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Crisis On Campus: Case Studies In University Policy Evolution

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CRISIS ON CAMPUS: CASE STUDIES IN UNIVERSITY POLICY EVOLUTION

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ABSTRACT

"The issue of what to do in response to suicidal students is anything but a clear one" (Harshbarger, 2014, para. 3). How to best support students with severe mental illness is an ongoing challenge for institutions of higher education. Institutions must adapt to a rapidly changing landscape of evolving federal policy, case law, and notable public incidences. This dissertation examined two universities in crisis and how their policies evolved after the related incidents. Using a historical case study orientation, I conducted document analysis on policy related to student crisis at Appalachian State University and Virginia Tech. The results from this analysis can serve as a guide for administrators at other universities who are designing institutional policies to prevent mental health crises.

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CHAPTER 1

INTRODUCTION

Elizabeth Shin began her first year of her undergraduate education at Massachusetts Institute of Technology (MIT) in 1998. The next semester, she overdosed on prescription pain medication and was admitted to the hospital for a week of intensive psychiatric care (*Shin v. MIT*, 2005). After she was released from the hospital, she and her father met with a psychiatrist at MIT's Mental Health Services Department. They agreed she would begin regular treatment at MIT. She continued to struggle with her mood, relationships, and academics.

In Shin's second year at MIT, her psychiatrist noted Shin was self-harming in October (*Shin v. MIT,* 2005). In November 1999, she admitted to another therapist that she was cutting herself. In December, her biology instructor reported Shin was suicidal. In March 2000, Shin was admitted to MIT's infirmary for self-harm and suicide ideation. After her return to the residence hall, there were several reports from residence hall staff that her condition was deteriorating. She was prescribed medication from an MIT psychiatrist.

In April 2000, Shin saw two new MIT mental health professionals (*Shin v. MIT*, 2005). Worried faculty and staff continued to report their concerns. On April 8, a student called campus police after Shin threatened suicide. She was transported to the MIT Mental Health Center where a physician had Shin place a five minute phone call to her MIT psychiatrist. Her psychiatrist determined she was not suicidal, and she was released. Two days later the MIT Campus Police

found her in her dorm room engulfed in flames. She died on April 14, 2000, as a result of the fire.

Shin's parents sued MIT and several administrators, therapists, and psychiatrists at MIT (*Shin v. MIT,* 2005). The lawsuit against MIT was dismissed but a trial was scheduled for the claims against the administrators and mental health professional for negligence, wrongful death, and pain and suffering. The parents claimed that the staff should have foreseen a suicide attempt and that they had neglected a duty to care for her. The university settled in a confidential agreement (Capriccioso, 2006).

Elizabeth Shin's death began a public conversation about mental illness, but more specifically about suicide at MIT. There were 12 suicides at MIT between the years 1990 and 2002 (Sontag, 2002). Before MIT employees were instructed by the MIT administration to make no comments to the media, MIT's chancellor was quoted as saying that the MIT mental health facilities were "remarkably inadequate" (Dana, 2002, para. 7). A 2002 cover story in the New York Times described the public perception of MIT as a "pressure cooker" (Sontag, 2002, para. 6). With an average of one student suicide a year for 12 years, MIT clearly lacked the internal policy and public relations management to handle student mental health crises.

The media response to a student suicide creates another layer of pressure on administrators to respond quickly and accurately and also to frame the university in the best light possible in the face of crisis. After Shin's death and during the subsequent lawsuit, administrators at MIT struggled with public perception of the Shin case and the public perception

of MIT as a pressure cooker with serial suicides (Sontag, 2002). MIT continues to publicly struggle with their suicide rate, which is routinely above the national average (Rocheleau, 2015).

Other universities have experienced similar media challenges after an incident of student deaths. When a residence hall at Seton Hall University caught on fire and three students died and 60 were hospitalized, the university did not immediately respond to media inquiries (Rennie, 2007). Desperate for information, the media began to report all the circulating student rumors, including those of disconnected hoses and a lack of sprinklers. These rumors and concerns were reported on a continuous cycle in the national media. When Seton Hall finally held a press conference, they were overwhelmed by the press demanding responses to all the student rumors.

Policy on how to respond to a campus crisis is different from university to university and across a university's timeline. A university's response to student death will take into account the specifics of the incident, who was directly affected, the media interest, and the potential for litigation (Cintrón et al., 2007). Policy may also change after an incident when the policy was found to be ineffective or harmful. As reported in *College Student Death*, one case of well-developed and practiced emergency policy was changed after a miscommunication between an emergency room nurse and a dean (McCauley & Powell, 2007). The dean conveyed the information he was given by the nurse to the student body, and the information proved to be inaccurate. This resulted in a large number of upset students who suspected an administrative conspiracy. In another incident, an administration waited so long to make statements about a student's death that misinformation and conflicting information spread throughout the campus. In response, the university modified its notification protocols.

After a public crisis or lawsuit, there typically are hasty and earnest efforts, and staff scramble to prevent suicide and improve mental health at the university in crisis. During the

2003–2004 academic year, six New York University (NYU) students jumped from buildings to their deaths (Winerip, 2011). One photo of a NYU student falling 24 stories was published in the New York Post. The following year, NYU began a system-wide prevention strategy that included physical barriers, general staff training, and a nearly doubling of their mental health professional staff. Between 2000 and 2005, Cornell University had 10 documented suicides, many of which took place at very public gorges, earning themselves the reputation as the "suicide school" (Gabriel, 2010, para. 3). After another series of six student suicides in 2010, Cornell began installing fences and nets around the gorges (Tobin, 2014). Faculty and staff at Cornell, including custodians, are now trained to spot emotional distress (Gabriel, 2010). After the lawsuit brought by the Shin family, MIT made several changes to their mental health services that included a focus on prevention, more hired staff that were fluent in languages other than English, and a different staffing model (Capriccioso, 2006).

No institution of higher education is immune from student suicide. In one study of over 100,000 undergraduate students, 1.5% of students reported having attempted suicide (Drum et al., 2009). Completed suicide rates for college students are about 6.5 to 7.5 per 100,000 students, or 1 or 2 a year for a campus of 25,000 students. Although student suicide is an ongoing issue in higher education, the incidences at Cornell, MIT, and NYU illustrate the potential for institutions to be unprepared and caught rushing policy changes when an event draws the attention of the public or court of law.

Statement of the Problem

About 10% of higher education students report having seriously considered suicide and 1.5% have attempted suicide (Drum et al., 2009; Kisch et al., 2005). There have been significant changes that may influence policy focused on suicidal ideation and threatened self-harm. Federal

laws, such as Section 504 of the Rehabilitation Act (1973), the Americans with Disabilities Act of 1990 (ADA), and the Family Educational Rights and Privacy Act (FERPA; 1974) have been major contributors to higher education policy related to disability and mental health since 1973. Case law continues to evolve regarding universities' responsibilities concerning student suicidal ideation, including *Schieszler v. Ferrum College* (2002), and *Mahoney v. Allegheny College* (2008; Dyer, 2008; Kalchthaler, 2010; McAnaney, 2008). Campus shootings in 2007 and 2008 on the campuses of Virginia Tech and Northern Illinois University caused many universities to revisit their policies on students with mental illness (Davies, 2008; Rasmussen & Johnson, 2008). In addition, these incidents led to public demand for changes in federal law with the hopes to prevent campus violence.

There is no clear protocol for institutions of higher education when they have a student experiencing a suicidal crisis. According to the *Higher Education Law Report,* "the issue of what to do in response to suicidal students is anything but a clear one" (Harshbarger, 2014, para. 3). The consequences for not having up-to-date policy can be severe for institutions of higher education. A number of colleges and universities have been involved in lawsuits and civil rights complaints related to the handling of suicidal students. Georgetown University received a U.S. Department of Education Office of Civil Rights (OCR) complaint in 2011 because it did not have clear and communicated policy on how decisions are made on whether a student may return to the university following a medical leave (U.S. Department of Education, 2011b). St. Joseph's College was found to be in violation of Section 504 by the OCR in 2011 for, among other complaints, not having a process for which a student could defend or explain her actions or to appeal her suspension related to her mental illness (U.S. Department of Education, 2011a). In 2010, Spring Arbor University was found to be in violation for not having appropriate

investigation procedures or written procedures for readmitting students after a medical leave and for requiring a particular student to submit mental health documents and plans that were not required of other students (U.S. Department of Education, 2010). In the Spring Arbor University case, the university was required to reimburse the student for tuition expenses. Other institutions have scrambled to address clusters of student suicide, trying to prevent the next potential suicide and heal a grieving student body at the same time. Statistical analysis of the six student suicides at Cornell University during the 2009–2010 academic year point to evidence of a suicide contagion, and not a randomized probability (MacKenzie, 2013). This is a particularly frightening conclusion for administrators who could find themselves trying to prevent a cluster of suicides while remaining within the bounds of student civil and privacy rights.

Purpose of Study

The purpose of this study was to provide historical and particularistic case studies that will allow administrators at institutions of higher education to better understand the successes and challenges of other institutions. The institutions chosen in this study have experienced significant controversial events that garnered media attention and public scrutiny and discussion.

The cases in this study detail when institutions of higher education have been challenged in court or in the media. The OCR has investigated many student complaints when institutions have removed students from campus or refused to readmit them after a medical leave (Harshbarger, 2014). Several institutions have been sued for allegedly not doing enough to support mentally ill students, and others for allegedly becoming too involved in treatment or preemptively removing students from campus (Dyer, 2008; Kalchthaler, 2010). Other public relations cases have included suicide clusters (including Cornell earning the nickname "suicide

school") and school shootings. Without clear legal direction on how to address students thinking about suicide (Harshbarger, 2014) institutions are facing a potential minefield.

The qualitative case study here examines the evolution of university policies regarding student mental illness before and after the university and its policies were unexpectedly in the midst of public controversy. By examining the evolution of these policies, administrators may gain the benefit of foresight before they may face their own lawsuit, OCR investigation, media investigation, or crisis.

Significance of Study

When administrators face a challenge and the institution of higher education does not have a standard policy response, administrators must rely on their own training, best judgment, and understanding of the case. Many landmark lawsuits in higher education are a result of administrators making decisions when there was no policy or policy was incomplete or vague. Policy regarding student self-harm and suicide ideation has never been more relevant, as university counseling center professionals are reporting the highest rates of severe mental illness and self-harm than ever before (Gallagher et al., 2004). A litigious environment has made educators in higher education aware of the possibility of being held liable, but the legal guidance from case law related to student suicide and mental illness has been sporadic and spread across a number of years which can be confusing to universities. Because there are many ways to interpret the ADA and relevant case law, there is an opportunity to examine how important policy decisions are made and implemented in uncertain legal environments. By examining

successes and challenges particularly in the frame of student self-harm and suicide ideation, administrators can learn from the decisions and interpretations of other administrators.

Research Questions

This study addressed the following research questions:

1. How did policy on student mental health crisis evolve at the institutions after the controversial and public event?
2. What can institutions of higher education learn from peer institutions that have experienced mental health crises?

To address the research questions, case studies were created using public documents and published material from the universities, local and national media, and state records.

Limitations, Delimitations, and Scope

Because this research involves case studies, the research may not be applicable to any other universities and will not be applicable to all universities. The study was limited to relevant policies to the universities in the cases and only within a scope of a few years of the notable public incident. While response to student suicide can be traced to 1920 (Kraft, 2011), it is not feasible to track all policy creation and changes since the founding of a university. I also did not have access to policy ideas that were proposed but not adopted.

This study examined two large, public, residential universities in the United States. External factors identified that were relevant include case law, federal policy such as the ADA, the Clery Act, and FERPA. Although internal incidents that only apply to the university of study may not have had an effect elsewhere, the general response of university stakeholders is worthy of study.

CHAPTER 2

LITERATURE REVIEW

The purpose of this study was to examine how policy changed at two universities that experienced crises related to student mental health. Framed by the policy theory of incrementalism (Lindblom, 1979) and Lasswell's (1956) theory of policy as process, this chapter addresses the evolution of federal and state policy and case law that impact how university administrators address the issue of suicidal threats or behaviors on campus. This chapter also reviews literature related to the mental health mental health needs of university students

Evolution of Related Public Policy

According to Lindblom (1959), policy is always in the process of being changed and revised. The following section explores some of the policies and case law that could impact an institution of higher education's policies on student suicide. Within the federal policies there are ongoing revisions and amendments. The following section will explore the significant changes to the legal landscapes that may impact policy on student suicide.

Section 504 of the Rehabilitation Act and the Adults with Disabilities Act

Section 504 of the Rehabilitation Act of 1973 (Section 504) is a federal law that prevents discrimination against people with disabilities including those with physical disabilities, mental disabilities, and chronic illnesses. The Civil Rights Act of 1964 was used as a framework for Section 504 and then for the ADA (Heller & Harris, 2012). Section 504 only applies to "any

program or activity receiving Federal financial assistance" or "any program or activity conducted by any Executive agency" (Rehabilitation Act, 1973 para 1). The Americans with Disabilities Act of 1990 (ADA) builds upon Section 504 and applies to public and private institutions regardless of their funding status. The ADA, as amended in 2008, defines "disability" as an individual with "a) a physical or mental impairment that substantially limits one or more major life activities of such individual; b) a record of such an impairment; or c) being regarded as having such an impairment." (ADA, Section 12102).

The History of Passing Section 504

Section 504 was the first legislative act to prevent discrimination against people with disabilities (Myers et al., 2013). Section 504 required that any public or private institution receiving federal funds must not discriminate against people with disabilities. Section 504 applied to all institutions of higher education that admitted students receiving federal aid.

In 1970, although approximately 9% of people in the United States had disabilities, there was little self-advocacy due to societal barriers (Scotch, 2001). Poverty rates were higher among people with disabilities than the general population. Many people with disabilities were living in institutions or group homes. People with disabilities were not guaranteed access to public transportation or public buildings. Children with disabilities were not receiving services in public schools. Despite all the barriers, disability legislation including Section 504 passed.

There are several explanations for the ease with which Section 504 passed. The Civil Rights Act of 1964, Title IX (Education Amendments of the Civil Rights Act of 1972), and the Vietnam War provided significant momentum to the passage of Section 504 (Scotch, 2001). In addition, the Disability Rights Movement, which took on the distinct flair of the 1960s and 1970s campus protests and student activism, helped spur national legislation (Myers et al., 2013;

Scotch, 2001). The 1970s were thick with political activism, especially on college campuses. In addition to Civil Rights and Free Speech Movements, campuses were seeing the "left-wing political movement, a women's liberation movement, a youth movement, and a movement toward general cultural change" (Sanford, 1985, p. 17). Vietnam veterans returning from war were sometimes physically disabled from war, and many of them were young activists (Scotch, 2001). Disabled Vietnam veterans provided visibility to disabilities that had been missing until the 1970s. Medical breakthroughs contributed to the quality of life for people with disabilities, and people were able to live longer and fuller lives. Edward Roberts, the first paraplegic to attend the University of California at Berkley in 1962, is one such individual. Edward Roberts survived polio as a child but was paralyzed and required the use of an iron lung while he slept (Roberts, 1994). Roberts was determined to attend a university and ultimately became a student activist for disability rights and later the Director of Rehabilitation Services for the State of California. One employee for the State of California, who was also disabled, said of the time, "It was kind of the honeymoon for disability, and we took advantage of that, and we started writing laws left and right . . . really fundamental things were just popping up all over" (Donald, 1998, p. 95).

Impact of Section 504 on Higher Education

For higher education institutions, Section 504 and the ADA require that reasonable accommodations are provided to students with disabilities (Gordon et al., 2002). The disability must be severe enough that the individual is unable to perform a major life activity (Americans with Disabilities Act, 1990). A "major life activity" is defined in the ADA as "caring for one's

self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working" (American with Disabilities Act, 1990, section i).

While major life activities are defined, neither statute defines what a reasonable accommodation is or what exactly a disability is (Gordon et al., 2002). Therefore, higher education institutions have been navigating complex and evolving case law to determine what mental illnesses fall under these laws and what accommodations are reasonable or unreasonable. As case law and common practices continue to shape what standard practice looks like, administrators and clinicians struggle to remain updated. In 2003, researchers found that 83% of psychologists who provided documentation for ADA accommodations wanted more training and 41% diagnosed a disability where there was none on a case study. To add further to the misconceptions, educators often viewed Section 504 as a special education law and not what it was intended to be: a civil rights law (Schraven & Jolly, 2010).

In some cases, courts have found that particular incidences of psychiatric illnesses do not interfere with major life activities, and, therefore, no accommodations were required (Kiuhara & Huefner, 2008). For example, one student was dismissed from the university golf team for missing practices to see a therapist, but the court found his obsessive compulsive disorder was not interfering with major life activities and, therefore, he did not fall under protections of Section 504. In another case, a student with a panic disorder wanted to teleconference to class. The court found that while the student's panic disorder fell under the protections of Section 504,

the student was requesting unreasonable accommodations that would substantially alter the course.

The Jeanne Clery Act of 1990

The Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (Clery Act) was passed in 1990 and signed by President George W. Bush. The Clery Act was named for Jeanne Clery, Lehigh University student who was raped and murdered in her dorm room in 1986. The Clery Act law requires that all colleges and universities that receive federal funding must report their crime statistics annually, including murders, sexual assaults, robberies, assaults, and motor thefts.

History of Passing the Clery Act

After Jeanne Clery was murdered in 1986, a grassroots effort was launched to make crime statistics more available to students and parents (Sloan et al., 1997). The Clery Center for Security on Campus, was established as a nonprofit to advocate for and support transparency of security information (Clery Center, 2022. These efforts first resulted in the Pennsylvania state law titled Pennsylvania College and University Security Information Act of 1988. This law was a precursor to the federal Clery Act, which would pass two years later. In the years between Jeanne Clery's murder and the passing of the Clery Act of 1990, the public perception was that administrators were hiding crime from parents and students in order to protect the reputations of their institutions.

According to the theory of incrementalism put forward by Lindblom in the mid 1950s,) policy is always evolving. Incrementalism can be found in the several amendments to the Clery Act that have been added since 1990 (Congress Research Services, 2014). In 1991, the reporting period was changed. In 1992, new requirements for sexual assault reporting were introduced. In

1998, new categories were introduced including new requirements about reporting hate crimes, and the law was named for Jeanne Clery. In 2000, an amendment was included that required universities to inform students how to search the sex offender registry. In 2008, several changes were introduced, including improvements upon previous language, and the requiring of emergency response and warning procedures. As of 2008, all institutions of higher education must notify the campus community of immediate threat to safety.

Impact of the Clery Act

The impact of the Clery Act has not been thoroughly researched, but there have been a few small studies published. Similar to research regarding the ADA and FERPA, there is research that concludes that administrators have difficulty understanding the specifics of the law (Sloan et al., 1997). Administrators may have challenges understanding what they are supposed to report and how the information is supposed to be shared (Sloan et al., 1997). Researchers are attempting to understand the relationship between actual crime and reported crime, and why and where crime might not be reported. The reliability and validity of the data reported have never been analyzed.

In 2006, a hearing was held in Congress where congressional representatives and members of the public made statements about the impact of the Clery Act (*Campus Crime: Compliance and Enforcement Under the Clery Act*, 2006). Many that testified felt the act had raised awareness about crime on campus, but others were unsure if the act was deterring crime. Several representatives were concerned with the number of institutions that were violating the Act but were not being fined. Particularly, Senator Santorum voiced concern that 253 violations had been found since 1994, and only three institutions had been fined. Other testimony revealed

that only a third of campuses were correctly reporting rapes and that most campuses were not issuing timely warnings to victims of sexual assault.

Pennsylvania State University testified that they had established award-winning best practices regarding crime prevention and tracking (*Campus Crime: Compliance and Enforcement Under the Clery Act*, 2006). Maureen Rush, Vice President for Public Safety, outlined these best practices including tracking the city's 911 calls, assigning campus police officers as liaisons to different parts of the campus, and publishing a crime log and a daily email to administrators reporting crime in the past 24 hours. Reverend John Stack from Villanova University then testified about their best practices, which were similar to Pennsylvania State University's. Reverend Stack noted that these best practices were not created to best meet the law's requirements but to "render the spirit of the Clery Act" (*Campus Crime: Compliance and Enforcement Under the Clery Act*, 2006, p. 22).

Changes in the Legal Environment After 2000

There have been four major legal cases since the year 2000 that relate specifically to policy on student suicidal ideation. Two of these cases, *Shin v. MIT* (2005) and *Schieszler v. Ferrum* (2002) addressed the responsibility that institutions of higher education have when their students commit suicide (Dyer, 2008; Pavela, 1996). Two other cases, *Jane Doe v. Hunter College* (2006) and *Nott v. GWU* (2006) addressed whether it was legal for the institution of higher education to expel a student who threatened suicide (Kalchthaler, 2010; McKendall, 2009). While there have been significant discussions in the higher education and legal

communities about these cases, all four cases were settled by the university before the court issued a final ruling.

