



European Monitoring Centre
for Drugs and Drug Addiction



**2006 NATIONAL REPORT (2005 data) TO THE
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by the Reitox National Focal Point**

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

REITOX

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SUMMARY

In 2005, mainly regional surveys were conducted and in a few specific groups in Hungary. The outcome of these surveys is of great importance when a local drug strategy is formulated in accordance with the objectives set by the National Drug Strategy. The series of data collection in Budapest covering 13 years assume that the spread of illicit drug use among Hungarian youths slowed down or stopped in the previous years.

Based on the results of attitude surveys conducted in 2005, summarizing conclusions cannot be made on the attitude and awareness of the respondents towards drugs and the drug phenomenon. The results of these surveys draw experts' attention to the lack of sufficient social communication.

As compared to the previous years, there were no significant changes in the field of school based prevention. A more comprehensive picture on prevention interventions in the school setting is expected after implementing the planned accreditation system. We do not have as detailed information on out-of-school prevention as on school-based programmes. As a first step, the activities of organisations involved in out-of-school prevention have been mapped, according to data provided by the Coordination Fora on Drug Affairs. A recent survey identified the programmes of only 54 organisations, although further programmes of similar nature are likely to operate on this scene.

Treatment centres recorded 14,793 drug users in 2005. The number of new clients (6,319) increased by 12% compared to the year before. The number of heroin users in treatment and especially injecting users has been continuously decreasing since 2000. Since 2002, the proportion of cannabis users has been slowly increasing among clients, and it has recently been the „leading” drug type. The number of amphetamine users in treatment also increased in 2005. Through observing regular and long-term users of opiates, cocaine and amphetamines separately, the total number of the revealed and hidden users' population may be estimated at 24,204 with 95% confidence interval of 19,333-29,075. The number of injecting drug users in Hungary may be estimated at 3,941 with 95% confidence interval of 2,069-5,813. Based on calculations, we may conclude that problematic drug use is still less widespread in Hungary than in other countries of Europe.

As regards to the number of drug users per population, there are considerable differences in the geographical coverage of health care. Specialised outpatient treatment centres with high numbers of visits also admit clients from neighbouring counties. The current financing structure of the health care system does not enable large increases in the number of clients. Therefore, treatment centres are not able to meet the increasing demand for treatment (e.g. methadone treatment).

Act CLXX of 2005 amended Act III of 1993 on Social Administration and Social Care. In addition to primary care, this amendment included low-threshold services among community-based care types aimed at addicts with effect from January 1, 2007. The elaboration of low-threshold services' normative funding is in process. According to the TDI definition, treatment is also available in the frame of social care (e.g. community-based care, outreach work) but regular data collection on clients is still not complete.

HIV, HVB and HCV prevalence among injecting drug users did not show any significant changes in 2005 compared to the year before. No IDUs infected by HIV and HBV were found, while prevalence of HCV infection was 10.9%. It is hard to uncover the real epidemiological situation, because hardly any studies were published over the year that

included valuable information on screening injecting drug users. In the second half of the year, conditions of HIV/HCV testing for injecting drug users improved nationwide. A new outreach programme was launched aiming to reach the most problematic population. Data on the needle exchange programmes imply secondary needle exchange. The per capita number of needles and syringes has been continuously increasing over the last 3 years.

Considering recent trends, the number of deaths related to direct overdose decreased. Opiate users still represent the highest proportion among overdose cases. Compared to last year, an increase can be observed in the number of intoxications by heroin (8 cases in 2004, 13 cases in 2005) and by amphetamines (3 cases in 2004, 6 cases in 2005).

In most cases of deaths caused by violence – where drugs were involved – accident was identified as the cause of death. Amphetamines were traceable in 7 cases and heroin in 3 cases.

Although quantitative indicators of revealed drug-related crimes altered in Hungary in 2005, there was not any significant change in the qualitative features of the situation. Statistics show that 7,616 proceedings initiated on misuse of narcotic drugs were closed in 2005 as opposed to 6,670 closed files in 2004. Half of those who committed misuse of narcotic drugs and became revealed were diverted in 2004. Their rate increased up to 62.3% in 2005. A break-through increase occurred in the number of clients in diversion in 2003, after the amendment to the Criminal Code. This increase continued in 2005, although this tendency was not significantly influenced by the decision of the Constitutional Court. The group of cannabis users has been dominant among clients in diversion since 2003.

The structure of the drug market in Hungary did not substantially change in the past year. Change in purity of drugs at street level varies by substance. The most significant change could be observed related to ecstasy tablets. Tablets containing unusual active substances, amphetamine and various combinations of active substances emerged in a bigger amount on the market.

A newly emerging active substance in Hungary is mCPP – as stated in Act CLXXXI (XII. 19.) of 2005 – which is considered a psychotropic substance enlisted in Schedule I of the UN Convention in 1971. This means that mCPP cannot be used for therapeutically but only for scientific purposes.

1. NATIONAL POLICIES AND CONTEXT

1.1. LEGAL FRAMEWORK

Laws, regulations, directives in the field of drug issues

a) Act XXX of 2005 (VI.1.)

Decision of the Constitutional Court No. 54/2004 (see 2005 National Report) changed notably the provisions of the Criminal Code on misuse of narcotic drugs.

Act XXX of 2005 includes the original English version and a new Hungarian translation of the two UN Conventions as well as the Schedules I-IV of the Conventions with the official Hungarian terms of narcotic drugs, preparations and psychotropic substances.

Since the Decision of the Constitutional Court annulled the subsection (2) of section 286/A of the Criminal Code, interpretative provisions defining the criminal definition of narcotic drugs were replaced by Act XXX of 2005.

b) Act XCI of 2005 (VII. 4.)

Section 2 of Act XCI of 2005 on the Amendment of Act IV of 1978 on the Criminal Code and other acts amended Section 82 of the Criminal Code. Pursuant to paragraph h) of subsection (5), the Court or, in case of postponement of prosecution, the prosecutor may order obligations and/or prohibitions as rules of conduct in his decision, thus promoting the objective of probation. The Court or the prosecutor may send a person on probation to participate in a certain treatment or therapy, as long as the person accepts to participate. As a result, also offenders on probation who cannot be diverted to alternatives to prison for any reason may also participate in a form of treatment.

c) 153/2005 Government Regulation (VIII. 2.)

153/2005 Government Regulation (VIII. 2.) amended the 142/2004 Government Regulation (IV.29.) on activities related to narcotic drugs and psychotropic substances. It is important to highlight the following amendments: definition and interpretation of the terms laid down in the Government Regulation; embodying rules on how to reject drugs and psychotropic substances and how to make them harmless through destroying them; and the formalisation of application and authorisation forms needed to transport controlled substances for the purpose of special therapeutic use.

d) 34/2005 National Police Headquarters' Provision (VIII. 10.)

The objective of the 34/2005 National Police Headquarters' Provision (VIII. 10.) on tasks of the Police to combat drug-related crime is to regulate all activities of the Police related to precursors, drugs and psychotropic substances in one single, comprehensive norm.

e) 159/2005 Government Regulation (VIII. 16.)

159/2005 Government Regulation (VIII. 16.) sets particular procedural rules for and lays down tasks and competencies of authorities related to precursors. The Government Regulation implements the following Community Laws: Regulation (EC) No 273/2004 of the European Parliament and of the Council, Regulation (EC) No 111/2005 of the European Council and the Commission Regulation (EC) No 1277/2005.

f) 266/2005 Government Regulation (XII. 14.)

266/2005 Government Regulation (XII. 14.) amended the 295/2004 Government Regulation (X. 28.) on Health Authorisation and Administrative Procedures Office, the 142/2004. Government Regulation (IV. 29.) on Activities with drugs and psychotropic substances, and 217/1997 Government Regulation (XII. 1.) on the enforcement of Act LXXXIII of 1997 on care provided through compulsory health insurance.

It is worth noting among the amendments the statement that importers and exporters of poppy plants and/or cannabis herbs, as well as companies that buy and those that clean bulks of poppy seeds contaminated with poppy straws, are now obliged to report such activities to the Health Authorisation and Administrative Procedures 30 days before the start of such activity, and indicate the exact location and the name of the responsible person.

g) Act CLXX of 2005 (XII. 19.)

The Act CLXX of 2005 amended to Act III of 1993 on Social Administration and Social Care declared that low threshold services - beside primary care – belong to the community based care types of addicts from January 1, 2007.

h) Act CLXXXI of 2005 (XII. 19.)

Act CLXXXI. of 2005 on the amendment of certain health care-related acts amended to the Act XXV of 1998 on human pharmaceuticals by adding mCPP (meta-chlorophenilpiperazin) to List A of the annex.

Thus mCPP in Hungary is considered a psychotropic substance enlisted in Schedule I of the UN Convention on Psychotropic Substances signed in Vienna in 1971. It means that mCPP cannot be used for therapeutical but only for scientific purposes.

i) Act LI of 2006 (VII. 11.)

Act XIX of 1998 on Criminal Procedure was amended by Act LI. of 2006 that entered into force on 1 July, 2006, with the exception of subsections (2) and (3) of section 285. Legislative deficiencies and practical requirements that necessitate mainly technical and some conceptual amendments to the Act on Criminal Procedure emerged in the past two years that elapsed since its entry into force. Amendments to the Act on Criminal Procedure affect rules that are relevant to suspected persons using drugs in two cases:

- If a drug-using suspected person enters treatment for drug-addiction or other drug related treatment or preventive-consulting service treating drug use on voluntary basis, which may create grounds for the termination of culpability, it is not practical for the investigating authority to forward the documents proposing prosecution to the prosecutor and/or for the prosecutor to decide on postponement of prosecution pursuant to subsection (2) of section 222 of Act on Criminal Procedure. Therefore, if a drug-using suspected person voluntarily enters any of the treatment forms that can be the basis for the termination of culpability, and the treatment is still running at the time of the disclosure of investigation files, the investigation shall be suspended.

- Pursuant to paragraph a) of subsection (4) of section 227 of Act on Criminal Procedure, if prosecution is postponed in accordance with subsection (2) of section 222 of Act on Criminal Procedure and unless this suspected person is able to produce an official document to verify that he/she has been treated for drug-addiction for at least six consecutive months or that he/she has participated in other drug-related treatment or a preventive-consulting service within one year after the postponement of prosecution, a charge must be brought against him/her. In the course of law enforcement it was problematic that the treatment etc. that was started before the decision of the prosecutor's office on

postponement of prosecution, could not be included in the period of six months stipulated in subsection (1) of section 283 of the Criminal Code. Pursuant to the amended regulation a drug-using offender's participation in addiction treatment or other care or preventive-consulting service treating drug use that starts after the offence committed by such an offender but prior to postponement of prosecution and lasts for at least six consecutive months may create grounds for the termination of culpability irrespectively of the time and date of the postponement of prosecution.

Legislative intents

Legislative preparatory work arising from Council Framework Decision 2004/757/JHA was co-ordinated by the Ministry of Justice and the Ministry of Youth, Family, Social Affairs and Equal Opportunity.

No decision was made on this framework decision, because the Hungarian provisions meet the minimum rules of the Council Decision.

Law enforcement

Based on data of the Public Prosecutor's Office, 1,924 persons were sentenced for drug-related offences in 2005. These offenders committed 2,358 offences which they were called to account for on the following legal grounds¹:

- 1,485 offenders were sentenced for using type offences prohibited by Section 282 and Section 282/A of the Criminal Code;
- 101 offenders were sentenced for trafficking type offences prohibited by Section 282 and Section 282/A of the Criminal Code;
- 105 persons were sentenced for offences prohibited by Section 282/B (using or trafficking type offence to the injury of a person under the age of eighteen or by using such a person);
- 232 persons were sentenced for conducts as prohibited by Section 282/C (drug-addicted persons committing a using or trafficking type offence);
- 1 person was sentenced for an offence prohibited by Section 283 (Misuse of materials used for making narcotic drugs) of the Criminal Code

In 2005, the following punishments and measures were inflicted upon the 1,924 persons against whom final judgements were issued:

- 663 were sentenced to imprisonment: 309 were enforceable and 354 were suspended
- 99 were sentenced to perform work in the public interest
- 576 were fined
- and individual measures were inflicted in 586 cases

1.2. INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES

Coordination arrangements

The Hungarian Government has been undergoing restructuring at time of this report's preparation.

¹ For more details on crimes denoting „misuse of narcotic drugs” and offenders, see Chapter 8.

As a result of changes affecting the national administrative system, the institute responsible for the co-ordination of drug affairs has also been restructured. This is why the final structure shall be introduced in next year's National Report.

Co-ordination of drug affairs has recently been operating as a separate department within the structure of the Ministry of Social Affairs and Labour.

In 2006, the detailed result of the evaluation that was completed in 2005, prepared by the Dutch Trimbos Institute (Trautmann et al. 2005), was also published in Hungarian. The two-volume report is available to the public (Erdélyi 2005).

Authors of the report presented their findings to the Coordination Committee on Drug Affairs, its special committees and at the meeting of the parliamentary ad-hoc committee preparing the harmonisation of the „National Strategy to Combat the Drug Problem" with the Drug Strategy of the European Union that is underway.

Based on the findings, the following proposals were formulated:

- Due to the number of institutes involved in the Coordination Committee on Drug Affairs, its structure is not flexible enough in cases where developments necessitate quick reactions. Such wide spectrum of representation, however, has clear advantages, too. This is why "central governance" should be established that would act as an executive body.
- The Coordination Committee on Drug Affairs is more a body preparing policies than coordinating them. It is not entitled to make decisions, which is inevitable for a body with coordinative functions. It is essential to clearly identify the Committee's role and responsibility in decision making.
- Competencies and responsibility of the members of the Committee should also be identified.
- It is important to enhance the functioning of the management infrastructure.
- The implementation of policies should be made transparent as should priorities and results be shared with both strategy-setters and those who implement such strategy.

National Drug Strategy and its implementation

The National Strategy to Combat the Drug Problem was adopted in 2000 and has been in force since then. Its implementation is ensured through the new Action Plan worked out in 2004 [1129/2004 Government Decision (XI. 24.)].

1.3. BUDGET AND PUBLIC EXPENDITURE

The objective of the research, initiated by the National Focal Point in the summer of 2006, was to estimate the amount of drug-related public expenditure incurred in 2005. This survey was conducted along the methodological guidelines (Hajnal 2005) elaborated on the basis of international/EU practices and results.

When interpreting drug-related public expenditures, present study (Hajnal 2006) only considers significant expenditures born by the subsystems of the Hungarian public finances and indicated in the budget that directly arise from misuse of illicit drugs. The research only considered large-scale items, whereas activities being of similar importance but of lesser degree were ignored.

International and European practice basically distinguishes four public expenditure items:

- prevention/research,
- law enforcement/criminal justice,
- health treatment and

- harm reduction.

This study has been unique in its type in Hungary. Due to its uniqueness and the arising limitations in technical and human resources, the study has been confined to an estimation of two out of the four above-mentioned functional areas: criminal justice and health treatment. International experience shows that these areas have been the largest contributors to the total public expenditures. According to the international experience and information about Hungary at hand, the share of the two other areas omitted – prevention/research and harm-reduction – is expected to amount to 10-15% of the total Hungarian drug-related public expenditure.

The above general, functional categories had to be matched with real organisational areas in the course of the research. The following organisational systems have been covered:

- (a) organisations of criminal justice (including police, Hungarian Customs and Finance Guard, Prosecution Service, law courts and the Prison Service);
- (b) health-care system and
- (c) social care system.

It represented a basic problem of the research, that the concerned organisations did not collect any specific data on drug-related expenditures. So the question arose in each case: how can a reasonably accurate estimation of public expenditures be made on the basis of structured data and/or unstructured/qualitative information on a certain organisation?

The answer was different in the case of each organisation/organisational system:

- In the case of the five organisations in the field of criminal justice, the estimation was based on the share of drug-related cases among all cases processed by the given organisation. This proportion was used to calculate a raw estimate of drug related expenditures. This rough estimate was subsequently refined in several steps so that the final estimation reflected (i) significant differences between drug-related and non drug-related specific costs (if any), as well as (ii) some of the empirical and conceptual ambiguities related to the causal role of drug in a particular expenditure.

- Health-care expenditures were estimated on the basis of detailed activity data reported by health service providers to the National Health Insurance Fund. Although these data serve as a basis of actual funding of health services, due to the lack of adequate control mechanisms the validity of these data is rather doubtful. To improve the accuracy of the estimation expert judgement was used for identifying the specialized health centres, inpatient and outpatient care provided to drug addicts as well as the scope of lab tests.

- Public expenditure estimation in the social care system covers all services provided to clients – inpatient, outpatient as well as residential care – that fall under the definition of "health treatment". Budgetary estimation includes amounts directly transferred by the national government (so-called normative financing), as well as additional financing allocated to church-run centres and those provided by local and regional governments. In addition to that the expenditures of social inclusion and diversion programmes, managed by the Ministry of Social Affairs and Labour, have also been taken into account.

Table 1. *Major results of drug-related public expenditure in 2005:*

Subsystem	thousand EUR²
1. Criminal justice	
Police	14988 - 17899
Customs and Finance Guard	2080 - 2108
Prosecution Service	2572 - 3753
Law court	1963 - 2096
Prison Service	7216 - 7709
TOTAL criminal justice	28820 - 33565

² official medium exchange rate of EUR-HUF of 248.05

2. Health care and social care	
Health care system	8072
Social care system	1854
TOTAL health care and social care	9925
GRAND TOTAL	38746 - 43491

Source: Hajnal (2006)

1.4. SOCIAL AND CULTURAL CONTEXT

Debates on drug issues

At the demonstration on March 26, 2006, the Hempseed Association handed over 386 letters addressed to MPs who were elected in April 2006. Each one of these letters contained a petition in which the Hempseed Association asked the MPs to further a reform of provisions on misuse of narcotic drugs laid down in the Criminal Code and to promote the realisation of the National Drug Strategy's principles.

The Hempseed Association held their demonstration as part of the international event series "Million Marijuana March" in Hungary on May 14, 2006. The demonstration called for legalisation of cannabis derivatives. The demonstration was peaceful, with only one counter-demonstrator appearing.

Attitudes to drugs and drug users

A qualitative survey on the attitudes of the adult population to drugs and drug users

The objective of the survey conducted in the spring of 2005 (Elekes and Paksi 2005) was to understand and interpret what underlay the features and contradictions of attitudes of the adult population towards drugs and drug users, on which quantitative research had already been made (Paksi 2003a; Elekes and Paksi 2004). The survey also sought to reveal and simulate construction mechanisms of how society forms an opinion.³ Results of this survey show the following features of members of the tolerant and intolerant groups.

The tolerant:

- They usually said "yes, I do" to the question asked about whether they disapprove initial use of different drugs⁴. They however, separated cannabis derivatives from all other drugs and told that they did not disapprove of their use. They disapproved of the initial use of inhalants and heroin to a larger extent than other drugs.
- Risk perception of people belonging to this group is differentiated according to the frequency of use. They made a distinction between the risk of initial and regular use of drugs, they considered initial use as a moderate risk and regarded regular use as a great risk. A differentiated risk perception of cannabis derivatives to other drugs

³ The survey was conducted by the Behaviour Research Centre at Corvinus University of Budapest. The research was carried out in Budapest and based on ten focus groups that were homogeneous in respect of the group members' age and education. Based on their responses to the filter questionnaire, respondents in the sample were classified into two groups: a group of the "tolerant" (162 people) and one of the "intolerants" (359 people). Filter questions are identical to the questions about attitude asked in the ADE survey on Alcohol and Drug Use in the Adult Population conducted in 2003. Based on responses, homogeneously tolerant, homogeneously intolerant and mixed focus groups made up of members from both homogeneous groups were formed. Each of the focus groups was made up of four to seven members. 521 people were involved in the survey. The following major issues were researched: Population's perception of drugs and related risks; Attitude of the adult population towards drug users; How big a problem is drug use perceived by the adult population in Hungary; General perceptions on how to treat the drug problem; Perceptions of the population related to financing the battle against drugs.

⁴ The question was to be answered on a three-grade scale: "I do not disapprove", "I disapprove", "I strongly disapprove".

appeared here, too. Respondents perceived initial use of cannabis as a low risk and considered occasional or regular use as a moderate risk.

- They had a quite ambiguous opinion on whether to legalise cannabis use (partly agreed and partly disagreed). Their opinion was in favour of the drug policy which turns a blind eye on cannabis use.

The intolerants:

- They strongly disapproved drug use without any differentiation.
- Their risk-perception has been extremely homogeneous: no differences were revealed in their risk-perception of either the drugs used, or the frequency of use. They considered both initial and regular use of drugs as a great risk.
- They clearly represented a prohibitionist's approach towards every drug including cannabis derivatives.

