AGN. NO.

MOTION BY SUPERVISORS KATHRYN BARGER AND LINDSEY P. HORVATH

MAY 21, 2024

ADVANCING EFFORTS TO COORDINATE AND STREAMLINE LOS ANGELES COUNTY'S VETERAN SUICIDE PREVENTION EFFORTS AND 1-YEAR EXTENSION OF THE LOS ANGELES COUNTY VETERAN SUICIDE REVIEW TEAM PILOT

On May 17, 2022, the Los Angeles County Board of Supervisors (Board) took a groundbreaking and forward-thinking step to confront a pressing issue within the veteran community: suicides. Recognizing the gravity of the problem, the Board established one of the first veteran-specific suicide fatality review pilots in the state of California. This significant action followed a previous motion approved by the Board on May 4, 2021, which laid the foundation for the creation of the Los Angeles County Veteran Suicide Review Team (VSRT).

This marked the Board's unwavering commitment to addressing the alarming rates of veteran suicide fatalities within Los Angeles County, and it appointed Co-Chairs to lead the VSRT. These Co-Chairs were carefully selected from key county and government entities, including the Los Angeles County Department of Mental Health (DMH), the Department of Public Health's Office of Violence Prevention (OVP), the Department of Medical Examiner (DME), the United States Department of Veterans Affairs (VA), and the VA's Desert Pacific Healthcare Network (VISN22), recognizing their pivotal roles in shaping veterans' policies.

Following the ratification of the VSRT Charter, the Co-Chairs were directed, as outlined in the February 7, 2022 report, to guide the operations during the pilot period. The Board also approved the VSRT Guiding Document, which contained essential recommendations regarding the definition of "veteran," the purpose and objectives of the VSRT, team composition, case review criteria, and the initial process which would be further developed. The lead agency for this effort, DMH, worked closely with the Co-Chairs to ensure the appropriate representation within the VSRT Core Team. The Co-Chair Team received approval to commence the one-year pilot program, with the inaugural veteran suicide death review set for no later than September, 2022.

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At the core of the initial efforts of the VSRT initiative was the launch of a one-year pilot program aimed at aligning the definition of veteran status with the State of California's data collection and reporting standards. This initiative was designed to ensure consistent and accurate data regarding veteran suicides, thereby enhancing our understanding of this complex issue. The Co-Chairs were entrusted with various critical tasks, including adopting the VSRT charter, identifying and appointing core team representatives, initiating the pilot program, and delivering a six-month progress report, followed by annual reports.

Recognizing the importance of regular updates, the Board requested reports after the first six months of the pilot program. Subsequent reports from DMH covered various aspects, including case information matching with medical records, an analysis of the initial program phase, the list of Core Team representatives, and the review outcomes to date. Furthermore, the Co-Chairs were tasked with delivering an annual report to the Board following the first veteran suicide death review. This anticipated report would provide a more comprehensive analysis of reviewed cases, insights into the VSRT's continuation beyond the pilot phase, updates on data and IT infrastructure, and any legislative changes influencing their work.

Despite the tremendous dedication and hard work of County staff and all the partners involved, there were obstacles and delays encountered during the development and implementation of the VSRT pilot framework, leading to a delayed start of the initial suicide reviews. However, County staff persevered and successfully navigated these barriers and finalized agreements across county departments and with the VA to implement the next-of-kin consent approval form necessary for the suicide mortality reviews. Even though there were delays, staff made significant progress in collaborating with the VA and CalVet to advance this important work. Nonetheless, it has become increasingly clear through this process that strong collaboration and coordination are essential to leverage and maximize the efforts and investments by the VA in addressing veteran suicides.

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WE, THEREFORE, MOVE THAT THE BOARD OF SUPERVISORS:

1. Extend the Los Angeles County Veteran Suicide Review Team Pilot by one-additional year during which the co-chairs shall review and develop recommendations for the pilot to become permanent;
    a. Direct the Department of Mental Health, as the lead department administrating the VSRT pilot, to amend the VSRT charter to add the Department of Military and Veterans Affairs as the primary co-lead of the VSRT pilot;

2. Direct the Department of Mental Health and Department of Military and Veterans Affairs to work with the co-chairs to report back in writing in 120 days with a review and aggregation of the data of veteran suicides in Los Angeles County for calendar years 2020, 2021, 2022, and 2023 up to the date of the VSRT's first suicide review;
    a. The data shall be aggregated with the previously collected data to identify vulnerable populations at risk for suicide;
        i. An emphasis on veteran subgroups such as, but not limited to, minority veterans, LGBTQ+ veterans, and female veterans aggregated and reported separately;
    b. Request that the team explore the feasibility of concurrently tracking and identifying any veteran opioid deaths and provide recommendations to use some of the VSRT tracking and recommendation frameworks to address opioid mortality;

3. Direct the Department of Military and Veterans Affairs, the Department of Mental Health, and the Department of Medical Examiner to work with CEO and report back during the Supplemental budget on;
    a. Gaps in current resources within the Office of the Medical Examiner on necessary staffing and services needed for the VSRT and future suicide mortality efforts and explore the feasibility of developing and placing any adequate postvention services with the office of Medical Examiner;

4. Direct the Department of Military and Veterans Affairs and the Department of Mental Health to perform the following tasks and report back in 90 days;
    a. Review the current model for recommended changes to better address the collection and review of suicide decedent data and the linkage of family members and next of kin to the postvention services and benefits;
    b. Assess (Confirm) the need for an epidemiologist who can provide accurate data and comprehensive analyses to better track and understand root causes of the deaths that help support intervention and prevention strategies;

5. Direct the Director of the Department of Military and Veterans Affairs to develop a plan to coordinate and liaise with the California Department of Veterans Affairs and the United States Department of Veterans Affairs on suicide prevention pilots and initiatives;
    a. The plan should include but is not limited to the California Veteran Health Initiative (CVHI) Research and Surveillance Team (RST) with CalVet and the VA and SAMHSA's Suicide Mortality Review Efforts;
    b. Work with external partners, including but not limited to, the California Association of County Veterans Service Officers (CACVSO) and National Association of Counties (NACo) Veterans and Military Services Committee to establish collaborative efforts with other jurisdictions in California and nationally on veteran suicide mortality efforts;
    c. Work with CEO-Legislative Affairs and Intergovernmental Relations, in collaboration with the Medical Examiner and Department of Public Health to review the necessary legislative changes and priorities for the County to advance the work of VSRT at the state and federal levels; and provide recommended County legislative priorities;
        i. Report back on recommendations for the necessary county priorities and legislative positions for the county to advance the work of the VSRT;
        ii. Provide recommendations and opportunities to address issues to streamline veteran suicide mortality including but not limited to statutory authority to review deaths without the need for next of kin consent.
    d. Work with CEO-CIO to explore adding VetPro onto the County's InfoHub and to explore data sharing partnership with the VA's Desert Pacific Healthcare Network (VISN22) to enhance efforts to connect veterans with healthcare and benefits.

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