COMMONWEALTH OF VIRGINIA

OFFICE OF THE COMMONWEALTH'S ATTORNEY
CITY OF CHESAPEAKE

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TESTIMONY OF

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BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, HOMELAND SECURITY,
AND INVESTIGATIONS
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OR REPRESENTATIVES

FOR A HEARING ENTITLED

AMERICA'S GROWING HEROIN EPIDEMIC

PRESENTED ON

JULY 28, 2015

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Mr. Chairman, and distinguished members of the Subcommittee on Crime, Terrorism, Homeland Security and Investigations:

Thank you for the opportunity to appear today to discuss the important topic of the abuse of heroin and other dangerous drugs. It is an honor and a privilege to be invited to offer input on an issue that is impacting my city and my state.

I. Introduction

In the past twelve months, I have read, studied, discussed, debated, learned, argued about and compromised on what are the better ways to address the growing heroin use and prescription drug abuse in the Commonwealth of Virginia. I use the word "better" as opposed to "best" because the past twelve months have not convinced me that there is one, across the board, solution, prevention or intervention.

Serving on the Governor's Task Force on Prescription Drug and Heroin Abuse, on the State Child Fatality Review Team, and as President of the Virginia Association of Commonwealth's Attorneys, I have listened to and spoken about concerns and ideas to address this problem. I appreciate this opportunity to share some of this information.

II. Increase

In Chesapeake, Virginia, fatal drug overdose increased 72% from 2013 to 2014 and non-fatal overdoses increased 64% for the same period. The statistics for the first six months of 2015 appear to be stable for the fatal overdoses and higher for the non-fatal overdoses.

In reviewing autopsies for 2014 and 2015 deaths involving drug overdoses, I found that there have been twenty such deaths since January 2014. Eleven were male and nine were female. Ages ranged from 18 to 59 with the largest number in the 30's. Eleven died in their own homes apparently alone at the time. Ten had prior contact with the criminal justice system and

two of the ten were on bond. The prior criminal charges include DUI, domestic assault, robbery, burglary, malicious wounding, PWID, and simple possession. Not all twenty included heroin in the cause of death. However, ten did involve heroin. For the remaining ten, cause of death for five was fentanyl (had been bought as heroin), for one was methadone (no valid prescription), for one was prescription drugs, and for three was cocaine (including one with fentanyl).

According to my local law enforcement, the price of heroin has decreased by 50% or more because of the increase in supply and availability. Today's heroin is stronger and often deluded (cut) with other drugs (often Fentanyl aka "Drop Dead"). In Chesapeake, in a relatively short period of time, crack cocaine is becoming less common and heroin is becoming more common.

In Virginia, the statistics are overwhelming. According to the Office of the Chief Medical Examiner, each year approximately 70% of all drug deaths are due to one or more opiates (heroin and/or prescription drugs). In 2013, drug deaths became the number one (n=912) method of death in Virginia. Almost 82% of these deaths were determined to be accidental and only .1% homicide.[1] Kathrin Hobron, MPH, Statewide Forensic Epidemiologist, has advised me that this number could surpass 1,000 for 2014.

Also, in 2013, over 42% of the drug deaths in Virginia were caused by prescription drugs. Fentanyl, hydrocodone, methadone, and oxycodone (FHMO) were found to be partly or wholly responsible for 386 drug only deaths in 2013. Oxycodone was the most commonly used FHMO resulting in death.[2]

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[1] Office of the Chief Medical Examiner's Annual Report, 2013, Commonwealth of Virginia, Virginia Department of Health, created by Kathrin Hobron, MPH, January 2015, p. 160.
http://www.vdh.virginia.gov/medExam/Reports.htm

[2] *Id.* at 185.

I believe that the statistics regarding prescription drugs are important and cannot be overlooked because I have heard many testimonials about the progression from prescription drugs to heroin use. Parents who have lost a child to heroin have described how their child suffered an injury, was prescribed a narcotic pain reliever, became addicted and moved to heroin. Recovering heroin addicts have described being injured and being prescribed a narcotic pain reliever with little monitoring and no detoxification.

