pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

The Center for Rural Pennsylvania
Public Hearing
Heroin Crisis Facing Pennsylvania

Current DDAP Initiatives Addressing Heroin and Other Opioid Abuse and Overdoses

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Introduction

The epidemic of drug and alcohol abuse is widespread, causing a crippling level of human suffering that directly impacts one out of four families in the Commonwealth and in our nation. At the level of state government, the impact of untreated addiction reaches across most Commonwealth agencies, significantly driving up their costs and undermining their efforts to achieve their missions. We know that our responsibility under Act 50 of 2010 – to streamline, to coordinate and to ensure that we have the strongest possible drug prevention and treatment efforts across state government so that we're getting the greatest positive impact for our investment – is a formidable one. We are acutely aware of how high the stakes truly are.

You only have to open a newspaper, watch the news or glance through the obituaries that announce the untimely deaths of so many of our young people to understand why the words - epidemic and crisis - are used so regularly in connection with the word "overdose". The Department of Drug and Alcohol Programs (DDAP) is a small agency with a monumental task to reduce the number of overdoses that unfortunately lead to so many parents getting the life shattering phone call that no parent should ever get – telling them that their child has died of an overdose. DDAP's work is a matter of life and death every day for PA families and we know it has to be our most urgent priority. We also know that prescription opioid abuse has been escalating dramatically and we are convinced that the very recent increase in heroin use is directly related to prescription opioid abuse epidemic; individuals addicted to prescription opioids are transitioning to heroin use.

Heroin is a Schedule I narcotic, and users quickly develop a tolerance to the drug. In 2011, the National Institutes on Drug Abuse (NIDA) estimated that 4.2 million Americans age 12 or older had used heroin at least once in their lives. Heroin is associated with a number of serious health concerns, including fatal overdose, and infectious diseases such as hepatitis and HIV. Prescription opioid pain medications such as Oxycontin and Vicodin can have effects similar to heroin when taken in doses or in ways other than prescribed, and they are currently among the most commonly abused drugs in the United States. And, as stated, NIDA research shows that abuse of these drugs too often opens the door to heroin abuse and addiction because heroin can be cheaper and easier to obtain than prescription opioids.

The data from 2012 and later are preliminary; however, there clearly seems to be a strong, recent trend upward in heroin use since 2011. The federal Substance Abuse and Mental Health Services Association (SAMHSA) also reports that there has been a *doubling* of the number of heroin users between 2007 and 2012 (SAMHSA, 2012). Among a sample of misusers of prescription drugs who used heroin, 82% started with prescription drugs before transitioning to heroin (2013). Anecdotally, we are hearing from all over the state that heroin use is on the rise among our youth, often in communities that have not experienced heroin at such levels before.

We cherish and value our young people and we cannot wait for the data to catch up before we respond to this problem. For this reason, we have launched or are supporting the following.

Overdose Response

1. Overdose Rapid Response Task Force (ORRTF): A DDAP-convened Task Force, comprised of a wide range of federal, state and local stakeholder representatives includes, but is not limited to: Office of the Governor, Attorney General's Office, PA Coroner's Association, Drug and Alcohol Service Providers Organization of PA, United States Drug Enforcement Administration, PA Department of Health, PA Department of Public Welfare, Capitol Police/PA State Police, PA Association of County Drug and Alcohol Administrators, PA Association for the Treatment of Opioid Dependence, PA District Attorneys Association, Philadelphia/Camden High Intensity Drug Trafficking Areas, as well as representatives from the federal Substance Abuse and Mental Health Administration.

This Task Force was originally convened last summer in response to a possible upsurge in the use of Fentanyl laced heroin (a problem which has just resurfaced in western PA last month). The initial meeting of the task force occurred on July 22, 2013 and has met regularly since then. The general consensus of the group from the outset was that rather than focus on one particular substance of abuse, overdose *in general* should be the focus; therefore, the objectives of the Task Force are as follows:

- Determine particular overdose trends as a proactive/preventative measure;
- Determine what avenues can be established to communicate trends between different disciplines and state agencies (law enforcement, coroners, healthcare, treatment);
- Determine cross-system collaborative efforts between law enforcement, health and substance abuse providers for addressing identified trends/issues in a more robust fashion;
- Avert an upsurge in use of a particular trending substance;
- Prevent overdose deaths.

