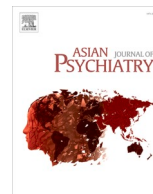




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Violence against mental health workers in China: Action needed

The recent shocking news about a senior psychiatrist in China, Jiong Tao who was attacked and severely injured by a former patient on Oct 31, 2020, and the shocking video, serve as a painful reminder of the violence against medical workers in China. Dr. Tao is a well-respected doctor, and he was also one of the early volunteers to care for patients during the most trying months at the beginning of the COVID-19 pandemic in Wuhan, China.

Although such incidents occur in other healthcare settings, violence in psychiatric settings in China is particularly concerning. In 2019, we conducted a national survey of 13,980 mental health workers from 41 tertiary psychiatric hospitals in China (total population sampling, response rate = 67.1%), including 4382 doctors and 9339 nurses. Results revealed the total 12-month prevalence of any violence was 80.3%, and the prevalence of physical violence reported by doctors and nurses was 30.5% and 56.4%, respectively (Table 1).

Violence negatively impacts the safety and well-being of healthcare workers. It is associated with poor mental health (depression and anxiety), burnout, and low job satisfaction, and may be associated with low patient safety and adverse medical events (Liu et al., 2019; Zhao et al., 2018). In addition, violence can worsen the quality of healthcare and lead to a higher turnover rate, depleting already limited mental health resources in China. Two recent reports showed that 20% of both psychiatrists and psychiatric nurses in China reported an intention to quit, and significant associations were found between the intention to quit and reported experience of patient-initiated violence and low job satisfaction (Jiang et al., 2018, 2019).

Several notable factors contribute to the high prevalence of violence in these healthcare settings. First, the proportion of the Chinese health expenditure (% of GDP), which was 5.15% in 2017, approximately half of the global average (9.88%), was considerably low (The World Bank, 2020). Also, the government's investment in psychiatric hospitals, which was only about 2.0% of the total investment in health institutions in recent years, is also insufficient (Que et al., 2019). By contrast, the global median percentage of mental health spending out of total health spending was 2.8% and the percentage in high income countries was 5.1% (WHO, 2011). Hospitals in China are often pressured to pursue profit, and it may further strain the doctor-patient relationship. Second, from 2012 to 2016, the number of psychiatric outpatient visits and hospitalizations in China increased 3.4 times and 4.1 times respectively, while the numbers of psychiatrists and psychiatric nurses (per 100,000 population) only increased 1.7 times and 2.3 times (Que et al., 2019). The excessive centralization of mental health resources, combined with the scarcity of community mental health services limit the availability and accessibility of mental health care to the majority of the population (Xia et al., 2021). The increasing shortage in both the mental health workforce and resources lead to a limited communication with patients and a decline in the quality of healthcare, possibly providing a breeding

ground for violence against mental health workers. Therefore, while it is imperative to increase the government's investment in psychiatric hospitals, decentralizing the resources and developing more community-based mental health services may be equally important (Xia et al., 2021). Developing and implementing graded treatment system and optimizing the access to healthcare services should be the focus of healthcare reform in China. In light of the rapid economic development and social progress in the past few decades in China, it is clear that the current healthcare system, medical culture and professionals have not caught up with the needs and demands of the citizens in China.

Institutionally, a number of recent high-profile cases in China clearly suggest that security measures and security training are often lacking or non-existent, and many hospitals are not adequately prepared for incidents involving severe violence. A logical solution for this issue is adopting security checks and/or police boxes, which has been an effective and often necessary tool for decreasing violence in most emergency departments and acute psychiatric facilities. Recent guidelines in China recommend that an alarm button be installed in all clinics, however, minimal improvement this intervention is expected to bring unless there is onsite presence of a well-trained security staff and rapid response when activated (Feng and Li, 2013). On the individual level, healthcare workers, especially those working in the emergency or outpatient setting, urgently need additional trainings aimed at improving both communication skills and other valuable skills to identify signs of increased violence risk and use of non-provocative verbal and non-verbal communication, to improve mental health workers' ability to de-escalate violent and aggressive behavior (Feng and Li, 2013; Price et al., 2015).

In summary, violence against medical workers, especially mental health workers in China is troubling and it is imperative to ensure workplace safety. We call on policymakers and hospital administrators to take urgent and important action, including increasing and optimizing resources allocation, hiring security staff and providing security checks in high-risk healthcare settings. A safe workplace ensures safety for all, including both healthcare workers and patients.

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Funding

This study was supported by the National Clinical Key Specialty Project Foundation (C) (no grant number).

<https://doi.org/10.1016/j.ajp.2021.102853>

Received 15 February 2021; Received in revised form 27 August 2021; Accepted 3 September 2021

Available online 9 September 2021

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Table 1

Twelve-month prevalence of violence against mental health workers in 41 tertiary psychiatric hospitals in China^a.

	Total (N = 13980)	Doctors (N = 4382)	Nurses (N = 9339)	Psychologists (N = 259)
Verbal violence N (%)	11046 (79.0)	3409 (77.8)	7490 (80.2)	147 (56.8)
Physical violence N (%)	6644 (47.5)	1337 (30.5)	5267 (56.4)	40 (15.4)
Any violence N (%)	11219 (80.3)	3443 (78.6)	7624 (81.6)	152 (58.7)

^a All tertiary psychiatric hospitals in 31 provinces (not including Hong Kong, Macao, or Taiwan).

CRedit authorship contribution statement

Huanzhong Liu and Yi-lang Tang designed research; Feng Jiang and Lei Xia contributed to the literature review; Lei Xia wrote the draft; and Yi-lang Tang revised the draft. All authors read and approved the final manuscript.

Conflict of interest

None.

Acknowledgements

None.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at [doi:10.1016/j.ajp.2021.102853](https://doi.org/10.1016/j.ajp.2021.102853).

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