European Monitoring Centre
for Drugs and Drug Addiction

2004 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point

"HUNGARY"
New Development, Trends and in-depth information on selected issues

REITOX

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SUMMARY

Working out the National Drug Strategy decision makers were influenced by the outcome evaluation of the laws being in force when deciding on necessary legal policies, accordingly on the amendment to the facts of misuse of narcotic drugs in 2003.
The most outstanding change was the amendment to the legal regulation of alternatives to prison in cases of misuse of narcotic drugs. The amendment to the Act IV of 1978 on the Criminal Code by the Act II of 2003 was declared on January 14, 2003. The new regulations came into force on March 1, 2003.
Section 283 regulates the diversion of drug users to alternatives to prison. Previous regulations only granted this option to drug-addicts provided that they participate in a continuous six-month-long treatment. The amendment of 2003 extended the availability of alternatives to prison to all drug users, instead of limiting it to addiction.
A drug user may be diverted to alternatives to prison "*provided the offender in question is able to produce an official document before he is sentenced in the first instance to verify that he has been treated for drug addiction for at least six consecutive months or that he has participated in a drug addiction program or a preventive-consulting service*"[1].

The amendment to the Criminal Code needed formulating laws on proceedings accordingly. Subsection 2 Section 222 of Act XIX. of 1998 on Criminal Procedure (in force since July 1, 2003) regulates the proceeding if grounds for the termination of culpability determined in Section 283 of the Criminal Code exist. "*The accusation against the offender may be postponed*" for one year provided that the drug user participates in treatment or preventive service. Should the drug user produce an official document verifying that he has participated in such treatment or service, namely the period of postponement has elapsed successfully proceeding shall be terminated. An offender committing misuse of narcotic drugs may be diverted to alternatives to prison only once within the period determined by the law.

As the availability of alternatives to prison has been extended also to non-addicted drug users widening of the appropriate alternatives to prison has become necessary. In addition to treatment of drug addiction other care and preventive-consulting services emerged as alternatives to prison. The execution of such care and services is regulated by the Decree No. 26/2003 (V.16.) of the Minister of Health, Social and Family Affairs and the Minister for Children, Youth and Sports.
34 organisations provide preventive-consulting services nationwide. Two thirds of the service providers are NGOs (foundations, associations), one third of them are other public institutions run by municipalities or the state. Providers of treatment of drug addiction and other care of use are mainly health-care institutions and specialised outpatient centres.

Patterns of drug use in the Hungarian population show an unquestionable increase but different intensity in illicit drug use among primary and secondary school students since the middle of the 90's. However students who had ever tried any drugs are mainly initial or occasional users. Beside the dominance of cannabis in the substance structure each study emphasises the spread of misuse of pharmaceuticals, especially among girls. The data indicate that use of illicit drugs starts at an even earlier time compared to data from previous years. Surveys proved that prevalence of illicit drugs increases with the age and the highest rates are observed in the age group of 18-24 and/or among university students. Surveys conducted among adults also showed an increased spread of illicit drug use. This increase was primarily due to the spread of marijuana use.
As for the attitudes of the Hungarian society, data still reflect a slender knowledge and disapproving attitudes towards illicit drugs and illicit drug users.

[1] Source: HMJ English – Act IV of 1978 – On the Criminal Code

In 2003 a long-term research project continued in the field of prevention. The objective of this research is the comprehensive monitoring and evaluation of prevention programmes. As the first outcome of this research a national register including all prevention programmes targeted at the school population has been built up according to the data collection criteria of EDDRA. That year 136 organisations ran 280 school-based prevention programmes in total. 60% of these programmes were directly targeted at students, a further 40% implied peer and teacher training. Nearly every fourth student of all Hungarian students aged between 6 and 18 was involved in a kind of drug-prevention programme.
No data of similar depth are available on out-of-school prevention activities. 121 organisations ran out-of-school prevention programmes all over the country. Prevention at workplace involved around 20,000 employees.

NGOs, organisations run by the church and self-help groups have a growing role in treatment of drug users. Social workers and abstinent drug-addicts are more and more involved in the work of such organisations and centres. According to recent trends treatment was provided to drug users decisively in outpatient treatment centres. The scope of activities of outpatient centres is heterogeneous. Homogenous treatment models are missing and diagnostic and treatment methods have not been crystallized yet. Two new rehabilitation centres were opened in addition to the existing 9 ones in 2003. One new institution providing substitution/methadone treatment started to operate in the capital.

As for the health correlates and consequences of drug use HIV prevalence in the injecting drug user population in Hungary is so low that it could not be measured by the methods used in 2003. Trends of acute Hepatitis B and Hepatitis C among injecting drug addicts reflect that no changes occurred in the number of new HBV infections in the last three years and the number of acute HCV infections have been continuously decreasing since 1998. To sum it up HCV prevalence in the population of injecting drug users at the age of under 25 was higher than the average, therefore further interventions are needed in order to reduce the risks at these “young” users becoming infected.
Organisations formed a unity and took concrete steps in even distribution of charity donations and nationwide coverage with the purpose of prevention and treatment of infectious diseases. National organisations providing low-threshold services employed skilled experts and had the tools to counselling and information dissemination.
Due to the lack of the data collection system we have no comprehensive view on drug-related deaths and mortality. As regards overdoses in 2003 the number of opiate-overdoses decreased in comparison with the preceding years’ trends but the number of overdoses of cocaine, amphetamine and licit drugs (mainly pharmaceuticals) increased.

The intention to reduce negative social consequences of drug use can be detected in the first phase amendment to the Implementation Order (Decree No. 1/2000 (I.7) of the Minister of Health, Social and Family Affairs on the Tasks and the Conditions of Operation of Social Institutions providing Personal Care) of Act III. of 1993 on Social Administration and Social Services that was concluded in 2003. This decree names low-threshold services in the context of both outpatient care and special primary care (community-based care for drug addicts) and lists psychosocial care and harm-reduction programmes as responsibilities of the service providers. Prior to the establishment and operation of the afore-mentioned institutions social reintegration model programmes, specialised at drug users, were run mainly by NGOs.

1. NATIONAL POLICIES AND CONTEXT

Overview

The Hungarian drug policy is based on the national strategic programme worked out for the reduction of drug-related problems and was accepted by the Resolution No. 96/2000 (XII.11) of Parliament on December 11, 2000, with political consensus. The Resolution remained in force following the change of the Government in 2002. General objective of the Strategy is the establishment of a '*free, confident and productive society*' that gives high importance to human dignity, bodily, spiritual and social welfare and creativity. It is able to *'manage the health, social and criminal hazards and harms related to drug use and trade' in order to* preserve and improve the mentioned values. Considering the interpretation models of the drug-phenomenon the Parliament agreed on the *multidisciplinary* approach and - in the context of the problem's management - it accepted the approach based on the *equilibrium of demand- and supply reduction*.

The Government developed an action plan in its Resolution No. 1036/2004 (IV.12.) to carry out the short- and middle-term tasks defined in the Strategy. A report is presented to the Government on the implementation every year.

The Coordination Committee on Drug Affairs is the key-organisation of the Strategy's implementation and the coordination at national level. The Committee's chairman is the Minister for Children, Youth and Sports, its co-chairman is the Minister of Health, Social and Family Affairs, its secretary is the Deputy Secretary of State being responsible for the Co-ordination of Drug Affairs working within the Ministry for Children, Youth and Sports. The Coordination Committee on Drug Affairs is to inform the Government on the drug situation in Hungary and on the evaluation of the implementation of the National Drug Strategy annually.

In 2003 one of the most important developments was the amendment to the rules of law on the "misuse of narcotic drugs" in the Criminal Code. The in 1998 aggravated regulations aroused serious public debates and their approach was not in harmony with the National Strategic Programme, accepted in the meantime. The Government reformed the earlier mitigations, distinctions and amendments to these regulations. At the same time the necessary amendments were also made to the Act XIX. of 1998 on Criminal Procedure.

The Government invited the Minister for Health, Social and Family Affairs in the Government Decree No. 1091/2003 (IX.9) to prepare a submission on the establishment and operation of the Hungarian National Focal Point. According to the Government Decree No. 28/2004 (II.28.) the Hungarian National Focal Point started its activity on January 1, 2004.

Drug issues aroused a number of public debates in 2003: on the amendment to the Criminal Code, on the decriminalisation of light drugs and the re-regulation of obligation to report in the Act on Public Education. Public opinion on drug issues is characterised with hardly differentiated risk-perception which leads to the highest level of disapproval concerning drug users among socially disapproved groups in Hungary.

1.1. LEGAL FRAMEWORK

Laws, regulations, directives in the field of drug issues

a.) **Amendment to the Act IV. of 1978 on the Criminal Code by Act II. of 2003**
In harmony with its criminal-political efforts, the Hungarian Government taking office in the summer of 2002 submitted a bill to the Parliament in the beginning of its term (Bill No. T/1218 on the amendment to the criminal statutes and the relating acts).
The new concept aims at the followings:

- formation of criminal laws facilitating the implementation of the National Drug Strategy to reduce drug-related problems,
- reduction of unfavourable trends in drug-related crime,
- a more differentiated criminal judgement of misuse with narcotic drugs by the actors on the drug scenes
- implementation of laws fostering the more efficient special prevention targeted to drug using offenders (that means both prevention of repeated drug use and prevention of the commission of drug-related crime),
- enforcement of security in law.[2]

The bill, which aroused huge public and political debate, was adopted by the Parliament of the Hungarian Republic on December 23, 2002 and declared on January 14, 2003. The new regulations entered into force on March 1, 2003.
The points of the amendment are:

- Section 282 regulates the "consumption-related drug offence" ("*...without authorization, produces, manufactures, acquires, possesses, imports of exports narcotic drugs into or from Hungary or who transport such through the territory of Hungary...*"[3]). *"....the punishment shall be up to two years' imprisonment for a misdemeanour in the case of....[4]"* commission of one of the crimes defined above, and the it shall be up to ten years' imprisonment in the most serious case. Considering this legal fact drug consumption is punishable in respect of "acquisition" and "possession" (namely, illegally possesses). If consumption is committed in respect of a small quantity of narcotic drugs (it is determined in the Act as max. 0.6 grams in the case of heroin and max. 1 gram of pure active-ingredient in the case of drugs containing THC), the punishment shall be up to two years' imprisonment. (The former regulation named "consumption" as such and it was – independently of the quantity of drug consumed – punishable by up to two years' imprisonment.)
- Section 282/A regulates the "distribution-related drug offence" (*"...without authorization, offers or supplies narcotic drugs or is engaged in distributing, trafficking or dealing narcotic drugs..."*). This legal fact focuses on the punishment of distribution and trafficking or dealing narcotic drugs and/or on the punishment of distributors, dealers. "*If the criminal act is committed in respect of a small quantity of narcotic drugs the punishment shall be up to two years' imprisonment for a misdemeanour in the case of..[5]."* commission of one of the crimes defined above. "*The punishment shall be even lifetime imprisonment if the criminal act is committed in respect of a substantial quantity of narcotic drugs*.[6]"
- Section 282/B secures more extensive criminal defence of the juvenile (persons under the age of 18) against misuse of narcotic drugs and/or substance or agent that has a narcotic effect but not classified as a narcotic drug. Offences are the

[2] cited from the General Rational of the Act II. of 2003
[3] Source: HMJ-English – Act IV of 1978 – On the Criminal Code
[4] Source: Subsection (5) Section 282 of the Act IV of 1978 on the Criminal Code
[5] Source: Subsection (6) Section 282/A of the Act IV of 1978 on the Criminal Code
[6] Source: Subsection (3) Section 282/A of the Act IV of 1978 on the Criminal Code

same as defined in the previous two legal facts. Punishments to be imposed are graver (certainly, no graver punishment can be imposed herein than lifetime imprisonment) and the offender should be "*over the age of eighteen*".

- Section 282/C relates to drug-addicted offenders and it orders more lenient punishment in the case of the afore-mentioned legal facts. "*If the criminal act is committed by a drug-addicted person in respect of a small quantity of narcotic drugs, the punishment shall be up to one year's imprisonment* (instead of former two years' imprisonment)*, community service or a fine...*[7]*". "The punishment shall be up to five years' imprisonment if the criminal act is committed with respect to a substantial quantity of narcotic drugs.*[8]*"* (replacing the former regulations ordering a punishment of from two to eight years' imprisonment).
- Section 283 regulates the cases and conditions of the offender's diversion to alternatives to prison by "grounds for the termination of culpability" in accordance with the principles in the Hungarian criminal law. The most important amendment to the previous regulation is that it is not presumed that only drug-addicted persons may be diverted to alternatives to prison. Alternatives to prison are available to each consumer category (occasional, regular, addicted user) (the regulations are again the most lenient for drug-addicted persons)[9]. Alternatives to prison are only available to a non-addicted user-offender if he commits the above-listed offences in respect of a small quantity of narcotic drugs. Regarding the commission of an offence, alternatives to prison may only be applied to consumption-related offences, especially to the lenient versions. Two distribution-related conducts, however, are exceptions for this regulation, namely those of "offers" and "supplies": "*if it* (the offence) *involves a small quantity offered or supplied to be consumed jointly*[10]*"* the offender may be diverted to alternatives to prison. (For more information on alternatives to prison targeted to drug-using offenders, please see Chapter 12.)

After the bill had become public, the last amendment became the most discussed and doubted. It is clear from the relevant commentary that it is not the offender of an offence like distribution or dealing who can claim to be diverted to alternatives to prison.

b.) **Amendment to the Act XIX of 1998 on Criminal Procedures**

Procedural stipulations to alternatives to prison are defined in the Act XIX of 1998 on Criminal Procedure being in force since July 1, 2003.

In case the proceeding against the offender is subject to postponement on the grounds for the termination of culpability listed in Section 283 of Act on Criminal Code, the public prosecutor shall postpone the accusation for a period of one year provided the offender undertakes to enter treatment of drug addiction or other care or preventive-consulting service treating drug use. If the accusation has not been postponed but the legal conditions of termination of the proceeding exist the jury shall postpone the proceeding provided that the offender agrees on entering treatment.

The essence of this amendment is that there is no possibility to postpone the proceeding during the investigation phase but legislator intends to involve alternatives to prison by forcing the state prosecutor to postpone the act of accusation. The role allotted to the state prosecutor is in accordance with the general concept of the new Act on Criminal Procedure. This, at the same time, can be of disadvantage to the offenders as they may

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[7] Source: Subsection (5) of Section 282/C of the Act IV of 1978 on the Criminal Code

[8] Source: Subsection (4) of Section 282/C of the Act IV of 1978 on the Criminal Code

[9] Paragraphes e) and f) of Subsection (1) of Section 283 "allows them more", so – for example – a drug-addicted person may also be diverted to alternatives to prison if he "produces, manufactures, acquires, possesses" narcotic drugs of a quantity exceeding small but not amounting to substantial quantity for own use [1. of Paragraph e) of Subsection (1) of Section 283. of the Criminal Code]

[9] Source: Subsection (1) of Section 283 of the Act IV of 1978 on the Criminal Code

only apply for treatment in a later phase of the proceeding thus replacing the act of accusation.

c.) **Decree of the Minister of Health, Social and Family Affairs and the Minister for Children, Youth and Sports No. 26/2003. (V. 16.)**
The joint Decree of the Minister of Health, Social and Family Affairs and the Minister for Children, Youth and Sports No. 26/2003 (V. 16.) includes detailed regulations on the treatment of drug addiction classified by Section 283 of the Criminal Code and other care or preventive-consulting service treating drug use. According to the decree a preliminary test has to be carried out in order to estimate the severity of addiction. Based on the results of this test drug addicts may enter only treatment of drug addiction. The joint decree determines the time period of diversion to alternatives to prison, the minimal frequency of sessions, the qualitative requirements of them, the time frame and parameters if changing the institution and the official documentation verifying that the person in question took part in diversion.

d.) The **Johan Béla National Programme for the Decade of Health** was accepted by a solid consent of the Parliament in the Decree No. 46/2003 (IV.16) of Parliament.
One of the main objectives of the programme is – in accordance with the alcohol policy - to reduce and prevent drug use and the health and social harms it may cause. This objective shall be accomplished by the improvement of prevention and treatment centres, by the sensitisation of the society and the establishment of a monitoring network.

e.) **Government Decree No. 162/2003. (X. 16.)** regulates the cultivation, trafficking and usage of plants used to produce narcotic drugs. (This decree was amended twice in 2004 by the Government Decree No. 56/2004 (III.31) and No. 142/2004 (IV.29)).

f.) Joint **Decree of the Minister for Justice, the Minister for Interiors and the Minister of Finance No. 11/2003. (V. 8.)** on seizures and handling, registration, preliminary sales and elimination of properties seized as well as on the execution of seizures. (Sections 78-88 include regulations on narcotic drugs, psychotropic substances and precursors.)

g.) Based on the **Amendment to the Act on Probation Officers by the Act XIV of 2003** a centralised organisation has been established under the Ministry for Justice operating along common professional criteria. The activities of probation officers concern drug prevention and treatment programmes related to the postponement of accusation on misuse of narcotic drugs. It also covers tasks arisen in context to probation and programmes starting in penal authorities and continuing after release.

h.) Section 76/A, B and C of **Decree of the Minister of Justice No. 6/1996 (VII.12)** on the execution of imprisonment and preliminary detention entered into force January 1, 2003. This decree allows the penal authorities to set up drug prevention departments for those prisoners who apply voluntarily. After the decree had entered into force such departments were set up in 12 penal authorities.

i.) **Government Resolution No. 1091/2003 (IX.9)** ordered the Minister of Health, Social and Family Affairs to prepare a submission on the Government Decree on the establishment and operation of the National Focal Point.

j.) The Parliament accepted the National Crime Prevention Strategy by the **Decree No. 115/2003 (X.28) of Parliament** that presumes and intends to develop close cooperation with the National Drug Strategy.
Objectives of the National Crime Prevention Strategy are:

1. to reduce child and juvenile delinquency,
2. to improve the safety of cities,

3. to prevent violence in families,
4. to prevent victimisation,
5. to prevent repeated crime.In accordance with the above the Government established the National Academy for Crime Prevention.

Laws implementation

A discrepancy between the intentions of legislation and law implementation could be observed under the force of the previous, aggravated Criminal Code. Judicial practice varied from county to county or from town to town. The annual fluctuation in the number of revealed cases of misuse of narcotic drugs also supposes a shift in the emphasis in criminal justice and primarily in the operation of the police.

There is still no common practice how to determine (calculate) the quantity of drugs used by the offender and for this reason not existing. Albeit committing the offence only on a small quantity of narcotic drugs is a fundamental condition to claim alternatives to prison. There are no common professional criteria on how to diagnose drug addiction either. In several cases only ideas or controversial and non-convincing opinions arise.

Recent experience shows that there has been a significant increase in the number of postponements of accusations for misuse of narcotic drugs in the capital. This causes different problems:

- can the offender's participation in treatment before postponing the accusation – in case of continuity – be added to the treatment period starting after the decision?
- can the state prosecutor investigate the voluntary participation in treatment before accusation?
- can he terminate the proceeding - for instance – provided that the defendant's participation in a six-month treatment is verified? This issue appears in health-care centres on a daily basis.

1.2. INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES

The change of Government in May 2002 followed by a change in person of the national drug coordinator in October 2003 did not result any realignment in basic frames of the drug-policy. The Parliament decree on National Drug Strategy remained in force and the political parties confirmed the necessity of this concept. The proposal for amendment to the Criminal Code submitted in the beginning of the new Government's term was targeted at "the formation of criminal laws facilitating the implementation of the National Drug Strategy".

Major tasks of the Coordination Committee on Drug Affairs are to monitor the implementation of the National Drug Strategy, to co-ordinate the operation of the competent ministries and the state-run institutions, to narrow sectional approaches. It is also the responsibility of the Coordination Committee on Drug Affairs to inform the Government about the development of the drug situation in Hungary and about the evaluation of the National Drug Strategy's implementation on a yearly basis. After the changes in the governmental structure the Coordination Committee on Drug Affairs reviewed its statute and submitted a proposal for amendment (Government Decree No. 1035/2003. (IV.24)) on November 21, 2002. As a consequence new representatives were delegated to the Coordination Committee and the National Committee for Crime Prevention became a member organisation with consultation rights.

In 2003 two most outstanding results of the operation of the Coordination Committed on Drug Affairs were as follows:

- an agreement in March on the allocation of an extra source of nearly HUF 700 million (EUR 2.8 million) reserved in the national budget to implement the so-far not implemented elements of the National Strategy
- declaration of the charges of the Coordination Committee on Drug Affairs in a government decree concerning the establishment of the REITOX National Focal Point.

The evaluation of the National Drug Strategy's implementation and effects is still running in the frame of the "MATRA Project".

1.3. BUDGET AND PUBLIC EXPENDITURE

The National Drug Strategy defines a uniform approach and an action plan supported by the professional organisations in Hungary. Substantial extra sources are, however, needed for its implementation. In the autumn of 2002 the Minister for Children, Youth and Sports presented to the Government in which a one-off support of HUF 7.9 billion (EUR 31.6 million) was requested for the Strategy's implementation. This submission constituted the extra-budget of HUF 700 million (EUR 2.8 million) for 2003 in the chapter of the Ministry for Children, Youth and Sports of the National Budget. The ministry being responsible for the co-ordination of drug affairs, discussed with the ministries being competent in the implementation of the National Drug Strategy, decided to spend the extra-budget on the most urgent tasks to reduce drug-related problems. Based on the proposals of each ministry a summary was prepared and accepted by the Decree of the Coordination Committee on Drug Affairs No. 2./2003 at its meeting on July 8, 2003.

Table 1. *Resource requests of ministries to reduce drug-related problems*

Ministry / Supreme Authorities	(EUR thousand)	(HUF million)
Ministry of Interiors	707.7	179.4
Ministry of Health, Social and Family Affairs	499.8	126.7
Ministry for Children, Youth and Sports	980.6	248.6
Ministry of Defence	80.9	20.5
Ministry for Justice	107.7	27.3
Ministry of Education	203.9	51.7
Ministry of Finance, (Customs Police)	111.6	28.3
Total	**2692.2**	**682.5**

Source: Decree No. 2/2003 of the Coordination Committee on Drug Affairs

We have no exact data on the allocation of the competent ministries when implementing the National Drug Strategy.

Act LXII. of 2002 disposes of the 2003 Budget of the Hungarian Republic. According to it (Chapter XXIV) the following amounts were allocated for the fields supported by the Ministry for Children, Youth and Sports.

Table 2. *Resources provided to programmes supported by the Ministry for Children, Youth and Sports*

Description of the programme	(EUR thousand)	(HUF million)
Drug-related training, extension training and peer training	341.2	86.5
Drug prevention	1313.2	332.9
Drug-related research and studies	157.8	40
Improvement of services provided by low-threshold and treatment centres	819.7	207.8
Implementation of the National Drug Strategy	3869.6	981.0
PHARE programme on the “Development of Institutions of Coordination Forums on Drug Affairs”	1026.4	260.2
Total	**7527.9**	**1908.4**

Source: Ministry of Finance

1.4. SOCIAL AND CULTURAL CONTEXT

Debates on drug issues

Although the National Drug Strategy and the necessity of its implementation was accepted with consensus the Criminal Code and the importance of criminal policy aroused serious political and public debates. The parliamentary debate on the bill of amendments to the criminal statutes and the corresponding acts lasted 13 hours and 20 minutes, followed by voting by name. The amendments to the criminal laws generated public debates not only at this time but also at the announcement by the President (January 14, 2003) and their entry into force on March 1, 2003. Most professional organisations – except for one – welcomed these amendments to the criminal policy. A number of social organisations, however, protested.

Hempseed Association organised a demonstration titled “Free Cannabis!” for the de-criminalisation of cannabis use on May 4, 2003. This event was part of the international event series “Million Marijuana March”. Reflections of the media before this event “organised” an anti-demonstration on May 4 where numerous conservative social organisations appeared.
The Ministry for Children, Youth and Sports organised a professional debate on May 21, 2003 to all those social and political organisations that joined the demonstration and/or the anti-demonstration on Vörösmarty Square on May 4. Despite the controversial concepts of the parties in several topics, a number of compromises were made following the debate where professionals also took part. The most important of these were the followings:

- drug-related problems should not be the basis of street actions in the future, they should be dealt within professional forums,
- the dialogue started on this issue should develop to a process,
- none of the organisations support drug-use, but prevention,
- criminal law may be the last tool in the process of reducing drug-related problems.

The third public debate aroused on the amendment to Act LXXIX. of 1993 on Public Education by Act LXI. of 2003. This debate was especially loud on the issue of parents' rights to be informed about students, including those who were caught because of drug use. The bill and the approved act considerably limited the rights of parents and stipulated information dissemination on the student's written permission.

Media representations

The late 80's
Public opinion on drug use and drug users was fundamentally determined by the distorted and negative images transmitted by mass communication (Oprics and Paksi 1998).
Exaggerating and biased publications led to the entire alienation and isolation of the public from the problem. Media emphasised the individual's responsibility. Due to limited knowledge of the problem society was not aware of the real dangers of drug use. It resulted in the following consequences:

- belief that only youth are involved in the drug problem
- excluding and stigmatising attitude towards drug users and drug use itself
- undifferentiated picture of drugs and drug users.

Changes in the 90's
By the end of the 90' drug-related problems had been given a great publicity in the written press. The number of normal-length articles increased by 50% and there was a growth in the number of illustrated publications. Most of these articles were endeavouring to reveal facts on the situation. There was a decrease in sensation-seeking articles and more unbiased publications were written. The most eye-catching change was the sevenfold increase in the number of publications on party-drugs. Such trends, however, were also seen in the number of articles on marijuana, heroin and other opiates. By the end of the decade professionals were asked for expertise on specific drug-related articles to an ever growing extent. Reasons began to be broadly revealed and the problem was no more addressed to the individual's responsibility. Offenders, drug maffia and the youth of today were most often blamed for the emergence and severity of drug-related problems. The number of publications listing solutions quadrupled. The improvement of drug-related education, health-care and aggravating punishment of drug dealers highlighted these proposed solutions. The development of drug policies and the reinforcement of the role of the family were lagging behind the aggravating punishment of drug dealers. Besides, the number of articles on effects and dangers of drugs tripled which could help shape of a more differentiated picture of drug types and improve risk awareness. (Nyírády and Schmidt 2000 Unpublished thesis)

Apart from this, conclusion can be drawn that the public radio station and TV channel and a few smaller commercial radio stations regularly broadcast programs on drug-related issues. Common feature of these programs is that they avoid informing the public in a sensational and distorting way in contrast to simple news-reading or occasional, event-related programs. These programs professionally look behind specific issues with reports and thematic interviews with experts.
Large commercial TV channels and radio stations primarily react on special cases (seizures, drug-related deaths...etc.).

The Ministry for Children, Youth and Sports has been supporting programs, information magazines, documentaries and films on drugs and drug-related prevention since 1999. It spent HUF 40,000,000 (EUR 160,000) on on-air and electronic media programs targeting drug-related prevention in 2003.
Major fields of allocated state funds:

- support of drug-related films,
- support of interactive games or programmes targeting drug-related prevention,
- support of construction of Internet surfaces targeting drug-related prevention,
- support of social advertisements targeting drug-related prevention,
- support of the release of leaflets and brochures on drugs,
- support of drug-related prevention programmes including media elements,
- support of events that receive substantial media representation.

Conclusions

The amendment to the Criminal Code and the Act on Criminal Procedure brought important changes in the legal regulation of drug issues in Hungary in 2003. The most outstanding amendment to the Criminal Code was the extension of the availability of alternatives to prison to non-addicted drug users. This amendment targeted the establishment of laws furthering the implementation of the National Drug Strategy.
Generally speaking, debates on drug-related criminal regulations intensified in the last couple of years. Endeavours for legalisation and decriminalisation became more active and intensive. It aroused significant social and – especially - political debates. The involvement of politics in these issues does not allow the debates to concentrate on the professional level.

2. Drug use in the population

Overview

In Hungary surveys on the spread of illicit drug use have been conducted in the general population and primarily in the youth population since the mid 70's. Due to the different methods most of these surveys were only able to record the existence of the problem.

