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Original article

Violence Among Schizophrenic Patients In AL Rashad Training Hospital

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Abstract:

- ***Background*:** Schizophrenia is a heterogeneous psychiatric disorder that includes subtypes with distinct behavioral profiles. The paranoid subtype, characterized by hostility and mistrust, is particularly associated with violent behavior. Forensic psychiatric services aim to manage such violence and reduce recidivism following discharge. This study aimed to identify patterns of violence among schizophrenic inpatients admitted to forensic units and compare them with those in general psychiatric wards.
- ***Methods:*** A cross-sectional study was conducted at Al-Rashad Training Hospital in Baghdad from March to December 2020. Seventy male schizophrenic patients from the forensic unit were compared to seventy from ordinary therapeutic wards. Data on sociodemographics and violent behaviors were collected using the Modified Overt Aggression Scale.
- ***Result:*** Violence-related admissions were significantly higher in the forensic group, with 37.1% for attempted murder and 21.4% for murder, compared to 5.7% and 0% in the ordinary ward ($p < 0.001$). However, post-admission assessments showed no significant difference in the expression of violence between groups. Surprisingly, the ordinary ward patients exhibited higher mean aggression scores.
- ***Conclusions:*** While forensic patients were admitted due to more severe violent acts, both groups exhibited comparable violence levels after treatment. This suggests that clinical setting and care quality may influence post-admission aggression outcomes.
- **Keywords:** Schizophrenia, Violence, Forensic

INTRODUCTION

Although often referred to as a single disease, schizophrenia is more accurately described as a group of disorders with diverse causes and clinical manifestations. Patients diagnosed with schizophrenia exhibit a wide range of symptoms, including disturbances in perception, emotion, cognition, thought processes, and behavior, all of which vary across individuals and over time. Despite this variability, the condition generally has a severe, chronic course that often begins before the age of 25 and affects people across all social classes (1). The disorder is further categorized into subtypes based on symptom presentation: some individuals appear disorganized and erratic, others display catatonic immobility and unresponsiveness, while some exhibit paranoid features such as hostility and distrust. Among these, paranoid schizophrenia is particularly associated with a heightened risk of overt physical aggression (2).

Violence, as defined by the World Health Organization, encompasses the intentional use of physical force or power—actual or threatened—against oneself, others, or communities. This definition emphasizes the outcomes, such as injury, death, psychological harm, or deprivation, rather than cultural or social interpretations of the act (3). Within the context of psychotic disorders like schizophrenia, violence may emerge, particularly when paranoid delusions or comorbid substance abuse are present.

In such states, patients may perceive threats and respond aggressively due to impaired self-control (3).

In daily life, aggression and violence are commonly observed phenomena, and interest in predicting aggressive behavior has grown over time. However, the lack of a universally accepted definition complicates research efforts. While some studies focus solely on physical violence, others expand the definition to include verbal aggression, threats, self-harm, or property damage (4). In psychiatric hospitals, violent behavior presents numerous challenges. Even though severe physical assaults are relatively rare, more frequent minor acts of violence can profoundly affect the hospital environment, especially in secure settings. Such incidents contribute to staff injuries, stress, reduced morale, and high turnover rates (5).

The incidence of violence is approximately twice as high in psychiatric units compared to other medical departments, placing mental health professionals at an elevated risk (6). Emergency and acute psychiatric wards are particularly vulnerable, necessitating robust precautions. Yet, interventions like seclusion or restraint may not offer genuine protection and might even exacerbate the risk of harm, leading to legal and ethical

concerns (6). When paranoid symptoms or substance use are present, the likelihood of violence increases significantly (7).

