

# The Ethical Dilemma of Abstinence-Only Service Delivery in the United States

Heather Sophia Lee, Ph.D., L.C.S.W.  
Rutgers Robert Wood Johnson Medical School  
[heather.sophia.lee@rutgers.edu](mailto:heather.sophia.lee@rutgers.edu)

*Journal of Social Work Values and Ethics*, Volume 12, Number 1 (2015)  
Copyright 2015, ASWB

This text may be freely shared among individuals, but it may not be republished in any medium without express written consent from the authors and advance notification of ASWB

## Abstract

The dominant service delivery model in substance abuse treatment in the United States is abstinence-only. Often attributed to the prominence of the twelve step approach to addiction, some argue that abstinence-only is a co-optation of the twelve steps, which are inclusive of anyone with the desire to stop drinking where “everyone deserves a seat at the table.” Drawing on my experience as a social worker and researcher of harm reduction approaches for the homeless population in substance abuse treatment, I argue that excluding individuals who do not commit to abstinence (i.e., “cherry picking”) is paradoxical (given our acceptance of the disease model of addiction) and ethically problematic in its exclusion of individuals in need of psychosocial support and basic services. Abstinence-only service delivery poses an ethical dilemma for health care and psychosocial service providers who work in institutions with abstinence-only policies. The work of social workers is cited as a case example that is particularly problematic given our Code of Ethics which prioritizes client self-determination. If leaders in health care and social services seek to address the needs of vulnerable populations and high utilizing patients, it is critical that we address the ways in which abstinence-only service delivery acts as a barrier to needed health care and social services. Abstinence-only service delivery must be called into question if we are to work toward

reducing and eliminating health and health care disparities in the United States.

**Keywords:** abstinence-only, harm reduction, substance abuse treatment, social work, disease model, addiction, alcohol and other drug use.

## 1. Introduction

I sat with the intake coordinator in his office as we welcomed a new family into the transitional housing agency where I was an intern. They were a white couple, most likely in their 40s. They had two children. There was an anticipatory energy in the room as they entered—relief, gratitude, and disbelief at their good fortune of finding a place to sleep that night after being evicted from their apartment. Their two children lingered in the background. The intake interview began with standard questions; all was well.

Then it happened. A simple question asked with the wrong answer given prompted a sea-change in the room. Warned that drug-testing must yield “clean” results before he could be eligible for housing for he and his family, the husband and father of two knew he had no choice but to disclose his recent marijuana use. The space was transformed—from one vast with possibility—to one that felt like a prison with no room for movement. The intake coordinator confirmed this indeed excluded them from housing services and their initial anticipatory energy was sucked out of the room by the metaphorical vacuum of

abstinence-only policy. The couple gathered their belongings, rounded-up their children, and headed back out into the Chicago winter with no assurance of a place to sleep that night.

For those who struggle with drug and alcohol dependency in the United States, this vignette illustrates an ethical issue in substance abuse treatment and allied social services. The abstinence-only service delivery model is a barrier to treatment services for the majority of substance users in need of services (Tatarsky, 2002). The vignette above is indeed anecdotal, but the narrative of being “kicked out” and shamed in the event of relapse is a commonly reported experience by individuals who choose to disengage from such programs. In my research, which investigates the client experience in harm reduction programs, many patients choose harm reduction programs as an alternative to “traditional” programs as it provides a safer space for healing (Lee & Zerai, 2010; Lee & Petersen, 2009). This narrative is an explanation as to why one chooses to disengage from treatment, but typically goes untold by clients themselves. Instead, a characterization of these clients as “unmotivated” for treatment is told *about* them, absent of their voices. This view of the substance user as unmotivated for change is couched in biases toward substance users as “trouble makers” as opposed to those in need of help (Reinarman & Levine, 1989), embedded in a culture of punitive approaches to drug policy unique to the United States. Alternative harm reduction approaches emerge in programs like Housing First, in frameworks like Relapse Prevention, and in techniques like Motivational Interviewing. Yet client voices tell us that harsh abstinence-only approaches are commonplace as well. The client lived experience of it is as shaming and stigmatizing, an experience which acts as a barrier to trust between client and provider (Lee & Zerai, 2010; Lee & Petersen, 2009).

In this article, I question the mainstream high-threshold model of service delivery which permits the “cherry picking” of certain clients over others. A disease model of addiction is embraced

asserting that the individual has little control over their disease and yet we require one to do the most difficult work of becoming abstinent before they can be “helped.” The value base of the social work field which rests on client self-determination provides guidance in this area.