Regular data collections started at the beginning of the 90's. First school surveys were conducted among secondary school students in the 11th grade (age of 17) in Budapest in 1992/1993 and later in some counties, as well. These used the methodological recommendations and questionnaire of the Pompidou Group at the Council of Europe (Elekes and Paksi 2000). In 1995, Hungary joined the European School Survey Project on Alcohol and Other Drugs (ESPAD). Hungary has participated in each ESPAD survey so far. Additional data were collected with the ESPAD questionnaire and methodological guidelines in Budapest in the years of ESPAD surveys and in 1998, 2000 and 2002. It enables to analyse the changes in patterns of use among secondary school students in Budapest between 1992 and 2003.
Hungary has been participating in the "Health Behaviour in School Aged Children" surveys since 1985 which is the comparative research series on health behaviour of school population at the age of 11-15 (incl. 17-year-old population in Hungary) on an international level. Although this survey does not focus on illicit drug use the questionnaire of 2002 asks detailed data on this issue (in the 9th and 11th grade, age of 15 and 17 in Hungary) for the first time (Aszmann 2003).
The data on secondary school students show that lifetime prevalence of illicit drugs and/or inhalants (based on the comparative data on students in the 10th grade, aged 16) nearly doubled in the second half of the 90's compared to the beginning of the decade. Lifetime prevalence of pharmaceuticals' misuse also grew by more than 25%. The rate of use of illicit drugs and/or inhalants considerably increased among those misusing pharmaceuticals.
Following the trends in other European countries, marijuana has become the most widespread drug among youths also in Hungary. Lifetime prevalence of marijuana is the highest among those of illicit drugs. Although it did not differ from prevalence of other substances in the first half of the 90's and incidence data clearly reflected initial use, data from the last couple of years show an extreme spread of marijuana-use. Beside marijuana consumption the use of LSD and other hallucinogens, amphetamines and ecstasy is rather widespread and keeps on further spreading. Compared to marijuana much fewer secondary school students tried these drugs, on the average every 20th or 25th of them. The use of heroin, crack and cocaine almost tripled. But the spread of these drugs is still around 1-2%. In the previous years initial use of several types of substances at the same time have become ever more typical.

The first data collection on a national sample in the adult population (aged from 19 to 65), was conducted in 2001 which is comparable on international level. It partly used the illicit drug-related questions of the EMCDDA and partly the questions included in GENACIS (Gender, Culture, Alcohol – a Multy-national Study) programme (Elekes 2002, Paksi 2003a).
The results of the survey show that 6.5% of the adult population, aged between 19 and 65, have ever abused – illicit and/or inhalant – drugs intentionally and the overwhelming majority (6.4%) of the respondents have tried illicit drugs. Structure of drug use in the adult population does not significantly differ from that among youths (Paksi 2003a).

The survey could be repeated on a national sample of the population aged 18 to 54 in 2003. It enabled to analyse the changes in the adult population (Elekes and Paksi 2003a) for the first time.
Beside the afore-described surveys a number of regional and local researches were carried out particularly in the school-aged population in the previous years. From all these the research conducted in the university population - which is highly involved but not examined yet - in the regional centre of Southern Transdanubia is introduced below (FACT 2003).

Surveys concentrating on specific groups were conducted among juvenile offenders living in reformatories (Kökönyei et al 2003 unpublished thesis) and among party-visitors (Demetrovics 2004a). As far as we know drug-related surveys were conducted in the army as well but the results are not public.

Methodology

Outcome of the following surveys are introduced in this report[11]:

Alcohol and Drug Use in the Adult Population (ADE) 2003. National representative sample (net sample size: 3675, response rate: 91.6%); multi-mode questionnaire including face-to-face and self-reporting elements (Elekes and Paksi 2003a, unpublished thesis)

Budapest School Survey 2003. Representative sample of students in the 8th, 9th and 10th grade (aged 14-16) in schools of Budapest (net sample size: 2453, response rate: 79.8%), self-reporting questionnaire based on the ESPAD standards. (Elekes and Paksi 2003b)

Additional questions to „ESPAD'03" and „ADE 2003" on the connection between visiting shopping malls and drug use. Sample frame and method of data collection coincided with the above-described surveys. (Paksi B. 2004a unpublished thesis)

Relation of the university population to drugs 2003. Representative sample of regular students enrolled in the Pécs University in the school year 2002/2003 (net sample size: 2533). Face-to-face interviews and self-reporting questionnaire on drug use. (FACT 2003 unpublished thesis)

Survey titled "Drug and Deviance" on sample of 176 juvenile males (aged 14-18) living in semi-open reformatories with self-reporting questionnaires. (Kökönyei et al. 2003 unpublished thesis)

Survey among youths visiting parties of electronic music. 1059 youths were questioned at parties of electronic music by self-reporting questionnaires nationwide (Demetrovics 2004a, Manuscript).

2.1. DRUG USE IN THE GENERAL POPULATION

In the adult population survey conducted on a representative sample in 2003 11.4% of the respondents reported to have tried illicit drugs. Last year prevalence is 4.4% and last month prevalence 1.6%. Nearly two fifths of those who have ever used illicit drugs used it in the last year; 13.5% of them used illicit drugs also in the last month. 6.6% of the respondents are quitters[12] and 4.3% are current users[13] in the population aged 18 to 54.

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[11] Surveys have been financed from national or regional resources through tenders or on an ad-hoc basis.
[12] ever used illicit drugs but not in the previous year
[13] used illicit drugs in the previous year

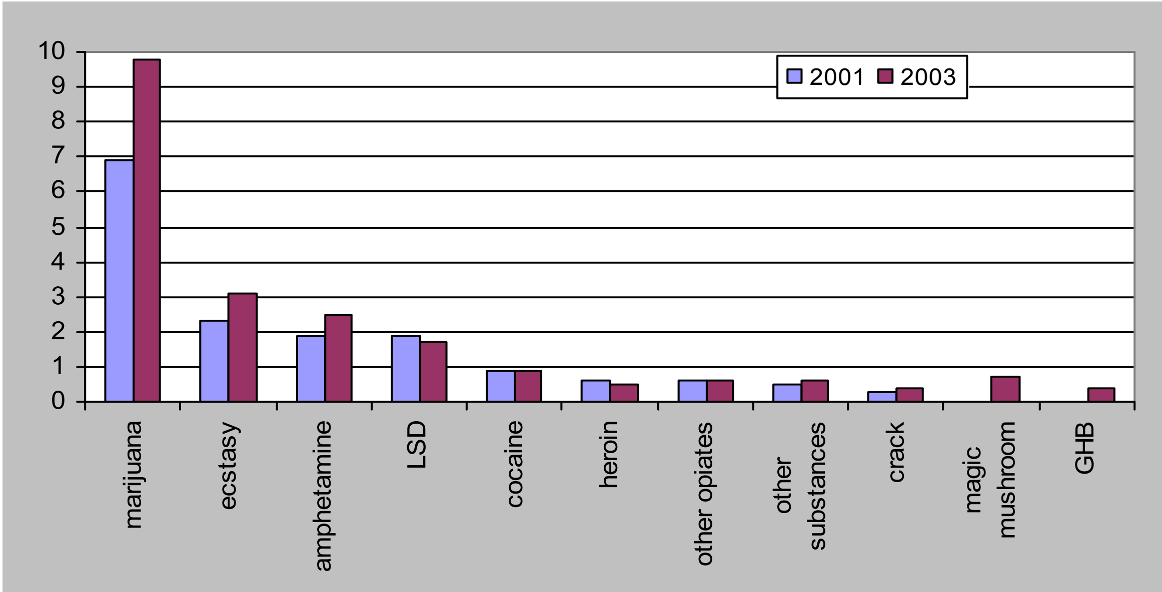
Alcohol is the most widely used legal drug but nearly half of the respondents (43.9%) also smoked in the previous month and the use of tranquillisers and/or sedatives on or without prescription was especially frequent among women.

The age of first use of illicit drugs in the adult population is under 25, on the average 19.5 years. More than half of the "ever users" were aged at or under 18 when trying illicit drugs and every fourth or fifth user experienced the first use at or under the age of 16.
In more than 75% of the cases, cannabis was the first substance used. 77% of those who ever used illicit drugs tried first marijuana or hashish. Every 20th or 25th user started with ecstasy or amphetamine. The number of those respondents who firstly used crack, cocaine or opiate was negligible and none of the respondents reported heroin as the first substance used.

Based on both lifetime and last year prevalence rates by substance cannabis was the most widespread (LTP was 9.8%, LYP was 3.9%). Incidence of all the other substances was much lower in the adult population. Based on lifetime prevalence ecstasy and amphetamines ranked second and third, their spread showed no considerable difference. LSD was hardly behind them at the fourth place. Lifetime prevalence of all other illicit drugs was lower than 1%.

Similarly to the research in 2001 data from the survey in the adult population suggest that illicit drug use is more typical for youths, men and those living in the capital or other big urban areas than for the national average.
Comparing the data of the research in 2003 to the corresponding age groups of the data collection in 2001 an obvious increase can be observed in the lifetime prevalence of illicit drug use. It grew from 7.7 % in 2001 to 11.4% in 2003. This rate of increase partly came from the increase in lifetime prevalence of marijuana (from 6.9% to 9.8%). The increase in the rate of regular use of all illicit drugs without incidence was within the limit of error (from 2.7% to 3.5%). It means that the rate of new users increased in the two years under review.

Figure 1. *Changes in lifetime prevalence of illicit drug use in the adult population aged 18-54, 2001-2003 (%)*



Source: Elekes, Paksi unpublished thesis 2003

An increase in the lifetime prevalence of illicit drug use can be detected among both women and men, in each age group.

2.2. DRUG USE IN THE SCHOOL AND YOUTH POPULATION

Primary and secondary school students

The outcome of the survey among school youths in the 8th , 9th and 10th grade (at the age of 14 to 16) in Budapest, conducted at the same time and applying the same methods as the ESPAD[14], indicate that in 2003 24.7% of respondents have tried illicit drugs. Last year prevalence is 18.6% and last month prevalence exceeds 10%. Illicit drug use is combined with a considerable use of pharmaceuticals among secondary school students. Based on lifetime prevalence rates tranquillisers and sedatives are the most often used substances by girls and take the second place after marijuana among girls and boys in respect of the last year and the last month prevalence (Elekes and Paksi 2003b). Party drugs like amphetamine or ecstasy rank the third in the structure of substances used.
The age of first use of illicit drugs is 14 to 15 years: two thirds of users tried drugs at this age. The majority of respondents reported marijuana or hashish as the first illicit drug used.

Table 3. *Age at first use*

Age	% of those who ever tried drugs
-11	2.3
12	6.3
13	13.0
14	31.0
15	32.4
16+	17.3

Source: Elekes, Paksi 2003b

The following changes can be detected when comparing the Budapest data in 2003 to those collected with the same methods among youths in the 10th grade in 1992[15]:

- After stagnation in the beginning of the decade cumulative prevalence of intentional drug use[16] drastically soared in the second half of the 90's followed by a repeated stagnation in 1999-2000. On the basis of data in 2002 and 2003 this stagnation is supposed to be temporary. Budapest data in 2003 suggest that the increase in lifetime prevalence of illicit drug use is primarily due to the increase of marijuana use.
- Spread of use was entailed by an increase in the intensity of use. Rate of the occasional and regular users increased in the second half of the 90's followed by a continuous increase in the rate of the most intense users (used drugs 40 or more times) in 1999 and 2002. In the last one year no significant change in this trend was observed (Elekes and Paksi 2000, Paksi 2002, Elekes and Paksi 2003c).

[14] Results of the national ESPAD survey are not public yet.
[15] The 1992 survey was conducted among students in the 11th grade
[16] illicit drugs and inhalants

Table 4. *Lifetime prevalence of drug use among secondary school students in the 10th grade (aged 16) in Budapest*[17]

Substance	1992[18]	1995	1998	1999	2000	2002	2003
Marijuana, hashish	5.4-7.2	6.0-8.6	12.9-20.9	20.9-28.1	21.1-28.3	25.7-32.9	27.9-35.5
Inhalants	2.7-4.1	3.5-5.5		2.3-5.5	1.6-4.4	2.0-4.8	2.2-5.2
Amphetamine	2.4-3.8	0.5-1.5	3.3-6.7	5.5-10.1	3.0-6.6	5.7-9.9	6.6-11.2
LSD and other hallucinogens	1.0-2.0	2.0-3.6	4.6-10.2	5.9-10.5	3.5-7.3	6.9-11.5	3.3-6.7
Crack	-	0.2-0.8	0.3-2.9	0.5-2.5	0.2-1.8	0.6-2.6	0.6-2.6
Cocaine	0.3-0.9	0.2-1.0	0.2-2.8	0.9-3.3	0.2-1.8	1.5-4.1	1.0-3.4
Heroin	-	0.2-0.8	0.1-2.5	0.3-2.3	0.2-2.0	0.8-3-0	0.2-2.0
Ecstasy	-	0.8-2.0	3.0-7.8	4.3-8.3	3.5-7.3	6.8-11.2	6.7-11.5
Injected drugs	-	0.2-0.8	0.2-2.8	0-1.1	0.3-2.1	0.4-2.2	0.1-1.5
Illicit drugs and/or inhalants	**10.4-12.8**	**10.5-13.7**	**-**	**25.0-32.6**	**23.4-30.8**	**28.3-35.7**	**31.10-38.9**
(N)	4518	2762	597	932	946	1083	982

Source: Elekes and Paksi 2000, Paksi 2002, Elekes and Paksi 2003c

University population

Data on the university population are available from the survey conducted at the Pécs University in 2003 (FACT 2003).
The outcome of this survey indicates that more than one third (35%) of the respondents have ever tried illicit drugs. 23% reported themselves to be initial users, 6.3% said they were occasional users and 1% proved to be regular users. As for the frequency of drug use differences are among girls and boys. 72.4% of girls have never used illicit drugs on the contrary to the 55.8% of boys. Each user's category reached higher proportion among boys. The most significant difference - exceeding 8% - was registered concerning initial use.
The proportion of those who never used illicit drugs was the lowest in the Technical College (56.3%) and the highest at the Faculty of Law (79%) comparing the various university and/or college faculties. Cannabis proved to be the most popular drug: one third (33.2%) of the respondents have already used it once or more times. Misuse of tranquillisers takes the second place behind cannabis: one tenth of the respondents reported this.
Most typical occasion for both licit and illicit drug use is "party time". The more frequent students go to a party the more chance they have to use illicit drugs.

Shopping mall visitors

The outcome of drug-epidemiology surveys, conducted on samples of youth population in the 8th to 10th grades (Elekes and Paksi 2003b) and on the representative sample of adult population (Elekes and Paksi 2003a), shows an increased vulnerability of regular shopping mall visiting youths. Parallel to the frequency of shopping mall attendance spread of illicit drug use also indicates an increase. Last year prevalence of illicit drug use among those students in the 8th to 10th grade (aged 14 to 16) who attend shopping malls several times a

[17] Actual prevalence data are supported by a 99% confidence interval
[18] Data collected on a sample of students in the 11th grade

week is twice as much as typical in this age group. Similar results came out of the surveys conducted in the adult population considering the frequency of shopping mall visits and the 18 to 34 year-old urban population being most at risk of illicit drug use.

Table 5. *Spread of illicit drug use among shopping mall visitors by frequency of attendance*

Frequency of attendance	Students in the 8th to 10th grade		Continuation rate, young adults aged 18 to 34 (N=1712)
	Lifetime prevalence (N=7890)	**Last year prevalence (N=7815)**	
Once a week	21.5	16.4	12
Several times a week	24.6	18.3	21.7
Nearly every day	29.7	24.4	26.3

Source: Elekes and Paksi 2003a, b

2.3. DRUG USE AMONG SPECIFIC GROUPS

In Hungary surveys have been conducted in two specific groups of boys living in reformatories. Although the size of the sample was small it represented the male population living in reformatories. These surveys indicated a lifetime prevalence of illicit drug use of 71%, last year prevalence reached 59.7%. These rates are much higher than that in the school-aged population. The rate of those who tried the most widespread drug, cannabis, was about three times higher than the rate measured in the school population by the HBSC survey. Use of party drugs (ecstasy, amphetamines and LSD) was ten times more widespread in these groups than in the school population. Use of inhalants and misuse of pharmaceuticals were also typical to these young offenders. It is a remarkable fact that the use of cocaine and heroin – which is less characteristic in the general population – was considerably high among youths living in reformatories.
25% of the respondents used any illicit drugs 40 times or more in the last 12 months (Kökönyei és mtsai 2003).

Based on a survey conducted among youths attending parties of electronic music in 2003 (Demetrovics 2004) conclusion can be drawn that illicit drug use among those attending parties on a monthly basis was 20 times higher than that in the general population. Nearly 90% of the respondents have already tried illicit drugs. 60 % of the respondents were men at a mean age of 23. Almost the half of such party visitors came from intellectual families (49.6% of fathers and 47.7% of mothers had a university or college degree); more than one third of them were students (38.9% in secondary school, 59.7% in higher education), rate of employment was 33.1%. 21% of the respondents were students and working at the same time. Attendants to such parties typically came from the higher income-brackets.
Differences can be detected among the illicit drugs used by the visitors of different genres:

Table 6. *Lifetime prevalence of party visitors*

%	Marijuana / hashish	LSD	Ecstasy	Amphetamine	Cocaine	Heroin	TOTAL
Goa	93.2	53.2	72.9	65.5	42.3	8.5	94.7
Drum'n'bass & Breakbeat	88.9	40.3	50.6	44.3	27.7	5.3	89.9
House & Trance	79.7	31.1	63	58.3	30.6	2.8	85.1
Techno & electronic music	79	35.6	64.4	57.4	27.9	4.9	48.3
Total	**87.21**	**41.34**	**58.52**	**51.93**	**30.86**	**5.67**	**89.5**
Non-users	12.8	58.7	41.5	48.1	69.2	94.4	10.5

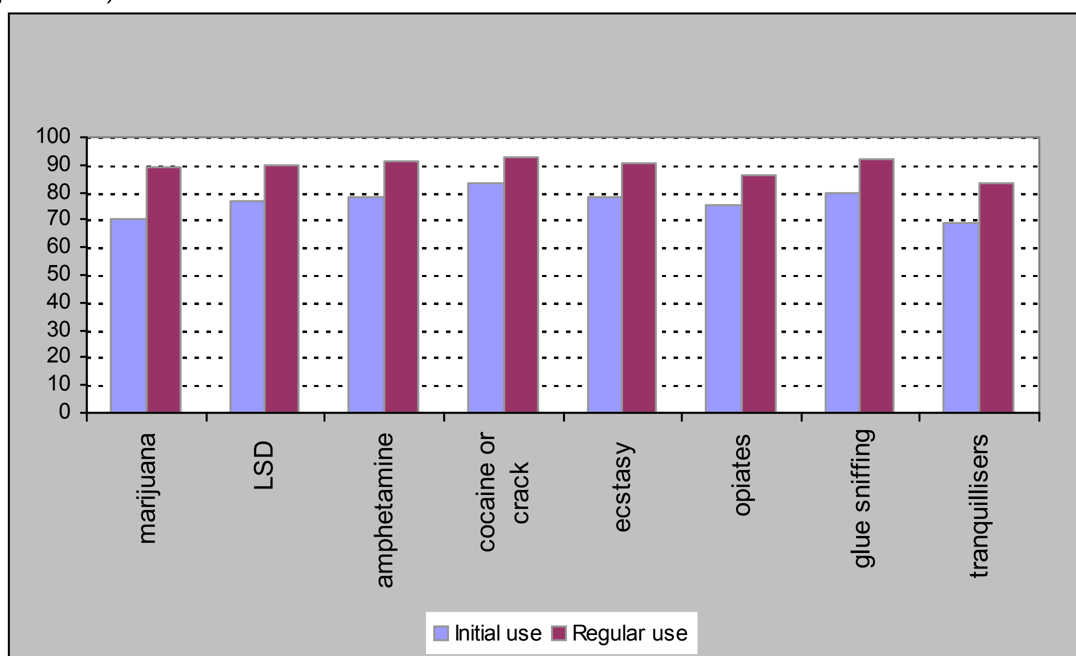
Source: Demetrovics 2004

Marijuana is the most widespread substance among visitors to all party genres followed by ecstasy and/or amphetamines. As for the frequency of party visits 80% of the respondents attend parties 1 to 3 times a month, one fifth of them go partying on a weekly basis or more frequently.
Lifetime prevalence of each substance was outstanding in this population compared to the general population.

2.4. ATTITUDES TO DRUGS AND DRUG USERS

There is a rather homogenous perception of illicit drugs in the adult population[19] in Hungary which can be characterised by increased and less differentiated risk awareness[20]. A consistent but rather inconsiderable differentiation is only to be revealed in relation to the perception of the dangers of drug use of different intensity – this is showed by the mutual situation of the bars in the chart bellow:

Figure 2. *Ratio of those considering the different frequencies of use "very dangerous" (% of the respondents)*



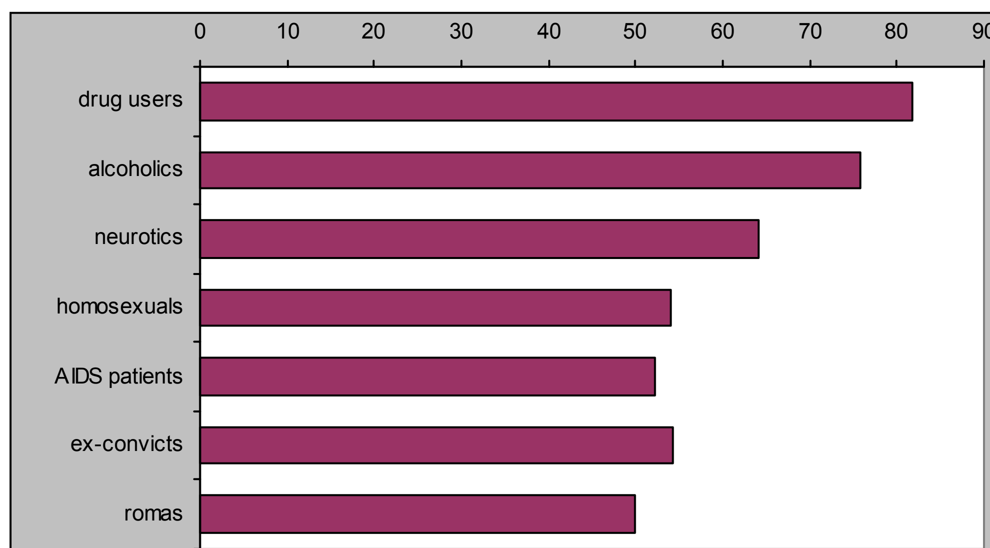
Source: Elekes, Paksi 2003a unpublished thesis

The society's perception and judgement on drug use***[21]*** practically reflects its perceptions on the danger of use. The level of differentiation is small in respect of the variety of drugs and the frequency of drug use. 90% of the total population disapprove illicit drug use and nearly 75% of them strongly disapprove it.

[19] Source of data: the national representative sample of adult population aged 18-54 of the ADE research in 2003 (Elekes and Paksi 2003a unpublished thesis).
[20] Respondents were asked – in accordance to the EMCDDA (1999) recommendations and the ESPAD (Hibell et al 2000) standards - to express their opinion on the risks of drug use of different frequency (initial, occasional, regular use) on a four-grade scale: 1 – not dangerous, 2 – a bit dangerous, 3 – medium dangerous, 4 – dangerous.
[21] Respondents were asked - in accordance to the EMCDDA (1999) recommendations and the ESPAD (Hibell et al 2000) standards – to express their opinion on users of different drugs and/or on regular and occasional marijuana use on a three-grade scale: 1 – does not disapprove, 2 – disapproves, 3 – strongly disapproves.

In context to other socially disapproved groups (roma population, ex-convicts, alcoholics, homosexuals...etc.) drug users are the least-tolerated social group in Hungary. Four fifth of the adult population have a negative attitude towards drug users living in their neighbourhood and more than half of them would clearly protest against them.

Figure 3. *Rate of rejection of socially disapproved groups (% of the respondents)*



Source: Elekes, Paksi 2003a unpublished thesis

Perhaps due to the increased risk awareness and the strong fears of the population 85% of the adult population believe that the society should spend “more” or “much more” on the reduction of the drug problem. This rate is higher than answers on alcoholism (75%) which is more widespread in Hungary. Although the majority (62.3%) consider drug addicts more as a patient the population primarily expect the problem to be reduced by criminal measures, secondly by the increase of preventive interventions and by the liquidation of community funds.

Comparing the results of the survey (ADE 2001) conducted two years ago no significant changes can be observed either in the social perception of the drug problem or in the population’s perceptions on drug policy although the rate of use significantly increased between the two surveys and the criminal regulations on consumption were amended.
In addition to that the longer-term data on specified indicators suggest that no change occcured in the social attitudes in the last ten years. Comparing these data to the tolerance-survey conducted in the adult population in 1994 (Gyenei, 1997) we can see that social exclusion was the most serious against drug users in Hungary and no shift could be revealed in rejection of the vicinity of drug users not only in the context to other social groups but also to itself.

Conclusions

Results of the surveys conducted among primary and secondary school students in the previous years have shown a definite but waving increase in illicit drug use since the mid 90’s. The data available on trends in Budapest in 2003 suggest that the increase will continue primarily due to the recent increase in marijuana use. Increase can not only be detected in lifetime prevalence but also in incidence data reflecting more frequent use. At the same time, survey results show that the majority of students trying drugs are still initial

or occasional users. Beside the dominance of cannabis, all studies underline the spread of misuse of pharmaceuticals, especially among girls.
The most typical age of first illicit drug use is 14 to 15 years which indicates that initial illicit drug use starts at an earlier age in contrast to the results in previous years.
Lifetime prevalence of illicit drugs is proved to increase with the age by all studies and the highest prevalence rate can be recorded in the age group of 18 to 24 and in the university population.
Surveys conducted in the adult population also show the spread of illicit drug use. This increase is due to the spread of marijuana use among adults as well. Although the increase can be observed in each age group illicit drug use is primarily typical to the younger age groups as well as to the out-of-school population.
Data on attitudes towards illicit drugs and illicit drug users reflect the society's unchanging slender knowledge and disapproving attitude.

3. PREVENTION

Overview

The second pillar of the National Drug Strategy co-ordinates the prevention activities and the professional priorities to be validated. Beside general target-setting, the Strategy identifies major scenes of prevention, target groups and its levels. In respect of the latter one the Strategy considers the interpretation frameworks of health promotion as standard and supports the adoption of the universal, selective and indicated prevention approaches for different specific actions.
The National Drug Strategy identifies the following target groups and scenes of prevention:

- family
- school
- place of work
- recreational facilities – places of entertainment
- church
- media
- information society
- army
- network of child-welfare institutions
- police
- at-risk groups / roma population

In Hungary, extensive prevention activities have been carried out. A reliable and valid database that was set up as a result of systematic data-collection is currently available only on school-based – primarily universal – prevention.
In the followings we endeavour to provide information in each field of the report. It is important to emphasise that due to the different data-collection methods the exact relationship between the data presented are not known in particular cases. At some points overlapping information should occur. In order to reveal the situation it is necessary to introduce data that are heterogeneous from a qualitative aspect - reliability and validity – with the intent to inform.

New developments

The most important professional developments in the last year refer to the comprehensive monitoring and evaluation[22] of the prevention activities and to the broader availability of the collected information. As a result of the research titled “Lights and Shadows” we have broad and reliable information on the content, objectives, methodology used, size of the covered population and geographical coverage of school-based prevention programmes.
To make such information broadly available a professional information portal is in progress. As a consequence of this development a portal based on dynamic database will be built up. It covers – beside prevention programmes - science-based research on drug issues, the different organisations and institutions providing care and their programmes and methods applied. The portal’s development started in 2003 and will be launched in the third quarter of 2004.

