

**THE ROLE OF FEDERAL HOUSING AND
COMMUNITY DEVELOPMENT PROGRAMS
TO SUPPORT OPIOID AND SUBSTANCE
USE DISORDER TREATMENT AND RECOVERY**

HEARING
BEFORE THE
SUBCOMMITTEE ON
HOUSING AND INSURANCE
OF THE
COMMITTEE ON FINANCIAL SERVICES
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
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**THE ROLE OF FEDERAL HOUSING AND
COMMUNITY DEVELOPMENT PROGRAMS TO
SUPPORT OPIOID AND SUBSTANCE USE
DISORDER TREATMENT AND RECOVERY**

Thursday, August 16, 2018

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOUSING
AND INSURANCE,
COMMITTEE ON FINANCIAL SERVICES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:10 a.m., in Courtroom A, U.S. District Court of the Eastern District of Kentucky, 101 Barr Street, Lexington, Kentucky, Hon. Sean P. Duffy presiding.

Present: Representative Duffy
[presiding].

Also present: Representatives Barr and Guthrie.

Mr. DUFFY. The Subcommittee on Housing and Insurance will come to order. Today's hearing is entitled, "The Role of Federal Housing and Community Development Programs to Support Opioid and Substance Use Disorder Treatment and Recovery." Without objection, the Chair is authorized to declare a recess of the Subcommittee at any time. Without objection, all Members will have 5 legislative days within which to submit extraneous materials to the Chair for inclusion in the record. Without objection, Members who are not Members of this Subcommittee may participate in today's hearing for the purpose of making an opening statement and questioning the witnesses.

The Chair now recognizes himself for an opening statement.

I want to thank our witnesses for joining us as we continue to look at how existing Federal Government programs can be utilized to combat opioid addiction and substance abuse. Today, we will be focused on programs run by HUD (U.S. Department of Housing and Urban Development) that help low-income families and the poverty stricken.

I want to thank Mr. Barr for hosting us in the fine city of Lexington and commend his leadership on the issue of opioid addiction and substance abuse, something that impacts the entire Nation. This crisis is not going away and it is only getting worse in some areas of our country. According to a 2016 report by the U.S. Surgeon General, 1 in 7 Americans will face substance addiction.

Opioids are now at the forefront of the fight against substance abuse.

On March 29 of last year President Trump signed an Executive Order to establish the President's Commission on Combating Drug Addiction and the Opioid Crisis and the House began its work by moving legislation. We have passed 50 bills related to addressing the opioid crisis ranging from treatment and recovery, to prevention, to the THRIVE (Transitional Housing for Recovery in Viable Environments) Act, championed by Chairman Barr.

Mr. Barr's bill recognizes that sometimes you have to use resources outside of traditional rehab programs to treat addicts and help them prepare for becoming a productive member of society.

The THRIVE Act would create a program setting aside 10,000 housing choice vouchers for individuals suffering from addiction. Those people would be able to use vouchers with transitional housing nonprofits that focus on maintaining sobriety, teaching valuable skills for jobs, and obtaining employment as they transition back into society. They'll have 24 months to complete the treatment program but most importantly are able to do so in a drug- and alcohol-free, clean, safe, and supportive structured environment.

I know some of you will be commenting on how this bill would work in implementation but Mr. Barr's bill is just one idea. You are the ones out there dealing with this through your organizations.

We want to hear your ideas.

Mr. King, you mention in your testimony needing the flexibility to meet specific needs at the local level by addressing the 20 percent limitation on tenant-based rental assistance for specific properties.

Ms. Minton, you mentioned Continuum of Care and the reallocation process to create new projects.

Mr. Thomas, you talk about a limited expansion of vouchers for graduates of THRIVE-based programs.

Dr. Walsh, your testimony describes what you are doing with the First Bridge Clinic and the PATHWAYS programs.

These are the ideas we need to hear about that can help us to combat the opioid epidemic with government programs already in place.

I look forward to today's discussion as it's one of the most important issues we should be addressing today.

I now recognize the gentleman from Kentucky, Mr. Barr, the Chairman of the Subcommittee on Monetary Policy and Trade, for an opening statement.

Mr. BARR. Thank you, Chairman Duffy, and thank you to the Housing and Insurance Subcommittee for calling this hearing today in my home State of Kentucky, which is truly on the front lines of the opioid crisis.

I'd also like to thank my colleague from the Kentucky delegation, Congressman Brett Guthrie for joining our Financial Services hearing today. Mr. Guthrie has been a leader on opioid issues on the House Energy and Commerce Committee and we are fortunate to have him here today to offer his insight.

We all know that the opioid epidemic is a major health crisis that has impacted every community and every congressional district. Kentucky has the third highest overdose mortality rate in the country. Last fall, President Trump declared a National Public Health Emergency and Congress recently passed a historic package

of legislation to address the opioid epidemic through research, treatment, and prevention.

H.R. 6, the SUPPORT (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment) for Patients and Communities Act that was passed in the House this summer, builds upon past resources authorized and funded by Congress including the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act. I was also proud to support the Consolidated Appropriations Act earlier this year that appropriated \$4 billion, the largest Federal investment to date, to address the opioid epidemic.

But there is more work to be done. Over 115 Americans continue to die every day from opioid overdoses. We cannot continue to focus our Federal efforts on prevention and treatment without looking toward long-term recovery through housing, job placement, financial literacy, and life skills training.

Too many individuals find themselves with limited housing choices after completing in-patient rehabilitation and are forced into housing situations where they are surrounded by people using the same illegal substances that they went to rehab to stop using. This perpetuates the cycle of addiction and prevents individuals from rising above substance abuse.

The opioid epidemic has also presented a major issue for workforce development and job placement. Local employers I meet with regularly in Kentucky are struggling to find workers to fill even low-skill jobs. According to the CDC, the opioid epidemic's cost to our economy now exceeds \$1 trillion.

I was proud that H.R. 6, the opioid package which passed the House earlier this year, included my legislation, H.R. 5735 the Transitional Housing for Recovery in Viable Environments or the THRIVE Act. This bill would allow a limited number of Section 8 Housing Choice Vouchers to be allocated directly to transitional housing non-profits that have evidence-based models of recovery and life skills training. I am hopeful that the Senate will act swiftly to pass this critical legislation.

I have also introduced H.R. 5736 the Comprehensive Addiction Recovery through Effective Employment and Reentry, or CAREER (Comprehensive Addiction Recovery through Effective Employment and Reentry) Act, which would address the decline in workforce participation as a result of the opioid epidemic by encouraging local businesses and treatment centers to form partnerships to secure job training, employment, and housing options for individuals in recovery. This legislation would also give States more flexibility to direct Federal funds through the Community Development Block Grant (CDBG) to local recovery initiatives. I am grateful to Leader McConnell for introducing the Senate companion to this legislation.

Meaningful employment and a safe place to live are key to helping individuals maintain sobriety and rise above poverty. Today you will hear from several non-profit, government, and academic experts who are on the frontlines of the opioid epidemic in Kentucky. They will offer their unique perspectives on ways our Federal housing and community development programs could be improved or further utilized to fight the opioid epidemic.

Reforms to these programs and greater investment in long-term recovery would save American lives as well as taxpayer funds in

the long run by helping more individuals rise above addiction and poverty.

Thank you and I yield back.

Mr. DUFFY. Thank you Mr. Barr.

I now recognize Mr. Guthrie for an opening statement.

Mr. GUTHRIE. Thank you Mr. Duffy, and thank you all for being here today. I have heard countless stories of the awful effects the opioid epidemic has had on families, communities, and the overall workforce. I have been working hard in my committee, the Energy and Commerce Committee, to pass meaningful legislation that will stop this awful epidemic. The SUPPORT bill, H.R. 6 which includes over 50 pieces of legislation is currently pending before the Senate. I am hopeful the Senate will act quickly to provide relief to so many suffering Americans. Most of the 50-something bills have come through our committee. And a lot of it comes from hearing from people like you, the witnesses here today.

I wish there was one single bill we could pass and it would make the problem go away. It is just not that simple. I wish that it was. It is very complicated. And when we hear from people like you—and I have heard over the last several days even stuff we need to improve in legislation that has already been passed out of the House and into the Senate. We do hear the insights because you all are the experts, you all are the ones on the frontlines dealing with it, and we are trying to—where there are roadblocks, we are trying to get flexibility, we are trying to move things forward.

And it is very appropriate we are having this hearing in this community today. I was in Elizabethtown about 3 or 4 days ago going through a recovery center, and the person who was walking me through said basically we get them here in residence for 30 days, and we can control that environment. Some of them leave and whatever, but for the most part, we can get them through our 30-day program because we have control. They are in our environment.

He said the biggest gap is the sober-living piece, and so it really struck me. I said, well, we are having a hearing on something that Congressman Barr has made great efforts and great strides to make sure the sober living piece is, one, known throughout—the issue needs to be dealt with and, one, hopefully given the tools using money that is already going to be spent by the Federal Government in housing to give people an opportunity and have that full—not just the in-residence service but another piece of the bigger wraparound service. But it was stated to me that the biggest loss of people in recovery is when they get the sober-living part.

So I appreciate your leadership on this, Congressman Barr. I certainly appreciate the Chairman coming to our wonderful Commonwealth, and I appreciate having the Governor here as well. We got to serve together in Frankfurt when I was in the legislature, and I am pleased to have you here and all of our witnesses. So thank you, and I yield back.

Mr. DUFFY. The gentleman yields back.

Again, I want to now welcome our witnesses. Our first witness, who actually is the Governor who I didn't recognize in my opening statement, Governor Fletcher, former Governor of Kentucky and the Founder of Recovery Kentucky, welcome; our second witness,

Mr. David Boggs, President and CEO of Opportunity for Work and Learning, also known as OWL; Mr. King, our third witness, Executive Director and CEO of the Kentucky Housing Corporation; Ms. Minton, Executive Director of the Chrysalis House. Our fifth witness is Mr. Tim Robinson, Founder and CEO of Addiction Recovery Care. Our sixth witness today is Mr. Jerod Thomas, President and CEO of Shepherd's House. And our final witness, but not least, is Dr. Sharon Walsh, Director of the Center on Drug and Alcohol Research and Professor of Behavioral Science and Psychiatry at the University of Kentucky.

To all of you, welcome. Thank you for giving us your time today. Again, this is important for us to get out of the bubble of Washington, D.C., and come and take the testimony and insights from those around the country who are on the frontline dealing with these issues so we can take that insight back to Washington to our colleagues.

The witnesses in a moment will be recognized for 5 minutes to give an oral presentation of their written testimony. Without objection, the witnesses' written statements will be made part of the record following their oral remarks. Once the witnesses have finished presenting their testimony, each Member of the subcommittee will have a length of time within which to ask the panel questions.

With that, Governor Fletcher, you are now recognized for 5 minutes.

STATEMENT OF HON. ERNIE FLETCHER

Mr. FLETCHER. Chairman Duffy and other Members, Congressmen Barr and Guthrie, thank you for this opportunity. And, Chairman Duffy, welcome to Kentucky. I hope you do get to spend some time and see what a wonderful State it is.

You have my testimony there, but let me just speak a little bit from the heart. It is obviously a public health crisis. It is a very challenging, complex crisis that we face. There is not a simple solution, as has already been noted. And even with the reports yesterday, every 7 minutes someone dies of overdose, if we look at combining that with alcohol where every 6-1/2 minutes someone dies from alcohol abuse and its consequences, and then if you combine that with about every 12 minutes someone dies from suicide, many of those suicides are related to substance abuse disorder, you can see the complexity of the problem of addiction that plagues this Nation.

Going back 10 years, we looked at models that worked in a residential program out of The Healing Place in Louisville and the Hope Center in Lexington, Kentucky. It is a residential program where folks come in. We use a peer-support 12-step model, and we had fairly good efficacy from that. I will say that it is not for everyone, and we think we can improve on that model.

But we took that model, we developed some very creative funding. This was done by an individual by the name of Don Ball. Don Ball is a builder/philanthropist here who had worked with the Hope Center. I appointed him as Chair of Housing Corporation, and he brought together several funding streams to fund the expansion of centers modeled after the Hope Center. Now, we have

18 of those. We have 2,100 beds at any one time. University of Kentucky's Drug and Alcohol Research Center does our surveys. Eighty-four percent are drug-free at 1 year. Seventy-five percent are gainfully employed at the end of that program. Recidivism rate, as the criminal justice system, is very low, and so it is an effective program.

I will give you the caveat that at the beginning, 30 percent of folks, as a voluntary program, walk away and it is not for them, and I think that would address the need for medication-assisted treatment and more of a comprehensive approach than just one-size-fits-all.

The bottom line is we have 18 centers here that are working very effectively and transforming lives, and we are taking and expanding that nationally. As you look at what we face expanding that nationally, let's look at the funding streams. We use low-income housing tax credits, we use some other Federal home-loan moneys for the capital construction of these facilities. That runs about \$5–6 million.

We use Section 8 vouchers, food stamps, per diems from corrections because up to 70 percent of our residents come out of corrections, whether it is parole, probation, or diversion from drug courts. And these are nonviolent offenders. It is a good investment for them. They pay a per diem, and as I mentioned, the recidivism rate is very, very low for these individuals, so it works for the benefit of the recipient, as well as for the Department of Corrections in saving money substantially.

As we are taking this nationally, though, what we find is that Section 8 housing is a little more challenging to get in the operational side of things, and for that reason, we are very supportive of the THRIVE Act, Congressman Barr, that you have put forward, because it sets aside some of these moneys for this type of program. And there are two advantages of that. One, we think it recognizes that these programs, when they are evidence-based or have some outcomes that show that they work, they help make sure that we are not funding programs that don't work. Unfortunately, in the recovery industry, let's face it; there are some scams out there and a lot of families spend a lot of money on recovery only to find that their loved one comes back and is not truly recovered or treated. Folks end up financially broke trying to get their loved ones the treatment they need. So this Act, making a stipulation, focuses on making sure that only quality programs are funded. So, thank you, Congressman, for that insight.

As you look at some of our other funding, we are working with the Department of Corrections. We have worked with Secretary Ben Carson. He has been here to Kentucky. We have met with him here, and Congressman Barr was in that meeting. We also met with him at his office, and they are very supportive looking at how can we work with HUD to make sure that we expand these programs and make it available. We are working in other States now, and Georgia is one of our first States that we are working. We want to expand them in Kentucky because we still have a need here. We are also working with other programs. Tim Robinson is here, and we are glad to collaborate with other programs to make

sure that we provide as many people as possible with this type of recovery.

The other thing that I want to say about the congressional funding, you have nearly \$6 billion that is coming, funding to fight this opioid crisis, much of that is going to medication-assisted treatment because it is the gold standard of treatment. Dr. Walsh will address a lot of this.

In our recovery program, what we find—and we are expanding because we see that it doesn't fit everyone. We have 30 percent at the beginning that may drop out, and they would likely, very likely benefit from MAT, or medication-assisted treatment.

We also have some folks that end up relapsing as they leave, so a program that combines the best of these I think is something that Congress needs to make sure that, as you are looking at the funding, as you—final passage of these bills, that you recognize this full continuum of care.

These vouchers that are set aside in Section 8, I think are very important. Congressman Guthrie, your bill, the Comprehensive Opioid Recovery Centers Act, I think is important and recognizes the issue we have talked about, so I appreciate and hope we can pass that.

I have a few specific recommendations, and I will close with that. One, I would like to recommend obviously passage of the THRIVE Act through the Senate as it becomes a part of this larger package to fight this public health crisis. There is always a challenging—and I think some of the criticism is that, well, you may be taking some money from some other folks that need it. Let me say there is no greater need than these folks that are held captive by addiction. If you look at the sequelae of their life, it is abysmal without some kind of treatment, so there is no greater need.

I would like you to consider to take some of the \$6 billion that you are looking at and making sure that it might be allocated toward more of these because we have a proven model. It is not the only model, but we have a proven model that we can take nationally, collaborating with MAT and collaborating with other centers to expand the treatment, and so let me ask you to take a look at that.

I would like to—part of our funding is Community Development Block Grants. That is always threatened. The President's budget usually cuts those. And when I was in Congress, and you all—usually, we have to put them back. But I would like you to take a look at a similar program.

You will find that part of what we are doing—and according to the CAREER Act is we want to be able to provide the skills that an individual needs in order to enter the workforce. What is important in recovery is having meaning and purpose, and a good job and a purpose in life with a skill is extremely important in preventing relapse. And so I think that is important as you look going forward at where you are putting the funding. And Community Development Block Grants, this is community development, so I would like you to take a look at that and see if there is not some other way that you can make that funding a little more assured and sustainable because, right now, our funding for these programs is sustainable, and that is what makes them strong.

Last, I will recommend—and this is just probably out of nowhere and you all don't have the jurisdiction except for—or maybe Guthrie in that second-best committee. But this is a public health crisis. We have the EOC, Emergency Operations Center, activated at the CDC right now for polio. It is affecting three countries right now, and they are: Pakistan, Congo, and I think Nigeria. It is not activated for this. I think it is a perfect center. This is an epidemiological problem. It is a public health problem, and I just encourage you to take a look at activating the Emergency Operations Center out of CDC for this. It will allow them to bring a lot of the silos that we have with NIDA (National Institute on Drug Abuse), NIH (National Institute of Health), SAMHSA (Substance Abuse and Mental Health Services Administration), other parts of HHS together.

So let me close with that and say thank you for this opportunity.

[The prepared statement of Mr. Fletcher can be found on page 40 of the Appendix.]

