A Lack of Options

Abuse of Drugs - Including Heroin - Is on the Rise, But the Upper Valley Is Sorely Lacking in Treatment Facilities
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It took six months for Danielle Pollari of Newport to get long-term inpatient treatment for her drug addiction.

Before her substance abuse problems began, Pollari, now 25, graduated among the top 10 in her class at Newport High School and was selected to represent New Hampshire in a National Cheerleading Association competition in Texas the summer before her senior year. She had a vivacious personality, said Sherry Lee, Pollari's mother. "This girl could walk into a funeral parlor at a wake and people would smile."

But Pollari started drinking heavily when she was 18, and her substance abuse problems escalated from there. She began using heroin, a highly addictive drug that has become increasingly prevalent in New England in the past several years.

Last summer, Pollari's mother called treatment centers across the state and found out that the wait would be four to six months.

"It's a scary thing," said Lee in an interview last week at the Sullivan County Department of Corrections, where she is assistant superintendent. "Do you let your child continue using heroin and take the chance that the next needle they're going to put in their arm is going to be the last?"

Pollari's difficulty getting long-term residential care reflects a shortage of treatment options in the Upper Valley, the Twin States and the nation, according to treatment providers. "I would characterize treatment in the Upper Valley as close to nonexistent -- certainly in need of a great deal of attention and support," said Mark Helijas, executive director of the Upper Valley Substance Abuse Foundation.

The problem is especially severe in the areas of inpatient, intensive outpatient and adolescent treatment, providers say. Headrest Inc. in Lebanon, the only Upper Valley organization to offer inpatient treatment specifically for substance abuse to the general population, has eight beds in its clinically managed detoxification and sobriety maintenance program. The Clara Martin Center offers the only intensive outpatient program locally through its Wilder office. There is no residential treatment available in the Upper Valley for adolescents and few beds in New Hampshire or Vermont.

The dearth of treatment programs doesn't mean the need isn't there, according to state officials and community leaders. Some 60,000 people in New Hampshire and Vermont need treatment, state officials say. New Hampshire ranks third highest among all states for binge drinking, ninth highest for marijuana use and 19th highest for illicit drug use,

according to a 2000 survey by the U.S. Department of Health and Human Services. Vermont ranks 11th highest among all states for binge drinking, third for marijuana use and fourth for illicit drug use.

Several organizations, including Dartmouth-Hitchcock Medical Center, are working on increasing treatment availability in the Upper Valley. Two groups seeking money to operate a new residential treatment center want to locate their facilities in Bradford, Vt., state officials say. In a separate initiative, a group is interested in establishing an opiate addiction clinic in White River Junction using money in Gov. Jim Douglas' proposed budget, state officials said.

But efforts to improve treatment options locally face obstacles that include poor managed care reimbursement and inadequate federal and state funding, especially in New Hampshire. Both states rank below average in state spending per person on alcohol and other drug services, with New Hampshire coming in near the bottom. Funding has generally remained flat for more than a decade in both states.

"(New Hampshire) has to realize it has a big problem, and I don't think this state has come to that recognition yet," Sullivan County Manager Ed Gil DeRubio said. "They seem to have other priorities on their plate."

New Hampshire and Vermont have a large number of substance abusers who don't get help. In both states, about 2 percent of the total population -- nearly 20,000 people in New Hampshire and 10,000 in Vermont -- need treatment for a drug problem but aren't receiving it, according to the U.S. health department. New Hampshire ranks eighth highest in the nation for the percentage of people whose treatment needs aren't being met, while Vermont ranks 13th.

Studies indicate that drug and alcohol use has increased steadily in New Hampshire and Vermont. Heroin, in particular, has gained a foothold in both states and in the Upper Valley, where police have reported an increase in crime related to the drug. Health care admissions for heroin have increase more than twelvefold in both states, although they still remain a small percentage of overall drug treatment episodes.

Heroin, which arrives from urban areas in Massachusetts and New York, has become popular because it's cheap, potent and easily accessible. It's also highly addictive. Ninety percent of Sullivan County inmates have substance abuse problems, primarily involving heroin, Gil DeRubio said. (A similar percentage of inmates across the state and in Vermont have drug and alcohol problems, according to state officials.)

"We de facto become like a detox center, if you will," he said. That's a problem because corrections officers aren't trained to deal with the severe symptoms of withdrawal and the cost of medications for addicted inmates is driving up the $2.2 million department of corrections operating budget, he said.

