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for Drugs and Drug Addiction



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“HUNGARY”

REITOX

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TABLE OF CONTENT

DRUG POLICY.....	8
T0. SUMMARY.....	8
T1. NATIONAL PROFILE.....	8
T1.1 NATIONAL DRUG STRATEGIES	8
T1.2 EVALUATION OF THE NATIONAL DRUG STRATEGIES.....	9
T1.3 DRUG POLICY COORDINATION.....	10
T1.4 DRUG RELATED PUBLIC EXPENDITURE.....	10
T3. NEW DEVELOPMENTS	11
T4. ADDITIONAL INFORMATION	11
T4.1 ADDITIONAL INFORMATION ABOUT DRUG POLICIES	11
T5. NOTES AND QUERIES.....	11
T5.1 PLANNED EVALUATIONS	11
T5.2 ESTIMATE FOR THE EUROSTAT OF THE CONTRIBUTION OF THE ILLICIT DRUG MARKET TO THE NATIONAL ACCOUNTS.....	11
T6. SOURCES AND METHODOLOGY.....	11
T6.1 SOURCES.....	12
T6.2 METHODOLOGY	12
LEGAL FRAMEWORK	13
T0. SUMMARY.....	13
T1. NATIONAL PROFILE.....	13
T1.1 LEGAL FRAMEWORK.....	13
T1.2 IMPLEMENTATION OF THE LAW	16
T2. TRENDS.....	17
T2.1 CHANGES IN THE LEGAL FRAMEWORK SINCE 2000	17
T2.2 CHANGES TO THE IMPLEMENTATION OF THE LAW SINCE 2000	18
T3. NEW DEVELOPMENTS	19
T3.1 CHANGES IN THE LEGAL FRAMEWORK IN THE LAST YEAR.....	19
T3.2 CHANGES IN THE IMPLEMENTATION OF THE LAW IN THE LAST YEAR.....	20
T3.3 EVALUATION OF LAW IN THE LAST YEAR.....	20
T4. ADDITIONAL INFORMATION	20
T5. NOTES AND QUERIES.....	20
T5.1 DEBATES ON CANNABIS LEGALISATION	20
T6. SOURCES AND METHODOLOGY.....	20
T6.1 SOURCES.....	20
T6.2 METHODOLOGY	20
DRUGS.....	21
T0. SUMMARY.....	21
T0.1 SUMMARY OF THE DRUGS WORKBOOK	21

CANNABIS	23
T1. NATIONAL PROFILE	23
T1.1 PREVALENCE AND TRENDS	23
T1.2 PATTERNS, TREATMENT AND PROBLEM/HIGH RISK USE	23
T2. TRENDS.....	25
T3. NEW DEVELOPMENTS	25
T4. ADDITIONAL INFORMATION	25
T4.1 ADDITIONAL SOURCES OF INFORMATION.....	25
T5. NOTES AND QUERIES.....	25
T6. SOURCES AND METHODOLOGY.....	25
T6.1 SOURCES.....	25
T6.2 METHODOLOGY	26
STIMULANTS	27
T1. NATIONAL PROFILE	27
T1.1 PREVALENCE AND TRENDS	27
T1.2 PATTERNS, TREATMENT AND PROBLEM/HIGH RISK USE	28
T2. TRENDS.....	33
T3. NEW DEVELOPMENTS	33
T4. ADDITIONAL INFORMATION	33
T4.1 ADDITIONAL SOURCES OF INFORMATION.....	33
T5. NOTES AND QUERIES.....	33
T6. SOURCES AND METHODOLOGY.....	34
T6.1 SOURCES.....	34
T6.2 METHODOLOGY	34
HEROIN AND OTHER OPIOIDS.....	35
T1. NATIONAL PROFILE	35
T1.1 PREVALENCE AND TRENDS	35
T2. TRENDS.....	37
T3. NEW DEVELOPMENTS	37
T4. ADDITIONAL INFORMATION	37
T4.2 FURTHER ASPECTS OF HEROIN AND OPIOID USE.....	37
T5. NOTES AND QUERIES.....	37
T6. SOURCES AND METHODOLOGY.....	38
T6.1 SOURCES.....	38
T6.2 METHODOLOGY	38
NEW PSYCHOACTIVE SUBSTANCES (NPS) AND OTHER DRUGS NOT COVERED ABOVE	39
PREVENTION.....	40
T0. SUMMARY.....	40
T1. NATIONAL PROFILE.....	40

T1.1 POLICY AND ORGANISATION.....	40
T1.2 PREVENTION INTERVENTIONS.....	43
T1.3 QUALITY ASSURANCE OF PREVENTION INTERVENTIONS	45
T2. TRENDS.....	46
T3. NEW DEVELOPMENTS	47
T4. ADDITIONAL INFORMATION	47
T5. NOTES AND QUERIES.....	47
T5.1 HAVE THERE BEEN RECENT RELEVANT CHANGES IN TOBACCO AND ALCOHOL POLICIES?	47
T5.2 HAS THERE BEEN RECENT RESEARCH ON ETIOLOGY AND/OR EFFECTIVENESS OF PREVENTION INTERVENTIONS?	48
T6. SOURCES AND METHODOLOGY	48
T6.1 SOURCES.....	48
T6.2 METHODOLOGY	48
TREATMENT	49
T0. SUMMARY.....	49
T1. NATIONAL PROFILE.....	50
T1.1 POLICIES AND COORDINATION	50
T1.2 ORGANISATION AND PROVISION OF DRUG TREATMENT.....	51
T1.3 KEY DATA.....	55
T1.4 TREATMENT MODALITIES.....	57
T1.5 QUALITY ASSURANCE OF DRUG TREATMENT SERVICES.....	59
T2. TRENDS.....	60
T2.1 LONG TERM TRENDS IN NUMBERS OF CLIENTS ENTERING TREATMENT AND IN OST	60
T3. NEW DEVELOPMENTS	63
T4. ADDITIONAL INFORMATION	63
T4.1 ADDITIONAL SOURCES OF INFORMATION.....	63
T5. NOTES AND QUERIES.....	68
T5.1 MONITORING THE MISUSE OF OPIOID SUBSTITUTION MEDICATIONS	68
T5.2 AVAILABILITY OF INTERNET-BASED TREATMENT IN HUNGARY.....	69
T5.3 SPECIFIC TREATMENT PROGRAMMES FOR NPS USERS.....	69
T6. SOURCES AND METHODOLOGY.....	69
T6.1 SOURCES.....	69
T6.2 METHODOLOGY	70
HARMS AND HARM REDUCTION.....	71
T0. SUMMARY.....	71
T1. NATIONAL PROFILE.....	72
T1.1 DRUG-RELATED DEATHS	72
T1.2 DRUG-RELATED ACUTE EMERGENCIES	74
T1.3 DRUG-RELATED INFECTIOUS DISEASES	74

T1.4 OTHER DRUG-RELATED HEALTH HARMS.....	78
T1.5 HARM REDUCTION INTERVENTIONS	79
T1.6 TARGETED INTERVENTIONS FOR OTHER DRUG-RELATED HEALTH HARMS	84
T1.7 QUALITY ASSURANCE OF HARM REDUCTION SERVICES	85
T2. TRENDS.....	85
T2.1 SHORT TERM TRENDS IN DRUG-RELATED HARMS AND HARM REDUCTION SERVICES	85
T2.2 LONG TERM TRENDS IN DRUG-RELATED HARMS AND HARM REDUCTION SERVICES	87
T3. NEW DEVELOPMENTS	89
T4. ADDITIONAL INFORMATION	89
T5. NOTES AND QUERIES.....	90
T5.1 IS THERE ANY EVIDENCE OF AN INCREASE IN ACUTE EMERGENCIES OR DEATHS RELATED TO STIMULANTS?	90
T6. SOURCES AND METHODOLOGY.....	90
T6.1 SOURCES.....	90
T6.2 METHODOLOGY	91
DRUG MARKET AND CRIME	93
T0. SUMMARY.....	93
T1. NATIONAL PROFILE.....	93
T1.1 DRUG MARKET.....	93
T1.2 DRUG RELATED CRIME	97
T1.3 DRUG SUPPLY REDUCTION ACTIVITIES.....	100
T2. TRENDS.....	101
T2.1 SHORT TERM TRENDS REGARDING THE MOST CHARACTERISTIC DRUGS ON THE MARKET	101
T2.4 DRUG LAW OFFENCES – SHORT TERM TRENDS.....	107
T2.7 CHANGES TO DRUG SUPPLY REDUCTION ACTIVITIES	108
T3. NEW DEVELOPMENTS	109
T4. ADDITIONAL INFORMATION	109
T5. NOTES AND QUERIES.....	109
T5.1 DOES THE NATIONAL FOCAL POINT HAVE ACCESS TO DESCRIPTIONS OF SUCH ACTIVITIES?	109
T6. SOURCES AND METHODOLOGY.....	109
T6.1 SOURCES.....	109
T6.2 METHODOLOGY	109
PRISON	111
T0. SUMMARY.....	111
T1. NATIONAL PROFILE.....	111
T1.1 ORGANISATION.....	111
T1.2 DRUG USE AND RELATED PROBLEMS AMONG PRISONERS	112
T1.3 DRUG-RELATED HEALTH RESPONSES IN PRISON	115

T1.4 QUALITY ASSURANCE OF DRUG-RELATED HEALTH PRISON RESPONSES	120
T2. TRENDS.....	120
T3. NEW DEVELOPMENTS	121
T4. ADDITIONAL INFORMATION	121
T5. NOTES AND QUERIES.....	121
T6. SOURCES AND METHODOLOGY.....	121
T6.1 SOURCES.....	121
T6.2 METHODOLOGY	122
BIBLIOGRAPHY	124
ANNEX	127
LIST OF TABLES.....	127
LIST OF CHARTS.....	128
LIST OF ABBREVIATIONS	130

DRUG POLICY¹

T0. SUMMARY

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

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

T1. NATIONAL PROFILE

T1.1 NATIONAL DRUG STRATEGIES

T1.1.1 The current national drug strategy

Preparations for the strategy document were started in 2011 with the involvement of the National Drug Prevention Office (NDI) and recognised Hungarian experts. After social and public administration consultations, the National Assembly approved National Assembly Decision 80/2013. (X.16.) with the title National Anti-drug Strategy 2013–2020, Clear consciousness, sobriety, and fight against drug crime. The National Anti-drug Strategy determines targets for the period between 2013 and 2020. Besides recognising the necessity of handling the personal and social risks and damage in connection with drug use, its main objective is the reduction of the use of illicit substances with the help of targeted, community-based interventions. The National Anti-drug Strategy desires to achieve this objective through wide-ranging prevention activities, by strengthening a recovery-oriented attitude and reintegration in the field of the care and treatment of drug addicts, by the more effective application of crime-prevention and crime-fighting interventions in the field of supply-reduction, and through strict action against trafficking.

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

The Policy Programme is in the process of being drawn up so that the current National Anti-drug Strategy can be implemented.

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

T1.2 EVALUATION OF THE NATIONAL DRUG STRATEGIES

T1.2.1 Evaluation of strategies and action plans

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

T1.2.2 Summary of the latest evaluation

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

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

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

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

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

The interviews also included some questions about the functioning of the KKB. Interviewees mentioned as strong points the inclusiveness of KKB, bringing together all relevant stakeholders, and its role in facilitating the flow and exchange of information to all stakeholders. There have been critical remarks that neither has the KKB the mandate to coordinate drug policy, nor are there clear-cut procedures for having results of KKB discussions endorsed as formal policy decisions.

T1.3 DRUG POLICY COORDINATION

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

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

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

Tasks related to the prevention and handling of the drug problem are carried out by the ministry's background institution, the NDI was operating as a unit of the National Institute for Family and Social Policy until September, 2015. The Office has recently been reorganised under the National Office for Rehabilitation and Social Affairs (NRSZH).

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

There are almost 90 KEFs operating in Hungary, with town, district, small-region, county or regional competence. Their task is to harmonise the work of the institutions of the four basic pillars of combating the drug problem – the community and collaboration, prevention, treatment and rehabilitation, and supply reduction. The members of the KEFs are representatives of state, local authority, civil and church organisations that play an important role in handling the drug problem (EMMI 2015a).

T1.4 DRUG RELATED PUBLIC EXPENDITURE

T1.4.1 Availability of data on drug related public expenditure

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

T1.4.2 Data on drug related public expenditure

The first comprehensive Hungarian survey (Hajnal 2009) examining the changing of drug-related public expenditure over time between 2000 and 2007, in four studied years was made at the end of 2008. (For more information see the 2009 National Report, Chapter 1.3.)

The study based on the results of an estimation procedure is a calculation of the proportion of public spending on drug affairs in the given organisational or activity system.

On the basis of the study data it can be shown that items related to criminal justice formed 2/3 to 3/4 of all spending in the entire examined period, and that no great change took place in the structure of this spending. Other spending is linked to the following areas, in order: treatment, prevention and research and harm reduction. According to the estimate the total amount of public spending in the base year was EUR 17.3 million², which almost doubled by the last study year of 2007.

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

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2014, is presented as part of the baseline information in T1.

T4. ADDITIONAL INFORMATION

T4.1 ADDITIONAL INFORMATION ABOUT DRUG POLICIES

A detailed description of the Budapest drug policy can be found in the 2012 National Report, Chapter 12 under the title: Drug policy of large European cities.

T5. NOTES AND QUERIES

T5.1 PLANNED EVALUATIONS

The ministry headed by the minister responsible for drug prevention and drug affairs coordination tasks is to draw up an interim report in 2016 on the implementation of the strategy. In its decision 80/2013. (X. 16.), half way through the implementation of the National Anti-drug Strategy, the National Assembly called upon the Government to inform it about the implementation of the National Anti-drug Strategy, about the review of the institution system and about its efficiency.

T5.2 ESTIMATE FOR THE EUROSTAT OF THE CONTRIBUTION OF THE ILLICIT DRUG MARKET TO THE NATIONAL ACCOUNTS

No such estimation was carried out.

T6. SOURCES AND METHODOLOGY

² Calculated using the EUR intermediate exchange rate valid for 2014 (EUR 1=HUF 308.51).

T6.1 SOURCES

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Hajnal, Gy. (2009): A kábítószerrel kapcsolatos költségvetési kiadások alakulása 2000 és 2007 között. In: Drogpolitika számokban. Felvinczi, K., Nyírády, A. (szerk.) pp. 375-409. L'Harmattan, Budapest.

T6.2 METHODOLOGY

Not applicable.

LEGAL FRAMEWORK³

T0. SUMMARY

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

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

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

T1. NATIONAL PROFILE

T1.1 LEGAL FRAMEWORK

T1.1.1 Characteristics of drug legislation

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

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

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

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

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

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

³ Author of the chapter: Orsolya Varga

treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service' then he/she may not be punished. The QCT may be initiated either in the prosecution or the court phase of the criminal proceedings. The possibility of QCT is not available for those persons who undertook QCT in the two years previous to the perpetration of the offence or whose criminal liability has been determined in a drug trafficking or drug possession case.

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

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

- a) the substances specified in the Schedules I and II of the Single Convention on Narcotic Drugs signed in New York on 30 March 1961 ratified by law decree no 4 of 1965, amended and supplemented by the Protocol of 25 March 1972 in Geneva on the amendment of the Single Convention on Narcotic Drugs ratified by law decree no 17 of 1988,
- b) the dangerous psychotropic substances specified in Schedule I and II of the convention signed in Vienna on 21 February 1971 on psychotropic substances, ratified by law decree no 25 of 1979 and
- c) the psychotropic substances specified in the annex of the Act XXV of 1998 on Medicines for human use.

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

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

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

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

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

T1.1.3 Control of new psychoactive substances

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

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

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

The individual compounds included in the schedule of new psychoactive substances must be subjected to a risk assessment within one year of their inclusion in the schedule. Depending on the result of the risk assessment, the compound must be transferred to the list of psychotropic substances (one of the schedules of Act XXV of 1998) or to Schedule D of the Government Decree. If there is insufficient data available to complete the above risk assessment according to the findings of the expert body, the classification of the new psychoactive substance may be extended for a further year. This risk assessment obligation is not applicable for compound groups, which remain in the schedule of new psychoactive substances until at least one of the substances in the group complies with the conditions for the preliminary assessment. Activities defined by the relevant legislation in connection with new psychoactive substances may only be performed in possession of a permit issued by the state administration body for health.

The Btk. contains a section entitled “Misuse of New Psychoactive Substances” (Art. 184, 184/A-D), which follows the structure of the previous articles, but regulates the offences related to new psychoactive substances with more lenient punishments. The aggravated cases of the new regulation are essentially the same as those relating to illicit drugs, however, it does not include perpetrations with a substantial quantity. The lenient cases relate to perpetration with a small amount, the upper limit of which is 10 grams with respect to the total amount of the given substance. The punishable acts also include acquisition and possession of new psychoactive substances as long as the amount exceeds the small amount. It was not the purpose of the legislators to establish the criminal liability of users of new psychoactive substances, therefore consumption is not punishable, nor is acquisition and possession of a small amount.

T1.2 IMPLEMENTATION OF THE LAW

T1.2.1 Sentencing practice

As a proportion of the illicit drug cases in process in 2014 fell under the force of the old Btk. and the rest of them under the new Btk. in force (see T.1.1.1), the Public Prosecutor's Office provided the data relating to 2014 on the basis of the two different structures of the old Btk. and the Btk. in force. (VIR 2015)

In 2014 1409 persons were sentenced according to the old Btk. due to drug-related offences according to the following articles:

- Article 282: 1085 persons (use-related offences)
- Article 282/A: 209 persons (trafficking-related offences)
- Article 282/B: 23 persons (use-related offences)
- Article 282/C: 74 persons (drug-addicts committing use- or trafficking-related offences)
- Article 283/A: 0 person (misuse of precursors)
- Article 283/B: 18 persons (trafficking type offences related to new psychoactive substances)

1215 persons were sentenced in criminal procedures started in 2014 according to the Btk. in force according to the following articles:

- Drug trafficking
 - Article 176: 218 persons
 - Article 177: 18 persons
- Possession of illicit drugs
 - Article 178: 949 persons
 - Article 179: 2 persons
- Inciting substance abuse: Article 181: 25 persons
- Aiding the manufacture of illicit drugs: Article 182: 2 persons
- Criminal offences with drug precursors: Article 183: 1 person

In 2014 the following punishments and measures were imposed on the 2624 persons convicted with a final judgement:

- 470 were sentenced to executable imprisonment
- 608 were sentenced to suspended imprisonment
- 619 were sentenced to community work
- 512 were fined (including suspended fines)
- 23 were reprimanded
- 418 were put on probation

T1.2.2 Sentencing practice – new psychoactive substances

In 2014 61 persons were sentenced related to the offence of misuse of new psychoactive substances, according to the following articles:

- Trafficking type:
 - Article 184: 52 persons
 - Article 184/A: 6 persons
- Possession type:
 - Article 184/B: 3 persons
 - Article 184/C: 0 person

In 2014 the following punishments and measures were imposed regarding misuse of new psychoactive substances on the persons convicted with a final judgement:

- 8 were sentenced to executable imprisonment
- 10 were sentenced to suspended imprisonment
- 11 were sentenced to community work
- 19 were fined (including suspended fines)
- 0 were reprimanded
- 15 were put on probation

T2. TRENDS

T2.1 CHANGES IN THE LEGAL FRAMEWORK SINCE 2000

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

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

The old Btk. also contained the cases and conditions of QCT. The most significant change as compared to the previous legislation was that drug addiction was no longer a condition for using QCT. With respect to persons, any category of users (occasional, regular, addict) had the opportunity to take advantage of QCT (with more favourable regulations for drug addicts).⁴ Non-addict perpetrators only had the possibility for QCT if the amount of drug was not more than the 'small amount' of the given drug. With respect to criminal acts, QCT were typically available in the case of - less serious - use-related offences. However, two trafficking-type behaviours represented an exception, 'offer' and 'hand over', because if the offered and handed over illicit drug was of a small amount, and the act in question took place 'on the occasion of joint drug consumption', the perpetrator of the aforementioned two acts might have also taken advantage of the opportunity of QCT. It was a condition in all cases of QCT that 'the perpetrator is able to present a document before being sentenced in the first instance that verifies that he/she has participated for at least six consecutive months in treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service'. The QCT might have been initiated either in the prosecution or the court phase of the criminal procedure. The wide application of QCT presented in the above text was declared to be unconstitutional by Constitutional Court decision no 54/2004. (XII. 13.), which decision caused the amendment of several points of the old Btk. (Be. Art. 188(1)h); Art. 222(2)). (For details see Chapter 1.1. of the 2005 National Report)

Act LI of 2006 on the amendment of Be. entered into force on 1 July 2006, with the exception of Article 285(2) and (3). The two years following the enactment of the Be. revealed legislative deficiencies and practical demands that required mainly technical amendments to

⁴ As Art. 283(1)e) and f) of the old Btk. is more lenient', for example, a drug addict may also take advantage of QCT if he/she "produces, manufactures, acquires or possesses illicit drugs for own consumption" exceeding the small quantity' but not reaching the significant quantity'.

the law and a number of conceptual changes. According to the amendment, if the suspected drug user had voluntarily participated in treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service, and this can result in exemption of culpability, it is not necessary for the investigating authority to send the investigation documentation to the public prosecutor with a recommendation that the suspected be formally accused or for the public prosecutor to make a decision on postponing formal accusation on the basis of article 222(2) of the Be. Therefore, if the suspected drug user subjected him/herself to any of the treatment forms serving as an QCT and this was still in process when the investigation documents were presented, the investigation must have been suspended.

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

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

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

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

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

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

T3. NEW DEVELOPMENTS

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

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

The regulatory document subjected to amendments ⁵	The amended regulatory document (current version)		
Title	Title	Summary of changes	Remarks
Act CLXXXVI of 2013 amended Act C of 2012	Act C of 2012 on the Criminal Code (Btk.)	Amendment of the offence 'Misuse of new psychoactive substances' (Art. 184 and 184/A-D) following the schema of the other drug offences. In force since 1 January 2014.	
	Government Decree 66/2012 On the activities that may be performed with illicit drugs, psychotropic substances and with new psychoactive substances, as well as on the scheduling of these substances and the amendment of the schedules	The Government Decree was amended on three occasions in 2014: a total of 19 new compounds were placed on the list of new psychoactive substances. See T1.1.3	
Government Decree 367/2014. (XII. 30.)	Ministry of Human Capacities Decree 55/2014. (XII. 30.) EMMI On substances or compound groups classified as new psychoactive substances	The schedule of new psychoactive substances was transferred from Schedule C of Government Decree 66/2012. (IV.2.) to Schedule 1 of Ministry of Human Capacities Decree 55/2014. (XII. 30.) EMMI	
Act CXI of 2014 (XII. 16.)	Amendment of Act XXV of 1998	After the risk assessment of certain new psychoactive substances, 42 substances classified until now as new psychoactive substances were reclassified as illicit drugs: into Schedule A) of Act XXV of 1998.	
Government Decree 19/2015. (II. 16.)	Government Decree 162/2003. (X. 16.) On the rules of production, distribution	Amendment to the definition of poppy straw: poppy head with the stem part harvested	

⁵ Texts and hyperlinks of the documents subjected to amendments are not available.

	and use of plants suitable for the production of illicit drugs	when fully mature not including the poppy seeds.	
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T.3.2 CHANGES IN THE IMPLEMENTATION OF THE LAW IN THE LAST YEAR

No information.

T3.3 EVALUATION OF LAW IN THE LAST YEAR

No information available.

T4. ADDITIONAL INFORMATION

No information available.

T5. NOTES AND QUERIES

T5.1 DEBATES ON CANNABIS LEGALISATION

No information available.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

EMMI (Emberi Erőforrások Minisztériuma) (2015a): Az EMMI Szociális és Gyermekjóléti Szolgáltatások Főosztályának beszámolója.

FM (Földművelésügyi Minisztérium) (2015): A Földművelésügyi Minisztérium beszámolója.

VIR (Legfőbb Ügyészség Vádképviselési Informatikai Rendszer) (2015): Legfőbb Ügyészség Vádképviselési Informatikai Rendszer adatai 2014.

T6.2 METHODOLOGY

Not applicable.

DRUGS⁶

T0. SUMMARY

T0.1 SUMMARY OF THE DRUGS WORKBOOK

T0.1.1 The main illicit drugs and polydrug use

a) With respect to the adult population, nearly every tenth person has used an illicit drug. According to the results of surveys, the drugs most frequently consumed were cannabis, ecstasy and amphetamine. However, according to the most recent data from 2013, synthetic cannabinoids have become the second most popular substance in just a small amount of time, and the popularity of the new psychoactive substances (hereinafter NPS) has approached that of amphetamine.

Every fifth pupil has tried an illicit drug. Cannabis is the most popular in this age group also, but misuse of medicines and consuming medicines with alcohol has also become widespread, also the use of inhalants has seen a steep rise in the last decade. Lifetime prevalence of substance use by pupils in Hungary increased four times between 1995 and 2003, then dropped a little in 2007, but the data recorded in 2011 showed a further significant increase in the lifetime prevalence of the consumption of all illicit drugs. The significant difference between boys and girls started to diminish in the middle of the 2000s, and by 2011 this figure was no longer significant.

The substance most frequently mentioned as the reason for addiction treatment in Hungary was cannabis, the proportion of its users entering treatment as an alternative to criminal procedure is especially high (60% of all persons treated). The second most characteristic substance use problem mentioned as the reason for treatment is stimulant use. Although treatment data mentions it only indirectly, other sources more directly confirm that treatment for the use of synthetic cannabinoids and synthetic cathinones is also becoming characteristic, which in terms of its extent is now competing with the treatment demand relating to classical illicit drugs (for more information see: Cannabis, Chapter T1.2.3).

b) A total of 108 new psychoactive substances have been identified in Hungary since 2010, with 42 being identified in 2014. Apart from cannabis, recreational drug use patterns include synthetic cannabinoids, designer stimulants: primarily cathinones and new amphetamine derivatives.

The group of cannabinoids is characterised by fast and continual change, about every six months a new group of these substances appears, first of all JWHs, and most recently substances in the FUBINACA, PINACA and CHMINACA groups have become widespread.

Among stimulants, a number of substances, if only relatively, are now more dominant on the market: in 2010 it was mephedrone, in 2011 MDPV and from 2012 pentedrone. From 2014 beside pentedrone alpha-PVP achieved a notable market share according to seizure data.

Accordingly, the number of treatment demands due to designer drugs – cannabinoids and stimulants – also increased. According to treatment data, the use of these substances is more intensive and the age of users has also dropped. Apart from treatment data, several studies have shown that a treatment demand develops sooner in the case of the use of designer drugs. Apart from addiction problems, according to reports, the number of those requiring emergency/clinical toxicology and psychiatric treatment has increased in the past years (for more information see: 2014 National Report, Chapter 4.4.).

⁶ Authors of the chapter: Gergely Csaba Horváth, Adrienn Nyírády, Anna Péterfi, Anna Tarján

Injecting drug use has also changed. While before 2010 half of the clients of needle/syringe programmes (NSPs) injected heroin the other half injected amphetamine, by 2014 68% of them injected a new psychoactive substance. On the basis of the data, shifting to NPS can be seen in both the heroin and amphetamine user groups. According to client reports, the effect of the new substances lasts for a shorter amount of time, so they inject them more frequently (for more information see: Stimulants, Chapter T1.2.1).

CANNABIS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 Cannabis use in the general population

The last, international standard-compliant survey was carried out in 2007, its results are now out of date and we will refrain from any discussion of its numerical findings (see 2008 National Report, Chapter 2.1.). Nevertheless, it must be noted that all the national surveys carried out to date uniformly show that cannabis is the most popular illicit drug in the Hungarian adult population, as well as in the entire population and among young adults, with respect to lifetime, last year and last month prevalence as well.

T1.1.2 Cannabis use in schools and other sub-populations

According to the results of the last ESPAD survey carried out in 2011 (for details see 2012 National Report, Chapter 2.3.) similarly to the adult population, cannabis is also the most frequently used illicit drug among secondary school students on the basis of lifetime prevalence rates (19.4%).

According to the results of the HBSC survey carried out in 2014 (Arnold and Németh 2015), 18.7% of students in grades 9 and 11 had already used cannabis. The large majority of students trying cannabis first used it after the age of 14 years, with the largest proportion of them – nearly a half – doing so at the age of 16 or above, and one quarter of them first consumed cannabis in their lives at the age of 15. Boys and older individuals are significantly more affected from the point of view of cannabis use: 23.3% of those studying in the 11th grade had tried herbal cannabis or hashish, while this figure in the 9th grade was 14.3%. The previously more significant gender difference is now disappearing, as it is just possible to show the difference between the lifetime prevalence rates of boys and girls ($p=0.48$): 19.9% of boys and 17.6% of girls had already used cannabis in their lives.

Cannabis lifetime prevalence has a significant connection to region: the highest prevalence rates were in Central Transdanubia (23.2%), in second place was the Southern Great Plain (21.6%), in third place Central Hungary (20.9%), and the least affected was the Northern Great Plain (12%). There was no significant relationship between place of residence and cannabis lifetime prevalence, however, there was a significant connection between cannabis and the type of settlement where the school is located. The highest prevalence rate was observed in villages (27.4%)⁷, Budapest was in second place (21%), and the lowest value was measured by the survey in towns (16.3%). Similarly to previous years, students in grades 9 and 11 studying in secondary modern schools and vocational schools were more markedly affected (24.1%) with respect to cannabis use as compared to students studying in grammar schools (17.7%).

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

T.1.2.2 Treatment for cannabis

⁷ This figure should be treated with care due to the small sample size.

In Hungary, cannabis use is the leading cause of entering treatment for illicit drug use (see Treatment Workbook, Chapter T1.3.1. and T2.1). In 2014 55.5% of those starting treatment reported cannabis as their primary substance (TDI data collection 2015). The proportion of cannabis users is characteristically higher among those starting treatment as an alternative to criminal procedure: in 2014 68.6% of them started treatment due to cannabis (while this figure was 36.4% in the case of those starting treatment not as an alternative to criminal procedure).

91.7% of those entering treatment because of cannabis were men, their mean age was 25.7 years and had used cannabis for an average of 7.7 years before starting treatment in 2014. Before treatment the typical route of administration was smoking (95.9%), and 30.4% of them had consumed the substance 2-6 days a week or daily.

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

The Hungarian language online self-help programme⁸ of the Kék Pont Alapítvány targets problem cannabis users, it provides a therapy accessible on the Internet for this user group⁹. (For more information see 2011 National Report, Chapter 5.2.)

T1.2.4 Synthetic cannabinoids

An omnibus survey was carried out in 2013 among the adult population (for details see 2014 National Report, Chapter 2.2). Synthetic cannabis first appeared among the substance types asked in this survey. On the basis of lifetime prevalence, it proved to be the second most frequently used illicit drug.

Most of the participants at the annual NSP expert meeting (HNFP 2015) highlighted the intensive use of synthetic cannabinoids (street name: 'herbal') among IDUs. According to service providers, there are users who periodically switch over to smoking 'herbal', while most of them use synthetic cannabinoids beside the injected substances. The organisations also pointed out the symptoms related to its use, for example, aggression, hysteria, intense hallucinations, and other psychotic symptoms.

According to the report on 2014 issued by a Budapest-based NSP (Tarján 2015b), certain number of their clients inject a substance called 'bio', which, according to what they say, is a synthetic cannabinoid, in other words, the substance that is sprayed onto the plant carrier when making 'herbal'.

In the TDI data collection, the service providers sometimes report users of synthetic cannabinoids as cannabis users, hence there is no way of differentiating the two user groups in this data collection. The results of a study carried out in 2015 among drug treatment units (Péterfi 2015) show that beside cannabis synthetic cannabinoids represent the second greatest problem among treated drug users. (For more information see Chapter T4.1, Treatment Workbook, Chapter T4.1 and T6.2.)

⁸ The site operated by the Jellinek Foundation, knowcannabis.org.uk was used as a basis when developing the website.

⁹ Source: http://kekpont.blog.hu/2010/06/02/titule_1561746 (06.06.2011)

T2. TRENDS

Presented in Chapter T1.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2014, is presented as part of the baseline information in Chapter T1.

T4. ADDITIONAL INFORMATION

T4.1 ADDITIONAL SOURCES OF INFORMATION

A national survey was carried out in 2013 among the school population with the title 'School Health Development and Universal Drug Prevention' (Grezsá and Surányi 2014). According to the results of the survey, 5.5% of the sample had already consumed cannabis in their lives. An insignificant proportion of elementary school children had tried this substance, 0.3%, but 11.6% of secondary school students had tried it. 7.1% of students in grade 9 of secondary school¹⁰ had already tried cannabis, and the lifetime prevalence among the older students in the 11th grade¹¹ was double this figure at 14.9%. According to the survey cannabis use is most widespread among boys, living in Budapest or county seats, and studying in secondary modern or vocational schools. The survey also examined use of the substance according to a regional breakdown, from which it was determined that trying cannabis is most characteristic in Budapest and South Transdanubia.

The information derived from the treatment data is supplemented by the Hungarian National Focal Point's treatment facility survey (Péterfi 2015), on the basis of which, according to the estimate of the service providers reporting 74% of the TDI data, the problem that was the most characteristic reason for treatment following cannabis (31%) was the use of synthetic cannabinoids (26%).

T5. NOTES AND QUERIES

Not applicable.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

Arnold P., Németh Á. (2015): Serdülők tiltott szer használata a HBSC 2014 adatok tükrében. Unpublished thesis.

¹⁰ 15 years old

¹¹ 17 years old

Grezsza, F., Surányi, Zs. (2014): Fiatalok szerhasználata, Nemzeti Család és Szociálpolitikai Intézet.

HNFP (2015): Tűcsere szolgáltatók országos szakmai találkozója

Péterfi, A. (2015): Kezelőhely vizsgálat 2015. Nemzeti Drog Fókuszpont. Unpublished thesis.

Tarján, A. (2015b): Tűcsere programok adatai, 2014. Nemzeti Drog Fókuszpont.

T6.2 METHODOLOGY

Substance Use of Young People (Grezsza and Surányi 2014): The booklet entitled 'Substance Use of Young People' publishes the results of the survey performed in the scope of the TÁMOP-7.2.1-11/K-2012-0004 project entitled "School Health Development and Universal Drug Prevention". The survey was performed by the National Institute for Family and Social Policy (study head: Dr Ferenc Grezsza), the data were recorded during April-May 2013. 6154 persons took part in the study from grades 1, 3, 5, 7, 9 and 11 in all school types. The distribution of the regions, genders and age groups was nearly the same. The self-administered questionnaire contained 395 questions in 10 different topics.

HBSC 2014: The data was recorded in spring 2014 from a nationally representative sample, with consideration to international standards. The survey extends to students studying in grades 5, 7, 9 and 11. The sample was set up using stratified sampling according to school grade, county, settlement type, type of training and maintainer. The net sample included 6153 persons. The data were collected via self-administered, anonymous questionnaires completed in class groups with passive consent and ethics committee approval. The survey was financed by the National Institute of Child Health. The survey examines substance use among students in grades 9 and 11 (N=3509). The students in grade 9 are 15.9 years old on average, and those in grade 11 are an average of 18 years old.

Needle/syringe programme (NSP) data collection: see Stimulants, Chapter T6.2

TDI data collection 2015: see Treatment Workbook, Chapter T6.2

Treatment facility survey 2015: see Treatment Workbook, Chapter T6.2

STIMULANTS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 The relative importance of different stimulant drugs

We also have information about the perceived availability of stimulants among secondary school students from the ESPAD surveys. In 2011 one fifth of the students found it easy or very easy to acquire ecstasy and amphetamine. The majority of them reported friends as the actual method of acquiring the illicit drugs. (For more details see the 2012 National Report, Chapter 10.2.)

In the case of cocaine, during its supply-reduction activity the Police experienced a clear, strong growth over the past years, both on the user and distributor sides. With respect to synthetic materials it may be said that ecstasy had almost completely disappeared from the Hungarian and European markets in 2009, and only reappeared on the domestic market in 2012. Methamphetamine is still unusual, however, according to police investigation information, it is appearing on the supply side more frequently in the northern part of the country (from consignments smuggled from Slovakia).

