

Chapter 8: Meetings in Special Settings

8.1 About This Chapter

This chapter is about convening LifeRing meetings in dual diagnosis clinics, residential treatment programs, halfway houses, prisons, and other special-purpose environments. It discusses the convenor's basic approach and goals, the adjustments that may need to be made in the typical meeting format, and the rewards that come from convening in these settings.

8.2 Introduction

The heavy use of alcohol and/or other drugs has a tendency to yank a person out of their usual environment and land them in special settings. Alcohol and drug use is a factor in a large proportion of arrests for a variety of crimes, and people convicted of drug possession form the major bulge in the large and rising U.S. prison population. (Robert Wood Johnson Foundation 2001) Alcohol and/or drug use are involved in a large number of psychiatric hospitalizations, as well as hospitalizations for physical trauma. Significant concentrations of people with alcohol and drug issues are to be found in a variety of treatment settings, including facilities for people with dual or multiple diagnoses.

In all or most of these special settings, a number of patients as well as clinical professionals are looking for recovery choices. There is, therefore, a field of opportunity and, many feel, a social duty, to

bring LifeRing into these settings. As of this writing, LifeRing convenors have more than four years' combined experience conducting meetings in a locked psychiatric ward for patients in acute crisis involving drugs/alcohol; more than five combined years in long-term residential dual or triple diagnosis facilities; more than three years in a 28-day residential substance abuse facility; dozens of convenor-years with patients in outpatient chemical dependency treatment programs; and several years in prison and parole settings. Although this is still a very modest experience base, we have come to an understanding of certain basic points:

- The LifeRing approach is viable in all of these settings, including with the "hard cases." Our message resonates with a significant proportion of people in these institutions and assists them in helping themselves in ways that are noticeable to them, to their peers, and to clinical staff.
- Convenors active in special settings need to adjust the meeting format and tailor their own role to meet the particular needs of the population in the host facility.
- Convening LifeRing meetings in special settings is among the most rewarding experiences available in recovery. LifeRing convenors providing these services not only get to feel good as human beings, they also tend to develop their convenor skills rapidly and to a high degree of proficiency.

The number of LifeRing convenors who have experience in special settings is still only a handful. They include Mark C., Marjorie J., Syl S., Bill S., Bettye D., Robbin L, Patrick B., Chet G., and myself. If we included outpatient facilities, it would be a much longer list of experienced convenors. This chapter aims to condense the experience of this small band of pioneers and to inspire other LifeRing convenors to take up this challenging and rewarding service.

In each of these settings, the LifeRing convenor will want to keep in close contact with clinical staff and learn their policies and preferences. The professionals have much to teach us. Staff are usually quite appreciative of the convenor's efforts because, at a minimum, we free up staff time for other chores. Occasionally the LifeRing convenor also has the opportunity to educate staff about LifeRing. This occurs not only in formal presentations, when requested, but also in sessions where student nurses, the chaplain, or visiting professionals sit in on the meeting.

8.3 Finding Level Ground

I remember the cold fear that I felt when I first stepped into the dual-diagnosis crisis intervention ward at a local hospital and saw the doors lock behind me. The physician in charge had advised me that most of the patients had been brought there by police on a “51-50” –they had tried to kill themselves, or someone else, or had been found wandering naked in the street. In my fear, I struggled to find ground on which to stand. At moments I pictured myself on a mountaintop, looking down on the rabble from my bastion of sanity and sobriety. At other times I wanted to crawl into a mouse hole and scurry away: I had no competence to deal with these people, and they would quickly see me as a fraud and hoot me out of the room. I had to struggle to find level ground. Other convenors have had similar experiences. (Jones 2001)

As usual, the anticipation was worse than the reality. Once I got settled in the room, said a few words, and got people talking, it began to dawn on me how much we had in common. That man over there with a bandage around his neck, who drank a fifth of bourbon and then picked up a kitchen knife and slashed his throat – I’ve come close to doing that. That nice-looking young man over there with a triple diagnosis (addiction, depression, HIV+) – that could have been me. That distraught-looking woman with the sunken eyes seeing visions, that could have been my grandmother. The longer I listened, the more I saw that there is no great chasm that separates people in special settings from those on the outside. It is more a matter of degrees and situations and sometimes luck, rather than a separation of kind. After one spends some time listening, the people with special challenges that one meets in these settings come to seem like friends and family, and sometimes they *are* friends and family.