[22] Research titled “Lights and Shadows” was carried out in the framework of the National Research and Development Programme. Member organisations of this syndicate research are the National Institute for Drug Prevention, Hungarian Academy of Sciences Psychology Institute, Budapest Corvinus University, Behaviour Research Centre, Budapest Social Resource Centre

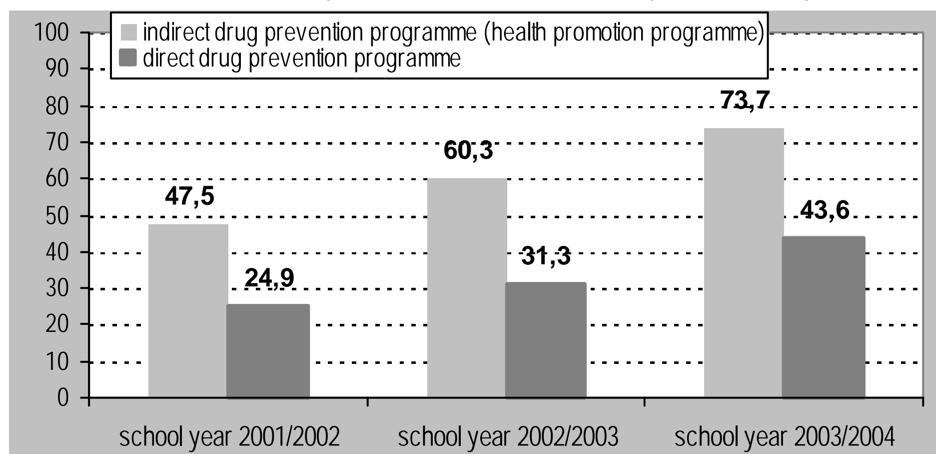
3.1 UNIVERSAL PREVENTION

School-based prevention

Support is given to school-based prevention primarily through a tender system that is based on the co-operation of two ministries (Ministry for Children, Youth and Sports and Ministry for Education). This tender system has been operating since 2000 and primary and secondary schools were allowed to apply in 2003. Each school participating has to work out its health-educational and drug-prevention strategy in accordance with the National Drug Strategy. The tender is structured as follows:
Applicant schools must contact one of the prevention service providers (civil organisation, State Public Health and Medical Officer Service, pedagogic service provider, individual expert) registered in a central (ministry's) database. During their co-operation they jointly elaborate the object of their activity which is tailored to the school's specific needs and harmonises with the tender priorities. Finally, they draw up an agreement and submit their application. In practice the teaching staff participates in an at least ten-hour training and the prevention service provider organises activities for small groups of students spending at least five hours on each programme applying interactive methods. In particular cases a teacher employed by the school is also allowed to train the students provided he/she finished an at least 40 hour health-promotion / drug prevention training and the school has implemented curricular health promotion activities for at least one year. School drug-coordinators play a highly important role in the implementation of school-based programmes within the frameworks of the tender system. These coordinators have the task to co-ordinate activities of schools instead of managing individual cases. School drug-coordinators have been lately enrolled in a 30-hour-long accredited extension training gratis as a result of which 23.7% of public schools employ teachers with such skills[23]. In addition to the training of school drug-coordinators, the Ministry for Education covers 100% of the operational costs of the network of county-coordinators skilled at such trainings. This network provides the school drug-coordinators further training and the opportunity to discussion of cases and consultation.
Through the above-described tender system, 540 public schools (15%) received support that involved 190,000 students in total.

Ratio and trends of the participation of public schools in prevention can be determined and described by the outcome of a recently conducted sample survey (Paksi et al. 2004)[24].

Figure 4. *Rate of schools participating in prevention, 2001-2003 (% of schools)*

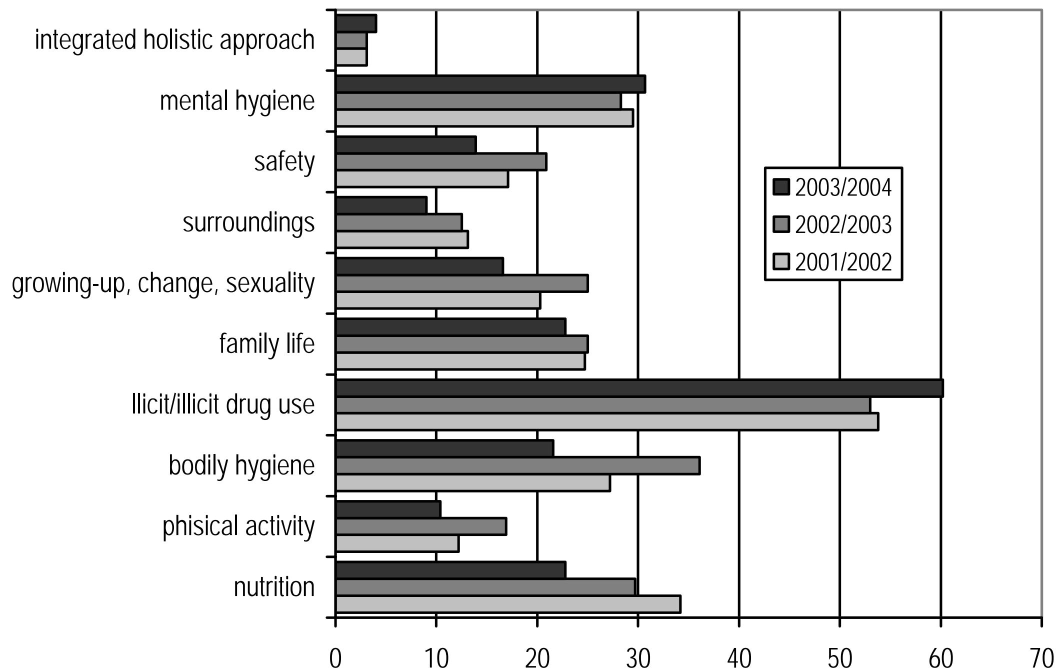


Source: Paksi et al. (2004)

[23] See table on page 10. Source: Public Education Development and Teacher Training Public Company
[24] See page 11 for the description of the survey's methodology

As the above figure shows the rate of public schools running prevention activities has been continuously increasing since the school year 2001/2002, especially the rate of those that explicitly dealt with licit and illicit drug use. Nearly half of public schools (43.6%) were carrying out any direct drug prevention activities in the school year 2003/2004.
It is also obvious from the above figure that school-based prevention is not limited to drug prevention but other health promotion-related issues also appear. At the same time it is undoubted that the most frequently mentioned issue is drug use.

Figure 5. *Breakdown of issues in prevention programmes 2001-2003 (in % of programmes applied in schools)*



Source: Paksi et al (2004)

Although the professional literature of prevention agrees that real and long-lasting effects can mainly be expected by an integrated holistic approach (Burkhart, Crusellas, 2002) it is only applied in about 5% of the cases under review.
As cited before a research project spanning over years was launched with the purpose of comprehensive monitoring and evaluation of prevention programmes in 2003. Within the frames of this research a register of all prevention programmes was built up (Paksi 2003b) that enables us to describe the currently operating prevention programmes targeted at school population according to the data-collection aspects of EDDRA.

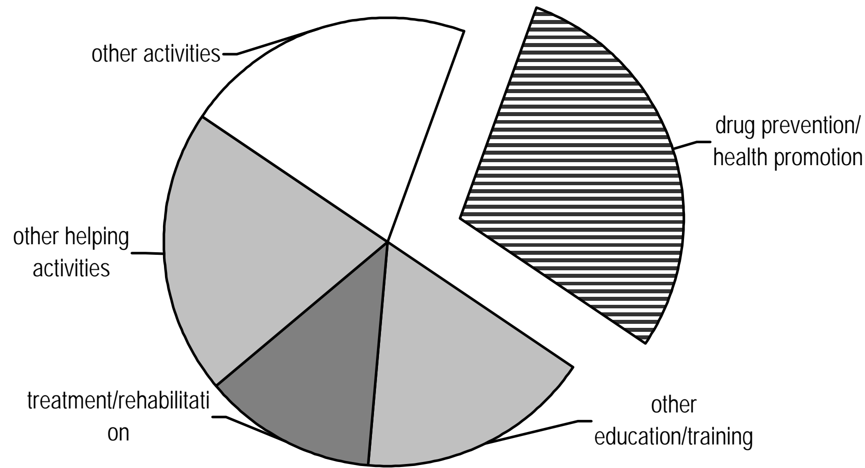
In total, 136 organisations were identified nationwide which

- carried out direct or indirect drug-prevention or school-based prevention programme (e.g. peer programmes or the training of peer tutors or teachers)
- carried out such activities programme-wise (not on an ad hoc basis)
- carried out school-based prevention activities in the school years 2001/2002 or 2002/2003 and intend to take out such activities also in the school year 2003/2004

On the basis of the research outcome we can conclude that most of the service providers do not carry out prevention activities as their main profile but beside other care or educational tasks. Main profile of one fifth of these service providers is focused on

completely different fields. Hardly more than one fourth of the reviewed organisations providing drug prevention / health promotion services are specialised.

Figure 6. *Breakdown of organisations providing school-based drug prevention by main profile (% of organisations)*

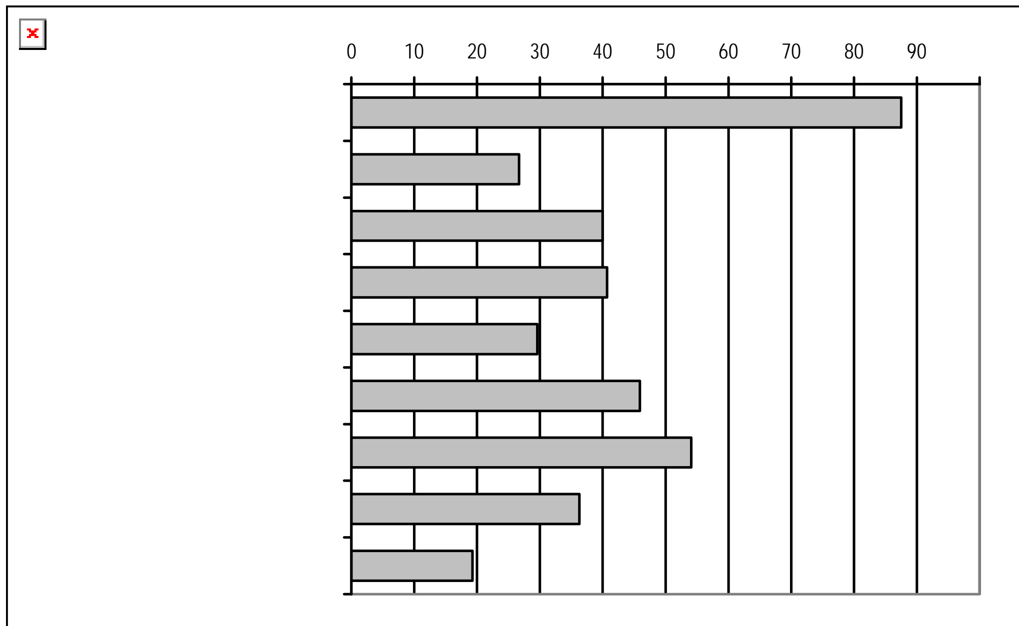


Source: Paksi (2003a)

The 136 analysed organisations ran 280 school-based drug prevention programmes in 2003. Detailed information is available on more than four-fifth of them which means 233[25] programmes. Around 60% of the 233 programmes involved students as the final target group of the prevention programmes. 40% of them – 94 programmes – are targeted at the students in public schools through the improvement of preparedness of teachers and students in the field of prevention. More than two-fifth of the indirect programmes (42 programmes) include peer training.
Indirect programmes report themselves to reach 310,000 students in a usual school year which means that on national level about every fourth student of all students in public schools in the 1st to 12th grade (at the age of 6-18) takes part in a drug prevention programme.

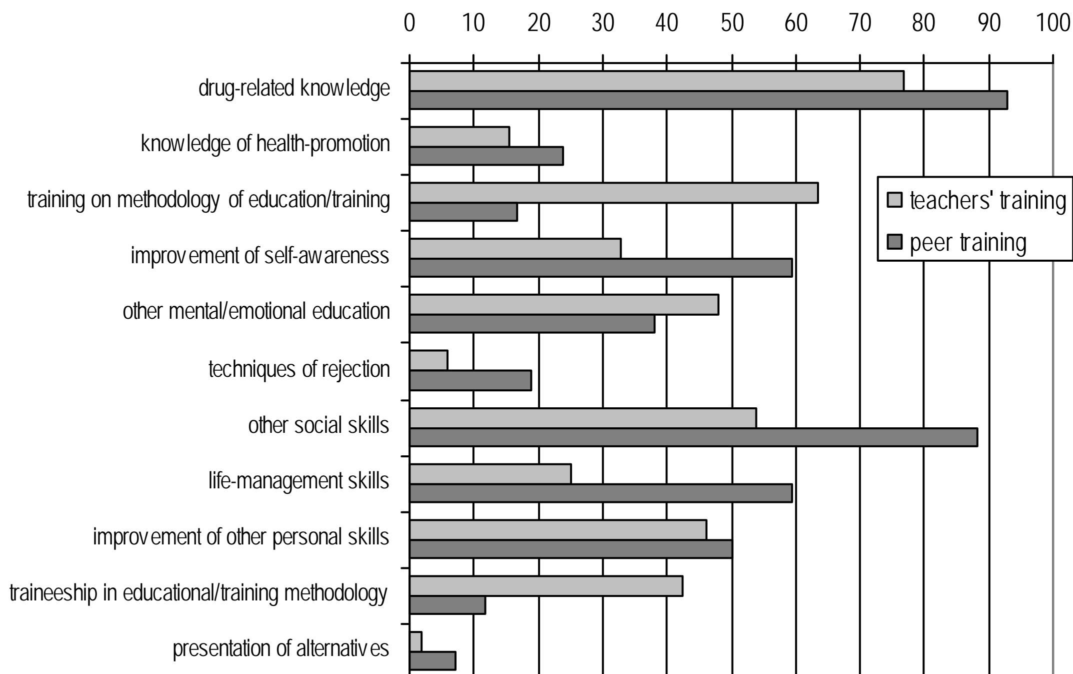
[25] 33 organisations have not filled in any fact sheets on each of their programmes, and only the names of 47 programmes are known without having any further data on them.

Figure 7. *Occurrence of different objectives of prevention programmes directly targeted at students (in % of programmes N=136)*



Source: Paksi (2003b)

Figure 8. *Occurrence of different objectives of teachers' training and peer training programmes (in % of programmes N=94)*

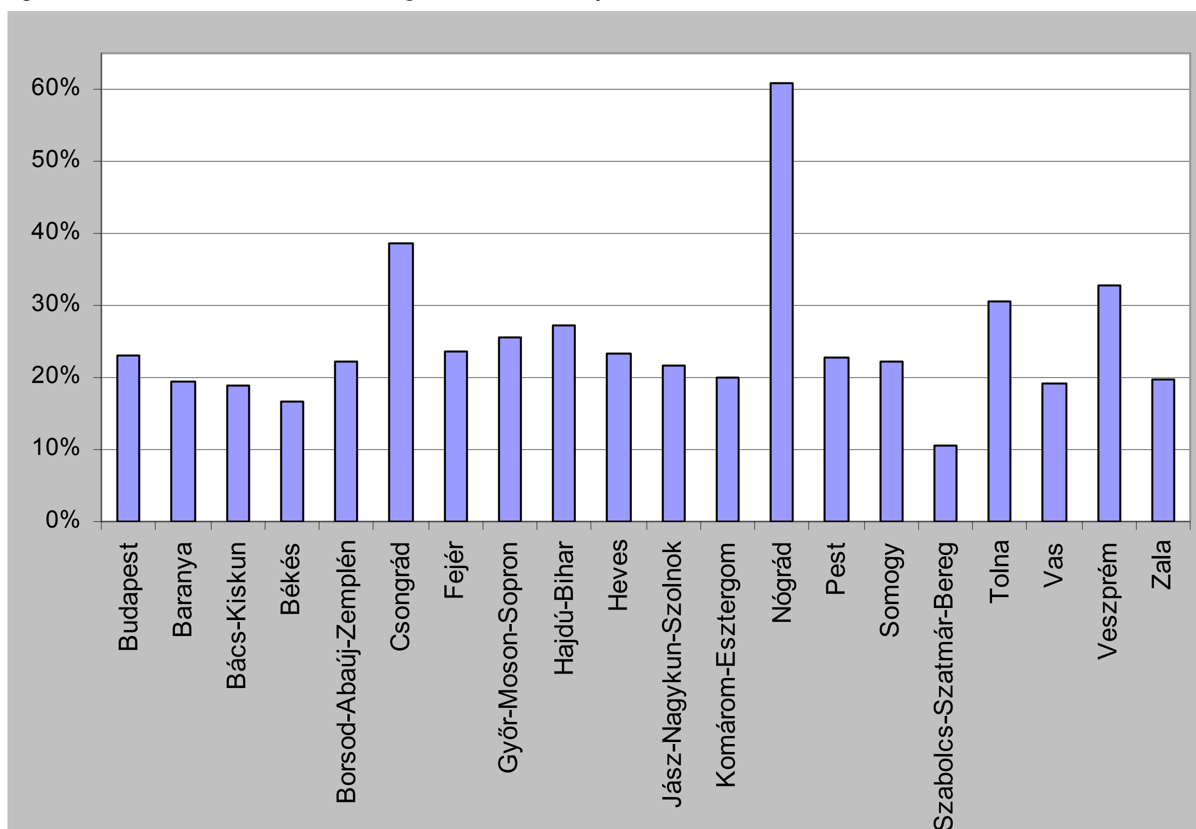


Source: Paksi (2003a)

"Only" 60% of teachers' training programmes aim at the improvement of teachers' and professionals' sensitivity to the problem. A further 40% of them have the purpose to enable the trained teachers carry out programme-wise/regular prevention among students. Most teachers' training programmes (48) offer services to secondary school teachers. Nearly two thirds of the teachers' extension programmes are accredited. The accreditation system was established in 1997. Recently there are 14 registered accredited teachers' training

programmes that especially aim to identify drug problems and to prevent them at schools. Besides, there are 14 comprehensive holistic programmes on the accreditation list. Their syllabus is based on mental hygiene and drug prevention is embedded in the comprehensive health education. One of the most important teachers' extension trainings related to drug prevention is the training of school drug-coordinators. Participation in this training programme is fully supported by the Ministry for Education and the Coordination Committee on Drug Affairs. The following county by county landscape shows the ratio of schools employing a coordinator of drug issues among all schools:

Figure 9. *Breakdown of school drug-coordinators by counties in 2003*



Source: Public Education Development and Teacher Training Public Company

Out-of-school prevention

There are no data on the spread of out-of-school prevention targeting youth (school-aged) population and the size of covered population similar in depth and reliability to those on school-based prevention activities. According to our experience, 121 organisations implemented such prevention programmes in a value of HUF 45 million (EUR 180,000) in 2003[26]. Two events are worth being mentioned from among such activities primarily due to their national coverage.

- The event series titled „Szenvedélyek napja", in which professional and/or NGOs present their activities in the form of a method fair initiating talks with each other and the potential target group, i.e. those affected by drug-related problems: youth, adults, parents...etc.
- Conference titled "Vészcsengő", which furthers the reinforcement of content and methodology in professional networking and the evolution of talks among experts' organisations and teachers who have been involved in the management of drug problems, especially in prevention activities.

[26] Source: Mobilitás – Tender Department

Prevention at workplace[27]

Prevention programmes at workplaces are carried out in the frameworks of the Association for Healthier Workplaces transparently. This association has been operating in Hungary along the recommendations and guidelines of the World Health Organisation since 1997.
The object of the Association is primarily up to the criteria of the integrated, holistic health promotion, within which it deals with target-setting related to drug-related prevention.
There is a number of work-places among the Association members where regular drug prevention and early intervention work is taken out. Going out of the work's nature, these institutions are employers where employees under the influence of alcohol and/or drugs represent increased danger (chemical firms, nuclear power plants, armed forces...etc.)
Syllabus of these programmes include:

- implementation of health-care and psychological testing systems,
- voluntary filling-in of psychological tests,
- identification of work stress,
- formulation of individual stress-management strategies,
- securing 24-hour crisis intervention at workplaces,
- pre-scheduled personal consultation,
- autogenous training, assertion-improvement groups,
- counselling on life-management at the workplaces,
- "Give a helping hand!" programmes to employers and families,
- presentations at the workplaces, information dissemination,
- training series on conflict-management.

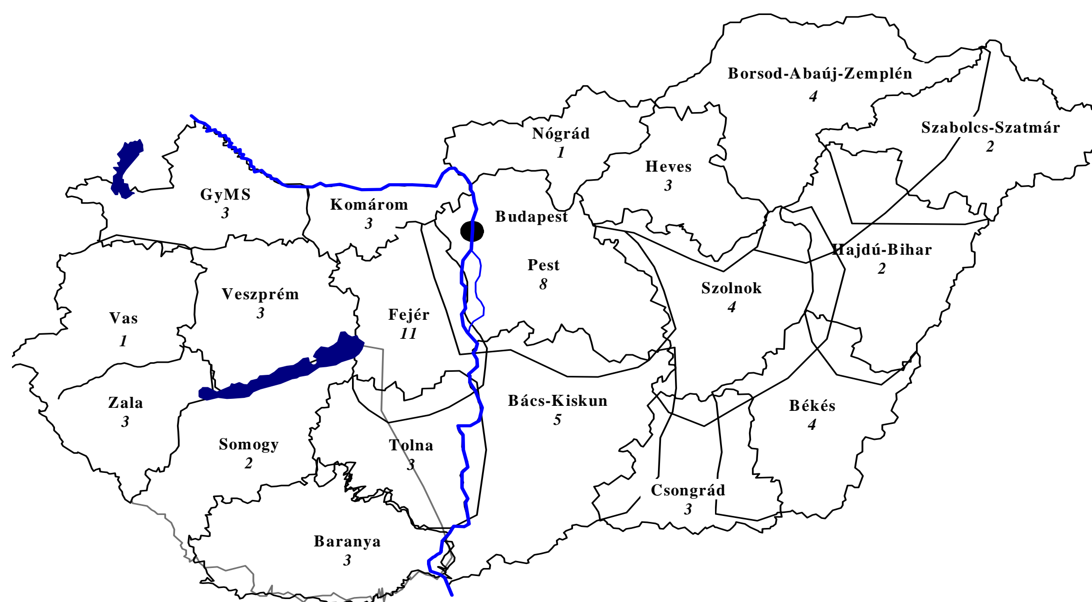
The number of employees involved in the above programmes is around 20,000.

Community-based programmes – Coordination Forums on Drug Affairs[28]

Coordination Forums on Drug Affairs are professional counselling bodies without legal entity that secure coordination of the professional drug-related activities of all local organisations, reveal the situation, set up strategic directions of professional activities, formulate local strategies and underlying initiations of in-field activities. The activities carried out by the Coordination Forums on Drug Affairs have a significant role in the initiation of community-based prevention programmes. 62 Coordination Forums on Drug Affairs were operating in the country in 2003, showed on the following map:

[27] Source: Kerek Judit, Secretary-General of the Association for Healthier Workplaces
[28] Source: National Institute for Drug Prevention

Map 1. *Geographical location of Coordination Forums on Drug Affairs by county, 2003*



Source: National Institute for Drug Prevention

Based on the annual reports from the Coordination Forums on Drug Affairs – that covers the content and target group of prevention activities in certain settlements – we know in what proportion the different prevention scenes and target groups are part of the activities co-ordinated by them.

Table 7. *Activities carried out by the Coordination Forums on Drug Affairs by the target group and/or scenes of prevention*

Scenes and target groups	Ratio (%)
Family	59
School	78
Workplaces	6
Places of entertainment	67
Church	25
Media	72
Information society	61
Institutions of child-welfare	28
The army	11
The police	47
At-risk groups	20
Roma population	6

Source: National Institute for Drug Prevention

3.2 Selective prevention

Recreational settings

Research data clearly indicate that illicit drug use of attendants to the recreational facilities like places of entertainment, shopping malls and Sziget Festival is higher than that measured in the average youth population (Demetrovics 2004b; Paksi 2003c; Paksi

2004b)[29]. This is one of the reasons why special prevention services should be available at these scenes.

"Civil Village" at Sziget Festival hosted 21 organisations providing special services like HIV/AIDS testing, "internet playground", tea houses, syringe exchange programmes, counselling and consultation in 2003. The provided services proved to be successful and highly attended (with 8000 national and nearly 1000 foreign visitors) (Paksi 2004b). Research data indicate that illicit drug use of the visitors of the "Civil Village" exceeds that of the average youth population - of corresponding age - in respect of both lifetime and last month prevalence data.

Three organisations (Blue Point Party Service, Bulisegély at Pécs, Agria Party service) provide prevention and harm-reduction services at places of entertainment in Hungary. Detailed data are only available on the activities of one organisation.

Blue Point Drug Counselling and Outpatient Centre primarily operates in Budapest, partly it runs a "Party Service" in the countryside. Its target population is made up of the members of subcultural groups of electronic music, drug users and potential drug users. Its objective is to disseminate information on safer drug use, safer sex and service providers. The methodology they apply is based on presence in discos and at parties, personal contact, word-of-mouth information, spread of information leaflets and condoms. They were present at 39 events in 2003. Number of contacts could be measured by the change in stocks of information brochures and leaflets (dextrose, condoms, vitamins, biscuits): they had 18,200 contacts. Number of registered personal contacts was 75 (case studies)[30].

At-risk groups

In the context of drug use a number of risk groups can be identified. In this report only ambitions to identify such groups in the roma population are introduced.
In addition to the social and cultural characteristics, accumulated disadvantageous living conditions and cultural settings of specific groups the roma population necessitate the launch of special programmes. These programmes may only be transmitted efficiently by credible NGOs and social workers coordinating them and being accepted by the roma community. Keeping an eye on the above criteria, prevention programmes directly or indirectly targeted at the roma population were launched and/or supported.
The costs of peer trainings, self-help groups, supervisions, different prevention programmes and low-threshold organisations were covered through tender and operated by a number of NGOs at several points of the country. A specific drug-coordinator training tailored to the special needs was worked out for the teaching and instructor staff of roma youths. Altogether 150 persons were involved in this training scheme.
The volume of the support provided for prevention programmes at risk groups was HUF 29.7 million in 2003, that is EUR 118,800.

Conclusions

The research project spanning over years was continued in 2003. The objective of this research was the comprehensive monitoring and evaluation of prevention programmes. In this research project a register including all comprehensive prevention programmes

[29] Lifetime prevalence of illicit drug use among attendants to different entertainment facilities is: 89,5%
[30] Since 2002, it means longer, personal conversations with the intention to help, detailed case studies are under preparation.

targeted at school population was built up which is in accordance with the EDDRA data collection protocol.

In total, 136 organisations were identified that operate programme-wise direct or indirect drug prevention activities or school-based drug prevention programme (for example through peer training and teachers' training). These 136 organisations run 280 school-based drug prevention programmes, detailed information are available on 233. 60% of the programmes are direct training of students while 40% of these programmes focus on peer and teachers' training. Annually, almost every fourth of the students at the age of 6 to 18 participate in any drug prevention programmes.

There is no information on out-of-school prevention activities of similar depth. 121 organisations provide out-of-school prevention in Hungary.

Prevention activities at workplaces are primarily co-ordinated by the Association for Healthier Workplaces. Around 20,000 employees are involved in their programmes.

A number of organisations run "Party Services" at recreational settings. They offer information programmes targeted at the guests of discos and parties.

4. PROBLEM DRUG USE

Overview

Until the beginning of the 1990s, very few drug related researches were conducted in Hungary because of the sensitiveness of the topic. Past years experience showed that there is more demand for ESPAD-like quantitative researches. Surveys, using ethnographic methods, targeting problem drug users are still quite rare in Hungary.
The first estimate for the number of the number of problem drug users was carried out in 2003, providing an estimate for the capital, Budapest. Data on the characteristics of the treated drug users are available from the Hungarian Central Statistical Office where data are collected from all treatment institutions. Due to the introduction of the system of alternatives to prison, there was a further increase in the number of treated drug users, and their characteristics have also changed.
Data on the characteristics of non-treated drug users were collected from the results of different qualitative and quantitative researches.