T1.1.2 Stimulant use in the general population

In 2007 stimulants formed the second most popular substance group among the adult population. A breakdown according to substance type shows that ecstasy was the second most frequently used drug, amphetamines came third and cocaine was the fifth most popular. (See 2008 National Report, Chapter 2.1)

According to the 2013 omnibus survey, stimulants were then the third most frequently used illicit drugs, as by then synthetic substances had become more popular and it was this survey that first asked about them. According to substance type, ecstasy was in third place, amphetamine in fourth and cocaine in seventh according to lifetime prevalence rates. (See 2014 National Report, Chapter 2.2)

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

In the latest 2011 ESPAD survey, on the basis of the lifetime prevalence rates amphetamine was in sixth place (5.4%), ecstasy in eighth place (4.4%), and cocaine in eleventh place (2.5%) in the substance use structure. (For more information see 2012 National Report, Chapter 2.2)

According to the results of the HBSC survey carried out in 2014 (Arnold and Németh 2015), 5.8%¹² of students in grades 9 and 11 had already tried one of the examined stimulants.¹³ Significantly higher prevalence rates could be observed among boys (6.8%) and among those in the higher school grade (grade 11: 6.8%) as compared to the girls (5.0%) and those in the lower school grade (4.9%).

¹² This data should be treated with care due to the low number of those trying stimulants.

¹³ Amphetamines, ecstasy, MDMA, cocaine. (Cocaine was indicated among other drugs, the survey did not ask about it separately.)

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

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

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

T1.2.1 Injecting drug use

With regard to the primarily injected substance, it can be said that while in the past it was heroin and then heroin and amphetamine that were the typically injected substances, today the most popular substances are designer stimulants (primarily synthetic cathinones). This pattern change can be observed in the data of several routine data collections.

Needle/syringe programmes' (NSP) client data

On the basis of NSP data (Tarján 2015b), the appearance of new psychoactive substances (NPS) in 2010 completely transformed the structure of injecting drug use patterns characteristic of the previous years: While in 2009 fewer than 44%¹⁴ of IDUs attending NSPs primarily injected stimulants, this proportion had risen to 86% by 2014.

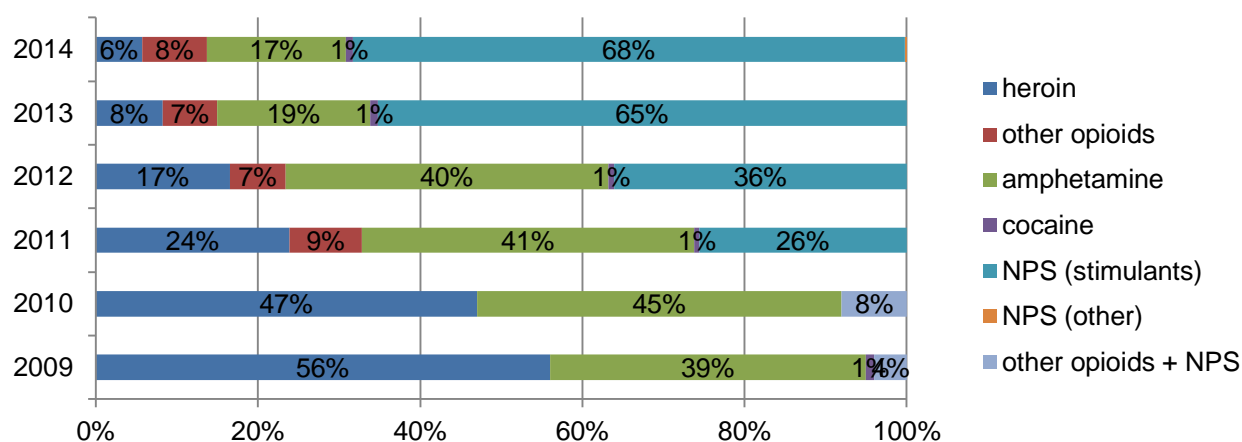
The proportion of those injecting classical stimulants, mainly amphetamine, was around 40% between 2009-2012, however, by 2013 this figure had dropped to 19% and remained at this level in 2014 (17%). The proportion of those injecting cocaine is negligible among IDUs attending NSPs.

The increase of NPS (mainly synthetic cathinones) injecting pushed out heroin from 2010 and then even amphetamine from 2013: While in 2010 fewer than 8%¹⁵ of NSP clients used designer stimulants, in 2014 this was the primarily injected substance for 68% of them.

¹⁴ The 4% for 2009 and the 8% for 2010 visible on the chart in the 'other opioids + NPS' category include both other stimulants and other opioids together. Therefore, the proportion of those injecting primarily other stimulants was probably even lower in these two years.

¹⁵ The 4% for 2009 and the 8% for 2010 visible on the chart in the 'other opioids + NPS' category include both other stimulants and other opioids together. Therefore, the proportion of those injecting primarily other stimulants was probably even lower in these two years.

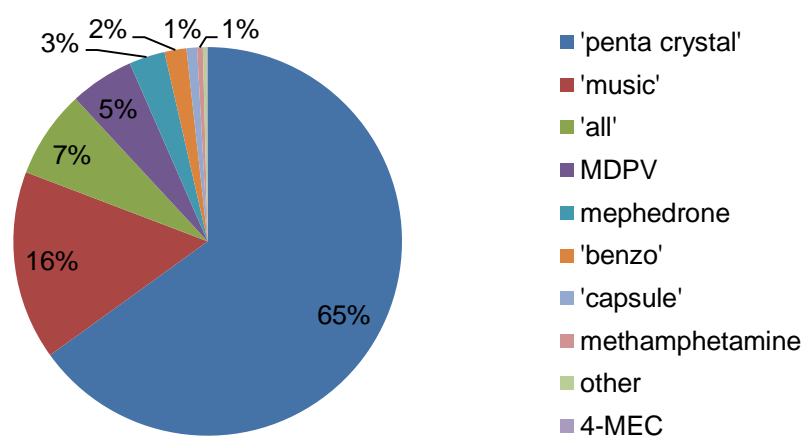
Chart 1. Breakdown of NSP clients by primarily injected drug between 2009-2014¹⁶



Source: Tarján 2015b

In 2010 the dominant injected designer stimulant was mephedrone, in 2011 it was MDPV, and since 2012 the substance with the street name 'penta crystal'¹⁷ has been in first place. Among designer stimulants, the use of 'penta crystal' decreased slightly in 2014 as compared to previous years; in spite of this it is still the most widespread designer stimulant. The substance with the street name 'music'¹⁸ had only just appeared in 2013, but by 2014 it had become the second most frequently injected NPS.

Chart 2. Breakdown of NSP clients injecting designer stimulants by primarily injected drug type in 2014 (N=2515 persons)¹⁹



Source: Tarján 2015b

Characteristics of IDUs participating in the national HIV/HCV seroprevalence survey

¹⁶ Before 2011 the service providers reported data in 4 closed categories: heroin; amphetamine; cocaine, other. From 2011 the 'other' category became an open-ended question, since then the substances categorized into that group could be named. As a consequence the 4% for 2009 and the 8% for 2010 visible on the chart in the 'other opioids + NPS' category include both other stimulants and other opioids together.

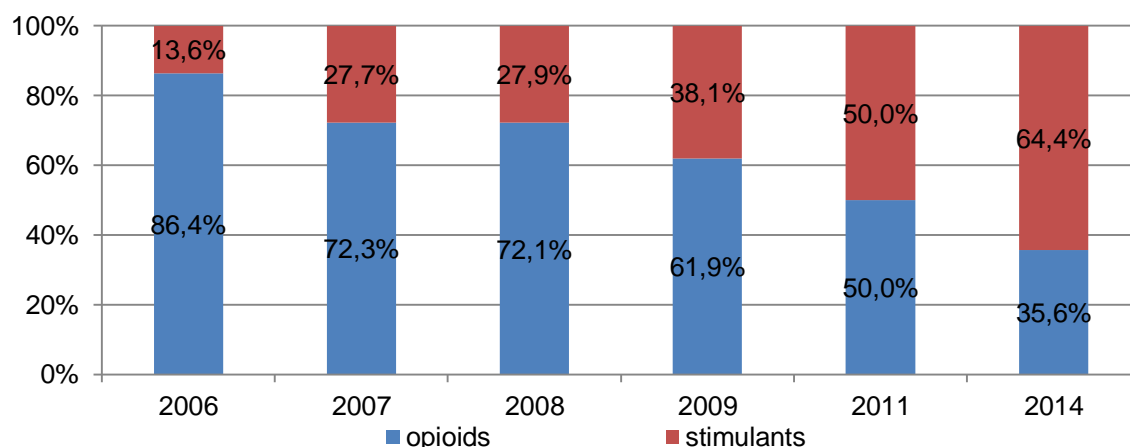
¹⁷ On the basis of seizure data, this is probably the street name for substances containing the active substance pentadrone.

¹⁸ On the basis of seizure data, this is probably the street name for substances containing the active substance alpha-PVP.

¹⁹ 'All' category as reported by clients refers to polydrug use of available designer stimulants. While those cases, when 'other designer stimulant' was recorded without specification of the street name, were classed in the 'other' category.

A similar trend can be determined on examining the distribution of IDUs participating in the national seroprevalence survey (Dudás et al. 2014) according to primarily injected substances: the proportion of those injecting stimulants gradually increased over the years in the sample. While in 2006 13.6% of them injected primarily stimulants, by 2014 nearly two thirds of the sample belonged to this group.

Chart 3. Breakdown of IDUs participating in the national HIV/HCV seroprevalence survey by primarily injected substance, between 2006-2014 (%)



Dudás et al. 2014, analysed by HNFP

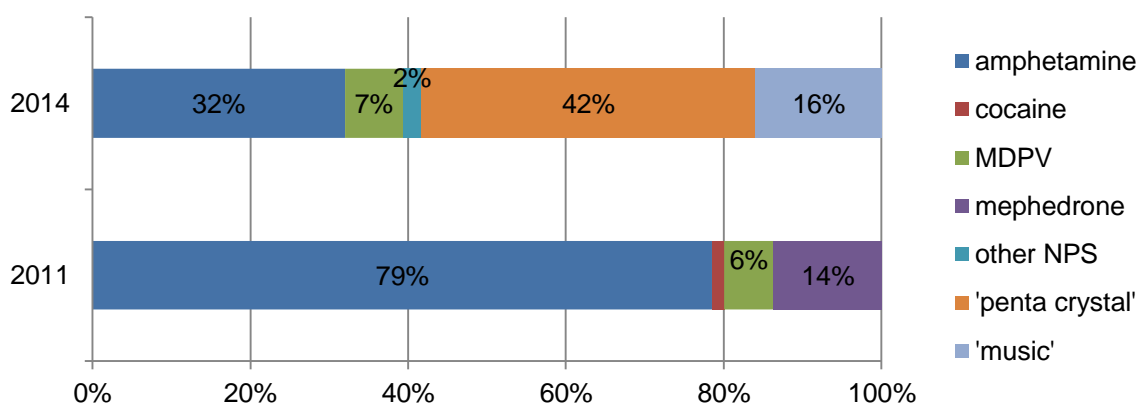
Selecting current stimulant injectors (injecting in the past 4 weeks) from the sample (in 2011: 64.2% of all current IDUs, in 2014: 70.6%), it can be seen that between 2011 and 2014 a significant move took place from amphetamines towards designer stimulants.²⁰ In 2011 78.5% of current stimulant injectors reported primarily using amphetamine, but in 2014 only 32% of them reported this. Opposite to this, the proportion of those primarily injecting designer stimulants grew from 20% to 68%. In 2011 the designer stimulant being mentioned the most was mephedrone, which by 2014 had been replaced by the designer stimulant most injected in the past year – and the most injected any kind of stimulant as well – ‘penta-crystal’²¹. In 2014 this was followed by the substance with the street name ‘music’²², and then by MDPV, which substance was also used by IDUs in 2011 already.

²⁰ In 2011 it first became possible during the national seroprevalence survey for the participants to name the primarily injected ‘other’ substance in an open-ended question. Until then the data had been collected in 4 closed categories: opioids; amphetamine; cocaine; other. Therefore the analysis only makes statements for these two years.

²¹ On the basis of seizure data, this is probably the street name for substances containing the active substance pentedrone.

²² On the basis of seizure data, this is probably the street name for substances containing the active substance alpha-PVP.

Chart 4. Breakdown (%) of current stimulant injectors participating in the national HIV/HCV seroprevalence survey by primarily injected drug type in 2011 (N=256 persons) and in 2014 (N=269 persons)

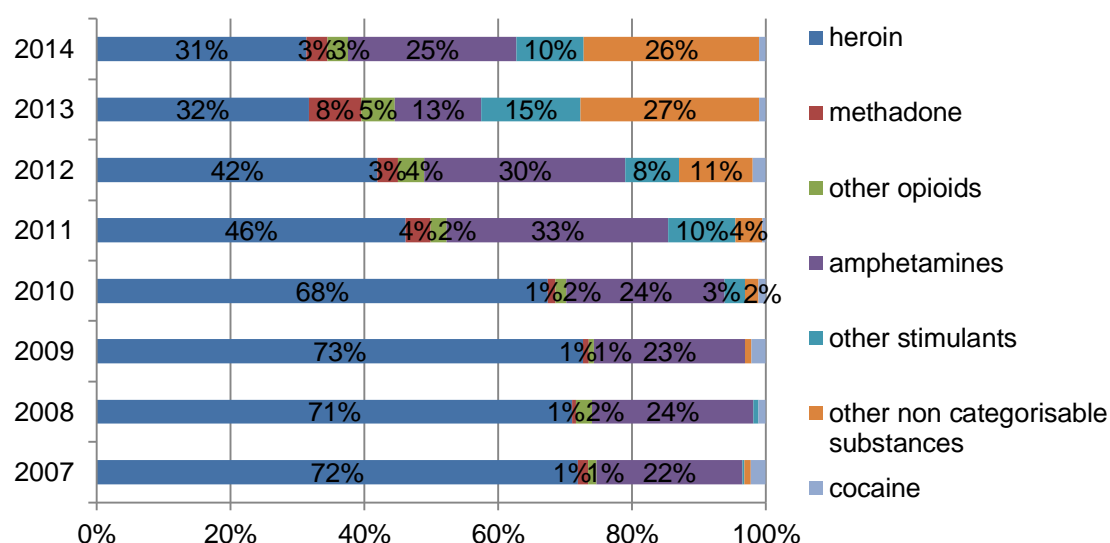


Dudás et al. 2014, analysed by HNFP

Treatment (TDI) data

With some delay, but by 2013 the change could also be seen among those starting treatment, which had been observed earlier in the other data sources: namely the decline in the use of opioids – primarily heroin – and the increase in the use of designer stimulants among IDUs.

Chart 5. Breakdown of IDUs entering treatment by primarily injected drug between 2007 and 2014 (%)



Source: TDI data collection 2015

For data on the active substance identified on injecting equipment presented as a part of the seizure data see the Drug Market and Crime Workbook, Chapter T1.1.5.

T1.2.2 Infectious diseases

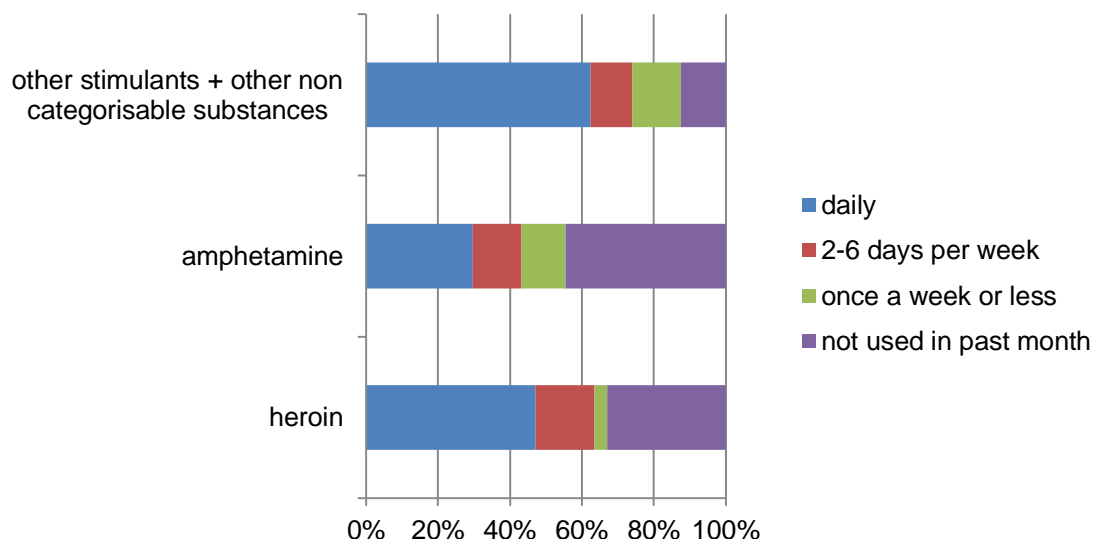
See: Harms and Harm Reduction Workbook, Chapter T1.3.1 and T2.2. b

T1.2.3 Patterns of use

For data in connection with risk behaviours related to stimulant injecting see: Harms and Harm Reduction Workbook, Chapter T1.3.4

Among IDUs starting treatment, the highest proportion of those injecting every day or 2–6 days a week is among those injecting designer stimulants (74.0%) (other stimulants + other non categorisable substances) as compared to those injecting heroin (63.5%) and amphetamine (43.2%).

Chart 6. Frequency of injecting drug use among IDUs entering treatment in 2014 (%)



Source: TDI data collection 2015

T1.2.4 Treatment of stimulant users

In Hungary stimulant use is the second most typical reason for drug users to start treatment (see Treatment Workbook, Chapter T.1.3.1. and T.2.1). In 2014 19.1% of those entering treatment reported to use a stimulant (apart from cocaine) as primary drug (amphetamine 584 persons, MDMA and other derivatives 82 persons, other stimulants 228 persons). (TDI data collection 2015)

96.1% of those entering treatment because of stimulants were men. The mean age of this user group was 28 years, and had used stimulant substances for an average of 8 years before entering treatment in 2014. The typical route of administration before entering treatment was sniffing (41.3%) and 32.2% of the stimulant users used the drug with a daily frequency or 2–6 times a week. (For data on injecting see Chapters T1.2.1 and T1.2.3.)

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

T1.2.6 Synthetic cathinones

Questions relating to cathinones first appeared in a national epidemiological survey, the ESPAD survey, in 2011. On the basis of the lifetime prevalence rates, mephedrone was in fifth place (6%), overtaking classical stimulants.

For data relating to the injecting of synthetic cathinones see: Chapter T.1.2.1; as well as the Harms and Harm Reduction Workbook, Chapter T1.3.1; T1.3.4. and T2.2.b.

For data on the synthetic cathinone users entering treatment see Chapters T1.2.1; T1.3.1 and T4.1, as well as the Treatment Workbook, Chapter T4.1)

T2. TRENDS

Presented in Chapter T1.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2014, is presented as part of the baseline information in Chapter T1.

T4. ADDITIONAL INFORMATION

T4.1 ADDITIONAL SOURCES OF INFORMATION

According to the results of the survey made in 2013 entitled 'School Health Development and Universal Drug Prevention' (Grezsá and Surányi 2014), 1.5% of the entire sample had used stimulants in their lives, most of them ecstasy (1%). 0.2% of elementary school pupils and 3% of secondary school students had tried them. The lifetime prevalence in grade 9 of secondary school was 2% and 3.8% in grade 11. Numerically, there were slightly more boys (1.7%) than girls (1.4%) among those trying stimulants, they are basically similarly popular for both sexes. Stimulant use is more characteristic in Budapest and in the county seats, most of them use ecstasy, beside this cocaine use is more widespread in Budapest than in the other settlement types. With respect to school type, lifetime prevalence rates were the highest among students attending secondary modern schools and vocational schools. In breakdown by region, the highest number admitted to trying a stimulant substance, most usually ecstasy, in South Transdanubia.

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

T5. NOTES AND QUERIES

Not applicable.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

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Dudás, M., Rusvai, E., Győri, Z., Tarján, A., Horváth, G., Minárovits, J., Takács, M., Csohán, Á. (2014): A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HCV) 2014. évi prevalenciájának vizsgálata. OEK. Manuscript Submitted for Publication.

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Péterfi A. (2015): Kezelőhely vizsgálat 2015. Nemzeti Drog Fókuszpont. Unpublished thesis.

Tarján, A. (2015b): Tűcsere programok adatai, 2014. Nemzeti Drog Fókuszpont.

T6.2 METHODOLOGY

Substance Use of Young People (Greza and Surányi 2014): see Cannabis, Chapter T6.2.

HBSC 2014: see the Cannabis, Chapter T6.2

Needle/syringe programme (NSP) data collection (Tarján 2015b): In 2015 the NSPs reported their data via the web-based data collection surface operated by the Hungarian National Focal Point (HNFP) since 2008. The service providers have been sending data on the demographic characteristics and injecting patterns of clients participating in NSPs to the HNFP through this interface since 2010. In 2012, the closed 'other' substance category was transformed to an open-ended question, where the service providers can name the other substance categories. With respect to 2014, 27 organisations uploaded the data of 4438 clients, which is the largest number to date, as this year the second largest Budapest NSP was able to provide data on their clients. In respect of the number of clients double counting control was performed at service provider level but not at national level. The same client may be registered at more NSPs. The service providers provided information in 2014 on a total of 3692 clients' primarily injected substance. (2009: 1483 persons; 2010: 1737 persons; 2011: 2237 persons; 2012: 1907 persons; 2013: 3128 persons)

National HIV/HCV seroprevalence survey (Dudás et al. 2014): see the Harms and Harm Reduction Workbook, Chapter T.6.2.

TDI data collection 2015: see Treatment Workbook, Chapter T6.2

Treatment facility survey 2015: see Treatment Workbook, Chapter T6.2

HEROIN AND OTHER OPIOIDS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 The relative important of different opioid drugs

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

T1.1.2. Estimates of opioid use

Estimate of heroin use prevalence was last made in 2013, with respect to a two-year interval (2010-2011). The point estimate value for those using heroin at least once in the given two years is 3244 persons. (For details see 2013 National Report, Chapter 4.2.)

T1.2 Patterns, treatment and problem/high risk use

T1.2.1 Injecting drug use

Needle/syringe programmes' client data

On the basis of the NSP data (Tarján 2015b) the increasing NPS injecting from 2010 has complete transformed the structure of injecting drug use patterns characteristic of previous years: while in 2009 56% of IDUs attending NSPs injected primarily heroin, by 2014 only 6% of the clients self-reported injecting primarily this substance. Last year – for the first time in the time series data – the proportion of those injecting primarily heroin was lower than that of those injecting primarily other opioids. (For the chart see: Stimulants, Chapter T1.2.1, Chart 1).

The proportion of those injecting other opioids, primarily methadone has not changed significantly over the past years: it was around 7-9% between 2011-2014.²³

In 2014 10.7% of NSP clients aged between 25 and 34 years injected primarily heroin or other opioids while this figure was 22.5% for those above 34 years. Regarding clients below the age of 25 only a negligible proportion (2.6%) injected primarily opioids. Examining only the group of heroin and other opioid injectors it can be determined that most of them are in the age group above 34.

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

It is also possible to see the decrease in the injection of opioids from 2006 when examining the IDUs participating in the national seroprevalence survey (Dudás et al. 2014) by primarily injected substance. While in 2006 86.4% of the sample injected primarily opioids, by 2014 only 35.6% of them reported primarily injecting an opioid. (for the chart see: Stimulants, Chapter T1.2.1, Chart 3)

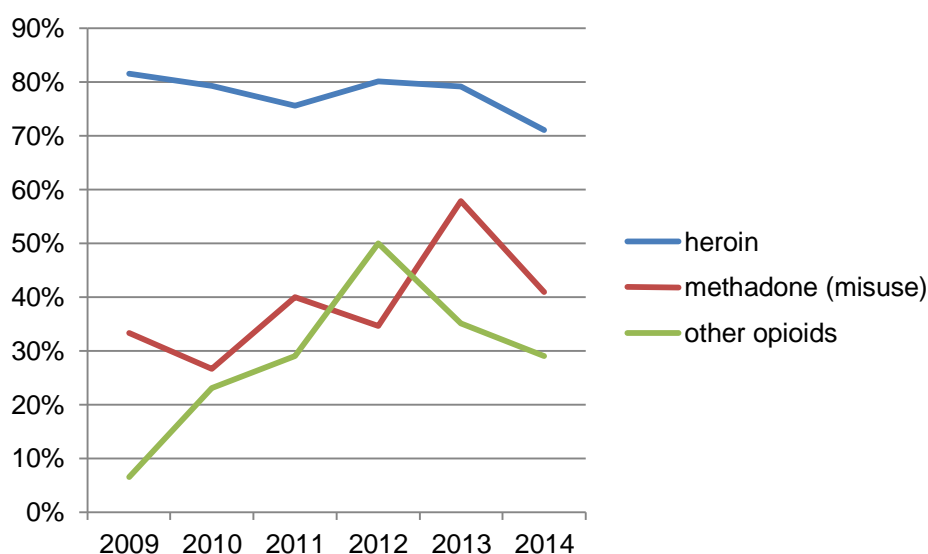
²³ Before 2011 the service providers reported data in 4 closed categories: heroin; amphetamine; cocaine, other. From 2011 the closed 'other' category became an open-ended question, the substance categories classed there can be named since then, therefore exact data on the injecting of other opioids has only been available since then.

Selecting current injectors from the sample relating to 2014, it can be said that among them the proportions of those injecting heroin and those injecting other opioids was low and nearly the same: 13.1% of them injected primarily other opioids, mainly methadone, while 15.5% of them reported heroin as their primary injected substance.²⁴

Treatment (TDI) data

A moderate decrease can be observed with respect to the injecting use of heroin over the past six years. Following a rise for 4-5 years in the case of methadone and other opioids, by 2014 a decrease could be seen regarding both substance types in this route of administration. An explanation for the rise, in case of the latter two substances, until 2013 may be the drop in the availability of heroin and the injecting of other types of opioids as a replacement for heroin.

Chart 7. *The proportion of injecting use among opioid users, by primary drug between 2009 and 2014.*



Source: TDI data collection 2015

On the patterns of opioid use see Chapter T1.2.4, for further trends in injecting use see Stimulants, Chapters T1.2.1 and T1.2.3.

T1.2.2 Infectious diseases

See: Harms and Harm Reduction Workbook, Chapter T1.3.1 and T2.2. b

T1.2.3 Patterns of use

For data in connection with risk behaviours relating to injecting opioid use see: Harms and Harm Reduction Workbook, Chapter T1.3.4.

During the annual NSP expert meeting (HNFP 2015) those participating organisations that also offered opioid substitution treatment (hereinafter OST) reported that significant number of their clients in OST also injected designer stimulants and/or used synthetic cannabinoids.

²⁴ For the first time, in 2014 the opioid category was broken up into heroin (closed category) and other opioids (open-ended question), therefore the analysis only makes statements for this year.

T1.2.4 Treatment for heroin and other opioids

Opioid use was the primary drug used in the case of 4.2% of those entering treatment in 2014 (see Treatment Workbook, Chapters T.1.3.1. and T.2.1) (heroin 140 persons, misuse of methadone 23 persons, other opioids 33 persons).

The proportion of male opioid users was 85.5%. The mean age of this user group entering treatment was 34 years and they had used opioid-type substances for an average of 14.5 years before entering treatment in 2014. Before treatment the typical route of administration reported was injecting (60.2%), and 66.9% of the opioid users used their primary drug daily or 2–6 days per week. 71.1% of heroin users injected their drug and 17.2% of them inhaled ('chasing the dragon'). (For more information on injecting see Stimulants, Chapters T1.2.1 and T1.2.3.)

With respect to treatment possibilities, OST is available to opioid users as a special treatment programme. For information on its availability and utilisation see Treatment Workbook, Chapters T1.4.8-T1.4.10 and T2.1.

T2. TRENDS

Presented in Chapter T1.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2014, is presented as part of the baseline information in Chapter T1.

T4. ADDITIONAL INFORMATION

T4.2 FURTHER ASPECTS OF HEROIN AND OPIOID USE

Over the past years several studies (Farkas 2011; Péterfi 2013) reported on the use of NPS, primarily designer stimulants by OST clients. Kapitány-Fövény et al. (2015) examined the appearance of individual psychiatric symptoms in the cases of clients ever using and never using NPS within the group of clients of an OST programme in Budapest. Of the 9 psychiatric symptoms examined on the BSI (Brief Symptom Inventory) symptom scale significantly higher values (i.e. more serious psychiatric symptoms) were identified in the case of 7 items among those ever using NPS.

T5. NOTES AND QUERIES

Not applicable.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

Dudás, M., Rusvai, E., Győri, Z., Tarján, A., Horváth, G., Minárovits, J., Takács, M., Csohán, Á. (2014): A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HCV) 2014. évi prevalenciájának vizsgálata. OEK. Manuscript Submitted for Publication.

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Kapitány-Fővény, M Farkas, J., Pataki, P.A., Kiss, A., Horváth, J., Szabó, T. Winter, Zs., Rigó, P. (2015): Designer droghasználók pszichiátriai tünetprofilja szubsztitúciós kezelésben részesülő opiátfüggők körében. Magyar Pszichiátriai Társaság XIX. Vándorgyűlése. At: Szeged, 28-31 January 2015.

HNFP (2015): Tűcsere szolgáltatók országos szakmai találkozója. Nemzeti Drog Fókuszpont.

Péterfi, A. (2013): Kvalitatív vizsgálat metadon programot működtető szolgáltatók körében 2013-ban. Nemzeti Drog Fókuszpont. Unpublished thesis.

Tarján, A. (2015b): Tűcsere programok adatai, 2014. Nemzeti Drog Fókuszpont.

T6.2 METHODOLOGY

Needle/syringe programme (NSP) data collection: see Stimulants, Chapter T6.2.

National HIV/HCV seroprevalence survey: see Harms and Harm Reduction Workbook, Chapter T.6.2.

TDI data collection 2015: see Treatment Workbook, Chapter T6.2.

The psychiatric symptom profiles of designer drug users among opioid addicts in OST (Kapitány-Fővény et al. 2015): 198 persons were involved in the voluntary, anonymous study carried out among the clients (210 persons) treated between 15 April and 21 August 2014 in the OST programme of the Outpatient Drug Treatment Centre of the Budapest Nyíró Gyula Hospital, OPAI. The study questionnaire included questions relating to the treatment and the client's demographic characteristics, questions relating to NPS use, also the BSI (Brief Symptom Inventory) and the LEQ (Life Events Questionnaire) were completed. The questionnaires were recorded face-to-face, in confidential conditions, by psychology students.

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

Beyond the substances mentioned in the above three sections – also presenting the developments about the new psychoactive substances there – abuse of no other drugs is relevant regarding the drugs problem in Hungary.

PREVENTION²⁵

T0. SUMMARY

Earlier study data (Paksi and Arnold 2010) showed that the majority of organisations operating prevention programmes perform universal prevention in the school setting. 70% of these organisations were NGOs with their financing coming mostly from the state in the form of grants. Among the organisations carrying out characteristically selective prevention activities outside of school, there were many state or local authority bodies (social care and child protection institutions) that came into contact with the target groups for different purposes anyway. Workplace prevention programmes only occurred occasionally.

The main financier of the prevention activity today is still the state and now European Union sources (TÁMOP (Social Renewal Operational Programme), EFOP (Human Resources Development Operation Programme) as well. The background institution responsible for drug prevention tasks is the National Drug Prevention Office (NDI). The database operated in the past is now out of date, in the recent years no research has been carried out that explores prevention activity, so we do not have up to date information on what the prevention programmes offer.

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

T1. NATIONAL PROFILE

T1.1 POLICY AND ORGANISATION

T1.1.1 Prevention objectives in the National Strategy

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

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

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

²⁵ Author of the chapter: Adrienn Nyírády

narrower interpretation of drug prevention, the focus of the programmes should be health development, comprehensive physical, psychological, intellectual and social well-being”.

In connection with prevention the Strategy determines tasks in 10 settings: local communities, family, public education and the child protection institution system, higher education, peer groups, the media, the workplace, penal institutions as well as the institution of ‘treatment as an alternative to criminal procedure’ (QCT). The priorities determined in the Strategy in connection with drug prevention are the following:

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

T1.1.2 Institutional background

The top Hungarian drug coordination body is the National Drug Prevention Coordination Department of the Ministry of Human Capacities (for more information see Drug Policy, Chapter T1.3). The Ministry of Human Capacities (EMMI) instruction number 33/2014. (IX. 16.) on its Organisational and Operation Regulations also specifies the tasks of the National Drug Prevention Coordination Department in connection with drug prevention:

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

The background institution responsible for drug prevention tasks is the National Drug Prevention Office (NDI), the related tasks of which are the following:

- “the provision of specialist support to the Government in the interest of the objectives of (...) the national strategic programme (...) in connection with the prevention of drug use, with special respect to the elaboration of prevention guidelines and implementation methods in the field of community and institutional drug prevention activities, and furthermore, with special respect to the representation of a uniform approach in Hungarian drug prevention practices,

- (...) with special respect to making the prevention activity more effective – it should provide a background for research and science,
- promoting and taking part in the initiation, implementation and support of research programmes related to drug prevention from a specialist and methodology point of view, as well as in the initiation of international research collaborations,
- participating in the creation of training courses and further training in connection with drug prevention, and in the elaboration of the content and methodology,
- distributing and publishing scientific and practical knowledge in connection with drug prevention for specialist target groups,
- participating in the planning, organising and specialist monitoring of drug prevention services,
- collaborating in the review and assessment of international drug prevention practices, in the examination of the possibilities of adapting them for use in Hungary, in the elaboration of model programmes, and, in connection with this, participating in international drug prevention collaborations and projects,
- elaborating and operating the comprehensive database system in connection with the specialist field, which database collects, systemises and makes accessible the various types of data and information in connection with (...) the prevention programmes,
- participation in the implementation of comprehensive programmes launched by the government in the field of drug prevention.”

(Source: NCSSZI 2015)

The large majority of the organisations running prevention programmes perform universal prevention activities in school setting and have a contractual relationship with the school. The data of a study from 5 years ago (Paksi and Arnold 2010) showed that nearly 70% of the programmes were run by civil (non-profit or church) organisations, beside these there were business associations, local authority and budgetary organisations, and private individuals as well in a number of cases. The large majority of the civil organisations or NGOs operated in the form of a foundation or association. The role undertaken by the business sector was minimal.

We have no information about the current number of the organisations or about the details of their activities.

The information available about the organisations operating in crime prevention setting can be found in Chapter T1.2.1.

T1.1.3 Financing system

One of the most determinant factors of the prevention activity is the method and amount of financing. According to the results of the research mentioned in Chapter T1.1.2, on average four fifths of the budgets of the prevention programmes came from grants, which puts a great deal of uncertainty into the system concerning the continuity of the operation of the programmes. The financer is mostly the state. Financing from the business sector, foundations and local authorities is significantly less than this. The proportion of financing from donations was 2.9%. The presence of a stable, permanent budget improving the reliability and sustainability of operation was not characteristic. (Paksi and Arnold 2010)

T1.2 PREVENTION INTERVENTIONS

T1.2.1 Environmental prevention

Policies/initiatives

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

Crime prevention strategies

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

T1.2.2 Universal prevention

The KAB-ME-14 project offered grants for the support of universal and selective prevention interventions offering an alternative to drug use in the school setting and in collaboration with participants of the local community as well as for the support of programmes strengthening the family system, in line with the National Anti-drug Strategy 2013-2020 document, with a total amount available of EUR 502,431. Of the 288 grant applications submitted, 164 were awarded funding to the amount of EUR 471,824. (EMMI 2015a) A half of the winning applications implemented universal prevention programmes in school or community settings.

TÁMOP-5.2.9-13/1 – 'Choose something different for your passion'

With the title 'Choose something different for your passion' the NDI implemented a special programme financed by the European Union, the contracted support amount of which was EUR 810,372. The campaign distributed relevant information to a wide sphere of society on the prevention of addictions and dependencies, about how to treat them and about how varied they are. The primary target group of the project consisted of children and their direct environment (family, community) because of their increased risk of harm from addictions, as well as young adults (the 12-29 year old age group of young people). The secondary target group consisted of the experts working in the specialist fields, who participate in prevention, recognition of problems and intervention.

