Place: 6120 Executive Blvd., Bethesda, MD 20892 (telephone conference call).

Contact Person: Richard Fisher, Ph.D., Scientific Review Administrator, NIDCD/DEA/SRB, EPS Room 400C, 6120 Executive Boulevard, MSC 7180, Bethesda MD 20892–7180, 301–496–8683.

Purpose/Agenda: To review and evaluate grant applications.

The meetings will be closed in accordance with the provisions set forth in sections 552b(c)(4) and 552(b)(6), Title 5, United States Code. The applications and/or proposals and the discussion could reveal confidential trade secrets or commercial property such as patentable material and personal information concerning individuals associated with the applications and/or proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

This notice is being published less than fifteen days prior to the meetings due to the urgent need to meet timing limitations imposed by the review and funding cycle.

(Catalog of Federal Domestic Assistance Program No. 93.173 Biological Research Related to Deafness and Communication Disorders)

Dated: March 21, 1997.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 97–7830 Filed 3–27–97; 8:45 am]

BILLING CODE 4140–01–M

Substance Abuse and Mental Health Services Administration

Estimation Methodology for Adults with Serious Mental Illness (SMI)

AGENCY: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, HHS.

ACTION: Solicitation of comments.

SUMMARY: This notice describes the proposed methodology for identifying and estimating the number of adults with serious mental illness (SMI) within each State. This notice is being served as part of the requirement of Public Law 102–321, the ADAMHA Reorganization Act of 1992.

COMMENT PERIOD: The Administrator is requesting written comments which must be received on or before May 27, 1997.

ADDRESSES: Comments should be sent to Ronald W. Manderscheid, Ph.D., Chief, Survey and Analysis Branch, Center for Mental Health Services, Parklawn Building Room 15C–04, 5600 Fishers Lane, Rockville, MD 20857. (301) 443–7926 fax.

FOR FURTHER INFORMATION CONTACT: A detailed paper outlining the estimation methodology described here is available from Ronald W. Manderscheid, Ph.D., Chief, Survey and Analysis Branch, Center for Mental Health Services, Parklawn Building Room 15C–04, 5600 Fishers Lane, Rockville, MD 20857. (301) 443–3343 voice, (301) 443–7926 fax.

Background

Public Law 102–321, the ADAMHA Reorganization Act of 1992, amended the Public Health Service Act and created the Substance Abuse and Mental Health Services Administration (SAMHSA). The Center for Mental Health Services (CMHS) was established within SAMHSA to coordinate Federal efforts in the prevention, treatment, and promotion of mental health. Title II of Public Law 102–321 establishes a Block Grant for Community Mental Health Services administered by CMHS, which permits the allocation of funds to States for the provision of community mental health services to children with a serious emotional disturbance and adults with a serious mental illness. Public Law 102–321 stipulates that States estimate the incidence (number of new cases) and prevalence (total number of cases in a year) in their applications for Block Grant funds. As part of the process of implementing this new block grant, definitions of the terms ''children with a serious emotional disturbance'' and ''adults with a serious mental illness'' were announced on May 20, 1993, in **Federal Register** Volume 58, No. 96, p. 29422. Subsequently, a group of technical experts was convened by CMHS to develop an estimation methodology to ''operationalize the key concepts'' in the definition of adults with serious mental illness. A similar group is preparing an estimation methodology for children and adolescents with a serious emotional disturbance.

Data Sources

Data from two major national studies, the National Comorbidity Survey (NCS) and the Epidemiologic Catchment Area (ECA) Study, were used to estimate the prevalence of adults with serious mental illness. The NCS, a nationally representative sample household survey conducted in 1990–91 assessed the prevalence of DSM–III–R disorders in persons aged 15–54 years old. This sample included over 1,000 census tracts in 174 counties in 34 States. The ECA, a general population survey of five local areas in the U.S., was conducted in 1980–85 to determine the prevalence of DSM III disorders in persons age 18 and older. The ECA data utilized for the present analysis was limited to the Baltimore site because that was the only site that had disability data needed to operationalize the criteria for SMI. Although the Baltimore sample is not nationally representative, it is used in this analysis because the ECA provides a rough replication and check on the NCS data. Also, the NCS does not have data on persons age 55 and older, so the ECA data are used to estimate the prevalence of serious mental illness among persons 55 years and older. The group of technical experts determined that it is not possible to develop estimates of incidence using currently available data. However, it is important to note that incidence is always a subset of prevalence. In future, incidence and prevalence data will be collected.

