

Set Up to Succeed

Deep Dive Modules · Professional Practice

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Part 1 · Overview

Set Up to Succeed

A Clinical Staff Intensive on Psychological Safety, Leadership,
and Creating Workplaces Where Clinicians Can Actually Thrive
For SUD Treatment Clinicians, Supervisors & Leadership

Embrace · Empower · Evolve — The Recovery Files

"Clients cannot receive better care than the environment allows clinicians to provide. Staff psychological safety is not a human resources concern — it is the clinical quality infrastructure on which everything else depends."

— The Recovery Files — Staff Wellness Series

The Staff Experience Spectrum

Surviving

Fear, hypervigilance, compliance over quality

Coping

Managed stability, unprocessed strain, quiet exit

Thriving

Safety, development, authentic clinical presence

Reading Sections

The Fear-Based Workplace: When Good Intentions Produce Toxic Outcomes

Clinical Supervision as a Clinical Intervention: What It Must Be and Why It So Often Isn't

Watching Colleagues Disappear: The Secondary Trauma of Witnessing Mismanaged Terminations

You Are the Treatment: Why Staff Wellbeing IS Client Outcomes

What Good Looks Like: Concrete Recommendations for Psychologically Safe SUD Treatment Workplaces

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Exercise 2: Leadership Impact Assessment — What It Costs to Work Here

Exercise 3: Clinical Supervision Audit — What I Need vs. What I Get

Exercise 4: Psychological Safety Scale — Can I Tell the Truth Here?

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Exercise 7: What Good Looks Like — Designing the Workplace I Need

Exercise 8: The Brave Conversation — What I Would Say If It Were Safe

Exercise 9: My Professional Resilience & Self-Protection Plan

Exercise 10: Advocacy & Leadership — Recommendations for Systemic Change

Part 2 · The Fear-Based Workplace: When Good Intentions Produce Toxic Outcomes

The Fear-Based Workplace: When Good Intentions Produce Toxic Outcomes

There is a particular and insidious form of organizational dysfunction that appears frequently in substance use disorder treatment agencies: the well-intentioned, mission-driven leadership team that produces a workplace organized around fear. The leaders are not malicious. Many entered this field because of a genuine calling — personal recovery, witnessing family addiction, a deep commitment to the work of healing. Their dedication to the mission is real. And yet the workplace they have built is one in which staff arrive uncertain about their standing, modify their clinical judgment to avoid perceived criticism, avoid raising legitimate concerns, and spend significant psychological energy managing the risk of termination rather than focusing on the clinical work they were hired to do.

Understanding how this happens requires separating intention from impact. A leader who micromanages clinical decisions because they are genuinely committed to quality outcomes is not producing safety — they are producing a culture of compliance and self-censorship that erodes exactly the reflective practice and clinical creativity that quality outcomes require. A leader who terminates staff quickly for performance concerns they have not clearly communicated or consistently managed is not protecting clients — they are producing a culture of job terror that makes staff less honest, less willing to acknowledge difficulty, and more likely to present a managed performance rather than a genuine clinical presence.

The road from good intention to toxic outcome is paved not with malice but with an absence of management training, self-awareness, and organizational accountability. The research on fear-based workplaces is substantial and consistent. When employees operate under chronic job insecurity, their cognitive performance narrows — the prefrontal cortex, the brain's executive function center, is progressively commandeered by the threat-detection system. Workers in fear-based environments are less creative, less honest, less collaborative, and less likely to report safety concerns. In healthcare settings, fear-based organizational culture is directly associated with worse patient outcomes. In substance use disorder treatment settings, where therapeutic alliance and clinical authenticity are among the strongest predictors of client progress, a staff culture organized around fear is not merely a human resources problem — it is a clinical quality problem.

The most damaging element of the fear-based SUD workplace is often not a specific policy or leader but the ambient uncertainty it produces. When staff cannot predict the criteria by which performance is evaluated, when they observe colleagues terminated without clear cause or due process, when policies are applied inconsistently, and when leadership behavior communicates that compliance and loyalty matter more than clinical excellence, the result is a systemic chill on professional authenticity. Staff learn to survive rather than to thrive. They learn to present well rather than to practice well. And the clients — who come to treatment already carrying profound experiences of unpredictability, broken trust, and systemic failure — receive treatment from

clinicians who are themselves operating in a microcosm of exactly those dynamics.

Reflection Questions

1. How accurately does the description of the "fear-based workplace" match your current work environment? Which specific elements are most recognizable to you?

2. Have you ever modified your clinical opinion, documentation, or behavior specifically to manage perceived risk rather than to serve clinical quality? Describe a specific instance.

3. The text says fear-based culture is a clinical quality problem, not only an HR problem. Do you see evidence of this in your agency — ways that staff fear directly affects client care?

4. What is the difference between a workplace that is accountable (high standards, clear expectations, consistent feedback) and a workplace that is fear-based (unpredictable, punitive, opaque)? Which does yours more resemble?

5. What would need to change in your leadership culture for staff to operate from confidence rather than fear? Be specific and realistic.

Part 3 · Clinical Supervision as a Clinical Intervention: What It Must Be and Why It So Often Isn't

Clinical Supervision as a Clinical Intervention: What It Must Be and Why It So Often Isn't

Clinical supervision in substance use disorder treatment is not a management activity that happens to use clinical language. It is a clinical intervention — a structured, professional relationship in which a more experienced clinician provides regular, intentional support, oversight, and developmental challenge to a less experienced one, with the explicit goal of protecting clients and developing clinicians. When it works, clinical supervision is one of the most powerful protective factors available in a challenging field: it reduces burnout, catches clinical errors before they become clinical crises, develops skills that training alone cannot produce, and provides the processing space for the emotional weight of this work. When it fails — or when what passes for supervision is actually administrative case review, productivity monitoring, or performative check-ins — the consequences cascade throughout the clinical system and eventually reach clients.

The most common failures of clinical supervision in SUD treatment agencies fall into predictable categories. The first is supervisors who lack adequate training in either clinical supervision methodology or the specific clinical population they are supervising. A counselor with ten years of experience in addiction treatment is not, by virtue of that experience alone, qualified to provide clinical supervision. Supervision is itself a distinct clinical skill requiring specific training in supervisory models, reflective practice facilitation, parallel process awareness, and developmental stage theory. Organizations that promote clinicians into supervisory roles without providing this training are not investing in supervision — they are replacing clinical supervision with experienced-clinician advice, which is different and inadequate.

The second failure is supervision that focuses exclusively on administrative concerns — caseload, documentation compliance, billing codes, productivity metrics — while leaving the clinical and emotional content of the work unaddressed. This is not supervision. It is case management oversight, and while case management oversight has legitimate value, it does not address the professional development, emotional processing, or clinical skill-building that actual supervision is designed to produce. The counselor who leaves every supervision session knowing whether their documentation is current but not having had a single authentic conversation about their clinical impact or emotional state is not being supervised. They are being monitored.

