

# Beyond the Blueprint

## Deep Dive Modules · Leadership

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# Part 1 · Overview

## Beyond the Blueprint

Why System Theories Fail in SUD Treatment Leadership — and What Works Instead

From Concept to Integration — The Recovery Files

Systems Theory

Roles, structures, abstract models

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People-Centered

Humans, context, daily integration

## Reading Sections

The Systems Theory Promise — and Why It Fails in SUD Treatment

Why People Are Not Parts: The Personality Problem Systems Theory Ignores

The Actionability Gap: When Beautiful Concepts Cannot Become Monday Morning Practice

What Systems Theory Cannot See: The Hidden Culture of SUD Treatment

From Concept to Integration: Building Leadership That Actually Works Here

## Self-Assessment

## Worksheets & Exercises

Exercise 10: From Theory to Culture — Your Integration Roadmap

## Part 2 · The Systems Theory Promise — and Why It Fails in SUD Treatment

### The Systems Theory Promise — and Why It Fails in SUD Treatment

Systems theory has dominated organizational thinking for decades, and for good reason. From Ludwig von Bertalanffy's General Systems Theory to Peter Senge's "The Fifth Discipline," from W. Edwards Deming's quality management revolution to the family systems theories of Murray Bowen — the idea that organizations are interconnected systems whose performance depends on the relationships between parts rather than the parts themselves — this idea is elegant, powerful, and in many contexts, genuinely useful.

The promise is seductive: understand the system, redesign the system, and the outcomes will change. Map the processes. Clarify the roles. Establish feedback loops. Align incentives. Reduce variation. Create continuous improvement cycles. If the system is right, the people within it will perform. If outcomes are poor, the problem is the system, not the individuals.

In manufacturing, this works beautifully. In technology companies, it scales impressively. In hospital systems, it produces measurable quality improvements. And so — naturally, inevitably — it was imported wholesale into behavioral health, including substance use disorder treatment. Strategic plans were written. Organizational charts were redesigned. Quality improvement committees were formed. Evidence-based practice implementation frameworks were adopted. Process improvement became the language of leadership.

And yet. In program after program, treatment center after treatment center, the results have been profoundly disappointing. Not because the theories are wrong in the abstract — they are often intellectually correct. But because they fundamentally misunderstand the nature of the work, the nature of the workforce, and the nature of the environment in which SUD treatment operates.

The central failure is this: systems theory treats people as functional components within a larger mechanism. It asks, "What role does this person fill? What function do they serve? How does their output connect to the next process?" What it does not ask — and cannot answer — is: "Who is this person? What is their story? What wounds brought them to this work? What personality traits make them brilliant with one client population and destructive with another? What happens to their clinical effectiveness when they are burned out, traumatized, or morally injured by the system itself?"

In SUD treatment, the people ARE the system. The therapeutic relationship IS the mechanism of change. The clinician's capacity for authentic connection, emotional regulation, clinical intuition, and genuine caring IS the treatment technology. No organizational chart captures this. No process map accounts for it. No systems theory that reduces a human being to a role and a function can possibly lead an organization where the product IS the humanity of its workforce.

This is not an argument against organization, structure, or systematic thinking. It is an argument against the uncritical importation of theories that were designed for contexts where the product is a widget, a code deployment, or a surgical procedure — and applying them without modification

to a context where the product is a human relationship offered to another human being in the most vulnerable moment of their life.

### Reflection Questions

1. What systems theories or organizational frameworks have you attempted to implement in your SUD treatment setting? What happened when theory met reality?

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2. When you think about your best clinical staff — the ones who produce the strongest client outcomes — does their effectiveness come from their role in the system, or from who they are as people? What does this tell you?

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3. Where have you seen the gap between "this looks great on the organizational chart" and "this is what actually happens on the unit at 8 AM on Monday"?

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4. How much of your leadership training has been borrowed from corporate, medical, or academic contexts? How well did it translate to SUD treatment?

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5. If the people ARE the treatment technology, what does that mean for how you lead, develop, and protect your clinical staff?

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## Part 3 · Why People Are Not Parts: The Personality Problem Systems Theory Ignores

### Why People Are Not Parts: The Personality Problem Systems Theory Ignores

Imagine two substance use disorder counselors. Both have their CADC. Both have five years of experience. Both work in the same program, under the same supervisor, with the same client population, using the same treatment curriculum. On paper — on the organizational chart, in the systems model — they are interchangeable. They fill the same role. They serve the same function. Systems theory would predict roughly equivalent outputs.

Now meet them as human beings. Counselor A is a person in long-term recovery who entered the field at forty-two after twenty years of active addiction. She carries profound experiential wisdom, an unshakable belief that recovery is possible, and a raw authenticity that clients instantly recognize and trust. She also carries the wounds of her own addiction — hypervigilance about relapse, difficulty with professional boundaries because she identifies so deeply with her clients, a tendency to overwork because rest feels like selfishness, and an unprocessed grief about the years she lost. She thrives with resistant, early-recovery clients who need someone who has been there. She struggles with adolescents, clinical documentation, and any supervision that feels controlling.

Counselor B is a twenty-seven-year-old with a master's degree in clinical mental health counseling who has never experienced addiction personally. She is intellectually sophisticated, fluent in evidence-based practices, excellent at documentation, and deeply committed to the field from an academic and humanitarian perspective. She also carries her own patterns — difficulty tolerating the chaos and emotional intensity of a treatment milieu, a tendency to intellectualize rather than connect, impostor syndrome around clinicians who have personal recovery experience, and a belief that she has to prove her worth through perfection. She thrives with clients who respond to structured, cognitive interventions and with co-occurring disorder treatment. She struggles with clients who perceive her as unable to understand their experience.

Systems theory sees two counselors filling one role. People-centered leadership sees two entirely different human beings who need entirely different support, development, supervision, and deployment to be effective.

The system cannot tell you that putting Counselor A in the documentation-heavy intensive outpatient role will crush her spirit, or that assigning Counselor B to the early-recovery detox unit will trigger her inadequacy. Only knowing the people — their personalities, their histories, their strengths, their wounds, their motivational structures — gives you that intelligence.

This is not soft, optional, nice-to-have leadership wisdom. It is the difference between a program that retains competent staff and one that cycles through clinicians every eighteen months. It is the difference between clinical teams that function with genuine collaboration and teams that operate in chronic low-grade conflict because the system keeps forcing square pegs into round holes.

The uncomfortable truth that systems theory cannot accommodate is this: in SUD treatment, you do not manage positions. You lead people. And people are irreducibly individual, maddeningly complex, beautifully unique, and fundamentally uninterchangeable. Any leadership framework that does not begin with this reality is built on a foundation that will not hold.

### Reflection Questions

1. Think about two clinicians on your team who fill similar roles. In what specific ways are they fundamentally different as people? How do those differences affect their clinical effectiveness?

