AGN. NO.____

MOTION BY SUPERVISORS KATHRYN BARGER AND SHEILA KUEHL

SEPTEMBER 29, 2020

EXPLORING THE FEASIBILITY OF ESTABLISHING A LOS ANGELES COUNTY VETERAN SUICIDE REVIEW TEAM

In the United States, Medical Examiner-Coroner offices are charged with investigating deaths that occur under unusual or specific circumstances through post-mortem examinations. The Medical Examiner-Coroner is vital, as these offices often gather epidemiological data that can assist in preventative efforts. In addition, their work can highlight disparities in mortality rates and provide valuable insight that can be used to guide policies, resources, and efforts to protect at-risk communities.

In 2016, the U.S. Department of Veterans Affairs (VA) released a report of the Nation's most comprehensive analysis of veteran suicide rates in the United States in which more than 55 million records were examined. The report revealed that 20 veterans die by suicide each day, only six of whom had accessed Veterans Health Administration (VHA) services. This was one of several reasons the Los Angeles County Board of Supervisors and the Department Mental Health (DMH) invested in rolling out a peer-based "vet to vet" access initiative known as the Veteran Peer Access Network (VPAN). There is a need for data to provide a better understanding of this population of veterans to enable Los Angeles County to enhance preventative efforts and save lives.

Across the U.S., the veteran suicide rate is more than twice the civilian rate. According to the Centers for Disease Control and Prevention (CDC), the U.S. standardized suicide rate is 14 per 100,000 individuals compared to 30.1 per 100,000 veterans. In California, the standardized suicide rate is 10.24 per 100,000 individuals. The California veteran standardized suicide rate is 39.1 per 100,000, demonstrating an increased risk for veterans within the state. In Los Angeles County, veterans constitute fewer than three percent of the overall population. However, data highlighted by the Los Angeles County Department of Public Health (DPH) indicated that in 2017, 891 County residents died by suicide, 93 of whom were veterans. This concludes that veterans are nearly four times likelier to die by suicide than non-veterans in Los Angeles County. The alarming veteran suicide rates that have pervaded California and Los Angeles County highlight the need to better understand the unique risk factors present in our local veteran community.

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The Los Angeles County Department of Medical Examiner-Coroner (DMEC) in collaboration with DMH, the Office of Suicide Prevention at the Greater Los Angeles VA Healthcare System (GLA), the VHA, and Department of Defense identified veteran deaths by suicide in Los Angeles County. Of the 4,448 suicide deaths identified by the DMEC from 2015 to 2019, 5.94% (n=264) were verified to have served in the military, and an additional 5.35% (n=238) had a record noted but had insufficient information to verify military service. The veteran population makes up 2.8% of the Los Angeles County population but accounted for 5.94% of suicides in Los Angeles County during this period. This is likely an underestimate due to the significant number of unverified records. In 137 of 264 cases (51.8%), the method of suicide was by firearm, which is consistent with national trends and higher than the non-veteran populations countywide.

Additionally, DPH, supported by funding from the California Department of Public Health (CDPH), participates in the National Violent Death Reporting System (NVDRS). Los Angeles County's violent death reporting system monitors the trends and circumstances of violent deaths affecting residents. In addition to identifying veteran deaths, information collected from NVDRS includes demographics, precipitating circumstances, toxicology reports, and mode of suicide. NVDRS adds detailed context on veteran suicides and how they compare to civilian suicides. This helps further inform decisionmakers and program planners about ways to prevent and intervene for veterans who are struggling in the community and at home. These partner agencies continue their work to establish prevention efforts and reduce veteran suicide rates in Los Angeles County.

In 2017, Assembly Bill 242 (Arambula) mandated that certificates of death include whether the decedent served in the Armed Forces. As a result of that legislation, CDPH recently implemented an electronic death registration system to compile a report on veteran suicide. In 2020, Assembly Bill 3371 (Committee on Veterans Affairs) mandated that the individual's county of residence and other pertinent information be included in the report. However, many Medical Examiner-Coroner offices, including Los Angeles County, are currently unable to verify, collect, and aggregate data pertaining to veteran status. In the absence of this data, it is impossible to detect the presence of disparities in local mortality rates within the veteran community. By tracking this data, it will allow Los Angeles County to better understand these disparities and develop policies that seek to address them.

