Garrett Lee Smith Campus Case Studies
Supporting Statement

A. JUSTIFICATION

The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting OMB approval for nine instruments to support data collection associated with the Campus Case Study (CCS) component of the cross-site evaluation of the Garrett Lee Smith (GLS) Memorial Campus Suicide Prevention Program ("Campus Suicide Prevention Program"). The Garrett Lee Smith Memorial Act (GLSMA), passed by Congress in October 2004, was the first legislation to provide funding specifically for State/Tribal and Campus Suicide Prevention programs. Under this legislation, funding has been set aside for states, tribes, and institutions of higher learning to develop, evaluate and improve early intervention and suicide prevention programs, and mandates that the effectiveness of programs be evaluated and reported.

SAMHSA awarded 55 Campus Suicide Prevention Programs with funds under the GLSMA. The GLS Suicide Prevention Program cross-site evaluation was designed to evaluate the effectiveness of suicide prevention activities across multiple campuses and to report those findings to Congress. The cross-site evaluation, through components designed to capture process, proximal and intermediate outcomes, as well as information regarding the current status of existing data systems, will supply critical information to the field that will ultimately lead to rigorous collection and interpretation of the long term outcomes of suicide prevention efforts.

The GLS Campus Case Studies (CCS) have been planned to provide additional context and information about successful suicide prevention activities on a select group of campuses. The case studies will use a three-stage model to describe and evaluate the public health approaches to suicide prevention used on up to six GLS-funded campuses.

Specifically the case studies will explore the suicide prevention related infrastructures and supports that exist on campus, the various student level factors that are related to suicide prevention efforts (e.g., protective factors, coping strategies, social norms, and facilitators and barriers to student access and receipt of behavioral healthcare), and the extent to which the campus infrastructure and supports address these factors. This submission includes the instrumentation and supporting materials (named below) for the CCS.

The CCS includes three data collection stages to: (1) identify campus infrastructures to support help-seeking behaviors, coping strategies, and protective factors; (2) identify facilitators/barriers to help-seeking behaviors, coping strategies and risk and protective factors; and (3) follow-up to identify campus infrastructure and discuss evaluation findings. There are 10 data collection instruments within the three evaluation stages for which clearance is being requested.

The table below summarizes the data collection instruments included in this clearance request.

Data Collection Stage	Data Collection Instrument
Stage 1	• Faculty Interview – Attachment A.1 • Student Interview – Attachment A.2 • Prevention Staff Interview – Attachment A.3 • Case Finder Interview – Attachment A.4 • Campus Police Interview – Attachment A.5 • Counseling Center Staff Interview – Attachment A.6 • Administrator Interview – Attachment A.7 • Student Focus Group Moderator Guide – Attachment B.1 • Faculty/Staff Focus Group Moderator Guide – Attachment B.2
Stage 2	• Enhanced Module for the Suicide Prevention Exposure, Awareness and Knowledge (SPEAKS)-Student Version – Attachment D
Stage 3	• Follow-up Key Informant Interviews[1]

1. Circumstances of Information Collection

a. Background

Suicide is the third leading cause of death amongst college-age students; suicide is believed to be the second leading cause of death amongst college-enrolled students, with an estimated 1,088 suicides occurring on campuses each year. (National Mental Health Association [NMHA] & the Jed Foundation [JED], 2002). Despite these available prevalence data, the scope of suicide and suicidality is not entirely known because of the manner in which cause of death is recorded on death certificates and because of the ambiguity of homicides and accidental deaths where the person attempting suicide intentionally places himself or herself in harm's way (U.S. Public Health Service, 1999). In fact, researchers have shown that amongst college-enrolled young adults, suicidal ideation is a continuum linked to unintentional injury and homicide, which are the first and second leading causes of death in the age-group (Barrios et al, 2000). In response to these issues, the National Strategy for Suicide Prevention's Objective 4.3 calls for increasing "the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide" (U.S. Department of Health and Human Services [DHHS], 2001, p. 66).

Approximately 12.5 million college and university students attend more than 3,400 institutions of higher learning in the United States (Brindis & Reyes, 1997). Campus counseling centers have reported increased demand and shifting needs of students seeking counseling services (Kitzrow, 2003). Data about the prevalence of depression and suicidal ideation among college students (e.g., Furr et al, 2001), several high profile

1 Stage 3 Follow-up Key Informant Interviews will closely track the Stage 1 Interviews, with some modifications to capture the participants' responses to preliminary findings gathered through Stages 1 and 2. Burden for these Stage 3 interviews (in terms of number of respondents and time per response) will not exceed those estimated for Stage 1.

campus suicides, lawsuits related to on-campus suicides (Lake & Tribbensee, 2002), and media coverage of college suicides have highlighted the need for comprehensive, multifaceted efforts to promote mental health, provide mental health services, and prevent suicides at colleges and universities (Suicide Prevention Resource Center, 2004).

Youth suicide can be linked to a number of mental health disorders as well as substance abuse. In 2003, the President's New Freedom Commission on Mental Health recognized youth suicide prevention as a major priority. This was due to the high rates of youth suicide, rates that included large numbers of individuals who had been diagnosed with a mental illness or substance abuse disorders (Institute of Medicine, 2002). Adolescence is a time of rapid maturity and increasing responsibility, which leave many youth with a feeling of hopelessness for the future. This can apply particularly to college students and older adolescents between the ages of 20 and 24, the ages where the highest youth suicide rates are observed (National Adolescent Health Information Center, 2006). In a study by the American College Health Association (ACHA) (as cited in the GLSMA, Public Law 108-355), 61 percent of college students reported feeling hopeless, and 45 percent reported feeling so depressed they could barely function; while 9 percent reported feeling suicidal.

College and university students also report higher utilization of alcohol and drugs as compared to the general population. Thirty percent of college students report at least one episode of binge drinking in the past month (Wecshler, et al, 2000), which has implications for the prevention of suicide, as drug and alcohol use are correlated with suicidal ideation and attempts (Hingson, et al, 2005). Furthermore, analyses of ACHA survey data show that students reporting suicidal ideation or attempts were also significantly more likely to report being sick, being injured in an accident, carrying a weapon, engaging in a physical fight, or being a victim of sexual assault or other crimes (Barrios, et al, 2000). This is strong support for collaborative and multi-disciplinary prevention approaches on campus, which target a number of risk behaviors which place students at higher risk for suicide and other poor mental and physical health outcomes. Unfortunately, there is little data on the implementation or effectiveness of such efforts.