4.1. PREVALENCE AND INCIDENCE ESTIMATES

In Hungary the first estimate for the prevalence of hidden problem drug use was conducted in 2003. It is a local estimate, concentrating on the capital, Budapest. The reason for this is the unreliability of the available data and the capital's "outstanding" role concerning both the prevalence of drug use and the number of prevention and treatment institutions.
In the estimation, we defined problem drug users as opiate users regardless of the route of administration. We used the multiplier method to estimate the number of hidden opiate users (EMCDDA 1997). The estimate is based on the number of all opiate users turned up in treatment (it must be noted that double counting is not excluded in the database that results in overestimation).
The proportion of the hidden population to the registered opiate users was obtained through a qualitative survey. 80 people were questioned, either clients of the methadone substitution treatment or participants of the syringe exchange programme.
According to the respondents' estimation 47% of the total opiate user population turned up in treatment. According to a procedure using the nomination technique 49% of the opiate users were in treatment in Budapest in 2003. The number of problem opiate users is around 4000 people in Budapest (the exact data of the different methods were 3848-4223). Their rate is 2.4 per 1000 people.
According to the clients' estimate 82% of the opiate user population in Budapest are injecting users. More than 90% of the opiate users in treatment are injecting drug users. One quarter of the respondents' regular opiate user friends was dropped out of school, 60% were unemployed and 20% were homeless. 75% have already had affairs with the police in connection with their drug consumption.

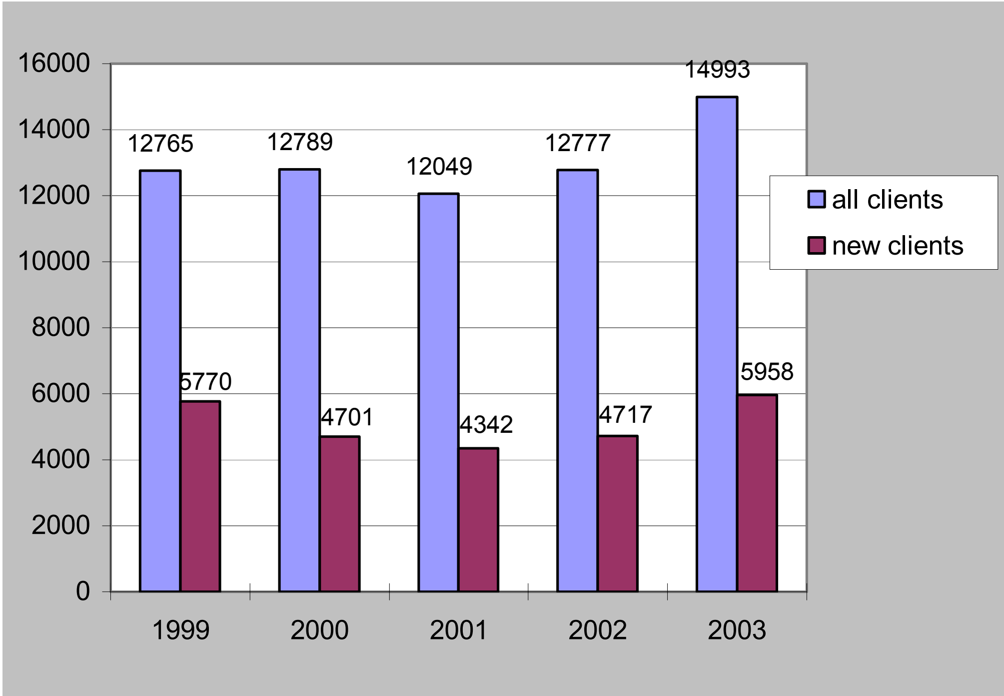
4.2. PROFILE OF CLIENTS IN TREATMENT

400 treatment centres provide data to the OSAP (National Statistical Data Collection Programme) on drug-related treatment on a yearly basis. Since 2003 data collection and data processing has been centralised by the National Institute of Addiction. Treatment centre types are described in Chapter 5.

In 2003 the number of clients in treatment showed an increase of 17% unlike the stagnating tendency of the previous years. Number of new clients also increased by a

significant 26% compared to the previous year. Considering the preceding three years the stagnation in the number of new clients finished and the growth in 2003 can be regarded as considerable. This growth is due the amendment to the Criminal Code in 2003 which extended the availability of alternatives to prison to a wider range of drug users and this form of punishment is carried out in treatment centres.

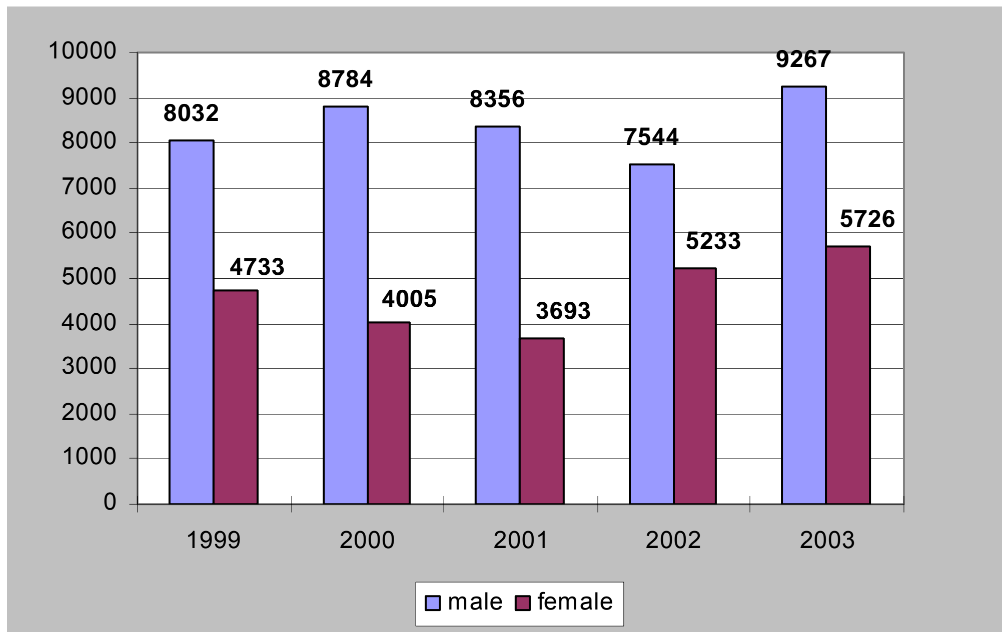
Figure 10. *Number of drug users entering treatment in Hungary, 1999-2003*



Source: OSAP

As regards the breakdown of drug users in treatment by genders the number of men always exceeded women, ratios were 62% and 38% respectively in 2003. Except for tranquillisers and sedatives the number of men remained higher in each substance category in the previous years. The substance category of tranquillisers and sedatives was the only one where the ratio of women was significantly higher every year.

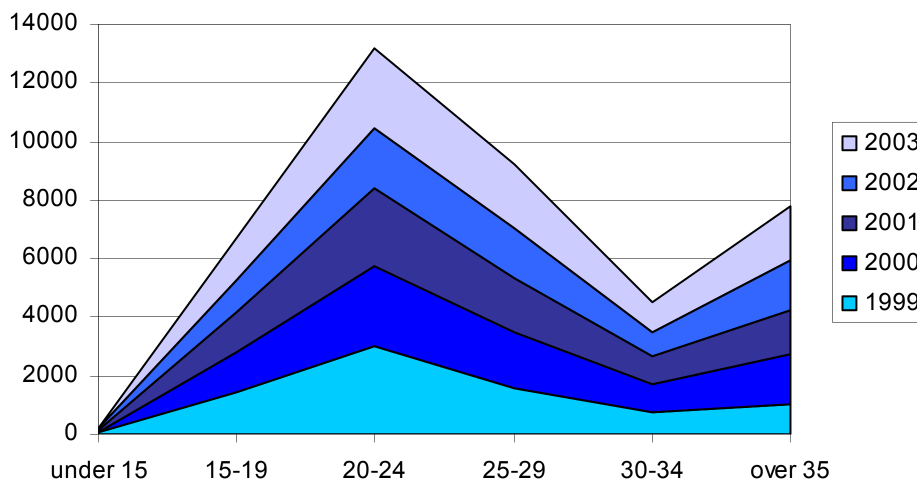
Figure 10 *Breakdown of clients in treatment by gender, 1999-2003*



Source: OSAP

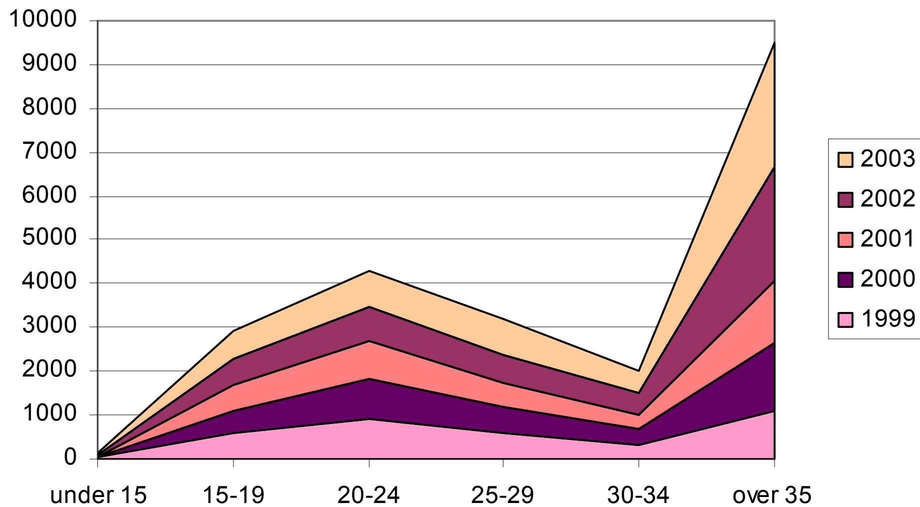
The breakdown of genders by age shows similar tendencies by age but different tendencies by gender. The number of men using drugs was the highest in the age range of 20 to 24 every year. The same growth can be observed among women over 35, however, the number of female drug users was also high in the age range of 20 to 24. Tranquillisers and sedatives were the most typically used substances by women over 35.

Figure 11 *Breakdown of MALE clients in treatment by age, 1999-2003*



Source: OSAP

Figure 12 *Breakdown of FEMALE clients in treatment by age, 1999-2003*



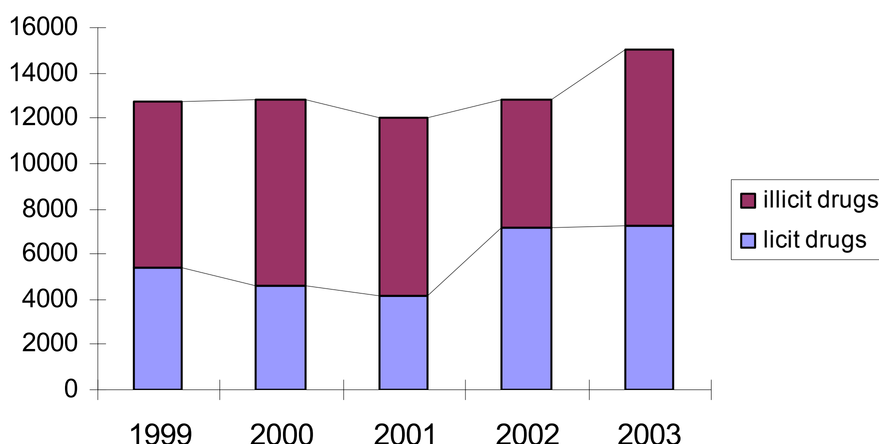
Source: OSAP

In 2003 the number of drug users decreased among male clients in treatment under 15 years unlike all other categories where the number of drug users increased markedly. Decrease in the number of female clients in treatment under 15 could be observed. This number stagnated in the age group 15-19 and an increase came about in the age range over 19 – however, not reaching the level of men.

By substance used

In 2003 rate of clients in treatment for illicit drug use grew significantly beside the considerable increase in the number of all clients in treatment.

Figure 13 *Breakdown of clients in treatment by substance used, 1999-2003*

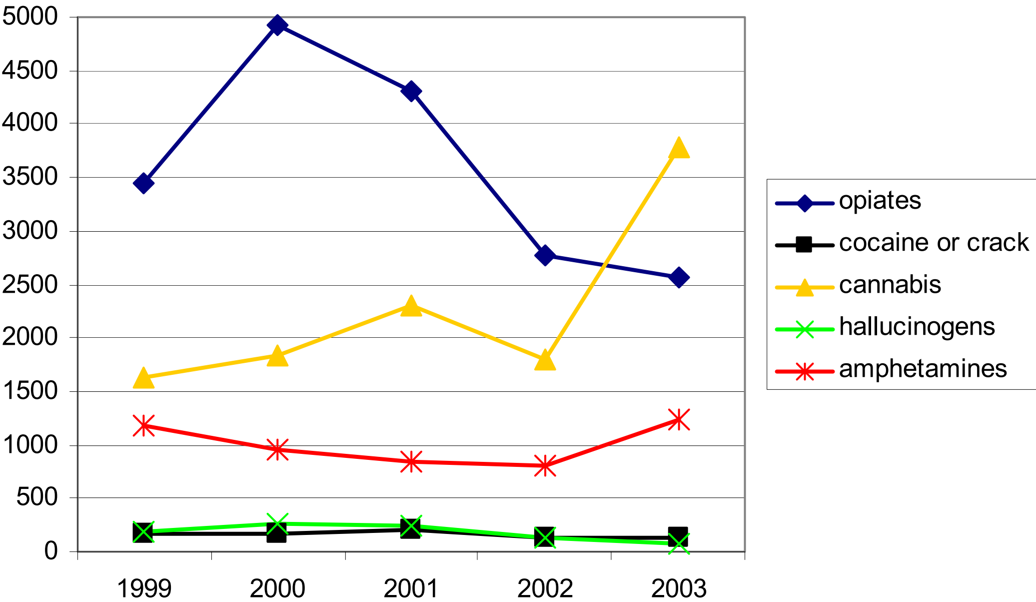


Source: OSAP

The number of opiate-users in treatment increased of 13% in 2001, followed by a further increase of 36% in 2002, and decreased by 7.4% in 2003 compared to the year before. It means that 17% of the total clients in treatment were opiate users!

There was a decrease of 22% in the number of cannabis (marijuana and hashish) users in 2002 resulting in a ratio of 14% compared to the number of all clients in treatment. In contrast to this decline an extreme increase of 109% was observed in the number of cannabis users in 2003. Therefore they ranked the second behind the rate of tranquilliser users among all clients in treatment.
The number of clients in treatment for amphetamine use was decreasing until 2002. In 2003, a considerable increase of 52% followed which means that they made up 8.2% of all clients in treatment.
The number of cocaine-users in treatment fell by 34% in 2002, followed by a further 3.7% decrease in 2003 thus resulting in a ratio of 0.9% of all clients in treatment.
The number of those using hallucinogens was always low and further decreased by 48% in 2002 and by 32% in 2003 compared to the prior year.

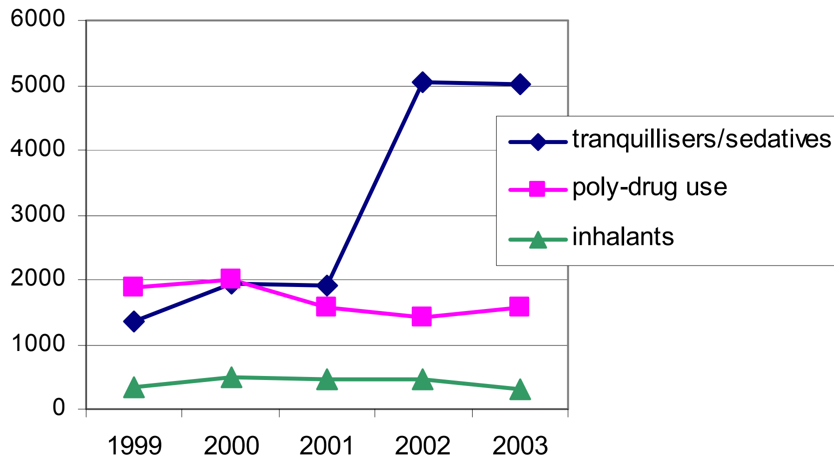
Figure 14 *Number of clients in treatment using illicit drugs, 1999-2003*



Source: OSAP

Rate of those in treatment using inhalants was relatively low: 2% among all clients in treatment in 2003.
Rate of those misusing tranquillisers and/or sedatives was 33.5% among all clients in treatment in 2003. The number of users not only represents the highest number among licit types of drugs but also exceeded the number of users in illicit drug categories. Although the number of tranquillisers users did not increase.
There was an increase of 11% in the number of poly-drug users (combining tranquillisers and/or sedatives with alcohol) again in 2003. The reason to this fluctuation has not been revealed yet and needs further examinations.

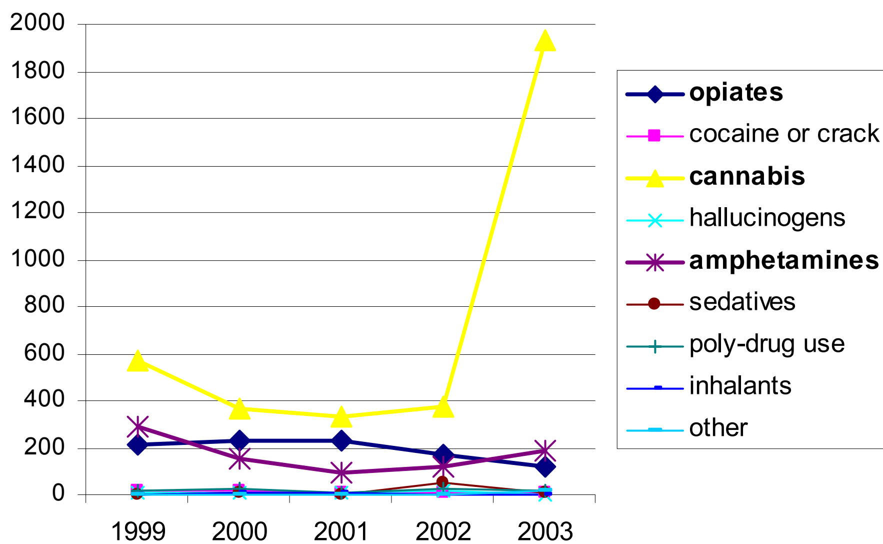
Figure 15 *Number of clients in treatment using licit drugs, 1999-2003*



Source: OSAP

There was a serious increase (212%) in the number of drug users diverted to alternatives to prison which was due to the amendment to the Criminal Code and the Act on Criminal Procedure. The underlying reason to the immense increase in 2003 is the increase of 417% in the number of cannabis users diverted to alternatives to prison.

Figure 16. *Number of drug users diverted to treatment by substance used*



Source: OSAP

By centre types

Based on the data of 2003, breakdown of drug users by centre type is as follows:

Table 8. *Breakdown of drug users by treatment-centre type*

Centre type	2000	2001	2002	2003
Addiction-treatment outpatient centres	3618	3447	3088	**2901**
Specialised outpatient centres	5689	3807	3160	**5112**
Psychiatric outpatient centres	434	267	117	**692**
Psychiatric and addiction-treatment inpatient departments	3032	3103	2451	**2277**
Other treatment centres (emergencies)	-	1397	4045	**3955**
Child psychiatric outpatient centres	16	28	16	**56**
TOTAL	**12789**	**12049**	**12877**	**14993**

Source: OSAP (2000-2003)

The recently available data show that treatment of drug users is mainly carried out in outpatient treatment centres. As mentioned above the amendment to the Criminal Code in 2003 extended the availability of alternatives to prison targeted to drug-using offenders. Such alternatives may be treatment or preventive-consulting services. 260 treatment centres provided these services. 14 of them are specialised outpatient centres and further 51 are addiction-treatment outpatient centres.

4.3. MAIN CHARACTERISTICS AND PATTERNS OF USE FROM NON-TREATMENT SOURCES

Risk behaviours of injecting drug users

A qualitative research aimed at describing risk behaviours of injecting drug users was conducted among 33 IDUs at the age of 22 to 25 living in Budapest and Pécs (22 men and 11 women) (Rácz 2004). Interviewees were users seeking treatment or having been involved in syringe exchange programmes or drug user friends of the latter ones.
Questions were asked about purchase, preparation and distribution of the substance, share of equipments and its psycho-sociological features, the individual strategies against hepatitis C, involvement in syringe exchange or other low-threshold programmes.
Respondents used to share equipments although they were aware of the risks of it. While sharing the syringe/needle was considered to be risky and avoided by the interviewees (no ritual share evolved) share of the boiler and filter seemed to be less dangerous to them. Users often jointly prepared the substance because none of them was usually able to raise enough money to cover the costs of a packet. Heroin can be evenly divided in liquid form which makes joint preparation necessary.
Joint purchase can also be observed as an attempt to control drug use; on such occasions users purchase less, make preparations for the administration and give a dose also to those who cannot afford it. In this way the symptoms of withdrawal leading to risk behaviours can be avoided. The less integrated drug users are more at risk by the evolution of withdrawal symptoms. They are the ones who share the filter as well as sometimes the syringe/needle.
Researchers did not find sharing forms (home-making, drug sale and purchase in syringe, mixing blood to the heroin-tincture) described to be typically Eastern-European. Legal

attitude of the police towards syringe and needle (qualified as exhibits to drug-related crime) has an increasing effect on risks of infection. Respondents are usually reluctant to have needles and syringe on them, just as they do not collect used needles for syringe exchange programmes either.

Characteristics of clients in methadone treatment

A survey was conducted among 201 clients in the methadone treatment of the Outpatient Centre in Jász Street in Budapest in the period of March 2001 and 2003. This survey included questionnaire and interviews. Its goal was to examine the efficiency of methadone treatments. In this chapter, however, information on main characteristics of clients and drug use will be introduced. (Demetrovics et al. 2004)

71.5% of the respondents were men. Their mean age was 27.2 years at the time of the survey, the youngest client was 16 years old and the oldest was 54 years old. The overwhelming majority of them (87.2%) lived in Budapest. As for their family status nearly every fifth client (18.1%) came from a complete (ascending) family. Most of them (22.4%) lived with their partners and 9.5% had their own (descending) families. Number of those who lived alone was equal (9.5%).
One third of the respondents finished primary school and the ratio of secondary school graduates was 21.8%. Number of graduates from higher education was negligible. (The questionnaire included questions about the qualification of their parents. From the answers we learned that 21.7% of the respondents' parents finished higher education.)
Nine of them reported themselves to have no income. Those who have any income live on a monthly net amount of HUF 149,000 (cc. EUR 600). (10% of the respondents confessed an income exceeding HUF 300,000 on a monthly basis.)

83.3% of the respondents already used marijuana and the rate of use of stimulants and/or hallucinogens was similar. The clients reported to have had times in their lives when they used these substances more times a week or even every day.
As for opiates, heroin was dominant. That is to say that almost all the respondents tried it. Use of other opiates was characteristic of one third of the clients. 60% of those who had ever used heroin did never use poppy tea. Average duration of opiate-use was 7 years (range of 2 to 22 years).

More than 80% of the clients already attended drug-related outpatient treatment and 70% of them inpatient treatment. Nearly every fifth respondent (21.5%) entered outpatient treatment for other psychiatric problems and 12.1% of them admitted to a psychiatric department. A significantly high number of clients being successful in methadone treatment had already been in inpatient treatment.
The start-up daily methadone dose of the clients in this survey was 47 mg. A gradual decrease of the dose was typical during the treatment. The average dose at the time of data processing was 24.7 mg.

Main characteristics of non-treated cocaine users

A quantitative survey was conducted in Budapest, asking 210, randomly chosen cocaine users; two thirds of them - 140 people - currently did not participate in any kind of treatment (Gerevich et al. 2004). The sample consisted of 137 males and 73 females; their average age was 28.7 years, it ranged from 19 to 50 years. The cocaine users were divided into three subgroups: party (weekend consumption, social integration), scene (members of marginal drug user culture) and therapy groups (in treatment).

The main characteristics of the two, currently non-treated, groups:
The average age of the members of the party and the scene groups is the same: 28 years. The proportion of women is the highest in the scene group with 44.3 per cent, 31.4 %in the party group. The last 30 days prevalence was 100 %in the party group and 98.6 %in the scene group. Multiple substance use occurred at 87.1 %of the scene group and at 81.4 %of the party group. The members of the scene group significantly more often used other substances than those in the therapy and party groups: 38.6 %used heroin, 31.4 %used illegal methadone, and 30 %used pharmaceuticals. The injecting use of cocaine was significantly higher among the members of the scene group. There was no difference in the needle sharing habits of the two groups.

The party group had the most favourable profile for physical and psychological problems as well as for committing crime: "the number of days spent with stealing" was significantly lower than in the scene group.
The number of days spent in unemployment was much higher and the number of days spent in work was lower among the members of the scene group.

A comparative analysis of the severity of the different problem areas gave a substantially worse profile for the scene group in the areas of employment, crime and risk factors, than for the other two groups.

Conclusions

Though the EMCDDA definition counts injecting and/or long-term or regular amphetamine users as problem drug users, and their number (according to the population surveys' and the treatment data) is increasing in Hungary (also see chapter 2.), it is still the opiate users considered as the most problematic population. Considering the risk behaviour of opiate users, qualitative researches revealed that the respondents have been using kind of opiate derivatives for an average of 7-8 years, 80% of them injecting. The injecting drug users are aware of the dangers of needle sharing, it is less widespread among them, share of other appliances is rather more typical. The incidence of HIV/AIDS is still very low in Hungary, and the prevalence of HCV is also low among IDUs compared to the Western European countries.

Problem cocaine use has not appeared in Hungary, neither in the population surveys nor in the treatment data. Their number remained constant, or changed within the margin of error; this could be due to this population's hiding lifestyle, to the deficiencies of the treatment system or to the fact that the use of cocaine is actually not a problem use. However, some kind of rearrangement has occurred, the number of opiate users is decreasing both among the treated patient and the participants of alternatives to prison. The importance of heroin has also decreased considering seizure data.

Due to the changes of the Criminal Code in 2003, cannabis users appear in the greatest numbers among those having legal problems, and participating (in alternatives to prison) in treatment.

5. DRUG-RELATED TREATMENT

Overview

Following the spread of drug use in the 80's, treatment system was built up on the existing health-care system, namely it was partly integrated into the psychiatric care, the child psychiatric care and the care system for alcoholics. Specialised outpatient centres started to open up in 1987. They could provide special treatment to that client population which changed in the meantime concerning patterns of drug use (illicit drug use and opiate use increased).

No matter whether it was about outpatient or inpatient treatment or even rehabilitation the therapeutic goal was to achieve the client's abstinence, to develop a drug-free lifestyle.
The National Drug Strategy (2000) defined the new approach to treatment as follows: beside the achievement of the client's abstinence the continuous treatment-chain should start with the first contact with the client and last until the complete rehabilitation, should also target the formation of the individual's personality and lifestyle. Beside abstinence-oriented treatment types, methadone treatment was given grounds in the treatment of serious heroin/opiate addicts.

Treatment concepts in Hungary:

- Psychiatric concept
- Psycho-social concept (social work and psychological help)
- Community-based treatment of addicts

The appearance of the new treatment concepts brought about the increase in the number of drug-using clients in treatment and widened the range of efficient therapeutic forms. The existing care system extended the range of services but no new type of care centres appeared.

"Responsibilities and minimal professional conditions of health care of drug users – independently from its form and operating organisation – are defined in the Act CLIV. of 1997 on Health Care and the Decree of the Minister of Health, Social and Family Affairs No. 60/2003 in the Minimal Professional Conditions to Provide Health Care."

Outpatient treatment centres:

- Specialised outpatient treatment centres: specialised in treatment for drug-users
- Addiction-treatment centres: provide treatment primarily to alcoholics and secondly to drug-users
- Child- and youth-welfare centres (their importance has been decreasing considering the number of clients)
- Other NGOs

Hospital care and inpatient treatment centres:

- Psychiatric departments
- Addiction-treatment departments: specialised departments providing care primarily for alcoholics
- Crisis intervention departments: there are only a few in Hungary
- Detoxification departments (providing emergency medical care)
- Rehabilitation and long-term treatment centres (therapeutic communities providing less health care but social care; mainly run by NGOs).

The institutions and therapeutic communities providing rehabilitation or long-term treatment usually accept clients after a short (hospital) detoxification. Their operational and therapeutic principles define "drug-free" treatment as a main objective.

Professionals of different knowledge play role in treatment, namely social workers, addiction consultants, psychologists, psychiatrists, priests, clerical social workers, abstinent addicts and self-help groups. Abstinence is not achieved in the first step, motivating programmes reducing the health and social consequences of drug use are herein of importance. Beside the state-run public health-care institutions NGOs and institutions established and operated by the church play a growing role in this field.

