DATE: August 7, 2007

RE: Legality of Prescribing Take-Home Naloxone to Treat Opiate Overdose in Rhode Island

INTRODUCTION

Naloxone, the standard treatment for heroin overdose, is a safe and effective prescription drug typically administered by emergency room personnel or first responders acting under standing orders of physicians. High numbers of overdose deaths and evidence that witnesses to heroin overdose are often unwilling or unable to call for help has motivated some public health professionals to institute programs that distribute naloxone directly to opiate drug users (ODUs). In such programs, drug users, their partners, or others are instructed in resuscitation techniques and provided a “take-home” dose of naloxone for administration in cases when medical help is not immediately available.

Evidence from US and abroad indicates that naloxone distribution helps reduce opiate overdose deaths and results in cost-savings to society.¹ Despite the high and rising incidence of overdose events in many US locales, however, both the number and the scope of overdose programs remain inadequate. Legal concerns about provider and program liability act as one of the most important limiting factors, often complicating or derailing authorization, expansion, funding and implementation of these programs.

We were funded by the Drug Policy Alliance to analyze the legal issues for naloxone distribution programs in the fifty United States. Our analysis finds that:

1. **Naloxone is not a controlled substance as defined by federal or state law, but is a prescription drug subject to the general laws and regulations that govern all prescriptions in regular medical practice.**

2. Prescribing naloxone to ODUs in this state is fully consistent with state and federal laws regulating drug prescribing.
3. Teaching overdose response techniques, including the administration of naloxone, to naloxone recipients and others who might be in a position to administer it to an ODU to whom it has been prescribed is legal and appropriate.
4. Naloxone may not be given to patients or participants in an overdose prevention program with the explicit purpose of encouraging them to distribute or administer the drug to other ODUs who are not patients.
5. Any legal risks in distributing naloxone in this state are not substantial and can be mitigated by informed program design; the risks of malpractice liability are consistent with those generally associated with providing healthcare, and can be further minimized by following the guidelines we describe.

This Memorandum addresses the following specific questions:

1. May a physician legally prescribe naloxone to an IDU patient?
2. May an allied health professional other than physician prescribe naloxone to an IDU patient?
3. What instructions should accompany naloxone prescription/dispensation?
4. How may naloxone be dispensed?
5. Is it legal to prescribe or dispense naloxone for recipients to give or administer to third parties who have not been prescribed the drug by a licensed professional?
6. What is the risk of disciplinary action by a professional board arising from naloxone prescription or distribution, and how can the risk be minimized?
7. What kind of malpractice liability may arise from naloxone prescription or distribution, and how can the risk of liability be minimized?
Executive Summary

From a legal standpoint, naloxone is no different than any other prescription drug. Authorized medical professionals can prescribe and dispense naloxone in the same way they would any other drug. Naloxone is indicated for patients who, upon examination, are at risk of opiate overdose and who are judged by the professional to be capable of benefiting from naloxone administration. The amount of naloxone prescribed or dispensed depends upon the prescriber’s assessment of need. (See Parts I & II describing who may prescribe naloxone.)

As part of the process of prescribing, the patient should be given information about when and how to use the drug, as well as other steps that are advisable in responding to an overdose. Because a person suffering an overdose may not be able to administer the drug him or herself, it is also appropriate to (1) teach groups of patients how to administer the drug so that they can assist each other in an overdose emergency; and (2) instruct—in person, or through written materials—friends, family members and others who may witness an overdose how to administer the drug to a patient. It is not uncommon for third parties to assist patients in administering their drugs, for all sorts of reasons. The key legal requirement is that the recipient have a valid prescription for the drug. (See Parts III & IV.)

Because a legal prescription requires some examination and a specific medical indication, naloxone may not be prescribed or dispensed to patients or program participants to hand out or administer to other ODUs who are not patients of the prescriber. A program based on this model would be legally vulnerable in this state. A professional distributing naloxone in this way could be found to be violating professional licensure laws; the patient or program participant distributing or administering the drug could be found to be guilty of the crime of practicing medicine without a license; and the recipient of a vial of naloxone for which she has no prescription could be found guilty of illegal possession of a prescription drug. (See Part V.)

