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for Drugs and Drug Addiction



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DRUG POLICY¹

T0. SUMMARY

In 2012, while determining the drug policy guiding principles, the demand for a new and different approach made it necessary to set up a new drug strategy. This is partially a consequence of the significant changes that took place in the areas involved in the treatment of the drug problem (e.g. healthcare, public education), partially a consequence of the profound social and economic changes that are having an unfavourable effect on the development of addictions, of the significant negative movements occurring in certain substance use tendencies (e.g. cannabis, amphetamine), and of the appearance of designer drugs. Accordingly, Hungary's new strategy document, the National Anti-drug Strategy 2013-2020, has determined domestic drug policy since 2013. The second action plan (called as policy programme) began in 2017, which includes 27 measures to achieve the objectives of the National Anti-drug Strategy.

Drug affairs coordination tasks belong to the jurisdiction of the Ministry of Human Capacities (EMMI), which includes supporting the work of the Inter-ministerial Coordination Committee on Drug Affairs (KKB) and of the Council on Drug Affairs (KT) and also performing the professional coordination of the ministry's background institutions.

No detailed information is available on public expenditure on tackling the drug problem.

T1. NATIONAL PROFILE

T1.1 NATIONAL DRUG STRATEGIES

T1.1.1 Previous drug strategies

Timeframe	Title	Focus
2000-2009	National Strategy to Reduce the Drugs Problem ²	Illicit drugs
2010-2020	National Strategy for Tackling the Drugs Problem ³	Illicit drugs
2013-2020	National Anti-drug Strategy 2013–2020, Clear consciousness, sobriety, and fight against drug crime ⁴	Illicit drugs

T1.1.2 The current national drug strategy⁵

Preparations for the strategy document were started in 2011 with the involvement of the National Drug Prevention Office (NDI) and recognised Hungarian experts. After social and public administration consultations, the National Assembly approved National Assembly Decision 80/2013. (X.16.) with the title National Anti-drug Strategy 2013–2020, Clear consciousness, sobriety, and fight against drug crime. The National Anti-drug Strategy determines targets for the period between 2013 and 2020. Besides recognising the necessity of handling the personal and social risks and damage in connection with drug use, its main objective is the reduction of the use of illicit substances with the help of targeted, community-based interventions. The National Anti-drug Strategy desires to achieve this objective

¹ Authors of the chapter: Gergely Csaba Horváth and Orsolya Varga

² National Assembly Decision 96/2000. (XII. 11.) about the approval of the National Strategy to Reduce the Drugs Problem

³ National Assembly Decision 106/2009. (XII. 21.) about the National Strategy for Tackling the Drugs Problem

⁴ National Assembly Decision 80/2013. (X. 16.) about the National Anti-drug Strategy 2013–2020

⁵ H/11798. National Assembly Decision on the National Anti-Drug Strategy 2013-2020 Pure awareness, sanity, fight against drugs: <http://www.parlament.hu/irom39/11798/11798.pdf>

through wide-ranging prevention activities, by strengthening a recovery-oriented attitude and reintegration in the field of the care and treatment of drug addicts, by the more effective application of crime-prevention and crime-fighting interventions in the field of supply-reduction, and through strict action against trafficking.

The strategy uses five basic values (Right to life, human dignity and health; Personal and community responsibility; Community activity; Cooperation; Scientific basis) to determine the general and concrete objectives in the following fields: Health development and drug prevention; Treatment, care, recovery; Supply reduction

The Policy Programme for the implementation of the current National Anti-drug Strategy had been approved by the Government Decision 2010/2015 (XII. 29.). The Policy Programme contained 31 measures and 56 tasks. In the field of demand reduction the programme envisages the quality assured system-wide development of health development and general drug prevention and the modernisation and capacity building based on the needs of the service-provision system and the reintegration. The main aim of the document regarding supply reduction was to hindrance the import to Hungary and the domestic trade of new psychoactive substances subject of misuse and the related intensified implementation of crime prevention aspects. In favour of this it was particularly important to hold in the crimes committed on the internet and the protection of the growing generations in all settings where the children and youngsters are at higher risk.

The above mentioned policy programme was followed by the 1669/2017. (IX.15) Government Decision about the Policy Programme of the National Anti-Drug Strategy 2017-2018.⁶ This policy programme contains 27 measures. The four pillars of the policy programme are: I. Development of the health promotion and drug prevention system; II. Development of the treatment, care and recovery system; III. Development of the system of supply reduction interventions; IV. Mobilizing human and social resources.

In the 2017-2018 policy programme, the development of health promotion and drug prevention system are supported by specific professional training, prevention network co-operation, impact assessment of the preventive-informative service (hereinafter: quasi compulsory treatment or QCT). The focus of the development of the treatment system is on the elaboration of the professional methodological guidelines (targeted interventions for early intervention, parental training packages, family and community interventions, policy measures) and the development of the efficiency and accessibility of the institutional system. Development of the system of supply reduction interventions in 2017-2018 is to be achieved through the modernization of methodological and technical conditions. To mobilize human and social resources through the support of the Coordination Fora on Drug Affairs (KEFs), to strengthen the functioning of the Early Warning System for new psychoactive substances, to evaluate the process of the implementation of the National Anti-Drug Strategy, to support research, and to improve cross-sectoral, professional and civil partnerships.

T1.1.4 Additional national strategy documents for other substances and addictions

<<táblázat>>

T1.1.6 The capital city's drug strategy

A detailed description of the Budapest drug policy can be found in the 2012 National Report, Chapter 12 under the title: Drug policy of large European cities. Additional information is not available since then.

⁶ 1669/2017. (IX.15) Government Decision about the Policy Programme of the National Anti-Drug Strategy 2017-2018 [<link>](#)

T1.2 EVALUATION OF THE NATIONAL DRUG STRATEGIES

T1.2.1 Evaluation of strategies and action plans

The interim (2004-2005) evaluation of the National Strategy (2000-2009)

The final (2009), external evaluation of the National Strategy (2000-2009)

The Government Decision 2010/2015. (XII. 29.) on the Policy Programme of the National Anti-drug Strategy (until the end of 2016)

T1.2.2 Summary of the latest evaluation

The first national Drug Strategy of Hungary was adopted by the National Assembly with its Decree 96/2000. (XII.11.) with a political consensus. The national strategic program to combat the drug-problem determined the drug-policy of the country between 2000 and 2009. The Hungarian drug coordination called upon the interim evaluation of the Strategy examining the short-term and mid-term aims which also included suggestions for the future. The project was financed by Netherlands State Department and Trimbos Instituut – the Netherlands Institute of Mental Health and Addiction – was selected to do this evaluation in close cooperation with the NDI. The results were issued in a two-volume publication in Hungarian and English by the Dutch partner (Galla et al. 2005a, Galla et al. 2005b). Hungary was the first country in Europe which mandated a third party from a different country to examine the national Drug Strategy to ensure an impartial and independent evaluation.

Checking to what extent the results formulated in the strategy have been reached, was done by interviews and focus groups with policy makers and people in the field. Key policy makers and representatives from national implementing agencies e.g. customs and the police, have been interviewed personally. Coordinators of 65 KEFs, being key stakeholders in the field and involved in realising the policy objectives, have been interviewed by telephone. Finally, focus groups have been held to discuss a selection of diverging and otherwise relevant outcomes of the interviews.

Interviews with the national key stakeholders show that in general the Drug Strategy is seen as an adequate policy instrument, especially because there was no comprehensive integrated drug policy before this strategy was written. There is general agreement that the inclusiveness of the strategy, presenting a holistic view of all relevant policy issues and their interrelationships is a major achievement. There is also general consensus that a policy paper written for this long-term period (10 years), spanning several governmental cycles of four years, is a strong point.

At the same time, interviewees expressed the concern that a fixed, long-term document misses the flexibility necessary to adequately respond to recent developments. Another weak point mentioned by the majority of the interviewed stakeholders was a lack of specific planning of the actions summed up in the strategy. They underlined a need for a clear prioritising of actions (e.g. presented in a timetable) and a need for an explicit division and assignment of responsibilities and tasks.

There is an overall agreement that the financial and for some part also the legal guarantees are missing for realising the plans. Furthermore, some interviewees referred to a lack of transparency of the policy making and implementing process. One key issue mentioned here was a lack of information from policy makers to policy 'implementers' on the contents of the strategy, on priorities and on what has been reached till now. A gap between national and regional/local level has been mentioned as one of the reasons for this.

The interviews also included some questions about the functioning of the KKB. Interviewees mentioned as strong points the inclusiveness of KKB, bringing together all relevant stakeholders, and its role in facilitating the flow and exchange of information to all stakeholders. There have been critical remarks that neither has the KKB the mandate to

coordinate drug policy, nor are there clear-cut procedures for having results of KKB discussions endorsed as formal policy decisions.

The external evaluation of the Strategy was ordered by the Ministry responsible for drug coordination in 2009. The research was conducted by the HealthMonitor Research and Consulting Non-profit Ltd. entrusted by the Nation Institute on Drug prevention. The research (Vitrai, 2009) was analysing the following questions:

- Are the changes observed in the Hungarian drug scene in harmony with the aims of the Strategy?
- Are the activities connected to the Strategy in accordance with the changes?
- How much were the aims of the Strategy in compliance with the assigned sources and the connected activities based on experiences and professional knowledge available?

Four different methods were used during the evaluation: document analysis, in depth interviews with decision makers and experts, discussion on the first results of the evaluation in focus groups, problem-tree analysis.

The short summary of the results: The document based analysis of activities connected to the 90 long term goals of the strategic document showed that 123 activities could be identified which could be clearly connected to the goals of the Strategy. 17 of the activities were connected to more goals. No activities could be connected to 14 of the goals, from which in the case of 5 goals the reason assumably was the too general wording. 8 of the identified activities was contradictory to the goals and all of these activities were implemented on the field of Treatment and care. In the field of Prevention were the most fulfilled (43%) and the less unfulfilled (16%) goals. Only 22% of the goals of Treatment and care was implemented fully and 64% was not fulfilled at all. The output of the Supply reduction pillar was similar with 18% and 54%. As it can be stated from above there was a smaller or larger positive movement on all fields of the Strategy despite to the ambitious aim setting identified during the earlier mid-term evaluation as well.

T1.3 DRUG POLICY COORDINATION

The Coordination Committee on Drug Affairs set up at the end of the 90s is a governmental body tasked to make proposals and formulate opinions, which, with its membership of representatives of state administration and national institutions, participates in the discussion and elaboration of the responses to the drug problem. It was restructured at the end of 2006 and four of its permanent government delegate members were replaced by members from civil organisations.

A further reorganisation of the Coordination Committee on Drug Affairs was carried out 2013 on the basis of Government Decision 1158/2011. (V.23.) on the review of bodies established with a legal act or public body control instrument, and Government Decision 1452/2011. (XII.22.) on the implementation of the tasks included in the former decision. As a result, the Coordination Committee on Drug Affairs continued its work with a new structure and name (Inter-ministerial Coordination Committee on Drug Affairs - KKB) with the involvement of representatives of ministries and government offices and the separate Council on Drug Affairs (KT) was set up with civil delegates.

Professional and political control of tasks related to drug prevention and drug affairs coordination is exercised by the state secretary of EMMI responsible for social affairs and social inclusion, the direct state head of the field is the deputy state secretary responsible for social policy. In 2017, the National Drug Prevention Coordination Department operated as a part of the Social and Child Welfare Services Department. The Social and Child Welfare Services Department cooperates with the competent departments of the State Secretary Responsible for Health in connection with drug prevention and public health tasks.

Practical tasks related to the prevention and handling of the drugs problem (application and grant management, coordination of KEFs and QCT etc.) were carried out by the ministry's background institution, NDI, that was operating as a unit of the National Institute for Family and Social Policy until September, 2015. The Office had been reorganised under the National Office for Rehabilitation and Social Affairs (NRSZH). Since 1 January 2017, the Directorate-General for Social Affairs and Child Protection as legal successor has been in charge of the drug policy. The Unit of Drug Prevention Programs - within the Directorate General's Equity Department - began operations on 1 April 2017. (SZGYF 2017)

The Coordination Fora on Drug Affairs (KEF) play an important role in the implementation of drug policy and consist of local-level professional consultation work groups that were created by local authority commitment, local professional collaborations aimed at handling the drug problem and by ministry grants.

There are currently 84 KEFs operating in Hungary, with town, district, small-region, county or regional competence. A national KEF conference was held on 13 December, 2017, where a KEF representative was elected, to represent the forums in the Council on Drug Affairs. Their task is to harmonise the work of the institutions of the four basic pillars of combating the drug problem – the community and collaboration, prevention, treatment and rehabilitation, and supply reduction. The members of the KEFs are representatives of state, local authority, civil and church organisations that play an important role in handling the drug problem (SZGYF 2018).

T1.4 DRUG RELATED PUBLIC EXPENDITURE

T1.4.1 Availability of data on drug related public expenditure

No current data or research results are available in connection with Hungarian public expenditure related to drug use. The results of the study carried out in the past (Hajnal 2009) can no longer be treated as valid.

T1.4.2 Data on drug related public expenditure

The first comprehensive Hungarian survey (Hajnal 2009) examining the changing of drug-related public expenditure over time between 2000 and 2007, in four studied years was made at the end of 2008. (For more information see the 2009 National Report, Chapter 1.3.) The study based on the results of an estimation procedure is a calculation of the proportion of public spending on drug affairs in the given organisational or activity system.

On the basis of the study data it can be shown that items related to criminal justice formed 2/3 to 3/4 of all spending in the entire examined period, and that no great change took place in the structure of this spending. Other spending is linked to the following areas, in order: treatment, prevention and research and harm reduction. According to the estimate the total amount of public spending in the base year was EUR 17.3 million⁷, which almost doubled by the last study year of 2007.

As a result of the effects of the international economic crisis after 2008, changes took place in both the amount and structure of spending, therefore the results of the study can longer be viewed as valid.

⁷ Calculated using the EUR intermediate exchange rate valid for 2014 (EUR 1=HUF 308.51).

T3. NEW DEVELOPMENTS

In response to the social and professional status in Hungary four organisations – Hungarian Association of Organisations for Drug Prevention and Harm Reduction (MADÁSZSZ), Hungarian Association of Institutions for Drug Therapy, Hungarian Association on Addictions and Society of Harm Reduction Providers - created the institution of Civil Ombudsman on Drug Affairs (CODA) in May 2014.

The task of CODA is to provide basic advocacy activities based on the claims of the organisations working in the field of drugs and on other cases. The CODA concentrates on outstanding infringements which can be observed system-wide and after the analysis of the situation he or she implements several activities.

T4. ADDITIONAL INFORMATION

T4.1 ADDITIONAL INFORMATION ABOUT DRUG POLICIES

No information available.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

Beszámoló a Drogszakmai Civil Ombudsman kétéves tevékenységéről 2014. május - 2016. május (2016), Budapest.

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Vitrai J. (2009): Tanulmány a „Nemzeti Drogstratégia a kábítószer-probléma visszaszorítására” megvalósulásának dokumentum- és mélyinterjú elemzésen alapuló értékeléséről. EgészségMonitor Kutató és Tanácsadó Nonprofit Közhasznú Kft., Budapest.

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SZGYF (Szociális és Gyermekvédelmi Főigazgatóság) (2018): A Szociális és Gyermekvédelmi Főigazgatóság beszámolója az EMCDDA 2018-as Éves Jelentéshez

T5.2 METHODOLOGY

Not applicable.

LEGAL FRAMEWORK⁸

T0. SUMMARY

Hungarian legislation has been characterised by multiple amendments to the Criminal Code over the past years. The Criminal Code in force since 2013 determines the country's criminal law in a new structure and, following the changed drug-situation, it has been supplemented with regulations relating to new psychoactive substances.

The rapid appearance of the new substances forced the country's decision-makers to elaborate a new monitoring and risk assessment system, which can be used to provide the appropriate information to make responsible decisions on the control of designer drugs.

Act XCV of 2005 on Medicines (hereinafter: Medicines Act) lays down the framework of the new legislation, while Government Decree 66/2012 (IV. 2.) (hereinafter: Government Decree) determines the processes and responsible institutions in connection with the reporting of new psychoactive substances, their preliminary assessment, scheduling and risk assessment.

T1. NATIONAL PROFILE

T1.1 LEGAL FRAMEWORK

T1.1.1 Characteristics of drug legislation

The new Criminal Code (hereinafter: Btk.) accepted by the National Assembly on 25 June 2012 entered into force on 1 July 2013.

Chapter XVII of the Btk. (Criminal offences against health) provides regulations in connection with illicit drugs in six statutory definitions: drug trafficking, possession of narcotic drugs, inciting substance abuse, aiding in the manufacture or production of narcotic drugs, criminal offences with drug precursors, and misuse of new psychoactive substances.

The statutory definition of drug trafficking (Art. 176-177) includes the offering, supply, distribution and trafficking of illicit drugs, as well as providing material assistance to these perpetrations. The law punishes the basic case with a term of imprisonment of between two and eight years.

Perpetrations involving the possession of illicit drugs (Art. 178-180) include producing, manufacture, acquisition, possession, import, export of illicit drugs and transporting them through the territory of the country. The punishment for the basic cases is imprisonment for a term of between one to five years. The Btk. separately names illicit drug consumption, the punishment for which is the same as the punishment for the acquisition of a small amount.

The Btk. orders the offence of inciting substance abuse (Art. 181) (a person over the age of eighteen years who persuades or who attempts to persuade a minor to engage in the consumption of a substance or agent that has a narcotic effect and that is either classified as an illicit drug or not) to be punished by imprisonment of up to two years.

The Btk. contains the cases and conditions of alternatives to criminal procedure (quasi compulsory treatment, hereinafter QCT) (Art. 180.) which, according to the Hungarian criminal law system, are given as grounds for exemption from culpability. The text of the law states that if a person who produces, manufactures, acquires or possesses a small amount of illicit drug for own consumption or who consumes illicit drugs 'is able to present a document before being sentenced in the first instance to verify that he/she has participated in

⁸ Author of the chapter: Réka Bálint

treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service' then he/she may not be punished. The QCT may be initiated either in the prosecution or the court phase of the criminal proceedings. The possibility of QCT is not available for those persons who undertook QCT in the two years previous to the perpetration of the offence or whose criminal liability has been determined in a drug trafficking or drug possession case. In the event of the crimes committed with new psychoactive substances, it is not possible to participate in QCT. (For more information about QCT and people participating in QCT see T1.2.2 and T1.3.1 in the Treatment workbook.)

T1.1.2 Factors influencing the punishment: the type of illicit drug, the quantity of illicit drug and addiction

According to the Hungarian criminal regulations the following substances specified in the law are classified as illicit drugs:

- a) the substances specified in the Schedules I and II of the Single Convention on Narcotic Drugs signed in New York on 30 March 1961 ratified by law decree no 4 of 1965, amended and supplemented by the Protocol of 25 March 1972 in Geneva on the amendment of the Single Convention on Narcotic Drugs ratified by law decree no 17 of 1988,
- b) the dangerous psychotropic substances specified in Schedule I and II of the convention signed in Vienna on 21 February 1971 on psychotropic substances, ratified by law decree no 25 of 1979 and
- c) the psychotropic substances specified in the annex of the Act on Medicines for human use.

The punishments associated with the offences listed in the Btk. may be influenced by several circumstances of the perpetration of the offence, and by the amount of illicit drug; however, the type of drug does not affect the extent of punishment, neither according to the law nor the court practice.

Aggravating circumstances include offences perpetrated in criminal association with accomplices or perpetrated by a public official or a person entrusted with public functions, as well as acts perpetrated by a person over the age of 18 years who offers or supplies illicit drugs to a person under the age of 18 years or who uses such a person to commit other drug-related offences.

In general, it may be said that the Btk. specifies four quantity thresholds for the illicit drugs forming the subject of offences, which quantities relate to the pure active substance content of the illicit drugs. Perpetration with a small amount of illicit drug is treated as a privileged case as compared to the basic case. The act determines the quantity of the substantial amount - treated as an aggravating circumstance - to be twenty times the upper limit of the small amount, while the quantity of a particularly substantial amount is determined to be two hundred times the upper limit of the small amount. The text of the Btk. also includes the specification of the small amount for each of the individual illicit drugs (Art. 461). The following general rule is valid in the case of those substances where the law does not specify a precise active substance content: the illicit drug is considered to be of a small amount if its pure active substance content is not more than seven times the average effective dose of an unaccustomed user.

With respect to drug trafficking (distribution, dealing) the case of small amount as a privileged case was removed, because stricter action was justified in the case of trafficking-type behaviours. In the interest of more effective action against drug trade, the Btk. introduced the category of possession of a particularly substantial quantity as an aggravating case.

The court has the possibility to take the addiction of the perpetrator into consideration when imposing the punishment.

T1.1.3 Control of new psychoactive substances

The rapid appearance of the new substances forced Hungarian decision-makers to elaborate a new monitoring and risk-assessment system, which can be used to provide the appropriate information to make responsible decisions regarding the control of designer drugs.

Act XCV of 2005 (hereinafter: Medicines Act) lays down the framework of the new legislation, while Government Decree 66/2012 (IV. 2.) (hereinafter: Government Decree) determines the processes and the responsible institutions in connection with the reporting of new psychoactive substances, their preliminary assessment, their scheduling and risk assessment. The Medicines Act defines “new psychoactive substances” as substances or groups of compounds recently appearing on the market that have no medicinal use and that, due to their effect on the central nervous system, are suitable for altering a person’s state of consciousness, behaviour or senses, and therefore represent a threat to public health similar to the substances listed in the illicit drug and psychotropic substance schedules, and so with respect to this, in the past the Government, currently the minister responsible for health, classified them as such materials in a decree. The Medicines Act and the Government Decree created a new schedule (Annex 1 of Decree no 55/2014. (XII. 30.) of Ministry of Human Capacities) for the new psychoactive substances, which contains both individual compounds and compound groups (through this providing both a list of individual compounds and a generic approach).

According to the Medicines Act and the Government Decree, if the EMCDDA sends a notification about a substance on the basis of Council Decision no 2005/387/JHA, the responsible department of the Ministry of Human Capacities subjects it to a special preliminary assessment to determine whether the substance may be included in the list. In order for a substance to be included in the schedule of new psychoactive substances it must be proved that the Hungarian authorities and professional institutions have no knowledge of any data that refers to the medical use of the substance indicated in the notice, and that excludes that the substance poses a similar risk to public health as the substances included in the schedule of illicit drugs and psychotropic substances.

The individual compounds included in the schedule of new psychoactive substances must be subjected to a risk assessment within one year of their inclusion in the schedule. Depending on the result of the risk assessment, the compound must be transferred to the list of psychotropic substances (one of the schedules of Medicines Act) or to Schedule D of the Government Decree. If there is insufficient data available to complete the above risk assessment according to the findings of the expert body, the classification of the new psychoactive substance may be extended for a further year. This risk assessment obligation is not applicable for compound groups, which remain in the schedule of new psychoactive substances until at least one of the substances in the group complies with the conditions for the preliminary assessment. Activities defined by the relevant legislation in connection with new psychoactive substances may only be performed in possession of a permit issued by the state administration body for health.

The Btk. contains a section entitled “Misuse of New Psychoactive Substances” (Art. 184, 184/A-D), which follows the structure of the previous articles, but regulates the offences related to new psychoactive substances with more lenient punishments. The aggravated cases of the new regulation are essentially the same as those relating to illicit drugs, however, it does not include perpetrations with a substantial quantity. The lenient cases relate to perpetration with a small amount, the upper limit of which is 2 grams with respect to the active substance of the given substance. The punishable acts also include acquisition and possession of new psychoactive substances as long as the amount exceeds the small amount. It was not the purpose of the legislators to establish the criminal liability of users of new psychoactive substances, therefore consumption is not punishable, nor is acquisition and possession of a small amount. If the new psychoactive substance does not reach the small amount, the prosecution will be suspended and an infringement procedure will be initiated against the drug owner of the new psychoactive substance.

T1.2 IMPLEMENTATION OF THE LAW

T1.2.1 Sentencing practice

No information available.

T2. TRENDS

T2.1 CHANGES IN THE LEGAL FRAMEWORK SINCE 2000

At the end of 2002, on the basis of its criminal policy endeavours, the government mitigated, differentiated and amended Act IV of 1978 on the Criminal Code (hereinafter: old Btk.) in several places. Along with this, necessary amendments were made to Act XIX of 1998 on Criminal Procedure (hereinafter: Be.).

The new legislation which entered into force on 1 March 2003 by the Act 2 of 2003 on the amendment of criminal and other laws placed the acts with varying risk levels in four separate articles determining different punishments. Acquisition type behaviour, trafficking type behaviours and, similarly to the previous legislation, the acts committed by drug addicts were to be found in different sections, the latter involving the threat of more lenient punishment as compared to the former. The amendment included a new provision: acts committed against minors and those perpetrated with the use of minors were included in a separate statutory definition, the aggravated cases of which were punishable with the most serious, lifetime imprisonment.

The old Btk. also contained the cases and conditions of QCT. The most significant change as compared to the previous legislation was that drug addiction was no longer a condition for using QCT. With respect to persons, any category of users (occasional, regular, addict) had the opportunity to take advantage of QCT (with more favourable regulations for drug addicts).⁹ Non-addict perpetrators only had the possibility for QCT if the amount of drug was not more than the 'small amount' of the given drug. With respect to criminal acts, QCT were typically available in the case of - less serious - use-related offences. However, two trafficking-type behaviours represented an exception, 'offer' and 'hand over', because if the offered and handed over illicit drug was of a small amount, and the act in question took place 'on the occasion of joint drug consumption', the perpetrator of the aforementioned two acts might have also taken advantage of the opportunity of QCT. It was a condition in all cases of QCT that 'the perpetrator is able to present a document before being sentenced in the first instance that verifies that he/she has participated for at least six consecutive months in treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service'. The QCT might have been initiated either in the prosecution or the court phase of the criminal procedure. The wide application of QCT presented in the above text was declared to be unconstitutional by Constitutional Court decision no 54/2004. (XII. 13.), which decision caused the amendment of several points of the old Btk. (Be. Art. 188(1)h); Art. 222(2); Art. 266(6)). (For details see Chapter 1.1. of the 2005 National Report)

Act LI of 2006 on the amendment of Be. entered into force on 1 July 2006, with the exception of Article 285(2) and (3). The two years following the enactment of the Be. revealed legislative deficiencies and practical demands that required mainly technical amendments to the law and a number of conceptual changes. According to the amendment, if the suspected drug user had voluntarily participated in treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service, and this can result in exemption

⁹ As Art. 283(1)e) and f) of the old Btk. is more lenient', for example, a drug addict may also take advantage of QCT if he/she "produces, manufactures, acquires or possesses illicit drugs for own consumption' exceeding the small quantity' but not reaching the significant quantity'.

of culpability, it is not necessary for the investigating authority to send the investigation documentation to the public prosecutor with a recommendation that the suspected be formally accused or for the public prosecutor to make a decision on postponing formal accusation on the basis of article 222(2) of the Be. Therefore, if the suspected drug user subjected him/herself to any of the treatment forms serving as an QCT and this was still in process when the investigation documents were presented, the investigation must have been suspended.

The amended provision made it possible to end the case with a cause for exemption of culpability irrespective of when suspension of formal accusation took place, if the quasi compulsory treatment (QCT) was started before the suspension of formal accusation.

On the basis of the Supreme Court's Criminal Unity Resolution 1/2007, the confession of the user relating to the amount of illicit drug consumed (but no longer existing) may also be used as evidence against the user, in this way the amount of illicit drug indicated in it is treated by the court as an influencing circumstance. The standpoint of the Unity Resolution in connection with offences forming a natural unit creates the possibility for stricter judgements against users perpetrating supply offences. (For details see 2008 National Report, Chapter 1.1.) However, as consumption is listed separately, in the Btk. in force several provisions of the Unity Resolution cannot be applied, including the summing of amounts used during consumption. The Unity Resolution is still in force with the text of the old Btk., which causes a serious degree of uncertainty in the implementation of the law.

The current Btk. entered into force on 1 July 2013, which presents the statutory definitions under separate subtitles (Art. 176-183), as opposed to the old Btk. which under the subtitle of misuse of narcotic drugs contained six types of perpetrations in four articles. (For details see chapter T1.1.1)

T2.2 CHANGES TO THE IMPLEMENTATION OF THE LAW SINCE 2000

Changes experienced in the implementation of the law were caused by the continuous changes to the legislative background. A comparative analysis of sentencing practices over time is impractical due to the multiple amendments to the criminal codes.

In 2012 a survey was carried out to examine legal efficiency in connection with trafficking-related drug offences. The aim of the impact assessment was to examine the assertion, applicability and effects of the legal norms in effect relating to trafficking-related drug offences; while it also examined the indirect effects induced by the use of the legal acts, i.e. how legal practice affects the drug market. (For the results of the study see 2013 National Report, Chapter 9.2.)

T3. NEW DEVELOPMENTS

T3.1 CHANGES IN THE LEGAL FRAMEWORK IN THE LAST YEAR

Table 1. *Changes in the legal framework in the last year*

The regulatory document subjected to amendments ¹⁰	The amended regulatory document (current version)		
Title	Title	Summary of changes	Remarks
378/2016. (XII.2.) Government Decree	74/2015. (III.30.) Government Decree	The administrative, legal and professional tasks related to the prevention-counselling	

¹⁰ Texts and hyperlinks of the documents subjected to amendments are not available.

		service were moved from the National Office for Rehabilitations and Social Affairs to the Directorate-General for Social Affairs and Child Protection.	
Act XXXIX of 2017	Act C of 2012	The amendment entered into force on the 23rd of May 2017: the new psychoactive substance is to be considered as small amount if the active substance amount does not exceed 2 grams (the limit was 10 grams before).	
Act CIII of 2016	Act C of 2012	The Criminal Code was extended with Art. 74/A: section (2) introduced expanded confiscation for drug related offenders.	

T.3.2 CHANGES IN THE IMPLEMENTATION OF THE LAW IN THE LAST YEAR

As a proportion of the illicit drug cases in process in 2016 fell under the force of the old Btk. and the rest of them under the new Btk. in force (see T.1.1.1), the Public Prosecutor's Office provided the data relating to 2016 on the basis of the two different structures of the old Btk. and the Btk. in force. (OBH 2017)

In 2016 438 persons were sentenced according to the old Btk. due to drug-related offences according to the following articles:

- Article 282: 293 persons (use-related offences)
- Article 282/A: 71 persons (trafficking-related offences)
- Article 282/B: 20 persons (use-related offences)
- Article 282/C: 42 persons (drug-addicts committing use- or trafficking-related offences)
- Article 283/A: 1 person (misuse of precursors)
- Article 283/B: 11 persons (trafficking type offences related to new psychoactive substances)

2363 persons were sentenced in criminal procedures started in 2016 according to the Btk. in force according to the following articles:

- Drug trafficking
 - Article 176: 315 persons
 - Article 177: 17 persons
- Possession of illicit drugs
 - Article 178: 1962 persons
 - Article 179: 0 persons
- Inciting substance abuse: Article 181: 66 persons
- Aiding the manufacture of illicit drugs: Article 182: 2 persons
- Criminal offences with drug precursors: Article 183: 1 person

In 2016 the following punishments and measures were imposed on the 2801 persons convicted with a final judgement:

- 478 were sentenced to executable imprisonment
- 603 were sentenced to suspended imprisonment
- 686 were sentenced to community work
- 593 were fined (including suspended fines)
- 19 were reprimanded
- 392 were put on probation

Sentencing practice – new psychoactive substances

In 2016 people were sentenced related to the offence of misuse of new psychoactive substances, according to the following articles:

- Trafficking type:
 - Article 184: 163 persons
 - Article 184/A: 30 persons
- Possession type:
 - Article 184/B: 18 persons
 - Article 184/C: 8 person

In 2016 the following punishments and measures were imposed regarding misuse of new psychoactive substances on the persons convicted with a final judgement:

- 60 were sentenced to executable imprisonment
- 76 were sentenced to (partly or fully) suspended imprisonment
- 21 were sentenced to community work
- 37 were fined (including suspended fines)
- 2 were reprimanded
- 23 were put on probation

T3.3 EVALUATION OF LAW IN THE LAST YEAR

No information available.

T4. ADDITIONAL INFORMATION

No information available.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

EMMI (Emberi Erőforrások Minisztériuma) (2016): Az EMMI Szociális és Gyermekjóléti Szolgáltatások Főosztályának beszámolója.

OBH (National Office for the Judiciary) (2017): Data from the Statistical Analytic Department 2016.

T5.2 METHODOLOGY

Not applicable.

DRUGS^{11,12}

T0. SUMMARY

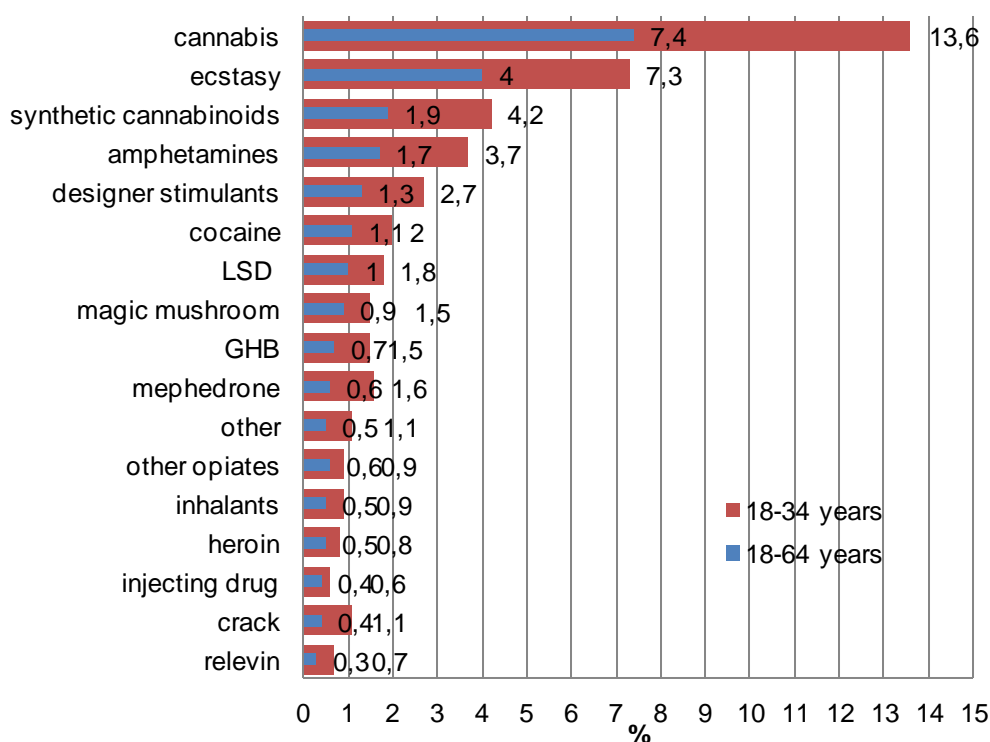
T0.1 SUMMARY OF THE DRUGS WORKBOOK

T0.1.1 The main illicit drugs, developments of the drug market and polydrug use

T0.1.1 a) The main illicit drugs and their relative importance

According to the latest survey data (Paksi et al. 2015) every tenth (9.9%) adult in the population between 18-64 years and almost every fifth (17.7%) young adult between 18-34 years used some kind of illicit drugs in their lifetime. Most adults, 7.4% of the adult population, tried cannabis. Prevalence rate of ecstasy use (4%) is half of it but still outstanding compared to other substances. The two most popular drugs are followed – significantly behind – by synthetic cannabinoids (1.9%), amphetamines (1.7%) and designer stimulants (1.3%). The sequence of drug preference of the young adults is equal to that of the adult population.

Chart 1. *Lifetime prevalence rates by substance types in the adult population between 18-64 years and 18-34 years, in 2015 (%)*



Source: OLAAP - Paksi et al. 2015

¹¹ Authors of the chapter: Gergely Horváth, Réka Bálint, Zsuzsa Kaló, Borbála Paksi, Anna Péterfi, Anna Tarján.

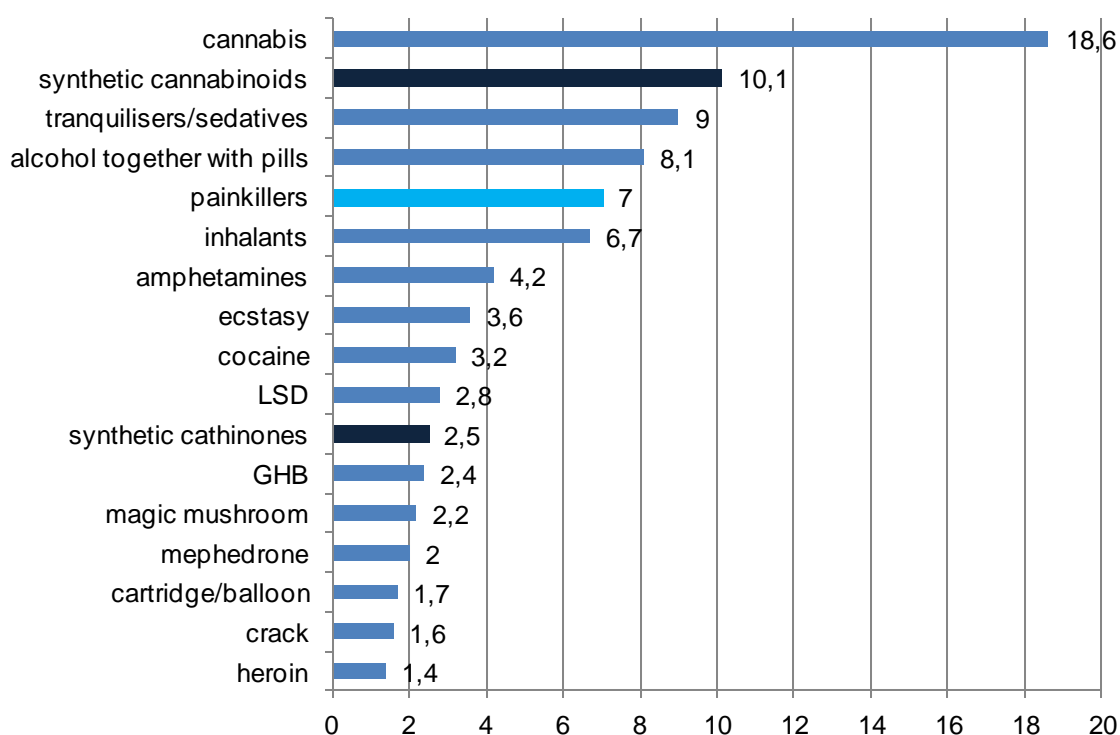
¹² Regarding the epidemiological studies about drug use the National Report in general classifies synthetic cannabinoids and designer stimulants appearing in larger volume from 2009 under the category of 'new psychoactive substances' regardless to their actual legal control status.

Last year prevalence of illicit drug use was 2.3% in the adult population and 5.3% among young adults. The importance of synthetic cannabinoids and designer stimulants¹³ is even more visible concerning recent drug use. Based on the last month prevalence rates synthetic cannabinoids are at the second and designer stimulants are in the fourth place.

In 2015, based on the lifetime prevalence rates (Elekes 2016) cannabis was the most widespread illicit drug in the school population, 9-10 grades). Synthetic cannabinoids, a type of new psychoactive substances (NPS) stood in the second place, reported for the first time in 2015. It was followed by the use of tranquilizers or sedatives without prescription and taking these pills together with alcohol. The consumption of painkillers in order to get high, reported for the first time in 2015, was similarly popular among school pupils. Inhalation of organic solvents was in the sixth place.

The next most prevalent illicit drug was amphetamine, in the seventh place. The use of ecstasy, cocaine and LSD was similarly widespread. The lifetime prevalence rate of the rest of the substances was around 2%. The use of the other group of designer drugs, synthetic cathinones, was less widespread among secondary school students.

Chart 2. *Lifetime prevalence rates by substance types among students on 9-10 grades, in 2015 (%)*



Source: ESPAD – Elekes 2016

Until 2011 the lifetime prevalence rate of the use of almost every type of drug increased, although at different rate and extent. The earlier tendency seemed to turn by 2015. The lifetime prevalence rate of the examined substances decreased compared to the results in 2011. The spread of cannabis fell at the largest extent, by 32.5%.

¹³The group of designer stimulants mainly cover drugs containing synthetic cathinones, although not exclusively, as to lesser extent novel amphetamines, phenethylamines, triptamines, piperazines or others may also appear in that category. Furthermore, surveys reported in this chapter are based on self-reported street names, thus, the term 'designer stimulants' is more adequately covers new psychoactive substances with stimulant effect instead of using names referring to each specific active content. Each subchapter defines which substance names were included in the broader categories by the given research.

In addition, designer drugs have also appeared in the consumption structure, mainly synthetic cannabinoids. But this does not indicate a change of the preferred substance as the total lifetime prevalence of all substances also decreased by 25%. The data show that the majority of designer drug users are illicit substance users too.

Injecting and high-risk drug use

Drug use patterns among high-risk drug users significantly changed over the past eight years on the basis of routine data collection and research in the field. This change can be attributed on the one hand to the emergence and increasing use of new psychoactive substances (NPS) - mainly synthetic cathinones and synthetic cannabinoids - and on the other hand to the decrease observed regarding potency and availability of classical substances related to high-risk drug use (heroin and amphetamine). This pattern change not only affected PWID but also other marginalized groups such as: homeless people; prisoners; people living in segregated areas; and young people in child protection care.

Regarding PWID a shift in the primary injected substance could be observed. While before 2010 half of the clients of needle/syringe programmes (NSPs) injected heroin and the other half injected amphetamine, in 2015 80% of them injected a new psychoactive substance as the primary substance. On the basis of the data, shifting to NPS can be seen in both heroin and amphetamine user groups. According to client reports, the effect of the new substances lasts for a shorter amount of time, so they inject them more frequently (for more information see: Stimulants, Chapter T1.2.5). Since 2016, injecting of synthetic cathinones appears to be moderating (primarily injected drug among NSP clients in 2016: 78%; 2017: 77%), in parallel with which recent research results underline a shift in the route of administration and the primary used substance among PWID, namely, increasing inhaling (foil) of injectable substances and periodic or permanent shift to synthetic cannabinoid use (smoking). Groups previously characterized by primary injecting use are becoming polydrug users switching between multiple substances and multiple routes of administration.

Over the last 3 years, a number of studies have examined drug use by groups of socially marginalized people, whose drug use patterns cannot be captured through general population surveys. Based on these, NPS use seems to be significantly widespread – due to its low price and easy accessibility – among homeless people (Paksi and Magi 2017; Kaló et al. 2018), people living in segregated areas (Szécsi et al 2016; Csák et al., 2017), prisoners (Kaló et al., 2018, Port 2016b) and young people in child protection care (Kaló et al. 2017; Barath et al. 2018).

Health consequences

The most frequent cause of entering treatment in Hungary is cannabis use, its proportion (68.6%) is especially high among clients entering treatment as an alternative to criminal procedure (QCT). The second most prevalent reason for addiction treatment is stimulant use. Although treatment data only indirectly indicate, two drug treatment facility surveys (Péterfi 2015; Péterfi et al. 2016; see methodology in Drugs/E, Chapter T5.2) directly confirmed the expansion of treatment demand related to synthetic cannabinoids and synthetic cathinones, that rivals the volume of treatment demand related to classical drugs.

According to treatment data pattern of NPS use is more intensive and the age of the users entering treatment also decreased. Beyond treatment data other researches proved that the treatment demand related to NPS use emerges after a shorter drug use carrier. Beyond addiction care emergency/clinical toxicology care and psychiatric care also experienced increased treatment demand in the past years according to several sources (for more information see Treatment Workbook, Chapter T4.4. in National Report 2015 and 2016).

Between 2011 and 2014 HCV prevalence doubled (from 24% to 49%) among PWID at national level, while in case of current¹⁴ injectors HCV prevalence reached 65% in 2014. Among primary NPS injectors prevalence of injecting equipment sharing and HCV were significantly higher when compared to those injecting classical substances (for more information see: Harms and Harm Reduction Workbook, Chapter T1.3).

T0.1.1 b) New developments in the drug market

With the emergence of new psychoactive substances in 2010, a major rearrangement was observed in the drug market, reaching a peak in 2014 when 60% of all police seizures were designer drugs. From 2015, their proportion on the market has steadily declined, and in 2017, they represented only 35% of all seizures. Among synthetic cannabinoids 5F-MDMB-PINACA, AMB-FUBINACA and ADB-FUBINACA were the most easily available substances on the market, while ethyl-hexedrone was the most popular designer stimulant.

On the basis of seizure and user information, cannabis derivatives remained the most prevalent drugs in the market. Amphetamine, ecstasy and cocaine also remained the most popular stimulants. In 2017, the proportion of high MDMA-containing ecstasy tablet seizures slightly increased and there was a continuous raise in retail cocaine seizures, suggesting a more intense spread of the drug (NSZKK 2018a).

T0.1.1 c) Polydrug use

According to the results of the latest survey (Paksi et al. 2015) conducted in the adult population, one third (32%) of the ever users in the 18-64-year-old population used only one type of drug from the examined 14 types of drugs. Another one third (33.5%) of the population used two types and one fifth (20.5%) used more than three types of drugs in their lives. Counting the six types of EMQ standard drugs (cannabis, ecstasy, amphetamine, cocaine, heroin, LSD) almost two third (65.2%) of the ever users tried only one type and 7.2% used more than three types of these drugs.

In order to define the separate user patterns a cluster analysis was conducted. It found that the misuse of prescription medication and cannabis use are independent patterns typical in young adults in Hungary. At the same time the use of NPS appeared as part of a polydrug use pattern, and the use of these substances could not be identified as a separate pattern in itself.

This conclusion was confirmed by several studies conducted in specific user groups as well: adult NPS user groups living in segregated areas (Csák et al., 2017) and the homeless population (Paksi and Magi 2017) also showed polydrug use pattern. A qualitative study based on expert interviews (Kaló et al., 2018) also described polydrug use pattern among NPS users in the homeless population and prison settings as well as among clients of harm reduction services.

¹⁴ injecting in the last 4 weeks

A. CANNABIS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 The relative importance of cannabis

Based on seizure data, in Hungary the most available cannabis derivative is herbal cannabis followed by cannabis resin (NSZKK 2018a). (For further information see Drug Market and Crime Workbook.)

In the questionnaire survey on street prices (Bálint 2018), respondents were given the opportunity to answer a question about changes in quality, price and availability. Based on the answers it can be concluded that the availability of cannabis derivatives is very broad, although it is more difficult or it can be much more expensive to access herbal cannabis with higher active substance content and these are mainly available in the capital. Conversely, many respondents believed that synthetic cannabinoids are extremely easy and inexpensive to reach, also outside of Budapest and on the Internet as well. (For more information on street drug prices, see T1.1.5 and on methodology T5.2 in Drug Market and Crime Workbook.)

In a qualitative study covering several drug user scenes (Kaló et al., 2018), the majority of experts mentioned *magic tobacco* as the most commonly used NPS in 2017, which is a new form of synthetic cannabinoids: instead of using any kind of plant material tobacco is impregnated with synthetic cannabinoids. Magic tobacco was first used in prisons but in 2017 it became widely available on the streets as well (NSZKK 2018a; Kaló et al. 2018).

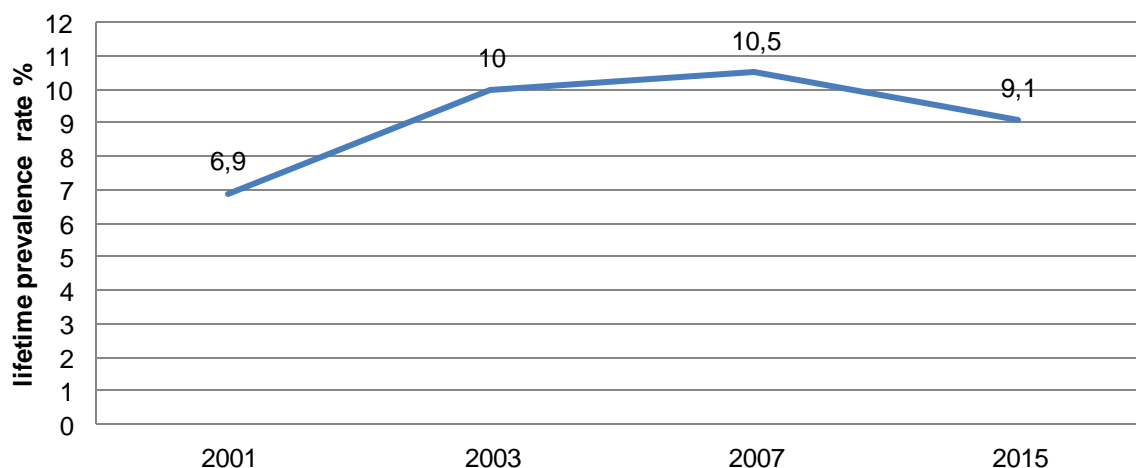
Another new, less commonly known form of use of synthetic cannabinoids is the toothpick. The toothpicks soaked with synthetic cannabinoids are torn into small pieces and rolled into cigarettes and then they smoke it (Kaló et al., 2018).

T1.1.2 Cannabis use in the general population

According to the data of the general population survey in 2015 (Paksi et al. 2015) cannabis is the most widespread illicit drug in the 18-64-year-old adult population, the lifetime prevalence rate is 7.4%, the last year prevalence rate is 1.5% and the last month prevalence rate is 0.7%.

Based on the earlier comparable studies, the spread of cannabis use significantly increased between 2001 and 2003, remained stable between 2003 and 2007 and decreased (with 68% confidence level) in the last 8 years.

Chart 3. *Changes in the lifetime prevalence (%) of cannabis use between 2001 and 2015, in the adult population between 18-53 years**



* Tendency can only be shown in the population between 18-53 years because of the different age ranges of the samples in the different surveys.

Source: OLAAP – Paksi et al. 2015

Cannabis use and the examined social indicators show significant correlation ($p < 0.005$). Age group shows marked differences: lifetime prevalence rate of the young adults (18-34 years old) is three times higher than that of the adult population between 18-64 years. The pattern of urbanisation shows that lifetime prevalence rate is twice as much in the settlements with over 50,000 inhabitants than in smaller settlements. The difference is similar between the capital and the countryside. Lifetime prevalence rate of males also significantly ($p = 0.005$) exceeds that of females. The level of education and the higher income of the household indicate higher exposure to drug use.

Table 2. *Lifetime prevalence of cannabis use along different socio-demographic characteristics in the general population between 18-64 years, in 2015 (%) (N= 100)*

socio-demographic characteristics		lifetime prevalence of cannabis use %	sign.
gender	male	9.5	p=0.005
	female	5.7	
young adult - adult	18-34 years	13.6	p<0.001
	35-64	4.3	
age group	18-24	14.6	p<0.001
	25-34	12.9	
	35-44	7.0	
	45-54	3.4	
	55-64	2.0	
highest level of education	primary school or lower	5.5	p=0.021
	vocational school	4.6	
	final examination	9.3	
	BA/BSC	8.0	
	MA/MSc	13.7	
size of the settlement	<50,000 inhabitants	5.8	p=0.003
	≥50,000 inhabitants	10.2	
capital-countryside	countryside	6.5	p=0.008
	capital	11.4	
net monthly income of the household	<325 EUR ¹⁵	6.5	p=0.003
	326 – 645 EUR	4.9	
	646 – 1290 EUR	8.3	
	above 1291 EUR	18.0	

Source: OLAAP – Paksi et al. 2015

The mode and median of the age at first cannabis use in the adult population being currently between 18-64 years are both 20 years. The risk of initial use is high between 15 and 20 years, increasing by 1-2% per year. Later the risk is lower and after 27 years first use of cannabis cannot be detected. Today's young adults most often tried cannabis at the age of 17 and on the average at the age of 18.7.

T1.1.3 Cannabis use in schools and other sub-populations

According to the results of the HBSC survey carried out in 2014 (Arnold and Németh, 2015), 18.7% of students in grades 9 and 11 had already used cannabis. The large majority of students trying cannabis first used it after the age of 14 years, with the largest proportion of them – nearly a half – doing so at the age of 16 or above, and one quarter of them first consumed cannabis in their lives at the age of 15. Boys and older individuals are significantly more affected from the point of view of cannabis use: 23.3% of those studying in the 11th grade had tried herbal cannabis or hashish, while this figure in the 9th grade was 14.3%. The

¹⁵ Prices were calculated using the EUR intermediate exchange rate valid for 2015 (EUR 1=HUF 309.69).

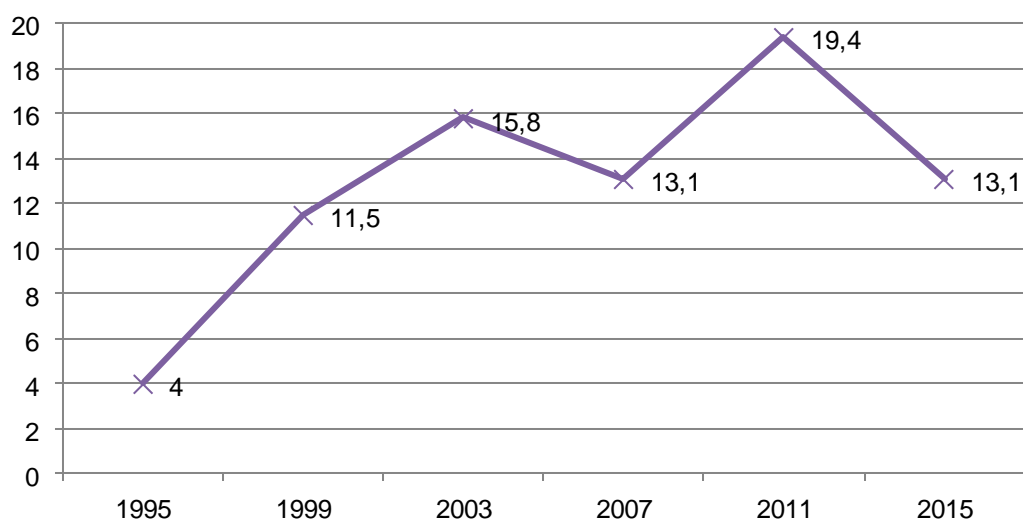
previously more significant gender difference is now disappearing, as it is just possible to show the difference between the lifetime prevalence rates of boys and girls ($p=0.48$): 19.9% of boys and 17.6% of girls had already used cannabis in their lives.

Cannabis lifetime prevalence has a significant connection to region: the highest prevalence rates were in Central Transdanubia (23.2%), in the second place was the Southern Great Plain (21.6%), in the third place Central Hungary (20.9%), and the least affected was the Northern Great Plain (12%). There was no significant relationship between place of residence and cannabis lifetime prevalence, however, there was a significant connection between cannabis and the type of settlement where the school is located. The highest prevalence rate was observed in villages (27.4%)¹⁶, Budapest was in second place (21%), and the lowest value was measured by the survey in towns (16.3%). Similarly to previous years, students in grades 9 and 11 studying in secondary modern schools and vocational schools were more markedly affected (24.1%) with respect to cannabis use as compared to students studying in grammar schools (17.7%).

According to the results of the latest ESPAD survey (Elekes 2016) cannabis is the most widespread illicit drug among students on 9-10¹⁷ grades, in 2015 too. 18.6% of the students tried it in their lifetime. 12.5% reported having used cannabis in the last year and 5.7% of them used in the last month as well. Two third of the ever users used cannabis in the last year and almost a third of them in the last month.

The ESPAD surveys from the last 20 years show that the prevalence rate of cannabis use increased at variable rate among 16-year-old students until 2011 (there were methodological changes in 2007). The earlier tendency turned by 2015. Compared to data from 2011 the prevalence of cannabis use decreased by the largest extent among all substances, by 32.5%.

Chart 4. *Changes in the lifetime prevalence of cannabis use between 1995-2015 among 16-year-old students (%)*



Source: ESPAD - Elekes 2016

Cannabis use and almost each examined social indicator show significant correlation. The boys and the students of vocational schools are significantly more involved in consumption,

¹⁶ This figure should be treated with care due to the small sample size.

¹⁷ 15-16 years old

especially if the school is in Budapest or in a municipality. Cannabis use is more widespread among the students living in the capital or bigger cities, only with one parent and perceive the family's financial situation below the average. However, the parents' level of education is not determinant regarding substance use.

Table 3. *Lifetime prevalence of cannabis use along different socio-demographic characteristics among students on 9-10 grades, in 2015 (%) (N=1230)*

socio-demographic characteristics		lifetime prevalence of cannabis use %	sign.
gender	male	21.0	p<0.001
	female	15.8	
school type	secondary grammar school	14.2	p<0.001
	secondary school	19.6	
	vocational training	24.2	
school address	Budapest	27.7	p<0.001
	county city	17.5	
	town	14.8	
	municipality	23.4	
residence	Budapest	24.3	p<0.001
	town	17.8	
	municipality	15.9	
family structure	intact	14.7	p<0.001
	patchwork	21.9	
	broken	25.1	
	no biological parents	27.2	
father education	less than final examination	18.3	not sig.
	final examination	18.7	
	higher education	17.7	
	not known	17.8	
mother education	less than final examination	17.7	not sig.
	final examination	20.1	
	higher education	16.5	
	not known	18.0	
family well off	much better off	19.1	p<0.001
	about the same or better off	17.1	
	less well off	25.5	

Source: ESPAD – Elekes 2016

Typical age of first use is 15 years among students on 9-10 grades.

T1.2 PATTERNS, TREATMENT AND PROBLEM/HIGH RISK USE

T.1.2.2 Treatment for cannabis

In Hungary, cannabis use is the leading cause of entering treatment for illicit drug use (see Treatment Workbook, Chapters T1.3.1. and T2.1). In 2017 63.0% (3031 persons) of those starting treatment reported cannabis as their primary substance (TDI data collection 2018). From 2016 to 2017, the number of cannabis users increased significantly (from 2323 to 3031). Among them, the number of cannabis users who started treatment as an alternative to criminal procedure increased to a greater extent (from 1826 to 2417, namely by 32.4%), but there was a notable increase in the number of non-QCT (starting treatment for another reason than to avoid criminal procedure) treatment entrants as well (from 493 to 603, namely by 22.3%). This phenomenon can partly be explained by the increase in police activity in respect of drug offences, due to which many consumers are channelled into the treatment system in order to avoid criminal procedure. (For more information see Treatment Workbook, Chapter T2.1 and Drug Market and Crime Workbook, Chapters T1.2 and T2.4.)

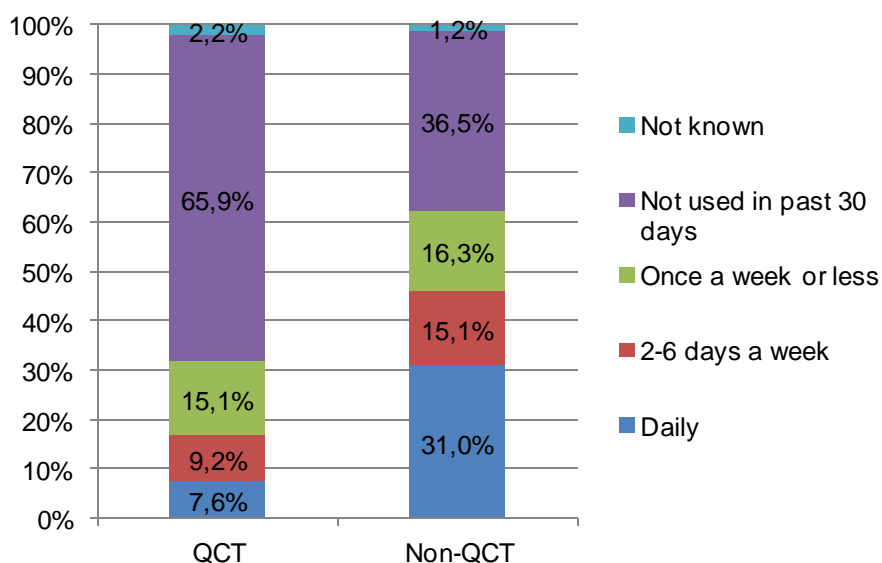
The majority of cannabis users (2417 persons, 79.7%) started treatment as an alternative to criminal procedure (QCT) and 51.7% of all primary cannabis clients (1567 persons) were referred to preventive-consulting services (a type of QCT programmes targeting less problematic users). In 2017 almost three-quarter of the QCT clients (2417 persons, 72.9%) started treatment because of cannabis use. Among the non-QCT clients the proportion of cannabis related treatment demand was significantly lower, 40.7% (603 persons).

