I wear many hats. I am a clinician by background, and I do three days of clinical work, so I am firmly grounded in a child and adolescent psychiatry practice, and I was appointed to the Virginia Tech Review Panel (Panel) by former Virginia Governor Tim Kaine four days after the tragedy struck.\(^1\) I was surprised by the appointment to the Panel because forensics is not my background. Nevertheless, as the work of the Panel unfolded, it became clear that it was more of a systems approach that needed to be taken in investigating the tragedy.\(^2\) I acknowledge the pain of the families who are in the audience today. It is indescribable, the experience of the families, students and staff at Virginia Tech, and all of my colleagues that worked on this Panel report. Listening to Lucinda Roy, I was struck by her riveting address not only in recognizing the need for utilizing this whole incident as a learning experience, but really keeping our eye on the ball in recalling the events as they occurred.\(^3\) The outcome that we require and want, within a college campus setting, is a challenge to define as mental health, and is really a small sliver of the entire pie of campus life that the Virginia Tech administration is grappling with. The academic life of a university is primarily focused on the task of teaching, and not focused on mental health

\(^{\dagger}\) Transcript of presentation given on Friday, November 6, 2009, at the Violence On Campus Symposium, held by the Washington and Lee Journal of Civil Rights and Social Justice.

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2. See id. at 6 ("The Panel used a variety of research and investigatory techniques and procedures.").

3. See LUCINDA ROY, NO RIGHT TO REMAIN SILENT 298 (2009) [hereinafter NO RIGHT TO REMAIN SILENT] (commenting that ")[t]hrough more open communication and a national commitment to education, it is possible to make this campus and others safer than they are currently. It’s not too late to engage in meaningful dialogue").
issues. The inherent dilemma is the public safety issue versus personal privacy. These are thorny issues with which we have grappled as we have looked at this tragedy and how it has informed university policies in the United States regarding mental health and the way we approach wellness in campus life.

We had about a four month period within which we were tasked to create the Panel Report. It was fast paced work with the first six weeks of the Panel’s work together hampered by the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA): the legal twins that impeded effective information sharing between the Virginia Tech officials and the gubernatorial Panel. It took an Executive Order from the governor and help from the law firm of Skadden and Arps to allow us to get the information from Tech and other entities in order to move forward with the investigation. The Freedom of Information Act was another legal act which hampered the work of the Panel, because anytime you had more than two people, it was necessary to invite the media, which turned things into quite a circus. Nevertheless, the Panel really gave our best. We reviewed more than about 1,100 documents, interviewed more than 220 people or so in the process of the Panel’s work, and reported on much of it firsthand. We did not take anything as information that was given to us as the absolute truth and I think that there was a tremendous amount of effort that went in to corroborate each piece of information by supporting evidence. And these are the Panel members, as you can see, the governor appointed people from different walks of life who brought a different level of expertise.

4. See generally Michael Luo, Senators to Discuss Preventing College Attacks, N.Y. TIMES, Apr. 24, 2007 (discussing the limitations of mental health resources on college campuses).
5. See VIRGINIA TECH REVIEW Panel, supra note 1, at viii ("[F]ocus on an individual’s privacy and confidentiality in higher education is sometimes so exclusive that it can exclude the welfare of everyone else.").
6. See id. (listing the date of the final report’s publication as August, 2007).
7. See id. at 58 ("[I]nterpretation of HIPAA and FERPA were key in stopping adequate exchange of information concerning Cho.").
8. See id. at 7 ("[T]he Executive Order of June 18, 2007, and the work of our outside counsel ultimately allowed the Panel to obtain copies of, review, or be briefed on all records germane to its review.").
9. See Virginia Freedom of Information Act, VA. CODE ANN. § 2.2-3707(A) (2010) ("All meetings of public bodies shall be open.").
10. See VIRGINIA TECH REVIEW PANEL, supra note 1, at 1 ("The Panel conducted over 200 interviews and reviewed thousands of pages of records.").
11. See id. at vii–viii (listing the members appointed to the Panel by Governor Kaine
was a person from the FBI, a former president from higher education who understood the hierarchy of the university and an emergency medicine physician who looked into the management of injuries and fatalities post event.\textsuperscript{12} Immediately after the tragedy, we had Tom Ridge, who really helped us work through some of the politics and the bureaucracy of our work.\textsuperscript{13} Probably one of the most important members of the Panel was Carol Ann Ellis, who turned out to be one of the strongest advocates for the families.\textsuperscript{14} She did a wonderful job of talking to the families and I have learned so much from her in how to handle a variety of situations.

