Advocacy & Allyship

Deep Dive Modules · Professional Practice

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Part 1 · Overview

Advocacy & Allyship

Creating Belonging and Equity in SUD Treatment Settings

Reading Sections

Self-Assessment

Worksheets & Exercises

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Part 2 · What Are Advocacy and Allyship in Treatment Settings?

What Are Advocacy and Allyship in Treatment Settings?

Advocacy and allyship in substance use disorder treatment settings involve the deliberate, sustained practice of using your position, voice, influence, and awareness to create environments where every colleague and every patient experiences genuine belonging, equitable treatment, and full participation — regardless of their identity, background, or social position.

It is the difference between believing in fairness as an abstract value and actively working to make fairness real in daily professional life.

The treatment field occupies a unique position in this work. We ask patients to be radically vulnerable — to disclose their deepest shame, their most painful secrets, their most desperate moments. We ask them to trust that the system they enter will treat them with dignity, respect, and equity.

And yet the systems we operate within often replicate the same patterns of exclusion, bias, and inequity that exist in the broader society. Patients of color receive different quality of care than white patients. LGBTQ+ individuals encounter providers who lack cultural competence or harbor implicit bias.

The same dynamics operate among staff. Treatment teams are microcosms of broader society, carrying the same patterns of privilege, bias, exclusion, and inequity into professional relationships and organizational structures.

Advocacy means taking concrete action to address these realities — not just feeling bad about them, not just acknowledging they exist, but actively intervening to change them.

Allyship is the relational dimension of this work. It means standing with and alongside colleagues and patients who face barriers you do not, centering their experience rather than your own, following their leadership rather than imposing your solutions, and earning trust through consistent action rather than declaring yourself an ally and expecting gratitude.

True allyship is not an identity you claim — it is a practice others recognize in you because of what you do, not what you say.

Reflection Questions

1. How do you currently define advocacy and allyship in your professional context? Has reading this shifted your understanding in any way?

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2. Think about the patients your organization serves. Are there populations that receive systematically different quality of care, access, or engagement?

3. Consider your treatment team. Who experiences full belonging, and who may face barriers to participation, voice, or advancement?

4. When you hear the word "ally," what is your internal reaction? Do you identify as an ally? What specific actions support that identification?

5. How does the idea that advocacy and allyship are clinical responsibilities — not optional extras — challenge or confirm your current approach to professional practice?

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Part 3 · Why This Work Matters in Substance Use Disorder Treatment

Why This Work Matters in Substance Use Disorder Treatment

The urgency of advocacy and allyship in substance use disorder treatment is not abstract — it is measurable in outcomes, retention, engagement, and lives.

Research consistently demonstrates that health disparities in addiction treatment are not explained by patient characteristics alone — they are driven by systemic factors including provider bias, cultural incompetence, inequitable access, and organizational practices that advantage some populations while disadvantaging others.

Black Americans are less likely to complete substance use disorder treatment than white Americans, even when controlling for severity, socioeconomic status, and other variables. The gap is not explained by patient motivation — it is explained by treatment environments that fail to create cultural safety.

Hispanic and Latino individuals face language barriers, immigration-related fears, and cultural stigma that treatment systems often fail to address. Native American and Indigenous communities carry intergenerational trauma that mainstream treatment approaches were not designed to honor.

LGBTQ+ individuals encounter providers who lack competence in their specific needs, face heteronormative program structures, and may experience outright hostility in settings that should be sanctuaries of healing.

These disparities are not inevitable — they are the product of human choices, organizational practices, and systemic structures. They persist because professionals who could challenge them remain silent.

Within treatment teams, the case is equally compelling. Diverse teams produce better outcomes than homogeneous ones — but only when diversity is accompanied by genuine inclusion. When every team member feels valued, heard, and empowered to contribute their full capability, the collective intelligence of the team multiplies.

When professionals from underrepresented backgrounds leave at higher rates — as they consistently do in organizations that fail to create belonging — the field loses the very voices and perspectives it most needs.

Advocacy and allyship are not about political correctness or performative gestures. They are about creating the conditions under which excellent treatment becomes possible for all patients and sustainable careers become possible for all professionals.

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Reflection Questions

1. What health disparities have you observed in your own treatment setting? Which patient populations receive different quality of care, engagement, or outcomes?

2. Think about staff turnover on your team. Have colleagues from underrepresented backgrounds left at different rates? What factors contributed to their departure?

3. How does your organization currently address cultural competence and equity in treatment delivery?

4. When you consider the claim that clinical excellence requires equity, does this feel true in your experience?

5. What is the personal cost to you of remaining silent when you observe bias or inequity? What is the professional cost to your patients and colleagues?