The negative factors behind the risk perception of drug use (addiction, health damages, financial problems, drug-related crime, disadvantages to relationships, loss of self-control, unpredictable behaviour) could hardly be determined or were associated to different patterns of use (drug types and/or frequency of use) and to different aspects of the problem without meaning. It was also typical of those who had direct or indirect personal experiences in this field.

It was clear that the lack of knowledge or superficial information was behind the stereotypes in different dimensions of the drug problem. Participants had little information on how much money had recently been spent on different social problems in Hungary. Nevertheless, most of them were of the opinion that handling the drug problem does not need more funds but a more efficient allocation. These findings draw attention to the deficiencies in social communication and in the activities handling the drug phenomenon.

When analysing the dynamics of focus groups, change in personal opinions could be observed many times during the interviews. Beyond the indication of uncertain opinions, it may also confirm the lack of information. However, quantitative surveys show stability in the attitudes of the population over time. (Paksi 2003a; Elekes and Paksi 2004) Changes in opinions during the interviews may be explained by conformity. In the focus groups conformity could be perceived as typical to the individual, meaning that the participants narrowed their opinions on the basis of different information and arguments heard during the interview. The fact that the initial opinions were changed and converted by the group members of the non-professional focus also draws attention to the lack of social communication. Social communication may either strengthen the population's stereotypes of the drug phenomenon but it cannot overwrite them because it hardly reaches the personal level of communication or does not take the basic situation into consideration. It is especially important in the case of intolerant groups with less differentiated opinions who base their opinion primarily on information from the media.

A survey on the attitude of members of the Coordination Fora on Drug Affairs towards drugs

The objective of the survey conducted in the spring of 2005 (Domokos et al. 2005) was to reveal the attitudes of experts and representatives of different institutions delegated to the Coordination Fora on Drug Affairs towards drug use.⁵ According to the survey concept, these fora play a key role in the implementation of the National Drug Strategy, which is why attitudes of delegated representatives and members towards drug use are of great importance in solving the drug problem. Attitudes of these experts, however, are not known or only to a limited extent. According to the survey members were in agreement that the drug

⁵ The survey was conducted by Echo Survey Social Research Institute. Data were collected by sending out postal questionnaires. Response rate to the questionnaires sent out amounted to 24%, thus 254 persons were included in the sample on a voluntary basis. Qualitative results from case studies and 15 experts' interviews were added to the research.

phenomenon shall be regarded as a serious social problem. The majority of the members of Coordination Fora on Drug Affairs (48%) were conservative, 27% of them were of a permissive viewpoint. Some 25% of respondents expressed a disapproving attitude towards the drug problem. A difference could basically be detected in opinions on how much the drug problem was socially embedded and how it should be managed. Members with conservative and members with permissive attitude accepted that drugs have a function in society similar to other licit substances such as alcohol and tobacco. Whereas those with a disapproving attitude did not agree, they believe that drugs are not a part of any society, but a foreign body that can be eliminated. Another important aspect of the difference in opinions is the way the problem should be tackled. Respondents belonging to the permissive group supported, while conservatives refused the idea of legalisation of cannabis derivatives. The permissive considered narcotic drugs much more risky than licit drugs and attributed a decisive role to outsiders (peer groups, strangers) in inducing drug use. The members of Coordination Fora on Drug Affairs with a disapproving attitude were of a more conservative viewpoint, but they not only rejected legalisation for its risks but also for their belief that drugs are not a part of society.

Respondents held the opinion, that it is alcohol, heroin, tobacco and cocaine that are the most likely to cause physical and mental addiction, whereas ecstasy, inhalants, amphetamines, methadone and cannabis derivatives are probably less addictive.

Respondents believe that a typical drug user is a daring, but easy to influence, young, urban and lonely person, who most often is a male. Three out of 254 participants of the survey believe that a drug user is a criminal. 28% of them consider drug users to be ill, whereas 67% of them expressed an opinion that a user shall be considered to be ill as long as he/she causes harm only to himself/herself. As soon as he/she causes harm to others, he/she shall be regarded as a criminal. A few respondents could not decide along these categories.

Forum members usually receive information about drug-related issues at further trainings and educational lectures. As a source of further information, they mentioned special literature second and special journals third. Coordination Fora were only mentioned on the fourth place among information sources and experts of drug-related issues such as doctors, the police, and staff of specialised outpatient treatment centres lagged behind.

Respondents were by no means satisfied with the performance of experts in prevention. Social workers, public health nurses and staff of family care centres are the most positively judged, whereas civil servants, journalists and cultural managers are the most negatively perceived. Forum members expect support from the state in the first place and they would impose a smaller share of costs (15 to 25%) of local drug prevention activities on local governments and civil societies. They believe that peer groups and different consulting services are needed.

Respondents are of the opinion that drug use among youths may be primarily aimed to relieve stress and escape from reality, but new experiences, curiosity and a modern way of entertainment may also play an important role in inducing drug use. They believe that friends, family and entertainment facilities primarily bear the responsibility and they are also the ones who could do the most in order to reduce drug use.

A survey on the attitude of media personalities toward drugs

Over the course of the survey conducted in the spring of 2005 (Kó and Münnich 2005), in-depth interviews were made with 118 well-known and lesser-known media personalities who are public opinion leaders in Hungary.⁶ It was the objective of this survey to become familiar with the attitude of media personalities towards drug-related issues. Most of the respondents

⁶ Respondents in this research (36 journalists, 38 reporters or editors working for a radio station, 44 reporters, editors and presenters working for a TV channel) were selected from among staff of media companies with a significant presence on the domestic media market. The circle of interviewees included on-screen media celebrities and editors, managers, editors, whose persons may not be well-known by the audience but play an active and sometimes crucial role in what is put on screen or what articles are written about. They participated in the research on a voluntarily basis and remained anonymous if they wished to.

(58%) believed the use of each drug type to be risky, while only a mere 6% said that they did not believe that drug use may imply any risks. A 36% of the interviewed perceived varying risk levels as to each illicit drug type: it was the use of cannabis, amphetamines or pharmaceuticals abuse that they typically held less risky or even not risky at all.

One-third (32.2%) of media personalities can be categorized as well-informed, i.e. they are familiar with more than three drugs and know the route of administration of these drugs, effects and possible consequences of their use. More than half of them (56.8%) are partly informed, meaning they cannot make a distinction between drug types. An 11% of media personalities are totally uninformed about drugs. Drug-related risk-perception significantly depends on the degree of information: the lesser-informed media personalities considered illicit drugs to be more risky than those who proved to be better-informed.

The opinions of women and men about drugs and drug use did significantly differ from each other. Women proved to be significantly better-informed than men. They proved to know more drug types and be more familiar with the different routes of administration than men did. Some 52% of women disapproved of the use of every drug type, while 46% made a distinction between different drugs and considered them to be risky or safe accordingly. 2% of women and nearly 10% of men did not hold drug use to be risky at all. 62% of men held drug use risky without a differentiation and 28% of them made a distinction between the different drug types.

Age and knowledge about drugs and drug use show a negative correlation: the younger a respondent is, the less he/she is informed about the issue. Those respondents that graduated from college held drug use to be the most risky, whereas respondents with lower education and those with a university degree may be characterised by a more permissive attitude. University graduates had the most differentiated opinion on drug-related issues: 41% of them perceived a difference in the risks of drugs. This rate is 32% among college graduates and 21.5% among those with only lower education.

Perception of risks related to drug use is significantly dependant on interpersonal relationships. It was married people who held drug use to be the least risky. The number of interpersonal relationships clearly affects opinions on drug use: the more friends and acquaintances one has, the less risky he/she perceives drug use. Disapproval of drug use did not reach 50% among those who have extended network, while more than 70% of those who have less extended network held drug use to be risky.

A survey on the attitude of society towards drug users

The objective of the survey conducted in 2004 and 2005 (Demetrovics and Gyalog 2005) was to explore the opinion of society on drug users and identifying dimensions shaping its attitudes towards drug users.⁷ Based on the survey the following six major dimensions could be defined: (1) destructive and antisocial behaviour, (2) antisocial behaviour and amorality, (3) deterministic addiction versus differentiated perception and normalisation of drug use, (4) mental illness, social impact, (5) attribution, (6) social recreation (differentiation). Characteristics of these factors are as follows:

Destructive and antisocial behaviour: This factor is made up of 38 items, in which drug users' destructive behaviour to society, the micro- and macro-environment and their own lives as well as the drug as a destructive element are assessed. This factor reflects the perceptions of society on a drug user's destruction including neglect, lack of any control of impulses, extreme hedonism and a distortion of personality.

⁷ 284 interviewees at an age of 14 to 64 gave a general description about a visualised drug user. These interviewees represented twelve different groups. 207 out of 284 interviews were made with people who did not have any drug-related experience as users, relatives or on the grounds of their work. 77 interviews were made with persons who had such experience as occasional users, drug addicts, abstinent, ex-users, relatives or staff working in treatment. 3,074 statements were identified from their descriptions. A questionnaire including 99 items based on previous research results (Demetrovics et al. 2005) and a grammatical analysis, analysis of contents and a pre-classificational filtration of statements was filled in by 205 persons. Data were processed by means of factor analysis.

Antisocial behaviour and amorality: This factor is made up of 17 items and underlines the antisocial behaviour and lack of morality of drug users. A user appears here as an antisocial, destructive and criminal element of society. These items emphasize drug use as a defect of character.

Deterministic addiction versus differentiated perception and normalisation of drug use: It is a bipolar factor containing nine items. Drug use is reflected in this factor as a „downward slope” that eventually ends up in addiction. It describes drug use as a deterministic path on which no one has an opportunity to turn back. Differentiated perception of risks of drug use is also reflected in this factor. The idea that drug users are also useful for society and the perception of drug use as a normal social phenomenon are on the other end of the scale.

Mental illness, social impact: This factor is made up of 13 items and highlights mental and social impacts in the background of drug use. It presents drug users as people deserving one’s sympathy.

Attribution: This factor of 13 items reflects a search for what induces drug use and implies the idea that there is always a reason why one starts using drugs, i.e. drug use is not a phenomenon that emerges by accident.

Social recreation (differentiation): This factor, containing nine items, underlines the feature of drug use being associated with entertainment and recreation with friends. A differentiating attitude appears in this factor to a certain extent.

Parliamentary debates on drug issues

Drug issues were raised in the form of bills, debates, interpellations and questions six times at 57 parliamentary sessions held between July 1, 2005 and June 30, 2006:

- A detailed debate on the draft parliament decree initiating the adoption of the report about the activities of the Parliamentary ad-hoc committee preparing the harmonisation of the „National Strategy to Combat the Drug Problem” with the Drug Strategy of the European Union and adoption of amendments and a draft decree.
- A question on whether any further amendments are to be expected to the legal facts denoting misuse of narcotic drugs set forth in Act IV of 1978 on the Criminal Code.
- Intervention for the interests of Hungarian harm-reduction programmes at international level.

Drug issues were raised six occasions less than in the year before, i.e. between July 1, 2004 and June 30, 2005. Such a decrease may also be explained by the fact that 80 sessions were held in the previous parliamentary period, whereas the Parliament convened at only 57 sessions between July 1, 2005 and June 30, 2006.⁸ The frequency of debates on drug issues and the number of parliamentary sessions decreased from 15% to 10.5% in this period.

Media representations

Drug issues in print media in 2005

The survey⁹ (Arnold 2006) aimed to detect the way drug users appeared in print media in 2005 and the attitude the press showed towards the drug problem. The results of the survey show that on average 157 articles of varying lengths dealing with drug issues appeared in each print media organ. The majority of articles (89.2%) were unbiased and did not use any dramatised or sensational expressions and phrases about drug issues.

Of all drug-related articles, 68.2% described the situation in Hungary, while the situation in foreign countries was dealt with in only half as many articles. The print media put a much

⁸ This period is considered to be a special period of the parliamentary sessions. Due to the parliamentary elections held in April 2006, the Parliament did not convene between March 9 and May 15, 2006.

⁹ The survey researched drug-related articles published in print daily papers (Magyar Hírlap, Magyar Nemzet, Népszava, Népszabadság) in the period of January 1 and December 31, 2005 through quantitative content-analysis based on code-system.

larger emphasis on the coverage of cross-border organisations and persons involved in drug issues in 2005, than it did in the period from 2001 to 2004.

Daily papers examined usually portrayed drug issues in the context of crime and pictured drug users as criminals, which may provoke society's alienation to the drug phenomenon. Eight times more articles described the drug problem in a way that it may reinforce readers' perception of drug users as if they were criminals to perceiving them as ill people.¹⁰ Of the articles, 48.6% dealt either with trafficking type or using type crimes. This means that nearly half of the articles were drug-related short news¹¹. Furthermore, 12.2% of the articles dealt with the decriminalisation of drugs and 10.7% of the articles were written about drug-related criminal regulations. Some 10.8% of the articles referred to illicit drug use among youths. Articles emphasising the importance of prevention were somewhat less in number and represented a proportion of 7.5%

Among all articles referring to the drug problem, 63.4% of them implicitly attributed a negative connotation to this phenomenon through their choice of subject. A mere 11.6% of the articles introduced the drug problem in a way that may result in the establishment or endurance of a tolerant attitude of society. A higher frequency of categories reinforcing an alienating attitude towards the drug problem may play a key role in provoking a sense of disapproval among the adult population towards the drug phenomenon.¹²

Most articles wrote about drugs in a general sense, with 61.5% of all the articles dealing with illicit drugs in general. This high rate of general drug-related articles may let us conclude that a relatively undifferentiated perception and description of drugs is typical to the media. Such a presentation of drug issues in the printed press is likely to have a decisive role in the Hungarian adult population's undifferentiated perception of drugs.¹³ Considering illicit drugs, most articles dealt with cannabis derivatives (26.6%) and cocaine (18.3%). Ecstasy (13.5%) and heroin (13.4%) were represented in the press with nearly the same frequency, while 9.7% of the articles were about amphetamines. Other drugs appeared in a smaller number of articles. Of all articles, 73.6% did not report any data on the prevalence of drug use and drug-related infectious diseases, seizures and drug-related deaths, etc. Furthermore, 93.2% of articles did not describe any scientific survey, analysis or study on drug issues to the audience.

Society cannot become familiar with the professional issues behind the drug problem through most of these articles, because only a mere 15.9% of all articles included statements directly from experts engaged in managing and research of the drug problem. The experts that were interviewed were mainly doctors, psychologists, psychiatrists and policemen. The articles approached drug users in a relatively participative way; for example, 5.2% of the articles let drug users express their own opinions. This open-minded way of introducing drug users to the audience may result in a more tolerant attitude.

The articles did not deal with factors inducing drug use in 96.6% of the case, and 92.4% of them did not make any suggestions on how to tackle the drug problem. Such low numbers of

¹⁰ The following categories were included in the „Criminals” model: availability of drugs, production of drugs, drug using type crime, trafficking type crime, drugs and crime, drug users and crime. The „Patient” model included categories such as treatment in the health service, by the church and unprofessionals; rehabilitation; harm-reduction; HIV/AIDS, HCV and other infectious diseases transmitted by blood.

¹¹ News in two-three sentences.

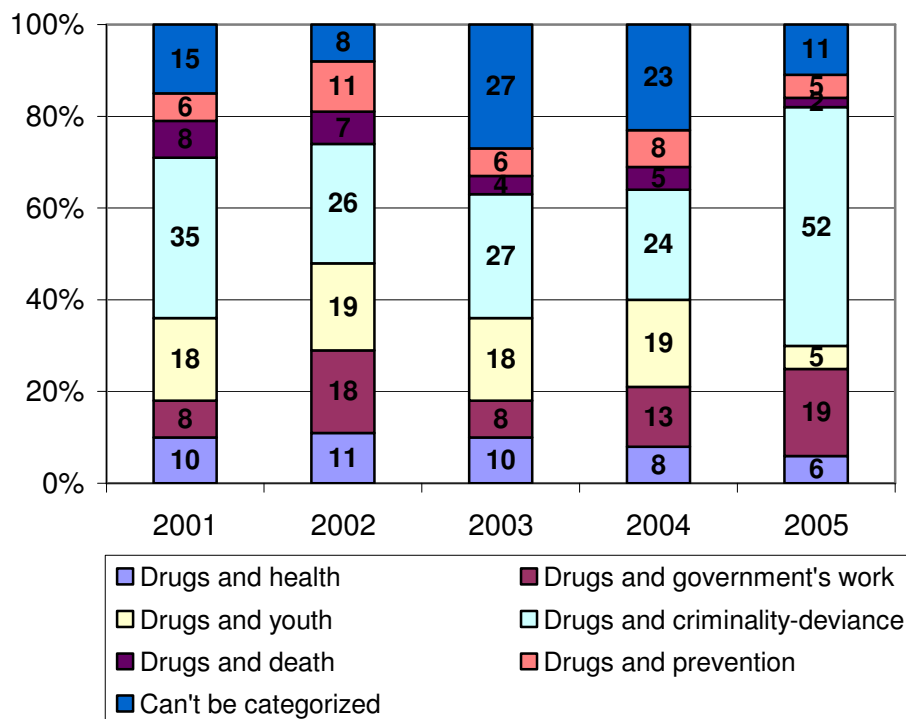
¹² Data resulting from the quantitative research conducted in 2003 show that 82% of the adult population would disapprove drug user living in the neighbourhood. (Gábor et al. 2004) Furthermore, disapproving and excluding attitude towards drug users was typical to respondents in the focus group survey carried out in 2005. (Elekes and Paksi 2005)

¹³ Data resulting from the qualitative survey on drug use among the adult population (Elekes and Paksi 2005) show that adult population have a non-differential opinion on drugs, which was accord with the quantitative survey conducted in 2003.

articles informing the audience about factors inducing drug use and suggestions on how the problem should be tackled suggests a hopelessness of the situation.

The importance attributed to drug issues in print media has been slightly decreasing in contrast to the late 90's. Half as many drug-related articles were published in the period from 2001 to 2004 as were published in the late 90's. In 2005, an increase of 70% could be observed in the number of articles published in one daily newspaper. However, the average number of articles published in a daily newspaper declined by 13% in 2005 in comparison to the average from the late 90s. The following table shows a breakdown of drug-related articles by topic in the period from 2001 to 2005.

Figure 1. Breakdown of drug-related articles by topic in 2001 to 2005 (%)¹⁴



Source: Arnold (2006)

Larger annual differences can be detected in the number of articles published about „drugs and drug-related crime” as well as „youths and drugs”. In 2001, a relatively high number of articles were published that described the drug problem in direct relation with crime. The number of crimes moderately decreased between 2002 and 2004, but articles introducing the drug problem in the context of drug-related crime increased again up until 2005. In contrast to the previous years, the number of articles dealing with the relationship between youths and drugs decreased in 2005, as did the number of articles emphasising the importance of prevention. The press paid more attention to governmental achievements in 2002 and 2005. This may be explained by the amendment of March 2003 to the legal facts of misuse of narcotic drugs as set forth in the Criminal Code, as well as the Decision of the Constitutional Court in 2004. The number of articles on the health dimension of drug use slightly increased in this period. When analysing the annual breakdown of articles by topic, the conclusion may be drawn that the proportion of each topic did not significantly change. A criminal context of

¹⁴ The number of all drug-related articles was 376 in 2001, 335 in 2002, 421 in 2003, 341 in 2004 and 629 in 2005. Each article was placed in only one category.

drug-related articles was typical in the period from 2001 to 2005, whereas other fields were represented in much less articles.

Conclusions

In summary, we may conclude that no significant amendments were made to the criminal regulation of drug consumption and drug distribution in 2005 in comparison to the previous year. Based on the attitude surveys conducted in 2005, summarizing conclusions cannot be made neither on the attitude of the respondents towards drugs and the drug phenomenon, nor on the level of their information. Results of these surveys draw expert's attention to the lack of sufficient social communication. The print media overwhelmingly published short articles on trafficking type and using type crimes. Articles on other related topics occurred to a smaller extent. Media representation of drug issues has typically been descriptive, non-sensational but non-differential.

2. DRUG USE IN THE POPULATION

Overview

No national data were collected among youths and adults in 2005. A number of surveys, however, were conducted on behalf of local governments and the Coordination Fora on Drug Affairs. These surveys analysed drug use among young people living in a particular region or city of the country. These surveys are of great importance when a local drug strategy is formulated in accordance with the objectives set by the National Drug Strategy.

The majority of these surveys applied different methodologies, but the fact that they have included an ever growing number of comparable data is considered to be a great success.

2.1. DRUG USE IN THE GENERAL POPULATION

No new information available.

