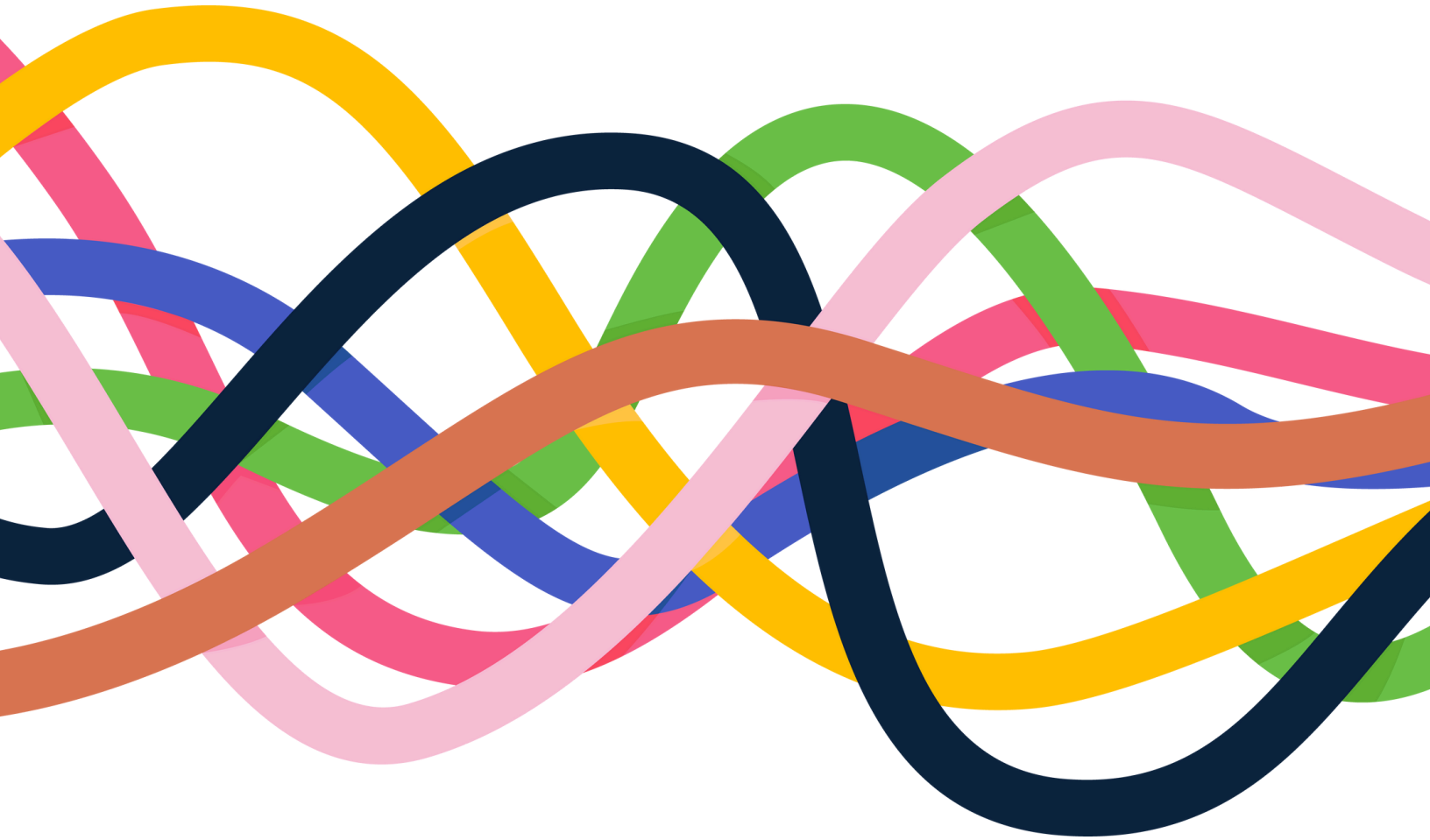
Community & Provider Voices

Strengths and Opportunities in the Suburban Cook County Crisis Care System



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Cook County DEPT. of Public Health
A division of Cook County Health
BUILDING HEALTHIER COMMUNITIES

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Community & Provider Voices

Strengths and Opportunities in the Suburban Cook County Crisis System

HOW SUBURBAN COOK COUNTY RESIDENTS USE THE CRISIS CARE SYSTEM

Cook County Department of Public Health conducted surveys and focus groups with suburban Cook County residents in 2024 and 2025.

55%

of survey respondents who had used the crisis care system said they called 911 or visited the emergency room instead of calling 988

30%

of survey respondents had used a local crisis line, mobile crisis team or living room