Serious Mental Illness (SMI)

As previously defined by CMHS, adults with a serious mental illness are persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of DSM–III–R *AND* ''* * * that has resulted in functional impairment which substantially interferes with or limits one or more major life activities * * *.'' The definition states that ''* * * adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses * * *.'' DSM–III–R ''V'' codes, substance use disorders, and developmental disorders are excluded from this definition.

The following criteria were used to operationalize the definition of serious mental illness in the NCS and ECA data:

(1) Persons who met criteria for disorders defined as severe and persistent mental illnesses (SPMI) by the National Institute of Mental Health (NIMH) National Advisory Mental Health Council (National Advisory Mental Health Council, 1993).

To this group were added:

(2) Persons who had another 12-month DSM–III–R mental disorder (with the exclusions noted above), *AND*

- Either planned or attempted suicide at some time during the past 12 months, *OR*
- Lacked any legitimate productive role, *OR*
- Had a serious role impairment in their main productive roles, for example, consistently missing at least one full day of work per month as a direct result of their mental health, *OR*
- Had serious interpersonal impairment as a result of being totally socially isolated, lacking intimacy in social relationships, showing inability to confide in others, and lacking social support.

Estimation Procedures

Two logistic regression models were developed to calculate prevalence estimates for adults with SMI.

(a) A Census Tract Model for years in which the decennial U.S. census is conducted.

(b) A County-Level Model to be used biannually in intercensal years.

In non-censal years, the county-level model will be used to estimate SMI prevalence, after adjusting for its known relationship with the census tract model.

Formula

Census-Tract Model

Using 1990 census data, a logistic regression model was developed to calculate predicted rates for each cell of an age by sex by race table for each of the 61,253 Census Tracts in the country. Next, the rates were multiplied by cell frequencies and subtotaled to derive tract-level estimates. Finally, the tract-level estimates were aggregated to arrive at county-level and state-level prevalence estimates of adults with SMI. This regression methodology is often used in small area estimation (Ericksen, 1974; Purcell & Kish, 1979). The actual census tract model equation is specified immediately below:

PARAMETER ESTIMATES FOR CENSUS-TRACT MODEL

Predictor	Odds ratio	95% confidence interval
Intercept	*0.02	(0.01–0.04)
Individual-Level Variables		
Age:		
18–24	*1.94	(1.18–3.17)
25–34	1.32	(0.86–2.03)
35–44	1.46	(0.96–2.21)
45–54	1.00	(—)
Sex:		
Female	*2.23	(1.57–3.19)
Male	1.00	(—)
Race:		
Nonhispanic white	1.00	(—)
Black/Hispanic/other	*0.49	(0.28–0.87)
Marital Status:		
Married/Cohabiting	1.00	(—)
Never Married	*3.90	(1.15–3.08)
Separated/Divorced/Widowed	*1.88	(2.41–6.31)
Census-Tract Level Variables		
F2 (High socio-economic status)	1.16	(0.90–1.49)
F4 (Immigrants)	0.99	(0.85–1.14)
County-Level Variables		
County Urbanicity:		
Metropolitan	1.12	(0.85–1.49)
Other	1.00	(—)
Interactions Among Variables		
FemaleXSeparated/Divorced/Widowed	*0.47	(0.24–0.91)
FemaleXNever Married	*0.47	(0.28–0.78)
Non WhiteXSeparated/Divorced/Widowed	*2.62	(1.29–5.33)
Non WhiteXNever Married	1.81	(0.95–3.44)
FemaleXF2	*0.70	(0.51–0.96)
UrbanicityXF2	*0.75	(0.52–0.95)
F2XF4	0.78	(0.64–0.94)

*Significant at the .05 level, two tailed test; F2=Census Tract factor score for high socioeconomic status (SES); F4=Census Tract factor score for immigrants.

The estimate for persons 55 years and older is derived from analysis of ECA data in conjunction with NCS data. The prevalence ratio among ECA respondents ages 55–64 and 65 years and above, were found to be 84 and 31 percent as large, respectively, as the prevalence estimate for NCS respondents 18–54 years old, after controlling for differences in gender and race. NCS State-level estimates were extrapolated using these ratios. These ratios did not differ significantly by sex or race. A factor of .81 was applied to State-level SMI estimates for the age range 18–54 to derive the rate for the age range 55–64, and .31 was used to arrive at the estimate for person 65 and older. A weighted sum (by age distribution of each State) was calculated to determine the final State-level SMI prevalence estimate.