2.2. DRUG USE IN THE SCHOOL AND YOUTH POPULATION

School survey in Budapest, 2005

The survey based on the ESPAD questionnaire and methodological guidelines in 2005 (Elekes and Paksi 2005b) analysed drug use among students studying in grade 9 and 10¹⁵ in Budapest.¹⁶ Results show that 31.5% of youths in the capital have ever tried any illicit drug.¹⁷ Lifetime prevalence of cannabis derivatives is 29.3%, 9.3% of ecstasy, 6.9% of amphetamines, 5.1% of inhalants, 4% of LSD and 4.8% of patron/balloon (nitrogenous-oxid). Lifetime prevalence of other drugs remained below 4%. Use of tranquillisers without prescription (12.9%) and combined use of alcohol and pharmaceuticals (7%) are widespread. Last year prevalence of illicit drugs amounted to 22.6%, while last month prevalence reached 12.9%. It means that 75% of those who have ever tried any illicit drug also used such substance in the last year and 40% of them used an illicit drug in the last month.

Budapest-specific data give us the opportunity to present longer-term changes. In years of the ESPAD surveys and in 2000 and 2002, additional data were collected on the basis of the ESPAD questionnaire and methodological guidelines in Budapest. Data from the survey conducted in 1992 are also comparable¹⁸. It enables us to analyse the changes in the patterns of use among students in grade 10¹⁹ in Budapest in the period of 1992 and 2005.

¹⁵ 15, 16 years old

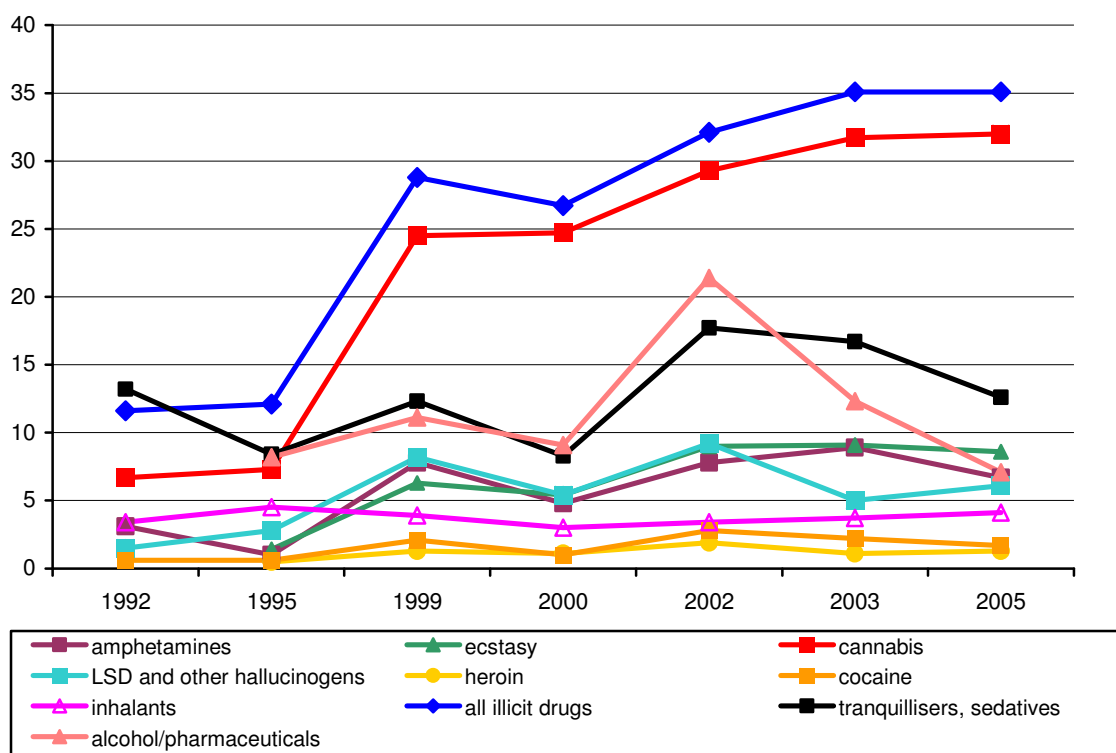
¹⁶ This survey was conducted by the Behaviour Research Centre at Corvinus University of Budapest by applying self-reporting method in school classes in grades 9 and 10 (respondents aged 15 to 16 years) in Budapest with the help of research assistants. The sample was stratified by school type and grade. Gross sample size included 2400 persons; net sample size covered 1846 persons.

¹⁷ Illicit drugs include the followings: cannabis, heroin, other opiates, cocaine, crack, amphetamine, ecstasy, LSD, magic mushroom, GHB.

¹⁸ Data were collected in grade 11 in 1992.

¹⁹ Students aged 16

Figure 2. Trends in lifetime prevalence of each substance used by secondary school students in grade 10 in Budapest in the period of 1992-2005



Source: Elekes and Paksi 2003a; Elekes and Paksi 2005b

Based on these surveys, we may come to the conclusion that lifetime prevalence of illicit drugs tripled (from 11.6% to 35.1%) among students in grade 10 in Budapest during the last 13 years.

The increase was significant in the second half of the 90's and it slowed down in the early years of this decade. There was no change in prevalence in the last two years. The increase is largely due to the spread of cannabis use. After an initial increase, stability could be detected in the use of other illicit drugs. It should be noted that despite significant fluctuations, use of tranquillisers without doctor prescription and combined use of alcohol and pharmaceuticals ranked second and third, respectively, during the entire period (Elekes and Paksi 2000, Elekes 2005, Elekes and Paksi 2005b).

2.3. DRUG USE AMONG SPECIFIC GROUPS

Drug use among persons living with disabilities

In 2005, surveys were conducted on a sample of 420 persons selected from five groups of disabled people (such as the visually, mentally and hearing impaired, the physically challenged and people living with behaviour problems) and from a control group (Farkas and Gerevich 2005)²⁰. Results of the survey show that illicit drug use was typical in the control group and among people living with behaviour problems. Lifetime prevalence of illicit drug use reached 25% and 26.1% in these two groups, respectively, whereas last month prevalence was 10% and 8.7%, respectively. In the other groups of disabled people, lifetime prevalence of illicit drug use was lower (8.8% among the visually impaired, 15.9% among the mentally impaired, 9.9% among the hearing impaired and 12% among the physically

²⁰ Data were collected through EuroDAD and ASI structured interviews. 72.6% of respondents were younger than 24 years of age.

challenged). Survey results show that illicit drug use has been less prevalent among the five groups of disabled people than among the youth and the general population.

Hungarian Army

The survey conducted in 2005 (Szilágyi 2006) analysed drug use patterns among staff of the Hungarian Army.²¹ Results of this survey show that 20.2% of the respondents have ever tried any illicit drug. Lifetime prevalence of illicit drugs was 22.8% among men and 7.4% among women. Lifetime prevalence of illicit drugs in the Hungarian Army is twice as high as among the adult population aged 18 to 54 in 2003, which was 11.4%.

Table 2. *Lifetime, last year and last month prevalence of illicit drugs in the army in 2005 (%)*

Substance	Lifetime prevalence	Last year prevalence	Last month prevalence
Cannabis	16.8	3.2	1.2
Amphetamine	2.4	0.8	0.5
LSD	1	0.2	0
Cocaine	0.3	0	0
Inhalants	2.2	0.2	0.2
Opiates	0.2	0.2	0
Anabolic steroids	3.5	1.3	0.6
Alcohol	92.1	88.8	79.6
Tobacco	74.5	58.9	54.1

Source: Szilágyi (2006)

According to the data we can conclude that the last month, last year and lifetime prevalence of alcohol, tobacco, cannabis derivatives and anabolic steroids was the highest among staff of the Hungarian Army. The mean age at first use of alcohol and tobacco are nearly the same among staff (16.5 years). Mean age at initial cannabis use is slightly higher (19 years).

Similar to previous years, a laboratory urine analysis was carried out among staff of the Hungarian Army also in 2005 (Gachályi 2006).²² A total of 10,234 such tests were run.

Table 3. *Laboratory urine analysis in 2005*

Test	Number of positive tests		
	THC	Opiates	Amphetamines
General health entrance exam (N=8169)	28	0	3
Ordered by authorities (N=210)	24	0	8
With preventive purpose (N=1855)	4	0	3
Total (N=10.234)	56	0	14

Source: Gachályi (2006)

²¹ Data were collected on a sample representative by gender, age, degree of rank, term and post of service (N=824 persons) through self-reporting in groups, on a voluntary basis and anonymously. Interviewers were employed for data-collection.

²² The survey was conducted by the Drugs Research Laboratory of the Toxicology Department of the Hungarian Army's Health Institute.

The total sample comprises of three sub-samples: tests were run at the time of the general health entrance exam of staff applying for the Hungarian Army, on official order if drug use was suspected, and once a month randomly with preventive purposes. THC was verified in 56 urinary samples and amphetamine was found in 14 samples. Opiates were not verified in any of the samples. Under declared zero tolerance to drug use, individuals whose drug use may be proven by a positive test are removed from the staff of the Hungarian Army.

A comparison of test results from 2005 and earlier do not show the real picture, because the composition of the Hungarian Army's staff changed in 2005 when compulsory military service was abolished, and in the spirit of a conversion to a voluntary military force, some of the staff withdrew from the organisational structure.²³

Conclusions

In 2005, mainly regional surveys were conducted and in a few specific groups in Hungary. The series of data collection in Budapest covering 13 years show that the spread of illicit drug use among Hungarian youths slowed down or stopped in the previous years. The survey conducted in the Hungarian Army indicates that the proportion of those who have ever tried any illicit drugs is (much) higher than that in the general population. The use of tobacco, alcohol and cannabis are the most widespread in the Hungarian Army.

²³ The Parliament adopted Act CV of 2004 on National Defence and the Hungarian Army on November 8, 2004. The act entered into force on January 1, 2005. This new provision lays down fundamental rules that are needed in the course of establishing and managing a voluntary military force. A major change came about in citizens' obligations related to national defence, inasmuch compulsory military service was abolished in times of peace.

3. PREVENTION

Overview

As a result of surveys conducted in the past few years (Paksi 2003b) detailed information is available on school-based prevention programmes. A national database enlists all revealed programmes, thus it enables the users of such programmes to inquire and make the most suitable choices. Not only the number of school-based drug prevention and health-promotion programmes has been increasing over the last couple of years, but also the spectrum of applied methods and approaches has been widening (Paksi et al. 2004.)

New developments

The number of visits on the Drug Information Portal for Professionals (www.ndi-szip.hu), launched by the National Institute for Drug Prevention (NDI) last year, as well as the number of registered organisations on the portal significantly increased in the past period. By July 2005, 228 organisations registered on the portal and their number grew to 487 by July 2006. Not only service providers but also a number of Coordination Fora on Drug Affairs and local governments are among the recently registered organisations. These organizations run 314 programmes, 80.6% of which - (253 programmes) - are prevention interventions. The proportion of treatment and other programmes has increased (from 14% to 20%) compared to last year.

This increase in the number of registered programmes may have been influenced by a prerequisite in the tender issued jointly by the Ministry of Youth, Family, Social Affairs and Equal Opportunity and the Ministry of Education for health promotion and drug prevention programmes for 2006. The tender stipulated, that an application may only be approved if the organisation or the expert is registered in the database.

The Coordination Committee on Drug Affairs submitted a proposal in preparation of the “decree on accreditation of drug prevention programmes and the operation of the accreditation system”.

3.1. UNIVERSAL PREVENTION

School-based prevention

The Ministry of Youth, Family, Social Affairs and Equal Opportunity and the Ministry of Education jointly issued tenders of school-based health promotion and drug prevention programmes for EUR 725,660 in 2005. In 2005, the tender’s objective again was to promote school-based programmes that reflect up-to-date professional concepts and apply interactive educational methods. At assessment, programmes were favoured that actively involved parents, peers and peer tutors in school-based health promotion tasks beyond dealing with crime prevention issues.

As a result, 309 schools from 708 tender applicants won subsidies in a total amount of EUR 645,394.²⁴ It means that 114,000 students in the population aged 11 to 18 participated in prevention activities within the frame of this tender.

²⁴ Based on data from Sulinova Kht.

Training of school drug-coordinators

Training of school drug-coordinators, which was first launched in 2002, took place five times with the participation of a total of 460 teachers in 2005. Drug-coordinators who pass the final training exams have had the opportunity to participate in a further training since 2003. From among more than 2,000 drug coordinators, 449 participated in further trainings in the school year 2004/2005.

Out-of-school prevention

Information on out-of-school prevention and drug prevention activities targeting risk groups are available from two surveys that were conducted last year. It was the objective of the survey carried out by the National Focal Point to map out-of-school interventions revealed by the Coordination Fora on Drug Affairs²⁵.

In the course of the interviews with the representatives of these organisations, 54 of them turned out to be running out-of-school drug prevention activities. 22 of these organisations are also present in the school setting. Other organisations specified by the Coordination Fora on Drug Affairs were either involved only in school-based prevention (58 organisations) or were not directly working in the field of drug prevention (64 organisations).

20 organisations being engaged (also) in out-of-school prevention did not specify any risk groups which their activities are directly targeting. Local population or community, or youths showing interest were primarily mentioned as their target population. The majority of these organisations (11 organisations) provide counselling and consulting, or offer alternative recreational activities (9 organisations) such as table-tennis at night. They organise such activities at settings that are suitable for recreation such as local culture centres.

Involvement of parents

Very few organisations (4 organisations) were identified that also provide activities exclusively targeted at parents.

A survey (Marton 2005) conducted by the “Children’s Paradise Foundation” also draws attention to the lack of programmes targeted at parents.²⁶ Although the basic objective of the survey was not to explore interventions, responding organisations were also asked to what extent they involve parents in their prevention activities. 141 organisations and institutes were asked in the survey. More than half of them, 81 organisations (representing 57.4%), hosted some kind of drug prevention activity. Although the resulting numbers let us conclude that 63% of all prevention interventions include elements that promote parents’ participation to a certain extent, a major part of these interventions only reaches parents in an indirect way. Parents usually receive information leaflets or are occasionally invited to meetings. There are very few areas where prevention interventions targeted specifically at parents can be found.

²⁵ The National Focal Point asked for the help of the heads of the Coordination Fora on Drug Affairs to name the organisations that are (also) involved in out-of-school prevention activities on their territories. From 192 organisations 176 were available for a phone interview. During the interviews, representatives of the organisations were asked to identify their target groups and the setting at which their intervention is implemented, and furthermore to summarise their drug prevention activities.

²⁶ The basic objective of the survey was to detect to what extent drug prevention is present in the experiences and the activities of experts, volunteers, peers and peer tutors working with children and youths outside school. 164 persons participating in activities for young people filled in questionnaires alone or with the help of the interviewers in 14 cities and four districts of Budapest. When interpreting the results it must be noted that this survey cannot be considered representative and the outcome does not clearly characterise the organisations working with youths.

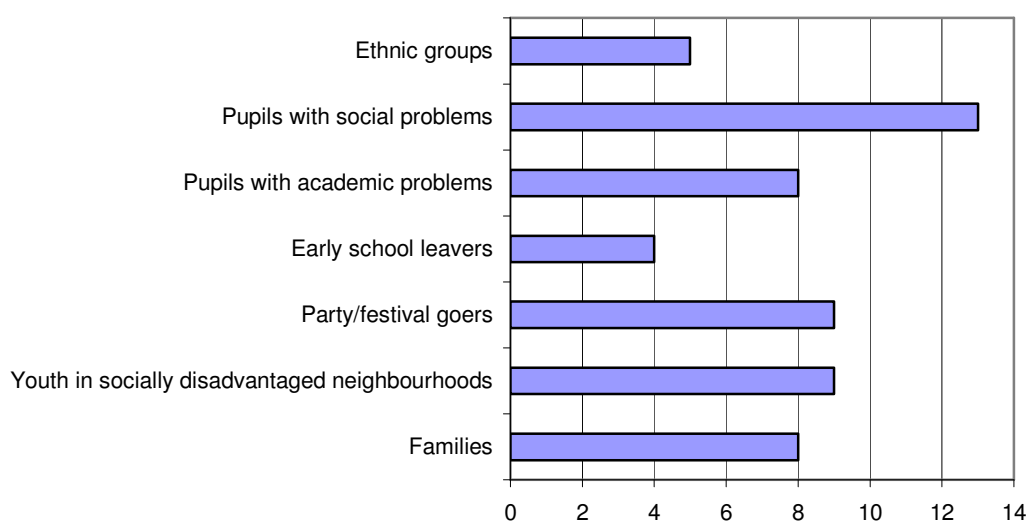
3.2. SELECTIVE PREVENTION

At-risk groups and families

Selective prevention interventions are targeted at groups of the total population whose members are considered to be at risk for substance abuse by virtue of their membership of a particular population segment. Such groups may be ethnic groups, school dropouts, young people in socially disadvantaged neighbourhoods, etc.

Organisations involved in prevention activities among risk groups mentioned the following as their target groups.

Figure 3. *Target groups specified by organisations involved in out-of-school prevention (number of mentions), N=54*



Source: National Focal Point (2005)

Organisations that work with young people with social problems and/or learning difficulties and/or living in deprived neighbourhoods mentioned at least two of these three target groups. There were ten such organisations. Half of the organisations working with at-risk youths are family-care or child-welfare services. Such services organise camps and clubs for young people. Most often the activities take place in their own premises. Other organisations working with youths facing similar problems and difficulties usually organise recreational activities and camps for them as well.

Interventions aimed at families typically offer alternatives to foster the joint recreation of parents and their children. Moreover, they try to involve drug user and socially disadvantaged parents in activities with their children. Nine of the organisations from among those specified by the Coordination Fora on Drug Affairs offer any kind of party service. None of the organisations are providing exclusively such activities, but most of them are also involved in school-based prevention (5 organisations) or peer-tutor trainings (3 organisations).

Roma youths

Five of the organisations that were interviewed said that they offered activities for young Roma people, three of them organise camps and other recreational activities, while another two offer peer-tutor trainings to these youths. In addition to these organisations, we know about one single foundation that offers peer-tutor trainings to Roma and non-Roma youths at the same time.

Prevention in prisons

Drug prevention activities have been carried out in prisons since 2003. The Hungarian Prison Service delivered an educational documentary series of 9 video tapes to each prison that is shown to prison inmates in 3-5 weeks intervals. The education material related to such documentaries was explained by educators and discussed by educators and prison-inmates in group activities. In the last three years since the launch of this programme, approximately 6,000 prison inmates took part in the activities. Transfer of knowledge about drug prevention, rehabilitation and health promotion is on the syllabus of schools run in prisons as well. These schools also employ drug coordinators in the course of their prevention work. In prisons for juvenile delinquents, parents may organise meetings in which they are also informed on anti-drug activities carried out by the particular penitentiary²⁷.

Drug prevention in the Hungarian Army

The Hungarian Army elaborated its drug-prevention programmes on the basis of drug-related surveys conducted among its staff. These surveys were not only aimed to measure the scale of initial and regular use of drugs, but also to learn which factors play a crucial role in starting and continuing drug use. Programmes targeted at the staff are aimed to decrease the incidence of drug use. These programmes principally apply methods to increase resistance against social impacts such as problem solving and crisis management techniques, self-esteem building, creating a realistic self-image, learning patterns of behaviour, raising self-assurance, critical attitude, etc.²⁸

Prevention at workplace

A programme called "Stay in the Green Zone! Movement of companies and employees for prevention of harmful alcohol and drug use" was elaborated by the Public Employment Service.

The objective of this programme is to involve heads of companies and employees in the prevention and to decrease all kinds of drug use (narcotic drugs, alcohol, pharmaceuticals). It emphasises that such ambitions may also result in an increase in a company's performance. This programme focuses on prevention, information and persuasion. Through involvement of community initiatives, it also seeks to assist treatment and rehabilitation of those in need. In the phase of preparation, feasibility studies on two company's pilot projects were completed (Paks Nuclear Power Plant, National Headquarters of the Hungarian Border Guards). The programme is expected to be implemented in the second half of 2006.

Conclusions

As compared to the previous years, there were no significant changes in the field of school based prevention. A more comprehensive picture on prevention interventions in the school setting is expected after implementing the planned accreditation system. We do not have information on out-of-school prevention as detailed as on school-based programmes. As a first step, however, activities of organisations involved in out-of-school prevention that have been revealed by the Coordination Fora on Drug Affairs have been mapped.

As a result of a recent survey, the programmes of only 54 organisations could be identified, although further programmes of similar nature are likely to operate on this scene. In order to obtain more information, further research is needed. Further data collection is also required in order to receive a more detailed description of prevention activities carried out in prisons and in the army.