I will quickly go through the work of four months by distilling it into twenty minutes. Many of you have read the report and so probably are familiar with the life of Seung-Hui Cho: his early childhood, his move from Korea to this country, and the fact that he was described very much as a loner, a very quiet child who had a significant amount of anxiety, and who, in his middle school years, was identified as needing mental health intervention.\textsuperscript{15} And, as has been pointed out before, despite the cultural issues, these parents were very adept at getting his mental health needs met at the multicultural center up in Northern Virginia, where he received mental health services for a long period of time.\textsuperscript{16} It was in his eighth grade year, while he was being seen in play therapy, that he utilized modeling clay and art work as part of the therapeutic work in the clinic.\textsuperscript{17} It is an unusual thing for someone as old as that to use play therapy as a mode for treatment.\textsuperscript{18} He was not verbal and he began to look more and more depressed.\textsuperscript{19} His therapist noted that change.\textsuperscript{20} Within two months of that the Columbine massacre occurred, he wrote within one of his essays that he and their different backgrounds).

\begin{enumerate}
\item See id. and accompanying text.
\item See id. at viii (acknowledging the efforts of Panelists such as Tom Ridge).
\item See id. at 142 ("The governor designated Carroll Ann Ellis as the Panel’s special Family Advocate.").
\item See id. at 21 (presenting a timeline documenting the early part of Cho’s life).
\item See id. at 21–22 (describing Cho’s experience receiving therapy at the Multi-Cultural Center for Human Services).
\item See id. at 34 (stating that Cho’s therapist used techniques such as "clay modeling, painting, drawing, and a sand table at each session").
\item See id. ("Typically, this form of therapy is used with younger children who do not have sufficient language or cognitive skills to utilize traditional ‘talk’ therapy.").
\item See id. (noting that Cho lacked sufficient verbal skills and persisted in isolating himself during middle school).
\item See id. at 35 ("[H]is art therapist observed a change in his behavior.").
\end{enumerate}
wanted to "do a Columbine" in school. The guidance counselor and his teacher suggested he see a therapist. The therapist was asked to follow up on this issue, and recognizing the depression, referred him for psychiatric help. He was put on Paroxetine, an antidepressant, and diagnosed with depression along with the previous diagnosis of selective mutism. He responded very well to that, and within eleven months was taken off the medication because he was looking brighter and no longer depressed. He went on to high school, graduated with a 3.58 GPA, with a number of accommodations put into place, continued therapy into his tenth grade year and then stopped. In repeated conversations with the counselors in the high school, they felt that he had achieved academic success. Their only suggestion to him was not to go into a large school like Virginia Tech in Blacksburg, Virginia, because he would get lost in the crowd. He was provided with the name of someone he could contact in case he ran into trouble, which obviously he did not at that point, but there was recognition of the fact that he would get into academic and emotional trouble in a large school such as Virginia Tech. Nevertheless, because he had the requisite grades for admission, they accepted him, and he enrolled at Virginia Tech.

Freshman year went pretty well for him, other than the fact that his parents would visit him every weekend. They were concerned about a

