

Building an Inquiry Culture

Intensives Library · Team Culture & Retention

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Part 1 · Overview

Building an Inquiry Culture

Where Asking Questions Is Professional Strength

A Leadership & Team Development Intensive — The Recovery Files

CLOSED

Questions feel risky

→

OPENING

Policy without practice

→

THRIVING

Curiosity drives growth

Reading Sections

Collaborative Problem-Solving: From Isolation to Collective Wisdom

Inquiry Culture Self-Assessment

Worksheets & Practice Labs

Part 2 · What Is Inquiry Culture? Why It Matters in SUD Treatment

What Is Inquiry Culture? Why It Matters in SUD Treatment

Inquiry culture is the organizational environment in which asking questions, seeking help, admitting uncertainty, and pursuing collaborative learning are not just permitted — they are valued, modeled, rewarded, and structurally embedded into how the organization operates.

It is the difference between a workplace that says "our door is always open" and a workplace where people actually walk through that door without fear.

In substance use disorder treatment, inquiry culture is not an abstract organizational concept — it is a clinical survival skill. SUD treatment is among the most complex, rapidly evolving, and emotionally demanding fields in healthcare. Clinicians routinely face situations that require knowledge they don't yet have, skills they haven't fully developed, and judgment calls that have life-or-death consequences.

In this environment, the ability to ask for help — quickly, openly, and without stigma — is not a luxury. It is a clinical necessity.

****Consider the parallel to what we teach our clients.****

We spend enormous energy helping people in recovery understand that asking for help is strength, not weakness. We teach them that isolation is dangerous, that vulnerability is courageous, and that no one recovers alone.

Yet in many treatment organizations, the staff who deliver these messages work in environments where the opposite norms apply to them. Clinicians who admit they don't know something risk being perceived as incompetent. Staff who ask "basic" questions risk being dismissed or judged. Professionals who seek help with a challenging case risk being seen as unable to handle their caseload.

The message our organizations often send — implicitly, through culture rather than policy — is: you should already know this, and asking means you don't.

****This is the inquiry culture problem, and it is pervasive.****

When clinicians are afraid to ask questions, they make decisions in isolation. When they make decisions in isolation, errors increase. When errors increase and there is no safe mechanism for reporting and learning from them, the errors repeat. When errors repeat, clients are harmed.

The chain from poor inquiry culture to client harm is direct, measurable, and preventable.

****Inquiry culture is built on seven interconnected pillars:****

1. ****Open-Door Leadership**** that models curiosity and accessibility
2. ****Collaborative Problem-Solving**** structures that normalize team-based learning
3. ****Mentorship and Peer Support**** systems that celebrate questions

4. **Knowledge-Sharing Platforms** that make information accessible
5. **Curiosity Recognition and Reward** systems that value learning
6. **Psychological Safety and Trust** that protects vulnerability
7. **Innovation and Continuous Improvement** processes that translate inquiry into action

Each pillar reinforces the others. Weakness in any one creates vulnerability in the system.

This intensive is designed for SUD treatment leaders, clinicians, and staff at all levels. Its purpose is not to add another initiative to your already full plate — it is to examine, honestly and specifically, whether the culture you work in supports or suppresses the kind of questioning, learning, and help-seeking that your clients need you to do, that your colleagues deserve, and that excellent treatment demands.

The goal is not perfection. The goal is awareness, honesty, and actionable improvement.

Reflection Questions

1. When you read the phrase "inquiry culture," what is your immediate emotional response? Do you think of your organization as a place where questions are genuinely welcomed, or does the idea feel aspirational rather than actual?

2. We teach clients that asking for help is strength. Do you experience that same principle in your own workplace? Where do you see the parallel working, and where does it break down?

3. Think about the last time you had a clinical question you were unsure about. What did you do? Did you ask someone, search for the answer alone, or move forward without resolving the uncertainty? What influenced your choice?

4. Of the seven pillars described above, which feels strongest in your organization? Which feels weakest? How does that weakness affect clinical practice?

5. If a brand-new clinician started at your organization tomorrow, what would they learn about question-asking within their first two weeks — not from what they are told, but from what they observe?

Part 3 · Open-Door Leadership: Beyond the Policy to the Practice

Open-Door Leadership: Beyond the Policy to the Practice

Almost every treatment organization claims to have an open-door policy. Very few have an open-door culture.

The difference between these two things is the difference between a sign on a wall and a lived organizational experience — and your staff know exactly which one you have.

An open-door **policy** says: "You can come to me with questions."

An open-door **culture** says: "When you come to me with questions, here is what you will experience — genuine attention, non-judgmental response, helpful engagement, and zero professional penalty for not already knowing the answer."

Policy is a statement of intent. Culture is a pattern of behavior. And in the gap between the two, inquiry either thrives or dies.

Leaders who genuinely model open-door accessibility do specific things:

They interrupt their own work when someone approaches with a question — or if they truly cannot, they name a specific time to reconnect rather than offering a vague "come back later."

They respond to questions with curiosity rather than irritation — "That's a great question — let's think about that together" versus "Didn't we cover that in training?"

They publicly normalize their own uncertainty: "I'm not sure about this either — let me find out and get back to you" or "I had to ask about that same thing when I was starting out."

They follow up, demonstrating that the question mattered enough to remember.

And they never — ever — use a staff member's question as evidence of incompetence in a later performance conversation.

The distinction between formal accessibility and genuine psychological safety is critical.

A leader can be physically available — door literally open, office accessible, calendar with open slots — and still be psychologically inaccessible.

Psychological accessibility is communicated through tone, facial expression, body language, patience, and follow-through. A leader who sighs when interrupted, who glances at their phone while listening, who answers with "You should know this by now," or who circles back to the question in a supervisory context as evidence of a deficit — that leader has an open door and a closed culture.

In SUD treatment specifically, open-door leadership carries additional weight because of the parallel process.

If clinicians work in an environment where asking for help feels dangerous, they will unconsciously replicate that dynamic in the treatment room. Clients will sense that their clinician

is performing competence rather than practicing authenticity. The inauthenticity leaks.