²⁷ Based on the report by the Hungarian Prison Service

²⁸ Based on the report by the Ministry of Defence

4. PROBLEM DRUG USE

Overview

Data providers apply the reporting method and format set by the Ministry of Health when reporting on drug users who enter treatment. Only a test of comprehensive data collection based on TDI could be carried out this year due to the delay of the relevant legal provision.

In line with health-care statistics, aggregated data were available on clients that received treatment in 2005 (unchanged from the 2004 format). The range of institutions obliged to provide data practically covers all in- and outpatient treatment centres for psychiatric and addiction problems.²⁹

In the past five years, a number of amendments were made to provisions of the Criminal Code reflecting the legislation's perception of drug use and alternatives to prison. Treatment demand may have been influenced by these changes, but the extent cannot be exactly determined.

National adaptation and reliability tests of TDI (Gerevich et al. 2005) and tests of TDI-based data-collection started in the meantime. Treatment centres managing a high number of visits can record clients' data by using software that generates a code identifying each client, while centres with a lower number of visits can do so via internet. This method of data-collection excludes double-counting. In order to facilitate the introduction and use of the software, the National Institute for Addictology and the National Focal Point organised regional trainings for the staff of health care and low-threshold services and treatment units in prisons. The system keeps records also on drug users participating in treatment as an alternative to prison. These records will be available for further statistical analysis later.

4.1. PREVALENCE AND INCIDENCE ESTIMATES

Problem drug use³⁰ cannot be measured with the traditional direct and indirect indicators. Therefore estimation methods were elaborated on the basis of direct and indirect indicators so that the spread of those hidden, problematic or rare and/or stigmatized patterns of use which represent considerable rate among drug users could be measured.

National data

In order to measure the spread of problem drug use in Hungary, a survey applying the capture-recapture method (Elekes and Nyírády 2006) was conducted on the basis of records kept by the police and health services in 2005. Police records were complete, i.e. they contained information on each suspected person who got in contact with the police last year on a nationwide level. Health-care records contained data provided by the large treatment centres across the country. 82% of all treatment cases last year were recorded here. Data were collected from these two databases only about those who were PDUs according to the EMCDDA criteria, i.e. those who use opiates, cocaine, amphetamine or MDMA derivatives and/or those who are injecting drug users. After excluding all double-counting, police records contained 1,384 persons and the health-care data counted 1,469 clients. 84 persons could be found in both databases.

Based on the above, we estimate the number of problem drug users at 24,204 with 95% confidence interval of 19,333-29,075. (see ST07)

²⁹ Primary health services are not obliged to provide data. This is why a definition of "special treatment demand indicator" may be more exact.

³⁰ According to the EMCDDA definition.

Estimation was also made of the population aged 15 to 64 and other major age groups.

Table 4. *Number of total and hidden population of problem drug users in major age groups*

Age group	Number of hidden population	Total number of problem drug users	Confidence interval
15-64	21404	24171	19307-29035
15-24	7890	9159	6618-11700
25-34	8238	9462	6691-12233
35-64	7410	7683	-2774-18140

Source: Elekes and Nyírády (2006)

Calculations let us come to the conclusion that problem drug use is more common among youths between 25 and 34 than in the younger age group, but the difference is not significant.

Separate calculations were made on injecting drug users. (see ST07) In the health care database, injecting use was indicated at 627 drug users who represented 42.7% of clients in treatment. The police records indicated injecting at 88 persons who represented 6.3% of suspected persons. Finally, 14 persons were found in both databases.

Consequently, we estimate the number of injecting drug users in Hungary at 3,941 within 95% confidence interval of 2,069-5,813.

Table 5. *Total and hidden number of injecting drug users in major age groups**

Age group	Number of hidden population	Total number of problem drug users (capita)	Confidence interval
15-64	3230	3929	2063-5795
15-24	1142	1307	-75-2689
25-34	1458	1885	905-2865

*No person in the overlap of databases was aged over 35, therefore we couldn't make any calculations for this age group.

Source: Elekes and Nyírády (2006)

Based on the results we may presume that the majority of problem drug users are males with mean age 25 years. The proportion of the age group over 35 is negligible.

Most of them use heroin, amphetamines or ecstasy. The share of heroin users is probably smaller, the share of amphetamine users, however, is probably higher among problem drug users than in treatment. As regards the division of problem drug users by place of residence, they spread rather evenly over bigger cities and small settlements. Injecting drug use is typical to around 15 to 20% of this population.

Budapest-specific data

The multiplier method using treatment data estimated the total number of registered and hidden opiate-users at 4,000 in Budapest in 2003. Because double-counting was not excluded from the database, this number is likely to be overestimated. (further details in National Report 2004)

Such estimation was prepared with the same method in 2005. Calculations based on the number of registered opiate users and the in-treatment rate revealed by qualitative research (Márványkővi et al. 2006) estimate the total number of hidden and registered opiate users at 2,669. (see ST08)

It must be noted that the number of opiate users in the treatment database decreased by more than 50%, from 1,886 to 849 clients. This may be explained by the general restructuring of drug use patterns and the more exact data provision.

The 62 problem drug users who were asked during the qualitative research estimated that 31.8% of the total population was involved in treatment in the year under review.

In 2005, the size of the hidden opiate users' population in Budapest was estimated with capture-recapture method after selecting national data for the capital in 2005. 576 persons from the health-care database and 65 persons from the criminal records belonged to this user group. 20 of them were found in both databases. According to the calculations the number of problem opiate users in Budapest may be estimated at 1,872 with 95% confidence interval of 1,201-2,543. (see ST08)

The hidden population in the 15-64 age group includes 1,249 persons, whereas the total number is 1,869 with 95% confidence interval of 1,199 to 2,539 in this age group.

The significant difference in the outcome of the two years may be attributed to the more exact data in the second year. Therefore, we assume that the population size of problem opiate users in Budapest is between 2000 and 2500.

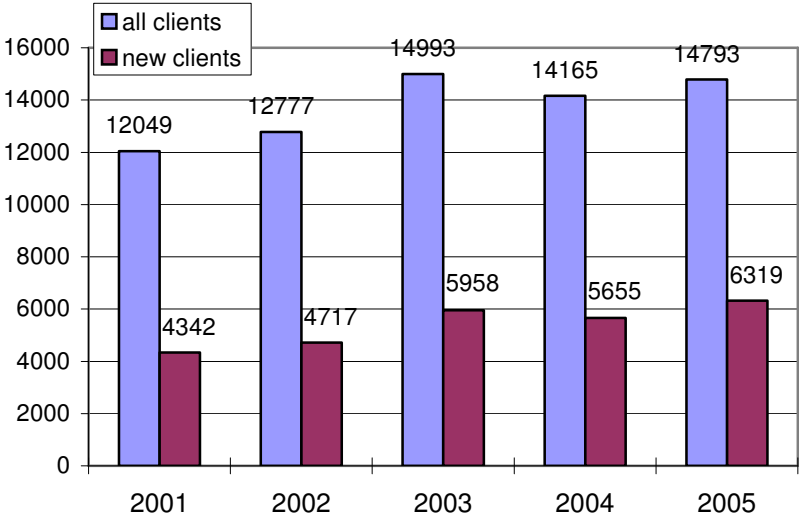
4.2. PROFILE OF CLIENTS IN TREATMENT

The number of drug users treated in specialised health centres grew by 4% to 14,793 (see TDI 1-2 tables). If we take the average of changes over time, we can conclude that in 2001-2002 the number of clients fluctuated between 12,000 and 13,000, which was followed by an increase of 2,000. The last three years the fluctuation shifted up to the 14,000 to 15,000 level.

Compared to 2004, the number of clients starting treatment showed a significant increase of 12%, thus crossing the 6,000 threshold (6,319). (see ST03)

In contrast to the past two years, we may say that the stagnation in the number of new clients ended in 2003, as a growth of 26% may be regarded as considerable. In comparison to 2003, a decrease of 5% in the number of new clients could be detected in 2004, which was followed by another increase of 12% in 2005. A gradual increasing tendency could be seen here too, however, the size of the fluctuations was larger than the total number of clients.

Figure 4. Number of drug users in treatment in Hungary



Source: Report No. 1647 by OSAP and Report No. 1211. by the Ministry of Health

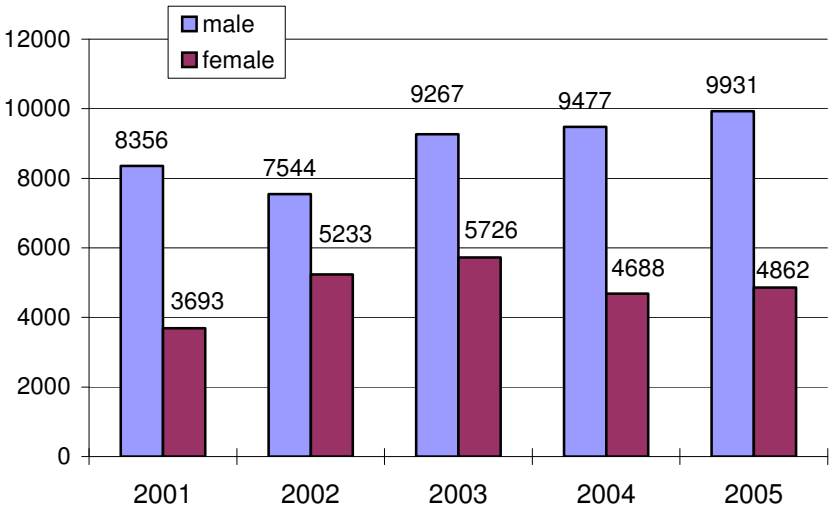
Annual fluctuations in the number of all clients and new clients and the gradual increase in treatment demand may be attributed to the amendments of the legal background in 2003 and 2004.

Socio-demographic characteristics

In 2002 and 2003, a considerable shift appeared in the gender-based breakdown of drug users treated in specialised health centres. The ratio of males changed from 2:1 to 3:2, meaning that the ratio of females increased.

Nevertheless, the male/female ratio became 2:1 again in the past two years.

Figure 5. Breakdown of drug users in treatment by gender



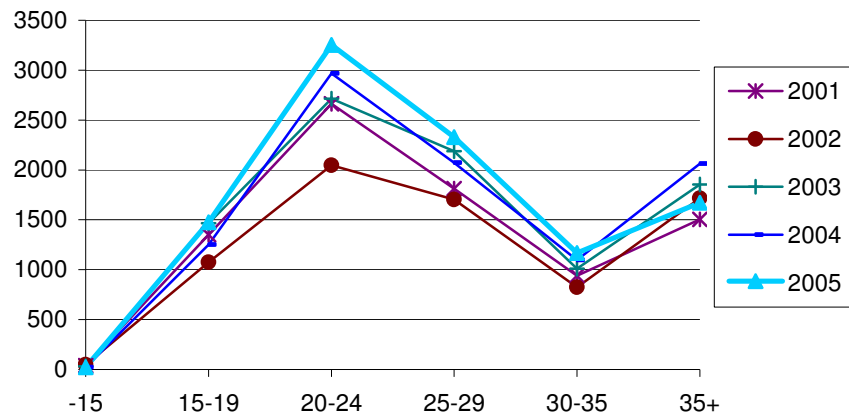
Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

The proportion of female clients abusing sedatives and tranquillisers was significantly higher in 2005 again. Nevertheless, in line with trends observed in the past years, the number of males was higher in each drug type except for sedatives.

A similar trend was detected among new clients. A shift followed by a return in the share of females was detected here, too. It must be noted that there was hardly any change in the proportion of female clients last year, whereas the number of new male clients increased by 16%. This also means that the increase in the number of visits of all clients as well as of new clients in 2005 may principally be attributed to an increase in the number of male clients in treatment.

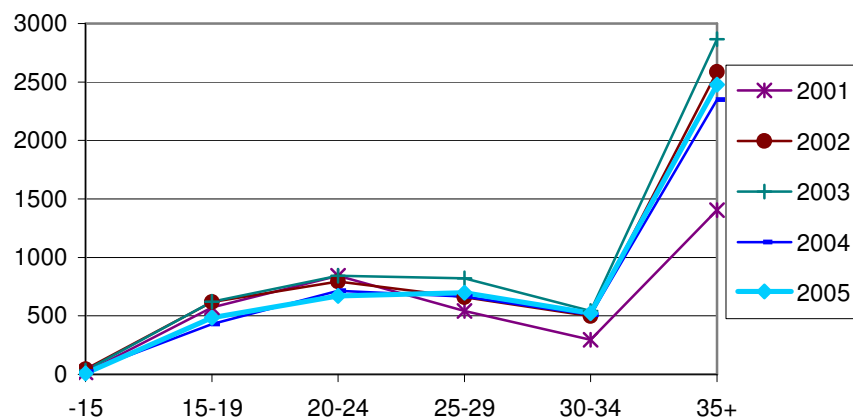
The breakdown by age shows unique trends that are similar per year but different by gender. The 20-24 age group of male clients represented the largest group (in the past three years increasingly) among all clients as well as among new clients each year between 2001 and 2005. The same age group of female clients was the largest until 2004. In 2005 the 25-29 age group of all clients grew the largest and similarly to the previous years, the frequency was relatively high in older age groups as well.

Figure 6. Breakdown of male clients in treatment for drug use by age



Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

Figure 7. Breakdown of female clients in treatment for drug use by age



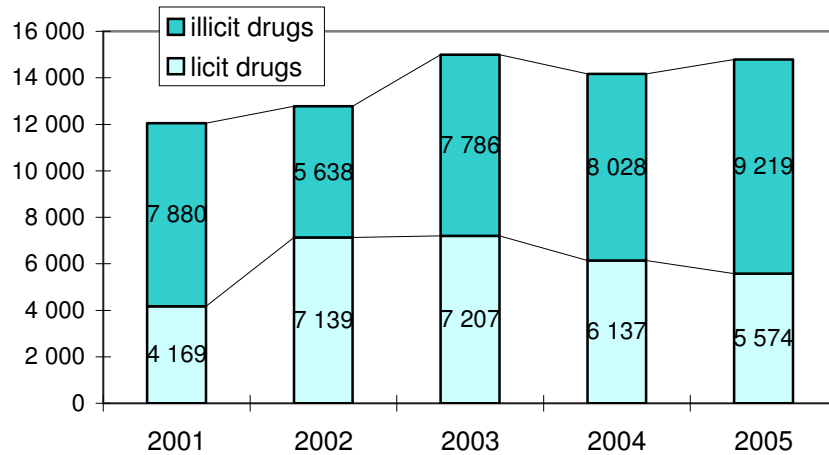
Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

The gender differences in the age groups may correlate to the abuse of sedatives and tranquillisers as well as these combined with alcohol (poly-drug use) by female clients which may lead to a longer drug career. The number of female clients over 40 largely exceeds the number of male clients.

Breakdown of clients by substance

In 2002, the share of licit substances (56%) exceeded illicit drugs (44%) because of a sharp increase in use of sedatives and tranquillisers. Besides a significant increase in the number of clients in treatment, illicit drugs took over again (with a share of 52%) in 2003. This tendency continued in 2004 and 2005: the number of clients using licit drugs kept decreasing, whereas the number of clients using illicit drugs increased significantly. Share of illicit drugs was 62% in 2005.

Figure 8. Breakdown of clients by substance



Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

The share of clients using opiates reached a peak of 39% in 2000 but it shows a continuous decreasing tendency until 2004. Although an increase of 5% was detected in 2005 the use of heroin and injecting drug use within this drug type kept decreasing. Due to this decrease, cannabis became the most frequently used drug. Opiate use took the third place after tranquillisers.

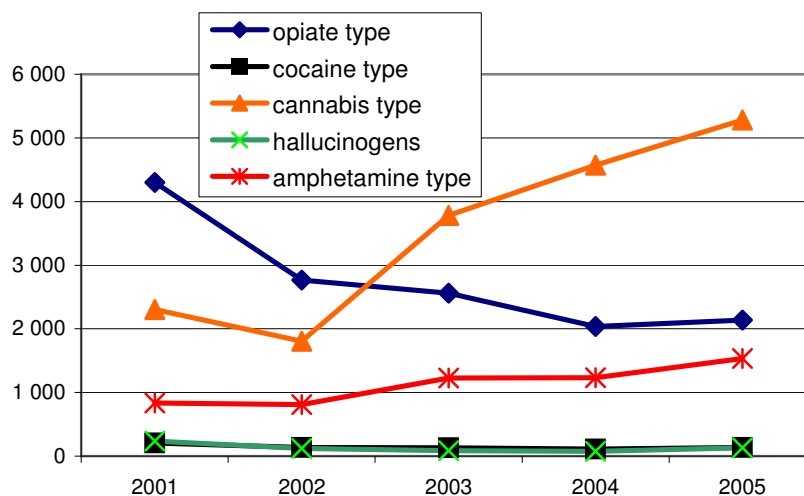
The number and proportion of cannabis users among all clients has been continuously and sharply increasing since 2002. The number of clients using cannabis grew by 21% in 2004, and by a further 16% in 2005. With a proportion of 36% they became the largest group among clients, surpassing tranquilliser users.

The number of clients using amphetamine grew by a significant 52% in 2003, but there was no change in 2004. Another major growth of 24% could be seen in 2005, meaning that 10% of all clients were amphetamine users.

Although after four years of constant decrease, the number of clients using cocaine increased by 22% (from 113 to 138) in 2005, their share among all clients reached 0.9%.

Following a steady decrease since 1999, the share of clients using hallucinogens increased considerably, by 72% from 76 to 131 in 2005. Their share is not significant (0.9%), similar to cocaine users.

Figure 9. Number of clients in treatment for illicit drug use



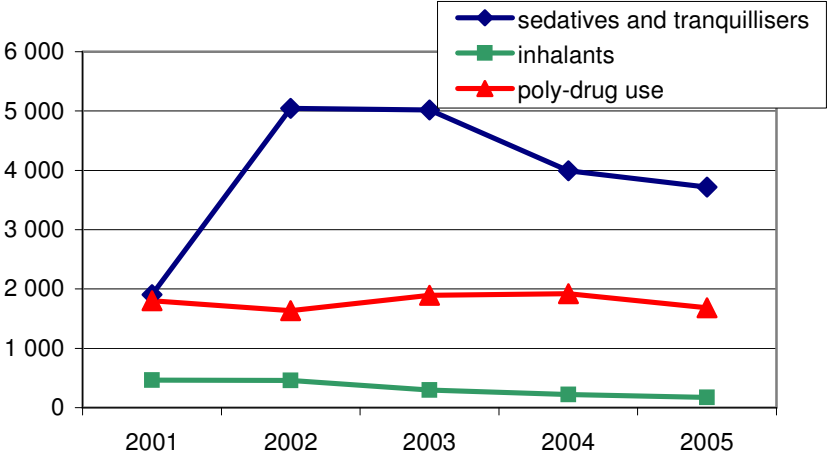
Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

The share of clients abusing sedatives and tranquillisers started to decrease in 2003. In 2005, they still represented a share of 25% among all clients, this is the highest not only among licit but – apart from cannabis – also among illicit drugs.

Although the number of clients for poly-drug use (sedatives and/or tranquillisers with alcohol) indicated some fluctuations in 2005, but it eventually remained constant in the average of the past five years' data. This “drug type” is particularly typical to female clients aged over 30-35. It represents a share of 11% among all users.

The number of clients using inhalants has constantly been decreasing and had a share of 1.2% among all clients in 2005.

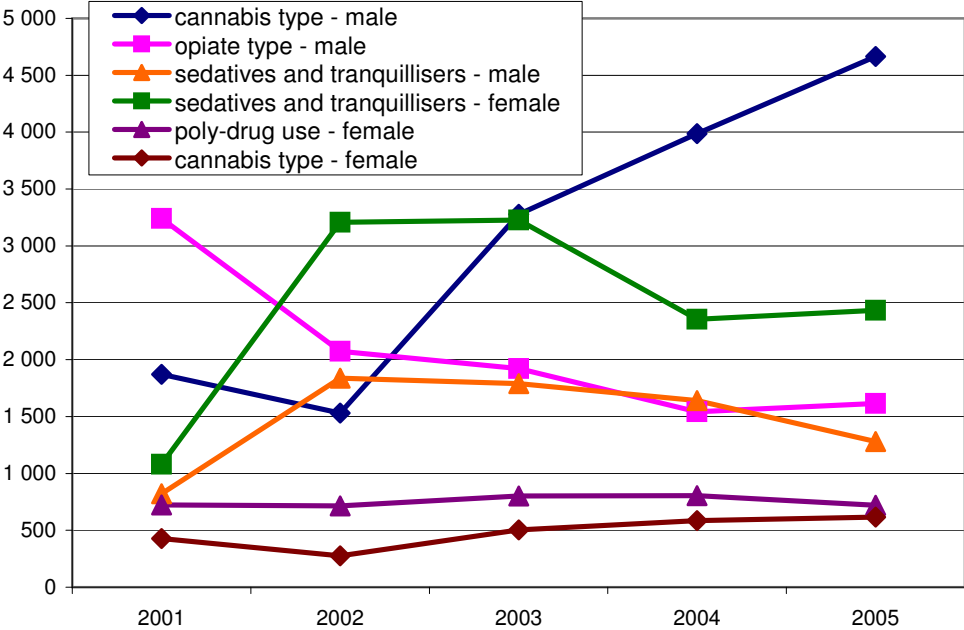
Figure 10. Number of clients in treatment for use of licit drugs



Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

The following figure illustrates gender-based differences in preference for each specific drug.

