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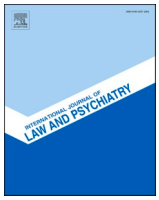

Research Paper

Abolition: Is this the only pathway to upholding human rights and ensuring epistemic justice in psychiatry? A key informant qualitative study

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ABSTRACT

Introduction: Mental health legislation authorises involuntary psychiatric intervention in certain circumstances. Although human rights concerns are becoming more prominent, debates among legal experts, clinicians and activists continue to swirl around people's rights to equal recognition before the law, such as described in the (United Nations Convention on the Rights of Persons with disabilities, 2006).

Aim: This qualitative descriptive study aimed to better understand diverse views of people known to hold a critique of coercion in mental health services, on the practical expression of upholding human rights in the context of mental health laws.

Method: Individual semi-structured interviews were conducted with 15 key informants from five different countries and data was analysed using an inductive, thematic approach.

Results: Overall, informants characterised mental health laws as discriminatory, harmful and unjustifiable. Three themes and six sub-themes were identified. This study reports on the major themes which include: an ethical position (focusing on the present harms associated with mental health laws), strategies, (an expression of the opportunity to bring about change) and a visionary position. We explore these three features in the views of key informants as important positions in the field of abolition, and analyse each for the 'hermeneutic resources' – forms of collective interpretive resources - they provide.

Conclusions: Abolition of mental health laws is often seen as not feasible in the context of psychiatry. However, abolition theories and practices are hermeneutic resources that need to be better understood because they offer social justice and community-led solutions beyond mental health laws and systems.

1. Introduction

There is increased global urgency surrounding reduction of coercion in mental health care (Aluh et al., 2023) in parallel with increased awareness and adoption of human rights approaches in the context of law reform and provision of care. While there is a significant degree of consensus on requirements to reduce coercion in psychiatry and numerous studies have attended to reducing reliance on these practices, its abolition is not readily discussed in clinical literature, and debates tend to be framed around specific cases where use of coercion might be justified (Faissner & Braun, 2023). This is despite direction from the (Parliamentary Assembly of the Council of Europe, 2019) (Ending Coercion in Mental Health: The Need for a Human Rights Based Approach), the (United Nations Committee on the Rights of Persons with Disabilities, 2014) (paras 17, 26, 40), and other UN bodies to end coercion (notwithstanding that other parts of the UN contest this interpretation see (United Nations Human Rights Committee, 2014), (UN Subcommittee on Prevention of Torture and Other Cruel, I. or D. T. or P, 2016), as do governments and judicial bodies (Martin & Gurbai, 2019). Consequently, very few papers have tried to detail the nuances and diversity of views around what psychiatric abolition is and how it might be achieved. This research aimed to address this gap by approaching people known to hold a critique of mental health laws and coercion in mental health services, or who described themselves as abolitionists, whether identifying as consumer/psych survivors, practitioners, scholars, or advocates, in line with our brief. (See Table 1.)

Coercion in health care can be defined as measures applied against the patient's will (Chieze, Clavien, Kaiser, & Hurst, 2021). We

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Table 1
Informant sample.

Country	Gender	Age-group	Expert role
India	Female	40–60 years	Activist
Germany	Male	40–60 years	Psychiatrist
Germany	Female	40–60 years	Survivor researcher
Switzerland	Male	Under 40 years	Advocate
Ireland	Female	40–60 years	Survivor researcher
Australia	Female	40–60 years	Academic
Australia	Female	40–60 years	Survivor researcher
Australia	Male	40–60 years	Lived expertise community development
Australia	Female	Under 40 years	Indigenous lived expertise advocate
Australia	Female	Under 40 years	Lived expertise
Australia	Male	Under 40 years	Academic
Australia	They/ them	Under 40 years	PhD candidate
Australia	Female	Over 60 years	Lived expertise consultant
Australia	Female	Under 40 years	Lived expertise academic
Australia	Male	Under 40 years	Advocate

acknowledge that coercion in psychiatry occurs along a spectrum from 'formal coercion' such as deprivation of liberty, mechanical restraint, manual restraint, seclusion or physically enforced administration of medication (Faissner & Braun, 2023; Lantta et al., 2023) through to 'informal coercion', including interpersonal leverage and threats (Gooding, McSherry, & Roper, 2020). We chose a broad definition of coercion that would encompass the range and intensity of psychological, spiritual, emotional, epistemological and ontological harms associated with coercion that are reported in the consumer/survivor literature. While there are a variety of ways people experience services, often depending on the level of coercion involved (Daya, Hamilton, & Roper, 2020), harms related to coercion in mental health services have been well-documented including physical harms (Kersting, Hirsch, & Steinert, 2019) ongoing trauma (Bartl et al., 2024; Steinert, Birk, Flammer, & Bergk, 2013) sense of psychological safety (Randall et al., 2024; Vogt et al., 2024) and harms to ontological freedom (Beaupert, 2018). Frameworks for rendering visible the harms enabled by mental health laws and ending coercion are needed.

The positions explored in this paper are novel, as abolition is not commonly put forward in law reform. For example, anti-coercion writers consider coercion within mental health laws as morally wrong (transgressive, wrong in delimited ways) and also harmful; but also justifiable and the 'least worst' course of action in certain circumstances. These are both principalist and consequentialist ethical arguments that differ in degrees. Abolitionists, however, assert these laws are wrong in all circumstances and do different harms (ie than those who argue for reduced coercion): intrinsic and indefensible harms. This is not a perspective that is often heard.