There are five workgroups that have been established and tasked with achieving particular objectives:

- **Coroners Workgroup**: In addition to Methadone related deaths, coroners have agreed to report on all overdose deaths. A *uniform* report form to submit all types of overdose deaths has been finalized and reporting has commenced.
- **Health Department Epidemiologic Workgroup**: This group is tasked with considering existing reporting systems from which overdose reporting information can best be obtained/reported that will potentially alert stakeholders of potential incidences requiring action. This information will be identified through overdose trends, visits to Emergency Departments, Emergency Medical Services, and reports to the Poison Control Centers. The DOH Workgroup was also assigned with informing the Task Force regarding PA's standards for the administration of naloxone by emergency medical services. It is standard protocol for all ambulance companies to use naloxone in the case of overdose.
- **Treatment/Warm Hand-off Workgroup**: The primary emphasis of this workgroup is to make sure that survivors of overdose receive immediate hand-offs to appropriate drug and alcohol services once they have been medically stabilized. An Overdose Policy Bulletin has been established and distributed to the county drug and alcohol

directors (SCAs) via DDAP indicating that each county office must have a policy for dealing with overdose; overdose victims *must be a priority* for treatment assessment and SCAs must also send a list of assessment sites to emergency healthcare providers. Ongoing considerations of this workgroup include the use of Screening, Brief Intervention and Referral to Treatment (SBIRT), inclusion of drug and alcohol recovery support services in medical assistance reimbursement, Good Samaritan Legislation, etc.

- **Information Sharing Workgroup**: This work group is addressing possible avenues that information pertinent to overdose prevention and response, use trends, etc. can be disseminated to stakeholders throughout the state (DDAP, DOH, SCAs, treatment providers, law enforcement, etc.) in a way that is timely, accurate and accessible. Pennsylvania State Police are establishing a Homeland Security Information Network portal that will contain a location to post reports, requests for information, collaborations, etc. Participants having access to this portal (Task Force members and potentially other identified stakeholders) will be invited and vetted through the Department of Homeland Security representative. Information shared within this portal will then have the potential to be shared with other stakeholders across the state as necessary and appropriate.
- **Naloxone Workgroup:** This workgroup has begun its review of overdose prevention, response strategies and legislation being utilized in other states. This includes Good Samaritan legislation and increased access to naloxone; this workgroup has made preliminary recommendations to the ORRFT regarding both of these issues and discussion is ongoing.

This Task Force is a groundbreaking initiative that is gaining interest from other states and local jurisdictions interested in creating similar multi-disciplinary overdose task forces in their area. In our state, this is the first time that all of the entities involved with overdose issues have come together to develop a unified approach to preventing and addressing overdose. This task force includes representation from national, state and local interests. Preliminary information sharing has begun regarding alerts, federal, state, and local initiatives, etc. with more effective, system-wide information sharing being a goal of the task force. SAMHSA (DDAP's federal agency) is reviewing the ODRRTF program to see if it can be replicated as a national model.

2. **Naloxone:** In addition to supporting legislation enabling third party prescribing, and distribution of naloxone to police departments, all emergency responders, and others well-positioned to save lives with this medication, a letter has been sent to all methadone providers encouraging them to have their doctors co-prescribe naloxone with the methadone. Since these individuals are at high risk of overdose if they relapse or if they combine methadone with other medications such as benzodiazepines, this should have some immediate impact.

3. **Methadone Death and Incident Review (MDAIR):** An unacceptable number of individuals are dying of methadone overdoses, or overdoses of drug combinations of methadone, benzodiazepines, and/or illegal drugs. As a result, even before the passage of Act 148 of 2012 – we proceeded to begin establishing an *internal* (DDAP and two DPW Medical Directors) methadone death review team to begin looking at methadone-related deaths and serious incidents to see what we could do to make methadone practice safer and more successful in helping more individuals attain drug-free recovery.

A few months after that internal team began working, the General Assembly enacted, and Governor Corbett signed, Act 148 in October, 2012. Act 148 established a much larger, diverse MDAIR Team to review each death where methadone was either the primary or contributing factor in the cause of death and to review all methadone related incidents (unreasonable risk of serious bodily harm or death).

The MDAIR Team has undertaken the responsibility of determining the role that methadone played in each death or incident; communicating concerns to regulators and to the General Assembly; facilitating communication within the health care and legal systems; and developing best practices to prevent future methadone related deaths and incidents. In addition, committee is tasked with making recommendations to elected officials in efforts to decrease the occurrence methadone deaths and serious incidences.

The Act also requires that an annual MDAIR Report be prepared detailing information, supporting data, and recommendations. Our final draft of the 2013 Report is about to be sent to the General Assembly, pursuant to Act 148.

