AGN. NO.

MOTION BY SUPERVISORS KATHRYN BARGER AND SHEILA KUEHL

MAY 17, 2022

COMMENCEMENT OF THE LOS ANGELES COUNTY VETERAN SUICIDE REVIEW TEAM ONE YEAR PILOT PROGRAM, INITIATING FIRST DEATH REVIEW

On May 4, 2021, the Board of Supervisors (Board) voted unanimously to approve the motion, "Implementing the Veteran Suicide Review Team (VSRT)" after receiving the March 26, 2021 report back from the named departments that included an implementation plan and timeline for the collection of veteran data and an analysis on the feasibility of creating a Los Angeles County Veteran Suicide Review Team. The report was produced after the Board approved the September 29, 2020 motion, "Exploring the Feasibility of Establishing a Los Angeles County Veteran Suicide Review Team." The Board accepted the recommendations outlined in the March 26, 2021 report and moved to implement next steps that: 1) designated the Department of Mental Health (DMH) as the administrative lead agency for a pilot period of one year (with option to extend based on implementation plans); 2) directed DMH, in close coordination with the VSRT working group and other relevant partners, to develop a VSRT implementation plan and timeline, linking data sharing agreements to include connections with the Los Angeles County Violent Death Reporting System, and report back to the Board at the end of calendar year 2021; 3) directed the Director of DMH to execute an Memorandum of Agreement (MOA) between DMH and the United States Department of Veterans Affairs (VA) Desert Pacific Healthcare (VISN22) Network to increase interagency collaboration and coordination; and 4) directed the County's Chief Information Office (CIO) within the Chief Executive Office (CEO) in coordination with the VSRT working group, to explore conducting a data analysis of the identified veteran suicides from 2015-2019, using the County's Enterprise Information Hub.

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On February 7, 2022, DMH and other partner departments and agencies issued the report back to the Board that included the development of a VSRT implementation plan with timelines, updates on the MOA between DMH and VISN22 and provided a full data analysis of the identified veteran suicides from 2015-2019 using the County's Enterprise Information Hub.

The Los Angeles County data analysis produced by the CIO-CEO, in partnership with the LA County Medical Examiner-Coroner (DMEC) and the United States Department of Veterans Affairs Greater Los Angeles Healthcare System (VAGLAHS) showed that suicide rates are higher and rising faster among our veterans compared to their non-veteran counterparts. In Los Angeles County, there was a 16% increase in veteran suicides from 2017 to 2018. In 2017, 93 veterans died by suicide, compared to 108 veterans in 2018. This is included in a statewide rise in veteran suicide deaths within the same period. In California, suicides amongst veterans increased from 636 in 2017 to 690 in 2018. The LA County data set also analyzed demographic content of suicide decedents and method of suicide amongst veterans and non-veterans. This revealed that based on the 4,464 decedents in the Coroner's suicide file from 2015-2019, 546 of whom matched VAGLAHS medical records, that veterans are about 75% more likely to use a firearm to die by suicide, and that race, ethnicity, gender and age play a significant role in assessing disproportionality amongst decedents.

In addition to the County's own data analysis, the United States Department of Veterans Affairs (VA) 2021 National Veteran Suicide Prevention Annual Report indicates that from 2018 to 2019 suicide rates for U.S. veterans fell 7.2% to an average of 17.2 veteran suicides per day. Despite the decrease, the rate of suicide deaths among veterans was 52.3% higher than non-veteran U.S. adults. The report further explains that from 2001 to 2019 the unadjusted suicide rate among U.S. veterans rose 35.9% from 23.3 per 100,000 in 2001 to 31.6 per 100,000 in 2019. Alarmingly in 2019 the unadjusted suicide rate for veterans aged 18-34 was the highest at 44.4 per 100,000. Although the report shows some positive trends, there were still a total 6,261 identified veteran suicides that occurred in 2019.

According to data from the California Association of County Veterans Service Officers, as of 2021 Los Angeles County is home to 279,196 veterans. Since early 2018, the Los Angeles County Board of Supervisors (Board) has been working to enhance the services it provides to veterans, service members, and their families. Through this work, the Board allocated funding to the Department of Mental Health (DMH) for the implementation of the Los Angeles County Veteran Peer Access Network (VPAN). Through this program, DMH has worked with the County Department of Military and Veterans Affairs (DMVA), California Department of Veterans Affairs (CalVet), the United States Department of Veterans Affairs (VA), county departments with programs impacting veterans and non-county stakeholders, on developing the partnerships, executing the necessary agreements, and preparing the landscape to better serve the veteran and military connected community.

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The implementation of VPAN has led to the integration of veteran peers into community access points in each Supervisorial District to assist in navigating the often-complex benefits and services systems within all levels of government. In addressing immediate needs of veterans, VPAN has established a peer support line to serve as the first step in getting connected to peers. This line is available 7 days per week and is staffed by veterans and their family members.

