



European Monitoring Centre
for Drugs and Drug Addiction



2012 NATIONAL REPORT to the EMCDDA by the Reitox National Focal Point

“HUNGARY”

New developments, trends and in-depth
information on selected issues

REITOX

CONTRIBUTORS:

TAMÁS CSESZTREGI, Hungarian Institute for Forensic Sciences

MÁRIA DUDÁS, National Centre for Epidemiology

ZSUZSANNA ELEKES, Corvinus University of Budapest, Institute of Sociology and Social Policy

RICHÁRD FEHÉR

GERGELY CSABA HORVÁTH, Hungarian National Focal Point

ADRIENN NYÍRÁDY, Hungarian National Focal Point

ANNA PÉTERFI, Hungarian National Focal Point

ÁGNES PORT, Hungarian National Focal Point

ANNA TARJÁN, Hungarian National Focal Point

ÁKOS TOPOLÁNSZKY, Association of Hungarian Drug Therapy Institutes

REVISED BY:

KATALIN FELVINCZI, ÁGNES FRECH, ÁKOS KASSAI-FARKAS, ÉVA KELLER, BORBÁLA PAKSI, JÓZSEF RÁCZ, NORBERT RÓDLER, PÉTER SÁROSI, JÁNOS SZEMELYÁCZ

TABLE OF CONTENTS

SUMMARY	5
1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS	7
1.1. OVERVIEW	7
1.2. LEGAL FRAMEWORK	7
1.3. NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION	11
1.4. ECONOMIC ANALYSIS	12
2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS	15
2.1. OVERVIEW	15
2.2. DRUG USE IN THE GENERAL POPULATION	15
2.3. DRUG USE IN THE SCHOOL AND YOUTH POPULATION	15
2.4. DRUG USE AMONG TARGETED GROUPS	21
3. PREVENTION	24
3.1. OVERVIEW	24
3.2. ENVIRONMENTAL PREVENTION	24
3.3. UNIVERSAL PREVENTION	24
3.4. SELECTIVE PREVENTION IN AT-RISKS GROUPS AND SETTINGS	25
3.5. INDICATED PREVENTION	27
3.6. NATIONAL AND LOCAL MEDIA CAMPAIGNS	28
4. PROBLEM DRUG USE	29
4.1. OVERVIEW	29
4.2. PREVALENCE AND INCIDENCE ESTIMATE OF PROBLEM DRUG USE	29
4.3. DATA ON PROBLEM DRUG USERS FROM NON-TREATMENT SOURCES	29
4.4. INTENSIVE, FREQUENT, LONG-TERM AND OTHER PROBLEMATIC FORMS OF USE	35
5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY	41
5.1. OVERVIEW	41
5.2. AVAILABILITY AND QUALITY ASSURANCE	41
5.3. ACCESS TO TREATMENT	44
6. HEALTH CORRELATES AND CONSEQUENCES OF DRUG USE	51
6.1. OVERVIEW	51
6.2. DRUG-RELATED INFECTIOUS DISEASES	51
6.3. OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES	60
6.4. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS	64
7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES	69
7.1. OVERVIEW	69
7.2. PREVENTION OF DRUG-RELATED EMERGENCIES AND REDUCTION OF DRUG-RELATED DEATHS	69
7.3. PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES	69
7.4. RESPONSES TO OTHER HEALTH CORRELATES AND CONSEQUENCES	74
8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION	76
8.1. OVERVIEW	76
8.2. SOCIAL EXCLUSION AND DRUG USE	76
8.3. SOCIAL REINTEGRATION	78
9. DRUG-RELATED CRIME, PREVENTION OF DRUG-RELATED CRIME, AND PRISON	79
9.1. OVERVIEW	79
9.2. DRUG-RELATED CRIME	79
9.3. CONSEQUENT CRIME – OFFENCES COMMITTED UNDER THE INFLUENCE OF ILLICIT DRUGS	85
9.4. PREVENTION OF DRUG-RELATED CRIME	86
9.5. INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM	87
9.6. DRUG USE AND PROBLEM DRUG USE IN PRISONS	88
9.7. RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS	89
9.8. REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON	92

10. DRUG MARKETS	93
10.1. OVERVIEW	93
10.2. AVAILABILITY AND SUPPLY	93
10.3. SEIZURES	96
10.4. PRICE / PURITY	100
11. RESIDENTIAL TREATMENT FOR DRUG USERS	105
11.1. HISTORY AND POLICY FRAMEWORKS	105
11.2. AVAILABILITY AND CHARACTERISTICS	109
11.3. QUALITY MANAGEMENT	112
11.4. DISCUSSION	112
12. DRUG POLICIES OF LARGE EUROPEAN CITIES	114
12.1. FUNCTIONS AND RESPONSIBILITIES OF LARGE CITIES IN DRUG POLICY	114
12.2. KEY FEATURES OF THE CAPITAL CITY'S DRUG POLICY	116
BIBLIOGRAPHY	123
ANNEX	127
LIST OF TABLES	127
LIST OF FIGURES	128
LIST OF MAPS	130
LIST OF ABBREVIATIONS	131

SUMMARY

In 2011 the most important development in drug policy was the elaboration of the legal background and rules of procedure that make it possible to register new psychoactive substances in the temporary schedule and restrict their trafficking. From 1 January 2012 nine new substances (4-FA, 4-MEC, MDPV, methylone, JWH-018, JWH-081, JWH-073, JWH-122, JWH-210) were added to the list of substances judged in the same way as narcotic drugs, and both the use and trafficking of these substances result in criminal liability.

The data recorded in Hungary during the ESPAD Survey in 2011 indicated a significant increase in the use of illicit drugs and substances for deliberate drug use as compared to 2007. Among the 16-year-old pupils interviewed the lifetime prevalence rate of all (illicit and licit) substance use was 28.8%. Among the examined substances cannabis is still the most commonly used drug and is followed by the use of medicines without medical indication and the inhalation of organic solvents. On the basis of the prevalence rates mephedrone – included in the questionnaire for the first time in 2011 – was in fifth position, and this was followed by amphetamines, other substances and ecstasy. The proportion of those who had ever tried illicit drugs increased more among girls and in the case of schools located in regions outside Budapest.

In the field of prevention, taking into consideration the project priorities determined in the previous years, projects aimed at professional developments in the field were announced, but often their realisation ran into difficulties because of late payments.

The structural change already described last year characterised by a reduction in the use of heroin accompanied by the increasing use of new psychoactive substances continued in 2011 among problem drug users. Among NSP clients the proportion of injecting heroin users dropped significantly as compared to 2010 – by 23 percentage points – while the proportion of users injecting other drugs increased significantly, by 26 percentage points, and the proportion of IDUs primarily injecting amphetamine slightly dropped. In the case of IDUs injecting other drugs the use of MDPV was the most typical, and it was followed by injected methadone and mephedrone in the order of frequency.

The changes observed in low-threshold programmes could also be detected among clients. Treatment demand deriving from heroin use dropped, while at the same time a continuously increasing number of users of other stimulants (probably mostly cathinone derivatives) contacted the treatment units (both in the case of new clients and already treated clients). Furthermore, among clients treated before, an increase in treatment demand associated with amphetamines could also be observed. As the proportion of new clients among all clients did not change as compared to the previous years, it can be presumed that the restructuring is due to changing substance rather than to new client groups entering treatment.

On the basis of the national prevalence surveys repeated since 2006, similarly to earlier years, in the IDU population the number of HIV positive persons is probably very low in Hungary, and the proportion of HBV positive persons is probably also low, below 1%, and the national HCV prevalence rate has been around 25% since 2006. At the same time prominent restructuring can be observed in the case of HCV prevalence rates according to drug type – the infection ratio of IDUs injecting drugs other than opioids has increased, while the infection ratio of IDUs injecting opioids has decreased – which carries further risks, as new psychoactive substances are characterised by a higher number of daily injections, so risk behaviours are also more probable within this group of drug users.

In the prison population 92% of identified HCV positive prisoners have injected drugs in their lives, so the history of injecting drug use is one of the most significant risk factors in respect of the HCV infection of prisoners.

Among clients receiving toxicological treatment the number of treatments demanded because of amphetamines and cannabis showed an abrupt increase. The increase of intoxications caused by amphetamine type drugs may be due to the increasing use of cathinones, while the increasing number of treatments demanded because of cannabis may be due to the increasing use of synthetic cannabinoids.

In 2011 the decreasing tendency observed in the field of drug-related deaths continued, especially in the number of deaths because of opiate use.

In 2011 in the NSPs both the number of distributed and returned+collected syringes and the number of clients and contacts increased significantly, the exchange rate increased to 72%. This is mainly due to the more prevalent injecting use of new psychoactive substances and to the more frequent injecting times of these substances. For financial reasons, the increased demand for sterile equipment forced NSPs with the highest turnover to restrict the number of syringes available on one occasion.

In 2011 both the number of registered drug offences and the number of drug offenders slightly increased as compared to the data recorded the year before. In 79.2% of drug offences the subject of the offence was cannabis, and in 8.5% of the cases it amphetamine. In the case of all substance types more than 80% of the offences was represented by demand-related offences. In 2011 the proportion of juvenile delinquents among drug offenders increased significantly.

The most significant change in the drug markets in 2011 was the disappearance of mephedrone after it had been added to the schedule of illicit substances, followed by the spreading of the compounds stepping in its place (4-MEC, MDPV), and the significantly increasing use of herbal blends treated with synthetic cannabinoids. In line with the appearance and spreading of new compounds, the frequency of occurrence of heroin dropped significantly. In 2011 90% of the seized tablets contained active substances not classified as illicit drugs, the most common active substance was fluoroamphetamine.

Currently there are 14 therapeutic communities in Hungary, with a total number of 353 beds on the basis of the latest available data. Concerning treatment demands, in the second half of the 80's drug users were admitted to residential treatment first of all because of using synthetic and natural opiates and barbiturate derivatives. After the political change heroin addiction became increasingly more characteristic among the treated clients. From the second half of the 90's an increasing number of amphetamine users started to contact the drug therapy institutes. In the past few years an increasing number of cannabis users and users of new psychoactive substances were admitted to the residential institutes, and patients with behavioural addictions also appeared in greater proportions. Although the therapy institutes are open towards drug users with special needs (e.g. juveniles, women, pregnant women, dual diagnosis patients), they do not have services suiting the special needs of these populations.

In the lack of a comprehensive strategy or an operating Coordination Forum on Drug Affairs (KEF) in Budapest, the drug policy processes taking place in Budapest can be identified in connection with the activity of the district KEFs. KEFs were established in 18 out of the 23 districts of the capital city of Budapest, first of all they perform their activity within the district borders, both in the interest of surveying the situation and organising treatment.

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS¹

1.1. OVERVIEW

In the past two years in Hungary the most dominant phenomenon associated with drugs was the rapid spreading of new psychoactive substances both on the supply and the demand side. The legislation amendments adopted in 2011 and in the first half of 2012 were mostly aimed at elaborating a regulatory background that makes it possible to settle the legal status of these substances and restrict their trafficking without unnecessary criminalisation of users.

Since 14 May 2012 the Ministry of National Resources (responsible for the coordination of drug policy) has been operating under the name Ministry of Human Resources (EMMI).

1.2. LEGAL FRAMEWORK

Laws, regulations, directives or guidelines in the field of drug issues

- a) Act II of 2012 on contraventions, contravention proceedings and the contravention registration system (I.6.)

According to article 199 of the act, from 15 April 2012 the breaching of the rules of conducting such activities with drugs, psychotropic substances and drug precursors, which are subject to licensing and registration, is regarded as a contravention. Proceedings instituted because of a contravention fall under the competence of the police.

- b) Government Regulation 66/2012. (IV. 02.) on activities that may be conducted with drugs, psychotropic substances and new psychoactive substances and on the scheduling of such substances and on the amendment of their schedules

Schedule C of Government Regulation 66/2012. (IV.02.) valid from 3 April 2012 contains a list of individual substances and compound groups classified as new psychoactive substances (*see section ca*)); determines the bodies participating in the procedure of adding new substances to the list and their tasks; and determines the tasks of the institutes proceeding when granting permission for activities conducted with new psychoactive substances.

Permission for therapeutic activities or ad hoc research permission may be granted for the purpose of conducting an activity with new psychoactive substances legally. Permission for other than therapeutic purposes, for the purpose of the manufacture, acquisition, storage, possession, transfer and use of drugs, psychotropic substances or new psychoactive substances and for the purpose of training, research and analysis related to such substances can only be granted to criminal prosecution and law enforcement bodies, to the Hungarian Army and to drug testing laboratories.

- c) Act CLXXVI of 2011 on the amendment of certain acts on healthcare (XII.14.)

ca) Act CLXXVI of 2011 amended Act XCV of 2005 *on pharmaceutical preparations for human use and on the amendment of the acts regulating the pharmaceutical market* (hereinafter: Gytv.), introducing the concept of new psychoactive substance. Article 1(37) of

¹ The authors of this chapter are: Gergely Csaba Horváth, Ágnes Port

the Gytv. defines a “*new psychoactive substance*” as a compound or chemical compound group that currently appeared on the market; has no therapeutic value; affects the central nervous system so it has the ability to change mental state, behaviour or perception; therefore it can pose as serious a threat to public health as the substances listed on drug schedules; and therefore the Government scheduled it in a decree.

Scheduling process

The rules of scheduling new psychoactive substances are specified in article 27 of Government Regulation 66/2012 and in articles 15/B-F of the Gytv.

New psychoactive substances can be added to Schedule C of the Government Regulation following a notification according to article 4(1) of Council Decision 2005/387/JHA and a preliminary professional assessment. The National Centre for Addictions (OAC) is specified as the body responsible for this activity. The purpose of preliminary assessment is to decide whether the conditions determined in article 15/B of the Gytv. exist, i.e. “to prove that no information available at national authorities or professional institutes

- suggests that the given substance has a medical use and
- rules out that it poses as serious a threat to public health as the substances listed on narcotic and psychotropic drug schedules”.

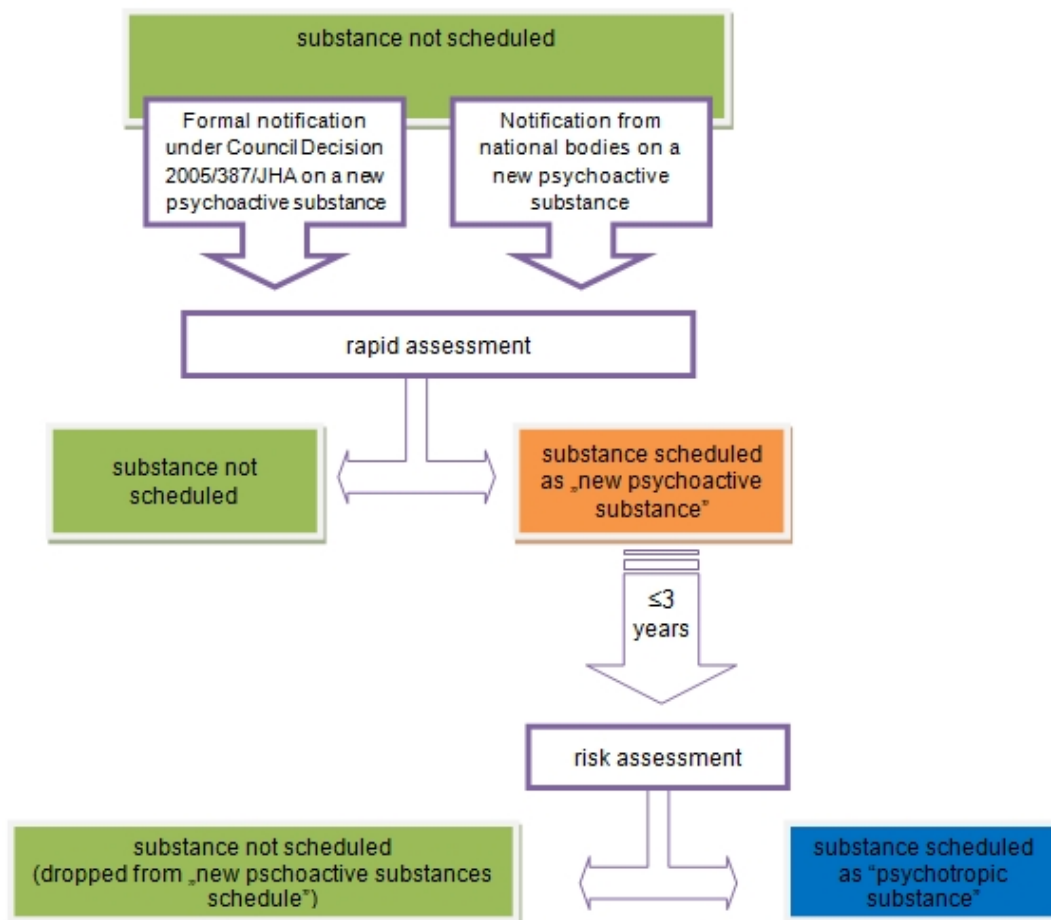
All substances listed individually on Schedule C must be risk assessed within three year² of their scheduling, if it has not been initiated by the Council of the European Union. Government Regulation 66/2012 (IV.02.) appoints the OAC as the body responsible for this activity too. The risk assessment has to decide

- a) whether the given substance can cause dependence or functional disorder of the central nervous system, or any misuse or harmful effect similar to any of the substances listed on the schedule of psychotropic substances, and
- b) whether there is good reason to presume that the substance provides a possibility for misuse representing a public health or social problem, which justifies the listing of the given substance in the Schedules of Act XXV of 1998.

Depending on the result of risk assessment the compound is either listed on one of the schedules of Act XXV of 1998 or it is removed from the schedule of new psychoactive substances. Risk assessment is not to be applied in the case of compound groups that remain on the schedule of new psychoactive substances as long as any substance in the given group fulfils the prerequisites determined in article 27(4) of the Regulation.

² Act CLXXVI of 2011 had provided 1 year for risk assessment originally which was modified to 3 years by Act LXXIX of 2012 on the amendment of certain acts on healthcare. The modification came into effect on 1 July 2012.

Figure 1. *The process of scheduling new psychoactive substances*



Source: NFP

cb) Article 161 of Act CLXXVI of 2011 amended Act IV of 1978 on the Criminal Code by adding new article 283/B containing a new statutory definition of the misuse of new psychoactive substances. From 1 March 2012 anyone who brings a new psychoactive substance into the country or takes it out of the country or carries it across the territory of the country, or manufactures, offers or supplies it, or is engaged in the distribution, trafficking or dealing of such, commits misuse of new psychoactive substances and shall be punishable with a term of imprisonment of up to three years.

cc) Act CLXXVI of 2011 on the amendment of certain acts on healthcare amended Schedule A of the Annex of Act XXV of 1998 on pharmaceutical preparations for human use, which lists substances that are to be judged in the same way as the substances listed in Schedule I of the Convention signed in Vienna in 1971. As a result of the amendment, the following nine substances were added to the schedule on 1 January 2012:

- 4-fluoroamphetamine / 4-FA, 4-FMP
- 4-methylethcathinone /4-MEC
- 3,4-methylenedioxypyrovalerone / MDPV
- methylone
- JWH-018
- JWH-081
- JWH-073
- JWH-122
- JWH-210

Consequently, from 1 January 2012 the above substances are regarded as dangerous psychotropic substances judged in the same way as narcotic drugs, which cannot be used for therapeutic purposes, but exclusively for scientific purposes, and any misuse of them (use or supply related) results in criminal liability.

d) Act CL of 2011 (XI.18.)

Act CL of 2011 on the amendment of certain criminal acts amended article 23 of law-decree 5 of 1979 (*Btké.*) on the enactment and implementation of Act IV of 1978 on the Criminal Code, which contains rules on the definition of small amounts of drugs. According to the amendment, from 1 January 2012, from the aspect of the statutory definitions of the misuse of narcotic drugs contained in the Criminal Code, tetrahydrocannabinol (THC) is regarded as of small amounts, if the pure and acidic THC content together (total THC) is not more than 6 grams. (Before the amendment classification was based on the pure THC content and the upper limit of small amount was 1 gram of pure delta-9-THC content. However such classification caused uncertainty in execution of the law, as the pure active substance content of herbal cannabis may increase with the drying of the plant, so determining the pure active agent content at the time of the offence may not be evident. This problem is solved by calculating the total THC content.)

e) Government Regulation 23/2011. (III.8.) on increasing the safety of music and dance events

“Government Regulation 23/2011. (III.8.) on increasing the safety of music and dance events” enacted on 16 March 2011 regulates the operating conditions of music and dance events. The scope of the regulation extends to music and dance events held in premises suitable for accommodating more than 300 people at the same time, and also to open-air events where the number of participants is above 1,000. Events within the scope of the regulation can only be held with a license from the competent notary public. The regulation prescribes preparing a security plan relating to the event, employing security staff in accordance with the size of the location and the presence of staff trained to give first aid at the location of the event, and it also determines the method and rules of inspecting the events.

Law implementation³

Based on data from the Public Prosecutor’s Office 2,473 persons were sentenced for drug-related offences in 2011, on the following legal grounds:

- 2,114 offenders (85.5%) were sentenced for use-related offences prohibited by article 282 and article 282/B of the Criminal Code;
- 627 offenders (25.4%) were sentenced for trafficking-related offences prohibited by article 282/A of the Criminal Code;
- 170 persons (6.9%) were sentenced for conduct prohibited by article 282/C (drug-addicts committing use- or trafficking-related offences);
- 4 persons (0.16%) were sentenced for other conduct (preparations, financing etc.).

In 2011, the following punishments and measures were imposed on the 2,473 persons convicted with a final judgement:

- 954 were sentenced to imprisonment (of this 392 were executable and 562 were suspended);
- 358 were sentenced to community work;
- 661 were fined;

³ Based on data from the Public Prosecutor’s Office’s Prosecution Information System (VIR).

- 42 were reprimanded;
- 449 were put on probation;
- 500 were sentenced to secondary punishment⁴.

1.3. NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION⁵

National strategy

In December 2010 the government decided to prepare a new basic drug policy document. In 2011 the ministry asked the head of the National Drug Prevention Office and 11 experts to prepare the new drug strategy. The strategy draft elaborated by the group of experts is centred around a drug free life model and the communication of health as a basic value, while with regards to the treatment of drug users it promotes a recovery-based approach. On the basis of legal obligations the draft is to be completed with strategic public administration elements in the first six months of 2012 and will be submitted to the Government in the second part of 2012.

Implementation of the action plan

No action plan was drawn up for 2011, the execution of the tasks associated with handling the drug problem was performed by the National Drug Prevention Coordination Department of the Youth Affairs Division under the professional control of the State Secretariat for Social, Family and Youth Affairs of the Ministry of National Resources (NEFMI).⁶

In 2011 the Ministry of National Resources announced calls for tenders in three drug-related categories:

- supporting coordination activities at local level,
- supporting prevention programs,
- supporting the operation and development of institutes and civil professional organisations participating in treatment and care.

A further two tasks of particular significance were also financed by reallocating earmarked resources. The Hungarian Institute for Forensic Sciences was awarded financial support for the increased monitoring of the active substance content of critical illicit drugs and new psychoactive substances (see chapter 10.1), while the Prison Service Headquarters was awarded financial support for ensuring drug prevention activities in detention facilities. (For data relating to the financing of the projects see chapter 1.4.)

Coordination arrangements

During 2011 the Coordination Committee on Drug Affairs (KKB) held four meetings. Among the special committees⁷ of the KKB the International Committee held two meetings during the

⁴ According to article 38(3) of the Criminal Code valid until 1 May 2010 prohibition from occupation, prohibition from driving and expulsion were secondary punishments that could be imposed on their own. The system of sanctions in effect from 1 May 2010 changed the types of punishment, and the following are listed under the title punishments: imprisonment, community work, fine, prohibition from occupation, prohibition from driving and expulsion. Secondary punishments involve only prohibition from public affairs and ban, which, however, cannot be imposed on their own, but only beside imprisonment (Act LXXX of 2009).

⁵ Based on the report on the activity of the National Drug Prevention Coordination Department in 2011 (EMMI 2012).

⁶ In connection with handling the drug problem the tasks of the Youth Affairs Division involve the preparation and elaboration of the professional directions and development concepts, the coordination of the elaboration and realisation of the related programs, and the operation of the government's drug advisory body, the Coordination Committee on Drug Affairs (KKB).

⁷ The KKB operates a Legal and Law Enforcement Committee, Health Committee, Prevention Committee, Laboratory Committee, International Committee, Social Committee, and the Committee on Controlled Substances.

year, partly related to Session 54 of the CND and partly to the annual UNODC questionnaire. In 2011 the Committee on Controlled Substances met six times, the subject of the meetings was to elaborate a framework for the regulation of new psychoactive substances. The Legal Committee of the KKB held a meeting in February 2012 concerning the planned amendment of the Criminal Code in order to discuss proposals relating to the statutory definitions of the misuse of narcotic drugs included in the legislative bill.

In the first six months of 2011 Hungary held the rotating presidency of the European Union. The Hungarian Presidency Programme identified the following topics for the thematic debates:

- Standardisation of drug prevention activities;
- Increasing the effectiveness of drug treatment, elaboration and improvement of treatment protocols;
- European level responses to the challenges raised by new drug trends:
 - New psychoactive substances;
 - Sharing best practices of drug analysing laboratories;
- Addressing the drug problem in prisons.

The lectures held on the topics emphasised by the presidency contributed to the identification and adoption of the EU level responses concerning the emerging new drugs, drug problem in prisons, EU consensus on minimum quality standards and benchmarks for drug demand reduction interventions. In respect of new psychoactive substances, within the scope of the HDG, the Hungarian presidency provided the possibility of introducing best laboratory practices and discussing the theoretical and practical problems of control.

As prescribed in the antidrug action plan of the European Union, the drug policy representatives of the EU member states – including the Council Secretariat, the European Commission and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) – met in Budapest in May 2011. The presidency's programme of the meeting focused on drug use in detention facilities and on the involvement of the civil sphere in drug affairs.

The *Conference on building an EU consensus for minimum quality standards in the prevention, treatment and harm reduction of illicit drugs* was organised by the European Commission in association with the Hungarian EU presidency in Brussels between 15-17 June 2011. The conference gave policymakers, professionals, NGOs and researchers active in the field of prevention, treatment and harm reduction the opportunity to discuss the preliminary results of the European Commission's study.

1.4. ECONOMIC ANALYSIS

Labelled expenditures of the Ministry of National Resources ⁸

The performance of drug-related tasks was funded from the KAB tenders coordinated by the Ministry of National Resources. In 2011 the support system included the following fields:

- 632 projects were submitted in the field of supporting prevention programmes, and 222 of them were granted support with a total value of EUR 716,596.
- 186 projects were submitted for supporting the recovery process of people suffering from addictions, and 62 of these programmes were granted support with a total value of EUR 432,098.

⁸ The amounts included in this chapter were calculated based on the official mid-rate of the EUR for 2011 (1 EUR = 277.7 HUF).

- 123 projects were submitted in the field of ensuring the conditions of operation of Coordination Forums on Drug Affairs and promoting the realisation of local strategies aimed at handling the drugs problem, and 85 of them were granted support of a total value of EUR 180,002.

In summary, in the scope of the KAB tenders a total amount of EUR 1,328,696 was allocated to 369 projects. In 2011 a total amount of EUR 51,134 (EMMI 2012) was disbursed in the form of specific grants (see chapter 1.3).

Table 1. *The project budget amounts announced by the Ministry of National Resources by target area in 2011*⁹

Supported target area	Project budget amount (EUR)
For drug prevention programmes /KAB-ME-11-A/B/C/	716,596
1) Child and youth prevention programmes (exclusively for institutes of education and special care)	198,313
2) Supporting programmes aimed at strengthening the family system	203,728
3) Programmes, initiatives supported from local community resources, which may represent attractive alternatives to drug use at settings such as spare time activities, child protection institutes, institutes of the criminal justice system, the internet and other media, the workplace	314,554
For supporting the recovery process of people suffering from addictions /KAB-FF-11/	432,098
1) Supplementary operation support for the programmes of low-threshold service providers and specialised outpatient treatment centres and rehabilitation institutes aimed at involving patients in treatment, development of human resources	123,515
2) Strengthening the therapeutic processes of patients suffering from addiction, supplementary operation support related to substitution therapy and other treatments	68,419
3) Development of rehabilitation programmes providing differentiated care, ensuring care for groups with special needs, supporting programmes aimed at the resocialisation and reintegration of former patients suffering from addiction	60,137
4) Supporting the institutional conditions and infrastructural development of organisations providing treatment services for patients suffering from addiction	180,028
For ensuring the conditions of operation of Coordination Forums on Drug Affairs and promoting the realisation of local strategies aimed at handling the drugs problem /KAB-KEF-11-ABC/	180,002
1) Supporting coordination activities	89,984
2) Supporting the initiations of drug prevention programmes, universal, selective and indicated complex prevention activities	57,353
3) Supporting programmes aimed at the recovery process of patients suffering from addiction, the handling of the drug problem and the development of the institutional system dealing with problem drug users	32,665
Total	1,328,696

Source: NCSSZI 2012, EMMI 2012a

⁹ Based on the summary of the KAB decision lists.

Conclusions

In respect of drug affairs coordination tasks 2011 was the year of institutional reorganisation and the elaboration of the new drug strategy. Among the important tasks of the coordination were the tasks relating to holding the rotating EU presidency as well.

In 2011 the most important development in drug policy was the elaboration of the legal background and procedural rules that make it possible to register new psychoactive substances in a temporary schedule and restrict their trafficking. From 1 January 2012 nine new substances were added to the list of substances judged in the same way as narcotic drugs, and both the use and trafficking of these substances results in criminal liability.

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS¹⁰

2.1. OVERVIEW

In 2011 a national representative survey was carried out only among secondary school pupils as a part of the ESPAD (European School Survey Project on Alcohol and Other Drugs) survey series conducted every four years. Furthermore, surveys were carried out into the drug use patterns of special populations, such as sex workers, refugees and students of medicine.

2.2. DRUG USE IN THE GENERAL POPULATION

No new information available.

2.3. DRUG USE IN THE SCHOOL AND YOUTH POPULATION

The extent of drug use

The fifth survey¹¹ of the ESPAD series was carried out in 2011 (Elekes 2012). 19.9% of the 16-year-old pupils interviewed have already used illicit drugs in their lives. The differences by gender were not significant, among boys the proportion was 20.9%, while among girls it was 18.9%. The proportion of those who used any substance with the purpose of abuse was higher, 24.9%¹². The lifetime prevalence of the use of substances with the purpose of abuse was 26% among boys and 23.7% among girls. (The difference is not significant.) The lifetime prevalence of the misuse of medicines¹³ was higher among girls: 18.7%, while among boys it was 11.1% ($p=0.000$). The lifetime prevalence relating to the entire sample was 14.7%. Among the 16-year-old pupils interviewed the lifetime prevalence of all (illicit and licit) substance use was 28.8%. 28.3% of boys and 29.4% of girls have already used a substance suitable for misuse in their lives.

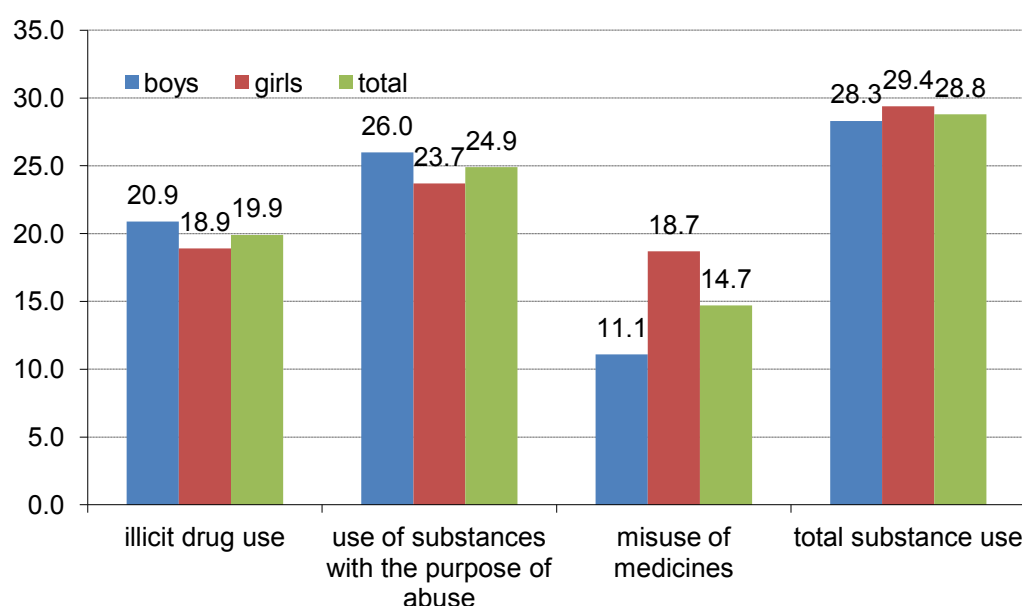
¹⁰ The authors of this chapter are: Zsuzsanna Elekes, Adrienn Nyírády

¹¹ The survey was carried out by the Institute of Sociology and Social Policy of 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 1995 and participating in full-time ordinary school education, in the form of class surveys, using the self-reporting method. The net sample of 16-year-olds included 3,062 pupils.

¹² In this group, besides illicit drugs there are also magic mushrooms, other opiates (e.g. poppy tea), inhalants, whippets/balloon, mephedrone and other drugs not listed in the questionnaire.

¹³ Tranquilisers/sedatives without prescription and alcohol combined with medicines.

Figure 2. *The lifetime prevalence of different types of drug use among 16-year-old pupils in 2011, by gender (%)*



Source: Elekes 2012

In respect of the frequencies of both illicit drugs and substances used with the purpose of abuse it can be determined that about two-thirds of drug users were 'trying' or 'occasional users', a significant proportion of them tried a substance suitable for misuse only on one or two occasions. At the same time, one-fifth or one-fourth of the users have used an illicit drug or a substance with the purpose of abuse on 20 or more occasions. Among all interviewed persons the proportion of those who used an illicit drug on 20 or more occasions was 4.2%, and the proportion of those who used a substance with the purpose of abuse at the same frequency was 5.3%.

Table 2. *Frequency of substance use among users in 2011 (%)*

Frequency	Illicit drugs			Substances used with the purpose of abuse		
	boys	girls	total	boys	girls	total
1-2 occasions	39.4	45.1	42.0	39.0	39.2	39.1
3-5 occasions	14.5	17.6	15.9	15.2	20.5	17.6
6-9 occasions	10.6	8.1	9.5	12.7	11.4	12.1
10-19 occasions	10.9	12.5	11.6	9.8	10.5	10.1
20-39 occasions	9.7	5.5	7.8	5.6	7.0	6.3
40 or more occasions	14.8	11.4	13.3	17.6	11.4	14.8
Total	100.0 (330)	100.0 (273)	100.0 (603)	100.0 (408)	100.0 (342)	100.0 (750)

Source: Elekes 2012

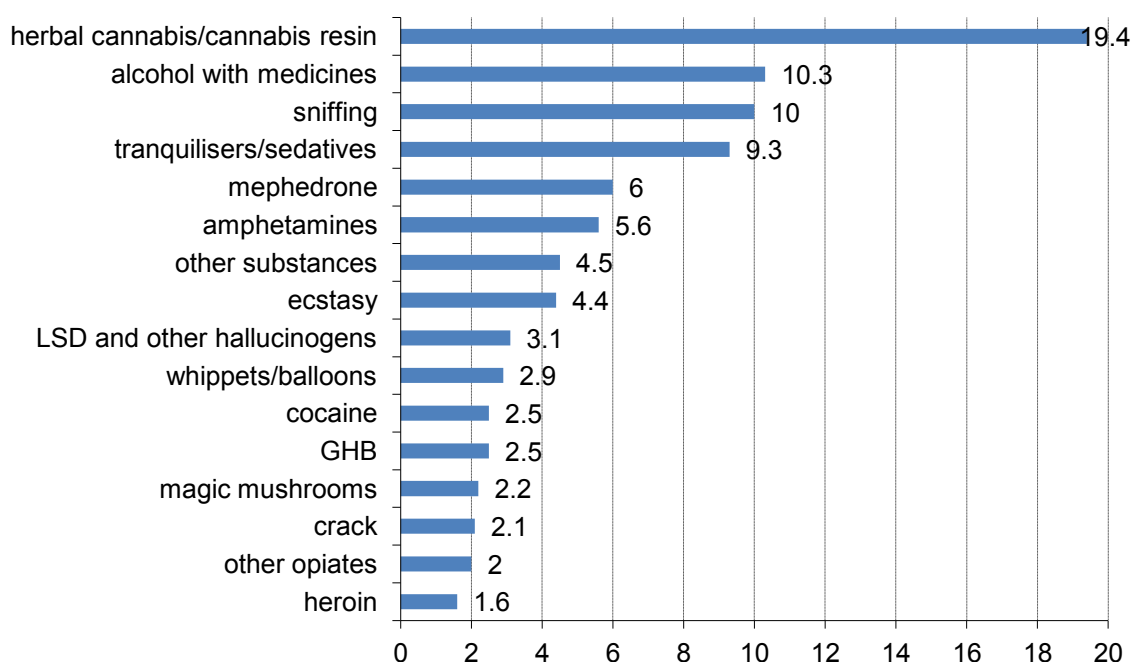
The data relating to the frequency of illicit drug use by gender clearly indicated that drug use at a greater frequency is more common among boys. While 24.5% of illicit drug user boys used drugs on 20 or more occasions, this proportion among girls was 16.9%. The proportion

of the use of substances with the purpose of abuse at a greater frequency was also slightly higher among boys.

The frequency of the use of tranquilisers/sedatives without prescription and/or medicines combined with alcohol was lower than the frequency of the use of substances with the purpose of abuse. 51.9% of young people using medicines misused these on 1-2 occasions, 8.7% of them misused medicines on 20 or more occasions. In this case also use at a greater frequency was more characteristic among boys.

Similarly to the years before, on the basis of lifetime prevalence, in 2011 the most commonly used drug among young people was cannabis. Also similarly to the years before, after cannabis, the most commonly used drugs were licit substances: alcohol combined with medicines, inhalants and tranquilisers/sedatives without prescription. Mephedrone – included in the questionnaire for the first time in 2011 – was in fifth position. It was followed by amphetamines, other substances and ecstasy.

Figure 3. *Lifetime prevalence by drugs among 16-year-old pupils in 2011 (%)*



Source: Elekes 2012

Age at first use

During the survey age at first use was examined in the case of illicit drugs such as cannabis, amphetamines and ecstasy. On summarising the results it can be seen that nearly half of ever users first used one of the three examined drugs at the age of 14 or earlier.

Social differences

On examining the differences in illicit drug use per settlement type according to the location of the school it can be determined that in 2011 the proportion of those who ever tried illicit drugs was the highest in Budapest (23.5%). In county towns the lifetime prevalence was 14.8%, while in smaller towns it was 20.5%. Similar differences can be observed in the case of the use of substances with the purpose of abuse (Budapest: 26.5%, county towns: 22.4%, other towns: 25.9%).

According to the parents' school qualifications neither the proportion of those who tried illicit drugs nor the proportion of those who tried substances with the purpose of abuse indicated any significant difference.

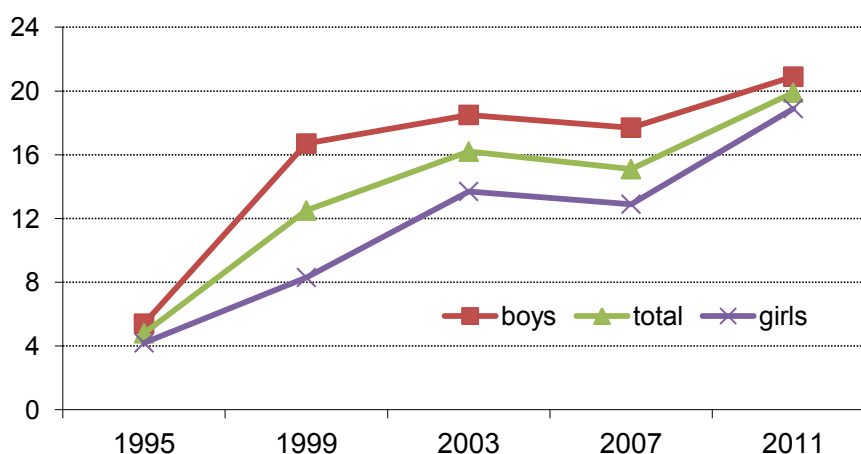
Attitudes related to drug use

In 2011 the proportion of those who found that trying cannabis and tranquilisers/sedatives without prescription is very dangerous dropped as compared to 2007. The extent of finding regular drug use dangerous also dropped slightly, although this drop is near the margin of error.

Trends

The totalled lifetime prevalence of illicit drug use increased by four times in Hungary between 1995 and 2003. At the beginning this increase was more intensive among boys, while between 1999 and 2003 it was more intensive among girls. In 2007 the proportion of those who ever tried illicit drugs dropped slightly both among boys and girls. The data collection in 2011 indicated a further significant increase in the lifetime prevalence of all illicit drug use. The lifetime prevalence increased by 3.2 percentage points among boys and by 6 percentage points among girls.

Figure 4. *Change in the lifetime prevalence of illicit drug use among 16-year-old pupils between 1995-2011, by gender (%)*



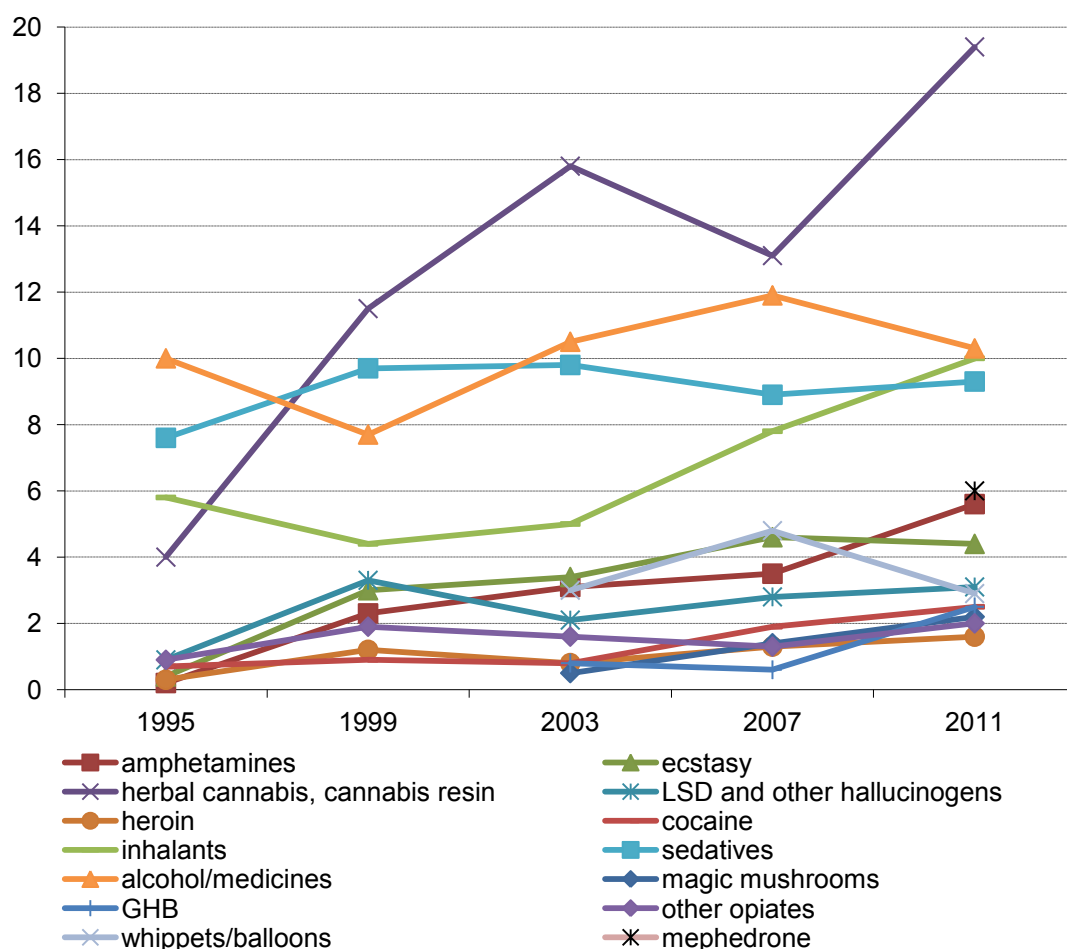
Source: Elekes 2012

Starting from 1999 drug use among Hungarian youngsters was always dominated by cannabis, and the highest prevalences were registered in the case of this drug. Cannabis was followed by three licit drugs for 16 years, and at the beginning of the survey series of the spread of these three licit drugs even exceeded the lifetime prevalence of cannabis. The lifetime prevalence of tranquilisers/sedatives without prescription and the use of medicines with alcohol were always in the second-third position in the substance structure. In 2011 the use of medicines with alcohol decreased by 1.6 percentage points, although the use of tranquilisers/sedatives hardly changed since 1999. A remarkable change took place in lifetime prevalence of inhalants. After a reduction in 1999, first a slight increase and then in 2007 and in 2011 a significant increase could be observed. This means that by 2011 the lifetime prevalence of sniffing increased 2.3 times compared to 1999.

On the basis of the lifetime prevalence recorded in the past 16 years illicit drugs other than cannabis are characterised by a lower extent of use, some increase could be observed in their use both in 2007 and 2011. A slight decrease could only be observed in the lifetime prevalence of ecstasy and whippets/balloons. In 2011 the most significant increase – by 2.1 percentage points – was registered in the case of amphetamines. A further significant

increase – by 1.9 percentage points – was observed in the prevalence of GHB, which had been hardly present at all before.