The specialist events and drug prevention programmes taking place during the duration of the project (27 March 2014 – 27 June 2015):

The national roadshow started off in September 2014, which visited more than 50 towns and smaller settlements. Local youth organisations, NGOs and prevention programmes offering alternative free-time activities were presented during the drug prevention programme series aimed at involving young people and when appearing at large youth events (festivals in 2014) targeting young people especially at risk.

By using info-communication technologies it became possible to directly address the young people with a comprehensive, universal drug prevention programme, in the scope of which

they were able to express their creativity and creative ability in connection with the subject²⁶. (NDI 2015)

Health development offices

Integrated with the healthcare system, health development offices were set up using European Union financing to support the system's prevention capacity, until the end of 2014 59 beneficiaries received positive decision. These offices play a substantial role in the implementation of universal prevention. The health development tasks that can be selected include prevention of smoking, drug use and excessive alcohol consumption, which were mainly implemented in the form of 'clubs for addicts' and mainly in the northern regions. (NEFI 2015, EMMI 2015b)

The drug prevention activity of the National Crime Prevention Council

A workbook was created entitled Spirit Wasters for younger age groups, which contains tales especially about smoking, alcohol consumption, drugs and the dangers of the Internet, the publication is recommended for teachers as background material for use in class.

The 'Choose sport for your passion!' campaign

As a part of the campaign the Hungarian Football Association, the Hungarian Coach Training Centre and the Council jointly produced leaflets for parents. A drawing competition was launched in 2014 in this subject in order to actively involve the children. (NBT 2015)

The drug prevention activity of the Police

In the academic year of 2013/14, 33,128 children in 1,293 classes from 342 schools in 193 different locations took part in the DADA programme for elementary school children, who received instruction from 157 police officers. In this same academic year, 7,098 students in 152 classes from 43 schools in 26 different locations around the country took part in the ELLEN-SZER (anti-substance) programme for secondary school students, who received instruction from 27 police officers (ORFK 2015). In 2014 the study material for this programme was updated. (NBT 2015)

Drug prevention mediators

To reduce drug use by young people, in 2014 the police launched a new drug prevention programme entitled 'Parents and family members are the special partners of the police in preventing drug-related crime'. The aim of the programme is for the parents of children aged 12–18 and family members to directly receive information about the risks of drug use and about its consequences under criminal law. The programme's local mediators can be reached at all police stations. (ORFK 2015)

T1.2.3 Selective prevention

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

²⁶More information may be obtained on the http://www.ndi-szip.hu/tamop-5_2_9/Rolunk.aspx website.

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

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

Drug prevention in the Hungarian Army

The main directions of the drug prevention activity performed within the organisational framework of the Hungarian Army are determined by the National Anti-drug Strategy 2013-2020 approved by the currently valid National Assembly Decision 80/2013 (X. 16.) and by the Hungarian Army's Drug Prevention Strategy. On the basis of these, over the course of 2014 the Hungarian Army implemented the following activities (Magyar Honvédség 2015):

- In the scope of cognitive knowledge transfer, informative publications and visual presentations, information lectures dealing with drug prevention were held on 16 occasions with the participation of 1,489 persons during training days. 9 lectures were held reaching a total of 3,300 persons on the basis of request, on the occasion of community setting programmes.
- The Hungarian Army Health-Protection Programme reached 82 persons in 2 corps in 2014.
- Personnel planned for missions are prepared in the subject of the prevention of addictions. In 2014 drug prevention training was held on 3 occasions with the participation of 60 persons.
- Training: in 2014 training course was held with the participation of 24 persons for those performing drug prevention tasks in the military organisations (specialist healthcare and corps psychologist personnel).

T1.2.4 Indicated prevention

A small number of indicated prevention programmes may also be found among the state-financed programmes (Chapter T1.2.2), which targeted especially at risk young people, students attending schools for special needs, and those living in drug-user families.

One of the types of alternatives to criminal procedure, the preventive-consulting service activity, may be viewed as a form of indicated prevention in as much as it is aimed at reducing and stopping further drug use by users who are involved in legal procedures. The data collected relating to this is a part of the TDI data, therefore a detailed description can be found in the Treatment Workbook.

T1.3 QUALITY ASSURANCE OF PREVENTION INTERVENTIONS

T1.3.1 Quality assurance standards, guidelines and objectives

Within the scope of the drugs-related pillar of the project dealing with modernisation of social services (TÁMOP5.4.1) completed in 2011, the international and Hungarian research experience, best practices and regulatory practices with respect to several areas dealing with prevention (selective prevention programmes operated in shopping centres/malls, selective prevention programmes created for young people living and hanging out in housing estates and other deteriorated residential environments, selective prevention and harm-reduction programmes established/operated in clubs, preventive-consulting services) were reviewed.

On the basis of these methodological documents (specialist regulatory documents) were drawn up for every individual area. (For more information see 2011 National Report, Chapter 3.2)

In the interest of the quality assurance of health development programmes implemented in school setting, as of 1 February 2013 a specialist monitoring procedure was introduced to regulate these programmes within the comprehensive school health development system, which is coordinated by the National Institute for Health Development (NEFI). (For details see 2014 National Report, Chapter 3.4.) The essence of the system introduced is that only those prevention programmes may operate in schools that have received professional approval in this procedure.

In 2014 41 applications were submitted to the National Institute for Health Development for approval of school health development programmes, of these 39 were prevention programmes relating to substance use. In the end 10 drug prevention programmes were given specialist approval. (NEFI 2015)

Table 2. *The number of school health development programme applications submitted to the NEFI for approval broken down by subject and number of programmes finally supported*

subject	no. of applications	supported applications
drug prevention	28	7
peer assistance	3	1
addictions	1	1
comprehensive	7	1
prevention of bullying and school violence	1	0
nutrition	1	1
total	41	11

Source: NEFI 2015

Table 3. *Number and final results of school health development programme applications relating to drug use submitted for professional approval to the NEFI*

	no. of submitted applications	supported	rejected for formal reasons	not supported
drug prevention	28	7	6	15
addiction prevention	1	1	0	0
peer assistance	3	1	0	2
comprehensive	7	1	1	5
total	39	10	7	22

Source: NEFI 2015

T2. TRENDS

School prevention/health development gained momentum in the academic year of 2001/2002 with the setting up of system level grant financing. The content, methods, target groups and even duration of the prevention programmes were more determined by the financier's expectations (the state in most cases – see Chapter T1.1.3), and less by changes in substance use patterns and the appearance of new phenomena. This is supported by, for example, that in 2006 a database was set up about more than 400 prevention programmes, because registration was a condition of application for funding. The shift from frontal teaching towards interactive personality development and attitude shaping was also included in the

grant application specifications. However, there were no significant responses to the observable spreading of new psychoactive substances in Hungary from the prevention service providers.

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

National quantitative surveys were carried out up to 2009 about preventive programmes inside and outside school settings, from which it was determined which drug prevention interventions the students came into contact with (a detailed description of the surveys can be found in the previous National Reports). Since 2010 only regional and qualitative studies have been performed, therefore we have no information at present about how many prevention programmes are in operation in the country or of their form or their methodology. Initiatives were started in 2008-2009 in the interest of the quality assurance of school prevention programmes, and finally the professional approval system was set up in 2013. A number of school prevention programmes were externally evaluated in 2003-2005, internal assessment is more characteristic, which is mainly limited to measurement of popularity index and of change in knowledge level.

T3. NEW DEVELOPMENTS

This year all current and available data and information, including data relating to 2014, are presented as part of the baseline information in Chapter T1.

T4. ADDITIONAL INFORMATION

No information available.

T5. NOTES AND QUERIES

T5.1 HAVE THERE BEEN RECENT RELEVANT CHANGES IN TOBACCO AND ALCOHOL POLICIES?

Yes.

The amended version of 'Act XLII of 1999 on certain rules relating to the protection of non-smokers and the use and marketing of tobacco products' accepted by the National Assembly on 6 April 2011 entered into force on 1 January 2012. The fundamental aim of the amendment was to ban smoking in all enclosed public spaces in order to protect the population against the health damaging effects of smoking. According to the legal act smoking is banned completely in institutes of public education, child welfare and child protection institutes, health service providers, on means of public transport and national transport and their waiting areas, playgrounds and other institutes realising public traffic. Exceptions are psychiatric institutes (where a smoking area may be designated for patients in a closed space also), prisons and police detention facilities (where a smoking area may be

designated for the imprisoned persons in a closed space also), and cigar rooms in hotels. (For more information see 2013 National Report, Chapter 3.2)

T5.2 HAS THERE BEEN RECENT RESEARCH ON ETIOLOGY AND/OR EFFECTIVENESS OF PREVENTION INTERVENTIONS?

No.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

EMMI (Emberi Erőforrások Minisztériuma) (2015a): Az EMMI Szociális és Gyermekjóléti Szolgáltatások Főosztályának beszámolója.

EMMI (Emberi Erőforrások Minisztériuma) (2015b): Az EMMI Egészségpolitikai Főosztályának és Népegészségügyi Főosztályának beszámolója.

Magyar Honvédség (2015): Beszámoló a kábítószerügyi Éves jelentéshez.

NBT (Nemzeti Bűnmegelőzési Tanács) (2015): Tájékoztató a Nemzeti Bűnmegelőzési Tanács 2014. évi tevékenységéről

NCSSZI (Nemzeti Család- és Szociálpolitikai Intézet) (2105): Nemzeti Család- és Szociálpolitikai Intézet Szervezeti és Működési Szabályzata IV.1.3.3.

NDI (Nemzeti Drogmegelőzési Iroda) (2015): Tájékoztató az EMCDDA számára készülő, 2015. Évi Jelentés elkészítéséhez

NEFI (Nemzeti Egészségfejlesztési Intézet) (2015): A NEFI kábítószerhez kapcsolódó tevékenységei

ORFK (2015): A Rendőrség 2014. évi tevékenységéről szóló beszámolója

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

T6.2 METHODOLOGY

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

TREATMENT²⁷

T0. SUMMARY

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

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

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

A significant determinant of the treatment system in Hungary is the legal possibility of treatment/preventive interventions that may be used as an alternative to criminal procedure (quasi compulsory treatment; hereinafter QCT). The majority of entering treatment are linked to this (60% in 2014).

Drug treatment is not a separate category neither within the social nor the healthcare systems; in general they belong to the group of treatment modalities related to addiction and psychiatric problems. This makes it difficult to monitor the treatment possibilities, capacity and utilisation. Reliable data about the field is available from the drug treatment (TDI) and OST data collection, which are suitable primarily for describing the characteristics of the clientele. On the basis of these sources, the greatest problem is posed by cannabis use, most users start treatment because of this. The consequences of the spreading of new psychoactive substances (hereinafter: NPS) can be seen indirectly from the treatment data and more directly from the market and NSP data, which can be observed in the changes of injecting drug use and treatment demand as well. In parallel with this, the decrease in the use of heroin and the relative stability of treatment demand linked to amphetamine can be observed.

²⁷ Author of the chapter: Anna Péterfi

T1. NATIONAL PROFILE

T1.1 POLICIES AND COORDINATION

T1.1.1 Main treatment priorities in the national drug strategy

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

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

The Strategy builds on a recovery-oriented approach, the objective of which is the improvement and restoration of the client's health, as well as promoting reintegration into society. The Strategy views low-threshold services as being the first link in the entire treatment chain, which, combined with outreach activity, may help with finding hidden substance users and bringing them into treatment, and in the prevention, screening and reduction of infectious diseases.

T1.1.2 Governance and coordination of drug treatment implementation

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

The financing of drug treatment on the healthcare side comes from the National Health Insurance Fund (OEP) and on the social services side from the social budget, overseen by the National Office for Rehabilitation and Social Affairs (NRSZH), in the form of fixed financing and grants. It is characteristic of both sectors that formally the treatment of drug users is not a separate category among the financed forms of treatment, instead they are handled as part of a wider patient group along with problem alcohol users, people living with addictions in general, or occasionally with psychiatric patients. In spite of this, there are some treatment centres that primarily target drug users in practice, however, with respect to their financing, this distinction cannot be recognised.

T1.2 ORGANISATION AND PROVISION OF DRUG TREATMENT

Treatment centres are maintained either by the state/local government, which provide either healthcare type treatment exclusively or both health treatment and social services, or by NGOs (incl. church organisations), which provide healthcare and social services as well or just the latter (Péterfi 2015). Preventive-consulting services may be provided by either of the above service provider types, or by non-governmental for profit organisations.

For information in connection with the treatment of prisoners see Prison Workbook Chapter T1.3.3.

Outpatient network

T1.2.1 Outpatient drug treatment system

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

- health care treatment:
 - outpatient treatment for addiction
 - children and youth addiction treatment
 - psychiatric outpatient treatment
 - children and youth psychiatric treatment
- social services (Act III. of 1993 on social administration and social services):
 - low threshold services for addicts
 - community care for addicts
 - day-care services for addicts

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

It is possible to distinguish between different profiles among drug treatment units. **Treatment centres with primarily a health care profile:** such are hospital addiction units and clinics, psychiatric units and clinics, as well as some of the specialised outpatient drug treatment centres (DTCs) characteristically operate as part of an institution with a state or local government background. **Treatment centres with a social profile** only receiving finance from the social budget, are normally operated by NGOs or church organisations. **Treatment centres with a mixed profile** receive financing from both budgets, such as the outpatient DTCs operated by NGOs (Péterfi 2015).

Due to the categorisation of drug treatment as part of wider treatment categories, there are no precise numerical data available about the number of treatment centres actually treating drug users. Data on drug treatment units is available from the TDI data collection, which, on the basis of expert estimate, has a good coverage regarding the number of clients in drug treatment. This data is presented in Table 4 and 0.

Table 4. *Network of outpatient treatment facilities (total number of units in 2014)*

	total number of units	definition (treatment unit types)
specialised drug treatment centres	41	Service providers identifying themselves in the TDI data collection as outpatient treatment units (within this as a specialised DTC, addiction unit or other treatment unit) (characteristically specialised DTCs, outpatient addiction units and clinics, and other outpatient treatment units providing healthcare treatment or preventive-consulting services)

		for drug users). Approximately 20% of these service providers provide OST.
low-threshold agencies ²⁸	22	Service providers identifying themselves in the TDI data collection as low threshold/drop-in/outreach units) (characteristically service providers providing psycho-social services).
general / mental health care	6	Service providers identifying themselves in the TDI data collection as outpatient treatment units (within this psychiatric units) (psychiatric units and clinics operating in hospitals and clinics).
prisons	7	Institutions also reporting on the treatment of prisoners in the TDI data collection (detention facilities and external service providers treating prisoners). The units providing outpatient and inpatient treatment are shown together in this table.

Source: TDI data collection 2015 –ST24_2015_HU_01

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

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

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

Those choosing an alternative to criminal procedure are referred to a preventive-consulting service– which is more like indicated prevention interventions – or to a treatment programme²⁹ by a psychiatrist or a clinical psychologist on the basis of a preliminary status assessment. The content of the treatment interventions is not specified, the healthcare service providers provide these services within the scope of regular outpatient or inpatient drug treatment programmes. The perpetrator is required to participate in the preventive or treatment programme for at least 1.5 hours every two weeks for six months in order for the certificate of completion to be issued. (For data on criminal procedures terminated because of QCT see Drug Market and Crime Workbook, Chapter T1.2.1.)

T1.2.3 Outpatient drug treatment system – Client utilisation in 2014

A total of 69 service providers reported on the outpatient treatment of drug user clients in 2014 (the treatment of prisoners is not included here) of the 90 reporting treatment units. 85% of all the clients (4003 out of the 4688 persons) started treatment at specialised outpatient units, low threshold service providers or at general/mental health care service providers.

²⁸ and other treatment units with a primarily social profile

²⁹ which the law classes as ‘treatment for drug addiction’ and ‘treatment of other conditions with drug use’.

Table 5. Outpatient treatment provision (the number of clients starting treatment in 2014)

	total number of clients (starting treatment)	characteristics of clients
specialised drug treatment centres	3079	Among them 1980 persons started treatment in the scope of a QCT.
low-threshold agencies ³⁰	775	Among them 539 persons started treatment in the scope of QCT.
general / mental health care	149	Among them 117 persons started treatment in the scope of QCT.
prisons	146	Among them 144 persons started treatment in the scope of QCT.

Source: TDI data collection 2015 - ST24_2015_HU_01

Inpatient network

T1.2.6 Inpatient drug treatment system

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

- health care treatment:
 - active, chronic and rehabilitation inpatient addiction treatment
 - rehabilitation addiction treatment for children and youth
 - psychiatric, chronic and rehabilitation inpatient treatment
 - psychiatric rehabilitation treatment for children and youth
- social services (Act III of 1993 on social administration and social services):
 - institutions providing nursing and care for psychiatric patients and addicts
 - rehabilitation institutions for psychiatric patients and addicts
 - institutions providing temporary accommodation for psychiatric patients and addicts
 - residential homes for psychiatric patients and addicts
 - supported housing

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

Due to the categorisation of drug treatment as part of wider treatment categories, there are no precise numerical data available about the number of inpatient treatment centres actually

³⁰ and other, treatment units with a primarily social profile

treating drug users. Data on inpatient treatment services is available from the TDI data collection, with a low coverage. This data is presented in Table 6 and Table 7.

Table 6. *Network of inpatient treatment facilities (number of treatment units in 2014)*

	total number of units	definition (types of treatment units)
hospital-based residential drug treatment	8	Treatment units identifying themselves in the TDI data collection as inpatient hospital addiction or psychiatric departments.
residential drug treatment (non-hospital based)	0	
therapeutic communities	6	Therapeutic communities operating in a non-hospital based environment – drug therapy/drug rehabilitation institutes/homes identifying themselves in the TDI data collection as inpatient treatment units.
prisons	0	Inpatient and outpatient treatment units treating prisoners are shown together in Table 4.

Source: TDI data collection 2015 - ST24_2015_HU_01

For further information on therapeutic communities in Hungary see 2012 National Report, Chapter 11.

T1.2.7 Further aspects of inpatient drug treatment provision

For alternatives to criminal procedure see Chapter T1.2.2.

The number of addiction and psychiatric departments is significantly higher than those reporting to the TDI data collection, however only a proportion of them treat drug users, and it may be assumed that only some of these report data to the TDI data collection. The number of therapeutic communities on the basis of the latest focussed study was 14 (for further details see 2012 National Report, Chapter 11), of these only 6 treatment units reported cases to the TDI data collection.

T1.2.8 Inpatient drug treatment system – Client utilisation in 2014

Approximately the half of the new drug user clients starting inpatient treatment were treated in therapeutic communities with a mixed profile, and the others were treated in hospital departments. 11.5% of all clients (539 out of 4688 persons) started treatment in 2014 in the scope of inpatient treatment.

Table 7. *Inpatient treatment provision (number of clients starting treatment in 2014)*

	total number of clients (starting treatment)	characteristics of clients
hospital-based residential drug treatment	266	Among them 7 persons started treatment in the scope of QCT.
residential drug treatment (non-hospital based)	0	
therapeutic communities	273	Among them 1 person started treatment in the scope of QCT.
prisons	0	Imprisoned clients are presented in 0.

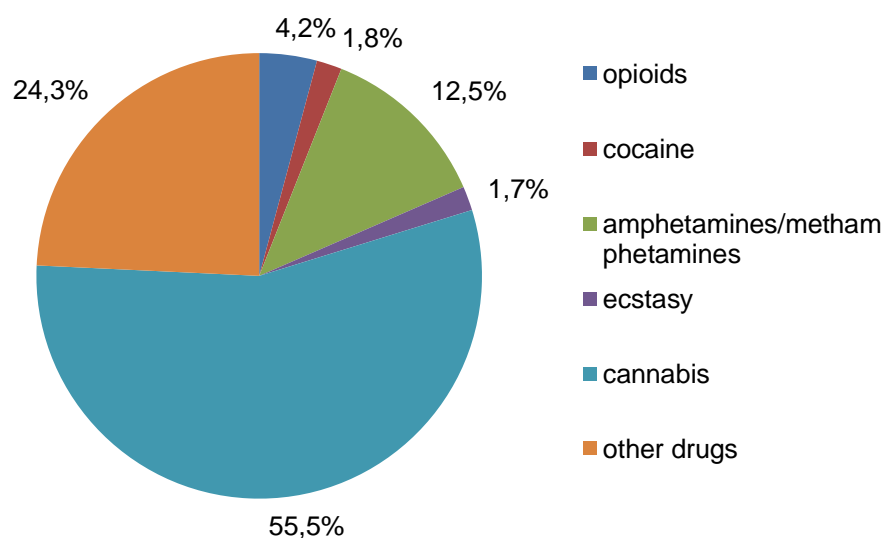
Source: TDI data collection 2015 - ST24_2015_HU_01

T1.3 KEY DATA

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

The 90 treatment units providing drug treatment and reporting to the TDI reported a total of 4688 clients entering treatment in 2014. 3120 of the clients entered drug treatment for the first time in their lives. The majority (55.5%) of those starting treatment due to drug problem – similarly to previous years – started a treatment programme because of cannabis use. 12.5% started treatment because of amphetamine use. Opioid use was the reason for starting treatment to a less significant extent (4.2%). The proportion of cocaine and ecstasy users was under 2% each. Nearly one quarter (24.3%) of treatment entrants indicated the use of other (non categorisable) substances as their primary substance.

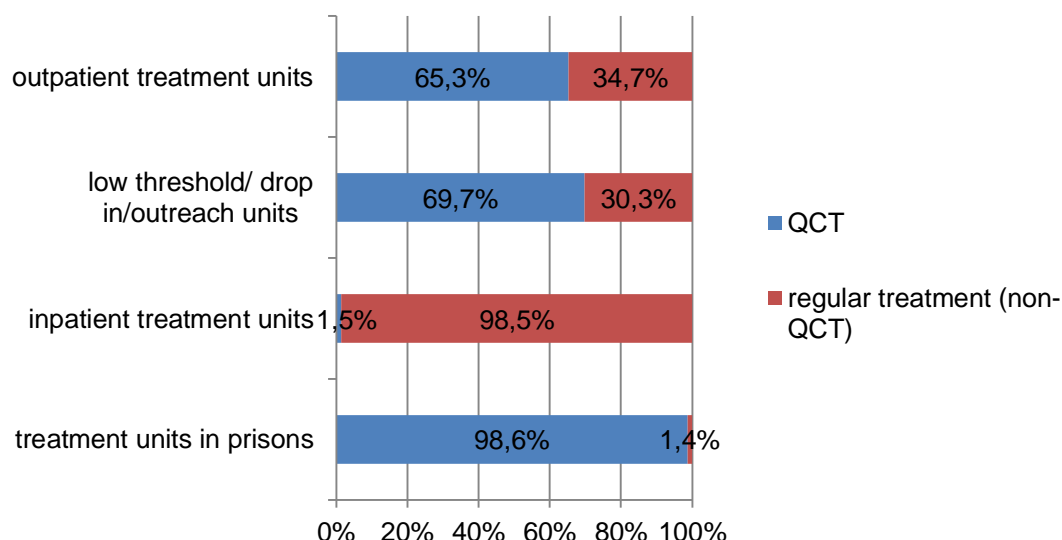
Chart 8. *Breakdown of treatment demand by primary drug (2014; %; N=4688)*



Source: TDI data collection 2015

Avoiding criminal procedure (QCT) was the main reason for entering treatment among drug users. With respect to all clients, 60% of them (2788 persons) entered treatment in this way. It is important to note, however, that on examining the treatment unit types, serious differences can be observed in the proportions of those avoiding criminal procedure. While approximately two third of the clients of inpatient and low threshold (social) service providers started treatment in this way (65% and 70%), only a very small fraction of those entering inpatient treatment (2%) started a treatment programme as an alternative to criminal procedure.

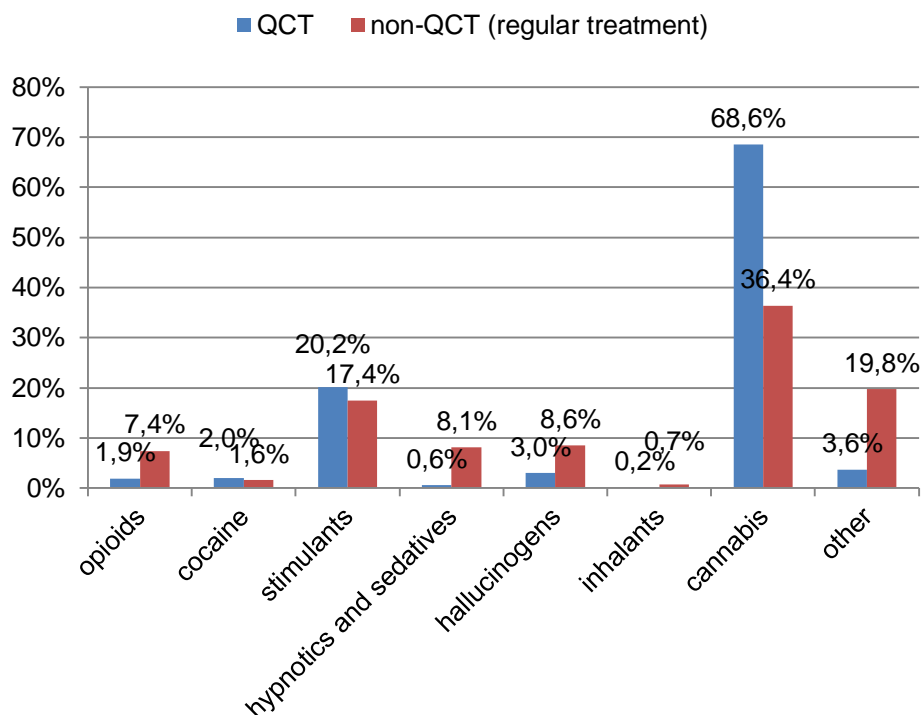
Chart 9. *The proportion of those starting treatment as an alternative to criminal procedure (QCT) among those entering treatment, by type of treatment unit (2014; N=4666)*



Source: TDI data collection 2015

The distribution according to primary drug also shows a different picture among those starting treatment as an alternative to criminal procedure (QCT, quasi-compulsory treatment) and those starting for other reasons. In the case of those in QCT the most marked difference was the extremely high proportion of cannabis users (68.6%). This was also the most characteristic primary drug among those starting treatment for other reasons, but among them the proportion of cannabis users was just 36.4%.

Chart 10. Breakdown of QCT and non-QCT (regular treatment) treatment entrants by primary drug (2014; $N_{QCT\ clients}=2788$; $N_{Non-QCT\ clients}=1878$)



Source: TDI data collection 2015

T1.3.4 Characteristics of clients in treatment

For a more detailed description of the characteristics of clients entering treatment see Drugs Workbook/Cannabis, Chapter T1.2.2, Drugs Workbook/Stimulants, Chapters T1.2.1 and T1.2.3, and Drugs Workbook/Heroin and other opioids, Chapters T1.2.1 and T1.2.3. For information on the characteristics of clients starting treatment in detention facilities see Prison Workbook, Chapter T1.2.2.

T1.4 TREATMENT MODALITIES

T1.4.1 Outpatient drug treatment services

For information available on outpatient drug treatment services see Chapter T1.2.1. For a detailed description of opioid substitution treatment see Chapter T1.4.8.

T1.4.3 Inpatient drug treatment services

For information available on inpatient drug treatment services see Chapter T1.2.6.

T1.4.7 Main providers of opioid substitution treatment

OST is typically provided in the scope of outpatient treatment, but there are some service providers who provide this pharmacologically assisted therapy in the scope of inpatient treatment (in a hospital or therapeutic community). OST provider treatment units are characterised by a health care profile and are typically hospital addiction or psychiatric units or clinics, or specialised outpatient units with a mixed profile. 15 service providers provide this type of treatment, however, only 7 service providers reported client data to the national reporting system (for the description of the data collection see Chapter T6.2).

The treatment units operating in prisons do not provide substitution treatment. Occasionally clients may obtain the substitution medication during preliminary custody as long as the detention facility cooperates with the external treatment unit providing the therapy before detention. (See also: Prison Workbook, Chapter T1.3.4.)

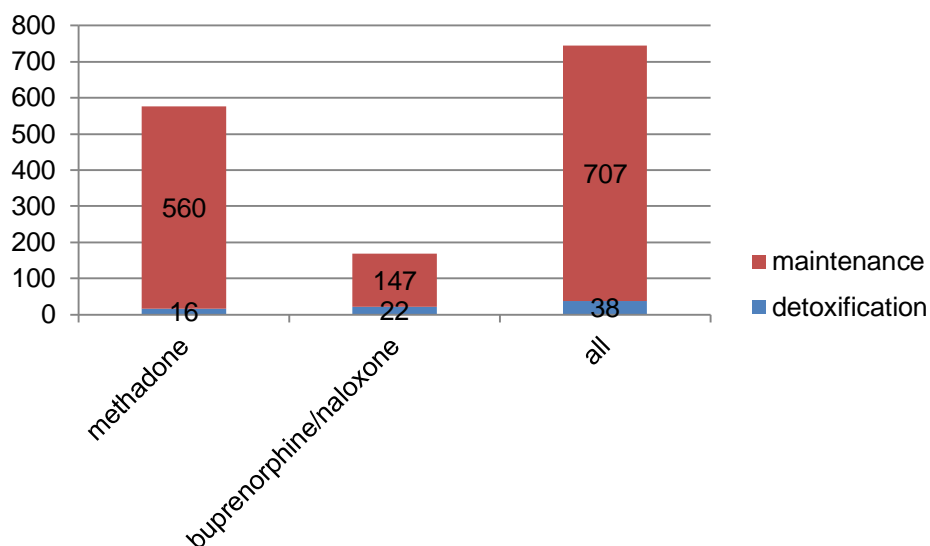
T1.4.8 Number of clients in OST

Two types of substitution medication are used in Hungary in OST programmes: methadone and buprenorphine/naloxone. Due to historical and financing reasons, the use of methadone is more widespread, typically $\frac{3}{4}$ of the annual number of cases receive this substitution medication (576 persons in 2014, 77%), while approximately $\frac{1}{4}$ of the clients receive the buprenorphine/naloxone combination (169 persons in 2014, 23%). Another difference in the use of the two substances is that buprenorphine/naloxone may be prescribed so that the medication is financed by the patient, which makes possible to treat clients who are willing to undertake the costs of treatment but otherwise would not obtain it due to the limited treatment capacities. In 2014 the Hungarian service providers sending OST data reported 745 clients, according to expert estimates this figure covers approximately 75% of all cases.

T1.4.10 Further aspect on organisation, access and availability of OST

95% of opioid substitution treatments in 2014 were maintenance treatments and 5% were detoxification treatments. It is important to note that these two forms of treatment sometimes alternate, hence it is difficult to isolate them from each other. The relevant professional guidelines (The methodological letter of the Ministry of Health on Methadone treatment) specifies the length of detoxification treatment at between 1 and 6 months.

Chart 11. *Breakdown of clients in OST by substitution medication and therapeutic purpose (2014; N=745)*



Source: OST data collection 2015

T1.5 QUALITY ASSURANCE OF DRUG TREATMENT SERVICES

T1.5.1 Quality assurance in drug treatment

Healthcare guidelines

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

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

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

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

Social guidelines

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

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

The social guidelines were elaborated by the Specialised Workgroup of Addictions. The guidelines have no designated target group, their content is based on professional consensus³¹. They describe the aims and guiding principles of the service, its quality assurance conditions and the activities covered by the service.

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

T2. TRENDS

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

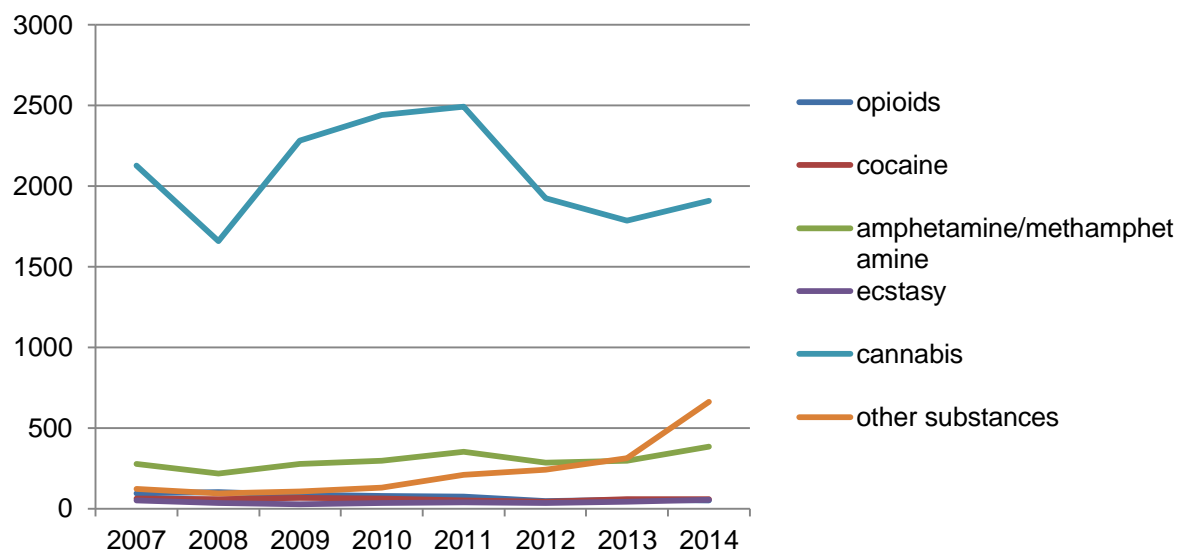
Among both first-time treatment entrants and all clients cannabis use is the most typical problem linked to treatment demand, especially among those starting treatment as an alternative to criminal procedure (QCT). The unique feature of the Hungarian treatment system already described above (see Chapters T1.2.2 and T1.3.1) is that the majority of clients start treatment in order to avoid criminal procedure. A proportion of these clients do not require addiction treatment, they are provided with a kind of indicated prevention intervention (the so called preventive-consulting service) by the service providers. In connection with the increased use of NPS, it is important to mention that until these substances are not scheduled in the lists of narcotic drugs and psychotropic substances and hence their use does not entail criminal liability the (infringement) procedures started in connection with them cannot be avoided by undertaking treatment (QCT), therefore, in this regard the regulatory background has an impact on 'treatment demand' trends.

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

Among all treatment entrants, a decrease in treatment demands linked to opioids can be seen starting from 2009. The spreading of NPS and the reduction in the use of heroin can also be observed in the seizure data (see Drug Market and Crime Workbook, Chapter T2.1).

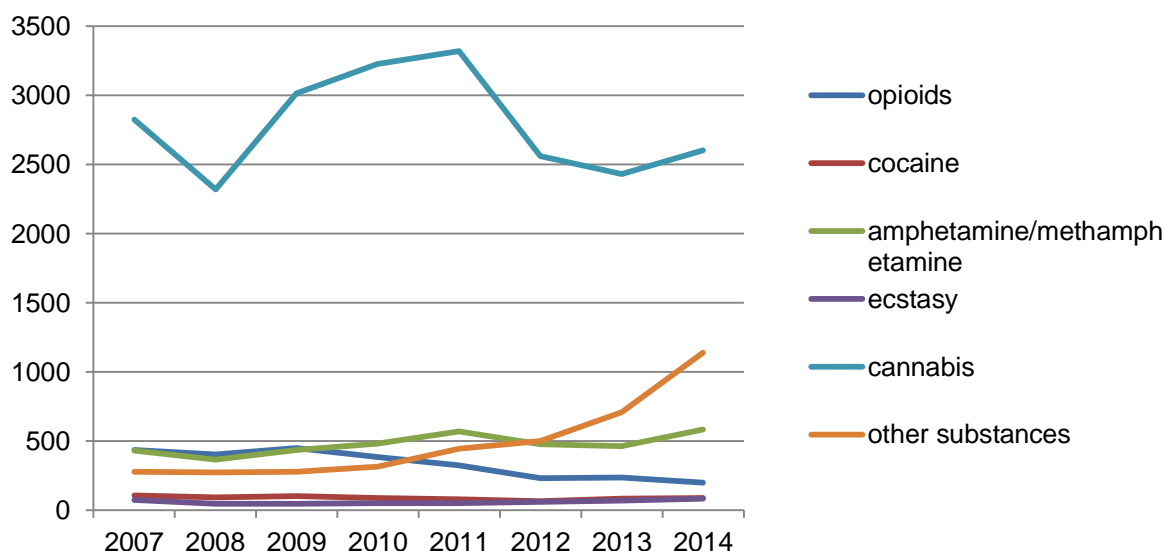
³¹ The draft guidelines were harmonised with the representatives of the field in the scope of a consensus conference.

