SUPPORTING STATEMENT: PART A

Rapid Response Suicide Investigation Data Collection

OMB# 0920-XXXX

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- Goal of the study: CDC requests approval for a 3-year period of a new Generic Information Collection Request (ICR) to rapidly respond to urgent requests for CDC assistance to investigate an apparent and unexplained potential cluster or increase in suicidal behavior. Rapid Response Suicide Investigation Data Collections are specifically designed to inform the implementation of prevention strategies in the requesting jurisdiction or community by describing (a) changes in rates of fatal or nonfatal suicidal behavior; (b) the risk factors associated with trends in rates; (c) the characteristics of the subgroups most affected; and (d) current risk and protective factors and prevention opportunities.

- Intended use of the resulting data: These public health data are used by requesting jurisdictions and communities to identify, prioritize, and implement strategies to prevent suicidal behavior and suicide. This generic clearance will not be used to conduct research or to collect data to inform Federal policies or funding priorities.

- Methods to be used to collect: Rapid Response Suicide Investigation Data Collections methods will vary and depend on the unique circumstances of the urgent and rapid response and objectives determined by CDC. Investigations may use descriptive and/or cohort- or case-control designs. Data collection modes may include: (a) archival record abstraction; (b) face-to-face interview; (c) telephone interview; (d) web-based questionnaire; (e) self-administered questionnaire; and (f) focus groups. Multiple data collection designs and modes are likely to be employed in a single investigation.

- The subpopulation to be studied: The subpopulation will vary and depend on the unique circumstances of the requests for assistance

- How data will be analyzed: The data analytic approach are likely to include descriptive analyses, logistic regression, and temporal and spatial cluster analyses.

A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control (NCIPC) requests approval for a 3-year period of a new Generic Information Collection Request (ICR) to rapidly respond to urgent requests for CDC assistance to investigate an apparent and unexplained potential cluster or increase in suicidal behavior. Rapid Response Suicide Investigation Data Collections are specifically designed to inform the implementation of prevention strategies in a state, county, community, or vulnerable population where a possible cluster or an increasing trend has been observed. This generic clearance will not be used to conduct research studies or to collect data designed to draw conclusions about the United States or areas beyond the defined geographic location or vulnerable population that is the focus of the investigation.

CDC is frequently called upon to respond to urgent requests from one or more external partners (e.g., local, state, territory, and tribal health authorities; other federal agencies; local and state leaders; schools; or other partner organizations) to conduct investigations of suicide. Traditionally, these data collections are conducted in the context of an urgent request from local or state health authorities for CDC to provide epidemiologic assistance (Epi-Aid), and these responses are led by Epidemic Intelligence Service (EIS) Officers. Urgent requests for CDC assistance typically include technical support in the form of expertise or information collection to help identify trends, risk and protective factors, and vulnerable groups and situations to effectively and rapidly implement prevention strategies.

Supporting rapid investigations to inform the implementation of effective suicide prevention strategies is one of the most important ways CDC can serve to protect and promote the health of the public. Prior to this request, CDC had collected data for a suicide investigation via the OMB-approved Emergency Epidemic Investigations (EEI) ICR (OMB No. 0920-1011; expiration 3/31/2020; Spies et al., 2015), which supported data collections for Epi-Aid investigations. However, 0920-1011 is limited to Epi-Aids requested by health authorities or other federal agencies and responses must be led by EIS officers. Epi-Aid related data collections supported with the EEI ICR must have current data to demonstrate the urgent need for an investigation. Typical requests to CDC for urgent assistance to understand and prevent suicide cannot be met only with Epi-Aids or the EEI ICR for several reasons, including: (a) many requests for assistance come from partners other than health authorities (e.g., schools, coalition of local organizations, coroner/medical examiner offices); (b) the volume of requests is increasing significantly resulting in the need for CDC staff in addition to a limited number of EIS officers to lead responses; and (c) suicide-related data informing a request for assistance to investigate increasing trends or possible cluster often are 1-2 years old. Consequently, a generic ICR for Rapid Response Suicide Investigation Data Collection will be useful for urgent responses to requests for assistance to understand suicide and inform prevention by the locale of interest.

The goal of a Rapid Response Suicide Investigation Data Collection is to inform the implementation of suicide prevention strategies. The legal justification for conducting urgent

data collection about suicide can be found in the Public Health Service Act (42 USC Sec. 301 [241] (a) (Authorizing Legislation, Attachment A).

