

Special Thematic Section on "Rethinking Prefigurative Politics"

What the Recovery Movement Tells Us About Prefigurative Politics

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Abstract

The concept of prefigurative politics has re-emerged following recent worldwide uprisings, such as the Occupy movement, to which this concept has been applied. In applying a contemporary analysis to prefigurative politics, we explore the contribution of community-based recovery groups to the recovery movement, a socio-political movement in the fields of mental health and addiction treatment. We argue that collective action in recovery groups is derived from the formation of an opinion-based social identity and results in alternative approaches to unmet needs, creatively addressing these identified needs through the utilisation of personal, social and collective resources within an emerging recovery community. To illustrate our argument, we provide examples of community-based recovery groups and the approaches they use in addressing the identified needs of their recovery community. We conclude with an analysis of what community-based recovery groups and the wider recovery movement can contribute to a contemporary understanding of prefigurative politics.

Keywords: recovery, social identity, collective action, mental health, addiction

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Prefigurative politics has been aligned with the New Left that emerged from student demonstrations in the US in the 1960s. Since then, this form of collective action has been employed by a range of movements supporting the rights of marginalised populations, such as the civil rights movement, feminist movement, and gay rights movement and, more recently and noticeably, the Occupy movement. In this paper, we argue that this form of politics is also characteristic of the emerging 'recovery movement' in promoting social change that supports people seeking to recover from mental health conditions and addiction. We go on to argue that this form of collective action has empowered individuals and communities in their own recovery journeys and, by doing so, has challenged professional hegemony and ownership of knowledge around the treatment of addiction and mental health.

In the wake of the worldwide Occupy movement, the term 'prefigurative politics' has come to prominence once more yet, given the changes in the socio-political landscape in the last few decades, there is a need for a fresh analysis of the term. As Yates (2015) argues, the processes underpinning prefigurative politics may have expanded,

or may need to be expanded upon, to encompass *new ways of acting in the social and political sphere*. He proposed that prefiguration may be understood as being based on five processes: experimentation as a community, continual and collective reproduction of the group's political framework, the creation of group norms and values that draw on the desired future, consolidation of the results of these processes into a cohesive vision, and the dissemination and diffusion of this vision within the wider community (Yates, 2015).

These processes build on the basic tenets of prefigurative politics proposed by Breines (1989), as captured in the title of her chapter discussing this topic 'Politics as Community', and these still appear to hold. Her definition of prefiguration describes a form of collective action that is embedded in a sense of community, and with a desire for a truly participatory democracy. This results in advocacy for decentralised decision-making through a politically and socially engaged community, where all members of society are represented and heard. In this way, prefiguration requires more than merely the creation of a subculture or counter-culture; it requires engagement of the wider community and an impact on the dominant culture, with the norms and values of various groups within society being supported and embraced by the wider society. It also requires proponents of the movement to demonstrate their values through collective action and in everyday practice.

Here we propose a theoretical analysis that applies these conceptualisations to the recovery movement, using a number of community-based addiction and mental health recovery groups as case studies to illustrate our analysis. This analysis will draw on existing theory and evidence from mental health, alcohol and other drug (AOD), and collective action literatures to further explore the evolution of prefigurative politics within one particular area of community engagement. We will argue that collective action within the recovery movement is mobilised through shared identification with the ideas held by various groups (see Bliuc, McGarty, Reynolds, & Muntele, 2007; Bliuc et al., 2015; Thomas, McGarty, & Mavor, 2009), in this case around the concept of recovery. We will further argue that the actions taken by various groups are prefigurative in nature, drawing on a group's resources to create the desired future in the present to promote the perspective and interests of the people being represented by these groups, and presenting an inadvertent challenge to the professions to whose models these groups do not conform. In creating this tension, the recovery movement thereby impacts on the wider community, forcing a rethink of service structure and provision.