Mr. DUFFY. Thank you, Governor Fletcher.

Mr. Boggs, you are now recognized for 5 minutes.

STATEMENT OF DAVID BOGGS

Mr. BOGGS. Thank you very much. Good morning, Chairman Duffy, Congressman Barr and Congressman Guthrie, and other guests. It is an honor to address this committee this morning in regards to the epidemic of opioid addiction in our Nation and the serious housing challenges that this population faces. Since housing is a vital step in the recovery and reentry process, the Acts that we have already talked about that have been introduced by Congressman Guthrie and Congressman Barr, THRIVE and CAREER Act and others, will have a major impact on abolishing this crisis that we are facing across our Nation.

Considering that this epidemic touches every family in our Nation, something needs to be done in the seriousness of it. Just this morning on our national news it was announced that the national lifespan for individuals has dropped because of a leading factor of drugs, and that is tragic for us to reach that point in our Nation today.

I would like to share with you the role of Opportunity for Work and Learning and how it plays with the topic at hand and some views of how the Federal Government, through our organization, can use existing housing and our community development program to complement community efforts to treat individuals experiencing the opioid epidemic. OWL provides key elements in the transitional path to self-sufficiency through job training and employment services.

Housing and employment definitely go hand-in-hand, so it is difficult to successfully maintain one without the other. And yet, too often, our offender reentry population, whom we work with a great deal, have at least one of these or both of these once they are released from incarceration. Consistent housing cannot be obtained without employment that will provide enough income to meet the demands of either renting or owning in the long term. Many of these individuals lose their employment due to the challenges faced through inconsistent living through a term that we often hear

called “couch surfing,” and that is very real for this population that we all serve, along with the homelessness.

Individuals come to OWL from many different paths. Some of them are coming from incarceration, some of them are coming from short- or long-term recovery programs, and there are a lot of people entering our program that are still struggling with the opioid addiction but yet trying to maintain employment. The struggle is overwhelming and often leads to more serious consequences for these.

The mission of OWL is, simply, OWL partners with communities to help individuals overcome barriers to achieve personal and professional growth. We have been doing that since 1961. But in our Nation there is—annually, 600,000 people are being released every year from incarceration, and the number of people at risk of falling back into this lifestyle that led them there in the first place continues to climb because of inadequate housing or the lack of employment. In addition to the criminal record preventing these individuals from finding jobs, statistics show that ex-offenders far too often have limited education and work experience and therefore do not have the skills necessary to enter today’s workforce with the adequate skills.

The Lexington Manufacturing Center (LMC), which is a wholly owned subsidiary of OWL, is an on-site advanced manufacturing center that provides training in the essential skills that are so desperately needed and demanded by today’s employers in every job sector. LMC employees earn more than minimum wage, and while they are there, they get benefits, the opportunity for bonuses, and they have the opportunity to work for other companies and earn a greater income because we are just a training facility in many aspects.

The various training programs that we provide such as our forklift certification, our manufacturing certification and material handling, third-party inspection, kitting, assembly, woodworking, all of these offer new opportunities for these individuals to reenter into the workplace and become successful. The programs that OWL and LMC have in place have proven to be successful as a research-based program in the path to self-sufficiency and attainment of stable housing and employment.

OWL has maintained a strong partnership with the Kentucky Office of Vocational Rehabilitation since its beginning in 1961. Over these years, our organization has successfully provided services for 23,000 individuals in central Kentucky. Through OWL’s services and programs in Fiscal Year 2018 alone, over 74 individuals found full-time employment, not temp service or not part-time but full-time employment with job benefits. Yet while this is successful numbers, over 60 percent of them had some type of opioid and substance abuse while they entered our program.

OWL completely adheres to the work being done with WIOA, the Work Innovation Opportunity Act, and we support all the mandates of community rehabilitation programs required in that through our youth grant, out-of-school youth grant.

Paul, a good example of our work, came to OWL as a result of an ongoing opioid addiction that cost him his home, his family, and also some incarceration time. Fortunately, after a period of time,

Paul became involved at a drug court diversion program, and they opened their doors to him instead of the long-term incarceration. Today, he is reunited with his family. He now has adequate funding and support through his job at OWL, and now he has homeownership. This is what we are all striving to reach together through this funding mechanism.

James came to us after serving 24 years in our Federal and State judiciary systems and still struggled with opioid addiction time after time. But thanks to our partnership with community housing agencies that we work with within our community, many of them represented here today, James was able to begin his pathway to a new life. Today, he has been fully employed at OWL for over 5 years and lives independently.

Paul and James are just two examples of individuals who have struggled because of the impact of the opioid addiction on their lives. Sadly, they are not alone, as we have already heard here today. There is an overwhelming need for housing and employment services for others trying to escape the opioid crisis in their life. Funding must be accessible—it is not an option—it must be accessible for research-based programs like OWL and others represented here today and have a proven track record of employment training, job placement, and housing. Programs that can easily be replicated and expanded upon in our individual communities must be provided oversight and guidance to establish consistency in collaboration among agencies to maximize resources and human capital.

Yes, we applaud the work being done by this committee and the leadership of our local Congressmen in Kentucky through bills that have already been sponsored and passed, but the battle against the housing and opioid crisis is not just a Kentucky epidemic but a national pandemic that has no borders.

Thank you again for this opportunity to share with you this morning.

[The prepared statement of Mr. Boggs can be found on page 36 of the Appendix.]

Mr. DUFFY. Thank you, Mr. Boggs. And it has no borders; you are right.

Mr. King, you are recognized for 5 minutes if we can figure out the microphone situation.

STATEMENT OF EDWIN KING

Mr. KING. Hopefully, you can hear me. Chairman Duffy, Congressman Barr, Congressman Guthrie, thank you all for holding this hearing. As you said, I am the Executive Director of the Kentucky Housing Corporation, the Commonwealth's housing finance agency. And on behalf of KHC's board of directors and staff, again, we thank you for conducting this hearing and affording me the opportunity to speak with you today.

I want to thank Congressman Barr and Congressman Guthrie publicly for bringing attention to the problem of the opioid addiction in the Sixth and the Second Districts. Thank you all. Congressman Barr, the passage of your bill, the Transitional Housing for Recovery in Viable Environments, the THRIVE Act, demonstrates your commitment to housing solutions for those on the road to recovery, so thank you for that.

It is my pleasure to share information about Kentucky's accomplishments through leveraging housing resources to help our citizens on the path of recovery from substance use disorders. There are multiple effective recovery strategies depending on the personal circumstances of those that are caught in the grip of addiction, as Governor Fletcher has alluded to. Access to stable housing is a basic human need and one of the primary social indicators of public health.

One of the most successful recovery strategies that we have seen here in Kentucky is of course the Recovery Kentucky model. In 2004, the late Don Ball took the helm as the Chair of Kentucky Housing Corporation under Governor Fletcher's administration. Mr. Ball brought with him a personal commitment, a strong will, and a solid plan to establish a network of recovery centers across Kentucky. Because of Mr. Ball's vision, Kentucky now has 14 recovery centers that have helped thousands of our residents start a new life of recovery from addictive substances. These 14 centers are in addition to the other four centers, two in Louisville—The Healing Place—and then the two Hope Centers here in Lexington. Today, these 18 recovery centers serve and help over 2,000 men and women daily.

The Recovery Kentucky Centers follow a peer-to-peer education and self-help model to provide sustained addiction recovery services. Peer mentors model behaviors and spiritual principles that focus on providing life skills to residents by following the spiritual principles of the 12 steps of Alcoholics Anonymous. Information from U.K.'s Center for Drug and Alcohol Research points to the significant successes that we have seen here in Kentucky, and I mention those in my written testimony.

Additionally, the program has saved taxpayer dollars through avoided cost to society or costs that would have been expected based on the rates of drug and alcohol use, and that can't be understated. For every dollar we spend on these recovery centers, we save \$2.60.

Recovery Kentucky would not have been possible without housing program dollars appropriated by Congress and administered by the Kentucky Housing Corporation (KHC). The recovery centers rely on a complex array of Federal funds for construction and operation, including the following: The bricks and mortar are built with the low-income tax credits and also HOME dollars and some affordable housing trust fund dollars that we have here in the State of Kentucky. There is also CDBG funds that are used, as well as Section 8 Housing Choice Vouchers for rent subsidies for the residents at these facilities, and also, as has been mentioned, food stamps.

It has become increasingly difficult to develop more of these recovery centers for two primary reasons. The first is of course less funding in Federal housing programs, but the second I really want to draw attention to, and that is red tape that surrounds certain Federal programs. For example, KHC has experienced significant challenges recruiting landlords to participate in the Section 8 Housing Choice Voucher tenant-based program, with many citing programmatic red tape as an obstacle. Additionally, Federal statutes restrict the amount of tenant-based rental assistance that may be used for a specific property to 20 percent of a public housing

authority's housing choice vouchers. One useful reform would be to raise that 20 percent cap and allow public housing authorities like KHC to project-base more housing choice vouchers to meet our specific needs here in the Commonwealth.

I sit on the board of directors of the National Council of State Housing Agencies, so I have the opportunity to speak with many of my colleagues across the country, including my distinguished colleague in Wisconsin—Mr. Winston does great work in Wisconsin—and I can tell you that, nationally, this would be accepted on a bipartisan basis. It is an option that allows housing choice vouchers to be project-based, but each State doesn't necessarily have to do that. So it would be a significant reform to potentially look at building more recovery-type models, regardless of treatment methods.

I will conclude my remarks with these key statements: Recovery Kentucky is a housing-based model that has produced remarkable outcomes and has proven to be highly cost-effective; housing is a key component of successful recovery programs and essential for long-term recovery; and greater flexibility with Federal housing program regulations will provide States with more control of the resources needed to achieve the goals of the President's Commission on Combating Drug Addiction and the Opioid Crisis.

Thank you for taking on this difficult but important work to help ensure access to effective recovery programs. Kentucky Housing Corporation led the way more than a decade ago, and we stand ready as a dedicated partner in the continuing effort. Thank you.

[The prepared statement of Mr. King can be found on page 49 of the Appendix.]

Mr. DUFFY. Thank you, Mr. King.

The Chair now recognizes Ms. Minton for 5 minutes.

STATEMENT OF LISA MINTON

Ms. MINTON. Thank you, Chairman Duffy, Congressman Barr, and Congressman Guthrie. I am the Executive Director of Chrysalis House, and I am very pleased to be with you today. And I would be remiss if I did not introduce our wonderful board president, Lindy Karns, who is also here today. That just shows what a wonderful program Chrysalis House is. Our board, our staff, our community partners, and everybody that we work with, we come together to do the best that we can for the women and children that we serve.

And we have been saving lives for over 40 years. We are Kentucky's oldest and largest licensed substance abuse treatment program for women. And the chrysalis is the protected stage just before the beautiful butterfly emerges, and that is what we want for the 200 women and babies that we serve every year.

As reported in the Herald Leader this past weekend, the CDC report recently stated that Kentucky had one of the highest rates in the Nation of pregnant women using opioids, and that is another example of the State's struggle with abuse of pain-killing drugs.

At Chrysalis House, we prioritize pregnant and parenting women, and we are one of the few programs in the Nation that allow women to bring their babies with them into treatment. We

believe the opportunity for our clients to be with their babies and young children is a powerful incentive for recovery.

A brief snapshot of the women that we are currently serving: Their average age is 26 to 30, 41 percent are pregnant, 61 percent report their primary substance abuse is heroin or other opioid, 85 percent have had one or more prior treatment episodes, 98 percent are unemployed, and 60 percent meet the homeless criteria for transitional housing. This population needs additional recovery supports. Housing and employment are imperative to long-term sobriety.

Chrysalis House received our first HUD Transitional Housing Grant in 1990, and we've received HUD permanent housing funding for over 20 years. In 2016, our \$200,000 grant was cut by our continuum of care due to the change in HUD's vision for moving forward and serving the chronically homeless and housing first, which we agree with, but we do think that there is room for transitional housing because our women and their children, after they go through 3-to-6 months of treatment at Chrysalis House, need sober, stable living in order to achieve long-term sobriety.

The next year, we lost our \$93,000 scattered-site apartment funding and our \$60,000 permanent-housing bonus apartments, so we have gone from \$360,000 a year in HUD funding to zero. And so this shift in HUD's view, I can see that, but we also think that there is room for transitional housing. And so we look forward to working with you all on the CAREER Act and the THRIVE Act and any other ways to help the women and children that we serve at Chrysalis House.

So I thank you for allowing me to speak today, and I am glad to take any questions.

[The prepared statement of Ms. Minton can be found on page 52 of the Appendix.]

Mr. DUFFY. Thank you, Ms. Minton.

Mr. Robinson, you are recognized for 5 minutes.

STATEMENT OF TIM ROBINSON

Mr. ROBINSON. Good morning, Chairman Duffy, Congressman Guthrie, Congressman Barr. My name is Tim Robinson. I am the CEO of Addiction Recovery Care. More people died from overdoses than car accidents last year, making addiction a national public health crisis that is taking too many lives and threatening our economic security, as employers struggle to find and retain employees. Last year, our Kentucky Chamber of Commerce CEO wrote in an op-editorial and he called addiction the number one economic concern in our State.

Everyone is looking for a silver bullet to address the addiction crisis. The reality is there isn't a silver bullet. Addiction recovery requires a whole-person approach, which starts with intervening with treatment, investing in someone's economic future by providing access to transitional housing, vocational rehabilitation, workforce development, and inspiring them from day one that there is hope to go from their crisis to a career.

I am thankful for the opportunity to speak to you because recovery is personal to me. I started drinking in my first year of law school at the University of Kentucky to cope with my mom passing

away during finals. For the next 8 years, I almost drank myself to death. Eleven years ago while I was a prosecuting attorney in Lawrence County, Kentucky, a court bailiff, who was a recovering alcoholic and pastor, led me to a spiritual awakening at my desk. He became my sponsor and my pastor. And addiction recovery is personal to me because I am a survivor.

Two years later in 2008, I resigned as prosecutor and in 2010 opened a residential center for women in rural eastern Kentucky. Today, we have 350 residential clients and 500 outpatient clients and centers across 12 counties in Kentucky. Our experience has taught us that addiction is a disease that devastates all aspects of a person's life, impacting someone's mind, their body, their spirit, and their purpose. And we have been determined to treat addiction holistically, medically, clinically, spiritually, and vocationally.

Our centers are led by an addictionologist and are nationally accredited. We have developed a spirituality program that inspires hope and offers redemption. Much like hospice centers, we employ chaplains who work alongside our clinical staff, and though we consider the spiritual aspect of our centers to be the heart of our success, our spirituality program does not replace medical and evidence-based clinical practices. It is in addition to them and makes our care more comprehensive.

Treating the whole person has led to great success. One of our payers recently reported to us that our centers reduced their members' healthcare costs by 33 percent during the 6 months after they completed our program.

We created an internship program with the promise that everyone who completes the program would be guaranteed a job. Today, 190 of our 380 employees are in recovery, and of those 380 employees, 130 are graduates of our programs.

We are a State-certified peer-support training program. A peer-support specialist is a Medicaid-billable professional who has 1 year of sobriety and completes a certification program.

We partnered with a workforce board, Eastern Kentucky CEP, and with Sullivan University to expand our internship into a 6-month career academy. Our graduates earn State certification and college credit. In just 1 year, a person in addiction can go from an IV heroin user to supporting themselves, literally going from their crisis to a career.

To date, 41 of our 46—or 85 percent—of our academy graduates are clean and sober, working full-time, paying taxes, and transitioning off public assistance. Some of the graduates have been promoted to management, and others are continuing their education for careers such as counseling. Prior to the academy, 40 percent of our clients chose to continue treatment beyond detox in residential care. After giving folks an opportunity to go from crisis to career, 70 percent of our clients now choose to continue treatment, doubling treatment motivation.

Vocational education that leads to a meaningful career that provides the dignity of work gives those reentering the workforce the confidence necessary to establish career goals and plan for their future. Because of this success, we are adding other programs such as an auto mechanics academy.

Kentucky may be leading the Nation when it comes to our drug crisis, but Kentucky is also leading the way in access to treatment because of the national leader on this issue, Congressman Hal Rogers, who has been working on this issue for more than a decade, and the efforts of our Governor Matt Bevin, who is making Kentucky a second-chance State.

But the two biggest challenges preventing us from taking more people from crisis to career is a lack of funding for workforce development and transitional housing. That is why I am so excited about Congressman Andy Barr's bill, the THRIVE Act, and our Senate Majority Leader Mitch McConnell's CAREER Act, and that Congressman Guthrie has convened joint committee hearings on the issue of helping people in addiction who are in recovery get the workforce development they need. And these two historic pieces of legislation have the potential to transform the national effort to combat the drug epidemic.

In closing, the hope of America is not merely surviving. The hope of America is an opportunity to flourish. That is what our brothers and sisters in addiction need. They need an opportunity, an opportunity for treatment, transitional housing, and workforce development that leads to a meaningful career path. And when the opportunity is given, I have seen not just survive but thrive. Our current human capital and labor shortage can be solved at the same time we combat the drug epidemic as we take those struggling with addiction from their crisis to a career.

[The prepared statement of Mr. Robinson can be found on page 55 of the Appendix.]

Mr. DUFFY. Thank you, Mr. Robinson.

Mr. Thomas, you are recognized for 5 minutes.