5.1. TREATMENT SYSTEMS

A crucial change came about in the co-operation of health-care and social care with the start of community-based treatment of addicts in 2003. The amendment to the Act III of 1993 on Social Administration and Social Care effected in 2002 added community-based treatment of addicts to the local governments' responsibilities and tasks. Community-based treatment is jointly provided by a number of professionals and treatment staff based on the client's treatment plan tailored to his needs and state with the involvement of a community care provider and community co-ordinator. Their long-term objectives are to reinforce primary health-care, to co-ordinate health-care, social, governmental and non-profit services and to exploit the disposable resources in the treatment of addicts efficiently.

5.2. DRUG-FREE TREATMENT

The achievement of drug-free/substance-free lifestyle is broadly understood by "drug-free" treatment in the treatment practice in Hungary which goes beyond simple health-care and medical interventions. Beside health-care institutions rehabilitation centres, self-help groups, partly family-help services and – to a minor extent - child-welfare centres can be regarded as scenes of abstinence-oriented "drug-free treatment". The notion "rehabilitation centre" mainly means long-term therapeutic centres or therapeutic communities where social programmes support the formation of a drug-free lifestyle.

Inpatient treatments

Although the number of clients in inpatient treatment is less than that of clients in other treatment the importance of this treatment-type is not of less significance. It is usually necessitated by acute intoxication, detoxification or diagnostic purposes. Acute detoxification is mainly carried out in general psychiatric or narcology clinics. Short-term treatments lasting 2 to 2.5 days are typical in these clinics. The Hungarian Psychiatric Association intended to change the above practice in 2003: detoxification may only be carried out at specialised medical departments with intensive care (just as it is in Budapest). The objectives after a short detoxification phase are the outpatient relapse prevention and the in- or outpatient treatment of psychiatric co-morbidity. The cut-back of slots as a general reform to the inpatient treatment, however, also affected psychiatric care. Treatment takes 11 to 15 days, on the average.
Access to treatment is discouraged by a serious lack of professionals in these departments that means the lack of personnel specially trained for care of drug users. The care of juvenile drug users/addicts needs to be developed since slots in specialised inpatient treatment centres are missing. No further long-term therapeutic plan is set up for the clients after release from acute intoxication: they are not directed to any further treatment centre according to their states.

An outreach program is run in the co-operation of Blue Point Outpatient Centre and Péterfy Sándor Street Hospital Toxicology Department for clients entering treatment due to heroin overdose.

Outpatient treatments

Specialised outpatient centres are heterogeneous as far as their status is concerned (they might be integrated in a municipality hospital department, in a national institution, or work in the form of an association or foundation). (Gerevich et al.2003)
Minimal conditions of operation are defined in a professional methodological recommendation. Operational permission is issued by the local branch of the State Public Health and Medical Officer Service. Such specialised outpatient centres operate in 11 counties and 4 of them are in Budapest.

Activities of the specialised outpatient centres are heterogeneous: some of them explicitly take out prevention while others put harm-reduction activities in foreground. Unified concepts of treatment are missing; diagnostic and treatment methods have not been crystallized yet and often lie on the basis of local traditions and actual possibilities instead of conceptual ideas. Specialised outpatient centres started to gradually join EuropASI courses; a number of treatment handbooks were published thus fostering the spread of a homogenous approach to treatment work. (Gerevich et al. 2003) In 2003, researches, professional publications, trainings and extension trainings were not significant in quantity.

There was only one single institution where systematic follow-up of clients happened:
In the frames of this follow-up survey researchers found 76 of the 139 clients who had been in treatment in Blue Point Outpatient Centre. The Hungarian EuropASI follow-up module was recorded with 61 of them. (Meyers). ASI (Addiction Severity Index) was also determined at first contact with the clients. 3 of the clients died, 7 of them rejected the interview and 63 were not found on the basis of disposable information. Researchers made qualitative interviews with 16 clients. Average time lapse between the first contact with the clients and the record of the follow-up questionnaire was 35 months (a minimum of 28 months and a maximum of 43 months). Based on the ASI data there was a significant improvement in respect of their drug use, employment, psychological state, family and social circumstances. At the same time no change came about as far as alcohol use, general state of health and legal situation was concerned. These qualitative interviews mainly highlighted the relationship between clients and treatment staff. The fact that the selection and follow-up of the clients was not random-based limited the research (Marián et al. 2004).

Outpatient treatment is not only provided in specialised outpatient centres but also in addiction-treatment centres (in centres providing treatment for alcoholics and drug users at the same time) to the same extent. Such treatment is also available for clients in mental-hygienic centres and psychiatric clinics (such centres primarily provide outpatient treatment to psychiatric patients), to a smaller extent.
The treatment staff carries out – among others - detoxification, long-term treatment of psychiatric disorders and co-morbidity, counselling to clients and their families, testing and medical consultation.

Rehabilitation centres

Rehabilitation centres are primarily run by NGOs supported from clerical, municipality and foundation funds and other resources. These centres usually offer a comprehensive rehabilitation in therapeutic communities. Clients may only enter such rehabilitation programmes after a short outpatient or inpatient detoxification. Time period of treatment varies from 6 months to 2 years. It is usual that health-care and social rehabilitation are

parts of such programmes at the same time. Besides, social care is dominant i.e. work therapy, social reintegration…etc.
The number of slots was considerably extended in 2002. Beside this quantitative increase a qualitative development was carried out by the implementation of modern therapeutic possibilities and the training of the treatment staff. Altogether 400 slots are available. Two further centres opened up in 2003 in addition to the 9 existing rehabilitation centres, one of them was supported by the Greek-Catholic Church and the other in the form of a civil organisation. According to the recent trends social workers and abstinent addicts have a growing part in these centres' work.

There are rehabilitation centres operating in the frames of both the health-care and the social care system. The Social Act currently being in force, that was amended to in 2003 presumes a "qualification for rehabilitation". As for rehabilitation, there are recent efforts made to harmonise the corresponding rules of law.

Social normative is the basis of the operation of these centres that is contributed to by the chronic patient care subsidy provided for health care. Objectives of these centres are to adapt modern diagnostic methods, to train the medical and paramedical staff and to examine efficiency.

A quality assurance system (that also relates to the data collection) was worked out by the Association of Hungarian Drug Rehabilitation Institutes in 2003, the acceptance of which is underway.

5.3. MEDICALLY-ASSISTED TREATMENT

Withdrawal treatment

In Hungary medically-assisted treatments targeting at detoxification and stabilisation of abstinence are run in the frames of both inpatient and outpatient treatment. Benzodiazepines and adrenergic substances are broadly used for treatment/mitigation of detoxification symptoms. Methadone is used for short-term withdrawal and substitution treatments of opiate- and heroin-addicts. Prescription of methadone has been discouraged, however, by former steps of the police. Both forms of methadone treatment are provided to clients for free. Alternative medical concepts use ear-acupuncture sporadically.

Substitution treatment

In addition to the existing five centres a new methadone treatment programme was launched by the Centre for Addictions in Soroksár (district of Budapest) in 2003. In recent years the number of clients registered in substitution treatment has increased for this reason. The most eye-catching growth was observed in the Outpatient Centre run by Nyírő Gyula Hospital in Budapest (from 32 clients in 1999 up to 260 clients in 2003). Since January 2002 data have been collected in this centre on a monthly basis. Registration of clients in methadone treatment is secured by service providers treating addictions with methadone treatment. Records have been kept on the basis of drug-related rules of law of the police. Clients are taken into a nationwide registry by a code securing anonymity. Register is kept by the outpatient centre of the Nyírő Gyula Hospital.
Protocol of methadone treatment was completed and published in the Official Health Journal in 2002. In the same year the National Health Insurance Fund undertook to finance methadone treatment.

Methadone is currently used in three types of therapeutic protocol:

1. short-term detoxification which means a fast-paced withdrawal. Treatment interval: maximum 30 days. Objective of treatment is detoxification, i.e. fast achievement of being opiate-free.
2. long-term detoxification where pace of withdrawal is slower and gradual. This treatment method is mainly adapted in the case of clients with a longer duration of opiate-addiction. Interval of this treatment type varies from 1 to 6 months. Objective of it is again being opiate-free.
3. Substitution treatment is where methadone is dosed on the long run because all attempts to withdraw have resulted in relapse. Substitution treatment may even last for years. It is advised to adapt such treatment in the case of opiate-addicted population where the clients may not abandon opiate-use in due time.

Table 9. *Number of clients in methadone treatment in 2003*

Jan.	Febr.	March	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
213	236	246	236	237	232	232	243	254	272	289	293

Source: Nyírő Gyula Hospital, Outpatient and Prevention Centre

Altogether 750 clients were registered in methadone treatment. Despite developments and increase in the number of slots, only a small number of opiate addicts have recently been involved in methadone treatment, yet.
Rate of officially registered opiate-addicts being involved in methadone treatment is around 5-6% which is still below the EU average (50%), moreover below the average in Slovenia (24%) and that in the Czech Republic (19%).

Conclusions

In the last one year NGOs, foundations, clerical organisations and self-help groups were contributing to the treatment of drug users to a growing extent. Recently emerging tendencies show that social workers and abstinent addicts are also involved in the activities of these centres at a larger scale. Currently available data suggest that outpatient treatment of drug users is preferred to other treatment frameworks in Hungary. Objects of outpatient centres are heterogeneous, unified treatment concepts are missing and diagnostic and treatment methods have not been crystallized yet. In addition to the 9 existing rehabilitation centres two further ones opened up in 2003 and another centre started its operation in the field of substitution treatment in the capital.

6. HEALTH CORRELATES AND CONSEQUENCES

6.1. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

Due to the inadequacy of the data-collection system reliable information is only available on drug-related deaths. Data in this chapter about deaths differ from the results of the national data collection (OSAP). This discrepancy is due to the fact that at the time of OSAP data collection January 21, 2004, the results from the toxicological examinations of autopsies in the end of 2003 were not available. The hereby published data-analysis and data corrections were made by the National Focal Point's working group on drug-related deaths. Data were provided by the Hungarian National Police Headquarter, National Institute of Forensic Medicine and the National Institute of Pathology. No data collection was taken out to determine the number of presumably intentional or accidental overdoses.

Direct overdoses and indirect drug-related deaths

In Hungary the number of drug-related deaths has shown an increasing trend compared to previous years, especially considering the number of direct overdoses. While 38 users died by overdose in 2000 this number amounted to 40 in 2001 and it decreased to 32 in 2003. It is a fact that the number of deaths due to heroin-overdose went back. Opiate users still represent the largest proportion among overdose-related deaths. In contrast to the few deaths in the preceding years 4 deaths by cocaine overdose and further 4 deaths by amphetamine overdose were reported in 2003. Parallel to the decreasing trends in overdose by illicit drugs number of overdose by licit drugs kept on rising in 2003.

All in all, the decrease in the number of drug-related deaths is partly a consequence of the fall in the number of autopsies. Increased number and volume of party-drug use is more important. The use of these drugs causes death in an indirect way: through heart-attack and other myocardial degenerations or arrhythmia. These cases are usually directed to the pathologist where no toxicological tests are made. Thus drug use remains a hidden cause of death. The National Institute of Pathology reported that – according to respondents – no autopsy was made on clients failing from drug use. The situation is similar in respect of cocaine.

Table 10. *Number of drug-related deaths 1997-2003*

Substance	1997	1998	1999	2000	2001	2003
Opiates	46	23	40	35	39	24
Cocaine and crack	-	3	-	-	-	4
Cannabis	-	-	1	1	-	
Hallucinogens	-	1	-		-	-
Amphetamines	1	4	1	2	1	4
Illicit drugs TOTAL	**47**	**31**	**42**	**38**	**40**	**32**
Sedatives	255	210	281	198	214	220
Poly-drug use	36	65	4	35	37	44
Solvents / inhalants	1	32	10	9	20	15
Other	-	-	-			9
Total	**339**	**338**	**337**	**280**	**311**	**320**

Source: OSAP 1997-2001, statistics by the NFP's working group on Drug-Related Deaths, 2003

Mortality and causes of deaths among drug users

Since no HIV and HCV testing was made on the clients deceased in 2003, no data are available.
During an autopsy, recently no cross-checks can be made on whether the client was in inpatient treatment or rehabilitation. Therefore we cannot provide any data on this, either.
As regards the causes of deaths, we only have information on overdose-related cases.

6.2. DRUG-RELATED INFECTIOUS DISEASES

Sources of indicators on the incidence of HIV, HBV and HCV are as follows:

- Reported HIV/AIDS cases and incidence data on acute HBV, HCV from the National Registry of Infected Patients kept by the Communicable Diseases Department of the National Centre for Epidemiology and the special HIV/AIDS and hepatitis surveillance database;
- Prevalence data from HIV, HBV, HCV tests on injecting drug users in the laboratories of the State Public Health and Medical Officer Service were provided by the local branches on instruct of the Head of the State Public Health and Medical Officer Service.
- Research financed by the National Public Health-Care Programme's AIDS Prevention sub-programme in 2003 aimed to monitor the volume of HIV/HBV/HCV infection among injecting drug users.

The establishment of the National Focal Point gave an impetus to centralise data collection on infectious diseases related to injecting drug use.

HIV / AIDS

In contrast to the previous years no significant change occurred in the nature and indicators of HIV / AIDS epidemics in Hungary in 2003. 63 newly-revealed HIV positive cases were reported and the incidence was lower (6.3 cases per million residents) than in the previous year (8 cases per million residents). By the end of 2003 the cumulative number of HIV infections that had been registered since 1985 grew to 1,104. Twelve of all registered HIV infected persons (1%) were injecting drug users. Only one new case was registered in 2003: a 35 year old, male, Vietnamese injecting drug user was diagnosed to be HIV infected. No HIV infection was diagnosed among injecting drug users of Hungarian nationality in the last seven years.

Table 11. *Breakdown of registered HIV infections by risk groups*

Year	Homo/bisexual	Heterosexual	Haemophiliac	Transfusion recipient	Injecting drug users	Nosocomialis	Maternalis	Unknown	Anonymous	Total
1986-1999	430	120	32	20	**6**	12	3	101	109	833
2000	17	16	0	0	**1**	0	0	14	0	48
2001	35	20	0	2	**3**	0	0	22	0	82
2002	35	26	0	0	**1**	0	0	16	0	78
2003	34	18	0	0	**1**	0	0	10	0	63
Total	**551**	**200**	**32**	**22**	**12***	**12***	**3**	**163**	**109**	**1104**

**Imported cases, Source: National Centre of Epidemiology, 2003 (Csohán Á., Székács A.)*

93,304 HIV tests were made in Hungary in 2003. In the laboratories of the State Public Health and Medical Officer Service (SPHMOS) and the National Centre of Epidemiology 133 serological tests were made on blood-samples from injecting drug users. All of these tests resulted in negative outcome. 95% of the tests were initiated in Budapest and in 4 counties (Baranya, Csongrád, Hajdú-Bihar, Veszprém). Most of them were carried out on request of outpatient centres and partly for voluntary testing.
HIV-sentinel screenings implemented in previous years were executed in Budapest, at the Péterfy Sándor Street Hospital Toxicology Department in 2003. No HIV positive infections were diagnosed among the 197 clients being admitted for drug overdose.
None of the 134 clients in methadone treatment in the Outpatient Centre run by Nyírő Gyula Hospital were diagnosed with HIV infection. (HIV test is a condition of admittance to the treatment programme.)

Table 12. *HIV infection among injecting drug users tested for HIV antibody in 2003*

	Laboratories of the SPHMOS and National Centre for Epidemiology		Péterfy Sándor Street Hospital Toxicology Department		Outpatient centre run by Nyírő Gyula Hospital		TOTAL	
	Number of tests	Positive results	Number of tests	Positive results	Number of tests	Positive results	Number of tests	Positive results
Male	100	0	130	0	94	0	324	0
Female	33	0	67	0	40	0	140	0
Total	133	0	197	0	134	0	464	0

Source: National Centre of Epidemiology, 2003 (Csohán Á., Székács A.), Research Riport, 2004 (Újhelyi E., Bánhegyi D.)

The majority of clients tested for HIV were aged between 25 and 34 years. Rate of youths aged under 25 was higher (38.1%) among clients tested for HIV due to heroin-overdose than that among clients in methadone treatment (26.9%) or among clients tested on request of outpatient centres (27.8%). Male-female ratio of those sent for test from outpatient centres was 3:1. This ratio was 2:1 among clients in methadone treatment and among those in treatment due to overdose.

Acute Hepatitis B

Hungary's position can be regarded as highly favourable among the European countries in respect to the epidemiologic state of HBV on the basis of incidence of acute HBV infections and data on presumably chronic HBV carriers.
143 infections were reported in 2003 representing an incidence of 1.4$\%_{000}$. This rate of incidence did not differ from the average of the preceding 5 years. (In the last five years less than 2 infections were diagnosed to 100,000 residents.)

7 of the 143 clients (4.9%) were injecting drug users in 2003. The number of diagnosed infections nearly equalled to that registered in the previous 2 years.

Table 13. *Number and rate of injecting drug users among clients reportedly infected by HBV*

	Reported acute HBV infections		
	total	Injecting drug users	
		number	%
1993	198	-	-
1994	223	3	1.3
1995	225	-	-
1996	183	1	0.5
1997	178	-	-
1998	178	3	1.7
1999	169	10	5.9
2000	130	-	-
2001	159	6	3.8
2002	159	6	3.8
2003	**143**	**7**	**4.9**

Source: National Centre of Epidemiology, 2003 (Csohán Á., Kaszás K.)

The mean age of these clients was 26 years. None of them were vaccinated against HBV. 6 of them were men and only one of them was a woman. All the seven clients were of Hungarian nationality and most of them were residents in Budapest. Among injecting drug users aged 15 to 19, no HBV infection was diagnosed in 2003. These clients are members of the generation that was immunized by a vaccination against HBV which is compulsory at the age of 14, officially determined in 1999.

Beside the reported cases 139 injecting drug users were tested for infection with the HBsAg antigen. The rate of HBsAg carriers among them proved to be 0.7% which was higher than the average of 0.3% among the total population. One third of these tests were initiated in the capital, in the county of Veszprém and in the counties of Baranya, Csongrád and Hajdú-Bihar, respectively.

Table 14. *Rate of HBV infection among injecting drug users tested for HBsAg antigen in 2003*

	Laboratories of the SPHMOS and National Centre for Epidemiology		Péterfy Sándor Street Hospital Toxicology Department		Outpatient centre run by Nyírő Gyula Hospital		TOTAL	
	Number of tests	Positive results	Number of tests	Positive results	Number of tests	Positive results	Number of tests	Positive results
Male	100	1	130	*	94	*	324	*
Female	39	0	67	*	40	*	146	*
total	139	1	197	6	134	2	470	9

** N.a.*

Source: National Centre of Epidemiology, 2003 (Csohán Á., Székács A.), Report on Research, ESZCSM, 2004 (Újhelyi E., Bánhegyi D.)

Acute Hepatitis C

Fewer acute hepatitis C infections were reported in 2003 compared to 2002. Two of the infections may have been caused by injecting drugs. These two infected patients were women over 25.

Rate of injecting drug users among hepatitis C infected clients reached its peak in 1998 (17.3%) followed by a continuous decrease. While in 1998, 14 of the patients infected by

acute hepatitis C were injecting drug users only 2 of them belonged to the same risk group in 2003. This decrease suggests that harm-reduction programmes ran in the last two years were more successful than before.
With regard to the fact that only one fifth of hepatitis C infections result in acute diseases, to be realistic, the number of new infections among drug users must be multiplied by at least 4 or 5 on a yearly basis. No national register is at our disposal on the prevalence and incidence of chronic HCV infections, HCV carriers and acute patients.

Table 15. *Rate and number of injecting drug users among reported acute hepatitis C patients*

	Reported acute HCV infections		
	total	Injecting drug users number	%
1993	48	1	2.1
1994	43	-	-
1995	32	-	-
1996	41	-	-
1997	88	7	8.0
1998	81	14	17.3
1999	68	8	11.8
2000	59	5	8.5
2001	43	5	11.6
2002	42	3	7.1
2003	30	2	6.7

Source: National Centre of Epidemiology, 2003 (Csohán Á., Kaszás K.)

135 injecting drug users were tested for HCV infection with anti-HCV antibody in 2003. One third of the tests were initiated in the capital, in the county of Veszprém and in the counties of Baranya, Csongrád and Hajdú-Bihar respectively. In accordance with the international data HCV infection is much higher (10.3%) in this population than in the normal population (0.6%). Prevalence was two times higher among women than among men.

Table 16. *Rate of HCV infection among injecting drug users tested for HCV antibody in 2003*

	Laboratories of the SPHMOS and National Centre for Epidemiology		Péterfy Sándor Street Hospital Toxicology Department		Outpatient centre run by Nyírő Gyula Hospital		TOTAL	
	Number of tests	Positive results	Number of tests	Positive results	Number of tests	Positive results	Number of tests	Positive results
Male	99	8	130	41	94	20	323	69
Female	36	6	67	18	40	13	143	37
total	135	14	197	59	134	33	466	106

Source: National Centre of Epidemiology, 2003 (Csohán Á., Székács A.), Report on Research, 2004 (Újhelyi E., Bánhegyi D.)

Sentinel research among heroin overdoses

The seroprevalence survey of 2003 was conducted among 331 (earlier not tested) injecting drug users. 197 of them were admitted to the Péterfy Sándor Street Hospital Toxicology Department for overdose and 134 of them were clients in methadone treatment at the Outpatient Centre run by Nyírő Gyula Hospital. The group of clients with heroin overdose can be qualified as a sentinel group because repeated surveys in this risk group

were conducted in periods of 1 or 2 years thus the changes in prevalence could be monitored.

3.0% of the tested injecting drug addicts with heroin overdose were HbsAg positive and markers of previous HBV infection were diagnosed at the rate of 19% of them. In the same group 30% of the addicts were infected by HCV. This rate is nearly equal to that in 2001 which means that no remarkable change could be detected.

Table 17. *A comparison of sentinel research results among clients with heroin overdose*

	Number of tested persons	**HIV-positive persons (%)**	**HBsAg positive persons (%)**	**Anti-HBV positive persons %**	**Anti-HCV positive persons (%)**
1996/1997	146	-	4	-	17
2001	136	-	1.4	-	28
2003	197	-	3.0	19	30

Source: National report 2003, Research report 2004 (Újhelyi E., Bánhegyi D.)

1.4% of clients in methadone treatment proved to be acute HBV carriers and markers of previous hepatitis B infection were diagnosed at the rate of 16% of them. (Rate of recovered HBV infections (16.4%) was lower than that among clients with heroin overdose (19%).)

Conclusions from the above survey:

- 21% of male clients in methadone treatment aged under 24 and 33% of clients with heroin overdose aged under 24 had positive HCV results. This rate was lower in older age groups. These facts suggest that the youngest population of drug users is not aware of the risks of drug-related infectious diseases transmitted by blood.
- HCV prevalence in the sentinel group was hardly different from that in 2001 which means that the number of HCV infected clients has not increased. The underlying reason for it must be the implementation of further syringe exchange programmes (the first syringe vending-machines also started to work in 2003) as a result of which the risk of becoming infected by HCV decreased in the risk group.

6.3. PSYCHIATRIC CO-MORBIDITY

No detailed, comprehensive and evidence-based research has been carried out to define exactly the co-morbidity of drug use and psychiatric disorders in Hungary yet. A few researches were conducted to define psychological personality features being characteristic to specific drug-using population.

Demetrovics and fellow-researchers revealed psychological and personality differences of opiate-addicts, cannabis users and amphetamine users.
Németh and fellow-researchers examined possible patterns of drug-use among psychotic patients admitted to Psychiatric Department of Nyírő Gyula Hospital.

6.4. OTHER DRUG-RELATED HEALTH-CORRELATES AND CONSEQUENCES

Data on other health correlates of drug use are only available on the overdosed patients treated in intensive medical care at the Toxicological Department of the Péterfy Sándor Street Hospital. Mean age of the patients with drug overdose was 23 years. 60% of them were male.

Patients requiring surgical or emergency care are usually admitted according to the rules set by the State Public Health and Medical Officer Service. The data on these patients are missing from our statistics just like data on patients in cardiologic treatment with thoracic pains caused by cocaine-use. Drug use often remains hidden in such cases.

Table 18. *Number of* d*rug users in treatment by drug overdose in 2003*

	male	**female**	**total**
Opiates	115	32	147
Cocaine	11	4	15
Cannabis	65	15	80
Hallucinogens	13	8	21
Amphetamines	103	210	313
Poly-drug use	21	18	39
Inhalants	82	24	106
total	410	311	**721**

Source: Péterfy Sándor Street Hospital Toxicology Department

80% of clients with drug overdose are heroin-addicts. These patients leave hospitals after a short period of care. Complication occurs only with around 5% of them. These complications are respiratory deficiency (dyspnoea) for heroin-lungs, rhabdomyolysis followed by renal insufficiency, inguinal infections, abscesses, superficial phlebitis and endocarditis. Annually 10 to 15 patients require treatment due to thoracic pains, mental disorders, high temperature and other complications caused by cocaine use. There were also LSD-using patients who suffered permanent mental damage.

Conclusions

Due to the inadequate data collection system, we don't have a comprehensive picture about drug-related deaths and morbidity. As regards cases of overdose in 2003 we can conclude that the number of opiate overdoses decreased whereas number of deaths caused by cocaine-, amphetamine and licit drug (mainly pharmaceuticals) overdoses increased.

Based on the fact that only one of the about 100,000 HIV tests in 2003 had a positive result and on the basis of the 464 selective HIV tests on injecting drug users we can say that the number of HIV infections still must be low in the Hungarian injecting drug users' population just like in the previous years. Prevalence is so low that it couldn't be measured by recent research methods.
Trends of hepatitis B and hepatitis C infections among injecting drug users show that there was no change in the number of newly-diagnosed acute HBV infections in the last three years and the number of acute HCV infections has been continuously decreasing since 1998. A prevalence of 10.3% among clients in outpatient treatment and a prevalence of 28% among clients with heroin overdose probably come from cumulating of HCV incidence before 2000. It is important to note that HCV prevalence has not changed in the latter group. HCV prevalence is still higher among those aged under 25 than in the general population. That is why further interventions must be implemented to reduce the risks of becoming infected by HIV, HBV, HCV faced by the "young" injecting drug users.

No data were collected on other health consequences of drug use. The only information we have in this respect is the information on patients admitted due to drug overdose to the Péterfy Sándor Street Hospital Toxicology Department in Budapest.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

7.1. PREVENTION OF DRUG-RELATED DEATHS

No special programmes exist. Education of safe injection is part of the syringe exchange programmes. No data are available.

7.2. PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

The first syringe exchange programme started to work 10 years ago run by an NGO. The National Drug Strategy gave grounds to harm-reduction programmes even though the legal frameworks securing their smooth working were not formulated in 2003. Drug use was qualified as a criminal offence, possession of syringe and needle was qualified as exhibits of an offence. This is why drug users are fundamentally suspicious of harm-reduction and especially of syringe exchange programmes. Due to the lack of normative support from the state these programmes face constant difficulties of operation. Established initiatives are supported through tenders by the competent ministries.

In Budapest two mobile (specially equipped buses) and two fixed needle and syringe exchange programmes ran and a syringe vending-machine was set up in 2003. Syringe exchange programmes located in Budapest agreed to co-ordinate their geographical coverage and to mutually help each other with donated food and sterile equipments.

Data on syringe exchange in Hungary:

- Number of syringes and needles given: 28964
- Number of syringes and needles taken back: 14921
- Number of used syringes and needles collected in public places: 529
- Number of client contacts: 3859
- Number of clients: 594

Testing and counselling

40 NGOs providing low-threshold services were questioned about their activities nationwide in 2003. Almost all of these harm-reduction centres provided information leaflets in a volume of thousands, as they reported.

Treatment of infectious diseases

No data are available.

7.3. INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY

As no detailed survey has been conducted to determine co-morbidity of drug use and psychiatric co-morbidity in Hungary so far, no data are available on the magnitude of the problem. There is no unified therapeutic protocol for the treatment of drug users with diagnosed psychiatric co-morbidity. Treatment is usually taken out on the basis of professional specialisation and preparedness of the treatment staff.
Institutions and professionals specialised in treatment of psychiatric patients usually treat the psychiatric problems of the co-morbid patient rather than his addiction.

