

The Recovery-Fluent Clinician

A 12-Month Knowledge Development Journey for SUD Clinical Supervisors
Timeline Mapping

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Part 1 · Getting started

The Recovery-Fluent Clinician

A 12-Month Knowledge Development Journey for SUD Clinical Supervisors

The Recovery Files · Embrace, Empower & Evolve

This timeline is a structured, private space for you to invest seriously in the knowledge that makes you a more effective guide for patients navigating recovery. Disease model. 12-step principles and traditions. Multiple pathways. Recovery capital. Clinical integration.

Your Role & Credentials

e.g., Clinical Supervisor, LCPC, CADC

Your Clinical Setting

e.g., Residential SUD, IOP, First Responder Program

Start Date for This Learning Plan

e.g., January 2025

Who Holds You Accountable? (optional)

e.g., Clinical mentor, peer supervisor

Part 2 · Phase I · Disease & Recovery Foundations

Phase I · Months 1-3

Disease & Recovery Foundations: The Knowledge Base Everything Else Rests On

"You cannot guide someone through territory you have never mapped yourself."

Clinical excellence in substance use disorder treatment begins with a deep, accurate, and current understanding of addiction as a disease — not a moral failure, not a choice, not a character defect. Many supervisors and clinicians working in SUD settings hold fragments of this knowledge: some disease model concepts, some recovery language, some 12-step familiarity. But fragments are not fluency. Phase I is about building — or rebuilding — a solid, integrated foundation in addiction science, the neurobiology of dependence, the nature of recovery as a process, the difference between abstinence and recovery, and the core clinical vocabulary that makes meaningful conversations with patients possible.

Overview

Phase Goals

1. Develop a thorough working knowledge of the disease model of addiction — neurobiological, psychological, and social dimensions
2. Understand the distinction between physical dependence, tolerance, and addiction as overlapping but distinct phenomena
3. Articulate the difference between abstinence and recovery — and why that distinction matters clinically
4. Learn the DSM-5 criteria for Substance Use Disorder across substance categories and severity specifiers
5. Understand the ASAM Criteria dimensions and how they shape level-of-care decisions
6. Build fluency in recovery-supportive language: what to say, what not to say, and why the words matter

Phase Focus — How to Approach This Period

Phase I is about building the foundation, not mastering everything at once. Choose one area per month — disease model, recovery framework, or clinical vocabulary — and go deep rather than wide. Read one book in this phase that challenges or expands your understanding (Father Martin's Chalk Talk, William White's Slaying the Dragon, or the ASAM Criteria manual are excellent starting points). Bring one learning from your reading into supervision with your staff each week. Teaching consolidates knowledge faster than any other method.

My Learning Commitment This Phase

Prompts Completed

Knowledge Score

Disease & Recovery Foundations

Current Phase

Overall Fluency

Reflection Prompts

These prompts are designed to surface what you actually know versus what you think you know.

1. Disease Model

How do you currently explain addiction as a disease to a patient who has been told their whole life that they 'just lack willpower'? Walk through your actual explanation — where does it feel strong and where does it feel uncertain?

The ability to translate the disease model into plain, compassionate, accurate language is one of the most important clinical skills in this field. Where are your gaps?

Record your reflection, honest assessment, or learning commitments here...

2. Disease Model

What do you know about the neuroscience of addiction — the role of dopamine, the prefrontal cortex, reward circuitry, and why the brain in active addiction makes decisions that defy logic? How does understanding this change how you sit with a patient who keeps relapsing?

When clinicians understand the brain science, their compassion becomes structural rather than merely personal. The patience is built into the knowledge.

Record your reflection, honest assessment, or learning commitments here...

3. Abstinence vs. Recovery

What is the difference between a patient who is abstinent and a patient who is in recovery? Can you describe what recovery looks like — behaviorally, relationally, and spiritually — beyond the absence of substance use?

Sobriety + Change = Recovery. Abstinence without change is a dry drunk. Clinicians who only measure sobriety miss the whole point of recovery.

Record your reflection, honest assessment, or learning commitments here...

4. Abstinence vs. Recovery

How do you talk about relapse with your patients and staff? Is it framed as failure, as part of the disease process, as data, or as something else? What clinical impact does your framing have on the patient's willingness to return to treatment?

How we talk about relapse determines whether patients come back or disappear in shame. The language is not neutral.

Record your reflection, honest assessment, or learning commitments here...

