site external evaluation of the impact of programs of screening, brief intervention (BI), brief treatment (BT) and referral to treatment on patients presenting at various health care delivery units with a continuum of severity of substance use. CSAT's SBIRT program is a cooperative agreement grant program designed to help six States and one Tribal Council expand the continuum of care available for substance misuse and use disorders. The program includes screening, Brief Intervention, Brief Treatment and Referrals (BI, BT) for persons at risk for dependence on alcohol or drugs. The primary purpose of the evaluation is to study the extent to which the modified models of SBIRT being implemented by the grantees expand the continuum of care available for treatment of substance use disorders.

A survey will be used to collect data from patients at the participating grantee health care delivery units at baseline using a computer-assisted personal interview (CAPI) and at a six-month follow-up primarily via computer-assisted telephone interviewing (CATI). A second survey will be administered to practitioners who are delivering SBIRT services using CAPI. The patient survey is composed of questions on substance use behaviors and other outcome measures such as productivity, absenteeism, health status, arrests and accidents. The practitioner survey is designed to evaluate the implementation of proposed SBIRT models by measuring their penetration and practitioners' willingness to adopt. Furthermore, the survey will document moderating factors related to practitioner and health care delivery unit characteristics.

ESTIMATED ANNUALIZED BURDEN HOURS

Instrument/activity	Number of respondents	Number of responses per respondent	Average burden per response	Total burden hours per collection
Patient Survey:				
Baseline Data Collection	3,600	1	.42	1,512
6-Month Follow-up Data	2,880	1	.47	1,354
Practitioner Survey	261	1	.40	104
Total	3,861			2,970

Written comments and recommendations concerning the proposed information collection should be sent by August 28, 2006 to: SAMHSA Desk Officer, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503; due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, respondents are encouraged to submit comments by fax to: 202–395–6974.

Dated: July 20, 2006.

Anna Marsh,

Director, Office of Program Services.

[FR Doc. E6–12028 Filed 7–26–06; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Request for Comment From the Field on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Addiction Technology Transfer Center (ATTC) Program

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

SUMMARY: This notice is to request comments from interested stakeholders in the substance use disorders treatment field regarding SAMHSA's ATTC Program. SAMHSA will be issuing a Request for Applications (RFA) for a new round of competitive cooperative agreement awards under the ATTC program in Federal fiscal year (FFY) 2007. To assist SAMHSA in developing the RFA, SAMHSA is seeking input from stakeholders and interested parties on a number of issues relating to these cooperative agreements.

Program Title: Addiction Technology Transfer Centers (ATTC) Program.

Catalog of Federal Domestic Assistance (CFDA) Number: 93.243.

Authority: Section 5001(d)(5) of the Public Health Service Act, as amended.

FOR FURTHER INFORMATION CONTACT: Catherine D. Nugent, SAMHSA/CSAT/DSI, 1 Choke Cherry Road, Room 5–1079, Rockville, MD 20857, phone: 240–276–1577, e-mail: *cathy.nugent@samhsa.hhs.gov.*

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) is committed to building resilience and facilitating recovery for people with or at risk for substance use and mental disorders. SAMHSA collaborates with the States, national associations, local community-based and faith-based organizations, and public and private sector providers to implement initiatives in its priority areas, including development of the workforce serving individuals needing treatment and recovery for substance use disorders. The Center for Substance Abuse Treatment (CSAT) supports training and technology transfer activities to promote the adoption of evidence-based practices in substance use disorders treatment and, more broadly, to promote workforce development in the addiction treatment field. CSAT's Addiction Technology Transfer Centers (ATTCs), funded by CSAT since 1993, are a major component of SAMHSA/CSAT's workforce development efforts.

The ATTC Network is dedicated to identifying and advancing opportunities for improving addiction treatment. The vision of the ATTCs is to unify science, education and services to transform the lives of individuals and families affected by alcohol and other drug addition.

