

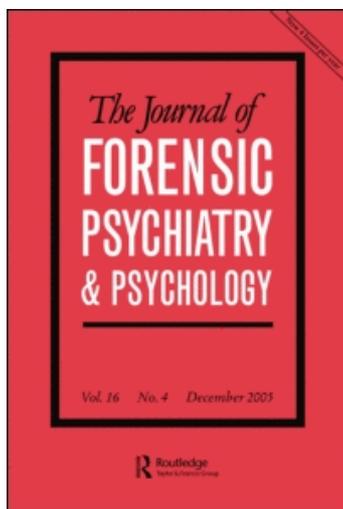
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RESEARCH ARTICLE

Forensic psychiatry assessments in Sichuan Province, People's Republic of China, 1997–2006

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Forensic psychiatry is a growing sub-specialty in the People's Republic of China (PRC). This article describes 3016 persons assessed by a service in Sichuan Province, over 10 years (1997–2006). Most assessments were referred by the police for courts in criminal cases to determine fitness to stand trial and degree of criminal responsibility. Those not responsible were more likely to be older, farmers, with poor education, schizophrenia, facing charges of serious violence. The largest increase in referrals over the study period was for civil assessments. Forensic psychiatrists also provided assessments of competency of alleged female victims of sexual violence to consent to sexual intercourse. Forensic psychiatry in Sichuan showed many similarities to clinical practice in western countries.

Keywords: China; forensic psychiatry; criminal cases; civil cases

Introduction

There is little current information on forensic mental health services in the People's Republic of China (PRC) in the scientific literature that is published in English. This is despite many similarities in clinical practice in Western countries (Hu, Yang, Huang, & Coid, submitted). In China, the notion that an individual with mental disorder should not bear the full weight of responsibility for criminal actions dates back to ancient times. Provisions within the regulation of the PRC to request a forensic assessment when doubts arise over the defendant's mental health have existed since the 1950s. But modern forensic psychiatry in China did not begin until the 1980s following the Criminal Law of PRC and Criminal Procedure Law of PRC,

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published in 1979. In a second version of the Criminal Law (1997), it was stipulated that if a mental patient causes dangerous consequences at a time when he is unable to recognize or control his own conduct, and such a circumstance must be confirmed according to the legal procedure (i.e. confirmed by a team of forensic psychiatrists), he shall not bear criminal responsibility, but his family members or guardian shall be ordered to keep him under strict surveillance and arrange for his medical treatment. Where necessary, it may also be arranged for medical treatment to be given under coercion by the government. The need to provide expert opinion is also necessary for persons whose condition is of an intermittent nature, as they shall bear criminal responsibility if they commit a crime in a normal mental state. Furthermore, psychiatric patients who do not completely lose their ability to recognize or control their conduct and who then commit a crime will bear criminal responsibility, but can be given a lighter or mitigated punishment. As in most Western jurisdictions, an intoxicated person who commits a crime will bear criminal responsibility in PRC. According to Chinese criminal law, there are three categories of criminal responsibility to be determined in a forensic assessment: full, diminished, and no responsibility. If offenders are competent to stand trial and retain full responsibility, they will be sentenced following the normal trial process. In cases of diminished responsibility, the sentence may be mitigated at the court's discretion to the minimum punishment for the crime in question. Perpetrators with no criminal responsibility are not sentenced but are usually committed to an Ankang Hospital to receive medical treatment. This is with the expectation that they will return to their family after recovery from the mental disorder on the recommendation of psychiatrists, the court playing no further part after the finding of no criminal responsibility. Ankang hospitals are for management and treatment of dangerous psychiatric patients managed by the public security system since the 1950s, and have some similarities to Maximum Security hospitals in North America and the High and Medium Secure facilities in the UK in terms of security and patients who are admitted for treatment. However, Ankang hospitals are not specifically designated as 'forensic' mental health facilities as in the UK and Germany. They can receive patients with any form of mental illness from the general community as well as the public security system, but remain within the management of the latter. Offenders with mental disorder assessed as not having criminal responsibility can be sent to Ankang Hospitals and receive similar treatment to patients admitted to general psychiatric hospitals. They can be transferred to other general psychiatric hospitals if their family or guardian requests, according to their specific rights of supervision under Chinese law.

