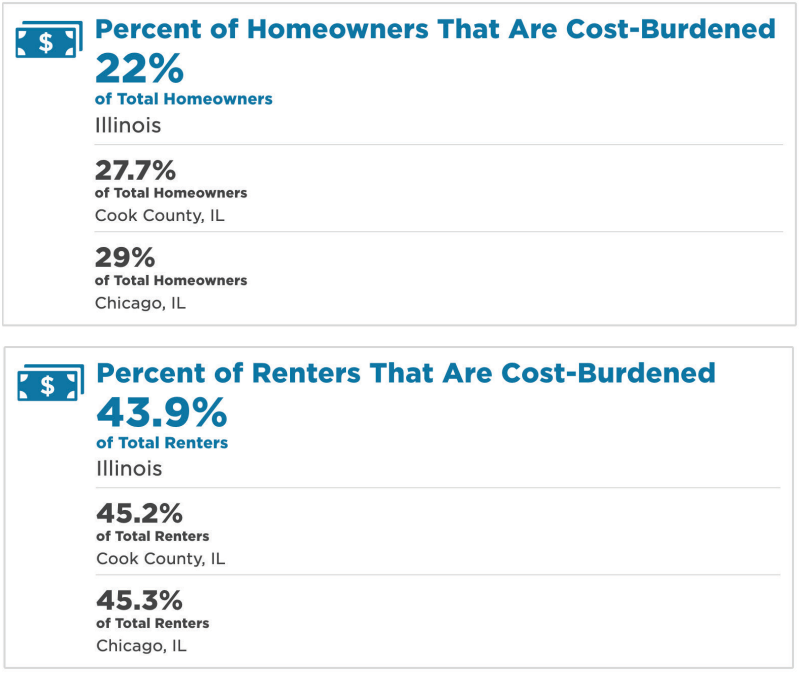
Housing instability

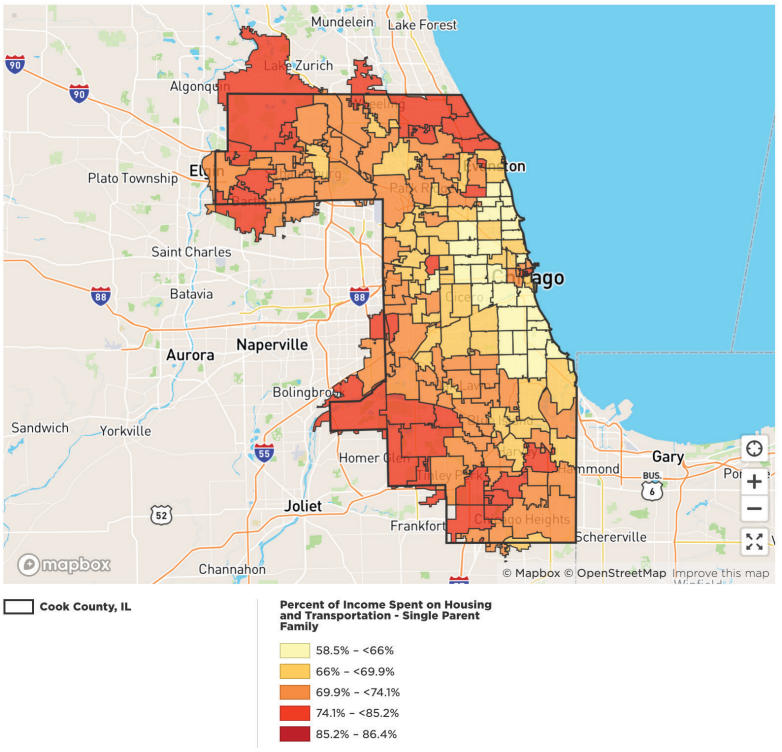
Housing instability and the impact it has on the Cook County population was one of the most cited issues during BHNA interviews and focus groups, especially for those with mental health and substance use challenges. Nearly 30% (27.9%) of those who participated in the BHNA survey cited housing as one of Cook County's top unmet needs/challenges. One of the reasons it is such a commonly cited need/challenge is the variety of ways that housing insecurity impacts individuals, families, and communities throughout Cook County.

The ability to obtain and sustain safe, affordable housing is challenging for nearly all Cook County residents, even for those in middle-income brackets who often struggle with high housing and tax costs as a result of a job loss or other sudden financial challenges. Based on quantitative data gathered and reported in the community need and behavioral health status section of this report, Figure 11 below shows that 45.2% of those who rent their housing and 27.7% of those who own their housing in Cook County are "cost burdened and at risk of housing instability." This is defined by the US Census Bureau as spending more than 30% of one's gross monthly income on housing. Other data drawn from the US Census Bureau shows that single-

parent families in Cook County spend more than half of their income on housing and transportation costs. There are also disparities between racial groups regarding home ownership, which impacts cost burden as mentioned above. Fifty-eight percent (58%) of Black/African American households are renters compared to only 26% of white households. Furthermore, several community-based organizations and providers mentioned the worsening housing crisis among migrant and refugee populations. Cook County is hardly alone in this regard, and the US Department of Health and Human Services' Healthy People 2030 initiative has identified housing instability as a leading priority.[66]

Figure 10, 11, and 12: Homeowners and Renters That are Cost Burdened





Sources: US HUD & DOT LAI V3.0 2016

For those with mild to moderate behavioral health issues, housing instability is often cited as a root cause of their stress and anxiety. There is a considerable body of research that shows the connection between housing insecurity and behavioral health.[67] Many of those who participated in BHNA interviews and focus groups reflected on the intense challenge that those in behavioral health treatment or recovery face finding safe, affordable, appropriate housing, including permanent supportive housing, recovery homes that include sober and non-sober individuals, transitional housing, and emergency shelters for crisis stabilization. The high cost of housing can also limit one's ability to pay for and engage in needed behavioral health services.

One BHNA focus group participant stated:

> *"People are not able to find housing, or they'll have housing and the vouchers will expire; they won't have the program anymore. They'll cut them off the program…the anchor of mental health is housing…you're more likely to be mentally ill [without housing], absolutely."*

Many people who participated in the BHNA discussed Cook County and the City of Chicago's intensive efforts to address the need for safe, affordable housing. Nonetheless, the need to address housing instability, particularly for those with behavioral health challenges, is a leading finding of the BHNA. There is a need for financial support, such as housing subsidies and rental assistance, housing assistance, and housing advocate programs to help people navigate the low-income housing opportunities, strategies to address discriminatory policies and unfair housing practices, and to address gaps in the continuum of housing options for those with mental health and substance use issues.

Public safety/community violence

Another major health-related social factor cited by many of those who participated in the BHNA's community engagement activities was public safety and community violence, particularly gun violence. Like housing instability, this issue was also brought up in many scenarios. First and foremost, cited is the mental health impact on those who are victims of violence and their families, friends, and caregivers. Many BHNA participants discussed the extreme trauma that those directly involved in gun violence or who witness gun violence experience. Moreover, they spoke of the need for programs and services specifically geared to addressing the trauma caused by gun and community violence more broadly. This issue also came up when discussing the long-term, profound impacts that violence has on those who are currently incarcerated, recently incarcerated and/or transitioning from prison, and those more generally involved in the justice system. This assessment clearly identified incarcerated and recently incarcerated individuals as a priority population in the context of the behavioral health crisis.

An interview participant mentioned that it is critical to have an understanding that individuals who are

> *"exposed to gun violence or coming home from prison are in the same communities that rely on Cook County's behavioral health resources." It is important to recognize how trauma can impact a community and its needs. Therefore, we need to think about "how do we frame the work we do to center those who have been impacted by [gun] violence? They are an important piece to the story."*

Another way that this issue was identified was with respect to health care workplace violence, particularly the behavioral health workforce and those in hospital emergency rooms and community health centers. While this issue only was broached in a couple of conversations, it was a leading theme among those at the Cook County Behavioral Health Summit in February

2024 and is a leading issue nationally. A recent systematic review of 17 research studies highlighted the prevalence of workplace violence involving health care workers and it was estimated that 47% of health care workers were impacted by workplace violence.[68]

Behavioral health stigma, discrimination, racism, and classism

One of the most common findings from BHNA community engagement activities, including those participating in lived experience focus groups and community interviews, was the prevalence and impacts of behavioral health stigma, discrimination, interpersonal racism, and classism. Nearly one third (31.1%) of BHNA survey respondents stated that biased health care staff was a top barrier for Cook County residents seeking needed behavioral health services.

As was mentioned above, behavioral health stigma, discrimination, racism, and classism profoundly impact individuals' willingness and ability to engage with the behavioral health system, often leading to delayed treatment, underutilization of services, and poor health outcomes. These barriers can discourage individuals from seeking help due to fear of judgment, bias, or negative experiences within the health care system. According to those who participated in the assessment's lived experience focus groups, it is not uncommon for those in the health care workforce to stigmatize those with behavioral health challenges or who are experiencing homelessness, or to inappropriately judge or show bias towards certain racial, ethnic, or other cultural groups. This can limit access and engagement in care and can exacerbate behavioral health conditions. Addressing these issues is critical to fostering an inclusive, equitable, and effective behavioral health system where all individuals feel safe, respected, and supported in their mental health journeys.

One BHNA focus group participant mentioned how they felt seeking treatment from providers without lived experience in behavioral health:

> *"You have in these organizations people who have master's degrees and doctorate degrees and all of these things, and they look down on you a little bit. Like they mean well...they want to help people, that's cool, but you're not helping people when you're making them feel worse...You can't relate at all. But just because you have a formal education...You're not more intelligent than me. I'm not more intelligent than you. But because I'm homeless...you can't relate. And they're not even trying to relate."*

As mentioned, stigma became a key theme throughout the BHNA as participants mentioned the need for cultural humility training for providers to help reduce stigma in seeking and receiving behavioral health treatment.

One BHNA survey respondent discussed the impacts of stigma more broadly on the African American/Black community and reflected how this impacts access and engagement in care by saying:

> *"The fear of being diagnosed with a mental health condition has not been easily acceptable in the African American communities, and it causes many people to walk around undiagnosed and suffer even more. Then when that one person suffers, the entire family suffers because we try to pretend that everything is okay when it is not. We do not see a lot of material on prevention, and I believe we need to have more information on the importance of the family helping the person diagnosed with mental health condition by giving that person support, making sure they know that as a family we want that person to be as healthy as possible and thrive in the community."*

Furthermore, providing patient-centered care and meeting patients where they are in their treatment process was also a key theme related to addressing stigma in behavioral health care. One focus group participant mentioned the importance of understanding that there are multiple approaches for behavioral health treatment and that we cannot assume one treatment will work for all.

> *"What I see and hear from my clients is that there is a diversity of approaches to substance use and mental health treatment--what works for one person may not work as well for others..."*

Using patient-centered approaches and meeting patients where they are in their behavioral health treatment is essential to increasing access to care and reducing stigma in seeking and receiving care.

Insurance coverage and the cost of health care

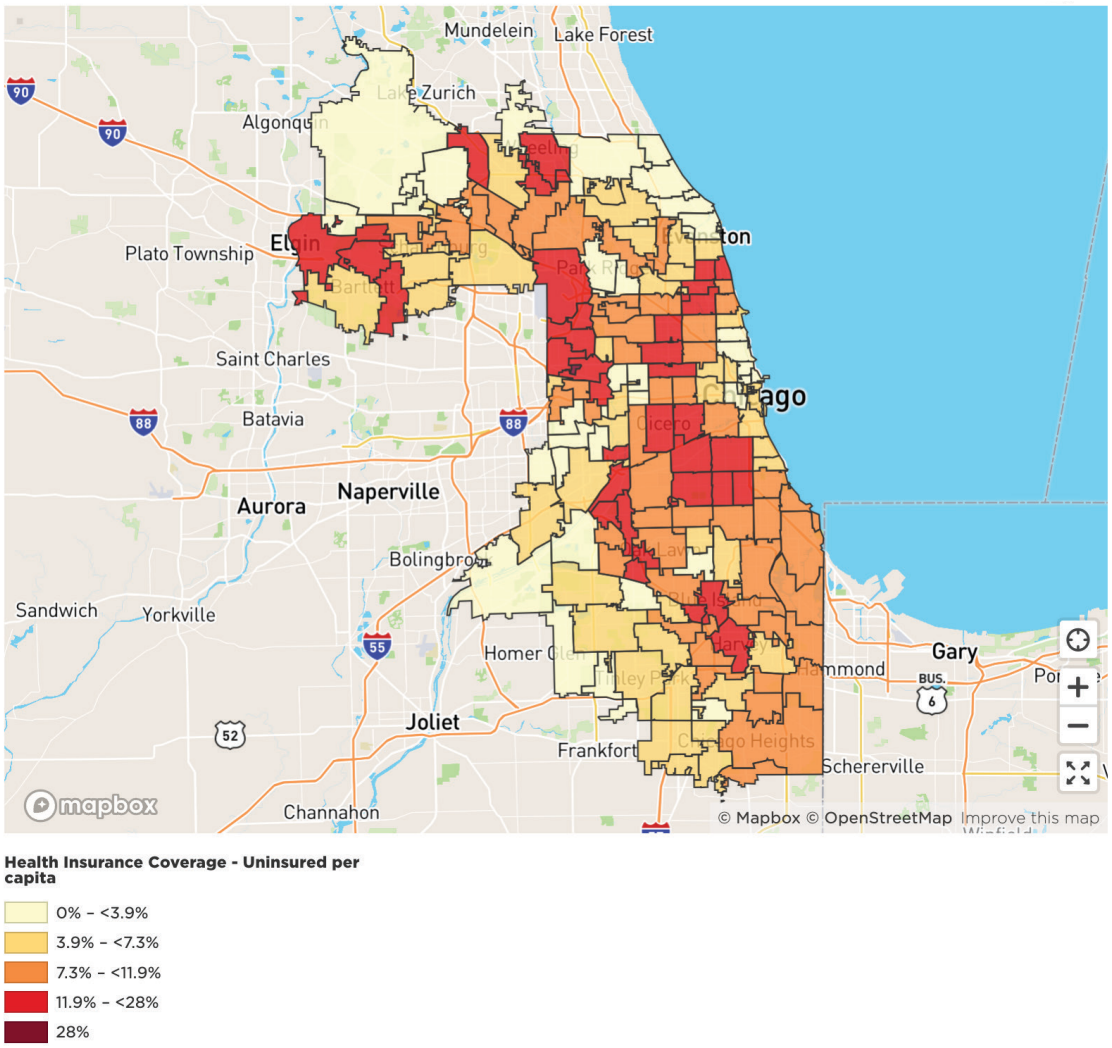
The inability to access needed behavioral health services due to lack of adequate health insurance and the high cost of care was cited as a major challenge/need by many of those who participated in the BHNA. There are significant disparities in health insurance coverage across Cook County, as can be seen in Figure 13. While the percentage of Cook County residents who do not have health insurance is low in comparison to the national average, this does not mean that those in need of behavioral health services are able to access the care they need, when and where they want it.

As indicated by a BHNA survey respondent:

> *"...insurance, cost, and choice are very intrinsically tied together. So much of our healthcare system is tied to insurance. You either usually have limited choices with insurance or limited choices with no insurance. I am not sure who the people are that have great insurance and all their mental health and substance use disorder needs being met. A lot of the stigma I had about seeking mental health services was related to the inaccessibility of our systems and not knowing where to start. And once I got past that, it wasn't easy at all. And that is with insurance." Not only are community members facing the stigma associated with seeking care, they are also struggling with finding affordable care and services that are covered by their insurance."*

As discussed subsequently in the Crisis Assessment, Treatment, and Linkages to Care segment of this section of the report, cost of care and lack of adequate insurance coverage was a major challenge impacting one's ability to receive and fully engage in behavioral health care services. Forty-five percent (44.5%) of BHNA survey respondents indicated that inadequate insurance coverage made it difficult to receive mental health or substance use services, and 46.4% indicated that the cost of services made it difficult to receive care.

Figure 13: Cook County Health Insurance Coverage - Rates of Uninsurance per Capita



Sources: US Census Bureau ACS 5-year 2018-2022

Transportation

When asked what the leading challenges were to accessing behavioral health services, many BHNA survey respondents cited the lack of timely, accessible, affordable transportation. This can lead to missed or rescheduled appointments, delayed care, and increased health expenditures. This barrier is especially detrimental for those who have limited options as to where they can go for services and who are reliant on public transportation. Despite the large network of trains and buses that are part of the region's public transit system, it can still require multiple buses and trains and upwards of an hour or more of travel for people to get to their appointments. This is exacerbated in some areas where buses and trains are infrequent or not present at all. Consequently, individuals may miss critical care, leading to untreated or worsening mental health conditions, further exacerbating disparities in health outcomes. These are especially challenging for those managing chronic behavioral health conditions, given the frequency of medical visits and the need to obtain medication refills.

Having access to adequate transportation can also be quite motivating and promote engagement. Several BHNA participants mentioned how important and motivating having access to affordable and reliable transportation can be, and the impact that this can have on people getting the care they need.

One focus group participant mentioned:

> *"...if you are trying to [provide] a cost-effective way to ensure that mental health gets taken care of, you can tie a 30-day bus card to showing up and getting to your appointment. That 30-day bus card also allows, especially [for] someone who is unhoused, the freedom to be able to move around and live and not have to try to hustle onto a bus. It shows a ton of respect. It doesn't cost a whole lot of money. And if you were to tell somebody, 'Hey, if you consistently show up, we will make sure you get a 30-day bus card', that would be incredibly incentivizing."*

Economic insecurity and employment

One of the leading themes and undercurrents in many of the discussions that occurred with BHNA participants was economic insecurity and the challenge that many people face with respect to employment. These issues are significant contributors to the behavioral health crisis, as they create chronic stress and limit access to essential resources. High housing, food childcare and transportation costs, and the cost of other essential items, including health care services, exacerbate this situation by forcing individuals and families to make difficult choices between basic needs. According to a recent study by the Pew Research Center, one in four parents (25%) in the United States say they have struggled to afford food, housing, childcare, transportation, or other basic needs in the past year.[69]

These stressors often lead to unstable living conditions, poor nutrition, unsafe living conditions, limited engagement in needed health care services. This ultimately leads to poor health status, including poor mental health status and emotional well-being, causing or worsening mental health and substance issues and creating a vicious cycle of economic hardship and deteriorating behavioral health. Additionally, the lack of jobs that pay a livable wage means that even those who are employed may struggle to cover their expenses, including expenses tied to health care services, further contributing to stress and anxiety. Addressing these economic factors is crucial for mitigating the behavioral health crisis, as stable housing, adequate nutrition, and financial security are foundational to mental well-being and overall health.

