

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6120 Executive Blvd., Rockville, MD 20852 (Telephone Conference Call).

Contact Person: Christine A. Livingston, PhD, Scientific Review Officer, Division of Extramural Activities, National Institutes of Health/NIDCD, 6120 Executive Blvd.—MSC 7180, Bethesda, MD 20892, (301) 496-8683, livingsc@mail.nih.gov.

Name of Committee: National Institute on Deafness and Other Communication Disorders Special Emphasis Panel; Autism Supplements.

Date: March 24, 2011.

Time: 12 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6120 Executive Blvd., Rockville, MD 20852 (Telephone Conference Call).

Contact Person: Susan L. Sullivan, PhD, Scientific Review Officer, National Institute of Deafness and Other Communication Disorders, 6120 Executive Blvd., Ste. 400C, Rockville, MD 20852, (301) 496-8683, sullivas@mail.nih.gov.

(Catalogue of Federal Domestic Assistance Program Nos. 93.173, Biological Research Related to Deafness and Communicative Disorders, National Institutes of Health, HHS)

Dated: February 10, 2011.

Jennifer S. Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2011-3479 Filed 2-15-11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276-1243.

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the

quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, through the use of automated collection techniques or other forms of information technology.

Proposed Project: Protection and Advocacy for Individuals With Mental Illness (PAIMI) Annual Program Performance Report (OMB No. 0930-0169)—Revision

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act at 42 U.S.C. 10801 *et seq.*, authorized funds to the same protection and advocacy (P&A) systems created under the Developmental Disabilities Assistance and Bill of Rights Act of 1975, known as the DD Act (as amended in 2000, 42 U.S.C. 15041 *et seq.*). The DD Act supports the Protection and Advocacy for Developmental Disabilities (PADD) Program administered by the Administration on Developmental Disabilities (ADD) within the Administration on Children and Families. ADD is the lead Federal P&A agency. The PAIMI Program supports the same governor-designated P&A systems established under the DD Act by providing legal-based individual and systemic advocacy services to individuals with significant (severe) mental illness (adults) and significant (severe) emotional impairment (children/youth) who are at risk for abuse, neglect and other rights violations while residing in a care or treatment facility.

In 2000, the PAIMI Act amendments created a 57th P&A system—the American Indian Consortium (the Navajo and Hopi Tribes in the Four Corners region of the Southwest). The Act, at 42 U.S.C. 10804(d) states that a P&A system may use its allotment to provide representation to individuals with mental illness, as defined by §42 U.S.C. 10802 (4)(B)(iii) residing in the community, including their own home, only, if the total allotment under this title for any fiscal year is \$30 million or more, and in such cases an eligible P&A system must give priority to representing PAIMI-eligible individuals, as defined by 42 U.S.C. 10802(4)(A) and (B)(i).

The Children's Health Act of 2000 (CHA) also referenced State P&A system authority to obtain information on incidents of seclusion, restraint and related deaths [see, CHA, Part H at 42 U.S.C. 290ii-1]. PAIMI Program formula grants awarded by SAMHSA go directly to each of the 57 governor-designated P&A systems. These systems are located in each of the 50 states, the District of

Columbia, the American Indian Consortium, and five (5) territories—American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands.

The PAIMI Act at 42 U.S.C. 10805(7) requires that each P & A system prepare and transmit to the Secretary HHS and to the head of its State mental health agency a report on January 1. This report describes the activities, accomplishments, and expenditures of the system during the most recently completed fiscal year, including a section prepared by the advisory council (the PAIMI Advisory Council or PAC) that describes the activities of the council and its assessment of the operations of the system.

The Substance Abuse Mental Health Services Administration (SAMHSA) proposes to revise the annual PAIMI Program Performance Report (PPR), including the advisory council section of the report for the following reasons: (1) To make it consistent with the annual reporting requirements under the Act and its Rules [42 CFR part 51], (2) to conform to the GPRA requirements that SAMHSA obtain information that closely measures actual outcomes of programs that are funded by the agency, and (3) to determine if the reporting burden can be reduced by removing any information that does not facilitate evaluation of the programmatic and fiscal effectiveness of a State P&A system.