Chinese law stipulates that a team (typically three) who work in the same organization (institute or hospital) undertake assessments. The forensic or documentary evidence must be a cooperative report of the team and

authorized by the organization appointed by the provincial government. This procedure differs markedly from that in UK or USA where forensic psychiatric reports are issued by individual forensic psychiatrists. It is similar to the Dutch system where a smaller number of multidisciplinary experts (typically two) conduct the evaluation and issue a cooperative report (van der Leij, Jackson, Malsch, & Nijboer, 2001). Forensic psychiatrists in China are also requested to carry out assessments of alleged victims that may later result in criminal charges, reflecting the development of the academic discipline of forensic psychiatry within forensic medicine.

This study describes all forensic psychiatric assessments carried out over a 10-year period by specialists from the forensic psychiatry department, School of Basic Science and Forensic Medicine in West China Medical Center (WCMC), Sichuan University, China. Time trends were examined and the outcome of assessments in relation to demography and mental disorders were described.

Method

The Forensic Psychiatry Department of WCMC of Sichuan University has accepted referrals mainly from Sichuan Province since its inception in 1983. The Department was recorded as one of 21 organizations providing forensic psychiatric assessments in 2005, and there were 103 forensic psychiatrists in the province. There were over 1389 psychiatrists in 75 general psychiatric hospitals and 1 Ankang hospital in the province in 2006 (Huang et al., 2009). Sichuan is located in the southwest of China, has a population of over 86 million (52% men, 48% women), with 77.6% of the population working in agriculture, a province at a low-middle level of socioeconomic development.

All persons referred to and assessed by the Forensic Psychiatry Department between the 1st of January 1997 and the 31st December 2006 were recorded retrospectively using a specially designed schedule. Data collection was rigorously monitored by one of the authors (J.H.) who also checked subsequent schedules for completion of all items. Case files were hand-searched for any missing data. The case register is believed to be complete for the years of study.

Each person was assessed by three different forensic psychiatrists. In a small number of cases, the person was seen by only two specialists. Diagnostic opinion was based on multiple sources of information: (1) standardized psychological tests such as Chinese versions of Wechsler Adult Intelligence Scale - Revision (WAIS-R) IQ; (2) Electroencephalogram (EEG); (3) Physical examination; (4) police records reported by the individual and others (victims, colleagues, relatives, school); and (5) observational records from plan of detention, previous institutions, or medical records.

Data were collected on demography, source of referral, criminal, or non-criminal behavioral disorder, previous service use, and diagnoses. Diagnostic data included axis I lifetime categories according to the Chinese Classification and Diagnostic Criteria of Mental Disorders (CSP, 2001) which is derived from the International Classification of Diseases-10 classification. Although an author (J.H.) checked the coding for each person, the diagnoses were primarily made by the medical staff carrying out the assessments. For the forensic assessments reported in this study only the primary diagnosis was used. The method did not include inter-rater reliability between clinicians.

Analyses in the study include all assessments carried out from 1997 to 2006. Simple descriptive statistics were used to compare subgroups of patients. Spearman's correlation coefficient was calculated and tested for trend of assessments changed over time. For assessments to determine level of responsibility, multinomial regression analysis was used to identify the characteristics (demographic, psychiatric diagnosis, and type of alleged crime) of cases in relation to the level of responsibility.

Results

Persons assessed by the service (n = 3016)

During the total 10-year study period, 3016 persons were assessed by forensic psychiatrists: 2132 (71%) men, 884 (29%) women. The majority were Han Chinese (2893, 96%), with 51 (1.7%) Tibetan, 43 (1.4%) Yi, and a further 29 (0.9%) from other minorities. Ages ranged from 6 to 92 years with the mean for males 38.87 years, SD 11.29, and women 31.65 years, SD 13.35, a significant difference ($t = 4.65, p < 0.001$). The majority (1519, 50.4%) were married, 1237 (41%) were single, 214 (7.1%) were divorced or separated, and 46 (1.5%) were widowed. Most described their occupation as farmers (2179, 72.2%), with 162 (5.4%) manual workers, 41 (1.4%) teachers, 38 (1.3%) administrators or managers, and 197 (6.5%) other occupations. A total of 145 (4.8%) were students. Only 254 (8.4%) were unemployed.

