US: Veteran turned away from military hospital commits suicide

Naomi Spencer
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On July 7, a Navy veteran suffering from psychological problems hanged himself after being turned away from the Veterans Affairs Medical Center in Spokane, Washington. A July 20 report by the *Spokesman-Review* notes that the death of Lucas Senescall was the sixth suicide this year of veterans under care of the Spokane Veterans Administration (VA).

In spite of lawsuits, legislation and countless pledges from officials for improved care, thousands of US veterans who return from occupied Iraq and Afghanistan bearing profound mental trauma continue to be denied adequate treatment. According to data from the advocacy group Veterans for Common Sense, the VA is currently treating 325,000 Iraq and Afghanistan war veterans, including nearly 134,000 for mental health problems.

One in four veterans wait for over a month to see a VA doctor, and the average waiting period for disability payments is six months, VA and Veterans Benefits Administration data suggest.

Senescall had served on the USS Kitty Hawk and had been honorably discharged. Following his military tour, he had completed a community college program in prosthetics, but struggled with bouts of depression and mental illness. His obituary read, "Luke had many beautiful attributes. His larger than life personality will leave a lasting mark on everyone he touched, but life was a struggle for him."

According to the *Spokesman-Review*, Senescall first visited the Spokane VA hospital in 2002; at that time he was diagnosed with bipolar disorder, which was compounded by drinking. VA records noted that the veteran had "a long history of childhood attention deficit disorder and depression" along with severe depression when he was not on medication.

On the day of his death, Senescall called his father to drive him to the VA medical center for mental health care. The *Spokesman-Review* explained that he was "despondent over a recent breakup with his girlfriend and domestic violence and malicious mischief charges stemming from an incident in which he removed an air conditioner from the apartment he once shared with her..."

Senescall's father told the paper that he had also been having stress about his slipping grades. When the two arrived at the VA center at 1 p.m., his father said Senescall was sobbing, "holding his hands on his mouth just to keep from screaming." He told his father, "My heart is just wanting to leave my body."

The *Spokesman-Review* quoted Senescall's mental health risk assessment completed by a VA social worker after an hour and a half of Senescall's arrival: "Veteran is tearful, angry and expresses hopelessness. He is frustrated with his care at the VA and feels like he is always accused of seeking medication... Veteran denies suicide plan but states, 'I don't want to exist.'" The social worker also noted that at times Senescall became so distraught that his father had to speak for him. In spite of expressing suicidal thoughts, the screener concluded, "Risk low. Patient commits to safety plan."

Senescall then met for 15 minutes with the VA psychiatrist, Dr. William Brown, whose diagnosis concurred with the social worker's assessment. Brown commented in his notes, "It's hard to know what is going on with Luc [sic] due to his poor follow-through... I point out to him and his dad that his last presentation to me in 2005 was almost identical. But he has had 2 NO SHOWS with me since then... If there was a quick solution to this problem, we would have given it to him by now. He is going to need to work at his recovery and show some motivation for this prior to being prescribed medications."

Less than two hours after leaving the VA, Senescall hung himself in his garage with an extension cord. "He was begging for help, and they kicked him to the curb," his father told the *Spokesman-Review*.

The paper reported that the same psychiatrist had been in consultation with another veteran who had committed suicide after being released from the Spokane VA. The veteran, Timothy Juneman, was a National Guardsman who had been diagnosed with Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD).

Significantly, despite these diagnoses, the *Spokesman-Review* noted, "The week before he died, Juneman received final notification that the National Guard had rescinded a promise not to send him back to Iraq for two years." And although the soldier had been on a suicide watch under VA care and had missed numerous scheduled appointments with the hospital, three weeks passed after he had hanged himself in his home before his body was found.

From such details emerges a picture of indifference within the military and political establishment toward wounded soldiers. Funding for medical care of veterans is grossly inadequate. At the Spokane VA, for example, a staff of only 52 behavioral health workers is responsible for some 4,500 patients.

More fundamentally, the fates of service members such as Lucas Senescall and Timothy Juneman underscore the exploitative character of the imperialist military and the war. In many cases during deployment, veterans are wounded physically, as well as witness to—or party to—horrific acts of brutality. Upon returning home, they enter an overburdened medical system in which their conditions are often denied, stigmatized, and untreated.

In a recent study by the Rand Corporation, 20 percent of military personnel returning from Iraq and Afghanistan reported suffering symptoms of PTSD or major depression. With PTSD and TBI, the afflicted can suffer intense feelings of isolation, depression, detachment, as well as severe headaches, memory loss and confusion.

Without adequate treatment, many veterans fall into alcoholism and other drug addictions as a means of dulling traumas. This can only compound difficulties relating to family and friends and holding down a job, which in turn exacerbates the alienation and stress. It is under these circumstances that thousands of veterans have committed suicide or acts of violence over the past several years.

An analysis of state-level death statistics commissioned by CBS News last year revealed that in 2005, over 6,250 US veterans committed suicide. The rate at which veterans took their own lives was double that of the non-veteran population, with the youngest veterans returning from occupied Iraq and Afghanistan the most likely to kill themselves.

In the course of a lawsuit brought against the VA by Veterans for Common Sense, a number of internal VA documents emerged that indicate the department was well aware of this growing social crisis. The suit was dismissed last month in US District Court in San Francisco on the grounds that the court lacked jurisdiction to order organizational changes to improve the government department's medical care.

Nevertheless, evidence introduced in the case established that the VA was aware of at least 1,000 suicide attempts every month, and a rate of four-five suicides every day, among veterans receiving care in VA facilities. These staggering figures—12,000 attempted suicides and at least 1,400 completed suicides per year—do not even include the thousands of veterans who have slipped through the bureaucratic cracks. Emails turned over to the court made it clear that top VA officials took pains to cover up this epidemic. (See "Emails suggest Veterans Administration cover-up of suicide rate")

One email obtained by the court also suggested that VA counselors, in an effort to reduce caseloads and cut costs, may have been pressured to diagnose fewer cases of PTSD. Norma Perez, coordinator for the VA PTSD department in Temple, Texas, wrote in an email to VA staff: "Given that we are having more and more compensation-seeking veterans, I'd like to suggest that you refrain from giving a diagnosis of PTSD straight out... We really don't or have time to do the extensive testing that should be done to determine PTSD."