5. DSM-5 & ASAM Criteria

Without looking it up — walk through the 11 DSM-5 criteria for Substance Use Disorder. Which ones do you know cold? Which ones are fuzzy? How does your comfort with these criteria show up (or not show up) in your clinical documentation and supervision?

Clinical supervisors who cannot articulate diagnostic criteria with confidence leave staff without a clear foundation. Your fluency becomes their fluency.

Record your reflection, honest assessment, or learning commitments here...

6. DSM-5 & ASAM Criteria

How familiar are you with the six ASAM dimensions? How do you currently use them in level-of-care decisions — are they a genuine clinical framework or a documentation requirement? What would change if you used them more intentionally?

ASAM is not paperwork. It is a clinical thinking tool. When supervisors understand it deeply, it transforms how they guide staff assessments.

Record your reflection, honest assessment, or learning commitments here...

7. Recovery-Supportive Language

What language do you use — and hear your staff use — that might inadvertently stigmatize patients or undermine their recovery identity? What would you change about the vocabulary in your clinical environment if you could?

Words like 'addict,' 'dirty,' 'clean,' 'abuser,' and 'failing' carry clinical weight. Person-first, recovery-supportive language is not political correctness — it is evidence-based practice.

Record your reflection, honest assessment, or learning commitments here...

8. Knowledge Gap Mapping

After reflecting on this phase, what is the most significant gap in your foundational knowledge of addiction and recovery? What would filling that gap make possible in your clinical work and supervision?

A named gap is a learning plan waiting to be written. What is yours?

Record your reflection, honest assessment, or learning commitments here...

Knowledge Scoring

Knowledge Scoring — Disease & Recovery Foundations

Rate your genuine clinical fluency in each domain from 1 (minimal) to 10 (deep, integrated, and teachable). Be honest.

Ability to explain the disease model of addiction clearly and compassionately to patients

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Fluency in the neuroscience of addiction at a clinically applicable level

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Clear understanding of abstinence vs. recovery and the clinical implications

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Comfort with DSM-5 SUD criteria and ASAM Dimensions in clinical application

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Consistent use of person-first, recovery-supportive language in practice

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Phase Score

This is honest early-stage territory. Low scores here mean the learning ahead of you is significant and valuable — not shameful.

Action & Notes

Month-by-Month Learning Plan for Months 1-3

What will you read, attend, practice, or explore each month? Name the specific resource.

Month A — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Month B — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Month C — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Phase Completion Checklist

Completed honest knowledge self-assessment for this phase

Engaged with all 8 reflection prompts (minimum 4 with written responses)

Knowledge scoring assessment completed and reviewed

Personal learning commitment written and in active use

Month-by-month learning plan drafted with specific resources named

At least one primary source read this phase (book, manual, or foundational text)

At least one learning brought directly into supervision or team discussion

Transition reflection: what knowledge am I carrying into the next phase?

My Private Learning Notes

What is becoming clearer? What surprised you? Where are the gaps bigger than you expected?

Part 3 · Phase II · 12-Step Principles, Traditions & Vocabulary

Phase II · Months 4–6

12-Step Principles, Traditions & Vocabulary: Understanding the Most Widely Used Recovery Framework in the World

"You don't have to work a program to understand one well enough to walk alongside someone who does."

The 12-step model — originating with Alcoholics Anonymous and adapted across dozens of fellowships — remains the most widely accessed recovery support structure in the United States and globally. Despite this, many clinical professionals have only surface-level familiarity with the steps, the traditions, the literature, and the culture. Phase II is not about personally endorsing the 12-step approach or requiring it of patients. It is about developing genuine, nuanced, accurate knowledge of what it is, how it works, what it asks of people, what its limitations are, and how to integrate it intelligently into a comprehensive clinical picture.

Overview

Phase Goals

1. Learn each of the 12 Steps in sequence — their purpose, their spirit, and their clinical relevance
2. Understand the 12 Traditions and how they govern AA/NA group culture and function
3. Develop fluency in 12-step vocabulary: Big Book concepts, slogans, meeting culture, and sponsorship
4. Understand the spiritual (not necessarily religious) framework of 12-step recovery and what it means to patients
5. Know the major 12-step fellowships and their focus populations (AA, NA, CA, OA, GA, Al-Anon, ACoA, etc.)
6. Develop a nuanced, respectful, and evidence-informed perspective on the benefits and limitations of 12-step involvement

Phase Focus — How to Approach This Period

Phase II requires reading primary source material — not summaries or clinical overviews, but the actual literature. Read the first 164 pages of the Big Book of Alcoholics Anonymous. Read the 12 and 12 (Twelve Steps and Twelve Traditions). Attend at least two open AA or NA meetings this phase as a professional observer. Bring specific questions from patients into this exploration. Your job is to understand the lived experience, not just the framework.