A comprehensive approach to suicide prevention on college and university campuses should employ multiple strategies targeted at both the general campus population and identifiable at-risk populations. These at-risk populations have been identified by researchers to include athletes; members of fraternities and sororities; graduate and older students; gay, lesbian, bisexual, and transgender students; and international students (Suicide Prevention Resource Center, 2004). Such a comprehensive approach should take into account the multiple social spheres in which students exist, and should engage key players in the campus community in a planning process that focuses on the assessment, design, implementation, and evaluation of suicide prevention activities (Suicide Prevention Resource Center).

The CCS will apply a case study methodology to study the public health approach to suicide prevention employed by up to six campus grantees. The case studies will focus on the individual and population risk and protective factors targeted by various campus prevention programs, campus procedures and policies related to mental health and crisis

response, educational and awareness strategies targeting multiple populations, social norms around help seeking, as well as access and barriers to mental health services. These case studies will be the first to present a comprehensive picture of a multi-faceted, public-health approach to suicide prevention on college campuses.

b. The Need for Evaluation

Section 520-E-2 (f) of the GLSMA mandates a cross-site evaluation of the Campus Suicide Prevention Program. The GLSMA specifies that a report must be submitted to Congress to include:

> *"an evaluation of the grant program outcomes, including a summary of activities carried out with the grant and the results achieved through those activities.", including "recommendations on how to improve access to mental and behavioral health services at institutions of higher education, including efforts to reduce the incidence of suicide and substance abuse."*

The CCS will provide in-depth and detailed information about campus-based public health models of suicide prevention, through which the overall Campus initiative will be understood, improved, and potentially sustained. The case studies will explore the ways in which campus grantees are implementing successful suicide prevention programs that build effective support infrastructure, address student level risk and protective factors, facilitate access to mental health services, and foster a campus climate that promotes student wellness.

c. Clearance Request

This submission requests OMB clearance for ten data collection instruments, which constitute the GLS Campus Case Studies. The CCS is designed to answer the following research questions on up to six select campuses:

- How are student-level and campus population-level risk and protective factors targeted by suicide prevention and mental health/wellness efforts on campus?
- What is the campus infrastructure available to support suicide prevention and student mental health/wellness?
- What is the campus approach to suicide prevention and reducing other risk factors facing college students?
- What is the campus climate related to mental health/wellness?

To assess these questions the proposed approach is a complex case study model with three stages of data collection that includes qualitative and quantitative methods. The proposed complex case study model builds upon a typical case study approach in that the "case" will not be limited to a study of the GLS-supported program only, but rather a comprehensive approach of campus-wide efforts and confounding factors.

The CCS data collection stages and related instruments are described below.

Stage 1: Identify Campus Infrastructures to Support Help-Seeking Behaviors, Coping Strategies, and Protective Factors – Case Study Approach

The first stage of data collection will use a typical case study methodology, including a systematic review of documents, **case study key informant interviews (Attachments A.1-A.7)**, and **focus groups (Attachments B.1 and B.2)**. In total, nine instruments will be used in Stage 1.

The instruments that will be used for the case study key informant interviews include:

- Campus Case Study Interview – Faculty Version (Attachment A.1)
- Campus Case Study Interview – Student Version (Attachment A.2)
- Campus Case Study Interview – Prevention Staff Version (Attachment A.3)
- Campus Case Study Interview – Case Finder Version (Attachment A.4)
- Campus Case Study Interview – Campus Police Version (Attachment A.5)
- Campus Case Study Interview – Counseling Center Version (Attachment A.6)
- Campus Case Study Interview – Administrator Version (Attachment A.7)

The instruments that will be used for the focus groups include:

- Focus Group Moderator's Guide - Student Version (Attachment B.1)
- Focus Group Moderator's Guide – Faculty/Staff Version (Attachment B.2)

Domains of suicide prevention related infrastructures and supports will be identified and assessed, looking beyond what is supported through the GLS-funded program to provide a comprehensive assessment of the campus factors contributing to student wellness and mental health as well as suicide prevention. A team of two people will conduct a site visit with each selected campus to collect data for the first stage. The case study team will work with the campus grantee to identify appropriate respondents which will include faculty, staff, and students for focus groups and key informant interviews.

Stage 2: Enhanced Module to Identify Facilitators/Barriers to Help-Seeking Behaviors, Coping Strategies and Risk and Protective Factors

In order to assess whether campus efforts related to infrastructures and supports are appropriately addressing student level factors, the second stage of data collection will add items to the OMB-approved Suicide Prevention Exposure, Attitudes, and Knowledge Survey (SPEAKS) Student Version (OMB No. 0930-0286) **(Attachment E.1)**, a web-based survey administered as part of the GLS Cross-site Evaluation, to explore the issues identified as being important at the student level. The issues explored by the **Enhanced Module** for the SPEAKS **(Attachment D)** will include coping strategies, help-seeking behaviors, awareness of available mental health services, and risk and protective factors.

Additionally, this stage will include a secondary analysis of data collected through the American College Health Association - National College Health Assessment Survey (NCHA), which is administered biennially on both campuses. Approximately 350 colleges and universities have participated in the NCHA since 2000 and more than 350,000 students have completed surveys.[2] This instrument gathers information on the

2 American College Health Association. American College Health Association - National College Health Assessment (ACHA-NCHA) Web Summary. Updated August 2007. Available at http://www.acha-

prevalence of behaviors that are known to place young adults at a greater risk for suicide, including drug and alcohol use and abuse, sexual health, weight control practices, mental health, and personal safety and violence. Data from the NCHA survey will be analyzed to complement and add context to primary data collected in the case studies.

Stage 3: Follow-up to Identify Campus Infrastructure – Case Study Approach

The third stage of data collection will follow an in-depth analysis of data collected in the first two phases of the study. Two members of the case study team will conduct a second on-site visit to each campus to conduct **case study key informant interviews.** These interviews will be based on the same interviews conducted in stage 1; however, the case study team will modify the instruments to present preliminary findings gathered as a part of stages 1 and 2 to key project staff with the intention of gathering contextual information, answering questions raised in the analysis, and capturing local interpretation of findings.