A Recovery Movement

Within both mental health and addiction, there has been an increasing disenchantment with a professionalised, pathology-based and medicalised treatment system (Barrett, Benson, Foster, & Leader, 2014; Smith-Merry, Sturdy, & Freeman, 2010; White, 2000). Concerns around the institutional treatment of people with mental health conditions were raised by sociologists Goffman (1961) and Foucault (1965) in the early years of what became known as the 'antipsychiatry movement'. Prominent psychiatrists R.D. Laing (1960) and Thomas Szasz (1961) had also begun to challenge how we understand mental illness, the power of the medical profession, and even the role of the state, to determine the boundary between 'sanity' and 'madness', and the subsequent need for treatment. Instead, they advocated for people who were suffering from what was labelled as 'mental illness' to be empowered and to own the response to their experiences. Service user movements, becoming active around this time, advocated for the rights of people being treated within the mental health service system, and worked to reduce discrimination against 'service users' by the treatment system itself, as well as by the wider community. Their aims of empower-

ment, autonomy, increased wellbeing and social inclusion are encapsulated in the concept of 'recovery' (Smith-Merry et al., 2010).

Similarly, the addiction recovery movement has been built on the recognition of alternatives to professional treatment, with 12 step peer support groups based on the model of Alcoholics Anonymous (AA) being the most prominent example of a non-professionalised pathway to recovery from addiction. The emerging tension between professional treatment of addiction or mental illness and community-based support for 'natural' recovery (Granfield & Cloud, 1996) is evident in attempts by those experiencing this phenomenon to define, or redefine, 'recovery' for themselves. Tension exists around debate over whose definition is more meaningful and useful – definitions citing objective features that may be observed by treatment centres or government departments (e.g. Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2008) or definitions adopting a first-person perspective of recovery that describe it as a subjective process of moving towards an increased sense of autonomy and overall wellbeing (e.g. Deegan, 1988; Repper & Perkins, 2012). Slade (2009) has argued for reconciling what he terms 'clinical' (objective) and 'personal' (subjective) recovery into an integrated model. White (2007) argues that, ideally, an agreed definition should encompass both perspectives – honouring the lived experience of people and their families managing mental illness or addiction whilst identifying observable characteristics that can be captured and measured at a governmental level to assist with effective service provision. However, this reconciliation has not yet been achieved.

Recovery-oriented community groups contributing to the recovery movement promote first-person perspectives to emphasise the validity of experiential knowledge, which has traditionally held less status in the creation of a knowledge base and thus limited decision-making power (Belle-Isle, Benoit, & Pauly, 2014). These attempts to provide a definition, from either perspective, could be seen as attempts to lay claim to knowledge of the concept of recovery and, consequently, to endorse the legitimacy of the approach taken to the management of recovery. While, traditionally, professionals have assumed all knowledge of the process of recovery, and this has been supported by mechanisms of the state, many people served by these state systems have found that the current system of diagnosis and treatment, or management, only furthers their distress and sense of hopelessness (Smith-Merry et al., 2010). Hence, the recovery movement seeks to define the role that the 'victim' of addiction or mental illness plays in their own recovery journey, and to translate that passivity into empowerment and ownership of the condition and its resolution. This ties into Foucauldian notions of power being embedded in and enacted through language, discourses and practices (Foucault, 1982). Consequently, Belle-Isle and colleagues (2014) argue that providing an alternative definition of recovery to that given by a professionalised treatment system generates a more democratic process of knowledge production, allowing all voices within society to be represented and heard.

Hence, a key prefigurative process within the recovery movement is enabling those engaged in the process of recovery to define what recovery means for them (Smith-Merry et al., 2010), and so to make choices for themselves about the best pathway for their personal and unique experience of recovery. This re-definition could even apply more broadly to include the application of externally driven, professionalised, illness-focused conceptualisations of addiction and mental illness, particularly the stigmatising implications of such labels and, by extension, at what point in their recovery people may relinquish these labels and the associated stigma. For example, schizophrenia has long been conceptualised as a degenerative illness (see Kraepelin, 1896), undermining any hope of recovery. Indeed, people in recovery from addiction still attract a significant level of public stigma (Phillips & Shaw, 2013) and the fear of stigma presents a barrier to seeking treatment for both mental health and addiction problems (e.g., Myers, Fakier, & Louw, 2009; Corrigan, Druss, & Perlick, 2014), and thus is counterproductive to recovery.

