TRANSCRIPT

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Conversation

Extended Interview: Virginia Tech Review Panel Member Discusses Cho Case

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SUSAN DENTZER: Let's start by talking a bit about what we know that is in the public domain about what happened to Seung-Hui Cho. From what is in the public domain, what do we believe was going on with him, from a mental health standpoint?

BELA SOOD: Well, as far as the mental health standpoint, I don't think we have delved enough to know exactly what was going on with him, but we do know that he did have a history of some mental health problems which led him to be committed into a psychiatry facility within that area in 2005.

And so we clearly know that there was some interaction with the mental health system, which one then assumes there was something going on with him as far as an illness is concerned, by virtue of which he was committed into that setting. And soon after that he was allowed to leave because it was felt he did not meet criteria for inpatient admission, and then was probably sent for outpatient treatment, and then there's practically no record of what exactly transpired.

SUSAN DENTZER: Now his mother apparently, when he was much younger, made reference to relatives back in South Korea that he was "autistic." What, if any, validity do we assign to that brief reference? We don't even know if it was a diagnosis or a description or what, but what would we take away from that?

BELA SOOD: Yes, I think in this day and age, especially with the Internet and the part that media plays, and the information that the lay public has access to, it's a very different era than it was about 50 years ago, where if you heard that kind of a label, you would pretty much be sure that this was something that was given to them by a professional.

It could very well be that someone had just made that statement, and the parents picked that up, and that seemed to be something that they expressed their concerns to a family member. But to say that that probably was going on is probably a stretch. And so I would take that with a grain of salt.

I guess what the parents were probably referring to was that someone had figured out there was something going on with this child, and that he'd been identified with having some sort of a problem which needed addressing, and that is what they were referring to.

SUSAN DENTZER: There has been a lot written about his social isolation, the fact that he lacked a lot of social interaction skills, or apparently even capacity.

BELA SOOD: Certainly the media talks about this young man being very withdrawn, very isolated, extremely and painfully shy as he was growing up.

Shyness by itself, what we call introversion, is not a sign of mental illness. People can be introverted. There are some people who are very gregarious and very people seeking, and there are some people who draw their energy from within themselves. And that by itself is not a sign of mental illness.

It is really a combination of that, along with other symptoms, which come together as a constellation of mental illness. So, you know, I think there are lots of people out there who would identify with that and be highly, highly shy, but there's nothing wrong with them. [...] Introverts can be very good with family members, and they can be very good with a few select peers. They may not be the life of the party, but they can make those connections.

It's when there's a complete lack of connectiveness with the rest of the world which then, along with other functionally impairing symptoms such as things that come out in creative writing which are very dark, which are very gloomy, where there is a threat which is posed which indicates that the person either intends to self-harm or harm someone else, or that you are beginning to see cruelty to animals, or you begin to see a real cruel sort of

interaction with others, that all of those begin to sort of come together, and then that poses a threat.

SUSAN DENTZER: And indeed some of the creative writings of Cho were precisely what gave many of his professors a good deal of alarm.

BELA SOOD: Absolutely. And that is always an area of confusion. You know, what poses a threat, and what is an actual imminent threat? How do you go about making a decision that what your students are writing creatively -- and how much do you aid and abet that process because it's creative -- is really posing a threat where there are absolute threats made in the content of the information, which then raises red flags to say something needs to be done.

I think that is one of the fears that this tragedy has brought, at least to the larger, wiser mental health community, is that you don't throw the baby out with the bath water. Any time that violence is connected with behavior, the assumption is that it must be driven by mental health problems, which then criminalizes the notion of mental health.

Because mental health is just like any other physical illness. It may be very much confined to the person -- they're very distressed, but that doesn't mean that there's a propensity for violence.

In fact, the literature and the research indicate that a lot of violent crimes are unconnected to mental health issues. So one really wants to be very worried about that aspect of the Virginia Tech tragedy, and to make sure that at the time of the commission of the crime, that indeed it was the mental status that was driving that or not. A lot of things go into that, looking at the premeditative nature, looking at what amount of thinking went into it, and that it was not an impulsive, explosive, rageful crime which just occurred at the spur of the moment.

Having said that, when you talk about making armchair diagnoses, that is a tendency for many people. You begin to speculate. And as you begin to speculate, it's not then based on data. You are just extrapolating based upon the little pieces of information. That's very dangerous because even the evaluations that I do at this stage of my career, which is 25 years into being a psychiatrist, I rarely ever make a diagnosis of anyone in the first ten minutes. Even though I know where I'm going, I take a good hour and a half in order to gather all the bits of information that can allow me to formulate the case, because unlike what people think about mental health, mental health is a much more complex and complicated arena of health than even physical diagnosis.