This paper emerges from an initiative of the Victorian State Government in Australia. Victoria is the second most populous state in Australia. In response to a major government inquiry, the Victorian Government passed the *Mental Health and Wellbeing Act 2022* and appointed a panel of non-government figures to review compulsory treatment criteria under the Act (the Independent Review of Compulsory Treatment Criteria and Alignment of Decision-making Laws Panel). This paper summarises research commissioned by the Panel, and led by the Consumer Academic Program (CAP), Centre for Mental Health Nursing, University of Melbourne, Australia ('the Mental Health Abolition Perspectives project').

The Panel asked the researchers to: 'consider creative ways to overt the voices and views inhering in the nuances of abolitionist perspectives', recognizing these perspectives were likely to be diverse and not likely to found in the formal literature. Hence an empirical approach was used, seeking out what those who call for the abolition of mental health legislation and the elimination of coercion in mental health settings mean in practice. We refer to this viewpoint in shorthand as an abolitionist perspective, noting that within this view there are likely to be differences about what is meant by this term and what might be the best path to achieving this aim. The present paper reports on research exploring these abolitionist perspectives. We are by no means suggesting these are the totality of activists and advocates who hold this perspective and we are aware that there is expansive diversity in views. Our aim was to better understand the ideas of at least some of this group, to try to synthesize these views and ideas, particularly for the purposes of those pursuing system reform or wanting to engage in community-led social justice.

2. Concepts

2.1. Abolition

Abolition has been described as a political, social and community movement to dismantle laws that create injustice and inequity, rooted within liberation struggles that is both a theory and a practice (Davies, Jackson, & Streeter, 2021). At the same time, abolition focuses on engaging in generative, daily small steps that "move us toward making our dreams real and that lead us all to believe that things really could be different. It means living this vision in our daily lives" (Gilmore, 2000, p. 197). Abolition has been described as "…an expansive and constructive movement, providing an opportunity for reimagining society" (Davies et al., 2021, p.3096) and has also been described as a cross-liberation movement that has been inclusive of "trans liberation, class struggle, anti-racism, climate justice, disability justice, migrant solidarity…" (Powell, 2022). The principle that decarcerating care and developing social justice solutions should be done by communities closest to the problem (Davies et al., 2021) rings true also for disability activists and activists in the context of psychiatry.

Prison abolitionists have well-developed theories, knowledges and practices, evolving over the past fifty years (Davis, 2024). More recently, 'grey' literature blogs and vlogs have argued why psychiatry should be seen as part of the prison industrial complex and should be joined with the dismantling of all oppressive social structures (Au Valencia, 2018; Harris, 2020; Mensah, 2020). These abolitionists see mental health laws as functioning as part of the broader carceral system and have drawn attention to the harms created by a mental health system which has the same features and colonial origins rooted in state-sanctioned torture, racism, and punishment. These authors draw parallels between prison systems and the mental health system employing coercion, detention, isolation, surveillance, and treatment without consent (Au Valencia, 2018).

2.2. Hermeneutic resources and epistemic justice

(Fricker, 2007), drawing from the works of feminist and anti-racist theorists, explored the notion that the knowledge of some individuals and groups are given less value, often because of widespread prejudice and discrimination that the individual or group knowledge holders experience because of their identity or lived experiences. Within epistemic injustice, Fricker articulates two distinct types of epistemic injustice: testimonial and hermeneutic. Testimonial injustice refers to instances where some individuals experience their knowledge or experience not being believed because of negative stereotypical assumptions attached to their identity or social group.

Hermeneutic injustice refers to occurrences where individuals or groups are not able to express their own experiences because of the lack of shared or common language or way of communicating ideas and experiences. This results from 'epistemic marginalization' whereby individuals or groups are not able to access places where conceptual and

semantic tools are constructed. As an example, the experiences of a marginalised group, or individuals within that group, may not be 'languaged' as oppression because there are not yet ways to make sense of these experiences as social powerlessness.

Hermeneutic injustice is serious in that it can negatively impact meaning-making, communicating our experience to others and self-interpretation, activities central to human life (Ritunnano, 2022) and can involve other inter-related real-world inequalities (Fricker, 2007). Fricker states that "Hermeneutical marginalisation is always a form of powerlessness, whether structural or one-off" (p. 153), therefore, solutions relate to political action for social change. For example, prior to black feminist scholar Kimberlé Crenshaw's concept of intersectionality, the cumulative nature of inequality that might be experienced by women across lines of class, race, gender and disability is less visible or not visible and difficult to articulate. Using Fricker's idea of hermeneutic injustice, until the concept of intersectionality, there were no readily available collective interpretive resources to explain experiences of multiple forms of identity oppression that a person or group may experience in society.

The consumer/survivor literature has argued that for psychiatrised people, (people who have been subject to psychiatric treatment, often against their will), available ways to understand, be understood, communicate, and make meaning, particularly at a structural/social level, are limited. These 'available ways' can also be called "hermeneutic resources" (Fricker, 2007). For example, the argument has been made that in psychiatry, a powerful medico-legal paradigm can discredit the knowledge, experience and testimony of people diagnosed with 'mental illness' (Daya, 2022; Leblanc & Kinsella, 2016; Liegghio, 2013; Roper, 2019). It has been argued that as a consequence, people's ways of making meaning, thinking, feeling, imagining and expressing, if outside that of psychiatry, are stifled, hindering legitimacy and identities as knowers (Beaupert, 2018; Russo, 2023; Voronka, 2019). Additionally, the consumer/survivor literature identifies that in this process of individualising illnesses, social injustice and inequality can be obscured and not addressed (Sinclair, 2018).