Assuming the provider does not violate regulations that generally apply to drug prescription in this state, acts competently, and follows the additional guidelines we set out, criminal or civil liability is very unlikely to arise out of naloxone prescription activities. (See Parts VI and VII.) Presumably, few prosecutors would be hard-hearted enough to punish a person for saving a life, but an ODU who uses his or her own naloxone to save the life of a person who has not been prescribed the drug does, technically, break the law. A few states have taken positive action to clearly legalize emergency administration of naloxone by

2 We will refer to a person who has received a legal prescription for naloxone as a “patient.”
3 We will define examination generally as an interaction sufficient to allow the physician to determine the patient's diagnosis and treatment needs in the context of the service being sought or medical issues being raised.
lay persons, and to protect medical professionals from tort and other liability. Such legislation can help lower legal barriers and increase access to naloxone here. (See “Conclusion.”)

The Legal Analysis in Detail

I. May a Physician Legally Prescribe Naloxone to an IDU Patient?

A. Professional Licensure Law

The practice of medicine in Rhode Island is governed by the Board of Medical Licensure and Discipline, with regulations found in the Code of Rhode Island Rules. The State Board of Medical Licensure and Discipline (the "Board") has the authority to license physicians and to punish licensed physicians who behave in ways that violate the law or beneath the standards of good faith and regular practice of medicine. Rhode Island case law authorizes the Board to set limits on allowable prescription practices, either by enacting specific regulations banning certain prescription practices, or through the disciplinary process.

Naloxone is labeled for administration to reverse opiate overdose in clinical settings, such as hospitals, but is often administered by first responders acting on standing orders of physicians in the field. Federal and state law affords physicians broad discretion to prescribe drugs for off-label uses, and such prescriptions are a routine part of medical practice. Naloxone is not a controlled substance under state or federal law. Therefore, a prescription for naloxone must meet the same standards as a prescription for any other drug.

In Rhode Island, a prescription can only be written by a “practitioner duly authorized by law in the state in which he practices to prescribe drugs or devices in the course of his or her professional practice for a legitimate medical purpose.” Using standard research techniques, we identified no case-law discussing physicians’ general authority to prescribe drugs and devices in the state, nor is there case-law challenging the legality of prescription of naloxone

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10 R.I. Gen. Laws § 21-28-1.02 ("Controlled substance' means a drug, substance or immediate precursor classified in schedules I – V of this chapter’); R.I. Gen. Laws § 21-28-2.8 (Naxolone is excluded from the list of controlled substances, so it is a legend drug).
specifically. This reflects physicians’ broad discretion in prescribing and dispensing medical agents such as naloxone in this state and elsewhere in the US.

The medical board is authorized to punish physicians whose prescription practices constitute unprofessional conduct. Disciplinary actions of this sort most commonly arise in the case of prescription of controlled substances, and turn on whether the prescription was written for a legitimate medical purpose, in the normal course of professional practice.

**B. Analysis**

To be valid under the standard described above, a prescription for naloxone should only be written for a patient at risk of opiate overdose. Normally, this would entail a physical examination or other clinical encounter, a history, the discussion of a treatment plan and alternatives with the patient, and some plan to ensure adequate follow-up care. The law does not specify the length or intensity of these interactions, leaving the precise contours of the clinical encounter and discussion to the judgment of the physician. Physicians have broad discretion about dosage of non-controlled drugs, and may decide to prescribe whatever amount of the agent they reasonably deem necessary to meet the patient’s needs. Physicians who have an on-going relationship with the patient do not have to conduct a physical examination every time they issue or renew a prescription. By law, physicians are also authorized to delegate some aspects of the prescription process to other health professionals (see Part II below).

**Conclusion:** A prescription for naloxone to an IDU patient is consistent with the standard for a valid prescription under Rhode Island laws governing the physician's authority to prescribe. The same rules that apply to any prescription drug in this state apply to naloxone.

**II. May Anyone Other Than Physician Issue A Prescription For Naloxone?**

**A. Professional Licensure Law**

Allied health professionals in this state are authorized to replace physicians in some or all aspects of a prescription program. The Board permits certified registered nurse practitioner (CRNPs) to prescribe prescription drugs within guidelines written with the medical director or physician consultant with whom they collaborate. Physician assistants (PAs) can prescribe prescription drugs, but only when that authority is granted by their supervising physician.

