requirements of Section 508 of the Rehabilitation Act to permit accessibility to people with disabilities.

From February 2022 to April 2022, the Organizer Survey—Initial will be completed by an estimated 500 Communities Talk activity organizers and will require only one response per respondent. It will take an average of 10 minutes (0.167 hours) to review the instructions and complete the survey. Similarly, from February 2023 to April 2023, the Organizer Survey—Follow-up will be completed by an estimated 500 Communities Talk activity organizers and will require only one response per respondent. It will take an average of 10 minutes (0.167 hours) to review the instructions and complete the survey. This burden estimate is based on comments from three 2019 Communities Talk activity organizers who reviewed the survey and provided comments on how long it would take them to complete it.

ESTIMATED ANNUALIZED BURDEN TABLE

Form name	Number of respondents	Responses per respondent	Total responses	Hours per response	Total hour burden
Organizer Survey—Initial	500	1	500	0.167	83.50
Organizer Survey—Follow-Up	500	1	500	0.167	83.50
Total	500		1,000		167.00

Send comments to Carlos Graham, SAMHSA Reports Clearance Officer, 5600 Fisher Lane, Room 15E57–A, Rockville, MD 20852 *OR* email him a copy at *carlos.graham@samhsa.hhs.gov.* Written comments should be received by March 21, 2022.

Carlos Graham,

Reports Clearance Officer.

[FR Doc. 2022–00860 Filed 1–18–22; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; 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 at (240) 276–0361.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will 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.

Project: Mental and Substance Use Disorders Prevalence Study (MDPS) Grant Funded by SAMHSA, Grant Number H79FG000030

SAMHSA is requesting from the Office of Management and Budget (OMB) approval to conduct recruitment activities and clinical interviews with household respondents and non-household facilities and respondents as part of the Mental and Substance Use Disorders Prevalence Study (MDPS) pilot program. Activities conducted will include: A household rostering and mental health screening of household participants and a clinical interview of both household and non-household participants. The information gathered by the clinical interview will be used to determine prevalence estimates of schizophrenia or schizoaffective disorder; bipolar I disorder; major depressive disorder; generalized anxiety disorder; posttraumatic stress disorder (PTSD); obsessive-compulsive disorder; anorexia nervosa; and alcohol, benzodiazepine, opioid, stimulant, and cannabis use disorders among U.S. adults ages 18 to 65 years.

Household Rostering

The household rostering includes inquiries about all adults ages 18 and older residing in the household, to assess eligibility for inclusion in the study, and then selecting up to two adults for the household mental health screening. The total number of household members and numbers of adults and children are first asked, followed by the first name, age and sex of all adult household members, as well as whether any adult in the household has had a serious medical condition. The best time to be interviewed is collected as well. The computerized roster can be completed online, by phone, on paper, or in-person. The target population is adults ages 18–65 residing in U.S. households; it is estimated that 45,000 household rosters will be completed. The primary objective of the household roster is to select up to two age-eligible participants for the mental health screening interview.

Household Mental Health Screening

The household mental health screening interview utilizes the Computerized Adaptive Testing for Mental Health Disorders (CAT–MH) or the World Health Organization's Composite International Diagnostic Interview (CIDI) instruments to assess symptoms related to the mental health and substance use disorders of interest, including schizophrenia or schizoaffective disorder; bipolar I disorder; major depressive disorder; generalized anxiety disorder; posttraumatic stress disorder (PTSD); obsessive-compulsive disorder; anorexia nervosa; and alcohol, benzodiazepine, opioid, stimulant, and cannabis use. The screening instrument also includes questions on treatment, receipt of Social Security Disability Income (SSDI), military experience, and exposure to and impact of COVID–19. The computerized mental health screening can be completed online, by phone, on paper or in-person. The primary objectives of the household mental health screening interview are to assess the symptoms endorsed and determine eligibility and selection for the MDPS pilot program clinical interview.

Clinical Interview

The MDPS pilot program clinical interview includes questions that assess the mental health and substance use disorders using the NetSCID, a computerized version of the Structured Clinical Interview for DSM–V (SCID). This instrument includes questions on symptoms and their duration and frequency for the disorders of interest. Also collected from respondents is demographic information, including sex, gender, age, education and employment status. Hospitalization and treatment history are asked as well as questions to assess exposure to COVID–19 of self or other close family members and the impact on mental health. Up to two adults per household will be selected to complete the clinical interview. Participants from the prisons, jails, homeless shelters and state psychiatric hospitals will complete the clinical interview as well. The computer-assisted personal interview (CAPI) is administered by a trained clinical interviewer, and can be conducted by video conference, such as Zoom or WebEx, phone or in person. Approximately 7,200 clinical interviews will be conducted as part of the MDPS pilot program. The primary objective of the clinical interview is to estimate the prevalence of the disorders of interest, including schizophrenia or schizoaffective disorder; bipolar I disorder; major depressive disorder; generalized anxiety disorder; posttraumatic stress disorder (PTSD); obsessive-compulsive disorder; anorexia nervosa; and alcohol, benzodiazepine, opioid, stimulant, and cannabis use, as well as unmet treatment needs.