When you look at problems of the heart, problems of the liver, problems of physical aspects of the body, those, I think, are much easier to diagnose. I'm a physician by training, and I know that.

On the other hand, when you're looking at behavior, it really requires a very high cognitive science to pull together all of the symptoms and say 'how do I understand this? Can this be understood merely by the parsimonious explanation of environmental factors like stressors, or is it really neurobiological?' How can I understand this person? Because people's behaviors are very complicated, and it really requires a great deal of training, a great deal of experience to really hang your hat on what's going on.

So I would strongly caution against the idea of making armchair diagnoses based upon finite amounts of data, and I think that's going to be one of the biggest challenges for this panel.

[...]So we can talk in generalities, but until we get the specifics, it's very hard for me, and I think any good card-carrying psychiatrist, to make a diagnosis based upon the finite amounts of data we have at this point.

Slipping through the cracks

Bela Sood
Virginia Commonwealth University

“ Schizophrenia ... typically presents in late adolescence, early adulthood. So even if indeed [Cho] did have schizophrenia ... his school teachers may not have seen the frank hallucinations and delusions that maybe his college peers could have seen. ”

SUSAN DENTZER: Some experts appear to have concluded that he possibly was schizophrenic.

BELA SOOD: Again, you know, schizophrenia is a thought disorder, which is characterized by delusional behavior, along with auditory and visual hallucinations. And when we talk about delusions, we are basically talking about fixed false beliefs which have got no basis in reality. And [Cho] talked about the rich kids who walked around, he talked about social injustice and so on and so forth.

It's very hard to be clear on what kind of life experiences did he have? Were these reality based? [...] His ranting and raving certainly indicated poor judgment in that a lot of this stuff, this rage, many of us feel a lot of social injustice in a variety of different ways. But it doesn't mean that we kind of go into a rampage of ranting and raving, and that drives our behavior.

So clearly it was poor judgment, poor thought processes, but that was a cross-sectional kind of a thing. If he indeed was truly schizophrenic, and [he] could be [...] in schizophrenia what you see is a gradually deteriorating functioning, which probably was there in his case, command and, you know, hallucinations and those kinds of things like voices, etc., which tell you to do particular things, which then you act upon. And there is enough out

there which tells you these are delusional beliefs, these are not based in reality, and those are the parameters that a psychiatrist uses to figure out: Is this real? Is this something that is part of the person's imagination?

You begin to see a cognitive decline, meaning that a person's ability to function intellectually goes down. So it's a diagnosis which really connotes gradual deteriorating sort of functioning, and it's characterized strongly by the presence of hallucinations and delusions, and one has to have data to support that.

SUSAN DENTZER: Which is a way of saying we really can't make that armchair diagnosis.

BELA SOOD: Exactly. And the other thing with schizophrenia is that it typically presents in late adolescence, early adulthood. So even if indeed he did have schizophrenia, it's pretty likely that the early school years saw him as being gradually withdrawing, but his school friends, for example, or his school teachers may not have seen the frank hallucinations and delusions that maybe his college peers could have seen if schizophrenia was developing.

SUSAN DENTZER: So again to distill this down, we can't necessarily rule it in, but we also can't rule it out.

BELA SOOD: Unless we are privy to information that someone who interfaced with him on a professional level--from a physician, psychologist, social worker relationship--[we can't] actually answer that.

SUSAN DENTZER: Without knowing exactly what diagnosis was made in 2005, there was at least initially a suspicion that he needed inpatient treatment. That order was then changed to mandatory outpatient treatment. What possible diagnoses could have been made?

BELA SOOD: Well, definitely psychotic disorder not otherwise specified (NOS). It could be schizophrenia, it could be major depression, the psychotic features. When you look at depression, depression is really in very dynamic terms, it's sadness and distress and anger, which is introflexed, meaning it's directed towards the inside.

When you have that aggression directed outwards, that's where more of the violence comes up, and the homicide and those kinds of things. That's how we understand it. So repressed rage, those kinds of things.