These issues impact large proportions of those in Cook County, once again having a particularly profound impact on those with behavioral health conditions. According to data drawn from the community need and behavioral health status section of this report, 13.5% of the Cook County population and 16.6% of Chicago's population live in low-income households earning less than 200% of the federal poverty level. In many of Cook County's Health Equity Zones, this figure can be as high as 26.3%. Unemployment rates are relatively low in Cook County, standing at roughly 5% in February 2024, but this does not mean that everyone is able to obtain stable employment with wages that allow them to live comfortably and consistently meet their basic subsistence needs. The countywide unemployment rates obscure the fact that many racial, ethnic, and cultural subsets of the population face tremendous challenges finding and maintaining employment that pays a livable wage. For example, in 2023, the unemployment rate for the State of Illinois across all races was 4.5%. For those identifying as white, the unemployment rate was 3.3%. For those identifying as Hispanic it was 5.5%, and for those identifying as African American/Black it was 10.5%.

Figure 14: Poverty by Population

Geography	Total House-holds Below Poverty Level	People Below Poverty Level - Age Under 18	People Below Poverty Level - Age 65 and Over	Family Below Poverty Level - with Children	Below Poverty Level and Foreign Born	Below Poverty Level and Employed
Illinois	12%	15.6%	9.4%	14%	11.9%	3.2%
Cook County, IL	13.5%	18.3%	12.1%	16.7%	12.9%	3.3%
Chicago, IL	16.6%	24.1%	16.6%	22.6%	16%	4.2%

Prevention and Early Intervention for Adults and Children

Overview

Prevention and Early Intervention for Adults and Children are essential components of the OBH Behavioral Health System Framework. These concepts focus on proactive investments, services, and programmatic activities that work to prevent the onset of behavioral health issues and/or to emphasize early intervention when symptoms first appear to minimize impact on individuals, families, and communities.

A comprehensive behavioral health prevention and early intervention strategy incorporates a range of primary, secondary, and tertiary prevention and early intervention activities focused on addressing mental health and substance use issues at different stages. Each level of prevention and intervention has distinct goals and objectives focused on reducing the incidence, severity, harm, and impact of behavioral health issues.

- **Primary prevention** aims to prevent the onset of behavioral health issues before they occur. This level of prevention focuses on the general population and focuses on promoting overall mental well-being and reducing risk factors. Typically, primary prevention includes public awareness campaigns, community education programs, and social and emotional learning programs in schools, as well as addressing HRSNs and creating safe, inclusive, and supportive environments across all key settings that promote mental and emotional well-being.
- **Secondary prevention/early intervention** focuses on early detection and intervention to halt the progression of behavioral health issues. This level is tailored to individuals who are at higher risk or showing early signs of mental health or substance use problems. Typically, secondary prevention includes screening, assessment and early identification, timely access to care, early intervention programs, and family and caregiver support programs.
- **Tertiary prevention/early intervention** aims to reduce the harm associated with behavioral health conditions by providing effective treatment recovery support. This level is tailored to individuals with diagnosed mental health or substance use disorders. Typically, tertiary prevention and intervention activities include comprehensive treatment plans that incorporate evidence-based interventions, recovery supports, chronic disease management, and relapse prevention, often with an emphasis on harm reduction, overdose prevention, and a reduction in the symptoms and causes of mental illness and substance use.

Incorporating prevention and early intervention strategies for both adults and children into OBH's behavioral Health System Framework helps to reduce long-term impact of behavioral health issues; decrease the costs associated with long-term treatment, hospitalization, and other intensive services; and improve the quality of life by addressing mental health and substance use issues before they emerge or become too severe.

Gaps, Challenges, and Needs

The following is a discussion of the leading needs and challenges relative to Prevention and Early Intervention for Adults and Children, including quantitative data drawn from the community need and behavioral health status section of this report and other more qualitative information drawn from BHNA community engagement activities. Where possible and appropriate, this discussion also cites national research that supports this report's findings.

Need to address behavioral health stigma

Based on a structured analysis of the qualitative information gathered through the BHNA interviews and focus groups, behavioral health stigma was one of the most commonly cited themes. Behavioral health stigma refers to the negative attitudes, beliefs, and discrimination directed toward individuals with mental health and substance use conditions. This stigma can lead to delayed care or not seeking care. It also can lead to social isolation, oftentimes limiting engagement in care and exacerbating people's behavioral health conditions. At the heart of these community-engaged discussions was a desire for the BHNA to elevate the importance of reducing stigma through public and workforce education, advocacy, policy changes, and more respectful representations or modeling of appropriate communication in the social media and/or by key influencers. Several people called for increasing public efforts to promote screening and crisis support services for those mental health, or harm-reduction activities such as Naloxone/Narcan distribution for active opioid users as a way of raising awareness, promoting open discussion, and reducing stigma. These efforts were thought to be critical to normalizing behavioral health issues, fostering greater understanding and empathy for those with behavioral health conditions, and encouraging those with behavioral health conditions to seek out and engage in care, reducing the prevalence and impact of behavioral health conditions.

Need to invest in small- and large-scale, targeted behavioral health education activities

Related to the above findings regarding reducing stigma is a more expansive need for health education efforts of all types, across all service and community settings, and focused on different audiences and different conditions. More than half of BHNA survey respondents (52.2%) shared that not understanding or knowing about services, their diagnoses, or treatment options were top reasons that Cook County residents do not get the services they need. This sentiment was also commonly cited in BHNA interviews and focus groups. While these sentiments were expressed in a variety of ways, reflecting the need for education in different settings, for different audiences, and for different reasons, they all spoke to the need for greater investment in health education aimed broadly at increasing awareness and knowledge of behavioral health issues, reducing behavioral health stigma, promoting early intervention and engagement in care, creating a greater understanding of the underlying risk and protective factors, and preventing onset or escalation of behavioral health issues.

Some BHNA participants spoke of the need of small-scale, focused efforts in different service-related or community settings, such as hospital emergency departments, community health centers, schools, libraries, barber shops, faith-based organizations, and other service- and community-based settings. Others spoke of the need for more comprehensive, multifaceted campaigns, drawing on the full breadth of available media portals, including bus and billboard ads, TV/cable/radio, print, and social media. Others spoke of the need for education directed at the general public and others spoke of the need for much more focused campaigns tailored to children/youth, older adults, opioid users, homeless individuals, or those who have been recently incarcerated. Finally, others spoke of the need for education of clinical and nonclinical service providers and staff in other community settings related to sensitivity training to promote cultural humility, reduce stigma, or support harm reduction, as well as education and training on best practices with respect to how to effectively engage, screen/assess, treat, and support those with mental health and/or substance use conditions.

Need to focus on the transition from childhood to adulthood, and its impact on access and services

There is growing understanding around the challenges and experiences young people face when transitioning from pediatric to adult health care, especially in their behavioral health needs.[70] This key theme presented itself throughout the BHNA process in discussions around health insurance and service access barriers, increased HRSNs and stressors, and knowledge/education around care and treatment needs. A US Centers for Disease Control and Prevention (CDC) study identified that young people (1 in 6) with a behavioral health diagnosis "did not receive the recommended support from their healthcare providers to help them transition from pediatric to adult care.[71] This study resulted in a recommendation that all adolescents starting at age 12 years discuss the transition of care to prepare for their entry to adulthood.

It is important that Cook County behavioral health providers and organizations work to better understand and integrate these challenges and changes into young people's care to prevent lapses in treatment and support while also designing patient-centered transition and care plans.

Need to promote person-centered care and harm-reduction efforts

Many of those engaged in BHNA interviews and focus groups spoke to the need for providers/organizations in Cook County to promote a more person-centered approach to supporting those with behavioral health issues, including a greater focus on harm reduction. A person-centered approach to care puts greater emphasis on understanding and addressing the unique needs, preferences, and values of individuals, and on fostering a collaborative and tailored treatment plan that supports a person's overall well-being and recovery. Many of those engaged believed that fostering a more person-centered approach to care was crucial to strengthening the behavioral health system and improving outcomes. Many expressed concern that service providers in Cook County did not fully appreciate the importance of understanding a patient's unique needs, preferences, values, and goals. As a result, either consciously or unconsciously, these providers were imposing their own perspectives to develop treatment and care plans. Many of those who talked about the importance of a person-centered approach also discussed the importance of harm-reduction activities. Harm-reduction interventions focus on addressing an individual's immediate safety and well-being concerns, and proactively support individuals in managing their conditions in a way that minimizes risk and enhances quality of life.

The importance of applying a person-centered approach to behavioral health services is widely understood in the academic literature and there is a growing body of literature on the importance of interventions that focus on harm-reduction.[72,73] A number of those who shared these ideas also expressed support for various harm-reduction interventions, including providing safe and supportive spaces for those with mental health conditions to congregate; increasing the distribution of Narcan/Naloxone; or supporting the creation of supervised injection sites for opioid users that meet the varied needs and desires of those with substance use disorders.[74-76]

While there are clearly a variety of perspectives and honest and productive debates regarding the most effective approaches to engaging, treating, and supporting those with behavioral health issues, a leading theme from this assessment was the need to encourage and support service providers to apply a more person-centered approach, including efforts to promote harm-reduction interventions.

Broad consensus regarding the extreme behavioral health challenges experienced by children and youth face, and the need to focus on prevention in school settings

Another common theme from the BHNA was the extreme behavioral health challenges experienced by children and youth of all ages. The overriding concern regarding the behavioral health challenges in children, youth, and young adults was lack of service capacity to serve this population, as well as the extreme shortages of pediatric clinical providers and other staff with the expertise to serve pediatric populations. These issues will be discussed in greater detail in other sections of the report. However, it should be noted that there were many who spoke passionately about the need for greater investment in

prevention and early intervention services for children and youth in school- and community-based settings. While there was some variation in participants' visions on how to remedy this issue, most reflected on the extreme behavioral health needs of this population, especially since COVID-19, and of the importance of addressing behavioral health issues in this population early before they escalated. For example, most reflected on the need for school-based programming, but others talked about a multifaceted approach that included interventions in faith-based and other community settings. Those who identified this challenge discussed the need for prevention interventions that spanned the continuum, from primary prevention providing basic knowledge to secondary and tertiary prevention interventions for those at-risk or who are already impacted by behavioral health conditions.

One BHNA interview participant shared:

> *"Prevention is key. We need to do work in the schools and focus on youth, especially high school students. We need to invest in more than stigma reduction. Investments need to be made in evidence-based prevention interventions, particularly for those at high-risk (secondary prevention) and those already impacted (tertiary prevention), including interventions that involve children, youth, and their parents."*

A survey respondent stated:

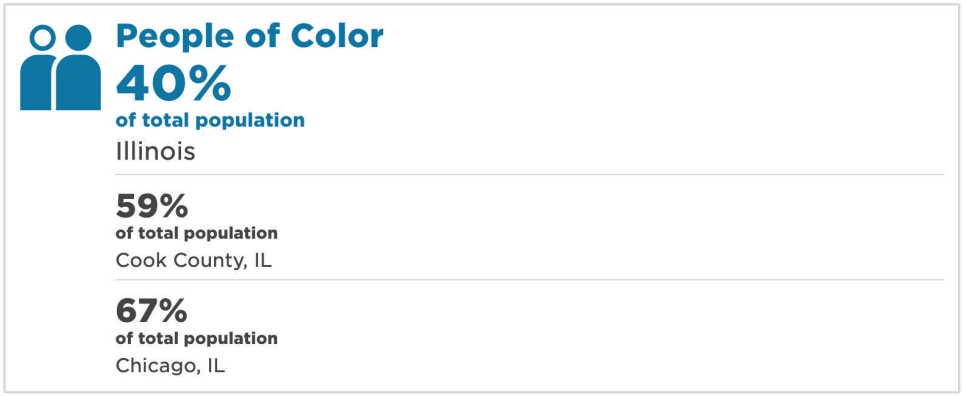
> *"Prevention services. I see a growing need among youth that is only going to escalate the problem of access. Prevention services are a very long-term solution, but very effective. It is difficult to get these services funded, but they are essential for a healthy community."*

The lifelong impacts of early intervention, particularly in children and youth, is widely discussed in the academic literature.[77] This literature discusses how promotion, prevention, and early intervention strategies have been shown to produce the greatest impact on people's health and well-being over time, as well as the importance of screening strategies, early detection interventions, and efforts to support peer support and the development of safe spaces for children and youth with emerging behavioral health challenges to congregate.[78,79]

Need for clinical and non-clinical staff training on providing culturally sensitive and responsive care

A common theme from the assessment's interviews and focus groups was the need to enhance the behavioral health system's ability to provide linguistically and culturally responsive services. Cook County is racially, ethnically, and linguistically diverse. There are more than 40 languages spoken by those who live in Cook County, with Spanish being the most spoken language other than English. This is followed by Chinese (Mandarin and Cantonese), Polish, Tagalog, Urdu, and Arabic. According to data from the community need and behavioral health status section of this report, 20.7% of Cook County households speak Spanish at home and 8.4% of Cook County households speak an Indo-European language at home. Furthermore, 59% of Cook County's population identifies as a person of color, jumping to 67% in Chicago. These data are illustrated below in Figures 16 and 17.

Figures 16 and 17: Languages Spoken at Home in Illinois, Cook County, and Chicago; Percent Population of Illinois, Cook County, and Chicago who Identify as People of Color



Sources: US Census Bureau ACS 5-year 2018-2022

Geography	Language Spoken at Home - English Only per capita over 5	Language Spoken at Home - Spanish per capita over 5	Language Spoken at Home - Other Indo-European per capita over 5	Language Spoken at Home - Asian-Pacific Islander per capita over 5	Language Spoken at Home - Other per capita over 5
Illinois	76.6%	13.6%	5.6%	3%	1.1%
Cook County, IL	64.8%	20.7%	8.4%	4.2%	1.9%
Chicago, IL	64.8%	23.5%	6%	4.2%	1.5%

Sources: US Census Bureau ACS 5-year 2018-2022

The importance of providing services that are culturally and linguistically responsive is widely understood and discussed in the academic literature. Nonetheless, there are major shortages of non-English speaking service providers, as well as service providers who are from different cultures or who have expertise serving specific populations by age, race, ethnicity, religion, and other identities.

Given the challenge and time that it will take to address the workforce shortages with respect to language and culture, many reflected on the importance of ensuring that the existing service providers were trained to provide culturally sensitive and responsive services. The need for cultural sensitivity and humility spans beyond ethnicity and language. Many talked about the need for providers to be trained to treat their patients with more respect and to provide care that is tailored to or sensitive to their particularly cultural background.

Access to Crisis Assessment, Treatment, and Linkages to Care

Overview

Access to services that support and stabilize individuals in crisis and connect them to necessary **care** is critical to an effective behavioral health system. These services provide immediate assistance to individuals experiencing acute mental health or substance use crises, ensuring timely assessment and **appropriate** intervention to stabilize and appropriately triage to follow-up care. The availability of clinics offering immediate behavioral health services (e.g., urgent care clinics, walk-in centers, Certified Community Behavioral Health Clinics (CCBHCs), mobile crisis response (MCR) teams, telephonic hotlines, and other programmatic modes **plays a pivotal role** in this process. Clinics offer a stable, walk-in location for in-person assessments and interventions. MCR teams bring services directly to individuals in crisis at home or in community-based settings. Telephonic hotlines offer immediate, around-the-clock access to support and guidance, serving as a **lifeline** for those in urgent need. These services are typically designed to link individuals in crisis with professionals who can provide immediate assistance, engage them in discussion, and connect them with behavioral health specialists. These efforts often include screening and assessment to ensure more precise linkages to care and support. This comprehensive array of services ensures that help is accessible in various forms, meeting the diverse needs of the population.

A "no wrong door" approach is often promoted, ensuring individuals seeking help are not turned away or shuffled between services without receiving appropriate care. This approach guarantees that individuals are connected to necessary services **without delays or barriers** regardless of their entry point into the system. Effective linkages to mental health care, substance use treatment, primary care, and other specialized services are essential to ensure holistic care addressing all aspects of health. Integrating services helps create a seamless patient experience, reducing gaps in care and improving overall outcomes.

Addressing **behavioral health challenges related to Health-Related Social Needs (HRSNs)** is equally important. Factors such as housing instability, unemployment, poverty, and social isolation significantly impact mental health and well-being. Effective crisis and assessment services must incorporate strategies to address these social needs. By linking individuals to housing support, employment services, and social networks, health systems can address the root causes of behavioral health issues. This comprehensive approach provides immediate relief and fosters long-term stability and recovery. Addressing these social factors is crucial to creating a **responsive, efficient system** in which every door is the right door for accessing care.

Gaps, Challenges, and Needs

The following section outlines the leading needs and challenges related to **accessing** crisis, assessment, treatment, and linkages to care within the Cook County Office of Behavioral Health's (OBH) Behavioral Health System Framework. It includes **quantitative data** from the community need and behavioral health status section of this report, as well as qualitative information drawn from community engagement activities. National research is also cited as appropriate to support these findings.

Crisis Assessment and Treatment Supports

Build on the CCBHC program and continue to enhance the crisis support system

In June 2024, Illinois was selected as one of ten states to participate in the (CCBHC) Medicaid Demonstration Program. This program is designed to expand and improve access to coordinated mental health and substance use services. The initiative will play a vital role in **supporting the state's efforts** to deliver comprehensive, coordinated care to individuals with mental health and substance use disorders. While CCBHCs offer a wide range of services, one critical aspect of the program is ensuring access to crisis response, crisis intervention, assessment and stabilization, and linkage to follow-up services as

needed. In the future, CCBHC's will also be required to offer urgent care to those with immediate needs or on the verge of crisis. CCBHCs are also available to those seeking help with longstanding, unattended behavioral health issues. In addition to crisis intervention and assessment services, the CCBHC program provides access to outpatient mental health and substance use disorder treatment, primary care screening, and connections to social services.