Institutions and professionals specialised in treatment of addicted patients primarily treat the drug-addiction of the co-morbid patient and care less about his psychiatric symptoms and disorders.

Outpatient treatment system
Experts in outpatient treatment centres are specialised in psychiatry and/or addictions. Most of these centres also employ a psychologist. The treatment of psychiatric patients using drugs in these outpatient centres is usually a matter of the personnel's competencies and willingness.
In the private praxis there are a number of psychiatrists, psychologists and professionals specialised in addictions who treat patients with dual diagnosis. But we do not have exact data on them.

Inpatient treatment system
Psychiatric and addiction-treatment departments in Hungary are obliged to admit drug users (and patients with psychiatric co-morbidity) from their geographical coverage. These departments only employ psychiatrists and/or professionals specialised in addictions and have psychologists in their personnel. Few of these departments also employ a professional staff specialised in psycho-therapy. In these departments, diagnosis and treatment of drug users with psychiatric co-morbidity are both possible.
In practice, psychiatric departments admit psychiatric patients with acute drug-related problems and addiction-treatment departments admit drug users with acute psychiatric symptoms to whom adequate care is provided by professionals.
Recently two departments have been operating in the country where declared special treatment is provided for drug-addicted psychiatric patients: Thalassa House and the Psychiatric Department No. 9 in the National Institute for Psychiatry and Neurology.

7.4. Interventions related to other health correlates and consequences

There is neither special intervention nor reliable data-collection in Hungary in this context. It is usual that clients in outpatient centres operating within a hospital are directed to other in-house departments providing adequate treatment to their needs.

Conclusions

A slow change in the health correlates and consequences of drug use started in Hungary in the last year. Organisations being active in the fields of prevention and treatment of infectious diseases took concrete steps by the formation of unity to reach nationwide coverage and to distribute donations evenly.
All Hungarian centres providing low-threshold services employ skilled and prepared professionals and have the tools for counselling and information dissemination at disposal.
Diagnosis of psychiatric co-morbidity is possible in every inpatient centre.

8. SOCIAL CORRELATES AND CONSEQUENCES

8.1. SOCIAL EXCLUSION

In Hungary socially excluded, marginalized population includes the disabled, the elderly, the mothers raising their children alone, immigrants, drug users and also most romas. Social exclusion can be interpreted as a negative outcome of problematic situations and resources mutually reinforcing each other affecting the life of those socially excluded and not as a factor reasoning drug use. The society associates typical forms of social exclusion, i.e. homelessness, unemployment, criminal or other risk behaviours automatically interfering with drug use.
The notion "social exclusion" reflects in the life of recreational drug users and problem drug users or drug-addicts in very different ways and at different levels. That is to say that social exclusion itself is less referring to drug use but is the result of reinforced social problems like homelessness, poor state of health or unemployment. Such problems, however, may principally arise in the lives of drug-addicts and become accompanying phenomena to them.
We have limited data available on problem-drug use in Hungary. National and regional methodological institutions have been established since 2000 but we have no information about their activity.

Homelessness
Six organisations provided low-threshold services in Budapest in 2003. 56 homeless drug users were contacted by their outreach programmes.

Unemployment
No data are available.

School drop-outs
No data are available.

Financial problems
No data are available.

Social network
95% of those being registered in social care are alcoholics. Act III. of 1993 on Social Administration and Social Care names and regulates community, outpatient and inpatient (temporary, rehabilitation and care providing) treatment centres within the health-care system.

Beside alcohol-addicts drug-addicted youths are the ones who apply for (outpatient and rehabilitation) services provided by the treatment system. In recent years a serious increase has been observed in demand for outpatient and rehabilitation centres providing treatment to drug users at particular points of the country (along transit roads, in the capital). Based on professional criteria, treatments provided for alcohol-addicts in the frames of social care were formulated and distinguished from those provided for drug addicts.

The extension of the tasks of family-care services include the resolution of problems faced by drug-addicts and their families. Amendment to the Act on Social Administration and Social Care in 2001 delegated the organisation of community-based care of drug addicts into the scope of responsibilities of municipalities and extended the range of tasks of

family-care services (in a way that they provide information to drug-addicted youths and their families, they keep in touch with treatment centres and care-service providers).

8.2. DRUG-RELATED CRIME

Data on crime in Hungary is collected by the Uniform Criminal Statistics of Police and Prosecution. This system is operated by the members of the official statistical services, the Ministry for Foreign Affairs and the Public Prosecutor's Office on the basis of the Act on Statistics.
Due to the outcome-oriented system data are registered with some delay: only at time of the closing of police and prosecution procedures. Therefore data introduced here refer to those acts where the procedures were finished in 2003. The number of offenders can only be determined from final sentences. As the success rate of accusations has been exceeding 96% for years the number of offenders at termination of the investigation may be implicit enough.
Criminal statistics can monitor proceedings with a delay. This shall not be neglected when analysing!

Table 19. *Dates of reported drug-related crimes, 2003*

Year of perpetration	No. of cases	%
Prior and in 2001	956	28.3
2002	1740	51.5
2003	682	20.2
Total	**3378**	**100,0**

Source: Uniform Criminal Statistics of Police and Prosecution

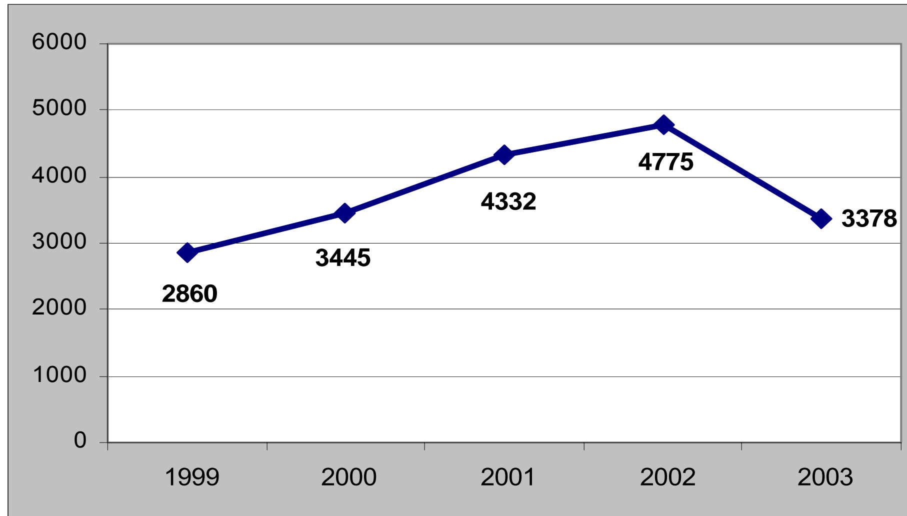
When analysing the dates of perpetration we see ratios differing from those having been typical in previous years. 26.8% of the data relate to crimes committed in the year under review. This rate hardly exceeded 20% in 2003.

Misuse of narcotic drugs

Crimes revealed

Proportion of drug-related crime within total crime was higher than 1% (1.13%) in 2002. The same rate in 2003 was only 0.81%. In order to be realistic about the importance of drug-related crime within total crime in Hungary this extremely low rate cannot be neglected. Drug-related crime decreased by 29.3% while total crime revealed decreased by only 1.8%.

Figure 17. *Development in the number of revealed misuse of narcotic drugs*



Source: Uniform Criminal Statistics of Police and Prosecution

This significant decrease apparently correlates with the amendment to the Criminal Code in 2003 and the entry into force of the new Act on Criminal Procedure. Namely, statistical data on drug-related crime revealed in the second half of 2004 converged to the number of drug-related crime of 3378 in 2003.
Amendment to the Criminal Code having been in force since March 1, 2003 targeted more drug-using offenders with the alternatives to prison. The new Act on Criminal Procedure entered into force on July 1, 2003, the diversion of drug-using offenders to alternatives to prison became more regulated, however longer in process. So the majority of proceedings that had been initiated in 2002 and before March 1, 2003 and were lasting at time of the amendment to the Criminal Code that granted the right to offenders to be diverted to the alternatives to prison could not be included in the statistics of 2003. The most proceedings that had been started after March 1, 2003 with a final sentence of "to be diverted to alternatives to prison" were not terminated in the year under review either. These cases – probably – will be included in the statistics of 2004.

Drug offences

Despite of the afore-mentioned amendment to the Criminal Code being ultimately important in respect of consumption as a drug offence, this conduct of offence still occurs with the highest frequency. Authorities initiated proceedings against 44.6% of offenders in 2001, against 54.5% in 2002 and against 32.7% in 2003 explicitly on misuse of narcotic drugs. Attention must be paid to what effects the amended legal facts of misuse of narcotic drugs in the Criminal Code that came into force March 1, 2003 and the new Act on Criminal Procedure as of July 1, 2003 had on the division of drug offences! Since March 1, 2003 misuse of illicit narcotic drugs has been punishable not only in respect of offence involving "consumption of narcotic drugs" but on offence "*if it involves a small quantity acquired or held for own consumption*". This is why the remarkable fall with regard to consumption (as an offence) in 2003 is not accidental. This decrease doesn't, however, imply an increase in the rate of offences on the supply side. This statement is underpinned by the increase in the number of those diverted to alternatives to prison.
13.1% of the offenders were drug-addicts. Most of them were still occasional users. Due to the relevant amendments, hereby we disregard a deeply-going analysis of the offences committed in 2003.

Offenders

The dispersion of those committing misuse of narcotic drugs by age shows that the juvenile and young adults (at the age of 18-24) still dominate. More than three fourths of all offenders in 2001 and 2002 were members of these age groups. This rate was 70.4% in 2003 which means that the number of offenders committing misuse of narcotic drugs at an older age is growing.

Table 20. *Breakdown of offenders who committed misuse of narcotic drugs by age, 2000-2003*

Age range	**2000**		**2001**		**2002**		**2003**	
	offenders	%	offenders	%	offenders	%	offenders	%
Children	5	0.1	13	0.3	11	0.3	7	0.2
Juvenile	530	14.8	689	17.1	766	17.8	393	13.4
18–24	2086	58.5	2334	58.0	2476	57.6	1675	57.0
25–30	618	17.3	707	17.6	728	16.9	644	21.9
31–40	204	5.7	215	5.3	259	6.0	177	6.0
41–50	48	1.3	46	1.1	46	1.1	32	1.1
51–60	12	0.3	11	0.3	7	0.2	6	0.2
over 61	59	1.6	10	0.2	4	0.1	6	0.2
Total	**3562**	100.0	**4025**	100.0	**4279**	100.0	**2940**	100.0

Source: Uniform Criminal Statistics of Police and Prosecution

Decrease in the number and rate of juvenile offenders is partly explained by the fact that offenders in this age group commit the least serious direct drug offences and proceedings are usually initiated against them due to demand-related offences. So the amendments to legal frameworks described above must affect the “proportion” of such offenders in the statistics of 2003, as the majority of these offenders have been diverted to alternatives of prison.
The fact shouldn’t be neglected that the police does not regard juvenile drug users as their ‘target group’. The reason is that the phenomenon of such offences without victims is hard to reveal and demonstrate and partly because such demonstrations are rather expensive. (Ritter 2003a)

Ratio of offenders committing revealed misuse of narcotic drugs by gender is 1:10 for men. Rate of female offenders was 9.7% in 2003. This rate has been constant for years.

49.3% of those committing misuse of narcotic drugs in 2003 finished primary school, 24.6% of them finished vocational school and 24.7% of them graduated from secondary-school. The statement that an “average” offender committing misuse of narcotic drugs is higher educated than an “average” offender committing any crime is still valid. There were hardly any offenders (0.3%) who did not finish at least primary school or who wasn’t finishing it at time of the offence.
Number of secondary school graduates among offenders slightly grew compared to that in 2002. This means that offenders committing misuse of narcotic drugs have been still ahead of other offenders in terms of education and actually have increased their advantages.

Drug-related crime

According to the criminal statistics 1356 crimes were committed under the influence of narcotic drugs in Hungary in 2003, namely that many were reported to authorities. 83.2% (1128 cases) were qualified as misuse of narcotic drugs.

In breakdown of crime categories, number of offenders committing ‘Crime against Public Order and Property’ was the highest (1157 and 137, respectively). The former one also includes the number of offenders who committed ‘Misuse of Narcotic Drugs’ (1128). ‘Grievous Bodily Harm’ was the most often committed one in the category of ‘Crime Against a Person’, ‘Driving under the Influence of Alcohol or Other Psychoactive Substances’ was the most typical in the category of ‘Traffic Crime’. ‘Endangering of a Minor and Omission of Support’ occurred the most often in the category of ‘Crime Against Marriage, Family and Youth’. ‘Violence Against an Official Person’ was the most typical in the category of ‘Crime Against the Purity of State Administration, the Administration of Justice and Public Life’ and ‘Burglary’ was the most often committed in the category of ‘Property Crime’.
Since prostitution is not qualified as crime in Hungary the relationship between drug-related crime and prostitution cannot be analysed on the basis of criminal statistics.

In 2002 1786 crimes were committed under the influence of narcotic drugs. The number of these crimes decreased of 24.1% in 2003. At the same time the breakdown of crime categories did actually not change. More than 80% of crimes committed under the influence of narcotic drugs have been made up by ‘Crimes against Public Order’, by ‘Misuse of Narcotic Drugs’ within for years. The number of such cases (1128) indicates that authorities initiated proceedings on misuse of narcotic drugs against that many offenders committing crime under the influence of narcotic drugs.
We have to note, that crimes committed under the influence of narcotic drugs are only revealed if the offender himself reports this to the authorities or if his bodily fluids are allowed to be examined by the Act on Criminal Procedure due to the features of crime. Therefore data in criminal statistics may only be used with reservations when analysing the magnitude and characteristics of indirect drug-related crime and consequent crimes to it.

The statistics include offenders committing crime under the influence of psychoactive substances (that are legally not narcotic drugs) separately. Number of them was some lower (756) in 2003 than that of offenders committing crime under the influence of narcotic drugs; number of offenders committing crime against public order or property was the highest also in this category of offenders. In the breakdown of crime types, number of offenders committing crime under the influence of alcohol significantly exceeded that of offenders who committed crime under the influence of illicit drugs (22,983 offenders in 2003).

8.3. DRUG USE IN PRISON

The first and only research targeting drug use in prison was carried out in Hungary in 1997.
Prisoners having been sentenced or imprisoned for “misuse of narcotic drugs” started to appear in the prisons of Hungary around the time of the transition. Earlier, inhalation of solvents in firms operating next to the prisons (furniture and textile factory) endangered the health of prisoners. Recently it is no more the case. According to an earlier, not representative, survey young prisoners whose ways led from the reformatories right into the prisons in the late 80’s form the inner circle of a bigger group which is probably trafficking with drugs in the penal institutions, similarly to other typically prison-born illegal activities.
About 800 of all prisoners in Hungary were imprisoned (sentenced for enforceable imprisonment or in preliminary detention) on drug-related crime in 2003. This makes up around 5% of the total prison population that is recently way behind the Western-European trends where at least 50% of the prison population is affected by the phenomena described above. Our registration system is only relevant to crimes listed in the Criminal Code, namely only the direct drug-related crimes.

From the Bulletin of Court Decisions we know that there is a number of prisoners in the Hungarian penal institutions – beside the above ones – who committed crime under the influence of narcotic drugs or in order to acquire drugs. There are no exact data available on the offenders of such indirect drug-related crime.

8.4. SOCIAL COSTS

As for social costs, there are data available on the costs covered by the National Health Insurance Fund. In the context of data on care for addictions it must be noted that drug-abuse and alcohol-addiction are not always clearly distinguished. Therefore some data do not imply exact information on costs of care for strictly drug-use.

Costs of care for addictions covered by the National Health Insurance Fund increased in 2003 in comparison to the previous year. The most significant increase was detected in respect of clearly drug-related outpatient treatment (609%). Costs of care unquestionably related to drug use also increased (by 83%).

Table 21. *Costs of care for addictions covered by the National Health Insurance Fund in 2002, 2003*

Treatment	**2002** (HUF thousand)	**2003** (HUF thousand)
Outpatient treatment, addiction treatment	95,675.6	113,128.4
Clearly drug-related outpatient treatment	5,209.9	36,944.6
Care for addiction	645,267.3	798,473.3
Care for drug use	73,998.5	135,827.7
Inpatient treatment, acute	59,780.8	53,849.3
Inpatient treatment, chronic	222,265.4	308,089.3

Source: National Health Insurance Fund

Costs listed in the above table do not include costs of sick leaves, medicine price supports and/or treatment of complications.

Conclusions

Social problems may become more acute in the lives of socially-excluded drug users. Services provided to drug users and other addicts started to separate during the establishment of the social-care system.
The new Act on Criminal Procedure being in force since July 1, 2003 and the amended Criminal Code diverted more drug-using offenders to the alternatives to prison and as a consequence made the frameworks of the institution of alternatives to prison more regulated and obvious.
Based on the data from 2003 5% of prisoners were imprisoned on drug-related crime.
In 2003 the total sum of funds spent on drug-related outpatient treatment is six times higher than in the previous year.

9. RESPONSES TO SOCIAL CORRELATES AND CONSEQUENCES

Overview

The amendment to the Implementation Decree of Act III of 1993 on Social Administration and Social Services was finished in 2003 (Decree of the Minister of Social and Family Affairs No. 1/2000. (I.7.) on professional competencies and operational conditions of social institutions providing personal care). This decree named *low-threshold services, psycho-social care and harm-reduction programmes* as tasks for the outpatient- and special primary health-care. Special primary health-care is one of the responsibilities of municipalities and outpatient care as special health-care is added to the compulsory tasks of all settlements of a population exceeding 30,000 residents.
Selective programmes furthering social re-integration of drug users have recently – until the organisations mentioned in the previous section are not established and operated - been run by specific NGOs.

Low-threshold centres
According to the viewpoint of the Ministry of Health, Social and Family Affairs, a low-threshold centre is an institution where one or a range of social services are provided to addicts seeking change and their peers, families and direct social settings.
The objectives of such centres are:

- to reach and accept the possibly widest circle of drug addicts and their direct settings,
- to reduce drug use and its correlates and to initiate and foster a change,
- to encourage the change in lifestyle and life-management,
- to follow up,
- to prevent relapse.

Characteristics of such centres are:

1. extension of the availability of social services,
2. follow up,
3. consultation and counselling,
4. networking (stipulation of efficient care is the continuous contact to and co-operation with municipalities, health-care/social and NGOs).

Psychosocial treatment
Definition of psychosocial treatment in Hungary: work targeted to mobilise resources being at the disposal of individuals, families, groups and the society in a way that favourable changes come about in the individual's behaviour and situation in a way that the individual is satisfied as far as his standards and aims and social opportunities are concerned.
Its objectives are to transfer knowledge, to reinforce self-esteem, to change behaviours and relationships and to explore resources.

Harm-reduction programmes
The major objective of harm-reduction is the reduction of negative health and social correlates of drugs without expecting the client total abandoning them. Harm-reduction programmes intend to motivate drug users to safer drug use by providing all necessary information. A further objective of harm-reduction is to divert drug users to the use of less dangerous drugs.

9.1. SOCIAL REINTEGRATION

Housing

Institutions that run rehabilitation, re-integration and/or social inclusion programmes as social services have been entitled to apply for a state support in order to obtain protected rented properties and protected housing forms since 2003. Such social services cover external slots or slots in a boarding home. Both service types receive constant state support in order to encourage the reintegration of clients.

External slots are closely related to rehabilitation it is not an independent care-type. The objective is to foster the client's social inclusion and reintegration after the rehabilitation period in a protected housing-scheme. Within the frames of this care-type, clients are involved into follow-up care of 1+1 year and are encouraged to compile savings for their future independent lives. Clients don't pay for the room as the costs of this are covered by the normative state support.

A boarding home is a housing form for small groups of 8 to 14 clients. In this care type (5+3 years), clients are not only involved into such a supported housing-scheme but also into rehabilitation and reintegration programmes.

Data of 2003 of the Central Statistical Office have not been processed yet.

Education and training

Three of the active labour-market tools had decisive role: *employment in the public interest*, *job training* and *employment of the permanent unemployed induced by wage support*.

From the special programmes and feedback of social service providers and labour centres we know that persons facing drug problems apply to numerous job trainings. Such schemes always contain groups on how to sustain motivation, job-search programmes, programmes on how to keep a job and other activities reinforcing the person's chances on the labour market.

Description of a programme model
"Megálló" Group (MCS as referred herein) of "Belvárosi Tanoda" Foundation (BTA as referred herein)

BTA MCS has been operating a joint programme with the drug-rehabilitation centre run by Leo Amici Foundation in the frameworks of which MCS undertakes the preparation and follow-up care of youth entering rehabilitation. The "half-way" home programme has been running since April 2003. The objective of this programme is to support the reintegration, social inclusion and rehabilitation of clients in the city where they intend to live in the future after they became permanently abstinent.
The programme was elaborated by ex-users who faced the problem of not being capable to manage there lives after their release from a rehabilitation programme. This "half-way home" has currently been operating in Budapest. BTA MCS maintains this real estate from its own resources. Clients may be in the programme for a maximum of 10 months. After being released from the programme, the client receives his savings of over the 10 months in one amount which shall cover the costs of a room rental and is a good basis for a new start in the outside world.
This home grants enough space for a maximum of four clients at the same time. There is a continuous demand for it. It is not co-educated but only for men. Eight clients participated in the programme in 2003. A number of them could leave the flat in a period shorter than

10 months because they could arrange for their future earlier. The foundation keeps contact with all of their ever-clients and only one client was reported to have been relapsed. Participants have the opportunity for secondary education within the MCS.
Since the foundation receives no normative state support, it shall raise funds to cover the operational costs from other resources. These slots are not enough in quantity and there is a need for such a home for also women. State-run "half-way home programmes" do not usually take place in the settlements or cities where participating clients intend to settle down in the future but remote from such places, what does not ensure the reintegration of the clients.

9.2. PREVENTION OF DRUG-RELATED CRIME

Assistance to drug users in prisons

The primary drug-related challenge to the penal authorities is supply-reduction that is hindering drugs from getting into the institutions. Harm-reduction services shall be provided to prisoners facing drug problems and demand-reduction shall be aimed at through preventive educational and other activities – says the Anti-Drug Policy of Penal Authorities.
The penal authorities in Hungary realised that prisoners with drug problems need different treatment/care than others and an increase in the number of such prisoners can be anticipated. This is why a part of the MATRA Project scheduled for the period 2001 to 2004 is titled 'Management of drug problems in penal institutions'. 70 security guards were trained by the penal authorities in the frames of this project. Primary objective of this training was demand-reduction and the identification of drug-using prisoners.

Sections 76/A, 76/B, 76/C of the Decree of the Minister for Justice No. 6/1996 (VII.12.) regulate imprisonment and preliminary detention and has been in force since January 1, 2003. The referenced provisions are about the establishment of drug-prevention departments: a prevention department may be set up for voluntary prisoners with the purpose of preventing drug use and drug trafficking. Prisoners who declare their written intention to undergo regular tests and provide test serum (bodily fluids) for drug-use control may be admitted to the prevention department. It is the admission committee who decide on the prisoner's admittance to the prevention department on recommendation of the commissar. (12 drug-prevention departments have been operated nationwide since January 1, 2004, two of which were established specially for juvenile prisoners.)
The operation of drug-prevention departments is regulated by the Provision of the Head of the Penal Authorities No. 1-1/54/2003 which has been in force since August 1, 2003. According to the internal rules, drug prevention work started in such departments shall be carried on after the prisoner's release thus the prisoners must be secured the opportunity to contact competent authorities and NGOs.
Drug prevention, health promotion and reintegration programmes were available to prisoners in penal institutions in 2003.
Educational documentaries were showed to prisoners in periods of 3 to 5 weeks. The education material related to such a documentary film was explained by the commissar to and discussed with the prisoners in group activities. Such activities involved around 6000 prisoners in 2003.
Drug-related training of the staff (commissars, psychologists, supervisors) being in direct contact to the prisoners is continuous in all penal institutions.

Penal authorities pay special attention to juvenile prisoners. There are two penal institutions for juveniles where also drug prevention departments have been set up. It is important to reintegrate juvenile offenders efficiently, thus to involve NGOs into relating programmes for prisoners. Heads of penal institutions involve NGOs into the work of all

drug-prevention departments because these organisations help the work of staff being in direct contact to the prisoners efficiently.
If a prisoner having withdrawal symptoms arrives at the penal institution (9 to 10 cases a year), after having been examined, he is to be transferred to the Institute of Forensic Psychiatry. Concept of care in penal institutions coincided with the principles of other health-care authorities in 2003. There is no methadone treatment in the Institute of Forensic Psychiatry but physical withdrawal symptoms are treated with karbamazepine- (Tegretol, Neurotop), benzodiazepine- (Rivotril) and butirofenorone-derivates (Haloperidol) in combination with vitamins.

Head of the Penal Authorities regulated the drug-addicted prisoners' participation in treatment with a temporal scope starting on July 15, 2000. This measure was amended to and has been recently under reform.
An prisoner is entitled to enter treatment of drug addiction after his written application has been judged upon and the proceeding in process against him on misuse of narcotic drugs has been postponeed.

According to the order on imprisonment and preliminary detention, the prisoner must be supported during the execution of imprisonment so that he can be prepared for a life after release. Before the prisoner is released the Probation Officers Service contacts him. Probation officers and the staff of penal authorities proceed with special care in order to meet the objectives set for the cases of prisoners with drug problems.

Prisoner facing drug problems	Measures taken	Outcome of measures
A person classified as a **suspect** by the Criminal Code	For a misdemeanour he is also entitled to alternatives to prison from penal authorities.	The prisoner receives an official document *" to verify that he has been treated."* thus becoming exempt from sanctions.
A person classified as a **convict** by the Criminal Code	He is entitled to apply for admission to a drug-prevention department.	The prisoner's chance for reintegration increases.
Prisoner producing physical symptoms of withdrawal	He is transferred to the Institute for Forensic Monitoring and Mental Treatment, where he is provided outpatient treatment.	The prisoner releases from physical symptoms of withdrawal.
Prisoner who used drugs outside	He is entitled to apply for admission to a drug-prevention department.	The prisoner's chance for reintegration increases.
Drug-using prisoner	If proven proceeding will be initiated.	Usual rules are also valid to the prisoner.

Alternatives to prison for drug users

The amendment to the Criminal Code entered into force on March 1, 2003 the most significant amendment to which was the extension of the personal scope of alternatives to prison.
Although supply crimes are still subject to graver punishment, according to the commentary of the Criminal Code, there are drug-addicted persons, juveniles, young adults and occasional users of small quantities of drugs among offenders who are not to be punished with the full force of the law and who shall be granted the opportunity to enter educational-treatment therapy and excluded from criminal liability.

The amendment to the new Act on Criminal Procedure entering into force July 1, 2003 regulates the execution of diversion to alternatives to prison, and the Joint Decree of the Minister of Health, Social and Family Affairs and the Minister for Children, Youth and Sports orders the rules of treatment of drug addiction, other care and preventive-consulting services of drug use.
In Hungary postponement of accusation in the pre-trial stage is the only alternative to prison to those committing misuse of narcotic drugs since July 1, 2003.
Subsection (2) of Section 222 of Act on Criminal Procedure declares: "In case the accusation against the offender may be subject to termination on the grounds for the termination of culpability listed in Section 283 of Act on Criminal Code, the public prosecutor shall postpone the accusation for a period of one year provided the offender undertakes to enter treatment of drug addiction or other care or preventive-consulting service treating drug use."
An accusation is subject to postponement in case the drug-addicted suspect undertakes continuous treatment. A drug user who cannot be classified as a drug addict is allowed to enter other care or preventive-consulting service treating drug use. The offender is on probation during the period of postponement of accusation.
Should the suspect – if conditions are met - reject treatment the public prosecutor shall either apply any measures or submit an accusation. No offender may be forced to enter treatment.