Aggressive behavior can be classified as either reactive or proactive. Reactive aggression is impulsive and emotionally driven, often arising in response to perceived provocation and linked to difficulties in processing social information. Proactive aggression, on the other hand, is deliberate and goal-oriented, frequently learned through observation and social reinforcement, aligning with social learning theory (8). In psychiatric wards, especially those housing involuntarily admitted patients, aggressive behavior is commonly encountered. Although physical violence may not be frequent, the persistent exposure to aggression significantly impacts staff well-being. In such settings, risk factors that are typically predictive in community samples—such as antisocial personality traits or substance abuse—may be less relevant (8).

Modern treatment guidelines in the US and UK emphasize the need for violence risk assessment in all individuals diagnosed with schizophrenia. More than a hundred tools have been developed for this purpose, though many are time-consuming and place a considerable burden on mental health services (9). Recent years have seen a notable rise in the number of mentally ill individuals in forensic-psychiatric hospitals. While

numerous studies have linked major mental illnesses—particularly schizophrenia—to violent or criminal behavior, it is important to note that only a small fraction of violence in society is attributable to individuals with serious mental disorders (10).

Despite widespread media attention following mass shootings and other high-profile events, only 3–5% of interpersonal violence is linked to mental illness. Most individuals with psychosis are more likely to be victims than perpetrators. However, when violence does occur, it can be influenced by a complex interplay of factors, including comorbid substance abuse, personality disorders, and treatment noncompliance (11,12). The literature indicates that male patients with schizophrenia are 6–8 times more likely, and female patients 8–10 times more likely, to engage in violent behavior compared to the general population. The presence of comorbid conditions—such as substance abuse or antisocial traits—further increases this risk (12).

Across Europe, mentally disordered offenders are managed in various settings, including forensic hospitals, general psychiatric units, and, unfortunately, correctional facilities where they may be inappropriately placed. Effective treatment in forensic settings demands individualized and multidisciplinary approaches involving pharmacotherapy, psychotherapy, and rehabilitation programs to optimize patient outcomes and reduce the

likelihood of recidivism (13,14). Accurate diagnosis and early intervention are crucial, along with structured treatment plans and continuous risk assessments tailored to each offender (14,15).

While most patients with schizophrenia are not chronically aggressive, the minority who are tend to be overrepresented in media portrayals, which contributes to public stigma and hinders the development of supportive mental health services. Environmental and situational factors within psychiatric institutions—such as ward structure, staff-patient relationships, and the availability of therapeutic activities—also play a significant role in influencing aggression levels. Poorly managed wards tend to experience higher rates of violence (16,17).

The deinstitutionalization movement of the 1960s and 1970s, coupled with hospital closures and reduced bed capacity, has led to a growing number of mentally ill individuals ending up in prisons rather than receiving adequate psychiatric care. This shift has contributed to overcrowded correctional facilities and highlights the urgent need for better forensic services (18). Although definitions of "violence" vary and research is limited, existing evidence suggests a need for innovative models in therapeutic approaches and risk management (19).

Medium secure psychiatric units have been developed to manage aggressive patients more effectively, though literature on their use remains sparse (20). Risk assessment tools, particularly structured professional judgment (SPJ) instruments, have been introduced to bridge the gap between clinical intuition and actuarial predictions. These tools have shown promise in improving the accuracy of violence prediction and guiding treatment planning (21,22). By identifying high-risk individuals, clinicians can implement appropriate interventions to mitigate the risk of harm to both staff and patients (23).

Still, forensic psychiatry faces critical challenges: patients may be detained under unnecessarily high security conditions or for prolonged periods, compromising their rights and well-being (24). Meanwhile, the prevalence of inpatient aggression continues to rise, emphasizing the need for alternative therapeutic strategies beyond traditional restraint methods. Factors such as staff training, environment design, and availability of structured programs are central to managing aggression effectively (25).

Epidemiological studies consistently link violent behavior with younger age, male gender, unemployment, low socioeconomic status, and substance abuse—factors that are even more potent among individuals with mental illness (26). A history of violence

remains one of the most reliable predictors of future violent acts (27). The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study found that 19.1% of schizophrenia patients reported some form of violence within a six-month period, and 3.6% engaged in serious violence (28).