2. Purposes and Use of the Information Collection

The goal of the CCS is to understand how a public health approach to youth suicide prevention may be successfully implemented in post-secondary educational settings. The CCS will explore, in a systematic manner: the suicide prevention related infrastructures and supports (e.g., clinical and non-clinical) on six selected GLS-funded campuses; the various student level factors that are related to suicide prevention efforts (e.g., protective factors, coping strategies, social norms, and facilitators and barriers to student access and receipt of behavioral healthcare); campus interdepartmental collaboration and the relationship between various efforts to promote student mental health and wellness; and the extent to which the campus infrastructures and supports promote and address these factors.

The case study approach has been chosen because it allows the opportunity to explore in more depth the issues identified above, including but not limited to motivations behind behaviors, the decision-making process, successes and challenges encountered, and relationships that hinder or facilitate suicide prevention efforts. The case study approach also provides an important advantage in that it allows field staff to utilize what they learn as part of the case study process to inform further data collection. The result will be a comprehensive assessment of efforts and issues on the selected campuses that can be explored, discussed, considered, and potentially replicated in other settings.

The data collected through this project will contribute to the knowledge base regarding a successful model for suicide prevention that integrates multiple prevention programs targeting risk and protective behaviors related to a host of negative mental and physical health outcomes correlated with suicide, including violence, stress, depression and mental illness, and academic failure. These factors are all located on a wellness continuum, and can not be successfully targeted in isolation, or without the involvement of the whole campus community.

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ncha.org/data_highlights.html. 2007.

As mentioned above, the CCS design includes three data collection strategies: (1) key informant interviews; (2) focus groups with students, faculty, and staff; and (3) an enhanced module for the already-administered SPEAKS Student Version web-survey. Data collection is planned for fall 2009 (site visits to conduct focus groups and case study interviews), and spring 2009 (administration of Enhanced Module for the SPEAKS and follow-up site visits to discuss findings). CCS activities will be implemented on up to six selected GLS-funded campuses.

3. Use of Improved Information Technology

Every effort was made to limit burden on individual respondents who participate in the GLS Campus Case Studies. Therefore, when possible, data collection activities will be web-based. Web-based survey technology will be used for the Enhanced Module.

The web-based system, which will house the Enhanced Module, is a completely secure system that maintains privacy through the provision of multiple levels of password-protected access. Data collected will be stored in the central data repository.

The campuses that will participate in the CCS have already been trained to use the web-based central repository by the cross-site evaluation team.

4. Efforts to Identify Duplication

The contractors developed the data collection activities for the CCS in such a way as to avoid duplication in data collection efforts, as well as to benefit from the state of the science and practice of suicide prevention in institutions of higher learning. Specifically, existing research studies and the efforts of other campus initiatives focused on the application of a public health model to the prevention of violence and other risk behaviors were reviewed. Measures from existing, previous tested research tools were used whenever possible. The evaluation team will meet representatives from each campus to discuss appropriate local data collection procedures and to ensure that the data to be collected through the CCS is of interest to the campuses and is not duplicating any prior, current, or planned data collection efforts.

a. Existing Research

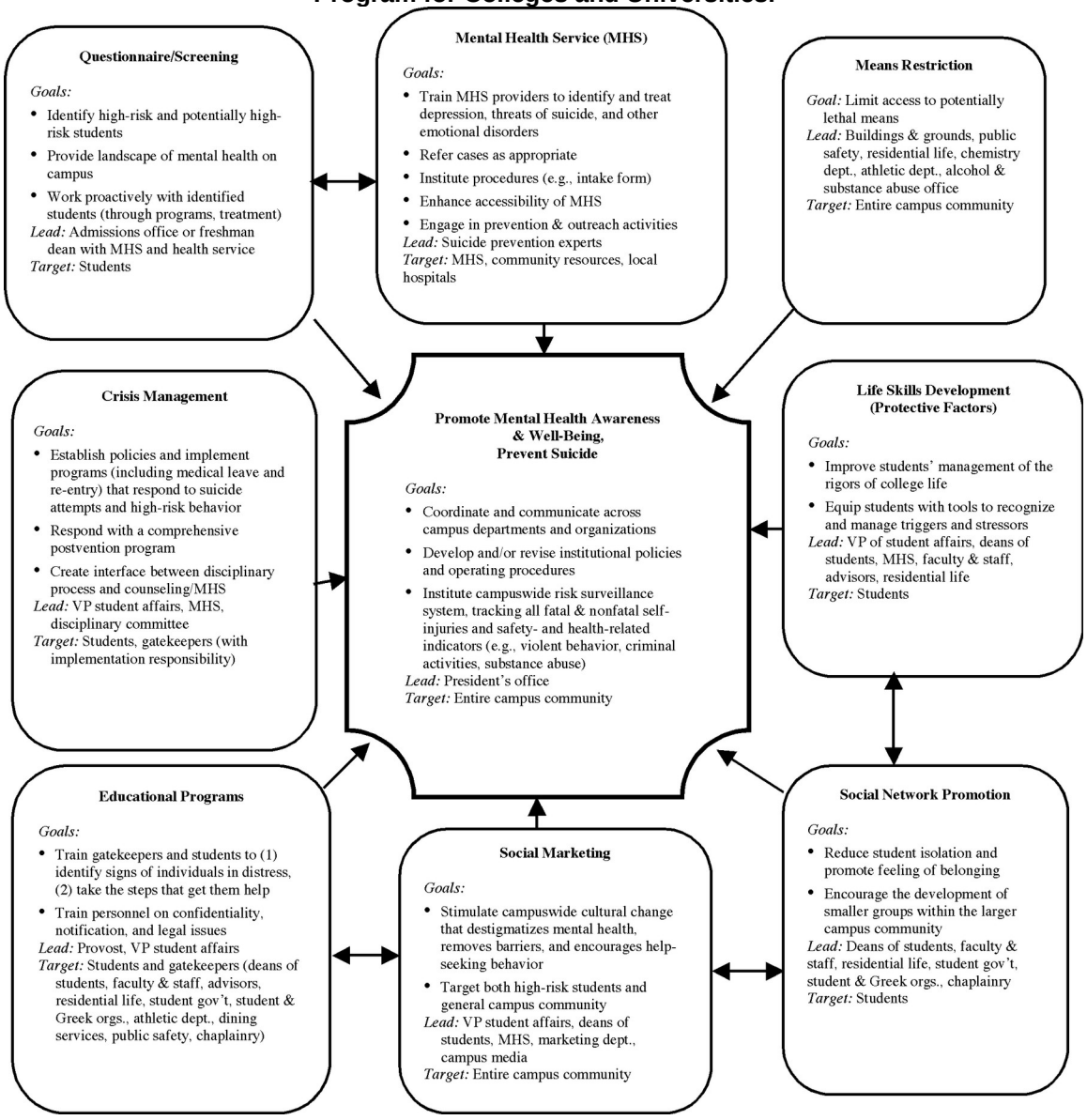
Professionals in the field of suicide prevention agree that there is a lack of information on the causes of suicide and even less information on how to prevent suicide (SPAN USA, Inc., 2001; Institutes of Medicine, 2002, U.S. Public Health Service, 2001). The studies on suicide prevention activities have provided important information, but are not readily generalizable to other populations, namely students enrolled at institutions of higher learning (Institutes of Medicine, 2002). Similarly, the lack of longitudinal and prospective studies has been a barrier to understanding and preventing suicide (Institutes of Medicine, 2002). Acknowledging the dearth of information on the effectiveness of suicide prevention programs, the Institutes of Medicine's Report, "Reducing Suicide: A National Imperative" provides several recommendations for increasing research on