Substance abuse is also an issue among teenagers: A licensed drug and alcohol counselor who spends time in both Newport and Claremont high schools saw more than 40 students with substance abuse issues in the first four weeks on the job, Gil DeRubio said.
"It's surprising to me that it's now a middle-class phenomenon," said Michele Rowland, who directs behavioral health services at Valley Regional Hospital in Claremont. In 2002, 187 people sought help there for alcohol and drug issues, up from fewer than 70 the year before, she said. They included business owners, young mothers and successful students and athletes.

Across the river in Vermont, some 5,500 people need alcohol and drug treatment in Windsor and Orange counties, according to state data that used indicators such as hospital admissions and drunken driving arrests to predict prevalence. (No county breakdown was available for New Hampshire.)

The only Upper Valley organization to provide some residential treatment for substance abuse to the general population is Headrest, whose eight beds are evenly divided among men and women. "Sometimes it's critical that patients receive inpatient treatment, particularly related to clinical detoxification," said Headrest Executive Director Karen Koskoff, adding that clients may be in extreme pain and unable to function, or they may be homeless.
"Certainly more than eight people need this," said Koskoff, who called the extent of treatment services locally "woefully inadequate."

The Veterans Affairs hospital in White River Junction provides detoxification services for veterans only, mainly in inpatient units because most patients don't have the community or family support to do it on an outpatient basis, according to Andrew Pomerantz, a physician and chief of mental services at the hospital.

DHMC offers outpatient detoxification for alcoholism, said Donald West, a physician who heads drug and alcohol services there. The hospital also provides detoxification evaluation, treatment and referral for the typically four or five patients in its psychiatric unit who have substance abuse issues occurring with another mental disorder. However, the primary reason for their admission cannot be their alcohol or drug problems, according to Medicare regulations under which the hospital operates.

Many providers also pointed to a lack of intensive outpatient programs, which typically provide treatment several times a week. The Clara Martin Center's Quitting Time, administered through its Wilder office, is the only such program in the Upper Valley. New Hampshire has no intensive outpatient programs north of Concord, West said; in Vermont, the nearest are in Rutland and Berlin, according to Yvette Vernette-Stevens, director of alcohol and other drug programs for the Clara Martin Center.

Another deficiency is in the area of adolescent treatment, providers say. "When they reach the point of wanting help, there's minimal options for help and it's frustrating," said Kassy Helie, the nurse for Newport Middle High School, which has about 725 sixth- through 12th-graders.

The school got a licensed drug and alcohol counselor in mid-April as part of the $134,000 that the county received through Governor's Commission funds. However, those funds were cut in the budget approved by the House in April and it's unclear whether part of the money will be restored in the final spending plan.

"It's just going to be Band-Aids until we have some inpatient adolescent treatment," said Donlon Wade, an addiction counselor who helped create Headrest and now has a private practice in Lebanon. Mascoma Valley Regional School District, where Wade is part of the substance abuse prevention team, recently dealt with an incident in which three girls snorted stolen prescription methadone in the high school bathroom.

The options for adolescent residential treatment are so limited that most teenagers trying to get into a program will encounter a delay of up to two months, said Mark McGovern, director of the Dartmouth Center on Addiction, Recovery and Education, which is working to help the community coordinate and expand efforts to address substance abuse. There's no inpatient treatment available for teenagers younger than 17 in the Upper Valley. New Hampshire and Vermont each have 15 residential beds for adolescents.

"To think that you can treat them on an outpatient basis is often unrealistic," because of possible negative influences at home and from friends, McGovern said. "They need to get away." But residential treatment without ongoing support is also insufficient since it's easy to fall into old patterns when they return, he said.

Helijas, of the Upper Valley Substance Abuse Foundation, said there's also a need for transitional, substance-free housing in the Upper Valley. Oxford House in White River Junction used to provide housing for five or six people in the early stages of their recovery, but it disbanded a couple of years ago, he said.

In addition, McGovern said, the Upper Valley and the nation have a shortage of programs that treat substance abusers with co-occurring mental disorders. Forty percent to 60 percent of people with alcohol or drug problems also have other psychological issues, most commonly depression, post-traumatic stress disorder and social phobias.

The Upper Valley has several programs that provide outpatient assessment, counseling and referrals, including West Central Behavioral Health, serving lower Grafton and Sullivan counties; the Clara Martin Center, which provides regular outpatient treatment at its offices in Randolph, Bradford, Chelsea and Wilder; Dartmouth-Hitchcock Medical Center; and Windham-Windsor Recovery Assistance Programs, run by Health Care and Rehab Services of Southeastern Vermont.

