Psychology of Addictive Behaviors
2013, Vol. 27, No. 4, 1102–1109

0893-164X/13/$12.00 DOI: 10.1037/a0030563

Acceptance of Non-Abstinence Goals by Addiction Professionals in the United States

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Previous research has found relatively limited acceptance of nonabstinence goals in addiction treatment settings in the United States. Because such attitudes may have changed over time, this study was designed to assess the current acceptance of nonabstinence goals by addiction professionals as a function of type of substance (alcohol vs. drug), severity of the disorder (*DSM–IV* abuse vs. *DSM–IV* dependence), and finality of the outcome goal (intermediate vs. final). The sample comprised 913 members of a national association of addiction professionals who completed a web-based survey. Over one half of respondents rated nonabstinence as somewhat or completely acceptable as both an intermediate and final outcome goal for clients with alcohol abuse, but considerably smaller proportions rated nonabstinence an acceptable intermediate or final outcome goal for clients with alcohol dependence. Regarding drug-taking clients, one half and one third of respondents rated nonabstinence at least somewhat acceptable as an intermediate goal and final outcome goal, respectively, for clients with drug abuse, but fewer rated nonabstinence an acceptable outcome goal for clients with drug dependence. One implication of the findings is that individuals with alcohol and drug problems who avoid treatment because they are ambivalent about abstinence should know that—depending on the severity of their condition, the finality of their nonabstinence goal, and their drug of choice—their interest in moderating their consumption will be acceptable to many clinicians, especially those working in outpatient and independent practice settings.

Keywords: harm reduction, nonabstinence, controlled drinking, controlled drug use

Substance use disorders (SUDs) are a major cause of morbidity and mortality to both those who abuse or are dependent on psychoactive substances, and to the larger nonabusing and nondependent community who experience direct and indirect biomedical (e.g., injury, transmission of blood-borne diseases) and psychosocial harms (e.g., acquisitive crime, family breakdown) as a result of others' substance use (Nutt, King, & Phillips, 2010). The risk to public health from substance use and abuse has been addressed using a combination of methods (MacCoun, 1998; Marlatt, Larimer, & Witkiewitz, 2012), including supply reduction (e.g., drug interdiction, prescription controls, age limits), demand reduction (e.g., education, psychotherapy), and harm reduction (e.g., needle exchange, drug replacement therapy). One intervention that serves as a means of both demand reduction and harm reduction is assisting clients with substance abuse or dependence to moderate or control their consumption of alcohol and drugs.

Definitions of moderate or controlled consumption—also referred to as nonabstinence—typically include two components: a) reduced quantity and/or less frequent consumption compared to one's typical problematic level of use, and b) the experience of few, if any, substance-related legal, medical, occupational, social, and familial problems (Rosenberg, 1993). Investigations of both natural recovery and treatment outcome studies have demonstrated that stable nonabstinent outcomes occur in a relatively small but meaningful subset of persons diagnosed with substance abuse and dependence (e.g., Maisto, Clifford, Stout, & Davis, 2007; Sobell, Ellingstad, & Sobell, 2000). What is perhaps especially discouraging is that many severely dependent clients experience multiple episodes of attrition or relapse, with only a subset maintaining long-term, continuous periods of either abstinence or controlled consumption (Cunningham & McCambridge, 2012; Hunt, Barnett & Branch, 1971; Kirshenbaum, Olsen, & Bickel, 2007).

Whatever its prevalence and stability, controlled or moderate consumption by recreational, abusive, and dependent drinkers and drug takers has several health benefits. For example, reduced consumption may arrest an escalating pattern of drinking or drug taking that could result in negative consequences later in life (Ambrogne, 2002). In addition, supporting clients to pursue controlled or moderate substance use might increase the appeal of treatment for many potential clients with SUDs. Openness to discussion of nonabstinence goals may attract and retain substance misusing or addicted individuals who are ambivalent about the prospect of lifelong abstinence, and who would otherwise not seek or participate in therapy (Heather, 2006). Furthermore, nonabstinence is an attractive and healthier intermediate goal for people who might decide to abstain after successfully (or unsuccessfully) attempting to moderate their consumption (Ambrogne, 2002).

This article was published Online First October 22, 2012.