90.3% of those entering treatment because of cannabis were men, 9.7% were women. Their mean age was 26.7 years and had used cannabis for an average of 8.4 years before starting treatment in 2017.

Almost two-third (65.9%) of the cannabis clients starting treatment as an alternative to criminal procedure (QCT) had not used the substance in the 30 days prior to treatment, intensive use (2-6 days a week or daily) was reported in 16.8% of the clients.

At the same time more than one-third (36.5%) of non-QCT clients reported not having used the substance in the 30 days prior to treatment, while intensive use was reported in 46.1% of non-QCT primary cannabis users.

Chart 5. Frequency of drug use among QCT and non-QCT clients starting drug treatment in 2017 ($N_{QCT}=2417$ persons; $N_{non-QCT}=603$ persons)



Source: TDI data collection 2018

With respect to treatment and harm reduction possibilities, the treatment of cannabis users takes place characteristically at general drug/addiction/psychiatric treatment units. There are elements in the programmes of certain treatment centres that are tailored specifically to the needs of cannabis users (Péterfi 2015), however, there is no specific treatment or harm reduction programme available for them in the country.

The Hungarian language online self-help programme¹⁸ of the Kék Pont Alapítvány targets problem cannabis users, it provides a therapy accessible on the Internet for this user group¹⁹. The online programme is accessible and free of charge for everyone. The programme, according to its description, targets those (problem) cannabis users, whose environment perceives their cannabis use as an increasing problem, as it decreases their work/school performance and it ruins their social relationships. (For more information see 2011 National Report, Chapter 5.2.)

T1.2.4 Synthetic cannabinoids

Adult population

According to the data of the general population survey in 2015 (Paksi et al. 2015) synthetic cannabinoids were among the most widespread drugs in the 18-64-year-old adult population. Based on the lifetime prevalence rate (1.9%) it was the third, based on the last year prevalence rate (1.1%) it was the second most popular type of drug. Last month prevalence rate was 0.2%.

Due to the low number of users (26 persons in the sample of 18-64 years, 58 persons in the sample of young adults between 18-34 years²⁰) social patterns of synthetic cannabinoid use can be examined only along some indicators. Age group and gender show significant differences. Lifetime prevalence rate (4.2%) among young adults was five times higher than in the older age group (0.8%). The youngest adults (18-24 years) were significantly more involved (LTP=6.2%). Lifetime prevalence rate of males was four times higher (3.3%) than among females (0.8%). Data does not show significant patterns of urbanisation. The social patterns among 18-34 year old young adults is equal to that in the adult population.

Synthetic cannabinoids were tried for the first time at the age of 18 on average and most often at 17.

In order to investigate the correlation between synthetic drug use and other drug use behaviours the researchers constructed a synthetic cannabinoids use pyramid that applies the method of the drug use pyramid²¹ traditionally built on cannabis use. (Paksi 2017) The pyramid shows that among those who used synthetic cannabinoids at least once in their lives how many people used other drugs as well, such as cannabis, ecstasy, new stimulants, amphetamines, LSD, cocaine or heroin. On the basis of the pyramid it can be concluded that three-quarters of 18-64 years old 'ever users of synthetic cannabinoids' used cannabis, more than half of them used ecstasy, two-fifth of them used designer stimulants or amphetamines, one in four used LSD as well as cocaine and one in five used heroin in their lifetime.

¹⁸ The site operated by the Jellinek Foundation, knowcannabis.org.uk was used as a basis when developing the website.

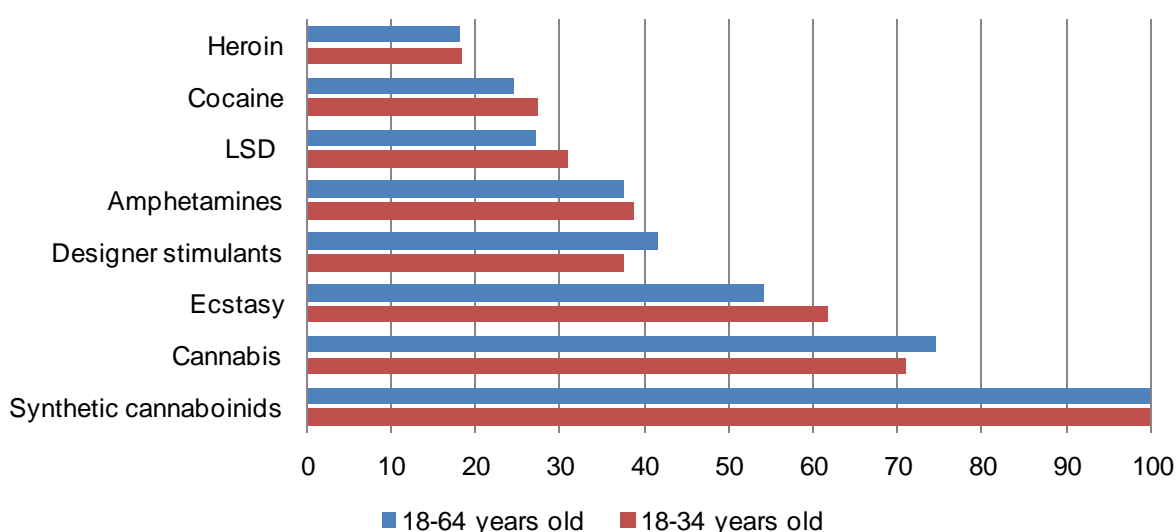
¹⁹ Source: http://kekpont.blog.hu/2010/06/02/titok_1561746

²⁰ Young adults were calculated using different weights in the two samples.

²¹ By default in the literature the drug use pyramid (EMCDDA 1999) is constructed to assess connection of cannabis use and other drug use behaviours, where lifetime prevalence rates are expressed among ever users of cannabis.

Comparing these values to the lifetime prevalence rates indicated under Chapter T0.1.1. in figure 1 it can be stated that among synthetic cannabinoid users lifetime prevalence rates of all the drugs included are multiple times higher than they are estimated in the general population. Among synthetic cannabinoid users odds of heroin use as well as of designer stimulants use are 30 times higher, LSD use or amphetamine use are 22-27 times more probable and cannabis or ecstasy use are 10 times more probable than in the general population. Drug use pyramid in the young adult population shows the same pattern as the pyramid built for the 18-64 years old population. By the pyramid it can be seen that it is not the synthetic stimulants that are the most prevalent drugs among synthetic cannabinoids users – even though the risk of their use increased remarkably.

Chart 6. Drug use pyramid of synthetic cannabinoid users indicating % of respondents in the 18-64 and 18-34 age groups in 2015



Source: OLAAP – Paksi 2017

By examining synthetic cannabinoids use with descriptive statistics, only demographic characteristics show significant differences. Lifetime prevalence of synthetic cannabinoid use is four times higher among males than among females. Age also has a strong effect: LTP of synthetic cannabinoid use is more than four times higher among young adults than in the 18-64 age group and among young adults the 18-24 age group has significantly higher LTP rates. Cultural, economic, labour, family and social integrity status values do not form special patterns, which implies that synthetic cannabinoid users do not differ from the general population in these characteristics. (Paksi 2017)

Synthetic cannabinoid use is most common in the 'polydrug user group' among the four groups identified conducting a cluster analysis. In this group all used a drug beside cannabis. Examining sociodemographic patterns of illicit drug use other than cannabis, results about gender and age are like of synthetic cannabinoids use. Examining settlement size, economic and cultural status values using other drugs show an urban, better-off population in opposition to the average situation of synthetic cannabinoids users. (Paksi 2017)

Table 4. *Lifetime prevalence rates of the use of synthetic cannabinoids and drugs other than cannabis by socio-demographic characteristics among 18-64 years old in 2015 (%)*

Socio-demographic characteristics		Synthetic cannabinoid use LTP	sign.	Drugs other than cannabis LTP	sign.
Gender	male	3.3	p=0.001	7.5	p=0.032
	female	0.8		4.9	
Age	18–24 years	6.4	p<0.001	12.4	p<0.001
	25–34 years	2.9		9.7	
	35–44 years	1.8		7.1	
	45–54 years	0.0		2.3	
	55–64 years	0.3		1.0	
Settlement size	<50.000	1.9	ns.	4.5	p<0.001
	≥ 50000	2.0		8.8	
Net income of household	<325 EUR ²²	2.0	ns.	4.5	p=0.075
	326 – 645 EUR	1.9		4.6	
	646 – 1290 EUR	2.5		7.7	
	above 1291 EUR	0.0		11.7	
Permanent work	no	1.7	ns.	3.6	p=0.004
	yes	2.1		7.3	
Mean deprivation index	did not use drugs	4.07	ns.	4.13	p=0.098
	used drugs	4.12		3.50	

Source: OLAAP – Paksi 2017

School population

According to the results of the ESPAD survey (Elekes 2016) conducted among secondary school students the synthetic cannabinoid derivatives, asked for the first time in 2015, are in the second place in the consumption structure. Every tenth student has already tried this drug (LTP=10.1%), 11.3% of the boys and 8.7% of the girls used it (p=0.002).

The use of synthetic cannabinoids (N=668) and each examined social indicator show significant correlation. Spread of use is three times higher in vocational schools (15.6%) than in grammar schools (5.8%). Schools in municipalities are much more involved (17.2%) than the average. The use of synthetic cannabinoids is more typical among those living in the capital (12.7%), in broken families (14.1%) and in deprivation (16.6%). Concerning the parents' level of education, the children of those completed higher education least tried synthetic cannabinoids.

The majority of the students tried synthetic cannabinoids at the age of 15 for the first time. (Elekes 2016)

²² 1 EUR=309.69 HUF

Comparison of cannabis and synthetic cannabinoid users based on treatment data

Equally among homeless people, people living in socially segregated areas and children living in residential child care facilities, there is a significant synthetic cannabinoid problem in Hungary - as referred to in this chapter (see Cannabis T4.1 and Stimulants T4.1) (Szécsi and Sík 2016; Kaló et al. 2017; Paksi and Magi 2017; Kaló et al 2018). Most of these groups are not likely to access drug treatment because of their lack of social security, or the lack of drug services in the vicinity of their place of residence, or other factors restricting access to health and social services (e.g. distrust towards the treatment system). Thus, the treatment needs of these socially marginalised groups and their characteristics are not represented or underrepresented in our treatment data. This must be taken into account when interpreting TDI data.

In 2017, 3031 people entered treatment (63.0% of all treatment entrants) with the primary problem of cannabis use, while 267 treatment entrants (5.5%) were primarily associated with the use of synthetic cannabinoids²³.

Cannabis users (3031 persons) and (assumed) synthetic cannabinoid users (267 persons) show a similar gender distribution: male clients represented 90.3% of cannabis users and 86.5% of synthetic cannabinoid users. In respect of the mean age synthetic cannabinoid users (24.9 years) were almost two years younger than those starting treatment due to cannabis use (26.7 years).

When comparing the two groups based on their social characteristics (employment, education, living conditions) synthetic cannabinoid users are a more marginalised user group in every dimension. The proportion of unemployed was 32.2% in synthetic cannabinoid users, that is twice as much as in cannabis users (16.0%). The proportion of those with a maximum of primary level of education was 1.5 times higher in synthetic cannabinoid users when compared to cannabis users (74.0% and 43.2% respectively). Unstable accommodation (incl. homelessness) was characteristic of 3.7% of synthetic cannabinoid users, 1.5 times the proportion measured in cannabis users (2.4%).

Table 5. Labour status, education and living status in cannabis and synthetic cannabinoid users starting treatment in 2017

	Cannabis (N=3031)	Synthetic cannabinoid (N=267)
Student	19.4%	18.7%
Regularly employed	54.4%	31.5%
Unemployed	16.0%	32.2%
Other/Not known	10.2%	17.6%
Maximum primary level of education	43.2%	74.0%
Secondary level of education	52.1%	24.8%
Higher level of education	4.7%	1.2%
Unstable accommodation and/or homeless	2.4%	3.7%
Stable accommodation	92.8%	83.9%
Other/Not known	4.8%	12.4%

Source: TDI data collection 2018

²³ In the TDI data collection synthetic cannabinoid users are not reported in a distinct category therefore it is hard to capture them. However, based on a consultation with treatment units it can be assumed that these users are typically recorded in the "other hallucinogens" or "other non categorisable" categories. Selecting those with a route of administration "smoke/inhale" within the above two categories we created a client group and compared its composition and characteristics with cannabis users, based on 2017 treatment (TDI) data.

From the aspect of frequency of drug use a more problematic pattern is characteristic of the synthetic cannabinoid user group: among them 40.4% reported having ingested cannabinoids 2-6 days per week or on a daily basis. The proportion of intensive users was only 23.2% among cannabis users.

T2. TRENDS

See Chapter T1.

T3. NEW DEVELOPMENTS

See Chapter T1.

T4. ADDITIONAL INFORMATION

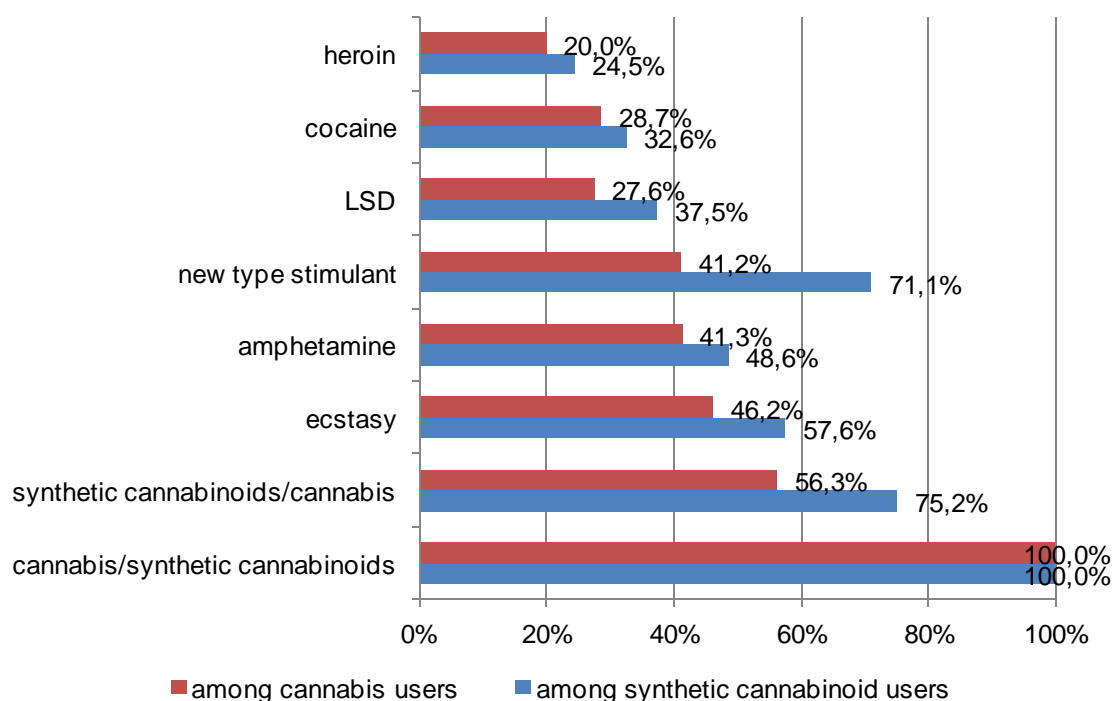
T4.1 ADDITIONAL SOURCES OF INFORMATION

Use of synthetic cannabinoids in socially marginalized populations

A representative study in the adult homeless population was conducted in 2017 to explore the extent of drug use (for details on methodology see Drugs Workbook/E, Chapter T5.2). Based on life prevalence values cannabis was the most commonly used illicit drug among the Hungarian homeless population: every fifth to sixth respondent has consumed herbal cannabis or cannabis resin in his life (Paksi, Magi 2017). Concerning recent drug use, in the drug-use pyramid based on the responses, the use of synthetic cannabinoids preceded the popularity of cannabis.

In the homeless population drug-use pyramid built on synthetic cannabinoid use showed the same results as the pyramid constructed for cannabis use (see the results of the 2015 OLAAP study in Section T1.2.4), with the exception that the likelihood of using other illicit drugs among synthetic cannabinoid users was not 4-6 times higher but 5- to 7-fold, and the consumption of designer stimulants (typically synthetic cathinones) was much more common among synthetic cannabinoid users than among cannabis users. (Paksi, Magi 2017).

Chart 7. Drug-use pyramid in the homeless population (% of ever-users of cannabis and/or synthetic cannabinoids), 2017²⁴



Source: Paksi and Magi 2017

Among adults living in socially segregated areas the use of synthetic cannabinoids ("synthetic grass", "bio", "herbals") is more common than the use of cathinones ("crystal") (Csák et al 2017). The study identified two patterns of synthetic cannabinoid use: a 1-2 times per month use pattern and an intensive use pattern characterized by at least 3 synthetic cannabinoid use per week. The former pattern was characteristic of 36.8% of the respondents, the latter of 41.1% of the respondents. (For information on methodology see Section T5.2 of the Drugs/E Workbook. For further results see Drugs/Stimulants/T4.)

According to the experts participating in the qualitative research conducted with child protection workers (Kaló et al. 2018) the use of NPS is becoming normative in some communities, especially among families with bad socioeconomic status. (Further results of this study are reported in Section T4.1 of the Drugs/Stimulants Workbook. Methodological information corresponding to the study is described in Section T5.2 of the Drugs/E Workbook).

A study involving girls in residential child care and experts working in residential child care facilities (Kaló et al., 2017), and information from the commission reporting on children and juveniles placed into specialized residential child care facilities (Baráth et al., 2018) both showed that the use of NPS – particularly synthetic cannabinoids – is a serious problem in this population.

A survey conducted among juveniles living in detention facilities (Port 2016b) also showed that NPS are the most commonly used drugs in this population: 58% of those who have ever consumed drugs in their lives reported to have used primarily synthetic cannabinoids and 36% designer stimulants. (For further results and methodology see Prison Workbook, Chapters T4 and T5.2).

²⁴ Life prevalence values for the most common drugs among ever-users of cannabis or synthetic cannabinoids.

In the summer of 2015 a field research (Szécsi and Sik 2016) has been conducted in a district of the North Plains region, in segregated areas of three selected settlements in order to explore drug use patterns of those living in extreme poverty, examining particularly new psychoactive substance use.

The results show that the older generation smokes, drinks alcohol and takes pills without prescription. The youth prefer new psychoactive substances (synthetic cannabinoids) from a very early age. They report that synthetic cannabinoids are cheap, have faster and more intensive effect, are easy to access and presume to be licit.

In the opinion of the respondents, new psychoactive substances are primarily used by youngsters from the age of 12-13. According to their estimates more than half of the youth in that area use it. Recreational use is typical but daily use is not rare either. The reasons for their choice of substance are the classical reasons: "to forget problems, reduce loneliness, cool, against boredom". Feeling sick because of drug use is common. Each respondent reported sickness in his/her case or among friends. This usually needs medical intervention and ends up in calling ambulance and treatment in hospital. The respondents do not know care centres, could not mention any form of help beside ambulance.

In December 2015 an online survey (Nyíri 2016) was conducted about the characteristics of synthetic cannabinoid use. 1319 persons filled in the questionnaire. Based on the data, the sample consisted of regular cannabis users who were mainly males, aged between 18-29 years, who lived in Budapest or other towns and already used synthetic cannabinoids, although half of them last used it more than 1 year ago. Nearly 70% used cannabis in the last month, 16% of them used synthetic cannabinoids too.

The reasons for trying synthetic cannabinoids were curiosity, low price and easy access. Most of them used it with friends for recreation or alone against boredom. More than half of the respondents used synthetic cannabinoids over 20 times, 70% of them 5 times at least in their lifetime. The substance was used typically in cigarettes mixed with tobacco, alone or with alcohol. Most of the respondents received or bought the drug from a friend. Less than 10% of them bought it via internet. The price varied mainly between 1.6 – 4.8 EUR²⁵ per gram. Concerning the effect of synthetic cannabinoids the respondents reported more intensive and shorter effect than experienced with classical cannabis. This substance causes psychotic symptoms, apathy, anxiety, hallucinations and coordination disorders more frequently than cannabis use. Change of perception and euphoria was also typical. Physical symptoms appeared as dry mouth and palpitations. The respondents' statements suggest that synthetic cannabinoids have more addictive potential than classical cannabis.

The information derived from the treatment data is supplemented by the Hungarian National Focal Point's treatment facility survey (Péterfi 2015), on the basis of which, according to the estimate of the service providers reporting 74% of the TDI data, the most characteristic reason for treatment following cannabis (31%) was the use of synthetic cannabinoids (26%). (For more information see National Report 2016, Treatment Workbook, Chapter T4.1 and T6.2.)

Another study conducted in 2015 in the Hungarian therapeutic communities (Péterfi et al. 2016) found that 27% of clients who participated in the rehabilitation programmes in 2014 started the programme due to primary synthetic cannabinoid use, while the proportion of cannabis users was only 5%. (For further information see National Report 2016, Treatment Workbook, Chapter T4.1 and T6.2.)

According to the interpretative phenomenological analysis of Kassai et al. (2017a,b) the interviewed users (6 persons) found the sensations after using synthetic cannabinoids significantly different compared to other substances. Users found synthetic cannabinoid use unpredictable: their initial positive experience turned rapidly into negative, it hijacked their

²⁵ Prices were calculated using the EUR intermediate exchange rate valid for 2015 (EUR 1=HUF 309.69).

personalities. They found it difficult to interpret their experiences or compare it with other substances, that was an obstacle from the aspect of treatment. The rapid alteration of effects and experiences may explain the severe psychopathological symptoms observed in synthetic cannabinoid users. (Kassai et al, 2017a,b)

B.STIMULANTS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 The relative importance of different stimulant drugs

According to survey data, almost one fifth (18.9%) of the 18-64-year-old population presumes that it is easy or very easy to obtain ecstasy and each sixth-seventh adult could obtain amphetamines. Regarding methamphetamines 10.8%, regarding cocaine 8.4% and regarding crack 7.8% of the population presumes easy or very easy access to the drugs. (Paksi et al. 2015)

We have information about the perceived availability of stimulants among secondary school students from the ESPAD surveys. Regarding amphetamines, ecstasy and cocaine, half of the respondents (51%; 51% and 53%) presumed impossible or very difficult access to these drugs and those who thought that they would be able to obtain them were far less (12%; 13% and 12%). However nearly quarter of the students could not estimate the availability of the substances, did not answer the question. (Elekes 2016)

In the case of cocaine, during its supply-reduction activity the Police experienced a clear, strong growth over the past years, both on the user and distributor sides, which is also strengthened by the raising seizure numbers. (NSZKK 2018a)

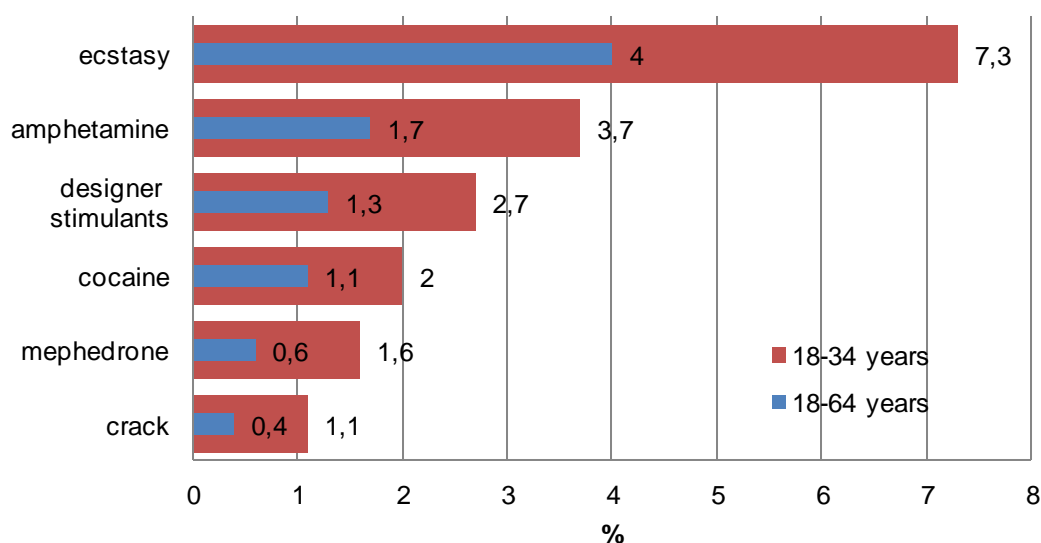
With respect to the amphetamine type synthetic materials it may be said that the substance content of ecstasy tablets containing MDMA has been increasing from 2012 and there were several seizures of small amount, extremely potent, nearly undiluted amphetamine powders (NSZKK 2018a). Methamphetamine is still unusual, however, according to police investigation information, it is appearing on the supply side more frequently in the northern part of the country (from consignments smuggled from Slovakia). (ORFK 2015)

Designer stimulants (typically synthetic cathinones) usually appear on the market in a powder form, among them the most popular substances were: mephedrone in 2010; 4_MEC and MDPV in 2011 and pentedrone from 2012. From August 2016, ethyl-hexedrone became the most common synthetic cathinone on the market. In 2017, next to ethyl-hexedrone, para-methyl-N-ethyl-norpentedrone, 4-CEC, N-methyl-pentedrone and ethyl-pentylone were the most popular designer stimulants. Overall, the number of seizures related to synthetic cathinones increased until 2014, and after a two-year decline, in 2017 there was a raise (2016: 631 cases; 2017: 735 cases) again in the number of seizures related to synthetic cathinones (NSZKK 2018a). (For more information on trends see Chapter T2.1 of Drug Market and Crime Workbook.)

T1.1.2 Stimulant use in the general population

According to survey data (Paksi et al. 2015) the most widespread classical stimulant is ecstasy in the 18-64-year-old general population, the lifetime prevalence rate is 4%. It is followed by amphetamines (LTP=1.7%), cocaine (1.1%), mephedrone (0.6%) and finally crack (0.4%). The prevalence order of these substances is the same in the young adult population but the lifetime prevalence rates are doubled (ecstasy 7.3%; amphetamine 3.7%; cocaine 2%; mephedrone 1.6%; crack 1.1%)

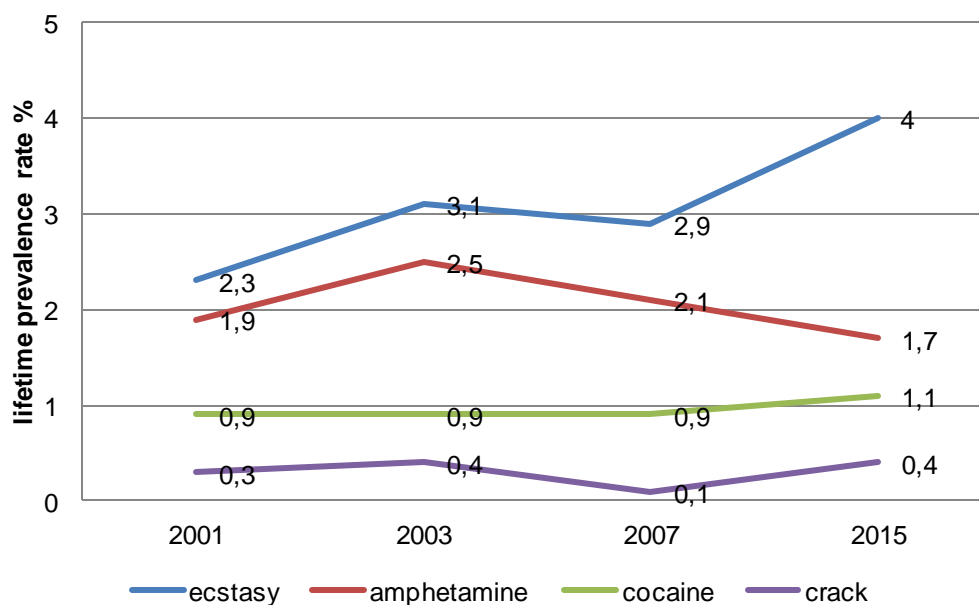
Chart 8. Lifetime prevalence rates of stimulants by drug type in the adult population between 18-64 years and 18-34 years, in 2015 (%)



Source: OLAAP - Paksi et al. 2015

Based on the earlier comparable studies the spread of cocaine and crack use did not change between 2001 and 2015. The use of amphetamine increased between 2001 and 2003 and had a declining tendency between 2003 and 2015. The spread of ecstasy use increased between 2001 and 2003, remained stable between 2003 and 2007, and increased again in the last 8 years.

Chart 9. Changes in the lifetime prevalence of classical stimulants between 2001 and 2015, in the adult population between 18-53 years*



* Tendency can only be shown in the population between 18-53 years because of the different age ranges of the samples in the different surveys.

Source: OLAAP - Paksi et al. 2015

According to the data of the general population survey in 2015 (Paksi et al. 2015) 4.5% of the 18-64-year-old population used any kind of classical stimulants (ecstasy, amphetamine,

cocaine, mephedrone or crack) in their lifetime. Last year prevalence rate of classical stimulants is 1%, last month prevalence rate was 0.7%. Lifetime prevalence rate in the 18-34-year-old young adult population was 8.2%, LYP was 2.3%, LMP was 1.7%.

Regarding classical stimulants use age group and pattern of urbanisation show significant correlation from the examined social indicators. Lifetime prevalence rate of the young adults (18-34 years old) is more than three times higher than that of the older generation. Lifetime prevalence rate is twice as much in the settlements with over 50,000 inhabitants than in smaller settlements. Gender, level of education and household income do not show significant correlation with the use of classical stimulants. The social patterns in the 18-34-year-old population is equal to those in the adult population.

Table 6. *Lifetime prevalence of classical stimulants use along different socio-demographic characteristics in the general population between 18-64 years, in 2015 (%) (N=60)*

socio-demographic characteristics		classical stimulants LTP %	sign.
gender	male	5.0	not sig.
	female	4.1	
young adult - adult	18-34 years	8.3	p<0.001
	35-64	2.6	
age group	18-24	8.9	p<0.001
	25-34	7.8	
	35-44	5.0	
	45-54	1.9	
	55-64	0.3	
highest level of education	primary school or lower	2.3	not sig.
	vocational school	4.3	
	final examination	5.4	
	BA	3.7	
	MA	8.2	
size of the settlement	<50,000 inhabitants	3.0	p=0.001
	≥50,000 inhabitants	7.0	
capital-countryside	countryside	4.0	p=0.059
	capital	6.6	
net monthly income of the household	<325 EUR ²⁶	2.6	p=0.070
	326 – 645 EUR	3.5	
	646 – 1290 EUR	5.2	
	above 1291 EUR	10.2	

Source: OLAAP - Paksi et al. 2015

Age at first use of classical stimulants varies in the 18-64-year-old population. Ecstasy is tried for the first time at the age of 20-21 on the average and most often at 18. First use of amphetamines occurs at the age of 22 on the average and most often at 25. The age of trying cocaine is 24 years in most of the cases (mean is 25 years). In the young adult

population age of first ecstasy and amphetamine use is 18-19 years. The age of trying cocaine is late, 25 years, similarly to the 18-64 years-old adult population.

T1.1.3 Stimulant use in schools and other sub-populations

According to the results of the HBSC survey carried out in 2014 (Arnold and Németh 2015), 5.8%²⁷ of students in grades 9 and 11 had already tried one of the examined stimulants.²⁸ Significantly higher prevalence rates could be observed among boys (6.8%) and among those in the higher school grade (grade 11: 6.8%) as compared to the girls (5.0%) and those in the lower school grade (4.9%).

There is no significant difference in the prevalence rates according to region, however, there was according to the type of settlement where the students lived or went to school. The largest proportion of students who had tried stimulants were those living in homestead (13%), and the lowest were those living in county seats (4.9%) and towns (5%). Similar results were observed when examined according to the type of settlement where the school is located: the students of schools in villages are more affected from the point of view of stimulant use – 13.6% of the students in these schools had consumed stimulants – and the least affected were students going to school in towns (5.2%).

As compared to students studying in grammar schools (5.1%), a markedly higher proportion (10%) of students studying in secondary modern schools and vocational schools – twice as many – had tried stimulants: every tenth student had consumed at least one type of stimulant.

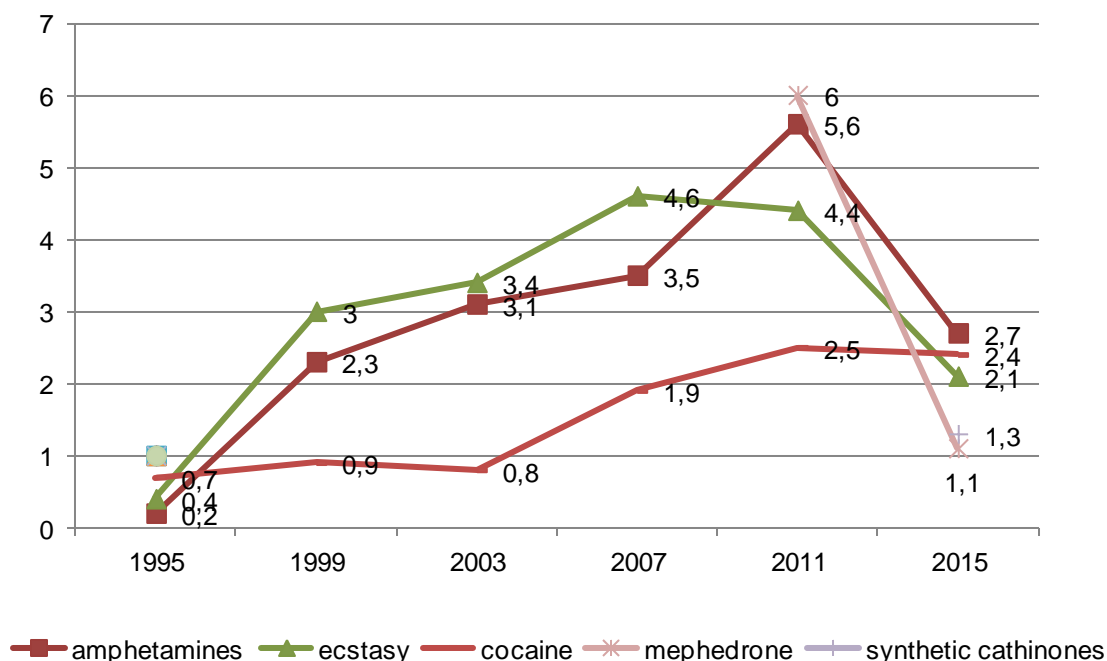
According to the results of the ESPAD survey (Elekes 2016) conducted in the secondary school population (16 years old) amphetamine is in the seventh place in the consumption structure (LTP=2.7%). The following substances are cocaine (2.4%), ecstasy (2.1%), and methamphetamine (2.1%). The substances tried by the least students were mephedrone (1.1%) and crack (1%).

The ESPAD surveys from the last 20 years show that the prevalence rate of classical stimulant use increased among 16-year-old students at variable rate until 2011. The earlier tendency turned by 2015. Spread of amphetamines and ecstasy showed great decline, lifetime prevalence rates dropped by half. Mephedrone was the fifth most popular substance in 2011. In the meanwhile, it was scheduled as a psychotropic drug and presumably this caused the drop from 6% in 2011 to 1.1% in 2015 in the lifetime prevalence rate. Proportion of those who tried cocaine at least once in their lifetime raised from 0.8% to 2.5% between 2003 and 2011 and it remained unchanged (2.5%) in 2015.

²⁷ This data should be treated with care due to the low number of those trying stimulants.

²⁸ Amphetamines, ecstasy, MDMA, cocaine. (Cocaine was indicated among other drugs, the survey did not ask about it separately.)

Chart 10. Changes in the lifetime prevalence of stimulants between 1995-2015 among 16-year-old students (%)



Source: ESPAD - Elekes 2016

Stimulant use and almost each examined social indicator show significant correlation. Stimulant use is more widespread among boys living in the capital, only with one parent and among those who perceive the family's financial situation below the average. The students of vocational schools are significantly more involved in consumption than grammar school students, especially if the school is in a municipality. However, the parents' level of education is not determinant regarding substance use.

Table 7. Lifetime prevalence of stimulant use along different sociodemographic characteristics among students on 9-10 grades, in 2015 (%) (N=454)

sociodemographic characteristics		lifetime prevalence of stimulants %	sign.
gender	male	7.6	p=0.010
	female	6.1	
school type	secondary grammar school	3.2	p<0.001
	secondary school	7.1	
	vocational training	12.9	
school address	Budapest	9.5	p<0.001
	county city	5.9	
	town	6.2	
	municipality	16.1	
residence	Budapest	8.5	p=0.023
	town	6.0	
	municipality	6.4	
family structure	intact	4.8	p<0.001
	patchwork	8.1	
	broken	9.0	
	no biological parents	17.1	
father's education	did not complete secondary education	7.5	not sign.
	secondary education	6.4	
	higher education	5.6	
	not known	6.1	
mother's education	did not complete secondary education	7.6	not sign.
	secondary education	6.7	
	higher education	5.3	
	not known	6.6	
family well off	much better off	8.2	p<0.001
	about the same or better off	5.6	
	less well off	12.2	

Source: ESPAD - Elekes 2016

Typical age of first use of stimulants is 15 years among students on 9-10 grades.

T1.2 PATTERNS, TREATMENT AND PROBLEM/HIGH RISK USE

T1.2.1 Patterns of use

For data in connection with risk behaviours related to stimulant injecting see: Harms and Harm Reduction Workbook, Chapter T1.3.4. Regarding the pattern of substance use in stimulant users entering treatment see Chapter T1.2.2.

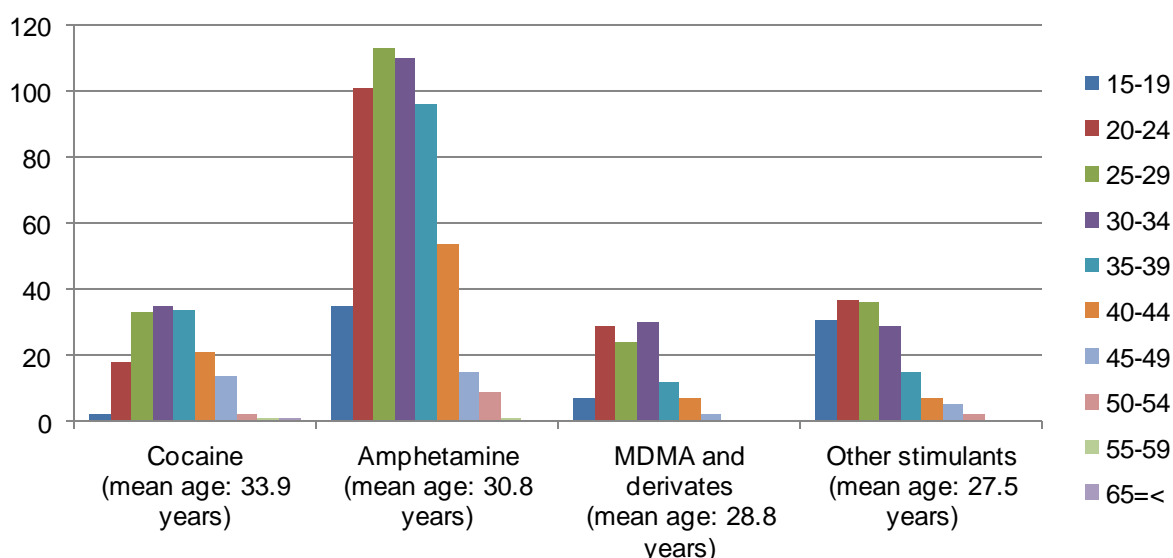
T1.2.2 Treatment of stimulant users

In Hungary stimulant use is the second most typical reason for drug users to start treatment (see Treatment Workbook, Chapter T.1.3.1. and T2.1). In 2017 16.8% (807 persons) of those entering treatment reported having used amphetamine type stimulants as primary drug (amphetamine 534 persons, MDMA and other derivatives 111 persons, other stimulants 162 persons). Further 3.5% (167 persons) started treatment due to cocaine use (cocaine: 161 persons; crack: 6 persons) (TDI data collection 2018)

83.6% of those entering treatment because of stimulants were men. The mean age of this user group was 30.5 years, and had used stimulant substances for an average of 8.5 years before entering treatment in 2017.

Observing the age distribution of the users of each drug, we can see that users of other stimulants (typically synthetic cathinones) are the youngest among the stimulant users: the majority (64.2%) of them belong to the age group 15-29 (mean age 27.5 years). They are followed by MDMA users entering treatment, most of whom (74.8%) are between 20 and 34 years (mean age 28.8 years). The majority of amphetamine users also belonged to the age-group 20-34 years (60.7%) (mean age: 30.8 years). The oldest group is the group of cocaine users: their mean age (33.9 years) exceeds that of other stimulants users with more than six years, most of them (63.4%) belong to the age group 25-39.

Chart 11. *Breakdown of primary stimulant users entering treatment by age and primary drug, 2017 (persons; N=968)*

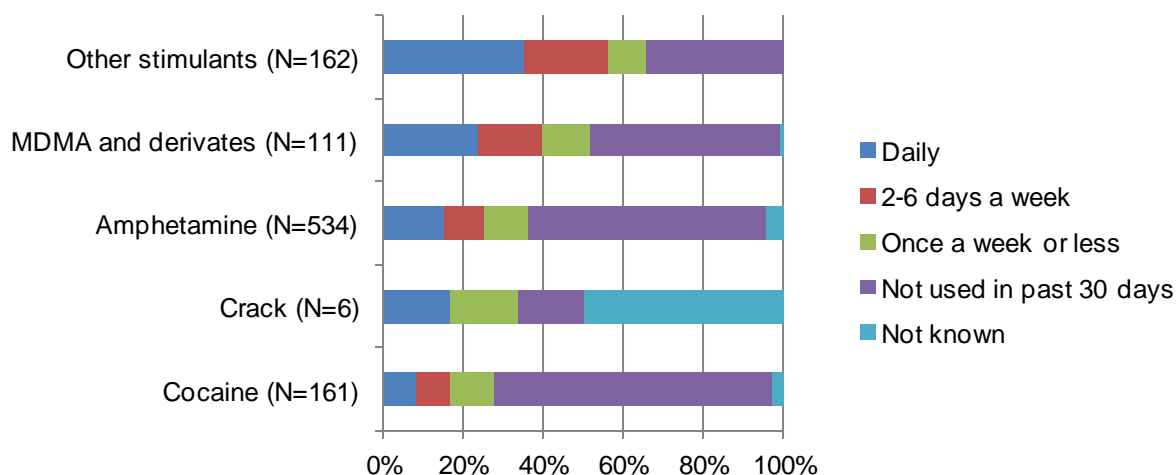


Source: TDI data collection 2018

The typical route of administration before entering treatment was sniffing (48.8%), that was followed by eating/drinking (24.7%), then smoking/inhaling (14.5%) and injecting (9.4%). (For more details on injecting use of stimulants see Chapter T1.2.5.)

When examining stimulant users from the aspect of frequency of use, „other stimulants” (synthetic cathinones) use could be characterised by intensive use (at least twice a week in the 30 days prior to treatment) in the greatest proportion (56.2%). 39.8% of MDMA users, 24.9% of amphetamine users, 16.7% of crack users, and 16.8% of cocaine (salt) users were characterized by intensive drug use patterns.

Chart 12. Breakdown of primary stimulant users entering treatment by frequency of use, 2017 (persons; N=974)



Source: TDI data collection 2018

As a more frequent drug use means greater risk, below we compare the groups of stimulant users along various social factors and patterns of drug use. The following table clearly shows that non-intensive users (using one day a week or less) are less affected than intensive drug users (using two days a week or more) by unstable accommodation (incl. homelessness), unemployment, and injecting drug use (ever), irrespective of the primarily used drug. At the same time, the picture varies in case of the different drugs. We can say that in respect of unstable accommodation, unemployment and ever injecting drug use, cocaine users were the least affected. Low school qualification (maximum primary level of education) was more common among intensive cocaine, amphetamine and other stimulant users, but in case of MDMA (and its derivatives) users, non-intensive users were more affected. Looking at the route of referral, in each stimulant user group intensive users typically start treatment based on their own motivation rather than being referred to treatment by the criminal justice system (i.e. entering treatment as an alternative to criminal procedure).

Table 8. *Characteristics of stimulant users entering treatment by primary drug and frequency of use prior to treatment, in 2017 (%) (N=454)*

	Intensive users		Non- intensive users
Cocaine	7%	Unstable accommodation /homelessness	2%
Amphetamine	18%		2%
MDMA and derivates	30%		2%
Other stimulants	23%		6%
Cocaine	22%	Unemployed	8%
Amphetamine	50%		16%
MDMA and derivates	70%		11%
Other stimulants	68%		28%
Cocaine	37%	Maximum primary level of education	22%
Amphetamine	50%		43%
MDMA and derivates	25%		38%
Other stimulants	74%		54%
Cocaine	33%	Referred to treatment by the criminal justice system	88%
Amphetamine	21%		86%
MDMA and derivates	25%		86%
Other stimulants	19%		69%
Cocaine	19%	Ever injecting	6%
Amphetamine	36%		19%
MDMA and derivates	36%		20%
Other stimulants	26%		22%

Source: TDI data collection 2018

With regard to the treatment and harm reduction possibilities, treatment of stimulant users characteristically takes place at general drug/addiction/psychiatric treatment units. Specific programmes for the users of these drugs are not available.

T1.2.4 Synthetic cathinones

According to the data of the general population survey in 2015 (Paksi et al. 2015) synthetic cathinones are between amphetamines and cocaine among the stimulants and take the third place in the preference order of the 18-64-year-old adult population. It means this substance group is the third most widespread type of drug. Lifetime prevalence rate in the 18-64-year-old population is 1.3%, in the 18-34-year-old young adult population is 2.7%.

Due to the low number of users (17 persons in the sample of 18-64 years, 38 persons in the sample of young adults between 18-34 years) social patterns of designer stimulants (synthetic cathinones) use can be examined only along some indicators. Only age group shows significant differences. Lifetime prevalence rate (2.7%) among young adults is four times higher than the rate in the older age group (0.6%). Lifetime prevalence rate of males is four times higher (3.3%) than among females (0.8%). Gender shows significant difference only in the young adult population. Data do not show significant patterns of urbanisation.

Designer stimulants were tried for the first time at the age of 19,5 on the average and most often at 16.

According to the results of the ESPAD survey (Elekes 2016) conducted among secondary school students the use of synthetic cathinones is less widespread. 2.5% of the student has already tried these in their lifetime, 3.3% of the boys and 1.8% of the girls used it ($p < 0.001$).

The use of synthetic cathinones ($N=169$) and almost each examined social indicator show significant correlation. The boys, those living in broken families ($LTP=3.9\%$) and deprivation (5.9%) are more involved. Important indicator is the type of the school. Lifetime prevalence rate is 0.4% in the grammar schools while 15 times higher in vocational schools, 6.5% . Spread of designer stimulant use is far beyond the average in schools of municipalities (10.9%). However, residence and the parents' level of education are not determinant relating substance use.

The majority of the students tried synthetic cathinones at the age of 15 for the first time. (Elekes 2016)

For data relating to the injecting of synthetic cathinones see: Chapter T1.2.1; as well as the Harms and Harm Reduction Workbook, Chapter T1.3.1; T1.3.4 and T2.2.b.

Synthetic cathinone users entering treatment are typically younger compared to other stimulant users starting treatment: one in every five is under 20 among them (19.1%). The proportion of unemployed (50.6%) and of those with a low school qualification (maximum primary level of education) (64.8%) is high among them. Most (56.2%) are intensive users, meaning they use synthetic cathinones at least two days a week. For more information, see Chapters T1.2.1; T1.3.1 and T4.1, as well as Chapters T1.3.1 and T2.1 of the Treatment Workbook.

Based on the national needle/syringe programme (NSP) data collection (for methods see: Harms and Harm Reduction Workbook T5.1.) in 2017 NSPs reported the availability of targeted counselling related to NPS injecting: out of the 26 reporting NSPs 21 organization provided this specific counselling, while none of them provided written material on this topic (Fóti and Tarján 2018).

T1.2.5 Injecting drug use

With regard to the primarily injected substance, it can be said that while in the past it was heroin and then heroin and amphetamine that were the typically injected substances, in recent years the most popular substances were designer stimulants (primarily synthetic cathinones). This pattern change can be observed in several routine data collections. In the meantime, when injecting drug use patterns started to transform in 2010 and 2011, the number, the quantity and the purity of heroin seizures dropped. As regards purity of amphetamine it also tended to be between 1-10% between 2009 and 2011 (see also: 2012 National Report, Chapter 10.) In parallel, number of synthetic cathinone seizures increased, in case of which substances high purity, lower price, easy availability, more intensive effects and previously legal status were characteristic (Péterfi et al. 2014; Horváth et al. 2011).

Number and quantity of heroin seizures remained low since 2011. A permanent increase could be seen in the case of amphetamine seizures, while the number of synthetic cathinone seizures, after a decreasing trend, rose again in 2017. Although the prevalence of cocaine injecting is very low according to routine data collections (NSP clients; TDI), the number of cocaine seizures also started to increase in recent years. (Regarding recent years' drug market and legal framework trends see: Drug Market and Crime Workbook T2.1 and Legal Framework Workbook T3.1). Since 2016 a moderation of NPS related need for treatment and harm reduction services can be traced in TDI and NSP client data compared to previous years' dynamic increase.

A 2015-2016 study (Péterfi 2016; Péterfi et al., 2017) aimed at the identification of substances injected by PWID also supported the dominance of synthetic cathinones on the basis of active substances found in used syringes. The chronological breakdown of results is described in the Drug Market and Crime Workbook, Chapter T4, while the geographical breakdown in the Treatment Workbook, Chapter T.4.2. For the methodology see Treatment Workbook, Chapter T5.2.

The active substance content identified in seized injecting equipment (as part of the seizure data) also confirm the marked presence of synthetic cathinones and an increase in amphetamine injecting, however the possibility of trend analysis is limited due to the low number of cases and the uncertainties of the sampling method. For details, see Section T2.1 of the Drug Market and Crime Workbook.

Information on heroin and methadone injecting can be read at Drugs Workbook/Heroin and other opioids/T1.2.5.

The following routine data collection systems collect data on the primarily injected substance and are not suitable to monitor polydrug use. Information on polydrug use of OST clients can be found in Drugs/Heroin and other opioids/T4.2.

Prevalence estimate of injecting drug use²⁹

At the beginning of 2016 a study (Horváth and Tarján 2016) was conducted relating to the size of the injecting drug user population (including both opioid and stimulants injectors). For the estimation the client turnover data of 2014 and 2015 of the national HIV/HBV/HCV seroprevalence survey series organised by the National Centre for Epidemiology since 2006 were used.

In 2014 and 2015, using point estimation, in the case of complete statistical independence, the size of the hidden IDU population was estimated at 1,594 persons. In the case of the estimated proportion of intentional participation of 76%, that is $\alpha=0.24$ ³⁰, the size of the hidden IDU population was estimated at 6,744 persons, and the size of the entire IDU population at 7,799 persons³¹. During the survey, besides taking blood samples, a behavioural questionnaire was recorded as well, which contained a question related to the time of last injecting. Based on this, proportion of recent PWID (those who had been injecting at least once in the previous year prior to the question) was 86% in 2015. Extrapolating this, the size of the recent IDU population was 6707 persons in 2015.

Needle/syringe programmes' (NSP) client data

On the basis of NSP data (Fóti and Tarján 2018), the appearance of NPS in 2010 completely transformed the structure of injecting drug use patterns characteristic of the previous years: While in 2009 fewer than 44% of PWID attending NSPs primarily injected stimulants, this proportion rose to 87% by 2017.

The proportion of those injecting classical stimulants, mainly amphetamine, was around 40% between 2009-2012, however, since 2013 it has shown a decreasing trend. In 2017 the proportion of primary amphetamine injectors was only 10% among NSP clients. The proportion of those injecting cocaine is negligible among PWID attending NSPs.

The increase of designer stimulants' (a group of NPS, mainly synthetic cathinones) injecting pushed out heroin from 2010 and then even amphetamine from 2013: while in 2010 fewer

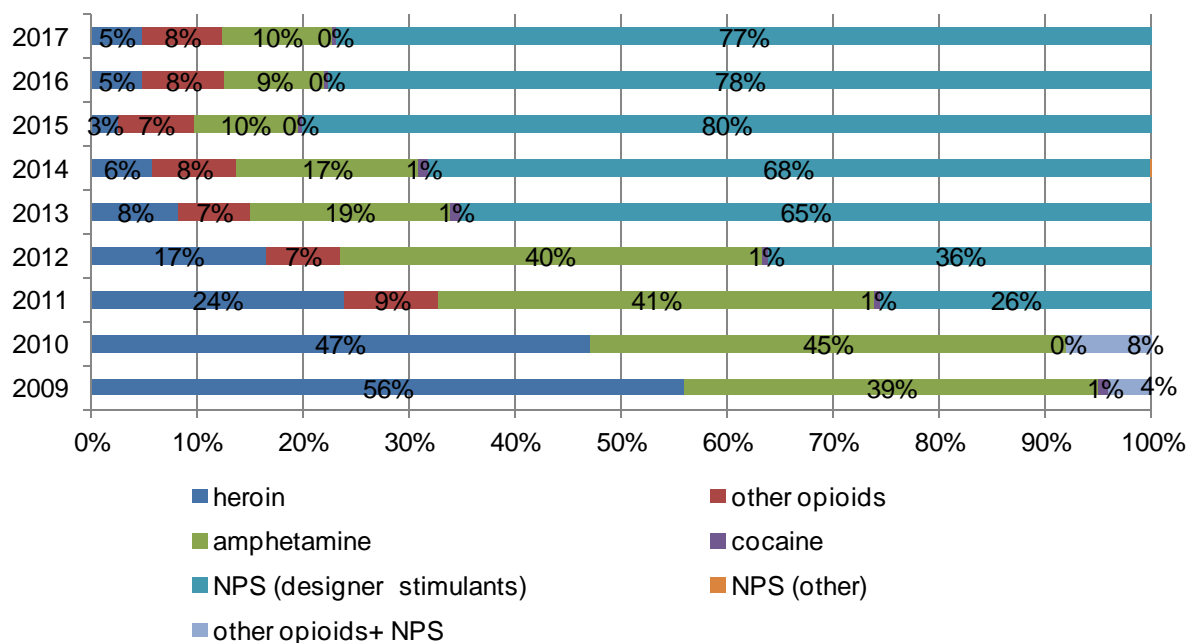
²⁹ The estimate refers to the entire injecting drug user population. Taking into account that according to the present trends injecting use mostly means stimulant injecting, the estimate is presented in this subchapter of 'Stimulants'.

³⁰ for further information see: E/T5.2

³¹ who injected at least once between 2013-2015.

than 8%³² of NSP clients used designer stimulants, in 2015 this was the primarily injected substance for 80% of them. Since 2016, injecting of synthetic cathinones appears to be moderating (primarily injected drug among NSP clients in 2016: 78%; 2017: 77%), in parallel with which recent research results (Kaló et al. 2018) underline a shift in the route of administration and the primarily used substance among PWID, namely, increasing inhaling (foil) of injectable substances and periodic or permanent shift to synthetic cannabinoid use (smoking). (See below: TDI data at T1.4.1).

Chart 13. Breakdown of NSP clients³³ by primarily injected drug between 2009-2017^{34,35}



Source: Fóti and Tarján 2018

In 2010 the dominant injected designer stimulant was mephedrone, in 2011 it was MDPV, and since 2012 the substance with the street name “penta crystal/crystal”³⁶ has been in first place according to the self-reported (street-name based) data by PWID. Among the injected designer stimulants (in case of a total of 1407 persons), “penta crystal” was the most frequently mentioned street name in 2017 as well (95% among designer stimulants; 1333 persons), which was followed by the street name “zene” (music) with 3% (43 persons). 2% of the cases referred to MDPV, while less than 1% to mephedrone.

Prevalence of NPS injecting is the highest among young injectors aged under 25 years, in 2017 83% of them injected primarily NPS.

Characteristics of PWID participating in the national HIV/HBV/HCV seroprevalence survey

A similar trend can be determined on examining the distribution of PWID participating in the national HIV/HBV/HCV seroprevalence survey (Dudás et al. 2015) according to primarily injected substances: the proportion of those injecting stimulants gradually increased over the

³² The 4% for 2009 and the 8% for 2010 in the ‘other’ category include both other stimulants and other opioids. Therefore, the proportion of those injecting primarily other stimulants was probably even lower in these two years.

³³ For the N of clients per year see the methodology at: Drugs/E/T5.2

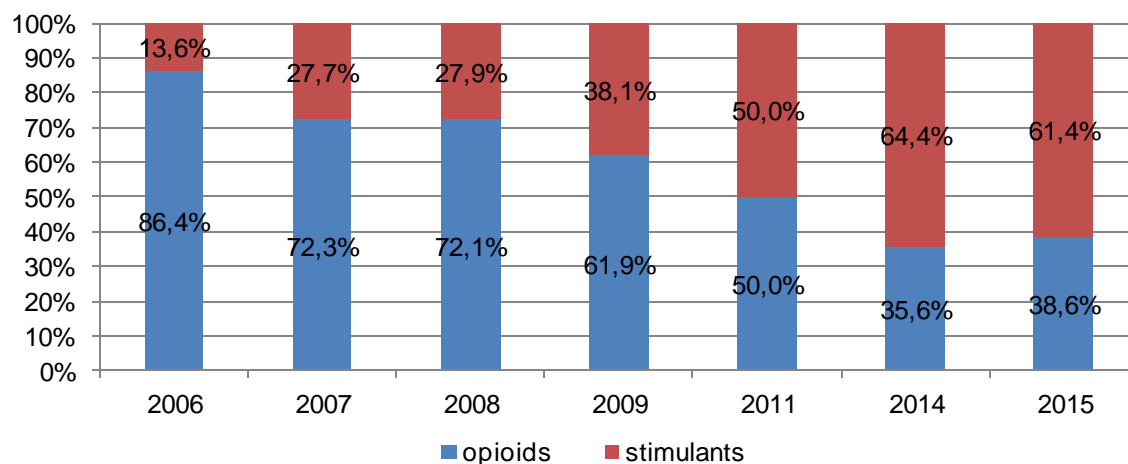
³⁴ In 2009 and 2010 other stimulants and other opioids were recorded in the category “other”.

³⁵ Data reported last year on 2016 was corrected due to post data cleansing.

³⁶ On the basis of earlier seizure data (2012-2014), this was probably the street name for substances containing the active substance pentedrone. While prevalence of pentedrone decreased and other types of synthetic cathinones started to spread on the basis of seizure data, the street name, “crystal” remained.

years in the sample. While in 2006 13.6% of them injected primarily stimulants, in 2014 and 2015 nearly two thirds of the sample belonged to this group³⁷. (For limitations on data comparability regarding the 2015 data see: Harms and Harm Reduction Workbook, T1.3.6)

Chart 14. Breakdown (%) of PWID participating in the national HIV/HBV/HCV seroprevalence survey by primarily injected substance, between 2006-2015



Dudás et al. 2015, analysed by HNFP

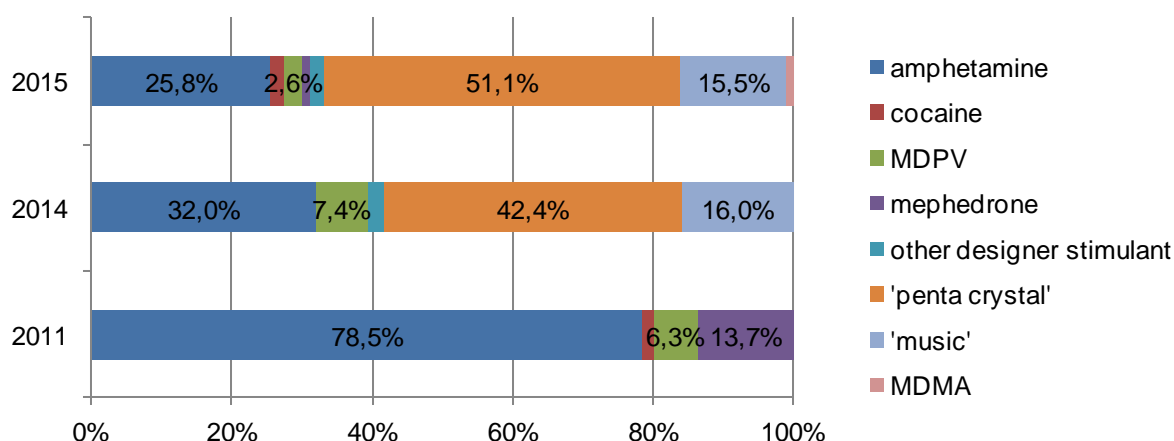
Selecting current stimulant injectors (injecting in the past 4 weeks) from the sample (in 2011: 64.2% of all current PWID, in 2014: 70.6%; in 2015: 66.4%³⁸), it can be seen that between 2011 and 2015 a significant move took place from amphetamines towards designer stimulants.³⁹ In 2011 78.5% of current stimulant injectors reported primarily using amphetamine, but in 2015 only 26% of them reported this. Opposite to this, the proportion of those primarily injecting designer stimulants grew from 20% to 72.2%. In 2011 the designer stimulant being mentioned the most was mephedrone, which by 2014 had been replaced by the designer stimulant 'penta-crystal/crystal' which was the most frequently injected stimulant as well both in 2014 and 2015.