My Learning Commitment This Phase

Prompts Completed

Knowledge Score

Current Phase

Overall Fluency

Reflection Prompts

These prompts are designed to surface what you actually know versus what you think you know.

1. The 12 Steps

Walk through each of the 12 Steps and describe, in clinical terms, what psychological and behavioral work each step is asking the patient to do. Which steps do you know deeply? Which ones have you glossed over?

Steps 1–3 address surrender and acceptance. Steps 4–9 are the action steps — inventory, honesty, amends. Steps 10–12 are maintenance and outreach. Each has direct clinical correlates in CBT, DBT, and motivational frameworks.

Record your reflection, honest assessment, or learning commitments here...

2. The 12 Steps

How do you currently incorporate step work into your clinical conversations with patients? Do you ask about where they are in the steps, what is coming up for them, where they are getting stuck? What would change if you could engage step work with genuine clinical depth?

Step work is not a separate track from clinical treatment — it is parallel psychological and spiritual work that informs and amplifies clinical treatment. Knowing the steps lets you integrate the two.

Record your reflection, honest assessment, or learning commitments here...

3. The 12 Traditions

How familiar are you with the 12 Traditions of AA/NA? Can you articulate what they govern and why they matter to patients who are deeply engaged in fellowship?

The Traditions govern the culture, the autonomy, the anonymity, and the unity of the fellowship. Patients who live inside that culture need clinicians who understand it.

Record your reflection, honest assessment, or learning commitments here...

4. 12-Step Vocabulary & Culture

How fluent are you in 12-step vocabulary — the Big Book, the phrases, the slogans, the concepts of sponsorship, home group, service, the 'rooms,' the 'fellowship,' 'working the steps,' 'burning desire,' 'picking up a chip'? Where do you feel lost in this language — and how does that show up with patients?

Patients who are actively working the program speak a specific language. When clinicians are unfamiliar with it, patients often sense the gap and filter what they share in treatment.

Record your reflection, honest assessment, or learning commitments here...

5. Spirituality in Recovery

The 12-step model asks patients to 'come to believe in a Power greater than themselves.' How do you navigate the spiritual dimension of 12-step recovery with patients who are atheist, agnostic, or spiritually wounded? What is your clinical framework for holding that tension?

The spiritual framework of 12-step is not a religious requirement — it is an invitation to something larger than ego-driven self-will. How you understand and communicate that distinction matters enormously to patients.

Record your reflection, honest assessment, or learning commitments here...

6. 12-Step Fellowships

How many 12-step fellowships can you name, and do you know the specific focus population of each? What do you know about Al-Anon and Adult Children of Alcoholics (ACoA) as distinct from the patient-facing fellowships?

AA, NA, CA, MA, OA, GA, SA, Al-Anon, Alateen, ACoA, CA, CMA — each serves a distinct population. Knowing which meeting to recommend for which patient is a clinical skill.

Record your reflection, honest assessment, or learning commitments here...

7. Clinical Limitations & Nuance

What are the documented limitations, criticisms, and contraindications of 12-step involvement for certain patient populations? How do you hold a respectful, evidence-informed perspective on 12-step involvement that neither dismisses it nor presents it as the only path?

12-step is not appropriate for every patient in every situation. Gender dynamics, trauma history, religious trauma, and co-occurring mental health conditions all require nuanced clinical thinking.

Record your reflection, honest assessment, or learning commitments here...

8. Knowledge Application

Have you ever attended an open AA or NA meeting as a professional observer? If yes — what did you learn? If no — what has prevented you from doing so, and what clinical benefit do you think it would provide?

There is no substitute for experiential knowledge. Reading about meetings is not the same as sitting in one.

Record your reflection, honest assessment, or learning commitments here...

Knowledge Scoring

Knowledge Scoring — 12-Step Principles, Traditions & Vocabulary

Rate your genuine clinical fluency in each domain from 1 (minimal) to 10 (deep, integrated, and teachable). Be honest.

Knowledge of all 12 Steps and their clinical and psychological purpose

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Familiarity with the 12 Traditions and what they mean to fellowship members

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Fluency in 12-step vocabulary, culture, and concepts at a patient-level depth

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Ability to hold the spiritual dimension of 12-step recovery with clinical nuance

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

—

Evidence-informed, respectful awareness of 12-step benefits and limitations

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Phase Score

This is honest early-stage territory. Low scores here mean the learning ahead of you is significant and valuable — not shameful.