Over the 10-year period, most individuals were assessed on one occasion, with only 51 (1.7%) being assessed on two occasions, and 34 (1.1%) being assessed three or more times. Major psychosis was the most frequent lifetime diagnosis in 1358 (45%) persons, schizophrenia in 1343 (44.5%), paranoid psychosis in 6 (0.2%), transient psychotic disorder in 8 (0.3%), induced psychosis in 3 (0.1%), and a culture-bound syndrome of travelling psychosis (Lee, 1998) in 16 (0.5%); dementia and mental retardation in 452 (15%) acute intoxication, alcoholism, or mental disorder caused by the use of alcohol 243 (8.1%), traumatic/organic brain disorder 210 (7%), stress-related neurotic disorder 165 (5.5%), epilepsy 156 (5.2%), affective disorder (including mania and depressive disorder) 114 (3.8%), severe neurotic

disorder including hysteria 41 (1.4%), and 57 (1.8%) other conditions. A further 202 (6.7%) were assessed and found not to be suffering from psychosis or other severe mental disorder.

There were primarily four types of cases. Most were criminal cases transported for assessment by the police to assess criminal responsibility. A further sub-group of persons were assessed as civil cases regarding compensation following accidents and allegations of negligence leading to injuries or illness, and competence of civil cases (testament, contract). A further sub-group of female, alleged victims of sexual crime were also brought by the police and assessed to provide evidence for the court. In these cases, competency was determined with regard to the woman agreeing to sexual intercourse. In the case of a woman incompetent due to mental disorder, the other party may be charged with a sexual offence according to regulation of government. A small number of prisoners were also assessed at the request of the prison authorities by a team of forensic psychiatrists to provide a diagnosis, advise on the need for psychiatric treatment, or the ability of serve sentence.

Table 1 shows time trends for assessments carried out over the 10-year study period. These demonstrate a progressive rise over 10 years, with the number more than doubling.

To test the trend of changes in assessments over time, Spearman's correlation analysis for ranks was used. The percentage of cases sent by courts for assessment decreased, indicated by a negative correlation coefficient $r = -0.845$ ($t = 4.41$, $df = 8$, $p = 0.0024$). Meanwhile, the percentage of cases for civil assessment and alleged female victims increased moderately, correlation coefficient 0.616 ($t = 3.58$, $df = 8$, $p = 0.008$) and 0.649 ($t = 3.85$, $df = 8$, $p = 0.005$), respectively. There was a significant

Table 1. Time trends for assessments over a 10-year study period ($n = 3016$).

Year	<i>n</i>	Court assessment		Female victim		Civil assessment		Prison assessment	
		<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
1997	178	143	(80)	10	(6)	25	(14)	0	(0)
1998	139	108	(78)	13	(9)	17	(12)	1	(1)
1999	234	179	(76)	27	(12)	28	(12)	0	(0)
2000	281	218	(78)	24	(8)	39	(14)	0	(0)
2001	294	212	(72)	30	(10)	52	(18)	0	(0)
2002	266	175	(66)	41	(15)	50	(19)	0	(0)
2003	291	206	(71)	37	(13)	48	(16)	0	(0)
2004	374	263	(70)	43	(12)	61	(16)	7	(2)
2005	456	307	(67)	63	(14)	82	(18)	4	(1)
2006	503	341	(68)	54	(11)	104	(20)	4	(1)
Total	3016	2152		342		506		16	

increase in number of cases overall assessed over time, $r = 0.951$ ($t = 8.70$, $df = 8$, $p = 0.000$).

Examining the demographic characteristics of persons assessed for court, civil assessments, and female victims, indicated that men dominated in court assessments with a gender balance in civil assessments ($\chi^2 = 1115.8$, $p = 0.000$). There was a significant difference in the age distribution of cases among different types of assessment ($\chi^2 = 518.7$, $p = 0.000$). Persons in civil assessments were older, with a mean of 34.4 years ($SD = 15.6$), compared to female victims who had a mean of 25.6 years ($SD = 11.4$), but with no difference from court cases who had a mean of 34.2 years ($SD = 10.6$). When compared with the other two types of assessment, court assessments comprised a moderately higher proportion of minority groups and more cases of low educational level ($\chi^2 = 294.4$, $p = 0.000$). Female victims were more likely to be single, with no education and mostly farmers. More civil cases were Han Chinese ($\chi^2 = 10.62$, $p = 0.005$), married ($\chi^2 = 73.2$, $p = 0.000$), and in an administrative post ($\chi^2 = 204.9$, $p = 0.000$).

