

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Adults ages 18 or older	Screener for land-line users (pp. 3–8 of the NATS)	125,000	1	2/60
	Screener for cell phone users (pp. 9–11 of the NATS)	41,000	1	1/60
	National Adult Tobacco Survey for landline users (pp. 12–end of the NATS).	56,250	1	20/60
	National Adult Tobacco Survey for cell phone users (pp. 12–end of the NATS).	18,750	1	20/60

Kimberly S. Lane,

Deputy Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2012–11096 Filed 5–7–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–12–12JF]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–7570 and send comments to Kimberly Lane, at CDC, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to omb@cdc.gov.

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 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. Written comments should be received within 60 days of this notice.

Proposed Project

Returning our Veterans to Employment and Reintegration (ROVER)-New-National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

NIOSH, under Public Law 91–596, Sections 20 and 22 (Section 20–22, Occupational Safety and Health Act of 1970) has the responsibility to conduct research relating to innovative methods, techniques, and approaches dealing with occupational safety and health problems.

Reintegrating Post-9/11 Veterans into civilian life and employment is complicated by recent exposure to war zone stressors (e.g., combat, bombs, improvised explosive devices, injury and death of military personnel and civilians) and development of clinical disorders, such as posttraumatic stress disorder (PTSD) and depression. PTSD, for example, is typified by such symptoms as re-experiencing war zone stressors (e.g., distracting intrusive thoughts and images, disturbing nightmares); hyper-arousal (e.g., intense startle response, poor concentration and memory, constantly being on-guard, disturbed sleep, high irritability); and avoidance of people (family, friends, co-workers), places (such as enclosed areas, crowds), and things (e.g., loud noises, certain sights and smells) that remind one of war zone stressors. Such symptoms can have a significant impact on the ability of a Veteran to work in a setting with features such as other people, enclosed work areas, constant movement and noise, tasks that require concentration to details or safety issues, and stress related to requests and feedback of supervisors or task speed and accuracy. An approach for helping Veterans with PTSD and other psychiatric impairments is that of using service dogs for assistance and support.

Although there is significant interest in service dogs for Veterans to aid in readjustment, the focus has not been on

employment. Although a service-dog program “feels good” and has face validity, there is a resounding lack of empirical evidence documenting whether the provision of service dogs is of therapeutic benefit for persons with PTSD—other than the generally accepted positive effects of human-animal companionship. For example, a descriptive review of the pet-facilitated therapy (PFT) literature by Brodie and Biley (1999) presages a more substantive review by Nimer and Lundahl (2007) in finding multiple studies with poor research designs and other methodological problems that made it hard for those authors to draw firm conclusions. Even where studies focused on “psychological” outcomes, these tended to be self-report measures of such constructs as stress, relaxation, loneliness, and morale. Some impact on the behavior of children was noted; standard measures of clinical disorders (e.g., depression, anxiety) were not noted.

Nimar and Lundahl (2007) conducted a meta-analysis of the animal-assisted therapy (AAT) literature; that is, studies examining the incorporation of animals in treatment plans. Over 250 studies were located, but only 49 (20%) met the criteria of sufficient statistical information to estimate effect sizes. Most of the studies utilized dogs with children with behavior problems or developmental disorders, or adults with chronic mental disorders, such as dementia or schizophrenia. None of the studies specifically included Veterans, and none focused on the work setting (although several looked at animals as an adjunct to occupational therapy). The overall effect size for the impact of AAT was considered to be “moderate,” with no differential effects related to the population receiving AAT—a positive point when considering extending this work to Veterans. Most of the outcomes were focused on emotional well-being, but there were positive findings for an impact on behavioral problems (mostly with children). In general, the literature is problematic for the lack of

consistency in operationally defining AAT and its implementation, and the poor to absent research methodology.

The present research study will focus on the following questions.

1. Among assistance dog providers sampled in the U.S., how many provide services to Veterans?

2. Among assistance dog providers that provide services to Veterans, what are the specific strategies used or services offered to address issues related to Veterans and, specifically, return to work?

3. From the perspective of assistance dog providers, have the services or the requests for services to assist Veterans return to work increased, decreased, or remained the same during the past 5 years.

The purpose of the study is to increase available information about services provided to Veterans by assistance dog training organizations. Thus, the approach used in this study is descriptive. The survey will be primarily administered in a web-based format, but it will also be administered by mail or telephone for organizations unable to complete the web-based survey.

The information and the Internet link to the web-based survey will be sent by email to approximately 1000 organizations. This number of organizations is estimated on the basis of a partially completed Google search that already identified hundreds of assistance animal providers. On the basis of similar surveys of small

businesses or non-profit organizations, it is estimated that approximately 300 or 30% of the organizations contacted will complete the survey.

Results of this survey will lead to recommendations and guidance for assistance dog providers, healthcare professionals, researchers, and policymakers pertaining to animal-assisted interventions to help facilitate the reintegration and reemployment of Veterans. This survey is part of a larger project that will identify priorities and new opportunities for research, as well as address policy implications associated with public access rights afforded to service dogs by the Americans with Disabilities Act. There are no costs to respondents other than their time.

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Representatives of service dog provider agencies.	web-based survey	300	1	30/60	150
Total	150

Kimberly S. Lane,

Deputy Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2012-11085 Filed 5-7-12; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day 0920-12IW]

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Proposed Project

Fetal Alcohol Spectrum Disorders Regional Training Centers—New—National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

This program will collect program evaluation data from participants of trainings for medical and allied health students and practitioners regarding fetal alcohol spectrum disorders (FASDs) conducted by the FASD Regional Training Centers (RTCs)

through a cooperative agreement with the CDC.

Prenatal exposure to alcohol is a leading preventable cause of birth defects and developmental disabilities. The term fetal alcohol spectrum disorders (FASDs) describes the full continuum of effects that can occur in an individual exposed to alcohol in utero. These effects include physical, mental, behavioral, and learning disabilities. All of these effects have lifelong implications.

Health care professionals play a crucial role in identifying women at risk for an alcohol-exposed pregnancy and in identifying effects of prenatal alcohol exposure in individuals. However, despite the data regarding alcohol consumption among women of childbearing age and the estimated prevalence of FASDs, screening for alcohol use among female patients of childbearing age and screening for FASDs are not yet common standards of care. In addition, it is known from surveys of multiple provider types that although they might be familiar with the teratology and clinical presentation of FASDs, they report feeling less prepared to identify for referral or to diagnose a child and even less prepared to manage and coordinate the treatment of children with FASDs. Similarly, among obstetrician-gynecologists, although almost all report asking their patients