County Model

U.S. Census Bureau tract-level data are available only for years in which the decennial U.S. Census is conducted. To obtain prevalence estimates for adults with a SMI during intercensal years, the group of technical experts used biennial individual- and county-level data from the Census Bureau's small area estimation program. Predicted values

from the logistic regression equation were used to calculate county-level estimates. In contrast to the census tract model, the initial estimates using this approach were generated at the county level. These county-level estimates are then summed to provide State-level prevalence estimates. The actual county-level model equation is specified immediately below:

PARAMETER ESTIMATES FOR COUNTY-LEVEL MODEL

Predictor	Odds ratio	95% confidence interval
Intercept	*0.04	(0.02–0.07)
INDIVIDUAL-LEVEL VARIABLES		
Age:		
18–24	1.69	(1.00–2.85)
25–34	1.10	(0.65–1.88)
35–44	1.24	(0.71–2.15)
45–54	1.00	(–)
Sex:		
Female	1.58	(1.17–2.13)
Male	1.00	(–)
COUNTY-LEVEL VARIABLES		
Urbanicity:		
Metropolitan	1.35	(0.99–1.85)
Other	1.00	(–)

*Significant at the 0.05 level, two-tailed test.

Adjustment for persons age 55 years and older is carried out as in the census-tract model. An adjustment factor (Census Bureau, Fay, 1987; Fay & Herriot, 1979) based on the ratio of county-level model estimates for 1990 and census-tract model estimates for 1990 can be used to adjust biannual estimates for subsequent years from the county-level model. This procedure assumes that the census-tract model is more accurate than the county-level model.

County and State Estimates

As stated earlier, census tract model prevalence estimates were summed to derive county estimates, and county estimates were summed to arrive at State estimates. The 12-month prevalence is estimated nationally to be 5.4 percent or 10.0 million people in the adult household population, of which 2.6 percent or 4.8 million adults have a serious and persistent mental illness (figure 1).

The above estimates are based on noninstitutionalized persons residing in the community. Limited information currently exists on SMI estimates for persons institutionalized (i.e., persons in correctional institutions, nursing homes, the homeless, persons in military barracks, hospitals/schools/homes for persons who are mentally ill or mentally retarded). Fischer and Breakey (1991), indicate that on average, the SMI prevalence rate for these groups (including about 5 million people or 2.7 percent of the U.S. adult population) is about 50 percent. The following assumptions were made in deriving rough estimates of SMI prevalence for persons who are institutionalized:

(a) For 1.1 million residents of correctional institutions, 100 percent of whom are adults, prevalence of SMI is estimated to be 57 percent.

(b) For 1.8 million residents of nursing homes, 100 percent of whom are adults, prevalence of SMI is estimated to be 46 percent.

(c) For 0.5 million persons who are homeless, 80 percent of whom are adults, prevalence of SMI is estimated to be 50 percent.

(d) For 0.6 million persons in military barracks, all of whom are adults, the SMI prevalence rate is equivalent to that of the adult household population.

(e) For 0.4 million persons in hospitals, homes, and schools for persons who are mentally ill, 80 percent of whom are adults, prevalence of SMI is estimated to be 100 percent.

(f) For 0.6 million persons in other institutional settings such as chronic disease hospitals, homes and schools for persons with physical disability, and rooming houses, 50 percent of whom are adults, prevalence of SMI is estimated to be 50 percent.

State estimates of each of these populations can be added to the State SMI populations identified below.

Only a portion of adults with SMI seek treatment in any given year. Due to the episodic nature of SMI, some persons may not require mental health service at any particular time.

Provision of Estimates to States

CMHS will provide each State mental health agency with estimates in order to initiate the first cycle of use. Subsequently, CMHS will provide technical assistance to States to implement the methodology using State demographic information.