The aim of this study is to identify patterns of violence among inpatients admitted to forensic units, as well as to analyze the distribution of these patterns according to various sociodemographic factors and compare them with those in general psychiatric units within the hospital.

PATIENT and METHOD

This cross-sectional study was conducted at Al-Rashad Training Hospital in Baghdad, Iraq, which is the largest psychiatric facility in the country, established in the early 1950s and comprising 1,200 beds—650 for male patients, 350 for female patients, and 200 for forensic cases. The hospital accommodates both short- and long-term psychiatric care. The study focused on male patients diagnosed with schizophrenia, comparing those admitted to the forensic unit (Ibn Al-Haithim wing) with those in general therapeutic wards (Al-Kindi and Al-Razi wards). A total of 140 patients were included, with 70 selected randomly from each group.

All participants were diagnosed with schizophrenia based on DSM-5 criteria by a forensic psychiatric committee. Patients with mood disorders, personality disorders, or intellectual disabilities with psychosis, as well as all female patients, were excluded from the study. Each patient underwent a full psychiatric history and mental state examination.

Violent behaviors were assessed using the Modified Overt Aggression Scale, which measures the frequency and severity of aggression across four domains: verbal aggression, aggression against objects, self-directed aggression, and physical

aggression toward others. Each domain is scored across four levels of severity, with a total possible score ranging from 0 (no violence) to 40 (maximum violence) based on behaviors exhibited in the week preceding the interview.

Data were collected using a structured questionnaire that included two parts. The first captured sociodemographic variables such as age, educational level, marital status, and duration of admission. The second assessed the presence and type of violent behaviors—including verbal aggression, property damage, self-harm, and physical aggression—within the previous week. Data were gathered through personal interviews conducted in the presence of nursing staff and verified with clinical notes documented by psychiatrists.

All patients were receiving antipsychotic treatment at the time of the study, with some prescribed both depot and oral medications and others on oral therapy alone. Ethical approval was obtained from the scientific and ethical committee of the Iraqi Board of Psychiatry, and verbal informed consent was secured from all participants after explaining the study's aims and ensuring data confidentiality.

Data analysis was performed using SPSS version 24. Descriptive statistics were tabulated, and associations between categorical variables were analyzed using the Chi-square test. A p-value of less than 0.05 was considered statistically significant.

RESULTS

The sociodemographic characteristics of both the study and control groups are presented in Table 1. In the forensic group, 57.14% of patients were aged ≤40 years and 42.86% were older than 40. This age distribution did not differ significantly from the control group ($p = 0.734$). Regarding educational level, the majority in both groups had only primary education (71.43% in the forensic group vs. 68.57% in the control group), with no significant difference between the groups ($p = 0.251$). However, marital status showed a statistically significant difference, with 80% of the control group being single compared to 65.71% in the forensic group ($p = 0.033$). Residency (urban vs. rural) showed no significant variation between the groups ($p = 0.680$).

Table 1. Characteristics Sociodemographic Description of Both Study Sample and Control Group

Variables		Forensic Group 70		Ordinary Group 70		P value
		N	%	N	%	
Age	≤40 year	40	57.14%	38	54.29%	0.734
	>40 year	30	42.86%	32	45.71%	
Education	Primary	50	71.43%	48	68.57%	0.251
	Secondary	13	18.57%	19	27.14%	
	University	7	10.00%	3	4.29%	
Marital status	Single	46	65.71%	56	80.00%	**0.033**
	Married	16	22.86%	5	7.14%	
	Other	8	11.43%	9	12.86%	
Residence	Urban	54	77.14%	56	80.00%	0.68
	Rural	16	22.86%	14	20.00%	

As shown in Table 2, the most common reasons for admission in the forensic group were attempted murder (37.1%), murder (21.4%), and verbal violence (24.2%). In contrast, 80% of the control group were admitted for causes unrelated to violence. This difference was highly significant (p = 0.001), highlighting a greater initial severity of violent behavior among forensic patients.