Serving the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and the Pacific Islands, the ATTC Network operates as 14 individual Regional Centers and a National Office. At the regional level, individual Centers focus primarily on meeting the unique needs in their areas while also supporting national initiatives. The National Office leads the Network in implementing national initiatives and concurrently supports and promotes individual regional efforts.

The current ATTC program is funded through cooperative agreements initially awarded in 2001 and 2002. These cooperative agreements will end in FFY 2007. SAMHSA/CSAT will be issuing a new funding announcement to re-compete the ATTCs in FY 2007. To assist CSAT in designing the

requirements and parameters for the next round of ATTCs, CSAT is requesting comments on the directions and priorities for the ATTC program and on meeting the workforce development needs of the addiction treatment field in an equitable manner across all the States, the District of Columbia, the Carribean Islands, and Pacific Islands.

DATES: Submit all comments on or before September 11, 2006.

ADDRESSES: Address all comments concerning this notice to: Catherine D. Nugent, SAMHSA/CSAT/DSI (ATTC Notice), 1 Choke Cherry Road, Room 5–1079, Rockville, MD 20857.

Electronic Access and Filing Address: You may submit comments by sending electronic mail (e-mail) to *cathy.nugent@samhsa.hhs.gov.*

Overview

The ATTC Network undertakes a broad range of initiatives that respond to emerging needs and issues in the substance use disorders treatment field. The ATTC Network is funded to upgrade the skills of existing practitioners and other health professionals and to disseminate the latest science to the treatment community. Resources are expended to create a variety of products and services that are timely and relevant to the many disciplines represented by the addiction treatment workforce.

Background

History

SAMHSA/CSAT funded 11 centers, which were known as the Addiction Training Centers (ATCs), in 1993. These ATCs covered 19 States and Puerto Rico. In 1995, SAMHSA expanded the program to cover six additional States, which brought the total number of States served to 25. In 1996, the program was renamed the Addiction Technology Transfer Center (ATTC) program. In 1998, a new round of cooperative agreements was funded and the ATTC network was expanded to include 13 Regional Centers and a National Office, serving 39 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. New cooperative agreements were funded in 2001 and 2002 for 14 ATTC Regional Centers and a National Office covering all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Islands. The funding announcements for the ATTC cooperative agreements awarded in 2001 and 2002 may be found on the SAMHSA Web site, *http://www.samhsa.gov*. Click on ''Grants'' at the top of the page and then on ''SAMHSA Grant Archives'' to find a listing of SAMHSA funding announcements for 2001 and 20021.

Purpose of the ATTCs

The primary purpose of the ATTCs is to enhance professional development by training the addiction treatment workforce to use evidence-based practices in providing treatment services and to train allied health professionals on the interdisciplinary foundation of addiction treatment, In 2001 and 2002, the ATTCs were tasked with the following:

- Building and maintaining collaborative networks with academic institutions, State and local governments, substance abuse/mental health/primary care fields, counselor credentialing boards, professional, recovery, community and faith-based organizations, managed care and criminal justice entities;
- Creating linkages with and disseminating research from the National Institute on Drug Abuse (NIDA, the National Institute of Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Mental Health (NIMH), SAMHSA, and other government agencies;
- Developing and updating state-of-the-art research-based curricula, including curricula based on new and revised Treatment Improvement Protocols (TIPs), and developing faculty and trainers;
- Enhancing the clinical and cultural competencies of professionals from a variety of disciplines to help individuals with substance abuse problems;
- Upgrading standards of professional practice for addictions workers;
- Serving as technical resources to community-based and faith-based organizations, consumers and recovery organizations, and other stakeholders; and
- Providing feedback from the field to SAMHSA regarding the development of a comprehensive agenda for learning about and applying state-of-the-art treatment approaches.