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Part 4 · Understanding Privilege, Bias, and Blind Spots

Understanding Privilege, Bias, and Blind Spots

Privilege, in the context of advocacy and allyship, refers to unearned advantages that come from belonging to a social group that has historically held power, access, and influence. It is not about individual guilt — it is about systemic patterns that advantage some people and disadvantage others based on characteristics they did not choose.

Understanding privilege is essential for effective advocacy because you cannot address what you cannot see, and privilege, by its nature, is invisible to those who possess it.

The invisibility of privilege is its most powerful feature. When the systems around you were designed for people like you, they feel natural, neutral, and fair. The meeting schedule that works for you because your childcare arrangements are stable does not feel like a privilege — it feels like a meeting schedule.

Privilege makes the water invisible to the fish.

Bias operates alongside privilege — and it operates in everyone. Implicit bias refers to the unconscious associations, stereotypes, and attitudes that influence perception, judgment, and behavior without conscious awareness or intention.

A clinician who consciously believes in equitable treatment may still demonstrate implicit bias in clinical decision-making — spending less time with certain patients, making different diagnostic assumptions, providing different quality of empathic engagement based on patient identity.

These biases are not character flaws — they are cognitive patterns shaped by socialization in a society structured by inequality.

Blind spots are the natural consequence of privilege and bias operating together. If your privilege makes certain systems invisible and your bias shapes your perception without your awareness, then there are significant aspects of your colleagues' and patients' experience that you simply cannot see — not because you are uncaring, but because your position in the system limits your line of sight.

The path forward is not guilt, shame, or paralysis. It is awareness, humility, and action. Awareness means developing the capacity to see what privilege has hidden. Humility means accepting that your perspective is incomplete and that others can see what you cannot. Action means using your awareness to change the systems, behaviors, and practices that create inequity.

This is ongoing work — not a destination you reach but a practice you maintain. You will make mistakes. You will discover blind spots you did not know you had. You will receive feedback that is uncomfortable to hear. The measure of your advocacy is not perfection — it is your willingness to keep learning, keep listening, and keep showing up.

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Reflection Questions

1. What areas of privilege do you hold? Consider identity dimensions such as race, gender, sexual orientation, socioeconomic background, education, ability, neurotype, religion, and citizenship status.

2. Can you identify a time when a system or practice that felt neutral or fair to you was experienced as a barrier by someone else?

3. What implicit biases might you carry that could affect your clinical work or your interactions with colleagues?

4. How do you typically respond when someone points out a blind spot you did not know you had? What is your honest emotional reaction?

5. Write a privilege inventory for yourself — not as an exercise in guilt, but as an exercise in awareness. What advantages do you carry that you did not earn?

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Part 5 · From Awareness to Action: The Practice of Effective Advocacy

From Awareness to Action: The Practice of Effective Advocacy

Awareness without action is complicity in better-informed packaging. The bridge between understanding inequity and addressing it is the daily practice of advocacy — concrete, consistent, and courageous actions that use your position, voice, and influence to create change.

Effective advocacy operates at three levels simultaneously: interpersonal, institutional, and intrapersonal.

Interpersonal advocacy involves the direct interactions where you witness bias, exclusion, or inequity and choose to intervene. This includes speaking up when a colleague makes a biased comment, redirecting a conversation to include voices being overlooked, challenging assumptions about patients based on their identity, and supporting colleagues who face discrimination.

Interpersonal advocacy requires courage — the willingness to risk social discomfort, professional friction, or personal criticism in service of equity. It also requires skill — the ability to intervene in ways that create learning rather than defensiveness.

Institutional advocacy involves working to change the policies, practices, structures, and cultures that create or maintain inequity. This level of advocacy recognizes that individual bias operates within systems that either amplify or constrain its effects. A biased individual in an equitable system produces less harm than the same individual in a biased system.

Institutional advocacy includes examining hiring practices for embedded bias, reviewing treatment protocols for cultural assumptions, challenging meeting structures that silence certain voices, advocating for equitable professional development and advancement opportunities, and working to create accountability systems that measure inclusion outcomes.

Intrapersonal advocacy involves the ongoing personal work of examining your own bias, expanding your perspective, building your knowledge, and developing the emotional capacity to sustain advocacy over time. This is the level most people skip — assuming that because they have good intentions, they are doing good work.

Critical principles for effective advocacy include centering those most affected — letting people speak for themselves rather than speaking for them, amplifying their voices rather than replacing them with yours, and following their leadership rather than imposing your solutions.

Effective advocacy also means accepting that you will make mistakes, that good intentions do not guarantee good impact, and that the measure of your commitment is not whether you stumble but whether you learn, repair, and continue.

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Reflection Questions

1. At which level — interpersonal, institutional, or intrapersonal — is your advocacy currently strongest? Where is the most significant gap?