suicide (2002). The report recommends that federal funding be provided for the development, testing, and expansion of suicide prevention interventions, and for longitudinal studies that focus on the medium to long-term impacts of suicide prevention activities, such as the impact on risk and protective factors and treatment and prevention. Specifically, the report recommends exploring the impact of suicide prevention programs through large nationally coordinated efforts.

The US Air Force developed, implemented, and evaluated a comprehensive, multi-faceted effort to address suicide and promote mental health (Knox, et al, 2003). This effort provides a sound basis for considering a similar, customized approach for college and university communities. Figure 1 shows a model developed by the National Mental Health Association in partnership with the Jed Foundation, and proposes elements for a comprehensive suicide prevention program to include leadership to promote mental health and suicide prevention, screening, crisis management, educational programs, mental health services, life skills development, means restriction, social marketing, and social network promotion (NMHA & Jed, 2002).

In 1984, the University of Illinois instituted a formal program to reduce the suicide rate on its campus (Joffe, 2003). This program has been adapted at the University of Albany, one of the participating campuses in the CCS. The University of Illinois instituted a "mandated assessment" policy, which required any student who threatened or attempted suicide to attend four sessions of professional mental health assessment. Consequences for noncompliance included mandatory withdrawal from the university. In 2003, 19 years after the program had taken effect, the suicide rate at the University of Illinois dropped 55.4%; from 6.91 to 3.08 suicides per 100,000 enrolled students. The mandated assessment approach has implications for mental health center staffing and resources, which will also be explored in these case studies.

Figure 1: Jed/EDC Partnership Model: Elements of a Comprehensive Suicide Prevention Program for Colleges and Universities.



b. Other Federal Efforts

As mentioned above, SAMHSA is sponsoring a cross-site evaluation of the GLS Early Intervention and Suicide Prevention State/Tribal and Campus programs. The CCS is designed to collect in-depth, comprehensive information from up to six campuses that have successfully implemented suicide prevention programs using a public health approach without duplicating efforts of the cross-site evaluation. The CCS consists of focus groups; an enhanced module to the Suicide Prevention Exposure, Awareness, and Knowledge Survey (SPEAKS) Student Version that is implemented in the Campus cross-site evaluation; and key informant interviews. The case study key informant interviews differ from the Campus Infrastructure Interviews utilized in the Campus cross-site evaluation in focus and items.

Additionally, SAMHSA and NIMH sponsor an evaluation of the National Suicide Prevention Lifeline, the national crisis hotline. The purpose of the evaluation is to assess the impact of the national crisis hotline connecting callers to mental health professionals by assessing participation with the Lifelines networks. Furthermore, comparative evaluation of the two hotline numbers is also underway. Although the data collection activities planned as part of this effort will provide valuable information on the effectiveness of this important service for at-risk youth, the scope of the evaluation focuses on all callers (adult and youth) to the national hotline (and the alternate number) and is specific to one intervention. The Centers for Disease Control and Prevention (CDC) through an interagency agreement with SAMHSA is sponsoring Enhanced Evaluations of three GLS State/Tribal grantees, in order to get additional and extensive data on 1) school-based prevention programs; 2) gatekeeper training initiatives; and 3) Native American youth populations. These Enhanced Evaluations are in various stages of implementation or planning. While important efforts, these enhanced evaluations will not further the understanding of suicide prevention on college campuses.

CDC supported evaluations of evidence-based suicide prevention programs in Maine and Virginia as part of it's Targeted Injury Prevention Programs. The programs in Maine and Virginia supported research that documented the efficacy of a community-based cognitive therapy program for preventing suicidal behavior among suicide attempters identified in emergency departments. The focus of the intervention was to help youth develop more adaptive ways of thinking and more functional ways of responding to periods of emotional distress. These evaluations will provide valuable information on the efficacy of interventions for youth displaying suicide risk factors.

CDC is also collecting and examining data from hospital emergency departments to assess the prevalence of suicide and suicide attempts. The National Electronic Injury Surveillance System-All Injury Program tracks data on all types and external causes of nonfatal injuries and poisonings treated in U.S. hospital emergency departments. With these data, CDC can generate national estimates of nonfatal injuries, including those related to suicidal behavior. The CDC-administered National Violent Death Reporting System (NVDRS) and Youth Risk Behavior Survey (YRBS) also capture nation-wide data about self-inflicted injury and death as well as many related factors at the population level. NVDRS and YRBS data are critical for monitoring these phenomena over time and

for providing background information that has guided the conceptualization and planning of the CCS. Although these efforts are significant in providing a broader understanding of suicide, the information gathered through the CCS focuses on the implementation and evaluation of a public health approach to suicide prevention within a specific campus context and population.

5. Impact on Small Businesses or Other Small Entities

All data will be collected from students, faculty, and staff working and learning on the participating campuses. These data collection activities will not have a significant impact on these individuals or their departments, nor on any small businesses within the community. Data collection activities will be restricted in length and confined to times when participants are available.