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2. Have you ever placed a staff member in a role that was perfect on paper but wrong for who they actually are? What happened?

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3. How well do you know the personal motivational drivers of each person on your team — not what their job description says should motivate them, but what actually does?

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4. What is the "personality" of your clinical team as a whole? What unspoken dynamics shape how the team actually functions versus how the organizational chart says it should?

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5. If you could redesign your team assignments based purely on personality fit rather than credential and role, what would change?

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## Part 4 · The Actionability Gap: When Beautiful Concepts Cannot Become Monday Morning Prac

### The Actionability Gap: When Beautiful Concepts Cannot Become Monday Morning Practice

There is a particular experience that every SUD treatment leader has had, usually multiple times. You attend a training, a conference, or a leadership development program. The presenter is brilliant. The framework is compelling. The research is solid. You take copious notes. You feel inspired. You return to your program on Monday morning energized and ready to implement what you have learned.

And then Monday happens. The client in detox is in medical crisis. Two staff called out sick. The state surveyor is coming Thursday. Your best clinician just gave two weeks notice. The EHR is down. There are twenty-seven progress notes overdue. A client's family member is in the lobby threatening to call their legislator. And the beautiful framework from the conference — the one about transformational leadership and organizational learning and continuous quality improvement — sits in your notebook, gathering dust, while you fight fires that the framework never anticipated, never addressed, and has no practical answer for.

This is the actionability gap, and it is arguably the single greatest failure of systems theory as applied to SUD treatment leadership. The gap exists at multiple levels:

**The resource gap.** Most systems theories assume a baseline of organizational resources — adequate staffing, reasonable caseloads, sufficient funding, functional technology, and enough time for reflection, planning, and implementation. In SUD treatment, these assumptions are farcical. Most programs operate at 60-80% of the staffing they need. Caseloads routinely exceed recommended levels by double or triple. Funding is perpetually uncertain and often tied to documentation metrics that bear no relationship to clinical quality.

**The translation gap.** Systems theories speak in abstractions: "Create a learning organization." "Establish feedback loops." "Foster psychological safety." "Build adaptive capacity." These are meaningful concepts. They are not actionable instructions. What does "create a learning organization" look like at 8 AM on Monday when your clinical team is already overwhelmed and you have thirty minutes before the first group of the day?

**The sustainability gap.** Even when a concept can be translated into a specific action, sustaining that action over time in the chaos of SUD treatment is an entirely different challenge. Any leadership practice that cannot survive being interrupted seven times in an hour, deferred for two weeks during a regulatory visit, and resumed without starting over from scratch will not survive in this field.

**The cultural gap.** Systems theories are typically developed by and for people in positions of organizational power — executives, directors, consultants. The language is managerial. The perspective is top-down. In SUD treatment, the most powerful clinical work often happens in the spaces systems cannot see or control — the spontaneous conversation in the hallway, the moment of honest connection between a clinician and a client at midnight, the peer support specialist who says exactly the right thing because they have lived it.

The actionability gap is not a call to abandon theory. It is a call to demand more from it. Any theory that cannot answer the question "What specifically do I do differently tomorrow at 8 AM?" is incomplete. Any framework that cannot survive contact with the chaotic, underfunded, emotionally intense, perpetually understaffed reality of SUD treatment is not a framework for SUD treatment — it is a framework for an imaginary organization that does not exist.

### Reflection Questions

1. Name a specific leadership concept you learned that inspired you but that you were never able to implement. What specifically prevented the implementation?

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2. What is the gap between the organizational resources your leadership framework assumes and the resources you actually have? How does that gap affect your ability to lead?

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3. When was the last time you took a theoretical concept and successfully translated it into a specific, observable behavior change in your program? What made that one work when others did not?

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4. If you could only implement one leadership practice — one concrete, daily action — that would make the biggest difference for your clinical team, what would it be? What stops you from doing it?

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5. How much of your leadership time is spent managing crises versus creating the conditions for your team to do their best work? What would have to change to shift that ratio?

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## Part 5 · What Systems Theory Cannot See: The Hidden Culture of SUD Treatment

### What Systems Theory Cannot See: The Hidden Culture of SUD Treatment

Every SUD treatment program has two organizational structures. The first is visible: the organizational chart, the policy manual, the strategic plan, the committee structure, the reporting relationships. This is the structure that systems theory sees, analyzes, and attempts to optimize. The second structure is invisible but infinitely more powerful: the culture. The unwritten rules. The things everyone knows but no one says. The real hierarchy — which is rarely the one on the organizational chart.

Systems theory cannot see this second structure. And yet this second structure determines virtually everything that matters: whether staff stay or leave, whether clinical work is authentic or performative, whether the team functions as a unit or as a collection of isolated individuals surviving side by side, whether the program produces genuine recovery outcomes or produces documentation that looks like recovery outcomes.

The culture of SUD treatment has distinctive features that no generic organizational theory addresses:

The helper identity. Most people who work in SUD treatment do so because they want to help. But the helper identity — when unexamined — creates profound leadership challenges. Helpers who define their worth through helping others are vulnerable to burnout, boundary violations, codependency with clients and colleagues, and the inability to receive help themselves. No systems theory accounts for this.

The martyrdom culture. In SUD treatment, overwork is not just tolerated — it is celebrated. The counselor who stays late every night, who takes calls on weekends, who never uses vacation time, who sacrifices personal health for client welfare — this person is held up as the ideal. This martyrdom culture is devastating to staff wellness, clinical quality, and organizational sustainability.

The recovery identity complexity. A significant portion of the SUD treatment workforce consists of people in personal recovery. This brings enormous gifts — experiential wisdom, credibility with clients, genuine empathy born of shared experience. It also brings complications that no organizational chart captures: the clinician whose client's relapse activates their own relapse fears, the team dynamic where recovery identity affects credibility hierarchies.

The parallel process. SUD treatment teams frequently replicate the dysfunctional dynamics of the families and systems their clients come from. The team enables the underperforming counselor the same way the family enables the person in active addiction. The program avoids confronting the toxic supervisor the same way it teaches clients' families to stop avoiding confrontation. This parallel process is invisible to systems theory but glaringly visible to anyone who understands the clinical work.

The moral injury. SUD treatment clinicians routinely face situations where the system requires them to act against their clinical judgment and their core values. Discharging a client for insurance reasons when they are not ready to leave. Prioritizing documentation over clinical contact because the billing system demands it. This moral injury is a primary driver of burnout, compassion fatigue, and workforce attrition.

Leading in SUD treatment requires seeing what systems theory cannot see. It requires looking past the organizational chart to the living, breathing, wounded, gifted, struggling, passionate human beings who show up every day to do work that most people could not endure.