Although many interviewed prior to the CCBHC funding announcement did not voice crisis intervention as a **gap**, they emphasized the need for focus from Cook County stakeholders and the City of Chicago on strengthening the county's behavioral health system. CCBHC services are essential to developing a **comprehensive, integrated approach** that ensures individuals receive holistic care tailored to their needs, with an emphasis on person-centered, trauma-informed, evidence-based practices.

Universal screening to promote engagement in care for those in crisis or on the verge of crisis

Participants in the community engagement process highlighted the importance of **universal screening** for mental health (especially suicide) and substance use. Universal screening, particularly in primary care and other community settings, was identified as crucial for early identification of at-risk individuals and for promoting engagement in care before conditions escalate into crises. Integrating routine screening in these environments, allows health systems to connect individuals to appropriate interventions early, while also reducing the stigma surrounding behavioral health care.

By extending universal screening to community settings (e.g., schools, shelters, workplaces), those with acute behavioral health needs can receive the necessary support, fostering an inclusive approach to behavioral health challenges. A robust body of literature that speaks to the importance of universal screening, early detection, early detection, and engagement in care, demonstrating how these efforts can significantly improve outcomes, reduce emergency services' burden, and enhance community well-being. [80-83]

Need for same-day behavioral health urgent care (including mobile treatment)

Community feedback revealed a significant demand for **same-day behavioral health urgent care,** exposing a critical gap in the current care continuum. Emergency departments, often relied on for urgent mental health needs, are ill-equipped to manage behavioral health crises effectively, leading to long wait times, inadequate treatment, and frequent law enforcement involvement. The CCBHC program offers promise, but effective, implementation remains essential.

Additionally, the feedback underscored the importance of mobile treatment units in addressing behavioral health needs. These units can **reach individuals** facing barriers to accessing traditional services, such as those in remote areas or lacking transportation. Mobile units offer crisis intervention, assessments, and follow-up care, particularly benefiting high-risk populations like homeless individuals or those with severe mental health conditions who struggle to engage with clinic-based services.

Expanding same-day urgent care and mobile treatment units can enhance access, **reduce strain on emergency departments,** and improve overall mental health outcomes, contributing to a more responsive and efficient behavioral health system.

Need for better coordination and awareness of telephonic behavioral health hotlines in Cook County

Many participants identified gaps in coordination and awareness surrounding telephonic behavioral health hotlines, such as NAMI Chicago's Behavioral Health Helpline, Illinois' 988 Lifeline, and the National Suicide Prevention Lifeline.[84,85] Although these hotlines provide critical, **around-the-clock support** to those in crisis, there is room for improvement in how they are coordinated and marketed. **Effective coordination** ensures that individuals are connected to the most appropriate resources without confusion, while increased awareness helps individuals in need understand the services available to them.

Need for behavioral health navigation and care coordination

One of the most common reflections from the BHNA was the need to expand behavioral health navigation and care coordination services. Participants who discussed this issue emphasized the essential role that these services can play in ensuring that individuals in need are identified and supported in their efforts to access, engage, and effectively navigate the behavioral health system. The BHNA revealed that many individuals, particularly those with complex or severe mental health conditions, often face significant challenges in finding appropriate care due to the fragmented nature of the behavioral health system. This fragmentation leads to confusion, delays in treatment, and, in some cases, a complete lack of access to necessary services. These issues are felt particularly acutely for those who do not speak English, are from diverse cultures, are recent immigrants, or face HRSNs (e.g., economic housing insecurity, community violence) that make seeking care complex and challenging.

Behavioral health navigation services play a vital role in addressing these challenges by guiding individuals through the barriers that can prevent proper engagement. Navigators assist patients in understanding their treatment options, connecting them with appropriate providers, and coordinating appointments and follow-up care. This support is particularly important for vulnerable populations, such as those with co-occurring disorders, the elderly, those who do not speak English or are new to the United States, and low-income individuals who may struggle with additional barriers like transportation and insurance issues. The BHNA highlighted that effective navigation services can reduce stigma, develop coping skills, promote resilience and self-sufficiency, and significantly reduce the time and effort required to access care, improving both the timeliness and appropriateness of the treatment received.

Care coordination services are equally critical in ensuring continuity and quality of care. Many BHNA interview participants spoke of the importance of a holistic, multidisciplinary care coordination approach, involving many health and social service providers, and a range of community support. Effective care coordination ensures that these different elements are seamlessly integrated, preventing gaps in treatment and reducing the risk of fragmented care. Behavioral health navigators who are specifically trained to support those with mental health and substance use issues work to identify and navigate the appropriate services, share information among providers, and, in some cases, monitor patient progress, which enhances the overall effectiveness of care. Organizations in Cook County is in the process of implementing novel community-assisted interventions that engage, train, and empower people in community settings like barbershops, recreation centers, and corner stores to assist those who are in need of behavioral health support.

Expanding behavioral health navigation and care coordination services has profound implications for improving access, quality, and efficiency within the behavioral health system. These services ensure that individuals are not left to navigate the complex and often intimidating health care landscape on their own, thereby increasing the likelihood of timely and appropriate interventions. By facilitating smoother transitions between different levels of care and providers, navigation and coordination services help to minimize disruptions in treatment, reduce the risk of relapse, and promote better long-term outcomes. Overall, the expansion of these services is essential for creating a more responsive and patient-centered behavioral health system that can effectively meet the diverse needs of all individuals.

Linkages to Care

Care transition challenges are one of the most substantial issues for behavioral health providers

One of the most common issues discussed by BHNA participants was related to the challenge of transitioning and coordinating care from one provider to another. The effectiveness of these transitions has a substantial impact on the quality of care, success of engaging people in care in the long term, and ability for patients to achieve their goals. Challenges with respect to care transitions and care coordination was mentioned particularly in the context of transitioning or coordinating care for patients seen in the primary care setting, when patients are transitioned from the hospital inpatient or emergency depart-

ment setting, and when patients are "stepping up" or "stepping down" from different types of care across the behavioral health continuum. When these transitions do not go well, they can lead to increased costs for providers and patients as well as poor patient satisfaction. For hospitals botched transitions can exacerbate the issue of hospital "boarding" if patients are required to stay in the hospital longer than necessary.

Boarding challenges can manifest themselves in many ways. Patients may need to stay in the hospital inpatient or emergency department setting longer than necessary or may have long wait-times or delays in care with respect to specialty care referrals, different levels of care across the continuum, or social service linkages. Patient care may also be challenged by limited information flow about a patient's status and the care received in prior settings, leading to patients having to repeatedly answer the same questions or undergo duplicate screenings or assessments. BHNA participants frequently commented on this issue due to how the issue affects all service settings across the continuum. Arguably, hospitals are most impacted due to the challenge for both the hospital and the patient to board in the hospital or the emergency room for extended periods of time, but so too are primary care providers, behavioral health specialty care providers, social service providers, first-responders, public health staff, and essentially any provider that is supporting care navigation.

BHNA participants often shared information on the efforts their organizations were making to enhance the transition process and create a more seamless, efficient flow of information, including enhancements to health information exchange, service inventories, value-based payment models focused on care transitions, close-loop referral processes and other enhanced referral protocols. Nonetheless, the challenges remain extreme, and efforts must continue to ensure that these transitions are happening smoothly and that information flows effectively.[86]

One service provider who was interviewed shared the following reflection:

> *"...the interconnectivity of it all can be overwhelming...so often we scramble to identify resources for our patients...A lot of staff and patients are unaware that services exist, either when we're doing our linkage to care work or when patients are trying to get the services they need. Where can people go? Who do we connect them with?"*

A BHNA focus group participant shared:

> *"...in the perfect world a universal referral system would be available that would give everyone a menu of services that individuals can be referred to, and support not just for the referral process but to help the case manager to know when or if that referral happened...These resources exist, like in EPIC, but not everyone has access to them. That might be unrealistic right now, but I think it would be great to have something that everyone could access in the future."*

Focus on Linkage to Services that Address Health-Related Social Needs (HRSNs)

When issues related to care transitions, care coordination, and linkages to care were discussed during the assessment, one of the most common areas of focus was regarding the linkages to services that address HRSNs (e.g., housing, food assistance, domestic and community violence services, employment supports). As discussed in depth above, these services are thought to be essential for those with behavioral health challenges to address their challenges, reduce their barriers to care, and achieve their goals. The health-related social needs significantly impact an individual's mental and physical well-being, and without addressing these underlying factors, clinical interventions alone are likely to fall short. For instance, unstable housing or food insecurity can exacerbate stress and anxiety, making it difficult for individuals to engage fully in their treatment plans.

By integrating services that address these social needs, healthcare systems can provide a more holistic approach to care that promotes long-term recovery and stability. This requires a concerted focus on identifying these needs through routine screening and establishing robust referral mechanisms that ensure patients can access the necessary support services.

Enhanced referral mechanisms between clinical service providers and community-based organizations are critical for bridging the gap between health care and social services. Effective screening for HRSNs in both clinical and nonclinical community settings or schools allows for early identification of these social issues. Once identified, seamless referral systems are needed to connect individuals to the appropriate community resources. This can involve creating formal partnerships between healthcare providers and social service organizations, using technology to streamline referrals, and training staff to navigate these systems efficiently.

Care, Treatment, Support, and Recovery

Overview

The concept of Care, Treatment, Support, and Recovery within the Office of Behavioral Health (OBH) Behavioral Health System Framework encompasses a comprehensive, patient-centered approach that ensures individuals receive the necessary interventions, support, and resources to achieve and maintain mental health and well-being. This framework emphasizes continuous and coordinated efforts to address mental health conditions and substance use disorders, facilitating sustained recovery and improved quality of life. Success can be subjective; however, not all individuals living with a behavioral health diagnosis choose recovery as their ideal state. Understanding and supporting these differing levels of need relies on individuals having access to intensive care and support, which can be sought both proactively at the onset of an acute episode and reactively during scheduled activities initiated by a primary care provider, case manager, recovery coach, or behavioral health peer navigator.

- **Care** involves the initial and ongoing management of an individual's behavioral health needs, focusing on providing safe, effective, and compassionate services that emphasize: 1) personalized care plans based on comprehensive assessments of an individual's unique needs, beliefs, preferences, and goals; 2) a holistic approach that integrates emotional, social, physical health, and potentially spiritual considerations; and 3) care coordination ensuring that the activities included in the care plan are seamlessly integrated.
- **Treatment and Support** refer to the clinical interventions used to address mental health and substance use conditions, including 1) evidence-based interventions that apply therapies and treatments proven effective; 2) integrated care models that combine treatment for co-occurring conditions (i.e., mental health, substance use, physical health, and comorbidities) and promote overall health; 3) case management, peer support, and social services that help to ensure individuals are engaged and supported throughout their treatment or recovery; and 4) resources and support that are linguistically and culturally appropriate to individuals' specific needs and interests.
- **Recovery** describes the process through which individuals achieve improved health, wellness, and quality of life. It emphasizes the individual's ability to lead a fulfilling life, as they define it, despite the presence of mental health conditions or substance use challenges. Ideally, recovery resources emphasize: 1) a strengths-based approach focusing on individuals' strengths and the resources available to support their recovery if they choose; 2) recovery-oriented services that promote hope, empowerment, and self-determination, building resilience and coping skills; and 3) community integration, facilitating individuals' reintegration into the community through social, vocational, and recreational opportunities.

Integrating care, treatment, support, and recovery into the OBH Behavioral Health System Framework is crucial for ensuring a comprehensive, patient-centered approach that addresses all aspects of an individual's well-being, from initial care and clinical treatment to ongoing support and recovery. This well-integrated approach leads to better health outcomes, increased patient satisfaction, resilience, and enhanced quality of life.

Gaps, Challenges, and Needs

The following narrative discusses the leading gaps and challenges to the Care, Treatment, Support, and Recovery component of the OBH Behavioral Health System Framework, including quantitative data drawn from the community needs and behavioral health status sections of this report, as well as qualitative information gathered from community engagement activities. Where appropriate, the discussion below cites national research that supports this report's findings.

Limited Access to Behavioral Health Services and Inability to Access and Fully Engage in Care

One of the leading findings was that substantial portions of Cook County's population have limited access to behavioral health services or are unable to fully engage in the care they need when and where they want. While there are numerous community-based organizations that either specialize in providing behavioral health services or offer integrated behavioral health services, such as in primary care settings, these providers often lack the capacity to meet community needs. Many organizations also struggle to sustain themselves, as those in need frequently are either uninsured or significantly underinsured and cannot afford the necessary services.

This finding is corroborated by numerous national studies that document the struggles that individuals face navigating the behavioral health system, including finding providers who accept their insurance, managing insurance denials, and paying for costly treatments.[87,88] Although there exists a diverse and geographically well-distributed network of behavioral health services that offer a comprehensive array of high-quality, integrated services to residents of Cook County, substantial portions of the population remain disengaged and struggle to access care when needed.

The dominant issue is the extreme shortage of behavioral health providers, including psychiatrists, counselors, therapists, specialty clinicians, case managers, and peer-support staff. These workforce shortages lead to long waitlists and major delays in treatment, which limit engagement in care. The situation worsens when the need for culturally and linguistically similar workforce members is considered.

According to the findings, factors such as stigma, lack of parity in health insurance benefits, and challenges navigating the system significantly impact individuals' ability to access services. Furthermore, the influence of social determinants of health (SDOH), including economic insecurity, violence, housing, transportation, job opportunities, and crime, exacerbates community barriers to accessing services.

It is important to note that many engaged in the community assessments cited how the COVID-19 pandemic exacerbated the crisis further,[89] limiting access to behavioral health services. Anxiety and depression have surged since 2020, and although the severity of the pandemic has decreased, behavioral health challenges persist, with access to services worsening.

From qualitative engagement activities, the following issues were identified as leading barriers for individuals in Cook County seeking access to care:

- **Behavioral health stigma.** Many individuals are reluctant to seek help due to fear of judgment or discrimination from peers, employers, providers, and family members. This stigma is pervasive across all age groups but is particularly pronounced in certain racial, ethnic, and cultural segments, where societal pressures discourage open discussions about mental health and substance use. According to qualitative data analysis from interviews and focus groups with service providers and community residents, stigma was identified as a challenge in 50% of key informant interviews and 100% of focus groups.

  This stigma often results in feelings of shame, isolation, and low self-esteem, contributing to increased stress, anxiety, and fear. Most critically, stigma can lead to avoidance or delays in seeking care, which can worsen conditions and necessitate more complex and costly interventions.

- **Lack of parity in health insurance benefits.** Another significant barrier is the lack of parity in benefits for behavioral health services compared to physical health services. Despite legal mandates such as the Mental Health Parity and Addiction Equity Act, many insurance plans still fail to provide adequate coverage for mental health and substance use disorder treatments.[90] This lack of parity means that even individuals with insurance often struggle to access the necessary services, facing high out-of-pocket costs that lead to treatment discontinuation or reliance on medication alone rather than counseling or a combination of medication and counseling.
- **Lack of service providers willing or able to serve those who are Medicaid-insured.** A common finding from interviews with service providers and other stakeholders was the lack of providers willing to serve Medicaid-insured individuals. This results in delayed access to counseling and specialized medication management services. A behavioral health outpatient service provider noted that while individuals may receive an initial assessment but, subsequent visits can be scheduled months later. One provider stated, "We do a lot of work with kids and have to tell a parent whose child is in crisis that, there aren't any beds, available, despite our recommendation for hospitalization." Consequently, individuals may go without care, seek treatment in emergency departments, or self-medicate with substances.
- **High cost of care and out-of-pocket expenses.** As previously mentioned, the high cost of care, whether for insured individuals with limited benefits or the uninsured, poses a significant barrier to access, especially for those in low- to moderate-income brackets. For insured, individuals, copayments, deductibles, and costs of uncovered services can be prohibitive.

Lack of Providers Able to Provide Person-centered, Culturally and Linguistically Responsive Care

Data in the community needs and behavioral health status sections indicate considerable diversity in Cook County. Common findings from interviews and focus groups highlighted the urgent need to enhance access to culturally and linguistically responsive services. There is broad consensus that the demand for behavioral health services far exceeds the supply, particularly for non-English speakers and individuals from diverse cultural backgrounds. Participants often expressed that information or services were not provided in a person's preferred language or were not culturally responsive.

Given Cook County's diverse population, participants emphasized the importance of expanding the diversity of the behavioral health workforce. Many stressed the necessity for providers without lived experience in various cultures to be trained in culturally humble approaches. While matching patients with providers from similar cultures is ideal, it is crucial that all providers receive training to be culturally humble and responsive.

Participants reported that information is often communicated in an untimely, rushed, culturally inappropriate, or disorganized manner. Spanish-speaking focus group participants discussed the barriers they face when accessing services without bilingual and culturally responsive providers, stating that these obstacles hinder consistent and comprehensive treatment and ultimately affect their ability to achieve and maintain mental wellness.

The findings underscored the need for policy changes, increased funding, case management, navigation support, and service delivery modifications to ensure that behavioral health services are affordable and accessible to all who need them.

Need to Expand Access to More Intensive Services (e.g., intensive outpatient, residential, partial hospitalization, and transitional housing)

Participants frequently cited the need for more intensive outpatient and residential services, including intensive outpatient, residential, partial hospitalization, and transitional housing programs. Expanding access to these services is critical for providing comprehensive care for individuals facing behavioral health challenges. These programs offer varying levels of support and treatment intensity to address patients' diverse needs. Intensive outpatient programs (IOPs) and partial hospitalization

programs (PHPs) provide structured, multifaceted treatment options that allow individuals to receive significant therapeutic support while continuing to live at home. Residential programs offer higher levels of care for those requiring intensive, round-the-clock support, while transitional housing addresses housing insecurity.

Need for Increased Care Coordination and Support During Transitions

Community engagement activities highlighted the need for improved care coordination and support for individuals transitioning between different levels of care. This is especially important when individuals move from higher levels of treatment back into the community, where they may face significant challenges related to housing, employment, and social reintegration.