## **2. Abstinence-Only Service Delivery**

The majority of problematic alcohol and other drug users are those who cannot or will not stop their use entirely (Tatarsky, 2002). The majority of substance abuse treatment programs and other social service agencies which serve those who struggle with substance dependency rest on an abstinence-only service delivery model which requires users to abstain from use before they are deemed able to receive help (Denning, 2004). This presents a paradox in treatment delivery wherein those most in need of help are least able to obtain it.

Abstinence-only policy rests on a narrative story line (Stone, 1989) which says that addiction is a disease and an individual must be abstinent from their problem drug before they can be helped. The high-threshold, “one size fits all” model of abstinence-only provides no place for help-seeking users unless they are able to cease (or lie about) their use. The result is a service structure wherein those most in need of help are least able to access it and where providers serve clients who demonstrate a high level of readiness for change.

## **3. The Disease Model of Addiction**

The disease model characterizes addiction as a disease and informs mainstream service delivery. Prior to the disease model, the moral model framed alcoholism as one of moral failing for which the disease model offered a humanistic challenge. It no longer attributed moral failing from the drug user by assuming underlying physical dependency attributed to predisposing physiological factors (Marlatt, 1985). Traceable to the early nineteenth century, E. M. Jellinek introduced the current version of the model in the 1940s. It has been sanctioned by the American Medical Association and World Health Organization (Marlatt, 1985) and has dominated scientific inquiry and treatment approaches since

the 20th century, dating back more than 200 years (Bride & Nackerud, 2002).

The moral and disease models are typically viewed as distinct, yet Marlatt (Marlatt, 1985) noted that the two models form an “alliance” present in Alcoholics Anonymous, which incorporates aspects of both models; the organization views alcoholism as an illness but also emphasizes “a power greater than ourselves,” “a searching and fearless moral inventory of ourselves,” and “defects of character,” as written in the twelve AA steps (Al-Anon Family Group Headquarters, 1983).

Few practitioners view addiction as purely a physiological condition, as biopsychosocial models have gained prominence in recent years. The addictive behavior model conceptualizes addictive behaviors as resting on a continuum as opposed to fixed, discrete categories (Marlatt, 1985). Miller (Miller, 2002) reviews “evolving models of treatment” and discusses the medical model as one which grew out of earlier conceptions of the disease model, yet adopting a biopsychosocial view. While the disease model has given a framework (Iyengar, 1990; Roggeband & Verloo, 2007) for treating individuals who struggle with addiction with more compassion, it also seems to provide support for the service rationing to many individuals in need of help.

#### **4. Twelve-Step Facilitation and Abstinence-Only Service Delivery: Not the Same**

Around the same time that the disease model arrived into consciousness so did Alcoholics Anonymous (AA). In 1935, Bill Wilson wrote the AA “big book” which would become a canonical text in addiction treatment. The twelve step program originated as a grass roots organization—technically not considered treatment or psychotherapy “eschewing psychiatric and behavioral science research, intervention techniques, and concepts” (Hartel & Glantz, 1999). Twelve step groups are support groups which provide a framework for recovery resting on the twelve steps and twelve traditions. Members of AA and other twelve step programs are encouraged to obtain a

peer sponsor also in recovery (Hartel & Glantz, 1999) as it is believed that those in recovery could provide treatment to those newer to recovery. Twelve step approaches consider addiction to be a disease for which the response should be spiritual, and is seen as metaphorical to recovery from a disease, but one which can never be cured. Abstinence is seen as the mechanism for through which past substance-related problems may be remedied, a process through which members are encouraged to “admit their powerlessness over the disease” (Hartel & Glantz, 1999).

Twelve step approaches do support recovery for many; however, research on this process is difficult due to its emphasis on group member anonymity. Although twelve step approaches take the form of support groups, Denning claims that “...97% of all substance abuse programs in the United States use twelve-step practices and groups as the primary vehicle for treatment...” (Denning, 2004). The majority of those in a recovery program are in a program which is based to some extent on twelve step based principles (Wallace, 1999).

In its origin, twelve-step facilitation was open to anyone with the desire to quit drinking (Lee, Engstrom, & Petersen, 2011). The question of how the foundational basis of twelve-step facilitation led to abstinence-only service delivery is unclear, but its implications reach far into the experience of those in need of help, the way in which they interface with social service systems, and our ethos around addiction in United States culture.