3. Methods

3.1. Study design

We undertook a qualitative exploratory descriptive study with "key informants" known to hold a critique of mental health laws and coercion in mental health services, or who described themselves as abolitionists, in line with our brief. We thematically analysed semi-structured interview data. The sampling strategy and the interview schedule were designed to elicit informants' nuance and detail of their views of abolition, and not to engage with the arguments for or against abolition. A key informant sample approach is often used when seeking high-level insights on the topic at hand, its organization, or to understand the debates on an issue (Pahwa, Cavanagh, & Vanstone, 2023). This approach was chosen to seek out the views and opinions of people who had knowledge based on an "ability to 'meaningfully' synthesize their experiences and to offer rich, reflexive insights" (p.1253). Overall, we interpreted the task as an opportunity to amplify a perspective seldom heard in the context of law and policy development.

3.2. Sample and recruitment

We approached nineteen people known to hold a critique of mental health laws and coercion in mental health services, whether identifying as having lived experience of mental health laws, or otherwise, in line with our brief. Of these, three did not reply, one did not wish to participate and 15 agreed to be interviewed. Interviews were up to one hour in duration. A combination of recruitment methods was used. First, names of experts were generated by the research team based on familiarity with advocates' published work, followed by use of 'snowballing' (asking each interviewee for the name of anyone they thought we should approach). One informant came from each of the countries, India, Switzerland, Ireland, two from Germany and ten from Australia.

Rather than aiming to be a representative sample, or attempting international representativeness, our study aimed to seek the opinion of a range of experts on a particular topic. Empirical studies can reach data or thematic saturation within a range of 9–17 interviews, and this is particularly so in research with relatively homogeneous samples addressing tightly defined objectives (Hennink & Kaiser, 2022).

3.3. Data collection and analysis

Individual online (zoom) interviews were audio recorded, transcribed by an independent transcription service and prepared for inductive coding. Semi-structured interview guides were developed by the research team in order to explore general opinions of mental health laws and alternatives. Fourteen of the 60 to 120 min interviews were video-recorded and one audiotaped. Interviews were conducted and analysed by three lived experience researchers (initials CR, NJK and PS); one interview was independently coded by all analysts and reviewed for soundness. The three overarching questions during the semi-structured interviews were: what are your opinions on mental health laws, are there laws or policies you are aware of that would support human rights, and are there community practices or initiatives you are aware of that would support people in crisis? Further prompts were included in an interview schedule. Data were first clustered with reference to the categories of the interview questions. They were then analysed, developing codes and clustered into sub-themes then into three themes. Data sufficiency was achieved in the sense that informants were speaking beyond their personal specific experiences or, integrating these with expert knowledge (Malterud, Siersma, & Guassora, 2016), for example knowledge of law, advocacy, the consumer/survivor social movement or other expertise.

3.4. Ethics approval and consent to participate

Ethics approval was granted by the relevant University reference 2023–27,382–42,858-5 and all contributors were sent a plain language statement about the research and signed a consent form. The data collected were anonymised and protected with a password accessible only by the research team.

4. Results

Informants included people identifying in a range of ways, as advocates/activists, survivor researchers, practitioners, legal and consumer academics. For the purposes of this paper, the term 'lived expertise ' describes intentionally and publicly adopting a lived experience lens, with its own distinctive philosophy and values. It can be contrasted with someone who 'happens' to have lived experience (Byrne & Wykes, 2020). Survivor is a term chosen by some who consider themselves survivors of psychiatry's interventions.

Analysis revealed three themes and six sub-themes as discussed in the following section. The first theme, *These laws are wrong* comprised two subthemes: a) human rights breaches and discrimination and b) harms of mental health laws. The second theme, *strategies for change*, focused on two subthemes: mental health laws and coercion are not inevitable, and changing community attitudes. The third theme: *Achieving justice: Re-imagining support without force* comprised two subthemes: first, understanding and investing in social determinants, community and human connection, and second: activism.

4.1. Theme

4.1.1. "These laws are wrong"

While not all informants explicitly asserted that mental health laws

needed to be abolished, implicit in the opinions of all informants was the view that reforms to mental health laws could never be fully human rights informed, harm-free, and non-coercive. While some people focused their advocacy/activism on mental health laws, others believed mental health laws were just one part of a colonial, patriarchal, capitalist complex needing dismantling.

4.1.2. Human rights breaches and discrimination

Opinions of informants about mental health laws across the dataset were that they were discriminatory for a range of reasons:

"I would say in general terms that whether it's mental health law or guardianship law, at least in Australia, they are all fundamentally problematic because they to varying degrees prevent individuals from making their own decisions" (interview 1, Academic).

The justification of human rights restrictions on the basis of an attribution of mental illness was raised as discriminatory:

"I think mental health laws by and large are discriminatory in as far as they justify or legitimize restrictions of freedom based on attributions of mental illness or psychiatric disorders" (interview 14, Psychiatrist).

Informants pointed to the discrimination inherent in the displacement of consent under mental health laws:

"…we've always argued that there is no other branch of medicine where you are forced or you have no, there is no way you can refuse the treatment that's being offered. So I mean I think the principle of informed consent would mean that there should be, the person has alternative choices…But if you don't have acceptable choices well then you don't really, you can't really offer consent or it's not free consent, it's kind of coerced consent" (interview 11, survivor researcher).

Beyond not having choices, one informant expressed incomprehension at involuntary treatment especially when a person is at their most vulnerable:

"…where else in the world in health would you put the person who's the most distressed somewhere against their will in a little hole of a room that is bare and disgraceful and peer at them through a window every 15 minutes, and leave people confused and distraught, and just - you know - distressed beyond belief. Where else would you do that for the most unwell person. How, I just don't understand how we can have laws that treat people that way" (interview 6, lived expertise Advocate).