Participants noted that, while they receive adequate support during their treatment, the transition period often lacks sufficient guidance and resources. This gap can lead to increased risks of relapse, disengagement from care, and a loss of progress made during treatment. Improved care coordination, including case management and peer support, is essential to ensure that individuals receive ongoing support as they transition back into their communities.

Fill Gaps in Peer Support, Intensive Case Management, and Behavioral Health Navigation

Many participants in the assessment identified significant gaps and needs regarding community health workers (CHWs), peer-support specialists (PSSs), intensive case management workers, and behavioral health navigators. These workforce roles are increasingly vital to establishing a comprehensive and effective behavioral health care system. CHWs and PSSs typically possess lived experience with mental health or substance use issues, providing invaluable support and understanding to individuals struggling to engage with care and sustain their recovery journeys. They offer empathy, encouragement, and practical insights that can significantly enhance engagement and motivation in treatment.

Intensive case management and behavioral health navigators are equally critical in addressing complex behavioral health needs. Intensive case managers work closely with individuals to coordinate care, connect them with resources, and advocate for their needs across various systems, including health care, housing, and social services. Behavioral health navigators assist individuals in understanding and accessing the behavioral health care system, helping them find appropriate services and navigate barriers to care. Both roles are essential for creating a seamless, integrated care experience that addresses the multifaceted challenges individuals face.

However, due to increased demand, low compensation, challenges with reimbursement of services, and the demanding nature of the work, there are significant shortages nationally, including in Cook County. Many engaged in the assessment reflected on the extreme shortages of workers. Addressing workforce gaps through tailored training programs and career development opportunities is crucial for promoting engagement in care, improving care coordination, reducing fragmentation of services, and ensuring that individuals receive continuous, comprehensive support throughout the recovery process.

The Importance of Person-Centered Care and the Need to Expand Access to Programming with a Non-Abstinence Living and Harm-Reduction Approach

As discussed throughout this report, one of the most common themes was the need for person-centered, individualized care plans that embrace an individual's specific experiences, goals, and needs. Many participants noted the necessity of expanding access to and building the capacity of person-centered programs that adopt a non-abstinence living and harm-reduction approach. It is critical that any behavioral health system provides a breadth of programming capable of effectively addressing the diverse needs of individuals with behavioral health issues. Harm-reduction approaches recognize that not all individuals are ready or able to achieve complete abstinence; they instead focus on minimizing the negative consequences of mental health and substance use challenges. This approach includes strategies such as non-sober living, needle exchange programs, supervised consumption sites, and the provision of overdose reversal agents to prevent overdose deaths. By meeting individuals where they are in their recovery journey and providing them with practical tools to reduce harm, these

programs can significantly improve health outcomes, reduce the spread of infectious diseases, and decrease the risk of overdose. Additionally, harm reduction programs often serve as entry points to other forms of treatment and support, fostering a nonjudgmental environment that encourages individuals to seek further help.

Non-abstinence environments for those living with mental health and substance use diagnoses, such as housing that supports harm reduction principles and peer-support groups that do not require abstinence, are equally important. These settings provide safe, stable programming for individuals who are not yet ready for abstinence-based living but still need support and a safe environment to manage their substance use. By offering a supportive community and access to resources, non-abstinence living environments help individuals stabilize their lives, reduce risky behaviors, and improve their overall well-being. These programs acknowledge the complexities of addiction and behavioral health recovery, providing a compassionate, realistic approach to managing one's condition, avoiding acute crises, and supporting long-term recovery. Many participants reflected on the need for expanding access to these types of programs, asserting that such access is essential for creating a more inclusive and effective system of care.

Need to Expand Access to Behavioral Health Services for Children and Youth

Another prevalent theme cited by those engaged in the assessment was the substantial needs and gaps in the continuum of care for children and youth, particularly for those who are uninsured, Medicaid-insured, non-English speakers, or from diverse cultural backgrounds. These gaps are particularly pronounced regarding psychiatry and residential programs. While these gaps in the more intensive services affect all ages, parents of children and youth face significant challenges in finding appropriate care. Several participants highlighted the closure of numerous county residential support programs for mothers/pregnant individuals and their children. These gaps are exacerbated by the workforce shortages, particularly the lack of licensed clinical social workers, psychiatric nurse practitioners, psychiatrists, and case managers/care navigators with pediatric experience.

Address Service Gaps, Disparities in Health Outcomes, and Limited Engagement in Care by Race, Ethnicity, and Geography

One of the primary aims of the assessment was to identify demographic and geographic segments of the population that should be prioritized due to gaps in accessible services, limited engagement in care, or disparities in health outcomes. A review of both the quantitative data and the information gathered through community engagement activities, reveals significant disparities in behavioral health access and outcomes by race/ethnicity and geography in Cook County. The data identified disparities in access and health-related outcomes for those living in the South Side and West Side equity zones, as well as for the Black/African American population more generally. Substantial disparities also exist in the South Suburban neighborhoods of Cook County.

Other population segments highlighted by the data include children and youth, individuals recently incarcerated or justice-involved, and those who identify as LGBTQIA+, non-English speakers, or recent immigrants or refugees.

Need to Promote Tele-Behavioral Health Approaches

Many participants referenced the need for and importance of supporting tele-behavioral health approaches with the goals of 1) Supporting patient access and person-centered care; 2) Helping to alleviate workforce shortages; and 3) Assisting in lessening the maldistribution of services. Advocates express that tele-behavioral health could play a vital role in addressing gaps in the current behavioral health care system. Nearly one-quarter (23.5%) of survey respondents listed workforce shortages as a top unmet need/ or challenge in Cook County. Proponents highlighted how tele-behavioral health could improve access to timely and effective care without the need for travel, especially beneficial for individuals with mobility issues, transportation barriers, or scheduling constraints. It also could also help to reduce the impact of stigma for those who are reluctant to access care in-person due to fear of being seen or recognized by others in their community.

One outreach worker reflected that some individuals were unable to access care "across the lines" of gang territories due to community and gang violence. Telehealth approaches could address some of these issues.

Promoting tele-behavioral health can also help alleviate workforce shortages and the maldistribution of care by providing options for those needing to work from home. Additionally, it can extend the reach of well-resourced behavioral health providers who can serve clients beyond their immediate geographic location, thus optimizing the utilization of available mental health professionals.

Need to Invest in and Enhance School-Based Behavioral Health Services, Including the Development of Safe Spaces for Youth to Build Coping Skills and Resilience

A significant insight regarding the leading behavioral health issues facing Cook County stakeholders was the considerable mental health and substance use needs of children and youth, underscoring the need for enhanced behavioral health programming and capacity in school settings. Data indicated high levels of anxiety, depression, and other mental health issues exacerbated by academic pressures, social challenges, and, for some, difficult home and community environments. Schools, being a primary environment where youth spend a considerable time, are uniquely positioned to provide early intervention and ongoing support. School-based behavioral health services are essential for identifying and addressing these challenges in a timely manner before they escalate into more severe conditions. Integrating such services within the school setting can also help reduce the stigma associated with seeking mental health support, as students can receive care in a familiar and less intimidating environment.

These findings emphasize the need for substantial investment in and enhancement of school-based behavioral health services. Developing safe spaces within schools for students to build coping skills and resilience is essential. These spaces can serve as refuges for students to decompress and access resources and support, facilitating a proactive approach to mental health. Furthermore, equipping schools with trained mental health professionals can ensure that students receive the necessary guidance and support to navigate their challenges effectively. This strategic focus on enhancing school-based behavioral health services is crucial for creating resilient, well-adjusted individuals capable of thriving both academically and personally.

Expand the Use of Medications for Opioid Use Disorder (MOUD)

Participants in community engagement activities identified a pressing need to expand access to medications for opioid use disorder (MOUD). Despite the proven efficacy of these treatments and ongoing efforts to enhance their utilization, access remains limited, particularly among communities and population segments that are less engaged with services. This gap has contributed to higher rates of untreated addiction, overdose, and associated health complications. Expanding MOUD services is essential to address these critical gaps and ensure that individuals with substance use disorders receive comprehensive and effective care.

Furthermore, the expansion of MOUD services has significant implications for public health and safety. Integrating these medications into a broader continuum of care, including counseling and support services, can enhance treatment effectiveness, leading to sustained recovery and improved quality of life for individuals. Many participants emphasized that increasing access to MOUD is crucial for Cook County's efforts to mitigate the substance use crisis and improve the overall health and well-being of affected communities.

Promote Behavioral Health Integration in Primary Care and Beyond

There is a continued need to promote the integration of behavioral health services into primary care and other health and community settings. This includes efforts to implement "reverse integration," where primary care medical services are incorporated into existing behavioral health settings. Stakeholders noted significant strides in this area but stressed the importance of ongoing efforts to ensure that individuals with behavioral health issues are screened, assessed, and treated within

primary care settings, including facilitating referrals and promoting sustained recovery. Evidence supports that integrating behavioral health into primary care, or vice versa, can improve access to necessary services, reduce the stigma associated with seeking behavioral health care, and provide a more holistic approach to patient health.

Furthermore, efforts should extend to integrating behavioral health services into community settings beyond primary care, such as schools, workplaces, and social service agencies. This approach can enhance the accessibility of mental health care, ensuring there is "no wrong door" for individuals seeking support. By breaking down the silos between physical and mental health, substance use, and social service systems, integration efforts can create a more responsive and patient-centered healthcare system that effectively meets the comprehensive needs of individuals and communities.

Support Those Experiencing Trauma and Violence, Especially Gun Violence

Participants in community engagement efforts spoke of the urgent need to address and support individuals who are victims of or witnesses to community violence, particularly gun violence. The profound impacts of such experiences on mental and physical health. were emphasized. Trauma from violence can lead to various psychological issues, including post-traumatic stress disorder (PTSD), anxiety, depression, and substance use disorders. Immediate and long-term support services, including community outreach, trauma-informed care, counseling, and therapeutic interventions, are essential for helping individuals process their experiences, manage symptoms, and begin healing. These services provide a safe space for individuals to address their trauma, develop coping strategies, and regain stability and control in their lives.

Initiatives like the Collaborative for a Trauma-Informed Chicago (CTI Chicago), funded by the Chicago Department of Public Health's Office of Violence Prevention, build on the city's commitment to integrating trauma-informed practices. Healing Hurt People Chicago is another program developed by Cook County Health, designed to help individuals heal emotionally and physically from injuries caused by community violence through assessment, psychoeducation, practical support, and both individual and group therapeutic work.

Addressing the broader community impact of violence, especially gun violence, is crucial for fostering resilience and preventing the cycle of violence from perpetuating. Numerous community-based programs in Cook County provide support and resources to individuals and families affected by violence. These initiatives, including support groups, outreach efforts, and community engagement activities, can be strengthened to mitigate the broader social and economic consequences of violence, focusing on rebuilding trust and cohesion within impacted neighborhoods.

Cross-Cutting Structural Issues That Impact the Behavioral Health System

Workforce Development, Training and Technical Assistance

As discussed previously regarding service-related gaps, workforce shortages emerged as the most frequently cited challenge in key informant interviews. Participants highlighted two main areas of concern: 1) shortages of clinical staff across various skills and credentials, and 2) difficulties in recruiting and retaining not only clinical providers, but also case managers, ancillary staff, and administrative personnel. Many individuals expressed frustration with long waitlists, scheduling difficulties, and delays in obtaining care, primarily due to insufficient capacity within the behavioral health network. Addressing these workforce shortages is crucial for meeting patient needs.

The success of any behavioral health system depends on a talented, diverse, well-distributed, and resilient clinical and non-clinical workforce. Roles such as psychiatrists, counselors, clinical specialists, case managers, and peer support workers are vital in ensuring that patients are engaged in their care and receive comprehensive education, prevention, assessment, treatment, and recovery services. Continuous professional development and medical education focused on developing new

expertise or maintaining existing skills are essential for keeping staff informed of the latest advancements and applying best practices. Training and professional development also foster engagement, reduce stigma, enhance quality, and ensure that care is patient-centered and well-communicated.

Organizational challenges related to recruitment and retention are particularly acute for those serving high proportions of Medicaid-insured and uninsured patients. Financial limitations tied to lower reimbursement rates contribute to lower salaries and limited benefits for staff. One BHNA survey respondent stated

> *"you have to have a heart for this field; we do the most and are paid the least. I just wish we could be paid our worth."*

Many small community-based organizations struggle to compete for staff due to their inability to offer competitive salaries compared to larger, better-resourced entities. Furthermore, participants acknowledged the significant challenge of hiring culturally and linguistically responsive staff to serve diverse patient populations.

High turnover rates and staff burnout are persistent issues, exacerbated by the impact of COVID-19 and increasing acuity and safety concerns in behavioral health care. Many organizations emphasized the need for staff development and training resources to ensure the provision of appropriate evidence-based, trauma-informed, person-centered care. A peer support specialist shared

> *"...we would greatly appreciate a path where folks who wanted to enter the field could do so debt-free, all the way to full licensure. That would inspire more folks to enter the field...and then get paid a meaningful livable wage proportional to their education and the personal sacrifice they make to the field. That would be the type of long-term investment that will yield a significant return."*

Administrative barriers to credentialing and certification complicate hiring, while challenges in recruiting human resources staff with updated expertise further hinder organizational capacity.

Payment Models and Value-Based Payment

Discussions during community engagement highlighted the importance of new payment models and value-based payment (VBP) methods, emphasizing their potential to promote innovative service delivery and enhance care quality.[91] However, smaller organizations often face challenges in participating in these models, particularly due to less sophisticated electronic medical records and limited administrative support.

Traditional fee-for-service (FFS) models, which reimburse providers based on service volume, can lead to unnecessary treatments and higher costs without necessarily improving patient outcomes. In contrast, VBP models prioritize patient outcomes and cost efficiency. By linking reimbursement to quality metrics, and the effectiveness of care, these models incentivize providers to deliver high-quality services that meet patient needs, promote engagement, streamline transitions, and address leading cost drivers in care delivery.

Improving the patient experience is another critical aspect of VBP models, which often incorporate patient satisfaction and engagement metrics into performance measures. Focusing on patient-centered care encourages providers to consider patients' preferences, values, and needs in treatment plans. Enhanced communication, shared decision-making, and personalized care contribute to more engaged patients, higher satisfaction, and better adherence to treatment recommendations, ultimately improving health outcomes.

As detailed in the recommendations section, the Office of Behavioral Health (OBH) should explore ways to enhance the use of VBP models within the behavioral health realm, emphasizing innovations related to the findings of this assessment, particularly in promoting engagement, care transitions, utilization of community health workers (CHWs) and peer support specialists (PSSs).

Financial Solvency and Sustainability Issues

Participants frequently noted that financial challenges limit providers' ability to expand access, meet community needs, and sustain operations. They described inadequate payments, high workforce recruitment and retention costs, escalating technology expenses, and administrative overhead. Providers reported that revenue from service reimbursements, grants, and other sources often fails to cover the full cost of delivering high-quality, person-centered, innovative care. This financial gap forces many behavioral health organizations to operate on minimal margins, making it difficult to maintain financial stability, recruit and retain staff, and invest in necessary technologies. Consequently, providers struggle to sustain operations, let alone expand services or adopt innovative practices.

Workforce issues exacerbate these financial pressures, as the behavioral health sector faces a significant shortage of trained professionals, including psychiatrists, psychologists, social workers, and counselors. Low reimbursement rates and the high cost of education, and training deter many individuals from entering the field, resulting in a limited supply of qualified providers. Those who do enter often experience burnout and high turnover due to overwhelming caseloads and inadequate support. This shortage negatively impacts both access and quality of care, leading to longer wait times and less personalized treatment. Additionally, insufficient workforce resources hinder innovation by limiting opportunities to develop and implement new therapeutic approaches or adopt advanced technologies.

These combined financial solvency and sustainability issues threaten behavioral health providers' overall ability to meet growing demand. Access to care is increasingly restricted, particularly for underserved populations, as financial instability compels providers to limit patient intake, or the range of services offered. Overburdened staff and cost-cutting measures undermine treatment effectiveness. Furthermore, limited financial resources stifle innovation, and workforce constraints hinder the adoption of improved practices. Addressing these challenges is essential for ensuring the long-term sustainability and effectiveness of the behavioral health sector, ultimately enhancing access, quality, and innovation in care delivery.

Administrative, policy, and program requirements

Numerous participants identified challenges related to administrative, regulatory, and licensure requirements that impact provider operations and service expansion efforts. One major issue is the complexity and volume of administrative tasks providers must navigate, including extensive service-related documentation, compliance with various state and federal regulations, and adherence to multiple reporting standards. The administrative burden associated with these tasks consumes substantial time and resources, diverting attention from direct patient care and limiting providers' capacity to serve more patients. This inefficiency reduces the overall productivity of the behavioral health workforce and increases operational costs, further straining organizational financial stability.

Regulatory and licensure requirements pose significant challenges to the growth and expansion of behavioral health services. Obtaining and maintaining licensure involves rigorous processes, including extensive paperwork, background checks, continuing education mandates, and compliance with specific criteria. These requirements can be particularly burdensome for smaller providers and those operating in multiple states, as they must navigate a complex web of differing standards. The cost and effort needed for compliance can deter new providers from entering the field and inhibit existing ones from expanding services or opening new locations.

Overall, findings underscore the necessity of streamlining administrative processes, reducing barriers to entry and regulatory standards, and simplifying licensure requirements. Addressing these issues could alleviate operational burdens on providers, allowing them to focus more on patient care and innovation. These efforts would also enhance workforce recruitment throughout Cook County, making it more competitive with neighboring states.

Health Information Exchange (HIE)

During the BHNA interviews with service providers and key stakeholders, **Health Information Exchange (HIE)** emerged as a critical topic, especially regarding its role in supporting care transitions and coordination. HIE encompasses coordinated systems designed to facilitate the electronic sharing of health-related information among various organizations. These systems enable healthcare providers, patients, and other stakeholders to access and securely share vital patient information, including health history, service provider appointments, lab results, medication prescriptions, referrals, and other essential health data. The overarching goal of HIE is to streamline patient care across various health-diverse healthcare settings effectively.

