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# **Police Assisting Addicts towards Recovery: A Preliminary Analysis of Drug Policy**

*Sherah Dickinson*

## **ABSTRACT**

The War on Drugs began in 1967 with the hope of ending the devastating effects of drug addiction. Unfortunately, the prevalence of drug use and abuse has only spread across socioeconomic, cultural, and geographic lines. This research describes the implications of criminalizing drug addiction, for example: crowded prison populations and disparate treatment of minority and disadvantaged groups. This review further investigates alternative methods and policies using evidence-based practice to treat substance addiction such as the ANGEL Program in Gloucester Massachusetts.

## **INTRODUCTION**

Since the wake of the War on Drugs in 1967, the number of prisoners in the United States has grown exponentially, reaching an all-time high in 2009 with over 2.3 million people incarcerated (Drucker, 2013). According to a bulletin for the Bureau of Justice Statistics (BJS), from 1995 to 2003 forty-nine percent of prison growth was related to drug crimes, indicating a correlation between mass incarceration and drug policy (Harrison & Beck, 2007). A similar rise in arrests was seen in other countries. In Portugal for instance, “Throughout the 1990s, the number of arrests for drug offenses generally, and heroin use specifically, rose steadily. By 1998, more than 60 percent of drug-related arrests were for use or possession, rather than for sale or possession to sell” (Greenwald, 2009, p. 14). This demonstrates a loss of focus on fighting drug trafficking, as these statistics reveal the drug war has targeted people who use and abuse drugs rather than people who distribute and sell illicit drugs.

Drug policies to date have focused on symptoms, rather than root causes. Specifically, punitive approaches to drug possession have resulted in a failed War on Drugs, rather than creating policies that have addressed drug trafficking. Many countries have begun to examine alternate approaches that are less punitive; Portugal for instance has changed its approach and seen promising results. Other nations, especially those in Latin America, are now looking to the United States to recognize the failure of the War on Drugs and to adopt new policies that are prevention and treatment-based (Drucker, 2013). “Over the last two decades, the United States has single-mindedly agitated for greater criminalization approaches and appears, at least to EU officials, interested solely in enforcement actions, rather than empirically vindicated policy changes at the user level designed to manage usage rates and ameliorate drug-related harms” (Greenwald, 2009, p. 27). Meanwhile, individual states across the U.S. such as Colorado and Washington are starting to legalize medical and recreational marijuana which may exacerbate the issue if other policies are not put in place to fight drug trafficking.

While many have advocated for a radical departure from the punitive War on Drugs approach, the recent opiate crises found across the country may be a large enough issue to lead to

actual discussion on various alternative drug policies. Current punitive efforts to stop the epidemic of heroin and opioid addiction have failed as evidenced by public attention received about overpopulation in the prison system. For example, in 2012 California amended the three strikes law, (which predetermined a life sentence for offenders after 3 felonies), with proposition 36, waving sentences if the most recent felony was not serious or violent and also allowed resentencing for qualifying inmates contingent on public safety (Drucker, 2013). This was in response to the Supreme Court decision in *Brown vs. Plata* which ordered the state of California to reduce the prison population by 25% over the course of two years (Gottschalk, 2014). Because people who struggle with a substance use disorder (SUD) are more likely to participate in crimes, have run-ins with law enforcement, or face incarceration, they are also more likely to account for a large portion of prison population (Record, 2014 and Kopak, 2015).

Opiates have played an especially significant role in addiction and incarceration over the last three decades. Since the 1990's doctors have relied heavily on opium-based medication to reduce patients' pain, as pharmaceutical companies pushed use and claimed they were non-addictive (Jangi, 2014). The Center for Disease Control (CDC) stated that, "In 2012, health care providers wrote 259 million prescriptions for opioid pain medication," allowing one prescription per adult citizen of the US (2016). The increase in opiate prescriptions is strongly linked to illicit drug use as indicated by Record (2014) "4 out of 5 users are addicted to prescription painkillers when they first try heroin." The majority of opium related deaths initiated with an opioid-based prescription, and growing evidence reveals that exposure to opium just one time can dramatically increase chances of addiction (Jangi, 2016).

The opiate epidemic cuts across all socioeconomic divides. Whereas the previous War on Drugs was focused on viewing addiction as an "inner city problem" (NDCP, 2014), the opiate epidemic is classless and affects all populations and all ages. Sadly, it may take a drug problem of epidemic proportions that finally impacts the wealthy, including the families of politicians and corporate leaders, to encourage actual debate and exploration of less punitive and more promising approaches to preventing and dealing with addiction.

