CHAPTER: I

INTRODUCTION

Forensic psychiatry is a branch of psychiatry dealing with the assessment and treatment of offenders in prisons, secure hospitals and the community with mental health problems. It requires a sophisticated understanding of the links between mental health and the law. Forensic psychiatry is a subspecialty of psychiatry and is related to criminology. It encompasses the interface between law and psychiatry. According to the American Academy of Psychiatry and the Law, it is defined as "a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory, or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment." A forensic psychiatrist provides services – such as determination of competency to stand trial – to a court of law to facilitate the adjudicative process and provide treatment, such as medications and psychotherapy, to criminals. [11]

Forensic psychiatrists work with courts in evaluating an individual's competency to stand trial, defences based on mental disorders (e.g., the insanity defence), and sentencing recommendations. The two major areas of criminal evaluations in forensic psychiatry are competency to stand trial and mental state at the time of the offense. [11]

The Narcotic Drugs and Psychotropic Substances Act, 1985, commonly referred to as the NDPS Act, is an Act of the Parliament of India that prohibits a person to produce/manufacture/cultivate, possess, sell, purchase, transport, store, and/or consume any narcotic drug or psychotropic substance. The Narcotic Drugs and Psychotropic Substances Bill, 1985 was introduced in the Lok Sabha on 23 August 1985. It was passed by both the Houses of Parliament, received assent from then President Giani Zail Singh on 16 September 1985, and came into force on 14 November 1985. The NDPS Act has since been amended thrice - in 1988, 2001 and 2014. The Act extends to the whole of India and it applies also to all Indian citizens outside India and to all persons on ships and aircraft registered in India. [12]

Addiction is a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences. The initial decision to take drugs is voluntary for most people, but repeated drug use can lead to brain changes that challenge an addicted person’s self-control and interfere with their ability to resist intense urges to take drugs.

These brain changes can be persistent, which is why drug addiction is considered a "relapsing" disease—people in recovery from drug use disorders are at increased risk for returning to drug use even after years of not taking the drug. It's common for a person to relapse, but relapse doesn't mean that treatment doesn't work. As with other chronic health conditions, treatment should be on-going and should be adjusted based on how the patient responds. Treatment plans need to be reviewed often and modified to fit the patient's changing needs. [13]

As a person continues to use drugs, the brain adapts by reducing the ability of cells in the reward circuit to respond to it. This reduces the high that the person feels compared to the high they felt when first taking the drug—an effect known as tolerance. They might take more of the drug to try and achieve the same high. These brain adaptations often lead to the person becoming less and less able to derive pleasure from other things they once enjoyed, like food, sex, or social activities. [13]

A number of different offenses fall into the sex crimes category, but they generally involve illegal or coerced sexual conduct against another individual. Every state has laws against prohibiting the various types of sex crimes, such as rape and sexual assault, and each state has its own time limit in which victims of sex crimes may file a lawsuit against the alleged offender. People convicted of sex crimes, regardless of severity, are considered "sex offenders" by their respective state and face having their names added to state and federal sex offender registries. [14]

It is illegal for a person to expose their genitals in public. Here's a basic description of the indecent exposure laws, with links to related topics and state penal code section

Description of the crime of offering or engaging in sexual acts for payment and links to the relevant penal code section. [16]Highlights situations that may constitute the crime of rape, including date rape and statutory rape, and contains links to state penal codes and federal laws against sexual abuse. Describes the catch-all crime that encompasses unwanted sexual touching of many kinds, with links to state penal code and federal law on related crimes.

It's illegal to entice someone else to commit a crime (such as prostitution). This article explains the elements to prove solicitation, as well as defences and penalties. [16]

People below the age of consent cannot legally consent to having sex, even if there was no force or the perpetrator believed the victim was old enough. Sex under the influence of drugs or alcohol is associated with high risk sexual behaviour. Heterosexual men (n=505) in substance abuse treatment completed a

computer administered interview assessing sexual risk behaviours. Most men (73.3%) endorsed sex under the influence in the prior 90 days, and 39.1% endorsed sex under the influence during their most recent sexual event. Sex under the influence at the most recent event was more likely to involve anal intercourse, sex with a casual partner, and less condom use. Patients might benefit from interventions targeting sexual behaviour and substance use as mutual triggers. [16]

Specific substances may be linked to different sexual effects, user expectations, and levels of sexual risk. Although it is widely accepted that stimulant use can enhance sexual pleasure, and that high levels of alcohol and opioid use suppress male sexual performance, little research has examined the differences in perceived feelings, performance, and function between the ranges of drugs that are commonly used by treatment seeking individuals. Rawson et al.16 examined differences between drug category and sexual effects while under the influence. They found that cocaine and methamphetamine users were more likely to associate drug use with sexual behaviour, and reported more positive sexual effects while under the influence, than alcohol and opiate users. [18]

For example, stimulant users were more likely to report that drug use was so strongly associated with sex that it would be difficult for them to separate it from sexual behaviour, and that drug use made them preoccupied with sex and/or significantly elevated their sex drive. [18]Most men (73.3%) reported engaging in sex under the influence of drugs or alcohol during the prior 90 days, however the percent reporting sex under the influence at the most recent event dropped to 39.1%. Most men (72.6%) reporting sex under the influence at the most recent event reported their partners were also under the influence.

An additional 5.2% of men reported that their partners were under the influence when the men themselves were not. Alcohol, cocaine, heroin and cannabis were the most frequently used drugs. Men who were not married, in methadone treatment, and who had been employed for fewer days were more likely to report sex under the influence in the past 90 days. Similarly, men reporting that they or their partner were under the influence during the most recent event were more likely to be older, not married, in methadone treatment, employed for fewer days, and report there had been more days since their most recent sexual event. [11]

That the prospect of enhancing sex or enhancing sexual opportunities might serve as a relapse trigger is evident. Not surprisingly, men who reported engaging in sex under the influence during days or during the most recent sexual encounter were more likely to report having been tempted to use drugs either to enhance their experience and/or increase the likelihood that a sexual event would occur. Nearly 25% reported they had been tempted to use drugs to meet sexual needs. Men were significantly more likely to report being tempted to use cocaine compared to all

other substances (except alcohol) to meet these needs. Similarly, men were significantly more likely to report being tempted to use alcohol compared to all other substances except cocaine and heroin to meet these needs. [12]

Sexual assault and substance abuse are frequently intertwined for a number of reasons. First, drugs and alcohol may be used to facilitate sexual assault. Second, the trauma of being a victim of sexual abuse or assault may lead to the use of drugs or alcohol to cope. . [13]

Finally, suffering from addiction may place an individual at a greater risk of becoming a victim of an assault. Drug-facilitated sexual assault (DFSA) is any act of sexual assault that occurs while a victim is under the influence of drugs or alcohol. This can involve a perpetrator giving a victim drugs with the intention to assault the person or a perpetrator taking advantage of an already intoxicated victim. While the majority of sexual assaults involve male perpetrators and female victims, this is not always the case. The majority of sexual assault victims know their offenders.