Healthcare Practices

1. Safe and Effective Opioid Prescribing Practices and Pain Management Task Force: Secretary Gary Tennis and Physician General Carrie DeLone, founded and co-chaired this initiative with the purpose of reducing prescription drug abuse and overdoses, while maintaining effective pain management. The Task Force includes representation from most medical fields, as well as their professional associations and regulatory agencies.

After two long meetings in December, 2013 and April, 2014, this Task Force has adopted the Pennsylvania Opioid Prescribing Guidelines (attached), designed primarily for primary care physicians, nurse-practitioners, physicians' assistant, and to the extent appropriate, pain doctors. These Guidelines have been considered and endorsed by the PA Medical Society and the Pennsylvania Family Physicians, and we expect endorsement from other major health care practitioners' associations.

This group's next step is to adopt guidelines that are appropriate for use in our hospital emergency departments. PaMED has adopted guidelines recommended by **the** Pennsylvania Chapter the American College of Emergency Physicians (PACEP). The Task Force will consider these emergency room guidelines at its next meeting in July.

After that, the next step is to explore the ways that the stakeholders at the table (representing various state Departments and private organizations) can most effectively promote those practices.

Another goal of this group is to ensure not only that prescribers and dispensers are not only trained in best pain medicine practices, but that they also are trained in identifying drug abuse and addiction problems in their patients, and that they know where to refer them for treatment. At a minimum, prescribers and dispensers should have training in SBIRT (screening, brief intervention, referral to treatment), an evidence-based practice proving to be effective in reducing alcohol abuse and showing great promise with respect to drug abuse as well.

2. Prescription Drug Monitoring Program (PDMP): The Corbett Administration supports the General Assembly's efforts to enact a strong and effective PDMP legislation which, once enacted and implemented, will be a historic step forward for Pennsylvania to reign in prescription drug abuse. This legislation will enable doctors to identify drug-seeking doctor-shoppers and, if properly crafted, will provide the intervention that is appropriate – treatment for the addicted patient or impaired health care professional, and criminal justice sanctions for the profit-seeking prescription drug dealer. It will also enable the PDMP administrators to identify and conduct appropriate interventions by providing for further training for prescribers and dispensers who inadvertently are prescribing and dispensing at inappropriate levels.

This kind of program has proven to be effective in other states; by reducing the number of individuals getting addicted to prescription opioids, it will reduce the number who then transition to heroin use. We expect, similar to other states where a PDMP was enacted, that there may be a

temporary spike in the demand for treatment related to individuals being cut off from other prescription opioid use/abuse. However, the long-term effect of empowering health care providers to identify doctor-shoppers - so they can stop prescribing drugs that feed their patients' addiction - and then assess and refer them to treatment - is enormously positive. This program will result in a significant and permanent reduction in the level of prescription drug addiction in our communities. In turn, this will lead to similar reductions in the level of addiction to and overdoses from both prescription opioids and heroin.

We anticipate that much of the resources needed to address this temporary spike in demand for treatment by those addicted to opioids, will be addressed by Governor Corbett's HealthyPA proposal. Under HealthyPA, any income-eligible (under 133% of poverty level) individuals who are uninsured and who show up with a drug and alcohol problem, will be eligible for Medicaid along with its robust treatment benefit pursuant to Act 152. If accepted by the federal government, HealthyPA will constitute yet another historic step forward toward expanding and strengthening our response to drug and alcohol abuse in Pennsylvania.

Tamper-Resistant Opioids: Oxycontin and other opioid abuse began dropping for the first time in years when their producers began producing them in tamper-resistant form. But their patents are running out, and the FDA has been having to decide whether it will require the generic prescription opioid makers to also use tamper-resistant technology. We have written, and have urged the National Association of State Drug and Alcohol Directors to write, the FDA to strongly request that the FDA require tamper-resistant technology for the generic opioids as well. While only one piece of a multi-faceted response to prescription drug abuse, this is an important one that will also lead to less drug abuse and unnecessary loss of life.

Best Practices in Prevention, Education and Outreach

1. LifeSkills Training - DDAP/PCCD/PDE Collaboration: In 2013, DDAP worked closely with the Pennsylvania Commission on Crime & Delinquency (PCCD) and the Pennsylvania Department of Education (PDE) to increase the implementation of the LifeSkills program in Commonwealth schools. This evidence based prevention program has demonstrated outcomes in reducing a range of high risk behaviors among 6th, 7th and 8th graders: 75% reduction in marijuana use; 66% reduction in other drug use; 60% reduction in alcohol use; and 87% reduction in tobacco use. Last year, we contacted every school superintendent in the Commonwealth to offer this program for free (paid for by University of Colorado *Blueprints*): Fifty out of 500 school districts took us up on it and added LifeSkillsTraining at no cost.