The ATTCs are currently organized as 14 Regional Centers and one national coordinating center (National ATTC Office—NATTC). This organizational structure was predicated on the belief that the ATTCs can more effectively advance the addiction field through a unified effort among a coordinated network of education and training centers than through a number of free-standing centers. The NATTC serves a coordinating function, building and maintaining a viable infrastructure that promotes internal and external communication among the ATTC Network and between the Network and its various audiences.

Core Priorities of the Current ATTCs

A major focus of he ATTCs has been on professional development and training the workforce in the adoption of evidence-based practices to improve the provision of treatment for substance use disorders. In addition to training substance use disorders counselors, the ATTCs have trained professionals from related disciplines including social workers, criminal justice workers, nurses, and other allied health professionals. The blending of science and service is particularly evident in the NIDA/SAMHSA Blending Research and Practice Initiative carried out by the ATTCs. Using evidence-based protocols developed by NIDA's Clinical Trials Network (CTN), teams from the CTN and the ATTCs work together to create toolkits and training material for dissemination to the field. This project exemplifies collaboration between research and practice and serves as an illustration of technology transfer.

Working with the International Coalition for Addiction Studies Education (INCASE), the ATTCs have promoted professional development activities for addictions educators. For example, they have conducted training for addictions educators and have disseminated ''curriculum infusion packages,'' resource materials on specific topics in addictions studies that educators can use to update their course materials. Several of the ATTCs provide pre-service training for individuals in academic settings preparing for a career as a substance use disorder professional. This training is provided both in classroom settings and through on-line courses.

With the continuing aging of the addiction treatment workforce, the need for emerging leaders has been well noted. The ATTCs have offered a leadership training program in each region to help prepare the next generation of leaders in the field. This intensive program pairs emerging leaders with mentors, thereby offering opportunities for ongoing dialogue and support.

In addition, many of the ATTCs have conducted workforce surveys in their respective regions that provide demographic, job satisfaction, training/educational, and retention and recruitment information. These surveys have been a vital source of data on workforce conditions and trends in the past several years, particularly in the absence of any national survey of the substance use disorders treatment workforce.

ATTCs also work to support the recovery community through educational programs, development of materials, collaboration on special initiatives and support of Recovery Month activities.

The NATTC serves a coordinating role for the ATTC Regional Centers and hosts a Web site that provides many important resources to the field, such as:

• Addiction Science Made Easy—a library of cutting-edge research articles taken from the Journal of Alcoholism: Clinical and Experimental Research and re-written in lay terms.
• Addiction ED—a catalogue of addiction-related distance education opportunities offered by organizations around the world.
• Certification Info—a listing of State, national and international licensing and credentialing information for alcohol and drug counselors.
• ATTC Publication Catalog—a directory of ATTC Network products and resources including curricula, videos, presenter materials, and trainings.
• Eye on the Field—a monthly electronic magazine which features important topics in substance abuse treatment and provides useful tools for practitioners and administrators.

The National Office has also hosted committees with representation from the regional ATTCs and experts from the field that have produced such products as the TAP 21 Addiction Counseling Competencies and The Change Book. These publications have been milestones in the addiction treatment field, helping set national competency standards and a process to adopt evidence-based practices respectively.

New Request for Applications

For FY 2007, SAMHSA will be issuing a new Request for Applications (RFA) for the ATTC program. The FY 2007 President's Budget requests approximately $8.1 million for the ATTCs, about the same funding level as the current program. At this time, SAMHSA does not anticipate changing the number of ATTCs from the current number (i.e., 14 Regional Centers and 1 national coordinating center); however, SAMHSA might consider changing the geographic areas each ATTC regional center covers. To assist SAMHSA in developing the RFA, SAMHSA is seeking input from stakeholders and interested parties on a number of issues relating to these cooperative agreements.

SAMHSA wants to explore how the ATTCs can provide more equitable access to ATTC services throughout the States. The current ATTC regions vary greatly in population, square miles covered, and number of treatment facilities within their borders. Therefore, SAMHSA is seeking comments on possible alternative regional configurations that may address some of these differences.