In other jurisdictions, suicide review teams have been established at the state and county level to engage in active surveillance, in-depth analysis, and development of policy and programmatic recommendations for prevention efforts. The Montana Suicide Mortality Review Team Act was passed in 2013 as a result of the approval of House Bill 583, which established the nation's first statewide suicide review team. The role of the suicide review team is limited to: (a) performing an in-depth analysis of suicides that occur in Montana, including a review of records available by law; (b) compiling statistics related to suicides for use in reports published by the department; (c) analyzing the causes of suicides; and (d) recommending measures to prevent future suicides. In New York's Suffolk County, a Suicide Fatality Review Committee was developed to ensure a coordinated response that fully addresses systemic concerns regarding deaths due to suicide. The purpose of the Suicide Fatality Review Committee in Suffolk County is to conduct a thorough review of suicide deaths occurring within the county and deaths by suicide of county residents in other jurisdictions to better understand causes of suicide and to prevent future fatalities by suicide.

In Los Angeles County, the Inter-Agency Council on Child Abuse and Neglect (ICAN) Multi-Agency Child Death Review Team was established by the Board of Supervisors in 1977. It is comprised of representatives of DMEC, the Los Angeles County Sheriff's Department, Los Angeles Police Department, District Attorney's Office, Los Angeles City Attorney's Office, Office of County Counsel, Department of Children and Family Services, Department of Health Services, Office of Education, Department of Mental Health, California Department of Social Services, and representatives from the medical community. The team's multi-disciplinary perspective allows for a detailed analysis of quantitative and demographic data of children killed by caregivers, youth suicides, accidental deaths, and undetermined deaths. ICAN's Child and Adolescent Suicide Review Team (CASRT) is an additional multi-disciplinary committee lead by ICAN and DMEC. The team reviews child and adolescent suicides, analyzes trends, and pursues system-level intervention and prevention measures to provide recommendations to recognize and prevent suicide and suicidal behaviors. The CASRT developed and implemented a supplemental data form in partnership with DMEC to collect additional information related to mental health treatment, social support, family, and academic circumstances for all suicides among children and adolescents in Los Angeles County.

Although DMH developed, funded, and began the implementation of the VPAN to assess the risk and to prevent veteran suicide, there is currently no ongoing review team to study and better understand veteran suicide in the county. The development of a Veteran Suicide Review Team modeled like the ICAN Team would enable a coordinated response that fully addresses systemic concerns with veteran suicide and provides sound recommendations based on thorough review. Los Angeles County recognizes the importance of collecting veteran data to best inform new policy decisions, funding recommendations, and support services for this population.

WE, THEREFORE, MOVE that the Board of Supervisors direct the Medical Examiner-Coroner and Chief Executive Office, in coordination with the Department of Mental Health, the Department of Public Health, County Counsel, the Suicide Prevention Office at the Greater Los Angeles VA Healthcare System (GLA), the VA Central Office, and any other pertinent stakeholders to do the following:

1. Develop an implementation plan and timeline for the collection of veteran data, linking data sharing agreements to include a connection with the Los Angeles County Violent Death Reporting System and establishing a data sharing agreement between the Medical Examiner-Coroner and the Chief of Suicide Prevention at VA Greater Los Angeles Healthcare System to be included in the annual Medical Examiner-Coroner reports for surveillance of veteran suicide rates in Los Angeles County and to ensure the definition of veteran is clearly defined and aligned with data collection efforts across jurisdictions.

2. Report back in 90 days with a feasibility analysis on the creation of an L.A. County Veteran Suicide Review Team that will include recommendations on the composition of the proposed team, team member selection, which department should house the team, and ways the team can work with the California Department of Public Health's initiative on suicide prevention. The report should include participation by and feedback from the following entities and organizations:

    - Suicide Prevention Office at the Greater Los Angeles VA Healthcare System, Los Angeles County Department of Mental Health, Los Angeles County Department of Public Health's Office of Violence Prevention, Los Angeles County Department of Military and Veterans Affairs, Los Angeles Sheriff's Department Veteran Mental Evaluation Team, California Department of Veterans Affairs, Los Angeles County Department of Probation, Los Angeles Police Department, and other relevant stakeholders.

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