TOP CONCERNS PEOPLE RAISED ABOUT THE CRISIS CARE SYSTEM

COST OR INSURANCE ISSUES

LONG WAIT TIMES

TRANSPORTATION ISSUES

LAW ENFORCEMENT ISSUES

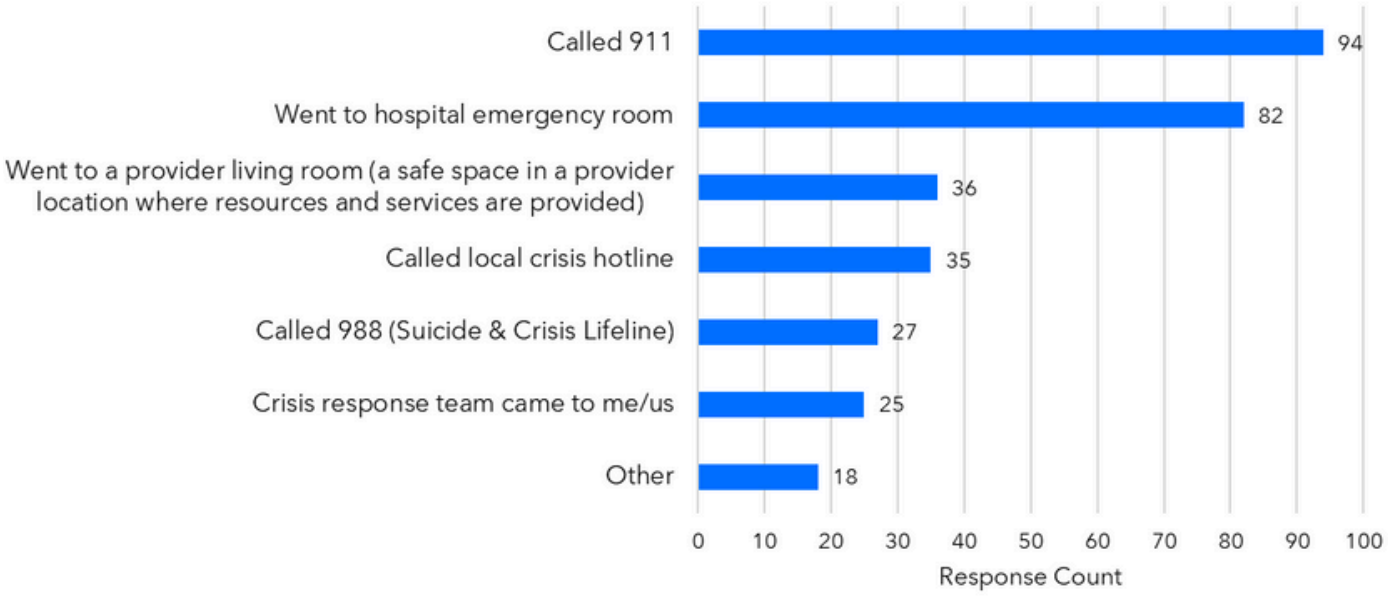
SUMMARY

In 2022, the Cook County Alternative Health Intervention and Response Task Force, co-led by the Cook County Justice Advisory Council (JAC) and Cook County Department of Public Health (CCDPH), elevated approaches to handling behavioral health issues that did not rely on law enforcement presence. The *Alternative Health Intervention and Response Task Force Final Report* identified the need for a comprehensive local assessment of the crisis care in suburban Cook County. This 2025 report, *Community & Provider Voices: Strengths and Opportunities in the Suburban Cook County Crisis System* is the result of that assessment. The assessment combines findings from key informant interviews, focus groups, and surveys with community residents, behavioral health treatment providers, social service agencies, and mental health advocates.

Since 2021, the state of Illinois has made substantial investments in the behavioral health crisis care system – a network designed to support people who are experiencing a mental health or substance use emergency that would benefit most from care delivered by behavioral health professionals. In addition to launching the 9-8-8 Suicide & Crisis Lifeline, Illinois has expanded key crisis services, including Mobile Crisis Response and Certified Community Behavioral Health Clinics (See Figure 7 for descriptions of these supports). Illinois has also established structures to enhance coordination locally and across the major administrators of crisis programs.

Although Illinois has made great strides in improving the crisis care system for its communities, opportunities remain to improve awareness of 9-8-8 and collaboration across crisis providers. Awareness of 9-8-8 and crisis services is limited among community members, community organizations, and other institutions in suburban Cook County. Many community members reported through focus groups and community surveys that they had not heard of 9-8-8, or that they did not utilize its services, despite high utilization of crisis services (see Figure 1). Community members also voiced distrust of law enforcement.

FIGURE 1 | ***Where Suburban Crisis Care System Users Said They Received Help (2024-25)***



Most community members accessed the crisis care system through 9-1-1 or emergency departments.

SUMMARY CONTINUED

Suburban Cook County residents and providers also identified the need for culturally and linguistically responsive outreach about 9-8-8 and the crisis care system, especially when there are high levels of distrust toward local law enforcement, and in some cases, emergency response.

The need for crisis services varies across regions of suburban Cook County. From 2020-2022, suburban Cook County, as a whole, had a rate of 40 emergency department (ED) visits per 1,000 people for mental health concerns. By comparison, the Cook County ZIP code with the highest rates of ED visits for mental health conditions had almost six times the average rate: 227 visits per 1,000 people in the 60426 ZIP code, which is primarily the Harvey community. Inequities also exist for substance use ED visits (see Figures 2-4). These differences highlight the behavioral health impacts of structural racism and access to culturally responsive care in communities of color, especially in the south and west suburbs. Mobile Crisis Response Teams provide coverage for almost all of the suburbs. There are three Certified Community Behavioral Health Clinics (CCBHCs) in suburban Cook County — in Elgin, near Cook County's northwestern border with Kane County; in South Holland, in the south suburbs; and in Berwyn, in the west suburbs.

FIGURE 2 | ***Emergency Department Visit Rates per 1,000 for Mental Health and Substance Use (2020-2022)***

	Mental Health	Substance Use
Average ED Visit Rates Suburban Cook County	**40** Suburban Cook County	**21** Suburban Cook County
Highest ED Visit Rates ZIP Code, City	**227** 60426, Harvey	**177** 60153, Maywood
Lowest ED Visit Rates ZIP Code, City	**4** 60302, Oak Park	**2** 60302, Oak Park

As more elements of the system are established and service gaps are filled, coordination between crisis response entities also need to be strengthened. Protocols can be formalized with the input of behavioral health providers, and trust between providers can be strengthened through improved communication and partnership development. Crisis is often conceptualized as a one-time interaction, but social service and behavioral health advocates have noted that individuals who are treated in the crisis care system deserve follow-up care and ongoing support to prevent future crises. CCDPH is committed to working together with community partners to elevate suburban needs and help ensure a robust crisis care system across suburban Cook County.

FIGURE 3 | ***Mental Health Emergency Department Visits in Suburban Cook County***