Finding level ground does not mean having identical diagnoses. I do not need to have slashed my own throat or experienced clinical depression or had psychotic episodes or a murder conviction in order to relate as a peer to the people I find in special settings. It does mean, I believe, having had some experience in life where one falls into the abyss, loses one's bearings, abandons all pretense, looks death in the face, but survives and recovers. The AA historian Ernest Kurtz refers to such experiences as “kenosis” – literally, emptying out, figuratively a dark night of the soul, a visit to the abyss. (See White 1998:333) Nearly every person who has followed the call of alcohol/drugs for some considerable distance in life has had such experiences.

Achieving “authenticity of emotional contact” (White's phrase) with people in special settings is a two-way process. People in special settings tend to have low expectations of the people who come in from outside to see them. They may expect to be judged and preached at, or pitied and held in contempt. When someone makes an effort to meet them on level ground they tend to react with pleasant surprise. They will teach patiently, if the convenor is willing to learn. The convenor's evident desire to establish a level relationship goes a long way toward achieving success.

It is helpful if the convenor begins the meeting by clarifying the convenor's role. In the locked psychiatric crisis ward, for example, I usually begin by saying that I am not a doctor or other clinical professional, I am not employed by the hospital or otherwise paid for being here, I have no particular credentials in psychology, and my only qualification for being here is that I used to do alcohol and drugs a lot but have now been clean and sober for a period of time, and I want to share the insights and methods of the group in which I am doing my recovery.

Throughout a meeting in a clinical setting the LifeRing convenor needs to avoid posing or being seen as a doctor or other authority figure. We don't make diagnoses, we don't recommend or dispute treatments. At the same time, the convenor can be firm about asking people to participate in our process. We have something to contribute and we are there for a legitimate reason. We are present without pretense or apology. We stand on level ground.

8.4 A Base to Build On

In special settings no less than in ordinary community-based meetings, the convenor's role is to bring people together in recovery. But in order to come together with others, people have to believe in themselves, and the convenor has to believe in them. The quality of emotional resonance, of relating to people on level ground, communicates a belief in the potential for recovery.

To my mind, the foundation of the LifeRing effort is the belief that there is good in bad people. No matter how low a person has sunk, there is a basis of recovery within them to build on. As long as they are alive, they are not one hundred per cent zero. This is as true in the psychiatric ward and in the felony lockup as in the community meeting.

This message resonates positively with the hardest of hard cases: the alcoholics/addicts who have attempted suicide. These make up the majority in the locked acute psychiatric crisis ward.

- They don't need to hear that their life is unmanageable; they know that, that's why they tried to end it. Even their death was unmanageable.
- They don't need to hear that alcohol and drugs are very bad and may kill them; that's what they were trying to accomplish.
- They don't need to hear that their characters are defective; they already feel like double failures – failed at living and failed at dying.
- They don't need promises that God will pull them out; if they still had faith in those promises, they would not have tried to kill themselves in the first place.

What they do need to hear is that there is something valid within them to build on. When we come in with the attitude that there is something good within them as they are, they tend to pick up their spirits. When we tell them we are not a twelve-step program, they sit up and pay attention. When we assume that there is the capacity within them to recover, they tend to come out of their paralysis and to validate our assumption. When we tell them that success depends on their own efforts, they tend to start connecting with others and entering into networks of support. We adapt the meeting format to bring out these basic qualities (see below). That works for many people in this setting. People rise to our level of expectation. Many patients come out of the LifeRing meeting in the institution with a positive attitude, and some begin to take up their own recoveries.

This has not gone unnoticed by facility staff. At an Acute Dual Diagnosis Intervention Unit where LifeRing meetings had been going on weekly for nearly two years, the Patient Care Manager wrote:

We have found that this [LifeRing] approach encourages patients to begin to think positively about themselves and to find a reason to live productively. This approach resonates with the significant portion of our patients [...] who have received little or no benefit from past 12-Step involvement. [...] Our treatment team believes that there are many viable paths to recovery, LifeRing being one very positive adjunct to our traditional offerings. The LifeRing meeting is a bright spot in the patients' week, and staff find that participation in the

meeting enhances patients' motivation to get well. (Quoted in Nicolaus, ed., 2000:7; see full letter below.)