### **ALTERNATIVE TO THE WAR ON DRUGS**

The War on Drugs has resulted in rigid habitual offender policies and mandatory sentencing laws at a federal level. Rather than alleviating problematic drug use and distributing, families have been separated and minorities have been exploited. The number of African American men currently imprisoned is comparable to the number of slaves here in the United States in 1864 (Drucker, 2013). Current federal level policy has not improved outcomes related to drugs. Instead, policies have resulted in the spread of disease, overdoses, increased incarceration, drug related crime, and increases in mental illness (Degenhards, 2012). Additionally, a strong armed approach has resulted in fear about exploring less punitive policies and stunted open discussion about viable alternatives.

In examining possibilities, two key policy alternatives have been analyzed: decriminalization and legalization. Too often, these policy options are conflated as one policy alternative. In reality, they represent unique policy alternatives with vastly different values and

approaches to addressing drug use. Benefits and drawbacks for each approach will be briefly reviewed with specific examples given.

### **DECRIMINALIZATION**

According to Greenwald (2009), the definition of decriminalization is the “removal of a conduct or activity from the sphere of criminal law. Prohibition remains the rule, but sanctions for use (and its preparatory acts) no longer fall within criminal law.” Under this approach, violators are not placed in the criminal justice system but are issued citations, comparable to a traffic citation. Aspects of the citations may include seeking out treatment. More severe penalties may apply to repeat offenders.

This is the foundation of Portugal’s national drug strategy which was designed to decrease the harm of penal sanctions on personal drug use, as well as to expand both treatment and preventative measures in hopes of producing harm reduction and better reintegration into society (Hughes & Stevens, 2010). After analyzing research from several different data sets, Hughes and Stevens believe Portugal’s drug problems are decreasing, especially when compared to the drug problems found in other parts of the European Union (EU). Additionally, the number of people seeking treatment more than doubled in the first two years of decriminalization as fears of prosecution and shame had been lifted. Portugal also had a steady decrease in drug related deaths from 1999 to 2006 (Greenwald, 2009).

### **LEGALIZATION**

Legalization, on the other hand, is significantly different from decriminalization. Greenwald’s (2009) definition is: “No prohibitions of any kind under the law on drug manufacturing, sales, possession, or usage.” A drug that is legalized can be used without fear of any repercussions. Rules around age of use, how much of the substance can be purchased, or who can grow or sell the substance may still apply. Under this arrangement, as long as these rules are abided by, substance users of legalized drugs need not fear punishment or criminal repercussions for use of the substance. Such a course of action has been taken in places like Colorado which legalized marijuana in 2012. The Netherlands has also legalized marijuana, as businesses are permitted to sell it in small quantities (Glick, 2014).

Decriminalization and legalization represent two policy alternatives, each standing in contrast to the extremely punitive War on Drugs policies; however, they both have the same target of harm reduction. These policy alternatives can be used in varying ways for varying substances. A description of some of the challenges and benefits will first be examined. An overview of Portugal’s drug policy will then provide an additional demonstration of how decriminalization serves as a viable policy option.

### **OPPONENTS**

Opponents of legalization and decriminalization are concerned about an increase in drug use due to availability, lowered costs, and/or decreased concerns of punishment. Some studies have found that legalizing drugs could result in a higher prevalence of users (Bretteville-Jensen, 2006). Opponents are also apprehensive about the mix of alcohol and illicit drugs both readily available; alcohol is linked to approximately 100,000 fatalities a year (Hartnett, 2005). Hartnett

shares this belief, further suggesting that legalization would likely induce more experimental drug use by the adolescent population and send the message that substance use is not truly harmful (2005).

Additional concerns associated with decriminalization or legalization include wider spread of diseases such as HIV and hepatitis, a rise in drug related violence, and increases in emergency services (Hughes & Stevens, 2012). With higher risks for health issues, opponents fear an increase in public health costs, as well as a decrease in productivity (Bretteville-Jensen, 2006).