Action & Notes

Month-by-Month Learning Plan for Months 4-6

What will you read, attend, practice, or explore each month? Name the specific resource.

Month A — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Month B — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Month C — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Phase Completion Checklist

Completed honest knowledge self-assessment for this phase

Engaged with all 8 reflection prompts (minimum 4 with written responses)

Knowledge scoring assessment completed and reviewed

Personal learning commitment written and in active use

Month-by-month learning plan drafted with specific resources named

At least one primary source read this phase (book, manual, or foundational text)

At least one learning brought directly into supervision or team discussion

Transition reflection: what knowledge am I carrying into the next phase?

My Private Learning Notes

What is becoming clearer? What surprised you? Where are the gaps bigger than you expected?

Part 4 · Phase III · Multiple Pathways to Recovery

Phase III · Months 7–9

Multiple Pathways to Recovery: No Single Road, No Single Destination

"Recovery is bigger than any one model. The clinician's job is to know all the roads."

One of the most significant evolutions in the recovery field over the past two decades has been the recognition that there is no single pathway to lasting recovery from substance use disorder. While 12-step remains the most widely available model, millions have found sustained recovery through SMART Recovery, Refuge Recovery, medication-assisted treatment, faith-based programs, natural recovery, peer support models, therapeutic communities, and more. Phase III is about developing genuine fluency across the full landscape of recovery pathways.

Overview

Phase Goals

1. Develop working knowledge of the major non-12-step mutual aid and recovery support models
2. Understand the evidence base for medication-assisted treatment (MAT/MOUD) and be able to discuss it without stigma
3. Learn the SMART Recovery model — its tools, its philosophy, and the populations it tends to serve well
4. Explore faith-based recovery pathways and how to hold spiritual diversity in a clinical setting
5. Understand natural recovery and what the research says about people who resolve SUD without formal treatment
6. Build a clinical framework for pathway-matching: how do you assess which recovery approach is the best fit for which patient?

Phase Focus — How to Approach This Period

Phase III is about breadth and humility — the recognition that no single model holds all the answers. Attend a SMART Recovery meeting (many are online). Read about Refuge Recovery, LifeRing, and peer recovery support. Challenge yourself to recommend a non-12-step pathway to at least one appropriate patient this phase. Examine any anti-MAT language in your team's culture and name it explicitly in supervision. Read William White's work on recovery capital.

My Learning Commitment This Phase

Prompts Completed

Knowledge Score

Multiple Pathways to Recovery

Current Phase

Overall Fluency

Reflection Prompts

These prompts are designed to surface what you actually know versus what you think you know.

1. Recovery Pathways Overview

Can you name at least eight distinct pathways to recovery from substance use disorder — formal, informal, mutual aid, clinical, faith-based, and medication-assisted? For each one, what population tends to benefit most?

A pathway is not just a treatment modality. It is a complete orientation toward recovery — a community, a philosophy, a set of practices, and an identity.

Record your reflection, honest assessment, or learning commitments here...

2. SMART Recovery

What is SMART Recovery, how does it differ philosophically and structurally from 12-step programs, and what types of patients tend to respond well to it?

SMART (Self-Management and Recovery Training) is secular, science-based, and cognitive-behavioral in orientation. It is an excellent fit for patients who resist the spiritual framework of 12-step.

Record your reflection, honest assessment, or learning commitments here...

3. Medication-Assisted Treatment

What is your genuine clinical perspective on Medication-Assisted Treatment — buprenorphine, methadone, naltrexone? What biases or assumptions are you aware of in yourself or your staff about MAT?

MAT stigma is rampant in SUD treatment — including among clinicians who should know better. MAT is evidence-based, life-saving, and a legitimate recovery pathway.

Record your reflection, honest assessment, or learning commitments here...

4. Medication-Assisted Treatment

How do you supervise staff conversations about MAT with patients who are using medication as part of their recovery? What clinical language do you model?

The 'MAT is not real sobriety' argument persists in pockets of the treatment world and has driven people away from life-saving medication. Supervisors set the tone.

Record your reflection, honest assessment, or learning commitments here...

5. Faith-Based Recovery

What do you know about faith-based recovery programs beyond AA — programs like Celebrate Recovery, Teen Challenge, or faith-community recovery support groups?