The third failure is the power differential without the safety structure. Supervision is, inherently, an evaluative relationship — the supervisor has authority over the supervisee's employment. In a psychologically safe organization, this authority is bounded by clear expectations, consistent standards, and an organizational culture that treats supervision primarily as development rather than discipline. When the supervisory relationship exists within a fear-based culture, the power differential without safety produces exactly the opposite of what supervision is designed to do.

What good supervision looks like is specific and documentable. It includes regular scheduled meetings that are rarely cancelled. It includes review of actual clinical work — recorded sessions,

process recordings, live observation, or detailed case presentations — rather than only verbal report. It includes both administrative oversight and clinical development. It includes explicit attention to the emotional impact of this work on the clinician. It includes specific, behavioral, evidence-based feedback that the clinician can act on. And it includes a supervisory relationship in which the clinician feels genuinely safe to bring their failures, uncertainties, and struggles without fear that doing so will be used against them.

Reflection Questions

1. Rate the clinical supervision you currently receive: primarily administrative, primarily clinical and developmental, or a genuine balance of both? What evidence supports your rating?

2. Is your supervisor qualified to provide clinical supervision in SUD treatment — do they have training in supervision methodology, not only clinical experience? Has that ever been addressed?

3. Have you ever brought a genuine clinical failure, a crisis you were uncertain how to handle, or a client who triggered you personally to supervision? What happened when you did — or what prevented you from doing so?

4. What specific things do you need from supervision that you are currently not receiving? Name them concretely.

5. If you are in a supervisory role yourself: how does this reading describe the gap between what you are currently providing and what genuine clinical supervision requires? What would you need to change?

Part 4 · Watching Colleagues Disappear: The Secondary Trauma of Witnessing Mismanaged Ter

Watching Colleagues Disappear: The Secondary Trauma of Witnessing Mismanaged Terminations

There is a form of workplace harm that receives almost no clinical attention in the SUD treatment literature despite its pervasive presence in treatment settings: the cumulative secondary traumatic stress experienced by staff who regularly witness colleagues terminated in ways that seem arbitrary, unjust, or grossly disproportionate to what they observed of that colleague's work. This experience — watching a competent colleague be let go without apparent cause, watching a valued team member disappear after a single incident that was neither communicated nor corrected, watching the pattern repeat with enough frequency that every staff member has started calculating their own vulnerability — produces a specific cluster of psychological responses that are rarely named and never addressed by the organizations producing them.

The psychological mechanism is not mysterious. Human beings are social primates with a profoundly developed capacity for threat-generalization — the ability to learn from observed danger, not only experienced danger. When a member of your group is suddenly removed, the threat-detection system updates its model of the environment: this place is less safe than I thought. The threat can happen to me. This update is adaptive in genuinely dangerous environments. In a workplace, it produces a chronic hypervigilance that is incompatible with the focused, empathically present, emotionally regulated clinical work that SUD treatment requires. The clinician who is monitoring their own survival cannot simultaneously be fully attending to a client's therapeutic process.

What makes this particularly damaging in SUD treatment settings is the double bind it creates for clinicians who came to this work motivated by their own recovery or by deep commitment to populations who have been let down by systems. They cannot simply leave — they are often too invested in the work, too identified with the mission, or too economically constrained. But staying means tolerating an organizational environment that chronically activates the same nervous system responses that substance use was, for many clients, designed to manage. The clinician is being asked to practice trauma-informed care while working inside an organizational structure that is itself traumatizing.

The organizational behavior most responsible for this pattern is what management researchers call "organizational silence" — the absence of transparent communication about personnel decisions combined with the absence of clear, consistently applied, publicly understood performance standards. When staff do not know why colleagues are terminated, they fill the vacuum with speculation, and speculation in a fear-based environment almost always errs toward threat amplification. The antidote to this speculation is not enforced positivity or leadership reassurance — it is structural transparency: clear, communicated, consistently applied performance management systems that make the criteria for employment security knowable in advance.

Reflection Questions

1. Can you name two or three colleagues who were terminated or left under circumstances that felt unclear, unjust, or poorly managed? What impact did each departure have on your own sense of safety and stability?

2. How have you managed the emotional impact of witnessing colleague losses? Have you processed it with anyone, or has it gone largely unacknowledged?

3. The text describes a "double bind" for clinicians who cannot easily leave but are harmed by staying. Does that resonate with your situation? What keeps you in place, and what is the psychological cost of staying?

4. Have you ever noticed that your hypervigilance about your own job security affects your clinical presence — that managing your own survival competes with clinical attention? Give a specific example.

5. What do you wish your organization had done differently after the departure of colleagues — what communication, process, or support would have helped?

Part 5 · You Are the Treatment: Why Staff Wellbeing IS Client Outcomes

You Are the Treatment: Why Staff Wellbeing IS Client Outcomes

The most empirically supported finding in substance use disorder treatment research is not about a specific modality, medication, or therapeutic technique. It is about the therapeutic relationship: the quality of the alliance between clinician and client is the single strongest predictor of positive treatment outcomes across all treatment modalities, all substances, and all client populations. Not CBT over motivational interviewing. Not residential over outpatient. Not medication-assisted over abstinence-based. The relationship. The human being sitting across from the client, and the quality of connection, authenticity, empathy, and collaborative engagement that person brings to the room.

This finding has a direct and largely unacknowledged implication for how SUD treatment agencies should understand staff wellbeing: staff wellbeing is not a separate concern from clinical quality. It is clinical quality. The counselor who arrives at work already depleted by organizational hypervigilance, who has not received adequate clinical supervision to process the previous week's emotional weight, whose professional judgment is constrained by fear of leadership response, who is monitoring their job security instead of the therapeutic process — that counselor is not delivering the therapeutic relationship that produces outcomes.

Compassion fatigue — the progressive erosion of a clinician's empathic capacity through repeated exposure to traumatic material without adequate support — is not a personal failing. It is a predictable occupational hazard of trauma-adjacent work, and it is the employer's organizational responsibility to structure against it. Secondary traumatic stress, moral injury, and burnout operate on the same principle: they are not signs that a clinician is insufficiently resilient. They are signs that a clinician is doing a high-demand job without adequate organizational support. The organization that responds to burnout with exhortations to practice self-care — without changing the structural conditions that produce the burnout — is engaging in precisely the kind of good-intentioned harm this intensive is designed to address.

The business case for investing in staff wellbeing is straightforward and consistently supported by data. High staff turnover in SUD treatment agencies has direct, measurable costs: recruitment and onboarding expenses, productivity loss during transition periods, the clinical disruption of client treatment when trusted therapeutic relationships are severed by departures, and the organizational culture damage produced by chronic instability. Conservative estimates of turnover cost in healthcare settings range from 50% to 200% of the departing employee's annual salary.

The reframe this intensive advocates for is simple but radical: staff are not the means by which the organization delivers treatment. Staff are the treatment. The agency's most important clinical instrument is not its evidence-based curriculum or its outcome measurement system. It is the collection of human beings it employs, their psychological wellbeing, their clinical skill, their sense of professional worth, and their capacity for genuine human presence with clients who have often known very little of it. Anything that degrades that capacity — fear, inadequate

supervision, poor leadership, chronic instability — is not a staff issue. It is a treatment quality issue.