SAMSHA has researched the population, square miles covered, and number of treatment facilities in the current ATTC regions, as well as the regions used by CSAT's Division of State and Community Assistance (DSCA), the Department of Health and Human Services (DHHS) Public Health Service, and the DHHS Health Resources and Services Administration (HRSA) regions. This information is presented in the table below.

TABLE. 1.—REGIONS BY POPULATION, SQUARE MILES, AND TREATMENT FACILITIES

Entity	Number of regions	Range of population in the regions	Range of square miles in the regions	Range of treatment providers in the regions
Current ATTCs	* 14	3,809,000–45,154,000	5,330–830,670	199–2,747
DSCA	5	47,560,000–65,948,000	178,510–1,542,760	2,764–4,133
HHS	10	9,327,000–53,252,000	61,400–824,290	915–3,152
HRSA	11	9,987,000–47,241,000	56,070–971,540	386–2,938

* Plus a Coordinating Center.

The tables below give a state-by-state breakout for each of the four regional structures shown above.

Region	State
ATTC Regions	
New England	ME, NH, VT, MA, CT, RI.
Northeast	NY, NJ, PA.
Central East	DC, DE, KY, TN, MD.
Mid-Atlantic	VA, MD, NC, WV.
Southeast	GA, SC.
Southern Coast	AL, FL.
Caribbean Basin & Hispanic	PR, VI.
Great Lakes	IL, OH, WI, IN, MI.
Prairielands	IA, NE, ND, SD, MN.
Mid-America	MO, KS, OK, AR.
Gulf Coast	TX, LA, MS.
Pacific Southwest	CA, AZ, NM.
Mountain West	NV, MT, WY, UT, CO.
Northwest Frontier	AK, WA, OR, ID, HI, Pac. Isl.

Region	State
HHS Regions	
I	ME, NH, VT, MA, CT, RI.
II	NY, NJ, PR, VI.
III	MD, VA, WV, PA, DE, DC.
IV	AL, FL, GA, KY, MS, NC, SC, TN.
V	IL, IN, OH, MI, MN, WI.
VI	AR, LA, NM, OK, TX.
VII	IA, KS, MO, NE.
VIII	CO, MT, ND, SD, UT, WY.
IX	AZ, CA, HI, NV, Pac. Isl.
X	AK, ID, OR, WA.
DSCA Regions	
Northeast	ME, NH, VT, MA, CT, RI, NY, NJ, PA, DC, DE, MD.
Southeast	PR, VI, VA, WV, KY, TN, MS, AL, GA, SC, NC, FL.
Central	IA, ND, SD, MN, IL, OH, WI, IN, MI.
Southwest	NE, CO, KS, MO, AR, OK, NM, TX, LA.
Western	CA, MT, WY, NV, UT, AZ, AK, WA, OR, ID, HI, Pac. Isl.
HRSA Regions	
New England	ME, NH, VT, MA, CT, RI.
New York/New Jersey	NY, NJ.
Pennsylvania/Mid-Atlantic	PA, OH, WV, VA, MD, DC, DE.
Southeast	KY, TN, NC, SC, AL, GA.
Florida/Caribbean	PR, VI, FL.
Delta Region	AR, LA, MS.
Midwest	MN, WI, MI, IN, IL, IA, MO.
Oklahoma/Texas	OK, TX.
Mountain Plains	ND, SD, WY, UT, CO, NE, KS, NM.
Pacific	CA, NV, AZ.
Northwest	WA, ID, MT, OR.

In addition to the factors discussed above, there are a number of critical program priorities or cross-cutting principles affecting the addiction treatment field that need to be addressed by professionals providing services. SAMHSA is seeking guidance on whether it would be advisable to have the ATTCs house of Centers of Excellence on the critical priorities. The products and resources developed by these Centers of Excellence could then be disseminated throughout the ATTC Network and the field. This would avoid duplication of effort while addressing important clinical issues.