³⁷ Some organizations participating in the survey were also providing OST (7 out of 19 in 2015) due to which there is a bias towards opioid injecting regarding prevalence of primary injected drug.

³⁸ The remaining part of the sample were opioid injectors, for more data on them see: Drugs/Heroin and other opioids/T1.2.5.

³⁹ In 2011 it first became possible during the national seroprevalence survey for the participants to name the primarily injected 'other' substance' in an open-ended question. Until then the data had been collected in 4 closed categories: opioids; amphetamine; cocaine; other. Therefore the analysis only makes statements for these three years.

Chart 15. Breakdown (%) of current stimulant injectors⁴⁰ participating in the national HIV/HBV/HCV seroprevalence survey by primarily injected drug type, 2011-2015

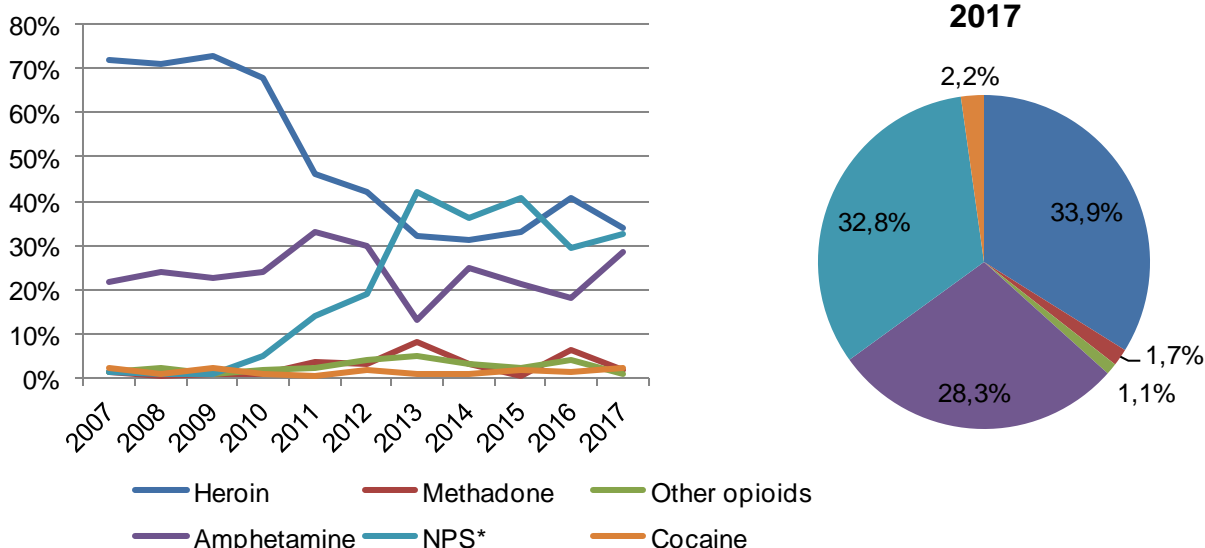


Dudás et al. 2015, analysed by HNFP

Treatment (TDI) data

With some delay, but by 2013 the change which had been observed earlier in other data sources could also be seen among those starting treatment: namely the decline in the use of opioids – primarily heroin – and the increase in the use of designer stimulants (typically synthetic cathinones) among PWID. Following 2015, the proportion of designer stimulant users among injecting drug users slightly decreased in TDI data, similarly to needle and syringe programmes' client data. The proportion of heroin-related injecting cases has decreased slightly from 2016 to 2017 following some increase, however, due to the low number of cases it is difficult to interpret the shift. With regard to the actual number of cases, the number of clients entering treatment with a primary heroin injecting use has decreased slightly in the last years (2015: 71, 2016: 69, 2017: 61).

Chart 16. Breakdown of PWID entering treatment by primarily injected drug⁴¹ between 2007 and 2017 (%; N₂₀₁₇=180)



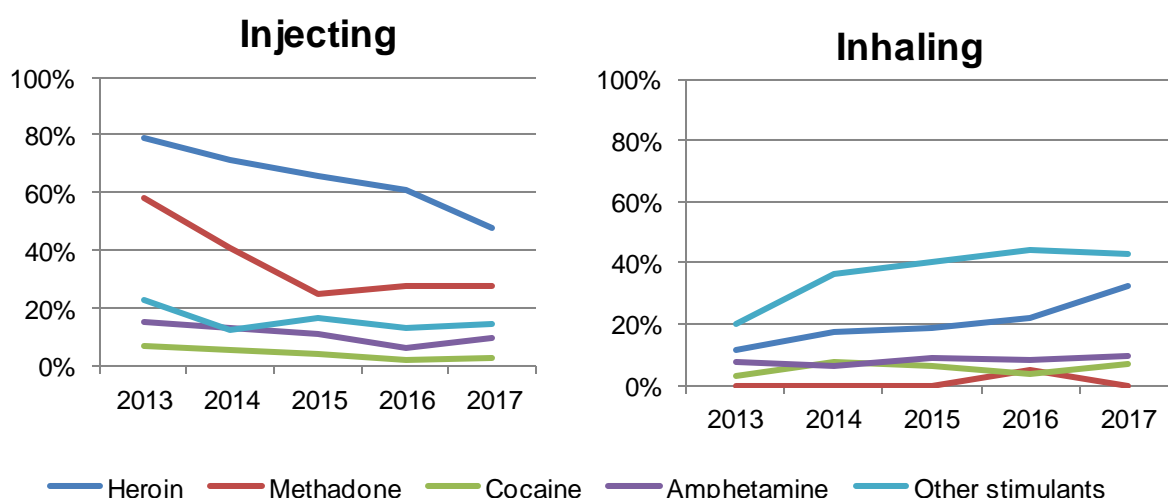
*other stimulants + other, non categorisable substances
Source: TDI data collection 2018

⁴⁰N₂₀₁₁=256 persons; N₂₀₁₄=269 persons; N₂₀₁₅=233 persons.

⁴¹ Considering only heroin, methadone, other opiates, amphetamine, other stimulants and cocaine injector clients.

When examining the route of administration of injectable drugs, we can see that there was a shift in clients starting drug treatment. In the case of heroin and methadone users there was a marked decrease (from 79% to 48% and from 58% to 27% between 2013 and 2017) in the proportion of those who reported injecting as the primary route of administration, and in case of cocaine, amphetamine and other stimulants (synthetic cathinones) users, there was a slight decrease. At the same time, a marked increase can be seen in the proportion of those who inhaled the substance among heroin users (from 11% to 32%) as well as among other stimulants users (from 20% to 43%). Among cocaine, amphetamine and methadone user clients, the proportion of those reporting inhalation as the primary route of administration remained relatively stable throughout the period.

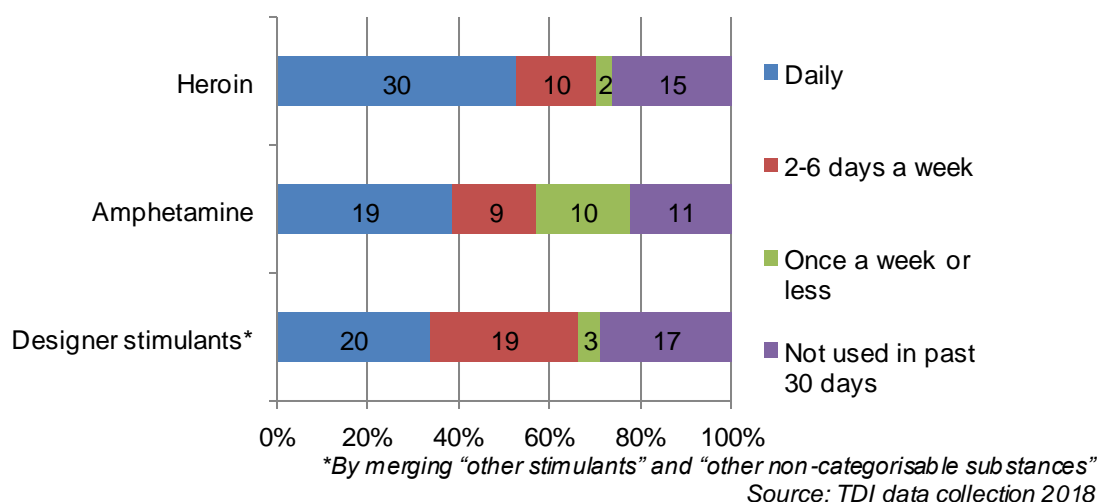
Chart 17. The proportion of those injecting and those inhaling (using foil) their primary drug in each substance group, among clients entering treatment between 2013 and 2017 (% of each studied substance user group)



Source: TDI data collection 2018

Heroin injectors reported of intensive use (daily or 2-6 days per week) in highest proportion among PWID starting treatment (70.2%, 40 persons). The percentage of intensive users was 66.1% (39 persons) among designer stimulant injectors and 57.1% (28 persons) among amphetamine injectors.

Chart 18. Frequency of injecting drug use⁴² among PWID entering treatment in 2017 (persons; N=165)



⁴² In the last 30 days before entering treatment.

For the analysis on PWID's risk behaviours see: Harms and Harm Reduction Workbook, Chapter T1.3.1.

Further studies on injecting drug use in Drugs/Stimulants, Chapter T4.1.

T1.2.6 Infectious diseases

See: Harms and Harm Reduction Workbook, Chapter T1.3.1.

T2. TRENDS

See: Chapter T1.

T3. NEW DEVELOPMENTS

See: Chapter T1.

T4. ADDITIONAL INFORMATION

T4.1 ADDITIONAL SOURCES OF INFORMATION

The information obtained from the treatment data is supplemented by the treatment facility survey performed in 2015 by the Hungarian National Focal Point (Péterfi 2015), on the basis of which according to the estimates of the service providers reporting 74% of the TDI data, among the clients treated because of a drug problem, the use of designer stimulants (21%) was the third most typical problem as the reason for treatment in 2014, following cannabis (31%), and synthetic cannabinoids (26%). (For more information see National Report 2016, Treatment Workbook, Chapter T4.1 and T6.2.)

Another study conducted in 2015 in the Hungarian therapeutic communities (Péterfi et al. 2016) found that 43% of clients who participated in the rehabilitation programmes in 2014 started the programme due to primary synthetic cathinone use and 27% due to synthetic cannabinoid use. (For further information see National Report 2016, Treatment Workbook, Chapter T4.1 and T6.2.)

The study about the problematic NPS use of adults living in non-urban settlements classified as socially segregated areas by the Central Statistical Office was conducted in three districts of two regions (Northern Hungary and Southern Transdanubia) (Csák et al 2017). The results of the study show that the use of synthetic cannabinoids is more common in the examined socially segregated areas than the use of synthetic cathinones (for a methodological description of the study, see Drugs/Section E, Section T5.2). About one fifth (150 persons, 19.5%) of those who reported use of NPS in the last month have not tried any synthetic cathinones, whereas this proportion was 3.4% in the case of synthetic cannabinoids. In the whole sample, the proportion of current users (last month) for synthetic cathinones was 56.4%. Overall, in the examined population the frequency of synthetic cathinones use was 1-2 times per month (50 persons, 36.8%). The proportion of intensive (at least 3 times a week) synthetic cathinone users was 23.7% among the responding NPS users. In the sample 28

respondents (19%) indicated that they had already injected drugs in their lives. 18 of them said that they used some kind of drug intravenously over the past 30 days as well, mainly synthetic cathinones (14 out of 15 respondents). 7 out of the 15 respondents indicated that they shared injecting equipment with someone in half or more of the cases. (The methodological description of the study is provided under T5.2 of Section E in the Drugs Workbook).

According to the qualitative study (Kaló et al 2018) conducted among experts working in treatment and harm reduction settings as well as among current drug users, NPS injecting became less common or became less open. In general, they described the NPS phenomenon stagnating. According to those experts working in the treatment setting the new drug use patterns (using foil, straw, toothpick) are related to more strict law enforcement activities. The interviewed current drug users perceived the composition of the NPS user population to have become younger. In the field of harm reduction, several experts mentioned the shift from injecting synthetic cathinones to smoking synthetic cannabinoids ('herbal, bio'), and the change from injecting to inhaling (using foil) was also confirmed, as seen in treatment data as well (see T1.2.5 in this chapter). They also mentioned the deterioration of the quality of NPS. These changes were associated with the behavioral change of drug users: they are more hidden/reclusive. They also perceived that „designer drug users” can be characterized by polydrug use behavior and are „dependent on being intoxicated” (the primary aspect when choosing a substance is that it should be potent). The experts explained the changes (route of administration; hiding) with more control and police activity. (The methodological description of the survey is provided under T5.2 of Section E in the Drugs Workbook).

On the basis of the risk behaviour questionnaires administered by the HIV/STI programme of the Alternativa Alapítvány (Altalap) in 2015 and 2016⁴³ (see T5.2 and T1.4.1. in Harms and Harm Reduction Workbook) (Altalap 2017; Csák and Rácz 2018) out of the 144 current (injected in the last 30 days) injecting drug users 77% injected primarily an NPS, 9.7% used heroin, 6.3% used amphetamines and 5.6% injected methadone. The findings of this study are in line with the patterns observed by the national register of NSP clients.

⁴³ Only data from the first phase is described here (excluding non-injecting users), as from the second phase sub-data on PWID could not be retrieved.

C. HEROIN AND OTHER OPIOIDS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 The relative important of different opioid drugs

Based to general population survey data in 2015 (Paksi et al. 2015), 6.9% of the 18-64-year-old population presumes that it is easy or very easy to access heroin. 9% of the young adult population reported the same.

According to survey data opiate use is very rare in the general population. The cumulative prevalence rate is 0.7%, the LTP of heroin is 0.5%, that of other opiates is 0.6%. Last year and last month prevalence can hardly be measured.

Based on the results of the earlier comparable surveys the spread of opiates did not change in the last 15 years, only very low rate of the population tried it.

According to the results of the ESPAD survey (Elekes 2016) in 2015 heroin is the least widespread among students on the 9-10 grades compared to the examined drugs, LTP is 1.4%.

Based on the trends detected among 16 year old students in the last 20 years few have tried, lifetime prevalence rate was 1-2% between 1995 and 2015.

During its supply reduction activity, in connection with heroin the Police experienced that Hungary's earlier role as a destination country has gradually and by now almost entirely disappeared. However, as a transit country, Hungary still plays a significant role on the European market (NSZKK 2018a).

With regard to seizure data, between 2009 and 2010 both the number of seizures and the amount of heroin seized significantly decreased compared to previous years. After the regression, there was no significant shift in heroin seizures between 2010 and 2017. In spite of this, there were several nearly 1 kilogram transit-traffic seizures in 2017. The same trends can be observed regarding samples from injecting drug use related equipment, as from 2009 to 2010 and then to 2011 the proportion of samples connected to heroin use radically declined (67%, 28%, 1%). It is also apparent from the tested samples, that injecting drug users replaced heroin with synthetic cathinones (designer stimulants) (NSZKK 2018a).

Besides heroin, methadone is the most available opioid type substance on the Hungarian black market. In addition to the formerly available tablet form, in 2016 liquid methadone sold under the name of Misyo was introduced in Hungary, which replaced the tablet formula previously used by several OST providers (Csorba 2018). As most clients continue to prefer the tablet format and the volume of these releases was reduced, it is likely that the tablet format will be less available on the black market as well. The increasing demand with declining supply resulted in a rise in street prices of tablet methadone: from 2016 to 2017 the price of the 20 mg methadone tablets raised from 1200 HUF to 2000 HUF, while that of the 5 mg methadone tablets from 500 HUF to 1000 HUF (see more in Chapter T1.1.5 of the Drug market and Crime Workbook).

New synthetic opioids are less available in Hungary: only 9 seizures occurred between 2015 and 2017 which were mostly related to fentanyl derivatives. Apart from fentanyls, U47700 was identifiable on the Hungarian market (NSZKK 2018a).

T1.1.2. Estimates of opioid use

For the study (Horváth and Tarján 2016) on the estimate about the prevalence of injecting drug use in 2015 see Drugs workbook/Stimulants, Chapter T1.2.5.

Estimate of heroin use prevalence was last made in 2013, with respect to a two-year interval (2010-2011). The point estimate value for those using heroin at least once in the given two years was 3244 persons. (For details see 2013 National Report, Chapter 4.2.) Since then, due to changes in the drug market and drug use patterns, it can be assumed that the size of this population has dropped significantly.

T1.2 PATTERNS, TREATMENT AND PROBLEM/HIGH RISK USE

T1.2.1 Patterns of use

For data in connection with risk behaviours relating to injecting opioid use see: Harms and Harm Reduction Workbook, Chapter T1.3.4. For the patterns of use of opioid users starting drug treatment see Chapter T1.2.2.

T1.2.2 Treatment for heroin and other opioids

Opioid use was the primary drug used in the case of 4.0% (192 persons) of those entering treatment in 2017 (see Treatment Workbook, Chapters T1.3.1. and T2.1) (heroin 154 persons, misuse of methadone 12 persons, other opioids 26 persons). The number of (primary) heroin users entering drug treatment increased from 122 persons in 2016 by 26%, while the number of methadone clients decreased by 71% from 41 persons recorded in 2016. The number of heroin users entering treatment thus increased overall, even though their proportion among injecting drug users entering treatment had decreased (see Drugs/Stimulants, Chapter T1.2.5). At the same time, the number of methadone abusers decreased significantly. This latter phenomenon can be explained by the fact that from 2016 onwards, in many treatment centres the tablet format was replaced by liquid methadone.

The proportion of male opioid users was 79.5% (140 persons), 20.5% (36 persons) were female. The mean age of this user group entering treatment was 36.0 years and they had used opioid-type substances for an average of 15.8 years before entering treatment in 2017. Prior to treatment the typical route of administration reported was injecting (40.5%), that was followed by smoking/inhaling (25.8%), eating/drinking (25.2%) and sniffing (6.1%).

It is noteworthy that 48.0% (61 persons) reported injection as the main route of administration and 32.3% (41 persons) reported inhalation among heroin users entering treatment. This shows a clear shift towards inhaling, which has been apparent since 2013 in clients entering drug treatment (for trend data, see Section T1.2.5 of the Drugs/Stimulants Workbook). This is in line with service provider feedback from the field (Fóti and Tarján 2018; Kaló et al, 2018).

Regarding frequency of use, 44.3% of the clients used opioids on a daily basis, 17.1% used them 2-6 days per week, 6.3% once a week or less and 32.3% have not used them in the last 30 days prior to entering treatment. (For more information on injecting see Drugs/Stimulants, Chapter T12.5.)

With respect to treatment possibilities, opiate substitution treatment (OST) is available to opioid users as a special treatment programme. In the scope of OST methadone and buprenorphine/naloxone (suboxone) are the available medications in Hungary. In OST,

based on the latest data available, 669 persons were treated during 2015. For information on its availability and utilisation see Treatment Workbook, Chapters T1.4.7-T1.4.9 and T2.1.

T1.2.5 Injecting drug use

Regarding injecting drug use, NPS injecting continues to be the dominant pattern in the population. See Drugs/Stimulants/T1.2.5.

With regard to heroin, it can be said that its availability is still very limited. Based on seizure and NSP data, availability and use of heroin have not changed (thus not increased) recently at national level.

Needle/syringe programmes' client data

On the basis of the NSP data (Fóti and Tarján 2018) the increasing NPS injecting from 2010 has completely transformed the structure of injecting drug use patterns characteristic of previous years: while in 2009 56% of PWID attending NSPs injected primarily heroin, in 2017 only 5% of the clients self-reported injecting primarily this substance. Since 2013 the prevalence of primary heroin injecting has fluctuated between 3%-8% among NSP clients. (For the chart on trends see: Stimulants, Chapter T1.2.5; for N of clients per year see Drugs/E/T5.2).

The proportion of those injecting other opioids, primarily methadone has not changed significantly over the past years: it was around 7-9% between 2011 and 2017.⁴⁴

The proportion of opioid injectors among young people (below 25 years of age) is very low. In 2017, 3% of heroin injectors (85 persons) were under 25; 35% were between 25 and 34, and 61% were over 34 years of age. Similar distribution was observed regarding injecting of other opioids (mainly methadone, 139 persons), breakdown by the above age groups was 2%, 39% and 59% respectively.

The characteristics of PWID participating in the national HIV/HBV/HCV seroprevalence survey

It is also possible to see the decrease in the injection of opioids from 2006 when examining PWID participating in the national seroprevalence survey (Dudás et al. 2015) by primarily injected substance. While in 2006 86.4% of the sample⁴⁵ injected primarily opioids, by 2015 only 38.3% of them reported primarily injecting an opioid.⁴⁶ (for the chart on trends see: Stimulants, Chapter T1.2.1)

Selecting current injectors from the sample relating to 2015 (total N of current injectors: 2015: 351 persons; 2014: 381 persons), it can be said that among them the proportions of those injecting heroin and those injecting other opioids was still low: 22% of them injected primarily other opioids (13.1% in 2014), mainly methadone, while 15.9% of them reported heroin as their primary injected substance (15.5% in 2014).⁴⁷ (For limitations on data comparability regarding the 2015 data see: Harms and Harm Reduction Workbook, T1.3.6)

About the patterns of opioid use see Chapter T1.2.2, for further trends in injecting use see Stimulants, Chapter T1.2.5.

⁴⁴ Before 2011 the service providers reported data in 4 closed categories: heroin; amphetamine; cocaine, other. From 2011 the closed 'other' category became an open-ended question, the substance categories classed there can be named since then, therefore exact data on the injecting of other opioids has only been available since then.

⁴⁵ ever injectors

⁴⁶ Some organizations participating in the survey were also providing OST (7 out of 19 in 2015) due to which there is a bias towards opioid injecting regarding prevalence of primary injected drug.

⁴⁷ For the first time, in 2014 the opioid category was broken up into heroin (closed category) and other opioids (open-ended question), therefore the analysis only makes statements for 2014 and 2015.

T1.2.6 Infectious diseases

See: Harms and Harm Reduction Workbook, Chapters T1.3.1.

T2. TRENDS

See Chapter T1.

T3. NEW DEVELOPMENTS

See Chapter T1.

T4. ADDITIONAL INFORMATION

T4.2 FURTHER ASPECTS OF HEROIN AND OPIOID USE

Over the past years several studies (Farkas 2011; Péterfi 2013; Kapitány-Fövény et al. 2015) reported on the use of NPS, primarily designer stimulants, by OST clients. Kapitány-Fövény et al. (2017) examined the reasons of NPS use in OST clients of the National Institute of Psychiatry and Addiction. The study found that instead of pharmacological preferences the choice of NPS use was made based on rather practical reasons: most typically curiosity, replacing other drugs and easy availability. The study also found that lifetime amphetamine use and more severe psychiatric symptoms may predict NPS use. (For methodology see E.) Sources and Methodology, Chapter T5.2.)

At the 2016 annual meeting of needle and syringe programmes (NFP 2016) the organisations providing both NSP and OST reported that a significant proportion of their OST clients inject designer stimulants or use synthetic cannabinoids beside the therapy.

A 2015/2016 study (Péterfi 2016; Péterfi et al., 2017) which investigated drug residues in used syringes identified a significant presence of methadone during the examined time period (20%-30% per month). Injecting methadone, in other words, misuse of it (presumably as part of a polydrug use pattern) is an important outcome of this research, but the possibility of extrapolating this prevalence data to the PWID population is limited due to data collection sites⁴⁸ and methodological limitations of sampling. No significant increase in methadone injecting is found via analysis of active substances detected in seized injecting equipment.

⁴⁸ At 5 out of the 7 sampling sites from which and in the surroundings of which used syringes were collected for the project, OST is also provided.

D. NEW PSYCHOACTIVE SUBSTANCES (NPS) AND OTHER DRUGS NOT COVERED ABOVE

T1 NEW PSYCHOACTIVE SUBSTANCES (NPS)

For information on new psychoactive substances see A) Cannabis Chapters T1.2.4 and T4.1, B) Stimulants Chapters T1.2.4 and T1.2.4 and C) Heroin and other opioids Chapters T1.2.4 and T4.2.

T4 FURTHER INFORMATION

T4.3 NON-SPECIFIC DRUG USE AND POLYDRUG USE

In the OLAAP study a cluster analysis was conducted to assess the latent user groups on the basis of the different drug use patterns. (Paksi 2017). In the group of the 18-64 years old adult population four groups were identified that cover 86.8% of the total sample.

- 1) The biggest group – 83.1% of the cases covered by the cluster analysis – was not engaged in any drug use behaviour, they form the group of 'non-users'.
- 2) The second group (7.9%) was called the 'pharmaceuticals users', all of whom used sedatives with or without a doctor's prescription in their lives and nearly half of whom were ever engaged in pharmaceuticals abuse. Members of this group used illicit drugs minimally: lifetime prevalence was 2% for cannabis use and 2% for the use any other illicit drugs.
- 3) The third latent group 'polydrug users'⁴⁹, (5.2%) consists of users who all used an illicit drug other than cannabis, though 60% of them used cannabis as well. In this group the use of all drug types have high prevalence rates among which classical stimulants use is dominant with a lifetime prevalence rate of 85%. New psychoactive substance use is the highest in this group out of the four (synthetic cannabinoids use 33%, designer stimulants use 19%) though NPS are not the dominant substances in this group.
- 4) The fourth and smallest group is the group of 'cannabis users'. All of them used herbal cannabis or cannabis resin in their lives and only 5% of them used another illicit drug other than cannabis. Pharmaceuticals use was also rare among them. (Paksi 2017).

⁴⁹ The term 'polydrug users' refer to those who reported to have used two or more different drugs in their lives.

Table 9. *Latent groups of drug users identified among 'ever users' between 18-64 years of age*

Final cluster centres (cases included: 1293; missing data: 197)								
	Clusters							
	polydrug users		pharmaceuticals users		non-users		cannabis users	
	18-64	18-34	18-64	18-34	18-64	18-34	18-64	18-34
sedatives (with or without prescription)	.23	.42	1.00	1.00	.00	.00	.01	.01
pharmaceuticals abuse	.21	.32	.46	.71	.01	.01	.04	.02
cannabis use	.61	.77	.02	.18	.00	.00	1.00	.81
synthetic cannabinoids use	.33	.68	.02	.08	.00	.00	.00	.14
designer stimulants use	.19	.59	.01	.02	.00	.00	.01	.05
cocaine use (inclusive)	.22	.54	.00	.00	.00	.00	.00	.04
classical stimulants	.85	1.00	.00	.18	.00	.00	.00	.34
hallucinogens use (inclusive)	.19	.54	.00	.02	.00	.00	.01	.04
other illicit drug use	.14	.49	.00	.02	.00	.00	.01	.02
illicit drug use other than cannabis	1.00	1.00	.02	.26	.00	.00	.05	.50
N	67	41	102	54	1075	1080	49	169
%	5.2	3.0	7.9	4.0	83.1	80.4	3.8	12.6

Source: OLAAP – Paksi 2017

In the age group 18-34 – applying the same cluster analysis as for the adult population – the latent groups identified were close to the groups of the complete adult population, although the proportion of each group was different, and in all groups (excluding the non-users) the researcher found more diverse drug use patterns than in the complete 18-64 population. (Paksi et al 2017)

On the basis of the cluster analysis aiming to differentiate the drug use patterns it was concluded that cannabis use is stand-alone and dominant among the young adults in Hungary, whereas NPS use is part of the polydrug use pattern and does not form a separate user group. (Paksi 2017).

E. SOURCES, METHODOLOGY

T5. SOURCES, METHODOLOGY

T5.1 SOURCES

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T5.2 METHODOLOGY

Altalap HIV/STI programme (2017): see Harms and Harm Reduction Workbook, Chapter T5.2.

Breaking the Drug Cycle' (Péterfi 2016): see Treatment Workbook, Chapter T5.2.

Drug use in the homeless population (Paksi, Magi 2017): The purpose of the study was to estimate the use of drugs and other psychoactive substances in the homeless population, a social group that is not covered by general population surveys, and to identify the specific drug use characteristics of the homeless population through interpreting the results in a general population context. Data collection - similarly to the 2007 study was performed using omnibus method, together with the 2017 data collection of the "Február Harmadika (The 3rd of February) (F3)" data collection series, which is the best available estimation on the homeless population. The target population of the research was the homeless population in Hungary and the sampling frame was the 8014 homeless people who were reached during the 2017 F3 data collection in homeless shelters and in public areas, covering the whole country. The research was carried out on a one-sixth random sample stratified according to the sampling frame's access-location (specific accommodation and street services). Based on the size of the sample frame, the calculated gross sample size of the research was 1335 persons, and the net sample size was 1302 persons. Because of the high access ratio, sample weighting was not required. In the analyses carried out with this sample size, the theoretical margin of error was $\pm 2.5\%$ at 95% confidence level. Data was recorded using self-administered questionnaires handed out in closed envelopes - similarly to the 2007 study and the general population studies. In designing the study material the recommendations of the EMCDDA, changes in the demands of the indicator (perceived accessibility), recommendations on the monitoring of the use of new psychoactive substances (NPS), and comparability with the national general population studies (OLAAP 2007, 2015) were taken into consideration.

NPS use in socially segregated areas (Csák et al., 2017): The study of the use of NPS by adults living in non-urban areas classified as socially segregated areas by the Central Statistical Office (KSH) was conducted in three districts of two regions (Northern Hungary and Southern Transdanubia). Sampling was done using the method of privileged access and outreach based on social networking. Sampling criteria were at least 18 years of age and the use of NPS - synthetic cannabinoids ("synthetic grass", "herbal", "bio") and/or "crystals" (typically containing synthetic cathinones) - at least once during the last 30 days. 75 questionnaires and 25 interviews were recorded in each region (150 questionnaires, 50

semi-structured interviews in total). Data collection took place between 1 June 2017 and 30 September 2017.

Qualitative study among experts (Kaló et al 2018): The focus of the study was the identification of changes and novelties in the use of new psychoactive substances by analysing expert perceptions and data during a 6-month period (June-December 2017) in Hungary. The aim of the study was to carry out an analysis that goes beyond descriptive indicators, by exploring the new NPS scenes identified by national and international experts (Hungarian LGBT community, child protection and homeless care, online scenes) besides the scenes already identified in the scientific literature (injecting drug use, treatment and care, prison, nightlife), as well as exploring the information available from the media and authorities. The non-representative study used a pragmatist philosophical approach and a mixed method model with a primary qualitative data collection and a secondary qualitative and quantitative data analysis.

1) Qualitative Testing: The (primary) data collection was conducted between January and April 2018 with interviews and focus groups. 10 thematic working groups (injecting drug use, treatment-care, prison, nightlife, LMBTQ communities, child protection, homeless care, online scene, media), 20 focus groups (53 participants + 10 working group leaders), 12 interviews (12 people) and 2 expert focus groups (working group leaders + 6 experts) were carried out with a total of 81 participants.

2) Media monitoring: The content analysis of the expert interviews identified 21 keywords. Based on the keywords a systematic analysis was run on Hungarian online media publications from the research period (that identified a total of 382 media reports).

3) The collection and analysis of secondary data (seizures, epidemiological and research data from the research period) were completed (20 documents). The data analysis was done with deductive content and document analysis at Atlas.ti 8.2.0. programme.

Qualitative study of the drug use of 5th and 8th grade students in segregated areas (with special focus on NPS) (Lannert 2017): The study was conducted in 3 regions (Northern Hungary, Eastern Hungary, Southern Transdanubia), in 3-3 schools in each region. The study among the children in lower grades used an innovative focus group technique (eg. story cube, creative description) within the framework of an age-appropriate activity (eg. drama session). Among upper-grade students a national, non-representative, self-assessed questionnaire survey was conducted (3289 persons completed at least half of the questionnaire, 3127 completed the full questionnaire), 90% of the sample were 7th or 8th grade students, 18% lived in Budapest or Pest county.

Survey on drug use among juveniles in detention homes (Port 2016b): see Prison Workbook, Chapter T5.2.

ESPAD 2015 (Elekes 2016): The next data collection of European School Survey Project on Alcohol and Other Drugs was conducted in March 2015. The survey was carried out by the Institute for Sociology and Social Policy, at Corvinus University of Budapest. In Hungary data collection took place in accordance with the ESPAD protocol, on a national representative sample of young people born in 1999 and participating in full-time ordinary school education, in the form of class surveys, using the self-reporting method. The total sample size on the 9-10 grades was 6664, the net sample of 16-year-olds included 2647 students.

HBSC 2014 (Arnold, Németh 2015): The data was recorded in spring 2014 from a nationally representative sample, with consideration to international standards. The survey extends to students studying in grades 5, 7, 9 and 11. The sample was set up using stratified sampling according to school grade, county, settlement type, type of training and maintainer. The net sample included 6153 persons. The data were collected via self-administered, anonymous questionnaires completed in class groups with passive consent and ethics committee approval. The survey was financed by the National Institute of Child Health. The survey

examines substance use among students in grades 9 and 11 (N=3509). The students in grade 9 are 15.9 years old on average, and those in grade 11 are an average of 18 years old.

Kapitány-Fövény, M., Farkas, J., Pataki, P.A., Kiss, A., Horváth, J., Urbán, R., Demetrovics Zs. (2017): A structured questionnaire was filled in with 198 opioid dependent clients of the National Institute of Psychiatry and Addiction in 2014. The questionnaire covered socio-demographic characteristics, the characteristics of treatment, lifetime substance use, potential reasons for NPS use, negative life events and psychiatric symptoms.

National HIV/HBV/HCV seroprevalence survey (Dudás et al. 2015): see the Harms and Harm Reduction Workbook, Chapter T5.2.

Needle/syringe programme (NSP) data collection (Fóti and Tarján 2018): In 2018 NSPs reported their 2017 data via the web-based data collection surface operated by the Hungarian National Focal Point (HNFP) since 2008. The service providers have been sending data on the demographic characteristics and injecting patterns of clients participating in NSPs to the HNFP through this interface since 2010. In 2012, the closed 'other' substance category was transformed to an open-ended question, where the service providers could name the other substance categories. On the basis of previous years' experiences the list of closed categories (which were mainly the classical substance types before) was extended in 2015 with new closed categories: 'penta crystal'; 'zene' ('music'); methadone; MDPV. With respect to 2017, 25 organisations uploaded the data of 2093 clients. In respect of the number of clients double counting control was performed at service provider level but not at national level. The same client may be registered at more NSPs. The service providers provided information in 2017 on a total of 1831 clients' primarily injected substance. (2009: 1483 persons; 2010: 1737 persons; 2011: 2237 persons; 2012: 1907 persons; 2013: 3128 persons; 2014: 3692 persons; 2015: 2985 persons; 2016: 2366 persons)

OLAAP 2015 (Paksi et al. 2015): The survey was carried out on a representative sample of the Hungarian population between the ages of 18-64, stratified by settlement size, region and age group, over-representing the population between the ages of 18-34. The gross sample size was 2477 (net sample 2247 persons). The national representative sample of 18-64-year-old population included 1490 persons, the one of 18-34-year-old population included 1534 persons. Data were recorded using a so-called mixed methodology, a face-to-face technique combined with self-reporting elements, in the spring of 2015. The survey was financed by OTKA (application identification: K.109375) and EMMI.

Online survey (Nyíri 2016): In December 2015 online survey was conducted about the characteristics of synthetic cannabinoid use. 1319 persons filled in the questionnaire. Based on the data, the sample consists of regular cannabis user who are mainly males, between 18-29 years, live in Budapest or other towns and have already used synthetic cannabinoids.

Prevalence of injecting drug use (Horváth and Tarján 2016): Estimation took place using the method of capture-recapture recurring in time. For further information about the studies corresponding to the two databases used (2014 and 2015 national HIV/HBV/HCV seroprevalence surveys), see the 2015 and 2016 Harm and Harm Reduction Workbooks, Chapters T1.3, T2.2 and T5.1 and T5.2.

Those injectors tested were involved in the estimate, who took part in a NSP in the given time interval or received treatment at a specialised outpatient drug treatment centre. 19-19 service providers participated in the survey in both years. Ever injecting drug use was the recruitment criteria for participation.

During the survey series people who inject drugs PWID were identified using a so-called 'generated code' used in the TDI system, which made it possible to monitor the reoccurrence of clients. (For the socio-demographic data of PWID and their data relating to drug use see

the 2015 and 2016 Harm and Harm Reduction Workbooks Section T1.3 and the Drugs Workbook, Sections T.1.2.2 under certain substances (primarily under Stimulants, but also under Opioids.))

It was not possible to break down the estimate by different drug types. The result of the first step of the estimate relate to a two-year interval, indicating injecting drug use during the two years determined.⁵⁰ As the second step of the estimate, the results were modified according to the question about the time of the last injecting that was included in the questionnaire of the testing so that the estimation refers to the recently (last 12 months) injecting population. A condition of using the capture-recapture method is independence between the two time points when measurement is performed. Presumably this condition of independence was not fulfilled in the testing programme, so the basic formula⁵¹ of capture-recapture was modified, distinguishing accidental and systematic or intended participation as the cause of repeated occurrence in the testing programme. By modelling the intention to participate, sensitivity analysis was performed. The coefficient of the intention to participate was determined after interviewing the testing sites, using the method of expert estimation. On the basis of the average of the answers given by the interviewed service providers, 76% of the clients intentionally participated in the seroprevalence survey repeatedly.⁵² The clients participating in the seroprevalence survey were given an incentive (meal vouchers in the value of about EUR 3), so the proportion of participants, who took part in the survey for the second time because of this, is presumably high, even higher than the estimated value.

Psychological analysis of synthetic cannabinoid users (Kassai et al. 2017a,b): In the scope of this psychological study 6 semi-structured qualitative interviews were conducted with synthetic cannabinoid dependent users in treatment. The study focused on the experience of substance use and on identity change and the analysis of interviews was carried out by interpretative phenomenological analysis.

Substance use in the segregated areas of a disadvantaged district (Szécsi és Sik 2016): The methods of the research were field work, survey and semi-structured interviews. The first-year students of social work in the Faculty of Social Sciences at ELTE participated in the research and data processing. The research was funded by the Faculty of Social Sciences at ELTE. Each of the 30 university students carried out 25 hours of observations, and 204 questionnaires and 33 interviews were made (half with adults, half with minors under 18 years) in the summer of 2015.

⁵⁰ Repeated occurrence in the testing programmes between 2014 and 2015

Year	2015	
	Occurrence	No
2014	No	458
	Yes	463

⁵¹ The so-called Lincoln-Petersen formula was modified, so the formula used for estimating injecting drug use is:

$$x = \frac{a_{21} \cdot a_{12}}{a' \cdot a''_{22}} + (1 - \alpha) \cdot a'_{22}$$

where:

X = hidden population

a₂₁ = IDU population occurring in one of the years

a₁₂ = IDU population occurring in the next year

a'22 = IDU population reoccurring in testing intentionally

a''22 = IDU population occurring in testing accidentally

α = coefficient of the intention to participate, in the case of 100% all repeated occurrences were accidental, that is the two tests are statistically independent

⁵² During the survey the service providers participated in the seroprevalence survey were contacted and requested to estimate the proportion of reoccurring clients, that is clients who occurred in testing in the two consecutive years, who returned to the testing programme consciously and the proportion of those who returned accidentally. All 15 service providers answered the question, where, according to the TDI generated code, there were reoccurrences.

TDI data collection 2017: See Treatment Workbook, Chapter T5.2.

Treatment facility survey 2015 (Péterfi 2015): See National Report 2016, Treatment Workbook, Chapter T6.2.

Treatment facility survey in the therapeutic communities 2015 (Péterfi et al 2016): See National Report 2016, Treatment Workbook, Chapter T6.2.

PREVENTION⁵³

T0. SUMMARY

The National Anti-drug Strategy, entered into force in 2013, determines priorities in the field of prevention and tasks in 10 settings as well. Drug prevention activities – beside several drug-related tasks – are coordinated by the National Drug Prevention Coordination Department of the Ministry of Human Capacities. (See the Drug Policy Workbook, Chapter T1.3.1)

National study data show that the majority of organisations operating prevention interventions perform universal prevention in the school setting. 70% of these organisations are NGOs with their financing coming mostly from the state in the form of grants. Among the organisations carrying out characteristically selective prevention activities outside of school, there are many state or local authority bodies (social care and child protection institutions) that come into contact with the target groups regularly for different purposes. Workplace prevention programmes only occur occasionally. The main financer of the prevention activity is the state and European Union sources (TÁMOP (Social Renewal Operational Programme), EFOP (Human Resources Development Operation Programme)) as well.

In the past years it has been a priority of those formulating the drug policy for the prevention programmes to progress towards professionalization. The regulatory materials compiled for the field and the quality assurance process of school prevention programmes aimed that goal.

T1. NATIONAL PROFILE

T1.1 POLICY AND ORGANISATION

T1.1.1 Prevention objectives in the National Strategy

The fundamental approach framework of the National Anti-drug Strategy that entered into force in 2013 (see also the Drug Policy Workbook, Chapter T1.1) is ‘the strengthening of health and health support processes as well as the personal, community and environmental conditions that lead to these’. The Strategy states that ‘health and a healthy lifestyle, as a value and a resource, should be available to everyone and an example to be followed’. Through this ‘a community environment will be developed in which the possibility of the development of the most varied dependency or psychological health problems and those having a negative effect on life conduct is significantly lower’.

Beside this, an important element of the approach is to encourage local-level initiatives in the interest of ‘a community – civil – professional network being created that provides equal access to the various development, prevention and treatment programmes in every settlement’.

The National Anti-drug Strategy also determines priorities in the field of prevention. According to section V.2. of the Strategy dealing with drug prevention: ‘the prevention activity in connection with the drug problem must be conceived in all settings and target groups with respect to health development in the wider sense’ and it is important that ‘instead of a

⁵³ Author of the chapter: Ágnes Port

narrower interpretation of drug prevention, the focus of the programmes should be health development, comprehensive physical, psychological, intellectual and social wellbeing'. In connection with prevention the Strategy determines tasks in 10 settings: local communities, family, public education and the child protection institution system, higher education, peer groups, the media, the workplace, penal institutions as well as the institution of 'treatment as an alternative to criminal procedure' (QCT). The priorities determined in the Strategy in connection with drug prevention are the following:

- Increasing the number of programmes promoting a substance-free lifestyle;
- The comprehensive school health development programmes should reach 50% of pupils by 2020;
- Programmes using the family approach should reach 20% of families with children once a year;
- The proportion of adolescents trying and occasionally using drugs should drop by 10% within the given age group;
- The establishment and introduction of a quality assurance system for the prevention and information programmes;
- Only those health development programmes may be realised in Hungary that have professional approval and include a quality assurance system, including in this the activities of public education institutions as well;
- The local role played by the Coordination Fora on Drug Affairs (KEF) and their coordination activity should be strengthened;
- The national strategies and programmes to be approved aimed at psychological health development and dealing with the alcohol problem and other behavioural dependencies should be harmonised with the anti-drug strategy.

The Government adopted a Policy Program for 2017-2018 in connection with the National Anti-Drug Strategy (2013-2020, Clear consciousness, sobriety, fight against drug crime) (Government Decree 1669/2017. (XI.15.)). In the field of demand reduction, the policy program seeks to promote the development of health promotion and drug prevention with priority being given to the implementation of universal, selective and indicated programs in the widest possible target groups and settings. It focuses on involving families and communities, reaching vulnerable target groups (eg. child protection), and taking into account special considerations (eg. disadvantaged people).

T1.1.2 Institutional background

The top Hungarian drug coordination body is the National Drug Prevention Coordination Department of the Ministry of Human Capacities (for more information see Drug Policy Workbook, Chapter T1.3.1). The Ministry of Human Capacities (EMMI) instruction number 33/2014. (IX. 16.) on its Organisational and Operation Regulations also specifies the tasks of the National Drug Prevention Coordination Department in connection with drug prevention:

- in the framework of the National Anti-drug Strategy and action plans it should elaborate guidelines for professionals, development concepts and programmes serving the handling of the drug problem, and harmonise and monitor the realisation of the tasks contained in them,
- collaborate in the performance of the demand and supply reduction tasks related to the handling of the drug problem, in the performance of health development tasks, and coordinate the drug prevention activity;
- collaborate with the background institution responsible for drug prevention tasks,
- collaborate with the relevant departments in connection with drug prevention,
- collaborate in the elaboration and assessment of the specialist content of grant programmes in connection with the handling of the drug problem.

As a background institution of the EMMI, drug policy related tasks are carried out by the Directorate-General for Social Affairs and Child Protection (SZGYF) as well. The Department of Drug Prevention Programmes of SZGYF takes part in the implementation of the National Anti-Drug Strategy, in setting up drug policy programmes, and in preparing, carrying out and evaluating drug related tenders of the EMMI. It also coordinates the operation of preventive-consulting services (available as an alternative to criminal procedure for drug law offenders), as well as assisting in the cooperation between prevention professionals and prevention institutions.⁵⁴

Health development offices

Integrated with the healthcare system, health development offices were set up using European Union financing to support the system's prevention capacity, until the end of 2014 59 beneficiaries received positive decision. These offices play a substantial role in the implementation of universal prevention. The health development tasks that can be selected include prevention of smoking, drug use and excessive alcohol consumption.

T1.1.3 Financing system

One of the most determinant factors of the prevention activity is the method and amount of financing. According to the results of an earlier research, on average four fifths of the budgets or the prevention programmes came from grants, which puts a great deal of uncertainty into the system concerning the continuity of the operation of the programmes. The financer is mostly the state. Financing from the business sector, foundations and local authorities is significantly less than this. The proportion of financing from donations was 2.9%. The presence of a stable, permanent budget improving the reliability and sustainability of operation was not characteristic. (Paksi and Arnold 2010)

In 2017 drug use prevention tasks of special importance were financed by the state via individual grants, in a total amount of 318.308 EUR⁵⁵. The Directorate-General for Social Affairs and Child Protection (SZGYF) with the support of the EMMI provided an additional 323.196 EUR for the financing of the preventive-consulting services (available as an alternative to criminal procedure for drug law offenders).

In 2017 drug use prevention tenders (KAB-ME) were only available in the Central Hungary region. In the scope of the KAB-ME grant schemes a total of 678.711 EUR was available for the funding of universal, selective or indicated prevention programs that build on school health development, health education and the involvement of local community members and to support prevention programs that contribute to preventing and reducing the use of drugs among children in temporary child protection care and young adults receiving after-care. (EMMI 2018a)

In 2017, the Ministry of Human Capacities assisted in the drawing up of two international tenders. The aim of EFOP-1.8.7-16 "Selective Prevention Programs for Preventing Addiction" is to improve the health culture of the population, to increase health awareness thorough efficient health communication tailored to the target groups, and to implement awareness-raising and prevention programs with particular attention to community and family involvement. The available resources were EUR 9.7 million and a total of 43 applications were submitted.

In the scope of EFOP-1.8.9-17 "Have Other Passions! 2." a total of EUR 8.2 million is available for the support of specialized child protection institutions to support the prevention

⁵⁴ 13/2017. (III. 31.) EMMI utasítás a Szociális és Gyermekvédelmi Főigazgatóság Szervezeti és Működési Szabályzatáról, <https://www.szgyf.gov.hu/hu/foigazgatosag/szmsz>

⁵⁵ The prices in the Workbook were calculated using the EUR intermediate exchange rate valid for 2017 (EUR 1=HUF 309.41).

and reduction of drug use. As part of the program beneficiary institutions will have the opportunity to carry out prevention activities that have a positive impact on the children in specialized child protection care. There are currently 17 institutions with existing support contracts. (EMMI 2018a)

T1.2 PREVENTION INTERVENTIONS

T1.2.1 Environmental prevention

Policies/initiatives

In 2011 the extension of the legal regulations relating to new psychoactive substances represented a significant change at national level. A government decision was made and legislation drawn up in order to set up and introduce generic control. Eliminating the legal distribution of these new psychoactive substances is an important element of the process.

Crime prevention strategies

The National Crime Prevention Council was set up by Government in 2011. Its most important task was to create the National Crime Prevention Strategy. The Strategy determines crime prevention targets for ten years, until 2023. Among the key priorities of the Strategy child and juvenile crime prevention is also included, one area of which is the prevention of addictions, alcohol and drug prevention. (For more information see 2014 National Report, Chapter 9.5.)

T1.2.2 Universal prevention

National quantitative surveys were carried out up to 2009 about preventive programmes inside and outside school settings, from which it was determined which drug prevention interventions the students came into contact with (a detailed description of the surveys can be found in the previous National Reports). Between 2010 and 2015 only regional or qualitative studies were conducted. In 2015 national data collection was prepared again which provides updated information about the features of prevention activities (see chapter T4). Comparing the results of the two latest national data collections, both in 2009 and 2015 NGOs ran the overwhelming majority of the prevention interventions, however the presence of state institutions increased by 10%. Compared to earlier data, in 2015 only half of the organisations ran prevention activities as their main activity. Examining content related issues, it can be stated that the majority of the programmes/services continued to operate directly in the final target population. In addition, the interventions provided by school teachers and teacher-training drug use prevention programmes also appeared. The objectives of the programmes became more up to date and the service providers met the students more hours/more times than earlier. While in 2009 the interventions targeted the 10-14 age range and the 15-18 age range at almost the same rate, in 2015 most of the interventions targeted those above 14 years.

In the course of 2017 the KAB-ME-17-KMR-A/B tender (operated in collaboration by EMMI and NRSZH) offered grants for universal, selective and indicated prevention interventions related to health promotion and health education in the school setting. From 2017 onwards, the award of the grant is conditional on the program having a professional recommendation received in the EMMI's preliminary assessment procedure (see T1.3.1). Of the 15 applications submitted, 14 received support amounting to a total of EUR 188,746.

Tender KAB-ME-17-KMR-C provided funding for special interventions targeting drug users who show the early signs of drug dependency but cannot be considered as addicts; for the implementation of community programmes; for the implementation of programs that promote emotional and value-based education; for implementing programs combining online and offline methods; for selective and indicated interventions and trainings aimed at strengthening family relations and improving parental skills; and for trainings and sensitizing programs for professionals working in the field (teachers, tutors, social workers). In the category C, 46 applications were submitted, of which 35 received grants totalling EUR 490, 278.⁵⁶

In all three categories it was possible to support universal, selective or indicated prevention programs contributing to the prevention and reduction of drug use among young adults in temporary child protection care or post-nursing care.

The drug prevention activity of the Police

16/2016 (VII. 21.) ORFK order on the “Implementation of children- and juvenile protection programmes” constitutes the basis of the drug prevention activity of the Police and regulates thoroughly Police tasks and responsibilities in connection with school and nursery programmes. In 2017 the following activities were carried out:

In the OVI-ZSARU programme 418 nurseries from 244 communities participated from the country and the programme reached 17,778 children. In the DADA programme for primary school aged children 300 schools participated from 187 communities; a total of 23,778 pupils were reached. The ELLEN-SZER programme targeting secondary school students was realized in 44 schools in 32 communities, with the participation of 2615 students.

In the school year 2016/2017 111 crime prevention consultants were available in 272 secondary schools in 110 communities, reaching 110,530 students. Measures were taken or initiated by the consultants in 452 cases related to drug use, possession or distribution of drugs, small scale offences against property and bodily harm, harassment. (Police 2018)

Drug prevention mediators

To reduce drug use by young people, in 2014 the police launched a new drug prevention programme entitled ‘*Parents and family members are the special partners of the police in preventing drug-related crime*’. The aim of the programme is for the parents of children aged 12–18 and family members to directly receive information about the risks of drug use and about its consequences under criminal law. The programme’s local mediators (drug prevention correspondent officers) can be reached at all police stations, who offer help (advice and information) to parents through e-mails, lectures, meetings and through providing monthly consultation times and bi-weekly telephone counsel service.

In the school year 2016/17 within the scope of the program drug prevention mediators received 93 personal and 138 telephone requests, answered 297 e-mails, participated in 503 teacher-parent meetings and delivered 1225 educational lectures. (Police 2018)

T1.2.3 Selective prevention

Some of the winning programmes mentioned in Chapter T1.2.2 – in accordance with the stipulations of the grants – are viewed as selective prevention, which designated target groups such as those living in state care, in penal institutions, those living in socially disadvantaged neighbourhoods, as well as homeless young people and pregnant women. Almost all of the programmes realised in family settings dealt with the relatives of substance users.

⁵⁶ <https://szgyf.gov.hu/index.php/hu/palyazatok/category/542-palyazati-felhivas-kabitoszer-prevencios-programok-tamogatasara>

As their financing is provided for 1 year in the framework of the grants, the long-term operation of the programmes is questionable.

A proportion of the party service programmes may be classed as selective prevention, the majority of them, however, deal with harm reduction, therefore their detailed description can be found in the Harms and harm reduction Workbook, Chapter T1.5.3.

Drug prevention in the Hungarian Army

The main directions of the drug prevention activity performed within the organisational framework of the Hungarian Army are determined by the National Anti-drug Strategy 2013-2020 approved by the currently valid National Assembly Decision 80/2013 (X. 16.) and by the Hungarian Army's Drug Prevention Strategy. On the basis of these, over the course of 2017 the Hungarian Army implemented the following activities (Magyar Honvédség 2018):

- 11 lectures were held reaching a total of 1390 persons on the basis of request, on the occasion of community setting programmes. As part of these lectures cognitive knowledge transfer and personal counselling took place and prevention publications were disseminated.
- The Hungarian Army Health-Protection Programme (the aim of which is the development of health-conscious behaviour of the personnel) reached 418 persons in 14 corps in 2017 via interactive drug prevention sessions held in small groups.
- Personnel planned for missions are prepared in the subject of the prevention of addictions. In 2017 drug prevention training was held on 2 occasions with the participation of 55 persons.

The Hungarian Army operates a screening system, in the scope of which 3 types of examinations may be carried out to detect drug use: screening as part of suitability assessment (related to occupational health examination); checking of the ability to perform duty (spot checks with preventive purposes); (official) examination of drug influence in case drug use is suspected. In 2017, a total of 13,099 tests were performed, of which 20 samples proved to be positive (8 THC, 3 cocaine, 4 amphetamine, 5 DES).

T1.2.4 Indicated prevention

Some of the state-financed programmes are indicated prevention programmes targeting strengthening the family system and developing parental skills (Chapter T1.2.2), among at risk young people, students attending schools for special needs, and those living in drug-user families.

One type of the quasi compulsory treatment available as an alternative to punishment for drug law offenders is the preventive-consulting service which may be considered a form of indicated prevention interventions. Information and data on QCT are presented in the Legal Framework Workbook, Chapter T1.1.1, Treatment Workbook, Chapters T1.2.2 and T1.3.1, and Drug Market and Crime Workbook, Chapter T1.2.1.

T1.3 QUALITY ASSURANCE OF PREVENTION INTERVENTIONS

T1.3.1 Quality assurance standards, guidelines and objectives

Within the scope of the drugs-related pillar of the project dealing with modernisation of social services (TÁMOP5.4.1) completed in 2011, the international and Hungarian research experience, best practices and regulatory practices with respect to several areas dealing with prevention (selective prevention programmes operated in shopping centres/malls, selective prevention programmes created for young people living and hanging out in housing estates and other deteriorated residential environments, selective prevention and harm-reduction programmes established/operated in clubs, preventive-consulting services) were reviewed. On the basis of these methodological documents (specialist regulatory documents) were drawn up for every individual area. (For more information see 2011 National Report, Chapter 3.2.)

In the interest of the quality assurance of health development programmes implemented in school setting, as of 1 February 2013 a specialist monitoring procedure was introduced to regulate these programmes within the comprehensive school health development system, which was coordinated by the National Institute for Health Development (NEFI) until the operation of the institution was terminated in March 2017. From April 2017 coordination tasks were taken over by the Ministry of Human Capacities (EMMI), the legal successor of the institution. The essence of the system introduced is that only those prevention programmes may operate in schools that have received professional approval in this procedure. The professional approval system is a prior assessment system in terms of quality assurance. (For details see 2014 National Report, Chapter 3.4.)

In 2017 15 applications were submitted to the EMMI for approval, of these 9 applications were prevention programmes relating specifically to substance use or addictions. Each programme contained social competence development or emotional education elements beyond knowledge transfer. In the end 8 drug prevention programmes were given professional approval. (EMMI 2018b)

T2. TRENDS

School prevention/health development gained momentum in the academic year of 2001/2002 with the setting up of system level grant financing. The content, methods, target groups and even duration of the prevention programmes were more determined by the financier's expectations (the state in most cases – see Chapter T1.1.3), and less by changes in substance use patterns and the appearance of new phenomena. This is supported by, for example, that in 2006 a database was set up about more than 400 prevention programmes, because registration was a condition of application for funding. The shift from frontal teaching towards interactive personality development and attitude shaping was also included in the grant application specifications. However, there were no significant responses to the observable spreading of new psychoactive substances in Hungary from the prevention service providers.

The other factor determining the content of the programmes was the legislative environment and the prevailing drug strategy. In 2011 the National Curriculum made it obligatory for schools to perform prevention activities. As of 2012, a ministerial decree prescribes the introduction of comprehensive health development in schools, a part of which is drug use prevention. In 2013 the professional approval system was introduced, which, apart from placing a great deal of emphasis on professional programme structuring, international recommendations and the knowledge of good practices also appeared as a strong filter. (See Chapter T1.3.1.)

A number of school prevention programmes were externally evaluated in 2003-2005, internal assessment is more characteristic, which is mainly limited to measurement of popularity index and of change in knowledge level.

T3. NEW DEVELOPMENTS

The Act on Public Education obliges schools to perform youth protection tasks, and the head of the educational institution is responsible for the organization and provision of these tasks.⁵⁷ The institution may employ an external expert as a person responsible for youth protection duties, but this is not mandatory.

EMMI Regulation 2/2018. (I.18.) on the *Modification of NM Decree 15/1998. (IV.30.) on the professional duties and operating conditions of the child welfare, child protection institutions and persons providing personal care* introduces the concept of kindergarten and school social assistance service (instead of the former school social work). According to the Regulation, from 1 September 2018, the kindergarten and school social assistance service provides support to the children belonging to the public education institution, the child's family and the pedagogues of the public education institution, in order to prevent the child's vulnerability by means of social assistance work. In the scope of this it aims to help:

- the detection and exploration of the obstacles to the fulfilment of the child's educational obligations;
- the identification of the child's vulnerability using preventive devices;
- the operation of a warning system.

T4. ADDITIONAL INFORMATION

In the spring of 2018 an online survey was conducted (Sárosi, Magi 2018) among young Hungarians participating in high school drug prevention programs in the last 5 years. The aim of the research was to learn more on the types and content of the secondary school drug prevention programmes juveniles participated in and on how they assess the effectiveness of these programmes. (For methodological data see Section T5.2).

Respondents⁵⁸ were asked about the types of drug prevention activities they had participated in (more than one answer could be selected). Most of them participated in drug prevention lectures (85%), the second most common form - film screening – followed far behind (32%). 10% of the students participated in activities involving games and drama, 8% attended exhibitions and 8% took part in sporting activities. The proportion of participants involved in individual consultations was 4%, and the proportion of those attending family sessions was just over 3%. Most students attended school drug prevention activities organized within the school, and only 15% reported of out-of-school attendance.

