RTIA Recovery Training Institute of Alberta

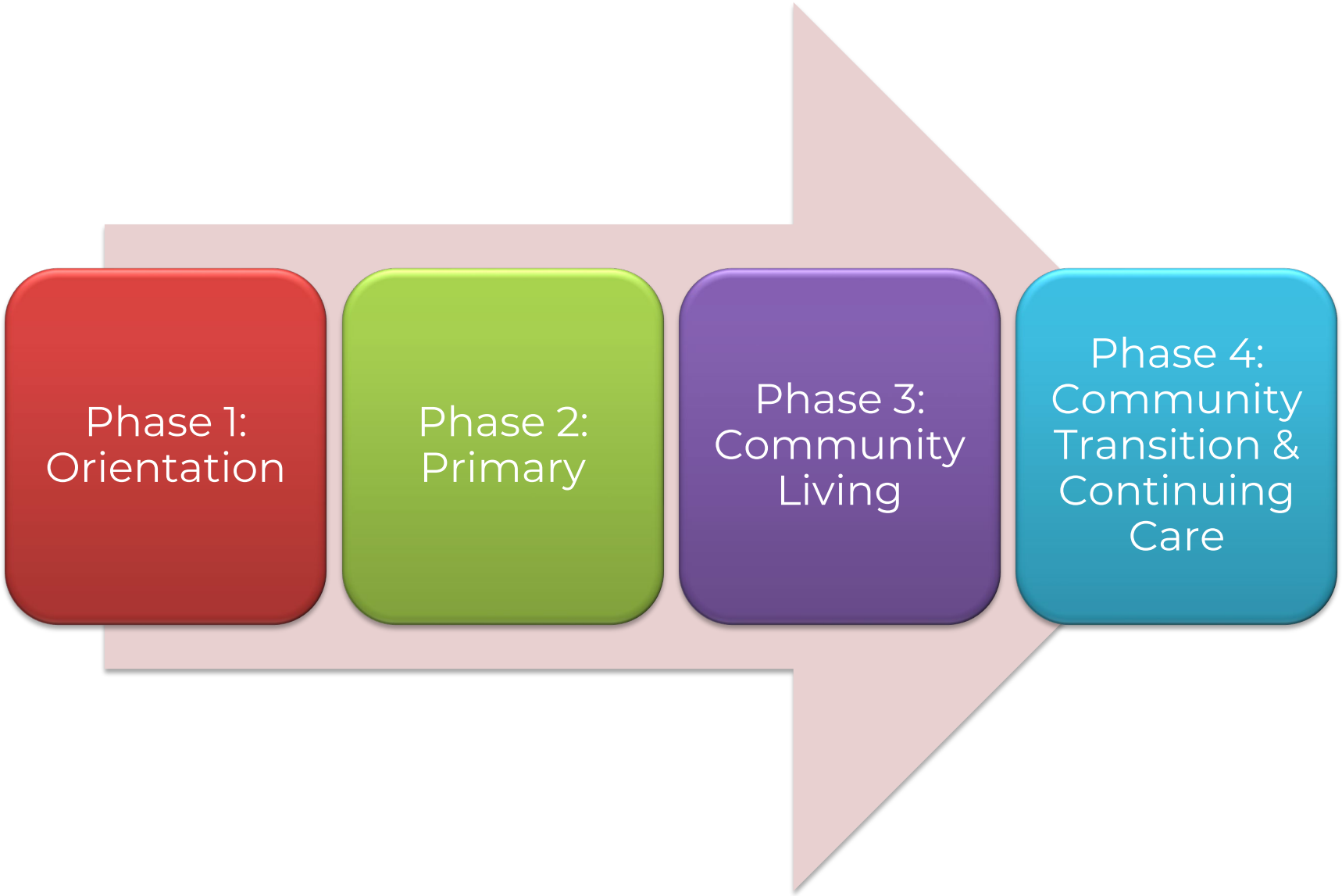
RTIA WEBINAR SERIES

The Recovery Community Pathway

Agenda

- The Four Stages of Care
- Core Phase Outcomes
- Critical decision points
- Integrated support

The Four Phases of Care



Phase 1: Orientation Outcomes

- **Have stabilized physically**
- Begins to stabilize emotionally and cognitively