Shin v. MIT (2005) and Schieszler v. Ferrum (2002)

Institutions of higher education have been historically granted deference in their treatment towards students (Kaplin & Lee, 2014). Before the 1960s, universities had the freedom to act in loco parentis or in the place of the parent. As parents were given leeway to parent their children as they felt best, universities were allowed the flexibility to act as a surrogate parent. After several court cases in the 1960s that held that universities were unable to reasonably protect students from the dangers of the world, universities shifted away from the en loco parentis model and toward a bystander approach in which they were less likely to accept a duty to care for students' well-being. In the 1980s, however, courts began to rule that universities had a duty to protect their students under certain circumstances (Dyer, 2008). Prior to the cases of *Shin v. MIT* and *Schieszler v. Ferrum College,* universities had not been found to have a duty to protect students from their own self-harm.

Shin v. MIT (2005) and *Schieszler v. Ferrum College* (2002) caused some concern in the higher education mental health community (Dyer, 2008; Pavela, 1996). In the case of *Shin*, the student had made several suicide threats and was being treated by campus mental health clinicians. After a suicide threat on April 8, the dean, housemaster, and psychiatrist agreed the student would begin treatment off campus (Dyer, 2008). The student overdosed on prescription medication and died when she set her dorm room on fire (Capriccioso, 2006; Dyer, 2008). The parents sued the administration of the university and the court held in a preliminary order that because the college administrators had involved themselves in the student's mental health treatment, they had established a special relationship with the student. Because of this special

relationship, the administrators had a duty to care for the student and could be held liable for the student's death (Capriccioso, 2006; Pavela, 1996). Ultimately, MIT settled the case before a final judgement in court. The American Council on Education released a statement saying they were concerned that the holding in this case would discourage colleges from providing mental health care that could establish special relationships between students and the college and leave the college vulnerable to lawsuits (Capriccioso, 2006).

In *Schieszler v. Ferrum College* (2002) a resident assistant saw evidence of self-harm on a student and consulted with a dean (Dyer, 2008). The student was made to sign a no-harm contract. The student later hanged himself in his dorm room. The courts found the dean and the resident assistant had a special relationship to the student and therefore had a duty to prevent the suicide. The court also found that the college could have foreseen the suicide and that it was preventable (Kalchthaler, 2010).

The courts further defined the meaning of special relationship between the administrators and the students in the case *Mahoney v. Allegheny College* (2006) in which a student receiving counseling on campus hanged himself (McAnaney, 2008). His parents sued two administrators who had contact with their son, but the court dismissed the claims against the administrators as the student had only known them for a few days. The judge found there was no special relationship between the administrators and the student due to the cursory relationship. The court also made a statement that assigning this particular duty of care to administrators would result in universities acting to prevent liability over the interest of the student.

Literature analyzing the *Shin* and *Schieszler* cases and their impact on higher education is limited, but there are a few pieces typically found in law journals. Dyer (2008) noted in the *Michigan Law Review* that in both cases, the administrators and not the university were found

liable for the student suicide. Thus, Dyer agreed that universities do not have a general duty of care to prevent suicide. Dyer also argued, however, that university administrators should also not be held liable for student suicide even if the administrators establish a special relationship with the student. Both *Shin* and *Schieszler* found special relationships between administrators and the students because according to the court, the administrators could have foreseen the suicide of the students. Dyer argued that due to low numbers of suicides even among high-risk populations, suicide is not foreseeable. Additionally, in the case of *Shin,* mental health professionals had judged her not acutely suicidal, so why would an administrator foresee suicide more clearly than her psychiatrist?

Analysis of *Shin* and *Schieszler* has determined that the courts' decision to task administrators with a duty to prevent suicide is overly burdensome. Analysts fear that the rulings will result in over hospitalizing students, expelling students, or "discontinuing outreach services altogether so that suicides would no longer be foreseeable" (Dyer, 2008, p. 1397). In the Virginia Law Review, McAnaney (2008) noted, "the *Shin* ruling sends a disturbing message to college officials. *Shin* comes close to punishing officials who are actively involved with a student's treatment" (p. 216). McAnaney believed that the ruling in favor of the institution in *Mahoney* and against the institution in *Shin* will encourage universities to seek to be ignorant of students who are mentally ill in order to deny foreseeability.

***Jane Doe* v. *Hunter College* (2006) *and Nott* v. *GWU* (2006)**

In 2004, a Jane Doe student at Hunter College residing in an on-campus dorm overdosed on Tylenol PM and admitted herself to the hospital (McKendall, 2009). The student stayed at the hospital for four days before being released with instructions for follow up care. She returned to Hunter College to find her lock had been changed and she had been placed on mandatory leave.

The housing contract for her dorms stated that any student who self-harmed would be placed under a one-year leave of absence and would need to be evaluated before the student could return. The student sued the university claiming that her rights under the ADA, Section 504, and the Fair Housing Act had been violated. The court denied the university's motion to dismiss, and the university settled the case. Hunter College has stated they have withdrawn their policy on student suicide attempts (Wei, 2007).

Nott v. GWU also occurred in 2004 (McKendall, 2009). Nott, a student at George Washington University, lost a close friend to suicide while enrolled at the university (Kalchthaler, 2010; McKendall, 2009). Depressed and unable to stop thinking about his friend, he sought psychiatric help at a local hospital. Nott was still at the hospital 12 hours later when he received a letter from the university barring him from returning to his dorm. A day later he was instructed by the university to withdraw from the university, or he would be expelled. According to Nott, he had never claimed to be suicidal. Nott sued the university and claimed that his rights under ADA, Section 504, and the Fair Housing Act had been violated (McKendall, 2009). He also claimed invasion of privacy and breach of confidentiality. The university settled in 2005 for an undisclosed amount and stated they were revising their policy (Wei, 2007). However, after the Virginia Tech shooting in 2007 the president of GWU penned an editorial in the *Washington Post* defending administrator actions in *Nott* writing, "We stand by the result that a life may have been saved" (Trachtenberg, 2007, para. 3).

Literature on *Doe* and *Nott* pointed to *Shin* and *Mahoney* as related cases (Dyer, 2008; McAnaney, 2008). McAnaney (2008) reported:

> The Office of Civil Rights (OCR) will undoubtedly continue to find blanket withdrawal policies discriminatory in violation of Section 504 . . . at the very least, blanket policies

> that do not allow for individual assessment will be struck down for failure to make reasonable accommodations. (p. 225)

However, McAnaney also predicted that universities with blanket leave policies will not revise those policies because if a student complains and the OCR finds the university in violation of the law, the consequence is simply fixing the policy.

Nguyen v. Massachusetts Institute of Technology (2018)

Dzung Duy Nguyen was a graduate student who had documented struggles with test taking and depression (*Nguyen v. MIT*, 2018). He had multiple contacts with MIT services due to referrals from his professors, including disability support and mental health. In addition to on-campus services, Nguyen sought services from a number of therapists and a psychiatrist in private practice. He discontinued the majority of campus and private services, stating they were not helpful. On the morning of June 2, 2009, a professor confronted Nguyen about an email Nguyen had sent a principal investigator that was described as "totally out of line" (*Nguyen v. MIT,* 2018, p. 446). At approximately 11 A.M. on June 2, Nguyen died from jumping off the roof of the lab. The administrator of Nguyen's estate sued MIT for wrongful death and negligence.

Nguyen v. MIT differs from many university suicide related lawsuits in that the university did not settle in this case, and an opinion was written by the Massachusetts Supreme Court. In 2018, the Massachusetts Supreme Court upheld the lower court's ruling that MIT was not responsible for Nguyen's death (*Nguyen v. MIT*, 2018). The opinion discussed that while students and colleges have a special relationship, students are also adults. "The modern university-student relationship is respective of student autonomy and privacy" (*Nguyen v. MIT*,

2018, p. 451). The court agreed that colleges have a duty to protect students who have made serious attempts or specific threats.

> Nonclinicians are also not expected to discern suicidal tendencies where the student has not stated his or her plans or intentions to commit suicide. Even a student's generalized statements about suicidal thoughts or ideation are not enough, given their prevalence in the university community. (*Nguyen v. MIT*, 2018, p. 455)

While the court ruled in favor of MIT, it discussed several hypotheticals in which a university may have responsibility to protect a student. The court ruling in this case does not absolve universities from all responsibility to protect students, and it provides some guidelines for universities (Jaschik, 2018). Holdings in a state court are only binding to that state, so while this holding may provide guidance, it does not apply if a university is sued outside Massachusetts.

Virginia Tech and Northern Illinois Campus Shootings

On April 16, 2007, Seung Hui Cho murdered 32 students and professors at Virginia Tech before he shot and killed himself (Schulte & Jackson, 2009). He had been assessed three times by the university's counseling center and had been reported by a female student for harassment. Later, he spent one night in a community hospital after telling his roommate he would kill himself.

On February 14, 2008, Steven Kazmierczak, a graduate of Northern Illinois University (NIU), shot and murdered five students and injured 21 (NIU, 2008). As an adolescent between the ages of 16 and 18, he was hospitalized a total of nine times for suicidal gestures. He spent most of his 18th year in a psychiatric facility where he was reportedly self-destructive, aggressive, and unpredictable. At the psychiatric facility, he was diagnosed with schizoaffective disorder and schizoid personality traits, and he admitted to auditory and visual hallucinations and

feelings of paranoia. He enrolled at NIU in 2001, and although he was viewed as socially odd, he graduated with a Bachelor of Arts, received a Dean's Award, and co-authored a paper with a professor. He did not have any contact with the mental health clinic or the university police, and he did not have any judicial reviews.

Despite the Virginia and Illinois shooters having minimal or no contact with university mental health professionals, state-elected officials called on universities to re-evaluate their procedures for working with mentally ill students. The "Virginia Tech Mass Shooting Report" (Virginia Tech Review Panel, 2007) recommended, "The college counseling center should report all students who are in treatment pursuant to a court order to the threat assessment team" (p. 54) and recommended making the FERPA emergency exemption more explicit so that counselors would feel freer to contact parents and student affairs employees. The Virginia Tech Mass Shooting Report also recommended that universities re-evaluate policy on when to notify parents and roommates if a student is mentally ill.

After a review of FERPA, The Governor's Virginia Tech Investigation Panel found that FERPA laws did not need to be changed but that institutions were interpreting FERPA incorrectly (Davies, 2008):

> FERPA allows much more freedom to share information than many in the higher-education community assume. Personal observations and conversations with a student, for instance, fall outside FERPA; teachers or administrators who observe troubling behavior are not restricted from telling other administrators, law enforcement, or parents what they observe. (p. 11)

The Governor's Virginia Tech Investigation Panel made several recommendations including that universities enforce compliance with gun laws, engage in ongoing FERPA training, and form

threat assessment teams. They also suggested that universities consider asking for access to student's mental health records after students are admitted.

The Midwest Higher Education Compact wrote a review assessing the impact of the Virginia Tech shooting on policy in which over 100 campuses in the Midwest were surveyed on the changes in policies at their campuses after the shooting at Virginia Tech (Rasmussen & Johnson, 2008). A myriad of policy changes were found at institutions of higher education including ones related to privacy, notification systems, security monitoring, and responding to student behavior. Most institutions reviewed FERPA and their responsibilities under it. Of the institutions reviewing FERPA, about 25% revised some policies to fall better in line with FERPA guidelines.

When surveyed about student history and behavior, about 5% of institutions reported they had implemented undergraduate background checks and another 15% were still considering a background check proposal (Rasmussen & Johnson 2008). A fourth of institutions reported they had revised their student handbook language in regard to student behavior. Two percent of surveyed institutions started asking applicants if they were taking psychiatric medication.

Higher Education Response to Public Policy

In 2006, after the *Nott* case, the Jed Foundation for Suicide Prevention published a *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student* (Jed Foundation, 2006). This publication does not recommend protocol but provides a guideline for creating policies. Although no specific policies were recommended, the document serves as a framework for considering all the issues an institution must address. Zarb (2010) concluded that there is no current standard model for addressing suicide ideation in university students, and that administrators were using "trial and error" (p. 62). Zarb recommended that

administrators at higher education institutions lower barriers for student access to treatment and expand services to include long-term and affordable treatment.

Student Privacy After 2006

In response to the conflicting messages sent by case law, lawyers Smith and Fleming (2007) penned an editorial in the *Chronicle of Higher Education* that advocated requiring students to report mental illness when applying to college:

> Requiring students to report mental illnesses as part of the application process, much like they report SAT scores and learning issues, would also permit colleges to marshal their resources and develop long-term treatment plans where appropriate. Although such a requirement seems radical and would probably be struck down under the current antidiscrimination laws, it is worth considering. The current legal system holds institutions responsible for student suicides without giving them the tools to deal with the problem. (p. 24)

The Governor's Virginia Tech Review Panel (2007) raised the issue of student privacy several times and recommended a similar approach to Smith and Fleming (2007). The Virginia Tech Review Panel (2007) raised the issue of K-12 schools informing colleges of a student's past mental health records, stating that "perhaps students should be required to submit records of emotional or mental disturbance and any communicable diseases after they have been admitted but before they enroll at a college" (p. 39).

The Virginia Tech Review Panel (2007) found that over interpretation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and FERPA lead to incomplete communication about Cho's symptomatic behavior. While the report recommended the loosening of both HIPAA and FERPA to allow for more communication about students, the

panel also conceded HIPAA and FERPA had been interpreted incorrectly, and more communication would have been legal and appropriate. The panel also questioned the length of Virginia's 48-hour involuntary psychiatric inpatient hold and raised the discussion of changing the language from "imminent danger" to "significant risk" (Virginia Tech Review Panel, 2007, p. 56) so that hospitals were authorized to hold more patients for a longer duration.

Others disagreed with the recommendations to loosen privacy laws. One critic wrote that "psychiatric monitoring on campus resembles the eugenics movement's attempts to solve the problem of madness by eliminating the mad" (Reiss, 2010, p. 32). The same critic argued that teachers and professors as well as clinicians overly predict dangerous behavior, and the results are stifled liberties of students who do not fit social norms. Instead of identifying and neutralizing a threatening student, schools and lawmakers should address systemic threats like access to guns.

Student Leave Policy After 2006

The week after the 2007 shooting at Virginia Tech, Stephen Trachtenberg, president of George Washington University, published an opinion in the *Washington Post*, defending his university's mandatory leave policy (Trachtenberg, 2007):

> GW was in the news last year for its attempts to serve the best interests of a student who had sought mental health treatment, while also considering the well-being of all of our students. Ultimately, the university decided that an interim involuntary leave was the best course of action to protect a life. We were sued by the former student, and the media and others were quick to fault the university. Had the student stayed at GW and hurt himself or others, it's likely the criticism would have been that the university should have done

> even more. We probably still would have faced a lawsuit. In this case, we stand by the result that a life may have been saved. (para. 3)

George Washington University was not the only university with a mandatory leave policy for students. The associate director for the university counseling center at the College of William and Mary wrote in the *Washington Post* that after the shooting at Virginia Tech, there was intense administrative scrutiny of the counseling center, with a mandated shift in direction from student care to avoiding liability (Svrluga, 2015). After 2007, William and Mary began to unenroll students and evict them from the residence halls if they were deemed to be a risk to themselves. Where the counseling center was once the authority on mental health, after 2007 the authority shifted to attorneys, deans, and the police department. Articles in the William and Mary student newspaper began to address that the "predominant fear students have in coming to the counseling center is being kicked out of school" (Svrluga, 2015, para. 33).

A survey of colleges and universities in Virginia in 2008 showed that 47% of public colleges and 91% of private colleges had a policy that allowed the removal of students due to mental illness (Monahan et al., 2011). In the survey of 63 institutions, 14 students had been removed involuntarily for mental illness during the 2008–2009 academic year. In the same academic year, 138 students had a parent notified of severe mental illness.

Theoretical Frameworks

This case study was framed by theories found in policy studies and the studies of higher education. Lindblom's (1979) theory of incrementalism and Lasswell's (1956) theory of policy as process serve to provide a background for understanding the ongoing input and revision of policy. Bolman and Deal's (2013) structural and political frameworks put the policy process in context of organizational and power structures. Critical policy analysis is a lens through which

data can be perceived with special attention given to power structures and the hidden agendas or latent functions of policy (Gildersleeve et al., 2010).

Lindblom and Incrementalism

In *The Science of "Muddling Through"* political scientist Lindblom introduced the foundational work for what became known as the theory of incrementalism (Scott, 2010). In this work, Lindblom asserted that policy does not and should not change dramatically, but that policy changes by a constant series of increments. Incremental changes are often the result of compromises between opposing parties. They also serve another important purpose:

> A wise policy-maker . . . expects that his policies will achieve only part of what he hopes and at the same time will produce unanticipated consequences he would have preferred to avoid. If he proceeds through a succession of incremental changes, he avoids serious lasting mistakes in several ways . . . he need not attempt big jumps toward his goals that would require predictions beyond his or anyone else's knowledge, because he never expects his policy to be a final resolution of a problem. (Scott, 2010, p. 86)

In this way, incrementalism serves as a protective factor for the administrator's intentions. If the administrator was able to create and enforce policy that was too dramatic a shift from current practice, the administrator may discover that too many unintended consequences and too much change has occurred to undo the mistakes.

Lindblom's incrementalism theory presented two methods of policy creation: The root method and the branch method (Scott, 2010). The root method is rational and requires the policy maker to analyze every possible outcome and option. In the branch method, the policy maker continually adds onto the policy in a series of steps. The incremental changes to the policy act as branches growing from a tree. Lindblom theorized that the root method is impossible to employ

in cases of complex policy. Policy decisions have so many value judgements required, and the values conflict and intersect in ways that the values cannot be objectively ranked and prioritized. Therefore, the branch method is employed and policy is created by *muddling through*.

The Patient Protection and Affordable Care Act of 2010 signified an evolution of health policy in the United States that is always growing and changing (Sparer et al., 2011). Health care policy in the United States can be traced back to the Thomas Jefferson administration and the 1800s. The belief at the time was that aid to the poor, such as healthcare, was not the government's responsibility. The road from the Jefferson's administration to the Patient Protection and Affordable Care Act of 2010 was a long series of incremental changes that included major landmarks such as The New Deal, Medicare, Medicaid, children's health insurance programs, and maternity programs. Within these landmark policies were a series of smaller adjustments, such as the expanding of Medicaid or the raising or lowering of caps on Medicare (Sparer et al., 2011; Vladeck, 2001).

Some critics have demanded that the shortcomings in higher education should be addressed by dramatic and radical change, although innovation in higher education is difficult and often unsuccessful (Evans & Henrichsen, 2008). Instead, several education experts have used Lindblom's foundation of incrementalism to suggest that incremental changes in education have been the strongest strategy in education policy. Tyack and Cuban (1995) wrote that "tinkering is one way of preserving what is valuable and reworking what is not" (p. 5). Tinkering is the subject of their work, *Tinkering Towards Utopia,* which analyzes the continual change in policy over time in the U.S. public education system.

Cuban (2001) later addressed incremental change in the higher education system by introducing a series of models that illustrate incremental to fundamental change. Cuban

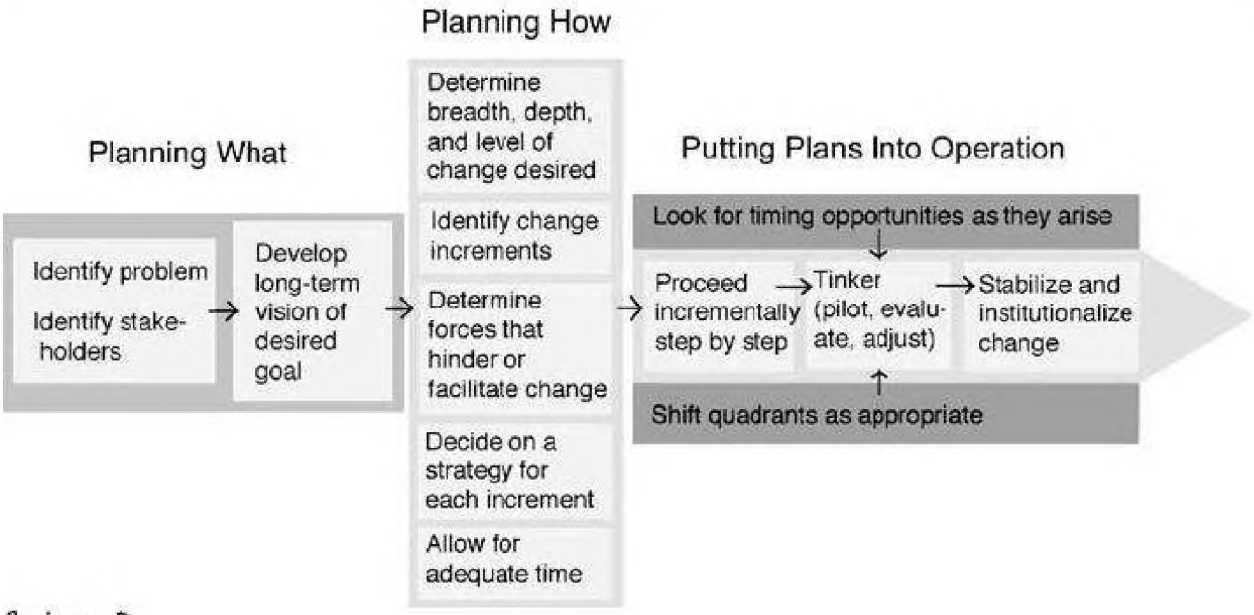
postulated that the more incremental the change, the easier it is to implement and the more likely it is to succeed. The other two dimensions affecting difficulty of change are level and speed. The higher the level of policy change, such as university-wide instead of departmental, the more difficult the change. The faster the change is implemented, the more difficult the change. Evans and Henrichsen (2008) combined Tyack and Cuban's (1995) tinkering theory with Cuban's (2001) model of incremental change in higher education and created a policy planning model for higher education, as shown in Figure 1.