### Reflection Questions

1. What are the "unwritten rules" in your program — the things everyone knows but no one says? How do these invisible rules affect clinical care and team functioning?

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2. How does the helper identity show up on your team? Where do you see it creating problems that look like dedication but are actually dysfunction?

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3. If your program has staff in personal recovery, how does recovery identity affect team dynamics, credibility hierarchies, and supervision relationships?

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4. Where do you see parallel process — your team replicating the same dysfunctional patterns you teach clients to change? Be specific and honest.

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5. Where does your organization create moral injury for your clinical staff — where does the system require them to act against what they know is right? How does this affect retention and clinical quality?

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## Part 6 · From Concept to Integration: Building Leadership That Actually Works Here

### From Concept to Integration: Building Leadership That Actually Works Here

If systems theories are insufficient — if they cannot account for the people, the culture, the resource constraints, and the emotional reality of SUD treatment — what replaces them? The answer is not another theory. The answer is integration: the disciplined practice of translating useful concepts into specific, sustainable, people-centered actions that work in the actual environment where you lead.

Integration is fundamentally different from implementation. Implementation is top-down: a leader learns a concept and deploys it into the organization. Integration is organic: a leader absorbs a concept, adapts it to the specific people, culture, and constraints of their setting, pilots it in small ways, gets feedback from the humans affected by it, adjusts based on that feedback, and gradually weaves it into the fabric of daily practice until it becomes "how we do things here" rather than "the new initiative."

Integration requires five capacities that systems theory does not develop:

First, translation capacity — the ability to take an abstract concept and express it as a concrete, observable, daily behavior. "Foster psychological safety" is a concept. "In our Monday morning clinical meeting, I will start by sharing one thing I struggled with last week, and I will explicitly invite each person to share one concern without judgment" is a behavior. The distance between these two statements is the distance between theory and practice, and bridging it is the leader's primary responsibility.

Second, contextual intelligence — the deep, specific understanding of your particular program, your particular people, your particular culture, your particular constraints. This cannot be learned from a textbook or a conference. It is learned by being present, listening carefully, observing patterns, asking questions, and building relationships with the humans who do the daily work.

Third, relational currency — the trust, credibility, and genuine connection with your team that makes change possible. People do not change their behavior because a system tells them to. They change their behavior because a person they trust and respect invites them to, models the change, supports them through the discomfort, and holds them accountable with care rather than coercion. Building relational currency requires time, consistency, vulnerability, follow-through, and the willingness to be changed by the relationship yourself.

Fourth, adaptive persistence — the ability to sustain a change effort through the inevitable interruptions, setbacks, resistance, and competing demands of SUD treatment. Adaptive persistence means accepting that in SUD treatment, no change will ever proceed in a straight line — and continuing to move forward anyway, adjusting the approach while holding the intention.

Fifth, generative practice — the capacity to create new approaches rather than simply adopting existing ones. The SUD treatment field does not need more imported models. It needs leaders who understand their context so deeply that they can generate practices that fit their specific

environment, their specific people, and their specific challenges.

The path from concept to integration is not linear. It looks more like this: Learn a concept → Ask "What would this look like here, with these people, given these constraints?" → Design a small, specific experiment → Try it → Get honest feedback → Adjust → Try again → Gradually expand what works → Let go of what doesn't → Keep the people at the center of every decision.

The leaders who transform SUD treatment programs do not do so by finding the right theory. They do so by knowing their people, understanding their context, translating concepts into daily behaviors, building trust one interaction at a time, persisting through chaos, and never losing sight of the fact that in this work, the human being always comes first — before the system, before the theory, before the organizational chart.

### Reflection Questions

1. Think of one leadership practice that you have successfully integrated — something that has become "how we do things here." What made that integration work? What can you learn from it?

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2. How strong is your contextual intelligence? Could you describe the hidden dynamics, unspoken rules, and real power structures in your program? Where are the gaps in your understanding?

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3. Assess your relational currency with your team honestly. If you asked each team member whether they trust you enough to be vulnerable about their struggles, what would they say?

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4. Where do you need adaptive persistence right now — what change effort have you started and abandoned, or started and let slide, that deserves to be picked up again?

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5. If you committed to generating one people-centered practice from your own contextual knowledge rather than importing another external framework, what would you create?

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## Part 7 · Leadership Integration Self-Assessment

### Leadership Integration Self-Assessment

Rate each statement: 1 (Not at all like me) to 5 (Very much like me)

I rely primarily on organizational systems models (flowcharts, hierarchies, process maps) to guide my leadership decisions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When problems arise in my program, my first instinct is to restructure the system rather than talk to the people involved

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I believe that getting the right system in place will fix most clinical team problems

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have implemented organizational theories that looked excellent on paper but failed in practice with my team

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I tend to focus on role functions rather than individual strengths when assigning clinical responsibilities

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I find myself frustrated when staff don't perform as their position description says they should

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have borrowed leadership frameworks from corporate, medical, or academic settings without modifying them for SUD treatment

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I spend more time building systems and structures than building relationships with my clinical staff

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can identify each staff member's unique strengths, communication style, and motivational drivers

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I regularly adjust my leadership approach based on the individual I am working with

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand how each team member's personal recovery history (if applicable) influences their clinical work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize when a staff member's personality or temperament is being mismatched with their assigned role or client population

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I create opportunities for staff to use their natural gifts rather than forcing them into standardized role expectations

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand that what motivates one clinician may completely demoralize another

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have meaningful individual relationships with each member of my clinical team beyond task-oriented interactions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can sense when a team member is struggling personally and it is affecting their clinical work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have attended leadership trainings that felt inspiring but I could not implement in my actual work setting

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I struggle to translate theoretical concepts into concrete daily actions my team can follow

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

There is a significant gap between what I know about good leadership and what I actually do day to day

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My team would say they hear about new initiatives but rarely see them fully implemented or sustained

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I sometimes adopt leadership terminology or frameworks without fully understanding how to operationalize them

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I find that most leadership models assume resources, time, and support that simply don't exist in SUD treatment

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have watched promising programs or initiatives die because the implementation plan was too abstract

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When I try to implement change, I often encounter resistance I didn't anticipate because the model didn't account for the real human dynamics on my team

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand that SUD treatment culture — the helper identity, savior complex, burnout cycle, vicarious trauma — creates leadership challenges that generic systems theory does not address

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize when the unique emotional labor of addiction counseling is being ignored by organizational models

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am aware that many SUD clinicians entered the field through personal recovery experience, which creates distinct leadership dynamics

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand how underfunding, understaffing, and regulatory burden create a culture of survival that makes systems theory feel disconnected from reality

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize that treatment team dynamics often mirror the dysfunction of the families and systems our clients come from

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am aware of how toxic positivity, martyrdom, and overwork are normalized in SUD treatment settings

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand that clinical staff in SUD treatment face moral injury when system demands conflict with client needs

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can identify when my organization's stated values do not match the lived experience of my clinical team

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can take an abstract leadership concept and break it into specific, observable, daily behaviors

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When I learn a new approach, I pilot it in small ways before attempting organization-wide implementation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I regularly seek feedback from my clinical staff about whether leadership changes are actually helping or hurting their work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I evaluate leadership models through the lens of "what will this look like at 8 AM on a Monday in my program?"