Figure 11. Substances mainly used by males and females (by number of users)

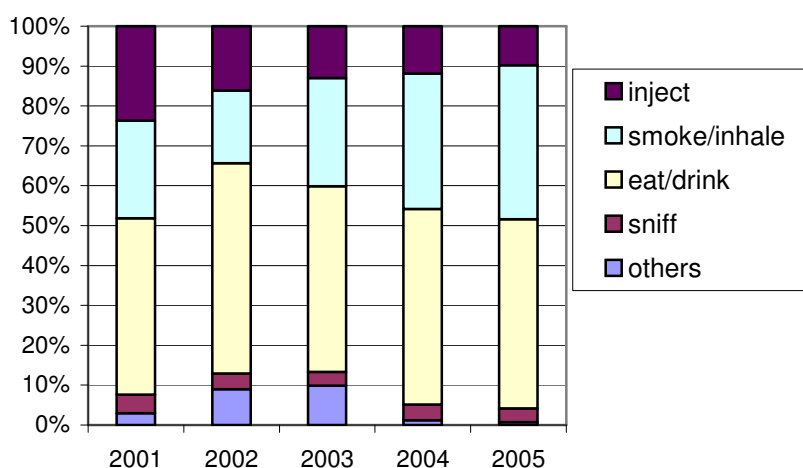


Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

Breakdown by route of administration

The routes of administration among clients considerably changed in the past five years. Injecting drug use has been constantly decreasing. Over the last five years it nearly halved compared to the level of 2001. In the same period, except for 2002, the share of smoking/inhalation eventually doubled. These two trends are clearly in line with the decrease of opiates and the rapid increase of cannabis among substances used. The share of oral administration of drugs (eating/drinking) also rose but not so sharply as the smoking of drugs. This is the most common route of administration among clients, which is in accordance with the large shares of sedatives, tranquillisers and poly-drug use. Sniffing has a small share and shows slight fluctuations. The “others” category represented a large share in 2002 and 2003 but has subsequently dropped back to tenth. This phenomenon may be explained by the fact that data providers are now able to report more detailed information on routes of administration, therefore they indicate the category “others” less.

Figure 12. Breakdown of clients by route of administration³¹



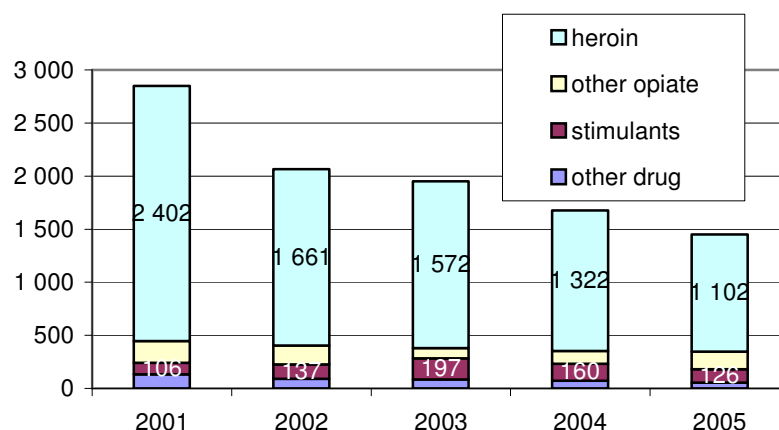
Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

Injecting drug use was decreasing among all clients in the past five years. In the background of the significant decrease (from 23.6% to 9.8%) is the fall of injecting heroin use. The share of injecting heroin use dropped 50% among injecting drug users in treatment in the period of 2001 to 2005.

Injecting use of other substances also shows a decreasing tendency: 8.2% of stimulants users injected the substance, while this share was two times higher in 2002.

³¹ Route of administration was not known in 19 cases in 2004.

Figure 13. Breakdown of injecting drug users in treatment (number)

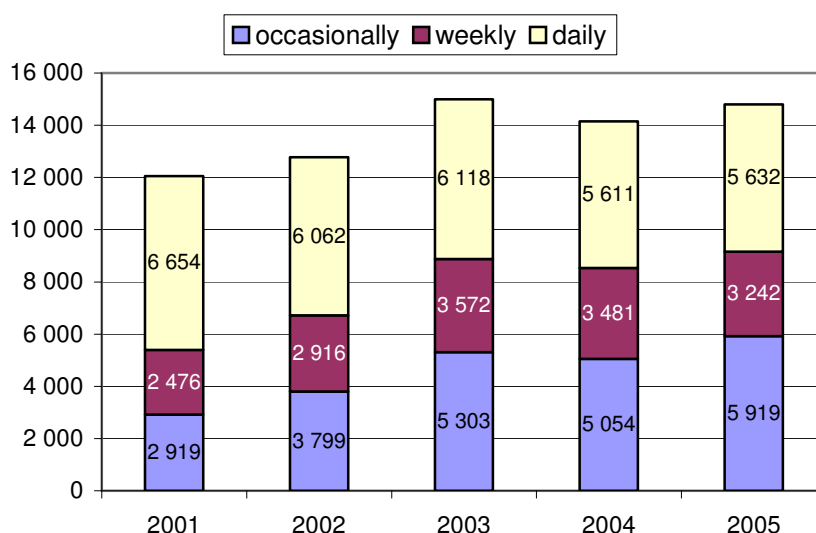


Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

Breakdown by frequency of use

The breakdown of the frequency of use among clients shows a mixed picture. Apart from a slight decrease in 2004, the number of all occasional users in treatment has been increasing. The number of those using drugs on a weekly basis increased between 2001 and 2003 which was followed by a slight decrease in the last two years. As regards the number of those using drugs on a daily basis, a decreasing tendency could be observed in general, apart from slight annual fluctuations.

Figure 14. Breakdown of clients in treatment by frequency of use (number)³²



Source: Report no. 1647 by OSAP and report no. 1211 by the Ministry of Health

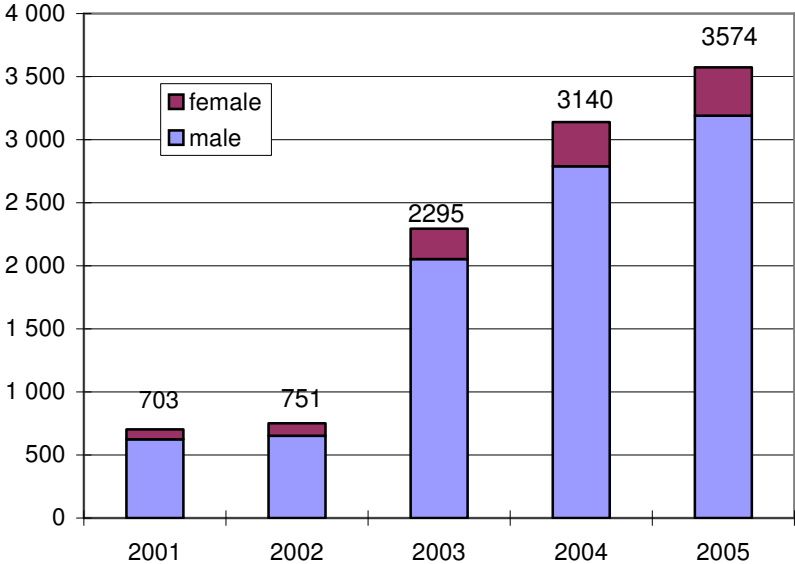
Changes in the number of clients in diversion

The number of clients in diversion hardly changed between 2001 and 2002. A break-through increase occurred in 2003, which may be attributed to the amendment to the Criminal Code. This increase continued in 2004 (37%) as well as in 2005 (14%). In 2005, 2,285 persons

³² No information were available on 19 cases in 2004

entered preventive-consulting service and 3,574 persons started diversion in one of the health care type services. The results of former surveys show that it is most likely that only a small portion of offenders were involved in criminal procedures for an offence in which cases diversion was no longer available since December 2004.

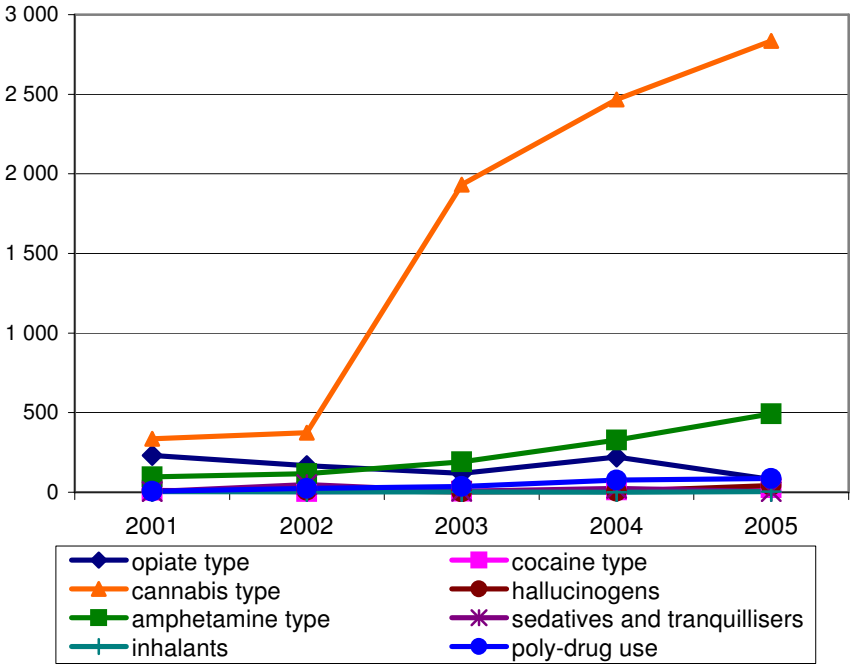
Figure 15. Number of clients in diversion



Source: Report no. 1647 and report no. 1211 by the Ministry of Health

The major increase from 2003 is due to the outstanding rise in the number of cannabis users in diversion (increase by 417% in 2003, by 71% in 2004 and by only 15% in 2005).

Figure 16. Breakdown of clients in diversion by drug type (number)



Source: Report no. 1647 and report no. 1211 by the Ministry of Health

In 2005, the number of clients in diversion for opiate use decreased by 64%, while the number of those involved in diversion for amphetamine use increased by 50% compared to the year before. Although the share of all other substances is small, it must be noted that the share of hallucinogens grew by six fold in the past year.

Gender differences of clients in diversion are even more remarkable than of all clients. Between 2001 and 2005 the share of female clients in diversion was 11%-13%, while nearly a third of all clients were women.

The Methodological and Legal Department of the Ministry of Justice Hungarian Probation and Legal Aid Service Directorate conducted a study in 2004. The study examined the experiences of probation officers regarding clients in diversion and primarily clients of preventive-consulting services. The study declares among other things that the majority of clients in diversion (especially those involved in preventive-consulting service) are young, adult males having some kind of qualification or graduated in a secondary school. They usually have an income or are supported, and they either work or study. At the beginning of their criminal procedure, they have no previous criminal record and the prosecutor does not claim any further rules of conduct. The charged usually have only little reliable information on the criminal and health correlation of diversion, although the majority of them have already participated in a preliminary status assessment.

In 2005, a test of the new data collection system was run in cooperation with selected preventive-consulting service providers managing a high number of consultations. On the basis of its results, the National Institute for Addictology found that 85% involved in preventive-consulting services were men. 65% to 80% lived with their parents, 50% were permanently employed and 25% to 40% were students.

The share of students was smaller (below 20%) in one of the services operating in an economically deprived region of the country, while the share of clients with elementary school education was the highest (60%) here. The substance most often used at the time the offence was cannabis. 85 to 95% of clients in diversion had not participated in drug-related treatment earlier.

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

No new information available.

Conclusions

Based on the number of problem drug users per 1000 inhabitants aged 15-64 (3.48) we may conclude that problem drug use is still less widespread in Hungary than in other countries of Europe. It is in accordance with findings coming from illicit drug epidemiology surveys and statistical data.

Treatment centres recorded 14,793 drug users in 2005. Compared to the previous year, the number of new clients increased by a significant 12% and reached 6,319. The number of heroin users in treatment and especially injecting users has been continuously decreasing since 2000. Since 2002, the proportion of cannabis users has been gradually increasing among clients, and it has recently been the "leading" drug type. The number of amphetamine users also increased in 2005. The share of cocaine and hallucinogen users has also been growing, but neither of these drug types reached 1%.

A break-through increase occurred in the number of clients in diversion in 2003, after the amendment to the Criminal Code. This increase continued in 2005, and this tendency was not significantly influenced by the decision of the Constitutional Court. The group of cannabis users has been dominant among clients in diversion since 2003.

5. DRUG-RELATED TREATMENT

Overview

Concerning drug-related health care, an increase in the number of clients in methadone maintenance treatment (MMT) could be detected in 2005. Institutional frameworks have not essentially changed: specialised outpatient centres provide drug-related treatment for the majority of clients. There are major differences in these centres' organisational forms (whether NGO or part of the national health-care system) and their equipment and professional staff, though the minimum conditions of providing health care services are declared by the regulation 60/2003 (X. 20.) of the Ministry of Health, Family and Social Affairs. Geographical coverage of treatment centres has not improved either: in certain regions treatment can only be accessed after travelling long distances.

The so-called output volume restriction (TVK) influences the financing of the health-care. What this means is that the health care costs arising at a treatment centre that exceed the subsidies allocated to that treatment centre in the preceding year are degressively financed by the National Health Insurance Fund (OEP). This implies that TVK limits the potential increase in the number of visits at treatment centres.

5.1. TREATMENT SYSTEM

Health care

As regards to health care, specialised outpatient centres have a growing importance in drug-related treatment besides the traditional role of addiction treatment outpatient centres (see ST24). Inpatient treatments also have a large share in health care. The table below shows the number and proportion of clients (including abusers of pharmaceuticals and inhalants) in different institute types of the health care system in 2005.

Table 6. *Breakdown of clients in drug-related health care by centre type in 2005*

Centre type	All clients		New clients	
	number	%	number	%
Addiction treatment outpatient centres	3,954	26.7	1,486	23.5
Specialised outpatient centres	5,270	35.6	2,958	46.8
Child and youths psychiatric outpatient centres	47	0.3	20	0.3
Psychiatric outpatient centres	269	1.8	165	2.6
Psychiatric and addiction-treatment inpatient departments	2,552	17.3	818	12.9
Other treatment centres (e.g. toxicology)	2,701	18.3	872	13.8
Total	14,793	100.0	6,319	100.0

Source: Report no. 1211 by Ministry of Health

In Hungary, data on clients have been collected since 1996. It was primarily data from the health care institutions and their service organizations that was collected, however, over the years the data collection has been extended to include emerging non-governmental and religious organizations as well.

Drug-related treatment is free of charge to drug users, i.e. they are entitled to the OEP's financing. There are two centres (Addiction-Treatment Outpatient Centres in Soroksár and

Szolnok) in Hungary that also provide drug-related treatment free of charge to clients, but they are financed by the Hungarian Interchurch Aid.

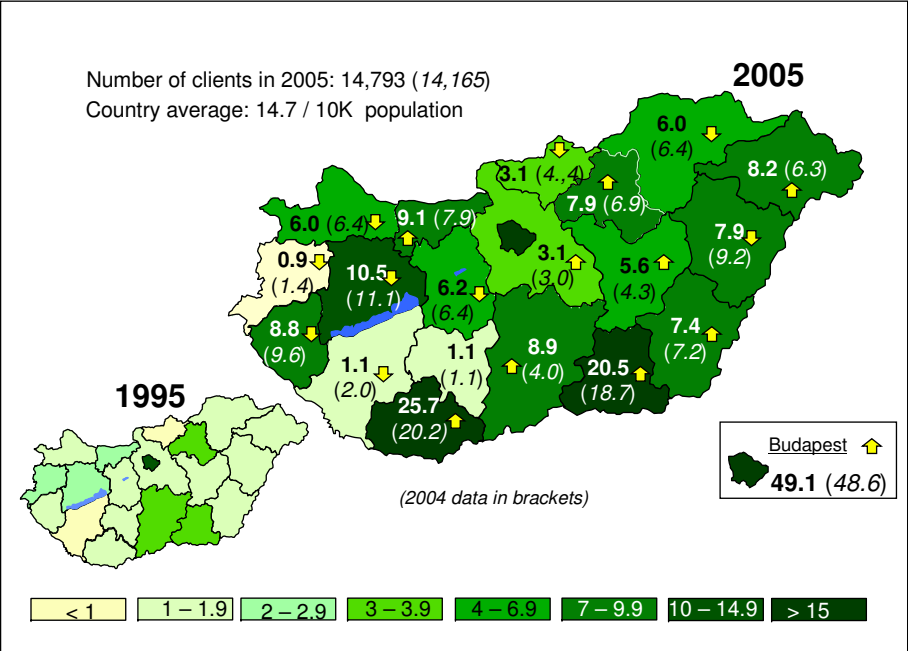
There are a number of private practices providing treatment for addicts in Hungary, but the costs must be covered by the clients themselves. The exact number of these private practices is unknown, they are roughly estimated at 50.

Geographical differences in treatment

Drug-related treatment is structured on a regional basis. Number of visits in a county is largely influenced by whether a specialised outpatient centre works within that particular county's borders.

There is no significant difference between the Eastern and Western part of the country in the number of clients per population. There is an outstanding difference between the Budapest metropolitan area and other parts of Hungary.³³ This difference has multiplied since 1996.

Map 1. Breakdown of clients by county in 2005



Source: Report no. 1627 by OSAP and Report no. 1211 by the Ministry of Health

According to the amendment of the Social Act³⁴ in 2005, in the frameworks of community-based addiction treatment, community-based care and outreach work can be provided with normative financing.

Although these forms of care are classified as social care in Hungary, the EMCDDA definition of TDI considers them – a part of community-based care and outreach – to be treatment forms. New forms of drug-related health care are not financed by the OEP, and that could be the reason for the increasing importance attributed to social care.

³³ There is a special Toxicology Department in Budapest providing emergency inpatient treatment (detoxication) for 50% of all clients.

³⁴ Act III of 1993 on Social Administration and Social Care

Social care

The situation is similar in other areas of social care as well. The National Institute of Family and Social Policy conducted a survey (Gyuris et al. 2005) by sending out questionnaires to social care centres taking care of addicts in 2005³⁵. Findings of this survey claim that there are four types of specialised social care centres: day-care centres; transitory homes; nursing and care homes; and rehabilitation centres. Some 98% of clients in nursing and care homes are alcohol addicts, the number of drug users is negligible. The ratio of drug users is 9% in transitory homes (for addicts), 33% in day-care centres and 25% in rehabilitation centres. These centres also provide treatment defined by EMCDDA's TDI. Only rehabilitation centres joined the national data-collection system.

A Hungarian therapeutic community (Leo Amici Foundation, Pécs) was awarded with the Euro TC (European Treatment Centres for Drug Addiction) quality assurance certificate in 2005. Further development in 2005 included the opening of the first private psychiatric and addiction-treatment health centre providing rehabilitation in Western Hungary. 24 persons were involved in treatment in 2005, around 40% were drug users (most of them heroin and cocaine users).

Diversion (see SQ31)

As a result of the amendment of the Criminal Code in 2003, the number of those diverted into treatment increased, which caused a growth in the number of institutions providing drug-related treatment.

In December 2004, the Constitutional Court formally narrowed the range of offences in which diversion was available as an alternative to prison. This limitation did not bring any noticeable changes in the operation of the institutions.

There are three ways to participate in diversion:

- through treatment for drug-addiction
- through other drug-related treatment (provided for e.g. non-addicted but co-morbid users)
- through preventive-consulting services.

The first two ones can only be provided by health institutions. Preventive-consulting services may also be provided by so-called prevention service providers accredited and financed by the National Institute of Drug Prevention.