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12 According to our research, no lawsuits challenging the legality of naloxone prescription have been brought anywhere in the US.
   (a) Prescriptive privileges for the certified registered nurse practitioner:
   (1) Shall be granted under the governance and supervision of the department, board of nurse registration and nurse education; and
B. Analysis

We have concluded above that a physician's prescription for naloxone, issued under the procedures outlined in Part I, is valid under Rhode Island law. In the same way, a prescription issued by an allied health professional in accordance with the relevant regulations is valid. A consultation with a non-physician healthcare provider may eliminate the need for the patient to actually meet a physician before a naloxone prescription is issued. CRNPs can be authorized in Rhode Island to prescribe medicine without physician supervision.\textsuperscript{16} Provided the required supervision of a collaborating physician is available, PAs could also staff a naloxone prescribing program.\textsuperscript{17}

Conclusion: Allied health professionals may replace a physician in specific functions during the prescription process. The same rules that govern the prescription and/or dispensation of any other prescription drug apply to naloxone.

III. What Instructions Should Accompany Naloxone Prescription or Dispensing?

(2) Shall include prescription of legend medications …
(b) A certified registered nurse practitioner (R.N.P.) as stated in § 5-34-3 is permitted to prescribe in accordance with annually updated guidelines, written in collaboration with the medical director or physician consultant of their individual establishments.

\textsuperscript{15} R.I. Gen. Laws §5-54-8 (1956):
(a) … Physician assistants may perform those duties and responsibilities consistent with the limitations of this section, including prescribing of drugs and medical devices, which are delegated by their supervising physician(s). Physician assistants may request, receive, sign for and distribute professional samples of drugs and medical devices to patients only within the limitations of this section. Notwithstanding any other provisions of law, a physician assistant may perform health care services when those services are rendered under the supervision of a licensed physician.

…
(c) Physician assistants may write prescriptions and medical orders to the extent provided in this paragraph. When employed by or extended medical staff privileges by a licensed hospital or other licensed health care facility a physician assistant may write medical orders for inpatients as delineated by the medical staff bylaws of the facility as well as its credentialing process and applicable governing authority. Physician assistants employed directly by physicians, health maintenance organizations or other health care delivery organizations may prescribe legend medications … according to guidelines established by the employing physician, health maintenance organization or other health care delivery organization.

\textsuperscript{16} \textit{Supra} fn 14.
\textsuperscript{17} \textit{Supra} fn 15.
A. The Regulatory Scheme

As noted in the licensure law described in section I, in general it is recommended that a healthcare provider formulate a therapeutic plan for their patient and discuss such plan, along with the basis for the plan and the risks and benefits of various treatment options, with the patient before issuing a prescription.

B. Analysis

The intended use of naloxone is to prevent opiate overdose. Indications for and methods of administration should be explained to patients, along with risks and benefits. Because of the nature of overdose, patients may not always be able to self-administer the necessary dose. Some overdose prevention programs properly instruct pairs or groups of patients in naloxone administration and other emergency measures so that patients can assist each other. Prescribing staff may also provide written and oral instructions that patients can relay to their friends, family, or others who can help administer the drug in an event of an overdose. Such instructions parallel information given to patients who may need emergency injections of insulin or epinephrine and are entirely consistent with the legal prescription of the drug. These instructions should include:

1. information on how to spot symptoms of an overdose;
2. instruction in basic resuscitation techniques;
3. instruction on proper naloxone administration, and
4. the importance of calling 911 for help.

Naloxone distribution programs in Rhode Island should not instruct clients to administer naloxone to persons who do not have a prescription for the drug (see Part V below).

Conclusion: Program participants receiving a take-home dose of naloxone should receive verbal and written instructions on how and when to use this drug. Program staff should not instruct patients to administer naloxone to persons who do not have a valid prescription for the drug.

IV. How May Naloxone be Dispensed?

A. The Regulatory Scheme

Naloxone is subject to the general rules covering dispensing of prescription drugs under state law. The practice of pharmacy in Rhode Island is
governed by the statutory code,\(^{18}\) with regulations found in the Code of Rhode Island Rules.\(^{19}\) Pharmacists are generally expected to fill a prescription that meets regulatory guidelines.

The prescribing healthcare provider may also dispense the agent at the point of service. Physicians, certified registered nurse practitioners and physician assistants can dispense prescription drugs to their patients\(^{20}\) and are not subject to the dispensing rules that govern pharmacists as long as they do not operate as regular pharmacies.\(^{21}\) Finally, regulations on maintaining proper medical records include requirements for the dispensing of drugs from the provider’s office.\(^{22}\)

**B. Analysis**

Pharmacists should and ordinarily will fill a valid prescription for naloxone. Provided that the healthcare provider has followed the prescription guidelines, she or another licensed professional so authorized (see part II) can dispense the drug directly to the clients. If a program decides to dispense naloxone on premises, it must follow standard dispensation rules for practitioners, which include the requirement to maintain a dispensation log, and proper labeling of the agent, including the patient’s name and other essential information.\(^{23}\)

**Conclusion:** Dispensing naloxone by valid prescription does not violate Rhode Island law and may be done on premises of the distribution program.