Jail Mental Health Screening

The jail mental health screening interview utilizes the CIDI screening instruments to assess symptoms related to the primary mental health and substance use disorders of interest including schizophrenia or schizoaffective disorder; bipolar I disorder; major depressive disorder; generalized anxiety disorder; posttraumatic stress disorder (PTSD); obsessive-compulsive disorder; anorexia nervosa; and alcohol, benzodiazepine, opioid, stimulant, and cannabis use. The screening instrument also includes questions on treatment, receipt of Social Security Disability Income (SSDI), military experience, and exposure to and impact of COVID–19. The computerized mental health screening will be completed in person or by phone. The target population is a convenience sample of incarcerated 18–65-year-old adults, in up to six jails identified by the MDPS co-investigator team. Up to 208 mental health screening interviews will be conducted among incarcerated respondents. Respondents will be provided with a card that includes contact information and asked to contact the project personnel when they are released for inclusion in the household clinical interview sample. The primary objective of the jail mental health screening interview is to determine the feasibility of conducting mental health screening interviews within a jail population, as well as whether they would have been included in the household sample during the data collection period should they not have been incarcerated.

Facility Recruitment

Information packets will be sent to all selected prisons, state psychiatric hospitals, homeless shelters and jails including a letter of invitation, letters of support, an overview of the project and an overview of the data collection process in the facility. Facilities will be contacted by telephone, to answer any questions and provide additional information regarding the MDPS pilot program. Once approval is obtained, a logistics manager will contact the facility to provide instructions on the rostering and selection processes, to schedule the data collection visit, and to determine the appropriate space to conduct the interviews and the number of days and hours per day for data collection. Facilities will be asked to provide a roster (deidentified or identified) of eligible residents within one week of scheduling the data collection visit and again one-to-two weeks prior to the actual data collection visit (note: Data collection can be scheduled up to 4 months in advance). At the time of data collection, facility staff will assist with data collection activities including escorting selected inmates to and from the data collection area.

The primary objective of the MDPS pilot program is to examine methods to estimate the prevalence of specific mental illnesses, particularly adults with psychotic disorders and serious functional impairment, and treatment in both populations to answer two core research questions:

- What is the prevalence of schizophrenia/schizoaffective disorder (lifetime and past year), bipolar I disorder (past year), major depressive disorder (past year), generalized anxiety disorder (past year), posttraumatic stress disorder (past year), obsessive-compulsive disorder (past year), anorexia nervosa (past year), and alcohol, benzodiazepine, opioid, stimulant, and cannabis use disorders (past year) among adults, ages 18–65, in the United States?
- What proportion of adults in the United States with these disorders received treatment in the past year?

In addition to these research questions, the MDPS pilot program will allow for procedural evaluation to:

- Identify which set of screening instruments might be best to accurately identify mental and substance use disorders within the U.S. household population;
- Understand the best approaches to conducting data collection within non-household settings, to gather information on mental illness and treatment;
- Design protocols for collecting clinical interviews from proxy respondents; and
- Establish a protocol that can be used at a larger scale to understand the prevalence and burden of specific mental disorders in both non-household and household populations across the United States.

EXHIBIT 1—TOTAL ESTIMATED ANNUALIZED RESPONDENT BURDEN BY INSTRUMENT AND FACILITY RECRUITMENT

Activity	Total number of respondents	Number of responses per respondent	Total number of responses	Average hours per response	Average burden hours	Average hourly wage **	Total cost
Instrument:							
Household Rostering	45,000	1	45,000	0.13	5,850	$19.83	$116,006
Household contact attempts*	45,000	1	45,000	0.17	7,650	19.83	151,700
Household Screening	45,000	1	45,000	0.25	11,250	19.83	223,088
Screening contact attempts*	45,000	1	45,000	0.17	7,650	19.83	151,700
Clinical Interview (household and non-household)	7,200	1	7,200	1.40	10,080	19.83	199,886
Clinical Interview contact attempts*	7,200	1	7,200	0.25	1,800	19.83	35,694
Jail Screening Interview	208	1	208	0.33	69	19.83	1,369