STATEMENT OF JEROD THOMAS

Mr. THOMAS. First, let me thank you for including me today. It really is an honor. My name is Jerod Thomas. I am the President and CEO of the Shepherd's House. The Shepherd's House is a non-profit, long-term transitional living home for men 18 years and older that have a drug or alcohol addiction. We have been providing this treatment for 29 years, since 1989. We are one of the few transitional-living houses that offer recovery care for our clients 24/7. We offer a lot more than just a roof over your head.

Our long-term residential recovery program is very similar to the model of the THRIVE Act. We are a therapeutic community, and our primary focus is on helping these men acquire daily living skills. In our day, we offer individual counseling, group counseling, conflict resolution, anger management classes, parenting classes, education programs, money management classes, and art therapy. We also feature a one-of-a-kind jobs program in which 90 percent of our clients get a job within 3 weeks of entering our transitional-living house.

Employment is mandatory at the Shepherd's House. To prepare our clients for employment, we provide professional assistance with resume building, interview skills training, personal presentation, employment goalsetting, and teambuilding. We partner with DVA Kitchen, Employment Solutions, Vocational Rehab of Lexington, and OWL.

The Shepherd's House has never received any Federal grant money for any of our programs, but we have received grant money from Federal Home Loan Bank and Kentucky Housing Corporation in the form of brick-and-mortar grants, which require income and special-needs verifications, which are similar to the Section 8 rental assistance voucher program, so we are very familiar with the process.

Under our transitional housing model, clients pay a portion of their income as rent. That does not cover my utilities, my food, and my professional therapies cost. The bulk of our expenses are funded by the donations the Shepherd's House receives, so basically what I am telling you all today is the good people of Lexington, Kentucky, keep my doors open. Because we have had so much success, the donations have increased. I believe the THRIVE Act will have similar results. The financial support the THRIVE Act could provide would ensure our continued success, as well as allowing us to serve more people.

And I really wanted you guys to hear me today, but I thought it was more important that you feel me today, so I brought Donna Schuler with me today. Donna, could you stand up? Thank you, Donna.

Donna is a great friend of mine and a wonderful mother. Her 28-year-old son Luke Andrew Schuler died of a drug overdose on December 9, 2016. Luke was on my waiting list at the Shepherd's House. He was 2 weeks away from his bed date. We live with that every day, knowing a life was lost because we didn't have room. There are perhaps countless others who are waiting that we don't know about. Luke's mother Donna, in spite of her unimaginable grief, rose to the challenge and has worked tirelessly to get contributions to grow the Shepherd's House so that no other parents have to bury their son because a bed wasn't available.

The Shepherd's House currently has a 6-month waiting list. The funding the THRIVE model facilities will receive would allow us to expand our current bed capacity and offer more services to more individuals. The housing cost burden will be significantly reduced, and these precious funds will be freed up to provide more services and more beds.

We currently follow all the Section 8 housing rules but with more restrictions and services for the client. Like Section 8, we require our clients to stay drug-, alcohol-, and crime-free, but unlike Section 8, we provide the programs and support to help them do so. We provide a 24-hour-a-day, 7-day-a-week therapeutic community that gives you access to the daily living skills necessary to stay sober and participate in the game of life. Our focus is on the whole person. Our aim is to meet all the client's needs while they are in our safe and drug-free environment. The THRIVE-based model includes programs like the Shepherd's House that have proven results of long-term sobriety. Most of our clients are either income-eligible for Section 8 or qualify as homeless, so the reallocation of these vouchers still meets the letter and spirit of Section 8.

In preparing to give testimony today, I have looked at the support offered by Section 8 vouchers, and I am excited that we may be able to use those funds for people who want to live sober, but the Section 8 voucher in and of itself is not the end game. There

are more pieces to this puzzle of life than the housing issue. The THRIVE Act takes the intent of Section 8 to provide safe and stable housing and partners that with the very best treatment model we know of today. The union of these three things—a treatment model with daily living skills incorporated, job placement and education to secure a financial future, and stable and adequate housing—that is the end game. Through those relationships and funds, the THRIVE Act will give drug addicts and alcoholics tools for change and solutions for life.

Let me leave you with the sobering facts we live with here in Kentucky. By the end of the day today, five more Kentuckians will have died of a drug overdose. That means five more sets of parents will bury kids, and five more kids will lose their parents. Kentucky is always in the top five in overdose death. At the end of our day today, let's use the THRIVE Act and the CAREER pilot program in Kentucky to save those five lives. Thank you.

[The prepared statement of Mr. Thomas can be found on page 59 of the Appendix.]

Mr. DUFFY. Thank you, Mr. Thomas. And, Donna, thank you for being here today, and we are sorry for the loss of your son Luke. Thank you.

Dr. Walsh, you are recognized for 5 minutes.

STATEMENT OF DR. SHARON L. WALSH

Dr. WALSH. Thank you. Chairman Duffy and distinguished Members of the committee, thank you for the opportunity to appear today to discuss the role of Federal housing and community-development programs to support opioid and substance use disorder treatment and recovery. I want to thank Congressman Andy Barr from Kentucky's Sixth congressional District for inviting the committee to Lexington—I wish that the weather was better for you—to discuss the Nation's opioid crisis and how Kentucky leaders are responding.

My name is Sharon Walsh, and I am the Director of the Center on Drug and Alcohol Research at the University of Kentucky, and for the past 25 years, I have been engaged in conducting research on opioid misuse, dependence, its medical complications, best practices, and the development of novel treatments for opioid use disorder. I have been fortunate to have had funding throughout my career from the National Institute on Drug Abuse, along with other sources, including SAMHSA and the FDA (U.S. Food and Drug Administration). I am here today representing the University of Kentucky.

The University of Kentucky has launched many initiatives to increase access to care and accelerate the discovery of novel approaches to address the opioid crisis in the Commonwealth and the Nation. I will highlight only a few with my limited time today.

The University of Kentucky Hospital emergency rooms see approximately 1,000 non-fatal opioid overdoses in a given year with approximately 50-plus cases of fatal overdoses. This does not include those patients who present with significant and life-threatening medical complications from injecting drug use behavior who present virtually every day, nor does it include all of those individuals who never make it to the emergency department. Historically,

emergency departments in our region would treat the presenting problem and return the patient to the street without attempting referral or linking patients to care for their opioid addiction.

With the support from the CURES funds, through SAMHSA and the State of Kentucky and the Cabinet for Health and Family Services, a new service has been developed to address this critical gap in care. The First Bridge Clinic is a new initiative that allows our emergency departments to directly refer individuals at high risk for fatal overdose and link them to care. Patients can quickly begin receiving evidence-based care, including medication-assisted treatment and start on the path to remission and recovery. However, these patients often have many other psychosocial problems that are barriers to treatment success and retention in treatment. For example, a criminal record is a barrier to employment, and unemployment is a barrier to housing. Linking all patients to the requisite supportive services is essential for long-term recovery, especially housing when needed.

Another U.K. program that is having a profound impact that Congressman Barr mentioned earlier is PATHWAYS, a program designed specifically for the care of pregnant women suffering from opioid use disorder. PATHWAYS opened in 2014 and has treated more than 200 women and their newborns. Women are able to receive evidence-based care, medication-assisted treatment, and good prenatal care. The large majority of women achieve abstinence and deliver their babies with no illicit opioids in their systems. And the incidence of babies suffering from neonatal abstinence withdrawal has been reduced by more than half. U.K. just opened a specialized NACU unit that is an eight-bed unit that is specifically for the care of babies born with drug exposure. Our postpartum program for the support of new mothers, Beyond Birth, is also expanding with the help of Medicaid assistance.

Young mothers with new babies may be the most vulnerable of all the patients that we see. This is a high-risk group that may require housing services, housing that allows infants and other children in order to promote retention in care and sustained remission.

In Kentucky, there was little to no opioid abuse before the current prescription opioid epidemic began. There was no heroine historically. Most existing treatment facilities and housing services were not designed to address the unique issues associated with opioid use disorder that set it apart from other substance use disorders. This is a very unforgiving disorder. A single lapse or relapse can lead to the immediate death of a person who is striving to sustain their recovery. A single mistake ends a life.

Federal agencies, including the FDA, SAMHSA, and NIH, all agree that the most effective approach to the treatment of opioid use disorder is pharmacotherapy, also known as medication-assisted treatment, including buprenorphine, methadone, and naltrexone, and all are calling for its expanded use. These medications effectively reduce drug use, improve health, reduce the transmission of infectious disease, and, most importantly, protect individuals from fatal overdose.

It is commonly recommended that part of the path of recovery is to change the people, places, and things that are associated with one's past drug-using lifestyle. This may involve moving into resi-

dential care or recovery housing. Unfortunately, many of these facilities prohibit or exclude patients who are receiving all or specific FDA-approved medications under the supervision of a trained physician. Providing healthy- and safe-living housing environments for all patients seeking recovery is essential, and programs receiving government support should not only allow but should also promote the use of all evidence-based practices in treatment and housing programs.

The University of Kentucky looks forward to working with Congress and other leaders to leverage the expertise and resources of the Federal Government in a strategic and coordinated manner. As a historic land-grant and flagship research university, the University of Kentucky was founded for the people of Kentucky 150 years ago. That is why we are here, to keep a deep and abiding promise of better tomorrows for our community, our region, and the Commonwealth.

I sincerely appreciate the opportunity to present testimony before the subcommittee, and I am happy to address any questions. Thank you.

[The prepared statement of Dr. Walsh can be found on page 64 of the Appendix.]

Mr. DUFFY. Thank you, Dr. Walsh. I want to thank our panel for their insights and their testimony. The Chair now recognizes himself for roughly 5 minutes for questioning.

First, I neglected to mention how grateful I am for the warm welcome that you have given me in Kentucky, especially after Wisconsin ended your undefeated season in 2015 in the Final Four. Mr. Guthrie was at that game.

With that said, listen, this is a heart-ripping conversation. I was a prosecutor for 10 years, and over 10 years ago in my small county we saw more deaths from opioids than anything else in our community. And there was really no national conversation or even a Statewide conversation at that time, and so we put together a community taskforce. That is what we do, right? We try to go, how do we help our other community members when we see a crisis that burns? We don't always look up the food chain; we look to ourselves to try to address the problem.

And I was the prosecutor, so I had the D.A., I had the judge, we had the school, law enforcement, the pharmacist, everyone was getting involved, and one of the problems that we had was—if we have any doctors in the room, I am sorry—but the doctors were the ones where, again, they were the flow of the OxyContin, which was our issue of opioids. They were the flow-out, and we couldn't get their participation early on to even deal with random pill counts, to do random testing. And when someone comes in on a Friday afternoon and says that the dog ate their Oxy and they want another 30-day supply and they were getting it, this was insane stuff.

And so no wonder we have a crisis on our hands that was made not by the drug dealers, but whether we want to talk about pharmaceuticals or whether we want to talk about doctors and hospitals, and it has absolutely ravaged all of our communities across America.

In Wausau, Wisconsin, I did a roundtable with many of my sheriffs and our attorney general, and what you see is how it is even

addressing our kids, parents that are doing heroin in the car outside the drug house and the kids are in the back seat in the carseats as the parents are strung out in the front or what is happening inside homes of cereal being dumped on the floor for kids to eat for a couple days as the parents are on a drug binge.

And some of the sheriffs were talking about how some of their deputies have started to drink more to cope with what they are seeing in our community, so you have seen drug use that translates even to some of our law enforcement deputies starting to consume more alcohol to deal with the pain of what they are seeing in their community with kids and with adults. And there is no silver-bullet answer here I don't think, but trying to find bright spots that can help our communities deal with these issues is incredibly important.

Just to the panel, I don't know if you guys have this scenario. Are you seeing more out-of-home placements for children in your community because of this epidemic? Is that a fair assessment, Governor?

Mr. FLETCHER. Yes, we are involved with the group in Georgia, Rome, Georgia, and up to 70 percent of foster home placements are related to substance use disorder. And a lot of the data across the country shows increase in foster care, and we don't have near the adequate number of foster parents or volunteers to accommodate that, so we are facing—one of the consequences of opioid use disorder is going to be a tremendous impact on the children going forward, and the NAS that Dr. Walsh mentioned as well.

Mr. DUFFY. And just for my smaller counties, we don't come from a wealthy area in America or in Wisconsin. We have some pretty poor counties. The counties don't have the resources to actually fund the out-of-home placements, which you want money to address addiction, but then you are spending money to address the consequences of it with the out-of-home placement for children, which a lot of our counties are struggling to go, how do we deal with this? It is a financial problem; is that fair to say, Governor?

Mr. FLETCHER. Yes. One of the things that I think as we put this in the context of other works being done with NIH and the healing communities and NIDA is—and we are starting a project in Rome, Georgia, where we are looking at a group that handles foster care in addressing women. It is going to have to be a community-wide program of having a community that addresses these issues comprehensively, similar to what you started off with, your effort with the taskforce on opioids in your community.

But I do think the healing community and having part of MAT, residential continuum of care that even addresses to reduce the incidence or the need of foster care by addressing these generally single moms early on or maybe both parents that are under substance use, but getting them into recovery so that you can reunify that family, which has historically been the best impact on a child's well-being is reunification.

Mr. DUFFY. Yes. Mr. King?

Mr. KING. And what we are seeing in housing, we are really focused on two populations: Seniors and children. And you are seeing this spillover effect among youth and youth who are aging out of foster care. We have dedicated our resources to try to alleviate

some of the issues with seniors, grandparents housing, having to house or find the resources to house their grandchildren.

Mr. DUFFY. Yes.

Mr. KING. I talk often about a holistic approach to housing. When you are looking at the spillover of an increasing population of youth and youth aging out of foster care, another housing approach that we have introduced in Kentucky is the Scholar House model, which helps single parents go to college or technical school and receive a degree and become a participating member of society. We are now over the next year going to be introducing a Scholar House model for youth who have aged out of foster care. But we are definitely seeing an uptick in housing resources going specifically for seniors who are caring for their grandchildren.

Mr. DUFFY. Anyone else want to comment?

Ms. MINTON. Well, I want to say that is one of the great things about Chrysalis House is that we allow the babies and children under 2 to live with their mothers while in treatment and older children come and spend the night on the weekends. Then the whole family reunites when they move into transitional housing. And so we can help them all along the way. And here in Kentucky the DCBS has a specialized team called START, which stands for sobriety, treatment, and recovery teams. And Chrysalis House works closely with the START team and with the court system because a lot of times the judges would take the children away, put them in out-of-home placement. But if the woman is at Chrysalis House and is doing well and working on her treatment plan, then they will allow the children to stay with the mother, and so that does save our citizens a lot of tax money.

Mr. DUFFY. I don't know if anyone knows the answer to this question. In regard to how we treat pain in America and if you have been to the doctor—my wife and I, we have eight kids, so at least every 2 years I have been to the doctor dealing with pain in childbirth, not my pain but my wife's pain, and the little smiley faces to the grimacing frown of the little face in the doctor's office. And anyone have any comment about the reimbursement method as it is tied to pain treatment with people in hospitals? And if your assessment of pain is low and doctors get a benefit for that, don't we start pushing drugs on people when we should say, well, we don't want to actually push some of these high-octane, highly addictive drugs on folks to necessarily manage pain. Maybe a little bit of pain might be beneficial instead of the possibility of getting hooked on a very powerful drug. Am I off base, Dr. Walsh? Am I crazy up here?

Dr. WALSH. You are not crazy. So I think the contingencies are a little bit different, though, than what you have described, so the contingencies aren't really about reimbursement. Where the requirement came for physicians to treat pain came out of JCAHO, the Joint Commission on Accreditation of Hospitals, when they adopted the policy that pain was going to be a vital sign—

Mr. DUFFY. Right.

Dr. WALSH. And that initiative was I think unknowingly pushed by groups that appeared to be legitimate scientific and medical societies, but they were actually funded by the pharmaceutical industry.

Mr. DUFFY. That is right.

Dr. WALSH. So they were able to persuade the accreditation, which every hospital needs to maintain in order to operate, that pain was going to need to be treated well. And then the other thing that drives it are patient satisfaction scores because that is another thing that hospitals pay attention to and that doctors are held accountable for.

Mr. DUFFY. Have we changed that model now?

Dr. WALSH. So JCAHO certainly is reevaluating things, and at the national level, there are a lot of physician organizations that are really trying to do a better job with coming up with guidelines. The CDC, I am certain, released new pain treatment guidelines, but they are guidelines so they are not mandatory. So we see some of the same bad practices continuing both in hospital settings, outpatient settings, dentist, mid-level providers. So while there is a lot of popular news about this, you cannot possibly not know that this is the biggest crisis that we are facing.

We still see a lot of bad prescribing practices. And just as an example, in our State, the State Government changed the law so that you could only have a 3-day prescription for a Schedule II agent, and so what a responsible doctor would do would give a 3-day prescription. What some who don't want to get called on the weekends do instead, they will give a 3-day prescription for 4 times as much as they would have prescribed for a 3-day prescription so that there is more available so that they are not getting patients calling up and saying that they are in pain.

So I think that is really important when we are thinking also about how we do both regulations around this, guidelines, what is it that we are incentivizing because sometimes we are missing the mark a little bit and—

Mr. DUFFY. And we want to manage pain. We don't want people not to be able to get medicine to manage their pain, but also we don't want to push that pendulum too far over, which I think you have mentioned, Dr. Walsh, that we have and it has to be reevaluated. And frankly, we are not done with that process. It is a little bit shocking based on the crisis that we are seeing across America.