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\(^{19}\) Code R.I. R. r. 14 130 001 (2007), et seq.


> Nothing contained in this chapter shall apply to any practitioner with authority to prescribe who *does not* keep open shop for the retailing, dispensing of medicines … nor prevent him or her from administering or supplying to his patients such articles as he or she may deem fit and proper (emphasis added).

Code R.I. R. r. 14 130 001(1.84) (2007) ("Practitioner' means a physician … nurse or other person duly authorized by law in the state in which they practice to prescribe drugs").

\(^{22}\) Code R.I. R. r. 14 130 001 (11.4) (2007):

> Medical Records shall be legible and contain the identity of the physician or physician extender and supervising physician by name and professional title who is responsible for rendering, ordering, supervising or billing each diagnostic or treatment procedure. The records must contain sufficient information to justify the course of treatment, including, but not limited to: active problem and mediation lists; patient histories; examination results; test results; records of drugs prescribed, *dispensed*, or administered; and reports of consultations and hospitalizations (emphasis added).

\(^{23}\) Code R.I. R. r. 14 130 001(13.22).
V. Is It Legal To Prescribe Or Dispense Naloxone For Recipients To Give Or Administer To Third Parties Who Have Not Been Prescribed The Drug By A Licensed Professional?

A legal prescription requires a specific patient who has been examined and found to have a medical indication for the drug. Before the drug can properly be dispensed, the patient must be given information about the indications for the drug, its proper use, and its risks and benefits. Naloxone could not properly be prescribed to a person who was not an ODU at risk of overdose, even if that person promised to give it to or use it on a person in need. Although a physician may prescribe multiple doses to a patient for whom they are indicated, the physician may not prescribe “extra” naloxone to a patient with explicit instructions to give it to or use it on a person in need.

A licensed professional who distributed naloxone in this way could be subject to charges of professional misconduct (see section VI) and be subject to heavy fines. The patient or volunteer who distributed or administered naloxone to recipients who were not prescribed this agent could be charged with practicing medicine without a license. We cannot say that a person who saved a life in this way would actually be charged with a crime or harshly punished if convicted, but the act would be technically illegal. We found no provision making it a crime to possession a prescription drug without a valid prescription.

None of this should be taken as suggesting that a program cannot teach patients to properly administer the drug on others. Such training is necessary, as discussed above, to deal with the fact that patients may be unable to self-administer in an overdose situation, or may be called upon to assist another patient. But a program in this state that explicitly encouraged distribution to or administration upon non-patients would be open to legal challenge. Legislatures in a few states have taken action to eliminate legal barriers to emergency use of naloxone among non-patients. These are discussed in the Conclusion, below.

VI. What Is The Risk Of Disciplinary Action By A Professional Board Arising Kind Of Medical Discipline Or Criminal Liability May Arise From

24 R.I. Gen. Laws § 5-37-25 (1956) (“[A]ny person who violates any provision of this chapter or any rule or regulation adopted under this chapter, shall, upon conviction, be punished by a fine of not more than one thousand dollars ($1,000), or by imprisonment for not more than one year, or both”).

25 While there is no Rhode Island law that prohibits the distribution of a legend drug, distributing legend drugs is normally considered practicing medicine, so a volunteer could be charged under the relevant statute for practicing medicine without a license. R.I. Gen. Laws § 5-37-12 (1956):

Any person who is not lawfully authorized to practice medicine within this state … who practices medicine or surgery or attempts to practice medicine … shall be imprisoned not more than three (3) years, or fined not more than one thousand dollars ($1,000), or shall suffer both fine and imprisonment; and in no case when any provision of this chapter has been violated shall the person violating these provisions be entitled to receive compensation for services rendered.
Naloxone Prescription Or Distribution, And How Can The Risk Of Liability Be Minimized?

Non-compliance with prescription and other professional practice rules\(^26\) may carry license sanctions and fines.\(^27\) There is no risk of professional censure.