But as far as diagnostic general thinking, psychosis is definitely one of those. So a range of things, and the most, I think, schizophrenia definitely, psychosis not specified, it could be major depression with psychotic features. As I said, depression usually if you think of it in dynamic terms, it's the sadness and the angst and the distress which is turned inwards, which is why people then inflict self-harm, because their rage comes out at one's own self, because you don't want to project it onto the world.

In homicide, it is the rage and distress which is projected onto the outside world. I want to make you feel as bad as I do, and so the rage and violence is directed more towards the outside.

If one looked at it in terms if none of this was there, and it was a very premeditated, cold-blooded kind of carnage that this young man visited upon his peers, you would think of it as sociopathic. Sociopathic behavior, which really is more with a criminal intent, which in earlier years you see as conduct disorder.

So the conduct disorder usually presents itself as vandalism, breaking and entering, a complete disregard for the rights of others, so violating other people's rights, and these individuals, if they don't -- if they're not corrected by the juvenile system, then end up being sociopathic. They can be charming sociopaths or they can be, you know, sociopaths who are just sort of out there, who just don't care about anyone, and they hurt people, and hurt animals, and hurt others. They rob banks and write bad checks and so on and so forth. But that does not appear to be the case here.

SUSAN DENTZER: Another issue is that of stigma. It's been reported that his parents possibly felt some element of stigma about their son's condition, and that that may have been a barrier to them seeking any kind of help for it.

BELA SOOD: Yes. In this particular instance, I think there were many compounding factors. We do know that this family came from a different culture. They had immigrated, and they probably dealt with what we always see with immigrants, the desire to assimilate and acculturate.

[...]Immigrants come in all sizes and fashions, and the ability to sort of get into mainstream American culture, and education does play a part, what kind of occupation you have. And oftentimes when immigrants are struggling with making do -- and I'm an immigrant, so I know that first-hand -- that in the beginning years you are struggling with just trying to make ends meet. Children get neglected or, you know, the parents kind of do what they can to help the children, but they're also dealing with their own issues.

So there are a lot of cultural issues that came into play for this family probably, and so then they were dealing with the cultural barriers of being here, and secondly, if you have a child who is having problems -- you know, I know that this young man had a sibling who did exceptionally well, achieved educationally. So you can't attribute everything to that, because you're clearly seeing that there was one sibling who had acculturated well, and has

been successful, and then you have this young man who probably had his own set of problems.

But mental health carries a bigger stigma within the Eastern culture--because academics are so valued and work ethic is so valued, that it is seen as a personal failure of probably a much higher magnitude in the Eastern culture than, say, here.

So we know within mainstream culture, mental health carries with it a great deal of stigma, and then you multiply that further with some of the Eastern values, you get a much more full-blown picture of someone not wanting to seek treatment. So that could be one. Again, we don't know the details of this particular family.

The second thing that I wonder is that when -- even in the best of situations, access to care is a problem. The work force shortage issues; we have very much fewer trained people for individuals who even come forward and seek treatment.

To get an appointment with a child psychiatrist or psychologist, my waiting list is about eight months. So you can imagine, you know, how difficult that is. So they may have self-treatment, and the system may have not responded to it appropriately.

People get very jaded by that kind of experience, or someone may have acted in ways that were not culturally sensitive to this family's needs, and that may have pushed the family away. So they would rather kind of sweep the stuff under the rug and not seek treatment.

Again, I'm merely speculating because we don't have access to the family, and I don't want to say anything which might be pejorative because they may have sought treatment. They may have been very well aware of what the needs were, but access may have been an issue.

So there are many complicated kinds of reasons why this young man slipped through the cracks, but this is a major societal problem for us. Stigma, access to care, work force shortage issues, poor funding of mental health. And the fifth is - I mean, that we see that all around us, the lack of parity for mental health coverage.

So you can have X amount of dollars being paid for physical illness, but X minus five or six for mental health. And so when you have a high co-pay or you have to pay for all of it yourself, you're not going to go.

And unfortunately or fortunately, mental health follow-ups, in order for it to be successful, you almost need weekly visits for it to make any dent in whatever is going on. And then you have high co-pays, and when something is not covered, you see the multiplying complexities of access that go on. And as a society we just don't do a good job. So that's where we are at.

Psychological impact of bullying

SUSAN DENTZER: As we say, it's difficult to make the automatic assumption that his mental health issues run in a straight line and connect automatically to the violence, but potentially there was a component of that which everybody acknowledges.

Bela Sood
Virginia Commonwealth University

“It is, I believe, the right of every child to live within a safe environment within the school so that they can do what they're supposed to be doing, which is learning.”