### **PROPONENTS OF LEGALIZATION**

Hughes and Stevens (2010) argue many of these concerns, highlighting that drug reform alone does not make the difference in the prevalence of drug use. Their findings indicate that it is not just the legality that determines utilization of drugs as demonstrated in the Netherlands, “where the rise in cannabis use did not immediately follow its depenalization, but coincided with the development of ‘coffee shops’ that openly promoted their illicit wares” (2010, p. 2). Research examining outcomes in Portugal has found that overall there have been drops in nearly every category of drug use for youth ages 13 to 19, contradicting beliefs that decriminalization would decrease the inhibitions of the youth. This is particularly important as policy specialists believe that usage from ages 15 thru 24 are indicators of life time drug use (Hughes & Stevens, 2012).

Despite fears around the health implications of increased drug use, the numbers of people with SUD’s who have contracted blood borne diseases such as HIV has been on a steady decline in Portugal since drug reform in 2001; the use of needle exchange programs and opiate replacements have also assisted in decreasing the spread of infectious diseases (Greenwald, 2009). Hughes and Stevens (2012) convey that South Australia’s decriminalization of cannabis in 1987 was linked to an increase in employment and better relations with the public and law enforcement. Overall, these statistics reveal a holistic view of better health by examining biopsychosocial results from drug reform.

### **INTERNATIONAL COMPARISONS**

Problematic illegal drug use is obviously not exclusive to the United States. It is an international problem spread across the globe. There have been international agreements in place for over 50 years as an effort to maintain drug control. Degenhardt (2012) posits that more developed countries tend to have higher rates of illicit drug use. In the 1990’s, Portugal commissioned the Comissão para a Estratégia Nacional de Combate à Droga (Commission for a National Anti-Drug Strategy) in response to problematic drug use trends. In 2001, the commission recommended and enacted decriminalization of drug use (Greenwald, 2009).

The Institute on Drugs and Drug Addiction seeks to ensure that Portugal adopts innovative and beneficial drug policies that continue to pursue better treatment efforts and decrease the harm caused by addiction (Hughes and Stevens, 2010). Decriminalization has largely been the strategy adopted by Portugal. While it remains illegal to use many substances, users do not face strict jail sentences. It should be noted that incarceration is still available to

those caught selling and distributing illegal substances. Furthermore, harsher penalties may be placed on anyone who has more than 10 days' worth of a substance in their possession regardless of intent, has repeated offenses, or is suspected of having an SUD and refuses treatment (Greenwald, 2009).

Decriminalization is a policy that has resulted in meaningful improvements. MacCoun and Reuter (2001), who have extensively studied the drug war and alternative policies, found that the primary impact of decriminalization was reducing the burden and cost on the criminal justice system. Reform in Portugal has not only reduced pressure on the criminal justice system, but has also assisted in lowering the rate of drug use, disease, and death linked to drugs. Part of these improvements are due to the treatment that is made available through Portuguese drug policy (Greenwald, 2009). This claim is based on research that examined Portugal's drug policy as compared to Spain and Italy. Portugal's drug reforms have led to improvements in the availability of treatment, increased reintegration from prison to society, decreased illicit drugs use among younger populations, and lowered prison rates (Hughes & Stevens, 2010).

### **A TIME TO CHANGE**

Current drug use rates and incarceration rates are problematic for the United States. Prison costs alone suggest current policies will lead to unsustainable and unfair outcomes for our nation. While there is likely no single solution that will ever truly resolve the drug problems in the US, decriminalization and legalization both serve as solutions that may at least alleviate the pressures that drug addiction inflicts upon law enforcement, clinicians, policy makers, and the general public.

Local approaches more in line with depenalization and decriminalization can be found in varying places across the nation. The Civil Citation Network in Leon County Florida, for example, gives law enforcement the discretion to submit a civil citation to offenders who have no prior offenses (usually pertaining to drug and alcohol offenses). If the offender accepts the citation, they attend an intake interview within seven days, still having the option to face normal criminal charges; following the interview and completion of an assessment, the program is adapted to the needs of each individual (Kopak, 2015). Hawaii and South Dakota also have piloted programs to lessen the strain that drug addiction places on jails and prisons. Multidisciplinary Drug Courts are also spreading in different localities around the nation and may be most effective for people who are addicted to cocaine, crack, or heroin (Larkin, 2016).

One additional solution that could be aligned with decriminalization and legalization involves increased provision of treatment. Kopak (2015) claims high-risk drug offenders, especially those who have a severe substance abuse disorder as defined by the DSM-V, benefit the most from intense supervision in conjunction with rehabilitation, as seen utilized in drug courts. Another approach could be removing minimum drug sentencing laws and replacing them with a short sentence that escalates for repeat offenses (Larkin, 2016).

