



European Monitoring Centre  
for Drugs and Drug Addiction



**2016 NATIONAL REPORT to the EMCDDA  
by the Reitox National Focal Point**

**“HUNGARY”**

**REITOX**

**CONTRIBUTORS:**

TAMÁS CSESZTREGI, Hungarian Institute for Forensic Sciences

GERGELY CSABA HORVÁTH, Hungarian National Focal Point

ADRIENN NYÍRÁDY, Hungarian National Focal Point

ÁGNES PORT, Hungarian National Focal Point

ANNA TARJÁN, Hungarian National Focal Point

ORSOLYA VARGA, Hungarian National Focal Point

**REVISED BY:**

MÁRIA DUDÁS, GERGELY FLIEGAUF, GYÖRGY IGNÁCZ, TAMÁS KOÓS, ZSOLT  
PETKE, JÓZSEF RÁCZ, JÁNOS SZEMELYÁCZ, RÓBERT SZMODICS

## TABLE OF CONTENT

Drug policy .....	6
T0. Summary .....	6
T1. National profile.....	6
T3. New developments .....	10
T4. Additional information .....	10
T5. Notes and queries.....	10
T6. Sources and methodology .....	10
Legal framework.....	12
T0. Summary .....	12
T1. National profile.....	12
T2. Trends .....	15
T3. New developments .....	17
T4. Additional information .....	19
T5. Notes and queries.....	19
T6. Sources and methodology .....	19
Drugs .....	20
T0. Summary .....	20
A. CANNABIS.....	24
T1. National profile.....	24
T2. Trends .....	30
T3. New developments .....	30
T4. Additional information .....	30
T5. Notes and queries.....	31
B. STIMULANTS.....	32
T1. National profile.....	32
T2. Trends .....	44
T3. New developments .....	44
T4. Additional information .....	44
T5. Notes and queries.....	45
C. HEROIN AND OTHER OPIOIDS.....	46
T1. National profile.....	46
T2. Trends .....	49
T3. New developments .....	49
T4. Additional information .....	49
T5. Notes and queries.....	49
D. NEW PSYCHOACTIVE SUBSTANCES (NPS) AND OTHER DRUGS NOT COVERED ABOVE .....	50
E. SOURCES, METHODOLOGY .....	50

T6. Sources, methodology .....	50
Prevention .....	55
T0. Summary .....	55
T1. National profile.....	55
T2. Trends .....	60
T3. New developments .....	61
T4. Additional information .....	64
T5. Notes and queries.....	64
T6. Sources and methodology .....	64
Treatment.....	65
T0. Summary .....	66
T1. National profile.....	67
T2. Trends .....	78
T3. New developments .....	81
T4. Additional information .....	81
T5. Notes and queries.....	92
T6. Sources and methodology .....	92
Harms and Harm Reduction .....	95
T0. Summary .....	95
T1. National profile.....	96
T2. Trends .....	111
T3. New developments .....	115
T4. Additional information .....	115
T5. Notes and queries.....	116
T6. Sources and methodology .....	116
Drug Market and Crime .....	119
T0. Summary .....	119
T1. National profile.....	119
T2. Trends .....	129
T3. New developments .....	137
T4. Additional information .....	137
T5. Notes and queries.....	140
T6. Sources and methodology .....	140
Prison.....	143
T0. Summary .....	143
T1. National profile.....	143
T2. Trends .....	155
T3. New developments .....	155
T4. Additional information .....	155

T5. Notes and queries.....	156
T6. Sources and methodology .....	156
Bibliography .....	159
Annex.....	163
List of tables .....	163
List of charts .....	165
List of abbreviations.....	167

# DRUG POLICY<sup>1</sup>

## 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 for the implementation of the current National Anti-drug Strategy was approved by the Government Decision 2010/2015 (XII. 29.). The Policy Programme contains 31 measures and 56 tasks. In the field of demand reduction the programme envisages the quality assured system-wide development of health development and general drug prevention and the modernisation and capacity building based on the needs of the service-provision system and the reintegration. The main aim of the document regarding supply reduction is to hindrance the import to Hungary and the domestic trade of new psychoactive

---

<sup>1</sup> Authors of the chapter: Gergely Csaba Horváth and Orsolya Varga

substances subject of misuse and the related intensified implementation of crime prevention aspects. In favour of this it is particularly important to hold in the crimes committed on the internet and the protection of the growing generations in all settings where the children and youngsters are at higher risk.

## **T1.2 EVALUATION OF THE NATIONAL DRUG STRATEGIES**

### **T1.2.1 Evaluation of strategies and action plans**

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

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

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

### **T1.2.2 Summary of the latest evaluation**

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

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

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

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

There is an overall agreement that the financial and for some part also the legal guarantees are missing for realising the plans. Furthermore, some interviewees referred to a lack of transparency of the policy making and implementing process. One key issue mentioned here was a lack of information from policy makers to policy 'implementers' on the contents of the

strategy, on priorities and on what has been reached till now. A gap between national and regional/local level has been mentioned as one of the reasons for this.

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

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

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

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

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

### **T1.3 DRUG POLICY COORDINATION**

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

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

Professional and political control of tasks related to drug prevention and drug affairs coordination is exercised by the state secretary of EMMI responsible for social affairs and social inclusion, the direct state head of the field is the deputy state secretary responsible for social policy. 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 million<sup>2</sup>, 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.

---

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

### **T3. NEW DEVELOPMENTS**

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

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

### **T4. ADDITIONAL INFORMATION**

#### **T4.1 ADDITIONAL INFORMATION ABOUT DRUG POLICIES**

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**

#### **T6.1 SOURCES**

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

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

Galla, M., von Gageldonk, A., Trautmann, F., Verbraeck, H. (2005a): Hogyan erősíthető meg a magyar drogpolitikai koordináció az értékelés tükrében? Trimbos Instituut, Utrecht.

Galla, M., von Gageldonk, A., Trautmann, F., Verbraeck, H. (2005b): A Nemzeti Stratégia féltidő értékelésének részletes tapasztalatai. Trimbos Instituut, Utrecht.

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.

Report on the biannual activity of the Drug NGO Ombudsman between May 2014 and May 2016 (2016), Budapest

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

## **T6.2 METHODOLOGY**

Not applicable.

# LEGAL FRAMEWORK<sup>3</sup>

## 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

---

<sup>3</sup> 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 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**

No information available.

## **T2. TRENDS**

### **T2.1 CHANGES IN THE LEGAL FRAMEWORK SINCE 2000**

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

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

The old Btk. also contained the cases and conditions of QCT. The most significant change as compared to the previous legislation was that drug addiction was no longer a condition for using QCT. With respect to persons, any category of users (occasional, regular, addict) had the opportunity to take advantage of QCT (with more favourable regulations for drug addicts).<sup>4</sup> Non-addict perpetrators only had the possibility for QCT if the amount of drug was not more than the 'small amount' of the given drug. With respect to criminal acts, QCT were typically available in the case of - less serious - use-related offences. However, two trafficking-type behaviours represented an exception, 'offer' and 'hand over', because if the offered and handed over illicit drug was of a small amount, and the act in question took place 'on the occasion of joint drug consumption', the perpetrator of the aforementioned two acts might have also taken advantage of the opportunity of QCT. It was a condition in all cases of QCT that 'the perpetrator is able to present a document before being sentenced in the first instance that verifies that he/she has participated for at least six consecutive months in treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service'. The QCT might have been initiated either in the prosecution or the court phase of the criminal procedure. The wide application of QCT presented in the above text was declared to be unconstitutional by Constitutional Court decision no 54/2004. (XII. 13.), which decision caused the amendment of several points of the old Btk. (Be. Art. 188(1)h); Art. 222(2); Art. 266(6)). (For details see Chapter 1.1. of the 2005 National Report)

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

---

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

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

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

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

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

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

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

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

### T3. NEW DEVELOPMENTS

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

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

The regulatory document subjected to amendments <sup>5</sup>	The amended regulatory document (current version)		
Title	Title	Summary of changes	Remarks
<b>221/2015. (VIII.7.) Government Decree</b>	<b>74/2015. (III.30.) Government Decree</b>	The administrative, legal and professional tasks related to the prevention-counselling service were moved to the National Office for Rehabilitations and Social Affairs from National Institute for Family and Social Policy.	
<b>Law 76. of 2015</b>	<b>Law 19. of 1998 on the Criminal Procedure</b>	Creation of the legal background for temporary blocking of the electronic data related to offences on drugs and new psychoactive substances already during the criminal procedure.	
<b>Government Decree 367/2014. (XII. 30.)</b>	<b>Ministry of Human Capacities Decree 55/2014. (XII. 30.) EMMI</b> 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	
<b>Government Decree 19/2015. (II. 16.)</b>	<b>Government Decree 162/2003. (X. 16.)</b> On the rules of production, distribution and use of plants suitable for the production of illicit drugs	Amendment to the definition of poppy straw: poppy head with the stem part harvested when fully mature not including the poppy seeds.	

<sup>5</sup> Texts and hyperlinks of the documents subjected to amendments are not available.

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

As a proportion of the illicit drug cases in process in 2015 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. (OBH 2016)

In 2015 775 persons were sentenced according to the old Btk. due to drug-related offences according to the following articles:

- Article 282: 578 persons (use-related offences)
- Article 282/A: 107 persons (trafficking-related offences)
- Article 282/B: 17 persons (use-related offences)
- Article 282/C: 53 persons (drug-addicts committing use- or trafficking-related offences)
- Article 283/A: 0 person (misuse of precursors)
- Article 283/B: 20 persons (trafficking type offences related to new psychoactive substances)

1513 persons were sentenced in criminal procedures started in 2015 according to the Btk. in force according to the following articles:

- Drug trafficking
  - Article 176: 205 persons
  - Article 177: 14 persons
- Possession of illicit drugs
  - Article 178: 1251 persons
  - Article 179: 2 persons
- Inciting substance abuse: Article 181: 40 persons
- Aiding the manufacture of illicit drugs: Article 182: 0 persons
- Criminal offences with drug precursors: Article 183: 1 person

In 2015 the following punishments and measures were imposed on the 2288 persons convicted with a final judgement:

- 302 were sentenced to executable imprisonment
- 464 were sentenced to suspended imprisonment
- 516 were sentenced to community work
- 470 were fined (including suspended fines)
- 22 were reprimanded
- 352 were put on probation

#### *Sentencing practice – new psychoactive substances*

In 2015 people were sentenced related to the offence of misuse of new psychoactive substances, according to the following articles:

- Trafficking type:
  - Article 184: 117 persons
  - Article 184/A: 15 persons
- Possession type:
  - Article 184/B: 9 persons
  - Article 184/C: 17 person

In 2015 the following punishments and measures were imposed regarding misuse of new psychoactive substances on the persons convicted with a final judgement:

- 19 were sentenced to executable imprisonment
- 59 were sentenced to (partly or fully) suspended imprisonment

- 14 were sentenced to community work
- 29 were fined (including suspended fines)
- 0 were reprimanded

Chart 1.21 were put on probation  
Chart 2.

### **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) (2016): Az EMMI Szociális és Gyermekjóléti Szolgáltatások Főosztályának beszámolója.

FM (Földművelésügyi Minisztérium) (2016): A Földművelésügyi Minisztérium beszámolója.

OBH (National Office for the Judiciary) (2016): Data from the Statistical Analytic Department 2015.

#### **T6.2 METHODOLOGY**

Not applicable.

# DRUGS<sup>6,7</sup>

## T0. SUMMARY

### T0.1 SUMMARY OF THE DRUGS WORKBOOK

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

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

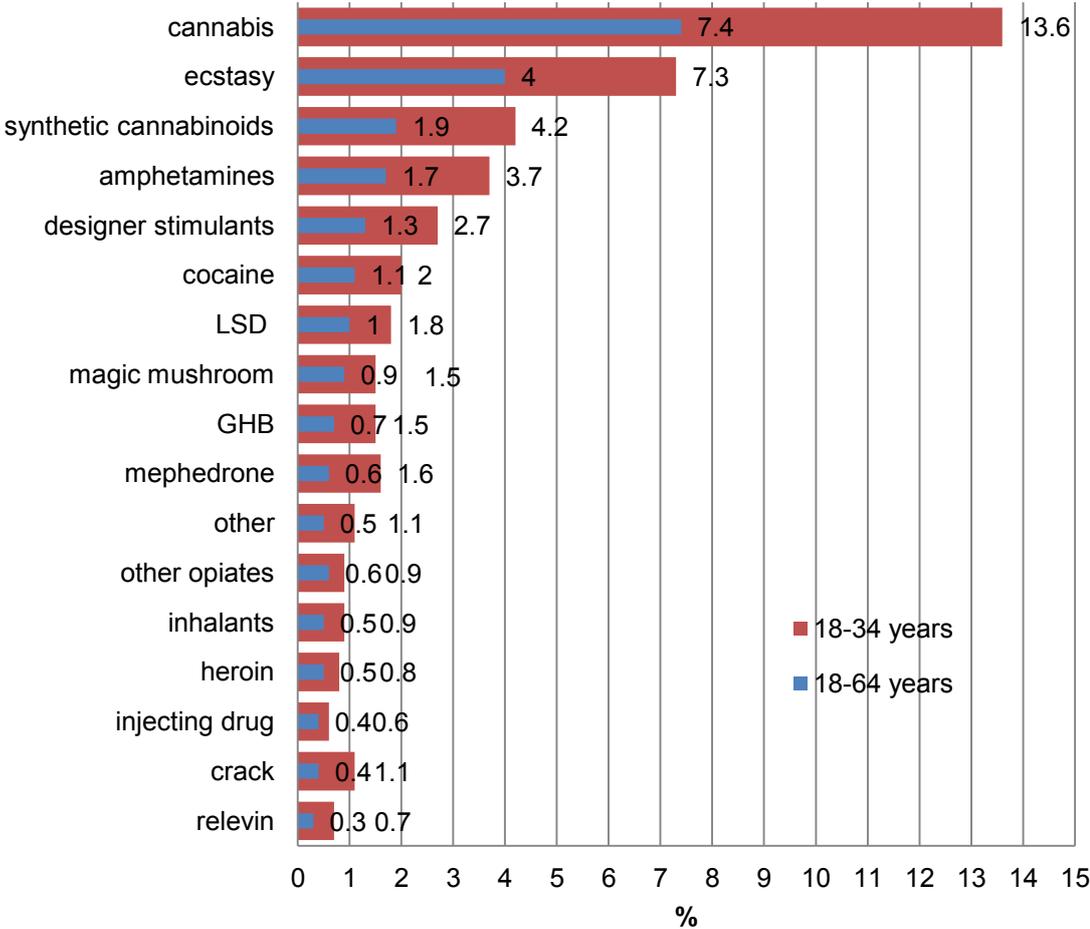
According to the latest survey data (Paksi et al. 2015) every tenth (9.9%) adult in the population between 18-64 years and almost every fifth (17.7%) young adult between 18-34 years used any kind of illicit drugs in their lifetime. Most adults, 7.4% of the adult population, tried cannabis. Prevalence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

---

<sup>6</sup> Authors of the chapter: Gergely Horváth, Adrienn Nyírády, Anna Tarján, Orsolya Varga

<sup>7</sup> Regarding the epidemiological studies about drug use the National Report in general classifies synthetic cannabinoids and designer stimulants appearing in larger volume from 2009 under the category of 'new psychoactive substances' regardless to their actual legal control status. The group of designer stimulants mainly cover drugs containing synthetic cathinones, although not exclusively, as to lesser extent novel amphetamines, phenethylamines, triptamines, piperazines or others may also appear in that category. Furthermore, surveys reported in this chapter are based on self-reported street names, thus, the term 'designer stimulants' is more adequately covers new psychoactive substances with stimulant effect instead of using names referring to each specific active content. Each subchapter defines which substance names were included in the broader categories by the given research.

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

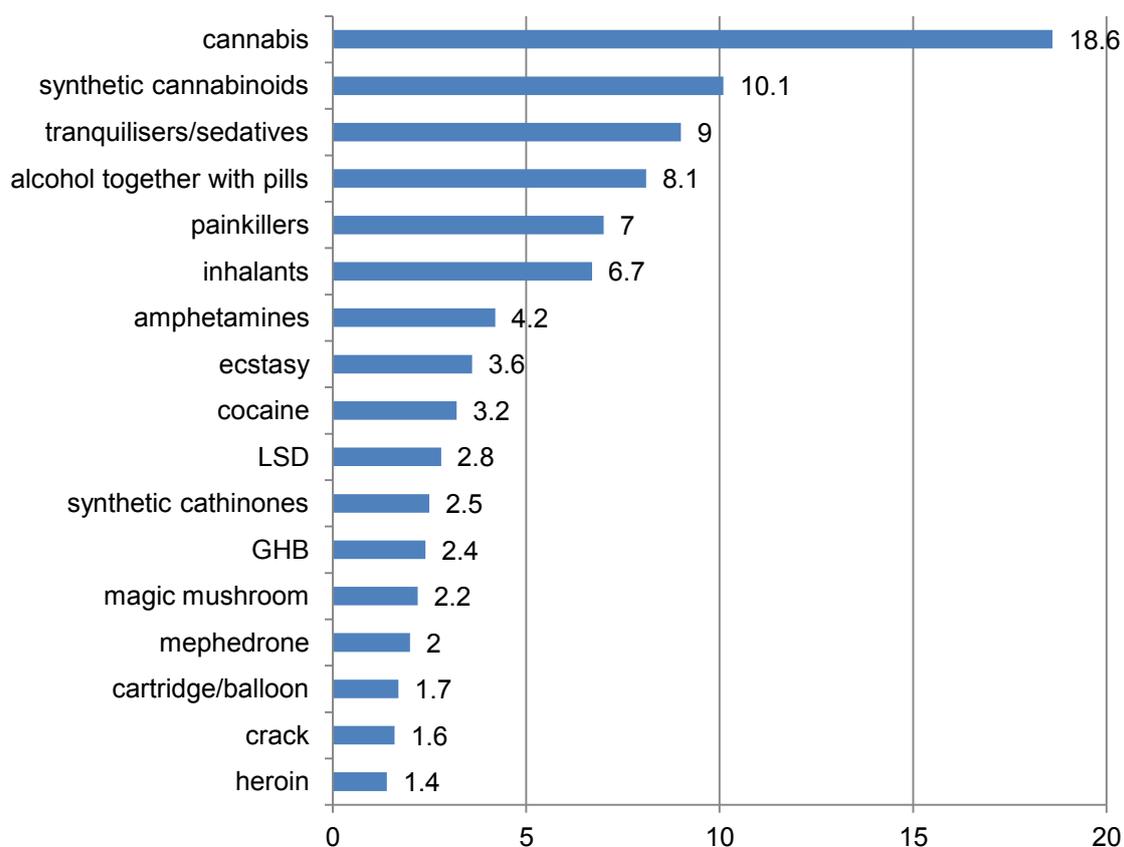


Source: Paksi et al. 2015

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

In 2015, based on the lifetime prevalence rates (Elekes 2016) cannabis was the most widespread illicit drug in the school population, at the 9-10 grades. The subsequent drugs are legal or partially legal substances. New psychoactive substance (NPS) is in the second place which is the synthetic cannabinoid substance group, reported for the first time in 2015. It is followed by tranquilizers or sedatives without doctor's prescription and taking these pills together with alcohol. Painkillers in order to get high, reported for the first time in 2015, are similarly popular among school pupils. Inhalation of organic solvents is in the sixth place. The next illicit drug is amphetamine, in the seventh place. The use of ecstasy, cocaine and LSD is similarly widespread. The lifetime prevalence rate of the rest of the substances is around 2%. The use of the other group of designer drugs, the synthetic cathinones, is less widespread among secondary school students.

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



Source: Elekes 2016

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

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

#### Injecting drug use

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, in 2015 80% of them injected a new psychoactive substance. On the basis of the data, shifting to NPS can be seen in both the heroin and the 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).

#### Health consequences

The most frequent cause of entering treatment in Hungary is cannabis use, its proportion (64.7%) is especially high among clients entering treatment as an alternative to criminal procedure (QCT). The second most prevalent reason for addiction treatment is stimulant use. Although treatment data only indirectly indicate, other data sources directly confirm the

expansion of treatment demand related to synthetic cannabinoids and synthetic cathinones as well, that has equalised the volume of treatment demand of the classical drugs in terms of the extent of the problem. (For more details see Cannabis Chapter T1.2.3).

Treatment demand related to new psychoactive substances (NPS) – synthetic cannabinoids and stimulants – has risen. This has been confirmed by treatment data (Treatment Chapter T1.2) and other researches (Péterfi 2015, Péterfi et al 2016) as well. According to treatment data pattern of NPS use is more intensive and the age of the users also lowered. Beyond treatment data other researches proved that the treatment demand related to NPS use emerges after a shorter drug use carrier. Beyond addiction care emergency / clinical toxicology care and psychiatric care also experienced increased treatment demand in the last years according to several sources (for more information see Treatment Chapter T4.4. in National Report 2015 and 2016).

Among primary NPS injectors prevalence of injecting equipment sharing and HCV is typically high (for more information see: Harms and Harm Reduction, Chapter T.1.3).

#### T0.1.1 b) New developments in the drug market

A total of 181 new psychoactive substances have been identified in Hungary since 2010, with 24 being identified in 2015. 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 and the spread of alpha-PHP could be observed in 2015.

#### T0.1.1 c) Polydrug use

According to the results of the latest survey (Paksi et al. 2015) conducted in the adult population, one third (32%) of the ever users in the 18-64-year-old population used only one type of drug from the examined 14 types of drugs. Another one third (33,5%) of the population used two types and one fifth (20,5%) used more than three types of drugs in their lives. Counting the six types of EMQ standard drugs (cannabis, ecstasy, amphetamine, cocaine, heroin, LSD) almost two third (65,2%) of the ever users tried only one type and 7.2% used more than three types of drugs.

## A. CANNABIS

### T1. NATIONAL PROFILE

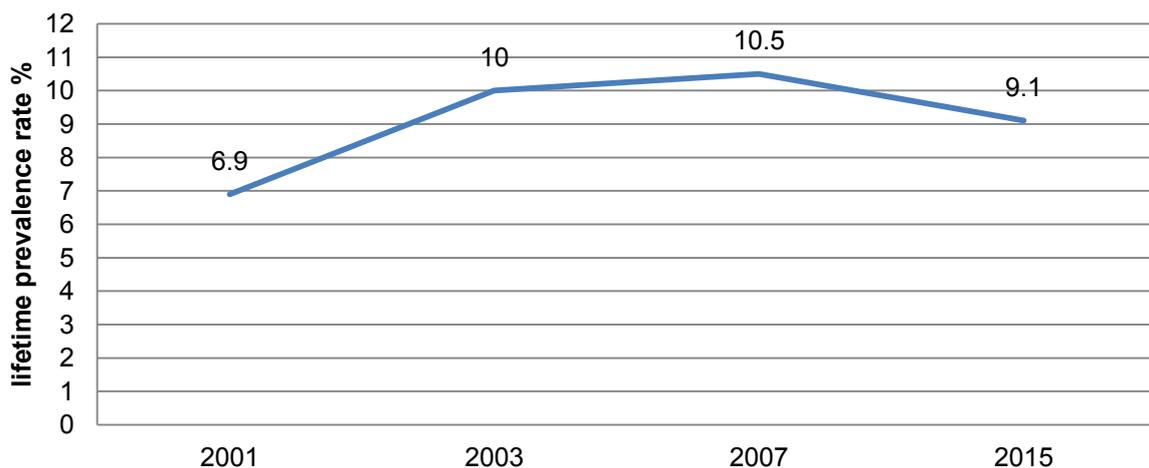
#### T1.1 PREVALENCE AND TRENDS

##### T1.1.1 Cannabis use in the general population

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

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

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



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

Source: Paksi et al. 2015

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

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

sociodemographic characteristics		lifetime prevalence of cannabis use %	sign.
gender	male	9.5	p=0.005
	female	5.7	
young adult - adult	18-34 years	13.6	p<0.001
	35-64	4.3	
age group	18-24	14.6	p<0.001
	25-34	12.9	
	35-44	7.0	
	45-54	3.4	
	55-64	2.0	
highest level of education	primary school or lower	5.5	p=0.021
	vocational school	4.6	
	final examination	9.3	
	BA	8.0	
	MA	13.7	
size of the settlement	<50,000 inhabitants	5.8	p=0.003
	≥50,000 inhabitants	10.2	
capital-countryside	countryside	6.5	p=0.008
	capital	11.4	
net monthly income of the household	<325 EUR <sup>8</sup>	6.5	p=0.003
	326 – 645 EUR	4.9	
	646 – 1290 EUR	8.3	
	above 1291 EUR	18.0	

Source: Paksi et al. 2015

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

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

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

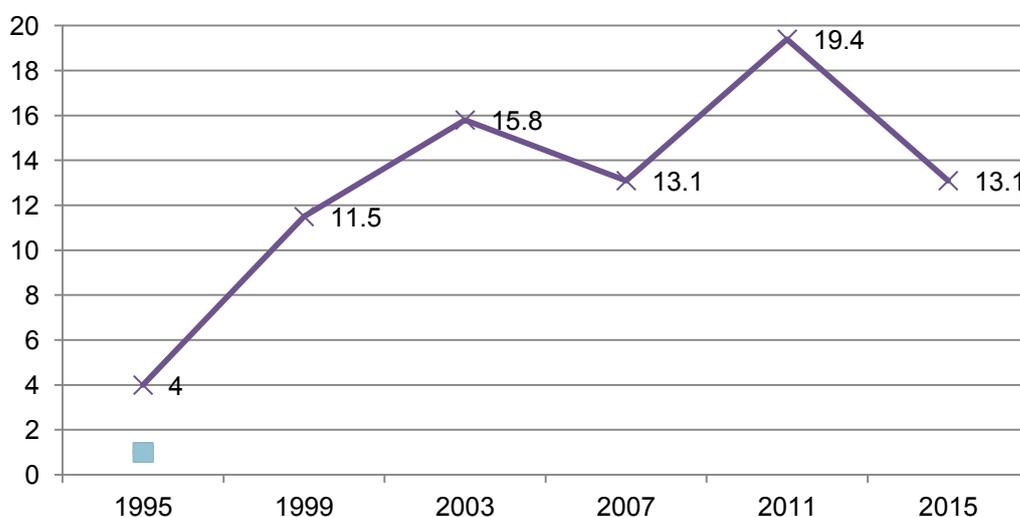
<sup>8</sup> 1 EUR=309.69 HUF

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%)<sup>9</sup>, Budapest was in second place (21%), and the lowest value was measured by the survey in towns (16.3%). Similarly to previous years, students in grades 9 and 11 studying in secondary modern schools and vocational schools were more markedly affected (24.1%) with respect to cannabis use as compared to students studying in grammar schools (17.7%).

According to the results of the latest ESPAD survey (Elekes 2016) cannabis is the most widespread illicit drug among students on 9-10<sup>10</sup> grades, in 2015 too. 18.6% of the students tried it in their lifetime. 12.5% reported that had used cannabis in the last year and 5.7% of them in the last month as well. Two third of the ever users used cannabis in the last year and almost third of them in the last month.

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

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



Source: Elekes 2016

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

<sup>9</sup> This figure should be treated with care due to the small sample size.

<sup>10</sup> 15-16 years old

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

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

Source: Elekes 2016

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

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

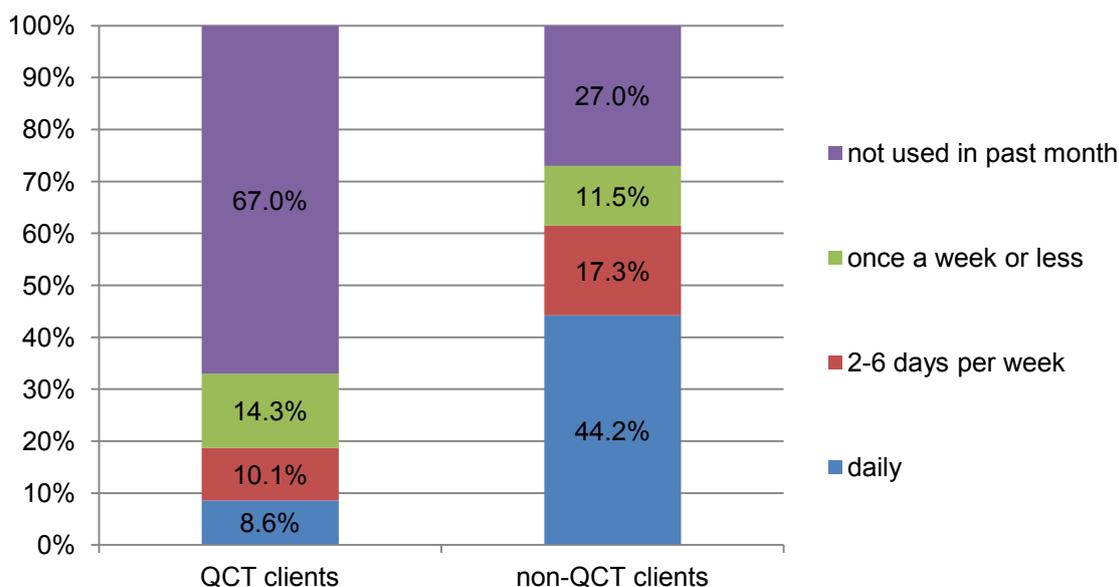
### T.1.2.2 Treatment for cannabis

In Hungary, cannabis use is the leading cause of entering treatment for illicit drug use (see Treatment Workbook, Chapter T1.3.1. and T2.1). In 2015 56.2% of those starting treatment reported cannabis as their primary substance (TDI data collection 2016). The majority of cannabis users (1944 persons, 80.3%) started treatment as an alternative to criminal procedure: in 2015 more than two-third of the QCT clients (1944 persons, 69.7%) started treatment because of cannabis use. Among the non-QCT clients proportion of cannabis related treatment demand was significantly lower, 31.3% (476 persons).

91.4% of those entering treatment because of cannabis were men, their mean age was 26.8 years and had used cannabis for an average of 8.4 years before starting treatment in 2014. Before treatment the typical route of administration was smoking (92.2%), the second most prevalent route of administration was eatind/drinking (4.7%).

Two-third of the cannabis clients in QCT have not used the substance in the 30 days prior to treatment, intensive use (2-6 days a week or daily) was present in 18.7% of the clients. Among the non-QCT clients intensive use was present in 61.5% of the cannabis related cases.

Chart 5. Frequency of drug use among QCT and non-QCT clients in 2015 (N=2350 persons)



Source: TDI 2016

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 programme<sup>11</sup> of the Kék Pont Alapítvány targets problem cannabis users, it provides a therapy accessible on the Internet for this user group<sup>12</sup>. (For more information see 2011 National Report, Chapter 5.2.)

<sup>11</sup> The site operated by the Jellinek Foundation, knowcannabis.org.uk was used as a basis when developing the website.

<sup>12</sup> Source: [http://kekpont.blog.hu/2010/06/02/title\\_1561746](http://kekpont.blog.hu/2010/06/02/title_1561746) (06.06.2011)

## T1.2.4 Synthetic cannabinoids

### Adult population

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

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

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

### School population

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

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

The majority of the students tried synthetic cannabinoids at the age of 15 for the first time.

### Problem drug use

Most of the participants at the annual Needle/syringe programme (NSP) expert meeting (HNFP 2015; HNFP 2016) highlighted the intensive use of synthetic cannabinoids (street name: 'herbal') among IDUs regarding the years 2014 and 2015. According to service providers, there are users who periodically or permanently 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.)

## **T2. TRENDS**

Presented in Chapter T1.

## **T3. NEW DEVELOPMENTS**

Presented in Chapter T1.

## **T4. ADDITIONAL INFORMATION**

### **T4.1 ADDITIONAL SOURCES OF INFORMATION**

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

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

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

There are no secrets around drug use. Knowledge or ignorance of drugs and addictions are rather collective. Drugs are used in front of the children. The children at 9-10 years know the name of the drugs. They are able to explain in detail how these drugs look like, how to use them and what are the effects. The parents and the professionals exactly know that the children use drugs. The head and the teachers of the school know the drug using habits of the students. They are even aware of drug use inside the school. Nothing is a secret in these communities but they have no means to solve the problem.

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

The reasons for trying synthetic cannabinoids were curiosity, low price and easy access. Most of them used it with friends for recreation or alone against boredom. More than half of

the respondents used synthetic cannabinoids over 20 times, 70% of them 5 times at least in their lifetime. The substance was used typically in cigarettes mixed with tobacco, alone or with alcohol. Most of the respondents received or bought the drug from a friend. Less than 10% of them bought it via internet. The price varied mainly between 1,6 - 4,8 EUR<sup>13</sup> per gram. Concerning the effect of synthetic cannabinoids the respondents reported more intensive and shorter effect than experienced with classical cannabis. This substance causes psychotic symptoms, apathy, anxiety, hallucinations and coordination disorders more frequently than cannabis use. change of perception and euphoria was also typical. Physical symptoms appeared as dry mouth and palpitations. The respondents' statements suggest that synthetic cannabinoids have more addictive features than classical cannabis.

The information derived from the treatment data is supplemented by the Hungarian National Focal Point's treatment facility survey (Péterfi 2015), on the basis of which, according to the estimate of the service providers reporting 74% of the TDI data, the 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**

See Section E.

---

<sup>13</sup> 1 EUR=309,69 HUF

## **B.STIMULANTS**

### **T1. NATIONAL PROFILE**

#### **T1.1 PREVALENCE AND TRENDS**

##### **T1.1.1 The relative importance of different stimulant drugs**

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

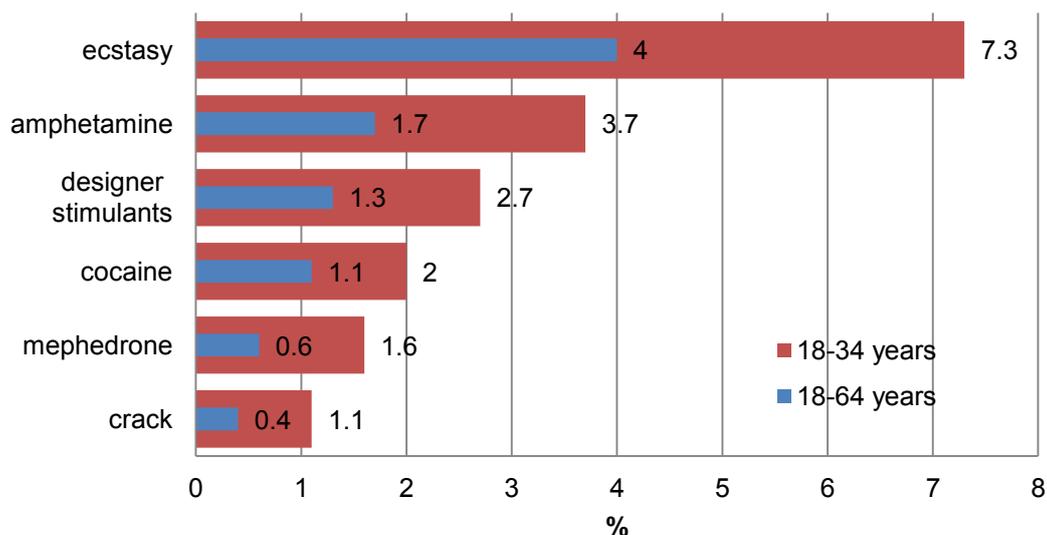
We have information about the perceived availability of stimulants among secondary school students from the ESPAD surveys. Regarding amphetamines, ecstasy and cocaine, half of the respondents (49.1%) presumed impossible or very difficult access to these drugs and only 13.6% thought to be able to obtain them. However nearly quarter of the students could not estimate the availability of the substances, did not answer the question. (Elekes 2016)

In the case of cocaine, during its supply-reduction activity the Police experienced a clear, strong growth over the past years, both on the user and distributor sides. 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). (ORFK 2015)

##### **T1.1.2 Stimulant use in the general population**

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

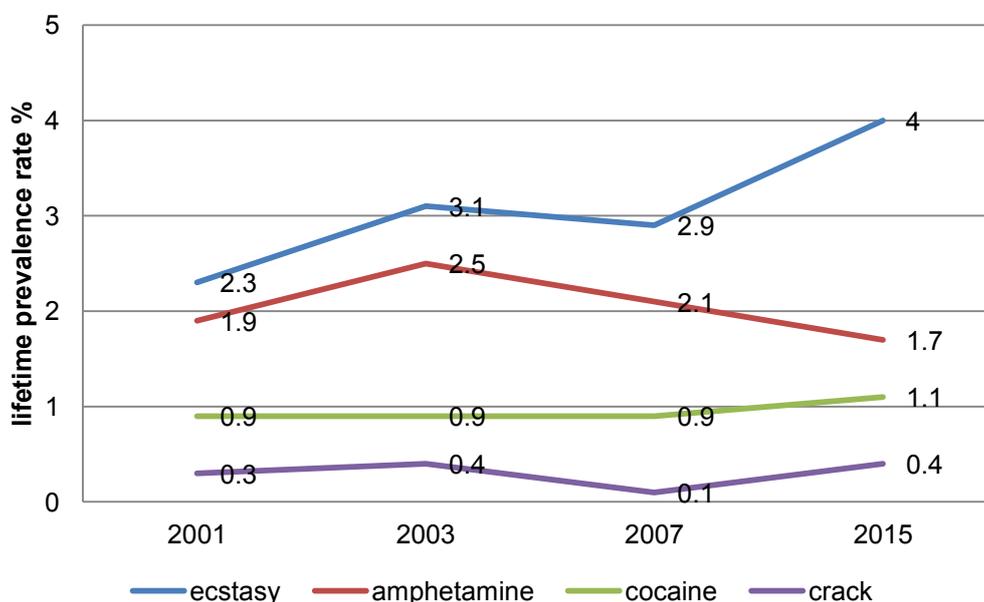
Chart 6. Lifetime prevalence rates of stimulants by drug type in the adult population between 18-64 years and 18-34 years, in 2015 (%)



Source: Paksi et al. 2015

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

Chart 7. Changes in the lifetime prevalence of classical stimulants between 2001 and 2015, in the adult population between 18-53 years\*



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

Source: Paksi et al. 2015

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

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

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

Table 4. Lifetime prevalence of classical stimulants use along different sociodemographic characteristics in the general population between 18-64 years, in 2015 (%) (N=60)

sociodemographic characteristics		classical stimulants LTP %	sign.
gender	male	5.0	not sig.
	female	4.1	
young adult - adult	18-34 years	8.3	p<0.001
	35-64	2.6	
age group	18-24	8.9	p<0.001
	25-34	7.8	
	35-44	5.0	
	45-54	1.9	
	55-64	0.3	
highest level of education	primary school or lower	2.3	not sig.
	vocational school	4.3	
	final examination	5.4	
	BA	3.7	
	MA	8.2	
size of the settlement	<50,000 inhabitants	3.0	p=0.001
	≥50,000 inhabitants	7.0	
capital-countryside	countryside	4.0	p=0.059
	capital	6.6	
net monthly income of the household	<325 EUR <sup>14</sup>	2.6	p=0.070
	326 – 645 EUR	3.5	
	646 – 1290 EUR	5.2	
	above 1291 EUR	10.2	

Source: Paksi et al. 2015

Age at first use of classical stimulants varies in the 18-64-year-old population. Ecstasy is tried for the first time at the age of 20-21 on the average and most often at 18. First use of amphetamines occurs at the age of 22 on the average and most often at 25. The typical age of trying cocaine is 24. In the young adult population age of first ecstasy and amphetamine use is 18-19 years. The age of trying cocaine is similarly late, 25 years.

<sup>14</sup> 1 EUR=309,69 HUF

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

According to the results of the HBSC survey carried out in 2014 (Arnold and Németh 2015), 5.8%<sup>15</sup> of students in grades 9 and 11 had already tried one of the examined stimulants.<sup>16</sup> Significantly higher prevalence rates could be observed among boys (6.8%) and among those in the higher school grade (grade 11: 6.8%) as compared to the girls (5.0%) and those in the lower school grade (4.9%).

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

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

According to the results of the ESPAD survey (Elekes 2016) conducted in the secondary school population amphetamine is in the seventh place in the consumption structure (LTP=4.2%). The following substances are ecstasy (3.6%), cocaine (3.2%) and methamphetamine (2.9%). The least students tried mephedrone (2%) and crack (1.6%).