BELA SOOD: I would like to say one particular thing about mental health versus not mental health, because it's a very sort of provocative notion that at the time of the commission of the crime, that there was no mental health issue. And we know from public domain about the amount of ammunition he had, the number of guns that he purchased, and how he went about it and got it, and the amount of ammunition that was left over, which was two-thirds the amount that he had used, and had evaded any discovery of any of that in the months preceding this incident, you really wonder how much thought went into it.

If someone has a major mental health problem, we know that there is slippage. There are things which kind of are tell-tale signs which people pick up, and begin to just by hopefully there's not the degree of problems that sometimes we see resulting from it, because people, when they're not in the right mental status, are going to let their peers or someone, you know, sit up and pay notice.

The fact that he was able to padlock the doors, and how skillful he was means that it's really marvelous that the police force and the SWAT teams were on the scene as quickly as they were, and they were able to stop the thing from going forward, that it really begs the question how much was he with it, and how much did the mental health aspect contribute to what had been done.

SUSAN DENTZER: So you're saying that maybe the degree of sophistication of thought that he brought to this could detract from the notion that he really was overcome by mental illness.

BELA SOOD: Certainly. That is a thought that we have to consider.

I certainly would also want to talk about the access to firearms, and that's a very controversial area. But if one

doesn't bring it, I think that we are missing a very important piece, and I know that this is a politically charged issue for the country to grapple with. But as a child psychiatrist and as a citizen, I do firmly believe that this mighty tension between the notion that somehow if the other fellow, you know, peers were allowed to carry guns, they could have protected themselves and this could have been stopped, makes you really -- at least it makes me really surprised that argument could be posed [...]. If guns were the solution, as a safety measure, we would be the safest country in the world, and that is not the case.

And so certainly the amount of fire power that he had, and he was able to get as Joe Q. Public makes you wonder what would have happened had he just accessed a knife then, those kinds of things.

You may want to edit that, I don't know. But I have to say that as a child psychiatrist.

SUSAN DENTZER: Back to the notion of issues that may have arisen for him, another allusion has been made to the fact that partly because he was so socially withdrawn when he was in elementary and secondary school, that he could possibly have been the target of some bullying.

BELA SOOD: Yes. Bullying is a major - I mean, so there are many things that go on within school systems where we don't do an effective job in identifying factors that do not protect kids. Bullying is a major one.

I as a child psychiatrist run into this all the time because I do see a very skewed population, a population that does not have the resilience and the competence elements that you would see in the general public, and it breaks my heart to watch school systems talk about, you know, the notion that boys will be boys, or, you know, they just need to establish a pecking order and they'll figure it out. Let them just sort of figure it out. And I think that that's a mistake.

I think in elementary school, it sets the stage of the way the child views themself in context with the word. It really is important for adults to establish a safe environment for children [...] because it is, I believe, the right of every child to live within a safe environment within the school so that they can do what they're supposed to be doing, which is learning.

If you are so worried that you're constantly watching over your shoulder of who is going to take you and rub your nose into the sand of the sandbox in the playground, you're not going to be focusing on your work. And unfortunately we leave it too much to the discretion of the kids within schools, and the schools need to take a much more active role in making them a safe environment, to be taking a much more stronger role in watching over drugs, other noxious influences which come into schools, because you can quite understand and empathize with young people who begin to start taking the law in their hands when they become physically powerful, and they become old enough, and they have the wherewithal to start taking care of themselves. But by then the hate and the anger is so ingrained, it's almost sort of rubbed into every cell of the child that you can see where they're coming from.

SUSAN DENTZER: So what is the long-term psychological impact of bullying?

BELA SOOD: I don't think it takes a rocket scientist to figure that one out. If you're constantly told that you're no good, or you are a geek, or you're a nerd and you don't fit in, and we don't want you, and that there is no one out there in the adult world to save you, you end up really believing those things.

Well, that has a very important ramification of the way you view yourself in the world -- low self-esteem. Low self-esteem then leads to academic difficulties. Academic difficulties then allow you to swirl downwards and really reach a peer group in which you feel wanted and love and respected, and not challenged.

And who is that? These are the people who are also not making it. These are the ones who may be using substances in order to medicate their mood or the way that they feel. You know, what is substance use? Substance use, some of it's biological, but some of it's reactive. We're trying to make ourselves feel good. And so you're medicating your sense of self by using mind-altering substances, which make you be in a good place. So all of those things -- and then honestly, the worst part of it is suicide, so far, because you don't feel very good about yourself. And these are long-lasting consequences.