Background: Suicide is a major public health issue in the United States. In 2016, more than 44,000 people died from suicide making it the tenth leading cause of death across all age groups (CDC, 2018). Unlike other leading causes of death and forms of violence that are declining, the United States is experiencing a significant increase in suicide rates (31% increase from 2000 to 2018). Suicide is increasing across all age groups (CDC, 2018; Curin, Hedegaard, & Warner, 2017). In addition, approximately 9.8 million adults aged 18 and older report they have thought seriously about killing themselves (SAMHSA, 2017).

Suicide affects all types of individuals in a community, but some age groups and populations have a heightened vulnerability. For instance, middle-aged adults (aged 35-64) account for the largest proportion of suicides (52% in 2016). In this age group, suicide is the fifth leading cause of death, and the suicide rate has increased 34% since 2000. Adults who are active duty service personnel or veterans have suicide rates that exceed the rate for civilians (Department of Veterans Affairs, 2016). Suicide is the second leading cause of death among adolescents and young adults (aged 10-24), and rates have increased 34% among adolescent males and doubled among adolescent females since 2007 (CDC, 2018). American Indian/Alaska Native youth's suicide rate is higher than all other youth.

These increasing suicide trends overall and in vulnerable populations are contributing to substantial increases in requests to CDC for urgent assistance to conduct investigations of suicide patterns and associated risk and protective factors to inform public health action. CDC and key stakeholders are identifying vulnerable populations based on their shared sociodemographic backgrounds, activities, or exposure to known risk factors (e.g., Fowler et al., 2014; Ivey-Stephenson et al., 2017; Leavitt et al., 2018; McIntosh et al., 2016; Stone et al., 2014). Like other public health problems, suicide is preventable. Years of research have resulted in actionable information about prevention programs, policies, and practices that reduce the risk for suicide and enhance protective factors. To help communities make informed decisions about suicide prevention strategies, CDC provides technical assistance and support, including a recently released technical package, to help communities plan and prioritize prevention approaches that are based on the best available evidence (Stone et al., 2017).

A.2. Purpose and Use of Information Collection

External partners, such as local and state health authorities, are responsible for tracking and taking action to control significant public health issues, such as suicide. However, these partners often require epidemiologic assistance and support from CDC to collect data so that complex and immediate demands for information can be met to inform action. Resources to prevent suicide are significantly limited in most communities, and current and reliable data help to ensure these resources are prioritized and applied to strategies most likely to improve health and safety. If suicides are not prevented, suicide clusters or contagion is possible, particularly among vulnerable populations. External partners rely on CDC to respond quickly to their requests for short-term data collection support and prevention guidance. NCIPC is uniquely qualified to assist in data collection and prevention planning on suicide given its expertise in investigating

emerging trends in suicide, risk and protective factors associated with trends, and the groups most affected by suicide.

The purpose of this generic ICR entitled "Rapid Response Suicide Investigation Data Collection" is to allow CDC to quickly investigate potential suicide clusters or increases in suicidal behavior for external partners who request urgent assistance in developing suicide prevention strategies.

The scope of the Rapid Response Suicide Investigation Data Collection ICR is *limited* to those collections that meet *all* of the following criteria:

1. Circumstances limited to:
    a. Data collections necessary for CDC to provide rapid, short-term assistance with developing suicide prevention strategies in response to a suspected cluster in suicide or increases in suicidal behavior.

    b. Data collections requests from:
        - local, state, territory, and tribal health authorities;
        - local, state, or tribal leaders;
        - school districts or other educational organizations;
        - other federal agencies, coalition of local organizations, coroner/medical examiner offices; or
        - in the case of CDC hypothesized cluster, CDC may propose a Rapid Response Suicide Investigation Data Collection to an external partner.