- **Demonstrate adherence to Therapeutic Community structure**
- Begin to discuss their involvement with addiction

- **Begins to feel a part of the TC community, building trust in the process**
- Understands the TC model

- **Make ownership statements of addiction as a disorder**
- Beings to communicate on a feeling level

- **Begins to demonstrate increased emotional regulation**
- Demonstrate an ability to follow day-to-day structure

Phase 2: Primary Treatment Outcomes

- **Developing the ability to communicate on a feeling level**
- Demonstrate greater awareness of how addiction has affected their own life and relationships with others

- **Begin to demonstrate increased motivation for recovery**
- Identify relapse behavior and demonstrate appropriate alternative behaviors

- **Awareness of distorted beliefs and new beliefs begin to form**
- Be willing to ask for help in completing daily and weekly goals

- **Attend all recovery meetings**
- Begin to identify goals for post treatment

- **Demonstrate a willingness to become involved with others on a feeling level**
- Show genuine behavioral changes as a result of gaining insight into their addictive behavior and thought patterns

- **Demonstrate leadership with new residents & peers**

Phase 3: Community Living Outcomes

- **Participate in volunteering, employment, and education**
- Volunteer at the RC or in the wider community

- **Understands and demonstrates the TC concepts in their language and everyday behavior**
- Be able to identify relapse behavior and make appropriate changes
- Begin peer support training

- **Continue to regularly connect with alumni**
- Be aware of 12 Step/SMART in their home community – alumni, meetings and supports etc

- **Demonstrate success at work and leadership roles in the TC**
- Provide feedback to other residents regularly

- **Continue to discuss post treatment plans and any challenges that may arise**

Phase 4: Community Transition & Continuing Care Outcomes

- **Have recovery contacts in their home community or has developed alternative plan that supports recovery**
- Follow planners honestly and completely

- **Hold others accountable to their planners and recovery behaviors**
- Sponsor/Support new residents

- **Find employment and/or Education outside the TC**
- Be able to provide feedback to peers and staff regularly

- **Re-evaluate post treatment goals**
- Be leaders in the community

- **Complete their continuing care plan in consultation with staff**
- Be able to demonstrate awareness of the importance of following all aspects of the continuing care plan

Phase Progressions

LAKEVIEW
RECOVERY COMMUNITY

Phase 2 to Phase 3 Progression Package

Lakeview Recovery Community (LRC)

Name: _____

Date: _____

Introduction

The Community Building Phase (Phase 3) represents a deepening of your learning journey within LRC. This phase is about demonstrating integration, not through perfection, but through reflection, leadership, and connection. It marks your growing ability to live out the values of recovery, community, and right living in your daily actions and the initial steps towards transitioning from Lakeview to the next stages of your recovery journey.

This application is an opportunity to reflect on what you've learned, how you've changed, how you now contribute to the learning and healing of others, and begin to identify your next steps.

Section 1: Commitment and Understanding

Knowing and Applying the Lakeview Philosophy

1. How has your understanding of **Community-As-Method** grown since Phase 2? What does it mean to you to live within a learning community?

2. Describe a time when you used a community tool (e.g., push-ups, pull-ups, accountability, or mediation) to support your own or another's growth. What did you learn from that experience?

- **Progression Package:**
  - Completed by resident
  - Reflections provided by and co-signed by Senior residents and Staff
  - Focused on individual learning and progression
  - Evidence provided on learning on Key Outcomes
  - Describing how they have put learning into practice
  - Ensure all required assignments have been completed

Treatment Planning

Collaborative & Person-Centered Treatment Planning

- Develop treatment plans collaboratively between the resident and treatment team using shared decision-making, transparency, and informed consent.
- Initiate treatment planning as early as possible, ideally within the first 72 hours following medical and psychological assessments.
- Ensure treatment plans are individualized and strength based, reflecting the resident's culture, recovery goals, identity, learning style, values, and strengths.
- Ensure aligned with phase milestones
- **Review and update treatment plans regularly, at minimum:**
  - Once per phase
  - After therapeutic incidents or major changes
  - At resident request
  - When goals have been met or require adjustment

Notes:

- **Treatment and recovery planning is a living process that must evolve throughout program phases.**
- **The four-phase model provides structure; the resident's lived experience drives personalization.**
- **Phase transitions must be clinically justified, not solely behaviour-based or attendance-based.**
- **Cultural safety, trauma-informed practice, and Indigenous wellness pathways must be integrated at every phase.**

Treatment Plan Components

A safety plan including:

- Early exit strategy
- Crisis procedures
- Relapse/overdose prevention
- Elopement risk strategies

Phase / Program Progression

- Clear goals, clinical progression and intervention review for each phase, tied to phase-gate criteria and readiness indicators.
- Group and community participation.