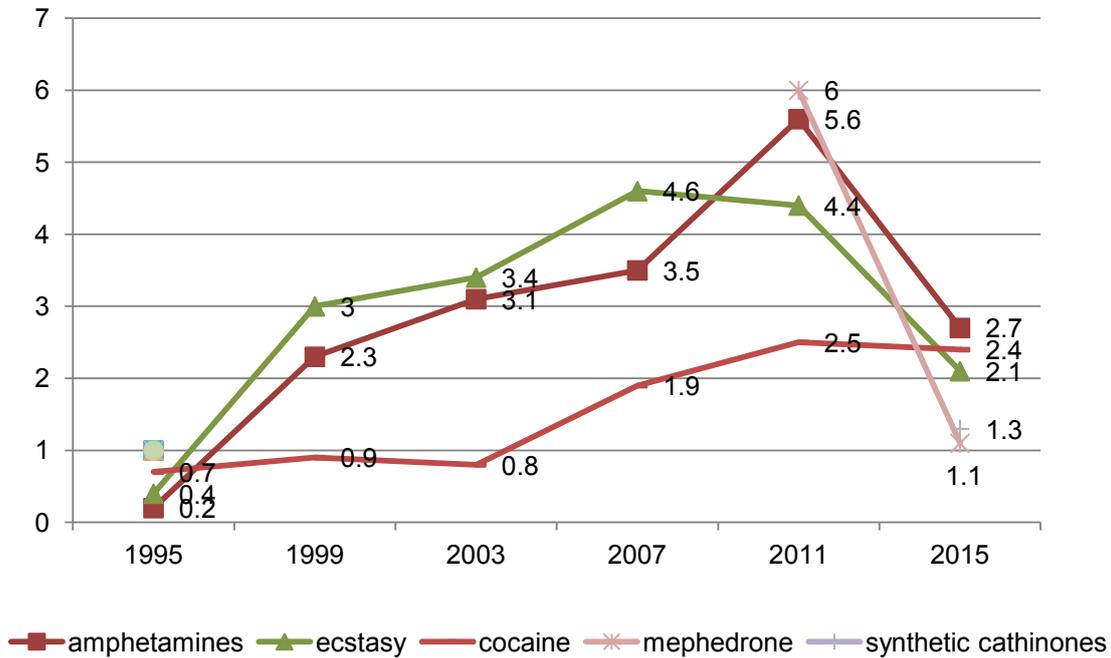
The ESPAD surveys from the last 20 years show that the prevalence rate of classical stimulant use increased among 16-year-old students at variable rate until 2011. The earlier tendency turned by 2015. Spread of amphetamines and ecstasy show the largest decline, lifetime prevalence rates dropped by half. Mephedrone was the fifth most popular substance in 2011. In the meanwhile, it was scheduled as drug. It seems to disappear by 2015, the prevalence rate fell by 80%. Only the lifetime prevalence rate of cocaine has not changed considerably.

---

<sup>15</sup> This data should be treated with care due to the low number of those trying stimulants.

<sup>16</sup> Amphetamines, ecstasy, MDMA, cocaine. (Cocaine was indicated among other drugs, the survey did not ask about it separately.)

Chart 8. Changes in the lifetime prevalence of stimulants between 1995-2015 among 16-year-old students (%)



Source: Elekes 2016

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

Table 5. Lifetime prevalence of stimulant use along different sociodemographic characteristics among students on 9-10 grades, in 2015 (%) (N=454)

sociodemographic characteristics		lifetime prevalence of stimulants %	sign
gender	male	7.6	p=0.010
	female	6.1	
school type	secondary grammar school	3.2	p<0.001
	secondary school	7.1	
	vocational training	12.9	
school address	Budapest	9.5	p<0.001
	county city	5.9	
	town	6.2	
	municipality	16.1	
residence	Budapest	8.5	p=0.023
	town	6.0	
	municipality	6.4	

<b>family structure</b>	intact	4.8	p<0.001
	patchwork	8.1	
	broken	9.0	
	no biological parents	17.1	
<b>father education</b>	less than final examination	7.5	not sign.
	final examination	6.4	
	higher education	5.6	
	not known	6.1	
<b>mother education</b>	less than final examination	7.6	not sign.
	final examination	6.7	
	higher education	5.3	
	not known	6.6	
<b>family well off</b>	much better off	8.2	p<0.001
	about the same or better off	5.6	
	less well off	12.2	

Source: Elekes 2016

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

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

### 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. In the meantime, when injecting drug use patterns started to transform in 2010 and 2011, the number, the quantity and the purity of heroin seizures dropped. As regards purity of amphetamine it also tended to be between 1-10% between 2009 and 2011 (see also: 2012 National Report, Chapter 10.) In parallel, number of synthetic cathinone seizures increased, in case of which substances high purity, lower price, easy availability, more intensive effects and previously legal status were characteristic (Péterfi et al. 2014; Horváth et al. 2011). Number and quantity of heroin seizures remained low, however in 2015 a slight increase (number) could be detected. A similar slight increase could be seen in the case of amphetamine seizures, while the number of synthetic cathinone seizures stagnated with less quantity seized. (Regarding recent years' drug market and legal framework trend see: Drug market and crime T2.1 and Legal Framework T3.1). Trends measured in the 2015 drug market data are not in line yet with results of the below described epidemiological data (data of NSP clients; PWID participating in the HIV/HBV/HCV seroprevalence surveys and PWID entering treatment).

The following routine data collection systems collect data on the primarily injected substances and are not suitable to monitor polydrug use. Information on polydrug use of OST clients can be found in Heroin and other opioids, T.1.2.3..

### *Prevalence estimate of injecting drug use<sup>17</sup>*

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

Those IDUs tested were involved in the estimate, who took part in a needle exchange programme in the given time interval or received treatment at a specialised outpatient clinic. 19-19 service providers participated in the survey in both years. Ever injecting drug use was the recruitment criteria for participation (For further information on the HIV/HBV/HCV seroprevalence survey series see section T1.3, T.2.2 and T6.2 of the chapter Harms and Harm reduction)

During the survey series IDUs were identified using a so-called 'generated code' used in the TDI system, which made it possible to monitor the reoccurrence of clients. (The socio-demographic data of IDUs and their data relating to drug use is introduced in the Drugs chapter under T.1.2.1 sections of certain substances (primarily under Stimulants, but also under Opioids.))

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

### *Needle/syringe programmes' (NSP) client data*

On the basis of NSP data (Tarján 2016b), 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%<sup>18</sup> of IDUs attending NSPs primarily injected stimulants, this proportion had risen to 87% by 2015.

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%). In 2015, proportion of primary amphetamine injectors dropped by a further 7 percentage points. The proportion of those injecting cocaine is negligible among IDUs attending NSPs.

The increase of NPS (designer stimulants)<sup>19</sup> injecting pushed out heroin from 2010 and then even amphetamine from 2013: While in 2010 fewer than 8%<sup>20</sup> of NSP clients used designer stimulants, in 2015 this was the primarily injected substance for 80% of them.

---

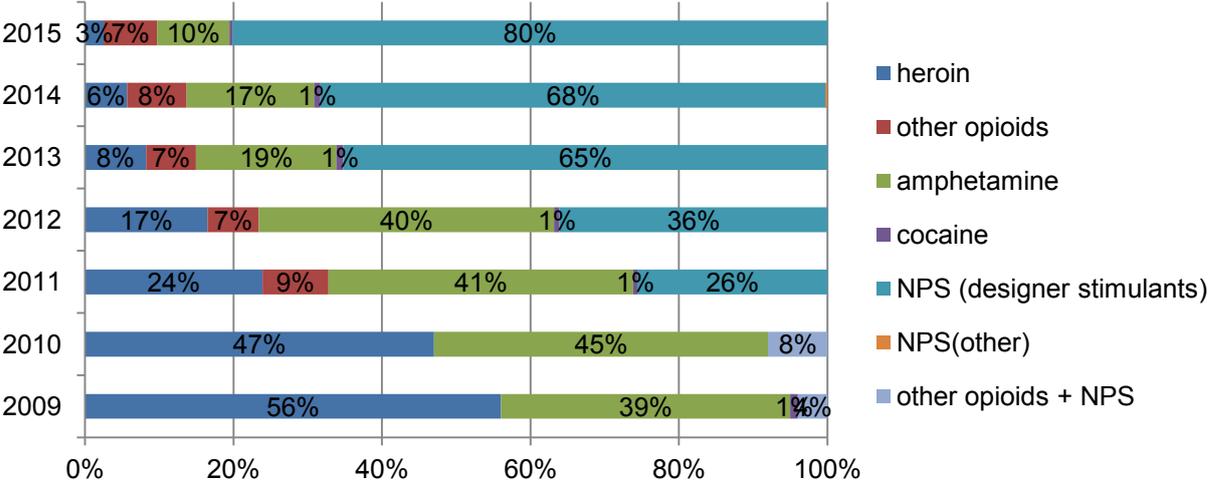
<sup>17</sup> The estimate refers to the entire injecting drug user population. Taking into account that according to the present trends injecting use mostly means stimulant injecting, the estimate is presented in this subchapter of 'Stimulants'.

<sup>18</sup> 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.

<sup>19</sup> For street names categorized as designer stimulants see: chart 10.

<sup>20</sup> 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.

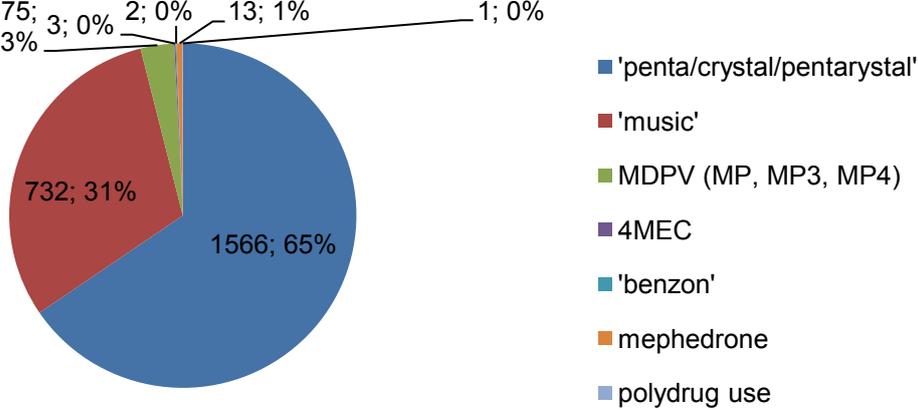
Chart 9. Breakdown of NSP clients by primarily injected drug between 2009-2015<sup>21</sup>



Source: Tarján 2016b

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'<sup>22</sup> has been in first place. Among designer stimulants, the use of 'penta crystal' decreased slightly in 2014 and 2015 as compared to previous years, in spite of this it is still the most widespread designer stimulant. The substance with the street name 'music'<sup>23</sup> had only just appeared in 2013, but in 2014 and 2015 it had become the second most frequently injected NPS.

Chart 10. Breakdown of NSP clients injecting designer stimulants by primarily injected drug type in 2015 (N=2392 persons)<sup>24</sup>



Source: Tarján 2016b

<sup>21</sup> 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. Street name 'bio' was categorized as NPS (other) which may refer to the injecting use of synthetic cannabinoids.

<sup>22</sup> On the basis of seizure data, this is probably the street name for substances containing the active substance pentedrone.

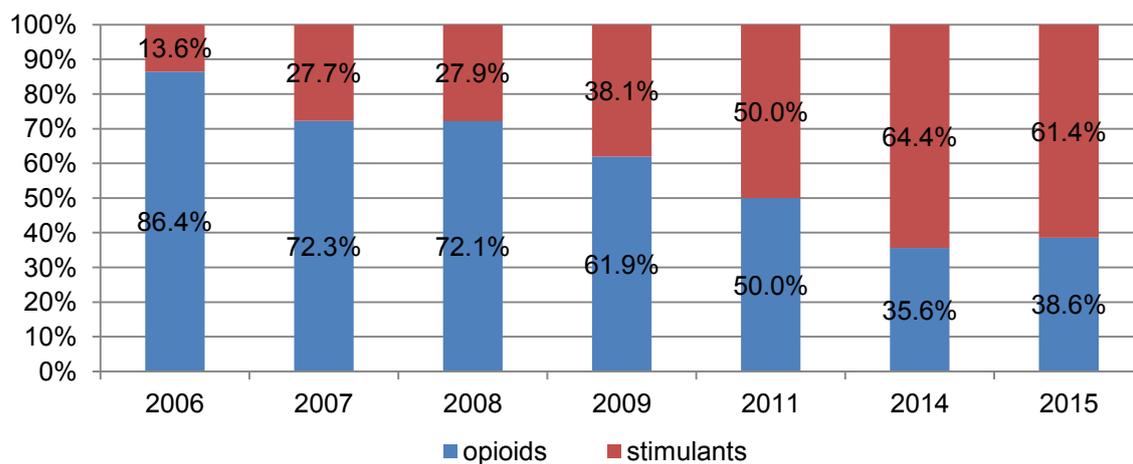
<sup>23</sup> On the basis of seizure data, this is probably the street name for substances containing the active substance alpha-PVP.

<sup>24</sup> 'Polydrug use' category stands for the polydrug use of available designer stimulants.

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

A similar trend can be determined on examining the distribution of IDUs participating in the national HIV/HBV/HCV seroprevalence survey (Dudás et al. 2015) according to primarily injected substances: the proportion of those injecting stimulants gradually increased over the years in the sample. While in 2006 13.6% of them injected primarily stimulants, in 2014 and 2015 nearly two thirds of the sample belonged to this group. (For limitations on data comparability regarding the 2015 data see: Harms and Harm Reduction Workbook, T1.3.6)

Chart 11. Breakdown (%) of IDUs participating in the national HIV/HBV/HCV seroprevalence survey by primarily injected substance, between 2006-2015



Dudás et al. 2015, analysed by HNFP

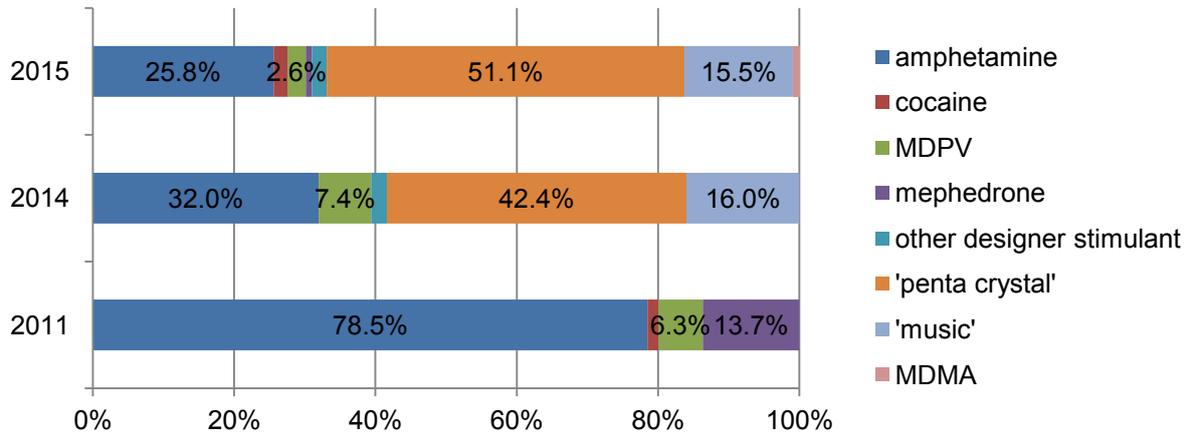
Selecting current stimulant injectors (injecting in the past 4 weeks) from the sample (in 2011: 64.2% of all current IDUs, in 2014: 70.6%; in 2015: 66.4%), it can be seen that between 2011 and 2015 a significant move took place from amphetamines towards designer stimulants.<sup>25</sup> In 2011 78.5% of current stimulant injectors reported primarily using amphetamine, but in 2015 only 26% of them reported this. Opposite to this, the proportion of those primarily injecting designer stimulants grew from 20% to 72.2%. In 2011 the designer stimulant being mentioned the most was mephedrone, which by 2014 had been replaced by the designer stimulant 'penta-crystal'<sup>26</sup> which was the most injected any kind of stimulant as well both in 2014 and 2015. Since 2014 it has been followed by the substance with the street name 'music'<sup>27</sup>.

<sup>25</sup> In 2011 it first became possible during the national seroprevalence survey for the participants to name the primarily injected 'other' substance in an open-ended question. Until then the data had been collected in 4 closed categories: opioids; amphetamine; cocaine; other. Therefore the analysis only makes statements for these three years.

<sup>26</sup> On the basis of seizure data, this is probably the street name for substances containing the active substance penthedrone.

<sup>27</sup> On the basis of seizure data, this is probably the street name for substances containing the active substance alpha-PVP.

Chart 12. Breakdown (%) of current stimulant injectors<sup>28</sup> participating in the national HIV/HBV/HCV seroprevalence survey by primarily injected drug type, 2011-2015

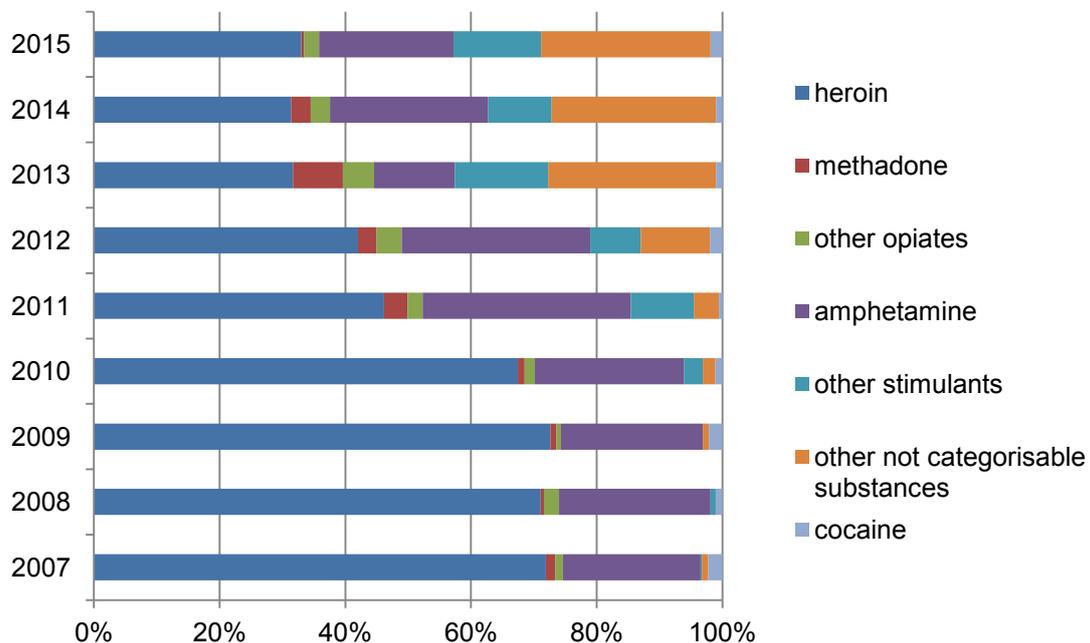


Dudás et al. 2015, analysed by HNFP

### Treatment (TDI) data

With some delay, but by 2013 the change 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 13. Breakdown of IDUs entering treatment by primarily injected drug between 2007 and 2015 (%)



Source: TDI data collection 2016

On active substance content found in syringes analyzed in the framework of the 'Tisztább kép' project see the Drug Market and Crime Workbook, Chapter T4. As part of the project a survey was carried out among clients providing used syringes, survey results can be found in T4.1.

<sup>28</sup>N<sub>2011</sub>=256 persons; N<sub>2014</sub>=269 persons; N<sub>2015</sub>=233 persons.

For data on the active substance identified on seized injecting equipment presented as a part of the seizure data see the Drug Market and Crime Workbook, Chapter T2.1.

**T1.2.2 Infectious diseases**

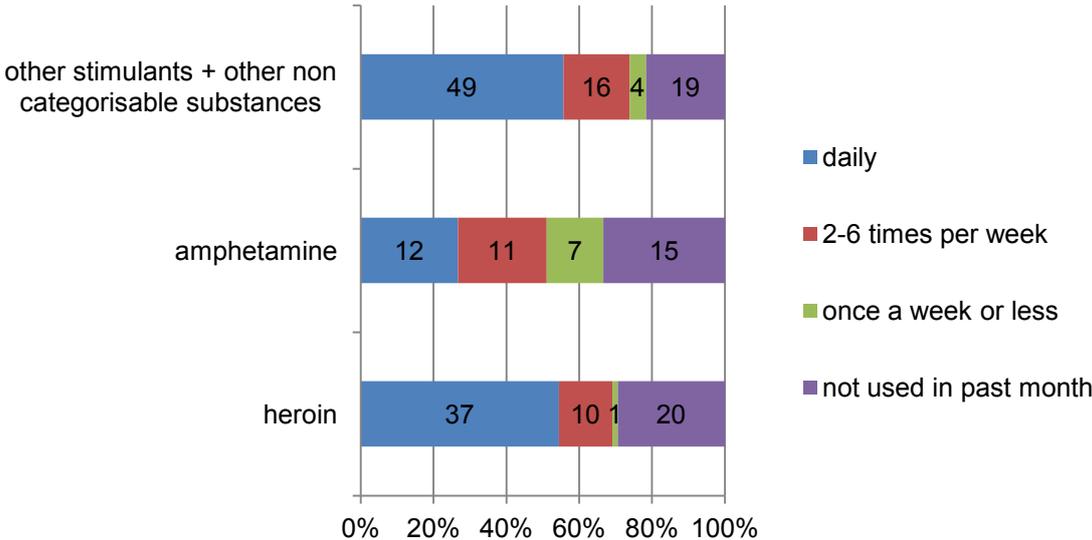
See: Harms and Harm Reduction Workbook, Chapter T1.3.1 and T2.2. b

**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 (73.9%) (other stimulants + other non-categorisable substances) as compared to those injecting heroin (69.1%) and amphetamine (51.1%).

Chart 14. Frequency of injecting drug use among IDUs entering treatment in 2015 (%)



Source: TDI data collection 2016

**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 2015 16.6% of those entering treatment reported to use a stimulant (apart from cocaine) as primary drug (amphetamine 489 persons, MDMA and other derivatives 85 persons, other stimulants 143 persons). (TDI data collection 2016)

85.5% of those entering treatment because of stimulants were men. The mean age of this user group was 29.6 years, and had used stimulant substances for an average of 6.8 years before entering treatment in 2015. The typical route of administration before entering treatment was sniffing (37.5%), that was followed by smoking/inhaling (15.2%) and injecting (12.3). Most of the clients (59%) have not used the this primary substance in the last 30 days

prior to entering treatment, 16.5% were daily users, 9.2% used it 2-6 times per week, 11.7% once a week or less frequently. (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**

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

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

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

According to the results of the ESPAD survey (Elekes 2016) conducted among secondary school students the use of synthetic cathinones is less widespread. 2.5% of the student has already tried these in their lifetime, 3.3% of the boys and 1.8% of the girls used it ( $p < 0,001$ ).

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

The majority of the students tried synthetic cathinones at the age of 15 for the first time.

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)

In the framework of the national needle/syringe programme (NSP) data collection system (for methods see: Harms and Harm Reduction Workbook T.6.2.) in 2015 NSPs reported for the first time on availability of NPS injecting related targeted counselling: out of the 28 reporting NSPs 22 organization provide this specific counselling, while 5 NSPs also provide written material on this topic (Tarján 2016b).

## T2. TRENDS

Presented in Chapter T1.

## T3. NEW DEVELOPMENTS

Presented in Chapter T1.

## T4. ADDITIONAL INFORMATION

### T4.1 ADDITIONAL SOURCES OF INFORMATION

During the 'Tisztább kép' project ( Péterfi 2016, for methods and results of the laboratory analysis see: Drug Market and Crime Workbook T4 and T6.2) a questionnaire was recorded with clients providing the used syringe for analysis in case of 145 samples, questions included street name of the purchased substance. In the framework of this project, for the first time street name could be linked case-based to the active substance content (main component)<sup>29</sup>. The results underline the incidental nature of links between street names and the actual active substance content.

Table 6. Breakdown of streetnames by the laboratory confirmed active substance (main component) in the 'Tisztább kép' project (N=100)<sup>30</sup>

heroin	methadone	amphetamine	synthetic cathinone	other NPS	other
heroin (1)	methadone (11)	speed (11)	crystal (12)	pink bull (1)	speed (4)
	crystal (8)	amphetamine phosphate (1)	music (9)	speed (1)	crystal (1)
	amphetamine (3)	MDPV (1)	methadone (4)		'poppy seed tea' (1)
	4-MEC (1)		brown crystal (3)		
	sugar (1)		MDPV (3)		
	heroin (1)		kati (2)		
	capsule (1)		penta (2)		
	kati cocktail (1)		speed (2)		
	speed (1)		4-MEC (1)		
	music (1)		brown music (1)		
			ecstasy (1)		
			heroin (1)		
			cocktail (1)		
			methadone and crystal		

<sup>29</sup> Limitations: In certain cases more syringes or other items of injecting equipment were linked to one questionnaire (51 cases out of 145), consequently a direct link cannot be defined between the street name and the main component in all the cases. Also it is important to note that injecting drug users tend to share syringes, that is why reported street names may not always be in line with the confirmed main component, they rather refer to the substance last injected with that syringe.

<sup>30</sup> Excluded cases: Laboratory analysis could not define the main component (40 cases); Analysed equipment was not injecting related equipment (5 cases);

(1)  
MP (1)  
rough crystal (1)  
pentacystal (1)  
superman (1)  
versace (1)

*Source: Péterfi 2016*

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**

See Section E.

## **C. HEROIN AND OTHER OPIOIDS**

### **T1. NATIONAL PROFILE**

#### **T1.1 PREVALENCE AND TRENDS**

##### **T1.1.1 The relative important of different opioid drugs**

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

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

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

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

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

During its supply reduction activity, in connection with heroin the Police experienced that Hungary's earlier role as a destination country has gradually and now almost entirely disappeared. However, as a transit country, Hungary still plays a significant role on the European market. (ORFK 2015)

##### **T1.1.2. Estimates of opioid use**

For the study (Horváth and Tarján 2016) on the estimate about the prevalence of injecting drug use in 2015 see Drugs workbook Stimulants chapter under section T1.2.1 Injecting drug 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 2015 only 3% of the clients self-reported injecting primarily this substance. (For the chart see: Stimulants, Chapter T1.2.1., chart 9).

The proportion of those injecting other opioids, primarily methadone has not changed significantly over the past years: it was around 7-9% between 2011-2015.<sup>31</sup>

In 2015 7% of NSP clients aged between 25 and 34 years injected primarily heroin or other opioids while this figure was 16% for those above 34 years. Regarding clients below the age of 25 only a negligible proportion (3%) injected primarily opioids. Examining only the group of heroin and other opioid injectors it can be determined that most of them (64%) are in the age group above 34.

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

It is also possible to see the decrease in the injection of opioids from 2006 when examining the IDUs participating in the national seroprevalence survey (Dudás et al. 2015) by primarily injected substance. While in 2006 86.4% of the sample injected primarily opioids, by 2015 only 38.3% of them reported primarily injecting an opioid. (for the chart see: Stimulants, Chapter T1.2.1, chart 11.)

Selecting current injectors from the sample relating to 2015, it can be said that among them the proportions of those injecting heroin and those injecting other opioids was still low: 22% of them injected primarily other opioids (13.1% in 2014), mainly methadone, while 15.9% of them reported heroin as their primary injected substance (15.5% in 2014).<sup>32</sup> (For limitations on data comparability regarding the 2015 data see: Harms and Harm Reduction Workbook, T1.3.6)

#### *Treatment (TDI) data*

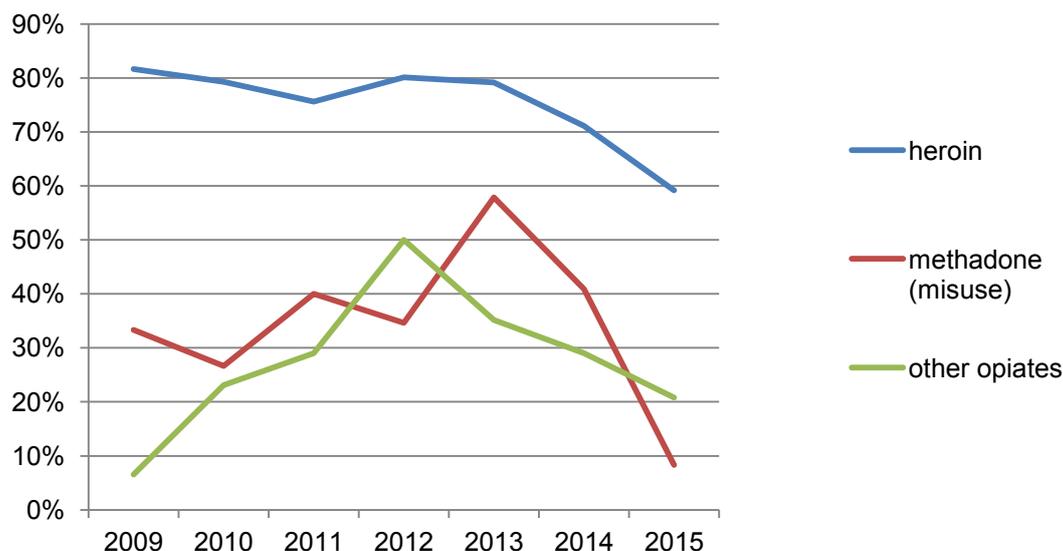
A continuous decrease can be observed with respect to the injecting use of heroin over the past six years. Following a rise for 4-5 years in the case of methadone and other opioids, by 2014 a decrease could be seen regarding both substance types in this route of administration. An explanation for the 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. Following that, the explanation could be the increasing proportion of those clients, who did not use heroin before entering treatment (entering treatment repetitively).

---

<sup>31</sup> 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.

<sup>32</sup> 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 2 years.

Chart 15. *The proportion of injecting use among opioid users, by primary drug between 2009 and 2015.*



Source: TDI data collection 2016

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.

On active substance content found in syringes analysed in the framework of the 'Tisztább kép' project see the Drug Market and Crime Workbook, Chapter T4. As part of the project a survey was carried out among clients providing used syringes, survey results can be found in T4.1.

For data on the active substance identified on seized injecting equipment presented as a part of the seizure data see the Drug Market and Crime Workbook, Chapter T2.1.

### 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 2016) 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.

### T1.2.4 Treatment for heroin and other opioids

Opioid use was the primary drug used in the case of 3.6% of those (156 persons) entering treatment in 2015 (see Treatment Workbook, Chapters T.1.3.1. and T.2.1) (heroin 120 persons, misuse of methadone 12 persons, other opioids 24 persons).

The proportion of male opioid users was 81.4%.(127 persons), 18.6% (29 persons) were female. The mean age of this user group entering treatment was 34.9 years and they had

used opioid-type substances for an average of 16 years before entering treatment in 2015. Before treatment the typical route of administration reported was injecting (49.4%), that was followed by eating/drinking (16.7%), smoking (14.7%) and sniffing (10.9%). Half of the clients used the substance daily, 10.3% 2-6 days per week, one-quarter of them (27.6%) have not used it in the last 30 prior to entering treatment. (For more information on injecting see Drugs/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**

Presented 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-Fövényi 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**

See Section E.

## **D. 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.

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.

## **E. SOURCES, METHODOLOGY**

### **T6. SOURCES, METHODOLOGY**

#### **T6.1 SOURCES**

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

Dudás, M., Rusvai, E., Győri, Z., Tarján, A., Horváth, G., Minárovits, J., Takács, M., Csohán, Á. (2015): A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HBV, HCV) 2015. évi prevalenciájának vizsgálata. OEK. Manuscript Submitted for Publication.

Elekes, Zs. (szerk.) (2016): Európai iskolavizsgálat az alkohol- és egyéb drogfogyasztási szokásokról – 2015, Magyarországi eredmények, Budapesti Corvinus Egyetem, Budapest

Farkas, J. (2011): Hungary. EMCDDA Trendspotter találkozó, 2011. október 18-19., Lisszabon.

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.

Kapitány-Fövény, 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. Szeged 2015 január 28-31.

NFP (2015): Tűcsere szolgáltatók országos szakmai találkozója.

NFP (2016): Tűcsere szolgáltatók országos szakmai találkozója

Nyíri, N. (2016): Új pszichoaktív szerek, a szintetikus kannabinoidok (biofű/herbál) fogyasztásának vizsgálata. Fogyasztók tapasztalatainak felmérése. Budapest, Unpublished thesis.

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

Paksi B., Magi A., Felvinczi K., Demetrovics Zs. (2015): Drogfogyasztás a magyarországi felnőtt népesség körében - a 2015. évi „Országos Lakossági Adatfelvétel Addiktológiai Problémákról” (OLAAP 2015) első eredményei. Magyar Addiktológiai Társaság X. Országos Kongresszusa 2015. november 26-28, Siófok, Supplementum kötet, pp. 53. [http://www.mat.org.hu/doksi/2015/Absztraktfuzet\\_MAT\\_X\\_2015.pdf](http://www.mat.org.hu/doksi/2015/Absztraktfuzet_MAT_X_2015.pdf)

Paksi, B., Magi A., Felvinczi K., Demetrovics Zs. (2016a): The prevalence of new psychoactive substances in Hungary – based on a general population survey dealing with addiction related problems (OLAAP 2015). IV. International Conference on Novel Psychoactive Substances (NPS). Budapest, 30-31 May

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

Péterfi A., Major M., Dunay M. (2016): KEzelőhely vizsgálat terápiás közösségek körében. Nemzeti Drog Fókuszpont. Unpublished thesis.

Péterfi, A. (2016): „Tisztább kép” időközi beszámoló az első 10 hónap eredményeiből. Magyar Ökumenikus Szervezet. Budapest. Manuscript. [http://www.segelyszervezet.hu/sites/default/files/documents/isec\\_idokozi\\_beszamolo\\_hu\\_peterfi\\_05\\_0.pdf](http://www.segelyszervezet.hu/sites/default/files/documents/isec_idokozi_beszamolo_hu_peterfi_05_0.pdf)

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

Peterfi, A., Tarjan, A., Horvath, G. C., Csesztregi, T., & Nyirady, A. (2014). Changes in patterns of injecting drug use in Hungary: a shift to synthetic cathinones. *Drug Test Anal*, 6(7-8), 825-831. doi: 10.1002/dta.1625

Szécsi, J., Sik, D. (2016): Szerhasználat egy hátrányos helyzetű járás szegregátumaiban, *Esély* 2016/2, 115-131. old.

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

Tarján, A. (2016b): Tücsere programok adatai, 2015. Nemzeti Drog Fókuszpont. Manuscript.

TDI data collection 2016.

## T6.2 METHODOLOGY

*Designer droghasználók pszichiátriai tünetprofilja szubsztitúciós kezelésben részesülő opiátfüggők körében (Kapitány-Fövény et al. 2015):* The clients involved were recruited voluntarily and anonymously from the opioid substitution programme of Nyíró Gyula Hospital OPAI Drug Treatment Center between 15 April and 21 August 2014. 198 clients were included out of the total (210) clients of the programme in that period. The questionnaire contained items about the clients' sociodemographic features, treatment intervention, NPS use and further two tools were administered: BSI (Brief Symptom Inventory) and LEQ (Life Experience Questionnaire). The interview was conducted in privacy and confidentiality, with employment of of university students of psychology.

*ESPAD 2015 (Elekes 2016):* The next data collection of European School Survey Project on Alcohol and Other Drugs was conducted in March 2015. The survey was carried out by the Institute for Sociology and Social Policy, at Corvinus University of Budapest. In Hungary data collection took place in accordance with the ESPAD protocol, on a national representative sample of young people born in 1999 and participating in full-time ordinary school education,

in the form of class surveys, using the self-reporting method. The total sample size on the 9-10 grades was 6664, the net sample of 16-year-olds included 2647 students.

*HBSC 2014 (Arnold, Németh 2015):* The data was recorded in spring 2014 from a nationally representative sample, with consideration to international standards. The survey extends to students studying in grades 5, 7, 9 and 11. The sample was set up using stratified sampling according to school grade, county, settlement type, type of training and maintainer. The net sample included 6153 persons. The data were collected via self-administered, anonymous questionnaires completed in class groups with passive consent and ethics committee approval. The survey was financed by the National Institute of Child Health. The survey examines substance use among students in grades 9 and 11 (N=3509). The students in grade 9 are 15.9 years old on average, and those in grade 11 are an average of 18 years old.

*Prevalence of injecting drug use (Horváth and Tarján 2016):* Estimation took place using the method of capture-recapture recurring in time. It was not possible to break down the estimate by different drug types. The result of the first step of the estimate relate to a two-year interval, indicating injecting drug use during the two years determined.<sup>33</sup> As the second step of the estimate, the results were modified according to the question about the time of the last injecting that was included in the questionnaire of the testing. A condition of using the capture-recapture method is independence between the two time points when measurement is performed. Presumably this condition of independence was not fulfilled in the testing programme, so the basic formula<sup>34</sup> of capture-recapture was modified, distinguishing accidental and systematic or intended participation as the cause of repeated occurrence in the testing programme. By modelling the intention to participate, sensitivity analysis was performed. The coefficient of the intention to participate was determined after interviewing the testing sites, using the method of expert estimation. On the basis of the average of the answers given by the interviewed service providers, 76% of the clients intentionally participated in the seroprevalence survey repeatedly.<sup>35</sup> The clients participating in the seroprevalence survey were given an incentive (meal vouchers in the value of about EUR 3.), so the proportion of participants, who took part in the survey for the second time because of this, is presumably high, even higher than the estimated value.

<sup>33</sup> Repeated occurrence in the testing programmes between 2014 and 2015

Year	2015		
	Occurrence	No	Yes
2014	No		458
	Yes	463	133

<sup>34</sup> The so-called Lincoln-Petersen formula was modified, so the formula used for estimating injecting drug use is:

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

where:

X = hidden population

a<sub>21</sub> = IDU population occurring in one of the years

a<sub>12</sub> = IDU population occurring in the next year

a'<sub>22</sub> = IDU population reoccurring in testing intentionally

a''<sub>22</sub> = IDU population occurring in testing accidentally

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

<sup>35</sup> During the survey the service providers participated in the seroprevalence survey were contacted and requested to estimate the proportion of reoccurring clients, that is clients who occurred in testing in the two consecutive years, who returned to the testing programme consciously and the proportion of those who returned accidentally. All 15 service providers answered the question, where, according to the TDI generated code, there were reoccurrences.

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

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

*National HIV/HBV/HCV seroprevalence survey (Dudás et al. 2015)*: see the Harms and Harm Reduction Workbook, Chapter T.6.2.

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

*TDI data collection 2016*: See *Treatment Workbook, Chapter T6.2.*

*Treatment facility survey 2015*: See *Treatment Workbook, Chapter T6.2.*

*Treatment facility survey in the therapeutical communities 2015*: See *Treatment Workbook, Chapter T6.2.*

*Needle/syringe programme (NSP) data collection (Tarján 2016b)*: In 2016 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 could name the other substance categories. On the basis of previous years' experiences the list of closed categories (which were mainly the classical substance types before) was extended in 2015 with new closed categories: 'penta crystal'; 'music'; methadone; MDPV. With respect to 2015, 26 organisations uploaded the data of 3415 clients. While client data of the closed Blue Point Foundation NSP operating in the district 8 until the second half of 2014 is not included in 2015 data, client data of Alternatíva Alapítvány and of the Baptista Szeretetszolgálat starting NSP services in the same district in 2015 is included. The client data of the closed and then relocated Drogprevenció Alapítvány (who could operate NSP only until the end of 2014) in the district 13, was not included for 2015, however they observed similar patterns in 2015 compared to previous years<sup>36</sup>. (further information on the closures can be found in the Harms and Harm Reduction Workbook in T.1.5.3). 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 2015 on a total of 2985 clients' primarily injected substance. (2009: 1483 persons; 2010: 1737

---

<sup>36</sup> Personal communication with the manager of the given low-threshold service.

persons; 2011: 2237 persons; 2012: 1907 persons; 2013: 3128 persons; 2014: 3692 persons)

*Tisztább kép” - Együtműködési program az új szintetikus drogok feltérképezéséért (Péterfi 2016): see the Drug Market and Crime Workbook, Chapter T.6.2.*

# PREVENTION<sup>37</sup>

## T0. SUMMARY

The National Anti-drug Strategy, entered into force in 2013, determines priorities in the field of prevention and tasks in 10 settings as well. Drug prevention activities – beside several drug-related tasks – are coordinated by the National Drug Prevention Coordination Department of the Ministry of Human Capacities. National study data show that the majority of organisations operating prevention interventions perform universal prevention in the school setting. 70% of these organisations are NGOs with their financing coming mostly from the state in the form of grants. Among the organisations carrying out characteristically selective prevention activities outside of school, there are many state or local authority bodies (social care and child protection institutions) that come into contact with the target groups regularly for different purposes. Workplace prevention programmes only occur occasionally. The main financer of the prevention activity is the state and European Union sources (TÁMOP (Social Renewal Operational Programme), EFOP (Human Resources Development Operation Programme)) as well.