III. Change

Changes are being made in Virginia and, hopefully, we are moving in the right direction. In 2015, the Virginia General Assembly enacted statutes that address some of the concerns presented at forums across Virginia and to the Governor's Task Force on Prescription Drug and Heroin Abuse.

Section 54.1-3408 of the Code of Virginia, as amended, was expanded to allow a pharmacist to dispense naloxone or other opioid antagonist pursuant to an order issued by a prescriber and in accordance with protocols and to allow a person to possess and administer naloxone or other opioid antagonist to a person who is, or is about to, experience a life-threatening overdose. This statute also allows law enforcement officers and firefighters who have completed a training program to possess and administer naloxone.

This legislation expands earlier pilot programs. The use of naloxone by law enforcement officers and firefighters is not mandatory. The legislation specifically made it discretionary so each law enforcement agency may determine if it is appropriate for its needs and circumstances.

A concern that I have expressed about family members and friends having access to naloxone to administer to persons who are experiencing life-threatening opiate overdoses is, admittedly, not a popular one. In the pilot programs and as enacted, the persons administering

the naloxone are not required to call 911 or seek further medical attention for the person experiencing the overdose. I understand the need to have naloxone available quickly when a loved one is experiencing an overdose. However, I also see a need for intervention and treatment which cannot always be provided by a family member or friend.

Many people have expressed concerns about users being arrested if 911 is called or if the person is taken to a hospital. I understand this concern. It is hard to see a loved one arrested. However, with no evidence other than the overdose itself, it is rare for people who overdose to be charged with possession of heroin or other drugs.

To address the concern for the user being arrested and the concern for the person who calls 911 for the friend being arrested, the Virginia General Assembly enacted § 18.2-251.03, which provides an affirmative defense for simple possession charges. This section states specifically what facts have to exist before this affirmative defense can go forward.

Also, the rise in prescription drug abuse and the connections to using illicit drugs led to recommendations from the Governor's Task Force on Prescription Drug and Heroin Abuse regarding Virginia's Prescription Monitoring Program, and collaboration with medical and healthcare schools.[3]

IV. Treatment, Diversion and Incarceration

There are too few treatment programs. There are too few affordable treatment programs. There is insufficient funding for valid treatment programs. There is a stigma related to seeking treatment. Money addresses the first three problems and education can address the fourth.

[3] Recommendations of the Governor's Task Force on Prescription Drug and Heroin Abuse, Implementation Plan, June 30, 2015.

Also, treatment programs need to be funded and need to be created for people who are incarcerated. Follow up treatment has to be provided upon release from incarceration. Treatment should not and cannot exist only for those not incarcerated.

Also, there should be more diversion programs including Drug Courts in all levels of the system (Circuit, General District and Juvenile). Chesapeake has had a Drug Court in Circuit Court for several years with no additional funding. It is small but it is successful. In the Juvenile and Domestic Relations District Courts, there should be an opportunity to have Family Drug Courts to address the dynamics of family addiction issues.

In Virginia, everyone charged with a first offense possession charge is eligible for the First Offender Program. This program allows the court to withhold a finding of guilt by placing the offender on supervision for a period of time ranging from twelve months to twenty-four months. If the offender successfully completes the supervision period, then the charge is dismissed. This is provided by statute. However, not all jurisdictions have the resources to offer an effective treatment oriented supervision period. Therefore, resources are needed to make certain that offenders are doing more than submitting a urine sample.

V. Impact

C.B. was arrested in 2006 and 2007 and, in 2007, was incarcerated for violation of probation on an unauthorized use of a vehicle charge. At that time, she requested and was allowed to enter our Drug Court program. She knew and admitted that she was an addict, she had lost custody of her daughter and she "dried out" in jail. C.B. needed help and the incarceration scared her and "woke her up". She experienced a couple of setbacks in Drug Court but the immediate sanctions reinforced the concept of consequences for all her actions and choices. She successfully completed and graduated in 2009. She has been clean since then, has

regained custody of her daughter, and works full time. C.B. stays in contact with my office and thanks me regularly for "locking her up for 60 days".