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We thank Blaise Morrison for his assistance coding open-ended questions, Nick Heather for his comments on a presubmission draft of the paper, and those members of NAADAC who undertook the survey.

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Despite the public health and therapeutic advantages of accepting and encouraging nonabstinence goals, research conducted in North America, Western Europe, and Australia has shown that the acceptance of nonabstinence goals by treatment providers varies depending on the country, selected characteristics of the client (e.g., severity of dependence), and type of treatment setting (e.g., outpatient vs. inpatient). For example, two studies conducted in the United States revealed that abstinence is the most frequently encouraged outcome goal for clients with substance abuse and dependence in American inpatient detoxification, rehabilitation, and halfway house programs; however, almost half of outpatient agencies reported that moderate consumption was appropriate, though for fewer than 25% of their clientele (Rosenberg & Davis, 1994; Rosenberg & Phillips, 2003). Assessments of Canadian alcohol treatment counselors and administrators found that about two fifths of treatment providers endorsed nonabstinence goals for at least some of their clientele, and again that acceptance varied by type of setting (Brochu, 1990; Rush & Ogborne, 1986; Rosenberg, Devine & Rothrock, 1996).

Nonabstinence goals are more frequently accepted by clinicians and agencies in several Western European countries and Australia. In the United Kingdom, repeated investigations conducted over the past three decades have reported acceptance of nonabstinence as a goal choice by about three-quarters of a diverse set of British addiction treatment programs (Robertson & Heather, 1982; Rosenberg, Melville, Levell, & Hodge, 1992; Rosenberg & Melville, 2005). A recent survey of Swiss alcohol service agencies (Klingemann & Rosenberg, 2009) found that large majorities (~90%) of respondents working in outpatient settings found nonabstinence goals acceptable for clients with alcohol abuse; however acceptance was considerably less frequent (~40%) among counselors working in inpatient settings with clients with alcohol dependence. Although now over 20 years old, a survey of Norwegian alcohol treatment centers found that 90% of respondents reported allowing outpatient clients to choose between abstinence and moderate drinking, and 59% allowing inpatient clients a choice of outcome goals (Duckert, 1989). Similarly, two studies of Australian alcohol treatment agencies found that large majorities of outpatient or mixed inpatient-outpatient services endorsed acceptance of nonabstinence goals, although nonabstinence was less often acceptable in residential services (Donovan & Heather, 1997; Dawe & Richmond, 1997).

This body of research provides a foundation for understanding the acceptance of nonabstinence goals in addiction treatment settings, but it has been 10 and 20 years, respectively, since the prior nationwide assessments of the acceptability of nonabstinence goals for drug takers (Rosenberg & Phillips, 2003) and for problem drinkers (Rosenberg & Davis, 1994) in the United States. Those findings may be stable, but several changes over the past decade could have influenced the acceptance of nonabstinence by American addiction professionals. These changes include increased education about the goals and interventions of harm reduction and growing recognition of the health benefits of reducing hazardous substance use (e.g., Marlatt et al., 2012; Ritter & Cameron, 2006; Sobell & Sobell, 2006).

In addition to questions about the stability of attitudes over time, the two previous nationwide assessments of the acceptability of nonabstinence goals in the United States surveyed clinical administrators of addiction treatment agencies (Rosenberg & Davis, 1994; Rosenberg & Phillips, 2003). Although the attitudes and practices of administrators are important influences on services provided by those they supervise, there may be differences between administrators who set and enforce policy, and clinicians who work more directly with clients and who may be more or less accepting of nonabstinence goals.

Therefore, to evaluate the current attitudes of a nationwide sample of professionals working in a wide range of clinical settings, we designed the present study to assess their acceptance of nonabstinence goals as a function of type of substance (alcohol vs. drugs), severity of the disorder (*DSM–IV* abuse vs. *DSM–IV* dependence), and finality of the outcome goal (nonabstinence as intermediate goal vs. as final outcome goal). We also asked respondents to report the proportion of their clientele for whom they allowed nonabstinence goals, and which of six listed reasons explained their rejection of nonabstinence (if relevant). We next asked them to rate the relative importance of various psychiatric, demographic, and social characteristics as considerations when judging a client's appropriateness for nonabstinence. To facilitate collection of data from a large, nationwide sample of practicing clinicians, we used a web-based survey—modeled after paper-based surveys used in previous research—that was e-mailed to every listed member of a national association of addiction professionals.