A self-managed process of recovery may well include limited or no engagement with the formal treatment system, avoiding the stigma and sense of hopelessness embedded within that experience, instead opting for a self-driven and community-supported recovery process that draws on the knowledge and support of others in recovery. In fact, as one of the pillars of the recovery movement is 'mutual aid' groups, such as Alcoholics Anonymous (AA), this suggests that people are not just an expert in their own recovery journey but that their experiential knowledge makes them well placed to help others and, by doing so, further support their own recovery (Humphreys, 2004). The perceived success of such self-help, peer-based initiatives represents a significant challenge to a treatment orthodoxy rooted in a bio-medical model of addiction or mental illness and its resolution.

In this way, the recovery movement prefigures an alternative in which people are free to choose to question professionalised, detached, and pathologising definitions of what they are experiencing and, instead, mobilise resources to support and empower one another in whatever recovery pathway they choose to take. The processes of reframing shared experiences and mobilising support redefines recovery in the here and now, without the need for an agreed consensus from 'experts', placing the recovery movement within the sphere of social movements that work to empower their members by building new networks of support, strengthening existing ones, and redefining power relations, with consequences for professionals and for the wider society.

We argue that building a movement around a shared belief about what recovery means draws on what is referred to in the collective action literature as 'opinion-based' groups – groups formed through people connecting with each other around shared beliefs, often around world views about how particular things should be (see Smith, Thomas, & McGarty, 2015). Identifying with a group formed around shared beliefs, thus deriving one's sense of self from membership of such a group (one's social identity; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987), has been shown to be a reliable predictor of subsequent collective action (Bliuc et al., 2007, 2015). Such opinion-based social identities create a platform for collective action that is likely to mobilise not only individuals in the process of recovery but also those who may have some stake in the redefinition of the term, such as support workers, family or carers of someone affected by mental illness or addiction, and therefore hold the same shared ideals around the issue (Bliuc et al., 2007).

William White, the most prolific author on the history of the recovery movement in the field of alcohol and other drug addiction, writes of the recovery movement in the following terms:

The focus of this new movement is not on the source or nature of addiction, nor on the solutions that science may provide tomorrow. Instead, the focus is on the solutions that are possible at this moment if resources can be mobilized to effectuate them. (White, 2000, p. 8)

Research on self-managed recovery within the alcohol and other drug field refers to these resources as 'recovery capital' (Cloud & Granfield, 2008). This terminology draws on notions of alternative forms of capital beyond economic capital, as first proposed by Bourdieu (1986). By evoking an alternative use of this term, Bourdieu built on a capitalist discourse, whilst acknowledging that money was not the only resource people had available to them. Particularly people who have very little economic capital may use other resources at their disposal to meet their needs. As stated by Alinsky (1971), money is only one source of power; the other is people, and this ties in well to the notion of recovery capital as it is conceptualised.

Recovery capital combines three different types of existing capital – personal capital, social capital and community or collective capital (Groshkova, Best, & White, 2013), to describe a dynamic process where personal networks and community engagements have a symbiotic relationship with individual growth and wellbeing. Running counter

to the dominant treatment system paradigm that focuses on rehabilitation of the individual in isolation, recovery-oriented community support takes into account the full range of recovery capital, considering not only the person but also the social networks in which they are embedded, and a sense of social inclusion through belonging to a community, which in turn has positive effects on wellbeing (Jetten, Haslam, & Haslam, 2012). Thus, recovery capital not only includes social support from people who share the recovery journey but also support from people with a shared understanding of the meaning of recovery.

Personal capital consists of physical and psychological resources, such as psychological resilience or physical wellbeing, that are available to an individual. This is the type of capital traditional treatment systems work to increase. While these personal resources may assist individuals in managing day-to-day symptoms, and may offer unique skills within a group, the type of resources mobilised in a recovery-based community or support group are more often social and community capital.

The concept of social capital pertains to social resources gained from belonging to a group, such as a valued social identity, and the benefits of social connection (Bourdieu, 1986). At the group level, it also includes obligations, norms, values and broader networks, as well as intergroup connection, which may serve to strengthen a community (Putnam, 1995). Both group- and individual-level perspectives are relevant, as we argue that social resources available to an individual could facilitate access to a recovery community, and vice versa.