So unless you are temperamentally very resilient where you can adjust -- and what is temperamental resilience? The ego or the mind begins to split off that says I can't deal with this, I don't want to live in this world psychologically. So you split yourself off, and you go off into some other place.

That works for a while, but that association carries with itself a great deal of -- it takes a toll on the person's personality. They can't be themselves. They have to live in an 'as if' world, which then leads to what we call personality disorders, because that becomes the defensive structure of the person. And these are the people who are our spouses. These are the people who are our employees. They are the people who work around us. These are the walking people who are functioning, but portions of their lives and their psyche and the way they are, are damaged beyond belief.

So it wreaks havoc in our society, and these are the controllable aspects. There are some things which we are

born with biologically. We can't do much with it. These are the genes we carry. If I have affective stuff in my family pedigree, the likelihood of my having that, you know, are high, but they don't occur in a vacuum. They occur because I am put into an environment which is negative. It's an interaction of that negative environment, lack of support, plus a pedigree [...] which then precipitates a depression.

The likelihood of me having the depressive episode, if I have a warm supportive environment around me, is low.

Where the system failed

SUSAN DENTZER: The most glaring gap in the Cho case is the gap that you mentioned earlier, where it was obviously determined that he had some very serious mental health issues. He was, indeed, committed, and Virginia does have the mandatory commitment law that allows that. And the administrative judge then changed that to mandatory outpatient commitment, and nothing happened [...] Let's talk about that failure.

BELA SOOD: So in December, because of [...] the stalking, the emails, the dangerous kind of stuff which led to -- and the fact that at one point he became suicidal -- led to the commitment to an inpatient facility, but is a very normal occurrence, and he went in to an inpatient setting. And usually in an inpatient setting, there's a hearing, a commitment hearing, which allows the judge to then order a mandatory, compulsory inpatient treatment versus letting the person out, and that's really based upon a decision that 'does the person pose an imminent risk?'

At that point it was felt he -- and indeed a person can convince a judge or a magistrate, or legal people who are within there that they're safe because it just depends upon what a person is saying, which is a major system gap in my mind, because a current involuntary commitment into inpatient settings assume that we have the tools and the capability of figuring out what is the long-term consequence of a certain behavior, and predictive nature to that, which I don't think exists. I think anyone would agree.

And it is something to do with funding because [...] that 48 hour, 72 hour period is the covered period, which is funded, and then after that people make a decision whether they pose such a risk that they need to remain committed, or they should be left. And most of the time they are usually let go under the premise of fundamental rights, of being treated in the least restrictive setting.

Bela Sood
Virginia
Commonwealth
University

“ My worry is that with this tragedy, that stampede and jumping off the cliff, that people are going to clamor for a policy which may not be based upon a real rational review of what needs to happen. So we've got to be very, very careful with that. ”

SUSAN DENTZER: Let me see if I can restate this. The Virginia law requires once somebody -- and when we say he was an imminent danger, we're saying he was an imminent danger to himself -- the law says that when somebody is an imminent danger to himself or herself, that that person can be held for 48 to 72 hours.

BELA SOOD: Yes.

SUSAN DENTZER: But at that point a determination has to be made about whether the situation is going to carry on indefinitely.

BELA SOOD: Yes.

SUSAN DENTZER: And what you're saying here is we don't have the tools to make that determination.

BELA SOOD: Yes. And in fact, this is an area that is actually being looked at by a task force, which is appointed by one of the chief justices in Virginia to look at the commitment laws, because there are such glaring problems with the system -- the criminalization of the mentally ill, you know, how commitment occurs, and the notion of what is the outcome that we desire.

The outcome that we desire is that people who are identified with mental health issues are actually getting the treatment, and how do we make that happen? So that's a wonderful task force. It actually has about 200 people on it, who are the experts in the land, and are pulling together hopefully a good document which will inform a rational policy to its commitment.

SUSAN DENTZER: And that task force predates the shooting.

BELA SOOD: Yes. It was appointed in the fall of 2006, and in fact we have been in touch with them, and they are going to inform the panel about what would be rational ways of approaching this.