21. See id. (describing that Cho’s essay indicated his desire to replicate the events of Columbine).
22. See id. ("The family was urged to have Cho evaluated by a psychiatrist.").
23. See id. (stating that Cho’s therapist reached out to a psychiatrist for Cho after conducting a therapy session).
24. See id. ("The doctor diagnosed Cho with ‘selective mutism’ and ‘major depression: single episode.’ He prescribed the antidepressant Paroxetine.").
25. See id. (describing the positive results Cho experienced from the new treatment and the resulting decision of his psychiatrist to stop the use of medication).
26. See id. at 22 ("Cho graduate[d] from Westfield High School with a 3.5 GPA in the Honors Program.").
27. See id. at 37 ("In the eleventh grade, Cho’s weekly sessions at the mental health center came to an end.”).
28. See id. at 39 ("His high school guidance counselor felt that his high school career was a success.”).
29. See id. at 37 (describing the recommendation of Cho’s guidance counselor for him to attend a small school near home out of concern for Cho’s ability to transition in a large school like Virginia Tech).
30. See id. and accompanying text.
31. See id. ("[Cho’s] GPA, along with his SAT scores (540 for verbal and 620 for math registered in the 2002 testing year) were the basis for acceptance at Virginia Tech.").
32. See id. at 40 (stating that Cho’s parents visited every Sunday during his first
roommate who was drinking too much, because they would see the beer cans in the trash. Their basic focus was trying to get him into another room in the dorm, which was achieved by the second semester of his freshman year. At that point, the visits began to drop off. He had a 3.0 GPA in his freshman year. Sophomore year is when he decided that he wanted to change his major and go into creative writing. He seemed very excited about this. His high school counselors were very surprised when we actually interviewed them about this choice, as he was always recognized for his acumen in the sciences. His move to creative writing was something he decided independently. His parents and sister were interviewed and the sister was the main person I spoke to as she served as the interpreter and a person who gave us insight into what type of a person he was. Needless to say that his interest in writing delighted his family because they felt that he had found a focused interest. His sister would frequently see him on a computer, typing away, and he had seemed to find a passion.

As we all know, much of the psychological autopsy after his death was patched together piecemeal because of the fact that we do not have much information after his death. We believe the summer between his sophomore and junior year is when the trouble began. He received a rejection letter from a New York publishing house, at which point, although

33. See id. (describing the beer cans that Cho’s parents observed in his dorm room).
34. See id. (noting that Cho received his requested room change at the start of his second semester).
35. See id. (“Parental visits became less frequent.”).
36. See id. (listing Cho’s freshman courses and his ultimate achievement of a 3.00 GPA).
37. See id. (“He became enthusiastic about writing and decided he would switch his major to English beginning the fall semester of 2005.”).
38. See id. and accompanying text.
39. See id. (“English had not been one of his strongest subjects in high school.”).
40. See supra note 37 and accompanying text.
41. See id. at 31 (“Cho’s sister, Sun, interpreted the answers to every question posed to Mr. and Mrs. Cho.”).
42. See id. at 41 (“His family was thrilled that he found something he could be truly excited about.”).
43. See id. at 22 (noting that Cho’s sister observed that he seemed very passionate about writing).
44. See generally Ian Urbina, Va. Tech Gunman’s Mental Health Records Found, N.Y. TIMES, July 22, 2009 (noting that Cho’s mental health records were unavailable for the investigation following the 2007 shooting).
he had switched his major to creative writing, he returned to Virginia Tech that fall and began to have difficulty. One assumes that the rejection from the New York publishing house set into motion his response, which was getting more and more depressed and unhappy and dark in his thinking. This is what Eileen Ryan had been pointing out: the diathesis for emotional problems based on one’s temperament and the stressor that precipitates the illness, a combination of the two produces a perfect storm. And as we began to piece together the information from the fall of his junior year, this is when the telltale signs of the problem began, which Dr. Roy referred to. His behavior was unraveling in the classroom and he was taking cellphone photographs of female students who were getting more and more anxious and reporting it to the faculty. In fact, this was the first time that Nikki Giovanni, English professor at Virginia Tech, noted that attendance in her classroom was dropping. When she interviewed some of the female students they said they were afraid of this guy who wore a hat and was taking photographs of them. Graphically violent writings began to show up in creative writing classes, stalking behavior began, and odd behaviors with a suitemate were noted in which he took knives and would poke at the carpet. His suitemates began to shun him, refusing to invite him with them because they were embarrassed and also afraid of him.