Robust, inclusive, and accessible HIE processes are essential for any health system's success. By ensuring that clinicians have access to the most accurate and current patient information, HIE fosters enhanced care coordination, reduces the risk of errors, minimizes redundant tests and procedures, and promotes more informed decision-making. This ultimately enhances the patient experience, improves care quality, and lowers costs. When effectively implemented, HIE also alleviates the burden. on service providers. For behavioral health patients with chronic or acute conditions, HIE supports continuous monitoring and timely interventions, leading to improved service delivery, seamless care transitions, and better health outcomes. Furthermore, HIE significantly enhances care coordination and operational efficiency within the healthcare system.

BHNA participants highlighted the need for improved systems specifically tailored for behavioral health providers, emphasizing the importance of facilitating relevant information sharing, including efforts to obtain patient consent for sharing behavioral health data with medical and other service providers.

Data Structures to Support Analysis and Transparency

Data systems and structures that analyze and report on the strengths and capacities of existing care systems, including behavioral health, are increasingly recognized as vital to the success of health systems. These systems can evaluate service delivery trends, quality metrics, and future projections. When implemented effectively, they serve as a backbone for informed decision-making, oversight, and accountability. By systematically collecting, analyzing, and disseminating data related to health system performance, costs, revenues, utilization, and quality, these structures provide an objective understanding of the current health system landscape. This information is crucial for identifying gaps, inefficiencies, and areas needing improvement, enabling policymakers, healthcare providers, and stakeholders to collaboratively make informed decisions, prioritize resources, and design targeted interventions.

While discussions with OBH staff addressed these issues, no BHNA participants specifically referred to the existence or necessity of such data structures and systems. Moreover, the BHNA was not structured to fully explore the current state of data systems in Cook County. OBH, Cook County Department of Public Health, and the Chicago Department of Public Health play key roles in facilitating assessment, planning, and system-strengthening efforts. However, the BHNA findings suggest gaps in data and systems to support analysis, oversight, and transparency.

Nationally, many public and quasi-public entities regularly produce reports or share datasets that allow service providers and stakeholders to monitor health system performance, thereby creating transparency regarding utilization, capacity, quality, costs, revenues, and other measures. To address these needs, OBH and local health departments should explore systematic strategies for tracking service capacity, quality, and the financial sustainability of the existing core service provider network.

Recommendations and Strategic Opportunities

The Cook County Behavioral Health Needs Assessment (BHNA) was developed to ensure that strategic efforts to build and sustain an equitable, integrated, and well-coordinated behavioral health system across the County are community-informed and data-driven. This BHNA report is meant to provide a roadmap for this work, including the development of a comprehensive, accessible, equitable behavioral health care system capable of providing high-quality, trauma-informed, patient-centered services. Specifically, this report is meant to clarify community needs and barriers to care, service capacity and gaps, workforce shortages, and overall system strengths and weaknesses.

Based on the assessment findings, a series of recommendations and strategic opportunities are presented. They are organized according to the service-related segments of the Office of Behavioral Health's (OBH) Behavioral Health System Framework. Additionally, recommendations that address cross-cutting structures affecting the behavioral health system are denoted.

1 Priority Area 1:
Prevention and Early Intervention for Children and Adults

STRATEGIC OPPORTUNITY 1: Implement a comprehensive targeted county-wide campaign to end behavioral health stigma.	
Proposed Activities/Strategies:	Implement a multifaceted, culturally humble public education campaign aimed at raising awareness and destigmatizing mental health and substance use disorders and treatment. This campaign should foster an appreciation for the signs, symptoms, root causes, and implications of behavioral health. It should also provide guidance on how to support those in need and educate community members on where and how to access services.
	Invest in programs that normalize and foster a more positive, hopeful, and supportive view of behavioral health with the goal of reducing the negative stereotypes associated with behavioral health.
	Implement a Cook County "Behavioral Health In-All-Policies" approach that identifies ways for Cook County agencies, departments, offices, and partners to lift up a more positive, normalized view of behavioral health, strengthen the behavioral health system, and support individuals facing behavioral health challenges.
STRATEGIC OPPORTUNITY 2: Invest in new or expand existing prevention and early intervention strategies in a tailored, prioritized manner, with an emphasis on the segments of the population facing the greatest disparities and challenges.	
Proposed Activities/Strategies:	Support the effective implementation of Illinois' Certified Community Behavioral Health Clinic (CCBHC) initiative, ensuring consumer engagement, financial sustainability, and smooth transitions to services that address health-related social needs (HRSN) and other specialized services..
	Invest in evidence-informed, school-based interventions focused on prevention, early intervention, and reducing stigma.
	Expand or enhance outreach programs, including street outreach, mobile outreach, and behavioral health urgent care clinics, to promote education, identification, screening, and engagement in care.

STRATEGIC OPPORTUNITY 3: Support the development of harm-reduction programs focused on reducing risks and supporting long-term recovery for individuals using substances and with chronic behavioral health conditions.	
Proposed Activities/Strategies:	Expand access to behavioral health programs that apply non-abstinence, harm-reduction programming.
	Address workforce shortage in community health workers, peer-support specialists, recovery coaches, and peer-navigators.
	Continue to explore how to best implement and support needle exchange and supervised consumption sites.

2 Priority Area 2:
Access to Crisis, Assessment, Treatment, and Linkages to Care

STRATEGIC OPPORTUNITY 1: Expand and enhance existing crisis support and early intervention strategies with an emphasis on the demographic, geographic, and other segments of the population facing the greater disparities and challenges.	
Proposed Activities/Strategies:	Support the effective implementation of the Illinois' CCBHC initiative, including efforts to raise awareness, ensure consumer engagement, ensure financial sustainability (particularly for those who are uninsured), support seamless transitions to specialized services outside of the CCBHC package and services that address health-related social needs.
	Expand access to same-day behavioral health crisis care, including efforts to raise awareness, promote engagement, facilitate sharing of information with a patient's regular primary care provider, and support seamless transitions to services to specialized services and services that address health-related social needs.
	Raise awareness and better coordinate the implementation of the various telephonic behavioral health hotlines in Cook County to promote their use, and ensure that consumers access the hotline that best suits their needs.
STRATEGIC OPPORTUNITY 2: Promote behavioral health integration in clinical and nonclinical settings to identify those in crisis or on the verge of crisis, and link them to services.	
Proposed Activities/Strategies:	Continue to promote and enhance behavioral health integration into primary care and other clinical settings, including integrating medical services into behavioral health clinics.
	Promote behavioral health integration into social service settings and other community-based settings to facilitate identification and engagement in care.
	Promote universal screening in clinical and nonclinical settings to promote engagement in care, especially for those in crisis or on the verge of crisis.
	Enhance coordination, communication, and integration of behavioral health screening, assessment, and referral across different sectors of the health care system, including clinical and nonclinical components of the system.

STRATEGIC OPPORTUNITY 3: Expand engagement and the effective application of Cook County's health information exchange (HIE) resources.	
Proposed Activities/Strategies:	Support providers to implement certified electronic medical records capable of seamlessly interfacing with other Cook County resources.
	Invest in enhancements in the functionality of health information exchange (HIE) in ways that promote engagement and leverage resources to the benefit of the behavioral health providers (e.g., informed consent, more-tailored reporting, training and technical assistance).
	Support community partnerships or collaborative initiatives that pilot certain use cases to the benefit of all parties in the collaborative.
STRATEGIC OPPORTUNITY 4: Continue to support programs that enhance screening, assessment, and referrals related to addressing individual and familial challenges with respect to health-related social needs.	
Proposed Activities/Strategies:	Expand health-related social needs screening activities in clinical and community-based settings.
	Develop tools to support those who have been assessed and are in need of services to address health-related social needs to access services, including service inventories and mechanisms to make and track referrals.
	Support hospitals and other community-based service providers to implement universal social needs screening and community service referrals.
	Invest in the development and/or enhancement of existing service inventories that link people to health-related social needs

3 Priority Area 3:
Care, Treatment, Support, Recovery, and Sustainability

STRATEGIC OPPORTUNITY 1: Expand access and promote engagement in behavioral health services, with an emphasis on the segments of the population facing the greatest disparities and challenges.	
Proposed Activities/Strategies:	Address gaps in capacity with respect to more intensive behavioral services, such as outpatient and residential programs, partial hospitalization programs, and transitional housing to expand access to care and support seamless, timely care transitions.
	Implement programs that further promote behavioral health integration into primary care and other clinical settings to expand access and promote engagement in care.
	Expand the use of Medications for Opioid Use Disorder (MOUD) to expand access, promote engagement in care, and support those seeking recovery.
	Promote the adoption and use of tele-behavioral health approaches to expand access, address the maldistribution of services, support staff retention, and expand the health care workforce.
	Implement a multifaceted public education campaign focused on raising awareness and educating the public about mental health and substance use, with the goal of fostering a deeper appreciation for the signs, symptoms, root causes, and implications of behavioral health. The campaign would also provide guidance on how to support people in need and educate people on where to access services.
	Invest in efforts that support seamless transitions of care by promoting programs that facilitate collaboration, partnership, enhanced operations, and use of HIE.

STRATEGIC OPPORTUNITY 2: Expand access and promote engagement in behavioral health care for specific demographic and geographic population segments.	
Proposed Activities/Strategies:	Develop programs that address service gaps, disparities in health outcomes, and more limited engagement for certain racial, ethnic, and geographic communities.
	Expand programs that support those experiencing trauma and who are exposed to community violence, especially gun violence, to reduce the prevalence of serious behavioral health issues and promote engagement in care.
	Expand programs that support those who have been recently incarcerated and/or who are justice involved to ensure that people are linked to appropriate treatment in a timely manner so as to reduce the prevalence of serious behavioral health issues and promote engagement in care.
	Expand access to behavioral health services for children and youth through tailored and focused school- and community-based programs.
STRATEGIC OPPORTUNITY 3: Support the development of harm-reduction programs focused on reducing risks and supporting long-term recovery for active substance users and those with chronic behavioral health issues.	
Proposed Activities/Strategies:	Promote training and technical assistance efforts that stress the importance of person-centered care and the need for individualized care plans.
	Expand access and ensure an adequate supply of behavioral health programs that apply non-abstinence, harm-reduction methods.
	Address workforce gaps in community health workers, peer-support specialists, recovery coaches, and peer-navigators.
	Expand or enhance outreach programs, including street and mobile outreach, and behavioral health crisis care clinics that promote education, identification, screening, and engagement in care.
	Continue to explore how to best implement and support needle exchange and supervised consumption sites.
	Expand the application “Living Room” models that provide safe spaces for those in recovery.

4 Priority Area 4:
Health-Related Social Needs

STRATEGIC OPPORTUNITY 1: Continue to address gaps in safe, affordable housing for those in the general public and those with behavioral health conditions, particularly those with serious mental illnesses (SMI).	
Proposed Activities/Strategies:	Continue to invest in the development of safe/affordable housing options for the general public and those with behavioral health conditions.
	Continue to invest in housing assistance programs and public housing navigators to support those in the general public who are in search of safe, affordable housing, with an emphasis on those who are unstably housed or at risk of homelessness and those with behavioral health conditions.
	Address shortages of transitional, recovery, and family/parent-child housing options for those with behavioral health conditions.
STRATEGIC OPPORTUNITY 2: Develop and/or expand programming to reduce the prevalence and impact of community violence and support those who are victims of violence.	
Proposed Activities/Strategies:	Enhance existing programming focused on addressing community violence, especially gun violence.
	Enhance existing programming focused on promoting the use of trauma-informed care, particularly care focused on those impacted by community violence, especially gun violence.
	Expand street outreach and other outreach programs that raise awareness, identify, and engage those who are struggling with the impacts of community violence, especially gun violence.
	Focus on enhanced programming for those who live in Chicago's South Side and West Side Health Equity Zones.

STRATEGIC OPPORTUNITY 3: Expand and enhance programming focused on supporting those in need of employment, particularly those with behavioral health conditions.	
Proposed Activities/Strategies:	Continue to invest in and link those in need to public/private partnerships that support people to identify job opportunities, and provide training and links to livable wage jobs, with an emphasis on engaging those with behavioral health conditions, such as the Chicago Cook Workforce Partnership program and the American Job Centers (AJCs) in Suburban Cook County.[92]
	Continue to invest in job training programs, including focused efforts to engage people in these programs, with an emphasis on engaging those with behavioral health conditions.
	Promote the efforts and link people to the Illinois Behavioral Health Workforce Center (BHWC).[93]

STRATEGIC OPPORTUNITY 4: Continue to support programs that enhance screening, assessment, and referrals related to addressing individual and familial challenges with respect to health-related social needs.	
Proposed Activities/Strategies:	Expand health-related social needs screening and referral activities in clinical and community-based settings.
	Develop tools to support closed-loop referrals to health-related social needs services for those who have been assessed and are in need of services to address social determinants of care to access services, including service inventories and mechanisms to make and track referrals.
	Support hospitals, clinics, and other community-based service providers to implement universal social needs screening and community service referrals.
	Invest in the development and/or enhancement of existing service inventories that link people to health-related social needs.

5 Priority Area 5:
Cross-Cutting Structures that Impact the Behavioral Health System

STRATEGIC OPPORTUNITY 1: Address workforce shortages through efforts that expand the pool of potential employees interested and able to join the healthcare workforce.	
Proposed Activities/Strategies:	Implement initiatives focused on increasing behavioral health workforce capacity with respect to psychiatrists, therapists, community health workers and peer-support staff, and other behavioral health specialists for both children/youth, adults, and older adults.
	Implement initiatives focused on strengthening and increasing the cultural and linguistic responsiveness of the behavioral health workforce.
	Implement initiatives focused on reducing stigma, as well as promoting greater sensitivity and an understanding of those with behavioral health conditions to enhance the quality of care and the providers' ability to build trusting, engaged patient/provider relationships.
	Develop partnerships with local universities, training programs, and technical assistance centers to develop pipelines to develop the health care workforce.
	Develop programs that promote partnerships with middle schools and high schools that implement internship and mentorship programs to grow the healthcare workforce.
	Develop programs that reduce the burden of state, county, and local governmental processes and policies to expedite licensure and reduce the burden on providers relative to recruitment and retention of staff.
	Implement programs that pay healthcare workers to participate in training and technical assistance activities related to program quality, operations, financing/billing payment, human resources, and other administrative responsibilities.
	Implement initiatives that promote workforce wellness and reduce burnout.

STRATEGIC OPPORTUNITY 2: Promote adoption of Value-Based Payment (VBP) models in behavioral health settings.	
Proposed Activities/Strategies:	Increase the total share of behavioral health revenues flowing through VBP models to support innovation and the application of evidence-based service delivery approaches.
	Support Managed Care Organizations (MCOs) and other payers to simplify the administrative burden of alternative payment models on providers to encourage their adoption.
	Provide training and technical assistance and other technological supports to behavioral health providers to increase their capacity and ability to participate in VBP models.
STRATEGIC OPPORTUNITY 3: Develop data analysis, oversight, and accountability structures that support decision making and promote transparency.	
Proposed Activities/Strategies:	Develop and implement data systems that assess the capacity of the existing behavioral health system so as to better understand, track, and address service gaps.
	Develop and implement initiatives that establish and track appropriate quality and access standards, and then track and monitor to the extent in which providers meet these standards.
	Develop and implement initiatives that track and report on provider revenues and costs to promote transparency and support decision-making and policy development.
	Develop and implement initiatives that track and report on the total share of behavioral health revenue flowing through VBP models to assess the impact of strategies and promote adoption of VBP.
	Develop and implement initiatives that track and analyze the health care workforce data with respect to salaries and benefits, as well as workforce satisfaction and attitudes to promote recruitment and retention.
STRATEGIC OPPORTUNITY 4: Expand engagement and the effective application of Cook County's health information exchange (HIE) resources.	
Proposed Activities/Strategies:	Support providers in the implementation of certified electronic medical records capable of seamlessly interfacing with Cook County's HIE resources.
	Invest in enhancements in the functionality of HIE in ways that promote engagement and leverage Cook County's resources to the benefit of the behavioral health providers (e.g., informed consent, more-tailored reporting, training and technical assistance).
	Support community partnerships or collaborative initiatives that pilot certain HIE use cases to promote the use of HIE and promote more effective information sharing and to improve care transitions and care coordination.

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Appendices

Appendix A - Partners In Action (PIA) Committee Materials

- PIA One Pagers - Lived Experience + Community Organizations
- PIA Recruitment Flyers - Lived Experience + Community Organizations
- PIA Committee Members + Organizations

Appendix B - Data Collection and Recruitment Materials

- Focus Group Recruitment Flyers
- Focus Group Questions
- Focus Group Demographics Data Collection Form
- Focus Group Interest Forms
- KII Interview Guide/Questions
- BHNA Survey Questions in English + Spanish
- BHNA Survey Results

Appendix C - Community Health Needs Assessments and Other Reports

- Ann & Robert H. Lurie Children's Hospital of Chicago Community Health Needs Assessment and 2023-2025 Implementation Strategy 2022 www.luriechildrens.org/contentassets/30f62f0d60b24e83af34cfb9edc74876/2022-chna-report-and-2023-2025-implementation-strategy_august31.pdf
- Cook County Health Department of Public Health Community Health Status Assessment 2025 cookcountypublichealth.org/wp-content/uploads/2022/06/CHSA_appendix-D_final.pdf
- Cook County Health Office of Behavioral Health Summit Report 2024 cookcountyhealth.org/about/office-of-behavioral-health/
- Healthy Chicago 2.0 Partnering to Improve Health Equity 2016-2020 www.chicago.gov/content/dam/city/depts/cdph/CDPH/HC2.0Plan_3252016.pdf
- Illinois Public Health Institute: A Landscape Analysis of Chicago's West and South Sides iphionline.org/wp-content/uploads/2021/04/Landscape-Analysis_Full-Report_121820.pdf
- Loyola University Medical Center and Gottlieb Memorial Hospital Community Health Needs Assessment 2022 www.loyolamedicine.org/sites/default/files/hg_features/mercury_standard_layout/35b582c2c7124b8f3d83353b6ae026d3.pdf
- Mount Sinai Hospital Community Health Needs Assessment 2022 www.sinaichicago.org/wp-content/uploads/2022/06/Sinai-Chicago-2022-CHNA_Mount-Sinai-Hospital_final-compressed.pdf
- Northwest Community Hospital Community Health Needs Assessment 2021 www.nch.org/wp-content/uploads/2021-CHNA-2.pdf
- Norwegian American Hospital Community Health Needs Assessment 2019 www.hph.care/wp-content/uploads/2020/03/CHNA-Report.pdf
- RUSH University Medical Center and Oak Park Hospital Community Health Needs Assessment 2022 www.rush.edu/sites/default/files/chna-chip-2022.pdf
- University of Chicago Medicine Community Health Needs Assessment 2021-2022 issuu.com/communitybenefit-ucm/docs/ucmc-chna-2021-2022?fr=sNTc0NTE0ODc0MDM

Appendix A

COOK COUNTY MENTAL HEALTH NEEDS ASSESSMENT PARTNERS IN ACTION COMMITTEE LIVED EXPERIENCE

What is a Partners in Action (PIA) Committee?