Occasional users, mostly cannabis users, participate in preventive-consulting services. Such service is not classified as a treatment form in Hungary but according to the TDI definition of EMCDDA it can be regarded as treatment. All three treatment forms last for six months, irrespective of the client's health status and severity of drug use.

In 2005, there were 40 service providers in the country offering preventive-consulting services. The majority of them were operated by NGOs (16) or local governments (12) but church institutes (9), state institutions (2) and one business company provided this service, too.

5.2. DRUG-FREE TREATMENT

Inpatient treatment

Inpatient psychiatric and addiction-treatment centres are in charge of providing hospital care in case of withdrawal symptoms and other related or co-morbid psychiatric symptoms,

³⁵ The self-reporting questionnaires were filled in by 21 institutes reporting data on 305 clients. Regarding the geographical coverage, it included a day-care centre and a rehabilitation centre (apart from the Transdanubian Region) from all regions.

according to the place of permanent residence. Inpatient treatment is provided by psychiatric departments, addiction-treatment wards of psychiatric departments and, to a lesser extent, independent addiction-treatment departments. It is hard to give a realistic picture about addiction-treatment capacity (especially available for clients) and about the number of clients: a part of slots in addiction-treatment is financed as slots allotted to psychiatric patients. When drug users are treated for other than drug-related problems they are not reported as clients. The reason for that is the low score (Homogenous Group of Diseases) given for drug-related treatment which means low financing. Share of slots in inpatient addiction-treatment decreased from 13% to 10%.

Outpatient treatment

Specialised outpatient treatment service is provided by specialised outpatient treatment centres that operate within an inpatient department, independent specialised clinics, psychiatric and addiction-treatment centres and specialised outpatient centres providing care only for drug users. Care is provided by regionally competent centres. Number of visits in adult psychiatric outpatient centres increased in 2005 but the annual number of visits per client in such treatment centres decreased at the same time.

A new outpatient treatment centre, the Addiction-treatment Centre in Szolnok, was opened in 2005.

5.3. MEDICALLY ASSISTED TREATMENT

Medically assisted treatments are provided in both inpatient and outpatient centres in Hungary. It primarily covers methadone treatment, both withdrawal and maintenance treatments are available for clients free of charge. Medically-assisted treatment largely applies anti-depressants and pain-killers for withdrawal symptoms. Naltrexon is occasionally applied in treatment of opiate-addiction, especially in specialised outpatient centres.

There is no methadone treatment centre in Hungary, MMT programmes are operated by specialised outpatient centres. Preparations for the development of a new national methadone treatment protocol started in November.

Withdrawal treatment

Methadone treatment is applied for short-term detoxification in one hospital department in Budapest and in two further departments in the countryside. It is available to a limited number of clients. Outpatient treatment centres principally provide substitution treatment but long-term withdrawal treatment is also available in such centres. Since the fall of 2004, each client in methadone treatment in an outpatient centre may continue their long-term detoxification in the Rehabilitation Centre of Deszk.

Substitution treatment

Still 8 outpatient treatment centres provide substitution treatment (MMT) to clients. 3 of them operate in the capital. Since 2002, data have been collected and assessed by the specialised outpatient treatment centre of Nyíró Gyula Hospital.

766 clients entered MMT in 2005. 75% of clients participated in Budapest. There is also a long wait list with further applicants. They have to wait for 2-3 months.

Table 7. *Number of clients involved in MMT in 2005 by treatment centre*

Nyíró Gy. Hospital	Buda	Soroksár	Veszprém	Pécs	Gyula	Szeged	Miskolc
429	67	79	12	37	32	72	38

Source: Specialised Outpatient Treatment Centre of Nyíró Gyula Hospital

Table 8. *Breakdown of clients involved in MMT in 2005 by month*

Jan.	Febr.	March	April	May	June	July	August	Sept.	Oct.	Nov.	Dec.
453	451	489	498	505	524	443	466	428	428	413	405

Source: Specialised Outpatient Treatment Centre of Nyíró Gyula Hospital

Conclusions

As regards the number of treated drug users per population, there are considerable differences in the geographical coverage of the health care and these differences seem to be growing. The difference can be explained by the geographical coverage of the specialised outpatient centres: the largest centres are in Budapest, in Pest, Baranya and Csongrád counties which accept clients from surrounding counties as well.

The current financing system of health care does not enable any large increase in the number of clients. Therefore, treatment centres are not able to meet the increasing treatment demand (for e.g. methadone treatment).

According to the TDI definition, treatment is also available in the frame of social care (e.g. community-based care, outreach work) but regular data collection on clients is still not complete.

6. HEALTH CORRELATES AND OTHER CONSEQUENCES

6.1. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

Data on drug-related deaths in Hungary were collected again on the basis of reports prepared in the framework of the National Statistical Data Collection Programme (OSAP) in 2005. Data were corrected by experts of the National Institute of Forensic Medicine. Data were provided by the Institutes of Forensic Medicine, County Police Headquarters and the National Institute of Forensic Medicine. We define drug-related death as death caused by direct intoxication, i.e. direct overdose, and indirect drug-related death by nature or violence.

Direct overdoses

National data

The number of deaths cases due to illicit drug use decreased in 2005 compared to the years before. While the number of deaths caused by overdose was 40 in 2001, 32 in 2003 and 34 in 2004, 28 persons died due to overdose in 2005 (see ST05, 06).

Table 9. *Number of direct drug-related deaths in 2005*

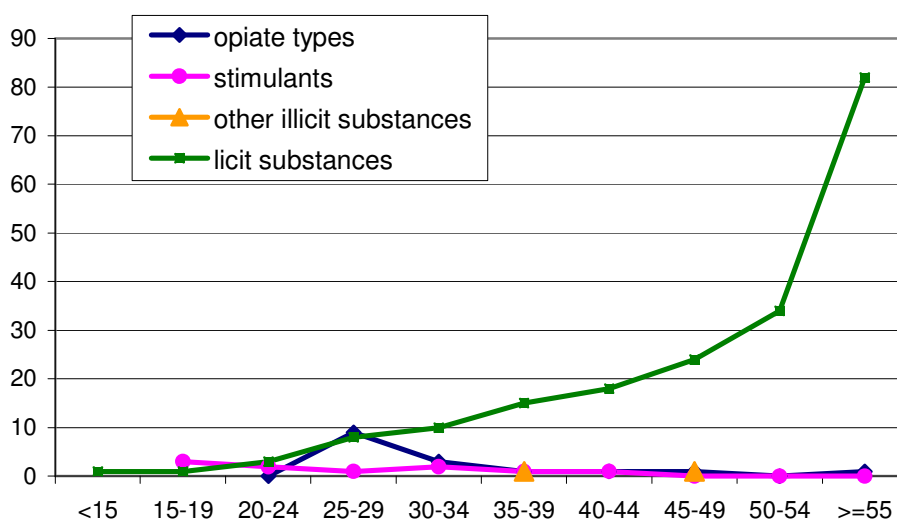
	Male	Female	Total
Heroin	12	1	13
Methadone	1	1	2
Other opiates	1	0	1
Hallucinogens	1	1	2
Amphetamines	6	0	6
Ecstasy (MDA, MDMA, MDE, MBDB, 4-MTA)	2	1	3
Cocaine	0	1	1
Illicit drugs TOTAL	23	5	28
Solvents, inhalants	5	3	8
Sedatives, tranquillisers	73	105	178
Poly-drug use	2	8	10
Total	103	121	224

Source: National Institute of Forensic Medicine

Opiate users still represent the highest proportion among overdose cases. The number of heroin overdoses has increased, while 8 users died due to heroin overdose in 2004, their number was 13 in 2005. The number of intoxications by amphetamines also grew in contrast to previous years. Three MDMA intoxications were recorded nationwide, while use of amphetamine derivatives caused 6 overdoses. Although the number of ecstasy pills seized by the Hungarian Customs and Finance Guard and by the Hungarian Police and analysed by the Criminal Professional and Researcher Institute increased, quantities and purity of heroin seized do not indicate any noticeable changes in comparison to those in preceding years. Two methadone overdoses occurred, both of the deceased persons participated previously in methadone treatment.

The number of overdoses related to licit drug use decreased but after a decrease in last year, the number of deaths due to solvent use increased again.

Figure 17. Drug-related deaths by age group and substance



Source: National Institute of Forensic Medicine

The mean age at deaths related to illicit drug use was 31.1 years: 32 years among males and 27 years among females, heroin overdoses occurred most often in the 25-29 age group. In case of licit substances, the mean age is 47 years among males and 49.5 years among females. Intoxications related to licit drug use indicate an increasing trend by age.

Ten deaths related to poly-drug use were caused by combined use of a psychoactive substance and sedatives and/or tranquillisers. Substances most often used are Tegretol (carbamazepin), Rivotril (clonazepam) and Andaxin (meprobamat).

The highest number of drug-related deaths was recorded in Budapest (86 deaths) followed by the county of Pest (29 deaths), Hajdú-Bihar (19 deaths), Vas (13 deaths) and Veszprém (14 deaths). The county of Baranya, Borsod and Tolna did not report any overdose cases related to either licit or illicit drug use in 2005. In the gender-based breakdown of drug-related deaths, no significant differences can be observed between the counties.

The number of deaths was the highest in Budapest both among males and females, which is obvious, since the number of registered drug users is the highest in the capital.

Indirect drug-related deaths

Indirect deaths include cases that are not directly related to overdose. Deaths by violence where a positive toxicological result was found and deaths by drug-related diseases classify as indirect drug-related deaths.

Acts of violence include acts as set forth by Decree no. 34/1999 (IX.24.) of the Minister of Interior, the Minister of Justice and the Minister of Health, which are, for example, (traffic, labour, etc.) accidents, suicide, hypothermia and act by a third party.

Table 10. Indirect drug related deaths among cases of deaths caused by violence

	Male	Female	Total
Heroin	2	1	3
Cocaine	1	0	1
Cannabis	1	0	1
Amphetamines types	6	1	7
Sedatives, tranquillisers	11	6	17
Total	21	8	29

Source: National Institute of Forensic Medicine

In cases of deaths caused by violence amphetamines were traceable in 7 cases, where accident was identified as the cause of death. 3 indirect deaths related to opiate use occurred in Budapest, the cause of all 3 was related to traffic accidents. THC was traceable in the blood of one deceased who died of hypothermia.

Drug-related diseases, like endocarditis, may also classify as causes of indirect deaths. Nevertheless, such diseases often remain hidden as a cause of death, since no preliminary, detailed anamnesis is usually available on them and no autopsy is performed. According to data on Budapest, acute endocarditis that was followed by sepsis developed in 2 cases related to injecting heroin use. Lethal complications developed in 3 cases related to amphetamine use. Cardiac failure caused by cardiomegalis (Vályi 2005) related to amphetamine abuse was determined to be the cause of one of these deaths. Two deaths were caused by hyperthermic crisis due to high fever, acute liver and renal insufficiency and blood coagulation disorders related to MDMA use. Drug users usually fail to indicate preliminary drug use at hospital or primary care, that is why it is lengthy to set up a diagnosis and many other diseases need to be excluded.

Two HCV-positive results and 1 HCV-HBV-positive result were found among drug related deaths cases in Budapest during HIV, HCV and HBV testing. All 3 deceased were injecting heroin users, whose deaths were caused by heroin overdose.

Mortality and causes of deaths among drug users

No information available.

6.2. DRUG-RELATED INFECTIOUS DISEASES

Infectious diseases transmitted through injecting drug use

Similar to last year, relatively little information is available on the prevalence of HIV, HBV and HCV among injecting drug users (IDUs) in 2005 (Csohán et al. 2006). In this year's national report, we can only report on the results of serological tests for HIV, HBV and HCV done on injecting drug users, which were carried out in regional microbiological laboratories of the State Public Health and Medical Officer Service.

HIV/AIDS

In 2005, 106 newly-revealed HIV positive cases were reported, thus the incidence of HIV infections was 40% higher (10.4 cases/million population) compared to the year before (7.4 cases/million population). 17.9% of all newly registered HIV positive person were foreign citizens.

Table 11. Registered HIV positive persons by risk groups

Year	Homo/bisexual	Heterosexual	Haemophiliac	Transfusion recipient	Injecting drug users	Nosocomialis	Maternalis	Unknown	Total
2001	35	20	0	2	3*	0	0	22	82
2002	35	26	0	0	1*	0	0	16	78
2003	34	18	0	0	1*	0	0	10	63
2004	45	13	0	0	2*	0	0	15	75
2005	55	20	0	0	2**	3*	0	24	104
Total	204	97	0	2	9**	3*	0	87	402

* Imported cases. ** Together with imported cases.

Source: National Centre for Epidemiology (Csohán and Lendvai 2006)

The cause of infection remained hidden in case of 23.1% of HIV-infections revealed in 2005. The overwhelming majority (67%) where the transmission route is known belonged to the homo-/bisexual risk group. Only 2.5% (2 persons) were infected through injecting drug use. Only 1 of the 2 HIV-positive injecting drug users was a Hungarian citizen whose infection was revealed in the phase of AIDS.

The HIV/AIDS situation in Hungary may not be considered unfavourable even though the incidence of infections increased in contrast to last year's level. This increase draws the attention to develop programmes aimed to screen and educate risk groups.

Acute Hepatitis B

In 2005, 119 acute infections were reported, that is 9.2% less than in the previous year. The annual incidence was 119 cases/100K population.

The transmission route was known in less than 50% of all cases. The proportion of drug users among patients decreased compared to last year: 1 patient, representing a mere 2.1% of all patients in identified risk groups, was an injecting drug user. This male patient, who was younger than 25 and lived in Budapest, was not vaccinated against Hepatitis B. (ST9 N4 Results HBV notif). As expected, no acute hepatitis B infection was diagnosed among injecting drug users (between ages 14 to 20) who had been immunized by HBV vaccination.

Table 12. Number and proportion of IDUs among reported acute HBV-cases

Year	Reported acute HBV infections		
	Number	IDUs Number	%
2001	159	6	3.8
2002	159	6	3.8
2003	143	7	4.9
2004	131	6	4.6
2005	119	1	0.8
Total	711	26	3.7

Source: National Centre for Epidemiology (Csohán and Kaszás 2006)

Acute Hepatitis C

Less acute Hepatitis C cases (22) were reported in 2005 than in the year before (40). A 13.6% of patients (compared to 27.5% in 2004) in identified risk groups were infected through injecting drug use.

The number of acute HCV infections diagnosed among injecting drug users decreased between 1998 and 2003. Only 2 infections were reported in 2003 followed by an abrupt increase up to 11 in 2004. In 2005, only 3 infections (2 males and 1 female) were reported again. One of these 3 patients was younger than 25 and 2 of them belonged to the 25-34 age group (ST9 N2 Results HCV notif). The youngest patient was 24, the oldest was 30. Most patients with acute hepatitis C lived in Budapest.

Table 13. *Number and proportion of IDUs among reported acute HCV patients*

Year	Reported acute HCV infections		
	Number	IDUs Number	%
2001	43	5	11.6
2002	42	3	7.1
2003	30	2	6.7
2004	40	11	27.5
2005	22	3	13.6
Total	177	24	13.5

Source: National Centre for Epidemiology (Csohán and Kaszás 2006)

Prevalence of HIV, HBV and HCV infections among IDUs

On request of specialised outpatient treatment centres, seven institutes in the counties of Baranya, Bács-Kiskun, Békés, Borsod-Abaúj-Zemplén, Csongrád, Hajdú-Bihar and Veszprém, run by the State Public Health and Medical Officer Service (ÁNTSZ), provided data on results of tests for HIV, HBV and HCV on injecting drug users in 2005. These tests were carried out in regional laboratories of ÁNTSZ.

HIV prevalence among IDUs

Seventy-nine tests were carried out on 57 male and 22 female IDUs. All results were negative. Some 26.6% were younger than 25, 58.2% belonged to the 25-34 age group, and 15.2% were older than 34. (ST9 P2 results prev HIV)

HBV prevalence among IDUs

Eighty-two HBsAG tests were carried out on 59 male and 23 female IDUs. None of them had a positive test result. Some 29.3% were younger than 25, 54.9% belonged to the 25-34 age group, 15.8% were older than 34. (ST9 P2 Results prev HBV)

HCV prevalence among IDUs

Eighty-two tests were carried out for HCV-antibody on 59 male and 23 female IDUs, of which 9 (10.9%) were infected with HCV. Prevalence of HCV infections was lower than that measured in a similar population a year before. Prevalence of HCV infections among males and females indicated only a slight difference, with 11.9% of males and 8.7% of females had positive test results. (ST9 P2 Results prev HCV)

Table 14. HIV, HBV, HCV infections among IDUs

Age group		Persons tested for HIV antibody		Persons tested for HBsAg			Persons tested for HCV antibody		
		Number of tests	Positive results	Number of tests	Positive results Number	%	Number of tests	Positive results Number	%
below 25	Male	16	0	17	0	0.0	16	0	0.0
	Female	5	0	7	0	0.0	6	2	33.3
25 to 34	Male	33	0	33	0	0.0	34	5	14.7
	Female	13	0	12	0	0.0	13	0	0.0
over 34	Male	8	0	9	0	0.0	9	2	22.2
	Female	4	0	4	0	0.0	4	0	0.0
Total	Male	57	0	59	0	0.0	59	7	11.9
	Female	22	0	23	0	0.0	23	2	8.7
Total		79	0	82	0	0.0	82	9	10.9

Source: National Centre for Epidemiology (Csohán and Kaszás 2006)

Tuberculosis and drug use

A surveillance centre run in the Korányi National Institute for TB and Pulmonology started to monitor drug use as a risk factor in April 2005 (Jónás et al. 2006).

Table 15. Risk factors found with patients suffering from tuberculosis

Risk factor	Number of cases	% of cases
Alcohol addiction	375	18.5
Homeless	162	8.0
Contact person	57	2.8
Immigrant	14	0.7
Health professional	19	0.9
Living alone	129	6.4
Diabetic	69	3.4
Treated with steroid	14	0.7
Closed community ³⁶	78	3.9
Drug user	1	0.05
HIV infection	7	0.3
Other risk factor	385	19.0
No risk factor	983	48.6
Incidence	2024	113%*
Total	2292*	

* The total is higher than the total number of patients/ or % because more risk factors could be indicated per one case.

Source: Epidemiological and operational data of treatment centres for pulmonary diseases, 2005

One drug user was diagnosed with tuberculosis in 2005.

The most frequent risk factors were alcohol addiction and homelessness. The prevalence of tuberculosis among the homeless is twelve times higher than the average. It is a major

³⁶ Prison, nursing home, care home, children's home.

problem in the capital, where 162 from 522 persons infected with tuberculosis are homeless. (Jónás et al. 2006)

Screening for infectious diseases in prisons³⁷

The system of screening in prisons changed as Decree no. 25/2003 (VII.1.) of the Minister of Justice³⁸ entered into force.

Before 2003, the test for HIV was carried out on each newly-admitted prison inmate. In accordance with the new system of screening, the HIV test may be carried out on voluntary basis, on request of the inmate after information is given by the doctor responsible for admission. Following procedural provisions, anonymous tests may also be carried out. Tests are done by laboratories determined in a separate law. Due to the amendment to the aforementioned regulation of the Minister of Justice, inmates are informed about the rules of screening in an information booklet in 17 languages.

Prior to the afore-mentioned regulation, the average number of HIV tests was more than 17,000. After the amendment this number significantly decreased to 2,294 in 2005. There weren't any additional positive test results found: 8 HIV positive prison inmates are known. Only one of them was related to drugs.

6.3. PSYCHIATRIC CO-MORBIDITY

No new information available.

6.4. OTHER DRUG-RELATED HEALTH-CORRELATES AND CONSEQUENCES

Consequences of drug use during pregnancy, embryonic drug syndrome

Use of licit and illicit drugs may cause severe tocological complications and damage to the embryo during pregnancy. (Görbe 2006) Substances with light-weight molecules like cocaine, heroin, alcohol, nicotine, pharmaceuticals; easily pass through the placenta and get into embryonic tissues (Szabó 2006).

Table 16. *Drug-related health correlates to newborns*

Cannabis derivates	<ul style="list-style-type: none"> - no teratogenic effect - fine tremor - increased reflexes and frequent awakening - sleep disorders for years - behavioural and emotional problems, learning disability
Cocaine	<ul style="list-style-type: none"> - premature birth, stillbirth, asphyxia, placenta ablation - cardiovascular, renal, urogenital and gastrointestinal teratogenic effects - intrauterine retardation, microcephalia (a development disease, where small circumference of the head is typical, intracranial haemorrhage, spasm - higher blood-pressure, urinary tract infections, Necrotizing Enterocolitis - scarce withdrawal symptoms

³⁷ Based on the report of the Hungarian Prison Service

³⁸ Regulation of the Minister of Justice no. 25/2003. (VII. 1.) on the Amendment to Regulation of the Minister of Justice no 5/1998 (III. 6.) on Health Care provided to Prisoners. Pursuant to this regulation, the opportunity shall be provided to prisoners to take part in EKG screening and routine lab tests aimed at early diagnosis upon first admission. Furthermore they shall be provided with the opportunity to participate in pulmonary and dental screenings on a yearly basis and annual gynecological screening shall be available to female prison inmates.