2. Describe a time when you witnessed bias or exclusion and chose to intervene. What happened? What did you learn?

3. How do you distinguish between centering those affected and speaking over them? Can you identify a time when well-intended advocacy actually displaced the voice of the person it was meant to support?

4. What institutional policies or practices in your organization create or maintain inequity? What would it take to change them, and what role could you play?

5. What is the most uncomfortable equity conversation you have avoided? What would it take for you to have it? What is the cost of continuing to avoid it?

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Part 6 · Advocacy & Allyship Self-Assessment

Advocacy & Allyship Self-Assessment

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

I can recognize when colleagues may be experiencing belonging challenges or feeling excluded from team activities and decisions

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice subtle forms of exclusion, bias, or microaggressions that affect team members from different backgrounds

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I understand how organizational culture and team dynamics can create barriers to full participation for some colleagues

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can identify patterns in who tends to be heard versus overlooked in team meetings and decision-making processes

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am aware of how language choices, meeting structures, and informal norms may unintentionally exclude certain team members

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I pay attention to whether patients from different backgrounds receive equitable quality of care and clinical attention

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice when hiring, promotion, or assignment practices may disadvantage certain groups within our organization

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can distinguish between surface-level inclusion (presence) and genuine belonging (valued participation and influence)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can identify my own areas of privilege and how they affect my perspective on workplace equity and inclusion

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

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Not at all · Very much

I am aware of my unconscious biases and actively work to recognize how they influence my interactions with colleagues

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I understand how my identity and experiences may create blind spots regarding challenges faced by other team members

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can recognize patterns in my own behavior that may inadvertently contribute to exclusion or inequity

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I regularly reflect on assumptions I make about colleagues and patients based on their identities or backgrounds

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am comfortable acknowledging when my privilege has given me advantages that others did not receive

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can identify how systems I benefit from may simultaneously disadvantage others in my organization

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I actively seek out perspectives different from my own rather than assuming my experience is universal

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I actively speak up when I witness exclusion, bias, or inequitable treatment rather than remaining a passive bystander

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I know the difference between actively supporting inclusion and passively allowing exclusion to occur

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I have specific strategies for intervening when I witness microaggressions or biased behavior

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

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I am willing to risk personal discomfort or social cost to advocate for colleagues facing exclusion

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I follow up after incidents to check on colleagues who were affected and to ensure systemic follow-through

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I use my influence — formal or informal — to create opportunities for colleagues from underrepresented backgrounds

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I advocate for policy and practice changes that address systemic barriers to equity in our organization

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I take action consistently rather than only when it is convenient or when I am being observed

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I prioritize listening to and learning from colleagues who experience exclusion rather than centering my own perspective

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I follow the leadership of those most affected by inequity rather than imposing my own solutions

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can receive feedback about my advocacy efforts without becoming defensive or attempting to justify my actions

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize that my understanding of inclusion challenges is always incomplete and requires ongoing learning

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I educate myself about equity and inclusion rather than expecting colleagues from marginalized groups to teach me

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I understand that good intentions do not automatically produce good outcomes in advocacy work

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

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I can acknowledge mistakes in my advocacy without abandoning my commitment to equity and justice

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I seek out diverse sources of learning — books, training, community voices — to deepen my understanding

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize when advocacy needs to address systemic issues rather than only individual incidents

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I actively work on organizational policies and practices that affect inclusion and equity

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I understand how individual advocacy connects to broader efforts for systemic change and justice

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can identify which approaches create lasting structural change versus temporary improvements

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I use my position — whatever it may be — to influence organizational culture toward greater inclusion

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I support colleagues from underrepresented backgrounds in their professional development and career advancement

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I connect internal advocacy efforts with external community organizations and justice resources

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I help create accountability systems that measure progress on inclusion goals rather than relying on assumptions

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

Scoring guide

Reset all progress? This cannot be undone.

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Part 7 · Exercise 1: Advocacy Skills Wheel Explorer

Advocacy Skills Wheel Explorer

Five Spokes, and the One That Is Shortest

A Wheel Rolls on Its Shortest Spoke

The self-assessment on this page measures five capacities and reports them as five separate percentages. That is not how advocacy behaves in practice. A clinician with sharp recognition and no willingness to speak sees everything and changes nothing. A clinician who acts constantly without listening does damage at speed, and does it sincerely. The five carry each other, which means the number that matters is not your average but your lowest spoke. Name it here, in your own words, before the percentages name it for you.

1. How reliably do you notice exclusion, bias or inequity in your setting while it is happening, rather than afterward?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. Describe the most recent moment you noticed something exclusionary as it happened. What tipped you off — a look, a silence, an interruption, a decision about who was asked?

