AN ORAL HISTORY EXPLORATION OF CHANGE AT THE UNIVERSITY OF KENTUCKY FOLLOWING THE VIRGINIA TECH SHOOTING

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Digital Object Identifier: https://doi.org/10.13023/etd.2019.007

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AN ORAL HISTORY EXPLORATION OF CHANGE
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DISSERTATION

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A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Education
at the University of Kentucky

By
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Lexington, Kentucky

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Lexington, Kentucky
2019

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ABSTRACT OF DISSERTATION

AN ORAL HISTORY EXPLORATION OF CHANGE AT THE UNIVERSITY OF KENTUCKY FOLLOWING THE VIRGINIA TECH SHOOTING

Following the mass shooting at Virginia Tech on April 16, 2007, institutions of higher education appeared to restructure themselves and change the way that they worked with students who may pose a risk to self or others. They formed committees, sometimes known as Communities of Concern, to help review these concerns and respond appropriately. The purpose of this study was to examine how the Community of Concern Committee at the University of Kentucky was developed following the incident at Virginia Tech. Particular attention was focused on the change and learning that took place. Using the frames of single-loop and double-loop learning, this study examined six oral history accounts of the development of the Community of Concern Committee at the University of Kentucky. The oral histories coupled with historical documents provided a timeline of events related to the development of the committee. In addition, the oral histories revealed a complex learning process which blended single and double-loop learning to guide this institutional change. The comparison between this incident and other legal issues within higher education was explored as well as the opportunity to expand this exploration outside of the current case study.

KEYWORDS: Student Affairs, Virginia Tech, Higher Education Law, Community of Concern, Organizational Change

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AN ORAL HISTORY EXPLORATION OF CHANGE
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DEDICATION

To Jay, Thomas, and Thea.
ACKNOWLEDGEMENTS

I first want to acknowledge the victims of the Virginia Tech shooting as well as their families and friends. It is my hope that this work plays a small part in helping to prevent another horrific tragedy. I also want to thank the six individuals who shared their oral histories regarding their work in creating organizational change at the University of Kentucky. Without their stories, this dissertation would not have been possible.

Many thanks for the support of my dissertation committee members: Dr. Kathi L. H. Harp for kindly agreeing to serve as my outside examiner and providing cross-disciplinary perspective; Dr. Douglas A. Boyd for generously sharing his love of oral history and guidance with methodology; Dr. Willis Jones for pushing me to consider things from multiple theoretical views and sharing his scholarly expertise; Dr. Michael Covert for reminding me to connect to my practitioner roots and for being a part of the process from my start as an undergraduate student to the very end; and Dr. Jane Jensen who I will never be able to repay for her patience, wisdom, expertise, and support as well as her willingness to have confidence in me when I often did not have it in myself. In addition to these amazing scholars, I want to thank Dr. Neal Hutchens who sparked my love of learning, provided mentorship and opportunities for educational and professional growth, and stuck with me to the very end. Thank you all for investing in me.

There is absolutely no way that I can thank each person who provided support and encouragement along the way; I have been lucky that there have been many. However, I do want to recognize my supportive supervisors, Dr. Scott Kelley and Adrienne McMahan, who provided me the opportunity and space to do this as well as Dr. Brendan O’Farrell and Robert Hayes who have traveled the educational path with me. Without Dr.
Casey Shadix and Dr. Sarah Ballard, I do not think I could have done this. Their constant support and words of wisdom were transformative.

I want to thank my mom, Donita Lodmell; brothers, John, David, James, and Matthew; and sisters, Carlene and Darlene, for instilling in me the importance of education. Even though he could not be here, I know my dad, Dr. John D. Lodmell, would be proud of this work and I thank him for watching out for me from above.

Lastly, I want to thank Jay, Thomas, and Thea. You all were what kept me going. I wish I had better words to express how much you all have meant to me on this journey and I hope that you know how much I appreciate the love, patience, and support you have shown. Jay, thank you for always finding a way to make this possible.
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CHAPTER ONE: INTRODUCTION

On April 16, 2007, Seung Cho, a student at Virginia Polytechnic Institute and State University (Virginia Tech) in Blacksburg, Virginia, entered a residence hall on campus and killed two people with a gun. After cleaning himself up, he went to the post office to mail letters to various individuals detailing his contempt and negative feelings towards his fellow students and a faculty member in the English Department at Virginia Tech. Cho deposited the letters and returned to campus. He entered an academic building and opened fire, killing 32 people and wounding 17 more. As police began their intervention, Cho ended his life (Davies, 2008; Jenson, 2007).

Cho’s actions devastated the Virginia Tech community. Everyone on campus mourned the loss of students and faculty and they hoped for healing among not only those injured during the attack, but also those left without visible wounds. They sought answers as they wondered why one of their own would hurt other people. With resolve, campus leaders searched for ways to keep this from ever happening again. The institution began its own probe into the incident. At the same time, state and federal authorities conducted their own investigation. Again, the overwhelming question was why Cho committed such a horrific act.

Although, that question can never be answered, investigators tackled another important question: could this violent incident have been prevented? Investigators looked to the past hoping to find some insight into how to prevent this type of targeted violence (Drysdale, Modzelski, & Simons, 2010). The results of these investigations had implications far beyond the hills of Blacksburg. Across the nation, in places of higher
learning, corporate America, and the private sector, people wanted to ensure such violent acts never happened again.

To understand the institutional response, it is important to understand the history of violence on college campuses. It was not that Virginia Tech was the first time that violence had ever occurred on campus, but the circumstances and scale of the incident that made it significant in the higher education community. This study will provide that context as well as an examination of how the incident impacted one particular institution in terms of the way that they approach supporting individuals who may be at risk to themselves or others. This examination will include documenting the historical timeline of the institution’s response as well as an exploration of how the institution changed as a result of the information it gathered regarding how to make decisions involving these types of campus issues.

**History of Violence in Higher Education**

The history of violence on college campuses is lengthy and unfortunately dates back to the early beginnings of the academy. American higher education history includes ebbs and flows of student unrest, protests, and violence (McGee & Platt, 2015). Examples date back to 1825 at the University of Virginia when students protested the arrival of European administrators instead of “American” administrators and to 1845 when students threw rocks and sticks at the faculty chair’s home and rode through campus on horseback shooting pistols into the air following their suspension from the institution (McGee & Platt, 2015; Pace, 2011). These early incidents rarely ended with fatalities and mostly centered on campus protests or unrest.
A 2007 report to the President of the United States analyzed the Virginia Tech incident and recommended a joint project to examine the history of fatal violence in higher education. The United States Secret Service, the United States Department of Education, and the Federal Bureau of Investigation collaborated to develop a context to understand the scope of targeted violence in higher education. The goal was to identify ways to prevent future attacks. This group reviewed 272 incidents of violence that had occurred at higher education institutions between 1900 and 2008 in an attempt to understand any patterns, potential risk factors, and/or potential triggers (Drysdale et al., 2010). The report did not include the campus or university names where the incidents took place.

Their historical investigation of violence on college campuses included two incidents where the victim was clearly identified as the target for the violent act. The first fatal incident on April 29, 1909, involved a man who shot his former girlfriend after she refused his marriage proposal and then took his own life. Though he was not a student at that institution, he did carry out his act of violence at the campus where she was a student. The second incident of targeted campus violence was a shooting perpetrated by a faculty member on April 25, 1950. The report describes a professor who shot and killed the president of his institution as well as his department chair for his belief that they were going to fire him. The professor also ended his life. Unlike the incident at Virginia Tech, these two shooting incidents targeted specific individuals.

The history of violence on campus detailed in this report also included incidents like that which was seen at Virginia Tech where the campus community was targeted. A 1966 incident at the University of Texas-Austin campus involved Charles Joseph
Whitman, a student and former United States Marine, who seized the observation tower on campus and fired at individuals below the tower for over an hour-and-a-half before police shot and killed him. His attack began just after midnight on the same day when he stabbed both his mother and his wife. Thirteen people were killed and thirty-one others were injured as a result of his shooting spree on campus (Prescott, 2008).

A 1970 incident at Kent State marked the next major incident of campus violence, (Hall, 1985; McGee & Platt, 2015; Pusey, 2017) but this incident was a bit different from those that had previously occurred on college campuses. The incident began like those mentioned from the 1800’s wherein the catalyst for the violence was students protesting, but the shooting came from officials and not citizens or students. Students across the United States were protesting the war in Vietnam and more specifically the entrance of troops into Cambodia. Student protests at Kent State University in Ohio became particularly intense and resulted in property damage to the downtown area. Though students returned the next day to clean up the mess, Governor James Rhodes determined that the presence of the National Guard was necessary.

Instead of calming the student protests, the presence of the National Guard lead to even more unrest and property destruction. When a fire broke out at the ROTC building on the Kent State campus, protestors interfered with efforts to stop the blaze by cutting fire hoses. Things eventually came to a head on May 4, 1970, when a National Guard officer attempted to break up protestors with tear gas. What started the next sequence of events is still unclear, but the National Guard fired sixty-seven rounds into the student crowd. Four were killed, nine others were injured, and protestors across the country were further enraged by this incident.
This turbulence had polarized much of American society and served as a background to the most massive outpouring of student dissent in American history. In the first week of May 1970, nearly five hundred colleges and universities were shut down, either by their administrations or by the students themselves, in reaction to the Cambodian invasion and the deaths at Kent State. (Hall, 1985, p.36)

This incident resulted in a $750,000 settlement between the state of Ohio, the families of those killed, and the individuals who were injured (Pusey, 2017).

At this same time and in reaction to the shootings at Kent State, the War in Vietnam, and a climate of civil rights tension, another act of violence against students took place on May 14, 1970, at Jackson State University in Jackson, Mississippi. In response to a string of fires on campus, police encountered a crowd of students. It was reported that the sound of a bottle breaking lead officers to believe that a gun had been fired, but it is still unclear and up for debate as to exactly what happened. Police opened fire on the crowd, killing two and wounding eight. The officers were acquitted and no settlement was awarded (McGee & Platt, 2015).

The next three incidents of violence on campus involved a member of the campus community (current student, former student, or employee) targeting people in retaliation (Drysdale et al., 2010). On October 6, 1979, a student opened fire at a fraternity party injuring five. The student reported that he was upset that his cover charge was not refunded after police broke up a party at the same fraternity house two weeks prior. In a series of four shooting incidents, which spanned from February 1982 to August 1982, a former student killed three and wounded one other. The incidents took place at campus
bathrooms and a bus stop on campus. The shooter held neo-Nazi beliefs and targeted his individuals based on those beliefs. Lastly, on May 4, 1983, a former employee of the campus library entered his previous place of employment, wounded the Director of Libraries, and attempted to shoot his previous supervisor. The individual had been an employee at the university library for 19 years and was upset that he had been let go three months prior to the incident. The incident ended with the individual’s surrender.

The next incidence of violence took place in 1986 and resulted in the murder of a Lehigh University student. A fellow student murdered Jeanne Clery in her residence hall room in Bethlehem, Pennsylvania on April 5th of that year. Her parents sued the university alleging that had Jeanne been aware of the thirty-eight previous violent crimes that had taken place in the area surrounding her place of residence, she would have taken more precautions for her safety (Wood & Janosik, 2012). The Clery family won the case against the university and eventually this lead the Jeanne Clery Disclosure of Campus Security Policy and Campus Statistics Act. This Act became a point of contention during the Virginia Tech trials and investigations and will be reviewed in more detail later in this chapter.

The next series of incidents of campus violence are all a part of the joint report from the U.S. Secret Service, The U.S. Department of Education, and the Federal Bureau of Investigation (Drysdale et al., 2010) mentioned earlier. The events are detailed below in chronological order.

- On August 12, 1986, a student killed one individual and wounded four more before surrendering to police. This individual targeted his laboratory supervisor
and members in the financial aid office. The student was in a dispute with financial aid for $717.

- On November 1, 1991, a disgruntled doctoral student who had graduated the previous May opened fire on campus. The student fatally wounded his academic advisor, the chair of his department, a professor, a previous roommate, and the Vice President for Academic Affairs. He also wounded a student assistant. The student was retaliating for the fact that his dissertation did not receive an academic award. The student believed that he not been treated fairly and was upset that he had not been able to find work. He ended the shooting incident by ending his life.

- From December 1991 to January 1992, an individual engaged in three separate shooting incidents. The motive behind the shootings is not certain but the incident involved an individual who had been denied admission to a graduate program four years earlier. While this may have been the motive for the attack, it could not be confirmed. The incidents took place on a university campus and resulted in one death, one injury, and ultimately the shooter’s death after police pursuit.

- On December 14, 1992, a student killed one professor, one student, and wounded four others. The incident began at a guard shack on campus and ended after the shooter made his way through campus to the library and later a residence hall. Police were able to end the incident when the shooter’s gun jammed. The motive for the shooting incident was not known.

- On January 16, 2002, a former student shot and killed the college's dean and a professor. The student was protesting his dismissal from the institution due to his
academic performance. He wounded three others and killed one student after he opened fire in a common area.

- **In October 2002**, a student entered a building on campus looking for three particular instructors. He ended up killing one in her office and shooting two other individuals in front of a class of students. The individual ended his life before police intervened. Though the violence was targeted, the motive was not certain.

- **On May 9, 2003**, an individual randomly fired shots throughout a campus building killing one and wounding two others. The individual was in search of a computer lab technician who he believed had hacked his website. The shooter also believed that the institution had protected the lab technician. Officers ended the incident by shooting and wounding the individual.

The next major episode of violence was the Virginia Tech incident. Since this event in particular is the focus of this study, I will spend some time detailing the facts and timeline of the event.

**Virginia Tech.** In many of the cases of campus violence previously mentioned, the individuals responsible for the shootings had been involved in a dispute with academic administration for disciplinary action or academic standing. The case at Virginia Tech is similar in that regard. In the time leading up to the Virginia Tech incident, faculty members and several other members of the academic community had reported concerning behavior from Cho including “stalking, taking cell-phone photos of female students during class, violent writing, and unwillingness to participate in classes” (Davies, 2008, p. 12; Reiss, 2010).
Cho’s problematic behavior had reached a point where a small group of faculty members had started discussing how to handle this student and had made two pleas to the administration at Virginia Tech to take action during the eighteen months leading up to the shooting (Reiss, 2010). In addition to faculty concerns, a female student on campus and one of Cho’s suitemates reported that Cho had stated he was going to kill himself. This incident led to Cho’s admission to a mental health facility in December 2005 under the belief that Cho was a danger to himself and others (Davies, 2008).

Cho was instructed to follow up with a counseling center after his time at the mental health facility and though he spoke with them several times, Cho never received treatment. He made one appointment with the counseling center but did not keep the appointment. Though he was required to receive treatment, his failure to obtain treatment was not communicated back to any courts or officials. The documentation surrounding Cho’s interactions with the counseling center were either lost or destroyed and a specific timeline of his communication could not be established (Davies, 2008). After a thorough investigation was authorized by the Governor of Virginia just days after the shooting, it was discovered that Cho had a previous mental health diagnosis, had previously been supported by an individualized educational plan in high school, and had been fascinated by the school shootings that took place at Columbine High School (Davies, 2008, p. 12).

Virginia Tech officials were criticized for not responding or following up with Cho even though multiple reports of behaviors suggested that Cho was in distress and could potentially be a danger to himself and others. In addition, some questioned whether Virginia Tech officials responded appropriately following the first targeted shooting incident in the residence hall that took place two hours and eleven minutes prior to the
second shooting notification that occurred in the academic building. The key question revolved around whether Virginia Tech’s notification to the campus community was in compliance with the Clery Act’s (1990) timely reporting requirement (Freedom du Lac; 2013; Graham, Hall, & Gilmer, 2008; Lipka; 2012). The Clery Act requires institutions that receive federal funding under Title IV to report incidents considered a threat to students and employees to the campus community in timely manner. They must also keep a public record of incidents of violence that take place on or near campus property (Harshman, Puro, & Wolff, 2001; McNeal, 2007).

The two hour and eleven-minute time span from when the first call was made following the residence hall shooting to 9:26 am when a warning was sent to the campus community that a shooting incident had occurred on campus is where Virginia Tech came under scrutiny for determining whether they complied with the Clery Act in terms of making a timely warning. The warning came after Cho had entered the academic building and started his second shooting episode (Lipka, 2012). The question then became what may have happened differently if the campus had been notified after the first round of shots? Would students and faculty have taken different safety precautions on that day as Jeanne Clery’s parents had wondered in her case? These are questions that cannot be answered, but these are the question that the families of the victims asked the court system.

Virginia Tech settled out of court with all but two families for $11 million dollars. The two families who declined the original settlement won a jury trial case against Virginia Tech and were awarded $4 million each in March 2012 for the university’s failure to notify the campus in a timely manner. The courts believed that if the institution
had made a warning to the campus community in a timely fashion, the second round of victims might have been saved. This amount was reduced to the cap on civil cases against the Commonwealth of Virginia to $100,000 each.

In October 2013, the Virginia Supreme Court overturned the decision that found the university at fault. The court determined that the Commonwealth “did not have a duty to warn students about the potential for criminal acts” (Freedom du Lac; 2013, p.1). This finding is interesting given that the United States Department of Education fined Virginia Tech $27,500 for failure to comply with the Clery Act (Freedom du Lac, 2013; Graham, Hall, & Gilmer, 2008; Lipka; 2012). The two government agencies seem to be saying two different things with one saying they do not have a duty to warn students about potential for criminal acts and the other saying that they have a duty to report potential threats to campus communities. These contradictory rulings left many institutions of higher education wondering what the right response should be.

The results of the settlements and court findings are also of interest because they raise questions regarding the institution’s responsibility in the deadly incident. Overall, the entire incident left many institutions wondering what they could and should do to protect their campus communities and prevent these types of incidents from happening again. In order to answer these questions, institutions started looking for sources on how to approach this situation. Ultimately, they ended up learning from other institutions and in particular learning from Virginia Tech.

**Threat Assessment Teams**

In the same way that institutions learned how to respond to student unrest following the Kent State shooting and how Jeanne Clery’s death lead to legislation
requiring higher education officials to share security information with their communities and issue timely warnings, the Virginia Tech incident also resulted in concrete lessons. The response to Virginia Tech lead to the creation of something that had not been widely present prior to Virginia Tech in institutions across the United States. These institutions learned how vital it was to share information across multiple departments.

Investigative analysis of the Virginia Tech incident found that a lack of communication between campus offices and service providers resulted in Cho not being identified as a student who was in need of additional mental health support. This finding, regarding a lack of communication, is perhaps why the Virginia Tech incident garnered such a widespread response from institutions across the United States. Unlike the previous incidents of campus violence, the Virginia Tech shooting had warning signs that could have lead the institution towards intervening with Cho before the incident took place. There is no way to determine if the incident could have been prevented had Virginia Tech officials intervened, but Virginia Tech and institutions across the United States have considered what could have been done differently to try to prevent these types of incidents from happening again.

Research has shown that the national development of threat assessment teams rose significantly following the incident at Virginia Tech. Designed to address the communication issue that may have contributed to the incidents in Blacksburg, the committees include campus partners from various departments so that information from different offices can be shared in a way that may help identify individuals in need of additional support. Essentially, these groups can connect the dots with what is going on with students to intervene. Marklein (2011) estimates that fewer than two dozen college
campuses had these committees prior to the Virginia Tech shooting. The estimate now is that approximately 80% of colleges and universities have these teams (Randazzo & Cameron, 2012). In fact, having a threat assessment team is considered a standard of care on campuses with two states, Virginia and Illinois, actually requiring institutions of higher education to have these teams (Randazzo & Cameron, 2012).

In addition to few institutions having threat assessment teams prior to the incident at Virginia Tech, Graham, Hall, and Gilmer (2008) found in their preliminary review of Emergency Operation Plans at public and private institutions that none contained information for addressing a concern similar to what happened at Virginia Tech prior to the incident. These plans would have included information about how to respond to an active shooter on campus for emergency personnel, staff, faculty, and students and this information could have limited the impact of the shooting event. Just as there was an increase in the number of threat assessment teams on college and university campuses following the incident at Virginia Tech, there was also an increase in the number of institutions including information on how to respond to an active shooter in their Emergency Operation Plans (Graham et al., 2008; Leavitt, Spellings & Gonzalez, 2007; National Association of Attorneys General, 2007; Randazzo & Cameron, 2012).

While these types of teams are relatively new to institutions of higher education, the history of this type of organizational risk assessment and deterrence stems back to publications from the late 1800’s. At that time the focus was on protecting kings from potential attacks (Meloy, Hoffman, Guildmann, & James, 2011; Randazzo & Cameron, 2012). As time passed, the application of threat assessment shifted to include protecting celebrities and members of Congress. Techniques were further developed and researched
by the United States Secret Service and forensic experts with extensive history in deviant behavior (Randazzo & Cameron, 2012). As the scope and research literature surrounding threat assessment has grown, so too have the techniques and applications of the findings.

One particular area where threat assessment theory has grown is through the work of the United States Secret Service. In order to develop their techniques, the United States Secret Service began the Exceptional Case Study Project where they reviewed the profiles of individuals who had previously attempted or completed attacks on public figures. With their findings, they were able to significantly enhance their processes and they later published their work in the late 1990’s. These techniques are now utilized by not only the United States Secret Service, but also the Royal Canadian Mounted Police, the United States Postal Service, several United States federal agencies, and private businesses (Randazzo & Cameron, 2012).

The scope later expanded to include school systems following the shooting at Columbine High School in 1999. After that incident, the United States Secret Service and the United States Department of Education began the Safe School Initiative. The goal of these programs was to identify and intervene with youth who may be at risk of harming others, though they have found that their work in the school systems has also decreased other troubling behaviors leading to suspensions and a reduction in bullying (Randazzo & Cameron, 2012). Though commonplace in high schools and middle schools across the United States, the idea of these teams in institutions of higher education did not arise until after the Virginia Tech shootings in 2007. Thus, began the development of threat assessment teams in higher education.
**Definition of threat assessment.** While the threat assessment approach has made important growth over an extended period of time, there is still a bit of confusion over what threat assessment is. Threat assessment is not the same as risk assessment. Risk assessment is a process wherein professionals determine the likelihood that an individual may engage in violence based on individual characteristics and the prevalence of violence found in individuals with those characteristics, but risk assessment does not require that an individual act or threaten to act. Mitigating factors are also a part of the equation. Findings are typically expressed in low, medium or high risk for general violence in the future (Meloy et al., 2011; Randazzo & Cameron, 2012).

Additionally, threat assessment is not profiling. Profiling uses the characteristics from previous offenders and compares an individual to those characteristics. The closer the individual meets the characteristics, the more likely the individual may pose a risk. Even if they have not acted or threatened to act. For instance, when looking at the profile of a school shooter, Seung-Hui Cho met several of the characteristics of a school shooter. He was a male, had a history of previous behavioral incidents, was fascinated by prior school shootings, and had produced violent writings (Randazzo & Cameron, 2012). These characteristics mirrored those found in other individuals who had engaged in acts of violence at other educational institutions.

While not risk assessment nor profiling, threat assessment is a behavior-based deductive process (Randazzo & Cameron, 2012). Threat assessment focuses on individuals who have either communicated a threat or their behavior has lead others to be concerned about their future behaviors (Cornell, 2010). They have made a threat or acted in a threatening manner to themselves or others. This is the major difference between
threat assessment, profiling, and risk assessment. Risk assessment and profiling do not necessarily require a threat to be made, but with threat assessment an individual has to have communicated a threat or exhibited threatening behavior. Once the team receives a report of concern, the team responds to and investigates the situation involving the identified individual(s). Teams typically follow the same basic steps when completing their investigation.

**Basic response procedures.** There are multiple variations of threat assessment models. Two of the models that are often used are the Assessment-Intervention of Student Problems: AISP Model (Delworth, 2009; Eells & Rockland-Miller, 2011; Hollingsworth, Dunkle, & Douce, 2009) and the College and University Behavioral Intervention Team: CUBIT model (Eells & Rockland-Miller, 2011). Regardless of the model, they each follow essentially the same basic formula. Cornell (2010) outlines these basic steps in his guide to threat assessment within institutions of higher education.

First, the team determines whether the situation that has been reported is an emergency and warrants further investigation. This is where the team can determine if the behavior poses a risk to the community or is simply unusual behavior. After all, not every act of unusual behavior is a marker for concern. If the team determines that there is a threat or that the behavior warrants further investigation, then the team conducts a full threat assessment wherein they follow up with individuals who may have witnessed and/or reported the incident. The team may look to multiple sources for additional information.