There were plenty of unusual behaviors that were popping up here and there, which were being pointed out by faculty and that came to the attention of the Care Committee at Virginia Tech. Professor Lucinda

45. See id. at 41 (describing the negative events following Cho’s receipt of the rejection letter).
46. See id. ("Cho would become known to a growing number of students and faculty not only for his extremely withdrawn personality and complete lack of interest in responding to others in and out of the classroom, but for hostile, even violent writings along with threatening behavior.").
47. See id. ("The fall semester of Cho’s junior year (2005) was a pivotal time.").
48. See id. at 43 (describing Dr. Giovanni’s discovery that Cho took unauthorized cell phone pictures of students).
49. See id. at 42 ("Dr. Giovanni began noticing that fewer students were attending class.").
50. See id. at 42–43 (noting that Cho disrupted Dr. Giovanni’s class by taking pictures of other students and also by wearing a hat).
51. See id. at 42 (describing Cho’s disturbing behavior in Dr. Giovanni’s class and in the dormitories).
52. See id. (noting that after several odd encounters with Cho, his roommates started to distance themselves from him).
53. See id. at 43 ("The concern about Cho was brought before the university’s ‘Care Team.’").
Roy, chair of the English department, was the one who offered and actually did the one-on-one tutoring so that he would not create a fearful environment for the class. 54 Rather than saying that he needed to quit the creative writing class, she probably felt that if she were to give him more one-on-one attention, things might turn around. It is critical to note, before the records were found in the home of Dr. Miller, former director of Cook Counseling Center (CCC), that there were three contacts with the CCC in which three "triages" were done. 55 The triages primarily gathered the demographic information, and the recent records that revealed the December 14th, 2005 contact also did not have any depth as far as the psychiatric assessment. 56 They noted that he had been committed and so on and so forth, but beyond that, the information lacked usefulness. 57 Based upon the progress and lack thereof, the English department was really pushing this young man to get help as he was having significant problems. 58 But as we looked at the records, we saw that there was a lack of communication and a lack of connecting the dots between the Care Committee, CCC, faculty, and peers of Seung-Hui Cho. There was no action from Cook Counseling or Judicial Affairs for the photos, emails, et cetera, meaning that no one was able to put all of these things together. 59 The sentinel event, which led to the commitment to Carilion hospital, was based upon a negative interaction of Cho with a suitemate. 60 The suitemate’s father was a friend of the local police chief. 61 The police chief sent out someone who evaluated Cho, who in turn stated, probably

54. See id. at 44 (commenting that Dr. Roy agreed to privately tutor Cho as an alternative to Dr. Giovanni’s class).
55. See id. at 23 (listing the three different periods over fifteen days that Cho was triaged by the Cook Counseling Center).
56. See id. ("The staff psychiatrist dictates in his evaluation summary that ‘there is no indication of psychosis, delusions, suicidal or homicidal ideation.’ The psychiatrist finds that ‘his insight and judgment are normal. . . . Followup and aftercare to be arranged with the counseling center at Virginia Tech; medications, none.’").
57. See id. and accompanying text.
58. See id. at 43 ("Dr. Roy contacted the Dean of Student Affairs, Tom Brown, the Cook Counseling Center, and the College of Liberal Arts with regard to the objectionable writing that Dr. Giovanni showed Dr. Roy.").
59. See id. at 52 (discussing the failure of the different resources in position to help Cho to see the warning signs and communicate with each other).
60. See id. 46–47 (describing the disturbing communications one suitemate received from Cho and the events that followed).
61. See id. at 46 ("The father spoke with his friend, the chief of police for Christiansburg, who advised that the campus police should be informed.").
mortified, that, "I might as well kill myself," after the police accosted him.62 At this point, the loop was closed. A prescreener came in to assess him and he was hospitalized at Carilion.63 Basically the community service board pre-screener’s (LCSW) write-up is probably the most comprehensive about Cho’s mental status at that time.64 The use of the collateral information from the suitemates as well as the reason for the concern is probably what gives us a very good snapshot of what was going on with him. Fortunately, a psychiatric bed was found very quickly,65 because that’s one of the gaps in the mental health system nationally.66 A TDO (Temporary Detention Order) was issued and he stayed there overnight.67 He was given a diagnosis of mood disorder NOS (Not Otherwise Specified).68 To treat this, he received one dose of Ativan, which is typically given to calm someone down.69 He then was seen by an independent evaluator (a psychologist) who spent about fifteen minutes with him.70 The decision was made to discharge him.71 The special justice on the case, whose previous background was in social work, was concerned enough that he committed him to ordered outpatient psychiatric treatment.72 As we all know, those of us who work in the mental health system, you can mandate outpatient [OP] treatment, but there is no enforcement mechanism to assure that outpatient