The use of coercion enabled by mental health laws was identified as deeply entwined with a highly biomedical response to peoples' crises. Additionally, this model was seen as causing: false distinctions between people; stigma and discrimination; and 'Othering', that is the reductive action of labelling and defining a person as someone who belongs to a socially subordinate category.

"Why do these laws exist in the first place? They exist because there's this group of people that needs to be ruled and regulated, because there is something that makes them into another sort of people" (interview 7, survivor researcher).

Informants drew attention to ways in which several processes of dehumanization might occur through these laws.

4.1.3. Harms of mental health laws

Interviews associated multiple harms with the practices of mental health law including physical, emotional, psychological and spiritual violence, to loss of agency, citizenship, sense of self, humanity, and status. Some informants drew parallels between operations of prison systems and psychiatric systems, seeing both as part of broader carceral systems also known as the prison industrial complex (PIC). Throughout the interviews, carceral systems were characterised as inflicting harm on individuals, families and communities through surveillance and police violence. It is noteworthy that data for this theme were the most compelling and prevalent. Informants also drew attention to the harms of colonialism, white supremacy and carceral responses to distress, which they situated in colonial and penal histories intrinsically connected to coercion and punishment:

"The particular type of format that is being presented today in many countries is the old British colonial mental health legal formulation and I think that is quite hazardous because it was based on a penal formulation, and that hasn't changed. Still today they're struggling with coercion and what is the source of that coercion, very often it's these laws and policies" (interview 9, Activist).

Not only was this legacy identified, but harms were seen as impacting unevenly through social distributions of oppression, privilege and power, and were intersectional, cumulative and related to other carceral institutions:

"Like quite a lot of really interesting thinking is happening within the abolition of, the widest abolition of the movement which includes prisons as well as psychiatric institutions in the need for abolition. Recognizing how Intricately complex and convoluted the systems of oppression are, whether it's sexist, racist or classes, the things that oppress people and the whole system operates to maintain the status quo of the powerful (interview 11, survivor researcher).

Practices authorised by mental health laws such as detention, confinement and forced treatment were characterised by participants as violence, and often expressed with visceral language:

"…I'm not really articulate in finding the words to express everything, but my views on mental health laws is that those practices of restricted confinement and surveillance and tension against you know against my will is hugely damaging and a form of violence and more…" (interview 10, lived expertise).

A deep incomprehension was expressed by many as to why societies even have mental health laws:

"I was absolutely mortified when I realised I didn't have a right to refuse treatment, and just completely gobsmacked that that could be the case. Like how could I not have a say in what they're going to do to me and my body" (interview 6, lived expertise consultant).

Harms were not conceived of as limited to service users. Adopting the idea of 'moral injury', one informant identified staff including peer workers being harmed by a system that permits and enacts practices against people's will:

"So I'm thinking people who are in there working in the system and then realising what they're doing or coming to a new understanding of the experience of involuntary treatment like that that's something that has a profound, you know, moral injury on our lives we have to carry…" (interview 2, survivor researcher).

The point was also made that once diagnosed, people could be subject to additional harms, for example, instances where a person is threatened with losing custody of children if not adhering to medication. From an Aboriginal and Torres Strait Islander staunch advocacy perspective, one informant emphasized cultural safety practices could be jeopardized because of perceived risk or other reasons, in ways that could damage a person's experience, for example through having sacred objects being confiscated.

4.2. Theme

4.2.1. Strategies for social and legal change

A common observation was that existing cultures and ideologies would need to transform and steps would need to be taken to build a future of new possibilities.

4.2.2. Mental health laws and coercion are not inevitable

Informants pointed out that countries like Thailand, Indonesia and Nepal do not have mental health laws which, although leaving unaddressed the question of how well cared for people were in their communities, did mean that mental health laws are not inevitable. Mexico was put forward as an example of a country which has tried to include some mental health provisions under general laws, to minimize the impact of mental health laws:

"… they don't have specific provisions on involuntary treatment, they have a general provision for all health services around situations of medical emergencies, but even in those cases they have tried to

incorporate some provisions that make it difficult to be interpreted in a way that will allow involuntary commitment (interview 4, Advocate).

Comparisons were made between countries whose mental health legislation was more concerned with coercion and involuntary treatment and measures, including Community Treatment Orders, (like Australia) and countries who have put more effort into community based mental health responses such as Latin American countries. The policy and practice in 'Trieste', Italy, was put forward by many as a useful reference point in terms of a ***vision*** for abolition of mental health laws and the use of force in psychiatry. One respondent talked of their experience of providing services free from coerced treatment and without the use of locked doors during the day:

"…the more you progress, actually the easier it gets. So once you get on the way of not detaining or detaining fewer people, and even those who are detained we release them quickly, not force them to take medication. So the more you do of that or the more you don't do certain things, the easier it gets" (interview 14, Psychiatrist).

For this person, motivation for change over the long haul came from recognition that current ways of working were "wrong" and the user movement, human rights instruments and examples like Trieste provided inspiration for a vision and plan for change.

In the context of Australian laws, one informant pointed out that getting rid of mental health legislation tomorrow would make no difference to the functioning of the system *as it is now,* because there are already laws placing restrictions on people's decision-making, such as guardianship laws, and medical treatment decision-making laws. Another informant proposed that common law doctrines of Medical Necessity, Good Samaritan rules, and personal protection laws could be used in a non-discriminatory way – that is, in a way that does not target consumers/service users – in which some measures are available to potentially intervene when a person is experiencing a mental health or personal crises (so long as human rights are upheld), with additional restrictive laws such as guardianship and mental health laws being discriminatory and unnecessary.