6. Consequences of Collecting the Information Less Frequently

In stage 1 of the CCS, the case study team will conduct one-time focus groups with staff, faculty, and students to gather information about each of the four research questions that guide the CCS (see Table 4). Campus staff will identify six groups of students to participate in the focus groups whose ideas and opinions are of particular interest to the campus in terms of its suicide prevention efforts. Finally in stage 1, the case study team will conduct case study key informant interviews. This will ensure a breadth of information, as well as the ability to triangulate responses for reliability and accuracy without excessive redundancy.

During stage 2, the case study team will administer the Enhanced Module for the SPEAKS once, to gather population-level data on relevant student risk and protective behaviors.

In stage 3, the case study team will conduct an additional fourteen to sixteen case study interviews (CSIs). These interviews will be conducted on the second site visit to clarify questions raised during the first phase of analysis, incorporate findings from the first two stages of data collection for the implementation of additional follow-up questions, and ensure comprehensiveness.

In each stage, data are only collected once. It is likely that some subset of the key informants interviewed during stage 1 may also be interviewed again in stage 3, but both the context and questions will be different based on findings from stages 1 and 2.

7. Consistency with the Guidelines of 5 CFR 1320.5(d)(2)

The data collection fully complies with the requirements of 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

a. Federal Register Notice

A 60-day notice was published in the *Federal Register* on August 18, 2008 (Volume 73, Number 160, page 48225). SAMHSA did not receive any comments on the planned data collection.

b. Consultation Outside the Agency

Consultation on the concept and design of the case studies has occurred with individuals outside of SAMHSA. A meeting with the evaluation steering committee members, SAMHSA, and Macro International occurred on March 27 – 28, 2007 where the case studies were discussed and input and guidance in design and implementation were gathered. Representatives on the steering committee include leaders in the field of suicide prevention and evaluation. In addition, representatives from the universities selected to participate in the case studies provided information, feedback, and guidance on research questions, instrumentation and study design.

These consultations had several purposes: (1) to ensure continued coordination of related activities, especially at the Federal level; (2) to ensure the rigor of the evaluation design, the proper implementation of the design, and the technical soundness of study results; (3) to verify the relevance and accessibility of the data to be collected; and (4) to minimize respondent burden.

9. Payment or Gift to Respondents

A lottery incentive structure is already in place for the GLS Cross-site Evaluation SPEAKS – Student Version. This structure will remain in place when the Enhanced Module is added to the survey. Remuneration is a standard practice on university campuses, and has proven to increase response rates for college student surveys (Dillman, 2000). In a study examining response rates in the National Survey of College Graduates, incentives provided to an experimental group resulted in an increase in response rates of nearly 11% versus no incentives (Dillman, 2000). In a study examining the impact of a lottery incentive, there was a slight but significant increase in response rates for students entered into a lottery versus a control group offered no incentive (Porter & Whitcomb, 2003).

Focus group participants will receive a $20 gift card in appreciation of their time. In addition, the case study team will provide pizza and soda during all focus groups.

Payment will not be provided to interview respondents as part of the CCS because they will be identified as key members of the suicide prevention initiative and therefore have organizational and institutional motivation to participate and their participation may reasonably be considered as part of their support for the initiative.

10. Assurance of Confidentiality

Descriptive and identifying information will be requested from respondents to facilitate the CSIs and the Enhanced Module for the SPEAKS. Identifying information will not be

stored with data collection responses and specific procedures to protect the privacy of respondents are described below for each data collection activity. A web-based data collection and management system was designed to facilitate data entry and management for the SPEAKS and will be utilized only for the Enhanced Module for the SPEAKS. Focus group participants will not be asked for identifying information and may use alternate names for the purpose of facilitation. .

Case Study Key Informant Interviews (CSIs). Interview respondents will sign a consent form **(Attachment C.1)**; however, no identifying information will be entered or stored in the data collection or management system and will not be linked to responses. The case study team will fill out a cover sheet with respondent information and respondent IDs. This cover sheet will be removed from the hard-copy interview and stored separately. IDs will be kept in a password-protected Microsoft Access tracking database separate from the interview content database. Other procedures for assuring the privacy of respondents will include limiting the number of individuals who have access to identifying information, using locked files to store hardcopy forms that include identifying information, assigning unique code numbers to each participant to ensure anonymity, and implementing guidelines pertaining to data submission and dissemination. Data collectors will be extensively trained and will be responsible for entering data into the web-based data collection system.

Enhanced Module for the SPEAKS. Identifying information will be necessary in order to facilitate the administration of the Enhanced Module for the SPEAKS. However, identifying information will be limited to email addresses and campus affiliations and will not be stored with survey responses. Respondents will be assigned a unique password to log into the survey. To ensure privacy, no identifying information will be entered in the data collection and management system and therefore no identifying information will be associated with individual responses. Only the web survey programmers will have access to identifying information (i.e., email addresses) in order to administer the survey, but again, identifying information will not be connected to individual responses for analysis or reporting efforts. Students will read and consent to take the survey on the web before the survey begins **(see Attachment E.1)**.

In addition, because student respondents to the Enhanced Module will be eligible to receive an incentive, those students wishing to enter the incentive lottery will provide identifying information for distribution of the incentive. This information will be collected through a web-enabled interface stored separately from the survey database and its contents. There will be no way to link the student contact information to the information provided on the survey.

Focus Groups. Students, faculty and staff members affiliated with the universities selected for the case studies will participate in focus groups during the first on-site visit **(see Attachments B.1 and B.2).** Focus groups will be audio-recorded and transcripts will be produced. Participants will sign a hardcopy consent form **(see Attachments C.2 and C.3)**, but no identifying information will be obtained. In addition, respondents will be asked to use first names only or alternate names during focus groups. Consent forms will be stored in locked cabinets, separate from the qualitative data collected. In addition, the

case study team will maintain anonymity and privacy by implementing guidelines pertaining to data submission and dissemination. Data collectors will be extensively trained and will be responsible for entering data into the web-based data collection system.

Six focus groups will be comprised of students, faculty will participate in two focus groups, and staff will participate in one. We are requesting that students each receive one gift card of $20 for their participation in the focus groups. In addition, the focus group facilitator will provide pizza and soda for the student focus group participants. Faculty and staff members who participate in focus groups will not be remunerated for their time but they will be provided pizza and soda during the focus groups. The local campus suicide prevention program may offer a gift incentive to faculty and staff respondents as a way of showing gratitude for volunteering to be part of a research study.