Reflection Questions

1. Do you believe your organization understands that staff wellbeing is directly connected to client outcomes — that these are the same concern, not separate ones? What evidence supports your assessment?

2. Describe a specific time when your own organizational stress, fear, or emotional depletion affected the quality of your clinical presence with a client. What happened? What did it cost?

3. What would your clinical work look like if you were working in an organization that provided excellent supervision, genuine psychological safety, and consistent investment in your development? How would your presence in the room be different?

4. The text says compassion fatigue is an organizational responsibility, not a personal failing. How does that reframe your understanding of what you are experiencing? Does it change what you think should be done about it?

5. If you were presenting the business and clinical case to your organization's leadership for significant investment in staff wellbeing, what would be the three strongest arguments? What data would you use?

Part 6 · What Good Looks Like: Concrete Recommendations for Psychologically Safe SUD Treatment

What Good Looks Like: Concrete Recommendations for Psychologically Safe SUD Treatment Workplaces

The following recommendations are not aspirational ideals — they are evidence-based, practically implementable organizational structures and practices that, when consistently maintained, produce measurable differences in staff retention, clinical quality, and client outcomes. They are organized across four domains: leadership practice, clinical supervision structure, organizational culture, and staff wellbeing infrastructure.

LEADERSHIP PRACTICE: (1) Leaders must be trained in management, not promoted for clinical excellence. The decision to promote a skilled clinician into a supervisory role without providing management training is the single most common source of the good-intentioned poor leadership this intensive describes. (2) Performance expectations must be written, specific, and communicated proactively rather than retrospectively. Staff should know, in writing, what successful performance looks like before they are evaluated against it. (3) Progressive performance management must be the default for performance concerns. Termination without documentation of prior communication, coaching, and opportunity for improvement — except in cases of ethical violation or client safety — is organizational malpractice. (4) Leadership must model the culture it claims to want.

CLINICAL SUPERVISION STRUCTURE: (5) Every clinician must receive a minimum of one hour of individual clinical supervision per week in high-acuity settings, bi-weekly in lower-acuity outpatient settings. (6) Supervisors must be trained in clinical supervision methodology — not merely experienced clinicians. (7) Supervision must address both administrative and clinical content, with explicit and protected time for clinical material. (8) Group supervision, peer consultation, and case conference structures should supplement individual supervision.

ORGANIZATIONAL CULTURE: (9) Psychological safety must be assessed and monitored as a formal organizational indicator, not assumed. (10) Staff departure should be accompanied by honest, respectful, privacy-respecting communication to the team. (11) Staff who raise concerns about clinical quality or organizational practice must be protected from formal and informal retaliation. (12) Exit interviews should be conducted by someone external to direct supervision, findings aggregated and acted upon.

STAFF WELLBEING INFRASTRUCTURE: (13) A formal secondary traumatic stress and burnout prevention program — not a list of self-care suggestions — must be part of the organizational structure for clinical staff. (14) Staff recognition, professional development investment, and career pathway clarity must be active leadership functions. (15) Compensation must be regularly benchmarked against comparable roles in comparable settings and adjusted to remain competitive.

Reflection Questions

1. Reading through the 15 recommendations — which three are most urgently needed in your current organization? What is the evidence for each priority?

2. Which of the recommendations is your organization already implementing with reasonable fidelity? What is producing that success?

3. Are you in a position to advocate for any of these recommendations? What is the most realistic entry point?

4. The text says "most organizations that fail in these areas do so not from lack of intent but from lack of implementation discipline." Is that true in your organization?

5. If you could give one piece of anonymous feedback to your leadership about what would most change your experience of working in this organization, what would you say?

Part 7 · Workplace Wellbeing Assessment

Workplace Wellbeing Assessment

Rate each statement 1 (Not at all true) to 5 (Very much true)

I regularly worry that my position could be eliminated or that I could be let go without clear cause

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I feel that I am walking on eggshells at work — uncertain about what behaviors or words might put me at risk

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have modified my clinical opinions or professional judgment to align with what I believe leadership wants to hear

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I avoid raising concerns about policy, clinical practice, or leadership decisions because of potential retaliation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I experience anxiety on Sunday evenings or before the start of a work week related specifically to workplace conditions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have witnessed colleagues terminated in ways that seemed unjust, arbitrary, or disproportionate to what they observed of that colleague's work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I do not feel that I can be fully honest with my supervisor about my clinical challenges or professional struggles

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

The fear of losing my job influences my clinical decision-making in ways I am not always comfortable with

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My supervision sessions are scheduled consistently and rarely cancelled or cut short

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My supervisor reviews actual clinical work — case notes, treatment plans, recordings, or live observation — rather than only discussing caseload logistics

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My supervisor creates a space where I can bring clinical failures, client crises, and professional uncertainty without fear of evaluation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I receive specific, evidence-based feedback that improves my clinical skills rather than only administrative direction

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My supervisor is clinically trained and qualified to provide supervision in substance use disorder treatment specifically

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

The emotional and psychological impact of working with this population is addressed in supervision

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have a clear understanding of my performance expectations and what success looks like in my role

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My professional development — training, continuing education, advancement — is actively supported by my organization

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I feel safe to raise concerns about client safety or clinical quality without fear of personal consequences

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When I disagree with a clinical or administrative decision, I have a legitimate and effective way to express that disagreement

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My professional opinion is sought and genuinely considered by leadership in decisions that affect clinical practice

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have witnessed colleagues punished — formally or informally — for speaking up about workplace problems

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

The culture of my organization allows for honest dialogue about what is not working

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I believe leadership is genuinely interested in staff wellbeing rather than primarily interested in compliance and output

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I feel valued by my organization as a professional, not merely as a functionary filling a required role

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I would be comfortable telling my supervisor the full truth about a difficult clinical situation or a personal struggle affecting my work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I experience emotional exhaustion at work that does not fully resolve with rest or time away

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have noticed a reduction in my empathy or compassion for clients that concerns me

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I find myself dreading client sessions or interaction that I previously found meaningful

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I carry clients' trauma stories, crises, and suffering home with me in ways that affect my personal life

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My organization has a formal, structured program for addressing staff burnout and secondary traumatic stress

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I feel that I have adequate support to process the emotional weight of this work

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am experiencing or have experienced depersonalization — relating to clients in a detached, mechanical way

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am seriously considering leaving the SUD treatment field within the next two years, at least in part because of workplace conditions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My organization provides consistent, quality training and professional development beyond the minimum required

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My compensation is fair relative to the demands, expertise, and emotional labor required by my role

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When I make a mistake or face a clinical challenge, the first response from leadership is support and learning rather than discipline

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Staff retention and turnover are treated as organizational indicators that leadership takes seriously

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

My agency has clear, written, and consistently applied policies for performance management so I know where I stand

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

Leadership models the values — self-care, honest communication, psychological safety — they ask of staff

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I feel that my organization genuinely understands the difficulty of this work and structures accordingly

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I believe my organization views staff wellbeing as directly connected to client outcomes — not as a separate concern

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

1. Which domain reflects your greatest area of workplace distress right now? What is producing it?

Your honest reflection...