I have to end in one moment, but you all agree that housing is a key component to recovery. We are all agreeing on that. Good. We are on the same page. And just I thought that, Mr. Boggs, you made an interesting point. When we are talking about, you are dealing with those that have been convicted of crimes who have served sentences, I don't know if you have the same problem in Kentucky, but in Wisconsin, we don't have enough workers to fill our jobs, and if we can move people, whether it is from incarceration with skill sets into jobs or from those who have drug abuse issues to skills sets to meaningful jobs that give purpose in life, not only does it help the individual, their family, but it helps our broader economy because they are filling places in our workforce that aren't being filled right now.

You talk about a—this is a holistic issue that we face as a community and as a country. Mr. Thomas?

Mr. THOMAS. That is a perfect example. What better place to get your employees than living at our facility where they are being drug-tested 3 days a week, and if you are positive, we will not send

a guy that is under the influence of drugs or alcohol to work. We will simply call the employer and say he is not going to be available today, but we have a guy that we can send to you and you can start training today.

So we are actually doing that for you, so we take the cost of the drug test and we monitor, so if you are in our facilities or any of our facilities getting drug tests, you have a safe and sober employee. That also saves money on the other end almost like an employee assistance program would. There are not as many workplace accidents when nobody is drunk or high.

Mr. DUFFY. That makes sense. I am going to pass it over in a second to Mr. Barr, but again, we are talking about 10,000 vouchers out of 2.1, 2.2 million as a demonstration project to see if this works. Again, this is how the government should work to say let's take a little sliver and see if we can have a real impact, and if it works, we can expand it, but it is only 10,000 vouchers, again, out of 2.2 million. I think that point needs to be made also.

The fact that we are trying to address an opioid crisis is different than—we have all dealt with alcohol and alcohol abuse in many of our families. This is a new animal we are trying to get our hands around and how we address addiction. I know we are not talking about meth today, but that is a whole other problem as well, and it is going to be all of us partnering together. And I want to thank you all for the work that you do to make Kentucky a healthier place, to help families, individuals who are going through this incredibly difficult time, helping them get to a place of health. And to hear stories like Donna's, to make sure we don't have those five people today, Mr. Thomas, go through what she had to go through in her family, it is heartbreaking, and I appreciate her strength and willingness to help other families and have her and her son's story be told.

So with that, my time is expired, and I recognize the gentleman from Kentucky, Mr. Barr, for as much time as he may consume.

Mr. BARR. Thank you, Mr. Chairman. And again, thank you, Mr. Chairman, for coming to Kentucky and listening to our constituents about models of hope, about models of recovery. Wisconsin has a crisis, Kentucky has a crisis, the whole country is dealing with an opioid addiction crisis, an overdose crisis. And the fact that you have spent the time and the willingness to come to Kentucky and hear from people on the frontlines who are offering solutions and taking our testimony is something that I really appreciate.

Mr. Chairman, since you did mention the 2015 NCAA tournament, I just respectfully remind the Chairman about 2014 and the 30-foot shot with 2 seconds left by Aaron Harrison that knocked out your Badgers, so just for the record. I can say that to the Chairman because—

Mr. DUFFY. Duly noted.

Mr. BARR. —he is a good friend of mine.

On a more serious note, I do just want to make note of the fact that it is altogether appropriate that this field hearing is taking place in the United States District Courthouse. In my conversations with members of the Federal judiciary, the criminal docket here in the Eastern District is disproportionately inundated with

criminal cases that are connected in some way or another to the opioid addiction crisis.

Well, all of you have made very good points today, but let me start my questions with Governor Fletcher. Thank you for your testimony. Thank you for your leadership. Thank you for your innovation with Mr. Ball a decade ago and for your continued work in trying to take the Recovery Kentucky model nationwide. It is a unique model. We know it works. My question to you is besides the THRIVE Act—and we thank you for your words of support for more Section 8 vouchers for addiction recovery, but you mention the CDBG program, the Community Development Block Grant, and I fully agree with you that recovery is community development because of the connection to the workforce development issue.

What statutory changes does the Congress need to make, continue to make besides the THRIVE Act to provide more CDBG funds or other resources to take the Recovery Kentucky model nationwide?

Mr. FLETCHER. That is a tough question. Congressman, let me say this. As I have thought about the CDBG grants, 15 percent of those are available for service, and we are using those, but they are very competitive because most of the communities out around the State, knowing that these funds are controlled primarily by the Governor, make it very difficult to direct some of these moneys to a recovery effort.

I do think, maybe similar to what you are doing in the THRIVE Act under the CDBG funding, is looking at considering setting aside, taking some of that \$6 billion that is going and set aside for community development similar to the CAREER Act but making sure there is a funding stream available that is sustainable, that helps us address directly that particular need. That could be tied with the quality measures that you have already done in the THRIVE Act. It could be tied with making sure that they have job training, that they are involved with the local economic development, all part of this healing community effort.

What particular piece of legislation? I think the CAREER Act might be a place, but looking also at the—I guess the appropriations for CDBG but the authorization for CDBG and where those come from and looking at the language in that authorization bill to see if we couldn't specify, as you have done in the THRIVE Act, some moneys for that particular development effort.

Mr. BARR. Thank you. That is helpful.

Mr. Boggs, I appreciate all the good work that you all do at OWL to take people from a period of incarceration into sustainable employment. Do you have any specific suggestions for how Federal housing programs can work more closely with nonprofits like yours to help residents find jobs and rise above poverty? And the question is animated by my own personal experience traveling the central Kentucky area and talking to employers.

And, Mr. Thomas, you made a great point about providing sober workers. It is ubiquitous. Every single employer in central Kentucky, whether it is a farm, whether it is a manufacturing firm, whether it is a healthcare-related business, whatever the business is, the hiring manager, the H.R. manager, the plant manager, they all tell me the same thing, which is we have job openings we can't

fill because people can't pass a drug test. How can Federal programs partner more with organizations like you to provide that labor supply?

Mr. BOGGS. Yes. As I mentioned several times, the correlation between housing and employment is so critical because of—simply for the fact if people do not have a place to stay, they do not feel like getting up and going to work in the morning. They are not capable of getting up to work in the morning. So if they have stable housing, then that provides them a place, a residence, a place of safety that enables them to go to a place like OWL and receive the necessary job training.

And you are correct; every individual that comes through our doors that wants to work, we can find employment for them. The big issue is so many times they come to work and then the next day they don't show up. That is because they don't have transportation. That is another big barrier that goes in this whole piece that none of us have mentioned today. So getting back and forth to work and having that stable place to live brings that full circle together.

And when we do have partnerships like I stressed earlier, that makes it so meaningful to connect it all together, and the collaboration is going to be the ultimate key for all this among agencies and maximum utilization of dollars.

Mr. BARR. Mr. King, can you expand on how the current cap on project-based vouchers—you mentioned the 20-percent cap—has limited specifically here in Kentucky. How has that limited the Kentucky Housing Corporation's ability to invest in housing programs that serve those who are recovering from opioid addiction?

Mr. KING. Yes, and when I—thank you. When I mentioned that earlier, there are PHAs throughout the Nation who have done some demonstration projects where they can exceed that 20-percent cap. However, Kentucky Housing Corporation is not one of those. What you have seen in Kentucky is 14 recovery centers that do great work, but they all use housing choice vouchers that are project-based to those centers, so you have those 14 recovery centers. You also have, I believe, 13 Scholar Houses, which I just mentioned a little bit earlier where, again, those vouchers are attached to those projects.

So these have been very innovative approaches to address a particular issue like the opioid epidemic and like education and workforce training. However, because of those efforts, we have hit that cap. And so allowing us more flexibility, maybe increasing that 20-percent cap to potentially 40 percent or greater, to me it presents an option for States to utilize those resources. I think we have to take—as a country, I think we have to take a holistic approach to housing, and we can't just look at providing a roof over somebody's head. We have to address the things that lead to chronic homelessness like the opioid addiction epidemic and like educational opportunities for parents. So by raising that cap, we are allowed to target individuals into particular housing models.

The purpose of the housing choice voucher was a good purpose, to give people choice in where they want to live. That is a good and noble goal. The problem is that you have a lot of landlords who are not willing to take tenants. So someone might get a voucher and

they might not be able to find a house to live in because there are no landlords that will take them. So by increasing that, you are guiding them into a particular project.

We administer at Kentucky Housing approximately 4,600 vouchers, Housing Choice Vouchers. There is a waiting list of 5,600. So while the increase in cap, the 20-percent cap would be beneficial, vouchers are the single most effective resource to address a homelessness issue, so obviously increasing those would certainly help.

Mr. BARR. Thank you for your testimony, Mr. King, and I look forward to working with you and the Kentucky Housing Corporation to address that arbitrary statutory cap and looking forward to working with Chairman Duffy to achieve that once we get the THRIVE Act signed into law.

Ms. Minton, you talked a lot about—and we applaud the great work of the Chrysalis House and what you do for women and newborns suffering from neonatal abstinence syndrome. And we want to work with you on the problems that you described with HUD. We want to fix those problems, so I look forward to working with you on that. That is precisely why we introduced the THRIVE Act, to provide alternative resources to replace some of the funding that you lost. And I think your respectful pushback of the Housing First program I think is appropriate for us to take into consideration as we exercise oversight over HUD and encourage HUD to re-evaluate the priorities and the need for more transitional housing services.

But my question to you, Ms. Minton, is because you are at the frontlines of the neonatal abstinence syndrome issue, could you just describe for the record, at least here in central and eastern Kentucky, the dimension of the problem of women who come to you with newborns who are suffering from this problem?

Ms. MINTON. Well, Chrysalis House prioritizes pregnant women, so we try to get the women in before the baby is born, and that we are working with U.K. PATHWAYS and Beyond Birth to ameliorate the effects so that the baby is born healthy or as healthy as possible. And so we are working closely with the doctors.

And Lindy left, but we have our board meeting tonight at 6 o'clock to officially vote on opening a new 16-bed facility on the grounds of Eastern State Hospital for 16 pregnant and postpartum women, working very closely with U.K. PATHWAYS and Beyond Birth, and so we will have access to MAT services—the buildings are right next door on the campus—and hep C services because that is another problem with many of the women that we work with, and just trying to partner as best we can to help the women and their babies because they do recover and they do get better.

I think that one of the things that Dr. Walsh alluded to is the number of women in rural Kentucky who do come to Lexington for services but are often reluctant to enter into treatment, especially long-term treatment. And so that is one of our obstacles that we are working on, and trying to do the telehealth I think is making great strides for our State.

Mr. BARR. Thank you. Mr. Robinson, thanks for your powerful personal testimony, and I wanted to ask you from your experience, do the program participants that you contemplate coming into your program, how will they have success finding work, and how will

they have success moving out of government assistance? What are some of the factors that will, in your judgment, lead to hope and thriving as you say, as opposed to just getting by?

Mr. ROBINSON. Well, there has been a big effort for reentry programs, whether that is helping people transition out of prison or transition out of 30-day treatment programs or detox facilities. We have put a lot of effort there. And the problem is that often when that person leaves jail, if they leave a 30-day treatment program, there is a big gap from that moment when they walk out the jail cell, they walk out the treatment center until they are able to even be employed. And there are some things on the life skills side; there are some things on financial literacy. Those things have to be a part of that gap between when they come in crisis to putting them in a career.

The other thing is you have to get them on a path where they can see a career path that is better than a petty drug dealer because we compete in their mindset with why should I go work a minimum wage job when I can do one petty drug deal. And so the hope has to be a real hope. It has to be a real economic opportunity. It has to be that you can become somebody who can support yourself, support your family, and we are not competing with that.

And so I think having wraparound services like what the Shepherd House is doing, what we are doing, what others are doing, Recovery Kentucky, to get people in that zone where we lose most of them and make sure they have peer support, make sure they have counseling, make sure that they have people that really are re-parenting them because a lot of the things that we do we take for granted, getting up every morning, knowing what is appropriate to wear to work. If we leave that to them when they have never done that, we are setting them up to fail. So our efforts, whether it is MAT, whether it is abstinence, whether it is whatever, all of those are going to require us to have transitional housing, workforce development.

One of the things in the CAREER Act is not only giving more targeted project-based vouchers, not only giving more targeted-based community block grants, but giving targeted workforce development, that the WIOA funds have a certain amount that are targeted for people coming out of addiction because I have seen time and time again if somebody doesn't have that hope, then they are going to go right back to petty drug dealing, and it is not going to be long before they are going to relapse and they are going to be right back in the mess that we have already once rescued them out of. Instead, if we will make the investment with a whole-person approach, we can see them succeed.

Mr. BARR. Thank you for that. And, Mr. Thomas, first of all, let me just address Donna and express my condolences to you for the loss of your son Luke, and that is exactly why we are here today. Luke is exactly why we are holding this hearing, and we want to make sure that we bring every resource to bear from Congress to prevent this happening to any other family.

And the Shepherd's House is a wonderful program that needs resources, and Congress has responded to this epidemic with billions of dollars in appropriations, but guess what? Not all of the resources that we have appropriated are actually addressing the

transitional housing need. And so I fully, fully agree with Mr. Thomas' testimony that we need to make sure that there are no shortages of beds, and we need to rethink all of the priorities within the context of these appropriations so that organizations, not-for-profits like Shepherd's House, are eligible to receive some of the resources. And again, that is what is motivating the THRIVE Act.

So, Mr. Thomas, you mentioned no Federal funding to the Shepherd's House outside of some Federal Home Loan Bank and KHC funds. How would the THRIVE Act specifically help Shepherd's House and similar programs?

Mr. THOMAS. Point-blank, it is a game-changer. I spent a ton of time reading it and researching it. We made a joke in getting ready for this. We are at the Shepherd's House, we are the forgettables. And by that I mean, my clientele falls through the cracks. We don't qualify for anything. I understand why pregnant ladies will go first. It makes absolute sense to me. But again, we are getting left behind. We are the forgettables. So our guys fall through the cracks.

But what I love about it, what I love about the THRIVE Act, I think it was the fact that it ties it all together as the whole person as opposed to just addressing one issue because that is what always happens to a drug addict now. It is always one issue that takes them out, so you get them sober, but then they don't have anywhere to live so they get high. Well, you get them sober and then it turns out they are bipolar and you didn't provide them any mental health services, so they relapse. You get them sober and they get fired from their job and they can't get another job, so they get high.

The thing I love about the THRIVE Act is it ties it all together and it allows us to work as a team on this panel with the THRIVE Act. So now, when you are putting them and giving them vouchers for a place to live, you are not just saying here is your money, good luck. You are saying here is your money, here is peer support, here is job training, here is mental health counseling, here is individual counseling, here is group therapy. Well, now, you have provided them with all the tools they need to take that voucher.

And eventually the endgame always has to be—I would honestly say this and hope not to offend, but if I had a guy that was 10 years' sober still living in Section 8, I would be extremely upset because the endgame has to be move them on in life. And I think that gives them the start that they need. And I thought it was genius. I am so excited about it, so thank you.

Mr. BARR. Well, thank you for the testimony.

And, Dr. Walsh, we want to get to Congressman Guthrie here, so just a quick comment and a quick question. The comment is a follow up from Chairman Duffy's exchange with you about pain management reimbursement and narcotics avoidance. The American Society of Anesthesiologists and some anesthesiologists in Kentucky are doing some groundbreaking work on enhanced recovery after surgery. We need to pursue that. I think Congress needs to appropriate funding to tie narcotics avoidance to pain management, and we need to work with our physician community to do that. So I appreciate the fact that the accreditation standards may

be revisiting that issue, and I want to work with you and U.K. and other healthcare facilities to achieve that.

The question is, following their treatment at the University of Kentucky—and the PATHWAYS program is a wonderful program; I had the privilege of visiting with the fine people there at U.K.—are there currently sufficient housing options for these women and their babies to have a safe place to live in a sober environment?

Dr. WALSH. So I think that, overall, hearing from the other panelists that there are insufficient opportunities for housing, when we hear about waitlists and the need for an additional, what was it, over 4,000 vouchers to meet the needs. And so we really need expanded access, but we need expanded access to meet people where they are.

So, for example Chrysalis House, which is an outstanding program, allows women with their children. Many programs don't allow that. As I said in my testimony, many programs will not allow people who medication is part of their recovery to participate in their programs. And I think that we need to align what it is that we know from the evidence that works.

Let me be clear: My position is not that medication is the sole answer, but it is an important component. And so I think that for places to actually make a decision and say we are going to exclude this evidence-based practice that has been endorsed by the Federal Government and not allow that in their setting I think is a disservice to the patients that we are trying to reach. So I think that we need additional resources, but we also need to have a more integrated approach.

And so Mr. Thomas just talked about integrating and everyone is talking about holistic, but I think that we really need to think about who the patients are, where they are, and then what unique things they bring and then loosening up some of the reins around some of the restrictions that we put on some of the programs. And some of them are from within.

Mr. BARR. Thank you, Dr. Walsh. And my time is more than expired, but again, as I yield back, I want to thank Chairman Duffy for coming all the way from Wisconsin to be with us in Kentucky, for your leadership on this issue, for helping as you chair the subcommittee, moving the THRIVE Act through the markup process and off the House floor over to the Senate. Thank you for your continued dedication and commitment to this very important issue.

And, Congressman Guthrie, thank you as well for your leadership and for joining us here today in Lexington.

I yield back.

Mr. DUFFY. The gentleman yields back.

The Chair now recognizes the other gentleman from Kentucky from the Energy and Commerce Committee, a Ranking Member on the Health Committee, also the author of the Comprehensive Opioid Recovery Centers Act, which passed the House almost unanimously, but like many other bills, is still waiting action I believe in the Senate.