Several organizations said they had waiting lists. "It can be very hard to serve the people who are seeking treatment," Vernette-Stevens of the Clara Martin Center said. The outpatient programs use group treatment that allows them to stay away from waiting lists, providing people with coping skills before they move on to individual work. The

intensive outpatient program had a wait of about three weeks within the past six months, but it has since shrunk to about one week, she said.

Not only do waiting lists prevent people from receiving treatment right away, but they may deter them from getting assistance altogether, treatment providers said. Because people may feel ambivalent about seeking help, it's important to be able to provide services when they're willing to take advantage of them. "It's one of those businesses where you really have to strike when the iron is hot," Vernette-Stevens said.

Vermont recently increased the number of student assistance professionals in schools. While calling the expansion a needed step, Vernette-Stevens said it has led to more referrals that have prevented the organization from linking clients with clinicians as quickly.
At West Central, people seeking appointments may be seen promptly, but could also end up waiting several weeks if calls come in at once. The agency will prioritize according to need; for instance, the agency would try to help a pregnant heroin user right away, said David Pelletier, West Central's director of substance abuse services.

Rowland of Valley Regional Hospital said she believed that fewer than 10 private practices provide substance abuse treatment in the Upper Valley.

The Upper Valley also has a recovery center, the Turning Point Club in White River Junction, that provides ongoing support for people dealing with substance abuse issues. The club is the primary program of the Upper Valley Substance Abuse Foundation and charges no fees for services. The volunteer-based program has been used as a model for recovery centers around the state, Vermont officials said.

Will Shakespeare, director of Windham-Windsor Recovery Assistance Programs, said he doesn't feel the situation on the Vermont side is "awful." Families can become frustrated because their loved ones need help and they sometimes expect to find a "magic bullet," which no treatment program has, he said. "The reality is there are services but the client has to get there and has to participate actively in them," he said.

Nonetheless, he said the Windham-Windsor Recovery Assistance Programs is experiencing a significant demand on its programs, with the number of people seeking appointments doubling in the past year. If the demand rises much more, the organization would need additional staff and funding to meet it.

McGovern said the Upper Valley is in some ways below the national average for treatment options. He said he has referred clients to programs in Massachusetts or Arizona or had to treat them daily in his office. Although a treatment gap exists throughout the United States, "I think that the discussion here is proving there's a greater imbalance between the size of the problem and the size of the solution."

The shortage locally reflects deficiencies across New Hampshire and Vermont and nationwide, according to providers and states officials.

"It's dreadful," said Riley Regan, the new director of the state's Division of Alcohol and Drug Abuse Prevention and Recovery, referring to the availability of treatment in New Hampshire. He said that for every $1 spent on treatment, $7 is saved on costs associated with the damage substance abuse causes, such as incarceration and health care.

The state has 20 to 30 short-term residential beds for adults, about 60 longer-term beds for children and mothers or pregnant women and about 75 crisis beds, he said. The wait for a regular residential program may be more than 20 days, Regan said; a short-term crisis center in Manchester has an eight-day waiting list, Regan said, and 10 days isn't unusual.
"It's so crazy it's almost funny, although I'm having a tough time laughing about it right now," he said.

Because of its small size, Vermont is able to provide a network of community mental health centers in each county that can treat substance abuse. "That isn't to say we don't have real needs and gaps in services that we need to fill," said Peter Lee, chief of treatment at the state's Division of Alcohol and Drug Abuse Programs.

One of those gaps is in residential treatment. Vermont has about 65 acute care residential beds and an additional 50 beds for less intense residential options, such as transitional living, Lee said. At least 250 people in state care are sent to New York and New Hampshire annually for residential treatment, although a planned 80-bed facility is expected to relieve some of the pressure, said Tom Perras, director of the alcohol and drug division. (The state also needs more transitional housing for people who want a substance-free environment and can't go back to the living situation they had before, Lee said.)

Although most people who need substance abuse treatment don't require the highest levels of care -- residential or inpatient hospitalization -- those who do need it badly, McGovern said. He compared offering outpatient servvices to someone with severe substance abuse issues to scheduling an outpatient appointment for someone bleeding to death.