Table 2. Admission Reasons (Types of Violence) for Both Forensic and Ordinary Wards

Admission reasons	Forensic ward 70		Ordinary ward 70		P value
	N	%	N	%	
murder	15	21.4%	0	0.0%	**0.001**
Attempted murder	26	37.1%	4	5.71%	
Verbal violence	17	24.2%	3	4.28%	
Damage of property	5	7.1%	3	4.28%	
Self-infliction violence	2	2.85%	4	5.71%	
Causes other than violence	5	7.1%	56	80%	

According to Table 3, when assessing violent behavior during hospitalization using the Modified Overt Aggression Scale, there was no significant difference between the two groups in terms of verbal, property, auto-aggression, or physical violence ($p > 0.05$ for all comparisons).

Table 3: Association Between Type of Violence in Study Group and Control Group

		Forensic Group 70		Ordinary Group 70		P value
		N	%	N	%	
Verbal	Yes	12	17.14%	18	25.71%	0.217
	No	58	82.86%	52	74.29%	
Property	Yes	4	5.71%	7	10.00%	0.346
	No	66	94.29%	63	90.00%	
Auto	Yes	0	0.00%	4	5.71%	0.121
	No	70	100.00%	66	94.29%	
Physical	Yes	6	8.57%	13	18.57%	0.084
	No	64	91.43%	57	81.43%	

In Table 4, the mean scores for all types of violence were higher in the ordinary ward compared to the forensic ward. Notably, the total mean violence score was 2.185 in the control group compared to 0.885 in the forensic group, suggesting a relatively higher expression of violence in the ordinary ward.

Table 4: Distribution of Data According to the Mean Scores of Different Types of Violence and Group of Study

Variables	Group	N	Mean	Std. Deviation
Verbal	Forensic ward	70	0.50	1.189
	Therapeutic ward	70	0.67	1.348
Property	Forensic ward	70	0.16	0.673
	Therapeutic ward	70	0.51	1.622
Auto	Forensic ward	70	0.00	0.000
	Therapeutic ward	70	0.39	1.609
Physical	Forensic ward	70	0.23	1.079
	Therapeutic ward	70	0.61	1.788
Total violence	Forensic ward	70	0.885	2.337
	Therapeutic ward	70	2.185	4.622

Age-stratified analysis in Table 5 revealed that verbal and auto-aggressive behaviors were significantly more frequent among patients aged ≤40 years in the ordinary ward than in the forensic unit (p = 0.048 and p = 0.035, respectively). No significant differences were noted in older patients across other types of violence.

Table 5: Violence Distribution Among Study Sample and Control Group According to Age

Variables	Category		Forensic ward 70		Ordinary ward 70		P value
			N	%	N	%	
Verbal	≤ 40 years	Yes	6	15.0%	13	34.2%	**0.048**
		No	34	85.0%	25	65.8%	
	> 40 years	Yes	6	20.0%	5	15.6%	0.652
		No	24	80.0%	27	84.4%	
Property	≤ 40 years	Yes	2	5.0%	7	18.4%	0.064
		No	38	95.0%	31	81.6%	
	> 40 years	Yes	2	6.7%	0	0.0%	0.138
		No	28	93.3%	32	100.0%	
Auto	≤ 40 years	Yes	0	0.0%	4	10.5%	0.035
		No	40	100.0%	34	89.5%	
	> 40 years	Yes	0	0.0%	0	0.0%	
		No	30	100.0%	32	100.0%	
Physical	≤ 40 years	Yes	4	10.0%	10	26.3%	0.061
		No	36	90.0%	28	73.7%	
	> 40 years	Yes	2	6.7%	3	9.4%	0.696
		No	28	93.3%	29	90.6%	

As demonstrated in Table 6, there were no statistically significant differences in any type of violence when patients were grouped according to marital status (single, married, or other), with p-values all above 0.05.