Be specific and honest...

3. Now describe something you only recognized later, sometimes much later. What made it invisible to you at the time?

Be specific and honest...

The reading says privilege makes the water invisible to the fish. This spoke is the capacity to see the water anyway.

1. How clear a view do you have of the ways your own privilege and bias shape what you notice and what you miss?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

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2. Name one arrangement at your workplace that feels neutral to you and is not neutral for everyone — a schedule, a location, a norm, an expectation, a social ritual.

Be specific and honest...

3. What have you learned about your own blind spots from someone else rather than by introspection? Who told you, and what did it cost them to tell you?

Be specific and honest...

1. When you witness bias or exclusion, how consistently do you say or do something in the moment rather than afterward or not at all?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. Write down the last three times you noticed something and did not act. For each, name what stopped you in one word — hierarchy, uncertainty, timing, fatigue, fear, or doubt about whether it was your place.

Be specific and honest...

3. Which of those three would you handle differently now, and what specifically would you say? Write the actual sentence, not a description of it.

Be specific and honest...

This is the spoke that separates advocacy from rescue. It is also the one most often rated highly by people who are not doing it.

1. How well do you take direction from the colleagues most affected, rather than arriving with your own solution already formed?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

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2. Recall a time your advocacy went past someone rather than behind them — you spoke for a colleague who could have spoken, or solved something they had not asked to have solved. What did it produce?

Be specific and honest...

3. Who in your organization has told you, in words, what they need? What have you actually done with it? If nobody has told you anything, write what you think that silence means.

Be specific and honest...

A response that resets the situation and leaves the conditions intact will be needed again, with a different person on the receiving end.

1. How much of your advocacy addresses policies, structures and standing practice rather than individual incidents?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. Name one pattern you have responded to more than twice as though it were a separate incident each time. What is the structure underneath it?

Be specific and honest...

3. Look back at your five ratings. Which spoke is shortest, what does your advocacy actually do because of it, and what would raising that one spoke by a single point require of you this month? Answer all three parts, and date the third.

Be specific and honest...

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Part 8 · Exercise 2: Personal Privilege & Blind Spot Inventory

Personal Privilege & Blind Spot Inventory

An Accounting of Advantages You Did Not Earn

This Is Not a Guilt Exercise

The reading is explicit that privilege is not about individual fault — it is about systemic patterns that advantage some people for characteristics nobody chose. Guilt is a poor motivator and a worse tool, because it turns the work into a matter of your feelings rather than other people's conditions, and it invites reassurance you should not be asking for. What this inventory wants is accuracy. Where you hold an advantage, write it down without softening it. Where you do not, write that too. An honest inventory is short on apology and long on specifics.

1. Go through these one at a time and write, for each, whether it has mostly opened doors in your professional life, mostly closed them, or done neither: race, gender, sexual orientation, socioeconomic background, education, ability, neurotype, religion, citizenship, age, first language, caregiving responsibilities. Then mark which ones you had to stop and think about — those are usually the ones where you hold the advantage.

Be specific and honest...

The reading gives the example plainly: a meeting schedule that works for you because your childcare arrangements are stable does not feel like a privilege — it feels like a meeting schedule.

1. List three arrangements at your workplace that work well for you — a schedule, a location, a dress expectation, a social ritual, a communication norm, a physical space. For each, name one colleague for whom it works less well.

Be specific and honest...

2. Pick the one where the gap is largest. What would it take to change it, and who holds the authority? If the answer is you, write that down rather than around it.

Be specific and honest...

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The reading names the specific forms this takes: less time spent with certain patients, different diagnostic assumptions, a different quality of empathic engagement. None of them announce themselves, and all of them are visible in a caseload.

1. How willing are you to examine your own clinical decisions for a pattern you would rather not find?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. Look at your current caseload. Which patients get your best listening, and which get an efficient version of you? Write the initials in two columns, then read the columns for anything they have in common.

Be specific and honest...

3. Recall a diagnostic or level-of-care judgment you made quickly. What did you assume about that person, and would you have assumed the same about someone from a different background presenting identically?

Be specific and honest...

The reading says the measure of your advocacy is not perfection but the willingness to keep learning. That willingness is tested at exactly one moment: when somebody tells you that you got it wrong.

1. Describe the last time someone pointed out a blind spot of yours. Write what you felt in the first ten seconds — not what you said, what you felt.

Be specific and honest...

2. What did you do in the days that followed? Did you repair, explain, avoid the person, or change something? Be specific about which, and about what the person would say happened.

Be specific and honest...

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An inventory that ends in awareness has stopped one step short. Privilege is not only something to acknowledge — it is a resource that can be spent.

1. Name one room you are in, or one conversation you have access to, that a colleague affected by an inequity is not in. What could you carry into it that they cannot?