Based on the information that they gather, the team will then determine if the person or situation presents a threat. If the team determines that there is a threat, they will
develop a plan to address the concern. This can take various forms depending on the type and severity of the threat. The team will work together to carry out that plan and make whatever interventions are necessary within legal boundaries to keep the campus community and the individual that is exhibiting the concerning behavior safe.

The team will continue to monitor the situation until it is determined that there is no longer a threat to the individual or the campus community. After the team determines that the individual or situation no longer poses a threat, the team will close the case (Pollard, Nolan, & Deisinger, 2012). Throughout this entire process, the team is also careful to document their decisions and findings in case they are needed for future reference in court proceedings or should additional incidents with an individual arise (Eells & Rockland-Miller, 2011).

**Threat assessment team composition and name.** While the process that the team follows is certainly important, the composition of the team is also something to examine. The reason that the team plays a vital role lies within what research has shown about the importance of potential threats being identified. Threat assessment teams are comprised of a variety of professionals from different areas of the institution in hopes that they will be better able to identify an individual of concern, essentially creating eyes and ears throughout the campus community. These team members can also share information with staff, faculty, and students in their respective areas about how to report issues of concern.

Threat assessment focuses on a narrower group of individuals who have either communicated a threat or aroused concern because of threatening behavior.

Nearly all of the multi-victim shootings studied by the FBI and Secret Service
were committed by individuals who could have been identified by a threat assessment approach. In many cases, the individuals had clearly expressed their intentions to carry out a shooting, and some had warned potential victims of a specific time and place to avoid. The critical shortcoming was a failure to identify and investigate threats. (Cornell, 2010, p. 10)

Having members of the team dispersed throughout campus increases the likelihood of learning about an individual who is exhibiting threatening behavior or who has communicated a threat.

In addition to covering different physical areas throughout campus, the threat assessment team also covers a variety of specialty knowledge areas. Threat assessment teams often include student conduct officers, law enforcement officers, mental health professionals, disability services representatives, academic affairs administrators, student affairs administrators, legal counsel, residence life staff, and any other individuals who may be helpful in assessing a particular threat (Pollard et al., 2012; Sulkowski & Lazarus, 2011). Each member represents and can provide information related to their campus unit or specialty area. Thus, if an individual has exhibited concerning behavior in the residence halls, for instance, the representative from residence life may have information about not only the incident, but also the policies and procedures that were used to respond. The role of mental health professionals on this team is unique when considering the other members of the team. While the mental health professional would not be able to share privileged information about a client in therapy, they would be able to provide a better understanding of certain behaviors.
Even though the teams all typically follow this basic process and include similar individuals, they may choose to title themselves a bit differently. Some institutions have found Threat Assessment Team to be a bit intimidating for the campus community and thus have chosen a different title. Some of the titles include Behavioral Intervention Team, Students of Concern Committee, Campus Assessment Team, Student Behavior Consultation Team, Assessment and Care Team, Behavioral Assessment Team, Community of Concern, or College Concerns Team (Eells & Rockland-Miller, 2011).

**Threat Assessment Literature**

Much of the literature surrounding threat assessment teams in higher education focuses on the basic details outlined above such as the history, process, and team membership. In addition to prevalence data mentioned above, there is also quite a bit of literature surrounding threat assessment teams and the legal and ethical issues that they may face. One discussion in this area revolves around what becomes part of the student record and the best way to document the information found and steps taken by the threat assessment team. Since students have a legal right to their educational record this could lead to challenging situations with students having the potential to request the information that the threat assessment teams have gathered or discussed during an investigation.

The literature also includes the exploration of the legal issues involving information sharing within the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, as well as confidentiality concerns with mental health practitioners on the team. Both of these privacy rules dictate what information can be shared and with whom that information can
be shared with FERPA protecting the privacy of information related to the student’s academic record and HIPAA protecting an individual’s health records. They are both particularly relevant to these committees since information about the student’s academic record and potentially information about the student’s health record could be of importance for the committee when reviewing a concern. How much and even what information can be shared within this group gets tricky when one considers that both academic and health representatives are present on the committee. Can a health provider divulge that a student is being seen at the campus clinic for depression? Can a mental health provider verify that a student has been attending counseling appointments? Or, can the community of concern review a student’s transcript?

Many of the investigative reports following the Virginia Tech incident found that there was great confusion over the limits of confidentiality dictated by FERPA, HIPAA, and state privacy laws (Leavitt et al., 2007; National Association of Attorney Generals, 2007). Scholars in this area recognize that more information needs to be shared in order to support students, but there is also cautioning to protect the confidentiality rights of students (Davenport, 2009; Nolan & Moncure, 2012). Thus, there is a great call towards further clarification of these various federal and state laws.

**Research Question**

Within the vast research examining threat assessment teams, there is one particular area that has not been thoroughly investigated. To date, there has not been an examination of how institutions essentially learned from Virginia Tech to change their campus operating procedures and organizational structures to create their own committees of concern. We know why these committees were created, but there has not
been an examination of how these committees were created. Thus, the purpose of this study was to examine how the Community of Concern Committee at the University of Kentucky was developed following the incident at Virginia Tech. Particular attention was focused on the learning and change that took place. Using the frames of single-loop and double-loop learning, this study examined six oral history accounts of the development of the Community of Concern Committee at the University of Kentucky.

This study is of value for not only the University of Kentucky, but for other institutions of higher education as well. The University of Kentucky is a rather typical four-year public research institution that matches the Carnegie Classification (a categorical framework for comparing institutions of higher education) for Virginia Tech so the comparison between these two institutions makes sense. The epistemological beliefs which ground this study lie within social constructivism and thus the interest in this project lies with understanding the story, the people, and the events that have created learning at the University of Kentucky. Therefore, qualitative methodology was the most appropriate research approach for this study because it allowed for the individualized story to be told of how learning took place. Collecting oral histories of the creation of the committee at UK not only provided the basic details of how the change took place, but also an analysis of these histories provided a lens to consider the motivations and reasons behind why those changes took place. This is where this research project differs from the research that has already been completed. There is clear evidence indicating that changes took place within higher education following Virginia Tech and an oral history collection brings some insight into the learning took place to allow those changes to be made.
To provide context for the analysis of the oral history narratives, chapter two provides a literature review of the legal responsibilities for institutions of higher education and organizational learning. This includes single and double-loop learning which served as the lens through which each oral history was examined. Chapter three details the specific research process used to collect the oral histories. Chapter four examines the individual oral histories and creates a timeline of events. Chapter five uses these same oral histories to highlight the changes which took place through single and double-loop learning, and chapter six provides the final synthesis of the oral histories as well as a discussion of potential future directions for this area of research. Let’s first review the pertinent literature surrounding legal responsibility and organizational learning to develop a foundational understanding of the issues at play with the development of the Community of Concern at the University of Kentucky.
CHAPTER TWO: LITERATURE REVIEW

While this research project was a case study focused on the development of the Community of Concern at the University of Kentucky, the legal history relevant to this work is quite extensive and includes cases from multiple institutions. Specifically, the legal focus was on an institution’s responsibility to protect students and the legal options that an institution has to carry out this responsibility. The next body of literature germane to this study, focuses on the framework that I will be using to examine the learning that occurred between Virginia Tech and the University of Kentucky which resulted in institutional change. Single and double-loop learning from organizational learning is the focus for the second part of the literature review.

The incident at Virginia Tech fell under review from multiple federal and state agencies who were not only looking for ways to prevent these types of incidents from happening in the future, but also looking at whether Virginia Tech fulfilled all legal duties to those involved in the incident. Institutions of higher education became concerned about what role they should play in protecting students on their campuses. They also considered what responsibilities they had towards protecting members of the campus community as well as those individuals who may pose a risk to self or others. The question of what responsibility institutions have for their students has been of particular interest since Gott V. Berea College in 1913.

This landmark case was decided by the Kentucky Court of Appeals and involved a Berea College rule which prohibited students from patronizing certain businesses which did not have an affiliation with the college (White, 2007). One of the owners of a business who had been adversely impacted by this rule sued Berea College and
challenged the idea that a college had the authority to determine which businesses students could patronize. The court ruled in favor of Berea College and provided a clear case for *in loco parentis*, which is the idea that the institution serves in place of the parent. "College authorities stand *in loco parentis* concerning physical and moral welfare, and mental training of the pupils, and we are unable to see why to that end they may not make any rule or regulation for the government or betterment of their pupils that a parent could for the same purpose" (*Gott v. Berea College*, 1913). As long as students were enrolled in an institution, that college or university had the authority to make decisions that they thought were in the best interest of the student in the same way that a parent would.

This ruling and the idea of *in loco parentis* held strong for institutions of higher education with courts rarely finding institutions guilty for student injury (Blanchard, 2007; Kalchta, 2010; White, 2007). “In its heyday, *in loco parentis* located power in the university—not in courts of law, or in the students. *In loco parentis* promoted the image of the parental university and insured that most problems were handled within the university, by the university, and often quietly” (Bickel & Lake, 1999, p. 17). Institutions had the ability to deal with whatever situations arose on campus and the court systems stayed away from interfering with issues involving students on university and college campuses. Student rights were limited, and ultimate power resided with institutions of higher education.

In the 1960s, a shift occurred. Court rulings began to look at the student and institutional relationship a bit differently (Lee, 2011). During this time, we saw a shift in the role that institutions played in their students' lives. This coincided with the political
and civil unrest happening in the United States which manifested in protests and agitation on college campuses. Institutions became concerned about playing too much of a role in taking responsibility for their students as this may increase their liability should something go wrong (Blanchard, 2007). Students also became vocal about wanting to have more personal autonomy for their choices.

College students were protesting for their individual rights and the desire to be treated as adults. Having gained the ability to vote with the Twenty-Sixth Amendment and with many students being drafted to military service in Vietnam at this time, students argued for the ability to be seen as adults in all aspects of their lives. In response, courts started ruling against in loco parentis in favor of less responsibility on the part of the institution and more individual autonomy (Kalchthaler, 2010). A great example of this was the ruling from Bradshaw v. Rawlings (1979). In this case, a student sued the institution over an automobile accident following a campus event. The student was injured by an intoxicated driver and sought damages from the university. The courts in this case found that the institution was not "an insurer of the safety of its students. Whatever may have been its responsibility in an earlier era, the authoritarian role of today's college administrators has been notably diluted" (Bradshaw v. Rawlings, 1979).

This diminished responsibility for the consequences of student behavior changed in 1991 with Furek v. University of Delaware (1991) (Kalchthaler, 2010). In this case, the courts ruled against the University of Delaware and applied the tort standard to the institution. The court held that the institution had a responsibility to the student similar to that of a landlord and tenant relationship after a student became injured following a fraternity hazing situation. Because the student lived on campus in this instance, the
courts ruled that the University had a duty to protect the student from foreseeable danger and assumed responsibility for warning the student about potential harm. Instead of in loco parentis, the standard by which institutions would be held accountable turned to tort law in the court system and the premise that a special relationship exists between the student and the institution (Kalchthaler, 2010). Institutions now had a higher level of responsibility to protect their students.

While tort law varies from state to state, there are four basic premises that must be met in order to reach the tort standard. For the sake of higher education law and tort standard, it must first be established that the institution has a duty to the student. Secondly, the institution would have to have breached that duty to the student. Because of this breach, a student would have to have been harmed, which represents the third standard. Lastly, the institution's negligence and breach of duty was the cause for the student's injury (Blanchard, 2007, p. 463). To explore this further, institutions can look at the results of several different court cases where these tort standards came into play.

The first case, often mentioned in regard to the responsibility that institutions have for the safety and well-being of their students, is Jain v. State of Iowa (2000). According to Jain v. State of Iowa, Sanjay Jain was a first-year student at the University of Iowa. Though he lead his parents to believe that things were going well, Jain had experienced some behavioral problems and was placed on disciplinary probation after being caught smoking marijuana in his room. He later engaged in a domestic argument with his girlfriend who claimed that Jain was attempting to end his life by inhaling the exhaust fumes from his motorized cycle. This incident resulted in Jain meeting with members of residence life staff who encouraged him to seek counseling.
On December 4, 1994, one of Jain’s suite-mates awoke to find their apartment filled with smoke. The RA on duty was summoned and unlocked the door to Jain’s room and found him unconscious with his moped running. Emergency personnel responded and pronounced that Jain was dead as a result of self-inflicted carbon monoxide poisoning. His roommate reported that Jain had kept the moped in the room for the past three weeks and had reportedly indicated that he would kill himself by running the moped while his roommate was gone (p. 2). His roommate thought he was merely joking.

Jain’s father sued the university for wrongful death claiming that the University of Iowa was negligent for not notifying him of his son’s previous suicide attempts. He claimed that he could have prevented the suicide if the University had followed their unwritten policy of disclosure to parents after a suicide attempt. In this case, the courts ruled in favor of the institution indicating that the university’s limited intervention in the case neither increased the likelihood of him committing suicide nor kept him from seeking assistance (Pavela, 2006). The tort standard of whether the institution was directly responsible for Jain's death came into play with the court first having to determine whether a special relationship existed between Jain and the university. In this case, the court decided that there was not a special relationship and therefore the institution did not have a responsibility to protect him from self-harm.

The courts, however, came to a different conclusion in terms of the institution's responsibility in Shin v. Massachusetts Institute of Technology (2005). This case represents a time where courts found that the university should have intervened in order to protect the student. Elizabeth Shin, a student enrolled at the Massachusetts Institute of Technology (MIT), started to engage in self-injurious behavior during the spring semester
of her freshman year. Ultimately, Shin overdosed during that time and was hospitalized as a result.

Following this hospitalization during her freshman year at MIT, Shin was presented with three options from one of the psychiatrists at MIT: Shin could seek treatment at MIT, seek treatment at a facility outside of MIT, or take a leave from school and seek treatment at another facility. At that time, Shin chose to seek treatment at MIT and remain enrolled as a student. As she continued her studies at MIT, Shin continued to experience episodes of suicidal ideation and engaged in self-injurious behavior. On numerous occasions, the MIT community intervened with the student. For the remainder of her freshman year it was reported that Shin entertained the idea of leaving MIT and indicated that she was not doing well medically.

After spending the summer at home, Shin returned to MIT for her sophomore year where she was again evaluated after expressing suicidal ideations. Shin also engaged in cutting behavior during this time. It was later discovered that her patterns of self-injury first began with cutting behavior in high school. She was seen several more times for mental health counseling during her sophomore year as a result of her self-injurious behavior including a hospitalization in March of that year. After the hospitalization, Shin returned home, but then came back to MIT after spring break. She continued to be seen by mental health professionals and it was reported that members of the academic community expressed concern regarding her mental health status. The administration also indicated that they were caring for Shin when a member of the academic community expressed concern about her. Though she expressed a desire to move out of the residence hall, Shin was discouraged from leaving the residence hall by her housemaster.
After returning from a hospital evaluation for potential suicidal ideation manifested by expressing that she was going to kill herself with a knife, students in Shin’s residence hall reported to the housemaster that Shin had indicated that she was going to kill herself that day. Her housemaster reported this information and was instructed to check on Shin throughout the morning. At a meeting of Deans and psychological professionals at MIT, Shin’s situation was discussed though it is not clear what, if any, treatment options were reviewed. At the conclusion of the meeting, the team made an appointment for Shin at a treatment facility and this appointment information was left for her on her answering machine.

Later that night, MIT Campus Police were called to Shin’s residence hall because of the fire alarm sounding in her room. Shin was found in her room and was engulfed in flames. Though emergency personnel responded immediately, doctors determined that Shin suffered irreversible brain damage as a result of the fire and her life support was terminated. The medical examiner ruled that the cause of death was suicide.

Following her suicide, Shin’s parents brought 25 counts against MIT including negligence and gross negligence. The Massachusetts Superior Court found that MIT owed the student a duty of care given the special relationship that existed between MIT and Elizabeth Shin in the summary judgment ruling (Pavela, 2006). The case settled out of court for an undisclosed amount (Hoover, 2006).

In the Shin case, all four tort standards were met. MIT was found to have a special relationship with the student and therefore a duty to protect her. That duty was breached when MIT failed to appropriately intervene with a student who had expressed suicidal ideation. The student was injured and later died as a result. Because the institution knew
about her intent to self-harm and they did not intervene, her death was linked to the institution's negligence.

The Shin and the Jain cases not only inform the role that institutions play in their duties to students, but they also illustrate the second side of responsibility that we see in the Virginia Tech incident. While the focus of the Virginia Tech court case was on the responsibilities that Virginia Tech had toward those who were injured or killed during the shooting events, the case also speaks to the responsibility institutions have to students with mental health concerns in general. Following the investigations at Virginia Tech, it was discovered that Seung Cho was a student in need of mental health support and had signs of mental illness prior to his acceptance to the institution. This sparked a debate on whether institutions should be admitting students with mental health concerns. Again, this is an issue that the court systems have adjudicated for over a decade.

For example, Jordan Nott, a student at George Washington University, checked himself into a mental health facility only to then face disciplinary sanctions at his university (Appelbaum, 2006). While in the hospital, he was informed that he was not allowed to return to campus until cleared by the Counseling Center under the “psychological distress policy” (Appelbaum, 2006, p. 914). The next day, he was further cited as being in violation of the endangering behavior policy, was suspended from school, banned from campus, and given two choices: he could withdraw himself from the university or undergo a hearing before the judicial board at George Washington University. Nott was informed that the likelihood that he would win his judicial case was slim to none and Nott eventually transferred to another institution (Appelbaum, 2006).
The policies that Nott was charged with violating all came under the assumption that Nott was suicidal. What is puzzling about Nott’s story is that while he admitted feeling depressed, he denied ever mentioning that he wanted to harm to himself and denied ever feeling the desire to harm himself (Appelbaum, 2006). So, by following policies that had been established at the institution that related to students who expressed suicidal ideation, George Washington University dismissed Nott for seeking mental health support and not for an expression of suicidal ideation.

Had Nott been hospitalized for a burst appendix would the University have responded in the same manner? The answer is most likely no, but given that more college students are entering institutions of higher education with mental health concerns, how can students be assured that their mental health status will not prevent them from becoming active members of the university community (Hollingsworth et al., 2009)? How can they be assured that their mental health status does not put them in a situation primed for discriminatory consequences? What responsibility does the institution have for protecting its community and the students under its care while simultaneously maintaining policies that do not discriminate against mental illness? Two federal laws which provide protections for just these types of concerns are detailed below.

**ADA and 504 Protections**

Federal laws and even some state laws address this concern and provide protections against discrimination of students with mental health concerns. Legally, an individual’s mental health status is protected the same as a disability would be protected. Federally, students are protected by Section 504 of the Rehabilitation Act (Section 504) and the Americans with Disabilities Act (ADA) (Bowman, 2011; Grace & Smith, 2014;
Grasgreen, 2011; Grasgreen, 2014; Hadley, 2011; Hollingsworth et al., 2009; Lewis, Schuster, & Sokolow, 2012; Martin, 2017; Simon, 2011; The Jed Foundation, 2008). Any institution who receives federal funding must comply with these laws (Hollingsworth et al., 2009). Looking more specifically into each of these laws will help identify the specific concerns that institutions of higher education need to take into consideration when working with and writing policies concerning individuals with mental health concerns.

Section 504 “prohibits organizations receiving federal financial assistance from discriminating on the basis of disability” (Bowman, 2011, p. 85). The Americans with Disabilities Act provides these same protections but is outlined in a different way. The ADA is composed of three titles. Title I addresses discrimination in employment while Title II addresses discrimination in any program or activity conducted by a public entity, including public institutions of higher education. Title III covers accessibility in public places, prevents discrimination in this area, and includes entities like restaurants, places of entertainment, healthcare, and private higher education institutions (Bowman, 2011, pp. 85-86; Lewis et al., 2012). Essentially, Section 504 and the ADA afford the same protections to students with mental health concerns enrolled in institutions of higher education and they are often cited interchangeably (Simon, 2011, p. 95).

Prior to the most recent amendment to the Americans with Disabilities Act in 2008, the courts took a very narrow view of which individuals could be protected under this Act. More time was spent determining whether someone was covered by the ADA than affording individuals protection from unnecessary discrimination based on a disability. In contrast, the amended Americans with Disabilities Act includes a broader
range of individuals with disabilities because of this simplified definition (Bowman, 2011; Simon, 2011).

The official definition of a disability that one must meet to be protected under this standard is that an individual must have “a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment” (Bowman, 2011, p. 87). The amendment also broadened the definition of what was considered a major life activity which expanded protections to more individuals as well (Bowman, 2011). The expansion of coverage under the amended ADA was also extended to section 504 of the Rehabilitation Act (Bowman, 2011).

What does this specifically mean for colleges and universities and the students that they serve? Specifically, the ADA and section 504 prohibit actions that:

- Deny qualified students with disabilities an equal opportunity to participate in programs and activities
- Provide aids and services that are not “equal to” or as “effective as” those provided to others
- Provide different or separate aids, services, or benefits than those necessary for providing meaningful access
- Provide significant assistance to third parties that discriminate against qualified individuals with disabilities
- Use methods of administration that result in discrimination
- Use eligibility criteria that screen out or tend to screen out individuals with disabilities
• Fail to provide reasonable accommodations (Simon, 2011, p. 96)

So, an institution that fails to admit a student to their program solely due to the fact that they have a mental health concern would be in violation of these regulations. Or as another example, a university who dismisses a student based solely on their mental health status would also be in violation of these Acts.

Aside from protection, Title II and Title III of the ADA also detail an important exception to that protection which occurs when an individual’s mental health status may put an individual or others at risk for harm. The ADA has a direct threat regulation which is the standard which must be met for the individual to no longer be covered by the ADA. To meet this standard an individual must pose a “direct threat to health or safety” (Lannon, 2014, p. 1; The Jed Foundation, 2008). The direct threat regulation comes into play when considering whether an institution can intervene with a student who poses a risk to self or others without violating a student’s rights as an individual with a mental health condition.

Prior to a revision in September of 2010, Title II and Title III had slightly different language on what a direct threat would be. Title II used the phrase “harm to self or others” while Title III only listed “harm to others” (Lewis et al., 2012, p. 4). Even though they had different language, both public (covered by Title II) and private (covered by Title III) institutions were dismissing students who posed a risk of self-harm with the understanding from the United States Department of Education’s Office for Civil Rights that the language from Title II of the ADA could be applied in the reading of Section 504 as well as Title III cases. The Department of Justice recognized the discrepancy between Title II and Title III and sought the remedy it with a revision which changed the language
in Title II to the narrower definition of a direct threat standard only including “harm to others” in September 2010 (Lewis et al., 2012, p. 4). Institutions can legally dismiss or intervene with a student who poses a risk to others, but they do not have that same ability when it concerns an individual who only poses a risk to him or herself.

The change in interpretation of the direct threat standard surfaced for institutions of higher education with one case in particular being highlighted as the case that brought the change in the direct threat standard into the spotlight. Spring Arbor University received notice from the United States Department of Education’s Office of Civil Rights in 2010 that they had violated a student’s rights by requiring a student who had voluntarily left the university to meet certain conditions in order to return. The student had previously engaged in cutting behaviors and was asked to provide various pieces of medical documentation upon applying for readmission. With self-harm no longer being included in the direct threat standard, the institution was violating the student’s rights, as the Office of Civil Rights pointed out, by requiring this student to submit different readmission documents than other students (Grasgreen, 2011; Lannon, 2014; Lewis et al., 2012).

Returning to the case involving Jordan Nott, how was George Washington University able to legally dismiss this student who sought help for his mental health situation? Should he not have been protected by the ADA and Section 504? Nott’s story took place in 2004 prior to the amendments which broadened protections for individuals with disabilities and prior to the change in the definition of direct threat in the ADA. Even then, however, it turns out that Nott had a legal case against the institution and Nott actually used the narrower definitions of the ADA and Section 504 regulations in his suit
against George Washington University after his dismissal (Appelbaum, 2006; Grasgreen, 2011). While the two settled out of court with a confidential agreement, this case illustrated that higher education institutions cannot simply dismiss a student because of their mental health situation; students are afforded certain rights and protections. These rights and protections have been further clarified with an expanded definition of disability and consistency in the language for the direct threat standard in Title II and Title III.