Table 6: Violence Distribution Among Study Sample and Control Group According to Marital State

Variables	Category		Forensic ward 70		Ordinary ward 70		P value
			N	%	N	%	
Verbal	Single	Yes	9	19.6%	14	25.0%	0.513
		No	37	80.4%	42	75.0%	
	Married	Yes	1	6.3%	1	20.0%	0.361
		No	15	93.8%	4	80.0%	
	Other	Yes	2	25.0%	3	33.3%	0.707
		No	6	75.0%	6	66.7%	
Property	Single	Yes	3	6.5%	6	10.7%	0.458
		No	43	93.5%	50	89.3%	
	Married	Yes	0	0.0%	0	0.0%	
		No	16	100.0%	5	100.0%	
	Other	Yes	1	12.5%	1	11.1%	0.929
		No	7	87.5%	8	88.9%	
Auto	Single	Yes	0	0.0%	4	7.1%	0.064
		No	46	100.0%	52	92.9%	
	Married	Yes	0	0.0%	0	0.0%	
		No	16	100.0%	5	100.0%	
	Other	Yes	0	0.0%	0	0.0%	
		No	8	100.0%	9	100.0%	
Physical	Single	Yes	5	10.9%	9	16.1%	0.447
		No	41	89.1%	47	83.9%	
	Married	Yes	1	6.3%	1	20.0%	0.361
		No	15	93.8%	4	80.0%	
	Other	Yes	0	0.0%	3	33.3%	0.072
		No	8	100.0%	6	66.7%	

Educational level-based distribution in Table 7 showed a significant difference only for auto-aggression among patients with primary-level education, which was more common in the ordinary ward (8.3%, p = 0.037). Other violence types did not show significant variation across educational levels.

Table 7: Violence Distribution Among Study Group and Control Group According to Educational Level

Variables	Category		Forensic ward 70		Ordinary ward 70		P value
			No.	%	No.	%	
Verbal	**Primary**	**Yes**	9	18.0%	12	25.0%	0.399
		No	41	82.0%	36	75.0%	
	Secondary	**Yes**	0	0.0%	4	21.1%	0.077
		No	13	100.0%	15	78.9%	
	University	**Yes**	3	42.9%	2	66.7%	0.490
		No	4	57.1%	1	33.3%	
Property	**Primary**	**Yes**	3	6.0%	7	14.6%	0.161
		No	47	94.0%	41	85.4%	
	Secondary	**Yes**	0	0.0%	0	0.0%	
		No	13	100.0%	19	100.0%	
	University	**Yes**	1	14.3%	0	0.0%	0.490
		No	6	85.7%	3	100.0%	
Auto	**Primary**	**Yes**	0	0.0%	4	8.3%	0.037
		No	50	100.0%	44	91.7%	
	Secondary	**Yes**	0	0.0%	0	0.0%	
		No	13	100.0%	19	100.0%	
	University	**Yes**	0	0.0%	0	0.0%	
		No	7	100.0%	3	100.0%	
Physical	**Primary**	**Yes**	5	10.0%	9	18.8%	0.216
		No	45	90.0%	39	81.3%	
	Secondary	**Yes**	0	0.0%	3	15.8%	0.132
		No	13	100.0%	16	84.2%	
	University	**Yes**	1	14.3%	1	33.3%	0.490
		No	6	85.7%	2	66.7%	

Table 8 highlights violence distribution based on residency. Auto-aggression was significantly more common among urban residents in the ordinary ward (7.1%, p = 0.045). All other types of violence showed no statistically significant association with place of residence.