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have successfully adapted generic leadership frameworks to fit the specific realities of SUD treatment

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I prioritize sustainability over novelty — I would rather do one thing well than implement five things poorly

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can articulate the difference between understanding a concept intellectually and integrating it into practice

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I build in accountability structures that help me and my team actually do what we say we are going to do

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

1. Which domain scored highest? What does this reveal about your leadership approach?

Your reflection...

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2. How does your Systems Theory Dependency score compare to your People & Personality Awareness score? What does the gap tell you?

Your reflection...

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3. Which specific items did you rate as 5 in the Actionability Gap domain? These represent the most urgent areas where theory is failing your practice.

Your reflection...

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4. How does your SUD Treatment Culture Awareness compare to your actual leadership behavior?

Your reflection...

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5. Based on this assessment, what is the single most important shift you need to make — from theory to practice — to better serve your clinical team?

Your reflection...

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## Scoring guide

Reset all progress? This cannot be undone.

Your Leadership Integration Profile

For Domains 1 and 3, higher scores indicate greater reliance on theory over practice — areas for growth. For Domains 2, 4, and 5, higher scores indicate leadership strengths. The gap between your theory-dependency and your integration capacity reveals how much work remains to bridge

concept and practice.

## Part 8 · Exercise 1: The Theory-Reality Audit

### The Theory-Reality Audit

Examining Where Theory Promised and Reality Delivered

Why This Matters

Every leader has a graveyard of implemented theories that didn't survive contact with reality. This audit isn't about shame — it's about learning. By honestly examining where theory failed, you develop the critical lens necessary to evaluate future frameworks before investing your team's time and trust in them.

The Theory/Framework/Model: What did you attempt to implement?

e.g., "Strengths-based supervision model," "Lean process improvement"

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The Promise: What was this supposed to accomplish?

Be specific and honest...

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The Reality: What actually happened when you tried to implement it?

Be specific and honest...

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The People Factor: What did this theory fail to account for about the actual human beings on your team?

Be specific and honest...

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**The Culture Factor:** What did this theory miss about the specific culture of your SUD treatment setting?

Be specific and honest...

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**The Resource Factor:** What resources did the theory assume that you didn't have?

Be specific and honest...

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**The Lesson:** What did this experience teach you about what actually works in your setting?

Be specific and honest...

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**The Theory/Framework/Model:** What did you attempt to implement?

e.g., "Strengths-based supervision model," "Lean process improvement"

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**The Promise:** What was this supposed to accomplish?

Be specific and honest...

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**The Reality:** What actually happened when you tried to implement it?

Be specific and honest...

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**The People Factor:** What did this theory fail to account for about the actual human beings on your team?

Be specific and honest...

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**The Culture Factor:** What did this theory miss about the specific culture of your SUD treatment setting?

Be specific and honest...

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**The Resource Factor:** What resources did the theory assume that you didn't have?

Be specific and honest...

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**The Lesson:** What did this experience teach you about what actually works in your setting?

Be specific and honest...

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**The Theory/Framework/Model:** What did you attempt to implement?

e.g., "Strengths-based supervision model," "Lean process improvement"

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**The Promise:** What was this supposed to accomplish?

Be specific and honest...

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The Reality: What actually happened when you tried to implement it?

Be specific and honest...

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The People Factor: What did this theory fail to account for about the actual human beings on your team?

Be specific and honest...

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---

The Culture Factor: What did this theory miss about the specific culture of your SUD treatment setting?

Be specific and honest...

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---

The Resource Factor: What resources did the theory assume that you didn't have?

Be specific and honest...

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---

The Lesson: What did this experience teach you about what actually works in your setting?

Be specific and honest...

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---

The Theory/Framework/Model: What did you attempt to implement?

e.g., "Strengths-based supervision model," "Lean process improvement"

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---

The Promise: What was this supposed to accomplish?

Be specific and honest...

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---

The Reality: What actually happened when you tried to implement it?

Be specific and honest...

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---

The People Factor: What did this theory fail to account for about the actual human beings on your team?

Be specific and honest...

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The Culture Factor: What did this theory miss about the specific culture of your SUD treatment setting?

Be specific and honest...

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The Resource Factor: What resources did the theory assume that you didn't have?

Be specific and honest...

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The Lesson: What did this experience teach you about what actually works in your setting?

Be specific and honest...

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---

**The Theory/Framework/Model:** What did you attempt to implement?

e.g., "Strengths-based supervision model," "Lean process improvement"

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**The Promise:** What was this supposed to accomplish?

Be specific and honest...

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**The Reality:** What actually happened when you tried to implement it?

Be specific and honest...

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**The People Factor:** What did this theory fail to account for about the actual human beings on your team?

Be specific and honest...

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**The Culture Factor:** What did this theory miss about the specific culture of your SUD treatment setting?

Be specific and honest...

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**The Resource Factor:** What resources did the theory assume that you didn't have?

Be specific and honest...

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The Lesson: What did this experience teach you about what actually works in your setting?

Be specific and honest...

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1. Looking across all five audits, what patterns do you see? Do the same factors keep causing failure?

Synthesize your audit findings...

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2. What is the most common reason theories fail in your setting — people factors, culture factors, or resource factors?

Synthesize your audit findings...

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3. If you had a "theory filter" — a set of questions to evaluate any new framework before attempting implementation — what would those questions be?

Synthesize your audit findings...

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4. What has actually worked in your setting? What do your successful practices have in common?

Synthesize your audit findings...

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## Part 9 · Exercise 2: Staff Personality & Strength Map

### Staff Personality & Strength Map

Knowing Your People Beyond Their Job Descriptions

The Foundation of People-Centered Leadership

Systems see roles. Leaders see people. This exercise builds a detailed map of each team member as a whole human being — their strengths, their struggles, their motivational drivers, and their unique gifts. This map becomes your primary leadership intelligence, far more valuable than any organizational chart.

Use initials or a code name if you prefer — the point is honest reflection, not documentation.

Who (initials or identifier):

Be honest and specific...

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---

Their Role/Title — what the system sees:

Be honest and specific...

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Who They Actually Are — what the system cannot see:

What is this person like as a human being?

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Their Real Strengths — not job competencies, but what they are naturally gifted at:

Be honest and specific...

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**Their Real Struggles — the human challenges they carry:**

Be honest and specific...

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**What Actually Motivates Them:**

Be honest and specific...