Regarding the person/organization delivering the drug prevention program⁵⁹, 54% of respondents took part in a program held by a police officer, 42% in a program held by an external drug prevention expert, and 37% in a program held by a teacher (37%). 20% of the respondents also participated in drug prevention programmes held by former drug addicts, 18% in a program held by a physician, and 4% in a program held by a priest (4%). 89 respondents (8%) marked other types of professionals as lecturers (nurse, psychologist, medical student and actor, in the order of the frequency of mentions).

⁵⁷ Act CXCV. of 2011. on National Public Education, Section 69.(2)(f)

⁵⁸ Approximately 95% of the 1133 youngsters participating in the survey were between 14-25 years old and 63% belonged to the 14-18 year age group. The proportion of girls was 50%, that of boys 48%, and 3 respondents reported to be transgender. Approximately a quarter of the participants (26%) attended secondary school in Budapest, while 33% in a county seat and 36% in other cities. The lowest proportion (3%) attended secondary school in a village. According to school type the largest group (36%) attended a vocational high school (formerly known as vocational secondary school), followed closely by the group of 4-grade high school students (35%), followed by vocational secondary school (formerly vocational school) (11%). 10% went to 6-grade high school and 8% to 8-grade high school.

⁵⁹ Several answers could be selected simultaneously.

According to the respondents most drug prevention programs (82%) focused on raising the awareness of the dangers of drugs, 68% gave information about the types and effects of drugs, 44% emphasized that drug use was prohibited, while 40% educated young people about how to say no to drug use. 30% of students were educated about safer nightlife and how to have fun more securely. 27% of students took part in a training session about the forms of help they could give to their drug using peers, and 23% was educated about being aware of the choices they have and 15% about alternative ways to spend their free time. Only 12% of the programs focused on harm reduction methods and 9% on the better understanding of social relationships.

The answers to the questions on the credibility of drug prevention programs revealed that most of the students accepted the programs as credible. The majority of participants (53%) found the drug prevention program to be believable and convincing, the minority (29%) did not. 44% of the participants agreed to the statement that the drug prevention program exaggerated the harms of drugs, while 37% did not.

The questionnaire also asked how much the program changed the students' previous opinions about drugs. Only 9% agreed totally with the statement "I felt that my opinion changed a lot from the program", while 32% did not agree at all. With the statement "I got answers to a lot of questions I had been interested in for long" 31% agreed and 47% did not agree. 49% of the students disagreed with the statement "I can honestly speak about my own experience", and only 10% felt that there was completely confidential atmosphere during the program. Among those who fully agreed with this statement, there was a significantly higher proportion of those who participated in a peer-led (former drug addict) program (19% in the whole sample, 31% among those who fully agreed) or in a program led by an external expert (42% versus 50%).

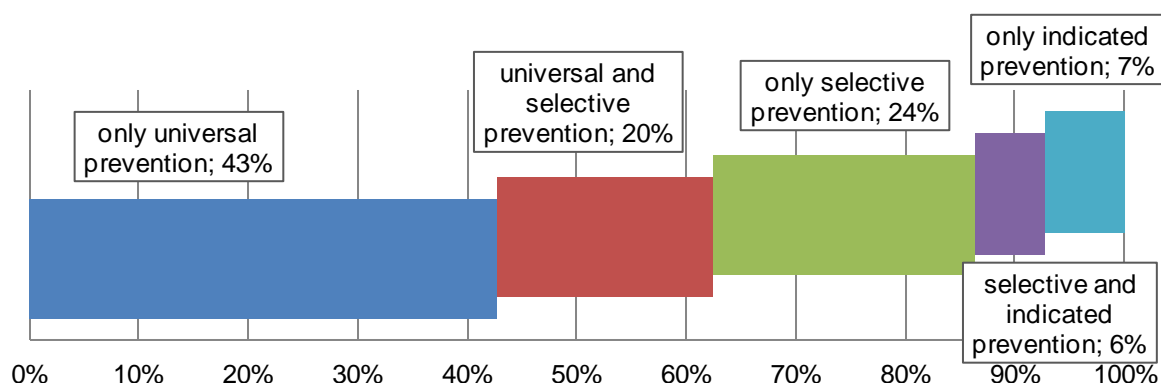
34% of students would have liked to participate in similar programs in the future, but 43% wouldn't have.

The national data collection (Paksi et al 2016, for methodology see T5.2) aiming at mapping prevention programmes identified 253 organisations dealing with addiction prevention (as well), operating between 2013 and 2015. From those currently 194 organisations run their own prevention programmes (i.e. objectives and methods are homogenous in each target group). One third of the service providers can be found in Central-Hungary (Budapest and Pest county). 7-8 service providers by county are present in the rest of the country.

76 organisations from the 194 filled in the questionnaire of the study, we have detailed information about these. According to the results most of the service providers (85%) run prevention programmes not as their main activity but as part of it, which consists mostly of treatment and care, or other supporting or training/educational activity. The majority of the organisations (70%) are NGOs. Local governments and budgetary institutions also represent a relatively high rate (24%). For profit organisation only run 6%. The organisations most often run 1, on average 1.8 and a total of 139 prevention programmes or interventions. The study describes 115 interventions in detail. The number of the programmes operating directly in the final target group is 96. The detailed information about these 96 programmes are presented below.

37 programmes run in Budapest and an average of 24 programmes run by county currently in Hungary. 21% of the known prevention interventions contact their target groups in the school setting only. Other 49% do so inside and outside the school as well. Almost half of the programmes are implemented in schools, quarter of them (24%) in the target population's own setting too. The interventions mainly target the youth of 14-18 years.

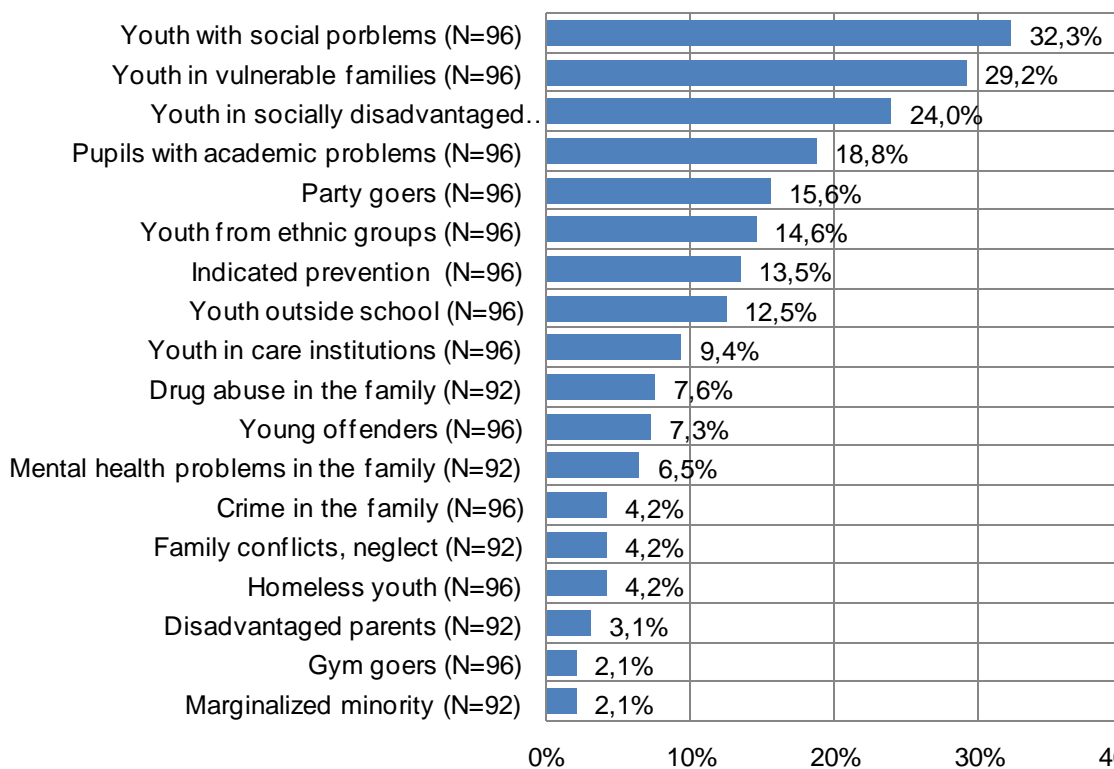
Chart 19. *Types of interventions aimed directly at the final target group (N=96)*



Source: Paksi et al. 2016

Nearly two third of the prevention interventions (62.5%) indicates the general population (as well) as its target group. However no interventions are aimed at young refugees.

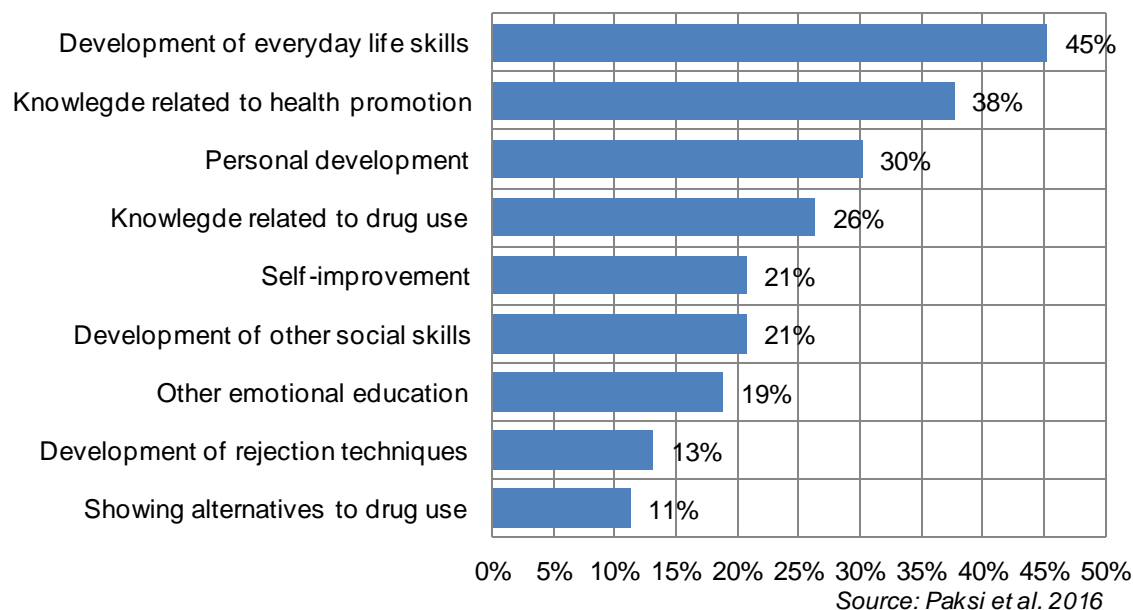
Chart 20. *Special target groups of interventions aimed directly at the final target group (%)*



Source: Paksi et al. 2016

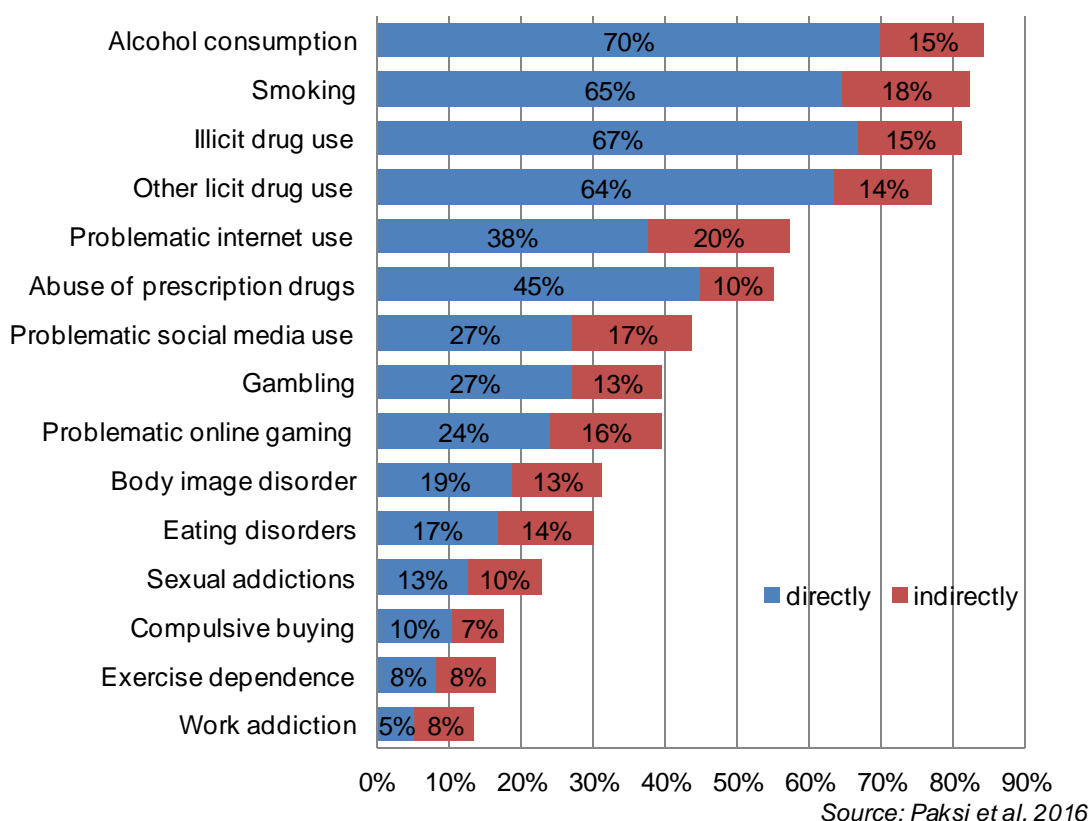
Examining the objectives of the interventions aimed directly at the final target group 9 main types can be described (see the chart below). Service providers usually define 2-3 objectives per intervention. The most common objectives are the development of everyday life skills, transfer of knowledge related to health promotion and personal development.

Chart 21. *Different objectives of interventions aimed directly at the final target group (N= 53, %)*



Examining the targeted addictive behaviour, it can be stated that the majority (82.3%) of the interventions directly aim at preventing a defined form of addiction and two third of them directly aim at illicit drug use.

Chart 22. *Addictive behaviours in prevention interventions aimed directly at the final target group (N=96)*



Prevention programmes longer than 10 hours are nowadays dominant (60%). Most of the programmes are implemented in 1-4 months, but 40% of them is even longer and 21% of

them take a school year. The way of implementation does not differentiate sharply depending on whether universal, selective or indicated interventions are performed.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

EMMI (2018a): Az EMMI Nemzeti Drogmegelőzési Koordinációs Osztályának beszámolója a 2018-as EMCDDA Jelentéshez

EMMI (2018b): az EMMI Egészségmagatartási és Mentálhigiénés Osztály iskolai egészségfejlesztési programokkal kapcsolatos adatai

Magyar Honvédség (2018): A honvédelmi tárca beszámolója az EMCDDA számára készülő 2018-as Éves Jelentéshez

Paksi B., Arnold P. (2010): Az ország három régiójában drog területen jelen lévő civil szervezetek jellemzői, az általuk végzett tevékenység tartalmi vonatkozásai és a projekttel szembeni igények. <http://www.madaszsz.hu/beszam.php>

Paksi, B., Magi, A., Demetrovics, Zs. (2016): Szenvedélymagatartásokra irányuló prevenciók beavatkozások országos katasztere, Budapest, Kézirat

Police (2018): A Rendőrség 2017. évi tevékenységéről szóló beszámolója

Sárosi, P., Magi, A. (2018): Online felmérés a középiskolai drogprevenciók programban részt vett fiatalok körében. Manuscript.

T5.2 METHODOLOGY

Paksi B., Arnold P. (2010): The survey was made in the scope of the TÁMOP-2.5.1-07/1-2008-0136 project in three regions in the country (in Pest, Csongrád, Bács-Kiskun, Békés, Hajdú-Bihar, Jász-Nagykun-Szolnok, and Szabolcs-Szatmár-Bereg counties and in Budapest). The datasheet for describing the activity of the target group was completed by 63 prevention service providers, who operated a total of 125 prevention programmes.

Paksi, B., Magi, A., Demetrovics, Zs. (2016): From the autumn 2015 to the spring 2016 national data collection was conducted aiming at setting up the database of prevention programmes targeting the age range of 9-24. Comparative analyses of 8 data sources resulted 1766 organisations. During the time of data collection 773 organisations could be contacted. From those 253 service providers ran prevention activities between 2013 and 2015. 194 organisations implemented prevention programmes (i.e. same objectives and methods implemented each time). The study describes the features of the 115 programmes run by 76 service providers uploaded in the prevention database. Data collection was conducted by ELTE PPK Eötvös Loránd University Faculty of Education and Psychology and financed by the CSR programme of Szerencsejáték Zrt.

Sárosi, P., Magi, A. (2018): Online data collection took place between 23 April and 4 May 2018. The SurveyMonkey online questionnaire consisting of 8 questions was available on drogriporter.blog.hu and Drogiporter's Hungarian facebook page with 30,000 fans and it was also shared on other thematic pages (CannabisKultusz, Daath.hu). The questionnaire could

be downloaded by young people who are currently attending or have attended high school in the last 5 years in Hungary and have participated in some kind of school drug prevention program. In order to extend the scope of the survey beyond young people with special drug-related interest, researchers released post-boosted ads on Facebook for 18 and 24-year-old young people in Hungary for \$15. The Drogiporter facebook post reached a total of 46,102 people and generated 2942 clicks. The online questionnaire was filled in by 1144 people, of which 1133 responses were found valid.

TREATMENT⁶⁰

T0. SUMMARY

The inpatient and outpatient treatment of drug users is a shared task of the healthcare system and the social services system. The treatment of drug users and the operation of the treatment system are coordinated and monitored by the *State Secretariat for Social Affairs and Social Inclusion* and by the *State Secretariat for Health* of the Ministry of Human Capacities (EMMI) with the help of its professional background institutions and consulting bodies.

Numerous forms of inpatient and outpatient treatment and treatment units for the treatment of drug users are accessible all over the country. The demand for specialised outpatient treatment of drug addicts was acknowledged in the 1980s and it was then that the first services were set up.

The treatment is generally provided by public institutions operated by the state or local governments (hospitals, clinics) and by nonprofit organisations run by churches and NGOs. With regard to the present treatment possibilities, there are no specialised treatment programmes targeted at the users of individual substance types, instead programmes target the users of all substance types or addictions or psychiatric problems in general. An exception to this is opioid substitution treatment (hereinafter OST), which has been available in Hungary since 1994 for substance users struggling with opioid addiction for an extended period.

A significant element of the treatment system in Hungary is the legal possibility of treatment/preventive interventions that may be used as an alternative to criminal procedure (quasi compulsory treatment; hereinafter QCT). The majority of treatment demand is linked to this (68.6% in 2017).

Drug treatment is not a separate category neither within the social nor the healthcare systems; in general they belong to the group of treatment modalities related to addiction and psychiatric problems. This makes it difficult to monitor the treatment possibilities, capacity and utilisation. Reliable data about the field is available from the drug treatment (TDI) and OST data collection, which are suitable primarily for describing the characteristics of the clientele. It is important to note that problem drug use and consequences of drug use (e.g. dependence, injecting drug use, problematic use, getting in the sight of the criminal justice system) make the users visible in data collections at different points of their drug carrier. Our treatment (TDI) data can provide a reliable picture primarily on clients starting outpatient treatment, its ability to describe inpatient treatment is limited. Our information on inpatient treatment is complemented by ad hoc studies conducted in the field.

On the basis of these sources, the most prevalent problems originate in cannabis use, most users start outpatient treatment because of this.

The spread of new psychoactive substances (hereinafter: NPS) could be first detected in drug seizures and NSP (needle and syringe programmes') data, followed by an increasing trend in clients entering treatment due to NPS use. The increase of NPS users in treatment data could be observed starting from 2010. Based on treatment data we can see that from 2014-2015 new treatment episodes associated with primary NPS use started to decline in the outpatient treatment setting. Nevertheless study results show that in certain groups (e.g. in injecting drug users, homeless people, children in specialised childcare and in residents of socially segregated areas) the use of NPS is still relatively prevalent. Studies of inpatient services providers also indicate that NPS use is the most typical reason of treatment in their

⁶⁰ Author of the chapter: Anna Péterfi

clientele. Besides, treatment data show the decrease in heroin use since 2009 and the relative stability of treatment demand linked to amphetamine use.

T1. NATIONAL PROFILE

T1.1 POLICIES AND COORDINATION

T1.1.1 Main treatment priorities in the national drug strategy

With respect to treatment provided for drug users, among its specific objectives the National Anti-drug Strategy 2013-20 (hereinafter Strategy) lists the establishment of an institution system that provides services for children and young people that meets their real needs, with national coverage and general access. The Strategy has set the objective of at least 20% of problem drug users and drug addicts being provided with treatment, and that the accessibility and national coverage of the institution system providing healthcare and social services to addict patients should be improved in general, and that by 2020 there should be a harmonised, comprehensive services system that uses common operation indicators in every district and active outreach techniques that search for clients and bring them into treatment. A further priority in the field of treatment and care services is that at least 80% of healthcare and social service providers should perform their activities on the basis of the related professional directives, and all of the service providers should be subjected to a clinical or social institution quality assurance audit.

The Strategy lays down so-called basic treatment organisation principles, the elements of which include the building onto one another of the various treatment services provided in different fields, the harmonisation of the professional content and territorial coverage of the services, transparent patient pathways between the various treatment types and institutions, as well as preventing clients from getting onto the wrong path, keeping them in treatment and monitoring them.

The Strategy builds on a recovery-oriented approach, the objective of which is the improvement and restoration of the client's health - building also on the clients' active personal participation, responsibility taking and mobilization of personal resources - as well as promoting reintegration into society. The Strategy views low-threshold services as being the first link in the entire treatment chain, which, combined with outreach activity, may help with finding hidden substance users and bringing them into treatment, and in the prevention, screening and reduction of infectious diseases. On the input side, from the first moment of entering treatment the approach and experiences of the twelve-step recovery programmes (NA, AA) also play a role in the professional programmes of the service providers.

T1.1.2 Governance and coordination of drug treatment implementation

The state healthcare and social systems are equally involved in the treatment of drug users. The treatment of drug users and the operation of the treatment system are coordinated and monitored by the *State Secretariat for Social Affairs and Social Inclusion* and by the *State Secretariat for Health* of the Ministry of Human Capacities (EMMI) with the help of its professional background institutions and consulting bodies.

The licensing of specialised (secondary and tertiary) medical addiction treatment services is the responsibility of the EMMI Vice State Secretariat for the National Medical Officer's

Service's Tasks. These services are covered from the budget of the National Health Insurance Fund Administration (NAEK). The primary and specialised social addiction services are licensed by the local government agencies and financed via the Hungarian State Treasury (MÁK) (except the low threshold services that are financed by the Hungarian Directorate-General for Social Affairs and Child Protection <SZGYF>). It is characteristic of both sectors that formally the treatment of drug users is not a separate category among the financed forms of treatment, instead they are handled as part of a wider patient group along with problem alcohol users, people living with addictions in general, or occasionally with psychiatric patients. In spite of this, there are some treatment centres that primarily target drug users in practice, however, with respect to their financing, this distinction cannot be recognised.

T1.2 ORGANISATION AND PROVISION OF DRUG TREATMENT

Treatment centres are maintained either by the state/local government, which provide either healthcare type treatment exclusively or both health treatment and social services, or by NGOs (including church organisations), which provide healthcare and social services as well or just the latter (Péterfi 2015). Preventive-consulting services available as an alternative to criminal procedure may be provided by either of the above service provider types, or by non-governmental for profit organisations (for further information on treatment as an alternative to criminal procedure see Chapter T1.2.2.).

For information in connection with the treatment of prisoners see Prison Workbook Chapter T1.3.2.

Outpatient network

T1.2.1 Outpatient drug treatment system

The financing categories relevant from the point of view of the outpatient treatment of drug users:

- outpatient health care treatment (on the basis of Decree 2/2004 (XI. 17.) of the Ministry of Health):
 - outpatient treatment for addiction
 - children and youth addiction treatment
 - psychiatric outpatient treatment
 - children and youth psychiatric treatment
 - psychotherapy
 - specialised psychology
- outpatient social services (primary care services) (on the basis of Act III. of 1993 on social administration and social services):
 - low threshold services for addicts
 - community care for addicts
 - day-care services for addicts

Apart from this, the preventive-consulting services used as an alternative to criminal procedure are financed separately but also from the social budget.

It is possible to distinguish between different profiles among drug treatment units. **Treatment centres with primarily a health care profile:** such are hospital addiction units and clinics, psychiatric units and clinics, as well as some of the specialised outpatient drug treatment centres (DTCs) characteristically operate as part of an institution with a state or local government background. **Treatment centres with a social profile** only receiving finance

from the social budget, are normally operated by NGOs or church organisations. **Treatment centres with a mixed profile** receive financing from both budgets, such as the outpatient DTCs operated by NGOs (Péterfi 2015).

Due to the categorisation of drug treatment as part of wider treatment categories, there are no precise numerical data available about the number of treatment centres actually treating drug users. Data on drug treatment units is available from the TDI data collection, which, on the basis of expert estimate, has a good coverage regarding the number of clients in drug treatment. This data is presented in the table below.

In 2017 a total of 67 treatment units reported new clients starting outpatient drug treatment out of the 86 treatment units reporting clients, excluding prison units. Altogether 90.7% (4365 persons) of the reported drug patients (4813 persons) started drug treatment in specialised outpatient drug treatment centres, in low threshold services or at general/mental health care units. Out of them, 3173 persons (72.7%) started treatment as an alternative to criminal procedure, most of them (2042 persons; 46.8% of all outpatient clients) in the scope of preventive-consulting services.

Table 10. *Network of outpatient treatment facilities (total number of units and clients in 2017)*

	Total number of units	National definition (treatment unit types)	Total number of clients
Specialised drug treatment centres	42	Service providers identifying themselves in the TDI data collection as outpatient treatment units (within this as a specialised DTC, addiction unit or other treatment unit) (characteristically specialised DTCs, outpatient addiction units and clinics, and other outpatient treatment units providing healthcare treatment or preventive-consulting services for drug users). Approximately 20% of these service providers provide OST.	3528 (out of which 2565 persons started treatment as an alternative to criminal procedure)
Low-threshold agencies⁶¹	23	Service providers identifying themselves in the TDI data collection as low threshold/drop-in/outreach units) (characteristically social service providers providing psychosocial services).	786 (out of which 557 persons started treatment as an alternative to criminal procedure)
General mental health care	2	Service providers identifying themselves in the TDI data collection as outpatient treatment units (within this psychiatric units) (psychiatric units and clinics operating in hospitals and clinics).	51 (out of which 51 persons started treatment as an alternative to criminal procedure)
Prisons (inreach and external service providers)	3 prison units and 3 external units providing services inside prison	Institutions also reporting on the treatment of prisoners in the TDI data collection (detention facilities and external service providers treating prisoners). The units providing outpatient and inpatient treatment are shown together in this table.	146 (out of which 134 persons started treatment as an alternative to criminal procedure)

Source: TDI data collection 2018–Standard table 24

⁶¹ and other treatment units with a primarily social profile

T1.2.2 Further aspects of outpatient drug treatment provision – Alternatives to criminal procedure

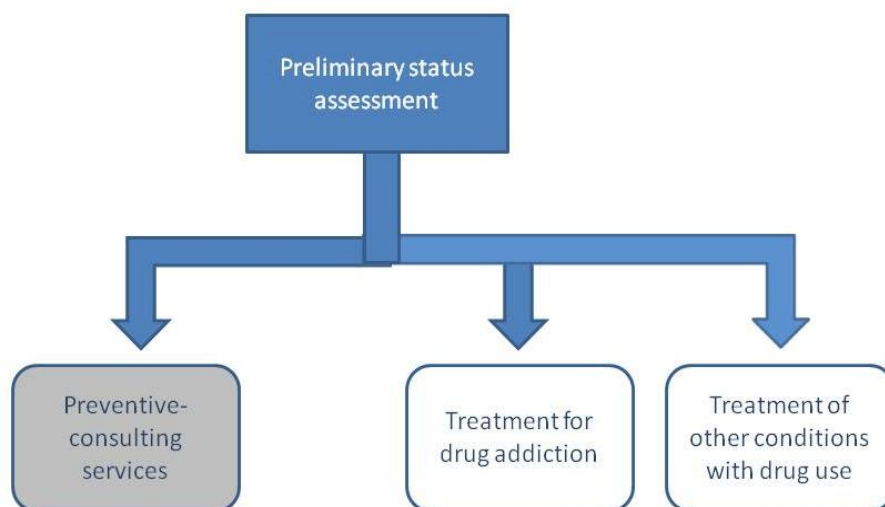
In the case of certain drug-related offences, the perpetrator has the opportunity of avoiding criminal procedure by participating in treatment/preventive interventions (referred to as QCT-quasi compulsory treatment), as long as the perpetrator complies with the following conditions:

- he/she produces, manufactures, acquires, possesses or consumes a small amount of illicit drug for personal use;
- he/she admits to committing the offence;
- he/she has not been found to be criminally liable in connection with drug possession or trafficking in the previous two years;
- he/she did not take part in treatment/preventive interventions in order to avoid criminal procedure in the previous two years. (Criminal Code Article 180)

Those choosing an alternative to criminal procedure are referred to a preventive-consulting service – which is more like indicated prevention interventions – or to a treatment programme⁶² by a psychiatrist or a clinical psychologist on the basis of a preliminary status assessment. The content of the treatment interventions is not specified, the healthcare service providers provide these services within the scope of regular outpatient or inpatient drug treatment programmes. The offender is required to participate in the preventive or treatment programme for at least 1.5 hours every two weeks for six months in order for the certificate of completion to be issued.

Based on TDI data, 68.6% of all clients entered treatment as an alternative to criminal procedure: 44.4% of all clients were referred to so-called *preventive-consulting services* and 24.5% to *treatment for drug addiction* or *treatment of other conditions with drug use*.

Chart 23. Types of treatment as an alternative to criminal procedure



When interpreting treatment data linked to QCT it is important to note that the primary drug recorded in the data collection does not necessarily correspond with the substance that was involved in the offence. Furthermore, due to the link between data reporting and funding in case of preventive-consulting services (and not in the case of non QCT treatment), it is presumable that QCT cases are overrepresented in the national TDI data collection.

For further information and data on QCT see Legal Framework Workbook, Chapter T1.1.1; Drug Market and Crime Workbook, Chapter T1.2.1.; Prison Workbook, Chapter T1.3.2.

⁶² as for the treatment the law distinguishes two types: 'treatment for drug addiction' and 'treatment of other conditions with drug use'.

T1.2.4 Inpatient drug treatment system

The relevant financing categories with respect to inpatient treatment programmes targeting drug users:

- inpatient health care treatment (based on Decree 2/2004 (XI. 17.) of the Ministry of Health):
 - active, chronic and rehabilitation inpatient addiction treatment
 - rehabilitation addiction treatment for children and youth
 - psychiatric, chronic and rehabilitation inpatient treatment
 - psychiatric rehabilitation treatment for children and youth
- social services (specialised services) (Act III of 1993 on social administration and social services):
 - institutions providing nursing and care for psychiatric patients and addicts
 - rehabilitation institutions for psychiatric patients and addicts
 - institutions providing temporary accommodation for psychiatric patients and addicts
 - residential homes for psychiatric patients and addicts
 - supported housing

In the case of inpatient units, there are treatment **units with** a primarily **health care profile** such as hospitals' addiction and psychiatric departments. Here the treatment is provided typically by psychiatrists, addiction specialists, clinical psychologists and specialised nurses. Traditionally and typically the programmes offered by hospital wards focus on the treatment of patients with psychiatric and alcohol problems, the treatment of drug users is less typical in these institutes. Partly due to difficulties of definition and partly because of the low level of treatment monitoring, no appropriate data is available to describe this form of residential treatment. Beside non-hospital based treatment there are also **mixed profile treatment units** which receive financing from both budgets. Therapeutic communities are organisational units that typically do not operate within the framework of the traditional system of hospital-healthcare institutes; they give a long-term therapeutic response to the multiple treatment demand of psychoactive drug users and patients suffering from behavioural addictions while living in a therapeutic community; and they are typically maintained by the church, NGOs or municipalities. These treatment units employ a multidisciplinary team and frequently recovering or recovered, qualified (addiction consultant, social worker, mental care worker) former substance users as well. They can also provide linkage to the twelve-step programmes.

A total of 3 therapeutic communities operate in the country with an under 18-year-old target group. Two of them admit boys only (on a capacity of 30 and 10 beds) and one admits both boys and girls (on a capacity of 15 beds). In the three treatment units the social services were financed in the scope of a model programme in the past years, its observations are described in T1.2.5. This new treatment type will be funded by individual grants by the ministry secretariat responsible for social affairs until the final funding scheme is developed, foreseeably till 2019.

As the majority of drug treatment interventions are categorised under professional codes that include the treatment of problem alcohol users and patients with psychiatric problems as well, there are no precise quantitative data available about the number of treatment centres actually treating drug users. Data on inpatient treatment services is available from the TDI data collection, with a low coverage. A total of 13 inpatient units reported clients entering inpatient drug treatment in 2017 (shown in the below table).

30.8% (93 persons) of the drug user clients starting inpatient treatment were treated in therapeutic communities with a mixed (social and healthcare) profile, and 69.2% (209 persons) were treated in hospital-based residential units. 6.3% (302 persons) of all clients entering treatment (4813 persons) started treatment in 2017 in the scope of inpatient treatment, 9 of them in the scope of QCT.

Table 11. *Network of inpatient treatment facilities (number of treatment units and number of clients in 2017)*

	Total number of units	National definition (types of treatment units)	Total number of clients
Hospital-based residential drug treatment	9	Treatment units identifying themselves in the TDI data collection as inpatient hospital addiction or psychiatric departments.	209 (out of which 9 persons started treatment as an alternative to criminal procedure)
Therapeutic communities	4	Therapeutic communities operating in a non-hospital based environment – drug therapy/drug rehabilitation institutes/homes identifying themselves in the TDI data collection as inpatient treatment units.	93 (out of which 0 persons started treatment as an alternative to criminal procedure)
Prisons	-	Inpatient and outpatient treatment units treating prisoners are shown together in Table 11.	

Source: TDI data collection 2017 – Standard table 24

For further information on therapeutic communities in Hungary see *Therapeutic communities facility survey* (Péterfi et al. 2016) in Chapter T4.1 of the 2016 National Report, and the results of an earlier study (Topolánszky et al. 2009) in the 2012 National Report, Chapter 11.

T1.2.5 Further aspects of inpatient drug treatment provision

For alternatives to criminal procedure see Chapter T1.2.2.

The number of addiction and psychiatric departments is significantly higher than those reporting to the TDI data collection, however only a proportion of them treat drug users, and it may be assumed that only some of these report data to the TDI data collection. Therefore there is no available data on the number of inpatient units providing drug treatment. The number of therapeutic communities on the basis of the latest focussed study was 15 (Péterfi et al. 2016), that increased by further 2 units since then (see Chapter T3.). To the TDI data collection only 4 therapeutic communities reported cases in 2017. All in all, it can be said that TDI data collection is moderately suitable for describing drug

users entering inpatient care because the coverage of data collection in the inpatient setting is low both in respect of treatment units and client numbers.

The operation of children and youth addiction rehabilitation institutes (Berényi et al. 2017)

A study in 2016 aimed to explore the operation of the three children and youth addiction rehabilitation institutes in the country. The purpose of the project was to investigate the professional activities of the service providers, to map the correspondence and differences in the operation of the units and to lay the foundations for the systematic establishment and funding scheme of this treatment modality (for methodology see chapter T5.2). The study, based on interviews, expert focus groups and document analysis, resulted in findings to be considered when developing the regulatory environment, financing and treatment chain associated with these services.

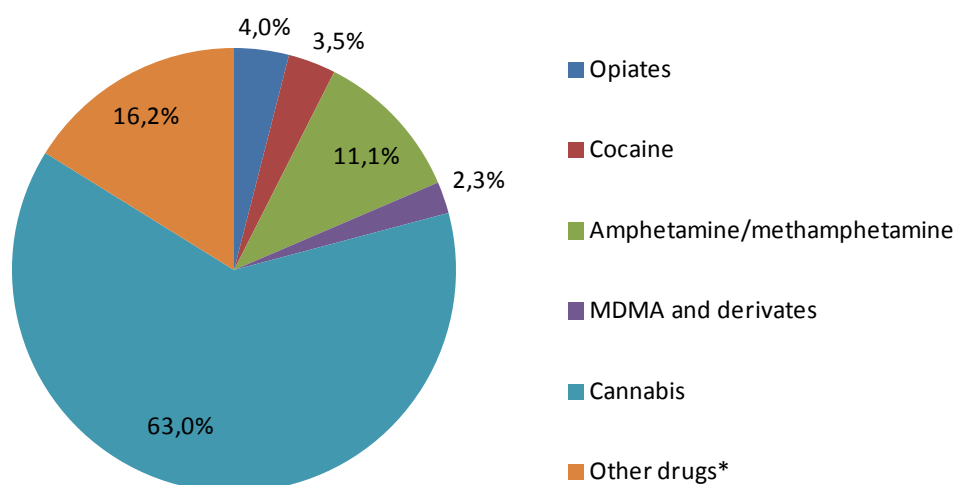
The results of the study suggest that the addiction rehabilitation treatment of children and youth has to be complemented with services that go beyond the minimum conditions set out in Decree 60/2003 (X.20.). The first years' experience of the studied three Hungarian service providers show that further human resources, professional and physical conditions are crucial for the proper operation of these services – in addition to those set out in the Decree – in order to ensure the necessary social and educational activities, the management of clients' criminal cases as well as to provide them with proper leisure activities. In order to develop and ensure these conditions and services, it is crucial to provide adequate funding for children and youth addiction rehabilitation institutes. Based on the units' experience, the institutions have no capacity to provide pre- and after-care, therefore they have to solve it by involving partner organisations. However, it is clearly necessary to establish and develop addiction outpatient and after-care reintegration services for children and youth so that these institutions do not function isolatedly in the health and social system but are embedded as part of a differentiated institutional system and treatment chain (Berényi et al., 2017).

T1.3 KEY DATA

T1.3.1 Summary table of key treatment related data and proportion of treatment demands by primary drug

The 86 treatment units providing drug treatment and reporting to the TDI reported a total of 4813 clients entering treatment in 2017. The majority (63.0%; 3031 persons) of those starting treatment due to drug problem – similarly to previous years – started a treatment programme because of cannabis use. 11.1% (534 persons) started treatment because of amphetamine (or methamphetamine) use. Opioid use was the reason for starting treatment in 4.0% (192 persons) of clients in drug treatment, and cocaine or crack use in case of 3.5% (167 persons). The proportion of primary ecstasy users was 2.3% (111 persons). Further 16.2% (778 persons) of treatment entrants indicated the use of 'other substances' as their primary substance was not categorisable in the above substance groups.

Chart 24. Breakdown of treatment demand by primary drug (2017; %; N=4813)



*"Other drugs" includes: "other stimulants", "inhalants", "hallucinogens", "hypnotics and sedatives" and "other non categorisable substances"

Source: TDI data collection 2018

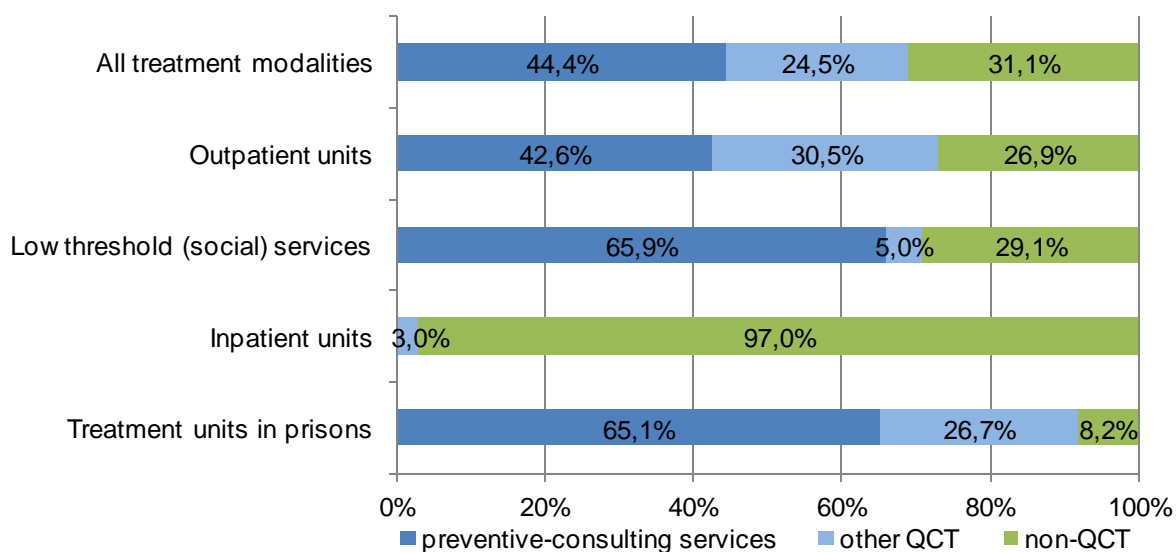
Table 12. Summary table – Clients in drug treatment in 2017 (persons)

	Number of clients
Total clients in treatment	no available data
Total OST clients	no available data (in 2015: 669)
All clients entering treatment	4813

Source: ST24 and TDI data collection 2018

Avoiding criminal procedure (QCT) was the most typical reason for entering treatment among drug users. With respect to all clients, 68.9% of them (3316 persons) entered treatment for this reason. It is important to note, however, that on examining the treatment unit types, significant differences can be observed in the proportions of those avoiding criminal procedure. While the majority of the clients of outpatient and low threshold (social) service providers started treatment in this way (73.1%; 2616 persons and 70.9%; 557 persons), only a very small fraction of those entering inpatient treatment (3.0%; 9 persons) started a treatment programme as an alternative to criminal procedure. Most of the prison clients (91.8%; 134 persons) started treatment as an alternative to criminal procedure according to reported data in 2017.

Chart 25. *The proportion of those starting treatment as an alternative to criminal procedure (QCT) among those entering drug treatment, by type of treatment unit (2017; N=4813)*

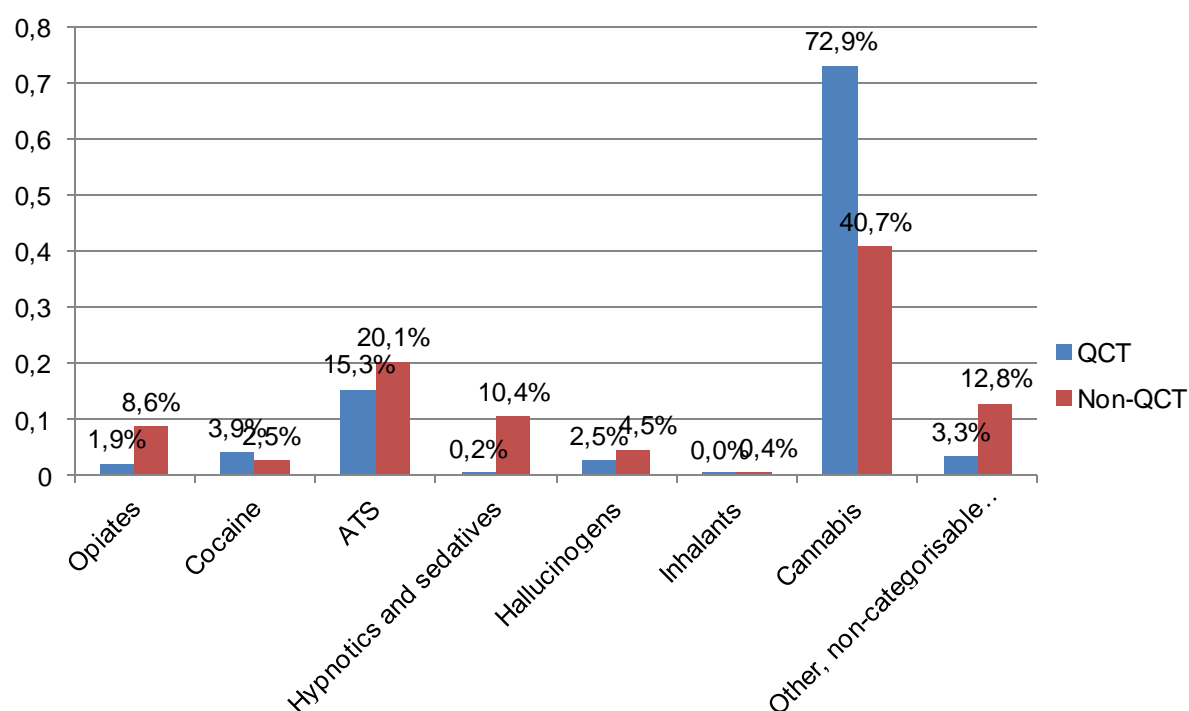


Source: TDI data collection 2018

The distribution according to primary drug shows a slightly different picture among those starting treatment as an alternative to criminal procedure (QCT) and those starting for other reasons. Cannabis (2417 persons, 72.9%) was the most prevalent primary drug among all clients starting QCT (3316 persons). That was followed by amphetamine type stimulants (507 persons, 15.3%). Proportion of all the other drugs remained under 12% (11.8%; 392 persons) among QCT clients.

Among non-QCT clients (1483 persons) cannabis use (40.7%; 603 persons) and amphetamine type stimulant use (20.1%; 298 persons) were the most frequent causes for treatment as well. Beside cannabis and ATS, 'other drugs' (that also covers NPS) and 'sedatives and inhalants' was associated with a remarkable treatment demand, above 10%. For more on treatment demand attributed to NPS use see Chart 11.

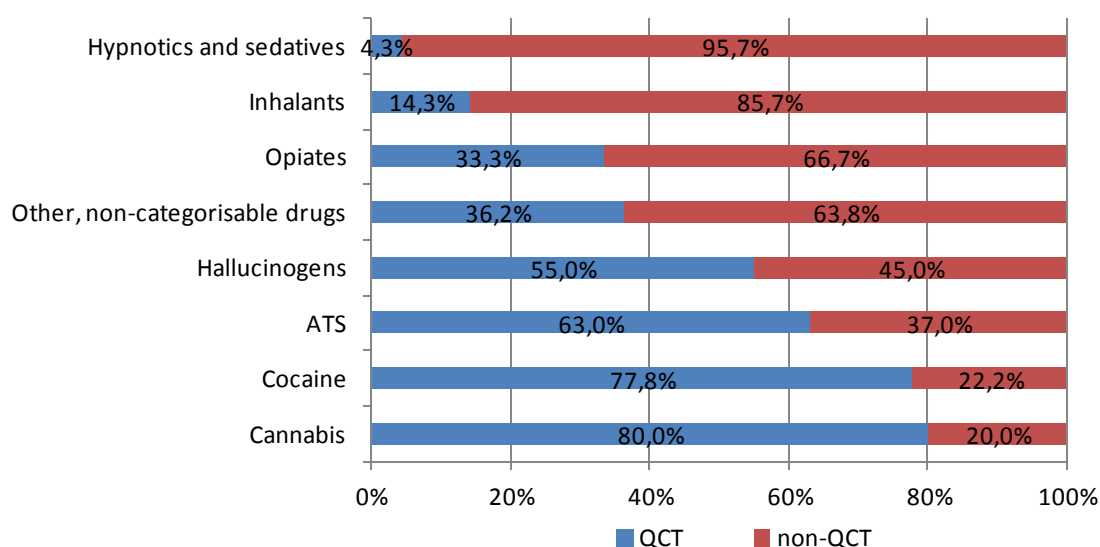
Chart 26. Breakdown of QCT and non-QCT treatment entrants by primary drug (2017; N_{QCT} clients=3316; $N_{Non-QCT}$ clients=1483)⁶³



Source: TDI data collection 2018

Proportion of clients participating in QCT shows significant variations within the different categories of primary drugs as well. While in the case of all drugs QCT clients stood for more than two-third of the cases (69.1%) their ratio was significantly higher among cannabis users, where four out of five cases (80.0%) started treatment as an alternative to criminal procedure. In the case of amphetamine type stimulant users this proportion was 63.0%, among opioid users 33.3% and among clients using 'other drugs' 36.2%.

Chart 27. Proportion of QCT and non-QCT clients among clients entering treatment by primary drug (2017; $N=4799$)

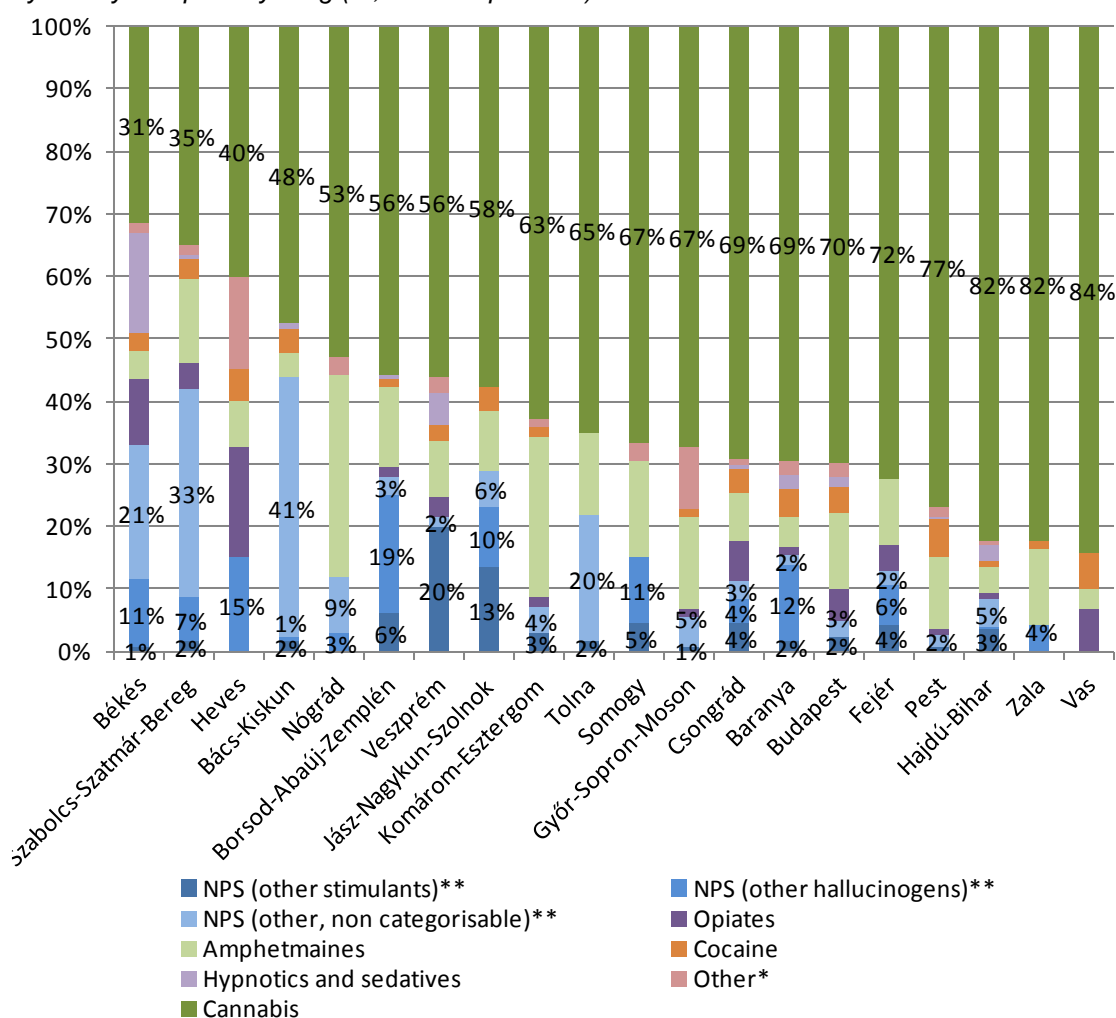


Source: TDI data collection 2018

⁶³ In case of 14 persons the source of referral was not known.

When looking at the geographical breakdown of outpatient treatment data (including clients of outpatient units and social services) by primary drug, can be said that although in all counties cannabis use is behind the greatest portion of treatment demand, yet the problem of cannabis use is less dominant in the eastern part of the country, compared to western counties. At the same time, more eastern, north-eastern counties are experiencing the expansion of new psychoactive substances' (NPS) impact in the treated population. Specifically, in Bács-Kiskun, Szabolcs-Szatmár-Bereg and Békés County, the use of NPS appears to be a major problem, as in these counties over 30% of treatment entrants are indicating the use of these drugs as a primary problem. The proportion of cannabis related treatment demand in the individual counties varied between 31% and 84% (their proportion in total outpatient data was 66.3%). Amphetamine is slightly behind NPS, which are associated with 11.5% of the treatment demand in the studied treatment units. Their proportion for each county ranged between 0% and 44% in 2017. 3-32% of clients (mean 10.8%) entered treatment due to ATS use at these unites. However, when interpreting this data it is important to consider that geographical data was recorded according to the location of the treatment facilities, some of which may accept patients from several counties.

Chart 28. Outpatient clients (including those in low threshold/social services) starting treatment in 2017 by county and primary drug (%; N=4365 persons)



*Other: MDMA and derivatives + LSD + inhalants

**The marked categories were linked to NPS use on the basis of a consultation with treatment units.

Source: TDI data collection 2018

T1.3.4 Characteristics of clients in treatment

For a more detailed description of the characteristics of clients entering treatment see Drugs Workbook/Cannabis, Chapter T1.2.2, Drugs Workbook/Stimulants, Chapters T1.2.2 and T1.2.5, and Drugs Workbook/Heroin and other opioids, Chapters T1.2.2 and T1.2.5.

For information on the characteristics of clients starting treatment in detention facilities see Prison Workbook, Chapter T1.2.2.

T1.4 TREATMENT MODALITIES

T1.4.1 Outpatient drug treatment services

For information available on outpatient drug treatment services see Chapter T1.2.1. For a detailed description of opioid substitution treatment see Chapter T1.4.7.

T1.4.3 Inpatient drug treatment services

For information available on inpatient drug treatment services see Chapter T1.2.4.

Opioid substitution treatment

T1.4.7 Main providers of opioid substitution treatment

OST is typically provided in the scope of outpatient treatment, but there are some service providers who provide this pharmacologically assisted therapy in the scope of inpatient treatment (in a hospital or therapeutic community). OST provider treatment units are characterised by a health care profile and are typically hospital addiction or psychiatric units or clinics, or specialised outpatient units with a mixed profile. In 2016 14 service providers provided this type of treatment. The last OST data collection was carried out in 2015 (on clients in treatment in 2015) with 8 units reporting data out of the 15 then operating units. (For the description of the data collection on substitution treatment see Chapter T5.2.)

Opioid substitution treatment practically is not available within the detention facilities, although the detention facilities are legally obliged to provide substitution therapy for prisoners who ask for it: in such cases they have to transfer those clients to external service providers with geographical obligations to provide OST. Occasionally clients may obtain the substitution medication during preliminary custody as long as the detention facility cooperates with the external treatment unit providing the therapy before detention. (See also: Prison Workbook, Chapter T1.3.4.)

T1.4.8 Number of clients in OST⁶⁴

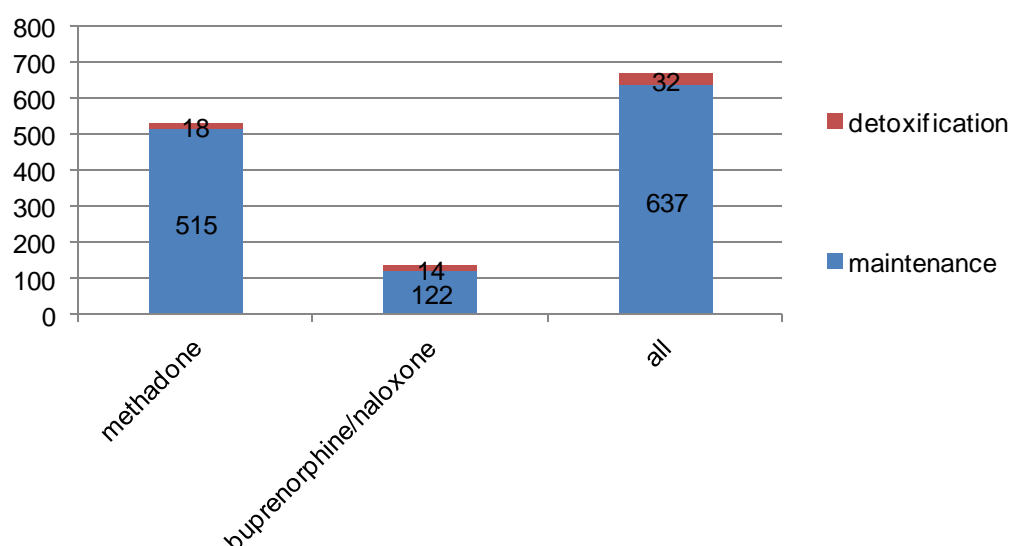
Two types of substitution medication are used in Hungary in OST programmes: methadone and buprenorphine/naloxone. Service providers participating in the national data collection on substitution treatment reported a total of 669 clients in 2015. Due to historical and financing reasons, the use of methadone is more widespread, typically $\frac{3}{4}$ of the annual

⁶⁴ The last OST data collection was carried out in 2015.

number of cases receive this substitution medication (533 persons in 2015, 79.7%), while approximately ¼ of the clients receive the buprenorphine/naloxone combination (136 persons in 2015, 20.3%). Buprenorphine/naloxone medication may be prescribed by any psychiatrist, whereas methadone is an 'institution drug' (acquisition and provision is done by the health service provider). Thus the buprenorphine/naloxone medication may appear in private health care, about which there is no information available.

95.2% of opioid substitution treatments (637 cases) in 2015 were maintenance treatments and 4.8% were detoxification treatments (32 cases). It is important to note that these two forms of treatment sometimes alternate, hence it is difficult to isolate them from each other. The relevant professional guidelines (The methodological letter of the Ministry of Health on Methadone treatment, for details see Chapter T1.5.1) specifies the length of detoxification treatment at between 1 and 6 months.

Chart 29. Breakdown of clients in OST by substitution medication and therapeutic purpose (2015; N=669)



Source: OST data collection 2016

T1.4.9 Characteristics of clients in opioid substitution treatment

In 2015 out of the total of 669 patients 75.9% (508 cases) were men and 24.1% (161 cases) were women. Mean age of the patients was 39.4 years without significant gender differences (men: 39.7 years, women: 38.4 years).

Vast majority of the clients (606 persons, 90.6%) had settled residence status. Nearly half of the clients (290 persons, 43.3%) were regularly employed. One-quarter of the clients (174 persons, 26%) reported 'other employment status', 20.9% (140 persons) were unemployed and 8.4% (56 persons) were inactive.

T1.5 QUALITY ASSURANCE OF DRUG TREATMENT SERVICES

T1.5.1 Quality assurance in drug treatment

Healthcare guidelines

Currently there are 3 protocols and one methodological letter in force in connection with the treatment of drug users:

- The methodological letter of the Ministry of Health – On methadone treatment,
- The professional protocol of the Ministry of Health – On the treatment of diseases related to opioid use,
- The professional protocol of the Ministry of Health – On the treatment of clinical conditions associated with amphetamine use, and
- The professional protocol of the Ministry of Health – On disorders related to cannabis use.

All three protocols were elaborated by the National Institute of Addictions primarily for specialists in psychiatry and addiction treatment. They are based on evidence and on professional consensus. The protocols contain the description of the disease, the process and recommended methods of diagnosing, treatment, rehabilitation and care and partly the indicators of efficiency. They need to be updated every two years.

The methodological letter is a guideline, which is much more specific than the protocols and exclusively describes the diagnostic and treatment processes and the indicators of efficiency.

A non specifically drug treatment guidelines, the *Professional Guidelines of the Ministry of Human Capacities on the treatment of pre- peri- and postnatal mental disorders in the integrated unity of the baby-mother-father* addresses the health care treatment of the drug user/dependent pregnant women (Health Gazette 2017)

Social guidelines

Presently there are three professional guidelines dealing with social services provided for patients with addiction problems:

- the 'Day-time care for addicts – Professional recommendation',
- the 'Low-threshold services provided for addicts – Professional recommendation'
- and the 'Community social care provided for addicts - Professional recommendation'.