The offender may be diverted to alternatives to prison in the following cases:

- *"if it involves a small quantity produced, manufactured, acquired or held for own consumption"*[31] and/or *"if it involves a small quantity produced, manufactures, acquired or held by a person over the age of eighteen by using a person under the age of eighteen for own consumption"*[32]
- *"if it involves a small quantity offered or supplied by a person between the ages of eighteen and twenty one to a person under the age of eighteen, or by a person under the age of twenty-one inside or in the proximity of a building serving the purpose of education, public learning, child welfare, child protection or cultural and educational activities to be consumed jointly"*[33]
- *"if it involves a drug-addicted person who produces, manufactures, acquires, possesses, imports or exports a small quantity of narcotic drugs into or from Hungary or transports such through the territory of Hungary for own consumption and offered or supplied a small quantity of narcotic drugs to be consumed jointly"*[34]
- *"if it involves a drug-addicted person who has committed another crime – that is punishable by up to two years' imprisonment – in connection with the criminal act (defined under Paragraph (e))"*[35].

Alternatives to prison within the Penal authorities in Hungary

Subsection (2) of Section 4 of the Joint Decree of the Minister of Health, Social and Family Affairs and the Minister for Children, Youth and Sports on treatment of drug addiction and other care or preventive-consulting service treating drug use orders that if a drug user in the trial-phase is imprisoned, the penal authorities shall provide – on the basis of a separate rule - treatment of drug addiction or other care or preventive-consulting service to him.
The Budapest Prison provides the place for such treatment and services as alternatives to prison. However, they are scarcely available to women and juvenile offenders, since the

[31] Source: Paragraph a) Subsection (1) of Section 283 of Act IV of 1978 on the Criminal Code
[32] Source: Paragraph c) Subsection (1) of Section 283 of Act IV of 1978 on the Criminal Code
[33] Source: Paragraph d) Subsection (1) of Section 283 of Act IV of 1978 on the Criminal Code
[34] Source: Paragraph e) Subsection (1) of Section 283 of Act IV of 1978 on the Criminal Code
[35] Source: Paragraph f) Subsection (1) of Section 283 of Act IV of 1978 on the Criminal Code

single penitentiary providing such care admits only men. Alternative to prison to women and juvenile offenders may be services provided by local outpatient centres. Another problem is represented by the fact that a number of treatments of prisoners diverted to alternatives to prison is broken at the time of the prisoner's release. Released prisoners are informed about the opportunity to carry on treatment or the legal consequences of breaking treatment, but the Penal authorities receives no feedback on whether the ex-convicts carry on treatment or not.

The number of treatments finished or broken due to release from a penal institution by the end of 2003 was 92, the number of prisoners in treatment is constantly around 33 to 35. It is, however, anticipated that an increase in the number of prisoners opting to be diverted to alternatives to prison will come about. The reason for this is that there is a constant increase in the number of those offenders who committed another drug-related crime in addition to the main offence and intend to be diverted to alternatives to prison during the period of their imprisonment.

Other interventions for prevention of drug-related crime

Criminal justice does not offer any further alternatives to prison to those committing misuse of narcotic drugs. But the above-mentioned National Crime Prevention Strategy puts special emphasis on the avoidance of the social exclusion of those misusing narcotic drugs and/or on the reintegration of those facing drug problems.

Conclusions

Rehabilitation, reintegration and social inclusion programmes are primarily run by civil organisation. A considerable number of persons facing drug problems take part in job trainings.
Prisoners in penal authorities are entitled to apply for admission to drug prevention, health promotion and reintegration schemes.
The amendment to the Criminal Code as of 2003 extended the personal scope of the alternatives to prison, the new Act on Criminal Procedure regulates the execution of offenders' diversion to alternatives to prison.
This alternative to prosecution plays role in the prevention of drug-related crime.

10. DRUG MARKETS

Overview

The new Act on Criminal Procedure entered into force on July 1, 2003 and brought about serious changes in the investigation powers of the Customs Police. The Police remains the general investigation authority but it is ruled in Paragraph e) Subsection (2) Section 36 of Act XIX. of 1998 that the Customs Police initiates investigation in the context of offences involving Misuse of Narcotic Drugs by "*any person who, without authorization ... imports or exports narcotic drugs into or from Hungary or who transports such through the territory of Hungary*"[36] or those involving Misuse of Materials Used for Making Narcotic Drugs (precursors)[37] provided such offences are perceived by or reported to the Customs Police.

Government Resolution No. 1036/2002 was issued in order to achieve short- and middle-term objectives defined in the "National Drug Strategy for the Reduction of Drug-related Problems" accepted by the Resolution No. 96/2000 of Parliament.
Paragraph 19/a of this resolution decided on and set a deadline to the preparation of an action plan on the effectuation of the organisational changes, the extension of staff and the development and actualisation of technical and material conditions being necessary at the Police.
According to the plans prepared by deadline the organisational modernisation and reforms of the Police will be executed in 2004.
As a result, a more efficient unit meeting the EU requirements in staff and technical development level will be set up.
The concept places this organisation within the Department for the Investigation of Organised Crime in the Criminal Chief Administration of the Hungarian National Police Headquarter operating with one central – Department for the Investigation of Drug-related Crime – and six regional departments with a staff of around 80 persons.

10.1. AVAILABILITY AND SUPPLY

Heroin

Brown heroin imported from the countries in the 'Golden half-moon' is mainly available in Hungary, but sometimes white heroin is also available at Asian drug dealers. Subsequently statistics do not distinguish the different types of heroin.
Due to its geographical position, Hungary has been a transit country as well as a destination of drug trafficking. The majority of drugs has been transported on the 'Balkan' route over Hungary which is the route of heroin-trafficking from the 'Golden triangle' to Western-Europe. Turkish and Albanian criminal gangs from Kosovo keep on having a leading role in the organisation of drug trafficking on the 'Balkan' route. These groups have information and logistics centres that are operated in the form of shelf companies that are registered in Hungary and operated with the underlying purpose of money laundering. These companies most typically appear as roadhouse restaurants and motels. Different transport and wholesale companies are also operated as shelf companies but these are less in focus.

In Hungary problem drug users are mainly from among heroin users and most acquisition-related crime is committed by them. District police stations also perceived that the number

[36] Source: Section 282, 282/A, 282/B, 282/C of Act IV of 1978 on the Criminal Code
[37] Source: Section 283/A of Act IV of 1978 on the Criminal Code

of reduced severity (car-breaks, thefts of small amounts) has increased around centres of heroin distribution.

Cocaine

Cocaine being available in Hungary mainly comes from the Netherlands. Ferihegy Airport has been used as a stop on the transit route several times. In such cases, typical method of trafficking was to swallow the drugs. There are, however, also other methods reported. Hungarian drug-couriers take also a hand in cocaine-trafficking. Earlier, these couriers were mainly young women. But it has been recently changing as a result of which men and older women also appear among couriers. It is characteristic to the routes of these cocaine couriers that their destination is not Hungary. Criminals of Nigerian origin are mainly into the organisation of couriers who are then transferred to contacts in Western-European countries. Couriers receive instructions abroad and packs of drugs are also to arrive there.

Marijuana

Based on the experiences of proceedings marijuana is the most markedly present among the drugs in this report on the Hungarian drug market. This statement is also underpinned by the statistical data in the Uniform Criminal Statistics of Police and Prosecution and by the seizures of the police.

An increasing tendency is to be detected in the number of cannabis plants and cannabis herbs. The majority of cannabis on the drug market in Hungary comes from domestic illegal plants while cannabis from abroad mainly arrives from the Netherlands and the area of the former Yugoslavia. Both outdoor and indoor (in glass houses or hangars) cannabis cultivation are characteristic to illegal domestic plants in Hungary. Indoor cannabis production preconditions a technical background that is automatically able to produce cannabis herbs. Technological know-how is mainly from the Netherlands as well as the necessary tools and seeds of high quality. It is a disadvantage to the outdoor production that can only be harvested once a year in contrast to indoor production like production in glass-houses where changes in lights may result in several harvests a year.

Synthetic drugs

Use of ecstasy tablets is fairly popular among recreational users and the use of amphetamine (powder) is spread in specific groups of users. Party-visitors can obtain the preferred types of drugs at parties and other entertainment facilities attended by masses of youths. (Demetrovics 2001)

A place where unauthorised chemical production of drugs takes place is meant by the notion “illegal drug laboratory”. No such illegal laboratories were found in Hungary in 2003. The most probable reason for this is that synthetic drugs are available at an extremely low price in the Netherlands and there exist no special obstacles against the import of such drugs to the area of Hungary. The outfitting of a laboratory, the quest for an expert and the purchase of precursors represent a more serious challenge and higher risks to organised criminal groups. Since the permission and control of activities with the help of precursors are fairly organised, precursors would also be a subject to trafficking to Hungary. Such precursors arrive to the EU Member States from China and India. Control at the outer borders of the EU is stricter resulting in a higher probability of arrests.
The venue of preparing pills is not an illegal laboratory. Illegal preparing of pills were not reported in Hungary in 2003 either.

Other drugs

In addition to the drugs listed above, psylocibyn - magic - mushroom, mescal from cactus peyotl, LSD and other hallucinogens primarily used in veterinary therapeutics (like ketamine) are available in Hungary. The spread of and demand for these drugs is, however, not considerable.

Perceived availability in the student population

In the frames of a survey conducted in 2003, 2074 secondary-school students in the 9th and 10th grade, living in Budapest were asked about the places where marijuana was available and about the general availability of the specific drug types. (Elekes and Paksi 2003b)

As for places where marijuana was available, the majority of respondents (29%) reported discotheques and bars where marijuana was the most easy-to-access. Plazas are places where marijuana was the hardest to obtain (92.5%). Streets and parks were indicated as places where this drug was easily available by around the same rate of respondents (18.4) as those who indicated schools (18.5%). In comparison to this, the number of those who thought marijuana was most available at the flat of a dealer was higher by 1.7% resulting in a rate of 20.1%.

Table 22. *Availability of marijuana by places by students in year 9 and 10*

Place	"could easily obtain it"	„could not easily obtain it"
On the streets or in parks	18.4%	81.3%
In schools	18.5%	81.2%
In discos, bars	29%	70.7%
At the flat of a dealer	20.1%	79.7%
In shopping malls	7.2%	92.5%

Source: Elekes, Paksi 2003b

The responding students in years 9 and 10 thought marijuana or hashish to be the most easily to obtain among the substance types in the below table. 22.2-22.9% of the respondents regarded cocaine and heroin impossible to obtain.
On the average, 36% of the respondents did not have any information on the availability of drugs.

Table 23. *Availability of each of the substance types in the opinion of students in years 9 and 10*

Type of drugs	**Impossible**	**Very difficult**	**Rather difficult**	**Fairly easy**	**Very easy**	**Don't know**
marijuana or hashish	13.9%	11.5%	16.3%	16.0%	16.6%	25.6%
ecstasy	18.6%	13.6%	13.4%	10.9%	11.6%	31.6%
amphetamines	18.0%	14.2%	15.6%	10.9%	8.9%	32.1%
cocaine	22.2%	17.9	12.9%	5.5%	5.0%	36.3%
heroin	22.9%	18.1%	12.5%	5.9%	4.5%	35.9%
LSD, other hallucinogens	17.7%	14.2%	18.8%	9.4%	7.7%	32.0%
crack	20.7%	15.1%	14.9%	6.7%	4.8%	37.7%
other opiates	20.6%	14.4%	13.3%	7.6%	6.1%	38.0%

Source: Elekes, Paksi 2003b

According to the results of a survey conducted in 2003 (FACT 2003), university students did not find any special difficulties to obtain drugs in Pécs.

10.2. SEIZURES

As a consequence to the afore-described organisational and procedural changes, the data introduced below are relevant both for drugs found by the Police and the Customs Police.

An average increase of 33% was brought about in the number of seizures in 2003 in contrast to the preceding year. There was an increase in the quantity of seized drugs, especially in the quantity of those for which demand was the highest (ecstasy, cannabis and heroin). Ecstasy showed the most boosting increase in seized quantity (545%) against a mere 19% increase in the number of seizures.
The quantity of seized marijuana (100%) and heroin (60%) also grew significantly, however, the number of seizures did not considerably rise, as a matter of fact, the number of heroin seizures decreased by 8%.
The quantity of seized cocaine decreased by 50% despite the growth in the number of seizures.

Table 24. *Number of seizures and quantity of seized drugs*

	2002		2003	
	Number of seizures	Seized quantity	Number of seizures	Seized quantity
Marijuana (kg)	1965	103.44	2015	206.8
Heroin (kg)	97	159.65	90	256.33
Cocaine (kg)	57	54.9	95	23.47
Amphetamines (kg)	256	3.51	373	12.11
Ecstasy(tablet)	304	24854	362	135634
LSD (doses)	17	623	17	345.5

Source: Criminal Professional and Researcher Institute

10.3. PRICE/PURITY

Price

In the context of street price of drugs we have no comparable data since data collection started in 2003. The table below summarises data from 2003.

Table 25. *Street price of drugs (in EUR)*

	Min.	Max.	Average
Hashish (1 gram)	4.8	8	4.8
Marihuana (1 gram)	3.2	10	4.8
Heroin (1 gram)	24	48	30
Cocaine (1 gram)	48	100	60
Amphetamine powder (1 gram)	3.2	10	8
Ecstasy (1 tablet)	2.4	8	4.8
LSD (1 dose)	4	6.8	6

Source: Police Intelligence

Purity

All seized substances being suspicious for drugs are tested by the Department of Organic Chemistry and Analyses of the Criminal Professional and Researcher Institute of the Ministry of Interiors independently from whether they have been seized by the Police or the Customs Police. This central laboratory has four departments where the substances' professional chemical classification is regionally taken out. During a classification process substances are examined whether they contain any narcotic drugs. If so, the type of drug is defined and the active ingredient is measured. Photos are also taken of ecstasy tablets. In selected cases or on international requests these laboratories are also able to classify the drugs' profiles.

Most synthetic drugs have a form of a tablet and the most frequently active agent of these synthetic drugs is MDMA. Tablets containing other agents (MDA, 4-MTA, 1-PEA, PMA) are also available on the market. In addition, amphetamine is also available in the form of either powder or tablets.
91.7% of tablets contain MDMA, 0.3% of them contain MDEA, 0.4% have MDA as an active agent, 2% contain a combination of these agents and 0.2% contain either amphetamine or metamphetamine.

Average purity of amphetamines did not show any changes in 2003 in comparison to the preceding year.

The most significant increase in active agent content was observed in marijuana (40%) while purity of heroine and cocaine distributed on the streets decreased (by 62.5% and 33%).

Table 26. *Purity of drugs distributed on the street* (%)

	2002				2003			
	Sample size	Min.	Max.	Average	Sample size	Min.	Max.	Average
Hashish	72	0,5	10	N.a.	83	0,5	10	N.a.
Marijuana	2610	0,01	6	0,5	3011	0,01	6	1,2
Heroin	133	10	55	40	123	3	35	15
Cocaine	72	20	80	60	116	25	90	40
Amphetamines	346	4	50	15	534	2	55	15

Source: Criminal Professional and Researcher Institute

Conclusions

The Act on Criminal Procedure that entered into force on July 1, 2003 brought about serious changes in the investigation powers of the Customs Police.
As for the seizures carried out in 2003 the quantity of seized drugs considerably increased in comparison with that in the preceding year. The degree of purity of drugs distributed on the streets varies by substance. While purity of heroin and cocaine decreased, the THC content of marijuana increased by 40% compared to the data from 2002.
Not only statistical data registered by the police but also other practical experiences and results of epidemiologic surveys are successfully utilised in the national fight against drug-supply.

11. BUPRENORPHINE, TREATMENT, MISUSE AND PRESCRIPTION PRACTICES

Medicines containing buprenorphine are legally available in Hungary but are not used in treatment for drug-addiction.
No data are available on misuse of buprenorphine.

12. ALTERNATIVES TO PRISON TARGETING TO DRUG USING OFFENDERS

Overview

In Hungary controversial opinions were formulated – and appeared in legislation – in connection with two basic concepts of the international criminal policy. (The first concept regards imprisonment as ultima ratio emphasising its ineffectiveness and the recognition of its unfavourable aftermaths. The second concept aims at a more efficient fight against the increasing and aggravating crime by the extension of the scope of criminal culpability and by the increase of criminal repression.)
The principles of these two concepts have been affecting criminal legislation after the 90's. Principles of the first-cited concept were dominating until the amendment to the Criminal Code by the Act LXXXVII. of 1998 as the amended regulations implemented by the Act XVII. of 1993 mainly had effects in this direction.
The amendment to the Criminal Code by the Act LXXXVII. of 1998 were clearly diverted from the previous trends and was based on the principles of the second-cited concept.
The Act II. of 2003 – as emphasised in the Minister's commentary – refuses the principal considerations constituting the basis of Act LXXXVII. of 1998, especially the one saying that crime is to be reduced more efficiently by aggravating punishments, accentuates at the same time the importance of re-establishment of rates of statutory regulations against individualisation of cases by the jury traditionally evolved in the Hungarian criminal history.

Hereby we introduce how alternatives to prison targeting drug users were adapted along the Hungarian criminal policies and what results they induced:
Treatment and prevention were first made applicable as alternatives to prison by the amendment by Section 282 of the Act XVII. of 1993 on the Criminal Code.
In Section 282/A of the Criminal Code, legislators secured a differentiated judgement for drug users at statement of misuse of narcotic drugs and at infliction of punishment accordingly. Paragraphs a) and b) of Section 282/A list grounds for the termination of punishment. In Paragraph a) in the referenced section, it is classified as a ground for the termination of punishment if a person "*produced, manufactured, acquired or held* (a small quantity of narcotic drugs) *for own consumption"* or - as in Paragraph b) – the drug user "*committed another crime that is punishable by up to two years' imprisonment*" related to drug use. In this case the offence could be an act underlying drug acquisition (acquisition-related crime, crime aimed at profit-making) but could also be targeted at the reveal of drug use.
In such cases, "*the offender in question* shall be *able to produce an official document before he is sentenced in the first instance to verify that he has been treated for drug addiction for at least six consecutive months or that he has participated in a drug addiction program or a preventive-consulting service."* It was, however, not presumed that the treatment is successful, only the fact of treatment was to be verified.

At time of the Council's Comment No. 155 was issued, the press labelled this as the liberalisation of the domestic drug-policy. This comment defined small quantity and substantial quantity of narcotic drugs and this definition aroused debates. Experts who considered the responses formulated by Act XVII. of 1993 to establish the grounds for a different criminal assessment of drug-dealers and drug users and the realisation of the "medicalisation concept" to be reasoned, agreed on this comment. The Ministry for People's Welfare and representatives of the police heavily criticised Sections of the Council Comment on (the definition of) quantities of drugs. The latter ones argued that the

definition of small quantity of narcotic drugs grants the opportunity to drug dealers to act as drug users in cases they are caught in the act of crime. (Lévay 2001)
This criticism was refuted by the results of the sample survey conducted in Budapest on the effects of offenders diverted to alternatives to prison (Ritter 2000) as results indicated that in fact drug users seized the treatment opportunity secured by Section 282/A, provided the authority initiating proceeding "did not forget" to inform the suspect about it. (Ritter 2003b)

Section 282 and 282/A were amended by Section 62 of Act LXXXVII. of 1998 of the Criminal Code entering into force on March 1, 1999.
Regulations implemented by the Act XVII. of 1993 are based on the criminal policy according to which criminal law should handle those differently who may be partly also victims and those who benefit from a crime.
In the meantime, this regulation was criticised by various parties. In the meanwhile Paragraph 3 of Resolution No. 125/1997. (XII.18.) of the Parliament and the report submitted by the „Ad-hoc Committee for the Reduction of the Drug Use" ordered the revision of the provisions in Section 282-282/A. Criticisms basically referred to the definition of small and substantial quantities as a consequence of which the objection arose against the legal fact that it provides no real opportunity to the jurisdiction to unambiguously distinguish a drug user from a drug dealer. Precision of the regulatory construction of the legal facts in Sections 282-282/A of the Criminal Code was also regarded as to be necessary.

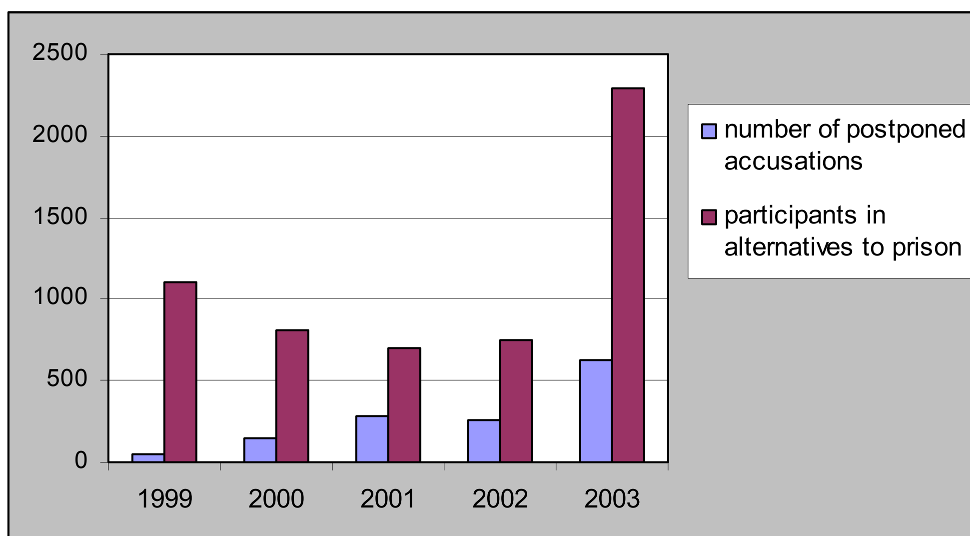
After March 1, 1999 alternatives to prison became only available to drug-addicted persons. According to the Minister's commentary: "(...) The bill starts from the principle of the original criminal policy that the ones who the criminal policy intends to divert to alternatives to prison are the drug-addicted users. The ones who purely want to enjoy the effects of drugs are different from this. (...) The bill provides the privilege to be diverted to alternatives to prison only to the offenders who committed a offence that has been distinguished by the new principle."

Subsequently, drug users who were not addicted to narcotic drugs, i.e. were not classified to be drug addicted by the forensic expert, were not provided traditional alternatives to prison.
"The criteria to classify drug-addiction were not defined, the forensic experts usually classified the offenders on what they said about the symptoms – this gap in the law was regularly used by offenders who were skilled in enforcing their interests (they knew what to say to the forensic expert at an examination.)
The number and rate of those being diverted to alternatives to prison showed a decreasing tendency as legislators restricted the number of those being entitled to this privilege. Although alternatives to prison became partly available to non-addicted occasional users of narcotic drugs by the amendment to the Act on Criminal Procedure, in most cases this was practically not feasible or the authorities regarded it as inexpedient" – can be concluded from the results of the examination of the Act. (Ritter 2003b)

In 2002 – the last year of the former regulations being in force – the number of postponements of accusations against offenders committing misuse of narcotic drugs amounted to one third of those having been diverted to treatment as an alternative to prison. This resulted in a ratio 3:1 to treatment in 2002. This is strange because, on the basis of criminal statistics, in spite of the afore-mentioned gap in the law - the rate of drug-addicts among offenders who committed demand-related offence in respect of a small quantity of narcotic drugs (against who proceeding was mainly initiated due to consumption or possession) was below 20%.
But where did occasional users disappear?

Many of them were arraigned. (In 2002, 71.8% of the offenders who were reported to commit misuse of narcotic drugs were arraigned. However we must note that proceeding was initiated against 54.4 % of all offenders due to “only” consumption. So most of these offenders were arraigned.) We must emphasise that no one in Hungary has been sentenced to enforceable imprisonment exclusively due to use of narcotic drugs. Although the Criminal Code foresees enforceable imprisonment for any misuse of narcotic drugs also including consumption by acquisition/possesion, legislators have also formulated grounds for the termination of culpability for the existence of specific conditions. Furthermore, public prosecutors and judges in Hungary do not regard the conduct of consumption in respect of a small quantity of drugs to be so dangeorus for society as to initiate or impose a sentence of enforcable imprisonment.

Figure 18. *Number of clients in treatment as an alternative to prison and the number of postponed accusations (1999-2002)*



Source: Uniform Criminal Statistics of Police and Prosecution; Ministry of Health, Social and Family Affairs, National Institute of Psychiatry and Neurology

After 1999, the number of offenders in treatment as an alternative to prison has been decreasing and this trend of different intensity continued until 2001. In 2002, however, a slight increase could be observed. In the period of 1999 to 2001, the number of postponements of accusations grew to its fivefold followed by some decrease in 2002. This number was still much below the number of offenders in treatment as an alternative to prison.

12.1. Political, organisational and structural information

Sections 282-283/A of Act IV of 1978 on the Criminal Code include regulations on drug-related crime, Section 283 includes the grounds for diversion to alternatives to prison. The Act XIX of 1998 on Criminal Procedure contain the regulations on how to execute diversion of alternatives to prison. Since July 1, 2003 the only opportunity for those misusing narcotic drugs to be diverted to alternatives to prison is the postponement of accusation in the pre-trial stage. Legislators extended the availability of diversion to alternatives to prison to a much wider circle of offenders, the joint Decree of the Minister of Health, Social and Family Affairs and the Minister for Children Youth and Sports No. 26/2003 (V.16) ESZCSM-GYISM on Treatment of Drug-Addiction and Other Care and Preventive-Consulting Services clearly set the frames of the execution of diversion, the personal scope of which included also drug users who were arraigned.

The official document of the Hungarian drug policy does not formulate any detailed relating strategy but lists monitoring of the alternatives to prison among its objectives as well as examination of the results of legal regulations having been previously in force, thus fostering the establishment of potentially necessary interventions by decision makers. Among others, at birth of the National Drug Strategy, when deciding on necessary legal policies - thus on the amendment to the legal facts of Misuse of Narcotic Drugs in 2003 - decision makers were influenced by the outcome of evaluation of laws being in force at that time (Ritter, 2003).

The major merit of this amendment was that it extended the alternatives to prison more than the regulations being in force in the period of 1993 to 1998 did. According to the Criminal Code's commentary: "Misuse of narcotic drugs shall be strictly punished in accordance with Sections 282-282/C of the Criminal Code". There are drug-addicted persons, moreover juveniles, young adults and occasional users of small quantities of drugs among offenders against whom it is not necessary to apply the full force of the law and who shall be granted the opportunity to enter educational-treatment therapy thus becoming exempt from criminal liability. The grounds for the termination of culpability are regulated in Section 283 of the Criminal Code."
The grounds for the termination of culpability and stipulations to the offender's being diverted to alternatives to prison are:

- *"if it involves a small quantity produced, manufactured, acquired or held for own consumption"*[38] and/or *"if it involves a small quantity produced, manufactures, acquired or held by a person over the age of eighteen by using a person under the age of eighteen for own consumption"*[39]
- *"if it involves a small quantity offered or supplied by a person between the ages of eighteen and twenty one to a person under the age of eighteen, or by a person under the age of twenty-one inside or in the proximity of a building serving the purpose of education, public learning, child welfare, child protection or cultural and educational activities to be consumed jointly"*[40]
- *"if it involves a drug-addicted person who produces, manufactures, acquires, possesses, imports or exports a small quantity of narcotic drugs into or from Hungary or transports such through the territory of Hungary for own consumption and offered or supplied a small quantity of narcotic drugs to be consumed jointly"*[41]
- *"if it involves a drug-addicted person who has committed another crime – that is punishable by up to two years' imprisonment – in connection with the criminal act (defined under Paragraph (e))"*[42].

Grounds for the termination of culpability are constituted by the legal fact "for own use" according to the regulations in Paragraph a) and c) and e) of Subsection (1) of Section 283 of the Criminal Code. This may only be stated if the above-mentioned legal fact is undoubtedly attested.
A ground for the termination of culpability may only be stated "*provided the offender in question is able to produce an official document (....) to verify that he has been treated for drug addiction for at least six consecutive months or that he has participated in a drug addiction program or a preventive-consulting service."* The local branch of the State Public Health and Medical Officer Service or experts employed by any health-care centres specialised in treatment of drug users or experts of preventive-consulting services are entitled to issue such official document.