As if the federal regulations did not afford students enough protection, some states have decided to pass their own legislation prohibiting discrimination against individuals with disabilities. For instance, in 2007, Virginia became the first state to make it illegal for a school to dismiss a student based solely on them seeking help for thoughts of self-harm or for making an attempt to self-harm (Smith & Fleming, 2007). Though the protection is redundant in a sense since these protections are already federally afforded to students through the ADA and Section 504, it is still important to note that there may be specific state regulations that strengthen protections for individuals with disabilities from discrimination.

The legal history, which details institutional and individual rights and responsibilities as well as protections against discrimination, is lengthy and complicated. As seen in the previous cases, courts seem to rule in conflicting ways at times. Institutions have a responsibility to protect their students from harm, but they cannot adopt policies which would discriminate against their students. This leaves institutions looking for ways to protect their community while at the same time protecting the rights of all of the individuals in that community, even those who may pose a risk of harm to themselves. The balance is particularly challenging when the risk of harm moves beyond
harm to self and moves towards harming others as was the case with Cho at Virginia Tech.

While institutions do look to the courts for answers on how to respond, they also look to other institutions in order to resolve this dissonance. Institutions are able to learn from one another when trying to achieve this delicate balance and look for ways to make appropriate change. This kind of organizational learning played a significant role in learning how to respond to students of concern in higher education following Virginia Tech. and provides a clearer understanding of how institutions can learn from one another in order to make effective changes.

**Organizational Learning**

The legal arena is one place that institutions of higher education can learn from one another. By examining the outcomes of various court cases, institutions are able to judge what role they are required to play in taking responsibility for their students and how to approach difficult situations. Following the case of the Virginia Tech shootings, colleges and universities saw that the institution came under legal scrutiny for failing to connect the dots and protect members of the campus community after multiple warning signs and reports of concern. The legal case and national dialogue among higher education practitioners highlighted the need for higher education institutions to clarify policies and procedures regarding individuals on campus who may be a threat to themselves or others. The literature surrounding the reasons for establishing student of concern committees to prevent this type of event from happening again is robust. However, there has not been research on what else could have been learned from Virginia Tech. For instance, how would one develop this type of committee? This is where the
concept of organizational learning comes into play with this study as it provided a framework for examining the oral history accounts of change at the University of Kentucky.

Understanding organizational learning first starts with understanding the basic building block of any organization, the individual. “Individual learning is as much important for an organization as it is important for an individual because individual learning provides a basis for organizational learning” (Aslam et al., 2011, p. 739). Individual learning can take place in three different ways in an organizational setting. The first way being through formal training, the second being through informal training, and the third being through incidental learning (Aslam et al., 2011; Marsick & Watkins, 1990; Marsick & Watkins, 2001). Individuals learn formally through training sessions, informally through the completion and practice of their daily jobs, and incidentally through a trial and error basis. Informal learning, in particular, plays a significant role in individuals learning about major portions of their jobs (Eraut, 2000).

These concepts may be best explained in an example rooted in higher education. An academic advisor at an institution of higher education can learn how to perform their role in a variety of ways. First, they may receive formal training when they begin their position, which might include a review of the academic curriculum for students or formal trainings regarding the student information system software, for example. In addition to this formal training, the academic advisor can learn more about his/her position while completing his/her daily job assignment. So, an advisor may learn about how to file an exception to an academic rule while in the course of assisting a student. Lastly, with incidental learning, an academic advisor may learn about the best way to work with a
student who is on probation. After working with multiple students over the course of several semesters, he or she may incidentally learn what works well and what does not work well for different types of students. In this study, individual learning was examined as a part of six individual oral history accounts of change from employees at the University of Kentucky.

Building from this description of individual learning, we can start to explore what learning looks like at an organizational level. One definition of organizational learning is that it is “the study of whether, how, and under what conditions organizations can be said to learn” (Fiol & Lyles, 1985). It should be noted that there have been multiple approaches to defining organizational learning presented from a variety of different researchers. They all tend to share the same basic ideas of institutions responding to organizational conditions wherein learning takes place at the collective level rather than solely at the individual level. In other words, the organization responds to external conditions by learning from those conditions and responding accordingly. However, there is a bit of confusion in the literature regarding the difference between organizational learning and a learning organization. Organizational learning is considered more of the academic side of this concept while the term learning organization is more of a management approach for which to strive. Though they are used interchangeably, it is important to know that the two concepts are in fact different. The focus of this research project was organizational learning as the examination of the oral histories is more academic in nature.

The concept of organizational learning emerged in the 1950’s from organizational psychology and included researchers like Simon (Kezar, 2005, p. 10), Cyart, and March
Throughout the 1960’s, this concept was popular as organizations became focused on learning given the need to adapt in a competitive environment (Imran, Rizvi, & Ali, 2011). Since the better an organization can learn, the better it can adapt to the environment, organizational learning became an important part of organizational success. Researchers noticed organizational learning taking place when entire groups of people learned collectively rather than just individually. Organizational learning then is seen as the bridge between individual learning and collective learning. Researchers also noted that organizational learning resulted from environments where individual learning is supported for the collective good. For this study, organizational learning is represented in what happened at the university level in addition to their own personal experiences.

The focus in organizational learning remains neutral without making statements about whether the learning that is taking place is good or bad. This contrasts with organizational development which focuses on forward movement of the organization to become more effective (Kegan, 1971). In addition, while there is recognition that there is a connection between individual learning and organizational learning, there is much debate about exactly what that relationship might be. But, once again the concept remains mostly academic in nature in the organizational learning research literature.

The academic debates among researchers of organizational learning also include how this concept can be studied if no behavioral changes take place. Some researchers argue that in order to say that learning has taken place, there must be some type of behavioral change or evidence of change in the way that work gets done. Other researchers argue that simply developing new ways of thinking about things is sufficient
(Garvin, 1993). Thus, many of the concepts in organizational learning remain topics of debate among organizational scholars.

**Concepts in organizational learning.** One of the main topics of discussion in organizational learning of relevance to this study is single-loop learning versus double-loop learning. This was the lens used to examine the oral history accounts of change. Argyris & Schon draw a distinction between these two with single-loop learning being more reactive in nature and double-loop learning being more self-reflective and prescriptive in nature (1978). In single-loop learning, an alternative course of action is chosen if one path does not work. If that new path does not work, then another path is chosen.

In double-loop learning, instead of simply choosing a different path if something is not working, there is a portion of reflection wherein one determines whether values surrounding the issue need to be examined and readjusted in addition to the path that is being chosen. Heorhiadi, Venture, and Conbere provide a great example of the difference between single and double-loop learning. “We find that many people miss the essential difference between single and double-loop learning. In single-loop learning, if one tries to do something and it does not work, then one changes something. For example, if one cooks and the dish is too salty, the next time one adds less salt” (2014, p. 6).

In this example, there is a mismatch between one’s intentions (creating a tasty meal that is not too salty) and their behavior (using too much salt). With single-loop learning, the next time the individual cooks the dish, they will use less salt. However, with double-loop learning, there would be a fundamental change or examination in the person’s beliefs or assumptions regarding using salt in cooking or an examination of the
ratio of salt preferred in dishes so that that the next time a dish is cooked, the appropriate amount of salt could be used.

Double-loop learning leads to examination instead of just changing a behavior; there is time for reflection on what really needs to change. Again, Heorhiadi, Venture, and Conbere, provide an excellent example.

Double-loop learning is needed when the problem originates in how people think or believe, and thus correcting this problem requires a change in the governing beliefs. For instance, if a manager tries to get her work team to work more efficiently by micromanaging the work and finds that this tactic does not succeed, the change that is needed is in the manager’s belief about the effectiveness of micromanagement. (2014, p.7)

In contrast to single-loop learning, the change comes as a result in changing one’s underlying assumptions regarding the issue and not simply by choosing a new behavior.

Let me give one more example to distinguish between double and single-loop learning as this will play an important role in analyzing the learning which took place at UK. “Single-loop learning is like a thermostat that learns when it is too hot or too cold and then turns the heat on or off” (Argyris & Schon, 1978, p. 3). In this case, once the issue is detected the problem is either fixed by turning the heat or air conditioning on or off. “Double-loop learning occurs when error is detected and corrected in ways that involve the modification of an organization’s underlying norms, policies, and objectives” (Argyris & Schon, 1978, p. 3). Instead of correcting the temperature issue by turning on the heat or air conditioning to achieve a desired temperature, double-loop learning is characterized by the reflection and evaluation of that set temperature. The double-loop
learning may involve a discussion about whether the temperature is even the right one for
the room or if the heating and air should be running at all. The learning moves beyond the
solution to a discussion or evaluation of norms, policies and/or objectives.

In relation to this study and institutions working with individuals who may be at
risk of harming themselves or others, the assumptions and beliefs that may come into
play circle back to those same questions that arose in the legal arena. What role does the
institution play in protecting the campus community? What responsibility does the
institution have for protecting individuals who may be at risk of self-harm or harm to
others? How much of a role does the institution play in following up with individuals
who have exhibited concerning behaviors?

The following case study explored one institution’s journey to change policies
and establish new practices following the Virginia Tech shooting and subsequent legal
case. Using an oral history approach, this study explored the events that led to the
establishment of a Community of Concern Committee at the University of Kentucky.
Again, the literature describing why institutions took this approach is robust; however,
this study examined how the process unfolded with special attention to the lessons
learned from the Virginia Tech case and the ways this learning took place at UK. Oral
histories with individuals who were a part of the change at the University of Kentucky
shed light on the learning and changes that took place.
CHAPTER THREE: RESEARCH DESIGN

The beauty of research is that there are often many ways to answer research questions and each methodology and research approach can tell us something a bit different. So why did I choose the methodology that I chose? Why does that particular methodology resonate with me and the questions that I wanted to answer? First, my understanding of knowledge led me to the oral history methodology as a social constructivist. While I see value in quantitative analysis, I have always preferred qualitative methods as a means to tell the story. Numbers can hint at areas for further analysis, but they cannot necessarily speak to the story, to the people, or to the events that lead to the numbers. Based on the questions that I wanted to explore, my methodology emerged from both my understanding of knowledge and the questions I wanted to analyze.

This dissertation focused on two essential questions: 1. How was the Community of Concern developed at the University of Kentucky following the shooting incident at Virginia Tech, and 2. What did the learning that took place look like during this change based on the organizational learning concepts of single-loop and double-loop learning? Both questions lend themselves to a qualitative approach since the first relies on the recollection of institutional policies and procedural changes and the second question is the analysis of that recollection. I chose organizational learning as the lens through which to examine the change that was noted in the oral histories as it represented an opportunity to examine the learning which occurred at an organizational level through individual interviews. The concept of single and double-loop learning also provided a parsimonious lens to examine the complex issue of organizational change.
Given these questions and my understanding of how knowledge is created, the dissertation utilized an oral history narrative methodology. “Properly done, an oral history helps to interpret and define written records and makes sense out of the most obscure decisions and events” (Ritchie, 2003, p. 117). Henry Glassie’s statement on the purpose of history perhaps best describes how oral history played that role. “History tangles the past with the present in webs of fact. Its practice is to treat things that exist here and now as though they are concerned with the past and to use them in new compositions designed to equip people for their trip into the future (Glassie, 1994, p. 961). As we examine the development of the Community of Concern at the University of Kentucky, there will be a tangling between the current structure as it stands now and what it took to get to that point. That development process and the purpose of this work also plays a role in the future of this committee and how higher education responds to individuals who are at risk of harming self or others. Glassie goes on to say that “this process can be segmented to provide students of history with two tasks. One studies the things of the present—documents, broken crockery, elicited memories—in order to speak about past cultures. Another studies the ways people construct understandings of the past in order to speak about culture in the present” (1994, p. 961). This project utilized university documents to help untangle the history of how this committee was developed at the University of Kentucky as well as an analysis of the learning which took place as a way to examine how the institution constructed an understanding of why it made the changes that it did. The supporting documents helped ground the oral histories and provided validity to the information that was being shared about the timeliness of events. This is not a simple story as there are many departments involved and the University of
Kentucky is a large institution. However, the narrative methodology is helpful when “detailed stories help understand the problem” (Creswell, Hanson, Clark Plano, and Morales, 2007, p. 241).

When selecting methodologies for this dissertation, the sensitive nature of the topic was a factor. What happened at Virginia Tech was something that had an impact on people throughout the United States and beyond. Whether you knew someone who was there on that day, you connected with what the campus must have experienced because of your relationship to higher education, or you were someone who felt the pain of those who lost loved ones on that day, this time in higher education history was traumatic for many. An oral history narrative allows individuals the freedom to express those experiences in a way that other formats cannot and with a respect for the story.

Robert Reynolds’ discussion of oral history involving traumatic events highlights the delicate balance that oral historians must find. Reynolds is both an oral historian and a psychotherapist, so I connected with his perspective in a unique way given that this mirrors my own background. He cautions that while some oral historians believe that these life-history interviews provide an opportunity for closure, trauma is not so simple. One must be careful to recognize that trauma can reappear and attach itself to a variety of different events and while many may argue that oral history has a component of closure, this was certainly not the intent of my interviews. As Reynolds points out in his discussion of an oral historian, Field, working with the traumatic oral histories of the South African Apartheid, “instead of the ‘redemptive myth of healing’, Field offered a more modest goal: oral histories of trauma can help produce individual and cultural regeneration which integrates loss, grief and anger into everyday life” (2012, p. 84).
The goal of this research was to examine how this traumatic event lead to learning and ultimately institutional change from a variety of different perspectives. The purpose of my oral history interviews was to give interviewees an opportunity to have their story told and to document the institutional story. The oral history methodology was an appropriate format in which to provide this platform because these stories need to be approached and told with care. A survey or any other means of data collection may have detracted from the personal and careful consideration that each individual should have when telling their story.

This type of methodology has also been widely used in recollecting historical events and how they relate to institutions of higher education. Mitchell Hall (1985) detailed the impact that the American invasion of Cambodia had on college campuses across the United States. In particular, he mentioned the shooting event that took place on the campus at Kent State that resulted in multiple injuries and the death of four students after members of the National Guard opened fire on a group of students protesting the Cambodian invasion. He connected these events with events at the University of Kentucky at that time and demonstrated how an event at one campus can impact another institution. This relates to this project as I examined how the events at Virginia Tech impacted the University of Kentucky campus through the development of the Community of Concern.

Hall’s research design included oral history interviews of several administrators and officials involved with the events. Through their oral histories, the connection between Kent State and the University of Kentucky becomes clearer. Mitchell Hall’s interviews gathered multiple perspectives on the events that took place at the University
of Kentucky in 1970 which included demonstrations, marches, an altercation between a university board member and a student, and the burning of a campus building. His oral history interviews triangulated with newspaper articles during that time helped to specifically support the case that events happening on one campus can have a significant impact at a completely different institution. The design for my dissertation is similar to this format in that I used university documents and newspaper articles to help establish a timeline for the development of the Community of Concern at the University of Kentucky in conjunction with the information gathered during the oral history interviews. This process also established a connection between Virginia Tech and the University of Kentucky to demonstrate that one institution changed as a result of what it learned from the other institution.

Perhaps the statement made at the end of Joseph Burch’s (Hall & Burch, 1980) oral history interview with Mitchell Hall sums up the many reasons why I chose qualitative methods as a means to answer my dissertation research questions.

My point is that as hard as they tried--and I knew some of the people in the TV and the newspapers and all that--as hard as they tried, it is so very difficult to see the whole picture, all of what's going on, and to report on it for the next day's press. It becomes an emergency-time-limit-kind-of thing. And all of that meant to me is that I had experienced things that, um, seemed to me to be one way in the whole, and, uh, in terms of their significance, and, uh, other people see them a different way, and the press sees them a different way, and history is gonna record them in probably a wholly different way. And it, it just makes, it tempers my, uh, uh, observations, I guess, when I read about historical facts that took place a
hundred years ago, or in 1920, or something, and wonder, I often wonder, is that really what happened? No, it's just one person's perceptions of what happened.
And, um, you've got to read a lot, and read a lot of different perspectives to ever come to a conclusion of what might've been the causal effects of this, or that, or what really occurred. And having lived through and participated in this part of history, I'll be very interested some years from now as an older person to sit back and read about what happened on the U.K. campus in 1970. Because they really didn't grasp it in, uh, in the press at the time. And I'm not sure whether historians of the future will really grasp it. I'm not saying I could grasp it either. I'm not saying I could write about it. I'm not sure I could. But there's so many different perspectives. (Hall & Burch, 1980)

**Research Site and Participants**

This was a case study of organizational change and learning which utilized an oral history methodology. I chose the University of Kentucky due to my familiarity with the institution, which helped me with locating participants for the study. My working relationship with the interviewees was helpful as I did not have to start at square one in terms of developing rapport. We already had a shared language and a shared past. I just had to be cautious that I did not let this cloud the information that was being shared. I had to make sure that the readers of this work could understand the story without feeling like they were being left out of the conversation.

Though I was aware of potential participants at the institution, I was also cognizant that having a “warm” recruitment line may make individuals more inclined to participate in a research project (Sadler, Lee, Lim, & Fullerton, 2010). In order to recruit
participants ethically for this study, I ensured that the consent process and explanation of participant rights was thorough and non-obligatory. It was important that the oral histories came from individuals who want to tell their stories and not from individuals who felt like they should tell their stories. Not only is this the most ethical thing to do, but it also results in richer oral histories.

The institution also seemed to be a rather representative example of how institutions responded following the incident at Virginia Tech in terms of the creation of the Community of Concern team. The University of Kentucky also matches Virginia Tech in that it is a rather typical four-year public research institution. This made it easier to make direct comparisons between the two institutions. Having worked at the University of Kentucky in residence life prior to the incident at Virginia Tech and then again after the 2007 incident in academic advising, I was aware that the institution did experience a change following the 2007 shooting incident and that there was a story here to be told. Knowing that there was an institutional response and change following the Virginia Tech incident meant that any oral histories collected at this site could document any learning that took place which resulted in the changes that occurred.

I also chose an institution other than Virginia Tech to observe what impact outside influences have on higher education institutions. Virginia Tech has already had numerous studies and reports generated for the changes that they experienced. By choosing to study a different institution, this helps to enhance the field of knowledge regarding the impact that campus incidents have on higher education as it provides a different perspective and an additional source of information.
Recruitment of participants involved passive recruitment techniques. The University of Kentucky Institutional Review Board does not allow direct participant recruitment. Thus, information about the study (Appendix A) was sent to all current members of the Community of Concern Committee at the University of Kentucky through the committee coordinator, Therese Smith. Those individuals were also asked to share this information with people outside of the committee who they thought might be able to provide information on the development of this committee.

This first round of recruitment emails resulted in three interviews: Dr. Robert Mock, Dana Macaulay, and Therese Smith. The second group of interviewees came through word of mouth recruitment. I let individuals across campus know about the study and asked them to pass my contact information along to any individuals who they thought might be able to share information. This tactic resulted in three additional interviews. The first was with Captain Thomas Matlock, the second individual recruited during this wave was Jim Wims, and lastly, Dr. Mary Chandler Bolin. All participants agreed to have their names used as a part of this study and all participants also agreed to have their oral history interviews archived in the Louis B. Nunn Center for Oral History at the University of Kentucky.

There was one additional participant who contacted me to participate in the interview process, but the participant did not respond to a request for an oral history interview after reaching out multiple times. This participant is not included in this study.

Six participants are included in this study:

Dr. Mary Chandler Bolin started at the University of Kentucky in February of 1997 as a senior staff psychologist at the Counseling Center. She had previously worked
in the Counseling Center part-time while completing her doctorate. In July of 1998, Dr. Mary Chandler Bolin became the Director of the University of Kentucky Counseling Center. At the time of her interview, she was still serving as the Director of the Counseling Center (M. Bolin, personal communication, May 18, 2017).

Dana Macaulay started working at the University of Kentucky in 2004 as the Assistant Director for Student Rights and Responsibilities in the Office of Residence Life. She was responsible for safety and security in the residence halls and student conduct. She later became the Associate Dean of Students. Dana worked as an Assistant Director for six years and as Associate Dean for four years. Dana did not currently work at the University of Kentucky at the time of her interview (D. Macaulay, personal communication, October 18, 2016).

Captain Tom Matlock has served in various capacities since 2002 at the University of Kentucky. He was a patrol officer and then became a member of the Joint Terrorism Task Force which worked with the FBI in the early portion of his career. From 2005-2006, he served in the Navy Reserves in Kuwait. Upon his return in 2006, he continued his work with the Joint Terrorism Task Force. He was promoted to lieutenant about a year after his return and then promoted to Captain. In 2012, Emergency Management became part of the police department and he was named the Crisis Management and Preparedness Captain. He was still serving in that capacity during the time of his oral history collection (T. Matlock, personal communication, February 21, 2017).

Dr. Robert Mock started at the University of Kentucky in 2010 as the Vice President of Student Affairs. During his time at UK, he was an active faculty member in
the College of Communications and in the Department of African American Studies in addition to his role as Vice President of Student Affairs. Dr. Mock left the University of Kentucky in the fall of 2015 to serve as President of Johnson & Wales University in Charlotte, North Carolina and at the time of his interview was still serving as President at Johnson & Wales (R. Mock, personal communication, October 4, 2017; Purvis, 2015).

Therese Smith began her work at the University of Kentucky in September of 2007 in the Emergency Management Office before joining the Dean of Students Office. She was the first Student of Concern Case Manager in the Dean of Students Office. She started in this position on December 1, 2011. In the summer of 2013, Therese was promoted to Director of the Community of Concern following organizational restructuring. At the time of her interview, Therese was still serving as the Director for the Community of Concern at the University of Kentucky (T. Smith, personal communication, October 18, 2016).

Jim Wims began his work at the University of Kentucky as the Director of Residence Life in 1996. In 2003 he was also named the Vice President for Student Affairs. In this position, Mr. Wims worked in not only residence life, but also provided oversight for dining services. At the time of his oral history, Mr. Wims was serving as the Senior Assistant Provost in Student and Academic Life at the University of Kentucky (J. Wims, personal communication, March 1, 2017; The President’s Commission on Diversity, n.d.)

After multiple requests to the campus community for additional participants, no additional participants emerged. While this oral history interview group is small, there is representation from a cross section of all the different departments who are represented
on the Community of Concern Committee. While I would have liked to have had additional participants in this study, I am not concerned with the generalizability of the information given that it is a case study.

**Procedure**

Once individuals indicated their interest in participating in an oral history, they were emailed the consent forms (Appendix B) and asked to pick a time and date that would work with their schedules. Each participant was asked if they had any questions regarding their participation. Two of the participants gave their oral histories over the phone due to their location. The rest of the participants chose to have their oral histories collected in their offices at the University of Kentucky.

Upon meeting each of the participants in their offices or connecting via phone, we reviewed the consent paperwork again and I asked if they had any questions about the process, whether they were okay with using their name or if they preferred to use a pseudonym. I also asked each participant if they were okay with their interview being recorded and if they were okay with the interview being archived in the Louis B. Nunn Center for Oral History at the University of Kentucky. There was a secondary consent form for the individuals to complete if they were okay with having their oral histories archived (Appendix C).

The Louie B. Nunn Oral History Archive allows interviewees and interviewers to add restrictions to their oral histories if they so choose. This includes being asked for permission before accessing their oral history or not releasing the oral history until a certain date. I placed a restriction on the entire collection of interviews, which kept the oral histories from being accessed by the public until the year 2020 or the completion of
this project, whichever would come first, in order to keep the integrity of this oral history project. Each participant agreed to be recorded and included in the oral history archive.

After obtaining consent for participation and inclusion in the Louie B. Nunn Center for Oral History collection from each participant, I started the recording equipment and began the interview process. Upon completion of each interview, I made sure that each participant was still comfortable including their oral history in the archive just in case the interview had gone in a direction that they were not intending. I completed field notes for each oral history and submitted each interview to the Louie B. Nunn Center for Oral History. An archivist in the Center transferred each oral history to a digital format and noted the release restrictions on each interview.

**Instrument**

The instrument used in an oral history project is the oral history questionnaire. Donald Ritchie (2003) provides a comprehensive review of how to effectively conduct an oral history interview. He suggests beginning the interview with open-ended questions that relate to the scope of the oral history interview. In this case, all of the oral history interviews started with an inquiry of the individual’s time at the University of Kentucky. Ritchie goes on to indicate that the interview from there should be a mixture of open and closed-ended questions. The closed-ended questions would be to seek specific information that the individuals may not have included in the open-ended answer.