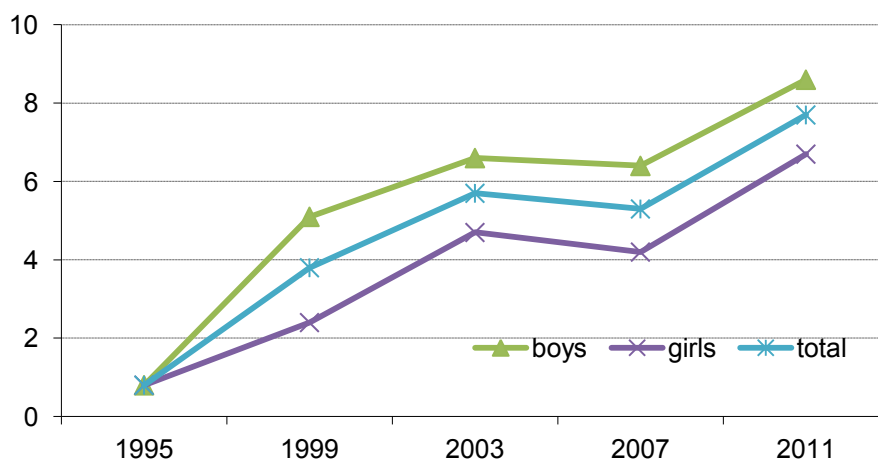
Figure 5. *The lifetime prevalence of illicit and licit substances among 16-year-old pupils between 1995 and 2011 (%)*



Source: Elekes 2012

The change in the lifetime prevalence of cannabis use was followed by another change in the proportion of persons using cannabis in the preceding 30 days. As compared to 2007 the proportion of persons using cannabis in the last month increased by 2.4 percentage points. The increase was similar among boys and girls.

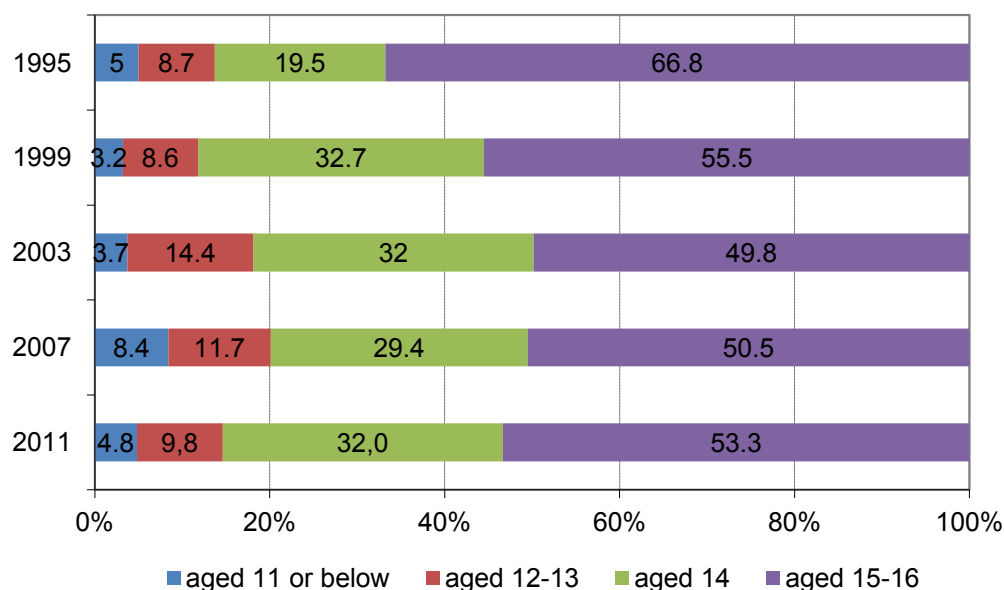
Figure 6. *The last month prevalence of cannabis between 1995-among 16-year-old pupils, by gender (%)*



Source: Elekes 2012

On comparing the age at first use with the data recorded in the years before it can be observed that the proportion of those who try drugs at a very early age dropped.

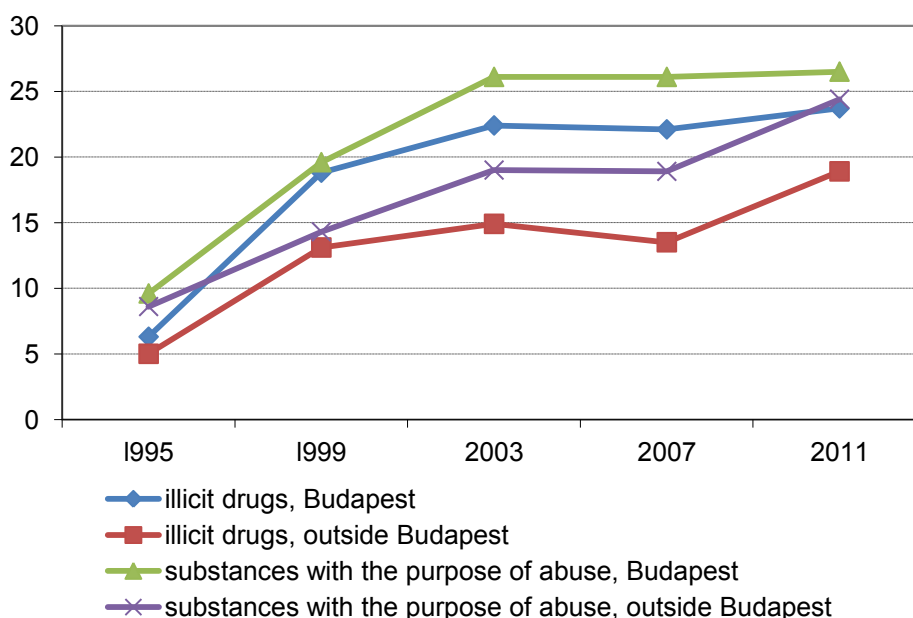
Figure 7. Age at first illicit drug use as percentage of users, between 1995-2011



Source: Elekes 2012

On examining the changes that took place between 2007-2011 broken down to Budapest and the regions outside of Budapest, it was observed that both the proportion of those who ever tried illicit drugs and substances with the purpose of abuse increased first of all in the regions outside of Budapest, so the urbanisation pattern of the drug use phenomenon is less prominent as compared to previous years.

Figure 8. The lifetime prevalence of drug use among 16-year-old pupils between 1995-2011 according to the location of their school (%)

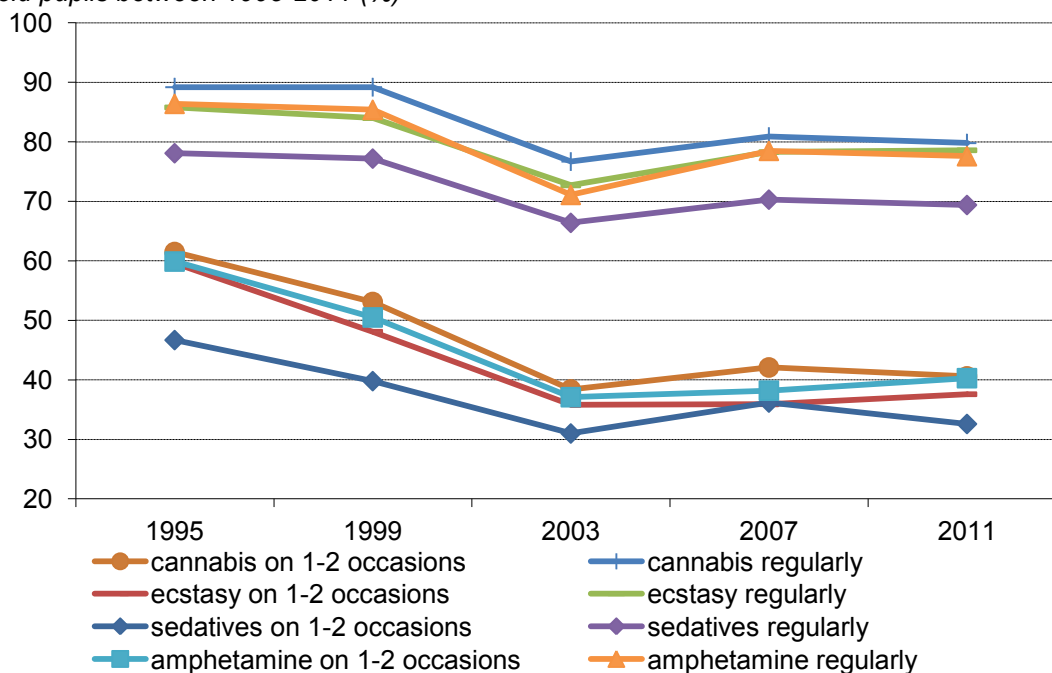


Source: Elekes 2012

As compared to the start of the ESPAD surveys the proportion of pupils who find that the use of the examined drugs is dangerous dropped significantly. A significant reduction in risk perception took place between 1995 and 2003, and it mainly affected the assessment of the

occasional use, on 1-2 occasions. In the case of all examined substances regular use was regarded dangerous by a much higher proportion of young people than occasional use.

Figure 9. The proportion of those who regard the use of different drugs very dangerous among 16-year-old pupils between 1995-2011 (%)



Source: Elekes 2012

2.4. DRUG USE AMONG TARGETED GROUPS

The army

The Hungarian Army Military Health Centre Scientific Institute Toxicology Research Department and the troop healthcare services conducted drug screening tests in 11,694 cases, on the basis of which the type of drugs used could be determined among the soldiers tested. (Hungarian Army 2012)

Table 3. Results of the drug screening tests conducted in 2011 in the Hungarian Army

Aim of test	Number of samples	Positive results							
		Preliminary screening				Confirmed test			
		THC	AMF	OPI	COC	THC	AMF	OPI	COC
I. Occupational health (aptitude test)									
Civil*	1,350	6	3	6	0	0	0	0	0
Soldier	6,635	2	0	5	0	0	0	0	0
II. Soldiers performing service (preventive purposes)									
Troop healthcare service	3,290	17	2	8	1	5	0	0	1
III. On the basis of suspicion (authority)									
Commander's order	419	6	1	0	0	2	1	0	0
Ministry of Defence, Chief of General Staff order	0	0	0	0	0	0	0	0	0
Total	11.694	31	6	19	1	7	1	0	1

*6 persons withdrew from the test, no confirmation test was carried out in their case.

Source: Hungarian Army 2012

In the army illicit drug use was proved in 9 cases, and the typically used drug was cannabis.

Sex workers¹⁴

During the survey (Fact 2011) the answers given by 246 sex workers (21 men and 225 women) were processed, their average age was 25.9 years, on average they had been working as prostitutes for 3.6 years. 38% of them had completed 8 grades of elementary school at the most, 29.7% of them completed vocational training school, and 18.3% of them had graduated from secondary school. 6 sex workers had a university or college degree.

One-third of the sex workers interviewed (32.5%) had never smoked, the proportion of occasional smokers was 9.8%, while half of the respondents (49.6%) were regular smokers.

In the past 12 months 8.1% of the sex workers had not drunk any alcohol, and one-third of them drank alcohol rarely. Nearly half of the respondents (43.2%) drank alcohol at least once a week, and 3.7% of them drink alcohol every day.

One-third of the sex workers (33.7%) contacted during the survey said that they had not used drugs or other narcotic substances¹⁵ in the past 12 months. 42.3% of the respondents used drugs once a week, and one-quarter of them (25.6%) used drugs several times a week. Basically all of those who used drugs at least once a week (95%) used cannabis, nearly half of them used amphetamines or mephedrone, 40% of them used cocaine, and every fifth sex worker within this group also used heroin. Five sex workers used herbal cannabis or cannabis resin daily, and also heroin at least once a week.

In the past 12 months the majority of the sex workers (78%) did not use tranquilisers, sedatives or stimulating medicines without prescription, but one-third of them (52 respondents) used such substances on a daily basis.

Refugees living at receiving stations¹⁶

The survey (Csorba et al. 2011) was carried out as an experiment at the Debrecen Receiving Station. The respondents (N=100 persons) came from 27 different countries, most of them from Afghanistan, the Yugoslav successor states and Palestine. The majority of the respondents (72%) were from a Muslim country, 91% of the respondents were men, Muslim women were less approachable by the interviewers. The mean age of the sample was 28.6 years. A decisive majority of the respondents (70 persons) said that they were unmarried. In the case of more than one-third of the sample (39 persons) the highest school qualifications were elementary or even lower qualifications, 33 persons had completed secondary school, and 17 persons had higher education qualifications. Nearly half of the respondents had worked in their home country in some form, and nearly the same proportion of them had been unemployed, but by the time of the interview these proportions had deteriorated to 13% and 83%. In respect of family relationships it could be determined that one-third of the spouses and nearly half of the children were left in the country of origin. They had been staying in Hungary for 13.9 months on average.

Among those respondents who had ever drunk alcohol (62%) the mean age was 19.9 years on the first occasion when they tried it (in the case of those who came from countries with a Muslim majority the mean age at trying alcohol for the first time was 20.8 years). In the past 12 months 59% of them had drunk alcohol, while in the past 30 days 54% of them had drunk alcohol. Only 6% of them found that they had alcohol problems, which is 9.7% of all alcohol users.

¹⁴ The survey was carried out by the FACT Research Institute of Applied Social Sciences of Pécs.

¹⁵ During the survey the use of the following substances was examined: herbal cannabis/cannabis resin, speed/amphetamine, ecstasy, cocaine, heroin, mephedrone, other narcotic substances.

¹⁶ The survey was carried out by Matrix Association, on a simple random sample of refugees above the age of 18, using the face-to-face technique (in English, French and Serbian), by interviewing a total number of 100 persons.

The lifetime prevalence of illicit drugs was 24%, which is not significantly different to the value (20.9%) recorded among the Hungarian young adult population in 2007. The most commonly mentioned drug was cannabis (18%), but the cumulative lifetime prevalence of the various opiate derivatives (heroin: 6%, prescribed methadone: 8%, non-prescribed methadone: 2%, non-prescribed suboxone: 4%) was higher (20%). Consequently the use of opiates indicated a very high proportion. The last year and last month prevalences were more favourable (7% and 4%), they are similar to the rates recorded in the Hungarian young adult population (6.4% and 3%). Cannabis and opiates were followed by the use of tranquilisers and sedatives with 10% lifetime prevalence. Typically no other substances were used, the new psychoactive substances spreading in the national drug use patterns (mephedrone, ketamine, GHB) had not appeared among the respondents.

The subjective opinion of the respondents on drug use perceived among the refugees living at the receiving station were also surveyed. On the basis of the data it can be observed that the more characteristic active drug use was, the more intensive illicit drug use was perceived among the refugees living at the receiving station. 27.3% of those who had used drugs in the last month thought that among the refugees living at the receiving station the proportion of drug users was above 20%. At the same time, among those who had never used drugs, this proportion was only 10.5%. On the basis of this it can be presumed that among the refugees living at the receiving station a subculture of drug users has been or is being established, these drug users know about each other, while those who do not use drugs know less about them.

Students of medicine¹⁷

The survey (Sima 2012) examined the forms of health-damaging behaviour of students in the fourth grade in the academic years of 2009/2010 and 2010/2011. According to the results 12.3% of the entire sample (N=942 persons) said that they smoke at least one cigarette a day (men: 14.9%, women: 10.7%), one-third of them (34.9%) get drunk at least once a week (men: 47.2%, women: 27.2%), one-tenth of them take medicines affecting the central nervous system several times a month (men: 6.6%, women: 13.4%), nearly one-third of them (31.6%) have already used illicit drugs (men: 39.5%, women: 26.7%), and 30 persons said that they used illicit drugs regularly. It means that more than half of the students (55.4%) regularly use some sort of health-damaging substance.

Smoking and the use of medicines is the most characteristic of the faculty of pharmaceuticals, the use of alcohol and trying illicit drugs is the most characteristic among students of dentistry. Among men there is a greater proportion of those who smoke, drink alcohol and try drugs, while among women there is a greater proportion of those who take medicines regularly.

Conclusions

The data recorded in Hungary during the ESPAD survey in 2011 indicated a significant increase in the use of illicit drugs and substances with the purpose of abuse as compared to 2007. Among the examined substances cannabis is still the most commonly used drug, and is followed by the use of medicines without prescription and the inhalants. The proportion of those who had ever tried illicit drugs increased both among boys and girls, but the rate of the increase was higher among girls. Similarly, the increase was greater in regions outside of Budapest than in schools located in Budapest.

¹⁷ The survey was carried out by Semmelweis University, Institute of Public Health Sciences, using the survey method, interviewing a total number of 942 students (Faculty of General Medicine: 626 persons, Faculty of Pharmaceuticals: 180 persons, Faculty of Dentistry: 136 persons).

3. PREVENTION¹⁸

3.1. OVERVIEW

During the year the scope and the professional priorities of prevention activities were determined partly by the realisation of the (national and EU) tenders announced in 2010 and partly by the drug-related tenders announced in 2011 by the Ministry of National Resources. The realisation of the latter mostly could not be started in 2011 due to late payment.

3.2. ENVIRONMENTAL PREVENTION

In 2011 the extension of the legal regulations relating to new psychoactive substances represented a significant change at national level, which may influence the entire drug problem and may be categorised within the scope of environmental prevention. Mephedrone, one of the new synthetic substances, was added to the list of illicit substances at the beginning of the year, and preparations have been made and legislative steps taken to ban a further 9 compounds (MDPV, 4-MEC, methylone, 4-FA and five synthetic cannabinoids) (see chapter 1.2). Furthermore, a government decision was made and legislation drawn up in order to set up and introduce generic control. These legislative steps are aimed at handling the increasingly serious problem represented by new psychoactive substances in recent years and at reducing the extent of the problem. Eliminating the legal distribution of these new substances is an important element of the process.

The insufficient regulation of dance and music events and the lack of safety measures applied in the premises accommodating such events were brought into focus by the West Balkán tragedy¹⁹. The government regulation on increasing the safety of the operation of music and dance events was enacted on 16 March 2011 (for more details see chapter 1.2); its aim is to make occasional or regular music and dance events safer and to protect the participants' life and health.

3.3. UNIVERSAL PREVENTION

There was an opportunity for comprehensive programmes based on the cooperation of the participants of local communities to be supported in the scope of the KAB-ME-11-A/B/C tenders, which programmes are associated with the prevention of drug use and offer a positive example against drug use.

In the KAB-ME-11-A project category 91 school programmes were granted support to a total amount of EUR 198,311²⁰.

Tenders aimed at strengthening the family system and developing parental skills were supported in the scope of the KAB-ME-11-B project category. In this category 56 tenders were granted support to a total amount of EUR 203,727.

Programmes and initiatives based on local community resources, which may represent attractive alternatives against drug use at settings such as spare time activities, child protection institutes, institutes of the criminal justice system, the internet and other media, the workplace, were supported within the KAB-ME-11-C project category. In this category 75 tenders were granted support to a total amount of EUR 318,152.

¹⁸ The authors of this chapter are: Adrienn Nyírády, Anna Tarján

¹⁹ 3 young persons died at a place of entertainment in Budapest, where panic probably broke out and they were suffocated by the pressure exerted by the crowd.

²⁰ The amounts in this chapter were calculated based on the official mid-rate of the EUR for 2011 (1 EUR = 277,7 HUF).

21 programmes were granted support to an amount of EUR 57,353 in the scope of the KAB-KEF-11-B project announced for supporting the prevention activity of Drug Coordination Fora. A general aim defined in the tender was to initiate and coordinate programmes that respond to the drug prevention and health promotion needs in the region.

Programmes, carried out by the police, aiming partly at drug prevention are described in chapter 9.4.

Training professionals

The Ministry of Human Resources, State Secretariat for Education granted support for a 30-hour training course entitled Mental Hygiene Basic Further Training for Teachers organised in the Zánka Children and Youth Centre with the participation of 96 teachers. (EMMI 2012c)

Prevention at work

The workplace health programme of Kék Pont Alapítvány [Blue Point Foundation] entitled Health Agency was introduced in June 2011 in the scope of the KAB-ME-10-MM project, at a construction company. The programme deals with the interactive discussion of topics such as alcohol consumption, drug use, gambling games, work-life balance, saving money, stress at work, and it encourages employees to show greater awareness when making their decisions and to make an effort to manage individual and community resources more efficiently, more favourably, more harmonically²¹.

3.4. SELECTIVE PREVENTION IN AT-RISKS GROUPS AND SETTINGS

Drug prevention in the Hungarian Army

On the basis of the Hungarian Army's Drug Prevention Strategy the following activities were performed in 2011 (Hungarian Army 2012):

1. Cognitive knowledge transfer, informative publications, visual presentation:
 - Information provided in the scope of disciplinary meetings, with the participation of a total number of 843 persons during the year.
 - Programmes organised in community settings in the scope of central and other military events, reaching 2,192 persons.
 - Billboard exhibition, organised at two bases in Budapest and at one base in Szolnok.
2. Operating the Hungarian Army's Health Protection Programme, which is not restricted to passing on knowledge exclusively about certain risk factors or disease groups, but it is a complex, comprehensive prevention programme focusing on interrelated health problems. It was organised at military units in interactive team sessions with small groups (20-25 persons), taking into consideration the demands and needs of the military units, with the participation of a total of 843 persons.
3. Training and further training of prevention service providers: an accredited training course entitled "Tasks relating to the operation of the Hungarian Army's drug monitoring system" was organised in Budapest on one occasion, with the participation of 38 persons.
4. Preparing a mission troop, with the participation of 138 persons.

²¹ Source: <http://www.kekpont.hu/egeszseg-ugynokseg/>

In accordance with Directive 103/2011. (IX.23.) of the Minister of Defence on the tasks relating to the organisational and staff rationalisation of the Ministry of Defence and certain organisations under its control, certain organisational elements of the Dr. Radó György Military Health Centre performing drug prevention at the Ministry of Defence were integrated into the Army Hospital. The legal successor took over drug prevention tasks – as determined in the organisational and operational rules currently waiting to be approved – assuming full competence.

Recreational settings

In 2011 a total number of 17 service providers carrying out harm reduction / prevention services in recreational settings operated in the country, including 6 city, 5 micro-regional, 2 county, 2 regional and 2 national programmes. (Tarján 2012a)

Map 1. *Geographical breakdown of organizations providing harm reduction services in recreational settings (N=17) in 2011*



Source: Tarján 2012a

In 2011, the 17 reporting organisations provided services in a total number of 603 events, where they contacted nearly 22,500 young people. The average number of contacts per event was 37 (in 2010: 41 contacts).

According to the data received from the service providers: 11,876 litres of mineral water, 17,391 condoms, 13,073 flyers, 1,376 packets of glucose tablets, 5,647 tubes of fizzy drink tablets, 5,675 vitamin tablets, moreover biscuits and fruits were distributed.

Four organisations organised training courses on 8 occasions for the managers and staff of clubs cooperating with the organisations about the conditions for ensuring safer nightlife. Outstanding attention was paid to providing information on new psychoactive substances during the training courses conducted by an organisation based in Szeged.

The Parti Szolgáltatók Szakmai Szövetsége - PASSSZ [Association of Harm Reduction Service Providers in the Recreational Setting] was founded in 2011; its aim is to facilitate active collaboration and information exchange between service providers performing harm reduction activities in recreational settings. Furthermore, the founding NGOs wanted to establish an association that efficiently enforces the guidelines and standards of safer nightlife to the operators of clubs, to government representatives and to partying people as well. The guidelines of the association are determined in the methodological letter drawn up

in 2011 (see 2011 National Report, chapter 3.4.). Currently the continuously growing organisation links up service providers in 9 cities²².

The National Focal Point carried out a qualitative survey (Csák 2012) on the extent of the use of new psychoactive substances (for the methodology see chapter 4.4), in the scope of which harm reduction service providers operating in recreational settings perceived the increasing use of synthetic cathinones to a lesser extent. At the same time all professionals reported the use of other licit substances. Synthetic cannabinoids were mentioned in the highest proportion, but GHB/GBL was also mentioned in many cases. In connection with the characteristics of drug use they pointed out that the use of licit drugs is coupled with undertaking a greater risk: drug use has become much more open (users sniff powders or smoke 'synthetic weed' even on the dance floor), and users think that licit substances are less harmful. On the basis of the answers it can be determined that during festivals, in pubs and at clubs alcohol causes the most problems, while the use of new psychoactive substances is a problem mostly at places where entertainment is offered even until the following afternoon. On the basis of the answers it can be presumed that these clubs are the most reluctant to cooperate with low-threshold service providers, which was mentioned as a significant problem mainly by service providers in Eger and Budapest. The extent to which a given service provider operating in the recreational setting faces the phenomenon of new psychoactive substances partly depends on the target group to which the given service is provided and partly on the clubs they can cooperate with.

Government Regulation No 23/2011. (III.8.) on increasing the safety of music and dance events is described in chapter 1.2.

Quality assurance

In the interest of the more efficient use of the methodological letters elaborated within the framework of the TÁMOP 5.4.1 project (for further details see the 2011 National Report, chapter 3.2) a special document²³ was published to support the monitoring of the actual realisation of the recommendations drawn up in the methodological letters and to provide professional inputs for the operation of the future accreditation process.

3.5. INDICATED PREVENTION

In 2011 4,148 clients participated in preventive-consulting services. Some of them (1,290 persons) had started QCT in the previous year (2010).

The methodological letter drawn up in the scope of the TÁMOP 5.4.1 project (see 2011 National Report, chapter 3.2) resulted in numerous changes at the service providers. Some of these changes are aimed at the unification of case documentation and administration (forms for individual intervention plans, for treatment contracts to be concluded with the clients, client satisfaction questionnaires, etc.), furthermore the interventions are classed into categories such as compulsory, compulsory to choose, and optional. Regional consultations were held during the year at 5 locations (Budapest, Eger, Debrecen, Szeged, Szolnok) in order to promote professional acceptance of the methodological letter.

²² Pécs, Kaposvár, Budapest, Szeged, Orosháza, Gyula, Békéscsaba, Nyíregyháza, Szekszárd

²³ Sebestyén, E. (2011): Preparing the scripts and reports of central expert and on-site assessments, National Institute for Family and Social Policy, Budapest. The study can be downloaded from: <http://www.modernizacio.hu/index.php?page=dokumentum&piller=20&dokid=433>

3.6. NATIONAL AND LOCAL MEDIA CAMPAIGNS

No new information available.

Conclusions

Taking into consideration the project priorities determined in the previous years, tenders aimed at professional developments in the field were announced, but often their realisation ran into difficulties because of late payments.

4. PROBLEM DRUG USE²⁴

4.1. OVERVIEW

Besides their turnover data (see chapter 7.3.), needle/syringe programmes (NSPs) again reported the gender of their injecting drug user clients, their primarily injected drugs and age groups²⁵. In the case of drug types for the first time in 2011, service providers could specify the substances classified in the category of “other” substances. (Tarján 2012b)

In 2011 the National Centre for Epidemiology (OEK) provided the opportunity of HIV/HBV/HCV testing for IDUs in the scope of two programmes. In the national HIV/HBV/HCV prevalence survey carried out between January and May 2011, 666 persons were tested at NSPs and outpatient drug treatment centres (DTC) (Dudás et al., 2011; for the methodology, serological results and risk behaviour analysis see chapters 6.1. and 6.2.; ST9_2012_HU_01). The voluntary HIV/HBV/HCV diagnostic testing programme in 5 cities started in 2010 also continued, 186 persons were tested in 2011 (Dudás et al. 2012; for the methodology, serological results and risk behaviour analysis see chapters 6.1. and 6.2.; ST9_2012_HU_02). This chapter describes the main socio-demographic and drug use patterns of IDUs participating in these two surveys.

The Hungarian National Focal Point carried out a survey on the new phenomena observed in 2011, and the main findings of this survey are included in chapter 4.4. In this chapter further research results are presented (Demetrovics 2011, Móró 2011, Kalapos 2011, Csák 2012, Tistyán 2012, Rácz 2012) in connection with drug user groups outside of treatment and the changes of drug use patterns in 2011.

4.2. PREVALENCE AND INCIDENCE ESTIMATE OF PROBLEM DRUG USE

No new information available.

4.3. DATA ON PROBLEM DRUG USERS FROM NON-TREATMENT SOURCES

On the one part the trend of the breakdown of IDUs according to age, gender and primarily injected drug type is presented on the basis of NSP client data with national coverage. On the other part, in the course of examining the data of IDUs participating in HIV/HBV/HCV testing programmes, on the basis of the time-series analysis of the proportion of clients below the age of 25 and the proportion of persons who started injecting drug use within the past two years it was possible to monitor how the structure of the IDU group changed or whether younger groups or groups recently starting injecting drug use appeared, and the trend of the breakdown by primarily injected drugs could also be observed.

NSP client data

Since 2009 the proportion of women within the clientele has slightly increased (2009: 21%, 2010: 24%, 2011: 25%).²⁶

²⁴ The authors of this chapter are: Gergely Csaba Horváth, Anna Tarján

²⁵ In 2011, 19 of the 22 NSPs participated in data reporting on their clients, they provided data on a total number of 2,506 clients. Double counting control could be performed at the level of service providers but not at national level.

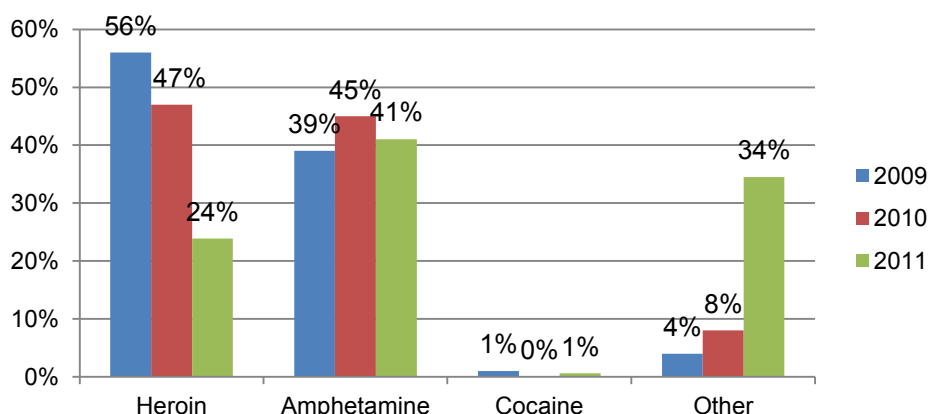
²⁶ This may be due to a special service launched in 2010 for women; see 2011 National Report, chapter 7.2.

In respect of age distribution it can be stated that in 2011 again the greatest proportion, 50% of the clients belonged to the age group 25-34. Clients below the age of 25 and above the age of 34 represented nearly the same proportion, 25% each. The proportions are similar to the age distribution observed in the previous year.

The primarily injected drug type became known in the case of 2,239 persons. 24% of them primarily injected heroin, 41% injected amphetamine, and other drugs were reported in the case of 34%.

The proportion of IDUs injecting heroin dropped significantly as compared to 2010 – by 23 percentage points – while the proportion of IDUs injecting other drugs increased significantly (by 26 percentage points). In 2011 the proportion of IDUs primarily injecting amphetamine dropped slightly as compared to 2010. Cocaine, as a primarily injected drug is represented by an insignificant proportion among IDUs attending NSPs.

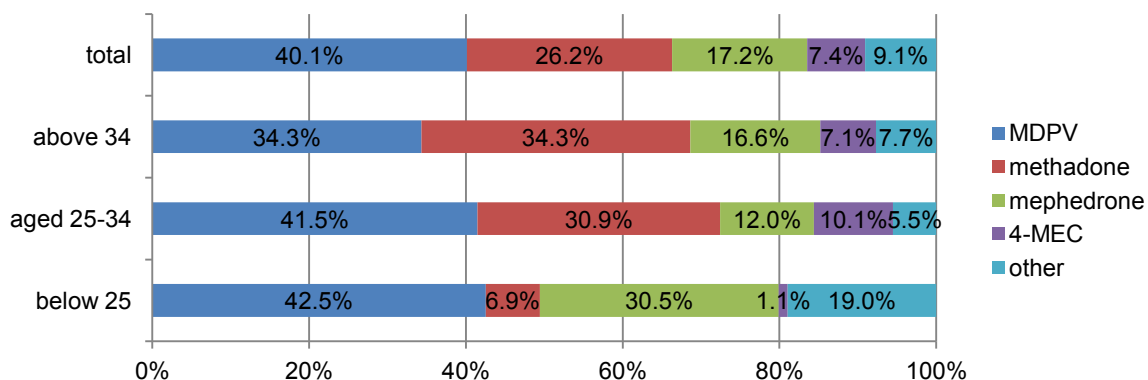
Figure 10. *Breakdown of NSP clients by primarily injected drug type (%), between 2009-2011*



Source: Tarján 2012b

In the case of IDUs injecting other drugs (N=760) the use of MDPV was the most prevalent, 40% of them primarily injected MDPV in 2011. MDPV was followed by methadone and mephedrone in the order of prevalence. While below the age of 25 MDPV and mephedrone were the most commonly injected primary drugs, in the age group 25-34 MDPV and methadone occupied the first two positions, and above the age of 34 methadone and MDPV were represented in identical proportions.

Figure 11. *Distribution of NSP clients primarily injecting other drugs (N=760) by drug type (%) and broken down by age group in 2011*



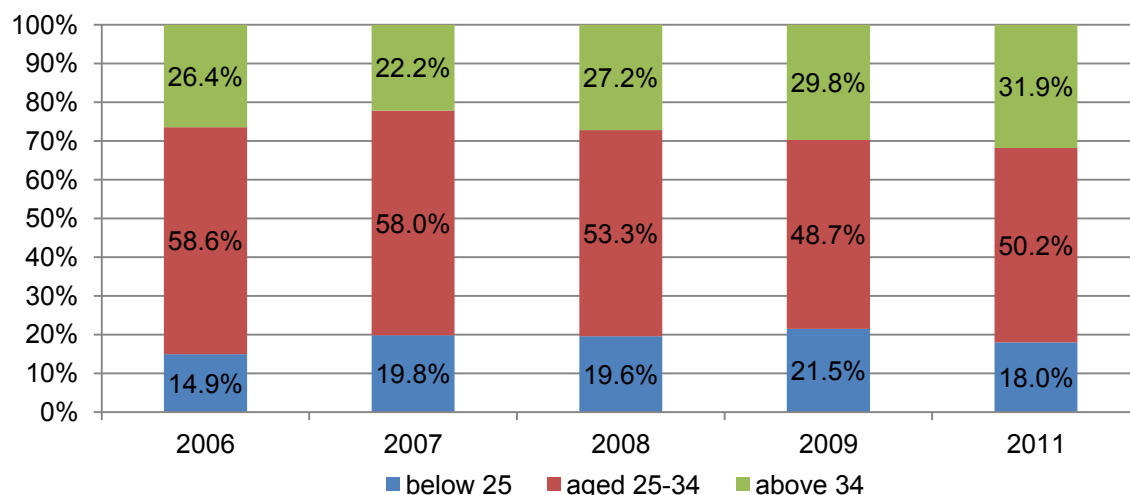
Source: Tarján 2012b

Trends among IDUs participating in the national HIV/HBV/HCV prevalence survey

72.2% of the 666 persons tested in 2011 were men (481 persons) and 27.8% of them were women (185 persons) (Dudás et al., 2011; for further information see chapters 6.1. and 6.2.; ST9_2012_HU_01). In respect of gender distribution no change could be observed during the surveys performed since 2006.

Between 2006 and 2011, in the examined population the proportion of IDUs below the age of 25 was between 18-20%.

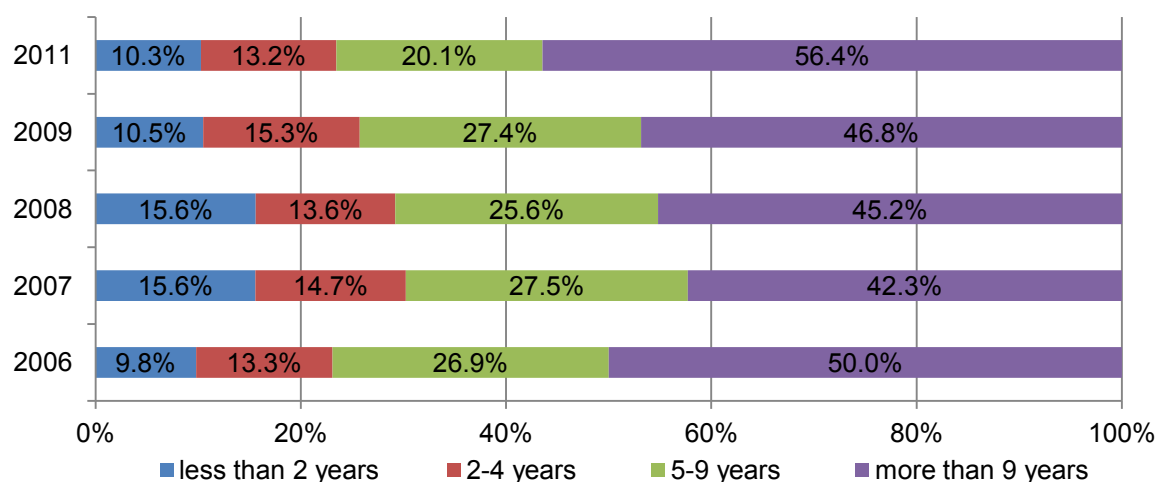
Figure 12. Breakdown of IDUs tested during the national HIV/HBV/HCV prevalence surveys by age group, between 2006-2011, (%)



Source: OEK and NFP

On examining the years since first injection it can be stated that the proportion of new IDUs who started injecting within the past 2 years dropped in recent years. While in 2007 and 2008 this proportion was 15.6% it decreased to 10.3% by 2011.

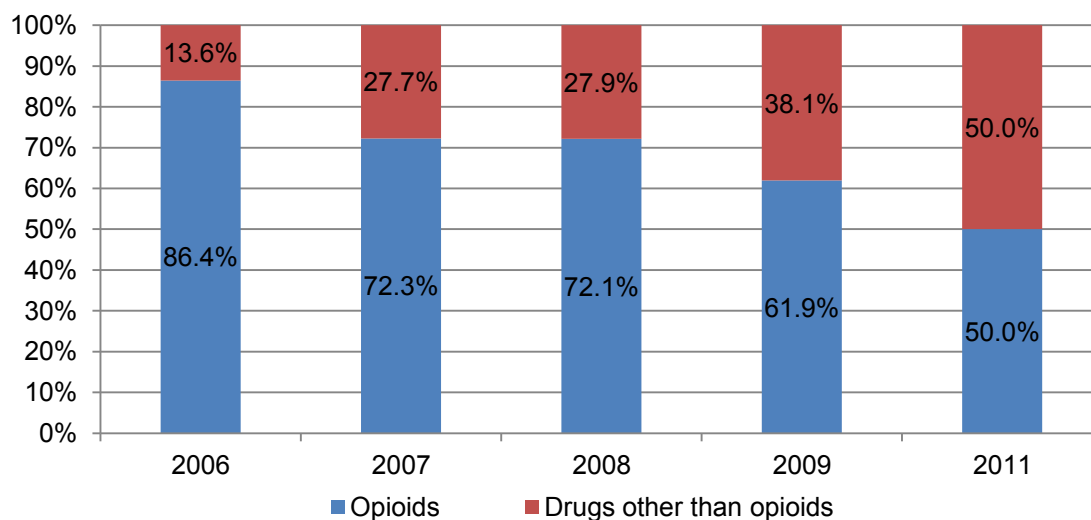
Figure 13. Breakdown of IDUs tested during the national HIV/HBV/HCV prevalence surveys by years since first injection, between 2006-2011, (%)



Source: OEK and NFP

Regarding the primarily injected drug type²⁷ it could be seen that since 2006 the proportion of IDUs injecting opioids has reduced monotonically. In 2011 only half of the clients reported injecting primarily opioids.

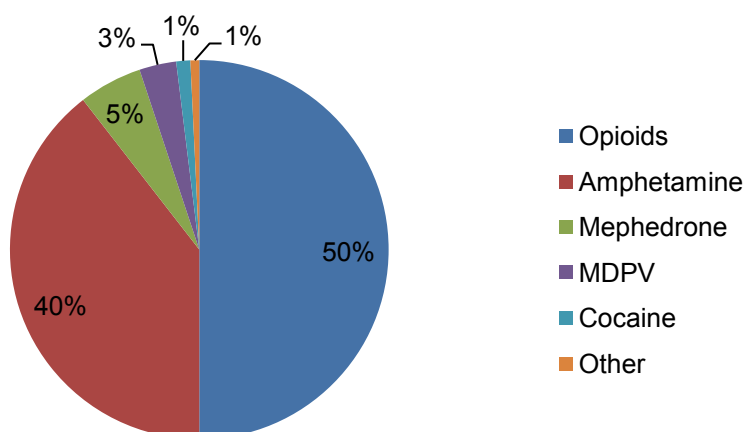
Figure 14. Breakdown of IDUs tested during the national HIV/HBV/HCV prevalence surveys by primarily injected drug type, between 2006-2011, (%)



Source: OEK and NFP

In 2011 half of the 666 tested persons reported primarily injecting drugs other than opioids. 39.5% said that they primarily injected amphetamines. 57 persons (8.6%) mentioned injecting primarily new psychoactive substances (typically mephedrone and MDPV).²⁸

Figure 15. Breakdown of IDUs tested during the national HIV/HBV/HCV prevalence survey by primarily injected drug type, in 2011, (%)



Source: OEK and NFP

²⁷ In the surveys from 2006 – 2009 the substances could not be specified in the category of other drugs. Closed categories were: opioids, amphetamines, cocaine, and other drugs.

²⁸ For the first time in 2011 IDUs could specify the primarily injected “other” substance by answering an open-ended question.

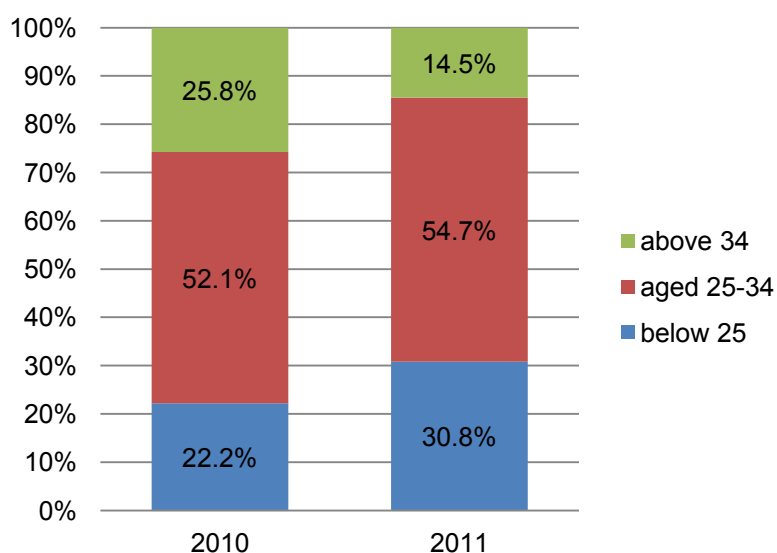
Trends among IDUs participating in the voluntary HIV/HBV/HCV diagnostic testing programme

In 2011 186 IDUs participated in the voluntary HIV/HBV/HCV diagnostic testing programme in 5 cities²⁹ (Dudás et al. 2012, for further information see chapters 6.1 and 6.2.; ST9_2012_HU_02).

The gender distribution of the participants was similar to the one observed in 2010 (2011 National Report, chapter 6.1.). In 2011, 70.4% of the 186 participants were men and 29.6% were women.

On examining the distribution by age group it can be seen that the proportion of IDUs below the age of 25 increased from 22.2% in 2010 to 30.6% in 2011. The proportion of IDUs aged 25-34 also increased slightly.

Figure 16. *Breakdown of IDUs tested in the diagnostic testing programme by age group, in 2010 and 2011(%)*

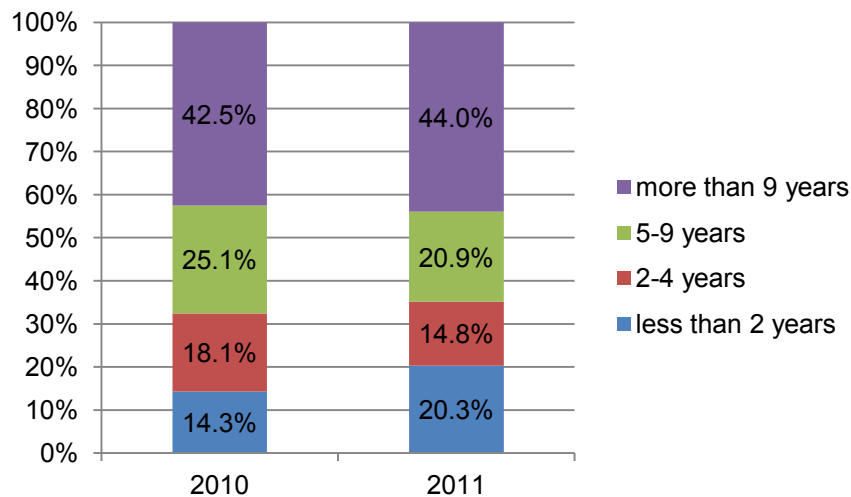


Source: OEK and NFP

²⁹ Budapest, Debrecen, Gyula, Pécs, Szekszárd

Regarding years since first injection an increase could be observed in the proportion of new IDUs starting injecting drug use within the past 2 years. While in 2010 their proportion was 14.3%, in 2011 it was 20.3%.

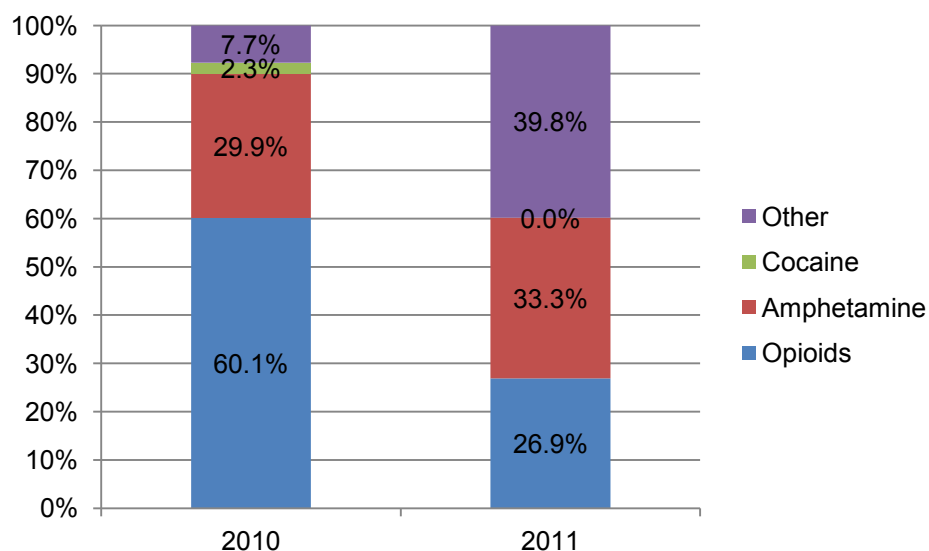
Figure 17. *Breakdown of IDUs tested in the diagnostic testing programme, by years since first injection, in 2010 and 2011 (%)*



Source: OEK and NFP

From 2010 to 2011 the distribution by primarily injected drugs changed significantly as well: while in 2010 60.1% of IDUs typically injected opioids, in 2011 their proportion dropped to 26.9%. The proportion of IDUs injecting amphetamines slightly increased, but the most significant change occurred in the proportion of IDUs injecting other types of drugs: in 2011 their proportion was 39.8% as compared to 7.7% measured in 2010.