While we all know people who say incarceration "woke them up" or was "their rock bottom they needed to hit", we, also, all know people who overdosed or continued to use shortly after release on bond or after serving their sentence. A defense attorney from Norfolk shared with me that he will never forget the feeling he experienced when the parents of his client called him the morning after the bond hearing where he convinced the court to set a bond over the prosecutor's objection, to tell him that their daughter died from an overdose twelve hours after they posted bond. We all know that no matter how untrue and unfair, the attorneys (both defense and prosecutor), the parents, and the court all blame themselves for a part of her death.

VI. Federal Assistance

I, and many of my colleagues across the Commonwealth, have requested assistance from the United States Attorney's Office (USAO) in prosecuting cases involving deaths resulting from the illegal distribution of narcotics (illicit and prescription) for a variety of reasons. The federal agencies have more resources than many of our jurisdictions and the federal grand jury lends itself to preparing and presenting indictments for crimes committed in multiple jurisdictions by one person or one group.

Additionally, in 2013, the Virginia Court of Appeals in Woodard v. Commonwealth, 61 Va.App. 567 (2013), held that the killing must occur in the same place as the underlying felony (the distribution) for the felony homicide statute to apply. Felony homicide is punished as second degree murder with a sentence range of 5 years to 40 years in prison with no mandatory minimum. An attempt was made to alleviate this new obstacle through legislation in 2015.

However, it failed. Therefore, the federal law has become more important to Virginia's prosecutors.

Also, the USAO has the opportunity to work with defendants after they are sentenced and transferred to a federal prison because they have the ability to continue to present to the court evidence of cooperation for a possible reduction in sentence. Under Virginia law, once the defendant is transferred to the Department of Corrections, the sentence cannot be modified.

The federal grand jury is now somewhat reflected in our state multijurisdictional grand juries which allow for longer terms and more in depth presentation of cooperating and non-cooperating witness testimony before indictment. This is helpful but the vast majority of cases prosecuted by Virginia's prosecutors are initiated by warrants and citizens expect and deserve quick action when they call the police.

Additionally, there are no state or local funds for witness protection or relocation. The Virginia State Police have a program by statutory authority but there are no funds for its operation. Our witnesses encounter the same threats and intimidation as federal witnesses and we cannot protect them. Their safety is another reason we seek assistance from the USAO.

Because of the quantity of cases and arrests made by local law-enforcement, federal funds are needed for intervention through diversion programs and treatment. Also, Virginia's prosecutors and local law-enforcement are becoming much more involved in community outreach to prevent criminal activity including drug use. Federal funds would be helpful in establishing and continuing these programs. In particular, educating the public about the dangers prescription drugs can present when used incorrectly, when used by people to whom they are not prescribed, and when accessed by small children, is costly. Not only do people need to be

educated but safe secure boxes for storage need to be provided and the disposal of unused prescriptions by incineration needs to be available to all jurisdictions on a regular basis.

VII. Conclusion

The growing heroin epidemic must be attacked through a multi-disciplinary approach. Reducing the distribution of, use of, abuse of and addiction to heroin, prescription drugs and other narcotics involves many disciplines which include law enforcement, prosecutors, pharmacists, medical doctors, health professionals, substance abuse counselors, first responders, mental health providers, addictionologists, recovering addicts, family members, and legislators to name a few. I do not know the right answer or solution but I do know that people need to be at the table for the discussion and to express their concerns, issues and perspective. Only through an open and honest discussion can the issues of education, treatment, monitoring, safe storage and disposal, enforcement and protection of society be addressed and progress made.

§ 54.1-3408. Professional use by practitioners

A. A practitioner of medicine, osteopathy, podiatry, dentistry, or veterinary medicine or a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice.

B. The prescribing practitioner's order may be on a written prescription or pursuant to an oral prescription as authorized by this chapter. The prescriber may administer drugs and devices, or he may cause drugs or devices to be administered by:

1. A nurse, physician assistant, or intern under his direction and supervision;

2. Persons trained to administer drugs and devices to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the Department of Behavioral Health and Developmental Services who administer drugs under the control and supervision of the prescriber or a pharmacist;

3. Emergency medical services personnel certified and authorized to administer drugs and devices pursuant to regulations of the Board of Health who act within the scope of such certification and pursuant to an oral or written order or standing protocol; or

4. A licensed respiratory therapist as defined in § 54.1-2954 who administers by inhalation controlled substances used in inhalation or respiratory therapy.