2. Which domain reflects something your organization is actually doing reasonably well?

Your honest reflection...

3. Were there specific items in the Workplace Fear category that you rated high and that concern you?

Your honest reflection...

4. Were there items in Clinical Supervision or Organizational Investment that you rated low?

Your honest reflection...

5. Looking at the full picture: what does this assessment tell you about the gap between what you are receiving and what you need?

Your honest reflection...

Scoring guide

Reset all progress? This cannot be undone.

Your Workplace Wellbeing Profile

Higher scores in Workplace Fear reflect significant environmental risk. Lower scores in Clinical Supervision and Organizational Investment reflect gaps in what your employer owes you as a professional. This profile is designed to support honest self-assessment and advocacy — not to

produce shame or resignation.

Part 8 · Exercise 1: My Workplace Fear Inventory

My Workplace Fear Inventory

Naming the Fear That No One Officially Acknowledges

Why This Matters Clinically

A clinician operating under chronic workplace fear is not simply uncomfortable — their nervous system is chronically in threat-detection mode. Naming workplace fear specifically and honestly is the beginning of addressing it.

The pervasive sense that your position is not secure regardless of performance — that decisions about your employment may be made for reasons outside your control or visibility.

Rate the intensity of this fear for you right now (1 = not present, 10 = constantly active):

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

110

1. How often does fear of termination enter your thinking at work or outside of work?

Be honest about what you are actually experiencing...

2. Can you identify specific incidents or patterns that produced or sustain this fear?

Be honest about what you are actually experiencing...

3. How does this fear change your behavior at work — what do you do differently because of it?

Be honest about what you are actually experiencing...

4. Is this fear based on direct experience, witnessed experience with colleagues, or a general organizational climate?

Be honest about what you are actually experiencing...

The suppression of clinical concerns, policy questions, or quality issues because raising them feels professionally risky.

Rate the intensity of this fear for you right now (1 = not present, 10 = constantly active):

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

110

1. Have you ever had a legitimate clinical or professional concern that you chose not to raise because of fear of the response?

Be honest about what you are actually experiencing...

2. What specifically do you fear would happen if you raised concerns honestly?

Be honest about what you are actually experiencing...

3. How has the silence of not speaking up affected you professionally and personally?

Be honest about what you are actually experiencing...

Anxiety about how your clinical work, decisions, and documentation are being evaluated — not as healthy accountability but as threat.

Rate the intensity of this fear for you right now (1 = not present, 10 = constantly active):

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

110

1. When you are evaluated, does your primary response feel like an opportunity for growth or a test you might fail?

Be honest about what you are actually experiencing...

2. Does fear of evaluation affect how you document — do you write to protect yourself rather than to serve the client record?

Be honest about what you are actually experiencing...

3. Are the standards against which your work is evaluated clear, specific, and communicated in advance?

Be honest about what you are actually experiencing...

Concern about non-formal consequences of authentic behavior — being excluded, marginalized, assigned difficult caseloads, or targeted through indirect means.

Rate the intensity of this fear for you right now (1 = not present, 10 = constantly active):

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

110

1. Have you witnessed colleagues experience informal retaliation after raising concerns or drawing leadership attention?

Be honest about what you are actually experiencing...

2. Do you engage in self-protective behaviors that go beyond ordinary professional judgment?

Be honest about what you are actually experiencing...

3. What is the cumulative psychological cost of sustained self-protective vigilance in your work environment?

Be honest about what you are actually experiencing...

1. Which of the four fear types is most active and most costly in your professional life right now?

With clarity and self-respect...

2. Is the fear you are experiencing proportionate to the actual risk in your environment, or has it become self-amplifying?

With clarity and self-respect...

3. Who, if anyone, knows about the fear you are carrying?

With clarity and self-respect...

4. What would it mean for your clinical work and your personal wellbeing if you could address the root cause of this fear?

With clarity and self-respect...

5. Write a brief statement of what you deserve as a professional: the working conditions that would allow you to do your best clinical work.

With clarity and self-respect...

Part 9 · Exercise 2: Leadership Impact Assessment — What It Costs to Work Here

Leadership Impact Assessment

What It Actually Costs to Work Here

This Is a Professional Assessment, Not a Complaint

Assessing leadership impact is not an act of disloyalty. It is a professional act of self-clarity that allows you to distinguish between what is your responsibility to address and what is the organization's responsibility to provide. Confusing them is how good clinicians burn out in silence.

Rate this domain in your current organization (1 = absent/poor, 10 = strong/consistent):

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

110

1. What are your performance expectations, and how were they communicated to you?

Be specific and honest...

2. Can you predict, based on communicated criteria, whether your performance would be rated as successful right now?

Be specific and honest...

3. Have you ever been surprised by a negative evaluation for behavior that was not previously identified as problematic?

Be specific and honest...

Rate this domain in your current organization (1 = absent/poor, 10 = strong/consistent):

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

110

1. How consistent is your leadership — are the same standards applied to all staff?

Be specific and honest...

2. Name a specific instance when leadership behavior was inconsistent with stated organizational values.

Be specific and honest...

3. How predictable is your supervisor — can you reliably know how they will respond in different situations?

Be specific and honest...

Rate this domain in your current organization (1 = absent/poor, 10 = strong/consistent):

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

110

1. How does your organization communicate significant changes and is that communication adequate and honest?

Be specific and honest...

2. Are there significant organizational matters that you know are happening but are not being communicated to staff?

Be specific and honest...

3. Do you have access to your supervisor in ways that are adequate for the clinical complexity of your role?

Be specific and honest...

Rate this domain in your current organization (1 = absent/poor, 10 = strong/consistent):

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

110

1. Describe the professional development you have received in the last twelve months.

Be specific and honest...

2. Does your supervisor actively support your professional growth?

Be specific and honest...

3. Is there a clear career pathway for you in this organization?

Be specific and honest...

Rate this domain in your current organization (1 = absent/poor, 10 = strong/consistent):

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

110

1. When did your organization last communicate that your work was valuable through a specific, concrete recognition?

Be specific and honest...

2. Does compensation, workload, and organizational support communicate that your employer understands the difficulty and value of your work?

Be specific and honest...

3. Name one thing your leadership could do that would communicate genuine recognition of your professional worth.

Be specific and honest...

1. What is the single most significant leadership failure that is affecting your professional wellbeing and clinical performance?

With professional clarity and self-respect...

2. What is the cumulative psychological and professional cost of working under these leadership conditions?

With professional clarity and self-respect...

3. Is there any leadership domain where you see genuine strength or recent improvement?

With professional clarity and self-respect...

4. What would the organization need to change in the next 90 days for you to feel meaningfully safer and better supported?

With professional clarity and self-respect...

5. What portion of this cost is the organization's responsibility to address, and what portion is yours?

With professional clarity and self-respect...