Finally, community capital has been conceptualised as the sum of resources that contribute to a healthy and successful community, combining economic, ecological, social and human capital (Hancock, 2001). In terms of recovery capital, such resources may include sufficient funding to support the full range of needs of people in recovery, or urban planning that minimises exposure to triggering factors, for example limiting the number or accessibility of venues supplying alcohol to minimise relapse in symptoms of alcohol addiction. This may also include the creation of 'therapeutic landscapes', spaces of varying size that provide a safe recovery-supportive environment for people seeking to recover, from small public spaces appropriated by psychiatric 'survivors' to engage in informal support groups (Laws, 2009) to entire towns whose growth and culture is predicated on the contribution of former members of local residential recovery programs (Wilton & DeVerteuil, 2006).

The emergence of a community-based recovery movement draws on these three aspects of recovery capital to collectively support individual members in their recovery journeys and to strengthen their sense of wellbeing and belonging. In addition to this, the recovery movement seeks to increase the overall status of those in recovery in the wider society through increasing the visibility of the recovery community, particularly highlighting the positive contributions this community makes to society, thereby challenging public stigma. These collective resources and a shared commitment to a social and interpersonal perspective of recovery are mobilised in a sustained effort to change the position in society of people in recovery, from being marginalised and socially excluded to being recognised and integrated as valuable members of society. This ties into both the subjective, first-person perspective of recovery and government-driven definitions that promote meaningful participation in the community as central to a definition of recovery.

Recovery Communities in Mental Health and Addiction Recovery

White (2000) cites a number of communities in the US, and Roth (2011), in an editorial for a Special Issue on recovery in the UK in the *Journal of Groups in Addiction and Recovery*, cites a number of communities in the UK, that draw on their own resources and experiment with new ways to provide support, peer education, advocacy and a visible presence of people in recovery in the wider community. Through their actions, these communities prefigure the desired societal change towards a recognition of the legitimacy of self-managed recovery and accessible means by which to achieve this, in the here and now (White, 2000). This is not done in a way that is hidden (anonymous) or associated with shame and the internalisation of stigma; instead it promotes the idea that recovery is worthy of acknowledgement, even celebration, and that capacity for achieving this is intrinsically located in local communities. These communities operate under the belief that recovery can be achieved through social processes that do not necessarily require the mechanisms of professional intervention. Treatment may be a part of the process for some people but it is not a prerequisite, nor is validation of recovery from a professional a requirement for success.

What binds these communities is the shared experience of seeking to recover but finding existing services and social institutions unable to meet all identified needs, most of these being identified as social needs (Laudet, Stanick, & Sands, 2009) and, particularly in mental health recovery groups, a sense of not being heard by mainstream treatment services (e.g. Barrett et al., 2014; Waegeli, 2014). However, in identifying with a community of like-minded others that share the same view of the process of recovery, this shared sense of dissatisfaction with the status quo can be unifying, and conducive to collective action to find meaningful solutions (Smith et al., 2015). In the case of recovery communities, this occurs by prefiguring an alternative to what is currently provided by the treatment system and available within the wider community. This process of identifying with the views of others and taking action in line with these views occurs in a similar fashion to social movements that produced social change in other areas of society, such as the US civil rights movement the 1960s (McGarty et al., 2009). Here we discuss several examples of community-based recovery groups to illustrate current applications of the concept of prefiguration as it applies to recovery.

DARE (Drug & Alcohol Recovery Expeditions)

The need identified by the founding members of this group was not recovery-related. DARE was based on a shared goal of people in a rehabilitation program to climb 15 peaks in Wales in one day, with the additional aim of raising money for charity. Existing evidence shows that meaningful activity can increase quality of life in recovery and improving treatment outcomes (Best et al., 2013). In a paper explaining the historical and theoretical underpinnings of the group, Livingston and colleagues (2011) describe DARE as a 'recovery-orientated mountaineering group' and 'participant-owned', based on mutual aid principles, and the group purposely seeks to avoid involvement from formal treatment agencies and government agencies.