Be specific and honest...

2. What is one thing you could do that would cost you relatively little and would cost a colleague from an underrepresented background a great deal? That difference is the entire argument for you being the one to do it.

Be specific and honest...

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Part 9 · Exercise 3: Belonging Barrier Assessment

Belonging Barrier Assessment

Who Is Present, and Who Is Actually Included

Presence Is Not Belonging

The assessment on this page draws a line between surface-level inclusion — being in the room — and genuine belonging, which is valued participation and influence. A team can be diverse on paper and still operate as a place where a small number of people decide things and everyone else attends. This exercise looks for the difference using evidence rather than impression, because impressions of inclusion are least reliable in the people the arrangement already suits. Who talks, who is interrupted, who is asked, who gets the work that builds a career, and who leaves.

Use the next team meeting as data rather than as a memory.

1. At your next team meeting, keep a private tally: who spoke and roughly how long, who was interrupted, and whose point was later repeated by someone else and credited to that second person. Write the results here.

Be specific and honest...

2. What do the numbers say that your impression of the meeting did not? If they match your impression, write that too — a confirmed impression is still evidence.

Be specific and honest...

A great deal of what happens in an organization happens outside meetings: the corridor conversation, the shared lunch, the text thread, the person who is asked to cover the high-visibility case.

1. Who has informal access to decision-makers in your organization, and who does not? Write names rather than categories, then name what creates the access — shared history, shared background, shared schedule, shared social life.

Be specific and honest...

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1. How equitably are development opportunities, visible assignments and difficult-but-valuable cases distributed on your team?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. Over the past year, who has been given the assignments that build a career — the presentation, the new program, the supervision role, the committee seat? List them.

Be specific and honest...

3. Who has been given the work that is necessary and invisible — the coverage, the documentation cleanup, the difficult family, the shift nobody wants? List them, then read the two lists side by side.

Be specific and honest...

The reading is direct: professionals from underrepresented backgrounds leave at higher rates in organizations that fail to create belonging, and the field loses the very voices it most needs.

1. List everyone who has left your team in the past two years and what the organization said about why. Then write what you believe was actually true in each case.

Be specific and honest...

2. Was any departure treated as a signal about the organization rather than about the individual? If nothing changed after any of them, name what that tells a person who is currently deciding whether to stay.

Be specific and honest...

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1. On your team, whose contributions do you seek out and whose do you overlook? Answer with names. Everyone has a pattern here, and yours is not neutral simply because it is unexamined.

Be specific and honest...

2. Name one person on your team who has less belonging than you do. What is one specific thing you could do in the next two weeks that would change their experience — not their feelings about you, their actual access.

Be specific and honest...

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Part 10 · Exercise 4: Bystander-to-Advocate Transformation

Bystander-to-Advocate Transformation

The Distance Between Noticing and Doing

Awareness Without Action Is Complicity in Better-Informed Packaging

That sentence is from the fourth reading, and it is the hardest one on this page. It means that noticing more than your colleagues do is not by itself a moral achievement — it can be the opposite, because it removes the defense of not having known. This exercise is about the gap between the moment you see something and the moment you do something, and about the specific, ordinary and entirely understandable reasons that gap stays open. None of what follows works if you write the version of yourself you would prefer.

1. Write down three moments in the past six months when you witnessed bias, exclusion or inequitable treatment and said nothing. Two sentences each.

Be specific and honest...

2. For each, what were you doing in the ten seconds afterward? People rarely do nothing — they change the subject, look at a screen, make a joke, or leave the room. Name yours.

Be specific and honest...

Silence is a choice with a price on both sides. Treating it only as a failure of nerve makes it harder to change, because it does not account for what the silence is protecting.

1. How much personal or professional risk are you actually willing to carry in order to intervene?
○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. What does staying silent protect for you — a working relationship, a reputation, a promotion, an already-full week, your standing with a supervisor? This is an accounting, not a confession.

Be specific and honest...

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3. What does it cost the person on the receiving end, and what does it cost the person who said it, who now has no information that anything was wrong?

Be specific and honest...

The reading separates courage from skill: intervening in a way that creates learning rather than defensiveness is a technique, and techniques can be prepared in advance. Nobody improvises well under social pressure.

1. Write one sentence you could say in the moment that interrupts without escalating — naming what you observed rather than what you concluded. Make it a sentence you would say out loud, in your own voice.

Be specific and honest...

2. Now write a second version for when the person is senior to you, and a third for when the person is someone you like and do not want to lose.

Be specific and honest...

The assessment on this page asks whether you follow up after incidents. Most training stops at the intervention; most of the repair happens afterward.

1. Think of an incident where you did intervene. Did you check on the person affected afterward, privately? Write what you said, or what stopped you.