	<ul style="list-style-type: none"> - apnoea, periodic respiration - increasing number of SIDS - dissatisfactory relationship of mother and child, child abuse - maternal and embryonic anaemia
Opiates	<ul style="list-style-type: none"> - toxemia, asphyxia, atrophy, premature placenta ablation - anomalies do not occur more frequently - withdrawal symptoms after 48 hours recurring until an age of 4 to 6 weeks - tremor, irritability, convulsions, spasms - nurturing difficulties, vomiting, diarrhoea - high toned crying, fever, pallor
Amphetamines	<ul style="list-style-type: none"> - placental haemorrhage - IUGR, premature birth - congenital deformities (microcephalia) - behavioural problems: tremor, high blood-pressure - ecstasy: skeletal, cardiac disorders (deformities of the osseous system and heart disorders)
Sedatives/tranquillisers	<ul style="list-style-type: none"> - no intrauterine retardation - irritability, recurrent crying and singultus at an approximate age of seven days (2-14) - sub-acute symptoms: increased appetite, regurgitation, vomiting, anxiety, exudation

Source: Szabó (2006)

Neonatal withdrawal syndrome usually develops within 72 hours after birth and may last for a few hours up to two weeks. The syndrome culminates on the third day after birth and its symptoms subsided in a week on average. The so-called Finnegan score is adopted to recognize and assess symptoms of neonatal withdrawal. It summarizes all symptoms in a table and allocates scores to each to enable quick assessment. The medical treatment of an infant is determined based on these scores, which must be checked several times a day.

Treatment of newborns born to drug users

Schöpf-Merei Hospital, Budapest

Schöpf-Merei Hospital has been running a “Baby Rescue Programme” since 1996. This programme aims at supporting women in crisis caused by social circumstances, homelessness, financial difficulties, relationship problems, a hidden pregnancy, abuse, drug use, and minor or neglected pregnancy. These crises are managed by a doctor, a nurse, a social worker and a psychologist together. A district unit of the National Child Welfare Service has also been set up in the hospital. (Vajda 2005)

The operators of the programmes only accept voluntary applications. In case of those incapable of submitting their own application, the application may also be submitted by their legal representative. If that is not feasible, involvement of such applicants in care may also be ordered by law.

Table 17. Breakdown of 1,260 pregnant women involved in care provided through the „Baby Rescue Programme” (1996-2004)

Marital status	Single	915
	Divorced	45
	Married	210
	Common-law marriage	60
	No data	30
Place of residence	Budapest	611
	Countryside	349
	Homeless	223
	No data	77
Custody of newborns	Adoption	172
	Placement with another family	1
	Infants' home	330
	Placement with the birth family	499
	Shelter for mothers	108
	Family shelter	30
	Foster-parents	30
	Infants' home also providing shelter to mothers	15
	Born in another hospital	57
	Redirected to an addiction-treatment inpatient department during pregnancy	18

Source: Vajda (2005)

In the past ten years, 1,400 pregnant women were interested in the programme and 1,260 gave birth in Schöpf-Merei Hospital. Eighteen of them were sent to different addiction-treatment inpatient departments and 15 newborns were taken into care, whose mothers used drugs during pregnancy (verified by a drug test). (Szabó 2006)

Drug-using mothers who gave birth in the Schöpf-Merei Hospital were of between 16 and 32 years of age. Glue sniffing was typical among mothers at the age of 16-17, while heroin use was characteristic of mothers between 20 and 30 years of age. Poly-drug use can also be considered frequent. Such pregnancies were usually neglected or prenatal care started shortly before birth. Therefore, necessary tests (AFP, HBsAg, VDRL, and ultrasound) were not always carried out. Lack of medical examinations resulted in increased risk of anaemia, malnutrition and infectious co-morbidity (Hepatitis C, condyloma, STD).

Drugs passing through the placenta directly caused intrauterine retardation and premature birth. Abruption related to cocaine use - caused by the abrupt detachment of the placenta from the uterus that leads to premature birth where mother and child may both suffer from anaemia - was observed. Newborns often needed to be resuscitated, which correlated to the date of last drug use and the substance used. Low Apgar-score was observed³⁹ among children of heroin using mothers.

Withdrawal symptoms (Finnegan-score) were intense with newborns whose mothers used drugs shortly before birth. Spasms developed in a heroin-using mother's baby a few hours after birth. In case of high Finnegan-scores, combined treatment of the baby was needed for a longer period of time. Symptoms like diarrhoea, exudation, vomiting and excoriations observed in the acute phase subsided, but chronic neurological symptoms endured for weeks.

This also emphasizes the importance of follow-up of newborns. Because of the mother's neglected and non-treated drug addiction and often chaotic social and family circumstances,

³⁹ It measures each newborn on a scale ranging from 0 to 10 along five health aspects: pulsation of the heart, respiration, activity, reflexes and complexion. The maximum score is 10.

most of the newborns were placed at infants' homes, and in only 5 cases were mothers allowed to take their newborns home with them.

Gynaecology and Obstetrics Clinics No. 1 of the Semmelweis University, Budapest (Görbe 2006)

Three newborns were treated for neonatal withdrawal syndrome in the Neonatal Intensive Care Centre (NIC) run in the Gynaecology and Obstetrics Clinics No. 1 of the Semmelweis University.

Table 18. *Data on neonatal withdrawal syndromes diagnosed in the Neonatal Intensive Care Centre (NIC) run by the Gynaecology and Obstetrics Clinics No. 1 of the Semmelweis University, 2004-2005*

Year	Total number of childbirths	Number of treatments for neonatal withdrawal syndrome	Gender	Premature births	IUGR ⁴⁰	Drug	Ultrasound	EEG ⁴¹	Malformation ⁴²
2004	3557	1	Male	-	+	Heroin-methadone	-	-	+
2005	3641	2	Female	+	+	Andaxin	+	-	-
			Female	+	+	Poly-drugs	+	+	-

Source: Görbe (2006)

Two of the 3 newborns were born as premature babies. All 3 of them were diagnosed with intrauterine retardation.⁴³ There was 1 case, where Caesarean section was needed because of the mother's (Andaxin) intoxication.

One baby was diagnosed with malformation (bilateral dilatation of the renal pelvis). This baby's nephrologic care started.

Two newborns were diagnosed with malformation that was detectable by ultrasound. One of them had cardiovascular troubles (caused by the mother's meprobamat intoxication), while the other one was diagnosed with increased echogenity⁴⁴ and cystic leucomalacia. Such cysts develop in three to four weeks, suggesting intrauterine encephalic circulation troubles and/or anoxia. Withdrawal symptoms in one case were accompanied by changes in brain waves on EEG recordings that indicated spasms and a reduced basic activity of the brain. It was assessed as a symptom of developing epilepsy and the medicine used in treatment was replaced by carbamazepine, a spasmolytic medicine. Hearing tests (TOAE) of all the 3 newborns produced normal results on both sides.

Resuscitation and artificial respiration of one of the newborns was needed to be administered in the maternity ward. A temporary artificial respirator was needed for two babies.

Such cases are small in number, yet severe in nature: almost all of these patients need immediate treatment, artificial respiration and continuous monitoring in the maternity ward. One newborn was diagnosed with withdrawal symptoms verified by the Finnegan score (18). In other cases, chronic convulsions, starring, changes in EEG or increased irritability served as grounds for spasmolytic treatment.

Each case needed intensive care and continuous monitoring.

⁴⁰ IUGR: Intrauterine growth retardation.

⁴¹ EEG: elektroencephalogram, is a drawing on the electric activity of the brain.

⁴² Malformation, growth deformity at birth.

⁴³ Intrauterine retardation was defined on the basis of the textbook titled „A szülészet és nőgyógyászat” written by Zoltán Papp (Semmelweis Kiadó, 2002).

⁴⁴ Echogen indicates more dense areas than ultrasound. It may also show cardiovascular troubles, oedema, but by all means an anormal picture.

Drugs intoxications

The Health Toxicological Information Service (ETTSZ), a department of the National Institute of Chemical Safety of the József Fodor National Centre of Public Health keeps records of intoxications that are reported by health centres.

The centre reported on 307 drug-related intoxications and 26 intoxications related to the use of inhalants in 2005. The gender-based breakdown of intoxications shows a larger share of males: 72% of illicit drug-related intoxications and 88.5% of inhalants related intoxications were males. Concerning the substances used, one third (34.2%) of all reported intoxications were caused by heroin overdose followed by herbal cannabis (22%) and amphetamines (12.4%). Nearly half of the intoxications (45%) were reported at the age group of 15-24, where most intoxications were related to herbal cannabis and ecstasy use. In the age group of 25-34 more than half of the intoxications were related to heroin overdose followed by ecstasy overdose.

In 73% of intoxications related to the use of inhalants, some kind of solvent was inhaled. More than half of these intoxications (58%) occurred in the age group of 25-34.

Table 19. Breakdown of intoxications related to illicit drug use by age groups in 2005

		< 15	15-24	25-34	35-44	45-54	55-64	>= 65	Total
<i>Opiates</i>	Opium, morphine	0	1	1	2	0	0	1	5
	Opiate-glutemicid	0	0	1	0	0	0	0	1
	Heroin	0	26	67	10	2	0	0	105
	Poppy tea	0	0	1	0	0	0	0	1
<i>Cocaine</i>	Cocaine	0	1	6	3	1	0	0	11
<i>Cannabis</i>	Cannabis resin	1	0	0	1	0	0	0	2
	Herbal cannabis	5	47	10	3	2	0	1	68
<i>Hallucinogens</i>	LSD	0	0	0	0	0	0	0	0
<i>Amphetamines</i>	Amphetamine	2	14	7	7	5	1	2	38
	Speed	0	11	7	0	0	0	0	18
	Ecstasy	0	27	5	1	0	0	0	33
<i>Other drugs</i>		0	11	11	1	2	0	0	25
TOTAL Illicit drugs		8	138	116	28	12	1	3	307

Source: Report on intoxications, 2005

Table 20. Breakdown of intoxications related to inhalants use by age groups in 2005

		< 15	15-24	25-34	35-44	45-54	55-64	>= 65	Total
<i>Organic solvents</i>	Nitrogen-based solvents	0	2	2	0	1	0	0	5
	Other solvents	1	3	9	0	0	1	0	14
<i>Glues</i>	Pálmatex, Technokol	1	0	1	0	0	0	0	2
<i>Other solvents</i>		0	2	3	0	0	0	0	5
TOTAL Intoxications related to the use of inhalants		2	7	15	0	1	1	0	26

Source: Report on intoxications, 2005

Conclusions

Considering recent trends, the number of deaths related to direct overdose decreased. Opiate users still represent the highest proportion among overdose cases. Compared to last year, an increase can be observed in the number of intoxications by heroin and by amphetamines. Still very few information is available on indirect drug-related deaths cases. Cases of deaths due to disorders or caused by violence related to drug use remain hidden in many cases because no forensic autopsy is carried out.

HIV, HVB and HCV prevalence among injecting drug users did not show any significant changes in 2005 compared to the year before. It is hard to understand the real epidemiological situation, because hardly any studies were published over the year that included valuable information on screening injecting drug users.

In Hungary, there is no uniform data collection on drug use during pregnancy and newborns with embryonic drugs syndrome. Studies of two hospitals in Budapest show that drug use remains hidden in most cases. There is no information on the number of newborns treated in neonatal intensive care because of the mother's drug use during pregnancy.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

7.1. PREVENTION OF DRUG-RELATED DEATHS

No new information available.

7.2. PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

New developments

The low-threshold service was dealt with in the amended Social Act⁴⁵ in December 2005 among primary social care, within community-based care. The amendment comes into force on January 1, 2007.

The elaboration of normative funding for low-threshold services is currently in progress. The local government of each settlement with a permanent population of at least 30,000 has to provide accessibility to low-threshold services by December 31, 2007.

Syringe exchange programmes (see ST10)

Thirteen organisations operated syringe exchange programmes in 2005, of which 4 were in Budapest. A new programme was launched in Békéscsaba, where syringe exchange was provided in outreach work. A further change is that the fixed needle and syringe exchange programme (NSP) was terminated in the specialised outpatient treatment centre in Miskolc in 2005, but since December 2004, a syringe vending machine has been operating.

Further organisations operate in the following cities: Debrecen, Gyula, Kecskemét, Miskolc, Pécs, Szeged, and Veszprém.

Injecting drug users have the option of turning to 2 fixed NSPs in Budapest and 4 in other cities. In the frame of these 6 programmes 58,504 needles and syringes were distributed, representing a 92% increase. Of this outstanding increase 97% was due to the turnover of needles and syringes of the programme run by the Drug Prevention Foundation, Budapest. The number of needles and syringes distributed in other cities varied from 210-370. The proportion of needles and syringes returned by clients was 56% in fixed syringe exchange programmes across the country, which represents a 5% reduction.

The turnover at vending machines nearly tripled: 20,263 needles and syringes were distributed in 5 programmes (1 in Budapest). During the year, 496 needles and syringes were found in special waste containers placed in the vicinity of a few vending machines (mainly in Miskolc).

Two services in Budapest provided mobile syringe exchange. The number of needles and syringes distributed doubled (5,500 pieces) but the return rate decreased from 83% to 68%. In outreach programmes (2 in Budapest and 3 in other cities) 20,823 needles and syringes were distributed. These programs maximize the chances of reaching hidden injecting drug users and providing needle and syringe exchange to them. This represents a significant decrease (from 38,742 in 2004), although return rate significantly improved from 55% to 74%. Three programmes involved peer users in outreach work.

⁴⁵ Act III of 1993 on Social Administration and Social Care

Table 21. *Data on needle and syringe circulation and client contacts of NSPs, 2003-2005*

	Fixed programme	Mobile programme	Outreach programme	Vending machine	Total
2003					
Distributed	19,600	682	28,970	2,415	51,667
Returned (and collected)	7,984	695	15,081	5	23,764
Return rate	40.7%	101.9%	53.1%	0.2%	46.5%
Number of clients	490	37	424	-	951
Number of client contacts	2,321	912	426	-	3,659
2004					
Distributed	30,649	2,870	38,742	7,510	79,771
Returned (and collected)	18,739	2,370	21,384	65	42,558
Return rate	61.1%	82.6%	55.2%	0.8%	53.4%
Number of clients	561	82	471	-	1,114
Number of client contacts	3,665	1,590	1,007	-	6,262
2005					
Distributed	58,804	5,500	20,823	20,263	105,390
Returned (and collected)	32,941	3,722	15,343	496	52,502
Return rate	56.0%	67.7%	73.7%	2.4%	49.8%
Number of clients	440	131	388	-	959
Number of client contacts	5,172	2,148	1,380	-	8,700

Source: National Focal Point

The total number of needles and syringes distributed increased by 32% in 2005 compared to the year before, and the return rate decreased by 3%. According to the data, 959 clients were involved in NSPs. This was a 13% decrease; however, the increasing number of needles and syringes per person implies secondary exchange. The number of needles and syringes per person was 54 in 2003, 72 in 2004 and 110 in 2005. The number of client contacts was 8,700, which also indicates a significant increase of 39%.

NSPs in Budapest and the Budapest Police Headquarters agreed that the use of an anonymous client card given by NSPs would exempt clients of NSPs from police measures, provided that sterile or discarded needles and syringes were found on them. According to the experiences of syringe exchange providers, the usage of this client card is not trouble-free yet, but it is constantly improving.

The situation is different in other cities. Before the nationwide extension of the client card, the National Police Headquarters turned to the General Prosecutor's Office and asked for a statement⁴⁶ that resulted in a failure of the cause.

Prevention of drug-related infectious diseases

In accordance with the national medical officer's order (since August 2005), regional laboratories of the ÁNTSZ (nationwide coverage) carry out free of charge HIV/HCV testing of samples of IDUs, sent in by specialized outpatient and other treatment centres.

⁴⁶ "Assistance to illicit drug use in any way and with any purpose – as I understand – suggests a suspicion of a crime. Should any such act be detected, investigative authorities shall officially proceed." (quoted from the official statement written by the Department in charge of Supervision of Investigations and Preparation of Indictments of the General Prosecutor's Office to the National Police Headquarters. Dated May 24, 2005)

Vaccination against hepatitis B is the last element of the obligatory and free of charge state immunisation programme until the age of 14. Children at the age of 14 receive this vaccination at school since 1999.

In the second half of the year, the HIV/AIDS consultation office operated by the National Centre for Epidemiology was renovated in Budapest, where voluntary tests and counselling is provided based on a protocol. Similarly, free of charge, anonymous, voluntary HIV tests are available in each county in limited consulting hours at the HIV/AIDS Testing and Counselling Offices. In 2005, 110 professionals engaged in testing and counselling participated in HIV counselling courses that were based on a WHO manual and financed by the National Public Health Programme.

On the occasion of the World AIDS Day, a comprehensive campaign was implemented to promote voluntary tests for HIV in each county. This campaign primarily aimed at youths and risk groups.

7.3. INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY

No new information available.

7.4. INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES

No new information available.

Conclusions

In the second half of the year, conditions of HIV/HCV testing for injecting drug users improved nationwide.

A new outreach programme was launched aiming to reach the most problematic population. Data on the needle exchange programmes imply secondary needle exchange; the per capita number of needles and syringes has been continuously increasing over the last 3 years. Fewer clients contacted the NSPs, but they did so with greater frequency and they took more needles and syringes.

8. SOCIAL CORRELATES AND CONSEQUENCES

8.1. SOCIAL EXCLUSION

No new information available.

8.2. DRUG-RELATED CRIME

Although quantitative indicators of revealed drug-related offences changed, qualitative features did not significantly alter in 2005. Increase in the number of cases can be regarded as a consequence of amendments in the legal background including the widening of the range of persons taking part in diversion (postponement of prosecution) and the implementation of the institution of diversion. While 50% of the offenders of revealed misuse of narcotic drugs took part in diversion in 2004, this rate was 62.3% in 2005.

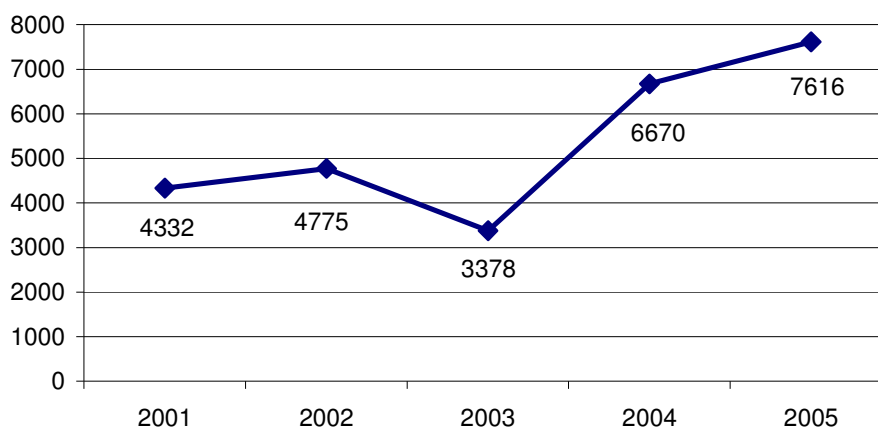
As a result of the output, system data are registered with some delay: only at time of closing of police and prosecution procedures. Therefore data introduced here only refer to offences in the case which procedures were finished in 2005. Criminal statistics can only monitor such acts with a certain delay. This fact shall not be neglected when analysing data.

Drug offences

In the Hungarian criminal statistics, drug-related crime means misuse of narcotic drugs (Sections 282/A, 282/B and 282/C of the Criminal Code). Statistics show that 7,616 proceedings initiated on misuse of narcotic drugs were closed in 2005.

Data from the Uniform Police and Prosecutors' Criminal Statistics (ERÜBS) indicate an increase in the number of revealed drug-related offences in 2005. The rate of this increase was 114.2%.

Figure 18. *Number of revealed offences of misuse of narcotic drugs*



Source: ERÜBS

The rate of revealed offences of misuse of narcotic drugs within total crime was 1.7% in 2005, which may be considered as low.