62. See id. at 47 ("Following the visit from the police, Cho sent an instant message to one of his suitemates stating, ‘I might as well kill myself.’").
63. See id. at 47 (stating that after a prescreener interviewed Cho, she recommended that he be hospitalized at St. Albans Behavioral Health Center of the Carilion New River Valley Medical Center).
64. See id. (noting that the prescreener’s report indicated that Cho was "mentally ill, was an imminent danger to self or others, and was not willing to be treated voluntarily").
65. See id. (commenting that the prescreener successfully located a psychiatric bed for Cho).
66. See id. at 56 (describing mental health professionals’ concern "that often psychiatric inpatient bed space is not available within the 48 hours").
67. See id. (noting that after the magistrate issued a TDO, Cho spent the night at the hospital).
68. See id. ("The diagnosis on the admission orders was ‘Mood Disorder, NOS’ [non specific].").
69. See id. ("Ativan was prescribed for anxiety, as needed.").
70. See id. ("The evaluator . . . believes that the independent evaluation took approximately 15 minutes.").
71. See id. (noting that the psychiatrist decided Cho should be treated with outpatient counseling).
72. See id. at 48 ("The special justice ruled that Cho ‘presents an imminent danger to himself as a result of mental illness’ and ordered ‘O-P’ (outpatient treatment) ‘—to follow all recommended treatments.’").
WHAT THE GOVERNOR’S PANEL LEARNED

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treatment will occur. This remains a controversial area. Commitment for mental health service delivery as an OP venue remains difficult to implement in Virginia and nationally.

The data utilized during the psychiatric assessment of Cho at Carilion was primarily the patient self-report. Mental health professionals know that the vast majority of the work that goes on in making an assessment about an individual is very much based upon collateral data, because that collateral data really informs the process of how you are formulating the case. If we focus our attention primarily on the cross-sectional mental status exam, we are going to get a very finite assessment. A good psychiatric assessment needs to take collateral information from individuals who know the patient well, and that does require a great deal of time. So, there was no corroborative data gathered, the patient reported no drug or alcohol abuse, which is usually a red flag for problems. What was really missing was the lack of collateral information from police, the suitmates, and the prescreener. There was no direct contact with the attending physician, a typical phenomenon. The mission of the attending psychiatrists and the independent evaluators are totally different. A shared vision of what we were trying to achieve is missing, and there is a

73. See id. at 59 ("There is no contempt provision in the Virginia Code for those noncompliant with involuntary outpatient orders.").
74. See id. at 58–59 (describing the disagreement over what additional guidance should be given to supplement existing standards for outpatient treatment orders).
75. See generally id.
76. See id. at 22 (noting that "[a] staff psychiatrist at Carilion evaluat[ed] Cho, conclude[d] he [was] not a danger to himself or others, and recommend[ed] outpatient counseling. [The doctor] gather[ed] no collateral information").
77. See id. at 52 ("[C]hecking for collateral information . . . help[s] determine if [an] individual truly pose[s] a risk or not.").
78. See id. at 55 (emphasizing that a four-hour cross-sectional mental exam does not allow "sufficient time to gather meaningful collateral information from family, friends, or other health care providers nor to secure proper evaluations for medical clearance").
79. See id. at 48 ("The psychiatrist also said that the time it takes to gather collateral information is prohibitive in terms of existing resources.").
80. See id. at 48 ("The psychiatrist’s conclusion was based in part on Cho’s denying any drug or alcohol problems or any previous mental health treatment.").
81. See id. at 56 ("[T]he independent evaluator for Cho had only the report from the CSB [Community Service Board] pre-screener and no collateral information or medical records.").
82. See id. ("As for the relationship between the independent evaluator and the staff psychiatrist, they rarely see each other and they function independently.").
83. See id. ("The role of the independent evaluator is to provide information to the court and the job of the attending psychiatrist is to provide clinical care for the patient.").
great deal of importance given to the assessment of the independent evaluator and not to that of the attending physician, as the patient’s rights are protected by the independent evaluator while the attending physician focuses on clinical care. There is this great discrepancy of opinions of how to assess the patients’ functioning during the commitment process. When we interviewed the psychiatrist who had worked on this particular case, his feedback to us was that the privacy laws prevented him from gathering collateral data. This is very typical of what psychiatrists say. It is common to have no contact with the independent evaluator either because these two roles are very different. To add to the problem, surrounding universities around Virginia Tech also have threadbare OP resources for mental health. Therefore, when a hospital comes up with a treatment plan, the likelihood of it being followed through is very low. There is a lack of outpatient providers in both the private and public sector, a finding endorsed by the report from the OIG’s office.