The dearth of nonresidential options for substance abusers -- such as intensive outpatient programs and transitional housing -- ends up exacerbating the shortage of inpatient treatment by tying up needed beds, McGovern said. For instance, a judge might recommend a residential facility as part of an inmate's parole or probation program because that's the only option available, when a halfway house and intensive outpatient program would be more appropriate. Or, clients might be unable to move out of a facility because of the lack of transitional, substance-free housing.

"It makes the few spots that are available not particularly fluid," McGovern said.
That, in turn, creates a problem for facilities such as Headrest that provide crisis detoxification, which should take three to 10 days. With a shortage of residential treatment beds, residents often languish at the short-term centers for months.

No publicly funded treatment is available for roughly two-thirds of the 12,700 criminal offenders in New Hampshire, according to Under the Influence, a report from the New Hampshire Center for Public Policy. About 5,500 of those untreated inmates have been released and are free or on probation or parole.

Another statewide need is methadone maintenance treatment, several providers said. Methadone is a long-acting drug that doesn't give people a high and prevents them from craving heroin at the same time.

New Hampshire has two facilities in Manchester and Hudson and Vermont has one that opened in Burlington last fall. In addition, Southern New Hampshire Medical Center in Nashua distributes methadone for pregnant addicted women through a state-funded program.

In Vermont, at least 70 people travel to out-of-state methadone maintenance clinics. West said he knows one person who drives 150 miles from northern Vermont to southern New Hampshire for methadone treatment.

Sherry Lee's experience with the treatment shortage began last summer when she tried to help her daughter enter a drug treatment facility. With no beds available, she ended up helping Pollari detox at home -- a process lasting several days that generally isn't life-threatening, although the heroin addict becomes violently ill with flu-like symptoms. In mid-October, she went to Serenity Place in Manchester, which provides short-term sobriety maintenance, and then to Farnum Center, a 28-day program, in early November. After completing the program there, she tried to get into a longer-term facility.

"That 30 days had filled her with all this hope -- and she just knew that wasn't enough," said Lee, who cares for her daughter's 21-month-old son. "She said, 'I need more. I want more. This isn't going to do it.'"

No beds were available, however. Pollari returned home to live with her mother and stepfather. She had been clean for six months when she "relapsed hard" in late January and stole from family members to support her addiction, her mother said. Lee said she doesn't blame her daughter's relapse on the lack of beds.

Pollari was charged with taking her grandmother's ATM and using it to withdraw $4,675 in cash and stealing additional cash from her uncle's house, Lee said. She had also been charged with stealing guns from her aunt's home in early August, Lee said. Pollari, who was sentenced to 12 months in a drug treatment facility, could face 7 _ to 15 years of jail time for the three felonies if she violates probation. Lee keeps the court papers on her desk to remind herself of what she still finds hard to believe.

After spending 2 _ months in the Grafton County jail, Pollari entered a 28-day residential drug treatment program in Bethlehem, N.H., and then was accepted to a long-term

residential treatment center. She remains in the program and couldn't be reached for this report.

But her mother said the struggle to find treatment made dealing with her daughter's addiction even more stressful. Hearing about the wait for a bed, "Your first reaction is what the hell do you mean? What do you expect people to do?" she said. "Each time you call you get a little more frustrated because they've all got waiting lists."

Only one in 12 people who need substance abuse treatment get it, Dartmouth's McGovern said. If only one of 12 people with breast cancer was getting treatment, he said, "I think we'd be horrified."

The proliferation of managed care is a major reason for the dramatic change in substance abuse treatment that has occurred in the past 10 to 15 years, said Rowland of Valley Regional Hospital.

Managed care's drive to control costs led them to determine that treatment wasn't effective, although the disease by its nature often causes people to relapse multiple times before staying clean, Rowland said.

"No question treatment works," said West, the DHMC psychiatrist. Fifty percent to 60 percent of people with alcohol problems were sober two years later after receiving adequate treatment -- a success rate at least as good as that for other chronic diseases such as diabetes, hypertension and asthma, he said.

The money set aside for mental health and substance abuse services shrank even as medical advances led to more effective treatment and greater understanding of addiction as a chemical disease rather than a character defect, said Carr Robertson-Allen, director of community health improvement at DHMC. "We're still stuck with financing that developed at a time when (substance abuse) was seen as a moral failing," she said.

Since the early 1990s, some 15 New Hampshire residential treatment programs, including two in the Upper Valley, have closed primarily because managed care companies wouldn't pay for services. But the loss of inpatient beds wasn't offset by an increase in outpatient programs, Rowland said.