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

## T1. NATIONAL PROFILE

### T1.1 POLICY AND ORGANISATION

#### T1.1.1 Prevention objectives in the National Strategy

The fundamental approach framework of the National Anti-drug Strategy that entered into force in 2013 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 narrower interpretation of drug prevention, the focus of the programmes should be health development, comprehensive physical, psychological, intellectual and social wellbeing’.

---

<sup>37</sup> Author of the chapter: Adrienn Nyírády

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

From 1 September 2015, according to the Government Decree 74/2015 (III.30) drug policy tasks has been delegated from the **National Institute for Family, Youth and Population Policy** (in which organizational framework the National Drug Prevention Office operated) to the National Office for Rehabilitation and Social Affairs as a legal successor, in the form of Social Affairs, Social Inclusion and Drug Policy Programmes Division. (NRSZH 2016)

#### *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 2016)

### **T1.1.3 Financing system**

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

## **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-15 project offered grants for health promotion and health education interventions in the school setting and in collaboration with participants of the local community, in line with the National Anti-drug Strategy 2013-2020 document, with a total amount available of EUR 505,500<sup>38</sup>. Of the 298 grant applications submitted, 119 were awarded funding to the amount of EUR 499,107. (EMMI 2016) 20% of the winning applications implemented universal prevention programmes in school or community settings.

---

<sup>38</sup> The prices in the table were calculated using the EUR intermediate exchange rate valid for 2015 (EUR 1=HUF 309.69).

### *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 targeted age group could participate in prevention programmes offering alternatives to drug use. 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.

Regarded as a merit of the programme, its objectives included response to the spread of designer drugs. By using info-communication technologies it became possible to directly address the young people with a comprehensive, universal drug prevention intervention, in the scope of which they were able to express their creativity and creative ability in connection with the subject<sup>39</sup>. (NDI 2015)

#### *The drug prevention activity of the Police*

##### 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. (Rendőrség 2015)

### **T1.2.3 Selective prevention**

Approximately one third 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.

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.

---

<sup>39</sup>More information may be obtained on the [http://www.ndi-szip.hu/tamop-5\\_2\\_9\\_/Rolunk.aspx](http://www.ndi-szip.hu/tamop-5_2_9_/Rolunk.aspx) website.

## *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 2015 the Hungarian Army implemented the following activities (Magyar Honvédség 2016):

- In the scope of cognitive knowledge transfer, informative publications and visual presentations, information lectures dealing with drug prevention were held on 23 occasions with the participation of 598 persons during training days. 4 lectures were held reaching a total of 1500 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 2015.
- Personnel planned for missions are prepared in the subject of the prevention of addictions. In 2015 drug prevention training was held on 5 occasions with the participation of 135 persons.
- Training: in 2015 training course was held with the participation of 30 persons for those performing drug prevention tasks in the military organisations (specialist healthcare and corps psychologist personnel).

### **T1.2.4 Indicated prevention**

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

## **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. The professional approval system is a prior assessment system in terms of quality assurance.

In 2015 20 applications were submitted to the National Institute for Health Development for approval, all of them were prevention programmes relating to substance use. Each programme contained social competence development or emotional education elements beyond knowledge transfer. In the end 9 drug prevention programmes were given professional approval. (NEFI 2016)

Table 7. *The number of school health development programme applications submitted to the NEFI for approval broken down by subject and number of programmes finally supported*

<b>Subject</b>	<b>No. of applications</b>	<b>Supported applications</b>
drug prevention	8	3
addictions	4	2
complex	8	4
<b>Total</b>	<b>20</b>	<b>9</b>

Source: NEFI 2016

Table 8. *Number and final results of school health development programme applications relating to drug use submitted for professional approval to the NEFI*

	<b>No. of submitted applications</b>	<b>Supported</b>	<b>Rejected for formal reasons</b>	<b>Not supported</b>
drug prevention	8	3	1	5
addiction prevention	4	2	1	1
complex	8	4	1	2
<b>Total</b>	<b>20</b>	<b>9</b>	<b>3</b>	<b>8</b>

Source: NEFI 2016

## **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). Between 2010 and 2015 only regional or qualitative studies were conducted. In 2015 national data collection was prepared again which provides updated information about the features of prevention activities. (see chapter T3) Comparing the results of the two latest national data collections it turns out that the number of the explored school prevention programmes (49 programmes by county, 75 programmes in Budapest) was twice as much 10 years ago than last year, which means that the willingness to respond significantly decreased. Similarly to the earlier status, NGOs run the overwhelming majority of the prevention interventions, however the presence of state institutions increased by 10%. Compared to earlier data only half of the organisations run prevention activities as the main activity. Examining content related issues, it can be stated that today the majority of the programmes/services operates directly in the final target population. In addition, the interventions provided by the school teachers and the teacher-training drug use prevention programmes also appear. The objectives of the programmes are more up to date and the service providers meet the students more hours/more times than earlier. While in 2009 the interventions targeted the 10-14 age range and the 15-18 age range at almost the same rate, today most of the interventions target those above 14 years. 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.

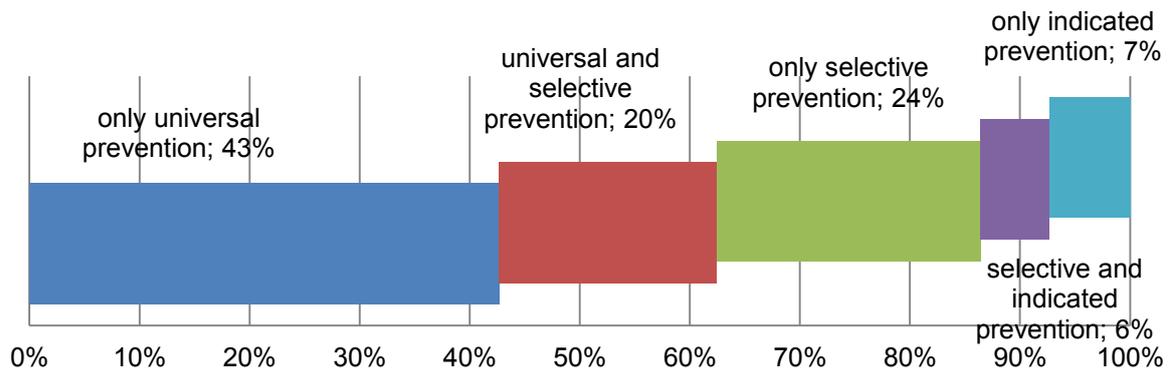
### T3. NEW DEVELOPMENTS

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

76 organisations from the 194 filled in the questionnaire of the study, we have detailed information about these. According to the results most of the service providers (85%) run prevention programmes as part of their main activity which is mostly treatment and care, other supporting or training/educational activity. The majority of the organisations (70%) are NGOs. Local governments and budgetary institutions also represent a relatively high rate (24%). For profit organisation only run 6%. The organisations most often run 1, on average 1,8 and a total of 139 prevention programmes or interventions. The study describes 115 interventions in detail. **The number of the programmes operating directly in the final target group is 96.** The detailed information about these 96 programmes are presented below.

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

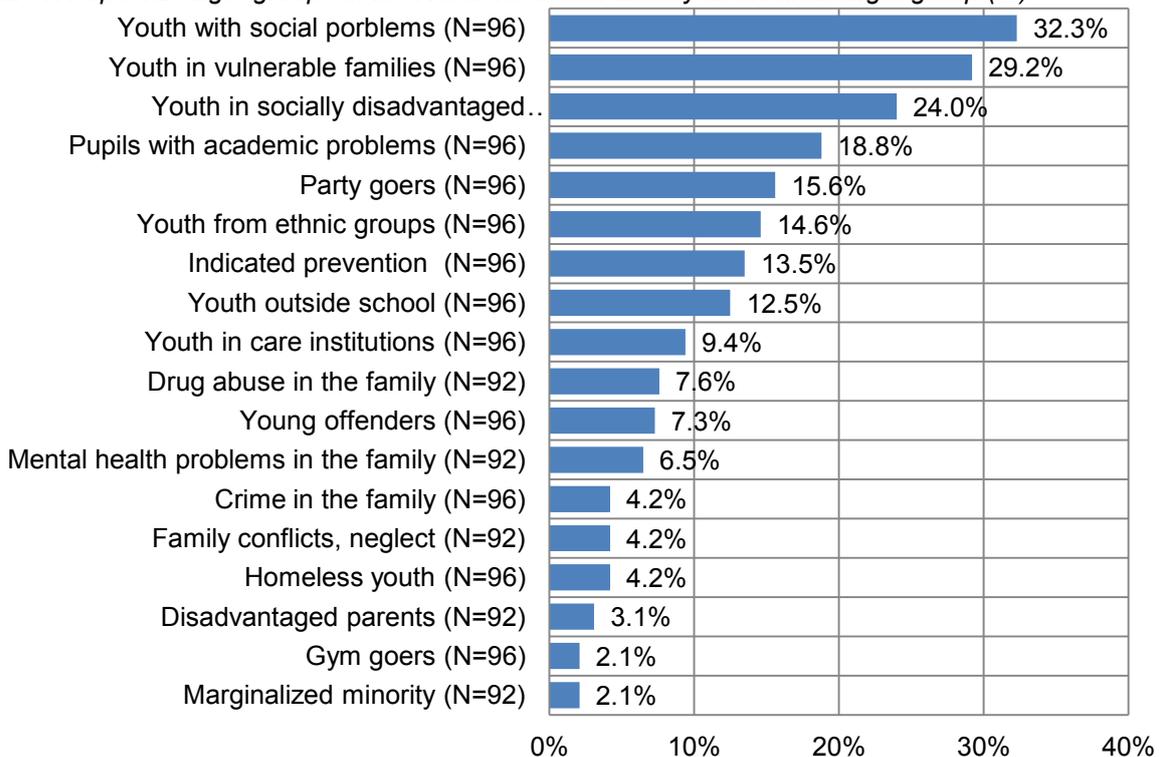
Chart 16. Types of interventions aimed directly at the final target group (N=96)



Source: Paksi et al. 2016b

Nearly two third of the prevention interventions (62,5%) indicates the general population (as well) as its target group. However no interventions aim at young refugees.

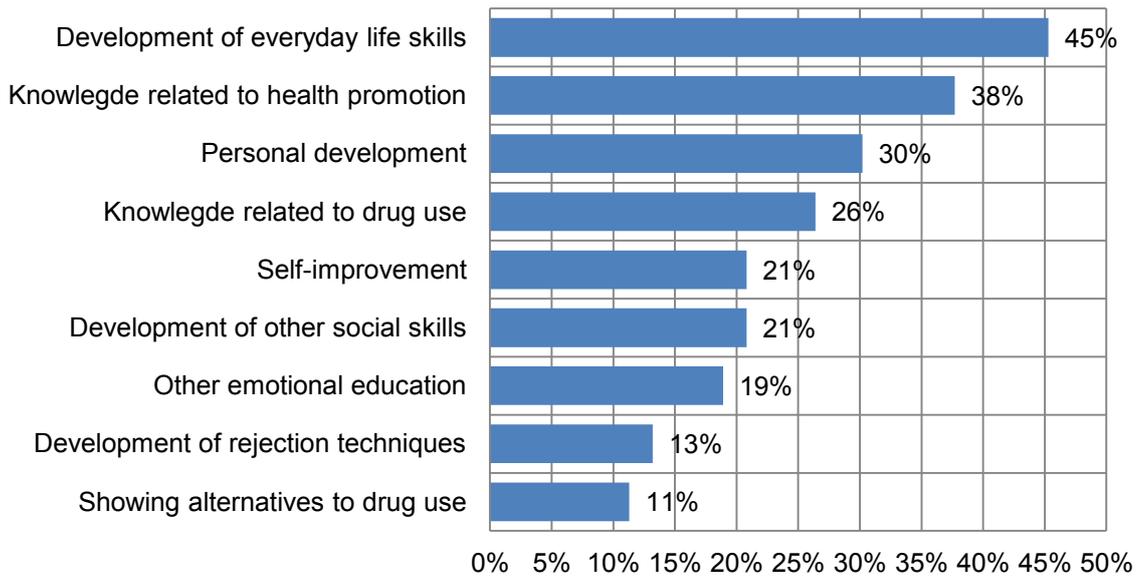
Chart 17. Special target groups of interventions aimed directly at the final target group (%)



Source: Paksi et al. 2016b

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

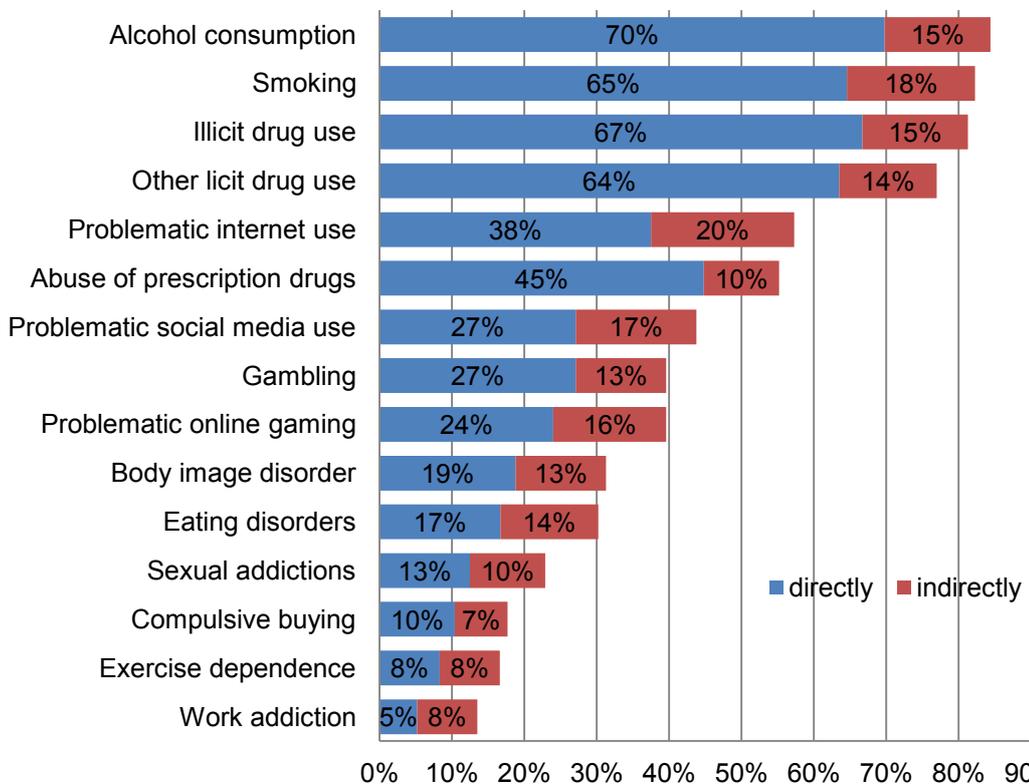
Chart 18. Different objectives of interventions aimed directly at the final target group (N=53, %)



Source: Paksi et al. 2016b

Examining the targeted addictive behaviour, it can be stated that high majority (82,3%) of the interventions directly aim at preventing a defined form of addiction, two third of them directly aim at illicit drug use.

Chart 19. Addictive behaviours in prevention interventions aimed directly at the final target group (N=96)



Source: Paksi et al. 2016b

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

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

#### **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) (2016a): Az EMMI Szociális és Gyermekjóléti Szolgáltatások Főosztályának részanyaga

Magyar Honvédség (2016): Beszámoló a kábítószerügyi Éves jelentéshez.

NRSZH (Nemzeti Rehabilitációs és Szociális Hivatal) (2016): Tájékoztató az EMCDDA számára készülő, 2016. Évi Jelentés elkészítéséhez

NEFI (Nemzeti Egészségfejlesztési Intézet) (2016): A NEFI kábítószerhez kapcsolódó tevékenységei

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

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

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

## **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.

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

## TREATMENT<sup>40</sup>

### T0. SUMMARY

The inpatient and outpatient treatment of drug users is a shared task of the healthcare system and the social services system with the participation of NGOs. 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. In these days, however this approach might need some reconsideration with regards to the recent and effective community-financed community-based interventions.

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

A significant element of the treatment system in Hungary is the legal possibility of treatment/preventive interventions that may be used as an alternative to criminal procedure (quasi compulsory treatment; hereinafter QCT). The majority of treatment demand is linked to this (64.7% in 2015, 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.

---

<sup>40</sup> Author of the chapter: Gergely Csaba Horváth, 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) lists the establishment of an institution system that provides services for children and young people that meets their real needs, with national coverage and general access. The Strategy has set the objective of at least 20% of problem drug users and drug addicts being provided with treatment, and that the accessibility and national coverage of the institution system providing healthcare and social services to addict patients should be improved in general, and that by 2020 there should be a harmonised, comprehensive services system that uses common operation indicators in every district and active outreach techniques that search for clients and bring them into treatment. A further priority in the field of treatment and care services is that at least 80% of healthcare and social service providers should perform their activities on the basis of the related professional directives, and all of the service providers should be subjected to a clinical or social institution quality assurance audit.

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

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

#### **T1.1.2 Governance and coordination of drug treatment implementation**

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

The 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 (including 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 9 and Table 10.

Table 9. Network of outpatient treatment facilities (total number of units in 2015)

	total number of units	definition (treatment unit types)
specialised drug treatment centres	39	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 <sup>41</sup>	19	Service providers identifying themselves in the TDI data collection as low threshold/drop-in/outreach units) (characteristically service providers providing psychosocial services).
general / mental health care	5	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 2016 –Standard table 24

### 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 programme<sup>42</sup> by a psychiatrist or a clinical psychologist on the basis of a preliminary status assessment. The content of the treatment interventions is not specified, the healthcare service providers provide these services within the scope of regular outpatient or inpatient drug treatment programmes. The offender is required to participate in the preventive or treatment programme for at least 1.5 hours every two weeks for six months in order for the certificate of completion to be issued.

(For further information and data on QCT see Legal Framework Workbook, Chapter T1.1.1; Drug Market and Crime Workbook, Chapter T1.2.1.; Prison Workbook, Chapter T1.3.3.)

<sup>41</sup> and other treatment units with a primarily social profile

<sup>42</sup> as for the treatment the law distinguishes two types: ‘treatment for drug addiction’ and ‘treatment of other conditions with drug use’.

### T1.2.3 Outpatient drug treatment system – Client utilisation in 2015

A total of 63 service providers reported on the outpatient treatment of drug user clients in 2015 out of the 79 reporting treatment units, excluding treatment units in prisons. 90.5% of all the clients (3900 out of the 4308 persons) started treatment at specialised outpatient units, low threshold service providers or at general/mental health care service providers. In the scope of outpatient treatment 2780 persons started treatment as an alternative to criminal procedure (QCT).

Table 10. *Outpatient treatment provision (the number of clients starting treatment in 2015)*

	<b>total number of clients (starting treatment)</b>	<b>characteristics of clients</b>
specialised drug treatment centres	3020	Among them 2043 persons started treatment in the scope of a QCT.
low-threshold agencies <sup>43</sup>	725	Among them 583 persons started treatment in the scope of QCT.
general / mental health care	60	Among them 59 persons started treatment in the scope of QCT.
prisons	95	Among them 95 persons started treatment in the scope of QCT.

Source: TDI data collection 2016 –Standard table 24

#### *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

<sup>43</sup> and other, treatment units with a primarily social profile

treatment. Beside non-hospital based treatment there are also mixed profile treatment units which receive financing from both budgets. Therapeutic communities are organisational units that typically do not operate within the framework of the traditional system of hospital-healthcare institutes; they give a long-term therapeutic response to the multiple treatment demand of psychoactive drug users and patients suffering from behavioural addictions while living in a therapeutic community; and they are typically maintained by the church, NGOs or municipalities. These treatment units employ a multidisciplinary team and frequently recovering or recovered, qualified (addiction consultant, social worker, mental care worker) former substance users as well. They can also provide linkage to the twelve-step programmes.

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 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 11 and Table 12.

Table 11. *Network of inpatient treatment facilities (number of treatment units in 2015)*

	<b>total number of units</b>	<b>definition (types of treatment units)</b>
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	5	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 09.

Source: TDI data collection 2016 – Standard table 24

For further information on therapeutic communities in Hungary see *Therapeutic communities facility survey* (Péterfi et al. 2016, Chapter T4.1) and 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 15 (Péterfi et al. 2016; for earlier details see 2012 National Report, Chapter 11), of these only 5 treatment units reported cases to the TDI data collection.

### T1.2.8 Inpatient drug treatment system – Client utilisation in 2015

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. 9.5% of all clients (408 out of 4308 persons) started treatment in 2015 in the scope of inpatient treatment, 6 of them in the scope of QCT

Table 12. *Inpatient treatment provision (number of clients starting treatment in 2015)*

	total number of clients (starting treatment)	characteristics of clients
hospital-based residential drug treatment	242	Among them 6 persons started treatment in the scope of QCT.
residential drug treatment (non-hospital based)	0	
therapeutic communities	166	Among them 2 persons started treatment in the scope of QCT.
prisons	0	Imprisoned clients are presented in Table 10Table 10.

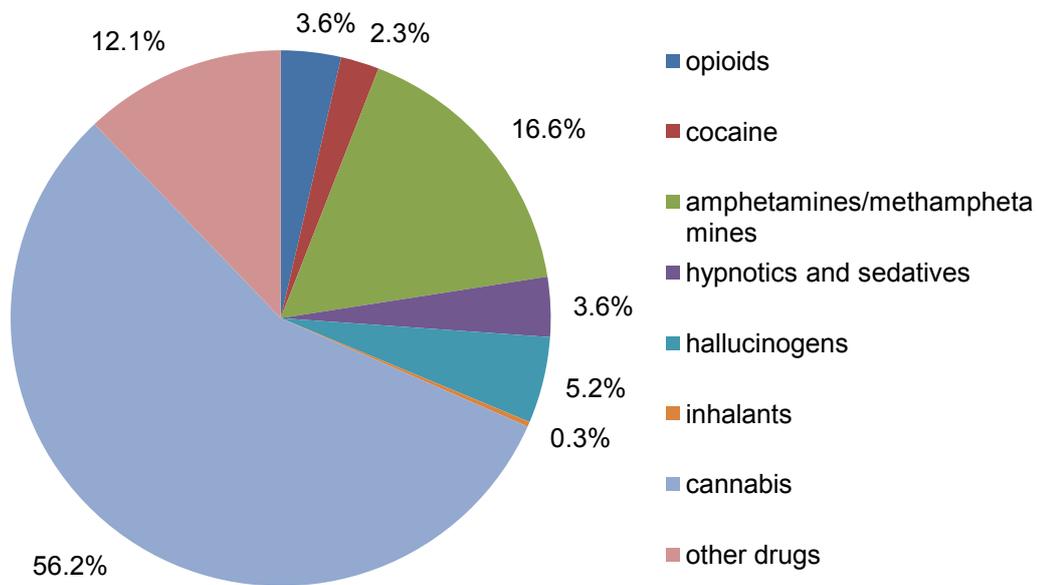
Source: TDI data collection 2016 - ST24

## T1.3 KEY DATA

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

The 79 treatment units providing drug treatment and reporting to the TDI reported a total of 4308 clients entering treatment in 2015. The majority (56.2%) of those starting treatment due to drug problem – similarly to previous years – started a treatment programme because of cannabis use. 16.6% started treatment because of amphetamine type stimulants use, including ecstasy. 5.2% of the clients entered treatment because of the use of hallucinogens. . Opioid use was the reason for starting treatment to a less significant extent (3.6%). The proportion of cocaine and ecstasy users was around 2% each. 12.1% of treatment entrants indicated the use of ‘other’ non-categorisable substances as their primary substance.

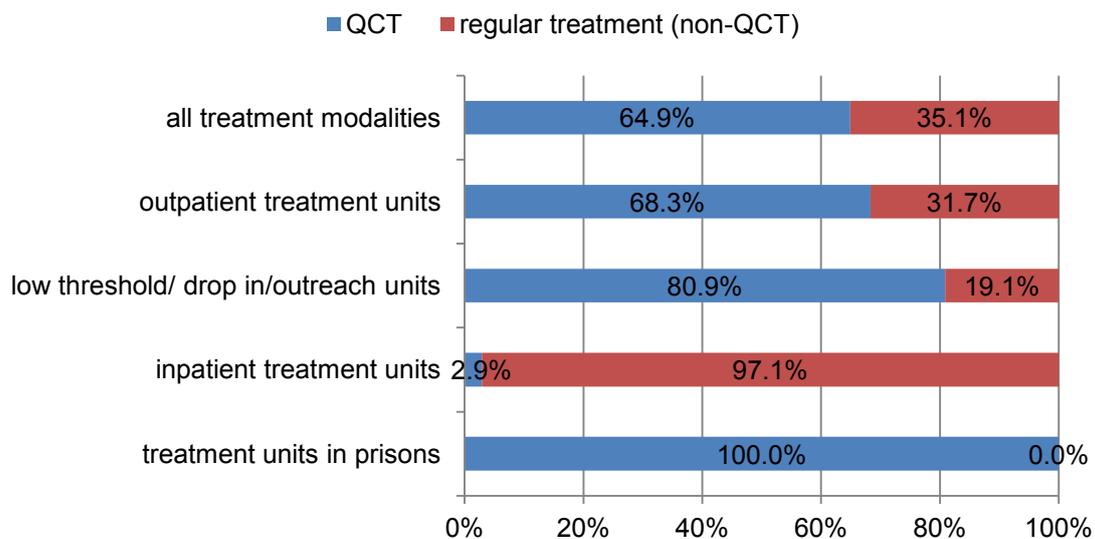
Chart 20. Breakdown of treatment demand by primary drug (2015; %, N=4308)



Source: TDI data collection 2016

Avoiding criminal procedure (QCT) was the main reason for entering treatment among drug users. With respect to all clients, 64.9% of them (2788 persons) entered treatment in this way. It is important to note, however, that on examining the treatment unit types, significant differences can be observed in the proportions of those avoiding criminal procedure. While the majority of the clients of outpatient and low threshold (social) service providers started treatment in this way (68.3% and 80.9%), only a very small fraction of those entering inpatient treatment (2.9%) started a treatment programme as an alternative to criminal procedure. Treatment units in prisons only reported clients participating in QCT treatment in 2015 in the TDI system.

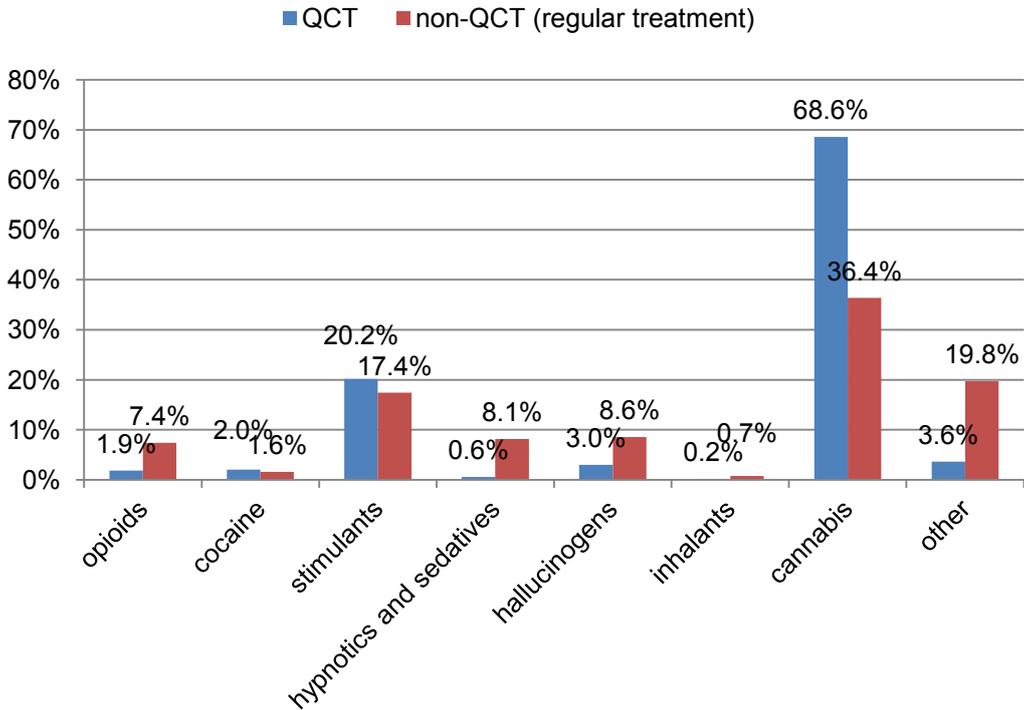
Chart 21. The proportion of those starting treatment as an alternative to criminal procedure (QCT) among those entering treatment, by type of treatment unit (2015; N=4298)



Source: TDI data collection 2016

The distribution according to primary drug also shows a different picture among those starting treatment as an alternative to criminal procedure (QCT) and those starting for other reasons. Cannabis (1944 persons, 69.7%) was the most prevalent primary drug among all clients starting QCT treatment (2788 persons). That was followed by amphetamine type stimulants (493 persons, 17.7%). Proportion of all the other drugs remained under 5% each. Among the non-QCT clients (1510 persons) cannabis use was the most frequent cause for treatment as well (469 persons, 31.1%), the category of ‘other drugs’ was in the second place (409 persons, 27.1%) that mostly covers NPS. This is followed by amphetamine type stimulants (224 persons, 14.8%) and hallucinogens (124 persons, 8.2%), the latter is also presumed to contain NPS. For more on treatment demand assumed to be attributed to NPS use see Chart 27.

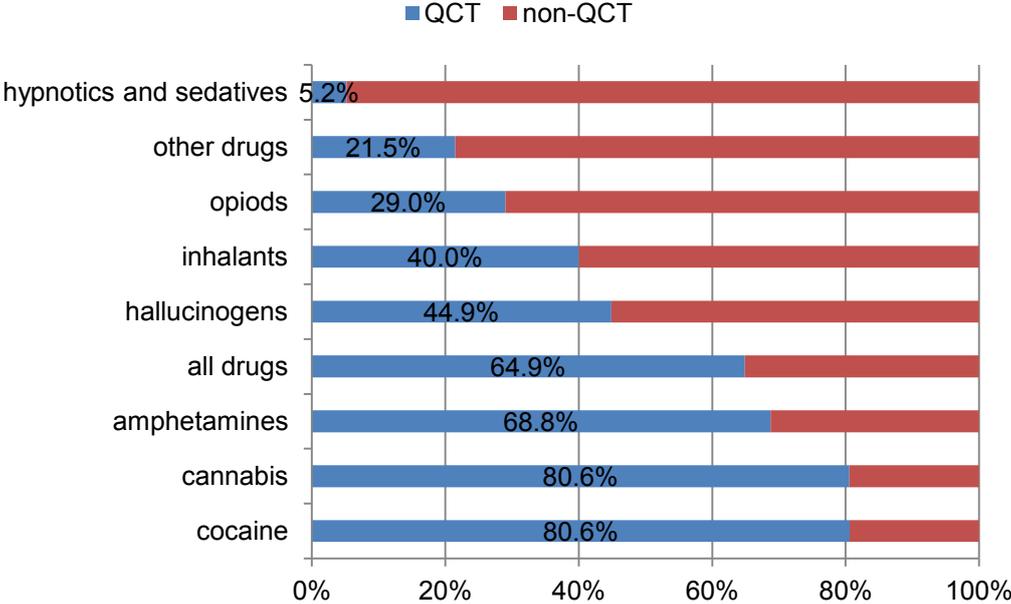
Chart 22. Breakdown of QCT and non-QCT (regular treatment) treatment entrants by primary drug (2015;  $N_{QCT\ clients}=2788$ ;  $N_{Non-QCT\ clients}=1510$ )



Source: TDI data collection 2016

Proportion of clients participating in QCT shows significant variations within the different categories of primary drugs as well. While in the case of all drugs QCT clients stand for two-third of the cases (64.9%) the ratio is higher among cannabis users, where four out of five cases (80.6%) are related to the alternative of criminal procedure. In the case of amphetamine users this proportion is 68.8%, among opioid users 29% and 21.5% among clients using ‘other drugs’.

Chart 23. Proportion of QCT and non-QCT clients among clients entering treatment by the category of the primary drug (2015;  $N_{QCT\ clients}=2788$ ;  $N_{Non-QCT\ clients}=1510$ )



Source: TDI data collection 2016

**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 8 service providers reported client data to the national reporting system (for the description of the data collection on substitution treatment see Chapter T6.2).

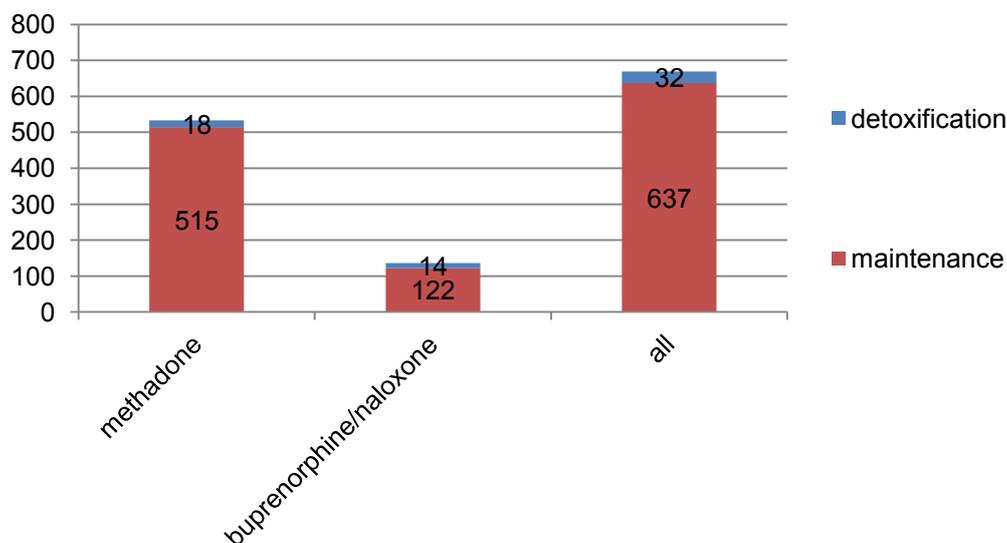
Opioid substitution treatment is not available within the detention facilities, although the detention facilities are legally obliged to provide substitution therapy for prisoners who ask for it: in such cases they have to transfer those clients to external service providers with geographical obligations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

#### **T1.4.8 Number of clients in OST**

Two types of substitution medication are used in Hungary in OST programmes: methadone and buprenorphine/naloxone. Service providers participating in the national data collection on substitution treatment reported a total of 669 clients, that covers around 80% of all the clients according to expert estimates. 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 (533 persons in 2015, 79.7%), while approximately  $\frac{1}{4}$  of the clients receive the buprenorphine/naloxone combination (136 persons in 2015, 20.3%). Buprenorphine/naloxone medication may be prescribed by any psychiatrist, whereas methadone is an 'institution drug' (acquisition and provision is done by the health service provider). Thus the buprenorphin/naloxone medication may appear in private health care, about which there is no information available.

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

Chart 24. Breakdown of clients in OST by substitution medication and therapeutic purpose (2015; N=669)



Source: OST data collection 2016

#### T1.4.9 Characteristics of clients in opioid substitution treatment

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

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

### T1.5 QUALITY ASSURANCE OF DRUG TREATMENT SERVICES

#### T1.5.1 Quality assurance in drug treatment

##### *Healthcare guidelines*

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

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

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

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

### *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 consensus<sup>44</sup>. 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 certain proportion of these clients do not require addiction treatment, they are provided with a kind of indicated prevention intervention (the so called preventive-consulting service). 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.

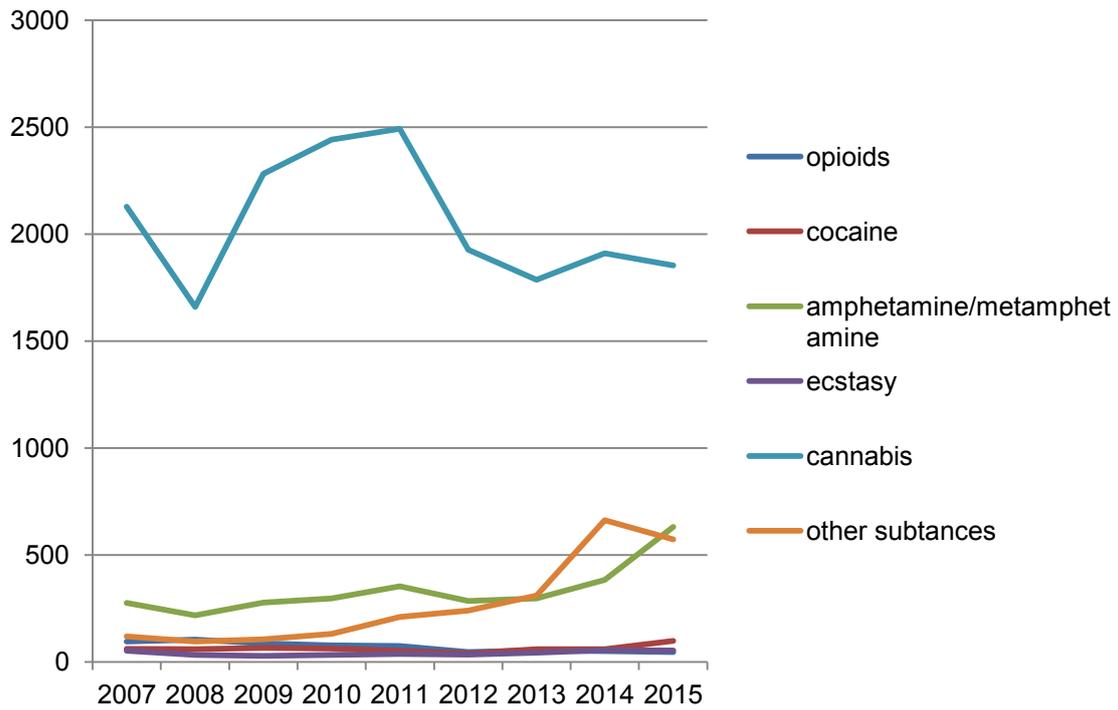
The other noticeable trend is the marked increase in 'other substances' from 2010 onwards considering the primary drug of treatment entrants. This phenomenon is obviously linked to the spreading of NPS. On the basis of the estimates of the treatment units participating in the Hungarian National Focal Point 2015 treatment facility survey (Péterfi 2015), 26% of their clients treated for a drug problem demanded treatment because of synthetic cannabinoids and 21% because of a designer stimulant in 2014 (for details see 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). There is no significant difference in the trends by primary substance regarding all clients and clients entering treatment for the first time because of the dominance of QCT.

---

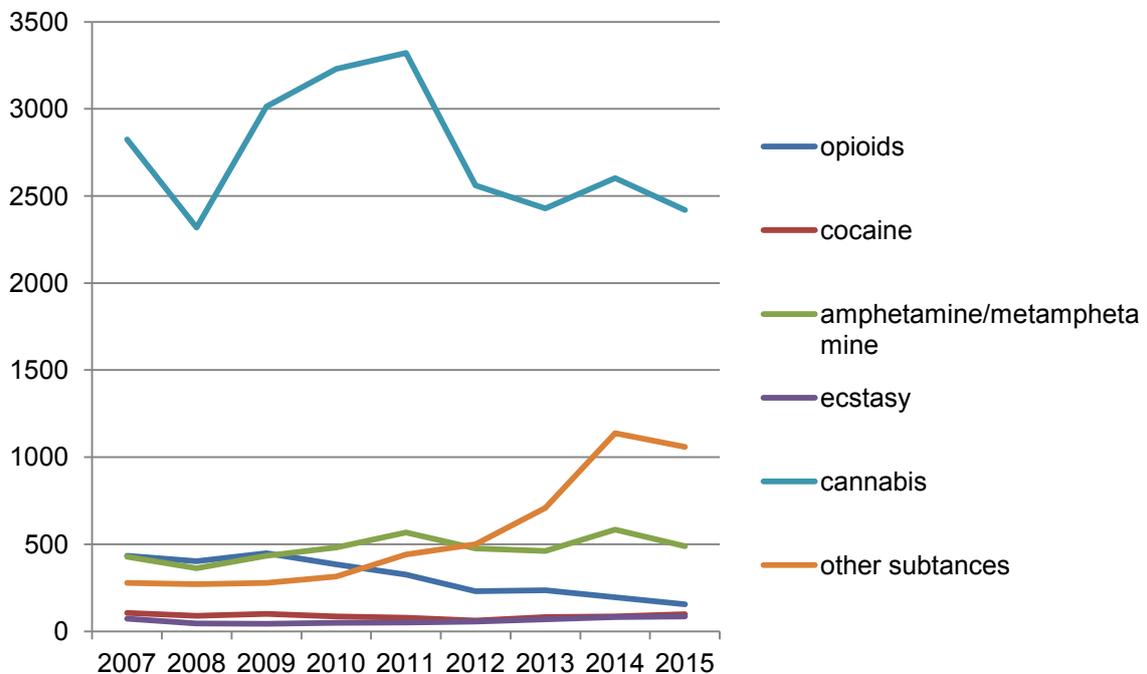
<sup>44</sup> Representatives of the field were consulted on the draft guidelines in the scope of a consensus conference.