Part 10 • Exercise 3: Clinical Supervision Audit — What I Need vs. What I Get

Clinical Supervision Audit

What You Are Getting vs. What You Professionally Need

Clinical Supervision Is a Professional Right, Not a Privilege

Adequate clinical supervision is not a benefit your organization provides because it is generous. It is an ethical requirement for clinical practice. This audit establishes the gap between what you are receiving and what you need so that gap can be named and addressed.

What This Dimension Includes

- Frequency and regularity of supervision sessions
- Adequacy of time allocated per session
- Whether sessions are consistently held or frequently cancelled/rescheduled
- Whether the physical or virtual space provides adequate privacy and focus

Rate the quality of your current supervision in this dimension (1 = absent, 10 = exemplary):

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

110

1. How consistently is your supervision provided — in practice, not in policy?

Assess honestly against professional standards...

2. Is the time provided adequate for both administrative and clinical content, or is it always rushed?

Assess honestly against professional standards...

What This Dimension Includes

- Review of actual clinical work (recordings, notes, process recordings, live observation)
- Discussion of specific client cases with clinical depth
- Skill development and evidence-based practice guidance
- Discussion of clinical challenges, uncertainties, and failures

Rate the quality of your current supervision in this dimension (1 = absent, 10 = exemplary):

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

110

1. In your last five supervision sessions, how much time was spent on administrative tasks vs. genuine clinical content?

Assess honestly against professional standards...

2. Has your supervisor ever reviewed your actual clinical work — a recording, a session, a detailed process recording?

Assess honestly against professional standards...

What This Dimension Includes

- Explicit attention to the emotional impact of case material on the clinician
- Space to discuss burnout, compassion fatigue, and secondary traumatic stress
- Discussion of countertransference and parallel process
- Supervisor's awareness of their supervisee's overall professional wellbeing

Rate the quality of your current supervision in this dimension (1 = absent, 10 = exemplary):

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

110

1. Has your supervisor ever explicitly asked about how this work is affecting you emotionally?

Assess honestly against professional standards...

2. Do you feel that you could bring a client who is triggering your own material to supervision and have it processed safely?

Assess honestly against professional standards...

What This Dimension Includes

- Training in clinical supervision methodology
- Familiarity with SUD-specific clinical models and populations
- Understanding of trauma-informed practice and secondary traumatic stress
- Skill in feedback delivery, developmental support, parallel process awareness

Rate the quality of your current supervision in this dimension (1 = absent, 10 = exemplary):

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

110

1. Does your supervisor have specific training in supervision methodology, or are they supervising based on accumulated clinical experience alone?

Assess honestly against professional standards...

2. Does your supervisor's clinical knowledge actually apply to the population and setting in which you work?

Assess honestly against professional standards...

What This Dimension Includes

- Ability to bring clinical failures without fear that disclosure will be used evaluatively
- Ability to disagree with supervisory direction without relationship damage
- Experience of supervision as primarily developmental rather than primarily evaluative
- Trust that what is disclosed in supervision stays in supervision

Rate the quality of your current supervision in this dimension (1 = absent, 10 = exemplary):

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

110

1. On a scale of 1-10, how safe do you feel bringing a genuine clinical failure to supervision?

Assess honestly against professional standards...

2. Has supervision ever felt like an interrogation or a performance review rather than a protected developmental space?

Assess honestly against professional standards...

1I need supervision to provide: (describe the specific content and focus you require)

Speak as a professional who knows what they need...

2I need my supervisor to have: (describe the qualifications, training, and skills required)

Speak as a professional who knows what they need...

3I need supervision to feel: (describe the emotional climate — safe, developmental, honest, respectful)

Speak as a professional who knows what they need...

4I need supervision to happen: (describe the frequency, duration, and consistency required)

Speak as a professional who knows what they need...

5. The single most important change to my current supervision that would improve my wellbeing and clinical quality is:

Speak as a professional who knows what they need...

6I will request this change by: (name the action, the person, and the timeline)

Speak as a professional who knows what they need...

Part 11 · Exercise 4: Psychological Safety Scale — Can I Tell the Truth Here?

Psychological Safety Scale

Can I Tell the Full Truth Here — and What Happens If I Do?

Psychological Safety: A Research Definition

Psychological safety, as defined by Harvard researcher Amy Edmondson, is 'a shared belief held by members of a team that the team is safe for interpersonal risk-taking.' High-performing teams are high-accountability AND psychologically safe — accountability without safety produces silence; safety without accountability produces complacency.

Rate your safety to raise legitimate clinical or organizational concerns (1 = completely unsafe, 10 = fully safe):

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

110

1. Describe the most significant legitimate concern you have not raised because it felt unsafe to do so. What was the concern, what prevented you, and what was the cost?

Be as specific as the question requires. Safety is built through honest naming.

Rate your safety to bring a clinical failure to supervision or leadership (1 = completely unsafe, 10 = fully safe):

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

110

1. Describe how clinical mistakes are typically handled in your organization — is the first response learning and support, or discipline and documentation?

Be as specific as the question requires. Safety is built through honest naming.

Rate your safety to respectfully disagree with a supervisory or leadership decision (1 = completely unsafe, 10 = fully safe):

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

110

1. Describe a situation where you disagreed with a clinical or administrative decision but did not raise the disagreement. What happened, and what was the cost?

Be as specific as the question requires. Safety is built through honest naming.

Rate your safety to be your genuine professional self at work (1 = must perform constantly, 10 = fully authentic):

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

110

1. How much of your professional energy goes toward managing the impression you make on leadership versus actually doing excellent clinical work?

Be as specific as the question requires. Safety is built through honest naming.

Rate your safety to acknowledge difficulty, uncertainty, or personal struggle to your supervisor (1 = completely unsafe, 10 = fully safe):

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

110

1. Have you ever been going through something personally or professionally that was affecting your work, and you did not feel able to be honest about it with your supervisor?

Be as specific as the question requires. Safety is built through honest naming.

1. What is the overall psychological safety level in your workplace, and what is producing it?

With clinical and organizational clarity...

2. What specific leadership behaviors or organizational practices most undermine psychological safety?

With clinical and organizational clarity...

3. Have you ever experienced high psychological safety at work? What was different about that environment?

With clinical and organizational clarity...

4. What is one thing within your influence that could increase psychological safety in your immediate team?

With clinical and organizational clarity...

5. Amy Edmondson's research shows teams with high psychological safety perform better. What is the cost to your clients of the current safety level?

With clinical and organizational clarity...

Part 12 · Exercise 5: Processing Witness Losses — When Colleagues Disappear

Processing Witness Losses

When Colleagues Disappear and No One Talks About It

Disenfranchised Grief in the Workplace

Grief researchers use the term 'disenfranchised grief' for losses that are not socially recognized or supported. The loss of a valued colleague through organizational mismanagement is often exactly this kind of grief: real, impactful, and entirely unacknowledged by the institution that caused it.

Who was this person — what was your professional relationship, and what did they bring to the team and to clients?