Mr. GUTHRIE. Right.

Mr. DUFFY. That is the story of our life.

With that, the gentleman from Kentucky, Mr. Guthrie, is recognized for as much time as he may consume.

Mr. GUTHRIE. Thank you very much. I appreciate it. I guess I should take back all my nice comments about Wisconsin after your comment about that ballgame, but, no, it is great. It is a great rivalry. It is a great rivalry.

So I was going to ask my first question, and I think it has really been answered. But I think, Mr. King, since you are in the housing world more than the recovery world really, just what specifically the THRIVE Act was empowering you to do that you can't do now. I know a lot of people—so we come to the agreement, we all agree, and then I said earlier that leaving inpatient care and going into sober living is vital. So what specifically does the THRIVE Act allow you to do that you can't do now?

Mr. KING. Well, I think the THRIVE Act goes directly to the participants. It is a set-aside of the Housing Choice Vouchers, and it goes directly to the nonprofits.

Mr. GUTHRIE. The Section 8 isn't administered to you at all?

Mr. KING. It is a portion, I believe, the funds. And I—

Mr. GUTHRIE. OK. So I thought Section 8 probably went through you guys as well, but it doesn't, so—

Mr. KING. No, it—

Mr. GUTHRIE. I am not on this committee so—

Mr. KING. It—

Mr. GUTHRIE. —I don't know how Section 8 was administered through—

Mr. KING. Yes. But I think it is good in the fact that it targets a need for housing in recovery services. And again, it goes back to my suggestion that we increase that cap of 20 percent because we need to target specifically those individuals in recovery.

Mr. GUTHRIE. So it would help your specific role to do it more than this specifically?

Mr. KING. Yes. And I would say that by increasing that cap, I can do more at KHC in line with the THRIVE Act.

Mr. GUTHRIE. Oh, perfect. Great.

So, Dr. Walsh, I am interested in the First Bridge Clinic you were talking about earlier. So I am on the Healthcare Subcommittee of Energy and Commerce, and we had a group of 10 parents that came in that had lost a child and one that specifically just—so when you talk about 50 bills, well, what are you doing in 50 bills instead of one big bill? But there are a lot of different things we found were roadblocks.

And we had one family from New Jersey that specifically said they got a phone call that their son had overdosed and passed away. They didn't get the phone call from the emergency room until they came to pick up his body. That was actually his eighth trip to the emergency room, and he was over 18. He was a college student. They were paying his bills. He was on their insurance. The parents were still completely responsible for him, but by law, he was an adult.

So because of HIPAA (Health Insurance Portability and Accountability Act), that is what we are trying—some privacy. We understand the privacy side, but we also understand that parents are wanting the information, too, of their child. And I don't know the specifics of every trip to the emergency room, but you leave yourself going, if somebody has been there 8 times, is there not some

connection between the emergency care and getting them into care? So exactly—if you want to further talk about First Bridge, I would love to hear a little more.

Dr. WALSH. Sure. I am happy to talk about that. But if you don't mind, I will just reflect on what you just described because what you are describing is exactly what is happening all over the country. So people come in and out; it is a revolving door. The emergency department staffs are completely overwhelmed, and in many places they have absolutely nothing to offer to people, so they really are just treating them and then getting them out the door. People will come, they will be reversed with their overdose in the ambulance. They won't even come in the door. They don't want to be at the hospital. So we are not really making that connection at that very critical time when we have identified someone who is at high risk.

I can tell you it is actually even very difficult for us to count accurately the number of overdoses that are occurring within any hospital system because we are not even necessarily testing people's urine to determine that they have opioids and that is the cause of the overdose because if you give them naloxone and it works, then you know that is what it is, and they just send them back out. So at every level this has just been an incredible challenge.

And what we are trying to do with the First Bridge Clinic is really provide an immediate warm handoff, and that way, within an integrated system, the physician can identify that this person has either an overdose or maybe they have an ulcer from injecting drug use or some other thing that alerts them to the fact that the person has an opioid issue. They can do a pulldown on the computer to do an electronic referral directly to us. If they reach out to us from the emergency department, we have actually spoken to patients from their beds in the emergency room. We can get hospital transportation to bring them to our clinic, and we can try to start them on treatment right away.

We have just started the clinic in January. We now have 5-day-a-week coverage. We are working on having some walk-in hours so people don't have to deal with making an appointment even; they can just show up.

I can tell you the issue that you are raising about adult children whose parents are still really the caretakers, a lot of patients we have are brought in by their parents. They are adults, but they are brought in by their parents, and they sit in the waiting room and they have an argument about things, and then the person with the disorder leaves. They don't want to be there. They feel like they are being coerced, and the parents really have no influence.

And the HIPAA issue is not just that the systems aren't connecting. This area of medicine is so completely separate from everything else. If someone is in a methadone program, we don't have any way of knowing that in our program because that is also siloed by Federal law. So I think that we need to come up with some creative solutions for figuring out how we can move forward to actually empowering people to get the help that they need for their family members.

I know Massachusetts is working on a law that would actually require people to be forced into care. I am not one personally who agrees with that, but I think people are looking at innovative solutions so that we can try to help people who either are failing to recognize that they need help but really are on the verge of a complete crisis or death.

Mr. GUTHRIE. Yes, trying to get that information where emergency rooms will have that information because you are right; it is siloed. If you are in treatment or have drug issues, it is not in the medical records by law.

Dr. WALSH. Even if it is in the same health system.

Mr. GUTHRIE. Exactly. And so actually what is interesting, one of these 50 bills is on specifically—and you couldn't have two different Members of Congress. There is one gentleman from Portland, Oregon, who would be more you would describe to the left, another from Oklahoma would certainly be described more conservative, to the right, and those two together—and the debate was not really Republican/Democrat, left/right. It was more different groups on privacy versus practicality of having this done. And that bill did pass. It is in the Senate. So it is interesting. I think a lot of people outside of Washington think everything is just always a battle, but there are groups of people who have different opinions on other things that come together and they have common solutions. And that bill has passed.

And I guess I am going along, but what is interesting as I walk into every—so I told you the last couple of weeks I have been going to recovery centers, and you hear the patients there, the people talking, it just seems like everything is working well.

I did bring up the—you talked about the 16 beds. That is by Medicaid law, and we are looking for opioids, expanding that, because I saw one place that had an eight-bed room and an eight-bed room and a different administration so they could have—or that is eight beds, 16—or eight rooms had two to a room, so they essentially had 32, but they were trying to get around the law. We need to fix that so people aren't having to game it to get things done.

But the point we were talking about opening that 16-bed exclusion or limit for opioid, and it should be for more but it is just funding I guess we get back to. But one person when I said that, well, if you do that, people just create these big warehouses that have 100 beds. They will have people in them and not get the treatment.

So the question—and in those—so, Dr. Walsh, this is for you. In those 10 families we had, there was one specific family. They had different issues they were trying to address. And one family, typically from high-income families, I will spend anything it takes to get my child—so they were from New Jersey as well, suburban New York, and they were very high-income family, and whatever it takes, and so they sent their child to Florida, had passed away. It is everywhere, not just Florida, but it seemed to be an industry down particularly in southern Florida where it was like patient brokering, which was new to me where the intent didn't seem—this parent said that. I am not saying it because I don't know, but the parent said the intent didn't seem for their son to get out, but son just to go from one to the other to the other as long as they were paying.

And so I guess to get into if we are going to warehouse—the ones I have seen I have been impressed with, but how do we know a good one? I have a bill called the Comprehensive Opioid Recovery Centers to try to sort out how do we—what kind of evaluations they do in placement, be longer than a few-minute answer. But kind of in just—the THRIVE program, the THRIVE Act, because it is demonstration, how should we judge these things and test them and evaluate them?

Dr. WALSH. That is a very important question, and there really isn't a standard. And I can tell you that the American Society of Addiction Medicine does have standards of care, and they have different levels of care that they define that may be needed depending on the severity of the disorder. And you could use that framework, and people have talked about using that framework to try and grade treatment facilities.

However, the problem at least here in Kentucky is that we only have a few of those levels of care. We don't have the whole complement based on what the ideal circumstance would be. We are not the only ones, though, so I do think that there are evidence-based practices that have been defined and they are on the website for SAMHSA. We know what they are. I think that we can start by developing guidelines that check off those boxes and that actually are doing the monitoring that is necessary.

So when somebody is saying that people are successfully abstaining, then I want to see your drug screen results from that. I don't want to see just self-report. So, like Mr. Thomas said, when they are linking with an employer, they are testing people 3 times a week, they know exactly what is happening. That is not occurring in all settings.

In some of the treatment programs, there is a lot of drug use that goes on. And I am not talking about anybody that is at this table. I am just saying that there are places where, as you described, they are in it for the profit, and they are less concerned about the well-being of people as long as they are getting care.

There was a big exposé about some of those programs in southern Florida, and there is some suggestion that those same places that were pill mills before have been shut down, and now this is a different business model for them. We know that there are a lot of overdoses, fatal overdoses that take place in some of these programs. They are not publicized. That is not a good outcome when that happens. But oftentimes, people are not made aware of it.

So I think that we can take what we know from the scientific literature about how one would do a study to assess the efficacy of a treatment and borrow those same types of monitoring practices and implement them and customize them for recovery houses and for treatment programs for residential because we know what the goals are. If the goals are to get jobs, if the goals are to get somebody so that they are surviving, these are really objective markers. But I think then you want some external source doing that evaluation. You don't want to necessarily have people reporting on their own without some external evaluation.

Mr. GUTHRIE. Thank you. And I am not going to ask another question, but I just want to say I know Mr. Robinson has been to

Washington to testify. Mr. Boggs, I appreciate what you guys do specifically, and all of you.

I am also on the Education and Workforce Committee, Chairman of the Higher Ed Subcommittee that has the jurisdiction of the Workforce Investment Act or WIOA Opportunity Act, and so it is all vital to tie together. And I think you are seeing all sides in Washington. As Chairman Duffy said, we are all agreeing that we need to put this together, and I think once we know we are paying for the good programs and the funding, we want to make sure we are, the funding is following, and so there is a lot of work to be done but a lot of effort is being done and a lot of—trying to understand it and trying to comprehend it and trying to move forward and getting—and I am left convinced, getting people into sober living is probably our most critical part now because we have a lot of residential treatment. There may be a waiting list for them but not a big control on the sober living side of it, and so I appreciate Congressman Barr's leadership and appreciate everybody coming together to talk about that because this is important to highlight.

Thank you, Mr. Chairman, and I yield back.

Mr. DUFFY. The gentleman yields back.

I want to again thank our panel for their participation in today's hearing. I want to thank Chairman Barr for all the work he did in putting this hearing together, making sure we had a well-rounded panel, providing us excellent insights.

If I could make one parting note, the best ideas for legislation come not from Washington, it comes from all of you who are on the frontlines doing this work. And there is a great partnership that happens. If you have an idea and you get it to Mr. Guthrie, Mr. Barr, or myself and we introduce it, one, we have stolen your idea and we look really smart; and two, you get your idea into legislation. But in the end we are helping people. We are getting the right bills, the right legislation that do the most to help the most vulnerable among us, and that is what is really critical here.

And I just want to thank all of you for the work that you do, for taking the time out of your day to participate in this hearing so we can take the information garnered in this hearing back to our colleagues in Washington. So thank you for your time and your effort and your good work.

Without objection, all members will have five legislative days within which to submit additional written questions to the chair, which will be forwarded to our witnesses. If we have any of those additional questions, I would ask the witnesses to respond as promptly as feasibly possible.

With that, and without objection, this hearing is now adjourned.

[Whereupon, at 11:05 a.m., the subcommittee was adjourned.]

A P P E N D I X

August 16, 2018



**Testimony of David I. Boggs,
President/CEO of Opportunity for Work and Learning**

**Before the House Financial Services Subcommittee on
Housing and Insurance**

**Hearing on
“The Role of Federal Housing and Community Development
Programs to Support Opioid and Substance Use Disorder
Treatment and Recovery”**

**Thursday, August 16th, 2018 at 9:00 AM
Courtroom A, U.S. District Court of the Eastern District of
Kentucky
101, Barr Street, Lexington KY, 40507**

Good afternoon Chairman Duff, Ranking Member Cleaver, and other distinguished members. It is an honor to address this committee in regards to the epidemic of opioid addiction in our nation and the serious housing challenges this population faces. Since housing is a vital step in the recovery and reentry process, the THRIVE Act and CAREER Act can have a major impact on abolishing this crisis. Considering that this epidemic touches every family in our nation, establishing long term solutions should indeed be a top priority.

I would like to share with you the role Opportunity for Work and Learning (OWL) plays in the topic at hand, and my views on how the Federal government can use existing housing and community development programs to complement community efforts to treat individuals experiencing opioid addiction. OWL provides key elements in the transitional path to self-sufficiency through job training and employment services.

Housing and employment go hand-in-hand, so it is difficult to successfully maintain one without the other. And yet too often, ex-offenders are lacking at least one of these once they are released from prison. Consistent housing cannot be obtained without employment that will provide enough income to meet the demands of either renting or owning. Many of these individuals lose their employment due to the challenges faced through inconsistent living conditions such as "couch surfing".

Individuals come to OWL from many different paths: returning citizens recently released from incarceration, a short or long-term recovery program, or someone struggling with opioid addiction while still trying to maintain employment. The struggle is overwhelming and often leads to more serious consequences.

OWL partners with communities to help individuals overcome barriers to achieve personal and professional growth. Annually, 600,000 people in our nation are being released from prison. The number of people at risk of falling back into the lifestyle that led them there in the first place continues to climb because of the lack of housing and employment. In addition to the criminal record preventing these individuals from finding jobs, statistics show that ex-offenders far too often have limited education and work experience, and therefore do not have the skills required to perform in the workforce.

The Lexington Manufacturing Center (LMC), a wholly owned subsidiary of OWL, is an on-site advanced manufacturing center that provides training in the essential skills so desperately needed and demanded by today's employers in every job sector. LMC employees earn more than minimum wage and have the opportunity for increases every 90 days. Other benefits include production bonuses, health insurance options, matching retirement and other company benefits. The various trainings LMC provides include a manufacturing certification in forklift and material handling as well as third-party inspection, kitting, assembly, and woodworking. The programs OWL and LMC have in place have proven to be successful in the path to self-sufficiency and the attainment of stable housing and employment.

OWL has maintained a strong partnership with the KY Office of Vocational Rehabilitation since 1961. This relationship has led to the employment or related services being provided to over 23, 000 individuals in central Kentucky. Through OWL's services and programs in FY18, over 74 participants gained full-time employment while more than 60% of them had some type of opioid or other substance abuse history. We fully adhere to WIOA mandates for youth and adults with barriers that are mandated for Community Rehabilitation Programs.

Paul came to OWL as a result of an on-going opioid addiction that cost him his home and family as well as jail time. Fortunately, a Drug Court diversion program opened their doors to him rather than long-term incarceration. Today, he is reunited with his family, whom he can now adequately support, and has home ownership.

James came to OWL after he had served over 24 years in our state and federal judicial systems. Thanks to OWL's partnership with community housing agencies, James was able to begin his pathway to a new life. Today, he has been employed at OWL for over five years, has full employee benefits, and lives independently.

Paul and James are just two examples of individuals who have struggled because of the impact the opioid addiction had on their lives. Sadly, they are not alone; there is an overwhelming need for housing and employment services for others trying to escape the opioid crisis in their life. Funding must be accessible for research based programs like OWL and others represented here today that have a proven track record of employment training, job placement and housing. Programs that can easily be replicated and expanded upon in our individual communities must be provided oversight and guidance to establish consistency and collaboration to maximize resources and human capital.

We applaud the work being done by this committee and the leadership Congressman Barr is providing in Congress and Kentucky through Bills he has sponsored. The battle against the housing and opioid crisis is not just a Kentucky epidemic but a national pandemic that has no borders. Thank you again for this opportunity to share with you the mission of OWL and our efforts to join with you in conquering this crisis.

Testimony for the Subcommittee on Housing an Insurance Hearing Entitled:
**“The Role of Federal Housing and Community Development Programs to Support Opioid and
Substance Use Disorder Treatment and Recovery”**

August 16, 2018, 9-11am

US District court of Eastern District of Kentucky
101 Barr Street
Lexington, KY 40507

Ernie Fletcher, MD
Former Governor, Commonwealth of Kentucky
Chair, Fletcher Group, a not for profit corporation

Good morning, Chairman Duffy and Ranking Member Cleaver. Let me welcome you to Kentucky and thank Congressman Barr for bringing this important hearing to the 6th District.

In America, every 8.5 minutes someone dies from a drug overdose with about 80% due to opioids. Every 6.5 minutes someone dies from alcohol abuse. Every 12 minutes some dies of suicide—many associated with substance use disorder (SUD). This is a public health emergency of the most challenging nature. In a conversation with NIDA Director, Dr. Nora Volkow, she reported an increase in methamphetamine use in areas where efforts have reduced opioid abuse, which points to the fact that most who abuse drugs do not use just one drug, they are likely to use two or more, as well as alcohol.

One way of addressing this crisis is through programs like Recovery Kentucky that include transitional housing along with peer support based upon the 12-step model. We now have 18 centers in Kentucky with over 2100 recovery beds. Our outcomes are very good—at one year, 84% of individuals have not relapsed. I refer you to our outcomes at a glance attached to this testimony for a complete summary.

