

whether an applicant's proposed program of utilization is an approvable public health program, and then recommends to the Administrator which excess and surplus real property is needed for that approved program in the protection of the public health. 40 U.S.C. 550(d); 45 CFR 12.3(a).

Title V of the McKinney Act, which was enacted in 1987, directs HHS to include, as a permissible use in the protection of public health, the furnishing of surplus real property to assist homeless individuals and families. Title V does not prescribe appropriate homeless assistance programs.

HHS concluded in 1992 that long-term housing did not constitute an appropriate public health use of surplus real property under Title V. HHS subsequently adopted the Department of Housing and Urban Development's (HUD) standard, limiting occupancy in Title V's transitional housing programs to 24 months. Until now, HHS has not considered whether the provision of long-term, community-based housing linked with supportive services for persons experiencing homelessness was a permissible public health use.

The Secretary exercises the authority to approve permanent supportive housing programs for Title V, consistent with HHS' mission to protect the public health. There are several critical distinctions between the policy decision in 1992 regarding the use of surplus real property for low-income housing and the current proposal to allow surplus real property to be used for permanent supportive housing. Low-income housing is defined as subsidized housing opportunities for individuals with low incomes. The provision of low-income housing (i.e. the Section 8 Housing Choice Voucher Program) is under the purview of HUD. HHS, as the nation's public health agency, does not operate low-income housing programs, and does not possess the experience or expertise to complement HUD's mission. The proposed policy revision is intended to reaffirm HHS' 1992 determination that the provision of low-income housing does not constitute an appropriate public health use of surplus real property under Title V. In contrast, we are proposing a permanent supportive housing program that is long-term, community-based, and linked to supportive services for homeless persons with disabilities.

## II. Proposed Policy Revision

HHS has historically been involved in the provision of permanent supportive housing, such as through the Projects for Assistance in Transition from

Homelessness (PATH) program that is operated in SAMHSA. Given HHS' history of involvement in the health service component of supportive housing programs, there is precedent to suggest that this would be an appropriate public health use of surplus real property under Title V.

Permanent supportive housing is a service model that links housing and services together, without the 24-month time limit traditionally imposed by a transitional housing program. Initial research thus far suggests the effectiveness of permanent supportive housing for individuals with disabilities and those who are chronically homeless. In several studies, this model has been successful at achieving housing stability. For example, placement of homeless people with severe mental illness in permanent supportive housing is associated with reductions in subsequent use of shelters, hospitalizations, and incarcerations (Culhane et al., 2001). Early outcomes in a study of supportive housing with integrated services suggest that these services reduced the use of emergency health care rooms, psychiatric and detoxification programs as well as inpatient care (Corporation for Supportive Housing, 2000). Experimental studies comparing the relative impact of case management and housing resources suggest that long-term housing resources are distinctively effective in reducing homelessness (Rosenheck, 2003).

The proposed policy revision would allow property acquired through the Title V process to be utilized for the development of permanent supportive housing programs that provide permanent housing along with supportive services to homeless people in need of public health assistance and/or services (e.g., substance abuse, mental health, case management, and disabled and frail elderly homeless services). This change would not preclude communities from using surplus property to develop transitional housing programs, emergency shelter programs, or any other homeless assistance program currently approvable by HHS, but simply expands the options available under Title V.

For the purpose of the Title V program, permanent supportive housing means programs that provide long-term, community-based housing that is linked to appropriate supportive health and social services (e.g., substance abuse, mental health, case management, and disabled and frail elderly services) that enable homeless individuals and homeless families with disabilities to maintain housing. Eligible populations

for this program include homeless individuals with disabilities, homeless families with a disabled family member (either parent or child), and homeless frail elderly populations.

The same evaluation criteria outlined in the joint regulation will continue to apply to all applications received for consideration under Title V, including those requesting property to be used for permanent supportive housing. Applicants must fully describe the proposed program, demonstrate how the services to be provided will address the needs of the homeless population to be served, and otherwise comply with the requirements of Title V and the joint agency regulation.