Some informants put their views about how to achieve change very simply, in terms of abolishing mental health laws:

"I mean in my view you don't need a good alternative to stop doing something that is bad" (interview 1, Academic).

And:

"…psychiatric coercion should be abolished as an inhumane practice, breaching all rights of people, you know, to their own bodily and other integrity" (interview 7, survivor researcher).

Some made the point that international human rights law and legal instruments already prohibit compulsory treatment, according to what they view as the most authoritative interpretation of human rights law by the UN Committee on the Rights of Persons with Disabilities:

"I think on a kind of strict human rights analysis - you have to be an abolitionist, there's not really an accurate interpretation of the CRPD or its Charter or of the European Human Rights Legislative Framework that allows for compulsory treatment" (interview 15, Academic).

Another made the point that mental health laws could create:

"…a positive right to diverse, inclusive and non-coercive and non-discriminatory emotional and crisis support. So it could create a positive right to expect something from the state. But it doesn't do any of that stuff, it just pretty much only is about permitting compulsory treatment…." (interview 5, Advocate).

4.2.3. Changing community attitudes

Broader cultural and community prejudicial attitudes formed a barrier to change. A lack of community understanding of the harms permitted through mental health laws was also pinpointed: "it's still trying to establish that actually these are wrong and harmful and need to change" (interview 1, Academic.

Listening to, being present with a person and making space for people's experiences rather than interpreting them through a medical lens was put forward as important:

"I feel like ideally I would love to see a world where or just even down in Victoria where there could be an opportunity to just uphold people's experiences. It's such a human right, but I think so many medical models are just, they're I feel like especially within the First Nations community, it's all white man's way and so much of it has been to oppress and suppress and to really minimize so much" (interview 8, Indigenous lived expertise).

Another informant expressed optimism that countries could come to see coercion as a failure and provide better responses:

"…I'm more and more convinced that that's possible, that it's possible to push countries to more pragmatic ways to see coercion as a failure of the system, and the need to address it through better responses and different types of responses" (interview 4, Advocate).

One informant highlighted the use of moral argument to dismantling a coercive system:

"And so one of the ways that we can attack at the foundations of that system and dismantle it is to remove its social licence to operate, as in say that what's currently happening and our conceptualisations of mental health care are wrong, like they're morally wrong. And define what morally right would look like and drag the law from where it is to where we want it to be, to reflect that" (interview 5, advocate).

Others identified that people expect solutions before they abolish something, yet possibilities would emerge once something is abolished:

"We'll never get rid of mental health legislation while we're looking to change society in order to not need it anymore, we just need to get rid of it and we'll work out what to do afterwards" (interview 15, Advocate).

Theme.3: Achieving justice: Re-imagining support without force.

It was recognized that there will always be experiences of crisis in people's lives, but informants held a belief that it was possible to respond in non-violent ways. For some, abolition was already evident in the world, for example, through different ways of dealing with Madness, through political activism, or through alternative community-led supports. Informants thought governments needed to invest significant resources into community responses and at the same time, defund carceral institutions.

4.2.4. Understanding and Investing in social determinants, community and human connection

Abolition was understood as not merely dismantling mental health laws, but also providing needed resources and changing attitudes towards Madness and distress:

"…but yeah that abolition is not just stopping existing practices or closing doors or whatever it's also about providing those alternative materials, supports or accommodation or whatever, and also about the kind of epistemic - about changing how we think about disability or, psycho-social disability or distress or whatever" (interview 1, Academic).

The role of social determinants, of access to material things such as food, stable and secure housing, in alleviating and/or avoiding crisis was stressed:

"…so that they might have material conditions that are beneficial to thriving as opposed to just surviving. That means access to schools, access to healthcare that is genuinely free, access to parenting supports - things like that - all seem doable. They're all things that we know about and they're all there a little bit, but they could be expanded on" (interview 13, PhD candidate).

By the same token, social determinants were cast as causal of distress and trauma when they were not attended to: "Yeah and even you know things like it, it feels like such a no-brainer to support people around social and economic factors that impact their experience, like homelessness and unemployment and discrimination…" (interview 2, survivor researcher). One informant spoke about the importance of creating environments where a feeling of safety can be developed:

"…my practice is: number one address the housing needs, food, shelter, safety, feelings of safety which comes even first before, like

somebody that I live with might be experiencing psychosis on and off but we're not even going to address that until we've talked about you're safe now, how does that feel, how are you going to integrate that, you know, what needs to change in how your body, your mind feels to understand that you're safe because you've spent 20 years unsafe…" (interview 3, lived expertise Academic).

Abolition was seen as inextricably tied to the formation of more equal and fair societies:

"I think it would need to be societies that are much more communal in the sense of actually having communities that work together and look after each other rather than patriarchal competitive, you know racist, cruel societies that we have now" (interview 11, survivor researcher).

Investing in spaces where people could grow connection, home and belonging and address loneliness was identified as important. Instead of placing care in the hands of professionals, communities could be empowered and resourced to identify and solve their own issues:

"So going back to the mental health discussion and around like, abolitionism I really struggle to imagine how this is solved without community. Like I think if we keep the individualistic or very liberal way of thinking well it's not going to work. You need something to be there" (interview 4, Advocate).