Each individual oral history is unique and as Ritchie (2003, p. 102) points out, no interview questionnaire can anticipate that individuality. He instead suggests having a standard set of core questions to cover and then to let the interview go where it may within the confines of relevancy. The individual protocol varied based on whether the
individual was at UK prior to the incident at Virginia Tech or played a role in the Community of Concern Committee following the incident. As the interviewer, I made sure that the topics of conversation stayed on track, but I did allow each interviewee to personalize and share what they thought would be important information regarding this topic.

The protocol (Appendix D) provided the framework for the oral histories collected as a part of this research. Each oral history opened with questions about the individual’s time at UK and then the interviews moved organically through questions about their relationship to the Community of Concern and any knowledge that they may have had about how the group was formed and their role related to the formation of the group. Since each individual’s responses may have answered different questions on the interview protocol, I made sure to guide the interviews through the different topics without necessarily following the exact order of the questions on the interview protocol. Each interview ended with the same question about whether there was anything additional that they would like to share about the development of the Community of Concern at UK. This final question gave individuals the ability to share any information that we had not yet covered and was also my acknowledgement that my interviewing skills and interview protocol may not have guided the conversation through every important aspect of the development of the Community of Concern. This open question gave space for the interviewees, the experts on the topic, to provide any additional information that they found important to share.
Oral History Data

At the conclusion of each oral history I submitted the digital recording to the Louie B. Nunn Center for Oral History at the University of Kentucky. An archivist saved and cataloged each interview under a collection dedicated to my dissertation topic. I listened to each oral history multiple times and took notes on important themes and ideas that I wanted to explore in more detail. Each oral history recording was sent to a transcription company and I received digital transcriptions for each oral history. Each transcript was reviewed no fewer than five times before starting the coding process. The audio files and transcripts represent a significant portion of the data used to create a timeline of events as well as the data to explore the change which happened at UK through the lens of single and double-loop learning. In order to make sure that this project represented shared authority, the timeline of events was shared with each of the interviewees and they were provided the opportunity to share additional information about the sequence of events for the timeline. Four of the six interviewees responded with two of those four providing additional details for the timeline. The other two interviewees indicated that the timeline appeared accurate.

The idea of shared authority in oral history was first brought to the methodological conversation by Michael Frisch in 1990 (Shopes, 2003) and is an important factor to consider when thinking about who the author is of an oral history. Frisch recognizes that “sharing authority is a beginning, not a destination” (Frisch, 2003, p. 112) and is something with which many oral historians have been wrestling. In addition to Linda Shopes’ (2003) overview of the dedication that shared authority requires from the beginning of the project to the end, Lorraine Sitzia (2003) provides
another great example of this dedication. In her discussion of her oral history project, Sitzia explores what she learned about collaborative oral history over the six-year span that she worked with narrator, Arthur Thickett, who is someone with whom she had developed a personal relationship before starting the oral history project. Questions that she struggled with included: who owned the work, who decides what material is made public, and how to navigate sharing her interpretations of the oral history with the narrator when concerned about his reactions.

She cautions that shared authority can make it difficult to push the narrator or may lead a researcher to not examine responses in as much depth. However, she also highlighted that the type of relationship needed for shared authority can also result in access to information that would otherwise remain hidden. So, through each stage of her work, she remained challenged by how to answer these questions of shared authority. Even though it was not easy, through her commitment she was able to find a balance with which both she and the narrator felt comfortable.

Sitzia’s concerns also presented me some challenges when thinking about how to conduct my oral history work. I believe that shared authority is an important goal to strive for when conducting my work. However, I found times when information from one source conflicted with another source. I also have working relationships with most of the people who I interviewed. The one framework, however, that I kept coming back to which I also think helped me stay grounded, was that I am not in pursuit of the one right answer to my dissertation question; I was there to tell the story.

The conflicting information adds richness to the story and provides a glimpse at how the development of this committee was not necessarily a linear process. It does not
discredit the work, it adds layers and shows the complexity of the process. It also stays true to the oral histories and each interviewee's perspective. By not presenting discrepant cases, I would be imposing my judgement on someone else’s story by excluding one perspective in the story.

Data Analysis

The overall goal in my analysis of the interview data was to answer two basic questions. The first question was how the University of Kentucky developed a Community of Concern Committee and the second question was to explore the change that took place using the lens of single and double-loop learning from organizational learning literature. The historical portion was guided by the information shared in the oral histories as well as the artifacts that helped create the timeline for the development of the Community of Concern Committee. I also used oral histories to analyze the institutional changes as well.

To answer these two questions, I had to work with the interviewees to develop a shared understanding of their story. Janesick (2007) points out that “the interviewer as oral historian shares an interpretive role with the participant being interviewed” (p. 112). Member checking is an important part of developing this shared understanding. For this project, I provided each participant the opportunity to review the historical sequencing behind how the Community of Concern was formed at the University of Kentucky. This happened following my review and compilation of the information each interviewee provided in their oral history. They each had the opportunity to clarify any of the information that I interpreted incorrectly or to provide additional information or context.
to the story. This helped me make sure that I fully understood their story and interpreted their words appropriately while analyzing their oral histories.

One of the differences between chapter 4 which focuses on the historical timeline of events and chapter 5 which focuses on the examination of institutional change through an organizational learning lens is how the oral histories are used. Chapter 4 relies on the full use of the oral histories, meaning that every word that the interviewer and interviewee spoke are included in the chapter. This was important to me so that the oral histories stood on their own and represented the perspectives and experiences of the interviewees without my bias or editing. Chapter 5 includes direct quotes from the interviewees, but some of the quotes represent portions of their statements. Since I imposed my own beliefs while analyzing the statements in my exploration of institutional change, I moved beyond the traditional representation of oral history data into a more general qualitative interview/data analysis.

Coding

In order to examine the change which happened during the development of the Community of Concern Committee at the University of Kentucky through the single-loop and/or double-loop learning lens, I developed a coding system to classify each of the categories of learning. Because I had focused research questions, I only coded based on examples of single or double-loop learning. I categorized statements which demonstrated examples of how the organization was thinking about processing information through the committee as well as information which related to the development of the committee. For my first round of coding, I just highlighted moments which related to the learning that
was taking place. After coding each interview, I reviewed the coded sections to determine whether the statement was more demonstrative of single or double-loop learning.

Remembering back to our definitions of single and double-loop learning, single-loop learning is the type of learning that takes places without a real discussion of why the change is being made. This type of thinking was represented in the oral history interviews by statements which do not have a connection to a higher purpose or a discussion of student development. This would include statements that reference that a change was made or a decision is based upon something now being scrutinized in the court systems. For example, the University of Kentucky may have done something one way and then discovered through court rulings that they were at legal risk, so they started doing it a different way. This did not include instances where the discussion of why the courts came to the decision since that would indicate a higher level of discussion about why a decision was being made.

The second category of learning and coding category was double-loop learning. This type of learning does include a discussion and higher-level thinking and reasoning about why a decision was being made. These types of statements are represented in the oral history interviews with decisions being explained with student development theory, organizational theory, or as the result of a discussion with campus partners.

With this coding system, it is important to keep in mind that there is not one single interpretation for the oral history. While one might view one statement as evidence for single-loop learning, that same statement may appear to someone else to represent double-loop learning. Since the difference between these two types of learning lies in whether there was an examination of one’s beliefs or thoughts on a topic, it can be
difficult to identify this type of internal process. Interpretation in oral history, as well as qualitative research in general, is difficult in that there can be multiple interpretations (Janesick, 2007). Therefore it was important to let the oral histories stand on their own. When a passage is utilized as proof of a claim, it has been included for the reader. This allows the reader the ability to make his or her own interpretation of the data and it also helps the reader understand what evidence I used to make the claims that I have made as well.

After identifying these different passages, I reviewed all the highlighted examples from the six oral histories and tried to identify similarities. Using an etic (from an observer’s perspective) approach, I tried to make a thematic decision about what each passage was detailing. As I read passages, I was able to sub-code all but four statements into one of four categories: evolution, legal, team goals, and discussion. I created one additional category entitled unique to hold the statements which did not fit into one of the sub-coded categories while I worked to find categories that would house all the examples. After reviewing the statements again, I was able to group the passages into four new sub-codes: decision-making, team structure, committee goals, and evolution which now included all the passages. The process of narrowing down the examples into these four areas took several iterations, but ultimately, I was able to find terminology that was inclusive enough for each of the different examples.

Threats to Validity

As with any research project, there are threats to the validity of the information and conclusions that have been found. One of the biggest threats to validity was me, the researcher. I bring my own biases and interpretation to the information. I have tried to
minimize this impact by developing a clear coding system and providing direct citations from the oral history interviews. This allows the reader to come their own conclusions about whether my interpretations fit with their understanding of the data.

Secondly, oral history interviews are based on the recollection of information from different sources. They each have their own lenses through which they viewed an event. In addition to their personal interpretations and understandings, time plays a factor in how much they remember about the event and their memory is impacted by external sources of interference. With an event like Virginia Tech, there have been multiple stories and reports in the public arena. An individual can be influenced by the information that they hear, and this impacts their personal narrative and understanding of an event.

Thinking back to my social constructivist roots, I believe that information is socially created. To some extent, the memories and understanding that people have of events is impacted by the narrative of those around them. So, one area that may come under scrutiny with this research is whether the information gathered from the oral histories is in fact the true account of what happened. John Bodnar (1989) tackled the question regarding the influence of outside factors on an individual’s memory and concluded that there is a collective memory that is affected by dominant perspectives and a more personal memory. The more influence an institution has over the social discourse, the more hegemonic the memories become and the opposite can be said for the more personal memories. It would be wrong to deny that memories are shaped socially and in the course of this project, this influence is a part of the story that is being told as well as a part of the examination of learning and change. My interest lies in that institutional story
of change so the collection of memories from all the interviewees is representative of the learning and story I am examining.

I also recognized the limits of reconstructing a perfect timeline of events. As Bodnar also points out, “memories are limited, and a complete reconstruction of the past through memory (or any other means) is not possible. Oral historians have generally combined the memories they recorded with other kinds of records or cross-checked their interview material with data gathered from other interviews” (1989, p. 1201). For this project, much of the historical timeline that has been reconstructed is supported by print artifacts from the time of the event creating as detailed of a timeline of events as could be constructed with what was available in the memories of the oral history interviewees and the University of Kentucky archives and newspaper articles.

This project was also informed by the range of oral history interviews I was able to conduct. Although I was unable to collect an oral history interview from every member of the Community of Concern team, I was able to collect interviews from a representative sample of different kinds of practitioners involved in this type of university committee. I eventually chose to move on with the interpretation process and use the interviews that I had to piece together the story. The legal perspective in this project is extremely important. While I was not able to interview someone on the legal side of this at the University of Kentucky, I do have case law to help understand that side of the story.

Lastly, one of the major challenges that I anticipated working through with my oral history project came during analysis. Given the individual nature of an oral history, I foresaw that it would be possible that there will be different accounts about what took place at the University of Kentucky following the incident at Virginia Tech. In fact, this
was the case with the memories surrounding the naming timeline for the Community of Concern. Some may say that this highlights the error in oral histories, but it can instead highlight the different perspectives that were present during an event as mentioned before. Discussing these discrepancies is also a strategy that Creswell (2003) mentions as a way to bring greater accuracy to qualitative research.

A great example of this can be seen once again by returning to the work of Mitchell Hall (1985) and his oral histories with administrators and officials following the events that took place at the University of Kentucky in response to the Kent State shootings and the Cambodian invasion. During his oral history interviews with three interviewees, Hall came across differing opinions regarding whether outsiders had an influence in the events that took place on campus. During his interview with Jack Hall, Dean of Students at that time, Mitchell Hall specifically asked whether individuals outside of the University of Kentucky campus community played a role in the protests and vandalism that took place. Halls response was, “Well--(laughs)--yeah. Uh, to this, to, to this extent, that question was asked to me in a federal court proceeding, and I provided the court with a list of people who were active, uh, during the demonstrations but who were not students here” (Hall & Hall, 1980). Additionally, in the interview with Louie Nunn, governor at the time, the mention of outside instigators comes into play. His response to this same inquiry was, “… I think that it was being incited here at the university by individuals who, uh, wanted to create a turmoil all, all across the United States. And, uh, they, many of the students were being innocently used” (Hall & Nunn, 1980).
However, in Mitchell Hall’s exploration of these oral histories and other documents created at this time, there were no outside instigators to be found. “The combination of Kent State and armed military forces at the university, more than the work of campus radicals, produced mass protest at Kentucky. It was certainly not the product of outside agitators alluded to by Governor Nunn. If in fact there were outside radicals at UK during that time, they appear to have been ineffective” (Hall, 1985).

Even though the oral histories and the analysis of documents and the events of that time period conflict, the differing information provided some unique insight into why individuals may have made the decisions that they did or perhaps how they interpreted what was happening at the University of Kentucky. It is this discovery that makes oral history the perfect mechanism for exploring the changes that took place at the University of Kentucky following the incident at Virginia Tech.

The next two chapters will explore my two research questions with chapter four focusing on the historical creation of the Community of Concern at the University of Kentucky. The story starts prior to the incident at Virginia Tech and outlines the ways in which UK would have responded to a student who was at risk of harming self or others. From there, the story moves to the creation of the committee as well as the evolution of the committee over time. Chapter five explores the change which happened organizationally at the University of Kentucky as a result of the learning that took place. This change will be examined through the single and double-loop learning lens. As mentioned earlier in the chapter, four specific themes are a part of that analysis: decision making, team structure, committee goals, and evolution.
CHAPTER 4: HISTORICAL TIMELINE

The first research question for this study was to discover and document the historical timeline of how the Community of Concern was created at the University of Kentucky. In order to do this, I reviewed the oral histories and noted any dates or references to a time period which would help establish an official time sequence. Using a timeline found at the end of this chapter (Figure 1) with the start dates for each individual who provided an oral history included on the timeline, I added the events noted in the oral histories. After creating this, I searched the University of Kentucky archives as well as the University of Kentucky’s website which included links to news articles released by the University of Kentucky for artifacts which could also help establish the timeline of events for the creation of the Community of Concern at the University of Kentucky. Looking at each of the oral history interviews and the timeline of events which eventually emerged, the history of this group actually started prior to the incident at Virginia Tech.

Procedures Prior to the Virginia Tech Incident

Four of the six interviewees were employed at the University of Kentucky prior to 2007: Dr. Mary Chandler Bolin started in 1997, Dana Macaulay started in 2004, Captain Matlock in 2002, and Jim Wims started in 1996. In each of their interviews, they mentioned that there was an awareness of and a process in place to identify and support students who may be a risk to themselves or others prior to the creation of the Community of Concern at the University of Kentucky.

During the interview with Mr. Wims, who was the Director of Residence Life prior to 2007 and following the incident at Virginia Tech, he specifically noted that residence life had policies and procedures in place. Connecting students to the right
resources was the work of residence life staff at that time as described below from his interview.

Marianne Young: Okay. Was there, um, a specific protocol or process that would be followed at that time?

Jim Wims: Yeah, because the, the Res Life team in particular had been trained on, on what--

Marianne Young: --um-hm--

Jim Wims: --to look for, what to do, when, in fact, they discerned that there was something, uh, out of the ordinary with a student behavior. So they knew how to refer, and refer those upline. My role primarily was to make sure they were doing those things, so w-when I would hear about something, um, one of our associate directors reporting up the line to say, "This happened," my, my question was more quality control. Like--

Marianne Young: --um-hm--

Jim Wims: --"okay, did you do A, B, C, and D?" And then, then, on the back end of that, was, okay, I need to know then what's happening as we continue on through this. So it was important for us because they're not--we're not counselors. Marianne Young: Right.

Jim Wims: Um, they're not police. So the, the, the important thing was to make sure you would get this information to the right person at the right office, um, and then to have some follow-up conversations with the colleagues in other offices, like counseling, or in the UK, um, Police Department here on campus. And so
that was really kind of my role. (J. Wims, personal communication, March 1, 2017)

Prior to Virginia Tech, residence life was intervening with students in need of additional support, but in a less formal way. While Captain Tom Matlock, Crisis Management and Preparedness Captain, was not formally involved in the early history of the development of the Community of Concern at UK, he did mention the type of collaboration that Jim Wims detailed.

Captain Matlock: But before that, we, we had a really good--the Police Department, because I was in patrol at the time--so we had a good res--a good--a relationship with the individuals in the Dean of Students Office, like Dean Hazard, and, and, uh, Dana Macaulay. We worked really well together, and if they had any issues that might have come up that needed to be addressed, then we would pull--they would pull in the chief, or myself, or the--or the major, um, and we would discern whatever information was available, and work to assess the, the threat, and, you know, do whatever we needed to do to ensure that, you know--to try--to try to keep the campus as safe as possible.

Marianne Young: So thinking about the structure--um, it became a more formal thing--how would the structure of when that committee started--how might it look different, or what, what's--what does it look like compared to what it looks like now?

Captain Matlock: So back then it--there wasn't a nor--we didn't have a weekly meeting. It wasn’t as necessary.

Marianne Young: Okay.
Captain Matlock: So we basically would, uh, come together if a, a meeting would be called, or they--or there would be phone calls that would be necessary. They would--basically the h--the hub would've been, from what I understand--and Dana would know more about this than me, but s-something would come in to the Dean of Students that would s--that would be--that would raise concern. And then they would reach out to whatever resources they need, whether it be VIP, the Counseling Center, uh, Behavioral Health, uh, you know, Student Conduct, whatever the--whatever those entities were, they would reach out, find out what--you know, provide the information, and then it--they would bring it all together. And then do whatever they needed to do to ensure the student was okay, that they were getting their needs met, those kind of things. (T. Matlock, personal communication, February 21, 2017)

Dana Macaulay, who was an Assistant Director for Residence Life responsible for student rights and responsibilities, is who Captain Matlock was referring to in his interview. She also mentioned the policies that Residence Life had in place prior to 2007 and how they were used to intervene with students.

Marianne Young: Okay. So, um, I want to talk to you about your position that you had when you started in 2004, and so that would have been prior to April of 2007. And you mentioned that you were in charge of, like, student rights, responsibilities, adjudicating things. Um, can you talk a little bit specifically about your role in working with students who may pose a risk to themself or others?
Dana Macaulay: Yes. Um, largely my intervention was doing, you know, making sure that those students were referred to the Counseling Center, if appropriate, or University Health Services. Um, and then responding to them from a student conduct perspective. So in terms of the concerning behavior, addressing that behavior, um, and setting kind of guidelines and parameters for those students, you know, moving forward, to make sure that they could continue their relationship with the university.

Marianne Young: Can you think of any policies or procedures that you would have followed at that time, prior to 2007, when you first started that would have maybe guided the direction that you went with the student who was posing a risk to self or others?

Dana Macaulay: Hmm, in Residence Life there was a provision in the residence hall contract that, um, prohibited behavior that was distressing or disturbing to the community.

Marianne Young: Okay.

Dana Macaulay: And so that was probably the largest, um, kind of policy that I used when I was in Residence Life. There was a mirror image provision in the Code of Conduct as well. So both of those provisions were largely what we used to kind of, um, guide. And well, it was like the ruler that we used to guide behavior by students.

Marianne Young: Okay. And then, so we know that, um, that the shooting incident of Virginia Tech took place in 2007. Can you think--

Dana Macaulay: --um-hm--
Marianne Young: --about how maybe your position changed as a result of that incident?

Dana Macaulay: Um, that's a funny question. I was actually reflecting back on this yesterday, and the idea that we were just a little bit ahead of the Virginia Tech incident, because we had a student who was exhibiting really concerning behaviors on campus. And then the Virginia Tech incident happened. So we were able to kind of use, you know, all of the hindsight from Virginia Tech, as well as the incident we were dealing with on our campus all at the same time, to kind of craft a Students of Concern process that I think we did a good job the first time out, without having to, you know, go through a bunch of iterations of trial and error, and messing it up. (D. Macaulay, personal communication, October 18, 2016)

In these interviews, each of the individuals mentioned having policies and procedures in place to support students who may have been at risk of harming themselves or others prior to April 2007. A search of the University of Kentucky Archives revealed that the institution undertook a major review of the Student Code of Conduct in 2002. These updates reflected the first major revision of the code conduct in over thirty years. A memo dated June 14, 2005 from the Office of the President contained the newly revised Student Code of Conduct. The University indicated that this code not only applied to the behavior that one exhibits on-campus, but also off-campus should the conduct pose “a possible serious threat to the safety, security or well-being of any member of the University community” (p. 5). In addition to the jurisdiction that the Student Code of Conduct had, it also indicated that “the threat or commission of physical violence against
self or other persons” is prohibited conduct (p. 6). Exhibiting this type of behavior could result in sanctions ranging from a warning, disciplinary expulsion, or another sanction such as “compulsory psychiatric/psychological evaluation and counseling” (p. 8).

The archives did not contain copies of the housing contracts that students would have signed at that time, but according to Dana Macaulay’s oral history, the housing contract and the Student Code of Conduct were similar. I also wanted to see if the training program for members of the residence life staff included emergency response procedures. While the Office of Residence Life was able to provide a training schedule for 2006, 2007, and 2008, the schedule was not detailed enough to indicate the exact content which was covered. The University of Kentucky Archives did not contain any training manuals or schedules for Residence Life training at that time. So, the Student Code of Conduct is the only artifact other than the oral histories to help establish policies and procedures which were in place prior to the shooting incident at Virginia Tech.

While each of these interviews provided great insight into the policies and procedures in the residence life area, the interview with Dr. Mary Chandler Bolin provided an additional perspective as she was the director of the Counseling Center at the time. During her interview, Dr. Mary Chandler Bolin highlighted two initiatives that pre-dated Virginia Tech, but that were focused on intervening with students who may have been at risk to themselves or others. The first program directed by the Counseling Center was a suicide intervention program called QPR which stands for Question, Persuade, and Refer that was initiated in the Fall of 2003 (Bryant, February 20, 2009) and is still offered at the University of Kentucky at the time this dissertation was written. Dr. Mary Chandler Bolin articulated how this particular program started getting the campus community
thinking about supporting and intervening with individuals who may be a risk of harming themselves.

Dr. Mary Chandler Bolin: So the other piece I'll say that kind of ties in here is that not as part of the CoC but as sort of parallel to it we've been doing, uh, QPR, the, the q-question, persuade, not question. I cannot talk today. Question, Persuade, Refer suicide risk assessment. Uh, or that's not even the correct term. It's really suicide prevention. It's not really designed to be risk assessment. It's really more for laypersons to know what to do to intervene.

Marianne Young: Right.

Dr. Mary Chandler Bolin: Uh, and so we've been doing that here at UK since 2004. And I think because of that I b--I think that started--which again this was ahead of the CoC. I think it began a little to open up people's thinking that if you're worried about somebody it's okay to ask directly, because I think, uh, you know, again I think as human beings, uh, in the Western world or United States, I think we tend to have this sense of don't get in people's business too much, you know.

Marianne Young: Um-hm.

Dr. Mary Chandler Bolin: If somebody needs something they'll tell you. Or if they're talking about suicide they're really not suicidal, they're just trying to get attention or they're just crying wolf, which is completely wrong, that's a longstanding myth. So I think the QPR work out on campus had begun to sow some seeds of as a community we need to look out for one another. (M. Bolin, personal communication, May 18, 2017)
Along with creating an atmosphere where the community looks out for each other, Dr. Mary Chandler Bolin also discussed a formal group which met to review situations which may pose a potential safety concern.

Dr. Mary Chandler Bolin: Years ago, long before Virginia Tech, we had a monthly risk management meeting. And it was a small group. It was much smaller than the Risk Management Advisory Committee now, which we call the RMAC, which, uh, is headed up by Bill Swinford. But the old risk management, uh, meeting was fairly small. It was largely Student Affairs, but also had representation from UKPD. And this would have been back when Rebecca Langston was the chief, because we always joked with her about, you know, she'd come in wearing a good-looking business suit, carrying a great Coach handbag, and packing a pistol, you know.

Marianne Young: (laughs)

Dr. Mary Chandler Bolin: I was like, "You're the only person I know who carries a Coach bag and packs heat." So, uh, that's why this sticks in my head because we would joke about it.

Marianne Young: Yeah.