Be specific and honest...

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2. Did anything change structurally — a report made, a policy conversation opened, a supervisor told? If it stayed between individuals, the same thing will happen again to somebody else.

Be specific and honest...

You will witness something in the next month. What happens then is decided now or not at all.

1. Predict it: given what happens in your setting, what is most likely to occur, and where? Then write exactly what you will do — the words, the timing, and who you will tell afterward.

Be specific and honest...

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Part 11 · Exercise 5: Microaggression Recognition & Response

Microaggression Recognition & Response

Small Things, Repeated, That Add Up to a Message

The Unit of Harm Is the Hundredth Remark

Any single comment can be explained away, and that is exactly what makes this difficult to address. One instance sounds trivial when described to somebody who did not receive it — which is why the person who received it usually says nothing, and why the pattern continues undisturbed. The harm here is not in the remark; it is in the accumulation, and in the message the accumulation delivers about who belongs. This exercise works from real examples in your own setting rather than from a training list, because the ones that matter in your workplace are specific to your workplace.

1. Write down five things you have actually heard said in your workplace — to a colleague or about a patient — that carry an assumption about someone based on their identity. Use the real words; sanitized versions are not usable. Then mark which you noticed at the time and which you are only recognizing now, as you write them out.

Be specific and honest...

The reading points out that we ask patients to be radically vulnerable and to trust that the system will treat them with dignity. What gets said about patients in team rooms is said about people who have handed us their worst moments.

1. How often do you hear patients described in your team room in ways you would not repeat in front of them?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. Write down what gets said about patients in your setting when no patient can hear it. Include the jokes; the jokes are where the beliefs live.

Be specific and honest...

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3. Which patient population takes the worst of it in your workplace, and what does that team-room language predict about the care they actually receive?

Be specific and honest...

The aim is not to win the exchange. It is to make the pattern visible to the person producing it, in a way that leaves them able to change.

1. Take the worst example from your catalog and write three different responses to it: one that asks a question, one that names what you observed, and one you would use if you were the most senior person present.

Be specific and honest...

2. Which of the three could you say tomorrow? Which one do you avoid, and what is the avoidance actually about?

Be specific and honest...

This exercise assumes you will sometimes be the one who said the thing. The reading is unambiguous that good intentions do not guarantee good impact.

1. Recall a time you said something that landed badly across a difference of identity. What did you say, and what did you do next?

Be specific and honest...

2. Write what a good repair sounds like — brief, with no defense of your intent, and without asking the other person to reassure you. Three sentences at most.

Be specific and honest...

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1. Reading everything in this exercise together, what is the recurring theme in your setting? Name it in one sentence.

Be specific and honest...

2. What would have to change structurally for that theme to stop — who runs the team room, what the most senior person present models, what happens when it is named? Individual responses do not close a pattern on their own.

Be specific and honest...

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Part 12 · Exercise 6: Deep Listening Across Difference

Deep Listening Across Difference

Learning From People Whose Experience You Do Not Share

Your Understanding Is Permanently Incomplete

The assessment on this page contains a statement almost everyone rates themselves highly on: that they recognize their understanding of inclusion challenges is always incomplete. It is easy to agree with in the abstract and hard to practice, because practicing it means treating your own reading of a situation as one account among several rather than as the accurate one. What advocacy requires is a particular kind of listening — the kind that changes what you do, rather than the kind that confirms what you already thought.

1. Whose account of your workplace do you actually have — not who do you like, but who has told you something true about how this place works for them? Name them.

Be specific and honest...

2. Whose account do you not have? Which colleagues have you never heard describe their own experience of working here?

Be specific and honest...

The assessment asks whether you educate yourself rather than expecting colleagues from marginalized groups to teach you. Explaining your own exclusion, repeatedly, to people who could have looked it up, is work — and it is unpaid.

1. What have you asked a colleague to explain to you in the past year that you could have learned from a book, a training or a published source? Write it down without defending it.

Be specific and honest...

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2. What have you read, watched or attended on your own initiative in the same period? If the list is short, that is the finding, and the last section is where you do something about it.

Be specific and honest...

The reading is clear that receiving feedback without defending yourself is a skill. The reflex to explain your intent is the most common way these conversations end early.

1. Write the sentence you reach for when you feel misunderstood about something like this. Everyone has one — "that is not what I meant", "I was only", "you know me". Write yours exactly.

Be specific and honest...

2. What could you say instead that keeps the conversation open and asks for more rather than closing it down? Write the actual words, not the principle behind them.

Be specific and honest...

The reading says to center those most affected: let people speak for themselves, amplify rather than replace, follow their leadership rather than imposing your solutions.