Figure 18. *Breakdown of IDUs tested in the diagnostic testing programme by primarily injected drug type, in 2010 and 2011 (%)*



Source: OEK and NFP

For data interpretation it must be pointed out that while the NSP client data provide information on a current IDU population³⁰, the national HIV/HBV/HCV prevalence survey and the data deriving from the diagnostic testing programme describe a more heterogeneous IDU population. 13 NSPs and 5 outpatient DTCs participated in the national survey, the proportion of current IDUs was 61%, while voluntary diagnostic testing was provided by 8 NSPs and 3 outpatient DTCs, and 79% of the tested persons were current IDUs.

In respect of 2011 the data on NSP clients with a national coverage demonstrate the increasing frequency of the injecting use of new psychoactive substances.

This increasing trend is also supported by data on IDUs participating in the voluntary diagnostic testing programme in 5 cities in 2011. Besides this, although there is only a limited possibility of observing trends due to the geographical coverage and the incidental nature of testing uptake, the results indicate that the proportion of IDUs below the age of 25 and the proportion of new IDUs injecting for less than 2 years also increased as compared to 2010.

On the basis of the data of the national HIV/HBV/HCV prevalence survey – providing information on the period January-May 2011 – the increasing proportion of drugs other than opioids could be detected as could the appearance of the injecting use of new psychoactive substances. On the basis of the national prevalence survey, in the last 5 years examined, the proportion of young and new IDUs did not change significantly.

In chapter 5.3.2. the restructuring distribution of IDUs starting treatment by drug type is described on the basis of TDI data (on clients entering drug treatment) for the last 5 years.

4.4. INTENSIVE, FREQUENT, LONG-TERM AND OTHER PROBLEMATIC FORMS OF USE

GHB users in emergency treatment

Demetrovics (2011) and his team carried out a survey among the GHB-intoxicated patients of a toxicology unit³¹ in Budapest. 103 persons were involved in the survey³², their outpatient treatment sheets and the results of their toxicology tests were examined as was the data relating to the seriousness of the intoxication. Most of the patients, 87 persons, were taken to the hospital unit by ambulance. Loss of consciousness occurred in 41% of the cases, loss of memory was observed in 19.4% of the cases. In three-quarters of the cases the degree of intoxication was slight, in the case of 13.5% it was medium, while in the cases of 5 persons (4.9%) serious intoxication was diagnosed. The clinical sample was completed with the data of 48 other persons recruited with the help of snowball sampling³³.

According to the data relating the first use most of the users received GHB/GBL free of charge for the first time, about half of them received it from a close friend first. Two-thirds of the users tried the substance in the company of several friends, most of them at a place of entertainment or at a private party. At the time of first use the mean age of the examined persons was 22.4 years.

Data was also collected about current use. Most commonly the substance occurs in liquid form and is consumed after being mixed with a drink. The factors motivating use, in order of succession, were 'experiencing an altered state of consciousness', 'relaxation and recreation', 'narrowing or inhibiting attention to the outside world'. The most commonly

³⁰ IDUs injecting drugs at least once within the past 4 weeks.

³¹ Péterfy Sándor Street Hospital, Outpatient Clinic and Traumatology Centre, Clinical Toxicology Department

³² 51 of the patients were men and 52 of them were women. The mean age was 27 years. The results of the blood and urine tests performed among the patients were processed for the purpose of identifying GHB concentration, alcohol and drug concentration. On top of the above, on the basis of the patients' own reports the occurrence of crime against property, outward signs of injury, suicidal intention and sexual abuse was also surveyed, sexual abuse was confirmed with a gynaecological examination.

³³ The sample included 48 persons, the mean age was 26.2 years, there were 36 men and 12 women. 27 respondents were from Budapest, 15 persons came from another city, and 6 persons were from a village. Data recording took place between October 2010 and June 2011.

mentioned subjective experience was experiencing a nice, pleasant mood', 'light-heartedness' and 'increased sexual excitement'. The users reported negative consequences following use, which were the following in order of succession: 'fatigue, depression'; 'feebleness, weakness'; 'bad mood and confusion'. 31.4% of the respondents have sexual intercourse exclusively with their permanent partner when using GHB, while 22.9% also have sex with other persons occasionally. 20% of the respondents have sex even with strangers when using drugs, which can be regarded as risky sexual behaviour. The most commonly used drugs besides GHB were herbal cannabis and cannabis resin. The second most commonly used drugs were ecstasy and amphetamines, and cocaine was nearly as commonly used too.

In the scope of the study a literature review of the epidemiological studies was prepared relating to the prevalence of GHB use³⁴.

Qualitative information on the new phenomena experienced in 2011

In 2011 the Hungarian National Focal Point carried out a survey on the new phenomena experienced in 2010 among the clients of NSPs and outpatient treatment units in Hungary (for further detail see 2011 National Report, chapter 4.3.). In 2012 the survey was carried out again (Csák 2012), and it was extended to hospital inpatient units, drug therapy institutes and low threshold programmes operating in recreational setting.³⁵

Nearly all of the treatment units interviewed said that in 2011 the most important phenomenon was the increasing use of new psychoactive substances, first of all synthetic cathinone derivatives. After mephedrone was banned at the beginning of January 2011, despite the fact that several substances were available on the market, on the basis of the service providers' reports MDPV was clearly the most widely used drug among clients. On examining the type of services it can be determined that while in NSPs, outpatient and inpatient treatment units and drug therapy institutes the phenomenon was clearly detected, the use of synthetic cathinones was a less significant problem for low-threshold programmes operating in recreational setting.

Several service providers reported that the number of opiate users had dropped in line with the increasing of the number of persons using new psychoactive substances. This change was more emphatic in the case of NSPs and drug therapy institutes.

NSPs reported an increase in the number of drug injecting occasions on the same day accompanied by an increase in their turnover at the same time.

On the basis of the reports received from the service providers contacted, in connection with the users of new psychoactive substances no clear demographic characteristics can be determined in respect of school qualifications, income and labour market situation.

The service providers reported that because of the legal nature of these substances they experienced a typically more open, less concealed form of use in their case.

In connection with new psychoactive substances, a much higher proportion of polydrug use was experienced among clients. In some cases polydrug use is done consciously (e.g. these substances are often mixed, even with amphetamine), but the unintended use of drug combinations and being unaware of changing substances is also common (due to lack of knowledge of the active agent).

According to the service providers' reports it is a prominent problem that drug use causes physical and mental problems for users much sooner than that observed before the appearance of new psychoactive substances. Many service providers reported about clients losing weight rapidly and that after a relatively short period of use of a few months users

³⁴ Németh Zs., Kun B., Demetrovics Zs.: The involvement of gamma-hydroxybutyrate in reported sexual assaults: a systematic review. In: Journal of Psychopharmacology. 2010 szeptember. 24/9. sz. 1281-1287. p.

³⁵ During sample selection, on the basis of the client numbers in 2011 first of all the service providers with the highest turnover were included in the survey. Participating institutes: NSPs (9), low-threshold programmes operating in recreational setting (6), outpatient treatment units (9), inpatient treatment units (3) and drug therapy institutes (5). A total number of 38 service providers were contacted, and 6 of them refused to participate in the survey.

went into a psychotic state, they had paranoid delusions and hallucinations. Due to this synthetic cathinone users got in contact with the treatment system very soon, partly because of acute crisis-type situations and partly because following the rapid deterioration of their physical and psychic condition they themselves asked for help in quitting the use of the substance. At the same time, both the staff of outpatient and inpatient treatment units and drug therapy institutes pointed out that the motivation level of these clients was very low. The probable reason is that although they got to the point where they asked for help, only a short period of time had passed between regular use and the crisis situation, so in many cases their social relationships, earning a living or career (school progress) had not deteriorated to such an extent as, for example, in the case of several years of heroin use.

The factors listed among the causes of the increasing use of psychoactive substances repeated the results of the survey carried out a year before (National Report 2011, chapter 4.3.).

Tistyán et al. (2011) conducted a study on the situation of new psychoactive substances in Hungary in 2010 and 2011. The study consisted of four parts: a qualitative study based on in-depth interviews; the content analysis of the print press, media; the content analysis of information found in blogs; and the analysis of the marketing strategy of webshops.

In the scope of the qualitative study based on in-depth interviews 60 interviews were recorded with drug users, dealers, employees of places of entertainment, police staff, members of the local Coordination Forums on Drug Affairs and employees of treatment units³⁶. The parties interviewed had different opinions on the new phenomena experienced. Although all respondents clearly stated that the most important change was the rapidly increasing use of new psychoactive substances, some of them found that these substances had taken the place of former illicit substances, first of all pushing out amphetamines; others thought that these substances had made supply more abundant, they had appeared besides substances, and they were used mostly as secondary substances by long-term users. Many of the respondents find that the new substances are used for recreational and social purposes. On the basis of the answers, in general the increasing frequency of use, the rapid development of addiction and the development of psychic dependence can be identified. In connection with trafficking the respondents said that dealers extended their supply of substances by new psychoactive substances, but their role had not changed.

Based on the content analysis of online forums it was found that in 2011 users started to look for the successor of mephedrone, which demonstrates that the change of substances to mephedrone in 2010 was followed by a further change to a new substance or substances in 2011. After mephedrone, which has been an illicit drug since January 2011, users mentioned encountering substances such as MDPV, methylene and 4-MEC.

Qualitative information on mephedrone use

Kapitány-Fövény et al. (2012) carried out a survey among 135 mephedrone users in 2011³⁷. The questionnaire addressed the general characteristics of substance use, the circumstances of the first use and the current use of mephedrone.

Typically the first use of mephedrone took place in recreational setting, at places of entertainment or in discos (56.3%), most typically jointly with one or more friends (91.9%). The substance was typically obtained from a close friend (48.9%) or acquaintance (34.1%), only a few respondents mentioned a person they did not know (8.9%) or the internet (5.2%) as their source.

The route of administration was sniffing in the case of a significant proportion of the respondents³⁸ (85.2%) besides oral administration (34.8%). Injecting use was mentioned by

³⁶ Data was collected in the following cities: Szeged, Pécs, Kaposvár, Gyula, Szekszárd.

³⁷ The sample recruited with the snowball sampling method consisted of 96 men and 39 women, their mean age was 24.3 years (SD=5.68). 73.3% of the respondents (99 persons) were from Budapest, 17.8% of them (24 persons) were from other cities, and 8.9% (12 persons) lived in a village or settlement. At the time of the survey mephedrone was already an illicit drug.

12.3% of the respondents, i.e. 17 persons, 11 of whom said that injecting use was their only route of administration. Other drugs used besides mephedrone were typically cannabis and amphetamines, opiate use was not typical.

The most common answers relating to the cause of drug use included 'experiencing an altered state of consciousness' (57.2%) and 'relaxation and recreation' (41.2%). The most typical answers describing the effect of the substances mentioned 'pleasant mood' (80.3%), 'light-heartedness' (68.3%) and 'euphoria' (68.2%). Two negative effects were mentioned, such as 'lack of appetite' (58.6%) and 'troubled sleep, insomnia' (50.7%).

75.4% of the respondents answered yes to the question whether mephedrone use caused dependence.

The online survey (Móro 2011) performed among users registered on the psychedelic community web site daath.hu³⁹ (N=319) concentrated specifically on the characteristics of mephedrone use. 81% of the users encountered the substance for the first time in 2010, but it is not to be neglected either that 17% of them had met it a year earlier. Two-thirds of them received/obtained the substance from a friend, and only a quarter of them bought it on the internet, in the dominant majority of cases it was sold in powder form. Typically the users sniffed the substance, injecting use was insignificant in this group. The average monthly frequency of use was 8 occasions. According to the respondents it is a typical social drug, it is typically used in company. Nearly half of the respondents use it only a few times a month and they do not regard themselves as regular users. One-fifth of them regard themselves as regular users, and 8% of them use mephedrone several times a day.

Typical purposes of use included "mood enhancing" (60%), "enhancing perception and a pleasant feeling" (54%) and "satisfying curiosity" (40%). According to the users' reports the effect of mephedrone is similar to that of ecstasy, 65% of the respondents gave this answer, but a third of the respondents also mentioned the effect of cocaine, and another third of them mentioned the effect of amphetamines⁴⁰.

Qualitative information on the use of new psychoactive substances

Rácz et al. (2012) studied the phenomenon of IDUs changing substances by qualitative interviews⁴¹. From the answers the conclusion can be drawn that the phenomenon was not due to an expansion of the drug market, but typically a shift, change of substance or simultaneous use of mephedrone could be observed, which means that mephedrone became a primary substance, and the former drugs were used as secondary substances. Mephedrone has similar effects to amphetamines, cocaine and ecstasy, users mentioned short-term euphoria, and then after a period of 30 minutes negative effects and craving. In general the respondents reported on the rapid development of addiction and more frequent or more intensive use.

Mephedrone, even while it was still legal, was obtained from the old dealers. The legal status of mephedrone occurred only as an indirect issue concerning access, so it only influenced supply and not demand. At the end of the recruitment period (February 2011), when mephedrone was already illegal, the interviewed persons also mentioned the use of MDPV.

Csák et al. (2011) monitored the changing of the group of clients of an NSP located in Budapest and the changing of the clients' patterns of use after mephedrone had been

³⁸ Respondents could select more than one options.

³⁹ Data collection was conducted from 8 February 2010 to 17 February 2011.

⁴⁰ Several answers could be selected.

⁴¹ In the scope of the Blue Point Foundation's "Contact" Programme 17 IDUs were recruited. The inclusion criterion was the injecting use of mephedrone at least once within the past 30 days. Recruiting took place between December 2010 and February 2011. The sample is not representative of IDUs or the clients of the above programme.

controlled as an illicit drug⁴². According to the data collected by the service provider, in 2010 62% of the clients injected amphetamine, 25% injected heroin and 5% injected mephedrone. By the end of 2011 the distribution of primarily used substances had changed significantly: 46% of users said that their primary substance was amphetamine, while 48% of users identified MDPV and 4% identified heroin as their primary substance. Clients could select several substances besides their primary substance. In respect of all mentions 60.2% of the clients injected amphetamines, 55.4% injected MDPV, and 8.6% injected heroin. 71.5% of the clients selected one injected substance, while 20.4% of them selected two and 8.1% selected three or more substances. The analysis according to age group did not identify any pattern by age. The length of injecting use did not influence the proportion of primary substances, about half of the clients injected MDPV independently of the number of years of injecting drug use⁴³. At the end of 2011 among clients reported to have used heroin as the first drug of injection regarding current use, the primary injection of MDPV was dominant (43%) besides amphetamines (39%) and heroin (13%). Among clients injecting amphetamines for the first time amphetamines remained the most commonly injected substance, half of the clients used it still, while 45% reported MDPV and 3% heroin as their currently used drug.

In his article Kalapos (2011) reviewed the literature data relating to the chemistry, biochemistry and metabolism of MDPV, and on the basis of his own clinical observations⁴⁴ he discussed the symptoms perceived by the clients during intoxication and withdrawal following the use of MDPV. The most common symptoms are summarised in the table below.

Table 4. *Prevalence of symptoms associated with the use of MDPV among the clients during intoxication and withdrawal*⁴⁵ (N=15) (persons)

	Symptoms and occurrence during intoxication		Symptoms and occurrence during withdrawal	
1.	Agitation	9/15	Pain in the bones/muscles	7/15
2.	Loss of appetite	8/15	Paleness	4/15
3.	Paranoia/delusional disorder	8/15	Drowsiness/hypersomnia	4/15
4.	Perception disorder	8/15	Blurry vision	3/15
5.	Aggressiveness	8/15	Irritability	3/15

Source: Kalapos 2011

Conclusions

The structural change already described last year characterised by a reduction in the use of opiates accompanied by the increasing use of cathinones continued in 2011.

The surveys aimed at measuring the prevalence of infectious diseases and risk behaviours among IDUs and the data of NSP clients – due to the transformation of the data collection process – were the first ones with a national coverage to indicate the changing structure of primarily injected drugs: The former typical distribution of opiates and amphetamines injection transformed, injecting amphetamines and cathinones became dominant over opiate use among IDUs.

⁴² In the Blue Point Foundation's "Contact" Programme. The client data deriving from the service provider's data collection in 2010 was updated by a short questionnaire at the end of 2011 (13 September – 15 October 2011) on a voluntary basis, anonymously. Analysis took place on the basis of 186 valid questionnaires.

⁴³ The proportion of injecting MDPV per years of injecting use: 1 year or less: 43%, 2-5 years: 40%, 6-10 years: 52%, 11-15 years: 56%, 16 or more years: 48%.

⁴⁴ Based on the self-report of clients admitting MDPV use contacting the Specialised Outpatient Treatment Unit of Józsefváros Health Centre between 15 May and 15 September 2011. Among the 15 clients there were 13 men and 2 women.

⁴⁵ The five most common symptoms have been selected.

Users were interviewed at different geographical locations and in different settings, but despite this the interviews and surveys reveal several similar statements, on the basis of which it can be presumed that a few general characteristics of the phenomenon have been identified. According to the qualitative studies users reported that the effects of mephedrone were similar to those of ecstasy, amphetamines and cocaine. During recreational use sniffing or maybe oral use are typical routes of administration, but injecting use is also present in Hungary, especially among those who were injecting users before and used to inject amphetamines or heroin.

Mephedrone is regarded as a social drug, and it has been used in open settings, i.e. at places of entertainment, but even in the street or in parks, disregarding the fact that during the time of the surveys mephedrone was controlled as an illicit substance.

In connection with new substances the possibility of internet purchases is often mentioned as one of the causes of the rapidly increasing use of such substances, but the Hungarian studies do not prove that it is a typical channel of acquisition. The majority of the interviewed persons purchased such substances from a friend or acquaintance, or from their ordinary dealer, there is a minimal number of internet purchases among them. At the same time they use the internet as a source of information about new substances, and the users' reports on the forums have a significant influence on the choices made by potential users.

The studies described above presume that the banning of mephedrone in January 2011 did not result in the reduction of demand on the users' side, but it changed the supply side, as new licit psychoactive substances appeared instead of mephedrone during 2011. Among the clients of the NSP with the highest turnover in Hungary MDPV appeared the most prominently. Besides this, the increasing use of methylone and 4-MEC can be presumed (as the actual substance is not known by the user or the treatment professionals) among users.

5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY⁴⁶

5.1. OVERVIEW

The pilot data collection introduced in 2010 on clients participating in substitution treatment and coordinated by the National Centre for Addictions⁴⁷ provides data relating to a complete year first in 2011. Clients participating in methadone or buprenorphine-naloxone treatment are introduced on the basis of the new data collection. The data is suitable for time-series comparison only limitedly due to the methodological differences between the old data collection (determined in the Methadone Methodological Letter and coordinated by the Specialised Outpatient Treatment Centre of Nyíró Gyula Hospital) and the new data collection.

Essential supplementary information for the interpretation of the TDI data is that the treatment units registered their cathinone user clients typically in the category of other stimulants (Csák 2012).

5.2. AVAILABILITY AND QUALITY ASSURANCE

5.2.1. Strategy/policy

The treatment financing affecting the outpatient treatment of clients suffering from addiction changed as of 1 November 2011⁴⁸: instead of mixed (formula and performance-based) financing entirely performance-based accounting⁴⁹ was introduced (EMMI 2012b).

One of the measures taken to reduce the years-old lack of specialists in the field is that from 1 July 2011⁵⁰, besides doctors and nurses working at inpatient psychiatric wards, doctors and nurses working at outpatient psychiatric and specialised treatment centres are also entitled to a psychiatric bonus⁵¹. Furthermore, in 2011 the minister of health classified psychiatry as a shortage occupation again, as a result of which healthcare service providers working under the professional code of psychiatry received supplementary support⁵² after their residents for the entire term of their specialisation training, which they are obliged to pay to their residents monthly on top of their wages⁵³ (EMMI 2012b).

With regard to the increase in the number of children with addiction problems and to the difficulties of their treatment (e.g. missing treatment modalities), in August 2011 the Drug

⁴⁶ The authors of this chapter are: Gergely Horváth, Anna Péterfi

⁴⁷ The aim of the pilot substitution data collection coordinated by the OAC is to determine the number of characteristics of the clients participating in methadone and buprenorphine-naloxone treatment. The reporting organisations are: service providers providing substitution (methadone or buprenorphine-naloxone) and detoxification treatment. Reporting frequency: monthly. Data: anonymous, case-based data with individual identifier (also used in TDI data collection). Data is reported on a voluntary basis, there are no legal obligations or financing connections.

⁴⁸ When Decree 60/2011. (X. 25.) NEFMI of the Ministry of National Resources on the amendment of Decree 9/1993. (IV. 2.) NM of the Ministry of National Economy on the social insurance financing of specialised healthcare services entered into force.

⁴⁹ Profession-specific homogenous dispensary (collective) codes (HGK) have been created with an increased point value, based on the treatment OENO code used so far by the dispensaries.

⁵⁰ When Government Regulation 73/2011. (IV. 29.) on the amendment of certain government regulations concerning healthcare entered into force.

⁵¹ The amount of which is 120% of the bonus base.

⁵² The amount of which is 50% of payment grade 1 of payment class H determined in the act on the legal status of public servants (Kjt.).

⁵³ Government Regulation 122/2009. (VI. 12.) on the specialised medical higher education system.

Prevention Coordination Department of the Ministry of National Resources initiated the setting up of a working group of specialists to elaborating a plan aimed at the comprehensive development of the field, as a part of which a proposal is made concerning the establishment of a system of professional minimum conditions relating to the drug rehabilitation care of children under the age of 16 (EMMI 2012a).

As a result of the amendment of the Act on Social Affairs (Szt.)⁵⁴, since 1 January 2011 young people between the age of 16 and 18 can enter basic community care and daytime care provided for people suffering from addictions without their parents' approval (without the consent or subsequent approval of their legal representative) (article 93 (4) of the Szt.).

5.2.2. Treatment systems

Organisation and quality assurance

On the basis of the data of the Office of Health Authorisation and Administrative Procedures, in Hungary there are 189 persons specialised in addiction treatment, and 184 of them have a valid operation licence concerning this specialisation. 1,325 persons have a specialisation in psychiatry, and 1,217 of them have a valid operation licence concerning this specialisation (Horváth 2012).

In the interest of supporting the performance of the tasks of community and low-threshold services provided for people suffering from addiction and disseminating good practices, in 2010 the National Employment and Social Office (FSZH) invited applications and selected an institute operating at a high standard in each field, which, as the so-called reference institutes of the two service forms, provided professional support for the institutes operating on the area between February 2010 and March 2011 (FSZH 2010). Forrás Mentálhigiénés Központ [“Spring” Centre of Mental Hygiene] based in Debrecen was the reference institute of community services provided for people suffering from addiction, while the Contact Programme of the Blue Point Foundation in Budapest was the reference institute of the low-threshold services. In the scope of the supporting activities the two reference institutes organised open days, professional forums and provided permanent professional consulting for the maintainers and operators of the respective institutes. In 2011 no reference institutes were appointed due to a lack of resources.

In 2011 the Addiction Methodological Working Group of the National Institute for Family and Social Policy (NCSSZI) revised and renewed its professional recommendation relating to community services provided for people suffering from addiction and to low-threshold services.

In 2011 the Psychiatric Methodological Working Group of the NCSSZI drew up a methodology document to support the treatment of patients with a dual diagnosis entitled “Dual diagnosis – Psychiatric disorders and the treatment of addiction with special respect to the family system”.

In 2011 the social methodology institute of the Southern Great Plain region, in cooperation with the institutes operating in the region and providing basic social services and care for psychiatric patients and patients suffering from addiction issued a publication presenting good practices⁵⁵. One of the aims of the publication is to give addiction-related professions an insight into the possibilities and experience of the social care provided for psychiatric patients and patients suffering from addiction.

⁵⁴ Act CLXXI of 2010 on the amendment of certain acts on social affairs, child protection, family support, disability affairs and employment.

⁵⁵ Mentálhigiénés Egyesület: A dél-alföldi régió Jó gyakorlatokat bemutató kiadványa 2011

Availability and diversification of treatment

The changes occurring on the market (see chapter 10) and, partly due to this, in drug use patterns during 2010 and 2011 had a significant effect on treatment demand and, as a result of this, on the treatment system. Both inpatient and outpatient treatment units reported a drop in treatment demand related to heroin use (Horváth et al. 2011, Csák 2012), similarly to NSPs (Csák 2012; Tarján 2012b). At the same time they pointed out an increase in treatment demand due to the problems deriving from the use of new psychoactive substances, first of all cathinone derivatives. Treatment units contacted by the National Focal Point in the spring of 2012 (for the methodology and the results see chapter 4.3.) pointed out, as a characteristic change associated with new psychoactive substances, that younger drug users had entered treatment, and another change was observed in the low level of motivation to remain in treatment. Consequently the set of problems of clients applying for treatment is different from that of the populations entering treatment before. The treatment units satisfied the new demands without extending their services, but their work was very much characterised by searching for information relating to the new substances and by a closer cooperation with the other members of the treatment system.

Substitution and detoxification treatment

The increasing use of new psychoactive substances could also be observed among clients in substitution treatment. The service providers reported the use of mephedrone and other cathinones within their clientele that is partly due to the fact that urine tests are not suitable for detecting these substances⁵⁶. The results of another survey⁵⁷ carried out in autumn 2011 examining the consequences of the reduced availability of heroin also demonstrate the use of cathinones among clients in substitution treatment (Farkas 2011). Although willingness to respond was significantly influenced by the fact that the interviewers were members of the treatment staff, 14% of the respondents admitted using a cathinone derivative instead of heroin to ease withdrawal (out of the 41 persons who named a drug).

In 2011, in the course of the pilot data collection coordinated by the National Centre for Addictions, 9 service providers reported clients participating in methadone or buprenorphine-naloxone treatment (out of the 12 service providers providing such treatments in the country). On the basis of the service providers' reports a total number of 715 clients received methadone or buprenorphine-naloxone treatment during the year. This value indicates a 31% drop as compared to the 1031 cases reported in the previous year, and this is due to the coverage of data collection and to the measures to control double counting⁵⁸. In summary the quality of the data improved, but coverage slightly decreased (from about 98% to 90% of the cases).

In 2011 9.9% of the clients receiving methadone or buprenorphine-naloxone treatment (70 persons) received their substitution drug for the purpose of detoxification, 90.1% (639 persons) in the scope of substitution treatment⁵⁹. In respect of the substitution drug, 79.8% of the clients participating in substitution treatment (510 persons) were prescribed methadone, while 20.2% (129 persons) were prescribed buprenorphine-naloxone. In the case of

⁵⁶ Based on consultations with the service providers at expert meetings.

⁵⁷ The survey was ordered by ELTE-PPK Department of Clinical Psychology and Addiction Treatment, and it was carried out in September 2011. The survey was carried out among the clients of two national substitution treatment units with the largest turnover in the country (Nyíró Gyula Hospital Specialised Outpatient Treatment Centre in Budapest and MÓSZ Specialised Outpatient Treatment Centre in Soroksár). The total number of 118 clients was selected via expert sampling. The inclusion criterion was participation in the substitution program. The interviews were conducted by the treatment staff. Participation in the survey was voluntary.

⁵⁸ As opposed to earlier years the new data collection is based on cases, so duplicate data can be filtered out.

⁵⁹ In the case of another 6 persons the type of the treatment is unknown.

detoxification treatments the use of buprenorphine-naloxone was more typical (in 46 cases, 65%).

Table 5. *Breakdown of clients participating in detoxification and substitution treatment by the prescribed drug, in 2011 (%) (N=709⁶⁰)*

	detoxification		substitution	
	N	%	N	%
methadone	24	34%	510	80%
buprenorphine-naloxone	46	66%	129	20%
total	70	100%	639	100%

Source: Substitution data collection (OAC 2012c), analysed by: NFP

The treated clients are described in point 5.3.1 herein.

On clients treated at detention facilities see chapter 9.7.

Online self-help for problem cannabis users

The online self-help program launched in June 2010 entitled “kannabiszpont.hu” had 468 registered users by the end of 2011, and 192 of them registered themselves in the program in 2011 (Blue Point Foundation 2012). In order to make logging and daily entries easier, Blue Point Foundation, the creator and operator of the portal, also developed a free smart phone application⁶¹. In 2011 chat counselling was added to the services offered on the website. With regard to the increasing popularity of synthetic cannabinoids, the information relating to cannabis and its use was supplemented on the portal with a summary on synthetic cannabinoids. In order to promote the four-week online self-help therapy the Foundation started a “blogger finding campaign” in November. The applicants selected during the campaign undertook the four-week therapy and also to write a public blog on which they shared their experiences of the therapy.

5.3. ACCESS TO TREATMENT

5.3.1 Characteristics of treated clients⁶²

Clients starting treatment because of a drug problem (on the basis of TDI data)

A summary of the most important characteristics of the treatment units reporting to the TDI system and of the cases reported

In 2011 new clients treated for drug use were reported by 85 treatment units. 36 further institutes reported that although they were entitled to treat drug users, they had no such clients during the year. 53 out of the 85 units treated clients in the scope of outpatient service, 16 units in the scope of inpatient service, 22 units in the scope of low-threshold service, and 6 units reported the treatment of prisoners⁶³.

⁶⁰ In the case of 709 out of the total number of 715 treated clients both the type of the treatment and the substitution drug is known.

⁶¹ <https://play.google.com/store/apps/details?id=com.imsinvent.kannabiszpont>

⁶² The percentages stated in this part of the chapter were calculated with the exclusion of “not known” cases.

⁶³ The same unit may provide and report several types of treatment.

Out of the total number of 4,783 persons entering treatment during the year 3,222 persons (73%) entered treatment for the first time in their lives due to drugs problem⁶⁴. 78% of all cases (3,740 persons) were treated at outpatient treatment units, 6% (299 persons) at inpatient treatment units, 12% (577 persons) at low-threshold service providers, and 3% (167 persons) at detention facilities.

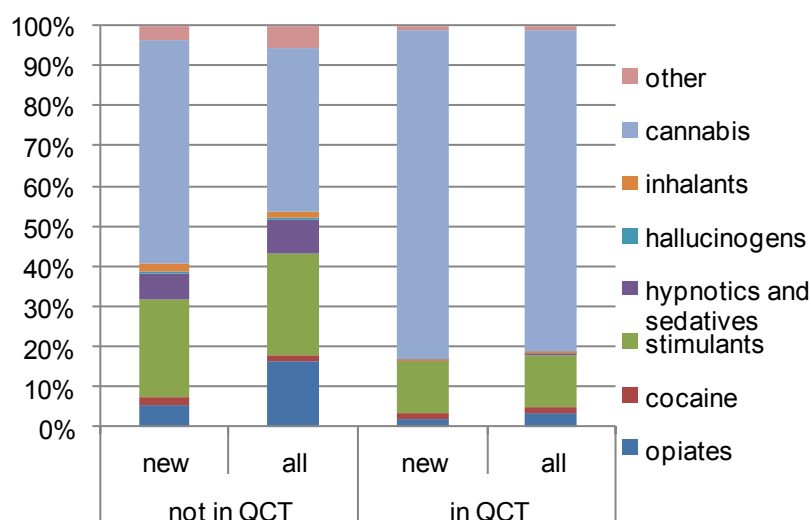
On examining the clients treated by primary drug (including clients both involved and not involved in QCT programmes), the highest number of clients entered treatment because of cannabis use (3,321 persons, 69%), and the following two most common drug types were stimulants (786 persons, 16%) and opiates (325 persons, 7%).

Clients entering treatment not in QCT (not in the scope of a quasi compulsory treatment but voluntarily)

In 2011 the service providers reported a total number of 1,330 clients – 27.8% of all cases – (1,024 men and 295 women, in 11 cases the client's gender was not indicated) who entered treatment “voluntarily” and not in QCT. 562 of the clients had been treated before for problems related to drug use, 601 persons demanded treatment for the first time in their lives (in the case of 167 persons it is not known whether they had been treated in the past).

Serious restructuring can be observed when examining all clients entering treatment on the basis of their primary drugs. On the one part, the treatment demand because of opiates continued to decrease: it dropped to half of the value recorded in 2009 (2009: 32%; 2010: 21%, 2011: 16%). At the same time treatment demand because of the use of stimulants continued to increase: as compared to the proportion recorded in 2009 it increased by 14 percentage points, and as compared to 2010 by 9 percentage points (2009: 11%, 2010: 16%, 2011: 25%). Taking into consideration the tendency observed on the basis of the seizure data (chapter 10.2.), which is also supported by NSP client data (chapter 7.3.) and by the 2012 qualitative survey of the National Focal Point (Csák 2012 – chapter 4.3.), this restructuring can be explained by the low accessibility of heroin observed since the second half of 2010 and by the increasing use of new psychoactive substances, especially the problematic use of cathinone derivatives.

Figure 19. Primary drug among all clients and among (new) clients starting treatment for the first time, participating and not participating in QCT programmes in 2011 (%)



Source: TDI data collection (OAC 2012b); analysed by: NFP

⁶⁴ In the case of 382 persons earlier treatment history is not known.

Clients entering treatment in QCT

In 2011 3,453 persons entered treatment as an alternative to criminal procedure. Similarly to the year before, no significant change can be observed in the substance distribution structure of clients starting QCT programmes as compared to the previous year: the proportion of cannabis users (80%), stimulant users (13%) and opiate users (3%) remained practically the same. Consequently, the changes observed among clients not participating in QCT still cannot be observed among clients participating in QCT programmes.

Characteristics of the individual drug user groups⁶⁵

Opiate users

In 2011 325 opiate users started treatment, 79% (258 persons) of them used heroin as a primary drug, 11% (35 persons) reported the misuse of methadone, and 10% (32 persons) reported the use of other opiates. As compared to the year before this distribution has slightly changed (in 2010 heroin: 89%; methadone: 4%; other opiates: 7%), which is probably due to the lower accessibility of heroin. 34% of opiate users (112 persons) started treatment as an alternative to criminal procedure and 66% (213 persons) for other reasons. 75 persons (26%⁶⁶) entered treatment for the first time in their lives.

In respect of their socio-demographic composition more than three-quarters of the clients starting treatment because of opiate use were men (245 persons, 79%)⁶⁷. Most of them were between the ages of 30-34 (30%), 35-39 (23%) or 25-29 (21%).

Typically, first drug use took place between the ages of 15-19 (41%) or 20-24 (29%). 57% of the opiate users (169 persons) are intensive users, meaning they use opiates daily or several times a week. Among clients entering treatment for the first time the proportion of intensive users is slightly lower, 47% (32 persons).

Regarding the route of administration, 76% of heroin users were primarily injecting users, and only 18% were smokers. As opposed to this, if exclusively those clients are examined who entered treatment for the first time, among them the proportion of injecting users and heroin smokers were nearly the same (49% injects, 44% smokes).

In the case of opiate users the most common secondary drug was a stimulant (mostly amphetamine) with 128 mentions (39%), while the second most common secondary drug was cannabis with 109 mentions (33%).

Cocaine users

In 2011 overall 78 cocaine users (76 cocaine and 2 crack users) entering treatment were reported by the service providers, and 52 of them (70%) entered treatment for the first time in their lives. Among cocaine users 24 persons (31%) entered treatment voluntarily, while 54 persons (69%) started treatment in the scope of a QCT programme.

Regarding gender distribution, 88% of them were men and 12% were women⁶⁸. Typically, these clients belonged to the age groups between 30-34 (24%) and 25-29 (23%).

Among them, typically the first cocaine use took place between the age of 15-19 (30%) or 25-29 (26%). In respect of the frequency of drug use only 17% of them (13 persons) can be

⁶⁵ In this part of the chapter groups in and not in QCT are not separated, but clients entering treatment are examined exclusively on the basis of their primary drug.

⁶⁶ Among those whose treatment past is known – this calculation method is used in the case of all substance types.

⁶⁷ 66 persons - 21% - were women, and the gender of 14 persons is not known.

⁶⁸ The gender of one person is not known.

regarded as intensive users (daily or several times a week), occasional use is more typical (73%; 53 persons).

Among clients starting treatment because of cocaine use the most commonly mentioned secondary drugs were stimulants (first of all amphetamines) with 28 mentions (36%) and cannabis with 25 mentions (32%).

Stimulant users

As it has been mentioned above in this chapter, one of the most significant changes in recent years is the increase in the number and proportion of clients entering treatment because of the use of stimulants. It can be observed among all treated clients (in and not in QCT altogether) (2009: 11%; 2010: 13%; 2011: 16%), but it is more prominent among clients not participating in QCT programmes (2009: 11%, 2010: 16%, 2011: 25%), in the case of whom treatment is probably more justified. 43% of all stimulant users (335 persons) started treatment voluntarily, 57% of them (451 persons) started treatment as an alternative to criminal procedure.

68% of the clients (486 persons) starting treatment because of the use of stimulants entered treatment for the first time in their lives in 2011.

More than three-quarters of stimulant users starting treatment were men (79%, 617 persons)⁶⁹. Regarding distribution by age this population typically belonged to the 20-24 (25%) and 25-29 (25%) age groups.

On examining clients according to the individual substance categories within the group of stimulants, it can be observed that, first of all, the number of clients using amphetamines (2010: 481 persons; 2011: 567 persons) and other stimulants (2010: 40 persons; 2011: 169 persons) increased among clients entering treatment, while the treatment demand observed in connection with MDMA and its derivatives did not change as compared to the previous year (2010: 50 persons; 2011: 49 persons). This shift is even more conspicuous among clients entering treatment voluntarily. As it has been pointed out above in the 'overview' part, this change is partly due to cathinone use, as typically the treatment units registered these cases in the category of other stimulants.

24% (181 persons) of the total number of 786 stimulant users who started treatment in 2011 reported injecting as the primary route of administration, which indicates an increase by 7 percentage points as compared to 2010. The proportion of users whose primary route of administration was injecting was 23% among amphetamine users and 25% among users of other stimulants. For more detailed information on the injecting use of cathinone derivatives see chapter 4.3.

Among stimulant users the most commonly mentioned secondary drug was still cannabis with 302 mentions (38%), and this was followed by problem alcohol use with 128 mentions (16%).

Cannabis users

In 2011 the number and proportion of clients entering treatment because of cannabis use did not change substantially as compared to the year before. A total number of 3,321 persons started treatment or joined some sort of indicated prevention programme (preventive-consulting service), 543 persons (16%) voluntarily and 2,985 persons (91%) as an alternative to criminal procedure. Among cannabis users 2,492 persons (81%) entered treatment for the first time in their lives.

91% of the clients starting treatment because of cannabis use were men (2,985 persons)⁷⁰.

⁶⁹ 21% (166 persons) were women, and in another 3 cases the clients' gender was not known.

⁷⁰ 9% (301 persons) were women, and in the case of 35 persons the gender was not known.

Among all clients entering treatment 38% belonged to the age group 20-24, 23% belonged to the age group 20-25, and the third largest group, 20%, was formed by clients aged 15-19.

Typically drug use started between the ages of 15-19 (60%).

In respect of the frequency of drug use, 20% of the clients reported intensive use (daily or several times a week) (16% of clients in QCT and 42% of clients not in QCT).

Among secondary drugs stimulants were the most common with 895 mentions (27%), within which amphetamine was mentioned the most. This was followed by alcohol use with 523 mentions (16%).

Clients in substitution treatment and detoxification treatment

Due to the new data collection, in 2011 we have more detailed data about clients in substitution and detoxification treatment.

Clients in substitution treatment have been treated for 3.3 years on average⁷¹ (SD: 3.1), 19% of the clients entered treatment in 2011.

On examining the gender distribution of the treated clients (independently of the prescribed drug), 70% of the clients in detoxification treatment and 75% of the clients in substitution treatment were men. The mean age was 31.9 years among clients in detoxification treatment and 35.6 years among clients in substitution treatment.

5.3.2 Trends of clients in treatments

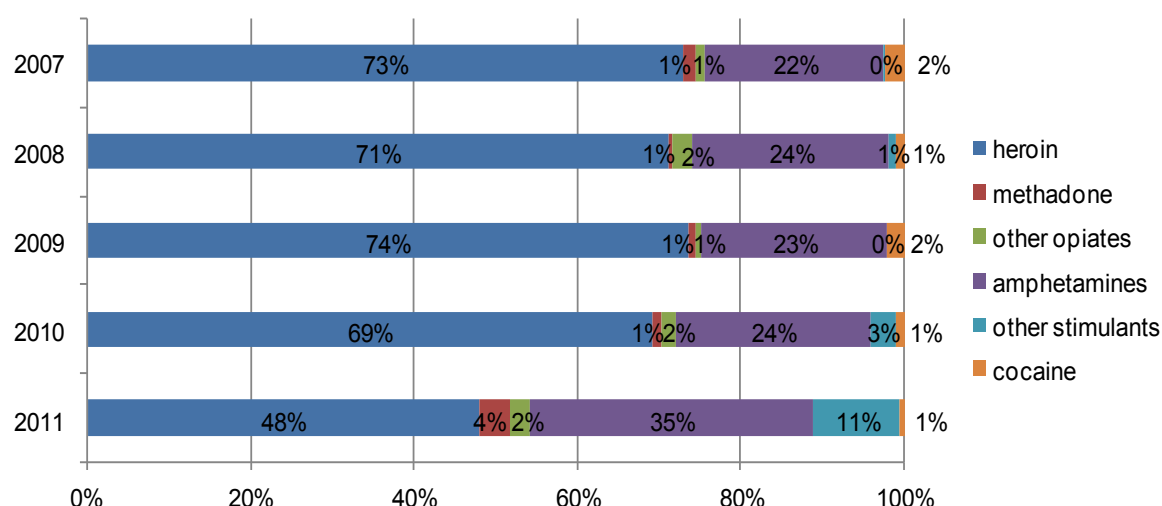
On the basis of TDI data

The most significant restructuring in the past 2-3 years – the decreasing treatment demand deriving from heroin use and the increasing number of clients entering treatment because of amphetamine and cathinone use – is described below along several aspects.

On examining injecting use, which involves the greatest risk from the aspect of public health, the phenomenon observed on the basis of the NSP data (Tarján 2012) and the results of the survey carried out by the largest NSP service provider in Hungary (Csák et al. 2011) can also be observed in the treatment data as well. While a few years ago injecting use was mostly associated with heroin use, by 2011 this picture changed significantly. Among IDUs heroin users (48%) and stimulant users (46%: of which 35% use amphetamine and 11% use other stimulants) are represented by nearly the same proportions. A slight increase can also be observed in the proportion of users injecting methadone and other opiates among all IDUs. One of the most dominant factors behind the restructuring is presumably the decreasing accessibility of heroin (see chapters 9.3., 10.2. and 10.3.).

⁷¹ Calculated from the difference between the current year and the year of starting treatment.

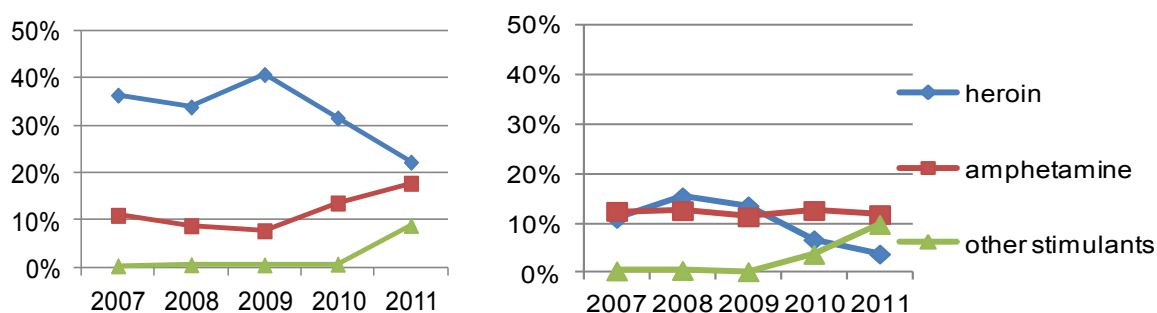
Figure 20. *Distribution of the injected substances among all IDUs between 2007 and 2011⁷² (%)*



Source: TDI data collection (OAC 2012b); analysed by: NFP

As it is described in section 5.3.1., the changes observed in the distribution according to primary drug could be observed first of all among clients starting treatment voluntarily (i.e. not as an alternative to criminal procedure), which also affected figures of all the other cases. On examining clients entering treatment voluntarily on the basis of their treatment history, a drop in the proportion and number of treatments because of heroin use can be observed both among clients entering treatment for the first time and among clients already treated in their lives. Parallely the treatment demand deriving from the use of other stimulants increased at the same time. In the case of clients treated before there is also an increase in the treatment demand deriving from amphetamine use. It may be due to the wrong categorisation of cathinones, but the possibility cannot be excluded either that some of the former heroin users have changed over to amphetamine (similarly to the substance changes observed among NSP clients by Csák et al. (2011) – see chapter 4.3.).