Of course the records are available, but there was confusion regarding who would follow Cho upon discharge. We do know that commitment information was provided to CCC; Cho was asked to make the appointment because CCC policy was that it would not accept any involuntary patients.

84. See id. at 48 (noting that “privacy laws impede the gathering of collateral information”).

85. See No Right to Remain Silent, supra note 3, at 72 (“It was a violation of state and federal laws to make public a student’s health and academic records. But . . . had the administration taken it upon itself to lobby aggressively for a suspension of those laws, given the scale of the tragedy, they would have received unanimous support.”).

86. See Virginia Tech Review Panel, supra note 1, at 65 (discussing both HIPAA and Virginia state law, and noting that health information is private and can only be disclosed in exceptional circumstances).

87. See id. at 48 (describing the difference between psychiatrists and independent evaluators).

88. See id. at 2 (“Virginia’s mental health laws are flawed and services for mental health users are inadequate. Lack of sufficient resources results in gaps in the mental health system including short term crisis stabilization and comprehensive outpatient services.”).

89. See id. at 48 (“The lack of outpatient providers who can develop a post-discharge treatment plan of substance is a major flaw in the current system.”).

90. See id. at 54 (emphasizing that Virginia should study the community needs and related costs of outpatient service necessary, and that “[o]nce this information is available it is recommended that out-patient services be expanded statewide”).

91. See id. at 58–59 (summarizing the conflicting reports, noting “[a]n appointment had been scheduled by Cho with the assistance of the clinical support representative for St. Albans. The representative . . . faxed a copy of the discharge summary to Cook. Cook . . . contends that they did not receive any written documentation until January”).

92. See id. at 48 (noting that it was a recent "practice" to have students be on the
He got there and he kept his three o’clock appointment at CCC, and at that point in time a small sort of passage indicates that they were aware of the commitment. Then, Christmas break came and there was no follow-through. There was no follow-up of this individual. They had no idea that there were parents who knew what was going on, and essentially in the spring of 2006 to April 16, 2007, there were new problems in two of his English classes. Incidents of threatening teachers, especially on April 16, 2006, in which there was an allusion to the Holocaust in one of his essays, and that information was reviewed by the professor in the English department. This was again not tied to previous incidents, again underscoring the lack of a trickle-up or trickle-down phenomenon that is essential for tying together relevant information to form an opinion about this rather aberrant behavior in a student. There was no Care Committee involvement and no information was shared with the parents either. The reason why that is so important is illustrated by elements of this story that almost run like a controlled experiment. We have a history regarding Cho as a middle and high school student who at the time had very similar problems to his time at Virginia Tech, but with appropriate interventions was able to overcome whatever emotional difficulties he was experiencing and was reasonably successful; while in college, there were no interventions tried to address his regression. And as we saw, the results

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93. See id. at 23 (noting that on December 14, 2005, Cho "made and kept" an appointment with the Cook Counseling Center).

94. See id. (stating that in January the Cook Counseling Center received a psychiatric summary from St. Albans, after which "no action" was taken by Cook Counseling Center or the Care Team to follow up on Cho).

95. Id.

96. See id. at 22 (referring to the parents of several female students whom Cho harassed).

97. See id. at 23 (referring to problems with Professor Carl Bean and Professor Lisa Norris).

98. See id. (referring to a conversation between Professor Bean and Cho, during which Cho "followed" the professor to his office, raised his voice angrily, and [was] asked to leave); see also id. at 51 (noting that "in [an] April 16 letter Cho wrote numerous times that Bean 'went Holocaust on me'"").