11. Questions of a Sensitive Nature

Because this project concerns suicide prevention, survey, interview and focus group instruments include questions that are potentially sensitive. These questions collect information about mental health, substance abuse, and family circumstances. These questions are central to the agency's goal of learning about the protective factors and campus wellness context related to suicide prevention. Names and email addresses collected as part of the consent process will be kept separate from responses as stated above. All data will be managed and stored in the manner described above and therefore will be unavailable to anyone but authorized project staff. Active consent forms **(see Attachments C.1, C.2, C.3, and E.1)** explicitly advise potential respondents and participants about the sensitive nature and content of the data collection protocol as well as the voluntary nature of all data collection activities. Unanticipated or negative consequences will be reported immediately to the campus and Macro International Institutional Review Boards. The Principal Investigator and Project Director will also consult with appropriate clinical professionals and immediately determine if the participant presents a risk to themselves or others and make appropriate referrals.

12. Estimates of Annualized Hour Burden

Data collection for the GLS Campus Case Studies is scheduled to begin in fall 2009. Table 1 shows the burden associated with the GLS Campus Case Studies. Hour estimates are based on prior experience with similar data collection with the same participant populations. The cost was calculated based on the hourly wage rates for appropriate wage rate categories using data collected as part of the National Compensation Survey (BLS, 2007) and the American Association of University Professors (AAUP) National Survey of University Faculty Salaries.

Table 1: Annualized Estimate of Respondent Burden

Type of respondent	Instrument	Number of respondents	Number of responses per respondent	Hours per response per respondent	Total Burden hours	Hourly wage rate ($)	Total Cost ($)
College Student[3]	Enhanced Module	1,200	1	.17	204	$5.15	$1,050.60
College Student[3]	Focus group—Student Version	324	1	1.5	486	$5.15	$2,502.90
College Faculty[4]	Focus group—Faculty Version	108	1	1.5	162	$32.94	$5,336.28
College Staff[3]	Focus group—Counseling Staff Version	54	1	1.5	81	$28.52	$2,310.12
College Student[3]	Interview—Student Leader Version	12	1	1	12	$5.15	$61.80
College Student[3]	Interview—Case Finder Version	6	1	1	6	$5.15	$30.90
College Faculty[4]	Interview—Faculty Version	12	1	1	12	$32.94	$395.28
College Staff[3]	Interview—Campus Police Version	12	1	1	12	$22.82	$273.84
College Staff[3]	Interview—Counseling Staff Version	12	1	1	12	$28.52	$342.24
College Staff[3]	Interview—Prevention Staff Version	18	1	1	18	$28.52	$513.36
College Staff[4]	Interview—Administrator Version	12	1	1	12	$35.77	$429.24
Total		**1,770**			**1,017**		**$13,246.56**

13. Estimates of Annualized Cost Burden to Respondents

Both participating campuses are already collecting several data elements as part of their suicide prevention program operations. These elements are used by campuses for their own program planning, quality improvement, and reporting purposes and analyzed secondarily by the subcontracted Cross-site Evaluator for the purpose of the campus case study. Therefore, there are no site-level capital or start-up costs associated with the GLS Campus Case Studies. There will be some additional burden on campus programs to provide the evaluation team with respondent lists for data collection activities and to help recruit participants. However, these operation costs will be minimal and fall within ongoing administrative and suicide prevention program activities.

3 National Compensation Survey, Bureau of Labor Statistics (BLS) US Dept of Labor, Professional-specialty and technical occupations, July 2007.

4 Based on the 2004-2005 American Association for University Professor's (AAUP) Annual Salary Survey, http://www.aaup.org/.

14. Estimates of Annualized Cost to the Government

SAMHSA has planned and allocated resources for the management, processing, and use of the collected information in a manner that shall enhance its utility to agencies and the public. Including the Federal contribution to local grantee evaluation efforts, the contract with the cross-site evaluation team, and government staff to oversee the evaluation, the annualized cost to the government is estimated at $83,072. These costs are described below.

Expenses include approximately $2,250 for participant incentives, $13,955 for travel and subsistence related to two site visits to each campus, $1,400 in interview transcription costs, and approximately $39,718 in labor for data collection and analysis. Including travel, data collection, analysis, and other related expenses, the cross-site evaluation estimates that the campus case studies will cost $79,072. It is estimated that CMHS will allocate 0.05 of a full-time equivalent each year for government oversight of the evaluation. Assuming an annual salary of $80,000, these government costs will be $4,000 per year for a total level of effort of $83,072.

15. Changes in Burden

This is a new project.

16. Time Schedule, Publication, and Analysis Plans

a. Time Schedule

The time schedule for implementing the GLS Campus Case Studies is summarized in Table 2.

Table 2: Time Schedule

Begin Focus Group data collection	1 month after OMB approval
Begin Key Informant Interview data collection	1 month after OMB approval
Begin Survey data collection	4 months after OMB approval
Analyze data	Ongoing

b. Publication Plans

The GLSMA requires annual reports summarizing the results of the evaluation. Each report will include data and analysis about the GLS Campus Case Studies. Dissemination plans specifically focus on two audiences: local (i.e., university program staff, faculty, and students at the participating schools), and national (i.e., researchers, advocates, and policy-makers). Initial dissemination efforts are targeted to provide useful information to program staff and other key stakeholders that can be used to inform program efforts to

implement campus suicide prevention activities. Local formative evaluation feedback will be used to guide program planning and will include summaries of findings, analysis of campus community needs from available data, and reports on progress toward achieving grant goals and objectives.

Examples of journals that will be considered as vehicles for publication include the following:

- American Journal of Public Health
- American Psychologist
- American Journal of Diseases of Children
- Child Development
- Chronicle of Higher Education
- Evaluation Review
- Evaluation Quarterly
- Journal of the American Academy of Child and Adolescent Psychology
- Journal of Applied Development Psychology
- Journal of Child and Family Studies
- Journal of Clinical Child and Adolescent Psychology
- Journal of Consulting and Clinical Psychology
- Journal of Health and Social Behavior
- Journal of Higher Education
- Journal of Mental Health Administration
- Review of Higher Education
- Psychological Reports
- Social Services Review
- Suicide and Life Threatening Behavior

c. Data Analysis Plan

Evaluation Question 1. What are the student-level and population-level factors impacted by suicide prevention and mental health efforts on campus?