Conversely, when clinicians work in an environment where their own learning is genuinely supported, they bring that same generous, curious, patient energy to their clinical relationships.

Leadership accessibility is also modeled across the organizational hierarchy — not just by the clinical director or executive team. Supervisors model it to their supervisees. Senior clinicians model it to newer staff. Experienced peer support specialists model it to those just entering the field.

Inquiry culture is a cascade: it flows from the top, but it also flows laterally and upward.

****The practical question for every leader in SUD treatment is not "Is my door open?"****

It is: "When was the last time someone walked through it with a question that revealed vulnerability — and what did they experience when they did?"

Reflection Questions

1. Honestly assess: does your organization have an open-door policy, an open-door culture, or both? What specific evidence supports your answer?

2. Think about the last time you approached a leader or supervisor with a question. What was their response — verbally and nonverbally? How did that experience affect your willingness to ask again?

3. If you are in a leadership role, recall the last time a staff member came to you with a question. Were you genuinely present, or were you performing accessibility while internally wanting them to figure it out themselves?

4. Consider the parallel process: how does the way leadership treats your questions mirror how you treat your clients' questions? Where do you see the connection?

5. What is one specific, observable behavior change a leader in your organization could make that would transform open-door policy into open-door culture?

Part 4 · Collaborative Problem-Solving: From Isolation to Collective Wisdom

Collaborative Problem-Solving: From Isolation to Collective Wisdom

One of the most dangerous phrases in SUD treatment is: "I've got it — I'll figure it out on my own."

Not because independence is wrong, but because in a field this complex, isolated problem-solving produces inferior clinical decisions, increased burnout, and missed opportunities for the kind of cross-pollination that transforms good treatment into great treatment.

****Collaborative problem-solving**** is the organizational practice of bringing multiple perspectives, knowledge bases, and clinical experiences to bear on challenging situations — systematically and without hierarchy determining whose voice matters most.

It is the structural embodiment of the principle that questions asked in community produce better answers than questions asked in isolation.

In many SUD treatment organizations, case consultation exists — but it exists as a formality rather than a genuine learning structure. Staff present cases, the most senior person in the room offers guidance, and everyone else nods. Questions that challenge the prevailing approach feel risky. Questions that reveal unfamiliarity with a concept or technique feel embarrassing.

The "collaborative" process is actually hierarchical, and everyone in the room knows it.

****Genuine collaborative problem-solving looks fundamentally different.****

It begins with an explicit norm: every perspective in this room has value, and the best clinical decisions emerge when we combine our different lenses rather than deferring to a single authority.

****The most effective collaborative structures include several key practices:****

****First****, they normalize the question as the starting point. Instead of presenting a case with a pre-formed plan and asking for validation, the clinician says: "Here's what I'm seeing, here's where I'm stuck, and here's what I need help thinking through." The request for help is the opening move, not the backup plan.

****Second****, they include cross-functional perspectives. The best solutions to complex clinical challenges often emerge from the intersection of different professional lenses. A counselor sees the therapeutic dynamics; a case manager sees the environmental barriers; a peer support specialist sees the lived-experience parallel; a medical professional sees the biological factors; an administrator sees the systemic constraints.

****Third****, they explicitly protect the question-asker. The person who brings a challenging case to the team — especially one that reveals uncertainty, mistakes, or clinical struggles — is demonstrating professional courage. Collaborative structures must protect that courage.

****Fourth****, they produce actionable outcomes. Collaborative problem-solving that generates interesting discussion but no concrete plan is intellectually stimulating but clinically useless. Effective structures end with specific next steps, assigned responsibilities, and follow-up timelines.

****The organizational payoff is enormous:****

Clinicians make better decisions. Staff feel less isolated and more supported. Knowledge transfers naturally rather than through formal training alone. New clinicians accelerate their competence by learning from collective experience. And clients receive treatment informed by multiple perspectives rather than limited by a single clinician's experience and blind spots.

The barrier to collaborative problem-solving is almost never logistical. It is cultural. The barrier is the belief — sometimes conscious, often not — that asking for help with a clinical challenge means you are not good enough to handle it yourself.

Dismantling that belief is leadership work.

Reflection Questions

1. Describe the case consultation or collaborative problem-solving process in your organization. Is it genuinely collaborative, or does it function as a hierarchical process where the most senior voice dominates?

2. When was the last time you brought a case you were truly struggling with to a team setting? What made that possible — or what prevented it?

3. Think about a clinical decision that went poorly. Would the outcome have been different if multiple perspectives had been engaged? What barriers prevented that collaboration?

4. Which professional perspectives (clinical, peer support, medical, administrative, case management) are systematically included in your problem-solving processes? Which are excluded?

5. What would need to change in your organization for a new clinician to feel safe saying "I don't know what to do with this client" in a team meeting?

Part 5 · Mentorship That Teaches Rather Than Judges

Mentorship That Teaches Rather Than Judges

The mentorship relationship is one of the most powerful vehicles for inquiry culture — and one of the most frequently squandered.

In SUD treatment organizations, mentorship can be the bridge that transforms a new clinician's anxiety about what they don't know into a confident, growth-oriented relationship with their own learning.

Or it can be the mechanism through which the message "you should already know this" is transmitted from one generation of clinicians to the next.

****The difference between mentorship that teaches and mentorship that judges is not about intention**** — most mentors intend to be helpful. It is about behavior, specifically the behaviors that occur in the moments when a mentee reveals vulnerability.

The question "Can you show me how to do a biopsychosocial assessment?" is a moment of professional vulnerability. The mentor's response in that moment — their tone, their facial expression, the words they choose, and the emotional quality of their engagement — will determine whether the mentee asks another question or learns to hide what they don't know.

****Mentorship that teaches does several things consistently:****

****It meets questions with warmth rather than surprise.**** "Of course — let me walk you through how I approach it, and then we can look at one of yours together" communicates something fundamentally different than "You haven't done one of those yet?" — even though both are followed by instruction.

The teaching quality may be identical; the relational quality is completely different. And it is the relational quality — the emotional safety of the learning experience — that determines whether the mentee will return with their next question.