Medicated assisted therapy (MAT) is another avenue professionals and medical personnel are examining to treat addiction and should be a piece of the policy puzzle. Antabuse, for example, has been used since 1951 to inhibit the body from metabolizing alcohol, often resulting

in nausea, vomiting, and other negative side effects (Kopak, 2015). The EU is currently treating approximately 730,000 people who are addicted to opiates with MAT's such as methadone and buprenorphine. While this method is controversial, research has shown positive results in decreasing both drug use and crime, as well as cost effectiveness. "The National Treatment Agency states that for every £1 spent on drug treatment £2.50 is saved in health and social costs" (Matheson et al., 2014, p. 408). While treatment and rehabilitative services have been recognized as a need going forward, a larger scale adjustment in line with decriminalization or legalization should be explored.

### CONCLUSION

As we have examined, current drug policies in response to the drug war have had negative effects on the spread of drug addiction, disease, incarceration, and discrimination. Pharmaceutical companies have further aggravated this issue by pushing medical personnel to more liberally prescribe opioid-based pain relievers such as hydrocodone and fentanyl. This study has sought to find the implications of such practices and policies and to offer possible solutions to the drug war such as decriminalization and legalization.

There are clearly benefits and drawbacks to both decriminalization and legalization. Should either approach be enacted in the future, those in favor of the policy that is not enacted will feel a great injustice has been committed (Glick, 2014). Finding a compromise between the two sides may be a viable solution but must be done with caution. Policymakers should consider types of drugs being used, where they are most prevalent, and average age upon developing an SUD to such substances. Furthermore, cost benefit analysis will need to be performed prior to and routinely after the implementation of such policies in order to get an accurate measurement of success rates. These costs could then be compared to the current costs of the drug war. While it may be easy to quantify the costs to incarcerate drug users because of the War on Drugs, the cost to our economy and to families of individuals serving such severe prison sentences is incalculable. "How can one hope to accurately measure the psychological and long-term productivity costs borne by a young child with a parent who is imprisoned solely on repeated drug possession violations?" (Glick, 2014, p. 361). This statement lends itself to the cause of a softer approach to drug addiction as utilized in Portugal.

Currently, attitudes toward illicit drugs are evolving. The public has increased tolerance for legalization, especially for marijuana, even with a menagerie of views and policies across varying states and even cities and/or counties (Drucker, 2013). New York, which once led the states in mandatory minimums with the "Rockefeller laws" of 1973, is now leading in reform with an almost 20% reduction in felony drug arrests from 2008 to 2013. As of 2008, twelve states including Nebraska have decriminalized the use of marijuana. The use of medical marijuana is now legal in 24 states; among these states, recreational use is legal in Alaska, Colorado, Oregon, Washington, and The District of Columbia. Over half of Americans in 2012 no longer view drug addiction as crime to go to war over but instead view it as a health issue (Drucker, 2013). Viewing it in this light suggests a drastically different approach more in line with legalization and decriminalization.

Law Enforcement's perception and management of illicit drug use also varies across the states. For example, New York had approximately 50,000 arrests related to marijuana in 2011, while Law Enforcement in California tends to ignore even recreational use of marijuana (Drucker, 2013). However, law enforcement has also demonstrated a desire for reform as seen through programs such as HOPE as South Dakota's 24/7, and drug court (Larkin, 2016). Regardless of differing views and opinions across the states, current drug policies are clearly ineffective as demonstrated by this research. Further analysis of these programs may provide a possible solution in conjunction with policy changes that seek to decriminalize substance addiction. One such innovative program is examined in the attached appendices.

Despite the shortcomings of existing policies, societal trends and adoption of various alternative approaches throughout the country and world suggest that a new approach is feasible and likely to produce better outcomes. Working toward these new approaches will take much effort, but it will be worth it, particularly in consideration of the potential impact on individuals, families, and children who are currently influenced or impacted in a negative manner by the war on drugs.

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## APPENDIX 1

### ANGEL Program Product Analysis

*\*\* see Appendix 2 for a flow chart outlining the ANGEL Program*

#### **Allocations:**

On June 1, 2015 Chief Leonard Campanello of the Gloucester Police Department (GPD) in Massachusetts launched the ‘Angel Program.’ This program was designed to take a more innovative approach to ending the drug epidemic, particularly that of opioids, as it has become the source of a public health crisis across the state of Massachusetts. Chief Campanello was met with support by Sheriff Frank Cousins Jr. of Essex County, who also hoped to lower the jail population, which was predominantly populated with inmates who struggled with substance abuse.