2. Pennsylvania Youth Survey (PAYS): DDAP has been working closely with PCCD and PDE to provide funding and support to increase the implementation of the PAYS. This expanded survey will be implemented in the current school year and will provide an update on current trends in substance use and risk factors among Pennsylvania youth. The PAYS provides school districts and DDAP an important baseline from which to measure trends and evaluate the success or failure of the drug and alcohol prevention programming being offered.

Coordination with Criminal Justice System

Leveraging more federal resources for treatment for county jail releasees – DDAP/DPW/ County Stakeholders: Under Pennsylvania's Act 152, clinically appropriate treatment is available for those on Medicaid who need such treatment. When an eligible individual applies under the Medical Assistance (MA) Health Choices managed care program, there is roughly a 60% federal match to help pay for that treatment. But it can take several weeks after an individual is initially MA eligible to actually get the person enrolled in Health Choices. During that "gap' time period between their signing up and actually being placed on the Health Choices rolls, state taxpayers are paying for treatment the individual receives with 100% state dollars.

This is particularly problematic for those who are coming out of county jail or state prison. With roughly 70% of those in our prisons and county jails having untreated substance abuse problems, their prospects for reintegrating as a law-abiding and productive taxpaying citizen very much hinge on getting them the clinically-appropriate treatment they need to win recovery from their abuse and addiction problems. But in Pennsylvania, those who are incarcerated have their medical assistance terminated rather than merely suspended (as in some other states). Upon their release they are again eligible for Health Choices but, again, it can take up to six weeks to process that application. Meanwhile, nothing good can come from this processing gap; the offenders (1) are not paroled – greatly increasing our costs for incarceration, (2) are out on the street not getting treatment and, as a result at *very* high risk of re-offending, or (3) are getting treatment paid for by 100% state dollars (thus using up scarce treatment resources) instead of the 60% federally-matched Health Choices dollars.

The Department of Public Welfare (DPW) and DDAP have collaborated to work, county-by-county to eliminate this unnecessary delay. We are facilitating a *new* procedure where the county stakeholders (judiciary, county drug and alcohol office, county jails, etc.) work with their DPW County Administrative Office to handle all of the medical assistance eligibility processing *before* the individual is released from prison or jail. By doing so for those eligible, Health Choices can be turned on *at the time of release,* and the addicted parolee can be transported directly from county jail into clinically-appropriate drug and alcohol treatment, paid for by federally-matched funding. This has been an outstanding collaboration between DDAP and DPW; by leveraging more drug and alcohol treatment with federally-matched dollars, the people of Pennsylvania realize several significant benefits:

1) State dollars that were spent for this "gap" period for parolees will become freed to meet currently unmet treatment needs for those suffering from addiction who are not in the criminal justice system. You shouldn't have to commit a crime to get treatment, and this change will increase our ability to treat those who haven't gotten caught up in the criminal justice system;

2) It will enable us to parole more promptly those whose parole is conditioned (properly) on getting residential drug and alcohol treatment. Given that some 70% to 80% of offenders have serious substance abuse problems, this will have a significant impact on prison and county jail costs across the Commonwealth.

3) It will make our communities much safer from crime. By providing these parolees with addiction the treatment they need, we know from an overwhelming body of research that re-offending rates by those who get clinically-matched treatment are reduced by two-thirds.
4) It will save taxpayers money. We know that every dollar invested in treatment results in a seven dollar savings to taxpayers, primarily in reduced criminal justice costs, but also in reduced hospital, motor vehicle, workplace, children and youth, domestic violence, welfare and other costs. This continued collaboration with DPW to leverage additional treatment dollars is evident in the success of the next highlighted initiative.

As a result, the following counties implemented pilots over the past fourteen months:

Armstrong & Clarion:	Commenced December 2012
Lycoming & Indiana:	March, 2013
Berks:	August, 2013
Clinton:	December, 2013
Dauphin:	January, 2014.

The preliminary results of these pilots are very encouraging, resulting in reduced adverse impact on SCA funding (freeing more funds for community level treatment) and reduced costs to jails and prisons by diverting offenders into treatment, rather than criminal justice beds. With seven pilot counties in operation, there have been a total of several hundred referrals to date with a remarkable 90% rate of completing treatment.