Dr. Mary Chandler Bolin: So it was a smallish group. We met in the small conference room over at the old--the old Student Center, Room 251. And so, uh, and more of that though was not specific to students, but more about like events or things that were coming up. So if there was a controversial speaker coming to campus, or things happening around homecoming. It was a bit more event, campus activity. Things we should all just be--
Marianne Young: --um-hm--

Dr. Mary Chandler Bolin: --aware of kind of thing. I will say though that did set the scene that, uh, that a number of kind of key people knew each other on a face-to-face basis. So when there were some campus emergencies, like student deaths that happened overnight, uh, and I walked, you know, got called and came on scene, I wasn't having to introduce myself to people. Like, uh, uh, kind of a bunch of us knew each other. Not that--

Marianne Young: --right.

Dr. Mary Chandler Bolin: We certainly didn't all know each other. But, but so I think that was kind of a precursor. And then, uh, the shift away from kind of those kind of what do you need to know about upcoming events or things we should be concerned about. Then the shift after Tech to really more student or stu--occasionally student group-focused.

So while the risk assessment group described by Dr. Mary Chandler Bolin was not focused on directly intervening with students like we saw in the examples given by Jim Wims, Captain Tom Matlock, and Dana Macaulay, it was focused on bringing different departments together to share information and create lines of communication across multiple campus offices. The incident at Virginia Tech, according to Dr. Mary Chandler Bolin, then created a shift to moving the focus of those meetings to individual students rather than just events that might be happening on campus. We saw this same shift and evaluation of policies and procedures in the residence life area according to Mr. Wims following Virginia Tech as well.
Marianne Young: Um, how, how did that impact, or what did campus look like following that incident as far as, um, the Residence Life side of things, and managing students who might be at risk of hurting themselves or others?

Jim Wims: Yeah, um, and so, again, we, we always had this, this notion that, even before Virginia Tech, that, you know, anything could happen in--

Marianne Young: --sure--

Jim Wims: --residence halls. And so I think the Virginia Tech incident was rather sobering for us. Um, first of all, our hearts went out to the colleagues who, who had experienced that, and--

Marianne Young: --right--

Jim Wims: --even in that situation, one of the realities that hit us, uh, very early on was that one of the first victims was an RA--

Marianne Young: --um-hm.

Jim Wims: --and that RA was doing his job when he stepped out into the hallway to see what was goin' on. And so it hit home for us, uh, and so it, it heightened, uh, I, I think our sense of, uh, uh, of awareness relative to what can the community be looking for. But I think it moved us toward conversations with other, um, units on campus, i.e. the police. You know, we, we were doing things all along related to active shooting and things like that. We were meeting informally, uh, with colleagues in counseling and others--areas to just talk about students, um, but that was more informal. And I think the thing that we know from the Virginia Tech shootings now that we really hadn't thought or talked about was the need to connect, connect the dots--
Marianne Young: --um-hm--

Jim Wims: --um, because one of the things that came out of that report was, you know, that there was some behavior on one side of campus, and in this unit and that unit, that this young man had exhibited, but there was a failure to connect the dots.

Marianne Young: Right.

Jim Wims: And so even though we had been doing that on a very form--informal basis, it was, for us, a-again, a wakeup call that maybe we, we need to be thinking more formally about how we address these cases, and who needs to be involved in these conversations. (J. Wims, personal communication, March 1, 2017)

In each of these three interviews, the interviewees had recollections of ways that the University of Kentucky was thinking about and supporting students who were at risk of harming themselves or other prior to the incident at Virginia Tech. Mr. Wims, Dana Macaulay, and Dr. Mary Chandler Bolin also recollected that the incident at Virginia Tech played a role in changing or restructuring the way that the University of Kentucky approached working with at-risk students. There was one recollection regarding the feasibility of developing this group at the University of Kentucky during the early stages of the development of the committee that only one interviewee recalled. This seemed to be an important part of the history and worth noting.

Dana Macaulay recalled that before the Community of Concern Committee became an official part of the University of Kentucky, she worked on conducting a feasibility study just following the incident at Virginia Tech. This feasibility study laid
the foundation for the Community of Concern Committee to officially be established. She also detailed the small nature of the group which first started working as the committee.

Dana Macaulay: Um, so with my supervisor, and with the other people that we thought we'd probably needed to have around the table in order to make good decisions about how to handle this, because it certainly had more far-reaching implications for the student conduct. Um, so we started with Mary Bolin from the Counseling Center, the--we had one of the captains from the police department, the department chair where the concerning behavior happened, the instructor for the class where the behavior happened, the academic ombuds, and at first, that was it.

Marianne Young: Okay.

Dana Macaulay: That was the initial student for concern team. And we kind of handled ad hoc cases as they came up, for the next probably year and a half, two years, while we then went back and wrote a feasibility study and started kind of institutionalizing the process and procedures around Students of Concern. (D. Macaulay, personal communication, October 8, 2016)

Through the exploration of these different oral histories, it is clear that students exhibiting concerning behaviors was something that was on the radar for the University of Kentucky. The incident at Virginia Tech was an impetus for formalizing policy and thinking of better ways to integrate information from across the university.

Committee Development

In order to provide the context for the organizational structure just following the incident at Virginia Tech in April 2007, the oral histories detailed the following
organizational structure at the University of Kentucky: Kumble Subbaswamy (Swamy), Provost; Pat Terrell, Vice President of Student Affairs; Victor Hazard, Dean of Students; Jim Wims, Director of Residence Life; Dana Macaulay, Assistant Director for Student Rights and Responsibilities; Dr. Mary Chandler Bolin, Director of the Counseling Center (D. Macaulay, personal communication, October 8, 2016; J. Wims, personal communication, March 1, 2017; M. Bolin, personal communication, May 18, 2017).

All six interviewees recalled the development of this committee stemming from Student Affairs or more specifically the Dean of Students Office and the Counseling Center. These two areas were specifically reporting to the Vice President of Student Affairs as Jim Wims noted.

Marianne Young: Which office took kind of the leadership role in formalizing that process?

Jim Wims: Well, I, I think Student Affairs, I would say, primarily, um, at that time, and, and it still does counseling report it up through the Vice President. He was very much interested in this, as we all were. Um, but I would say it really came out of Student Affairs, um, Pat Terrell and some of the other folks--Mary Bolin at that time--um, really had a real heart for l-let's figure out a way to deal with these as they come. (J. Wims, personal communication, March 1, 2017)

Dr. Mock, who was Vice President for Student Affairs starting in 2010, very clearly identified Student Affairs as the area responsible for developing this committee at UK.

Marianne Young: Um, do you know how this committee--like, where this committee started at UK? Whose idea was it to come up with this?
President Mock: It came from Student Affairs. (R. Mock, personal communication, October 4, 2017)

In addition to Dr. Mock indicating that Student Affairs was responsible for developing the committee, Captain Tom Matlock also recalled the Dean of Students Office, which would have been a part of Student Affairs, playing a lead role.

Marianne Young: Okay. Prior, um--so thinking, um, prior to when the Community of Concern kind of emergency management stuff became part of the Police Department, do you know how that office operated prior to 2012?

Captain Matlock: You mean the--you mean the Community--

Marianne Young: --the Community of Concern piece of it.

Captain Matlock: I don't. I, I believe that basically the Dean of Students, um, were, were the main, main individuals responsible for student conduct, um, and that's where a lot of the information would come in is through student conduct. If there were behavioral issues or whatever, they would deal it--deal with it on that level, and they would pull in whoever they would need. (T. Matlock, personal communication, February 21, 2017)

To get even more specific on who led the charge, three individuals were specifically mentioned as playing a role in developing this team in more than one interview: Dr. Mary Chandler Bolin, Dana Macaulay, and Victor Hazard (who was serving as the Dean of Students at that time). Dr. Mary Chandler Bolin’s involvement was previously noted in the interview excerpt from Jim Wims. Her involvement was also mentioned by Dana Macaulay who outlined the first group of people to be involved in creating this group.
Marianne Young: Who was a part of the team that was going back and kind of doing that research into developing that committee? Do you remember who kind of was driving that? Was it you? Was it a team? Was it--

Dana Macaulay: --I think it was kind of a team, in that what I remember off the top of my head is that Mary and Victor and I had a conversation about who else we might need to have around the table.

Marianne Young: Okay.

Dana Macaulay: So I think between the three of us, we came up with kind of that initial iteration of the team. (D. Macaulay, personal communication, October 18, 2016)

Dr. Mary Chandler Bolin also noted this group of three in her interview. “And then because initially the head person, uh, sort of coordinator for the CoC back when it was the CARE team, uh, was Dana Walton-Macaulay, who was the associate dean of students--or assistant dean of student--associate dean of students I guess was her title under Victor Hazard” (M. Bolin, personal communication, May 18, 2017).

Therese Smith, who became the first official Director of the Community of Concern at the University of Kentucky, also recalled Dana Macaulay’s role in developing the committee.

Marianne Young: You had mentioned, um, you know, that the Dean of Students Office, and, and that, that was the group that kind of took over this whole idea of-

Therese Smith: --um-hm--

Marianne Young: --having a Student of Concern--and people were doing it as an- -as, uh, other duties as assigned--
Therese Smith: --um-hm--

Marianne Young: --type of job. Do you remember any of the people who were kind of watching that or monitoring--

Therese Smith: --um-hm--

Marianne Young: --that at the time?

Therese Smith: So when I started in December 2011, um, Dana Walton-Macaulay was the Associate Dean of Students at the time, and that's actually, um, when my position was originally created who it reported to. And so Dana was one of the people that was, um, sort of in other duties as assigned, running that process. (T. Smith, personal communication, October 18, 2016)

The consistent message throughout the interviews in terms of committee development was that the initiative started in Student Affairs, which would include the Dean of Students Office, and that three key players emerged, Dana Macaulay, Victor Hazard, and Dr. Mary Chandler Bolin, who were all employed in Student Affairs at the time.

**Committee Name Evolution**

With Student Affairs leading the way on forming and developing this committee, and with three people being identified as the major players to get this committee working, the next major stage of developing this Community of Concern Committee at the University of Kentucky coincided with some of the evolution of how this team functioned. As noted in the literature review, this type of committee goes by several different names throughout higher education. While there is some discrepancy among the interviewees on which name came first, there were three basic iterations before the team
finally landed on Community of Concern. It seems from the interviews that the most common recollection was that the team started as Care Team and then moved to Students of Concern Committee.

Two team members remembered the group starting as the Care Team but then changing to Student of Concern Committee. Dr. Mary Chandler Bolin’s recollection provided some reasoning about why the change was made from Care Team to Student of Concern Committee.

Uh, so at one point in time it was called the CARE team, C-A-R-E. Uh, and the intention was to have it--to have it feel benign and caring. Uh, but this is not something--it's not like being sent to the principal's office. You're not in trouble. But the idea of encouraging potential reports, uh, incident reporters, to have a sense of like I'm not getting this student in trouble; I'm like getting them connected to help. There was some confusion though. And I had even raised that question initially. Because CARES, C-A-R-E-S, is a student support and service area that, uh, years ago developed under what was then minority affairs, and, uh, now is part of the Office of Institutional Diversity. And so there was confusion around that about CARES and the CARE team. So then we moved to Students of Concern. (M. Bolin, personal communication, May 18, 2017)

Mr. Wims’ interview provided some additional insight into why the next name was chosen. His recollection of the naming history was that Care Team was first followed by Students of Concern.

Marianne Young: Um, with the name of the committee, was there any particular reason that you honed in on "Student of Concern," and then obviously when you
added in employee it became "Community of Concern"? Was there any particular reason that the name was chosen, or...?

Jim Wims: Uh, uh, good question. I think--and, by the way, initially it was called the Care Team. I should point that out.

Marianne Young: Okay.

Jim Wims: Before it became Students of Concern it was called the Care Team. Um, and I think Swamy was saying, you know, let's call it what it is. I mean, it was like, we're dealing with students who, who have some issues that concern us. Um, and so we moved, I think, from the Care Team model to the Students of Concern model, to the Community of Concern. (J. Wims, personal communication, March 1, 2017)

Unfortunately, I was unable to get specific dates on when the name changed, but there was an interesting layer of complexity to the original names. While Dana Macaulay had the same recollection of the first two names (Care Team and Students of Concern), she recalled the committee naming happening in the reverse order from Mr. Wims and Dr. Mary Chandler Bolin with first name being the Student of Concern Committee.

Marianne Young: Okay. Um, I want to talk specifically about the title of the group. Ah, was there a particular reason, um, it's now called the "Community of Concern." Has it always been that? Or has it had other titles along the way?

Dana Macaulay: It's had other titles along the way. So it started as "Students of Concern," just because we thought that was the most accurate name for what we were doing.

Marianne Young: Okay.
Dana Macaulay: Um, and I think as the case volume grew again, and people referred more and more students, um, it was renamed once to the Care Team so that it didn't--so that--to kind of remove the stigma away from being called to that office. And so "care" sounded a little more compassionate and supportive than "Students of Concern." So that was the first renaming. And then the "Community of Concern," I think, came mostly from the idea that we weren't dealing with just students anymore, we were dealing with student faculty and staff, and that it was a community large team at that point.

Marianne Young: And so that second iteration was, "Care Team"?

Dana Macaulay: Uh-huh.

Marianne Young: Okay. I wanted to make sure that I had that right.

Dana Macaulay: Um-hm.

Marianne Young: And so it's kind of--

Dana Macaulay: --and I don't remember, I was trying to remember earlier whether "care" was an acronym or not, and I can't remember.

Marianne Young: Okay. So maybe an acronym. I'll go back and see if I can see anything that might indicate what acronym that stood for. Um--

Dana Macaulay: --yeah, if it was an acronym, Theresa would know.

Dana’s memory falls in line with what Mr. Wims said about the team name being reflective of what the group was doing and with what Dr. Mary Chandler Bolin said about the team name not being stigmatizing. Regardless of which name came first, Care Team or Students of Concern, the interviewees were consistent with the memory of Care Team and Student of Concern Team being the early renditions of this group.
There was also consensus among the interviewees about the group becoming more inclusive after realizing that there were more than just students who would be brought to the attention of this committee. In many cases, employees would surface to this group who may be of concern. Dr. Robert Mock, Vice President of Student Affairs during the early development of the Community of Concern, provided an example of how some of these complex issues outside of student life came to this group.

President Mock: Here was the issue that would occur with faculty, is that--and I'm just us--again, another hypothetical--

Marianne Young: --sure--

President Mock: --that's really not hypothetical, it's real. You know, a faculty member and their spouse are having a, um, you know, a domestic abuse situation. Well, that spilled over into the work environment. Because now you have a faculty member who is dating a staff member, who--and they've had a domestic dispute. And now the domestic partner has filed an injunction against--you know, a perimeter that the faculty member can't be inside this person's space, right? Well, they work at the same university. So now we have to manage that particular situation. When that person comes to us and let us be aware that this situation has occurred. And there would be times, too, when, ah, Human Resources would be in that meeting as well, if it was a, uh, faculty or staff issue. When it was students, Student Affairs weren't in the room. I mean, ah, Human Resources wasn't in the room. (R. Mock, personal communication, October 4, 2017)
So this type of situation laid the foundation for the second group which was the Employee of Concern Committee. When the Student of Concern Committee and the Employee of Concern Committee merged, the team changed to Community of Concern. Therese Smith detailed this evolution in her interview.

The Students of Concern team had been created some years earlier, as a response to the shooting at Virginia Tech, uh, but there hadn't been a staff person whose sole responsibility was to manage that process. Various other employees just--it was another duty that was assigned. Um, and so, in 2011, that fiscal year, they created the, the new position and I was hired. Uh, and then, as sort of the evolution of that, in the summer of 2013, the office changed scope and we became Community of Concern. Um, and ultimately what that meant was that we went from having an Employee of Concern team and a Student of Concern team to one Community of Concern team and everything managed out of one centralized office, which was mine. (T. Smith, personal communication, October 18, 2016)

The first mention of the Community of Concern name in the official University of Kentucky Bulletin was in the 2014-2015 issue. Prior to this, there was no other mention of the Care Team, Students of Concern Committee, or Employee of Concern Committee in the University of Kentucky Bulletin (University of Kentucky, n.d.). There was also no mention of the Care Team in the Kentucky Kernel, a University of Kentucky newspaper. April 15, 2008 marks the first mention of the Student of Concern team at UK in the Kentucky Kernel. The article entitled, "Program to address ‘students of concern’ may help retention", noted that a new committee involving seven departments across UK was launched with the hopes of helping students who may need additional support in order to
be successful. The article mentioned that this committee was formed following the incident at Virginia Tech just one year earlier (Kentucky Kernel, 2008).

Piecing this information with the information available from the oral histories, it appears the Care Team name was not long-standing and perhaps was only in place for a short period of time considering that the name Student of Concern Committee is documented in 2008 and that there is no mention of the Care Team in any of the university documents that I reviewed. The evolution of the Student of Concern to Community of Concern seems to have occurred around 2013 which is consistent with the information shared by Therese Smith as well as when this group was first included in the University of Kentucky Bulletin.

**Technological Evolution**

In addition to the evolution of this group's name, many of the oral history interviews included information about the technological aspect of this committee. An important and necessary piece for this group to work properly is to have an avenue through which community members can report information to the committee. Dana Macaulay spoke to the evolution of the technological side of the Community of Concern noting the early phase consisted of email or phone calls.

Marianne Young: Um, in working with this group, um, so we've looked at kind of, is there, like, a general process for how, how information would get to this group? What, what--what was the procedure put in place for how somebody in the community might get information to this group?
Dana Macaulay: So initially, we took those referrals to them through email, or people calling the dean of students' office. Um, and that was where our [inaudible] selection. Then over the course of time, we developed a database.

Marianne Young: Okay?

Dana Macaulay: And then we eventually purchased software that was designed to select and, and to notate. So after a while, we had--we got an advocate [inaudible]. But the needs now--the official needs is for people to produce it online, or if they don't want to submit them, then they call the offices, one of the office assistants submits the incident, you know.

Marianne Young: Okay. So it was called, "Advocate"?

Dana Macaulay: Yes, it was "Advocate."

Dana’s oral history detailed the move from an email-based system, to a homegrown system, and finally to an official data management system called Advocate. President Mock provided some additional details about the homegrown data management system created by the University of Kentucky Information Technology Services.

So the very first computer program that we, that we had for us to be able to track this behavior was a homegrown computer system that created with IT. They developed it for us, so that we all could share in the information, and the information was spread out, and we were very clear about who had access to it. Well, eventually, we were able to purchase some software that was designed to deal with this type of sharing of information, and how we deal with students who we had to have our eyes on. (R. Mock, personal communication, October 4, 2017)
The oral histories from Dana Macaulay and President Mock provided context into the evolution of the system. While Dr. Mock’s oral history also provided some reasoning about why the homegrown database was created (information sharing and data security), Dr. Mary Chandler Bolin’s oral history provided some additional background on why the evolution of this technology was needed at that time.

Dr. Mary Chandler Bolin: Uh, and initially it really was--it was because the-- initially there was not a really good way to receive information.

Marianne Young: Um-hm.

Dr. Mary Chandler Bolin: I mean people were mainly--they were sending e-mails. Which it's not great because they're not confidential, they're not protected, you know.

Marianne Young: Right.

Dr. Mary Chandler Bolin: And you can misfire an e-mail and all of a sudden you put stuff out there.

Marianne Young: Sure.

Dr. Mary Chandler Bolin: So, uh, so that was--I will say that's been really the bigger evolution.

Marianne Young: OK.

Dr. Mary Chandler Bolin: Is how information is received. Because it--for-- initially it was phone calls or e-mails. Uh, but again building some sort of a database. How do you capture stuff? Again a lot of times it would be phone calls and, you know, handwritten notes that then had to be typed into the system. Over time now evolving to where there's a secure way where there can be online
submissions. So I need to back up and add one step. So in terms of the way UK had it set up, we did not go directly to an outside vendor at first. They said, "Let us build a system that'll hopefully talk to SAP or whatever." So I was involved with that in terms of contacting colleagues elsewhere who had similar systems to find out like what fields do you have, how do you have it set up--

Marianne Young: Right. Right.

Dr. Mary Chandler Bolin: --what--what's the info that you're capturing. I felt like we don't need to start this from scratch. So we were able to provide that. So we had kind of an in-house-built system. However, the only people that could admit-who could submit through that format were people who had within SAP like, uh, a student admin tab.

Marianne Young: Yeah.

Dr. Mary Chandler Bolin: So, uh, so again so academic alerts were coming in that way as well as behavior alerts. But, uh, anybody who didn't have that at--that particular access just had to phone it in.

Marianne Young: Um-hm.

Dr. Mary Chandler Bolin: Which again f--made a lot more work on their end and s--I think slowed down the ability to process information. Then eventually getting to a place where they've, they've been using Advocate Symp-Symplicity as the current, current software. And now--and this is something I had really p-pushed for. I think it's really important that twenty-four/seven somebody can get information into the system. So a concerned parent.

Marianne Young: Right.
Dr. Mary Chandler Bolin: A parent who's conc--not so concerned that they need to call 911. It's not like they think their s-student has been abducted.

Marianne Young: Right.

Dr. Mary Chandler Bolin: But, you know, I'm just really worried about my student, you know, they don't c--they don't talk as often, they just seem to really be struggling, I can't really get them to tell me what's going on. Is there somebody there at UK who could just reach out to them? Great. If that concern comes up at two in the morning to be able to put it in the system. It's real clear on the CoC Web site that it is not an emergency response option. It's big bold red letters.

Marianne Young: Right.

Dr. Mary Chandler Bolin: If this is an emergency do these other things first and then s--give us your information. So I think that has really helped a lot in terms of being able to get a lot of different kinds of information into the system. Uh, I think the drop-down menus are better because they're more specific. A lot of people would mark other. I mean just--

Marianne Young: --what is other? (laughs)

Dr. Mary Chandler Bolin: What is other? Like, you know, because we racked our brains and really I think had a pretty good, pretty exhaustive list of like major, you know, kinds of areas and things you would be reporting.

Marianne Young: Right.

Dr. Mary Chandler Bolin: And so again trying to encourage people to please use--please check one of these boxes unless really what you're talking about just
totally doesn't, doesn't apply. So again refining that. Uh, I think by this fall there's talk of going to a different system, a different vendor that'll have some better options. (M. Bolin, personal communication, May 18, 2017)

Dr. Mary Chandler Bolin’s additional context clarified why the system evolved over time and she started to explain how the system works. Captain Matlock’s oral history further explained the purpose and function of the database that the University of Kentucky was able to purchase.

Advocate is the database that is used to basically report any referral type information. So if the, the RAs or RDs have a situation in the residence halls, that's where they report it is through Advocate. And then Advocate is also the database for the Community of Concern, as well. So it's a secure database that allows us to share information confidentially, so we're not, um--so it's, it's much easier to keep track of the number of cases that we have. So really everything kind of comes through this office, so I'm able to, uh, get that information. If it--if it hasn't been put into the Community of Concern, I, I enter it in there. Uh, if, if for some reason Theresa or the Community of Concern has information or questions about a particular case, she'll let me know. She'll assign the case to me. I'll look it over. I'll get the detectives or whoever I need to get involved to do certain infor--you know, collect information and do certain things, just to ensure on the police side we're covering our bases with any, any, any issues that may come up. (T. Matlock, personal communication, February 21, 2017)

The oral histories from Captain Matlock, Dr. Mock, Dana Macaulay, and Dr. Mary Chandler Bolin provided a detailed look into how the reporting system evolved over time
as well as how the Advocate system functioned. There was one additional piece of technology that entered the picture with the Community of Concern. A campus-wide emergency notification system was introduced to the University of Kentucky. Therese Smith’s oral history provided context regarding the implementation of this system on campus in August 2007 and subsequent upgrades to that system.