Chart 12. Trends in the numbers of first-time clients entering treatment, by primary drug, 2007-2014



Source: TDI data collection 2015

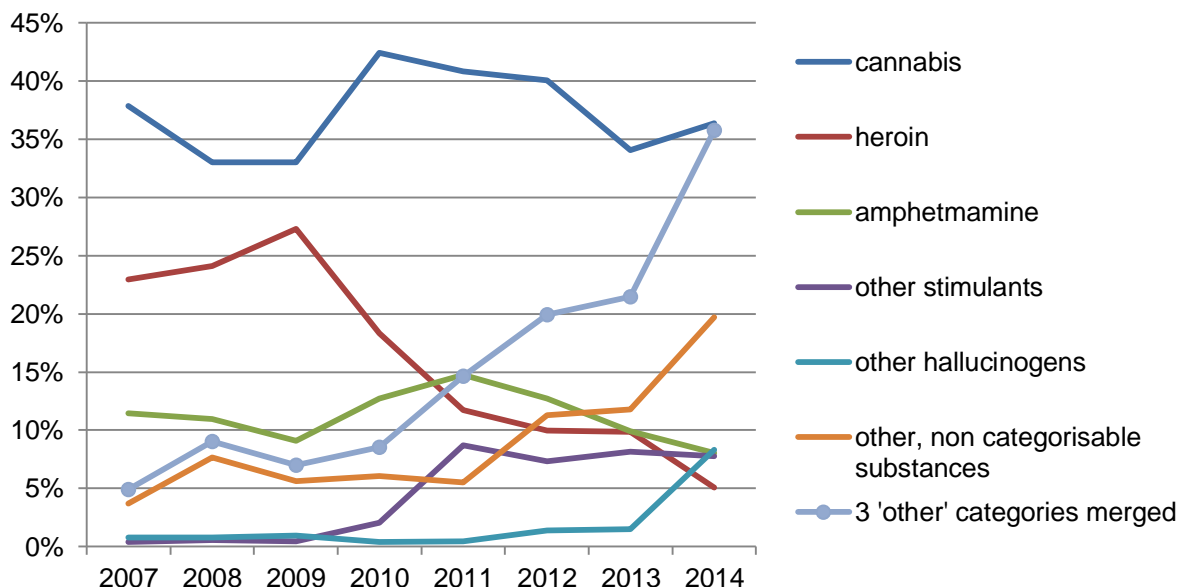
Chart 13. Trends in numbers of all clients entering treatment, by primary drug, 2007-2014



Source: TDI data collection 2015

Since QCT clients dominate the observable trends, selecting and analysing those cases when the reason for entering treatment is not to avoid criminal procedure but something else, can provide additional information on treatment demand. The proportion of heroin clients decreased from 23% to 5% in the period of 2009-2014 among non-QCT clients. Meanwhile, treatment demand associated with new psychoactive substances (according to the consultations with service providers these cases are reported in the 'other stimulants', 'other hallucinogens' and 'other non categorisable substances' categories) was constantly increasing since 2009, reaching the level of cannabis related treatment demand in 2014, as shown in Chart 14 (see '3 'other' categories merged').

Chart 14. Trends among treatment entrants excluding QCT clients* between 2007-2014

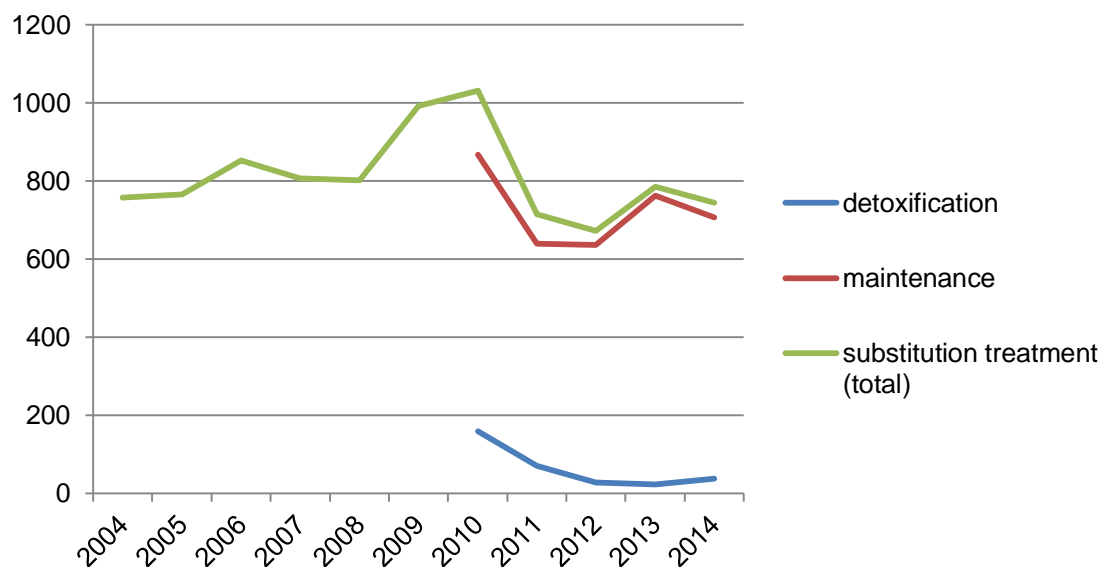


*Calculating with all non-QCT clients, showing the most important primary drugs
Source: TDI data collection 2015

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

The number of those treated in OST was relatively stable over the studied years: there was a minor increase following 2008, which can be linked to the introduction of buprenorphine/naloxone (and the introduction of the possibility of self-financed treatment), then a development in the methodology of data collection (which provided the possibility of double counting control at the national level), which caused a decrease in 2011. The reason for the relatively stable availability is that the financed treatment capacity has not changed over the years. The last estimate on the number of heroin users in Hungary was made in 2013 with respect to 2010-2011. On the basis of this in 2010 those receiving substitution treatment represented 22% of the total number of heroin users.

Chart 15. Trends in numbers of clients in OST, 2004-2014



Source: OST data collection 2015 – ST24_2015_HU_01

For the trends in injecting drug use see Drugs Workbook /Stimulants, Chapter T1.2.1 and T1.2.3.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2014, is presented as part of the baseline information in Chapter T1.

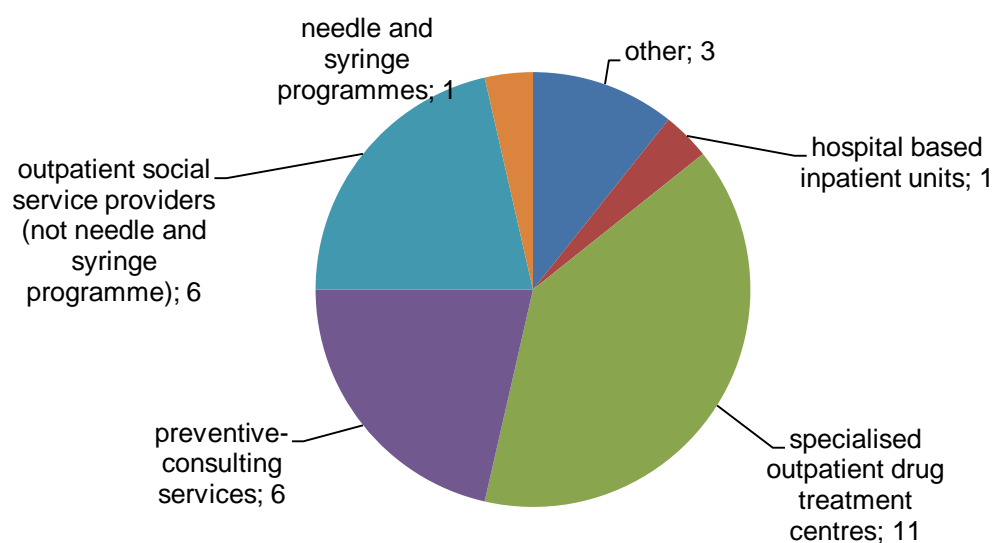
T4. ADDITIONAL INFORMATION

T4.1 ADDITIONAL SOURCES OF INFORMATION

The Hungarian National Focal Point carried out a study in 2015 (Péterfi 2015) among the largest Hungarian treatment units treating drug users (the description of the methodology is included in Chapter T6.2). The treatment units in the sample were responsible for treating 74% of the clients starting treatment in 2013 (on the basis of TDI data). Although the sample is not representative of the Hungarian drug treatment system, these are the service providers with the greatest turnover, therefore their characteristics are still determinant from the point of view of Hungarian treatment network.

The majority of the respondents identified themselves as outpatient units, the largest proportion in the sample consisted of specialised outpatient DTCs.

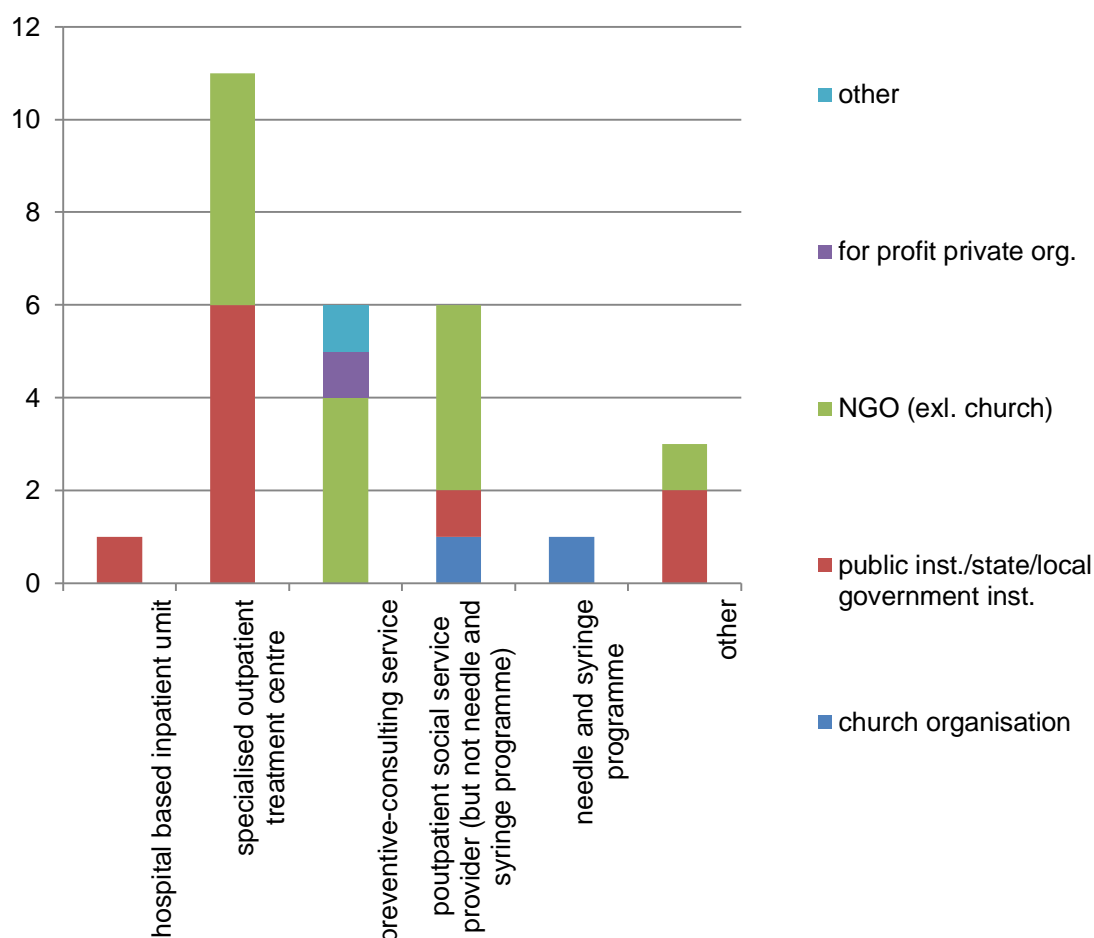
Chart 16. *Treatment unit type (N=28)*



Source: Péterfi 2015

From the point of view of form of operation, approximately half of the specialised outpatient drug treatment centres were operated by NGOs and the other half by organisations with a state/local governmental background. The majority of social outpatient service providers and preventive-consulting service providers classed themselves as NGOs. Altogether half of the 28 respondents (14 treatment units) classed themselves as NGOs.

Chart 17. Form of operation by type of treatment unit (N=28)



Source: Péterfi 2015

With respect to the state financing available for treating drug users, financing from both the health care and the social budget is equally important, and it is not possible to describe the services provided considering just one of the sources. The majority of those in the sample (9) indicated that they were exclusively health care financed³², 7 treatment units reported to use only funding allocated for social services³³, 6 service providers operated with mixed financing, while another 6 organisations only provided preventive-consulting services, so they could not apply for other resources allocated for the health and social care of drug users³⁴.

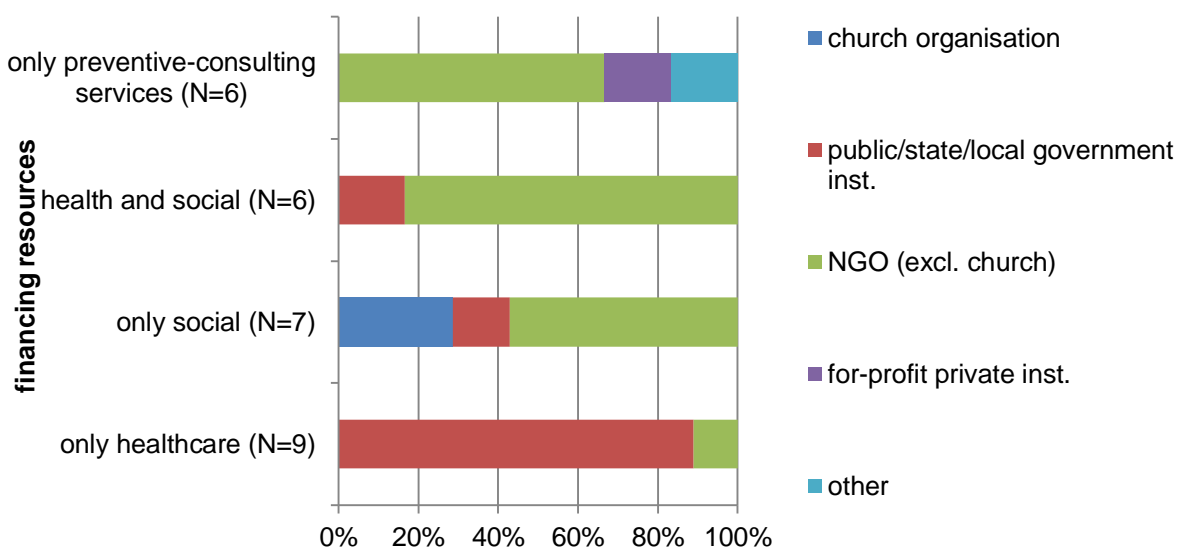
Comparing form of operation with the sources of financing used, there is a greater proportion of nonprofit NGOs among those institutions that have mixed financing, the provision of exclusively social services is more characteristic among church organisations and NGOs. The majority of those only using healthcare financing are public institutions, and those units only offering preventive consulting services are characteristically NGOs, profit oriented organisations or reported other forms of operation.

³² National Health Insurance Fund financed addiction (or drug) or psychiatric inpatient or outpatient treatment

³³ Community care for addicts (National Office for Rehabilitation and Social Affairs), Low threshold services for addicts (National Office for Rehabilitation and Social Affairs), Day-care services for addicts (National Office for Rehabilitation and Social Affairs)

³⁴ When categorising the financing possibilities the financing available for preventive-consulting services were not included among the social services sources.

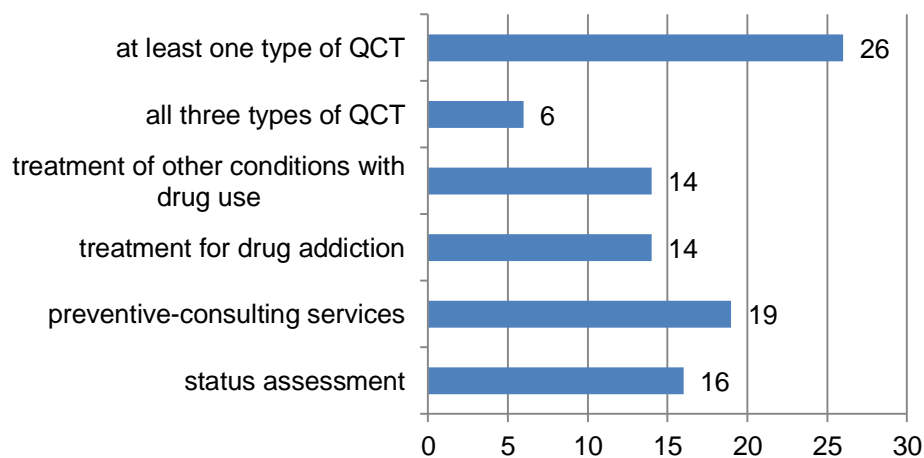
Chart 18. Form of operation by financing resources (N=26)



Source: Péterfi 2015

QCT was available at 26 of the 28 service providers, with preventive-consulting services being available in the greatest proportion.

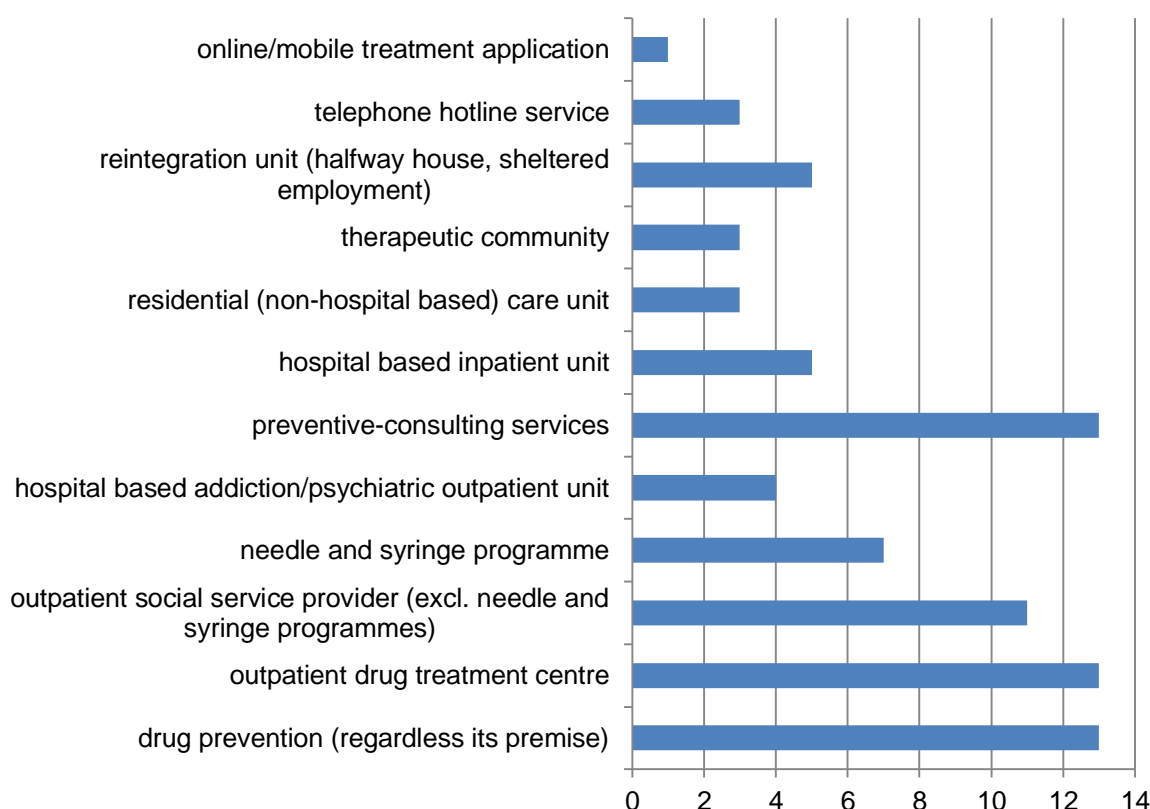
Chart 19. Availability of QCT (N=28)



Source: Péterfi 2015

With respect to the other programmes operated by the parent institution, preventive-consulting services, outpatient drug treatment centre and drug prevention were the units/programmes mentioned the most, which are typically provided by a separate unit.

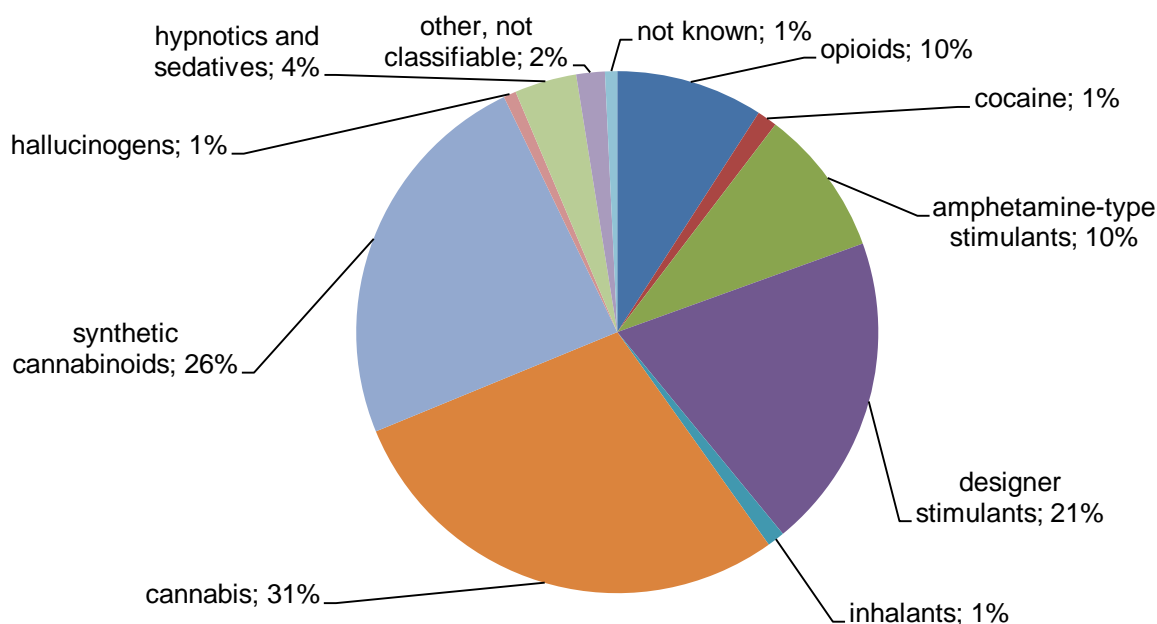
Chart 20. *Other units/programmes operated by the parent institution (N=28)*



Source: Péterfi 2015

With respect to the clientele of the treatment units, on the basis of the responses from 25 respondents, 17 treatment units provide treatment for both drug and alcohol problems, and among these only 3 reported that they had treated more alcoholics in 2014 than drug users. A further 8 treatment units reported that they had only treated drug users. With the help of the estimated distribution of drug user clients by primary drug and the reported annual number of clients, the distribution by primary drug of the population treated by the 25 treatment units providing data could be estimated, according to which, – similarly to the treatment (TDI) data – cannabis use was the main problem (31%). The two largest client groups following cannabis received treatment in 2014 because of the use of NPS, namely synthetic cannabinoids (26%) and designer stimulants (21%). Approximately 10% of the cases were linked to opioid use and 10% to the use of amphetamine-type stimulants on the basis of the estimates.

Chart 21. *The estimated breakdown of drug user clients by primary drug in 2014 (on the basis of the responses from 25 treatment units)*



Source: Péterfi 2015

T5. NOTES AND QUERIES

T5.1 MONITORING THE MISUSE OF OPIOID SUBSTITUTION MEDICATIONS

(Is there any monitoring in place and data available on the misuse of opioid substitution medications?)

There is no data collection in Hungary specifically monitoring the misuse of substitution medications, there are, however, other data collections in which the existence of this phenomenon can be seen. These are:

- The data collection performed by the Hungarian National Focal Point on street drug prices: survey on the street prices reported by substance users (and indirectly on the availability of the substances), the substances mentioned by those in the sample included both methadone, and buprenorphine/naloxone (see Drug Market and Crime Workbook, Chapter T1.1.5);
- TDI data collection: routine data collection, which also provides information on the number of those starting treatment in the given year primarily due to the misuse of methadone (see Drugs Workbook/Heroin and other opioids, chapter T1.2.1 and T1.2.3);
- Drug-related deaths: routine data collection, which provides information on the number of deaths in the given year due to drug overdose broken down by drugs (which data may also include the deaths linked to methadone) (see Harms and Harm Reduction Workbook, Chapter T1.1.1);
- The data collection performed by the Hungarian National Focal Point among service providers running needle and syringe programmes: routine data collection among Hungarian service providers, which covers the primarily injected substance of the clients. Both methadone and buprenorphine/naloxone appear among the reported substances (see Drugs Workbook /Stimulants, Chapter T1.2.1);

- The seizure data from the Hungarian Institute for Forensic Sciences (BSZKI): the seizure data provided annually by the BSZKI includes a separate statistic on the active substances detected on injecting equipment, among these methadone is also included. (see Drug Market and Crime Workbook, Chapter T1.1.5).

T5.2 AVAILABILITY OF INTERNET-BASED TREATMENT IN HUNGARY (Is internet-based treatment available in your country?)

Yes.

On the basis of information from the Magyarországi Online Tanácsadás Egyesület (Hungarian Online Counselling Association), there are 4 online programmes available in Hungary for drug users:

- a self-help programme operated by the Kék Pont Alapítvány aimed at cannabis users (kannabiszpont.hu);
- the harm reduction application and online counselling for drug users (drogstoponline.hu) operated by Drog-Stop;
- the online counselling programme of the Félúton Alapítvány primarily targeting addicts (<http://www.feluton.hu>);
- and the online counselling programme aimed at drug users of the Kallódó Ifjúságot Mentő Missziós Támogató Alapítvány (<http://drogproblemak.hu/index.php/online-tanacsadas>).

T5.3 SPECIFIC TREATMENT PROGRAMMES FOR NPS USERS (Has your country developed any specific treatments for NPS users?)

No.

In the treatment facility survey performed by the Hungarian National Focal Point (see chapters T4.1 and T6.2) 1 service provider mentioned a special programme offered to NPS users: an abstinence support group especially for members of this substance user group.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

Csák, R. (2012): A 2011-ben tapasztalt új jelenségek a különböző típusú szolgáltatók megkérdezése alapján. Nemzeti Drog Fókuszpont. Unpublished thesis.

EMCDDA (2000): Treatment demand indicator, standard protocol 2.0.
<http://www.emcdda.europa.eu/html.cfm/index65315EN.html> (last accessed: 04.06.2015)

Global Drug Survey (2014): Global Drug Survey 2014 findings.
<http://www.globaldrugsurvey.com/facts-figures/the-global-drug-survey-2014-findings/>
(last accessed: 25.06.2015)

Horváth, G. Cs., Péterfi, A., Tarján, A. (2011): A kábítószer-fogyasztással kapcsolatos új jelenségek 2010-ben az ellátóhelyek tapasztalatai alapján. Nemzeti Drog Fókuszpont. Unpublished thesis.

Péterfi A. (2015): Kezelőhely vizsgálat 2015. Nemzeti Drog Fókuszpont. Unpublished thesis.

T6.2 METHODOLOGY

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

TDI data collection 2015: The TDI (Treatment Demand Indicator) data collection is coordinated by the National Centre for Addictions, and the data are processed and analysed by the Hungarian National Focal Point. On the basis of Ministry of Health, Social and Family Affairs decree 76/2004. (VIII. 19.), Hungarian service providers must report every drug user who enters treatment to the TDI. The data collection questionnaire was developed in line with the guidelines of the TDI 2.0 protocol (EMCDDA 2010). The data is collected using anonymous identifiers, so duplication can be controlled in the annual statistics – in other words one person appears just once in the data per year. For further details see the protocol (EMCDDA 2010).

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

HARMS AND HARM REDUCTION³⁵

T0. SUMMARY

With respect to drug-related deaths, over the past 10 years in Hungary there have been some 20–30 deaths per year directly related to overdoses. The annual fluctuation in the number of deaths before 2010 was mainly due to the purity of street heroin. The drastic fall in the availability of heroin in 2010 also caused a drop in the number of deaths linked to this substance. The falling tendency after 2011 was counterbalanced in 2012 and 2013 by the rise in the number of deaths linked to new psychoactive substances (NPS). In 2014 the number of deaths linked to opioids rose slightly once again. The change occurring in the substance structure overall did not cause any change in the number of deaths (ST6_2015_HU_01).

In 2014 23 overdose deaths directly related to illicit drug use and 42 deaths indirectly related to drug use were reported to the mortality special register. In about a half of the cases, the combined use of an opioid and other substances led to fatal intoxications. The other half of the cases were linked to a stimulant: amphetamine, methamphetamine or a designer stimulant (ST5_2015_HU_01 'SR').

In the case of drug related infectious diseases, during the national HIV/HCV seroprevalence survey being carried out since 2006, in 2014 persons infected with HIV were found for the first time among the tested injecting drug users (IDU) (2 persons, 0.3%). The national hepatitis C virus (HCV) prevalence rate among IDUs was about 25% up to 2011, however, this figure turned out to be 48.7% in 2014, which is twice the national HCV prevalence value measured in the previous years.

Before NPS became so widespread, HCV prevalence was usually significantly higher among those injecting opioids. This then changed: in 2011 a higher HCV prevalence rate was found among those primarily injecting stimulants (amphetamine or designer stimulants), while the national prevalence rate had not changed yet. In 2014 HCV prevalence doubled both among opioid and stimulant injectors.

In 2014 among current IDUs injecting in the past 4 weeks, NPS injectors formed the largest group. Among them HCV prevalence was 73.9%.

In the field of responses, the number of syringes distributed by needle/syringe programs (NSPs) rose sharply in 2011 as compared to the previous years, the cause of which was the spread of NPS starting in 2010, as these substances are injected much more frequently than classical illicit drugs. The increasing trend lasting until 2011 was stopped in 2012 by the decrease in resources, when in spite of the increasing syringe demand due to the new substance use patterns, the organisations distributed about 220,000 less syringes. Although as a result of one-time ministerial supports the number of distributed syringes has increased in the past 2 years, however, their number was still well below the data measured in 2011. Contrary to the change in the number of distributed syringes, the number of clients attending NSPs, or the number of contacts showed a steep rise after 2012. It can be assumed that clients compensated for the restricted availability of sterile syringes per contact with a larger number of appearances and with the involvement of peers not attending NSPs before.

In 2014 the programmes distributed a total of 460,977 sterile syringes to the clients, and the number of used syringes returned by the clients or collected was 296,716. A total of 4,442 IDUs attended the programmes in 2014 on 41,535 occasions. 81 syringes were distributed per IDU in the year in question.

³⁵ Authors of the chapter: Gergely Csaba Horváth, Anna Tarján

T1. NATIONAL PROFILE

T1.1 DRUG-RELATED DEATHS

T1.1.1 Overdose deaths

Direct drug-related death cases

In 2014 23 deaths directly related to drug use were reported to the mortality special register, which means a return to the number experienced in previous years after the high number of cases in 2013 (2013:31; 2012: 24; 2011:14, 2010:17 cases)³⁶. Of the 23 deaths, in 2 cases the deceased was female. (ST5_2015_HU_02 'SR')

There was no clear evidence of intention to commit suicide in the cases in 2014.

Table 8. *Breakdown of direct drug-related deaths in 2014 by gender and substance type (persons)*

	male	female	total
intoxication caused by opioids ³⁷	8	2	10
overdose/intoxication caused by methadone (without other drugs) ³⁸	2	0	2
intoxication caused by other, non-opioid drugs	4	0	4
intoxication caused by other substances ³⁹	7	0	7
total	21	2	23

Source: National Centre for Addictions (OAC 2015a)

Among cases of fatal overdose, the mean age of the males was 33.3 years and of the females it was 38 years, and together 33.7 years. Deaths linked to opioids and methadone were characteristic in the age group over 35 years.

The most deaths, 7 cases (30.4%), belonged to the 30-34 age group, a further 5 cases (21.7%) each belonged to the 35-38 and the 40-44 age group, overall three-quarters of the cases were over 30 years of age.

Table 9. *Breakdown of direct drug-related deaths by age group and substance type in 2014 (persons)*

	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	60-64	total
overdose/intoxication caused by opioids (without methadone and other substances)	0	0	0	0	0	0	0	0	0	0
overdose/intoxication caused by opioids and other substances	0	0	0	3	4	3	0	0	0	10
overdose/intoxication caused by methadone	0	0	0	0	0	1	1	0	0	2
intoxication caused by other, non-opioid drugs	0	0	1	2	0	1	0	0	0	4

³⁶ The cases linked to tramadol were excluded.

³⁷ Beside opioid metabolites (morphine) other substances may also occur, including methadone also, but cases linked exclusively to methadone were excluded.

³⁸ Beside the occurrence of alcohol and/or benzodiazepines.

³⁹ With the exclusion of psychoactive substances and medicinal products not classed as illicit drugs.

intoxication caused by other substances	1	3	0	2	1	0	0	0	0	7
total	1	3	1	7	5	5	1	0	0	23

Source: National Centre for Addictions (OAC 2015a)

Of the 23 deaths 13 (56.6%) – including the female deaths– happened in Budapest, three deaths took place in county seats or large towns, three in small towns, and two happened in villages. In one case the deceased was a homeless person, and in one other the deceased was a foreign citizen, a citizen of an EU Member State.

The trends in drug-related deaths is presented in Chapter T2.2.

Indirect deaths

In 2014 42 indirect drug-related death cases were reported to the mortality special register. Among the deceased, 33 were male and 9 were female.

Among the cases, 11 deaths can be traced back to a natural cause related to previous drug use. The cause of death was most frequently of cardiology nature (myocardial degeneration). An illicit drug was found in the biological samples of 17 suicides. Violent death occurred in 14 cases (murder, accident or self-harm where intent could not be determined).

T1.1.2 Toxicology of overdose deaths

Toxicology of overdose deaths

There was no death exclusively related to heroin use in 2014 either. The polydrug use of an opioid and other illicit drug was fatal in 10 cases. All of the cases linked to heroin were related to polydrug use, typically other 4–5 substances could be identified in the biological samples of the deceased. The most common such substances were benzodiazepines, codeine and methadone.

The forensic medical specialist determined fatal intoxication due to methadone in two cases, in one case benzodiazepine was also found to be present beside the metabolite of methadone.

There were four cases of death caused by other, non-opioid illicit drugs. In three cases amphetamine and methamphetamine were found to be present beside other drugs. The use of GHB with various medicines was the cause of the fourth polydrug-related death.

In seven cases the cause of death was linked to another substance, these were typically deaths linked to new psychoactive substances (NPS). α -PVP was present in three cases and α -PVT in one case. Synthetic cannabinoids were found in the samples in four cases (AB-PINACA, ADB-CHMINACA, AB-CHMINACA) beside other substances. The other new psychoactive substances found were pentadron, bk-MPA and MXP, and other illicit drugs and medicines were also found. In 3 cases the samples contained designer stimulants and synthetic cannabinoids together.

Alcohol was also found to be present in the blood of 12 of the deceased.

Table 10. *Number of direct drug-related deaths in 2014*⁴⁰

	total
overdose/intoxication caused by opioids (without methadone and other substances)	0
overdose/intoxication caused by opioids and other substances	10
overdose/intoxication caused by methadone ⁴¹	2
intoxication caused by other, non-opioid drugs	4
intoxication caused by other substances	7
total	23

Source: National Centre for Addictions (OAC 2015a)

T1.2 DRUG-RELATED ACUTE EMERGENCIES

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

T1.3 DRUG-RELATED INFECTIOUS DISEASES

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

Notifications of HIV/AIDS, HBV, HCV

In 2014 a total of 271 newly diagnosed HIV-positive cases were reported in Hungary, the incidence rate was 27 cases/1 million population. The transmission route was known in the case of more than three quarters of the registered HIV positive persons. Among the HIV-positive cases and AIDS patients belonging to the identified risk groups, one Hungarian citizen belonged to the risk group of injecting drug users (IDU). (Csohán et al. 2015).