The social guidelines were elaborated by the Specialised Workgroup of Addictions. The guidelines have no designated target group, their content is based on professional consensus⁶⁵. They describe the aims and guiding principles of the service, its quality assurance conditions and the activities covered by the service. In 2017, the revision of the above three professional guidelines was carried out with the help of EU funds in the field of addiction care (EMMI 2018).

For further information on the operation of the quality assurance system see 2010 National Report, Chapter 11. On the quality assurance of harm reduction interventions see also the Harms and Harm Reduction Workbook, Chapter T1.7.

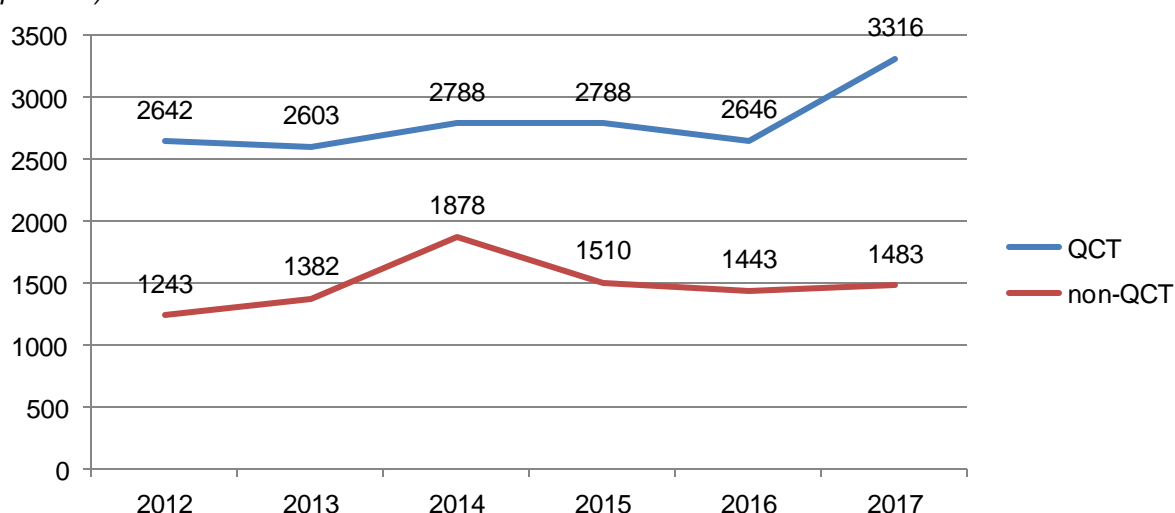
⁶⁵ Representatives of the field were consulted on the draft guidelines in the scope of a consensus conference.

T2. TRENDS

T2.1 LONG TERM TRENDS IN NUMBERS OF CLIENTS ENTERING TREATMENT AND IN OST

Among both first-time treatment entrants and all clients cannabis use is the most typical problem linked to treatment demand, especially among those starting treatment as an alternative to criminal procedure (QCT). The unique feature of the Hungarian treatment system already described above (see Chapters T1.2.2 and T1.3.1) is that the majority of clients start treatment in order to avoid criminal procedure. A certain proportion of these clients do not require addiction treatment, they are provided with a kind of indicated prevention intervention (the so called preventive-consulting service). A remarkable change is that the number of people who are being treated as an alternative to the criminal procedure (and their proportion within all treatment entrants) increased significantly from 2016 to 2017 (by 25.3%). The rise is probably attributable to the greater activity of the police, as there is a shift in the number of drug offenses as well (see section T1.2 of the Drug Market and Crime chapter for the related ENYÜBS data).

Chart 30. Breakdown of clients entering treatment by source of referral between 2012 and 2017 (persons)



Source: TDI 2018

In connection with the increased use of NPS, it is important to mention that until these substances are not scheduled in the lists of narcotic drugs and psychotropic substances and hence their use does not entail criminal liability the (infringement) procedures started in connection with them cannot be avoided by undertaking treatment (QCT), therefore, in this regard the regulatory background has an impact on 'treatment demand' trends.

One of the noticeable trends is the increase of 'other substances' from 2010 onwards considering the primary drug of treatment entrants. This phenomenon is obviously linked to the spreading of NPS. On the basis of the estimates of the outpatient and inpatient treatment units participating in the Hungarian National Focal Point 2015 treatment facility survey (Péterfi 2015), 26% of their clients treated for a drug problem demanded treatment because of synthetic cannabinoids and 21% because of a designer stimulant in 2014 (for details see the 2016 National Report, Chapter T4.1).

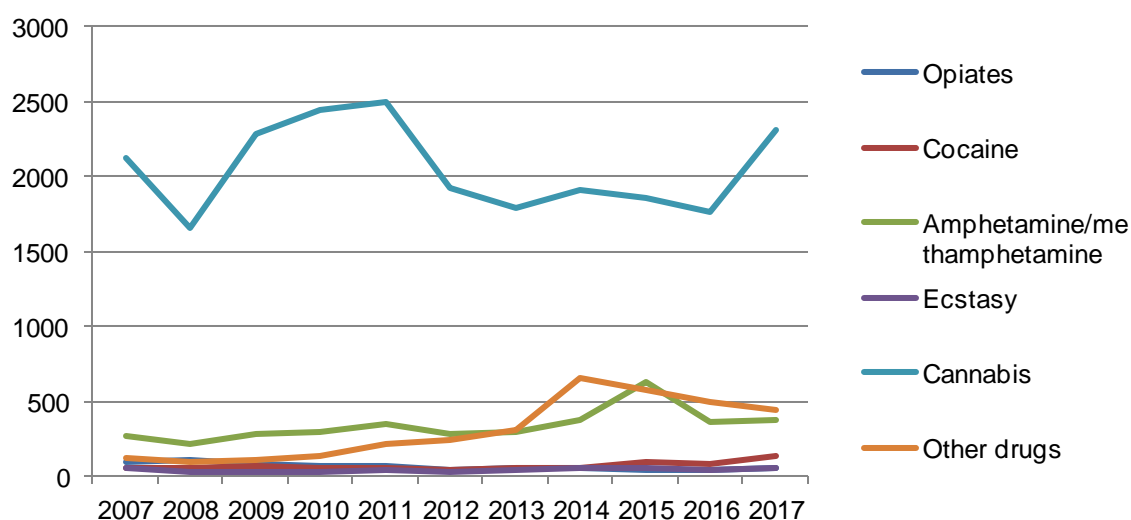
On the basis of a study on Hungarian therapeutic communities conducted in 2015 (Péterfi et al 2016), 43% of the clientele of these units reported having started treatment due to primary designer stimulants use and 27% reported the use of synthetic cannabinoids as the main problem. Therefore a total of 70% of therapeutic communities' clients were treated due to a

NPS use related disorder in 2014. This is confirmed by the study of Berényi et al. (2017), which was conducted at the three Hungarian youth rehabilitation institutes, examining their operation in 2016. The qualitative study found that clients in the three youth institutions appear in addiction rehabilitation programme mainly due to the use of new psychoactive substances, secondly to prescription medicines.

According to the national TDI data collection, among all treatment entrants, a decrease in treatment demands linked to opioids can be seen starting from 2009 (2009: 449 persons; 2017: 192 persons). In parallel, between 2009 and 2014, the number of new treatment admissions linked to 'other drugs'⁶⁶ (among them new psychoactive substances) increased (2009: 278 persons, 2014: 1137 persons), followed by a recession between 2014 and 2017 (2014: 1137 persons, 2017: 778 persons). The spread of NPS and a reduction in the availability of heroin can also be observed in the seizure data (see Drug Market and Crime Workbook, Chapter T2.1). There is no significant difference in the trends by primary substance regarding all clients and clients entering treatment for the first time in their lives due to the dominance of QCT. The main reason behind this is that QCT clients make up a large proportion of treatment data, and the fact that QCT clients typically enter treatment for the first time. Treatment demand associated with amphetamine use shows a different trend when comparing all and new (first time) clients. In case of new clients a slight increase could be observed between 2013 and 2015 in amphetamine use related treatment demand, while regarding all clients this demand remained relatively stable in this period.

It seems that the increase in the number of clients starting treatment as an alternative to criminal procedure went hand in hand almost exclusively with the increase of cannabis users entering treatment, meaning that increased police activity affected primarily cannabis, (based on seizures) typically marijuana users.

Chart 31. Trends in the number of clients entering treatment for the first time, by primary drug, 2007-2017⁶⁷

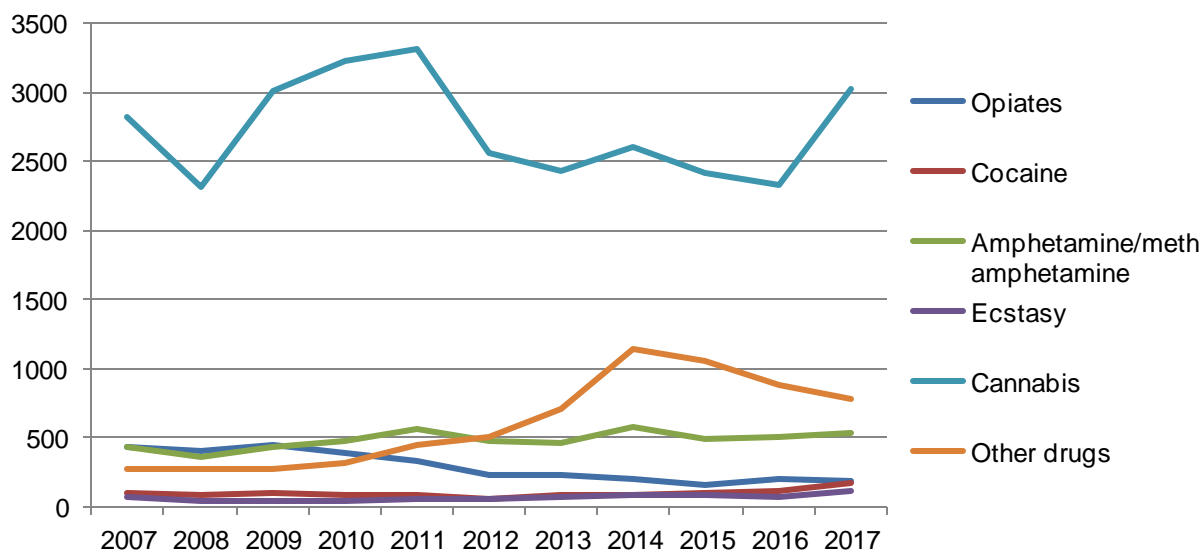


Source: TDI data collection 2018

⁶⁶ Other drugs: hypnotics and sedatives + inhalants + hallucinogens + other stimulants + other non categorisable substances.

⁶⁷ „Other substances”: „hypnotics and sedatives”, „inhalants”, „hallucinogens”, „other stimulants”, „other non categorisable substances”

Chart 32. Trends in the number of all clients entering treatment, by primary drug, 2007-2016⁶⁸



Source: TDI data collection 2018

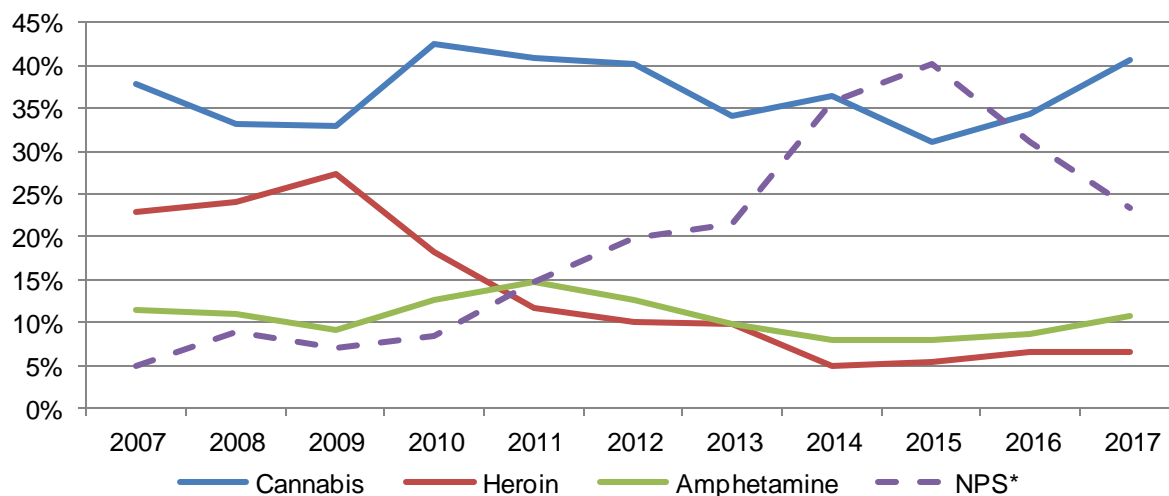
Although the increasingly growing treatment demand resulting from the use of NPS (primarily synthetic cannabinoids and designer stimulants) can be observed in the TDI data and other data sources (Péterfi 2016; Péterfi 2015; Csák 2012; Horváth et al. 2011), it is important to note that no specialised therapeutic possibilities are available for these user groups at the moment in Hungary. Therefore, the special needs linked to the use of NPS (including young people being affected, lack of motivation, more intensive use, more frequent need for emergency treatment) (GDS 2014; Csák 2012; Horváth et al. 2011) may remain unmet. Due to this, expert opinions suggest that this user group is probably underrepresented in the treatment data.

In those starting treatment on a voluntary basis (i.e. not in order to avoid criminal procedure), the proportion of treatment demand linked to new psychoactive substances⁶⁹ increased between 2009 and 2015 (2009: 8.5%; 2015: 40.1%). Between 2015 and 2017, however, there was a decline in treatment demand linked to new psychoactive substances (based on seizure data they are synthetic cannabinoids and synthetic cathinones,) (2015: 40.1%, 2017: 23.5%). In parallel, amphetamine and heroin-related treatment demand mildly increased (2.9 and 1.0 percentage points), while cannabis related treatment demand showed a strong increase (9.6 percentage points) in this group since 2015.

⁶⁸ Other substances": „hypnotics and sedatives", „inhalants", „hallucinogens", „other stimulants", „other non categorisable substances"

⁶⁹ Treatments started due to new psychoactive substance use may supposedly be reported under three categories in the TDI system (TDI v2.0). The category 'other stimulants' covers cathinones and other stimulants use, 'other hallucinogens' typically cover the use of synthetic cannabinoids, and 'other drugs (not classified)' may also be dominated by treatment demand for NPS use.

Chart 33. Trends in drug treatment demand by primary drug between 2007-2017 (among non QCT clients, showing the most relevant drug types⁷⁰)



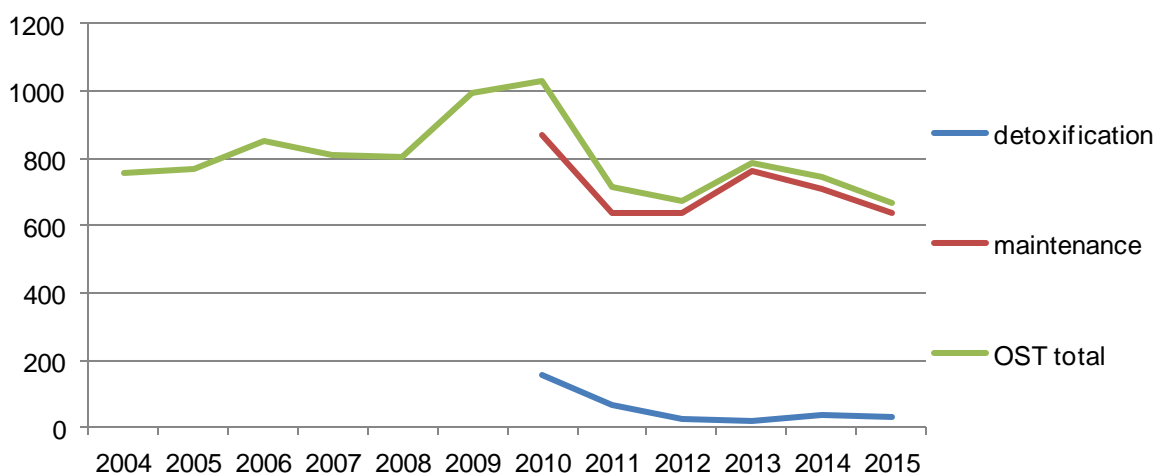
*Other stimulants, other hallucinogens, other non-categorisable substances
Source: TDI data collection 2018

Opioid substitution treatment (OST)

The number of those treated in OST was relatively stable over the studied years: there was a minor increase following 2008, which can be linked to the introduction of buprenorphine/naloxone (and the introduction of the possibility of self-financed treatment), then a development in the methodology of data collection (which provided the possibility of double counting control at the national level), which caused a decrease in 2011. In the number of clients a slow monotonous decrease can be seen since 2013 besides the stability of accessibility, that is supposedly connected to the significant setback of heroin market, and thus, to the relating decrease in treatment demand.

The reason for the relatively stable availability is that the treatment capacity financed did not change over the past years.

Chart 34. Trends in numbers of clients in OST, 2004-2015



Source: OST data collection 2016 – Standard table 24

⁷⁰ The chart excludes the trend line of „methadone“, „other opiates“, „cocaine“, „crack“, „MDMA and derivatives“, „inhalants“, „LSD“ and „hypnotics and sedatives users“, however it considers them in the calculation of percentages.

For the trends in injecting drug use see Drugs Workbook /Stimulants, Chapter T1.2.2 and T1.2.5, and the Health Consequences and Harm Reduction Workbook.

T3. NEW DEVELOPMENTS

Information regarding the changes in the drug treatment system are presented as part of the baseline information in Chapter T1.

T4. ADDITIONAL INFORMATION

T4.1 ADDITIONAL SOURCES OF INFORMATION

Drug use and treatment of girls in residential child care facilities (Kaló et al., 2017)

In 2017, a consensual qualitative study was carried out on the substance use of girls in residential child care facilities and the responses given to them. (For a detailed methodological description of the study, see chapter T5.2.) Within the framework of the research, individual and focus group interviews were conducted with a total 43 women, each living in aftercare programmes during the time of the interview. The interviewees were over the age of 18 and spent at least 2 years as a minor in residential child care facilities. The aim of the study was to explore the patterns of substance use, background of their drug use and the responses received. In addition to them, 24 professionals working in residential child care were also interviewed, also in the form of individual or focus group interviews, which, in addition to girls' drug use, also addressed the responses provided by the institutions concerned. Besides, gender differences in patterns of use and in respect of responses were also discussed in both samples.

Interviews with "girls" indicate that girls are in contact both with licit (tobacco, alcohol, medications) and illicit substances (drugs, new psychoactive substances). According to their reports typically the frequent use of tobacco, alcohol, cannabis and synthetic cannabinoids ('biofű') characterised the girls in residential child care facilities. Consumption of the more expensive drugs, due to the limited financial resources of the population, was less common among them. The expert interviews have partially confirmed this. According to them, the use of cheaper psychoactive drugs is widespread, in which smoking, the consumption of energy drinks and synthetic cannabinoids were included primarily. The use of alcohol and classical drugs is, in their view, rare, due to financial constraints.

As a cause of substance abuse typically traumas, crisis situations, parental problems and institutional abuse experienced in childhood (e.g. early entry, shifts between multiple care facilities/forms) were mentioned by the girls and experienced practitioners. According to practitioners, drug use typically starts prior to the provision of residential child care, as the previous environment of the child or family is also struggling with substance abuse (multi-generation drug use). According to practitioners, drug use is often linked to psychological problems and criminal behaviour. There are significant differences between institutional levels in residential child care. In average residential child care facilities drug problems are less prevalent, while in specialised facilities they are more likely to occur.

Regarding the perceptions of the problem and responses, girls believe that there is no systemic response to drug problems in these facilities. According to them, due to lack of professional skills and competence, drug problems are identified on an ad hoc basis. The

symptomatic treatment of the problem is the typical response, which mostly means calling the ambulance in case of intoxication.

The picture was enriched by the practitioners' interviews. In their opinion, their competencies are limited, and their employees are not prepared for the proper professional-patient relationship with a drug user. However, practitioners in specialised residential child care facilities are better prepared for the problem of drug use. Cooperation between residential child care facilities and drug treatment units are rare, typically based on the personal relationships and the professional network of the practitioners.

Long-term interventions and responses are reported to have two patterns. The first one is the deterrent approach, namely the application of some sort of punishment, with the secondary purpose of deterring others. However, this also affects the roles and behaviours of educators/practitioners, further strengthening the system, and also distancing the practitioner from the child. The other is a more attentive, supportive, empathic approach, the limitation of which is the above mentioned lack of competence.

Two practices can be identified in the acute treatment of drug use in residential child care facilities based on the interviews with practitioners. In one of the cases, it is typical that if the practitioner detects drug in the environment of the child, (s)he immediately calls an ambulance and/or the police. The other is that they do not call police, they take responsibility for the child, they try to find a solution to the problem themselves. This, however, places greater responsibility and frustration on practitioners working in the residential child care system.

One of the interesting findings of the study on gender differences is that girls are more likely to seek reinforcement and contact from outside the institution, therefore they typically use drugs outside the institution and their drug use is not related to their peers. In their case, the influence of a partner is more significant in the onset, development and secession of drug use. All this increases the suggestibility and vulnerability of girls to actors and factors outside the institutions. Practitioners working in co-ed facilities saw that peer relationships and community was stronger in case of boys, and it was more common to use drugs with peers. This difference also affects the effectiveness of interventions. According to practitioners, it is easier to involve boys in programmes and activities provided by the facility, while girls are harder to motivate.

The link between sex work and in general sexuality and drugs were mentioned both in interviews with girls and practitioners, in relation to the topics of vulnerability and the influence of partners.

Maternity is important to mention as well, which often occurs at an early age in the examined population. Falling pregnant is often followed by changes in drug use as they are typically willing to make more sacrifices for their children than for themselves.

An important topic was the role of day-offs (when children are allowed to visit their families) and escapes in the maintenance and treatment of drug problems. Both questioned groups believed that there was a close link between more severe substance use, sex work and time spent in escape. Institutions have limited tools to prevent escapes, while girls are particularly vulnerable (both to substance abuse and victimization) during the time spent outside the institution. According to practitioners, the time spent on leave (for family visit) is determining from the aspect of drug use, as girls may return to the traumatising, abusive, and/or drug-affected environment/family that reasoned her protection and displacement.

The role of family was mentioned not only in respect of leaves, but also as the influencer of the relationship between the practitioners and the girls, which, in the narratives it seemed, was less determining for boys.

The study identified the following necessary interventions in order to better prevent and treat the drug use of girls living in residential child care facilities, and to integrate them in society more effectively:

- Strengthening the basic care of the child protection system: the employment of specialists in the treatment of addiction problems, the integration of intensive family engagement and retention services into basic care.
- Strengthen the institutions for children with special needs, revision of the structure and displacement practices (foster parents instead of residential facilities).
- Monitoring drug-related incidents at the local level (sickness, pharmacological treatment, ER or police notifications, etc.).
- Strengthen and develop access to aftercare for girls with drug problem or other problems.
- Strengthen intra-professional co-operation: regular exchange of experiences between the employees of youth addiction institutes and residential child care facilities.
- Providing training for employees of the facilities and for foster parents providing information and practical tools to manage addictions and psychiatric problems.
- Ensure regular supervision and team meetings for practitioners working directly with girls.
- Establish institutional drug strategies, develop and clarify internal rules.
- Extending the availability of the addiction treatment system (providing different levels of care) for people living in rural areas too.
- Providing training on gender-sensitive methods in the scope of residential child care and addiction treatment (e.g. treatment of co-dependence as a risk factor of initiation of drug use).
- Promote and broaden access to trauma-therapies.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

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T5.2 METHODOLOGY

Berényi et al. 2017: Review of the operation of children and youth addiction rehabilitation institutes

In 2016, a study was carried out to map the operation and operational needs of the existing 3 children and youth addiction rehabilitation institutes in Hungary. The study consisted of a documentary analysis (professional programme and other professional documentations), interviews with clients (5 interviews per institution), interview with the head of the institution and focus group discussions involving the professional team working with the institution and the cooperating partners.

Kaló et al. 2017: Drug use and treatment of girls in residential child care facilities

In 2017, a consensual qualitative study was carried out on the substance use of girls in residential child care facilities and the responses given to them. The study was implemented with the funding of EMMI (application num. KAB-KT-16-25624). As part of the project, an information repository was prepared on institutions providing residential child care services in Hungary; a scientific review was prepared on gender differences in drug use; a research study was conducted among practitioners and clients of residential child care services; the institutional framework of national residential child care services was described based on a documentary analysis; and a tool was developed for the assessment of patterns of use, treatment and options for treatment in girls/young adult women living in Hungarian residential child care facilities.

In the scope of the research study individual and focus group interviews were conducted among clients and practitioners of residential child care facilities. The practitioners and clients were recruited from facilities located in Budapest, Veszprém and Baranya counties. Interviews were conducted between March and August 2017. Research planning, implementation and analysis of the data were carried out according to the rules of Consensual Qualitative Research. The interview thread of the individual, semi-structured interviews and the focus groups were thematically consistent within each studied group. A total of 43 clients were interviewed in the scope of individual or focus group interviews, all of them female and received after-care services at the time of the interview. The interviewees were over the age of 18 and spent at least 2 years as a child in residential child care facilities. Involvement in drug use was not among the inclusion criteria. The aim of the interview was to explore the patterns of substance use of the clients or their peers, the background of their substance use and the institutional responses to their problems. In addition to clients, 24 practitioners were also interviewed, also in the form of individual or

focus group interviews. Their interviews covered the pattern of drug use of the girls and the responses to these problems provided by the facilities.

OST data collection 2016

The OST data collection was coordinated by the National Centre for Addictions. Reporting the data is voluntary. OST providers report data to the National Centre for Addictions on a monthly basis, which is then assembled and analysed by the Hungarian National Focal Point. Double counting is controlled at national level therefore each client only appears once in the annual statistics (on the basis of the last report of the given year). The last OST data collection was carried out in 2016 on clients of 2015.

Péterfi 2015: Treatment facility survey 2015

The Hungarian National Focal Point carried out a study in May-June 2015 among service providers reporting large numbers of drug users entering treatment (Péterfi 2015). The purpose of the study was to map the Hungarian healthcare and social services targeting drug users: determining the treatment types available, the capacities, the operation circumstances of the treatment units, the institutional links and the main characteristics of the treated population. The service providers included in the study were those reporting the 30 largest numbers of cases in 2014 in the TDI data collection. 28 of the 30 service providers completed the online questionnaire, which was based on the questions of the European Facility Survey Questionnaire developed by the EMCDDA. For the description of results see National Report 2016, Treatment Workbook, Chapter T4.

Péterfi et al. 2016: Treatment facility survey in the therapeutic communities 2015

The Hungarian National Focal Point conducted a study among the therapeutic communities in Hungary (Péterfi et al. 2016). The questionnaire was based on the items and methodology of the European Facility Survey Questionnaire developed by the EMCDDA. The EFSQ was implemented and tailored to the Hungarian features and the target group. The 40-item online tool was self-administered, managers of the therapeutic communities were asked to participate. The aim of the study was to map the institutional characteristics of the therapeutic communities. After the administrative information questions on the institutional aspects (characteristics of the parent institution, capacity of the therapeutic institution), the target group (number of clients and their characteristics, inclusion criteria), staff, quality assurance and service provision (therapeutic programme, parallel health services, waiting lists, cooperations, changes of target group) were included. Some of the questions covered the entire previous year (2014), others referred to the day of the completion of the questionnaire. For the description of results see National Report 2016, Treatment Workbook, Chapter T4.

TDI data collection 2018

The TDI (Treatment Demand Indicator) data collection was coordinated by the National Centre for Addictions until April 2017, and the data were processed and analysed by the Hungarian National Focal Point. On the basis of Ministry of Health, Social and Family Affairs decree 76/2004. (VIII. 19.), Hungarian service providers must report every drug user who enters treatment to the TDI. The data collection questionnaire was developed in line with the guidelines of the TDI 2.0 protocol (EMCDDA 2000). The data is collected using anonymous identifiers, so duplication can be controlled in the annual statistics – in other words one person appears just once in the data per year. In the report the category of “clients starting treatment as an alternative to criminal procedure” (or “quasi compulsory treatment” - QCT) refers to those who reported to be referred to treatment by “court/probation/police”. For further details see the protocol (EMCDDA 2000).

HARMS AND HARM REDUCTION⁷¹

T0. SUMMARY

Overview of drug related harms

With respect to drug-related deaths, over the past 10 years in Hungary there have been some 20–30 deaths per year directly related to overdoses. The annual fluctuation in the number of deaths before 2010 was mainly due to the purity of street heroin. The drastic fall in the availability of heroin in 2010 also caused a drop in the number of deaths linked to this substance. The falling tendency after 2011 was counterbalanced in 2012 and 2013 by the rise in the number of deaths linked to NPS. In 2014 the number of deaths linked to opioids rose slightly. Although the change occurring in the substance structure overall did not cause any change in the number of deaths in 2015, some increase could be observed in the number of cases in 2016 and then in 2017.

There is no detailed statistical data on clinical toxicology treatment provision available. Anecdotal information refers to high number of treatment demand associated with the use of synthetic cannabinoids both in 2016 and 2017.

In the case of drug related infectious diseases, during the national HIV/HBV/HCV seroprevalence survey being carried out since 2006, in 2014 persons infected with HIV were found for the first time among the tested PWID (2 persons, 0.3%). In 2015 one person tested positive for HIV (0.2%). The national HCV prevalence rate among PWID was about 25% up to 2011, however, this figure turned to be 48.7% in 2014, which is twice the national HCV prevalence value measured in the previous years. In 2015 a similar proportion, 49.7% of the national sample tested positive for HCV. Before NPS became so widespread, HCV prevalence was usually significantly higher among those injecting opioids. This then changed: in 2011 a higher HCV prevalence rate was found among those primarily injecting stimulants (amphetamine or designer stimulants), while the national prevalence rate had not changed yet. In 2014 HCV prevalence doubled both among opioid and stimulant injectors. Research results show that doubling of the HCV prevalence can be largely attributed to the dynamic increase of high-risk NPS injecting and in the meantime steep decrease of needle and syringe programmes' (NSP) availability. In 2015 HCV prevalence broken down by primary injected substance was similar to the prevalence values measured in 2014. Trend analysis should be carried out carefully due to the change in testing sites during the 2015 survey. (see: T1.3.6).

Overview of harm reduction services

In the field of responses, the number of syringes distributed by NSPs rose sharply in 2011 as compared to the previous years, the cause of which was the spread of NPS starting in 2010, as these substances are injected much more frequently than classical illicit drugs. The increasing trend lasting until 2011 was stopped in 2012 by the decrease in resources, when in spite of the increasing syringe demand due to the new substance use patterns, the organisations distributed about 220,000 less syringes. Although as a result of one-time ministerial supports the number of distributed syringes increased until 2014, however, their number was still well below the data measured in 2011. Contrary to the change in the number of distributed syringes, the number of clients attending NSPs, or the number of contacts showed a steep rise after 2012. It can be assumed that clients compensated for the restricted availability of sterile syringes per contact with a larger number of appearances and

⁷¹ Authors of the chapter: Gergely Csaba Horváth, Anna Tarján

with the involvement of peers not attending NSPs before. Due to the closure of the two largest NSPs in Hungary, the syringe and client turnover significantly further decreased in 2015 at national level. The downward trend in 2016 and 2017 was moderate but continued, mainly attributed to the closure of further programmes, capacity problems at Budapest-based NSPs and changing patterns among people who inject drugs (more hidden injecting drug use due to increased presence of the police, increasing synthetic cannabinoid use (smoking), increasing inhaling (foil) of injectable substances.)

T1. NATIONAL PROFILE

T1.1 DRUG-RELATED DEATHS

T1.1.1 Overdose deaths

Direct drug-related death cases

In 2016 33 deaths directly related to drug use were reported to the Special Registry of drug related deaths, which means 2017 was a year with a higher number of deaths similarly to 2013 (2016:29; 2015: 25; 2014:23; cases)⁷². Of the 33 deaths, in 1 case the deceased was female. (ST5_2018_HU_01)

There were no cases with a clear evidence of intention to commit suicide in 2017.

Table 13. *Breakdown of direct drug-related deaths in 2017 by gender and substance type (persons)*

	male	female	total
intoxication caused by opioids and other substances ⁷³	9	0	9
overdose/intoxication caused by methadone (without other drugs) ⁷⁴	1	0	1
intoxication caused by other, non-opioid drugs	11	1	12
intoxication caused by other substances ⁷⁵	11	0	11
total	32	1	33

Source: NFP 2018

Among cases of fatal overdose, the mean age of the males was 31.2 years, together 31.3 years. Mean age of deaths linked to opioids was 32.9 years, mean age of non-opioid cases was 32.7 years. Compared to these, mean age of cases linked to other substances (new psychoactive substances) was slightly lower, 29.7 years.

10 cases (30.3%) belonged to the 30-34 age group, a further 9 cases (27.3%) belonged to the 25-29 age group. Only four cases were registered over 40 years of age. Although due to low number of cases it can only be stated with care, there seems to be a decrease in the mean age of the fatal cases – presumably in relation to the increase of the proportion of new psychoactive substances.

⁷² The cases linked to tramadol were excluded.

⁷³ Beside opioid metabolites (morphine) other substances may also occur, including methadone also, but cases linked exclusively to methadone were excluded.

⁷⁴ Beside the occurrence of alcohol and/or benzodiazepines.

⁷⁵ With the exclusion of psychoactive substances and medicinal products not classed as illicit drugs.

Table 14. *Breakdown of direct drug-related deaths by age group and substance type in 2016 (persons; N=33)*

	15- 19	20- 24	25- 29	30- 34	35- 39	40- 44	45- 49	50- 54	55- 59	>=60	total
overdose/intoxication caused by opioids (without methadone and other substances)	0	0	0	0	0	0	0	0	0	0	0
overdose/intoxication caused by opioids and other substances	0	0	4	2	2	0	0	0	1	0	9
overdose/intoxication caused by methadone	1	0	0	0	0	0	0	0	0	0	1
intoxication caused by other, non-opioid drugs	0	1	3	4	2	1	1	0	0	0	12
intoxication caused by other substances	2	1	2	4	1	0	1	0	0	0	11
total	3	2	9	10	5	1	2	0	1	0	33

Source: NFP 2018

Of the 33 deaths 14 persons (37%) – including one female – were residents of Budapest. In three cases the deceased were homeless people, in one case the deceased was the citizen of another EU country.

Indirect drug-related deaths

In 2017 46 indirect drug-related death cases were reported to the special registry of drug related deaths. Among the deceased, 42 were male and 4 were female.

Among the cases, 7 deaths could be traced back to a natural cause related to previous drug use. In one case a criminal act (homicide by poisoning) was conducted with an illicit drug, in 3 suicide cases fentanyl of medical origin – controlled as illicit substance – was detected in the biological samples. In the further 35 cases violent deaths – mostly suicides, some fatal traffic accidents – were reported where the victims had biological samples positive to illicit drugs.

T1.1.2 Toxicology of overdose deaths

There was no death exclusively related to heroin use in 2017 either. The polydrug use of an opioid and other illicit drug was fatal in 9 cases. All of the cases linked to opioids were related to polydrug use, typically other 3-4 substances could be identified in the biological samples of the deceased: typically methadone, a medication applied in OST and codeine.

The forensic medical specialist determined fatal intoxication only due to methadone in one case, in further 4 cases other substances were also detected beside the OST medication.

There were 12 cases of death caused by other, non-opioid illicit drugs (20 in 2016). The most frequent substances detected in the cases of this category were amphetamine (5 occurrences), ecstasy metabolites (4 occurrences), synthetic cathinones (4 occurrences), cocaine (4 occurrences) and synthetic cannabinoids (2 occurrences). New psychoactive substances that are under legal control (as psychotropic substances) are classified under the category of 'non-opiate drugs'.

11 cases (33.3%) fall under the category of 'other drugs', that covers new psychoactive substances that were not under legal control (as psychotropic substances) at the time of the death: typically the concurrent use of synthetic cannabinoids and synthetic cathinones. New psychoactive substances – regardless their legal status – were detected in 14 deceased people (42.5%; in 2016: 45%). The most frequently detect NPS were ethyl-hexedrone and ADB-FUBINACA. Other detected NPS were: 5F-ADB, Cumyl-PeGaClone, 5F-MDB-Pinaca, AMB-Fubinaca and 4-CEC.

There were blood alcohol tests taken in 28 out of the 33 cases, 11 were found positive. Track of injecting were found in 15 cases by the forensic pathologists.

Table 15. *Number of direct drug-related deaths in 2017*⁷⁶

	total
overdose/intoxication caused by opioids (without methadone and other substances)	0
overdose/intoxication caused by opioids and other substances	9
overdose/intoxication caused by methadone ⁷⁷	1
intoxication caused by other, non-opioid drugs	12
intoxication caused by other substances	11
total	33

Source: NFP 2018

T1.1.4 Trends of drug induced deaths

Before the appearance of new psychoactive substances in 2010, direct drug-related deaths were typically linked to opioid use, more specifically, to heroin use. The variation in the number of deaths per year was primarily caused by the changes in the purity of street heroin. In parallel with the drastic reduction of the availability of heroin starting from 2010, the number of deaths linked to this substance also dropped. At the same time the number of deaths linked to methadone showed a slow rise in this period. Methadone was also present in samples taken from the deceased in 2017, typically accompanied by other opioids as well.

Since 2012 the use of the new psychoactive substances can also be seen in the biological samples of the diseased. Initially it was mephedrone, and then later it was MDPV, pentedrone and 4-MEC that could be associated with a number of deaths. Occasionally, the appearance of certain, especially dangerous new psychoactive substances was linked to several deaths: in 2012 the use of 5-API, and in 2013 the use of 4,4'-dimethylaminorex (4,4'-DMAR) caused the death of several persons. In 2014 no especially dangerous NPS appeared that could have caused the deaths of several people, typically α -PVP and synthetic cannabinoids were detected. In 2015 there were several occurrences of α -PHP in biological samples, beside pentedrone and α -PVP, synthetic cannabinoids were not detected this year.

In 2016 ethyl-hexedrone was the NPS detected with the highest occurrence (5 cases), but α -PVP (in 4 cases) and pentedrone (in 3 cases) were also detected in several cases. Among synthetic cannabinoids AMB-FUBINACA was detected in 2 cases and further 9 different synthetic cannabinoids were detected in 1-1 case each (sometimes more than one compounds within a sample).

In 2017 cocaine or its metabolites were detected in five cases. The most frequently (13 out of the 33 cases) identified substances were novel synthetic cannabinoids and ethyl-hexedrone was also prevalent (6 cases) just as in 2016.

⁷⁶ Special register Selection D.

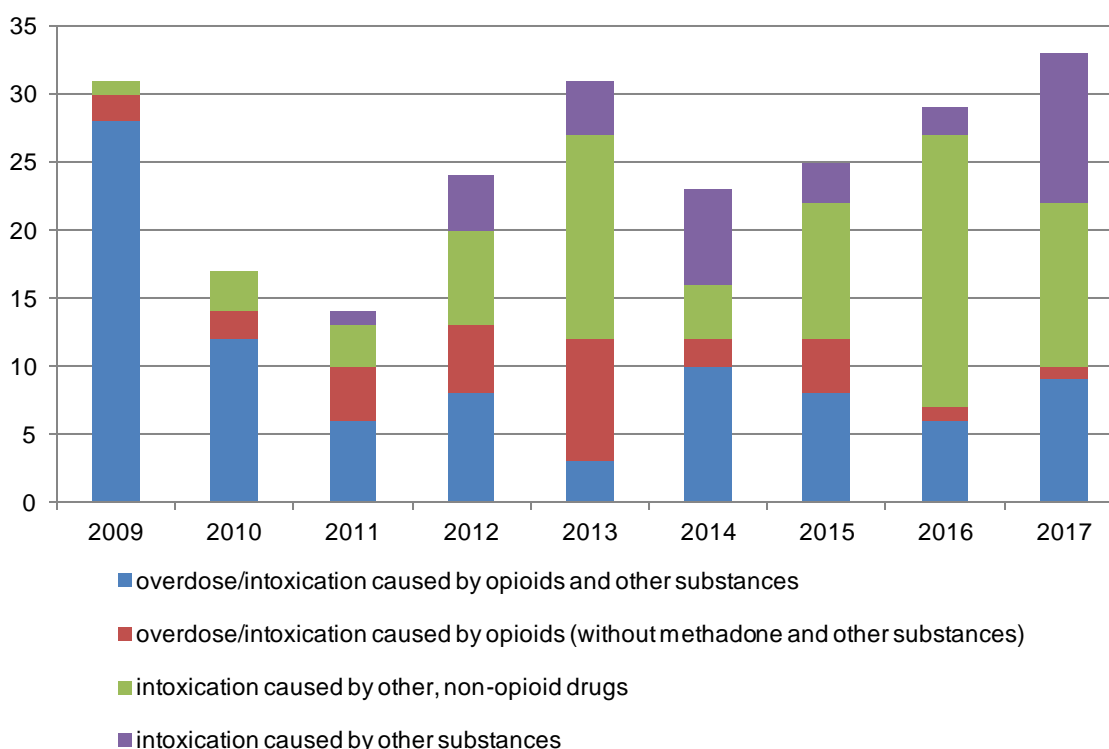
⁷⁷ Beside the occurrence of alcohol and/or benzodiazepines.

The role of NPS in the cause of death could not be clearly determined due to polydrug use and the limited pharmacological knowledge.

The substance use patterns of the deceased people include injecting use and polydrug use, frequently methadone and a benzodiazepine were detected in the biological samples in addition to other illicit drugs, as well as alcohol.

Overall, the decreasing tendency explained by the drop in heroin use after 2011 was counterbalanced by the rise in the number of deaths linked to new psychoactive substances in 2012 and 2013. In 2014 the number of deaths linked to opioids, primarily heroin, rose slightly. In 2016 a significant increase could be observed in the number of deaths linked to other, non-opioid substances (including new psychoactive substances classified as illicit psychotropic substances).

Chart 35. Breakdown of direct drug-related deaths, between 2009-2017 (persons)



* Beside opioid metabolite (morphine) other substances may also occur, including methadone, but cases exclusively linked to methadone were excluded

** Beside the occurrence of alcohol and/or benzodiazepines
Source: NFP 2018

T1.2 DRUG-RELATED ACUTE EMERGENCIES

There is no systematic, national level data collection performed in Hungary about non-fatal intoxications related to drug use.

T1.3 DRUG-RELATED INFECTIOUS DISEASES

T1.3.1 Main drug-related infectious diseases among injecting drug users – HIV, HBV, HCV

Notifications

In 2017 a total of 223 newly diagnosed HIV-positive cases were reported in Hungary, the incidence rate was 22 cases/1 million population. The transmission route was known in the case of nearly 60% of the registered HIV positive persons. Among the HIV-positive cases and AIDS patients belonging to the identified risk groups, one person belonged to the risk group of injecting drug users (PWID – people who inject drugs). (Personal communication, Dudás 2018)

Table 16. Breakdown of registered HIV-positive persons (N) by risk group between 2012-2017

	2012	2013	2014	2015	2016	2017
homo/bisexual	146	160	171	133	117	110
heterosexual	23	24	28	21	28	22
haemophiliac	0	0	0	0	0	0
transfusion cases	1*	0	0	0	0	0
PWID	0	1*	1	2	3	1*
nosocomial	0	0	0	0	0	0
perinatal	1	1	1	2	1	2
unknown	48	54	70	113	79	88
total	219	240	271	271	228	223

* Imported cases

Source: EMMI, Department of Hospital Hygiene and Epidemiological Surveillance (personal communication, Dudás 2018)

In 2017 42 cases of acute hepatitis B were reported, the incidence rate was 0.4‰. The transmission route was known in the case of 5 patients among whom two males over 35 belonged to the risk group of PWID.

In 2017 11 cases of acute hepatitis C were reported, the incidence rate was 0.1‰. Among the 11 patients, the transmission route was known in 3 cases among whom a female aged under 25, and two males between the age of 25 and 34 became infected via injecting drug use. (Personal communication, Dudás 2018)

HIV/HBV/HCV prevalence among PWID

National HIV/HBV/HCV seroprevalence survey (2015)

Of the 596 PWID tested in the national HIV/HBV/HCV seroprevalence survey (Dudás et al. 2015), 452 (76%) were males and 144 (24%) were females. Among the three age groups (<25, 25-34, 34+) the age group above 34 represented 49% of the study participants, the 25-34 age group represented 39%, the smallest group (12%) was formed by participants below 25 years. For injecting patterns see: Drugs Workbook/Stimulants, Chapter T1.2.1 and Drugs Workbook/Heroin and other opioids, Chapter T.1.2.1.

HIV

On the basis of the HIV/HBV/HCV seroprevalence survey in 2015, 1 male out of the 596 persons tested HIV-positive (0.2%), he belonged to the 25-34 age group. He had last injected within the past 4 weeks prior to the survey and reported 'penta crystal' as his primarily injected substance. (ST9P2_2016_HU_01)

HBV

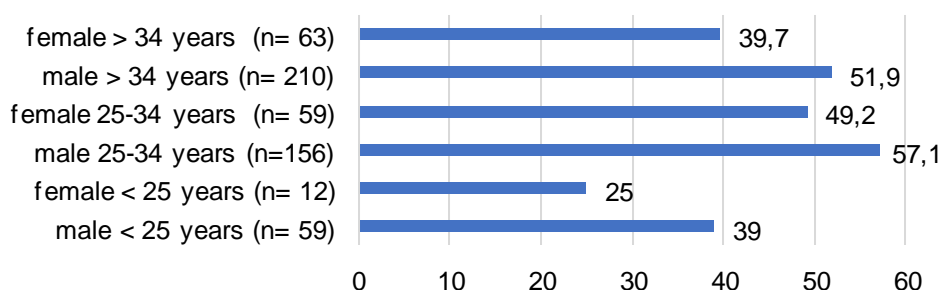
During the national HIV/HBV/HCV prevalence survey conducted in 2015, 13 persons (2.2%) tested positive for the hepatitis B surface antigen among 596 tested PWID. 12 of the 13 HBV positive persons were also HCV antibody positive at the same time, while in case of one person the HCV result was inconclusive. (ST9P2_2016_HU_02)

HCV

The laboratory tests for HCV gave a conclusive result in 559 cases (see Chapter T5.1). Among them 278 persons tested positive for hepatitis C antibodies (49.7%) (ST9P2_2016_HU_03). Among current PWID injecting in the past 4 weeks prior to the survey (365 PWID), 60.3% tested positive for hepatitis C antibodies.

The difference between the prevalence rates of HCV infection among males and females (52.0% and 42.5%) was not significant. The HCV prevalence rates of males in the 25-34 age group and above the age of 34 were in excess of the average prevalence rate. Apart from this it is important to mention that the HCV prevalence of young male PWID below the age of 25 was over 39%.

Chart 36. Breakdown of HCV prevalence (%) among PWID tested during the national HIV/HBV/HCV seroprevalence survey, by gender and age group in 2015



Source: Dudás et al. 2015

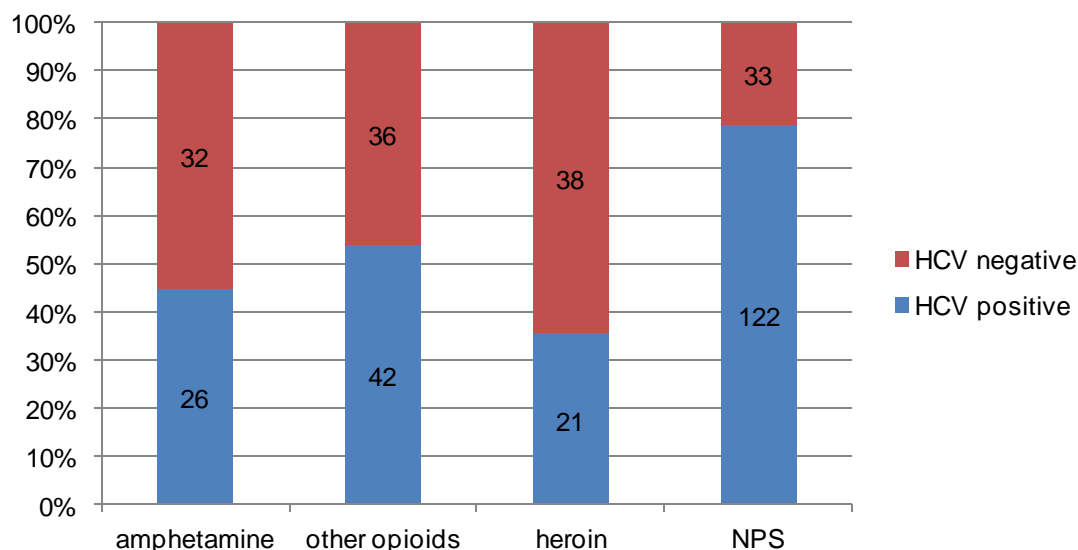
HCV prevalence rates higher than the national average were measured among those injecting for 5-9 (59.3%) and those injecting for more than 9 years (52.2%). The prevalence of HCV among those injecting for less than 2 years was 31%, and 47.5% among those injecting for 2-4 years.

HCV prevalence rate among those primarily injecting non-opioids⁷⁸ was 56.8%, while it was 39.5% among PWID injecting primarily opioids. (ST9P2_2016_HU_03)

Selecting current PWID from the total sample – those who are the most exposed to virus acquisition and transmission – it can be seen that the rate of HCV infection was the highest among those injecting NPS (78.7%). For further data on injecting patterns see: Drugs Workbook/Stimulants, Chapter T1.2.5 and Drugs Workbook/Heroin and other opioids, Chapter T.1.2.5.

⁷⁸ non opioids: new psychoactive substances ('penta crystal'; MDPV; mephedrone, 'bio'; other designer drug; 'music'), methamphetamine, amphetamine, MDMA, cocaine, other.

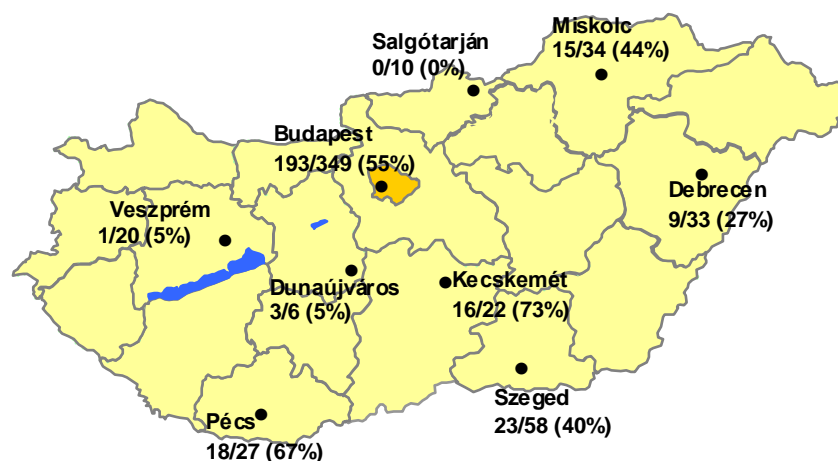
Chart 37. Breakdown of HCV prevalence among current PWID tested during the national HIV/HBV/HCV seroprevalence survey by primarily injected drug in 2015



Source: Dudás et al. 2015, analysed by HNFP

As regards geographic distribution, 193 of the 349 samples from Budapest proved to be hepatitis C positive, which means a 55.3% rate of infection (ST9P2_2016_HU_04). As opposed to this, 40.5% of the samples coming from outside Budapest were tested hepatitis C positive (85 of the 210 samples) (ST9P2_2016_HU_05). Outside of Budapest the highest HCV prevalence rates were measured in Kecskemét (72.7%) and Pécs (66.7%).

1. map Number of HCV tests and HCV prevalence during the national HIV/HBV/HCV seroprevalence survey by city, 2015



Data source: Dudás et al. 2015; map: HNFP

Trends: HIV/HCV prevalence among PWID

HIV

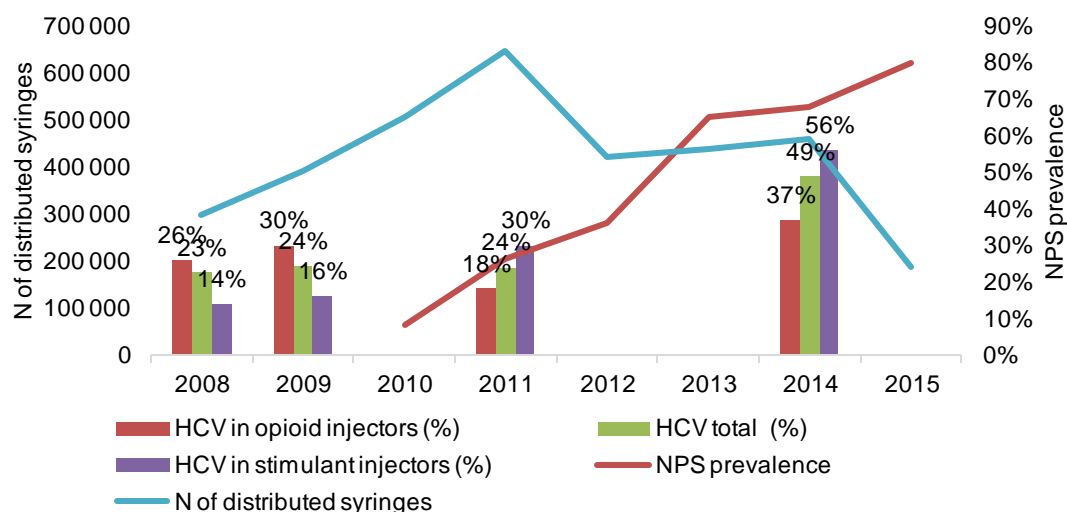
During the national HIV/HBV/HCV seroprevalence survey series carried out among PWID since 2006, it was in 2014 for the first time that persons tested positive for HIV (2 persons; 0.3%), while in 2015 one person tested positive (0.2%). The HIV positive person – on the basis of the anonym individual identification code – is one of the two positive cases identified in 2014.

HCV

With respect to primarily injected substances, a restructuring has been visible since 2010 in PWID: the proportion of those injecting stimulants, primarily NPS has risen from year to year. (For further data on injecting patterns see: Drugs Workbook/Stimulants, Chapter T1.2.5.) According to the national HIV/HBV/HCV seroprevalence survey data, before 2011 the proportion of opioid injectors was higher in the sample than that of stimulant injectors (see: Drugs Workbook/Heroin and other opioids, chapter T1.2.5.), and the prevalence of HCV was always higher in the opioid injector group. The situation, however, reversed: in 2011 HCV prevalence rate was 30% among those injecting primarily amphetamine or designer stimulants. As the national HCV prevalence rate did not change significantly in 2011, the restructuring of the prevalence rates by substance types is probably a consequence of new injecting patterns, namely of PWID' switching over from opioid injecting to injecting amphetamine or NPS (For more information on changing patterns see: 2012 National Report, Chapter 4.3. and 4.4., and 2011 National Report, Chapter 4.3.)

In 2014 the proportion of stimulant injectors – more specifically designer stimulant injectors – further increased in the sample. One third of the sample were primarily opioid injectors while two thirds of them were primarily stimulant injectors (see also: Drugs Workbook/Stimulants, Chapter T1.2.5.). With respect to HCV infection, it can be said that HCV prevalence doubled both among opioid injectors and stimulant injectors, and also if the total sample is considered. Beside the steep increase in NPS injecting, which substances are injected more frequently thus sharing and reusing injecting equipment is also more prevalent, another important factor of the significant increase of the HCV prevalence rates in 2014 could be the limited availability of NSP services taking place since 2012 in parallel with the phenomenon of NPS injecting (see: Chapter T1.5.4).

Chart 38. *The impact of the spread of NPS injecting (among NSP clients) and the decrease in the number of distributed syringes on HCV prevalence by primary injected drug type (national HIV/HBV/HCV seroprevalence survey series, ever injectors) between 2008-2015*



Source: Tarján 2018

In 2015 HCV prevalence broken down by substance type did not change significantly compared to 2014, prevalence at national level and by substance type was similar to that of 2014, however comparability of data points are limited (see: T1.3.6).

There are significant differences if data is analysed by geographical breakdown between 2011 and 2014: overall the prevalence rates outside of Budapest were around 10% up to 2011, while in Budapest they were between 35% and 40% in the same period. However, in 2014 HCV prevalence rate measured in Budapest (60.9%) almost doubled as compared to the value in 2011, and outside Budapest the proportion of those tested positive for HCV (32.5%) tripled in comparison to the survey conducted three years ago. In 2015 HCV prevalence rate outside of Budapest further increased (to 40.5%) while it did not change significantly in Budapest (55.7%), however comparability of data points in Budapest is limited (see: T1.3.6).

T1.3.3 Prevalence data of drug-related infectious diseases outside the routine monitoring

In the 'Altalap HIV/STI programme' of the Alternative Foundation (Alternatíva Alapítvány), HIV, HCV and syphilis infections were tested between June 2015 – April 2016 (Altalap 2017, Csák and Rácz 2018, for methodology see: T.5.2). The study involved other risk groups (MSM, sex workers) besides injecting drug users. During the screening, 511 persons were screened, and behavioural questionnaire was recorded 475 times. Two thirds of the subjects (326 persons, 63.8%) have ever injected drugs.

Of the 326 people, 175 (53.7%) were HCV antibodies positive, 15 persons (4.6%) were syphilis positive and 2 persons (0.6%) were HIV positive. More detailed analysis was only available regarding the first phase of the study (June 2015 to November 2015, N = 201⁷⁹): Among current injectors, HCV prevalence was 60%. Among NPS injectors (N = 108), HCV prevalence was significantly higher (67%) than among injectors of classical substances (N = 32, HCV: 38%). For more information on injecting patterns and risk behaviours, see Drugs/ Stimulants / T4.1 and in this workbook: T1.3.4.)

The results of sero-behavioural surveys conducted among prisoners (Treso et al., 2011 and Ritter 2013) that examined HIV/HBV/HCV prevalence and associated risk behaviours in prisoners with history of injecting drug use can be read at Prison Workbook, chapter T.1.2.2.

T1.3.4 Drug-related infectious diseases – behavioural data

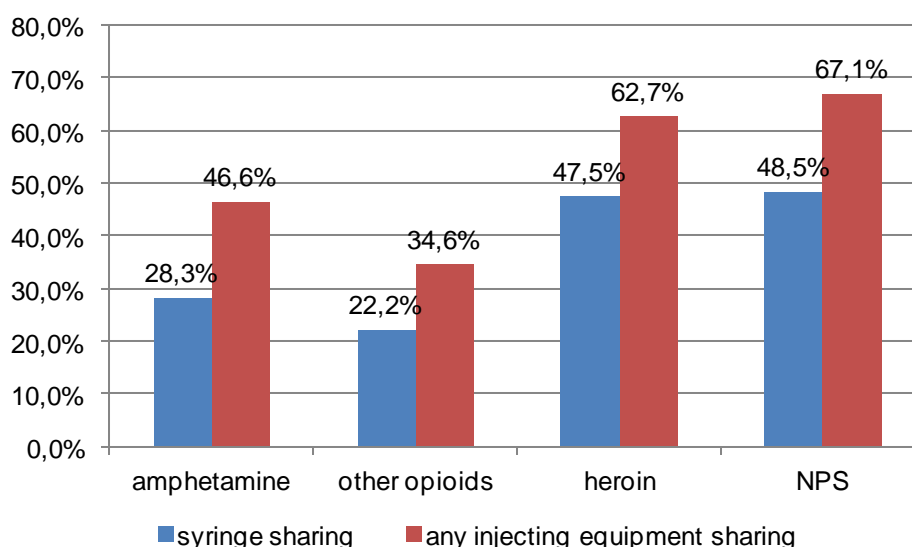
National HIV/HBV/HCV seroprevalence survey (2015)

According to the results of the HIV/HBV/HCV seroprevalence survey, 38.9% of current⁸⁰ PWID had shared syringes in the past 4 weeks, while the prevalence of sharing any injecting equipment in the past 4 weeks was 55.7%. If equipment sharing is examined broken down by primary injected substances, it can be said that the prevalence rates are the highest among NPS injectors, which in their case is also coupled with high HCV prevalence.(ST9P3_2016_HU_01)

⁷⁹ Among them 173 persons have ever injected drugs. 29% (58 persons) of ever injectors were also involved in sex work (provided or paid for it). 86% of ever injectors (149 persons) have been injected in the last 30 days.

