European Network of (Ex-) Users and Survivors of Psychiatry

Store Glasvej 49, 5000 Odense C., Denmark

enusp.info@gmail.com / www.enusp.org

Coercion Is Not Care: Europe Must End Violence in Psychiatry

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The European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP) expresses our solidarity and support for the statement of the Croatian organization SUMEZ regarding the death of Kristian Josip Periš**,** age 32, on 21 October at the Sveti Ivan Psychiatric Clinic in Zagreb. ENUSP also expresses our sincere condolences to the family and friends of Kristian.

According to the deeply disturbing description of the CCTV footage included in the police report and published by the media, hospital staff used physical force against the patient while he was being mechanically restrained to his bed. He subsequently died.

Media reports state that Kristian Josip Periš was strapped to his bed while several staff members held him down. A pillow was reportedly held over his face for approximately eight minutes, apparently obstructing his breathing, while pressure was applied to it and to his neck and chest with knees. He was also struck in the chest with an elbow and fists, including after he appeared to have stopped resisting. At certain points, seven or more staff members, including a doctor, were present in the room, yet no one appears to have intervened.

The preliminary autopsy findings, as reported by the media, include multiple rib fractures, a fractured sternum, and swelling of the lungs and brain.

Although the investigation is still ongoing and the cause of death has yet to be established, one fact remains undeniable: this young, physically active man died while restrained in a psychiatric hospital.

ENUSP is deeply saddened to note that deaths of patients in psychiatric institutions resulting from violence, abuse and neglect, including those occurring during the use of restraints, are a well-documented reality. For example, in the latest review of Spain, the UN CRPD Committee expressed its concern on “reported deaths of persons with psychosocial disabilities resulting from involuntary restraint and improper medical treatment in psychiatric hospitals.”[1]
This reality has driven many individuals and organisations, including ENUSP since its foundation in 1991, to advocate against the use of coercion in psychiatry[2] and for adoption of support and care services that will respect human rights, autonomy and dignity of persons with mental health conditions and/or psychosocial disability.

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[1] Concluding observations on Spain, by the UN CRPD Committee, 2019. https://documents.un.org/doc/undoc/gen/g19/137/18/pdf/g1913718.pdf

[2] See for example the Declaration of Dresden Against Coerced Psychiatric Treatment, 7 June 2007 at https://drive.google.com/file/d/1loedI565T1MDliW-PsXkVwpwS2_alUS1/view and ENUSP call on the Council of Europe to ban coercion, 2021 https://drive.google.com/file/d/1ufyJRHrZiMl4dczj0o48_x5rjm-udSWR/view

Many of our members have personally experienced or witnessed coercion and violence during their stays in psychiatric hospitals, including the use of chemical and mechanical restraints. This is not an issue confined to Croatia. Despite variations in practice, coercive measures continue to be used in psychiatric settings across Europe and throughout the world. Most European countries have legislation that attempts to regulate coercion, stipulating that it should be used only as a "last resort", when no alternatives are available. Yet, despite this wording, coercive measures continue to be used systematically, while alternatives are rarely introduced, developed or actively promoted by mental health services and policymakers.

Human rights bodies and healthcare organisations increasingly recognise that coercion is not care and that it must be replaced with non-coercive alternatives. The UN Committee on the Rights of Persons with Disabilities (CRPD Committee) has repeatedly reminded States Parties to the Convention (including all EU Member States and the European Union itself) that coercion in mental healthcare must be eliminated. For example, in the above mentioned review of Spain, the Committee recommended the State to “eliminate the use of restraint measures for reasons relating to disability in all settings”, while in the recent review of Denmark the Committee recommended the State: “to prohibit the use of coercion, forced treatment and restrictive practices against children and adults with disabilities who are still in places of detention and social care and psychiatric institutions, establish alternative non-coercive, age-appropriate support measures that respect the will, preference, dignity and rights of persons with disabilities, and provide training to all medical and non-medical staff on these measures”.[3]

WHO has published several resources directly relevant to replacing coercive practices in psychiatry, including legislative guidance[4], practical strategies for ending restraint and seclusion[5], examples of services operating without coercion[6], and WHO QualityRights training[7], which helps all interested parties, including healthcare professionals and decision-makers, understand how to apply human rights principles when supporting people with mental health conditions and psychosocial disabilities.

Nevertheless, progress in raising awareness of the need for change and, more importantly, in actually implementing it remains painfully slow. Meanwhile, hundreds and thousands of people across Europe continue to experience coercion in psychiatric institutions. Many are traumatised by the very systems that are supposed to support them, and, tragically, some lose their lives, as happened to Kristian.

When coercive measures are used, the underlying reasons often include staff shortages, lack of time, low salaries and poor motivation, insufficient training in how to support people experiencing a crisis, and a lack of professional supervision and accountability. But none of these circumstances can justify traumatising people through coercion, let alone their deaths. This is a systemic problem, not merely a matter of individual misconduct by those who directly commit acts of violence.

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[3] Concluding observation on Denmark, by the UN CRPD Commmittee https://digitallibrary.un.org/record/4063540/files/CRPD_C_DNK_CO_2-3-EN.pdf
[4] https://www.who.int/publications/i/item/9789240080737
[5] https://www.who.int/publications/i/item/9789241516754
[6] https://www.who.int/publications/i/item/9789240025721
[7] https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/QualityRights

Even one death is one too many. Yet the problem of forced interventions in psychiatry persists, and people continue to die. Most of these deaths never attract public attention. Evidence of violence in psychiatric institutions rarely reaches the public, and deaths occurring in institutional settings can all too easily be attributed to natural causes, leaving abuse and neglect undisclosed and unchallenged.

Some may argue that what happened in this case was not a problem with coercion itself, but rather with the way it was applied. According to this argument, had the measures been applied "correctly", the person would still be alive. But this misses the fundamental problem with coercion. Its very premise opens the door to the use of force against another human being within certain legally or institutionally defined limits. Even when applied within the limits permitted by national legislation, coercive measures can be deeply traumatising. And when accountability is absent, staff are inadequately trained and insufficiently motivated to put the person first, those limits can easily be crossed. What begins as an authorised intervention can escalate into extreme violence and appalling neglect, with staff beating a helpless person without justification or simply failing to intervene as that person suffers, until it is too late and they die.

Real change begins with a change in mindset: seeing a person as a human being in need of support, rather than as an object to be placed in a particular institution and subjected to whatever procedures the system prescribes. Achieving this change requires political will, but it also requires public pressure and a collective demand for a fundamentally different mental health system.

We call on the Government of Croatia and Croatian society not to limit their response to investigating the case and punishing the individuals directly involved. They must go further and consider the future of mental health services and the people who will experience mental health crises in the years to come.

What kind of support should these people receive? Should they face forced interventions and potentially physical violence at the hands of those whose responsibility is to care for them? Should they be placed in institutions where such violence can take place out of public sight and may easily go unpunished? Is it enough to occasionally punish individuals who commit such acts of violence, or should the priority be to prevent them from happening in the first place?

The same questions must be addressed to all European countries where coercive measures remain part of psychiatric practice. Do we all have to wait until another person dies in a place that is supposed to provide care and support in times of crisis? Do we have to wait until someone we know personally is traumatised or killed by such a system?

Or shouldn't we instead join forces – society as a whole, policymakers, people with lived experience of mental health crises, their families and loved ones, and, naturally, the service providers themselves – to build something we can all be proud of: community-based mental health services, beyond the walls of psychiatric institutions, free from coercion, violence and abuse?