Prisoners live in a world filled with authority figures, and conflicts with authority in more than one case got them where they are. The last thing they need for their recovery is one more authority figure in their lives. The LifeRing convenor comes in with a different attitude. We do not pretend that we bring The Answer to their drug and alcohol problem. We come in with the expectation that the prisoners can probably find those answers within themselves and each other. We sidestep their natural resistance to authority. We give them a message of self-help, backed by tools that allow them to work out a viable recovery program for themselves. That also works sometimes where other approaches fail – a fact not unnoticed by chemical dependency staff in a growing number of correctional settings, who use the LifeRing Press *Recovery by Choice* workbook to reach their most hardened, most unreachable populations.

8.5 Meeting Formats in Special Settings

The basic guideline for LifeRing convenors is to adapt the meeting format to serve the recovery needs of the people present. With that in mind, LifeRing convenors working in special settings may want to consider some of the following situations and issues:

8.5.1 Creating a Circle of Choice

In some institutional settings, people are compelled to attend the LifeRing meeting during a given hour just as they are compelled to attend twelve-step meetings at other times. This is a different situation from the case where patients or prisoners are given a choice between two or more meetings – LifeRing and twelve-step – in the same time slot. In that case, LifeRing attendance is by choice, not by compulsion. But in settings where there is no choice, the LifeRing convenor needs to make some adjustments.

The convenor knows that the healing process in LifeRing meetings cannot be coerced. People can be forced to enter the room but they can't be forced to open up and connect with their peers. For the LifeRing process to work at all, the convenor will need to establish a bubble of choice within the box of coercion. In meetings with compulsory attendance, some people may brag about their drinking/drugging, testify for Jesus, or recite the twelve steps from memory. In such a setting, the convenor is not entitled to “show the

door” to people who are on a fundamentally different page philosophically. Argument is counterproductive. Only a strictly positive approach can work here. The convenor will want to identify and work mainly with the subset of people within the room who do acknowledge having drug/alcohol issues, who do entertain abstinence as a goal, and who are open to a secular self-help approach.

Essentially, the convenor will be conducting a meeting within the meeting, actively involving and positively energizing those who voluntarily resonate with the LifeRing approach, and encouraging the remainder to stay quiet on the margins. With a good crowd on a good day, the convenor will have practically everyone participating in a supportive manner, and for most of that hour the coercive framework will be forgotten.

People in coercive settings deserve to have the LifeRing option available to them. It is not their fault that the institution gives them no choice during that hour. If we refuse to play when these are the rules, many people who would benefit from LifeRing will never hear about it. It's better to light a candle than to denounce the darkness. The positive response from the participants when the convenor succeeds, or even makes the effort, supplies ample validation. There are active LifeRing convenors in community-based meetings today whose first contact with LifeRing came in one of those temporary microcosms of freedom within the locked steel doors.

8.5.2 Topics for Minds in Turmoil

In the acute psychiatric setting, the usual “How Was Your Week” format that we use in community meetings runs into limits. Prescribed medications severely constrict the horizon of some participants' recent memory. Others have the requisite horizon, but spent their previous week ramping up to and then performing the attempted suicide, homicide, or breakdown that got them into the institution.

There is generally no compelling reason for us to elicit the patients' “How I got into the ward” stories. They may excite our morbid curiosity or educate us but they serve little recovery purpose. In our usual community meetings, the point of talking about events of the week is that the person is engaged in an ongoing life-weaving project called recovery, and the meeting is an opportunity to share the current status of that work-in-progress. In the acute psychiatric ward, most people don't yet define themselves as in recovery; they have not yet become proactive and got busy at the loom of their lives. The objective is to help them move toward that starting point.

For that reason, LifeRing convenors who work in this kind of setting generally ignore the patients' immediate history and utilize a topic format. After the introduction, we ask people to talk about a broad, positive topic such as:

- Is there a clean and sober place inside of me, and if so, what does it look like?
- A clean and sober dream or vision I have for my life
- A clean and sober memory that I have
- A good time that I have spent with clean and sober friends
- People I know who love me as a clean and sober person

Most of these topics were developed by LifeRing convenor Marjorie Jones. The point of these topics is to focus mental effort and social energy on affirming something positive and recovery-related within the person – some clean and sober identity, vision, memory, or friend. These can be moving sessions. Revisiting better times, re-claiming a better self, reaffirming a better vision for one's life can help people whose minds are in turmoil gain a few moments of comfort and a little boost of energy to pick themselves up and start over.