99. See id. at 2 ("During Cho’s junior year . . . numerous incidents occurred that were clear warnings of mental instability. Although various individuals and departments within the university knew about each of these incidents, the university did not intervene effectively. No one knew all the information and no one connected the dots.").

100. See id. at 43 ("At the Care Team meeting . . . [t]he perception was that the situation was taken care of and Cho was not discussed again by the Care Team. The team made no referrals of Cho to the Cook Counseling Center. The Care Team did nothing.").
were disastrous. The parents were asked what would they have done had they come to know that their son was committed to a hospital for suicidal thoughts, and their response was a definite "we would have taken him out of the school and we would have got treatment for him." And there again, hindsight is always 20/20, nevertheless, there’s no reason to suspect that that would not have happened because despite their immigrant status and cultural background, these parents had been able to find him the kind of treatment he needed in the past.

Spring of 2007 he amasses the ammo, the firearms, and the rest of the events we all know about. How did this happen? What were Cho’s specific issues? What were the system failures? Are these code failures? Where did these failures reside? And what can be learned, and how does that inform policy, is what the work of the Panel really focused on. As far as the role of the university, basically no one connected the dots to pick up on the danger signals. The question of the loco parentis role of the university versus the notion of emancipated young people who need no adult interference is a major policy struggle for universities. This is something that we have talked about this morning, so I will not belabor it, but it is a big issue because, transitionally, we are dealing with older adolescents rather than young adults, who have, in theory based on chronological age, achieved maturity, but psychologically may be quite vulnerable to the stress of transition and becoming independent of previously existing support systems. It is necessary that universities

101. See id. at 36–38 (detailing the history of Cho’s successful mental counseling during his high school years).

102. See id. at 49 (quoting Cho’s parents as saying, "We would have taken him home and made him miss a semester to get this looked at . . . but we just did not know . . . about anything being wrong").

103. See id. ("From [Cho’s parents’] history during the high school years, we do know that [Cho’s parents] were dedicated to getting [Cho] therapy consistently and also consented to psychopharmacology when the need arose.").

104. See id. at 24 (describing the process by which Cho acquired his weapons and ammunition).

105. See id. at 3 (highlighting Report’s "Findings of Fact" that noted "[n]o one [in the Virginia Tech administration] knew all the information and no one connected the dots").

106. See NO RIGHT TO REMAIN SILENT, supra note 3, at 278–84 (summarizing the conflict between an attempt at in loco parentis on behalf of a university versus a young adult’s need for autonomy and independence).

107. See id. at 278 (noting that on college campuses the "lack of a stable, nurturing community that foster[s] interaction with older people can mean that a young person may have little guidance from anyone").
recognize this and have a coherent policy to address these issues. On the role of the Care Committee, I have to say that when Virginia Tech presented its Care Committee to the Panel, on paper it looked terrific. However, in reality, the kind of information that I was getting from faculty who we interviewed, and from parents of students who had left Virginia Tech because of substance abuse or mental health problems, did not reflect that this university was responsive to psychological issues that their student body was grappling with.

My personal goals regarding using the Virginia Tech tragedy were to look at the system’s gaps in mental health, because that is really the larger system’s issue that trickles down to a campus such as Virginia Tech, and that this tragedy focuses the national eye on the overall system’s gaps in mental health. We all know now that since the tragedy, the TDO commitment process has been changed. It moved from imminent dangerousness to significant risk because Virginia has been very stringent in defining imminent risk and hence many individuals did not receive the type of care needed when they were critically ill. This gives a lot more flexibility in a person meeting criteria for a commitment. Certainly the safe harbor provisions, that when information is provided with good faith, information should be shared, have also helped with inter-professional information sharing. The safe harbor provisions help in reducing the fear around HIPPA and FERPA. Now, I do think that the risk assessment for

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108. See id. at 281 (suggesting that "open communication" is the "best approach," not only "in defense" against student attacks on schools, but also as a means for parents to know and guide their children through this difficult transitional period).

109. See VIRGINIA TECH REVIEW PANEL, supra note 1, at 2 (acknowledging that in the situation of Cho, as in others, "the university’s Care Team failed to provide needed support and services," due to "lack of resources, incorrect interpretation of privacy laws, and passivity").