Assessments for court (n = 2152)

Most assessments for courts (2082, 96.7%) were to determine level of responsibility for criminal acts. A further 22 (1%) persons were assessed to determine competence to stand trial, with 48 (2.2%) assessed to determine solely the presence of mental disorder. Excluding persons assessed to determine the presence of mental disorder, a total of 2104 persons were assessed for the purpose of determining responsibility, 1801 (86%) men and 303 (14%) women. Their ages ranged from 14 to 84 years, with a mean of 34.12 ($SD = 10.59$). The majority (1937, 92%) were referred by the police, with 114 (5%) referred by the court, 34 (2%) by the procurator, 8 (0.5%) by the prison authorities, and 11 (0.5%) by other referral sources.

Table 2 demonstrates that the largest proportion of persons assessed for the court had been charged with homicide offences. Over one half (54%) were assessed as not responsible for their criminal actions, with 585 (57.6%) diagnosed as suffering from schizophrenia. Motoring and fraud/deception were mostly committed by persons assessed as having full responsibility. More than half of those charged with wounding, assault, and arson were assessed as not responsible and diagnosed with schizophrenia; 266 (65.4%) cases of wounding and assault had schizophrenia, as had 72 (59.5%) of persons committing arson. After adjusting for demographic factors and psychiatric diagnosis and then comparing with the group assessed as fully responsible, multinomial regression analysis demonstrated that offences committed by persons assessed as partially responsible were significantly more likely to be wounding/assault ($OR: 1.53$, 95% $CI: 1.13-2.06$), arson (1.81, 1.10-2.98), and less likely to be rape (0.48, 0.29-0.79), theft (0.40, 0.25-0.65), or 'other' types of offending (0.38, 0.22-0.63). Categories of offence

Table 2. Level of criminal responsibility according to main offence ($n = 2081$)^a.

Offence	Level of criminal responsibility							
	Full		Partial		Not responsible		Total	
	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
Homicide	248	30	164	16	532	54	944	47
Wounding/assault	67	17	78	20	248	63	393	20
Rape	56	36	71	45	29	19	156	8
Arson	23	19	23	20	71	61	110	6
Robbery	57	52	37	34	16	15	117	6
Theft	41	41	37	38	21	21	83	4
Vandalism	27	32	22	27	34	41	99	5
Fraud/deception	12	75	4	25	0	0	16	0.5
Motoring	7	70	2	20	1	10	10	0.5
Other	38	57	6	9	23	34	67	3
	$\chi^2 = 271.53^a$				df = 20, $p = 0.000$			

^a86 missing data.

committed by persons assessed as not responsible were significantly more likely to be wounding/assaults (1.40, 1.05–1.89), arson (2.19, 1.35–3.55), and significantly less likely to be rape (0.07, 0.04–0.13), robbery (0.17, 0.11–0.26), vandalism (0.51, 0.030–0.87), theft (0.08, 0.05–0.14), and ‘others’ (0.18, 0.11–0.29).

Table 3 demonstrates that the majority of court assessments (54%) were of persons subsequently diagnosed with schizophrenia. Persons found not responsible for their criminal actions were also significantly more likely to have schizophrenia, followed by stress-related disorders. Persons found fully responsible for their criminal actions were more likely to be diagnosed with alcohol use disorder followed by personality disorder. As expected, all persons with no psychiatric disorder (9%) were assessed as fully responsible for their criminal actions. Further multinomial regression analysis demonstrated that after adjusting demography, persons with schizophrenia were considerably more likely to be found not responsible. This was reflected in very small odds ratios for other diagnosis in the group considered partially responsible, indicating they were less likely to have personality disorder (OR: 0.14, 95% CI: 0.05–0.37), dementia (0.47: 0.32–0.68), epilepsy (0.20, 0.13–0.30), affective disorder (0.48, 0.30–0.76), stress-related disorder (0.10, 0.05–0.24), or other mental disorders (0.15, 0.07–0.27). Persons found not responsible were less likely to be diagnosed with dementia (0.05: 0.03–0.08), organic brain syndrome (0.03, 0.01–0.09), epilepsy (0.05, 0.03–0.07), affective disorder (0.11, 0.07–0.17), stress-related disorder (0.14, 0.08–0.25), or other mental disorder (0.02, 0.01–0.04).

Table 3. Level of criminal responsibility according to primary diagnosis ($n = 2081$)^a.

Diagnosis	Level of criminal responsibility							
	Full		Partial		Not responsible		Total	
	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
Schizophrenia	60	5	228	21	820	74	1108	54
Alcohol use disorder	203	89	13	6	11	5	227	11
Dementia	48	26	98	53	38	21	184	9
Epilepsy	50	40	39	31	36	29	125	6
Affective disorder	26	29	37	41	28	31	25	1
Stress-related disorder	20	33	6	10	35	57	91	4.5
Other	18	64	7	23	3	1	61	3
Personality disorder	14	70	6	30	0	–	20	0.5
Organic brain syndrome	9	36	11	44	5	20	28	1
No disorder	181	100	0	–	0	–	181	9
	$\chi^2 = 1393.6$				$df = 20, p = 0.000$			

^a31 missing data.