2. Purpose of data collection and analysis limited to:
    a. Rapidly identifying effective prevention strategies for the requesting jurisdiction or community. Data collection and analysis will focus on documenting and describing:
        - changes in rates of fatal or nonfatal suicidal behavior;
        - risk factors associated with changes in rates;
        - characteristics of the subgroups most affected;
        - current risk and protective factors and prevention opportunities; and/or
        - other specific requests from the jurisdiction that entail data collection associated with short-term assistance with developing suicide prevention strategies in response to a suspected cluster in suicide or increases in suicidal behavior.
    b. This generic clearance will not be used to collect information for research purposes or to collect data to inform Federal policies, funding priorities, program evaluation.
    c. This ICR will not be used for studying or monitoring broadly defined subpopulations or following cohorts over time (with the exception of pre- and post-intervention assessments, which should be submitted as two separate GenICs). For example:
        - This ICR is not for use in developing prevalence rates of suicide or investigating potential risk factors for subpopulations defined by broad demographic characteristics (e.g., urban teens, low income groups,

middle aged men living in rural areas). This ICR can only be used for narrowly defined investigations (e.g., potential clusters). Such investigations may be defined by sociodemographic characteristics only in conjunction with narrowly defined geographic, temporal, or other boundaries that clearly define the scope of the assistance requested (e.g., urban teens in three adjacent counties or school districts; men aged 45-65 living in rural communities in a particular state between 2016-2018).

- This ICR is not for use in conducting surveys to ascertain rates of suicide or suicidal behaviors or explore potential risk factors for or broad geographic areas (e.g., a focus on "the rust belt" or "rural parts of southeastern United States" would be too broad but a response to a request from specific communities in these areas would be appropriate).
- This ICR is not for use in conducting any national studies.
- This ICR is not for routine, ongoing surveillance.

3. Methods limited to:
    a. qualitative methods (e.g., one-on-one guided interviews; focus groups);
    b. low burden questionnaires (less than 30 min) limited to information necessary to determine risk factors (e.g., telephone, in person, or web-based); and/or
    c. requests for data from administrative sources.

4. Respondents limited to:
    a. At risk individuals
    b. Relatives, friends, and colleagues of fatal and nonfatal cases
    c. Hospitals or other health care or public health entities
    d. Service providers in affected areas
    e. Law enforcement
    f. Emergency medical responders
    g. Medical examiners
    h. School administrators
    i. Community leaders.

Data collection Approach: CDC staff and the external partners will collaborate on establishing the data collection objectives and methods. CDC staff may provide technical assistance with developing data collection materials (e.g., questionnaires, interview and focus group materials) and a data analysis plan. CDC staff may be deployed to the field to assist in some or all of the operations of the investigation. This can include conducting training, determining sampling frames, and collecting data. CDC staff may analyze the data in the field or at CDC. CDC staff may assist in report writing and presenting the final analyses and prevention recommendations to external partners. The overarching goal when collecting data is to inform the identification, prioritization, and implementation of immediate prevention and control measures based on the findings from the investigation to minimize adverse health consequences.

A Rapid Response Suicide Investigation Data Collection Generic ICR is needed to respond quickly to potential suicidal clusters and increasing trends in order to implement effective prevention strategies to mitigate morbidity and mortality. Data collection methods and instruments need to be rapidly created and implemented to meet the unique needs of the situation, and sufficient information is often not available to allow for complete development of data collection instruments far in advance. Data collection instruments typically are developed prior to initiating the investigation in the field. On rare occasions, revisions are identified while investigators are in the field. The choice of data collection methods may be influenced by what is already known about the problem; the location, size, and characteristics of the affected population; and resources available to external partners and investigators in the field. Multiple data collection modes could be employed in a single investigation. It is anticipated that the most common data collection modes will include record abstraction, in-person interviews, questionnaires, and focus groups.

The overarching goal when providing data collection support is to guide implementation of immediate suicide prevention and control measures based on the findings from the investigation to minimize adverse health consequences.

A.3. Use of Improved Information Technology and Burden Reduction

The urgency of a Rapid Response Suicide Investigation Data Collection often results in most data being collected by record abstraction, individual or group interviews, and/or self-administered paper-and-pencil questionnaires. The need for quick action often allows insufficient time to develop, test, and launch electronic systems for collection of data. However, online or electronic submission of responses can be done when feasible and will be password-protected. To minimize burden, existing data from medical records, for instance, could potentially be used to pre-populate data collection tools.

Data collection protocols are designed to be as unobtrusive as possible, and only the minimal information necessary is collected to reduce burden to the respondents. The specific data collection protocol is tailored to meet the immediate needs of the external partner and specific suicide investigation to help inform immediate public health action.