Analyses will focus on the risk and protective factors associated with suicide prevention and campus wellness. A blended qualitative and quantitative design will be used for data collection and analyses. Qualitative measures will be anchored around issues of protective internal (cognitive) factors such as problem-solving, planning, and positive thought as well as external (behavioral) factors such as seeking help and advice, and avoiding risky situations. Analytical anchors for the risk measures will include cognitive factors such as denial and negative thought, suicidal ideation, and depression as well as behavioral factors including substance abuse and risky behaviors. Multivariate analyses of quantitative measures of help seeking, coping, mental health status, and student demographics will focus on the interrelationships between these factors.

Evaluation Question 2. What is the campus infrastructure available to support suicide prevention and student mental health?

The analyses for this question ties key informant interviews and focus groups together to develop a detailed qualitative description of the core policy, finance, and procedural

components of campus' well-being efforts. Analytical anchors for these qualitative measures include referral protocols, information sharing policies, finance policies, emergency mental health protocols, student monitoring procedures, and mental health service accessibility.

Evaluation Question 3. What is the campus approach to suicide prevention?
Analyses corresponding to this question will also be based on the key informant interview and focus group questions with a specific focus on the campus' programmatic approach to suicide prevention and the resources promulgated by and built around the GLS project funding. Analytical anchors for these qualitative measures include social marketing campaigns, suicide prevention training, and program-specific outreach.

Evaluation Question 4. What is the campus climate around mental health and wellness?
This question will be addressed through a blended qualitative and quantitative analytical approach. Qualitative data generated through key informant interviews and focus groups will be anchored by measures of student, faculty, and staff perceptions about high-risk behaviors, mental illness, mental health services with a specific focus on coping and help-seeking facilitators and barriers on the campuses. Quantitative measures from the SPEAKS-E will be matched with these qualitative measures at the student level to examine the interrelationships between climate, service utilization, and perceptions about well-being.

Table 4 summarizes the evaluation questions and the associated data sources and analytic approach.

Table 4: Evaluation Questions, Data Sources, and Analysis Techniques

Evaluation Questions	Data Sources	Data Analysis
How are student-level and population-level factors targeted by suicide prevention and mental health efforts on campus?	• Enhanced Module • Focus Groups • Key Informant Interviews	• Descriptive analysis • Bivariate analysis • Multivariate and multi-level analysis • Structural Equation Modeling • Qualitative analyses
What is the campus infrastructure available to support suicide prevention and student mental health?	• Key Informant Interviews • Focus Groups	• Descriptive analysis • Qualitative analyses
What is the campus approach to suicide prevention?	• Key Informant Interviews • Focus Groups	• Descriptive analysis • Qualitative analyses
What is the campus climate around mental health and wellness?	• Enhanced Module • Focus Groups • Key Informant Interviews	• Descriptive analysis • Bivariate analysis • Multivariate and multi-level analysis • Structural Equation Modeling • Qualitative analyses

17. Display of Expiration Date

All data collection instruments will display the expiration date of OMB approval.

18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions.

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

1. Respondent Universe and Sampling Methods

Key Informant Interviews. Key informants will be identified by the local program staff or project evaluator three weeks prior to a visit by the case study team. The key informants identified will represent seven key roles on each campus: (1) Administrator, (2) Counseling Staff, (3) Coalition Member – Faculty, (4) Prevention Staff, (5) Case Finder, (6) Campus Police, and (7) Student Leader. No more than three respondents in each category will be interviewed for each of the campus grantees for a total of up to 14 respondents per site. We estimate that this number of respondents will be sufficient to ensure saturation of themes in the content analysis of results from the qualitative interviews.

Enhanced Module for the SPEAKS. The Enhanced Module for the SPEAKS will be administered in the spring of 2009 to a random sample of 200 students in six campuses for a total of up to 1200 respondents. The administration and sampling strategy will correspond with the OMB-approved SPEAKS at the participating campuses. Local program staff or project evaluators will be responsible for pulling the sample. Response rates of 30-40% per campus are anticipated, given the difficult population we are surveying. Therefore, oversampling by approximately 300% will be required. The campus evaluation team will draw a proportionately weighted stratified random sample within each grantee site targeted for SPEAKS administration from the matriculated student register. The matriculated student sample will be stratified by gender, matriculation year, and race/ethnicity. This approach will achieve a margin of error of +/- 1.3% with a 95% confidence interval across campuses. In addition, within each grantee site, group sample sizes of 200 independent respondents at each wave achieve 80% power to detect a difference of -0.14 between groups with standard deviations of 0.5 in each group at alpha = .05 using a two-sided two-sample t-test.

Focus Groups. Focus groups will be conducted during the first on-site visit. Local program staff and evaluators will be responsible for recruiting focus group participants across respondent types. For each focus group faculty, staff and students will be contacted until 9 participants for each respondent type have been successfully recruited. This number of participants is needed in order to conduct 8 focus groups with 9 people in

each for each respondent type, which allows for a broad range of opinions to be voiced while keeping the groups small enough that everyone will have an opportunity to speak. Student participants will be informed of the financial incentive for participation in the groups.

2. Procedures for Collection of Information

Enhanced Module. The enhanced module will be administered in conjunction with the (OMB-approved) SPEAKS to students in both Campus grantee sites participating in the CCS in spring 2009. Local program staff or project evaluators will be responsible for identifying the list of respondents. The case study team will develop the sampling plan and local program staff will be responsible for identifying the sampling frame and pulling the sample. Once the sample has been pulled, local program staff will forward contact information (i.e., email addresses) to the case study team for administration of the SPEAKS. Implementation of this survey will adhere to accepted methods for Internet surveys. Following recruitment activities and verification of email addresses, the case study team will begin emailing potential respondents to complete the OMB-approved SPEAKS along with the CCS enhanced module. A pre-survey email explaining that the recipient will be asked to participate in a survey will be sent to selected respondents. The initial email will be followed 1 week later by an email containing directions for logging onto a Website to complete the Internet survey. A follow-up reminder postcard will be sent 1 week later, and 1 week after that; another reminder email will be sent to all students who have not completed the Web survey **(see Attachments E.2, E.3, E.4, E.5)** (Dillman, 2000). The log in page of the SPEAKS and Enhanced Module will provide an introduction, instructions on how to complete the survey, and a description of the OMB-approved SPEAKS consent process. Each respondent will be provided a unique password to log in to the web-based survey and logging in and completing the survey will imply consent.