Table 11. *Breakdown of registered HIV-positive persons (N) by risk group between 2010-2014*

	2010	2011	2012	2013	2014
homo/bisexual	124	106	146	160	171
heterosexual	19	18	23	24	28
haemophiliac	0	0	0	0	0
transfusion cases	0	2*	1*	0	0
IDU	0	0	0	1*	1
nosocomial	0	0	0	0	0
perinatal	0	0	1	1	1
unknown	39	36	48	54	70
total	182	162	219	240	271

* Imported cases

Source: National Centre for Epidemiology (Csohán et al. 2015)

In 2014 67 cases of acute hepatitis B were reported, the incidence rate was 0.7‰. The transmission route was known in the case of 10 patients among whom two men between the ages of 25-34 belonged to the risk group of IDUs.

⁴⁰ Special register Selection D.

⁴¹ Beside the occurrence of alcohol and/or benzodiazepines.

In 2014 44 cases of acute hepatitis C were reported, the incidence rate was 0.4‰. Among the 44 patients, the transmission route was known in 8 cases among whom a woman under 25 and another between the ages of 25 and 34, three men under 25 and two men between the ages of 25 and 34 became infected by injecting drug use. (Csohán et al. 2015)

HIV/HCV prevalence among IDUs

Of the 592 IDUs tested in the national HIV/HCV seroprevalence survey (Dudás et al. 2014), 438 (74%) were men and 154 (26%) were women. Among the three age groups (<25, 25-34, 34<) the 25-34 age group and the age group above 34 included 40-40% of the study participants, the smallest group, 95 persons (20%) was formed by participants below 25 years. For injecting patterns see: Drugs Workbook/Stimulants, Chapter T1.2.1 and Drugs Workbook/Heroin and other opioids, Chapter T.1.2.1.

HIV

On the basis of the HIV/HCV seroprevalence survey in 2014, 2 men out of the 592 persons tested HIV-positive (0.3%), they were in the 25-34 age group. Both of them had been injecting drugs for 2–4 years. Both had been injecting primarily new psychoactive substances (NPS). The two HIV-positive persons had last injected within the past 4 weeks prior to the survey. (ST9P2_2015_HU_01)

HCV

The laboratory tests for HCV gave a conclusive result in 573 cases (see Chapter T1.6.2). Among them 279 persons tested positive for hepatitis C antibodies (48.7%) (ST9P2_2015_HU_02). One of the HIV positive persons also tested positive for HCV. Among current IDUs injecting in the past 4 weeks prior to the survey, 64.9% tested positive for hepatitis C antibodies.

The difference between the prevalence rates of HCV infection among men and women (49.8% and 45.6%) was not significant. The HCV prevalence rates of men in the 25-34 age group and of men and women above the age of 34 were in excess of the average prevalence rate. Apart from this it is important to mention that the HCV prevalence of young male and female IDUs below the age of 25 was over 30%.

Table 12. *Breakdown of HCV prevalence among IDUs tested during the national HIV/HCV seroprevalence survey, by gender and age group in 2014*

age group	gender	number of IDUs tested (N)	number of HCV positive IDUs (N)	proportion of HCV positive IDUs (%)
< 25 years	male	61	21	34.4
	female	32	10	31.3
25-34 years	male	173	95	54.9
	female	66	31	47.0
> 34 years	male	191	96	50.3
	female	49	26	53.1

Source: Dudás et al. 2014

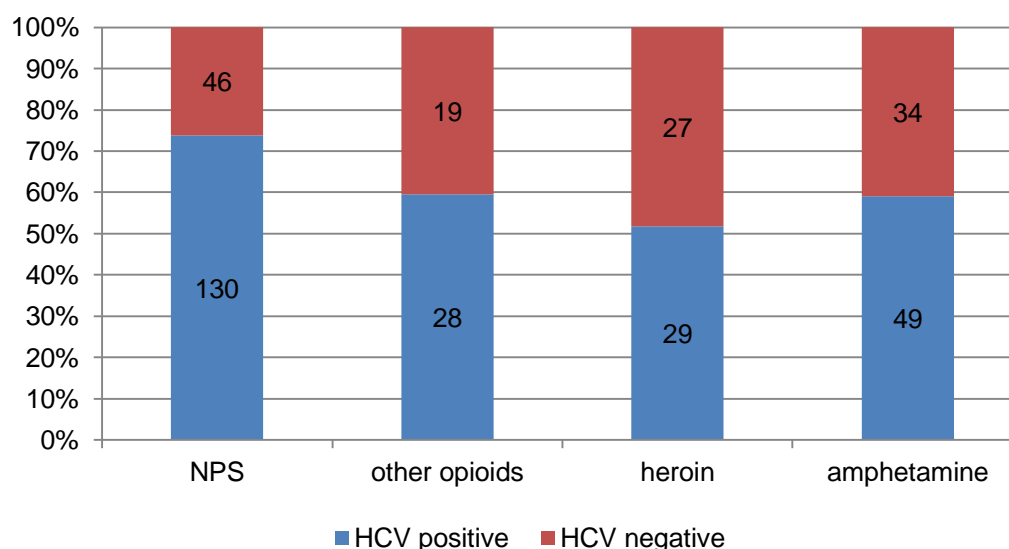
HCV prevalence rates significantly higher than the national average were measured among those injecting for 2–4 years (54.1%) and those injecting for more than 9 years (55.6%). The prevalence of HCV among those injecting for less than 2 years was 21.4%, and 44.9% among those injecting for 5–9 years.

HCV prevalence rate among those primarily injecting stimulants (amphetamine, cocaine or NPS) was 55.7%, while it was 36.6% among IDUs injecting primarily opioids. It is to be

highlighted that 79% of stimulant injectors residing in Budapest were HCV positive (150 samples from 190). (ST9P2_2015_HU_02)

Selecting current IDUs from the total sample – those who are the most exposed to virus acquisition and transmission – it can be seen that the rate of HCV infection was the highest among those injecting NPS (73.9%). For further data on injecting patterns see: Drugs Workbook/Stimulants, Chapter T1.2.1 and Drugs Workbook/Heroin and other opioids, Chapter T.1.2.1.

Chart 22. Breakdown of HCV prevalence among current IDUs tested during the national HIV/HCV seroprevalence survey by primarily injected drug, in 2014



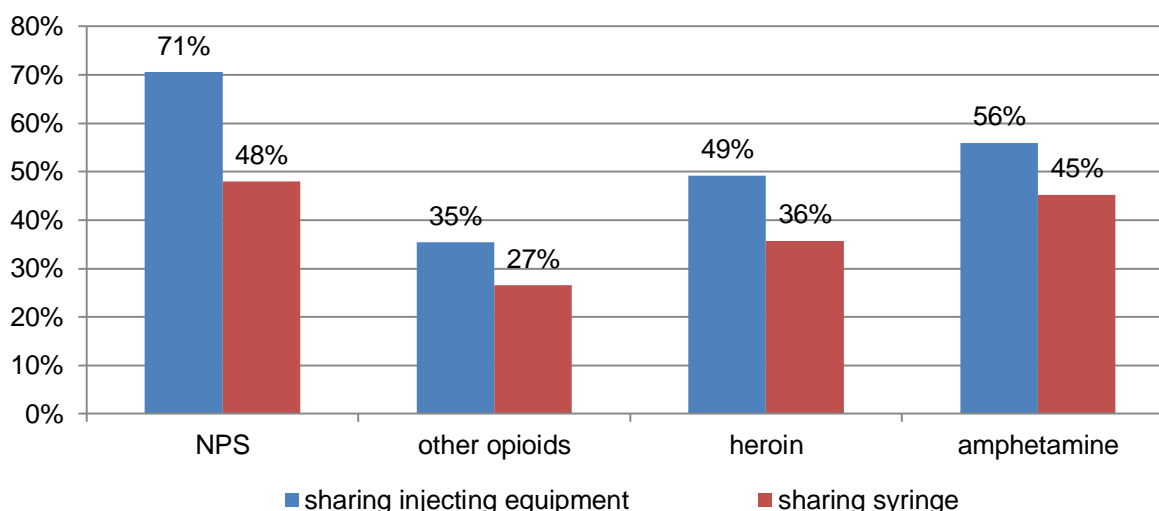
Source: Dudás et al. 2014, analysed by HNFP

As regards geographic distribution, 199 of the 327 samples from Budapest proved to be hepatitis C positive, which means a 60.9% rate of infection (ST9P2_2015_HU_03). As opposed to this, 32.5% of the samples coming from outside Budapest were tested hepatitis C positive (80 of the 246 samples) (ST9P2_2015_HU_04). Outside of Budapest the highest HCV prevalence rates were measured in Miskolc (52.5%), Szeged (37%) and Pécs (36.2%).

T1.3.4 Drug-related infectious diseases – behavioural data

According to the results of the HIV/HCV seroprevalence survey, 42.7% of current IDUs had shared syringes in the past 4 weeks, while the prevalence of sharing any injecting equipment in the past 4 weeks was 59.2%. If equipment sharing is examined broken down by primary injected substances, it can be said that the prevalence rates are the highest among NPS injectors, which in their case is also coupled with high HCV prevalence. (ST9P3_2015_HU_01)

Chart 23. *The prevalence of sharing needles/syringes and sharing any injecting equipment in the past 4 weeks (%) among current IDUs participating in the national HIV/HCV seroprevalence survey⁴² in 2014*



Source: Dudás et al. 2014, analysed by HNFP

The number of injecting episodes per day and the number of reuses of the last syringe was generally the highest among those injecting the NPS mentioned as 'music'.

Table 13. *The number of injecting episodes on the last day when injecting and the number of reuses of the last discarded syringe (group mean) among IDUs participating in the national HIV/HCV seroprevalence survey by primary injected substances, in 2014*

		no. of injections	no. of respondents	no. of reuses	no. of respondents
classical drugs	amphetamine	3.46	127	1.87	128
	other opioids	2.35	79	2.09	78
	heroin	3.13	127	2.09	127
NPS	other NPS	3.50	10	2.40	10
	MDPV	3.16	31	1.88	32
	'penta crystal'	3.38	152	2.15	153
	'music'	5.02	42	2.42	43

Source: Dudás et al. 2014, analysed by HNFP

60.4% of current IDUs admitted to inject every day (injecting once or several times a day). 86% of current IDUs injected with a sterile syringe on the last occasion, 70.6% obtained 15 or more sterile syringes for personal use in the past 4 weeks.⁴³

Among the 524 IDUs giving valid responses, 202 persons (38.5%) had never been tested for HIV before the present seroprevalence survey. 117 persons (22.3%) stated that they had been last tested for HIV in 2013 or 2014.

Excluding those who self-reported being HCV-positive from the analysis, there were 434 valid responses relating HCV testing uptake. 187 (43.1%) IDUs stated that they had never been tested for HCV before the survey. Among those who had been tested for HCV at some time in their lives in the past, 97 persons stated that they had been last tested for HCV in

⁴² Number of respondents in the case of syringe sharing (N): NPS=173; other opioids=49; heroin=56; amphetamine=84. Number of respondents in the case of equipment sharing (N): NPS=180; other opioids=48; heroin=57; amphetamine=84

⁴³ When interpreting the data it is important to take into consideration that the study was carried out in outpatient DTCs or NSPs, so it involved IDUs who were covered by treatment or harm reduction services.

2013 or 2014, which figure represents 22.4% of those giving valid responses. (ST9P3_2015_HU_01)

2.9% of all respondents (17 persons) had provided sex for money or drugs or other benefits in the past 4 weeks. A total of 77.9% of IDUs who had had a sexual intercourse in the past 4 weeks had not used a condom during the last sexual intercourse. (ST9P3_2015_HU_01)

Of those participating in the survey, 1.9% (11 persons) was born outside of Hungary. 30.8% of the respondents had lived in a homeless shelter or on the streets without a stable address for more than 1 week during the past year. Nearly every second IDU (48.9%) had been imprisoned at some time in their lives. (ST9P3_2015_HU_01)

T1.4 OTHER DRUG-RELATED HEALTH HARMS

T1.4.1 Other drug-related health harms

Driving accidents

In 2014, in the case of 84 driving accidents the police sent blood and/or urine samples to the National Institute for Toxicology for forensic toxicology examination, under the suspicion of drug-impaired driving. Out of the 84 samples the institute determined positivity for illicit drugs and/or NPS in 53 cases.

Table 14. *Prevalence of the presence of illicit drugs/new psychoactive substances (N) in blood and/or urine samples originating from driving accidents by active substance in 2014*

active substance	no. of cases
4-methyl-buphedrone + alpha-PVT	1
AB-CHMINACA	2
AB-CHMINACA + alpha-PVP	2
AB-CHMINACA + MDMB-CHMICA	1
AB-CHMINACA + PB-22	1
alpha-PVP	1
amphetamine	13
amphetamine + ketamine	1
amphetamine + cocaine + THC	1
amphetamine + MDMA	1
amphetamine + pentedrone	1
amphetamine + THC	3
ketamine	2
cocaine	2
cocaine + alpha-PVP + 4F-alpha-PEP	1
cocaine + THC	1
methamphetamine + cocaine + THC	1
pentedrone	3
pentedrone + alpha-PEP	1
THC	14
<i>negative</i>	31
total	84

Source: National Institute for Toxicology

Pregnancies and children born to drug users

In Budapest in 2014, 45 drug user women participated in the 'Alternative Prenatal and Family Care' programme set up by the Józan Babák Klub (Oberth et al. 2015) who were pregnant in the year in question, or had had a miscarriage/abortion, or who had given birth between 2012 and 2014. Amphetamine was reported as a primary substance by 15 persons, heroin by 6 persons and 'penta crystal' by another 6. A further 7 persons primarily consumed herbal cannabis, while 5 persons mentioned alcohol and prescription drug abuse and 6 persons prescription drugs as their primarily used substance types. For the description of the programme see Chapter T.1.6.1.

T1.5 HARM REDUCTION INTERVENTIONS

T1.5.1 Drug policy and main harm reduction objectives

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

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

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

T1.5.2 Organisation of harm reduction services

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

For the results of the 2015 Treatment facility survey, see: Treatment Workbook, Chapter T4.1.

Among the organisations providing harm reduction services at recreational settings (23 organisations) 15 operated as non-profit NGOs (Tarján 2015a), 4 organisations were operated by the state/local government, 2 services by church organisations and 2 services operated with other organisational background.

Among the 23 programmes, through the parent institution 5 were linked to outpatient drug treatment centres, and 4 to therapeutic communities. In the case of 13 service providers, the parent institution, besides harm reduction services in the recreational setting, also operated other low threshold /day care/ community services.

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

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

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

Table 15. *Collaboration of NSPs with other service providers (N) – outside of their parent institutions – by the type of service provider, in 2014, (N of respondents =29)*

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

Source: Tarján 2015c

With respect to service providers, the organisations outside of their parent institutions most frequently referred their clients to therapeutic communities (25 organisations), psychiatry/addiction units (24 organisations), self-help groups (23 organisations), homeless shelters (22 organisations) or outpatient DTCs (21 organisations).⁴⁴

The financing of harm reduction services

The state supports the operation of services offering community and low threshold services through financing contracts concluded for a three-year-long period providing a fixed annual funding⁴⁵ via the National Office for Rehabilitation and Social Affairs (NRSZH). Both forms of service target all kinds of addictions (including alcohol and other dependencies), funding available for drug-related services cannot be specified. When applying for the support, the provision of two out of the following 3 basic services is a requirement: psycho-social

⁴⁴ During the analysis the number of organisations indicating the categories 'occasionally', 'frequently' and 'very frequently' were merged in case of each service type.

⁴⁵ The amount of funding is not adjusted proportionally to the number of clients of the given service or to their equipment demand (in the case of NSPs).

interventions; counselling services; street outreach services. The supplementary services for which service providers can apply only in union with the basic services are the following: telephone counselling; harm reduction in the recreational setting; needle/syringe exchange services; drop in centre.

The last three-year support cycle started in 2012 (2012-2014) during which the funding was reduced as compared to the previous three-year cycle (2009-2011) (for details see: 2013 National Report, Chapters 5 and 7). During expert meetings, several large organisations reported that it would be difficult to maintain their harm reduction services without the financial assistance of their integrated institutional background (HNFP 2015).

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

In response to the lack of sterile equipment occurring at NSPs as a consequence of the reduced funding and as a result of the consultations between the organisations concerned and the Ministry of Human Capacities (EMMI), between 2013 and 2014, the EMMI provided one-off support on two occasions amounting to EUR 42,138⁴⁶ for purchasing syringes (553,400 syringes). According to reports from the organisations (Tarján 2015b) the large majority (72%) of the syringes (462,735) acquired in 2014 were purchased from ministerial/local governmental grants, the greatest proportion of which is covered by the syringes acquired in the scope of the EMMI one-off support. The organisations obtained 12% of the syringes from donations. Only 7% of the syringes were acquired from the fixed funding support.

Volunteers are often employed by harm reduction services in the recreational setting (Tarján 2015a), the organisations providing data employed a total of 88 paid employees and 298 volunteers in their services in 2014.

T1.5.3 Harm reduction services

Prevention of drug-related death and emergencies

Harm reduction in recreational setting

In 2014 a total of 23 organisations participated in the data collection⁴⁷, of which 13 operated harm reduction service in the recreational setting at city-level, 3 at micro-regional level, 3 at county level, 1 at regional level and 3 at national level (Tarján 2015a). In 2014, 2 new organisations started operating in Budapest: the Tiszta Jövőért Alapítvány (city-level), and the Helperek Önkéntes Segítők Közhasznú Egyesület (national-level). However, the programme provided by the Kék Pont Alapítvány was no longer in operation in 2014.

In 2014 the organisations cooperated with a total of 79 clubs/party organizers and took part in 622 events. They had contact with a total of 41,817 persons. The mean number of contacts per event was 66 (50 in 2013). The items most typically provided by the organisations were water, condoms, leaflets, glucose tablets and effervescent tablets. Distribution of earplugs, sterile wipes and snorting tubes were mentioned in the 'other' category.

⁴⁶ The prices in the table were calculated using the EUR intermediate exchange rate valid for 2014 (EUR 1=HUF 308.51).

⁴⁷ Of the 24 service providers contacted one organisation outside Budapest did not provide data.

Table 16. *Types of harm reduction equipment distributed by harm reduction services in the recreational setting (N of responding organisations=23)*

type	no. of organisations
water/mineral water	23
condoms	22
leaflets on drug use	22
glucose tablets	22
effervescent tablets	22
leaflets on overdose and emergencies	14
vitamins	10

Source: Tarján 2015a

Four organisations outside Budapest indicated that they had held training sessions for the operators and staff of clubs collaborating with them on a total of 9 occasions, involving 190 persons. The training covered the following topics: legal framework, substance types, handling drug users, harm-reduction approach, recognition of symptoms caused by drug use, crisis intervention, and first aid.

For information on opioid substitution treatment see the Treatment Workbook, Chapters T1.4.8-10 and T2.

For harm reduction services provided by NSPs see below in this chapter.

Prevention of drug-related infectious diseases

Needle/syringe programmes

During the major part of last year, the service structure established through the 3-year-long (2012-2014) fixed funding did not change, in 2014 31⁴⁸ service providers operated NSPs in 21 cities, which covered 14 counties and all the 7 regions (Tarján 2015b) (17.HU_ST10_2015). However, it is important to highlight that in the second half of 2014 the two largest NSPs in Budapest had to close down as a consequence of local governmental decisions. The Kék Pont Alapítvány terminated its needle/syringe programme in district 8 in August and the Drogprevenció Alapítvány stopped its service in district 13 in November.

In 2014 30 fixed location NSPs operated in the country, 15 organisations performed street outreach work, 1 organisation operated a mobile NSP, and in 4 cities IDUs could purchase syringes from syringe vending machines.

11 organisations operated two types of programmes, this in all cases was street outreach attached to a fixed location NSP. Four service providers operated three different programme types, and 15 service providers only had one type of NSP service, which was mostly a fixed NSP.

In 2014 NSPs distributed a total of 460,977 sterile syringes, the number of returned and collected syringes was 296,716.⁴⁹ The exchange rate was 64%. As the restrictions on the number of syringes that could be distributed/exchanged per contact introduced in the previous two years at the larger service providers remained, it is probable that a significant proportion of the used syringes not returned to the programmes – primarily in the capital –

⁴⁸ The number of service providers did not increase as compared to the previous year, only as a consequence of administrative changes the number of organisations grew from 29 to 31, as the INDIT Egyenlítő programme in Baja was added to the list of service providers (where NSP services has been available since 2012), also the INDIT TÉR programme in Pécs appears from now on as a separate service provider on the list.

⁴⁹ Including syringes obtained from syringe vending machines and disposed in the special waste containers placed near the vending machines.

were reused or shared (HNFP 2015). In 2014 4442 IDUs⁵⁰ used NSP services on a total of 41,535 occasions. 1,844 new clients⁵¹ were registered by the programmes in the course of the year. On average 102 syringes were distributed and 67 returned per client, the mean number of contacts per client was 9 in the year in question. (ST10_2015_HU_01)

According to the breakdown by programme types the majority of syringes were distributed and collected by fixed location NSPs. In 2014 the data originating from this programme type formed 83% of the total national turnover if the number of distributed syringes is considered.

Table 17. *Syringe and client turnover data of NSPs in 2014*

	fixed location	mobile NSP	street outreach	syringe vending machine	total
distributed	381,992	58,655	14,125	6,205	460,977
returned (+collected)	226,560	57,995	11,188	973	296,716
exchange rate	59%	99%	79%	16%	64%
number of clients	4,096	231	115	-	4,442
number of new clients	1,652	141	51	-	1,844
number of contacts	38,184	2,055	1,296	-	41,535
number of NSPs*	30	1	15	4	31

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

Source: Tarján 2015b

On examining geographical distribution, NSPs located in Budapest had the decisive proportion of both the number of distributed/returned and collected syringes and the number of clients/contacts (the rates varied between 86-89% in respect of the individual indicators) in 2014 as well. Due to the closures in 2014, the share of the Kék Pont Alapítvány and the Drogprevenációs Alapítvány (the terminated programmes) of the national NSP turnover was examined. According to the data of 2014, in spite of this being an incomplete year for the two organisations, 40-60% of the number of distributed/returned and collected syringes and the number of clients/contacts can be attributed to these 2 organizations.

Beside sterile syringes, most NSPs provide counselling on safe injecting (23 out of 27 reporting organisations). The majority of NSPs provide alcohol pads, condoms and vitamins. Sterile filters and mixing containers were available at less than half of the locations. Nearly a third of the organisations provide sterile injecting equipment in pre-assembled packages. (Tarján 2015b)

T1.5.4 Contextual information on routine harm reduction monitoring

In 2014 the number of distributed syringes per IDU was 81, which although being slightly higher than the figures from previous years (2013: 76; 2012: 74), the estimate of the number of IDUs is static and was carried out in 2010, therefore, it does not reflect the changes that have taken place in the IDU population since then. On the one hand there were steep rises experienced in the number of clients and number of contacts during 2013 and 2014 (see Chapter T.2.1), which, among other things, may indicate the increasing prevalence of injecting drug use. On the other hand, the estimate mentioned (see: 2010 National Report, Chapter 4.1.) refers to the two-year period of 2008 and 2009, so the effects of the changes caused by the emergence of new psychoactive substances starting in 2010 are not reflected in the estimate (see: Drugs Workbook/Stimulants, Chapter T1.2.1.).

⁵⁰ In respect of the number of clients double counting control was performed at service provider level but not at national level. The same client may be registered at more NSPs.

⁵¹ In respect of the number of new clients double counting control was performed at service provider level but not at national level. The same client may be registered at more NSPs.

For further contextual information see: Chapter T2.1.

T1.5.5 Additional information on harm reduction activities

In 2013 the Public Health Division of the Ministry of Human Capacities announced a call for applications in the framework of 'Healthcare treatment and development tasks' allocation (20/22/02) through a tender entitled 'Participation of NGOs in the prevention of HIV/AIDS'. The purpose of the programme was to inform communities exposed to a high risk of HIV infection about the risks involved, to reduce the risks and to provide the opportunity for voluntary testing and counselling. 10 NGOs received a total of EUR 48,621⁵² support. Among the organisations procuring funding, the target group of three applicants was the IDU population. The programmes were conducted in 2014, in the scope of which the 3 programmes in Budapest tested 550 IDUs for HIV. (EMMI 2015b)

For the methodology of the national HIV/HCV seroprevalence survey among IDUs see Chapter T.6.2.

Information on counselling, testing and treatment of prisoners can be found in the Prison Workbook, Chapter T1.3.2.

T1.6 TARGETED INTERVENTIONS FOR OTHER DRUG-RELATED HEALTH HARMS

T1.6.1 Targeted interventions for other drug-related health harms

Interventions targeting drug-using pregnant women and their children

For the description of the programme of the Józan Babák Klub entitled 'Alternative Prenatal and Family Care' see: 2012 National Report, chapter 7.4. In 2014 a total of 61 persons were enrolled in the programme in Budapest district 8 (Oberth et al. 2015). Of these, 53 drug user women visited the programme while 8 women contacted the programme by telephone or via the Internet. In the scope of a follow-up in 2014, 14 former female clients took part in the programme, they had got involved in the work of the organisation before 2011. The majority of those participating took part in or were referred to higher threshold, non-anonymous healthcare and social services.

In 2014 the Józan Babák Klub, the human rights advocacy foundation Magyar Emberi Jogvédő Központ Alapítvány and the Hungarian Association of Child Health Visitors concluded a professional cooperation agreement with the purpose of receiving notifications on pregnant drug user women in crisis situations through a crisis telephone hotline service, and to provide them with effective help in entering treatment. The launch of the new low threshold service was supported by funding from the EMMI, and the programme has been receiving funding from the central budget since September 2014.

⁵² The prices in the table were calculated using the EUR intermediate exchange rate valid for 2014 (EUR 1=HUF 308.51).

T1.7 QUALITY ASSURANCE OF HARM REDUCTION SERVICES

T1.7.1 Quality assurance for harm reduction services

Harm reduction activities taking place in the scope of social services, including the service provided in needle and syringe programmes, are regulated by Act III of 1993 on social administration and social services, and Ministry of Social and Family Affairs regulation 1/2000. (I. 7.) on the tasks and operation conditions of social institutions providing personal care (Csák et. al 2011).

The social guideline 'Professional recommendation – Low threshold services provided to addicted persons' was elaborated by the Specialised Workgroup on Addictions in 2007 (2010 National Report, chapter 11). The recommendation describes the types, purposes, guiding principles, characteristics, quality assurance conditions of the services and the activities they cover. This document serves as a basis in the call for and the assessment of applications for the three-year-long fixed state financing (see Chapter T1.5.2).

Furthermore, in 2011, within the framework of TÁMOP⁵³ 5.4.1 project aimed at drug-related developments, national guidance documents were elaborated determining recommendations based on wide expert consensus for harm reduction programmes operating in recreational settings and for needle/syringe programmes (2011 National Report, chapter 3.2). The recommendations in the documents are in line with the objectives of the social guidelines issued in 2007.

Details of Government Regulation 23/2011. (III.8.) on increasing the safety of music and dance events can be read in the 2012 National Report, Chapter 1.2.

T2. TRENDS

T2.1 SHORT TERM TRENDS IN DRUG-RELATED HARMS AND HARM REDUCTION SERVICES

- a) Drug induced death among adults: Chapter T2.2
- b) Prevalence and notification of infections: see: Chapter T2.2
- c) Drug-related acute emergencies

Systematic data collection is not carried out about non-fatal intoxications related to drug use in Hungary.

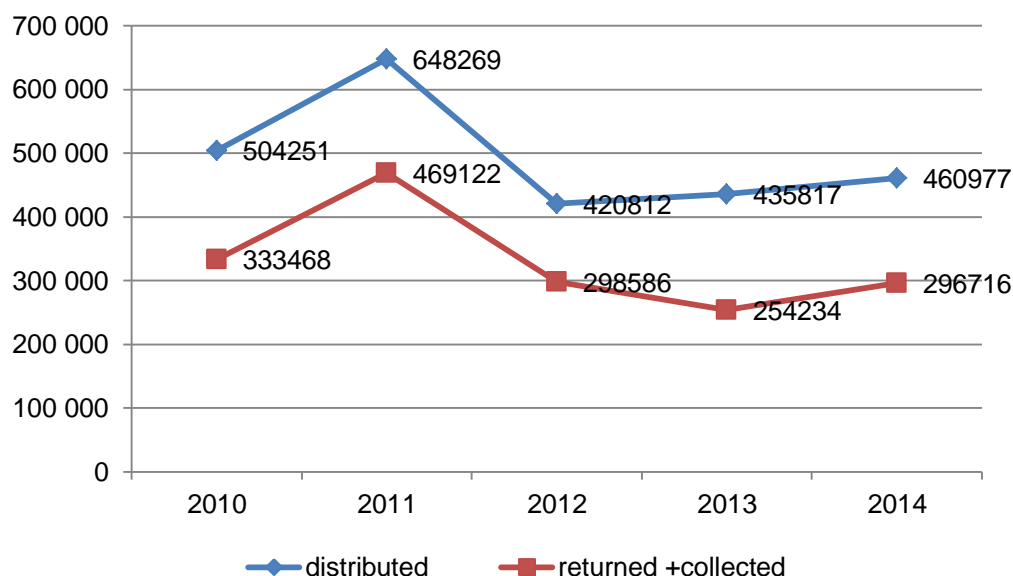
- d) The number of syringes distributed to injecting drug users

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

⁵³ Social Renewal Operative Programme

of syringes that could be distributed per contact, and in certain cases reduced their opening hours. Some programmes had to either temporarily or completely shut down their operation. In 2013 and then in 2014 the number of syringes distributed rose slightly, which is primarily the consequence of the one-off grants provided by EMMI (see: Chapter T.1.5.2), however, the number has still not reached the 2011 level and probably still does not satisfy the current syringe needs of IDUs. This is supported by the drop in the exchange rate observed in 2013, which suggests that a significant proportion of the used syringes not returned to the programmes – primarily in Budapest – are reused by the clients or are shared (HNFP 2015).

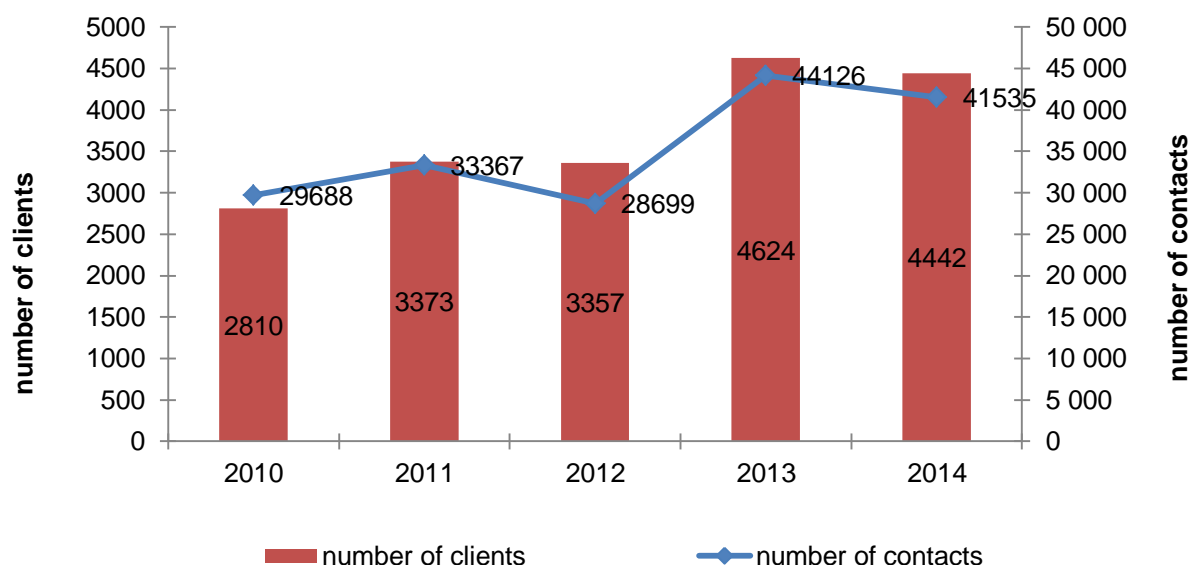
Chart 24. *The syringe turnover data of NSPs, between 2010-2014*



Source: Tarján 2015b

Contrary to the changes in the number of distributed syringes, the number of clients and the number of contacts showed a steep rise after 2012. It may be assumed that the restriction of the availability of sterile syringes per day was compensated by the clients with a greater number of contacts and the involvement of IDU peers who did not attend NSP programmes before. The number of clients decreased slightly in 2014 by 4.1% (182 persons), following the sudden rise from 2012 to 2013. As for the number of contacts following a drastic increase in 2013, this figure also dropped slightly (6.2%) in 2014. However, it is important to note that if the two Budapest programmes with the largest turnover had been able to operate all year (see T1.5.3), then the total figures at the end of the year would have resulted in a higher client / contact number as compared to 2013.

Chart 25. Number of NSP clients and number of contacts, between 2010-2014



Source: Tarján 2015b

Examining the turnover data by geographical breakdown it can be said that the proportion of the turnover taking place outside Budapest has increased compared to 2013. While in the past, in the case of the individual indicators, the share of Budapest was 89-91%, in 2014 it was only 86-89%. According to the trend data by geographical breakdown, it can be concluded that the turnover outside Budapest shows a continuous increase, i.e. it was not affected by the tendencies observed in the national data, however, the data registered in Budapest are fully in line with the national decreasing tendencies.

T2.2 LONG TERM TRENDS IN DRUG-RELATED HARMS AND HARM REDUCTION SERVICES

a) Drug induced deaths among adults

Before the appearance of new psychoactive substances in 2010, direct drug-related deaths were typically linked to opioid use, more specifically, to heroin use. The variation in the number of deaths per year was primarily caused by the changes in the purity of street heroin. In parallel with the drastic reduction of the availability of heroin starting from 2010, the number of deaths linked to this substance also dropped. At the same time the number of deaths linked to methadone showed a slow rise in this period. Methadone was also present in samples taken from the deceased in 2014, but typically accompanied by other opioids as well.

In recent years the use of the new psychoactive substances can also be seen in the biological samples of the corpses. Initially it was mephedrone, and then later it was MDPV, pentadone and 4-MEC that could be associated with a number of deaths. Occasionally, the appearance of certain, especially dangerous new psychoactive substances was linked to several deaths: in 2012 the use of 5-API, and in 2013 the use of 4,4'-dimethylaminorex (4,4'-DMAR) caused the death of several persons. In 2014 no especially dangerous NPS appeared that could have caused the deaths of several people, typically α -PVP and synthetic cannabinoids were detected, but their role in the cause of death was not clear due to polydrug use.

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

Overall, the decreasing tendency explained by the drop in heroin use after 2011 was counterbalanced by the rise in the number of deaths linked to new psychoactive substances in 2012 and 2013. In 2014 the number of deaths linked to opioids, primarily heroin, rose slightly, but the rising tendency of all cases turned downward due to the low number of deaths linked to new psychoactive substances.

Table 18. *Breakdown of direct drug-related deaths, between 2009-2014 (persons)*

	2009	2010	2011	2012	2013	2014
intoxication caused by illicit opioids ⁵⁴	28	12	6	8	3	10
overdoses/intoxication caused by methadone (without other drugs) ⁵⁵	2	2	4	5	9	2
intoxication caused by other, non-opioids	1	3	3	7	15	4
intoxication caused by other substances	0	0	1	4	4	7
total	31	17	14	24	31	23

Source: National Centre for Addictions (OAC 2015a)

b) Prevalence and notification of infections:

i) HIV prevalence among IDUs

During the national HIV/HCV seroprevalence survey series carried out among IDUs since 2006, it was in 2014 for the first time that persons tested positive for HIV (2 persons; 0.3%).

ii) HCV prevalence among IDUs

With respect to primarily injected substances, a restructuring has been visible since 2010 in the IDU population: the proportion of those injecting stimulants, primarily NPS has risen from year to year. (For further data on injecting patterns see: Drugs Workbook/Stimulants, Chapter T1.2.1.) According to the HIV/HCV seroprevalence survey data, before 2011 the proportion of opioid injectors was higher in the sample than that of stimulant injectors (see: Drugs Workbook/Heroin and other opioids, chapter T1.2.1.), and the prevalence of HCV was always higher in the opioid injector group. The situation, however, reversed: in 2011 HCV prevalence rate was 30% among those injecting primarily amphetamine or designer stimulants. As the national HCV prevalence rate did not change significantly in 2011, the restructuring of the prevalence rates by substance types is probably a consequence of new injecting patterns, namely of IDUs' switching over from opioid injecting to injecting amphetamine or NPS (For more information on changing patterns see: 2012 National Report, Chapter 4.3. and 4.4., and 2011 National Report, Chapter 4.3.)