Figure 21. *The changing of the proportion of users of heroin, amphetamine and other stimulants among clients already treated before (first chart) and among clients starting treatment for the first time (second chart) (not in QCT), between 2007-2011 (%)*



Source: TDI data collection (OAC 2012b); analysed by: NFP

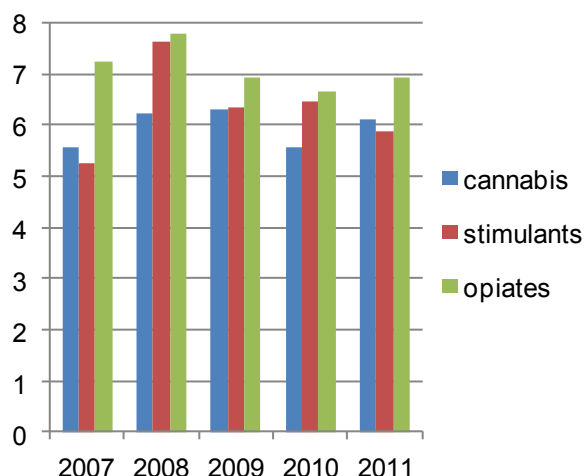
Latency period

The period between first drug use and first appearance in treatment – i.e. the latency period (or treatment lag) – was examined among new clients entering treatment voluntarily (not in QCT programmes). The longest period until entering treatment for the first time was

⁷² Taking into consideration users of opiates, amphetamines, other stimulants and cocaine, on the basis of the typical route of administration in the 30 days before entering treatment.

observed in the case of opiate users again: an average of 6.9 years in 2011. An interesting change observed in 2011 is that the latency period was the shortest in the case of stimulant users (5.9 years) between its first use and first appearance in treatment.

Figure 22. Average latency period in the case of the different drug types between 2007–2011 (years)



Source: TDI data collection (OAC 2012b); analysed by: NFP

Conclusions

From the aspect of health care management, in 2011 the most important change was the reorganisation of treatment financing from mixed (formula and performance-based) financing to entirely performance-based accounting.

The changes observed on the market and in problem drug use affected the composition of clients entering treatment and, by this, the entire treatment system as well. The restructuring observed in the low-threshold programmes could also be detected among clients. On the one part, the phenomenon was characterised by a decrease in treatment demand deriving from heroin use, while at the same time a continuously increasing number of users of other stimulants (presumably mostly cathinone derivatives) contacted the treatment units (both in the case of new clients and clients having been in treatment earlier). Furthermore, among clients treated before, an increase in treatment demand associated with amphetamines could also be observed. As the proportion of new clients among all clients did not change as compared to the previous years, it can be presumed that the restructuring is due to changing substance rather than to new client groups entering treatment.

The change in treatment demand represented a challenge for treatment units too. In connection with new substances an increasing demand for information could be observed, and there was a greater emphasis on cooperation between service providers. A further difference observed in connection with cathinone users is that while the negative consequences of drug use on health and mental health develop rapidly, social problems (observed after years of heroin use for example) do not appear in the same pace. It may also be the reason for the lack of motivation observed by the service providers in connection with remaining in treatment, which also resulted in additional burden for the organisations.

6. HEALTH CORRELATES AND CONSEQUENCES OF DRUG USE⁷³

6.1. OVERVIEW

Data referring to reported HIV/AIDS cases among injecting drug users (IDU) and the incidence of acute cases of hepatitis caused by HBV or HCV in Hungary originate from the national registry of infectious patients operating in the National Centre for Epidemiology (OEK) and from the special HIV/AIDS and hepatitis surveillance database (Csohán et al. 2012).

Between January and May 2011 the National Centre for Epidemiology repeated the national HIV, HBV, HCV seroprevalence survey among IDUs (Dudás et al. 2011). Since 2006 it was the fifth year when testing⁷⁴ was performed among IDUs with the same method (see 2007 National Report, chapter 6.2.), under similar circumstances. Besides testing, risk behaviours were also surveyed.⁷⁵ (ST9_2012_HU_01).

Furthermore, in 2011 voluntary diagnostic HIV, HBV, HCV testing was provided in 5 cities for IDUs all year round⁷⁶, also coordinated by the National Centre for Epidemiology (for the methodology see 2011 National Report, chapter 6.1.). Therefore, data originating from this programme is also available for describing the prevalence of HIV, HBV, HCV and risk behaviours⁷⁷ among IDUs in 2011 (Dudás et al. 2012). (ST9_2012_HU_02)

The main socio-demographic and drug use patterns of IDUs participating in these two surveys are described in chapter 4.3.

During the HCV screening programme conducted in 2010 the possible (injecting) drug use history and other risk behaviours of prisoners participating in the screening were surveyed in seven detention facilities (Tarján et al. 2012, for the methodology see 2009 National Report, chapter 6.1.). (ST9_2012_HU_03)

Similarly to earlier years, the mortality data relating to 2011 derive from the mortality module of the reporting system of the National Centre of Addictions (OAC) relating to illicit drug use. Data processing took place with the help of the employees of the National Institute of Forensic Medicine (for the methodology see 2011 National Report, chapter 6.3.).

6.2. DRUG-RELATED INFECTIOUS DISEASES

HIV/AIDS

In 2011 in Hungary a total number of 162 newly diagnosed HIV positive cases were reported, the incidence rate was 16 cases/1 million inhabitants. The transmission route was known in the case of four-fifths of the registered HIV positive persons. Within the identified risk groups of the HIV positive persons and clients with AIDS no one belonged to the risk group of IDUs (Csohán et al. 2012).

⁷³ The authors of this chapter are: Mária Dudás, Gergely Csaba Horváth, Anna Tarján

⁷⁴ 18 organisations participated in the survey, in Budapest five needle/syringe programmes (NSP) and two outpatient drug treatment centres (DTC), outside of Budapest eight NSPs and three outpatient DTCs took part in the survey.

⁷⁵ The questions were based on the Protocol for the implementation of the EMCDDA key indicator: Drug-related infectious diseases (DRID), draft version 6 October 2006, Project CT.04.P1.337., and on part 2 and 3 of standard table 9.

⁷⁶ In 2011 a total number of 11 organisations (eight NSPs and three outpatient DTCs) participated in this programme.

⁷⁷ The questions were based on the Protocol for the implementation of the EMCDDA key indicator: Drug-related infectious diseases (DRID), draft version 6 October 2006, Project CT.04.P1.337., and on part 2 and 3 of standard table 9.

Table 6. Breakdown of registered HIV positive persons (N) by risk groups between 2007-2011

Risk group	2007	2008	2009	2010	2011
MSM	63	93	87	125	106
Heterosexual	15	17	23	18	18
Haemophiliac	0	0	0	0	0
Transfusion recipient	1*	0	0	0	2*
Injecting drug user	3*	2	0	0	0
Nosocomial	1*	0	0	0	0
Maternal	2	0	0	0	0
Unknown	34	33	2	39	36
Total	119	145	140	182	162

* Imported cases

Source: OEK (Csohán et al. 2012)

Acute hepatitis B

In 2011, 66 acute hepatitis B infections were reported, the incidence rate was 0.7‰. The risk group was known in the case of 18 patients, 6 of whom were IDUs. Among these six persons four men and one woman was in the age group 25-34, and one man was above the age of 34. (Csohán et al. 2012) (ST9P4_2012_HU_01)

Acute hepatitis C

In 2011, 43 cases of acute hepatitis C infection were reported, the incidence rate was 0.4‰. The risk group was known in the case of 22 out of the 43 patients, 16 of them probably became infected through injecting drug use.

Five men out of these 16 persons were below the age of 25, six men and four women were in the age group 25-34, and one man was above the age of 34. 62.5% of the patients were registered in the territory of Borsod-Abaúj-Zemplén county. While between 2006 and 2010 an average of four IDUs were identified per year among the registered cases of acute hepatitis C infection, in 2011 this number increased to 16. (Csohán et al. 2012) (ST9P4_2012_HU_02).

Prevalence of HIV, HBV and HCV infections among IDUs

National HIV/HBV/HCV prevalence survey

During the national HIV/HBV/HCV prevalence survey conducted in 2011⁷⁸ (Dudás et al. 2011, also see chapter 6.1) (ST9_2012_HU_01), all of the 666 IDUs tested negative for HIV (ST9P2_2012_HU_01), the samples of 157 persons (24%) were HCV antibody positive (ST9P2_2012_HU_03), and in three cases (0.5%) hepatitis B surface antigen was detected (ST9P2_2012_HU_02). Two out of the three HBV positive persons were also HCV antibody positive at the same time.⁷⁹

⁷⁸ A total number of 700 blood samples were submitted to the National Centre for Epidemiology. After double counting control on the basis of generated codes (that is an individual identification code and ensures anonymity), 666 cases were included in the statistical analysis. Persons were involved in the survey who had attended one of the institutes during the sampling period, declared themselves to be IDUs, or remembered ever injecting drugs, disregarding whether in the past year/years they were tested for HIV, HBV or HCV. Selection, the sampling procedure, coding and the analysis of the samples took place in the same way as in the previous four years, for the methodology see 2007 National Report, chapter 6.2.

⁷⁹ In respect of HCV the results were inconclusive in 14 cases, while in respect of HBV the results were inconclusive in 2 cases, thus these cases were excluded from statistical analysis.

61% of the tested persons (399 persons) were current IDUs who had injected drugs in the last 4 weeks, 20% (132 persons) had injected drugs within the past 12 months, while 19% had injected drugs more than 12 months before.

72.2% of the IDUs participating in the survey were men, and 27.8% were women. More than half of the persons providing samples (50.2%) belonged to the age group 25-34, 31.8% were above the age of 34, and the smallest group (18%) consisted of persons below the age of 25. (ST9P2_2012_HU_01; ST9P2_2012_HU_02; ST9P2_2012_HU_03)

Examining only HCV prevalence rates and its correlates further on, the difference between the infection ratio of men and women (21.9% and 30%) is significant. The difference between the HCV prevalence rate measured among men and the average prevalence rate (24%) is not significant, but a significant difference could be detected in the case of women. The prevalence rates of women between the ages of 25-34 and above the age of 34 significantly exceed the average prevalence rate, by 8.5% and by 11.5%. Among IDUs below the age of 25 the infection ratio is higher among men than among women, but both values remain below the average prevalence rate. (ST9P2_2012_HU_03)

Table 7. Breakdown of HIV, HCV, HBV infections among IDUs tested during the national prevalence survey, by gender and age group in 2011

Age group		IDUs tested for the presence of HIV antibodies		IDUs tested for the presence of HBsAg antigen			IDUs tested for the presence of HCV antibodies		
		positive		positive			positive		
		N		N	N	%	N	N	%
< 25 years	male	81	0	81	0	0	80	17	21.3
	female	39	0	39	0	0	38	6	15.8
25-34 years	male	253	0	252	0	0	249	54	21.7
	female	81	0	80	1	1.3	80	26	32.5
> 34 years	male	146	0	146	1	0.7	142	32	22.5
	female	65	0	65	1	1.5	62	22	35.5
Total	male	480	0	479	1	0.2	471	103	21.9
	female	185	0	184	2	1.2	180	54	30
male+female		665	0	663	3	0.5	651	157	24.1

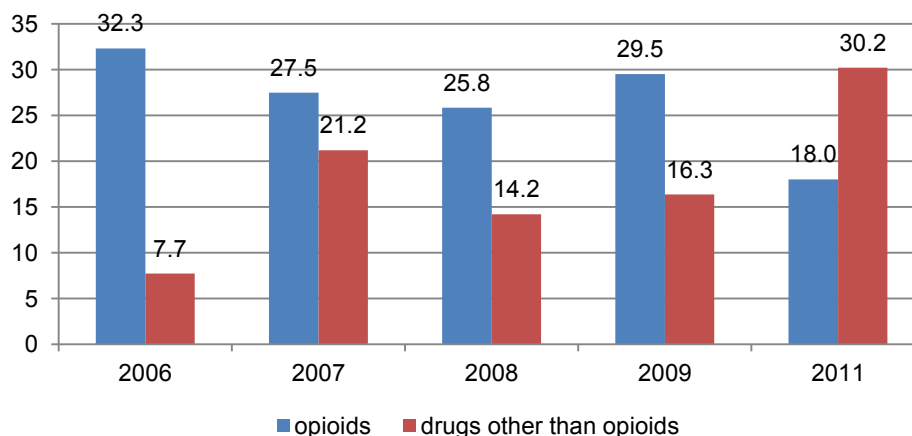
Source: OEK (Dudás et al. 2011)

On examining years since first injection, in the group of IDUs who first injected drugs more than 10 years ago 26.7%, while in the case of IDUs who had been injecting drugs for 5-9 years 34% tested positive for HCV. The rate of infection among IDUs injecting drugs for 2-4 years was 11.8%, and seven (10.4%) of the new IDUs (injecting drugs for less than 2 years) were infected with the virus. (ST9P2_2012_HU_03)

On examining breakdown by drug type, a significant change could be observed as compared to previous years: on the one hand, the proportion of IDUs primarily injecting drugs other than opioids increased in the total sample (see chapter 4.3.). On the other hand, while in the previous 4 years significantly higher hepatitis C prevalence could be observed in primarily opioid injectors, in 2011 18% of the IDUs primarily injecting opioids and 30.2% of those who were primarily injecting drugs other than opioids were HCV positive. The difference was significant. As the HCV prevalence rate in the total sample did not change significantly as compared to the previous years (see the trend analysis below), presumably the rate of HCV infection among IDUs did not increase by a measurable extent. Probably the restructuring of the HCV prevalence rates per drug type is due to the new injecting drug use patterns that can be observed since 2010, namely the tendency of changing over from injecting opioids to

injecting amphetamines or new psychoactive substances (for more detail see chapters 4.3. and 4.4., and 2011 National Report, chapter 4.3.). (ST9P2_2012_HU_03)

Figure 23. *Breakdown of HCV prevalence (%) among IDUs tested during the national HIV/HBV/HCV prevalence survey, by primarily injected drug type, 2006 – 2011*

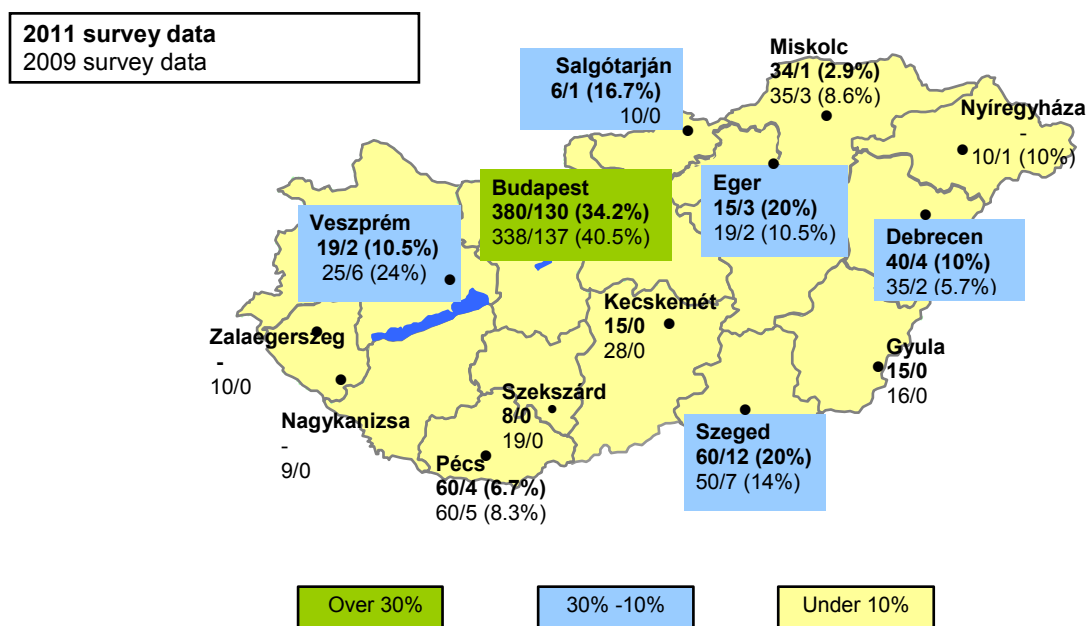


Source: OEK and NFP

Regarding the breakdown of IDUs primarily injecting drugs other than opioids (333 persons), in 2011 the rate of HCV infection was 30% among amphetamine injectors (257 persons), 37.5% among cocaine injectors (8 persons), 20% among MDPV injectors (20 persons), and 40% among mephedrone injectors (35 persons).

If the geographical breakdown is considered, 130 of the 380 samples originating from Budapest proved to be HCV positive, which represents a 34.2% infection rate (ST9P2_2012_HU_04). As opposed to this, HCV positivity was detected in the case of 9.9% of the samples from outside of Budapest (27 of 272 samples) (ST9P2_2012_HU_05). The difference between the HCV prevalence rates recorded in and outside of Budapest is significant.

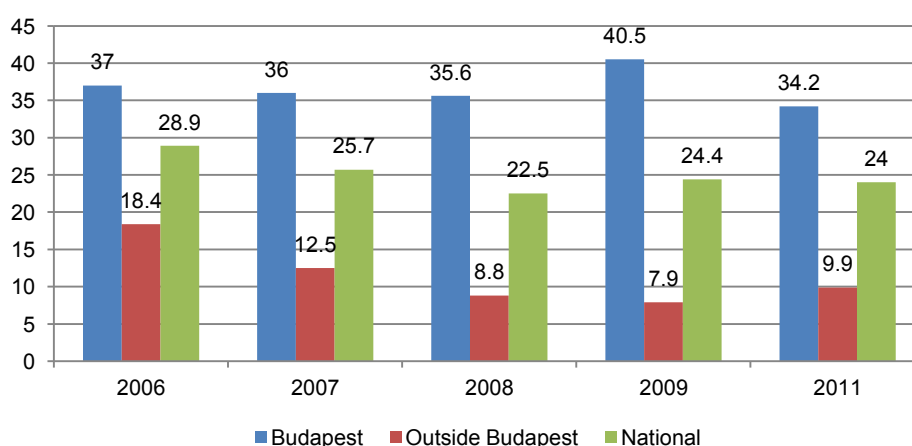
Map 2. Geographical breakdown of the number of IDUs tested and the number and percentage of HCV positive cases during the national prevalence survey by region in 2009 and 2011



Source: OEK and NFP

On analyzing the last 5 years it can be seen that in Budapest the HCV infection rate – which was high on a national scale but stagnating between 2006-2008 – slightly increased by 2009 and then dropped again in 2011. A continuous decrease can be observed in respect of data relating to regions outside of Budapest starting from 2006, but in 2011 the infection rate increased slightly. The national average HCV prevalence rate has been around 25% for 5 years.

Figure 24. Geographical breakdown of HCV prevalence (%) among IDUs tested in the national prevalence survey between 2006–2011



Source: OEK and NFP

145 out of the 666 persons involved in the survey in 2011 also took part in the prevalence survey conducted in 2009. In the case of five of these persons seroconversion was detected,

that is clients who were HCV antibody negative in 2009 tested HCV antibody positive in 2011.⁸⁰

Voluntary HIV/HBV/HCV diagnostic testing programme at NSPs and outpatient DTCs

During the voluntary diagnostic testing programme available all year round in 2011 (Dudás et al. 2012), also see chapter 6.1.) organisations in 5 cities⁸¹ covering 5 counties collected blood samples from a total number of 186 IDUs (for the methodology see 2007 National Report, chapter 6.2.) (ST9_2012_HU_02). Among the 186 persons there were 131 (70.4%) men and 55 (29.6%) women. More than half of the persons providing samples belonged to the age group 25-34 (101 persons, 54.6%), nearly one-third of the participants were below the age of 25 (57 persons), and the smallest group was formed by persons above the age of 34 (27 persons, 14.6%) (ST9P2_2012_HU_07; ST9P2_2012_HU_08; ST9P2_2012_HU_09). 78.7% of the tested persons were current IDUs, 18.6% of them injected drugs less than 12 months before. (ST9_2012_HU_02)

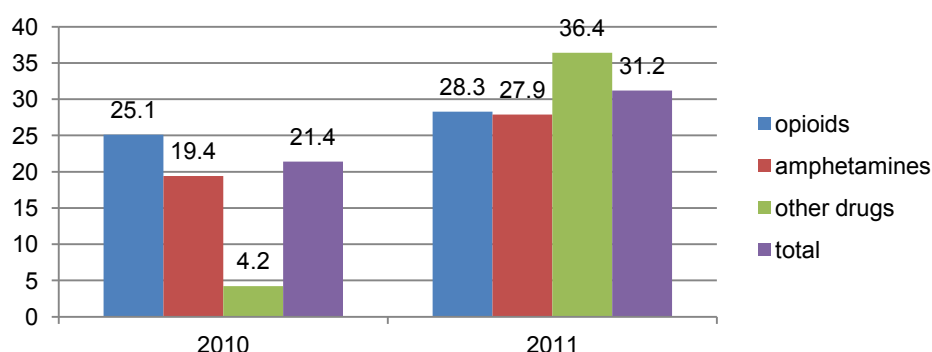
All of the tested persons proved to be HIV negative (ST9P2_2012_HU_07). Three of the 184 clients tested positive for HBsAg (1.6%) (ST9P2_2012_HU_08), and two of these three clients tested also HCV antibody positive at the same time. 54 out of the 173 tested persons were HCV antibody positive (31.2%) (ST9P2_2012_HU_09).⁸²

The difference between the HCV infection ratio of men and women (25.2% and 44.9%) was significant. The HCV prevalence in women was above the average prevalence rate in all age groups, while in the case of men it remained below the average prevalence rate in all age groups. (ST9P2_2012_HU_09)

In the group of IDUs who first injected drugs more than 10 years before or had been injecting drugs for 5-9 years, more than one-third of the drug users were HCV positive. The rate of infection among IDUs injecting drugs for 2-4 years was 30.8%, and only four (12.1%) of the new IDUs were infected with the virus. (ST9P2_2012_HU_09)

On examining breakdown by primarily injected drug type, in 2011 the largest group was formed by IDUs injecting other drugs⁸³ (see chapter 4.3.). The results show that the rate of HCV infection was the highest in this group (36.4%). One of the causes of this, already mentioned above, may be the restructuring of drug use patterns observed among IDUs (see national seroprevalence survey above). Furthermore, as compared to 2010, in this survey the HCV infection rate of the total sample also increased significantly. (ST9P2_2012_HU_09)

Figure 25. *Breakdown of the HCV prevalence (%) among IDUs tested in the diagnostic testing programme by primarily injected drug type, in 2010 and 2011*



Source: OEK and NFP

⁸⁰ Recurrences based on the generated code – that is an individual identification code and ensures anonymity – were controlled by gender and age categories.

⁸¹ Budapest, Debrecen, Gyula, Pécs, Szekszárd.

⁸² During the laboratory tests, with the methods used reliable results could be issued in the case of all of the 186 tested persons concerning HIV infection. The antibody tests aimed at detecting viral infection had inconclusive results in 13 cases in respect of the hepatitis C virus and in 2 cases in respect of the hepatitis B virus, so these cases were excluded from statistical analysis.

⁸³ In this survey it was not possible to specify the “other drug type”.

Regarding geographical breakdown, 51 out of the 129 samples originating from Budapest tested HCV positive (39.5%). As opposed to this, HCV positivity was diagnosed only in the case of 6.8% of the samples (3 out of 44 samples) from outside of Budapest (4 cities). The difference between the HCV prevalence rates recorded in and outside of Budapest is significant.

For the interpretation of the data it is essential to point out that in respect of voluntary diagnostic testing programme data originating from 5 cities the possibility of analyzing trends is limited because of the geographical coverage and because of the criteria⁸⁴ and incidental nature of testing uptake.

On comparing the national prevalence survey and the routine diagnostic testing programme it can be presumed that the different trends (distribution by drug type and infection ratios) may also be due to the fact that while the national prevalence survey presented data measured in the first five months of 2011, the data of the diagnostic testing programme cover the entire year. Furthermore, it is also important to highlight that while 61% of the IDUs involved in the national prevalence survey were current IDUs, this proportion among clients participating in the voluntary diagnostic testing programme was 79%.

Infectious diseases in detention facilities

In 2011 the counselling, screening and treatment/care programme aimed at the prevention of viral infections continued in 17 detention facilities (for the background see 2008 National Report, chapter 6.2.). In 2011 a total number of 2,634 inmates, 15.3% of the average number of prisoners (17,210 persons⁸⁵) were tested for HCV, 126 (4.78%) of them were HCV antibody positive. Hepatitis B infection was also tested in the case of 2,575 inmates, 15% of the average number of prisoners, among whom 35 persons (1.36%) tested positive for HBsAg. In 2011 HIV testing was performed only for 5.2% (899 persons) of the average number of prisoners, among whom 2 persons (0.2%) tested positive for the virus (BVOP 2012).

During the screening programme conducted one year earlier, in 2010 the possible (injecting) drug use history and risk behaviours of prisoners participating in the screening were surveyed in 7 detention facilities, the questionnaire was filled in by 1,048 inmates⁸⁶ (Tarján et al. 2012). The methodology of the survey was the same as in previous years (see 2009 National Report, chapter 6.1.) (ST9_2012_HU_03). 60.5% of the sample consisted of men and 24.4% of women. The average age was 36.9 years. 11.3% of the respondents were below the age of 25, 33.7% were between the ages of 25 and 34, and 55.1% were above the age of 34. The respondents had been in prison for 2.6 years on average.

4.8% (50 persons) of the 1,048 inmates were HCV positive. 40.5% of the total sample had already used drugs, 1.6% of all respondents had used drugs in prison for the last time. Lifetime prevalence rate of herbal cannabis was the highest (25.4%), which was followed by amphetamines (21.8%), ecstasy (17.3%), cocaine (15.3%), and heroin (8.6%).

18.8% (189 persons) of the respondents reported that they had already injected drugs, among them the mean number of years since first injection was 9.5 years. 9% (90 persons) of the sample last injected drugs 30 days prior to imprisonment, and 1.6% (16 persons) in prison. Most of them had injected amphetamine in their lives (129 persons), and this was followed by cocaine (68 persons) and heroin (68 persons).

A significantly greater proportion, 23.8% of ever injecting drug user inmates were hepatitis C positive (45 persons) (ST9P2_2012_HU_06), while among non-users and non-injecting users (816 persons)⁸⁷ 0.4% (4 persons) were tested positive for the virus. 45 out of the 49

⁸⁴ Testing is only offered to persons who were last tested more than 12 months previously.

⁸⁵ Static data recorded at the end of 2011.

⁸⁶ The data of the questionnaires could not be linked with the serological results until 2012 because of data supply problems.

⁸⁷ In the case of 43 persons the data relating to drug use was missing.

HCV positive prisoners identified during the survey had already injected drugs. Most of these 45 persons had last injected drugs before imprisonment, and only 3 persons reported that they had last injected drugs while in prison.

The results of the surveys (see 2010 and 2009 National Report, chapter 6.1. and Tresó et al. 2011) carried out so far are also supported by the present survey, according to which HCV positive prisoners identified in detention facilities probably acquired the HCV virus during their injecting drug use carrier. The antiviral treatment provided in prisons during imprisonment is a good possibility for IDUs who are otherwise difficult to reach and treat. Information on treatment of infected prisoners is described in chapter 9.7, the analysis of risk behaviours can be found in chapter 9.6.

For data on TB infections among prisoners see below in this chapter.

Tuberculosis and drug use

On the basis of the data from the institutes of pulmonology (Csoma et al. 2012), among the 1,515 new cases with TB there were a total number of 543 persons in the case of whom a risk group became known: most of them were alcohol-dependents (214 persons, 39.4%) or homeless (177 persons, 32.6%). 2 new TB cases (0.4%) belonged to the risk group of drug users. In the case of 1 person (0.2%) infected with TB, HIV co-infection was detected.

18,013 inmates were tested for tuberculosis in 2011. 17 persons with active TB and 43 persons with latent TB were detected among them during the screening (BVOP 2012).

Risk behaviours

National HIV/HBV/HCV prevalence survey

Risk behaviours were surveyed again linked to the HIV/HBV/HCV prevalence survey conducted by the National Centre for Epidemiology (Dudás et. al 2012).

Nearly one-third of the 666 IDUs involved in the survey had never been tested for HIV (29%), and 92% of those who had been tested knew that he/she was HIV negative. Nearly one-third (152 persons) of those who had ever been tested were last tested for HIV within the past 12 months, this is 22.9% of the total sample.

70% of the IDUs involved in the survey (472 persons) had been tested for HCV in their lives, one-third of them within the past 12 months, they represent 23.7% of the total sample. 80% (375 persons) of the clients who had been tested self-reported being HCV negative, but 16% (59 persons) of them tested positive in the laboratory tests. 40% of those who had been tested for HCV before this survey but did not know its result (or there was no information available for this variable) were HCV antibody positive (14 out of 35 persons).

Sharing needles/syringes and injecting equipment was only examined among current IDUs⁸⁸. 35.9% of current IDUs had shared needles/syringes in the past 4 weeks. Distributive needle/syringe sharing took place in the case of 23% of current IDUs, while receptive needle/syringe sharing was recorded in the case of 26.3% of them. 50.8% of current IDUs had shared any injecting equipment. The prevalence of needle/syringe and any injecting equipment sharing both increased as compared to 2009⁸⁹. One of the factors in the

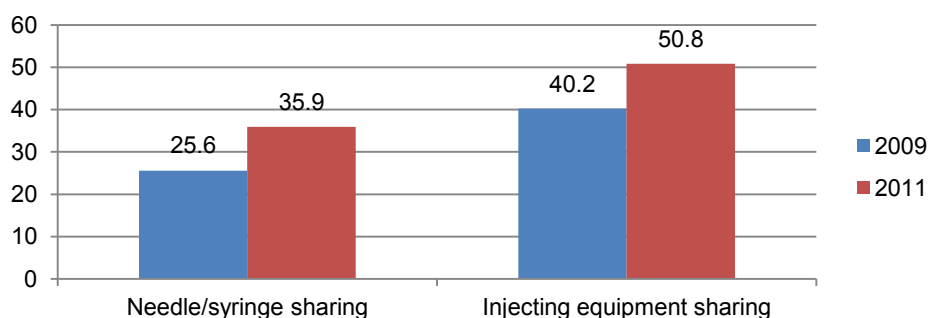
⁸⁸ IDUs injecting at least once in the past 4 weeks.

⁸⁹ This may be due the change in the methodology that while in 2009 the questionnaire contained a question only about sharing needles/syringes, in 2011 there was a separate question relating to distributive and receptive needle/syringe sharing. After answers for receptive and distributive sharing were merged and controlled for double counting, the variable relating to needle/syringe sharing (borrowing and lending) was obtained.

Regarding sharing any injecting equipment: in 2011 sharing any injecting equipment but syringes/needles was asked which data was merged with variable sharing needles/syringes and this is how results for sharing any injecting equipment was obtained after double counting control. In 2009 question referred to any injecting equipment sharing (including needles/syringes).

background of this may be the increasing use of new psychoactive substances among IDUs, and the more frequent injecting times characteristic of these substances (for more detail see chapters 4.3. and 4.4. and 2011 National Report, chapter 4.3.). The prevalence of needle/syringe sharing and any injecting equipment sharing was the highest among drug users injecting amphetamines (39% and 55.7% respectively). (ST9P3_2012_HU_03; ST9P3_2012_HU_04; ST9P3_2012_HU_05)

Figure 26. *The prevalence of sharing needles/syringes and sharing any injecting equipment in the past 4 weeks (%) among current IDUs, 2009-2011*



Source: OEK, analyzed by: NFP

Voluntary HIV/HBV/HCV diagnostic testing programme at NSPs and outpatient DTCs

In 2011 risk behaviours were also surveyed linked to the HIV/HBV/HCV diagnostic testing programme at NSPs and outpatient DTCs coordinated by the National Centre for Epidemiology (Dudás et. al 2012).

As compared to the previous year, in the sample the proportion of IDUs injecting several times a day increased from 17% to 29%.

29.8% of current⁹⁰ IDUs shared their needles/syringes in the past 4 weeks, and 50.7% of them shared any injecting equipment. Sharing was the most typical among IDUs injecting other type of drugs⁹¹. Needles/syringes were shared by 19.6% of IDUs injecting amphetamine, 25% of IDUs injecting opioids, and 40.7% of IDUs injecting other drugs. Injecting equipment was shared by 46.7% of IDUs injecting amphetamine, 38.9% of IDUs injecting opioids, and 61% of IDUs injecting other drugs.

As compared to 2010 the proportion of those current IDUs who received a used syringe from 2 or more persons in the past 4 weeks increased (from 13% to 20%).

In the past four weeks 65.9% (122 persons) of the total sample had had sexual intercourse, and 79.2% (86 persons) of them had not used a condom during the last sexual intercourse. 6 (5%) of the sexually active persons had provided sex for money or drugs in the past 4 weeks.

In the last 12 months 26.3% of the IDUs involved in the survey had lived in a homeless shelter or on the streets without a steady address for more than 1 week, which also indicates an increase by 13 percentage points as compared to 2010. 42.5% of the sample had already been imprisoned, which is also 15 percentage points higher than in the previous year.

While in 2010 current IDUs obtained an average of 59⁹² sterile needles/syringes, in 2011 they obtained 80 sterile needles/syringes in the past four weeks.

56% (82 persons) of current IDUs had purchased syringes in a pharmacy in the past 4 weeks, 18% of them had not contacted an NSP in the period of 4 weeks preceding the interview, 59% contacted 1 NSP, 15% contacted 2 NSPs, 8% had contacted 3 NSPs, and 1% had contacted 4 NSPs.

⁹⁰ IDUs injecting drugs at least once in the past 4 weeks.

⁹¹ In this survey it was not possible to specify the "other drug type".

⁹² There is no information if this was for personal use or it was further distributed to others.

35 of the 186 IDUs had entered treatment at least once since 2005⁹³, and all of them entered treatment in 2011 on the last occasion, in the case of 16 of them it was the first time they entered treatment. (ST9P3_2012_HU_02)

28.6% (14 persons) of the IDUs primarily injecting opiates (49 persons) had been in substitution treatment in the past 4 weeks. (3 of the service providers participating in the screening programme also provide substitution treatment.)

For the risk behaviours of prisoners see chapter 9.6.

Chapter 4.4. contains reports on three qualitative surveys (Csák 2012, Rácz et al. 2012, Csák et al. 2011) describing new patterns of drug use observed among IDUs, the increase in the number of daily injections and risk behaviours.

In chapter 5.3.2. the restructuring of the breakdown of IDUs entering treatment per drug type is described on the basis of TDI data in the past 5 years.

6.3. OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

Drug intoxications⁹⁴

In 2011 2,662 persons were treated for intoxication of illicit drugs or inhalants/solvents (in 2010: 1,962 persons) at the department of toxicology, which represents a 35.7% increase. There was a significant increase in the number of male patients treated, in 2011 1,766 persons received emergency treatment, which is a 59% increase as compared to 2010 (1,111 persons). There was no change in the number of female patients receiving toxicology treatment, in 2011 896 persons were treated (2010: 851 persons).

As compared to the previous year the number of treatments for intoxication of opiate type drugs dropped slightly, in 2011 397 persons received treatment (in 2010: 465 persons), the decreasing tendency observed since 2009 continued. Within the category of opiates, the number of intoxications associated with heroin use (73 persons, 18.4%) dropped to about half of the cases recorded in the previous year and to a quarter of the cases recorded in 2009 (2010: 132 persons, 2009: 241 persons). In 2011 no cases of morphine intoxication were recorded, methadone intoxication was recorded in 20 cases (5%). Similarly to earlier years, the proportion of intoxications caused by opiates not classified was very high, this represents about three-quarters of the cases (76.6%, 304 persons).

Among amphetamine type substances it was not possible to determine further subcategories. The number of clients treated for intoxication of such substances has been increasing markedly for years, in 2011 1,638 were treated, which represents a 85.7% increase as compared to the previous year (2010: 882 persons, 2009: 685 persons). 61.5% of all cases of intoxication can be associated with amphetamines, the proportion among women (70.8%) is slightly higher than among men (56.9%). Intoxications caused by amphetamines are the most typical among users aged 20-24 (20.9%), this is followed by users aged 25-29 (18.4%), and then by users aged 30-34 (16.3%). 11.8% of the cases of intoxication associated with amphetamines affected users aged 15-19. No gender patterns could be observed within the proportions of the different age groups. The significant increase

⁹³ TDI data collection has been performed in Hungary since 2005. During the screening tests the same generated code is used as the one used in TDI data collection, as a result of which it can be seen how many tested IDUs have entered treatment.

⁹⁴ On the basis of data recorded at the Clinical Toxicology Department of Péterfy Sándor Street Hospital. On the problems of data collection see the 2007 National Report, chapter 6.3.

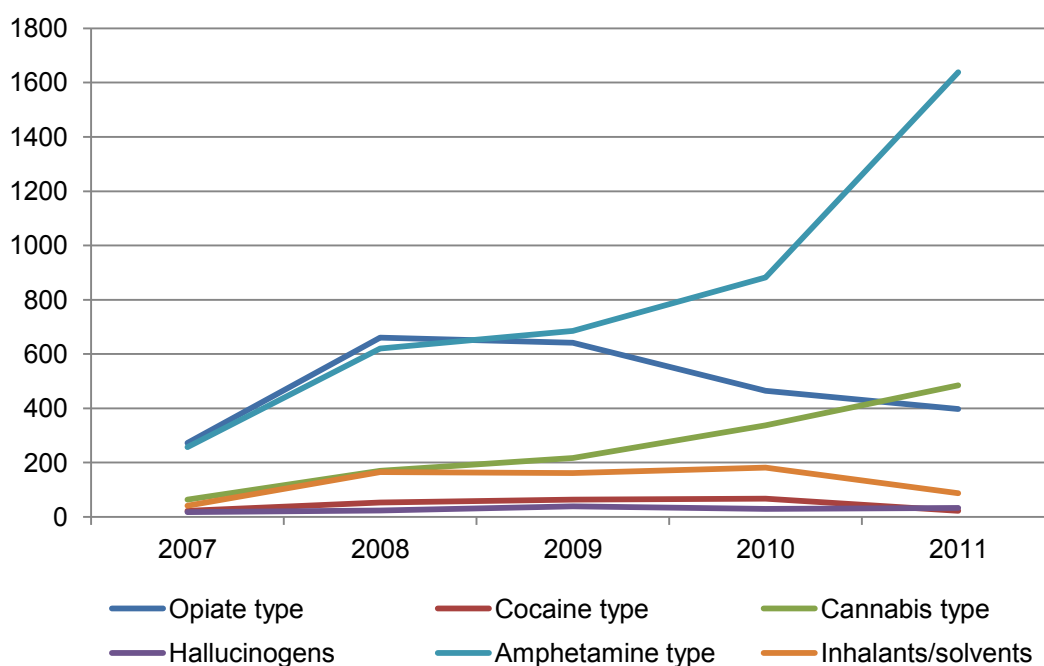
in the number of intoxications associated with amphetamine type stimulants may be due to the increasing use of cathinones, which continued in 2011.

The number of intoxications associated with the use of cannabis type substances also increased significantly. While in 2010 337 clients, in 2011 485 clients received emergency treatment, which is a 43.9% increase as compared to the previous year. In the past five years the number of emergency treatments associated with cannabis type substances increased significantly and monotonically.

In 2011 22 clients were treated for cocaine use, which indicates a decrease as compared to the previous year (2010: 67 persons).

A decrease could be observed in the number of intoxications caused by inhalants/solvents, in 2011 87 persons were treated, while in 2010 more than twice as many persons, 187 clients were treated.

Figure 27. *The number of patients treated for drug intoxication at the Clinical Toxicology Department of Péterfy Sándor Street Hospital between 2007-2011 (persons)*



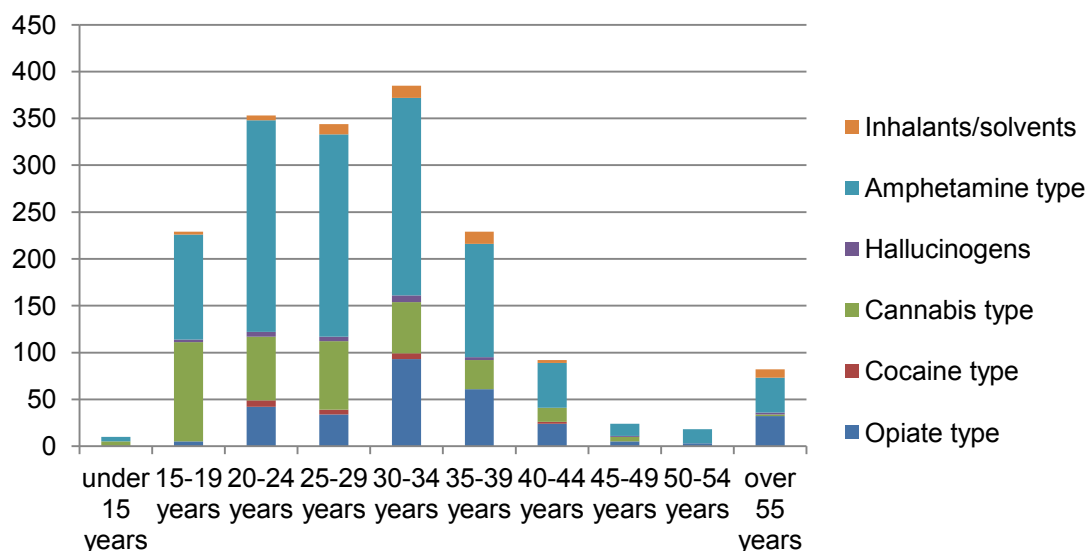
Source: OAC 2012b

Concerning breakdown by age group, it can be stated that in the case of men the age groups between the ages 20-24, 25-29 and 30-34 are the most affected (353 persons, 344 persons, 385 persons respectively). In the case of women the distribution per age group is slightly different, here the most affected age group between 20-24 (154 persons) is followed by the age groups between the ages 15-19 and 25-29 (148 persons and 143 persons). As a whole, as compared to the earlier years no restructuring of the different age groups could be observed.

On examining breakdown by gender, a significant increase above the average could be observed in the number of male clients aged 30-34 and female clients aged 15-19 receiving emergency treatment.

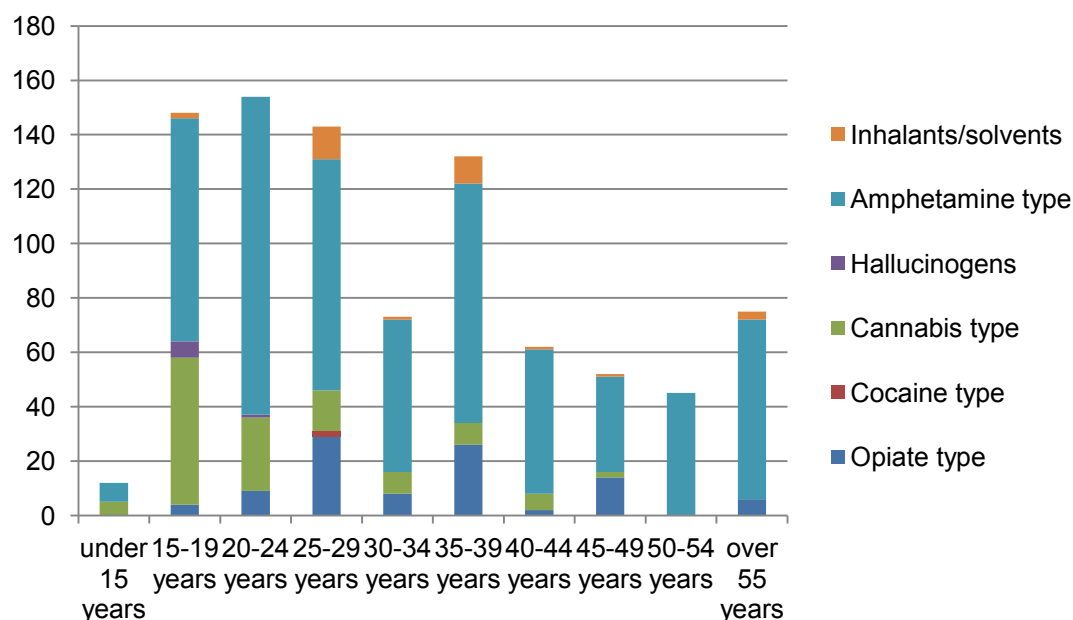
The overdose cases of opiate and amphetamine type drugs in older age groups are presumably cases of overdose of drugs available on prescription.

Figure 28. Breakdown of drugs among men treated at the Clinical Toxicology Department of Péterfy Sándor Street Hospital for drug intoxication by age group, in 2011 (N=1766) (persons)



Source: OAC 2012b

Figure 29. Breakdown of drugs among women treated at the Clinical Toxicology Department of Péterfy Sándor Street Hospital for drug intoxication by age group, in 2011 (N=896) (persons)



Source: OAC 2012b

Driving accidents

In 2011, in the case of 132 road accidents the Police sent urine samples to the National Institute for Toxicology for further examination, under the suspicion of the presence of

substances in the body having a disadvantageous effect on the ability to drive, as the preliminary test was positive.

Out of the 132 samples the Institute for Toxicology determined positivity in 87 cases.

Table 8. *Breakdown of the presence of drugs (N) in urine samples originating from road accidents by active substance in 2011*

Active substance	Number of cases
THC	23
Benzodiazepines	16
Amphetamine + THC	11
Amphetamine	7
THC + cocaine	7
Benzodiazepines + amphetamine	7
Amphetamine + methamphetamine	3
Benzodiazepines + THC	3
Cocaine	2
Morphine (heroin)	2
Mephedrone	2
MDMA + MDA	2
Morphine + methadone	1
Morphine (heroin) + THC	1
Total	87

Source: National Institute for Toxicology

Health consequences of new psychoactive substances

The survey carried out by the National Focal Point in respect of 2011 (Csák 2012) in which the health consequences of new psychoactive substances were also examined is described in chapter 4.4.

Pregnancies and children born to drug users

In the scope of the supplementary data collection conducted by the Specialised Drug Treatment Centre of the Nyíró Gyula Hospital and the National Focal Point, the 12 opioid substitution treatment service providers reported a total of 7 pregnant women in 2011, 5 of whom received substitution treatment in Budapest, and 2 of whom at service providers outside of Budapest.

In 2011, 66 drug user women who were either pregnant or whose children were still below the age of 2 in the year in question participated in the “Alternative Prenatal and Family Care” programme organised by the Józan Babák Klub [Sober Babies Club] in Budapest (see also chapter 7.3.).⁹⁵ The mean age of the participants was 26.9 years, the youngest participant was 16 years old, and the oldest participant was 40 years old.