110. See NO RIGHT TO REMAIN SILENT, supra note 3, at 293 ("In April 2008, less than a year after the shootings, Governor Kaine signed omnibus mental health bills to reform and fund strained mental health services, [and] adjust legal commitment criteria.").

111. See VA. CODE ANN. § 37.2-808 (2010).

112. See NO RIGHT TO REMAIN SILENT, supra note 3, at 294 ("The new legislation should result in a more coordinated and thoughtful response to troubled students, particularly as it relates to such things as the sharing of information, commitment criteria, student records, and parental notification.").

113. See VIRGINIA TECH REVIEW PANEL, supra note 1, at 68 (emphasizing the importance of "safe harbor" provisions in privacy laws that "insulate a person or organizations from liability . . . for making a disclosure with a good faith belief that the disclosure was necessary to protect the health, safety, or welfare of the person involved or members of the general public").

114. See NO RIGHT TO REMAIN SILENT, supra note 3, at 171 (noting that schools
violence in institutions through threat assessment teams should be considered important in campus life. This issue has to be approached in a systematic way. One framework could be viewing this from a primary, secondary, and tertiary prevention model that includes a student, faculty, and staff code of conduct, against which students’ behavior ought to be assessed. Faculty are not therapists and they are not mental health counselors, but they need to be able to recognize aberrant behavior when it does occur, and there needs to be some sort of a feedback loop to the dean of students affairs or some entity that takes on the administrative burden of ensuring that the issue gets addressed through a team with expertise in triaging the student to the appropriate resource in the university. It is very important for faculty mentors who have identified an issue that a feedback loop be in place that acknowledges that an action has been taken. The communication should not divulge the details of the intervention. But it is essential that the faculty know that something has been done. Now, when the student comes back, and the aberrant behavior continues on, then the faculty needs to determine, based on whether the student’s behavior falls within the range of acceptable student code of conduct, whether they are going to dismiss the student from the class, or go revisit the issue with the dean of students. The university should create a watertight—but just—loop of communication in which the roles of these individual entities, including a student, are made clearer and explicit, all tied to an acceptable code of conduct. The dean of student affairs or the administrative body should be expected to triage the individual through threat assessments to a counseling setting or the police, but the bottom line is to hold faculty, staff, and students all to a code of conduct on campus. Human resources for staff code of conduct, faculty through ratings on professionalism in their performance evaluation, and students by the dean of students, would create a culture on the campus that will promote safety. I feel that these mechanisms and ways of organizing campus life in which mental health is approached in the same way as physical health will be important to the evolution of a responsive and safe culture within a university.

There is an intense amount of heavy lifting that we as a nation have to do around the issue of campus mental health. Not only campus mental

115. See id. at 143 (quoting a New York Times article on the Virginia Tech shootings, noting that neither teachers nor the university are a "part of the mental health system").

116. See VIRGINIA TECH REVIEW PANEL, supra note 1, at 54–60 (providing a detailed
health, but mental health in general, because as has been said before, this is an incident that can occur anywhere.\footnote{See \textit{No Right to Remain Silent}, supra note 3, at 296 (emphasizing the global nature of mental health problems and the easy spread of ideas, noting "the problems we face here are being encountered elsewhere . . . "). "[Movies and the Internet] have enabled a kind of ideological miscegenation . . . . A young man in Finland can watch videos posted by a young man in Virginia." \textit{Id.}} Refining how we go about screening and intervening when incidents arise from emotional and behavioral issues will help us take a step towards preventing sentinel events and tragedies such as this event and mature as a nation. The linking of physical health with mental wellbeing is an integral part of the health reform that we are contemplating as a nation. Unless we link the two together, mental health will always remain stigmatized, and will not get the kind of place it deserves as we consider resource allocation.

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list of recommendations of how to improve campus mental health, put forth by the review Panel).

117. See \textit{No Right to Remain Silent}, supra note 3, at 296 (emphasizing the global nature of mental health problems and the easy spread of ideas, noting "the problems we face here are being encountered elsewhere . . . "). "[Movies and the Internet] have enabled a kind of ideological miscegenation . . . . A young man in Finland can watch videos posted by a young man in Virginia." \textit{Id.}