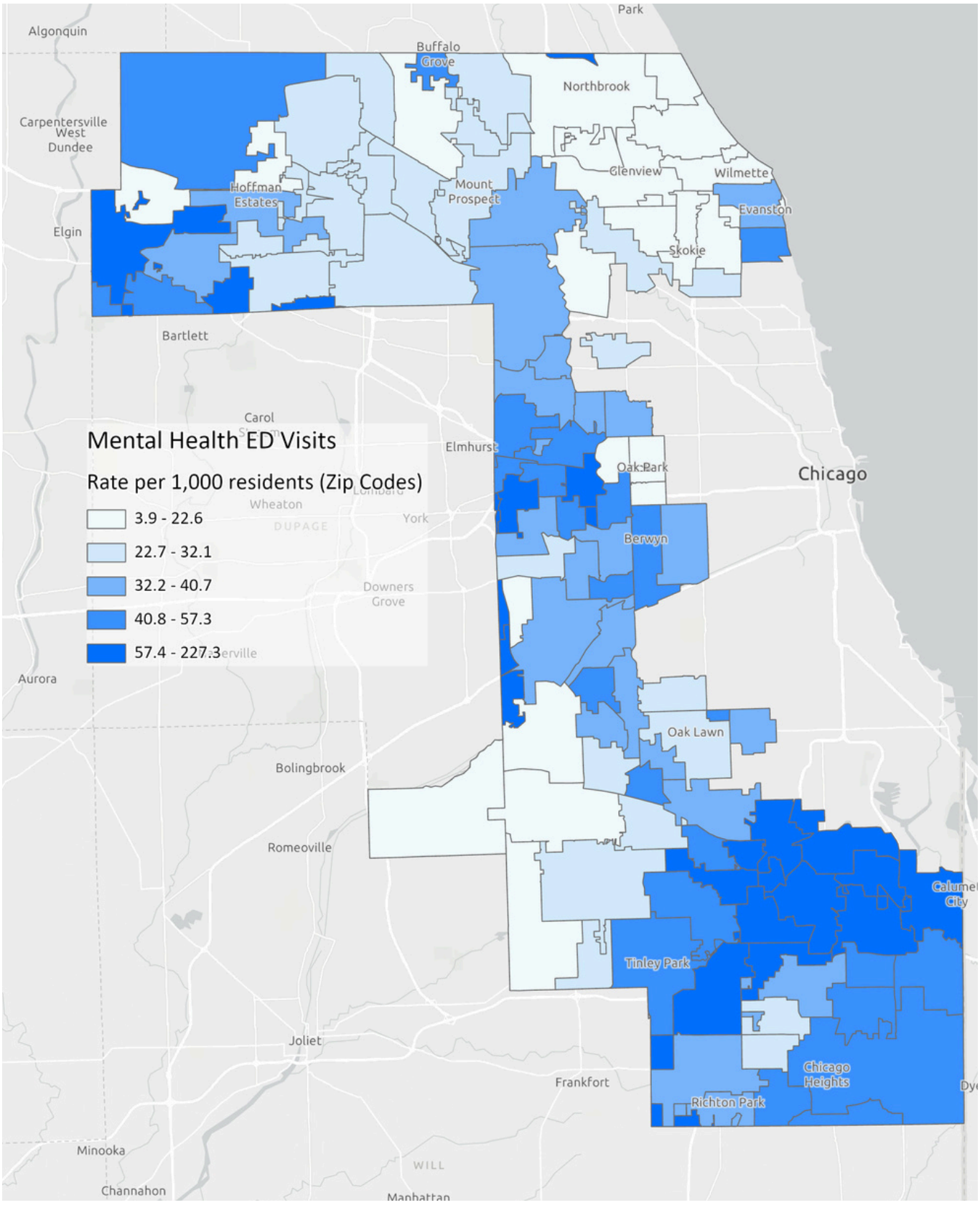
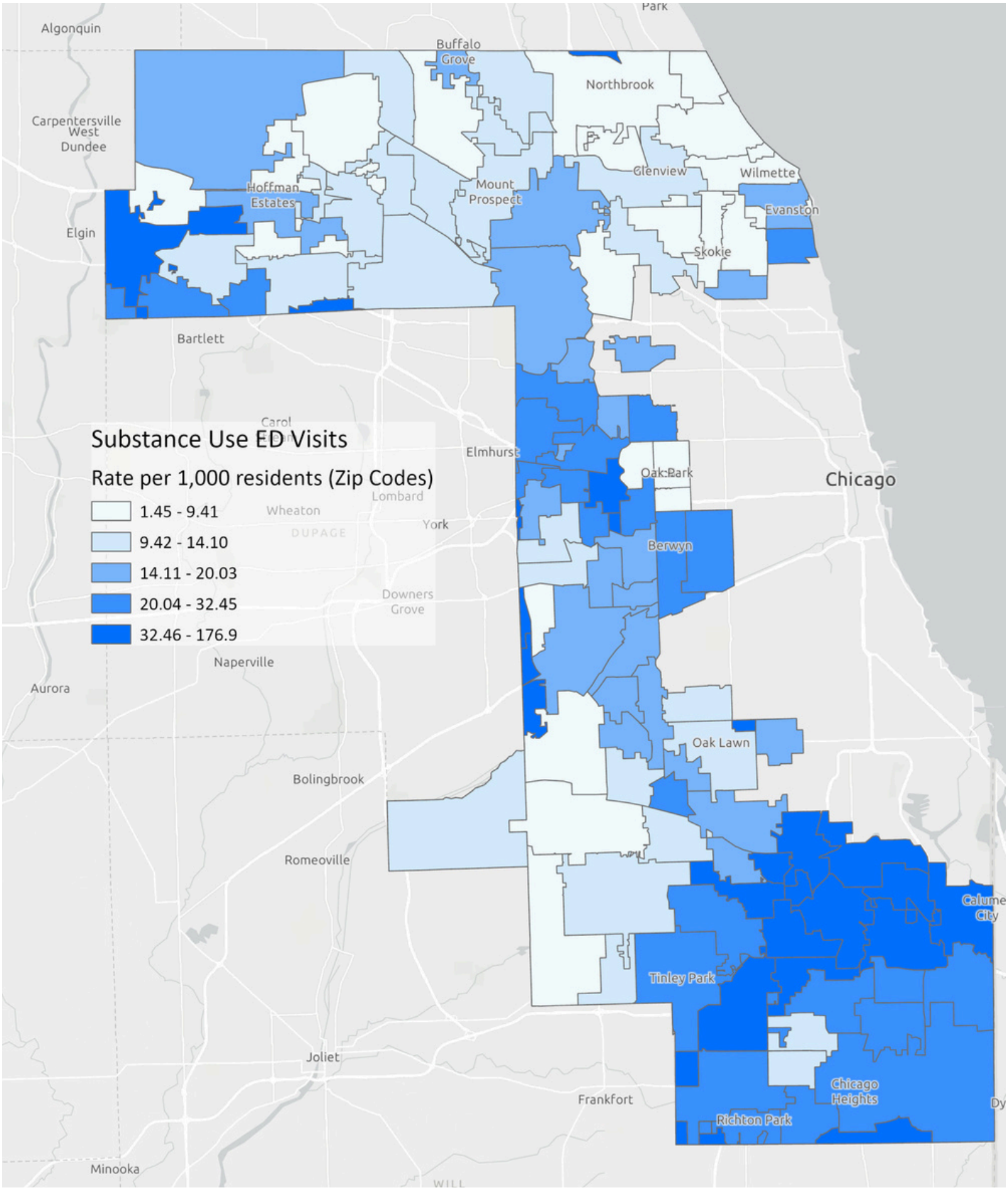


FIGURE 4 | ***Substance Use Emergency Department Visits in Suburban Cook County***