Therese Smith: So the only way we would in--be involved on an individual basis is when I started working there in 2007--and, again, this was--this was September; the shooting of Virginia Tech happened in April--um, UK was in the process--had just purchased an emergency notification system. If you remember, that was part of sort of the, um, assessment or, or c--or sometimes the critique of the Virginia Tech response is that they had some emergency notification systems. And depending on who you talked to, maybe there was a delay in sending out those notifications, although my argument would be based on the information they had at the time I could see why they didn't feel the need to send out a mass alert--

Marianne Young: --mm--

Therese Smith: --on campus. Now, that has all changed with what we know now, but--so UK had just purchased that, that August, the beginning of that semester, so we were implementing that, meaning letting people sign up for that. And then we wrote the scripts, and determined what are the triggers that would send out an alert, a mass notification to the University, um, through email text, whatnot. And that has continued to be expanded. I mean, again, that was the fall of 2007. We're now in 2016. So there's been lots of expansion and updates to that, um,
with sirens on campus and loudspeakers on campus that didn't exist in 2007. (T. Smith, personal communication, October 18, 2016)

The technological rollout of the emergency management systems on campus is something that has been documented in the campus paper, the Kentucky Kernel, in addition to this oral history account. A UK Alert launch article published on January 15, 2008 in the Kentucky Kernel highlighted the system’s features as well as some of the early technical and administrative issues the system encountered (Haymond, January 15, 2008). On April 16, 2008, the paper noted that the emergency alert system officially launched in January and had 13,000 subscribers at that time (Haymond, April 16, 2008).

Overview of Timeline

The development of the technological aspects of emergency management system as well as the Community of Concern Committee at UK has been an on-going process. From the reconfigurations of the policies, procedures, and team meetings that took place prior to the incident at Virginia Tech, to the evolution of the committee name, the history over the last decade has been multi-faceted. At the time of the dissertation, the Community of Concern was still operating out of the Dean of Students Office which is now housed in the area of Student and Academic Life. The committee consists of representation from the Academic Ombud, the Dean of Students Office, the Disability Resource Center, Office of Institutional Equity and Equal Opportunity, the Office of Student Conduct, the Office of the President, the Office of the Provost, The UK Counseling Center, UK General Counsel, the UK Police Department, University Health Service (Behavioral Health), and others on a case-by-case basis. The Community of
Concern Office includes one Director, one Assistant Director, and two Case Managers (www.uky.edu/concern).

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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| 1990’s     | • 1996- Mr. Jim Wims starts at the University of Kentucky as the Director of Residence Life  
• 1997- Dr. Mary Chandler Bolin starts at the University of Kentucky in the Counseling Center  
• 1998- Dr. Mary Chandler Bolin becomes the Director of the University of Kentucky Counseling Center |
| 2000-2006  | • 2002- Captain Thomas Matlock starts at the University of Kentucky as a Patrol Officer  
• 2002-2005- University of Kentucky revises the Code of Student Conduct  
• 2003- QPR Suicide Intervention Program launches in the Fall at the University of Kentucky, with support from the Graham Memorial Fund  
• 2003- Jim Wims named Vice President for Student Affairs  
• 2004- Ms. Dana Macaulay starts at the University of Kentucky |
| 2007       | • April 16- Shooting incident at Virginia Tech  
• Ms. Therese Smith starts at the University of Kentucky in the Office of Emergency Management  
• CARE Team/Student of Concern Committee forms  
• Emergency Notification System (UK Alert) under development at the University of Kentucky |
| 2008       | • January 15- Kentucky Kernel articles note that UK Alert has officially launched  
• April 15- First mention of the Student of Concern team at the University of Kentucky in the Kentucky Kernel |
| 2009       |                                                                      |
| 2010       | • Dr. Robert Mock starts at the University of Kentucky as the Vice President for Student Affairs |
| 2011       | • Ms. Therese Smith hired as Students of Concern Case Manager at the University of Kentucky |
| 2012       | • Emergency Management becomes part of University of Kentucky Police Department  
• Captain Matlock named Crisis Management Preparedness Captain |
| 2013       | • Committee name changes from Student of Concern and Employee of Concern as two separate committees merge to become the Community of Concern  
• Ms. Therese Smith is promoted to Director of the Community of Concern |
| 2014       | • Community of Concern first mentioned in the University of Kentucky Bulletin |

*Figure 1. Community of Concern Timeline at the University of Kentucky. This figure illustrates the timeline of events which took place during the development of the Community of Concern at the University of Kentucky.*
CHAPTER 5: EXPLORATION OF CHANGE

This chapter focuses on an examination of the changes and learning that took place following the incident at Virginia Tech. From my personal experience as an employee at the University of Kentucky, I knew that changes were implemented to policy and organizational structure following the incident at Virginia Tech. My goal was to examine the learning that happened which guided these changes. Specifically, I examined the ways that single and/or double-loop learning took place. The major difference between these two types of learning revolves around whether some type of higher-level discussion about what direction to take took place. With single-loop learning, a choice is made without higher-level discussion and with double-loop learning, there is a discussion about what choice to make next. Before we can examine this learning, however, I need to first establish that the University of Kentucky learned from Virginia Tech and used that knowledge to guide the changes at the University of Kentucky. The oral histories provided a strong foundation for this connection.

Connection to Virginia Tech

It is difficult to say what the University of Kentucky learned from Virginia Tech and used that knowledge to inform their organizational changes without first establishing some type of connection between the two institutions. As Captain Matlock, one of the interviewees, pointed out, there are multiple places that the University of Kentucky could have gathered information as the incident at Virginia Tech was not the first incident of violence on college campuses. "There were other active shooting scenarios, and other violent scenarios in different schools across the nation, right? I mean, it started in Texas with the clock tower, right? So that, that was in the '70s. Um, so really, I think that
Virginia Tech was the--was that, that, that spark that really got people to try to see what was going on” (T. Matlock, personal communication. February 21, 2017). So, the first thing we have to establish is the link between the University of Kentucky and Virginia Tech.

It is safe to assume that Virginia Tech was not the only place that the University of Kentucky looked to for information on how to respond to a similar event, but for the sake of this study, I can establish that Virginia Tech was one of the places that the University of Kentucky used as a model for the organizational changes to policies, procedures, and structure. In fact, the interviews validated a strong and clear connection between the two institutions. In each of the six interviews, the interviewees specifically referenced Virginia Tech and in particular either lessons that they learned from the incident or even directly communicating with members of the Virginia Tech community following the incident. This was guided, in part, by my interview recruitment as well as interview protocol as I specifically mentioned Virginia Tech when introducing the oral history interviewees to the topic of the oral history interview. However, I believe that the connection between Virginia Tech and the University of Kentucky goes beyond the framing which was set by my recruitment letters. The literature surrounding the impact that the incident at Virginia Tech had on higher education outlined in Chapter 2 supports this claim as well as the detailed connections made in the oral history interviews.

Jim Wims, one of the oral history interviewees, referenced one of the main areas of concern from the Virginia Tech investigations which was the failure to connect the dots. As previously noted, this lack of communication between campus offices and
departments was something that was cited in many of the investigative reports following the Virginia Tech incident.

And I think the thing that we know from the Virginia Tech shootings now that we really hadn't thought or talked about was the need to connect, connect the dots -- um, because one of the things that came out of that report was, you know, that there was some behavior on one side of campus, and in this unit and that unit, that this young man had exhibited, but there was a failure to connect the dots. (J. Wims, personal communication, March 1, 2017)

These statements indicated that not only had Mr. Wims read the reports, as he directly referenced the reports and the “connect-the-dots” language that came out of the Virginia Tech investigation, but that he was also making an association between what the reports said and how those reports connected to his work in higher education. Beyond the findings from the investigation, Mr. Wims also noted that they invited the Vice President for Student Affairs at Virginia Tech to come to the University of Kentucky to talk with the staff and faculty here.

We even went so far as to, um, invite, uh, the Vice President for Student Affairs at Virginia Tech--um, um, Zenobia Hikes--to come and, and, and address not just Student Affairs but other, um, affected units, or units that would be involved in addressing these behaviors going forward. She really did an outstanding job, uh, of, of kind of breaking down the, the Virginia Tech issue, and what happened, and what they did and didn't do. Uh, and so we, we used that information to help us frame, if you will, kind of our approach going forward. (J. Wims, personal communication, March 1, 2017)
His interview detailed how the information gathered following the incident at Virginia Tech framed the University of Kentucky’s approach. He also referenced the invitation to the Vice President of Student Affairs from Virginia Tech to come to speak to UK faculty and staff. These two references to Virginia Tech created a direct link between the two institutions.

Dr. Mary Chandler Bolin's oral history interview contained these same direct linkages. When asked if there were models or places that she looked to when benchmarking the Community of Concern, she pointed directly to Virginia Tech. “What I will say is certainly I was in really active communication with Virginia Tech…” (M. Bolin, personal communication, May 18, 2017). Dr. Mary Chandler Bolin also mentioned bringing individuals to the University of Kentucky from Virginia Tech for consultation.

What I will say is that we did tap into some of Virginia Tech's experience because Gene Deisinger, who was the former police chief there and who's also a psychologist, now has a consulting firm, fabulous, uh, he and, and Marisa Randazzo wrote a book together about basically campus, uh, risk assessment. We've brought him to campus. Uh, I have brought Chris Flynn, the director from Tech, the counseling center director from Tech, and another colleague who was at Arkansas at the time, to come in and do like a day of just kind of consulting with us about--how their campuses respond to emergencies, how they prepare to respond, that kind of thing. (M. Bolin, personal communication, May 18, 2017)

This portion of her interview once again revealed that Virginia Tech was not the only place that the University of Kentucky gathered information, but it was certainly one of the sources that they reached out to and looked to for guidance as the institution
considered how to move forward in working with individuals who may be at risk of harming themselves or others.

Dana Macaulay, one of the oral history interviewees who was at the University of Kentucky prior to the incident at Virginia Tech, worked directly in the area where the Community of Concern developed. She too made a direct connection between the lessons learned from Virginia Tech and the developments that took place at the University of Kentucky when asked to reflect on how her position changed following the shooting incident at Virginia Tech.

Um, that's a funny question. I was actually reflecting back on this yesterday, and the idea that we were just a little bit ahead of the Virginia Tech incident, because we had a student who was exhibiting really concerning behaviors on campus. And then the Virginia Tech incident happened. So, we were able to kind of use, you know, all of the hindsight from Virginia Tech, as well as the incident we were dealing with on our campus all at the same time, to kind of craft a Students of Concern process that I think we did a good job the first time out, without having to, you know, go through a bunch of iterations of trial and error, and messing it up. (D. Macaulay, personal communication, October 8, 2016)

In addition to referencing the hindsight they were able to use from Virginia Tech, she also recollected the impact that Zenobia Hikes, the Vice President for Student Affairs at Virginia Tech at the time of the incident, had on the work done at UK. This was the same reference that Jim Wims made in his interview as well.

We did a little bit, a tiny bit of benchmarking. There wasn't very much at the time. Um, and so I think we--actually, we had Zenobia Hikes come to campus that
next year. Um, and she talked with us a little bit. But her talk wasn't lar--it wasn't aimed directly at Students of Concern. But while she was there, we picked her brain. Ah, and you know, the hindsight on what they had that was--and Zenobia Hikes was the VPSA [Vice President of Student Affairs] at Virginia Tech, sorry. And so we talked with her, too, while she was on our campus about, um, what her thoughts might be. And so we used her guidance, and just talking with colleagues around the country about what, what kinds of things they were doing. But then I think we collectively came back and said, these are the things that we think make the most sense for us. (D. Macaulay, personal communication, October 8, 2016)

So, from this portion of Ms. Macaulay's interview we see two repeated themes. First, the theme that there were multiple sources that the University of Kentucky looked to for information and Virginia Tech was definitely one of those sources. Secondly, the visit from Zenobia Hikes to the University of Kentucky emerged as a significant event for those in conversations about the Community of Concern as this was the second interviewee that specifically mentioned her visit. Dr. Mock, another oral history interviewee, was not at UK when Zenobia Hikes came to the campus, but even he alluded to her visit and the impact that it had prior to his arrival.

Marianne Young: Um, do you know how this committee--like, where this committee started at UK? Whose idea was it to come up with this?

Dr. Mock: It came from Student Affairs. And it came after the vice president for Student Affairs. I think her name was Zenobia Hikes; I think that's her last name. I'm pretty confident about Zenobia--is her first name. She came--Student Affairs brought her to the University of Kentucky to do a public presentation to talk about
the Virginia Tech situation. And remember, she was the sitting vice president at Virginia Tech. So she was in my role. So she came to University of Kentucky, told the story about what happened at Virginia Tech. And that is what initiated the need for us to have that particular protocol in place.

Marianne Young: Okay. Do you remember when she came to campus off the top of your head?

Dr. Mock: No, but it was before--before 2010, and after '07, right? So in that window. And I don't know, because I wasn't there. It preceded me. (R. Mock, personal communication, October 4, 2016)

In addition to the visit from Zenobia Hikes, Therese Smith and Captain Matlock pointed out other ways that the University of Kentucky looked to Virginia Tech for knowledge and guidance; namely, publications, consultations with colleagues at Virginia Tech with first-hand knowledge, and theoretical guidance as noted in the description of the procedural manual that the Community of Concern uses. Therese Smith’s interview provided the first example.

So--yeah--we have a procedural manual. It is the--I want to quote it exactly. There are a variety of theories that different campuses are using. The one that the University of Kentucky--that we are using is the, um--it's the student affairs case management model that was published in "Student Affairs Case Management: Merging Social Work Theory with Student Affairs Practice," um, by Adams, Hazelwood, and Hayden. It was published in 2014. And, um, and some of those folks, specifically Sharrika Adams, who's one of the authors, is actually--they're actually from Virginia Tech. Um, and so for a lot of reasons our colleagues at
Virginia Tech, we've looked to them for a lot of guidance, um, because they've had firsthand experience, the--you know, a lot of study. (T. Smith, personal communication, October 18, 2016)

Captain Matlock shared this same connection between Virginia Tech and the University of Kentucky when discussing the theoretical purpose behind community of concern committees.

That's really the goal, and Deisinger and, and some of these, uh, individuals that were involved in Virginia Tech that have kinda came out and really talked about what these teams are about, and why you do them. And--because you can't--there's--no matter how much you do for students or for a p-person, it's still possible for them to act out in this way. But we try to be proactive and do whatever we possibly can to ensure that they're getting their needs met, and they're not getting to that point where they have no other choice but to do this. (T. Matlock, personal communication, February 21, 2017)

Outside of the theory behind the Community of Concern and the procedural manual published by individuals from Virginia Tech that the University of Kentucky uses, Therese Smith also connected the lesson learned from Virginia Tech regarding timely warnings to the emergency notification system at UK. Remembering back to one of the issues that arose after the incident at Virginia Tech, the institution was cited by the Department of Education for failing to meet the Clery Act standards for timely warning. Virginia Tech did not warn the campus that a shooting incident had taken place on campus until the second round of shooting was taking place. Therese Smith particularly
recalled this point when thinking about the connection between Virginia Tech and the
University of Kentucky.

UK was in the process--had just purchased an emergency notification system. If
you remember, that was part of sort of the, um, assessment or, or c--or sometimes
the critique of the Virginia Tech response is that they had some emergency
notification systems. And depending on who you talked to, maybe there was a
delay in sending out those notifications, although my argument would be based on
the information they had at the time I could see why they didn't feel the need to
send out a mass alert on campus. Now, that has all changed with what we know
now, but--so UK had just purchased that, that August, the beginning of that
semester, so we were implementing that, meaning letting people sign up for that.

(T. Smith, personal communication, October 18, 2016)

With all six interviewees making specific references to Virginia Tech as a source for
information in the development of the Community of Concern at the University of
Kentucky, the connection between the two institutions was consistent with other areas of
research pointing to Virginia Tech as one of the reasons why these types of committees
formed. The connection provided an opportunity to examine the learning that took place
from one institution to the another which resulted in changes at the University of
Kentucky. In this case, did the learning which resulted in changes at the University of
Kentucky resemble single and/or double-loop learning?

Analysis of Changes

Decision-Making. The first area for examination came from how the team
learned to respond to cases. Remembering that single-loop learning takes place without

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an examination of the options, but simply results in a different decision being made and that double-loop learning involves an examination and discussion of the issue before a decision is made, these oral histories provided a window into the type of learning that took place at the University of Kentucky following the incident at Virginia Tech which shaped how the Community of Concern engaged in the decision-making process.

Dr. Mock, for instance, shared that each year the team would get new information from the Department of Education and they would implement the regulations at the University of Kentucky.

And also, every year we would go through training, because we would also have--the laws would change midstream. We would get new rules and regulations from the Department of Education, based on something that would happen, right? So they would institute a new rule or a new policy that we were responsible for, right? And we would have to implement it. And so we would get trained every fall, prior to school starting. And then sometimes, they would institute these, um--what's the word I'm looking for? These mandatory orders, or these directives from the Department of Justice, or the Department of Education would come out with a, with a mandate-- executive orders that would come about, and we would have to do it. (R. Mock, personal communication, October 4, 2016)

These types of mandates would resemble things like the updates to the direct threat standard in Title II and Title III of the ADA, for example, which leaves little room for discussion and the team appeared to be making changes and learning in a single-loop process. Essentially the responses were based on guidance from the Department of Education. If it fell in line with their mandates, then it remained the same and if the
regulations changed, then the team responded in a way that was consistent with the new regulations. The changes seen in the decision-making process were the result of policy changes being made external to the institution and not the result of discussions at the university-level. Single-loop learning makes sense for mandates since there is no room for the type of discussion that is needed for double-loop learning to occur. The institution based the changes to the decision-making process using single-loop learning rooted in policy mandates from federal agencies.

The second example related to the decision-making process that the team developed that one might argue is representative of single-loop learning was found in the response that the committee had to cases. Dr. Mock's description of how the committee would respond to similar cases brought before the team explicated this "if-this-then-that" structure as well.

Because--because there's lots of stuff that, you know, there was this, ah, how do I call it, repetitive type of cases that was very similar to other cases, right? It's a fistfight; it's a disserving paper. We already know what to do with that. We've done that eighty--eighty times. So we're going to do the exact same thing we've done the other eighty times. You reach out to the students, call them in, have a discussion with them, do a contract, they're done. (R. Mock, personal communication, October 4, 2016)

This example, however, while seeming to be a clear case of single-loop learning because it appears to lack discussion, seemed to be more a demonstration of consistency with responses and does not necessarily represent what took place prior to the decision of what to do with a particular kind of case. Taking one step back, there were a couple of points
in the interviews which talked about what happened prior to a decision being made on how to respond to incidents. One example came from Dr. Mock.

Marianne Young: But when you had a situation that didn't have a clear-cut law, or didn't have a clear-cut order, or something along those lines was there a guiding principle that the team used to make decisions?

Dr. Mock: Yeah. We turned to Legal Counsel. Whenever there was clearly--and a--there was lots of debate. 'Cause remember, we're dealing with a caseload every year that would reach the three hundred plus mark, right? Because remember, we have also rolling cases from last year, right, that we're touching base with. And, um, you know, yeah. We're dealing--it would always lead to Legal at the end. (R. Mock, personal communication, October 4, 2016)

As demonstrated during his interview, the team would react to situations based on the Office of Legal Counsel’s advice. The team wanted to function within legal parameters and given the complex history surrounding liability, mental health protections, and legal reporting obligations for institutions of higher education, checking with the experts seems prudent. His recollection was also supported by Dana Macaulay's interview. When asked about how a final decision would be made, her response supported the premise that the team would defer to the Office of Legal Counsel.

Marianne Young: If there was, um, you know, discussion around the table, and there wasn't a consensus on the kind of direction to go, was there one particular, like, office or group that kind of was, like, okay, we're gonna make the final decision on what to do? Um, where, maybe, was the final decision? How did--or did it always come to consensus?
Dana Macaulay: Um, I think probably Victor, that's my supervisor, would have said to defer to legal counsel. Um, and I think ultimately, if there was a disagreement, we would probably go with what legal counsel said.

Dana Macaulay: That rarely happened, but I think that's my sense of how those conflicts would have been resolved. (D. Macaulay, personal communication, October 8, 2016)

Within the context of both interviews, however, I started to see a bit of double-loop learning coming into play. Dana Macaulay's recollection of the decision-making process included a team discussion before deferring to legal as did Dr. Mock's statement about there being "lots of debate". While it may have appeared to be single-loop learning with deferment to legal counsel, the team may have been using the legal representative as a part of the discussion. Jim Wim's description of the legal representative's presence may best describe this dynamic.

…And, oh, I didn't mention this early on--I was trying to think of some of the other people on the committee--our legal team is involved--so we always have a representative from the legal office, because, you know, you, you get into these conversations and you say, "So what, what does this do for the institutional legally if we make this decision versus that decision?" So you really need to have legal advice, too, um, because that's important. Um, because, again, if you're trying to help a student, but at the same time you're violating his or her rights by saying "You gotta go home"-- when they didn't violate a policy, I mean, mm, you're walkin'... There's a fine line there, so... (J. Wims, personal communication, March 1, 2017)
It seemed from the combination of these three interviews, that what may appear to be single-loop learning, may have actually been double-loop learning in the context of deciding how to respond to student cases. The team needed to keep the legal complexities in mind as they certainly did not want to break the law, but their decisions were based on a discussion of each individual's situation.

Mr. Wims, again, provided an excellent example of how these types of discussions took place.

So we've got a psychiatrist from University Health, in addition to our Counseling Office. Um, so they may say, "Well, you don't want to do that, because..." They might even have this student as a client, say, "Well, you know, here's what we know." Um, they might say, "Yeah, it's time for us to do a forensic evaluation, because the student is really beha--be--uh, exhibiting behaviors that cause us much concern, even in our office." The, the, the legal people might say, "Okay, but if we do this, we need to be careful about this." And so we, we talk--and there's a lot of discussion. And we don't leave the room until we have a decision made about how we're going to deal with this. Um, and so it's not left up to one person to kind of decide how we're gonna address it, but it's all of s--the collective wisdom around the table, and what's best for the student, and what's best for the institution. (J. Wims, personal communication, March 1, 2017)

Ms. Macaulay also provided some great context to these discussions which took place during the meetings as well.

Marianne Young: Okay. And what role, like you mentioned that legal was there. What role did they have in this group?
Dana Macaulay: Um, advising. Just kind of making sure that we weren't stepping outside of the company lines, or anything. And we did, I'm sure--I think that the one thing that was really great about the team, and probably still is, is that there was a lot of discussion about ideas, or how to handle situations, and how to move forward with students. And so we, um, you know, there was a lot of expertise around that table, and we did a lot of idea exchanging. And I think that that's one of the things that they--the team worked so well, was that we would come up with these. We had all this confidence, that's how we met with the students, for ways that we might move forward that would help students, and then the students could kind of navigate through those with us. But, um, I think that all the expertise that was at the table, between the ombud and legal general counsel, the Legal Office and all of those people I think really kind of helped us come up with the best potential solution for each of those students. (D. Macaulay, personal communication, October 8, 2016)

As Ms. Macaulay pointed out in her interview, the composition of the team allowed expertise to factor into the decision-making process. While Dr. Mock's interview excerpt as well as Ms. Macaulay’s interview excerpt may have made it seem like there were standardized responses for particular situations, some additional context to these interviews has helped to form a picture that shows the process is quite unique for each student. In addition, several of the excerpts from the interviewees seemed to indicate that the team deferred to legal counsel on what decision to make without discussion, however, once again, some additional context provided a different perspective. Dana Macaulay's
interview has a couple of examples which highlight this unique process and perspective for decision-making.

Marianne Young: But was there, in making decisions, was there, like, a decision tree that you would go through to say, um, if this is happening, we would err on the side of this, or we would go this direction? Or was it more of a case-by-case type of assessment?

Dana Macaulay: More of a case-by-case—um, a case-by-case assessment. And I think that we did that intentionally, because we thought that having case-by-case assessment was the best practice in these cases. Um, so we didn't want to limit ourselves with regards to what we should do, because, you know, like, some students may get depressed; suicidal ideology will respond better to a firm time out, or time out of the university, where others really need to hold onto that relationship. So we left it open intentionally, so that those things were almost always a case-by-case basis. (D. Macaulay, personal communication, October 8, 2016)

She again brought up the importance of the process being individualized as we closed out our interview.

Marianne Young: Okay. And, um, is there anything else about the process of how, like, a student might go through that you think is important that we haven't talked about at this point?

Dana Macaulay: Mmm, no. I don't think so. I think, yeah, just being mindful of the idea that it is very individualized, and it's very tailored to the individual
student needs and situation. But other than that, no. (D. Macaulay, personal communication, October 8, 2016)

So, what appeared at first to be strictly single-loop learning in regard to decision-making could arguably be considered both single and double-loop learning. In cases where there are mandated responses, the team used single-loop learning when deciding how to respond. While the group did have a consistent manner in which they responded to similar cases and while the group did consult with the Office of Legal Counsel on how to respond, the Community of Concern Committee appeared to have engaged in double-loop learning as evidenced by the individualized discussions which took place with each case. Their decisions were based on more than an if-then structure and involved higher level discussion about what would be the best decision for the student and the institution. Pulling in the expertise from a variety of individuals across campus directly connects a lesson learned from the incident at Virginia Tech and informed the Community of Concern on how to develop their processes for decision-making.