So at the commitment hearing, then, a decision is made whether they need to remain in-patient versus going to outpatient treatment. There are some states which have outpatient commitment laws, and others don't. In this case, the outpatient commitment was made that he was told to seek outpatient treatment. But at that point, that's where the system broke, in that there was no follow-up. There is no trail left as to what happened, and we don't know what transpired, whether he did attend one outpatient session, did he attend two, and what are the reasons why he was lost to follow-up. But he was clearly lost to follow-up, and we have no information on that.

SUSAN DENTZER: And it's not clear who was responsible, if anybody, for that.

BELA SOOD: Yes, and so that is going to be one of the areas that we will be looking into, and these are a set of interviews that we have set up within the system to be asking those very questions, as to where that broke.

SUSAN DENTZER: Just a final point on that, what apparently happened here was that he went first to the County Mental Health Board, correct?

BELA SOOD: Yes.

SUSAN DENTZER: And that was the entity that did the evaluation of him, or somebody at the County Mental Health Board did the evaluation. And then he was referred to the administrative judge, who made the determination about commitment. And there has been some suggestion that it was then supposed to be the County Mental Health Board that picked that up again.

BELA SOOD: They should have. They should have. In fact, the CSB [Community Service Board], because of funding issues, they -- routinely in the past they would send a representative from the CSB to hear the commitment hearing and to see what were the issues that were raised, what kind of follow-up was required. They no longer do that because each visit to this kind of commitment hearing carries with it some money that is attached to it.

And so this was a decision that was made several years ago to forego that, and so that link of the CSB having to carry the mandate of making sure that he had outpatient treatment was not there. It didn't exist. It really depended upon the system to somehow inform the CSB, to say what followed through. And the question that comes up is that, say, for example, within this inpatient setting, we have a hearing with a kid who was here, and we say that not meeting imminent dangerous criteria, but we really feel that this issue needs to be addressed in an outpatient setting. We suggest that you go to outpatient treatment.

Outpatient treatment can be provided by a variety of different systems. It can be the Community Service Board, it can be a private provider, it can be an academic provider, it can be a whole host of things. What is that link which says to the provider that you've got to make sure that this person appears on your doorstep? And if they don't, then do you just let it go, or do you go back to the legal system and say such and such did not come, so they need to be picked up.

I'm exaggerating picked up, but what teeth does the system have to make sure that when you have a high index of suspicion for the mental illness unraveling and creating greater community danger, what teeth do we have to make sure that that doesn't occur?

And the second thing would be: [does] the outpatient commitment [mean] that this young man posed a substantive community risk, or was it because the person felt that their internal illness was bad enough that they needed treatment? Because those are two different things. It's just like saying if I have high blood pressure and my internist says to me you really need to get help for your blood pressure because down the road you could stroke out, how pushy does the internist become in saying you have to seek treatment? Is it a danger to me? Is it a danger to my family? I mean, what are those parameters within which we operate? And those are very complex issues, because you can become very intrusive, or you can become very laissez-faire, and the field and society has to grapple with those issues of where you want to go.

My worry is that with this tragedy, that stampede and jumping off the cliff, that people are going to clamor for a policy which may not be based upon a real rational review of what needs to happen. So we've got to be very, very careful with that.

Possible interventions

Bela Sood
Virginia
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" It stands to reason that you can't just look at the academic aspect of a child's functioning, but you have to start looking holistically at physical health, mental health, and how it impacts the child's ability to function well academically. "

SUSAN DENTZER: Two of the potential interventions that various experts have recomm could not necessarily have prevented the Virginia Tech shootings, but probably are a gc things, and also possibly would have been useful in this case, are school-based screeni community treatment. So I'd like to talk first about school based screening and the mode you're familiar with, pioneered by people at Columbia University. What do you think abo program in particular, school based mental health screening in particular, and also woul perhaps in Cho's case?

BELA SOOD: Well, I think that identifying at-risk people, and this being one of those too good idea as far as primary prevention is concerned. If the data suggest that these tools same light as [...] when you have screenings for a child partaking in any school physical physical screen, and we want to make sure that physically they're doing well, and if not t treatment. [...]

Our tendency in mental health and in any other area of illness as a country is that [...] that after the illness has occurred, not only has the illness occurred, it has produced its own set of problems, secondary problems, meaning that aftereffects of the problem, then we deal with the aftereffects and we deal with the problem.

By then it's mushroomed into a very complicated, complex thing. It stands to reason that what you want to do is to nip the problem in the bud before it begins to express itself. That's what we call primary prevention.