Evans and Henrichsen (2008) noted that "change takes longer than most people think" (p. 9) and that an appropriate strategy, using the above model, is key. This includes strategically using all natural opportunities to their maximum benefits and modifying when resistance becomes too insurmountable. "When opposition to a broader fundamental change arises, it may be advisable to modify the change to be more narrow or incremental. When conditions are right, broader or more fundamental changes may be attempted" (Evans & Henrichsen, 2008, p. 10).

Since the original publishing of *Muddling Through* in 1956, it has been reprinted more than 40 times in various anthologies (Lindblom, 1979). Lindblom added to the original theory in 1979, emphasizing incompleteness of all policy. Policy will always be incomplete, either through oversight or poor analysis, or by strategic design. He summed up his 1979 revisit with an illustration of incrementalism, noting that his theory will always be changing and will never be complete.

Figure 1

Process Model for Long-Term Strategic Incrementalism



Note. Reprinted with permission from "Long-term Strategic Incrementalism: An Approach and a Model for Bringing About Change in Higher Education" by N. Evans & L. Henrichsen, 2008, *Innovations in Higher Education*, *33*(2), p. 10.

Policy Process Models

Several theorists have written about policy as a process. Rose (1969) wrote that policy is not one document stagnant in time, but a process of input and reaction to that input. Lasswell (1956) first introduced a model of policy creation that cycled from defining a problem to evaluating and then revising the policy. Lasswell's original model includes the seven stages of

decision making: Intelligence, promotion, prescription, invocation, application, termination, and appraisal.

Lasswell's original model of seven stages has been modified over the years by several theorists (Fischer & Miller, 2007). Fischer and Miller's (2007) policy process model based on Laswell's work includes the following five stages:

1. Agenda setting: The problem is defined
2. Policy formulation: The policy falls under a particular jurisdiction
3. Decision making: The policy is written
4. Implementation: The policy is enforced
5. Evaluation: New information is introduced to the agenda phase, and the policy is modified

The policy process model illustrates the policy process as rational and methodical (Fischer & Miller, 2007). According to this model, information is weighed carefully at all stages. The model assumes that policy makers are rational decision makers who are making the choices neutrally to achieve the best results for their constituents.

Agenda setting, the first step of the policy process model, is not a value-neutral act (Fischer & Miller, 2007). "Problem recognition and agenda-setting are inherently political processes in which political attention is attached to a subset of all possibly relevant political problems" (Fischer & Miller, 2007, p. 45). Agenda setting relies on the framing of the issues and the political power behind those who want their interests addressed. Interests may be brought to

an agenda by democracy or by special interests. Critical policy theory and the inclusion or exclusion of political agendas are addressed later in this chapter.

Agenda setting in the policy process model may be paired with the multiple streams metaphor introduced by Kingdon in 1984. The multiple streams metaphor claims that a brief window of opportunity emerges for a problem to be set on the agenda (Kingdon, 1995). The window of opportunity occurs when multiple streams cross. According to this metaphor, policy and politics are streams running parallel until the window of opportunity emerges and a policy entrepreneur, who has been waiting for the window, will appear with a solution. "These entrepreneurs are waiting for problems to float by to which they can attach their solutions, waiting for a development in the political stream they can use to their advantage" (Kingdon, 1995, p. 165).

Policy formation and decision making result in an artifact that reflects the place and time the policy was formed. The boundaries and rules of a policy reflect the institution that created the policy, whether it be the federal legislature, a small public institution, or an unofficial group of citizens. Similarly, whether a policy was created in a democratic or top-down way will influence the policy (Fischer & Miller, 2007). The narrative that policy makers use to discuss those who will be affected by potential policy will ultimately influence the language in the policy. Policy makers are not immune from categorizing people as 'deserving' and 'undeserving' and those unspoken (or spoken) categories affect how policies are written (Schneider & Ingram, 2005). As

policies that favor those that fall into the "deserving" category elevate the dominant culture and marginalize others, these policies actively work against social equality.

Structural and Political Frames

Bolman and Deal (2013) constructed four frames of institutional leadership: Political, structural, human resources, and symbolic. The structural and political frames are both used to understand policy at a large institution of higher education. A structural frame predicts that authority and decision making depends upon the structure of the institution and who has the most legitimate power in the structure. The decisions made by the person carrying the most legitimate power are rational and unbiased. A political frame would recognize the messier influences on the decision maker, including influences of favors, funding, and the moral beliefs of the decision makers.

The structural framework details how organizational structure affects the institution and its employees. Structural framework is important to understand who in an institution is responsible for what and why. According to Bolman and Deal's (2013) structural framework, policy may vary from university to university depending on the organizational networks and matrixes and the level of bureaucracy. Other imperatives included "size and age, core process, environment, strategy and goals, information technology, and the nature of the workforce" (Bolman & Deal, 2013, p. 59). This framework would predict that a university's policy would be more complex and formal at a large and historical university or at a university in an uncertain political environment. Additionally, the structural frame stated that outside influences or the environment will impact the organization even if the organization is highly insulated. Even

though external events impact organizations, those organizations steeped in bureaucracy will react slowly.

The structural framework management style is not most administrators' expressed preferred management style (Little, 2010). One assessment of community college administrators found the high-touch human resources frame was what most administrators believed they used. However, subordinates reported that the structural framework is the most-used leadership style by administrators.

Bolman and Deal's (2013) political frame states that power is a commodity in institutions of higher education, much like tangible resources. Both supervisors and subordinates reported that the political frame is the least-used management style (Wolf, 2001). This seems to conflict with Bolman and Deal (2013), who wrote that higher education leadership is inherently political. The political frame also predicted that as resources become more and more scarce for higher education, the already political management systems will become more obvious as administrators divide and allocate resources.

Those with political power make management decisions including policy. Policy may be created through negotiation, bargaining, and alliance building. Administrators will lobby for their policy agendas and stakeholders are important in the political frame. Institutions of higher education have a wide constituency and each group feels ownership over parts of the institution and their own agendas. The political frame also accepts policy as a process much like Lasswell (1956) and Lindblom (1959). In the political frame, there is an ongoing negotiation among those who have power. The political framework would predict that policy is influenced by outside constituencies, advocacy, negotiation, and agendas set by those who have the most political power.

The political and structural frames can work together but may also conflict depending on how power and structure are manifesting at the institution of higher education (Bolman & Deal, 2013).

Critical Analysis of Higher Education Policy

Historically, "marginalized and vulnerable groups of people have been systematically denied access to higher education" (Liasidou, 2014, p. 122). Critical analysis of higher education has been used as a method to challenge and expose the systematic domination of marginalized groups seeking equal access to higher education. Critical theory rejects the assumption that gender, race, social class, and sexual orientation are unimportant in research. Bensimon and Bishop (2012) described critical race theory in higher education as framing scholarship and policy questions in the terms of race "critically and knowledgeably," while "focusing on structural racism: the systemic but often invisible way in which routine practices, traditions, values, and structures perpetuate racial inequity in higher education" (p. 2).

Critical policy analysis, whether through a race or feminist lens, has received some attention in higher education literature, although the field is currently small. According to those who write about critical policy analysis, "policy analysis is never value-neutral" (Shaw, 2004, p. 1).

When analyzing the impact of public policy agendas on higher education, it is important to acknowledge the intersection of political agenda and issues of power, social identity, and marginalized groups (Gildersleeve et al., 2010). Public policy for higher education is meant to be written for the public, but depending on the experiences, backgrounds, and motivations of policy makers, who 'the public' is may differ. Marginalized groups or groups not represented by agenda makers may find themselves overlooked as the public. When marginalized groups are included in

policy, there may be latent effects, or even hidden agendas, in that inclusion. When analyzing policy critically, the language the policy uses as well as the explicit meaning of the policy should be analyzed.

Critical disability theory is not commonly used in critical theorist work on higher education. Disability is typically not included in critical studies along with race, gender, sexual orientation, and social class because of the assumption that disability is a pathology or defect (Liasidou, 2014). Critical disability theory rejects the view of disability as pathology and instead frames it as a normal part of diversity (Hosking, 2008; Liasidou, 2014).

Critical disability theory (CDT) has been used to analyze public policy and law. Critical disability theory focuses on:

> Disabled people's (individual) rights to autonomy and (social) rights to full participation in society… CDT exposes the ways in which liberal rights theory has failed to respond adequately to the needs and interests of disabled people individually and collectively by failing to incorporate the diversity of the disabled community within the scope of its conception of equality. (Hosking, 2008, p. 12)

Critical disability theory has been used in the literature to challenge policies that keep students with disabilities separate from other students, challenge policies and pedagogy that is not inclusive, and challenge ablest education law (Hosking, 2008; Runswick-Cole, 2011).

Student Suicide Ideation and University Response

Colleges and universities have been challenged to respond to student mental health needs since the early 1900s (Barreira & Snider, 2010). Mental health professionals on college campuses are reporting an increasing number of suicidal and self-injurious behaviors (Gallagher et al., 2004, and the number of college students attempting and completing suicides continues to

grow (Drapeau & McIntosh, 2019; Drum et al., 2009). College students have the typical risk factors of suicidal ideation such as depression and anxiety but also experience special challenges such as personal or familial expectations of high achievement (Dean et al., 1996; MacKenzie et al., 2011). Colleges and universities are responding to student mental health needs as efficiently and creatively as possible, while reporting shrinking resources (Reetz et al., 2014).

Prevalence of Suicidal Behaviors in Undergraduate Student Populations

Policy regarding student suicide is timely and relevant to all institutions of higher education. Suicide is the third leading cause of death for young people ages 15 to 24 years; in 2013, 40% of people ages 18 to 24 years were enrolled in institutions of higher education and that number continues to grow (Drapeau & McIntosh, 2019).

An estimated 16% to 18% of undergraduate students have seriously considered suicide in their lifetimes (Drum et al., 2009; Garlow et al., 2008) and approximately 6% to 11% of students have current thoughts of suicide (Garlow et al., 2008; Kisch et al., 2005; MacKenzie et al., 2013). Despite campus efforts to reduce the number of suicides, every campus with an undergraduate class of 25,000 students will experience, on average, one to two deaths by suicide every year given that suicide rates for college students are about 6.5 to 7.5 per 100,000 students (Drum et al., 2009). The completed suicide rate for students is slightly lower than suicide rates for non-students in the same age group (Schwartz, 2006).

Risk Factors of Suicide Ideation in University Students

There are many fewer students who report attempting suicide than students who report considering suicide. In a study where 8% of students reported seriously considering suicide, only 1.6% of students reported a suicide attempt, approximately 20% of the suicidal ideation sample (American College Health Association, 2013). In another study of over 100,000 students, 14% of

undergraduates who seriously considered suicide reported at least one attempt (Drum et al., 2009).

Depression. College and university undergraduate students are much more likely than their nonstudent peers to experience a major depression episode, with one study finding 26% of college students screening positive for depression during routine health clinic exams (MacKenzie et al., 2011). Although students with severe depression are at the highest risk of suicidal ideation, students with subclinical depression symptoms and mild or moderate depression are also at risk of suicidal ideation (Cukrowicz et al., 2011). In three studies that varied by region and racial makeup as well as depression screening tool, undergraduate students who screened positive for subclinical and mild depression were found to be at risk of suicidal ideation. As subclinical depression often does not result in counseling center referrals, these students are often not referred or connected with campus intervention. Despite the emphasis on depression screening as a suicide prevention technique, multiple studies have found that only about 40% of undergraduate students who are considering suicide meet the criteria for depression as measured by the Beck Depression Inventory (Arria et al., 2009; De Man, 1999).

Perfectionism. Students with tendencies towards perfectionism appear to have a higher risk of suicidal ideation (Dean et al., 1996). Student perfectionism can be socially oriented, in which the student's social support system sets unrealistically high expectations, or it can be self-oriented, in which a student sets unrealistically high expectations for themselves. Perfectionism may lead to suicidal ideation when an individual internalizes their negative outcomes and self-blames. "Evidence suggests that perfectionistic individuals experience increased negative affect before, during, and after evaluative tasks, judge their work as lower in quality than non-perfectionistic, and report the quality of their work should have been better" (Hamilton &

Schweitzer, 2000, p. 830). Hewitt and Flett (1994) noted that self-oriented perfectionists self-blame and self-criticize while socially oriented perfectionists feel hopeless, alienated, and out of control.

Hewitt and Flett (1994) found that students with strong self-oriented perfectionism were more likely to respond to stress with symptoms of depression than other students. However, depression is not the only link between perfectionism and suicidal ideation. Both socially oriented perfectionism and self-oriented perfectionism are associated with suicidal ideation, independent of depression and hopelessness. Students who are paralyzed by perfectionism and who suffer from indecision and inaction have been found to have higher rates of suicidal ideation (Hamilton & Schweitzer, 2000). Female students who chronically procrastinate have significantly more thoughts of suicide than their peers (Klibert et al, 2011).

Minority Populations. Research shows that sexual minority college students have higher risk of suicide than other college students (Blosnich & Bossarte, 2012). Lesbian, gay, and bisexual students report higher rates of physical assaults, partner violence, family problems, and discrimination than the heterosexual group which can increase these individuals' risk of suicide. Data indicate that Alaska Native/American Indian, Asian American, and multiracial students have the highest risk of suicidal thoughts and are less likely to seek help than White students (Shadick & Akhter, 2013). Depression and perceived burdensomeness were significantly correlated with higher suicide ideation in Asian American students of all immigrant and generational statuses (Kleiman et al., 2012). Research has shown that Asian students, both

international students and Asian Americans, have higher rates of suicidal ideation than White, Black, and Latino students (Shadick & Akhter, 2013).

Mental Health Providers on Campus

Mental health services began at colleges and universities in the form of advisors who worked with students on any nonacademic issues from financial advice to adjustment problems (Barreira & Snider, 2010). Some campuses now have campus counseling centers that house both therapists and psychiatrists, while others have no psychiatric services (Reetz et al., 2014). With strained and limited campus counseling resources and a large number of students with suicidal ideation who never seek treatment from campus counselors, universities are searching for other ways to identify suicidal students (Reetz et al., 2014; Jodoin & Robertson, 2013).

Current Trends in Mental Health Providers on Campus

Directors of campus counseling centers are reporting increased numbers of students presenting with suicidality, self-injurious behavior, severe anxiety or depression, and personality disorders (Gallagher, 2004; Gilbert, 1992). Of college students seen at counseling centers, 18% were seen for suicidal ideation and 12% for self-injury (Reetz et al., 2014). Traditionally, most of these diagnoses are not typically treated with short term psychotherapy, leaving counseling offices to determine what they may ethically treat and what they should refuse to treat (Gilbert, 1992). While counseling centers are reporting an increase in severe illness, in 2014 only 14% of college students who died by suicide had visited a campus mental health provider (Gallagher, 2004). Of all students with suicide ideation, 12.4% are in psychotherapy, and 13.6% are on psychoactive medication (Garlow et al., 2008). Of students who have attempted suicide, about

20% are on psychoactive medication and 19% are seeing a therapist on or off campus (Kisch et al., 2005).

Due to student resistance to counseling (Morgan et al., 2003) and stressed and inadequate counseling centers, campus counseling centers cannot be solely responsible for suicide prevention (Jodoin & Robertson, 2013). Suicide prevention in college students requires a public health approach with awareness and training at all levels on campus, including faculty, advisors, athletics, housing, and students. According to the Jed Foundation (2015), suicide prevention and intervention require a comprehensive approach including implementing life skills development and crisis management plans, restricting access to lethal means of harm, and increasing help-seeking behavior from students.

History of Mental Health Services on Campus

Beginning in the early 1900s, student advisors working under a variety of titles advised students on their financial, vocational, moral, and mental problems (Barreira & Snider, 2010). Because the practice of combining all advice to students in one office continued at some universities until the 1930s, it is difficult to determine whether universities had mental health staff or just vocational counselors. However, it is possible to identify several key developments in the history of university mental health.

The first college mental health office was run by Stewart Paton, MD, a psychiatrist who practiced at Princeton University in 1910 (Kraft, 2011). Paton was an 1886 Princeton graduate and taught neurobiology (Leitch, 1978). His counseling interest was focused on student adjustment (Kraft, 2011; Leitch, 1978).

In 1920, two cadets at the US Military Academy at West Point committed suicide (Barreira & Snider, 2010). West Point hired a psychiatrist shortly after to study student

adjustment. In 1921, Frankwood Williams, MD, the Associate Medical Director of the National Committee for Mental Hygiene, delivered an address on mental hygiene in college students (Williams, 1921). In it, Williams outlined symptoms of the mental disorders that college students may experience, including loss of interest, anxiety, feelings of worthlessness, and overwhelming sadness. He advocated for mental health care on campuses for college students. He argued,

> The university . . . has seen the failure but has not been interested in carefully investigating the cause or in protecting against it. It would be just as reasonable to neglect a student who had broken his leg . . . and to expel him for not attending classes. (Williams, 1921, p. 348)

Between 1910 and 1925 several universities introduced a psychiatrist's office on campus for students, including the University of Wisconsin in 1914, Washburn College in 1920, the United States Military Academy in 1920, Dartmouth in 1921, Vassar in 1923, and Yale in 1925 (Kraft, 2011; Whitaker, 2010).

In the 1940s, universities and the government began to focus more attention on mental health services available to university students (Barreira & Snider, 2010). World War II veterans struggling with post-war psychological stresses on campuses raised the visibility and urgency of student mental health. By the 1950s, half of all U.S. universities had a mental health office and the number continued to rise (Whitaker, 2010). Many evolved from the psychiatrist-only model to one that incorporated psychologists and social workers (Kraft, 2011). Mental health services became a normed service provided by most universities.

As the number of university students climbed in the 1960s and 1970s, so did the demand for mental health services on campus (Kraft, 2011). Universities began to offer drug and alcohol treatment at the mental health offices. Costs began to rise as more students utilized a broader

spectrum of mental health services. To offset costs, universities began to merge mental health services with other health services in order to capitalize on student health fees.

CHAPTER 3

METHODOLOGY

I conducted a historical case study designed to examine two cases of policy evolution related to student suicide ideation at two large, public institutions of higher education. My study analyzed two cases of policy evolution after a public incident regarding student suicide. I designed the study using Merriam (1998) and Stake's (1995) works on qualitative case study.

A case study founded in a historical orientation was used to study change over time as it is impacted by new input. Historical orientations are used in case studies that are "descriptions of events, programs, or organizations as they have evolved over time" (Hancock & Algozzine, 2011, p. 35). Hancock and Algozzine (2011) recommended document analysis and interviews to complement a historical orientation. The cases were examined only through the lens of published policy, and therefore relied solely on document analysis.

The case studies were particularistic. Particularistic case studies "examine a specific instance but illuminate a general problem" (Merriam, 1998, p. 30). The specific cases detailed one institution's policy changes while also accounting for evolving internal and external pressures on the institution. Each case contained at least one crisis, and the details of the crisis may or may not be similar to those experienced at other institutions. While the crisis may not be familiar to all administrators, the struggle to create clear, effective policy will be.

Particularistic cases also "can suggest to the reader what to do and what not to do in a similar situation" (Merriam, 1998, p. 30). Examining how institutions evolved their policy decisions over a number of years allows the benefit of hindsight. While observing how administrators responded to students, the media, the public, and the courts, the reader can decide what worked well and what did not. I collected data through document analysis.