1. When a colleague has described a problem to you, what is your first instinct — to fix it, to reassure them, to escalate it, or to ask what they want? Be accurate rather than aspirational.

Be specific and honest...

2. Name one situation right now where you have a solution in mind and have not asked the affected person what they want. Write your question to them, and the day you will ask it.

Be specific and honest...

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3. What would a colleague have to be able to say about you for the description "listens well" to be earned rather than assumed? Write it, then say plainly whether they could say it today.

Be specific and honest...

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Part 13 · Exercise 7: Clinical Equity Audit

Clinical Equity Audit

Whether Your Care Is Equitable Is a Measurable Question

Not a Question of Intention

The second reading gives numbers rather than sentiments: Black Americans are less likely to complete substance use disorder treatment than white Americans even when severity and socioeconomic status are controlled for, and the gap is not explained by patient motivation. A claim of that kind can only be answered locally, with local data. Some of what this audit asks for, your organization may not measure at all — and finding that out is itself a result worth having, because a disparity nobody counts is a disparity nobody has to answer for.

1. Does your organization break down completion, retention, readmission or discharge-against-advice rates by race, ethnicity, language, gender identity or sexual orientation? Write what is measured and what is not.

Be specific and honest...

2. If those numbers exist, what do they show? If they do not, who would have to decide to collect them, and what do you think has kept that decision from being made?

Be specific and honest...

A system-level disparity is produced by individual decisions, including yours. This section is uncomfortable by design.

1. How confident are you that patients on your caseload receive the same quality of engagement from you regardless of their background?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. List your discharges against medical advice and early disengagements from the past year. What, if anything, do those patients have in common?

Be specific and honest...

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3. Which patients do you find easiest to build an alliance with, and which do you find hardest? Write both lists, then say what each list has in common beyond the individuals on it.

Be specific and honest...

The reading names language barriers, immigration-related fear, and program structures built around one set of assumptions. Most of these operate before a patient ever reaches a clinician.

1. Walk your own intake process from the outside in — the phone line, the paperwork, the reading level, the documents required, the hours, the location, the transport. Where would someone fall out who genuinely wanted treatment?

Be specific and honest...

2. Which of those barriers is fixable by your organization this year, and which is genuinely structural? Name at least one of each, so the list is honest in both directions.

Be specific and honest...

The reading points to intergenerational trauma that mainstream approaches were not designed to honor, and to heteronormative program structures in settings that should be sanctuaries of healing.

1. What does your program assume about family, faith, gender, work, or what recovery is supposed to look like? Write the assumptions embedded in your groups, your forms and your materials.

Be specific and honest...

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2. Pick one assumption and describe a real patient for whom it does not fit. What happens to that patient in your program as it is currently designed?

Be specific and honest...

1. From everything above, name the single change that would most improve equity of care in your setting — then name who holds the authority to make it, what they would need from you, and your first step. A conversation, a memo, a number pulled, a meeting requested. Date it.

Be specific and honest...

Part 14 · Exercise 8: Difficult Conversation Practice

Difficult Conversation Practice

Preparing the One You Have Been Avoiding

The One You Are Avoiding Is the One This Is For

The fourth reading closes by asking what the most uncomfortable equity conversation you have avoided is, and what the cost of continuing to avoid it has been. This exercise takes that conversation and prepares it — not rehearsed into a script you deliver, but thought through far enough that the discomfort in the room does not get to decide the outcome. Pick one real conversation, with one real person, and stay with it through every section. A general answer here produces a general readiness, which is the same as none.

1. What is the conversation, and who is it with? One sentence for each.

Be specific and honest...

2. How long have you been avoiding it, and what has the avoidance cost — to you, to the person affected, and to whoever else has been living with the situation in the meantime?

Be specific and honest...

The reading distinguishes intervening in ways that create learning from intervening in ways that create defensiveness. The difference usually lies in how accurately you understood the other person before you started.

1. How likely is it that this person believes they are acting fairly?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

2. Write their account of the situation as they would tell it, in their words, as sympathetically as you can manage. If you cannot construct one, you are not ready to have the conversation.

Be specific and honest...

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3. What do they stand to lose here — status, self-image, a relationship, the belief that they are a fair person? Whatever you name is what the defensiveness will be protecting.

Be specific and honest...

Most difficult conversations are decided in the opening, before either person has said anything of substance.

1. Write your opening two sentences. Observation before conclusion, specific before general, and no preamble that softens it into unrecognizability.

Be specific and honest...

2. What is your one clear ask? A conversation with no ask is a complaint, and it will be received as one.

Be specific and honest...

1. Define success in advance. Is it agreement, a changed behavior, a next meeting, or simply that the thing has been said out loud and can no longer be unsaid?

Be specific and honest...