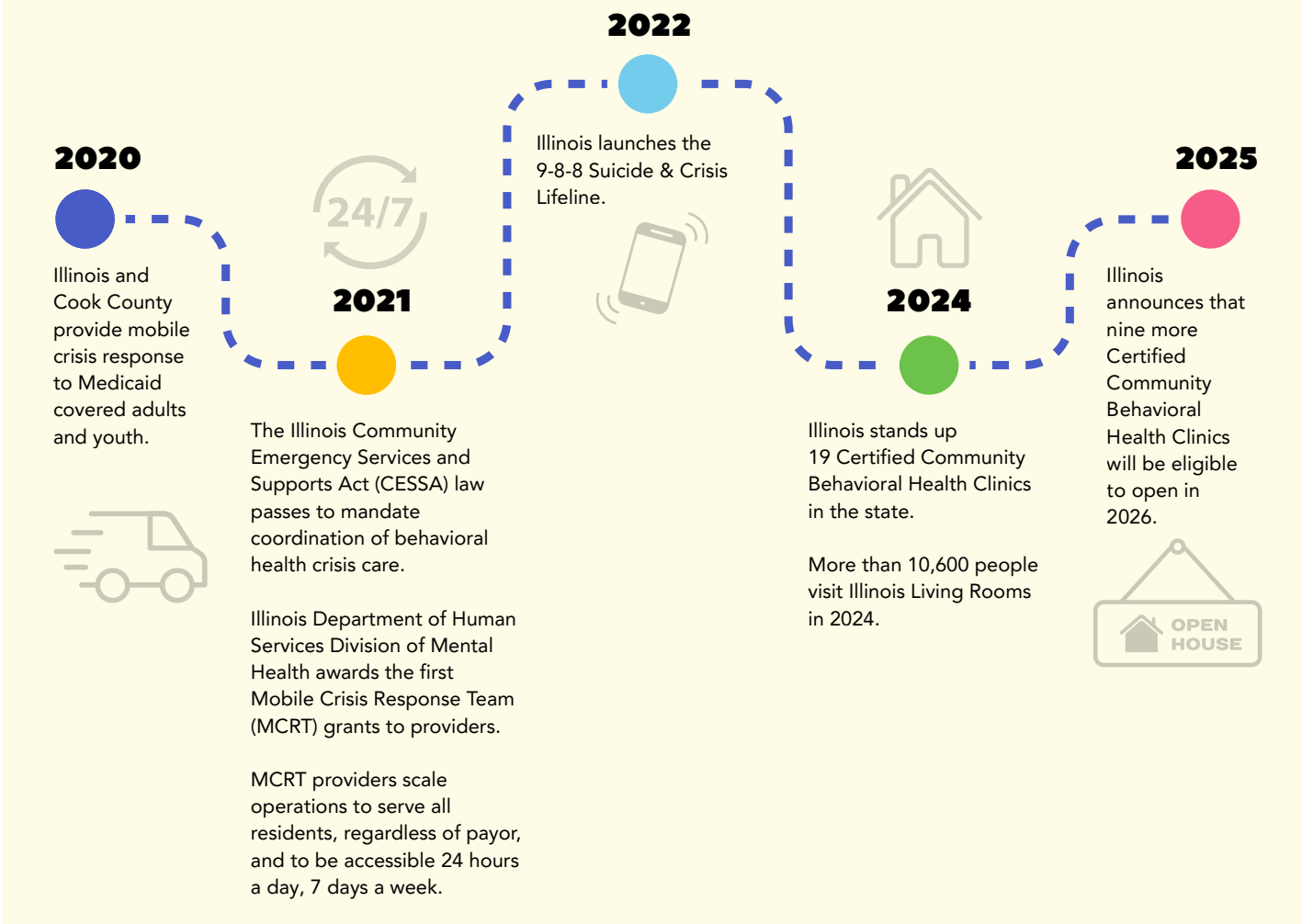
BACKGROUND

For decades, public safety considerations have driven responses to people perceived as posing dangers to themselves or others. People with mental health or substance use disorders are at increased risk of encountering excessive force leading to injury or fatality in law enforcement interactions. Across Illinois, people with substance use disorders and major psychiatric conditions are more likely to suffer an injury from law enforcement that requires hospital care. Between 2016 and 2023, more than 2,300 Cook County civilians were treated in outpatient and inpatient settings for injuries stemming from law enforcement legal intervention (University of Illinois at Chicago School of Public Health, 2024). These numbers underscore the need for behavioral health professionals, not law enforcement, to drive the response to crisis situations.

History of Local and National Crisis Response Services

The 9-8-8 Suicide & Crisis Lifeline was established as a result of federal legislation, the National Suicide Hotline Improvement Act of 2018 (P.L. 115–233). This act required states to develop statewide crisis referral networks to connect people in behavioral health crisis to needed services (U.S. Congress, 2018). On July 16, 2022, the 9-8-8 Lifeline officially transitioned to a 3-digit phone number, from the 10-digit National Suicide Prevention Line (See Figure 5).

FIGURE 5 | Illinois has made steady progress in establishing the elements of a crisis care system



BACKGROUND CONTINUED

Illinois Governor J.B. Pritzker signed the Community Emergency Services and Supports Act (CESSA) on Aug. 25, 2021, prior to the launch of 9-8-8 Suicide & Crisis Lifeline, in accordance with the Federal Communications Commission's final rule on implementing P.L. 115–233 (U.S. Congress, 2018). Illinois' legislation, also known as the Stephon Edward Watts Act, is intended to enhance Illinois' crisis care to provide better support, without law enforcement presence, to individuals with mental health conditions that may cause them to need emergency services. The Illinois Department of Human Services Division of Mental Health (IDHS/DMH) was awarded a grant from Vibrant, operator of the National Suicide Prevention Lifeline, to plan for the implementation of 9-8-8.

According to the Alternative Health Intervention and Response Task Force Final Report, the 9-8-8 Suicide & Crisis Lifeline offers 24/7 call, text, and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crises or any other kind of emotional distress. Individuals may also call, text, or chat with 9-8-8 staff if they are worried about a loved one who may need crisis support.

Data from 36 states shows that in 2024, 61% of 9-8-8 Suicide & Crisis Lifeline contacts were resolved during that first point of contact, with no need for any additional services to be dispatched (NRI, 2025). According to the National Council for Mental Wellbeing, "Numerous studies show that most callers feel significantly less depressed, less suicidal, less overwhelmed and more hopeful after speaking to a Lifeline crisis counselor" (2022).

FIGURE 6 | A Framework for Understanding the Crisis System

The crisis care system in Cook County and across the country is often conceptualized in the framework below as: someone to contact, someone to respond, and a safe place for help. Not everyone who engages the crisis care system receives care from each category. Data from 36 states shows that in 2024, 61% of calls were resolved with a call to the crisis call center ("someone to contact") (NRI, 2025). Please see Figure 7 for definitions of crisis care providers that reflect this framework.

Source: SAMHSA, 2025

BACKGROUND CONTINUED

Despite the growth of 9-8-8, coordination and communication between crisis care providers needs improvement. Many individuals instinctively dial 9-1-1 during a mental health crisis; however, this practice can lead to unintended consequences. The Substance Abuse and Mental Health Services Administration (SAMHSA) notes that, while 9-1-1 is the primary contact for medical emergencies, fire, crimes in progress, or other situations requiring immediate physical intervention, and 9-1-1 is highly effective for emergencies involving physical harm, it is not specialized to manage behavioral health crises (SAMHSA, 2023).

In addition, a 2025 study revealed that the national launch of 9-8-8 in July 2022, "did not coincide with significant and equitable growth in availability of most crisis services, except for a small increase in peer support services," signaling an ongoing, significant gap in the country's continuum of crisis care (Cantor et al., 2025). The crisis care system also includes two other key elements, often described as "someone to respond" and "a safe place for help" (see Figure 6). Figure 7 describes the types of crisis care providers.

In 2021, the state launched the Key Stakeholder Coalition, which served as an advisory group for the Illinois Department of Human Services (IDHS) 9-8-8 Planning Grant Team. The Key Stakeholder Coalition was comprised of five subcommittees that focused on statewide coverage, statewide standards, community linkages, public messaging, and funding mechanisms.

The original subcommittees and coalition were consolidated into the CESSA Statewide Advisory Committee and the Regional CESSA Advisory Committees. The Regional CESSA Advisory Committees use the preexisting EMS Medical Directors Committee structure under the Illinois Department of Public Health's 11 EMS regions. The regional committees are charged with the development of regional best practices and protocols consistent with the realities of their local communities (Illinois Department of Human Services, 2024). While this approach supports communication across regions, some CESSA regions cross municipal and county boundaries. This can create challenges for coordination. To help bridge the gaps, Illinois plans to connect the 9-1-1 system to 9-8-8 and Mobile Crisis Response Teams statewide by July 2027.