In 2014 the proportion of stimulant injectors – more specifically designer stimulant injectors – further increased in the sample. One third of the sample was primarily opioid injector while two thirds of them were primarily stimulant injectors (see also: Drugs Workbook/Stimulants, Chapter T1.2.1.). With respect to HCV infection, it can be said that HCV prevalence rate has doubled both among opioid injectors and stimulant injectors, and also if the total sample is considered.

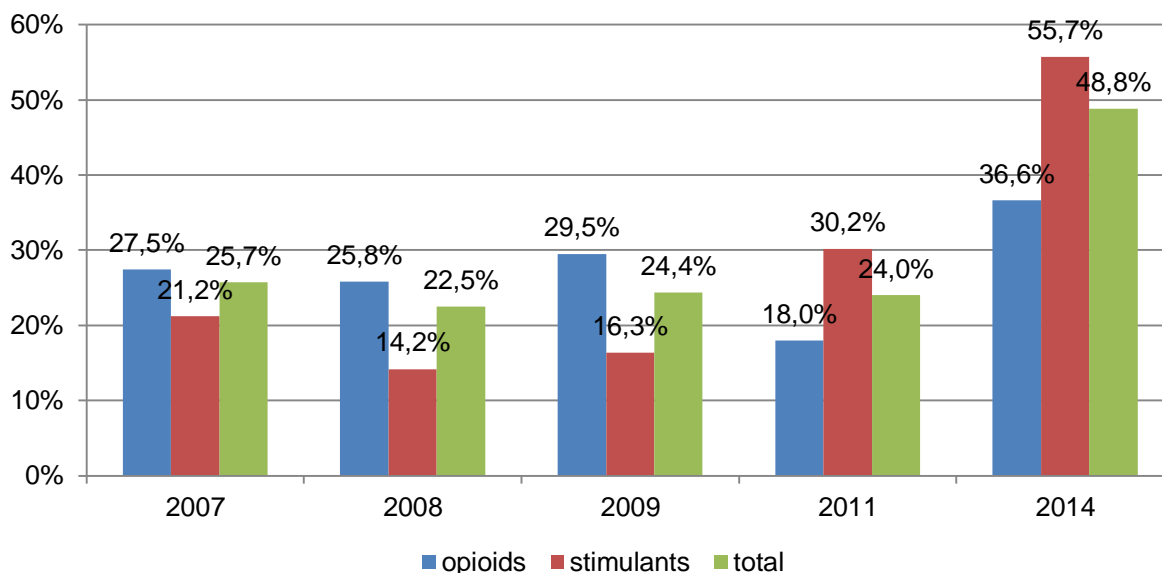
Beside the steep increase in NPS injecting, which substances are injected more frequently thus sharing and reusing injecting equipment is also more prevalent, another important factor

⁵⁴ Beside opioid metabolite (morphine) other substances may also occur, including methadone, but cases exclusively linked to methadone were excluded.

⁵⁵ Beside the occurrence of alcohol and/or benzodiazepines

of the significant increase of the HCV prevalence rates in 2014 could be the limited availability of NSP services taking place since 2012 in parallel with the phenomenon of NPS injecting (see: Chapter T2.1 d).

Chart 26. Breakdown of HCV prevalence (%) of IDUs participating in the national HIV/HCV prevalence survey by primarily injected drug, between 2007-2014



Source: Dudás et al. 2014

There are significant differences if data is analysed by geographical breakdown between 2011 and 2014: overall the prevalence rates outside of Budapest were around 10% up to 2011, while in Budapest they were between 35% and 40% in the same period, however in 2014 HCV prevalence rate measured in Budapest (60.9%) almost doubled as compared to the value in 2011, and outside Budapest the proportion of those tested positive for HCV (32.5%) tripled in comparison to the survey conducted three years ago.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2014, is presented as part of the baseline information in T1.

T4. ADDITIONAL INFORMATION

No new information available.

T5. NOTES AND QUERIES

T5.1 IS THERE ANY EVIDENCE OF AN INCREASE IN ACUTE EMERGENCIES OR DEATHS RELATED TO STIMULANTS?

No.

There is no systematic data collection about non-fatal intoxications related to drug use, therefore an increase in the number of cases linked to stimulants cannot be confirmed. With respect to overdose deaths, no increasing tendency linked to stimulant use can be seen. Although a small number of cases involving amphetamine derivatives can be shown, due to the low number of cases (3 in 2014) no trends can be determined. Every year since 2012 new psychoactive substances with a stimulant effect have appeared in the biological samples of the deceased (e.g. 5-IT, pentedrone, mephedrone, 4'4'-DMAR), however, the increase in the number of deaths is not a trend, instead it is dependent on how dangerous the substances appearing on the market are. The use of such designer stimulants could be confirmed in about five cases per year between 2012 and 2014.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

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T6.2 METHODOLOGY

Drug-related death (National Centre for Addictions OAC 2015a): The data relating to deaths originate from the Special Mortality Register, the technical operation of which is performed by the National Centre for Addictions. The data has been collected by the Hungarian National Focal Point with the support of the National Forensic Medicine Institute since 2009. This register is anonymous, case based, and in all cases contains detailed toxicology data, which can be linked to the treatment data, providing the possibility of a more in-depth analysis. The case definitions and the recorded characteristics in the register fully comply with the requirements of the EMCDDA DRD protocol (Drug-Related Deaths (DRD) Standard Protocol, version 3.2 2009; Selection D).

Notifications of HIV/ AIDS, HBV, HCV (Csohán et al. 2015): Data of reported, injecting drug use related HIV/AIDS cases and the incidence of injecting drug use related acute cases of hepatitis caused by HBV or HCV in Hungary originate from the national registry of infectious patients operating in the National Centre for Epidemiology and from the special HIV/AIDS and hepatitis surveillance database.

National HIV/HCV seroprevalence survey among IDUs (Dudás et al. 2014): Between March and May 2014 the National Centre for Epidemiology repeated the HIV/HCV national seroprevalence survey among IDUs. The study was financed by the State Secretariat for Healthcare. This was the sixth survey in the series since 2006 applying consequently the same methodology throughout the years.

In 2014 19 organisations were involved: five NSPs and two DTCs in Budapest while outside of Budapest six NSPs, two DTCs and four DTCs also operating NSPs took part in the study. Those persons were recruited in the study who had ever injected illicit drugs/new psychoactive substances. Apart from the testing for HIV/HCV, socio-demographic characteristics, injecting patterns and risk behaviours were also recorded. The questionnaire was based on the EMCDDA DRID guidelines, and on parts 2 and 3 of Standard Table 9. The questionnaires and the blood samples were given unique identifiers generated from the personal data but cannot be traced back, which makes it possible to link the serological and questionnaire data, and control the sample for double counting. Participating organizations were assigned a target sample size based on the number of their IDU clients. During the study period the organisations invited all their IDU clients – after informed consent – to participate until the target sample size at each location was reached. The IDUs participating in the study received an incentive in the form of food vouchers (HUF 1000/ EUR 3).

The laboratory results were sent back from the National Centre for Epidemiology to the organisations and results were given back to clients attached to which post-test counselling was also possible if clients required it.

A dried blood sample was used for the serological tests – after blood was taken from the client's fingertip. The Vironostika HIV Ag/Ab ELISA (bioMérieux) test was applied for the HIV test. The samples giving a reactive result were controlled with another test suitable for demonstration of the virus antigen, the combined ELISA test (Genscreen Ultra HIV Ag-Ab; BIO-RAD). Apart from this the INNO-LIA HIV I/II Score (FUJIREBIO) Line Immuno Assay, using the Immuno blot principle, was also carried out. In the case of the hepatitis C virus, the HCV Ab Screening ELISA kit manufactured by DiaPro and the INNOTEST HCV Ab IV kit manufactured by Innogenetics were applied. The anti-HCV positive results were verified with the INNO-LIA HCV Score test (Line Immuno Assay technique) manufactured by the Fujirebio.

After double-counting control, the data of 592 persons were analysed. Inconclusive test results were excluded from the analysis (19 samples in the case of HCV; 0 in the case of HIV).

The electronic recording and statistical analysis of the data was performed by using the Epi Data and the Epi Info Windows 3.5 programme packages, and with the SPSS programme package.

Needle/syringe programme (NSP) data collection (Tarján 2015b): In 2015 again NSPs reported their data via the Internet-based data collection tool set up and operated by the Hungarian National Focal Point. The organisations have been providing data to the Hungarian National Focal Point through this interface since 2008 on their syringe turnover, the provision of other harm reduction services, about their syringe supply management, as well as about the socio-demographic characteristics and injecting patterns of their clients. Management, quality assurance and analysis of the national, aggregate data are carried out by the Hungarian National Focal Point. The number of clients/new clients is controlled for double-counting at service provider level but not at national level. The same client may be registered at more NSPs.

Integration of NSPs in the treatment and care system (Tarján 2015c): The Hungarian National Focal Point carried out an online survey in May-June 2015 among all NSPs, during which their institutional affiliation, their integration in the treatment/care system, position on the treatment chain, and their institutional connections were examined. 29 online questionnaires were completed, which represents 100% coverage.

Data collection on harm reduction services in the recreational setting (Tarján 2015a): The Hungarian National Focal Point has been collecting the operational and turnover data of organisations performing harm reduction services in the recreational setting since 2007, with the help of a structured questionnaire, which was filled in online for the first time in 2014. Of the 24 service providers contacted, 23 completed the questionnaire.

T0. SUMMARY

The characteristics of drug-related offences are monitored on the basis of the data recorded, when investigations are completed, in the Unified Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS). The largest proportion of drug offences in Hungary is related to cannabis and a smaller proportion to stimulants. Misuse of new psychoactive substances (NPS) has involved criminal liability since 2012, and from this point onwards they have been the subject of perpetrations. The large majority of drug related offences are consumption-related.

The Hungarian Institute for Forensic Sciences (BSZKI) performed the analysis of substances seized by the police and suspected of being illicit drugs in 2014. A detailed picture of the Hungarian drug market can be obtained by analysing the seizure data and the police reports. Data on substances analysed preliminarily by the Forensic Institute of the National Tax and Customs Administration (formerly: Hungarian Customs and Finance Guard) but not considered as illicit drugs or new psychoactive substances based on the analytical results are not included in the following analysis.

On the basis of seizure and user information, the drug market has gone through a large-scale restructuring process over recent years. The new psychoactive substances are taking the place of 'classical' drugs, and their continual replacement on the market represents a serious challenge to supply reduction efforts.

T1. NATIONAL PROFILE

T1.1 DRUG MARKET

T1.1.1 Domestic drug cultivation and production

With respect to Hungarian illicit drug cultivation, the investigating authorities typically discovered small cannabis plantations in the greatest number⁵⁷. The larger plantations (1400-1500 plants) are usually maintained by groups of Vietnamese perpetrators. In 2014 during the procedures launched due to the 148 discovered cannabis cultivation sites requiring a forensic chemical analysis, a total of 3503 plants were seized. Approximately 4% of the discovered plantations involved more than 100 plants.

Opioids are mainly produced in the eastern part of the country from illegally used opium poppy. Small groups produce a liquid cooked from poppy-heads in sparsely populated areas, which is then smuggled into Ukraine via the known smuggling routes. There is no demand market in Hungary typically for this substance.

The production of synthetic substances in Hungary is typical in small scales. During the course of 2014, an illegal laboratory was detected where, based on the quantities of the seized material and equipment, amphetamine was being manufactured from benzaldehyde in an estimated volume of a few hundred grams.

⁵⁶ Authors of the chapter: Ágnes Port, Orsolya Varga

⁵⁷ In the case of cannabis plantation seizures, it is possible to launch criminal procedures only on the basis of an analysis performed by a botanical specialist. The police authority involved has information on the amounts seized.

In connection with the new psychoactive substances, a tableting unit was discovered in 2014 where cathinone-derivatives were being diluted and formed into tablets at the kilogram level. During the year there were several investigations during which beside acetone the authorities seized pure active substances of the synthetic cannabinoid group or preparations impregnated with these substances. In these cases the amount of the seized material did not exceed a few hundred grams. The seizures point to an impregnation activity being carried out in Hungary characteristically in smaller volumes. No laboratories producing new psychoactive substances were discovered.

T1.1.2 Routes of trafficking (imported and transit consignments)

According to the experience of the investigating authorities, herbal cannabis is typically smuggled from the Czech Republic to the territory of Hungary by Vietnamese organised crime groups. The better quality 'skunk' cannabis, mainly destined for the Western European market, comes from Albania. The herbal cannabis originating from the Czech Republic is frequently smuggled in cars, while it comes in larger quantities (250-400 kg) from Albania hidden in trucks.

Heroin continues to be smuggled into the country from Afghanistan, along the classical Balkan route through Turkey. The large majority of the consignments – similarly to previous years – goes to other EU states and only a very small amount gets to the domestic market. Hungary continues to act as a transit country for this substance. The heroin arriving over the Romanian and/or Serbian border is smuggled into the country in hidden compartments of cars and trucks.

The origin of cocaine, its smuggling routes and methods are varied: the consignments entering Europe in cars get to Hungary from Spain and the Netherlands. But smuggling in packages and in swallowed packets directly from South America continues to be typical.

Synthetic illicit drugs (amphetamine and ecstasy) primarily come to Hungary from Belgium and the Netherlands. It is usually smuggled in cars and buses, because this is the least risky method within the Schengen borders.

The acquisition source of the new psychoactive substances is characteristically China. The dealers and even the users order them directly online and have it transported into the country by package delivery services. However, according to investigation information, a proportion of the raw materials comes to Hungary from Slovakia.

According to a study mapping the Hungarian amphetamine supply market (Ritter 2010), most drug types (herbal cannabis, cocaine, amphetamines) get into Hungary through the Netherlands, however, the raw materials, precursors needed for their production get to the Netherlands from Hungary or through Hungary as a transit country. The substances not produced locally get to the Netherlands usually by ship passing through the Netherlands Antilles; this is characteristically cocaine, the main source of which is South America. Hungarian perpetrators usually only bring substances from the Netherlands, Belgium and Spain and rarely from the Balkan countries or South America. Products also come to Hungary from the South Slavic States, but the distributors from there only have a small share of the market. The substances smuggled into the country are usually amphetamines and the raw materials needed for their production, and the smuggling groups have interests primarily in rural areas, mainly in Szeged. According to the research, methamphetamine originating from the Czech Republic and Slovakia is not typical in the Hungarian drug market. The online ordering of precursors is increasingly popular, however, primarily from China.

T1.1.3 Trafficking within the country

For the available information see Chapter T1.1.5.

T1.1.4 Wholesale drug and precursor market

During 2014 no large scale drug-precursor seizure took place in Hungary.

With respect to the most characteristic diluents and adulterants, on one occasion the authorities seized a significant quantity (about 4 kg) of a caffeine-paracetamol mixture, next to which about 2 kg of heroin was seized. Apart from the tableting laboratory mentioned in Chapter T1.1.1, no other significant drug dilution related seizure was made in Hungary.

The most frequent diluents and adulterants in the seized preparations in the case of amphetamine are caffeine and lactose, in the case of cocaine phenacetin and caffeine, while caffeine and paracetamol are used for heroin. New psychoactive substances on the market in the form of powder are usually distributed undiluted, in their pure form.

During its exploratory activities the investigating authority collects information on the wholesale prices characteristic on the market. According to expert estimates based on the data obtained the average prices are as follows: cannabis: EUR 3,750 /kg, heroin: EUR 18,000 /kg, cocaine: EUR 28,000 /kg, amphetamine: EUR 4,500 /kg.

T1.1.5 Retail drug market

According to a study carried out in 2010 (Ritter 2010) new drugs and legal substances have brought about a significant change in the characteristics of the actors on the drug market. An increasing number of smaller groups and individuals breaking away from several organised groups are trying out production (although the risks involved are characteristically still higher than smuggling), which means that the amphetamine market is becoming more fragmented. The dealers and other low level buyers usually deal with one or two substance types, wider ranges of substances only appear at trafficker level. Amphetamines are usually accompanied by cocaine, and rarely with herbal cannabis. The social characteristics of the financing and trading members of Hungarian criminal groups dealing with amphetamine trafficking are different to those of the 'average' criminal: they are usually around 30 years old with at least secondary school qualifications and come from middle class families or from those that became rich in the recent past. It happens that people with experience in crime and punished for offences other than drug offences start dealing with amphetamine by investing their assets originating from other offences, but young people without a criminal record also frequently get involved in this illegal activity in the hope of a significant return in a short period of time.

Online trade

At the beginning of 2011 the Hungarian National Focal Point carried out a survey⁵⁸ (Péterfi and Port 2011) on the Internet acquisition possibilities and trading characteristics of new licit psychoactive substances that are not yet included in the drugs list and that may be legally acquired via Internet. The survey focused on four substances, namely: GBL, JWH-018, mefildronon (a virtual compound sold as a licit substitute of mephedrone) and MDPV.

According to the results of the survey the most common sales channels for Internet trading are small/classified advertisements and websites created for the sale of specific substances. The amount that can be ordered of the individual substances ranges from the minimal (1 g) up to large quantities (1000 g). Everywhere the price varied according to the amount purchased (for more detailed results of the survey see 2011 National Report, Chapter 10.1.)

Joining the EMCDDA online snapshot survey, in January 2012 the Hungarian 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

⁵⁸ The survey only extended to Hungarian sites. The keywords used for searching were the following: GBL cleaner, GBL ordering, gamma-butyrolactone, MDPV for sale, MDPV online shop, JWH-018, JWH potpourri, mefildronon. The search was performed between 13 January and 4 February 2011.

were identified that suited the given conditions⁵⁹. (For more detailed results of the survey see 2012 National Report, Chapter 10.2.)

Street prices

As compared to previous years, the Hungarian National Focal Point performed a survey among clients of outpatient drug treatment centres regarding the street level prices of drugs (Varga 2015). (ST_16_HU_01)

Apart from the classical drugs, the questionnaire also asked about the prices of mephedrone, MDPV, pentedrone and synthetic weed (herbal mixtures treated with synthetic cannabinoids, known as Spice for example) when last purchased.

Table 19. *Price of drugs at street level in 2014 in HUF*

substance	lowest	highest	mode	mean	number of respondents
herbal cannabis (g)	1000	3500	2500	2256	124
cannabis resin (g)	1500	5000	2500	2604	52
heroin (g)	4000	30000	10000	12190	18
heroin (packet)	3000	6500	5000	4500	16
cocaine (g)	1500	40000	15000	17478	41
amphetamine (g)	1000	6000	3000	3178	83
ecstasy (tablet)	200	4500	1000	1648	72
methamphetamine (g)	800	3500	2000	2187	17
LSD (dose)	500	10000	3000	3300	32
methadone (20 mg)	700	3500	1000	1478	30
methadone (5 mg)	250	2000	1000	785	10
GBL (dose)	500	5000	2000	1992	13
mephedrone (g)	500	6000	2000	2700	27
MDPV (g)	1000	8000	1000	3267	15
pentedrone (g)	800	6000	4000	3298	41
'Spice' (g)	200	3500	1000	1124	73

Source: Varga 2015

Table 20. *Price of drugs at street level in 2014 in EUR⁶⁰*

substance	lowest	highest	mode	mean	number of respondents
herbal cannabis (g)	3.2	11.3	8.1	7.3	124
cannabis resin (g)	4.9	16.2	8.1	8.4	52
heroin (g)	13.0	97.2	32.4	39.5	18
heroin (packet)	9.7	21.1	16.2	14.6	16
cocaine (g)	4.9	129.7	48.6	56.7	41
amphetamine (g)	3.2	19.4	9.7	10.3	83
ecstasy (tablet)	0.6	14.6	3.2	5.3	72
methamphetamine (g)	2.6	11.3	6.5	7.1	17

⁵⁹ 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.

⁶⁰ The prices in the table were calculated using the EUR intermediate exchange rate valid for 2014 (EUR 1=HUF 308.51).

LSD (dose)	1.6	32.4	9.7	10.7	32
methadone (20 mg)	2.3	11.3	3.2	4.8	30
methadone (5 mg)	0.8	6.5	3.2	2.5	10
GBL (dose)	1.6	16.2	6.5	6.5	13
mephedrone (g)	1.6	19.4	6.5	8.8	27
MDPV (g)	3.2	25.9	3.2	10.6	15
pentedrone (g)	2.6	19.4	13.0	10.7	41
'Spice' (g)	0.6	11.3	3.2	3.6	73

Source: Varga 2015

Purity

The active substance content of the seized substances in 2014 differed from the proportions detected in the previous year on numerous occasions. (ST_14_HU_01) While there was no significant change in the case of herbal cannabis, the typically lower than 20% THC content of cannabis resin in the previous year changed and about a half of the samples analysed had a THC content of 20-40%. Small quantities of powders containing heroin had an active substance content of 15-25%, while the heroin base content of amounts over 100 grams was characteristically in the range of 40-60%. In the case of cocaine, the active substance content of amounts under 100 grams was usually 4-80%, and the active substance content of larger amounts was between 40-85%. The active substance content of powders containing methamphetamine did not change significantly as compared to the previous year. The concentration of the seized amphetamine powders was in the range of 1-70%. A distinct change as compared to previous years was that on several occasions small amounts of amphetamine were seized that had an active substance content of around 70%, i.e. they were practically undiluted powders. The active substance content of ecstasy tablets also rose. (ST_15_HU_01) About 10% of the tablet seizures analysed had an MDMA base content higher than 140 milligrams. The MDMA base content of tablets with a lower active substance content was generally between 40-100 milligrams.

Regarding new psychoactive substances consumed in powder form, there is measured active substance content data available with respect to pentedrone: the pentedrone base content of seized and tested powders was between 15-85%. The active substance content of various synthetic cannabinoids applied to herbal material was 1-10%.

T1.2 DRUG RELATED CRIME

T1.2.1 Drug law offences

The characteristics of drug offences and their perpetrators are presented on the basis of the data recorded when investigations are completed in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS). The data are analysed by the Hungarian National Focal Point.

In 2013 the Special Part of the Hungarian Criminal Code was significantly amended, including the statutory definitions related to drug offences. Offences committed after 1 July 2013 fall under the force of Act C of 2012 on the Criminal Code (hereinafter new Btk.), while offences committed before 1 July 2013 fall under the effect of Act IV. of 1978 on the Criminal Code (hereinafter old Btk.). (For details see the Legal framework Workbook Chapter T1.1.1, and the 2014 National Report, Chapter 1.2.)

The investigation phase of a total of 6509 offences related to drugs or new psychoactive substances was closed in 2014, of these 3215 cases fell under the force of the old Btk. and 3294 under the new Btk. A total of 347 (5.3%) drug related offences involved substances classified as new psychoactive substances (56 cases fell under the force of the old Btk. and 291 under the new Btk.). (Misuse of new psychoactive substances has involved criminal

liability since March 2012. For details see the Legal framework Workbook, Chapter T1.1.3, and the 2012 National Report, Chapter 1.2.)

Drug related offences represented 1.97% of all offences registered in Hungary. 38% of all drug offences were committed in Budapest or Pest county.

Substance types

57.7% (3758 cases) of the 6509 registered drug offences were committed with cannabis, 23.3% (1515 cases) with stimulants, and 5.8% with new psychoactive substances (379 cases).⁶¹ The most frequently occurring stimulants were amphetamine (83.1%), MDMA (ecstasy) (9.2%) and methamphetamine (4.7%). The most frequent new psychoactive substances were cathinone derivatives (28%), phenethylamines (18.5%), synthetic cannabinoids (16.9%) and piperazine derivatives (11.6%).

Opioids were registered as the subject of the offence in 2.9% of the cases (heroin 1.1% and methadone 0.7%), cocaine in 2.5%, hallucinogens in 1.2%, precursors in 0.3%, and other substances in 1.7% of cases.⁶² (ST_11_2015_HU_01)

Perpetrations

As of 2014 the offence types are categorised according to the EMCDDA's new data collection protocol relating to drug law offences, which is different to the reporting structure used in previous years in several respects. When interpreting the data it is essential to take into consideration that the breakdown of offences on the basis of the EMCDDA perpetration type categories does not give a reliable picture of the share of consumption related perpetrations because the structure of Hungarian substantive law differs significantly from the categorization of perpetration types in the protocol, and as a consequence of inconsistent law enforcement recording practices. In the Criminal Code (both in the old and the new version) the statutory definitions of 'cultivation and production of illicit drugs' include the cultivation/production activities for personal use and for trafficking purposes as well, which are not separated during statistical data recording either. At the same time, as in the new Btk. these two perpetration methods appear under the section 'possession of illicit drugs', it can be assumed that consumption-related perpetrations are over-represented among them.

Of the offences registered in 2014, 2425 offences (37.3%) were linked strictly to possession of an illicit drug (acquisition or possession for personal use). 59% of these cases were committed with cannabis, 29% with stimulants. Other types of substances appeared in relatively low proportions (opioids 3.3%, cocaine 2.6%, NPS 2.8%). (ST_11_2015_HU_01)

Drug cultivation or production was the form of perpetration in 3012 cases (46.3%). On examining the production related perpetrations by drug types, the subject of the offence was cannabis in 64.7%, stimulants in 21.8%, opioids in 2.9%, and cocaine in 2.4% of the cases.⁶³

Perpetrations strictly classed as supply-related offences⁶⁴ made up 14.5% of the offences (941 cases). Within this trafficking involving a small quantity took place in 6.1% of cases (421

⁶¹ The number of cases committed with new psychoactive substances broken down by statutory definitions and by substance types does not match. The reason for this is that the categorisation by substance type took place according to the categories defined by the EMCDDA where substances not listed on the UN drug schedules were classed as new psychoactive substances, while in case of categorisation by statutory definition offences committed with substances scheduled as new psychoactive substances according to Hungarian law were classified here. As the Hungarian legislation is stricter in places than international legislation and certain substances not included on the UN lists are classed as illicit drugs in Hungary, when totalled according to statutory definition the number of offences committed with new psychoactive substances is lower than when categorised according to substance type.

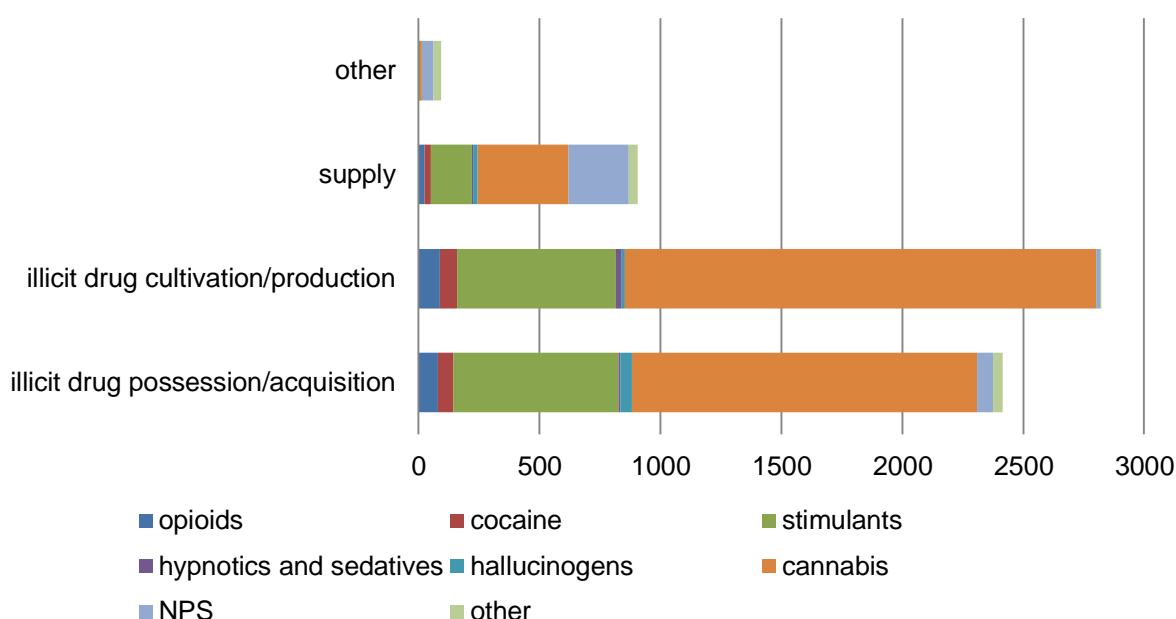
⁶² The substance type was not recorded in 234 cases.

⁶³ The substance type was not recorded in 5.6% of cases.

cases), trafficking according to the basic definition made up 6.5% of the cases (396 cases), and offences committed with a substantial or particularly substantial quantity made up 1.9% of the cases (124 cases). The large majority of trafficking related perpetrations were linked to cannabis (40.2%), although the proportion of cannabis offences was somewhat lower than within use-related behaviours. New psychoactive substances were recorded as the subject of perpetration in 26.2% of cases, exceeding the proportion of offences with stimulants (18%). Opioids (heroin) and cocaine (7% and 11%) appeared more frequently as the subject of perpetration among offences committed with a substantial amount than among other offences (in all other perpetration categories the proportion of these two drug types was under 3% for each).

Other perpetration types listed under a separate title in the Criminal Code (inciting substance abuse, aiding the production of illicit drugs) were recorded in 109 cases (1.7%). Nearly a half of these cases were linked to new psychoactive substances. (ST_11_2015_HU_01)

Chart 27. Breakdown of drug offences by perpetration and substance type, 2014



Source: ENYÜBS 2015, analysed by HNFP

Alternatives to criminal procedure

The large majority of criminal procedures⁶⁵ launched in drug related cases are closed before the court phase starts, as a result of the institution of quasi compulsory treatment (QCT), which may be undertaken as an alternative to punishment. (The legislative background of the alternatives to criminal procedure is described in the Legal framework Workbook, Chapter T2.1 and the data of those entering treatment in the scope of QCT may be read in the

⁶⁴ Trafficking related behaviours: offers, supplies, distributes, deals, imports, exports, transports through the country, and all offences committed with a substantial or particularly substantial quantity.

⁶⁵ The number of registered offences and criminal proceedings data must be treated separately. The data relating to criminal proceedings show how many criminal proceedings were launched due to a specific act in the given period, irrespective of how the proceedings were closed. The data relating to registered offences show the number of offences of a particular type that were registered as an offence when the investigation was closed. Several criminal proceedings may be launched in relation to one act, but it will only be registered in the statistics as an offence once. It may also happen that at the end of the investigation the police or the public prosecutor do not determine that a crime has been committed, or the public prosecutor applies a method of closing the investigation different from formal accusation (e.g. the proceedings are terminated, suspended due to lack of evidence, etc.), and in this way the given case is not registered as an offence. Therefore, the data on criminal proceedings form a much wider data set than the data on registered offences.

Treatment Workbook, Chapter T1.3.1.) Only some of those participating in QCT will have a criminal record (for example, if the offender only starts QCT during the court phase of the procedure), the others will not be registered in the criminal statistics, because when a perpetrator starts QCT the criminal proceedings are terminated and the case is not registered as an offence.

In 2014 a total of 13358 drug-related criminal proceedings were launched, however, of these formal accusation was made in just 2377 cases, the larger proportion of the cases were closed before the court phase. The criminal proceedings were closed because of QCT in 3638 cases (under the legal title of 'postponement of formal accusation' or 'other reason terminating culpability').

Drug law offenders

In 2014 the criminal statistics registered 6078 offenders linked to the 6509 registered drug offences⁶⁶. 90% of the offenders were males and 10% were females. Regarding distribution by age groups, 13% of them were under 18 years, 35% of them were between 19 and 24 years, and 25% were between 25 and 30, so overall three quarters of drug law offenders were younger than 30 years of age.

T1.2.2 Consequent crime – Offences committed under the influence of illicit drugs

In 2014 a total of 4687 persons committed offences under the influence of illicit drugs, which is 4.3% of all registered offenders. The large majority of those committing offences under the influence of illicit drugs committed a drug related offence (4340 persons, 92.6%), and a total of 347 persons (7.4%) committed other types of offences. Among the perpetrators committing non-drug related offences under the influence of illicit drugs, 91 persons (26.2%) committed offences against property, 152 persons (43.8%) committed traffic offences (of these 147 persons committed the offence of driving under the influence of alcohol or other substances), 33 persons (9.5%) committed offences against persons⁶⁷ (of these 4 persons committed murder, and 20 persons bodily harm), 33 persons (9.5%) disturbing the peace, and 23 persons (6.6%) committed other offences.

T1.3 DRUG SUPPLY REDUCTION ACTIVITIES

T1.3.1 Drug supply reduction activities

It is an objective specified in the National Anti-drug Strategy to force back the extent of drug use in Hungary as completely as possible by 2020 using all the instruments available, while ensuring the balance of demand and supply reduction. This is especially important in those settings where children and young people are subjected to increased risk: in schools, institutions of public culture and in music venues/clubs.

The National Security Strategy specifies in detail the challenges and adequate responses at national level arising in connection with drug trafficking. It states that the preconditions of rapid and more effective action against drug related crime are the following: increasing the effectiveness of the work performed by the police, improving the equipment used by the competent bodies and the training of personnel, as well as effective information exchange and collaboration with the competent international bodies. In the interest of this, according to

⁶⁶ One offender may commit several offences. The data on offences are complete, however, they are not with respect to the perpetrators, as an offender is recorded only with the most serious offence or if the offender is a minor.

⁶⁷ It contains all the cases falling under the force of the old Btk., but only some of those under the force of the new Btk., as the individual statutory definitions listed in the old Btk. under the title of offences against persons are listed under different titles in the new Btk.

the Strategy the effectiveness of the countermeasures must be increased, the bodies responsible for action against organised crime groups and the personnel, material and technical resources of forensic experts must be strengthened. Apart from the above, a national level anti-drug crime service must be set up. The fight against drugs also represents a comprehensive social task, therefore, from the point of a successful action, the use of the crime prevention possibilities are especially important.

Based on above, the main strategic objective of supply reduction is to prevent any psychoactive substance suitable for misuse getting into Hungary and prevent access to the substances appearing in the country, and realise the crime prevention aspects related to this.

The National Police Anti-drug Strategy entered into force in February 2014. Apart from reducing supply, the document lists the priorities as strengthening the activities of forensic experts, reducing the number of road accidents related to drug use and increasing the effectiveness of investigations. According to the main priorities stated, the number of procedures launched due to trafficking behaviours needs to be increased and collaboration between the Hungarian Post and delivery companies must be established that assists the restriction of distribution made in this way.

The primary participant in the supply reduction activity is the criminal and public order protection service of the Police, also involved in this activity is the drug policing work performed by the police administration service, which reduces and prevents diversions by inspections among those with permits (healthcare service providers, manufacturers, wholesalers).

Due to organisational changes in 2012, at the moment there is only one unit with a staff of 25 persons at the Operational Police National Bureau of Investigation, which performs a designated anti-drug crime fighting activity. Before this, there was a designated unit at the Budapest Police Headquarters, which performed this activity with a staff of 67. At present it is the crime and investigation departments of the county (and Budapest) Police Headquarters that carry out the procedures required due to drug related offences, as well as investigating all other offences, there is no body specially dedicated for this task.

T2. TRENDS

T2.1 SHORT TERM TRENDS REGARDING THE MOST CHARACTERISTIC DRUGS ON THE MARKET

Seizures

During 2010-2011, the authorities seized more than 10000 plants per year at large-scale cannabis plantations of more than 100 plants. This amount significantly dropped in the period between 2012-2014. However, no outstanding change can be seen in the number and proportion of plantations of under 10 plants and between 10–100 plants over the period between 2010 and 2014.

The amount of herbal cannabis seized in large quantities jumped significantly in 2012, then dropped continuously. While during the 2010-2011 period a few hundred kilograms of herbal cannabis was seized, in 2012 the amount seized was nearly 1.8 tonnes, which fell back to 807 kg in 2013 and 480 kg in 2014.

The number of cannabis resin seizures rose continuously from about 40 cases in 2010 up to approximately 100 cases per year by 2013-2014. The rise in the number of cases can be mainly linked to small seizures of under 10 grams.