Further examining demographic characteristics according to the assessment outcome category, the distribution of gender and ethnicity did not demonstrate any significant differences among the three outcomes. Cases found not responsible were significantly older ($F = 22.2, p = 0.000$). Marital status was significantly different among the outcome groups, with more single, divorced or widowed held partially responsible ($\chi^2 = 35.9, p = 0.000$). Those with full responsibility tended to have a higher level of education, whilst those with no responsibility tended to have less education ($\chi^2 = 47.9, p = 0.000$), and were significantly older. Most were farmers ($\chi^2 = 81.3, p = 0.000$).

Corresponding to the three levels of responsibility, we used a further multinomial regression model to identify characteristics of cases in relation to outcome categories. Partial and not responsible were contrasted with full responsibility in this analysis. Age, ethnicity, education, marital status, and occupation were entered into the model and diagnoses of mental disorder adjusted for independent association between demographic characteristics and the outcome of assessment. The analysis demonstrated that being single, divorced, or a farmer was significantly more likely among those in the partially responsible category compared to those in the fully responsible category. The odds-ratio of the three factors was 1.76 (95% CI: 1.36–2.30), 4.13 (95% CI: 2.72–6.22), and 2.86 (95% CI: 1.26–6.48), respectively. The analysis also showed that the not responsible category was mainly characterized by older ($t = 7.0, p = 0.000$), minority (OR: 2.42, 95% CI: 1.41–4.16), divorced (OR: 3.27, 95% CI: 2.19–4.88), widowed persons (OR: 3.38, 95% CI: 1.28–8.91), and farmers (OR: 2.67, 95% CI: 1.27–5.58).

Civil assessments (n = 506)

A sub-group of 506 (17%) persons, 275 (54%) men and 231 (46%) women, were assessed for the purpose of civil court proceedings. These included assessments for alleged psychiatric disturbance resulting from the behavior of others, usually threatening, aggressive behavior, or negligence (186, 37%); assessments of the level of psychiatric and cognitive disability affecting specific functioning, e.g. ability to drive, and sometimes resulting in their eligibility for compensation (155, 31%); assessments of civil competence in making decisions, such as making wills (92, 18%); assessments within the context of a civil case being carried out to determine the presence or absence of mental disorder (41, 8%); and determination of ability to work in relation to presence or absence of mental disorder (32, 6%). The majority of these persons (219, 43%) were referred for an opinion by the civil courts, particularly in the case of allegations of disability due to the behavior of others leading to claims for compensation (96, 52%) and competence to make an important decision (61, 66%). However, the potential for subsequent criminal charges was indicated by 73 (39%) cases where psychological harm was alleged due to the behavior of others and where they had been referred by the police. A further 18 (44%) cases, where the question of whether mental disorder was present or absent, had also been referred by the police. Most cases requiring an assessment of functioning due to psychiatric disability were referred by the traffic bureau (58, 37%), the civil court (42, 27%), or a range of other sources (32, 21%), but with a further small number of individuals (18, 12%) referred by the police.

Persons referred after complaints that mental disorder had been caused by the behavior of others comprised two main groups: the first included those mainly complaining about the behavior of neighbors, of whom more were women (60, 61%, c.f. 38, 39% men). Their mean age was 37.28, SD 11.06, 80 (82%) were married, 63 (64%) had no schooling, or no more than elementary school education. Forty-four (45%) were found to be suffering from stress-related disorder, 19 (19%) major psychosis, and 19 (19%) organic brain syndrome. The second group was students (59, 32%) who mainly complained of psychiatric disability due to the behavior of their teachers or classmates. More were males (39, 66%, c.f. 20, 34% females), their mean age was 14.85 years, SD 3.35, and with a similar pattern to the first group with 27 (46%) diagnosed as suffering from stress-related disorders, 14 (24%) psychoses, and 9 (15%) organic brain syndrome.

The primary aim of assessment in these cases was to determine whether the mental disorder was connected with the alleged behavior of the other party or not. There were no demographic differences observed among those whose mental disorder was considered to be due to the alleged behavior. However, a direct relationship was more likely to be observed by the

forensic psychiatrist among persons with traumatic/organic brain syndrome and stress-related mental disorder, and less likely among persons with psychotic illness, mood disorder, and other psychiatric conditions ($\chi^2 = 43.25$, $df = 4$, $p < 0.001$).