C. Pursuant to an oral or written order or standing protocol, the prescriber, who is authorized by state or federal law to possess and administer radiopharmaceuticals in the scope of his practice, may authorize a nuclear medicine technologist to administer, under his supervision, radiopharmaceuticals used in the diagnosis or treatment of disease.

D. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered nurses and licensed practical nurses to possess (i) epinephrine and oxygen for administration in treatment of emergency medical conditions and (ii) heparin and sterile normal saline to use for the maintenance of intravenous access lines.

Pursuant to the regulations of the Board of Health, certain emergency medical services technicians may possess and administer epinephrine in emergency cases of anaphylactic shock.

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, any school nurse, school board employee, employee of a local governing body, or employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education, or any employee of a private school that

complies with the accreditation requirements set forth in § 22.1-19 and is accredited by the Virginia Council for Private Education who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order issued by the prescriber within the course of his professional practice, an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services may possess and administer epinephrine, provided such person is authorized and trained in the administration of epinephrine.

Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize pharmacists to possess epinephrine and oxygen for administration in treatment of emergency medical conditions.

E. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed physical therapists to possess and administer topical corticosteroids, topical lidocaine, and any other Schedule VI topical drug.

F. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed athletic trainers to possess and administer topical corticosteroids, topical lidocaine, or other Schedule VI topical drugs; oxygen for use in emergency situations; and epinephrine for use in emergency cases of anaphylactic shock.

G. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health pursuant to § 32.1-50.2, such prescriber may authorize registered nurses or licensed practical nurses under the immediate and direct supervision of a registered nurse to possess and administer tuberculin purified protein derivative (PPD) in the absence of a prescriber. The Department of Health's policies and guidelines shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention for preventing transmission of mycobacterium tuberculosis and shall be updated to incorporate any subsequently implemented standards of the Occupational Safety and Health Administration and the Department of Labor and Industry to the extent that they are inconsistent with the Department of Health's policies and guidelines. Such standing protocols shall explicitly describe the categories of persons to whom the tuberculin test is to be administered and shall provide for appropriate medical evaluation of those in whom the test is positive. The prescriber shall ensure that the nurse implementing such standing protocols has received adequate training in the practice and principles underlying tuberculin screening.

The Health Commissioner or his designee may authorize registered nurses, acting as agents of the Department of Health, to possess and administer, at the nurse's discretion, tuberculin purified protein derivative (PPD) to those persons in whom tuberculin skin testing is indicated based on protocols and policies established by the Department of Health.

H. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of a school board who is trained in the administration of insulin

and glucagon to assist with the administration of insulin or administer glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician, or physician assistant is not present to perform the administration of the medication.

Pursuant to a written order issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services to assist with the administration of insulin or to administer glucagon to a person diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia, provided such employee or person providing services has been trained in the administration of insulin and glucagon.

I. A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing, the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present, by (i) licensed pharmacists, (ii) registered nurses, or (iii) licensed practical nurses under the immediate and direct supervision of a registered nurse. A prescriber acting on behalf of and in accordance with established protocols of the Department of Health may authorize the administration of vaccines to any person by a pharmacist, nurse, or designated emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health under the direction of an operational medical director when the prescriber is not physically present. The emergency medical services provider shall provide documentation of the vaccines to be recorded in the Virginia Immunization Information System.

J. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.

Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § 54.1-2722, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, as well as any other Schedule VI topical drug approved by the Board of Dentistry.

In addition, a dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia.

K. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered professional nurses certified as sexual assault nurse examiners-A (SANE-A) under his supervision and when he is not physically present to possess and administer preventive medications for victims of sexual assault as recommended by the Centers for Disease Control and Prevention.

L. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a prescriber's instructions pertaining to dosage,

frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) an individual receiving services in a program licensed by the Department of Behavioral Health and Developmental Services; (ii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; (iii) a resident of a facility approved by the Board or Department of Juvenile Justice for the placement of children in need of services or delinquent or alleged delinquent youth; (iv) a program participant of an adult day-care center licensed by the Department of Social Services; (v) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services; (vi) a resident of a private children's residential facility, as defined in § 63.2-100 and licensed by the Department of Social Services, Department of Education, or Department of Behavioral Health and Developmental Services; or (vii) a student in a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education.