Substance Use Recovery Strategies

- Recognition of substance use patterns, risks, and consequences.
- Strategies to modify behaviours, thinking patterns, and triggers.
- Harm reduction education where appropriate.

Life Skills & Functional Abilities

- Goals for daily living skills, self-care, time management, emotional regulation, and personal organization.

Family, Social & Community Supports

- Family engagement (with consent), social skill development, and strengthening of supportive networks.

Cultural & Spiritual Needs

- Access to ceremony, Elders, spiritual practices, land-based activities, and cultural identity integration.

Vocational & Educational Development

- Goals related to employment readiness, job skills, education upgrading, financial literacy, and long-term vocational planning. Work As Therapy roles.

Housing & Transition Planning

- Identification of housing needs and steps toward stable accommodation upon transition (Phase 4).

Legal & Child Welfare Considerations

- Strategies to address ongoing legal obligations or child welfare requirements.

Recreational & Physical Wellness

- Activities that promote physical health, structured recreation, identity-building, enjoyment, and pro-social engagement.

Mental and Physical Health Updates inc OAT / MAT (as required) and Risk Status

Any other personalized strengths, risks, or needs identified by the resident or staff.

Recovery Skill Development & Application

Teams work with residents to build a broad foundation of recovery-oriented skills that support long-term wellness and recovery capital development.

Communal & Social Skills

- Communal living and community participation
- Healthy communication
- Boundary setting
- Conflict resolution
- Building supportive relationships with staff and residents

Cognitive & Emotional Skills

- Problem-solving
- Emotional regulation
- Cognitive restructuring
- Identifying and managing triggers
- Understanding substance use patterns
- Strategies to reduce shame and build self-efficacy

Behavioural & Recovery Maintenance Skills

- Coping with cravings and high-risk situations
- Relapse prevention and early warning sign recognition
- Stress management skills
- Mind-body grounding, mindfulness, and somatic awareness
- Taking accountability for self and others

Cultural, Spiritual & Identity-Based Skills

- Incorporating cultural practices and ceremony
- Supporting cultural identity development and reconnection
- Indigenous land-based teachings (where appropriate)

Health, Wellness & Self-Care Skills

- Healthy nutrition and food planning
- Sleep hygiene and daily routine building
- Physical activity and recreation
- Harm reduction education
- Social activity with minimal isolation

Practical & Life Skills

- Time management and planning
- Household responsibilities
- Learning through rehearsal, role-play, and repetitive practice
- Developing self-advocacy skills
- Vocational skill training

Evidence-Based Modalities

- **Cognitive Behavioral Therapy (CBT)**
- **Contingency Management Principles**
- **Motivational Interviewing (MI)**
- **Trauma-Informed Care Models (e.g., Seeking Safety principles, psychoeducation)**
- **Relapse Prevention Theory & Practice**
- **DBT skills-based approaches**
- **Recovery-oriented group programming**
- **Culturally informed and Indigenous healing approaches, when appropriate and led by Elders/Knowledge Keepers**

Case Reviews

Notes:

- **Review of Progression and Treatment Plan alignment**
- **Discuss any relevant and potential issues / risks**
- **Discuss how to address any specific areas of concern and how best to support**

Interdisciplinary Case Review

Hold weekly interdisciplinary case conferences involving the core care team.

1. **Required attendees include:**
    - Clinical lead or clinical director
    - Recovery coaches
    - Behavioral Health Navigators (counsellors or therapists)
    - Support staff
    - Medical staff (or delegated nurse)
    - Cultural or spiritual support personnel (when relevant)
2. **Each case review must produce clear documentation and actionable next steps which are fed into the Treatment Plan.**