Overall, Recovery Kentucky clients make significant strides in all targeted areas and have much more support for their recovery after participation. In addition, the Recovery Kentucky Program saves taxpayer dollars and adds value via workforce development as over 75% of graduates become gainfully employed.

The recovery programs have been named “A Model That Works” by the U.S. Department of Health and Human Services and the Louisville Courier-Journal called the Recovery Kentucky Centers a “bright spot” for dealing with prescription-drug abuse.

We are pleased with the outcomes but recognize that up to 30% drop out of this voluntary program and leave before entering the program. Those individuals may be better suited for medication assisted treatment or MAT. MAT is evidenced based, but it too does not work for everyone and it is primarily focused on opioid use disorder.

One size does not fit all and a holistic approach that combines the recovery model and MAT may provide the best approach to meet individual needs. For that reason, as my organization seeks to expand this model to other states, we are partnering with MAT providers to offer program alternatives and provide effective intervention for a larger number of people. Congress has allocated nearly \$6 billion for MAT based grants and research. Some of this may be directed toward residential recovery program efforts if they combine MAT, but most will not.

Our program depends upon funding thru HUD and is consistent with the HUD *Recovery Housing Policy Brief* that defines Recovery Housing in an abstinence-focused and peer-supported community. Facility funding depends upon Low Income Housing Tax Credits and money from Federal Home Loan programs. Operational funding combines Section 8 vouchers, SNAP, Community Development Block Grants and per diems paid for by state Department of Corrections along with local fundraising. Nearly 70 % of our residents are from Corrections--parole, probation or diversion from drug courts. For Corrections, it is a prudent use of tax dollars with a great ROI. Why? Because in large part we stop the cycle of poverty and criminal activity often associated with drug seeking behavior, as well as responding to the chronic health conditions represented by drug and alcohol addiction. Our recidivism rate is low because lives are transformed by engendering meaning and purpose and teaching skills necessary for self-sufficiency.

This type of transformation is only possible when housing is incorporated in the program that extends beyond 28 days as often found in residential treatment programs. The controlled environment found in the Recovery Kentucky programs provides the discipline, training and support that overwhelmingly stops the cycle of poverty, homelessness and criminal activity by addressing root causes. With low rates of relapse, we reduce the risk of overdose as well--an important goal of your efforts.

Given this backdrop, I want to thank Congressman Barr and each of you here today for the work you are doing to combat the opioid crisis.

As part of the Fletcher Group we have established the Don Ball Foundation for Recovery Hope and are working to take our Recovery Model nationally in honor of Don, a local businessman and philanthropist who is responsible for founding Recovery Kentucky.

We are establishing a Technical Assistance Center that will provide consultation, training and support to states for the establishment of similar programs, expanding capacity and building on best practices that enhance recovery efforts such as access to education, job training and skills development, and participation in program sponsored businesses.

We currently utilize creative funding streams from HUD, USDA and the Department of Corrections. But as we take this model nationally, we face a challenge that section 8 housing is limited and competitive and when we apply for this type of housing there are those, well intended, who see this as taking from the allocation to help others who have real and valid housing needs. We believe that pitting those needs against the needs of those who have been held captive from addiction is not the best public policy.

Congressman Barr's bill, the THRIVE Act, helps solve this problem by providing project-based vouchers, which will help foster residential recovery programs important to address the opioid crisis.

Setting aside project vouchers in this way will make it easier to provide more effective recovery programs. Unfortunately, there are, as in every industry, those who run programs that are little more than scams. Thankfully, this legislation has stipulations to ensure the programs funded are effective and well run, like Recovery Kentucky and other well-run programs across the nation.

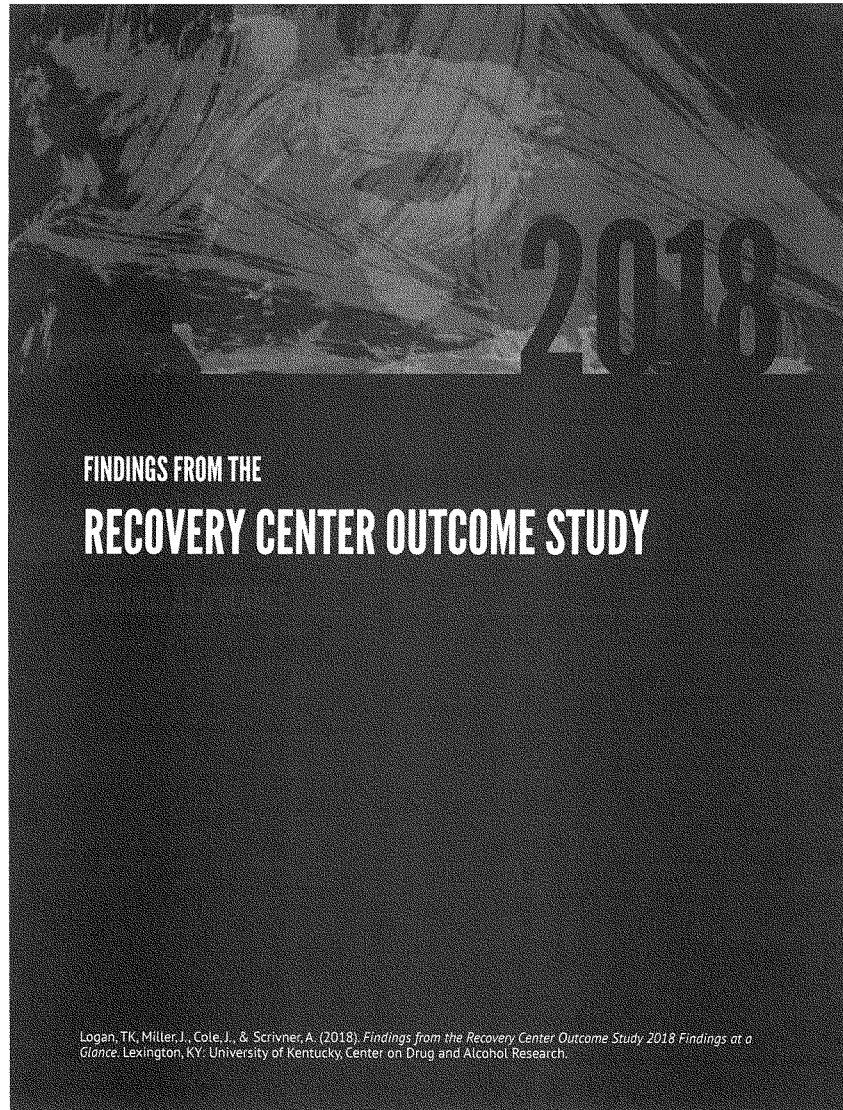
Another of our funding sources is CDBG grants. These funds are always at risk and I would recommend that you look at making funds available for proven and effective residential recovery programs as well as traditional MAT.

I also want to thank Congressman Guthrie and Green for their legislation, The Comprehensive Opioid Recovery Centers Act of 2018 which would award grants on a competitive basis to eligible entities to establish or operate Comprehensive Opioid Recovery Centers. I am hopeful those who want to establish recovery centers based upon the Recovery Kentucky model will be eligible.

In summary to provide the best continuum of care to address this crisis, the Don Ball Foundation for Recovery Hope recommends:

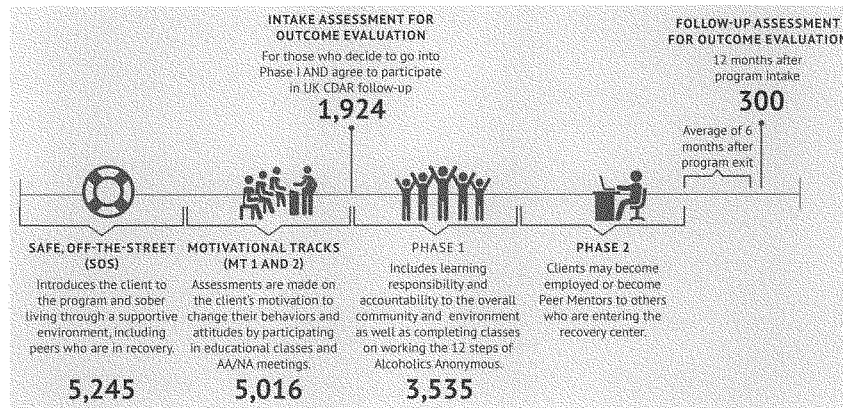
- Passage of the THRIVE Act
- Recommend taking some of the already identified opioid budgeted funds to add additional funding for more of these project-based vouchers because of the pressing need and effectiveness of residential programs
- More allocation of the Opioid appropriations be directed toward proven recovery efforts in addition to MAT
- Provide funding that would offset cuts for CDBG grants recognizing that substance abuse treatment is an important part of community development
- Lastly, I recommend that the CDC activate the Emergency Operations Center to help coordinate and oversee this fight. It is at the heart of CDC's purpose and it is the right agency to coordinate the epidemiological effort against this public health crisis

Again, thank you for your work and coming to Kentucky. I will be glad to answer any questions.



INTRODUCTION

Recovery Kentucky was created to help Kentuckians recover from substance abuse, which often leads to chronic homelessness. There are 17 Recovery Kentucky centers across the Commonwealth, providing housing and recovery services for up to 2,100 persons simultaneously. Recovery Kentucky is a joint effort by the Kentucky Department for Local Government (DLG), the Department of Corrections, and Kentucky Housing Corporation. Local governments and communities at each Recovery Kentucky center location have also contributed greatly to making these centers a reality.¹ The overall program is composed of 4 main components through which clients advance:



The Behavioral Health Outcome Studies team at the University of Kentucky Center on Drug and Alcohol Research (UK CDAR) independently conducts the Recovery Center Outcome Study (RCOS) which is an annual outcome evaluation that includes 15 of the Recovery Kentucky centers who participated in RCOS this fiscal year. Recovery center staff conduct an intake interview when clients enter Phase I after completing SOS and MT 1 and 2 to assess behaviors and problems clients had prior to entering the recovery center. Follow-up interviews are then conducted over the telephone by an interviewer at UK CDAR with eligible, consenting RCOS clients 12 months after Phase 1 entry. A random sample of eligible clients, stratified by target month (based on the intake month), gender, and Department of Corrections (DOC) referral into the program, was selected. Client responses are kept confidential to help facilitate the honest evaluation of client outcomes and program services.

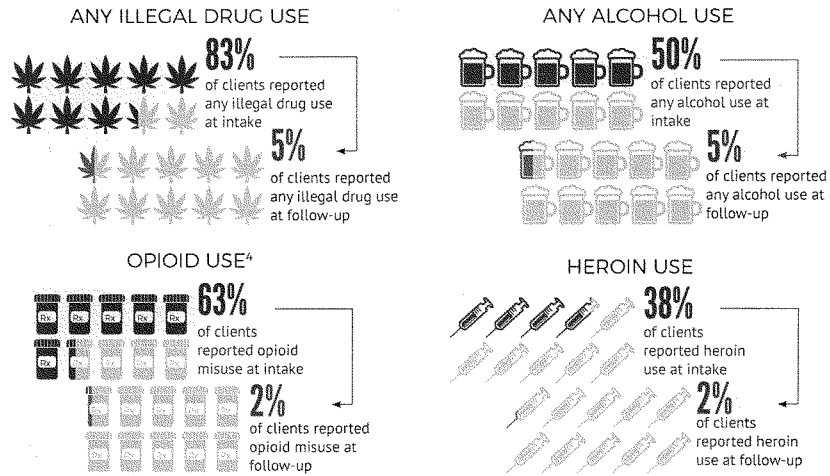
This Findings at a Glance report summarizes outcomes for 300 men and women who participated in a Recovery Kentucky program, completed a Phase 1 intake interview between July 2015 and June 2016 and a follow-up interview between July 2016 and June 2017.² At intake, most clients included in this report were White (92%), not currently married (89%), predominately female (57%) and, on average, 34 years old.

¹ For more information about Recovery Kentucky, contact KHC's Mike Townsend toll-free in Kentucky at 800-633-8896 or 502-564-7630, extension 715; TTY711; or email MTownsend@kyhousing.org.

² Fifteen of the currently established Recovery Kentucky programs participated in the Recovery Center Outcome Study between July 2015 and June 2016 and 12-month follow-up survey between July 2016 and June 2017.

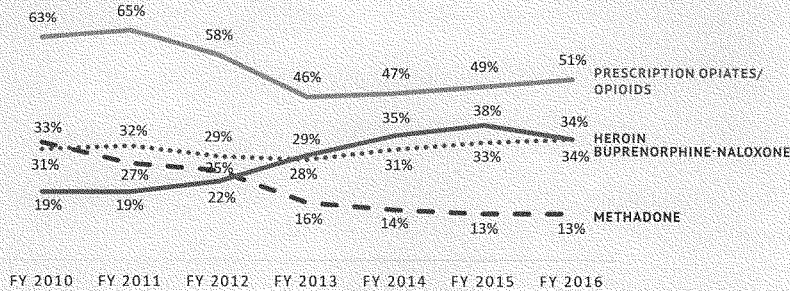
FACTORS EXAMINED AT INTAKE AND FOLLOW-UP

PAST-6-MONTH SUBSTANCE USE³



HOW MUCH HAS OPIOID AND HEROIN USE CHANGED OVER TIME?

This trend analysis examines the percent of RCOS clients who reported misusing prescription opiates/opioids, non-prescribed methadone, non-prescribed buprenorphine-naloxone (bup-nx), and heroin in the 6 months before entering the program from FY 2010 to FY 2016.⁵

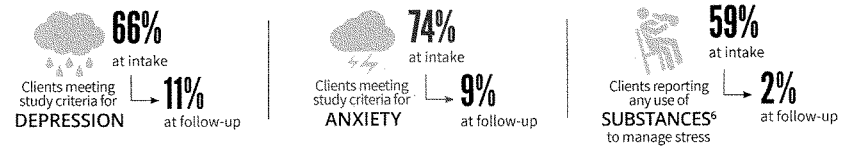


³ Because being in a controlled environment inhibits opportunities for alcohol and drug use, clients who were incarcerated the entire period measured at intake were not included in this substance use analysis (n = 17).

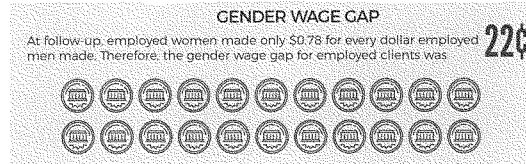
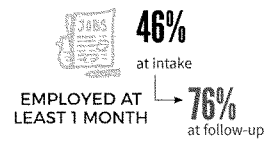
⁴ Misuse of opioids other than heroin, including prescription opiates, methadone, and buprenorphine-naloxone.

⁵ On average, there were 1,200 intake surveys submitted each fiscal year.

PAST-6-MONTH MENTAL HEALTH AND STRESS

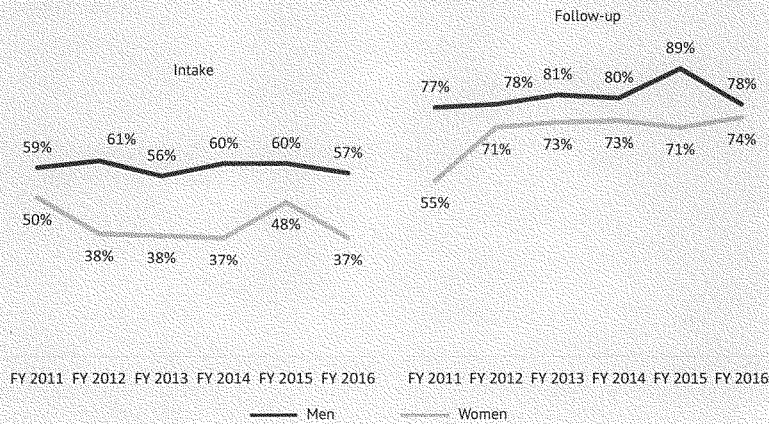


PAST-6-MONTH ECONOMIC INDICATORS



EMPLOYMENT TRENDS BY GENDER

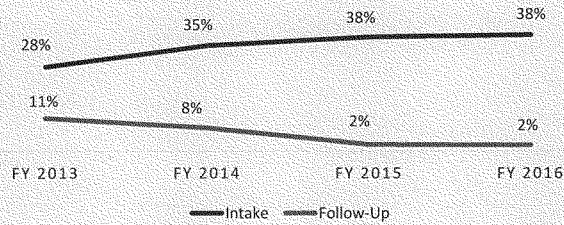
Since FY 2011, the disparity in employment between men and women in the RCOS follow-up sample has been documented.



* Includes alcohol, prescription drugs, and illegal drugs.

TRENDS IN HOMELESSNESS

In the past four fiscal years, the number of people reporting homelessness at intake has increased slightly and the number of people reporting homeless at follow-up has decreased.



PAST-6-MONTH CRIMINAL JUSTICE INVOLVEMENT

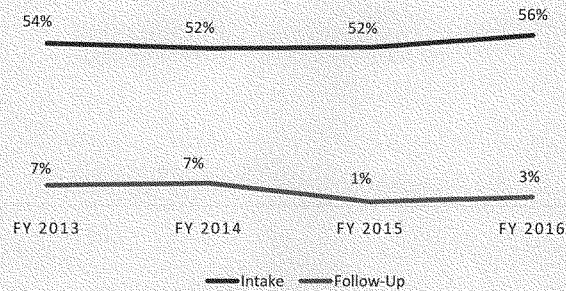


“The program changed me and I’m now a peer mentor. I know about this disease better and I have the tools to stay sober.”