Approximately 4 out of every 5 sexual assaults are committed by someone close to the victim, such as a spouse, family member, friend, or acquaintance. [14] Drug addiction is a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences. Brain changes that occur over time with drug use challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs. This is why drug addiction is also a relapsing disease. Relapse is the return to drug use after an attempt to stop. Relapse indicates the need for more or different treatment. [16]

Most drugs affect the brain's reward circuit by flooding it with the chemical messenger dopamine. Surges of dopamine in the reward circuit cause the reinforcement of pleasurable but unhealthy activities, leading people to repeat the behaviour again and again. Over time, the brain adjusts to the excess dopamine, which reduces the high that the person feels compared to the high they felt when first taking the drug—an effect known as tolerance. They might take more of the drug, trying to achieve the same dopamine high. No single factor can predict whether a person will become addicted to drugs. A combination of genetic, environmental, and developmental factors influences risk for addiction. The more risk factors a person has, the greater the chance that taking drugs can lead to addiction.

Drug rehabilitation is the process of medical or psychotherapeutic treatment for dependency on psychoactive substances such as alcohol, prescription drugs, and street drugs such as cannabis, cocaine, heroin or amphetamines. The general intent is to enable the patient to confront substance dependence, if present,

and cease substance abuse to avoid the psychological, legal, financial, social, and physical consequences that can be caused, especially by extreme abuse. [11]

Treatment includes medication for depression or other disorders, counselling by experts and sharing of experience with other addicts. Psychological dependency is addressed in many drug rehabilitations programs by attempting to teach the person new methods of interacting in a drug-free environment.

In particular, patients are generally encouraged, or possibly even required, to not associate with peers who still use the addictive substance. Twelve-step programs encourage addicts not only to stop using alcohol or other drugs, but to examine and change habits related to their addictions. Many programs emphasize that recovery is a permanent process without culmination. For legal drugs such as alcohol, complete abstention rather than attempts at moderation, which may lead to relapse's also emphasized. [14]

Whether moderation is achievable by those with a history of abuse remains a controversial point, but is generally considered unsustainable. The brain's chemical structure is impacted by drugs of abuse and these changes are present long after an individual stop using. This change in brain structure increases the risk of relapse, making treatment an important part of the rehabilitation process. [15]

Certain opioid medications such as methadone and more buprenorphine are widely used to treat addiction and dependence on other opioids such as heroin, morphine or oxycodone. Methadone and buprenorphine are maintenance therapies intended to reduce cravings for opiates, thereby reducing illegal drug use, and the risks associated with it, such as disease, arrest, incarceration, and death, in line with the philosophy of harm reduction. Both drugs may be used as maintenance medications taken for an indefinite period of time, or used as detoxification aids [18].

All available studies collected in the 2005 Australian National Evaluation of Pharmacotherapies for Opioid Dependence suggest that maintenance treatment is preferable, with very high rates (79–100%) of relapse within three months of detoxification from levo-α-acetylmethadol (LAAM), buprenorphine, and methadone. [18]

According to the National Institute on Drug Abuse (NIDA), patients stabilized on adequate, sustained doses of methadone or buprenorphine can keep their jobs, avoid crime and violence, and reduce their exposure to HIV and Hepatitis C by stopping or reducing injection drug use and drug-related high risk sexual behaviour. Naltrexone is a long-acting opioid antagonist with few side effects. It is usually prescribed in outpatient medical conditions. Naltrexone blocks

the euphoric effects of alcohol and opiates. Naltrexone cuts relapse risk during the first three months by about 36%.

However, it is far less effective in helping patients maintain abstinence or retaining them in the drug-treatment system the retention rates average was 12% at 90 days for naltrexone, average was 57% at 90 days for buprenorphine, average was 61% at 90 days for methadone.[16]In-patient residential treatment for alcohol abuse is usually quite expensive without proper insurance. Most American programs follow a traditional 28–30-day program length. The length is based solely upon providers' experience. During the 1940s, clients stayed about one week to get over the physical changes, another week to understand the program, and another week or two to become stable.70% to 80% of American residential alcohol treatment programs provide 12-step support services. These include, but are not limited to AA, Narcotics Anonymous, Cocaine Anonymous and Al-Anon. One recent study suggests the importance of family participation in residential treatment patient retention, finding "increased program completion rate for those with a family member or significant other involved in a seven-day family program". [17]

Perpetrators use substances in approximately 60–65% of sexual assault incidents, compared to 35–55% of victims, based on community samples. Alcohol is the most commonly used substance in sexual assaults, and victims who are drinking are usually assaulted by drinking offenders. [16]There have been several studies examining the impact of alcohol use on sexual assault outcomes e.g., severity of sexual abuse and physical injury. Because the results of these studies have been mixed, it is important to continue to examine the role alcohol plays in sexual assault incidents, especially when controlling for demographic and Situational characteristics. Furthermore, few studies have examined victim and offender substance use in relationship to both sexual victimization severity and injury outcomes, which is the purpose of this study.

There have been numerous studies that have analysed the relationship between pre-assault alcohol use and sexual victimization severity analysed two national studies using path analyses. The first using a sample of 1,667 college women found a weak positive relationship between offender alcohol use and sexual aggression severity, whereas the second study with a sample of 694 college men did not find any relationship between the two variables. In both studies, victim drinking was related to greater sexual victimization severity. In an analysis of 859 sexual assaults from the National Violence against Women Survey (NVAWS), offenders who were drinking were more likely to commit completed rape, though victim drinking didn’t affect rape completion. In a study of 132 college women, the number of drinks an offender had did not relate to whether the rape was completed or attempted, however there was a positive relationship between victim alcohol consumption and rape completion. [15]

Substance use was not related to completion of intercourse, but this may be due to the high percentage of cases involving completed intercourse 85.1% and more. A lot of completed rapes in this sample resulted from our methodology of asking victims for details regarding their most serious assault, unlike other past studies. While this is a limitation perhaps, these are also more serious incidents that are in need of study. According to Testa (2002), offender drinking is more prevalent in the more severe incidents of sexual victimization e.g., attempted and completed rapes than less severe incidents e.g., sexual coercion, which is consistent with these results. [19]