TABLE 1.—ESTIMATED 12-MONTH PREVALENCE OF SERIOUS MENTAL ILLNESS (SMI) AMONG PERSONS AGES 18 AND OLDER, BY STATE, 1990*+

State	Number of people with SMI	Total adult population 18 yrs+	Prevalence of SMI
Alabama	172,944	2,981,799	5.8
Alaska	23,795	377,699	6.3
Arizona	179,835	2,684,109	6.7

TABLE 1.—ESTIMATED 12-MONTH PREVALENCE OF SERIOUS MENTAL ILLNESS (SMI) AMONG PERSONS AGES 18 AND OLDER, BY STATE, 1990*+—Continued

State	Number of people with SMI	Total adult population 18 yrs+	Prevalence of SMI
Arkansas	95,128	1,729,594	5.5
California	1,386,586	22,009,296	6.3
Colorado	160,586	2,433,128	6.6
Connecticut	129,414	2,537,535	5.1
Delaware	28,661	502,827	5.7
District of Columbia	28,409	489,808	5.8
Florida	624,445	10,071,689	6.2
Georgia	299,308	4,750,913	6.3
Hawaii	31,468	828,103	3.8
Idaho	38,409	698,344	5.5
Illinois	500,570	8,484,236	5.9
Indiana	237,115	4,088,195	5.8
Iowa	109,067	2,057,875	5.3
Kansas	103,510	1,815,960	5.7
Kentucky	161,141	2,731,202	5.9
Louisiana	176,570	2,992,704	5.9
Maine	48,703	918,926	5.3
Maryland	220,773	3,619,227	6.1
Massachusetts	265,811	4,663,350	5.7
Michigan	410,192	6,836,532	6.0
Minnesota	179,666	3,208,316	5.6
Mississippi	100,455	1,826,455	5.5
Missouri	216,728	3,802,247	5.7
Montana	30,002	576,961	5.2
Nebraska	62,066	1,149,373	5.4
Nevada	65,152	904,885	7.2
New Hampshire	49,830	830,497	6.0
New Jersey	314,328	5,930,726	5.3
New Mexico	69,441	1,068,328	6.5
New York	768,930	13,730,906	5.6
North Carolina	296,326	5,022,488	5.9
North Dakota	23,634	463,415	5.1
Ohio	474,795	8,047,371	5.9
Oklahoma	133,898	2,308,578	5.8
Oregon	124,973	2,118,191	5.9
Pennsylvania	508,863	9,086,833	5.6
Rhode Island	48,222	777,774	6.2
South Carolina	156,556	2,566,496	6.1
South Dakota	24,877	497,542	5.0
Tennessee	230,617	3,660,581	6.3
Texas	850,547	12,150,671	7.0
Utah	71,201	1,095,406	6.5
Vermont	24,341	419,675	5.8
Virginia	280,957	4,682,620	6.0
Washington	216,318	3,605,305	6.0
West Virginia	70,195	1,349,900	5.2
Wisconsin	205,359	3,602,787	5.7
Wyoming	17,812	318,063	5.6
*Total	9,995,579	185,103,320	5.4

Does not include persons who are homeless or are institutionalized.

+ The total for the U.S. is based upon direct, weighted counts from the survey results. The total for each State is based upon synthetic modeling at the county level and then summing across counties to derive a State total. These two approaches are subject to different types of sampling and nonsampling errors. Therefore, the sum of the state totals will not necessarily equal the U.S. total.

Limitations

The ECA and NCS were designed to study lifetime prevalence of mental disorders rather than 12-month prevalence. As a result, the emphasis in diagnostic assessment was on lifetime disorders. In addition, functional impairment was not a primary focus in either the ECA or the NCS.

Current data cannot provide estimates of incidence. Additional information needs to be collected in the future.

Scope of Application

Inclusion in or exclusion from the definition is not intended to confer or deny eligibility for any service or benefit at the Federal, State, or local levels. Additionally, the definition is not intended to restrict the flexibility or responsibility of the State or local government to tailor publicly funded service systems to meet local needs and priorities. However, all individuals whose services are funded through Federal Community Mental Health Services Block Grant funds must fall within the criteria set forth in these definitions. Any ancillary use of these definitions for purposes other than those identified in the legislation is outside the purview and control of CMHS.

It is anticipated that additional work will be done in future years to refine and update the estimation methodology. CMHS will keep States apprised as this work develops.

References

Ericksen, E. P. (1974). A regression method for estimating population changes of local areas. *Journal of American Statistical Association, 69,* 867–875.

Fay, R. E. (1987). Application of multivariate regression to small domain estimation. In R. Platek, J.N.K. Rao, C.E. Sarndal & M.P. Singh (Eds.), *Small Area Statistics: An International Symposium,* Pp. 91–102. New York: John Wiley and Sons.

Fay, R. E., & Herriot, R. A. (1979). Estimates of income for small places: An application of James-Stein procedures to Census data. *Journal of the American Statistical Association, 74,* 269–277.