The convenor doesn't need a long list of such topics; there is high patient turnover and this handful of tested topics goes a long way.

8.5.3 Crosstalk in a Psychiatric Setting

Crosstalk in the acute psychiatric setting can work wonders. To see patients engage with one another in a positive, supportive, sobriety-affirming manner is almost like watching miracles of healing happen before one's eyes. Some patients can talk quite sanely and insightfully about their insanity. They can help each other recover in ways that may be quite difficult for physicians. When patients recognize one another as valid, worthwhile people, you can sometimes see their whole demeanor improve from one moment to the next. In my experience, peer-to-peer conversation can be even more effective in the acute crisis setting than in the ordinary community-based recovery meeting.

But – and it is an important proviso – crosstalk must be explicitly consensual. In the psychiatric setting, LifeRing convenors always ask the participant whether they want to have feedback, and get a clear “yes,” before inviting others to respond. By contrast to the community meeting, crosstalk in the psychiatric setting is off by default, and each patient is empowered to turn it on if they want it. The con-

venor also must be on the alert for the usual snags that may come up in the crosstalk process, discussed in a previous chapter.

8.5.4 High-Turnover Settings

High turnover is the norm in short-term institutional settings. In the acute psychiatric ward the average stay is less than a week. In a nominally 28-day inpatient program, the actual patient stay may average less than two weeks. In outpatient programs, patients may cycle through meetings as quickly as they cycle through the various phases of the program. Often the patients have never heard of LifeRing and have no clue what it is about. Some may assume that it is just another flavor of twelve-step meetings and proceed accordingly. Others may think it's group therapy, or career counseling, or any number of other things. The convenor may get one chance only, or a few at the most, to communicate the LifeRing approach to them.

In such settings, the usual one-minute LifeRing opening statement may not suffice. The participants may ask for, and the convenor will want to present, a more extended positive presentation of the basics of LifeRing practice and philosophy. On occasion, presenting and answering questions about the LifeRing approach will occupy the whole hour. That's fine if that is what the participants wanted to do that particular day. At other times, a few sentences of amplification on the opening statement will be enough. The convenor needs to play it by ear. The priority is to keep the participants engaged and participating. All other things being equal, I strive for a 1:4, 1:3 or 1:2 ratio between explaining LifeRing and doing LifeRing. So, in a one-hour session, we may spend 12 to 20 minutes discussing LifeRing concepts, and the remainder of the hour having a LifeRing meeting.

In some settings, the convenor will face the competing demands of people who are new and want explanations, vs. people who heard the explanation last week or the week before, and want to have the actual meeting. One effective device in this situation is to ask the veterans, who heard the explanation last week, to act as presenters for the newcomers. LifeRing convenor Robbin L. introduced this method. This approach has multiple benefits. The presenters deepen their own understanding, on the principle that one way to learn something is to teach it. The presenters are also more likely than the convenor to be on the same wavelength as the newcomers in that setting, and their words may be more immediately accessible. Finally, the convenor can measure the effectiveness of last week's explanation by listening to its echo this week, and can make the appropriate adjustments.

High-turnover settings also challenge the convenor to come armed with LifeRing literature, particularly handouts and meeting schedules, and to keep the host institution's literature racks filled at all times.

The convenor's Rule One – train your successor – can't be applied in the usual way in high-turnover settings. A core group of regulars cannot form there. Instead, the convenor will need to recruit a successor from meetings in community settings.

8.5.5 "Talked Out" Settings

A different kind of challenge faces the LifeRing convenor in long-term residential facilities where the population is not only stable but is engaged in a constant round of other meetings. Here, the convenor may find that the participants feel "talked out." The conventional opening, "How Was Your Week?" may bring responses such as "We already talked about that in community meeting this morning."

The convenor in this situation will want to ask some questions to find out what the participants really want and need. What was it that resonated with them in the introductory LifeRing presentation that they heard, or in the LifeRing materials they read? When faced with a "talked out" population, the convenor needs to decide whether to prioritize LifeRing content or the LifeRing process.