The majority of the 155 persons assessed to determine their level of psychiatric/cognitive ability (131, 85%) were diagnosed as having traumatic/organic brain syndrome; 98 (63%) were men, 57 (37%) women, with a mean age of 35.41, $SD = 14.91$, but a wide range between 16 and 72 years. Most were farmers (91, 59%) followed by students (21, 14%) and had been referred by the traffic bureau in 58 (37%) cases, courts in 42 (27%), the police in 18 (12%), and a range of other sources of referral in 37 (24%).

The 92 cases where civil competence was determined for the purpose of making decisions included a similar proportion of men and women (41, 44% men, 51, 55% women), with a mean age of 43.28 years, $SD 19.23$, ranging from 18 to 92 years. Most gave their occupation as farmers (42, 46%), manual workers (16, 17%), or unemployed (16, 17%). Most were referred by the court (61, 66%); 39 (42%) were diagnosed with psychotic illness, 14 (15%) post-traumatic/organic brain syndrome, 10 (11%) dementia, 6 (7%) affective disorder, 6 (7%) alcohol-related disorder, and 8 (8%) other conditions. A further 9 (10%) were not found to be suffering from mental disorder. After the assessment, civil competence was determined as present in 29 (32%) cases, partial in 14 (15%), and lack of competence in 49 (53%). Level of competence did not appear to be associated with the demographic characteristics of the persons assessed. However, lack of civil competence was significantly more likely to be associated with a diagnosis of psychosis and dementia, but less likely to be associated with alcohol-related disorder and absence of mental disorder ($\chi^2 = 23.9$, $df = 7$, $p < 0.001$).

Among the 32 persons assessed for their ability to work, most (29, 91%) were subsequently considered unfit to work, with 12 (88%) diagnosed with psychosis, 10 (31%) dementia, 6 (19%) post-traumatic/organic brain syndrome, and 4 (12%) other mental disorders.

The final group of civil assessments for the purpose of determining the presence or absence of mental illness had been referred by a wide range of different organizations, although the civil court accounted for the largest sub-group of cases (11, 34%). All were found to be suffering from some form of mental disorder. There were no cases of alcohol-related disorder. Their demographic characteristics were similar to those of the overall group of civil cases.

Assessment of women to determine competency to consent to sexual intercourse (n = 342)

Forensic psychiatrists carried out assessments on 342 women for the purpose of determining whether they had been the victim of a sexual offence,

with the potential that criminal charges would subsequently be made against the alleged perpetrator. In 332 (94%) cases, the assessment was to determine their competency to consent to sexual intercourse, and in 20 (6%) to determine their competency in being able to protect themselves from exploitation in the case of women alleged to have been trafficked for sex. A physical as well as a psychiatric examination was conducted in all cases.

Women trafficked ($n = 20$) reported that an individual, who was originally a stranger was the perpetrator in all cases except one, who reported her father; 14 women were diagnosed as suffering from schizophrenia and 6 with dementia: 12 were reported as additionally having learning difficulties; 14 were married. None were considered by the forensic psychiatrist to be competent to protect themselves against exploitation.

Women assessed to determine competency to consent to sexual intercourse ($n = 322$) ranged from between 9 and 78 years, with a mean of 25.37 years, SD 11.46; 180 (56%) were single, 138 (43%) married, and 4 (1%) divorced; many (145, 45%) had received no more than elementary education, and 139 (43%) no education. The majority (85%) described themselves as farmers, with 25 (8%) unemployed, 17(5%) students, and only 5 (2%) other occupations. Data on the alleged perpetrator was absent in 86 (27%) cases. However, the majority of the remaining women (126, 39%) alleged that the perpetrator was a neighbor, 74 (23%) originally a stranger, 7 (2%) a family member, including two reporting their fathers, with 29 (9%) a range of other perpetrators. All women except one were found to be suffering from some form of mental disorder, the majority (228, 71%) with dementia, 75 (23%) psychosis, 13 (4%) post-traumatic/organic brain syndrome, and 5 (2%) other diagnoses. The severe level of psychopathology among most of these women resulted in the majority (301, 94%) being determined to lack competence to consent to sexual intercourse, with only 3 (1%) considered partial, and only 3 (1%) fully competent to decide (data on outcome of the assessment were missing in 15 (5%) of women).