CHAPTER: II

LITERATURE REVIEW

Anja Leue et.al, (2003), studied mental disorders in a forensic sample of sexual offenders. Several studies have documented a relationship between sexual delinquency and mental disorders, mostly on the basis of questionnaires. Using this methodology, sexual offenders have described themselves as socially anxious and depressed, or have reported regular alcohol abuse. However, these studies are constrained because it is unclear whether participants fulfil diagnostic criteria, since questionnaires allow a screening assessment but no assured diagnosis of mental disorders. Recent studies focused explicitly on DSM III R or DSM IV diagnoses in sexual offenders by using structured diagnostic interviews. The present study shows that sexual offenders with hands-on-sex-offenses suffer from a variety of axis I disorders and personality disorders. The prevalence of mental disorders in this sample exceeded lifetime prevalence rates in the population and partly in out-patient sexual offenders and offenders in prison. Anxiety, mood, and substance use disorders. [1]

Silke Harsch, et.al (2005), studied Prevalence of mental disorders among sexual offender's in forensic psychiatry and prison. The objective of this study was to compare the prevalence of mental disorders among sexual offenders in forensic psychiatry (SF) with the prevalence of such disorders among sexual offenders in prison (SP) and violent offenders in prison (VP). In a cross-sectional study, 40 of 47 SF detained in forensic psychiatry in Baden-Wuerttemberg, Germany, could be included. They were compared with 30 SP and 26 VP. All study participants were interviewed by means of SCID I and SCID II and assessments of functioning (GAF, BSS). There was a high prevalence of mental disorders (DSM-IV: Axis I) in all three groups (SF: 80%, SP: 63%, VP: 73%). Among SP and VP, this was attributed mainly to substance use disorders. The prevalence and comorbidity of personality disorders was significantly higher in the group of the SF (prevalence: SF: 85%, SP: 27%, VP: 39%). In a psychopathological view, SP were all together more similar to the imprisoned non-sexual delinquent VP than to the SF. [2]

Jill D. Stinson, Judith V. Becker (2011), studied Sexual offenders with serious mental illness: Prevention, risk, and clinical concerns Individuals with serious and persistent mental illness who have also engaged in illegal sexual behavior present a unique challenge for our legal and clinical systems. Frequently, these individuals may engage in problematic sexual behaviours which result in hospitalization rather than incarceration, and an overburdened and resource-deficient public community mental health system is ill-equipped to address the seriousness of these sexual behaviours. We have a rather limited understanding of how prevention programs, intervention strategies, and risk assessment would work with this population.

Here we evaluate data from a sample of 245 inpatient psychiatric sexual offenders in a forensic mental health setting and compare these with what information has already been presented in some of the literature. Through an examination of seriously mentally ill sexual offenders and their clinical presentation, legal history, and risk management concerns, we illustrate a variety of tertiary prevention needs. Future directions in the area of prevention and risk management for seriously mentally ill sexual offenders are also discussed. [3]

Peer Briken et.al, (2014), studied Sexual Sadism in Sexual Offenders and Sexually Motivated Homicide Evaluators must differentiate sexual sadists from rapists, including looking at the viability of no sadistic explanations for sexual violence.64 A distinction must be made between consensual and non-consensual sexual acts in individuals identified as sadists or masochists. Frances and Wollert64 suggest that evaluators attempt to reduce diagnostic errors by documenting the presence of the DSM-defined required features of sexual sadism, and ruling out differential diagnoses. As noted, however, in a forensic context most sadists likely would deny being sexually excited by their Sexual Sadism in Sexual Offenders 11victim's suffering, so other evidence may need to be relied on. Sexual sadism may be relevant in only around 10% of men who rape and in one-third of sexual homicide perpetrators. Therefore, especially in sexual homicide perpetrators, the assessment of sexual sadism is important if it has a relationship with a motivational pathway toward sexual offending. [4]

Alexander Martins Valence et.al, (2015), studied A forensic-psychiatric study of sexual offenders in Rio de Janeiro, Brazil. Sexual violence is defined as any sexual act forced upon a person who did not give his or her consent. Our objective is to investigate the socio-demographic features, clinical correlates, criminal behaviour characteristics, and the level of penal responsibility of sexual offenders who were referred to forensic psychiatric assessment in the city of Rio de Janeiro, Brazil. This is a cross-sectional descriptive study. All written reports made by court-appointed psychiatric experts on individuals charged with having committed sexual crimes and referred to the main forensic hospital in the State of Rio deJaneiro, Brazil, for assessment were reviewed. Forty-four expert reports were identified. All alleged offenders were male. Nineteen (43.2%) offenders did not receive any psychiatric diagnostic. Nine offenders(20.4%) were diagnosed with mental retardation. In 16 cases (36.4%), some form of mental or neurological disorder was diagnosed. The offender was under alcohol influence at the moment of the crime. The profile of Brazilian sex offenders subject to forensic psychiatric assessment were male, Caucasian, single, working part time, with no mental disorder, who perpetrated indecent assault. [5]

Birgit A. Völlm et.al, (2018), studied European Psychiatric Association (EPA) guidance on forensic psychiatry: Evidence based assessment and treatment of mentally disordered offenders Forensic psychiatry in Europe is a specialty

primarily concerned with individuals who have either offended or present a risk of doing so, and who also suffer from a psychiatric condition. These mentally disordered offenders (MDOs) are often cared for in secure psychiatric environments or prisons. In this guidance paper we first present an overview of the field of forensic psychiatry from a European perspective. We then present a review of the literature summarising the evidence on the assessment and treatment of MDOs under the following headings: The forensic psychiatrist as expert witness, risk, treatment settings for mentally disordered offenders, and what works for MDOs. We undertook a rapid review of the literature with search terms related to: forensic psychiatry, review articles, randomised controlled trials and best practice. We present the findings of the scientific literature as well as recommendations for best practice drawing additionally from the guidance documents identified. We found that the evidence base for forensic-psychiatric practice is weak though there is some evidence to suggest that psychiatric care produces better outcomes than guidance as well as that for offenders, adapted for the complex needs of this patient group, paying particular attention to long-term detention and ethical issues. [7]

Daniel Turner, PhD, MD, and Peer Briken, MD, FECSM, (2018), studied Treatment of Paraphilic Disorders in Sexual Offenders or Men with Risk of Sexual Offending With Luteinizing Hormone-Releasing Hormone Agonists: An Updated Systematic Review. Different pharmacologic agents are used in the treatment of paraphilia disorders in sexual offenders or men with a risk of sexual offending, with luteinizing hormone-releasing hormone (LHRH) agonists being the agents introduced more recently to treatment regimens. LHRH agonists are a useful treatment when combined with psychotherapy in patients with a paraphilic disorder and the highest risk of sexual offending. However, throughout treatment, close monitoring of side effects is needed and ethical concerns must always be kept in mind. [8]