Method

Measure

We developed the survey for this study based on previously published questionnaires designed to assess the acceptability of nonabstinence goals by American and British administrators of addiction treatment programs (Rosenberg & Melville, 2005; Rosenberg & Phillips, 2003). The key items of the survey asked respondents to rate the acceptability (Completely acceptable, Somewhat acceptable, Somewhat unacceptable, Completely unacceptable) of nonabstinence goals (defined as "limited or moderate alcohol/drug use") for each of eight types of clients who varied by type of substance (alcohol or drug), severity of problem (based on *DSM–IV* abuse or *DSM–IV* dependence), and finality of outcome goal (intermediate goal on the way toward abstinence or final outcome goal).

After respondents provided their rating of acceptance for each type of client, they were asked to indicate the proportion (none, 1–25%, 26–50%, 51–75%, 76–100%) of each of the eight types of clients who they allowed to pursue nonabstinence as an outcome goal. Next, those who checked "none" were asked to select any one or more of six provided reasons why they did not allow that type of client to pursue nonabstinence (see Table 3 for a list of reasons and frequency counts). All respondents were then asked to rate the acceptability of nonabstinence goals (without reference to type of substance, severity of diagnosis, or finality of outcome goal) in five different clinical settings (Detoxification center, Residential rehabilitation program, Group-based Intensive Outpatient Program, DUI/DWI education program, Independent practice), and to rate the relative importance of 19 specific characteristics that might be considered when evaluating a client's suitability to pursue a nonabstinence goal (see Table 4 for list of characteristics). Finally, respondents answered a series of questions regarding their

work environment (e.g., type of agency, age of clientele), their professional background (e.g., years of experience, education, professional discipline) and personal characteristics (e.g., age, ethnicity, personal history of alcohol or drug problem). To evaluate the degree to which we were able to mask our own acceptance of nonabstinence goals, we also asked whether respondents perceived the survey as unbiased, as biased in favor of nonabstinence, or as biased against nonabstinence as an outcome goal.

Respondents

To obtain a nationwide sample of addiction professionals, we recruited members of the National Association of Alcoholism and Drug Addiction Counselors (NAADAC; *http://www.naadac.org*) to participate in this study. The membership of NAADAC comprises addiction and mental health professionals who work in a variety of public and private settings across the United States. Following approval of our application, a NAADAC administrator sent by e-mail the initial request for participation (and two follow-up requests approximately 1 week apart) to all NAADAC members with an e-mail address in September, 2011. The e-mail provided a brief explanation of the purpose of this study, the benefits of participating, and a hyperlink to click if one wished to participate. As an incentive, respondents were offered a summary of the results and informed that we would donate $2.00 for every completed survey to the American Cancer Society (up to a maximum of $150). The questionnaire, which was posted using SurveyGizmo (*http://www.surveygizmo.com*), is available to readers as a PDF at the following link: (*http://psych.bgsu.edu/Acceptability Survey.pdf*).

Once at the survey website, each participant was presented with the informed consent document approved by our institutional review board. After providing consent online, respondents saw all of the same survey questions presented in one of two orders to reduce the possible impact of survey fatigue on the findings. Those born in an odd-numbered month (January, March, May, etc.) were presented first with the questions regarding the acceptability of nonabstinence goals for clients with alcohol abuse and dependence, followed by questions about clients with drug abuse and dependence; those born in an even-numbered month (February, April, June, etc.) were presented first with the questions regarding the acceptability of nonabstinence goals for clients with drug abuse and dependence, followed by questions about clients with alcohol abuse and dependence.

Of 6,407 e-mails sent to members requesting their participation, 350 of them were returned as "undeliverable." Out of the remaining 6,057 possible contacts, 1,226 members (~20%) clicked the hyperlink to our questionnaire. Of these, 913 members (~15%) completed the key questions regarding acceptability of nonabstinence goals by substance, severity of diagnosis and finality of outcome goal and thus comprised the sample for analysis.