A.4. Efforts to Identify Duplication and Use of Similar Information

Literature searches and discussions with internal and external partners (e.g., local, state, territory, and tribal health authorities; other federal agencies; local and state leaders; schools; or other partner organizations) are conducted to determine the extent of existing information. NCIPC discusses any potential Rapid Response Suicide Investigation Data Collection with the CDC office coordinating Epi-Aids and OMB desk officer to prevent duplication of activities. NCIPC has a long-standing relationship with the Substance Abuse and Mental Health Services Administration (SAMHSA), and NCIPC engages with this partner to ensure the proposed data collection is not duplicative of any of their efforts and determine areas for collaboration when appropriate. If previous information is available, it is used whenever appropriate to contribute to an investigation. For instance, NCIPC has conducted suicide Epi-Aids for over two decades (e.g., Annor et al., 2017; Davidson et al., 1989; Fowler et al., 2013; Garcia-Williams et al., 2017;

Spies et al., 2015). These previous investigations are reviewed to determine if there is relevant data, data collection instruments, or other information that can be utilized. This experience demonstrates that most urgent suicide investigations require the collection of data specific to the particular area or population as each situation is unique in many aspects (e.g., risk factors, locations, methods, affected populations).

The NCIPC OMB-IRB coordinator serves in the role of the Rapid Response Suicide Investigation Data Collection Information Collection Request Coordinator (ICRC). The ICRC is responsible for maintaining a data collection instrument library, which will include the final data collection instruments administered under this ICR. When a data collection is requested, the ICRC requires a determination of whether or not the information already exists and encourages use of data collection instruments (or components of such instruments) that have already been approved in previous Rapid Response Suicide Investigation Data Collections.

A.5. Impact on Small Businesses or Other Small Entities

Small businesses have not been involved with previous suicide epidemiologic and prevention assistance provided by CDC, and it is anticipated they will not be involved with a future Rapid Response Suicide Investigation Data Collection. It is possible a future suicide investigation could involve information from persons in small businesses or other small entities, such as organizations that provide suicide prevention supports, because this information may be necessary to inform prevention strategies. If this need for data collection arises, information collected will be held to the absolute minimum required to inform immediate effective prevention and control measures. Every effort is made to minimize the burden on all respondents during a Rapid Response Suicide Investigation Data Collection.

A.6. Consequences of Collecting the Information Less Frequently

A Rapid Response Suicide Investigation Data Collection involves one-time, rapid data collection efforts related to a specific possible cluster or increasing trend in suicidal behavior or suicide in a state, county, community, or vulnerable population. Not collecting this information impedes CDC from responding to technical assistance requests and identifying effective prevention and control measures that could lead to reduced morbidity and mortality associated with suicidal behavior and suicide.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

The Rapid Response Suicide Investigation Data Collection generic ICR supports urgent and rapid data collection to prevent suicidal behavior and suicide. Because of the need for rapid data collection to minimize threats to public health, respondents are asked to respond to requests for data in fewer than 30 days. To comply with the regulation 5 CFR 1320.5 and at the same time ensure that public health data are collected in a timely manner as necessary to protect the health of the public, a Rapid Response Suicide Investigation Data Collection covered by this generic ICR will adhere to the following timeline and processes:

1. At the request and in consultation with external partners, CDC decides to organize and deploy staff to provide epidemiological assistance to inform suicide prevention;

2. After CDC has determined staff can be deployed, a formal request from an external partner has been received, and the need for new data collection decided, through CDC/ICRO the OMB Desk officer is notified of the Rapid Response Suicide Investigation Data Collection immediately via e-mail from CDC. This notification will be followed by receipt of the Generic Information Collection (GenIC) Rapid Response Suicide Investigation Data Collection Protocol following its development (Attachment D). This GenIC description of the investigation protocol, includes: the circumstances, purpose, case definition, study population, variables of interest, respondents, anticipated burden hours, data analysis plan, plan to synthesize and report results, and draft data collection instruments.
3. The OMB desk officer commits to responding with comments on the proposed GenIC Rapid Response Suicide Investigation Data Collection Protocol within 5 business days.
4. While in the field, if modifications to the protocol are required (which is anticipated to be a rare event), CDC staff provides a copy of revised data collection instruments and protocol to the ICRC. The ICRC makes a determination as to whether the modifications entail a substantial change in scope or burden hours. If the ICRC makes a determination that the modifications do not constitute a substantial change, CDC staff uses the revised instruments that incorporate the minor modifications (e.g., modifications to item wording). If a substantial change is needed (e.g., changes to burden, scope, respondent type), the ICRC works with CDC staff to submit an additional GenIC with the revised data collection instruments to ICRO. ICRO sends the GenIC with the revised data collection instruments to the OMB desk officer for review, along with an e-mail to the OMB Desk officer. The OMB desk officer responds with approval or comments for revision within 3 business days. In this time frame, CDC will not use the revised GenIC until changes are approved by OMB. If no response is received within 3 business days, CDC staff assumes that the revisions have been accepted.
5. At the completion of the Rapid Response Suicide Investigation Data Collection, CDC staff submit the final data collection instrument(s) and associated burden to the ICRC using the "burden memo" (Attachment E).
6. CDC maintains a library of data collection instruments that includes all final data collection instruments conducted under the Rapid Response Suicide Investigation Data Collection generic ICR.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A.8.a) Federal Register Notice