Focus Groups. There are two focus group guide versions, one for students and one for faculty/staff (see **Attachments B.1** and **B.2**). Six of the following student focus groups will be conducted on each campus: (1) first-year students, (2) athletes, (3) international students, (4) Lesbian, Gay, Bisexual, and Transgender (LGBT) students, (5) Greek life students, (6) graduate students, and (7) residential advisors/peer educators. The case study team will hold two focus groups with faculty and one with staff members. Each respondent prior to administration of the focus groups will provide written consent **(see Attachments C.2 and C.3)**.Local program staff and evaluators will be responsible for identifying up to 9 participants per focus group and scheduling the focus groups. Two case study team members will facilitate the focus groups. Focus groups will be audio recorded but respondents will not be identified by name.

Key Informant Interviews. There are seven versions of the qualitative Key Informant Interviews; (1) Administrator, (2) Counseling Staff, (3) Coalition Member – Faculty, (4) Prevention Staff, (5) Case Finder, (6) Campus Police, and (7) Student Leader **(see Attachments A.1, A.2, A.3, A.4, A.5, A.6, and A.7)**. Local program staff will be

responsible for identifying appropriate respondents for each Key Informant Interview version and scheduling the interview to occur during a site visit by Campus Case Study evaluation staff. Each respondent prior to administration of the Key Informant Interviews will provide written consent **(see Attachment C.1)**. The case study team will be responsible for administering the interview and have been trained in qualitative interviewing. Interviews will be audio recorded but respondents will not be identified by name and no identifying information will be included on the data collection instrument.

3. Methods to Maximize Response Rates

The case study team has taken a number of steps to minimize the burden on the campuses participating in the GLS Campus Case Studies to ensure that completion is timely. These steps include developing a web-based data collection system, and providing training and technical assistance to each grantee.

To maximize response rates specifically for the Enhanced Module and the SPEAKS web-based survey, a 4-stage mailing process will be utilized (Dillman, 2001) **(see Attachments E.2, E.3, E.4, and E.5)**. All efforts have been made to minimize the burden on individual respondents by limiting the number of items on the questionnaire and building in functions to facilitate ease in responding. Additionally, students who complete the SPEAKS and Enhanced Module will be eligible for an incentive. For the Enhanced Module, no personal contact will be made to nonresponders beyond the 4-stage mailing process described above, which is already being used in administrations of the OMB-approved SPEAKS. Because student populations are difficult populations to survey, it is expected that there will be nonresponders. However, using the Dillman method and the incentive lottery will maximize the response rate.

Methods that will be used to maximize response rates for the qualitative interviews and focus groups include having local program staff schedule respondents, which will result in more accurate information, thus increasing response rates. If any identified respondents for the qualitative interviews are nonresponsive, the case study team will request that local program staff identify replacement respondents. In addition, student focus group respondents will receive an incentive for their participation.

4. Tests the Procedures

The instruments to be used in the GLS Campus Case Studies were customized to meet the needs of the initiative. As these measures were developed, standard instrument development procedures including review of the literature, item development, and content review by the Campus Case Study evaluation team members and members of participating campuses were used. All instruments underwent review and pilot testing. These procedures were used to enhance question accuracy and determine administration times. First, a thorough review of the literature was conducted related to suicide awareness and knowledge and suicide risk and protective factors. Second, drafts of the instruments were developed and reviewed by National Evaluation team members, representatives from SAMHSA, campus representatives, and content experts in the field

of suicide prevention. Third, the revised instruments underwent pilot testing on no more than 9 respondents matching the type appropriate for the instrument.

5. Statistical Consultants

Macro International, a contractor for SAMHSA, has full responsibility for the development of the overall statistical design, and assumes oversight responsibility for data collection and analysis. Training, technical assistance, and monitoring of data collection will be provided by the evaluator. The individual responsible for overseeing data collection and analysis are:

Christine M. Walrath-Greene, Ph.D.
Macro International Inc.
116 John Street, Fl. 8
New York, NY 10038
(212) 941-5555

The following individuals will serve as statistical consultants to this project:

Christine M. Walrath-Greene, Ph.D.
Macro International Inc.
116 John Street, Fl. 8
New York, NY 10038
(212) 941-5555

Robert Stephens, Ph.D.
Macro International Inc.
3 Corporate Square, Suite 370
Atlanta, GA 30329
(404) 321-3211

Lucas Garraza
Macro International Inc.
116 John Street, Fl. 8
New York, NY 10038
(212) 941-5555

The agency staff person responsible for receiving and approving contract deliverables is:

Richard McKeon, Ph.D.
Prevention Initiatives and Priority Programs Development Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services
1 Choke Cherry Road
Room 6-1105
Rockville, MD 20857
Phone: (240) 276-1873

6. List of Attachments

1. Attachment A.1 - Campus Case Study Interview – Faculty Version
2. Attachment A.2 - Campus Case Study Interview – Student Version
3. Attachment A.3 - Campus Case Study Interview – Prevention Staff Version
4. Attachment A.4 - Campus Case Study Interview – Case Finder Version
5. Attachment A.5 - Campus Case Study Interview – Campus Police Version
6. Attachment A.6 - Campus Case Study Interview – Counseling Center Version
7. Attachment A.7 - Campus Case Study Interview – Administrator Version
8. Attachment B.1 - Focus Group Moderator's Guide - Student Version
9. Attachment B.2 - Focus Group Moderator's Guide – Faculty/Staff Version
10. Attachment C.1 - Campus Case Study Key Informant Interview Consent Form
11. Attachment C.2 - Campus Case Study Focus Group, Faculty/Staff Consent Form
12. Attachment C.3 – Campus Case Study Focus Group, Student Consent Form
13. Attachment D - Enhanced Module for the Suicide Prevention, Exposure, Awareness, and Knowledge Survey (SPEAKS) – Student Version
14. Attachment E.1 - Suicide Prevention Exposure, Awareness, and Knowledge Survey (SPEAKS) Student Version
15. Attachment E.2 - Advance Email SPEAKS - Student
16. Attachment E.3 - Introduction Email SPEAKS-Student
17. Attachment E.4 - Reminder Email SPEAKS-Student
18. Attachment E.5 - Final Reminder Email SPEAKS-S
19. Attachment F - References