> Documents… enable us to (a) place symbolic meaning in context; (b) track the process of its creation and influence on social definitions; (c) let our understandings emerge through detailed investigation; and (d) if we desire, use our understanding from the study of documents to change some social activities, including the production of certain documents. (Altheide & Schneider, 2013, p. 20)

Research Design

I selected the institutions through purposeful, or criterion-based selection (LeCompte & Priessle, 1993; Merriam, 2009). The criteria for the institution selection were created to elicit the richest data for the case study. Once the institutions were identified, I collected data through current university webpages, libraries, internet archives (archive.org/web/), staff and student handbooks, university mental health and health clinic public documents, government reports, grant reports, and other public, published information. I used Altheide and Schneider's (2013) document analysis protocols, which recommend reading a few documents, forming questions, and then exploring further documents. Within this design, the data collection and research questions unfolded together, and the protocol was revised as more data were collected.

Institution Selection

I chose the institutions through a list of criteria. The institutions selected are classified as a medium sized campus or larger (3,000 or more full-time equivalent), according to Carnegie

Classification (Carnegie, n.d.). The institutions are classified as primarily residential or highly residential by the Carnegie Classification. Primarily residential campuses have between 25% and 49% of undergraduate students living on campus and highly residential campuses have 50% or more of undergraduate students living on campus. Lastly, the institutions had at least one controversy where policy on student mental health or suicide ideation was publicly discussed. The study defined *publicly discussed* as an incident where the university's response was discussed by local or national media.

Participant Selection

The case studies were conducted using document analysis. Universities were purposefully selected to provide a variety of stories within established criteria. As this is a case study, the goal was not to apply the results to all other universities, but to describe the case as thoroughly as possible. "Purposeful sampling is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned" (Merriam, 2009, p. 77). Other researchers have called this *criterion-based selection*, in which there is a list of criteria for participants before participants are sought (LeCompte & Preissle, 1993). The list of participant criteria is included in the sample traits section below.

Universities included in this study have met the following criteria:

- The university is classified as a medium sized campus or larger by the Carnegie Classification
- The university is classified as primarily residential or highly residential by the Carnegie Classification

- The university has experienced an incident related to student suicide that was captured by the media
- There is evidence that the university has updated (or implemented) policy on student mental health in the student affairs webpage and student handbook.

The institutions profiled were Virginia Tech and Appalachian State University.

Sample Size

There are two issues related to sample size in this study. The first issue relates to the number of universities included in the study. The second issue relates to the amount of documentation gathered from each university.

One of the most important aspects of case study is gathering enough data to span the entire case (Merriam, 1998). Neither Merriam (1998) nor Stake (1995) recommended sample sizes larger than needed to cover the case. Both Merriam (1998) and Stake (1995) recommended document triangulation to validate data. Therefore, in each case I gathered as much information as possible through all available sources until there were no more sources of information available or all relevant aspects of the case were covered and supported by more than one source.

I initially chose three universities to act as cases with the assumption that there was a possibility one or two of the chosen universities may have less data available than others. This assumption proved correct, and only two universities provided enough information for full case studies. The third case study was not completed, and I address that case at the end of this chapter.

Virginia Tech

In 2007, Virginia Tech was forced into a national spotlight when a student killed himself and 32 other people on campus. The relentless media attention caused politicians all over the state to call for answers. Several government reports were published, including "Mass shootings

at Virginia Tech, April 16, 2007: Report of the Virginia Tech Review Panel" (Virginia Tech Review Panel, 2007). A follow up report was published in 2009, "Mass Shootings at Virginia Tech Addendum to the Report of the Review Panel" (Virginia Tech Review Panel & TriData Corporation, 2009). President G.W. Bush received a report titled "Report to the President on Issues Raised by the Virginia Tech Tragedy." These three reports total hundreds of pages of information, including conclusions on Virginia Tech policy and recommendations for future practice.

Appalachian State University

During the 2014–2015 academic year, nine students died at Appalachian State: Four by suicide. In 2013, Appalachian State University was awarded a three-year grant through Substance Abuse and Mental Health Services Administration (SAMHSA). With funds from the SAMHSA grant, Appalachian State wrote and published at least two new policies: "Crises Response Protocol for Suicide Ideation and Attempts" (Appalachian State University, 2015b) and "Student Death Protocol" (Appalachian State University, 2015c).

Document Collection

A document analysis was conducted using a series of written policies. I collected each iteration of the policies over time, as they were updated. Documents analyzed included any published or distributed material meant to clarify university or employee response to students who have threatened self-harm or suicide as well as any other relevant mental health policy. Documents included faculty and student handbooks, training materials and written policies for student health centers or counseling centers, commission reports, board materials, and grant reports. The documents were published or distributed any time between the year before the incident and the present day. The intended audiences were students, faculty, employees, or

stakeholders. Hancock and Algozzine (2011) recommend gathering documents from as many sources as possible for a thorough analysis.

Document analysis is "particularly applicable to qualitative case studies" (Bowen, 2009, p. 29). Document analysis as a technique of data triangulation is used to "reduce the impact of potential bias and corroborate findings across data sets" (Bowen, 2009, p. 28). Data from document analysis "can furnish descriptive information, verify emerging hypotheses, advance new categories and hypothesis, offer historical understanding, track change and development" (Merriam, 1998 p. 126).

Data Analysis

Analysis of qualitative data begins as soon as the researcher collects data (Merriam, 1998). In qualitative research, the researcher is the instrument of analysis (Hancock & Algozzine, 2011; Merriam, 2009). I began the formation of themes as soon as I started collecting the data. The data from the documents worked together to support hypotheses and themes. Because case study data are used to create a descriptive and complete picture of the case, all of the data were compiled together without edits before any information was removed for the report (Merriam, 1998).

After the documents were collected, I made every effort to ascertain the history and origins of each document and verify the document's authenticity (Merriam, 1998). I documented the timeline, author, audience, and context of each document. A timeline was established and supported by documents from all sources. The triangulation of collecting data from multiple sources speaks to the reliability and validity of the data. I looked for instances when written policies where changed, added, or rewritten and the places of those changes on the timeline.

I used category construction to analyze all of the data that related to the research questions as they became available and as I looked at all of the data together (Merriam, 1998). Every "unit of data" or "any potentially meaningful segment of data" was categorized in the beginning as I experimented with what became my final categories (Merriam, 1998 p. 179). Categories were all related to the research question (Merriam, 1998). I titled the categories as clearly as possible for outside readers. In order to provide a succinct analysis for the reader, I presented as few categories as possible while keeping them specific enough to avoid vagueness or confusion. After all of the data were collected and organized into chronological order and the base categories were constructed, I began the process of moving each unit of data into a category. Because I prefer the flexibility and transferability of keeping data in an electronic format, I used Microsoft Excel to store and organize my data.

The report relies heavily on descriptive data (Merriam, 1998). The data have been organized chronologically for the reader and include enough thick description for the reader to make their own interpretations. I used interpretive commentary when necessary in order to guide the reader.

Reliability and Validity

Without reliability and validity, the results of a study are not trustworthy. While reliability and validity in qualitative research cannot be controlled in the same manner as they are in positivist research, Stake (1995) and Merriam (1998) suggested several approaches to ensuring trustworthy data. Stake (1995) called for triangulation to confirm data. The amount of triangulation required is not prescribed before data collection, but it is determined by the importance and contestability of the data. Data that are suspicious are confirmed by another

source, but "data critical to an assertation needs extra effort towards confirmation" (Stake, 1995, p. 122).

Altheide and Schneider (2013) recommended beginning by gathering 6 to 10 pieces of documentation and testing the data analysis protocol first and then revising as necessary. Using this strategy, the process of data analysis is constantly being revised based on the new additions of data. A data analysis process that is continually updated remains relevant.

Confidentiality

This study only contains information available for public consumption. All data gathered are available to any member of the public, and therefore this study does not contain any confidential or anonymous details. Confidentiality was not required when gathering data for this study.

Addendum: Studying Traumatized Institutions

When I decided I wanted to do research on how universities manage crisis, my first idea was to interview administrators at the universities I was studying. I started with a list of universities that had experienced a crisis in the last 15 years, and I began making phone calls and email inquiries. Many emails went unanswered, and I cannot assume the reasons for those missed connections. When I was connected with someone considered appropriate for making decisions about being included in research, I would explain my interest area and ideas. The tone of the conversation would change. The person I was talking with would tell me that no one would be allowed to talk to me about that incident, and they would quickly excuse themselves from our conversation. One phone call was so startling to me that I can still hear the words in her voice. I had been referred to this administrator by someone else at the university, and we had started the conversation with a casual chat that felt friendly to me. I brought up the incident about

which I was interested in talking to administrators, and she cut me off. She sounded caught off-guard and frankly, scared. "Oh, I can't talk to you about that." [pause] "At all." [pause] "No one is going to talk to you about that." The punctuated way she said, "at all" made me feel like I had broken some kind of unknown superstitious rule, like I had wandered into the Emergency Department at a hospital and declared it "too quiet."

One individual I spoke to at another university described how proud his institution was about the work they had done to make excellent policy. We chatted briefly about how I suspected that institutions that had gone through a crisis would be most up-to-date on the policy needs of institutions. He agreed, saying his university had worked hard to update their policies and he believed they were best practices. When we met a second time, he told me that unfortunately, his university was not willing to allow people to talk to me. He reiterated that they felt the work they had done was the best it could be, but there might be areas that could use improvement, and there might be incomplete work. They did not feel comfortable having their work examined closely.

When I began this project, one factor I did not take into consideration was the trauma the universities had experienced as an institution. I did not consider that universities that have been criticized publicly in the media might remain too sensitive to revisit the experience. Even administrators who were not involved in the incident or were not employed at the university at the time seemed traumatized in a way I did not anticipate, as if they were affected by the institutional trauma second hand.

After an unsuccessful period attempting to find an institution that would allow administrators to talk to me, I rewrote and re-defended my dissertation proposal. My second

proposal was for document analysis case studies. Future research should examine this topic further using interviews with administrators who experienced cases like those in this study.

Personal Statement

I obtained my Bachelor of Social Work in 2007 and my Master of Social Work (MSW) in 2008. My concentration within my MSW program was leadership, formerly macro practice. I am a licensed social worker and consider myself a macro practitioner. I have worked at Ivy Tech Community College since July of 2008 and have occupied four job titles and five offices. I have been a case manager, a director, a faculty member, and am now an associate professor and program chair of human services. I also teach Introduction to Social Work at Indiana University.

I am passionate about the intersection of social work and macro practice. I wrote the statewide online course "Program Planning and Policy Issues in Human Services" for Ivy Tech Community College. I have been on several college policy development teams and contributed to the Ivy Tech Community College policies "Student Domestic Travel Policies," "International Travel for Students," and "Service Learning Policy." I chair the statewide human services curriculum committee, have contributed to the creation of the certificate in case management and the creation of the associate to bachelor transfer degrees, and have edited several course outlines of record (CORs) including "Program Planning and Policy Issues" and "Interviewing and Assessment." My favorite lecture day of the semester is the day I teach the Lily Ledbetter Fair Pay Act.

I believe administrators can collectively improve if we share information with each other. We are, after all, just "muddling through" (Lindblom, 1959).

CHAPTER 4

RESEARCH

The following case studies detail universities as they manage crises of mental health. The cases are organized in the following order: overview of the case, timeline of events, raised concerns, and policy changes.

Case Study 1: Appalachian State University

*"I don't know if I can give you a logical explanation. It's just happened, and we are having to deal with it." - ASU Police Chief Gunther Doerr (*Wood, 2015, para 9*)*

Overview of the Case

In the five months from September 2014 to January 2015, nine Appalachian State University students died (Wood, 2015). Two students died in car accidents, four were suicides, one was a suspected drug overdose, one was only reported as a medical emergency, and one had no public details per the family's request.

Anna Smith went missing in September 2014, three weeks into the semester. The community searched for her for 11 days before her body was found in the woods. Her disappearance, and the subsequent aftermath, were heavily reported in the media. Headlines from September and October (Table 1) illustrate the media spotlight:

Table 1

Appalachian State University Headlines

Date	Headline	Source
9/4/2014	Appalachian State student reported missing	(Lyttle, 2014a)
9/6/2014	Appalachian State police search woods for missing woman	(Lyttle, 2014b)
9/8/2014	Police: missing Appalachian State student is 'endangered'	(Wootson, 2014a)
9/9/2014	Friends: Missing ASU student was 'distressed'	(Lyttle et al., 2014)
9/10/2014	ASU student was distraught from attack before she disappeared, family reveals	(Washburn, 2014a)
9/11/2014	Father of missing AppState student Anna Smith wants more resources put into search	(Washburn, 2014b)
9/12/2014	Electronic trail is invisible for missing AppState student Anna Smith	(Washburn, 2014c)
9/13/2014	Anna Smith, missing ASU student, found dead in woods	(Washburn & Lyttle, 2014)
9/14/2014	Autopsy set for Anna Smith, ASU student found dead in woods	(Wootson, 2014b)
9/15/2014	Police: Anna Smith 'intent on harming herself'	(Wootson, 2014c)
9/17/2014	Autopsy indicates AppState student committed suicide by asphyxia	(Wootson & Washburn, 2014a)
9/18/2014	Rape report that roiled Appalachian State was a hoax, police say	(Washburn, 2014d)
10/6/2014	Death of ASU student Anna Smith ruled a suicide	(Washburn, 2014f)
10/29/2014	Autopsy on AppState student Anna Smith shows no trace of drugs	(Washburn, 2014e)

After Anna Smith was reported missing, students began to receive email messages from Appalachian State University Communications. Between September 4 and September 15 2014, 15 messages were sent to all students and parents (Appalachian State University, 2020).

Three more students died in November. Kristin Freeman, a former Appalachian State student who was taking classes at the community college, was found having hanged herself in her apartment (Washburn, 2015b). A few days later, Appalachian State freshman Jeremy Sprinkle was found asphyxiated his dormitory's bathroom. The following week, Appalachian State student Grayson Huffman was found dead of a presumed accidental drug overdose in his apartment. On Friday, November 14th, another message from Appalachian State was sent to students and parents from Chancellor Sherri Evert (Appalachian State University, 2020). The message reads in part,

> Yesterday, we received the tragic news that Appalachian State University student Jeremy A. Sprinkle, an 18-year-old freshman from Kernersville, was found deceased in his campus residence hall Thursday morning. The official cause of death has not yet been determined; however, foul play is not suspected and there is no evidence to suggest there is any threat to the university community.
>
> Last night, I sent a message to the campus community, which you can read here. In this message, I stressed the importance of open communication with family and loved ones, as it is often the most important resource our students can have. There are many resources available to our students, and the university's Counseling and Psychological Services Center also provides resources for parents and families as well. You can find them here. I hope you will find this information helpful. Should you need additional resources, feel free to contact the Dean of Students Office at 828-262-8284. (Appalachian State University, 2020, para. 42)

Dean of Students J.J. Brown sent out his own message on Monday, November 17 to parents and students. The message read in part,

> At Appalachian, we are uniquely tied to this mission of helping one another, and I feel strongly we need it right now more than ever. We all contribute or take away from this environment every day by our actions and our words. Our actions and words matter, and I encourage you to look for ways to use your actions and words to make others feel welcome at Appalachian, and embrace opportunities for meaningful discussions and exchanges. College campuses are amazing places where we can learn in and out of the classroom, and when we take the time and dedicate our thoughts to reaching out and really understanding a perspective we had never before considered, we can have powerful learning experiences that really do change the world.
>
> I ask you to think about this as you approach even the little things in your life. The anonymity and distance of social media outlets like Yik Yak can offer freedom to express ourselves, but we must hold one another as accountable in these spaces as we do in face-to-face situations.
>
> Maintaining our caring culture requires each member of our community to actively engage in finding solutions to the challenges we face. I am committed to working to find meaningful solutions to these challenges. Do your part as well. Think about how you are treating others with your actions and words. Take time to be involved in organizations, discussions, events and people who contribute in positive ways to you

> as a person, and to this community as a whole. Remember to Be Aware. Ask and Listen. Have a Plan. And if you See (or hear) Something… Say Something.
>
> (Appalachian State University, 2020, para. 41)

Between the end of the fall semester and the start of the spring semester, Appalachian State student Amanda Philips died in a car accident (Washburn, 2015b). Three more Appalachian State students died in January after returning to campus after the holiday break (Washburn, 2015b). Freshman Mary Catherine Johnson was found dead of asphyxiation in her dorm room. Jacob Whitaker died in a car crash a few days after Mary Catherine Johnson was found. Michael Schmitt died after paramedics were called after he was found in distress. The media did not release additional details on the circumstances around Michael Schmitt's death.

Appalachian State University Police Chief Gunther Doerr was quoted in the *High County Press* story about the cluster of student deaths:

> We've run into a very strange cycle of [not just suicides but] student deaths in general. This has been the last three years or so highly unusual. I don't know if I can give you a logical explanation. It's just happened, and we are having to deal with it (Wood, 2015, para 9).

The timeline for events related to the Appalachian State student deaths is found in Table 2.

Table 2

Appalachian State University Timeline of Events

Date	Event	Source
9/3/2014	Anna Smith is reported missing from the dorms by her roommate.	(Lyttle, 2014)
9/13/2014	Anna Smith is found on the edge of campus, in the woods. Two anonymous sources report to the media that it appears she has asphyxiated herself.	(Washburn & Lyttle, 2014)
9/3/2014-9/14/2014	Fourteen messages are sent from university administrators to the university community. Two messages are sent on September 13: one from Chancellor Sheri Everts, and one from Dean of Students J.J. Brown.	(Appalachian State, 2020)
9/15/2014	A second newspaper article is published with two anonymous sources reporting that Anna Smith asphyxiated herself.	(Wootson, 2014c)
9/15/2014	A memorial book is placed in Plemmons Student Union for Anna Smith's family.	(Appalachian State, 2020)
9/17/2014	The media reports that the autopsy indicates Anna Smith student committed suicide by asphyxia.	(Wootson & Washburn, 2014)
10/6/2014	Media reports that the death of ASU student was Anna Smith ruled a suicide.	(Washburn, 2014)
11/8/2014	A local community college student and former Appalachian State student Kristin Freeman, 23, is found asphyxiated in her off-campus apartment.	(Washburn, 2015)
11/13/2014	Student Jeremy Sprinkle, 18, is found in a locked dormitory bathroom dead of self-inflected asphyxiation.	(Washburn, 2015)
11/13/2014	Counseling center staff are made available by the university at Jeremy Sprinkle's dorm.	(Appalachian State, 2020)

Table 2 (cont.)

Date	Event	Source
11/17/2014	Grayson Huffman, 22, is found dead of a drug overdose in his apartment.	(Lyttle, 2014c)
11/17/2014	One message is sent from Dean J.J. Brown to students encouraging them to stay connected and reminding them of their importance. He encourages them to distance themselves from anonymous social media platforms, such as Yik Yak.	(Appalachian State, 2020)
12/21/2014	Student Amanda Phillips dies in a car accident over the semester break.	(Wood, 2015)
1/8/2015	Boone police officially rule Anna Smith's death a suicide.	(Washburn, 2015f)
1/19/2015	Mary Catherine Johnson, 19, is found dead in her residence hall room during a welfare check by police.	(Wood, 2014)
1/20/2015	One message is sent to students from the university administration. The announcement reports a student death, but in a break from previous messages about student deaths, this announcement does not name the student.	(Appalachian State, 2020)
1/22/2015	Senior Jacob Whitaker dies in a car accident.	(Wood, 2015a)
1/22/2015	Student writes a blog post picked up by the media that criticizes the university response. "I understand that the university is trying. I really do. It's nice that the Chancellor takes time out of her busy day of posing for photographs to write us an email about how much this death has affected her personally. But you guys really aren't trying hard enough."	(Anonymous, 2015)
1/23/2015	The High Country Press reports, "Parents have been flooding the campus' official social media pages with their concerns and fears."	(Wood, 2015, para 24)
1/30/2015	Michael Schmitt, 23, is found transported to Watauga Medical Center, where he later dies.	(Wood, 2015)

Raised Concerns

Improving mental health care was a topic that Appalachian State was exploring before the academic year 2014–2015. In 2013, Appalachian State reported that there were two known student suicides in the previous 3 years (Appalachian State University, 2013). Despite the lower-

than-average number of known student suicides, Appalachian State sought to improve their student outreach and prevention strategies.

At the time of their 2013 needs assessment, the Appalachian State Counseling Center had 10 full-time therapists, three doctoral students, and seven counseling interns (Appalachian State University, 2013). The counseling center also employed one case manager and one psychiatrist. Services at the counseling center were free, but in order to meet demand, students were limited to 5 to 10 visits a year. The Counseling Center webpage informed students,

> In light of the high demand for counseling services, the Counseling Center offers brief therapy. We find that most students experience improvement within 1-5 sessions. Students who present with concerns that are likely to require more than ten sessions are referred to off-campus practitioners who are able to provide longer term and more appropriate care. (Appalachian State University, 2012a, para. 4)

Appalachian State's needs assessment reported during the 2012–2013 academic year that, "15% of students seeking counseling services (on campus) identified 'suicidal thoughts' as a presenting concern" (Appalachian State University, 2013, p. 4). The needs assessment also noted that during the same academic year, a minimum of 25 students had "received in-patient psychiatric care related to suicidal ideation, intent, and/or attempts to commit suicide" (Appalachian State University, 2013, p. 4).