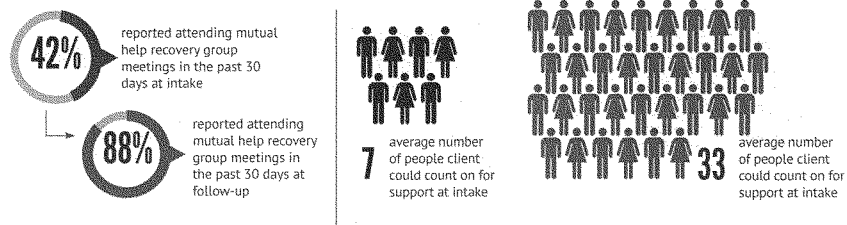
—RCOS FOLLOW-UP CLIENT

TRENDS IN ARRESTS

Over the past 4 years, over half of RCOS clients reported being arrested at least once in the past 6 months. At follow-up, significantly fewer clients reported an arrest in the past 6 months.



RECOVERY SUPPORTS



RETURN ON INVESTMENT IN RECOVERY CENTER SERVICES

\$2.60
ESTIMATED
RETURN FOR EACH
DOLLAR INVESTED

Estimates of the cost per drug user and alcohol user were applied to the sample to examine the total costs of drug and alcohol abuse to society in relation to expenditures on the Recovery Kentucky program. The cost savings analysis suggests that for every dollar invested in recovery services there was an estimated \$2.60 return in avoided costs (i.e., costs to society that would have been expected given the costs associated with drug and alcohol use).

CONCLUSION

Overall, Recovery Kentucky program clients made significant strides in all of the targeted areas and have much more support for their recovery after participating in program services.⁷ In addition, the Recovery Kentucky Program saved taxpayer dollars through avoided costs to society or costs that would have been expected based on the rates of drug and alcohol use.

“They truly, honestly cared about me and want me to have a fruitful and productive future.”

—RCOS FOLLOW-UP CLIENT

⁷ It is important to keep in mind that the RCOS sample includes only clients who advanced to Phase 1 after completing the SOS and Motivational Tracks and who agreed to be contacted for the follow-up survey 12 months after entering Phase I.

Testimony of Edwin King
for the
House Subcommittee on Housing and Insurance
August 16, 2018 – Field Hearing in Lexington, KY

Chairman Duffy, Members of the Subcommittee:

I am Edwin King, executive director of Kentucky Housing Corporation (KHC), the Commonwealth's housing finance agency. On behalf of KHC's Board of Directors and staff, thank you for conducting this field hearing in Lexington and affording me the opportunity to provide testimony. I want to thank Congressman Barr publicly for bringing attention to the problem of opioid addiction in the Sixth District and for working to implement common-sense solutions. The passage of his bill, the Transitional Housing for Recovery in Viable Environments (THRIVE) Act, demonstrates his commitment to housing solutions for those on the road to recovery. It is my pleasure to share information about Kentucky's accomplishments in leveraging housing resources to help our citizens on the path of recovery from substance use disorder.

We all understand that opioid addiction is a major public health issue with significant personal and societal consequences. We have found that there are many effective recovery strategies, depending on the personal circumstances of those caught in the grip of addiction. Stable housing is a basic human need and one of the primary social indicators of public health. Access to stable housing is one common factor that is essential for all of these strategies to produce positive results.

One of the most successful recovery strategies we have seen in Kentucky is the Recovery Kentucky model. In 2004, the late Don Ball took the helm as chair of the KHC Board of Directors. Mr. Ball brought with him a personal commitment, a strong will, and a solid plan to establish a network of recovery centers across Kentucky. Because of Mr. Ball's vision, Kentucky now has 14 recovery centers that have helped thousands of our residents start a new life of recovery from addictive substances. These 14 centers are in addition to the four prototype recovery centers (two in Louisville, The Healing Place for men and The Healing Place for Women, and two in Lexington, The Hope Center for men and The Hope Center for women). Today, these 18 recovery programs serve over 2,000 men and women daily.

The Recovery Kentucky Centers follow a peer-to-peer education and self-help model that uses mutual self-help, a "social model" approach, to provide sustained addiction recovery services. The centers are not licensed medical facilities and, thus, do not qualify for Medicaid reimbursement. All residents have Medicaid or private health insurance. Therefore, physical or mental health needs can be provided through licensed service providers in their local community. The recovery centers provide a highly structured program for residents. Peer Mentors model behaviors and spiritual principles that focus on providing life skills to residents by following the spiritual principles of the 12 steps of Alcoholics Anonymous.

Information from the University of Kentucky Center for Drug and Alcohol Research points to the significant success of the Recovery Kentucky model:

- 83% of all residents in the recovery programs used illegal drugs 6 months before entering a recovery center. Follow-up surveys of former residents showed that only 5 % had used illegal drugs within six months of having left a recovery center.

- Six months prior to entering a recovery center, 63% of residents reported opioid misuse. At follow-up one year later, only 2% reported opioid misuse since leaving the recovery center.
- 38% of residents were homeless at intake; 2% were homeless at follow-up.
- 56% had been arrested and 76% had been incarcerated six months before entering a recovery center. At follow-up, 3% had been arrested and 13% had been incarcerated.
- Cost savings analysis suggests that for every dollar invested in recovery services there has been an estimated \$2.60 return in avoided costs.

Overall, Recovery Kentucky program clients made significant strides in all the targeted areas and have much more support for their recovery after participating in the program. The program saves taxpayer dollars through avoided costs based on the rates of drug and alcohol use.

Recovery Kentucky – and the tremendous impact this program has had on so many plagued by the scourge of drug addiction – would not have been possible without the housing program dollars appropriated by Congress. The Recovery Centers rely on a complex array of federal funds for construction and operation, including the following:

- Low Income Housing Tax Credits
- HOME Investment Partnerships Program
- Community Development Block Grant (CDBG) Funding
- Section 8 Housing Choice Voucher Program
- Supplemental Nutrition Assistance Program (formerly Food Stamps)

Other important sources of funding come from the Kentucky Affordable Housing Trust Fund and Department of Corrections, as well as the Federal Home Loan Bank.

It has become increasingly difficult to develop more Recovery Centers for two primary reasons:

- There is less funding in key federal programs.
 - HOME Program funds have contributed to constructing the Recovery Centers. The 50% reduction in HOME funds since the Recovery Kentucky initiative began has sharply limited the ability of developers to pull construction financing together to build more centers.
 - CDBG funding has been critical for the ongoing operation of the facilities.
 - The Section 8 Housing Choice Voucher program provides rental assistance that supports residential facility maintenance and operating costs. KHC currently has a three-year waiting list for our Housing Choice Voucher program. Additional funding would help meet the need for people in recovery in addition to the low-income residents of rural Kentucky who also receive assistance from these vouchers.
- These federal programs have stringent regulations that impede the effective use of the dollars.
 - KHC has experienced significant challenges recruiting landlords to participate in the Section 8 Housing Choice Voucher, tenant-based program, with many citing programmatic red tape as an obstacle. Additionally, federal statutes restrict the amount of tenant-based rental assistance that may be used for a specific property (pursuant to the project-based rental assistance option) to 20% of a public housing authority's Housing Choice Vouchers. While some urban public housing authorities have been permitted to exceed this limit under a demonstration program, many authorities,

including KHC, are at or near the 20% limitation. One useful reform would be to raise the 20% cap and allow public housing authorities, like KHC, to use these vouchers to meet our specific needs at the local level to connect people to housing with services. This is an extremely important source of funding for developing supportive housing for individuals completing recovery and acute treatment programs to keep them on the path toward employment, self-sufficiency, and family reunification. I sit on the Board of Directors of the National Council of State Housing Agencies, and after speaking with my counterparts in other states, I can tell you that this policy change would be welcomed on a bipartisan basis across the country.

- Many other states have expressed interest in replicating the Recovery Kentucky model because of its demonstrated effectiveness. However, many of these states report that they have not been able to access resources like CDBG for a Recovery Kentucky Model. The operations of almost all of the Recovery Kentucky centers are subsidized by CDBG funds. It would be helpful to have a dedicated source of funding for recovery centers outside of the CDBG funding, so that CDBG funds can be freed up for infrastructure and other community needs, while recovery centers receive their own dedicated source of funding.

I will conclude my remarks with these key statements:

- Recovery Kentucky is a housing-based model that has produced remarkable outcomes and has proven to be highly cost effective.
- Housing is a key component of successful recovery programs and is essential for long-term recovery.
- Greater flexibility with federal housing program regulations will provide states more control of the resources needed to achieve the goals of the President's Commission on Combating Drug Addiction and the Opioid Crisis.

Thank you for taking on this difficult, but important, work to help ensure access to effective recovery programs. KHC led the way more than a decade ago and remains a dedicated partner to this effort.

**TESTIMONY OF LISA MINTON, EXECUTIVE DIRECTOR
CHRYSLIS HOUSE, INC.
FOR THE
HOUSING AND INSURANCE SUBCOMMITTEE FIELD HEARING
“THE ROLE OF FEDERAL HOUSING AND COMMUNITY DEVELOPMENT
PROGRAMS TO SUPPORT OPIOID AND SUBSTANCE USE DISORDER
TREATMENT AND RECOVERY”**

AUGUST 16, 2018

**COURTROOM A, U.S. DISTRICT COURT OF EASTERN DISTRICT
101 BARR ST. LEXINGTON, KENTUCKY**

Good morning Congressman Barr, Congressman Guthrie, Chairman Duffy, Ranking Member Cleaver, and other interested parties.

I am Lisa Minton, Executive Director of Chrysalis House, a 501(c)(3) nonprofit agency located in Lexington, Kentucky. Chrysalis House was established in 1978. We have been saving lives for 40 years. We are Kentucky's oldest and largest licensed treatment program for women with substance use disorders.

The Chrysalis is the protected stage just before the beautiful butterfly emerges. That is what we want for the 200 women and children we serve each year.

Our mission to support women and their families in recovery from alcohol and other drugs led to our family-centered approach to treatment. We serve women from across the state.

As reported in the Herald Leader on Sunday, the CDC report released on Friday cited, “Kentucky had one of the highest rates in the nation of pregnant women using opioids...another example of the state's struggle with abuse of painkilling drugs.”

We prioritize pregnant and parenting women on our waitlist, which has a daily census of approximately 120 women. We are one of the few programs that allow babies to accompany their mothers to treatment. We believe the opportunity for our clients to be with their babies and young children is a powerful incentive to recovery.

A brief snapshot of the women we are currently serving:

average age is 26-30;

41% are pregnant;

61% report their primary substance of abuse is heroin or other opioid;

85% have had one or more prior treatment episodes;

98% are unemployed; and,

60% meet the homeless criteria for transitional housing.

This population needs additional recovery supports. Housing and employment are imperative to long-term sobriety.

We received our first Department of Housing and Urban Development (HUD) Supportive Housing Program-Transitional Housing grant in 1990 and had received HUD Permanent Housing grants for over 20 years.

In 2016, our Transitional Housing renewal \$200,000 grant application for our Family Program and Serenity Place Apartments was not selected by our Continuum of Care (CoC). The funding ended June 30, 2017.

This came as a surprise because a few months earlier in March 2016, our Family Program and Permanent Housing Bonus Program data tables were accepted for use in the Annual Homeless Assessment Report (AHAR). The AHAR is a report to the U.S. Congress on the extent and nature of homelessness in America. The report is prepared by HUD and provides nationwide estimates of homelessness. To my knowledge, the Lexington CoC had never had any data tables accepted for use in the AHAR until then.

Our two permanent housing applications were selected for funding: \$93,000 for scattered site apartments, and \$60,000 for permanent housing bonus apartments.

In 2017, we lost both of those grants as well.

We have gone from about \$360,000 a year in HUD funding to support homeless families with histories of substance abuse to 0.

The loss of funding was due to a shift in HUD's funding priorities (FY17 NOFA):

*CoCs should use the reallocation process to create new projects that improve their overall performance and better respond to their needs.

Our CoC has done this; choosing new projects over existing projects.

*CoCs should use a Coordinated Entry process which measures average length of homeless episodes and rates of return to homelessness, prioritizing chronic homelessness. Each agency receiving HUD funding through the CoC must utilize a Coordinated Entry process which prioritizes chronic homelessness.

Having been in residential treatment, the women we serve would not meet that definition. We phased families from residential/transitional housing into permanent housing funded by HUD. HUD's policies prioritize the chronically homeless who could be actively using over those seeking a supportive community dedicated to their sobriety, income, and family reunification.

*CoCs should use a Housing First approach which does not have a service participation requirement or preconditions.

This policy is strictly looking at if people stay in housing. For women, particularly those with children, housing represents more than just shelter; it is safety, a crucial support for recovery. They need supportive services. Transitional Housing is a place to learn the skills necessary to manage a disease, a job, transportation, childcare, etc. prior to managing a household.

We did meet the HUD's old definition for transitional housing: having a lack of financial resources and support, efforts have been made to obtain housing, without assistance they would be living on the street or in a shelter or they have been discharged from an institution having lived there for a long time and no resources, no support, and no subsequent residence. All conditions that mitigate against sobriety.

Policymakers are seeing a link between homelessness and substance use disorders. But the policy at HUD ignores that link and actually enables non-sober housing.

Senate Majority Leader Mitch McConnell recognizes the needs for long-term success and we are grateful for his continued support and leadership. We are encouraged by the CAREER Act and the opportunity it provides for the women and families we serve as they work to rebuild their lives.

Additionally, we look forward to the passage of Congressman Andy Barr's THRIVE Act. The Bill will create a demonstration program that allocates a limited number of Section 8 Housing Vouchers to transitional housing nonprofits. 10,000 vouchers will be set aside, allowing nonprofits to directly report to HUD.

The Thrive Act will show how crucial supportive services are to support those seeking sobriety break the cycle of addiction, poverty, and homelessness. It is an important means to re-connect the link between addiction and homelessness in HUD policy.

Thank you for inviting me to share with you today. I am happy to take questions.



NARRATIVE OF TESTIMONY BY TIM ROBINSON,
CEO OF ADDICTION RECOVERY CARE
FOR THE
SUBCOMMITTEE ON HOUSING AND INSURANCE
AUGUST 16, 2018 IN FRANKFORT, KENTUCKY

Good morning. My name is Tim Robinson, CEO of Addiction Recovery Care.

More people died from overdoses than car accidents last year making addiction a national public health crisis that is taking too many lives and threatening our economic security as employers struggle to find and retain employees. Last year our Kentucky Chamber of Commerce CEO wrote an Op Editorial that called addiction the number one economic concern in our state.

Everyone is looking for a silver bullet to address the addiction crisis. There isn't a silver bullet. Addiction recovery requires a whole-person approach which starts with intervening with treatment, investing in someone's economic future by providing access to transitional housing, vocational rehabilitation, workforce development, and inspiring them from day one that there is hope to go from crisis to a career.

I am thankful for the opportunity to speak to you because recovery is personal to me. I started drinking in my first year of law school at the University of Kentucky to cope with my mom passing away during finals. For the next eight years, I almost drank myself to death. Eleven years ago, while I was a prosecuting attorney in Lawrence County, Kentucky, a court bailiff who was a recovering alcoholic and pastor, led me to a spiritual awakening at my desk. He became my sponsor and my pastor. Addiction recovery is personal to me because I am a survivor.

Two years later in 2008, I resigned as prosecutor and in 2010 opened a residential center for women in rural Eastern Kentucky. Today we have 350 residential clients and 500 outpatient clients in centers across 12 counties in Kentucky. Our experience has taught us that addiction is a disease that devastates all aspects of a person's life impacting someone's mind, body, spirit, and purpose. We have been determined to treat addiction medically, clinically, spiritually, and vocationally.

Our centers are led by an addictionologist and are nationally accredited. We have developed a spirituality program that inspires hope and offers redemption. Much like hospice centers, we employ chaplains who work alongside of our clinical staff. Though we consider the spiritual aspect of our centers to be the heart of our success - our spirituality program does not replace medical and evidence-based clinical practices - it is an addition to them and makes our care more comprehensive.

Treating the whole person has led to great success. One of our payors recently reported to us that our centers reduced their members' healthcare costs by 33% during the 6 months after program completion.

We created an internship with a promise that everyone who completes the program would be guaranteed a job. Today, 190 of our three hundred and eighty (380) employees are in recovery and 130 are graduates of our programs.

We are a state-certified, Peer Support Specialist (PSS) training program. A Peer Support Specialist is a Medicaid-billable professional who has one year of sobriety and completes a certification program.

We partnered with workforce board, Eastern Kentucky CEP, and with Sullivan University to expand our internship into a 6-month career academy. Our graduates earn state certification and college credit. In just one year, a person in addiction can go from an IV heroin user to supporting themselves, literally going from crisis to career.

To date, 41 of our 46 or 85% of our academy graduates are clean and sober, working full time, paying taxes and transitioning off public assistance. Some of the graduates have even been promoted to management, and others are continuing their education for careers such as counseling.

Prior to the Academy, 40% of our clients chose to continue treatment beyond detox and residential care. After starting the Academy, 70% of our clients now choose to continue treatment doubling treatment motivation.

Vocational education that leads to a meaningful career that provides the dignity of work gives those reentering the workforce the confidence necessary to establish career goals and plan for their future. Because of this success we are adding other programs such as an auto mechanics academy.