Livingston and colleagues (2011) attribute the longevity of the group to this approach, which creates a sense of ownership within the group and allows the group to determine their own direction, thus drawing on the personal capital of its members and the social capital embedded within the shared identity of the group. This also allows for a more democratic approach to activities, with all members contributing to decisions about which walks to un-

undertake, thus aligned with the prefigurative principles of decentralised decision-making. [Livingston and colleagues \(2011\)](#) contrast this democratic approach with the professionalised approach to activities, under which walks would likely be pre-determined and details already mapped out, drawing a parallel between this approach and treatment planning. In line with the principles of the recovery movement and its prefigurative foundations, all members are considered to bring a valid perspective and their own skills to the group, thus all members are encouraged to participate in preparatory discussions about which walk to undertake each time and how to approach the walk. [Livingston and colleagues \(2011\)](#) argue that this approach empowers group members and facilitates a positive self-image for members as competent and valued, and it encourages in members a sense of belonging and commitment to the group, allowing them to feel they have a space, not only in the wilderness but also within the wider community. We argue that this process creates a strong social identity as well as another form of therapeutic landscape, through what Livingston and colleagues refer to as ‘affiliational support’, which draws on and contributes to the social and community capital of the group.

Serenity Café

The Serenity Café in Edinburgh, Scotland, is a social hub for people in recovery from alcohol and other drug addictions, run by people in recovery ([Campbell, Duffy, Gaughan, & Mochrie, 2011](#); [Serenity Café, 2011](#)), providing effective mutual aid. Its origins stemmed from the shared dissatisfaction of a small group of people in recovery, in part with the type of social events hosted by local 12-step groups but more so with the alcohol-laden atmosphere of local nightclubs. This was tied in with a sense of social exclusion from “normal” nightlife and associated social experiences ([Campbell et al., 2011](#)). Thus the group’s disenchantment with the status quo centred around nightlife available to those in recovery from alcohol and other drug addictions, insofar as it often involved the ubiquitous use of alcohol and/or drugs.

Unlike DARE, who avoided any involvement with formal agencies, financial support for this initiative was sought, and gained, with the assistance of a local community development agency ([Campbell et al., 2011](#); [Serenity Café, 2011](#)). With this funding, the founders reached out to other like-minded people seeking support in recovery, considered the first step towards effective collective action ([Smith et al., 2015](#)), which was achieved through early experiments with ‘café-club’ nights, a prefigurative process in line with [Yates’s \(2015\)](#) reconceptualisation. This proved successful and became a source of social support and inclusion in a meaningful and desirable form of nightlife for the recovery community. This is an example of the use of community capital by people in recovery to build cohesion and a shared sense of identity with others in recovery (social capital). This enabled collective action through the prefiguration of the desired alternative to “normal” nightlife, in the present, and for the benefit of their community.

This venue and its activities evolved into an ongoing social enterprise, run by people in recovery, that now provides the recovery community with opportunities for employment, training, and other business roles. The main focus of the café remained creating a drug and alcohol-free social space for people in recovery ([Serenity Café, 2011](#)), but did this through drawing on the resources within the community, whilst providing the community with a source of recovery capital that boosted personal, social and community resources, and allowed opportunity for people to increase their sense of overall wellbeing in recovery through community participation, specifically employment and career development opportunities.

By modelling the successful prefiguration of an alternative to a substance-focused night-time environment, extending this to a feasible social enterprise, and demonstrating a working partnership with an existing community development

organisation, Serenity Café gained the attention of policy-makers, who sought the views of volunteers from the café on issues of alcohol and other drug policy (Serenity Café, 2011). This provided an opportunity for the group to influence policy and practice around recovery, in a way that was not necessarily intended and, it was eventually decided by the group, that risked detracting from their original purpose (Campbell et al., 2011). Thus they decided to continue focusing on the needs of the community, on shared decision-making, and on continuing to model their workable alternative to the issues affecting their community.