Table 8: Violence Distribution Among Study Group and Control Group According to Residency

Variables	Category		Forensic ward 70		Ordinary ward 70		P value
			N	%	N	%	
Verbal	**Urban**	**Yes**	11	20.4%	15	26.8%	0.429
		No	43	79.6%	41	73.2%	
	Rural	**Yes**	1	6.3%	3	21.4%	0.222
		No	15	93.8%	11	78.6%	
Property	**Urban**	**Yes**	4	7.4%	5	8.9%	0.771
		No	50	92.6%	51	91.1%	
	Rural	**Yes**	0	0.0%	2	14.3%	0.118
		No	16	100.0%	12	85.7%	
Auto	**Urban**	**Yes**	0	0.0%	4	7.1%	**0.045**
		No	54	100.0%	52	92.9%	
	Rural	**Yes**	0	0.0%	0	0.0%	
		No	16	100.0%	14	100.0%	
Physical	**Urban**	**Yes**	5	9.3%	11	19.6%	0.123
		No	49	90.7%	45	80.4%	
	Rural	**Yes**	1	6.3%	2	14.3%	0.464
		No	15	93.8%	12	85.7%	

Finally, Table 9 compares clinical settings between forensic and ordinary units. The forensic unit had better staffing ratios, more qualified nursing personnel, and a shorter average duration of admission (1–3 years) compared to the ordinary ward (3.7 years). The number of psychiatrists and nursing staff was more favorable in the forensic ward, which may partially explain the unexpectedly higher violence levels in the ordinary unit despite its lower initial admission severity.

Table 9: Clinical Settings for Both Forensic and Ordinary Units

Clinical settings	Forensic	Ordinary
Ideal no of beds / unit	60	60
No of patients (range) / unit	< 60	> 70
No of senior psychiatrist / patient	1 / 60	1 / >120
No of resident psychiatrist / patient	1 / 60	1 / 280
No of staff nursing (morning shift)	4 / 60	< 4 / 70
No of staff nursing (night shift)	4 / 60	1 / 70
No of nursing staff qualified (dealing with violent patient)	>80%	< 50%
Duration of admission in years	Range 1–3	3.7

DISCUSSION

The present study aimed to examine the frequency and patterns of violence among schizophrenic patients admitted to the forensic unit at Al-Rashad Hospital, compared to their counterparts in ordinary therapeutic wards. Analysis of sociodemographic variables revealed that 57% of the forensic group were aged 40 years or younger, a finding consistent with international data. For example, Catenisi et al. in Italy reported that 53.4% of violent schizophrenic patients were between 25 and 40 years old (29), while similar age profiles were noted in Turkish studies by Belli et al. and Ural et al. (30, 12). However, this age distribution did not differ significantly from the control group ($p = 0.73$).

Most forensic inpatients (74%) came from urban areas, aligning with findings by Mittal, who reported that 77.8% of schizophrenic offenders lived in urban settings (31). Yet again, this urban predominance was not statistically different from the control group ($p = 0.68$). Marital status showed that 65.5% of the forensic group were single, which is comparable to previous studies conducted in Iraq and Iran (32, 33). Interestingly, the control group had a significantly higher proportion of single patients ($p = 0.033$), potentially explained by differences in schizophrenia subtypes. Paranoid schizophrenia, associated with later onset and more violent behavior, may allow more

time for affected individuals to marry prior to illness onset, unlike other subtypes which manifest earlier in life.

In terms of educational attainment, the majority of forensic patients had completed only primary education (71%), a result similar to the study by Catenesi, where 55.3% had not completed their compulsory schooling (34). This contrasts with data from Iran, where secondary education was more prevalent among offenders (38). However, the difference in educational levels between the forensic and control groups was not statistically significant ($p = 0.251$), possibly reflecting the broader educational challenges in Iraq.

Admission reasons were markedly different between groups. In the forensic unit, attempted murder (37.1%) and murder (21.4%) were the leading causes for hospitalization, while such causes were almost nonexistent in the control group. This contrast underscores the higher level of dangerousness at the point of admission for forensic patients. The proportion of admissions for reasons unrelated to violence was significantly higher in the control group (80%) than in the forensic group (7.1%) ($p < 0.001$), a finding expected given the design of forensic services.