As examination of Table 1 reveals, we recruited a diverse sample in terms of age, gender, ethnicity, education, professional discipline, years of work experience, geographic region, and work environment. To evaluate the representativeness of our sample of respondents, we compared the sample to demographic information of the NAADAC membership provided by the organization. Evaluating those characteristics on which we could make comparison revealed that 86% of our sample was over 41 years of age, as were 95% of NAADAC members; 84% of our sample identified as Caucasian, as did 85% of NAADAC members; 60% of our sample was female, as were 55% of NAADAC members; and 71% of our sample had at least 10 years of professional experience working with clients with an SUD, as did 77% of NAADAC members.

Table 1
Background Characteristics of Sample

Characteristic	Mean (*SD*) or % endorsing each category
Years of experience with SUD clients	16.9 (10.1)
Years of experience with MH clients	15.0 (10.2)
Type of clients with whom respondent works	
Alcohol abusing/dependent	91%
Drug abusing/dependent	90
Dually diagnosed	89
Mental health without SUD	44
Respondent age	
Under 30	3%
31 to 40	11
41 to 50	19
51 to 60	40
Over 61	27
Respondent ethnicity	
Caucasian	84%
African American	7
Hispanic	3
Native American	3
Other	4
Personal history of SUD	
Yes	55%
No	40
Preferred not to answer	5
Geographical location of respondents	
South	39%
West	23
Midwest	25
Northeast	13
Theoretical orientation (could select more than one)	
Cognitive-behavioral	87%
12-step principles	76
Motivational enhancement	69
Humanistic	44
Family systems	43
Rational-emotive	38
Reality therapy	37
Psychodynamic	26
Type of work setting (could select more than one)	
Private practice	36%
Outpatient SUD agency	27
Inpatient/residential rehabilitation	21
Outpatient mental health agency	18
Halfway house	6
Proportion of caseload presenting with SUD	
None	1%
1 to 50%	19
50 to 100%	80
Educational achievement	
High school	2%
Associates degree	5
Bachelors degree	24
Masters degree	59
Doctoral degree	10

Note. Totals may not sum to 100% due to rounding and option to select more than one option of those provided. *N*s per characteristic vary due to missing data.

These comparisons suggest that our sample was representative of the entire NAADAC membership on these characteristics. When asked if they ever had an alcohol or drug problem, 55% of respondents reported they had, 40% reported they had not, and 5% preferred not to answer this question. Finally, we note that 5% of respondents perceived the survey as biased against nonabstinence goals, 27% perceived it as biased in favor of nonabstinence goals, and the majority—68%—perceived it as unbiased.

Results

Acceptance of Nonabstinence by Type of Drug, Severity of Problem, and Finality of Outcome Goal

We split the eight conditions by type of substance into two subsets to examine acceptance ratings for clients with alcohol problems separately from clients with drug problems. First, we conducted a oneway repeated measures ANOVA to test whether acceptance ratings of nonabstinence (which could range from −2 "Completely unacceptable" to +2 "Completely acceptable") varied across the four alcohol conditions [$M_{\text{alcohol abuse/intermediate goal}} = .05\ (1.6)$; $M_{\text{alcohol abuse/final goal}} = -.19\ (1.6)$; $M_{\text{alcohol dependence/intermediate goal}} = -.91\ (1.5)$; $M_{\text{alcohol dependence/final goal}} = -1.36\ (1.3)$]. The test statistic was significant, $F(3, 886) = 216.9$, $p < .001$, partial eta squared = .42, and post hoc tests revealed that every pair of means were also significantly different (all ps $< .001$). As examination of frequency counts for each level of acceptability indicates (see Table 2), at least one half of respondents were somewhat or completely accepting of clients with alcohol abuse selecting nonabstinence as an intermediate (58%) and final (51%) outcome goal. Nonabstinence was less acceptable for clients with alcohol dependence, with 28% reporting it as acceptable as an intermediate goal and 16% reporting it acceptable as a final goal for those with this diagnosis.