****Teaching-oriented mentorship normalizes the learning curve.**** It says, explicitly and repeatedly: "What you're experiencing right now — the uncertainty, the feeling of being overwhelmed, the cases that make you feel like you're in over your head — that is not evidence that you're failing. That is evidence that you're growing. I felt the same things. Every competent clinician I know felt them."

This normalization is particularly important in SUD treatment, where clinicians are routinely exposed to situations that graduate programs did not prepare them for — complex trauma histories, active psychosis with concurrent use, families in crisis, clients in imminent danger, and ethical dilemmas without clear answers.

****Teaching-oriented mentorship also celebrates the question itself.**** "That's a really important question" is one of the most powerful phrases a mentor can use. It reframes the act of not-knowing from a deficit to a strength. It communicates that the mentee's willingness to ask —

their intellectual courage — is being noticed and valued.

Over time, repeated experiences of having questions celebrated rather than tolerated rewires the mentee's relationship with uncertainty. They become clinicians who are comfortable saying "I need to think about that" or "Let me consult on this" — clinicians whose intellectual humility makes them safer practitioners.

****Peer mentorship is equally important and often overlooked.****

The support that clinicians at similar experience levels can offer each other is qualitatively different from the support offered by senior mentors. Peer mentorship creates a learning community rather than a learning hierarchy.

When two clinicians with three years of experience can sit together and say "I had a session today that really threw me — can I talk through it with you?" — that is inquiry culture operating horizontally, not just vertically.

****The "no question is too small" environment is not created by saying those words.**** It is created by demonstrating them — hundreds of times, in hundreds of small moments, until the experience of asking a question and being met with generous, non-judgmental engagement becomes the expected norm rather than the hoped-for exception.

For treatment organizations, the practical imperative is clear: mentorship structures must be intentionally designed, not left to chance. Mentor-mentee pairs should be thoughtfully matched. Mentors should receive training not just in clinical content but in how to create psychologically safe learning relationships.

And the organizational culture must consistently reinforce that mentoring is not a burden — it is one of the most important clinical contributions a senior staff member can make.

Reflection Questions

1. Think about the best mentor you have ever had — in any field, not just SUD treatment. What specific behaviors made that relationship a safe space for your questions?

2. If you serve as a mentor, honestly assess: how do you respond when a mentee asks something you think they should already know? What do they experience in that moment?

3. Does your organization have formal mentorship structures, informal mentorship, or neither? What is the impact of that structure (or lack thereof) on new clinicians' development?

4. When was the last time a peer — someone at your level — came to you for help with a clinical challenge? When was the last time you went to a peer? What does the frequency of these exchanges tell you about your peer support culture?

5. Write the three things you would want every new clinician at your organization to hear from their mentor in the first week about question-asking, help-seeking, and uncertainty.

Part 6 · Psychological Safety: The Foundation Beneath Everything

Psychological Safety: The Foundation Beneath Everything

Every pillar of inquiry culture rests on a single foundation: psychological safety.

Without it, open doors feel like traps. Collaboration feels like surveillance. Mentorship feels like evaluation. Knowledge-sharing feels like exposure. And the entire inquiry structure — no matter how well-designed — collapses under the weight of fear.

****Psychological safety****, as defined by Harvard researcher Amy Edmondson, is the shared belief that the team is safe for interpersonal risk-taking.

In practical terms, it means staff believe they can ask questions, admit mistakes, raise concerns, and offer ideas without experiencing punishment, humiliation, or marginalization.

It does not mean an absence of accountability. It means an environment where accountability and learning coexist — where "we need to understand what happened" and "we need to prevent this from happening again" replace "whose fault is this?"

****In SUD treatment specifically, psychological safety has clinical implications that go beyond organizational health.****

When clinicians do not feel safe admitting uncertainty, they make clinical decisions in isolation — decisions about medication interactions, crisis interventions, discharge timing, and treatment intensity that directly affect client safety.

When clinicians do not feel safe reporting near-misses or errors, the organization loses the feedback loop that prevents recurrence.

When clinicians do not feel safe challenging a clinical approach or organizational decision, groupthink replaces critical thinking — and groupthink in a treatment setting can be literally dangerous.

****The research on psychological safety in healthcare is unequivocal:**** teams with higher psychological safety have lower error rates, better patient outcomes, higher staff retention, and more effective innovation.

The mechanism is straightforward — when people feel safe to speak up, the collective intelligence of the team is activated. When people feel unsafe, they self-censor, and the team operates on partial information.

****There are specific leadership behaviors that build psychological safety, and specific behaviors that destroy it.****

****Safety-building behaviors include:****

- Responding to mistakes with curiosity rather than blame ("Help me understand what happened so we can learn from it")

- Explicitly inviting dissent ("What am I missing? Who sees this differently?")
- Acknowledging your own fallibility ("I made an error on this — here's what I learned")
- Following through on commitments to learning ("Remember when we talked about changing that process? Here's the update")
- Protecting people who take interpersonal risks (defending a staff member who raised an uncomfortable question in a meeting)
- Separating the person from the error (addressing the system failure rather than attacking individual character)

****Safety-destroying behaviors include:****

- Public shaming for mistakes
- Using questions as evidence of incompetence in evaluations
- Punishing or marginalizing staff who raise concerns
- Dismissing input with "that's how we've always done it"
- Allowing gossip about staff who admit struggles
- Inconsistency between stated values and actual responses to vulnerability
- Creating an environment where the safest strategy is silence

****The most important thing to understand about psychological safety:**** it is not created by policy or intention. It is created by behavioral consistency — by what happens, reliably and repeatedly, when someone takes the risk of being vulnerable.

A single instance of a leader responding to a mistake with blame can erase months of trust-building. Psychological safety is earned slowly and destroyed quickly. It requires sustained, consistent, authentic commitment to protecting the very vulnerability that makes learning possible.

For SUD treatment organizations, the question is not whether psychological safety matters — the evidence is overwhelming. The question is whether you are willing to examine, honestly and unflinchingly, what actually happens in your organization when someone admits a mistake, challenges a practice, or says "I don't know what to do."

The answer to that question is your psychological safety. Everything else is aspiration.