Chart 25. Trends in numbers of clients entering treatment for the first time, by primary drug, 2007-2015



Source: TDI data collection 2016

Chart 26. Trends in numbers of all clients entering treatment, by primary drug, 2007-2015



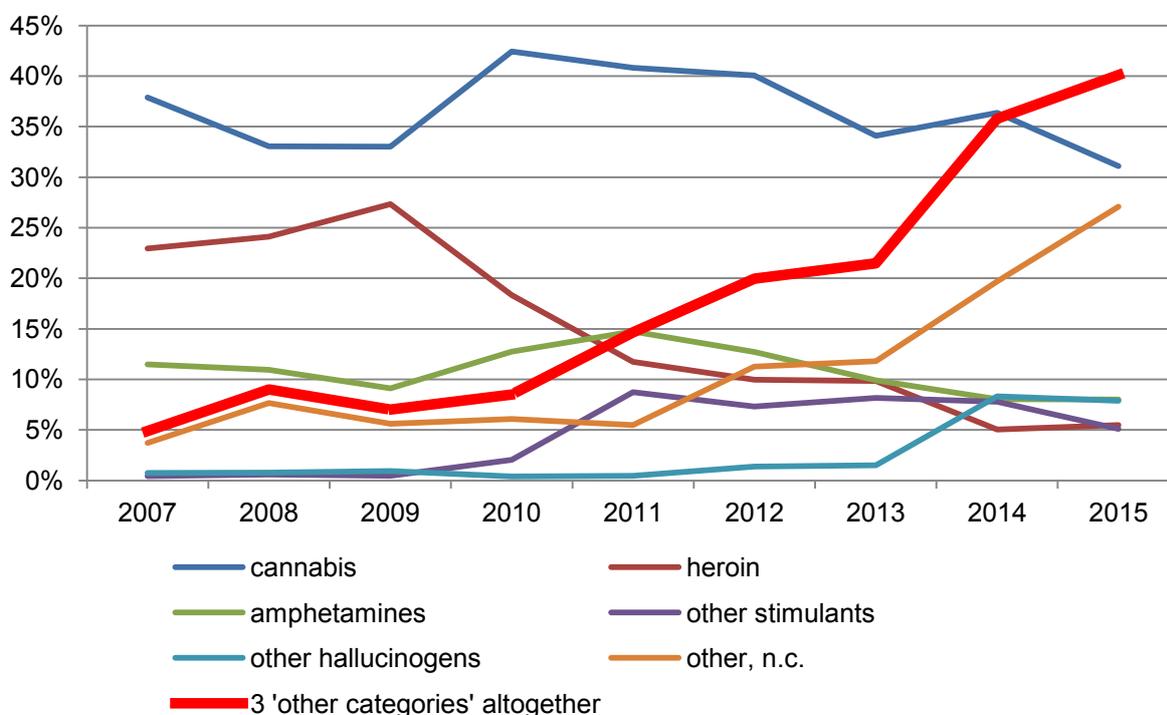
Source: TDI data collection 2016

Although the increasingly growing treatment demand resulting from the use of NPS (primarily synthetic cannabinoids and designer stimulants) can be observed in the TDI data and other

data sources (Péterfi 2015; Csák 2012; Horváth et al. 2011), it is important to note that no specialised therapeutic possibilities are available for these user groups at the moment in Hungary. Therefore, the special needs linked to the use of NPS (including young people being affected, lack of motivation, more intensive use, more frequent need for emergency treatment) (GDS 2014; Csák 2012; Horváth et al. 2011) may remain unmet. Due to this, expert opinions suggest that this user group is probably underrepresented in the treatment data.

Treatment due to new psychoactive substance use may supposedly be reported under three categories in the TDI system (TDI v2.0). The category 'other stimulants' covers cathinones and other stimulants, 'other hallucinogens' covers synthetic cannabinoids, and 'other drugs (not classified)' may also be dominated by treatment demand for new psychoactive substance use. Even if taking methodological uncertainties into account it is noteworthy that these three categories altogether stand for about 40% of all treatment demand in 2015.

Chart 27. Trends in the number of clients entering treatment by categories of 'primary drugs' applied in the reporting and the three categories for 'other drugs' altogether between 2007-2015 ábrafeliratok!



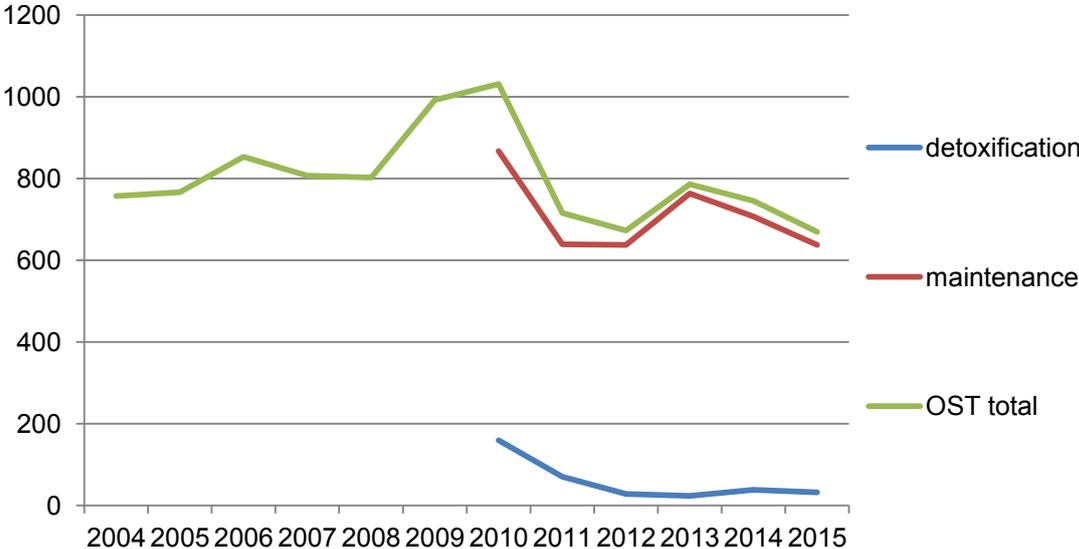
Source: TDI data collection 2016

### Opioid substitution treatment (OST)

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

The reason for the relatively stable availability is that the treatment capacity financed did not change while the financing of buprenorphine/naloxone has improved over the past years.

Chart 28. Trends in numbers of clients in OST, 2004-2015



Source: TDI data collection 2016 – Standard table 24

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

**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**

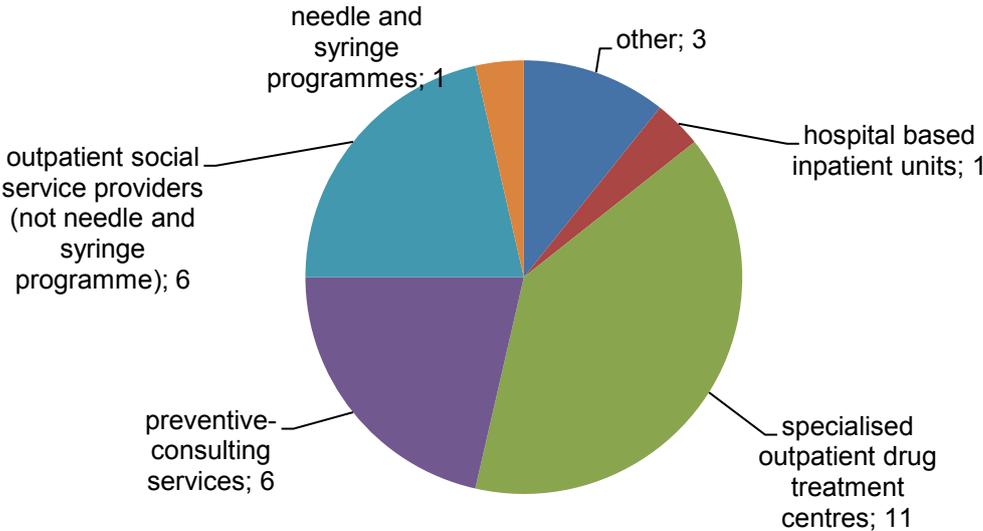
**T4.1 ADDITIONAL SOURCES OF INFORMATION**

**Treatment facility survey 2015**

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 the Hungarian treatment network.

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

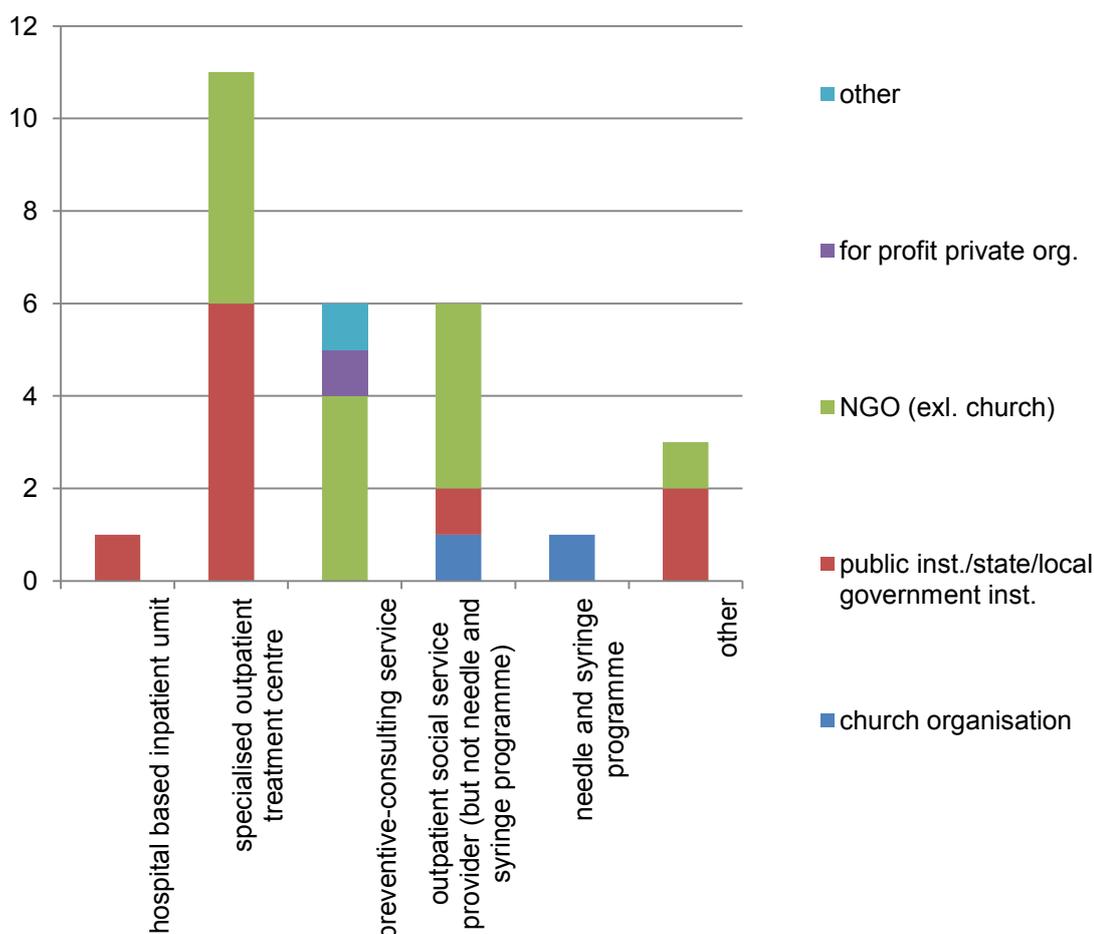
Chart 29. Treatment unit type (N=28)



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 30. 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 financed<sup>45</sup>, 7 treatment units reported to use only funding allocated for social services<sup>46</sup>, 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 users<sup>47</sup>.

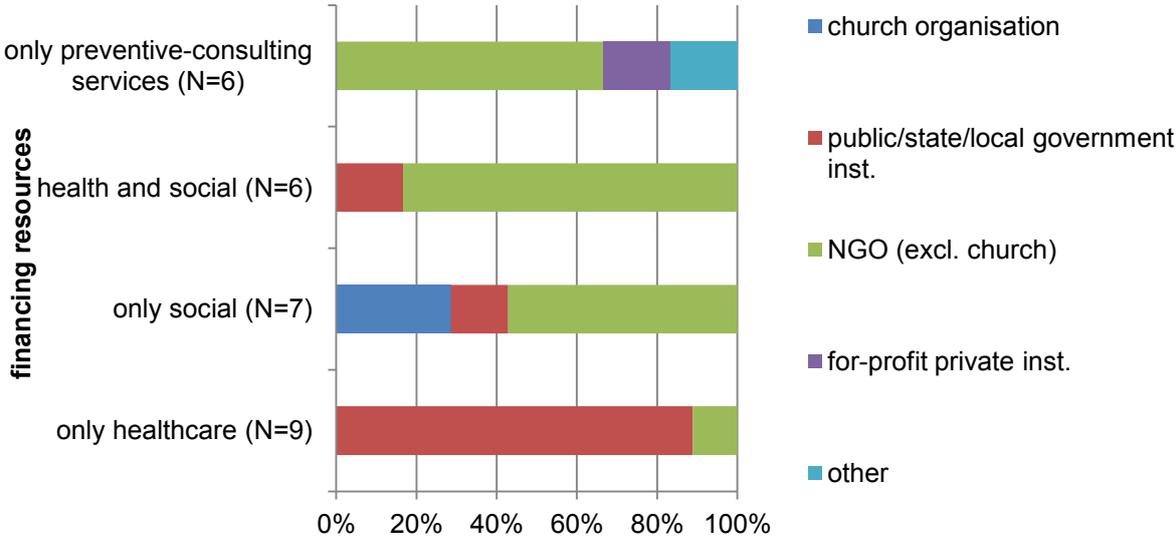
Comparing form of operation with the sources of financing used, there is a greater proportion of non-profit NGOs among those institutions that have mixed financing, the provision of exclusively social services is more characteristic among church organisations and NGOs. The majority of those only using 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.

<sup>45</sup> National Health Insurance Fund (OEP) financed addiction (or drug) or psychiatric inpatient or outpatient treatment

<sup>46</sup> Community care for addicts (National Office for Rehabilitation and Social Affairs, NRSZH), Low threshold services for addicts (NRSZH), Day-care services for addicts (NRSZH)

<sup>47</sup> When categorising the financing possibilities the financing available for preventive-consulting services were not included among the social services sources.

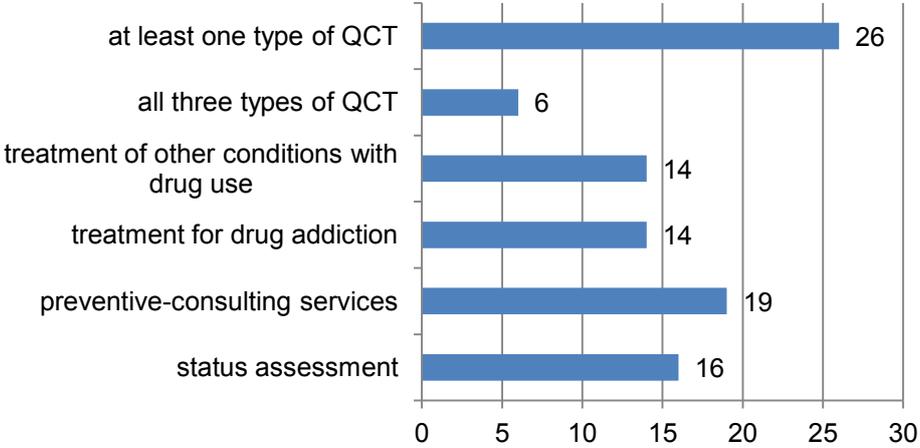
Chart 31. Form of operation by financing resources (N=26)



Source: Péterfi 2015

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

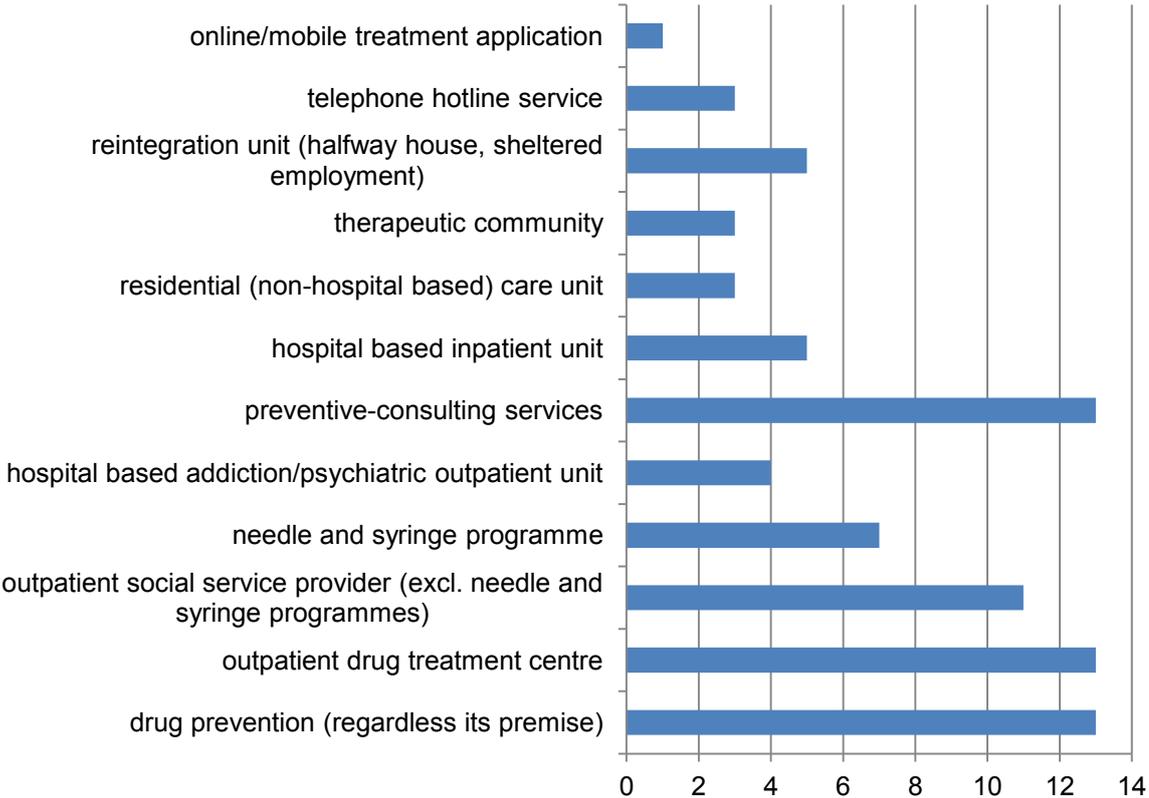
Chart 32. Availability of QCT (N=28)



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.

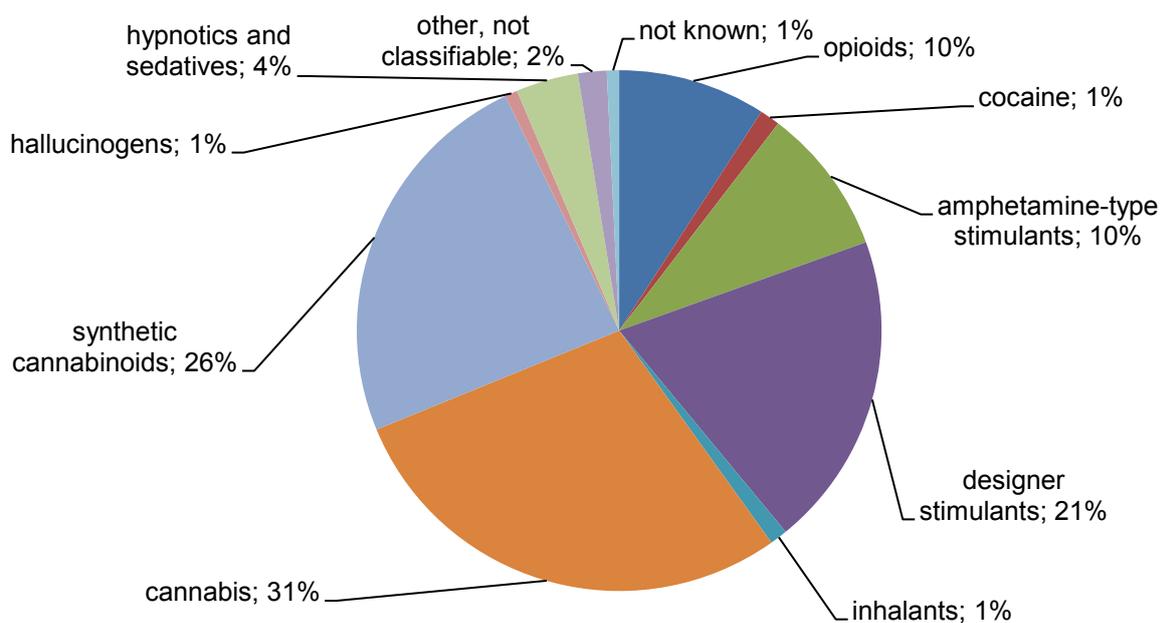
Chart 33. Other units/programmes operated by the parent institution (N=28)



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 34. 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

### Treatment facility survey among the therapeutic communities 2015

The Hungarian National Focal Point carried out a survey among therapeutic communities and non-hospital inpatient treatment service providers (Péterfi et al 2016, for methodological description see T6.2.). The research involved all the 15 non-hospital inpatient service providers providing rehabilitation primarily for drug users and financed by public sources. The survey was completed by all the 15 invited service providers, thus the following results depict a reliable picture of non-hospital based rehabilitation services for drug users at national level in 2014 and 2015.

#### Organisational information

Considering the organisational form the survey differentiated four types: 'public organisation/state or local government organisation/public foundation'; 'profit-oriented non-governmental organisation'; 'non-profit non-governmental organisation' and 'church organisation'. On the basis of the results out of the 15 institutions 8 were non-profit NGOs, 3 were church organisations and 4 were (state or local government) public organisations..

Most service providers (13) operated within the framework of a larger parent institution. Examining the type of the service provider unit, 11 units defined themselves as therapeutic communities, 2 as non-hospital based inpatient service providers, further 2 as 'other' (child care) institutions out of the 15 units. Considering the financing of these institutions 8 out of the 14 respondents stated that they got provisions for 'addiction' or 'psychiatry' inpatient treatment from the National Health Insurance Fund (OEP). 10 units reported that they were financed for providing 'specialized service for personal care' by the National Office for Rehabilitation and Social Affairs (NRSZH)<sup>48</sup>.

<sup>48</sup> Financing from OEP and NRSZH can be provided parallelly.

The survey covered the capacity of the institutions as well as the 'number of beds' financed by the social care budget or the health fund (OEP). At the time of the survey the 15 respondents claimed a total of 380 beds. More than two-thirds of the inpatient treatment slots were financed by both sources.<sup>49</sup> 90 slots were financed in therapeutic communities operated as public (state, local government or public foundation) organisations and 72 slots in church organisations. The largest proportion of capacity (218 slots, 57%) was available in non-profit NGOs.

At the time of the survey the uptake was 82.6% at national level (314 clients for 380 beds). The average number of beds was 25.3 per unit in 2015. Three institutions are open for clients under 18 years that stand for 18% (52 beds) of the total capacity.<sup>50</sup>

#### Target group and client information

On the basis of data of 12 respondents 807 clients entered non-hospital based inpatient treatment in 2014, the client number per unit was between 22-161 persons.<sup>51</sup>

592 clients (73%) entered rehabilitation treatment relating primarily to illicit drug use, 197 clients (25%) entered because of alcohol use and 18 clients (2%) for other reasons out of the total of 807 clients. In the category of 'illicit drug related problems' beyond the classical drugs the questionnaire included the use of new psychoactive substances, the use of organic solvents and the abuse of hypnotics and sedatives as well.

Based on 11 respondents'<sup>52</sup> data for nearly half of the clients (43%) the primary drug was a designer stimulant. The second most prevalent cause for treatment was synthetic cannabinoid use (26%). 9% of the clients reported sedatives/tranquiliser use as the reason for treatment. Amphetamine use and opioid use were both indicated as the cause of treatment in 7% of the cases.

---

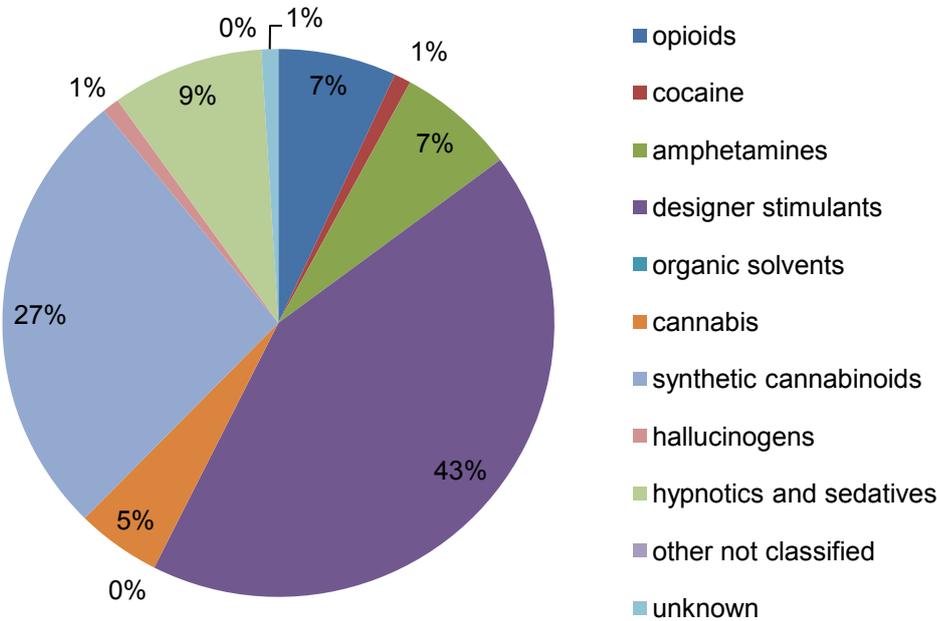
<sup>49</sup> According to data from 2009 published in the 2012 National Report the total national capacity covered 353 slots in 2009. 269 were financed by the OEP and 340 were financed by the social care budget. (Hungarian National Report 2012, p.111)

<sup>50</sup> At the time of the survey the unit in Ráckeresztúr (MRE KIMM – Fiatalokorúak Dropterápiás Otthona) was not yet operating, thus that unit was excluded from the research.

<sup>51</sup> 2 institutions did not respond, one operated from 2015.

<sup>52</sup> 3 institutions did not respond, one operated from 2015.

Chart 35. Distribution of primary drug among clients entering rehabilitation treatment for 'illicit drug use', 2014 (% , N=555)



Source: Péterfi et al. 2016

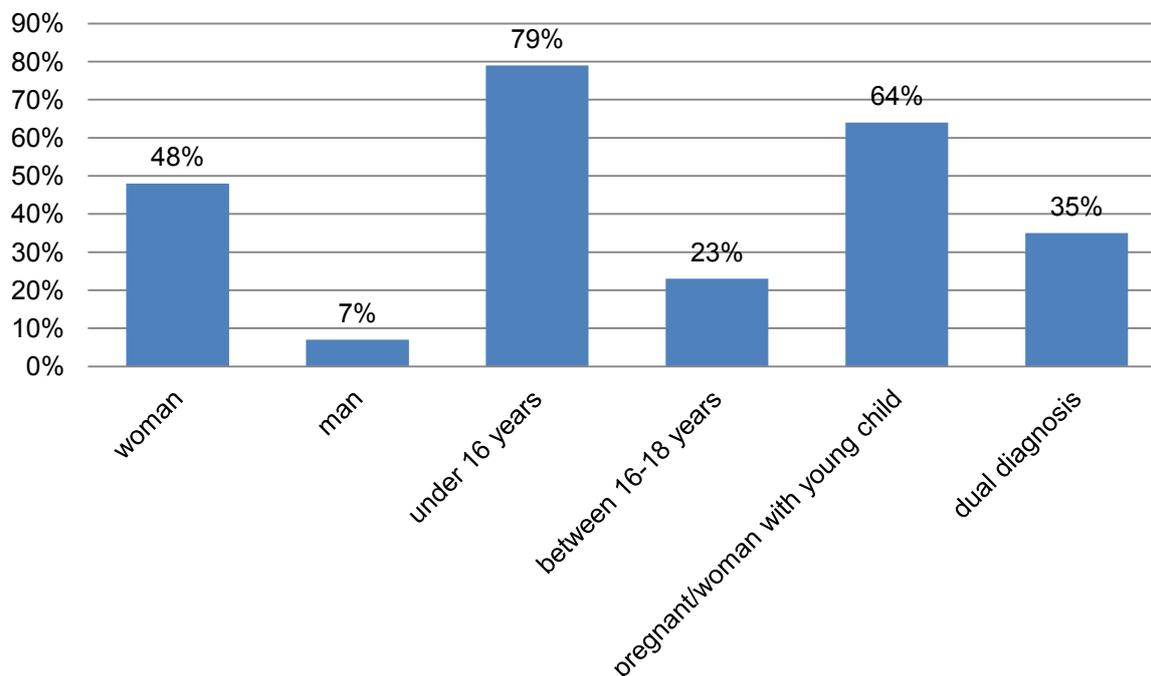
The survey also assessed which substances contributed to the drug related problems beyond the primary drug. All the respondents mentioned abuse of medicines, and a large number of units (9) mentioned new psychoactive substance use, as well as other behavioural addictions (7) and alcohol (6).

There were differences found in the groups who could enter services.<sup>53</sup> Probation service, HIV or hepatitis C infection and homelessness were not mentioned by any of the institutions as exclusion criteria. 10 service providers (77%) did not accept clients under 16 years, but only 4 units (31%) excluded clients between 16 and 18 years. Women are accepted in 7 institutions (54%). One unit is open for women only. Out of those units accepting women 2 institutions did not accept pregnant women or women with young children. Dual diagnosis did not mean an exclusion criterion in most of the institutions.

Exclusion criteria projected on capacity (treatment slots) – on the basis of the 286 slots reported by 13 units – shows that 48% of the slots are available for men only and 7% for women only. On 64% of the beds pregnant women or women with young children are not allowed. From the total of the 286 beds covered by the survey, 79% are solely available for clients older than 16 years old and 23% are available for clients over 18. Clients with dual diagnosis are excluded from 35% of the beds.

<sup>53</sup> Information on exclusion criteria were available for 13 institutions.

Chart 36. Exclusion criteria projected on capacity (% , N=286)



Source: Péterfi et al. 2016

Compared to the previous year in 2014 there was no decrease in the number of clients entering treatment in any of the 14 units. 3 organisations reported stagnation while the other 11 (79%) indicated an increase to some extent.

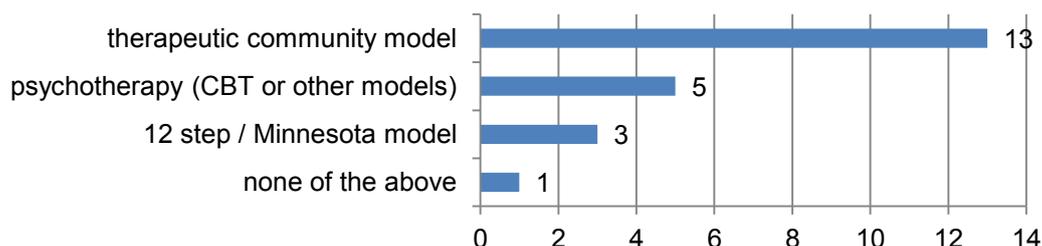
As the reasons for the increase in the client figures the respondents mentioned the followings: drug market changes, spread of new psychoactive substances and the low prices and easy accessibility of NPS. Some organisations also mentioned discrepancies in societal and family functioning among the reasons.

In connection with the spread of NPS and increase of client figures some units noted that the average age of the clients decreased while many of them were not motivated. Relating to NPS use some organisations mentioned the need to reshape the therapeutic programmes: some units recommended shorter therapy and new programme elements (e.g. 'positive experience therapy').

#### Therapeutic programme and other services

Among the therapeutic approaches the categories defined by the EMCDDA were used as follows: 'therapeutic community model', '12 step or Minnesota model', 'psychotherapy', 'other, not classified approach' among which more than one could be selected in the questionnaire. Out of the 15 respondents 13 organizations reported the 'therapeutic community model' as the dominant approach, 5 reported on the cognitive behavioural therapy or other psychotherapy model and 3 mentioned the '12 step or Minnesota model'. One unit did not consider any model dominant out of the above three.

Chart 37. *Therapeutic approach applied by the organisations (N=15)*



Source: Péterfi et al. 2016

Planned duration of the therapeutic programme ranged from 5 to 24 months. The average duration planned was 12,5 months among the 15 units. In general, 3 units planned a 6-month or shorter programme, 5 units planned for more than 12 months. Most organizations (7 units) planned the duration of the treatment to be between 7-12 months.<sup>54</sup>

There was a waiting list in 10 units out of the 15 reporting with an average of 3.4 persons waiting at the time of the survey. In these institutions clients were waiting for 1.3 months on average before entering rehabilitation treatment starting from the preparatory interview.

There was no participation fee in 8 institutions, 5 units reported of a fee for the treatment programme that is not obligatory.<sup>55</sup> One organisation stated that the participation fee is determined as a certain percentage of the income, 2 stated an exact amount of around 25 and 30 EUR and in one case the fee was around 380 EUR per month.<sup>56</sup> One institution provides opportunity for the patients to work for income above subsistence while the inpatient programme lasts..

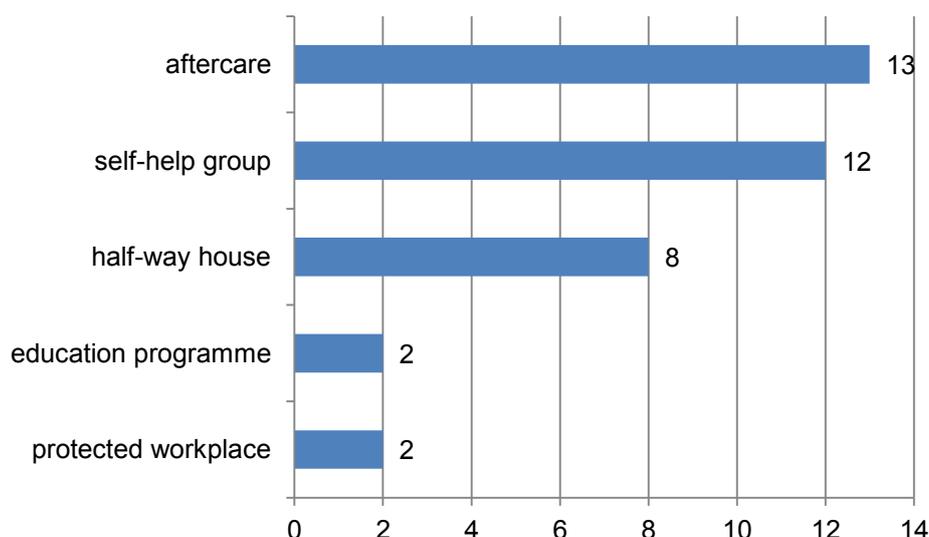
14 organisations mentioned some reintegration programmes operated by themselves or their parent institutions targeting/aimed at clients leaving the inpatient treatment form. 'Aftercare' was reported most frequently (13 units) ahead of 'self-help groups' (12 units) and 'half-way house' (8). 'Protected workplace' and 'education programme' were both mentioned two times as reintegration services available after quitting.

<sup>54</sup> In the case of two service providers juvenile clients were referred to the institution as juridical obligation instead of applying voluntarily. In the special case of child care institutions the duration of the stay is also affected by legal regulations and the decision of the authorities. The service might be terminated by the end of the obliged care time, by reaching the age of 18 years or based on the decision of the 'child protection legal committee'. (Act XXXI. of 1997)

<sup>55</sup> Out of the 13 units for which this information was available.

<sup>56</sup> The prices were calculated using the EUR intermediate exchange rate valid for 2015 (EUR 1=HUF 309.69).

Chart 38. *Reintegration programmes (N=15)*



Source: Péterfi et al. 2016

Regarding cooperation with other service types, in 2014 clients were referred to long-term rehabilitation treatment by low threshold service providers as well as specialised (by both types: specialised for alcohol and drug use treatment) outpatient treatment service providers, inpatient- and general medical service providers and social care services.

#### Treatment and health services during the therapeutic programme

Regarding the services in the framework of quasi-compulsory treatment (QCT) 4 units provided 'preliminary status assessment', 12 provided 'treatment for drug addiction', 3 provided 'treatment for other conditions with drug use' and 2 provided 'preventive consulting service'.<sup>57</sup>

Opioid substitution treatment was not allowed in 13 units out of the 15. 1 unit allowed detoxification programmes shorter than 6 months, 1 unit allowed participation in a longer maintenance programme beyond the detoxification.

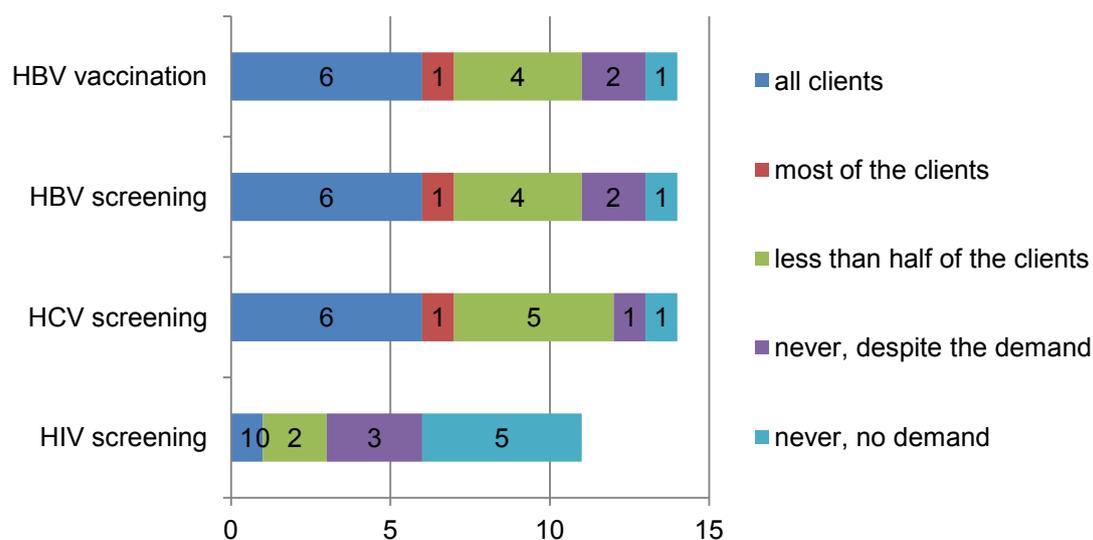
Participation in drug-assisted psychiatric treatment was not possible in 6 units, in 9 units this option was also available.

At least one of the four medical services of HIV, hepatitis C and hepatitis B screening and immunisation for hepatitis B was available in 2014 in the 14 responding institutions.<sup>58</sup> Clients participated in HIV screening in 11 units, in HCV screening in 12 units, in HBV screening in 11 units and they could obtain HBV vaccination in 3 units. Regarding HIV and HCV screening there were one-one institution respectively where the services were not provided despite the demand, 2 units stated that about HBV screening and 3 stated that about HBV vaccination. 10 service providers provided opportunity for hepatitis antiviral treatment in cooperation with an external organisation, which was actually used in 6 units. In 5 units there was no hepatitis antiviral treatment available, although being HCV positive was not an exclusion criterion in any of the organisations.

