

**Revisiting William White: Can Recovering People Drink?
A Historical Footnote with Current World Relevance – William Stauffer**

“So what does one take from this interesting historical footnote? History promises us important lessons if we sit at her feet and listen carefully to her stories.” – William White, Can Recovering People Drink?

I recently ran across a 2007 Paper by William White, [Can Recovering People Drink? A Historical Footnote](#). He documents facets of our history that are important to understand in the context of our own era now. The paper explores historical policies and evolving attitudes on whether individuals recovering from drug addiction should abstain completely from alcohol or may responsibly consume it. Few people in our space are aware of how treatment associated with drug addiction other than alcohol was often segregated from that of alcohol in the era from the 1950s to the early 1980s. That division created differences in how alcohol and other drugs were perceived of in some circles. It led to a belief that alcohol was in some way different in respect to addictive properties. The paper also explores the evolution in how alcohol use was considered in respect to both staff and clients using alcohol while abstaining from other drugs.



It is a relevant issue in our current era for a myriad of reasons. We understand more fully now that addiction is on a continuum and not all people are the same in respect to their risk and protective factors, not only for alcoholism but for all addictive substances. For newer people in the space, papers like this one make clear that those in the trenches and on the front lines of the field decades ago also understood these risk and protective factors from a direct practice perspective.

We still grapple with these very same conundrums now. As this [Washington Post article notes](#), we have “California recovery” in which one abstains from everything other than cannabis. There is “Northern California sober” (mushrooms only), “Bushwick sober” (ketamine only) and “Florida sober” (meth only) and “Jelly Roll sober” in which one abstains from hard drugs and uses cannabis and alcohol. Yet as White’s article suggests, the practice experience from generations ago shows that sometimes, people pursuing these paths can experience tragic consequences. This is an opportunity for our historical experience to inform current generation’s practices.

We can learn a great deal from the experiences of our field. In the 2007 paper, White documents the evolution of Therapeutic Communities (TCs), established in the 1950s to address addiction to drugs, including heroin. In certain TCs, particularly those working primarily with people using heroin, those who demonstrated progress were granted supervised “drinking privileges” in later treatment stages. Some were successful in doing so over the long term, but many others fell back into full addiction. At times this occurred rapidly, in other instances it took a long time, often dependent on their historical use of alcohol or other similarly classed sedative like drugs. Across our history, including in this chapter, when [field leaders end up getting into trouble](#) with their use, it can lead to tragedy in their own lives and significant harm to our collective efforts.

Decades ago, what they did was apply practice-based evidence, which as described in the paper was experimental in respect to differing interventional strategies and adopting ones that they could see were beneficial and abandoning or revising strategies that they determined did not work. They used what they learned to improve their understanding of who faced the greatest risk of death or other consequence from attempts to moderate alcohol use.

One of the things that the paper opens a window into is how an abstinence only orientation in TCs shifted over time to allowing alcohol privileges of a drink or two. People he interviewed recounted instances in which light alcohol use devolved into heavy drinking escapades and how more commonly staff and clients fell back into

destructive addiction with all the same dynamics of a dysfunctional system in which open discussion on what was unfolding became quite difficult. Do we see parallels in our own times that are similar to this?

We can also see in parallel chapters of alcohol and other addiction recovery and treatment efforts influenced and supported each other. In the book, [My Years with Narcotics Anonymous](#), Bob Stone writes about Dick Flanagan, who as a recovering alcoholic in Philadelphia in 1965 did a 12 step call with a young man using heroin and how this encounter led to the proliferation of Narcotics Anonymous on the eastern Seaboard and influenced how addiction to alcohol and narcotics were treated together at White Deer Run in Allenwood Pennsylvania. Flanagan was the first director of treatment in the program when it began operations in 1970. A professional who worked with him at that time recalled that when she went to work for him in 1971, he warned her that treating alcohol addiction and other drug addiction together was considered a bit of a radical approach at the time (D. Beck, personal communication, June 24, 2025).

While much of White's paper discussed here focuses on TCs, this window into non-TC program development in the same era provides a hint at how mutual aid support and treatment programs were attempting to address alcohol and other drug use to determine what was effective. All of these efforts are part of our rich history and body of knowledge that can inform us what we do moving forward, if only we take the time to understand and apply what we learn accordingly.

In 2007, White interviewed key leaders in the Therapeutic Community movement, including Michael Darcy, then President / CEO of Gateway Foundation, Inc.; David Deitch, then Chief Clinical Director, Phoenix House Foundation; Charles Devlin former Sr. Vice President of Treatment Services, Daytop; Michael Harle, then President and Executive Director of Gaudenzia, Inc.; and John Ruocco Founder of Gaudenzia and former Director of Programming, Phoenix House. As White wrote about, over time they identified risk factors for people in treatment that made it less likely that some staff and clients would be able to moderate their alcohol use. For me, it is one of the most interesting sections of the paper.

Directly from White's paper, the risk factors that they identified decades ago through trial and observation that suggest that a person was a poor candidate for experimenting with moderation if they had:

1. a family history of alcohol problems,
2. a history of alcohol problems predating the emergence of another pattern of drug dependence,
3. co-addiction to alcohol and other drugs prior to entry into treatment,
4. the presence of a co-occurring psychiatric illness,
5. a history of childhood victimization,
6. later developmental trauma (e.g., loss via death or separation),
7. enmeshment in a heavy drinking social network.

Questions to consider:

- In looking back now with over several more decades of progress in understanding substance use conditions and their resolution, how do these seven considerations stand the test of time?
- Would we add to, delete or articulate any of these risk factors differently?
- In respect to groups promoting alternative pathways of substance use resolution that include moderated use of addictive drugs, are they also articulating risks to educate people for whom full abstinence may be required? If not, what are the ethical and real-world consequences of not doing so?
- Are we seeing loss of life and other consequences for some who pursue pathways of resolution in respect to ongoing alcohol or other drug use within our SUD workforce and those we serve?
- What responsibilities do we have to increase our understanding in respect to these risks and to reduce them?

One of the things that is most evident in respect to White's paper here is that it clearly shows a way of knowing that comes from lived practice experience. What he knew is that most of what we understand about

addiction treatment and recovery in America comes from practice-based evidence. He documented those lessons on drinking in recovery in the 2007 piece. We tend to overvalue what we consider academic evidence based and discount how people on the front lines of this work apply trial and error strategies to real world conditions and learn through observation. It is one of the key takeaways from a paper he wrote last year [Frontiers of Recovery Research](#). To effectively move forward, we must not continue to discount lived experience in the way we continue to do. We must embrace all pathways and processes of understanding.

Right now, in this chapter of history, we see treatment and recovery organization leaders getting into trouble with their substance use in ways that are thinly veiled, broadly whispered about and well known across the whole field even as we do not openly discuss them. We have seen program staff die of overdoses, get arrested for multiple DUIs and countless other scandals and tragedies. We tell the people we serve that they are only as sick as their secrets, and this is also true for us as well. While some in our own era may be able to use in moderation, we lack frameworks of considering this in ways we ethically require. We can't change something we cannot talk about. We are one group who should well know that truth.

We can learn from our past, if we decide to. How can we apply what these leaders of our field a generation ago knew in ways that it could benefit us now? We should insist that any discussion on pathways of resolving an addiction to one or more substances should consider what we have learned in respect to risk factors. Caution should be our stance in considering the following of pathways that attempt to moderate the use of some substances while abstaining from others because the consequence of an error here can mean death. We should focus effort on learning what is occurring in real world circumstances and then formally research these lessons to expand our knowledge base even further. Anything less is unethical and unacceptable.

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Source

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