2. What will you do if it goes badly — if they are angry, if they cry, if they reach your supervisor before you do? Decide now, because you will not decide well afterward.

Be specific and honest...

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3. Write the day you will have this conversation. Everything above is preparation, and preparation that never terminates in a conversation is a more sophisticated form of avoidance.

Be specific and honest...

Part 15 · Exercise 9: 7-Day Advocacy Practice Check-In

7-Day Advocacy Practice Check-In

A Week of What You Saw and What You Did

The Week Is More Honest Than the Intention

Advocacy is not tested in the dramatic moment; almost nobody gets one of those in a given month. It is tested in an ordinary week — the meeting where somebody was talked over, the team-room remark, the assignment handed to the same person again, the patient described in a way nobody would say to their face. None of those feels large enough to write down, which is precisely why they need writing down. Take five minutes a day for seven days. Seven small entries will show you something a single honest reflection cannot.

One thing you noticed today — an exclusion, a bias, an inequity, however small, whether or not you did anything about it.

Your response...

One thing you did about something you noticed. If nothing, write "nothing" — a run of them is the finding.

Your response...

One moment you let pass. What stopped you, in one word?

Your response...

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One thing you learned today from someone whose experience differs from yours. If nobody told you anything, that is data about who you are talking to.

Your response...

Advocacy rating today (1 = observed only, 10 = acted on what I saw)

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

Observed only · Acted on it

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Your response...

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Your response...

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Your response...

One moment you let pass. What stopped you, in one word?

Your response...

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Your response...

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

Observed only · Acted on it

1. Look at the seven ratings together. What separates your highest day from your lowest? The cause is usually nameable — who you were with, how full the day was, whether the person involved outranked you.

Review your week...

2. Count your noticed column against your acted column. That ratio is the practical measure of this week, and it is the thing the fourth reading is actually about.

Review your week...

3. Read the one-word reasons in your passed column as a set. Is it the same word most days? A single recurring obstacle is far easier to work on than a general shortage of courage.

Review your week...

4. Count the days where you learned nothing from anyone whose experience differs from yours. What does that number say about the range of people you are genuinely in conversation with?

Review your week...

5. Name the one change this week has earned — small enough to start on Monday, specific enough that you would know afterward whether you had done it.

Review your week...

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Part 16 · Exercise 10: Advocacy & Allyship Action Plan

Advocacy & Allyship Action Plan

The Practices You Will Actually Hold

An Ally Is Not Something You Are

The first reading is blunt about this: allyship is not an identity you claim but a practice others recognize in you because of what you do. That makes a plan of this kind more than an organizing device — it is the only form the commitment can actually take. Select what would survive an ordinary bad week rather than what sounds right on a good one, write your own wherever the list does not fit your setting, then commit to the few you will genuinely hold. A short plan you keep is worth more than a long one you announce.

The reading calls this interpersonal advocacy: the direct interactions where you witness something and choose to intervene. Every item here is small, repeatable, and available regardless of your position.

Write your own — the version that fits your actual setting, your actual week:

The practice, and when in the week it actually happens...

Institutional advocacy changes the conditions rather than the incident. The reading puts it plainly: a biased individual in an equitable system produces less harm than the same individual in a biased system.

Write your own — the version that fits your actual setting, your actual week:

The practice, and when in the week it actually happens...

The reading names this as the level most people skip, on the assumption that having good intentions is the same as doing good work.

Write your own — the version that fits your actual setting, your actual week:

The practice, and when in the week it actually happens...

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Amplify rather than replace, and follow the leadership of the people most affected. Every item here transfers something to somebody else rather than adding something to you.

Write your own — the version that fits your actual setting, your actual week:

The practice, and when in the week it actually happens...

Advocacy in a treatment setting has a patient-facing half. These are practices inside the clinical hour rather than around it.

Write your own — the version that fits your actual setting, your actual week:

The practice, and when in the week it actually happens...

This work is long, and most of it is unrewarded. People who burn out stop, and stopping helps nobody. These are the practices that let advocacy outlast enthusiasm.

Write your own — the version that fits your actual setting, your actual week:

The practice, and when in the week it actually happens...

1. Which practice from this plan will you start first, and when in the next seven days does it actually happen? Put it at a day and a time, not in a category.

Make this concrete...

2. What will you stop doing, or give up, to make room for it? A commitment with nothing given up is a wish.

Make this concrete...

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3. Who will know you made this commitment, and does that person have permission to ask you about it? The reading says allyship is a practice others recognize in you because of what you do — recognition requires a witness.

Make this concrete...

4. Write your commitment as one paragraph in your own words, and finish it by naming the specific colleague or patient population it is for. An action plan addressed to nobody in particular gets carried out by nobody in particular.

Make this concrete...