FIGURE 7 | Types of Crisis Service Providers (Courtesy of IDHS)

9-1-1 Call Centers

9-1-1 Call Centers are responsible for receiving 9-1-1 emergency calls, including Voice over Internet Protocol (VoIP),* text and chat messages for first responder assistance 24 hours a day, 7 days a week, 365 days a year. 9-1-1 Call Centers use callers' answers to standardize protocols to determine the types of emergencies, urgency and appropriate dispatch responses.

9-8-8 Suicide & Crisis Lifeline

The 9-8-8 Suicide & Crisis Lifeline is a nationwide prevention and crisis hotline that is accessible 24 hours a day, 7 days a week, 365 days a year for individuals experiencing mental health, substance use and suicide crises, and for family members and loved ones of individuals experiencing these crises. Trained crisis counselors provide real-time crisis intervention and suicide prevention services. Illinois has seven 9-8-8 Suicide & Crisis Lifeline call centers that belong to the national network.

Emergency Medical Services

The Emergency Medical Services (EMS) System is an organization of hospitals, vehicle service providers and personnel approved by the Illinois Department of Public Health (IDPH) in a specific geographic area, that coordinates and provides pre-hospital and inter-hospital emergency care and non-medical transport. EMS providers are licensed by IDPH.

* VoIP is a technology that transmits voice and video calls digitally over an internet connection instead of traditional phone lines

FIGURE 7 | Types of Crisis Service Providers (Courtesy of IDHS) - Continued

Mobile Crisis Response Team

Mobile Crisis Response Teams (MCRT) provide rapid response 24 hours a day, 7 days a week, 365 days a year, to meet and assess an individual wherever they are – at home, work, school, or anywhere else in the community – and offer community-based interventions and stabilization.

According to SAMHSA, "To fully align with best practice guidelines, teams must meet the minimum expectations and: 1. Incorporate peers within the mobile crisis team; 2. Respond without law enforcement accompaniment, unless special circumstances warrant inclusion, in order to support true justice system diversion; 3. Implement real-time GPS technology, in partnership with the region's crisis call center hub, to support efficient connection to needed resources and tracking of engagement; and 4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care."

MCRT is a grant program funded by the Illinois Department of Human Services, Division of Mental Health (DHS/DMH), to provide Mobile Crisis Response Team services to individuals experiencing behavioral/mental health crises. Illinois Department of Healthcare and Family Services (HFS) funds mobile crisis response services for Medicaid customers across the lifespan or unfunded children under age 18.

Crisis Stabilization Center

Crisis Stabilization Centers are observation units that provide brief, medically-monitored, or supervised care to individuals experiencing a mental health crisis. They are considered to be less restrictive than traditional inpatient psychiatric units.

FIGURE 7 | Types of Crisis Service Providers (Courtesy of IDHS) - Continued

Certified Community Behavioral Health Clinics (CCBHCs)

Certified Community Behavioral Health Clinics (CCBHCs) provide services to anyone who requests care for substance use or mental health services, regardless of their ability to pay, place of residence, or age. Both SAMHSA and the State of Illinois require CCBHCs to provide a comprehensive scope of services and meet specific criteria. SAMHSA requires CCBHCs to provide: crisis services; outpatient mental health and substance use services; person- and family-centered treatment planning; community-based care for veterans; peer family support and counselor services; targeted case management; outpatient primary care screening and monitoring; psychiatric rehabilitation services; and diagnosis and risk assessment. Illinois also requires CCBHCs to provide, within a year of the CCBHCs operating: behavioral health urgent care with observation units; access to Medication Assisted Recovery (MAR) within 24 hours of a substance use disorder event; short-term crisis stabilization units; and other criteria.

Living Room

The Living Room Program is based on a philosophy that crises are an opportunity for growth and learning. The Living Room Program operates from the Crisis Now approach. It is an alternative to emergency departments and jails for individuals in self-defined crises by providing services that match people's needs. The Crisis Now approach promotes services built on recovery-oriented practices, trauma-informed care, significant use of peer recovery support staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for individuals served and staff providing services, and collaboration with law enforcement. State-funded Living Rooms are open 24 hours a day, 7 days a week, and can receive individuals that arrive on their own, are transported by law enforcement, or are referred from another level of care.

[See references in the back of this report.]

BEHAVIORAL HEALTH CRISIS EXAMPLES

Below are examples of how professionals respond to behavioral health situations and make determinations.

Example 1

Situation: The boyfriend of a 49-year-old woman calls 9-1-1 because she is threatening to hurt herself and "end it all."

Response: Local law enforcement and the mobile crisis team are dispatched, and the mobile crisis team evaluates the patient.

The boyfriend of the patient mentions that she recently started threatening to shoot him and her 15-year-old daughter, but he doesn't think she has a gun. The patient feels trapped and abused. She is having trouble sleeping and doesn't have an appetite. The patient is also having trouble coping with her sister, who has schizophrenia, and lives with her on and off.

The patient appears depressed, anxious, and feels helpless. She is unable to de-escalate and shares that she plans overdose once everyone leaves. She has access to aspirin and other medications, but the response team confirms that she does not have access to a firearm.

The patient was arrested in the last six months threatening to stab a police officer but did not have a weapon. The patient has a history of aspirin overdose three years ago.

Determination: The mobile care team decides to take the patient to the emergency room because she has tried to die by suicide, has a plan to overdose, and has access to aspirin and medications to overdose.

BEHAVIORAL HEALTH CRISIS EXAMPLES CONTINUED

Below are examples of how professionals respond to behavioral health situations and make determinations.

Example 2

Situation: A wife calls a crisis hotline on a Saturday night, because her husband, a 30-year-old man, is expressing thoughts of suicide, because he "can't cope any more or live this way." The husband is being verbally aggressive and pacing quickly. He is threatening to hurt himself and blocking his wife from leaving.

Response: A mobile crisis team is dispatched and meets with the husband. They learn that the couple has broken up and gotten back together every few months. In tonight's argument,the wife threatened to leave the marriage.

During the crisis intervention, the husband is tearful, shaking, and expresses feeling hopeless. He is coherent and willing to answer questions. He mentions a previous history of alcohol use, multiple DUIs, outpatient treatment, and job loss. He is not currently using any substances. There is no history of suicide attempts, no current means, and no identified plan.

The crisis worker successfully de-escalates the situation, and the patient agrees to complete a safety plan. The patient does not have any natural social supports except for out-of-state siblings.

Determination: Hospitalization is not necessary. Some options for follow-up care include:

- **Crisis Stabilization Center** – Because the call happened on the weekend, a crisis stabilization center would provide further assessment and possible psychiatric evaluation. The center would also provide additional intervention related to education about on-going mental health support, referrals for employment services, and support for relationship issues. A crisis stabilization center provides further time and space for immediate stabilization, exploration of the patient's safety plan, and identification of appropriate follow-up/referrals.