In the case of 46 out of the 66 participants reliable data was available about the number of children they had ever had, which was in total 80 children (at least 1 and maximum 4), thus on average they gave birth to a live-born baby on 1.73 occasions.

12 out of the 66 women were HCV positive, 1 of them had HIV-HCV coinfection, 10 persons were currently in psychiatric treatment. In the case of 19 women the primary source of income was prostitution.

Nearly all of the respondents had used herbal cannabis, 59 of them had used amphetamine, 35 had used heroin, 19 had used mephedrone, and 17 of them had used MDPV. The last

⁹⁵ 20 women were pregnant, 22 women had an induced abortion in 2011, 4 women gave birth in 2011, 10 women in 2010, while a further 10 women gave birth in 2009.

month prevalence was the highest in the case of MDPV⁹⁶, even in the breakdown by injecting use (Józan Babák Klub 2012).

Table 9. *Breakdown of pregnant women (N) ever using drugs / using drugs in the last 30 days / injecting drugs in the last 30 days by drug types in 2011 (N=66 persons)*

Drug type	Ever	in the past 30 days	injected in the past 30 days
Herbal cannabis	65	9	0
Cocaine	10	1	0
Amphetamines	59	4	4
Heroin	35	2	2
Amphetamines-heroin	26	0	0
Prescribed methadone	4	4	0
Street methadone	2	0	0
LSD	2	0	0
Mephedrone	19	0	0
MDPV	17	12	12
Synthetic cannabinoid	4	4	0

Source: Józan Babák Klub 2012

In 2011, among the clients of the organisation there were two women who gave birth after a pregnancy during which they injected MDPV regularly. According to the experience of the organisation, in the case of pregnant women using new psychoactive substances more intensive care was required: in the case of the two women more regular meetings once or twice a week had to be encouraged, in the case of missed occasions they had to be contacted, and one of them had to be admitted to hospital for a few days because of the increasing use of the substance.

6.4. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

The mortality data derive from the mortality module of the reporting system of the National Centre for Addictions related to illicit drug use.

Due to the data collection system a case-based database is available on drug-related deaths, which database can be linked with the help of the unique identification code with treatment (TDI) and other (DRID) data. We have detailed information on indirect drug-related deaths too, which can be analysed broken down to further categories (natural deaths and deaths by violence).

Table 10. *Breakdown of direct, natural and violent drug-related deaths in 2011 (persons)*

	Total
Direct	14
Natural	8
Violent	21
Total	43

Source: OAC 2012c

⁹⁶ It was not controlled in 2011.

Direct overdoses

National data

In 2011 14 cases directly related to illicit drug use were reported, which indicates a slight decrease as compared to the previous years (2010: 17 cases, 2009: 31 cases, 2008: 27 cases, 2007: 25 cases, 2006: 25 cases) (ST5_2012_HU_01 (SR), ST5_2012_HU_02 (GMR), ST6_2012_HU_01).

8 of the deceased persons had a place of residence in Budapest or its immediate agglomeration, and 2 further homeless men died here too. In 4 cases the deceased persons lived in a large city other than Budapest.

Among the 14 direct drug-related deaths there were 13 men and one woman. In 3 cases there was intoxication by an opiate (excluding methadone or other drugs), in 3 cases other substances could also be detected besides opiate, and in 4 cases fatal intoxication was caused by methadone. In 3 cases intoxication was caused by other non-opiate type substances, in these cases amphetamines could be detected. Intoxication caused by other drugs was recorded in one case, death was caused by inhaling organic solvent vapours, and cannabis was also detected in the biological samples. In 9 out of the 14 cases polydrug use was detected.

6 cases were excluded from the report. Although in the samples the metabolites of an opiate were detected (morphine), so these cases appeared in statistical selection, the age of the deceased persons (the youngest person was 68 years old and the oldest person was 90 years old) and their serious health conditions lead to the conclusion that in their case the preparations containing opiate were not used in the form of abuse.

Table 11. *Number of direct drug-related deaths in 2011*⁹⁷

	Male	Female	Total
Overdose / intoxication caused by opiates (without methadone or other drugs)	3	0	3
Overdose / intoxication caused by opiates and other drugs	3	0	3
Overdose / intoxication caused by methadone	4	0	4
Intoxications caused by other drugs not including opiates	3	0	3
Intoxications caused by other drugs	0	1	1
Total			

Source: OAC 2012c

The mean age of the persons deceased because of direct overdose was 32.1 years. The youngest deceased person was a 16-year-old woman (overdose caused by other drugs), the oldest deceased person was a 52-year-old man (opiate overdose).

⁹⁷ Special Register Selection

Table 12. *Breakdown of direct drug-related deaths by age groups, in 2011 (persons)*

	15-19	20-24	25-29	30-34	35-39	45-49	over 50	total
Overdose / intoxication caused by opiates (without methadone or other drugs)	0	1	0	0	1	0	1	3
Overdose / intoxication caused by opiates and other drugs	0	1	0	1	0	1	0	3
Overdose / intoxication caused by methadone	0	1	2	0	1	0	0	4
Intoxications caused by other drugs not including opiates	0	0	1	0	2	0	0	3
Intoxications caused by other drugs	1	0	0	0	0	0	0	1
Total	1	3	3	1	4	1	1	14

Source: OAC 2012c

Indirect drug-related deaths

In 2011 29 indirect drug-related deaths were reported into the mortality special register. This is a significant increase as compared to the 12 indirect deaths reported in 2010, but the increase observed is probably due to more advanced data collection.

In 2011 a natural cause, typically some sort of heart disease was registered in 8 cases.

In 2011 21 deaths by violence were reported. The 21 cases of violent death can be broken down into three subcategories: suicide was committed in 9 cases, murder in 1 case, and there was an accident in 11 cases.

Deaths by violence, the presence of illicit drugs in the biological samples

In 2011, on 4 occasions out of the 9 cases of suicide the metabolites of amphetamines were detected, on 3 occasions the metabolites of cannabis and benzodiazepine were detected, on one occasion the metabolites of methadone, and on one occasion the metabolites of an opiate, amphetamines and other drugs were detected. Typical forms of suicide were hanging and jumping from a height.

In the one murder case the metabolites of amphetamines were identified in the victim's body. In 6 out of the 11 accidents amphetamines (in one of these cases methamphetamine) were detected, in 3 cases cannabis, in 1 case morphine, and in 1 case a combination of cocaine and amphetamines was identified in the samples of the deceased persons by forensic pathologists.

Table 13. *Breakdown of violent drug-related deaths by drug type in 2011 (persons)*

	Suicide	Murder	Accident	Total
Opiates	2	0	1	3
Cocaine and amphetamine	0	0	1	1
Amphetamine only	3	1	2	6
Amphetamine and other drugs	1	0	3	4
Methamphetamine	0	0	1	1
Cannabis only	0	0	3	3
Cannabis and benzodiazepine	3	0	0	3
Total	9	1	11	21

Source OAC 2012c

The mean age of the victims of death by violence was 31.7 years (2009: 29.7 years). The youngest victim was an 18-year-old man (amphetamines, drowning accident), and the oldest victim was a 66-year-old man (morphine, suicide by hanging).

Circumstances of drug-related deaths

In respect of the location where discovered, most typically the deceased persons were discovered in their own or someone else's accommodation. In the case of deaths by violence, due to the victims of accidents, the most typical scenes were public roads. Because of the low number of cases no detailed analysis is possible.

Table 14. *Breakdown of direct, natural and violent drug-related deaths by location discovered, in 2011 (persons)*

	own apart ment	somebody else's apartment	public road	other public area	hospit al	other	total
Direct	5	5	2	1	0	1	14
Natural	3	1	0	1	1	2	8
Violent	4	1	9	3	1	3	21
Total	12	7	11	5	2	6	43

Source: OAC 2012c

In the case of the victims blood and urine alcohol tests were also performed⁹⁸. In one of the 14 cases of direct overdose no blood alcohol test was performed, in 11 cases the result was negative, and in one case medium influence of alcohol was demonstrated. In 10 out of the 21 violent deaths the blood alcohol tests had a negative result, in 7 cases very mild, in 2 cases medium and in one case serious influence of alcohol was detected. Among natural deaths (9 persons), in one case medium influence of alcohol could be demonstrated. The influence of alcohol could not be demonstrated in the only case of murder.

The cases are recorded with the help of a unique identification code also used in the TDI system, which makes it possible to find the treatment history of the deceased persons in the treatment database operated since 2005. 6 out of the 14 persons who died of overdose participated in addiction treatment. Among indirect deaths, 1 of the 8 persons who died of a natural cause, 3 of the 9 persons who committed suicide, and 1 of the 11 persons who died in an accident had participated in addiction treatment.

Consequently a total number of 11 persons had appeared in the data collection out of the victims of the 43 drug-related deaths reported in 2011.

Conclusions

On the basis of the national prevalence surveys repeated since 2006, similarly to earlier years, in the IDU population the number of HIV positive persons is probably very low in Hungary, and the proportion of HBV positive persons is probably also low, below 1%. The national HCV prevalence rate has been around 25% since 2006. At the same time it is important to point out that in 2011 again a higher HCV prevalence rate was recorded among women than among men. Furthermore, significant restructuring can be observed in the case of HCV prevalence rates broken down by drug type – the infection ratio of IDUs injecting drugs other than opioids has increased, while the infection ratio of IDUs injecting opioids has

⁹⁸ <0.2 ‰ = alcohol consumption is not proved, 0.21-0.50 ‰ = alcohol was consumed, but there is no influence of alcohol, 0.51-0.80 ‰ = very mild influence, 0.81-1.50 ‰ = mild, 1.50-2.50 ‰ = medium, 2.51-3.50 ‰ = serious, above 3.51 ‰ = very serious influence of alcohol.

decreased –, which may imply further risks, as new psychoactive substances are characterised by a higher number of daily injections, therefore risk behaviours are also more probable to occur within this group of injecting drug users.

On the basis of the national prevalence survey the proportion of IDUs sharing needles/syringes and sharing any injecting equipment has also increased, according to the results of the voluntary diagnostic testing programme the proportion of IDUs injecting several times a day has increased among the tested clients.

In the entire prison population the prevalence of HIV and hepatitis B infection is still low (HIV: 0.2%, HBV: 1.4%). The prevalence of hepatitis C infection is also low, 4.8%. According to a survey conducted in 2010, 92% of the HCV positive prisoners have injected drugs in their lives, thus the history of injecting drug use is one of the most significant risk factors in respect of HCV infection among prisoners.

Among clients appearing in toxicological treatment the number of treatments demanded because of amphetamines and cannabis indicated an abrupt increase. The increase of intoxications caused by amphetamine type drugs may be due to the increasing use of cathinones, while the increasing number of treatments demanded because of cannabis may be due to the increasing use of synthetic cannabinoids (for more details see chapter 4.3.).

According to the data of the Józan Babák Klub based in Budapest, among drug user pregnant clients or clients with a child below the age of 2 the last month prevalence of injecting MDPV was 18.2%. According to the experience of the organisation, the use of new psychoactive substances during pregnancy requires more intensive prenatal care.

In 2011 the decreasing tendency observed in the field of drug-related deaths continued. There was a reduction especially in the number of deaths because of opiate use, in 6 cases morphine was detected in the biological samples of the deceased persons, and in 3 out of these cases death was caused by the overdose of a pharmaceutical containing opiate. In 2011 the use of new psychoactive substances continued to increase, and at the same time the use of opiates – first of all heroin – significantly dropped (for more details see chapter 4.3.), consequently the number of opiate-related deaths also reduced.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES⁹⁹

7.1. OVERVIEW

In 2012 again needle/syringe programmes (NSP) reported their turnover and client data relating to the year 2011 to the Hungarian National Focal Point on the Internet portal set up for data collection four years ago (Tarján 2012b).

7.2. PREVENTION OF DRUG-RELATED EMERGENCIES AND REDUCTION OF DRUG-RELATED DEATHS

In the second half of 2011 the “Intensive monitoring of the active substance content of hazardous drugs” project operated by the Institute for Forensic Sciences was suspended (for further information see chapter 10.1.).

Harm reduction programmes in the recreational settings are described in chapter 3.4.

Government Regulation No 23/2011. (III.8.) on increasing the safety of music and dance events is described in chapter 1.2.

7.3. PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

Prevention

Access to and turnover data of NSPs

In 2011 24 organisations¹⁰⁰ were running NSP services in Hungary (Tarján 2012b) (ST10_2012_HU_01;16 HU_ST10_2012).

⁹⁹ The author of this chapter is: Anna Tarján

¹⁰⁰ In 2011 Viola Időskorúakat Gondozó Közhasznú Alapítvány Ózdi Alacsonyküszöbű Ellátás [Viola Public-Service Foundation Caring for the Elderly, Low-Threshold Treatment in Ózd] joined the National Focal Point's data collection. The organisation has provided NSP services in Kazincbarcika since May 2010 within the scope of fixed location and street outreach programmes.

Map 3. Geographical breakdown of NSP service providers (N=24) in 2011



Source: Tarján 2012b

The service providers distributed a total number of 648,269 syringes, and the number of returned+collected syringes was 469,122.¹⁰¹

In 2011, as compared to 2010, 29% more syringes were distributed by the service providers and the number of returned+collected syringes showed a significant increase, by 40%. This may be due to the new trend reported by the service providers that some of their clients were using new psychoactive substances in 2011, which are injected more often than heroin or amphetamine (for further information on new drug use patterns see chapter 4.3 and 4.4.). In 2011 again, the greatest increase could be observed in the number of syringes distributed/collected in the scope of the programmes with a fixed location. Three programmes with the highest turnover located in Budapest reported that due to their clients' increasing demand for syringes and because of their limited financial resources (for a description of the financing system of NSPs see 2011 National Report, chapter 7.2.) in the second half of 2011 they had to limit the number of sterile syringes distributed per contact in order to be able to maintain the programmes. This is one of the reasons why the number of returned+collected syringes increased at a greater rate than the number of distributed syringes, and the exchange rate also improved, in 2011 it increased to 72%.

Compared to 2010 in 2011 the number of clients continued to increase (by 20%), the programmes reached 3,373 persons, and the number of contacts increased even more, by 29%, clients used NSP services on 38,407 occasions. In 2011 the NSPs registered 61% more new¹⁰² clients (1,559 persons) than in the previous year.¹⁰³ (ST10_2012_HU_01)

The trend observed in the turnover data is also supported by the results of the qualitative survey carried out by the National Focal Point (Csák 2012, chapter 4.4.): the service providers contacted reported that with the appearance of synthetic cathinones injecting drug use also expanded, it could also be observed in communities where it had not been typical before. The effect of these substances lasts a shorter time, so they are injected more frequently, and this is why the demand for sterile injecting equipment has increased significantly in NSPs.

¹⁰¹ Also including syringes obtained from syringe vending machines and disposed in the special waste containers placed near the vending machines.

¹⁰² Clients who were first registered in the programme in the year in question.

¹⁰³ Double counting control could be performed at the level of service providers but not at national level. The same client may be registered at more NSPs.

Table 15. Syringe and client turnover data of NSPs in 2010 and 2011

	Fixed location	Mobile (by van/bus)	Street outreach	Syringe vending machines	Total
2010					
distributed	422,357	37,553	25,098	19,243	504,251
returned (+collected)	266,961	39,740	25,065	1,702	333,468
exchange rate	63%	105%	100%	9%	66%
number of clients	2,533	98	179	-	2,810
number of new clients	925	17	27	-	969
number of contacts	23,799	517	5,372	-	29,688
number of NSPs*	21	2	13	5	23
2011					
distributed	563,171	45,624	22,588	16,886	648,269
returned (+collected)	404,559	44,902	18,059	1,602	469,122
exchange rate	72%	98%	80%	9%	72%
number of clients	2,946	142	285	0	3,373
number of new clients	1,449	54	56	0	1,559
number of contacts	31,260	686	6,461	0	38,407
number of NSPs*	22	2	13	5	24

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

Source: Tarján 2012b

In 2011 the number of both distributed syringes (2010: 173; 2011: 187) and returned+collected syringes (2010: 118; 2011: 139) per client increased. At the same time, the number of distributed and returned+collected syringes per contact hardly changed, which may be due to that some of the programmes were forced to restrict the number of distributed syringes per contact in the second half of the year. The number of contacts per client did not change as compared to 2010.

Table 16. The number of distributed and returned+collected syringes per client and contact, and the number of contacts per client in 2011

Type of programme	distributed / client	(returned+collected) / client	distributed / contact	(returned+collected) / contact	contact / client
Fixed location	191	137	18	13	11
Mobile programme	321	316	67	65	5
Street outreach	79	63	3	3	23
Total	187	139	16	12	11

Source: Tarján 2012b

On examining the estimated number of IDUs in Hungary (see 2010 National Report, chapter 4.1.), NSPs reached 59% of the entire IDU population in 2011. The average number of sterile syringes per IDU was 114.¹⁰⁴ (ST10_2012_HU_01)

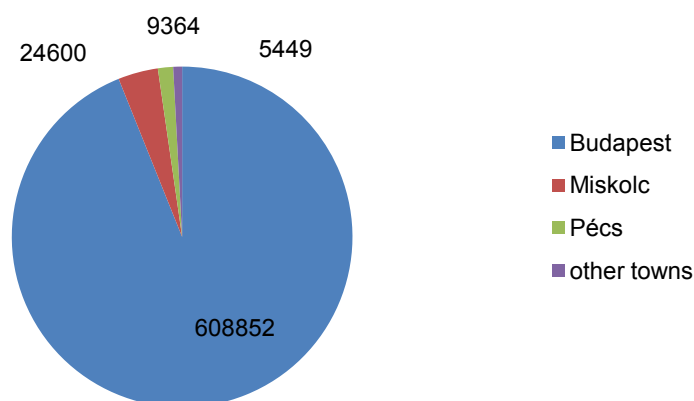
NSP turnover data by region

Concerning geographical breakdown, in 2011 more than 90% of the syringes were distributed and collected in Budapest, and a similar proportion can be observed when

¹⁰⁴ When interpreting the data it must be taken into consideration that double counting control could be performed at the level of service providers but not at national level. The same client may be registered at more NSPs.

examining the number of clients and contacts. This distribution was similar in the previous years too.

Figure 30. *Geographical breakdown of the syringes distributed by NSPs, in 2011 (N=648,269)*



Source: Tarján 2012b

NSP turnover data by programme type

In 2011 fixed NSPs were operated by 22 organisations, 5 of them were located in Budapest and 17 were located outside of Budapest. 87% of all syringes were distributed within the scope of this programme type.

In the scope of the 22 programmes a total number of 563,171 syringes were distributed, which number increased by 33% as compared to the previous year. The number of returned syringes was 402,328, which means that clients returned one and a half times more syringes in 2011 than in 2010. The exchange rate also shows an increasing tendency, it was 72%.

The increasing trend is still mainly due to the data registered in Budapest, while outside of Budapest syringe turnover of the INDIT foundation located in Pécs increased, but in the rest of the cities no significant change took place as compared to previous years.

The number of clients contacting fixed location services in 2011 was 2,946, which is a 16% increase as compared to 2010. In 2011 the number of contacts increased significantly, by 31% (2010: 23,799; 2011: 31,260). The increasing trend is partly due to the new drug use patterns and their consequences mentioned above (Csák et al. 2012), while on the other hand it may be due to that the programmes with the highest turnover had to limit the number of sterile syringes distributed per contact, thus clients attended the programmes more frequently.

In 2011 mobile NSP was still performed by only 2 organisations, one in Budapest and one in Miskolc. The number of distributed and returned+collected syringes, the number of clients and the number of contacts all indicate a slight increase as compared to 2010, which is mainly due to the data registered in Budapest.

In 2011 13 street outreach programmes were operated, 6 of these were located in Budapest and 7 outside of Budapest. The number of syringes distributed in the scope of these programmes dropped by 10% as compared to 2010, while the number of returned+collected syringes dropped by 28%. At the same time, the number of clients reached increased (by 60%) and the number of contacts also increased (by 20%). This trend is due to that most outreach programmes try to refer clients to their fixed location programmes.

As opposed to the increasing tendency observed in the previous year, the syringe turnover of vending machines dropped in 2011. This is partly due to the fact that because of financing reasons the vending machine in Budapest operated only in the first half of 2011. As for the

other vending machines, in Pécs, Miskolc and Békéscsaba the number of purchased syringes increased, while it dropped in Gyula.
(ST10_2012_HU_01)

The characteristics of NSP clients are described in chapter 4.3. The drug use and socio-demographic characteristics of IDUs participating in the national HIV/HBV/HCV prevalence survey and in the voluntary diagnostic testing programme in 2011 are also included in this chapter.

Chapter 4.4. contains the results of three qualitative surveys (Csák 2012, Rácz et al. 2012, Csák et al. 2011) on the new drug use patterns observed among IDUs, which had an effect on the turnover of NSPs in 2011.

For data on opioid substitution treatment see chapter 5.2.

Counselling, testing

IDUs tested during the national HIV/HBV/HCV prevalence survey and the HIV/HBV/HCV voluntary diagnostic testing programme available in 5 cities in 2011 (see chapter 6.2.) were given their test results at the outpatient DTCs or NSPs. In the case of positive test results they were given information about what they can do to prevent further transmission of the infection and where to turn for further medical care.

In 2011 43 professionals¹⁰⁵ from 7 counties and from Budapest – 25 from Budapest and 18 from outside of Budapest – participated in training concerning HIV testing and counselling supported by NEFMI.

In 2011 the State Secretariat for Healthcare of the Ministry of National Resources elaborated the draft of the 2nd National HIV/AIDS Strategy.

In 2011, in the scope of the TÁMOP 6.1.2 project a health promotion and prevention programme was conducted among sex workers in Budapest and Pest county with the participation of 283 persons (Fact 2011). The main elements of the project were preparing a health promotion plan tailored to the target group, organising a series of health promotion programmes¹⁰⁶, and distributing information booklets. Furthermore, the "train the trainers" method was also used, one of the key elements of which is peer-mentor training, which means that sex worker volunteers, after participating in the training, pass on their knowledge and distribute prevention booklets and condoms to other sex workers in their own communities.

A five-year-long action plan aimed at health promotion among sex workers was also prepared; its main goal in the long term is to improve the health of sex workers and improve their health-conscious attitude via specific programmes, and to encourage safer sex behaviour. The preliminary survey on which the project was based had been performed in 2011 in the target group (Fact 2011, for the results of the survey see 2.4.).

In 2011, within the framework of the Mental Health and AIDS Project, the employees of the HIV programme of the Hungarian Civil Liberties Union held a training course for 11 employees of the Drug-Stop telephone counselling service (TASZ 2012). During the training course they gave information about HIV/AIDS and its transmission routes, about the progress of the disease and its diagnosis. Special attention was paid to the types of

¹⁰⁵ Professionals of treatment centres dealing with venereal and skin diseases, specialised outpatient treatment units and NGOs.

¹⁰⁶ Central topics of these lectures – besides safer sex behaviour and sexually transmitted diseases – were the following: preventing and quitting smoking, alcohol consumption and drug use, developing self-care.

prevention and treatment for drug users, the mental help drug users may need, the risk factors of the different patterns of drug use, and interactions between antiretroviral and psychoactive substances and medicines.

In 2011 the Kék Pont Alapítvány [Blue Point Foundation] continued its programme for IDU women and the female relatives of IDUs attending the NSP, every second Monday (for the description of the programme see 2011 National Report, chapter 7.2.). The number of women attending the programme increased to 157 from 71 in 2010, and the number of contacts increased from 152 to 426. In 2011 the programme was attended by an average of 19 females per occasion, while this figure was only 8 persons in 2010.

For information on counselling, testing and treatment provided for prisoners see chapter 9.7.

Treatment

According to the financing protocol of the diagnostics and therapy of chronic hepatitis C accepted in 2010 (OEP 2010) and the professional recommendation published in 2012 (Makara et al. 2012) drug use is regarded as a contraindication to antiviral treatment. Combined antiviral treatment can only be started after three months of abstinence certified with at least two negative drug tests. Opioid substitution treatment is not regarded as a contraindication.

In Hungary there are 33 accredited hepatology treatment centres in 13 counties.¹⁰⁷

In the scope of the supplementary data collection conducted by the Outpatient Drug Treatment Centre of the Nyíró Gyula Hospital and the National Focal Point, the 12 opioid substitution treatment service providers reported a total of 11 persons who besides opioid substitution treatment (7 of them were treated in Budapest, 4 of them out of Budapest) also received antiviral treatment in 2011.

The results of the surveys that have been carried out so far (see chapter 6.2.; 2010 and 2009 National Reports, chapter 6.1.; Tresó et al. 2011) indicate that a significant proportion of the HCV positive prisoners tested at detention facilities probably became infected because of injecting drug use prior to imprisonment. During imprisonment antiviral treatment is provided at the detention facilities for IDUs who are otherwise difficult to reach and involve in treatment outside of prison. For information on the treatment of infected prisoners see chapter 9.7.

7.4. RESPONSES TO OTHER HEALTH CORRELATES AND CONSEQUENCES

Prevention of road accidents related to drug use

In 2011 again Hungary participated in the TISPOL international road monitoring campaign. Monitoring took place on 5 days in December and June. 2 out of the nearly 30,000 tests were positive for drugs according to the preliminary screening (rapid tests) of urine samples.

Interventions concerning drug-using pregnant women and their children

In 2011 66 drug user women who were pregnant or had a child below the age of 2, participated in the “Alternative Prenatal and Family Care” programme of the Józan Babák

¹⁰⁷ Source: <http://www.informed.hu/majambulancia/centrumok>

Klub [Sober Babies Club] in district VIII of Budapest. (For the socio-demographic and drug use patterns of the clients see chapter 6.3.)

In 2011 the programme operated on the basis of the three-step model set up and developed based on client demands and previous experiences: in the first step the applicant pregnant woman or mother with a child below the age of 2 can get in contact with a former drug user member of the Józan Babák Klub self-help group, who informs her about the available services. In the second step she can use medical, legal, social, psychological services in the Józan Babák Klub anonymously, and, if requested, accompanied by a member of the Józan Babák Klub self-help group. A pregnant woman or mother, if she participates in professional counselling for at least 60 minutes on an average of eight occasions, receives a grant of EUR 11¹⁰⁸ per occasion as a motivation fee. In the third step the organisation helps her to contact the prenatal care service (district nurse, GP, obstetrician-gynaecologist), or, in the case of women who already have a child, any healthcare, social or legal service, to where – if requested – a member of the Józan Babák Klub self-help group will accompany her.

In 2011 most of the women contacted the Józan Babák Klub after it was recommended to them by a friend (36 persons), and a significant proportion of them were referred to the programme by social or healthcare institutes (23 persons).

While some of the persons using the programme used certain non-low-threshold health and social services with the collaboration of the Józan Babák Klub (32 persons), others already had a relationship with the services or used them independently after receiving information (32 persons). There were only 2 pregnant women who did not get in contact with any prenatal care or other specialized services until giving birth (Józan Babák Klub 2012).

As a result of the joint work of the staff of the Józan Babák Klub and professionals from other organisations, in 2011 the book entitled “Drug Use and Having Children”¹⁰⁹ was published, which contains recommendations¹¹⁰ elaborated by professionals for low-threshold service providers concerning the subject.

Treatment of psychiatric comorbidity

In 2011 the Psychiatric Methodological Workgroup of the NCSSZI prepared a methodology document to support the treatment of patients with a psychiatric co-morbidity entitled “Dual diagnosis – Psychiatric disorders and the treatment of addiction with special respect to the family system”.

Conclusions

In 2011 in the NSPs both the number of distributed and returned+collected syringes and also the number of clients and contacts increased significantly, the exchange rate increased to 72%. The observed trend can partly be explained by the increased demand of IDUs for sterile equipment, which is mainly due to the more prevalent injecting use of new psychoactive substances and to the more frequent injecting times of these substances. For financial reasons, the increased demand for sterile equipment forced NSPs with the highest turnover to limit the number of syringes available per contact.

The “Alternative Prenatal and Family Care” programme of the Józan Babák Klub continued to operate in 2011 in district VIII of Budapest, as well as the programme of the largest NSP in Budapest supplemented with special services targeted exclusively at female clients.

In 2011 a recommendation entitled “Drug Use and Having Children” was published for low-threshold services.

¹⁰⁸ The amount was calculated based on the official mid-rate of the EUR for 2011 (1 EUR = 277.7 HUF).

¹⁰⁹ <http://www.scribd.com/doc/85098133/Gyermekvallalas-es-droghasznalet-Kalo-Zsuzsa-Oberth-Jozsef>

¹¹⁰ <http://jozanbabakterhesgondozas.blogspot.hu/p/szakmai-ajanlas.html>

8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION¹¹¹

8.1. OVERVIEW

In 2011 no extensive survey was carried out dealing especially with the issue of the social exclusion of drug users. It is introduced on the basis of the information available about clients entering treatment, by data originating from the TDI data collection.

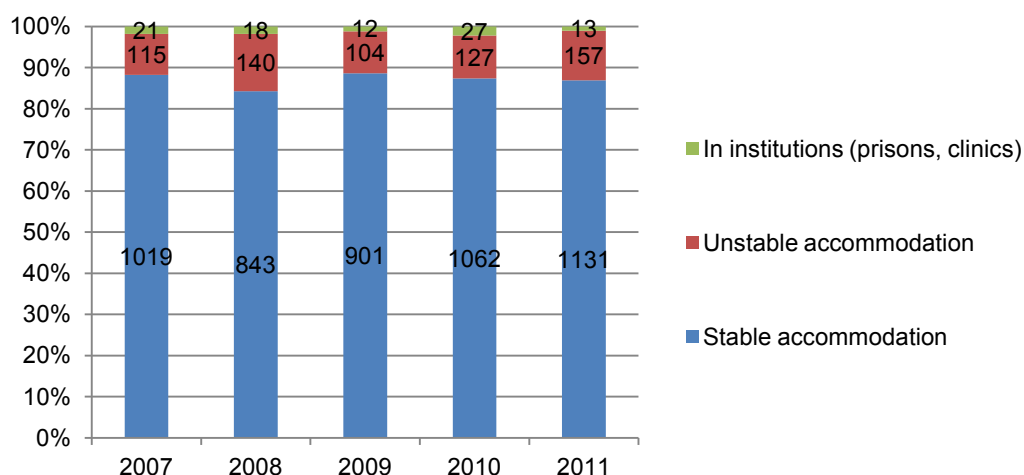
8.2. SOCIAL EXCLUSION AND DRUG USE

The treatment data presented in this chapter include the data of clients entering treatment in 2011 outside QCT (quasi compulsory treatment), i.e. not in the scope of a treatment programme that can be chosen as an alternative to criminal procedure (N=1330).

Housing

In 2011 the TDI database contained information about 1,301 clients concerning their living status (when selecting the cases defined above). In 2011, 1131 persons, 86.9% of the clients entering treatment lived under stable accommodation conditions, which is basically the same as the proportions observed in the previous years (2010: 87.3%, 2009: 89%).

Figure 31. *Living status of clients entering treatment between 2007-2011 (persons)*



Source: TDI data collection (OAC 2012b); analysed by: NFP

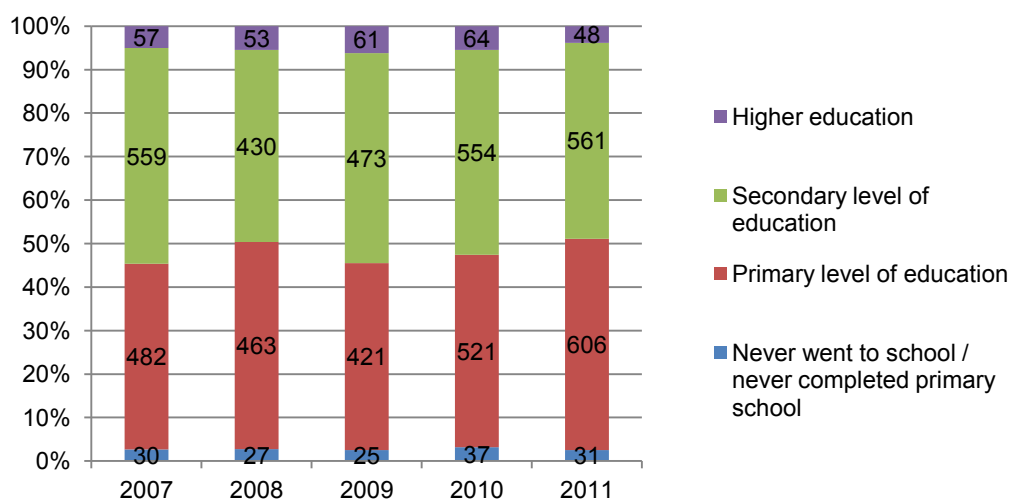
Education, training

In 2011, 31 persons, 2.5% of the clients entering treatment did not even have elementary qualifications, which indicates the same situation as observed in the previous years. 48.6% of the clients (606 persons) had elementary qualifications, which is slightly higher than the value observed in the year before (2010: 44.3%). Since the relatively significant decrease observed in 2009 the proportion of clients with elementary qualification has been increasing for three years. 45% of the clients (561 persons) had secondary qualifications (2010: 47.1%, 2009: 48%), which indicates a drop in the proportion of clients with secondary qualifications

¹¹¹ The author of this chapter is: Gergely Csaba Horváth, Anna Péterfi

in line with the increase of the proportion of clients with elementary qualifications. It is also valid in respect of the proportion of clients with higher qualifications: in 2011 48 persons, 3.8% of the clients had higher qualifications, in the previous years their proportion was always higher, between 5-6%.

Figure 32. *Completed school qualifications among clients entering treatment between 2007-2011 (persons)*

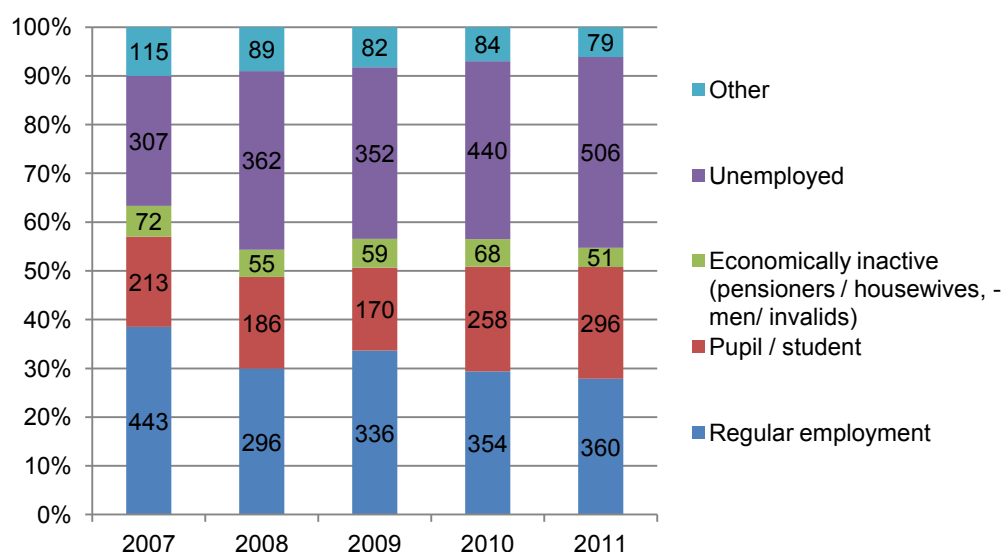


Source: TDI data collection (OAC 2012b); analysed by: NFP

Labour status

In 2011, 27.8% of the clients, 360 persons entering treatment had regular employment, in recent years their proportion has indicated a monotonic decrease (2010: 29.4%, 2009: 33.6%) The proportion of students was 22.9% (296 persons), which indicates a slight increase (2010: 21.4%, 2009: 17%). The proportion of unemployed clients had stagnated in past years (2010: 36.5%, 2009: 35.2%), but in 2011 it increased slightly to 39.2% (506 persons). 6.1% of the clients could not be classed in any of the above categories.

Figure 33. *Labour status among clients entering treatment, between 2007-2011 (persons)*

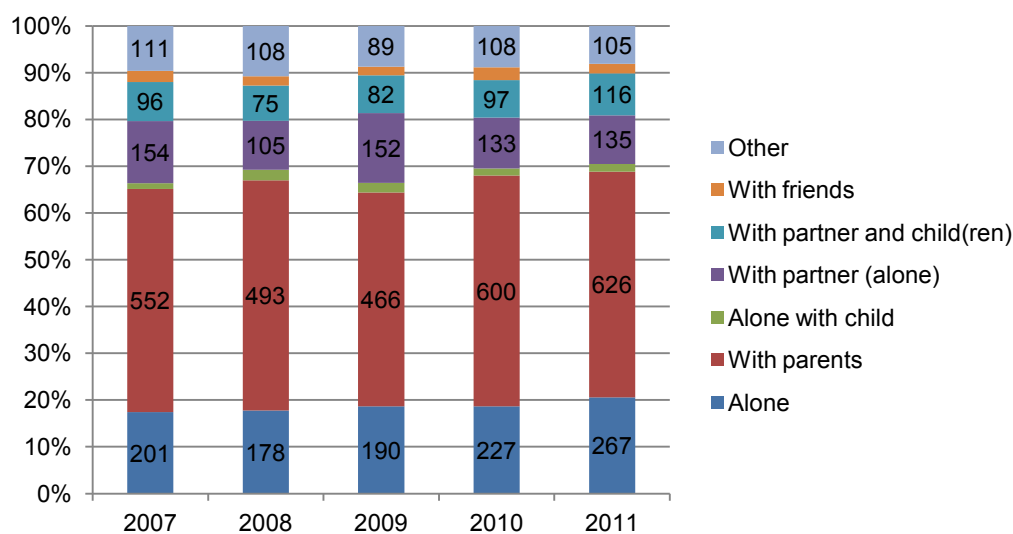


Source: TDI data collection (OAC 2012b); analysed by: NFP

Social relationships

In 2011, 267 persons, 20.6% of the clients entering treatment lived on their own, this proportion has not changed significantly as compared to previous years (2010: 18.6%, 2009: 18.6%). The majority of the clients, 48.2% (626 persons) lived with their parents, their proportion has been stable for years. A further significant proportion of clients are represented by those who live “with their partner only”, this indicator was 10.4% in 2011, no significant change has occurred as compared to the previous years. 8.9% of the clients (116 persons) lived with their partner and child in 2011. Both the proportion of “single parent” clients and of clients “living with friends” have been around 2% in recent years.

Figure 34. *Breakdown of clients entering treatment by cohabitation, between 2007-2011 (persons)*



Source: TDI data collection (OAC 2012b); analysed by: NFP

8.3. SOCIAL REINTEGRATION

No new information available.

Conclusions

In 2011, in respect of the social characteristics of clients entering treatment included in the TDI database there was no significant change as compared to the previous years.

9. DRUG-RELATED CRIME, PREVENTION OF DRUG-RELATED CRIME, AND PRISON¹¹²

9.1. OVERVIEW

In 2011 data concerning drug offences and the characteristics of the offenders (recorded at the end of investigations) was summarised by the Public Prosecutor's Office and analysed by the National Focal Point. (For details about data collection within the framework of the Unified Criminal Statistics System of the Investigation Authorities and Public Prosecution – ENYÜBS – see 2010 National Report, chapter 9 Overview and chapter 9.1.)

The characteristics of drug use patterns and risk behaviours among prisoners are described on the basis of the results of a survey carried out in 7 prisons in 2010 attached to the HCV screening programme (Tarján and Horváth 2012). The methodology of the survey was the same as in previous years (see 2009 National Report, chapter 6.1.; ST9_2012_HU_03), part of the data regarding sample description and infectious diseases is included in chapter 6.2. Further data relating to the prison service organisation originate from the 2011 report of the Hungarian Prison Service Headquarters, the TDI data collection and a survey relating to the treatment possibilities of drug user prisoners (Andrási 2012).

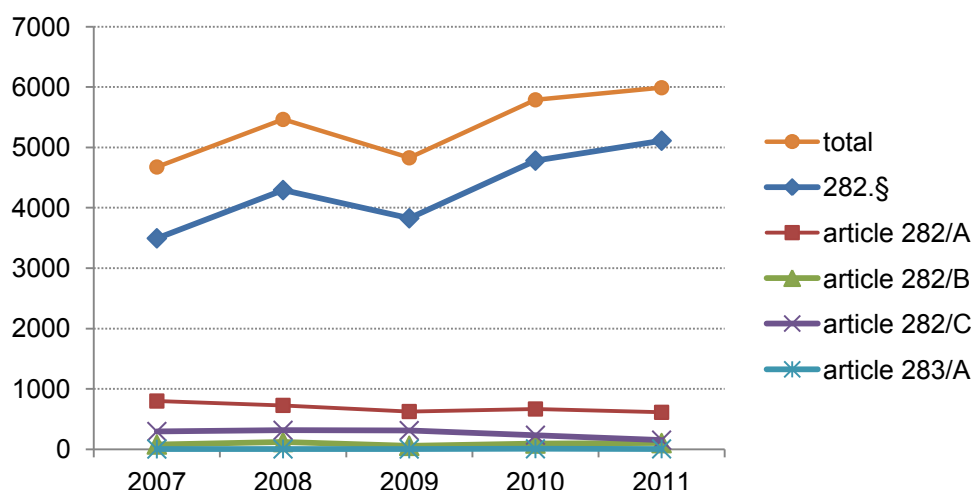
9.2. DRUG-RELATED CRIME

Drug offences

In 2011, 5,989 offences concerning the misuse of illicit drugs (drug offences) were registered in Hungary, which represents a minimal, 3.5% increase as compared to the 5,789 offences in the previous year. The proportion of drug offences among all registered criminal offences was 1.3%; this proportion has been basically the same for years.

¹¹² The authors of this chapter are: Anna Péterfi, Ágnes Port, Anna Tarján

Figure 35. The total number of registered drug offences, and registered drug offences broken down by drug-related Criminal Code sections¹¹³, between 2007-2011



Source: ENYÜBS 2012

In 2011, the police initiated criminal proceedings in 92.3% of the registered drug offences. In the remaining 7.7% of the cases the offended party or other persons, the Hungarian Customs and Finance Guard, the Public Prosecutor's office, civil defence or other penal authorities were among the initiators.

Breakdown of drug offences by substance type¹¹⁴

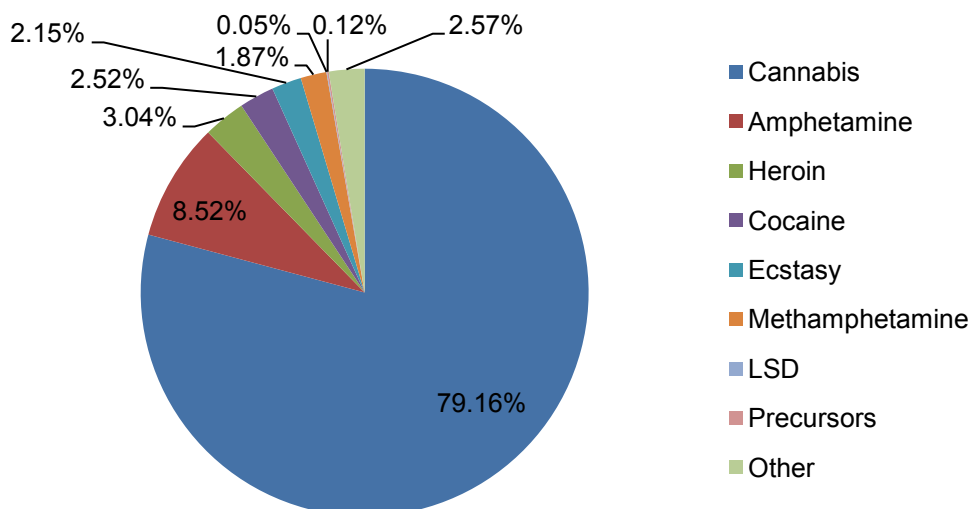
On examining registered drug offences according to the subject of the offence it can be stated that the decisive majority of drug offences are still committed with cannabis (2011: 79.2%). Last year 8.5% of all offences were committed with amphetamine, heroin was the subject of the offence in 3.0%, cocaine in 2.5%, ecstasy in 2.2%, and methamphetamine in 1.9% of the cases. Other substances were recorded in 154 cases, among which ketamine was the subject of the offence in 40 cases, morphine in 21 cases, methadone in 13 cases, GHB in 10 cases and BZP in 8 cases.¹¹⁵

¹¹³ Article 282: demand-related offences: grows, produces, acquires, possesses, brings into the country, takes out of the country, carries across the territory of the country;
 article 282/A: trafficking-related offences: offers, hands over, distributes or trades with it;
 article 282/B: demand- or trafficking-related offences committed by persons under the age of 18;
 article 282/C: drug-addicts committing demand- or trafficking-related offences;
 article 283/A: misuse of drug precursors.

¹¹⁴ When evaluating these data it must be taken into consideration that on the statistics sheet containing the data of the criminal offences only one drug type is recorded, and if several drugs were involved in the offence, there is no uniform guidance on how the drug type to be recorded should be selected.

¹¹⁵ The change in the number and proportion of the offences committed with the individual substance types is not analysed, because in 2011 the subject of the offence was recorded for all offences, while in the previous years in a relatively high proportion of the offences no substance type was recorded.

Figure 36. Breakdown of drug offences registered in 2011 by subject of offence



Source: ENYÜBS 2012

Perpetrations

On examining perpetrations from the aspect of drug types it can be stated that in the case of all individual drug types more than 80% of the offences were demand-related perpetrations. 79.5% of demand-related offences and 77.3% of supply-related offences were committed with cannabis. Amphetamine was the second most “popular” substance: 8.7% of demand-related offences and 7.1% of supply-related offences were committed with it. (ST11_2012_HU_01)

Among all registered drug offences the proportion of demand-related perpetrations was 87% (5,231 cases), and the proportion of supply-related perpetrations was 12% (721 cases). The remaining 1% included the following other perpetrations: 10 cases of punishable preparations, 14 cases of financing perpetrations, 13 cases of supplying substances needed for producing drugs. The decisive majority of these other perpetrations were also associated with cannabis.