West, who was medical director of the Alice Peck Day program in Lebanon from 1986 to 1989, said the program had a good reputation before it shut down in 1991. "It was absolutely financial," he said of the closure. (The other local facility that closed was the Seminole Point Hospital in Sunapee, a 71-bed facility that operated as an upscale drug and alcohol rehabilitation center until it was sold in 1997 because of the owner's ill health.)

Most insurance companies will pay for intensive outpatient treatment but not inpatient services unless people have serious co-existing psychological or medical problems, or cannot stop abusing substances after participating in an outpatient treatment, West said.

They also mandate strict preauthorization for care, said Rowland, adding that people can spend four to six hours in the emergency department while waiting preauthorization for care. The onerous process sometimes causes people simply to walk out. Also contributing to the difficulty of getting reimbursement are aggressive reviews to determine if people continue to merit care and often a lower lifetime maximum for substance abuse than for other illnesses.

In a 2001 report, the U.S. Department of Health and Human Services said there is "growing concern about the impact of managed care on substance abuse treatment."

But Rowland said for-profit behavioral health providers were partly responsible for the changes because of serious abuses that included adding unneeded beds and delivering unneeded services. She also said more research must be done to gather hard data about what works and what doesn't.

Inpatient treatment at prominent clinics costs about $14,000 to $15,000 a month, while intensive outpatient care costs $3,000 to $4,000, West said.

In addition, substance abuse treatment has received inadequate public funding, particularly at the state level, treatment providers say. In 1997, New Hampshire ranked seventh lowest in overall per capita expenditures for alcohol and other drug services, spending less than half the national average, according to the Portsmouth-based organization New Futures. Vermont ranked 27th and had below-average spending.

Representatives of the publicly funded organizations interviewed for this story said they receive between 25 percent and 45 percent of their funding from the state, with the rest coming from client fees, third-party insurance payments, organizations such as the United Way, contracts and public donations.

The New Hampshire House budget last month eliminated roughly $10 million for prevention and treatment from Gov. Craig Benson's proposed two-year spending plan. The funding came from a portion of liquor commission profits designated for prevention and treatment under legislation passed two years ago. Under the House budget, Grafton and Sullivan counties would lose about $1 million in proposed funding for 2004 and 2005. However, some of the money could be restored once the Senate comes up with its own plan and the two chambers negotiate a compromise.

"I think that the way the legislature has dealt with funding for substance abuse (in past years but particularly this year) is bordering on being criminal in terms of their attention to a major problem in the state," West said.

Most treatment providers said they felt that Vermont was doing a better job of making substance abuse a priority.

New Hampshire House Finance Chairman Neal Kurk of Weare told the Valley News last month that cuts for substance abuse prevention and treatment were necessary to fund

more critical state needs, such as nursing home care and physician services. He said all state services were funded at reasonable levels in the House budget.

Addiction hasn't had a strong voice to advocate for funding, Rowland said. People view treatment providers as biased when they ask for more resources, and clients may be reluctant to speak out because of the stigma associated with the disease. Substance abuse, which for some people may conjure up stereotypical images of bums in back alleys, often doesn't elicit the same sympathetic response as other illnesses.

"Raising funds for substance abuse is more difficult than (for) cancer, heart disease and little kids -- and yet cancer, heart disease and little kids are affected significantly because of addiction," Helijas of the Upper Valleyy Substance Abuse Foundation said.

"It's kind of been our dirty little secret that nobody wants to look at," he added. "Our culture is still in significant denial about the enormity of the problem."

Several treatment providers said a major shortage of drug and alcohol counselors makes it difficult to expand services. Vermont has just over 300 licensed drug and alcohol counselors, while New Hampshire has about 370, state officials said. Attracting and retaining the counselors is difficult because of the pay, which can be as low as $8 per hour. To be fully certified and licensed, a counselor must have three or four years of training in addition to a master's degree.

But other barriers besides the scarcity of treatment prevent people from getting help, providers said. A mother living in a rural area might not have anyone to take care of her children while she's undergoing detoxification, Koskoff said. The lack of public transportation in a rural area, where people might have to drive significant distances to treatment, can present challenges, particularly if someone loses a license for driving under the influence.

And sometimes people won't seek treatment because of the perception that it's not available or doesn't work, or a fear of discrimination, several providers said.