Appalachian State applied for a three-year, $64,579 grant from SAMHSA. The Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant was intended to

> (1) increase the number of youth-serving organizations who are able to identify and work with youth at risk of suicide; (2) increase the capacity of clinical service providers to

assess, manage, and treat youth at risk of suicide; and (3) improve the continuity of care and follow-up of youth identified to be at risk for suicide." (SAMSHA 2020, para. 1)

Appalachian State asked for funding for four activities:

- Hire a suicide prevention coordinator.
- Implement Kognito online gatekeeper training to train students and campus personnel.
- Prepare informational materials and marketing materials.
- Utilize the JED Foundation's JEDCampus program to evaluate and enhance the University's suicide prevention efforts. (Appalachian State University, 2013, p. 9)

Policy Updates

"We just did what we had done before, and what that year taught us is that we can't afford to do that." – Chief Communications Officer Megan Hayes, Appalachian State University (Brennan, 2019, para 3).

In 2015, two new policies were published: "Crises Response Protocol for Suicide Ideation and Attempts" (Appalachian State University, 2015b). and "Student Death Protocol" (Appalachian State University, 2015c). "Crises Response Protocol for Suicide Ideation and Attempts" replaced "Policy 403.2 Rendering Assistance to Students Who Have Attempted Suicide or Who Exhibit Other Life-Threatening Behaviors."

New Policy: Student Crisis Response Protocol

Two multipage protocols were released in 2015 by Appalachian State University: "Crises Response Protocol for Suicide Ideation and Attempts" (Appalachian State University, 2015b). and "Student Death Protocol" (Appalachian State University, 2015c). Both protocols were written in the summer of 2015, after the nine student deaths in the 2014–2015 academic year

(Brennan, 2019). Both protocols credit the Garrett Lee Smith Campus Suicide Prevention Grant. The "Crises Response Protocol for Suicide Ideation and Attempts" protocol informs students, faculty, and staff how to respond when a student is experiencing suicidal ideation or if a student has attempted suicide.

The "Crises Response Protocol for Suicide Ideation and Attempts" protocol describes who should be contacted under particular circumstances. If a member of the university is with a student that they feel is experiencing a crisis, they are instructed to follow the flowchart found on page 5 of the protocol:

> In addition to the crisis flowchart, there are other parties that should be contacted depending on the circumstances. If a student in crisis lives on campus, the University Housing Coordinator On-Call should be notified. If a student is taken to the hospital, the Dean of Students Office is contacted, or the Dean of Student's on-call staff is contacted if the call is after hours. The Dean of Students staff is responsible for creating a case in the "care and concern database" and arranging a "follow up visit … at the hospital" (Appalachian State University, 2015b, p. 9).

If University Police respond to a person in crisis, they are responsible for notifying (in order): Medical emergency personnel if the student requires emergency medical transportation,

counseling and psychological services center or Daymark if the student requires emergency evaluation, the Chief of Police, and the Dean of Student's on-call staff.

New Policy: Student Death Protocol (2015)

The "Student Death Protocol" addresses how the university community will respond when a student dies under any circumstances. The protocol addresses how and if the university community is informed, and how to address requests from the media.

Announcement Protocol. The campus community was given frequent updates about Anna Smith's disappearance due to concerns about keeping the community informed about potential dangers (Griffin, 2015). Dean of Students J. J. Brown noted that because there was no protocol before Spring 2015, the campus-wide updates about potential dangers began to evolve into updates about student deaths. Vice Chancellor for Student Development Cindy Wallace, Student Government Association President Carson Rich, and Assistant Dean of Students Alan Rasmussen reported hearing concerns from students that the number of campus-wide announcements were causing anxiety and distractions (Brennan, 2019; Griffin, 2015). Assistant Dean of Students Alan Rasmussen reported to *The Appalachian* that after notifications, students were calling the office crying or upset (Brennan, 2019). Coordinator for Student Mental Wellness Elisabeth Cavallaro, who was part of the team that developed the "Student Death Protocol," was also concerned about the possibility of suicide contagion. She and Alan Rasmussen both discussed with *The Appalachian* the fear that students already experiencing suicide ideation might be triggered by student death announcements.

The team that created the new protocol were also concerned about student and family privacy and questioned if student death details like names and circumstances were necessary to community members who did not know the student (Brennan, 2019; Griffin, 2015). The new

protocol for communication is for the Dean of Students to assemble a team called a Student Postvention Response Team (Griffin, 2015). This team includes representatives from the Office of Student Development, the Dean's office, the student's program, university police, and any other representation that the Dean of Students feels is appropriate (Appalachian State University, 2015c). This team will decide together on a community response. The University police will decide if a campus-wide safety announcement is necessary. If there is no safety concern, then there is no campus-wide announcement. The Dean of Student's office will be responsible for identifying and reaching out to individuals and groups that the office feels should be notified, including the student's roommates, academic program, friends, and social organizations. The Dean of Students is responsible for the first contact with the parents of the student (Brennan, 2019).

Media Protocol. Cindy Wallace, Vice Chancellor for Student Development for Appalachian State University, theorized with the *Watauga Democrat* whether the lack of protocol may have led to a piqued media interest in 2014–2015 (Oakes, 2015). The *Watauga Democrat* reported, "Rumors, hype and speculation swirled around each announcement of a student death at the university in 2014-15, including the comments, 'What is going on at ASU?'" (Oakes, 2015, para. 5).

The "Student Death Protocol" bolds the following instructions: "**Under no circumstances should staff make any comment or statement about the cause of death. In the event of the death of a student, all requests for information from news media personnel should be referred to the Office of University Communications**" (Appalachian State University, 2015c, p. 3). The instructions refer the reader to read further information about media response in the Media Guidelines section on page 9. The Media Guidelines on page 9 continue

with further bolded instructions: "**Accordingly, no person involved in the University's response to a student death will speculate as to the cause of death or make statements assigning responsibility for the cause of death**" (Appalachian State University, 2015c, p. 9) and again emphasize that media requests will be directed to University Communications and "**students, parents, faculty, and staff are discouraged from making comments or giving interviews to the media**" (p. 9).

Chief Communications Officer Megan Hayes reported to *The Appalachian* that when the "Student Death Protocol" was being developed, the university felt strongly that the focus of the message to the community should be on the contributions of the student and their life instead of their death (Brennan, 2019). Additionally, during her interview, she emphasized that only a medical examiner can determine a cause of death. Her statement is mirrored in the "Student Death Protocol" three times: "only a medical examiner has authority to determine the cause and manner of a death" (Appalachian State University, 2015c, p. 9).

Unaltered Policy: Rendering Assistance to Students Who Have Attempted Suicide

Policy 403.2 titled "Rendering Assistance to Students Who Have Attempted Suicide or Who Exhibit Other Life-Threatening Behaviors" was not altered after 2015, and it continued to remain unaltered in 2020. Before academic year 2014–2015, Policy 403.2 was the only policy related to student death in the policy manual and was last updated in April 2009 (Appalachian State University, 2012b). The policy states,

> A student's decision to take his or her own life is so serious that the University cannot ignore this act. In most circumstances, this decision shows that a student has emotional or mental health problems beyond the student's immediate psychological resources. It often indicates that the student is not prepared to continue at the University in the semester in

> which he or she attempted suicide. Unless there is clear and convincing evidence that the student is no longer at risk to himself or herself and strong evidence that the student's continuation at the University is in the student's best interest, it is the policy of the University to administratively withdraw a student who has attempted suicide or who exhibits life-threatening behavior. (Appalachian State University, 2012b, para. 11)

Updated Policy: University Policy Manual Updates

Policy 403.4 titled "Student Death Policy" was added to the manual in July 2015, in order to align policy with the "Student Death Protocol" written in the summer of 2015. Policy 403.4 describes how communication should be handled within the university (Appalachian State University, 2015a). The policy's opening statement states

> Appalachian State University intends to provide a safe and positive environment for all students. When tragedy does occur, it is incumbent upon the University to respond in a sensitive and caring manner. The death of a student affects the entire University community, as well as the family and friends of the deceased. This policy sets forth guidelines to support communications in the event of a student death.
> (Appalachian State University, 2015a, para. 8)

Policy 403.4 contains information similar to information found in the "Student Death Protocol," although the policy is primarily limited to communications and the information is conveyed in several short paragraphs and lists. The policy reiterates what alerts should be sent:

> 4.7.1 The University Police will send out a Campus Safety Alert if it is determined there is an on-going threat to the campus community.
>
> 4.7.2 Other than the Campus Safety Alert described in Section 4.8.1, the Office of Student Development, in consultation with the Student Postvention Response Team, will

determine as soon as practical what notifications will be made to the campus community. (Appalachian State University, 2015a, para. 15)

The policy also includes instructions for communicating with the media:

4.8.1 University Communications will be responsible for collecting and disseminating information to the media. All media requests for information should be directed to this office. University Communications will work with University Police, the Office of Student Development, and the Office of General Counsel to maintain the accuracy and ensure the legality of the information disseminated.

4.8.2 Under North Carolina law, only a Medical Examiner has authority to determine the cause and manner of a death that is not attended by medical personnel and other types of death, including but not limited to deaths that might reasonably have been due to a violent or traumatic injury or accident. Accordingly, no person involved in the University's response to a Student death will speculate as to the cause of death. (Appalachian State University, 2015a, para. 17)

In April 2016, Policy 403.5 titled "Awarding Degrees Posthumously" was added to the manual (Appalachian State University, 2016a). Policy 403.5 details the protocol for how a senior or graduate student will be awarded their degree if the student died before completing their requirements. Friends or family of the student may request that the student be awarded their degree if they were within 30 semester hours of graduation as an undergraduate or within 6 semester hours as a graduate student. Once a request is made to the dean of students, a series of approvals are needed from the student's department and college. After approvals, the deans and

faculty may hold a private ceremony for the family and friends of the student to confer the student's degree.

Case Study 2: Virginia Tech

On April 16, 2007, Virginia Tech student Seung-Hui Cho killed 32 people and himself on the Virginia Tech campus (Virginia Tech Review Panel & TriData Corporation, 2009). Cho was a senior undergraduate in the English department with a documented history of conflicts with students and faculty. He had been seen by several professionals at the Cook Counseling Center on campus and had been involuntarily admitted at St. Albans Behavioral Health Center after his suitemates had called the Virginia Tech Police Department (VTPD) when Cho threatened suicide.

Overview of the Case

The Virginia Tech case study will explore the administrative policies that were in place at the time of the incident, how the policies were interpreted by administrators, and what decisions were made when there was no policy to follow. Concerns that have been raised related to this incident but that are outside the scope of this study, such as how Cho obtained a firearm, are not addressed in this case study. The case study will conclude with new policies that have been implemented after the Virginia Tech incident and information about how the state of Virginia deconstructed the event.

Timeline of Events

The incident began about 7:15am when Cho followed student Emily Hilscher to her dorm room and shot her and her resident advisor, Ryan Christopher Clark (Virginia Tech Review Panel & TriData Corporation, 2009). He then left Hilscher's dorm and returned to his on-campus

suite before going to Norris Hall. Cho began shooting in Norris Hall about 9:40 a.m. He shot himself at 9:51 am, after police shot the lock on a door and entered Norris Hall.

There has been much discussion about what could have been done differently on April 17. Table 3 presents a timeline of events as written in the Virginia Tech Report Addendum. Parts of the timeline not relevant to the case have been omitted for sake of brevity and sensitivity.

Table 3

Virginia Tech Report Addendum Timeline

Time	Event
7:24 a.m.	The VTPD officer arrives at West Ambler Johnston Hall Room 4040, finds two people shot inside the room, and immediately requests additional VTPD resources.
7:26 a.m.	Virginia Tech Rescue Squad 3 arrives on-scene outside WAJ.
7:27 a.m.	Police dispatcher is advised of two victims. Officer on scene requests supervisor.
7:30 a.m.	Additional VTPD officers begin arriving at room 4040. They secure the crime scene and in effect lock down the dormitory, with police inside and outside. A housekeeper in Burruss Hall tells Dr. Ed Spencer, Associate Vice President for Student Affairs and member of the Policy Group, that an RA in WAJ was murdered. (The housekeeper had received a phone call from another housekeeper in WAJ.)
7:40 a.m.	VTPD Chief Flinchum is notified by phone of the WAJ shootings. Chief Flinchum tries repeatedly to reach the Office of the Executive Vice President.

Table 3 (cont.)

Time	Event
7:57 a.m.	Chief Flinchum finally gets through to the Virginia Tech Office of the Executive Vice President and notifies them of the shootings.
8:00 a.m.	Classes begin.
8:00 a.m.	The Virginia Tech Center for Professional and Continuing Education locks down on its own.
8:05 a.m.	At least two Policy Group members notify their families of the shootings.
8:10 a.m.	President Steger is notified by a secretary that there has been a shooting. He tells her to get Chief Flinchum on the phone.
8:11 a.m.	Chief Flinchum talks to President Steger via phone and reports one student is critical, one is fatally wounded, and the incident seems to be domestic in nature. He reports no weapon found and there are bloody footprints. President Steger tells Chief Flinchum to keep him informed. A staff member of the Policy Group and President Steger discuss the event, and Steger decides to convene the Policy Group no later than 8:30 a.m.
8:11 a.m.	BPD Chief Kim Crannis arrives on scene .
8:15 a.m.	Chief Flinchum requests the VTPD Emergency Response Team (ERT) to respond to the scene and then to stage in Blacksburg in the event an arrest is needed or a search warrant is to be executed.
8:16–8:40 a.m.	Hilscher's roommate, Heather Haugh, is interviewed inside WAJ by detectives. She explains that on Monday mornings Hilscher's boyfriend, Karl Thornhill, usually drops her off at WAJ and returns to Radford University where he is a student. She says he owns guns and practices shooting. Police then seek Thornhill as a "person of interest." His vehicle is not found in campus parking lots and officers believe he has left campus. VTPD and BPD officers are sent to his home, but he is not there. The Thornhill home is then put under surveillance.
8:16a.m.	Chief Flinchum informs the Policy Group that there is a person of interest who is probably now off campus.
8:16–9:24 a.m.	Police allow students in WAJ to leave. Some go to 9:00 a.m. classes in Norris Hall.
8:25 a.m.	The Policy Group convenes to plan how to notify students of the double shooting. Police cancel bank deposit pickups.

Table 3 (cont.)

Time	Event
8:40–8:45 a.m.	Phone calls are made from BPD to its units and to Montgomery County Sheriff's Office and Radford University police to be on the lookout for Thornhill's vehicle.
8:45 a.m.	A Policy Group member e-mails a Richmond colleague saying one student is dead and another critically wounded. "Gunman on the loose," he says, adding "This is not releasable yet."
8:49 a.m.	The same Policy Group member reminds his Richmond colleague, "just try to make sure it doesn't get out."
8:50 a.m.	First period classes end. The Policy Group begins composing a notice to the university about the shootings in WAJ. The Associate Vice President for University Relations, Larry Hinkler, is unable to send the message at first due to technical difficulties with the alert system.
8:52 a.m.	Blacksburg public schools lock down until more information is available about the incident at Virginia Tech. School superintendent notifies the school board of this by e-mail. The Virginia Tech Government Affairs Director orders the university president's office to be locked.
9:00–9:15 a.m.	Virginia Tech veterinary college locks down.
9:05 a.m.	Classes begin for the second period in Norris Hall. Virginia Tech trash pickup is cancelled.
9:15 a.m.	Both police ERTs are staged at the BPD in anticipation of executing search warrants or making an arrest.
9:15–9:30 a.m.	Cho is seen outside and then inside Norris Hall, an engineering building, by several students. He is familiar with the building because one of his classes meets there. He chains the doors shut on the three public entrances, from the inside. No one reports seeing him do this. A faculty member finds a bomb threat note attached to an inner door near one of the chained exterior doors. She gives it to a janitor to carry to the Engineering School Dean's office on the third floor.

Table 3 (cont.)

Time	Event
9:24 a.m.	A Montgomery County deputy sheriff initiates a traffic stop of Hilscher's boyfriend in his pickup truck off campus. He had heard there had been a shooting and was driving back to the campus to search for Hilscher after she did not answer his calls. Detectives are sent to assist with the questioning. A VTPD police captain joins the Policy Group as police liaison and provides updates as information becomes available. He reports one gunman at large, possibly on foot.
9:26 a.m.	Virginia Tech administration sends e-mail to campus staff, faculty, and students informing them of the dormitory shooting.
About 9:30a.m.	Radford University Police had received a request from BPD to look up Thornhill's class schedule and find him in class. Before they can do this, they get a second call that he has been found and stopped on the road.
9:30 a.m.	Police pass information to the Policy Group that it is unlikely that Hilscher's boyfriend, Thornhill, is the shooter (though he remains a person of interest).
9:31–9:48 a.m.	A Virginia State Police trooper arrives at the traffic stop of Thornhill and helps question him. A gunpowder residue test is performed and packaged for lab analysis. (There is no immediate result from this type of test in the field.)
About 9:40 a.m.	Cho begins shooting in room 206 in Norris Hall.
9:41 a.m.	A dispatcher receives a call regarding the shooting in Norris Hall. The dispatcher initially has difficulty understanding the location of the shooting. Once the location is identified as being on campus, the call is transferred to VTPD.
9:42 a.m.	The first 9-1-1 call reporting shots fired reaches the VTPD. A message is sent to all county EMS units to staff and respond.
9:45 a.m.	The first police officers arrive at Norris Hall, a three-minute response time from their receipt of the call. Hearing shots, they pause briefly to check whether they are being fired upon, then rush to one entrance, and then another but find the doors chained shut. An attempt to shoot open the chain or lock on one door fails.
About 9:45 a.m.	The police inform the administration that there has been another shooting. Virginia Tech President Steger hears what sounds like gunshots, and sees police running toward Norris Hall.

Table 3 (cont.)

Time	Event
9:50 a.m.	Using a shotgun, police shoot open the ordinary key lock of a Norris Hall entrance that goes to a machine shop and that could not be chained. These officers hear gunshots as they enter the building. They immediately follow the sounds to the second floor. Triage and rescue of victims begin. A second e-mail is sent by the administration to all Virginia Tech e-mail addresses announcing that "A gunman is loose on campus. Stay in buildings until further notice. Stay away from all windows." Four outside loudspeakers on poles broadcast a similar message. Virginia Tech and Blacksburg police ERTs arrive at Norris Hall, including one paramedic with each team.
9:51 a.m.	Cho shoots himself in the head just as police reach the second floor. Investigators believe that the police shotgun blast alerted Cho to police (starting entry into the building). Cho's shooting spree in Norris Hall lasted about 11 minutes.
9:52 a.m.	The police clear the second floor of Norris Hall. Two tactical medics attached to the ERTs, one medic from Virginia Tech Rescue and one from Blacksburg Rescue, are allowed to enter to start their initial triage.
9:53 a.m.	The 9:42 a.m. request for all EMS units is repeated.
10:08 a.m.	A deceased male student is discovered by police team and suspected to be the gunman.
10:17 a.m.	A third e-mail from Virginia Tech administration cancels classes and advises people to stay where they are.
10:52 a.m.	A fourth e-mail from Virginia Tech administration warns of "a multiple shooting with multiple victims in Norris Hall," saying "the shooter is in custody" and that as routine procedure police are searching for a second shooter.
12:42 p.m.	Virginia Tech President Charles Steger announces that police are releasing people from buildings and that counseling centers are being established.
4:01 p.m.	President George W. Bush speaks to the Nation from the White House regarding the shooting.

Table 3 (cont.)

Time	Event
April 17, 2007	
9:15 a.m.	VTPD releases the name of the shooter as Seung Hui Cho and confirms 33 fatalities between the two incidents.
9:30 a.m.	Virginia Tech announces classes will be cancelled "for the remainder of the week to allow students the time they need to grieve and seek assistance as needed."
11:00 a.m.	A family assistance center is established at The Inn at Virginia Tech.
2:00 p.m.	A convocation ceremony is held for the university community at the Cassell Coliseum. Speakers include President George W. Bush, Virginia Governor Tim Kaine (who had returned from Japan), Virginia Tech President Charles Steger, Virginia Tech Vice President for Student Affairs Zenobia L. Hikes, local religious leaders (representing the Muslim, Buddhist, Jewish, and Christian communities), Provost Dr. Mark G. McNamee, Dean of Students Tom Brown, Counselor Dr. Christopher Flynn, and poet Professor Nikki Giovanni.
8:00 p.m.	A candlelight vigil is held on the Virginia Tech drill field.
April 19, 2007	Virginia Tech announces that all students who were killed will be granted posthumous degrees in the fields in which they were studying. The degrees are subsequently awarded to the families at the regular commencement exercises, or privately, or in one case, at a Corps of Cadets event in Fall 2007. Governor Kaine appoints an independent Virginia Tech Review Panel to review the shootings.