- **Living Room** – A Living Room can provide similar post-crisis follow-up, including peer supports. A Living Room has direct access to clinical assessment by a Qualified Mental Health Professional, but not a psychiatrist.

Follow-up: Within 48 hours, refer the patient to outpatient services for post-crisis follow-up to support coordinating linkage to other treatment and supports. Provide a list of places to go or call if there is an immediate need prior to the outpatient appointment.

Strengths & Needs Assessment

In 2022, the Alternative Health Intervention and Response Task Force identified the need for a comprehensive local assessment of the crisis care system in suburban Cook County. This report is the result of that assessment.

METHODS

A mix of key informant interviews, focus groups, and community surveys were used to gather insights and identify gaps in services:

Key Informant Interviews

Ten interviews were conducted with a range of key informants, including health care providers, Mobile Crisis Response providers, community leaders, a hospital association, and law enforcement. These individuals were selected based on their roles in crisis service delivery, community health advocacy, and direct interaction with underserved suburban Cook County residents. The interview questions focused on access to crisis care.

Focus Groups

Eight focus groups were conducted: four focus groups with behavioral health or service providers, and four focus groups with people who have used the crisis care system. Over 60 people were engaged through these focus groups. Focus groups were distributed over each of the four Cook County Department of Public Health (CCDPH) administrative regions (South, Southwest, West, and North). The focus groups with service providers gathered insights about their experiences, challenges, and the effectiveness of current crisis intervention strategies. The focus groups with people who have used or may use the crisis care system asked about experiences with crisis services, benefits and barriers to services, and ways to improve the crisis care system. To ensure a more representative analysis, community-based organizations were engaged for their connections to the local community and their ability to represent the diverse demographics of suburban Cook County.

Community Surveys

In addition to focus groups, a total of 304 surveys were collected at community events, including health and wellness fairs and fall and winter festivals. Due to the timing of the project, many events focused on the holiday season. Community events were held in suburban Cook County communities, including Bridgeview, Matteson, Skokie, Hazel Crest, Evanston, and Harvey. These surveys were designed to gauge the general public's awareness of and impressions of the crisis care system with the goal of capturing a broad spectrum of views.

RESULTS Common Themes & Key Informant Interviews

Common Themes

Many common themes emerged from the key informant interviews, focus groups, and community surveys. CCDPH has included detailed insights to highlight the rich feedback from community members, behavioral health treatment providers, and social service providers collected through the assessment. The major themes heard across the three methods were:

- System coordination and quality
- Equitable access
- Distrust of law enforcement
- Workforce
- Awareness of 9-8-8 and crisis care system

Key Informant Interviews

Some key findings from the key informant interviews with 10 organizations include:

- ***System coordination and quality***
  - The limited coordination between 9-8-8, 9-1-1, and other crisis services creates inefficiencies. Warm handoffs and transitional services need strengthening.
  - There is a lack of coordination among schools, hospitals, and crisis care providers; processes for accessing care are complex and inconsistent.
- ***Distrust of law enforcement***
  - There is distrust between people of color and police, necessitating clear distinction between mobile crisis teams and law enforcement.
- ***Equitable access***
  - There are gaps in access to crisis stabilization units and residential care in underserved areas.
  - Gaps exist in serving diverse populations, such as those speaking less common languages (e.g., Polish, Sudanese).
  - Follow-up care durations longer than 30 days are needed for some individuals.
  - Housing access for housing-insecure clients is a constant challenge. There is a high volume of crises related to homelessness.
- ***Awareness of 9-8-8 and the crisis care system***
  - Awareness of 9-8-8 and crisis services remains limited, with many residents defaulting to 9-1-1 or emergency departments (EDs).
  - Local crisis lines and Living Room programs are underutilized due to low community awareness.
- ***Workforce***
  - There is high worker burnout, staff turnover, and difficulty sustaining a motivated workforce. Offering competitive pay, hiring bonuses, and night-shift incentives while continuing to refine onboarding and training for crisis workers would help address these issues.
  - Department of Children and Family Services (DCFS) background checks delay hiring.

RESULTS Focus Groups

Focus groups were conducted with two groups: crisis care system users, and treatment and social service providers. Feedback themes included deep distrust of local law enforcement response to crisis situations and low awareness of 9-8-8 and crisis services.

FEEDBACK FROM CRISIS SYSTEM USERS

Distrust of Law Enforcement

Some respondents preferred to avoid police involvement due to negative past experiences, including fear of escalation or being misunderstood (e.g., being perceived as intoxicated or unstable) or experiencing violence.

> *We try not to call 9-1-1 because sometimes it ends badly. My family mostly ends up going to the hospital because that's safer, even though the fire department doesn't always show up.*

> *Responses from public safety can be way too aggressive. They act like we're troublemakers, and that makes us afraid to reach out when we need help.*

System Coordination and Quality

> I wish I could get medicine more easily.

> The experience was positive but involved a long wait.

FEEDBACK FROM CRISIS CARE SYSTEM USERS

Awareness of 9-8-8 and the Crisis Care System

There's low awareness of 9-8-8 and the crisis care system.

Positive experiences were often linked to having a trusted advocate, such as a family member or community member, who has shared experiences.

There's a need for culturally and linguistically responsive materials that are developed with health literacy principles.

> *I learned about the 9-8-8 crisis line today and had not heard about it before.*

> *Honestly, we didn't know about crisis response team or 9-8-8. These resources aren't well-known at all. There's a huge gap in knowledge.*

> *Before today none of us had even heard of 9-8-8. If it works like you say, it sounds great, but I still worry they might take us to jail instead.*

FEEDBACK FROM TREATMENT & SOCIAL SERVICE PROVIDERS

Law Enforcement Response

Police and EMT response is uneven. Experiences have ranged from helpful to uncooperative, with delays, lack of coordination, and professionalism issues (i.e., questioning the training or expertise of behavioral health providers).

There is a strength in having trained officers who have had mental health first aid training, and some police stations are more helpful than others.

> *We need drastic changes. Crisis responses must involve specialized mental health workers, not just police…Real training and compassion are urgently needed.*

> *Police response times depend heavily on your location and can be painfully slow, which can be devastating if you're in dual diagnosis* crisis. Ideally, an ambulance arrives, but police often show up too, even though they're not best suited.*

** According to SAMHSA (2024), a dual diagnosis or co-occurring disorder, is: The coexistence of both a mental health disorder and a substance use disorder (SUD).*

System Coordination and Quality

Data sharing and internal/ external assessments are limited. There's a need for data-backed decisions, but a lack in mechanisms for tracking or evaluation.

Improve coordination on appointment scheduling, reminders, and follow-up care with families. Provide parent coaching and case management to encourage follow-through.

> *Language services are sometimes inadequate or inappropriate.*

> *We're listed as a 988-crisis provider and offer Mobile Crisis Response, but sometimes calls meant for 911 wellness checks get mishandled. It's critical these services coordinate clearly.*

FEEDBACK FROM TREATMENT & SOCIAL SERVICE PROVIDERS

Equitable Access

There's a need for safe, community-based walk-in centers, especially for people re-entering society or concerned about deportation or DCFS.