A range of independent peer-led supports were identified as helpful such as respite, 'warm lines' providing informal phone support, and day programs as well as other no-force community approaches. Being present with another person, sitting with the emotional nature of experiences, realizing the often temporary nature of frightening or difficult times and resisting the urge to 'do' something other than keep the space safe were valued. One informant called this process "intimate" and warned against "models and universal answers" (interview 7, survivor researcher).

4.2.5. Activism

Activism against an exclusively biomedical way of understanding people's experiences was identified across the data as foundational to ending coercion and creating new possibilities. The role of collective activism in changing discourse and ending coercion was recognized. Activism could take many forms, for example:

"One part is personal experience. Second part is many years of activism, which means working together with many people with similar experiences. And the third part is research work around these issues" (interview 7, survivor researcher).

The question of how to politicise and develop a critical mass to advocate for abolition and non-coercion was raised. Making training available for people interested in change, was one suggestion. From an Indian perspective, one informant's activism was to work with the person's ecosystem - individual, families and community members, raising awareness on inclusion to address social restrictions:

"so we build values of co-operation and trust and equity, social justice, all of that into the communities that we are working with. So that that provides the ethical, moral context within which communities look at persons with disabilities" (interview 9, Activist).

Aboriginal and Torres Strait Islander activism and leadership was highlighted as having a long history, and an exemplar for how communities are already engaging in abolitionist practice, for example in the establishment of self-determined community health and legal services, and campaigns resulting in successful dismantling of harmful laws:

"I think these are really sophisticated examples of strategic advocacy to repeal draconian laws that impact disproportionately on First Nations people, but also disabled populations, addicted populations, marginalized populations, other racialized and minoritized populations, like it's the same as with decriminalized public drunkenness, like that's a campaign that isn't just going to benefit First Nations people. …" (interview 10, lived expertise).

Being able to imagine present and future possibilities and engage in actions towards freedom was highlighted:

"You know, love is the way there or one of the ways there but the goal is freedom and that's why it's like you can see why people have gravitated towards the term abolition which comes from, in this case, the prison abolition, the police abolition movements and that in turn comes from the enslavement abolition movements from the United States because all have been about freedom. Our bodily freedom, freedom of expression, freedom to be who we are in safety, yeah economic freedom, all of that" (interview 3, lived expertise Academic).

Overall, informants could not justify mental health laws, because of the discrimination and harms they authorised. The concept of abolition arising from the data could be categorized in three distinct ways: 1) dismantling mental health laws on human rights grounds; 2) decarcerating care; and 3) First Nations, Indigenous activism and self-determination.

In the discussion section we adopt Fricker's concept of 'hermeneutic resources' to explore these approaches to abolition in turn, proposing that while they differ from each other in significant ways, there is value in each and that taken together, these approaches provide tools to both render structural oppression visible and also provide tools to make sense of experience, conceptualise justice, and develop community-led solutions in response. Hermeneutic resources such as shared language, ideas and concepts, cultural and other traditions can be used by marginalised groups to develop shared awareness of how structural oppression operates.

5. Discussion

This research aimed to better understand diverse views of people known to hold a critique of coercion in mental health services, on the practical expression of upholding human rights in the context of mental health laws, whether or not they identified as abolitionists. The core message related to harms of mental health laws, with abolition put forward as a necessary response to the injustices posed by these laws. A clear and overarching viewpoint was that informants could not justify the existence of mental health laws and that they were inherently discriminatory and harmful.

We are in a moment when there is no fully established single theory about what abolition is, in the mental health context. Our study suggested three broad themes: 1) dismantling mental health laws on human rights grounds 2) to de-carcerate care 3) an urgent need to consider First Nations and Indigenous activism and self-determination as abolition leadership.

The first approach to abolition was premised on the idea that mental health laws are inherently harmful and discriminatory and need to be abolished as a means to achieve non-discrimination and equality.The second approach to abolition placed psychiatric abolition into the context of broader societal change. This framework was underpinned by discourses around other forms of abolition in particular the abolition of the prison industrial complex (PIC), which exposes the interlocking intersections of powerlessness and injustice that disproportionally impact marginalised people (Davis, 2024; Fricker, 2007). The final approach to abolition explored a First Nations and Indigenous perspective arising from a long-standing history of activism and principles of self-determination and is interconnected with the second way of understanding abolition.

While the specifics of First Nations approaches may not resonate with all countries, collective self-determination of marginalised groups to attain social justice is a social phenomenon shared across many societies (Crossley, 2005). Additionally, elevating indigenous ways of knowing, doing, being and activism not only provides necessary learning in contexts of decolonisation but also for academia, health and other settings more broadly (O'keefe et al., 2022). Human rights and ethics frameworks have provided highly effective advocacy tools to point out discrimination and argue for justice, however our results show there is also much to be learned from the knowledge inhering in the second and third features of abolitionist views. The discussion focusses on conceptualisations of abolition, as hermeneutic resources (Fricker,

2007) to consumer survivors and their allies in activism.

Typically, clinical approaches regard coercion as 'sometimes necessary' and at times beneficial and that this reflects a majority public view (Birkeland, Steinert, Whittington, & Gildberg, 2024; Randall et al., 2024). Provisos advanced by this group include that coercion should only be used as a 'last resort' and as a 'proportional response' and in this equation, the short-term over-ride of a person's autonomy is seen as justifiable for the sake of their longer-term autonomy and wellbeing (Chieze et al., 2021). It has also been argued that this stance prevents people from seeing practices authorised under mental health laws as being harmful (Roper, 2019)In contrast, those holding an abolitionist perspective would argue that the harms authorised by mental health laws are inherently unjustifiable, regardless of majoritarian views.