Fischer, P.J., Breakey, W.R. (1991). The Epidemiology of alcohol, drug, and mental disorders among homeless persons. *American Psychologist. 46, 1115–1125.*

Kessler, R.C., et al. Estimation of the 12-month Prevalence of Serious Mental Illness (SMI). (1996). Unpublished document.

National Advisory Mental Health Council. (1993). Health care reform for Americans with severe mental illness. *American Journal of Psychiatry, 150,* 1447–1465.

Purcell, N. J., & Kish, L. (1979). Estimation for small domains. *Biometrics, 35,* 365–384.

Regier, D. A., Narrow, W.E., Rae, D.S., Manderscheid, R.W., Locke, D.Z., Goodwin, F.K. (1993). The de Facto US Mental and Addictive Disorders Service System. *Archives of General Psychiatry, 50,* 85–94.

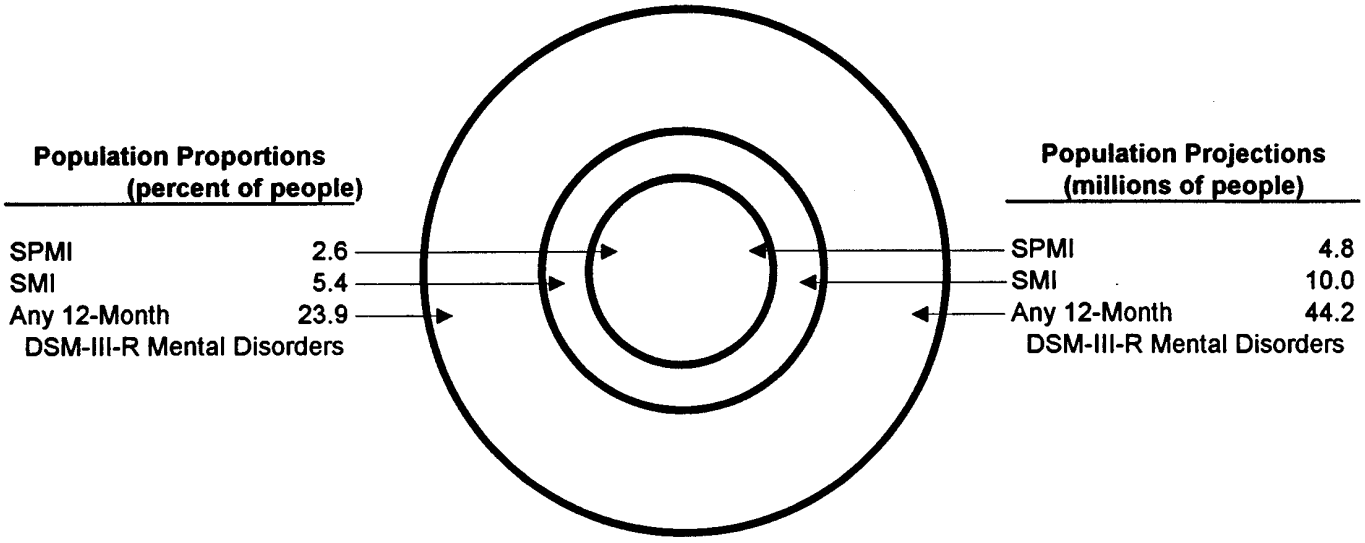
Dated: March 5, 1997.

Richard Kopanda,

Executive Officer, Substance Abuse and Mental Health Services Administration.

BILLING CODE 4162–20–P

Figure 1. Estimated Household Population (Ages 18+) 12-Month Prevalences and Population Projections of DSM-III-R Severe and Persistent Mental Illness (SPMI), Serious Mental Illness (SMI), and Any Mental Illness Based on Pooled Baltimore ECA/NCS Data



These estimates are based on extrapolation from household surveys and consequently exclude homeless people and residents of institutions such as nursing homes, prisons, and long-term care facilities. An estimated 2.2 million additional persons in these excluded sections are thought to have SMI, for 12.2 million in the total population.

[FR Doc. 97–7734 Filed 3–27–97; 8:45 am]

BILLING CODE 4162–20–C

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4124–N–31]

Federal Property Suitable as Facilities to Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

FOR FURTHER INFORMATION CONTACT: Mark Johnston, room 7256, Department of Housing and Urban Development, 451 Seventh Street SW., Washington,