Focusing on content would mean, for example, to organize the meeting around LifeRing readings, such as the three main brochures, the *Keepers* book, the *Presenting LifeRing* booklet, or the *Recovery by Choice* workbook. Collectively these contain more than enough content for many months of weekly meetings, without much repetition. The convenor could also bring in other interesting and compatible recovery literature as a focus of group discussion. To date we have not had a great deal of experience with content-centered LifeRing meetings, but there appears to be growing interest in them and it's only a matter of time before they become established.

Focusing on process means to move ahead with the "How Was Your Week?" format despite the initial concern that members feel "talked out." I have led LifeRing meetings with resident patient groups who have spent almost all their waking hours in meetings, but where the LifeRing process elicited feelings, ideas, insights and self-revelations that had not occurred to the patients – or that they had not dared express – in their other encounters. Despite the fact they had been talking all day, they talked way past the hour, and I had to eventually disengage myself.

There are meetings and meetings. In many treatment environments, and outside as well, meetings tend to be staged and scripted events at which most attendees are passive spectators. Even the so-called “process meetings” in treatment programs – sessions that on their face bear the nearest clinical resemblance to LifeRing meetings – can be stylized affairs, where people have to grovel and speak in formulas.

The down-to earth atmosphere (the secularism) of the LifeRing format often gives people permission to let their hair down and speak their real feelings without having to fit into some Sunday School formula. The LifeRing spirit, which sees the recovering person as proactive, can motivate people to hold their heads up straight and look monsters in the eye that they would otherwise believe themselves too weak to challenge. The open architecture of the LifeRing approach may get people thinking realistically and optimistically about their own forward path. In short, as they become comfortable with the LifeRing format, people may come to realize that although they had been moving their lips all day, they have not really talked at all. I have seen counselors in the hallway outside our door scratch their heads wondering what in the world the patients found to talk about after a full day of meetings. The LifeRing difference is not necessarily in what we talk about, but in how we talk.

8.5.6 Sticking Together On The Inside

This section was contributed by LifeRing convenor Patrick Brown. Patrick has successfully completed his parole and is currently studying for a degree in psychology at the University of Texas in Austin. His analysis and recommendations for substance abuse treatment in the correctional system is entitled “Substance Abuse Felony Punishment Facilities: Are They Working?” and is available online on www.unhooked.com.

Hello, my name is Patrick Brown, and this is the story of my experiences in the Texas Department of Criminal Justice (TDCJ) system. I was sent to a rehab program as a stipulation of my parole. It is called a Substance Abuse Felony Punishment Facility, putting stress on punishment. I remember the day that we first pulled up to the gates and I saw the razor wire. I thought to myself, “This place doesn't look like much of a rehab to me.” Little did I know.

The date was May 28th, 1999. The sun was beating down hard on the central Texas ground. Hondo, Texas would be my home for the next nine months, and I was anxious to get

acclimated to my new surroundings. I had heard some horror stories while locked up in the county about the place that I was about to enter, but had no idea just how strange and twisted the place really was. If I were to be asked now to describe the facility, the first word that would pop into my mind would be “cult.”

As soon as I was stripped of my street clothes and put into the TDCJ whites, I was led to a little room where they took all of my personal information and did paperwork. I was now classified as a “client” in a medical context, and with that I suddenly disappeared off the face of the earth. Anyone checking the TDCJ prisoner database would no longer find me.

When I first entered my building, they shaved my head completely bald to strip me of the last vestiges of my “street mentality.” For the first 35 days, I was in the orientation phase of the program. I was not allowed to speak to any of the other “clients” and was only allowed to sit in a certain place in the day-room called “the box.” I was segregated from all others, save for the few “clients” who happened to be in the orientation phase along with me. I was told that I was “toxic” and that I had not earned the privilege to speak with the “family members.” But every night I was forced to attend AA meetings, and was not allowed to talk during them. I was not allowed to attend the secular meeting that was going on, even though I said that attending AA was offensive to me.