The term 'unprofessional conduct' as used in this chapter includes, but is not limited to, the following items or any combination of these items and may be further defined by regulations established by the board with the prior approval of the director:

(7) Immoral conduct of a physician or limited registrant in the practice of medicine;

(17) Offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine;

(19) Incompetent, negligent, or willful misconduct in the practice of medicine which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board. The board does not need to establish actual injury to the patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical practice in this subdivision;

(24) Violating any provision or provisions of this chapter or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board;

(27) Failing to maintain standards established by peer review boards, including, but not limited to, standards related to proper utilization of services, use of nonaccepted procedure, and/or quality of care.

\(^{27}\) R.I. Gen. Laws §5-37-63 (1956):

If the accused is found guilty of unprofessional conduct as described in § 5-37-6.2, the director, at the direction of the board, shall impose one or more of the following conditions:

1. Administer a reprimand;
2. Suspend or limit or restrict his or her license or limited registration to practice medicine;
3. Require him or her to serve a period of probation subject to certain conditions and requirements including, where appropriate, sanctions or restitution;
4. Revoke indefinitely his or her license or limited registration to practice medicine;
5. Require him or her to submit to the care, counseling, or treatment of a physician or program acceptable to the board;
6. Require him or her to participate in a program of continuing medical education in the area or areas in which he or she has been judged deficient;
7. Require him or her to practice under the direction of a physician in a public institution, public or private health care program, or private practice for a period of time specified by the board;
for participating in a naloxone prescription program. Our analysis above makes clear that prescribing naloxone to ODU patients is well within the normal parameters of medical practice.

Of course, naloxone prescribing might give rise to political controversy in a particular place, exposing the professionals and the program to closer scrutiny by potentially hostile regulators. Program managers and staff have to be prepared to produce clear and detailed documentation of proper physician involvement, specific and detailed protocols, and licensure information. Case law confirms the general notion that courts defer to the judgment of licensed medical professionals, so long as they produce clear factual evidence of reasonable efforts to comply with the rules and regulations of professional conduct. Blatant non-compliance, cutting corners, cover-ups, and sloppy record-keeping have resulted in the imposition of professional censure and criminal charges.

VII. What Kind of Tort or Civil Liability May Arise from Naloxone Prescription or Distribution; What Remedies Exist to Minimize Such Risk?

A. The Legal Scheme

Any practice of medicine implies a risk that something may go wrong. In the context of a naloxone prescription/dispensing program, a patient may suffer one of the rare side effects from the drug. An error in administration by a patient’s companion, a failure to seek timely medical help after the administration of naloxone, or re-injection of opiates after naloxone might all lead to death or serious injury.

Generally, every tort claimant must establish that he or she suffered an injury that was actually caused by the defendant healthcare provider. A healthcare provider is required to practice his or her profession in a reasonably competent manner. Particular conduct is assessed by reference to the customary behavior of the relevant segment of the profession under the same or similar circumstances, which is said to establish the “standard of care.” The essence of the inquiry is whether the provider’s treatment decisions were reasonable and consistent with accepted medical principles, considering all the circumstances.

(8) Assess against the physician the administrative costs of the proceedings instituted against the physician under this chapter; provided, that this assessment does not exceed ten thousand dollars ($10,000);
(9) Any other conditions or restrictions deemed appropriate under the circumstances.

28 Williams v Ohio Bd. of Nursing, 1993 WL 69465 (Ohio App. 10 Dist. Mar. 9, 1993); Sermchiet v. Gonzales, 660 S.W.2d 683 (Mo. banc 1983).
In order to prove negligence, the plaintiff must prove that (1) the provider’s failure to meet the professional standard of care (2) caused an injury, and that the defendant provider (3) had a duty to avoid harming the plaintiff. Tort doctrine requires the plaintiff to prove that the injury would not have occurred “but for” the healthcare provider’s unreasonable behavior.

**B. Analysis**

Naloxone is the drug of choice for overdose. Assuming that the patient is an IDU at risk of a fatal overdose, and is properly instructed in the administration and risks of the drug, a simple risk–benefit analysis would suggest that the provider’s decision to prescribe was reasonable and not negligent. The reasonableness of the decision would be supported by the public health and clinical literature discussing take-home naloxone,\(^{31}\) and, in an actual case, by expert testimony from clinicians and public health experts. If the prescription of naloxone is reasonable, there can be no tort liability even if the other elements of the case are established.