Second, we conducted a oneway repeated measures ANOVA to test whether acceptance ratings of nonabstinence varied across the four drug conditions [$M_{\text{drug abuse/intermediate goal}} = -.25\ (1.6)$; $M_{\text{drug abuse/final goal}} = -.80\ (1.5)$; $M_{\text{drug dependence/intermediate goal}} = -.94\ (1.5)$; $M_{\text{drug dependence/final goal}} = -1.38\ (1.2)$]. The test statistic was significant, $F(3, 878) = 154.1$, $p < .001$, partial eta squared = .35, and post hoc tests revealed that every pair of means were also significantly different (all ps $< .01$). As examination of frequency counts for each level of acceptability indicates (see Table 2), almost one half of respondents were somewhat or completely accepting of clients with drug abuse selecting nonabstinence as an intermediate goal (47%), but only one third (32%) viewed nonabstinence as acceptable for clients with drug abuse if it is their final outcome goal. Both of these proportions are lower than the comparable acceptance rates for clients with alcohol abuse, but the more notable difference is between the proportions accepting nonabstinence as a final outcome goal for clients with alcohol abuse (51%) compared to clients with drug abuse (32%). Notably smaller proportions were either somewhat or completely accepting of nonabstinence for clients with drug dependence whether it is their intermediate (27%) or their final goal (15%). These latter percentages are strikingly similar to the proportions of respondents rating nonabstinence goals acceptable as an intermediate or final goal for clients with alcohol dependence (28% and 16%, respectively).

Proportions of Clientele Allowed to Pursue and Reasons Why Nonabstinence Goals Are Not Allowable

Next, we asked respondents to indicate the proportion of each type of clientele that they allow to pursue nonabstinence goals. As Table 2 (lower half) reveals, there was some variation depending on type of substance, severity of diagnosis and finality of outcome goal. However, approximately one half and often two thirds or more of respondents reported they would not allow any of their clients to pursue nonabstinence, regardless of whether that was their intermediate or final outcome goal.

Examination of Table 3 reveals that three of the listed reasons why nonabstinence was not allowed (i.e., respondent does not work with that type of client; another agency nearby allows nonabstinence; allowing nonabstinence could lead to loss of funding or accreditation) were rarely cited by respondents. The remaining three items (i.e., allowing nonabstinence would send the wrong

Table 2
Proportions Endorsing Each Acceptability Option For Nonabstinence Goals by Severity and Finality of Outcome Goal for Each Type of Substance (Alcohol and Drugs)

	Alcohol abuse		Alcohol dependence		Drug abuse		Drug dependence	
	Intermediate (n = 908)	Final (n = 906)	Intermediate (n = 908)	Final (n = 907)	Intermediate (n = 909)	Final (n = 909)	Intermediate (n = 906)	Final (n = 907)
Acceptability rating								
Completely acceptable	20%	15%	10%	7%	14%	9%	9%	6%
Somewhat acceptable	38	36	18	9	33	23	18	9
Somewhat unacceptable	13	12	14	9	16	16	14	10
Completely unacceptable	29	36	57	74	36	52	58	74
Proportion for which allowed								
None	45%	51%	63%	79%	51%	64%	64%	79%
1 to 50%	34	33	26	15	34	27	25	15
51 to 100%	21	16	10	6	15	10	11	6

Note: Percentages are based on number of valid respondents (i.e., not including as part of total those few respondents who left the item blank or noted they preferred not to answer). Totals may not sum to 100% due to rounding.

Table 3
Proportions Endorsing Each Listed Reason for Nonacceptance of Nonabstinence Goals by Substance and by Finality of Goal

	Alc abuse		Alc dependence		Drug abuse		Drug dependence	
	Interm	Final	Interm	Final[b]	Interm	Final	Interm	Final
Reasons for not allowing this intervention[a]								
2. It would send the wrong message to clients	20%	24%	30%	40%	24%	31%	30%	37%
3. This option is not effective	23	30	43	59	30	40	42	54
5. This option is not consistent with my own or our agency philosophy	31	33	40	48	33	40	38	48
6. If I offered this option, my agency or I might lose funding or accreditation	5	5	6	5	6	6	6	7
1. Because I don't work with these clients	1	2	2	1	1	1	1	1
4. Another agency or program nearby already offers this option	1	1	1	2	1	1	1	2

Note. Totals may not sum to 100% due to rounding and options to select more than one reason of those provided, to leave item blank, or select "other." [a] The numbers of the items indicate the order in which they appeared in the questionnaire. [b] Due to a programming error, approximately one half of participants were not asked the reasons why they did not allow clients with Alcohol Dependence to pursue nonabstinence as a Final outcome goal; proportions are based on remaining respondents ($n = 460$).

message; nonabstinence is not effective; allowing nonabstinence is not consistent with treatment philosophy) were endorsed by at least one fifth and sometimes as many as one half of respondents as reasons for not allowing their clients to pursue nonabstinence, with frequency of endorsement varying by type of drug, severity and finality of goal. Respondents were also given the option to enter their own reasons why they would not allow their clients to pursue nonabstinence. Commonly noted "other" reasons included clients having a medical condition or another psychiatric condition; respondent working in a setting in which nonabstinence would be patently unallowable (e.g., jail, prison, residential treatment); and illegality of illicit drug use of any kind or of underage drinking by adolescents.