Note. Timeline information from Virginia Tech Review Panel & TriData Corporation (2009)

Raised Concerns

"Dots were not connected, and signals were missed at Virginia Tech," Governor Tim Kaine to CNN, August 30, 2007 (Flick, 2007 para 8).

After the shooting, criticism began to mount toward Virginia Tech for its handling of what were perceived as red flags before the shooting as well as its emergency response on April 17 (MacGillis & Kilgore, 2007). Governor Tim Kaine issued an executive order calling for a

review panel to investigate several facets of the shooting (Shear & MacGillis, 2007). In 2009, an addendum to the original review was published with new available information (Virginia Tech Review Panel & TriData Corporation, 2009). The review and the addendum are 147 pages long and include an assessment of Cho's contact with student services and student service's assessment of relevant laws and policies as well as how those laws and policies were interpreted by Virginia Tech. Key items in the report related to administrative policy including university messaging, administrative response to red flags, and policy interpretation.

Timely Warnings

"The question everyone is asking is: How can you have two hours between the shootings and the place not be locked down?"- Anonymous Law Enforcement Source to the Washington Post (MacGillis & Kilgore, 2007, para. 12).

The police were called to the first shooting at approximately 7:15 a.m. President Steger was notified at approximately 8:10 a.m. and the Policy Group convened at 8:25 a.m., after classes had begun. President Steger told the *Washington Post*, "The question is, [where] do you keep them that is more safe? We concluded that it was best, once they got in their classrooms . . . to lock them down" (MacGillis & Kilgore, 2007, para. 8). However, most classrooms did not have locks (Virginia Tech Review Panel & TriData Corporation, 2009). In another interview, President Steger was quoted as saying they believed the shooting in the dorm was "a domestic fight, perhaps a murder-suicide" (CNN, 2007, para. 53). Critics of the lock down characterization noted that students were not informed of any danger until the 9:26 a.m. message and were not

informed of a shooter until 9:50 a.m. (MacGillis & Kilgore, 2007). The first email to the Virginia Tech community was sent at 9:26 a.m.:

> A shooting incident occurred at West Ambler Johnston earlier this morning. Police are on the scene and are investigating. The university community is urged to be cautious and asked to contact Virginia Tech Police if you observe anything suspicious or with information on the case. Contact Virginia Tech Police at 231 6411. Stay tuned to the www.vt.edu. We will post as soon as we have more information (Kleinfield, 2007, para 60).

The governor's review report raised the issue of timely warnings. The addendum notes, "Universities and colleges must comply with the Clery Act, which requires timely public warnings of imminent danger" (Virginia Tech Review Panel & TriData Corporation, 2009, p. 19). In order to provide clear and timely warnings, the addendum recommended:

> Campus emergency communications systems must have multiple means of sharing information. In an emergency, immediate messages must be sent to the campus community that provide clear information on the nature of the emergency and actions to be taken. The initial messages should be followed by update messages as more information becomes known. Campus police as well as administration officials should have the authority and capability to send an emergency message.
>
> (Virginia Tech Review Panel & TriData Corporation, 2009, p. 19)

After an investigation, the U.S. Department of Education found that Virginia Tech was in violation of the Clery Act for not providing a timely warning (Duncan, 2012). The Federal

Student Aid office stated that the 9:26 am email to students "was neither 'timely' nor a 'warning'" (Duncan, 2012, p. 3).

In a 2010 26-page letter, the Department of Education Federal Student Aid (FSA) outlined the Cleary Act violations that they determined Virginia Tech had committed:

> First, the warnings that were issued by the University were not prepared or disseminated in a manner to give clear and timely notice of the threat to the health and safety of campus community members. Second, Virginia Tech did not follow its own policy for the issuance of timely warnings as published in its annual campus security reports. (U.S. Department of Education, Office of Civil Rights, 2010, p. 6)

Each violation's maximum fine was $27,500 for a total fine of $55,000. Virginia Tech appealed the fine. (Crizer, 2011, p. 1). In 2012, Virginia Tech won an appeal, and a judge reversed the $55,000 fine (Duncan, 2012). Secretary of Education Arne Duncan reinstated $27,500 of the fine in a 13-page decision:

> It is alarming that Respondent argues that it had no duty to warn the campus community after the Police Department discovered the bodies of two students shot in a dormitory, and did not know the identity or location of the shooter. Indeed, if there were ever a time when a warning was required under the Clery Act, this would be it. Moreover, even if the Respondent had doubts about whether the shootings represented a threat to students and employees, as noted in *Havlik*, any doubts regarding issuing the notice should have been resolved in favor of providing a warning in order to assure safety and security for the campus community. (Duncan, 2012, p. 4)

Families of victims asserted in court that Virginia Tech had violated the Clery Act and that the state of Virginia was responsible for the wrongful death of students by failing to warn

students in a timely manner. In 2012, a jury found Virginia Tech was negligent for failing to warn students a gunman had shot two students and awarded the families four million dollars. The court reduced the award to the maximum allowed: $100,000 (Commonwealth of Virginia vs. Grafton William Peterson, Administrator of the Estate of Erin Nicole Peterson, 2013). In 2013, the Virginia Supreme Court overturned the ruling, stating,

> The circuit court erred in finding the Commonwealth, Virginia Tech, and/or their employees had a special relationship that imposed a duty even assuming that the Commonwealth, Virginia Tech, or their employees had a relevant special relationship under Virginia law, the evidence adduced did not give rise to a duty to warn of third party criminal acts. (Commonwealth of Virginia vs. Grafton William Peterson, Administrator of the Estate of Erin Nicole Peterson, 2013, para 16)

In addition to holding that the university did not have a special relationship to the students, the opinion also stated that because law enforcement believed that the first shooting was a domestic incident, it was unforeseeable that there would be additional violence on campus.

Messaging Logistics

Two messaging logistic issues have been raised. First, the information that an emergency was in progress traveled faster by rumor than by official channels. Second, a bottleneck occurred before information was released to the public.

Interviews by the Virginia Tech Panel of the Policy Group members indicated that at least two members knew about the shooting before VTPD reached the office of the Vice President (Virginia Tech Review Panel & TriData Corporation, 2009). Members of the Policy Group began to inform their families before President Steger was notified at 8:10 a.m. One member contacted their child, a student at Virginia Tech. Between 8:00 a.m and 9:00 a.m, both

the Virginia Tech Center for Professional and Continuing Growth and the Veterinary College locked down without having received an official notice of the shooting (Department of Education, Office of Civil Rights, 2010).

According to the Emergency Response Plan, the Virginia Tech Policy Group (a group of 10 university senior officials) and the police chief had the authority to send emergency notifications (Virginia Tech Review Panel & TriData Corporation, 2009). However, only two people had the actual codes to send an emergency message: the Associate Vice President for University Relations and the Director of News and Information. The typical process for sending a message required that the Policy Group and the police, if necessary, collaborate on the message content. There were no pre-written emergency messages.

> The review panel found several areas for improvement for the messaging system.
>
> The police had to await the deliberations of the Policy Group, of which they are not a member. The Policy Group had to be convened to decide whether to send a message to the university community and to structure its content. (Virginia Tech Review Panel & TriData Corporation, 2009, p. 17)

The panel also encouraged the adoption of an alarm system to alert students to check their phones or computers for a message.

Virginia Tech also had conflicting policies about warnings. The required statement provided by the Clery Act stated,

> At times it may be necessary for "timely warnings" to be issued to the university community. If a crime(s) occur[s] and notification is necessary to warn the university of a potentially dangerous situation then the Virginia Tech Police Department should be notified. The police department will then prepare a release and the information will be

> disseminated to all students, faculty, and staff and to the local community. (Duncan, 2012, p. 9)

The official Virginia Tech policy 5615 stated,

> University Relations and the University Police will make the campus community aware of crimes, which have occurred and necessitate caution on the part of students and employees, in a timely fashion and in such a way as to aid in the prevention of similar occurrences. (Duncan, 2012, p. 9)

Secretary of Education Arne Duncan found the discrepancies between the policies to be significant enough to warrant a fine. "Postsecondary institutions should not have multiple timely warning policies – only some of which are disclosed to the campus community – that are inconsistent with each other" (Duncan, 2012, p. 10).

University Inter-Department Communication

"I felt I'd said to so many people, 'Please, will you look at this young man?'"- Lucinda Roy, Chair of the English Department (Shapira & Ruane, 2007 para 17).

Finding 2 from the Virginia Tech Review Panel states that:

> During Cho's junior year at Virginia Tech, numerous incidents occurred that were clear warnings of mental instability. Although various individuals and departments within the university knew about each of these incidents, the university did not intervene effectively. No one knew all the information and no one connected all the dots. (Virginia Tech Review Panel & TriData Corporation, 2009, p. 2)

Cho presented several "red flags" during his time at Virginia Tech. Three staff at Cho's residence hall had reported to Residence Life that Cho's behavior in the dorm was disturbing other students (Virginia Tech Review Panel & TriData Corporation, 2009). Several women in

the dorm had reported receiving disturbing and threatening chat messages and marker messages on their doors from Cho.

The most well documented incident Cho had was in the fall of 2005 (Virginia Tech Review Panel & TriData Corporation, 2009). Professor Nikki Giovanni and the English department documented carefully Cho's behavior and writing in the class *Creative Writing: Poetry*. Professor Giovanni approached her the department chair several weeks into the fall semester and reported that Cho's writing and classroom behavior were frightening other students. After Cho read one of his works, several of her students did not return to class (Shapira & Ruane, 2007). Professor Giovanni felt so strongly she threatened to resign if Cho was not removed from her class. She presented a poem to the department chair and asked that someone with a mental health background evaluate the poem (Virginia Tech Review Panel & TriData Corporation, 2009). Ultimately, the *Creative Writing: Poetry* class incident involved the instructor, the English department chair, a dean, a counselor at the student health center, and a director of Judicial Affairs. Each division concluded that Cho's behavior was disturbing, but there was no immediate threat, and therefore no action would be taken. The chair of the department agreed to accept Cho as an independent study so he could finish the course without returning to Professor Giovanni's class.

Cho's behavior in Professor Giovanni's class was discussed by the university Care Team (Virginia Tech Review Panel & TriData Corporation, 2009). The Care Team includes representatives from Residence Life, Student Health, Student Affairs, and Judicial Affairs. The Care Team considered Cho's removal from the class the solution to his conflicts in the English department. The Care Team did not discuss Cho again, even when several students complained to Residence Life about Cho's stalking behavior and he was hospitalized involuntarily. An

assistant director in Judicial Affairs received an email from Residence Life about Cho's stalking behavior in the dorms but seemingly did not pass it on to the director or send it to the Care Team.

At the end of the fall 2005 semester, one of Cho's suitemates called the Virginia Tech police after Cho made what his suitemates considered to be suicidal threats (Virginia Tech Review Panel & TriData Corporation, 2009). The VTPD took Cho to an emergency evaluation, where the social worker judged Cho to be a danger to himself or others and unwilling to participate in treatment. She recommended he be held involuntarily. Within 48 hours, Cho was released, without medication, with court orders to attend outpatient counseling. He made an appointment with the student health center as part of his discharge. He may have attended the scheduled appointment, but the intake notes could not be found and the intake counselor did not remember him. He did not schedule another appointment. The counseling center is not told he is court ordered to attend counseling.

> Finding 4 from the Virginia Tech Review Panel and TriData Corporation (2009) stated, The Cook Counseling Center and the university's Care Team failed to provide needed support and services to Cho during a period in late 2005 and early 2006. The system failed for lack of resources, incorrect interpretation of privacy laws, and passivity. Records of Cho's minimal treatment at Virginia Tech's Cook Counseling Center are missing (p. 2).

In 2006, Cho took several courses from the English department. English faculty reported to each other and their chair Cho's continual behavioral issues in the classroom and violent writing (Virginia Tech Review Panel & TriData Corporation, 2009). Cho followed a professor back to his office and loudly berated him when the professor recommends Cho drop the class. His classmates described him to each other as, "the kind of guy who might go on a rampage

killing" (Virginia Tech Review Panel & TriData Corporation, 2009 p. 18). The English department doesn't receive any communication about Cho's hospitalization or issues with Residence Life.

Policy Updates

> *Those in a position to make critical decisions on behalf of (Virginia Tech) are aware that whatever future decisions they make may be subject to . . . public scrutiny (Randazzo & Plummer, 2009, p. 51)*

Between 2009 and 2011, a few policies regarding campus safety were modified. The official University Safety and Security Policy, which contributed to the fines from the Department of Education, received major revisions. A new policy was introduced for students, requiring them to report arrests to the Student Conduct Office. The student conduct policy was moved into the student handbook. No policies were introduced regarding student mental health and the mental health portion of the student handbook did not receive revisions.

Duty to Report Arrests Policy

In November 2010, Virginia Tech adopted a policy that required all students to report any arrests, convictions, or protective orders within 10 days of the event (Virginia Tech, 2011b). This policy was recommended by the campus University Safety and Security Policy Committee in order to enhance campus security. The intention of the policy was for the majority of reports to be addressed by the Student Conduct Office. Reports that raise concerns may be sent to the Threat Assessment Team. This policy depends primarily on self-reporting, and students must submit a *Self Disclosure of Arrest(s)/Conviction(s) Form* in person to the Student Conduct Office. Students are reminded of this policy during course registration. If students do not self-report, it is

considered a violation of student conduct, and the issue is referred to the Student Conduct Office. In a 2011 interview with Collegiate Times, Director of Student Conduct Francis Keene said,

> I actually think the majority of students, given the numbers we have had, are disclosing, and certainly not disclosing something is at your own risk. If you don't disclose something and we later find out about it, that would be something we would have a conversation with the student about (Haydu, 2011 para. 9).

Keene explained the policy, "is not intended to be a 'gotcha' program. It is just for us to be aware of issues that might be affecting our learning community." (Haydu, 2011, para 16). *The Collegiate Times* noted this policy was based on a policy put into place first by University of Virginia, after a University of Virginia student was murdered by another student in 2010.

Student Conduct and the Hokie Handbook

The *Hokie Handbook* is the student handbook at Virginia Tech. The Hokie Handbook is a very thorough document with information for students, and in the 2006-2007 academic year was 133 pages long (Virginia Tech, 2006). The 2006–2007 *Hokie Handbook* contained information for students on safety tips and reporting crimes but did not contain policies for student conduct. The 2006 *Hokie Handbook* policies for student conduct were found in the *University Policies for Student Life,* a separate document found on the Judicial Affairs webpage. This document includes information about hazing, underage drinking, misuse of campus equipment, and the

code of conduct. The code of conduct includes this information on conduct towards other individuals:

1. Abusive Conduct

Any words or acts that cause physical injury, or threaten any individual, or interfere with any individual's rightful actions, including but not limited to the following:

a. Assault - Words or actions that would cause an individual reason to fear for his or her immediate safety. Words can constitute assault when they are accompanied by the ability to inflict immediate harm.

b. Battery - The use of physical force against an individual.

c. Sexual Harassment - Unwelcome sexual advances, requests for sexual favors, and other verbal, non-verbal, or physical conduct of a sexual nature, under certain circumstances.

d. Sexual Misconduct - Sexual contact without consent.

e. Stalking - Repeatedly contacting another person when the contact is unwanted. Additionally, the conduct may cause the other person reasonable apprehension of imminent physical harm or cause substantial impairment of the other person's ability to perform the activities of daily life. Contact includes but is not limited to communicating with (either in person, by phone or computer) or remaining in the physical presence of the other person. (Virginia Tech, 2006 p. 4)

In 2009, the Student Code of Conduct is moved into the *Hokie Handbook*, and the language remains the same (Virginia Tech, 2011b). In 2020, The Code of Student Conduct

includes "Endangerment: Actions that intentionally or recklessly endanger the health, safety, or well-being of oneself or another person or group" (Virginia Tech, 2020, p. 9).

The 2006 Student Conduct Policy includes protocol for immediate suspension. "Students who engage in violent behavior, threaten themselves or others with violence, or act in an uncontrollably harmful manner, or otherwise threaten the health or safety of the university community may be immediately suspended from the university" (Virginia Tech, 2006, p. 10). The interim suspension protocol remained the same through 2020.

University Safety and Security Policy 5615

The wording of University Safety and Security Policy 5615 contributed to the fines the university incurred from Department of Education over the Clery Act violations. Policy 5615 was originally written in 1992. Between 1992 and 2002 the policy had three minor revisions, including changing the emergency number from 888 to 911 and changing the titles of committees referenced in the policy.

Between 2007 and 2020 policy 5615 has been updated 15 times with several significant updates. The notes on the 2009 revision show that the policy received "major changes to provide a comprehensive and overarching campus safety and security policy" (Virginia Tech, 2019, p. 16). The revisions included,

> Responsibilities of authorities; establishment of a Safety and Security Policy Committee appointed by the President; an overview of related safety, security, and violence prevention policies, plans, and programs; and procedures for reporting. The policy also

includes provisions that comply with various federal and state laws, regulations, and policies" (Virginia Tech, 2019, p. 16).

The 1992/2002 policy did not include any information on the university responsibilities required by the Clery Act. The updated 5615 policy includes a section on fulfilling the requirements of the Clery Act, including notifying students "immediately" (Virginia Tech, 2019, p. 8) in the event of a campus emergency. The language in the policy that includes the phrase, "immediately notify campus community" (Virginia Tech, 2019, p. 8) was added in 2011 after the U.S. Department of Education found in 2010 the university was not in compliance in 2007. The emergency notifications may be by "email notices; phone, cellular phone, and text messages; classroom electronic message signs; posters; university website notices; campus loud speakers and desktop alerts." (Virginia Tech, 2019, p. 8)

The updated policy includes the universities response regarding a missing person as required in the Higher Education Act of 1965 (Virginia Tech, 2019). The VTPD will investigate claims of missing students, and if the student has been determined to be missing more than 24 hours, they will notify the student's emergency contact and the Blacksburg PD.

The 1992/2002 policy did not include any information on safety committees. The updated policy 5615 named several safety-related committees and what each committee is responsible for (Virginia Tech, 2019). The committees are:

1. University Safety and Security Policy Committee, the members of which also make up the Policy Group. This group includes the president of the university, the senior vice

president, the provost, and other senior administrators. The university legal counsel has an advisory role on the committee.

2. Threat Assessment Team (TAT), which includes representation from Academic Affairs, Student Affairs, VTPD, and the Cook Counseling Center. The university legal counsel has an advisory role on the committee. The TAT's responsibility is to "assess, intervene, and follow policies for individuals whose behaviors may present a threat to the safety of the campus community" (Virginia Tech, 2019, p. 2)
3. Campus and Workplace Violence Prevention Committee
4. Health and Safety Committee
5. Emergency Management and Risk Assessment Committee, which reports to the University Safety and Security Policy Committee and is responsible for emergency preparedness.

Threat Assessment Team

Virginia Tech established its first TAT December 2007 through a Presidential Policy Memorandum (Randazzo & Plummer, 2009). The memorandum written by President Steger noted the Review Panel had recommended all public universities in Virginia adopt a TAT. President Steger named the following departments to have representatives on the TAT: Chief of Police (Chair), Dean of Students, Human Resources, Student Affairs, Clinical Psychology, Academic Affairs, and Legal Counsel.

Despite the unfavorable publicity the Care Team had drawn, the Care Team was not absorbed into the TAT and remains a separate committee. The objective of the TAT is to track and evaluate risk of violence or harm to the campus community. Concerns about student suicide

or self-endangerment without risk to others are handled by the Care Team. In 2014, more than 500 people were being tracked by the TAT (Korth, 2016).

Along with the establishment of the TAT, three case management positions were created (Randazzo & Plummer, 2009). Case managers were established to connect students to needed resources and track students who need services. The case management position is also being utilized as a way of facilitating communication across campus divisions. Virginia Tech Dean of Students Tom Brown told the Virginia Tech Demonstration Project his recommendation to other institutions is "above all else, implement a case management model and hire a case manager. Somebody needs to be dedicated full time to following 30, 40, 50-plus students who need assistance" (Randazzo & Plummer, 2009 p. 43).

Mental Health Practices

The Cook Counseling Center reported they have changed how they respond to students in a crisis. According to James Reinhard, medical director for Cook Counseling Center at Virginia Tech in 2017, now when students are committed to a mental health facility, a counseling staff member attends the commitment hearing (Rife, 2017). The university may also require students to attend counseling in order to stay at Virginia Tech or return to Virginia Tech. The case managers hired in 2007 attend psychiatric hearings with students as needed and follow students who have required treatment plans (Randazzo & Plummer, 2009).