Nonetheless, several local and state groups are working to develop additional treatment options. Dartmouth-Hitchcock Medical Center has some physicians, including West, who will be able to begin prescribing buprenorphine in several months to treat hero in addiction. Buprenorphine is a new drug similar to methadone, but best suited for people who are younger and have more social supports, and who have been addicted for less time, West said. The drug is manufactured with opiate blockers that make it less likely to be abused.

Since any individual or group practice is limited to 30 buprenorphine patients, the medical center will be able to serve about 60 people through the Hitchcock Clinic and the Department of Psychiatry, which are considered separate entities. West said he wasn't sure what the need might be for the drug locally.

DHMC is working on a community plan to address the substance problem in the Upper Valley. (See story, above.)

The Windham-Windsor Recovery Assistance Programs also plans to begin administering buprenorphine in mid-July through its in-house psychiatrist in collaboration with its counseling staff, Shakespeare said. And Valley Regional Hospital in Claremont is also exploring the possibility of prescribing buprenorphine for clinical detoxification rather than sobriety maintenance.

A group has discussed applying for state funds to open an opiate addiction clinic in White River Junction that would be able to prescribe methadone, Vermont's Perras said. The location would have several advantages, including its location at the junction of interstates 91 and 89 and Route 4, which would enable people to travel there easily from across the state, and its proximity to major medical centers that could offer support, such as DHMC and the VA, Perras said. He declined to say which group was considering the center until it had submitted a written proposal.

In addition, the VA, which currently prescribes methadone to veterans for chronic pain treatment, is exploring the possibility of using the drug for substance abuse treatment as well, Pomerantz said.

Methadone maintenance clinics "are kind of a tough sell in communities," said Pelletier. "People feel really nervous about having these facilities." He said residents fear that the clinics will attract addicts to the area and increase crime and social problems.

McGovern said studies show that methadone reduces dependence on street crime to support addiction, increases work productivity, decreases use of heroin and other narcotics and eases family and other social problems. "Frankly it's hard to argue against methadone maintenance programs on the basis of outcomes alone," McGovern said.

Douglas' proposed budget calls for roughly $3 million for the opiate addiction clinic, more outpatient clinicians and case managers, and additional student assistance counselors.
In addition, Vermont is reviewing four proposals for an 80-bed facility and hopes to make a recommendation this week. The new center would include roughly 40 beds for women, who have been over-incarcerated for lack of treatment options, said Perras. It would also have up to 20 beds for young people and about five beds for detoxification.

Two of four groups applying want to locate the facility in Bradford, while the others are proposing centers in Brandon and Brattleboro. Having more Vermont beds would improve the quality of treatment by allowing family members to be directly involved and help build a stronger continuum of care, Perras said.

The state budget called for $60,000 this fiscal year to establish three new recovery centers in Rutland, Burlington and Randolph, Lee said. The ones in Rutland and Burlington are in operation.

Despite the funding cut in the New Hampshire House budget, Regan said he's not discouraged and plans to seek more third-party payments to cover treatment. "We need to have every one of the hospitals in the state have a decent treatment program," he said. He said he hopes to convert a vacant state-owned building into a 100-bed facility that offered short-term detoxification and counseling programs. He also wants to see more transitional, substance-free housing through a program that provides state assistance for people in recovery to live together. And he wants local communities to have more control over spending decisions through the creation of planning bodies in each county that would consist of people involved in treatment and education.

But the area needs good treatment programs -- not just more of them, McGovern said. "We talk about all these kind of treatments as if just having them is a good thing .... but there's also an important piece and that's the assurance of the quality of the program."

Nearly three years ago, Sherry Lee's daughter was living on the streets in Nashua, doing drugs. Lee knew she was there but didn't know where to find her.

She had a dream that recurred many times, but particularly that summer, Lee recalled in an interview last fall. She dreamed that she was speaking at her daughter's funeral and that her daughter had found the peace she hadn't been able to find on Earth.

"It's like watching your child in the middle of the lake drown," she said of her daughter's addiction. "Just watching them. Not being able to throw them a lifejacket or anything."

"I prayed to God, literally prayed to God to take her because I didn't know what else to do. I thought it would be easier for her and for (her son.)"

Once, her daughter came back briefly from living on the streets. She was hungry and said she had been living out of a car. "I begged her then, please don't go back down there, and she was here and gone before I knew it. She only stayed a few minutes and I couldn't stop her from going."

Now, Lee writes Danielle every day while she's in treatment in Bethlehem, N.H., and sends her inspirational messages. She is hopeful, although she knows it will be a difficult journey for her daughter.

It's been about a month since she's dreamed of Danielle dying.