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**What Demoralizes or Shuts Them Down:**

Be honest and specific...

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---

**Current Role Fit — on a scale of 1-10, how well does their current assignment match who they actually are?**

Be honest and specific...

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---

Use initials or a code name if you prefer — the point is honest reflection, not documentation.

**Who (initials or identifier):**

Be honest and specific...

---

---

---

**Their Role/Title — what the system sees:**

Be honest and specific...

---

---

---

**Who They Actually Are — what the system cannot see:**

What is this person like as a human being?

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**Their Real Strengths — not job competencies, but what they are naturally gifted at:**

Be honest and specific...

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**Their Real Struggles — the human challenges they carry:**

Be honest and specific...

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**What Actually Motivates Them:**

Be honest and specific...

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**What Demoralizes or Shuts Them Down:**

Be honest and specific...

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---

**Current Role Fit — on a scale of 1-10, how well does their current assignment match who they actually are?**

Be honest and specific...

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---

Use initials or a code name if you prefer — the point is honest reflection, not documentation.

Who (initials or identifier):

Be honest and specific...

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---

---

Their Role/Title — what the system sees:

Be honest and specific...

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---

Who They Actually Are — what the system cannot see:

What is this person like as a human being?

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Their Real Strengths — not job competencies, but what they are naturally gifted at:

Be honest and specific...

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Their Real Struggles — the human challenges they carry:

Be honest and specific...

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What Actually Motivates Them:

Be honest and specific...

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What Demoralizes or Shuts Them Down:

Be honest and specific...

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---

Current Role Fit — on a scale of 1-10, how well does their current assignment match who they actually are?

Be honest and specific...

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---

Use initials or a code name if you prefer — the point is honest reflection, not documentation.

Who (initials or identifier):

Be honest and specific...

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---

Their Role/Title — what the system sees:

Be honest and specific...

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Who They Actually Are — what the system cannot see:

What is this person like as a human being?

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Their Real Strengths — not job competencies, but what they are naturally gifted at:

Be honest and specific...

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**Their Real Struggles — the human challenges they carry:**

Be honest and specific...

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**What Actually Motivates Them:**

Be honest and specific...

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**What Demoralizes or Shuts Them Down:**

Be honest and specific...

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---

**Current Role Fit — on a scale of 1-10, how well does their current assignment match who they actually are?**

Be honest and specific...

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---

Use initials or a code name if you prefer — the point is honest reflection, not documentation.

**Who (initials or identifier):**

Be honest and specific...

---

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---

**Their Role/Title — what the system sees:**

Be honest and specific...

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---

**Who They Actually Are — what the system cannot see:**

What is this person like as a human being?

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**Their Real Strengths — not job competencies, but what they are naturally gifted at:**

Be honest and specific...

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**Their Real Struggles — the human challenges they carry:**

Be honest and specific...

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**What Actually Motivates Them:**

Be honest and specific...

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**What Demoralizes or Shuts Them Down:**

Be honest and specific...

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**Current Role Fit — on a scale of 1-10, how well does their current assignment match who they actually are?**

Be honest and specific...

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---

---

Use initials or a code name if you prefer — the point is honest reflection, not documentation.

Who (initials or identifier):

Be honest and specific...

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---

---

Their Role/Title — what the system sees:

Be honest and specific...

---

---

---

Who They Actually Are — what the system cannot see:

What is this person like as a human being?

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---

---

Their Real Strengths — not job competencies, but what they are naturally gifted at:

Be honest and specific...

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---

Their Real Struggles — the human challenges they carry:

Be honest and specific...

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---

What Actually Motivates Them:

Be honest and specific...

---

---

---

What Demoralizes or Shuts Them Down:

Be honest and specific...

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---

Current Role Fit — on a scale of 1-10, how well does their current assignment match who they actually are?

Be honest and specific...

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1. Looking at your team map, where are the greatest mismatches between role assignment and personality/strength fit?

Synthesize your people map...

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2. Which team members are you leading as if they are interchangeable, and which are you leading as unique individuals?

Synthesize your people map...

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3. What gaps in your knowledge became apparent? Which team members do you know deeply, and which do you realize you don't actually know?

Synthesize your people map...

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4. If you reorganized your team based purely on who people are rather than what their credentials say, what would change?

Synthesize your people map...

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5. What is one specific action you can take this week to better align a team member's assignment with their actual strengths?

Synthesize your people map...

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## Part 10 • Exercise 3: Concept-to-Action Translation Lab

### Concept-to-Action Translation Lab

Turning Abstract Leadership Ideas into Monday Morning Behaviors

The Translation Test

Any leadership concept worth adopting must pass the 'Monday Morning Test': Can you describe exactly what you will do differently at 8 AM on Monday? This lab builds your translation muscle.

#### THE ABSTRACT CONCEPT

"Create an environment where people feel safe to speak up"

Translate to a Specific Behavior: What exactly will you DO? Use action verbs.

e.g., "In Monday's clinical meeting, I will..."

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---

---

When Specifically: What day, time, and context will this behavior occur?

Be concrete and specific...

---

---

---

What It Looks Like: If someone were watching you, what would they see and hear?

Be concrete and specific...

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---

---

What Could Prevent It: What specific real-world obstacles might prevent this behavior?

Be concrete and specific...

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---

---

How You'll Adapt: How will you maintain this practice when the inevitable crisis interrupts it?

Be concrete and specific...

---

---

---

#### THE ABSTRACT CONCEPT

"Lead with awareness of how trauma affects your staff and clients"

Translate to a Specific Behavior: What exactly will you DO? Use action verbs.

e.g., "In Monday's clinical meeting, I will..."

---

---

---

When Specifically: What day, time, and context will this behavior occur?

Be concrete and specific...

---

---

---

What It Looks Like: If someone were watching you, what would they see and hear?

Be concrete and specific...

---

---

---

What Could Prevent It: What specific real-world obstacles might prevent this behavior?

Be concrete and specific...

---

---

---

How You'll Adapt: How will you maintain this practice when the inevitable crisis interrupts it?

Be concrete and specific...

---

---

---

#### THE ABSTRACT CONCEPT

"Focus on what clinicians do well rather than what they do wrong"

Translate to a Specific Behavior: What exactly will you DO? Use action verbs.

e.g., "In Monday's clinical meeting, I will..."

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---

---

When Specifically: What day, time, and context will this behavior occur?

Be concrete and specific...

---

---

---

What It Looks Like: If someone were watching you, what would they see and hear?

Be concrete and specific...

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---

What Could Prevent It: What specific real-world obstacles might prevent this behavior?

Be concrete and specific...

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---

How You'll Adapt: How will you maintain this practice when the inevitable crisis interrupts it?

Be concrete and specific...

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### **THE ABSTRACT CONCEPT**

"Build a culture of continuous learning and improvement"

Translate to a Specific Behavior: What exactly will you DO? Use action verbs.

e.g., "In Monday's clinical meeting, I will..."