Reflection Questions

1. Rate the psychological safety of your team on a scale of 1 to 10. What specific experiences inform your rating?

2. Think about the last mistake that was made in your organization — by you or by a colleague. How was it handled? What did the response communicate about psychological safety?

3. Have you ever self-censored — held back a question, concern, or idea — because you feared the professional consequences of speaking up? What was the situation, and what was the cost of your silence?

4. Name one safety-building behavior you have personally witnessed in your organization. Name one safety-destroying behavior. Which is more common?

5. If psychological safety were measured on a daily basis in your organization, what would the trend look like over the past year? Is it improving, declining, or flat? What is driving the trend?

Part 7 · From Questions to Innovation: Closing the Loop

From Questions to Innovation: Closing the Loop

The ultimate test of an inquiry culture is not whether people ask questions — it is whether those questions lead to change.

An organization can celebrate curiosity, protect vulnerability, and build beautiful knowledge-sharing platforms, but if none of that inquiry translates into concrete improvements in clinical practice, organizational systems, or client outcomes, the culture is incomplete. It is intellectually stimulating but practically inert.

****Innovation in SUD treatment does not require breakthrough discoveries or radical paradigm shifts.****

It requires what we might call "inquiry-driven improvement" — the systematic translation of staff questions, clinical observations, collaborative insights, and learning experiences into actionable changes that make treatment better, more efficient, more responsive, or more effective.

Most innovation in treatment organizations starts not with a visionary idea but with a simple question: "Is there a better way to do this?" or "Why do we do it this way?" or "What would happen if we tried something different?"

****The feedback loop from question to innovation follows a recognizable pattern:****

****First****, someone asks a question or raises a concern. This requires psychological safety.

****Second****, the question is explored — through research, discussion, consultation, or experimentation. This requires collaborative problem-solving.

****Third****, a potential improvement is identified and tested. This requires organizational willingness to change.

****Fourth****, the results are assessed and the improvement is either adopted, adapted, or abandoned based on evidence. This requires intellectual honesty.

****Fifth**** — and this is where many organizations fail — ****the connection between the original question and the resulting improvement is made visible.**** The person who asked the question sees that their inquiry led to change. The organization sees that curiosity produces value.

This visibility is what sustains the inquiry cycle.

When this feedback loop is broken — when questions go nowhere, when good ideas die in committee, when "we've always done it this way" trumps evidence and innovation — inquiry culture erodes from within.

Staff learn that asking questions is tolerated but inconsequential. The questions become fewer, less bold, and less likely to challenge established practices. Over time, the organization becomes resistant to the very learning it needs to stay effective.

****SUD treatment is a field that demands continuous improvement.****

The evidence base evolves. Client populations change. New substances emerge. Regulatory requirements shift. Co-occurring conditions require integration of approaches. Technology creates new possibilities.

An organization that cannot learn — that cannot translate inquiry into adaptation — will fall behind. And in treatment, falling behind means delivering care that is less effective than what is possible.

****The practical question for every SUD treatment organization is:**** can you trace a line from a specific question someone asked to a specific improvement in how you deliver care?

If you can, that line is your inquiry culture working. If you cannot, that absence is your inquiry culture not yet complete.

The goal of this intensive is to help you build those lines — from question to exploration to improvement to visibility — so that curiosity does not remain abstract but becomes the engine of organizational excellence.

Reflection Questions

1. Can you identify a specific improvement in your organization that originated from a staff member's question or observation? What was the question, and what changed as a result?

2. When good ideas or valid concerns are raised by staff, what typically happens to them? Are they explored and implemented, or do they disappear into the organizational ether?

3. Think about a practice in your organization that you believe could be improved. Have you raised it? If so, what happened? If not, what prevented you?

4. How does your organization make the connection between inquiry and improvement visible? Do staff see that their questions lead to change, or does the connection remain invisible?

5. What is one question you believe your organization should be asking right now — about clinical practice, organizational systems, or client outcomes — that no one is asking? What would it take to ask it?

Part 8 · 7-Domain Inquiry Culture Assessment

Inquiry Culture Self-Assessment

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

Leaders in our organization genuinely welcome questions from all staff levels without visible impatience or judgment

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I feel comfortable approaching my direct supervisor with a question that reveals something I don't know

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Leadership models curiosity by openly asking questions and admitting when they need more information

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

There is a clear difference between our stated "open-door policy" and how psychologically safe it actually feels to walk through that door

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

New staff members quickly learn that asking questions is welcomed rather than viewed as incompetence

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Leaders respond to questions with teaching rather than judgment, even when the question seems basic

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I have witnessed a leader publicly say "I don't know — let me find out" without loss of credibility

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff across all levels feel equally comfortable seeking guidance — not just those with seniority or confidence

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Complex clinical cases are routinely discussed through collaborative team processes rather than handled in isolation

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Cross-functional collaboration on challenging situations is actively encouraged and structurally supported

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Problem-solving meetings explicitly invite questions and diverse perspectives rather than defaulting to the most senior voice

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff from different roles (clinical, administrative, peer support) are included in solution development

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

There are structured processes in place that normalize question-asking during case consultations

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Collaborative problem-solving produces better outcomes than when individuals work through challenges alone

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff feel their questions and perspectives are genuinely valued during team problem-solving, not just tolerated

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Our organization treats "I need help with this case" as professional strength rather than clinical weakness

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Formal or informal mentorship relationships in our organization explicitly encourage and celebrate question-asking

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Peer support systems among staff effectively normalize help-seeking without stigma or competitive dynamics

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

New clinicians are paired with experienced mentors who create "no question is too small" environments

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Supervisory relationships balance accountability with genuine learning support and intellectual safety

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Colleagues feel comfortable saying "I'm stuck on this — can you help me think it through?" to each other

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Mentorship in our organization teaches through shared exploration rather than top-down knowledge transfer

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Performance evaluation conversations include positive recognition of learning behaviors and intellectual humility

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

There are specific peer consultation structures (not just informal hallway conversations) that support ongoing learning

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Our organization has accessible systems where staff can ask clinical questions and receive timely, helpful responses

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Both formal channels (meetings, trainings) and informal channels (peer conversations, messaging) support question-asking