A 60-day Federal Register Notice was published in the Federal Register on November 9, 2017, vol. 82 No. 216, pp. 52046-52047 (Attachment B). There were no comments to the 60-day Federal Register Notice

A.8.b) Efforts to Consult Outside the Agency

The following are individuals outside of CDC who were consulted with to inform the development of this package. CDC has consulted with OMB staff on the scope and design of this generic ICR request and CDC's previous responses to requests for rapid assistance to

understand suicide and inform prevention strategies. SAMHSA has been a partner in three responses by CDC between 2014 and 2017 to urgent assistance requests by external partners to investigate potential suicide clusters and increasing trends. In those responses, SAMHSA staff assisted with determining data collection approaches and collecting data. CDC has also worked closely with many county and state health officials and their local partners to design and provide epidemiologic assistance to identify suicide trends, risk and protective factors, and vulnerable groups and situations to effectively and rapidly implement prevention strategies. These collaborations have involved accessing existing data sources, informing collection of new information, data analysis, and development of prevention recommendations based on findings. These consultants were supportive of this generic ICR, and there were no major problems that were not be resolved during the consultation.

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A.9. Explanation of Any Payment or Gift to Respondents

We do not anticipate providing any gift or payment for respondents' participation in any information collections. However, for certain collections, CDC's community partners may provide transportation, food, or child care to respondents. For any collections involving provision of incentives, amounts will not exceed OMB guidelines. A complete justification will be submitted with that GenIC for review by OMB.

A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

The overarching generic ICR does not have an associated data collection (Attachment F). When an individual data collection is requested under this generic ICR, the Privacy Act review and applicability will be included with each submitted request under this generic ICR. In most collections, we do not anticipate that the Privacy Act will apply. Data are treated in a secure manner, unless otherwise compelled by law. CDC maintains respondent information by using unique, investigation identification numbers on all data collection forms.

Data will only be collected in identifiable form when it is necessary to follow up on individuals or link data from different sources. In those cases, identifiers will be destroyed upon completion of data collection. In the interim, personal identifiers and the linkage to the study identification number will be maintained separately in locked file cabinets or in encrypted computer files. All personal identifiers are stripped from the data prior to establishing a final data analysis file. A privacy impact assessment will be performed when identifiable data are collected. If the plan is to link data provided by an individual to administrative data, a data linkage agreement may be necessary and a SORN may be required. Examples of potential SORNs include: Epidemiologic Studies and Surveillance of Disease Problems, HHS/CDC (09-20-0113) and Epidemic Investigation Case Records, HHS/CDC (09-20-0113).

Results are only published in aggregate form.

A.11. Institutional Review Board (IRB) and Justification for Sensitive Questions

IRB Approval

These investigations are responses to public health emergencies and not research based on the definition provided by the Federal Policy for the Protection of Human Subjects (45 CFR 46). A NCIPC Determination of Human Subjects review applicability will be included with each submitted generic information collection request under this ICR (Attachment C).

Sensitive Questions

Questions that might be considered sensitive (e.g., regarding risk behaviors, attitudes, or medical condition diagnoses) are included only when necessary for the public health response. Before administering data collections, investigators inform respondents (either verbally or in writing) that participation is voluntary, respondents can refuse to answer any questions, and that respondents are not personally identified in any published reports. Participants are also informed the data are being collected to identify effective prevention and control strategies for suicidal behavior and suicide. Social security numbers are not collected.