Give this loss the honest attention it deserves...

Describe the circumstances of their departure — as you understood them at the time and as you understand them now. What was communicated? What was left unsaid?

Give this loss the honest attention it deserves...

What did you feel when this person left — what was the emotional experience that may not have been fully acknowledged?

Give this loss the honest attention it deserves...

How did this departure change your behavior at work — what self-protective adjustments did you make?

Give this loss the honest attention it deserves...

What do you wish your organization had done differently — what communication, process, or acknowledgment would have helped?

Give this loss the honest attention it deserves...

Who was this person — what was your professional relationship, and what did they bring to the team and to clients?

Give this loss the honest attention it deserves...

Describe the circumstances of their departure — as you understood them at the time and as you understand them now. What was communicated? What was left unsaid?

Give this loss the honest attention it deserves...

What did you feel when this person left — what was the emotional experience that may not have been fully acknowledged?

Give this loss the honest attention it deserves...

How did this departure change your behavior at work — what self-protective adjustments did you make?

Give this loss the honest attention it deserves...

What do you wish your organization had done differently — what communication, process, or acknowledgment would have helped?

Give this loss the honest attention it deserves...

Who was this person — what was your professional relationship, and what did they bring to the team and to clients?

Give this loss the honest attention it deserves...

Describe the circumstances of their departure — as you understood them at the time and as you understand them now. What was communicated? What was left unsaid?

Give this loss the honest attention it deserves...

What did you feel when this person left — what was the emotional experience that may not have been fully acknowledged?

Give this loss the honest attention it deserves...

How did this departure change your behavior at work — what self-protective adjustments did you make?

Give this loss the honest attention it deserves...

What do you wish your organization had done differently — what communication, process, or acknowledgment would have helped?

Give this loss the honest attention it deserves...

1. Looking across the colleague departures you have witnessed: is there a pattern? What does it tell you about the organizational culture?

Name the pattern and its cost honestly...

2. What has the cumulative experience of these losses done to your trust in the organization?

Name the pattern and its cost honestly...

3. Has the impact of these losses ever been formally acknowledged by leadership or addressed in supervision?

Name the pattern and its cost honestly...

4. What would you want a leader who genuinely cared about staff experience to know about how colleague departures affect the people who stay?

Name the pattern and its cost honestly...

5. Write a brief statement of what you need from your organization to process and move forward from these losses.

Name the pattern and its cost honestly...

Part 13 • Exercise 6: My Burnout & Compassion Fatigue Profile

My Burnout & Compassion Fatigue Profile

An Honest Professional Self-Assessment

This Is an Occupational Hazard, Not a Personal Failure

Burnout and compassion fatigue are predictable occupational outcomes of sustained high-demand empathic work in under-resourced, poorly supervised, or organizationally chaotic settings. Acknowledging them is not weakness. It is the prerequisite for addressing them.

The progressive depletion of emotional resources that results from sustained high-demand empathic work without adequate restoration.

Common Indicators

- Arriving at work already depleted
- Feeling emotionally empty by midday
- Difficulty accessing genuine empathy for client situations
- Profound fatigue that sleep does not fully resolve
- Dreading client contact that was previously meaningful

Rate the current intensity of this domain for you (1 = not present, 10 = significantly active):

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

110

Describe specifically how this is present for you right now:

Be honest about what you are actually experiencing...

What organizational conditions are contributing to this?

Distinguish between what is the organization's responsibility and what is yours...

The development of emotional distance and mechanical responses to clients as a psychological self-protective adaptation to chronic stress.

Common Indicators

- Thinking about clients in clinical labels rather than as people
- Cynicism about clients' capacity for change
- Irritability or impatience with clients
- Going through clinical motions without genuine therapeutic presence
- Secretly relieved when clients cancel appointments

Rate the current intensity of this domain for you (1 = not present, 10 = significantly active):

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

110

Describe specifically how this is present for you right now:

Be honest about what you are actually experiencing...

What organizational conditions are contributing to this?

Distinguish between what is the organization's responsibility and what is yours...

The intrusion of clients' traumatic material into the clinician's own psychological experience — nightmares, intrusive thoughts, hyperarousal, and avoidance.

Common Indicators

- Intrusive thoughts about a client's trauma material
- Difficulty separating clients' experiences from your own emotional state
- Nightmares or sleep disturbance connected to case material
- Hypervigilance or safety anxiety activated by case exposure
- Physical symptoms following exposure to specific material

Rate the current intensity of this domain for you (1 = not present, 10 = significantly active):

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

110

Describe specifically how this is present for you right now:

Be honest about what you are actually experiencing...

What organizational conditions are contributing to this?

Distinguish between what is the organization's responsibility and what is yours...

The progressive erosion of confidence in one's clinical effectiveness and professional worth.

Common Indicators

- Questioning whether your work makes any real difference
- Reduced pride or satisfaction in clinical successes
- Difficulty articulating your clinical identity or strengths
- Feeling that you are going through motions rather than practicing clinically
- Considering leaving the field entirely

Rate the current intensity of this domain for you (1 = not present, 10 = significantly active):

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

110

Describe specifically how this is present for you right now:

Be honest about what you are actually experiencing...

What organizational conditions are contributing to this?

Distinguish between what is the organization's responsibility and what is yours...

1. Which of the four domains is most active and most urgent for you right now?

With honesty and self-compassion...

2. What is your organization currently providing to address burnout and secondary traumatic stress?

With honesty and self-compassion...

3. What do you need from your organization that you are not currently receiving?

With honesty and self-compassion...

4. What is within your own control to address right now?

With honesty and self-compassion...

5. What is one concrete action you will take in the next seven days to begin addressing your most significant burnout indicator?

With honesty and self-compassion...

6. Who will you tell about where you actually are — not the managed version but the real one?

With honesty and self-compassion...

Part 14 · Exercise 7: What Good Looks Like — Designing the Workplace I Need

What Good Looks Like

Designing the Workplace That Would Allow Me to Do My Best Clinical Work

Clarity About What You Need Is Not Entitlement — It Is Professional Self-Knowledge

You cannot advocate for what you cannot articulate. This exercise asks you to design — without immediately qualifying it with what seems realistic — the workplace conditions that would allow you to practice at your best.

Describe your ideal supervision experience in concrete, specific terms. Who is your supervisor? What are their qualifications? What does each session include? How do you feel in the room?

Your ideal (without filtering for what seems realistic):

Describe what good looks like without qualification.

Gap assessment — where does your current organization stand (1 = nowhere near it, 10 = largely achieving it)?

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

110

Describe the leadership behavior that would allow you to do your best work. What does your supervisor communicate, when, and how? What happens when you make a mistake? What does recognition look like?

Your ideal (without filtering for what seems realistic):

Describe what good looks like without qualification.

Gap assessment — where does your current organization stand (1 = nowhere near it, 10 = largely achieving it)?

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

110

What does the culture feel like when you arrive at work? What are staff relationships like? What happens when someone is struggling — clinically or personally?