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Information about clinical best practices, policies, and procedures is easily accessible without having to ask multiple people

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff who share knowledge generously are recognized and valued rather than being taken for granted

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

There are mechanisms for anonymous question-asking when staff feel uncomfortable asking publicly

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Knowledge is shared across shifts, teams, and departments rather than staying siloed in pockets

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Our organization invests in platforms and processes that make learning and information exchange convenient and rewarding

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Clinical knowledge from senior staff is systematically captured and shared rather than lost when people leave

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Our organizational culture visibly celebrates curiosity, learning, and intellectual humility as professional virtues

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Performance evaluations include criteria for learning behaviors, not just knowledge demonstration and productivity

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff who ask thoughtful questions are recognized as contributors rather than viewed as uninformed or disruptive

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

The organizational message is clear: asking for help is professional strength, not professional weakness

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

There are specific recognition systems or practices that reward curiosity, help-seeking, and collaborative learning

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Knowledge hoarding — keeping information to maintain personal power — is actively discouraged rather than rewarded

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Our organization invests in professional development that goes beyond compliance requirements to genuine skill-building

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff understand that intellectual curiosity and help-seeking behaviors support rather than threaten their career advancement

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff feel psychologically safe admitting uncertainty about clinical decisions without fear of professional consequences

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Trust levels in our organization allow vulnerability about knowledge gaps and learning needs

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Mistakes are treated as learning opportunities rather than occasions for blame, shame, or punitive action

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff can disagree with a clinical approach or organizational decision without fear of retaliation or marginalization

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

New ideas and alternative perspectives are welcomed even when they challenge established practices or seniority

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

There is a clear distinction between accountability (which promotes learning) and blame (which inhibits it)

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff feel safe enough to say "I was wrong" or "I made an error" without career-threatening consequences

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

The organization's response to mistakes and near-misses builds rather than erodes future willingness to be transparent

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Questions and collaborative learning regularly lead to concrete clinical practice improvements in our organization

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff-generated ideas are implemented often enough that people believe their input matters

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Our organization actively connects curiosity and inquiry to measurable improvements in client outcomes

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

There is a visible feedback loop: someone asks a question → the answer leads to change → the change is acknowledged

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Innovation is encouraged at all levels rather than being the exclusive domain of leadership or designated committees

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Our organization adapts quickly to new evidence and best practices because inquiry culture facilitates knowledge flow

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

The connection between learning culture and organizational effectiveness is understood and articulated

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Staff can point to specific examples where a question someone asked led to a meaningful improvement in care or operations

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

1. Which domain scored highest? What specific organizational practices or leadership behaviors have created this strength?

Your reflection...

2. Which domain scored lowest? What is the human cost of this weakness — to staff, to clients, to the organization?

Your reflection...

3. Look at your Psychological Safety score. If it is below 60%, what are the specific behaviors or experiences that suppress safety? Name them.

Your reflection...

4. Is there a gap between what leadership believes about your inquiry culture and what frontline staff experience? What creates that gap?

Your reflection...

5. Identify the single highest-priority change that would have the biggest positive ripple effect across multiple inquiry culture domains. What is it, and why would it matter most?

Your reflection...

Scoring guide

Higher scores indicate stronger inquiry culture in that domain. Scores below 50% identify areas where the culture actively inhibits question-asking and learning. The gap between your highest and lowest domains reveals where the inquiry culture chain is weakest — and the chain is only as strong as its weakest link. Psychological Safety scores below 60% warrant immediate attention, as safety is the foundation for all other domains.

Part 9 · Lab 1: Organizational Inquiry Audit

Organizational Inquiry Audit

An Honest Assessment of Where Questions Go to Live — or Die

The Purpose of This Audit

This audit examines the real-world journey of a question in your organization — from the moment someone has it, to whether they ask it, to what happens when they do. It reveals the invisible barriers, hidden costs, and missed opportunities that exist between 'I have a question' and 'I got the help I needed.'

Think of a clinical question you had recently. Walk through the journey: Did you ask it? Whom did you ask? How long did it take to get a helpful answer? What barriers did you encounter?

Be specific and honest — this audit is only valuable if it reflects reality...

Now think of a question you had but DID NOT ask. What stopped you? What was the cost — to you, to the client, to the team — of that unasked question?

Be specific and honest — this audit is only valuable if it reflects reality...

Estimate the average time between a staff member having a clinical question and receiving a useful answer. Is that timeframe acceptable? What delays exist?

Be specific and honest — this audit is only valuable if it reflects reality...

List the unwritten rules about question-asking in your organization. (Example: "Don't ask something in a meeting that makes the director look uninformed." "Don't ask the same question twice.")

Be specific and honest — this audit is only valuable if it reflects reality...

What topics or types of questions feel OFF-LIMITS — not because of policy, but because of culture? What can't people ask about?

Be specific and honest — this audit is only valuable if it reflects reality...

Who are the "safe" people to ask questions of in your organization? Who are the "unsafe" people? What makes them different?

Be specific and honest — this audit is only valuable if it reflects reality...

Describe a situation where a clinical error or poor outcome could have been prevented if someone had felt safe to ask a question or raise a concern.

Be specific and honest — this audit is only valuable if it reflects reality...

Estimate how many clinical questions go unasked in your organization in a typical week. What is the cumulative cost of that lost learning?

Be specific and honest — this audit is only valuable if it reflects reality...

How does the inability to ask questions affect staff morale, burnout, and retention? What is the human cost of an inquiry-toxic culture?

Be specific and honest — this audit is only valuable if it reflects reality...

Part 10 · Lab 2: Open-Door Leadership Action Plan

Open-Door Leadership Action Plan

From Policy Statement to Lived Practice

INQUIRY-TOXIC CULTURE

"My door is always open" — said by a leader who visibly sighs when interrupted, responds to questions with "Didn't we cover that?" and cancels one-on-ones regularly.

INQUIRY-RICH CULTURE

"My door is always open" — said by a leader who puts down their phone when approached, responds with "Good question — let's think about that," and protects scheduled check-in time.

1. Rate your organization's open-door leadership from 1-10. What specific behaviors inform your rating?

Your honest assessment...