<sup>57</sup> 13 service providers gave information about QCT provided by them.

<sup>58</sup> One service provider did not operate in 2014.

Chart 39. Utilisation of DRID medical services, 2014 (number of units)



Source: Péterfi et al. 2016

## T5. NOTES AND QUERIES

### T5.1 MISUSE OF OPIOID SUBSTITUTION MEDICATIONS

Misuse of opioid substitution drugs (in Hungary methadone and buprenorphine/naloxone) can be detected among clients entering treatment. Systematic data collection about that however does not exist in Hungary.

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

Specialised online treatment programme is not available in Hungary.

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

Specialised treatment programmes for NPS users are not available in Hungary.

## 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.

Péterfi A., Major M., Dunay M. (2016): Treatment facility survey in the therapeutic communities 2015. Nemzeti Drog Fókuszpont. Unpublished thesis.

Topolánszky, Á., Felvinczi, K., Paksi, B., Arnold, P. (2009): A magyarországi drogterápiás intézetek működése és értékelése című kutatás elsődleges eredményei. „Addiktológia a változó kihívások korában”. MAT VII. Országos Kongresszusa. 2009. november 19-21. Siófok. Supplementum kötet, pp. 75.

## **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 treatment types available, the capacities, the operation circumstances of the treatment units, the institutional links and the main characteristics of the treated population. The service providers included in the study were those reporting the 30 largest numbers of cases in 2014 in the TDI data collection. 28 of the 30 service providers completed the online questionnaire, which was based on the questions of the European Facility Survey Questionnaire developed by the EMCDDA.

*Treatment facility survey in the therapeutic communities 2015:* The Hungarian National Focal Point conducted a study among the therapeutic communities in Hungary (Péterfi et al 2016). The questionnaire was based on the items and methodology of the European Facility Survey Questionnaire developed by the EMCDDA. The EFSQ was implemented and tailored to the Hungarian features and the target group. The 40-item online tool was self-administered, managers of the therapeutic communities were asked to participate. The aim of the study was to map the institutional characteristics of the therapeutic communities. After the administrative information questions on the institutional aspects (characteristics of the parent institution, capacity of the therapeutic institution), the target group (number of clients and their characteristics, inclusion criteria), staff, quality assurance and service provision (therapeutic programme, parallel health services, waiting lists, cooperations, changes of target group) were included. Some of the questions covered the entire previous year (2014), others referred to the day of the completion of the questionnaire.

*TDI data collection 2016:* 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 2016:* 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 REDUCTION<sup>59</sup>

### T0. SUMMARY

In 2015 25 overdose deaths directly related to illicit drug use and 40 deaths indirectly related to drug use were reported to the mortality special register. In about 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, cocaine or a designer stimulant.

During the national HIV/HBV/HCV seroprevalence survey carried out among injecting drug users (IDU) in 2015 one person tested positive for HIV (0.2%). The HBV prevalence was 2.2%, while HCV prevalence resulted to be 49.7%. In 2015 among current IDUs injecting in the past 4 weeks, injectors of new psychoactive substances (NPS) formed the largest group. Among them HCV prevalence was 78.7%.

In 2015, the impact of the closure of the two largest needle/syringe programs (NSP) in the second half of 2014 could be measured. The number of distributed syringes decreased by 59% (to 188,696 syringes), while the number of used syringes returned by the clients or collected dropped by 49% (to 150,565 items). The number of clients decreased by 23% (to 3436 persons), while the number of contacts by 41% (to 24,368 occasions). 28 syringes were distributed per IDU in the year in question.

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

In the case of drug related infectious diseases, during the national HIV/HBV/HCV seroprevalence survey being carried out since 2006, in 2014 persons infected with HIV were found for the first time among the tested IDUs (2 persons, 0.3%). In 2015 one person tested positive for HIV (0.2%). The national 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. In 2015 a similar proportion, 49.7% of the national sample tested positive for HCV. Before NPS became so widespread, HCV prevalence was usually significantly higher among those injecting opioids. This then changed: in 2011 a higher HCV prevalence rate was found among those primarily injecting stimulants (amphetamine or designer stimulants), while the national prevalence rate had not changed yet. In 2014 HCV prevalence doubled both among opioid and stimulant injectors. In 2015 HCV prevalence broken down by primary injected substance was similar to the prevalence values measured in 2014. Trend analysis should be carried out carefully due to the change in testing sites during the 2015 survey. (see: T.1.3.6).

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

---

<sup>59</sup> Authors of the chapter: Gergely Csaba Horváth, Anna Tarján

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. The decrease measured in 2015 regarding syringe and client/contact turnover demonstrates the impact of the closure of the two largest NSPs in the second half of 2014.

This year all current, available data and information is presented as part of the national profile in T1.

## T1. NATIONAL PROFILE

### T1.1 DRUG-RELATED DEATHS

#### T1.1.1 Overdose deaths

##### *Direct drug-related death cases*

In 2015 25 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 (2014:23; 2013:31; 2012: 24; 2011:14, 2010:17 cases)<sup>60</sup>. Of the 25 deaths, in 4 cases the deceased was female. (ST5\_2015\_HU\_02 'SR')

There was clear evidence of intention to commit suicide in one case in 2015.

Table 13. *Breakdown of direct drug-related deaths in 2015 by gender and substance type (persons)*

	male	female	total
intoxication caused by opioids and other substances <sup>61</sup>	7	1	8
overdose/intoxication caused by methadone (without other drugs) <sup>62</sup>	3	1	4
intoxication caused by other, non-opioid drugs	9	1	10
intoxication caused by other substances <sup>63</sup>	2	1	3
total	21	4	25

Source: OAC 2016a

Among cases of fatal overdose, the mean age of the males was 34 years and of the females it was 29.5 years, and together 33.2 years. Mean age of deaths linked to opioids and methadone was 34.8 years.

The most deaths, 10 cases (40%), belonged to the 30-34 age group, a further 8 cases (32%) belonged to the 35-39 and 3 cases to the 40-44 age group, overall more than three-quarters of the cases were over 30 years of age (84%).

<sup>60</sup> The cases linked to tramadol were excluded.

<sup>61</sup> Beside opioid metabolites (morphine) other substances may also occur, including methadone also, but cases linked exclusively to methadone were excluded.

<sup>62</sup> Beside the occurrence of alcohol and/or benzodiazepines.

<sup>63</sup> With the exclusion of psychoactive substances and medicinal products not classed as illicit drugs.

Table 14. Breakdown of direct drug-related deaths by age group and substance type in 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	2	6	0	0	0	0	8
overdose/intoxication caused by methadone	0	0	1	2	0	1	0	0	0	4
intoxication caused by other, non-opioid drugs	0	1	1	4	2	2	0	0	0	10
intoxication caused by other substances	0	1	0	2	0	0	0	0	0	3
total	0	2	2	10	8	3	0	0	0	25

Source: OAC 2016a

Of the 25 deaths 10 (40%) – including three female deaths – happened in Budapest, one case took place in a county seat, one in a small town, and six happened in villages. In four cases the deceased were homeless people, in two cases the deceased people were foreign citizens, citizens of an EU Member State (the Netherlands).

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

#### *Indirect drug-related deaths*

In 2015 40 indirect drug-related death cases were reported to the mortality special register. Among the deceased, 37 were male and 3 were female.

Among the cases, 9 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 11 suicides. Violent death occurred in 20 cases (murder, accident or self-harm where intent could not be determined).

#### *Toxicology of overdose deaths*

There was no death exclusively related to heroin use in 2015 either. The polydrug use of an opioid and other illicit drug was fatal in 8 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 four cases, benzodiazepine was also found to be present beside the metabolite of methadone in all these cases.

There were ten cases of death caused by other, non-opioid illicit drugs. In five cases amphetamine was found to be present beside other drugs. The use of GHB/GBL was the cause in three drug-related deaths, cocaine was present in one case and in two cases antipsychotics were to be found in the biological samples. New psychoactive substances that

are under legal control are classified under the category of 'non-opiate drugs', of which the followings were identified:  $\alpha$ -PVP, 3-MMC, pentedrone, 4F-PEP, TH-PVP,  $\alpha$ -PVT.

Three cases fall under the category of 'other drugs', that cover new psychoactive substances that were not under legal control at the time of the death, in all the three cases  $\alpha$ -PHP could be identified among other substances in the biological samples.

There were blood alcohol tests taken in 24 out of the 25 cases, nine were found positive. Track of injecting were found in nine cases by the forensic pathologists.

Table 15. Number of direct drug-related deaths in 2015<sup>64</sup>

	<b>total</b>
overdose/intoxication caused by opioids (without methadone and other substances)	0
overdose/intoxication caused by opioids and other substances	8
overdose/intoxication caused by methadone <sup>65</sup>	4
intoxication caused by other, non-opioid drugs	10
intoxication caused by other substances	3
<b>total</b>	<b>25</b>

Source: OAC 2016a

## **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**

In 2015 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 nearly 60% of the registered HIV positive persons. Among the HIV-positive cases and AIDS patients belonging to the identified risk groups, two Hungarian citizens belonged to the risk group of injecting drug users (IDU). (Csohán et al. 2016).

<sup>64</sup> Special register Selection D.

<sup>65</sup> Beside the occurrence of alcohol and/or benzodiazepines.

Table 16. Breakdown of registered HIV-positive persons (N) by risk group between 2011-2015

	2011	2012	2013	2014	2015
homo/bisexual	106	146	160	171	133
heterosexual	18	23	24	28	21
haemophiliac	0	0	0	0	0
transfusion cases	2*	1*	0	0	0
IDU	0	0	1*	1	2
nosocomial	0	0	0	0	0
perinatal	0	1	1	1	2
unknown	36	48	54	70	113
total	162	219	240	271	271

\* Imported cases

Source: National Centre for Epidemiology (Csohán et al. 2016)

In 2015 43 cases of acute hepatitis B were reported, the incidence rate was 0.4‰. The transmission route was known in the case of 12 patients among whom one male between the ages of 25-34 belonged to the risk group of IDUs.

In 2015 19 cases of acute hepatitis C were reported, the incidence rate was 0.2‰. Among the 19 patients, the transmission route was known in 6 cases among whom a female under 25, two males under 25 and one male between the ages of 25 and 34 became infected via injecting drug use. (Csohán et al. 2016)

#### HIV/HBV/HCV prevalence among IDUs

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

#### HIV

On the basis of the HIV/HBV/HCV seroprevalence survey in 2015, 1 male out of the 596 persons tested HIV-positive (0.2%), he belonged to the 25-34 age group. He had last injected within the past 4 weeks prior to the survey and reported 'penta crystal' as his primarily injected substance. (ST9P2\_2016\_HU\_01)

#### HBV

During the national HIV/HBV/HCV prevalence survey conducted in 2015, 13 persons (2.2%) tested positive for the hepatitis B surface antigen among 596 tested IDUs. 12 of the 13 HBV positive persons were also HCV antibody positive at the same time, while in case of one person the HCV result was inconclusive. (ST9P2\_2016\_HU\_02)

#### HCV

The laboratory tests for HCV gave a conclusive result in 559 cases (see Chapter T1.6.2). Among them 278 persons tested positive for hepatitis C antibodies (49.7%) (ST9P2\_2016\_HU\_03). Among current IDUs injecting in the past 4 weeks prior to the survey (365 IDUs), 60.3% tested positive for hepatitis C antibodies.

The difference between the prevalence rates of HCV infection among males and females (52.0% and 42.5%) was not significant. The HCV prevalence rates of males in the 25-34 age

group and above the age of 34 were in excess of the average prevalence rate. Apart from this it is important to mention that the HCV prevalence of young male IDUs below the age of 25 was over 39%.

Table 17. Breakdown of HCV prevalence among IDUs tested during the national HIV/HBV/HCV seroprevalence survey, by gender and age group in 2015

age group	gender	number of IDUs tested (N)	number of HCV positive IDUs (N)	proportion of HCV positive IDUs (%)
< 25 years	male	59	23	39.0
	female	12	3	25.0
25-34 years	male	156	89	57.1
	female	59	29	49.2
> 34 years	male	210	109	51.9
	female	63	25	39.7

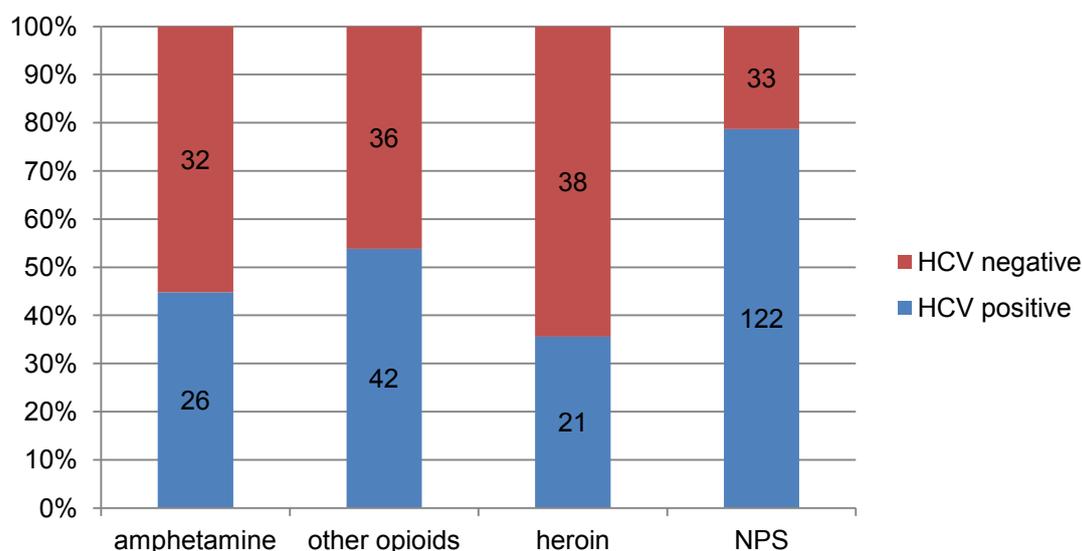
Source: Dudás et al. 2015

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

HCV prevalence rate among those primarily injecting non-opioids<sup>66</sup> was 56.8%, while it was 39.5% among IDUs injecting primarily opioids. (ST9P2\_2016\_HU\_03)

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 (78.7%). 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 40. Breakdown of HCV prevalence among current IDUs tested during the national HIV/HBV/HCV seroprevalence survey by primarily injected drug in 2015



Source: Dudás et al. 2015, analysed by HNFP

As regards geographic distribution, 193 of the 349 samples from Budapest proved to be hepatitis C positive, which means a 55.3% rate of infection (ST9P2\_2016\_HU\_04). As

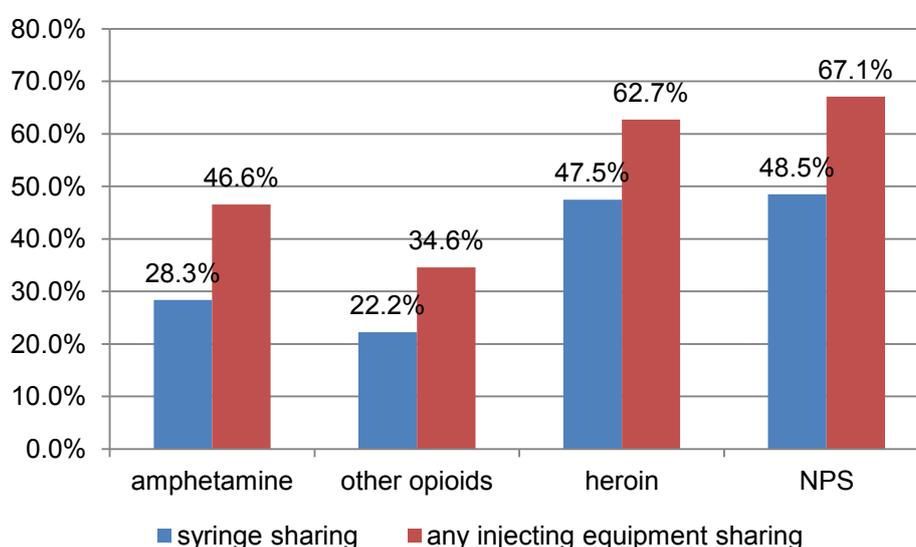
<sup>66</sup> non opioids: new psychoactive substances ('penta crystal'; MDPV; mefedron, 'bio'; other designer drug; 'music'), metamphetamine, amphetamine, MDMA, cocaine, other.

opposed to this, 40.5% of the samples coming from outside Budapest were tested hepatitis C positive (85 of the 210 samples) (ST9P2\_2016\_HU\_05). Outside of Budapest the highest HCV prevalence rates were measured in Kecskemét (72.7%) and Pécs (66.7%).

### T1.3.4 Drug-related infectious diseases – behavioural data

According to the results of the HIV/HBV/HCV seroprevalence survey, 38.9% 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 55.7%. If equipment sharing is examined broken down by primary injected substances, it can be said that the prevalence rates are the highest among NPS injectors, which in their case is also coupled with high HCV prevalence.(ST9P3\_2016\_HU\_01)

Chart 41. The prevalence of sharing needles/syringes and sharing any injecting equipment in the past 4 weeks (%) among current IDUs participating in the national HIV/HBV/HCV seroprevalence survey<sup>67</sup> in 2015



Source: Dudás et al. 2015, analysed by HNFP

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

Table 18. 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/HBV/HCV seroprevalence survey by primary injected substance, in 2015

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

Source: Dudás et al. 2015, analysed by HNFP

<sup>67</sup> Number of respondents in the case of syringe sharing (N): NPS=163; other opioids=81; heroin=59; amphetamine=60. Number of respondents in the case of equipment sharing (N): NPS=164; other opioids=81; heroin=59; amphetamine=58

53.8% of current IDUs admitted to inject every day (injecting once or several times a day). 85.1% of current IDUs injected with a sterile syringe on the last occasion, 58.6% obtained 15 or more sterile syringes for personal use in the past 4 weeks.<sup>68</sup>

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

Excluding those who self-reported being HCV-positive from the analysis, there were 465 valid responses relating HCV testing uptake. 162 (34.8%) 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, 158 persons stated that they had been last tested for HCV in 2014 or 2015, which figure represents 37.6% of those giving valid responses. (ST9P3\_2016\_HU\_01)

6.4% (22 persons) of IDUs having had a sexual intercourse in the past 4 weeks had provided sex for money or drugs or other benefits in the past 4 weeks. 76.3% (267 persons) of IDUs having had a sexual intercourse in the past 4 weeks had not used a condom during the last sexual intercourse. (ST9P3\_2016\_HU\_01)

Of those participating in the survey, 2% (12 persons) was born outside of Hungary. 35.3% of the respondents had lived in a homeless shelter or on the streets without a stable address for more than 1 week during the past year. Nearly every second IDU (48.4%) had been imprisoned at some time in their lives. (ST9P3\_2016\_HU\_01)

### **T1.3.6 Additional information on drug-related infectious diseases**

The two largest NSPs in Budapest (Kék Pont Alapítvány; Drogprevenziós Alapítvány) closed in the second half of 2014 were also the testing sites providing the largest samples during the national HIV/HBV/HCV prevalence survey series by 2014. While Kék Pont Alapítvány had tested nearly 80 IDUs per survey year at its NSP site in district 8 by 2014, its DTC site in district 9 only undertook 29 tests in 2015. This is important to consider, as the highest HCV prevalence by testing site had always been measured in the NSP clientele of Kék Pont Alapítvány (in 2014: 89%). The Drogprevenziós Alapítvány could reopen its low threshold service at a new location in the same district (13.) but could not operate NSP, thus presumably in 2015 they could test a clientele with a different composition compared to previous years. The Art Éra Alapítvány – still operating NSP in 2015 – undertook 40 less tests in 2015. The rest of the tests assigned to Budapest was re-distributed among the remaining organizations located in the capital, also a new low threshold service provider located in district 8, called Józán Babák Klub (profile, see T.1.6.1) was invited to the 2015 survey. The recruitment criteria of survey participants (having ever injected) did not change compared to previous years (see T.6.2). Comparability of 2015 data to previous years has limitation due to the changes in service profiles, and consequently in client profiles, and to changes in the number of tests offered by each service provider located in Budapest.

---

<sup>68</sup> When interpreting the data it is important to take into consideration that the study was carried out in outpatient DTCs or NSPs, thus it involved IDUs who were covered by treatment or harm reduction services.

Table 19. The number of IDUs participating in Budapest in the national HIV/HBV/HCV seroprevalence survey by testing site, 2014-2015

testing site	sample size 2014 (N; %)		service profile 2014	sample size 2015 (N; %)		service profile 2015
Art Éra Alapítvány	49	14%	NSP	10	3%	NSP
Baptista Szeretetszolgálat	33	10%	NSP	67	18%	NSP
Drog Prevenációs Alapítvány	88	26%	NSP/DTC/OST	129	35%	LTS/DTC/OST
Józan Babák	0	0%	LTS	10	3%	LTS
Kék Pont Alapítvány	77	23%	NSP ( district 8)	29	8%	DTC (district 9)
Nyirő Gyula Kórház	19	6%	DTC/OST	34	9%	DTC/OST
MÖSZ (Soroksár)	50	15%	DTC/OST	49	13%	DTC/OST
Válaszút Misszió	24	7%	NSP	40	11%	NSP
Total	340	100%		368	100%	

Source: Dudás et al. 2014 and Dudás et al. 2015, analysed by: HNFP

## T1.4 OTHER DRUG-RELATED HEALTH HARMS

### T1.4.1 Other drug-related health harms

#### *Driving accidents*

In 2015, in the case of 155 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 155 samples the institute determined positivity for illicit drugs and/or NPS in 96 cases.

Table 20. 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 2015

Active substance	Number of cases
3-MMC	1
3-MMC + 5F-AMB-PINACA + amphetamine + CMC + MDMA + THC	1
3-MMC + pentedrone	1
AB-CHMINACA	1
AB-CHMINACA + alfa-PVP + CMC	1
AB-FUBINACA + AB-PINACA + ADB-PINACA + AMB-FUBINACA	1
ADB-FUBINACA	1
ADB-FUBINACA + alfa-PVP + THC	1
ADB-FUBINACA + amphetamine	1
ADB-FUBINACA + amphetamine + THC	1
ADB-PINACA	1
alfa-PHP	1
alfa-PVP	3
alfa-PVP + pentedrone	1
amphetamine	22
amphetamine + alfa-PHP	1
amphetamine + alfa-PVP	1
amphetamine + CMC	1
amphetamine + CMC + THC	1

amphetamine + kokain	1
amphetamine + pentedrone	1
amphetamine + THC	6
CMC	1
ketamine	4
ketamine + THC	1
cocaine	4
cocaine + GHB	1
cocaine + THC	1
MDMB-CHMICA	1
MDMB-CHMICA + metoxifenidine	1
metamphetamine	1
morphine + THC	1
pentedrone	6
THC	24
<i>negative</i>	59
<b>Total</b>	<b>155</b>

Source: National Institute for Toxicology

### *Pregnancies and children born to drug users*

In Budapest in 2015, 59 drug user women participated in the low threshold service of the Józán Babák Klub (Oberth et al. 2016) who were pregnant in the year in question, or had had a miscarriage/abortion, or who had given birth between 2013 and 2015. Amphetamine was reported as a primary substance by 18 persons, heroin by 6 persons and 'penta crystal' by 9. A further 6 persons primarily consumed herbal cannabis, while 4 persons mentioned alcohol and prescription drug abuse, 7 persons prescription drugs, 4 person synthetic cannabinoids, 3 persons alcohol and 2 persons cocaine as their primarily used substance type. 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.

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

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

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

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

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

Table 21. *Collaboration of NSPs with other service providers (N) – outside of their parent institutions – by the type of service provider, in 2014, (N of respondents =29)*

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

Source: Tarján 2015

With respect to service providers, the organisations outside of their parent institutions most frequently referred their clients to therapeutic communities (25 organisations), psychiatry/addiction units (24 organisations), self-help groups (23 organisations), homeless shelters (22 organisations) or outpatient DTCs (21 organisations).<sup>69</sup>

### *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 funding<sup>70</sup> 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 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). In 2015 new applications were not called, financing was provided to the organizations accepted in 2012. 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 2015, the EMMI provided one-off support on three occasions amounting to EUR 58,123<sup>71</sup> for purchasing syringes (732,400 syringes). According to reports from the organisations (Tarján 2016b) the large majority (47%) of the syringes (297,993) acquired in 2015 were covered by the EMMI one-off support, while 42% was purchased from ministerial/local governmental grants. The organisations obtained 6% of the syringes from donations. Only 3% of the syringes were acquired from the fixed funding support.

Volunteers are often employed by harm reduction services in the recreational setting (Tarján 2016a), the organisations providing data employed a total of 80 paid employees and 278 volunteers in their services in 2015.

---

<sup>69</sup> During the analysis the number of organisations indicating the categories 'occasionally', 'frequently' and 'very frequently' were merged in case of each service type.

<sup>70</sup> 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).

<sup>71</sup> The prices in the table were calculated using the EUR intermediate exchange rate valid for 2015 (1€=309,69 Ft).

### T1.5.3 Harm reduction services

#### *Prevention of drug-related death and emergencies*

##### Harm reduction in the recreational setting

In 2015 a total of 23 organisations operated: 13 at city-level, 3 at micro-regional level, 3 at county level, 1 at regional level and 3 at national level (Tarján 2016a). In 2015, 1 new organisation (Magyar Máltai Szeretetszolgálat Egyesület) started operating in Győr at city level, while in Debrecen the Magyar Ökumenikus Segélyszervezet intermitted its services for 2015 and in Nyíregyháza the Adelante Alapítvány stopped running its harm reduction service in the recreational setting.

In 2015 the organisations cooperated with a total of 86 clubs/party organizers and took part in 583 events. They had contact with a total of 83,877 persons. The mean number of contacts per event was 143 (66 in 2014). The items most typically provided by the organisations were water, condoms, leaflets, glucose tablets and effervescent tablets. Distribution of earplugs, sterile syringe and snorting tubes were mentioned in the 'other' category.

Table 22. *Types of harm reduction equipment distributed by harm reduction services in the recreational setting (N of responding organisations=23)*

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

*Source: Tarján 2016a*

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

For information on opioid substitution treatment see the Treatment Workbook, Chapters T1.4.8-9 and T2.

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

#### *Prevention of drug-related infectious diseases*

##### Needle/syringe programmes (NSP)

In 2015 there was no new call for applications, therefore financing was provided to the same organizations who were accepted for the 3 year long period of 2012-2014 in 2012. In 2015 30 service providers operated NSPs in 21 cities, which covered 14 counties and all the 7 regions (Tarján 2016b) (17.HU\_ST10\_2016). 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 NSP in district 8 in August and the Drogrevenenciós Alapítvány stopped its service in district 13 in November.

In 2015 the Alternatíva Alapítvány launched its street outreach and mobile programme in district 8. The Drogprevenációs Alapítvány could reopen at a new location in the same district, however, they cannot distribute sterile syringes but other sterile injecting equipment, and they also collect discarded syringes as part of their street outreach programme. Partly to compensate the termination of services of the Kék Pont Alapítvány a ministerial one-off support was devoted to the Baptista Szeretetszolgálat who started to operate a new mobile programme at the Népliget. Outside of Budapest, in Miskolc the Baptista Szeretetszolgálat terminated its services in 2015.

In 2015 26 fixed location NSPs operated in the country, 13 organisations performed street outreach work, 3 organisations operated a mobile NSP, and in 4 cities IDUs could purchase syringes from syringe vending machines.

9 organisations operated two types of programmes, this in most of the cases was street outreach attached to a fixed location NSP. Three service providers operated three different programme types, and 18 service providers only had one type of NSP service.

In 2015 NSPs distributed a total of 188,696 sterile syringes, the number of returned and collected syringes was 150,565.<sup>72</sup> The exchange rate was 80%. Some NSPs outside Budapest reported that syringe purchasing in pharmacies was probably increasing as more syringes were returned to their programmes than what they distributed. Also the exchange criteria<sup>73</sup> of the Baptista Szeretetszolgálat having the highest syringe turnover in 2015 could contribute to high exchange rate in 2015. In 2015 3436 IDUs<sup>74</sup> used NSP services on a total of 24,368 occasions. 1530 new clients<sup>75</sup> were registered by the programmes in the course of the year. On average 54 syringes were distributed and 44 returned per client, the mean number of contacts per client was 7 in the year in question. (ST10\_2016\_HU\_01)

According to the breakdown by programme types number of syringes distributed and collected and number of clients were nearly equal between fixed location and mobile NSPs.

Table 23. Syringe and client turnover data of NSPs in 2015

	fixed location	mobile NSP	street outreach	syringe vending machine	total
distributed	73432	96114	16063	3087	188696
returned (+collected)	54581	82034	13377	573	150565
exchange rate	74%	85%	83%	19%	80%
number of clients	1580	1384	472	0	3436
number of new clients	656	807	67	0	1530
number of contacts	13297	8095	2976	0	24368
number of NSPs*	26	3	13	4	30

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

Source: Tarján 2016b

On examining geographical distribution, NSPs located in Budapest had the decisive proportion of both the number of distributed/returned and collected syringes and the number of clients/contacts in 2015 as well (the rates varied between 79-85% in respect of the individual indicators).

<sup>72</sup> Including syringes obtained from syringe vending machines and disposed in the special waste containers placed near the vending machines.

<sup>73</sup> The client receives 3 sterile syringes for 0-2 returned. If the client returns 3 or more syringes than he/she receives exchange on a 1 by 1 basis. A maximum of 20 syringes can be obtained at one contact.

<sup>74</sup> 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.

<sup>75</sup> 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.

Beside sterile syringes, most NSPs provided counselling on safe injecting (24 out of 28 reporting organisations). The majority of NSPs provided 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 provided sterile injecting equipment in pre-assembled packages. In 2015 NSPs reported for the first time on availability of NPS injecting related targeted counselling: 22 organizations provided this specific counselling, while 5 NSPs also provided written material on this topic (Tarján 2016b).

#### **T1.5.4 Contextual information on routine harm reduction monitoring**

In 2015 the number of distributed syringes per IDU was 28, which means a significant decrease compared to previous years (2014: 81; 2013: 76; 2012: 74). It is important to note that a new IDU population size estimate for 2015 was carried out (for data and methodology see: Drugs Workbook/Stimulants, Chapter T1.2.1), on which the 2015 coverage estimate was based. Until 2014 the coverage was estimated based on the population size estimate carried out in 2010 (see: 2010 National Report, Chapter 4.1).

Monitoring syringe purchasing in pharmacies is not part of the routine national monitoring system (See: T.6.2), which can also influence the number of distributed syringes per IDU. Some NSPs outside Budapest reported for 2015 that syringe purchasing in pharmacies was probably increasing as more syringes were returned to their programmes than what they distributed (NFP 2016). According to results from the HIV/HBV/HCV seroprevalence survey in 2015, 67% (258 persons) (in 2014: 58,7%) of current IDUs (385) purchased syringes in pharmacies in the past 4 weeks.

For further contextual information see Chapter T2.1.

#### **T1.5.5 Additional information on harm reduction activities**

The Public Health Division of the Ministry of Human Capacities provides an annual EUR 48,436 support for HIV prevention. In 2015 the total amount of the funding was given to Anonim AIDS Tanácsadó Szolgálat in order to carry out HIV counselling and testing for people belonging to high risk groups (MSM; IDU; sex workers). The supporting period started in 2015 November.

In 2015 September HIV/AIDS counselling training was organized by the National Centre for Epidemiology financed by the Public Health Division of the Ministry of Human Capacities (EUR 7750). 68 professionals participated in the training: 13 persons from sexual health clinics, 11 persons from public health services of county government offices, 18 persons from healthcare service providers, 11 persons from NSPs, 8 persons from the National Centre for Epidemiology or from the National Public Health and Medical Officer Service, and 7 persons from the Anonim AIDS Tanácsadó Szolgálat. (EMMI 2016)

HA-REACT project, a Joint Action on HIV and co-infection prevention and harm reduction was launched in 2014 with a mission to fulfil targets set by policies of the European Union. Purpose of the Joint action is to improve capacity to respond to HIV and co-infection risks to overdose and provide harm reduction with specific focus on people who inject drugs (PWID) and other related risk groups (PWID in and out of prison settings; PWID who are sex workers; pregnant injecting drug user women and their children; Sexual partners of PWID; MSM who are drug users). Contracting was realized in 2015 October, the project lasts 3 years. Hungary was nominated as a target country of the project along with Latvia and Lithuania. The National Public Health and Medical Officer Service participates in the following work packages: *Increased harm reduction and improved continuity of care for PWID in prison settings; Developing a suitable model of integrated treatment for PWID;*

*National programmes updated to overcome barriers to respond to HIV, TB and HCV-related needs of PWID in the EU. While the National Centre for Epidemiology participates in the work package Improved early diagnosis of HIV, viral hepatitis and TB, as well as improved linkage to care for PWID.*

Alternatíva Alapítvány – operating mobile and street outreach NSP in district 8 of Budapest – realized its HIV/STI project between March 2015 and April 2016 funded by the Norway Grants. In the framework of the project 600 HCV (oral fluid) and 600 HIV and syphilis tests (capillary blood) were taken primarily among IDUs. A risk-behaviour questionnaire was recorded attached to the serological result, tested IDUs also received pre and post-test counselling. 6 other NSPs also joined the project covering 4 other cities apart from Budapest. Results of the survey will be presented in the 2017 NR (Alternatíva Alapítvány 2015).

For the methodology of the national HIV/HBV/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 low threshold programme of the Józán Babák Klub located in district 8 entitled 'Alternative Prenatal and Family Care' see: 2012 National Report, chapter 7.4. This programme provides services for residents of the district 8 and surroundings. While the organization's crisis telephone hotline service helps those drug using pregnant women or drug using mothers and their children who live in Hungary but seeks help in Budapest. In 2015 a total of 59 persons were enrolled in the programme (Oberth et al. 2016) (for drug use patterns of clients see: T1.4.1). Of these, 19 drug user women visited the programme while 40 women contacted the programme by telephone or via the Internet. In the scope of a follow-up in 2015, 16 former female clients took part in the programme, they had got involved in the work of the organisation before 2013. The majority of those participating took part in or were referred to higher threshold, non-anonymous healthcare and social services.

In 2014 the Józán 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. As part of the cooperation the Józán Babák Klub held trainings for child health visitors in 2015 in 5 five cities outside of Budapest.

The Drogprevenció Alapítvány located in Budapest as part of its OST programme established the „academy of special parents” in 2014, while in 2015 launched the MENYA group and MENYA consulting hours for OST clients who are mothers (6 persons participated in it). In the framework of this programme they help their pregnant or mother clients with individual case management, psychiatric control, and referral between other institutions. The

organization also formed a MEPA group for OST clients who are fathers but with less thematic elements (5 persons participated in it).<sup>76</sup>

## **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 TÁMOP<sup>77</sup> 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

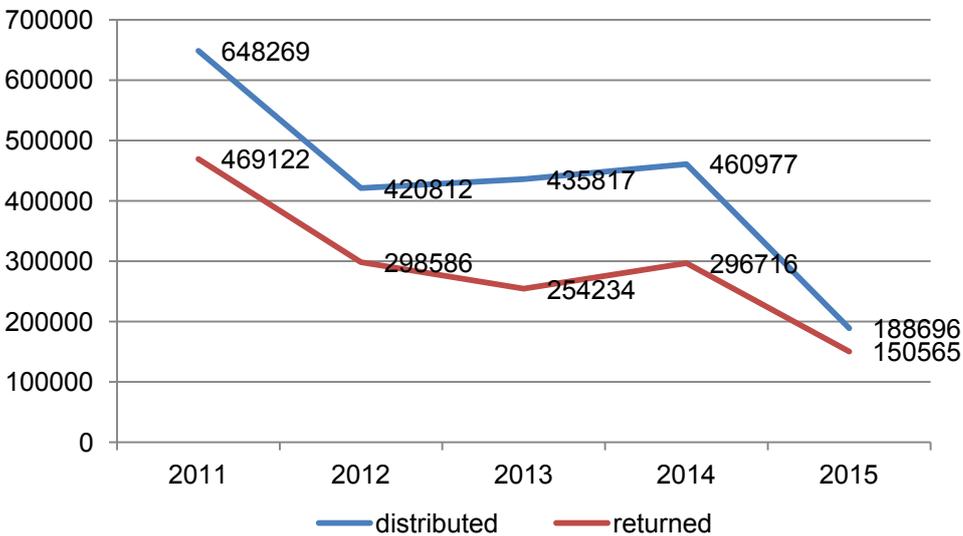
---

<sup>76</sup> Personal communication with the manager of the Drogprevenció Alapítvány.

<sup>77</sup> Social Renewal Operative Programme

drugs (see: Drugs Workbook/Stimulants, Chapter T1.2.1.). The rising trend lasting until 2011 was broken in 2012 by the reduction of the resources available for low threshold services when a new three-year-long funding period started (see: Chapter T1.5.2). Then, as compared to the previous year, about 220,000 less syringes were distributed by NSPs. In order to be able to maintain the services, NSPs with the highest turnover limited the number of syringes that could be distributed per contact, and in certain cases reduced their opening hours. Some programmes had to either temporarily or completely shut down their operation. In 2013 and then in 2014 the number of syringes distributed rose slightly, which is primarily the consequence of the one-off grants provided by EMMI (see: Chapter T.1.5.2), however, the number had still not reached the 2011 level and probably still did not satisfy the current syringe needs of 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 – were reused by the clients or were shared (HNFP 2015). The closure of the two largest NSPs in the second half of 2014 (see: T1.5.3) caused a significant decrease in the number of distributed (59%) and returned syringes (49%).

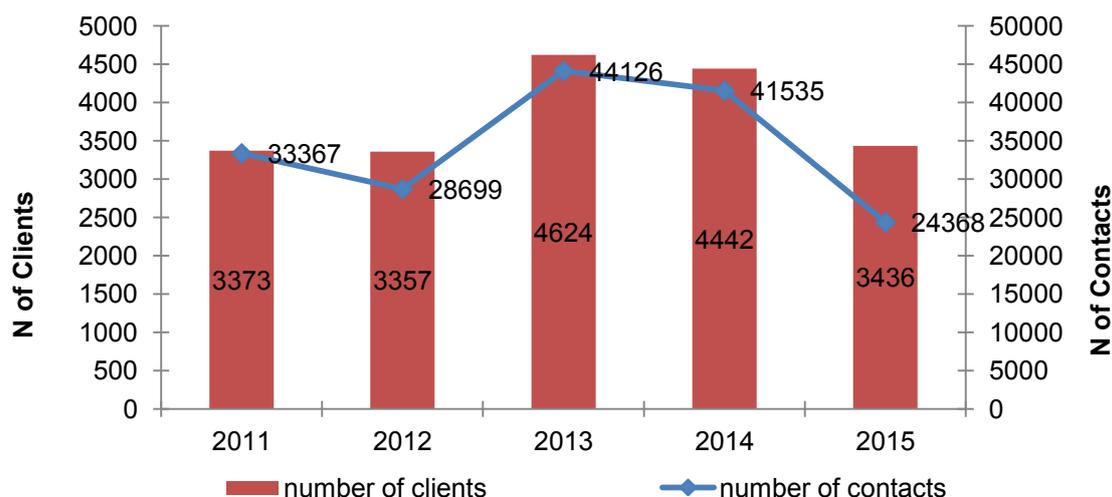
Chart 42. The syringe turnover data of NSPs, between 2011-2015



Source: Tarján 2016b

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. As a result of the closures the number of clients dropped by 23% while the number of contacts dropped by 41% in 2015.

Chart 43. Number of NSP clients and number of contacts, between 2011-2015



Source: Tarján 2016b

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 2014. While in the past, in the case of the individual indicators, the share of Budapest was 86-89%, in 2015 it was only 79-85%. According to the trend data by geographical breakdown, it can be concluded that while in the previous years only the data from Budapest followed the national decreasing tendency, in 2015 data in and outside of Budapest follow the national declining trend in each indicator.

According to the breakdown by programme type number of syringes distributed and collected and number of clients were nearly equal between fixed location and mobile NSPs in 2015, while in previous years number of distributed syringes and number of clients in fixed location NSPs had always been significantly higher compared to other programme types.