Members will be involved in the process of developing ways to capture the voice of those living with a mental health and/or substance use diagnosis. The Lived Experience Partners in Action Committee will help with multiple activities, including creating strong local connections when recruiting for focus groups and supporting the development of focus group guides. The committee will also help to review the focus group data, ensuring all communities are represented in the data.

What is the commitment I am making and will I be paid for my time?

You will be paid $50 per 90-minute meeting for your time as a member of the PIA Committee with a time commitment of up to 10 hours between February 2024 and May 2024.

What background do I need to become a member?

We are looking for individuals who are living with a mental health and/or substance use diagnosis, have lived experience accessing mental health services in Cook County, and/or are loved ones of individuals living with a mental health and/or substance use diagnosis. No prior experience is needed and you/your loved one do not need to be in active treatment.

What are my responsibilities as a member?

- Attend all 90-minute committee meetings virtually (3 virtual meetings that take place from February 2024 - May 2024)
- Assist in identifying participants for focus groups
- Help develop and review materials (for example recruitment flyers, questionnaires for focus groups, etc.) for community friendliness
- Review focus group findings to ensure accurate reflection of Cook County
- Help with reviewing final materials for the needs assessment to ensure accurate reflection of the Cook County community

Who do I contact with questions or to participate?

Nadia Syed at nadia_syed@jsi.com

COOK COUNTY HEALTH

COOK COUNTY MENTAL HEALTH NEEDS ASSESSMENT PARTNERS IN ACTION COMMITTEE COMMUNITY ORGANIZATIONS/PROVIDERS

What is a Partners in Action (PIA) Committee?

Members will be involved in the process of developing ways to capture the voice of those living with a mental health and/or substance use diagnosis. The Community Organizations/Providers Partners in Action Committee will help with multiple activities, including creating strong local connections for focus group outreach and supporting the development of focus group guides. The committee will also help to develop needs assessment survey questions, review data, and provide insights on the experience of providing mental health/substance use care in Cook County.

What is the commitment I am making and will I be paid for my time?

You will be paid $50 per 90-minute meeting for your time as a member of the PIA Committee with a time commitment of up to 10 hours between January 2024 and April 2024.

What background do I need to become a member?

We are looking for community leaders and providers who care for those living with a mental health and/or substance use diagnosis and have worked in or with the mental health system in Cook County.

What are my responsibilities as a member?

- Attend all 90-minute committee meetings virtually (3 virtual meetings that take place from January 2024 - April 2024)
- Assist in identifying participants for focus groups
- Help develop and review materials (for example recruitment flyers, questionnaires for focus groups, etc.) for community friendliness
- Review focus group findings to ensure accurate reflection of Cook County
- Help with reviewing final materials for the needs assessment to ensure accurate reflection of the Cook County community

Who do I contact with questions or to participate?

Nadia Syed at nadia_syed@jsi.com

COOK COUNTY HEALTH

SHARE YOUR VOICE

COOK COUNTY
BEHAVIORAL HEALTH NEEDS ASSESSMENT
COMMUNITY ORGS/PROVIDERS PARTNERS IN ACTION COMMITTEE

Join the Community Organizations/Providers Partners in Action Committee to help inform Cook County's Behavioral Health Needs Assessment. Share your experiences, feedback, and ideas regarding behavioral health needs in Cook County.

VIRTUAL KICK-OFF MEETING

TUESDAY, JANUARY 23, 2024
12:00PM - 1:30PM CT

Please contact Nadia at nadia_syed@jsi.com if interested

COOK COUNTY HEALTH

Participants will be compensated for their time.

SHARE YOUR VOICE

COOK COUNTY
BEHAVIORAL HEALTH NEEDS ASSESSMENT
LIVED EXPERIENCE PARTNERS IN ACTION COMMITTEE

Join the Lived Experience Partners in Action Committee to help inform Cook County's Behavioral Health Needs Assessment. Share your experiences, feedback, and ideas regarding behavioral health needs in Cook County.

VIRTUAL KICK-OFF MEETING

THURSDAY, FEBRUARY 29TH, 2024
TIME TO BE DETERMINED

Please contact Nadia at nadia_syed@jsi.com if interested

COOK COUNTY HEALTH

Participants will be compensated for their time.

Cook County Health Behavioral Health Needs Assessment 2024
Community Organizations + Providers Partners in Action Committee Roster

Name	Role	Organization
Katherine Bartholomew, LCSW	Executive Director	Family Service and Mental Health Center of Cicero
Mauricio Cifuentes, PhD, LCSW	Clinical Director	Family Service and Mental Health Center of Cicero
Ann Brekke, MS, LCPC	Program Director	Thresholds
Jeffrey Gilbert	Program Director	Thresholds
Sharronne Ward, EdD, LCPC	President + CEO	Grand Prairie Services
Jessica Gimeno, MPPA	Mental Health Policy Analyst	Access Living
Kerri Brown, JD, LLM	President + CEO	C4
Elvis Muñoz, MHA	Regional Director	Advocate Aurora Health
Lee Rusch	Senior Advisor	West Side Heroin Task Force

Cook County Health Behavioral Health Needs Assessment 2024
Lived Experience Partners in Action Committee Roster

Name	Title
Andrew Dehaan	Substance Use Specialist, community member
Cherry Davis	Peer Recovery Specialist, community member
Jalesa Truesdell	Community Member
Laresse Foster	Peer Recovery Specialist, community member
Maria Chavez	Community Member
Chris O'Hara	Community Member
Takeesha Brown	Peer Engagement Specialist, community member

Appendix B

SHARE YOUR VOICE

COOK COUNTY BEHAVIORAL HEALTH NEEDS ASSESSMENT LIVED EXPERIENCE FOCUS GROUPS

Cook County Health is conducting a needs assessment and we want to hear from people who are living with a mental health and/or substance use diagnosis, have experience accessing mental health services in Cook County, and/or are loved ones of individuals living with a mental health and/or substance use diagnosis and live in Cook County.

JOIN US FOR AN IN PERSON FOCUS GROUP ON
WEDNESDAY APRIL 24TH FROM 11AM-1PM
AT

CICERO FAMILY SERVICES

FOCUS GROUP PARTICIPANTS WILL RECEIVE A $50 GIFT CARD

*****FOOD WILL BE PROVIDED*****

If interested, please contact
Mauricio Cifuentes at
mcifuentes@cicerofs.org

COOK COUNTY HEALTH

SHARE YOUR VOICE

COOK COUNTY BEHAVIORAL HEALTH NEEDS ASSESSMENT LIVED EXPERIENCE FOCUS GROUPS

Cook County Health is conducting a needs assessment and we want to hear from people who are living with a mental health and/or substance use diagnosis, have experience accessing mental health services in Cook County, and/or are loved ones of individuals living with a mental health and/or substance use diagnosis and live in Cook County.

JOIN US FOR AN IN PERSON FOCUS GROUP ON
THURSDAY JUNE 20TH FROM 12-2PM
AT

NAMI CHICAGO
1801 W. WARNER AVE, SUITE 202, CHICAGO, IL

FOCUS GROUP PARTICIPANTS WILL RECEIVE A $50 GIFT CARD

*****LUNCH WILL BE PROVIDED FROM 12-12:30*****

If interested, please scan this QR code or contact Nadia at nadia_syed@jsi.com

COOK COUNTY HEALTH

SHARE YOUR VOICE

COOK COUNTY
BEHAVIORAL HEALTH NEEDS ASSESSMENT
LIVED EXPERIENCE FOCUS GROUPS

Cook County Health is conducting a needs assessment and we want to hear from people who are living with a mental health and/or substance use diagnosis, have experience accessing mental health services in Cook County, and/or are loved ones of individuals living with a mental health and/or substance use diagnosis and live in Cook County.

JOIN US FOR A VIRTUAL FOCUS GROUP

WEDNESDAY MAY 8TH FROM 12-1:30PM

FOCUS GROUP PARTICIPANTS WILL RECEIVE A $50 GIFT CARD

If interested, please scan this QR code or contact Nadia at nadia_syed@jsi.com

COOK COUNTY HEALTH

Lived Experience Focus Groups Questions

Strengths

1. What is currently going well when it comes to mental health/substance use services in Cook County

   ***Probes**:*

   a. *What made these services successful?*
   b. *What are some programs you can think of that have helped you or others you know when it comes to mental health/substance use services?*

Weaknesses/Opportunities for Improvement

2. What is currently not going so well when it comes to mental health/substance use services in Cook County?

   Probe:

   a. What went wrong with the examples you provided or can you provide more detail?

Community Impact

3. What makes it difficult or hard for Cook County residents like you or your loved ones to get the mental health/substance use support and services you need?

   ***Probes**:*

   a. *What social/societal factors do you think foster inequities such as racism and discrimination, language barriers, stigma, cost, transportation, etc.*
   b. *Prevention, Health promotion, education, stigma reduction?*
   c. *Identification/Screening?*
   d. *Treatment?*
   e. *Recovery support?*

Recommendations

4. What would be the number one thing you would change about mental health/substance use services in Cook County?

Conclusion

5. Are there any additional ideas or suggestions you would like to bring up or discuss regarding mental health/substance use services in Cook County?

Community Provider/Organization Focus Groups

Strengths

1. What do you feel are the current **assets or strengths** of the Cook County region when it comes to mental health/substance use services?

   ***Probes**:*

   a. *What made these services successful?*
   b. *What are some key policies or programs or initiatives in the County that have helped to reduce the burden of behavioral health issues, enhanced access to care, reduced disparities, increased engagement, etc?*

Weaknesses/Opportunities for Improvement

2. What do you feel are the current **unmet needs or challenges** of the Cook County region when it comes to mental health/substance use services?

   Probe:

   a. What made these services unsuccessful?

Community Impact

3. What communities/groups of people in the Cook County region do you feel are the most marginalized (not given equitable power or access) when it comes to mental health/substance use services and why?

4. What makes it difficult for Cook County residents to get the mental health/substance use support and services they need?

   ***Probes**:*

   a. *What social/societal factors do you think foster inequities such as racism and discrimination, language barriers, stigma, cost, transportation, etc.*
   b. *Prevention, Health promotion, education, stigma reduction?*
   c. *Identification/Screening?*
   d. *Treatment?*
   e. *Recovery support?*

5. Thinking about **your role and/or organization** in providing mental health/substance use services, what makes it difficult for you to provide Cook County residents with the support and services they need?

Recommendations

6. If you were granted one wish to invest dollars in additional mental health/substance use resources or programs in the Cook County region, what would your wish be?

Conclusion

7. Are there any additional recommendations or suggestions you would like to make regarding mental health/substance use services in the Cook County region?

Cook County Health Needs Assessment Demographics

Cook County Health Behavioral Health Needs Assessment Demographics

1. What is your age? *

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65 and older

2. Which focus group did you attend? *

- Tuesday April 9th 12-1:30pm (Virtual)
- Friday April 12th 10-11:30 am (Virtual)
- Thursday June 20th 12-2pm (In-Person)

3. Are you? Check all that apply. *

- [ ] Cook County Resident
- [ ] Person with a Mental Health Diagnosis (including those in recovery)
- [ ] Person with a Substance Use Diagnosis (including those in recovery)
- [ ] Staff Member at Cook County Health
- [ ] Staff Member at a Mental Health or Substance Use Service Organization that provides services in Cook County
- [ ] Staff person at a Health-Related Public/Government Agency (for example, Dept. of Human Services, Health Department, Housing Agency, Community Health Center, etc.)
- [ ] None of the above
- [ ] Other - Write In (Required)

*

- [ ] A loved one of individuals living with a mental health and/or substance use diagnosis

4. Zip code where you live *

5. Zip code where you work (if you work)

6. Race (Check all that apply) *

- [ ] American Indian or Alaska Native
- [ ] East Asian (For example, Chinese, Filipino, Japanese, etc.)
- [ ] South Asian (For example, Indian, Pakistani, Bangladeshi, etc.)
- [ ] Black or African American
- [ ] Middle Eastern or North African (MENA)
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Hispanic, Latino, or Spanish Origin
- [ ] Prefer not to say
- [ ] Other - Write In

7. What is the highest degree of level of education you have completed?*

- ○ Less than a high school diploma
- ○ High School Degree or Equivalent
- ○ Some College, No Degree
- ○ Associate's Degree
- ○ Bachelor's Degree (BS, BA, etc.)
- ○ Master's Degree (MA, MPH, MS, etc.)
- ○ Doctorate (PhD, MD, etc.)
- ○ Prefer not to answer

8. What languages do you speak? *

- [ ] English
- [ ] Spanish
- [ ] Russian
- [ ] Polish
- [ ] Ukrainian
- [ ] Chinese
- [ ] Tagalog
- [ ] Arabic
- [ ] Korean
- [ ] Other - Write In (Required)

*

9. What gender/sex do you identify as? *

- ○ Female
- ○ Male
- ○ Transgender Female
- ○ Transgender Male
- ○ Gender Non-Conforming
- ○ Prefer not to answer
- ○ Other - Write In

10. What is your annual household income? *

- $0-$10,000
- $10,000-$15,000
- $15,000-$25,000
- $25,000-$35,000
- $35,000-$50,000
- $50,000-$75,000
- $75,000-$100,000
- $100,000-$150,000
- $150,000-$200,000
- $200,000 or more
- Prefer not to answer

Lived Experience Focus Groups: Cook County Health Behavioral Health Needs Assessment

Focus Group Interest Form

1. First Name *

2. Last Name *

3. What is your phone number? *

4. What is your email? *

5. Are you a resident of Cook County? *

- Yes
- No

6. It is important that we talk with a diverse group of people. Please indicate any areas of life you have experience in. If none of these are applicable, please select I am not part of any of the above groups: *

- [ ] A person living with a mental health and/or substance use disorder
- [ ] A person who has experience accessing mental health services in Cook County
- [ ] A person who are loved ones of individuals living with a mental health and/or substance use diagnosis
- [ ] Other - Write In (Required)

*

- [ ] I am not part of any of these above groups

7. Which dates and times work for you to attend a focus group? Select all that apply. *

- ○ Wednesday May 8th 12-1:30pm-Virtual via Zoom
- ○ Thursday June 20th 12-2pm- In person at NAMI Chicago
- ○ None of these options work for me

8. Are there any special accommodations you would need to participate in a focus group?

9. Do you have any additional thoughts or concerns?

Community Providers Focus Groups: Cook County Health Behavioral Health Needs Assessment

Focus Group Interest Form

1. First Name *

2. Last Name *

3. What is your phone number? *

4. What is your email? *

5. Are you a resident of Cook County? *

- Yes
- No

6. What type of behavioral health organization do you work for? *

- [ ] Community Based Organization or Federally Qualified Health Center
- [ ] Crisis Response-emergency departments, crisis call centers, crisis stabilization settings, etc.
- [ ] Criminal Justice agencies and facilities
- [ ] Child welfare agencies
- [ ] Homeless Shelters or housing agencies
- [ ] Hospital System
- [ ] Health Department
- [ ] Residential Facilities
- [ ] Opioid Treatment Programs or other MAT clinics
- [ ] Veterans Affairs
- [ ] Other - Write In (Required)

*

7. What is your role/title? *

- [ ] Case Manager
- [ ] Social Worker
- [ ] Psychologist
- [ ] Peer Support Specialist
- [ ] Community Health Worker
- [ ] Outreach Worker
- [ ] Director- leadership
- [ ] Health Educator
- [ ] Other - Write In (Required)

*

8. Which dates and times work for you to attend a virtual focus group, via Zoom? Select all that apply. *

- [ ] Tuesday April 9th 12-1:30pm
- [ ] Friday April 12th 10-11:30am
- [ ] None of these options work for me

9. Are there any special accommodations you would need to participate in a focus group?

10. Do you have any additional thoughts or concerns?

2023-2024 Cook County Health Behavioral Health Needs Assessment Key Informant Interview Guide

Background and Instructions:

The Cook County Health and Hospital System's (Cook County Health) Office of Behavioral Health is in the process of conducting a countywide behavioral health need assessment with the support of JSI Research & Training Institute, Inc. (JSI), a non-profit, research and consulting organization, and Cook County-based community partners from SASU Project Management and Luna Consulting & Coaching. To begin the assessment JSI, SASU, and Luna Consulting are conducting key informant interviews with Cook County Health Staff and other organizational leaders to better understand the behavioral health landscape of Cook County. This assessment will serve as the foundation for Cook County Health's Behavioral Health Strategy and System Strengthening Initiative over the next 3 years. It will also be used to help inform Cook County Health's Behavioral Health Summit, being planned and hosted by their Office of Behavioral Health in February 2024.

JSI is applying a robust approach, including a review of existing quantitative data and the collection of qualitative information through interviews, group meetings, focus groups, and community resident forums. We appreciate you taking the time to talk with us today. Your input and ideas regarding the current and historical factors that have promoted or hindered access to behavioral health care, health equity, and wellness for those who live and work in Cook County are essential to the success of this project. The interview will cover a range of topics, including Cook County's leading behavioral health issues, barriers to access and engagement in care, service gaps, system strengths and weaknesses, and what actions the County should take to improve the behavioral health system and overall health and well-being.