In addition, this section shall not prevent a person who has successfully completed a training program for the administration of drugs via percutaneous gastrostomy tube approved by the Board of Nursing and been evaluated by a registered nurse as having demonstrated competency in administration of drugs via percutaneous gastrostomy tube from administering drugs to a person receiving services from a program licensed by the Department of Behavioral Health and Developmental Services to such person via percutaneous gastrostomy tube. The continued competency of a person to administer drugs via percutaneous gastrostomy tube shall be evaluated semiannually by a registered nurse.

M. Medication aides registered by the Board of Nursing pursuant to Article 7 (§ 54.1-3041 et seq.) of Chapter 30 may administer drugs that would otherwise be self-administered to residents of any assisted living facility licensed by the Department of Social Services. A registered medication aide shall administer drugs pursuant to this section in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; in accordance with regulations promulgated by the Board of Pharmacy relating to security and recordkeeping; in accordance with the assisted living facility's Medication Management Plan; and in accordance with such other regulations governing their practice promulgated by the Board of Nursing.

N. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

O. In addition, this section shall not prevent the administration of drugs by a person to (i) a child in a child day program as defined in § 63.2-100 and regulated by the State Board of Social Services or a local government pursuant to § 15.2-914, or (ii) a student at a private school that complies with the accreditation requirements set forth in § 22.1-19 and is accredited by the Virginia Council for Private Education, provided such person (a) has satisfactorily completed a training program for this purpose approved by the Board of Nursing and taught by a registered nurse, licensed practical nurse, doctor of medicine or osteopathic medicine, or pharmacist; (b) has obtained written authorization from a parent or guardian; (c) administers drugs only to the child identified on the prescription label in accordance with the prescriber's instructions

pertaining to dosage, frequency, and manner of administration; and (d) administers only those drugs that were dispensed from a pharmacy and maintained in the original, labeled container that would normally be self-administered by the child or student, or administered by a parent or guardian to the child or student.

P. In addition, this section shall not prevent the administration or dispensing of drugs and devices by persons if they are authorized by the State Health Commissioner in accordance with protocols established by the State Health Commissioner pursuant to § 32.1-42.1 when (i) the Governor has declared a disaster or a state of emergency or the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control, and supervision of the State Health Commissioner.

Q. Nothing in this title shall prohibit the administration of normally self-administered drugs by unlicensed individuals to a person in his private residence.

R. This section shall not interfere with any prescriber issuing prescriptions in compliance with his authority and scope of practice and the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such prescriber shall be deemed to be valid prescriptions.

S. Nothing in this title shall prevent or interfere with dialysis care technicians or dialysis patient care technicians who are certified by an organization approved by the Board of Health Professions or persons authorized for provisional practice pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.), in the ordinary course of their duties in a Medicare-certified renal dialysis facility, from administering heparin, topical needle site anesthetics, dialysis solutions, sterile normal saline solution, and blood volumizers, for the purpose of facilitating renal dialysis treatment, when such administration of medications occurs under the orders of a licensed physician, nurse practitioner, or physician assistant and under the immediate and direct supervision of a licensed registered nurse. Nothing in this chapter shall be construed to prohibit a patient care dialysis technician trainee from performing dialysis care as part of and within the scope of the clinical skills instruction segment of a supervised dialysis technician training program, provided such trainee is identified as a "trainee" while working in a renal dialysis facility.

The dialysis care technician or dialysis patient care technician administering the medications shall have demonstrated competency as evidenced by holding current valid certification from an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.).

T. Persons who are otherwise authorized to administer controlled substances in hospitals shall be authorized to administer influenza or pneumococcal vaccines pursuant to § 32.1-126.4.

U. Pursuant to a specific order for a patient and under his direct and immediate supervision, a prescriber may authorize the administration of controlled substances by personnel who have been properly trained to assist a doctor of medicine or osteopathic medicine, provided the method does not include intravenous, intrathecal, or epidural administration and the prescriber remains responsible for such administration.