⁸⁰ injecting in the last 4 weeks

Chart 39. *The prevalence of sharing needles/syringes and sharing any injecting equipment in the past 4 weeks (%) among current PWID participating in the national HIV/HBV/HCV seroprevalence survey⁸¹ in 2015*



Source: Dudás et al. 2015, analysed by HNFP

The number of injecting episodes per day was the highest among NPS injectors, while the number of reuses of the last syringe was the most prevalent among amphetamine or other opioid injectors.

Table 17. *The number of injecting episodes on the last day when injecting and the number of reuses of the last discarded syringe (group mean) among PWID participating in the national HIV/HBV/HCV seroprevalence survey by primary injected substance, in 2015*

Substance	N of injections	N of respondents	N of reuses	N of respondents
amphetamine	3.40	141	2.44	137
other opioids	2.19	108	2.44	106
heroin	3.32	111	2.15	113
NPS	3.59	202	2.26	200

Source: Dudás et al. 2015, analysed by HNFP

53.8% of current PWID admitted to inject every day⁸². 85.1% of current PWID injected with a sterile syringe on the last occasion, 58.6% obtained 15 or more sterile syringes for personal use in the past 4 weeks.⁸³

Among the 584 PWID giving valid responses, 163 persons (27.9%) had never been tested for HIV before the present seroprevalence survey. 46.2% (244 persons out of 528 with valid answers) stated that they had been last tested for HIV in 2014 or 2015 before the prevalence survey.

Excluding those who self-reported being HCV-positive from the analysis, there were 465 valid responses relating HCV testing uptake. 162 (34.8%) PWID stated that they had never been tested for HCV before the survey. Among those who had been tested for HCV at some

⁸¹ Number of respondents in the case of syringe sharing (N): NPS=163; other opioids=81; heroin=59; amphetamine=60. Number of respondents in the case of equipment sharing (N): NPS=164; other opioids=81; heroin=59; amphetamine=58

⁸² injecting once or several times a day

⁸³ When interpreting the data it is important to take into consideration that the study was carried out in outpatient DTCs or NSPs, thus it involved PWID who were covered by treatment or harm reduction services.

time in their lives in the past, 158 persons stated that they had been last tested for HCV in 2014 or 2015, which figure represents 37.6% of those giving valid responses. (ST9P3_2016_HU_01)

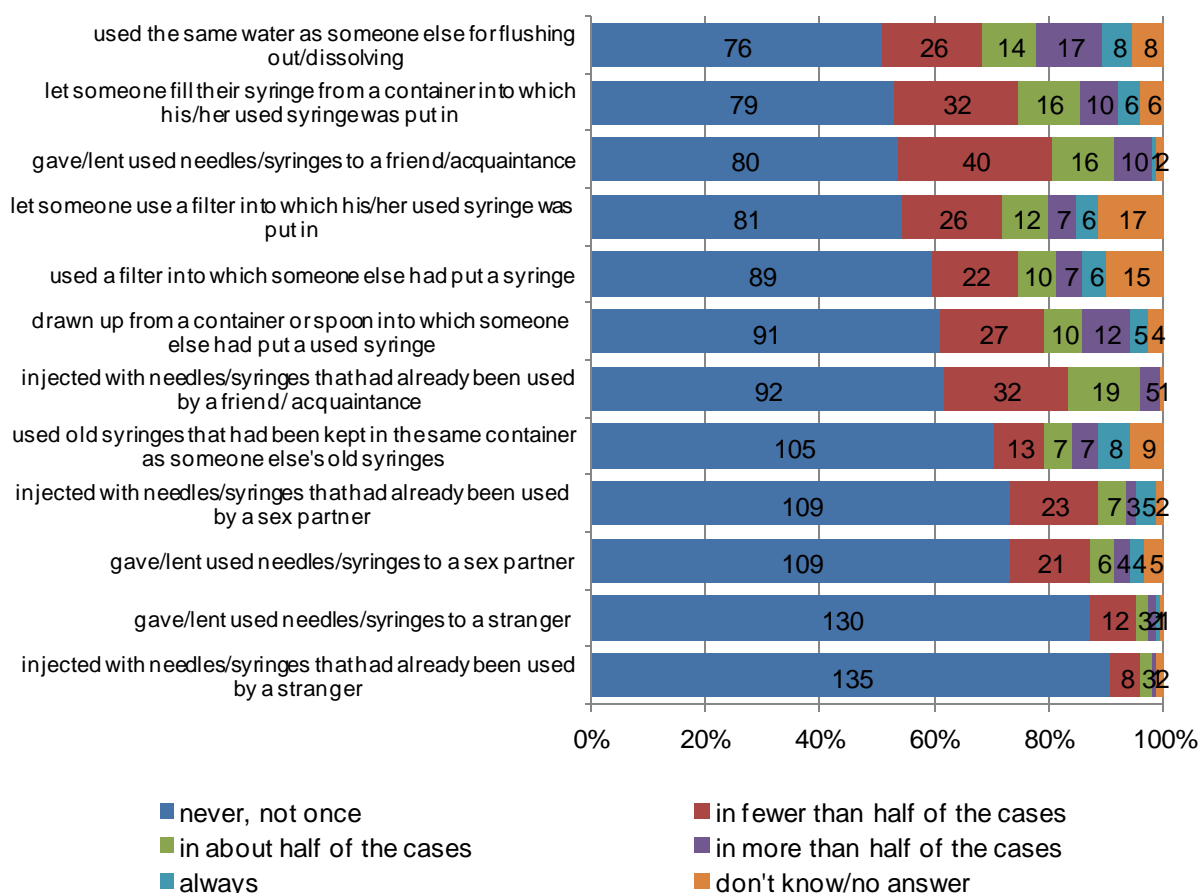
6.4% (22 persons) of PWID having had a sexual intercourse in the past 4 weeks had provided sex for money or drugs or other benefits in the past 4 weeks. 76.3% (267 persons) of PWID having had a sexual intercourse in the past 4 weeks had not used a condom during the last sexual intercourse. (ST9P3_2016_HU_01)

35.3% of the respondents had lived in a homeless shelter or on the streets without a stable address for more than 1 week during the past year. Nearly every second PWID (48.4%) had already been imprisoned. (ST9P3_2016_HU_01)

Altalap HIV/STI program (2015)

According to the results of the first phase of the Altalap HIV/STI program (Altalap 2017, Csák and Rácz 2018, methodology, data on injecting drug use patterns and infectious diseases, see T.5.2 and T.1.3.3 in this WB, and Drugs/Stimulants/T.4.1) less than a quarter of current injectors (N of respondents with valid answer: 147) said that they had not shared any injecting equipment in the past 30 days. Syringe reuse was also common among them, only 25% of current injectors did not reuse their syringe in the past 30 days, while 44% reported to use a syringe 3 or more times.

Chart 40. Risk behaviours in the last 30 days among current injecting drug users participating in the Altalap HIV/STI program in 2015 (n = 149)



Source: Csák and Rácz 2018

The authors found that the increased number of types of equipment sharing practiced by a person was correlated with an increased likelihood of becoming HCV infected: among those

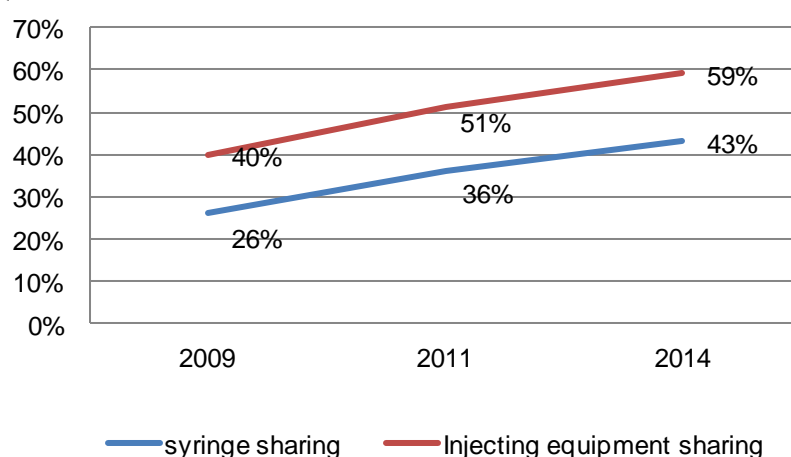
who were engaged in 0-2 injecting risk behaviours (N=69) in the past 30 days HCV prevalence was below the average (43%), while among participants with 3 or more types of equipment sharing (N=74) HCV prevalence rate was higher (73%). A relationship was also found between the number of risk behaviours and the number of people one shares his/her equipment with: only 15.6% of those who declared 1-2 types of equipment sharing shared equipment with 3 or more people, while 50% of the group with the highest number of risk behaviours (7 or more) shared their injecting equipment with 3 or more people.

Further data on the total sample (201 persons, including non-drug users) can be found in the article published by Csák and Rácz in 2018.

Trends on the basis of the national HIV/HBV/HCV seroprevalence survey (2009-2014)

Prevalence data⁸⁴ on syringe and injecting equipment sharing in the last four weeks among current injectors participating in the national HIV/HBV/HCV seroprevalence survey showed significant and steady increase between 2009 and 2014.

Chart 41. *Prevalence of syringe sharing and injecting equipment sharing in the last 4 weeks among current injectors participating in the national HIV/HCV seroprevalence survey series, 2009-2014*⁸⁵



Source: Tarján 2018

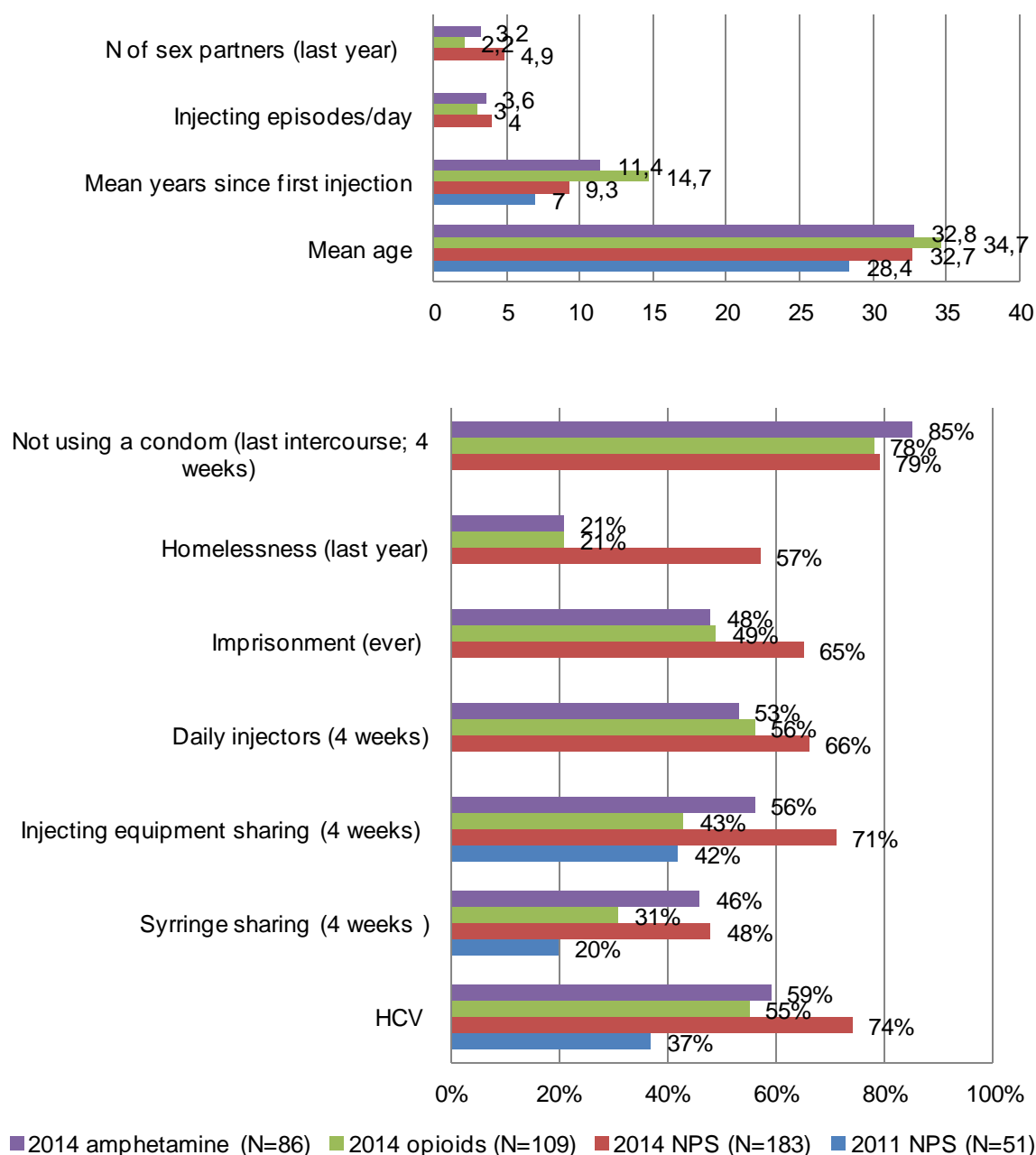
Trends of syringe/injecting equipment sharing on the one hand reflects the spread of NPS injecting associated with more frequent injecting and decreasing availability of NSPs during the study period, and on the other hand explains the doubling of HCV prevalence within the population between 2011 and 2014 (see T1.3.1.)

Tarján et al. (2017) investigated the prevalence of certain risk factors among current injectors involved in the national HIV/HBV/HCV seroprevalence survey series focusing on changes in NPS injectors between 2011-2014, and comparison of different injector groups in 2014 along individual and environmental risk factors. According to the results, mainly all risk behaviours and risk factors were significantly more prevalent among NPS injectors in 2014 than in PWID injecting amphetamine or opioids, and significant increase could be measured between 2011-2014 considering only NPS injectors in terms of syringe and equipment sharing and HCV.

⁸⁴ Data from the 2015 survey was excluded from the analysis due to the limits of comparability (see: T1.3.6 of this Workbook).

⁸⁵ n₂₀₀₉= 316 persons; n₂₀₁₁= 382 persons; n₂₀₁₄= 375 persons

Chart 42. HCV prevalence and risk factors by primary injected drug among PWID (current) participating in the national HIV/HCV seroprevalence survey series, 2011-2014



Source: Tarján et al. 2017

T1.3.6 Additional information on drug-related infectious diseases

National HIV/HBV/HCV seroprevalence survey

The two largest NSPs in Budapest (Kék Pont Alapítvány; Drogprevenció Alapítvány - DPA) closed in the second half of 2014 were also the testing sites providing the largest samples during the national HIV/HBV/HCV prevalence survey series by 2014. While Kék Pont Alapítvány had tested nearly 80 PWID per survey year at its NSP site in district 8 by 2014, its DTC site in district 9 only undertook 29 tests in 2015. This is important to consider, as the highest HCV prevalence by testing site had always been measured in the NSP clientele of

Table 18. Breakdown (n; %) of PWID participating in Budapest in the national HIV/HBV/HCV seroprevalence survey by testing site⁸⁶, 2014-2015

T1.4 OTHER DRUG-RELATED HEALTH HARMS

Driving accidents

Table 19. Prevalence of the presence of illicit drugs/new psychoactive substances (N) in blood and/or urine samples originating from driving accidents by active substance in 2017 (only positive cases, N=134)

⁸⁶ types: DTC: outpatient drug treatment centre; OST: opioid substitution treatment; NSP: Needle and syringe programme; LTS: low-threshold service (without NSP)

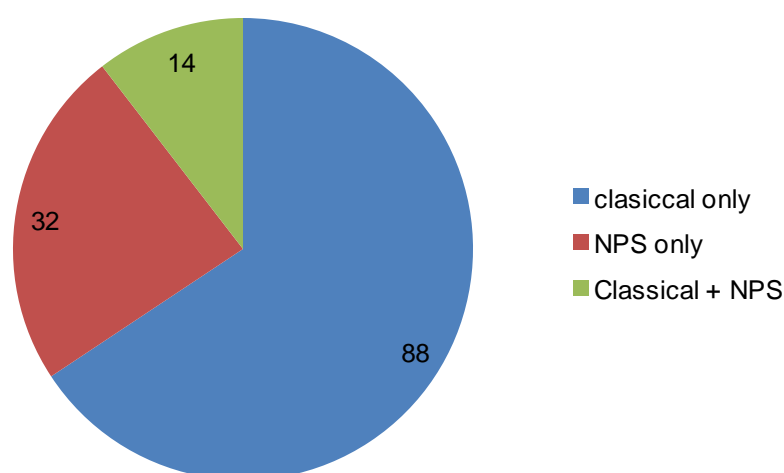
5F-AB/5F-AMB-PINACA + 5F-MDMB-PINACA + AB/AMB/EMB-FUBINACA + ADB-CHMINACA + ADB-FUBINACA	1
5F-ADB-PINACA + 5F-MDMB-PINACA + AB/AMB/EMB-FUBINACA	1
5F-ADB-PINACA + 5F-MDMB-PINACA + AB/AMB/EMB-FUBINACA + ADB/MDMB-FUBINACA	1
5F-MDMB-PICA + AB/AMB/EMB-FUBINACA	2
5F-MDMB-PINACA	1
5F-MDMB-PINACA + 5F-AB/5F-AMB-PINACA + AB-FUBINACA + AMB-FUBINACA	1
5F-MDMB-PINACA + 5F-MDMB-PICA + AB/AMB/EMB-FUBINACA	1
5F-MDMB-PINACA + AB/AMB/EMB-FUBINACA	1
5F-MDMB-PINACA + AB/AMB/EMB-FUBINACA + ADB-FUBINACA	2
5F-MDMB-PINACA + ADB/MDMB-FUBINACA + AMB-FUBINACA + EMB-FUBINACA	1
AB/AMB/EMB-FUBINACA	2
AB/AMB/EMB-FUBINACA + ADB-FUBINACA + MDMB-FUBINACA	1
AB/AMB/EMB-FUBINACA + MDMB-CHMICA + AMB-CHMICA	1
AB-FUBINACA + AMB-FUBINACA	2
ADB-FUBINACA	2
AMB-FUBINACA	1
AMB-FUBINACA + ADB-FUBINACA	1
amphetamine	5
amphetamine + 5F-MDMB-PINACA	1
amphetamine + fentanyl + THC	1
amphetamine + cocaine	3
amphetamine + MDMA	4
amphetamine + MDMA + 5F-ADB-PINACA + 5F-MDMB-PINACA + AB/AMB/EMB-FUBINACA + CUMYL-PEGACLONE	1
amphetamine + MDMA + cocaine	1
amphetamine + MDMA + cocaine + THC	2
amphetamine + MDMA + cocaine + THC + GHB	1
amphetamine + MDMA + THC	4
amphetamine + THC	8
amphetamine + THC + 5F-MDMB-PINACA + AB/AMB/EMB-FUBINACA	1
amphetamine + THC + AB-FUBINACA	1
amphetamine + THC + EMB-FUBINACA	1
fentanyl	4
fentanyl + THC	1
fentanyl + THC + ketamine	1
fentanyl + THC + mitraginin	1
ketamine	3
cocaine	5
cocaine + 4-CEC	1
cocaine + 5F-MDMB-PICA	1
MDMA	3
MDMA + N-ethyl-hexedrone + AB/AMB/EMB-FUBINACA + ADB-FUBINACA	1
MDMA + N-ethyl-hexedrone + ADB-FUBINACA + AMB-FUBINACA	1
MDMA + THC	3
methadone + 5F-MDMB-PINACA + AB/AMB/EMB-FUBINACA	1
methamphetamine	6
methamphetamine + MDMA + THC	1
morphine (heroin) + ethylmorphine + fentanyl	1

morphine (heroin) + methadone + N-ethyl-hexedrone	1
N-ethyl-hexedrone	5
N-ethyl-hexedrone + 5F-MDMB-PINACA + AMB-FUBINACA	1
THC	25
THC + 5F-MDMB-PINACA + 5F-MDMB-PICA + AB/AMB/EMB-FUBINACA	1
THC + ketamine	3
THC + cocaine	2
THC + N-ethyl-hexedrone	2
Total	134

Source: NSZKK 2018b

When breaking down the cases by classical and designer substances (NPS) the dominance of classical-only cases can be seen (88 cases, 66% of drug positive cases). New psychoactive substances (synthetic cathinones or cannabinoids) were detected (alone or in combination with other NPS or classical drugs) in a total of 46 cases (34%) in the blood and/or urine sample originating from driving accidents.

Chart 43. The presence of NPS and classical substances in drug positive blood and/or urine samples originating from driving accidents in 2017 (N=134; number of cases)



Source: NSZKK 2018b

Pregnancies and children born to drug users

In Budapest in 2017, 81 drug user women participated in the low threshold service of the József Babák Klub (Oberth et al. 2018) who were pregnant in the year in question (29 persons), had given birth between 2014 and 2017 (22 persons), or participated in the follow-up programme (30 persons)

Breakdown of primarily used substances among clients were the following: misuse of prescription drugs: 18 persons; amphetamines: 16 persons; alcohol: 10 persons; herbal cannabis: 9 persons, alcohol combined with prescription drugs: 8 persons; heroin: 6 persons; "crystal": 2 persons; cocaine: 1 person; synthetic cannabinoids: 1 person⁸⁷.

For the description of the programme see Chapter T1.6.1.

⁸⁷ Further 10 persons were admitted with codependency.

T1.5 HARM REDUCTION INTERVENTIONS

T1.5.1 Drug policy and main harm reduction objectives

The Health Promotion and Drug Prevention chapter of the National Anti-drug Strategy (hereinafter Strategy) (for further details see Drug Policy Workbook), which entered into force on 2013, emphasises the importance of harm reduction activities in recreational setting (clubs, music venues): i.e. the involvement of clubs in the implementation of a safer nightlife, ensuring the conditions for safer nightlife and clubbing by providing training for the staff, the provision of supporting services in the clubs and monitoring the implementation of minimum standards of these services.

The Treatment, Care, Recovery chapter of the Strategy highlights that harm reduction programmes are also parts of the treatment network operating on the basis of a recovery-oriented approach, they represent the first step. It identifies the following objectives in connection with the operation of such services: reaching hidden drug users, which gives an opportunity for them to enter treatment; decreasing infectious diseases and crime; and preventing overdose. At the same time the Strategy emphasises that harm reduction programmes should be integrated into recovery-oriented complex programmes and cooperate closely with treatment-rehabilitation centres.

In connection with NSPs, the Strategy states that in many cases exclusively these services have the ability to reach hidden drug user groups at risk, furthermore, the document names needle exchange in its list of definitions as an intervention for the prevention of infectious diseases. In the case of opioid users, it highlights the importance of maintenance treatment (OST), which must be provided within the framework of a comprehensive programme aimed at complete recovery.

T1.5.2 Organisation of harm reduction services

For the description of opioid substitution treatment see Treatment Workbook, Chapter T1.4.8.

Among the organisations providing harm reduction services at recreational settings (23 organisations) 15 operated as non-profit NGOs (Tarján 2016), 4 organisations were operated by the state/local government, 3 services by church organisations and 1 service operated with other organisational background in 2015.

Among the 23 programmes, through the parent institution 5 were linked to outpatient drug treatment centres, 11 to NSPs and 5 to therapeutic communities. In the case of 11 service providers, the parent institution, besides harm reduction services in the recreational setting, also operated other low threshold /day care/ community services (other than NSP).

According to a study (Tarján 2015) surveying the integration of NSPs within the treatment/care system, in 2014 two thirds (18) of the organisations operated as non-profit NGOs, 7 organisations were operated by the state/local government, while 4 services belonged to church organisations.

Among the 29 NSPs 9 of them were linked to outpatient drug treatment centres through their parent institutions, and 4 were linked to therapeutic communities. In the case of 16 service providers, beside needle exchange, the parent institution also operated other low threshold /day care/ community services.

Apart from their parent institutions, the NSPs most frequently established regular collaborations with units providing psychiatric/addiction treatment, family care centres and with organisations operating residential treatment units/therapeutic communities in 2014.

Table 20. *Collaboration of NSPs with other service providers (N) – outside of their parent institutions – by the type of service provider, in 2014, (N of respondents =29)*

	regular collaboration	ad hoc collaboration
psychiatric/addiction unit	19	7
family care centre	16	9
residential treatment unit/therapeutic community	14	9
child welfare service	13	10
outpatient DTC	12	7
self-help group	11	9
homeless shelter	11	13
HIV/hepatitis testing site	10	5
general practitioner	10	10
pharmacy	10	7
job centre	6	11
health institution treating HIV and/or hepatitis patients	5	8
Public Area Supervisor/ Auxiliary police	4	7
toxicology unit	3	11
service provider targeting pregnant drug user women	2	5
sexual health clinic	1	9

Source: Tarján 2015

With respect to service providers, the organisations outside of their parent institutions most frequently referred their clients to therapeutic communities (25 organisations), psychiatry/addiction units (24 organisations), self-help groups (23 organisations), homeless shelters (22 organisations) or outpatient DTCs (21 organisations).⁸⁸

The financing of harm reduction services

Operating licence for community and low threshold services is issued by the capital and county government offices. The financial admission of community services is the responsibility of the Ministry of Human Capacities' (EMMI). EMMI determines the financed capacity and thereafter the funding of the services are carried out in the scope of a fixed (normative) funding from the central state budget. Contrarily, the funding of low threshold services (that covers needle and syringe services) is carried out via tendering. The Hungarian Directorate-General for Social Affairs and Child Protection decides about the services admitted via tendering and signs the grant agreement for a fixed term (that was 1 year in 2017) providing a fixed annual funding⁸⁹ from the central state budget. No public call for tender had been issued since 2012, contracts signed in 2012 (thus organizations admitted) have been prolonged annually since then. Both forms of service target all kinds of addictions (including alcohol and other dependencies), funding available for drug-related services cannot be specified. When applying for the support, the provision of two out of the following 3 basic services is a requirement: psycho-social interventions; counselling services; street outreach services. The supplementary services for which service providers can apply only in union with the basic services are the following: telephone counselling; harm reduction in the recreational setting; needle/syringe exchange services; drop in centre.

⁸⁸ During the analysis the number of organisations indicating the categories 'occasionally', 'frequently' and 'very frequently' were merged in case of each service type.

⁸⁹ The amount of funding is not adjusted proportionally to the number of clients of the given service or to their equipment demand (in the case of NSPs).

During expert meetings, several large organisations reported that it would be difficult to maintain their harm reduction services without the financial assistance of their integrated institutional background (HNFP 2015).

Beside the fixed funding, it is possible for low threshold service providers to apply for supplementary operation support in the scope of the annual ministerial call for tender entitled 'Support for the recovery processes of addicts' (KAB FF).

The biggest proportion (44%; 43,640 syringes) of syringes acquired in 2017 were obtained as a donation according to the reports of the NSP service providers⁹⁰. 24% (23,200) of the syringes were purchased from ministerial grants, while 23% (23,000) were purchased at the expense of the low threshold fixed funding. Past years the Ministry of Human Capacities provided one-off support that was the major source of syringes for NSPs, however it was not available in 2017. (Fóti and Tarján 2018)

Harm reduction in the recreational setting is mostly provided by volunteers. Among reporting organizations a total of 80 paid employees and 278 volunteers were employed in 2015 (Tarján 2016).

T1.5.3 Harm reduction services

(a) Infectious diseases testing⁹¹

HIV testing

Anonymous, free of charge HIV testing is available in every county in Hungary in the general population. According to the 18/2002. (XII.28.) ESZCsM Decree, voluntary HIV testing is available at local sexual health clinics as well as at HIV/AIDS counselling centres operated by the capital and county governmental agencies⁹². At low-threshold services dealing with PWID, HIV testing is usually carried out if in the scope of centrally coordinated or through individual projects. A Budapest-based NSP permanently offers HIV testing to its clients (AATSZ - Anonim Aids Tanácsadó Szolgálat, fixed location NSP), while one of the main profiles of ALTALAP's (Alternatíva Alaptívány, Budapest) outreach NSP programme is the provision of HIV testing (depending on project-based funding).

HCV testing

Systematic decree-regulated anonymous, free of charge HCV testing (such as the case with HIV testing) is not available in Hungary neither for the general population nor for the risk groups. As a matter of fact, due to a previous - already outdated - regulation⁹³, capital and county governmental agencies in an ad hoc manner provide free of charge HCV testing for PWID.

At low-threshold services dealing with PWID, HCV testing is usually carried out in the scope of centrally coordinated or individual projects (e.g.: national HIV/HCV seroprevalence surveys [NCE], HAREACT project, ALTALAP HIV/STI programme). A Budapest-based NSP permanently offers HCV testing to its clients (AATSZ, fixed location NSP), while one of the main profiles of ALTALAP's (Budapest) outreach NSP programme is the provision of HCV testing (depending on project-based funding).

According to NSPs - as a grass-root level solution - if HCV testing is not available at a particular organization, the client is referred to the AATSZ.

⁹⁰ A total of 25 NSP units provided information on sources of supply, in terms of 98,403 syringes.

⁹¹ proof-read by Mária Dudás MD (EMMI) and Sándor Takács (AATSZ)

⁹² for the list of testing site see: <https://anonimaidis.hu/hasznos-infomaciok/szuroallomasok/>

⁹³ In 2005, the National Medical Officer ordered the laboratories operated by the former National Public Health and Medical Officer Service (NPHMOS) to provide free of charge HIV and HCV screening tests for samples of PWID if risk group is indicated in the submitted request.

The methodological and legal background of testing at low-threshold services is ambiguous and unsettled. According to the present regulation⁹⁴ only healthcare providers can provide HIV/HCV testing (if they meet the minimum requirements), the type of test is not distinguished (e.g. between blood tests and rapid e.g.: saliva tests). In contrast, guidelines of the former National Centre for Epidemiology on rapid HIV/HCV testing only sets out HIV/HCV counselling training of staff and cooperation with a healthcare provider as conditions for testing. The decisions of territorially competent governmental agencies responsible for authorizing testing are therefore not uniform.

In the case of higher-threshold healthcare providers (DTC/OST), HCV testing is also ad-hoc. The National Health Insurance Fund only funds diagnostic HIV/HCV testing (provided that the client has settled health insurance).

Protocol for annually offered, provider initiated routine HIV/HCV testing for PWID does not exist. The number of tests performed is service provider-dependent (available financing and service provider attitude).

In some rehabilitation centres, the condition for application is a recent HIV/HCV test result, testing is usually organized by DTCs or LTSs in the framework of pre-treatment.

For HIV/HBV/HCV testing in prison, see Prison / T.1.3.3.

b) Distribution of sterile syringes (Needle/syringe programmes (NSP))

In 2017 30 service providers operated NSPs in 21 cities, which covered 14 counties and all the 7 regions (Fóti and Tarján 2018) (17.HU_ST10_NUTS_DCR_THN (2018)).

In the second half of 2014 the two largest NSPs in Budapest had to close down as a consequence of local governmental decisions, that affected the availability of NSP services significantly. The Kék Pont Alapítvány (Kék Pont) terminated its NSP in district 8 in August 2014 and the Drogprevenció Alapítvány (DPA) stopped its service in district 13 in November 2014.

In Budapest, the Alternatíva Alapítvány (ALTALAP) launched its mobile and street outreach programme in 2015 in district 8 – where a large population of problem drug users congregate and were left without NSP after the closure of Kék Pont, however, in 2017 only their street outreach programme operated with a significantly lower turnover compared to the previous 2 years⁹⁵. Also the Baptista Szeretetszolgálat terminated the operation of its fixed-location NSP programme in district 10 in 2017.

Regarding locations outside of Budapest, The 'Egyenlítő' Programme of the INDIT Közalapítvány moved to Komló from Baja in 2016, and launched its NSP programme based on previous needs assessment. In Kecskemét, RÉV started to operate a new street outreach NSP beside its fix-location service. Street outreach programmes operating in 2016 were terminated in Szekszárd (RÉV), Pécs (INDÍT – TÉR; INDÍT – Tisztás) and Orosháza (MI-ÉRTÜNK). In 4 cities (Békéscsaba; Hódmezővásárhely; Nagykanizsa; Salgótarján) fixed-location NSPs were available, however, no one used them in 2017.

In 2017 25 fixed location NSPs operated in the country (2016: 26), 12 organisations performed street outreach work (2016: 14), 1 organisation operated a mobile NSP (2016: 2), and in 3 cities PWID could purchase syringes from syringe vending machines.

8 organisations operated two types of programmes, this, in most of the cases, was street outreach attached to a fixed location NSP. 1 service provider operated three different programme types, and 21 service providers only had one type of NSP service.

⁹⁴ 60/2003. (X. 20.) ESzCsM Decree

⁹⁵ Due to the termination of the Norway Grants support.

In 2017 NSPs distributed a total of 137,580 sterile syringes, the number of returned and collected syringes was 102,603.⁹⁶ The exchange rate was 75%. 2093 PWID⁹⁷ used NSP services on a total of 13,883 occasions. 594 new clients⁹⁸ were registered by the programmes in the course of the year. On average 65 syringes were distributed and 49 returned per client, the mean number of contacts per client was 7 in the year in question. (ST10_2018_HU_01)

According to the breakdown of client and syringe turnover by programme types fixed location programmes distributed the majority of syringes (65%) and reached the majority of clients (55%) in 2017.

Table 21. Syringe and client turnover data of NSPs in 2017

	fixed location	mobile NSP	street outreach	syringe vending machine	total
distributed	89,603	39,567	6,187	2,223	137,580
returned (+collected)	59,353	38,459	4,689	102	102,603
exchange rate	66%	97%	76%	5%	75%
number of clients	1,161	658	274	0	2,093
number of new clients	407	121	66	0	594
number of contacts	8,471	4,055	1,357	0	13,883
number of NSPs*	25	1	12	3	30

*The same NSP can run several types of programme at the same time, so the number of NSPs per programme type is not equal to the total number of NSPs.

Source: Fóti and Tarján 2018

On examining geographical distribution, NSPs located in Budapest had the decisive proportion of both the number of distributed/returned and collected syringes and the number of clients/contacts in 2017 as well (84%; 88%; 73%, 73% respectively regarding the data share of Budapest).

In 2017 the number of distributed syringes per injecting drug user was 21 at national level, that was calculated by applying the PWID population size estimate for 2015 (see: Drugs Workbook/Stimulants, Chapter T1.2.5).

Monitoring syringe purchasing in pharmacies is not part of the routine national monitoring system (See: T5.1). According to results from the HIV/HBV/HCV seroprevalence survey in 2015, 67% (258 persons) (in 2014: 58,4%) of current PWID (385) purchased syringes in pharmacies in the past 4 weeks.

c) Availability of further sterile drug use paraphernalia and harm reduction services

Beside sterile syringes, most NSPs provided counselling on safe injecting (24 out of the 27 reporting organisations). The majority of NSPs provided alcohol pads, condoms, vitamins and sterile filters. One third of the organisations provided sterile injecting equipment in pre-assembled packages. (Fóti és Tarján 2018).

⁹⁶ Including syringes obtained from syringe vending machines and disposed in the special waste containers placed near the vending machines.

⁹⁷ In respect of the number of clients double counting control was performed at service provider level but not at national level. The same client may be registered at more NSPs.

⁹⁸ In respect of the number of new clients double counting control was performed at service provider level but not at national level. The same client may be registered at more NSPs.

Table 22. *Distribution of injecting and harm reduction equipment and provision of other services by NSPs, in 2017 (N=27)*

Type of equipment/service	N of NSPs providing it
Counselling on safer injecting (oral)	23
Counselling on NPS injecting (oral)	21
Alcohol pad	20
Condoms	20
Vitamin	19
Sterile filters	14
Vein protection cream	12
Sterile injecting equipment in a pre-assembled package	10
Counselling on safer injecting (written material)	10
Citric/Ascorbic acid	9
HIV testing	9
HCV testing	8
Counselling on NPS injecting (written material)	8
Individual risk assessment	7
Sterile mixing container	6
Tourniquets	6
Dry wipes	4
Disinfectant for cleaning equipment	4
Distilled water for dissolving drugs	2
Foil	2
Band-aid	2
Sterile straw	1

Source: Fóti and Tarján 2018

Table 23. *Coverage of injecting and harm reduction equipment and provision of other services by NSPs, in 2017⁹⁹*

Type of equipment	routinely available	often available, but not routinely	rarely available, available in limited number of settings	equipment not made available	information not known
pads to disinfect the skin	x				
dry wipes			x		
water for dissolving drugs			x		
sterile mixing containers			x		
filters		x			
citric/ascorbic acid		x			
bleach			x		
condoms	x				
lubricants					x
low dead-space syringes	x				
HIV home testing kits				x	
non-injecting paraphernalia: foil, pipes, straws			x		
List of specialist referral services: e.g. drug treatment; HIV, HCV, STI testing and treatment	x				

Source: Fóti and Tarján 2018

d) Prevention of drug-related death and emergencies

⁹⁹ routinely available: available at > 70% of NSPs; often available, but not routinely: available at 30%-70% of NSPs; rarely available, available in limited number of settings: available at < 30% of NSPs.

Take-home naloxone programmes are not available in Hungary.

Harm reduction in the recreational setting

In 2015 a total of 23 organisations operated: 13 at city-level, 3 at micro-regional level, 3 at county level, 1 at regional level and 3 at national level (Tarján 2016).

Organisations cooperated with a total of 86 clubs/party organizers and took part in 583 events. They had contact with a total of 83,877 persons. The mean number of contacts per event was 143 (66 in 2014). The items most typically provided by the organisations were water, condoms, leaflets, glucose tablets and effervescent tablets. Distribution of earplugs, sterile syringe and snorting tubes were mentioned in the 'other' category.

Table 24. *Types of harm reduction equipment distributed by harm reduction services in the recreational setting (N of responding organisations=23)*

type	N of organisations
water/mineral water	18
condoms	18
leaflets on drug use	21
glucose tablets	20
effervescent tablets	17
leaflets on overdose and emergencies	10
vitamins	11

Source: Tarján 2016

Two organisations outside Budapest indicated that they had held training sessions for the operators and staff of clubs collaborating with them and to paramedic officers on a total of 6 occasions, involving 106 persons. The training covered the following topics: safe nightlife settings, introducing the harm reduction work of the organization, how to recognize and handle drug-related emergency cases, drug-related legal framework and first aid.

e) *Supervised drug consumption facilities*

Not available in Hungary.

f) *Post-release/transition management from prison to community, provided by drugs facilities*

For information on this, see Prison T1.3.3 - Reintegration, preparation for release.

g) *Vaccinations*

Special targeted vaccination programmes are not available for drug users. Hepatitis B vaccination has been compulsory for people aged 13 since 1999.

e) *Infectious diseases treatment*¹⁰⁰

HIV treatment

The treatment of verified HIV positive persons in Hungary is carried out in 4 cities: in Budapest and, since 2014, in 3 decentralized clinics in Miskolc, Pécs and Debrecen. Linkage to care and treatment are based on 18/2002. (XII. 28.) ESzCsM Decree and the HIV

¹⁰⁰ proof-read by Mária Dudás MD (EMMI) and Sándor Takács (AATSZ)

treatment protocol¹⁰¹ issued in 2017 by the expert group of the Joint Szent István and Szent László Hospital¹⁰². Drug use is not a contraindication to the initiation of HIV treatment.

HCV treatment

There are 43 hepatology centres in the country, located in 24 cities¹⁰³.

The national professional consensus related to HCV treatment being in force since May 2018 (Hunyady et al., 2018) does not include any more the previously prescribed 3 month abstinence of drugs, however, requires individual case assessment for current drug users. Since the release of DAA treatment, earlier waiting list for HCV treatment does not exist any more, and according to the 2016 position of leading hepatologists (Horváth et al., 2016), with the new medications also in case of hard to treat populations – in a shorter period of time and with less side effects compared to previous treatment – more than 90% of patients can be cured effectively. Taking into consideration professional aspects, treatment of all HCV infected persons is indicated.

In the HAREACT project (see T1.5.5.), low-threshold organizations conducting the HIV/HCV testing participated in trainings in 2016 and 2018 in connection with PWID's linkage to HIV/HCV care. In the framework of regionally organized working groups, different stakeholders (social workers, hepatologists, infectologists) operating in the same city gathered in order to elaborate and implement linkage to care at local level.

Additionally, there are individual initiatives: DPA has developed its "Follow-up" programme, which, in a case-management framework, follows the client from testing to treatment. For HCV positive clients they arrange an appointment at the Hepatology of the Szent János Hospital and also accompany them upon the client's request (2017: 2 persons). The number of PWID referred to treatment with an arranged appointment was 22 in 2017.

For information on prisoners' HIV/HCV treatment see Prison / T.1.3.3.

1) Sexual health counselling and advice, condom distribution

For information on condom distribution, see T.1.5.3 c) and d). In Hungary, there are two low-threshold (NSPs) services dealing with drug users (ALTALAP and AATSZ), which – besides drug use related harm reduction – provide counselling explicitly on sexual health.

T1.5.4 Harm reduction services: availability, access and trends

The number of syringes distributed to injecting drug users

As compared to the previous years, in 2011 the number of distributed syringes significantly increased, at the background of which stands the increased use of new psychoactive substances starting in 2010, which are injected much more frequently than traditional illicit drugs (see: Drugs Workbook/Stimulants, Chapter T1.2.1.). The rising trend lasting until 2011 was broken in 2012 by the reduction of the resources available for low threshold services when a new three-year-long funding period started (see: Chapter T1.5.2). Then, as compared to the previous year, about 220,000 less syringes were distributed by NSPs. In order to be able to maintain the services, NSPs with the highest turnover limited the number of syringes that could be distributed per contact, and in certain cases reduced their opening

¹⁰¹ „Antiretroviral therapy, vaccination and primary and secondary prophylaxis of opportunistic diseases in HIV-infected adults”

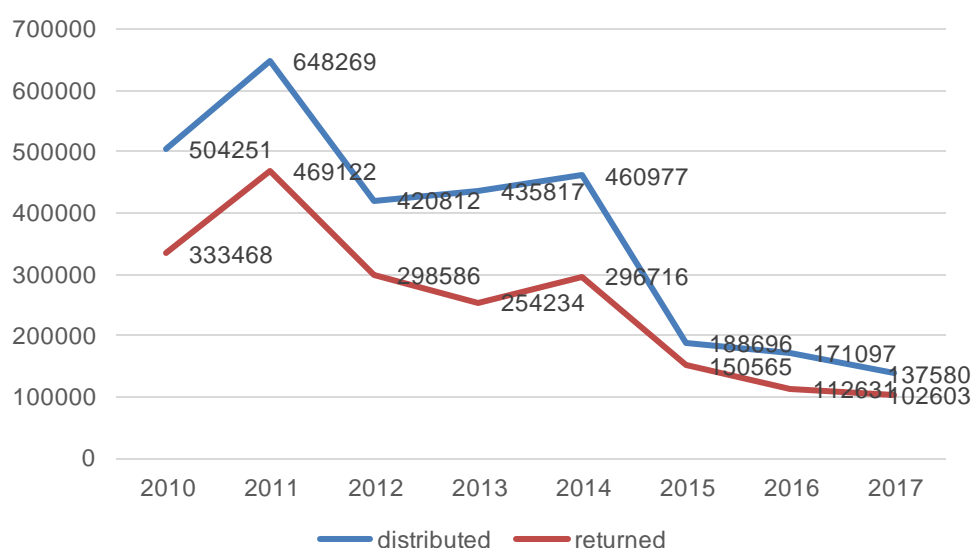
¹⁰² personal communication with János Szlávik MD

¹⁰³ https://hepreg.hu/custom/hepreg/doc/hepatologiai_centrumok.pdf

hours. Some programmes had to either temporarily or completely shut down their operation. In 2013 and then in 2014 the number of syringes distributed rose slightly, which is primarily the consequence of the one-off grants provided by EMMI (see: Chapter T.1.5.2), however, the number had still not reached the 2011 level and probably still did not satisfy the current syringe needs of PWID. This is supported by the drop in the exchange rate observed in 2013, which suggests that a significant proportion of the used syringes not returned to the programmes – primarily in Budapest – were reused by the clients or were shared (HNFP 2015). The closure of the two largest NSPs in the second half of 2014 (see: T1.5.3) caused a significant decrease in the number of distributed (59%) and returned syringes (49%) in 2015 which tendency further continued at a moderated level in 2016 and in 2017.

The research of Kaló et al. (2018) and the changes that can be observed in routine data collections (for relevant results see: Drugs/Stimulants/T1.2.5 and T4.1) reveal background factors of this decrease: among PWID a moderate transformation of drug use patterns have been taking place for the last 3 years. (increasing synthetic-cannabinoid use, increasing inhaling (with a foil) of injectable drugs). Additionally, according to NSPs PWID have become more hidden and harder to reach due to the growing presence of police (Kaló et al., 2018). Several organizations indicated (Kaló et al. 2018, Fóti and Tarján 2018) that due to the lack of capacity at existing NSPs and to the limited coverage of NSPs, smaller proportion of PWID come into sight of the services especially in Budapest. In the meantime also in other regions of Hungary out of treatment PWID groups can be identified¹⁰⁴ at locations that are not covered and reached out by NSPs.

Chart 44. *The syringe turnover data of NSPs, between 2010-2017*



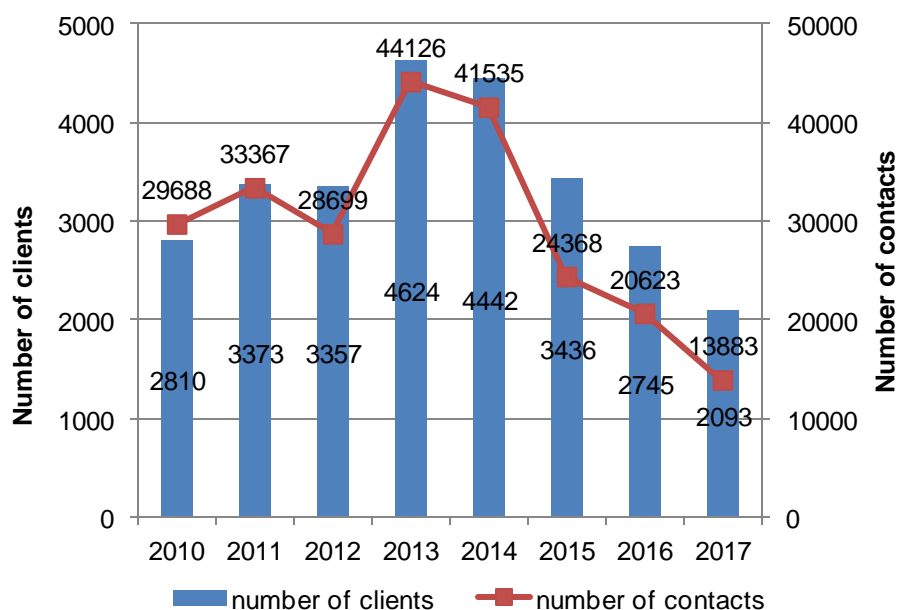
Source: Fóti and Tarján 2018

Contrary to the changes in the number of distributed syringes, the number of clients and the number of contacts showed a steep rise between 2012-2013. It may be assumed that the restriction of the availability of sterile syringes per day was compensated by the clients with a greater number of contacts and the involvement of PWID peers who did not attend NSP programmes before. The number of clients decreased slightly in 2014 due to the closure of the two biggest NSPs during the year. Due to the drop out of the two big NSPs the number of clients and contacts further declined in 2015. This trend continued also in 2016 and in 2017 due to reasons explained above relating to the decrease in distributed syringes in the same time period.

¹⁰⁴ on the basis of information originating from organizations not dealing with drug users (eg.: child welfare or family support services)

Altogether 2093 persons contacted NSPs in 2017 which is a 55% drop compared to 2013 data (4624 persons). The number of contacts dropped by 69% in the same period (2013: 44,126 contacts; 2017: 13,883 contacts). While in past years (2011-2016) 1100-1800 new clients were registered annually, in 2017 only 594 new clients were recorded. The trends of past years' NSP client-turnover data suggest – in spite of changing drug use patterns and thus probably slightly decreasing frequency of injecting drug use - that a significant proportion of PWID remain out of access to NSP services.

Chart 45. Number of NSP clients and number of contacts, between 2010-2017



Source: Fóti and Tarján 2018

Examining the turnover data by geographical breakdown it can be said that the proportion of the turnover taking place outside Budapest has increased between 2014-2016. While in previous years in the case of the individual indicators, the share of Budapest was 86-89%, in 2016 it was only 73-85%. According to the trend data by geographical breakdown, it can be concluded that the decline in the total national data of NSP clients and distributed syringes derived from the drop experienced in Budapest, while the availability outside of Budapest did not change considerably in the past years. In 2017, the share of Budapest increased slightly again. However, data both in Budapest and outside of Budapest regarding all indicators (except for number of clients outside of Budapest) show a declining trend between 2016 and 2017.

According to the breakdown by programme type the share of fixed location programmes further increased both in terms of number of clients and number of distributed syringes (clients 2015: 46%; 2016: 48%; 2017: 55%) (distributed syringes: 2015: 39%; 2016: 53%; 2017: 65%).

In 2017 the number of distributed syringes per injecting drug user was 21 at national level, which means a further decrease compared to previous years (2016: 25; 2015: 28; 2014: 81; 2013: 76; 2012: 74). It is important to note that the last PWID population size estimate was carried out in 2015 (for data and methodology see: Drugs Workbook/Stimulants, Chapter T1.2.5), on which the 2015-2017 coverage estimate was based. Until 2014 the coverage was estimated based on the population size estimate carried out in 2010 (see: 2010 National Report, Chapter 4.1).

T1.5.5 Additional information on harm reduction activities

HAREACT project, a Joint Action on HIV and co-infection prevention and harm reduction was launched in 2014 with a mission to fulfil targets set by policies of the European Union. Purpose of the Joint action is to improve capacity to respond to HIV and co-infection risks to overdose and provide harm reduction with specific focus on people who inject drugs (PWID) and other related risk groups (PWID in and out of prison settings; PWID who are sex workers; pregnant injecting drug user women and their children; sexual partners of PWID; MSM who are drug users). Hungary was nominated as a target country of the project along with Latvia and Lithuania. The former National Public Health and Medical Officer Service participated in the following work packages: *Increased harm reduction and improved continuity of care for PWID in prison settings; Developing a suitable model of integrated treatment for PWID; National programmes updated to overcome barriers to respond to HIV, TB and HCV-related needs of PWID in the EU*. While the former National Centre for Epidemiology participated in the work package *Improved early diagnosis of HIV, viral hepatitis and TB, as well as improved linkage to care for PWID*.

Because of institutional changes in Hungary, HIV/HCV testing in the framework of the HAREACT project could only get started in 2018. 11 low-threshold organizations¹⁰⁵ participated in the training supported by the project in 2016 and 2018, which covered the following topics: HIV/HCV testing (rapid testing) and counselling; harm reduction and specialized care targeted at female clients; linkage to HIV/HCV care; the model of integrated care; overdose prevention.

The project-funded HIV/HCV testing and attached behavioural survey¹⁰⁶ (600 HIV and 600 HCV rapid tests were distributed in the first phase) were launched in May 2018 at the participating organizations. Training on linkage to HIV/HCV care in April 2018 was also attended by hepatologists and infectologists alongside with low-threshold organizations. The aim of the training was to build up local cooperation between different fields and to develop feasible client pathways from testing to care at local level.

For the methodology of the national HIV/HBV/HCV seroprevalence survey among PWID see: Chapter T5.1.

Information on counselling, testing and treatment of prisoners can be found in the Prison Workbook, Chapter T1.3.3.

T1.6 TARGETED INTERVENTIONS FOR OTHER DRUG-RELATED HEALTH HARMS

T1.6.1 Targeted interventions for other drug-related health harms

Interventions targeting drug-using pregnant women and their children

For the description of the low threshold programme of the Józan Babák Klub located in district 8 entitled 'Alternative Prenatal and Family Care' see: 2012 National Report, chapter 7.4. This programme provides services for drug user pregnant women or women with babies living in district 8 and surroundings. In 2017 a total of 81 persons participated in the programme (Oberth et al. 2018) (for drug use patterns of clients see: T1.4.1).

The Józan Babák Klub and the Magyar Emberi Jogvédő Központ Alapítvány in cooperation with the Hungarian Association of Child Health Visitors operates a crisis telephone hotline since 2014 for pregnant drug user women in crisis situations with the purpose to provide

¹⁰⁵ Budapest: 4 NSPs and 2 LTSs; Pécs: 2 NSPs; Debrecen, Kecskemét and Miskolc: 1-1 NSP

¹⁰⁶ elaborated and funded by the HU-NFP

them with effective help in entering treatment. The crisis telephone hotline service helps those drug using pregnant women or drug using mothers and their children who live in Hungary but seek help in Budapest.

In 2017 Józan Babák Klub started a new supported housing programme. The halfway house programme “Babaház” provides accommodation for 8 pregnant women or women with children (together with the children) with drugs problem in district 20 of Budapest. In 2017 6 adults and 5 children used this service.

The DPA located in Budapest as part of its OST programme established the „academy of special parents” in 2014, while in 2015 launched the MENYA/MEPA consulting hours for OST clients who are mothers or fathers. In the framework of this programme they help their pregnant or mother/father clients with individual case management, psychiatric control, and referral between other institutions. The consultations covered specific topics, such as the communication of the disease (opioid dependence) and the treatment (OST) with the child health visitor¹⁰⁷, with the nursery/kindergarten, with child welfare or family support services, or with the child psychologist, HCV testing of babies with HCV positive parents; safer drug use in the environment of the family, disorders and diseases of the baby linked to the substance use of the parents. A total of 10 women and 7 men participated in the special consultation (among them 4 couples) in 2017 who were raising a total of 15 children.

T1.7 QUALITY ASSURANCE OF HARM REDUCTION SERVICES

T1.7.1 Quality assurance for harm reduction services

Harm reduction activities taking place in the scope of social services, including the service provided in needle and syringe programmes, are regulated by Act III of 1993 on social administration and social services, and Ministry of Social and Family Affairs’ regulation 1/2000. (I.7.) on the tasks and operation conditions of social institutions providing personal care.

The social guideline ‘Professional recommendation – Low threshold services provided to addicted persons’ was elaborated by the Specialised Workgroup on Addictions in 2007 (2010 National Report, chapter 11). The recommendation describes the types, purposes, guiding principles, characteristics, quality assurance conditions of the services and the activities they cover. This document serves as a basis in the call for and the assessment of applications for the fixed state financing (see Chapter T1.5.2). The guidelines were revised in the course of 2017, the renewed document stepped into force in July 2018¹⁰⁸.

Furthermore, in 2011, within the framework of TÁMOP¹⁰⁹ 5.4.1 project aimed at drug-related developments, national guidance documents were elaborated determining recommendations based on wide expert consensus for harm reduction programmes operating in recreational settings and for needle/syringe programmes (2011 National Report, chapter 3.2). The recommendations in the documents are in line with the objectives of the social guidelines issued in 2007.

Details of Government Regulation 23/2011. (III.8.) on increasing the safety of music and dance events can be read in the 2012 National Report, Chapter 1.2.

¹⁰⁷ a special and quasi compulsory service provided for pregnant women and women with babies

¹⁰⁸ Details on the new guidelines will be described in NR 2019.

¹⁰⁹ Social Renewal Operative Programme

T2. TRENDS

Trend data is included in T1.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2017, is presented as part of the baseline information in T1.

T4. ADDITIONAL INFORMATION

No new information available.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

DRD:

Drug-related death (Hungarian National Focal Point HNFP 2018): The data relating to deaths originate from the Special Mortality Registry. The data has been collected by the Hungarian National Focal Point with the support of the NSZKK (former National Forensic Medicine Institute) and Semmelweis Medical University Institute of Forensic and Insurance Medicine since 2009. This nation-wide register is anonymous, includes ICD-10 codes, case based, and in all cases contains detailed toxicology data besides the circumstances of the deaths. The case definitions and the recorded characteristics in the register fully comply with the requirements of the EMCDDA DRD protocol (Drug-Related Deaths (DRD) Standard Protocol, version 3.2 2009; Selection D).

DRID:

Notifications of HIV/ AIDS, HBV, HCV:

Data of reported, injecting drug use related HIV/AIDS cases and the incidence of injecting drug use related acute cases of hepatitis caused by HBV or HCV in Hungary originate from the national registry of infectious patients operating at the Department of Hospital Hygiene and Epidemiological Surveillance of EMMI (former National Centre for Epidemiology, Department of Epidemiology) and from the special HIV/AIDS and hepatitis surveillance database.

HIV/HBV/HCV prevalence data:

National HIV/HBV/HCV seroprevalence survey among PWID (Dudás et al. 2015) (ST9_2016_HU_01): Between April and September 2015 the National Centre for Epidemiology (NCE) repeated the HIV/HBV/HCV national seroprevalence survey among PWID. The study was financed by the State Secretariat for Healthcare. This was the seventh survey in the series since 2006 applying consequently the same methodology throughout the years (previous study years: 2006-2009 annually; 2011; 2014).

In 2015 19 organisations were involved: three NSPs, three DTCs, one LTS and one DTC with LTS in Budapest while outside of Budapest six NSPs, three DTCs and two DTCs also operating NSPs took part in the study. Those persons were recruited in the study who had

ever injected illicit drugs/new psychoactive substances. Apart from the testing for HIV/HCV, socio-demographic characteristics, injecting patterns and risk behaviours were also recorded. The questionnaire was based on the EMCDDA DRID guidelines, and on parts 2 and 3 of Standard Table 9, that was elaborated by HU NFP and the NCE jointly. The questionnaires and the blood samples were given unique identifiers generated from the personal data but cannot be traced back, which makes it possible to link the serological and questionnaire data, and control the sample for double counting. Participating organizations were assigned a target sample size based on the number of their PWID clients between 2006-2014, however this had to be modified in 2015 due to the closure of the two largest testing sites in 2014 (see: T1.3.6.). During the study period the organisations invited all their PWID clients – after informed consent – to participate until the target sample size at each location was reached. The PWID participating in the study received an incentive in the form of food vouchers (HUF 1000/ EUR 3).

The laboratory results were sent back from the National Centre for Epidemiology to the organisations and results were given back to clients attached to which post-test counselling was also possible if clients required it.

A dried blood sample was used for the serological tests – after blood was taken from the client's fingertip. The Vironostika HIV Ag/Ab ELISA (bioMérieux) test was applied for the HIV test. The samples giving a reactive result were controlled with another test suitable for demonstration of the virus antigen, the combined ELISA test (Genscreen Ultra HIV Ag-Ab; BIO-RAD). Apart from this the INNO-LIA HIV I/II Score (FUJIREBIO) Line Immuno Assay, using the Immuno blot principle, was also carried out. In the case of the hepatitis C virus, the HCV Ab Screening ELISA kit manufactured by DiaPro and the INNOTEST HCV Ab IV kit manufactured by Innogenetics were applied. The anti-HCV positive results were verified with the INNO-LIA HCV Score test (Line Immuno Assay technique) manufactured by the Fujirebio.

After double-counting control, the data of 596 persons were analysed. Inconclusive test results were excluded from the analysis (37 samples in the case of HCV; 0 in the case of HIV; 0 in the case of HBV). The electronic recording and statistical analysis of the data was performed by using the Epi Data and the Epi Info Windows 3.5 programme packages, and with the SPSS programme package.

The national seroprevalence survey has not been repeated since 2015. On the one hand, the study did not receive any further funding, as Hungary was included as a target country in the HAREACT international project in 2015 (see T.1.5.5) and one of its work packages providing rapid HIV/HCV rapid saliva testing kits. Attached to the HAREACT-funded HIV/HCV testing a one-time new bio-behavioural survey was launched in 2018 covering 5 regions of Hungary. On the other hand, in the national seroprevalence survey series comparability problems emerged in 2015 after the closure of the 2 largest NSPs – that were also the main testing sites – and hence the continuation of the survey series was hampered.

In the previous years, the results of ad hoc research projects (including the prison setting) (Csák and Rác 2018; Altalap 2017; Tresó et al. 2012) and of the regional HIV/HSV/HCV testing programme 2010-2013 supplemented the base data of the national seroprevalence survey series (see relevant chapters of the previous National Reports).