**Team Structure.** The second area of organizational change exploration came from how the team learned from others and decided on how the team would be structured. As they were designing the way the team functioned, the group was actually rather purposeful on making sure that the group was designed to address each situation in a unique way. Three different interviewees pointed out the unique way that the team was designed especially for the University of Kentucky. First, Mr. Wims talked about how the team was composed pulling bits and pieces of structural designs and processes from multiple sources.
Marianne Young: Um... You mentioned kind of modeling it from Virginia Tech. Um, were there any specific research models or other things that the team looked to? I know that you mentioned looking at some other institutions and how they were doing it, but was there anything that you could go back to, to say, "We picked this particular, um, organization of the team and process to follow because of this, this, or this"? Or was it more just, "Oh, this—we're kind of taking and pulling pieces of things that work"?

Jim Wims: Yeah, I think it was kind of taking and pulling--it was the latter, uh, trying to figure out what worked for UK. You know, every school obviously does things a little different, and so we were just trying to figure out what might work best for us. (J. Wims, personal communication, March 1, 2017)

This description provided an example of the double-loop learning that took place in trying to decide upon the structure for the team. In this instance, the team gathered multiple examples and pieces of information before deciding what would work best for the University of Kentucky. Dr. Mary Chandler Bolin's account of how the team used experts in the field and from Virginia Tech to build a model that would work for the University of Kentucky echoed Mr. Wim's recollection of trying to build something that would uniquely work for the University of Kentucky.

Dr. Mary Chandler Bolin: So I won't say that, that in terms of like a particular model. What I will say is that we did tap into some of Virginia Tech's experience because Gene Deisinger, who was the former police chief there and who's also a psychologist, now has a consulting firm, fabulous, uh, he and, and Marisa Randazzo wrote a book together about basically campus, uh, risk assessment.
We've brought him to campus. Uh, I have brought Chris Flynn, the director from Tech, the counseling center director from Tech, and another colleague who was at Arkansas at the time, to come in and do like a day of just kind of consulting with us about how their campuses respond to emergencies, how they prepare to respond, that kind of thing. So I think we've been--UK has--I say we. UK has been wise about tapping into connections that we have of known individuals or known, known, uh, consulting options that could come in and really not just say, "Here's how we do it," but talk about and how would you adjust that for your campus. Because I think that's really, really key. (M. Bolin, personal communication, May 18, 2017)

Again, the process of double-loop learning was displayed. The team gathered information and then thought about how the information that they learned could apply or be adapted for the University of Kentucky's group as it was being formed.

This example of double-loop learning carried through a third interview which discussed the University of Kentucky's Community of Concern Committee structure. We saw the importance for flexibility in this group as discussed in Ms. Macaulay's interview where she talked about how the university looked to multiple sources and developed what seemed like the best option for the University of Kentucky. This excerpt circled back to the visit that Zenobia Hikes made to campus.

Ah, and you know, the hindsight on what they had that was--and Zenobia Hikes was the VPSA [Vice President of Student Affairs] at Virginia Tech, sorry. And so we talked with her, too, while she was on our campus about, um, what her thoughts might be. And so we used her guidance, and just talking with colleagues
around the country about what, what kinds of things they were doing. But then I think we collectively came back and said, these are the things that we think make the most sense for us. I think that's something that UK does really well, is kind of look at what other schools do, their ways they deal with their problems, you know, picking up for ourselves and making sense of our own kind of deal. (D. Macaulay, personal communication, October 8, 2016)

The University of Kentucky did not simply copy the structure of the Community of Concern from Virginia Tech; they researched multiple examples and individually crafted a group which would meet the unique needs of the University of Kentucky. This reflected double-loop learning as it demonstrated that there was a discussion of multiple options and a discussion on which options would meet the individual needs of the campus as they considered the best way to create a team structure to respond to the new way the institution would be handling concerns related to individuals who may pose a risk to self or others

**Committee Goals.** This desire to respond to cases and function as a team that best meets the needs of the University of Kentucky and each individual student was grounded in the team goals that multiple interviewees shared. As this group was being created as an institutional response the incident at Virginia Tech, they had to consider what the goals of this new group would be. The first example came from the interview with Mr. Wims.

Marianne Young: Is there--th--is that one of the particular goals of that committee? Um, if you had to pick, like, what, what is that--what are the goals of this committee, what are they hoping to do, what would the goals be?
Jim Wims: Yeah, we always--again, we're looking at the student, and--and so the idea is we don't immediately start with w-we need to do somethin' to make sure the student's not here. I think we start from a premise that we want to figure out how we can help the student. Now, the challenge is many of the students who come through the system aren't interested in--there's a--there's a sense of there's nothin' wrong with me--you know, and so I don't need any help. What I need is for you to, you know, uh, change this coursework so that I can graduate at the end of the year, when the reality is you--they're not gonna make that, that, that goal because of behaviors that have prohibited them from, from finishing classes on time. Um, withdrawing at the--almost at the end of the semester, pulling out and saying, "I'm, I'm not gonna finish," and then still expecting to graduate at the end of, like, next year. That's not a reality that...you know, so just really kind of helping them to see that. So the idea is to help 'em first. Uh, we, we never come from the premise of we gotta--we gotta get 'em outta here as quickly as we can. Now, human nature would say, well, but Virginia Tech, but Virginia Tech. But, again, the goal is we've got to help the student. You know, we've got to try to fix what may be broken. And we're not--obviously we're not experts at it, but that's the goal. That's--from my perspective, that was always the goal. (J. Wims, personal communication, March 1, 2017)

This excerpt explicated how the team goals aligned with double-loop learning. Mr. Wims not only described what the goals are for the Community of Concern group, but also how those goals related to the incident at Virginia Tech. The goal was not simply to prevent another incident from happening, but to help the student. In this case, it seemed to reflect
that the group came together to decide how the lessons learned from the incident at Virginia Tech would guide them in determining what the goals were for the group. The goals for the group are also discussed in two other interviews. The first example came from Captain Matlock.

I just think that it's important to know that the goals of the team are definitely to ensure that we make the community, or try to keep the community, the campus community, safer by supporting students or employees or whoever who might be in some type of crisis. It's a--it's a... It's not... You know, the way I look at it is it, it can be--I, I've heard people. And I've seen things that have--it could have this negative connotation where, hey, you're keepin' databases of people and all this stuff, but really, we have the people that are in the room that know the laws, that know what, what can be said, done, those kind of things. And I think that it's important to know that it's for the betterment of the community, and, actually, the individuals that are in crisis, because it's all about trying to meet their needs, whatever they may be. And, and just--and the way that we do it is to ensure--and the case managers are some of the most important, 'cause they're constantly meeting with people, and setting goals, and putting people in the right place, and getting the resources to them that they need, and ensuring that they're--that they're, uh, you know, they're progressing. And so we want them to be able to stay in school and complete their degree, and, you know, deal with the things that they're dealing with, whether it be, you know, a death in the family or whatever it might be. So that's the part of the, the group that I really think is important to document, is that it, it really is a caring, functioning group of people.
that have the knowledge and the--and that have the professionalism and the ability to make decisions and to provide support to not only the students, but also to the director and her team. So I think that's really the basis of it. (T. Matlock, personal communication, February 21, 2017)

Finally, we saw these same aspirational goals mentioned by the Director of the Committee, Therese Smith.

Marianne Young: So if someone were to ask, you know, why does this committee exist at UK what would be kind of the team's response as why this committee exists?

Therese Smith: So our sort of mission, if you will, or--I don't know if it's like our mission statement, or--but it is we're looking at how do we help individuals successfully maintain relationships with the University of Kentucky. So I think that's, that's our barebones statement. We want to help individuals maintain successful and healthy relationships with the university. Um, and that can look a lot of different ways, depending on the situation, but ultimately that's what we're looking at. Um, and so that can mean they're a threat to themselves or others and we need to maybe remove them from the university temporarily so they can get help. It may mean, um, they're in financial crisis and we need to get them connected to the right resources so they can keep going to school and paying their tuition, and everything in between, if that makes sense. But ultimately, how do we help everybody have a sel--s--bluh--healthy, successful relationship with UK. (T. Smith, personal communication, October 18, 2016)
With these three examples, there are a couple of observations to make about the double-loop learning implications. First, the three examples spanned the two different interview groups contained in this study; those who were present prior to the development of the Community of Concern (Mr. Wims) and those who joined the team after the committee was developed (Captain Matlock and Ms. Smith). This seemed to indicate that the goals of the group are a topic of discussion among the team and that the topic has come up throughout the lifespan of the committee. As new people were brought into the group, the goals were shared with the team.

The sharing of goals, however, does not necessarily indicate double-loop learning. However, the actual goal itself was an example of double-loop learning. By needing to meet the individual needs of a person, the committee has committed to responding in a fashion that requires discussion and thought. The team has to decide what the individual needs before they can determine a response. This shows that they are discussing the individual, the particular situation, potential outcomes, and then using what they learned in this process to make a decision. This was a prime example of double-loop learning.

Evolution. The last example of double-loop learning came from the theme that the committee was constantly evolving as time passed. The Community of Concern was changing as a result of what they were learning during the process of functioning as a committee. This demonstrated double-loop learning because the team was having discussions about how things are going and looking for ways to change in order to become better or to better meet the needs of the campus. This evolution was seen in something as simple as the team's name. As discussed earlier, the team first started as a group focused on students of concern and was named the Student of Concern Committee.
After receiving reports of faculty or staff members who may have been in need of additional support, the team expanded to include faculty and staff concerns. At this point there were two committees, the Students of Concern Committee and the Employee of Concern Committee. In the last naming of the committee, however, the group merged to become the Community of Concern since the same people were essentially sitting on two different committees. The team chose the name because they did not want a name that would be intimidating and they wanted a name that would be inclusive. The team came to this final decision after discussing what the group represented and how they wanted it to function on the campus.

One could argue that the first name change to two separate groups may have been more indicative of single-loop learning. Since the group discovered that Student of Concern did not represent what they needed, they just added another group called Employee of Concern. The interviews do not provide evidence of much discussion on adding the second group except that the campus needed a place to address employee concerns and the Student of Concern Committee did not meet that need. With the information presented in the interviews, I do consider the first renaming an example of single-loop learning.

However, the third naming reflected that double-loop learning was taking place since there was a discussion and evaluation of options. The team used what they had learned from the experiences that they had had with the Student of Concern Committee and the Employee of Concern Committee before coming to the team's current name, the Community of Concern.
The idea of evolution and change was a constant theme in the oral histories outside of just the naming realm of the committee. Dana Macaulay's interview provided a great example of how in addition to changing the team name, the group also continued to change in terms of team composition.

What did happen though is that as we moved forward with handling more and more cases, and as our case volume increased, um, kind of institutional politics came into play. And so what that looked like was, we suddenly had, you know, all of the deans wanted to be involved, because they needed to be involved. And then the VPSA wanted to be there, and the dean wanted to be there. And at one point, we had, I think, seventeen people around the table because we had, you know, two or three people from the Legal Office. And after a while, that became cumbersome, and we kind of ramped it back and said, you know, we don't have to have all of these people here all of the time. Let's just pull in people as needed, and keep it down to a core group. (D. Macaulay, personal communication, October 8, 2016)

Here again, we see the group taking in information, thinking about who they needed on the team to function, and learning from this information to develop a team composition which would best suit the needs of the campus. This process is reflective of double-loop learning.

This team evolution was represented once again in how the team received communication from the community. As Dr. Mary Chandler Bolin mentioned in her interview, they moved from a system which relied heavily on email to a more formal system.
Uh, and initially it really was--it was because the--initially there was not a really
good way to receive information. I mean people were mainly--they were sending
e-mails. Which it's not great because they're not confidential, they're not
protected, you know. And you can misfire an e-mail and all of a sudden you put
stuff out there. So, uh, so that was--I will say that's been really the bigger
evolution. Is how information is received. Because it--for--initially it was phone
calls or e-mails. Uh, but again building some sort of a database. How do you
capture stuff? Again a lot of times it would be phone calls and, you know,
handwritten notes that then had to be typed into the system. Over time now
evolving to where there's a secure way where there can be online submissions. So
I need to back up and add one step. So in terms of the way UK had it set up, we
did not go directly to an outside vendor at first. They said, "Let us build a system
that'll hopefully talk to SAP or whatever." So I was involved with that in terms of
contacting colleagues elsewhere who had similar systems to find out like what
fields do you have, how do you have it set up what--what's the info that you're
capturing. I felt like we don't need to start this from scratch. So we were able to
provide that. So we had kind of an in-house-built system. However, the only
people that could admit--who could submit through that format were people who
had within SAP like, uh, a student admin tab. So, uh, so again so academic alerts
were coming in that way as well as behavior alerts. But, uh, anybody who didn't
have that at--that particular access just had to phone it in. Which again f--made a
lot more work on their end and s--I think slowed down the ability to process
information. Then eventually getting to a place where they've, they've been using
Advocate Symp-Symplicity as the current, current software. And now--and this is something I had really pushed for. I think it's really important that twenty-four/seven somebody can get information into the system. (M. Bolin, personal communication, May 18, 2017)

From the very beginning, the team was learning from what they had and looking for ways to improve it in order to meet privacy requirements such as FERPA and HIPAA. The team started with email and realized that that was not a confidential way to handle information so then they came together to build a communication system that would better suit their needs. In order to build this system, they had to talk about what they needed in terms of a communication system. Eventually, the team came back together and decided that the system that they had built was not meeting every need so they moved to an outside vendor for the software. As the team was developing, they were learning about what needs they had and what to either build or look for in a system. This is representative of double-loop learning because the team was discussing what they had learned about through this progression and weighing their options on how to proceed forward towards a better solution.

Another solid example of the team's evolution came from Jim Wims as he discussed how the team continued to learn and change based on emerging research and best practices.

Marianne Young: Um, how often do the consultants come. Is it a regular thing, or just...?

Jim Wims: Um, they haven't been in a while. I think a lot of what we're doing now, um, like last year we took the lead on planning a drive-in workshop for our
colleagues throughout the state. Um, now we're goin' to the professional
conferences to speak to this. Um, we do a lot of webinars, and so there's some
webinars on threat assessment, things like that. We haven't, to my knowledge,
haven't brought anybody in recently, so I, I think we take advantage of, again, the
webinars, and g--uh, goin' to professional development workshops to kind of get a
better sense of what's goin' on in the forefront. I think what--the thing we have
modeled is the need to increase, in, in many ways, the staff. And so we've done
that since the informal meetings. We've added more staff, um, because it's, it's, it's
a necessity. (J. Wims, personal communication, March 1, 2017)

This type of professional development is reflective of double-loop learning because it
shows that the group was invested in continuing the dialogue on how to most effectively
function as a team and the best ways to respond to incidents. This evolution as a team at
the University of Kentucky appeared constant and was not just representative of what
was seen at the University of Kentucky. This evolution seemed to be related to the field
of judicial and student affairs in relation to this topic as well. Dr. Mock made sure to
highlight that point at the end of his interview.

Ah, well, there's lots of people you could reach out to who could give you lots of
information associated with this, that's any of the people involved in Judicial
Affairs, in particularly. Um, but, ah, I, I would just say that this is constantly
evolving. And we are lightyears away from the Virginia Tech incident, or the
Northern Illinois incident, or the Huntsville, Alabama incident. And, and things
keep changing. And here are the things that have continually--here are some, ah,
defining moments that I think also altered these things. (R. Mock, personal communication, October 4, 2016)

Without the information and context that the oral histories provided, the complex, discussion-based system that the Community of Concern uses at the University of Kentucky may not have been as evident. The original creation and ongoing transformation of the team contained a mixture of both single and double-loop learning with the majority of the learning seeming to align with double-loop learning. It seemed like in instances where there was an opportunity to have discussion factor into the decision-making process, the team engaged in this type of double-loop learning. However, where there is no room for discussion, as seen with federal or state mandates, the team relied on single-loop learning since double-loop learning would not be productive for the group given that there is no choice on which direction to go. The learning which took place informed the committee on their decision-making process, team structure, committee goals, and played a significant part in the continuous evolution of the committee.

**Significance**

Without these oral histories, it may have appeared that single-loop learning was taking place at the University of Kentucky. As an external observer, it may have seemed like institutions looked at the legal issues that Virginia Tech faced following the shooting incident and then copied the solution that Virginia Tech created. This process would not have required a discussion of the issue, but rather an addition to the campus policy or process to avoid legal issues.
Being completely transparent during this research process, I fully expected to find multiple examples of single-loop learning. I expected to hear a detailed history of how the University of Kentucky based the group on legal recommendations following the Virginia Tech court case and simply replicated what Virginia Tech had with little-to-no discussion. Single-loop learning seemed like the most obvious path especially when considering the quick time frame for this committee to appear. I thought that there would not be enough time for double-loop learning to take place because in depth discussions take time and higher education is not known for making quick changes. What I found, however, was quite different than what I expected. There were some examples of single-loop learning within the context of these interviews, but further examination revealed a more complex learning process which blended single and double-loop learning.

The amount of discussion that this group undertook to follow up on student cases revealed an institutional desire to create the best situation for students. Additionally, the evaluation of processes and procedures within the Community of Concern demonstrated this same institutional desire to create the most effective response for individuals who may at risk of harm to self or others. I also think that making student safety and well-being a campus issue rather than an issue that is dealt with by only certain departments was at the core of this double-loop learning process for higher education. To even start to develop a Community of Concern team on a university campus required an evaluation of who is responsible for campus safety. With reporting options available to every member of the community, the University of Kentucky decided that everyone was a part of the process.
Given that these types of teams were rare prior to Virginia Tech, I think it was important to document this process and evaluate the type of learning that took place which informed the changes at the University of Kentucky. This type of a committee did not appear overnight and represented a significant addition to the campus’ operating structure. Reflecting on how this committee was added at the University of Kentucky was important to document not only for historical purposes, but it also provided some insight into the operating structure and organizational learning of an institution dedicated to higher learning. The development of the Community of Concern at the University of Kentucky represented a significant statement regarding the responsibility that an institution was willing to undertake for safety when one considers the complicated historical relationship between institutional responsibility and student rights and responsibilities outlined in Chapter 2.
I remember sitting outside of Dickey Hall at the University of Kentucky in April 2007 as a graduate student hearing the news about what was taking place at Virginia Tech. My college friend was working on her Ph.D. in chemistry at Virginia Tech at that time and I had gone to visit her several times on campus. So, when I first heard the news, I really thought that someone had made a mistake. Something like that could not happen at the beautiful campus that I had visited in Blacksburg, Virginia. I remembered school shootings happening while I was in high school, but for some reason I could not wrap my head around a shooting happening on a college campus. I do not know why I did not think that something like that would happen on a college campus, but for some reason, I had always thought of campus as a safe place. It was the place that I lived and learned and grew as a person. It was not a place where violence like this occurred.

I was studying counseling psychology at the time and was starting to become familiar with the complexity of human behavior and all the challenging situations and reasons which would lead someone to engage in disruptive or disturbing behavior. I had to be sure that what I was hearing was true. I confirmed the details once again with my classmates and when it finally registered that this was really happening, my heart dropped. I thought of all the students, who just like me, were sitting on their campuses waiting for classes, doing homework, or conducting research as a way to have a positive impact on their communities or to better their own lives. I also could not imagine what the employees must be experiencing. I was working as a graduate student for the Office of Residence Life at the University of Kentucky at that time and knew first-hand the
responsibility that accompanies someone in higher education during these types of challenging situations. You have students to protect and care for while trying to make sense of an incomprehensible tragedy. For them and for me, campus would never be the same.

I had no idea if my friend was even in class that day, but I had to know if she was okay. I tried to call her to check in; there was no response. I started trying to figure out where she might have been taking classes as a graduate student in chemistry, but I did not have much luck figuring anything out. I could not remember visiting any specific buildings on campus so all I could do was wait. I talked with my fellow graduate students about what was going on and everyone was just shocked. We all tried to imagine the trauma that those students, faculty, staff, and community members must be experiencing, and we could not imagine the mental state that the shooter had to have been in to think that shooting people was his only option. After a very long wait, I finally heard from my friend. She sent one message to a lot of people. I figured she had probably been bombarded with people reaching out to her to see if she was okay. Her message just said that she was safe and that she was taking cover. I was relieved, but I also recognized that there were many families and friends who would not be receiving that same message.

Following the incident, news reports were filled with details of the events that day. The question that seemed to keep coming up was how something like this could have happened. When looking back at all of the evidence, it seemed so clear that Seung Cho was in need of additional support and help. But, because all those pieces of information did not get connected, he never got the help that he needed. Did the institution fail him or was this just something that could not have been prevented? The
solution for this issue, or at least one of the solutions seen throughout higher education following the incident, was to get the right people in the room talking to each other and sharing information. This seems like such a simple solution to an extremely complex problem, but this one event changed the way that higher education operates. It had a significant impact on me as a student and a professional and this is why I chose this topic to more fully explore through this study. I am guessing that almost every person who was either enrolled in or working at an institution of higher education at that time has a story similar to mine and can remember exactly where they were and what they were doing when they learned about what happened at Virginia Tech in April 2007.

Beyond the individual stories, institutions across the United States started creating these committees with representation from different campus departments to share information, identify students who may be struggling, and help support those students in need. The majority of the research on Virginia Tech focused on the details of the event and how these committees can help connect the dots for better information sharing. However, I felt like the entire landscape of higher education had changed structurally in terms of the way that institutions identified and responded to students who may be in need of additional support, and there was a part of the story missing. I felt the need to fill that gap and explore this change.

From my collection of oral histories, I was able to document the historical sequence of events which led to the development of the Community of Concern at the University of Kentucky following the incident at Virginia Tech. What I learned in documenting that timeline was that the University of Kentucky was already working towards addressing the needs of students who may be at risk of harming themselves or
others by the policies and procedures that they set up through residence life. After the event, however, they were better able to focus their efforts and formalize a group to specifically respond to similar incidents. At the macro level, the University of Kentucky was also bringing together people to talk about mitigating risk at large scale events through their risk assessment group, but that focus changed to a more targeted approach following the incident at Virginia Tech.

Virginia Tech was the impetus that helped the institution realize that while they had some policies and procedures in place to support students who may be at risk of harming self or others, they may not be able to address all the concerns or risks that might surface from students who are in need of additional support. The institution took this opportunity to learn and make changes. The responsibility had to fall to the entire campus community in terms of identifying individuals who may need additional support rather than just residence life or the counseling center. They had to change their strategy to create a community in which they were looking out for every member in it.

The University of Kentucky also realized that the original structure focusing on students could be a benefit to more than just students; employees may also be in need of additional support. The team name went through multiple iterations (Care Team, Student of Concern, and Employee of Concern) before landing on the current name, the Community of Concern, in an effort to create a title which encompassed student, staff, and faculty issues as well as create a non-threatening title. One oral history in particular, from Dana Macaulay, revealed that she compiled a feasibility study for the group. This point is particularly interesting given that none of the other oral histories noted this document and this document was not available in any of the archives or through the Dean
of Student’s Office. Without her oral history, this detail may have been forgotten over time.

The composition of the group had some adjustments over time as the team started to realize what worked and who needed to be a part of the meetings. The group started very small with just a few members from Student Affairs and the Counseling Center trying to manage the cases that would come through. Over time, the Committee became more formal and eventually named Therese Smith as the first Director of the Community of Concern.

Lastly, the oral histories revealed just how important it was to document these stories before more time passed. At the time of collection, it had been around ten years since the incident at Virginia Tech. The interviews revealed conflicting information about the timeline and order of the different committee names which may have been the result of memories becoming faded over time. The University of Kentucky Archives also had limited information regarding the development of this committee. Archiving these oral histories provided the institution six different perspectives on what happened during this time of committee development. Without documenting these events and archiving them at the time that the oral histories were collected, I cannot be certain that these events could have been documented with the level of detail that I was able to capture.