## 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 2015, 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, pentedrone and 4-MEC that could be associated with a number of deaths. Occasionally, the appearance of certain, especially dangerous new psychoactive substances was linked to several deaths: in 2012 the use of 5-API, and in 2013 the use of 4,4'-dimethylaminorex (4,4'-DMAR) caused the death of several persons. In 2014 no especially dangerous NPS appeared that could have caused the deaths of several people, typically  $\alpha$ -PVP and synthetic cannabinoids were detected.

In 2015, beside pentedrone and  $\alpha$ -PVP,  $\alpha$ -PHP could be detected in some cases in the biological samples, synthetic cannabinoids were not present. Role in the cause of death of

new psychoactive substances could not be clearly determined due to polydrug use and the limited pharmacological knowledge, however.

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 overall rising tendency of all cases turned downward and considered to be stable in 2014 and 2015 due to the low number of deaths linked to new psychoactive substances.

Table 24. Breakdown of direct drug-related deaths, between 2009-2015 (persons)

	2009	2010	2011	2012	2013	2014	2015
intoxication caused by illicit opioids <sup>78</sup>	28	12	6	8	3	10	8
overdoses/intoxication caused by methadone (without other drugs) <sup>79</sup>	2	2	4	5	9	2	4
intoxication caused by other, non-opioids	1	3	3	7	15	4	10
intoxication caused by other substances	0	0	1	4	4	7	3
<b>total</b>	<b>31</b>	<b>17</b>	<b>14</b>	<b>24</b>	<b>31</b>	<b>23</b>	<b>25</b>

Source: OAC 2016a

b) Prevalence and notification of infections:

i) HIV prevalence among IDUs

During the national HIV/HBV/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%), while in 2015 one person tested positive (0.2%). The HIV positive person – on the basis of the anonym individual identification code – is one of two positive cases identified in 2014.

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/HBV/HCV seroprevalence survey data, before 2011 the proportion of opioid injectors was higher in the sample than that of stimulant injectors (see: Drugs Workbook/Heroin and other opioids, chapter T1.2.1.), 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 were primarily opioid injectors while two thirds of them were primarily stimulant injectors (see also: Drugs Workbook/Stimulants,

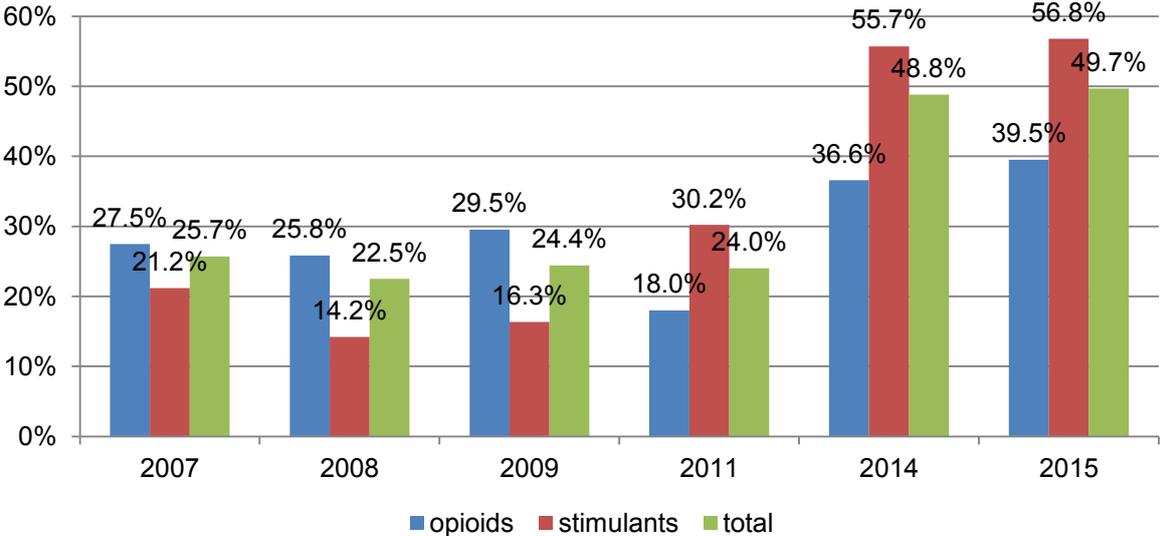
<sup>78</sup> Beside opioid metabolite (morphine) other substances may also occur, including methadone, but cases exclusively linked to methadone were excluded.

<sup>79</sup> Beside the occurrence of alcohol and/or benzodiazepines

Chapter T1.2.1.). With respect to HCV infection, it can be said that HCV prevalence doubled both among opioid injectors and stimulant injectors, and also if the total sample is considered. Beside the steep increase in NPS injecting, which substances are injected more frequently thus sharing and reusing injecting equipment is also more prevalent, another important factor of the significant increase of the HCV prevalence rates in 2014 could be the limited availability of NSP services taking place since 2012 in parallel with the phenomenon of NPS injecting (see: Chapter T2.1 d).

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

Chart 44. Breakdown of HCV prevalence (%) of IDUs participating in the national HIV/HBV/HCV prevalence survey by primarily injected drug, between 2007-2015



Source: Dudás et al. 2015, analysed by: HNFP

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

**T3. NEW DEVELOPMENTS**

This year all current, available data and information, including data relating to 2015, 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, 5 in 2015) 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'-DMAR,  $\alpha$ -PVP,  $\alpha$ -PHP), 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 2015.

## **T6. SOURCES AND METHODOLOGY**

### **T6.1 SOURCES**

Csák R., Gyarmathy V.A., Miletics M. (2011): Módszertani levél a túcsere programokat megvalósító szolgáltatók számára. NCSSZI

Csohán, Á., Krisztalovics, K., Molnár, Zs., Fehér, Á., Dudás, M., Bognár, Zs., Fogarassy, E., Mezei, E., Kaszás, K., Kozma, E. (2016): Magyarország járványügyi helyzete 2015. OEK

Dudás, M., Rusvai, E., Győri, Z., Tarján, A., Tresó, B., Horváth, G., Minárovits, J., Csohán, Á. (2015): A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HBV, HCV) 2015. évi prevalenciájának vizsgálata. OEK. Manuscript Submitted for Publication.

EMMI (Emberi Erőforrások Minisztériuma) (2016b): Az EMMI Egészségpolitikai Főosztályának és Népegészségügyi Főosztályának beszámolója

HNFP (2016): Túcsere szolgáltatók országos találkozója. Nemzeti Drog Fókuszpont.

OAC (2016a): TDI adatgyűjtés halálozási modul: Kábítószer-fogyasztással összefüggő halálozási adatok 2014.

Oberth J., Bíró Zs., Mándi B. (2016): Beszámoló a Józan Babák Klub 2015. évi várandósgondozási tevékenységéről

Tarján, A (2016a): A rekreációs szintéren ártalomcsökkentő/prevenációs tevékenységet végző szervezetek 2015. évi működési és forgalmi adatai. Nemzeti Drog Fókuszpont.

Tarján, A (2016b): Túcsere programok adatai, 2015. Kézirat. Nemzeti Drog Fókuszpont.

Tarján, A (2015): Tűcserék az ellátórendszerben 2014-ben. Nemzeti Drog Fókuszpont.

## T6.2 METHODOLOGY

*Drug-related death (National Centre for Addictions OAC 2016a):* 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. 2016):* 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/HBV/HCV seroprevalence survey among IDUs (Dudás et al. 2015) (ST9\_2016\_HU\_01):* Between April and September 2015 the National Centre for Epidemiology repeated the HIV/HBV/HCV national seroprevalence survey among IDUs. The study was financed by the State Secretariat for Healthcare. This was the seventh survey in the series since 2006 applying consequently the same methodology throughout the years.

In 2015 19 organisations were involved: three NSPs, three DTCs, one LTS and one DTC with LTS in Budapest while outside of Budapest six NSPs, three DTCs and two DTCs also operating NSPs took part in the study. Those persons were recruited in the study who had ever injected illicit drugs/new psychoactive substances. Apart from the testing for HIV/HCV, socio-demographic characteristics, injecting patterns and risk behaviours were also recorded. The questionnaire was based on the EMCDDA DRID guidelines, and on parts 2 and 3 of Standard Table 9. 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 between 2006-2014, however this had to be modified in 2015 due to the closure of the two largest testing sites in 2014 (see: T.1.3.6.). 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 596 persons were analysed. Inconclusive test results were excluded from the analysis (37 samples in the case of HCV; 0 in the case of HIV; 0 in the case of HBV).

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

*Needle/syringe programme (NSP) data collection (Tarján 2016b):* In 2016 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 2015):* The Hungarian National Focal Point carried out an online survey in May-June 2015 among all NSPs, during which their institutional affiliation, their integration in the treatment/care system, position on the treatment chain, and their institutional connections were examined. 29 online questionnaires were completed, which represents 100% coverage.

*Data collection on harm reduction services in the recreational setting (Tarján 2016a):* The Hungarian National Focal Point has been collecting the operational and turnover data of organisations performing harm reduction services in the recreational setting since 2007, with the help of a structured questionnaire, which has been filled in online since 2015. Of the 23 service providers contacted, 23 completed the questionnaire.

# DRUG MARKET AND CRIME<sup>80</sup>

## T0. SUMMARY

The characteristics of drug law offences are monitored on the basis of the data recorded, when investigations are completed, in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS).

In Hungary the number of registered drug offences committed in a year is between 5-6000, the largest proportion of which are related to cannabis (2015: 49.8%) while a smaller proportion to stimulants (2015: 27.3%). (Supply) offences related to new psychoactive substances (NPS) have involved criminal liability since 2012, and from this point onwards they have been the subject of perpetrations in a constantly increasing proportion. The large majority of drug related offences are consumption-related, the proportion of supply related offences tends to remain below 20%.

The Hungarian Institute for Forensic Sciences (BSZKI) performed the analysis of substances suspected of being illicit drugs in Hungary. A detailed picture of the Hungarian drug market can be obtained by analysing the seizure data and the police reports.

Data on substances analysed preliminarily by the Forensic Institute of the National Tax and Customs Administration (formerly: Hungarian Customs and Finance Guard) but 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 number<sup>81</sup>. The larger plantations (1400-1500 plants) are usually maintained by groups of foreign perpetrators. In 2015 during the procedures launched due to the 127 discovered cannabis cultivation sites requiring a forensic chemical analysis, a total of 4659 plants were seized. Approximately 4% of the discovered plantations involved more than 100 plants.

The production of synthetic substances in Hungary is typical in small scales. In the course of 2015, two illegal laboratories were 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.

---

<sup>80</sup> Authors of the chapter: Tamás Csesztregi, Ágnes Port, Orsolya Varga

<sup>81</sup> 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.

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 and untreated herbal materials. In some cases the amount of the untreated herbal material was several kilograms. The seizures point to an impregnation activity being carried out in Hungary. 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 (ORFK 2015), herbal cannabis is typically smuggled from the Czech Republic to the territory of Hungary by Vietnamese organised crime groups and by Hungarian offenders from the Netherlands. The better quality 'skunk' cannabis, mainly destined for the Western European market, comes from Albania. The herbal cannabis originating from the Czech Republic is frequently smuggled in cars, while it comes in larger quantities (250-400 kg) from Albania hidden in trucks.

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

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

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

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

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 through Hungary.

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. (ORFK 2015)

### **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 2015 no large scale drug-precursor seizure took place in Hungary.

With respect to the most characteristic diluents and adulterants, on five occasions the authorities seized a caffeine-paracetamol mixture (47.6 kg), along with heroin. The largest amount was seized in a case where 5.9 kg heroin and 46.1 kg diluents were found together. No other significant drug dilution related seizure was made in Hungary.

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

During its exploratory activities the investigating authority collects information on the wholesale prices characteristic on the market. According to expert estimates based on the data obtained the average prices are as follows: cannabis: EUR 3,750 /kg, heroin: EUR 18,000 /kg, cocaine: EUR 28,000 /kg, amphetamine: EUR 4,500 /kg. (ORFK 2016)

#### **T1.1.5 Retail drug market**

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*

In November 2015 the Hungarian National Focal Point carried out a survey with the aim of investigating the online availability of synthetic cannabinoids and designer stimulants and monitoring the current trends on the online market of new psychoactive substances (Dunay and Port 2015, for methodology see T6.2). According to the findings of the survey the number of such websites decreased: the present survey identified 38 active sites as opposed to the 54 websites identified via the last EMCDDA online snapshot survey in 2013 (Port 2013).

For the purposes of the study 3 categories of legal highs were distinguished: synthetic cannabinoids, designer stimulants and psychedelic plants. The substances sold most commonly were plant materials treated with synthetic cannabinoids which were available in 35 online shops (92%). Psychedelic plants were sold on 4 sites (10.5%), designer stimulants (tablets or powder) were available in 17 shops (45%). The sites selling synthetic cannabinoids typically offered their products as some type of 'herbal mix': 25 sites sold these as incense, but the names 'potpourri', 'bio weed', 'herbal mix' and in one case 'room freshener' were also used. Synthetic cannabinoids in powder form were sold on 15 sites (39%) (in 3 cases as plant salts, in one case as crystal, in two cases as herbal powder and in nine cases as 'cannabinoid powder'.) There was no precise information on the components

of the materials sold as 'crystal' either - these most probably contained some kind of designer stimulant as the active substance. The name used most frequently was 'amber crystal': this was used by 5 (42%) out of the 16 sites selling crystals, another 3 sites used the name 'penta'. Tablets (or 'legal pills') were sold by 10 sites (26%) under different fantasy names, without any reference to the components or effects. Among psychedelic plants the most commonly available were damiana and kratom (sold by 3 sites). Salvia was available in one shop only. In the 3 shops selling damiana and kratom, other ethnobotanical products were also offered such as wild dagga, leonorus sibiricus, marshmallow leaf, Mexican morning glory (Ipomoea), kanna, catuaba, khat etc.

All but two of the identified web pages were accessible in Hungarian (one site also had a Romanian and one other an English interface besides the Hungarian one). Purchase could be done in two steps on most of the sites: orders could be issued by establishing e-mail (or occasionally telephone or sms) contact with the site operator and then paying afterwards for courier or postal delivery. Only 4 of the identified sites operated as a classic webshop where the transaction could be completed in one visit.<sup>82</sup> Most of the sites could be contacted via e-mail (34 pages), 18 through telephone and one site had an active Facebook profile.

Almost none of the sites had information on the origin of the sold products. There was one site that mentioned that the product had come from abroad and another which marked China and India as the source of supply.

Regarding warnings about the products, 34 from the 38 sites (89%) indicated that their service was available only for adults. It was also frequently mentioned that the products were not suitable for human or animal consumption (28 sites, 74%). There were 9 sites (24%) which did not write about the legal status of the substances sold, the remaining 29 sites advertised their products as legal. Among the legal information in some cases a detailed description of data protection rules was also provided (on 4 sites).

24 sites had some information on the mode of use, but this usually served only to strengthen the apparent status of legality: they drew attention to the fact that the substances are intended for decoration, gardening or technical purposes and 12 herbal incense selling sites provided an almost identical instruction on how to use the incense sold. There were 4 sites which did not give any instructions regarding the proper use of the substances (apart from the name applied), and 10 sites only noted that the products are unsuitable for human consumption. One site gave detailed guidance on how to prepare herbal incense using cannabinoid powder.

Only a few of the sites provided any information on the potential effects of the substances and only the site selling kratom and salvia had a thorough description (together with real instructions for use). 4 other sites drew attention to the sedative or stimulant effect of the incense offered and one to the duration of the effects. There was one site which as a side effect referred to a stupor lasting for approximately two hours.

Compared to the previous online snapshot surveys (Péterfi and Port 2011, Port 2012, Port 2013) (for details see the 2011 National Report Chapter 10.1, and the 2012 and 2013 National Reports Chapter 10.2), there were no significant changes in the proposed use (incense/air freshener, plant salt, gardening), and the warnings and legal information provided on the sites. Regarding the origin of the substances sold the number of those sites which indicated the source country decreased from 2011 to 2015 (in 2011 4 sites out of 19 provided this information while in 2015 only 1 out of 38). The prices of the substances are hard to compare due to the different methodology used in 2011. In 2011 the price of JWH-018 applied on plant materials was monitored for which the average price was 7.62 EUR/g<sup>83</sup> when ordering a small quantity and 3.46 EUR/g upon a 100 g order. Comparing this with the prices of herbal incenses in the 2015 survey (3.95 EUR/g and 1.56 EUR/g depending on the

---

<sup>82</sup> There were four other such sites where payment was only possible in a second step but it could be done by bank transfer, in two cases via PayPal and in one case through Western Union or using bitcoins.

<sup>83</sup> Prices were calculated using the EUR intermediate exchange rate valid for 2015 (EUR 1=HUF 309.69).

quantity), a significant, almost 50% decline is indicated which is in line with the findings of the annual data collection on the street level prices of drugs (Varga 2015).

### *Street prices*

As compared to previous years, the Hungarian National Focal Point performed a survey among clients of outpatient drug treatment centres regarding the street level prices of drugs at the beginning of 2016 (Varga 2016, for the methodology see: T.6.2). (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/herbal for example) when last purchased.

Table 25. Price of drugs at street level in 2015 in HUF

<b>substance</b>	<b>lowest</b>	<b>highest</b>	<b>mode</b>	<b>mean</b>	<b>number of respondents</b>
herbal cannabis (g)	1000	5000	2500	2455	123
cannabis resin (g)	1000	5000	2500	2590	60
heroin (g)	3000	25000	5000	12385	24
heroin (packet)	3000	6000	5000	4263	20
cocaine (g)	10000	30000	20000	19379	56
amphetamine (g)	1000	5000	3000	2942	84
ecstasy (tablet)	500	4000	2000	1745	70
methamphetamine (g)	1500	5000	2000	2929	18
LSD (dose)	1000	10000	2500	3000	42
methadone (20 mg)	500	6000	1000	2435	28
methadone (5 mg)	400	3000	1000	890	20
GBL (dose)	1000	6000	2000	2800	14
mephedrone (g)	800	8000	2000	3052	23
MDPV (g)	1000	10000	3000	3674	23
pentedrone (g)	1000	10000	5000	3602	38
'Spice' (g)	200	5000	1000	1040	65

Source: Varga 2016

Table 26. Price of drugs at street level in 2015 in EUR<sup>84</sup>

substance	lowest	highest	mode	mean	number of respondents
herbal cannabis (g)	3.2	16.1	8.1	7.9	123
cannabis resin (g)	3.2	16.1	8.1	8.4	60
heroin (g)	9.7	80.7	16.1	40.0	24
heroin (packet)	9.7	19.4	16.1	13.8	20
cocaine (g)	32.3	96.9	64.6	62.6	56
amphetamine (g)	3.2	16.1	9.7	9.5	84
ecstasy (tablet)	1.6	12.9	6.5	5.6	70
methamphetamine (g)	4.8	16.1	6.5	9.5	18
LSD (dose)	3.2	32.3	8.1	9.7	42
methadone (20 mg)	1.6	19.4	3.2	7.9	28
methadone (5 mg)	1.3	9.7	3.2	2.9	20
GBL (dose)	3.2	19.4	6.5	9.0	14
mephedrone (g)	2.6	25.8	6.5	9.9	23
MDPV (g)	3.2	32.3	9.7	11.9	23
pentedrone (g)	3.2	32.3	16.1	11.6	38
'Spice' (g)	0.6	16.1	3.2	3.4	65

Source: Varga 2016

### Purity

The active substance content of the seized substances in 2015 differed from the proportions detected in the previous year on some occasions (for methodology see T6.2). (ST\_14\_HU\_01) While there was no significant change in the case of herbal cannabis, in case of cannabis resin about two-third of the samples analysed had a THC content of 5-20% but there were 0.1-1% active agent content in several cases as well. Powders containing heroin had an active substance content of 15-50%, both in smaller and in larger quantity seizures. In the case of seized cocaine, the active substance content was usually 10-80%. The active substance content of powders containing methamphetamine did not change significantly as compared to the previous year. The concentration of the seized amphetamine powders was in the range of 1-70%. Similar to the previous year 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 rose further. (ST\_15\_HU\_01) In several cases larger tablets with special shape were found with 150-200mg active substance content. The MDMA base content of tablets with a lower active substance content was generally between 40-130 milligrams. The active substance content of MDMA in crystal form was between 70-80% in most of the cases.

Regarding new psychoactive substances consumed in powder form typically sold with the name 'crystal', the purity was similar in the case of the most frequently identified active substances: the typical concentration in case of pentedrone was between 20-80%, in case of alpha-PVP 15-80%, and in case of alpha-PHP 30-85%. The active substance content of various synthetic cannabinoids applied to herbal material was typically between 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

<sup>84</sup> The prices in the table were calculated using the EUR intermediate exchange rate valid for 2015 (EUR 1=HUF 309.69).

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 6625 offences related to drugs or new psychoactive substances was closed in 2015, of these 856 cases fell under the force of the old Btk. and 5769 under the new Btk. A total of 562 (8.5%) drug related offences involved substances classified as new psychoactive substances (37 cases fell under the force of the old Btk. and 525 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 2.4% of all offences registered in Hungary.

Almost 40% of all drug offences were committed in Budapest or Pest county.

### *Substance types*

Half of the registered drug offences (52.1%, 3301 cases) were committed with cannabis, 28.7% (1811 cases) with stimulants, and 6.8% (432 cases) with new psychoactive substances.<sup>85</sup> Among stimulants, the most frequently occurring substances were amphetamine (83.4%), MDMA (ecstasy) (7.9%) and methamphetamine (5.4%). The most frequent new psychoactive substances were cathinone derivatives (33.6%), synthetic cannabinoids (22.5%) and phenethylamines (17.8%).

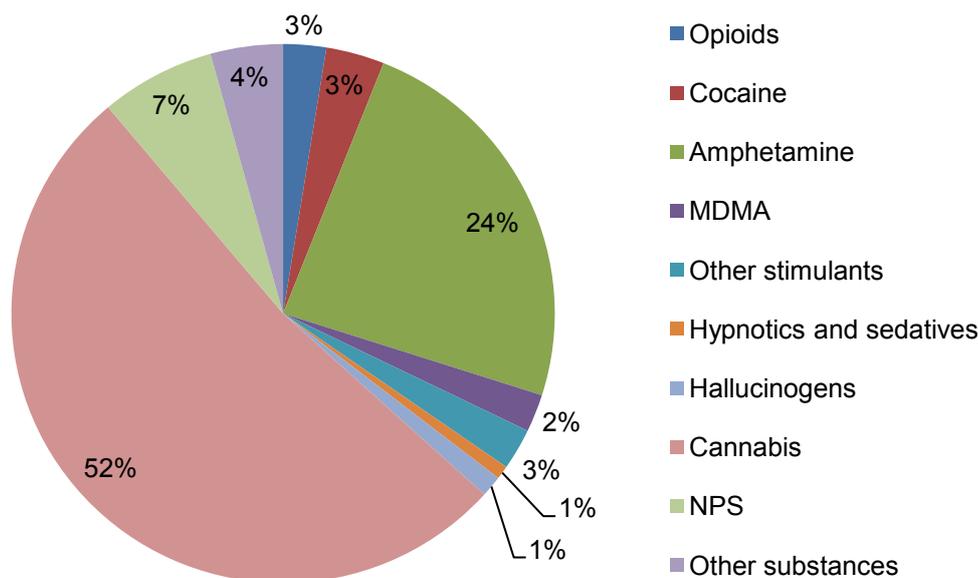
Cocaine was registered as the subject of the offence in 3.5% of the cases, opioids in 2.6% (heroin 1.1%, methadone 0.5%, morphine 0.4%), hallucinogens in 1.3% and other substances in 4.3% of cases.<sup>86</sup> (ST\_11\_2016\_HU\_01)

---

<sup>85</sup> The number of cases committed with new psychoactive substances broken down by statutory definitions of the Criminal Code and by substance types does not match. The reason for this is that the categorisation by substance type took place according to the substance categories defined by the EMCDDA DLO data collection protocol where substances not listed on the UN drug schedules were classed as new psychoactive substances, while in case of categorisation by statutory definition offences committed with substances scheduled as new psychoactive substances according to Hungarian law were classified here. The Hungarian legislation is stricter in places than international legislation and certain substances not included on the UN lists - and hence categorized as NPS according to the EMCDDA protocol - are classed as illicit drugs in Hungary. For this reason the number of offences committed with new psychoactive substances is different when totalled according to statutory definitions and when categorized by substance types.

<sup>86</sup> The substance type was not recorded in 287 cases (4.3% of all registered drug offences).

Chart 45. Breakdown of registered drug offences (N=6330)<sup>87</sup> by substance type in 2015



Source: ENYÜBS 2016, analyzed by HNFP

### Perpetrations<sup>88</sup>

Of the offences registered in 2015, 4985 offences (75.3%) were linked strictly to possession of an illicit drug (acquisition or possession for personal use). 57.2% of these cases were committed with cannabis, 31.4% with stimulants. Other types of substances appeared as the subject of use related offences in relatively low proportions (opioids 2.6%, cocaine 3.4%, NPS 1.8%). (ST\_11\_2016\_HU\_01)

Perpetrations classed as supply-related offences<sup>89</sup> made up 20.8% of registered drug offences (1378 cases). Slightly more than one third of supply related offences (36.4%, 501 cases) involved trafficking with a small quantity of drugs, offences committed with a substantial or particularly substantial quantity were recorded in only 151 cases (representing 11% of supply related offences and 2.3% of all drug offences). Cultivation or production of drugs was the type of perpetration in 137 offences (2.1%).

The large majority of trafficking related perpetrations were linked to cannabis (32.5%), 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 18.9% of cases, exceeding the proportion of offences with stimulants (17.1%). Opioids (heroin) (5.3%) and cocaine (17.2%) 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 3.5% for each). 90% of cultivation/production offences involved cannabis, stimulants made up 4.4%, opioids 2.9%, cocaine 2.4% of such cases.

Other perpetration types listed under a separate title in the Criminal Code (inciting substance abuse, aiding the production of illicit drugs) were recorded in 262 cases (4%). Nearly a third (31%) of these cases were linked to new psychoactive substances, while more than half of

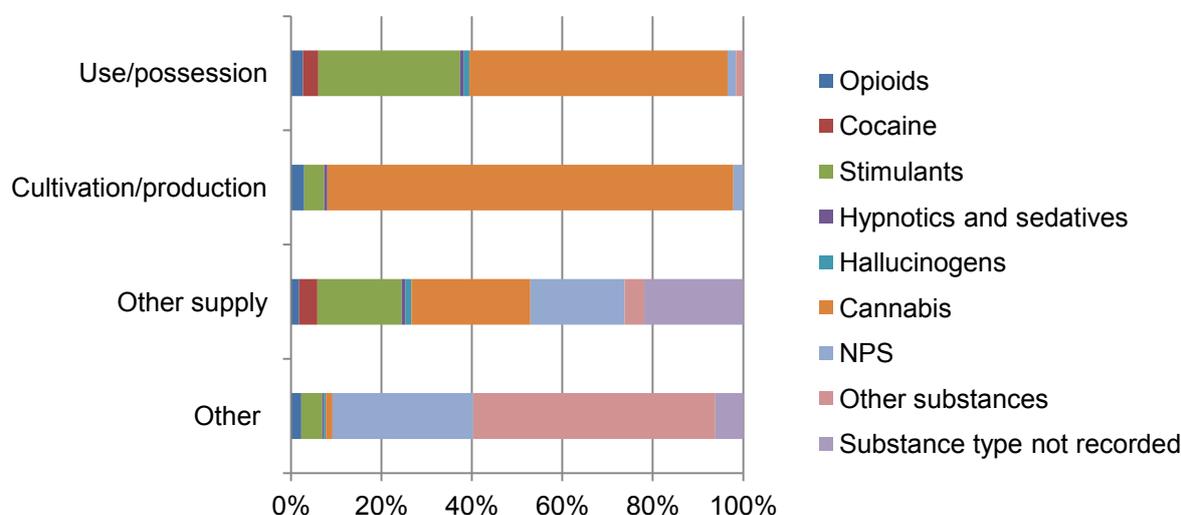
<sup>87</sup> Excluding precursors and those offences where the substance type was not recorded.

<sup>88</sup> Starting from 2014 offence types are categorized according to the EMCDDA's new drug law offences data collection protocol, which is different from the reporting structure used in previous years in several aspects.

<sup>89</sup> Trafficking related behaviours include: cultivation, production, offer, supply, distribution, dealing, import, export, transport through the country, and all offences committed with a substantial or particularly substantial quantity.

them involved offences with other, non-categorized substances or offences which could not be linked to a specific substance type. (ST\_11\_2016\_HU\_01)

Chart 46. Breakdown of registered drug offences by perpetration and substance type, 2015



Source: ENYÜBS 2016, analysed by HNFP

### Alternatives to criminal procedure

The large majority of criminal procedures<sup>90</sup> launched in drug related cases are closed before the court phase starts, as a result of the institution of quasi compulsory treatment (QCT), which may be undertaken as an alternative to punishment. (The legislative background of the alternatives to criminal procedure is described in the Legal framework Workbook, Chapter T2.1, the data of those entering treatment in the scope of QCT are presented in the Treatment Workbook, Chapter T1.3.1., while the data of prisoner clients entering QCT is reported in the Prison workbook, Chapter T1.2.2 and T1.3.2.) Only a smaller part of those participating in QCT will have a criminal record (for example, if the offender only starts QCT during the court phase of the procedure), the majority will not be registered in the criminal statistics, because when a perpetrator starts QCT the criminal proceedings are terminated and the case is not registered as an offence.

In 2015 a total of 13,439 drug-related criminal proceedings were terminated, of these formal accusation was made in just 2839 cases (21.1%). The remaining 80% of criminal proceedings were closed before the court phase due to procedural decisions suspension of investigation' (45.5%), 'rejection of complaint' (2.8%), 'other form of termination' (15.7%) or 'diversion'. The criminal proceedings were closed in relation to diversion (QCT) in 1999 cases (14.9%) but the actual number of proceedings terminated because of QCT is higher as a smaller proportion of QCT cases will be recorded among the 'other form of termination' procedural decisions, under the legal title of 'postponement of formal accusation' or 'other reason terminating culpability'.

<sup>90</sup> 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.

## *Drug law offenders*

In 2015 the criminal statistics registered 6043 offenders linked to the 6625 registered drug offences<sup>91</sup>. 90% of the offenders were males and 10% were females. Regarding distribution by age groups, 11% of drug law offenders were under 18 years, 35% of them were between 19 and 24 years, and 26% were between 25 and 30, so overall 72% of drug law offenders were younger than 30 years of age. In comparison with age distribution of all criminal offenders, drug offenders are significantly younger than other offenders: among all criminal offenders the proportion of those under 30 years of age was 44%.

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

In 2015 a total of 4801 persons committed offences under the influence of illicit drugs, which made up 4.7% of all registered offenders. The large majority of those committing offences under the influence of illicit drugs committed a drug related offence (4403 persons, 91.7%), and a total of 398 persons (8.3%) committed other types of offences.

Among the perpetrators committing non-drug related offences under the influence of illicit drugs, 201 persons (43.8%) committed traffic offences (of these 195 persons committed the offence of driving under the influence of alcohol or other substances). 62 persons (15.6%) committed offences against property, 27 persons (6.8%) committed offences against persons<sup>92</sup> (of these 4 persons committed murder, 3 persons attempted murder and 16 persons committed bodily harm), 46 persons (11.6%) disturbing the peace, and 62 persons (15.6%) other offences.

## **T1.3 DRUG SUPPLY REDUCTION ACTIVITIES**

### **T1.3.1 Drug supply reduction activities**

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

The National Security Strategy specifies in detail the challenges and adequate responses at national level arising in connection with drug trafficking. It states that the preconditions of rapid and more effective action against drug related crime are the following: increasing the effectiveness of the work performed by the police, improving the equipment used by the competent bodies and the training of personnel, as well as effective information exchange and collaboration with the competent international bodies. In the interest of this, according to the Strategy the effectiveness of the countermeasures must be increased, the bodies responsible for action against organised crime groups and the personnel, material and technical resources of forensic experts must be strengthened. Apart from the above, a national level anti-drug crime service must be set up. The fight against drugs also represents a comprehensive social task, therefore, from the point of a successful action, the use of the crime prevention possibilities are especially important.

---

<sup>91</sup> 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.

<sup>92</sup> 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.

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.

The customs activity of the National Tax and Customs Administration (NAV) includes the exploration of infringements related to substances considered as illicit drugs. With the aim of a strategic definition and management of these tasks the Anti-Drug Strategy of the NAV was published on 28<sup>th</sup> April 2015. The Strategy assigns tasks (e.g. acquisition of devices supporting exploration or identification of substances suspected to be drugs; education and trainings; analysis of seized substances; co-operation with fellow authorities) for the departments of the NAV for the period 2015-2016 in line with the aims of the National Anti-Drug Strategy. The Strategy of the NAV primarily serves supply reduction at the same time it specifies the departments of the NAV responsible for implementation of the tasks in order to achieve these aims.

## **T2. TRENDS**

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

#### *Seizures*

During 2010-2011, the authorities seized more than 10000 plants per year at large-scale cannabis plantations of more than 100 plants. This amount significantly dropped in the period 2012-2014. However, no outstanding change can be seen in the number and proportion of plantations of under 10 plants and between 10–100 plants over the period between 2010 and 2015.

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, 480 kg in 2014 and 531 kg in 2015.

The number of cannabis resin seizures rose continuously from about 40 cases in 2010 up to approximately 100 cases per year by 2013-2014 and this increase continued in 2015. The increasing trend can be observed both in case of small and large seizures.

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 significantly in 2015 either, however a growing tendency can be observed compared to the previous year.

With respect to cocaine seizures, rising trends can be identified in the number of seizures in the 2011–2015 period.

The number of amphetamine seizures – due to the trend of small seizures under 10 grams – showed a slight increase in the 2010-2015 period as well.

There were only 7 seizures of tablets containing MDMA in 2010, but the number of seizures increased continuously from 2012. During 2015 these tablets were seized in 219 cases. There were 7 larger scale seizures (1000 or more tablets) in 2015.

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\_2016\_HU\_02)

Table 27. Number of seizures between 2011-2015<sup>93</sup>

<b>type of drug</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
herbal cannabis	2073	2092	2040	2058	1945
cannabis plants	192	193	196	146	127
cannabis resin	63	103	101	101	141
heroin	22	26	32	31	48
cocaine	108	118	117	143	153
amphetamine	483	454	536	598	633
methamphetamine	33	38	50	54	62
ecstasy tablets /MDMA, MDA, MDE/	22	91	181	213	219
LSD	11	28	22	29	33
<i>plant materials with synthetic cannabinoids</i>	465	1298	2099	3876	2440
<i>synthetic cannabinoids in powder</i>	51	61	60	104	90
<i>cathinone derivatives in the form of powder</i>	595	700	855	863	802
<i>cathinone derivatives in tablets</i>	144	174	174	40	67

Source: BSZKI 2016

Table 28. Quantity seized between 2011-2015<sup>94</sup>

<b>type of drug</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
herbal cannabis (kg)	208.7	1776.7	863.4	529.23	58955
cannabis plants (plant)	14121	7382	5307	3288	2970
cannabis resin (kg)	18.2	3.1	5	7.91	18.15
heroin (kg)	3.2	2.5	5.7	70.06	11.74
cocaine (kg)	12.6	13.3	8.1	39.65	30.53
amphetamine (kg)	24.1	29.9	74.8	15.95	32.48
methamphetamine (kg)	0.1	0.06	0.2	0.41	1.17
ecstasy tablets (tablet) /MDMA, MDA, MDE/	270	12437	17664	13020	56420
LSD (dose)	274	599	342	965	398

<sup>93</sup> 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.

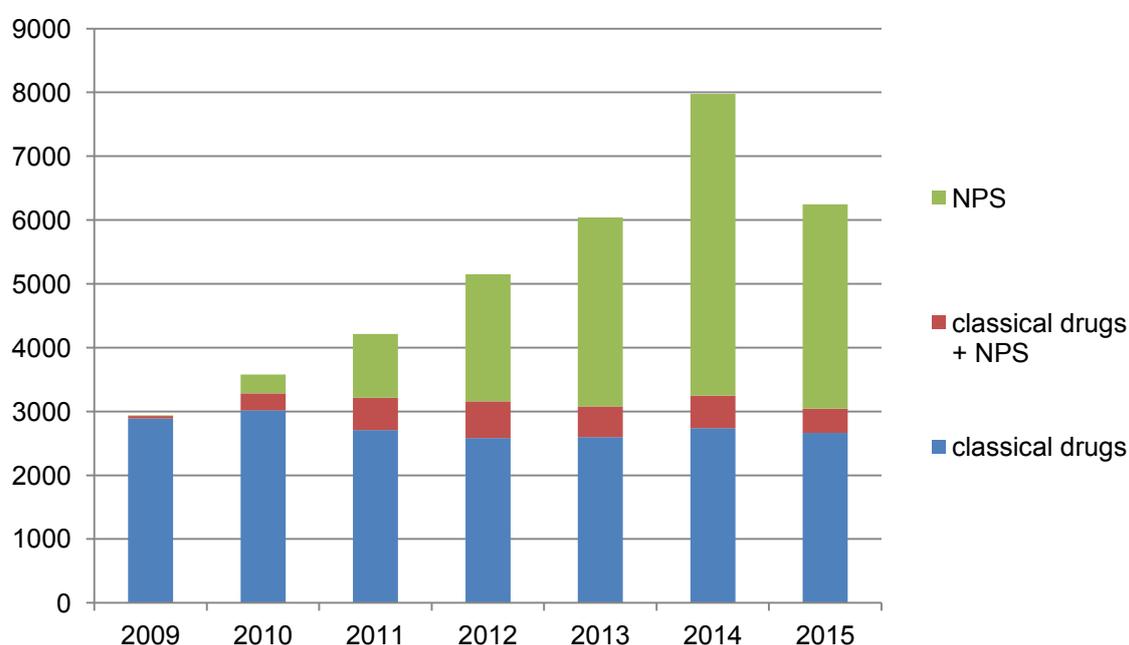
<sup>94</sup> The following table contains the data of the seizures analysed in the drug testing laboratory of the Hungarian Institute for Forensic Sciences, and the data of the cannabis plantations seized on site on the basis of the botanical examination.

<i>plant materials with synthetic cannabinoids (kg)</i>	10.2	179.2	44.5	100.01	21.18
<i>synthetic cannabinoids in powder (kg)</i>	13.2	4.3	15.5	5.52	5.55
<i>cathinone derivatives in the form of powder (kg)</i>	75.8	58.7	81.5	42.01	18.34
<i>cathinone derivatives in tablets (tablet)</i>	7951	27876	55421	12902	15578

Source: BSZKI 2016

During 2010–2014 new psychoactive substances completely restructured the Hungarian drug market (see Drugs T0.1.1 b). 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. The continuous increasing trend of seizures turned back in 2015, the seizures of new psychoactive substances fell back to the level of the classical drugs.

Chart 47. *The number of seizures of ‘classical drugs’<sup>95</sup> and NPS between 2009-2015*

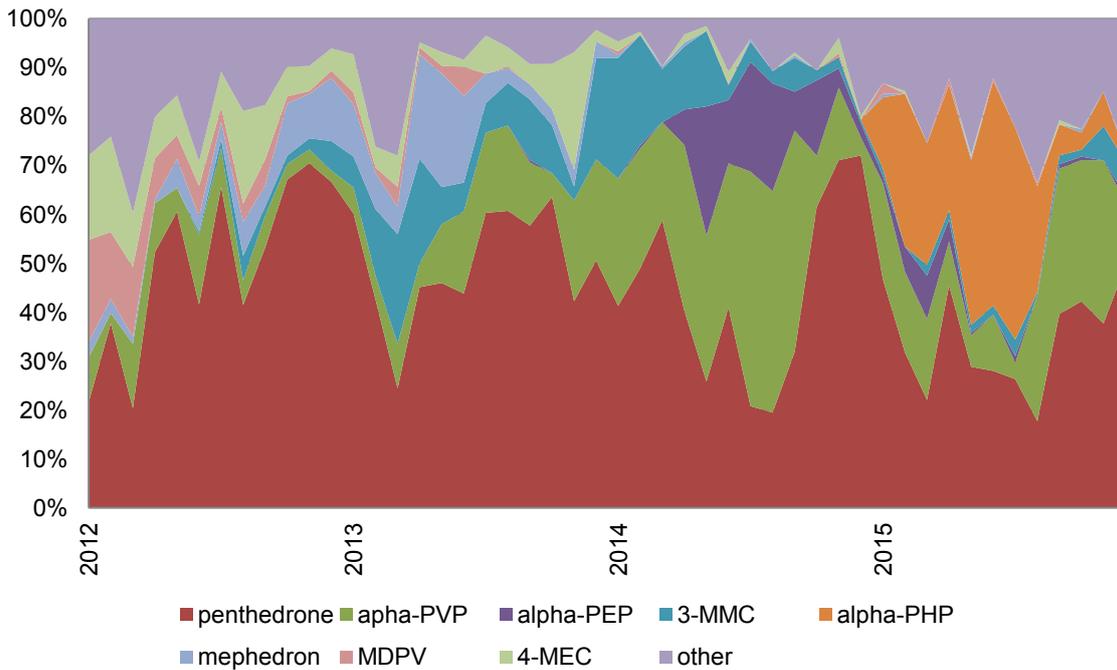


Source: BSZKI 2016

The share of two large groups of the new substances, cathinone derivatives and synthetic cannabinoids was the largest in the seizures. Cathinones are usually distributed in the form of powders. The most frequent active substances were: mephedrone in 2010, 4-MEC and MDPV in 2011, and pentedrone from 2012. During 2014 the proportion of alpha-PVP in the seizures rose significantly for a time, but by the end of the year it was pentedrone again that was the most characteristic substance. In 2015 besides pentedrone and alpha-PVP the substance called alpha-PHP appeared in seizures with a larger proportion typically in the period January-August.