Our day began at 4 a.m., when we were awakened for breakfast, and we were not allowed to lie back down until 8 p.m. We were “programming” for the bulk of that time, having very little time for anything else. It was a constant round of seminars with a monotonous content. The main answer that one always received to every problem was “turn it over to God.” We were forced to attend seminars on “Step Study,” and we would receive strict punishment, including the threat of unsuccessful discharge or an extension of our term if we tried to buck the system. I believe that being subjected to AA indoctrination is a violation of my freedom of religion. When I confronted the counselors on this matter, they would not give me a straight answer. I had to keep attending their twelve-step seminars.

I dealt with this problem the only way that I knew how: by passive-aggressive behavior. Whenever they gave a seminar, I would interrupt with points of clarification, like, “When you

say a power greater than myself, you mean God?" And they would give the typical sidestep answer, "A higher power can be anything." To which I would reply, "It couldn't be anything with a power less than mine, though, isn't that right?" We would go on and on like this, and they would always end up telling me, "Until you turn your life over to the care of God as you understand Him, then you are screwed. You will never be sober and you will always be a loser." That didn't make sense to me then and it still doesn't today.

As soon as I "got out of the box" i.e., became a "family member" (and my hair grew back out a little) I began to go to the secular meetings. I knew that I had found my answer when I first read *Unhooked* and saw the logic of this approach. It made sense and I knew that it would work, so I began to build it into my daily life as well as I was able.

At that time our group was ostracized by the other "clients" and we were branded as godless heathens. We were also slandered as racist, even though two of the original members of the group were minorities. We were not allowed the same privileges as were the other "clients" and we were not allowed to meet every day as were the twelve-step groups. They claimed that there was no room for us to have our own meetings, and so while the others were having their meetings, we would just have to sit on our bunks and read. We were okay with that, but then the others complained because it seemed a privilege to them. It turns out that they didn't really want to attend AA meetings after all! Go figure.

We ignored the name calling, stuck together, and just did our thing. We never quit asking questions in the mandatory twelve-step seminars. We used the LifeRing platform to get some pretty serious work done on ourselves and to really map out where our sobriety would take us. Our group remained small, averaging seven to nine people, for the first six months or so of my stay, but then matters improved. The private outside contractor who had been running the program changed, and there was a lot of hubbub in the background about pay rates and contracts. When the dust settled, we were recognized as a "real" group at last and we were allowed to give seminars on the secular approach to sobriety.

We put together a quality seminar on the secular approach. Some of the counselors who had been the target of our questions in their twelve-step seminars tried to retaliate with sniping of their own, but we knew our stuff and could not be

rattled. Grudging admission of the validity of the secular approach followed, and we were awarded an equal amount of meeting room space. I was named Liaison for our building and before I left (and passed on the torch) our numbers had swelled to equal AA and NA. We were finally getting the constitutional protection that we had fought so hard for.

There were two counselors who had a special hatred for our group. One of them told me to my face that I had no idea what sobriety was all about and that I would relapse as soon as I got home. The other used a mandatory meeting to deliver a church sermon complete with Bible quotes. He gave us all a handout with the scripture passages. I tried to mail it to the American Civil Liberties Union, but it disappeared from the prison's out basket. I hope that these counselors have grown in their sobriety as I have.

I am now enrolled in college pursuing a degree in psychology in hopes of becoming a therapist someday. The scars that I received in that hellhole are fading with time. I am still clean and sober. I am living my life and improving in some way every day. I am happy, finally. I took personal responsibility for my life and my sobriety, and I also take the credit for my success. I took my power back, and I feel good!