Gerd Weithmann et.al, (2019), studied Comparison of offenders in forensic-psychiatric treatment or prison in Germany Arrangements for the management of mentally disordered offenders vary widely across countries, as do rates of imprisonment and detention in forensic-psychiatric settings of such individuals. This study aims to quantify the characteristics of offenders detained in forensic-psychiatric settings in Germany over a 15-year period from 1995 and compare these with those sentenced to imprisonment over the same period. Relevant differences and similarities between the two treatment groups were identified. Compared to offenders in prison, those in forensic care were older, with a higher proportion of women and a lower proportion of those with foreign backgrounds. Significant previous offending and levels of diminished responsibility were present in both groups. [10]

M.Vanyaa, c, I.Devosab (2018), studied Prevalence of psychiatric disorder-related consequences in male prisoners: a cross-sectionalstudy. The prevalence of psychiatric disorders among prisoners was similar compared with prisoners from

the UK, the USA, Iran, Japan and other countries. The rate of previous nonviolent or violent crimes was 45% in the study sample, which is higher than the 20% reported by other studies, but much lower than the rate (69%) reported for the Danish population. The difference could be explained, in part, by sociocultural factors such as homelessness or family status. Homelessness was surprisingly rare in this study sample, much lower than reported by other authors. It is also possible that different substance abuse patterns across countries also contribute to different offence rates. [10]

Jerrod Brown et.al, (2019), studied Sex offender treatment professional perceptions of Fatal Alcohol Spectrum Disorder (FASD) in the Midwest. Fetal Alcohol Spectrum Disorder (FASD) is a neurodevelopmental condition that is precipitated by prenatal alcohol exposure. Typified by cognitive, social, and adaptive functioning impairments, FASD places impacted individuals at an elevated risk for involvement in the criminal justice system. In particular, it has been reported that some individuals diagnosed with FASD engage in inappropriate sexual behaviours. Because professionals working in the field of sexual offender treatment have the potential to strongly influence their clients, this study surveys professionals that provide treatment services to sexual offenders. Topics queried include knowledge of FASD, the role of FASD in criminal behavior, and training opportunities. The key findings from this study include that the respondents readily recognized symptoms, deficits, and consequences of FASD, but had very few opportunities to receive advanced training on FASD in the context of inappropriate sexual behavior. Findings suggest there is a strong need to develop educational and training programs that better equip professionals with the skills to assist clients with FASD in treatment settings for inappropriate sexual behavior. [6]

CHAPTER: III

AIM AND OBJECTIVES

AIM:

To study on the tendency of the drug addicts at de-addiction centers to commit crimes.

OBJECTIVES:

- To conduct a study on the mental condition of drug addicts and the link in the commission of crimes especially sex related crimes.
- To study the mental stability of drug addicts.
- To draw conclusion on whether Narcotic Drug and Psychotropic Substances has any major influence in commission of crimes.

CHAPTER: IV

MATERIALS AND METHODOLOGY

MATERIALS REQUIRED:

1. Recorder
2. Records of Patients
3. Paper
4. Pen

METHODOLOGY:

The interview was first purely based on the Narcotic Drug and Psychotropic Substances use of the addict, their first time and the cause of the usage, their feelings, physical and psychological changes in their body before and after the administration of NDPS, sexual desires and pleasures due to NDPS administration.

At St. Vincent Hospital, Thuvayoor, Pathanamthitta, District of Psychiatry Department, Dr. Cherian Mathew provided information regarding the mental disorders of Narcotic Drug and Psychotropic Substance addicted persons and their tendency in committing crimes especially sex-related crimes. The doctor introduced 7 addicts to Narcotic Drug and Psychotropic Substances who were male of varied age Subject I aged 29, Subject II aged 32, Subject III aged 32, Subject IV aged 24, Subject V aged 39, Subject VI aged 36 and Subject VII aged 28 was interviewed. The history and records of 43 other Subjects were taken and observed from data which were collected.

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Questionnaire

1. How old are you?
2. How many members are there in your family? Whom are you residing with?
3. What are doing currently?
4. What is the name of the Narcotic Drug and Psychotropic Substances you used for the first time?
5. At what age you used NDPS for the first time?
6. What is/are the NDPS do you use currently?
7. How often do you use drugs and alcohol?
8. How much NDPS do you use every time?
9. In what occasions do you use these substances?

a) Before/after examination or both
b) Before/after sports
c) On streets
d) At places where people gather
e) At home
f) Others

10. Why did you start using these Narcotic Drug and Psychotropic Substances?
    a) Curiosity
    b) Pleasure
    c) Somatic disease
    d) Psychological disorders
    e) Lack of knowledge
    f) Low self- confidence
    g) Family problems
    h) Peer pressure
    i) Others
11. How do you use these NDPS?
    a) Injection (intravenous, intramuscular, intrathecal)
    b) Sniff (inhalation)
    c) Smoking
    d) Others (specify)
12. What is the Physical or Psychological change that occurs after the use of NDPS?
13. What is the Physical or Psychological change that occurs before the use of NDPS?
14. What is the feeling that arises in you if the NDPS is not available to you?
15. Do you feel like having Sexual pleasure when NDPS is administered onto your body?
16. What are the sexual desires that you want to have after taking NDPS?
17. Do you feel attracted and desiring to women when subjected to NDPS?

CHAPTER V

OBSERVATIONS

SUBJECT I:

1. How old are you?

   ANS. 29

2. How many members are there in your family? Whom are you residing with?

   ANS. Four members that of consists Father, Mother, Sister, and Grand Father.

3. What are doing currently?

   ANS. I am a Painter.

4. What is the name of the Narcotic Drug and Psychotropic Substances you used for the first time?

   ANS. Cannabis

5. At what age you used NDPS for the first time

   ANS. Age of 22

6. What is/are the NDPS do you use currently?

   ANS. Cannabis, LSD, Cocaine

7. How often do you use drugs and alcohol?

   ANS. I am using drugs 6-7 times daily

8. How much NDPS do you use every time?

   ANS. 5gm

9. In what occasions do you use these substances?

   ANS. Before sports, on streets, at places where people gather and at home.