Chart 48. *The frequency of occurrence (%) of cathinone derivatives (proportion of cases when the active substance was detected) in the substances, broken down by month between 2012-2015*

<sup>95</sup> Substances listed in the schedules of the UN Drug Conventions were categorised as ‘classical’.

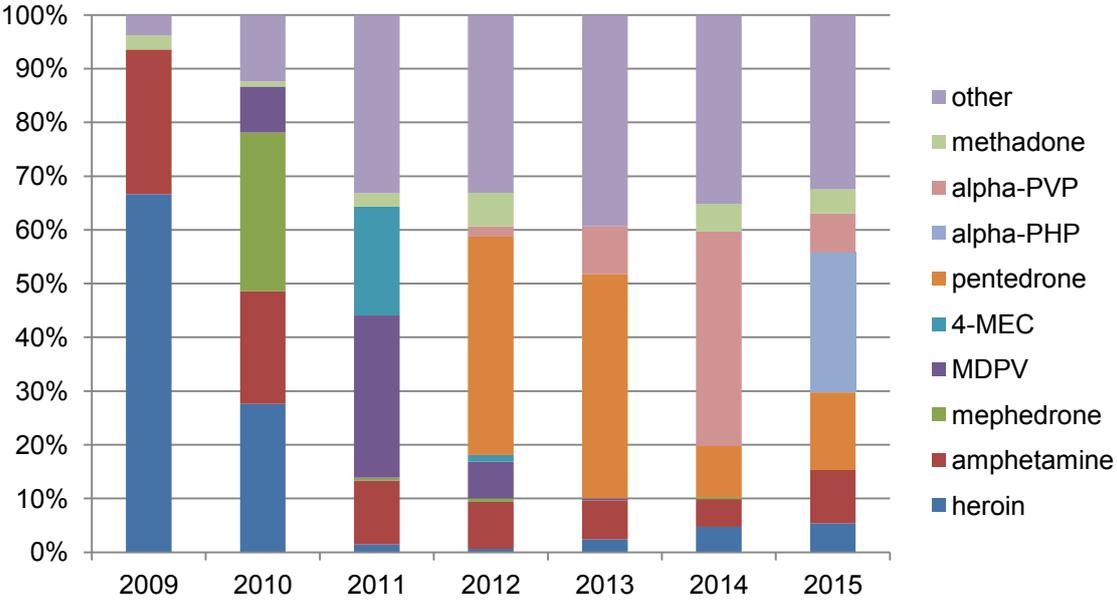


Source: BSZKI 2016

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 years continued in 2015, heroin and amphetamine, which had been dominant before 2010, were each detected in just 10 and 5% of the cases. In the majority of the cases cathinone derivatives were detected on the examined items, however, among them alpha-PHP was the most frequent: in 29 of the analysed 111 items this substance was identified. 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 in the data of clients attending needle/syringe programmes as well as in the data of those entering treatment due to drug use – see: Drugs /Stimulants, T1.2.1)

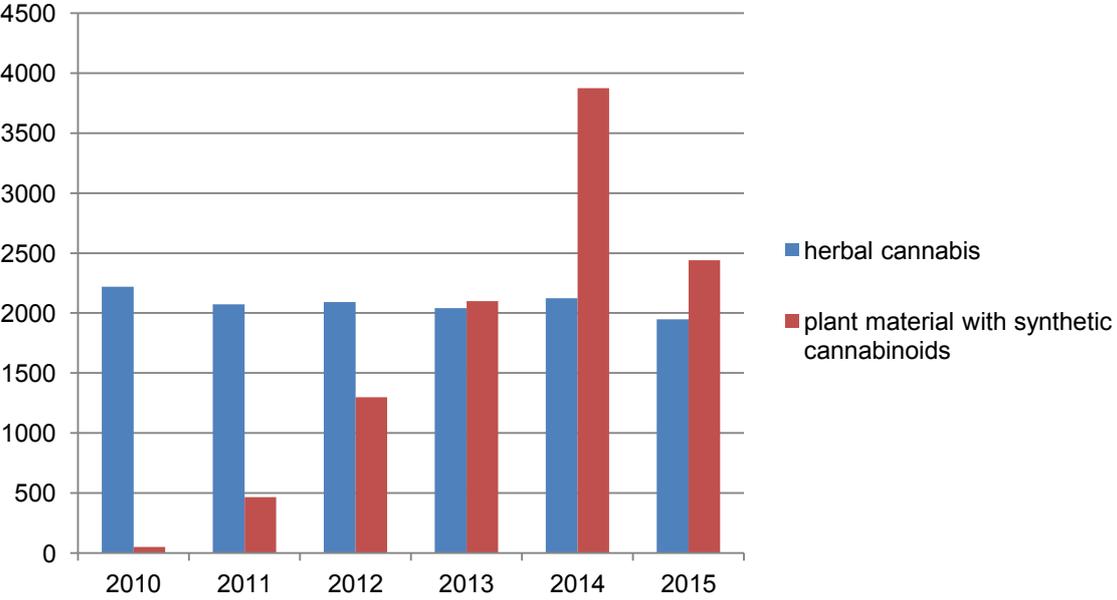
Chart 49. Prevalence of active substances (%) detected in/on injecting drug use related equipment between 2009-2015



Source: BSZKI 2016

Since autumn 2010 there has been a continuous rise in the seizures of plant material impregnated with synthetic cannabinoids. The number of seizures of the products known as 'herbal', 'bio weed' or 'sage' in 2014 was nearly double the number of seizures of herbal cannabis, however, a considerable relapse can be observed in 2015 in this case as well.

Chart 50. The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between 2010-2015

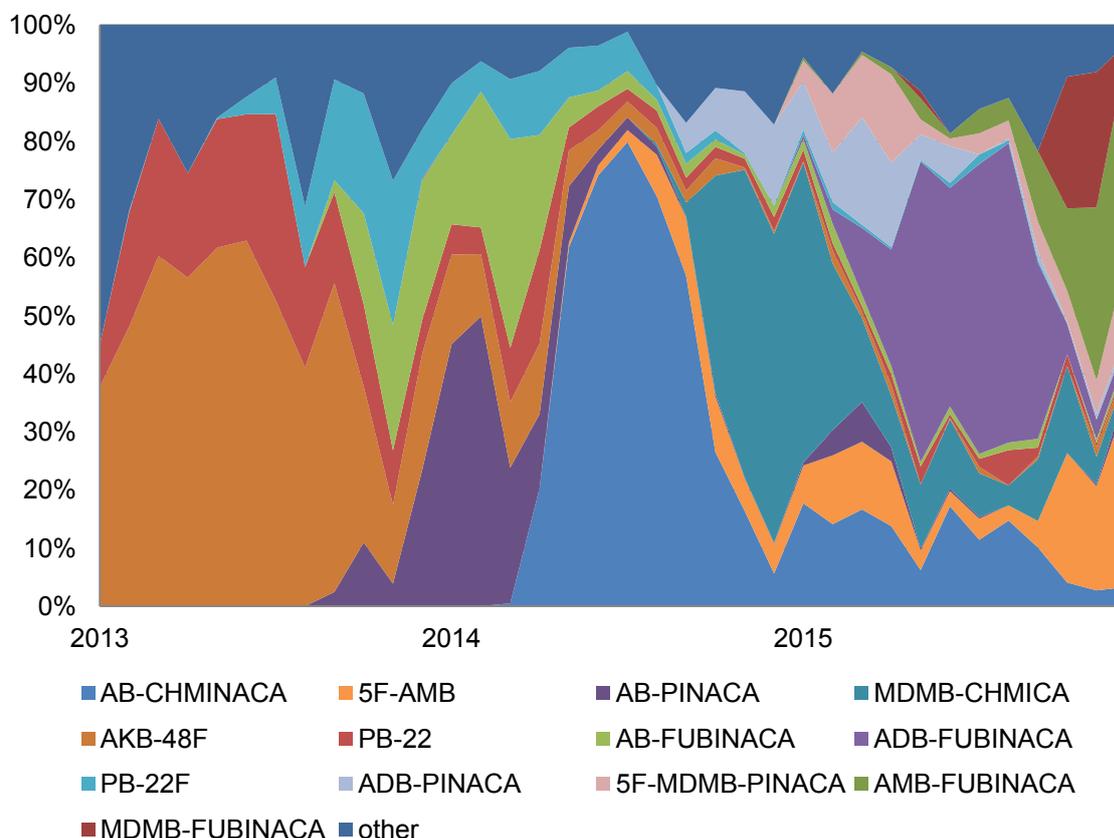


Source: BSZKI 2016

The range of active substances found in the products follow the changes in legislation dynamically, in individual periods characteristically 1–2 dominant active substances can be found on the market. After the individual active substances had become regulated, usually within 1–3 months their occurrence dropped significantly in the period 2011-2014 and their places were taken over by new active substances that were not yet regulated. In 2015 the

dynamics of these processes changed, as the scope of the substances that can be traded without any criminal consequences was narrowed drastically by the expansion of the generic regulation. The place of the ADB-FUBINACA which was legal until then and dominant in seizures was overtaken by AMB-FUBINACA and 5F-AMB by the end of the year regardless that these substances have already been controlled since October 2014.

Chart 51. The frequency of occurrences (N) of synthetic cannabinoid compounds (%), broken down by month between 2013 and 2015

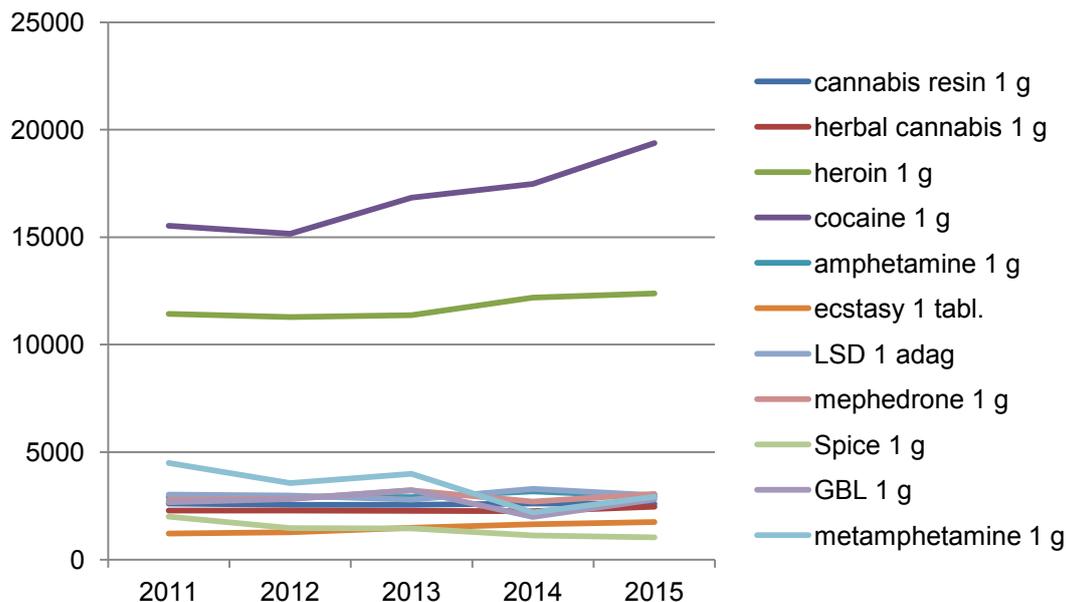


Source: BSZKI 2016

### Street prices

According to the research carried out by the Hungarian National Focal Point (Varga 2016), the tendencies observed in the street level prices of drugs in recent years have continued. After a continuous decrease in the prices of new psychoactive substances and methamphetamine a slight increase can be seen. 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 their changing role on the market: the decrease of their supply and the spread of new substances.

Chart 52. Average street prices (mean value) of illicit drugs in HUF between 2011-2015



Source: Varga 2016

### Purity

No significant change was experienced in the active substance content of herbal cannabis seizures in the period 2010-2015.

In case of cannabis resin the proportion of samples with a large active substance content fell back in 2015 compared to the previous year (see: T1.1.5.).

Undiluted, practically pure amphetamine sulphate is present among the substances. Substances with an active substance content over 50% formed about 10% of the cases in 2015.

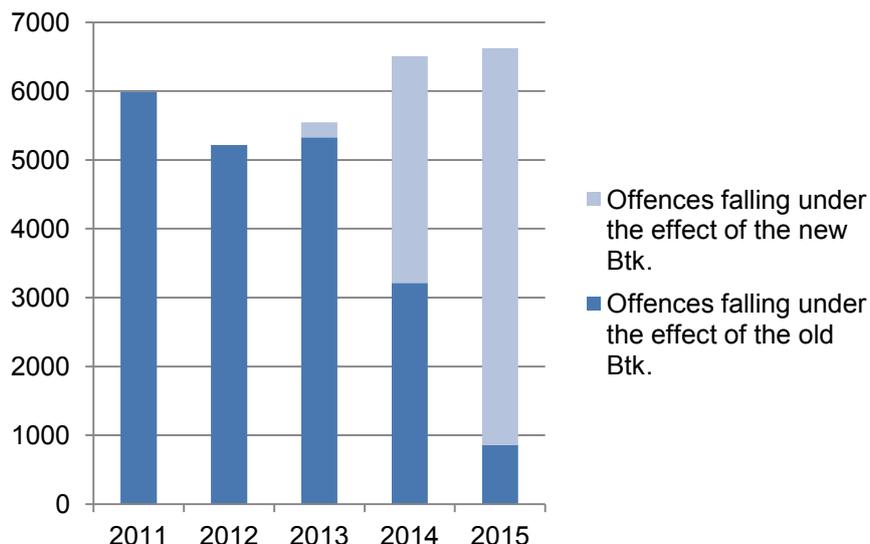
An increase in the active substance content of MDMA tablets can be observed, specially shaped, larger tablets with 150-200 mg MDMA content were seized on several occasions in 2015.

## 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 years; the number of registered offences in Hungary was the highest in 2015 since 2006.

Chart 53. The number of registered drug offences in Hungary between 2011-2015



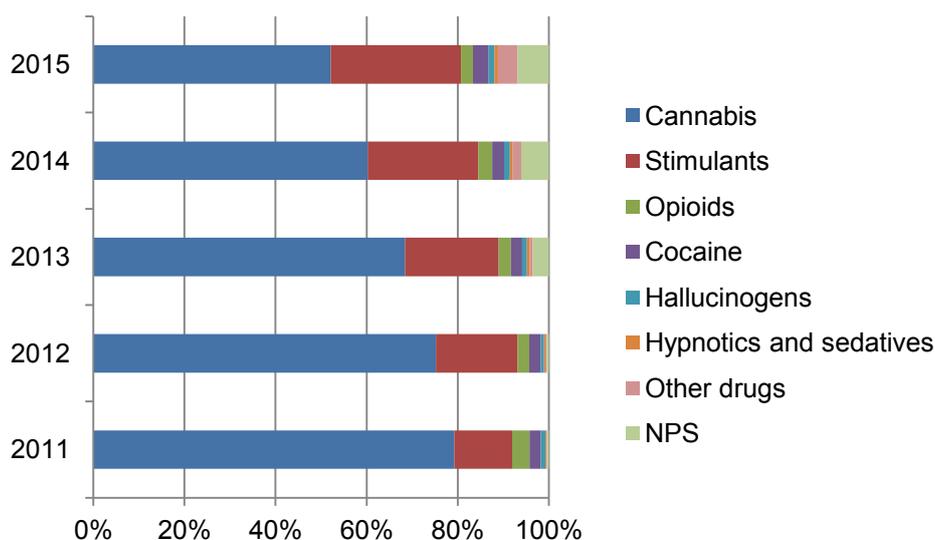
Source: ENYÜBS 2016, analyzed by HNFP

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 20%. 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 offences were committed with cannabis. At the same time, the proportion of cannabis among the substance types shows a gradual decrease: while in 2011 80% of the offences were committed with this substance, by 2015 cannabis was only involved in 50% of offences. The change in the distribution of drug related offences according to substance types followed to a certain extent the changes observed on the drug market (see Chapter T2.1) and in drug use patterns (see the Drugs/Stimulants and Drugs/Heroin and other opioids Workbook, Chapters T1.2): between 2012 and 2015 the proportion of cases involving opioids did not exceed 3% and the proportion of those involving heroin remained below 1%. Stimulants (typically amphetamine) at the same time appeared as the subject of perpetration in an increasing proportion from year to year, in 2015 offences committed with them represented 28.6% of all registered drug offences (2011: 12.7%, 2014: 20.5%). 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 (2013: 3.5%, 2015: 6.8%).

Chart 54. Breakdown of drug offences<sup>96</sup> by substance type between 2011-2015



Source: ENYÜBS 2016, analysed by HNFP

## T2.7 CHANGES TO DRUG SUPPLY REDUCTION ACTIVITIES

See Chapter T1.3.1

## 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

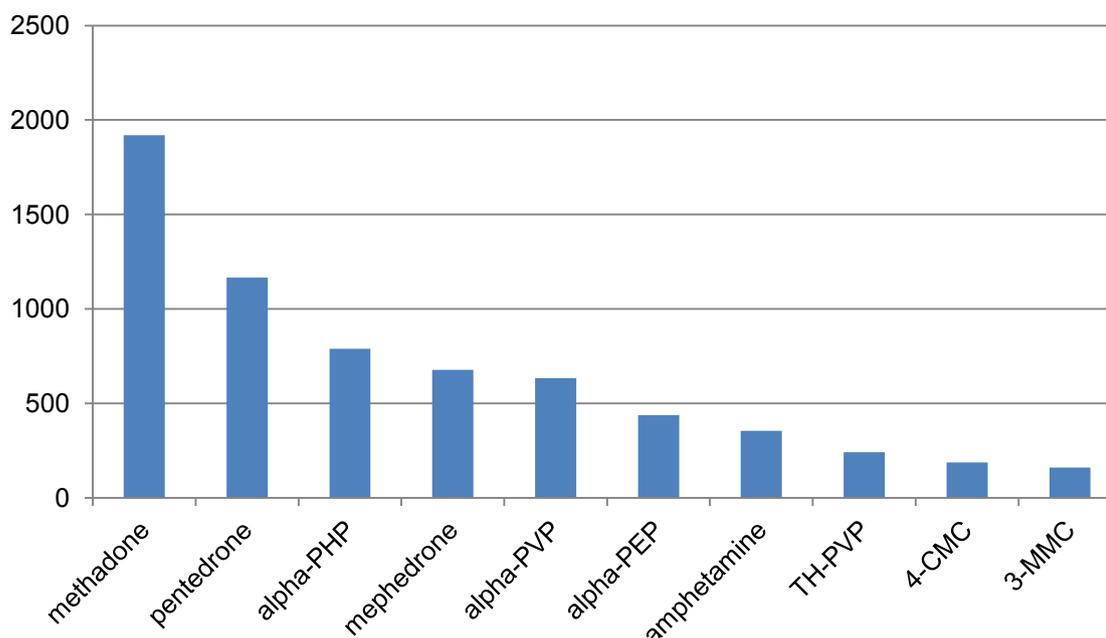
### Drug waste analysis

In January 2015 the Hungarian Interchurch Aid launched the ISEC pilot project with its partners financed by the EU: 'Breaking the drug cycle' Cooperation program to map new synthetic drugs, which identifies substances found on used injecting equipment (Péterfi 2016, for methodology see T.6.2).

Methadone was the most frequently identified substance: its presence could be observed in 1919 cases (73.9%) of 2598 analyzed samples (for limitations in methodology see in T.6.2). Eight out of the ten most prevalent active substances belong to the family of synthetic cathinones. Among classical substances – beside methadone – only amphetamine was in the first ten.

<sup>96</sup> Without cases committed with precursors and without those cases where the type of the substance was not recorded. Substance types were categorized in accordance with the EMCDDA 2014 data collection protocol on drug law offences, new psychoactive substances include substances not listed in the UN drug schedules.

Chart 55. Number of identifications of the 10 most prevalent classical drugs and new psychoactive substances identified as the main component in samples collected between March and December 2015 (N=2598)

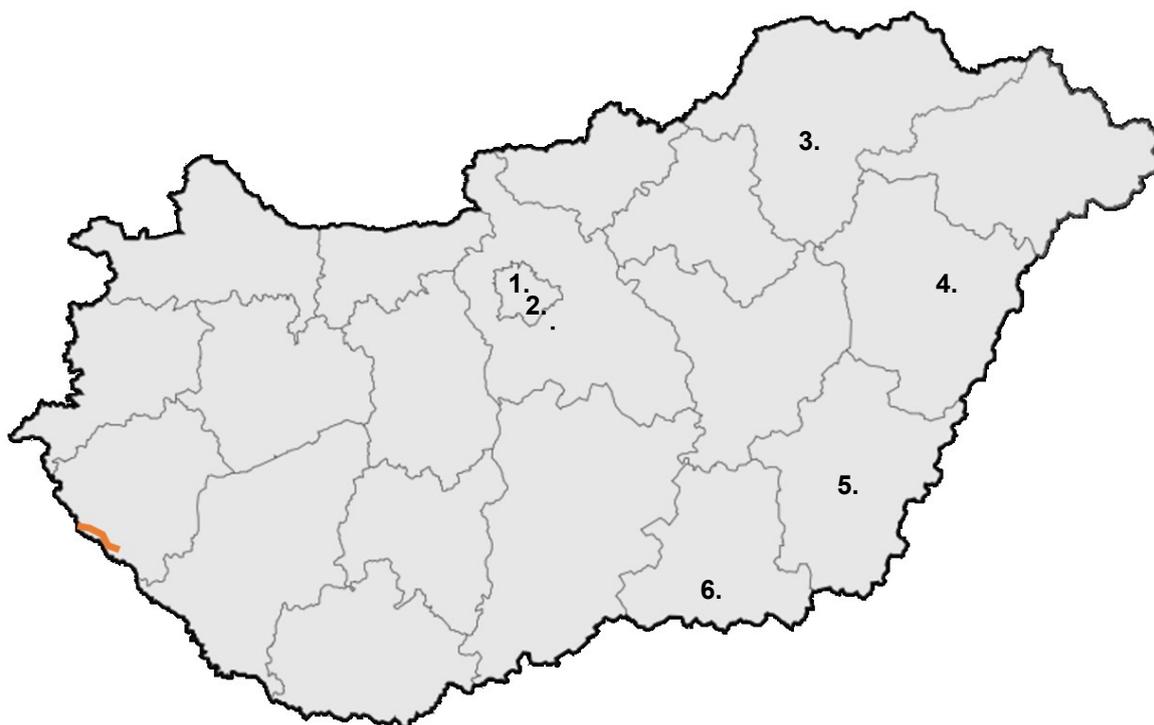


Source: Péterfi 2016

Regarding the number of identifications per month in case of the most frequent active substances it can be seen that while some substances seem to be quite stable others are replaced by new ones following a few months of dominance. Methadone was the most frequent active substance identified in the samples in each month. The frequency of samples with pentedrone among the active substances identified was relatively stable throughout the observed 10 months.  $\alpha$ -PHP was identified in higher number of cases between June and September 2015 but lost its second place following September 2015. Beside  $\alpha$ -PHP  $\alpha$ -PEP and mephedrone (4-MMC) were also much more prevalent during the first few months of the study while their presence was less typical after June 2015. An opposite trend can be observed in case of  $\alpha$ -PVP and TH-PVP which became more prevalent after August 2015.

As shown in the following table there are geographical differences in the content of syringes. Methadone was the most prevalent main component identified in the samples at three locations and was among the first 5 at an additional two.  $\alpha$ -PHP and pentedrone appear among the most prevalent main components only in three out of the studied six locations. Mephedrone was not a typical substance injected in Budapest, nevertheless it was in Szeged and Miskolc. Amphetamine appears among the five most prevalent substances at two locations (Budapest district 7 and Debrecen) while heroin only at one location (Békéscsaba/Gyula). ( for limitations in methodology see: T.6.2.)

Table 29. Geographical differences – the first 5 most prevalent main components identified in each location (in the proportion of all cases with a main component at the given location) in samples collected between April and December 2015



1. Budapest, District 7 NSP (N=826)		2. Budapest, District 23 OST/treatment centre (N=97) <sup>97</sup>		3. Miskolc NSP/ OST/treatment centre (N=553)	
Pentadone	45%	Methadone	88,7%	Methadone	41%
α-PHP	21%	α-PHP	4,1%	Buprenorphine	11%
Methadone	12%	Caffeine	2,1%	4-MMC	9%
α-PVP	4%			Ethylphenidate	8%
Amphetamine	3%			Pentadone	8%
4. Debrecen NSP (N=145)		5. Békéscsaba/Gyula NSP(N=57)		6. Szeged NSP/ OST/treatment centre (N=661)	
Amphetamine	17%	α-PHP	30%	Methadone	49%
α-PEP	16%	Methadone	25%	4-MMC	38%
Caffeine	16%	Heroin	14%	Pentadone	3%
4-MeO PV9	10%	Alprazolam	7%	3-MMC	2%
ADB- FUBINACA	8%	TH-PVP	7%	2-MMC	1%

Source: Péterfi 2016

<sup>97</sup> Only the top three substances were mentioned as the appearance of the other active substance was very low at this site.

## **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 (2016): A BSZKI lefoglalási adatai 2009 és 2015 között

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

ENYÜBS (2016): A Belügyminisztérium Egységes Nyomozóhatósági és Ügyészségi Bűnügyi Statisztikai Rendszerének kábítószer-bűnözéssel kapcsolatos, 2015. évre vonatkozó adatai.

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

Dunay, M., Port, Á. (2015): Az új pszichoaktív szerek online piacának vizsgálata 2015. Nemzeti Drog Fókuszpont. Unpublished thesis.

Péterfi, A. (2016): Breaking the drug cycle, Cooperation program to map new synthetic drugs, Midterm report on the outcomes of the first 10 months (April 2015 – January 2016). Hungarian Interchurch Aid. Manuscript.

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

Port, Á. (2012): Felmérés az új pszichoaktív anyagokat árusító magyarországi internetoldalakról az EMCDDA Online Snapshot vizsgálatának részeként, 2012. EMCDDA/Nemzeti Drog Fókuszpont. Unpublished thesis.

Port, Á. (2013): Felmérés az új pszichoaktív anyagokat árusító magyarországi internetoldalakról az EMCDDA Online Snapshot vizsgálatának részeként, 2013. EMCDDA/Nemzeti Drog Fókuszpont. Unpublished thesis.

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

Varga, O. (2016): A kábítószeres utcai árak alakulása 2015-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.

*Study of the online market of new psychoactive substances (Dunay and Port, 2015):* For the purposes of the study 3 categories of legal highs were distinguished: synthetic cannabinoids, designer stimulants and psychedelic plants. For each category two search strings giving the highest number of relevant results were identified. The searches were carried out between 23.11.2015 and 27.11.2015 using Google and Bing search engines. The study covered sites last updated in 2015, sites which were created in 2014 without further reference to date, and those sites as well which did not indicate any reference year. It was not a criterion for inclusion that order and payment was possible in one step.

Identified sites were analyzed according to the following criteria: substances sold, method of order, prices when ordering small (5 g) medium (100 g) and large (more than 1000 g) quantities, marketing, availability of warning and legal information, instructions for use and description of effects, contact information, language of the site, place of origin of sold substances.

*Seizures (BSZKI 2016):* The information regarding the substances seized was collected on the basis of the results of forensic analysis. Analysis on the active substance content is carried out if the active substance content of the given case is above the limit of the small amount set in the criminal legislation (amphetamine: 0.5 g, heroin: 0.6 g, MDMA: 1 g, cocaine: 2 g, THC: 6 g). The Institute carries out the analysis of injecting equipment related to injecting drug use only in the most necessary cases because of the high HCV prevalence among injecting drug users.

*Street level prices (Varga 2016):* 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 in 2016. Each organisation provided 20 questionnaires filled in by clients using drugs in 2015 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.

*Breaking the drug cycle Cooperation program to map new synthetic drugs (Péterfi 2016)*

Drug waste left on public spaces by drug users and gave in to needle exchange programmes were collected during the program. The Toxicology Laboratory of University of Debrecen analysed the substances found in the drug waste on monthly basis. Drug related litter were collected in 7 harm reduction services and in their neighbourhood during the first 10 months of the project: MÖSZ Debreceni Szociális és Fejlesztő Központ (Debrecen, NSP); MÖSZ Soroksári Addiktológiai Centrum (Budapest; OST/drug treatment centre); Art Éra Alapítvány (Budapest; NSP); Dr. Farkasinszky Terézia Ifjúsági Drogcentrum (Szeged; NSP/ OST/drug treatment centre); Mi-Értünk Prevenció és Segítő Egyesület, (Békéscsaba/Gyula; NSP); Drogambulancia Alapítvány (Miskolc; NSP/OST/drug treatment centre); INDÍT Közalapítvány (Pécs; NSP/OST/drug treatment centre, joined only in December) It is important to note that 4 services provide opiate substitution treatment which may have influence on the types of active substance found in the syringes (see geographical breakdown).

All together 18,066 objects were collected and transported to the laboratory for toxicological analysis throughout the 10 months. 2718 was the total number of analysis out of which 2598 were successful. Since the documentation of the analysis changed following the first month, some results are restricted to a 9 months period (May 2015 – January 2016). In these 9 months the number of successful analysis was 2339.

A questionnaire was also developed to record information from individual users submitting injecting equipment for toxicological analysis. The questionnaire is a self-administered anonymous questionnaire covering social-demographic characteristics of the client, variables on his/her drug use and on the sample(s) submitted. They were recorded in the participating harm reduction programmes (for data see Drugs/Stimulants T.4.1)

## T0. SUMMARY

Comprehensive, drug-related research in prisons with national coverage is relatively rare in Hungary: a national study on drug use among prisoners was last made in 2008. In the lack of this, information on the drug problem within prisons is obtained regularly from the data registered centrally by the Hungarian Prison Service Headquarters (BVOP), and from further small-scale, specific data collections. Noteworthy of the latter is the TDI data collection, in the scope of which the data of those entering drug related treatment in detention facilities are also recorded. With respect to recent years, the other significant, comprehensive sources of information were the surveys among all Hungarian detention facilities carried out in the scope of a collaboration between the Hungarian National Focal Point (HNFP) and the BVOP in 2013 and in 2016. The purpose of the studies was to assess the extent of the drug problem in prisons, as well as the coverage and characteristics of drug-related services available in detention facilities.

According to the available national data on drug use among prisoners, 30-40% of prisoners in Hungarian detention facilities had used an illicit drug in their lives prior to imprisonment. With regards to drug use inside prisons, increasing use of new psychoactive substances (mainly synthetic cannabinoids) among prisoners has been observed in recent years although reliable data is insufficient.

The prevalence of HIV, hepatitis B and C virus infections is higher among prisoners than in the general population. The studies performed in prisons indicate that the majority of prisoners tested positive for HCV probably became infected by injecting drug use prior to imprisonment.

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

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

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

## T1. NATIONAL PROFILE

### T1.1 ORGANISATION

In Hungary in 2015, 30 detention facilities were in operation, with space for a total of 13,209 persons. Among the institutions 15 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

---

<sup>98</sup> Author of the chapter: Ágnes Port

national authority, the prison service endeavors to take place of residence into consideration when allocating a detainee to a particular prison: during allocation the region is the priority, but this is not always implemented due to the overcrowdedness of facilities.

The number of prisoners in Hungarian detention facilities on 31 December 2015 was 17,449 persons, of these 16,199 (92.8%) were males and 1250 (7.2%) were females. The proportion of minors among all detainees was 2% (352 persons). Overcrowding is significant in Hungarian prisons: in 2015 the average utilization of the overall prison capacity was 135%. The average capacity utilization however decreased to 127% by the end of the year from 140% at the end of the previous year due to the inauguration of more than 500 new prison spaces. (BVOP 2016a) Overcrowding makes the drug problem in prisons worse.

The proportion of prisoners convicted for drug related offences<sup>99</sup> was 5.4% within the whole prisoner population.

## **T1.2 DRUG USE AND RELATED PROBLEMS AMONG PRISONERS**

### **T1.2.1 Drug use among prisoners**

#### *Drug use prior to imprisonment*

As part of the development of the data recording system in relation to the risk assessment system implemented recently in Hungarian detention facilities (see Chapter T1.3.3) questions on drug use were also asked from a sample of 1170 prisoners in March 2015. (For methodology see Chapter T6.2.) 31.8% (355 persons) of the prisoners participating in the survey self-reported having ever used drugs in their lives prior to imprisonment. 40.3% (139 persons) of ever users reported that they had also experienced negative consequences of their drug use. (ST12\_2016\_HU\_01)

Regarding the lifetime prevalence by substances types, cannabis use was reported by 218 prisoners (18.7% of the total sample and 61.4% of ever users). The second most frequently used substance type was stimulants<sup>100</sup>: 205 persons (17.5% of the total sample and 57.7% of ever users) reported to have tried them. Nearly the same proportion of respondents (202 persons, 28.2%) reported that they had taken regularly a medicine withdrawing from which would affect their behaviour. Use of hallucinogens<sup>101</sup> was reported by 50 prisoners (4.3% of the total sample and 14.1% of ever users), use of opioids by 43 persons (3.7%, 12.1%), use of inhalants by 23 persons (2%, 6.5%). 77 prisoners reported to have tried designer drugs (6.6%, 21.7%).

68.1% of the prisoners who had used drugs were younger than 35 and 24.4% of them were under age 25 which is significantly higher than the respective proportions (50.6% and 18.1%) describing the whole sample. Distribution by age was similar with regards to the users of different substance types; the ratio of those under age 25 was especially high among cannabis users (30.1%) and designer drug users (33.8%).

4 prisoners (0.3%) self-reported being a polydrug user<sup>102</sup> and 65 prisoners (5.9%) said that they had a behavioural addiction different from drug use (internet addiction, gambling etc.). The proportion of those who said that they had a behavioural addiction was 9.5% among those who had ever used drugs and it was 4.3% among those who had never used drugs.

---

<sup>99</sup> Possession of drugs, Aiding in the manufacture of drugs, Drug trafficking, Misuse of drug precursors, Inciting substance abuse, Misuse of new psychoactive substances, Misuse of substance used for the manufacturing of drugs, Misuse of drugs

<sup>100</sup> In the study the following substances were included among stimulants: cocaine, amphetamine derivatives, amphetamine (speed), methamphetamine (ice), MDMA (ecstasy).

<sup>101</sup> Mescaline, psilocybin, LSD

<sup>102</sup> Reported to have used multiple substance types.

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

Out of the 31 participating prisons 15 were able to provide precise data on the proportion of prisoners self-reporting being drug addicts<sup>103</sup>. The proportion of prisoners admitting to being drug addicts on admission was characteristically under 10%, however, this figure exceeded 30% in the case of 3 institutions; the average in the 15 prisons was 15% (859 persons). The questionnaire also asked how many persons self-reported during admission having ever used drugs in their lives. In the 16 institutions that were able to report on the number of prisoners and the number of ever drug users, the proportion of prisoners who reported ever using drugs in their lives was 38% (3,148 persons). During admission 219 persons admitted to having ever injected drugs, which, on average meant 4% of the prisoners in the 13 prisons able to provide information on this.

The latest national survey examining drug use among prisoners was carried out in 2008 (Paksi 2009). (ST12\_2009\_HU\_01) According to the results of this survey 43.8% of the population imprisoned in Hungarian detention facilities on the basis of a final decision had tried an illicit drug<sup>104</sup> prior to imprisonment. More than two-fifth of ever-users (41.6%), that is every fifth or sixth imprisoned person (18.2%), had a period in their lives before imprisonment, when they used an illicit drug at least once a week. In the year before starting to serve their sentence, every third prisoner, while in the last month before imprisonment every fifth presently imprisoned person used an illicit drug. 37.8% of the prisoners, that is a decisive majority (85.7%) of those who used an illicit drug at any time in their lives have already used herbal cannabis or cannabis resin in their lives. The prevalence rate of all other drugs was much lower. The findings of the survey are presented in detail in the 2009 National Report Chapter 9.4.

In 2012 a study was carried out within the scope of the annual counselling and screening programme aimed at the prevention of HIV/HBV/HCV infections in prisons entitled 'Infections and fears in detention facilities' (Ritter 2013), in the scope of which knowledge about, attitude to, affectedness by, and related risks of HCV infection among prisoners were examined. During the survey drug use patterns of the participating prisoners (852 persons) were also examined.<sup>105</sup> 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.

---

<sup>103</sup> Definition of drug addiction is not given on the admission form, prisoners report on their drug addiction status based on their own personal judgement.

<sup>104</sup> 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.

<sup>105</sup> 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.

### *Drug use inside prison*

According to data from the BVOP, during the course of 2015 materials suspected of being an illicit drug were seized on 252 occasions. Most of the substances were transported to the detention facilities via postal packages, soaked into paper, fabrics or other material, hidden in toys, food, toothpaste or tobacco, or blended into coffee or cream. Illicit substances were discovered before reaching the prisoners in 73% of the cases (185 cases), however preventing the entrance of new psychoactive substances poses a great challenge as institutions are not well-prepared to detect them (e.g. detection dogs are not trained to recognize such substances).

There is no unified reporting obligation relating to the seized substances but according to the reports from prisons (Port 2016) the majority of seizures involved herbal cannabis, plant materials and tobacco most likely treated with synthetic cannabinoids and non-prescribed psychoactive medicines. Seizure of tablets and powders was reported by 6-6 institutions.

Drug use inside prison was revealed in the case of 43 prisoners in 8 institutions although 30 out of the 43 cases was reported by one facility. The remaining prisons reported only one or two cases. Most of the revealed cases could be linked to the above substances as well (herbal cannabis, synthetic cannabinoids, Rivotril tablets).

The seizure of injecting equipment and injecting drug use is not characteristic in Hungarian detention facilities, there were no cases of such in 2015 either. (Port 2016)

According to the national study conducted in 2008 in relation to drug use among prisoners (Paksi 2009), 14.3% of the imprisoned persons, 29.4% of those who used illicit drugs at any point in their lives before imprisonment, and nearly half (46.3%) of those who were regular drug users before imprisonment used an illicit drug while being imprisoned. The decisive majority (90.9%) of ever users had also used illicit drugs earlier, prior to imprisonment. (ST12\_2009\_HU\_01)

### **T1.2.2 Drug related problems among prisoners**

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

Data on the socio-demographic and illicit drug use characteristics of persons entering treatment in the scope of a QCT programme (see: T1.3.2) within the Hungarian prison system are available from the National Centre for Addictions' (OAC) TDI data collection. According to the TDI protocol, prisons also report cases of persons entering treatment to the TDI database.<sup>106</sup>

On the basis of TDI data, in 2015 95 prisoners (91 males, 4 females) started treatment due to a drug problem, all of them in the scope of QCT.

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 31.1 years; non-prisoners 28.5 years). The proportion of males is characteristically high among drug users, it was 96% among prisoners entering treatment, while 87% among non-prisoner treatment entrants. This is partly due to the gender distribution of prisoners (93% males, 7% females). With respect to highest school qualification, half (48%) of those

---

<sup>106</sup> Numerically the TDI data does not match the treatment data supplied by the BVOP (see: T1.3.2). One reason for this is that the BVOP registers the number of ongoing, completed and interrupted treatments in a given year, while TDI registers started treatments in a given year. Also, not all the institutions report to the TDI data collection, i.e. TDI does not cover all detention facilities where drug related treatment of prisoners takes place.

entering treatment outside prison had elementary school qualification at the most, while among prisoners this proportion exceeded 80%.