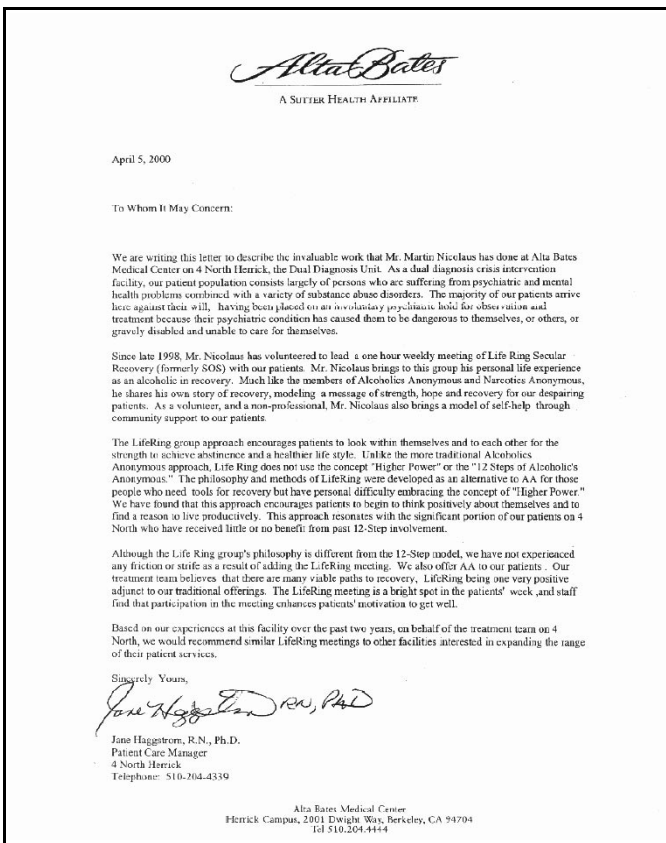
8.6 Special Rewards

The LifeRing convenor in special settings gets to experience dimensions of life that are out of the ordinary. This line of service rightly attracts those who are hungry for a broader, deeper knowledge of reality, and who are not happy unless they are working at the cutting edge. Special settings convenors display great emotional courage, resonating in empathy with fellow humans who are struggling through the most difficult passages. Special settings convenors also display strong analytical powers when they apply general concepts creatively to a diversity of unforeseeable situations. Many people in recovery don't feel challenged by what they are doing in life. They should become LifeRing convenors in special settings.

Special settings are excellent schools for the convenor. When it comes to presenting the LifeRing approach to audiences, there is no substitute for practice, practice, practice. In the high-turnover setting, the convenor faces a constantly shifting stream of diverse minds, each with a certain interest in LifeRing and questions about it. The convenor who listens to the questions and looks into the inquiring

eyes will soon grow in ability as a presenter. It is not only a matter of style, but of thinking hard about the questions people ask, and digging deep inside to find genuine ways of expressing the answer that engage people and lead to real understanding. The convenor in conventional settings who is rarely challenged to say much beyond “How was your week?” might gain a great deal of depth and proficiency as convenor by taking a turn at leading a special settings meeting with a highly transient population.

Convenors in special settings perform a strategically important service for LifeRing and for society at large. One of the ignorant criticisms that is often flung at us is that our approach won't work with hard cases. Convenors in special settings have the opportunity to



demonstrate that the LifeRing approach can work quite well in locked wards with people who are suicidal, homicidal, or out of control, and behind bars with prisoners who are considered recalcitrant, rebellious, and unreachable.

Society has frequently hammered these populations with the twelve-step message twelve times over, and has given up on them because they do not respond. The LifeRing convenor does not come with a hammer but with a piece of string. We look for the good in bad people, no matter how tiny it may be, and we help them connect up that good with the good in others who are as bad as themselves, so that the goodness flows between them and grows stronger within them. We do not stand as powers over them and we do not try to take their few remaining powers away from them; rather, we facilitate them to empower their better selves. In so doing, we are performing a service to the entire society. It is gratifying that from time to time, LifeRing convenors receive recognition for the efficacy of this approach from professionals in the field, as in the letter reproduced on the previous page.

It almost goes without saying that the convenor in special settings receives a powerful personal sobriety boost from this service. Convening meetings in special settings yields emotional rewards out of the ordinary. I do feel good at the end of our usual community meetings, but I have rarely felt such deep satisfaction as after leading a successful LifeRing meeting with people institutionalized in acute crisis. It's like the warm feeling you get when you have jumper cables and you stop and help a fellow motorist stranded with a dead battery on a freezing day – but better. Why would you want to relapse when you can get this kind of all-around satisfaction in sobriety?

8.7 Delegates From Special Settings Meetings

In regular LifeRing meetings, the convenor is not automatically the delegate to the LifeRing Congress. A delegate needs to be expressly elected as such. In special settings as a general rule it is impractical or meaningless to hold an election. Where that is true, the convenor automatically becomes the meeting's Congress delegate. (LifeRing Bylaws, Sec. 5.4, as amended by the 2nd Congress, 2002.)