Much of this work has been established not just due to the leadership of the Board of Supervisors and the Director of the Department of Mental Health, but also due to strong partnerships established across government and with many community partners. For example, in 2017, Los Angeles Mayor Eric Garcetti was one of the first Mayors in the nation to join the Mayor's Challenge to End Veteran Suicide, a project initiated by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). Since then, that challenge has been led by the joint efforts of the Mayor's Office, VA Greater Los Angeles' Office of Suicide Prevention, DMH, DPH, LAPD, LASD, Didi Hirsch and many other community partners. Mayor Garcetti's leadership provided a space for this group to reach many milestones including implementing screening measures for veteran status and suicide risk throughout law enforcement agencies, execution of an MOA between VISN 22 and DMH, LPS training facilitated at the VA, obtained VA Office of Mental Health and Suicide Prevention (OMHSP) funds for suicide prevention training, establishment of the first ever DMH suicide prevention liaison, development of the largest Veteran Mental Evaluation Team (VMET) program in the nation, passing of Senate Bill 172 permitting transfer of firearms in cases of acute crisis, and most importantly, the development of the Los Angeles County Veteran Suicide Review Team.

One of the stated objectives for implementing a countywide veteran specific service through DMH was to address the issue of veteran suicides and establish policies and programs to work toward veteran suicide prevention in Los Angeles County. That objective is shared amongst DMH, the Mayor's Challenge and its partners, and the establishment of the Veteran Suicide Review Team will serve as a culmination of these joint efforts to prevent and work toward ending veteran suicide in Los Angeles County.

WE, THEREFORE, MOVE THAT THE BOARD OF SUPERVISORS:

1. Adopts the Veteran Suicide Review Team (VSRT) Charter as written in the February 07, 2022 report back to the Board, contained in Attachment I, and adopt the definition of veteran status to align with the State of California's data collection practices and reporting and further:

    a. Appoints Department of Mental Health, Department of Public Health's Office of Violence Prevention, United States Department of Veterans Affairs (VA) Desert Pacific Healthcare (VISN22) Network and Department of Medical Examiner-Coroner as VSRT Co-Chairs (Co-Chairs) for the term of this pilot program, subject to amendment at the conclusion of the one-year pilot

2. Instructs DMH as the lead agency, in partnership with the Co-Chairs of the VSRT, to issue official correspondence to all VSRT Core Team participants requesting written appointment of a primary representative and an alternate to the VSRT no later than 60 days prior to the first suicide death review meeting

3. Instructs the Co-Chair Team to commence the one-year pilot program, effective on the date of the first veteran suicide death review, to occur no later than September of 2022

4. Instructs DMH, in partnership with the Co-Chairs of the VSRT, to report back to the Board six months after the first veteran suicide death review on the following:
    a. Provide a status update on the progress made to match DMEC case information to Veteran Health Administration (VHA) and Department of Defense (DoD) electronic medical records to verify veteran deaths by suicide and status update on progress DMEC has made in partnership with DPH and County Counsel to amend an existing MOU to ensure veteran status is included in the Los Angeles County Violent Death Report System
    b. Analysis of the first six months of the pilot program including but not limited to lessons learned, barriers to success, necessary changes to the charter including privacy forms and confidentiality processes
    c. Full list of Core Team representatives and alternates (as a confidential attachment to the Board) and a description of workflow for appointment of new members if staff changes occur
    d. Description of VSRT Special Advisors called to the reviews, analysis of their impact on the review and recommendations on advisors participating in existing capacity or as Core Team Members
    e. A data analysis on reviewed cases to date (at time of the report) that includes behaviors, trends, access to County services (specify), findings and recommendations for ongoing surveillance of veteran suicide rates, prevention, intervention and postvention activities, policy changes/enhancements and procedural needs across governmental jurisdictions and additional information that will inform the board on strategies to prevent veteran suicide

5. Instructs DMH, in partnership with the Co-Chairs of the VSRT, to report back to the Board in one year after the first veteran suicide death review. This shall be the first Annual VSRT Report to the Board and will include:

    a. Data analysis on reviewed cases from the first year (incorporates data from the 6-month report) that includes behaviors, trends, access to County services (specify), findings and recommendations for ongoing surveillance of veteran suicide rates, prevention, intervention and postvention activities, policy changes/enhancements and procedural needs across governmental jurisdictions and additional information that will inform the board on strategies to prevent veteran suicide

b. Analysis on continuation of the Veteran Suicide Review Team beyond the one-year pilot marker including feasibility of maintaining the current structure and full implementation plans in the context of the adopted VSRT Charter

c. Updates on necessary data and IT infrastructure including efforts to ensure consistency with the State data collection practices and reporting

d. Legislative updates and changes that may impact the work of the VSRT

WE, FURTHER MOVE THAT THE BOARD OF SUPERVISORS recognizes the Mayor's Challenge to End Veteran Suicide and hereby supports his office and the VA in the transition of that initiative to the LA Suicide Prevention Network's (LASPN) Veteran Working Group, to remain focused on Veteran Suicide Prevention efforts in Los Angeles County.

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