Examining drug use patterns, among those entering treatment inside prison, use of stimulants (mainly amphetamine) and opioids (mainly heroin) 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 21.5% of them this was the characteristic route of administration, and 30% reported that they had injected drugs at least once in their lives. In the non-prisoner population the proportion of those injecting their primary substance and the proportion of ever injectors were 5.4% and 12% respectively.

Table 30. *Main characteristics of prisoner and non-prisoner clients entering treatment in 2015* ( $N_{prisoners}=95; N_{non-prisoners}=4213$ )<sup>107</sup>

<b>Prisoners</b>		<b>Non-prisoners</b>
31.1 years	mean age	28.5 years
96%	proportion of males	87%
84%	proportion of those who completed 8 years of elementary school at the most	48%
38%	proportion of cannabis users	57%
40%	proportion of stimulant users	16%
17%	proportion of opioid users	3%
22%	proportion of those who inject their primary substance	5%
30%	proportion of ever IDUs	12%

Source: TDI data collection 2016; analysed by HNFP

*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

<sup>107</sup> The proportions were calculated by excluding those who responded 'not known' for the given variable.

among those ever sharing equipment was 30.7%, and 37.9% among those sharing needles/syringes.

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%.<sup>108</sup>

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 acquisition of the hepatitis C virus could have happened through needle/syringe sharing while injecting or through sharing needles used for tattooing.

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

According to the data of a national HIV/HCV prevalence study carried out in 2015 among IDUs (Dudás et al. 2015), nearly every second IDU (266 persons; 48.4%) has been in prison at sometime in their lives. Among them HCV prevalence rate resulted to be 65%. For further data from the study see: Harms and Harm Reduction Workbook, Chapters T.1 and T.2. (ST9P2\_2016\_HU\_03; ST9P3\_2016\_HU\_01)

### **T1.3 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

---

<sup>108</sup> 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.

- that are adapted to the individual needs of the group and the unique characteristics of the institution system.

According to its Articles of Association the Ministry of Interior is responsible for the central administration of the prison system from 2010 and thus the Hungarian Prison Service Headquarters governs and coordinates the operation of the prison institutions and other prison facilities (4 education and training related and 2 health related) under the supervision of the Ministry of Interior.

### **T1.3.2 Organising treatment and care**

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

Apart from the medical model, the security model<sup>109</sup> 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. The committee has not been active in recent years, in the course of 2014 and 2015 it 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). If the prisoner is entitled to take part in one of the three forms of QCT<sup>110</sup>, the preliminary assessment necessary in order to undergo the treatment is carried out by the psychiatrist, addiction specialist or clinical psychologist employed by the prison institution. The preliminary assessment determines the appropriate type and level of service. Following this, the prison providing the service is appointed.

The IMEI and another six detention facilities have been designated to provide treatment for drug addiction and treatment of other conditions with drug use in the scope of QCT for the different groups of prisoners (men, women, minors, persons under preliminary custody). The

---

<sup>109</sup> 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.

<sup>110</sup> 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.

preventive-consulting service for QCT participants must be provided by an external service provider with regional authority - which is determined by the National Office for Rehabilitation and Social Affairs (NRSZH) -, on the basis of a cooperation contract between the prison institution and the service provider.

According to data from the BVOP, in 2015 113 persons participated in treatment for drug addiction, 145 persons underwent treatment of other conditions with drug use, and 333 persons took part in a preventive-consulting service.<sup>111</sup> It is very difficult to organise QCT during preliminary custody, because the fluctuation of detainees is high and there is a lot of transportation between facilities. Due to this several QCTs are interrupted or take place in parallel. The large majority of QCT takes place in Budapest, i.e. the institution of QCT is centralised within the prison service. (The TDI data of persons entering drug treatment in detention facilities are presented in Chapter T1.2.2.)

### **T1.3.3 Drug related health and other services in prisons**

#### *Admission procedure*

The new Prison Code<sup>112</sup> in effect from January 2015 introduced the institution of risk assessment and risk management. During the risk assessment the general risks of detention and relapse are determined upon admission and the tasks concerning health, psychology, safety and reintegration necessary to reduce those risks are also defined. Risk assessment is carried out with the help of personal interviews, psychodiagnostic tests and health examinations. As part of the risk assessment the risk of psychoactive substance use is also assessed. People admitted to prison go through a medical examination as well, in the course of which questions are also asked about drug use and alcohol consumption. Answers are recorded in the healthcare subsystem, which can only be accessed by entitled specialists.<sup>113</sup> It is not possible to check whether the statements are valid. Generally no other standardized tools are used to measure addiction severity or involvement in drug use. If a positive answer is given to the question relating to drug use and if it is medically reasonable, the attending doctor takes measures about necessary further treatment (as in the case of all other health problems).

#### *Prevention*

A change in legislation in 2002 made it possible to set up prevention units or departments in detention facilities for volunteering prisoners<sup>114</sup>. The rules of operation of drug prevention units are laid down by Act no. CCXL. of 2013 on the execution of criminal sanctions (Prison Code), by Regulation 16/2014. (XII.19.) of the Ministry of Justice on the detailed rules of execution of imprisonment, misdemeanor detention, preliminary custody and detention replacing fine penalty and by order 7/2015. (I.20.) of the National Commander of the prison service on the operation of drug prevention units. Prisoners may request their

---

<sup>111</sup> Data cannot be compared to TDI data because the prison institutions record the aggregated number of completed, ongoing and interrupted treatments, while TDI records the number of prisoners entering treatment in a given time period. Furthermore, data recorded in the prison administration system is not controlled for double-counting: a prisoner might be recorded more than once for e.g. as a client continuing and then terminating treatment, or if he/she is transported to another institution, or if the treatment is temporarily suspended and then restarted.

<sup>112</sup> Act no. CCXL. of 2013 on effecting punishments, measures, certain coercive measures and misdemeanor detention

<sup>113</sup> Data are recorded as text. Obtaining aggregate and standardized data annually would require the improvement of the IT system which is currently in progress with the introduction of the unified risk assessment and risk management system.

<sup>114</sup> Previous drug use is not a condition of participation.

accommodation in the drug prevention unit in written form, the acceptance/rejection of the inquiry is decided by the so called Admission and Detention Committee based on the reports of the reintegration officer and the prison psychologist. Accommodation in the drug prevention unit is given priority in the following cases:

- the prisoner was convicted for a drug related offence
- data recorded at admission or during the preparatory phase suggest that the prisoner had used drugs prior to imprisonment
- the prisoner was already held responsible for drug use inside the detention facility
- the prisoner has not yet used drugs but reported continuous exposure to it.

If the admission to the prevention unit is rejected because of a lack of capacity, the prisoner can apply for admission to another institution's drug prevention unit.

In the drug prevention units the prisoners are accommodated in separate cells or department. The prisoners accommodated here agree to participate in drug tests that may take place at any time but occur at least once every month.

Reintegration programme of the prisoners held in the drug prevention units is carried out within the framework of a complex therapeutic programme. The reintegration officer designs a weekly activity schedule for the prisoners which includes drug prevention activities as well. Behaviour, activity, interest, cooperation skills, social contact and important incidents are assessed by the reintegration officer at least once in every 6 months. The large majority of the services and programmes provided in the prevention units are psychological/psychotherapy group sessions and individual consultations. A significant proportion of the drug prevention programmes and other not strictly medical services are provided with the participation of external NGOs via tender-based funding.

In 2015 20 detention facilities operated drug prevention units, with a total space for 378 prisoners. The number of prisoners accommodated here is fluctuating, on the 31<sup>st</sup> of December 2015 it was 204 persons in total.

According to data from the survey carried out by the BVOP and the NFP (Port 2016) services provided by the drug prevention units were realized jointly by the prison staff and an external service provider in most of the facilities (14 out of 18), in 3 facilities they were delivered by an external service provider and 1 facility relied solely on its own resources.<sup>115</sup>

Other than the services provided by the drug prevention units drug prevention programmes open for all prisoners were realized in 28 institutions in 2015. In the majority of the institutions (14) one programme, in some of them two or three programmes (6-6 institutions) were held. There was one institution where 5 and one where 7 drug programmes were carried out. In half of the institutions (14) the programmes were realized by an external service provider, in 10 of them they were realized in a collaboration between the institution and an NGO and in 4 of them they were held by the prison staff. The number of the prisoners participating in the programmes ranged from 5-6 persons to 225 persons (there were 3 programmes with more than a hundred participants), altogether it was approximately 1150 persons. The number of participants was usually between 10 and 50, on average it was 83 persons.

The general drug prevention programmes and the programmes available in the prevention units were similar in content: they focused on personality development (self-knowledge, stress and conflict management), improving individual and social competencies, health protection, preventing relapse, education and information dissemination. The range of methods used was wide: it included arts and crafts sessions, music therapy, fairy tale therapy, sport sessions, animal therapy, cultural programmes, film watching, reading groups, life coaching.

### *Treatment*

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

---

<sup>115</sup> Based on data from 18 institutions.

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 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 types<sup>116</sup>. 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 T1.2.2, and the information on opioid substitution treatment for prisoners is included in Chapter T1.3.4.

#### *Prevention, testing, and treatment of infectious diseases*

Organised by the Hungarian Prison Service Headquarters (BVOP), a hepatitis C counselling and screening programme has been carried out every year in Hungarian detention facilities with the involvement of an external healthcare partner since 2007<sup>117</sup>. HCV testing is preceded by a preliminary half-hour-long informative lecture, after which the prisoners may voluntarily undergo testing. The blood samples are examined in Szent László Hospital.

According to the survey carried out among detention facilities (Port 2016) during 2015, awareness raising lectures in connection with HCV/HBV/HIV/TB infections were held in 11 detention facilities with the participation of around 4100 prisoners (23% of the average prison population). Individual counselling in connection with infectious diseases was provided in 6 prisons in a total of 518 cases, and in 2 further facilities it took place during every admission. Written information was distributed to 1051 prisoners during the year in 7 prisons, another 2 facilities provided written information material to each prisoner on entry.

During 2015 a total of 2419 prisoners were tested for HCV, 13.6% of the average prison population. Among them 190 persons (7.9%, 1.1% of the entire prison population) proved to

---

<sup>116</sup> 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.

<sup>117</sup> In 2013 the programme was suspended due to lack of funds.

be HCV antibody positive, of these 96 persons were hepatitis C virus carriers as well. 594 prisoners were tested for hepatitis B (3.3% of the prison population), among them 2 HBV positive cases (0.3%) were identified. 750 prisoners were tested for HIV (4.2% of the prison population), and 1 new case was found.

TB testing is also available in detention facilities. According to the amendment of the Ministry of Welfare regulation no 18/1998., as of 2013 it is compulsory for all newly admitted prisoners to have a chest X-ray test. In the course of 2015 70 suspected cases of tuberculosis were found, among them 3 were active TB patients. 13 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 2015, 20 HIV-positive prisoners received antiretroviral treatment, while 137 HCV-positive and 3 HBV-positive prisoners received antiviral treatment. (Among those infected with HCV, 50 rejected the treatment, 9 did not receive treatment for health reasons and in 18 cases treatment was discontinued upon release.)

The prison health services and the regional hepatology centres together are in charge of the treatment of prisoners with hepatitis C. If necessary, the prisoners are taken to the outpatient treatment unit of the local hepatology centre. HIV positive persons are offered the possibility to serve their sentence at the Tököl National Prison, in a special unit of the prison maintained for HIV positive persons. In this special unit there is also a consulting room, where HIV positive prisoners are provided with medical attendance by a specialist from the Szent László Hospital. The number of prisoners accommodated here is varying, in March 2015 it was 17. 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*

In the scope of the survey carried out by the BVOP and the HNFP in 2016 (Port 2016) 3 institutions reported to have provided a programme or counselling aimed at preventing overdoses after release in 2015.<sup>118</sup> In one prison the sessions were held specifically with the above aim, in the other two institutions they were delivered as part of broader programmes (3 programmes altogether). The programmes reached a total of 76 inmates. Individual counseling about overdose prevention was available in 3 institutions<sup>119</sup>, among them in one institution it was open for all prisoners, in the other two prisons 3 and 5 persons participated in it respectively.

#### *Reintegration, preparation for release*

According to the results of the survey carried out in 2013 and 2016 in Hungarian prisons (Port and Tarján 2014, Port 2016) 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 - with which in many cases the institutions have a cooperation contract as well -, and that they provide opportunity for individual/group counselling regarding this problem.

In 2015 reintegration /resocialization programmes or individual support aimed specifically at or held with the participation of drug user prisoners was available in about half of the 30

---

<sup>118</sup> Out of the 30 prisons 25 responded no, in 2 prisons no information was available.

<sup>119</sup> Out of the 30 prisons 24 responded no, in 3 prisons no information was available.

prisons (53%, 16 prisons). Reintegration programme targeted specifically at drug users was provided in 9 institutions (13 programmes) reaching a total number of 162 prisoners. Other more general programmes in connection with resocialisation/reintegration which also dealt with the drug problem were organised by 7 institutions with the participation of 387 prisoners. Individual counselling was available in 5 prisons, 162 prisoners took part in it. (Port 2016).

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

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

The foundations Váltóság Alapítvány<sup>120</sup> and Tévelygőkért Alapítvány<sup>121</sup> are the most important NGOs in Hungary dealing with the resocialisation and reintegration of prisoners. Employees of Váltóság Alapítvány contact the prisoner in prison before release, and then maintain contact after release as well. They use various techniques, including: mentoring, group and individual sessions, training courses. The organisation has an occupation programme, a skills training programme as well as a programme especially for women, and they also operate a halfway house. Beside this, the foundation maintains an information database where released persons, their families and also professionals can find useful information regarding the topic. The foundation also regularly publishes information booklets in connection with the subject.

The purpose of Tévelygőkért Alapítvány is to eliminate social inequalities through working with marginalized populations and through social sensitization and within this its main field of activity is to support people disadvantaged by the prison system. The programme "Beszélj szabadon" of the organization is intended for high school students and aims to make them more tolerant and open towards people released from prison thereby reducing their social exclusion and fostering their reintegration. The primary aim of project "Mirkó" is to take care of and strengthen the (parent-child) relationship between prisoners and their children, and to follow and support their life. The project also aims to engage non-profit organizations and through this make society more sensitive, encouraging a communication practice free of prejudice and shame. "Plan B" (B-terv) is the organization's reintegration programme for released detainees in the scope of which a flat-sharing community is operated which provides opportunity for disadvantaged, freshly released prisoners who are unable to return to their family to practice loving, prejudice free and assertive communication. In the scope of Plan B former prisoners live in the flat-share community for 3-9 months after which they may take part in the foundation's projects as coworkers.

#### **T1.3.4 Opioid substitution treatment in prisons**

Rules regarding methadone treatment of prisoners are set out by order no. 38/2015. (V.20.) of the BVOP. According to the regulation all detention facilities must ensure methadone

---

<sup>120</sup> <http://www.valtosav.hu/>

<sup>121</sup> <http://www.tevelygokertalapitvany.info/>

treatment as a therapy option for opioid addiction, if the continuation of methadone treatment is indicated by the specialised outpatient treatment centre treating the prisoner before he/she was admitted to the detention facility, or if it is recommended by a specialist at the National Institute for Forensic Observation and Psychiatry and the affected person gives his/her written consent. The treatment must be carried out - in accordance with the respective methodological letter – at such therapeutic sites which are designated for acquiring, storing and using methadone, for which prison institutions are not entitled in the lack of an operating licence. For the purpose of methadone treatment the prisoners have to be transported to a specialised outpatient treatment centre or addiction or psychiatric unit which are designated in the region to provide such a service.

According to the survey carried out by the BVOP and the HNFP (Port 2016) in 2015 none of the prison institutions registered prisoners who had received OST treatment. Two institutions reported 5 prisoners that had participated in OST right before being admitted to prison but their treatment was not continued after imprisonment. In the preceding years OST was provided occasionally by external service providers, if requested by a detention facility, but the number of such cases was exceptionally low. According to the annual data collection (Tarján 2013) carried out among DTCs that provide substitution treatment, between 2005 and 2012, 3 prisoners in 2005 and 2 in 2006 were transported to the regionally competent outpatient drug treatment centre for the purpose of OST.

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

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

## **T2. TRENDS**

Not applicable for this workbook.

## **T3. NEW DEVELOPMENTS**

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

Act no. CCXL of 2013 on effecting punishments, measures, certain coercive measures and misdemeanor detention (Prison Code) was adopted on 17<sup>th</sup> December 2013 and entered into force on 1<sup>st</sup> January 2015. Drug related provisions of the new law (operation of drug prevention units, availability of services provided within the framework of QCT) and the content of the National Commander's orders specifying the details of the execution of the law are described in detail in Chapter T1.3.3. In terms of costs, according to the Prison Code 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.

## **T4. ADDITIONAL INFORMATION**

No information available.

## **T5. NOTES AND QUERIES**

### **T5.1 ARE THERE INDICATIONS OF NPS USE AND RELATED PROBLEMS IN PRISONS?**

Yes. According to the reports from the prisons, new psychoactive substances (predominantly plant materials treated with synthetic cannabinoids) are smuggled into the detention facilities in growing number. Reliable, systematically collected data on the number of NPS seizures and the number of revealed cases of NPS use or information on the extent of the problem is not yet available however. See also T1.2.1.

### **T5.2 ARE PEOPLE ENTERING PRISON SCREENED FOR DRUG ADDICTION?**

Yes. During the admission process risk of drug use is assessed as part of a risk assessment system. Newly admitted prisoners also go through a mandatory medical examination in the course of which questions concerning drug addiction are also asked, but no standardised tool is used for determining drug addiction status. (For more details see T1.3.3.)

## **T6. SOURCES AND METHODOLOGY**

### **T6.1 SOURCES**

BVOP (2016a): A BVOP 2015-re vonatkozó összesített adatai.

BVOP (2016b): Az elítéltekre vonatkozó kockázatelemzési rendszer bevezetése kapcsán végzett kérdőíves vizsgálat eredményei. BVOP Stratégiai, Elemzési és Tervezési Főosztály.

BVOP (2016c): BVOP Évkönyv 2015. (2015 Yearbook of the Hungarian Prison Service)

Paksi, B. (2009). A jogerősen elítélt fogvatartottak kábítószer- és egyéb szenvedélyszer használata Magyarországon 2008-ban. Budapesti Corvinus Egyetem Magatartástudományi és Kommunikációelméleti Intézet Viselkedéskutató Központ. Kutatási beszámoló. Unpublished thesis.

Port, Á. (2016): A Büntetés-végrehajtás Országos Parancsnoksága és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben 2016 júniusában végzett kérdőíves felmérés eredményei. Unpublished thesis.

Port Á., Tarján A. (2014): A Büntetés-végrehajtás Országos Parancsnoksága és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben végzett kérdőíves felmérés eredményeiről készült kutatási beszámoló. Unpublished thesis.

Ritter, I. (2013): Fertőzések és félelmek a büntetés-végrehajtási intézményekben, OKRI. Unpublished thesis.

Tarján (2013): Kiegészítő adatgyűjtés a szubsztitúciós kezelést biztosító drogambulanciák körében.

TDI adatgyűjtés 2016.

Tresó, B., Barcsay, E., Tarján, A., Horváth, G. Cs., Dencs, Á., Hettmann, A., Csépai, M., Győri, Z., Rusvai, E., Takács, M., (2011): Prevalence and Correlates of HCV, HVB, and HIV Infection among Prison Inmates and Staff, Hungary. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. doi:10.1007/s11524-011-9626-x.

## **T6.2 METHODOLOGY**

*BVOP (2016b)*: The survey was based on a questionnaire recorded primarily with the aim of risk assessment, secondarily with registration purposes which contained questions regarding drug use as well. (The primary purpose of the data collection was not research but to test the development of the data recording system carried out in relation to the implementation of the new risk assessment system.) Male prisoners admitted to the 5 participating detention facilities during the month of the survey were included in the sample, altogether 1170 persons. Questionnaires were recorded in March 2015, answers to the questions were based on the prisoners' self-report.

*BVOP and HNFP survey (Port 2016)*: The survey was carried out among the prison institutions (altogether 30) operating in Hungary in 2015. Questionnaires were recorded in June 2016, the questions referred to 2015. Questionnaires were completed by the staff of the institutions, responses and data were summarized and analyzed by the Hungarian National Focal Point.

*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 2016*: 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 EMCDDA<sup>122</sup>. 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.

---

<sup>122</sup> Protocol for the implementation of the EMCDDA key indicator: Drug-related infectious diseases (DRID), draft version 6 October 2006, Project CT.04.P1.337

## BIBLIOGRAPHY

1997. évi XXXI. tv. a gyermekek védelméről és a gyámügyi igazgatásról

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

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

BSZKI (2016): A BSZKI lefoglalási adatai 2009 és 2015 között.

BVOP (2016a): A BVOP 2015-re vonatkozó összesített adatai.

BVOP (2016b): Az elítéltekre vonatkozó kockázatértékelési rendszer bevezetése kapcsán végzett kérdőíves vizsgálat eredményei. BVOP Stratégiai, Elemzési és Tervezési Főosztály.

BVOP (2016c): BVOP Évkönyv 2015.

Csák R., Gyarmathy V.A., Miletics M. (2011): Módszertani levél a tícserre programokat megvalósító szolgáltatók számára. NCSSZI.

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

Csohán, Á., Krisztalovics, K., Molnár, Zs., Fehér, Á., Dudás, M., Bognár, Zs., Fogarassy, E., Mezei, E., Kaszás, K., Kozma, E. (2016): Magyarország járványügyi helyzete 2015. Országos Epidemiológiai Központ.

Dudás, M., Rusvai, E., Győri, Z., Tarján, A., Horváth, G., Minárovits, J., Takács, M., Csohán, Á. (2015): A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HBV, HCV) 2015. évi prevalenciájának vizsgálata. OEK. Submitted for publication.

Dunay, M., Port, Á. (2015): Az új pszichoaktív szerek online piacának vizsgálata 2015. Nemzeti Drog Fókuszpont. Unpublished thesis.

Elekes, Zs. (szerk.) (2016): Európai iskolavizsgálat az alkohol- és egyéb drogfogyasztási szokásokról – 2015, Magyarországi eredmények, Budapesti Corvinus Egyetem, Budapest

EMCDDA (2010): Treatment demand indicator, standard protocol 2.0. <http://www.emcdda.europa.eu/html.cfm/index65315EN.html> (utolsó elérés: 2015.06.04.)

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

EMMI (Emberi Erőforrások Minisztériuma) (2016a): Az EMMI Szociális és Gyermejkölési Szolgáltatások Főosztályának részanyaga

EMMI (Emberi Erőforrások Minisztériuma) (2016b): Az EMMI Népegészségügyi Főosztályának beszámolója

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

ENYÜBS (2016): A Belügyminisztérium Egységes Nyomozóhatósági és Ügyészségi Bűnügyi Statisztikai Rendszerének kábítószer-bűnözéssel kapcsolatos, 2015. évre vonatkozó adatai.

Farkas, J. (2011): Hungary. EMCDDA Trendspotter találkozó, 2011. október 18-19., Lisszabon.

FM (Földművelésügyi Minisztérium) (2016): A Földművelésügyi Minisztérium beszámolója.

Galla, M., von Gageldonk, A., Trautmann, F., Verbraeck, H. (2005a): Hogyan erősíthető meg a magyar drogpolitikai koordináció az értékelés tükrében? Trimbos Instituut, Utrecht.

Galla, M., von Gageldonk, A., Trautmann, F., Verbraeck, H. (2005b): A Nemzeti Stratégia félidős értékelésének részletes tapasztalatai. Trimbos Instituut, Utrecht.

Global Drug Survey (2014): Global Drug Survey 2014 findings. <http://www.globaldrugsurvey.com/facts-figures/the-global-drug-survey-2014-findings/> (utolsó elérés: 2015.06.25.)

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.

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.

Kapitány-Fövény, 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. Szeged 2015 január 28-31.

Magyar Honvédség (2016): Beszámoló a kábítószerügyi Éves jelentéshez.

NEFI (Nemzeti Egészségfejlesztési Intézet) (2016): A NEFI kábítószerhez kapcsolódó tevékenységei

Nemzeti Drog Fókuszpont (2010): Éves Jelentés 2010.

Nemzeti Drog Fókuszpont (2012): Éves Jelentés 2012.

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

NFP (2016): Tűcsere szolgáltatók országos találkozója. Nemzeti Drog Fókuszpont.

NRSZH (Nemzeti Rehabilitációs és Szociális Hivatal) (2016): Tájékoztató az EMCDDA számára készülő, 2016. Évi Jelentés elkészítéséhez

Nyíri, N. (2016): Új pszichoaktív szerek, a szintetikus kannabinoidok (biofű/herbál) fogyasztásának vizsgálata. Fogyasztók tapasztalatainak felmérése. Budapest, Kézirat

OAC (2016a): TDI adatgyűjtés halálozási modul: Kábítószer-fogyasztással összefüggő halálozási adatok 2014.

Oberth J., Bíró Zs., Mándi B. (2016): Beszámoló a Józan Babák Klub 2015. évi várandósgondozási tevékenységéről

OBH (Országos Bírósági Hivatal) (2016): Statisztikai Elemző Osztály adatai 2015.

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

Paksi, B. (2009). A jogerősen elítélt fogvatartottak kábítószer- és egyéb szenvedélyszer használata Magyarországon 2008-ban. Budapesti Corvinus Egyetem Magatartástudományi és Kommunikációelméleti Intézet Viselkedéskutató Központ. Kutatási beszámoló. Nem publikált tanulmány.

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

Paksi B., Magi A., Felvinczi K., Demetrovics Zs. (2015): Drogfogyasztás a magyarországi felnőtt népesség körében - a 2015. évi „Országos Lakossági Adatfelvétel Addiktológiai Problémákról” (OLAAP 2015) első eredményei. Magyar Addiktológiai Társaság X. Országos Kongresszusa 2015. november 26-28, Siófok, Supplementum kötet, pp. 53. [http://www.mat.org.hu/doksi/2015/Absztraktfuzet\\_MAT\\_X\\_2015.pdf](http://www.mat.org.hu/doksi/2015/Absztraktfuzet_MAT_X_2015.pdf)

Paksi, B., Magi A., Felvinczi K., Demetrovics Zs. (2016a): The prevalence of new psychoactive substances in Hungary – based on a general population survey dealing with addiction related problems (OLAAP 2015). IV. International Conference on Novel Psychoactive Substances (NPS). Budapest, 30-31 May

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

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

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

Péterfi, A., Tarjan, A., Horvath, G. C., Csesztregi, T., & Nyirady, A. (2014). Changes in patterns of injecting drug use in Hungary: a shift to synthetic cathinones. *Drug Test Anal*, 6(7-8), 825-831. doi: 10.1002/dta.1625

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

Péterfi A., Major M., Dunay M. (2016): Dropterápiás intézetek vizsgálata 2015. Nemzeti Drog Fókuszpont. Unpublished thesis.

Péterfi, A. (2016): „Tisztább kép” - Együttműködési program az új szintetikus drogok feltérképezéséért. Időközi beszámoló az első 10 hónap eredményeiből (2015. március – december) . Budapest. Magyar Ökumenikus Segélyszervezet. Unpublished thesis. [http://www.segelyszervezet.hu/sites/default/files/documents/isec\\_idokozi\\_beszamolo\\_hu\\_pet\\_erfi\\_05\\_0.pdf](http://www.segelyszervezet.hu/sites/default/files/documents/isec_idokozi_beszamolo_hu_pet_erfi_05_0.pdf)

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

Port, Á. (2013): Felmérés az új pszichoaktív anyagokat árusító magyarországi internetoldalakról az EMCDDA Online Snapshot vizsgálatának részeként, 2013. EMCDDA/Nemzeti Drog Fókuszpont.

Port Á., Tarján A. (2014): A Büntetés-végrehajtás Országos Parancsnokság és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben végzett kérdőíves felmérés eredményeiről készült kutatási beszámoló. Unpublished thesis.

Port, Á. (2016): A Büntetés-végrehajtás Országos Parancsnoksága és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben 2016 júniusában végzett kérdőíves felmérés eredményei.

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

Rendőrség (2016): A Rendőrség 2015. évi tevékenységéről szóló beszámolója

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

Ritter, I. (2013): Fertőzések és félelmek a büntetés-végrehajtási intézményekben, OKRI. Unpublished thesis.

Szécsi, J., Sik, D. (2016): Szerhasználat egy hátrányos helyzetű járás szegregátumaiban, Esély 2016/2, 115-131. old.

Tarján (2013): Kiegészítő adatgyűjtés a szubsztitúciós kezelést biztosító drogambulanciák körében.

Tarján, A (2015a): Tűcserék az ellátórendszerben 2014-ben. Nemzeti Drog Fókuszpont.

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

Tarján, A (2016a): A rekreációs színtéren ártalomcsökkentő/prevenációs tevékenységet végző szervezetek 2015. évi működési és forgalmi adatai. Nemzeti Drog Fókuszpont.

Tarján, A (2016b): Tűcsere programok adatai, 2015. Unpublished thesis. Nemzeti Drog Fókuszpont.

TDI adatgyűjtés 2016.

Topolánszky, Á., Felvinczi, K., Paksi, B., Arnold, P. (2009): A magyarországi drogterápiás intézetek működése és értékelése című kutatás elsődleges eredményei. „Addiktológia a változó kihívások korában”. MAT VII. Országos Kongresszusa. 2009. november 19-21. Siófok. Supplementum kötet, pp. 75.

Tresó, B., Barcsay, E., Tarján, A., Horváth, G. Cs., Dencs, Á., Hettmann. A., Csépai, M., Győri, Z., Rusvai, E., Takács, M., (2011): Prevalence and Correlates of HCV, HVB, and HIV Infection among Prison Inmates and Staff, Hungary. Journal of Urban Health: Bulletin of the New York Academy of Medicine. doi:10.1007/s11524-011-9626-x.

Varga, O. (2016): A kábítószeres utcai árainak alakulása 2015-ben. Nemzeti Drog Fókuszpont kérdőíves adatgyűjtés.

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

## ANNEX

### LIST OF TABLES

Table 1. Changes in the legal framework in the last year.....	17
Table 2. Lifetime prevalence of cannabis use along different sociodemographic characteristics in the general population between 18-64 years, in 2015 (%) (N=100).....	25
Table 3. Lifetime prevalence of cannabis use along different sociodemographic characteristics among students on 9-10 grades, in 2015 (%) (N=1230).....	27
Table 4. Lifetime prevalence of classical stimulants use along different sociodemographic characteristics in the general population between 18-64 years, in 2015 (%) (N=60).....	34
Table 5. Lifetime prevalence of stimulant use along different sociodemographic characteristics among students on 9-10 grades, in 2015 (%) (N=454).....	36
Table 6. Breakdown of streetnames by the laboratory confirmed active substance (main component) in the 'Tisztább kép' project (N=100).....	44
Table 7. The number of school health development programme applications submitted to the NEFI for approval broken down by subject and number of programmes finally supported ....	60
Table 8. Number and final results of school health development programme applications relating to drug use submitted for professional approval to the NEFI .....	60
Table 9. Network of outpatient treatment facilities (total number of units in 2015).....	69
Table 10. Outpatient treatment provision (the number of clients starting treatment in 2015).....	70
Table 11. Network of inpatient treatment facilities (number of treatment units in 2015).....	71
Table 12. Inpatient treatment provision (number of clients starting treatment in 2015).....	72
Table 13. Breakdown of direct drug-related deaths in 2015 by gender and substance type (persons).....	96
Table 14. Breakdown of direct drug-related deaths by age group and substance type in 2014 (persons).....	97
Table 15. Number of direct drug-related deaths in 2015 .....	98
Table 16. Breakdown of registered HIV-positive persons (N) by risk group between 2011-2015 .....	99
Table 17. Breakdown of HCV prevalence among IDUs tested during the national HIV/HBV/HCV seroprevalence survey, by gender and age group in 2015 .....	100
Table 18. 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/HBV/HCV seroprevalence survey by primary injected substance, in 2015.....	101
Table 19. The number of IDUs participating in Budapest in the national HIV/HBV/HCV seroprevalence survey by testing site, 2014-2015 .....	103
Table 20. 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 2015 .....	103
Table 21. 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).....	105
Table 22. Types of harm reduction equipment distributed by harm reduction services in the recreational setting (N of responding organisations=23).....	107
Table 23. Syringe and client turnover data of NSPs in 2015 .....	108
Table 24. Breakdown of direct drug-related deaths, between 2009-2015 (persons) .....	114
Table 25. Price of drugs at street level in 2015 in HUF .....	123
Table 26. Price of drugs at street level in 2015 in EUR.....	124
Table 27. Number of seizures between 2011-2015 .....	130
Table 28. Quantity seized between 2011-2015.....	130
Table 29. Geographical differences – the first 5 most prevalent main components identified in each location (in the proportion of all cases with a main component at the given location) in samples collected between April and December 2015.....	138

Table 30. Main characteristics of prisoner and non-prisoner clients entering treatment in 2015  
(N<sub>prisoners</sub>=95; N<sub>non-prisoners</sub>=4213)..... 147

## LIST OF CHARTS

Chart 1. Lifetime prevalence rates by substances in the adult population between 18-64 years and 18-34 years, in 2015 (%).....	21
Chart 2. Lifetime prevalence rates by substances among students on 9-10 grades, in 2015 (%).....	22
Chart 3. Changes in the lifetime prevalence of cannabis use between 2001 and 2015, in the adult population between 18-53 years*.....	24
Chart 4. Changes in the lifetime prevalence of cannabis use between 1995-2015 among 16-year-old students (%).....	26
Chart 5. Frequency of drug use among QCT and non-QCT clients in 2015 (N=2350 persons).....	28
Chart 6. Lifetime prevalence rates of stimulants by drug type in the adult population between 18-64 years and 18-34 years, in 2015 (%).....	33
Chart 7. Changes in the lifetime prevalence of classical stimulants between 2001 and 2015, in the adult population between 18-53 years*.....	33
Chart 8. Changes in the lifetime prevalence of stimulants between 1995-2015 among 16-year-old students (%).....	36
Chart 9. Breakdown of NSP clients by primarily injected drug between 2009-2015.....	39
Chart 10. Breakdown of NSP clients injecting designer stimulants by primarily injected drug type in 2015 (N=2392 persons).....	39
Chart 11. Breakdown (%) of IDUs participating in the national HIV/HBV/HCV seroprevalence survey by primarily injected substance, between 2006-2015.....	40
Chart 12. Breakdown (%) of current stimulant injectors participating in the national HIV/HBV/HCV seroprevalence survey by primarily injected drug type, 2011-2015.....	41
Chart 13. Breakdown of IDUs entering treatment by primarily injected drug between 2007 and 2015 (%).....	41
Chart 14. Frequency of injecting drug use among IDUs entering treatment in 2015 (%).....	42
Chart 15. The proportion of injecting use among opioid users, by primary drug between 2009 and 2015.....	48
Chart 16. Types of interventions aimed directly at the final target group (N=96).....	62
Chart 17. Special target groups of interventions aimed directly at the final target group (%).....	62
Chart 18. Different objectives of interventions aimed directly at the final target group (N=53, %).....	63
Chart 19. Addictive behaviours in prevention interventions aimed directly at the final target group (N=96).....	63
Chart 20. Breakdown of treatment demand by primary drug (2015; %; N=4308).....	73
Chart 21. The proportion of those starting treatment as an alternative to criminal procedure (QCT) among those entering treatment, by type of treatment unit (2015; N=4298).....	73
Chart 22. Breakdown of QCT and non-QCT (regular treatment) treatment entrants by primary drug (2015; N <sub>QCT clients</sub> =2788; N <sub>Non-QCT clients</sub> =1510).....	74
Chart 23. Proportion of QCT and non-QCT clients among clients entering treatment by the category of the primary drug (2015; N <sub>QCT clients</sub> =2788; N <sub>Non-QCT clients</sub> =1510).....	75
Chart 24. Breakdown of clients in OST by substitution medication and therapeutic purpose (2015; N=669).....	77
Chart 25. Trends in numbers of clients entering treatment for the first time, by primary drug, 2007-2015.....	79
Chart 26. Trends in numbers of all clients entering treatment, by primary drug, 2007-2015.....	79
Chart 27. Trends in the number of clients entering treatment by categories of 'primary drugs' applied in the reporting and the three categories for 'other drugs' altogether between 2007-2015.....	80
Chart 28. Trends in numbers of clients in OST, 2004-2015 nincs mögöttes excel.....	81
Chart 29. Treatment unit type (N=28).....	82
Chart 30. Form of operation by type of treatment unit (N=28).....	83
Chart 31. Form of operation by financing resources (N=26).....	84

Chart 32. Availability of QCT (N=28) .....	84
Chart 33. Other units/programmes operated by the parent institution (N=28) .....	85
Chart 34. The estimated breakdown of drug user clients by primary drug in 2014 (on the basis of the responses from 25 treatment units) .....	86
Chart 35. Distribution of primary drug among clients entering rehabilitation treatment for 'illicit drug use', 2014 (% , N=555).....	88
Chart 36. Exclusion criteria projected on capacity (% , N=286) .....	89
Chart 37. Therapeutic approach applied by the organisations (N=15) .....	90
Chart 38. Reintegration programmes (N=15).....	91
Chart 39. Utilisation of DRID medical services, 2014 (number of units) .....	92
Chart 40. Breakdown of HCV prevalence among current IDUs tested during the national HIV/HBV/HCV seroprevalence survey by primarily injected drug in 2015 .....	100
Chart 41. The prevalence of sharing needles/syringes and sharing any injecting equipment in the past 4 weeks (%) among current IDUs participating in the national HIV/HBV/HCV seroprevalence survey in 2015.....	101
Chart 42. The syringe turnover data of NSPs, between 2011-2015 .....	112
Chart 43. Number of NSP clients and number of contacts, between 2011-2015.....	113
Chart 44. Breakdown of HCV prevalence (%) of IDUs participating in the national HIV/HBV/HCV prevalence survey by primarily injected drug, between 2007-2015 .....	115
Chart 45. Breakdown of registered drug offences (N=6330) by substance type in 2015 .....	126
Chart 46. Breakdown of registered drug offences by perpetration and substance type, 2015 .....	127
Chart 47. The number of seizures of 'classical drugs' and NPS between 2009-2015 .....	131
Chart 48. The frequency of occurrence (%) of cathinone derivatives (proportion of cases when the active substance was detected) in the substances, broken down by month between 2012-2015.....	131
Chart 49. Prevalence of active substances (%) detected in/on injecting drug use related equipment between 2009-2015 .....	133
Chart 50. The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between 2010-2015.....	133
Chart 51. The frequency of occurrences (N) of synthetic cannabinoid compounds (%), broken down by month between 2013 and 2015 .....	134
Chart 52. Average street prices (mean value) of illicit drugs in HUF between 2011-2015...	135
Chart 53. The number of registered drug offences in Hungary between 2011-2015 .....	136
Chart 54. Breakdown of drug offences by substance type between 2011-2015.....	137
Chart 55. Number of identifications of the 10 most prevalent classical drugs and new psychoactive substances identified as the main component in samples collected between March and December 2015 (N=2598) .....	138

## LIST OF ABBREVIATIONS

BM – Ministry of Interior  
BSI – Brief Symptom Inventory  
BSZKI – Hungarian Institute for Forensic Sciences  
Btk. – Hungarian Criminal Code  
BVOP – Hungarian Prison Service Headquarters  
CODA – Civil Ombudsman on Drug Affairs  
DTC – drug treatment centre  
ELTE – Eötvös Loránd University  
EMCDDA – European Monitoring Centre for Drugs and Drug Addiction  
EMMI – Ministry of Human Capacities  
EMQ – European Model Questionnaire  
ENYÜBS – Uniform Criminal Statistics System of the Investigation Authority and Public Prosecution  
ESPAD – European School Survey Project on Alcohol and Other Drugs  
FM – Ministry of Agriculture  
GDS – Global Drug Survey  
HBSC – Health Behaviour in School-aged Children  
HBV - hepatitis B virus  
HCV – hepatitis C virus  
HIV – human immunodeficiency virus  
HNFP – Hungarian National Focal Point  
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  
NAV – National Tax and Customs Administration  
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  
NPS – new psychoactive substances  
OAC – National Centre for Addictions  
OBH – National Office for the Judiciary  
OEK – National Centre for Epidemiology  
OEP – National Health Insurance Fund  
OGY – National Assembly  
OKRI – National Institute of Criminology  
OLAAP –  
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