10. Why did you start using these Narcotic Drug and Psychotropic Substances?

    ANS. Love Failure

11. How do you use these NDPS?

    ANS. Smoking and Sniffing

12. What is the Physical or Psychological change that occurs after the use of NDPS?

    ANS. Loss of body control, curiosity, self-confidence increases, fearless, anxiety

13. What is the Physical or Psychological change that occurs before the use of NDPS?

    ANS. Less confidence, fear, laziness, restlessness, shivering, tension

14. What is the feeling that arises in you if the NDPS is not available to you?

ANS. Madness, I will do anything for getting the drugs

15. Do you feel like having Sexual pleasure when NDPS is administered onto your body?

    ANS. No

16. What are the sexual desires that you want to have after taking NDPS?

    ANS. Nothing

17. Do you feel attracted and desiring to women when subjected to NDPS?

    ANS. Yes.

SUBJECT II:

1. How old are you?

   ANS. 32

2. How many members are there in your family? Whom are you residing with?

   ANS. Six members that consists of Father, Mother, 2 Sisters, brother and Grandfather.

3. What are doing currently?

   ANS. I am a Shopkeeper.

4. What is the name of the Narcotic Drug and Psychotropic Substances you used for the first time?

   ANS. Cannabis

5. At what age you used NDPS for the first time

   ANS. Age of 23

6. What is/are the NDPS do you use currently?

   ANS. Cannabis, LSD, Heroine

7. How often do you use drugs and alcohol?

   ANS.I am using drugs 4-5 times daily

8. How much NDPS do you use every time?

   ANS. 10gm

9. In what occasions do you use these substances?

   ANS. On streets, at places where people gather and at home.

10. Why did you start using these Narcotic Drug and Psychotropic Substances?

    ANS. For experiencing the feeling of drugs.

11. How do you use these NDPS?

ANS. Smoking, Sniffing and Injection

12. What is the Physical or Psychological change that occurs after the use of NDPS?
    ANS. Loss of body control, Self Confidence Increases, Fearless, Anxiety, Strength Increases
13. What is the Physical or Psychological change that occurs before the use of NDPS?
    ANS. Less confidence, Fear, Restlessness, Shivering, Tension, weakness of body
14. What is the feeling that arises in you if the NDPS is not available to you?
    ANS. Mentally Disturbance will be felt.
15. Do you feel like having Sexual pleasure when NDPS is administered onto your body?
    ANS. No
16. What are the sexual desires that you want to have after taking NDPS?
    ANS. Nothing.
17. Do you feel attracted and desiring to women when subjected to NDPS?
    ANS. Yes.

SUBJECT III:

1. How old are you?
   ANS. 32
2. How many members are there in your family? Whom are you residing with?
   ANS. Three members that consists of Father, Sister, and Grand Father.
3. What are doing currently?
   ANS.I am a Barber
4. What is the name of the Narcotic Drug and Psychotropic Substances you used for the first time?
   ANS. Cannabis
5. At what age you used NDPS for the first time
   ANS. Age of 24
6. What is/are the NDPS do you use currently?
   ANS. Cannabis
7. How often do you use drugs and alcohol?
   ANS.I am using drugs 6-8 times daily
8. How much NDPS do you use every time?

ANS. 15gm

9. In what occasions do you use these substances?

   ANS. Before job, on streets, at places where people gather and friend's houses.

10. Why did you start using these Narcotic Drug and Psychotropic Substances?

    ANS. Family Problems

11. How do you use these NDPS?

    ANS. Smoking.

12. What is the Physical or Psychological change that occurs after the use of NDPS?

    ANS. Loss of body control, curiosity, self-confidence increases, fearless, anxiety

13. What is the Physical or Psychological change that occurs before the use of NDPS?

    ANS. Less confidence, fear, laziness, restlessness, shivering, tension

14. What is the feeling that arises in you if the NDPS is not available to you?

    ANS. Madness, I will lose my full body balance

15. Do you feel like having Sexual pleasure when NDPS is administered onto your body?

    ANS. No

16. What are the sexual desires that you want to have after taking NDPS?

    ANS. Nothing.

17. Do you feel attracted and desiring to women when subjected to NDPS?

    ANS. Yes

SUBJECT IV:

1. How old are you?

   ANS. 24

2. How many members are there in your family? Whom are you residing with?

   ANS. Five members that consists of Father, Mother, 2 Sisters, and brother.

3. What are doing currently?

   ANS.I am an Engineer.

4. What is the name of the Narcotic Drug and Psychotropic Substances you used for the first time?

   ANS. Cannabis

5. At what age you used NDPS for the first time

   ANS. Age of 18

6. What is/are the NDPS do you use currently?

   ANS. Cannabis, Heroin, Cocaine

7. How often do you use drugs and alcohol?

   ANS.I am using drugs 5-3 times daily

8. How much NDPS do you use every time?

   ANS. 10gm

9. In what occasions do you use these substances?

   ANS. Before sports, at places where people gather and at hostel.

10. Why did you start using these Narcotic Drug and Psychotropic Substances?

    ANS. Love Failure

11. How do you use these NDPS?

    ANS. Smoking, Sniffing and Injecting.

12. What is the Physical or Psychological change that occurs after the use of NDPS?

    ANS. Curiosity increases, energy increases, fearless, highly active in studies

13. What is the Physical or Psychological change that occurs before the use of NDPS?

    ANS. Fear, laziness, restlessness, shivering, tension, less confidence

14. What is the feeling that arises in you if the NDPS is not available to you?

    ANS. Staggering.

15. Do you feel like having Sexual pleasure when NDPS is administered onto your body?

    Anson

16. What are the sexual desires that you want to have after taking NDPS?

    ANS. Nothing.

17. Do you feel attracted and desiring to women when subjected to NDPS?

    ANS. Yes.

SUBJECT V:

1. How old are you?

   ANS. 39

2. How many members are there in your family? Whom are you residing with?

   ANS. Five members that consists of Wife, Mother, Son, Daughter and Father.

3. What are doing currently?

   ANS.I am an Auto Driver.

4. What is the name of the Narcotic Drug and Psychotropic Substances you used for the first time?

   ANS. Cannabis

5. At what age you used NDPS for the first time?

   ANS. Age of 26

6. What is/are the NDPS do you use currently?

   ANS. Cannabis, LSD

7. How often do you use drugs and alcohol?

   ANS.I am using drugs 2-3 times daily

8. How much NDPS do you use every time?

   ANS. 5gm

9. In what occasions do you use these substances?

   ANS. With friends, on streets and before driving.

10. Why did you start using these Narcotic Drug and Psychotropic Substances?

    ANS. For experience only.