SAMHSA also seeks input from the field on what the ATTC priorities should be. In view of the pivotal role the ATTCs have played in bridging the gap between science and service, and in gathering data on the workforce, they are an integral component of SAMHSA's workforce development efforts. Recruitment and retention, leadership and management skills, and increasing the diversity of the workforce have been identified as key workforce issues. What role, if any, should the ATTCs have on these subjects?

SAMHSA funds the Centers for the Application of Prevention Technologies (CAPTs) through the Center for Substance Abuse Prevention. The CAPTs assist State/jurisdictions and community-based organizations in the application of evidence-based substance abuse prevention programs, practices, and policies. The CAPT system is a practical tool to increase the impact of the knowledge and experience that defines what works best in prevention programming. Because knowledge application is a prime focus of both the ATTCs and CAPTs, SAMHSA is seeking input on what the relationship should be between the ATTCs and the CAPTs.

Questions To Consider in Making Your Comments

SAMHSA/CSAT is seeking response to questions on a number of issues regarding the configuration of the ATTC regions, the areas of emphasis, and the relationship with CAPTs, including the following:

- What should be the major areas of emphasis for the ATTCs?
- How well do the current priorities and activities of the ATTCs meet the needs of the field? Are there some activities the ATTCs are currently undertaking that are no longer necessary? Are there activities related to workforce development or other topics the ATTCs should be doing that they are not currently doing?
- How should ATTC activities be coordinated with those of the CAPTs and other similar centers maintained by other Federal agencies?
- Who should be the primary audiences for/recipients of ATTC services?
- Should the ATTCs be organized around Centers for Excellence? If so, what topics should these Centers address?
- What should the role of the National ATTC Coordinating Center be?
- What types of services and products should the ATTCs provide?
- Should the ATTCs function primarily as independent regional centers or as a unified network collaborating to provide services and products to the field a large?
- How well does the current geographic configuration of the regional ATTCs meet the needs of the various constituents, including the States, providers, and practitioners?
- How well does the current geographic configuration of the ATTCs provide effective and equitable delivery of technology transfer services throughout the State?
- Are there alternative regional configurations for the ATTCs that could provide more equitable access to ATTC services throughout the Nation?

Dated: July 20, 2006.

Eric B. Broderick,

Acting Deputy Administrator, Assistant Surgeon General, Substance Abuse and Mental Health Services, Administration.

[FR Doc. 06–6500 Filed 7–26–06; 8:45 am]

BILLING CODE 4162–20–M

DEPARTMENT OF HOMELAND SECURITY

[Docket No. DHS–2006–0036]

System of Records

AGENCY: Office of the Secretary, DHS.

ACTION: System of records notice.

SUMMARY: The Department of Homeland Security is republishing the Privacy Act system of records notice for the Automated Biometric Identification System in order to expand its scope and authority to serve all or most programs that collect biometrics as part of their mission. As previously published, this system stored biometric information as a result of encounters pursuant to the Immigration and Nationality Act. As now proposed, this system will store biometric and limited biographic data collected for all national security, law enforcement, immigration, intelligence, and other mission-related functions.

DATES: Written comments must be submitted on or before August 28, 2006.

ADDRESSES: You may submit comments, identified by DOCKET NUMBER DHS–2006–0036 by one of the following methods:

- Federal e-Rulemaking Portal: *http://www.regulations.gov.* Follow the instructions for submitting comments.
- Fax: (202) 298–5201 (not a toll-free number).
- Mail: Steve Yonkers, US–VISIT Privacy Officer, 245 Murray Lane, SW., Washington, DC 20538; Maureen Cooney, Acting DHS Chief Privacy Officer, Department of Homeland Security, 601 S. 12th Street, Arlington, VA 22202–4220.

FOR FURTHER INFORMATION CONTACT: Steve Yonkers, US–VISIT Privacy Officer, 245 Murray Lane, SW., Washington, DC 20538, by telephone (202) 298–5200 or by facsimile (202) 298–5201.