Recovery Colleges

A much larger initiative within the recovery movement is the development of recovery colleges. Recovery colleges have manifested in different ways in each area and in different countries. Collegiate recovery communities, and even schools, in the US focus on recovery from addiction, providing a space where students can feel comfortable that they will have a supportive environment of like-minded peers to help them continue their recovery through their educational experience (Laudet, Harris, Kimball, Winters, & Moberg, 2014). This creates a dynamic and generative model where participants tap into recovery capital to help them develop their own, while at the same time they learn to give back to the community, to contribute to recovery capital at a community level. These types of recovery communities develop through mobilisation of community resources to address a need with a particular community, in this case people seeking to further their recovery by gaining an education, that is not being addressed within mainstream services, such as standard student services or standard addiction services.

Recovery Colleges in the UK are based on prefigurative ideals of 'co-production, co-delivery and co-receiving', with short courses being developed and delivered in partnership between people with personal and professional experience of mental health conditions and recovery (Meddings, Byrne, Barnicoat, Campbell, & Locks, 2014; Perkins, Repper, Rinaldi, & Brown, 2012). Through the curriculum offered, recovery colleges aim to inspire hope, empower people to understand and manage their own symptoms, their treatment and other life areas, and to connect students to other learning opportunities (McGregor, Repper, & Brown, 2014). This educational approach operates in contrast to traditional treatment approaches that focus on deficits, which are externally defined and addressed by applying the expertise of professionals in a pre-structured way. Instead, recovery colleges help people to recognise and use their own skills and resources, to explore possibilities and pursue their goals, in an empowering environment where students choose the topics to best fit their own learning needs and teachers merely act as coaches (Perkins et al., 2012). In this way, recovery colleges prefigure an alternative to both traditional education and recovery institutions, by encouraging the mobilisation of resources within a community, formed through shared ideals of empowering people in recovery to self-manage all aspects of their recovery, and allowing people the choice to integrate their recovery with a personalised and individual educational programme.

Whilst recovery colleges were initially set in community health settings in England, proponents of the recovery movement in Scotland facilitated the inclusion of a recovery college in the curriculum offered by a faculty within a Scottish university. In line with prefigurative principles of community engagement and experimentation with valued alternatives, this is open to anyone with an interest in mental health and increased wellbeing, thereby further dissolving the traditional link between treatment services as sole facilitators of access to education for people with mental health issues (McCaig, McNay, Marland, Bradstreet, & Campbell, 2014). The inclusion of a recovery college within a mainstream educational institution aims to instil within people recovering from mental illness and addiction a sense of belonging within traditional educational settings, thus (re)connecting people with these environments

and further contributing to the social inclusion of people in recovery (McCaig et al., 2014; University of West Scotland, 2014).

Furthermore, the act of involving people with lived experience of these conditions in the co-production and co-delivery of teaching content is a prefigurative practice that not only challenges the traditional values and beliefs about people with mental health or addiction issues, but also encourages what Belle-Isle and colleagues (2014) referred to as a democratic process of knowledge production. This creates the desired alternative of people in recovery being truly socially engaged. It validates and draws on the existing knowledge of this segment of society and provides a platform for these voices to be heard. This also creates opportunities for skills development for people in recovery that are transferable to other sites of employment, in a similar way to employment and training opportunities offered through Serenity Café, thus providing yet another pathway to social inclusion.

The recovery groups explored here are seeking a recovery-supportive alternative that challenges the status quo – one in which solutions are negotiated within their groups and their communities, where the perspective of all group members is valued and, individually and collectively, they are empowered and recognised, and where, through their actions, the community itself is empowered and enriched. In these case studies, alternative supports for recovery include broader health-enhancing activities, connected to positive community action through DARE; a drug and alcohol-free social space, as an alternative to “normal” nightlife, at the Serenity Café; and a legitimate path to higher education and alternative knowledge production through recovery colleges.

Discussion

Community recovery groups are born from the need for alternative ways to support recovery from alcohol and other drug addiction and mental illness, based on a shared understanding of recovery as a holistic concept that empowers the person to live a meaningful life that maximises their wellbeing. This view of recovery and the associated aspirations need not only apply to people in recovery but to anyone who perceives a better alternative to the way people seeking to recover from mental health or addiction issues are treated and supported, in any area of life. This shared view becomes the basis of a new and meaningful social identity oriented towards social change, which increases the likelihood of participation in collective action thus the realisation of the group’s vision (Bliuc et al., 2007; Thomas, Mavor, & McGarty, 2012).