Faith is one of the most powerful sources of recovery capital for many patients. Clinicians who cannot engage respectfully with that dimension leave a significant portion of the patient's recovery unsupported.

Record your reflection, honest assessment, or learning commitments here...

6. Natural Recovery

Research suggests that a significant number of people resolve substance use disorders without formal treatment or mutual aid — what is called natural recovery. What does this research tell us about factors that support recovery independent of treatment?

Natural recovery is not an argument against treatment. It is evidence about the power of recovery capital — relationships, purpose, housing, employment, identity — that should inform every clinical plan.

Record your reflection, honest assessment, or learning commitments here...

7. Pathway Matching

Describe your clinical process for matching a patient to a recovery pathway. What assessment data do you use? What patient preferences do you elicit?

Pathway matching is a clinical art that sits at the intersection of assessment, motivational interviewing, and patient-centered care.

Record your reflection, honest assessment, or learning commitments here...

8. Recovery Capital

William White's recovery capital framework identifies personal, social, and community-level resources that support long-term recovery. How do you currently assess recovery capital with patients?

Recovery capital is arguably more predictive of long-term recovery outcomes than any treatment modality. Clinicians who assess it well can build on strengths rather than just addressing deficits.

Record your reflection, honest assessment, or learning commitments here...

Knowledge Scoring

Knowledge Scoring — Multiple Pathways to Recovery

Rate your genuine clinical fluency in each domain from 1 (minimal) to 10 (deep, integrated, and teachable). Be honest.

Fluency in at least six distinct recovery pathways beyond 12-step

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Ability to discuss MAT as a valid recovery pathway without stigmatizing language

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

—

Working knowledge of SMART Recovery philosophy and clinical fit

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

—

Capacity to hold faith-based recovery with clinical respect and engagement

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

—

Clinical framework for recovery capital assessment and pathway matching

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Phase Score

This is honest early-stage territory. Low scores here mean the learning ahead of you is significant and valuable — not shameful.

Action & Notes

Month-by-Month Learning Plan for Months 7-9

What will you read, attend, practice, or explore each month? Name the specific resource.

Month A — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Month B — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Month C — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Phase Completion Checklist

Completed honest knowledge self-assessment for this phase

Engaged with all 8 reflection prompts (minimum 4 with written responses)

Knowledge scoring assessment completed and reviewed

Personal learning commitment written and in active use

Month-by-month learning plan drafted with specific resources named

At least one primary source read this phase (book, manual, or foundational text)

At least one learning brought directly into supervision or team discussion

Transition reflection: what knowledge am I carrying into the next phase?

My Private Learning Notes

What is becoming clearer? What surprised you? Where are the gaps bigger than you expected?

Part 5 · Phase IV · Clinical Integration & Patient-Centered Application

Phase IV · Months 10-12

Clinical Integration & Patient-Centered Application: Knowledge That Lives in the Room With the Patient

"Knowledge becomes clinical wisdom only when it changes the way you sit with another human being."

Phases I through III have built the knowledge base. Phase IV is where that knowledge becomes clinical identity — a seamless, integrated fluency that lives in how you listen, how you ask questions, how you supervise, and how you help patients find their own way through the landscape of recovery. This final phase focuses on integration: bringing together disease model knowledge, 12-step literacy, pathway awareness, and recovery capital thinking into a coherent, patient-centered clinical approach.

Overview

Phase Goals

1. Demonstrate integrated use of foundational, 12-step, and multi-pathway knowledge in actual clinical conversations
2. Develop the capacity to teach and model recovery knowledge fluency for clinical staff
3. Create a team culture where diverse recovery literacy is a clinical standard, not a personal interest
4. Understand how co-occurring mental health disorders intersect with SUD and require integrated treatment knowledge
5. Build a personal continuing education plan for ongoing recovery knowledge development
6. Write a Recovery Knowledge Philosophy Statement: what you believe about recovery and how that commitment shapes your clinical work

Phase Focus — How to Approach This Period

Phase IV is about permanence and transmission. Your task is to ensure that the knowledge you have built does not stay inside you. Teach one formal learning session to your team this phase. Write the Recovery Knowledge Philosophy Statement — do not skip it. Create a continuing education plan with three specific commitments for the next year. The goal of this entire year of learning is to make you a better witness — someone who can sit with patients in the full complexity of their recovery journey because you have genuinely done the work to understand it.