11. How do you use these NDPS?

    ANS. Smoking, Sniffing

12. What is the Physical or Psychological change that occurs after the use of NDPS?

    ANS. Energetic, talk active, hard working

13. What is the Physical or Psychological change that occurs before the use of NDPS?

    ANS. Laziness, restlessness, shivering, tension.

14. What is the feeling that arises in you if the NDPS is not available to you?

    ANS.I just buy the drugs at very high cost where ever it is available

15. Do you feel like having Sexual pleasure when NDPS is administered onto your body?

    ANS. No

16. What are the sexual desires that you want to have after taking NDPS?

    ANS. Nothing.

17. Do you feel attracted and desiring to women when subjected to NDPS?

    ANS. Yes

SUBJECT VI:

1. How old are you?

ANS. 36

2. How many members are there in your family? Whom are you residing with?
   Five members that consists Wife, 2 children, Father and mother.
3. What are doing currently?
   ANS.I am a Businessman.
4. What is the name of the Narcotic Drug and Psychotropic Substances you used for the first time?
   ANS. Cannabis
5. At what age you used NDPS for the first time
   ANS. Age of 30
6. What is/are the NDPS do you use currently?
   ANS. Cannabis, Cocaine
7. How often do you use drugs and alcohol?
   ANS. I am using drugs 2-4 times daily
8. How much NDPS do you use every time?
   ANS. 5gm
9. In what occasions do you use these substances?
   ANS. Festivals, at places where people gather and at work sites.
10. Why did you start using these Narcotic Drug and Psychotropic Substances?
    ANS. Business Failure
11. How do you use these NDPS?
    ANS. Smoking, Sniffing
12. What is the Physical or Psychological change that occurs after the use of NDPS?
    ANS. Loss of body control, confident, fearless, anxiety, energetic.
13. What is the Physical or Psychological change that occurs before the use of NDPS?
    ANS. Less confidence, Fear, Laziness, Restlessness, Tension
14. What is the feeling that arises in you if the NDPS is not available to you?
    ANS. I use any kind of drug which is easily available.
15. Do you feel like having Sexual pleasure when NDPS is administered onto your body?
    ANS.No
16. What are the sexual desires that you want to have after taking NDPS?
    ANS. Nothing.

17. Do you feel attracted and desiring to women when subjected to NDPS?

    ANS. Yes

SUBJECT VII:

1. How old are you?

   ANS. 28
2. How many members are there in your family? Whom are you residing with?

   ANS. Five members that consists of Father, Mother, Brother, Sister, and Grand Father.
3. What are doing currently?

   ANS.I am a sale boy.
4. What is the name of the Narcotic Drug and Psychotropic Substances you used for the first time?

   ANS. Cannabis
5. At what age you used NDPS for the first time

   ANS. Age of 25
6. What is/are the NDPS do you use currently?

   ANS. Cannabis
7. How often do you use drugs and alcohol?

   ANS.I am using drugs 5-6 times daily
8. How much NDPS do you use every time?

   ANS. 6gm
9. In what occasions do you use these substances?

   ANS. At home, workplace, friend's house and at streets also.
10. Why did you start using these Narcotic Drug and Psychotropic Substances?

    ANS. Love Failure
11. How do you use these NDPS?

    ANS. Smoking
12. What is the Physical or Psychological change that occurs after the use of NDPS?

    ANS. Loss of body control, curiosity, fearless, anxiety
13. What is the Physical or Psychological change that occurs before the use of NDPS?

    ANS. Less confidence, fear, laziness, restlessness, shivering, tension
14. What is the feeling that arises in you if the NDPS is not available to you?

ANS. Madness, I will do anything for getting the drugs.

15. Do you feel like having Sexual pleasure when NDPS is administered onto your body?

    ANS. No

16. What are the sexual desires that you want to have after taking NDPS?

    ANS. Nothing.

17. Do you feel attracted and desiring to women when subjected to NDPS?

    ANS. Yes

A table was made from the data collected through personal interview with the patients and the records and history of other patients from the de-addiction documents based on their tendency to commit sexual crimes, violent crimes and non-violent crimes.

In the table Positive represents that the due to NDPS tendency to commit the particular crime is more, Negative represents that due to NDPS tendency to commit the particular is not much evident and Neutral represents the tendency due to NDPS to commit the particular crime is average where situation and mentality depends.

Table 1 : Data collected from De-addiction centre

S.No	Subject No.	Age	Sexual Crimes	Violent Crimes	Non-violent Crimes
1	Subject 1	29	Neutral	Positive	Positive
2	Subject 2	32	Negative	Positive	Neutral
3	Subject 3	32	Positive	Positive	Positive
4	Subject 4	24	Neutral	Neutral	Neutral
5	Subject 5	39	Positive	Positive	Negative
6	Subject 6	36	Positive	Positive	Positive
7	Subject 7	28	Neutral	Positive	Positive
8	Subject 8	22	Positive	Negative	Positive
9	Subject 9	23	Negative	Negative	Positive
10	Subject 10	31	Positive	Positive	Negative
11	Subject 11	29	Positive	Negative	Negative
12	Subject 12	37	Positive	Negative	Positive
13	Subject 13	24	Negative	Positive	Positive
14	Subject 14	42	Positive	Positive	Positive
15	Subject 15	16	Positive	Negative	Negative
16	Subject 16	38	Negative	Negative	Negative
17	Subject 17	36	Neutral	Negative	Positive

18	Subject 18	47	Positive	Positive	Negative
19	Subject 19	22	Negative	Negative	Positive
20	Subject 20	48	Positive	Negative	Negative
21	Subject 21	34	Positive	Negative	Positive
22	Subject 22	23	Positive	Negative	Negative
23	Subject 23	49	Positive	Positive	Negative
24	Subject 24	19	Neutral	Negative	Positive
25	Subject 25	25	Negative	Positive	Neutral
26	Subject 26	27	Positive	Positive	Neutral
27	Subject 27	49	Positive	Positive	Positive
28	Subject 28	27	Negative	Positive	Negative
29	Subject 29	30	Positive	Positive	Negative
30	Subject 30	46	Positive	Negative	Negative
31	Subject 31	35	Negative	Neutral	Negative
32	Subject 32	39	Negative	Positive	Positive
33	Subject 33	28	Positive	Positive	Negative
34	Subject 34	29	Negative	Negative	Positive
35	Subject 35	31	Negative	Positive	Positive
36	Subject 36	32	Neutral	Positive	Negative
37	Subject 37	44	Positive	Positive	Neutral
38	Subject 38	26	Negative	Positive	Neutral
39	Subject 39	58	Positive	Positive	Positive
40	Subject 40	49	Positive	Neutral	Positive