EXHIBIT 1—TOTAL ESTIMATED ANNUALIZED RESPONDENT BURDEN BY INSTRUMENT AND FACILITY RECRUITMENT—Continued

Activity	Total number of respondents	Number of responses per respondent	Total number of responses	Average hours per response	Average burden hours	Average hourly wage**	Total cost
Jail Clinical Interview	63	1	63	1.40	88	19.83	1749
Sub-total Interviewing Estimates	.....	.....	.....	.....	44,437	.....	881,192
Facility Recruitment							
Information package review for facility administrators	58	1	58	0.75	43.5	25.09	1,091
Initial call with facility staff	58	1	58	1	58	25.09	1,455
Telephone call with facility staff to explain roster file process	58	1	58	2	116	25.09	2,910
Facility staff provides roster	58	4	232	2	464	25.09	11,642
Facility staff coordinates time and location for clinical interview administration	58	4	232	2	464	25.09	11,642
Sub-total Facility Recruitment Estimates	.....	.....	.....	.....	1,145.5	.....	28,740
Total	.....	.....	.....	.....	45,582.5	.....	909,932

*Contact attempts include the time spent reviewing all follow-up letters and study materials, including the respondent website, interactions with field and telephone interviewers, the consent process including asking questions regarding rights as a participant and receiving responses, and all other exchanges during the recruitment and interviewing processes.

**To compute total estimated annual cost for Interviewing, the total burden hours were multiplied by the average hourly wage for each adult participant, according to a Bureau of Labor Statistics (BLS) chart called ''Median usual weekly earnings of full-time wage and salary workers by educational attainment.'' (Median usual weekly earnings of full-time wage and salary workers by educational attainment (*bls.gov*)). We used the median salary for full-time employees over the age of 25 who are high school graduates with no college experience in the 2nd quarter of 2021 ($19.83 per hour). * For the Facility Recruitment, the total average burden assumes an average hourly rate of $25.09 for Community and Social Service Managers, given in the Bureau of Labor Statistic's Occupational Employment Statistics, May 2020.

Send comments to Carlos Graham, SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57–A, Rockville, Maryland 20857, *OR* email a copy to *Carlos.Graham@samhsa.hhs.gov.* Written comments should be received by March 21, 2022.

Carlos Graham,

Reports Clearance Officer.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–0361.

Project: Government Performance and Results Act (GPRA) Client/Participant Outcomes Measure—(OMB No. 0930–0208)—Revision

SAMHSA is requesting approval to modify its existing CSAT Client-level GPRA instrument by removing 48 questions and adding 42 questions for a net decrease of six questions. In revising the CSAT–GPRA tool, we sought to improve functionality while also eliciting programmatic information that demonstrates impact at the client level. In this way, data from the revised GPRA tool can be used to assess resource allocation and to delineate who we serve, how we serve them, and how the program impacts clients from entry to discharge. Beyond this, much of the tool has been restructured to make its administration flow with greater ease, while also eliciting information that speaks to a client's experience with substance misuse, the concurrent use of substances and mental health. This is most apparent in Section B (Substance Use and Planned Services), where questions have been updated and restructured to elicit important aspects of a client's use of substances, namely the frequency of use and combinations of misused substances. This speaks to an emerging and urgent need to appropriately manage polysubstance misuse,[1] and the questions allow for evidence of change as the tool is readministered at different intervals. These questions do not rely on ICD–10 codes, so as to create a dialogue between the client and the individual administering the tool. Restructuring the tool has also included:

- Placing many questions from the general GPRA Tool, that have previously been viewed as being specific to patient populations or grants, in the menu items found in Section H. This section allows Program Officers the opportunity to introduce grant specific questions as needed;
- Removing or substantially altering existing questions viewed as being potentially traumatizing or incentive to clients;
- Removing questions that have not been used in program evaluation at the federal level; and
- Incorporating evidence-based questions from tools such as the Addiction Severity Index to better address program performance.

Currently, the information collected from this instrument is entered and stored in SAMHSA's Performance Accountability and Reporting System, which is a real-time, performance management system that captures information on the substance abuse treatment and mental health services delivered in the United States. Continued approval of this information collection will allow SAMHSA to continue to meet Government Performance and Results Modernization Act of 2010 reporting requirements that quantify the effects and accomplishments of its discretionary grant programs, which are consistent with OMB guidance.

SAMHSA will use the data for annual reporting required by GPRA and comparing baseline with discharge and follow-up data. GPRA requires that

[1] Substance Abuse and Mental Health Services Administration (SAMHSA): Treating Concurrent Substance Use Among Adults. SAMHSA Publication No. PEP21–06–02–002. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.