The interview will take approximately 45 minutes to an hour to complete. We will be taking detailed notes and recording our conversation, but our notes, recording, and whatever is included in various communications and reporting documents will never tie anything you say directly back to you. All of the reflections from our interviews will be aggregated in a larger summary report. If there is anything you want to share entirely off the record, please let us know, and we will ensure it is not included in notes or analysis.

Do you have any questions before we start?

Background Information

1. Tell me about yourself. What is your role and what are your primary responsibilities at Cook County or your organization?

Health System Strengths and Assets

2. What are some of the strengths or assets of Cook County's behavioral health system/services?
    a. **Probe**: What made these services successful?

3. What are some key policies or programs or initiatives in the County that have helped to reduce the burden of behavioral health issues, enhanced access to care, reduced disparities, increased engagement, etc?
    a. **Probe**: What made these policies or programs successful?

Weaknesses/Opportunities for Improvement

4. Next, we want to discuss Cook County's behavioral health system weaknesses and opportunities for improvement. What are the greatest barriers or challenges you think residents or patients face when seeking behavioral health care within the Cook County Behavioral Health system?

    Probes:
    a. Are there social/societal factors that you think foster disparities and inequities such as racism and discrimination, language barriers, stigma, cost, transportation, etc.
    b. Prevention, Health promotion, education, stigma reduction?
    c. Identification/Screening
    d. Treatment
    e. Recovery supports

5. What about health systems issues? How well does the County integrate and coordinate services, support care transitions, or share important information?
    a. Thinking of system integration and collaboration, what are the most important issues?

6. What issues of equity and disparities with respect to access and health outcomes? To what extent is the County and its partners addressing issues of equity? Are services distributed equitably?

Service or Workforce Capacity Gaps or Shortages

7. Based on another Cook County Health initiative looking at workforce shortages, we know that staffing is directly impacting behavioral health services for Cook County residents. What are some of the issues with respect to the quality and capacity of behavioral health services that you are seeing related to workforce?

Prioritization

8. Where do you feel the focus needs to be on Cook County's behavioral health system?

Recommendations

9. What should Cook County Health and its public and private partners do moving forward to improve behavioral health in Cook County?

    a. **Probes:** What specific policies should be enacted?
    b. **Probes:** What programs should be introduced?
    c. **Probes**: What initiatives should take place?
    d. **Probes:** What infrastructure improvements should be made?

Based on the weaknesses you just mentioned above, what might Cook County Health need to do to address those challenges?

    e. **Probe:** What are some barriers to addressing these challenges or weaknesses?
    f. **Probe**: What are some resources you might need to address these challenges or weaknesses?

For each recommendation you mentioned, what is your view of its feasibility for implementation?

    g. **Probe:** If you could only implement one program or policy, what would you do?

Conclusion

10. Are there any topics you wish to discuss that have not been raised in this discussion?

11. Are there any reports or data sources that we should be aware of that speak to the strength and capacity of the Cook County Health system?

12. Is there anyone else you recommend we speak with about current and future Cook County Health behavioral health issues?

13. Another activity for this Needs Assessment is to create community advisory committees including community leaders, provider organization staff, and Cook County residents and their families; is there anyone you would recommend we talk with to see if they might be a good fit?

Cook County Health Behavioral Health Needs Assessment Survey 2023-2024

Please see the upper-right-hand area to change the survey language to Spanish or English/Por favor consulte el área superior derecha para cambiar el idioma de la encuesta a español o inglés.

1. **Are you?** (Check all that apply) *

- [ ] Cook County Resident
- [ ] Person with a Mental Health Diagnosis [including those in recovery]
- [ ] Person with a Substance Use Diagnosis [including those in recovery]
- [ ] Staff member at Cook County Health
- [ ] Staff member at a Mental Health or Substance Use Service Organization
- [ ] Staff person at a Health-Related Public/Government Agency [for example: Dept. of Human Services, Health Department, Housing Agency, Community Health Center, etc.]
- [ ] None of the above

2. **What are the top 3 current assets or strengths of Cook County when it comes to mental health and substance use services?** (Choose up to 3) *

- [ ] Access to care
- [ ] Access to medicine
- [ ] Enough staff
- [ ] Community or non-profit organizations
- [ ] Equity
- [ ] Funding
- [ ] Housing
- [ ] Insurance coverage
- [ ] Outreach
- [ ] Patient education and knowledge
- [ ] Patient navigation or coordination of care
- [ ] Patient satisfaction
- [ ] Prevention
- [ ] Programs and services
- [ ] Quality of care
- [ ] School-based support
- [ ] Staff education and knowledge
- [ ] Other, please specify:

*

3. **Please provide any additional comments related to the current assets or strengths of Cook County when it comes to mental health and substance use services.**

4. **What are the top 3 current unmet needs or challenges of Cook County when it comes to mental health and substance use services?** (Choose up to 3) *

- [ ] Access to care
- [ ] Access to medicine
- [ ] Community or non-profit organizations
- [ ] Cost of services
- [ ] Fear (e.g., of diagnosis, of doctors, of people finding out about diagnosis, etc.)
- [ ] Funding or reimbursement
- [ ] Housing (e.g., affordable, accessible)
- [ ] Insurance coverage
- [ ] Outreach
- [ ] Patient education or knowledge
- [ ] Patient navigation or coordination of care
- [ ] Patient satisfaction
- [ ] Prevention
- [ ] Programs and services
- [ ] Quality of care
- [ ] Racism or Inequity
- [ ] Support from schools
- [ ] Lack of staff education and knowledge
- [ ] Staff shortages
- [ ] Stigma
- [ ] Transportation
- [ ] Other, please specify:

*

5. **Please provide any additional comments related to unmet needs or challenges in Cook County when it comes to mental health and substance use services.**

(untitled)

6. **When it comes to mental health and substance use services, what groups of people in Cook County are most marginalized? This means they are not given the same power or access.** *We know that this list is not complete. Please add any other groups of people under Other, below. (Choose up to 3) *

- [ ] Hispanic or Latino, please note country of origin:
- [ ] Black or African American, please note country of origin:
- [ ] Indigenous- American Indian
- [ ] Indigenous- Alaska Native
- [ ] Native Hawaiian
- [ ] Pacific Islander (non-Native Hawaiian), please note country of origin:
- [ ] Asian, please note country of origin:
- [ ] Middle Eastern or North African (MENA), please note country of origin:

- [ ] White, please note country of origin:

- [ ] Religious Affiliation, please note specific religion:

- [ ] Men, Boys or People who Identify as Male
- [ ] Women, Girls or People who Identify as Female
- [ ] LGBTQIA+
- [ ] Older Adults (over 65 years old)
- [ ] Youth (under 18 years old)
- [ ] People who used to be in prison
- [ ] Veterans
- [ ] Migrants or Immigrants
- [ ] Refugees
- [ ] People who are going through a homeless or insecure housing period
- [ ] People who speak a language other than English
- [ ] Pregnant or Postpartum people
- [ ] People with disabilities
- [ ] People actively using drugs or other substances
- [ ] People experiencing domestic violence
- [ ] People who have in the past experienced sexual violence (physical or mental)
- [ ] People living with Dementia or Alzheimer's Disease
- [ ] People living with chronic complex health conditions (e.g., HIV, heart disease, asthma, cancer)
- [ ] People living with chronic pain
- [ ] People living with a mental health issue (e.g., anxiety, depression, etc.)
- [ ] People living with a severe mental health diagnosis (e.g., bipolar, PTSD, schizophrenia, etc.)

- [ ] Other, please specify:

*

7. **What makes it hard for Cook County residents to get the mental health or substance use services they need?** (Check all that apply) *

- [ ] Access to medicine
- [ ] Biased health care staff (they treat you differently because of your identity)
- [ ] Childcare
- [ ] Open hours or schedule at the clinic
- [ ] Clinic location
- [ ] Community or non-profit organizations
- [ ] Cost of services
- [ ] Cultural beliefs
- [ ] Hard to navigate the healthcare system
- [ ] Fear (e.g., of diagnosis, of doctors, loss of privacy, etc.)
- [ ] Housing
- [ ] Insurance coverage
- [ ] Language barriers
- [ ] Don’t understand your or their diagnosis or treatment options
- [ ] Don’t understand or know about services
- [ ] Not enough outreach or outreach workers
- [ ] Racism or Inequity
- [ ] Lack of staff education or knowledge
- [ ] Long wait times for an appointment
- [ ] Staff shortages

- [ ] Stigma
- [ ] Transportation
- [ ] Other, please specify:

*

8. **If you were granted one wish to spend money for other mental health or substance use services in Cook County, what would it be?**

9. **What else would you like to share about mental health or substance use services in Cook County?**

(untitled)

10. **Zip code where you live** *

11. **Zip code where you work** [if you work]

12. **Race** (Check all that apply) *

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Middle Eastern or North African (MENA)
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Other, please specify:

13. **Ethnicity** *

- ○ Hispanic or Latinx/o/a
- ○ Non-Hispanic or Latinx/o/a
- ○ Other, please specify:

14. **Age** *

- ○ Under 18 years old
- ○ 18 - 29 years old
- ○ 30 - 39 years old
- ○ 40 - 49 years old
- ○ 50 - 65 years old
- ○ 65 years old or over

15. **What is your gender?** *

- Male
- Female
- Female to Male (FTM)/Transgender Male/Trans Man
- Male-to-Female (MTF)/Transgender Female/Trans Woman
- Genderqueer, neither exclusively male nor female
- Prefer not to answer
- Other, please specify:

16. **Are you a member of the LGBTQIA+ community?** *

- Yes
- No
- Do not know
- Prefer not to answer

17. **What language(s) do you speak?** *

- English
- English and language(s) other than English

18. **If you speak languages other than English, which languages do you speak?**

Encuesta: Evaluación de las necesidades en relación con la salud mental en el condado de Cook 2023-2024

---

1. **¿Es usted...? (Marque todas las respuestas que correspondan)** *

- [ ] Residente del condado de Cook
- [ ] Persona con diagnóstico relacionado con la salud mental [inclusive personas en recuperación]
- [ ] Persona con diagnóstico relacionado con consumo de sustancias [inclusive las personas en recuperación]
- [ ] Miembro del personal de Cook County Health
- [ ] Miembro del personal de una organización que ofrece servicios de salud mental o de tratamientos por consumo de sustancias
- [ ] Miembro del personal de una agencia gubernamental o agencia pública relacionada con la salud [por ejemplo: Departamento de Servicios Humanos, Departamento de Salud, agencia de vivienda, centro de salud comunitario, etc.]
- [ ] Ninguna de las alternativas anteriores

2.

¿Cuáles son los 3 recursos o puntos fuertes principales con los que actualmente cuenta el condado de Cook en cuanto a servicios de salud mental o tratamiento por consumo de sustancias?

(Elija un máximo de 3)

*

- [ ] Acceso a servicios
- [ ] Acceso a medicamentos
- [ ] Suficiente personal
- [ ] Organizaciones comunitarias o sin ánimo de lucro
- [ ] Equidad
- [ ] Fondos
- [ ] Vivienda
- [ ] Cobertura del seguro de salud
- [ ] Relaciones y comunicaciones comunitarias
- [ ] Educación y conocimiento de los pacientes
- [ ] Coordinación de servicios para el paciente
- [ ] Satisfacción del paciente
- [ ] Prevención
- [ ] Programas y servicios
- [ ] Calidad de los servicios y atención a la salud
- [ ] Apoyo en las escuelas
- [ ] Educación y conocimiento del personal
- [ ] Otra alternativa, por favor especifique:

*

3. **Por favor añada comentarios sobre los recursos o puntos fuertes actuales del condado de Cook en cuanto a servicios de salud mental o de tratamiento por consumo de sustancias.**

4. **¿Cuáles son las 3 áreas de necesidades o desafíos que actualmente requieren de mayor atención en el condado de Cook en cuanto a servicios de salud mental o de tratamiento por consumo de sustancias? (Elija un máximo de 3)** *

- [ ] Acceso a servicios
- [ ] Acceso a medicamentos
- [ ] Organizaciones comunitarias o sin ánimo de lucro
- [ ] El costo de los servicios
- [ ] Temores (e.g., al diagnóstico, de los doctores, de que la gente se entere del diagnóstico, etc.)
- [ ] Fondos o reembolsos
- [ ] Vivienda (e.g., asequible, accesible)
- [ ] Cobertura del seguro de salud
- [ ] Relaciones y comunicaciones comunitarias
- [ ] Educación y conocimiento de los pacientes
- [ ] Coordinación de servicios para el paciente
- [ ] Satisfacción del paciente
- [ ] Prevención
- [ ] Programas y servicios

- [ ] Calidad de los servicios y atención a la salud
- [ ] Racismo o falta de equidad
- [ ] Apoyo en las escuelas
- [ ] Falta de educación y conocimiento del personal
- [ ] Falta de personal
- [ ] Estigmas
- [ ] Transporte
- [ ] Otra alternativa, por favor especifique:

*

5.

Por favor añada cualquier comentario que desee en cuanto a necesidades o desafíos en cuanto a los servicios de salud mental o de tratamiento por consumo de sustancias en Cook County que requieren de mayor atención:

6. **Cuando consideramos los servicios de salud mental y de tratamiento por consumo de sustancias, ¿qué grupos de personas en Cook County son los más marginalizados? Esto significa que no se les da el mismo poder o acceso. *Reconocemos que ésta no es una lista completa. Por**

favor añada al final a cualquier otro grupo de personas que falte. (Elija un máximo de 3) *

- [ ] Hispano or latino, por favor indique el país de origen:
- [ ] Negro o afromericano, por favor indique el país de origen
- [ ] Indígena- nativo americano
- [ ] Indígena- nativo de Alaska
- [ ] Nativo de Hawái
- [ ] De las Islas del Pacífico (no nativo de Hawái), por favor indique el país de origen
- [ ] Asiático, por favor indique el país de origen:
- [ ] De Oriente Medio o del norte de África, por favor indique el país de origen:
- [ ] Blanco, por favor indique el país de origen:
- [ ] Afiliación religiosa, por favor especifique la religión en particular:
- [ ] Hombres, niños o personas que se identifican como personas masculinas
- [ ] Mujeres o niñas o personas que se identifican como personas femeninas
- [ ] LGBTQIA+
- [ ] Adultos mayores (mayores de 65 años de edad)
- [ ] Jóvenes (menores de 18 años de edad)
- [ ] Personas que estuvieron encarceladas
- [ ] Personas que son veteranas

- [ ] Personas migrantes o inmigrantes
- [ ] Personas refugiadas
- [ ] Personas que están pasando por un periodo sin hogar/en situación de calle o de inseguridad de vivienda
- [ ] Personas quienes hablan un idioma que no es el inglés
- [ ] Personas embarazadas o en etapa de postparto
- [ ] Personas con discapacidad
- [ ] Personas que actualmente consumen drogas u otras sustancias
- [ ] Personas que están experimentando violencia intrafamiliar
- [ ] Personas quienes en el pasado han experimentado violencia sexual (física o mental)
- [ ] Personas que viven con demencia o condición de Alzheimer
- [ ] Personas que viven con condiciones de salud crónicas complejas (e.g., VIH, condición cardiaca, asma, cáncer)
- [ ] Personas que viven con dolor crónico
- [ ] Personas que viven con condición de salud mental (por ejemplo, ansiedad, depresión, etc.)
- [ ] Personas que viven con un diagnóstico de salud mental severo (e.g., trastorno bipolar, trastorno de estrés postraumático, esquizofrenia, etc.)
- [ ] Otra alternativa, por favor especifique:

*

7. **¿Qué situaciones crean dificultades para las personas que residen en el condado de Cook en cuanto a obtener los servicios de salud mental o de tratamiento por consumo de sustancias que necesitan? (Marque todas las alternativas que correspondan)** *

- [ ] Acceso a medicamentos
- [ ] Prejuicios del personal de atención a la salud (A las personas se le trata de diferente manera según su identidad)

- [ ] El cuidado de niños
- [ ] El horario de la clínica
- [ ] La ubicación de la clínica
- [ ] Organizaciones comunitarias o sin ánimo de lucro
- [ ] Costo de los servicios
- [ ] Creencias culturales
- [ ] Dificultades en navegar el sistema de servicios de la salud
- [ ] Temores (por ejemplo al diagnóstico, de los doctores, de la falta de privacidad, etc.)
- [ ] Vivienda
- [ ] La cobertura del seguro de salud
- [ ] La barrera del idioma
- [ ] No se entiende el diagnóstico o las alternativas de tratamiento que existen
- [ ] No se sabe o no se entiende lo suficiente acerca de los servicios
- [ ] Falta de personas que trabajen en el área de comunicaciones y relaciones comunitarias
- [ ] Racismo o falta de equidad
- [ ] Falta de educación o de conocimiento del personal
- [ ] Tiempos de espera excesivos para obtener una cita
- [ ] Falta de personal
- [ ] Estigma
- [ ] Transporte
- [ ] Otra dificultad, por favor especifique:

*

8. **Si se le concediera un deseo en cuanto a fondos para gastar en servicios adicionales de salud mental o de tratamiento por consumo de sustancias en el condado de Cook, ¿qué pediría?**

9. **¿Qué más quisiera usted compartir acerca de los servicios de salud mental o de tratamiento por consumo de sustancias en el condado de Cook?**

10. **Código postal del lugar donde vive** *

11. **Código postal del lugar donde trabaja [de ser el caso]**

12. **Raza (Marque todas las alternativas que correspondan)** *

- [ ] Indígena americano o nativo de Alaska.
- [ ] Asiático
- [ ] Negro o afroamericano
- [ ] De Oriente Medio o del Norte de África
- [ ] Nativo hawaiano o de otra isla del Pacífico
- [ ] Blanco
- [ ] Otra raza, por favor especifique:

13. **Etnicidad** *

- ○ Hispana o latinx/o/a
- ○ No hispana ni latinx/o/a
- ○ Otra etnicidad, por favor especifique:

14. **Edad** *

- ○ Menor de 18 años
- ○ 18 - 29 años
- ○ 30 - 39 años
- ○ 40 - 49 años
- ○ 50 - 65 años
- ○ 65 años de edad o mayor de 65

15. **¿Cuál es su género?** *

- Hombre/masculino
- Mujer/femenino
- M a H (mujer a hombre) /hombre transgénero/ hombre trans/transmasculino
- H a M (hombre a mujer)/mujer transgénero/mujer trans/transfemenino
- Género queer, ni exclusivamente masculino ni femenino
- Prefiero no responder
- Otra alternativa, por favor especifique:

16. **Es usted parte de la comunidad LGBTQIA+?**

- Sí
- No
- No lo se
- Prefiero no responder

17. **¿Qué idioma/s habla usted?** *

- Inglés
- Inglés y otro/s idioma/s

18. **Si habla algún idioma que no sea inglés, ¿qué idioma/s habla?**

Report for Cook County Health Behavioral Health Needs Assessment Survey 2023-2024

Response Counts

Completion Rate:	**87.8%**		
	Complete		201
	Partial		28

Totals: 229

1. Are you? (Check all that apply)

Value	Percent	Responses
Cook County Resident	83.8%	192
Person with a Mental Health Diagnosis [including those in recovery]	23.6%	54
Person with a Substance Use Diagnosis [including those in recovery]	11.4%	26
Staff member at Cook County Health	4.8%	11
Staff member at a Mental Health or Substance Use Service Organization	30.6%	70
Staff person at a Health-Related Public/Government Agency [for example: Dept. of Human Services, Health Department, Housing Agency, Community Health Center, etc.]	16.6%	38
None of the above	1.7%	4

2. What are the top 3 current assets or strengths of Cook County when it comes to mental health and substance use services? (Choose up to 3)

Value	Percent	Responses
Access to care	28.9%	66
Access to medicine	18.4%	42
Enough staff	3.5%	8
Community or non-profit organizations	50.0%	114
Equity	8.3%	19
Funding	7.9%	18
Housing	4.8%	11
Insurance coverage	20.6%	47
Outreach	20.2%	46
Patient education and knowledge	7.9%	18
Patient navigation or coordination of care	4.4%	10
Patient satisfaction	2.2%	5
Prevention	7.9%	18
Programs and services	25.4%	58
Quality of care	11.8%	27
School-based support	10.5%	24
Staff education and knowledge	19.7%	45
Other, please specify:	6.6%	15

3. What are the top 3 current unmet needs or challenges of Cook County when it comes to mental health and substance use services? (Choose up to 3)

Value	Percent	Responses
Access to care	40.3%	91
Access to medicine	10.6%	24
Community or non-profit organizations	9.3%	21
Cost of services	22.1%	50
Fear (e.g., of diagnosis, of doctors, of people finding out about diagnosis, etc.)	17.7%	40
Funding or reimbursement	17.7%	40
Housing (e.g., affordable, accessible)	27.9%	63
Insurance coverage	17.3%	39
Outreach	9.3%	21
Patient education or knowledge	5.8%	13
Patient navigation or coordination of care	14.6%	33
Patient satisfaction	4.0%	9
Prevention	11.9%	27
Programs and services	14.2%	32
Quality of care	7.5%	17
Racism or Inequity	13.7%	31

Value	Percent	Responses
Support from schools	4.0%	9
Lack of staff education and knowledge	3.1%	7
Staff shortages	23.5%	53
Stigma	10.2%	23
Transportation	4.9%	11
Other, please specify:	3.1%	7

4. When it comes to mental health and substance use services, what groups of people in Cook County are most marginalized? This means they are not given the same power or access. *We know that this list is not complete. Please add any other groups of people under Other, below. (Choose up to 3)

Value	Percent	Responses
Hispanic or Latino, please note country of origin:	41.1%	86
Black or African American, please note country of origin:	51.7%	108
Indigenous- American Indian	8.1%	17
White, please note country of origin:	3.8%	8
Men, Boys or People who Identify as Male	8.1%	17
Women, Girls or People who Identify as Female	5.3%	11
LGBTQIA+	20.6%	43
Older Adults (over 65 years old)	6.2%	13
Youth (under 18 years old)	8.1%	17
People who used to be in prison	8.1%	17
Migrants or Immigrants	15.3%	32
People who are going through a homeless or insecure housing period	14.4%	30
People who speak a language other than English	4.8%	10
People with disabilities	4.8%	10

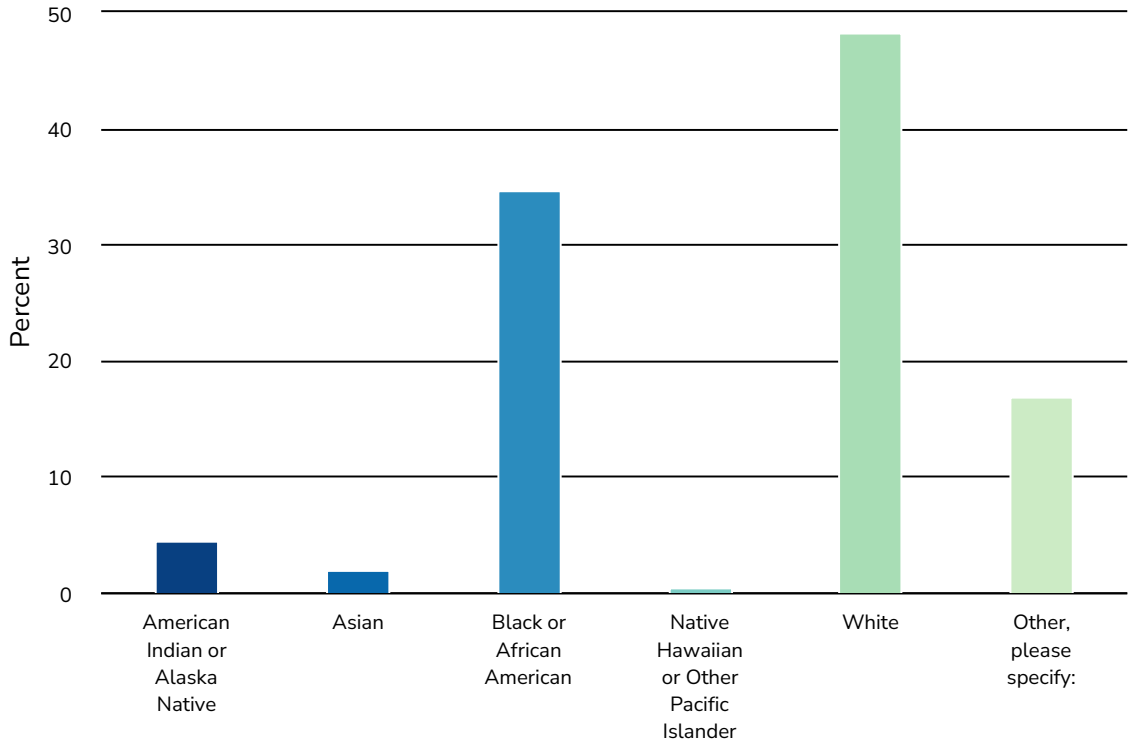
Value	Percent	Responses
People actively using drugs or other substances	7.7%	16
People living with chronic complex health conditions (e.g., HIV, heart disease, asthma, cancer)	3.8%	8
People living with a mental health issue (e.g., anxiety, depression, etc.)	7.2%	15
People living with a severe mental health diagnosis (e.g., bipolar, PTSD, schizophrenia, etc.)	14.4%	30
Other, please specify:	6.2%	13
Indigenous- Alaska Native	0.5%	1
Native Hawaiian	0.5%	1
Pacific Islander (non-Native Hawaiian), please note country of origin:	0.5%	1
Asian, please note country of origin:	2.9%	6
Middle Eastern or North African (MENA), please note country of origin:	2.4%	5
Religious Affiliation, please note specific religion:	1.0%	2
Veterans	2.4%	5
Refugees	1.9%	4
Pregnant or Postpartum people	2.9%	6
People experiencing domestic violence	1.0%	2
People who have in the past experienced sexual violence (physical or mental)	1.9%	4
People living with Dementia or Alzheimer's Disease	1.0%	2
People living with chronic pain	1.4%	3

5. What makes it hard for Cook County residents to get the mental health or substance use services they need? (Check all that apply)

Value	Percent	Responses
Access to medicine	22.5%	47
Biased health care staff (they treat you differently because of your identity)	31.1%	65
Childcare	20.6%	43
Open hours or schedule at the clinic	23.9%	50
Clinic location	31.1%	65
Community or non-profit organizations	8.6%	18
Cost of services	46.4%	97
Cultural beliefs	19.1%	40
Hard to navigate the healthcare system	39.2%	82
Fear (e.g., of diagnosis, of doctors, loss of privacy, etc.)	28.7%	60
Housing	23.9%	50
Insurance coverage	44.5%	93
Language barriers	24.9%	52
Don’t understand your or their diagnosis or treatment options	18.7%	39
Don’t understand or know about services	33.5%	70
Not enough outreach or outreach workers	28.2%	59

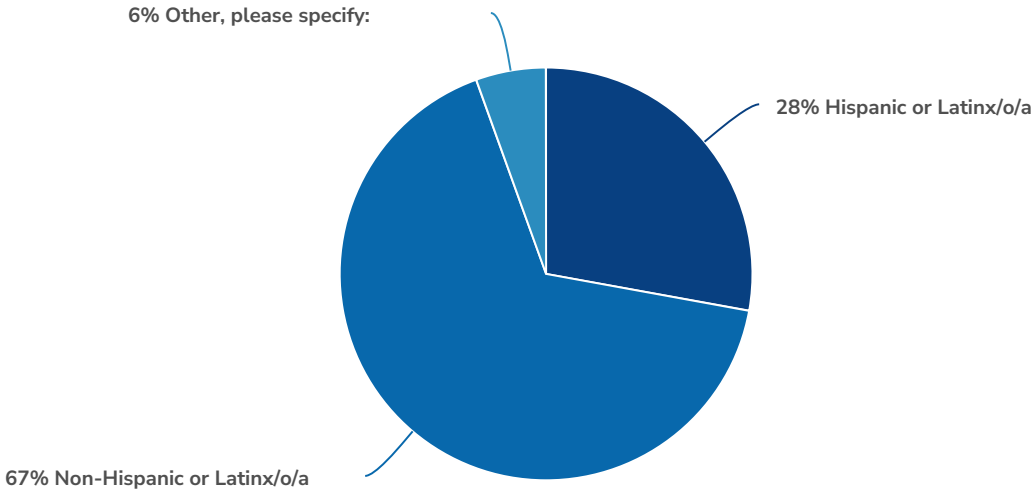
Value	Percent	Responses
Racism or Inequity	30.6%	64
Lack of staff education or knowledge	16.3%	34
Long wait times for an appointment	41.6%	87
Staff shortages	30.1%	63
Stigma	31.6%	66
Transportation	27.3%	57
Other, please specify:	1.9%	4

6. Race (Check all that apply)



Value	Percent	Responses
American Indian or Alaska Native	4.5%	9
Asian	2.0%	4
Black or African American	34.8%	70
Native Hawaiian or Other Pacific Islander	0.5%	1
White	48.3%	97
Other, please specify:	16.9%	34

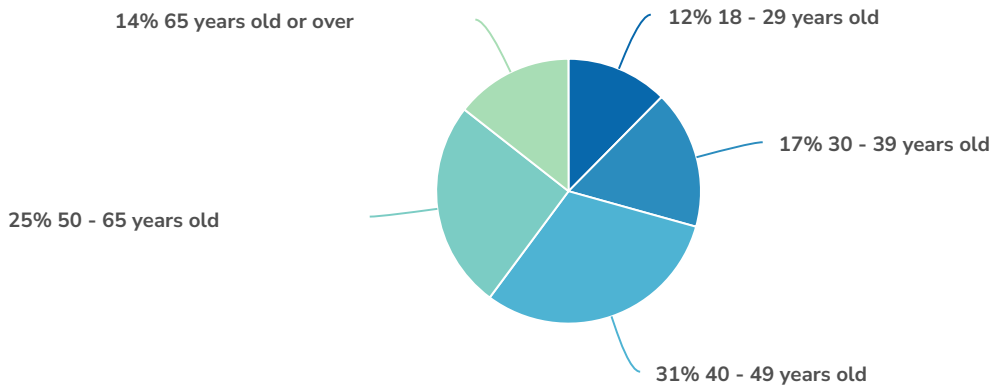
7. Ethnicity



Value	Percent	Responses
Hispanic or Latinx/o/a	27.9%	56
Non-Hispanic or Latinx/o/a	66.7%	134
Other, please specify:	5.5%	11

Totals: 201

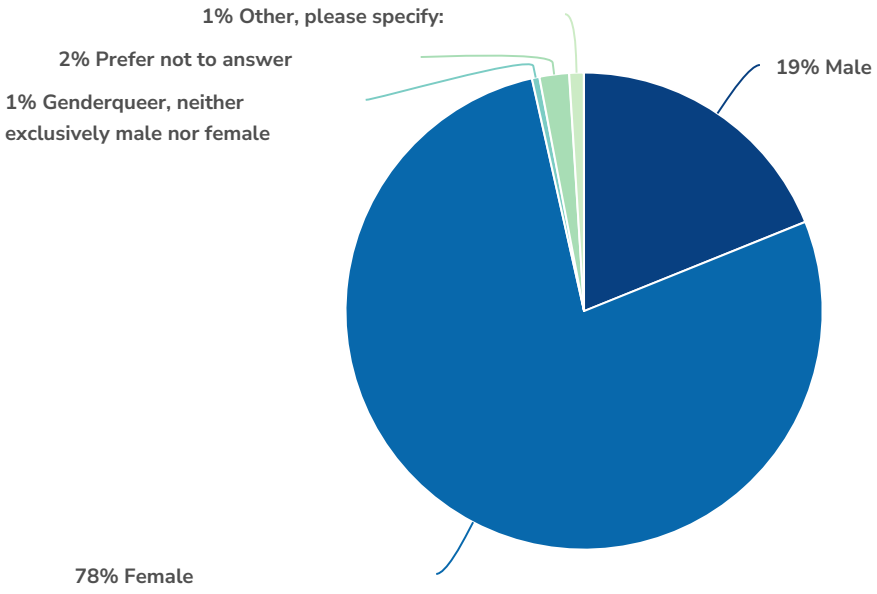
8. Age



Value	Percent	Responses
18 - 29 years old	12.4%	25
30 - 39 years old	16.9%	34
40 - 49 years old	30.8%	62
50 - 65 years old	25.4%	51
65 years old or over	14.4%	29

Totals: 201

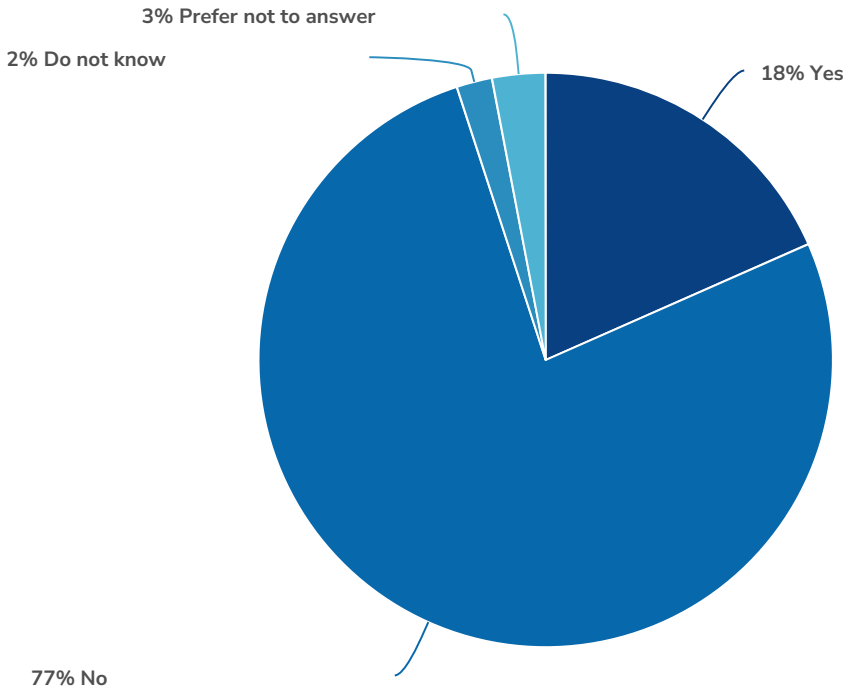
9. What is your gender?



Value	Percent	Responses
Male	18.9%	38
Female	77.6%	156
Genderqueer, neither exclusively male nor female	0.5%	1
Prefer not to answer	2.0%	4
Other, please specify:	1.0%	2

Totals: 201

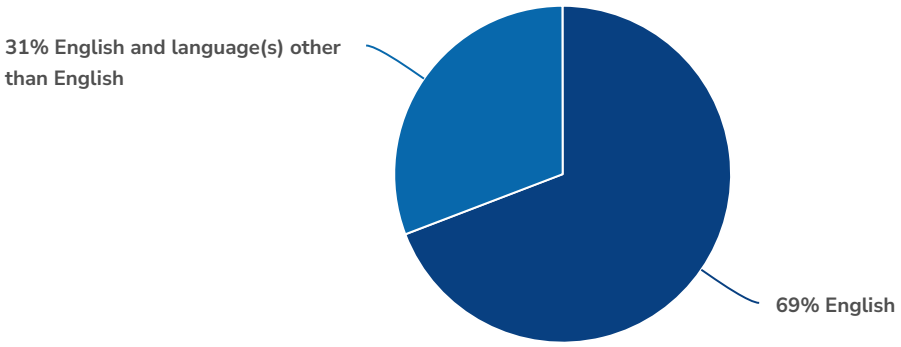
10. Are you a member of the LGBTQIA+ community?



Value	Percent	Responses
Yes	18.4%	37
No	76.6%	154
Do not know	2.0%	4
Prefer not to answer	3.0%	6

Totals: 201

11. What language(s) do you speak?



Value	Percent	Responses
English	69.2%	139
English and language(s) other than English	30.8%	62

Totals: 201