A.12. Estimates of Annualized Burden Hours and Costs

CDC projects 10 Rapid Response Suicide Investigation Data Collections annually in response to increasing suicide rates and requests for urgent assistance. The projected average number of

respondents per Rapid Response Suicide Investigation Data collection is 200, for a total of 2,000 respondents annually. CDC estimates the average burden per response is 0.5 hours, and each respondent is asked to respond once. Therefore, the total estimated annual burden in hours is 1,000 (Table 1). The actual number of respondents in each information collection and the number of responses per respondent varies depending on the purpose of each individual GenIC.

Table 1. Estimated Annualized Burden Hours

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (in hours)
Rapid Response Suicide Investigation Data Collection Participants	Rapid Response Suicide Investigation Protocol	2,000	1	30/60	1,000
				Total	1,000

A.12.b) Annual burden cost

There are no anticipated costs to respondents other than time. The mean national hourly wage in the United States for all occupations in 2017 based on data from the Bureau of Labor Statistics (available at https://www.bls.gov/oes/current/oes_nat.htm#00-0000) is $24.34. This wage is assumed for all Rapid Response Suicide Investigation Data Collection participants because of the variety of types of participants expected. With an estimated annual respondent burden of 1,000 hours, the overall annual cost of respondents' time for the proposed collection is estimated to be $24,340.00 (1,000 burden hours x $24.34; Table 2). $24,340.00

Table 2. Estimated Annualized Burden Costs

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Responses	Average Hourly Wage Rate (in dollars)	Total Respondent Cost
Rapid Response Suicide Investigation Data Collection Participants	Rapid Response Suicide Investigation Data Collection Instruments	2,000	1	.05	$24.34	$24,340.00
					Total	$24,340.00

A.13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There are no anticipated costs to respondents or record keepers other than time.

A.14. Annualized Cost to the Government

There are no equipment or overhead costs. The cost factors considered are related to routine procedures of the investigators in planning investigations; design, preparation, printing, and distribution of questionnaires; and editing, coding, tabulation, analysis, and presentation of the information. The annual cost is estimated based on the U.S. national average hourly wage for statisticians and epidemiologists in 2017 based on data from the Bureau of Labor Statistics (available at https://www.bls.gov/oes/current/oes_nat.htm#00-0000). On average, CDC staff contribute 672 hours per Rapid Response Suicide Investigation Data Collection, for a total annualized cost to the Government of $248,249.60 (Table 3).

Table 3. Estimated Annualized Cost to the Government

Type of Cost	Average Hours per Suicide Investigation	Average Hourly Rate	Number of Suicide Investigations Annually	Annual Costs
Statistician	32	$42.78	10	$13,689.60
Epidemiologist	640	$36.65	10	$234,560.00
Total Annual Estimated Costs	672			$248,249.60

A.15. Explanation for Program Changes or Adjustments

This is a new data collection.

A.16. Plans for Tabulation and Publication, and Project Time Schedule

The epidemiologic data collected in each Rapid Response Suicide Investigation Data Collection provide information necessary for an effective public health response to prevent suicidal behavior and suicide. Therefore, collecting data as soon as possible after the identification of a possible cluster or increasing trend is critical to the epidemiologic analysis and public health action. Table 4. Provides a general timeline for a Rapid Response Suicide Investigation Data Collection. The duration of the data collection varies by Rapid Response Suicide Investigation Data Collection.

Table 4. Estimated Rapid Response Suicide Investigation Data Collection Time Schedule

Activity	Time Schedule
Letter received from external partner requesting assistance or assistance offered to external partner accepted	Investigation initiation

Convening of external partners and CDC epidemiologists	Within 1 week after investigation initiation
External partners and CDC agree on objectives of investigation, data sources, and data collection methods	Weeks 2 to 3 after investigation initiation
Development of data collection instrument or selection from instrument library	Weeks 3 to 4 after investigation initiation
GenIC submission and approval	Week 4 after investigation initiation
Deployment into the field	Weeks 4 to 6 after investigation initiation
Data collection in the field	Weeks 4 to 10 after investigation initiation
Data collection from CDC	Weeks 6 to 12 after investigation initiation (all data collected within 3 months)

For each Rapid Response Suicide Investigation Data Collection, the lead investigator is responsible for developing an analysis plan and conducting the data analysis. A preliminary report summarizing the early findings of the investigation is written by the lead investigator and provided to CDC within 14 days of the completion of data collection in the field. Any publication of data derived from a Rapid Response Suicide Investigation Data Collection is subject to review by relevant external partners, CDC, or collaborating federal agencies. CDC may receive requests to release the information (e.g., congressional inquiry, Freedom of Information Act requests) and will disseminate the findings when appropriate, following Department of Health and Human Services' Guidelines for Ensuring the Quality of Information Disseminated to the Public (DHHS, 2002).