Virginia Tech does not have any mental health policies that penalize students for suicidal ideation if there is no risk of endangerment to others. Virginia Code § 23-9.2:8 (2014) was first introduced in January 2007 and applied to all Virginia public institutions of higher education (Virginia's Legislative Information System, 2012). The law stated,

> The policies shall ensure that no student is penalized or expelled for attempting to commit suicide or seeking mental health treatment for suicidal thoughts or behaviors. Nothing in this section shall preclude any public institution of higher education from establishing policies and procedures for appropriately dealing with students who are a danger to themselves, or to others, and whose behavior is disruptive to the academic community. (Virginia's Legislative Information System, 2012, para 2)

The 2012 legislative session introduced an amendment to this law, and the text above was struck from the law. The law now only requires institutions of higher education train faculty and staff on how to identify and address suicidal behaviors (Virginia's Legislative Information System, 2012).

CHAPTER 5

FINDINGS

In Chapter 4, I examined two stories of universities during and after a mental health crisis. In full disclosure, I began collecting data for three case studies. In this chapter, I will address the following themes from Chapter 4:

- Policy Punctuations and Limited Newfound Expertise
- The Experience of the Unflattering Media Spotlight
- Consequences of Falling Behind in Evolving Legislation
- Consequences of Underprepared Communication

Theme 1: Policy Punctuations and Limited Newfound Expertise

Both schools updated a significant amount of policy in the years after their crises. The universities began the process of updating policy under the public perception that the prior policies had failed, and these failures had consequences. Under those assumptions, the updates were written carefully and were very detailed. In many cases, the updates were written with external input.

The policies that received criticism displayed evidence of the branch method of development and incrementalism (Lindblom, 1959). Policy 5615 was written in 1992 and had only a few minor revisions for the next 10 years. The incremental changes were not enough to keep the policy up to date, illustrated by the overhaul Policy 5615 received in 2009. At

Appalachian State, policies the university would have relied on in 2015 had not been incorporated into written policy at all. These gaps in policy were primarily assigned to the Dean of Students' office after the policy was written.

The policies that were updated were, with few exceptions, finely targeted to the university's specific crisis and the criticisms they had received. Virginia Tech updated and created several policies related to safety and communication. Appalachian State created new policies around mental health, student death, and communication. Neither university used the opportunity of policy updates to examine other university policies that may have also been outdated or confusing.

Punctuated-equilibrium theory is a public policy theory that states that "political processes are generally characterized by stability and incrementalism, but occasionally they produce large-scale departures" (True et al, 2019, p. 97). Policies were not stagnant at Appalachian State or Virginia Tech before the cases studied, but both cases caused a rapid succession of updates in the policies specifically related to the crisis. Punctuated-equilibrium theory (True et al, 2019) is a theoretical explanation for how government policy is written. The events in these cases follow the pattern of incremental, slow changes followed by a trigger event and a flurry of revision. The departure from the traditional incremental muddling along is created by crisis or conflict. When the crisis or conflict occurs, it emerges in a familiar pattern: "a problem festers 'below the radar' until a scandal or crisis erupts; policymakers then claim 'nobody could have known' about the 'surprise' intervention of exogenous forces, and then scramble to address the issue" (Jones & Baumgartner, 2012, p. 9).

In the cases studied, the 'scramble to address the issue' was thorough but also finely targeted. After listing all the policy updates, I sorted them into the following categories:

- Inter-University Communication
- Media Communication
- Family Communication
- Campus Safety Measures
- Student Self-Harm Policies

The new policies were written with such fine detail and descriptions that they were pages longer than the former policies. Virginia Tech's Safety and Security policy grew from three pages to 18. Appalachian State created two new documents, one five, another 16 pages. Tables 4, 5, 6, 7, and 8 show the policy changes made in each category.

Table 4

Inter-University Communication

Policy	School	Policy Location
In the case of an ongoing or continuing serious threat Virginia Tech will immediately notify the campus using several sources outlined in policy.	Virginia Tech	University Safety and Security 5615
Departments and supervisors are responsible for creating, communicating, and training their departments in emergency protocols.	Virginia Tech	University Safety and Security 5615
Student Code of Conduct, including abusive behavior, is included in the Hokie Handbook.	Virginia Tech	Hokie Handbook
The Dean of Students will notify appropriate university departments in order of importance, from the police to the bookstore.	Appalachian State	Student Death Protocol 403.4
Clarification on how typical communication about students between university employees is not a FERPA violation, and where to obtain clarification on FERPA rules.	Appalachian State	Crises Response Protocol for Suicide Ideation and Attempts
The Office of Student Development and the Student Postvention Response Team will determine if and when notifications should be made to the community.	Appalachian State	Student Death Protocol 403.4
The University Police will send out a Campus Safety Alert if there is an on-going threat.	Appalachian State	Student Death Protocol 403.4

Table 5

Media Communication

Policy	School	Policy Location
University Communications will communicate with the media. Media requests should be directed to this office.	Appalachian State	Student Death Protocol 403.4
Only the State Medical Examiner may comment on a student's cause of death.	Appalachian State	Student Death Protocol 403.4

Table 6

Family Communication

Policy	School	Policy Location
The VTPD will notify a student's emergency contact if the student has been missing more than 24 hours.	Virginia Tech	University Safety and Security 5615
One person from the Dean of Students or Office of Student Development will serve as a point of contact for the family of a student who has died.	Appalachian State	Student Death Protocol 403.4
If a student is hospitalized for suicide ideation or attempt, the Dean of Students will check for FERPA release and communicate with the family.	Appalachian State	Crises Response Protocol for Suicide Ideation and Attempts
Upon family or friend request, the Dean of Students will work with the student's academic department to determine if a posthumous degree is appropriate. Academic progress and good standing are required.	Appalachian State	Awarding Degrees Posthumously 403.5
Requests for student records or information should be directed to the point of contact designee from the Dean of Students or Office of Student Development.	Appalachian State	Student Death Protocol 403.4

Table 7

Campus Safety Measures

Policy	School	Policy Location
All residence hall entrances are locked at all times.	Virginia Tech	University Safety and Security 5615
VTPD will review new and renovated buildings for security requirements.	Virginia Tech	University Safety and Security 5615
The university is required to develop an emergency management plan	Virginia Tech	Presidential Policy Memorandum, then University Safety and Security 5615
Establishes a Threat Assessment Team with representation from across departments.	Virginia Tech	University Safety and Security 5615
Self-disclosure of arrests and/or convictions is required of all students within 10 days.	Virginia Tech	Hokie Handbook

Table 8

Student Self Harm

Policy	School	Policy Location
Students in distress should be reported to the Dean of Students, or the VTPD after hours.	Virginia Tech	University Safety and Security 5615
Flowchart for parties to contact in event of a student with suicide ideation.	Appalachian State	Crises Response Protocol for Suicide Ideation and Attempts
If a student is hospitalized for suicide ideation, the Dean of Students will be contacted at any hour. The Dean of Students will create a case in the care and concern database and will arrange a visit with the student.	Appalachian State	Crises Response Protocol for Suicide Ideation and Attempts
If a student is in the process of a suicide attempt, the Off Campus Police or Campus Police will be called, depending on where the student is. The police will contact at any hour: Counseling and Psychological Services, Chief of Police, Dean of Students.	Appalachian State	Crises Response Protocol for Suicide Ideation and Attempts

The new policies were written during a time of intense public scrutiny and organizational stress. The universities devoted more resources to writing the new policies than they had in the past. The policies were checked out by external stakeholders. In the case of Virginia Tech, new language to clarify the responsibilities of the college under the Clery Act was added in 2009 and then further clarified in 2011 after feedback from the U.S. Department of Education. At Appalachian State, the new "Crises Response Protocol for Suicide Ideation and Attempts" booklet credits five colleges and a grant. Other updates brought the universities up to date to the newest practices, such as the establishment of a TAT, use of automated notification systems, and current practices for students in emotional crisis. The document "Crises Response Protocol for

Suicide Ideation and Attempts" has been replicated and revised for use at several colleges with credits to Appalachian State, including Molloy College (2017), Paul Smiths College (2019), and Pierpoint Community and Technical College (2019).

Both universities created new policies and updates that were so robust and advanced that they should be considered experts within the category of the policy. Each university's newfound expertise was strictly confined to the very specific issues each university experienced in crisis. One might conjecture from these cases that two outside forces influenced and informed the internal response: Theme 2: Media Exposure, and Theme 3: Legislative Action.

Theme 2: Media Exposure

Both cases had significant media attention. The Virginia Tech shooting gained immediate national media coverage. At Appalachian State, local news sources published almost daily updates on Anna Smith in September, and the coverage evolved to national attention by the end of the academic year. Coverage of the two schools was often critical. Members of the Virginia Tech community discussed the red flags they had seen from Cho, and questions were raised about what the university knew about Cho's behavior. Criticism began to emerge regarding the university's management of the crisis and about President Steger. News stories about deaths at Appalachian State often ended with a summary or reminder of the previous deaths that year at the college. The major media events in these cases all had critical coverage.

The Media Raises Questions at Virginia Tech

Between the 17th and 19th of April 2007, *The Washington Post* published eight articles in print and online about the Virginia Tech shooting. *The Washington Post* was awarded the Pulitzer Prize in Breaking News Reporting in 2008 for the reporting.

Table 9

Washington Post Virginia Tech 2008 Pulitzer Prize Articles

Date of Publication	Headline	Source
4/17/2007	Gunman kills 32 at Virginia Tech in deadliest shooting in U.S. history	(Shapira & Jackman, 2007)
4/17/2007	2-hour gap leaves room for questions	(MacGillis & Kilgore, 2007)
4/17/2007	Students make connections at a time of total disconnect	(Vargas, 2007)
4/18/2007	Student who wrote about death and spoke in whispers, but no one imagined what Cho Seung Hui would do	(Shapira & Ruane, 2007)
4/18/2007	Kaine orders independent investigation	(Shear & MacGillis, 2007)
4/18/2007	Weapons purchases aroused no suspicion	(Schulte & Horwitz, 2007)
4/18/2007	Tragedy beyond the imagination	(Jones, 2007)
4/19/2007	That was the desk I chose to die under	(Maraniss, 2007)

Articles included interviews with students and families and described in detail the survivors' experiences. The articles raised questions about the gap in time between the first shooting and the warning to the community, the concerns students had about Cho, and Cho's access to weapons. The criticisms from students, families, and anonymous staff were published as soon as one day after the shooting: "The question everyone is asking is: How can you have

two hours between the shootings and the place not be locked down?" (MacGillis & Kilgore, 2007, para. 12).

One article by *The Washington Post* had extensive information from Professor Nikki Giovanni, one of Cho's English professors, and Professor Lucinda Roy, Chair of the English Department, on how they had repeatedly voiced concerns to the university. "I don't want to be accusatory or blaming other people," Roy said, "I do just want to say, though, it's such a shame if people don't listen very carefully and if the law constricts them so that they can't do what is best for the student." (Shapira & Ruane, 2007, para. 17).

The litany of criticism directed at President Steger led to him giving several media interviews where he defended the actions of the university. President Steger was quoted as saying that the administrators believed the shooting in the dorm was "a domestic fight, perhaps a murder-suicide" (Broder & Hauser, 2007 para. 27). He defended the delay to warn students saying, "The question is, [where] do you keep them that is more safe? We concluded that it was best, once they got in their classrooms . . . to lock them down" (MacGillis & Kilgore, 2007, para. 8). The classrooms did not have locks at the time. In another interview, President Steger gave the following quote to *The Washington Post* in response to timing criticism,

> It's very difficult. This is an open society and an open campus with 26,000 people, and we can't have armed guards in front of every classroom every day of the year. It was one of those things no one anticipated. Honestly, every situation we face is different. (MacGillis & Kilgore, 2007 para. 16).

Appalachian State Escalates from Local to National Story

When Anna Smith went missing in September 2014 from Appalachian State, the local media immediately began publishing every update related to the case. Between September and

October 2014, *The Raleigh Observer* published 14 articles about Anna Smith's disappearance, alleged hoax rape allegation, and suicide. The other eight student deaths at Appalachian State that year also caught media attention, not just in local print and news channels. *Inside Higher Ed* published a story titled "Suicide Clusters," focusing on Appalachian State and Tulane University (New, 2015). The Daily Mail published an article titled "Freshman Becomes FOURTH Student to be Found Dead at North Carolina College" with a tagline "the university says they will not look into these student's deaths, leaving the work to 'local law enforcement'" (Spargo, 2015). Later, Cindy Wallace, Vice Chancellor for Student Development at Appalachian State theorized that a lack of media protocol fueled the firestorm (Oakes, 2015).

Media Lessons Learned

Both universities took different approaches to the unflattering media sensation around their crises. Virginia Tech did not introduce any new media communication policies. Throughout the aftermath of the 2007 year up until the present, no policies were found that instruct faculty or staff on limitations to media interview requests. Media were asked to leave campus in 2007, not by request of the administration but by the student government. The student government released a statement on April 23, 2007, that read,

> Students in general will also be declining all requests and contact from the media. Please grant us your understanding as this decision was made by the students, with the intent to regain a sense of normalcy as we prepare to move forward as an academic institution and as a community in the healing process. (Dobbins, 2008, para. 2).

Virginia Tech committed to the freedom to comment to the media despite media discussing whether President Steger was "unfeeling and defensive" or a stoic, grieving leader (Lewis, 2008, para. 14). Students, faculty, and families continued to give interviews and

comments about their experiences with the shooting, and occasionally criticized President Steger and called for his resignation.

Appalachian State made a visible effort to regain control of messaging. It is likely that someone at Appalachian State anonymously made a comment to the media during 2014 about Anna Smith's cause of death. On September 13, *The Raleigh Observer* printed that Anna Smith had been found and that, "two people familiar with the scene said it appeared she had asphyxiated herself" (Washburn & Lyttle, 2014, para. 2). On September 15, *The Raleigh Observer* published another article with two anonymous sources stating that the police believed Anna Smith asphyxiated herself (Wootson, 2014c). Appalachian State began internally communicating a persistent and consistent message: only a medical examiner may make comments about cause of death.

- The "Student Death Protocol" (2015) bolds the following instructions: "under no circumstances should staff make any comment or statement about the cause of death" (Appalachian State University, 2015c, p. 4).
- The "Student Death Protocol" (Appalachian State University, 2015c) includes media guidelines with further bolded instructions: "Accordingly, no person involved in the University's response to a student death will speculate as to the cause of death or make statements assigning responsibility for the cause of death" (Appalachian State University, 2015c, p. 9).

- Chief Communications Officer Megan Hayes emphasized in an interview dissecting the creation of the "Student Death Protocol" that only a medical examiner can determine a cause of death (Brennan, 2019).
- The "Student Death Policy" (Appalachian State University, 2015a), or Policy 403.4 states, "Under North Carolina law, only a Medical Examiner has authority to determine the cause and manner of a death that is not attended by medical personnel and other types of death, including but not limited to deaths that might reasonably have been due to a violent or traumatic injury or accident. Accordingly, no person involved in the University's response to a Student death will speculate as to the cause of death" (Appalachian State University, 2015a, para. 17).
- A message emailed to the university community on February 5, 2015 signed by Chancellor Sheri N. Everts, Executive Vice Chancellor Stan Aeschleman, and Dean of Students J.J. Brown included the statement, "it is important to note that under State law, the university must rely on a medical examiner to determine an official cause of death, and when a death occurs off campus the university may not be informed of the cause" (Everts et al., 2015 para 3).

The speculation on cause of death was not the only communication upon which Appalachian State placed limitations. New policy written during the time instructed faculty and staff who have been contacted by the media for comment to refer the request to University Communications. University Communications describes their Critical Communications expertise as:

> Positive public relations on behalf of Appalachian. Whether your target audience is internal or external, University Communications can help you establish and maintain

> positive relationships that are beneficial to you and your constituents. We can help you anticipate and avoid potential crises through proper management techniques. Our staff has four professionals certified in crisis communication to assist you with critical communications if an unexpected event occurs. (Appalachian State University, 2021, para. 1)

Theme 3: Legislative Action

To date, no academic institution has had their U.S. Department of Education funds withdrawn for violating the Clery Act, FERPA, or Title IX (U.S. Department of Education, 2021). Theoretically, a violation can result in an institution losing their U.S. Department of Education funds, including financial aid. The devastation of an educational institution losing federal aid cannot be understated.

The fear that Appalachian State and Virginia Tech had of violating federal law is recognizable in both cases. The employees involved in these cases had enough background knowledge of the applicable laws to be aware that those laws applied, but they were not prepared to confidently follow through with applying the laws. The fear of making the wrong decisions is not unfounded. For some of these administrators, they could have been making the most consequential decisions of their careers and in areas outside of their expertise. In some cases, trying to avoid the wrong decision may itself have caused consequences.

Virginia Tech Misinterprets Privacy Laws

The Virginia Tech Review Panel and TriData Corporation's finding 4 was that the Care Team "failed for lack of resources, incorrect interpretation of privacy laws, and passivity" (2009, p. 2). The review panel found that a too strict interpretation of HIPAA and FERPA cut off communication between agencies that were working with Cho and his parents. The Care Team

knew women were reporting stalking behavior to Residence Life and three residence hall staff had reported disturbing behavior. The Care Team knew the faculty in the English department were so upset one of them threatened to resign if Cho was not removed from her class. Students in Cho's classes were describing Cho as "the kind of guy who might go on a rampage killing" (Virginia Tech Review Panel & TriData Corporation, 2009, p. 18). The Care Team made no recommendations about Cho, and instead considered the issue resolved when the chair of the English department offered to remove Cho from a course and work with him individually.

After Cho was held for 48 hours for an emergency evaluation, he was released with court orders to attend counseling. The university did not follow up with Cho at the hospital, nor did it verify that Cho attended his court-ordered counseling. While FERPA and HIPAA are privacy laws that protect an individual's academic and medical records respectively, the interpretation that the university could not have any communication with the hospital or follow up with the student is not accurate.

The Virginia Tech report found that over interpretation of FERPA was responsible for poor communication between departments and between outside agencies and the college. The panel made several recommendations for FERPA to clarify, but not revise, the rules, because it was the belief in what FERPA required, not the actual rules, that caused communication problems.

Virginia Tech Violates The Clery Act

It has been established by the Virginia Tech panel and the U.S. Department of Education that mistakes were made in warning the university community of a possible threat on campus (Duncan, 2012; Virginia Tech Review Panel & TriData Corporation, 2009). The police arrived at the scene of the first shooting at 7:24 a.m. and the first message to students did not go out until

9:26 a.m. The 9:26 a.m. message was described in a scathing rebuke by Secretary of Education Arne Duncan as "neither 'timely' nor a 'warning'" (Duncan, 2012, p. 3). The Department of Education Federal Student Aid fined the university an initial $55,000 for the violation which was reduced to $27,000.

Virginia Tech is Sued for Duty to Warn

Commonwealth of Virginia v. Grafton William Peterson was filed by the families of the Virginia Tech victims, asserting that Virginia Tech had a duty to warn students that they were in danger. The trial jury found the university had violated their duty and awarded the families four million dollars. The awarded amount was reduced by the judge to the maximum allowable fine of $100,000. A year later, the Virginia Supreme Court reversed the ruling, finding that:

> Even if there was a special relationship between the Commonwealth and students of Virginia Tech, under the facts of this case, there was no duty for the Commonwealth to warn students about the potential for criminal acts by third parties.
>
> (Commonwealth of Virginia v. Grafton William Peterson, 2013, p. 1)

In this case, the university was ultimately not found responsible. While ultimately a victory for the university, the jury trial illustrates the public perception of Virginia Tech's failure and must have been an ordeal in which the university did not want to be engaged.

Appalachian State Was Impacted by The Clery Act and the Higher Education Act of 1965

Section 488 of the Higher Education Opportunity Act of 2008 requires that colleges that participate in federal student aid programs and provided student housing must have a missing student policy (Higher Education Opportunity Act, 2008). The policy must allow students to provide an emergency contact person and requires the college to notify the emergency contact person and law enforcement if a student is missing for more than 24 hours. In the case of Anna

Smith, law enforcement and Anna Smith's family were notified. The public was notified with a request for information within 24 hours of when she was last seen.

A sexual assault was reported while the search for Anna Smith was ongoing. The sexual assault was not considered related to Anna Smith's disappearance, but the timing of the two incident raised questions and rumors on campus. The university addressed both incidences in messages to students. The sexual assault was reported a week after the alleged incident, and the messages from the university do not suggest there was an immediate threat on campus. However, likely out of an abundance of caution and to address the concerns the incidents may have been related, the university released information to the campus about the perpetrator. The university also addressed additional safety measures on campus.