Acceptance of Nonabstinence as a Function of Setting

We also wanted to evaluate whether addiction professionals' overall acceptance of nonabstinence goals varied as a function of the setting in which services are offered. To assess this attitude, we asked them to rate, regardless of its acceptability in their own agency or independent practice, how acceptable or unacceptable nonabstinence goals should be in each of five listed settings. Perhaps because clinical setting serves as a proxy for severity of dependence, and independent practice provides more flexibility to consider nonabstinence goals, notably larger proportions of respondents rated nonabstinence as completely unacceptable for clients in inpatient settings such as residential rehabilitation programs (74%) and detoxification programs (68%) than for clients in outpatient settings such as intensive outpatient programs (57%), DUI/DWI education programs (45%), and independent practice (28%).

Relative Importance Ratings of Client Characteristics in Evaluation of Acceptability

We also assessed the relative importance of a set of 19 listed client characteristics that respondents might use to decide whether nonabstinence goals are appropriate for their clients. Examination of Table 4 reveals that having few medical/health problems, number of previous treatment episodes, having a comorbid psychiatric disorder, being under age 18, emotional stability, polydrug use, having children, and drug of choice were rated as very important by at least one half, and often more, of the respondents. Participants rated all of the remaining characteristics—except for gender, which was often rated as being of little or no importance—as being at least moderately important in the consideration of a client's appropriateness to pursue nonabstinence.

We also provided respondents the option to write in other characteristics that they considered important when evaluating a client's suitability for nonabstinence. A little over half wrote in one or more characteristics, many of which were redundant with the 19 listed. Our examination of the remaining characteristics revealed five themes: (a) therapy-related considerations (e.g., motivation for change, level of insight, therapeutic alliance, source of referral, number of previous treatments); (b) substance-related history (e.g., history of overdose, level of craving, length of sobriety, previous history of nonabstinence/moderation, route of administration, motivation for drug taking); (c) psychological characteristics (e.g., impulsivity/self-control, maturity/judgment, spiritual beliefs); (d) social and family support (e.g., involvement in support groups, family history of SUD, family dynamics/codependency); or (e) assorted personal or occupational characteristics (e.g., pregnancy, race/culture/ethnicity, drug testing at work). The extensiveness of this list of other noted characteristics highlights the wide variety of qualities addiction professionals say they consider when evaluating the appropriateness of nonabstinence goals.

Association of Acceptance With Selected Respondent Characteristics

We also wanted to evaluate whether acceptance of nonabstinence outcome goals for each of the eight types of clients was associated with three specific respondent characteristics: personal history of having an alcohol or drug problem, level of education, and years of professional experience treating clients with SUDs. Because we calculated 24 coefficients (eight conditions $\times$ three respondent characteristics), we adjusted the alpha for significance using the Bonferroni correction method ($.05/24 = .002$). Only one of the eight coefficients assessing the association of one's own history of having an alcohol or drug problem (no, yes) with acceptance levels was statistically significant. Specifically, acceptance ratings of nonabstinence as an intermediate goal for alcohol

Table 4
Participants' Ratings of the Relative Importance of Specific Client Characteristics When Deciding Whether Nonabstinence Goals Are Appropriate

	Very important	Moderately important	Of no or little importance
Client characteristic			
Having few medical/health problems	86%	8%	7%
Number of previous treatment episodes	70	21	9
Having a nonalcohol/drug psychiatric disorder	68	25	8
Being under age 18	67	19	15
Being emotionally stable	65	24	11
Using multiple substances	63	26	11
Having children	53	29	18
Drug of choice	51	30	19
Having family support	48	36	17
Having a criminal history	40	40	20
Being homeless	40	37	24
Being older than 60	39	38	24
Having a large social network	36	42	22
Being between 18 and 30	32	44	24
Being employed	30	42	29
Being between 30 and 60	25	46	29
Being in a relationship	24	46	30
Being female	22	32	46
Being male	20	33	47