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is not inappropriate.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

REFERENCES

Annor F, Wilkinson A, Zwald M. Epi-Aid # 2017-019: Undermined risk factors for suicide among youth, age 10-17 years-Utah, 2017. Available from Utah Department of Health;2017. https://health.utah.gov/wp-content/uploads/Final-Report-UtahEpiAid.pdf

Centers for Disease Control and Prevention. Web-Based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: US Department of Health and Human Services, CDC; 2018. http://www.cdc.gov/injury/wisqars/index.html

Curin SC, Hedegaard H, Warner M. Age-adjusted rate for suicide, by sex. National Vital Statistics System, United States, 1975-2015. MMWR 2017;66:285.

Davidson LE, Rosenberg ML, Mercy JA, Franklin J, Simmons JT. An epidemiologic study of risk factors in two teenage suicide clusters. JAMA 1989;262(19): 2687-2692.

Department of Health and Human Services. HHS Guidelines for Ensuring the Quality of Information Disseminated to the Public. Washington, DC, Office of the Assistant Secretary for Planning and Evalation;2002. https://aspe.hhs.gov/report/hhs-guidelines-ensuring-and-maximizing-quality-objectivity-utility-and-integrity-information-disseminated-public

Department of Veterans Affairs. Suicide among veterans and other Americans, 2001–2014. Washington, DC, Office of Suicide Prevention;2016. https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf

Garcia-Williams A, O'Donnell J, Spies E, Zhang X, Young R, Azofeida A, Vagi K. Epi-Aid 2016-018: Undermined risk factors for suicide among youth, age 10-24-Santa Clara County, CA, 2016. Available from Santa Clara County Public Health;2017. https://www.sccgov.org/sites/phd/hi/hd/epi-aid/Pages/epi-aid.aspx

Fowler KA, Crosby AE, Parks SE, Ivey AZ, Silverman PR. Epidemiological investigation of a youth suicide cluster: Delaware 2012. Delaware Medical Journal 2013;85(1):15-19.

Fowler KA, Gladden RM, Vagi KJ, Barnes J, Frazier L. Increase in suicides associated with home eviction and foreclosure during the US housing crisis: Findings from 16 National Violent Death Reporting System states, 2005-2010. American Journal of Public Health 2014;105(2):311-316.

Ivey-Stephenson AZ, Crosby AE, Jack SPD, Haileyesus T, Kresnow-Sedacca MJ. Suicide trends among and within urbanization levels by sex, race/ethnicity, age group, and mechanism of death — United States, 2001-2015. Morbidity and Mortality Weekly Report 2017;66(18):1-16.

Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicide among American Indian/Alaska Natives — National Violent Death Reporting System, 18 states, 2003-2014. Morbidity and Mortality Weekly Report 2018;67(8):237-242.

McIntosh WL, Spies EL, Stone DM, Lokey CN, Trudeau AT, Bartholow B. Suicide rates by occupational group — 17 states, 2012. Morbidity and Mortality Weekly Report 2016; 65(25):641–645.

Spies E, Ivey-Stephenson A, VanderEnde K, Lynch S, Dean D, Gleason B. Epi-Aid 2015-003: Undermined risk factors for suicide among youth, age 10-25-Fairfax County, VA, 2014. Available from Fairfax County Virginia Health Department; 2015. http://www.fairfaxcounty.gov/hd/hdpdf/va-epi-aid-final-report.pdf

Stone DM, Holland KM, Bartholow B, Crosby AE, Davis S, Wilkins N. Preventing Suicide: A Technical Package of Policy, Programs, and Practices. Atlanta, GA: National Center for Injury

Prevention and Control, Centers for Disease Control and Prevention;2017. https://www.cdc.gov/violenceprevention/pdf/suicide-technicalpackage.pdf

Stone DM, Luo F, Ouyang L, Lippy C, Hertz M, Crosby A. Sexual orientation and suicide ideation, plans, attempts, and medically serious attempts: Evidence from local Youth Risk Behavior Surveys, 2001-2009. American Journal of Public Health 2014;104(2): 262-271.

Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration;2017. https://www.samhsa.gov/data/