2. What is the most common experience when a staff member approaches a leader with a question? Describe what actually happens.

Your honest assessment...

3. Do leaders in your organization publicly model their own curiosity? Can you cite a specific example?

Your honest assessment...

For each behavior, rate how consistently it is demonstrated by leadership in your organization (1 = Never, 5 = Always):

Stops current activity and gives full attention when approached with a question

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Responds to questions with genuine curiosity rather than impatience or judgment

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Says "I don't know" publicly without apparent discomfort or loss of credibility

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Follows up on questions raised in previous conversations

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Celebrates good questions as much as good answers

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Never uses a staff member's question as evidence of incompetence in evaluations

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Actively seeks out questions: "What are you unsure about?" "Where do you need support?"

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Models help-seeking by publicly asking for input and acknowledging their own learning needs

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

1. Identify three specific leadership behaviors you (or your leaders) will START doing this week to make the open door genuinely safe.

Be specific and actionable...

2. Identify two specific leadership behaviors that need to STOP because they undermine psychological safety for question-asking.

Be specific and actionable...

3. How will you know the open-door culture is improving? What observable indicators will you track?

Be specific and actionable...

4. Write a commitment statement: what kind of leader do you want to be when someone walks through your door with a vulnerable question?

Be specific and actionable...

Part 11 · Lab 3: Collaborative Problem-Solving Design

Collaborative Problem-Solving Design

Building Structures That Make Collective Wisdom the Default

1. Describe how clinical case consultation currently works in your organization. Who participates? What is the format? Is it genuinely collaborative or hierarchically dominated?

Describe the reality, not the aspiration...

2. When a clinician is struggling with a case, what is the typical pathway they follow? (Work through it alone? Ask a specific person? Bring it to team? Avoid it?)

Describe the reality, not the aspiration...

3. Which professional perspectives are routinely MISSING from your collaborative problem-solving? (Peer support? Medical? Administrative? Case management?)

Describe the reality, not the aspiration...

4. What happens to the person who says "I don't know what to do with this case" in a team setting? Is it safe? How do you know?

Describe the reality, not the aspiration...

Design Principles

Effective collaborative problem-solving structures: (1) begin with a request for help, not a request for validation; (2) include cross-functional perspectives; (3) protect the question-asker; (4) produce actionable outcomes; (5) follow up on implementation.

Meeting Structure: How will collaborative case consultation be organized? (Frequency, duration, format, facilitation)

Design with specificity...

Participation: Who will participate? How will cross-functional perspectives be included? How will you ensure junior voices are heard?

Design with specificity...

Opening Protocol: How will cases be presented? Write a specific opening prompt that normalizes the request for help.

Design with specificity...

Ground Rules: What norms will protect psychological safety during collaborative sessions? Write 3-5 explicit ground rules.

Design with specificity...

Action Outcomes: How will collaborative discussions translate into specific next steps with accountability and follow-up?

Design with specificity...

Part 12 · Lab 4: Mentorship Culture Builder

Mentorship Culture Builder

Creating Relationships That Celebrate Questions

JUDGING MENTORSHIP

"You haven't done a biopsychosocial yet?" (surprise, implied judgment) → Mentee learns to hide what they don't know.

TEACHING MENTORSHIP

"Of course — let me walk you through how I approach it, and then let's look at one of yours together." (warmth, invitation) → Mentee learns that questions lead to growth.

1. Does your organization have formal mentorship structures, informal mentorship, or neither? What is the impact?

Reflect honestly...

2. Think about the best learning relationship you have experienced in your career. What specific behaviors made it safe to ask questions?

Reflect honestly...

3. Think about a learning relationship where you felt judged for not knowing something. What behaviors created that feeling?

Reflect honestly...

4. How do mentors in your organization respond when mentees ask "basic" questions? What do mentees learn from those responses?

Reflect honestly...

Mentor Selection: What qualities should mentors demonstrate? (Beyond clinical expertise — what relational qualities matter?)

Build your framework...

Mentor Training: What do mentors need to learn about creating psychologically safe learning relationships? Design a brief training outline.

Build your framework...

Peer Consultation Structures: How will you create structured peer support (not just hallway conversations)? What format, frequency, and norms?

Build your framework...

The "No Question Is Too Small" Message: How will this principle be communicated, modeled, and reinforced in every mentorship relationship?

Build your framework...

Write three things you want EVERY new clinician to hear from their mentor in the first week:

Build your framework...

Part 13 · Lab 5: Knowledge-Sharing System Design

Knowledge-Sharing System Design

Making Information Accessible and Inquiry Rewarding

1. Where does clinical knowledge currently live in your organization? (People's heads? Shared drives? Nowhere?)

Map the current reality...

2. What happens when a clinician needs a quick answer to a clinical question at 8 PM? What resources are available?

Map the current reality...

3. Are there mechanisms for anonymous question-asking? If not, what would it take to create them?

Map the current reality...

4. How is knowledge shared across shifts, teams, and departments? Where are the silos?

Map the current reality...

5. What happens to clinical knowledge when experienced staff leave the organization? Is it captured or lost?

Map the current reality...

Formal Channels: What structured forums for question-asking and knowledge exchange will you create or improve? (Clinical meetings, grand rounds, learning sessions)

Design with specificity...

Informal Channels: How will you support and normalize informal knowledge sharing? (Peer conversation, messaging platforms, lunch-and-learns)

Design with specificity...

Anonymous Options: Design a mechanism for staff to ask questions anonymously when they feel uncomfortable asking publicly.

Design with specificity...

Knowledge Capture: How will you systematically capture clinical knowledge from experienced staff? (Recorded consultations, written protocols, mentorship documentation)

Design with specificity...

Cross-Silo Bridges: What specific practices will connect knowledge across departments, shifts, and teams?

Design with specificity...

Part 14 · Lab 6: Psychological Safety Diagnostic

Psychological Safety Diagnostic

What Actually Happens When Someone Is Vulnerable

The Real Test

Psychological safety is not measured by policy statements or organizational values. It is measured by what actually happens — reliably and consistently — when someone takes an interpersonal risk. These scenarios test your organization's actual safety, not its aspirational safety.