#### **5. The Abstinence-Only Script**

Abstinence-only policy imposes a scripted conversation between social service providers and clients which states: “I cannot help you until you are ‘clean,’” which is to say that access to the agency is closed to one until they become abstinent. It is a peculiar interaction in psychosocial services as individuals who struggle with mental health diagnoses are not likely to be turned away for experiencing symptoms of depression, anxiety, or schizophrenia and yet one could argue that these diagnoses might also interfere with receptivity to treatment. Addiction is framed both as a disease

over which one has little control and for which that lack of control inhibits service access.

Reinarman and Levine articulate this when they say that the American framing of drug users is of those who “make trouble” rather than those who are “in trouble” (Reinarman & Levine, 1989). The disease model is a humanistic, compassionate stance on addiction as it removes attribution for problematic behavior from a take on one’s moral character. Yet having embraced the disease model as our mainstream causal explanation of addiction, why is our response to those who present in social service settings “in trouble” (Reinarman & Levine, 1989) so punitive? We define addiction as a disease and yet place the most difficult work of “treatment” for that disease (i.e., abstinence) on the individual for which “help” will arrive only after the most difficult part has been achieved.

According to Stone “Problem definition is a process of image making, where the images have to do fundamentally with attributing cause, blame, and responsibility” (Stone, 1989). In this case, the narrative is one of addiction as disease for which one cannot be helped until substance use is eliminated, and that no one other than the individual can be held accountable for ceasing the use.

Such logic removes accountability from service providers for working with “difficult” clients. The fact that one is likely more receptive to treatment after becoming substance-free is likely accurate, however, in what other “helping” field do we get to pick and choose the “easiest” clients to help?

Highlighted in this story line is the individuals’ alcohol and other drug use, but less visible is the often co-occurring mental health issues and history of trauma which often accompany one’s choices to use substances.

As Stone says, “there are many strategies for pushing responsibility onto someone else” (Stone, 1989). She goes on to say that “Causal theories, if they are successful, do more than convincingly demonstrate the possibility of human control over bad conditions...they can either challenge or protect an existing social order...they can assign responsibility to particular political actors

so that someone will have to stop an activity... they can legitimate and empower particular actors as ‘fixers’ of the problem...they can create new political alliances among people who are shown to stand in the same victim relationship to the causal agent” (Stone, 1989).

By placing the primary solution (i.e., giving up one’s drug use before engaging in treatment) service providers maintain their status of power over the client/user. Placing accountability only on the clients with complex needs rationalizes turning one away rather than to engage them in their suffering.

## **6. The Ethical Dilemma of Abstinence-Only Policy**

Abstinence-only service delivery often serves to re-traumatize clients for whom it takes courage to reach out for help, to only then be further shut out of a system from which they are already disengaged (Lee, 2006). As attention shifts toward greater integration of mental health and substance use services in primary care, reflecting on where we stand on such policies is time worth spent if we are interested in truly serving vulnerable populations and decreasing health disparities. To do this, a lower-threshold service delivery model must be considered alongside existing evidence-based practices and policies such as motivational interviewing and Housing First.

## **7. Social Work Code of Ethics**

Abstinence-only policy poses a particular dilemma for social workers whose professional practice is governed by the National Association of Social Work’s Code of Ethics. Additionally, it is social workers who are charged with serving our most vulnerable and disadvantaged clients.

The National Association of Social Worker’s code of ethics specifically states that: “Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients’ right to self-determination when, in the social workers’ professional judgment, clients’ actions or potential actions pose a serious,

foreseeable, and imminent risk to themselves or others.” (National Association of Social Workers) The abstinence-only policy of most agencies is arguably in opposition to such values as codified in the National Association of Social Workers’ Code of Ethics, particularly the emphasis on client self-determination (National Association of Social Workers).

Not only does this interfere with one’s access to substance abuse treatment, but also basic services such as housing and employment training as noted in the opening vignette. Nowhere in the code of ethics are alcohol and other drug users excluded from their right to self-determination. Similarly, theories and sensitizing frameworks which inform social work practice—such as ecological systems theory, person-in-environment, Carol Roger’s notion of client-centered therapy, and anti-oppressive frameworks—support the notion of self-determination for the whole person alongside a compassionate attitudinal stance by the provider toward the client. Social workers are particularly well-positioned to respond to substance abuse issues with vulnerable populations. Many argue that research on motivational interviewing, harm reduction, and other client-centered approaches demonstrates that tending to the relationship in clinical practice is an evidence-based practice. As health care transforms to more effectively integrate mental health, substance abuse, and physical health looking to the field for its value placed on self-determination could be instrumental.