Importantly, this study may be the first in Iraq to investigate not only pre-admission violent behavior but also the trajectory of violence after hospitalization and treatment. Surprisingly, post-admission evaluations using the Modified Overt Aggression Scale revealed no significant difference between the forensic and control groups in terms of current violent behaviors ($p > 0.05$). Even more unexpected was that patients in the ordinary wards exhibited higher mean violence scores (2.185) than those in the forensic unit (0.885), suggesting that violent tendencies may persist or emerge outside the forensic setting.

Further analysis of sociodemographic correlates showed that younger patients (under 40) in the control group demonstrated significantly more verbal and self-directed aggression ($p = 0.048$ and 0.035, respectively; Table 5). Similarly, patients with only primary education and those from urban settings also displayed higher levels of auto-aggression ($p = 0.037$ and 0.045, respectively; Tables 7 and 8). These results indicate that violence in ordinary psychiatric wards may be influenced by factors not strictly related to forensic status.

One possible explanation for these findings may lie in the clinical environment and resource allocation within the hospital. Despite similarities in physical conditions

across units, Table 9 highlights significant disparities in staffing levels, psychiatrist-to-patient ratios, and the qualifications of nursing staff trained in managing violent behavior. Forensic units were found to be relatively better staffed and supported than general therapeutic wards, which may account for the better containment and lower expression of violence in those settings. However, even in the forensic units, resources remained below recommended standards, suggesting systemic under-resourcing across the institution.

Taken together, the findings challenge common assumptions about the persistence of violence among forensic psychiatric patients and highlight the need to consider institutional factors such as staff training, patient-to-staff ratios, and ward structure as important determinants of post-admission aggression.

CONCLUSION

Although forensic patients were admitted primarily due to severe violent acts, including attempted murder, post-admission assessments revealed no significant difference in the levels of violence between them and patients in general psychiatric wards. Interestingly, individuals in the general wards exhibited slightly higher, though statistically insignificant, scores of violent behavior.

Sociodemographic variations between the two groups were limited, with the exception of a higher proportion of single individuals in the control group. Among those displaying more violent behavior, patients in the general wards were more often younger, had lower educational attainment, and were from urban backgrounds. These observations indicate that the expression of violence may be influenced not solely by patient history but also by environmental and systemic factors such as ward structure, staff adequacy, and institutional resources.

RECOMMENDATION

This study highlights several critical areas that require urgent attention to improve the management of violence among psychiatric inpatients. One of the primary concerns is the insufficient number of medical and paramedical staff relative to the large inpatient population in both forensic and general psychiatric wards. Addressing this staffing imbalance is essential to ensure safe and effective care.

There is also a pressing need to establish additional forensic psychiatric units in other major governorates. These units should be stratified by levels of security—high, medium, and low—based on the assessed risk and dangerousness of individual patients. Such a structure would allow for more appropriate and safer placements.

Moreover, mandatory training programs in the management of violent and high-risk patients should be developed for all healthcare professionals working in psychiatric settings, including both nurses and doctors, to enhance team coordination and crisis response.

Further research involving a larger sample size is recommended to better understand the severity and patterns of violence, beyond its mere presence or absence. Routine assessments of all forms of violent behavior should also be integrated into standard clinical practice.

Finally, there is a need to construct specialized, secure facilities within forensic units to ensure the safety of both medical staff and patients. These measures would significantly enhance the therapeutic environment and reduce the risk of harm.

Ethical Clearance:

Ethical approval was obtained from the scientific and ethical committee of the Iraqi Board of Psychiatry, and verbal informed consent was secured from all participants after explaining the study's aims and ensuring data confidentiality.

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Conflicts of interest:

There are no conflicts of interest.

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