SUPPLEMENTARY INFORMATION: In accordance with the Privacy Act of 1974, 5 U.S.C. 552a, the Department of Homeland Security (DHS) is publishing a revision to existing Privacy Act systems of records known as Enforcement Operational Immigration Records/Automated Biometric Identification System (ENFORCE/IDENT). The notice for these systems of records was last published in the **Federal Register** on March 20, 2006 (71 FR 13987).

ENFORCE is the primary administrative case management system for DHS' Bureau of Immigration and Customs Enforcement (ICE). IDENT is the primary repository of biometric information held by DHS in connection with its several and varied missions and functions, including, but not limited to: The enforcement of civil and criminal laws (including the immigration law); investigations, inquiries, and proceedings there under; and national security and intelligence activities. IDENT is a centralized and dynamic DHS-wide biometric database that also contains limited biographic and encounter history information needed to place the biometric information in proper context. The information is collected by, on behalf of, in support of, or in cooperation with DHS and its components and may contain personally identifiable information collected by other Federal, state, local, tribal, foreign, or international government agencies.

For business purposes ENFORCE and IDENT were operated jointly. Now, as a part of operational and technical restructuring these systems will be operated independently-IDENT under the management of US–VISIT and ENFORCE under the management of ICE. Consequently, the ENFORCE/IDENT system notice is being split into two system notices: one for ENFORCE and one for IDENT. Until a new notice is published by ICE, ENFORCE continues to operate under the system notice published March 20, 2006 (71 FR 13978).

In accordance with 5 U.S.C. 552a(r), DHS has provided a report of this system change to the Office of Management and Budget and to Congress.

DHS/2006–0036

SYSTEM NAME:

DHS Automated Biometric Identification System (IDENT).

SYSTEM LOCATION:

Department of Homeland Security (DHS).

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Categories of individuals covered by this notice consist of:

A. Individuals whose biometrics are collected by, on behalf of, in support of, or in cooperation with DHS concerning operations that implement and/or enforce laws, regulations, treaties, or orders related to the missions of DHS.

B. Individuals whose biometrics are collected by, on behalf of, in support of, or in cooperation with DHS as part of a background check or security screening connection with their hiring, retention, performance of a job function, or the issuance of a license or credential.

C. Individuals whose biometrics are collected by Federal, state, local, tribal, foreign, or international agencies for national security, law enforcement, immigration, intelligence, or other DHS mission-related functions, and who are the subjects of wants, warrants, or lookouts or any other subject of interest.

CATEGORIES OF RECORDS IN THE SYSTEM:

IDENT contains biometric, biographic, and encounter-related data for operation/production, testing, and training environments. Biometric data includes, but is not limited to, fingerprints and photographs. Biographical data includes, but is not limited to, name, date of birth, nationality, and other personal descriptive data. The encounter data provides the context of the interaction with an individual including, but not limited to, location, document numbers, and reason fingerprinted. Test data may be real or simulated biometric, biographic, or encounter related data.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

6 U.S.C. 202, 8 U.S.C. 1103, 1158, 1201, 1225, 1324, 1357, 1360, 1365a, 1365b, 1379, and 1732.

PURPOSE(S):

This system of records is established and maintained to enable DHS to carry out its assigned national security, law enforcement, immigration, intelligence and other DHS mission-related functions, and to provide associated testing, training, management reporting, planning and analysis, or other administrative uses by providing a DHS-wide repository of biometrics captured in DHS or law enforcement encounters.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, all or a portion of the records or information contained in this system may be disclosed outside DHS as a routine use pursuant to 5 U.S.C. 552a(b)(3), limited by privacy impact assessments, data sharing, or other agreements, as follows:

A. To appropriate Federal, state, local, tribal, foreign, or international Governmental agencies seeking information on the subjects of wants, warrants, or lookouts, or any other subject of interest, for purpose related to