Assessment of mental disorder in prisoners (n = 16)

Assessments were carried by a forensic psychiatrist on a small sub-group of 16 male prisoners whilst in a prison setting over the 10-year study period. The majority (12, 75%) were found to be suffering from schizophrenia, two with epilepsy, one thought to be suffering from severe symptoms of stress due to imprisonment, and one 'other' psychiatric disorder.

Discussion

Trends over time

The findings indicate increasing demand for forensic psychiatric opinions over the 10-year study period. This has been observed in Yunnan, China

(Zuhua, Shulian, & Xianling, 2000) and a national survey of 104 of 143 forensic psychiatric assessment organizations (Jinyun & Zhanpei, 2008) who reported that a total of 16,980 cases were assessed in 2006. This corresponds to Europe (Salize & Dressing, 2007) where the annual number of cases admitted for forensic psychiatric evaluation or treatment increased markedly throughout the 1990s in countries demonstrating fast growth (Denmark, the Netherlands) or consistent but less steep increases (Austria, Belgium, England and Wales). In previous years, understanding by the public and many criminal justice professionals in China of diagnostic and treatment issues was relatively limited due to lack of training in the importance and relevance of mental disorder to offending behavior. Most criminal suspects were not aware of these issues and were therefore not concerned to ensure their opportunities to receive forensic psychiatric assessments. In recent years, more Chinese citizens know their legal rights. Suspects or their families, lawyers, and victims of crime increasingly request these assessments. However, police officers were responsible for most referrals and will ask for an assessment when they are uncertain about the mental state of the accused.

It is probable that there has been a corresponding increase in assessments of defendants facing charges that may result in heavier sentences, including the death penalty. China is one of the countries that retains the death penalty, although sentences following convictions for homicide can include life imprisonment or 10 years or more in prison according to the criminal law of China. In these cases, the duty of the forensic psychiatrist is restricted to preparing a report on the mental condition and the level of responsibility of the offender. Sentencing is the duty of the court. Forensic psychiatrists do not make recommendations on sentencing or discuss mitigation in their reports as in some western countries.

Nevertheless, the greatest increase in referrals was for civil cases and of women thought to be victims of sexual offences. The reasons for the latter may be related to a shift from a traditionally stigmatized concept to a modern material and practical concept. In the past, it was shameful and barely accepted by society or within a family to be an abused woman. This change reflects improvements in the quality of assessment of cases of sexual violence in the PRC, where there was no other specialized health or professional social work service for abused women in mainland China, in contrast to Hong Kong (Chan, 2007). It also reflects the importance of a specialized forensic assessment provided by professionals who are experienced in this field, as lack of competency to consent to sexual intercourse will result in criminal charges. The increase in civil assessments may also reflect the growing recognition of forensic medicine by complainants, defendants, various government departments, and the public. It may also reflect a growing tendency in a rapidly developing economy to use the law to resolve civil disputes (Guan, Huang, & Tang, 2002), similar to western countries.

Court assessments

It was previously observed in the UK that the level of resources available to forensic psychiatry services largely determine how proactive they can be in meeting the needs of the populations for which they have clinical responsibility (Coid & Dunn, 2004). However, in PRC, forensic psychiatrists work as specialists giving opinions to courts, tribunals, and other clients at their request, and there are no designated forensic mental health inpatient services, such as in Scandinavia, Germany and the UK, where Forensic psychiatrists can continue assessment and treatment of mentally disordered offenders. In China, these patients may receive treatment in Ankang as well as some general psychiatric hospitals but from general or forensic psychiatrists.

An overwhelming proportion (92%) of referrals by the police involving criminal cases has previously been observed in China (Jinyun & Zhanpei, 2008). Police in China must collect all evidence for criminal cases and expert testimony of a forensic psychiatrist represents specialized evidence. This places in context the degree of involvement of the public security system at many levels of the criminal justice system of the PRC, and their involvement in roles that would be routinely carried out by other professionals in western countries. It also reflects the wider range of responsibilities of police officers in Chinese society. For example, the absence of a discipline of social work on mainland China during the study.

In many cases, the police would have been requested by the prosecution or defendant, or their families or other official bodies, to obtain forensic assessments, as well as requesting an assessment for evidential purposes. However, the findings also suggest that the police perform an accurate process of screening defendants for mental disorder in Sichuan province, judging by the high level of severe mental disorder diagnosed by forensic psychiatrists in these referred defendants, together with the large proportion found to have either partial or no criminal responsibility for their actions. On the other hand, this observation inevitably raises the question of how many other defendants, not referred for assessment, had mental disorder and whose responsibility may have been thought to be diminished had an assessment taken place. This would indicate an important area for further research, together with who should initiate assessments, whether forensic psychiatrists should always operate retroactively (as in most Western countries), waiting for their expertise to be requested.