[38] Source: Subsection (a) Section 283 of Act IV of 1978 on the Criminal Code
[39] Source: Subsection (c) Section 283 of Act IV of 1978 on the Criminal Code
[40] Source: Subsection (d) Section 283 of Act IV of 1978 on the Criminal Code
[41] Source: Subsection (e) Section 283 of Act IV of 1978 on the Criminal Code
[42] Source: Subsection (f) Section 283 of Act IV of 1978 on the Criminal Code

It is important to highlight an alternative to prison applied in the pre-trial stage, namely the *postponement of accusation* and the one applied in the trial stage which is the *postponement of proceeding*. According to the interpretations in Hungary, in the post-trial stage, after the offender was found guilty for drug-related crime, no further diversion to treatment of the convict may be considered to be an alternative to prison. At the same time, it is possible to apply probation as a measure if the offence committed by the drug addict involves production, manufacture, acquisition, possession, import or export of narcotic drugs (Subsection (1) of Section 282/C on the Criminal Code) and if the drug-addicted person "*is engaged in distribution, trafficking or dealing of narcotic drugs"* (Subsection (2) of Section 282/C on the Criminal Code) and/or *"if the criminal act is committed (...) in respect of a small quantity of narcotic drugs (...))*(Subsection (5) of Section 282/C on the Criminal Code). In such case, supervision by a probation officer may be ordered as well as the offender's entry to treatment so that he successfully finishes the probation period. Supervision by a probation officer may also be ordered parallel to the execution of a postponed imprisonment.

Alternatives to prison vary on the basis of whether the offender committed a offence on the supply or demand side.
Alternatives to prison do not apply to offenders, "*if the criminal liability of the offender has been established within the framework of criminal proceedings initiated owing to the offender's misuse of narcotic drugs on at least one occasion within the two years preceding the commission of the act or if the accusation against the offender has been postponed."*
If the first ever proceeding against the offender committing misuse of narcotic drugs reaches the pre-trial or trial phase and the public prosecutor postpones the accusation or the jury states the offence (sentenced by a reprimand, probation or conviction) and within two years the offender commits another offence that would serve as a ground for the termination of culpability, no alternative to prison shall be available to the offender. The institution of "diversion" is aimed to secure treatment as an alternative to prison to the offender committing misuse of narcotic drugs for the first time ever.

The law makes the official decisions on alternatives to prison possible to be repeated with respect to conducts related to drug use (on the demand side). This is based on the experience that the lifestyle of a offender on the demand side usually needs more time to change. It would not be reasonable for the law to exclude a simple drug user or drug addict from the availability of alternatives to prison at repeated commission of a offence due to the fact that the offender has not managed to cease drug use.

Beside the amendment to the Criminal Code in 2003, the new Act on Criminal Procedure entered into force in 2003. Subsection 2 of Section 222 of the Act on Criminal Procedure says: "In case the proceeding against the offender may be subject to postponement on the grounds for the termination of culpability listed in Section 283 of Act on Criminal Code, the public prosecutor shall postpone the accusation for a period of one year provided the drug-using suspect undertakes to enter treatment of drug addiction or other care or preventive-consulting service treating drug use. An accusation is subject to postponement in case the drug-addicted suspect undertakes continuous treatment. A drug user who cannot be classified a drug addict is allowed to enter other care or preventive-consulting service treating drug use. The offender is on probation during the period of postponement of accusation.

On the basis of Section 224 of the Act on Criminal Procedure, the suspect shall be made declare himself on all this at the attorney's audition. Should the suspect – if conditions are met - reject treatment, the public prosecutor shall either apply – in addition to the termination of investigation – reprimand or initiate an accusation against him. No offender may be forced to enter treatment.

12.2. INTERVENTIONS

The joint Decree of the Minister of Health, Social and Family Affairs and the Minister for Children, Youth and Sports No. 26/2003 (V.16.) on the execution of offenders' diversion to alternatives to prison distinguishes three forms of alternatives to prison:

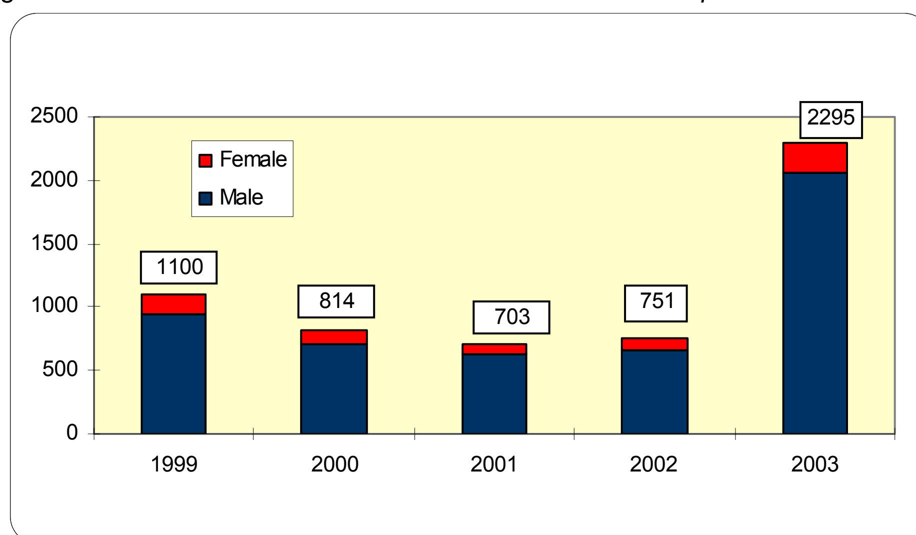
Preventive-consulting services are provided by 34 organisations nationwide (a date from the end of 2003). These service providers are entitled to provide such services through tender by the presentation of their programme, preparedness and their organisational and infrastructural conditions. Two thirds of these service providers are civil organisation (foundations, associations) being involved in patient care or prevention, one third of them are other public institutions run by municipalities or the state.

Content of the preventive-consulting services are made up of individual and collective drug-prevention techniques and general psycho-educational techniques improving personal skills. Conveyance of knowledge on drugs, mental-emotional education, improvement of skills and improvement of self-awareness are also elements of such services.

Term of preventive-consulting services – that is determined in the relating rules of law as 2 x 2 hours for six consecutive months – is split as follows: 25% individual activities and 75% group activities. Based on the clients' personal requests, nearly all service providers make such programmes available in the form of only individual activities. Clients have a free choice of preventive-consulting service providers, which means that they may apply for such services to the service provider they choose provided the service provider has free capacity after having fulfilled all its geographically-allotted duties. The national coverage of preventive-consulting services has been achieved. Preventive-consulting service providers are contracted for such services in 17 of the 19 counties in Hungary. In Budapest, 11 preventive-consulting service providers have been operating. These services are financed and evaluated by the National Institute for Drug Prevention.

Treatment of drug addiction and other care of drug use are typically provided by health-care centres, outpatient centres financed by the National Health Insurance Fund and authorised NGOs financed by the National Institute for Drug Prevention. Any treatment type – including also substitution treatment – in any kind of treatment centre (outpatient treatment, hospital care and/or rehabilitation) may be accepted, most important is from a criminal point of view is that the official document is issued by the local branch of the State Public Health and Medical Officer Service or experts employed by health-care centres specialised in treatment of drug users or experts of preventive-consulting services.

Figure 19. *Number of clients in treatment as an alternative to prison*



Source: OSAP

Nearly all programmes provided by such service providers include counselling on life-management, psycho-educational training and/or elements of trainings to improve assertion.
A number of service providers – by the client's consent - provide programmes that also involve the client's family. Experiences on family mediations are good at centres where such service is available. In the programmes of numerous service providers, elements of conflict-management techniques receive a bigger emphasis than those of schemes aiming at the improvement of other skills.

12.3. Quality Assurance

The operation of the institution of "postponement of accusation" was monitored in 2002 (Ritter 2003b), the results of which already prognosticated problems like:

- proceedings were drawn out;
- the disappearance of offenders caused bigger problems, as a growing number of officers were involved into the proceedings, therefore the offender was summoned to more administrative agencies

Officers being involved into proceedings by *former regulations*	**Officers being involved into proceedings by *recent regulations***
Scouting patrols, inspectors	Scouting patrols, inspectors
Investigators	Investigators
Experts (toxicologist, chemist)	Experts (toxicologist, chemist)
Forensic expert	Forensic expert
Staff of treatment centre	Public prosecutor
	Probation officer
	Staff of treatment centre

- the costs of such proceedings were higher;
- no treatment centres are in the neighbourhood;
- the probation officer being appointed as the contact person was active in a different settlement;
- the Probation Officers' Service was not prepared for the increased volume of tasks. (Ritter 2003b)

As an element of the quality assurance, it is obligatory for the preventive-consulting service provider – beside the preliminary presentation and evaluation of its programme as part of the accreditation - to be in a regular contact with a health-care provider or one of its experts providing treatment services for addiction in its proximity. This is how experts providing preventive-consulting services are supervised and how clients in need are provided health-care (and treatment of addiction).

List of rules of law

Act IV. of 1978 on the Criminal Code
Act XIX. of 1998 on Criminal Procedure
Commentary to the Criminal Code
Decree of the Minister of Health, Social and Family Affairs and the Minister for Children, Youth and Sports No. 26/2003. (V. 16.) ESZCSM-GYISM on Treatment of Drug Addiction and Other Care or Preventive-Consulting Services

Resolution No. 125/1997.(XII. 18.) of Parliament OGY on the Report of „Ad-hoc Committee for the Reduction of the Drug Use”
Criminal Council’s Comment No. 155
Resolution No. 96/2000. of Parliament OGY on the National Drug Strategy for the Reduction of Drug Problems

13. PUBLIC NUISANCE: DEFINITIONS, TRENDS IN POLICIES, LEGAL ISSUES AND INTERVENTION STRATEGIES

13.1. DEFINITIONS

No separate legal category has evolved in Hungary for the classification of drug-related crimes against public order lying outside the scope of drug-related crime (herein omitting the legal fact of misuse of narcotic drugs). There is no act or decree on how to sanction such crimes, legal responses are to be sporadically found among the criminal, administrative rules of law, penal rules of misdemeanour and among internal regulations of each of the authorities. There are offences to be found in the special part of the Criminal Code and among the legal facts of the Act and/or Decree on Misdemeanours that may be relevant to drug use. Under the influence of narcotic drugs or in order to acquire them, crime and/or misdemeanour against person, public order, property, crime of violence, traffic crimes or misdemeanours or crime and/or misdemeanour against marriage, family and youth are committed.

A science-based theoretical categorisation of drug-related crimes exists also in Hungary and Hungarian criminologists also apply it in accordance to the international special literature.

Due to the lack of a solid regulation in special respect of drug-related crimes (committed in order to acquire drugs or under the influence of narcotic drugs) in Hungary, only general categorisation exists; legal responses may be found among the legal facts of misdemeanours or "Crimes against Law and Order"[43] (that may also be stated in local decrees of municipalities) in relation to not only illicit drugs but also to alcohol and other substances or agents that have narcotic effects but are not classified as narcotic drugs.

13.2. LEGAL RESPONSES AND MEASURES TAKEN

The outward forms of *drug-related "public nuisance"* listed in the 1995 Study in the Netherlands exist without exemption in Hungary. Responses of the legislative authorities and bodies of law enforcement to this social phenomenon can be found in the Criminal Code and the Act on Misdemeanours. (Certainly regulations by authorities at the level of municipalities should not be omitted.)

Section 24 of the Criminal Code says that "*(1) That person shall not be punishable, who perpetrates an act in such insane state of mental functions – (...) – which makes him unable to recognize the consequences of the act or in acting in accordance with this recognition. (2) The punishment may be mitigated without limitation if the insane state of mental function hinders the offender in the recognition of the consequences of the act or in acting in accordance with this recognition."* The influence of alcohol or narcotic drugs may cause the same or a similar derangement of mental functions, however – as of the commentary of the Act – the objective of legislation must not be to provide grounds for the termination of punishment or mitigation of punishment without limitation to persons who make themselves legally irresponsible or partially insane. Therefore the provision described above does not apply to a person committing a offence under the influence of alcohol or other narcotic drugs through his own fault; such a offender shall be deemed to be legally responsible at time of the act of crime. Should a person get under the influence

[43] Source: Chapter XVI. of Act IV on the Criminal Code

of alcohol or other narcotic drugs through absolutely no fault of his own, this shall be deemed as a ground for the termination or mitigation of culpability. This is why, during the proceeding, great importance shall be attached to the examination of forensic experts on the circumstances of the drug use.

As regards the above, state under the influence of alcohol or other narcotic drugs may not be rated to the benefit of the accused person, on the contrary, "it shall be deemed to be an aggravating circumstance provided the offender has committed a crime under the influence of alcohol or other narcotic drugs through his own fault and this state of mental functions had an influence on acting so" reads the Criminal Council's Comment No. 154.
Drug addiction may have two different variables influencing the criminal evaluation. Physical and psychical addiction inspires the user to ease his carving for drugs. As a consequence he is willing to commit "Crimes against Property" or "Forgery of Official Documents" (inc. misuse of prescriptions). Such circumstances are not deemed to be valuable therefore the sections providing grounds for the termination or mitigation of culpability shall not be applied.
Drug addiction at an advanced stage may cause serious personality or mental disorders which exclude or limit the offender's legal responsibility, thus provisions in Section 24 shall be applied.

a.) Felonies and delinquencies

The provisions discussed before are included in the General Part of the Criminal Code, so they generally apply to all crimes. If, for example, a person commits a graver form of burglary under the influence of narcotic drugs, this state may not be evaluated as a mitigating circumstance and cumulating crimes may also be stated in respect of misuse of narcotic drugs.

In fact commission of a offence under the influence of narcotic drugs may emerge in respect of every crime defined in the Special Part of the Criminal Code, but in certain legal facts of drug-related crime they emerge more frequently. These are, for instance "Endangering of a Minor" and "Omission of Support". One possible modality of such crimes is if the offender "*induces or tries to induce a minor to (...) the pursuance of a dissolute way of life"*[44]*.* According to a decision of the Court (Court Decision 1985.51), the induction of a minor to use narcotic drugs is deemed to be a dissolute way of life. The offender shall be punished by imprisonment.
"The person who fails to perform his obligation to support (...) through his own fault, shall be punishable imprisonment (...), labour in the public interest or fine."[45]

The only legal fact in the Criminal Code where the offence under the influence of narcotic drugs is named is the crime of "Driving Under the Influence of Alcohol or Other Psychoactive Substances". The basic act is driving under the influence of such substances and graver consequences caused by a traffic misdemeanour by driving constitute a qualified case which shall be sanctioned by imprisonment.

Rowdyism, Disorderly Conduct and the Forgery of Private Documents from among "Crimes Against Law and Order" may be most connected to drug use. Forgery of a Private Document may emerge in relation to prescription offences with the purpose of non-medical use of medicines.

In Hungary, conducts against public order often give rise to indignation or shock in the society. Such crimes against public order are committed in public spaces. In Hungary, they

[44] Source: Section 195 of Act IV of 1978 on the Criminal Code
[45] Source: Section 196 of Act IV of 1978 on the Criminal Code

got into focus, especially rowdyism at sports events and political demonstrations. Beside the venue of perpetration, offences by youths and under the influence of alcohol (and recently narcotic drugs) are typical (Nagy 2003). Within crimes of violence the incidence of rowdyism increased significantly. Legal facts of rowdyism are constituted if a person *"displays such an ostensively anti-communal, violent conduct, which is suitable for inducing indignation or alarm in other people"*[46]. (In legal practice reckless perpetration under the influence of alcohol or other psychoactive substances are also deemed to be such conduct.) *"Banishment may also take place as (...) punishment"* at places where the offender committed disorderly conduct against public peace.
The legal fact of Disorderly Conducts was enacted in 2000 in order to efficiently curb sports-related vandalism. Such conduct may only be showed at public (cultural and sports...etc.) events by the offender being disobedient to measures taken by the organiser of the event. In such cases against public order it may be reasonable to ban the offender from one or more settlements or a specific part of the country. Banishment may be ordered in both cases provided the jury sentences the offender to imprisonment.

b.) Punishments and measures

According to the Criminal Code, *"a person who is unsuitable or unworthy for the profession in question may have the privilege restrained permanently"*[47] or *"such person may be prohibited from his profession, who commits a crime a) by the violation of the rules of a profession requiring special qualification, or b) commits it intentionally, by using his profession"*[48]. Unsuitability may be stated for reasons of health; if a person as a drug user committed, for example, a "crime of endangering" within the scope of his profession and he violated the rules of his profession by his addiction.

Forced medical treatment of alcoholics may be ordered in addition to enforceable imprisonment and is regulated in the Criminal Code. It is recently applicable for alcohol-addicted offenders, although the title of is was altered to Forced Cure of Alcoholics in 1987 and the personal scope of this regulation was extended to drug-using offenders provided their *"crime is in connection with his way of life"*[49]. This legal rule is not in force (yet). The jury usually order supervision by a probation officer in such cases and order medical treatment for the offender.

Confiscation may be ordered in addition to another punishment or in itself and shall not be omitted in respect of drug-related crime, because this would endanger the protected legal object and public order in the future. Forfeiture of Assets may be ordered provided the assets are proved to have been obtained from drug-trafficking.

c.) Misdemeanours

The Act on Misdemeanours regulates criminal liability for the offences committed under the influence of alcohol or other psychoactive substances in the same way as the Criminal Code. The legal fact of nuisance activities include a range of conducts of rowdyism nature (affray, rowdyism, disobedience to measures taken by the police etc.). Such conduct may be sanctioned by custody or a fine, in qualified cases banishment (from a specific area or settlement of the country) or expulsion (of offenders of non-Hungarian nationality from the territory of Hungary) may be ordered. In addition to nuisance activities, dangerous menace, offence against the rules of the drug-police and violation of prohibition on vending, serving and consuming alcoholic beverages stand out from misdemeanours.

[46] Section 271 of Act IV of 1978 on the Criminal Code
[47] Section 57 of Act IV of 1978 on the Criminal Code
[48] Section 56 of Act IV of 1978 on the Criminal Code
[49] Section 75 of Act IV of 1978 on the Criminal Code

A “dangerous menace” means a serious intimidation of the commission of a crime with the purpose of inducing alarm. It shall be punishable by custody or a fine.
An “offence against the rules of the drug-police” means the violation of rules set for the handing out and order of narcotic drugs and other psychoactive substances. Proceeding in such a case is to be initiated by the police and the State Public Health and Medical Officer Service, and it shall be punishable by a fine.
“Violation of the Rules on the Cultivation of Plants Used for Making Narcotic Drugs” is deemed to be a misdemeanour that may be sanctioned by a fine or confiscation.
“Prohibition on Vending, Serving and Consuming Alcoholic Beverages” are regulated by an act, a Government Decree or a Municipality Decree, the violation of which imply a fine or a fine on location imposed by the police, the Inspectorate of Roads and Sanitation and the State Public Health and Medical Officer Service.
The “Act on Sports” regulates the conditions of entry to a sports event. No persons being under the influence of alcohol or other psychoactive substances or possessing alcohol or narcotic drugs may be let enter and the organiser is entitled, in addition he is obligated to remove such person from the venue of such an event. The organiser of the event or any policemen is entitled to apply means of coercion, and have the right to search persons and baggage. Banishment may be applied against any persons having been removed from a sports event, the term of which may not exceed two or four years. It is the responsibility of the state or municipality to arrange for public safety at a sports event, therefore they share in normative support determined in the “Act on National Budget” in order to fulfil such responsibilities.

d.) Other measures, programmes

Narcotic drugs are often available at discotheques or other entertainment facilities. On the basis of Act I. of 1978 on Domestic Commerce, discotheques are business establishments that may be opened and operated on condition of a business license. Business license is issued by *“the town clerk of the settlement responsible for the place in which the business establishment is located”* prior consent of the proper authorities .The authorities involved in licensing business establishments such as discotheques are the State Public Health and Medical Officer Service, the environmental-protection, building-inspection, traffic-control and fire-control authorities. *“(1) The town clerk, the appropriate authorities, the Consumer Protection Agency and its regional branches shall have jurisdiction to oversee the compliance of business establishments with the requirements laid down in the operating license and with the legal provisions on commercial activities. The above-specified authorities shall also be entitled to conduct inspections jointly with the police on the basis of a cooperation agreement.”*[50]
“(2) If, according to the findings of an inspection, the business establishment (...) fail(s) *to meet the requirements set forth by law or if they violate such requirements, the town clerk may temporarily close down the business establishment for a maximum period of up to 90 days until such violation is rectified.”*[51] This implies the responsibility of a discotheque to provide unrestricted availability to drink water for free also outside the restroom, constant air conditioning and a separate chill-out room to – for example – prevent attendants under the possible influence of narcotic drugs from failing or panicking. No statistics are available on temporary closures of business establishments for failing to meet or violating requirements cited above.

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[50] Source: Subsection (1) of Section 8 of Government Decree No. 4/1997 (I.22.) Korm. On the Operation of Business Establishments and the Conditions for Conducting Domestic Trading Activities
[51] Source: Subsection (2) of Section 8 of Government Decree No. 4/1997 (I.22.) Korm. On the Operation of Business Establishments and the Conditions for Conducting Domestic Trading Activities

"*The town clerk may revoke a business license (...)".* A trader must provide the town clerk the information if the business establishment is to be operated as a discotheque which might also be rejected by the town clerk if it violates the rules of law or is against public taste or *"if (...) (e) the noise generated by the business establishment continues to disturb the peace and tranquillity of the public (...)"*[52].

Harm-reduction programmes are considered to be partly non-legal responses to drug-related offences. Such programmes are not aimed at the abandonment of drug-use but focus on the avoidance and reduction to a minimum of its consequences (infectious diseases, impoverishment, acquisition-related and resulting crime) and risk-factors. (Ritter 1999)

13.3. Results and evaluation

Drug-related street-crimes are harmful to the specific area's public safety and crime rates. Its indirect effects are, however, also be perceived in areas lying outside the crime scenes. Shop-lifting, pick pocketing, car-breaks and pilferage of removable goods from cars were typical at and around major scenes of drug use and drug trafficking in Hungary also in 2003 – reported the Police.
Criminal statistics do not allow us to measure the spread and volume of drug-related street-crimes, experts, however, anticipate an increasing tendency.
Primary prevention activities that were continuously carried out on the streets by public and NGOs in the last couple of years allowed an increase in the number and an improvement in the quality of available services. (National Report 2003)

The table describing the "Role of alcohol and narcotic drugs by offenders by crime categories" published in the Statistical Yearbook that has been issued by the Central Statistical Office since 1996 shows the rate of offenders committing a crime under the influence of narcotic drugs or other psychoactive substances to all other offenders (Central Statistical Office 2003).
The Public Prosecutor's Office provides the relating data to the Central Statistical Office. The number of offenders committing a crime under the influence of narcotic drugs has increased exceeding its tenfold (from 167 to 1786) since 1996 and 2002. 4.5% of them (80 offenders) committed a crime of violence or rowdyism. The number of cases was1356 in 2003. Their dispersion by crime category did, however, not change in comparison to that in 2002. The underlying reason for this decrease is to be found in the data-collection system.

In breakdown of crime categories (IT Department of the Ministry of Interiors 2003), the number of offenders committing a 'Crime against Public Order and Property' (1157 and 137, respectively) under the influence of narcotic drugs was the highest, but it must be noted, that the category of 'Crime against Public Order' includes 'Misuse of Narcotic Drugs' (the number of such offenders was 1128). 'Grievous Bodily Harm' was the most often committed one in the category of 'Crime against a Person', 'Driving under the Influence of Alcohol or Other Psychoactive Substances' was the most typical in the category of 'Traffic Crime'. 'Endangering of a Minor' and 'Omission of Support' were committed the most often in the category of 'Crime against Marriage, Family and Youth'. 'Violence against an Officer of the Law' was the most typical in the category of 'Crime Against the Purity of State Administration, the Administration of Justice and Public Life' and 'Burglary' was the most often committed crime in the category of 'Property Crime'.

[52] Source: Subsection (4) of Section 8 of Government Decree No. 4/1997 (I.22.) on the Operation of Business Establishments and the Conditions for Conducting Domestic Trading Activities

Statistics include offenders committing a crime under the influence of “other psychoactive substances” (that are legally not classified as narcotic drugs) separately. The number of such offenders was some lower (756) in 2003 than that of offenders committing a crime under the influence of narcotic drugs and the by them most often committed crime also belonged to the category of ‘Crime against Public Order and Property’. This table also includes the number of offenders committing a crime under the influence of alcohol which considerably exceeds that of offenders committing a crime under the influence of illicit drugs (22,982 offenders in 2003) and the breakdown of such offenders by crime categories.

Similarly to crimes, there are no detailed statistics on the number of misdemeanours either. Authorities register misdemeanours in their specific databases, however, no central summary is made of them. Statistics on misdemeanours were last published in the Statistical Yearbook by the Central Statistical Office in 1991. The annual Bulletin prepared by the Public Prosecutor’s Office includes corresponding data since each of the authorities submits statistics every year, the summary of which is held to be expedient by the Public Prosecutor’s Office even though the preparation of it is not in the extent of the employees’ obligations. Besides, the Hungarian National Police Headquarter may also prepare statistics on misdemeanours.

Legal responses to drug-related crimes against public order:

On the basis of the Criminal Code:

Conducts	Possible legal responses
Any crime committed by a person under the influence of narcotic drugs through his own fault (thus excluding or limiting his legal responsibility)	This cannot be applied as a ground for the termination or mitigation of culpability. Punishment shall be ordered.
Endangering of a Minor (for example her/his induction to a dissolute way of life)	Imprisonment
Driving under the influence of alcohol or other psychoactive substances - in case of graver consequences (i.e. fatal mass catastrophe, death)	Imprisonment or labour in the public interest or a fine - imprisonment
Forgery of Private Documents (i.e. prescription forgeries)	Imprisonment or labour in the public interest or a fine
Rowdyism	Imprisonment or labour in the public interest or a fine and/or banishment as a supplementary punishment
Disorderly Conduct	Imprisonment or labour in the public interest or a fine and/or banishment as a supplementary punishment
Crime by violating the rules of profession (i.e. as a drug user)	Prohibition from Profession (even permanently)
Crime committed by an alcohol-addicted or drug-addicted person	Forced Cure of Alcoholics (only in addition to enforceable imprisonment), and/or (in addition to supervision by a probation officer) medical treatment
Any drug-related crime	Confiscation of narcotic drugs

On the basis of the Act and Government Decree on Misdemeanours:

Conducts	Possible legal responses
Nuisance activities (affray, rowdyism, disobedience against a police measure etc.)	Custody or fine and/or banishment or expulsion
Violation of Prohibition on Vending, Serving and Consuming Alcoholic Beverages	Fine or a fine imposed on location
Dangerous Menace	Custody or a fine
Offence against the Rules of the Drug Police	Fine
Violation of the Rules on the Cultivation of Plants Used for Making Narcotic Drugs	Fine or confiscation

Other responses (non-legal or not settled by law) to drug-related crime against public order

Conducts	Possible responses
The trader operating/owning a disco violates the requirements set forth by law	Closure of the discotheque and/or revocation of the business license
Entry to a sports event being under the influence of and/or possessing alcohol/narcotic drugs	Rejection of the entry, removal from the venue and/or prohibition from the sports event for a specific period of time
Drug offences	Harm-reduction programmes

List of rules of law

Act IV. of 1978 on the Criminal Code
Act I. of 2004 on Sports
Government Decree No. 32/2001 (III.5.) on the Registration and Control of Banishments ordered in the Act LXIX. of 1999 on Misdemeanours
Government Decree No. 54/2004 (III.31.) Korm. on the Safety of Sports Events
Government Resolution No. 1025/2004 (III.31) Korm. on the Financing of Security at High-Risk Sports Events
Act LXIX. of 1999 on Misdemeanours
Government Decree No. 218/1999 (XII.28.) Korm. on Specific Misdemeanours
Act I. of 1978 on Domestic Commerce
Government Decree No. 4/1997 (I.22.) Korm. on the Operation of Business Establishments and the Conditions for Conducting Domestic Trading Activities
Government Decree No. 203/2002 (IX.14.) Korm. on the Amendment to the Government Decree No. 4/1997 (I.22.) Korm. on the Operation of Business Establishments and the Conditions for Conducting Domestic Trading Activities
Commentary on the Criminal Code
Criminal Council's Comment No. 154

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