Testimony of Don Flattery
Citizen Advocate and Impacted Parent
House Oversight and Government Reform Committee
July 26, 2017

Mr. Chairman, Ranking Member Cummings and members of the committee, thank you for conducting today's hearing about authorization of the Office of the National Drug Control Policy. It is a much needed discussion to ensure the federal government is prepared to fight to end the epidemic of prescription drug and heroin addiction the country is facing.

My name is Don Flattery and until recently lived in the Mt. Vernon area of Fairfax County, Virginia. I am a former federal manager, a recent member of the Virginia Governor's Task Force on Prescription Drug and Heroin Abuse, a policy advisor to the national addiction-fighting advocacy non-profit, the FED UP Coalition, and I am an active participant in my new adopted county of Brunswick, North Carolina's addiction task force. But I am not here today in any of those roles. I am addressing the committee solely as a grieving parent, someone who has lost his 26 year old and only son to an opioid overdose less than three years ago.

It is critically important to me and to my wife that we do our part to ensure that discussions about this scourge are personalized. In prior committee hearings, you have heard the appalling statistics about the explosion of opioid prescriptions, addiction rates and overdose deaths. I am intimately familiar with them and will not repeat them here. But those discussions are often far too clinical. As you, federal officials, state officials and public health practitioners deliberate and consider solutions, it is far too easy to become detached. As you proceed, I implore you to recall the personal impacts – we are not just speaking about shocking, obtuse statistics – we are speaking about my son, your daughter and our neighbors. They are real people, with real lives, suffering from a disease and their losses are the face of the epidemic we must stop.

Allow me to briefly share my son's story. On Labor Day weekend, 2014, my family lost my twenty-six year old Kevin to an opioid overdose. Like so many swallowed by this crisis, Kevin enjoyed the blessings of a typical suburban upbringing, attending private schools, participating in youth sports and high school athletics. He came from a loving two-parent home and led the quintessential middle class life, enjoying all of life's and God's blessings. He was a good student and was a graduate of a local all-male prep school in Washington, DC and later the University of Virginia where he actively participated in student and fraternity life.

Kevin came to his addiction as a working adult while pursing his talent and passion working in the film industry in Hollywood and New York City. He had been exposed to opioids as a teen after an injury and told me himself that "he thought nothing of them".

Like so many, he underestimated them.

While working, he began self medicating issues with anxiety and depression with the widely available opioid prescription drug OxyContin – which is a common story as many struggling with mental health issues develop co-incident addiction problems. He quickly became dependent and then addicted. He returned home to Northern Virginia in the fall of 2013 to his family, seeking treatment and support.

Like many struggling in search of treatment, he tried a variety of pathways including in-patient detoxification, intensive out-patient, medication assistance with buprenorphine, step program support and an outrageously expensive 28-day abstinence only residential program. Some of these were covered by insurance but others were covered out-of-pocket. But, like others in pursuit of recovery, he experienced the painful and common process of seeming progress followed by relapse. Days before he was to start a program of the medically-assisted treatment drug, naltrexone, he used again, and did not recover.

The short bio description I just gave you is an example of how the scourge of the opioid addiction epidemic before us today has no stereotypical victim. It is affecting people of all walks of life, all income levels and all backgrounds. This epidemic and my son's addiction do not respect income, social status or intelligence**.** That's what epidemics do. That point bears repeating in every hearing this committee conducts which touch upon this health crisis.

Since my son's loss, I have learned a great deal about the disease of addiction, this current epidemic, its underlying causes and painfully for me and my wife, some evidence-based treatment opportunities that offer hope, but now, only for others.

From the perspective of an impacted parent, as a citizen and as an advocate, I would like to add my voice to thousands traveling the same journey about some imperatives needed to stem the tide of the epidemic before us.

The first is the primary topic of this hearing. The need for a strong, well resourced and effective ONDCP has never been more important. A policy office directly tied to the Office of the President not only sends a message to the public about the importance of effective drug policy but it also ensures more effective development of integrated, cross-federal government programs and policies. ONDCP plays an essential role in being an integrator and coordinator for the widely disparate addiction fighting efforts of HHS's SAMHSA, NIDA, CDC and FDA as well as programs and activities in the VA, DOD and Indian Health Service. Interagency discussions and collaborations will be ineffective without this singular collaboration entity empowered to work across stove-piped efforts and programs. Addiction fighting advocates are pleased with ONDCP's emphasis on addressing the opioid addiction epidemic as a public health and not criminal justice issue, with the Drug Free Communities Program empowering local communities to address prevention at a local level and for its' championing expanded access to evidenced-treatment. Loss of the recent momentum created by ONDCP in these areas would be seen as a significant blow to the fight to end the epidemic.

The second imperative is reliable, continuous coverage of addiction treatment, especially medication-assisted therapy, as an essential benefit under any proposal to re-engineer our nation's health care system. Even with a good family insurance plan and the benefit of continued young-adult coverage provided by the Affordable Care Act, finding physicians with authorization to prescribe buprenorphine was difficult for my son. We must find ways to expand the number of physicians prescribing addiction fighting medications and also ensure insurance companies and providers do so at a reasonable cost.

Access to medication-assisted treatment already remains elusive for far too many patients – changes to the nation's health care system that remove mental health and substance use disorder coverage as an essential benefit will be a disaster for those, like my son, seeking such help.

Contemplated reductions in Medicaid coverage, which is now providing addiction treatment to vast numbers of people previously without any help, may become a death sentence for some. Finally, substitution of a possible opioid fund to offset Medicaid coverage, subject to annual appropriations decisions, is not an effective solution for a continuously expanding public health crisis.

Mr. Chairman and members of the committee thank you again for addressing the need for an effective ONDCP as part of the federal government's effort to combat the opioid addiction crisis. We need to ensure federal entities do their part to appropriately protect our loved ones and the public health. American's suffering from this scourge deserve no less.