Harm Reduction:

Needle/syringe programme (NSP) data collection (Fóti and Tarján 2018): In 2017 again NSPs (100% coverage) reported their 2017 data via the Internet-based data collection tool set up and operated by the Hungarian National Focal Point. The organisations have been providing data to the Hungarian National Focal Point through this interface since 2008 on their syringe turnover (based on categories set in ST10), the provision of other harm reduction services, about their syringe supply management, as well as about the demographic characteristics and injecting patterns of their clients. Management, quality

assurance and analysis of the national, aggregate data are carried out by the Hungarian National Focal Point. The number of clients/new clients is controlled for double-counting at service provider level but not at national level. The same client may be registered at more NSPs. For methodology on client data collection (demographic characteristics and injecting patterns) see: Drugs/E./ T.5.2).

Integration of NSPs in the treatment and care system (Tarján 2015): The Hungarian National Focal Point carried out an online survey in May-June 2015 among all NSPs, during which their institutional affiliation, their integration in the treatment/care system, position on the treatment chain, and their institutional connections were examined. 29 online questionnaires were completed, which represents 100% coverage.

Data collection on harm reduction services in the recreational setting (Tarján 2016): The Hungarian National Focal Point has been collecting the operational and turnover data of organisations performing harm reduction services in the recreational setting since 2007, with the help of a structured questionnaire, which has been filled in online in 2015. Of the 23 service providers contacted, 23 completed the questionnaire. Data collection has not been repeated since 2015.

T5.2 METHODOLOGY

T5.2.1. Further studies and data sources

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- NFP (2018): TDI adatgyűjtés halálozási modul: Kábítószer-fogyasztással összefüggő halálozási adatok 2017-ben.
- NSZKK (2018b): Kábítószer/pszichotróp anyag/új pszichoaktív szer jelenléte a közúti balesetekből származó vér- és/vagy vizeletmintákban 2017-ben. NSZKK.
- Oberth J., Bíró Zs., Mándi B. (2018): Beszámoló a Józan Babák Klub 2017. évi várandósgondozási tevékenységéről.
- Tarján, A (2015): Tűcserek az ellátórendszerben 2014-ben. Nemzeti Drog Fókuszpont.
- Tarján, A (2016): A rekreációs színtéren ártalomcsökkentő/prevenációs tevékenységet végző szervezetek 2015. évi működési és forgalmi adatai. Nemzeti Drog Fókuszpont.
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T5.2.1. Methodology of further studies and data sources

‘ALTALAP’ HIV/STI Programme (Altalap 2017, Csák and Rácz 2018): The Alternatíva Alapítvány's (ALTALAP) HIV/STI Programme conducted a two-wave testing programme for PWID and other groups exposed to infectious diseases (MSM, sex workers) between June 2015 and April 2016. During screening, HIV, syphilis (capillary blood) and HCV (saliva) were tested using rapid tests. The first wave of testing took place between June and November, 2015, at four locations with the participation of 7 NSPs: Budapest (3), Miskolc (2), Pécs and Szeged. In the first wave, 201 tests were performed, 173 of them were from PWID. During the second wave of the study, the screening was carried out with four out of Budapest and three Budapest service providers (December 2015 – April 2016). Both waves of the study were supplemented with questionnaires on injecting and sexual health related risk behaviours, further analysis of which were subject to methodological constraints. The aggregate data of the 2 waves for the sub-sample of PWID were only available in terms of the prevalence rates for each infectious disease. The analysis of drug use patterns and risk factors among PWID is only available for the first phase. 48% of the first phase samples were collected in Budapest; 24% in Miskolc; 13% in Pécs; while 15% in Szeged.

Monitoring of new psychoactive substances involving key experts in Hungary 2017-2018 (Kaló et al. 2018): See methodology in Drugs / E. / T.5.2.

T0. SUMMARY

Besides the Hungarian Institute for Forensic Sciences (NSZKK), in instances when the samples are taken during customs control or the investigations falling within its competence, the National Tax and Customs Administration (NAV) performed the analysis of substances suspected of being illicit drugs in Hungary. A detailed picture of the Hungarian drug market can be obtained by analysing the seizure data and the police reports.

On the basis of seizure and user information, the drug market has gone through a large-scale restructuring process since 2010. New psychoactive substances (NPS) had a significant presence next to 'classical' drugs, and their continual replacement on the market represented a serious challenge to supply reduction efforts. The market share of NPS has been increasing from 2010 to 2014, and in 2014, about 60% of the police seizures were made by these substances. This proportion has declined steadily since 2015, to about 35% in 2017. In Hungary, large quantities of narcotics are not cultivated or produced; only small plantations or labs have become known to the authorities. This means that Hungary is mostly considered as a transit country with many trafficking routes going through. As a destination country, cannabis, amphetamine, NPS and ecstasy tablets are the most common trafficked substances.

The characteristics of drug law offences are monitored on the basis of the data recorded, when investigations are completed, in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS). In Hungary the number of registered drug offences committed in a year is between 5-7000, the largest proportion of which are related to cannabis (2017: 60.7%) while a smaller proportion to stimulants (2017: 25%). (Supply) offences related to NPS have involved criminal liability since 2012, and from this point onwards they have been the subject of perpetrations in a constantly increasing proportion. The large majority of drug related offences are consumption-related especially among offences committed with a small amount of drug, 90% of which cases belong to this perpetration type. The proportion of supply related offences tends to remain below 20%.

Procedures to reduce drug supply are set out in the National Anti-Drug Strategy, along with other policy strategies. The tools that have been formulated to reduce the supply are - among other things - enhancing the efficiency of law enforcement and investigative work, enhancing forensic expertise, and increasing the number of procedures initiated for supply-related offences.

T1. NATIONAL PROFILE

T1.1 DRUG MARKET

T1.1.1 Domestic drug cultivation and production

With respect to Hungarian illicit drug cultivation, the investigating authorities typically discovered small cannabis plantations in the greatest number¹¹¹.. In 2017 during the procedures launched due to the 158 discovered cannabis cultivation sites, a total of 5287

¹¹⁰ Authors of the chapter: Bálint Réka, Tamás Csesztregi, Ágnes Port,

¹¹¹ In the case of cannabis plantation seizures, it is possible to launch criminal procedures only on the basis of an analysis performed by a botanical specialist. The police authority involved has information on the amounts seized.

plants were seized. Approximately 6% of the discovered plantations involved more than 100 plants.

The production of synthetic substances in Hungary is typical in small scales. In the course of 2017, two illegal laboratories were discovered where amphetamine was being manufactured from benzaldehyde. Production in one of the laboratories was assumed to be low-scale (in few grams), while in the other one a reaction mixture containing nearly 4 kg of amphetamine base was seized.

In 2017 there was one investigation during which besides acetone, the authorities seized pure active substances of the synthetic cannabinoid group, preparations impregnated with these substances and untreated herbal materials. No laboratories producing new psychoactive substances were discovered. (NSZKK 2018a)

T1.1.2 Routes of trafficking (imported and transit consignments)

According to the experience of the investigating authorities (ORFK 2015), herbal cannabis is typically smuggled from the Czech Republic to the territory of Hungary by Vietnamese organised crime groups and by Hungarian offenders from the Netherlands. The better quality 'skunk' cannabis, mainly destined for the Western European market, comes from Albania. The herbal cannabis originating from the Czech Republic is frequently smuggled in cars, while it comes in larger quantities (250-400 kg) from Albania hidden in trucks.

Heroin continues to be smuggled into the country from Afghanistan, along the classical Balkan route through Turkey. The large majority of the consignments – similarly to previous years – goes to other EU states and only a very small amount gets to the domestic market. Hungary continues to act as a transit country for this substance. The heroin arriving over the Romanian and/or Serbian border is smuggled into the country in hidden compartments of cars and trucks.

The origin of cocaine, its smuggling routes and methods are varied: the consignments entering Europe in cars get to Hungary from Spain and the Netherlands. But smuggling in packages and in swallowed packets directly from South America continues to be typical.

Synthetic illicit drugs (amphetamine and ecstasy) primarily come to Hungary from Belgium and the Netherlands. It is usually smuggled in cars and buses, because this is the least risky method within the Schengen borders.

The acquisition source of the new psychoactive substances is characteristically China. The dealers and even the users order them directly online and have it transported into the country by package delivery services. However, according to investigation information, a proportion of the raw materials comes to Hungary from Slovakia, the Netherlands and Spain.

T1.1.3 Trafficking within the country

For the available information see Chapter T1.1.5.

T1.1.4 Wholesale drug and precursor market

During 2017 no large scale drug precursor seizure took place in Hungary, however in one case, 200 kilograms of a substance was seized which could have been likely used for producing drug precursor.

With respect to the most characteristic diluents and adulterants, on three occasions the authorities seized a caffeine-paracetamol mixture (10 kg in total) on the Serbian border.. No other significant drug dilution related seizure was made in Hungary.

The most frequent diluents and adulterants in the seized preparations in the case of amphetamine are caffeine and lactose, in the case of cocaine phenacetin and caffeine, while caffeine and paracetamol are used for heroin. New psychoactive substances on the market in the form of powder are usually distributed undiluted, in their pure form.

During its exploratory activities the investigating authority collects information on the wholesale prices characteristic on the market. According to expert estimates based on the data obtained the average prices are as follows: cannabis: EUR 3,750 /kg, heroin: EUR 18,000 /kg, cocaine: EUR 28,000 /kg, amphetamine: EUR 4,500 /kg. (ORFK 2016)

T1.1.5 Retail drug market

Online trade

In November 2015 the Hungarian National Focal Point carried out a survey with the aim of investigating the online availability of synthetic cannabinoids and designer stimulants and monitoring the current trends on the online market of new psychoactive substances (Dunay and Port 2015, for methodology see T5.2). According to the findings of the survey the number of such websites decreased: the present survey identified 38 active sites as opposed to the 54 websites identified via the last EMCDDA online snapshot survey in 2013 (Port 2013).

For the purposes of the study 3 categories of legal highs were distinguished: synthetic cannabinoids, designer stimulants and psychedelic plants. The substances sold most commonly were plant materials treated with synthetic cannabinoids which were available in 35 online shops (92%). Psychedelic plants were sold on 4 sites (10.5%), designer stimulants (tablets or powder) were available in 17 shops (45%). The sites selling synthetic cannabinoids typically offered their products as some type of 'herbal mix': 25 sites sold these as incense, but the names 'potpourri', 'bio weed', 'herbal mix' and in one case 'room freshener' were also used. Synthetic cannabinoids in powder form were sold on 15 sites (39%) (in 3 cases as plant salts, in one case as crystal, in two cases as herbal powder and in nine cases as 'cannabinoid powder'.) There was no precise information on the components of the materials sold as 'crystal' either - these most probably contained some kind of designer stimulant as the active substance. The name used most frequently was 'amber crystal': this was used by 5 (42%) out of the 16 sites selling crystals, another 3 sites used the name 'penta'. Tablets (or 'legal pills') were sold by 10 sites (26%) under different fantasy names, without any reference to the components or effects. Among psychedelic plants the most commonly available were damiana and kratom (sold by 3 sites). Salvia was available in one shop only. In the 3 shops selling damiana and kratom, other ethnobotanical products were also offered such as wild dagga, leonorus sibiricus, marshmallow leaf, Mexican morning glory (Ipomoea), kanna, catuaba, khat etc.

All but two of the identified web pages were accessible in Hungarian (one site also had a Romanian and one other an English interface besides the Hungarian one). Purchase could be done in two steps on most of the sites: orders could be issued by establishing e-mail (or occasionally telephone or text message) contact with the site operator and then paying afterwards for courier or postal delivery. Only 4 of the identified sites operated as a classic webshop where the transaction could be completed in one visit.¹¹² Most of the sites could be contacted via e-mail (34 pages), 18 through telephone and one site had an active Facebook profile.

Almost none of the sites had information on the origin of the sold products. There was one site that mentioned that the product had come from abroad and another which marked China and India as the source of supply.

¹¹² There were four other such sites where payment was only possible in a second step but it could be done by bank transfer, in two cases via PayPal and in one case through Western Union or using bitcoins.

Regarding warnings about the products, 34 from the 38 sites (89%) indicated that their service was available only for adults. It was also frequently mentioned that the products were not suitable for human or animal consumption (28 sites, 74%). There were 9 sites (24%) which did not write about the legal status of the substances sold, the remaining 29 sites advertised their products as legal. Among the legal information in some cases a detailed description of data protection rules was also provided (on 4 sites).

24 sites had some information on the mode of use, but this usually served only to strengthen the apparent status of legality: they drew attention to the fact that the substances are intended for decoration, gardening or technical purposes and 12 herbal incense selling sites provided an almost identical instruction on how to use the incense sold. There were 4 sites which did not give any instructions regarding the proper use of the substances (apart from the name applied), and 10 sites only noted that the products are unsuitable for human consumption. One site gave detailed guidance on how to prepare herbal incense using cannabinoid powder.

Only a few of the sites provided any information on the potential effects of the substances and only the site selling kratom and salvia had a thorough description (together with real instructions for use). 4 other sites drew attention to the sedative or stimulant effect of the incense offered and one to the duration of the effects. There was one site which as a side effect referred to a stupor lasting for approximately two hours.

Compared to the previous online snapshot surveys (Péterfi and Port 2011, Port 2012, Port 2013) (for details see the 2011 National Report Chapter 10.1, and the 2012 and 2013 National Reports Chapter 10.2), there were no significant changes in the proposed use (incense/air freshener, plant salt, gardening), and the warnings and legal information provided on the sites. Regarding the origin of the substances sold the number of those sites which indicated the source country decreased from 2011 to 2015 (in 2011 4 sites out of 19 provided this information while in 2015 only 1 out of 38). The prices of the substances are hard to compare due to the different methodology used in 2011. In 2011 the price of JWH-018 applied on plant materials was monitored for which the average price was 7.62 EUR/g¹¹³ when ordering a small quantity and 3.46 EUR/g upon a 100 g order. Comparing this with the prices of herbal incenses in the 2015 survey (3.95 EUR/g and 1.56 EUR/g depending on the quantity), a significant, almost 50% decline is indicated which is in line with the findings of the annual data collection on the street level prices of drugs.

Street prices

As compared to previous years, the Hungarian National Focal Point performed a survey among clients of outpatient drug treatment centres regarding the street level prices of drugs at spring in 2018 (Bálint 2018) (for the methodology see: T5.2). (ST_16_2018_HU_01). Apart from the classical drugs, the questionnaire also asked about the prices of designer stimulants (known as “crystal”) and bio-weed” (herbal mixtures treated with synthetic cannabinoids, known as “herbal”) when last purchased.

The most common street price for cannabis derivatives (herbal cannabis; cannabis resin) was 8.1 EUR while Ecstasy costed 6.5, and amphetamines 9.7 EUR. The most common price of “synthetic weed” in 2017 was 3.2 EUR, while of designer stimulants 9.7 EUR.

Table 1. *Price of drugs at street level in 2017 in HUF*

substance	lowest	highest	mean	mode	number responses	of
cannabis resin(g)	1 500	4 500	2 572	2 500	77	
herbal cannabis (g)	1 500	4 000	2 551	2 500	126	
heroin (g)	7 500	20 000	12 308	12 000	19	
heroin (packet)	2 000	12 000	5 353	5 000	20	

¹¹³ Prices were calculated using the EUR intermediate exchange rate valid for 2017 (EUR 1=HUF 309,41).

cocaine (g)	12 000	30 000	21 024	20 000	65
amphetamine (g)	2 000	5 000	2 854	3 000	85
methamphetamine (g)	2 000	16 000	3 739	3 000	24
ecstasy (1 tabl.)	500	3 500	1 996	2 000	81
LSD (1 dose)	1 000	6 000	3 042	3 000	44
"herbal" (g)	500	5 000	1 227	1 000	65
methadone (20mg)	500	6 000	1 981	2 000	15
methadone (5mg)	300	2 000	1 030	1 000	13
"crystal" (g)	1 000	7 000	2 982	3 000	53

Source: Bálint 2018

Table 2. Prices of drugs at street level in 2017 in EUR¹¹⁴

substance	lowest	highest	mean	mode	number of responses
cannabis resin (g)	4.8	14.5	8.3	8.1	77
herbal cannabis (g)	4.8	12.9	8.2	8.1	126
heroin (g)	24.2	64.6	39.8	38.8	19
heroin (packet)	6.5	38.8	17.3	16.2	20
cocaine (g)	38.8	97.0	67.9	64.6	65
amphetamines (g)	6.5	16.2	9.2	9.7	85
methamphetamines (g)	6.5	51.7	12.1	9.7	24
Ecstasy (1 tabl.)	1.6	11.3	6.5	6.5	81
LSD (1 dose)	3.2	19.4	9.8	9.7	44
"herbal" (g)	1.6	16.2	4.0	3.2	65
methadone (20mg)	1.6	19.4	6.4	6.5	15
methadone (5mg)	1.0	6.5	3.3	3.2	13
"crystal" (g)	3.2	22.6	9.6	9.7	53

Source: Bálint 2018

Purity

The active substance content of the seized substances in 2017 differed from the proportions detected in the previous year on some occasions (for methodology see T5.2). (ST_14_2018_HU_01) There was no significant change in the case of herbal cannabis. There was a decrease in the proportion of low active substance content in cannabis resin seizures, substances under 2% active substance content nearly disappeared from the seizures. Regarding powders containing heroin, in 2017, there were more large-scale seizures with higher potency compared to in 2016, although high active substance content also appeared at the smaller seizure cases. In the case of cocaine seized in smaller scale packages, the active substance content was usually 15-85% but in large scale seizures weighting some hundred grams there were some cases where the active substance content was 30-40%. The active substance content of powders containing methamphetamine did not change significantly as compared to the previous year. The concentration of the seized amphetamine powders was in the range of 1-70%. Similar to previous years on several occasions small amounts of amphetamine were seized that had an active substance content of around 70%, i.e. they were practically undiluted powders. The active substance content of

¹¹⁴ The prices in the table were calculated using the EUR intermediate exchange rate valid for 2016 (EUR 1=HUF 309,41).

ecstasy tablets rose a little further. (ST_15_2018_HU_01) In several cases larger tablets with special shape were found even with 220 mg active substance content. The MDMA base content of tablets with a lower active substance content was generally between 70-150 milligrams.

Among NPSs consumed in powder form, typically sold on the streets with the name 'crystal' ethyl-hexedrone was the most popular substance in 2017, which was found undiluted frequently. However, there were multiple cases when powders with ethyl-hexedrone also contained 4-Cl-alpha-PVP. The active substance content of the various synthetic cannabinoids applied to herbal materials decreased and was typically 0,1-6% in 2017.

T1.2 DRUG RELATED CRIME

T1.2.1 Drug law offences

The characteristics of drug offences and their perpetrators are presented on the basis of the data recorded when investigations are completed in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS). The data are analysed by the Hungarian National Focal Point.

In 2013 the Special Part of the Hungarian Criminal Code was significantly amended, including the statutory definitions related to drug offences. Offences committed after 1 July 2013 fall under the force of Act C of 2012 on the Criminal Code (hereinafter new Btk.), while offences committed before 1 July 2013 fall under the effect of Act IV. of 1978 on the Criminal Code (hereinafter old Btk.). (For details see the Legal framework Workbook Chapter T1.1.1, and the 2014 National Report, Chapter 1.2.)

The investigation phase of a total of 6963 offences related to drugs or new psychoactive substances was closed in 2017, of these 55 cases fell under the force of the old Btk. and 6908 under the new Btk.

Misuse of new psychoactive substances has involved criminal liability since March 2012. (For details see the Legal framework Workbook, Chapter T1.1.3, and the 2012 National Report, Chapter 1.2.) A total of 415 (6.8%) drug related offences involved substances classified as new psychoactive substances, all of which fell under the force of the new Btk. Following the close of investigations in offences related to the misuse of NPS 1678 cases were transferred to infringement procedure in 2017. (Police 2018)

Drug related offences represented 3.1% of all offences registered in Hungary.

Almost 50% of drug offences were committed in Budapest (38.5%) or Pest county (8.1%). Among the other counties the share of those lying along the northern border was the highest (Győr-Moson-Sopron 5.2%, BAZ 4.6%).

Substance types

In 2017 60% of the registered drug offences¹¹⁵ (60.6%, 3951 cases) were committed with cannabis, the second largest group was that of stimulants¹¹⁶ (25.0%, 1631 cases). Among stimulants, the most frequently occurring substance was amphetamine (80.0%), followed by MDMA (ecstasy) (13.3%) and methamphetamine (3.7%). New psychoactive substances were recorded in only 1.1% (74 cases) of the registered cases.¹¹⁷ Among NPS mostly

¹¹⁵ Excluding cases linked to precursors (4) and those offences where the substance type was not recorded (437).

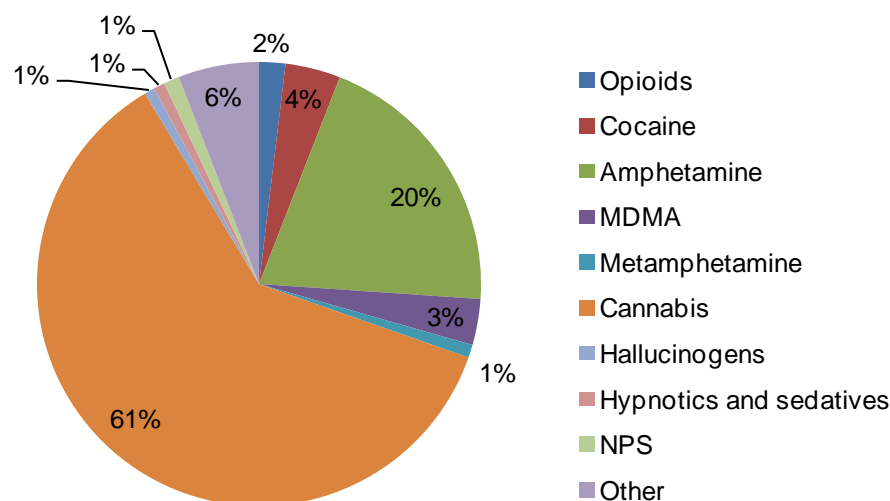
¹¹⁶ Stimulants other than cocaine.

¹¹⁷ The number of cases committed with new psychoactive substances broken down by statutory definitions of the Criminal Code and by substance types does not match. The reason for this is that the categorisation by substance type took place according to the substance categories defined by the EMCDDA DLO data collection protocol where substances not listed on the UN drug schedules were classed as new psychoactive substances, while in case of categorisation by statutory definition offences committed with substances scheduled as new psychoactive substances according to Hungarian law were classified here. The Hungarian legislation is stricter in places than international legislation and certain substances not included on the UN lists - and hence categorized

cathinone derivatives (40.5%); synthetic cannabinoids (23.8%); arylalkylamines (28.4%); piperazines (13.5%), phenethylamines (10.8%) were recorded.

Cocaine was registered as the subject of the offence in 4.0% (260 cases) of the cases, opioids in 2.6% (124 cases, among which: heroin 0.95%, methadone 0.85%, other opioids 0.80%), hallucinogens in 0.75% (49 cases) and other substances in 5.8% (381 cases).¹¹⁸ (ST_11_2018_HU_01)

Chart 1. Breakdown of registered drug offences (N=6522)¹¹⁹ by substance type in 2017



Source: ENYÜBS 2018, analyzed by HNFP

Perpetrations¹²⁰

Of the offences registered in 2017, 5587 offences (80.2%) were linked strictly to possession of an illicit drug (acquisition or possession for personal use). 60.7% of these cases were committed with cannabis, 25.3% with stimulants. Other types of substances appeared as the subject of use related offences in relatively low proportions (opioids 1.9%, cocaine 4.0%, other substances 5.6%, NPS 1.0%). (ST_11_2018_HU_01)

Perpetrations classed as supply-related offences¹²¹ made up 19.3% of registered drug offences (1343 cases). A third of supply related offences (31.7%, 426 cases) involved trafficking with a small quantity of drugs. Offences committed with a substantial or particularly substantial quantity were recorded in 219 cases (representing 16.3% of supply related offences and 3.2% of all drug offences). Cultivation or production of drugs was the type of perpetration in 109 offences, accounting for 8.1% of supply related cases.

The large majority of trafficking related perpetrations were linked to cannabis (41.6%). Stimulants were involved in 16.3%, cocaine in 2.9%, opioids in 1.3%, NPS in 0.9% and other substances in 4.0% of supply related cases. The proportion of offences where the substance type was unknown or unspecified was also relatively high (31.9%).

as NPS according to the EMCDDA protocol - are classed as illicit drugs in Hungary. For this reason the number of offences committed with new psychoactive substances is different when totalled according to statutory definitions and when categorized by substance types.

¹¹⁸ The substance type was not recorded in 437 cases (6.3% of all registered drug offences). Precursors were the subject of the offence in 4 cases (0.06%).

¹¹⁹ Excluding precursors and those offences where the substance type was not recorded.

¹²⁰ Starting from 2014 offence types are categorized according to the EMCDDA's new drug law offences data collection protocol, which is different from the reporting structure used in previous years in several aspects.

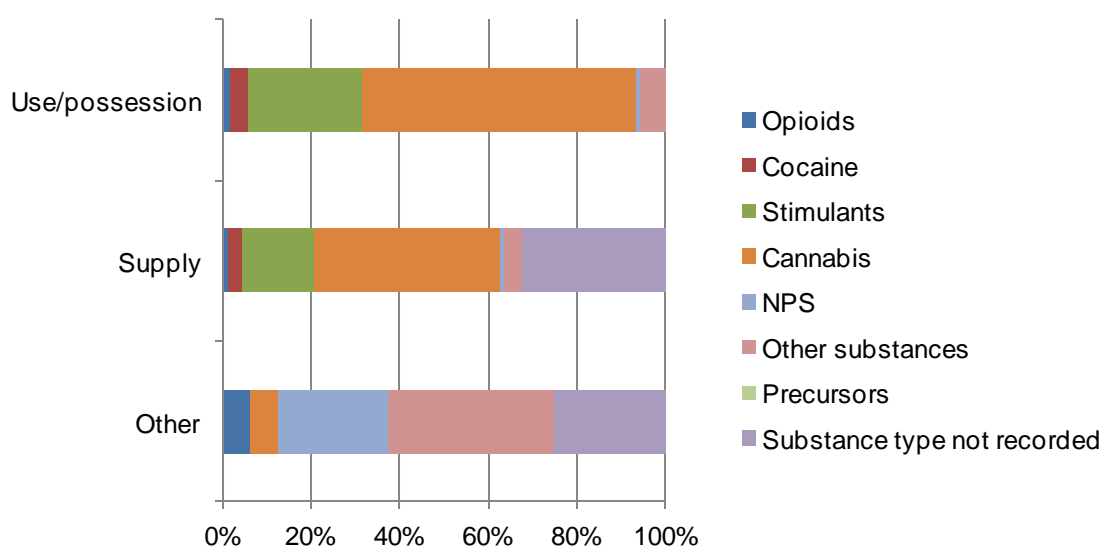
¹²¹ Trafficking related behaviours include: cultivation, production, offer, supply, distribution, dealing, import, export, transport through the country, and all offences committed with a substantial or particularly substantial quantity.

Among offences committed with a substantial amount of drug, cannabis (53.9%) and stimulants (25.1%) were recorded most frequently as the subject of the perpetration. Cocaine was recorded in 10.5%, opioids in 4.1% and other drugs in 1.4% of the cases. Among supply related offences committed with small amounts of drugs cannabis was the subject of the offence in 34.0% of the cases and stimulants were involved in 14.1% however, the proportion of offences committed with other substances (5.2%) or with unspecified substances (43.4%) was also high.

96.3% of cultivation/production offences involved cannabis.

Other perpetration types listed under a separate title in the Criminal Code (inciting substance abuse, aiding the production of illicit drugs) were recorded in 33 cases (0.5%). (ST_11_2018_HU_01)

Chart 2. Breakdown of registered drug offences by perpetration and substance type, 2017



Source: ENYÜBS 2018, analysed by HNF

Alternatives to criminal procedure

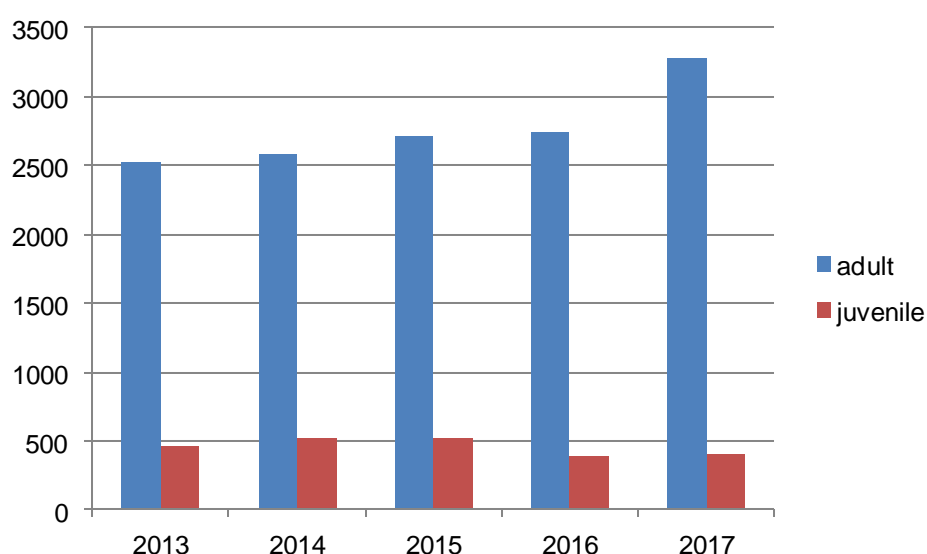
The large majority of criminal procedures¹²² launched in drug related cases are closed before the court phase starts, as a result of the institution of quasi compulsory treatment (QCT), which may be undertaken as an alternative to punishment. (The legislative background of the alternatives to criminal procedure is described in the Legal framework Workbook, Chapter T2.1, the data of those entering treatment in the scope of QCT are presented in the Treatment Workbook, Chapter T1.3.1., while the data of prisoner clients entering QCT is reported in the Prison workbook, Chapter T1.2.2 and T1.3.2.) Only a smaller part of those participating in QCT will have a criminal record (for example, if the offender only starts QCT during the court phase of the procedure), the majority will not be registered in the criminal statistics, because when a perpetrator starts QCT the criminal proceedings are terminated and the case is not registered as an offence.

¹²² The number of registered offences and criminal proceedings data must be treated separately. The data relating to criminal proceedings show how many criminal proceedings were launched due to a specific act in the given period, irrespective of how the proceedings were closed. The data relating to registered offences show the number of offences of a particular type that were registered as an offence when the investigation was closed. Several criminal proceedings may be launched in relation to one act, but it will only be registered in the statistics as an offence once. It may also happen that at the end of the investigation the police or the public prosecutor do not determine that a crime has been committed, or the public prosecutor applies a method of closing the investigation different from formal accusation (e.g. the proceedings are terminated, suspended due to lack of evidence, etc.), and in this way the given case is not registered as an offence. Therefore, the data on criminal proceedings form a much wider data set than the data on registered offences.

In 2017 a total of 12,575 drug-related criminal proceedings were terminated, of these formal accusation was made in just 3041 cases (24.2%). The remaining 76% of criminal proceedings were closed before the court phase due to procedural decisions 'suspension of investigation' (34.8%), 'rejection of complaint' (4.0%), 'other form of termination' (17.2%) or 'diversion'. The criminal proceedings were closed in relation to diversion (treatment as an alternative to criminal procedure) in 2482 cases (19.7%) but the actual number of proceedings terminated because of QCT is higher as a smaller proportion of QCT cases will be recorded among the 'other form of termination' procedural decisions, under the legal title of 'postponement of formal accusation' or 'other reason terminating culpability'.

Probation service linked to diversion¹²³ was provided in 3688 cases. 88.9% of the offenders of these cases were adults and 11.1% were juveniles.

Chart 3. *Number of probation services provided in connection with quasi compulsory treatment (QCT), 2013-2017*



Source: IM2018

Drug law offenders

In 2017 the criminal statistics registered 6963 offenders linked to the 6860 registered drug offences¹²⁴. 90% of the offenders were males and 10% were females, similarly to previous years.

Regarding distribution by age groups, 9.2% of drug law offenders were under 18 years, 34.2% of them were between 19 and 24 years, and 25.9% were between 25 and 30. Overall, 68.1% of drug law offenders were 30 years old or younger, while among all criminal offenders the proportion of those under 30 years of age was 42.8% and of those between 19-24 years was 16.7% which implies that drug offenders are significantly younger than other offenders.

30.8% of drug offenders had elementary school qualifications, 35.0% completed secondary school and only 2.6% had higher school qualifications.¹²⁵

¹²³ For the duration of the probation service imposed/ordered in connection with the postponement of accusation (diversion) on the basis of Article 222(2) of Act XIX. of 1998 on Criminal Procedures, according to Article 225(4) of the same Act it is obligatory to engage in preventive-consulting service, in treatment for drug addiction or in treatment of other conditions with drug use (the 3 forms of treatment available in the scope of diversion). Probation service ordered in connection with QCT is a special case of probation service the primary aim of which is to support and monitor the fulfillment of the additional obligation.

¹²⁴ One offender may commit several offences. The data on offences are complete, however, they are not with respect to the perpetrators, as an offender is recorded only with the most serious offence or if the offender is a minor.

T1.2.2 Consequent crime – Offences committed under the influence of illicit drugs

In 2017 a total of 5845 persons committed offences under the influence of illicit drugs, which made up 6.3% of all registered offenders. The large majority of those committing offences under the influence of illicit drugs committed a drug related offence (5300 persons, 90.7%), and a total of 545 persons (9.3%) committed other types of offences.

More than half of (317 persons, 58.2%) the perpetrators committing non-drug related offences under the influence of illicit drugs committed traffic offences, of these 315 persons committed the offence of driving under the influence of alcohol or other substances. 97 persons (17.8%) committed offences against property, 27 persons (4.95%) committed offences against persons¹²⁶ (of these 2 person committed murder, 4 persons attempted murder and 17 persons committed bodily harm). 45 persons (8.3%) committed the act of disturbing the peace, and 59 persons (10.8%) committed other offences.

T1.3 DRUG SUPPLY REDUCTION ACTIVITIES

T1.3.1 Drug supply reduction activities

It is an objective specified in the National Anti-drug Strategy to force back the extent of drug use in Hungary as completely as possible by 2020 using all the instruments available, while ensuring the balance of demand and supply reduction. This is especially important in those settings where children and young people are subjected to increased risk: in schools, institutions of public culture and in music venues/clubs.

The National Security Strategy specifies in detail the challenges and adequate responses at national level arising in connection with drug trafficking. It states that the preconditions of rapid and more effective action against drug related crime are the following: increasing the effectiveness of the work performed by the police, improving the equipment used by the competent bodies and the training of personnel, as well as effective information exchange and collaboration with the competent international bodies. In the interest of this, according to the Strategy the effectiveness of the countermeasures must be increased, the bodies responsible for action against organised crime groups and the personnel, material and technical resources of forensic experts must be strengthened. Apart from the above, a national level anti-drug crime service must be set up. The fight against drugs also represents a comprehensive social task, therefore, from the point of a successful action, the use of the crime prevention possibilities are especially important.

Based on above, the main strategic objective of supply reduction is to prevent any psychoactive substance suitable for misuse getting into Hungary and prevent access to the substances appearing in the country, and realise the crime prevention aspects related to this.

The National Police Anti-drug Strategy entered into force in February 2014. Apart from reducing supply, the document lists the priorities as strengthening the activities of forensic experts, reducing the number of road accidents related to drug use and increasing the effectiveness of investigations. According to the main priorities stated, the number of procedures launched due to trafficking behaviours needs to be increased and collaboration between the Hungarian Post and delivery companies must be established that assists the restriction of distribution made in this way.

¹²⁵ In the case of 2160 persons (31.5%) school qualification was unknown.

¹²⁶ It contains all the cases falling under the force of the old Btk., but only some of those under the force of the new Btk., as the individual statutory definitions listed in the old Btk. under the title of offences against persons are listed under different titles in the new Btk.

The primary participant in the supply reduction activity is the criminal and public order protection service of the Police, also involved in this activity is the drug policing work performed by the police administration service, which reduces and prevents diversions by inspections among those with permits (healthcare service providers, manufacturers, wholesalers).

Due to organisational changes in 2012, at the moment there is only one unit with a staff of 25 persons at the Operational Police National Bureau of Investigation, which performs a designated anti-drug crime fighting activity. Before this, there was a designated unit at the Budapest Police Headquarters, which performed this activity with a staff of 67. At present it is the crime and investigation departments of the county (and Budapest) Police Headquarters that carry out the procedures required due to drug related offences, as well as investigating all other offences, there is no body specially dedicated for this task.

Drug enforcement is carried out by the ORFK RFI Department of Public Administration, as a central body, along with a stable drug enforcement network (23 persons). In 2017 more than 8,000 control measurements were carried out, which resulted in 29 supervised annihilations. The body also found some deficiencies in 188 cases, penalized by offense reports in 6 cases and by protocol alerts in 182 cases.

The National Tax and Customs Administration (NAV) carries out supply reduction tasks by monitoring the legal traffic of illicit drugs, new psychoactive substances and drug precursors. NAV is also responsible for detecting illegal substances at border crossing points and at postal and courier services (NAV 2018).

T2. TRENDS

T2.1 SHORT TERM TRENDS REGARDING THE MOST CHARACTERISTIC DRUGS ON THE MARKET

Seizures

During 2010-2011, the authorities seized more than 10000 plants per year at large-scale cannabis plantations of more than 100 plants. This amount significantly dropped in the period 2012-2014. However, no outstanding change can be seen in the number and proportion of plantations of under 10 plants and between 10–100 plants over the period between 2010 and 2017.

The amount of herbal cannabis seized in large quantities jumped significantly in 2012, then dropped continuously until 2016. In 2017 significant seizures happened again in the border traffic from Serbia to Hungary. While during the 2010-2011 period a few hundred kilograms of herbal cannabis was seized, in 2012 the amount seized was nearly 1.8 tonnes, which fell back to 529 kg in 2014, 590 kg in 2015 and 494 kg in 2016, then in 2017 the amount rose to 2.1 tonnes again.

The number of cannabis resin seizures has been rising continuously since 2010. Comparing to previous years, in 2017, there was an outstanding quantity sized amounting to 114 kilograms out of which a single consignment was 108 kilograms.

In 2009/2010 the number of heroin seizures and the amount of seized material dropped significantly as compared to previous years. During the following time period the seizures per year did not rise significantly, and the total amount of substance seized was just a few kilograms per year. While in 2016 there were no major seizures, in 2017 in 5 cases the seizures were over 1 kg and in one case the seizure was nearly one kg.

With respect to cocaine seizures, a continuous rising trend can be identified in the number of seizures in the 2011–2017 period, the major part of which were on retail level. During 2016 and 2017 – compared to the previous years – the number of seizures significantly increased, which refers to the more dynamic spread of cocaine.

The number of amphetamine seizures – due to the trend of small seizures under 10 grams – showed a slight increase in the 2010-2017 period as well.

There were only 7 seizures of tablets containing MDMA in 2010, but the number of seizures increased continuously from 2012. During 2016 and 2017 MDMA tablets were seized in 332 and 502 cases. There were 11 larger scale seizures (1000 or more tablets) in 2017. Parallel to this the number of powder or crystal MDMA cases also show a continuously rising tendency.

The number of LSD seizures and also the seized quantity exceeded the data of previous years in 2017. In recent years LSD has been seized by the authorities in the forms of a solution and powder as well. Characteristically these cases may be linked to the internationally popular large summer music festivals. (ST 13_2018_HU_02)

Table 3. *Number of seizures between 2013-2017*¹²⁷

type of drug	2013	2014	2015	2016	2017
herbal cannabis	2040	2058	1945	2673	3674
cannabis plants	196	146	127	153	158
cannabis resin	101	101	141	149	153
heroin	32	31	48	34	34
cocaine	117	143	153	229	276
amphetamine	536	598	633	778	900
methamphetamine	50	54	62	54	68
ecstasy tablets /MDMA, MDA, MDE/	181	213	219	332	502
LSD	22	29	33	32	54
<i>plant materials with synthetic cannabinoids</i>	<i>2099</i>	<i>3876</i>	<i>2440</i>	<i>2373</i>	<i>2177</i>
<i>synthetic cannabinoids in powder</i>	<i>60</i>	<i>104</i>	<i>90</i>	<i>113</i>	<i>120</i>
<i>cathinone derivatives in the form of powder</i>	<i>855</i>	<i>863</i>	<i>802</i>	<i>671</i>	<i>735</i>
<i>cathinone derivatives in tablets</i>	<i>174</i>	<i>40</i>	<i>67</i>	<i>70</i>	<i>8</i>

Source: NSZKK 2018a

Table 4. *Quantity seized between 2013-2017*¹²⁸

type of drug	2013	2014	2015	2016	2017
herbal cannabis (kg)	863.4	529.23	589.55	494.12	2139.91
cannabis plants (plant)	5307	3288	2970	6482	5287
cannabis resin (kg)	5	7.91	18.15	3.69	114.46
heroin (kg)	5.7	70.06	11.74	2.11	20.56
cocaine (kg)	8.1	39.65	30.53	25.06	5.87
amphetamine (kg)	74.8	15.95	32.48	24.78	24.71
methamphetamine (kg)	0.2	0.41	1.17	0.19	0.74
ecstasy tablets (tablet) /MDMA, MDA, MDE/	17664	13020	56420	79702	51836
LSD (dose)	342	965	398	928	1476
<i>plant materials with synthetic cannabinoids (kg)</i>	<i>44.5</i>	<i>100.01</i>	<i>21.18</i>	<i>29.13</i>	<i>11.79</i>
<i>synthetic cannabinoids in powder (kg)</i>	<i>15.5</i>	<i>5.52</i>	<i>5.55</i>	<i>3.47</i>	<i>3.09</i>
<i>cathinone derivatives in the form of powder (kg)</i>	<i>81.5</i>	<i>42.01</i>	<i>18.34</i>	<i>36.14</i>	<i>30.76</i>
<i>cathinone derivatives in tablets (tablet)</i>	<i>55421</i>	<i>12902</i>	<i>15578</i>	<i>3256</i>	<i>551</i>

Source: NSZKK 2018a

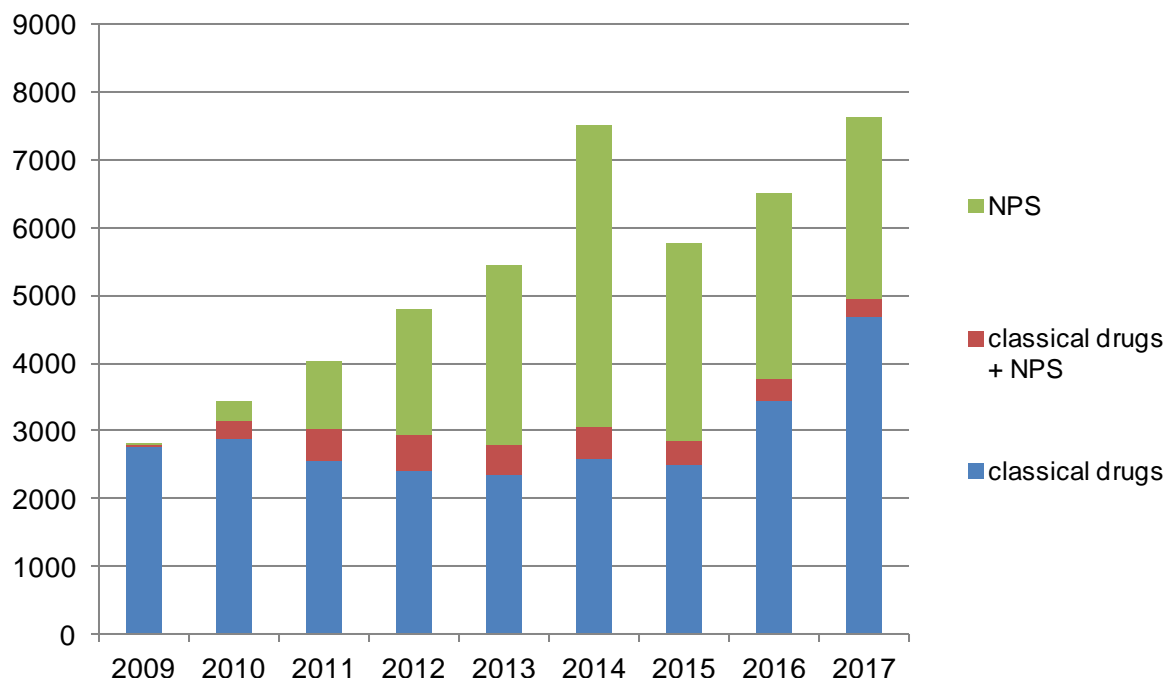
From 2010 NPS completely restructured the Hungarian drug market. Following the large-scale increase in the amount of mephedrone available in the summer of 2010, the proportion

¹²⁷ The following table contains the data of the seizures analysed in the drug testing laboratory of the Hungarian Institute for Forensic Sciences, and the data of the cannabis plantations seized on site on the basis of the botanical examination.

¹²⁸ The following table contains the data of the seizures analysed in the drug testing laboratory of the Hungarian Institute for Forensic Sciences, and the data of the cannabis plantations seized on site on the basis of the botanical examination.

of new psychoactive substances as compared to the classical drugs rose continuously for years. In 2014 NPS constituted nearly 60% of all police seizures. The continuously increasing trend of seizures turned back in 2015, in 2017 NPS seizures only represented 35% of all seizures.

Chart 4. The number of seizures of 'classical drugs'¹²⁹ and NPS between 2009-2017



Source: NSZKK 2018a

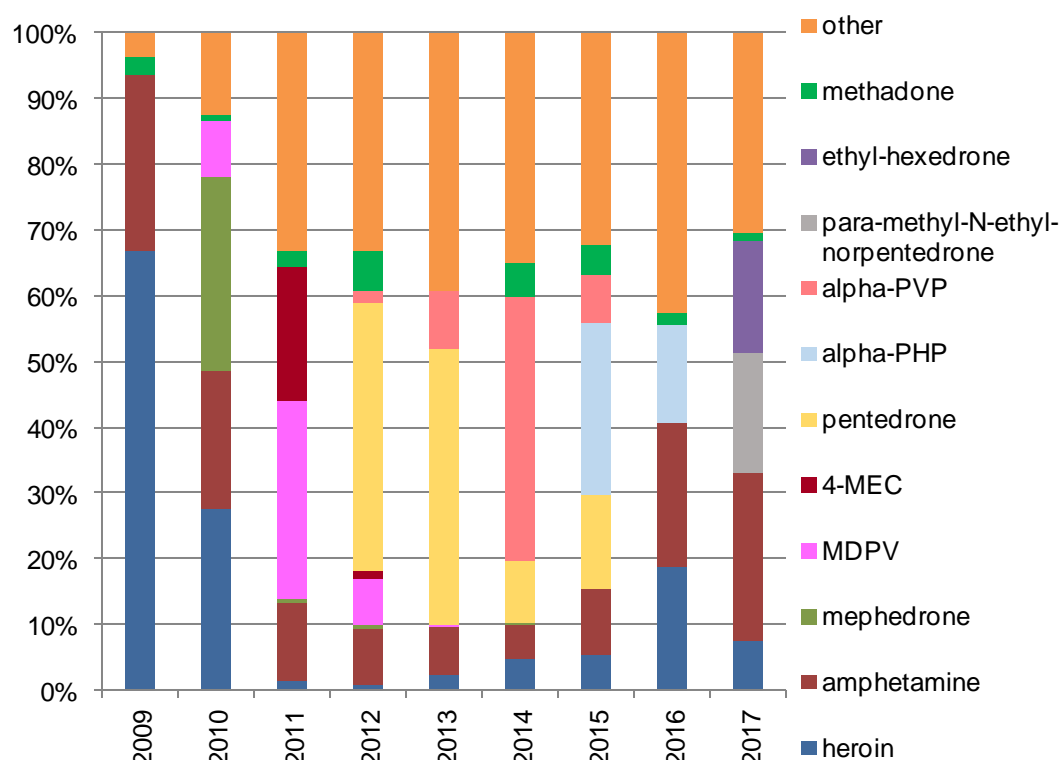
The share of two large groups of the new substances, cathinone derivatives and synthetic cannabinoids was the largest in the seizures. Cathinones are usually distributed in the form of powders. The most frequent active substances were: mephedrone in 2010, 4-MEC and MDPV in 2011, and pentedrone from 2012. During 2014 the proportion of alpha-PVP in the seizures rose significantly for a time, but by the end of the year it was pentedrone again that was the most characteristic substance. In 2015 besides pentedrone and alpha-PVP the substance called alpha-PHP appeared in seizures with a larger proportion typically in the period January-August. From August 2016 and also in 2017 ethyl-hexedrone seemed to be the most popular cathinone on the market. During 2017 a small amount of 4-Cl-alpha-PVP was detected in nearly quarter of the investigated ethyl-hexedrone powders. This year para-methyl-N-ethyl-norpentedrone, 4_CEC, N-methyl-pentedrone and N-ethyl-pentylone had also a significant proportion among seized cathinones.

On the basis of the active substances detected in/on injecting drug use related equipment subjected to laboratory testing, it is possible to monitor trends in the types and prevalence rates of substances injected by IDUs. While the dominance of cathinone derivatives could be detected in the past years, in 2016 and 2017 amphetamine and heroin were detected in one-third of the analysed subjects. Para-methyl-N-ethyl-norpentedrone and ethyl-hexedrone were the most frequently injected substances in 2017.

(The changing picture of substance use among IDUs can be followed in the data of clients attending needle/syringe programmes as well as in the data of those entering treatment due to drug use – see: Drugs /Stimulants, T1.2.1)

¹²⁹ Substances listed in the schedules of the UN Drug Conventions were categorised as 'classical'.

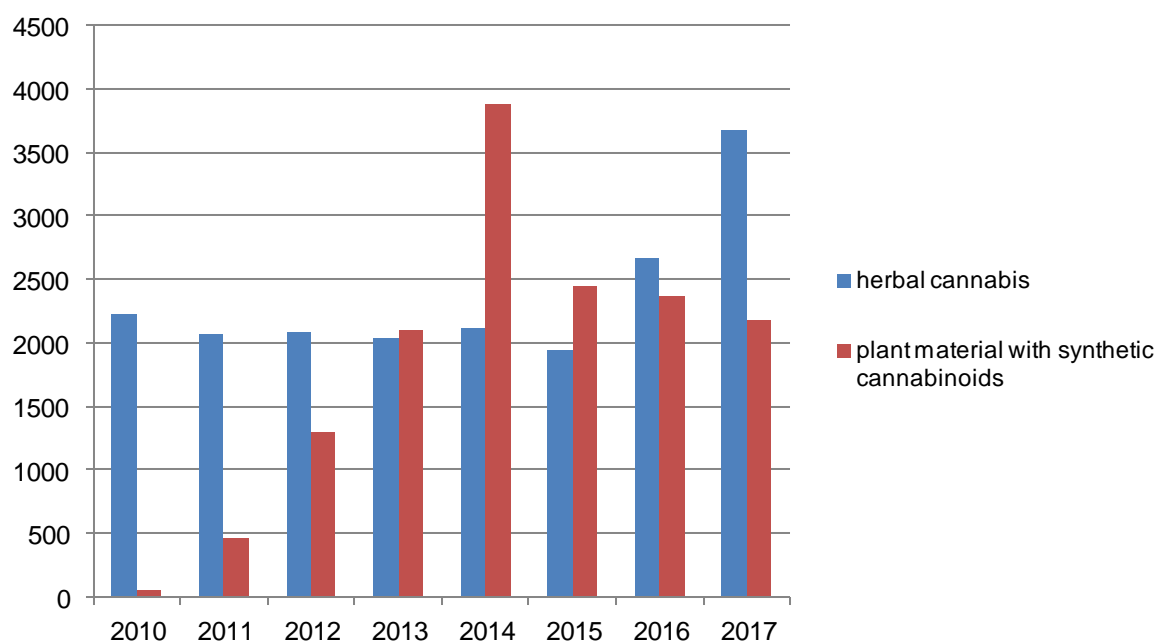
Chart 5. *Prevalence of active substances (%) detected in/on injecting drug use related equipment between 2009-2017*



Source: NSZKK 2018a

Since autumn 2010 there has been a continuous rise in the seizures of plant material impregnated with synthetic cannabinoids. The number of seizures of the products known as 'herbal', 'bio weed' or 'sage' in 2014 was nearly double the number of seizures of herbal cannabis, however, a considerable relapse can be observed since 2015 in this case as well.

Chart 6. *The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between 2010-2017*



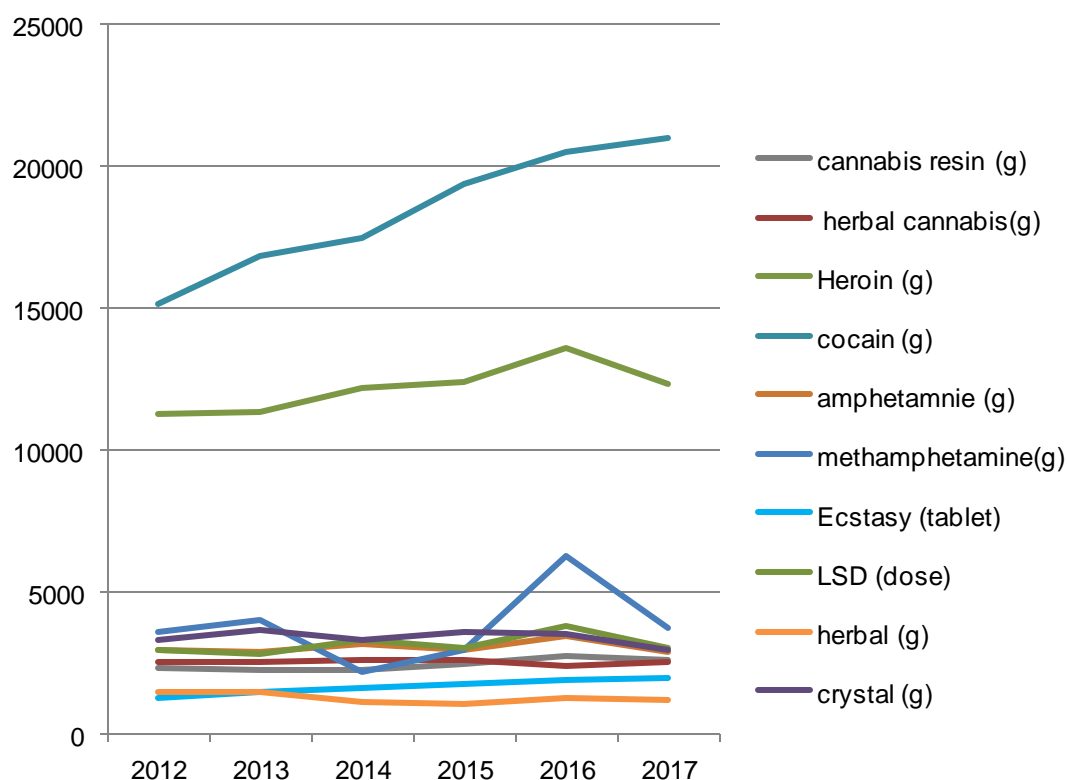
Source: NSZKK 2018a

The range of active substances found in the products follow the changes in legislation dynamically, in individual periods characteristically 1–2 dominant active substances can be found on the market. After the individual active substances had become regulated, usually within 1–3 months their occurrence dropped significantly in the period 2011-2014 and their places were taken over by new active substances that were not yet regulated. In 2015 the dynamics of these processes changed, and the number of herbal cannabis seizures was higher in 2016 than the number of seizures of products impregnated with synthetic compounds. The most frequent active substances were ADB-FUBINACA, AMB-FUBINACA and 5F-MDMB-PINACA in 2017. Synthetic cannabinoids are usually used by impregnating legally available herbs with it but it is also very common to put them on tobacco. The latter is known as “magic tobacco” on the streets, which took 15% of the seized plant materials treated with synthetic cannabinoids, which is a significant increase compared to last year’s 5%.

Street prices

According to the research carried out by the Hungarian national Focal Point (Bálint 2018), it can be stated that trends in the street drug prices of the recent years continued in 2017, therefore there are only a few notable changes. After a slight increase in the price of cathinones, synthetic cannabinoids and methamphetamine last year, there is a decline again in this year. The price of ecstasy tablets slightly further increased. By contrast, the mean prices of LSD and amphetamine in 2017 show a slight decrease compared to the previous year. For years, there has been a steep increase in the price of cocaine, which was associated with the low supply, while by 2017 this strong increasing trend slowed down. The street prices of herbal cannabis and cannabis resin have been almost the same for years, however they are still far higher than the prices of synthetic cannabinoid products.

Chart 7. Street prices (mean value) of illicit drugs in HUF between 2011-2017



Source: Bálint 2018

Purity

No significant change was observed in the active substance content of herbal cannabis seizures in the period 2010-2017.

Undiluted, practically pure amphetamine sulphate is still present among the seized substances. Substances with an active substance content over 50% formed about 10% of the cases in 2017.

An increase in the active substance content of MDMA tablets can be observed; specially shaped, larger tablets with even 220 mg MDMA content were seized on several occasions in 2017.

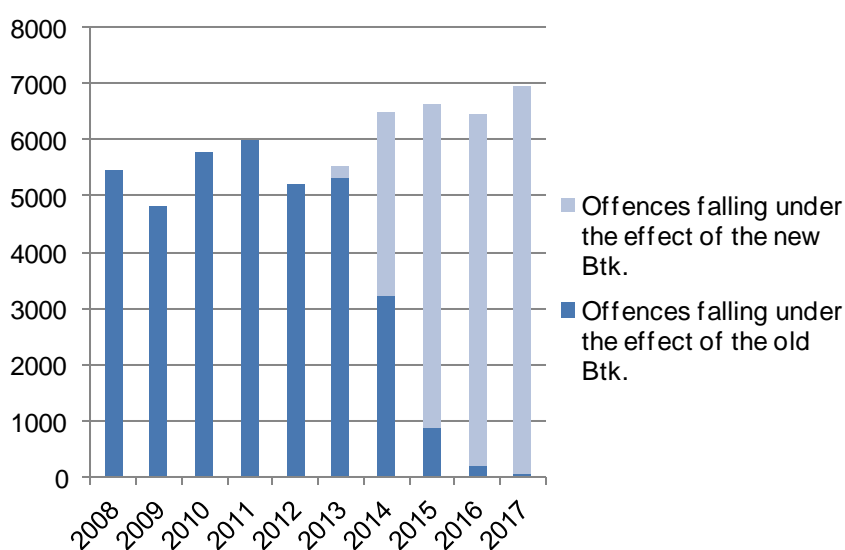
Among the plant materials impregnated with synthetic cannabinoids - compared to the previous years - lower concentrations also appeared on the market with 0.1% concentration, which is a significant change compared to substances analysed between 2014-2016 falling into the range of 1-10% and 0.5-6% potency. .

T2.4 DRUG LAW OFFENCES – SHORT TERM TRENDS

A chronological analysis of the number of drug related offences over the past 5 years is only partly possible, as offences committed before 1 July 2013 fall under the force of Act IV. of 1978 (old Btk.), while offences committed after this date fall under the force of Act C. of 2012 (new Btk.) and in the drug crime statistics the categories covering the statutory definitions of the old and the new Btk. do not always comply with each other. (For more information see 2014 National Report, Chapter 9.1). Furthermore, starting from 2014, offence types are sorted according to the categories of the new EMCDDA drug law offence protocol, which differs significantly from the reporting structure followed in the past. As a consequence data are only partially suitable for comparison and chronological analysis.

Examining the last 5 five years the annual number of registered drug law offences rose slightly and from 2016 to 2017 it increased by 7.6%. The rise might be explained by the fact that the police gave increased priority to the investigation of drug related offences in this period.