We invite public comment on all aspects of the proposed policy change, particularly on the proposed definition of permanent supportive housing.

Dated: December 19, 2005.

**J. Philip VanLandingham,**

*Deputy Assistant Secretary for Program Support.*

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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 (SAMHSA) 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, including through the use

of automated collection techniques or other forms of information technology.

**Proposed Project: National Evaluation of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program—NEW**

In recognition that systematic evaluation of this and other government programs are an expected practice under both the Government Performance and Results Act (GPRA) and the Office of Management and Budget's Program Assessment and Rating Tool (PART), the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (CMHS) will conduct an independent evaluation of the PAIMI Program. CMHS will employ information that is routinely collected under existing program requirements and is also expected to collect new, additional data that are also necessary for the conduct of the evaluation. [On January 1, each eligible State protection and advocacy (P&A) system is required to transmit to the Secretary and head of the State Mental Health Agency, in which the system is located, a report describing its activities, accomplishments, and expenditures during the most recently completed fiscal year. None of the data collection activities described above will be redundant with these existing reporting requirements.] The evaluation plan includes gathering information about the PAIMI program from persons with different perspectives. Accordingly, CMHS proposes to proceed with the following new data collection activities:

(1) Survey interviews with the Executive Directors of each of the Protection and Advocacy Grantees, as well as other staff whom they may ask to join them in these interviews to include:

- a. Characteristics and shared functions between the P&A Governing Board and the PAIMI Advisory Council
- b. Processes to establish PAIMI goals and priorities
- c. Federal support of the PAIMI program
- d. Federal oversight of the PAIMI program
- e. Organization and staffing of PAIMI responsibilities within the P&A
- f. Procedures for quality management
- g. Background of respondent
- (2) Surveys of and focus groups with persons who receive services from PAIMI programs to include:
  - a. Access to PAIMI services
  - b. Quality of services provided to clients
  - c. Satisfaction with services
  - d. Background of respondent
- (3) Surveys of the Chairs of the Advisory Councils of each PAIMI Grantee to include:
  - a. Characteristics and shared functions between the P&A Governing Board and the PAIMI Advisory Council
  - b. Processes to establish PAIMI goals and priorities and assessment of those priorities
  - c. Organization and staffing of PAIMI responsibilities within the P&A
  - d. Quality of services provided to clients
  - e. Background of respondent
- (4) Surveys of the Program Directors of State Mental Health Authorities to include:
  - a. Types of communication between the State Mental Health Authority and the PAIMI program
  - b. Processes to establish PAIMI goals and priorities and assessment of those priorities
  - c. Relationship between the State Mental Health Authority and the PAIMI program
  - d. Role of the PAIMI program in the mental health advocacy community

e. Background of respondent

(5) Survey of directors of other organizations who are likely to be familiar with or collaborate in PAIMI activities in each State; including family and consumer groups and other mental health advocacy organizations to include:

- a. Types of interaction between the State Mental Health Authority and the PAIMI program.
- b. Processes to establish PAIMI goals and priorities and assessment of those priorities
- c. Relationship between the organization and the PAIMI program
- d. Access to and quality of services provided to PAIMI recipients
- e. Role of the PAIMI program in the mental health advocacy community
- f. Background of respondent

The PAIMI program has never undergone an independent evaluation. The approach being used is to conduct survey interviews with a cross-section of five primary Stakeholder groups connected to the PAIMI program, including Program Directors/staff, Clients/Recipients of services, PAIMI Advisory Council Chairs, Directors of State Mental Health Authorities, and Directors of Other Mental Health Advocacy Organizations in an effort to obtain a representative sample of viewpoints about the PAIMI program. The surveys have been developed to include questions relevant to each of the respective Stakeholder groups named above and range from 22 questions to as many as 88 questions. Depending on the Stakeholder group, respondent surveys are expected to take from thirty minutes up to two hours to complete.