[But] that's not a very popular notion, because the fruits of primary prevention are usually seen 15 years after you put something into place, the tendency of this country is not -- because much of the political will is based upon four-year terms, or a one-year term in public office, and so people want to look good -- and so therefore primary prevention is not a typically popular thing. But that's where the interventions need to go.

And so tools like that, screening tools which carry with them the funding aspect of it because you want to be using your finite resources in the best possible way, but you want to make sure that the tools that you use have the ability to really find the true cases, meaning the true risk, rather than having red flags go up where these are red herrings, or false cases of the illness.

It's a controversial area where schools begin to feel that they are becoming mini health areas. But it stands to reason that you can't just look at the academic aspect of a child's functioning, but you have to start looking holistically at physical health, mental health, and how it impacts the child's ability to function well academically, and that's where these things come into play, and I feel they are on par with all of the physical screenings that we do. Because once you identify a child at risk, then the next sticky issue becomes how do you get them care.

And as I said, this kind of dovetails into the notion of access to care. If I have a six-to-eight-month waiting list, where do people go who have been identified? And what you will find is that when parents are told that their child really needs to be seen by someone and there's no one out there to see them, you can imagine the system failure because the next time they're really not going to seek the treatment out.

So screening tools are great, but then what is the next step, with access to a fully trained person? That's another sticky area because 80 percent of the mental health in this country is provided by people who are not trained in child mental health, and that's pediatricians, family practitioners, adult psychiatrists who have barely one or two weeks of interfacing with child psychiatry, and they're providing 80 percent of the mental health care.

Children are ending up on number of psychotropic drugs, poorly understood symptomotology, poor treatment, and failure of treatment.

SUSAN DENTZER: And I want to come back to that when we discuss what you would like to see -- without prejudging what's going to be and the recommendations coming out of your panel -- what might be the kinds of things you would like to see.

To stay on these possible interventions that some people think could have made a difference, one other model that's been cited, as we spoke about, is assertive community treatment, where there wouldn't have been the failure to follow up on the mandatory outpatient treatment order, that there really would have been the system that you described was necessary here, to go and get him and get him into care.

What about these assertive community treatment models [...] would that have helped in this case?

BELA SOOD: This is very, very complicated, and I think an area that this country has completely lost the mandate that was given to it actually in the sixties by President Kennedy, when he talked about community-based care. And that led to the deinstitutionalization movement. I think that's where you're going, if I understand it. I don't particularly understand the label, but I think this is what it talks about.

An idea that people don't get the right kind of care within the four walls of an institution, and they really get the best care and the least restrictive thing, a place which is in the communities, a community-based work. The system that exists today incentivizes our health systems, our providers to really fund inpatient care. They talk about community-based care, but that is utterly poorly funded. There are no step-down programs, there are very poorly funded community based settings.

Community system boards with the CSB, the public mental health system in my mind is scrounging around for resources, in fact for children particularly.

[...]So they talk a good game about having recovery-based programs and community-based settings, but when providers get a hundred dollars for inpatient care and get ten dollars for outpatient care, where do you think they're going to default sending people for treatment? Inpatient, which is the most restrictive because the outpatient stuff they pare down. They say this is not intense treatment, so we're going to fund it at this level.

Now, if they were to fund the outpatient treatment in the right manner, providers would be incentivized, health systems would be incentivized to run outpatient services, and have people within the community providing care.

Just as I mentioned to the CSB, the outpatient stuff just doesn't get followed through because there is no money attached to it. It's miniscule. And so people can talk a good game, but funding is where the buck stops. And as you noticed in this entire conversation, this is the first time that I have mentioned funding because I always feel that people jump on the bandwagon right away, and people don't quite understand. And then immediately the public sort of, you know, closes their ears because they say it's back again to the money.

But I think we have talked substantively about issues which are connected to the money, and the underfunding of the mental health system is the big elephant in the room. And until we begin to start saying we value people to be treated in communities, because we think that that's the right place for them to be in, and they will pay you for providing services within that setting. Until then, this issue is never going to be resolved.

You're going to see default into the inpatient setting for crisis-oriented services which are provided, which are cross-sectional in nature. People don't have a sense of, you know, why do pediatricians and family practitioners have such good relationships with their patients? Because it's a country doctor kind of a mentality where you have a person who you develop a relationship with, who you're seeing ongoing.

My pediatric colleagues get reimbursed at double or triple the rate that I do for the expertise that's turned to me constantly to say can you help me. That's -

SUSAN DENTZER: That says it all.

BELA SOOD: That says it all.