During 2009-2010 the number of heroin seizures and the amount of seized material dropped significantly as compared to previous years. During the period between 2011 and 2013 there were just some 20 seizures per year, and the total amount of material seized was just a few

kilograms per year. The number of seizures did not increase in 2014 either, however, the amount seized was more than 70 kilograms.

With respect to cocaine seizures, no trends can be identified in the number of seizures, in the amount seized or in the active substance content that are characteristic in the 2010–2014 period.

The number of amphetamine seizures – due to the trend of small seizures under 10 grams – showed a slight increase in the 2010-2014 period.

There were only 7 seizures of tablets containing MDMA in 2010, but the number of seizures increased continuously from 2012. During 2014 these tablets were seized in 206 cases. The large majority of the seizures were cases involving small amounts of less than 50 tablets. The annual number of tablets seized was usually determined by a small number of large seizures, therefore the amount data do not show a characteristic tendency.

The number of LSD seizures is not significant as compared to the above substances, the seizure of small numbers of stamps is typical, but in recent years LSD has been seized by the authorities in the forms of a solution and powder as well. Characteristically these cases may be linked to the internationally popular large summer music festivals. (ST 13_2015_HU_1)

Table 21. *Number of seizures between 2010-2014*⁶⁸

type of drug	2010	2011	2012	2013	2014
herbal cannabis	2,220	2,073	2,092	2,040	2,058
cannabis plants	213	192	193	196	146
cannabis resin	44	63	103	101	101
heroin	73	22	26	32	31
cocaine	132	108	118	117	143
amphetamine	484	483	454	536	598
methamphetamine	41	33	38	50	54
ecstasy tablets /MDMA, MDA, MDE/	9	22	91	181	213
LSD	12	11	28	22	29
<i>plant materials with synthetic cannabinoids</i>	<i>51</i>	<i>465</i>	<i>1,298</i>	<i>2,099</i>	<i>3,876</i>
<i>synthetic cannabinoids in powder</i>	<i>5</i>	<i>51</i>	<i>61</i>	<i>60</i>	<i>104</i>
<i>cathinone derivatives in the form of powder</i>	<i>353</i>	<i>595</i>	<i>700</i>	<i>855</i>	<i>863</i>
<i>cathinone derivatives in tablets</i>	<i>60</i>	<i>144</i>	<i>174</i>	<i>174</i>	<i>40</i>

Source: BSZKI 2015

Table 22. *Quantity seized between 2010-2014*⁶⁹

type of drug	2010	2011	2012	2013	2014
herbal cannabis (kg)	528.1	208.7	1,776.7	863.4	529.23
cannabis plants (plant)	14,824	14,121	7,382	5,307	3,288
cannabis resin (kg)	8.5	18.2	3.1	5	7.91
heroin (kg)	97.8	3.2	2.5	5.7	70.06
cocaine (kg)	14.4	12.6	13.3	8.1	39.65
amphetamine (kg)	71.2	24.1	29.9	74.8	15.95
methamphetamine (kg)	3.4	0.1	0.06	0.2	0.41
ecstasy tablets (tablet) /MDMA, MDA, MDE/	1,135	270	12,437	17,664	13,020
LSD (dose)	461	274	599	342	965
<i>plant materials with synthetic cannabinoids (kg)</i>	<i>14.8</i>	<i>10.2</i>	<i>179.2</i>	<i>44.5</i>	<i>100.01</i>
<i>synthetic cannabinoids in powder (kg)</i>	<i>0.01</i>	<i>13.2</i>	<i>4.3</i>	<i>15.5</i>	<i>5.52</i>
<i>cathinone derivatives in the form of powder</i>	<i>9.08</i>	<i>75.8</i>	<i>58.7</i>	<i>81.5</i>	<i>42.01</i>

⁶⁸ The following table contains the data of the seizures analysed in the drug testing laboratory of the Hungarian Institute for Forensic Sciences, and the data of the cannabis plantations seized on site on the basis of the botanical examination.

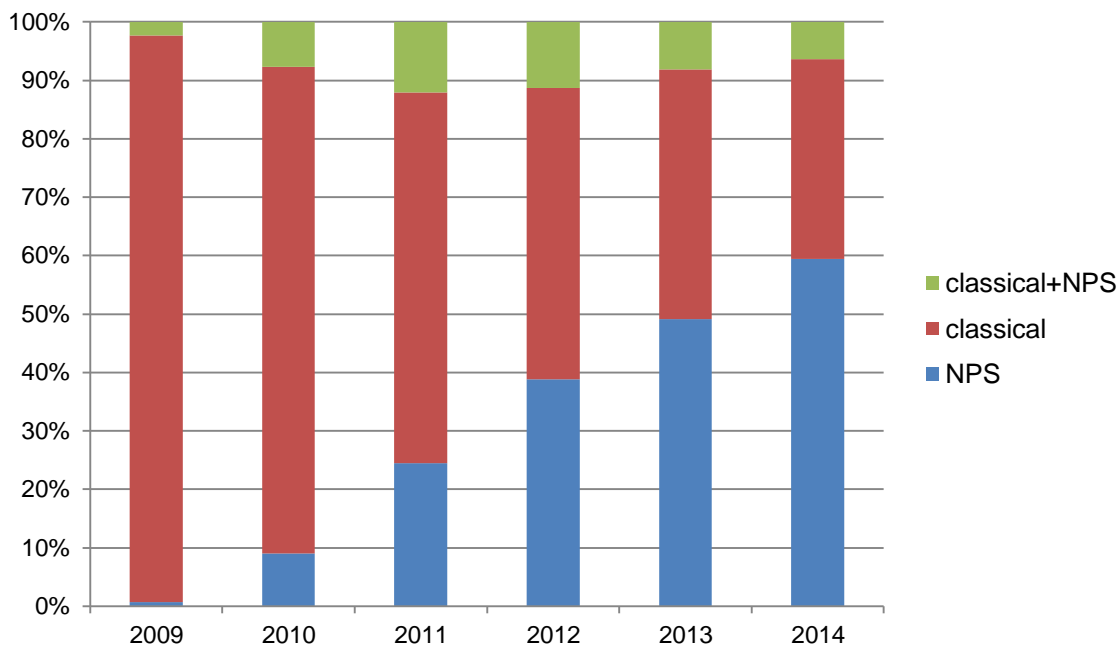
⁶⁹ The following table contains the data of the seizures analysed in the drug testing laboratory of the Hungarian Institute for Forensic Sciences, and the data of the cannabis plantations seized on site on the basis of the botanical examination.

(kg)					
cathinone derivatives in tablets (tablet)	3,990	7,951	27,876	55,421	12,902

Source: BSZKI 2015

During 2010–2014 new psychoactive substances completely restructured the Hungarian drug market. Following the large-scale increase in the amount of mephedrone available in the summer of 2010, the proportion of the new psychoactive substances as compared to the classical drugs rose continuously. In 2014 the new psychoactive substances constituted nearly 60% of all police seizures.

Chart 28. The frequency of occurrence of 'classical'⁷⁰ and NPS (%) among substances seized between 2009-2014

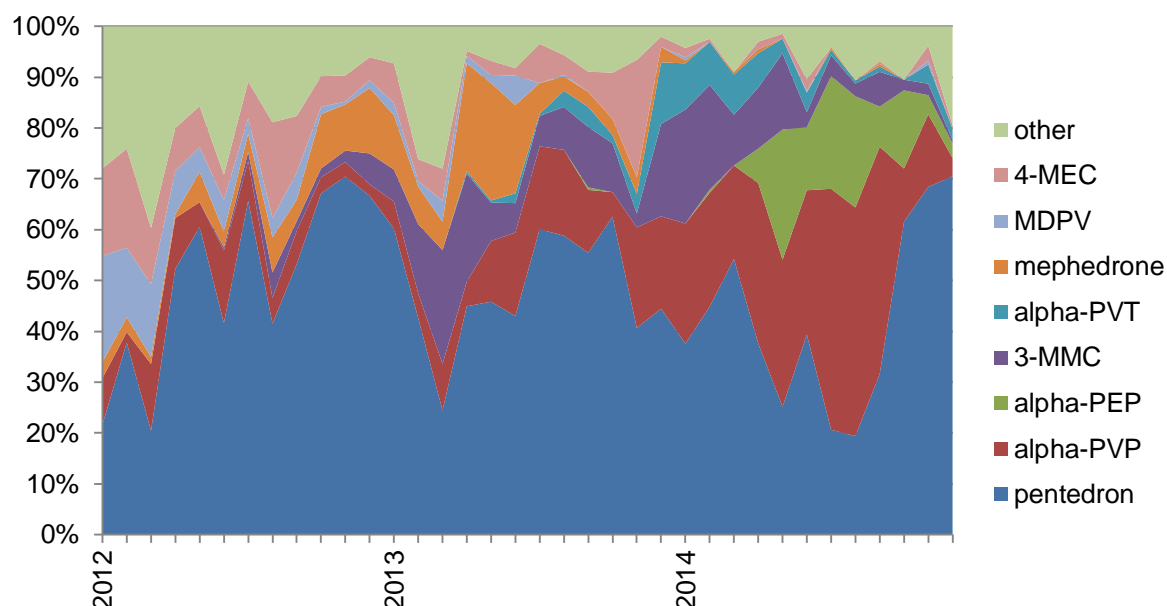


Source: BSZKI 2015

The share of two large groups of the new substances, cathinone derivatives and synthetic cannabinoids was the largest in the seizures. Cathinones are usually distributed in the form of powders. The most frequent active substances were: mephedrone in 2010, 4-MEC and MDPV in 2011, and pentedrone from 2012. During 2014 the proportion of alpha-PVP in the seizures rose significantly for a time, but by the end of the year it was pentedrone again that was the most characteristic substance.

⁷⁰ Substances listed in the schedules of the UN Drug Conventions were categorised as 'classical'.

Chart 29. *The frequency of occurrence (%) of cathinone derivatives (proportion of cases when the active substance was detected) in the substances, broken down by month between 2012-2014*

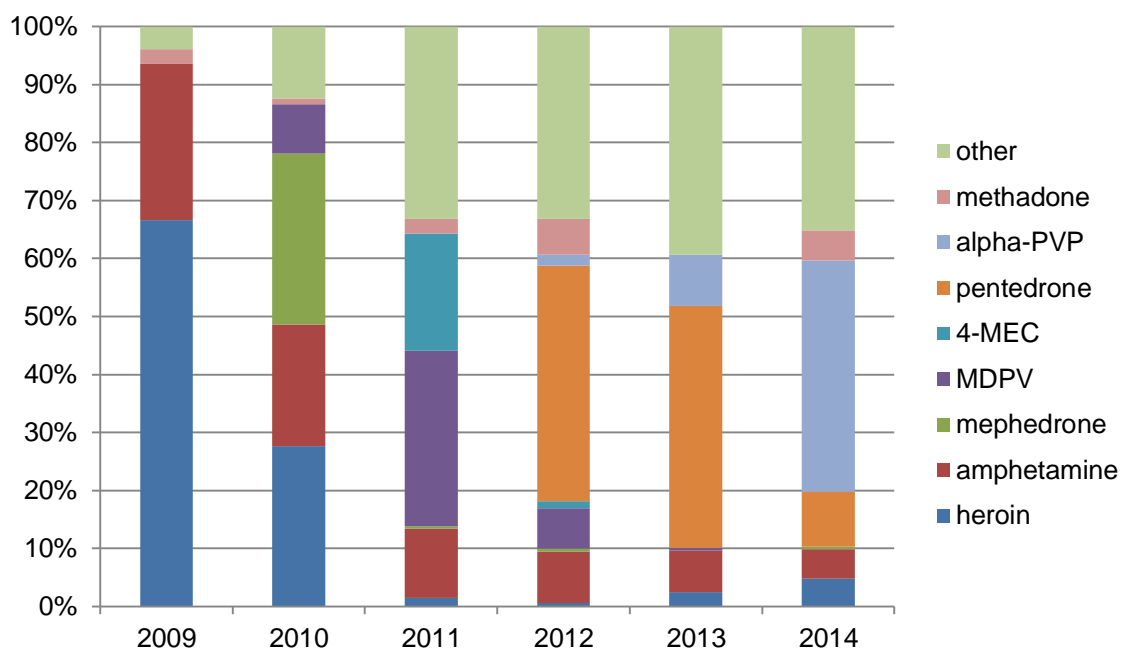


Source: BSZKI 2015

On the basis of the active substances detected in/on injecting drug use related equipment subjected to laboratory testing, it is possible to monitor trends in the types and prevalence rates of substances injected by IDUs.

The tendency experienced in the previous two years continued, heroin and amphetamine, which had been dominant before 2010, were each detected in just 5% of the cases. In the majority of the cases cathinone derivatives were detected on the examined items, however, among these it was not pentedrone that was the most frequent (9.5%) any more, but alpha-PVP (39.9% of the cases). In 35% of the cases several active substances were present, or other active substances occurring with less frequency were identified. (The changing picture of substance use among IDUs can be followed also in the data of clients attending needle/syringe programmes as well as in the data of those entering treatment due to drug use – see: Drugs Workbook/Stimulants, Chapter T1.2.1 and Drugs Workbook/Heroin and other opioids, Chapter T1.2.1.)

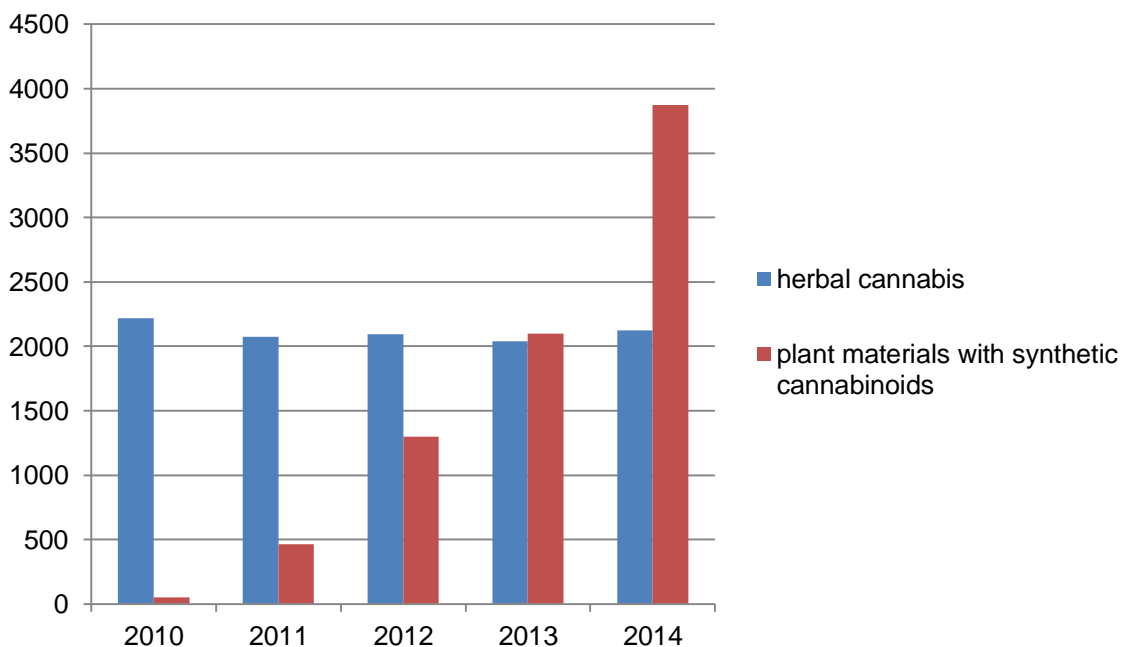
Chart 30. *Prevalence of active substances (%) detected in/on injecting drug use related equipment between 2009-2014*



Source: BSZKI 2015

Since autumn 2010 there has been a continuous rise in the seizures of plant material impregnated with synthetic cannabinoids. The number of seizures of the products known as 'herbal', 'bio weed' or 'sage' in 2014 was nearly double the number of seizures of herbal cannabis.

Chart 31. *The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between 2010-2014*

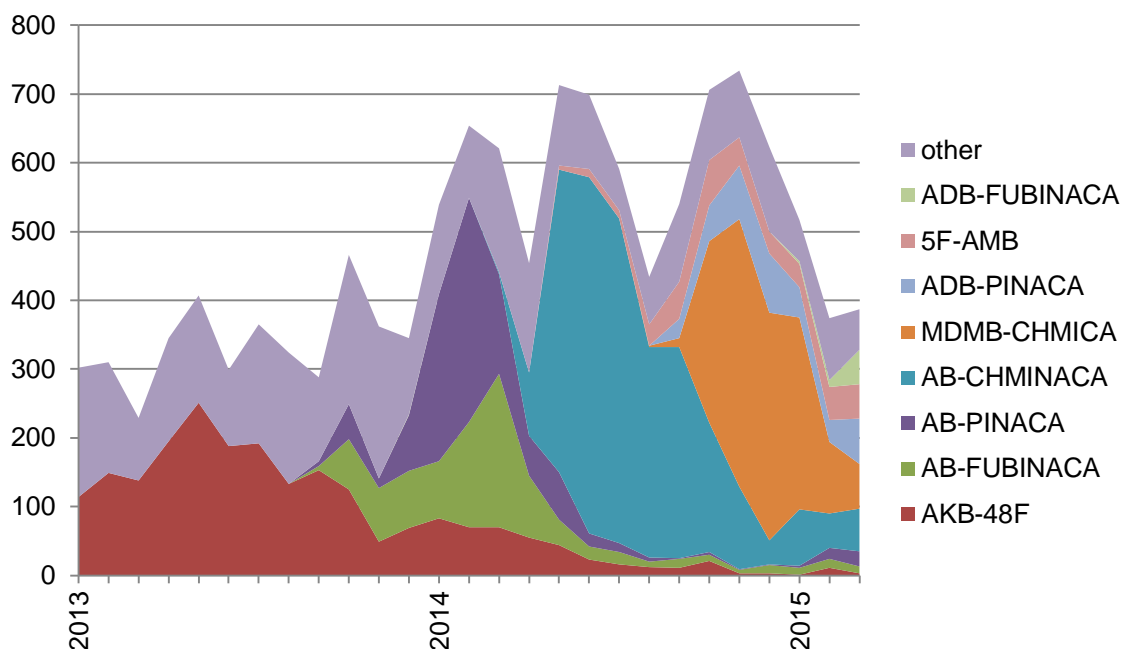


Source: BSZKI 2015

The range of active substances found in the products follow the changes in legislation dynamically, in individual periods characteristically 1–2 dominant active substances can be found on the market. After the individual active substances become regulated, usually within

1–3 months, their occurrence drops significantly and their places are taken over by new active substances that are not yet regulated. The most frequent active substance during 2014 was AB-CHMINACA.

Chart 32. *The frequency of occurrences (N) of synthetic cannabinoid compounds (number of cases when the active substance was detected), broken down by month between 2013 and the first quarter of 2015*

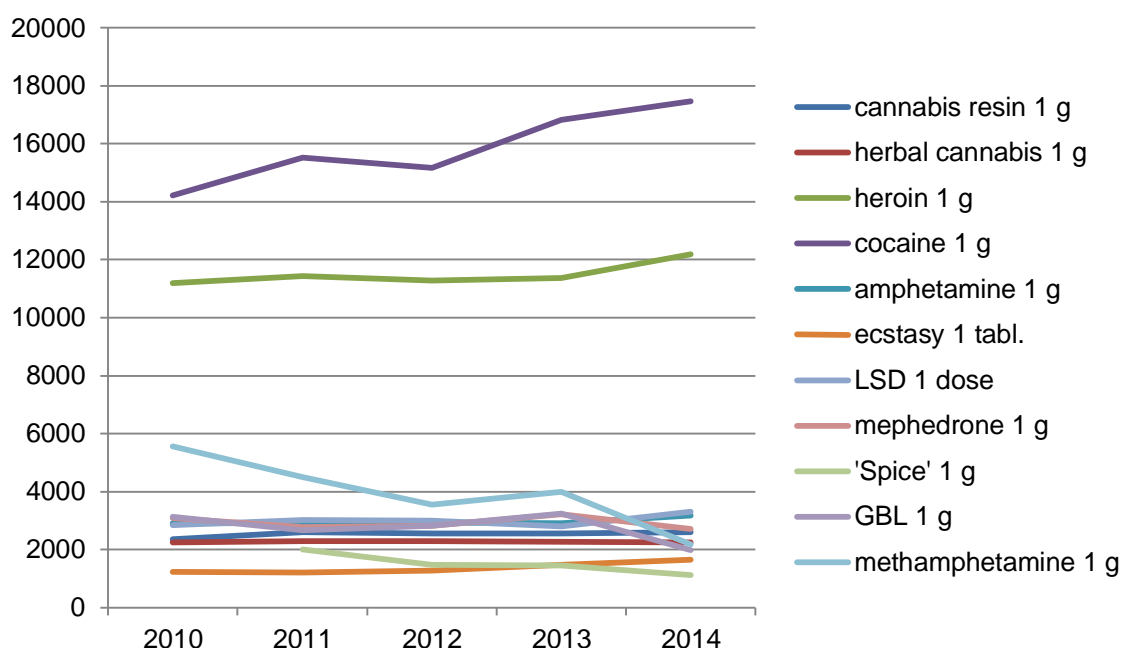


Source: BSZKI 2015

Street prices

According to the research carried out by the Hungarian National Focal Point (Varga 2015), the tendencies observed in the street level prices of drugs in recent years have continued. A continuous decrease in the prices of the new psychoactive substance and methamphetamine can be seen, however, the price of ecstasy tablets is increasing. The same rise can be observed in the cases of heroin and cocaine, which may be related to the change of their role on the market.

Chart 33. Average street prices (mean value) of illicit drugs in HUF between 2010-2014



Source: Varga 2015

Purity

No significant change was experienced in the active substance content of herbal cannabis seizures.

A significant change in the THC content of cannabis resin was the increase in the proportion of samples with a large active substance content (see: Chapter T1.1.5.).

The heroin powders with an active substance content above 30% appearing in recent years in user doses practically disappeared from the seizures, in 2014 the retail market was characterised by powders with an active substance content of 10-30%.

Undiluted, practically pure amphetamine sulphate appeared among the substances on an increasing number of cases. Substances with an active substance content of over 50% formed about 10% of the cases in 2014.

An increase in the active substance content of MDMA tablets can be observed.

T2.4 DRUG LAW OFFENCES – SHORT TERM TRENDS

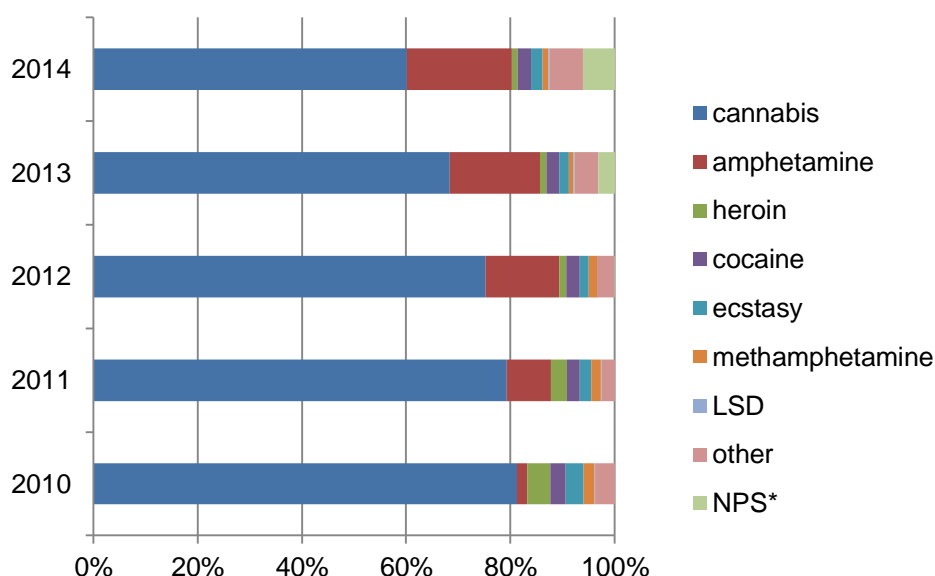
A chronological analysis of the number of drug related offences over the past 5 years is only partly possible, as offences committed before 1 July 2013 fall under the force of Act IV. of 1978 (old Btk.), while offences committed after this date fall under the force of Act C. of 2012 (new Btk.) and in the drug crime statistics the categories covering the statutory definitions of the old and the new Btk. do not always comply with each other. (For more information see 2014 National Report, Chapter 9.1). Furthermore, starting from 2014, offence types are sorted according to the categories of the new EMCDDA drug law offence protocol, which is significantly different to the reporting structure followed in the past. As a consequence of this the data are only partially suitable for comparison and chronological analysis.

Overall, the number of registered drug law offences showed a slightly increasing trend in the past 5 years; the number of registered offences in Hungary was the highest in 2014 since 2006. With respect to perpetration types, 80-90% of drug offences were consumption related, committed in connection with personal use, the proportion of trafficking type, supply related

offences was usually under 15%. The large majority of the offences were committed with a small amount of illicit drug, substantial amounts of illicit drug occurred in about 3% of cases. Examining the past five years, the majority of drug related offences⁷¹ were committed with cannabis. At the same time, the proportion of cannabis among the substance types shows a gradual decrease: in 2010 80% of the offences were committed with this substance, but by 2014 cannabis was only involved in 60% of offences. The change in the distribution of drug related offences according to substance types followed the changes occurring on the drug market, to a certain extent: between 2010 and 2014 the proportion of cases involving heroin had decreased to 1%, while amphetamine appeared as the subject of perpetration in an increasing proportion from year to year (2011: 8.5%, 2014: 20%). Following the decreasing tendency in the number of drug offences committed with ecstasy between 2010 and 2012, a slight increase can be seen from 2013.

Offences (trafficking type) with new psychoactive substances involve criminal liability since April 2012, such cases appeared in the criminal statistics in 2013. (See 2013 and 2014 National Report, Chapter 9.3.) Offences committed with new psychoactive substances form an increasingly larger proportion of drug law offences (2014: 6.1%).

Chart 34. Breakdown of drug offences⁷² by substance type between 2010-2014



*From 2014 offences committed with drugs classed as new psychoactive substances according to international regulation (substances not appearing in the UN drugs schedules) were placed in this category, in harmony with the new EMCDDA protocol on drug law offences.

Source: ENYÜBS 2014, 2015. Analysed by HNFP

T2.7 CHANGES TO DRUG SUPPLY REDUCTION ACTIVITIES

See Chapter T1.3.1

⁷¹ The data given in this part of the analysis were calculated without the cases committed with precursors, and without those cases where the substance type was not recorded.

⁷² Without cases committed with precursors and without those cases where the type of the substance was not recorded.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2014, is presented as part of the baseline information in Chapter T1 and T2.

T4. ADDITIONAL INFORMATION

No information available.

T5. NOTES AND QUERIES

T5.1 DOES THE NATIONAL FOCAL POINT HAVE ACCESS TO DESCRIPTIONS OF SUCH ACTIVITIES?

The Hungarian National Focal Point has no access to descriptions of specific seizures or other law enforcement activities.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

BSZKI (2015): A BSZKI lefoglalási adatai 2009 és 2014 között

ENYÜBS (2014): A Legfőbb Ügyészség Egységes Nyomozóhatósági és Ügyészségi Bűnügyi Statisztikai Rendszerének kábítószer-bűnözéssel kapcsolatos adatai 2004-2013.

ENYÜBS (2015): A Belügyminisztérium Egységes Nyomozóhatósági és Ügyészségi Bűnügyi Statisztikai Rendszerének kábítószer-bűnözéssel kapcsolatos, 2014. évre vonatkozó adatai.

ORFK (2015): A Rendőrség 2014. évi tevékenységéről szóló beszámolója

Péterfi, A., Port, Á (2011): Online kereskedelem Magyarországon. Nemzeti Drog Fókuszpont. Unpublished thesis.

Port, Á. (2012): Felmérés az új pszichoaktív anyagokat árusító magyarországi internetoldalakról. EMCDDA/Nemzeti Drog Fókuszpont.

Ritter, I. (2010): A hazai amfetamin kínálati piac. Kutatási beszámoló. Egészséges Ifjúságért Alapítvány.

Varga, O. (2015): A kábítószeres utcai árak alakulása 2014-ben. Nemzeti Drog Fókuszpont kérdőíves adatgyűjtés.

T6.2 METHODOLOGY

Drug law offences (ENYÜBS data collection): The investigating authority and public prosecutor collect and process the criminal statistics data on the rejection of accusation, and the data generated between the launching of criminal proceedings until the suspension of

investigation or formal accusation, in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS).

ENYÜBS issues a 17-digit statistic code to each of the forms of the offence, in the interest of detailed and legally precise differentiation of the individual perpetration behaviours according to the different statutory definitions. When the investigation is closed two separate statistics datasheets are filled in relating to the offence and the offender. The data obtained on the offences are comprehensive, but are not complete with respect to the perpetrators: one perpetrator may commit several offences, but the statistics datasheet is only completed for the most serious offence or for an offence committed as a minor. On the datasheet relating to the offence only one substance type is recorded (only one type of substance can be associated with one offence). If several drug types are involved in the offence, there is no uniform guidance for which substance should be selected and recorded.

Seizures (BSZKI 2015): The information regarding the substances seized was collected on the basis of the results of forensic analysis. Analysis on the active substance content is carried out if the active substance content of the given case is above the limit of the small amount set in the criminal legislation (amphetamine: 0.5 g, heroin: 0.6 g, MDMA: 1 g, cocaine: 2 g, THC: 6 g).

Street level prices (Varga 2015): 7 organisations from 7 cities participated in the survey. In the questionnaire the respondents were asked to determine the price at last purchase in 2014 per drug type. The questionnaires were recorded using self-administration method, between 1-30 January 2015. Each organisation provided 20 questionnaires filled in by clients using drugs in 2014 before entering treatment, thus the total sample included 140 persons. The clients only stated the price of the type of drug they purchased the last time. The maximum, minimum, mean and mode prices of the individual drug types were calculated from the price of the last purchase. The methodology of the survey is described in detail in the 2010 National Report Chapter 10.3.

Amphetamine supply market in Hungary (Ritter 2010): The objective of the survey carried out in 2010 by the Egészséges Ifjúságért Alapítvány with the support of the Ministry of Social Affairs and Labour was to discover the operational structure of the Hungarian amphetamine supply market. Indicators describing the supply side: seizures in the period under examination; criminal procedures in the period under examination; the activities of Hungarian producers, investors, acquirers; the level of organisation and structure of amphetamine distribution. The survey sample consisted of the criminal statistics and drug seizure data of the past 10 years, of conversations held with the specialists of the National and Budapest Police Headquarters, with public prosecutors and judges regularly acting in drug cases for at least 3 years, as well as of interviews with convicts convicted because of amphetamine dealing/distribution. A total of 48 interviews were made, of which 39 were with convicts and 9 with specialists.

T0. SUMMARY

Comprehensive, drug-related research in prisons with national coverage is relatively rare in Hungary: a national study on drug use among prisoners was last made in 2008. In the lack of this, information on the drug problem within prisons is obtained regularly from the data registered centrally by the Hungarian Prison Service Headquarters (BVOP), and from further small-scale, specific data collections. Noteworthy of the latter is the TDI data collection, in the scope of which the data of those entering drug-related treatment in detention facilities are also recorded. With respect to recent years, the other significant, comprehensive source of information was a survey among all Hungarian detention facilities carried out in the scope of a collaboration between the Hungarian National Focal Point (HNFP) and the BVOP. The purpose of the study was to assess the extent of the drug problem in prisons, as well as the coverage and characteristics of drug-related services available in detention facilities.

According to the available national data on drug use among prisoners, 40% of prisoners in Hungarian detention facilities had used an illicit drug in their lives prior to imprisonment. The prevalence of HIV, hepatitis B and C virus infections is higher among prisoners than in the general population. The studies performed in prisons indicate that the majority of prisoners tested positive for HCV probably became infected by injecting drug use prior to imprisonment.

On the basis of the TDI data, among prisoners entering drug related treatment, stimulant and opioid use and previous injecting drug use are significantly more frequent than among those starting treatment outside of detention facilities.

Treatment and care provided in prison are basically determined by the punitive frameworks of criminal law while these services are dominated by the medical model approach.

The most important elements of the treatment service in prison include a multilevel system of treatment as alternative to criminal procedure (quasi compulsory treatment, QCT), drug prevention units and general healthcare services affecting drug users. In the latter the prison healthcare services and the healthcare system outside of the prison system (mainly specialised outpatient treatment centres) both play a role. This system is supplemented by the programmes offered by different NGOs, which, however, due to their tender-based financing, have heterogeneous and ad-hoc contents.

T1. NATIONAL PROFILE

T1.1 ORGANISATION

In Hungary in 2014, 33 detention facilities (33 facilities belonging to 28 institutions) were in operation, with space for a total of 12869 persons. Among the institutions 18 facilities operated with national authority and 15 with county authority. The county facilities serve mainly for the preliminary custody of prisoners, where both women and men and minors may be accommodated. In detention facilities with national authority, the prison service endeavours to take place of residence into consideration when allocating a detainee to a particular prison: during allocation the region is the priority, but this is not always implemented due to the overcrowdedness of facilities.

⁷³ Author of the chapter: Ágnes Port

Of the facilities with national authority, 13 are entitled to accommodate men and 5 facilities are entitled to accommodate women⁷⁴, and 3 facilities accept both men and women. A total of 5 facilities accept minors⁷⁵, of these 4 facilities are entitled to accommodate men and 1 both men and women.

The number of prisoners in Hungarian detention facilities on 31 December 2014 was 17890 persons, of these 16541 (92.4%) were males and 1349 (7.5%) were females. The proportion of minors among all detainees was 2.4% (424 persons, 407 males and 17 females).

Overcrowding is significant in Hungarian prisons. In 2014 the average utilisation of the overall prison capacity was 141%, but there were institutions where twice as many prisoners were accommodated as the capacity of the facility. Overcrowding makes the drug problem in prisons worse. There are current government plans aimed at solving the overcrowding.

T1.2 DRUG USE AND RELATED PROBLEMS AMONG PRISONERS

T1.2.1 Drug use among prisoners

Drug use prior to imprisonment

The most current, reliable information relating drug use among prisoners prior to imprisonment is available from the survey (Port and Tarján 2014) conducted jointly by the Hungarian National Focal Point and the BVOP in 2013. Data of the survey refers to 2012.

Out of the 31 participating prisons 15 were able to provide precise data on the proportion of prisoners self-reporting being drug addicts. The proportion of prisoners admitting to being drug addicts on admission was characteristically under 10%, however, this figure exceeded 30% in the case of 3 institutions; the average in the 15 prisons⁷⁶ was 15% (859 persons). The questionnaire also asked how many persons self-reported during admission having ever used drugs in their lives. In those institutions⁷⁷ that were able to report on the number of prisoners and the number of ever drug users, the proportion of prisoners who reported ever using drugs in their lives was 38% (3,148 persons). During admission 219 persons admitted to having ever injected drugs, which, on average meant 4% of the prisoners⁷⁸ in the prisons able to provide information on this.

The latest national survey examining drug use among prisoners was carried out in 2008 (Paksi 2009). (ST12_2009_HU_01) According to the results of this survey 43.8% of the population imprisoned in Hungarian detention facilities on the basis of a final decision had tried an illicit drug⁷⁹ prior to imprisonment. More than two-fifth of ever-users (41.6%), that is every fifth or sixth imprisoned person (18.2%), had a period in their lives before imprisonment, when they used an illicit drug at least once a week. In the year before starting to serve their sentence, every third prisoner, while in the last month before imprisonment every fifth presently imprisoned person used an illicit drug. 37.8% of the prisoners, that is a decisive majority (85.7%) of those who used an illicit drug at any time in their lives have already used herbal cannabis or cannabis resin in their lives. The prevalence rate of all other drugs was much lower. The findings of the survey are presented in detail in the 2009 National Report Chapter 9.4.

⁷⁴ If necessary, 1 extra facility may be appointed.

⁷⁵ This picture is shaded by the fact that number of adult detainees is on average four times higher than the number of minor detainees in the central detention facility for minors (Tököl).