Note. Percentages are based on number of valid respondents (i.e., not including as part of total those few respondents who left the item blank). *N*s per item range from 848 to 858. Row totals may not sum to 100% due to rounding.

abusing clients was negatively correlated with the respondent having a history of an alcohol or drug problem, Spearman's $r(df = 841) = -.13$, $p < .001$; however, the coefficient was so small that having such a personal history accounted for no meaningful variance in one's acceptability ratings. Second, none of the Spearman coefficients assessing the association of education level (high school, associates degree, bachelor's degree, master's degree, doctorate) with acceptance levels met the adjusted alpha level (*r*s ranged from .00 to −.08). Third, none of the eight Pearson coefficients assessing the association of years of professional experience with acceptance levels met the adjusted alpha level (*r*s ranged between .00 to .06). In short, little or no variance in acceptance ratings across the eight different client types could be predicted by these three participant characteristics.

Discussion

We recruited a nationwide sample of 913 American addiction professionals to complete a web-based questionnaire assessing their views of nonabstinence goals for eight types of clients who varied by type of substance (alcohol vs. drug), severity of diagnosis (*DSM–IV* abuse vs. *DSM–IV* dependence), and finality of outcome goal (intermediate vs. final). Approximately one half of respondents were completely accepting of clients with alcohol and drug abuse selecting nonabstinence as an intermediate goal and approximately one half were also completely accepting of clients with alcohol abuse selecting nonabstinence as a final outcome goal. However, only one third viewed nonabstinence as acceptable for clients with drug abuse if it is their final outcome goal. Notably smaller proportions were accepting of nonabstinence as either an intermediate or final outcome goal for clients with either alcohol or drug dependence.

At least two thirds and as many as three quarters of respondents reported they would not allow any of their clients with alcohol or drug dependence to pursue nonabstinence, regardless of whether that was their intermediate or final outcome goal. The three more frequently endorsed reasons for not allowing this goal were that allowing nonabstinence would send the wrong message, that nonabstinence is not effective, and that allowing nonabstinence is not consistent with the respondent's treatment philosophy. We used the word *allow* in these latter questions because some addiction professionals are often unable or unwilling to work with clients who want to moderate their drinking or drug taking. However, we recognize that many clients may choose nonabstinence as an intermediate or final outcome goal even if their clinician does not "allow" it. It might have been more accurate or appropriate for us to have asked clinicians the proportion of their clientele for whom they would "support" a decision to pursue nonabstinence.

One aim of this study concerned the stability of American addiction professionals' attitudes regarding nonabstinence over the past two decades. Differences in the samples, variations in the method of recruiting participants, and changes in phrasing of the key questions and response options complicate the comparison across studies; however, it appears that acceptance of controlled drinking has increased over the past 20 years. For example, one half of the present sample rated nonabstinence as acceptable for clients with alcohol abuse (whether as an intermediate or final goal), which is twice the proportion of administrators of outpatient agencies who rated controlled drinking as acceptable 20 years ago (Rosenberg & Davis, 1994). In addition, the earlier study found that those working in residential settings, presumably with more severely dependent clients, almost never rated nonabstinence as an acceptable outcome goal for their clientele. This is notably differ-

ent from the proportions of the present sample who rated nonabstinence as acceptable for clients with alcohol dependence, especially as an intermediate goal on the way to abstinence. The apparent increase in acceptability could be the outcome of several factors, including reduced dominance of the 12-step, abstinence-only approach, increased acceptance of nonabstinence as a form of harm reduction, and surveying clinicians rather than agency administrators.

With regard to acceptability of nonabstinence goals by drug takers, comparison of the present findings with those published 10 years ago (Rosenberg & Phillips, 2003) is more straightforward because the key questions were phrased similarly. Specifically, both the current and previous investigations assessed acceptability as a function of diagnostic severity and finality of outcome goal. The results are strikingly similar with approximately 50% of both samples reporting nonabstinence as an acceptable intermediate goal for clients with drug abuse, and only 15% of both samples rating nonabstinence acceptable as a final outcome goal for those with drug dependence.