V. A physician assistant, nurse or a dental hygienist may possess and administer topical fluoride

varnish to the teeth of children aged six months to three years pursuant to an oral or written order or a standing protocol issued by a doctor of medicine, osteopathic medicine, or dentistry that conforms to standards adopted by the Department of Health.

W. A prescriber, acting in accordance with guidelines developed pursuant to § 32.1-46.02, may authorize the administration of influenza vaccine to minors by a licensed pharmacist, registered nurse, licensed practical nurse under the direction and immediate supervision of a registered nurse, or emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health when the prescriber is not physically present.

X. Notwithstanding the provisions of § 54.1-3303, pursuant to an oral, written, or standing order issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, a pharmacist may dispense naloxone or other opioid antagonist used for overdose reversal and a person may possess and administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opiate overdose. Law-enforcement officers as defined in § 9.1-101 and firefighters who have completed a training program may also possess and administer naloxone in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

Code 1950, § 54-497; 1956, c. 225; 1970, c. 650, § 54-524.65; 1973, c. 468; 1976, cc. 358, 614; 1977, c. 302; 1978, c. 224; 1980, cc. 270, 287; 1983, cc. 456, 528; 1984, cc. 141, 555; 1986, c. 81; 1987, c. 226; 1988, c. 765; 1990, c. 309; 1991, cc. 141, 519, 524, 532; 1992, cc. 610, 760, 793; 1993, cc. 15, 810, 957, 993; 1994, c. 53;1995, cc. 88, 529;1996, cc. 152, 158, 183, 406, 408, 490;1997, cc. 272, 566, 806, 906;1998, c. 112;1999, c. 570;2000, cc. 135, 498, 861, 881, 935;2003, cc. 465, 497, 515, 794, 995, 1020;2005, cc. 113, 610, 924;2006, cc. 75, 432, 686, 858;2007, cc. 17, 699, 702, 783; 2008, cc. 85, 694;2009, cc. 48, 110, 506, 813, 840;2010, cc. 179, 245, 252;2011, c. 292;2012, cc. 787 , 803, 833, 835;2013, cc. 114, 132, 183, 191, 252, 267, 328, 336, 359, 617;2014, cc. 88, 491;2015, cc. 302, 387, 502, 503, 514, 725, 732, 752.

§ 18.2-251.03. Safe reporting of overdoses

A. For purposes of this section, "overdose" means a life-threatening condition resulting from the consumption or use of a controlled substance, alcohol, or any combination of such substances.

B. It shall be an affirmative defense to prosecution of an individual for the unlawful purchase, possession, or consumption of alcohol pursuant to § 4.1-305, possession of a controlled substance pursuant to § 18.2-250, possession of marijuana pursuant to § 18.2-250.1, intoxication in public pursuant to § 18.2-388, or possession of controlled paraphernalia pursuant to § 54.1-3466 if:

1. Such individual, in good faith, seeks or obtains emergency medical attention for himself, if he is experiencing an overdose, or for another individual, if such other individual is experiencing an overdose, by contemporaneously reporting such overdose to a firefighter, as defined in § 65.2-102, emergency medical services personnel, as defined in § 32.1-111.1, a law-enforcement officer, as defined in § 9.1-101, or an emergency 911 system;

2. Such individual remains at the scene of the overdose or at any alternative location to which he or the person requiring emergency medical attention has been transported until a law-enforcement officer responds to the report of an overdose. If no law-enforcement officer is present at the scene of the overdose or at the alternative location, then such individual shall cooperate with law enforcement as otherwise set forth herein;

3. Such individual identifies himself to the law-enforcement officer who responds to the report of the overdose;

4. If requested by a law-enforcement officer, such individual substantially cooperates in any investigation of any criminal offense reasonably related to the controlled substance, alcohol, or combination of such substances that resulted in the overdose; and

5. The evidence for the prosecution of an offense enumerated in this subsection was obtained as a result of the individual seeking or obtaining emergency medical attention.

C. No individual may assert the affirmative defense provided for in this section if the person sought or obtained emergency medical attention for himself or another individual during the execution of a search warrant or during the conduct of a lawful search or a lawful arrest.

D. This section does not establish an affirmative defense for any individual or offense other than those listed in subsection B.

2015, cc. 418, 436.