My Learning Commitment This Phase

Prompts Completed

Knowledge Score

Current Phase

Overall Fluency

Reflection Prompts

These prompts are designed to surface what you actually know versus what you think you know.

1. Integration in the Room

Think about a recent clinical encounter where your deepened knowledge of addiction, recovery, or pathways changed how you showed up. What did you say or do differently? What was the impact?

Knowledge becomes clinical when it changes behavior. Can you identify specific moments where what you now know made a clinical difference?

Record your reflection, honest assessment, or learning commitments here...

2. Teaching Recovery Knowledge

How are you currently passing your recovery knowledge along to your clinical staff? What learning opportunities have you created — in supervision, in group consultation, in training?

A supervisor with deep recovery knowledge who keeps it to themselves is a missed opportunity for the whole team.

Record your reflection, honest assessment, or learning commitments here...

3. Co-Occurring Disorders

What do you know about the intersection of substance use disorder and co-occurring mental health conditions — depression, anxiety, trauma, PTSD, bipolar disorder, ADHD?

More than half of people with SUD have co-occurring mental health conditions. Clinicians who treat addiction in isolation miss the most important clinical picture.

Record your reflection, honest assessment, or learning commitments here...

4. Co-Occurring Disorders

How do you currently supervise staff in navigating the overlap between SUD and trauma? Are they equipped to hold a trauma-informed lens without either minimizing the addiction or minimizing the trauma?

Trauma and addiction are almost always co-travelers. The clinical skill is holding both simultaneously without collapsing one into the other.

Record your reflection, honest assessment, or learning commitments here...

5. Team Culture & Recovery Literacy

What does recovery literacy look like as a team standard in your current clinical environment? Is there a shared vocabulary, a shared commitment to multiple pathways, a shared respect for MAT?

Supervisors set the ceiling for team knowledge. The team rarely rises higher than the leader's comfort with the subject matter.

Record your reflection, honest assessment, or learning commitments here...

6. Lived Experience & Recovery Identity

How do you currently honor and integrate the lived experience of patients in recovery — their experiential knowledge of what recovery feels like, what it cost them, and what sustains it?

Patients in recovery are often the most knowledgeable people in the room about recovery. Clinical humility means letting that expertise be real.

Record your reflection, honest assessment, or learning commitments here...

7. Continuing Education Plan

What are the three areas of recovery knowledge you most want to deepen in the next 12 months? What specific resources will you use? How will you hold yourself accountable?

The recovery field evolves continuously. Harm reduction, emerging research on psychedelics, recovery housing models, peer support certification — the learning never ends.

Record your reflection, honest assessment, or learning commitments here...

8. Recovery Knowledge Philosophy

Write a Recovery Knowledge Philosophy Statement: what you believe about addiction and recovery, what you are committed to knowing and learning, and how that commitment lives in your clinical work.

A philosophy statement is not a job description. It is a living commitment to the patients who need a clinician who actually understands the terrain they are navigating.

Record your reflection, honest assessment, or learning commitments here...

Knowledge Scoring

Knowledge Scoring — Clinical Integration & Patient-Centered Application

Rate your genuine clinical fluency in each domain from 1 (minimal) to 10 (deep, integrated, and teachable). Be honest.

Integrated use of recovery knowledge across disease model, 12-step, and multiple pathways in clinical practice

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Active role in teaching and modeling recovery literacy for clinical staff

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

—

Fluency in co-occurring disorders as they intersect with SUD treatment

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

—

Team culture reflects diverse recovery literacy as a shared standard

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

—

Recovery Knowledge Philosophy Statement written and concrete continuing education plan in place

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Phase Score

This is honest early-stage territory. Low scores here mean the learning ahead of you is significant and valuable — not shameful.

Action & Notes

Month-by-Month Learning Plan for Months 10-12

What will you read, attend, practice, or explore each month? Name the specific resource.

Month A — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Month B — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Month C — Learning Focus, Resources & Application

What specific knowledge area will you focus on this month?

Phase Completion Checklist

- Completed honest knowledge self-assessment for this phase
- Engaged with all 8 reflection prompts (minimum 4 with written responses)
- Knowledge scoring assessment completed and reviewed
- Personal learning commitment written and in active use
- Month-by-month learning plan drafted with specific resources named
- At least one primary source read this phase (book, manual, or foundational text)
- At least one learning brought directly into supervision or team discussion
- Transition reflection: what knowledge am I carrying into the next phase?

My Private Learning Notes

What is becoming clearer? What surprised you? Where are the gaps bigger than you expected?