Table 17. Breakdown of drug offences registered in 2011 by subject of offence and by perpetration type

	Demand-related	Supply-related	Preparations	Financing	Production	Total
Cannabis	4,161	558	9	11	2	4,741
Amphetamine	459	51	0	0	0	510
Heroin	154	28	0	0	0	182
Cocaine	127	24	0	0	0	151
Ecstasy	104	24	1	0	0	129
Methamphetamine	99	9	0	0	4	112
LSD	3	0	0	0	0	3
other	124	27	0	3	0	154
precursor	0	0	0	0	7	7
Total	5,231	721	10	14	13	5,989

Source: ENYÜBS 2012

As compared to the previous year, the number of demand-related perpetrations increased by 5.6%, while the number of supply-related perpetrations dropped by 9.1%, thus the proportion of demand-related perpetrations among all drug offences increased by 2.1%.

In 2011 small amounts of drugs were involved in 88.2% of the registered drug offences (demand-related perpetrations: 91.5%, supply-related perpetrations: 64.8%). As compared to the previous year the proportion of offences small amounts of drugs continued to increase due to the slight increase of demand-related perpetrations involving small amounts.

The number of offences committed with the punishable basic case amount dropped both on the demand (-20.3%) and supply (-16.7%) side. Altogether, as compared to 2010, about 20% less proceedings were instituted because of basic case offences, and within all drug offences the proportion of basis case offences dropped from 11.1% to 8.7%.

Significant amounts were involved in only 3.1% of all drug offences. As compared to the previous year the number of such offences dropped by 21% among demand-related offences and increased by 42.5% among supply-related offences. As the resultant of the two, the number of drug offences committed with significant amounts increased by 5.7%.

Table 18. *Breakdown of the number and proportion of drug offences by perpetration type and amount of substance involved, in 2011*

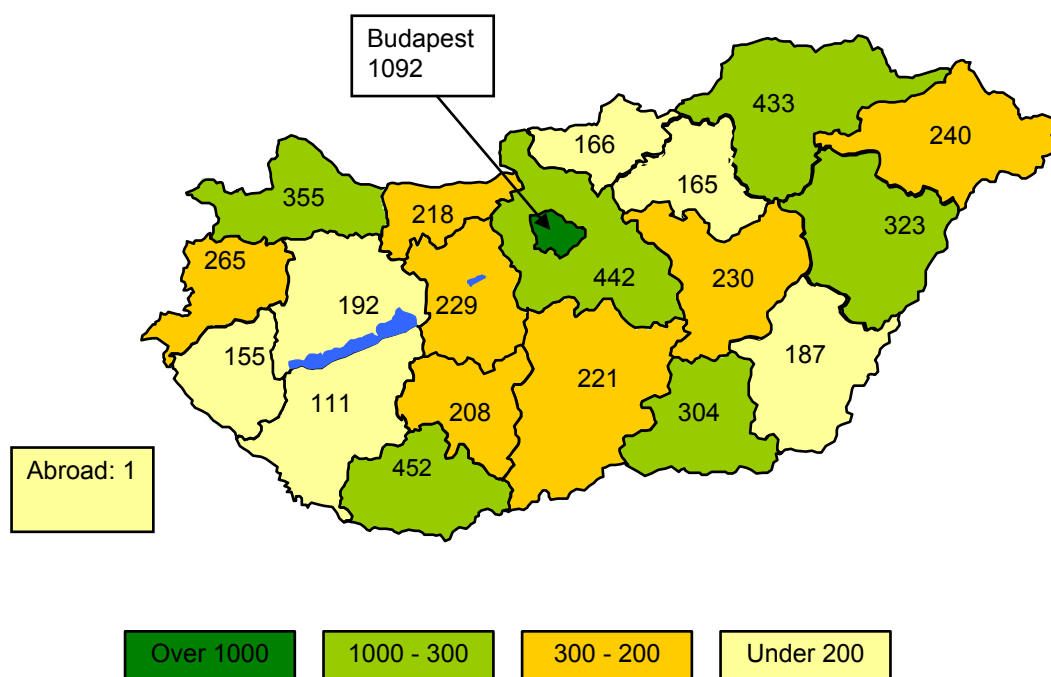
Perpetration	Small amount		Basic case		Significant amount		Total	
	N	%	N	%	N	%	N	%
Demand-related	4,785	91.5	365	7.0	81	1.6	5,231	100
Supply-related	467	64.8	150	20.8	104	14.4	721	100
Total	5,252	88.2	515	8.7	185	3.1	5,952	100

Source: ENYÜBS 2012

Place of offence

In 2011 again the highest number of drug offences were committed in Budapest, and then in Pest, Baranya, Borsod-Abaúj-Zemplén and Győr-Moson-Sopron counties. About one-fifth of the offences were committed in Budapest, and the offences committed in Budapest and Pest county altogether constituted about one-fourth of all drug offences. In Veszprém, Vas and Hajdú-Bihar counties the rate of increase of the number of offences was above 20%.

Map 4. Breakdown of the number of drug offences by county in 2011



Source: ENYÜBS 2012, NFP

Offenders

In 2011, 5,594 offenders were registered in the criminal statistics¹¹⁶ in connection with the 5,989 registered drug offences; the number of offenders was 5.7% higher than in 2010. The number of offenders increased at a slightly higher rate than the number of offences (+3.5%), but the rate of increase remained below the 20.7% rate observed in 2010.

Breakdown by gender and age

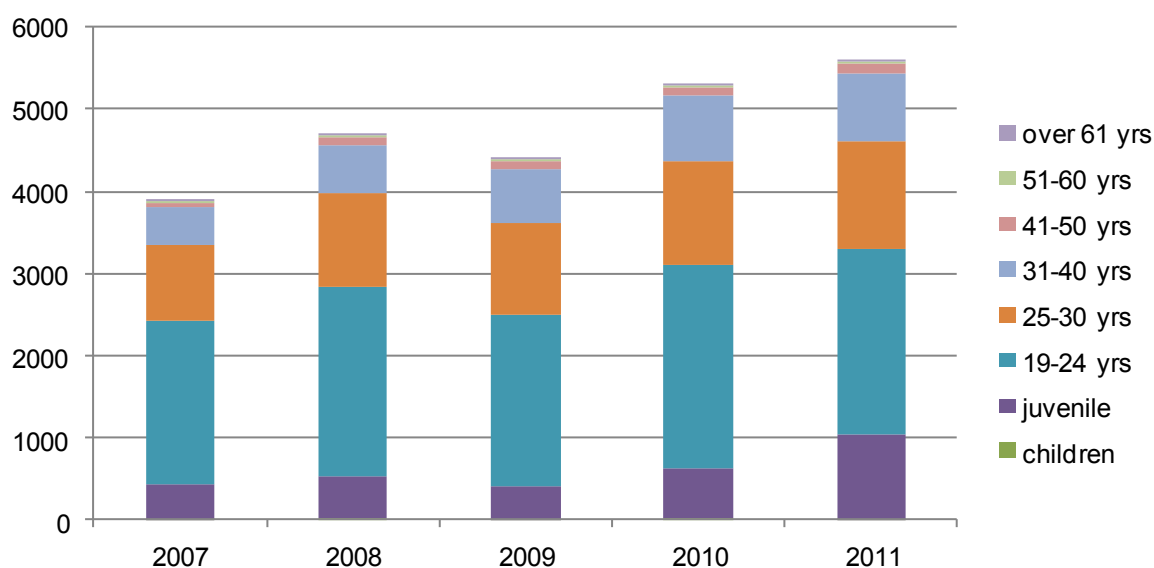
In 2011 the distribution by gender of the offenders committing drug offences did not change significantly as compared to the previous year.

On examining the distribution of offenders by age, the proportion of juvenile offenders increased significantly in comparison with the previous year, from 11.6% to 18.4%. At the same time, the proportion of offenders aged 19-24 dropped, although at a significantly lower rate, by 13%. There was no significant change in the proportions of the other age groups.

82% of all drug offenders were under the age of 30, similarly to 2010.

¹¹⁶ The same offender can commit several offences. In respect of offences the data obtained is complete, but the data relating to offenders can be incomplete because an offender is registered only with the most severe offence or with offences committed as a child or juvenile.

Figure 37. Breakdown of registered drug offenders by age, between 2007 and 2011



Source: ENYÜBS 2012, NFP

Breakdown by education

The breakdown of offenders by education was similar as in previous years: 0.3% of the offenders did not have any school qualifications, 44.5% had elementary qualifications, 43.4% had secondary qualifications and 1.9% had higher qualifications.¹¹⁷

Breakdown by previous conviction

Similarly to the previous year, nearly three-quarters of drug offenders had no previous conviction. Among those who had been convicted before the proportion of non-repeat offenders was 69%.

Table 19. Breakdown of drug offenders by previous conviction in 2011

Previous conviction	Persons	%
No	4013	71.7
No, but under investigation	149	2.7
All former convicts	1432	25.6
Of them:		
multiple repeat offenders	87	1.6
special repeat offenders	195	3.5
repeat offenders	161	2.9
non-repeat offenders	989	17.7

Source: ENYÜBS 2012

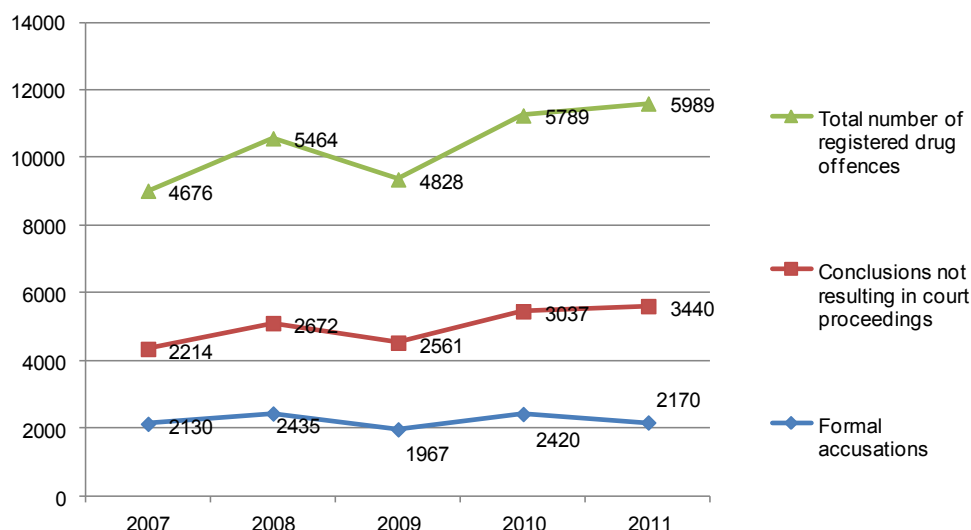
Suspension of accusation

Among proceedings instituted because of the misuse of illicit drugs, the proportion of investigations ending in formal accusation continued to drop last year (2011: 36.2%, 2010:

¹¹⁷ The total of the proportions remains below 100% because offenders are not obliged to state their school qualifications when they fill in the statistics sheet.

41.8%), in line with the increase of the proportion of conclusions not resulting in court proceedings (2011: 57.4%, 2010: 52.5%). Among conclusions not resulting in formal accusation, the proportion of conclusions for other reasons terminating culpability has been increasing continuously since 2007 (in 2011: 43.1%), and the use of reprimand (2011: 1.7%) and of the suspension of accusation (2011: 55.2%) is becoming less common.¹¹⁸

Figure 38. *Breakdown of procedural forms not resulting in court proceedings and formal accusations among registered drug offences between 2007-2011*



Source: ENYÜBS 2012

9.3. CONSEQUENT CRIME – OFFENCES COMMITTED UNDER THE INFLUENCE OF ILLICIT DRUGS

In 2011, 4,253 offenders committed a crime under the influence of illicit drugs, and 90% of them (3815 persons) committed offences concerning the misuse of illicit drugs. Among offenders committing non-drug related offences, offences against property accounted for the highest proportion (37.2%, 163 persons). Traffic offences under the influence of illicit drugs (typically driving under the influence of drugs) were committed by 119 offenders (27.2%). 42 offenders committed offences against other persons (of these bodily harm: 19, consummated homicide: 5, attempted murder: 3), and 40 offenders committed offences against public order.

¹¹⁸ This trend can be explained by the 2006 amendment of the rules of criminal procedure (Act LI of 2006) so that treatment as an alternative to criminal procedure started after committing the offence but before the suspension of accusation can be regarded as a cause terminating culpability, regardless of when the suspension of accusation takes place.

Table 20. Breakdown of offenders committing offences under the influence of drugs, in 2011

Offence committed under the influence of drugs	Number of offenders	Proportion of offenders among offenders committing non-drug-related offences	Proportion of offenders among all offenders committing offences under the influence of drugs
Offences against property	163	37.2%	3.8%
Traffic offences	119	27.2%	2.8%
Offences against other persons	42	9.6%	1.0%
Offences against public order	40	9.1%	0.9%
Other offences	74	16.9%	1.7%
Total	438	100%	10.3%
Drug offences	3,815		89.7%
Altogether	4,253		100%

Source: ENYÜBS 2012

9.4. PREVENTION OF DRUG-RELATED CRIME

Most of the programmes aimed at the prevention of drug-related crime are realised as a part of drug prevention programmes or general crime prevention programmes.

The National Committee for Crime Prevention, which had been responsible for coordinating crime prevention programmes and announcing projects, ceased to exist in April 2011. According to Government Regulation 1087/2011 (IV.12.) its tasks were passed on to the National Crime Prevention Council. The task of the Council is to elaborate a new social crime prevention strategy and to coordinate the realisation of that strategy.

In 2011 crime prevention lectures held by the Police reached about 34,000 elementary school pupils and 4,500 secondary school pupils in the framework of thematic school programmes (DADA, Ellen-SZER). One of the elements of both programmes is a preventive, informative and interactive session relating to drugs. Furthermore regional police bodies satisfy numerous specific drug prevention requests and they visit institutes of education and child protection, clubs for the elderly, parent groups and other events. In accordance with the training programme of the National Police Headquarters (ORFK), in September 2011 a basic training course was organised for police officers recently joining the programmes entitled DADA and ELLEN-SZER, with the participation of a total number of 54 persons (BM 2012).

As a part of a project run by the Budapest Police Headquarters (BRFK 2012) relating to school violence, entitled NE TEDD! NE TÚRD! [DON'T DO IT! DON'T PUT UP WITH IT!], interactive drama performances were held (Interactive Police roadshow) to show schoolchildren how they can get into dangerous situations; what happens when they are involved in a police measure; and what are the risks of driving under the influence of alcohol or drugs.

For several years, the police have had a crime prevention tent at the SZIGET festival, where they talk to people about the risks of drugs and especially alcohol.

Drug prevention was also a topic of the interactive lectures held by the BRFK, also organised for schoolchildren and linked with a guided tour at the Police History Museum. Although the topics are chosen by the schools in line with demand, drug prevention is included in nearly 90% of the lectures.

In 2011 a short film making competition dealing with drug prevention organised jointly by the Éltrevaló Karitatív Egyesület¹¹⁹ [Go-Ahead Charity Association] and the Police Headquarters of Budapest was extended to the national level. Young people below the age of 35 were invited to submit work in two categories: 5-minute and 40-second films, in any film genre, using optional technical tools. A total number of 35 films were submitted from 22 settlements of the country by 102 creators, involving many participants. The winning works were published on DVD and sent to the police headquarters and to civil organisations in contact with the police. (BRFK 2012)

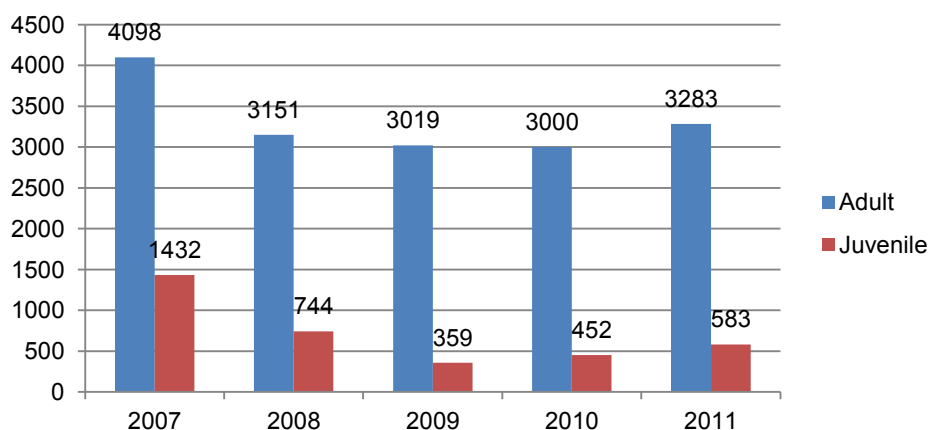
9.5. INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

Alternatives to criminal procedure

For the detailed analysis of data of clients entering treatment as an alternative to criminal procedure see chapter 5.3. For the data of clients entering treatment as an alternative to criminal procedure within the prison system see chapter 9.7.

The Hungarian Probation Service of the Office of Justice should also be mentioned in the case of clients entering treatment as an alternative to criminal procedure. (For the detailed description of the activity see 2010 National Report, chapter 9.3.) In 2011 the number of probation services slightly increased both among juvenile and adult offenders, which is in compliance with the age distribution of drug offenders.

Figure 39. *The number of probation services relating to drug offences, between 2007-2011*



Source: KIMISZ 2012

¹¹⁹ Source: <http://www.eletrevaloegyesulet.gportal.hu/>

Other interventions in prisons

Prevention

In 2011, prevention units were operating at 25 out of the 31 prisons, which could accommodate 372 voluntarily applying prisoners (see 2011 National Report, chapter 11.3.). The average number of prisoners accommodated in these units was around 260-270 on a national scale. Prisoners were accommodated in separate cells or units.

In 2011 drug prevention programmes were organised in 15 prisons, with the participation of 13 NGOs, on the basis of the KAB-ME-11-C tender (see chapter 1.4.).

Personality and competence developing sessions were organised in a prison¹²⁰ as part of drug prevention programmes in the framework of the TÁMOP 5.2.5, priority - supporting the social integration of children and juveniles.

In 2011 the Váltóság Alapítvány [Change Lanes Foundation] published a book entitled “Drug Prevention and Treatment in the Criminal Justice System” (Váltóság Alapítvány 2012), which contains description of best practices of the foundation and a further six NGOs working in prisons.

9.6. DRUG USE AND PROBLEM DRUG USE IN PRISONS

Patterns of use, risk behaviours

According to the results of a survey carried out in 2010 in 7 prisons linked to the hepatitis C screening programme in order to examine drug use and risk behaviours (Tarján and Horváth 2012) (for the methodology, infectious diseases and drug use patterns data see chapter 6.2.; ST9_2012_HU_03; ST9P2_2012_HU_06), 45 out of the 49 HCV positive persons detected in the total sample had already injected drugs. 41% of ever injecting drug user prisoners (189 persons) had already shared needles/syringes with someone else in their lives. Among IDU prisoners ever sharing needles/syringes the HCV prevalence was 40%, while among those not sharing needles it was 12%. 49.7% of ever injecting drug user prisoners had already shared any kind of injecting equipment. 33.7% of those who shared equipment and 12.9% of those who did not were HCV positive. In both cases the risk behaviour showed a significant relationship with HCV positivity.

65.5% of all prisoners (1048 persons)¹²¹ participating in the survey had tattoos, 12.5% of them had their last tattoo done while in prison. 6.3% (42 persons) of those with tattoos and 2.3% (8 persons) of those without tattoos tested positive for hepatitis C (the HCV positivity of the total sample was 4.8%). On examining only prisoners with tattoos it can be determined that 3.9% (5 persons) of those who had their last tattoo done in prison were infected. Although neither tattoos obtained before nor tattoos obtained in prison showed a significant relationship with HCV infection, it can be said that 84% (42 persons) of HCV positive prisoners (50 persons) had tattoos, and 10% (5 persons) of them had their last tattoo done in prison.

89.5% of the interviewed prisoners had last had sexual intercourse before imprisonment, while 2.5% had had their last sexual intercourse in prison, 16% of those having a sexual intercourse had used a condom during the last occasion. 20 out of the 26 persons who had their last sexual intercourse in prison did not use a condom during their last sexual intercourse.

(ST9P3_2012_HU_01)

For data on drug user prisoners participating in the survey carried out in the Budapest Penitentiary and Prison (Andrási 2012) see chapter 9.7.

¹²⁰ Baranya County Detention Facility

¹²¹ 1,032 persons answered the question relating to tattooing.

Availability of drugs in prison

According to the report of the Hungarian Prison Service Headquarters (BVOP 2012), the number of cases when substances suspected of being illicit drugs were found showed a minimal increase. While in 2010 substances suspected of being illicit drugs¹²² were found in 76 cases with 73 prisoners involved, in 2011 substances suspected of being illicit drugs were found in 81 cases in the possession of 82 prisoners. Typically, substances suspected of being illicit drugs were found in packages (30 cases), in the cells (20 cases) or during body search (16 cases), and in 6 cases such substances were seized during prison entry.

During the survey carried out in prisons in 2010 linked to the hepatitis C screening programme to examine drug use and risk behaviours (Tarján and Horváth 2012, for the methodology see chapter 6.2.; ST9_2012_HU_03) the availability of drugs in prison was also examined. 59.1% of the respondents (800 persons) thought that it was impossible to obtain drugs in prison, 14.1% found it very difficult, 16.6% found it moderately difficult, and only 3.3% of the prisoners thought that it was easy and 9.9% thought that it was very easy to obtain drugs in prison.

9.7. RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS

Treatment

Based on the report of the Hungarian Prison Service Headquarters, in 2011 42 persons received a certificate on completion of the treatment for drug addiction, and in the case of 11 persons the treatment was interrupted. 44 persons received a certificate on completion of other treatment for drug use; in the case of 15 persons the treatment was interrupted. 81 persons received a certificate on participation in preventive-counselling services, in the case of 57 persons it was interrupted (BVOP 2012).

Number and characteristics of clients entering drug treatment while in prison

Based on TDI data (TDI_2012_HU_04) a total number of 167 prisoners started treatment in 2011 in connection with a drug problem. 70% of the prisoners applying for treatment (104 persons) entered drug-related treatment for the first time, and 30% (45 persons) had participated in treatment previously (in the case of a further 18 persons the treatment history is not known). All clients entered treatment in the scope of QCT (quasi-compulsory treatment) to avoid punishment (because of committing a drug-related offence prior to their imprisonment involving a small amount of drugs before being admitted to prison, or in the case of addicted users because of possessing drugs of an amount remaining below the significant amount, for their own use). Taking into consideration that all reported prisoners started participation in treatment / indicated prevention programmes as an alternative to criminal procedure, this data does not reveal much information about the prisoners' real drug-related treatment demand.

In respect of socio-demographic characteristics, 93% of the imprisoned clients were men (154 persons) and 7% (11 persons) were women.¹²³ Most clients starting treatment belonged to the age groups between 25-29 (28%), 20-24 (24%) and 30-34 (20%). Their mean age was 28.6 years. 86% of them (136 persons) had had completed elementary school at the most¹²⁴. 13% (20 persons) had completed secondary school¹²⁵, and 1 of them had higher education qualification¹²⁶.

¹²² No precise information is available on the type of drugs.

¹²³ In two cases the gender of the clients was not known.

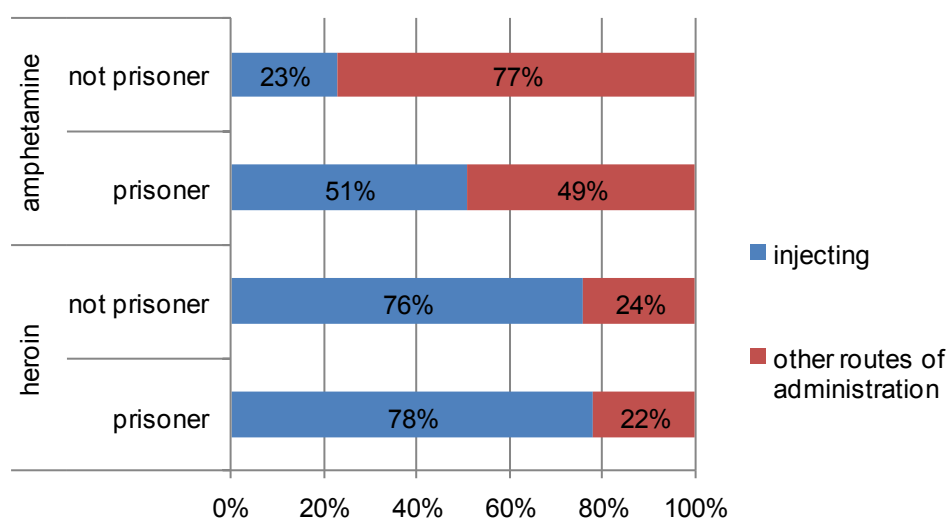
¹²⁴ ISCED 2

¹²⁵ ISCED 3-4

¹²⁶ ISCED 5-6

On examining the drug use pattern of these treated persons, 47% of them (78 persons) used cannabis, 25% (41 persons) used opiates, 25% (41 persons) used stimulants, and a further 3% (7 persons) reported other primary substance used before being admitted to prison. 56% (90 persons) typically smoked their primary drug, 29% (47 persons) injected it, 9% (14 persons) sniffed it, and 6% (9 persons) ate or drunk it¹²⁷. In the case of amphetamine users the proportion of IDUs (before being admitted to prison) is much higher among clients treated in prisons (51%) than among clients treated outside of prisons (23%). In the case of heroin the proportion of IDUs is similar in the two populations (prisoners 78%, not prisoners 76%).

Figure 40. Breakdown of amphetamine and heroin users entering treatment in prison and outside of prison by route of administration in 2011 (%)



Source: TDI data collection (OAC 2012b); analysed by: NFP

Substitution treatment

According to the results of the complementary data collection conducted by the Outpatient Drug Treatment Centre of the Nyíró Gyula Hospital and the Hungarian National Focal Point no imprisoned person was in opioid substitution treatment in 2011 at the 12 outpatient drug treatment centres providing OST in the country. (For further information on substitution treatment provided for prisoners see 2011 National Report, chapter 11.3.)

Responses to treatment demands

In 2011 a survey was carried out under the title “Drug users and therapeutic possibilities among prisoners” (Andrási 2012) with the participation of 60 drug user prisoners¹²⁸ from the Budapest Penitentiary and Prison. The mean age of the prisoners filling in the questionnaire was 35.5 years. 49 had used cannabis in their life, 37 – 37 persons had used amphetamine and cocaine each, 31 persons had used ecstasy, 23 persons had used heroin, 21 persons had used LSD, 7 persons had used methadone, 4 persons had used mephedrone. 26 of the respondents had already injected drugs in their lives.

46 persons answered that after being admitted to prison their drug use habits had changed, typically they had stopped using drugs because they did not have access to them. 10 persons answered that their drug use habits had not changed, 6 of them were not regular users before imprisonment.

¹²⁷ In the case of 7 persons the route of administration was not known.

¹²⁸ The persons included in the sample were selected by the educators, the questionnaires were anonymous and self-administered.

42 of the prisoners filling in the questionnaire thought that drug addiction was a problem for them, but after being admitted to prison only 29 prisoners requested help because of drug use.

The most typical response to seeking help by prisoners was that they were accommodated in a drug prevention unit (15 cases), this was followed by medically assisted treatment (5 cases), while being referred to a psychologist, group therapy, QCT and counselling was mentioned in 1 case each. Most respondents (22 out of the 29 persons) were satisfied with the help they received, and 4 of them were not satisfied. Those who did not give a clear answer (3 persons) thought that it would turn out how efficient the help was after being released, when they can have access to drugs again.

In connection with the question asking about the demand for further help most prisoners mentioned individual and group therapy.

Prevention and treatment of infectious diseases

Vaccinations

For the background of providing vaccinations against Hepatitis B see 2010 National Report, chapter 9.5. In 2011, 47 prisoners received this vaccination.

Counselling

Within the framework of the TÁMOP 6.1.2 priority, in 4 prisons¹²⁹ in the region of Central Hungary a health promotion programme was organised for prisoners and prisoners to be released in collaboration with the Váltóság Alapítvány NGO, which was the main applicant in the project. The programme provided help to obtain knowledge and skills needed for a healthy way of life in the following fields: prevention of smoking, alcohol consumption, drug use and related infectious diseases; protecting and maintaining mental health; life management skills; developing the ability of self-care; preparing for family life; education on safe sexual behaviour. In the scope of the project a long-term sustainable health promotion plan was prepared, and the participants were also given two information booklets about AIDS and related risk behaviours and about behavioural addictions. The Foundation held health counselling sessions in the 4 prisons once a week for 10 weeks, and established supporting relationships. 70 people were involved in the project, and in the end 56 of them completed the programme successfully.

Furthermore, the foundation held a training course for the prison staff in Budapest on 10 occasions, with the participation of 16 staff members, in order to sustain the results of the project (Mészáros 2012).

Testing

For the 2011 data of the counselling and screening programme performed since 2007 to prevent HIV/HBV/HCV infections in prisons see chapter 6.2. (For the antecedents see chapter 9.5. of the 2009 and 2010 National Report and chapter 11.3. of the 2011 National Report.) Between 2007 and 2011 the blood samples of a total number of 13,879 prisoners were tested for HCV, 11,016 prisoners were tested for HBV and 12,421 prisoners were tested for HIV. So far 29 out of the 31 prisons have taken part in the screening programme (BVOP 2012).

TB screening was also available in detention facilities in 2011, 18,013 persons were tested (for the data see chapter 6. 2.).

¹²⁹ Budapest Detention Facility; Márianosztra Penitentiary and Prison; Vác Penitentiary and Prison; Prison for Juvenile Delinquents, Tököl

Treatment, care

The treatment of prisoners tested HBV or HCV positive and meeting the therapeutic criteria was started or continued, the others were taken into care. In 2011 the Hungarian prison Service Headquarters did not provide data relating to the number of HBV and HCV positive persons receiving antiviral treatment. For the description of the HIV/HCV/TB treatment of prisoners see 2009 National Report, chapter 9.5.

The number of HIV positive and treated clients varies due to fluctuation; in 2011 it was between 10-15 persons.

Prisoners tested positive for active TB in 2011 (17 persons) received treatment.

9.8. REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON

In 2010 the Váltóság Alapítvány issued an information booklet entitled “Practical knowledge on release” for prisoners being released. Furthermore, in 2011 the Foundation published a book entitled “CLOSED IN/OUT – Integration of prisoners and released prisoners in society and on the labour market”, in which best practices and case studies are described and professional recommendations are made.

Conclusions

In 2011 both the number of registered drug offences (5,989) and the number of drug offenders (5,494) slightly increased as compared to the data recorded in the year before.

In 79.2% of drug offences the subject of offence was cannabis, and in 8.5% of the cases it was amphetamine. In the case of all individual substance types more than 80% of the offences were demand-related offences.

In 2011 the proportion of juvenile drug offenders increased significantly, from 11.6% to 18.4%.

On the basis of the survey examining drug use and risk behaviours linked to the 2010 hepatitis C screening programme, it can be stated that 92% of the HCV positive prisoners had injected drugs in their lives, during which risk behaviours were also characteristic of their drug use.

In 2011 167 prisoners were reported to have started a drug-related treatment / indicated prevention programme, all of them in the scope of a QCT programme, i.e., as an alternative to criminal procedures.

In 2011 the Váltóság Alapítvány organised a health promotion programme for prisoners and prisoners to be released in 4 prisons.

10. DRUG MARKETS¹³⁰

10.1. OVERVIEW

Since 1 January 2011 the Hungarian Institute for Forensic Sciences (BSZKI), which used to operate under the control of the Ministry of Interior, has been operating integrated into the Police organisation, as an independent body of the National Police Headquarters (ORFK). In 2011 only the BSZKI was entitled to analyse seized substances, the earlier investigation authority of the Hungarian Customs and Finance Guard (VPVI) was terminated and when they found substances suspected of being illicit drugs, the competent police body conducted the procedure.

The project entitled “Intensive monitoring of the active substance content of hazardous drugs” launched in May 2009 (for further information see 2010 National Report chapter 7.1) was suspended in June 2011 due to lack of funds. However, in December 2011 an agreement signed by the Ministry of National Resources, the Ministry of Interior, the National Police Headquarters and the Institute for Forensic Sciences made it possible to restart the project and include also results relating to new psychoactive substances.

10.2. AVAILABILITY AND SUPPLY

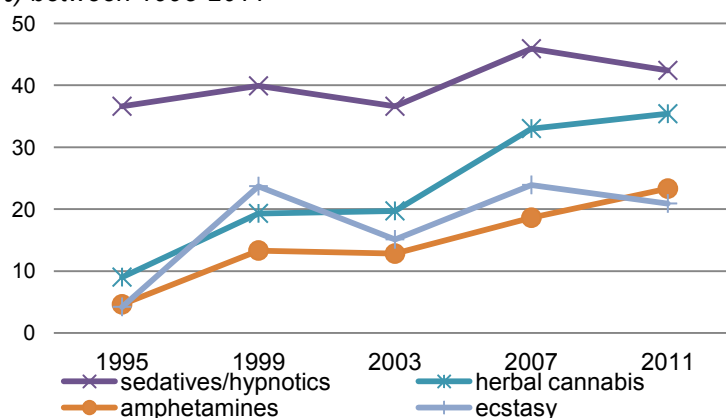
Availability

ESPAD 2011

According to the results of the ESPAD survey carried out in 2011 with the participation of 3,062 16-year-old pupils (Elekes 2012, for more detail see chapter 2.3.) the perceived availability of the different drugs increased significantly as compared to 1995. The proportion of those who find that herbal cannabis is easy or very easy to obtain has increased four times, and the proportion of those who find that amphetamines and ecstasy are easy or very easy to obtain has increased five times. The perceived availability of sedatives/hypnotics used without medical indication has also increased slightly over the past 16 years.

As compared to 2007 only the perceived availability of herbal cannabis and amphetamines has increased by 2.4 and 4.7 percentage points respectively.

Figure 41. *The proportion of those who find different substances easy or very easy to obtain among 16-year-old pupils (%) between 1995-2011*

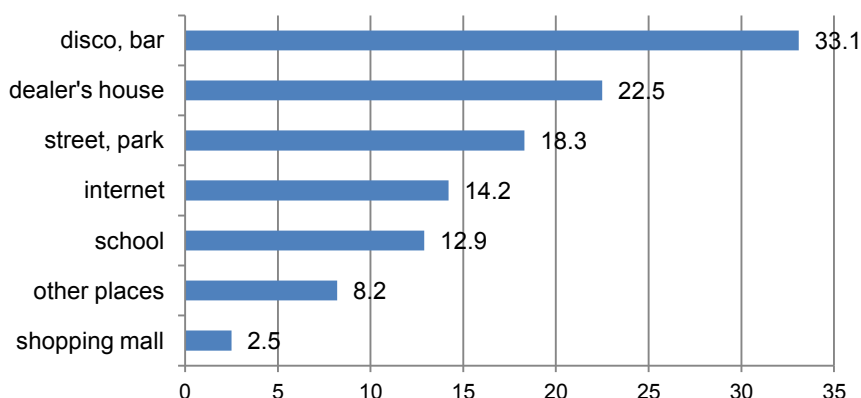


Source: Elekes 2012

¹³⁰ The authors of this chapter are: Tamás Csesztregi, Ágnes Port

55.3% of the pupils interviewed could mention a place where they thought they could easily get herbal cannabis or cannabis resin if they wanted to. Most of them mentioned discos, bars and similar places of entertainment, and many of them thought that the easiest way of getting herbal cannabis was by going to the dealer's house.

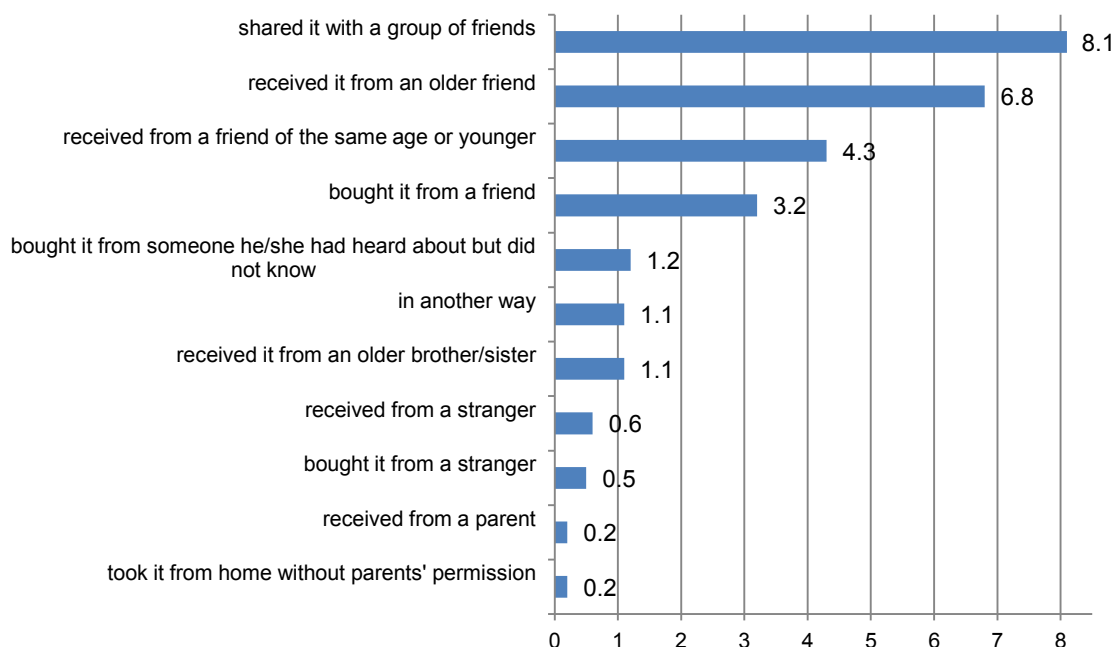
Figure 42. *Places where it would be easy to obtain herbal cannabis or cannabis resin according to 16-year-old pupils (%) in 2011*



Source: Elekes 2012

The majority of pupils mentioned relationships with friends as the actual way of getting drugs (herbal cannabis, ecstasy, amphetamines). Most of them shared drugs with a group of friends, or received drugs from older friends or from friends younger/of the same age. They mentioned strangers as a source of acquisition much more rarely than friends. There were hardly any pupils who mentioned their parents as the source of acquisition.

Figure 43. *Source of acquisition of drugs among 16-year-old pupils – expressed as a percentage of all the respondents (%) in 2011*



Source: Elekes 2012

Online availability of NPS-s in Hungary

Joining the EMCDDA online snapshot survey, in January 2012 the National Focal Point carried out a survey on Hungarian internet sites selling new psychoactive substances,

between 23 January and 3 February 2012 (Port 2012b). A total number of 21 internet sites were identified that suited the given conditions¹³¹.

At the time of the survey the sites examined had already responded to the change enacted in January 2012, according to which 9 substances were added to the schedule of controlled substances (see Chapter 1.2): nearly all sites stopped distribution of these substances as of January. Various herbal incense blends treated with synthetic cannabinoids were the most common products in the substance selection available in Hungarian web shops (they were offered on 15 sites). JWH substances were replaced by AM-2201 and by herbal blends treated with it. Among stimulants pentedrone (on 4 sites), pentylone (on 4 sites) and 4-EMC also sold under the name EMMA (on 5 sites) were the most common at the time of the survey. 4-fluorococaine, offered as a legal alternative for cocaine, could also be purchased on 5 sites. On several sites stimulants were offered in the form of tablets named after coloured fruits (Pink Apple, Red Apple, Yellow Cherry).

Survey on the use of new psychoactive substances

In spring 2012 the National Focal Point carried out a survey among drug treatment centres and harm reduction service providers on the use of new psychoactive substances (Csák et al. 2012, for the methodology and further results see chapter 4.4.). Among the causes of the increasing use of new psychoactive substances, service providers mentioned easy availability at the first place besides low price and legal status. Several service providers mentioned that new psychoactive substances could become so popular so quickly due to the bad quality and low active substance content of other classic drugs (first of all heroin and amphetamine, but cocaine and ecstasy were also mentioned). Several service providers reported that there had been periods when heroin could not be obtained at all, which may also have contributed to the fact that several heroin users changed over to mephedrone or, after it was banned, to other synthetic cathinone derivatives.

Sources of supply: national production

In Hungary the first cannabis plantations operated by Vietnamese organised criminal groups appeared in the first half of 2008. As compared to previous years the number of cannabis plantations of an industrial scale and quality seized by the police has increased by nearly ten times. Most of the equipment and the necessary financial background comes from Vietnamese groups residing in the Czech Republic. By now, plantations are set up not only in houses and industrial/agricultural properties but in apartments as well. The people working on the plantations are mostly illegal immigrants who probably pay people-smugglers by working for them (Ministry of Interior, 2012).

For data on seizures of illicit drug producing laboratories in 2011 see chapter 10.3.

Smuggling routes, structure of the national market

Cannabis

Besides the traditional Dutch source, a new phenomenon observed in cannabis distribution in the past two years is that it arrives from the Czech Republic and it is smuggled into the country or its smuggling is organised by Vietnamese wholesale distributors settled in Hungary. Recently cannabis has also been arriving from the Balkan countries, in most cases

¹³¹ Only those sites were recorded where purchase could be realised during one single visit, that is, an order could also be made directly on the site and not only by sending an e-mail or by phoning a number. On Hungarian NPS selling websites it is common however that the purchase cannot be done directly but the order must be sent to a certain e-mail address. Taking these sites into consideration too, a further 11 sites were identified, but the content of these sites was not analysed in the survey.

it is transported in cars and trucks through Hungary to Western Europe (Ministry of Interior, 2012).

Heroin

Based on seizures and drug offences data, heroin use has been decreasing continuously and in 2011 it subsided almost entirely. At the same time, as no transit consignments were seized in 2011, the transit status of the country cannot be clearly described in respect of 2011, but it is for sure that in the past few years the Balkan route lost a great deal of its significance. On the basis of the data of earlier years large, sometimes 100-200 kg amounts are smuggled through Hungary to Western Europe. However, latency is quite significant in this field, because the consignments do not bear Hungarian relations (Ministry of Interior, 2012).

Cocaine

In respect of the characteristics of cocaine smuggling no significant change can be observed as compared to the previous years. In 2011 the police instituted several proceedings against trafficking groups of black African origin and also against Yugoslavian, Romanian and Hungarian groups of offenders. Similarly to other states along the Balkan route, several criminal proceedings were instituted because of cocaine smuggling and trafficking against offenders who had previously dealt with heroin trafficking (Ministry of Interior, 2012).

Drug precursors

As a new phenomenon, the smuggling of so-called pre-precursor substances (formamide, APAAN) is becoming more prominent. In possession of an official licence the base materials are shipped from China to European ports (e.g. Koper, Slovenia), from where, in smaller batches, they are transported to illicit laboratories in Western Europe, where they are used for making the base material of synthetic drugs (Ministry of Interior, 2012).

10.3. SEIZURES

The table below contains the amounts seized by the Police and sent to the drug analysing laboratories of the Hungarian Institute for Forensic Sciences. (ST13_2012_HU_01)

Table 21. *Number and quantity of seizures in 2010 and 2011*

Type of drug	number of seizures		quantity seized	
	2010	2011	2010	2011
Herbal cannabis (kg)	2,220	2,073	528.1	208.7
Cannabis plant (plant)	213	192	14,824	14,121
Cannabis resin (kg)	44	63	8.5	18.2
Heroin (kg)	73	22	97.8	3.2
Cocaine (kg)	132	108	14.4	12.6
Amphetamine (kg)	484	483	71.2	24.1
Methamphetamine (kg)	41	33	3.4	0.1
Ecstasy tablets (pc) /MDMA, MDA, MDE/	9	22	1,135	270
LSD (dose)	12	11	461	274
<i>Herbal substances with synthetic cannabinoids (kg)</i>	<i>51</i>	<i>465</i>	<i>14.8</i>	<i>10.2</i>
<i>Synthetic cannabinoids in powder form (kg)</i>	<i>5</i>	<i>51</i>	<i>0.01</i>	<i>13.2</i>
<i>Cathinone derivatives in powder form (kg)</i>	<i>353</i>	<i>595</i>	<i>9.08</i>	<i>75.8</i>
<i>Cathinone derivatives in tablet form (pc)</i>	<i>60</i>	<i>144</i>	<i>3,990</i>	<i>7,951</i>

Source: BSZKI 2012

In 2011 the number of cannabis plant seizures and the amount of seized plants slightly dropped as compared to the previous year. Among the seizures the proportion of cannabis plants cultivated in artificial conditions was significant. Based on seizures data it can be presumed that a significant part of the Hungarian cannabis market is supplied from domestic production.

The number of herbal cannabis and cannabis resin seizures has not changed significantly as compared to the previous two years. On the basis of the number of seizures the black market share of cocaine, amphetamine, methamphetamine and LSD is similar to that in the years before.

After the slight decrease in 2010, the number of heroin seizures and the quantity of the seized substance dropped significantly in 2011: even if it is taken into account that three-quarters of the amount seized in 2010 originated from one single transit consignment, in 2011 the quantity seized dropped nearly to one-tenth of the quantity seized in the year before. The change observed in the seizure data is consistent with the experience reported by NSPs and treatment centres, according to which a proportion of injecting heroin users changed over to more easily accessible, licit new psychoactive substances (see chapter 4.3. and 4.4).

The number of seizures of GBL, which is not classified as a drug, continuously increased until 2010. In 2011, the number of seizures basically did not change as compared to the previous year (2010: 85, 2011: 84) but the quantity seized dropped significantly, from 26.7 litres to 6.5 litres.