There is limited availability of crisis response teams (e.g., Mobile Crisis Response Teams (MCRT), particularly in the south suburbs.

> *Honestly, we don't know enough about area crisis response teams or the [MCRT] providers. We're operating in silos, and there's a serious lack of general knowledge about what crisis services actually exist.*

Workforce

Individuals with lived experience and peer support are underutilized assets; many communities want helpers who understand their realities, not just professionals.

> *We must recruit from our communities. Workers have to understand us culturally and speak our languages, and remove stigma. Don't assume you know us – get out here and actually talk to us.*

Awareness of 9-8-8 and the Crisis Care System

Ensure messaging clarifies 9-8-8 is for more than suicide — include postpartum parents, non-suicidal mental health crises, etc.

> *Some individuals, particularly within certain cultures, do not understand what constitutes a mental health crisis.*

> *When people know how the system is supposed to work, they have a good experience. But I've also witnessed negative situations, even deaths, because people didn't know what to do or where to go.*

Community Survey

The community survey responses echoed observations from the key informant interviews. Overall, individuals who completed the community survey were largely utilizers of crisis services, with many of them having to access crisis support multiple times within a short period of time. Most respondents shared that they view law enforcement and hospital emergency departments as the sole crisis providers. They were unsure whether they had a mobile crisis provider in their community. When asked who should respond to a crisis call, only 26% of the respondents said law enforcement, while 48% said behavioral health professionals, counselors, or paramedics.

The survey responses identified several barriers or perceived barriers, views, and sentiments regarding the current crisis care system:

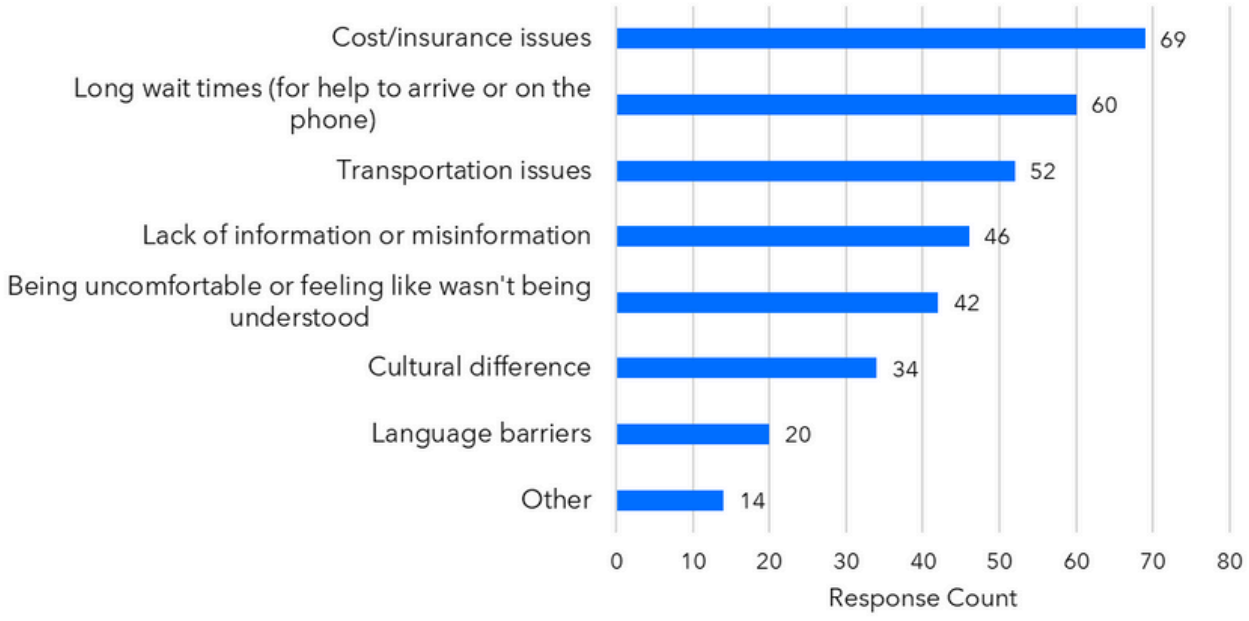
Equitable access

- More than half (59%) of survey respondents reported using crisis services in the past three years.
- More than 75% of the individuals who accessed the crisis care system had to use it more than once, with 28% needing crisis services more than five times.
- When individuals needed crisis services, 55% of respondents said that they called 9-1-1 or went to a hospital emergency department. Thirty percent of respondents used a local crisis line, mobile crisis team, or provider living room.

System coordination and quality

- Of the respondents who have utilized the crisis care system, 56% rated their overall experience as a 4 or 5 (1 being "very poor" and 5 being "excellent").
- The top two challenges with navigating the crisis care system were cost/insurance issues and long wait times (See Figure 8).
- The number one reported benefit from crisis services was receiving immediate assistance.

Figure 8 | ***Common Challenges Mentioned by Suburban Crisis Care System Users (2024-25)***



System coordination and quality (continued)

- Employment and income were reported as being the most critical primary need to support a person's overall health and well-being, with housing being a close second.
- Follow-up care was the top suggestion when asked about additional supports to offer for individuals in crisis.
- Most (59%) individuals suggested utilizing community outreach education programs to raise awareness and utilization of 9-8-8.

Awareness of 9-8-8 and the crisis care system

- When asked if they knew who to call during a crisis, 72% of respondents said "yes"; however, most of these responses centered on calling 9-1-1.
- When asked if they knew where to go during a crisis, fewer individuals responded "yes" (55%), and most responses centered on going to a hospital or an emergency department.
- Nearly half (46%) of respondents reported either "no" or "I don't know" when asked if a crisis provider was available in their community.

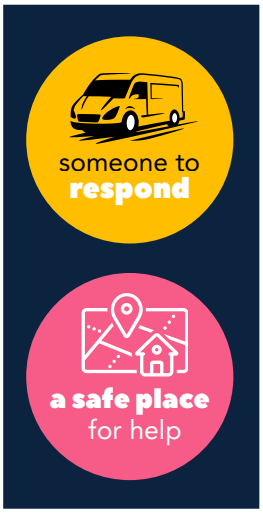
RECOMMENDATIONS

The recommendations in this report are based on information gathered from key informant interviews, focus groups, and community surveys. They are intended to address systemic issues, with goals of enhancing the crisis care system, improving cross-sector collaboration, maximizing opportunities for access to care and treatment, and closing gaps in services for priority populations and between suburban Cook County regions. The vision is to create a system in which crisis services are not only more accessible and effective but also integrated with the larger healthcare and social service frameworks to ensure continuity of care and support for individuals affected by crises.

RECOMMENDATION #1:
Increase awareness of 9-8-8 in the community using outreach through trusted community leaders, organizations, and institutions.