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---

---

When Specifically: What day, time, and context will this behavior occur?

Be concrete and specific...

---

---

---

What It Looks Like: If someone were watching you, what would they see and hear?

Be concrete and specific...

---

---

---

What Could Prevent It: What specific real-world obstacles might prevent this behavior?

Be concrete and specific...

---

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---

How You'll Adapt: How will you maintain this practice when the inevitable crisis interrupts it?

Be concrete and specific...

---

---

---

#### **THE ABSTRACT CONCEPT**

"Put the needs of your team before your own"

Translate to a Specific Behavior: What exactly will you DO? Use action verbs.

e.g., "In Monday's clinical meeting, I will..."

---

---

---

When Specifically: What day, time, and context will this behavior occur?

Be concrete and specific...

---

---

---

What It Looks Like: If someone were watching you, what would they see and hear?

Be concrete and specific...

---

---

---

What Could Prevent It: What specific real-world obstacles might prevent this behavior?

Be concrete and specific...

---

---

---

How You'll Adapt: How will you maintain this practice when the inevitable crisis interrupts it?

Be concrete and specific...

---

---

---

#### **THE ABSTRACT CONCEPT**

"Guide your team through organizational transitions effectively"

Translate to a Specific Behavior: What exactly will you DO? Use action verbs.

e.g., "In Monday's clinical meeting, I will..."

---

---

---

When Specifically: What day, time, and context will this behavior occur?

Be concrete and specific...

---

---

---

What It Looks Like: If someone were watching you, what would they see and hear?

Be concrete and specific...

---

---

---

What Could Prevent It: What specific real-world obstacles might prevent this behavior?

Be concrete and specific...

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---

How You'll Adapt: How will you maintain this practice when the inevitable crisis interrupts it?

Be concrete and specific...

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# Part 11 · Exercise 4: Leadership Blind Spot Inventory

## Leadership Blind Spot Inventory

What You Cannot See Is Leading You

Courageous Self-Examination

Every leader has blind spots. In SUD treatment, we teach clients that denial is the primary obstacle to recovery. The same principle applies to leadership. What you cannot see about your own leadership is shaping your team's experience more than what you can see.

Prioritizing organizational structure, processes, and metrics over the emotional and relational needs of individual staff members.

How strongly does this blind spot apply? (1-10)

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

When have I chosen to fix the system rather than connect with the person?

Be specific — name a real situation...

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---

---

What would change in your leadership if you addressed this blind spot?

Name the change and the step...

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---

---

Using theoretical frameworks to avoid the messiness and vulnerability of genuine human leadership.

How strongly does this blind spot apply? (1-10)

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

When have I retreated into theory because leading with presence felt too uncomfortable?

Be specific — name a real situation...

---

---

---

What would change in your leadership if you addressed this blind spot?

Name the change and the step...

---

---

---

Assuming staff experience the organization the way leadership intends. The leader sees the strategic plan; the clinician sees an impossible caseload.

How strongly does this blind spot apply? (1-10)

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

When have I assumed my team experienced a decision the way I intended it, only to discover they experienced something completely different?

Be specific — name a real situation...

---

---

---

What would change in your leadership if you addressed this blind spot?

Name the change and the step...

---

---

---

Continuously introducing new frameworks without fully implementing or sustaining previous ones.

How strongly does this blind spot apply? (1-10)

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

How many initiatives have I introduced in the past two years that are no longer actively practiced?

Be specific — name a real situation...

---

---

---

What would change in your leadership if you addressed this blind spot?

Name the change and the step...

---

---

---

Measuring what is countable rather than what counts. Productivity numbers are easy to measure. Clinical effectiveness and staff morale are not.

How strongly does this blind spot apply? (1-10)

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

What do I measure that doesn't actually matter, and what do I fail to measure that does?

Be specific — name a real situation...

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What would change in your leadership if you addressed this blind spot?

Name the change and the step...

---

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Underestimating how much your positional power shapes what people say and don't say to you.

How strongly does this blind spot apply? (1-10)

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

What might my staff be afraid to tell me? What would I learn if they felt truly safe to be honest?

Be specific — name a real situation...

---

---

---

What would change in your leadership if you addressed this blind spot?

Name the change and the step...

---

---

---

The leader who solves everything for their staff rather than developing their capacity.

How strongly does this blind spot apply? (1-10)

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

When do I solve problems for my team that they could solve themselves? What am I getting from being the rescuer?

Be specific — name a real situation...

---

---

---

What would change in your leadership if you addressed this blind spot?

Name the change and the step...

---

---

---

Failing to see how your leadership team replicates the same dysfunction patterns you teach clients to change.

How strongly does this blind spot apply? (1-10)

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

What dysfunctional pattern that I would immediately identify in a client family is currently operating in my leadership team?

Be specific — name a real situation...

---

---

---

What would change in your leadership if you addressed this blind spot?

Name the change and the step...

---

---

---

1. Which blind spot scored highest? How has this been affecting your team without your awareness?

Synthesize your blind spot inventory...

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2. If you asked a trusted staff member to rate your blind spots, would their assessment match yours? Why or why not?

Synthesize your blind spot inventory...

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---

3. How are your leadership blind spots connected to the failures of systems theory in your setting?

Synthesize your blind spot inventory...

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4. Write a commitment to address your top blind spot: what specifically will you do differently, starting when?

Synthesize your blind spot inventory...

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## Part 12 · Exercise 5: The "Works on Paper" Autopsy

### The "Works on Paper" Autopsy

Dissecting the Beautiful Plans That Died on Contact with Reality

Learning from What Failed

In medicine, autopsies reveal the true cause of death — often different from what was assumed. In leadership, examining why well-designed plans failed reveals the hidden factors that no system model accounted for.

The Plan: Describe the initiative that looked great on paper.

Conduct your autopsy honestly...

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---

The Paper Version: How was it supposed to work?

Conduct your autopsy honestly...

---

---

---

Week 1 Reality: What happened in the first week? Where did reality first diverge from the plan?

Conduct your autopsy honestly...

---

---

---

The People's Reaction: How did your staff actually respond?

Conduct your autopsy honestly...

---

---

---

The Hidden Cost: What did this plan cost that wasn't anticipated?

Conduct your autopsy honestly...

---

---

---

The Fatal Assumption: What did this plan assume that turned out to be wrong?

Conduct your autopsy honestly...

---

---

---

What Actually Killed It: The real reason it could not survive in your environment.

Conduct your autopsy honestly...

---

---

---

The Diagnostic Lesson: What question should you have asked BEFORE attempting implementation?

Conduct your autopsy honestly...

---

---

---

The Plan: Describe the initiative that looked great on paper.

Conduct your autopsy honestly...