⁷⁶ N_{prisoners}=5732

⁷⁷ 16 institutions, N_{prisoners}=8259

⁷⁸ 13 institutions, N_{prisoners}=5417

⁷⁹ In the survey the following drugs were regarded as illicit drugs: cannabis, ecstasy, amphetamine, cocaine, heroin, other opioids, LSD, magic mushroom, crack, GHB, any injected drug, herbal drugs, rush, angel dust, ketamine.

In 2012 a study was carried out within the scope of the annual counselling and screening programme aimed at the prevention of HIV/HBV/HCV infections in prisons entitled 'Infections and fears in detention facilities' (Ritter 2013), in the scope of which knowledge about, attitude to, affectedness by, and related risks of HCV infection among prisoners were examined. During the survey drug use patterns of the participating prisoners (852 persons) were also examined.⁸⁰ 49.7% of the prisoners included in the sample had used any illicit drugs/new psychoactive substance in their lives. Most of them had used cannabis (35.5%), which was followed by amphetamines (27.6%), ecstasy (26.9%), cocaine (18.7%), and LSD (12.9%). The appearance of new psychoactive substances could also be detected among prisoners, the most frequently reported new substance was mephedrone, which had been used by 12.6% of the respondents in their lives. 8.1% of the respondents self-reported being a drug addict and 9.9% of all participants regarded themselves as regular drug users. Among those who regarded themselves as drug addicts the number of those who had become addicts due to the use of amphetamines or other stimulants was twice the number of those who had become addicts as a result of opioid use.

Drug use inside prison

According to data from the BVOP, during the course of 2014 drug possession was revealed on 9 occasions with the involvement of 13 persons, material suspected of being an illicit drug was discovered in 179 cases involving 179 prisoners. Drug use inside prison was revealed in the case of 57 prisoners, among them 5 were minors. There is no unified reporting obligation relating to the seized substances but according to the reports from prisons the majority of seizures involved herbal cannabis, synthetic cannabinoids and non-prescribed sedative medicines (Rivotril tablets containing clonazepam). The seizure of injecting equipment and injecting drug use is not characteristic in Hungarian detention facilities, there were no cases of such in 2014 either. (BVOP 2015)

According to the national study conducted in 2008 in relation to drug use among prisoners (Paksi 2009), 14.3% of the imprisoned persons, 29.4% of those who used illicit drugs at any point in their lives before imprisonment, and nearly half (46.3%) of those who were regular drug users before imprisonment used an illicit drug while being imprisoned. The decisive majority (90.9%) of ever users had also used illicit drugs earlier, prior to imprisonment. (ST12_2009_HU_01)

T1.2.2 Drug related problems among prisoners

Number and characteristics of clients entering treatment in prisons on the basis of TDI data

Data on the socio-demographic and illicit drug use characteristics of persons treated in a QCT programme within the Hungarian prison system are available from the National Centre for Addictions' (OAC) TDI database. According to the TDI protocol, prisons also report cases of persons entering treatment to the TDI database.⁸¹

On the basis of TDI data, in 2014 146 prisoners (137 males, 7 females, the sex of 2 persons is not known) started treatment due to a drug problem, most of them in the scope of QCT (144 persons).

⁸⁰ When interpreting prevalence data, it has to be considered that besides prisoners who took part in the screening test and were willing to participate in the study and fill in the anonymous questionnaires, prisoners with known hepatitis C and wishing to participate in the study were also included in the sample.

⁸¹ Numerically the TDI data does not match the treatment data supplied by the BVOP (see: T1.3.2). One reason for this is that the BVOP registers the completed and interrupted treatments in a given year, while TDI registers started treatments in a given year. Also, not all the institutions report in the TDI, i.e. TDI does not cover all detention facilities where drug related treatment of prisoners takes place.

Numerous differences can be observed between those entering treatment outside the prison and those entering treatment inside, regarding both socio-demographic and drug use characteristics.

Average age was slightly higher among those entering treatment in detention facilities (prisoners 29.9 years; non-prisoners 27.1 years). The proportion of males is characteristically high among drug users, it was 95% among prisoners entering treatment, while 88% among non-prisoner treatment entrants. This is partly due to the gender distribution of prisoners (92% males, 8% females). With respect to highest school qualification, 50% of those entering treatment outside prison had elementary school qualification at the most, while among prisoners this proportion was 75%.

There are also differences in drug use patterns. Among those entering treatment inside prison, use of stimulants and opioids was more characteristic, while cannabis use was predominant among non-prisoners as the primary cause for treatment.

Prisoners entering treatment were also more involved in injecting drug use. For 26% of them this was the characteristic route of administration prior to imprisonment, and 43% reported that they had injected drugs at least once in their lives. In the non-prisoner population these figures were 6% and 15% respectively.

Table 23. *Main characteristics of prisoner and non-prisoner clients entering treatment in 2014* ($N_{\text{prisoners}}=146$; $N_{\text{non-prisoners}}=4542$)⁸²

prisoners		non-prisoners
29.9 years	mean age	27.1 years
95%	proportion of males	88%
75%	proportion of those who completed 8 years of elementary school at the most	50%
38%	proportion of cannabis users	56%
42%	proportion of stimulant users	18%
12%	proportion of opioid users	4%
26%	proportion of those who inject their primary substance	6%
43%	proportion of ever IDUs	15%

Source: TDI data collection 2015

Risk behaviours, infectious diseases

The prevalence of HIV, hepatitis B and C virus infections is higher among prisoners than in the general population. Research carried out in detention facilities indicates that the majority of prisoners tested positive for HCV probably became infected by earlier injecting drug use.

A study performed between 2007 and 2009 (Tresó et al. 2011) in 20 detention facilities among 4894 prisoners found HBV prevalence to be 1.5% and HCV prevalence to be 4.9%. 1553 persons also completed questionnaires in connection with risk behaviours. A third (35.6%) of the latter respondents had ever used an illicit drug, and among them 37.8% had injected at least once in their lives. Among those who had used an illicit drug, HCV prevalence was 9.4%; and among those who injected as well HCV prevalence was 22.5%. There was a link between risk behaviours and HCV infection: the HCV prevalence rate among those ever sharing equipment was 30.7%, and 37.9% among those sharing needles/syringes.

⁸² The proportions were calculated by excluding those who responded 'not known' for the given variable.

According to the results of a survey carried out in 2012 in the scope of the counselling and screening programmes aimed at the prevention of HIV/HBV/HCV infections in prisons (Ritter 2013), 20.7% of all respondents (N=852) reported having injected drugs ever in their lives, and 4.2% of the total sample reported having injected drugs while in prison. Among the tested prisoners the HCV prevalence rate was 8.2%, the prevalence rate among ever injecting prisoners was 24.8%.⁸³

82.9% of the 70 HCV positive prisoners said that they had ever injected drugs, the majority of them (56.9%) primarily injected amphetamine, and 24.1% primarily injected heroin. 10% of the HCV positive prisoners reported injecting drugs even during imprisonment, typically they injected amphetamine derivatives. Among those who were HCV positive there were 3 persons who probably became infected while in prison, as they were tested in the year preceding the study and then their result was negative, but in 2012 they were diagnosed with HCV infection and they had been imprisoned in a detention facility for at least 2 years.

61.3% of the HCV positive inmates reported on sharing needles/syringes with others at least once when injecting drugs, 14.8% of them shared needles/syringes only once and 85.2% of them on several occasions.

60.5% of the HCV positive inmates reported that they had tattoos done in such a way that the same needle had been used before on someone else. 20.6% of them had tattoos done also during imprisonment in a way that the same needle had been used before on someone else and it had not been sterilised.

71.8% of all the HCV infected prisoners had a tattoo, however only 32.4% of them said that it was done always without sharing needles used for tattooing. In case of two-third of the infected prisoners acquirement of the hepatitis C virus could have happened through needle/syringe sharing while injecting or through sharing needles used for tattooing.

Only 10.5% of the HCV positive inmates included in the sample reported that they often or always used condoms during sexual intercourse. The majority of them used condoms very rarely or did not use condoms at all.

According to the data of a national HIV/HCV prevalence study carried out in 2014 among IDUs (Dudás et al. 2014), nearly every second IDU (282 persons; 48.9%) has been in prison at sometime in their lives. Among them HCV prevalence rate resulted to be 64.9%. For further data from the study see: Harms and Harm Reduction Workbook, Chapters T.1 and T.2. (ST9P2_2015_HU_02; ST9P3_2015_HU_01)

T1.3 DRUG-RELATED HEALTH RESPONSES IN PRISON

T1.3.1 Strategy

The 2013-2020 National Anti-Drug Strategy (see also: Drug Policy Workbook, Chapter T1.1) mentions the prisons specifically in two places: in the prevention and the treatment-care pillars. The section dealing with prevention lists the criminal justice institutions as an independent setting, and requires them to promote the social integration of prisoners, to operate drug prevention units with expanded scope and to improve the access of drug addict prisoners to appropriate treatment. With respect to treatment-care, the Strategy aims at setting up special treatment-care programmes (therapeutic interventions) and follow-up care programmes for disadvantaged groups and for those with special needs, including prisoners that are adapted to the individual needs of the group and the unique characteristics of the institution system.

⁸³ When interpreting prevalence data, recruitment of the sample has to be considered as prisoners who took part in the screening test and who were willing to participate in the study and fill in the anonymous questionnaires were involved in the sample, but also prisoners who were already known hepatitis C positive and wished to participate in the study were also included.

T1.3.2 Organising treatment and care

Fundamentally, treatment and care is organised on the basis of a medical model, the system considers drug use primarily as a medical problem. Certain elements of the care system are provided by the health service of the prison system, including the National Institute for Forensic Observation and Psychiatry (IMEI), the detention institutes designated to provide treatment as an alternative to criminal procedure, the doctors and psychologists providing basic healthcare service, while other elements – especially preventive-consulting services – are provided by regionally competent external service providers (mostly outpatient drug treatment centres). In the course of performing its tasks the prison system closely cooperates with numerous governmental, local governmental research-training and programme providing non-governmental organisations as well.

Apart from the medical model, the security model⁸⁴ also characterizes the approach to the drug problem, which represents the greatest obstacle to the introduction of harm reduction interventions.

A Special Drug Affairs Committee of the Prison System was set up in 2008. The Committee's tasks involve the national coordination of drug supply, demand and harm reduction programmes within the framework of the criminal justice organisation, supervising prevention programmes, elaborating guidelines relating to the training and further training of professionals on the drugs problem, elaborating methodological guidance relating to the planned provisions, preparing tenders, finding resources for operation. It cooperates with criminal justice bodies, and with drug related national and international social organisations and NGOs. In the course of 2014 the committee did not hold any meetings.

QCT within detention facilities

The Hungarian legal system provides the opportunity for prisoners committing a drug related offence before imprisonment to participate in QCT (quasy compulsory treatment) as an alternative to criminal procedure – in the case of the possession of a small amount of illicit drug for the purpose of personal use, on one occasion within two years (for a more detailed description see the Treatment Workbook, Chapter T1.2.2).⁸⁵ The IMEI and another six detention facilities have been designated to provide treatment for drug addiction and treatment of other conditions with drug use in the scope of QCT. Prisoners undergoing drug addiction treatment are accommodated in the specifically designated detention facility. The preventive-consulting service for QCT participants must be provided by an external service provider with regional authority, which is determined by the National Drug Prevention Office (NDI).

According to data from the BVOP, in 2014 40 persons participated in treatment for drug addiction or treatment of other conditions with drug use, and 175 persons took part in a preventive–consulting service. It is very difficult to organise QCT during preliminary custody, because the fluctuation of detainees is high and there is a lot of transportation between facilities. Due to this several QCTs are interrupted or take place in parallel. The large majority of QCT takes place in Budapest, i.e. the institution of QCT is centralised within the prison service. (The TDI data of persons entering drug treatment in detention facilities are presented in Chapter T1.2.2.)

⁸⁴ According to this the drugs and paraphernalia related to drug use found in prisons are primarily classified as 'prohibited articles'. It is the obligation of the security staff to find and seize these, even in spite of the contraindications originating from any demand or harm reduction programmes.

⁸⁵ 3 forms of treatment are available in the scope of QCT: preventive-consulting service; treatment for drug addiction, and treatment of other conditions with drug use.

T1.3.3 Drug related health and other services in prisons

Admission procedure

People admitted to prison go through a medical examination, and at most institutes a psychologist also performs an examination. In the course of the examination questions are also asked about drug use and alcohol consumption. Answers are recorded in the healthcare subsystem, which can only be accessed by entitled specialists.⁸⁶ It is not possible to check whether the statements are valid. If a positive answer is given to the question relating to drug use and if it is medically reasonable, the attending doctor takes measures about necessary further treatment (as in the case of all other health problems). Generally no other addiction severity or standardized drug use measuring tools are used.

Prevention

A change in legislation in 2002 made it possible to set up prevention units or departments in detention facilities for volunteering prisoners⁸⁷. The prisoners are accommodated in separate cells or department. The prisoners here receive certain benefits and treatments in return for making a written declaration to agree to participate in drug tests that may take place at any time but occur at least every month, i.e. to provide a biological sample in the interest of monitoring that the prisoners are not taking drugs. The large majority of the services and programmes provided in the prevention units are psychological/psychotherapy group sessions and individual consultations. In 2014 20 detention facilities operated drug prevention units, the total number of prisoners accommodated here was 501 persons over the course of the year. There is a drug prevention unit in every facility where sentenced minors and women are held in detention. A significant proportion of the drug prevention programmes and other not strictly medical services are provided with the participation of external NGOs via tender-based funding.

The study carried out in 2013 in the cooperation of the BVOP and the NFP (Port and Tarján 2014) found that in 2012 22 institutions⁸⁸ realized drug prevention programmes independent of the prevention units: 8 institutions operated 1, 11 institutions operated 2, 1 institution had 3 and 2 institutions had 6 such programmes during the year. The content of the programmes did not differ very much from services available in the prevention units: they typically included individual and group therapy sessions, and informative lectures. The range of methods used was wide: consultation, guided conversations, peer help groups, life coaching, psychodrama, work therapy, fairy tale therapy, autogenic training, etc. The following were mentioned as the objective of the sessions: information provision, preventing drug use and the provision of information on the consequences of drug use, promoting self-knowledge and self-help, abstinence after release, psycho-education, acquiring coping skills, reducing prison harm, preparation for release, reintegration after release, conflict management, health promotion. With the exception of one prison, the programmes were realised with the collaboration of an external organisation.

Treatment programmes available in detention facilities

18 institutions reported on the realisation of drug treatment programme(s) in 2012 in the course of the questionnaire survey carried out in 2013 (Port and Tarján 2014). The institutions realised the majority of the treatment programmes as part of the treatment available as an alternative to criminal procedure (QCT), in the form of preventive-consulting services (12 institutions) and, occasionally in the form of drug addiction treatment programmes (2 institutions), with the involvement of external service providers. In several

⁸⁶ In order to obtain aggregate data annually it would be necessary to improve the IT system.

⁸⁷ Previous drug use is not a condition of participation.

⁸⁸ Based on data from 30 prisons out of the 31 prisons participating in the survey.

institutions there was no sharp division between the treatment and prevention programmes, that is, the treatment also took place in the framework of the prevention unit/group. Similarly to the prevention programmes, the treatment programmes took place mainly in the form of personal or group therapy sessions and counselling, and were aimed at the development of competencies such as identification of personal resources and acquiring coping skills, reduction of prison harms, preparation for release, improving self-knowledge, development of social competence, increasing assertiveness, and the prevention of relapse. With respect to their methods the programmes were varied: psychodrama, film, behaviour therapies, etc.

25 of the 31 institutions provided information on the availability of the different treatment types⁸⁹. On the basis of this low-intensity, outpatient-type treatment was available in 14 institutions, and medium/high intensity, inpatient-type treatment was available in 5 institutions. 18 institutions provided access to preventive-consulting services. The questionnaire also asked how prisoners with drug withdrawal symptoms were treated in the individual institutions. Of the 27 institutions providing a valid response, withdrawal symptoms were treated via pharmacologically assisted treatment in 11 institutions, and in a further 12 institutions pharmacologically assisted treatment was accompanied by psycho-social interventions as well. Several institutions indicated that withdrawal symptoms were not treated within the institution, because that had taken place before the prisoner was admitted.

A description of QCT used as an alternative to criminal procedure can be read in Chapter T1.3.2, the TDI data of prisoners entering treatment can be found in Chapter T.1.2.2, and the information on opioid substitution treatment for prisoners is included in Chapter T.1.3.4.

Prevention, testing, and treatment of infectious diseases

Organised by the Hungarian Prison Service Headquarters (BVOP), a hepatitis C counselling and screening programme has been carried out every year in Hungarian detention facilities with the involvement of an external healthcare partner since 2007⁹⁰. HCV testing is preceded by a preliminary half-hour-long informative lecture, after which the prisoners may voluntarily undergo testing. The blood samples are examined in Szent László Hospital.

During 2014, awareness raising lectures in connection with HCV/HBV/HIV/TB infections were held in 26 detention facilities on a total of 31 occasions. A total of 4273 prisoners attended the lectures (23.9% of the average prison population). Individual counselling in connection with infectious diseases was attended by 5529 persons (30.9%). This was provided on request in 4 facilities, and in 3 facilities it took place during every admission. According to the BVOP written information was distributed to 2997 prisoners during the year in 8 prisons. 3 facilities provided written information material to every prisoner on entry. (BVOP 2015)

During 2014 a total of 3082 prisoners were tested for HCV, 17.2% of the average prison population. Among them 339 persons (11%, 1.9% of the entire prison population) proved to be HCV antibody positive, of these 71 persons were hepatitis C virus carriers as well. 394 prisoners were tested for hepatitis B (2.2% of the prison population), among them 3 HBV positive cases were identified. 835 prisoners were tested for HIV (4.7% of the prison population), and 1 new case was found. (There were a further 6 known HIV positive cases.)

⁸⁹ Treatment types:

- Low intensity programmes: interventions providing counselling, and short-term programmes that are provided within the prison institution within the framework of 'outpatient type' treatment. Pharmacologically assisted treatment with an exclusive aim of detoxification does not belong to this category.
- Medium/high intensity programmes: Non -pharmacologically assisted treatment forms that are realised in the form of 'inpatient-type' treatment within the prison in a residential unit. Pharmacologically assisted treatment with an exclusive aim of detoxification does not belong to this category.
- Medium and long-term opioid substitution treatment (methadone/Suboxone).
- Preventive-consulting service.

⁹⁰ In 2013 the programme was suspended due to lack of funds.

TB testing is also available in detention facilities. According to the amendment of the Ministry of Welfare regulation no 8/1998., as of 2013 it is compulsory for all newly admitted prisoners to have a chest X-ray test. Accordingly, in 2014 a greater number of chest x-rays were performed than in previous years, in a total of 24840 cases, of which 90 suspected cases of tuberculosis were found. There were no active TB patients among the tested cases, and 14 passive TB cases were found. 26 prisoners received treatment for TB during the year.

Prisoners testing positive for HIV, HBV or HCV and meeting the therapeutic criteria receive treatment for their condition, those not receiving treatment for a health reason are taken into care. In 2014, 11 HIV-infected prisoners received antiretroviral treatment, and 134 HCV-infected and 6 HBV-infected prisoners received antiviral treatment. (Among those infected with HCV, 30 rejected the treatment, and 18 did not receive treatment for health reasons.)

The prison health services and the regional hepatology centres together are in charge of the treatment of prisoners with hepatitis C. If necessary, the prisoners are taken to the outpatient treatment unit of the local hepatology centre. HIV positive persons are offered the possibility to serve their sentence at the Juvenile Prison in Tököl, in a special unit of the prison maintained for HIV positive persons. In this special unit there is also a consulting room, where HIV positive prisoners are provided with medical attendance by a specialist from the Szent László Hospital. New patients diagnosed with tuberculosis are separated and treated at the Department of Pulmonology of the Prison Service Central Hospital.

Harm reduction and prevention of overdose after release

The survey carried out by the BVOP and the HNFP (Port and Tarján 2014) also examined whether a programme or counselling aimed at preventing overdoses after release was available in the individual institutions. 4 prisons reported that such intervention was available.⁹¹ However, among these institutions only one indicated that a general programme specifically of this nature was provided for all prisoners, in the other 3 institutions personal counselling was available in the subject in accordance with individual. One institution reported that they dealt with the subject in the scope of a drug prevention group therapy. According to information from the BVOP, in 2014 307 persons received information with the above purpose (via group or individual counselling).

Reintegration, preparation for release

According to the results of the survey carried out in 2013 in Hungarian prisons (Port and Tarján 2014) usually there is no formal procedure in the institutions relating to prisoners receiving drug related treatment before release, however, several institutions mentioned that they had informed the prisoners about how to contact the appropriate organisations or referred them to the local outpatient drug treatment centres or psychiatric departments, and that they provide opportunity for individual/group counselling regarding this problem. Two institutions mentioned that the counsellor/support person dealing with the prisoners remains in contact with the prisoners requiring such contact following release.

Out of the 31 detention facilities participating in the survey, 6 institutions had specific programmes (12 programmes altogether) for drug-user prisoners promoting social reintegration and resocialisation in the course of 2012.⁹² In all cases the programmes were realised with the involvement of external organisations. The programmes were characteristically carried out in the framework of group sessions, their objective was to provide psychological support for prisoners, and the provision of knowledge to assist them in reintegration following release. Other programmes in connection with

⁹¹ Out of the 31 participating institutions 21 responded no, and in the case of 6 institutions information was not available.

⁹² 25 of the 31 institutions gave information on the number of resocialisation/reintegration programmes.

resocialisation/reintegration which were not specifically aimed at drug-user prisoners but which also dealt with the drug problem were organised by 7 institutions.

Within the scope of the probation service operating in the detention facilities, the probation officers also assist with reintegration – as prescribed by law – of the prisoners placed under their supervision or of those approaching them voluntarily. The purpose of reintegration care and follow-up care is to provide support aiding the reintegration of the prisoner into society in the form of individual counselling, case management and group sessions. The support covers the following areas: healthcare treatment, labour market integration, accommodation, assistance in enrolling in training, preparation for social administration, group information sessions on the possibilities of reintegration care, follow-up care and legal aid, and finally preparing the prisoner's family for the return of the prisoner. Among the forms of support provided in the scope of individual case management, the relevant decree separately mentions 'the reduction of harmful consequences of addictions by dealing with the social and mental deficits linked to them'.

In the scope of follow-up care, the probation officers help newly released prisoners who want help with their social reintegration through the forms of support detailed above.

The foundation Váltóság Alapítvány⁹³ is one of the most important NGOs in Hungary dealing with the resocialisation and reintegration of prisoners. They contact the prisoner in prison before release, and then maintain contact after release as well. They use various techniques, including: mentoring, group and individual sessions, training courses. The organisation has an occupation programme, a skills training programme as well as a programme especially for women, and they also operate a halfway house. Beside this, the foundation maintains an information database where released persons, their families and also professionals can find useful information regarding the topic. The foundation also regularly publishes information booklets in connection with the subject.

T1.3.4 Opioid substitution treatment in prisons

The Ministry of Justice Decree 8/2014. (XII. 12.) IM regulating the provision of health care services to prisoners contains no provisions relating to the possibility of opioid substitution treatment (OST). In practice, OST is not available within the prisons, an external service provider can possibly provide such a service if requested by a detention facility, but the number of such cases is exceptionally low.

According to the annual data collection (Tarján 2013) carried out among DTCs that provide substitution treatment, between 2005 and 2012, 3 prisoners in 2005 and 2 in 2006 were transported to the regionally competent outpatient drug treatment centre for the purpose of OST. According to information from the BVOP, 2 prisoners received OST in 2014.

T1.4 QUALITY ASSURANCE OF DRUG-RELATED HEALTH PRISON RESPONSES

At present there are no regulatory documents relating specifically to the quality assurance of drug treatment services provided in detention facilities.

T2. TRENDS

Not applicable for this workbook.

⁹³ <http://www.valtosav.hu/>

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2014, is presented as part of the baseline information in Chapter T1.

On 17th December 2013, the Hungarian Parliament adopted Act CCXL of 2013 on the Execution of Criminal Sanctions ('Bv. tv.') which entered into force on 1st January. An article in the new law is dedicated to the drug prevention units to assure successful treatment and care of drug user detainees. According to this a complex program has to be set up which is tailored to the individual needs of the prisoners and includes rehabilitation and trainings to help the person with reintegration after release. According to the 'Bv. tv.' the costs of transportation in case of activities related to drug prevention and treatment or preventive-consulting service undertaken as part of QCT, shall not be borne by the detainee.

The law emphasizes that special attention has to be given to the involvement with drugs and ethnic conflicts of prisoners of foreign nationality. Extra measures are to be taken to facilitate their integration within the prison population.

The 'Bv. tv.' specifies the conditions of participating in treatment or preventive-consulting service in the scope of diversion (QCT) outside the penal institution with permission from the head of the prison.

T4. ADDITIONAL INFORMATION

No information available.

T5. NOTES AND QUERIES

Not applicable.

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES

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T6.2 METHODOLOGY

BVOP and HNFP survey (Port and Tarján 2014): The questionnaires were recorded in July-August 2013, the responses referred to 2012. The questionnaire was filled in by all 31 Hungarian detention facilities. The questionnaires were completed by the employees of the facilities, the responses and data were summarized and analyzed by the Hungarian National Focal Point. Standard questionnaire 23 and 27 of the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) and previous EMCDDA guidelines for the National Report chapter on prisons served as the basis of the questionnaire.

TDI data collection 2015: See Treatment Workbook, Chapter T6.2.

Paksi (2009): The survey was carried out by the Corvinus University of Budapest, Institute of Behavioural Sciences and Communication Theory, Centre for Behavioural Research, it was financed by the National Institute for Drug Prevention and supported by the Hungarian Prison Service Headquarters (BVOP). The target population of the survey included adult convicts with Hungarian citizenship imprisoned in detention facilities in Hungary on the basis of a final decision. In the case of the national detention institutes, on the basis of the current registers of imprisoned persons, using SPSS program on the site, applying a simple random sampling method, a proportionate sample was taken during the survey, 5% in the case of men, and one-third in the case of women – with overrepresentation ensuring an analysable number of respondents. In the case of county detention facilities, sampling took place in two stages: at one location in each region selected by expert sampling, a random sample was selected in proportion with the number of imprisoned persons in the given region. The total sample included 652 persons, the final size of the national sample representing genders proportionately was 503 persons. The so-called 'A' questionnaire on socio-demographic background, habits other than drug use, status of present imprisonment and previous offences prior to this imprisonment were recorded using 'face to face' technique. Questions on drug use prior to and inside prison were recorded by offering the self-administered technique. 71.6% of the sample filled in this second part of the questionnaire alone, while in the case of 28.4% the self-administered part was recorded by using 'face to face' technique. Data collection took place between 14 October and 12 December in 2008.

Ritter (2013): The sample was formed by inmates participating in the anonymous HCV, HBV tests financed and performed by Bristol-Myers Squibb Ltd. in 2012, who were imprisoned in the 7 randomly selected detention facilities. Prisoners who took part in the screening test and who were willing to participate in the study and fill in the anonymous questionnaires were involved in the sample, and prisoners who were known hepatitis C positive and wished to participate in the study were also included. Typically the questionnaires used in the study contained closed questions. Questionnaire data recording took place after the screening tests, days or weeks later. Besides questionnaire data collection in-depth interviews were also held with the inmates and the educators about the phenomenon and about screening. The blood samples were analysed at the Szent László Hospital's Department of Immunology. The blood sample and the questionnaire were linked with an anonymous identifier.

Tresó et al (2011): A national blood sample screening programme was carried out among the prison population between June 2007 and June 2009 aimed at identifying infectious diseases, with the participation of 20 Hungarian detention facilities. A total of 4894 prisoners took part in the test voluntarily (34.2% of the prison population), and a further 1066 volunteers also took part from among the employees of the facilities as a comparison group. On the initiative of the Hungarian National Focal Point, after obtaining the approval of the BVOP, between June 2008 and June 2009, volunteering prisoners who had been tested also filled in a questionnaire about their past drug use / injecting drug use, as well as about any risk behaviours related to the transmission of hepatitis C. By June 2009 1553 prisoners had completed the questionnaire in 7 facilities in parallel with the screening test. The questionnaire was elaborated by the Hungarian National Focal Point on the basis of the recommendations of the EMCDDA⁹⁴. The prisoners taking part in the screening completed the questionnaire before being tested. The questionnaires and the serological results were linked by a unique, anonymous identifier. The questionnaires were self-administered and anonymous.

⁹⁴ Protocol for the implementation of the EMCDDA key indicator: Drug-related infectious diseases (DRID), draft version 6 October 2006, Project CT.04.P1.337

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ANNEX

LIST OF TABLES

Table 1. Changes in the legal framework in the last year.....	19
Table 2. The number of school health development programme applications submitted to the NEFI for approval broken down by subject and number of programmes finally supported.....	46
Table 3. Number and final results of school health development programme applications relating to drug use submitted for professional approval to the NEFI	46
Table 4. Network of outpatient treatment facilities (total number of units in 2014).....	51
Table 5. Outpatient treatment provision (the number of clients starting treatment in 2014) ...	53
Table 6. Network of inpatient treatment facilities (number of treatment units in 2014).....	54
Table 7. Inpatient treatment provision (number of clients starting treatment in 2014)	55
Table 8. Breakdown of direct drug-related deaths in 2014 by gender and substance type (persons)	72
Table 9. Breakdown of direct drug-related deaths by age group and substance type in 2014 (persons)	72
Table 10. Number of direct drug-related deaths in 2014	74
Table 11. Breakdown of registered HIV-positive persons (N) by risk group between 2010-2014	74
Table 12. Breakdown of HCV prevalence among IDUs tested during the national HIV/HCV seroprevalence survey, by gender and age group in 2014.....	75
Table 13. The number of injecting episodes on the last day when injecting and the number of reuses of the last discarded syringe (group mean) among IDUs participating in the national HIV/HCV seroprevalence survey by primary injected substances, in 2014 ..	77
Table 14. Prevalence of the presence of illicit drugs/new psychoactive substances (N) in blood and/or urine samples originating from driving accidents by active substance in 2014	78
Table 15. Collaboration of NSPs with other service providers (N) – outside of their parent institutions – by the type of service provider, in 2014, (N of respondents =29)	80
Table 16. Types of harm reduction equipment distributed by harm reduction services in the recreational setting (N of responding organisations=23)	82
Table 17. Syringe and client turnover data of NSPs in 2014	83
Table 18. Breakdown of direct drug-related deaths, between 2009-2014 (persons)	88
Table 19. Price of drugs at street level in 2014 in HUF	96
Table 20. Price of drugs at street level in 2014 in EUR.....	96
Table 21. Number of seizures between 2010-2014	102
Table 22. Quantity seized between 2010-2014.....	102
Table 23. Main characteristics of prisoner and non-prisoner clients entering treatment in 2014 (N _{prisoners} =146; N _{non-prisoners} =4542)	114

LIST OF CHARTS

Chart 1. Breakdown of NSP clients by primarily injected drug between 2009-2014	29
Chart 2. Breakdown of NSP clients injecting designer stimulants by primarily injected drug type in 2014 (N=2515 persons).....	29
Chart 3. Breakdown of IDUs participating in the national HIV/HCV seroprevalence survey by primarily injected substance, between 2006-2014 (%)	30
Chart 4. Breakdown (%) of current stimulant injectors participating in the national HIV/HCV seroprevalence survey by primarily injected drug type in 2011 (N=256 persons) and in 2014 (N=269 persons)	31
Chart 5. Breakdown of IDUs entering treatment by primarily injected drug between 2007 and 2014 (%).....	31
Chart 6. Frequency of injecting drug use among IDUs entering treatment in 2014 (%)	32
Chart 7. The proportion of injecting use among opioid users, by primary drug between 2009 and 2014.....	36
Chart 8. Breakdown of treatment demand by primary drug (2014; %; N=4688)	55
Chart 9. The proportion of those starting treatment as an alternative to criminal procedure (QCT) among those entering treatment, by type of treatment unit (2014; N=4666) ..	56
Chart 10. Breakdown of QCT and non-QCT (regular treatment) treatment entrants by primary drug (2014; N _{QCT clients} =2788; N _{Non-QCT clients} =1878).....	57
Chart 11. Breakdown of clients in OST by substitution medication and therapeutic purpose (2014; N=745).....	59
Chart 12. Trends in the numbers of first-time clients entering treatment, by primary drug, 2007-2014	61
Chart 13. Trends in numbers of all clients entering treatment, by primary drug, 2007-2014..	61
Chart 14. Trends among treatment entrants excluding QCT clients* between 2007-2014	62
Chart 15. Trends in numbers of clients in OST, 2004-2014	63
Chart 16. Treatment unit type (N=28)	64
Chart 17. Form of operation by type of treatment unit (N=28)	65
Chart 18. Form of operation by financing resources (N=26)	66
Chart 19. Availability of QCT (N=28).....	66
Chart 20. Other units/programmes operated by the parent institution (N=28)	67
Chart 21. The estimated breakdown of drug user clients by primary drug in 2014 (on the basis of the responses from 25 treatment units).....	68
Chart 22. Breakdown of HCV prevalence among current IDUs tested during the national HIV/HCV seroprevalence survey by primarily injected drug, in 2014.....	76
Chart 23. The prevalence of sharing needles/syringes and sharing any injecting equipment in the past 4 weeks (%) among current IDUs participating in the national HIV/HCV seroprevalence survey in 2014	77
Chart 24. The syringe turnover data of NSPs, between 2010-2014	86
Chart 25. Number of NSP clients and number of contacts, between 2010-2014.....	87
Chart 26. Breakdown of HCV prevalence (%) of IDUs participating in the national HIV/HCV prevalence survey by primarily injected drug, between 2007-2014	89
Chart 27. Breakdown of drug offences by perpetration and substance type, 2014.....	99
Chart 28. The frequency of occurrence of 'classical' and NPS (%) among substances seized between 2009-2014.....	103
Chart 29. The frequency of occurrence (%) of cathinone derivatives (proportion of cases when the active substance was detected) in the substances, broken down by month between 2012-2014.....	104
Chart 30. Prevalence of active substances (%) detected in/on injecting drug use related equipment between 2009-2014.....	105
Chart 31. The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between 2010-2014	105

Chart 32. The frequency of occurrences (N) of synthetic cannabinoid compounds (number of cases when the active substance was detected), broken down by month between 2013 and the first quarter of 2015	106
Chart 33. Average street prices (mean value) of illicit drugs in HUF between 2010-2014 ...	107
Chart 34. Breakdown of drug offences by substance type between 2010-2014	108

LIST OF ABBREVIATIONS

BM – Ministry of Interior

BRFK - Budapest Police Headquarters

BSZKI – Hungarian Institute for Forensic Sciences

Btk. – Hungarian Criminal Code

BVOP – Hungarian Prison Service Headquarters

DADA – Hungarian acronym for smoking-alcohol-drugs-AIDS

DTC – drug treatment centre

ELTE – Eötvös Loránd University

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

EMMI – Ministry of Human Capacities (former NEFMI)

EMQ – European Model Questionnaire

ENYÜBS – Uniform Criminal Statistics System of the Investigation Authority and Public Prosecution

FM – Ministry of Agriculture

GDS – Global Drug Survey

HBV - hepatitis B virus

HCV – hepatitis C virus

HIV – human immunodeficiency virus

HNFP – Hungarian National Focal Point

IDU – injecting drug user

IMEI - National Institute for Forensic Observation and Psychiatry

KEF – Coordination Forum on Drug Affairs

KKB – Inter-ministerial Coordination Committee on Drug Affairs (former Coordination Committee on Drug Affairs)

KT – Council on Drug Affairs

NBT – National Crime Prevention Council

NCSSZI – National Institute for Family and Social Policy

NDI – National Drug Prevention Office (former National Institute for Drug Prevention)

NEFI – National Institute for Health Development

NPS – new psychoactive substances

NRSZH - National Office for Rehabilitation and Social Affairs

NSP – needle/syringe programme

OAC – National Centre for Addictions

OEK – National Centre for Epidemiology

OGY – National Assembly

OKRI – National Institute of Criminology

ORFK – National Police Headquarters

OST – opioid substitution treatment

OTKA – Hungarian Scientific Research Fund

QCT – quasi compulsory treatment (treatment as an alternative to criminal procedure)

TÁMOP – Social Renewal Operational Programme

TB – Tuberculosis

TDI – Treatment Demand Indicator

VIR – Public Prosecutor's Office Prosecution Information System