The burden estimate for conducting the surveys under the evaluation plan for the PAIMI Program is as follows:

Surveys	Number of respondents	Responses per respondent	Burden per response (hrs.)	Total burden (hrs.)
P&A Executive Director Survey .....	57	1	2	114
PAIMI Client Survey .....	100	1	1.5	150
PAIMI Advisory Council Chair Survey .....	57	1	1	57
State Mental Health Program Directors Survey .....	57	1	.5	28.5
Directors of Other Mental Health Advocacy Organizations Survey .....	171	1	.5	85.5
Totals .....	442	.....	.....	425

Send comments to Summer King, SAMHSA Reports Clearance Officer, Room 71–1044, One Choke Cherry Road, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: January 20, 2006.

**Anna Marsh,**

*Executive Officer, SAMHSA.*

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#### Proposed Project: National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program: Phase V—NEW

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center of Mental Health is responsible for the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program that will collect data on child mental health outcomes, family life, and service system development and performance. Data will be collected on 25 service systems, and roughly 7310 children and families.

The data collection for this evaluation will be conducted over a five-year period. The core of service system data will be collected every 18 to 24 months throughout the 5-year evaluation period, with a sustainability survey conducted in selected years. Service delivery and system variables of interest include the following: maturity of system of care development, adherence to the system of care program model, and client service experience. The length of time that individual families will participate in the study ranges from 18 to 36 months depending on when they enter the evaluation. Child and family outcomes of interest will be collected at intake and during subsequent follow-up interviews at six-month intervals. Client service experience information is collected at these follow-up interviews. Measures included in an outcome interview are determined by the type of assessment (intake or follow up), child's age, and whether the respondent is the caregiver or a youth.

The outcome measures include the following: Child symptomatology and functioning, family functioning, material resources, and caregiver strain. The caregiver interview package includes the Caregiver Information Questionnaire, Child Behavior Checklist, Behavioral and Emotional Rating Scale (BERS), Education Questionnaire, Columbia Impairment Questionnaire, Living Situations Questionnaire, Family Life

Questionnaire, and Caregiver Strain Questionnaire (caregivers of children under age 6 complete the Vineland Screener to assess development, and do not complete the BERS) at intake, and also complete the Multi-service Sector Contacts Form, Culturally Competence and Service Provision Questionnaire and the Youth Services Survey (a national outcome measurement tool). The Youth Interview package includes the Youth Information Questionnaire, Revised Children's Manifest Anxiety Scale, Reynolds Depression Scale, BERS (youth version), Delinquency Survey, Substance Use Survey, GAIN-Quick: Substance Dependence Scale, and Youth Services Survey (youth version).

In addition the evaluation will include two special studies: (1) An evidence-based practices study will examine provider use of evidence-based practices, community readiness and implementation of evidence-based practices, and consumer experience with these practices; (2) A cultural and linguistic competence study will examine the extent to which the cultural and linguistic characteristics of communities influence program implementation and provider adaptation of evidence-based treatments, and provider service delivery decisions based on provider culture and language. The national evaluation measures address the national outcome measures for mental health programs as currently established by SAMHSA.

Internet-based technology will be used for data entry and management, and for collecting data using Web-based surveys. The average annual respondent burden with detail provided about burden contributed by specific measures is estimated below. The estimate reflects the average number of respondents in each respondent category, the average number of responses per respondent per year, the average length time it will take for each response, and the total average annual burden for each category of respondent, and for all categories of respondents combined.

#### ESTIMATE OF RESPONDENT BURDEN

[Note: Total burden is annualized over a 5-year period.]

Instrument	Respondent	Number of respondents	Total average number of responses per respondent	Hours per response	Total burden hours	5 year average annual burden hours
System-of-care Assessment: Interview Guides and Data Collection Forms. Interagency Collaboration Scale (IACS).	Key site informants.	525	3	1.00	1,575	315
	Key site informants.	525	3	0.13	210	42
Cross-sectional Descriptive Study:						