We are working closely with DPW to take this project statewide by the end of the calendar year.

Leveraging more federal resources for treatment for state prison releasees - DDAP/DPW/ DOC/State Board of Probation and Parole: DDAP is also working with the above stakeholders to commence the above project with DOC inmates. Our initial pilot, targeting those being released from Graterford Prison to Bucks, Chester, Delaware and Montgomery Counties, did not identify released offenders appropriate for treatment. We are working to identify a pilot with a larger number of eligible DOC inmates being released.

Pre-Trial Diversion – DPW/PCCD/DPW/County Stakeholders Collaboration: A PCCD study about to be released will show that the Restrictive Intermediate Punishment (RIP) treatment diversion program is highly effective, resulting in a remarkably low 13.9 percent recidivism rate, measured at 12 months after completion of RIP. However, rather than wait until sentencing to begin treatment for Level 3 (RIP-eligible) offenders, this pilot proposes to assess and divert addicted offenders to treatment pre-trial. The pilot would also encourage inclusion of Level 4 offenders, which would result in a more substantial long-term impact on DOC populations, as well as even greater increased public safety. These individuals would be assessed between preliminary arraignment and preliminary hearing, and would be diverted out of jail and into treatment at the time of, or shortly after, the preliminary hearing. Diverting to treatment shortly after arrest has six powerful over waiting until sentencing:

1. **Amenability to treatment.** Addicted individuals are more clinically receptive to treatment at the time of arrest because they are more acutely experiencing the unmanageability of their lives.
2. **Greater external leverage ensuring treatment retention and engagement.** The individual is also more likely to constructively engage in treatment, because the result of their upcoming plea negotiations and sentencing depends on their doing so. Research shows that powerful external incentives increase successful treatment outcomes.
3. **The individual is less "hardened" by exposure to other inmates in the county jail.**
4. **More individuals will participate in treatment diversion if it starts after arrest.** On the other hand, if the accused have served several months pre-trial in county jail, they often can plead to "time-served" and be released immediately to the street. Such individuals more likely than not will refuse treatment.
5. **District Attorneys and Judges have solid information about the individuals amenability to treatment, to guide their plea negotiation and sentencing decisions.** As a result, District Attorneys and judges have indicated that they would be more amenable to treatment diversion sentences if they know the individuals have been successfully engaging in treatment for several months. They no longer have to "fly blind" when agreeing to such a sentence.
6. **Counties have the potential to reap enormous savings in county jail costs.** Offenders who are diverted shortly after arrest to treatment will not be taking up a county jail bed during the months between preliminary hearing and final disposition. Once enough offenders are diverted to justify a reduction in infrastructure, the savings can be substantial and can be used to help pay for the treatment. Moreover, expedited enrollment in Medicaid Health Choices can result in even greater savings to the county (and ultimately, to the state).

Union County Pre-trial Diversion: The infrastructure reduction threshold stated in the above paragraph is not necessary in any county that is paying a *per diem cost* to other counties to house their inmates. Union County Commissioners, who are paying surrounding counties $72/day to house about 25 prisoners on any given day, have pledged immediate savings from post-arrest diversion, to help pay for their treatment. After two half-day DDAP meetings in late January with the President Judge and Drug Court Judge, the County Commissioners, the District Attorney, the defense bar, the county drug and alcohol director, and County Probation and Parole, and other stakeholders, the President Judge issued a judicial order effective January 29, 2014, implementing the pre-trial project immediately.

Lackawanna/Luzerne/Wayne/Wyoming Pre-Trial Diversion: In Governor Corbett's budget proposal is a request for funds for PCCD, in collaboration with DDAP, to launch the same kind of pre-trial project in four northeastern Pennsylvania counties. Because inmates there are *not* being housed out-of-county, there is *no* immediate cost-offset to the counties. Our projections show that by the second year of this project, however, counties will in fact realize sufficient county jail savings to fund this pre-trial diversion project going forward. Lackawanna Drug Court Judge Michael Barrasse, formerly the President of the National Drug Court Judges Association, is organizing the four-county judiciary for this project.

Access to Treatment

Introduction: Nationally, funding currently exists to pay for treatment for about 11% of addicted Americans in need of such treatment. Due to strong insurance laws (Act 106 and Act 152), Pennsylvania is able to do a little better, but still drug and alcohol addiction remains the one disease for which, for the most part, we do not provide funding to treat with clinical integrity. This national public policy failure is extraordinarily costly, both in terms of suffering to the one in four families dealing with addiction in the family, and in terms of cost (70% of our jail and prison populations committed their crimes while addicted to drugs/ alcohol).