In this case, the reported rape was a false report. The fact that the report was addressed in several of the messages from administration about Anna Smith raised the profile of the report and tied the two incidents together despite being unrelated. In this case, in an effort to be transparent and informative, the college publicized a false report, which was picked up by the local media.

Virginia Tech Ignites Political Debate

Bolman and Deal's (2017) structural frame states that "organizations work best when rationality prevails over personal agendas and extraneous pressures" (p. 78). The policy updates in these cases (Theme 1) were carefully written to address the gaps in the policies and bring policies up to date with federal laws. Outside the institutions, politicians used the shooting to highlight their political agendas. Bolman and Deal's political frame predicts negotiations and maneuvering for power and resources. Debate sparked around gun laws and concealed carry at the state and national levels. Republican Arizona State Senator Karen Johnson wanted concealed

carry at all public schools, kindergarten and older (Archibold, 2008). "I feel like our kindergartners are sitting there like sitting ducks" (Archibold, 2008, para 5). *The New York Times* reported in 2008 that 15 states were considering legislation on concealed carry at colleges and universities (Archibold, 2008). A bill to allow concealed carry at public schools in Virginia did not make it out of subcommittee in the Virginia General Assembly in 2007 (Associated Press, 2007). The bill's sponsor, Republican Representative Mark L. Cole, argued that Virginia Tech's policy of banning weapons on campus had not stopped Cho.

Theme 4: Consequences of Underprepared Communication

Virginia Tech and Appalachian State were both criticized for how they communicated with students. Virginia Tech was generally criticized for too little communication, and Appalachian State was criticized for over communication. In both cases, the universities made policy changes to improve their messaging to students. The messaging changes can be found under Theme 1. Theme 4 refers to the consequences of the communication strategies at the time of the cases.

Virginia Tech Emergency Messaging Confusion

The police were called to the first shooting at approximately 7:15 a.m. President Steger was notified at approximately 8:10 a.m., and the Policy Group convened at 8:25 a.m. (Virginia Tech Review Panel & TriData Corporation, 2009). According to the Emergency Response Plan at the time, both the police chief and the group of 10 Virginia Tech officials comprising the Virginia Tech Policy Group had the authority to send emergency notifications. An internal Virginia Tech policy on timely warning stated,

> If a crime(s) occur[s] and notification is necessary to warn the university of a potentially dangerous situation then the Virginia Tech Police Department should be notified. The

> police department will then prepare a release and the information will be disseminated to all students, faculty, and staff and to the local community. (Duncan, 2012, p. 9)

However, at the time, only two people had the actual codes to send an emergency message: the Associate Vice President for University Relations and the Director of News and Information. There were no pre-written emergency messages.

According to the written policy, the VTPD was responsible for notifying the community in a written release. The VTPD may not have been aware at the time of the shooting that the notification was the VTPD's responsibility, as they did not have the codes to send out emergency messages. Another conflicting policy gave the responsibility to the policy group. The responsibility of the group instead of one or more specific administrators likely diffused the responsibility and encouraged the messaging delay.

Appalachian State Overwhelms Students with Messages

At Appalachian State, Assistant Dean of Students Alan Rasmussen and Coordinator for Student Mental Wellness Elisabeth Cavallaro both reported concerns that the response to student deaths was causing harm (Brennan, 2019). After receiving student feedback, they concluded that sending multiple messages regarding each student death overwhelmed students. The messages were meant to inform students of student deaths and safety concerns, keep students up to date on developments, and encourage students to reach out for help. Some of the messages were brief, and some read as page-long heartfelt letters from administrators to students and families. In the month of September, 15 messages were sent to the entire campus about mental health, suicide,

and safety. Students began to report to the Dean that the number of messages were detrimental to their mental health (Brennan, 2019). A critical blog post by a student read,

> These tragedies have rocked Appalachian's campus and caused a great deal of grief and uproar from students and faculty alike. In response, Appalachian State sent an email from Chancellor Sheri Everts with a vague link to a university website dedicated to giving you all sorts of phone numbers . . . including 911. (Anonymous, 2015, para. 6)

In retrospect, administrators became concerned that the continual reminder of tragedy could contribute to a contagion effect (Brennan, 2019).

CHAPTER 6

IMPLICATIONS

Appalachian State and Virginia Tech both experienced crisis and tragedy. Higher education administrators will spend their careers hoping to avoid tragedies of this magnitude. In this study, I wrote two case studies with a focus on how policies and procedures at the universities changed after each crisis. I discussed themes within and between the case studies. Here, I will discuss recommendations for practice and research. As case studies, the findings may not be applicable to other universities. With the rapid evolution of technology, public policy, and case law, the decisions made by the institutions in this study may already be outdated. However, there are generalizable lessons from these cases that should be considered. Implications may be organized into the following categories: implications for practice, implications for teaching, and implications for research.

Implications for Practice

Administrators should consider how the policy needs in higher education will change. There is preliminary evidence that social media will continue to have an increasing influence on university students and how news is consumed. Additionally, mental health services continue to be under pressure by rising need. Administrators should consider distributing the work of policy development across multiple institutions.

The Increasing Influence of Social Media

In 2007, Twitter and public Facebook use had only been available for a year. The two cases in this study were impacted by social media, and the use and audiences of social media continues to grow. Early research is now supporting concerns that social media is also impacting the mental health of college age young people.

University Communications and Social Media

Communication between and among the academic community and the public is becoming easier and faster. At Appalachian State in 2015, the university struggled with rumors, public criticism, and worried families on their Facebook page. An editorial was written and published in the student paper about the dangers of YikYak, the anonymous social media application. The dean of students warned students about harmful social media posts, particularly YikYak.

In recent years, students have been communicating their experiences on social media to large audiences. On October 1, 2021, a student filmed a school evacuation and crime scene when a former student entered YES Prep Southwest and shot the principal, Eric Espinoza. At least one student posted videos of the crime scene to TikTok, which gained 12 million views (Colombo, 2021). On February 14, 2018, a 14-year-old freshman tweeted, "I am in a school shooting right now" from Marjory Stoneman Douglas High School. He continued to tweet for two hours while hiding in his classroom (Griggs, 2018). Administrators should be prepared for the near-live or live broadcasting of any crisis on campus.

In the Fall 2021 semester, the University of North Carolina at Chapel Hill (UNC) experienced several student suicides, and information traveled on social media faster than UNC released statements. UNC canceled classes on October 12, 2021, for a student mental health day,

and the national news picked up the story. The two students interviewed by *USA Today* both remarked they had learned about the suicides on social media before the university released a statement. Senior Emma Olson was quoted saying, "Honestly, I was quite angry because I watched people on social media beg the school to release a statement" (Tebor, 2021, para. 11). At the time of this writing, UNC was not releasing the number of suspected suicides, but students and faculty on Twitter were reporting four in the month of October. Anthropology faculty member Angela Stuesse tweeted on October 11:

> Unsure how many UNC students have died from suicide this fall, because our institution isn't telling us. Four? Classes are cancelled Tues but I'll be holding open office hours all morning, and I welcome any student—mine or not—who needs company or a listening ear to join me. (Stuesse, 2021)

UNC students posting on Twitter have been critical of the university response, including complaints that UNC took down the student memorial for campus tours and concerns that the university is not prioritizing mental health.

The UNC Subreddit had 158 comments on the post "UNC crime log reports another suicide 3 am Sunday at Granville Towers South" by an anonymous UNC professor (Lynncy1, 2021). Students reported that a fourth chair was added to the student memorial, and several students expressed anger that the university had not released a statement. Several students reported difficulty with the CAPS system and described that they were being referred to outside therapists that were not taking new clients.

Rising Mental Health Needs and Social Media

The rise of social media has created a wave of criticism about the impact of social media on young people's mental health. Internal documents released from Facebook in September 2021

show the negative impact: one in three teenage girls struggling with body image reported feeling worse after using Instagram (Gayle, 2021). Other Facebook internal documents linked depression, anxiety, low self-esteem, eating disorders, and suicidal thoughts to Instagram use The Facebook internal documents indicate that Facebook has known about the effects of Instagram on youth mental health since 2019.

At the time of this writing, a current mental health concern from mental health clinicians and medical practitioners is psychosomatic tic-like behaviors linked to TikTok (Olvera et al., 2021). Clinicians are reporting rapid onset functional tic-like behaviors, or psychosomatic tic and Tourette syndrome-like behaviors in teenage girls and women. In a 2021 study of content creators with tics on TikTok, neurology researchers found that 67.9% of creators indicated they had acquired specific tic behaviors from other users, such as shouting the word 'beans' or imitating a cartoon character. The authors postulate that pandemic stress and the pressure to garner views and the subsequent income, are contributing to the rise in functional tic-like behaviors.

In the cases in this study, the primary public critiques were published by professional media, although social media was a developing issue. The ability of the academic community to post and read immediate, unfiltered content was a factor in both cases, despite the relative newness of social media. The expectation for immediate, publicly sourced content continues to grow. While the challenges of social media are concerning, framing social media as an enemy of the university communications team will not be productive. Instead, communications teams must learn how to exist alongside social media.

Administrators should be prepared for any institutional crisis to appear immediately on social media. Administrators should expect public criticism from students and from the larger

community. It is important that decisions are not made solely out of concern for potential social media reaction, but communications teams should consider how social media will affect the messaging.

Institutions should be aware of the increasing mental health needs of students and the demand for more mental health services. Early research is indicating that social media is negatively impacting student mental health (Gayle, 2021). Early interventions for social media related mental health concerns should be considered. Mental health offices that work with young people should stay updated with social media trends that may impact mental health.

Sharing Expertise

Appalachian State and Virginia Tech both developed detailed up-to-date policies in their particular areas of crisis. Both universities experienced ongoing public criticism from outside stakeholders, faculty, and students for their decisions, and these stakeholders were invested in the improvement process. The scrutiny resulted in the universities carefully crafting their policy revisions. It is likely that after the period of re-examination and rewriting, the institutions became experts in their specific areas of revision. Institutions do not have the time and staff available to devote this level of research and development to every area of policy.

Universities that need to update policy should seek out other institutions that have experienced a crisis or public scrutiny around the topic they are updating. One of the consequences of being in a spotlight is that the university will utilize every resource to create accurate policies. Universities with outdated or no policies can choose to spend their own efforts crafting policy that is up-to-date and compliant with federal law, or they can seek out universities that already did the work.

Another possibility for showcasing expertise in policy would be through the creation of a central portal or hub. "Crises Response Protocol for Suicide Ideation and Attempts" (Paul Smiths College, 2019) was a policy that was shared collegially between several institutions. A centralized portal would encourage sharing of large numbers of policies through one location. Institutions of higher education would submit policies to share with a description of why they believe it is a best practice and the credentials of the people involved in the writing process. A central hub would promote more standard policy across institutions and reduce work spent researching. Institutions without experts in particular areas would have a starting point for developing common practice. Institutions that are considered best practice writers would be motivated to continually update their policies and may reduce the number of policies that are created and then left without updates for twenty years. Experts who serve on institutional committees that write and update policies that are considered national best practices could consider their contributions as research and service.

While a centralized hub for the collegial sharing of policy may promote common practices, the current environment around higher education may make it difficult or impossible. First, there are states that have state laws that would impact policy requirements for institutions. For example, in the state of Virginia, universities may not expel a student solely for a suicide attempt. They may, however, remove a student for being a danger to themselves or others, or for disruptive behavior. A policy that is considered a best practice in Virginia may be slightly different from a best practice in Indiana, where there is no similar law.

The current environment of unwanted media attention and legal fears will likely prevent a more public collegial sharing of policy. Universities may be hesitant to promote policies if there is a small chance the policy will be challenged in court. If a university is sued over a policy,

would the originating university also be liable for promoting their policy as a best practice? If the sued university settles without admitting fault, can the originating university still consider their policy a best practice?

This study illustrated the concern and fear institutions hold around revisiting an institutional trauma. During the early stages of this study, I had conversations with several administrators at different institutions that had experienced crisis, and the fear and concern over revisiting the trauma was evident. There was considerable concern about the exposure to more criticism. However, there is also proof in the Appalachian State case that policy sharing is a possibility. "Crises Response Protocol for Suicide Ideation and Attempts" (Paul Smiths College, 2019) has been revised and shared between several colleges and universities, and Appalachian State is one of the universities credited.

Administrators should continue to use professional development opportunities for sharing policy practices. Conferences and other professional development for administrators can be an opportunity to discuss and share policy. Discussing policy at professional development opportunities would allow administrators to share policy without the concerns of a formalized hub or a formalized

Cross Departmental Policy Training

Institutions of higher education are required to follow federal policy, and federal policy is continually evolving. The study in this paper illustrates the importance of universities keeping up to date and acting within the guidelines of federal policy. For institutions of higher education, the consequences of not following federal policy can be severe. According to the Department of Education (2021), there has never been an instance of an institution of higher education losing their funding due to violating federal policy. The Department of Education emphasizes their

focus on voluntary compliance and not punitive compliance. The Department of Education's guidelines for institutions of higher education appear to imply that their focus is on institutional effort and not compliance by fear.

When institutions of higher education train employees on federal policy, they are training employees at all levels and positions. Training and protocols that emphasize consequences as the primary reason for compliance may promote fear, inaction, or overreaction over accuracy. In the cases in this study, one university learned that overcommunication had unintended consequences. Appalachian State intended to be as forthcoming with students and families as possible and may have also been motivated to cover any concerns regarding the Clery Act, the Higher Education Opportunity Act, and danger on campus. In the beginning of their crisis, they had a missing student and a rape allegation, and in an attempt to be transparent, set a tone of communication that was not sustainable. Virginia Tech had multiple departments with pieces of information that were not shared, partially out of concern that student privacy laws restricted communication. Over-compensation in order to ensure that certain laws are followed is not a safe strategy.

Cross-departmental training may be enhanced by the use of case studies. Case studies are a common learning tool for students and professionals. Social work, nursing, psychology, law, and other professional fields use case studies to immerse students in cases like ones they may see as professional. Professional practitioners publish case studies they have seen in their field to inform their peers about a rare occurrence. Case studies for professionals allow the professional to apply their foundational knowledge to a real problem in a less risky environment. Case studies are interesting and dramatic.

Case studies may be used by institutions for role-play of crisis scenarios, such as tabletop training exercises. Tabletop scenarios allow decision makers to talk through hypothetical crisis situations in a low-risk environment. Tabletop training exercises are discussion-based training events focused on roles and communication and are used by FEMA, Homeland Security, law enforcement, and other emergency preparedness groups. The Department of Homeland Security offers tabletop training scenarios for K-12 institutions and institutions of higher education for preparedness for emergencies, including tornadoes, cyber breaches, hurricanes, and active shooters (Department of Homeland Security, 2022).

Tabletop role plays at institutions of higher education should involve multi-department participation and legal representation. Representation should include staff that are not managers or administrators, as policies like FERPA and interdepartmental communication affect all levels of staff. While tabletop trainings are typically used to role play safety crises, for higher education they could be written for staff to practice applying federal and internal policies to real scenarios. Having legal representation at the tabletop scenarios gives decision makers the opportunity to apply their understanding of federal policy requirements and receive immediate feedback.

In a training scenario, a chosen leader would present part of a case study to a roundtable of administrators and representatives from across an institution. Participants would include members of a Behavioral Intervention Team, representatives from student advising, student health, student affairs, residential services, disability support services, deans, program chairs, and security. The first part of the case would be introduced to the team, followed by a series of questions or decisions for the team to make.

For example, the leader would present a student's history of being reported for sexual harassment in a residence hall. Then, the leader would introduce a new problem: the student's

creative writing teacher has reported the student is frightening other students in his class with violent language and writing and has possibly taken pictures of students in class without permission. What will the team do? A good leader would encourage a discussion that covers what the team is allowed to do, and what the team feels is an appropriate intervention. After a decision is reached, the leader proceeds with an update: the student is currently hospitalized for suicidal ideation because his roommate called 911 over the weekend. What does the team do? To consider the importance of communication, the leader could assign one person to hold the information and ask who they would like to "loop in": "The dean of student affairs receives a call that the student is hospitalized, what do you do?" If certain departments or individuals who would have contributed to the scenario were not informed about the issues, they could speak up at the end of the discussion and educate the participants on what they could have contributed if they had been called.

Interdepartmental Communication

Employees at the same institution are members of the same team. Communication across departments or between staff is critical for the operations of a large institution. At Virginia Tech, Associate Vice President Dr. Ed Spencer was the first member of the Policy Group to learn about the shooting at the dorm (Virginia Tech Review Panel & TriData Corporation, 2009). A housekeeper from the WAJ dorm called another housekeeper at Burruss Hall, who told Dr. Spencer. Dr. Spencer immediately left Burruss Hall and walked to WAJ, arriving before any other member of the Policy Group had been notified. This unofficial channel of communication was much swifter than the planned emergency communication.

As a member of a Behavioral Intervention Team (BIT), I have had conversations about what the team feels is appropriate to share and who to share it with. If a staff or faculty member

have an experience with a student where the student has threatened violence, is it appropriate to inform other faculty or staff that have contact with the student? Some believe that incidents involving student behavior are confidential and cannot be shared outside a BIT or other intervention team. This misinterpretation of privacy laws was present in the Virginia Tech case. Several groups within the university had important information about Cho, including Residence Life, the English Department, VTPD, Judicial Affairs, and student health. The English Department documented the most communication about concerns they had about Cho. Faculty repeatedly brought concerns to each other and were seemly exasperated with the lack of action from the university. The Care Team knew about Cho's conflicts in the English Department and considered them resolved by the English Department chair. Later, student complaints to Residence Life and Judicial Affairs were not brought to the Care Team. Each of these systems dealt with the complaints using the information that was available to them. The English Department did not know students were reporting stalking behavior and suicide threats. The Care Team did not have all the stalking complaints and were not informed that Cho had been court ordered to mental health counseling. Judicial Affairs was not aware the English Department was reporting students were not returning to class because they were scared of Cho. The Care Team included representatives from Residence Life, Student Health, Student Affairs, and Judicial Affairs, and they still did not share the information they had. It is critical that institutions train all faculty and staff on what communication is allowable under FERPA.

Implications for Teaching

Educational leadership students should be taught the history of higher education laws, including the events leading up to the creation of the laws and how they have been applied in

court. Students should be prepared to examine the policies at their institution and question if they are up-to-date and complete.

Students who intend to work in higher education administration need detailed instruction on higher education related laws and relevant legal rulings. Students should have class experience applying policy and law to case studies in a low-risk environment. A cursory understanding of relevant policies like FERPA may lead to overreaction and under communication. Students should be prepared to lead teams with strong cross departmental communication. Students should be presented with case studies that demonstrate effective cross departmental communication and examples of failed communication and the subsequent consequences.

Implications for Research

Research is needed on how institutions train staff on policy at all levels. Due to the rarity of incidences like those in this study, the best trainings may not necessarily be the trainings that result in the fewest complaints or sanctions. Research is needed to find which training processes result in the most complete understanding of the laws and the most appropriate applications. For example, an institution where staff and faculty were trained to fear FERPA violations and have no interdepartmental communication will have few FERPA complaints but will not be applying FERPA correctly.

Further research is needed on how policies are or are not consistent between institutions. Currently, there is no centralized process for sharing policy and each institution must create their own policy individually. Policies are public at public institutions and it is possible that institutions are already borrowing policy from each other in informal ways. How much policy is being recycled and from which institutions is not known. If institutions are already borrowing

policies from each other, a centralized hub for sharing practices may improve the quality and efficiency of the sharing practices.

Research needs to continue in areas related to college student stress, mental health, and suicide prevention. There is a breadth of research in this area, as outlined in the literature review in this paper, but best practices in the area of suicide prevention continue to be elusive. The low incidence of suicidal behaviors at universities makes it difficult to parse out which universities are utilizing substandard practices and which are experiencing a statistical anomaly.

Closing Thoughts

Lindblom (1959) wrote that that complex American government policy will always be incomplete, growing like branches from a tree. In this study, incrementalism is applied to the policy revision process at universities. At these institutions, existing policies were continually revised as external factors evolve. Failure to revise led to stagnant policies and practices. Policies and practices that have stagnated are not useful when they are needed and may ultimately be harmful.

Continually nurturing the growing branches of all policies at an institution may not be feasible without sharing the work. Sharing practices, either through independent organizations or direct collegiality between institutions, will allow institutions to keep policy up to date even when the policies are not drawing attention.

Most importantly, administrators need to make decisions and write policies based on the most accurate and up-to-date information available. Poor input will result in poor outcomes. Case law, federal law, and state law that impact higher education have been in a continual cycle of change. Institutions must always be in the process of reevaluating and updating. It can be

tempting to declare policy "finished" and to step away. Instead, we must view the policy process as a living document that must be continually nurtured for it to serve us when we need it most.

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