Your ideal (without filtering for what seems realistic):

Describe what good looks like without qualification.

Gap assessment — where does your current organization stand (1 = nowhere near it, 10 = largely achieving it)?

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

110

What training, education, mentorship, and career development does your ideal organization provide?

Your ideal (without filtering for what seems realistic):

Describe what good looks like without qualification.

Gap assessment — where does your current organization stand (1 = nowhere near it, 10 = largely achieving it)?

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

110

What does your ideal organization provide specifically for the occupational hazards of this work — burnout prevention, secondary traumatic stress support, peer consultation?

Your ideal (without filtering for what seems realistic):

Describe what good looks like without qualification.

Gap assessment — where does your current organization stand (1 = nowhere near it, 10 = largely achieving it)?

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

110

In your ideal organization, what does it feel like to raise a concern, disagree with a decision, admit a clinical mistake, or acknowledge that you are struggling?

Your ideal (without filtering for what seems realistic):

Describe what good looks like without qualification.

Gap assessment — where does your current organization stand (1 = nowhere near it, 10 = largely achieving it)?

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

110

1. Looking across your six ideal domains: which gap is the most urgent?

From vision to specific, actionable priority...

2. Which gap is most likely within the range of your influence to address?

From vision to specific, actionable priority...

3. What would a realistic 90-day improvement in your most critical gap look like?

From vision to specific, actionable priority...

4. Write your ideal workplace statement: the clear, professional articulation of what you need to do your best clinical work.

From vision to specific, actionable priority...

Part 15 · Exercise 8: The Brave Conversation — What I Would Say If It Were Safe

The Brave Conversation

What I Would Say If It Were Fully Safe to Tell the Truth

Writing It First

Brave conversations are easier when you have drafted them first — when you have practiced the language, found the specific words, and discovered what you most need to say. This exercise does not require you to have the conversation. It asks you to prepare it.

Write what you would say to your direct supervisor if you were fully confident that doing so would not harm your employment. Include what you appreciate, what you need, and what you would ask them to do differently.

What I appreciate genuinely about you and our working relationship:

Write with the honesty that the conversation deserves...

What I need from you that I am currently not receiving:

Write with the honesty that the conversation deserves...

What I have not been able to tell you because I was not sure it was safe:

Write with the honesty that the conversation deserves...

What I would ask you to do specifically and differently:

Write with the honesty that the conversation deserves...

Write what you would say to your organization's senior leadership if you could speak with full professional confidence, without fear of consequences.

What the clinical staff are experiencing that leadership may not fully know:

Write with the honesty that the conversation deserves...

What the current organizational culture costs — in clinical quality, in staff wellbeing, in client outcomes:

Write with the honesty that the conversation deserves...

What I most need from you as an organization to do my best clinical work:

Write with the honesty that the conversation deserves...

What you could change in the next 90 days that would make the most difference:

Write with the honesty that the conversation deserves...

Write what you would say to a colleague you believe is experiencing the same fear, burnout, or unsupported struggle you have identified in yourself.

What I see in you that I recognize from my own experience:

Write with the honesty that the conversation deserves...

What I wish someone had said to me earlier that I want to say to you now:

Write with the honesty that the conversation deserves...

What I think we both deserve from this organization that we are not currently asking for:

Write with the honesty that the conversation deserves...

What I am willing to do alongside you to address it:

Write with the honesty that the conversation deserves...

Write what you most need to say to yourself — the honest professional self-assessment, the acknowledgment of what you are carrying, and the commitment to address it.

The honest truth about where I currently am professionally and personally:

Write with the honesty that the conversation deserves...

What I have been tolerating or minimizing that deserves a more direct response:

Write with the honesty that the conversation deserves...

What I owe myself as a professional human being doing this demanding work:

Write with the honesty that the conversation deserves...

What I will commit to doing differently, starting now:

Write with the honesty that the conversation deserves...

1. Which of the four conversations is most needed right now?

From preparation to the next right action...

2. What would it take for you to actually have it? What is the minimum safety condition required?

From preparation to the next right action...

3. Write a specific action step: "By ____ (date), I will ____ (specific action) with ____ (specific person), and I will prepare by ____."

From preparation to the next right action...

4. If the full conversation is not yet safe, what is the smallest honest step you could take?

From preparation to the next right action...

Part 16 · Exercise 9: My Professional Resilience & Self-Protection Plan

My Professional Resilience & Self-Protection Plan

What I Can Build and Protect Independent of What the Organization Provides

Resilience Is Not Tolerance of Poor Conditions

This exercise asks what you can build and maintain regardless of organizational conditions — not because poor conditions are acceptable, but because waiting for the organization to change before taking care of yourself serves no one. Resilience planning and advocacy for better conditions are both necessary, and they support each other.

The structures that protect the self from the cumulative impact of high-demand clinical work — not emotional distance from clients but clear delineation between work and non-work self.

1. Describe your current approach to ending the workday — what practices, rituals, or transitions mark the boundary between clinical role and personal self?

Be honest about what you have, what you need, and what you will build...

2. Where are your professional boundaries most porous — where does the work follow you home in ways that compromise your restoration?

Be honest about what you have, what you need, and what you will build...

3. What one specific boundary, if established and maintained, would most protect your professional resilience?

Be honest about what you have, what you need, and what you will build...

The sustaining power of genuine connection with colleagues who understand the specific demands of this work — not complaint sessions but honest mutual support.

1. Do you have at least one colleague with whom you have an honest, mutual professional relationship?

Be honest about what you have, what you need, and what you will build...

2. Is peer consultation available and used in your organization?

Be honest about what you have, what you need, and what you will build...

3. What would a peer support structure look like in your setting that would genuinely sustain clinical staff?

Be honest about what you have, what you need, and what you will build...

The regular, intentional renewal of connection to why this work matters.

1. When did you last feel genuinely meaningful in your clinical work?

Be honest about what you have, what you need, and what you will build...

2. What brought you to this field originally? Is that motivation still accessible, or has organizational experience eroded it?

Be honest about what you have, what you need, and what you will build...

3. What practice, ritual, or structure could help you regularly reconnect with purpose?

Be honest about what you have, what you need, and what you will build...

Professional resources outside your immediate employment context — associations, external consultation, personal therapy, and peer networks.

1. What external professional support do you currently have — personal therapy, external supervision, professional community membership?

Be honest about what you have, what you need, and what you will build...

2. Is there an external consultant, supervisor, or mentor who could provide the developmental relationship your internal supervision is not providing?

Be honest about what you have, what you need, and what you will build...

3. What professional community do you belong to or could you develop that would sustain you independent of your current employer?

Be honest about what you have, what you need, and what you will build...

Identify one specific, concrete action in each category that you will begin in the next 30 days.

Boundary I will establish:

Name the specific action, the timeline, and what will tell you it's working...

Peer connection I will build or deepen:

Name the specific action, the timeline, and what will tell you it's working...

Meaning practice I will begin or restore:

Name the specific action, the timeline, and what will tell you it's working...

External support I will access:

Name the specific action, the timeline, and what will tell you it's working...