Objective	Lead Organization	Supporting Organization
Launch targeted linguistically and culturally appropriate campaigns to educate the community about the elements of the crisis care system, including information on 9-8-8, the differences between 9-8-8 and 9-1-1, and mobile crisis response.	IDHS	CCDPH
Build capacity among trusted community champions, such as Community Health Workers and other community leaders, to share information about 9-8-8 and the crisis care system in suburban Cook County.	Community Health Worker Learning Collaborative, CCDPH	Community-based organizations, power-building organizations, townships, CCH Office of Behavioral Health (Cook County Health OBH)
Develop and implement training programs for health care providers, first responders, local law enforcement, and community-based organizations to improve understanding and coordination of crisis services. In alignment with CESSA limits on law enforcement response to behavioral health crisis calls, acknowledge when law enforcement will be involved in a response throughout messaging and promotion.	University of Illinois at Chicago (UIC) Crisis Hub	CCDPH, CESSA Regional Advisory Committees, CESSA Sub-regional Advisory Committees

RECOMMENDATIONS



RECOMMENDATION #2:

Improve access to culturally responsive crisis care in all regions of suburban Cook County.

Objective	Lead Organization	Supporting Organization
Utilize population health data and crisis care system utilization data to better understand the need and utilization of crisis service.	UIC Crisis Hub	CCDPH, Cook County Health OBH
Ensure that Mobile Crisis Response Teams are equitably distributed across all regions, based on need, and incorporate a coordinated approach between response providers.	IDHS, IDHFS	
Create more crisis stabilization centers in high-need areas of suburban Cook County.	Cook County Health	IDHS, CCDPH
Address transportation barriers by partnering with local transit authorities and townships that provide transportation options for individuals needing crisis services.	CCDPH	Local transit authorities, councils of government, townships, municipalities
Ensure access for all community members by completing an inventory of community-based providers with specialty programs (e.g., youth, older adults, members of the LGBTQIA+ community); create grant opportunities to expand these services.	Cook County Bureau of Economic Development; CCDPH	211 Metro Chicago, Illinois Public Health Institute

RECOMMENDATIONS

RECOMMENDATION #3:
Improve coordination between service providers for smooth transitions of care and "no wrong door" entry points, in coordination with CESSA oversight bodies, and balancing regional assets and needs with consistency across the state.

Objective	Lead Organization	Supporting Organization
Create standardized operating procedures for crisis intervention and follow-up care, including transitions of care that mobile crisis teams, 9-1-1 Public Safety Access Points, and other first responders all agree to follow to ensure consistency across suburban communities	CESSA Sub-Regional Advisory Committees, UIC Crisis Hub	CESSA Regional Advisory Committees
Increase community-based activities that meet people where they are (i.e., no wrong door approach focused on prevention as well as early intervention).	CCDPH, CCDPH Building Healthier Communities Behavioral Health Action Groups	Cook County Health OBH Suburban Regional Behavioral Health Collaboratives
Incentivize collaboration between regions to ensure seamless care transitions and follow-up for individuals crossing regional boundaries and sharing of best practices; leverage existing models (e.g., the Illinois Health Practice Alliance, where multiple providers collaborate to keep people engaged in treatment); complete ecosystem mapping for each district as first step toward forming linkage agreements; and create standardized performance metrics to create transparency around volume and equitable distribution of support.	IDHS, UIC Crisis Hub	CESSA Regional Advisory Committees, CESSA Sub-Regional Advisory Committees

RECOMMENDATIONS

someone to **respond**

a safe place for help

RECOMMENDATION #4:
Invest in diversification and a reinforced crisis workforce

Objective	Lead Organization	Supporting Organization
Invest in Behavioral Health Workforce Apprenticeship and Retention Hub and recommendations made in the Cook County Behavioral Health Workforce Report, including strategies to improve job quality and compensation.	Cook County Health OBH	
Identify pilot partners to leverage tools that will result in the reduction of administrative burden for the crisis workforce.	Illinois Behavioral Health Administrative Burden Task Force	

someone to **respond**

a safe place for help

RECOMMENDATION #5:
Create systems for ongoing aftercare support and engagement, including opportunities to address social determinants of health

Objective	Lead Organization	Supporting Organization
Increase collaboration and coordination between mobile crisis providers, behavioral health treatment providers (including CCBHCs), Living Rooms, and other providers of behavioral health care and support to ensure seamless follow-up care post-crisis.	CESSA Regional Advisory Committees, CESSA Sub-Regional Advisory Committees	IDHS, HFS
Invest in wraparound supports, including housing and follow-up care.	Cook County Government	

RECOMMENDATIONS CONTINUED

The recommendations aim to create a more responsive, integrated, and coordinated crisis care system in suburban Cook County. By leveraging data from focus groups, community surveys, and key informant interviews, we identified key areas of improvement to address the existing gaps and challenges within the current infrastructure. These recommendations are designed to enhance coordination, improve access to care, and foster cross-sector collaboration, ensuring that individuals experiencing crises receive timely, effective, and compassionate support. By continuing to support cross-sector partnerships and collaborations, suburban Cook County will have a more equitable, efficient, and effective crisis care system that meets the needs of our entire community, and improves the mental health of all Cook County residents.

To help identify additional strategies that build on regional assets and nuances, CCDPH will engagement community groups and collaborate with a network of Community Health Workers. Of particular interest are strategies for enhancing resident, community-organization, first responder, and other partner awareness of 9-8-8 via trusted community leaders and organizations.

Examples of awareness campaigns for 9-8-8 already exist. In May 2025, in honor of mental health awareness month, the Community Memorial Foundation led a campaign in the western suburbs to raise awareness of 9-8-8. Informed by ideas from a gathering of non-profits, business partners, and others, the campaign slogan was, “There is HELP. There is HOPE.” A variety of community partners contributed to spreading the campaign’s messages through cards, magnets, social media messages, and ads on Metra trains. CCDPH hopes to inspire similar efforts to spread awareness of 9-8-8 and to continue to elevate suburban needs.

Moving forward, the successful implementation of these recommendations will require ongoing collaboration and investment in both the workforce and infrastructure, ensuring that the crisis system effectively serves all residents of suburban Cook County when they need it most.

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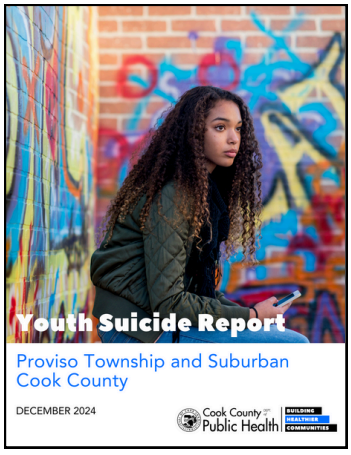

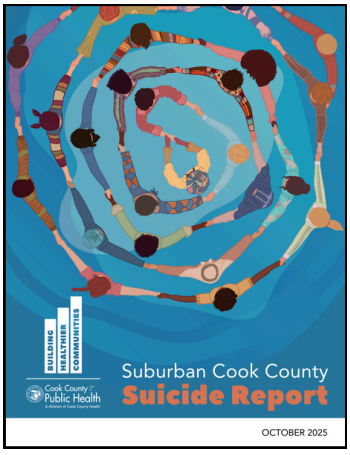

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