## **8. Conclusion**

This paper has problematized abstinence-only service delivery, arguing that we cannot claim to have a system which serves if it excludes those in need of help. This problematization was made through a social constructionist lens where we acknowledge our choice in defining problems (Blumer, 1971) as we have in framing addiction as a disease and with an accompanying causal story about the way in which a substance-dependent individuals need to be “helped.”

We have a service delivery model which is not grounded in clinical evidence and poses an

ethical dilemma for clinicians who are asked to turn away individuals seeking help. In other areas of mental health treatment this would be considered foolish; one would not be asked to rid oneself of depression, for example, before they could access services for depression. This common practice also cannot be attributed to the influence of Alcoholics Anonymous (AA) and twelve-step approaches, which in its origins did not advocate one to be sober to participate but rather to have a desire to stop drinking. Alcoholics Anonymous’ open-door policy, where “progress not perfection” was prioritized and where “everyone deserves a seat at the table” (Lee, Engstrom, & Petersen, 2011) was a low-threshold delivery model.

The causal story that one can only recover through being turned away to fend for him/herself so that he can return to be helped later may have evolved for reasons not entirely known. It becomes clear that to keep this policy intact maintains the privilege and power of institutions to decide who to serve and who not to serve while many clients in need are left with few to no options.

## **References**

- Al-Anon Family Group Headquarters, I. (1983). *Alateen: A day at a time*. New York: Al-Anon Family Group Headquarters, Inc.
- Blumer, H. (1971). Social problems as collective behavior. *Social problems*, 18(3), 298-306.
- Bride, B. E., & Nackerud, L. (2002). The disease model of alcoholism: A Kuhnian paradigm. *Journal of Sociology and Social Welfare*, 29(2), 125-141.
- Denning, P. (2004). *Practicing harm reduction psychotherapy: An alternative approach to addictions*. New York: The Guilford Press.
- Hartel, C., & Glantz, M. (1999). The treatment of drug abuse: Changing the paths. *Drug abuse: Origins and interventions* (pp. 243-284). Washington, DC: American Psychological Association.
- Iyengar, S. (1990). Framing responsibility for political issues: The case of poverty. *Political Behavior*, 12(1), 19-40.
- Lee, H. S., Engstrom, M., & Petersen, S. R. (2011).

- Harm reduction and 12 steps: Complementary, oppositional, or something in-between? *Substance Use & Misuse*, 46(9), 1151-1161.
- Lee, H.S., & Zerai, A. (2010). "Everyone deserves services no matter what": Defining success in harm-reduction-based substance user treatment. *Substance Use & Misuse*, 45(14), 2411-2427.
- Lee, H.S., & Petersen, S. R. (2009). Demarginalizing the marginalized in substance abuse treatment: Stories of homeless, active substance users in an urban harm reduction based drop-in center. *Addiction Research and Theory*, 17(6), 622-636.
- Marlatt, G. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G. Marlatt & J. E. Gordon (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: The Guilford Press.
- Miller, W. (2002). Enhancing motivation for change in substance abuse treatment. *Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP) Series No. 35*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- National Association of Social Workers. *Code of ethics of the National Association of Social Workers*. Retrieved from <http://www.socialworkers.org/pubs/code/code.asp>.
- Reinarman, C., & Levine, H. (1989). Crack in context: Politics and media in the making of a drug scare. *Contemporary Drug Problems*, 16(4), 535-577.
- Roggeband, C., & Verloo, M. (2007). Dutch women and liberated, migrant women are a problem: The evolution of policy frames on gender and migration in the Netherlands, 1995-2005. *Social Policy & Administration*, 41(3), 271-288.
- Stone, D. (1989). Causal stories and the formation of policy agendas. *Political Science Quarterly*, 104(2), 281-300.
- Tatarsky, A. (2002). Introduction. In A. E. Tatarsky (Ed.), *Harm reduction psychotherapy: A new treatment for drug and alcohol problems* (pp. 1-15). Northvale, NJ: Jason Aronson Inc.
- Wallace, J. (1999). The twelve-step recovery approach. In P. Ott, R. Tarter & R. E. Ammerman (Eds.), *Sourcebook on substance abuse: Etiology, epidemiology, assessment, and treatment* (pp. 293-302). Boston, MA: Allyn & Bacon.