Person I will tell about this plan and ask to check in with me:

Name the specific action, the timeline, and what will tell you it's working...

Part 17 · Exercise 10: Advocacy & Leadership — Recommendations for Systemic Change

Advocacy & Systemic Change

Recommendations for Building a Workplace Where Clinical Staff Can Succeed

15 Evidence-Based Organizational Recommendations

Domain 1: Leadership Practice

R1

Train Leaders to Lead — Not Just to Practice Clinically

Promote to supervisory roles only with concurrent management training covering: performance management, difficult conversations, power and authority in supervision, adult learning theory, and organizational culture development.

R2

Written, Communicated, Advance Performance Standards

Every clinical staff member must have written performance expectations before they are evaluated against them. Standards must be communicated at onboarding, reviewed quarterly, and updated through collaborative dialogue.

R3

Mandatory Progressive Performance Management

Except for ethical violations or client safety issues, termination must be preceded by documented verbal coaching, written performance improvement planning with specific goals, and honest ongoing assessment shared with the employee.

R4

Leadership Behavioral Accountability — Walk the Talk

Leaders must be evaluated against the organizational culture they claim to want. If psychological safety is an organizational value, leaders must demonstrate it behaviorally — responding non-defensively to honest feedback and communicating transparently.

Domain 2: Clinical Supervision Structure

R5

Minimum Frequency Standards: Weekly in High-Acuity Settings

Individual clinical supervision must be provided at minimum biweekly for outpatient staff and weekly for staff working with high-acuity populations. Sessions must be scheduled, protected, rarely cancelled, and of adequate duration.

R6

Train Supervisors in Supervision Methodology

Clinical supervisors must complete a recognized supervisor training program covering supervision models, parallel process, countertransference, and the specific ethical and clinical demands of SUD treatment supervision.

R7**Actual Clinical Work Must Be Reviewed**

Supervision based entirely on verbal case report is inadequate. Every clinician's actual clinical work must be reviewed by their supervisor at regular intervals. Live or recorded observation of sessions must be part of the supervisory structure.

R8**Group Supervision, Peer Consultation & Case Conference**

Structured peer consultation and team case conferences must supplement individual supervision. They must be structured, facilitated, and protected — not left to informal emergence.

Domain 3: Organizational Culture**R9****Formally Assess and Monitor Psychological Safety**

Team psychological safety must be measured using validated tools at minimum annually, with results reviewed transparently with staff and acted upon visibly. Safety measurement not followed by action communicates that the measurement is performative.

R10**Transparent Communication Around Staff Departures**

When staff members leave, the remaining team deserves honest, privacy-respecting communication that acknowledges the departure's impact. Organizational silence following departures produces fear and speculation more damaging than transparent communication.

R11**Visible, Credible Non-Retaliation Protection**

Staff who raise clinical quality or safety concerns must be protected from formal and informal retaliation. This protection must be visibly demonstrated — not only stated in policy — through organizational responses that make speaking up genuinely safe.

R12**Meaningful Exit Interview Programs**

Exit interviews must be conducted by someone external to the direct supervisory relationship, aggregated into organizational trend reports, and explicitly linked to organizational improvement action.

Domain 4: Staff Wellbeing Infrastructure**R13****Formal Secondary Traumatic Stress & Burnout Prevention Program**

A structured organizational program — not a list of EAP resources — for secondary traumatic stress and burnout prevention must be built into clinical staff support, including regular group processing structures and explicit organizational permission to acknowledge difficulty.

R14**Active Staff Recognition, Development & Career Pathways**

Professional development investment, specific behavioral recognition, and visible career pathway structures must be active leadership functions. Staff retention is directly associated with perceived investment in their development.

R15**Compensation Benchmarking and Regular Adjustment**

Clinical staff compensation must be benchmarked annually against comparable roles in comparable settings and adjusted to remain competitive. Chronic underpayment communicates organizational valuing of staff more powerfully than any stated value.

You cannot advocate effectively for all 15 recommendations simultaneously. Identify the three that are most urgently needed and most within range of your influence.

Priority 1

The recommendation (by number and title):

Be specific. Vague advocacy produces vague results.

Why this is most urgent — the specific evidence of its absence and cost:

Be specific. Vague advocacy produces vague results.

Who has the authority to address this, and what is your entry point?

Be specific. Vague advocacy produces vague results.

What you will say, to whom, and by when:

Be specific. Vague advocacy produces vague results.

Priority 2

The recommendation (by number and title):

Be specific. Vague advocacy produces vague results.

Why this is most urgent — the specific evidence of its absence and cost:

Be specific. Vague advocacy produces vague results.

Who has the authority to address this, and what is your entry point?

Be specific. Vague advocacy produces vague results.

What you will say, to whom, and by when:

Be specific. Vague advocacy produces vague results.

Priority 3

The recommendation (by number and title):

Be specific. Vague advocacy produces vague results.

Why this is most urgent — the specific evidence of its absence and cost:

Be specific. Vague advocacy produces vague results.

Who has the authority to address this, and what is your entry point?

Be specific. Vague advocacy produces vague results.

What you will say, to whom, and by when:

Be specific. Vague advocacy produces vague results.

If You Are a Leader or Supervisor: Your Direct Responsibilities

1. Looking at the 15 recommendations: which are you currently providing with genuine fidelity?

What evidence would staff give for that assessment?

With the honesty that leadership self-assessment requires...

2. Which recommendations are you not providing — and what story are you telling yourself about why?

With the honesty that leadership self-assessment requires...

3. Have you ever terminated or significantly disciplined a staff member without prior written performance documentation and a genuine opportunity to improve?

With the honesty that leadership self-assessment requires...

4. When a staff member raised a concern about clinical quality or organizational practice, what happened? Would they tell the same story you would tell?

With the honesty that leadership self-assessment requires...

5. What is the most important thing you could do in the next 30 days that would meaningfully change the psychological safety experience of the staff who report to you?

With the honesty that leadership self-assessment requires...

6. Who holds you accountable for your leadership behavior — not your output metrics but your cultural impact?

With the honesty that leadership self-assessment requires...

Staff Welfare Is Client Welfare

The person who completes this intensive and does nothing with it has missed its purpose. Whether you are a clinician advocating for yourself, a supervisor committed to building something better, or a leader with the authority to implement structural change — the clients in your agency's care are best served by the version of you that is supported, supervised, psychologically safe, and working in conditions that allow genuine clinical presence.

1. Write your vision for the clinical workplace you are committed to building, creating, or advocating toward — not what exists, but what should exist, and what you specifically will do to close the gap.

Write from your most honest and courageous professional place...

2. What do you commit to doing — specifically, concretely, starting this week — to move your organization one step closer to the 15 recommendations?

Write from your most honest and courageous professional place...

3. Who will you bring this intensive to — a supervisor, a colleague, a leadership team — and what conversation will you initiate?

Write from your most honest and courageous professional place...

4. Write the single most important thing you want any leader who is genuinely committed to their staff to hear.

Write from your most honest and courageous professional place...