41	Subject 41	21	Neutral	Negative	Positive
42	Subject 42	20	Negative	Neutral	Positive
43	Subject 43	18	Positive	Positive	Negative
44	Subject 44	22	Negative	Positive	Neutral
45	Subject 45	39	Positive	Neutral	Negative
46	Subject 46	47	Positive	Positive	Positive
47	Subject 47	18	Neutral	Neutral	Neutral
48	Subject 48	32	Positive	Negative	Negative

49	Subject 49	25	Negative	Positive	Positive
50	Subject 50	26	Neutral	Negative	Positive

Table 2 : Tendency of individuals in committing sexual crimes based on their age groups

Age Group	Positive	Negative	Neutral
15 - 20	2	1	2
21 - 25	2	6	2
26 - 30	4	3	3
31 - 35	4	3	1
36 - 40	4	1	2
41 - 45	2		
46 -50	7		
51 - 55			
56 - 60	1		

GRAPH 1: Tendency of individuals in committing sexual crimes due to NDPS based on age groups

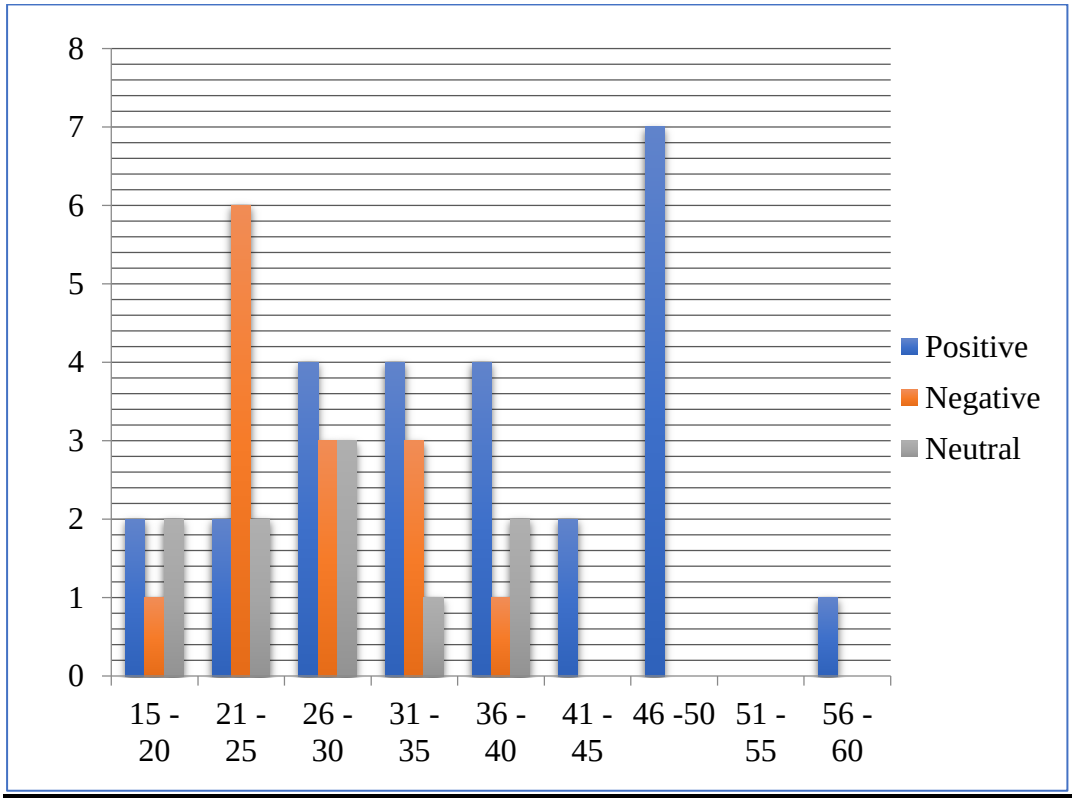


Table 3 : Tendency of individuals in committing violent crimes based on their age groups

Age Group	Positive	Negative	Neutral
15 - 20	1	2	2
21 - 25	3	5	1
26 - 30	7	3	
31 - 35	5	2	1
36 - 40	3	3	1
41 - 45	2		
46 -50	4	2	1
51 - 55			
56 - 60	1		

GRAPH 2: Tendency of individuals in committing violent crimes due to NDPS based on age groups

