performance of the function of the agency, including whether the information will have practical utility; (2) The accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) Ways to enhance the quality, utility, and clarity of the information to be collected; and (4) Ways to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and instruments, contact: Charles Grewe, Contracting Officer, NICHD, NIH. Address: 6100 Executive Blvd., Suite 7A07, Bethesda, MD 20892–7510 ; e-mail address *cg59b@nih.gov;* Phone: (301)496–4611 (collect calls can not be accepted).

Comments Due Date: Comments regarding this information collection are best assured of having their full effect if received within 60-days of the date of this publication.

Dated: January 15, 2002.

Thomas E. Hooven,

Associate Director for Administration, NICHD.

[FR Doc. 02–2115 Filed 1–28–02; 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 (301) 443–7978.

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 Comprehensive Community Mental Health Services for Children and Their Families Program, Phase Two—(OMB No. 0930–0192, Revision)—SAMHSA's Center for Mental Health Services (CMHS) is conducting Phase II of this national evaluation project. Phase II collects data on child mental health outcomes, family life, and service system development and performance. Child and family outcomes of interest include the following: child symptomatology and functioning, family functioning and material resources, and caregiver strain. Delivery system variables of interest include the following: system of care development, adherence to system of care principles, coordination and linkages among agencies, and congruence between services planned versus those received.

To address the research questions in the national evaluation, a longitudinal quasi-experimental design is being used that includes data collection in all grantee sites and comparison sites (where services are delivered in a more traditional manner). This multi-level evaluation is comprised of several major components. Data collection methods include interviews with caregivers and youth, site visits, case record reviews, service diaries, and provider surveys.

Data collection for this evaluation will be conducted over a six year period. The length of time that families will participate in the study ranges from 18 to 36 months depending on when they enter the evaluation. The average annual respondent burden is estimated below; this represents an annual average burden reduction of 5,537 hours from the level currently approved by the Office of Management and Budget.

This revision to the currently approved data collection activities involves: (1) Reducing the number of sites where data collection will occur from 27 to 25, (2) extending the time frame for data collection by an additional 18 months, (3) adding a treatment effectiveness study in two sites including assessment of outcomes, treatment fidelity, and interaction of the treatment with the larger system of care, (4) adding a survey of clinicians/practitioners on their use of evidence-based treatments, and (5) adding a study of how systems of care are sustained after program funding ends.

Respondent	Number of respondents	Responses/ Respondent	Burden/ Response	Total burden hours
Caregiver	5550	.86	2.36	11,264
Youth	3330	.69	1.15	2,642
Provider	1993	.54	.53	570
Total				14,476

Send comments to Nancy Pearce, SAMHSA Reports Clearance Officer, Room 16–105, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: January 22, 2002.

Richard Kopanda,

Executive Officer, SAMHSA.

[FR Doc. 02–2086 Filed 1–28–02; 8:45 am]

BILLING CODE 4162–20–P

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 (301) 443–7978.

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: 2002 Survey of Mental Health Organizations, General Hospital Mental Health Services, and Managed Care Organizations (SMHO)—(OMB No 0930–0119, Revision)—The 2002 SMHO, to be conducted by SAMHSA's Center for Mental Health Services (CMHS), will be conducted in two phases. There will be only minor changes to the forms used in the 2000 SMHO. Phase I will be a brief two-three page inventory consisting of four forms: (1) A specialty mental health organization form; (2) A general hospital or Veterans Affairs Medical Center with either separate mental health services or integrated mental health services forms; (3) A community residential organization form; and (4) A managed behavioral healthcare organization form. This short inventory will be sent to all known organizations to define the universe of valid mental health organizations to be sampled in Phase II. The inventory will collect basic information regarding the name and address of the organizations, their type and ownership, size measures (e.g., number of staff), and the kinds of services provided.

Phase II will sample approximately 2,000 mental health organizations and utilize a more detailed survey instrument. Although the Sample Survey form will be more comprehensive, it will be very similar to surveys and inventories fielded in 2000 and earlier. The organizational data to be collected by the Sample Survey form include university affiliation, client/patient census by basic demographics, revenues, expenditures, and staffing.

The resulting data base will be used to provide national estimates and will be the basis of the National Directory of Mental Health Services. In addition, data derived from the survey will be published by CMHS in *Data Highlights,* in *Mental Health, United States,* and in professional journals such as *Psychiatric Services* and the *American Journal of Psychiatry. Mental Health, United States* is used by the general public, state governments, the U.S. Congress, university researchers, and other health care professionals. The following table summarizes the burden for the survey.

Questionnaire	Number of respondents	Responses/ respondent	Average hours/ response	Total burden (Hrs.)
Phase I (Inventory)				
Specialty Mental Health Organizations	3,342	1	0.25	836
General Hospitals:				
with Separate Psych. Units	1,622	1	0.25	406
without Separate Psych. Units	3,514	1	0.25	879
VA Medical Centers	145	1	0.25	36
Community Residential Organizations	945	1	0.025	236
Managed Care Organizations	990	1	0.025	248
Phase II (Sample Survey)				
Specialty Mental Health Organizations	1,308	1	3.50	4,578
General Hospitals and VA Hospitals with Separate Mental Health Services	692	1	3.50	2,422
Total	12,558			9,641
3-year Average	4,186			3,214