The Chief and Sheriff both recognize addiction as a family disease; therefore the ‘Angel Program’ is designed to assist both drug addicts and their families. This unique program is intended to lower inmate populations, treat drug addiction, strengthen families of addicts, and reduce drug related deaths. According to the Commonwealth of Massachusetts Part 1, Title 17, Chapter 123, Section 35, an alcoholic or person with alcohol use disorder consumes alcohol to the extent that they have loss of control and/or it effects them socially, financially, or physically and may pose danger to others. The Commonwealth uses this same description for a person with a substance abuse disorder, adding “the chronic or habitual consumption or ingestion of controlled substances or intentional inhalation of toxic vapors” to the definition.

#### **Individuals who meet this definition are eligible for the ANGEL Program with the following exceptions:**

- Outstanding arrest warrant
- Three or more drug related convictions, with one conviction in a school zone
- Reasonable belief by Watch Commander or assigned officer that the participant may pose a danger to the Angel
- Under the age of 18 and without parental or guardian consent
- Participants who have symptoms of withdrawal or other medical conditions will be transported to Addison Gilbert Hospital for evaluations.

#### **Social Provision:**

The ‘Angel Program’ allows addicts to voluntarily turn in their illegal substances and paraphernalia without facing punishment of jail. Instead, they are processed into detox and treatment upon meeting the criteria of the program. Subjects are assigned a monitor by the watch commander until a volunteer ‘Angel’ is located; they then receive support from their ‘Angel’ during the intake process while awaiting treatment and/or detox. The main function of the Angel is to provide emotional support to the participant and to assist them in completing the intake and agreement forms, as well as finding the most appropriate placement. The Angel Program does not exclude out of state facilities as sometimes the distance for participants is beneficial. This prevents visits from fellow addicts and helps to keep beds open in local

facilities. Upon admittance into treatment or detox, the Angel is no longer involved in the case. Those who are ineligible will still be met with amnesty, provided they seek treatment. The lifesaving drug, nasal narcan, will also be provided to those in need, regardless of insurance or monetary means as part of this program.

**Delivery:**

Upon surrender of substances and paraphernalia, the Watch Commander will take specific steps to complete the intake process:

1. Assign an officer to monitor and find a volunteer 'Angel.' (Both participant or Angel may request a different volunteer for any reason)
2. Assure that program intake and agreement form is completed and run a Criminal Offender Record Information (CORI) check.
3. Document and properly dispose of surrendered substances and paraphernalia.
4. Contact treatment and detox centers, hospital, and ambulance as needed.
5. Arrange a success plan and refuge if treatment or detox is unavailable.

The intake process involves a variety of programs and entities: public, private, and nonprofit. This ensures successful completion of the program for the participant and good practices from all who are involved, including:

- Gloucester Police Department
- Angel Program
- Beauport Ambulance
- Addison Gilbert Hospital
- Conley's, CVS, and Walgreens Pharmacies
- Lahey Health Behavioral Services
- Police Assistance Addiction Recovery Initiative (PAARI)
- Varying treatment and detox facilities (not exclusively in Massachusetts)

**Financing:**

Chief Campanello has been able to fund this program through volunteers, state and federal funds, private donations, scholarships, and the nonprofit he started, PAARI.

- The Angel program itself is run exclusively by volunteers
- State and federal assets forfeitures are acquired from adjudicated drug cases to help pay for nasal narcan, which is made available to anyone in need regardless of prescription or ability to pay, thus localizing drug money to fight against drugs.
- Beauport Ambulance helps to transport participants as needed for only 5% of the cost, which is covered by PAARI and GPD.

- Treatment facilities such as Addiction Campuses in Brentwood, TN are providing scholarships for participants who cannot afford treatment, and PAARI is also assisting with funding treatment.

### **FINAL CONCLUSION**

While this program is too young to have statistical data, it appears to have promising results with both excellent networking and funding properly allocated into the program. Drug arrests are still taking place; this simply gives offenders a chance to turn in their paraphernalia and receive treatment in place of jail time. The process has also smoothed out over the first year, as it took 11 hours to complete the intake procedure for the first participant; GPD and the Angels have cut this time down to fifteen minutes. They are also working on a handbook to assist other areas and/or agencies who are interested in starting a similar program (Lamont, 2015).

APPENDIX 2

Angel Project Flow Chart