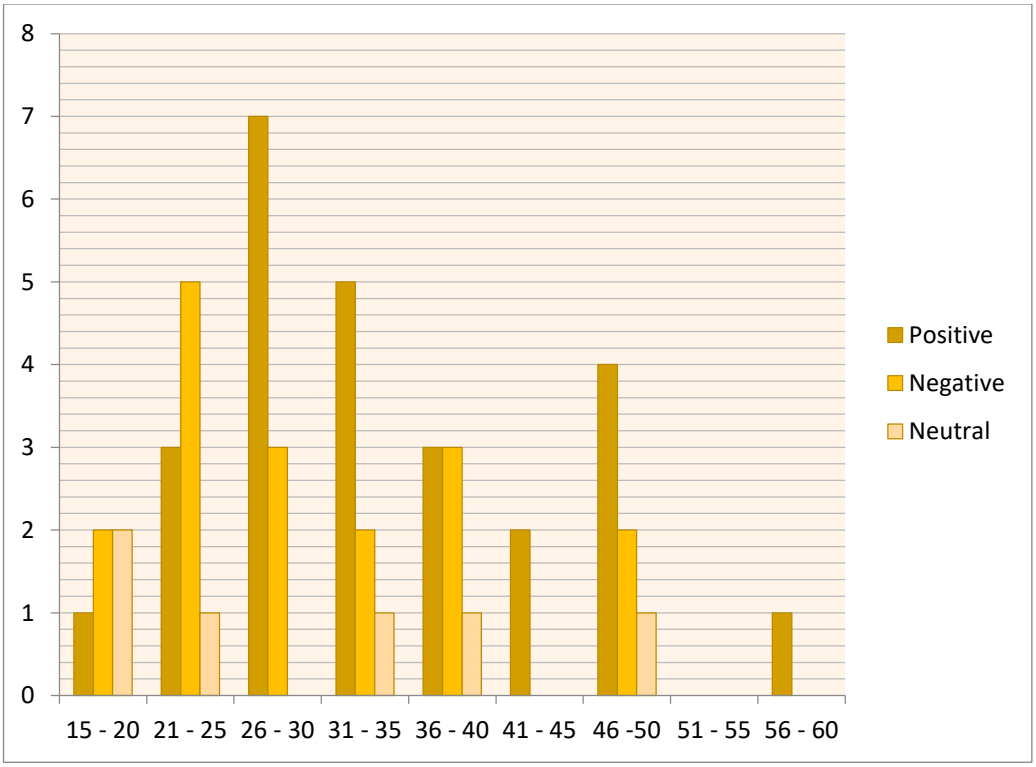
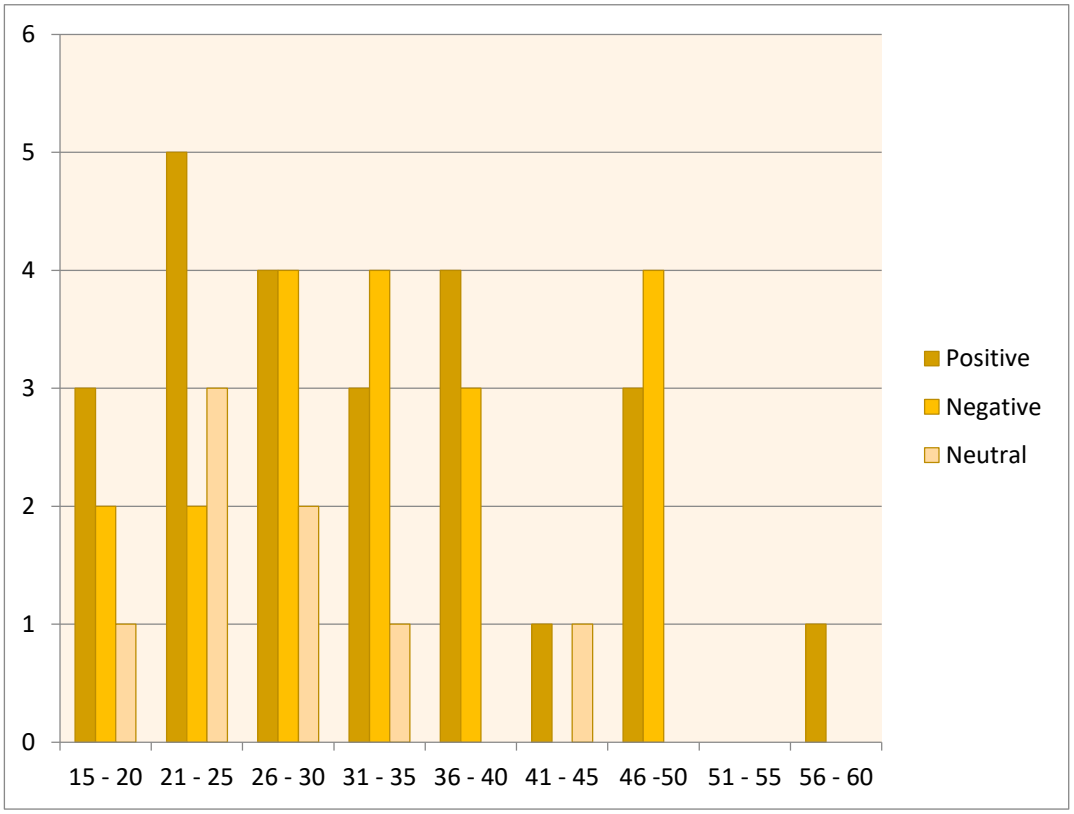


Table 4 : Tendency of individuals in committing non – violent crimes due to NDPS based on age groups

Age Group	Positive	Negative	Neutral
15 - 20	3	2	1
21 - 25	5	2	3
26 - 30	4	4	2
31 - 35	3	4	1
36 - 40	4	3	
41 - 45	1		1
46 -50	3	4	
51 - 55			
56 - 60	1		

GRAPH 3: Tendency of individuals in committing non – violent crimes due to NDPS based on age groups



CHAPTER: VI

RESULT AND CONCLUSION

RESULT:

The following are the results for tendency of committing sexual crimes, violent crimes and non – violent crimes for the people who come out from rehabilitation centre:

For sexual crimes from 15 – 20 of age groups has 2 subjects, 21 – 25 of age group has 2 subjects, 26 – 30 of age groups has 4 subjects, 31 – 35 of age groups has 4 subjects, 36 – 40 of age groups has 4 subjects, 41 – 45 of age groups has 2 subjects, 46 – 50 of age groups has 7 subjects, 51 – 55 of age groups does not have any subjects and 56 – 60 of age groups has only 1 subject are prone to commit above crimes.

From the above data it is proved that 46-50 of age group has the highest tendency in committing sexual crimes.

For violent crimes from 15 – 20 of age groups has 1 subjects, 21 – 25 of age group has 3 subjects, 26 – 30 of age groups has 7 subjects, 31 – 35 of age groups has 5 subjects, 36 – 40 of age groups has 3 subjects, 41 – 45 of age groups has 2 subjects, 46 – 50 of age groups has 4 subjects, 51 – 55 of age groups does not have any subjects and 56 – 60 of age groups has only 1 subject. From the above data it is proved that 26-30 of age group has the highest tendency in committing violent crimes.

CONCLUSION:

The mental condition of drug addicts were studied and brought into a conclusion that they feel anxiety, inactive and depression in general before the administration Narcotic Drug and Psychotropic Substances and therefore after the administration of NDPS in general they are energetic, active and sometimes hyperactive which leads to the commission of crimes. The drug addicts even though after full recovery will be having a tendency in getting back to the life of using drugs. This perhaps can lead to another new level of drug addiction and mental behavioural changes. In these circumstances one would not be in their senses and that there is a high chance of a tendency commit sexual, violent or nonviolent crimes and even at times leading to the commission of all of the crimes or any two.

Therefore the mental stability of the patients at the de-addiction centres is fluctuating which cannot be predicted thereby leading to the commission of crimes.

It is to be concluded that NDPS does have fully influence in the commission of crimes. Characteristically a person will have behavioural changes and influences due to NDPS in the body which can lead to the commission of crimes at about half of the percentage. In future after discharging from the rehabilitation centres, if these individuals are not completely de-addicted from the drugs and also if these individuals again get subjected to the drugs there are chances for them to commit crimes under circumstances and dosages.

It was found that the tendency towards the drugs was not completely stops when the drug addicted person was leave from the rehabilitation centre but the person should have a control in using the Drugs. It was found that the usage of drugs will reduced after leaving from Rehabilitation centre than before coming to the Rehabilitation Centre. It was found that the behaviour of the drug addicted persons to commit crimes and helps to relate any cases which are suspected on that particular person with the records.

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