It was important for me to archive this important change to the way that an institution responds to a student who may be a risk of harming themselves or others, but it also provided an opportunity to examine how institutions learn from one another. As examined in Chapter 5, the University of Kentucky engaged in multiple instances of single and double-loop learning during the process of creating the Community of
Concern. There were strong examples of single-loop learning as demonstrated from the statements that cases would result in similar outcomes based on previous cases. Or, that cases brought to the committee were decided based on the legal perspective without conversation or discussion on the details of the potential outcomes for those cases. In contrast, there were also multiple instances of double-loop learning where discussion about the beliefs surrounding students who may be at risk of harming self or others was directly part of the conversation. A prime example came from Dr. Mary Chandler Bolin who shared the campus-wide conversation which took place around looking out for other members of the community and offering help or intervening when someone needed support. The oral histories revealed the complex learning process that took place following the incident and also highlighted that learning was an ongoing process with multiple instances of adaptations and changes being made to the committee as new members were added and new processes and procedures were adapted to better meet the needs of the community and the committee as a result of that learning.

In addition to understanding the learning which took place at the University of Kentucky that resulted in changes to their policies and procedures as well as organizational structure, the comparison of institutional responses following Virginia Tech also lends itself to helping us better understand institutional isomorphism. Institutional isomorphism is a concept asserting that institutions within a field will ultimately be similar in structure (DiMaggio & Powell, 1983). In the case of Communities of Concern, these are now common committees found within institutions of higher education. However, twenty years ago they were not necessarily a part of the institutional structure. Paul DiMaggio and Walter Powell (1983) assert there are three
mechanisms by which this happens: coercive isomorphism (political influence and the organization wanting to demonstrate its legitimacy within the field), mimetic isomorphism (where an institution looks to another to model a response in uncertain times), and normative isomorphism (resulting from the professionalization of a field) (p. 150).

Being able to compare the history of the development of these committees might help to shed light on how higher education came up with a similar response from individual campuses to the shooting incident at Virginia Tech. There is certainly the possibility of political influence based on the legal and political response to what occurred as well as mimetic isomorphism. This study clearly documented how the University of Kentucky looked to Virginia Tech in developing their institutional response to an individual who may be at risk of harming self or others. There may also be normative isomorphism as this becomes an area of study and best practice within higher education. The development of Community of Concern teams throughout higher education provides a rich opportunity to further understand institutional isomorphism as it relates to all three of the mechanisms of institutional isomorphic change.

Expanding this type of exploration beyond a single institution and looking at how change occurred and policies were developed across the academy could also provide an interesting comparison to the research conducted in public administration regarding policy diffusion. Policy diffusion is the study of how one government’s policy decisions are impacted by other governments (Shipan & Voldan, 2008; Shipan & Volden, 2012). With policy diffusion, policy makers look to other government bodies for models of policies that they may or may not want to adopt for their jurisdiction. There are four
mechanisms which impact the likelihood that one government will adopt a policy from another: learning, competition, imitation, and coercion (Shipan & Volden, 2008). For higher education, expanding the exploration of change beyond a case study could lead to a better understanding of how policy diffusion happens within higher education and establish an understanding of how the widespread adoption of communities of concern happened.

Clearly, this study only represents the tip of the iceberg when one considers the entirety of the impact that the Community of Concern can have on a college or university campus. My work only reflects what happened on a single college campus and only represents six perspectives. There are so many more perspectives which could help enrich the storyline which I have started to establish for the University of Kentucky. Adding an oral history from a representative from the Office of Legal Counsel and/or a member of the upper administration serving during that time is one addition which may help provide some additional perspective. During my search for artifacts to document the historical timeline, I was not able to uncover anything regarding the perspectives of these two areas nor was I able to collect an oral history interview from them. The oral histories that I did collect are almost entirely representative of individuals who work in student affairs. I wonder if the Office of Legal Counsel or a member of the upper administration would see the development of this committee with the same lens as a student affairs professional.

I think it would also be valuable to collect oral histories from those who were not a part of the Community of Concern development. In particular, what role did faculty play in the development of this committee and how did this committee impact the work that they do? The scope of this project was defined by what took place to create the
Community of Concern, but I wonder if the narrative surrounding the launch and then use of this committee by the campus community would provide some additional context. It would also be of value to explore discrepant oral histories to the ones which were collected for this work. The six oral histories presented a rather harmonious creation of this committee at the University of Kentucky. I wonder if there is a counternarrative which would highlight the concerns or challenges that this committee faced during its creation? Was there opposition to the development of this committee or perhaps a different perspective on the function of this committee? All six interviewees either serve or have served on the committee so expanding the oral history collection to include those discrepant cases would be important. It would help enrich the historical timeline as well as provide different perspectives on how this committee came to be a part of the University of Kentucky and how it operates.

In addition to the historical context and exploration of institutional isomorphism and policy diffusion, there is also an opportunity to explore the effectiveness of this format for university and college campuses. While future behavior cannot be predicted, it would be worth investigating whether these types of committees are having an impact with individuals who are at risk of harming themselves or others. In 2018, there have been multiple headlines involving individuals who displayed signs of distress to university officials and even with intervention, these individuals went on to harm themselves or others. A student enrolled in Hamilton College took his own life after exhibiting multiple warning signs. The student’s advisor and professors shared concern with the administration about this student’s well-being, but this student did not make it to Hamilton’s Student of Concern Committee. Business cards for various campus resources
were found on the student’s desk following his suicide (Hartocollis, 2018). In this case, the structure for support and warning signs were present, but somehow the information did not get to the committee designed to help students in these situations. Just like in the aftermath of Virginia Tech, one cannot help but wonder what could have been done differently to get this student the help that he needed.

Even with intervention, however, there can still be a tragic ending. In March 2018, a student at Central Michigan University shot and killed both of his parents in his residence hall. The student had displayed concerning behavior to campus officers and was admitted to the hospital for drug-related incident the night before. He was released the next day and university officials believed that he would be heading home with his parents for Spring Break. The student shot both of his parents as they were coming to pick him up (Sanchez & Watts, 2018).

With each incident comes the opportunity to explore how things can be done better. This study revealed how the University of Kentucky was continually changing their processes and procedures in order to best meet the needs of their committee and the campus community. Do other universities have this same approach? Perhaps for every incident which is reported in the news, there are ten others which have been prevented. This type of information, which would be hard to quantify since one can never be certain what the outcome would have been without intervention, would be helpful in determining whether these committees are having the type of impact that higher education thinks they are having on college or university campuses.

Thinking outside of the Community of Concern, this exploration of organizational learning and change may have connections to another legal concern facing institutions of
Higher education: upholding Title IX of the Education Amendments of 1972. Title IX “prohibits discrimination on the basis of sex in education programs or activities operated by recipients of Federal financial assistance” (1972). Sexual harassment and sexual assault represent two forms of discrimination which have been the focus of Title IX cases as of late. Russlyn Ali, Assistant Secretary for Civil Rights for the United States Department of Education, released a *Dear Colleague* letter (2011) outlining guidelines for a school’s obligation to respond to these two forms of discrimination. The letter served as a significant guidance document for institutions of higher education and guided them to use a preponderance of evidence standard when evaluating cases of sexual harassment and assault. This burden of proof looks at whether the evidence indicates that an incident is more likely to have happened than to have not have happened. With this guidance, institutions started shaping their Title IX processes and procedures around this burden of proof standard in relation to sexual harassment and sexual assault cases.

On September 22, 2017, The United States Department of Education’s Acting Assistant Secretary for Civil Rights, Candice Jackson, released another *Dear Colleague* letter withdrawing many of the standards outlined in the 2011 guidance document for educational institutions. These new guidelines increase the burden of proof standard and afford different procedural and due-process protections for all parties involved. This left institutions trying to reconfigure their processes and procedures to meet these new interpretations of Title IX. In the meantime, colleges and universities have been the subject of legal battles surrounding this topic as they learn what their responsibilities are in preventing and responding to sexual harassment and sexual assault. The Title IX situation parallels the topic of this research project in a couple of ways.
Both Title IX and responding to a campus community member who may be a risk of harm to self or others involves the complex world of mental health and well-being. Each individual responds to situations in different ways. While one person may exhibit a behavior which would be concerning in one situation, it could be completely healthy for another individual. Or, an incident of sexual harassment may be something that one person wants to have investigated, but another may not wish for the complaint to be pursued. While there are some behaviors which clearly indicate distress or sexual harassment, there are others which are not as clear. Human behavior is incredibly complex and, in both instances, a complicating factor in determining an appropriate response.

Secondly, these examples both involve the court system. Institutions are able to gather information about ways that they either should or should not respond based on court decisions. Though there may be conflicting decisions based on different rulings from different courts, these decisions do provide some guidance on the interpretation and application of these regulations for institutions. Just as institutions looked to the investigations and legal outcomes from the shooting incident at Virginia Tech, so too do they look at the Title IX cases being brought to court for guidance on how to respond.

Lastly, there is a parallel between having a Community of Concern team on campus and having a Title IX coordinator. The Dear Colleague letter from 2011 spells out the expectation that each institution has a coordinator for Title IX complaints just as some states legally require institutions to have a Community of Concern team or at least consider it a best practice. These parallels would make for an intriguing comparison between the history of developments between these two groups. It would be interesting to
compare whether the development of the Title IX coordinator mirrored that of the Community of Concern team on campuses. It would also be worth exploring the impact that the legal case outcomes and campus incident responses have on how the Title IX coordinator responds. Would the changes taking place at the institutional level reflect single and/or double-loop learning? The example from this study showed that the Community of Concern team evolved as it was being developed. Would this also be seen in the responsibilities and practices of the Title IX coordinator? While there has been ongoing guidance from the Department of Education regarding Title IX policies and procedures, there has not been that same level of involvement in the development of community of concern committees throughout higher education. After the incident at Virginia Tech, an investigative report was released following the directives of President George W. Bush. After that, there has not been the same type of guidance documents being released in regards to campus violence even though incidents of campus violence are still occurring. What makes the involvement of the federal government different between these two areas?

Moving beyond the future possibilities for additional research questions, this study highlighted some important lessons for practitioners to take into consideration for their current work. First, this study highlighted the importance that a group of people can play in helping higher education evolve. The concept of the community of concern is that multiple constituents come together from different areas of campus to share knowledge so that students and employees in need of additional support can be identified and offered resources. The evolution of this group came about from one institution, Virginia Tech, sharing the lessons that they learned as well as individuals from the University of

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Kentucky seeking out knowledge from their colleagues at other institutions of higher education. The importance of people coming together to share information and knowledge cannot be overstated. Practitioners need to keep sharing the lessons that they have learned through both formal and informal channels so that best practices continue to evolve and improve to support the campus community.

Secondly, as a practitioner it can be daunting thinking about protecting both individuals and the larger campus community from harm. It is important to note, however, that the vast majority of students with mental health concerns do not pose a threat to themselves or the community (Appelbaum, 2006; Hollingsworth et al., 2009; Pavela, 2008). Dr. Mary Chandler Bolin’s remarks regarding the entire community looking out for one another is a vital statement to keep in mind. Remember that the University of Kentucky did not just create a Community of Concern; they also started offering suicide awareness and intervention training (QPR) throughout the institution. Pavela (2008) notes “suicide prevention is violence prevention” (p. 3). Rampage shootings, like the one at Virginia Tech, often end in suicide (Pavela, 2008). Thus, reaching out to students who are at risk of harming themselves can also help prevent incidents of campus violence. Just like sharing knowledge among colleagues is critical for the evolution of communities of concern in higher education, so too is sharing the knowledge of how to identify individuals who might be in need of additional support and how to connect those individuals to appropriate resources. One person cannot do this alone and the teamwork described throughout the oral history interviews supports this notion. My hope is that practitioners will remember this if/when they start to feel overwhelmed.
In addition to sharing knowledge with colleagues and utilizing your entire campus community to support individuals who may be in need of additional support, practitioners can also use the analysis of single and double-loop learning when examining their own learning. The development of the Community of Concern at the University of Kentucky involved both single and double-loop learning. Becoming aware of these types of learning might help to either simplify or expand your decision-making process. For example, when deciding on something that was governed by laws or policies, the group used single-loop learning. However, for cases which did not have these regulations, the team used double-loop learning to explore multiple options. It might be helpful to see if using a different type of learning would be helpful in the decision-making process. Perhaps relying on single-loop learning in instances where there really is not an opportunity for discussion can save time. In addition, opening the floor for discussion and talking about potential options may create a space for novel solutions and ideas.

This study also highlights the challenges that practitioners face when trying to follow the legal parameters which have been set. The legal history is complex with conflicting rulings on how to proceed or react. In addition, those guidelines can change and policies which were previously legal are no longer. Practitioners need to make sure that they are staying on top of the most up to date legal and policy decisions. One area that practitioners may want to consider seeking clarification involves the FERPA and HIPAA privacy guidelines. Not just with the Virginia Tech shooting, but also in some of the other cases outlined in this work, information sharing was critical to making sure that the right people got the help that they needed. When there is confusion over what can and
cannot be shared, this could delay someone getting help and an intervention happening expeditiously.

Lastly, this study highlighted the importance of documentation and I do not mean documentation in the sense of student records, but rather the historical trail. The documents that I was able to collect to support the historical timeline were extremely helpful. Without them, I would not have had that anchoring support for the oral histories. However, there were some documents, such as the housing contract, that I was not able to locate which could have enriched this study further. Becoming aware of how historical artifacts play a role in creating the history of student affairs and higher education may help practitioners start to leave more bread crumbs on the historical trail.

We have just begun to scratch the surface of these important issues within higher education. The more that we explore these challenging issues, the more that we can start to understand how to serve and support the students who enter the higher education community. This study does not represent the entire history of one campus’ journey to respond to students and campus community members who may be at risk to self or others. It instead catalogs and explores the beginning of that journey so that others who look back on how this group started at the University of Kentucky will know the important work that a group of people did to try to keep another horrible act of violence from ever happening on another college or university campus.
Appendices
Appendix A

Participant Recruitment Email

Dear Potential Participant,

You are being invited to take part in a research study about the development of the Community of Concern Committee at the University of Kentucky. You are being invited to take part in this research study because of your work associated with this committee. If you volunteer to take part in this study, you will be one of about ten people to do so.

The person in charge of this study is Marianne R. L. Young, M.S., Ed.S., Ph.D. Candidate of the University of Kentucky Department of Educational Policy Studies and Evaluation. She is being guided in this research by Dr. Jane Jensen, Ph.D. There may be other people on the research team assisting at different times during the study.

By doing this study, we hope to learn how the University of Kentucky developed a Community of Concern Committee following the shooting incident at Virginia Tech. You will not be asked about individual cases presented to the committee, but rather the administrative development of this team at UK.

You should not participate in this study if you are not aware of the Community of Concern Committee at the University of Kentucky or if you are not involved with this committee in any way at the University of Kentucky.

If you choose to participate, the research procedures will be conducted at a location that is convenient for you at the University of Kentucky and is mutually agreed upon. You will need to come to that location one time during the study. The single visit will last about 90 minutes. You will be asked to sign a consent form and make a decision on whether to include your interview in the Louie B. Nunn Center for Oral History Archive or not. If you do not wish to include your interview in the archive, you can determine whether to use a pseudonym or if your real name can be included. You will then be asked a series of questions related to the development of the Community of Concern Committee at the University of Kentucky. The interview will be recorded and cataloged and indexed using a system called Oral History Metadata Synchronizer (OHMS). The final analysis and research document will be made available to you for review.

If you choose not to submit your interview into the Louie B. Nunn Center for Oral History Archive and prefer to use a pseudonym, we will make every effort to keep confidential all research records that identify you to the extent allowed by law. Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. The interview will be kept on the researcher's password protected computer.
We will keep private all research records that identify you to the extent allowed by law if you choose to use a pseudonym. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from the University of Kentucky.

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. You may find some questions we ask you to be upsetting or stressful. If so, we can tell you about some people who may be able to help you with these feelings. In addition to the risks listed above, you may experience a previously unknown risk.

If you decide to take part in the study, it should be because you really want to volunteer as you won’t get any personal benefit from taking part in this study aside from contributing to the knowledge of the development of this team at UK. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

If you do not want to be in the study, there are no other choices except not to take part in the study.

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study. The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you.

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Marianne R. L. Young, M.S., Ed.S, Ph.D. Candidate at m.young@uky.edu or 859-257-0134. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky between the business hours of 8am and 5pm EST, Mon-Fri. at 859-257-9428 or toll free at 1-866-400-9428.

I hope that you will consider taking part in the study. If you wish to learn more about this study or if you wish to participate please contact Marianne R. L. Young at 859.257.0134 or at m.young@uky.edu.

Best,

Marianne R. L. Young, M.S., Ed.S., Ph.D. Candidate
Appendix B

Consent to Participate in a Research Study

Organizational Learning at the University of Kentucky: An Oral History
Exploration of Change Following the Virginia Tech Shooting

You are being invited to take part in a research study about the development of the Student of Concern Committee at the University of Kentucky. You are being invited to take part in this research study because of your work associated with this committee. If you volunteer to take part in this study, you will be one of about ten people to do so.

The person in charge of this study is Marianne R. L. Young, M.S., Ed.S., Ph.D. Candidate of the University of Kentucky Department of Educational Policy Studies and Evaluation. She is being guided in this research by Dr. Jane Jensen, Ph.D. There may be other people on the research team assisting at different times during the study.

By doing this study, we hope to learn how the University of Kentucky developed a Student of Concern Committee following the shooting incident at Virginia Tech.

You should not participate in this study if you are not aware of the Student of Concern Committee at the University of Kentucky or if you are not involved with this committee in any way at the University of Kentucky.

The research procedures will be conducted at a location that is convenient for you at the University of Kentucky and is mutually agreed upon. You will need to come to that location one time during the study. The single visit will last about 90 minutes.

If you agree to participate, you will be asked to sign this consent form and make a decision on whether to include your interview in the Louie B. Nunn Center for Oral History Archive or not. If you do not wish to include your interview in the archive, you can determine whether to use a pseudonym or if your real name can be included. You will then be asked a series of questions related to the development of the Student of Concern Committee at the University of Kentucky. The interview will be recorded and cataloged and indexed using a system called Oral History Metadata Synchronizer (OHMS). The final analysis and research document will be made available to you for review.

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life.

You may find some questions we ask you to be upsetting or stressful. If so, we can tell you about some people who may be able to help you with these feelings.

In addition to the risks listed above, you may experience a previously unknown risk.

You will not get any personal benefit from taking part in this study.
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

If you do not want to be in the study, there are no other choices except not to take part in the study.

There are no costs associated with taking part in the study.
You will not receive any rewards or payment for taking part in the study.

If you choose not to submit your interview into the Louie B. Nunn Center for Oral History Archive and prefer to use a pseudonym, we will make every effort to keep confidential all research records that identify you to the extent allowed by law.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. The interview will be kept on the researcher’s password protected computer.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from the University of Kentucky.

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you.

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Marianne R. L. Young, M.S., Ed.S,
Ph.D. Candidate at m.young@uky.edu or 859-257-0134. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky between the business hours of 8am and 5pm EST, Mon-Fri. at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

_________________________________________
Signature of person agreeing to take part in the study                     Date

_________________________________________
Printed name of person agreeing to take part in the study

_________________________________________
Name of (authorized) person obtaining informed consent                     Date

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Appendix C

Louie B. Nunn Center for Oral History Release

LOUIE B. NUNN CENTER FOR ORAL HISTORY RELEASE

We, __________________________ (Interviewee) and __________________________ (Interviewer), do hereby give to the University of Kentucky Libraries for scholarly and educational uses, the following recorded interview, recorded on __________ (Date), as a gift, and transfer to the University of Kentucky Libraries legal title and all literary property rights including copyright. This gift does not preclude any use that we ourselves may wish to make of the information in the recording and/or subsequent transcripts of such. Unless otherwise specified I place no temporary access restrictions on the University of Kentucky Libraries regarding usage of this interview.

SIGNATURE OF INTERVIEWEE

ADDRESS

ADDRESS

EMAIL

PHONE

DATE

SIGNATURE OF INTERVIEWER

ADDRESS

ADDRESS

EMAIL

PHONE

DATE

Temporary Access Restrictions (Only fill this section out if you want to place a temporary access restriction on this interview)

As stated above, I am transferring legal title and all literary property rights, including copyright, to the University of Kentucky Libraries. However, I wish to place the following temporary restrictions on public access to this recorded interview (including the recorded audio/video and subsequent transcripts of the interview):

☐ I wish to require written permission for usage of this interview during my lifetime.

☐ I wish to restrict access to this interview to this recording until (date): ________________

☐ Other (must include end-date for restriction or verifiable condition for future release). Please specify:

If a restriction has been placed, please make sure your contact information remains current with Nunn Center records.

Accepted for the University of Kentucky Libraries

By: __________________________ Date: __________________________
Appendix D

Interview Protocol

Organizational Learning at the University of Kentucky: An Oral History

Exploration of Change Following the Virginia Tech Shooting

Participant Name or Pseudonym: _________________________________

Location:

Interviewer: Marianne Young

Interview Time:

Date:

Start:_______  End:________

Introduction: Thank you for meeting with me today. Before we start the interview, I want to make sure to review some key components of this process. Today we will be talking about the development of the Community of Concern Committee at the University of Kentucky. You will not be asked about individual cases, but rather the administrative development of this group. You may choose to have your interview recorded and included in the Louie B. Nunn Oral History Archive at the University of Kentucky. If you do not wish to include it in the archive you can also choose whether to use your real name during the interview or a pseudonym. We will review the consent form together and you can ask any questions that you may have before you sign it. You may skip any question that you do not feel comfortable answering and you may end your interview or withdraw from the study at any time with no penalty to you. Your participation is completely voluntary.

Opening Question
Tell me about your professional time at UK?

a. When did you start working here?

b. What positions have you had?

Community of Concern Development

1. I would like to talk specifically about the position that you were in prior to April of 2007 (if applicable).

c. What position were you in at that time?

d. What was your role in working with students who may pose a risk to self or others?

e. Can you share any policies or procedures that you would have followed at that time in regards to a student posing a risk to self or others?

2. What was the response from the University of Kentucky following Virginia Tech?

f. Were there any new policies or procedures?

g. Did any new trainings or professional development happen?

h. Can you remember any specific lessons that your office learned from the reports that were written following Virginia Tech?

i. What role did this incident play in how you conducted your daily work?

3. Do you remember how you first heard about the Community of Concern Committee at UK?

j. Who started it?

k. When did it first start?

l. Where did the idea come from?

m. Was there a model that was followed?
n. What were the main factors in why this committee was formed?

o. Why was the name Community of Concern chosen?

p. Have any changes taken place in the operation of this committee since it was development?

**Closing Question**

Is there anything I haven’t asked or that you would like to share about the development of the Community of Concern Committee at the University of Kentucky?

Field Notes:
References


Bryant, T. (February 20, 2009). *UK recognizes depression screening day*
[Memorandum]. Lexington, Kentucky: University of Kentucky Public Relations & Marketing. Retrieved from https://www.uky.edu/prmarketing/search/node/uk%20recognizes%20depression%20screening%20day


*Gott v. Berea College*, 161 S.W. 204 (Ky. 1913).


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*Jain v. State of Iowa*, 627 NW2d 293, 300 (Iowa 2000).


behaviors in threat assessment: An exploration and suggested typology. 


Title IX of the Education Amendments of 1972 (Title IX), 20 U.S.C. §§ 1681 et seq.


Marianne R.L. Young

EDUCATION

**Educational Specialist**
December 2007
Counseling Psychology
Graduate Certificate in Developmental Disabilities
University of Kentucky, Lexington, Kentucky

**Master of Science**
May 2006
Counseling Psychology
University of Kentucky, Lexington, Kentucky

**Bachelor of Arts**
May 2004
Majors: Psychology & Spanish
Minor: Communications
*Summa Cum Laude*
Transylvania University, Lexington, Kentucky

PROFESSIONAL EXPERIENCE

**University Director for Academic & Career Advising: University of Kentucky**
April 2017-present

**Assistant Dean: UK Gatton College of Business & Economics**
August 2014-April 2017

**Retention Director: UK Gatton College of Business & Economics**
June 2009-August 2014

**Graduation Certification: UK Gatton College of Business & Economics**
January 2009-June 2009

**Behavior Specialist: Bluegrass MH/MR Board**
October 2007-December 2008

**Programming Coordinator: University of Kentucky Residence Life**
August 2006-May 2007

**Hall Director: University of Kentucky Residence Life**
July 2004-May 2006

PUBLICATIONS


CONFERENCE PRESENTATIONS