---

---

---

The Paper Version: How was it supposed to work?

Conduct your autopsy honestly...

---

---

---

Week 1 Reality: What happened in the first week? Where did reality first diverge from the plan?

Conduct your autopsy honestly...

---

---

---

The People's Reaction: How did your staff actually respond?

Conduct your autopsy honestly...

---

---

---

The Hidden Cost: What did this plan cost that wasn't anticipated?

Conduct your autopsy honestly...

---

---

---

The Fatal Assumption: What did this plan assume that turned out to be wrong?

Conduct your autopsy honestly...

---

---

---

What Actually Killed It: The real reason it could not survive in your environment.

Conduct your autopsy honestly...

---

---

---

The Diagnostic Lesson: What question should you have asked BEFORE attempting implementation?

Conduct your autopsy honestly...

---

---

---

The Plan: Describe the initiative that looked great on paper.

Conduct your autopsy honestly...

---

---

---

The Paper Version: How was it supposed to work?

Conduct your autopsy honestly...

---

---

---

Week 1 Reality: What happened in the first week? Where did reality first diverge from the plan?

Conduct your autopsy honestly...

---

---

---

The People's Reaction: How did your staff actually respond?

Conduct your autopsy honestly...

---

---

---

The Hidden Cost: What did this plan cost that wasn't anticipated?

Conduct your autopsy honestly...

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---

The Fatal Assumption: What did this plan assume that turned out to be wrong?

Conduct your autopsy honestly...

---

---

---

What Actually Killed It: The real reason it could not survive in your environment.

Conduct your autopsy honestly...

---

---

---

The Diagnostic Lesson: What question should you have asked BEFORE attempting implementation?

Conduct your autopsy honestly...

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Based on your autopsies, create a set of diagnostic questions that you will ask BEFORE implementing any future initiative.

**1. Diagnostic Question #1:**

Write a question that would test for implementation viability in YOUR specific setting...

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**2. Diagnostic Question #2:**

Write a question that would test for implementation viability in YOUR specific setting...

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**3. Diagnostic Question #3:**

Write a question that would test for implementation viability in YOUR specific setting...

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**4. Diagnostic Question #4:**

Write a question that would test for implementation viability in YOUR specific setting...

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**5. Diagnostic Question #5:**

Write a question that would test for implementation viability in YOUR specific setting...

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**6. Diagnostic Question #6:**

Write a question that would test for implementation viability in YOUR specific setting...

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**7. Diagnostic Question #7:**

Write a question that would test for implementation viability in YOUR specific setting...

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## Part 13 · Exercise 6: Your People-First Leadership Framework

### Your People-First Leadership Framework

Building a Framework Generated FROM Your Context, Not Imported INTO It

Generating Rather Than Importing

The most effective leadership frameworks in SUD treatment are not imported from outside — they are generated from deep understanding of the specific context. This exercise guides you through creating YOUR framework, built from YOUR experience, YOUR people, and YOUR setting.

Why You Lead: Not your job description — your real reason. Why do you do this work?

Be honest with yourself...

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Your Best Leadership Moment: Describe a time you led excellently. What were you doing? What made it work?

Be honest with yourself...

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Your Worst Leadership Moment: What happened? What did you fail to see or do?

Be honest with yourself...

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Your Three Non-Negotiable Leadership Values: Not aspirational values — the values you actually lead from.

Be honest with yourself...

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Part 2: Your Leadership Principles (Generated From Experience)

Write 5-7 leadership principles that are genuinely yours. Not borrowed. Not theoretical. Earned through experience.

**1. Leadership Principle #1:**

e.g., "I will never ask my team to do something I am not willing to model first."

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**2. Leadership Principle #2:**

e.g., "I will never ask my team to do something I am not willing to model first."

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**3. Leadership Principle #3:**

e.g., "I will never ask my team to do something I am not willing to model first."

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**4. Leadership Principle #4:**

e.g., "I will never ask my team to do something I am not willing to model first."

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**5. Leadership Principle #5:**

e.g., "I will never ask my team to do something I am not willing to model first."

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**6. Leadership Principle #6:**

e.g., "I will never ask my team to do something I am not willing to model first."

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**7. Leadership Principle #7:**

e.g., "I will never ask my team to do something I am not willing to model first."

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For each principle above, define one daily practice — a specific, observable behavior — that brings the principle to life.

**1. Daily Practice for Principle #1:**

What specific action will you take daily to live this principle? (Must pass the Monday Morning Test)

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**2. Daily Practice for Principle #2:**

What specific action will you take daily to live this principle? (Must pass the Monday Morning Test)

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**3. Daily Practice for Principle #3:**

What specific action will you take daily to live this principle? (Must pass the Monday Morning Test)

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---

**4. Daily Practice for Principle #4:**

What specific action will you take daily to live this principle? (Must pass the Monday Morning Test)

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---

**5. Daily Practice for Principle #5:**

What specific action will you take daily to live this principle? (Must pass the Monday Morning Test)

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**6. Daily Practice for Principle #6:**

What specific action will you take daily to live this principle? (Must pass the Monday Morning Test)

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**7. Daily Practice for Principle #7:**

What specific action will you take daily to live this principle? (Must pass the Monday Morning Test)

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## Part 14 · Exercise 7: The Actionable Leadership Plan

### The Actionable Leadership Plan

From Insight to Action — Your 30-Day Integration Commitment

One Thing, Done Well

This is not another strategic plan. It is a commitment to do ONE THING differently for 30 days. Systems theory fails because it tries to change everything at once. Integration succeeds because it changes one thing deeply.

The One Change: What is the single most important thing you need to do differently as a leader?  
Be concrete...

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Why This One: Why did you select this change over everything else?  
Be concrete...

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The Specific Behavior: Describe exactly what you will do. Use action verbs.  
Be concrete...

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When & Where: When exactly will this behavior occur?  
Be concrete...

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How You'll Know It's Working: What will you observe that indicates this change is having an impact?

Be concrete...

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When a crisis interrupts your practice (and it will), what is your plan for returning to it?

Plan for reality...

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If your team responds with skepticism or resistance, how will you maintain the change?

Plan for reality...

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When the initial energy fades, what will keep you going?

Plan for reality...

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Who will hold you accountable? Who will you tell about this commitment?

Plan for reality...

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Write a personal commitment statement. This is a promise to yourself and to your team — not a policy, but a human commitment to lead differently.

I commit to... because... My team deserves a leader who... Starting [date], I will...

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## Part 15 • Exercise 8: Staff Experience Mapping

### Staff Experience Mapping

Seeing Your Program Through Your Team's Eyes

The Experience Gap

Leaders experience the organization from the top. Staff experience it from the middle and the bottom. The gap between these experiences is often enormous — and invisible to leadership. Systems theory maps processes. This exercise maps human experience.