Most of the initiatives in the above section, in addition to creating greater coordination between the criminal justice and addiction treatment systems, also have the impact of increasing access to treatment by pulling in increased federal resources. But more needs to be done.

Regulatory relief: a more streamlined, rational regulatory process. DDAP has begun and is continuing its comprehensive review with a goal toward the updating and streamlining of licensure and regulatory requirements that govern DDAP-licensed treatment providers. These outmoded and cumbersome regulations have not been updated in nearly three decades. This reform will enhance client health, safety, and positive treatment outcomes; in addition, it will to enable treatment programs to shift staff resources from nonproductive administrative functions to actually providing treatment. While this doesn't add to the resources being provided to treatment, it does permit more of those resources to *actually be used on treatment,* which in many ways can be equivalent to increased resources.

DDAP partnered with stakeholders and the Governor's office and has proposed changes to the General Standards For Free-Standing Treatment Facilities, which apply to over 80% of licensed treatment facilities. The proposed changes are currently in the formal Independent Regulatory Review (IRRC) process. They have been published in the Pennsylvania Bulletin in the near future. We are optimistic about IRRC finalization and publishing of the initial round of regulation review. When that is complete, DDAP will begin the same process to look at recommended changes in the Treatment Standards for the various treatment types (inpatient hospital and non-hospital, outpatient, detox, etc).

In the second stage of its Licensure Reform Initiative, DDAP will also be reviewing cumbersome and outdated internal policies and procedures within the Program Licensure. In both of those areas, we are collaborating with stakeholders to identify ways to reduce redundancy in regulatory and public payer oversight – so that treatment programs don't have different agencies doing extensive and redundant inspections of the same components each year. In the second decade of the 21st century, there is simply no good reason that regulators and payors cannot combine and streamline their efforts so that redundancy is eliminated altogether.

Again, these efficiencies will allow us to shift our resources to the more important job of working with our system to: (i) get more people with drug and alcohol addictions into recovery,

(ii) keep more of our citizens from contracting the disease of addiction, and (iii) make sure our taxpayers' hard-earned money is invested to greatest effect. By doing our job well, we make sure that dollars invested in drug and alcohol programming reduce several-fold the fiscal demands faced by our larger Departments.

HealthyPA and Expanded Access to Drug and Alcohol Treatment: Governor Corbett's HealthyPA proposal will provide Pennsylvania's robust drug and alcohol treatment insurance benefit to many thousands of currently uninsured Pennsylvanians who now lack health insurance, by enabling them to become insured for the first time. In addition, citizens who fall under 133% of poverty level, who are diagnosed with a drug or alcohol addiction for the most part will be deemed medically frail and be eligible for Medicaid. This expansion in access to treatment will help address the treatment needs of those currently addicted who previously did not have coverage for treatment. HealthyPA certainly strengthens Pennsylvania's ability to meet the substance abuse treatment needs of our citizens.

Conclusion: The Department of Drug and Alcohol Programs has a vision of a Pennsylvania where drug and alcohol addiction exists at a small fraction of the level that it does today. As a result of ensuring that our prevention programs are robust, well-resourced and evidence-based, and that all Pennsylvanians struggling with the disease of drug and alcohol addiction can get the level and duration of treatment and recovery supports they need, the Pennsylvania of the future will look quite different than anything we have seen before. As someone who has spent his life trying to make our criminal justice system work well, I am convinced that our future is a bright one in which crime rates are less than half of what we have seen throughout our lifetime, we need only half the number of prison and jail cells we use today, we've dramatically reduced the number of Pennsylvania's children who go to bed at night afraid of their own parents getting drunk or high and then becoming abusive or seriously neglectful. We envision a future where Commonwealth's resources, now spent on addressing the costly consequences of untreated addiction, (crime, domestic violence, car crashes, workplace theft, absenteeism and accidents, etc.) are freed up for more positive programs for our citizens.

The work of the Governor's Heroin and Other Opioid Abuse & Overdose Work Group is an important next step toward that vision; by expanding the number of Pennsylvanians who have access to drug and alcohol addiction treatment and prevention services, they focus on innovative and collaborative ideas that will not only bring the commonwealth savings, but will provide for a healthier, safer and more prosperous Pennsylvania.