“But for” causation will be extremely difficult to establish where the injury results from overdose, because at the moment naloxone was administered serious injury was already likely to happen. Where the injury is caused by the rare occurrence of side effects of naloxone, the causal connection is still tenuous: the behavior of the injured party, in overdosing on heroin, is the key causal factor that necessitated treatment with the agent. Injury was likely to be as severe, if not more so, had naloxone not been administered. It is not considered malpractice to prescribe a drug that carries a low risk of side effects to avert death or severe impairment, particularly if the patient is adequately informed of the risks. Even in the unlikely cases in which “but for” factual causation may be established, the provider’s actions must represent a major contributing factor to the injury for liability to arise. It is hardly fair to blame a prescribing professional for a harm primarily caused by a patient’s decision to inject heroin; courts have usually applied the rule of “superseding cause” to hold that people who voluntarily use dangerous drugs cannot blame others for the harm the drugs cause.\(^{32}\)

Programs and providers cannot be found liable for actions of clients who administer naloxone to third parties who were not prescribed the drug, unless the program or provider have expressly instructed clients to administer naloxone in this manner. Program and providers should not issue such instructions. The

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actions by third parties are superseding cause of injury, not connected directly to the actions of providers or the program. Under doctrine, the court would likely ask if such an outcome was reasonably foreseeable. A death or injury resulting from an unauthorized administration of a low risk medication prescribed to a non-patient is arguably too unforeseeable a result to establish liability. Informing clients of the need to contact first responders and administer the necessary resuscitation procedures to overdose victims can further mitigate the risk of any liability under these circumstances.

Any practice within the scope of the practitioner’s usual duties is covered by malpractice insurance, which will pay for any litigation arising out of that practice according to the terms of the insurance contract. Naloxone prescription to prevent opiate overdose is a practice accepted by a significant number of physicians and is within the scope of practice for providers working with the general population.

In the case of volunteer providers, the US Volunteer Protection Act shields volunteers for acts committed within the scope for their work for a non-profit or government agency, so long as the acts are not criminal, reckless or grossly negligent.

Conclusion: The risk of tort liability in a naloxone program is low. Conceptually, this risk is no different from any other healthcare context. By following state rules and general standards of practice, providers can protect themselves from the imposition of tort liability. Malpractice insurance and laws that apply specifically to volunteer providers may provide additional protection.

CONCLUSION

A. Guidelines

Naloxone prescription is legal in this state. However, as with any healthcare practice, institutions and professionals providing this service should follow the relevant rules and regulations that govern their practice to avoid professional, civil, and criminal liability.

The following is a summary of the program guidelines dictated by Rhode Island law we have outlined above:

1. Each patient receiving naloxone must be issued a prescription for the drug by a physician or licensed medical provider working in collaboration with a physician.
2. In order to receive a prescription, each patient must undergo an examination that is reasonable in light of professional standards to produce a proper diagnosis and treatment plan.
3. The prescription must be made out to the specific patient and must contain all the information required by law.
4. Each prescription should be accompanied by oral and/or written information on the following:
   • information on how to spot symptoms of an overdose;
   • instruction in basic resuscitation techniques;
   • instruction on proper naloxone administration, and
   • the importance of calling 911 for help.

B. Changes in State Law

Under the current law of this state, dispensing or administering naloxone to third parties who have not been prescribed the drug is illegal. Passing legislation to allow these practices would help reduce overdose deaths and ease the concerns of providers and clients about possible legal penalties. New York’s legislature recently passed a law to provide clear authorization of medical providers to “prescribe” or “dispense” naloxone to unknown ODUs via trained patients or volunteers (“Trained Overdose Responders” under NYS law); establish immunity for providers participating in such programs; and establish immunity for patients and volunteers using naloxone in providing first aid to victims of heroin overdose.35

C. Cooperation with First Responders

Programs should also work with police and EMTs to inform them about program goals and practices. Alerting first responders to the presence of take-home naloxone can help inform their work and alleviate resistance or roadblocks to program implementation. By building their programs according to the regulatory schemes we have referenced above, programs can successfully navigate the legal questions around dispensation of this life-saving agent to IDUs.

   [T]he purchase, acquisition, possession or use of an opioid antagonist by an Opioid Overdose Prevention Program or a Trained Overdose Responder in accordance with this section and the training provided by an authorized Opioid Overdose Prevention Program shall not constitute the unlawful practice of a professional or other violation under title eight of the education law or article 33 of the public health law.