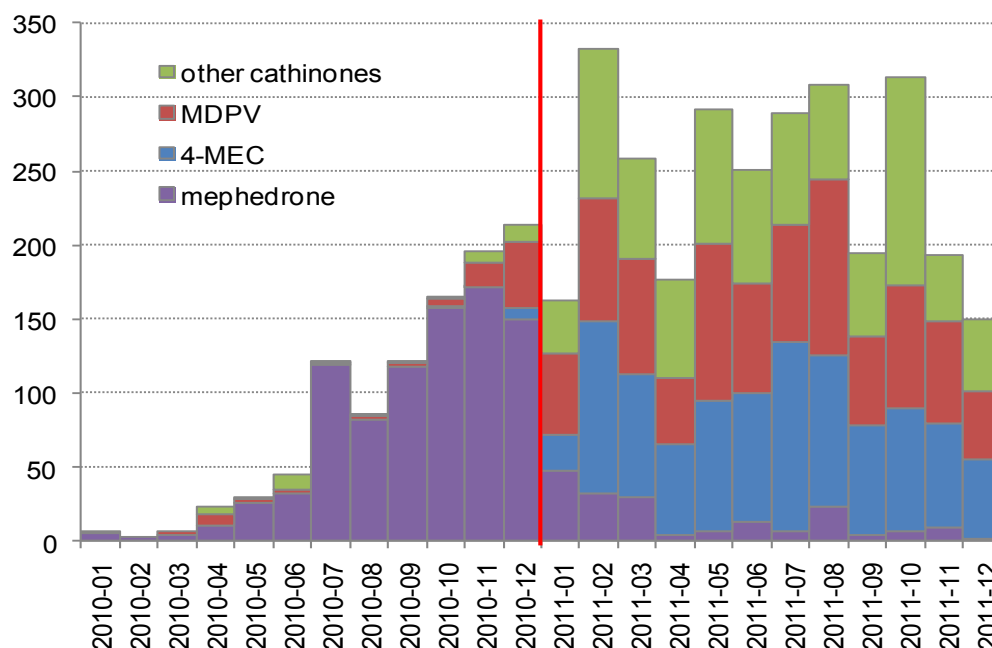
The number of seizures of powders containing ketamine decreased considerably as compared to 2010. In 2011 a total amount of 44 grams of powder was seized in 16 cases as opposed to the 1.13 kilograms seized the year before. A total number of 426 bottles of pharmaceutical ketamine solution were seized on 19 occasions in 2011.

A total number of 19,160 tablets were seized during 2011 containing illicit drugs or new active substances – not classified as illicit drugs –, which is similar to the amount seized in the previous year (18,411).

New synthetic substances

On 1 January 2011 mephedrone was added to the schedule of illicit drugs, as a result of which in January 2011 the number of occurrences dropped significantly, and by April it almost completely disappeared from the seizures. At the same time, two further cathinone compounds, 4-MEC (4-Methylethcathinone) and MDPV (3,4-Methylenedioxypropylone), became as widespread as mephedrone before. Besides these two substances, other cathinones such as methylone, 3,4-DMMC, pentadrone, butylone, fluoromethcathinone, MDPBP and PVP also occurred in numerous seizures. In 80% of the cases cathinones occurred in a powder form, and in 20% of the cases they occurred as the active agent of tablets. The number of cathinone seizures increased more than one and a half times as compared to 2010, the quantity of the seized substances in a powder form was eight times as much, and the number of seized tablets containing cathinone was twice as much as in the year before.

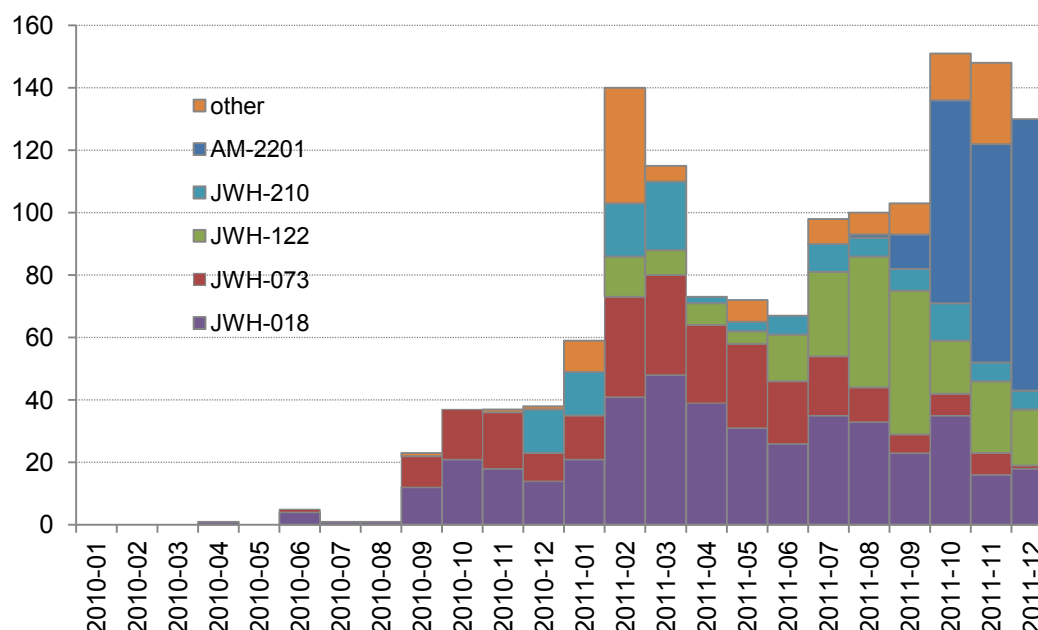
Figure 44. The frequency of occurrence of cathinone derivatives (number of cases) in the materials and on objects analysed, broken down by month, in 2010 and 2011



Source: BSZKI 2012

Synthetic cannabinoid compounds started to occur in the seizures in significant amounts in autumn 2010. In 2011 the number of seizures containing synthetic cannabinoid components increased nearly ten times as compared to the previous year. In 90% of the cases the compounds were applied onto a herbal carrier, while in the remaining 10% of cases the active substance occurred in powder form. Until autumn 2011 JWH-018 and JWH-073 were the most common active agents found in herbal blends treated with synthetic cannabinoids, but significant amounts of JWH-122 and JWH-210 were also found. By autumn 2011 a professional recommendation was signed to add the most common synthetic cannabinoids (five "JWHs") to the schedule of illicit drugs, after which the proportion of herbal substances treated with AM-2201 increased significantly in the seizures.

Figure 45. The frequency of occurrence of synthetic cannabinoid compounds (number of cases) in the materials and on objects analysed, broken down by month, in 2010 and 2011



Source: BSZKI 2012

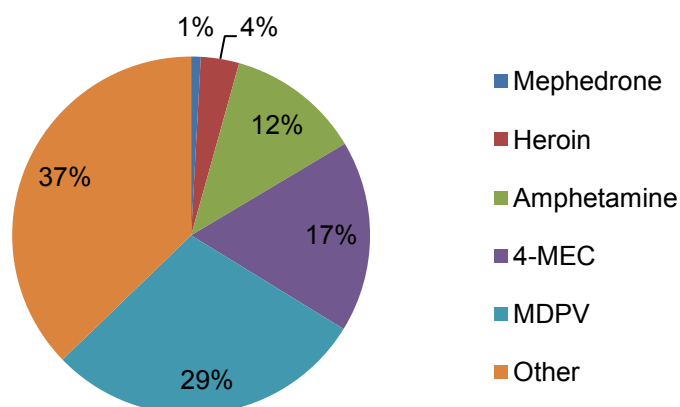
Among phenethylamines the most common compound was 4- Fluoroamphetamine (4-FA). In 2011, in 167 cases a total amount of 127 grams of powder and 10,692 tablets containing fluoroamphetamine were seized, which means a six-fold increase in the number of cases compared to 2010 (28 cases). The quantity of powders containing 4-FA seized increased two and a half times (2010: 52 grams), and the number of tablets seized increased thirty times (2010: 363 tablets). In powders fluoroamphetamine often occurred in combination with amphetamine, while tablets typically contained only fluoroamphetamine as an active substance. Among other derivatives the most significant was the seizure of a total of 1.76 kilograms of N-ethylamphetamine powder, seized in two cases.

Among compounds that cannot be classified in the above compound groups the occurrence of methoxetamine (MXE) found in 16 cases in 2011 can be regarded significant. The number of occurrences of other active agents was not significant.

Seizures related to injecting drug use

On summarising the active substances detected on injecting equipments and analysed in laboratories, trends can be followed regarding the type and approximate proportion of injected substances. On the basis of the test results obtained in previous years, in 2007-2009 injecting drug use could be associated mainly with heroin (50-60%) and amphetamine (20-35%). In 2010 both amphetamine and heroin represented a 30% proportion and the proportion of mephedrone was also nearly 30%. In 2011 the most commonly used substances were MDPV and 4-MEC, the occurrence ratio of heroin was only 4%.

Figure 46. *Distribution of active substances detected on injecting equipment in 2011 (N=231)*



Source: BSZKI 2012

Illicit laboratories

In September 2011 an illicit laboratory producing amphetamine was seized in Pest county in which, besides producing the active substance, tablets were also manufactured. The available information suggests that in the laboratory kilograms of amphetamine were produced. Linked to the laboratory, on further sites cannabis and psilocybin mushrooms were also cultivated.

In December 2011 a laboratory producing amphetamine was seized in Veszprém county where amphetamine was produced in small volumes, below the kilogram scale.

One “laboratory” producing poppy extract was found in 2010, while in 2011 three were discovered. At the processing sites poppy alkaloids were extracted from ground poppy seeds using an organic solvent (nitro-solvent), and then the solvent was evaporated to obtain a concentrated solution. While at the site found in 2010 about 26 kilograms of dilute and concentrated extract were found, in 2011 at three sites a total of 1,240 kg of ground poppy seeds to be processed and 501 kg of ground and processed poppy seeds, 1,970 litres of dilute solution and 102 kg of concentrated extract were found. It must be noted that there were no further seizures relating to the further processing of the produced extracts in Hungary or to their distribution on the black market.

10.4. PRICE / PURITY

Price of drugs at street level

Every year the Hungarian National Focal Point carries out a survey among clients of outpatient drug treatment centres about the prices of drugs at street level (Port 2012a).¹³² (ST16_2012_HU_01)

This year questions were also asked concerning the price of MDPV and herbal blends treated with synthetic cannabinoids sold under the name Spice or as synthetic marijuana. Slightly more than one-third of the respondents bought MDPV last year, the mean price of the substance per gram upon last purchase was EUR 12. More than half of the respondents

¹³² The survey was carried out with self-administered questionnaires between 1 January – 15 February 2012 with the participation of 7 outpatient drug treatment centres in 7 cities. The methodology of the survey is described in the 2010 National Report chapter 10.3.

had information about the price of synthetic marijuana, customers paid a mean price of EUR 7.2 for a gram.

It was also asked whether the clients had bought any other new psychoactive substance during the past year and at what price. In respect of the answers there was a great difference between the cities involved: most of the clients who mentioned a new substance were from Pécs and Debrecen, while there were three cities where none of the clients mentioned new substances. The substances mentioned included the following: 4-MEC, 4-FMC, methylone, penta crystal, 4-FA, 3-FA, 2-FA. However, the number of mentions relating to the individual substances was so low that no general conclusion could be drawn regarding the price of the substances.

Table 22. Price of drugs at street level in 2011 in EUR¹³³

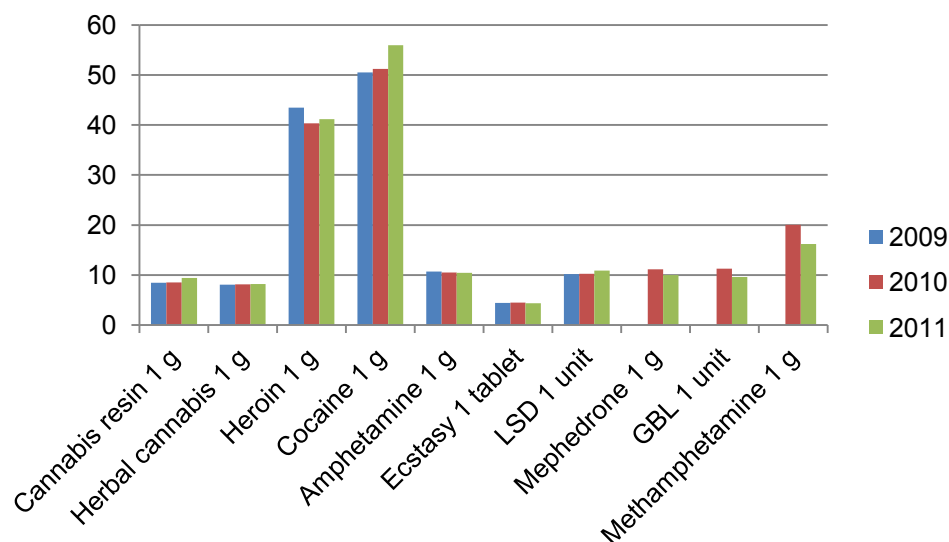
Substance	Lowest	Highest	Most frequent	Mean	Number of respondents
Herbal cannabis (g)	3.6	10.8	9.0	8.2	119
Cannabis resin (g)	5.4	21.6	9.0	9.4	77
Heroin (g)	12.6	108.0	36.0	41.2	37
Heroin (packet)	7.2	46.8	18.0	20.1	27
Cocaine (g)	36.0	82.8	54.0	55.9	60
Crack (g)	14.4	108.0	0.00	53.9	9
Amphetamine (g)	5.4	18.01	10.8	10.5	81
Ecstasy (tablet)	1.1	10.8	3.6	4.4	77
Methamphetamine	7.2	72.0	10.8	16.2	24
LSD (dose)	4.3	28.8	7.2	10.9	46
Methadone (20 mg)	1.8	18.0	3.6	7.4	23
Methadone (5 mg)	1.1	7.2	1.8	3.1	10
GBL (dose)	3.6	21.6	7.2	9.6	26
Mephedrone (g)	3.6	18.0	10.8	10.0	49
MDPV (g)	7.2	21.6	10.8	12.0	43
Spice (g)	1.8	12.6	7.2	7.2	71

Source: Port 2012a

As compared to the previous year the street level price of cannabis resin and cocaine increased, both by an average of 10%. According to the results of the survey the price of methamphetamine per gram increased by about 15%, the price of GBL and mephedrone slightly dropped as compared to 2010. However, in the case of these substances the relatively low number of respondents should be taken into consideration. The prices of the other drugs did not change significantly as compared to the previous year.

¹³³ The prices included in the table were calculated based on the official mid-rate of the EUR for 2011 (1 EUR=277.7 HUF)

Figure 47. Mean price of drugs at street level in EUR between 2009-2011



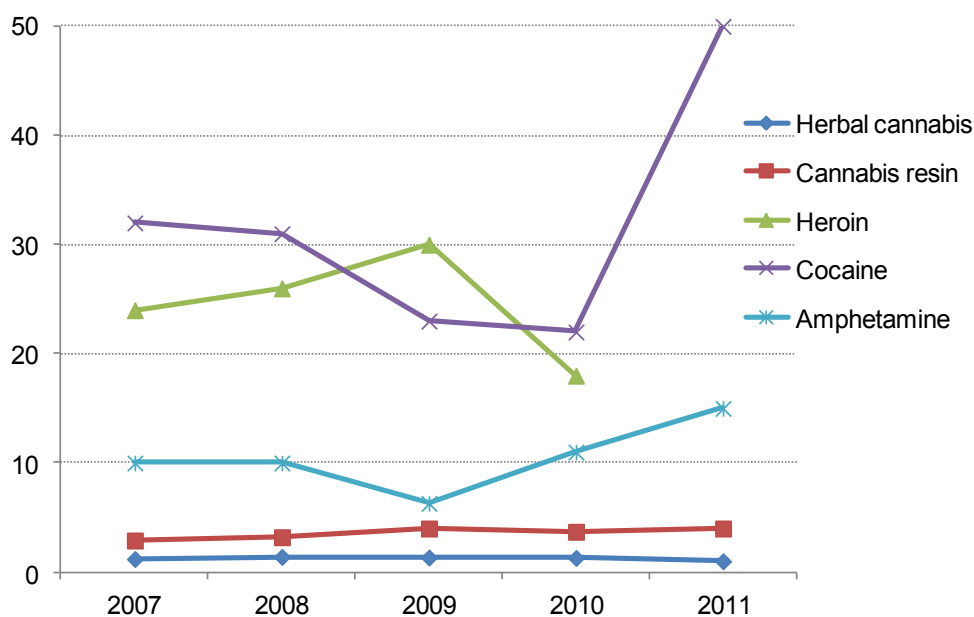
Source: Port 2012a

Purity

The average active substance content of the herbal cannabis and cannabis resin samples analysed has not changed essentially for years.

In the case of cocaine the proportion of significantly diluted powders continued to drop: in 2011 the active substance content was at least 50% in half of the seized samples. Both in the case of batches packaged in small quantities (a few grams) and in the case of larger batches (several hundred grams), cocaine powders with a cocaine base content of more than 80% (that is nearly pure cocaine hydrochloride) occurred in numerous cases. Due to this the average active substance content of cocaine powders also increased significantly, from 20% observed in 2010 to 50%.

Figure 48. Mean active substance content (%) of drugs between 2007 and 2011¹³⁴



Source: BSZKI 2012

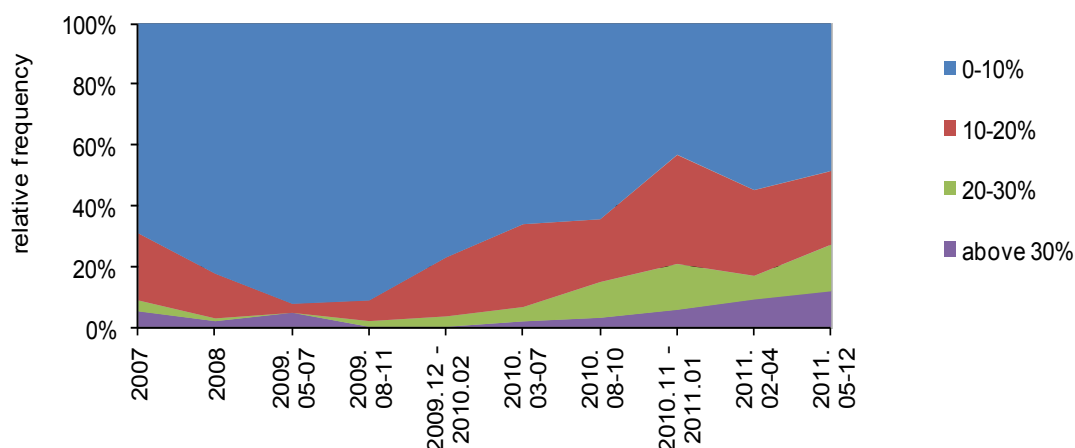
¹³⁴ For heroin there was not sufficient data available for 2011.

Monitoring the active substance content of heroin and amphetamine

In respect of the active substance content of user-dose powders containing heroin¹³⁵ and amphetamine data is collected in the framework of the “Intensive monitoring of the active substance content of hazardous drugs” project, which supplements the results of measurements carried out during the analysis of seizures (see chapter 10.1.).

As compared to 2010 the distribution of the active substance content of powders containing amphetamine did not change significantly. As a long-term tendency a slight increase of the proportion of powders with an active substance content above 30% can be observed.

Figure 49. Active substance content of powders containing amphetamine, seized in user-doses between 2007-2011



Source: BSZKI 2012

Composition

New synthetic substances

Test results show that the new psychoactive substances generally occur in powder form, many times in an undiluted, pure form. Frequently, individual powders do not only contain a single active substance, but they are mixtures of 2-3 substances. In 2011 nearly one-third of the powders contained more than one active substance, typically several cathinone derivatives.

In 40% of the cases herbal substances treated with synthetic cannabinoids contained a mixture of several active substances.

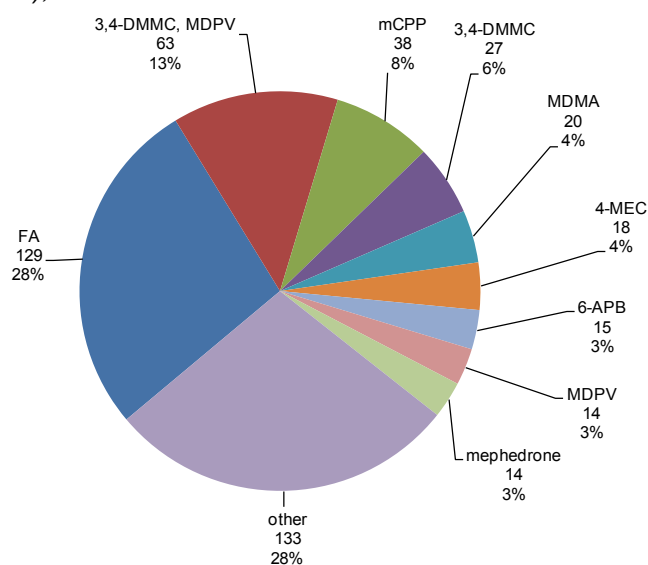
It must be noted that the widely used names for NPS-s (e.g. “MP”, “MP4”, “crystal”) cannot be clearly associated with a given active substance, and sometimes the name given on the packaging does not match the contents. In the case of samples deriving from a popular online store examined in the autumn of 2011, the substance bearing the name “ZZ-1” according to the label was pure methylone, the product bearing the name “ZZ-2” was pentedrone containing a large amount of isopentedrone (presumably a by-product), while a package bearing the label “benzo fury” contained pure lidocaine.

¹³⁵ In 2011 heroin was seized in only 22 cases. Among these only a few were powders packaged in user-doses, from which no conclusion can be drawn concerning the trends.

Tablets

On examining the composition of tablets containing illicit drugs or psychoactive substances not classified as illicit drugs it can be stated that the shift that started in 2010 towards “licit” active substances continued. In 2011 90% of the tablets contained active substances not classified as illicit drugs, as opposed to the 50% proportion observed the year before. The tablets contained many different types of active substances, the most common substance – both on the basis of the number of seizures¹³⁶ and the amount of tablets – was fluoroamphetamine (FA). Besides the active substances, most commonly the tablets contained caffeine, cellulose or lactose as a cutting agent. (ST15_2012_HU_01)

Figure 50. Frequency (N, %) of occurrence of active substances in the tablets seized, examining the number of seizures (N=471), in 2011



Source: BSZKI 2012

Conclusions

The most significant change in 2011 was the rapid disappearance of mephedrone after it had been added to the list of illicit substances, followed by the rapid spreading of other cathinone compounds stepping in its place (4-MEC, MDPV), and the significantly increasing use of herbal blends treated with synthetic cannabinoids. In line with the appearance and spreading of new compounds, the frequency of occurrence of heroin dropped significantly. In 2011 90% of tablets seized contained active substance not classified as illicit drugs, the most common active substance was fluoroamphetamine (FA).

As compared to the year before, the price of cannabis resin and cocaine per gram at street level increased by 10%. On examining the active substance content of the samples seized it can be observed that the active substance content of cocaine powder also increased significantly: in 2011 the average active substance content of the analysed cocaine powders was 50% as opposed to 22% observed in 2010.

¹³⁶ One seizure means identical tablets in the same packaging, seized from the same location.

11. RESIDENTIAL TREATMENT FOR DRUG USERS¹³⁷

Overview

In Hungary the residential treatment¹³⁸ of drug users takes place in hospital addiction and psychiatry wards financed from the health fund and at drug therapy institutes financed from mixed (health and social) funds. The two types are not clearly distinguished from each other, from the aspect of control and financing they are not separately defined either. 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.

Because of the above this chapter is restricted to describing drug therapy institutes and the treatment provided by them. The TDI data presented contain both clients treated in hospital wards and those treated in drug therapy institutes.

Drug therapy institutes 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.

11.1. HISTORY AND POLICY FRAMEWORKS

11.1.1. History of residential treatment

In Hungary the first drug therapy institutes were established in 1986, before the change of the political regime, in a socio-political environment that was not open to civil initiatives and that refused to acknowledge the drugs problem. In this period the treatment system had no institutional healthcare or social answer to illicit drug use. The first two specialised outpatient treatment centres in Hungary were established at the same time as the first therapy institutes. Typically, these residential institutes were founded by the church. At the beginning the therapy programmes were set up based on the relationship with foreign sponsors, applying typically faith-based, closed and hierarchic models (e.g. Teen Challenge). The first few years were characterised by a lack of professional experience, appropriate forms of training and literature in Hungarian, and also by extremely limited finances. The first institutes financed their properties and operation exclusively from foreign grants; they could not rely on state resources at all. The state started to undertake responsibility only at the end of 1988, directly before the change of the political regime, first by issuing low-budget calls for tenders, and from 1989 in the form of small-scale social formula (per capita) financing. The latter represented the first stable national resource for the institutes.

During the 90's the institutes slowly consolidated their status. In this period the controlling and regulating activity of the state increased. The Association of Hungarian Drug Therapy Institutes, an umbrella organisation for representing the interests of civil initiatives in the field,

¹³⁷ The authors of this chapter are: Anna Péterfi, Ákos Topolánszky

¹³⁸ In this context "residential treatment" is defined as a range of treatment delivery models or programmes of therapeutic and other activities for drug users, including medical-psychosocial interventions within the context of residential accommodation. One defining characteristic of such programmes is that they address multiple treatment needs, including but not limited to the following domains: drug use, health, quality of life and wider social functioning.

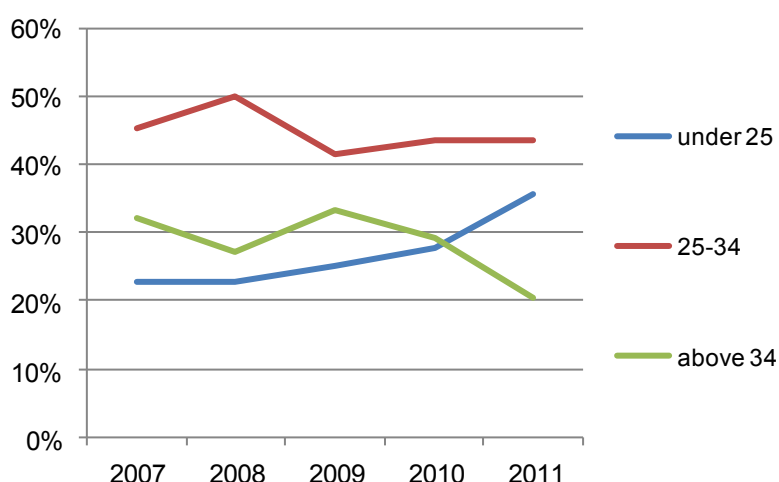
was founded in 1995, at that time with the participation of 7 therapeutic homes. Currently the association unites all Hungarian drug therapy institutes (a Romanian organisation is also among its members).

Between 2001 and 2004 the capacity of therapy institutes more than doubled (from 147 beds to 353 beds) within the framework of a central budget support programme, while the already operating institutes were modernised and they were able to enrich their therapeutic programmes. Currently there are 14 therapeutic communities, on the basis of the latest available data they operate with a total number of 353 beds (data from 2009, covering the capacity of the 13 operating institutes at that time).

By now the institutes have significantly extended their therapeutic services, and within their own organisation they have set up low-threshold, halfway and follow-up care services, opened towards new client groups, and have a significant network of institutional relations. Many of the currently operating therapy institutes are so-called third-generation therapy systems. The capacity, recognition and budget of therapy institute treatment have not changed or only slightly in recent years.

Concerning treatment demands, in the second half of the 80's drug users were admitted to residential treatment first of all due to the use of synthetic opiates (medicines containing morphine), natural opiates (poppy tea) and barbiturate derivatives. After the political change heroin addiction became increasingly more characteristic among the clients treated. From the second half of the 90's an increasing number of amphetamine users demanded treatment in the drug therapy institutes. In the past few years an increasing number of cannabis users and users of new psychoactive substances have been admitted to the residential institutes, and patients with behavioural addictions also appeared in greater proportions. The qualitative survey carried out by the National Focal Point in 2012 among outpatient and inpatient treatment units and harm reduction services (Csák 2012) pointed out that among the users of new psychoactive substances (primarily synthetic cathinones) treatment demand develops even after a few months of use. Residential treatment units, including drug therapy institutes, are also contacted by an increasing proportion of such clients, who are typically younger than their usual group of clients and are generally characterised by a lack of motivation, which is a burden for the institutes (Csák 2012). Some of the drug therapy institutes participating in the survey reported that they do not have the right responses for younger clients, as in the past typically older clients were involved in their programmes, following several years of drug use, who had to be prepared for reintegration into the labour market, while for young people a school has to be found to complete their studies. (For further details concerning the survey see chapters 4.3. and 5.) On examining the data on clients starting treatment, the same trend can be observed: there is an increasing proportion of clients under the age of 25, while an increasingly lower proportion of users above the age of 34 is being admitted to residential treatment.

Figure 51. Breakdown of clients entering residential treatment¹³⁹ by age, between 2007-2011 (%)



Source: TDI data collection (OAC 2012b); analysed by: NFP

When therapeutic programmes were launched 25 years ago, their duration varied between 14 and 24 months. The results of the survey carried out by Topolánszky et al. (2009a, 2009b) show that today the programmes have become significantly shorter, 15 months on average, although in half of the cases an individual therapy length is determined.

11.1.2. Strategy and policy frameworks for residential treatment

Strategy

Long-term, typically abstinence-oriented treatment has become a stable part of national addiction treatment. The first National Strategy relating to the period between 2000-2009, besides other types of treatment, was also aimed at improving inpatient treatment in respect of capacity, availability and the efficiency of treatment. Basically the Strategy determined two forms of inpatient treatment: hospital based inpatient treatment, aimed at detoxification primarily, and treatment provided by long-term therapy institutes, therapeutic communities. In the document the following three basic therapeutic aims were set concerning the theoretical framework of the treatment:

- achieving a life free from psychoactive substances,
- assisting in performing the various life activities with the greatest possible satisfaction,
- prevention of relapse and reduction of harms arising from drug use.

The new drug strategy adopted in 2009 did not become the governing policy document of the field (see chapter 1.3.), so it is not discussed in this report.

Financing

With regard to the dual (health and social) nature of long-term treatment provided by them, the operation of drug therapy institutes is determined, regulated and supervised both by social and healthcare administrative bodies. Their operation is typically funded from state resources and, to a smaller extent, by the municipality (75.7% and 13.4%). All other sources of income represent an insignificant proportion (11% of the total budget) (Topolánszky et al. 2009a, Topolánszky et al. 2009b). The budget of the institutes can be planned well; as compared to other social services it is relatively stable even in the present economic situation.

¹³⁹ The cases were selected (here and in the other parts of the chapter as well) according to the definition given at the beginning of the chapter (they do not include all inpatient cases), and they include both the clients treated in therapy institutes and in hospital wards.

Basically the institutes can access two types of financing. On the one part, in accordance with Act III of 1993 on social administration and social services, they might receive financing on the basis of their turnover, in respect of which they render an account to the Social and Public Guardianship Authority of the county Public Administration Offices in a daily electronic reporting system. From a professional aspect their operation is controlled by the regional methodology institutes¹⁴⁰. Presently this support is not granted on a universal basis, which means that the institute does not always receive it based on its entire capacity (the total number of beds), because the available budget is limited, so the financing of capacities is distributed through the so-called regional compensation system. Among the standard support determined annually in appendix 3 of the Budget Act, within the category of the 'permanent residential care of people living with disabilities, of psychiatric patients and of patients suffering from addictions', in 2011 a fixed amount of EUR¹⁴¹ 2,559/person/year was available for the rehabilitation institutes for persons suffering from addictions. This is equivalent to EUR 7 per person per day. In the past years social formula financing remained nominally the same, but in real terms it decreased significantly. For the financing of halfway house beds the institutes can use the so-called 'residential rehabilitation homes for psychiatric patients, patients suffering from addictions, people with impaired vision, physically disabled persons, mentally disabled persons and for people with multiple disabilities' per capita support (EUR 2,199/person/year).

The other main type of financing is the healthcare financing provided by the National Health Insurance Fund (based on Act CLIV of 1997 on healthcare), also reported electronically and based on accounting of so-called client days, where the institutes appear as independent, daily financed (quasi) hospital service providers providing chronic treatment. In this respect the permission is issued by the Public Health Department of the county Public Administration Offices, on the basis of the act on healthcare and its related decrees. This type of support constitutes the largest part of the permanent and stable income of drug therapy institutes. Presently the amount of the financing is calculated by multiplying the chronic inpatient base (EUR 20.2) by the 1.2 multiplier¹⁴² determined for the institutes, which equals EUR 24.2 /person/day. For days when the client receives other health services as well, this type of financing cannot be requested.

Consequently, from the social and healthcare sources together, the maximum base funding that could be requested in 2011 for the treatment of a client in a drug therapy institute amounted to EUR 11,549/person/year (EUR 31.6/person/day).

These forms of finance are supplemented by two other forms of support that can be provided in the framework of social employment with the aim to prepare clients for the labour market. Earlier this type of financing was provided as a formula financing, but since 2010 it has to be applied for, for three year periods, on the basis of a so-called task indicator (number of working hours financed). The task indicator is determined annually. The two forms of the support are the work rehabilitation fee (EUR 2.8) and the employment support for development and coaching activities (EUR 1.3). Personnel payments and the operation costs of work rehabilitation can be financed from this support. The clients' eligibility for support is determined by the National Medical Expert Institute.

The institutes receive further training support for their employees with a so-called social registration number. The amount of this was EUR 33.1/person/year until 2008, and between

¹⁴⁰ On the basis of Decree 1/2000. (I. 7.) SZCSM of the Ministry of Social and Family Affairs on the professional tasks and conditions of operation of social institutes providing personal care, and on the basis of the professional programme of the institute, the Organisational and Operational Rules of the institute and the agreements concluded with the clients.

¹⁴¹ The amounts in this chapter were calculated on the basis of the official exchange mid-rate of the EUR for 2011 (EUR 1 = HUF 277.7).

¹⁴² Based on the categorisation of levels of treatment (in this case 3rd level of progression).

2009 and 2011 it was EUR 5.9/person/year. However, this financing covers only a fraction of the costs of compulsory further training courses.¹⁴³

The last financing element is tender financing (provided by the state, municipalities, for-profit sector), the amount of which dropped significantly in the past years because of the economic crisis. At the same time there are an increasing number of European Union support programmes first of all for supporting development, and to a lesser extent, for supporting operation.

11.2. AVAILABILITY AND CHARACTERISTICS

11.2.1. Availability and accessibility

A referral is needed in order to be admitted to a drug therapy institute. Only drug users with valid health insurance can apply to these treatment units. In institutes for adult clients the minimum age is 16 years. As school is compulsory until the age of 18, the institutes are obliged to provide education for their clients under 18, most often this is solved in a private pupil status.

Drug therapy institutes must determine a so-called institute fee, but they are not obliged to collect it. Typically this fee is very low (generally around EUR 72/month), and generally only a few clients can pay it (10-20% of the treated patients on average).

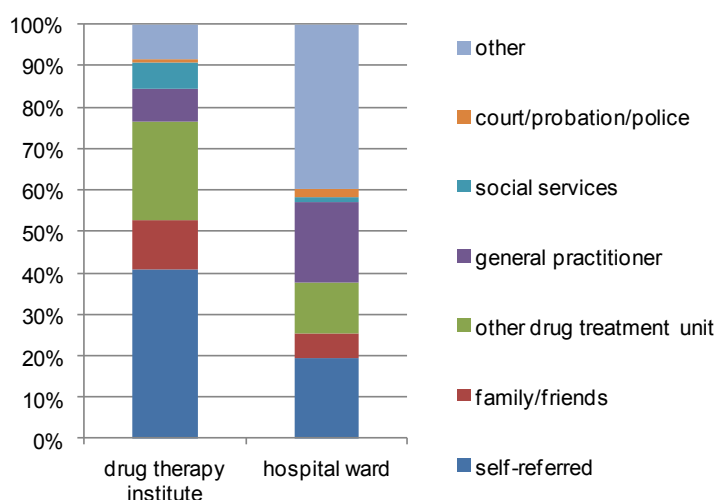
In more than half of the cases (53%) clients get in touch with drug therapy institutes informally (by contacting the institutes on their own, in person or via their family or friends). In respect of institutionalised patient paths, specialised drug treatment units play a significant role (24%). This is partly due to that therapy institutes operate low-threshold services and outpatient treatment units (providing preparation for therapy or motivation strengthening services) within their own organisational framework, or they cooperate with such services in order to reach patients.

Basic treatment services (general practitioners) and the social treatment system play a less significant role in referring patients to the institutes.

In the case of inpatient hospital wards, source of referral shows a different pattern.

¹⁴³ The number of credits to be obtained in a period of five years is 60 in the case of employees with secondary qualifications and 80 in the case of employees with higher education qualifications. The fee of a course providing 13-15 credit points is EUR 90-108 on average.

Figure 52. Breakdown of clients entering residential treatment¹⁴⁴ by source of referral in 2011 (%) (N=238)



Source: TDI data collection (OAC 2012b); analysed by: NFP

The capacity of drug therapy institutes can be regarded as sufficient compared to the manifested treatment demand. On the basis of the survey carried out by Topolánszky et al. in 2009 (Topolánszky et al. 2009a, b), 3% of the clients treated during the year at the national drug therapy institutes (25 persons) were currently on a waiting list (2.1 persons per institute on average). The degree of capacity utilisation varied between 90 and 100%.

The drug therapy institutes altogether are able to accommodate 353 persons at the same time (on the basis of data from 2009). Within this capacity 269 beds were financed by the national Health Insurance Fund, and 340 beds were supported by social formula financing (the same bed can be financed from several sources).

11.2.2. Types and characteristics of residential treatment units

11.2.2.1. Therapeutic approaches

Regarding their organisational form, all of the 13 institutes¹⁴⁵ participating in the survey¹⁴⁶ carried out in summer 2009 about the operation of drug therapy institutes (Topolánszky et al. 2009a, b), 4 institutes were operated by the state or by municipalities and 9 by non-governmental (NGO) institutes. Among the latter there were 3 private foundations, 2 associations, 2 public foundations, and 2 institutes maintained by a church.

¹⁴⁴ The cases were selected on the basis of the definition given at the beginning of the chapter (not all inpatient cases are included).

¹⁴⁵ The Fordulópont Terápiás Intézet [“Turning Point” Therapeutic Institute] of „Forrás Leiki Segítők Egyesülete [“Spring” Association of Mental Helpers] that was founded in the year of the study could not yet participate in the survey.

¹⁴⁶ The survey covered 13 member organisations of the Association of Hungarian Drug Therapy Institutes (MADRISZ) performing an active therapeutic activity (drug rehabilitation) at the time of the data recording. The survey was commissioned by the National Institute for Drug Prevention.

During data recording the heads of the 13 institutes were interviewed, which means a 100% response rate. At the time of the data recording, in the 13 drug therapy institutes 253 clients were treated by 180 employees, among whom 146 employees and 240 clients were interviewed. Data recording with the heads of the institutes was carried out by interviewers familiar with the field, typically applying face-to-face technique. The employee questionnaires were recorded by individual self-administered technique, while the client questionnaires were recorded by group self-administered technique. (For further details about the survey see chapter 8 of the 2010 National Report.)

In 2009 5 of the institutes were mixed – available both for men and women –, 7 were available only for men and 1 only for women. 2 institutes were for juvenile drug users.

The institutes are typically open towards groups with special needs. All of them admit clients from minority groups, the decisive majority of them admit people on probation, clients with a dual diagnosis, HCV positive people, homeless people and people suffering from behavioural addictions. 5 out of the 6 institutes available for women admit drug user mothers. At the same time, the institutes reported that they did not provide special services for these groups with special needs.

The majority of the institutes (10 institutes) could accommodate less than 25 people, the smallest institute was suitable for accommodating 10 people and the largest one could accommodate more than 100 people.

Group therapy, employment therapy and the therapeutic community model received the greatest emphasis among the therapeutic techniques applied by the institutes. On average, the 12-step model, pharmacotherapy and evangelisation were less emphatically present in the institutes.

Table 23. *Emphasis on the different therapeutic techniques in the therapeutic programmes offered in drug therapy institutes, on a 5-grade scale (1=not emphatic at all; 5=very emphatic) (2009)*

Therapeutic, counselling approach	Average	SD
Group therapy	4.92	0.277
Therapeutic community model	4.77	0.599
Employment therapy	4.62	0.65
Relapse prevention	4.38	1.502
Behavioural and cognitive therapy	4.38	1.121
Individual support, counselling	4.23	1.235
Motivation therapy	4.00	1.528
Sport and adventure therapy	3.92	1.32
Art therapy	3.38	1.325
Individual psychotherapy	3.15	1.676
Family therapy	3.15	1.625
Bibliotherapy, evangelisation	2.85	1.676
12-step model	2.23	1.598
Pharmacotherapy	1.85	1.282
Aversive therapeutic methods	1.54	0.877

Source: Topolánszky et al. 2009a, Topolánszky et al. 2009b

11.2.2.2 Typical mix of services

See chapter 11.2.2.1.

11.2.2.3. Integration of OST in residential treatment

Only one of the Hungarian drug therapy institutes provides substitution treatment, and psycho-pharmacotherapy is applied in a three further institutes to supplement other elements of the programme. Three institutes named the Minnesota model as their governing or prominent therapeutic approach (Topolánszky et al. 2009a, b).

11.2.2.4 Typical levels of collaboration and networking

The drug therapy institutes are parts of the social and healthcare system. In practice there is a high level of collaboration based on referrals. The majority of the institutes identify themselves at the formal or at the integrated collaboration level. The majority of the institutes run low-threshold services or have an organised relationship with a low-threshold service provider (see the information relating to the source of referrals in point 11.2.1.). Typically they have organised relationships with hospital detoxification units too, of which there are only a few in the country. Clients who cannot be admitted are generally referred to other drug therapy institutes or to other treatment suiting their needs. The institutes usually maintain follow-up care services, halfway homes, care programmes, and they support self-help groups.

11.3. QUALITY MANAGEMENT

11.3.1. Availability of guidelines and service standards for residential treatment

Drug therapy institutes do not have specific regulations neither from the aspect of healthcare nor social administration. Presently drug therapy institutes must fulfil the minimal professional conditions of psychiatric rehabilitation. The specific minimum conditions relating to drug therapy institutes and juvenile drug therapy institute treatment are currently being elaborated.

Concerning guidelines for the residential treatment of drug users, the three healthcare protocols about the treatment of drug users (protocols describing the treatment of opiate, amphetamine and cannabis users) and the methodological letter describing methadone treatment are governing. Nevertheless, these govern the operation of the institutes only partly and indirectly. (For a detailed description of the rules of procedure see chapter 11 of the 2010 National Report.)

On the social side, the operational framework is defined by the condition system set down in 'the permanent residential care of people living with disabilities, psychiatric patients and patients suffering from addictions' (appendix 3 to the currently valid Budget Act).

There is no direct standardised outcome evaluation relating to the individual institutes or to the institutional system, neither on the healthcare nor on the social side, but some of the institutes perform internal evaluation and follow-up studies (Topolánszky et al. 2009a, Topolánszky et al. 2009b).

There is no direct connection between therapeutic performance or efficiency and financing¹⁴⁷. Institutes that fulfil the formal operational conditions and regulations required in the legal acts receive financing.

11.4. DISCUSSION

From the aspect of the manifested treatment demands, the capacity of drug therapy institutes can be regarded as satisfactory, but referral to these higher-threshold residential treatment forms needs to be improved. Although the therapy institutes are open towards drug users with special needs (e.g. juveniles, women, pregnant women, dual diagnosis patients), they do not offer services tailored to these special needs.

¹⁴⁷ The individual institutes define the efficiency criteria of their own therapeutic approaches differently.

11.4.1. Outlook

The therapeutic institutes do not have their own regulations relating only to their service segment, neither from the aspect of healthcare nor of social administration. The specific minimum conditions for drug therapy institutes and juvenile drug therapy institute treatment are currently being elaborated, which will also aid the clear organisational identification of drug therapy institutes. In connection with the standards and minimum conditions currently being prepared, it is an important issue how the level of financing changes in line with the changing of the regulation-compliance expectations. If stronger expectations (relating to employment, qualification, training, equipment, application, maintenance, etc.) are linked to decreasing financing, it may endanger the sustainability of operation.

12. DRUG POLICIES OF LARGE EUROPEAN CITIES¹⁴⁸

12.1. FUNCTIONS AND RESPONSIBILITIES OF LARGE CITIES¹⁴⁹ IN DRUG POLICY

Drug policy in public administration

The municipal governance structure of Budapest is different from those in other parts of the country. On the one part, only local governments operate in the territory of Budapest and no county municipalities (the municipality of Budapest is at the same level as county municipalities), on the other part, in Budapest the municipal government system operates at two levels.

The double-level municipal government system on the one hand consists of the Metropolitan Municipality with a sphere of authority covering the whole of Budapest, and on the other hand it consists of district municipalities operating in each of the 23 districts of Budapest. The distribution of tasks and competences between the two levels is determined in the Act LXV of 1990 on municipalities. The Metropolitan Municipality has tasks and competences that affect the whole of Budapest or any part larger than an individual district, as well as tasks and competences relating to the special functions that Budapest has in the country, and in this respect it has the right of adopting decrees. The two levels of municipal government can also share tasks by assigning tasks to each other, by collaborating with each other or by performing tasks jointly via partnership.

According to Act LXV of 1990 on municipalities (Ötv.), provision of elementary education, basic healthcare and social services is within the competence of municipalities. In Budapest the district municipality is responsible for ensuring basic healthcare and social services. Municipalities participate in drug policy coordination bodies as the maintaining organisations of institutes providing such services.

Local level drug policy coordination: Coordination Fora on Drug Affairs

The so-called Coordination Fora on Drug Affairs (KEFs) were set up as a result of the National Drug Strategy adopted in 2000, with the aim of enabling the realisation of the strategy objectives at local level, in line with local needs.

The KEFs are advisory bodies without a legal entity, which, in accordance with the strategy guidelines, work with drug-related organisations such as state and municipal institutes and organisations and also such non-profit service providers whose activity may contribute to the prevention and handling of the drug problem or to reducing drug supply. The majority of these fora were established and are operated as bottom-up initiatives but are also supported by the municipalities and regulated in a municipal decree.

Coordination Fora on Drug Affairs have been established continuously since 2001. In 2011 there were 84 continuously operating KEFs.

¹⁴⁸ The authors of this chapter are: Richárd Fehér, Ágnes Port

¹⁴⁹ In Hungary the capital city of Budapest is the only city that suits the EMCDDA's definition of "large city" used in respect of the present chapter (population >300,000).