THE SITUATION

A new clinician admits in a team meeting that they are unsure how to handle a specific clinical situation.

THE PSYCHOLOGICALLY SAFE RESPONSE

The team responds with, "Thank you for raising that — let's think about it together." The supervisor follows up privately with additional support.

What would ACTUALLY happen in your organization? Describe the likely response.

Describe the likely ACTUAL response — be honest about the gap between ideal and reality...

THE SITUATION

A staff member disagrees with a clinical approach being recommended by their supervisor during a case conference.

THE PSYCHOLOGICALLY SAFE RESPONSE

The supervisor says, "I appreciate you seeing it differently — walk me through your thinking." The discussion is exploratory, not defensive.

What would ACTUALLY happen? Would the staff member feel safe disagreeing?

Describe the likely ACTUAL response — be honest about the gap between ideal and reality...

THE SITUATION

A clinician makes an error — a missed appointment, an incomplete assessment, a documentation mistake — and reports it proactively.

THE PSYCHOLOGICALLY SAFE RESPONSE

The response focuses on learning: "Thank you for catching that. Let's figure out what happened and how to prevent it." No punitive action for honest reporting.

What would ACTUALLY happen? Is honest error-reporting rewarded or punished?

Describe the likely ACTUAL response — be honest about the gap between ideal and reality...

THE SITUATION

A frontline staff member suggests a change to an established organizational process because they believe it could be improved.

THE PSYCHOLOGICALLY SAFE RESPONSE

The suggestion is genuinely explored. Even if it's not implemented, the staff member receives feedback explaining why and is thanked for the initiative.

What would ACTUALLY happen? Are suggestions from all levels taken seriously?

Describe the likely ACTUAL response — be honest about the gap between ideal and reality...

THE SITUATION

A staff member is visibly struggling emotionally after a difficult client session and takes a moment to compose themselves.

THE PSYCHOLOGICALLY SAFE RESPONSE

A colleague checks in: "That looked like a tough session. Do you need to debrief?" The organization normalizes the emotional impact of the work.

What would ACTUALLY happen? Is emotional vulnerability among staff treated as normal or problematic?

Describe the likely ACTUAL response — be honest about the gap between ideal and reality...

1. Based on the scenarios above, where is the biggest gap between psychologically safe responses and actual responses in your organization?

Your action plan...

2. Identify two specific safety-DESTROYING behaviors that currently exist. What would it take to eliminate them?

Your action plan...

3. Identify two specific safety-BUILDING behaviors you will commit to demonstrating this week. Be concrete.

Your action plan...

4. How will you repair psychological safety that has been damaged by past punitive responses to vulnerability?

Your action plan...

Part 15 · Lab 7: Curiosity Recognition & Reward Design

Curiosity Recognition & Reward Design

Making Learning as Valued as Knowing

KNOWLEDGE-HOARDING CULTURE

Staff who "know everything" are admired. Asking questions is seen as a deficit. Performance reviews focus exclusively on what you know, not how you learn. Information is power — sharing it diminishes your value.

CURIOSITY-CELEBRATING CULTURE

Staff who ask great questions are admired. Seeking help is seen as clinical strength. Performance reviews include learning behaviors and intellectual humility. Knowledge sharing is recognized and rewarded.

1. What does your organization currently celebrate: knowing or learning? How is that communicated through formal and informal recognition?

Assess honestly...

2. Are there any current recognition systems that specifically acknowledge curiosity, help-seeking, or collaborative learning? If so, what are they?

Assess honestly...

3. Do performance evaluations include ANY criteria related to learning behaviors, question-asking, or intellectual humility? What specifically?

Assess honestly...

4. Is knowledge hoarding rewarded — either explicitly or implicitly — in your organization? How does it show up?

Assess honestly...

Informal Recognition: What daily and weekly practices will leaders use to acknowledge and celebrate question-asking, help-seeking, and collaborative learning? (Be specific — "I'll recognize it" is not a system.)

Design with specificity...

Formal Recognition: Design a specific recognition practice — a monthly award, a standing agenda item, a peer nomination process — that celebrates curiosity. Name it.

Design with specificity...

Performance Evaluation Integration: Write 2-3 specific criteria for performance evaluations that recognize learning behaviors and intellectual humility.

Design with specificity...

Anti-Hoarding Measures: What practices will actively discourage knowledge hoarding and incentivize generous knowledge sharing?

Design with specificity...

Career Connection: How will you help staff understand that curiosity and help-seeking SUPPORT career advancement rather than threaten it?

Design with specificity...

Part 16 · Lab 8: Real-World Inquiry Scenarios

Real-World Inquiry Scenarios

Applying Inquiry Culture Principles to Common Challenges

A clinician with six months of experience is assigned a client with complex co-occurring PTSD and opioid use disorder. The clinician has minimal trauma training and feels out of their depth. They consider asking their supervisor for help but recall that the last time a colleague asked for reassignment, the supervisor responded with, "You need to learn to handle your caseload."

How should this scenario play out in an inquiry-rich culture? What structural supports should exist? What leadership behaviors need to change?

Apply inquiry culture principles to this scenario...

During a clinical team meeting, the clinical director presents a new treatment protocol. Several team members have concerns about the protocol's feasibility, but no one speaks up. After the meeting, staff discuss their concerns in the parking lot.

What does the "parking lot meeting" tell you about psychological safety? What would need to change for concerns to be raised in the meeting itself?

Apply inquiry culture principles to this scenario...

A clinician with 15 years of experience realizes they have been using an outdated assessment approach. They know they should update their practice but feel embarrassed that they've been doing it wrong for so long. They continue using the old approach rather than asking for training.

How does inquiry culture apply to experienced clinicians, not just new ones? What would make it safe for this person to say "I need to learn something new"?

Apply inquiry culture principles to this scenario...

A case manager notices that several clients are being discharged from residential without adequate outpatient follow-up plans. They want to raise the concern but are unsure if it's "their place" — they are not clinical staff and fear overstepping.

How should cross-functional inquiry work? What structures and norms would make it safe for anyone — regardless of role — to raise a clinical concern?