Unsurprisingly, our findings contrasted markedly with how ethico-legal concerns about coercion are generally discussed in the clinical literature. However, a recent survey of 167 'European… experts specifically dedicated to the reduction of psychiatric coercion, which included 'stakeholders from professional, patient, and carer groups' highlighted a gap between aspirations to abolish coercion and experts' actual beliefs about whether this was a possible or a desirable goal, but nevertheless showed about a third of those surveyed thought that it would be possible to abolish coercion (Birkeland et al., 2024). This minority within the study group argued that the negative consequences of coercion outweigh any gains. These results reveal differences between expert positions preferencing paternalism and coercive practices in certain circumstances, and those who see human rights as demanding an end to coercion, perhaps revealing that we are in a 'turn' indicating hope for future trends towards ending coercion.

5.1. Human rights as hermeneutic resources

Many of the key informants we spoke with talked about the violence inhering in involuntary treatment and detention, as well as other forms of coercion in psychiatry. The type of laws authorising involuntary psychiatric intervention which began to emerge in the late 20th century in high income countries may have introduced some procedural mechanisms to limit involuntary psychiatric intervention, for example, by instigating tribunals and court processes to oversee and potentially appeal such interventions. However, these laws arguably further obscured the violence being perpetrated against those who are subject to involuntary interventions, by giving it a veneer of legitimacy—something that Linda Steele has referred to in other contexts concerning legal oversight of state intervention on the bodies of disabled people, as 'lawful violence' (Steele, 2014).

Many of the advocates and activists we spoke with had used international human rights law to highlight discrimination and render visible the harms posed by mental health laws and end coercion. The majority of key informants we interviewed were well aware of, and used various Articles of the CRPD, for example, in their advocacy work. Such arguments are also reflected in the literature including that:

- mental health laws are discriminatory because they deny legal capacity on the basis of disability and allow substitute decision-making (Dhanda, 2012; Gooding, 2017; Minkowitz, 2011).
- forced psychiatric intervention should be abolished (Beaupert, 2018; Minkowitz, 2011; Russo, 2023; United Nations Committee on the Rights of Persons with Disabilities, 2014)
- forced treatment amounts to torture (Beaupert, 2018; Méndez JE., 2013; Minkowitz, 2011) and
- freedom of opinion and expression is violated through involuntary treatment (Beaupert, 2018)
- on a practical level, the CRPD could be adopted to provide non-coercive strategies to support people (Zinkler & von Peter, 2019)

Evidence of the impact of human rights advocacy can be seen, for example, in a joint report from the World Health Organization (WHO) and the Office of the High Commissioner on Human Rights (OHCHR) (2023) entitled "Mental health, human rights and legislation: guidance and practice" (2023). Such documents articulate human rights in a way that demonstrates a greater awareness of harms and rights to consent to treatment than heretofore. For example, the WHO/OHCHR released the following statement when launching the 2023 report:

Ending coercive practices in mental health – such as involuntary detention, forced treatment, seclusion and restraints – is essential in order to respect the right to make decisions about one's own health care and treatment choices.

Moreover, a growing body of evidence sets out how coercive practices negatively impact physical and mental health, often compounding a person's existing condition while alienating them from their support systems.

Informants in our study credited the CRPD with an enormous role in raising awareness of human rights concerns and violations and in providing leverage to practically move countries further towards human rights-based practices and policies. The CRPD was seen to provide a real-world advocacy tool to argue for non-discrimination and equality of people with disabilities, including in the mental health context. Such awareness-raising is also noted in the literature, for example, the impact of the CRPD on Peru's abolition of guardianship on the basis of disability (Russo, 2014). This type of activism and law reform can be interpreted as acts that provide hermeneutic resources for understanding how mental health laws violate people's rights and cause harm as well as providing new directions for how countries should develop mental health laws that emphasise consent.

Human rights laws, policies and conventions have been extremely useful in arguing for equality before the law for everyone, and for non-discrimination resulting in real-world change,though notably, Steele warns that even human rights rhetoric can be used to formalise regulation in ways that obscure forms of discipline and violence over a supposedly 'protected' group (Steele, 2016). These hermeneutic resources, taken together with other approaches to abolition theory and practice, provide potent real-world ways of rendering visible oppression and injustice so that it can be addressed and so that people's rights can be better upheld.

5.2. De-carcerating care

The second theme connects psychiatric abolition with broader societal change, founded on freedom, love and justice. This understanding of abolition inspires the possibility that abolition practices are not an ideal and can be engaged with every day. Abolitionists in the context of psychiatry have argued that a system founded on laws that are inherently discriminatory and perpetuate violence and oppression cannot be reformed. In this context, some psychiatric survivors have argued that abolition is the only pathway to achieving restorative justice and environments where mental health practices are supportive of the individual rather than harmful (Au Valencia, 2018).

For many of the informants, abolition was seen as a possible and necessary undertaking, accompanied by creating community alternatives based on consent. They contributed different ideas about how to dismantle mental health laws. Most thought that it would need a parallel process of building community resources at the same time as winding down legislative processes. Some believed that the community assets would need to be in place before attempting to remove mental health legislation. Others looked to countries that do not have mental health laws for inspiration in terms of creating strong communities. Some key informants drew on their knowledge of discourses around other forms of abolition, in particular the abolition of the prison industrial complex, (PIC) with its roots in the anti-enslavement movement of the eighteenth century and historical connections between imprisonment and enslavement and the over-incarceration of Black and Indigenous people and People of Colour (Davies et al., 2021).

The final abolition theme was a First Nations and Indigenous

perspective, arising from historical and current activism and principles of self-determination.