The SAMHSA revisions to the annual PPR and Advisory Council section reflect the statutory and regulatory requirements of the PAIMI Act. These revisions include, but may not be limited to the following items: (1) Clarifying the instructional guidance in the PPR, e.g., Section 3.—Living Arrangements; Section 4.—Complaints/Problems of PAIMI-eligible Individuals, at 4. D.2.—Intervention Strategy Outcome Statement, by using a chart format to capture the most significant outcome achieved per strategy used; eliminating the need for attachments, i.e., in Section 7—Grievance Procedures, a copy of the policies/procedures, in Section 8—Other Services and Activities a copy of agency policies/procedures for obtaining comments from the public (8.A.3.), and a copy of the public comment opportunity notice (8.A.1.); (2) clarifying the Advisory Council section of the PPR, e.g., Section B. PAIMI Advisory Council Membership, secondary identification instructions; and, (3) eliminating the submission of supplemental documents, e.g., PAIMI bylaws, etc. The revised report formats

will be effective for the FY 2011 PPR reports due on January 1, 2012.

The annual burden estimate is as follows:

	Number of respondents	Number of responses per respondent	Hours per response	Total hour burden
Program Performance Report	57	1	26	1,482
Advisory Council Report	57	1	10	570
Total	57	2,052

Send comments to Summer King, SAMHSA Reports Clearance Officer, Room 8–1099, 1 Choke Cherry Road, Rockville, MD 20857 and also send an e-mail copy of your comments to her at Summer.King@samhsa.hhs.gov. Written comments are due within 60 days of this notice.

Dated: February 7, 2011.

Elaine Parry,

Director, Office of Management, Technology and Operations.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

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Proposed Project—RECOVERY: Increasing Adoption of Patient Centered Behavioral Health Research by Primary and Behavioral Health Providers and Systems—NEW

SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) will conduct a study to evaluate the impact of different strategies for disseminating and promoting the adoption of patient-centered health research results among behavioral health and primary care providers and organizations that are responsible for delivering behavioral health services. Data collected by this study will allow CBHSQ to document and examine the impact of two dissemination strategies on the decision to adopt patient-centered health research; specifically, motivational interviewing and trauma-focused cognitive behavioral therapy.

These data will also allow for an examination of contextual factors, both organizational and individual, that influence this decision to adopt an evidence-based behavioral health intervention. Ultimately, data collected by this study will inform those who hope to improve the effectiveness of dissemination strategies aimed at increasing the adoption of patient-centered behavioral health interventions by identifying facilitators and barriers to the adoption process.

Data collection activities involve the administration of five separate surveys (a baseline survey, a followup survey, and three dissemination evaluation surveys) to individuals typically involved in the decisionmaking process pertaining to the adoption of new behavioral interventions at 40 community health organizations and 40 community behavioral health organizations across the United States. Enrolled organizations will submit their responses for all surveys via Qualtrics, a third-party, online Web-based survey platform.

The estimated burden for data collection is 940 hours across a total of 400 participants. Using median hourly wage estimates reported by the Bureau of Labor Statistics, May 2009 National Occupational Employment and Wage Estimates, and a loading rate of 25%, the estimated total cost to respondents is \$63,057.04. A breakdown of these estimates is presented in Table 1 below.

TABLE 1—ESTIMATED BURDEN FOR DATA COLLECTION

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total hour burden
Health Center Directors:				
Baseline Survey, Director Version	80	1	0.67	53.6
Followup Survey, Director Version	80	2	0.67	107.2
Dissemination Evaluation Survey of the Packets	80	1	0.17	13.6
Dissemination Evaluation Survey of the Training Webinar	40	1	0.17	6.8
Dissemination Evaluation Survey of the Coaching Webinar	40	1	0.17	6.8
Director Subtotal	80	188
Health Center Administrators:				
Baseline Survey, Staff Version	80	1	0.67	53.6
Followup Survey, Staff Version	80	2	0.67	107.2