Critique	Response
"Naloxone will provide a 'safety net' that will only encourage people to use more drugs or use drugs in riskier ways.	This hasn't been the experience of naloxone distribution programs. Naloxone puts opioid users into withdrawal – which is not a pleasant feeling – and it takes away the positive effects of the drugs. Research has actually shown that people who received overdose training with naloxone reported less drug use after the training.[1] Participation in naloxone programs is also associated with less syringe sharing.[2]
"Drug users won't be able to recognize an overdose or respond appropriately."	Research studies demonstrate that drug users can indeed recognize an overdose and respond correctly. In fact, after training, they are as competent in overdose response as doctors. And the good news about naloxone is that, if a victim doesn't have opioids in their system (if they are unconscious for some other reason) naloxone will have no adverse effect.[3]
"Naloxone will discourage people from seeking drug treatment."	Actually, experience shows that naloxone program participants may be more likely to access treatment.[4] Naloxone is a resource that drug users want. By providing it, harm reduction programs can get people in the door and build relationships with them. This may lead to other health benefits like HIV testing and treatment, wound care, psychosocial counseling, and perhaps even drug treatment when the person is ready.
"Providing naloxone will send the message that we condone drug use."	Providing naloxone will send the message that you value the person and care whether they live or die. This can be powerful and affirming, and can build a relationship of trust that can lead to other positive changes. Many methadone treatment and other drug treatment programs are now providing naloxone training. (See the case study on overdose education in a Russian detox center.)
"Receiving naloxone will make the victim violent, and I'm concerned for my safety."	Receiving naloxone can put someone into withdrawal, but if not given an excessive dose, and treated kindly upon waking up, they usually will not be violent. Reports of violence are extremely rare in situations where a friend, family member, or peer administers naloxone. Reports of violence in ambulance and hospital settings may have more to do with fears about punishment and ill-treatment of drug users by some medical professionals.
"Starting a naloxone program would be great, but I don't have the resources or time."	Overdose programming can often be incorporated into existing trainings and outreach activities. A basic training on recognizing overdose and responding with naloxone takes less than five minutes, and can easily be delivered during street outreach. You may also want to survey your participants to see how overdose ranks among their concerns – if it's high, it's justification for directing resources to fill this need. (For more ideas about how to incorporate overdose training and naloxone distribution into existing programs, see this powerpoint.) If you're trying to convince another entity, like a detox center or a prison to incorporate naloxone training, you may offer to go in and do the training yourself to alleviate their concerns about their own workload

[1] Maxwell S, Bigg D, Stanczykiewicz K, Carlberg-Racich S. Prescribing naloxone to actively injecting heroin users: a program to reduce heroin overdose deaths. J Addict Dis. 2006;25:89-96.
[2] Coffin P, Coffin L, Fitzpatrick T, Murphy S. Overdose, naloxone, and HIV risk in Seattle, USA. Poster from AIDS 2012 in Washington, DC 2012. Available online at: http://www.overdosepreventionalliance.org/2012/07/administering-naloxone-at-overdose-is.html.
[3] Green TC, Heimer R, Grau LE. Distinguishing signs of opioid overdose and indication for naloxone: an evaluation of six overdose training and naloxone distribution programs in the United States. Addiction. 2008;103:979-989.
[4] Seal KH, Thawley R, Gee L, et al. Naloxone distribution and cardio- pulmonary resuscitation training for injection drug users to prevent heroin overdose death: a pilot intervention study. J Urban Health. 005;82:303 – 311.

	(see for example the case studies on overdose training in prisons and in detox centers in Russia).
"In our country, laypeople are not allowed to administer injections."	You may be able to overcome this barrier in several ways. You could suggest a research pilot that would be allowed to circumvent local laws. If the pilot proves successful, you could advocate to change those laws. You may also be able to get an exemption for naloxone from a medical board, Ministry of Health, or other appropriate authority. Some programs have operated "underground," collecting evidence of successful overdose reversals until the climate is right to propose changes in legislation. The truth is that injecting drug users know well how to administer injections.
"As a nongovernmental organization, we're not allowed to store large quantities of medications on our premises."	Though this isn't the case in all countries, where it is, groups have found creative solutions. You could try partnering with an HIV organization or other group that's authorized to store medications, visiting them once a week to collect just enough naloxone for that week's trainings.
"What if someone tries to sue me for giving them naloxone?"	This seems like a far-fetched concern, but it's one we sometimes hear. Some groups have asked drug users to sign forms, following overdose trainings, saying that they give others permission to give them naloxone in an overdose emergency. You may also encourage participants to write out an "overdose plan" and share it with loved ones. These plans detail how they want people to respond in the event of an overdose. For the most part, people are not going to be mad at someone for saving their life.
"We don't have a doctor on staff, but a doctor is needed to prescribe naloxone."	Some programs have a doctor on staff a few days a week or partner with a doctor who can come on site to prescribe naloxone. But other programs have responded more creatively by using "standing orders," documents in which a doctor designates certain others (usually outreach workers) to train drug users on overdose prevention and distribute naloxone under the doctor's medical license. Recognizing the urgent need for overdose response, some health departments in the US have supported the standing order model, even without changes in current law (see the Standing Orders case study for more information and examples).
"I'm afraid the police will arrest me for providing naloxone."	You may want to get a letter from medical authorities describing the humanitarian nature of your work. But many programs have contacted police directly, to explain naloxone distribution to them and to get their support for this lifesaving work (see the case study about advocacy with police in Vietnam for one example).
"We can't get support from naloxone in our country, because there is so much stigma against drug users."	Unfortunately, there is just about nowhere that people who use drugs don't face stigma, and everyone seems to think that their context is the worst. But sometimes you can turn that stigma to your advantage. For example, in Boston, USA, a spate of news articles portrayed drug users negatively – showing them overdosing in parks, disturbing public order. Advocates used this series of articles to approach health authorities with an idea for an innovative program to respond to the overdose crisis – naloxone distribution. Because of the negative publicity, health officials were open to hearing new ideas (see the Media case study for the full story).

*This piece is inspired by an earlier document by Maya Doe-Simkins.