5.3. First Nations and Indigenous activism and self-determination as hermeneutic resources

The third theme concerns First Nations and Indigenous activism and self-determination and is influenced by the second conceptualisation discussed above. While it was raised in the Australian context, we expect there would be relevance in other colonized countries. Informants emphasized the intersections of colonisation, penal systems, capitalism, white supremacy and state violence in their theoretical frameworks of abolition. Aboriginal and Torres Strait Islander advocacy and abolition leadership have existed for as long as carceral systems have been in place in Australia, and the extensive work that First Nations and Indigenous leaders have done in the space of abolition positions these activists as leaders in the field of abolition theory and practice. It has been argued that self-determination and activism in developing legal services, and health services for community should be seen as acts of abolition leadership. First Nations, and Indigenous staunch advocacy has driven changes that benefit all, such as de-criminalising intoxication in public and ensuring that being affected by alcohol in public is regarded as a health issue requiring a health response.

Gunditjmara activist and storyteller, Tabitha Lean, speaks from having lived experience of incarceration (Lean, 2021). Lean suggests that abolition is not new, and that Aboriginal and Torres Strait Islander people have been fighting against their enslavement and incarceration more than 200 years. She expresses the twin sides of abolition, dismantling carceral systems and creating another world based on mutual responsibility: "If we dismantle systems that cage and punish, we can explicitly fight genocide and dispossession and create a world focused on radical reciprocity and accountability".

It was suggested to us that abolition cannot be dismissed as 'just an ideal' given the range of existing programs and practices that are already in place, as well as political activism that informants pointed to. We were told:

"I think the framing is really important to really centre and acknowledge and give space to the people that have fought for these campaigns and that are currently fighting these campaigns and movements and that are motivated by a desire for, driven by these abolitionist principles of collectivism and freedom and Black Power and people have dedicated their lives to this since invasion, you know, and I think that's why you have organizations like the Victorian Aboriginal Health Service and so many other examples of grassroots organizations that do this work (interview 10, lived expertise perspective).

LaToya Rule, who successfully campaigned for a ban on the use of spit hoods in South Australia, after the death of her brother has said:

"Abolition needs to be a daily process. And until our last breath until we finish we have to be doing abolition…when people say imagining abolition, that's something that I think we need to literally do when we wake up, that we need to try to embody. I think sometimes people see abolition as the end goal, and that there are strategies. And I know that that's a great way of how to explain the process of abolition but we really might not be here tomorrow in terms of physically. We can't wait for abolition. I guess the timeliness factor maybe needs to be taken out of it. It's not just in saying it can't be delayed, it's more like we need to step out into it with every step" (Rule, 2023).

For Rule and others, abolitionist praxis is anti-capitalist, anti-carceral, anti-colonial, involving imagining a queer, radical, creative world entirely unlike the one we live in today. It involves creating an archive of the oldest continuing culture on earth, maintaining and archiving indigenous epistemologies and ontologies, knowledges, being, doing and dreaming. It involves looking towards the future (Lean, 2021). Love and hope are central in abolitionist praxis and Rule acknowledges that abolition of carceral systems means creating a way of living and a means of living that others want. In their campaign work, Rule asks: how are we divesting from carceral arrangements, and how are we aligning with other groups? These queries are foundational to the solidarity and intention underpinning abolitionist practice (Lean, 2021). Abolition is not about waiting until something else is in place, they suggest, it is made and remade and engaged with every day (Rule, 2023). Abolition praxis is seen as political, full of possibilities, combining the energy of imagined futures alongside doing more of what is already being done. Abolition theory and practice links everyone's ability to thrive with everyone's liberation through the idea of 'leaving no one behind'.

Each abolition theme discussed provides hermeneutic resources that render visible harms authorised by mental health laws, and provide theoretical and practical tools for justice and transformative care that activists can use.

5.4. Strengths and limitations

Limitations of the study include a lack of generalisability of views, due to the informants sampling strategy chosen and the relatively small sample befitting the chosen qualitative method. However, this study makes a unique contribution in that it canvassed the opinions of people known to hold a critique of coercion in mental health services, on the practical expression of upholding human rights in the context of mental health laws, whether or not they identified as abolitionists. The informant sampling approach allowed us to seek out the views and opinions of people whose expert knowledge was based in meaningful examination of their experiences, offering rich, reflexive insights (Pahwa et al., 2023). Overall, we interpreted the task as an opportunity to amplify a perspective seldom heard in the context of law and policy development, rather than seeking a balance of views. Lived experience researchers leading data collection, interviews and analysis was a strength, enhancing the validity and relevance of our findings (Beresford, 2007) and contributing to epistemic justice by centring lived expertise.

6. Conclusions

Informants could not justify the existence of mental health laws, seeing them as inherently discriminatory and harmful with abolition put forward by most, as a necessary response. Three conceptualisations of abolition arose from the findings: dismantling mental health laws on human rights grounds; for psychiatry to be included in the total abolition of carceral responses in societies; and for First Nations and Indigenous activism and self-determination to be urgently regarded as abolition leadership. With a majority seeming unconvinced that abolition of mental health laws was possible, our findings instead showed that abolition is present in the world already, an inspirational practice of daily steps in the real-world, not an ideal and not something we have to wait for while we build up community resources. Our research demonstrated that abolition theories and practices are hermeneutic resources that need to be better understood. At its broadest expression abolition praxis provides examples of de-carceral care and social justice solutions developed by communities closest to the problem (Davies et al., 2021) well beyond dismantling coercive mental health laws and systems and generative of a world we all want to live in.

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Declaration of competing interest

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