extended for an additional two years. The first year of the new cycle funding, fourth year of operation, will be funded with approximately $2,500,000 in federal funds. This is not a request for applications. The cooperative agreement will be awarded to the Pennsylvania Department of Health only upon receipt of a satisfactory application which is recommended for approval by an initial review committee and the CSAT National Advisory Council.

**AUTHORITY/JUSTIFICATION:** The competing continuation award will be made under the authority of Section 510(b)(5) of the Public Health Service Act, as amended (42 U.S.C. 290bb–3).

An award is being made on a single source basis in response to the Senate Committee on Appropriations report 103–318, accompanying HR 4606, which has language that states: ''Sufficient funding has been provided for CSAT to conduct an application cycle in fiscal year 1995 to extend from 3 to 5 years funding for the target cities grantee that was funded out of the normal funding cycle in fiscal year 1991.'' The report further states: ''The Committee expects the Center will maintain an application criteria that is consistent with and that meets the review standards and other requirements subject to target city applicants in fiscal year 1993.''

**BACKGROUND:** In fiscal year (FY) 1990, the Office for Treatment Improvement (CSAT's predecessor agency) initiated the Target Cities Cooperative Agreement Demonstration Program to assist major metropolitan areas with linking, integrating, and enhancing the components of their addiction treatment and health and human service systems in order to overcome the problems described below. In 1990, eight target cities were funded for a three-year period. On June 1, 1992 a ninth target city was funded in Philadelphia, Pennsylvania. In 1993 a review cycle for target cities applications was conducted by CSAT. In addition to new applications, each of the original eight cities was given an opportunity to compete for a fourth and fifth year of continuation funding. Because the Philadelphia target city was in its second year of implementation, it was not eligible in 1993 to compete for a fourth and fifth year of funding. In order to address this lack of opportunity, and in response to the Senate Committee on Appropriations report 103–318, referenced above, a competing continuation application is being requested from the State of Pennsylvania for the Philadelphia target city based on the guidelines provided in the 1993 Program Announcement No. AS 93–07.

Many areas of the United States could benefit from additional financial aid designed to improve access to high quality, effective addiction treatment and recovery programs and related health and human services. Some cities are facing demand for these resources in crisis proportions.

Epidemiological data indicate that individuals who live near or below the poverty line in large metropolitan areas tend to exhibit a high prevalence of alcohol and drug use and a concomitantly high incidence of addiction-related medical, psychological and socio-economic problems. Escalating incidence rates for HIV/AIDS, tuberculosis and sexually transmitted diseases in the metropolitan areas are closely linked to alcohol and drug use, as are homelessness, unemployment, crime and violence.

In most metropolitan communities, multiple factors have combined over time to diversify and fragment the components of the health and human services system rather than to integrate and facilitate the provisions of services and case processing alternatives for those who suffer from alcohol and drug problems. In almost all cases, jurisdictions with high demand for addiction treatment and recovery services have lacked sufficient resources for the enhancement or expansion of diagnostic, coordinated case management and evaluation efforts necessary to improve the effectiveness of the services infrastructure. Of great concern from a public health perspective, is that many addiction treatment and recovery programs do not have the resources or appropriate linkages with health care facilities to ensure that individuals with addictive disorders and their sexual partners are screened and treated for HIV, tuberculosis, and other infectious diseases.

In the context of complex and fragmented metropolitan systems of health and human service delivery, it is not likely that the needs of alcohol and drug-involved individuals and their families who live near or below the poverty line will be addressed in a cost-effective manner, for one or more of the following reasons:

(1) The system is not capable of concisely and comprehensively assessing individual and family needs.

(2) The existing infrastructure is designed to provide interventions on a discrete basis rather than to address the bio-psycho-socio-economic needs of the individual and family as part of a coordinated continuum.

(3) Individuals with alcohol and drug problems and their collaterals are not capable of effectively negotiating the complexities of a system composed of discrete, uncoordinated programs and are often unable to locate the treatment program(s) that best suits their needs.

(4) Individuals may be turned away from programs that lack the capacity to provide needed assistance, and may be unaware that there are other treatment alternatives available within or adjacent to the community in which they live.

(5) Individuals may be admitted to programs that are not capable of addressing their unique needs or are not designed to provide services in a cost-effective manner.

(6) Services may be delivered in a manner that is inconsistent with the current racial, ethnic, cultural, socio-economic and practical realities of the individuals and families who request assistance.

Since June 1992, the Philadelphia Target City Project has addressed many of the problems discussed above by directly enhancing the public drug and alcohol service system through eight inter-related components. These components are a central intake unit, a management information system, an enhanced case management system, provider staff enhancements, training and staff development, project evaluation, and two special initiatives. The special initiatives include a Labor Initiative component that is implemented through the Department of Labor's Job Training Partnership Act, and a CSAT Criminal Justice Initiative. The Labor Initiative provides vocational assessment, training and employment opportunities to individuals that have successfully completed treatment. The Criminal Justice Initiative provided funds for the development and implementation of a criminal justice management information system (MIS). This MIS has coordinated services and provided for the tracking of individuals through the Philadelphia treatment and criminal justice systems. The criminal justice MIS has provided for an effective system of early release from criminal justice institutions to treatment providers. These components provide patients access to treatment, standardized assessment, and appropriate referrals to an enhanced, integrated, and comprehensive treatment, medical and social service system. During the period of project implementation 4,000 individuals have been assessed for treatment services and 2,300 admissions to treatment have been accomplished. This single source award is planned to continue the development and implementation of a project that has