Apply inquiry culture principles to this scenario...

A client experiences a serious adverse event. In the aftermath, leadership focuses on identifying who was responsible rather than examining what systemic factors contributed. Staff become more guarded, and help-seeking decreases for the next several months.

How does an organization's response to crises and adverse events either build or destroy inquiry culture? What should the response have looked like?

Apply inquiry culture principles to this scenario...

Part 17 · Lab 9: Weekly Inquiry Culture Check-In (7 Days)

Weekly Inquiry Culture Check-In

7 Days of Observing and Practicing Inquiry Culture

The Practice

Each day this week, observe and practice one aspect of inquiry culture. Notice what supports and what inhibits question-asking in your organization. Document your observations and your own learning behaviors. This daily practice builds awareness that is the first step toward cultural change.

What did you observe today about inquiry culture in your organization?

Describe what you noticed...

Did you ask a question, seek help, or share knowledge today? What happened?

Describe your own inquiry practice...

What supported or inhibited inquiry culture today?

What helped and what hindered...

Inquiry culture rating today (1 = questions suppressed, 10 = curiosity thriving)

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

What did you observe today about inquiry culture in your organization?

Describe what you noticed...

Did you ask a question, seek help, or share knowledge today? What happened?

Describe your own inquiry practice...

What supported or inhibited inquiry culture today?

What helped and what hindered...

Inquiry culture rating today (1 = questions suppressed, 10 = curiosity thriving)

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

What did you observe today about inquiry culture in your organization?

Describe what you noticed...

Did you ask a question, seek help, or share knowledge today? What happened?

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Inquiry culture rating today (1 = questions suppressed, 10 = curiosity thriving)

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

What did you observe today about inquiry culture in your organization?

Describe what you noticed...

Did you ask a question, seek help, or share knowledge today? What happened?

Describe your own inquiry practice...

What supported or inhibited inquiry culture today?

What helped and what hindered...

Inquiry culture rating today (1 = questions suppressed, 10 = curiosity thriving)

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

What did you observe today about inquiry culture in your organization?

Describe what you noticed...

Did you ask a question, seek help, or share knowledge today? What happened?

Describe your own inquiry practice...

What supported or inhibited inquiry culture today?

What helped and what hindered...

Inquiry culture rating today (1 = questions suppressed, 10 = curiosity thriving)

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

What did you observe today about inquiry culture in your organization?

Describe what you noticed...

Did you ask a question, seek help, or share knowledge today? What happened?

Describe your own inquiry practice...

What supported or inhibited inquiry culture today?

What helped and what hindered...

Inquiry culture rating today (1 = questions suppressed, 10 = curiosity thriving)

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

What did you observe today about inquiry culture in your organization?

Describe what you noticed...

Did you ask a question, seek help, or share knowledge today? What happened?

Describe your own inquiry practice...

What supported or inhibited inquiry culture today?

What helped and what hindered...

Inquiry culture rating today (1 = questions suppressed, 10 = curiosity thriving)

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

1. Looking at your 7 days of observations, what patterns did you notice about inquiry culture in your organization?

Synthesize your week...

2. Did your daily rating change over the week? What contributed to higher or lower days?

Synthesize your week...

3. What was the most important observation you made — something you hadn't noticed before this week?

Synthesize your week...

4. How did your own inquiry behavior change as you became more intentionally aware of the culture?

Synthesize your week...

5. What is one specific action you will take based on what you learned this week?

Synthesize your week...

Part 18 • Lab 10: Comprehensive Action Plan & Commitment

Comprehensive Action Plan & Commitment

Translating Awareness Into Organizational Change

Your Capstone Exercise

This final lab integrates everything from the intensive into a concrete, actionable plan for building inquiry culture in your organization. It moves from assessment to vision to specific commitments with timelines and accountability.

1. Based on your assessment scores, readings, and lab exercises, summarize the current state of inquiry culture in your organization in 3-5 sentences. Be honest.

Honest assessment...

2. What are the two or three BIGGEST barriers to inquiry culture in your organization? Name them specifically.

Honest assessment...

3. What existing strengths can you build on? What is already working, even partially?

Honest assessment...

1. Describe what your organization would look, sound, and feel like if inquiry culture were thriving. What would staff experience? What would clients experience?

Describe the vision concretely...

2. If a new employee started at your organization one year from now, what would they learn about question-asking in their first week? Write the experience you want them to have.

Describe the vision concretely...

3. What would you hear in team meetings, in the hallways, and in supervision if inquiry culture were fully alive?

Describe the vision concretely...

What will you do in the next 30 days?

Leadership Behavior Change: What specific open-door leadership behavior will you START this month?

Be specific, measurable, and time-bound...

Structural Change: What one collaborative or knowledge-sharing structure will you create or improve?

Be specific, measurable, and time-bound...

Safety Signal: What one thing will you do to increase psychological safety for question-asking?

Be specific, measurable, and time-bound...

What will you build in the next 90 days?

Mentorship: What formal or informal mentorship structure will you establish or strengthen?

Be specific, measurable, and time-bound...

Recognition: What curiosity recognition practice will you implement?

Be specific, measurable, and time-bound...

Innovation Loop: How will you connect staff questions to concrete organizational improvements?

Be specific, measurable, and time-bound...

What is the one-year transformation goal?

Culture Metrics: How will you measure inquiry culture improvement? What indicators will you track?

Be specific, measurable, and time-bound...

Sustainability: How will you embed inquiry culture into organizational systems so it persists through staff transitions?

Be specific, measurable, and time-bound...

Client Impact: How will a thriving inquiry culture translate into better outcomes for the people you serve?

Be specific, measurable, and time-bound...

1. Write your personal commitment statement: As a leader/clinician/team member, I commit to building inquiry culture by...

Make your commitment concrete...

2. Who will hold you accountable for this commitment? How and when will they check in?

Make your commitment concrete...

3. What is the first thing you will do TOMORROW to begin building inquiry culture? Make it specific and observable.

Make your commitment concrete...

4. Complete this sentence: "Building an inquiry culture in our organization matters because our clients deserve clinicians who..."

Make your commitment concrete...