The largest sub-group of persons referred in criminal cases was charged with homicide offences. They potentially faced the death penalty if convicted. Persons not responsible for their criminal actions were more likely to have been charged with violence, including homicide, and arson. They tended to be older, peasant farmers, single or divorced persons, with low levels of education, primarily suffering from schizophrenia. They

demonstrated many similarities to persons referred to, and treated by, forensic psychiatrists in other countries, such as the UK (Mendelson, 1992a, 1992b; Coid & Dunn, 2004). However, the high level of employment among cases differed markedly from western countries. This reflected the ability of many individuals to work in agriculture despite severe mental illness, together with an expectation within a socialist society that individuals should work with the state seen as providing work and support for persons with mental and physical ill health.

Persons found responsible for their actions tended to be better educated, manual workers, students, or unemployed, with no mental disorder, or who abused alcohol, as observed in a previous study in Sichuan province (Zhang, Lin, Mao, & Hu, 2007). Personality disorder as a primary diagnosis was found in only a small minority of all persons assessed. It is unclear whether this reflected exclusion by referring agencies, primarily the police, or an area of psychopathology of less interest to Chinese forensic psychiatrists than those in the UK and North America. Similarly, absence of persons with drug dependence suggested that they were not prioritized for assessments.

Assessments of alleged victims of sexual offences

Although there was no specialized health or professional social work services for women who had experienced sexual violence in mainland China, a small number of psychologists now offer this service. Forensic psychiatrists in these cases appeared to be providing specialist evidence to determine whether a prosecution would proceed. No data are currently available from PRC on levels of sexual violence. It is believed that reporting is still relatively low, with cases often not being reported due to 'loss of face' and fear of having a 'bad reputation' on the part of the woman, and where women are traditionally subordinate to men in the family hierarchy. It has been argued that economic development, but also the disparity in the male–female ratio as a result of male child preference, have led to a resurgence of prostitution, together with a return to the pre-revolutionary custom of bride-trafficking in rural villages. Abduction of women is more common in rural areas of Hunan, Guizhou, and Sichuan (Chan, 2007).

Limitations

We did not have information on other forensic psychiatry services in Sichuan province. Besides the limitations of retrospective data collection using clinical diagnoses, in what was a database collected for administrative purposes, we did not have full data on comorbid conditions and have reported only the primary diagnosis of our participants. Forensic psychiatrists in China have become increasingly interested in the development of instruments to determine competency to stand trial (Zhang et al.,

2004) and we had no information available on the question of how such evidence was received by the courts. Furthermore, forensic psychiatrists take considerably more information into account when determining criminal responsibility than is reported in our study. Sun and Hu (2006) observed three major aspects in the assessment of homicides, in descending order: the presence of pathological motivation, the presence of severe mental disorder, and whether the victim was a family member or a stranger. Cai, Shao, and Guan (2004) emphasized the importance of premeditation and preparation for the crime as the most important factor in assessment. We also did not have information on the outcome at court following our assessments to indicate whether the courts had been influenced by the recommendations of forensic psychiatrists.

Conclusion

This study described a large sample of persons assessed by forensic psychiatrists in Sichuan province, PRC, over a 10-year period. Forensic psychiatry has developed within a criminal justice system that has evolved independently of most western systems, and yet most aspects of the clinical practice of Chinese forensic psychiatrists would be familiar to their counterparts in the West. Clinical practice in China, as in many countries, is entirely dependent on cases being referred for expert opinions by other agencies. However, the organization of service provision by professionals and the academic basis of Forensic psychiatry are very different. Forensic psychiatry is a component of the broader discipline of Forensic Medicine in PRC. Furthermore, the role of the Forensic psychiatrist is limited by the absence of treatment facilities specifically designated for clinical practice in Forensic psychiatry and there are no inpatient treatment facilities, including Ankang hospitals, in which Forensic psychiatrists predominate. The involvement of Forensic psychiatrists in the treatment of prisoners is also very limited. Lack of designated facilities means that Chinese Forensic psychiatrists have not yet been involved in debates over their role in protecting the public from dangerous psychiatric patients as in some western countries.

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