SUSAN DENTZER: To augment that issue of funding, there's also the issue that we spoke about earlier, who has the responsibility to do anything. And in these assertive community treatment models such as the one we visited earlier this week in Rochester, somebody is paid to go out and get the person, whose very symptom of mental illness may be denying that he or she is actually ill, and basically make it impossible for that person, or make it as difficult as possible for that person to escape treatment. Talk about that.

BELA SOOD: Yes, absolutely. And you have mentioned the crux of the matter. People are not going to do this out of the goodness of their heart. It's a service, just like when you go to a restaurant and you ask for a meal, they expect to be paid for them giving you the meal.

In the same way, this person who is serving as a case manager or the person who is going to go out and make sure the treatment is occurring, this is an investment that that particular community has made in saying this is really important to us, because it's going to produce dividends down the road. But we have to fund it front end, otherwise it's just going to fall through the cracks.

But if people feel that when I call the school up and I'm making an extra effort to get in touch with the teacher because I want to know what's the child's classroom behavior rather than getting it secondhand from the teacher, because I'm really interested in the child, in knowing what's going on in the classroom, and I'm not paid for it, how many times will I do it? Probably two or three times, and then after that I'll say, this is just too onerous for me to be on the phone while I'm getting the guidance counselor to figure out which teacher should come on the phone and so on and so forth. After a while I'm going to say no.

But yes, if there's a CPT code which allows me to have the telephone conference with a teacher, I'm getting rich data which is going to inform my treatment in a very good way. But the system doesn't allow that. So the next time I don't do it.

So then I base my judgment upon pieces of data which are, you know, a small part of the pie, and that affects management and treatment.

So you bring up - you actually just answered that, and that is the reason why it probably happens, is because that person's salary and job is to hustle and to get the person into treatment, and make sure that that works.

SUSAN DENTZER: Please explain the CSB, the Community Services Board, and the function that it has here in Virginia.

BELA SOOD: Community Service Boards are entities which are the public mental health system basically, which are part of the Department of Mental Health and Mental Retardation, and are governed locally, but are getting state money into them. And they basically provide care to counties within which they reside, and are responsible for taking care of the mental health needs, substance abuse needs of adults and children. And they are mandated to do so by the Department of Mental Health and Mental Retardation.

So that's the public mental health system in Virginia, and they cater to several counties, so one CSB is responsible.

SUSAN DENTZER: And so as best as we understand the sequence here, when Cho was detained by the campus police at Virginia Tech for apparently sending these emails to students that were worrisome, did they

specifically take him over to the Community Services Board? Do we know how that happened?

BELA SOOD: Well, usually CSBs will be called to prescreen the person because they're the ones who are going to be responsible for the temporary detention order, or any person who is licensed actually has the right to what we call green warrant, or TDO [temporary detention order] the child or the adult into a facility. And so they have what are called prescreeners, who actually look at the clinical issues and determine whether the person is meeting imminent danger, and at that point they will issue the green warrant and the TDO. So that's their interface with this whole thing.

So policemen can call a CSB, a clinician can call a CSB to do the prescreening. At that point, based upon what the prescreener says [...] then that green warranting or TDO process is enough to get the person into the hospital without any further intervention by the legal system until 48 hours to 72 hours elapse.

The CSB then is the place where the person can go back for treatment, but at that point they're not mandated to provide the treatment.

SUSAN DENTZER: And he was not mandated to go back, apparently. It was a mandate --

BELA SOOD: For outpatient treatment.

SUSAN DENTZER: But a mandate to whom?

BELA SOOD: Yes, that's where the system gaps.

SUSAN DENTZER: So what I'm getting at is a lot of the right steps were followed up until that point. The police detected he was a problem, he was referred to the equivalent of the community mental health clinic, they screened him, they said he was a potential danger. He was referred to a psychiatric unit. He was, in fact, there for 48 hours. He was assessed by the judge. All of those things went according to plan, and it was really this last piece that was the issue. Is that fair?

BELA SOOD: That would pretty much seem the case. And there are a lot of people like that. I mean, so this is a tragedy that happened, but there are many times where people get told that you ought to be seeking treatment, and they're lost to follow-up. And in those cases, those tragedies don't happen, but in this one it did.

I think the issue of whether he could have bought a firearm, based upon the commitment that was actually on paper, and how did he manage to get through that is another issue.

SUSAN DENTZER: Right, exactly, and another one that your group will be looking at.

BELA SOOD: Yes.

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