Table 24. *Number of operating KEFs in 2011*

KEF level of organisation	
Settlement	51
District	16
Micro-region	10
County	4
Regional	3

Source: NCSSZI – NDI

From 2001 the ministry in charge of drug coordination has provided support through tenders in order to facilitate the establishment of KEFs. The ministry supported the establishment of forums in settlements with a population over 20,000. Between 2001 and 2004, with the exception of Budapest, drug coordination platforms were established throughout the country. In 2004 the districts of Budapest also joined the tender application system and they could apply for support from the central budget for their operation. This possibility initiated the establishment of KEFs in the districts of Budapest, too.

The KEFs were deliberately not integrated in a network, but the National Institute for Drug Prevention (NDI) operating as a background institute of the ministry in charge of drug coordination organised training courses and conferences for the fora and provided them with publications to support the professional development of the fora's member organisations. In 2011 these activities were referred to the competence of the National Drug Prevention Office (see 2011 National Report, chapter 1.2.).

It was a requirement towards KEFs both by drug coordination and by local decision makers that they should elaborate their specific local strategy and respective action plan. In the past few years there were about 80 operating KEFs in Hungary and 70 of them had a valid drug strategy also accepted by the local municipality. Each KEF publishes its strategy (as required by the project system) on the www.kef.hu website, where the list of member organisations and the currently relevant documents of the KEFs can also be found.

Role of local municipalities and NGOs in handling the drug problem

The KEFs became active participants in local drug policy and contributed to keeping the involvement of the non-profit sector equally active besides municipal institutes. As a result of the continuous strengthening of the non-profit sector an increasing number of new services are established by NGOs. This tendency is clearly indicated by the fact that between 2009 and 2011, out of the 72 organisations providing community treatment for people suffering from addictions nationwide, 22 organisations were maintained by municipalities, while the remaining 50 services were ran by associations (18), foundations (16) and churches (14). Only 3 of the 51 low-threshold services belong to municipalities. At the same time it must be noted that the role of municipalities is more dominant in case of outpatient treatment (only 5 of the 18 services are operated in the form of a foundation).

Drug coordination plays a role in local decision making, as in connection with introducing new services the organisations are informed about each other's work and they are assessed during the local licensing process (the municipality issues the operation licences needed to start services).

The member organisations of the KEFs, as independent organisations, are able to influence the national level drug policy in several ways. Starting from the 2000's, umbrella organisations were set up by organisations that perform activities with similar target groups and with similar professional approaches. These organisations are mainly seated in Budapest, but they organise their activities at national level. The experts representing civil

society organisations (4 persons) have also participated in the work of the government's drug advisory body (Coordination Committee on Drug Affairs – KKB) since 2007.¹⁵⁰

The majority of the KEFs have a dual management structure. In accordance with this an expert elected with the members' approval is put in charge of professional management, while in municipal decision-making the forum is represented by a local political actor (mayor, vice-mayor). The secretary or coordinator (generally a member of the municipal staff) has a dominant role in the organisation, who participates in organisational tasks as well as in wording proposals and recommendations submitted to the decision-preparing bodies (municipal committees) and to the decision-making forum.

12.2. KEY FEATURES OF THE CAPITAL CITY'S DRUG POLICY

The capital city's drug policy

In 1997, in decision No 432/1997 the Municipality of Budapest adopted its first drug strategy, which supported measures taken against drug supply and demand as a part of programmes realising coordinated tasks. The municipality determined the concrete tasks within the framework of the so-called "drug programme", and in August 1998 it adopted a further action plan entitled "Report on the situation of drug use and proposal for the preparation of an Action Programme for suppressing drug use in Budapest" (80-423/98).

After the National Strategy for 2000-2009 was adopted in December 2000, in decision No 80-327/2002 the Municipality of Budapest created a new drug strategy, revising the anti-drug strategy accepted in 1997. This strategy was quite comprehensive and did not determine concrete terms within which the individual objectives had to be reached.¹⁵¹

In the following years no further comprehensive professional policy document was published. A drug policy consultant, controlled by the vice-mayor in charge of healthcare and social policy, was responsible for coordinating the drug policy activity of Budapest. In its annual budget the Municipality of Budapest allocated an amount between EUR 72,000 and 144,000 for reaching the aims set in the national drug strategy. This amount was granted partly in the form of specific support and partly through issuing tenders, mainly to support the operation of non-profit organisations. The above organisational structure was reorganised in 2006 after the changes in the city management, and the position of drug policy consultant was also terminated. The drug strategy efforts of Budapest became more pronounced after 2007 but a new drug strategy was still not elaborated.

The KEF of Budapest

In 2007 the Healthcare Department of the Municipality of Budapest initiated discussions with the National Institute for Drug Prevention Institute, as a result of which – through the KEFs which were already active at district level – the department started to set up the Budapest KEF (FKEF). According to the plans the task of the FKEF would have been to advance the elaboration and then the realisation of the capital's drug strategy – with special respect to the necessity of handling the phenomena and tasks extending beyond the borders of the districts –; to collect and disseminate best practices; and to provide a professional forum for the governmental and non-governmental organisations of Budapest concerned.

In association with this, in 2008 the Healthcare Department of the Municipality of Budapest also prepared a comprehensive action plan with the participation of experts competent in the

¹⁵⁰ Currently the KKB has the following civil delegates: Association of Hungarian Drug Therapy Institutes (MADRISZ), Association of Hungarian Drug Prevention and Harm Reduction Organisations (MADÁSZSZ), Association of Harm Reduction Organisations (ÁSZ), Hungarian Association on Addictions (MAT).

¹⁵¹ The 7 main points of the drug policy document describe the events of the past (1.), the activities of the capital city between 1997 and 2002 (2.), and give a comprehensive picture of the situation (3.). It then describes drug prevention (4.), low-threshold (5.), high-threshold (6.) activities in line with the drug strategy pillars. In point 7 of the document proposals are made for improving the treatment system and about the coordination activity.

field (prevention, treatment-care, supply reduction). In order to realise the action plan, the Municipality of Budapest allocated EUR 250,000 from its 2009 budget via tender applications.¹⁵²

In 2009, in decision No 1466/2009. (10.12.) the General Assembly of Budapest supported the establishment of the Budapest Coordination Forum on Drug Affairs, as a professional advisory body working in teams and in charge of coordinating the realisation of the National Drug Strategy at the Budapest level. In accordance with the decision, the General Assembly asked the competent healthcare department to set up the FKEF by 31 March 2010.

Officially the FKEF was founded on 15 September 2010, after member organisations had discussed the operational rules in four work teams (prevention, treatment-care, low-threshold services, and supply reduction). After the municipal elections, with reference to the difficult economic situation of Budapest (e.g. transferring institutes and tasks of the Municipality of Budapest under state control) the handling of the drug problem and the forum were not regarded as outstanding issues; in summer 2011 the heads of the forum resigned from office. Presently the activity of the FKEF is suspended.

District KEFs

In the lack of a comprehensive strategy or an operating KEF in Budapest, the drug policy processes taking place in Budapest can be identified along the activity of the district KEFs.

KEFs were established in 18 out of the 23 districts of the capital city of Budapest. Primarily they perform their activity within the district borders, regarding both situation assessment and organisation of treatment. The district KEFs were established between 2003 and 2006. 11 of the 18 KEFs have been active without interruption since their foundation. 2 of the KEFs established have terminated operations completely, and 5 of them have suspended operations.

District drug strategies

After the district KEFs were established, they carried out situation assessments to be able to create an adequate district strategy. All of these strategies followed the structure of the national strategy, but their quality and extent varied depending on the local base of experts that were involved. In accordance with this the local documents were based on 4 pillars (community and cooperation, prevention, treatment-care, supply reduction), and when determining the term of the strategy they all used short-term, medium-term and long-term structuring.

Among the KEFs founded in Budapest (18), since 2005 12 fora have prepared their own individual drug strategy valid in their district. In respect of the term of validity of the district strategies no data is available in 3 cases (in one case it is currently being prepared, and in two cases there is no data because the wording is too general), and in 3 cases the strategy expires in 2012. The decisive majority of the district strategies are independent drug policy documents, two district strategies form parts of the crime prevention strategy.

¹⁵² Proposals were made in the action plan to support model programmes; set up a network (between related institutes and areas); continue to provide and improve already existing and efficiently operating harm reduction services; support the self-help culture; and strengthen prevention programmes (with special respect to high-risk groups).

Table 25. *Number of district drug strategies broken down by year of adoption and expiry*

District drug strategies	adopted	expires
2005	5	
2007	3	
2009	1	
2010	2	
2011	0	1
2012	1	3
2013		1
2014		2
2015		1
2018		1
n.a.		3

Source: NCSSZI – NDI

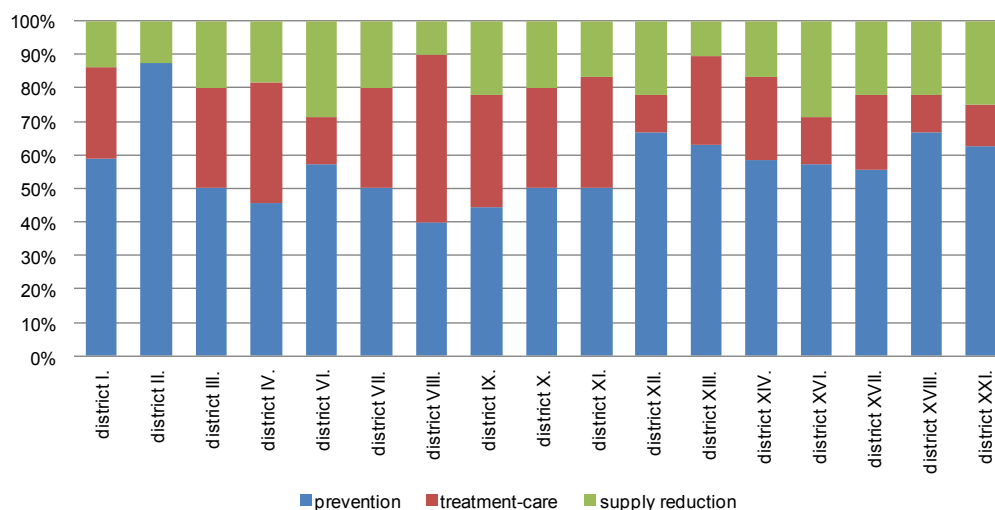
Structure and operation of district KEFs

The KEFs operating in the individual districts – despite the fact that they do not have an independent legal entity – operate according to the operational rules. Generally a person performing secretarial tasks is responsible for coordination, and this person submits the proposals of the KEF+ to the decision makers of the district. In all the operating district KEFs the coordinator's tasks are performed by an employee of the municipality or a municipal institute (mainly the family care centre).

In the individual districts the KEF members include non-governmental organisations operating drug-related services or undertaking drug-related tasks, representatives of the competent departments of the municipality, employees of the municipal institutes (e.g. Social Service Centres, schools) and their relevant divisions (family care, child welfare service providers) and a police delegate. The large number of office employees and municipal institutes may make NGOs seem underrepresented, but they bear decisive professional significance in the operation of the KEFs.

Civil society organizations perform tasks mainly in the field of prevention, and to a lesser extent in the field of treatment-care and supply reduction. Regarding service providers there is a relatively significant overlap between the districts, as during their work the individual organisations take into consideration their clients' needs rather than the district borders. Some organisations, during their activity extending over district borders, may have data in respect of other districts too (e.g. prevention programmes, harm reduction in the recreational setting, mobile NSP), which data may be important from the aspect of planning local services.

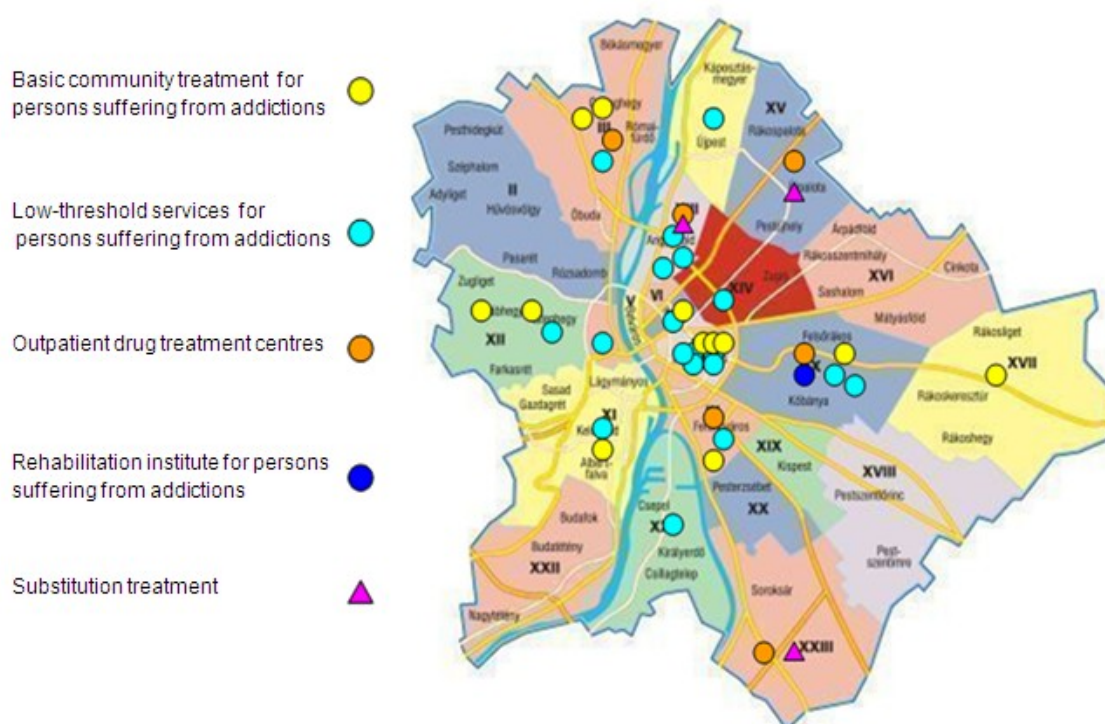
Figure 53. Breakdown of KEF members by field of activity in the individual districts (%)



Source: NCSSZI – NDI

The area of Budapest is relatively well covered with services for people suffering from addictions. Obviously the individual services are also provided for residents of other districts, and it is especially true in the case of outpatient drug treatment centres and drug therapy institutes. In the case of community type services (community care for people suffering from addictions, low-threshold services) the financier determines so-called “treatment areas” (several settlements, micro-regions). The centres of these community services are shown in the map below for the whole city of Budapest as the whole capital falls into one treatment area.

Map 5. Forms of treatment available in Budapest for people suffering from addictions, in 2011

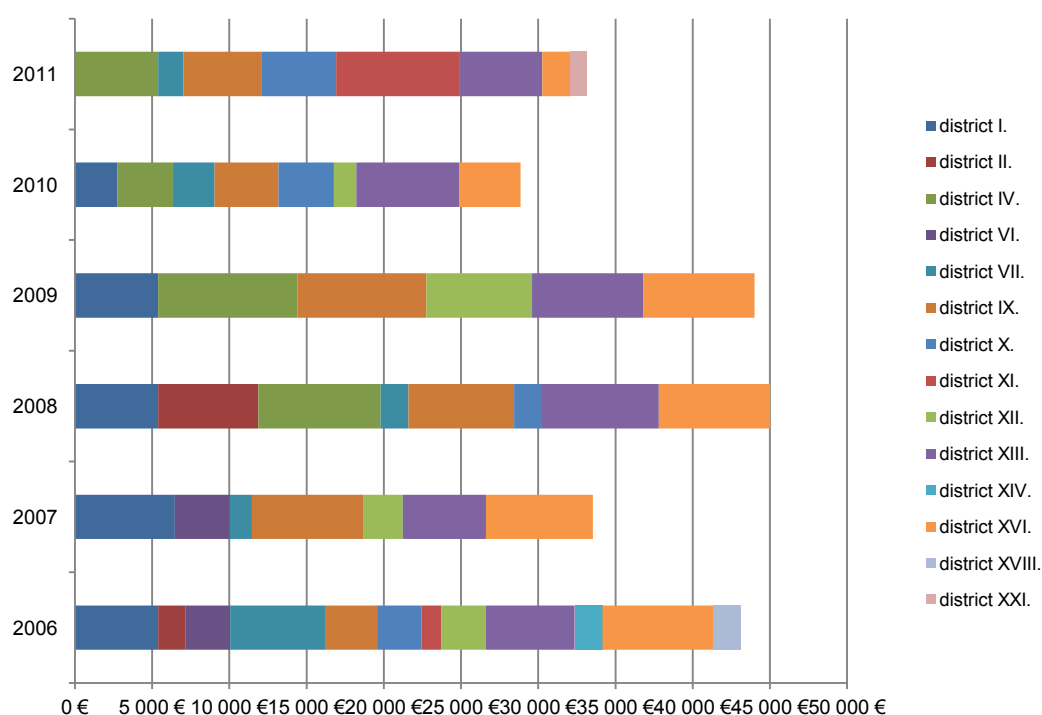


Source: NRSZH

Financing of district KEFs

The project application system of the ministry for supporting the operation of KEFs changed significantly in the past 10 years. In the initial years the main aim was to exclusively support the local coordination activity. From 2006 the project support system was significantly extended. Within the framework of the annual project, towns, districts, counties, micro-regions and regions that had a local drug strategy approved by the municipality were provided with the possibility to obtain resources for the realisation of the local strategy (for concrete projects) as well. The KEFs could use an amount between EUR 1,080¹⁵³ and EUR 1,800 from the project resources for coordination activity, and the support on top of this could be used for realising individual projects.

Figure 54. Amount of support received by district KEFs via tender applications between 2006-2011 (EUR)



Source: ESZA and NCSSZI

12.2.1. Four areas of drug policy in the capital city

Local policing strategies against open drug scenes

A survey was carried out in Budapest in July 2009 regarding open drug scenes.¹⁵⁴ (Rácz et al. 2010, for the detailed results of the survey see 2010 National Report chapter 7.1).

The phenomenon, which is clearly indicated by the presence of “drug litter” in public areas, is not only observed in district VIII. As a response to the situation, in 2011 in Budapest 4 NSPs operated street outreach programmes in 7 districts (IV, VII, VIII, X, IX, XIII, XV), in the scope of which they contacted hidden IDUs and also collected and properly disposed of litter deriving from drug use.

Besides NSPs, public area supervisors, municipalities, the civil guard, the police and other local NGOs also provided help in several cases.

¹⁵³ The amounts were calculated on the basis of the official exchange mid-rate of the EUR for 2011 (EUR 1 = HUF 277.7).

¹⁵⁴ For a detailed report on the survey see: http://demetrovics.hu/dokumentumok/Kutatasok_13_RaczJ_konyv.pdf

Interventions in recreational nightlife settings

In January 2011 three young people died at a party place called West Balkán in district VI, probably because they were suffocated by the pressure exerted by the escaping crowd after panic broke out. The victims were suspected of having used amphetamine, but later it was denied by the results of the forensic medical examinations. The tragedy received national publicity and caused an uproar both among the public and among political decision makers. Afterwards political decision makers called for more definite action, stricter use of official measures and places of entertainment were inspected more frequently. A government regulation was also issued to create safer conditions for entertainment (Government Regulation No 23/2011. (III. 8.) on increasing the safety of music and dance events, see chapter 1.2.). In line with this process several professional organisations received greater attention together with the harm reduction intervention, which, otherwise, had been performed by the organisations for several years. The tragedy gave professional organisations the opportunity to draw attention to already existing and successful practices (see chapter 3.4) through the media on several occasions, and several social consultations took place (e.g. between parents' organisations and professional organisations). The Coordination Committee on Drug Affairs also put the issue on its agenda while providers of low threshold services in recreational settings founded an association (PASSSZ) to facilitate active cooperation and information exchange between them. (For further information see chapter 3.4.)

At the same time, the majority of the managers still refuse to allow service providers to be present at the clubs. Another question is whether a potential large-scale demand for harm reduction interventions in the future could be satisfied, i.e. whether the organisations would have sufficient human and financial resources to perform all the tasks.

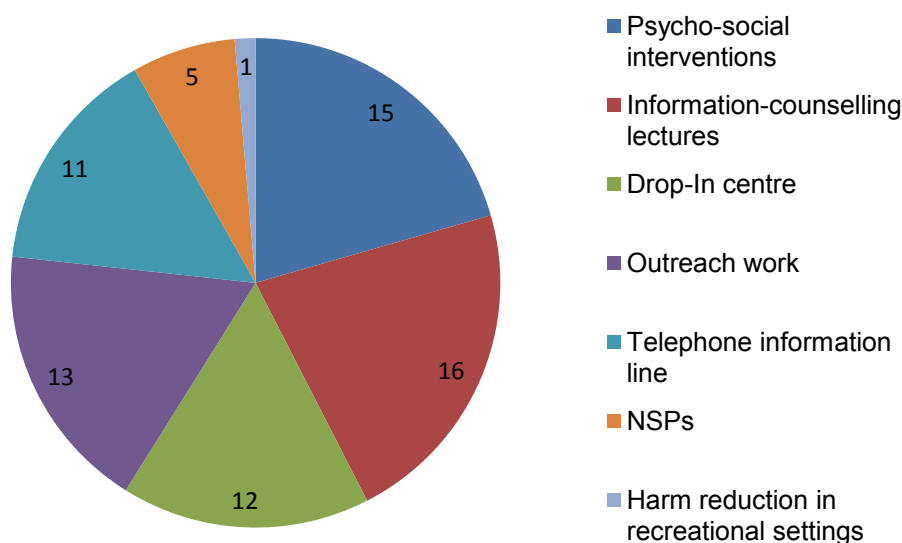
Low-threshold services for problem drug users

On the basis of Act III of 1993 on Social Administration and Social Care, as amended by Act CLXX of 2005, low-threshold services are included among the forms of community treatment for people suffering from addictions.

On the basis of Government Regulation No 191/2008. (VII.30.) on the financing of supportive services and community treatment, since 2009 the services have been maintained with the help of fixed state support available through tender applications. According to the application criteria the applying service providers must provide two of the supported low-threshold services (psycho-social interventions, informative-counselling services, outreach work, drop-in centre) compulsorily, while the so-called supplementary activities are not compulsory but they can be optionally undertaken (telephone information line, harm reduction in the recreational setting, NSPs). (For further information on the financing of low threshold services see 2011 National Report chapter 7.2.)

In Budapest 16 service providers operated between 2009 and 2011; the individual organisations operated several programme types at the same time.

Figure 55. Number of low-threshold services in Budapest in 2011, broken down by type of intervention



Source: NRSZH

In 2011 all of the NSPs (5) operated a fixed-location programme in Budapest, and the organisations also provided 1 mobile NSP and 6 street outreach programmes. The services were supplemented by a syringe vending machine in district XIII., which, however was in operation only in the first half of 2011. (For detailed data on NSPs see chapter 7.3.)

Responses to head/smart shops

In 2011 the emergence of the so-called “Amsterdam shops” and websites specialised in selling psychoactive substances not classified as illicit drugs generated great debates. Besides professional organisations, the public and the media also responded intensively to the phenomenon.

Last year there were no legal means yet to take measures against these shops and online trafficking, the shops could only be closed down via administrative measures. The notary of the municipality had to initiate the closing down of these shops, as at district level the operation licences are issued by the notary of the municipality. One shop was closed in Budapest, in district III, but not with definitive effect, which was regarded as a failure of the administrative bodies and of the municipality by the media. The situation was settled in April 2012 with the introduction of Schedule C and of the system of rules setting down the process of adding the new psychoactive substances to the schedule (see chapter 1.2.).

Conclusions

As the KEF of Budapest is currently not in operation, the districts must take greater responsibility in drug policy. At the Budapest level it is still a question whether a negotiation process will be started with the participation of the districts, in the interest of elaborating a common drug policy strategy for Budapest, and whether the FKEF, which has been established once already, can restart its operation.

Financing problems can make negotiations and the realization of action plans questionable, as in many cases the municipalities are only able to invest minimal amounts in the drug field, and drug-related costs are not labelled in their budget separately which makes transparency more difficult. At the same time, the increasingly limited budgetary resources of the KEFs call for greater municipal responsibility.

BIBLIOGRAPHY

Andrási, Z. (2012): Droghasználók és terápiás lehetőségek a fogvatartottak körében. MA thesis paper.

Arnold, P., Paksi, B. (2010): Kábítószer problémával foglalkozó civil szervezetek kapcsolatai. In: Addiktológia, 2010.4. 253-280. p.

Belügyminisztérium (2012): 2011. évi kábítószerügyi tevékenységről szóló beszámoló.

BRFK (Budapesti Rendőr-főkapitányság) (2012): A Budapesti Rendőr-főkapitányság 2011. évi drogprevenációs munkájáról szóló beszámolója.

BVOP (Büntetés-végrehajtás Országos Parancsnoksága) (2012): Éves beszámoló.

Csák, R. (2012): A 2011-ben tapasztalt új jelenségek a különböző típusú szolgáltatók megkérdezése alapján. Unpublished thesis. .

Csák, R., Gyékiss, R., Rácz, J. (2011): Dizájner drogok és szervátás a Kontakt túcsere programban. Presented at: Nemzeti Drog Fókuszpont, Túcsere szakmai találkozó. Budapest. 4. December. 2011.

Csohán, Á., Krisztalovics, K., Molnár, Zs., Dudás, M., Horváth, K., Szilágyi, A., Fogarassy, E., Lendvai, Gy., Kaszás, K., Molnárné Kozma, E. (2012): Magyarország járványügyi helyzete 2011. OEK.

Csoma, Zs., Kovács, G., Ostoros, Gy., Sótér, Sz., Strausz, J., Zsarnóczai, I. (2012): A pulmonológiai intézmények 2011. évi epidemiológiai és működési adatai. in: Korányi Bulletin 2012, 1. szám. Országos Korányi TBC és Pulmonológiai Intézet, Budapest.

Csorba, J., Pataki, Z., Klenner, Z., Dér, R. (2011): A Debreceni Befogadó Állomáson élők droghasználati mintázatai, és kapcsolataik az egészségügyi – szociális ellátórendszerekkel, kezelési igények feltárása. Study report.

Demetrovics Zs. (2011): A GHB használati mintázata és kockázatai, valamint szerepe a szexuális bűncselekményekben. KAB-KT-10-0007. Szakmai beszámoló. Unpublished thesis.

Dudás, M., Rusvai, E., Győri, Z., Tarján, A., Minárovits, J., Takács, M., Csohán, Á. (2011): A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HBV, HCV) 2011. évi prevalenciájának vizsgálata. OEK.

Dudás, M., Rusvai, E., Győri, Z., Tarján, A., Minárovits, J., Takács, M., Csohán, Á. (2012): A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HBV, HCV) 2011. évi prevalenciájának vizsgálata 5 városban. OEK.

Elekes, Zs. (2012): Droghasználat iskolában tanuló fiatalok körében – ESPAD 2011. Unpublished thesis.

EMMI (Emberi Erőforrások Minisztériuma) (2012a): Az EMMI Nemzeti Drogmegelőzési Koordinációs Osztályának 2011-es beszámolója.

EMMI (Emberi Erőforrások Minisztériuma) (2012b): Az EMMI Egészségpolitikai Főosztály 2011-es beszámolója.

EMMI (Emberi Erőforrások Minisztériuma) (2012c): Közsoktatás Fejlesztési Főosztály beszámolója kábítószerügyi éves jelentéshez.

EMMI (Emberi Erőforrások Minisztériuma) (2012d): Jelentés az Országgyűlés részére az Egészség Évtizedének Népegészségügyi Programja 2011. évi előrehaladásáról.

ENYÜBS (2012): Legfőbb Ügyészség Egységes Nyomozóhatósági és Ügyészségi Bűnügyi Statisztikai Rendszerének kábítószer-bűnözéssel kapcsolatos adatai, 2011.

Farkas, J. (2011): Hungary. Presented at: EMCDDA Trendspotter meeting, 2011. október 18-19., Lisszabon.

Fact Alkalmazott Társadalomtudományi Kutatások Intézete (2011): Egészségfejlesztés a szexmunkások körében. Study report.

Foglalkoztatási és Szociális Hivatal (FSZH) (2010): Referencia intézmények. Szakmai tanulmányok támogató szolgáltatásokról és közösségi ellátásokról. Budapest.

Horváth, I. (2012): Az addiktológiai ellátórendszer helyzetértékelése és fejlesztési irányai. NEFMI. KKB ülés.

Józan Babák (2012): A Józan Babák Klub 2011. évi beszámolója. <http://jozanbabakterhesgondozas.blogspot.hu/p/beszamolok.html> [accessed: 30.10.2012]

Kalapos, P. (2011): 3,4-metilén-dioxi-pirovaleron- (MDPV-) epidémia? In: Orvosi Hetilap. 152. évfolyam, 50. issue.

Kapitány-Fövény, M., Kertész, M., Urbán, R., Demetrovics, Zs. (2011): A mefedronhasználat jellemzői, viselkedésbeli és pszichológiai korrelátumai. Presented at: Magyar Addiktológiai Társaság VIII. Országos Kongresszusa, 24-26. November 2011, Siófok.

Kék Pont Alapítvány (2012): 2011. évi szakmai beszámoló.

KIMISZ (Közigazgatási és Igazságügyi Minisztérium Igazságügyi Szolgálat) – Pártfogó Felügyelői Szolgálat (2012): Éves összesítés a 2011. évről. <http://www.kimisz.gov.hu/data/cms28557/orszagos.eves.pdf> [accessed: 30.10.2012]

Magyar Honvédség (2012): Beszámoló a kábítószerügyi Éves jelentéshez.

Makara, M., Horváth, G., Gervain, J., Pár, A., Szalay, F., Telegdy, L., Tornai, I., Ujhelyi, E., Hunyady, B. (2012): Ajánlás a B-, a C- és a D-vírus hepatitisek diagnosztikájára és antivirális kezelésére. DOI: 10.1556/OH.2012.29338.

Mészáros, M., (2012): Egészségnevelés és - fejlesztés, szemléletformálás a börtönben. Presented at: Projektzáró előadás. 1. February 2012.

OAC (Országos Addiktológiai Centrum) (2012a): Az OSAP adatgyűjtés toxikológiai ellátási adatai, 2011.

OAC (Országos Addiktológiai Centrum) (2012b): TDI adatgyűjtés 2011.

OAC (Országos Addiktológiai Centrum) (2012c): Kábítószer-fogyasztással összefüggő halálozási adatok, 2011.

OEP (Országos Egészségbiztosítási Pénztár) (2010): Hepatitis C vírus okozta krónikus májgyulladás diagnosztikája és terápiájának finanszírozási protokollja. http://site.oep.hu/prot/A_hepatitis_C_diagnosztikajanak_es_kezelesenek_finanszirozasi_protokollja.pdf

[accessed: 30.10.2012]

Port, Á. (2012a): A kábítószeres utcai árának alakulása 2011-ben. Nemzeti Drog Fókuszpont kérdőíves adatgyűjtés.

Port, Á. (2012b): Felmérés az új pszichoaktív anyagokat árusító magyarországi internetoldalakról. EMCDDA/Nemzeti Drog Fókuszpont.

Rácz, J., Csák, R., Karátson, R., Vadász, V. (2012): A drogváltás jelensége injekciós droghasználókkal készült interjúkban. *Psychiatria Hungarica*, 27 (1) (29-47).

Rácz, J., Márványkövi, F., Melles, K., Vadász, V. (2010): Út a túléléshez – Nyílt színi droghasználat és „belövőszobák” Budapesten. L'Harmattan.

Sebestyén, E. (szerk.) (2008): Kézikönyv a Kábítószerügyi Egyeztető Fórumok számára. NDI Budapest.

Sima, Á. (2012): Orvosegyetemi hallgatók stressz-terhelésének és egészségkárosító magatartásának epidemiológiai vizsgálata. Presented at: MTA Környezet és Egészség Bizottság ülése, 22. March 2012. Budapest.

Tarján, A. (2012a): A rekreációs szintéren ártalomcsökkentő/prevenációs tevékenységet végző szervezetek 2011. évi működési és forgalmi adatai. Nemzeti Drog Fókuszpont

Tarján, A. (2012b): Tücsere programok adatai, 2010 – 2011. Nemzeti Drog Fókuszpont.

Tarján, A., Horváth, G. Cs. (2012): HCV fertőzöttség és a fertőző betegségekkel kapcsolatos kockázati magatartások a fogvatartottak körében 2010-ben. Unpublished thesis.

TASZ (Társaság a Szabadságjogokért) (2012): A Társaság a Szabadságjogokért egyesület közhasznúsági beszámolója a 2011-es évről.

http://tasz.hu/files/tasz/imce/eves_kozhasznusagi_szoveges_beszamolo.pdf

[accessed: 30.10.2012]

Tistyán, L., Szemelyácz, J., Füzesi, Zs., Kesztyüs, M., Busa, Cs. (2011): A dizájner drogok Magyarországon 2010–2011-ben. Study report.

Topolánszky, Á., Felvinczi, K., Paksi, B., Arnold, P. (2009a): A magyarországi drogterápiás intézetek működése és értékelése című kutatás elsődleges eredményei. Presented at: „Addiktológia a változó kihívások korában”. MAT VII. Országos Kongresszusa. 19-21. November 2009. Siófok. Supplementum kötet, pp. 75.

Topolánszky, Á., Felvinczi, K., Paksi, B., Arnold, P. (2009b): Drogterápiás intézetek körében végzett vizsgálat főbb megállapításai. Presented at: KEF Országos Konferencia, Budapest, 8. December 2009.

Tresó, B., Barcsay, E., Tarján, A., Horváth, G. Cs., Dencs, Á., Hettmann, A., Csépai, M., Györi, Z., Rusvai, E., Takács, M., (2011): Prevalence and Correlates of HCV, HVB, and HIV Infection among Prison Inmates and Staff, Hungary. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. doi:10.1007/s11524-011-9626-x

Váltóság Alapítvány (2012): Beszámoló. <http://www.valtosav.hu/index.html>
[accessed: 30.10.2012]

ANNEX

LIST OF TABLES

Table 1. <i>The project budget amounts announced by the Ministry of National Resources by target area in 2011</i>	13
Table 2. <i>Frequency of substance use among users in 2011 (%)</i>	16
Table 3. <i>Results of the drug screening tests conducted in 2011 in the Hungarian Army</i>	21
Table 4. <i>Prevalance of symptoms associated with the use of MDPV among the clients during intoxication and withdrawal (N=15) (persons)</i>	39
Table 5. <i>Breakdown of clients participating in detoxification and substitution treatment by the prescribed drug, in 2011 (%) (N=709)</i>	44
Table 6. <i>Breakdown of registered HIV positive persons (N) by risk groups between 2007-2011</i>	52
Table 7. <i>Breakdown of HIV, HCV, HBV infections among IDUs tested during the national prevalence survey, by gender and age group in 2011</i>	53
Table 8. <i>Breakdown of the presence of drugs (N) in urine samples originating from road accidents by active substance in 2011</i>	63
Table 9. <i>Breakdown of pregnant women (N) ever using drugs / using drugs in the last 30 days / injecting drugs in the last 30 days by drug types in 2011 (N=66 persons)</i>	64
Table 10. <i>Breakdown of direct, natural and violent drug-related deaths in 2011 (persons)</i>	64
Table 11. <i>Number of direct drug-related deaths in 2011</i>	65
Table 12. <i>Breakdown of direct drug-related deaths by age groups, in 2011 (persons)</i>	66
Table 13. <i>Breakdown of violent drug-related deaths by drug type in 2011 (persons)</i>	66
Table 14. <i>Breakdown of direct, natural and violent drug-related deaths by location discovered, in 2011 (persons)</i>	67
Table 15. <i>Syringe and client turnover data of NSPs in 2010 and 2011</i>	71
Table 16. <i>The number of distributed and returned+collected syringes per client and contact, and the number of contacts per client in 2011</i>	71
Table 17. <i>Breakdown of drug offences registered in 2011 by subject of offence and by perpetration type</i>	81
Table 18. <i>Breakdown of the number and proportion of drug offences by perpetration type and amount of substance involved, in 2011</i>	82
Table 19. <i>Breakdown of drug offenders by previous conviction in 2011</i>	84
Table 20. <i>Breakdown of offenders committing offences under the influence of drugs, in 2011</i>	86
Table 21. <i>Number and quantity of seizures in 2010 and 2011</i>	96
Table 22. <i>Price of drugs at street level in 2011 in EUR</i>	101
Table 23. <i>Emphasis on the different therapeutic techniques in the therapeutic programmes offered in drug therapy institutes, on a 5-grade scale (1=not emphatic at all; 5=very emphatic) (2009)</i>	111
Table 24. <i>Number of operating KEFs in 2011</i>	115
Table 25. <i>Number of district drug strategies broken down by year of adoption and expiry</i>	118

LIST OF FIGURES

Figure 1. <i>The process of scheduling new psychoactive substances</i>	9
Figure 2. <i>The lifetime prevalence of different types of drug use among 16-year-old pupils in 2011, by gender (%)</i>	16
Figure 3. <i>Lifetime prevalence by drugs among 16-year-old pupils in 2011 (%)</i>	17
Figure 4. <i>Change in the lifetime prevalence of illicit drug use among 16-year-old pupils between 1995-2011, by gender (%)</i>	18
Figure 5. <i>The lifetime prevalence of illicit and licit substances among 16-year-old pupils between 1995 and 2011 (%)</i>	19
Figure 6. <i>The last month prevalence of cannabis between 1995-among 16-year-old pupils, by gender (%)</i>	19
Figure 7. <i>Age at first illicit drug use as percentage of users, between 1995-2011</i>	20
Figure 8. <i>The lifetime prevalence of drug use among 16-year-old pupils between 1995-2011 according to the location of their school (%)</i>	20
Figure 9. <i>The proportion of those who regard the use of different drugs very dangerous among 16-year-old pupils between 1995-2011 (%)</i>	21
Figure 10. <i>Breakdown of NSP clients by primarily injected drug type (%), between 2009-2011</i>	30
Figure 11. <i>Distribution of NSP clients primarily injecting other drugs (N=760) by drug type (%) and broken down by age group in 2011</i>	30
Figure 12. <i>Breakdown of IDUs tested during the national HIV/HBV/HCV prevalence surveys by age group, between 2006-2011, (%)</i>	31
Figure 13. <i>Breakdown of IDUs tested during the national HIV/HBV/HCV prevalence surveys by years since first injection, between 2006-2011,(%)</i>	31
Figure 14. <i>Breakdown of IDUs tested during the national HIV/HBV/HCV prevalence surveys by primarily injected drug type, between 2006-2011, (%)</i>	32
Figure 15. <i>Breakdown of IDUs tested during the national HIV/HBV/HCV prevalence survey by primarily injected drug type, in 2011, (%)</i>	32
Figure 16. <i>Breakdown of IDUs tested in the diagnostic testing programme by age group, in 2010 and 2011(%)</i>	33
Figure 17. <i>Breakdown of IDUs tested in the diagnostic testing programme, by years since first injection, in 2010 and 2011 (%)</i>	34
Figure 18. <i>Breakdown of IDUs tested in the diagnostic testing programme by primarily injected drug type, in 2010 and 2011 (%)</i>	34
Figure 19. <i>Primary drug among all clients and among (new) clients starting treatment for the first time, participating and not participating in QCT programmes in 2011 (%)</i>	45
Figure 20. <i>Distribution of the injected substances among all IDUs between 2007 and 2011 (%)</i>	49
Figure 21. <i>The changing of the proportion of users of heroin, amphetamine and other stimulants among clients already treated before (first chart) and among clients starting treatment for the first time (second chart) (not in QCT), between 2007-2011 (%)</i>	49
Figure 22. <i>Average latency period in the case of the different drug types between 2007–2011 (years)</i>	50
Figure 23. <i>Breakdown of HCV prevalence (%) among IDUs tested during the national HIV/HBV/HCV prevalence survey, by primarily injected drug type, 2006 – 2011</i>	54
Figure 24. <i>Geographical breakdown of HCV prevalence (%) among IDUs tested in the national prevalence survey between 2006–2011</i>	55
Figure 25. <i>Breakdown of the HCV prevalence (%) among IDUs tested in the diagnostic testing programme by primarily injected drug type, in 2010 and 2011</i>	56
Figure 26. <i>The prevalence of sharing needles/syringes and sharing any injecting equipment in the past 4 weeks (%) among current IDUs, 2009-2011</i>	59
Figure 27. <i>The number of patients treated for drug intoxication at the Clinical Toxicology Department of Péterfy Sándor Street Hospital between 2007-2011 (persons)</i>	61

Figure 28. Breakdown of drugs among men treated at the Clinical Toxicology Department of Péterfy Sándor Street Hospital for drug intoxication by age group, in 2011 (N=1766) (persons)	62
Figure 29. Breakdown of drugs among women treated at the Clinical Toxicology Department of Péterfy Sándor Street Hospital for drug intoxication by age group, in 2011 (N=896) (persons)	62
Figure 30. Geographical breakdown of the syringes distributed by NSPs, in 2011 (N=648,269)	72
Figure 31. Living status of clients entering treatment between 2007-2011 (persons)	76
Figure 32. Completed school qualifications among clients entering treatment between 2007-2011 (persons)	77
Figure 33. Labour status among clients entering treatment, between 2007-2011 (persons)	77
Figure 34. Breakdown of clients entering treatment by cohabitation, between 2007-2011 (persons)	78
Figure 35. The total number of registered drug offences, and registered drug offences broken down by drug-related Criminal Code sections, between 2007-2011	80
Figure 36. Breakdown of drug offences registered in 2011 by subject of offence	81
Figure 37. Breakdown of registered drug offenders by age, between 2007 and 2011	84
Figure 38. Breakdown of procedural forms not resulting in court proceedings and formal accusations among registered drug offences between 2007-2011	85
Figure 39. The number of probation services relating to drug offences, between 2007-2011	87
Figure 40. Breakdown of amphetamine and heroin users entering treatment in prison and outside of prison by route of administration in 2011 (%)	90
Figure 41. The proportion of those who find different substances easy or very easy to obtain among 16-year-old pupils (%) between 1995-2011	93
Figure 42. Places where it would be easy to obtain herbal cannabis or cannabis resin according to 16-year-old pupils (%) in 2011	94
Figure 43. Source of acquisition of drugs among 16-year-old pupils – expressed as a percentage of all the respondents (%) in 2011	94
Figure 44. The frequency of occurrence of cathinone derivatives (number of cases) in the materials and on objects analysed, broken down by month, in 2010 and 2011	98
Figure 45. The frequency of occurrence of synthetic cannabinoid compounds (number of cases) in the materials and on objects analysed, broken down by month, in 2010 and 2011	99
Figure 46. Distribution of active substances detected on injecting equipment in 2011 (N=231)	100
Figure 47. Mean price of drugs at street level in EUR between 2009-2011	102
Figure 48. Mean active substance content (%) of drugs between 2007 and 2011	102
Figure 49. Active substance content of powders containing amphetamine, seized in user-doses between 2007-2011	103
Figure 50. Frequency (N, %) of occurrence of active substances in the tablets seized, examining the number of seizures (N=471), in 2011	104
Figure 51. Breakdown of clients entering residential treatment by age, between 2007-2011 (%)	107
Figure 52. Breakdown of clients entering residential treatment by source of referral in 2011 (%) (N=238)	110
Figure 53. Breakdown of KEF members by field of activity in the individual districts (%)	119
Figure 54. Amount of support received by district KEFs via tender applications between 2006-2011 (EUR)	120
Figure 55. Number of low-threshold services in Budapest in 2011, broken down by type of intervention	122

LIST OF MAPS

Map 1. <i>Geographical breakdown of organizations providing harm reduction services in recreational settings (N=17) in 2011</i>	26
Map 2. <i>Geographical breakdown of the number of IDUs tested and the number and percentage of HCV positive cases during the national prevalence survey by region in 2009 and 2011</i>	55
Map 3. <i>Geographical breakdown of NSP service providers (N=24) in 2011</i>	70
Map 4. <i>Breakdown of the number of drug offences by county in 2011</i>	83
Map 5. <i>Forms of treatment available in Budapest for people suffering from addictions, in 2011</i>	119

LIST OF ABBREVIATIONS

ÁSZ – Association of Harm Reduction Organisations
BRFK – Budapest Police Headquarters
BSZKI – Hungarian Institute for Forensic Sciences
BVOP – Hungarian Prison Service Headquarters
DADA – Hungarian acronym for smoking-alcohol-drugs-AIDS
DRID – Drug-related infectious diseases
DTC – drug treatment centre
ELTE PPK – Eötvös Loránd University Faculty of Education and Psychology
EMMI – Ministry of Human Resources (former NEFMI)
ENYÜBS – Uniform Criminal Statistics System of the Investigation Authority and Public Prosecution
ESPAD – European School Survey Project on Alcohol and Other Drugs
ESZA – European Social Fund
FSZH – National Employment and Social Office
IDU – Injecting drug user
ISZKI – National Institute of Forensic Medicine
KEF – Coordination Forum on Drug Affairs
FKEF – Coordination Forum on Drug Affairs of Budapest
KIMISZ – Central Office of Justice
KKB – Coordination Committee on Drug Affairs
MADÁSZSZ – Association of Hungarian Drug Prevention and Harm Reduction Organisations
MADRISZ – Association of Hungarian Drug Therapy Institutes
MAT – Hungarian Association on Addictions
NCSSZI – National Institute for Family and Social Policy
NDI – National Drug Prevention Office (former National Institute for Drug Prevention)
NEFMI – Ministry of National Resources
NPS – new psychoactive substance
NSP – Needle/syringe programme
NRSZH – National Office for Rehabilitation and Social Affairs
OAC – National Centre for Addictions
OEK – National Centre for Epidemiology
OENO – International Classification of Procedures in Medicine (ICPM)
OEP – National Health Insurance Fund
OSAP – National Statistical Data Collection Programme
OST – opioid substitution treatment

QCT – Quasi compulsory treatment

PASSSZ – Association of Harm Reduction Service Providers in the Recreational Setting

PDU – Problem Drug Use

SOTE – Semmelweis University

TÁMOP – Social Renewal Operational Programme

TASZ – Hungarian Civil Liberties Union

TB – Tuberculosis

TDI – Treatment Demand Indicator

VPVI – Chemical Analysis Institute of the Hungarian Customs and Finance Guard