Chart 8. The number of registered drug offences in Hungary between 2008-2017



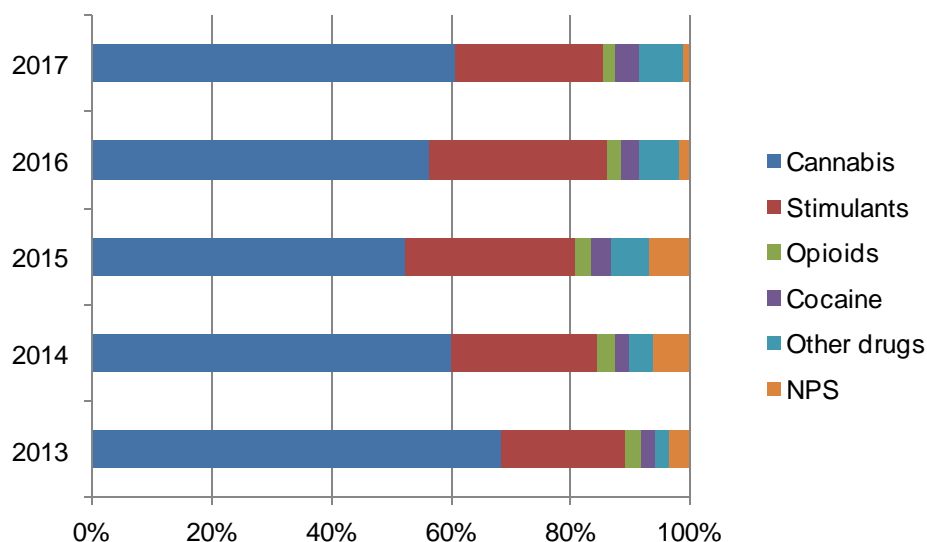
Source: ENYÜBS 2018, analyzed by HNFP

With respect to perpetration types, in the past 5 years about 80% of drug offences were consumption related, committed in connection with personal use. The proportion of trafficking type, supply related offences was usually under 20%. The large majority (80-90%) of the offences were committed with a small amount of illicit drug, substantial amounts of illicit drug occurred in only about 2-3% of cases.

Examining the past five years, the majority of drug related offences were committed with cannabis (2017: 60.6%). Following a decline between 2013 and 2016, the proportion of cannabis among the substance types started to rise again in 2017. The change in the distribution of drug related offences according to substance types followed to a certain extent the changes observed on the drug market (see Chapter T2.1) and in drug use patterns (see the Drugs/Stimulants and Drugs/Heroin and other opioids Workbook, Chapters T1.2): between 2012 and 2017 the proportion of cases involving opioids did not exceed 3% and the proportion of those involving heroin remained below 1%. Stimulants (typically amphetamine) at the same time appeared as the subject of perpetration in an increasing proportion from year to year, in 2016 offences committed with them represented 29.5% of all registered drug offences (2011: 12.7%, 2014: 20.5%, 2015: 28.6%). In 2017 the number of stimulant related cases fell slightly compared to the previous years. Following the decreasing tendency in the number of drug offences committed with ecstasy between 2010 and 2012, a slight increase can be seen from 2013 (2012: 1.8%, 2017: 3.3%).

Offences (trafficking type) with new psychoactive substances involve criminal liability since April 2012, such cases appeared in the criminal statistics in 2013. (See 2013 and 2014 National Report, Chapter 9.3.) Offences committed with new psychoactive substances constituted an increasingly larger proportion of drug law offences until 2015 (2013: 3.5%, 2015: 6.8%), but in 2016 and 2017 they accounted for less than 2% of drug offences. However, the number of offences committed with unknown substances has also been increasing since 2013 (2013: 23 cases, 2015: 287 cases, 2017: 437 cases). It can be assumed that part of the NPS related cases are represented in this category in the criminal statistics.

Chart 9. Breakdown of drug offences¹³⁰ by substance type between 2013-2017



Source: ENYÜBS 2018, analysed by HNFP

¹³⁰ Without cases committed with precursors and without those cases where the type of the substance was not recorded. Substance types were categorized in accordance with the EMCDDA 2014 data collection protocol on drug law offences, new psychoactive substances include substances not listed in the UN drug schedules.

T2.7 CHANGES IN DRUG SUPPLY REDUCTION ACTIVITIES

See Chapter T1.3.1.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2017, is presented as part of the baseline information in Chapter T1 and T2.

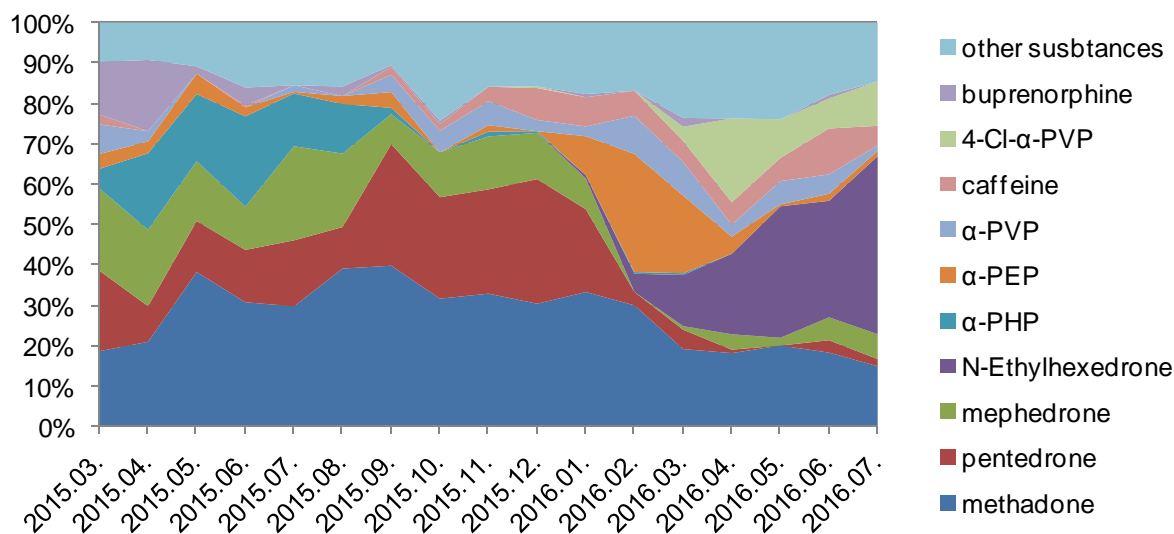
T4. ADDITIONAL INFORMATION

Analysis of drug related litter

In 2015 and 2016 the project 'Breaking the Drug Cycle' ('Tisztább kép') (Péterfi 2016; Péterfi et al. 2017; Gyarmathy et al. 2017) aimed to investigate the substances injected by PWID via the chemical analysis of substance residues found on used and discarded injecting paraphernalia (for methodology see Treatment Workbook Chapter T5.2).

When looking at the 10 substances identified most frequently by monthly breakdown it shows the dynamics of the drug market. Some substances remain at the market permanently for years while others, typically new psychoactive substances, disappear from the market following a few months of popularity. These trends could also be observed in case of the substances identified in injecting paraphernalia: methadone and pentedrone, although with varying frequency, were always among the most typical substances injected; while α -PEP, that belongs to the family of synthetic cathinones, appeared with high frequency only between December 2015 and April 2016. Similarly, α -PHP was among the most prevalent substances injected only for a short period of time (between March and August 2015). The emergence and spread of N-Ethyl-hexedrone (also synthetic cathinone) is a noteworthy process detected from February 2016. Its prevalence reached 44% in the last month studied (in samples from July 2016). Also it was the most prevalent main component detected in the composite samples starting from May 2016, overtaking the prevalence of methadone and pentedrone. (Péterfi 2016)

Chart 10. *The most prevalent substances identified as main components in injecting paraphernalia in a monthly breakdown (N=4109)*



Source: Péterfi 2016

For further results of the study see Treatment Workbook, Chapter T4.2.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

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Péterfi, A., Csorba, J., Figeczki, T., Kiss, J., Medgyesi-Frank, K., Posta, J., Gyarmathy, V.A. (2017): Drug residues in syringes and other injecting paraphernalia in Hungary. *Drug Testing and Analysis* 10.1002/dta.2217

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http://www.segelyszervezet.hu/sites/default/files/documents/tisztabb_kep_egyben.pdf

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Police (2018): A Rendőrség 2017. évi tevékenységéről szóló beszámolója

Port, Á. (2012): Felmérés az új pszichoaktív anyagokat árusító magyarországi internetoldalakról az EMCDDA Online Snapshot vizsgálatának részeként, 2012. EMCDDA/Nemzeti Drog Fókuszpont.

Port, Á. (2013): Felmérés az új pszichoaktív anyagokat árusító magyarországi internetoldalakról az EMCDDA Online Snapshot vizsgálatának részeként, 2013. EMCDDA/Nemzeti Drog Fókuszpont.

T5.2 METHODOLOGY

Drug law offences (ENYÜBS data collection): The investigating authority and public prosecutor collect and process the criminal statistics data on the rejection of accusation, and the data generated between the launching of criminal proceedings until the suspension of investigation or formal accusation, in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS).

ENYÜBS issues a 17-digit statistic code to each of the forms of the offence, in the interest of detailed and legally precise differentiation of the individual perpetration behaviours according to the different statutory definitions. When the investigation is closed two separate statistics datasheets are filled in relating to the offence and the offender. The data obtained on the offences are comprehensive, but are not complete with respect to the perpetrators: one perpetrator may commit several offences, but the statistics datasheet is only completed for the most serious offence or for an offence committed as a minor. On the datasheet relating to the offence only one substance type is recorded (only one type of substance can be associated with one offence). If several drug types are involved in the offence, there is no uniform guidance for which substance should be selected and recorded.

Seizures: (NSZKK 2018a): The information regarding the substances seized was collected on the basis of the results of forensic analysis. Analysis on the active substance content is carried out if the active substance content of the given case is above the limit of the small amount set in the criminal legislation (amphetamine: 0.5 g, heroin: 0.6 g, MDMA: 1 g, cocaine: 2 g, THC: 6 g). The Institute carries out the analysis of injecting equipment related to injecting drug use only in the most necessary cases because of the high HCV prevalence among injecting drug users.

Study of the online market of new psychoactive substances (Dunay and Port, 2015): For the purposes of the study 3 categories of legal highs were distinguished: synthetic cannabinoids, designer stimulants and psychedelic plants. For each category two search strings giving the highest number of relevant results were identified. The searches were carried out between 23.11.2015 and 27.11.2015 using Google and Bing search engines. The study covered sites last updated in 2015, sites which were created in 2014 without further reference to date, and

those sites as well which did not indicate any reference year. It was not a criterion for inclusion that order and payment was possible in one step.

Identified sites were analyzed according to the following criteria: substances sold, method of order, prices when ordering small (5 g) medium (100 g) and large (more than 1000 g) quantities, marketing, availability of warning and legal information, instructions for use and description of effects, contact information, language of the site, place of origin of sold substances.

Street level prices (Bálint 2018): 7 outpatient drug treatment centres from 7 cities participated in the study. Each organization recruited approximately 20 clients who used drugs in 2017 before entering treatment, the total sample was 146 persons. The clients only gave the price of those drugs that they personally purchased in 2017. In the self-administered questionnaire, clients had to give the price at the last purchase. The lowest, highest, mean and mode prices for each type of drug were calculated from last purchase prices by the HU-NFP.

'Breaking the drug cycle' (Péterfi 2016): See Treatment Workbook, Chapter T5.2.

T0. SUMMARY

Comprehensive, drug-related research in prisons with national coverage is relatively rare in Hungary: a national study on drug use among prisoners was last made in 2008. In the lack of this, information on the drug problem within prisons is obtained regularly from the data registered centrally by the Hungarian Prison Service Headquarters (BVOP), and from further small-scale, specific data collections. Noteworthy of the latter is the TDI data collection, in the scope of which the data of those entering drug related treatment in detention facilities are also recorded. With respect to recent years, the other significant, comprehensive sources of information were the surveys among all Hungarian detention facilities carried out in the scope of a collaboration between the Hungarian National Focal Point (HNFP) and the BVOP in 2013 and in 2016. The purpose of the studies was to assess the extent of the drug problem in prisons, as well as the coverage and characteristics of drug-related services available in detention facilities.

According to the available national data on drug use among prisoners, 30-40% of prisoners in Hungarian detention facilities had used an illicit drug in their lives prior to imprisonment. With regards to drug use inside prisons, increasing use of new psychoactive substances (mainly synthetic cannabinoids) among prisoners has been observed in recent years although reliable data is insufficient.

The prevalence of HIV, hepatitis B and C virus infections is higher among prisoners than in the general population. The studies performed in prisons indicate that the majority of prisoners tested positive for HCV probably became infected by injecting drug use prior to imprisonment.

On the basis of the TDI data, among prisoners entering drug related treatment, stimulant and opioid use and previous injecting drug use are significantly more frequent than among those starting treatment outside of detention facilities.

Treatment and care provided in prison are basically determined by the punitive frameworks of criminal law while these services are dominated by the medical model approach.

The most important elements of the treatment service in prison include a multilevel system of treatment as alternative to criminal procedure (quasi compulsory treatment, QCT), drug prevention units and general healthcare services affecting drug users. In the latter the prison healthcare services and the healthcare system outside of the prison system (mainly specialised outpatient treatment centres) both play a role. This system is supplemented by the programmes offered by different NGOs, which, however, due to their tender-based financing, have heterogeneous and ad-hoc contents.

T1. NATIONAL PROFILE

T1.1 ORGANISATION

In Hungary in 2017, 29 detention facilities were in operation. Among the institutions 15 facilities operated with national authority and 14 with county authority. The county facilities serve mainly for the preliminary custody of prisoners, where both women and men and minors may be accommodated. In detention facilities with national authority, the prison

¹³¹ Author of the chapter: Ágnes Port

service endeavours to take place of residence into consideration when allocating a detainee to a particular prison: during allocation the region is the priority, but this is not always implemented due to the overcrowdedness of facilities.

The number of prisoners in Hungarian detention facilities on 31 December 2017 was 17,343 persons, of these 16,067 (92.6%) were males and 1276 (7.4%) were females. The proportion of minors among all detainees was 1.4% (237 persons). Overcrowding is significant in Hungarian prisons: in 2017 the average utilization of the overall prison capacity was 124%. Overcrowding makes the drug problem in prisons worse.

The number of prisoners incarcerated in 2017 in connection with committing drug related offences¹³² was 3160. (BVOP 2018)

T1.2 DRUG USE AND RELATED PROBLEMS AMONG PRISONERS

T1.2.1 Drug use among prisoners

Drug use prior to imprisonment

As part of the development of the data recording system in relation to the risk assessment system implemented recently in Hungarian detention facilities (see Chapter T1.3.3) questions on drug use were also asked from a sample of 1170 prisoners in March 2015. (For methodology see Chapter T5.2.) 31.8% (355 persons) of the prisoners participating in the survey self-reported having ever used drugs in their lives prior to imprisonment. 40.3% (139 persons) of ever users reported that they had also experienced negative consequences of their drug use. (ST12_2016_HU_01)

Regarding the lifetime prevalence by substances types, cannabis use was reported by 218 prisoners (18.7% of the total sample and 61.4% of ever users). The second most frequently used substance type was stimulants¹³³: 205 persons (17.5% of the total sample and 57.7% of ever users) reported having tried them. Nearly the same proportion of respondents (202 persons, 28.2%) reported that they had taken regularly a medicine¹³⁴ withdrawing from which would affect their behaviour. Use of hallucinogens¹³⁵ was reported by 50 prisoners (4.3% of the total sample and 14.1% of ever users), use of opioids by 43 persons (3.7%, 12.1%), use of inhalants by 23 persons (2%, 6.5%). 77 prisoners reported having tried designer drugs (6.6%, 21.7%).

68.1% of the prisoners who had used drugs were younger than 35 and 24.4% of them were under age 25 which is significantly higher than the respective proportions (50.6% and 18.1%) describing the whole sample. Distribution by age was similar with regards to the users of different substance types; the ratio of those under age 25 was especially high among cannabis users (30.1%) and designer drug users (33.8%).

4 prisoners (0.3%) self-reported being a polydrug user¹³⁶ and 65 prisoners (5.9%) said that they had a behavioural addiction different from drug use (internet addiction, gambling etc.). The proportion of those who said that they had a behavioural addiction was 9.5% among those who had ever used drugs and it was 4.3% among those who had never used drugs.

¹³² Possession of drugs, Aiding in the manufacture of drugs, Drug trafficking, Misuse of drug precursors, Inciting substance abuse, Misuse of new psychoactive substances, Misuse of substance used for the manufacturing of drugs, Misuse of drugs

¹³³ In the study the following substances were included among stimulants: cocaine, amphetamine derivatives, amphetamine (speed), methamphetamine (ice), MDMA (ecstasy).

¹³⁴ The questionnaire did not specify if the medicine was prescribed by a doctor and was used as intended or not.

¹³⁵ Mescaline, psilocibin, LSD

¹³⁶ Reported to have used multiple substance types.

Information relating to drug use among prisoners prior to imprisonment is also available from the survey (Port and Tarján 2014) conducted jointly by the Hungarian National Focal Point and the BVOP in 2013. Data of the survey refers to 2012.

Out of the 31 participating prisons 15 were able to provide precise data on the proportion of prisoners self-reporting being drug addicts¹³⁷. The proportion of prisoners admitting to being drug addicts on admission was characteristically under 10%, however, this figure exceeded 30% in the case of 3 institutions; the average in the 15 prisons was 15% (859 persons). The questionnaire also asked how many persons self-reported during admission having ever used drugs in their lives. In the 16 institutions that were able to report on the number of prisoners and the number of ever drug users, the proportion of prisoners who reported ever using drugs in their lives was 38% (3,148 persons). During admission 219 persons admitted to having ever injected drugs, which, on average meant 4% of the prisoners in the 13 prisons able to provide information on this.

The latest national survey examining drug use among prisoners was carried out in 2008 (Paksi 2009). (ST12_2009_HU_01) According to the results of this survey 43.8% of the population imprisoned in Hungarian detention facilities on the basis of a final decision had tried an illicit drug¹³⁸ prior to imprisonment. More than two-fifth of ever-users (41.6%), that is every fifth or sixth imprisoned person (18.2%), had a period in their lives before imprisonment, when they used an illicit drug at least once a week. In the year before starting to serve their sentence, every third prisoner, while in the last month before imprisonment every fifth presently imprisoned person used an illicit drug. 37.8% of the prisoners, that is a decisive majority (85.7%) of those who used an illicit drug at any time in their lives have already used herbal cannabis or cannabis resin in their lives. The prevalence rate of all other drugs was much lower. The findings of the survey are presented in detail in the 2009 National Report Chapter 9.4.

In 2012 a study was carried out within the scope of the annual counselling and screening programme aimed at the prevention of HIV/HBV/HCV infections in prisons entitled 'Infections and fears in detention facilities' (Ritter 2013), in the scope of which knowledge about, attitude to, affectedness by, and related risks of HCV infection among prisoners were examined. During the survey drug use patterns of the participating prisoners (852 persons) were also examined.¹³⁹ 49.7% of the prisoners included in the sample had used any illicit drugs/new psychoactive substance in their lives. Most of them had used cannabis (35.5%), which was followed by amphetamines (27.6%), ecstasy (26.9%), cocaine (18.7%), and LSD (12.9%). The appearance of new psychoactive substances could also be detected among prisoners, the most frequently reported new substance was mephedrone, which had been used by 12.6% of the respondents in their lives. 8.1% of the respondents self-reported being a drug addict and 9.9% of all participants regarded themselves as regular drug users. Among those who regarded themselves as drug addicts the number of those who had become addicts due to the use of amphetamines or other stimulants was twice the number of those who had become addicts as a result of opioid use.

Drug use inside prison

¹³⁷ Definition of drug addiction is not given on the admission form, prisoners report on their drug addiction status based on their own personal judgement.

¹³⁸ In the survey the following drugs were regarded as illicit drugs: cannabis, ecstasy, amphetamine, cocaine, heroin, other opioids, LSD, magic mushroom, crack, GHB, any injected drug, herbal drugs, rush, angel dust, ketamine.

¹³⁹ When interpreting prevalence data, it has to be considered that besides prisoners who took part in the screening test and were willing to participate in the study and fill in the anonymous questionnaires, prisoners with known hepatitis C and wishing to participate in the study were also included in the sample.

According to data from the BVOP, during the course of 2017 materials suspected of being an illicit drug were seized on 280 occasions. Illicit substances were discovered before reaching the prisoners in 75% of the cases (210 cases).

There is no unified reporting obligation relating to the seized substances; according to the BVOP (BVOP 2018) the majority of seizures involved plant materials, and new types of psychoactive substances. Since the institutions – with one exception – did not receive feedback on the chemical composition of the substances seized, there is no statistics available on the exact types of products identified (except the one case where FUBINACA and PINACA type substances were identified).

In 2017 drug use inside prison was revealed in 51 cases in 6 institutions. The substances used were typically psychotropic substances of unknown origin. An extraordinary event related to drug use occurred in two detention facilities in a total of 6 cases, involving 13 persons: 10 inmates fell sick following the smoking of impregnated tobacco products, in the case of 3 prisoners the suspicion of being under the influence of drugs occurred while taken to trial, and in one case they tried to send a packet into the institution's territory in the name of an embassy. (Arzenovits 2018)

The seizure of injecting equipment and injecting drug use is not characteristic in Hungarian detention facilities, there were no cases of such in 2017 either. (BVOP 2018, Arzenovits 2018)

According to the national study conducted in 2008 in relation to drug use among prisoners (Paksi 2009), 14.3% of the imprisoned persons, 29.4% of those who used illicit drugs at any point in their lives before imprisonment, and nearly half (46.3%) of those who were regular drug users before imprisonment used an illicit drug while being imprisoned. The decisive majority (90.9%) of ever users had also used illicit drugs earlier, prior to imprisonment. (ST12_2009_HU_01)

T1.2.2 Drug related problems among prisoners

Number and characteristics of clients entering treatment in prisons on the basis of TDI data

Data on the socio-demographic and illicit drug use characteristics of persons entering treatment in the scope of a QCT programme (see: T1.3.2) within the Hungarian prison system are available from the TDI data collection. According to the TDI protocol, prisons also report cases of persons entering treatment to the TDI database.¹⁴⁰

On the basis of TDI data, in 2017 146 prisoners (134 males, 6 females, in the case of 6 prisoners the sex is unknown) started treatment due to a drug problem, among them 134 prisoners (91.8%) entered treatment in the scope of QCT.

Numerous differences can be observed between the TDI clients entering treatment within the prison system and those entering treatment outside of prison, regarding both socio-demographic and drug use characteristics. The following analysis compares the characteristics of TDI clients entering treatment as prisoners with the characteristics of all other non-prisoner treatment entrants.

Average age was slightly higher among those entering treatment in detention facilities (prisoners 31.6 years; non-prisoners 28.3 years). Regarding mean age at first use there was no difference between prisoners and non-prisoners (19.5 years). The time interval between the time of the first use and the time of entering treatment was slightly shorter in the case of non-prisoners (8.8 years) than for prisoners (12.1 years). The proportion of males is characteristically high among drug users and prisoners as well: it was 95.7% among prisoners entering treatment, while 86.6% among non-prisoner treatment entrants. With

¹⁴⁰ Numerically the TDI data does not match the treatment data supplied by the BVOP (see: T1.3.2). One reason for this is that the BVOP registers the number of ongoing, completed and interrupted treatments in a given year, while TDI registers started treatments in a given year. Also, not all the institutions report to the TDI data collection, i.e. TDI does not cover all detention facilities where drug related treatment of prisoners takes place.

respect to highest school qualification, half (44%) of those entering treatment outside prison had only elementary school qualification at the most, while among prisoners this proportion was almost 80%.

Examining drug use patterns, among those entering treatment inside prison use of stimulants (mainly amphetamine) and the use of opioids was more characteristic, while cannabis use was predominant among non-prisoners as the primary cause for treatment.

Prisoners entering treatment were also more involved in injecting drug use. For 8.7% of them this was the characteristic route of administration, and 19.5% reported that they had injected drugs at least once in their lives. In the non-prisoner population the proportion of those injecting their primary substance and the proportion of ever injectors were 4.2% and 10.2% respectively.

Table 25. *Main characteristics of prisoner and non-prisoner clients entering treatment in 2017* ($N_{\text{prisoners}}=146$; $N_{\text{non-prisoners}}=4667$)¹⁴¹

Prisoners		Non-prisoners
31.6 years	mean age	28.3 years
95.7%	proportion of males	86.6%
78.8%	proportion of those who completed 8 years of elementary school at the most	44.4%
50.0%	proportion of cannabis users	63.4%
24.0%	proportion of stimulant users	16.5%
4.1%	proportion of cocaine users	3.5%
9.6%	proportion of opioid users	3.8%
8.9%	proportion of users of other, non-classical substances	6.1%
8.7%	proportion of those who inject their primary substance	4.2%
19.5%	proportion of ever IDUs	10.2%

Source: TDI data collection 2018

Risk behaviours, infectious diseases

The prevalence of HIV, hepatitis B and C virus infections is higher among prisoners than in the general population. Research carried out in detention facilities indicates that the majority of prisoners tested positive for HCV probably became infected by earlier injecting drug use.

A study performed between 2007 and 2009 (Tresó et al. 2011) in 20 detention facilities among 4894 prisoners found HBV prevalence to be 1.5%, HCV prevalence to be 4.9% and HIV prevalence to be 0.04%. 1553 persons also completed questionnaires in connection with risk behaviours. A third (35.6%) of the latter respondents had ever used an illicit drug, and among them 37.8% (209 persons) had injected at least once in their lives. According to the results HCV infection to a large extent was linked to injecting drug use prior to imprisonment: the prevalence of HCV among prisoners who had injected was 23% and among non-injecting prisoners it was 1%; among the prisoners infected with HCV the proportion of those who had injected in the past was 76%. There was a link between risk behaviours and HCV infection: the HCV prevalence rate among those ever sharing equipment was 30.7%, and 37.9% among those sharing needles/syringes (the respective values for those who did not share equipment were 16.5% and 15.4%).

According to the results of a survey carried out in 2012 in the scope of the counselling and screening programmes aimed at the prevention of HIV/HBV/HCV infections in prisons (Ritter 2013), 20.7% of all respondents (N=852) reported having injected drugs ever in their lives,

¹⁴¹ The proportions were calculated by excluding those who responded 'not known' for the given variable.

and 4.2% of the total sample reported having injected drugs while in prison. Among the tested prisoners the HCV prevalence rate was 8.2%, the prevalence rate among ever injecting prisoners was 24.8%.¹⁴²

82.9% of the 70 HCV positive prisoners said that they had ever injected drugs, the majority of them (56.9%) primarily injected amphetamine, and 24.1% primarily injected heroin. 10% of the HCV positive prisoners reported injecting drugs even during imprisonment, typically they injected amphetamine derivatives. Among those who were HCV positive there were 3 persons who probably became infected while in prison, as they were tested in the year preceding the study and then their result was negative, but in 2012 they were diagnosed with HCV infection and they had been imprisoned in a detention facility for at least 2 years.

61.3% of the HCV positive inmates reported on sharing needles/syringes with others at least once when injecting drugs, 14.8% of them shared needles/syringes only once and 85.2% of them on several occasions.

60.5% of the HCV positive inmates reported that they had tattoos done in such a way that the same needle had been used before on someone else. 20.6% of them had tattoos done also during imprisonment in a way that the same needle had been used before on someone else and it had not been sterilised.

71.8% of all the HCV infected prisoners had a tattoo, however only 32.4% of them said that it was done always without sharing needles used for tattooing. In case of two-third of the infected prisoners acquirement of the hepatitis C virus could have happened through needle/syringe sharing while injecting or through sharing needles used for tattooing.

Only 10.5% of the HCV positive inmates included in the sample reported that they often or always used condoms during sexual intercourse. The majority of them used condoms very rarely or did not use condoms at all.

According to the data of a national HIV/HCV prevalence study carried out in 2015 among IDUs (Dudás et al. 2015), nearly every second IDU (266 persons; 48.4%) has been in prison at sometime in their lives. Among them HCV prevalence rate resulted to be 65%. For further data from the study see: Harms and Harm Reduction Workbook, Chapters T.1 and T.2. (ST9P2_2016_HU_03; ST9P3_2016_HU_01)

T1.2.3 Drug supply in prison

Information and data available on drug seizures in prisons are presented in T1.2.2 under the heading “*Drug use inside prison*”.

Most of the substances suspected to be drugs are transported to the detention facilities via postal packages, hidden in food or tobacco, clogged into cosmetics (toothpaste, deodorant sticks, cotton swabs), hidden in shoe sole or clothes. It is also common that illegal substances are thrown into the courtyard of detention facilities, or are handed over by visiting relatives. New psychoactive substances are found to be imported via different impregnated postal items (mainly letters and other paper goods). It poses a great challenge that institutions are not well-prepared to detect the new psychoactive substances (e.g. detection dogs are not trained to recognize such substances.) (BVOP 2017, Arzenovits 2018)

T1.3 DRUG-RELATED HEALTH RESPONSES IN PRISON

¹⁴² When interpreting prevalence data, recruitment of the sample has to be considered as prisoners who took part in the screening test and who were willing to participate in the study and fill in the anonymous questionnaires were involved in the sample, but also prisoners who were already known hepatitis C positive and wished to participate in the study were also included.

T1.3.1 Strategy

The 2013-2020 National Anti-Drug Strategy (see also: Drug Policy Workbook, Chapter T1.1) mentions the prisons specifically in two places: in the prevention and the treatment-care pillars. The section dealing with prevention lists the criminal justice institutions as an independent setting, and requires them to promote the social integration of prisoners, to operate drug prevention units with expanded scope and to improve the access of drug addict prisoners to appropriate treatment. With respect to treatment-care, the Strategy aims at setting up special treatment-care programmes (therapeutic interventions) and follow-up care programmes for disadvantaged groups and for those with special needs - including prisoners - that are adapted to the individual needs of the group and the unique characteristics of the institution system.

According to its Articles of Association the Ministry of Interior is responsible for the central administration of the prison system from 2010 and thus the Hungarian Prison Service Headquarters governs and coordinates the operation of the prison institutions and other prison facilities (4 education and training related and 2 health related) under the supervision of the Ministry of Interior.

T1.3.2 Organising treatment and care

Fundamentally, treatment and care is organised on the basis of a medical model, the system regards drug use primarily as a medical problem. Certain elements of the care system are provided by the health service of the prison system, including the National Institute for Forensic Observation and Psychiatry (IMEI), the detention institutes designated to provide treatment as an alternative to criminal procedure and the doctors and psychologists providing basic healthcare service, while other elements are provided by regionally competent external service providers (mostly outpatient drug treatment centres). In the course of performing its tasks the prison system closely cooperates with numerous governmental or local governmental research-training organisations and with programme providing non-governmental organisations as well.

Apart from the medical model, the security model¹⁴³ also characterizes the approach to the drug problem, which represents the greatest obstacle to the introduction of harm reduction interventions.

Within the prison service system there is no dedicated unit dealing with drug related issues. Arising issues are dealt with on a case by case basis and are coordinated by representatives of the areas involved.

QCT within detention facilities

The Hungarian legal system provides the opportunity for prisoners committing a drug related offence before imprisonment¹⁴⁴ to participate in QCT (quasy compulsory treatment) as an alternative to criminal procedure – in the case of the possession of a small amount of illicit drug for the purpose of personal use, on one occasion within two years (for a more detailed description see the Treatment Workbook, Chapter T1.2.2). A medical expert's opinion or, in the absence of this, the IMEI's preliminary status assessment will determine which of the

¹⁴³ According to this the drugs and paraphernalia related to drug use found in prisons are primarily classified as 'prohibited articles'. It is the obligation of the security staff to find and seize these, even in spite of the contraindications originating from any demand- or harm reduction programmes.

¹⁴⁴ Prisoners incarcerated for offences other than drug offences who committed a drug related offence before their imprisonment in which no judgment was pronounced in the first instance.

three types of diversion¹⁴⁵ should be applied. The preliminary assessment is carried out by the psychiatrist, addiction specialist or clinical psychologist employed by the prison institution. Following this, the prison providing the service is appointed.

On the basis of order 4/2009. (III.20.) of the IRM the IMEI and another six detention facilities have been designated to provide treatment for drug addiction and treatment of other conditions with drug use in the scope of QCT for the different groups of prisoners (men, women, minors, persons under preliminary custody). The preventive-consulting service for QCT participants must be provided by an external service provider with regional authority - which is determined by the Directorate-General for Social Affairs and Child Protection from the 1st of January 2017 - on the basis of a cooperation contract between the prison institution and the service provider. In 2017 QCT was provided by 12 detention institutions.

According to data from the BVOP, in 2017 48 persons went under preliminary status assessment at the IMEI within the scope of outpatient treatment. 32 persons participated in treatment for drug addiction, 120 persons underwent treatment of other conditions with drug use, and 173 persons took part in a preventive-consulting service.¹⁴⁶ It is very difficult to organise QCT during preliminary custody, because the fluctuation of detainees is high and there is a lot of transportation between facilities. Due to this several QCTs are interrupted or take place in parallel. The large majority of QCT takes place in Budapest, i.e. the institution of QCT is centralised within the prison service. (The TDI data of persons entering drug treatment in detention facilities are presented in Chapter T1.2.2.)

T1.3.3 Drug related health and other services in prisons

Admission procedure

The new Prison Code¹⁴⁷ in effect from January 2015 introduced the institution of 'Risk Assessment and Risk Management'. During the risk assessment the general risks of detention and relapse are determined upon admission and the tasks concerning health, psychology, safety and reintegration necessary to reduce those risks are also defined. Risk assessment is carried out with the help of personal interviews, psychodiagnostic tests and health examinations. As part of the risk assessment the risk of psychoactive substance use is also assessed. People admitted to prison go through a medical examination as well, in the course of which questions are also asked about drug use and alcohol consumption. Answers are recorded in the healthcare subsystem, which can only be accessed by entitled specialists.¹⁴⁸ It is not possible to check whether the statements are valid. Generally no other standardized tools are used to measure addiction severity or involvement in drug use. If a positive answer is given to the question relating to drug use and if it is medically reasonable, the attending doctor takes measures about necessary further treatment (as in the case of all other health problems).

¹⁴⁵ 3 forms of treatment are available in the scope of QCT: preventive-consulting service; treatment for drug addiction; and treatment of other conditions with drug use.

¹⁴⁶ Data cannot be compared to TDI data because the prison institutions record the aggregated number of completed, ongoing and interrupted treatments, while TDI records the number of prisoners entering treatment in a given time period. Furthermore, data recorded in the prison administration system is not controlled for double-counting: a prisoner might be recorded more than once for e.g. as a client continuing and then terminating treatment, or if he/she is transported to another institution, or if the treatment is temporarily suspended and then restarted.

¹⁴⁷ Act no. CCXL. of 2013 on effecting punishments, measures, certain coercive measures and misdemeanour detention

¹⁴⁸ Data are recorded as text. Obtaining aggregate and standardized data annually would require the improvement of the IT system which is currently in progress with the introduction of the unified risk assessment and risk management system.

Prevention

A change in legislation in 2002 made it possible to set up prevention units or departments in detention facilities for volunteering prisoners¹⁴⁹. The rules of operation of drug prevention units are laid down by Act no. CCXL. of 2013 on the execution of criminal sanctions (Prison Code), by Regulation 16/2014. (XII.19.) of the Ministry of Justice on the detailed rules of execution of imprisonment, misdemeanour, detention, preliminary custody and detention replacing fine penalty and by order 24/2017. (II.24.) of the National Commander of the prison service on the implementation of reintegration tasks concerning prisoners accommodated in units designated for prisoners with special treatment needs (in special treatment needs units) or in other special departments. Prisoners may request their accommodation in the drug prevention unit in written form, the acceptance/rejection of the inquiry is decided by the so called Admission and Detention Committee based on the reports of the reintegration officer and the prison psychologist. Accommodation in the drug prevention unit is given priority in the following cases:

- the prisoner was convicted for a drug related offence
- data recorded at admission or during the preparatory phase suggest that the prisoner had used drugs prior to imprisonment
- the prisoner was already held responsible for drug use inside the detention facility
- the prisoner has not yet used drugs but reported continuous exposure to it.

If the admission to the prevention unit is rejected because of a lack of capacity, the prisoner can apply for admission to another institution's drug prevention unit.

Drug prevention units should preferably be set up in a separate area or area section and the detainees in the prevention unit should be placed in separate cells.

Inmates accommodated here agree to participate in drug screening at least once a month that may take place at any time. A drug test must be carried out before the prisoner is accommodated in the drug prevention unit, following a return from outside delivery, and in case of suspected drug use.

11 institutions do not maximize the length of time detainees can spend in the prevention unit and detainees can remain in the department as long as they want, depending on capacity. In 4 institutions prisoners can spend a maximum of 12 months, in 3 institutions 6 months, and in one institution 3 months in the department, which can be extended at the request of the prisoner. (Arzenovits 2018)

The activities of the prevention units are carried out in a complex therapeutic system in close cooperation between the detention, the psychiatry and the health care sector of the prison and the prison clerical service.

For the prisoners accommodated in the prevention units the reintegration officer designs a weekly activity schedule which includes drug prevention activities as well. Behaviour, activity, interest, cooperation skills, social contact and important incidents are assessed by the reintegration officer at least once in every 6 months. The large majority of the services and programmes provided in the prevention units are psychological/psychotherapy group sessions and individual consultations. A significant proportion of the drug prevention programmes and other not strictly medical services are provided with the participation of external NGOs via tender-based funding.

In 2017 19 detention facilities operated drug prevention units, with a total space for 333 prisoners. The number of prisoners accommodated here is fluctuating, the average capacity utilization is 60%. During the year 262 inmates were accommodated in the prevention units and 27 detainees were removed due to drug use or suspicion of drug use, and 35 for other behavioural problems. (BVOP 2018, Arzenovits 2018)

According to data from the survey carried out among the detention facilities (Arzenovits 2018) in 2017 the programs provided by the prevention units were realized using both

¹⁴⁹ Previous drug use is not a condition of participation.

internal and external resources in 14 institutions, in 3 institutions they were implemented applying exclusively prison resources and staff, while in two institutions they were delivered by external organizations. In addition to programs provided by the drug prevention units, 26 institutes have, on a case-by-case basis (1-3 times per year), realized drugs prevention programs or programs with drug prevention elements. In such programs altogether 1778 inmates participated in 2017. These programs are not centrally coordinated, managed or organized, and their elaboration and implementation falls within the competence of the institutions. The programs were implemented using solely the institution's resources in 5 cases, 8 institutions realized them with the involvement of external service providers and 13 institutions used a combination of institutional and external resources.

The general drug prevention programmes and the programmes available in the prevention units are similar in content: they focus on personality development (self-knowledge, stress and conflict management), improving individual and social competencies, health protection, preventing relapse, education and information dissemination. The range of methods used is wide: it includes arts and crafts sessions, music therapy, fairy tale therapy, sport sessions, animal therapy, cultural programmes, film watching, reading groups, life coaching. (Port 2016a, Arzenovits 2018)

As part of the Risk Assessment and Management System introduced in 2015 (see above), institutions have the opportunity to provide a 12 occasion drug use prevention training program (implemented unified in the facilities included) dealing with problems related to drug use. The program mainly uses cognitive behavioural therapeutic methods. In the course of 2017 the 12-session training titled "Prevention of drug use" was carried out 30 times, with the participation of 290 detainees.

Treatment

According to the study carried out among detention facilities (Arzenovits 2018), outpatient care related to drug use was available within the institution in 9 institutions and it was provided by an external service provider in 8 institutions. Inpatient care of drug-related problems was provided within the institution in one case while 7 institutions provided it via an outside service provider.

With drug withdrawal symptoms in 13 institutions 422 detainees were treated. Only medicines were used in 11 institutions and 12 institutions provided a combination of medication and psychotherapeutic treatment. 6 institutions did not treat any prisoners with withdrawal symptoms, and one institution reported that drug treatment and counselling was the form of treatment in case of withdrawal symptoms. (Arzenovits 2018)

A description of QCT used as an alternative to criminal procedure can be read in Chapter T1.3.2, the TDI data of prisoners entering treatment can be found in Chapter T1.2.2, and the information on opioid substitution treatment for prisoners is included in Chapter T1.3.4.

Prevention, testing, and treatment of infectious diseases

Organised by the Hungarian Prison Service Headquarters (BVOP), a hepatitis C counselling and screening programme had been carried out every year in Hungarian detention facilities with the involvement of an external healthcare partner since 2007¹⁵⁰. In 2017 the program was suspended, thus the number of prisoners participating in screening or counselling related to infectious diseases was significantly lower than in previous years.

¹⁵⁰ HCV testing is preceded by a preliminary half-hour-long informative lecture, after which the prisoners may voluntarily undergo testing. The blood samples are examined in Szent László Hospital.

According to data from the prison institutions (Arzenovits 2018) during 2017, awareness raising lectures in connection with HCV/HBV/HIV/TB infections were held in 5 detention facilities with the participation of 1109 prisoners (6.4% of the prison population). Individual counselling was provided in 8 institutions for a total of 2102 prisoners. Written information material was handed out to some 4000 prisoners in 8 institutions. Information lectures were held in cooperation with external organizations in all of the institutions, while individual counselling was typically provided by associates of the institution.

During 2017 a total of 50 prisoners were tested for HCV, among them 6 persons (12%) proved to be HCV antibody positive.

40 prisoners in 3 institutions were tested for hepatitis B, no HBV positive cases were identified. 3 prisoners received vaccination against HBV in 2 institutions, according to prison reports.¹⁵¹

In 5 institutions 263 prisoners were tested for HIV (1.5% of the prison population), and 1 HIV+ case was found.

TB testing is also available in detention facilities. According to the amendment of the Ministry of Welfare regulation no 18/1998., from 2013 it is compulsory for all prisoners to have a chest X-ray test following admission and then once every year. In the course of 2017 2 active and 25 passive TB patients were discovered and 11 prisoners received treatment for TB.

Prisoners testing positive for HIV, HBV or HCV and meeting the therapeutic criteria receive treatment for their condition, those not receiving treatment for a health reason are taken into care. In 2017, 32 HIV-positive prisoners received antiretroviral treatment, while 18 HCV-positive and 2 HBV-positive prisoners received antiviral treatment. Among those infected with HCV, 1 person did not receive treatment for health reasons and in 2 cases treatment was discontinued upon release.

The prison health services and the regional hepatology centres together are in charge of the treatment of prisoners with hepatitis C. If necessary, the prisoners are taken to the outpatient treatment unit of the local hepatology centre. HIV positive persons are offered the possibility to serve their sentence at the Tököl National Prison, in a special unit of the prison maintained for HIV positive persons. In this special unit there is also a consulting room, where HIV positive prisoners are provided with medical attendance by a specialist from the Szent László Hospital. The number of prisoners accommodated here is varying, as of 31 December 2017 it was 20. New patients diagnosed with tuberculosis are separated and treated at the Department of Pulmonology of the Prison Service Central Hospital.

Harm reduction and prevention of overdose after release

Interventions or services specifically aimed at harm reduction are not available in Hungarian prisons.

In the scope of the survey carried out among Hungarian prisons (Arzenovits 2018) no institution reported to have provided programs or program elements aimed at preventing overdose after release. 3 institutions reported that such assistance was available via individual counselling provided by a psychologist, reintegration officers, or by an external service provider, this way reaching a total of 91 prisoners.

Reintegration, preparation for release

According to the results of the survey carried out in 2013, 2016 and 2018 in Hungarian prisons (Port and Tarján 2014, Port 2016, Arzenovits 2018) usually there is no formal

¹⁵¹ Data was available from 26 institutions out of the 29.

procedure in the institutions relating to prisoners receiving drug related treatment before release, however, several institutions mentioned that they had informed the prisoners about how to contact the appropriate organisations or referred them to the local outpatient drug treatment centres or psychiatric departments - with which in many cases the institutions have a cooperation contract as well -, and that they provide opportunity for individual/group counselling regarding this problem. In the 2018 survey one institution reported that if the detainee was under probation supervision, the staff of the service provided assistance after release in connection with diversion and one other institution reported that reintegration and psychology specialists provided individual consultation opportunities before release. (Arzenovits 2018)

In 2017 reintegration programme targeted at drug users was provided in 8 institutions (38 programmes) reaching approximately 600 prisoners. Individual counselling was available in 4 prisons, 55 prisoners took part in it. (Arzenovits 2018)

Within the scope of the probation service operating in the detention facilities, the probation officers also assist with reintegration – as prescribed by law – of the prisoners placed under their supervision or of those approaching them voluntarily. The purpose of reintegration care and follow-up care is to provide support aiding the reintegration of the prisoner into society in the form of individual counselling, case management and group sessions. The support covers the following areas: healthcare treatment, labour market integration, accommodation, assistance in enrolling in training, preparation for social administration, group information sessions on the possibilities of reintegration care, follow-up care and legal aid, and finally preparing the prisoner's family for the return of the prisoner. Among the forms of support provided in the scope of individual case management, the relevant decree separately mentions 'the reduction of harmful consequences of addictions by dealing with the social and mental deficits linked to them'.

In the scope of follow-up care, the probation officers help newly released prisoners who want help with their social reintegration through the forms of support detailed above.

The foundations Váltóság Alapítvány¹⁵² and Tévelygőkért Alapítvány¹⁵³ are the most important NGOs in Hungary dealing with the resocialisation and reintegration of prisoners. Employees of Váltóság Alapítvány contact the prisoner in prison before release, and then maintain contact after release as well. They use various techniques, including: mentoring, group and individual sessions, training courses. The organisation has an occupation programme, a skills training programme as well as a programme especially for women, and they also operate a halfway house. Beside this, the foundation maintains an information database where released persons, their families and also professionals can find useful information regarding the topic. The foundation also regularly publishes information booklets in connection with the subject.

The purpose of Tévelygőkért Alapítvány is to eliminate social inequalities through working with marginalized populations and through social sensitization and within this its main field of activity is to support people disadvantaged by the prison system. The programme "Beszélj szabadon" of the organization is intended for high school students and aims to make them more tolerant and open towards people released from prison thereby reducing their social exclusion and fostering their reintegration. The primary aim of project "Mirkó" is to take care of and strengthen the (parent-child) relationship between prisoners and their children, and to follow and support their life. The project also aims to engage non-profit organizations and through this make society more sensitive, encouraging a communication practice free of prejudice and shame. "Plan B" (B-terv) is the organization's reintegration programme for released detainees in the scope of which a flat-sharing community is operated which provides opportunity for disadvantaged, freshly released prisoners who are unable to return

¹⁵² <http://www.valtosav.hu/>

¹⁵³ <http://www.tevelygokertalapitvany.info/>

to their family to practice loving, prejudice free and assertive communication. In the scope of Plan B former prisoners live in the flat-share community for 3-9 months after which they may take part in the foundation's projects as coworkers.

T1.3.4 Opioid substitution treatment in prisons

Rules regarding methadone treatment of prisoners are set out by order no. 38/2015. (V.20.) of the BVOP. According to the regulation all detention facilities must ensure methadone treatment as a therapy option for opioid addiction, if the continuation of methadone treatment is indicated by the specialised outpatient treatment centre treating the prisoner before he/she was admitted to the detention facility, or if it is recommended by a specialist at the National Institute for Forensic Observation and Psychiatry and the affected person gives his/her written consent. The treatment must be carried out - in accordance with the respective methodological letter – at such therapeutic sites which are designated for acquiring, storing and using methadone, for which prison institutions are not entitled in the lack of an operating licence. For the purpose of methadone treatment the prisoners have to be transported to a specialised outpatient treatment centre or addiction or psychiatric unit which are designated in the region to provide such a service.

According to data from the prison institutions (Arzenovits 2018) in 2017 opioid substitution treatment (OST) was available in 1 institution and in 4 institutions it was provided by an external service provider. There were 8 detainees who had been participating in OST (methadone or suboxone) right before being admitted to prison, among them two (in separate institutions) continued the treatment after incarceration. Apart from these no other OST cases were reported by the institutions. In the preceding years OST was provided occasionally by external service providers, if requested by a detention facility, but the number of such cases was exceptionally low. According to the annual data collection (Tarján 2013) carried out among DTCs that provide substitution treatment, between 2005 and 2012, 3 prisoners in 2005 and 2 in 2006 were transported to the regionally competent outpatient drug treatment centre for the purpose of OST.

T1.4 QUALITY ASSURANCE OF DRUG-RELATED HEALTH PRISON RESPONSES

At present there are no regulatory documents relating specifically to the quality assurance of drug treatment services provided in detention facilities.

T2. TRENDS

Not applicable for this workbook.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2017, is presented as part of the baseline information in Chapter T1.

T4. ADDITIONAL INFORMATION

In the spring of 2016 a questionnaire survey was carried out in Hungarian juvenile detention homes (Port 2016b, for methodological details see T5.2).

Regarding age distribution 36% of the 180 respondents were younger than 16 years, 52% of them were aged between 16 and 18 years and 12% of them were from the 19-20 age group. 110 persons (61%) had tattoo, most of them (95 persons, 86%) acquiring the last one before admission to the detention institution; the remaining 15 persons acquired tattoos during imprisonment as well. Regarding accommodation 93% of the sample (167 persons) had stable accommodation and 7% (13 persons) stated that they had lived in a homeless shelter or in the street or had been without stable accommodation for longer than one week in the year preceding the survey.

Out of the 180 respondents 162 (90%) reported having ever tried drugs or new psychoactive substances in their lives¹⁵⁴, 158 (87.8%) only before imprisonment and 4 of them (2.2%) also while in the detention home (all of them longer than a month ago but within one year.) None of the surveyed adolescents self-reported having used drugs in the last month. All the 13 detainees who did not have stable accommodation reported having used drugs before imprisonment while the percentage of ever users among those with stable accommodation was 89%.

Regarding substance types the use of new psychoactive substances was the most prevalent among the detainees: 78% of the sample (127 persons) reported having used these. Among the 162 ever users 58% reported synthetic cannabinoids and 36% designer stimulants as the primarily used substance.

52% (66 persons) of the 128 persons who reported only one primary substance¹⁵⁵ reported synthetic cannabinoids¹⁵⁶ as their primarily used substance, 23% reported designer stimulants¹⁵⁷ and 20% cannabis. 4% of the respondents primarily used amphetamine; heroin and cocaine was reported as the primary substance by only 0.8% each.

Among those who reported more than one primary substance 59% (20 persons) indicated the two categories referring to new psychoactive substances (synthetic cannabinoids and designer stimulants) as their primarily used substances. There were 12 other cases (35%) where besides amphetamine-, cocaine- or cannabis use one of the two NPS categories was reported.

Four persons said that they had used drugs inside the detention homes as well, all of them reported having used new psychoactive substances primarily (two of them used designer stimulants, one used synthetic cannabinoids and one both).

30 persons (19% of ever users¹⁵⁸ and 16.7% of the whole sample) said that they had ever injected drugs, 23 before admission to the detention home and 7 persons within the institution as well. Two third of injecting drug users were males, one third were females; 6 of them was below age 16, 20 of them in the age 16-18, and 4 of them were older than 18. 70% of them had tattoos, 18 of them had these done before taken to the detention home, 3 of them also had new ones while in detention. 5 persons said they had been sexually active in the past four weeks, and none of them had used condoms during sexual intercourse. All but two¹⁵⁹ injecting drug users indicated designer stimulants as their primarily injected substance. Along with the survey HCV screening of the sample was also carried out, during which 5 infected cases were identified (4 tests were positive and 1 gave doubtful result), with regards to sex 4 of them were males and 1 was female. All of the 5 juveniles who tested positive had tattoos, two of them acquired new ones inside the detention home too. 2 of them did not have stable accommodation in the previous year. All HCV+ cases indicated an NPS category as their primarily used substance.

¹⁵⁴ It is important to note here that the selection of the juveniles in the sample was partly based on social, physical and mental health factors representing a risk for drug use (see T5.2).

¹⁵⁵ The instruction of the questionnaire was to report only one substance as the primarily (most frequently or typically) used substance, nevertheless there were 34 respondents out of the 162 ever users who reported more than one primary substance.

¹⁵⁶ synthetic weed, bio weed, substances having an effect similar to marihuana

¹⁵⁷ crystal, „music“, 4-mec, formek, penta, MDPV

¹⁵⁸ Excluding the two persons who did not answer the question.

¹⁵⁹ One person reported heroin and one LSD as the primarily injected substance.

Out of the 5 HCV+ cases 4 persons self-reported having ever used drugs intravenously, all four of them longer than 4 weeks ago but within a year and all of them injected for the first time in their lives longer than one year ago. One out of the four injecting users also injected drugs while in detention. The primarily injected substance was a designer stimulant in all four cases. 3 of the 4 juveniles used a non-sterile and not new syringe at the time of the last injection and all 4 of them used the syringe for injection more than once, 2 persons reporting reusing it 10-15 times. Frequency of injection was also high in all of the cases: all of them reported that they had injected more than once a day (5,10,30,40 times) at the time of the last injection.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

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TDI data collection 2018

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T5.2 METHODOLOGY

Arzenovits (2018): All Hungarian detention institutions operating in Hungary in 2017 (29) participated in the survey. The questionnaires were recorded in June 2018, data relates to 2017.

BVOP (2016): The survey was based on a questionnaire recorded primarily with the aim of risk assessment, secondarily with registration purposes which contained questions regarding drug use as well. (The primary purpose of the data collection was not research but to test the development of the data recording system carried out in relation to the implementation of the new risk assessment system.) Male prisoners admitted to the 5 participating detention facilities during the month of the survey were included in the sample, altogether 1170 persons. Questionnaires were recorded in March 2015, answers to the questions were based on the prisoners' self-report.

Paksi (2009): The survey was carried out by the Corvinus University of Budapest, Institute of Behavioural Sciences and Communication Theory, Centre for Behavioural Research, it was financed by the National Institute for Drug Prevention and supported by the Hungarian Prison Service Headquarters (BVOP). The target population of the survey included adult convicts with Hungarian citizenship imprisoned in detention facilities in Hungary on the basis of a final decision. In the case of the national detention institutes, on the basis of the current registers of imprisoned persons, using SPSS program on the site, applying a simple random sampling method, a proportionate sample was taken during the survey, 5% in the case of men, and one-third in the case of women – with overrepresentation ensuring an analysable number of respondents. In the case of county detention facilities, sampling took place in two stages: at one location in each region selected by expert sampling, a random sample was selected in proportion with the number of imprisoned persons in the given region. The total sample included 652 persons, the final size of the national sample representing genders proportionately was 503 persons. The so-called 'A' questionnaire on socio-demographic background, habits other than drug use, status of present imprisonment and previous offences prior to this imprisonment were recorded using 'face to face' technique. Questions on drug use prior to and inside prison were recorded by offering the self-administered technique. 71.6% of the sample filled in this second part of the questionnaire alone, while in the case of 28.4% the self-administered part was recorded by using 'face to face' technique. Data collection took place between 14 October and 12 December in 2008.

Port (2016a): The survey was carried out among the prison institutions (altogether 30) operating in Hungary in 2015. Questionnaires were recorded in June 2016, the questions referred to 2015. Questionnaires were completed by the staff of the institutions, responses and data were summarized and analyzed by the Hungarian National Focal Point.

Port (2016b): The survey was carried out as part of a tender project. The four juvenile detention homes operating in Hungary at the time of the project participated in the survey and also one specialized girl reformatory (EMMI Esztergomi Gyermekotthon) was included, to improve the ratio of girls in the sample. Altogether 180 juveniles (140 males, 40 females) were included in the sample: from the Juvenile Detention Home of Debrecen all inmates were surveyed and from each of the other 4 detention homes 20-20 juveniles were selected, based on social, physical and mental health factors¹⁶⁰ representing a risk for drug use, as the aim of the tender was to identify and engage in treatment the juveniles infected with HCV or prone to drug use problems.

¹⁶⁰ Social factors: anamnesis (not always sincere); private student fallen out of the traditional school system; substance use in the family/among family members, legal consequence linked to drugs. Health and mental factors: high blood test values; medicine intoxication; withdrawal symptoms upon admission (anxiety, sleep problems, mood swings, incapable of fitting in etc.); signs of injection on the skin and collapsed veins; unclear information about existing liver disease; window period in infectious disease testing.

Port and Tarján (2014): The questionnaires were recorded in July-August 2013, the responses referred to 2012. The questionnaire was filled in by all 31 Hungarian detention facilities. The questionnaires were completed by the employees of the facilities, the responses and data were summarized and analyzed by the Hungarian National Focal Point. Standard questionnaire 23 and 27 of the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) and previous EMCDDA guidelines for the National Report chapter on prisons served as the basis of the questionnaire.

Ritter (2013): The sample was formed by inmates participating in the anonymous HCV, HBV tests financed and performed by Bristol-Myers Squibb Ltd. in 2012, who were imprisoned in the 7 randomly selected detention facilities. Prisoners who took part in the screening test and who were willing to participate in the study and fill in the anonymous questionnaires were involved in the sample, and prisoners who were known hepatitis C positive and wished to participate in the study were also included. Typically the questionnaires used in the study contained closed questions. Questionnaire data recording took place after the screening tests, days or weeks later. Besides questionnaire data collection in-depth interviews were also held with the inmates and the educators about the phenomenon and about screening. The blood samples were analysed at the Szent László Hospital's Department of Immunology. The blood sample and the questionnaire were linked with an anonymous identifier.

TDI data collection 2018: See Treatment Workbook, Chapter T5.2.

Tresó et al (2011): A national blood sample screening programme was carried out among the prison population between June 2007 and June 2009 aimed at identifying infectious diseases, with the participation of 20 Hungarian detention facilities. A total of 4894 prisoners took part in the test voluntarily (34.2% of the prison population), and a further 1066 volunteers also took part from among the employees of the facilities as a comparison group. On the initiative of the Hungarian National Focal Point, after obtaining the approval of the BVOP, between June 2008 and June 2009, volunteering prisoners who had been tested also filled in a questionnaire about their past drug use / injecting drug use, as well as about any risk behaviours related to the transmission of hepatitis C. By June 2009 1553 prisoners had completed the questionnaire in 7 facilities in parallel with the screening test. The questionnaire was elaborated by the Hungarian National Focal Point on the basis of the recommendations of the EMCDDA¹⁶¹. The prisoners taking part in the screening completed the questionnaire before being tested. The questionnaires and the serological results were linked by a unique, anonymous identifier. The questionnaires were self-administered and anonymous.

¹⁶¹ Protocol for the implementation of the EMCDDA key indicator: Drug-related infectious diseases (DRID), draft version 6 October 2006, Project CT.04.P1.337

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LIST OF ABBREVIATIONS

BSI – Brief Symptom Inventory
Btk. – Hungarian Criminal Code
BVOP – Hungarian Prison Service Headquarters
CODA – Civil Ombudsman on Drug Affaires
DTC – drug treatment centre
EFOP – Human Resources Development Operation Programme
ELTE – Eötvös Loránd University
EMCDDA – European Monitoring Centre for Drugs and Drug Addiction
EMMI – Ministry of Human Capacities
EMQ – European Model Questionnaire
ENYÜBS – Uniform Criminal Statistics System of the Investigation Authority and Public Prosecution
ESPAD – European School Survey Project on Alcohol and Other Drugs
GDS – Global Drug Survey
HBSC – Health Behaviour in School-aged Children
HBV – hepatitis B virus
HCV – hepatitis C virus
HIV – human immunodeficiency virus
HNFP – Hungarian National Focal Point
IMEI - National Institute for Forensic Observation and Psychiatry
KEF – Coordination Forum on Drug Affairs
KKB – Inter-ministerial Coordination Committee on Drug Affairs (former Coordination Committee on Drug Affairs)
KT – Council on Drug Affairs
LEQ – Life Events Questionnaire
MÁK – Hungarian State Treasury
NBT – National Crime Prevention Council
NCSSZI – National Institute for Family and Social Policy
NDI – National Drug Prevention Office (former National Institute for Drug Prevention)
NEFI – National Institute for Health Development
NPS – new psychoactive substances
NRSZH – National Office for Rehabilitation and Social Affairs
NSP – needle/syringe programme
NSZKK – Hungarian Institute for Forensic Sciences
OBH – National Office for the Judiciary
OEK – National Centre for Epidemiology
OGY – National Assembly
OKRI – National Institute of Criminology
OLAAP – National Survey on Addiction Problems in Hungary
ORFK – National Police Headquarters
OST – opioid substitution treatment
OTKA – Hungarian Scientific Research Fund
PWID – people who inject drugs
QCT – quasi compulsory treatment (treatment as an alternative to criminal procedure)
SZGYF – Directorate-General for Social Affairs and Child Protection
TÁMOP – Social Renewal Operational Programme
TB – Tuberculosis
TDI – Treatment Demand Indicator