These groups advocate for what Gee and McGarty (2013a) called a “cooperative community” (p. 138) – an alliance of a range of stakeholders in a societal issue that involves challenges to an imbalance of power. Participants of cooperative communities recognise differences between stakeholders but share a vision for a better future, and this contributes to a shared sense of identity resulting in collective action to adequately resolve the issue, to the benefit of all parties, through social change.

The issue Gee and McGarty (2013a, 2013b) focused on was the reduction of stigma around mental health conditions, with stakeholders identified as people with mental health conditions, members of the broader public, and health professionals. Similar stakeholders to those cited by Gee and McGarty may be identified in the recovery movement, with the additional inclusion of policy makers and funding bodies (White & Hagen, 2005), and educational institutions (see McCaig, McNay, Marland, Bradstreet, & Campbell, 2014).

The case studies discussed here demonstrate prefigurative processes of experimentation with viable alternatives that meet the needs of the recovery group in the present, rather than relying on external knowledge or waiting for change to the current system. In these examples, alternative recovery support pathways have been shaped as community resources have been mobilised to respond to the evolving needs of the recovery community, from a broader, more holistic definition of recovery that extends beyond the values and definition underpinning professional-driven services, and in a way that enriches the wider community. This involves community ownership of the definition of recovery, in a way that is inconsistent with traditional professionalised treatment understandings and processes.

As can be seen from the examples of the types of prefigurative action undertaken by recovery-oriented community groups in promoting recovery, very little of the action taken is aimed towards directly changing the current service systems, although this may have come about as an indirect result, partly through the recovery groups epitomising and embodying a different discourse and approach. Through collective action that implicitly rejects a professionalised definition of recovery in favour of self-definition, these groups disengage from established structures, knowledge and power of the dominant system. They prefigure a new system that meets the needs of the identified community by drawing on the community's own resources, or recovery capital. This action is consistent with tenets of prefigurative politics posed by key theorists such as Breines (1989) and Holloway (2010) who suggested that collective action should not engage with or rely on the dominant power structures to initiate change but should instead build a new system within the cracks of the old, in other words create other ways of addressing needs not currently met by the existing system, in preparation for those systems changing.

Nonetheless, if success is to be measured in the impact an action has, the recovery movement has contributed to a paradigm shift in knowledge, in practice and in policy in addiction and mental health services in the UK (Best, 2008; Scottish Government, 2008; UK Drug Policy Commission, 2008), the US (Sheedy & Whitter, 2009), and more recently Australia (Commonwealth of Australia, 2013; Victorian Department of Health, 2011). In these countries, various levels of government have initiated a shift in policy and service provision towards a recovery-oriented model of care, often in consultation with people who use government services, and the process of developing policy has attempted to include at least some of the kinds of community recovery groups described here. However there continues to be room for improvement. As Best and Ball (2011) suggest, public policy would ideally be measured against outcomes that acknowledge all levels of the impact of recovery, including personal, self-reported measures of various aspects of recovery as well as family- and community-level indicators.

Conclusion

A prefigurative movement starts from the recognition of a shared viewpoint of how the world should be (Smith et al., 2015), one that rejects the status quo in recognition of a better alternative. Collective action then stems from the collective efforts and resources of groups and communities who subscribe to this point of view and are thus united by shared sense of identity around this, including aspirations for a better future (Bliuc et al., 2007; Gee & McGarty, 2013a). In the case of community recovery groups and their activities, this translates into advocacy for individuals' participation in and ownership of their own recovery journeys, and the means by which to support their needs. Collective action can take many forms and, as David Graeber (2011) asserts, the nature of this action can have subtle implications in the message it conveys, hence it is the action and the way it takes place that distinguishes a prefigurative movement from other kinds of collective action. What has happened in addiction and mental health is that a series of grass-roots community activities have coalesced into a prefigurative movement

that has drawn on their own resources to challenge, through collective action, professional ownership of knowledge around recovery and resulting professional practices by demonstrating viable and meaningful alternatives. In doing so, individuals, groups and communities have been empowered to own the definition of their own recovery, thus develop a valued social identity, and to become an alternative source of meaning and hope to disenfranchised and excluded populations.

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