Although respondents' acceptance of controlled drinking has increased over the past 20 years, and acceptance of controlled drug taking has remained stable over the past decade, nonabstinence as an outcome goal appears less acceptable in the United States than in several other countries. For example, in a nationwide survey of British alcohol and drug treatment agencies, Rosenberg and Melville (2005) found nonabstinence frequently acceptable as an intermediate goal (86%) and a final goal (81%) for clients with alcohol abuse, although somewhat less acceptable as an intermediate goal (68%) and a final goal (50%) for clients with alcohol dependence. Nonabstinence for drug takers also was more acceptable in the United Kingdom than it is in the United States, with at least 50% and as many as 80% of British treatment services rating nonabstinence as acceptable depending on whether the patient was described as abusing versus dependent on drugs and whether nonabstinence was their intermediate or final outcome goal (Rosenberg & Melville, 2005). Similarly, a survey of Swiss alcohol treatment agencies (Klingemann & Rosenberg, 2009) found that respondents rated nonabstinence as more acceptable for clients with both alcohol abuse and dependence than did our sample of American addiction professionals. However, similarly to American respondents, nonabstinence was more often rated an acceptable goal by Swiss counselors who worked in outpatient compared to those who worked in inpatient settings. Factors that may have influenced such differences include a history of more extensive and influential temperance and prohibition movements in the United States, and more people with a history of SUDs serving as counselors and/or developing policies in American treatment agencies.

There are several methodological limitations that may restrict the generalizability of the present study. First, even though our sample comprised a demographically and geographically diverse group of individuals, we recruited respondents from only one professional organization of addiction professionals, and NAADAC members may be more or less accepting of nonabstinence than those not belonging to this organization. In addition, to the degree that those who reject nonabstinence declined to participate, our findings would inflate the apparent acceptance of such goals. Furthermore, our sample was comprised mostly of older professionals with an average of 17 years of experience, and younger professionals exposed to more education about harm reduction may be more accepting of nonabstinence goals than their older colleagues. Even though acceptance ratings were not correlated with either education or years of professional experience, the truncated ranges on the latter two variables may have attenuated the correlation.

Second, there are several disadvantages to using web-based data collection. For example, participants might have taken the survey on a shared computer or in a shared office where they felt unable to report their genuine attitudes or where distractions could have influenced their responses. Additionally, some potential respondents may have decided not to participate in a web-based survey because of concerns regarding confidentiality, identity theft, and unfamiliarity with this method of data collection. This may account, in part, for the relatively low proportion of usable responses (15% of 6,057 apparently possible respondents). Nonetheless, these 913 respondents came from across the United States and were similar to the full NAADAC membership on those demographic characteristics on which we could compare the sample to the population. Furthermore, a recent meta-analysis (Hamilton, 2009) of studies of response rates to e-mail invitations to participate in web-based surveys revealed that the average response rate was only 13.35%, perhaps as a result of the large number of e-mails that people receive (Shannon & Bradshaw, 2002). These disadvantages are counterbalanced by several advantages of having individuals participate in a study on the Internet. For example, web-based surveys are less time consuming for the respondent. In addition, some respondents may perceive responding on the Internet as private and anonymous, thereby increasing the likelihood they report genuine beliefs or attitudes, even if they think their views differ from others in their profession.

Another limitation is that we asked respondents to rate the acceptability of nonabstinence from drugs per se, and acceptance of nonabstinence could vary as a function of specific type of drug. For example, 80% of our sample rated "drug of choice" as moderately or very important in judging the appropriateness of nonabstinence, and addiction professionals may be more accepting of moderate or controlled use of marijuana than of cocaine, methamphetamine, or heroin. We recommend that future research be designed to address this question.

These limitations notwithstanding, we believe these findings have implications for problem drinkers and drug takers who seek services from American addiction professionals. Specifically, individuals with alcohol and drug problems who avoid treatment because they are ambivalent about abstinence should know that—depending on the severity of their condition, the finality of their nonabstinence goal, and their drug of choice—their interest in moderating their consumption will be acceptable to many addiction professionals working in outpatient and independent practice settings. Therefore, clients may want to assess a clinician's or an agency's openness to nonabstinence outcome goals, and agencies may want to acknowledge their policy regarding negotiation of outcome goals as part of informed consent.

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Received March 29, 2012
Revision received July 10, 2012
Accepted September 15, 2012 ■