#### WHY THIS MATTERS

Understanding the daily emotional starting point reveals whether your team begins depleted or energized.

What does the first hour look like for your clinical staff? Not your schedule — their actual lived experience.

Describe the experience from your staff's perspective, not yours...

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What could you change about this experience? What is one specific action within your control? Name something concrete you can change...

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#### WHY THIS MATTERS

Supervision is where theory meets relationship. If supervision feels bureaucratic rather than developmental, no amount of system improvement will matter.

What is it actually like to be supervised in your program? Not your intentions, but the staff member's experience of sitting across from you.

Describe the experience from your staff's perspective, not yours...

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What could you change about this experience? What is one specific action within your control?

Name something concrete you can change...

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#### **WHY THIS MATTERS**

Meetings are where culture is performed. They reveal whether your leadership creates engagement or endurance.

What is the staff experience of your meetings? Are they energizing or draining? Is there space for honest conversation?

Describe the experience from your staff's perspective, not yours...

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What could you change about this experience? What is one specific action within your control?

Name something concrete you can change...

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#### **WHY THIS MATTERS**

How leadership shows up in crisis defines trust more than any policy or framework ever will.

When a crisis hits, what is the staff experience? Do they feel supported, abandoned, blamed, or invisible?

Describe the experience from your staff's perspective, not yours...

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What could you change about this experience? What is one specific action within your control?

Name something concrete you can change...

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#### **WHY THIS MATTERS**

The gap between "I became a counselor to help people" and "I spend 60% of my day on paperwork" is where moral injury lives.

What is the lived experience of documentation requirements? How much of their day is clinical contact versus paperwork?

Describe the experience from your staff's perspective, not yours...

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What could you change about this experience? What is one specific action within your control?

Name something concrete you can change...

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### WHY THIS MATTERS

The end-of-day emotional state predicts burnout, turnover, and clinical quality more accurately than any productivity metric.

What do your staff carry home? Not their briefcases — their emotional weight. What is the feeling state of your clinicians at 5 PM?

Describe the experience from your staff's perspective, not yours...

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What could you change about this experience? What is one specific action within your control?

Name something concrete you can change...

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1. What surprised you most about examining your staff's daily experience? Where was the gap between your perception and their likely reality the largest?

Synthesize your experience mapping...

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2. If your staff could redesign one aspect of their daily experience, what would they change?

Synthesize your experience mapping...

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3. How would a systems theory approach to improving staff experience differ from a people-centered approach?

Synthesize your experience mapping...

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4. Commit to one action this week that addresses the staff experience rather than the organizational process.

Synthesize your experience mapping...

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## Part 16 · Exercise 9: Weekly Integration Check-In (7 Days)

### Weekly Integration Check-In

7 Days of Practicing People-Centered Leadership

#### The Practice

Integration happens through daily repetition, not single insights. For seven days, track your leadership behaviors — not your intentions, beliefs, or plans, but your actual behaviors.

Did I lead from theory/system today, or from genuine knowledge of my people? Be specific.

Describe a specific leadership moment from today...

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Name one staff member I genuinely connected with today. What did I learn about them as a person?

Name the person and what you learned...

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Where did I default to system/process when the situation called for human presence?

Identify the moment honestly...

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What concept from this intensive did I translate into an actual behavior today?

Name the concept and the behavior...

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People-Centered Leadership rating today (1 = fully theory driven, 10 = fully people-centered)

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

Did I lead from theory/system today, or from genuine knowledge of my people? Be specific.

Describe a specific leadership moment from today...

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Name one staff member I genuinely connected with today. What did I learn about them as a person?

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Identify the moment honestly...

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What concept from this intensive did I translate into an actual behavior today?

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Name the person and what you learned...

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Describe a specific leadership moment from today...

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Name one staff member I genuinely connected with today. What did I learn about them as a person?

Name the person and what you learned...

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Identify the moment honestly...

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Name the concept and the behavior...

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People-Centered Leadership rating today (1 = fully theory driven, 10 = fully people-centered)

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

1. Looking at your 7 days of check-ins, what patterns do you notice? When do you default to theory and when do you lead from human understanding?

Review your week...

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2. Did your people-centered leadership rating change over the week? What contributed to higher or lower days?

Review your week...

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3. Which staff member did you connect with most meaningfully this week? What did that connection teach you about leadership?

Review your week...

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4. What was the hardest moment to stay people-centered? What pulled you toward system-level thinking?

Review your week...

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5. Will you continue this daily reflection practice? How will you sustain it when leadership crises compete for your attention?

Review your week...

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## Part 17 • Exercise 10: From Theory to Culture — Your Integration Roadmap

### From Theory to Culture

Your Integration Roadmap

The Final Integration

This final exercise synthesizes everything from the intensive into a personal leadership roadmap. Not a strategic plan — those are system artifacts. This is a human document: your commitment to lead differently, informed by who your people are and what your context demands.

Describe your leadership as it actually is right now — not as you wish it were, but as your team actually experiences it.

Radical honesty...

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Where have you been using theory as a substitute for genuine human leadership?

Radical honesty...

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What is your greatest strength as a leader of people (not systems)?

Radical honesty...

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What is the most important area for growth that this intensive has revealed? Name it directly.

Radical honesty...

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Not thirty changes. Three specific, observable, people-centered leadership practices that you will do consistently for 30 days.

Practice #1

What (the specific behavior):

Be specific...

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When (the specific time/context):

Be specific...

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Who benefits (the specific people this serves):

Be specific...

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How you'll know it's working:

Be specific...

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## Practice #2

What (the specific behavior):

Be specific...

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When (the specific time/context):

Be specific...

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Who benefits (the specific people this serves):

Be specific...

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How you'll know it's working:

Be specific...

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### Practice #3

What (the specific behavior):

Be specific...

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When (the specific time/context):

Be specific...

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Who benefits (the specific people this serves):

Be specific...

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How you'll know it's working:

Be specific...

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1. If you lead with genuine people-centered integration for 90 days, what will be different? Describe the team, the culture, and the clinical outcomes you envision.

Envision concretely...

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2. What will you STOP doing — what system-level, theory-based, or imported practice will you release because it does not serve your people?

Envision concretely...

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3. What will you START doing — what people-centered practice will become "how we do things here"?

Envision concretely...

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4. What support do you need to sustain this transformation? Who will you ask for help?

Envision concretely...

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Write a letter to your clinical team. Not a memo. A human letter. Tell them what you have learned about the gap between the theories you have led from and the people-centered leadership they deserve. You do not have to send this letter. But writing it will make the integration real.

Dear Team, I've been doing some difficult honest reflection about how I lead...

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In one powerful paragraph, declare who you intend to be as a leader. Not what systems you will implement or what theories you will follow. Who you will BE — for your team, for your clients, and for the field of SUD treatment.

I am a leader who...

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