Kentucky is leading the way in access to treatment because of the national leader on this issue, Congressman Hal Rogers and the efforts of our Governor Matt Bevin. The two biggest challenges preventing us from taking more people from crisis to a career is a lack of funding for workforce development and transitional housing. That's why I am so excited about Congressman Andy Barr's bill, the T.H.R.I.V.E. Act and Senate Majority Leader Mitch McConnell's C.A.R.E.E.R. Act. These two historic pieces of legislation have the potential to transform the national effort to combat the drug epidemic.

The hope of America is not merely surviving. The hope of America is an opportunity to flourish. That is what our brothers and sisters in addiction need; an opportunity. An opportunity for treatment, transitional housing, and workforce development that leads to a meaningful career path, and when the opportunity is given...I have seen us not just survive, but thrive. Our current human capital and labor shortage can be solved at the same time we combat the drug epidemic as we take those struggling with addiction from crisis to career.

**HOUSE FINANCIAL SERVICES COMMITTEE
HOUSING AND INSURANCE SUBCOMMITTEE**

TESTIMONY OF JEROD M. THOMAS, CEO
SHEPHERD'S HOUSE, INC.
LONG-TERM TRANSITIONAL RECOVERY RESIDENCE FOR MEN

***"The Role of Federal Housing and Community Development Programs
To Support Opioid and Substance Use Disorder Treatment and Recovery"***

AUGUST 16, 2018

**LADIES AND GENTLEMEN OF THE HOUSING AND INSURANCE SUBCOMMITTEE,
CONGRESSMAN BARR, CHAIRMAN DUFFY, AND ESTEEMED GUESTS:**

There's a saying in recovery that "The Only Thing that Has to Change is Everything."

At the Shepherd's House, we're in the business of helping drug addicts and alcoholics change everything about their lives, over the course of 18-24 months. We are a whole-person, holistic model. Our treatment is multi-dimensional because life is multi-dimensional. The only life that is one-dimensional is that of the man in active addiction whose only need is to feed his heroin or alcohol addiction. That lifestyle must be unlearned.

Our primary focus is the business of recovering from drug and alcohol addiction. But we know, after nearly 30 years of providing long-term transitional recovery residences in Central Kentucky, that long-term sustained sobriety is heavily reliant upon living in a safe, drug-free home, and learning daily living skills. It's a result of learning how to live and how to make choices -- on a daily basis -- in a way that doesn't cause harm to us or to others, but instead promotes and uplifts others, and as a result, ourselves. We learn self-support by supporting others.

These facilities are not sober living houses where there is only a roof overhead, but no actual treatment. They are Transitional Housing for Recovery and provide recovery care and treatment 24 hours a day, 7 days a week. What our facilities offer is rare. But as you will hear today, they are proven methods of treatment with quantifiable data supporting their efficacy.

**THE SIGNIFICANCE OF SECTION 8 VOUCHERS
FOR SAFE TRANSITIONAL HOUSING**

While the Shepherd's House doesn't currently use Section 8 vouchers, we do administer Federal Home Loan Bank funds and Kentucky Housing Corporation funds which require income and special needs verifications which are quite similar to the Section 8 rental assistance voucher program in the THRIVE Act. The Shepherd's House and other similar models have essentially adopted the tenets of Section 8 housing, but with additional restrictions. Under our transitional housing models clients pay a portion of their income as rent, and the rest is subsidized by the non-profit support the

Shepherd's House receives. Like Section 8, you are required to remain drug and alcohol free and commit no crimes. But unlike section 8, you are residing in a 24-hour a day / 7-day a week therapeutic community where you are accountable for your lifestyle, your choices, and your self-care. The additional requirements for employment, workforce training, counseling, therapy, recovery, home management and maintenance, etc., are MANDATORY for continued residence.

The significance of the THRIVE Act funding is that THRIVE-modeled facilities will be able to expand their client bases and offer more services to more individuals. There will be a significant reduction of the housing costs burden on the facilities and these funds will be freed up for more services and expanded facilities. Since most of the clients served are either income-eligible for Section 8 or qualify as "homeless," the resources are not misappropriated and will serve the double duty of providing housing and subsidizing treatment. It is a smart and efficient use of funds.

With regard to life skills, many clients come to recovery from diverse backgrounds where self-care and daily living skills weren't emphasized. Perhaps our family of origin was not a family that created a budget, paid bills on time, developed good parenting skills, or learned how to resolve conflicts in a healthy way. The Shepherd's House, and the model outlined in the THRIVE ACT gives addicts and alcoholics a second chance at learning healthy living tools. Our clients learn skills that teach them how to live within the rules, within the laws, in society and in sobriety. These are the collateral supports of sustained recovery.

In addition to our primary goal of learning to live sober, the Thrive and Career Acts support a complete recovery program. Some of the trainings under the Shepherd's House include:

1. Education: Completing a GED; applying for technical schools or trade and vocational schools; attending or finishing undergraduate degrees; helping clients find opportunities for financial assistance and teaching them how to apply for it.
2. Writing resumes and learning interviewing skills;
3. Understanding how to be a good employee, including accountability and consequences when there is under-performance, or a job is lost;
4. Creating a personal budget, sticking to it, and paying bills in a timely manner;
5. Appreciating the personal, legal, and moral obligations of paying child support and becoming current on all outstanding child support obligations, and paying all court costs and fines before graduating from the program;
6. Understanding the impact of drugs and alcohol on one's family and learning how to repair those relationships that can be supportive and healthy;
7. Learning what healthy relationships look like through therapy and group work and removing oneself from toxic relationships and households;
8. Learning healthy parenting skills and reunifying families; and
9. Improving conflict management including how to resolve conflicts without emotional or physical harm.

We know through experience and real-life examples that it is virtually impossible to sustain sobriety when daily living skills are lacking; when a person can't find or maintain

employment; and where there is no safe housing. The challenges of daily living -- when the client has no skills to conquer these problems and when they are in a destructive living environment -- will inevitably lead back to active addiction. Independence acquired as a result of living in stable residences and maintaining stable employment is how the client will THRIVE.

THE SIGNIFICANCE OF JOB TRAINING FOR THE RECOVERING PERSON

The partnerships with employers which are fostered by the staff at the Shepherd's House and are supported in the CAREER Act allow our clients to work in safe and sober environments, foster mentoring relationships, and provide opportunities for advancement.

The Commonwealth of Kentucky, with our skyrocketing addiction and unemployment rates, is the perfect state for inclusion as one of the five states to be selected in the CAREER Act Pilot program. Facilities like ours have already generated statistics that the CAREER Act Pilot Program require, but in a non-funded setting. We can provide statistics for funded vs. non-funded programs through comparison of new data to our existing data.

When the addict or alcoholic finally makes it to treatment, there is a universal brokenness. The hopes and dreams of yesterday have been crushed under the heavy shackles of addiction. Ambitions have been lost and the promise of a brighter future is as elusive as the freedom from addiction they are seeking.

The THRIVE Act, and the facilities that follow that model, have the time and resources to nurture the clients back to life. Within their therapeutic community they learn, one day at a time, that good things will come to those who stay sober. They witness the metamorphosis of recovery in their peers as they live and grow together in a safe home. Often this is the first safe home the client has ever had.

TIME is the recovering person's ally. We understand that a safe and nurturing living environment -- for 18-24 months -- is critical if the recovering person is to set about cleaning up the wreckage of their past so that they can move forward with their head held high, meeting the new challenges a sober life presents.

The THRIVE Program and the CAREER Act provide precisely the foundation for sustained recovery that we have seen succeed time and again at Shepherd's House.

Our programs are abstinence based. Unfortunately, as advocates for abstinence-based recovery, we have watched millions and millions of dollars be distributed for medically assisted treatment within the state. Based upon our treatment model, we were and will remain ineligible for this funding. And yet we can boast success rates of our clients after graduating from long-term residential recovery residences that far exceeds those for individuals who only rely on one-dimensional treatment (in this instance, MAT) and are not provided with additional modalities like recovery programs, job training, employment assistance, or stable housing.

We have also been ineligible for the millions of dollars that have been distributed to programs directed to mothers and pregnant women. In no way do we believe these funds for mothers programs are misappropriated. These programs are critical. But everyone deserves the chance to live sober. The massive distribution of funds excludes the type of programs THRIVE supports to non-mothers and others in abstinence-based treatment. There must also be adequate funding for those who have, quite frankly, fallen through the cracks. For the forgettables. For the men and women who want to learn to live sober, but who have no other options; who don't qualify for other government-funded programs. And so for those of us who know that a multi-faceted holistic model is a model of hope, we eagerly support these Acts.

RECOMMENDATIONS FOR LIMITED EXPANSION OF SECTION 8 VOUCHERS PROGRAM FOR GRADUATES OF THRIVE-BASED TRANSITIONAL HOUSING PROGRAMS

The THRIVE Act's Section 8 voucher program for transitional housing establishes rules for eligibility. The program excludes individuals with drug or alcohol addictions, or a history of criminal conduct from eligibility. As such, currently the recovering drug addict or alcoholic is not eligible for section 8 vouchers for safe and affordable housing *after release* from a transitional housing residence. The individual may be relegated to returning to destructive living environments.

Attendant to the THRIVE Act, I recommend an expansion of the Section 8 eligibility be carved out specifically for those drug addicts and/or alcoholics (with or without criminal histories) who are graduates of a THRIVE-based program. The client would be deemed eligible for Section 8 housing for a defined period of time upon completion of a THRIVE-based program. For example, upon completion of an 18-24 month transitional housing program, the graduate is entitled to apply for Section 8 vouchers for safe and affordable housing for a period of 12-60 months. The goal would be for the client to transition from the voucher program within 1 to 5 years, when employment is achieved that provides adequate income for safe and affordable housing outside of the subsidy.

The hope is that a person who graduates from a transitional housing program, who has remained sober; who has gotten his or her life back on track; who has maintained long-term employment; who has learned how to pay bills and keep child support current, that because of this person's success, that they would be able to obtain safe and affordable housing where drugs and alcohol are not acceptable. This further supports their continued recovery and provides the accountability they have come to rely upon. It is yet another form of treatment through continued accountability.

IN CONCLUSION

The THRIVE-based model, including existing facilities like the Shepherd's House, have proven results of long-term sobriety. But we are one small program in a sea of addiction. Replicating this Model will be a game-changer. It is sound and is the best and most successful tool not just for separating the addict from the drug; but for giving the addict an opportunity for a new life. There are simply not enough of them and so this funding is critical. The Programs will save lives.

At some level, the Shepherd's House and similar models have been undertaking and accomplishing the goals of the CAREER and THRIVE acts since 1989. The difference is that we are facilities operating on a shoestring budget, without governmental support. We have struggled and scraped to put together the private funding to help these men change their lives. We have been blessed by our generous donors, many of whom are our graduates. But with the opioid epidemic and the addiction explosion in Kentucky, we can't keep up with the need. We're nowhere near meeting the needs of our addicted population. We have a six-month waiting list every single day of the year.

As a result, too many families have buried their sons and daughters while they were waiting for a treatment bed or a spot at a transitional housing recovery residence that is safe and drug-free. A place where the addicted person could have not only survived but THRIVED.

By the end of the day, nearly 5 more Kentuckians will have died of a drug overdose. The THRIVE programs and the CAREER Act Pilot Program will reduce those numbers. These programs are the infusion of hope that Kentuckians have been waiting for and praying for.

Testimony of Sharon Walsh, Ph.D., Director, Center on Drug and Alcohol Research,
Departments of Behavioral Science, Psychiatry, Pharmacology and Pharmaceutical Sciences,
University Research Professor, College of Medicine, College of Pharmacy, University of
Kentucky

Chairman Duffy and distinguished members of the committee, thank you for the opportunity to appear today to discuss the role of federal housing and community development programs to support opioid and substance use disorder treatment and recovery. I want to thank Congressman Andy Barr from Kentucky's 6th Congressional District for inviting the committee to Lexington, Kentucky to discuss the nation's opioid crisis and how Kentucky leaders are responding.

My name is Sharon Walsh and I am the Director of the Center on Drug and Alcohol Research at the University of Kentucky. For the past 25 years, well before the present opioid epidemic took hold of the country, I have been engaged in conducting research and publishing the outcomes focused on opioid misuse, dependence, its medical complications and the development of novel pharmacotherapies for the treatment of those suffering from opioid use disorder. I have been fortunate to have had funding throughout my career from the National Institute on Drug Abuse along with other sources, including SAMHSA, the FDA, private foundations and pharmaceutical companies. I am here today representing the University of Kentucky.

I want to begin by sharing with the committee some of the current initiatives and projects underway at the University of Kentucky and UKHealthcare to increase access to care and

accelerate the discovery of novel approaches to address the opioid crisis in the Commonwealth and nation.

The emergency rooms at the University of Kentucky Hospitals are seeing approximately 1000 non-fatal opioid overdose cases in a given year with approximately 50 fatal cases per year. This does not include the additional patients presenting with significant and life-threatening medical complications from injecting drug use behavior who present virtually every day. Nor does it include all of those individuals who never make it to the emergency room. Historically, our emergency department along with most others in the region would address the immediate concern, for example reversal of the overdose with naloxone, and return the patient to the street without attempting referral or linking these patients to care for their opioid addiction.

With new support from SAMHSA through the CURES funds, the State of Kentucky and Cabinet for Health and Family Services, a new service has been developed at UK to address this critical gap in care. The First Bridge Clinic is a new initiative that allows the emergency department and the hospital to directly refer patients for treatment of their opioid use disorder. Here we are identifying those individuals at highest risk for fatal overdose and making a linkage to immediate care. Most patients can initiate evidence-based care, including medication-assisted treatment, within a day or two of referral and get onto the path of recovery; however, these patients often have many other psychosocial problems that are barriers to remaining in treatment and treatment success. For example, a criminal record is a barrier to employment, and unemployment is a barrier to housing. The First Bridge is offering wraparound services, such as counseling and

linkages to other social service programs. Linking all patients to the requisite supportive services is essential for long term recovery, especially housing when needed.

Another UK Program that is having a significant impact on improving outcomes is the PATHWAYS program, a program designed for the care specifically of pregnant women with opioid use disorder. At PATHWAYS, which opened in 2014, women are able to enter the program and immediately begin receiving evidenced-based care, medication-assisted treatment, and prenatal care. The large majority of women achieve abstinence and deliver their babies with no illicit opioids in their system. Importantly, the incidence of babies suffering from neonatal abstinence syndrome has been cut by about half. UK has also opened a new special unit, the NACU, that is specifically designed for the care of babies born with opioid physical dependence. The NACU was opened in 2017 and has 8 dedicated beds with specialized staff trained to treat drug-exposed infants. PATHWAYS retains women until they give birth, at which point, they can transfer to a linked program, Beyond Birth, where these young women may continue their care. Young mothers with new babies who are early in their recovery may be some of the most vulnerable of all those suffering from opioid use disorder, and the health and welfare of their baby is intimately linked to the well-being and success of the mother. This is a high-risk group who also may require housing services- housing that allows infants and other children in order to promote retention in care and sustained remission.

In Kentucky, prior to the current epidemic, there was little to no opioid abuse. Unlike the east and west coasts, heroin was historically unavailable in Kentucky. Therefore, Kentucky was only introduced to the scourge of opioid abuse once the pharmaceutical industry-driven epidemic of

prescription opioids began. Therefore, most of the existing treatment facilities and housing services for those affected by substance abuse were not designed to address the unique problems associated with opioid abuse when compared to other substances, such as alcohol or methamphetamine. Opioid use disorder is a very unforgiving disorder- a single lapse or relapse can lead to the immediate death of a person who may be striving to achieve remission or sustain their recovery. A single mistake ends a life.

Every federal agency that plays a prominent role in supporting the treatment and research of opioid use disorder, The Food and Drug Administration, SAMHSA and the NIH, are all in firm agreement that the most effective approach to the treatment of opioid use disorder is the use of pharmacotherapies also known as medication-assisted treatment or MAT. There are three medications presently approved for the treatment of opioid use disorder by the FDA, and these include buprenorphine, methadone and naltrexone. All federal agencies are calling for expansion of access to medication as the best strategy for turning the tide of the opioid epidemic. Approved medications have been demonstrated to reduce drug use, improve health, reduce the transmission of infectious disease and most importantly--- protect individuals against fatal overdose.

Those of us in the treatment community frequently recommend that the path to remission and recovery for those addicted to opioids is to change the people, places and things associated with their past drug-using lifestyle. This may often involve moving into residential care or recovery housing. Unfortunately, the majority of these facilities explicitly prohibit or exclude patients who are receiving medication-assisted treatment from accessing these programs- creating

additional barriers for those who are trying to sustain long-term recovery who are receiving evidence-based care under the supervision of a trained physician.

Providing healthy and safe living housing environments for ALL patients seeking recovery from their drug use disorder is essential to promote long-term success and turn the tide on the opioid epidemic. All programs receiving government support should encourage rather than discourage engagement by patients, should include rather than exclude patients attempting to sustain recovery, and should not only allow but also promote the use of all evidence-based practices in both treatment and housing programs.

The University of Kentucky looks forward to working with Congress, and other leaders here today, to provide an overarching framework to leverage the expertise and resources of the federal government in a strategic and coordinated manner. As a historic land grant and flagship research university, the University of Kentucky was founded for the people of Kentucky. This is why we are here; to keep a deep and abiding promise of better tomorrows for the Commonwealth. We are here, as we have been for more than 150 years, for our community, for our region, and for Kentucky.

I sincerely appreciate the opportunity to present testimony before the Subcommittee and welcome the opportunity to address any question at this time.