Date of offence

Considering the date of offence, the proportions are the following:

Table 22. Revealed offences of misuse of narcotic drugs by the date of the offence

Year of offence	Number of cases	%
2005	1568	20.6
2004	4319	56.7
Prior to 2004	1729	22.7
Total	7616	100

Source: ERÜBS

Considering lengthy proceedings, the situation has improved compared to 2004. Of all offences, 14.4% were comprised of misuse of narcotic drugs in 2004. It was 20.6% in 2005. This rate is still less than that detected in the period prior to amendments of the Criminal Code and the Act on Criminal Procedures in 2003.

As referred to in last year's report, change of laws brought more regulated but lengthier enforcement of diversion⁴⁷. Since that time the rate of such cases in criminal statistics has not reached the 30% level measured earlier.

Perpetrations

Drug use is still the most frequent perpetration, although the numbers of proceedings initiated purely on drug use are unknown, due to limits in the criminal statistics system which is only able to record cases under specific legal facts, without any further distinction between the cases. These legal facts also contain further conducts of offence.

Conducts of offence denoting the "production, manufacturing, acquisition, possession, importing" of narcotic drugs for demand-related activities of personal use, made up for 90.9% of all revealed offences of misuse of narcotic drugs. "Use" as such had a rate of 0.8% – this legal fact was still included in statistics because proceedings initiated prior to the amendments in 2003 were closed in 2005. Thus we can say that demand-related offences for personal use have a share of 91.7%.

Supply-related criminal acts (denoting offering, supplying, distributing, trafficking narcotic drugs) account for 8.3% of all revealed offences.

⁴⁷ Ritter (2005) conducted a survey on the effectiveness of diversion available to offenders committing misuse of narcotic drugs. The survey was carried out on a sample in Budapest in 2004. The survey's results were comparable to 1999 survey carried out on the same sample and with the same methodology (Ritter 2000). It claims that, "On average 9.8 months, i.e. 10 months elapse in Budapest between the time of initiating a proceeding and the time of taking a decision on postponement of prosecution on grounds of the client's participation in a treatment form for drug users. An offender committing misuse of narcotic drugs, if conditions are fulfilled and the drug-using offender participates in addiction treatment or other preventive-consulting service, he/she may enter treatment in 10 months after initiation of a proceeding. The 1999 survey on a Budapest sample claims that an average of 7.6 months elapsed between the time of a proceeding's initiation and the time of postponement of prosecution on grounds of participation in treatment.

Considering the fact that a drug-using offender must verify completion of a treatment of 6 consecutive months on top of the above-mentioned average time-lapse, "punishment" lasts for almost one and a half years. The average time-lapse between the time of a proceeding's initiation and the decision terminating the successfully postponed prosecution was 19.2 months in Budapest in 2004."

Offenders

The number of revealed offences of misuse of narcotic drugs increased by 14.2% compared to 2004. The number of offenders committing misuse of narcotic drugs grew by 9.6% from 6,466 to 7,085.

The mean age of offenders committing misuse of narcotic drugs did not change compared to earlier years. This offence type is usually committed at a younger age compared to other crimes. While 97.2% of drug-related offences are committed by offenders who are younger than 31, the rate of offenders of other crimes doesn't reach 60%.

Criminal statistics distinguishes two groups of offenders. *Perpetrators* are those who may legally be punished for the commitment of a criminal act. Another group of *offenders* include those who cannot be sentenced due to an exclusion of their culpability. Hereby we go into details on the breakdown of offenders by gender, age and education. Thus we analyse socio-demographic characteristics of offenders who committed misuse of narcotic drugs (irrespective of whether they could be punished or not) according to criminal statistics of 2005.

Breakdown by gender

As regards to the breakdown of crimes by gender, rates are similar to previous years. 89.7% were males and 10.3% were females among offenders committing misuse of narcotic drugs. The male-female ratio does not significantly differ from that among all offenders.

Breakdown by age

Breakdown of offenders by age did not considerably change in 2005 either. It is still young adults at the age of 18-24 against whom most proceedings were initiated (56.5%).

Table 23. *Breakdown of offenders of misuse of narcotic drugs by age in 2005*

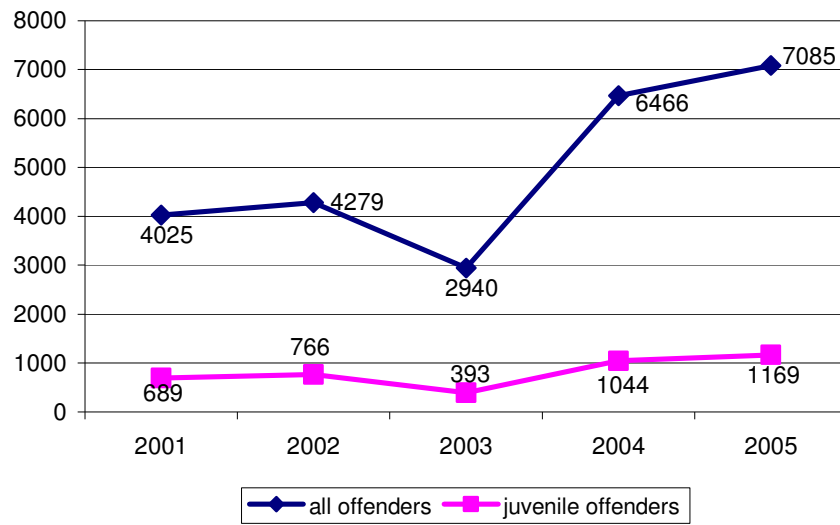
Age groups	No. of cases	%
Minors (<14)	9	0.1
Juvenile (14-18)	1169	16.4
18 – 24	3993	56.5
25 – 30	1401	19.8
31 – 40	447	6.3
41 – 50	54	0.8
51 – 60	9	0.1
> 61	3	0.0
Total	7085	100.00

Source: ERÜBS

Juvenile offenders

Juveniles made up 8.7% of all offenders in 2005. While the proportion of the juveniles among all offenders decreased, it has remained at 17% among offenders committing misuse of narcotic drugs. Juvenile offenders who committed misuse of narcotic drugs were 1,169. They represented 16.5% of all offenders committing drug-related crimes.

Figure 19. Number of offenders committing misuse of narcotic drugs



Source: ERÜBS

The figure above demonstrates that the line showing the number of juvenile offenders did not follow the increase in the line of all offenders committing misuse of narcotic drugs. The aforementioned level of 17-18% seems to remain stable.

Breakdown of offenders by education

Offenders committing misuse of narcotic drugs still remain in front of other offenders in terms of education.

Table 24. Breakdown of revealed offenders of misuse of narcotic drugs by education in 2005

Education	Number of cases	%
None	14	0.2
Elementary school	3611	51.0
Vocational school	1693	23.9
Secondary school	1589	22.4
University/college	117	1.6
N.a.	61	0.9
Total	7085	100

Source: ERÜBS

Breakdown by previous convictions

In 2005, 32.4% of revealed offenders who committed misuse of narcotic drugs had been previously convicted. Of those, 20.2% were persistent offenders (i.e. committed another malicious act in the last 3 years).

A major portion of these offenders were drug-addicts, and their previous offences were also related to drug use or acquisition of drugs. A minor part of this group comes from the criminal subculture, which suggests that trafficking with drugs is increasingly accompanied by drug use among them.

Most offenders committing misuse of narcotic drugs had never been convicted before. The rate of offenders who had never been convicted was 67.6% in 2005 that is higher than in other crime categories.

Consequent crime –offences committed under the influence of narcotic drugs

The rate of those who committed an offence under the influence of narcotic drugs or other psychoactive substances grew by 2% (up to 4,151) in 2005 compared to the year before. This rate has nearly doubled in contrast to 2003 (2,112).

Most of them (76.2%) committed misuse of narcotic drugs and proceedings were initiated against them because they were under the influence of narcotic drugs. This rate was 75.6% in 2004, so no significant change could be detected.

As regards to major crime categories, when under the influence of narcotic drugs or other psychoactive substances, 13.4% of offenders committed property offences, 1.9% committed traffic offences, 2% committed offences against another person and 2.3% were arrested for disrupting the peace.

Alternatives to criminal proceedings

Juvenile offenders participate in the diversion in a higher rate since the amendment of the Criminal Code. While 58.9% of juvenile offenders who committed misuse of narcotic drugs participated in preventive-consulting services or other treatment forms in 2004, nonetheless their rate increased to 70.7% in 2005.

8.3. DRUG USE IN PRISON

The report of the National Headquarters of the Hungarian Prison Service (BVOP) claims that abuse of anti-epileptic medicines has considerably increased in prisons in 2005. Presence of drugs also significantly increased: in 20 cases, officers mainly found pills containing MDMA and cannabis derivatives hidden in packets or clothes of 21 persons.

In a few cases, used syringes and needles were also found in prisons. As internal procedures do not require that these institutions report on such equipment found, there is no exact information available on their number.

If a convict arrives at a prison (9-10/ year) and shows severe withdrawal symptoms, after a medical examination they will be transported into the Institute for Forensic Monitoring and Mental Treatment. Drug use was revealed 12 times among prison inmates. Six cases of morphine, 4 cases of ecstasy and 2 cases of cannabis use were registered.

8.4. SOCIAL COSTS

No information available.

Conclusion

Although quantitative indicators of revealed drug-related crimes altered in Hungary in 2005, there wasn't any significant change in the qualitative features of the situation. Statistics show that 7,616 proceedings initiated on misuse of narcotic drugs were closed in 2005 as against to 6,670 closed files in 2004.

49.9% of offenders who committed the offence of misuse of narcotic drugs participated in diversion in 2004, and 62.3% were diverted in 2005. Juveniles who participated in diversion represented a rate of 58.9% in 2004 and 70.7% in 2005.

9. RESPONSES TO SOCIAL CORRELATES AND CONSEQUENCES

Overview

Act III of 1993 on Social Administration and Social Care (hereafter Social Act) distinguishes the following care forms associated with care for addicts.

Among primary social care services, family care, community-based care, outreach work and day-care service are named in the Social Act. Primary social services are available to clients in their homes and surroundings. In the frame of family care, counselling is to be provided to those facing drug problems. Community-based care has been granted normative subsidy since 2005 and the following tasks are met:

- assistance in surroundings to clients' individual life-management,
- preservation and improvement of a client's existing skills,
- monitoring of client's state of health,,
- psychosocial rehabilitation, social and mental care,
- encouragement and monitoring of clients' participation in medical or other therapeutic treatments or services and tests,
- organising outreach programmes in order to reach clients in need of care.

The local governments are in charge of providing community-based care if the permanent population exceeds 10,000 residents.

Act CLXX (XII. 19.) of 2005 amended the Social Act by declaring that the existing tasks of community-based care would be conceived as community-based primary care. Additionally, this amendment declares the low-threshold care as a special community-based care form. Low-threshold services are due to provide the following from January 1, 2007:

- encouragement and monitoring of clients' participation in medical or other therapeutic treatments or services and tests,
- organising outreach programmes,
- establishing harm-reduction services to minimize the health and social damages caused by drug use.,
- crisis management for life threatening, unmanageable situations stemming from the client's physical, social, relationship and lifestyle system.

Each local government with at least 30,000 permanent residents has to provide low-threshold services until December 31, 2007. The establishment of a normative funding system is in progress.

Drug-related day-care services provide day-time stay, sanitary facilities and facility for networking; organise catering on request and work out individual therapeutic plan to the rehabilitation and reintegration of those in need. Local governments are obliged to provide day-care services if their permanent population counts more than 3,000 residents.

Specialised social care services cover the following care forms: nursing and care home for addicts; rehabilitation centres; transitory homes for addicts; halfway houses. Nursing and care homes, in addition to complete care, may also provide employment and rehabilitation type care where necessary. Rehabilitation centres are for clients in need of complex care if such care is not available to them in outpatient or other treatment centres. Community work and other therapeutic activities are usually adopted in rehabilitation centres. The twelve-step, self-help recovery model has also been gaining importance.

Based on expertise of a psychiatrist or a professional specialised in addiction-treatment, transitory homes are available for a maximum of one year. Settlements where the permanent population exceeds 3,000 must provide such care.

A client who

- is at least partly capable of self-care,
- has enough income to cover the costs of such a new life-form,
- and does not need permanent care

may be admitted to a halfway house.

The regulation of the Ministry of Social and Family Affairs No. 1/2000 (I.7.) sets forth professional tasks and operational conditions of social institutions providing personal care.

A Working Group of Professionals Specialised in Addiction-Treatment (ASzM) was established in May 2005 supported by the Ministry of Youth, Family, Social Affairs and Equal Opportunity (ICsSzEM) and coordinated by the National Institute of Family and Social Policy (NCsSzI). The objective of the working group is to continuously cooperate in fulfilling the tasks arising from:

- the concept and guidelines of addiction-treatment,
- the National Drug Strategy and
- the recently developing National Alcohol Concept.

Such tasks are specified and delegated to the working group by the ICsSzEM and include discussions on field-specific issues; preparation of documents, written summaries, proposal papers, draft statements, guidelines and evaluation. Two smaller working groups were formed within the ASzM in 2005. In the same year, they worked out guidelines for professionals with the following titles:

- „Community-based Care for Addicts”,
- „Low-threshold Services in Primary Social Care for Addicts”,
- „Day-care centres in Primary Social Care for Addicts”.

9.1. SOCIAL REINTEGRATION

Reintegration in social care is the last phase of a client's recovery process. These forms are: community-based care (psychosocial aftercare), work rehabilitation and development-preparatory programmes in rehabilitation centres, protected work places and clients' accommodation in halfway houses.

In addition to model programmes which are specially tailored to drug users' needs – run by NGOs, primary social care centres also take a role in reintegration. This means that community-based care became the focus area in 2005. Normative subsidy for the community-based care of addicts was introduced. Day-care centres' capacity is still at a low level. Demand for community-based care centres as well as the number of such centres is increasing. (The exact number is not known due to current data collections. Around 110 community-based care centres were formed for clients coping with psychiatric and addiction problems.)

In 2005, a supporting system was established to implement social occupation in day-care and rehabilitation centres. These are named by the Social Act:

- Work rehabilitation: aims at preservation and development of a readiness to work and mental and physical skills through work. It also aims at clients' preparation for development-preparatory activities.
- Development-preparatory activities: the objective is to establish and to improve individual working skills through training to separate working processes and employment. They also aim to prepare clients to work in protected work places and on the labour market.

Clients discharged from rehabilitation centres may apply for slots in halfway houses. Another typical element of a client's aftercare is their involvement in self-help groups. A reinforcement of self-help groups (twelve-step recovery groups, Narcotics Anonymous groups) was observed in terms of their number, geographical coverage and the frequency of meetings in 2005. (Several new groups were formed in Budapest, Pécs and Szeged.)

In the fall of 2005, a new project was launched by the cooperation of 5 organisations engaged at different levels of addiction-treatment under the EQUAL project financed by the European Social Funds and the Hungarian Government. This project aims to provide complex, long-term and personal-based social support, care and reintegration throughout the course of addiction.

Housing

In December 2004, a programme providing protected accommodation was launched mainly for poly-drug users formerly living in state care.

Three halfway houses opened in 2005, and all of them are cooperating with rehabilitation centres. There is only one independent (from rehabilitation centre) halfway house which has been extended. It is now capable of accommodating 14 clients at the same time. Geographical coverage of halfway houses is uneven, i.e. a few parts of Hungary are not covered by such houses at all. This may be attributed to the uneven geographical coverage of rehabilitation centres.

Education and training

No new information available.

Employment

The availability of protected work places is also uneven in Hungary. They are mainly associated with rehabilitation centres. In the South-Western part of the country a new protected workplace offering jobs to those discharged from therapy was opened in 2005.

A new reintegration centre opened in Budapest by Emberbarát Foundation. This centre includes a shelter, an education studio, a transitory home and a protected workplace (bakery).

9.2. PREVENTION OF DRUG RELATED CRIME

Assistance to prison inmates

There are no NSPs in prisons because of the missing legal background. MMT is available in prisons. Prisoners having been involved in methadone treatment before imprisonment can participate in MMT. These prisoners start their imprisonment at the Institute of Forensic Monitoring and Mental Treatment and for the time of MMT they are taken to an outpatient treatment centre. One person participated in such treatment in 2005.

The number of groups engaged in alternative psychosocial / peer counselling prevention programmes in prisons increased in 2005.

In order to reduce drug supply for security reasons, the National Headquarters of the Hungarian Prison Service submitted a proposal on the limitation of the number of packages prisoners may receive. This proposal necessitates an amendment of provisions. The most critical point of drug smuggling is still packages sent to the prison.

Conclusions

Community-based care of addicts has been extended by low-threshold services; as a consequence increased interest in provision of community-based care is expected. There is limited information on programmes aimed at the social reintegration of drug users. Therefore, improvement of data collection on the operation of such programmes is necessary.

10. DRUG MARKETS

Overview

No institutional changes related to drug seizures and drug analysis took place in 2005. All seized substances which raise suspicion that they may be drugs are analysed by the Department of Organic Chemistry and Analysis Experts Department of the Criminal Professional and Researcher Institute (BSZKI), as well as by 5 regional drug-analysis laboratories, irrespectively of whether they have been seized by the Police or by the Customs.

10.1. AVAILABILITY AND SUPPLY⁴⁸

Cannabis is still the most widespread drug in Hungary. Much of cannabis arrives to the Hungarian drug market from domestic illegal plants, while cannabis from abroad mainly arrives from the Netherlands and the territory of the former Yugoslavia.

Synthetic drugs are usually smuggled from Western-Europe and the Netherlands in particular. It is a recent phenomenon that organised criminal groups of bigger cities other than Budapest are also engaged in importing synthetic drugs from the Netherlands illegally, and set up supplies on their own. This may be a result of the now eased border crossing inspections. The capital's former central role in such activities seems to have vanished.

Heroin still arrives to Hungary via the 'Balkan' route. The majority of these supplies are transported through the territory of the country and/or deposited here.

Turkish and Albanian criminal groups still have a leading role in heroin exporting/importing and wholesale-trafficking in Hungary. Beyond the Hungarian and Albanian groups, as a new phenomenon Chinese and Vietnamese persons play a part in low-level trafficking.

Drugs cultivation and production

An increase can be detected in the size of cannabis plantations.

The cannabis offered on the Hungarian drug market comes increasingly from illegal domestic plantations. In addition to outdoor production of herbs, indoor production in glass houses and closed hangars were also revealed last year. The necessary lighting and irrigation in such hangars and glass houses were automated.

A clandestine laboratory manufacturing materials (platina oxid catalysator) used for producing synthetic drugs was also seized by investigation authorities in 2005.

10.2. SEIZURES

The below data include drugs found by the Police and the Customs.

According to data on seizures cannabis was still the most popular drug in Hungary in 2005. Compared to the previous years, cannabis is followed by ecstasy, amphetamine and heroin in terms of frequency. Frequency of amphetamine showed an increasing tendency from 2001, which continued in 2005 (see ST13).

⁴⁸ Based on a report of the National Bureau of Investigation.

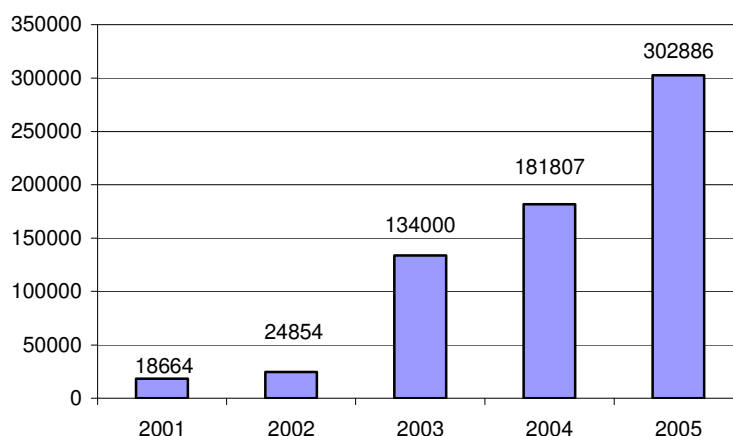
Table 25. Number and quantity of seizures of illicit drugs

	2004		2005	
	Number of seizures	Quantity seized	Number of seizures	Quantity seized
Herbal cannabis (kg)	1,722	91.733	1,707	161.613
Cannabis plants (plant)	62	2998	43	811
Cannabis resin (kg)	59	2.524	86	12.859
Heroin (kg)	113	89.85	108	237.842
Cocaine (kg)	96	94.43	89	7.581
Amphetamine (kg)	378	19.663	355	27.743
Metamphetamine (kg)	3	0.0015	5	0.107
Ecstasy (tablet) /MDMA, MDA, MDE/	1,226	181,807	366	234,582
LSD (dose)	18	3396	14	569

Source: BSZKI

The increase in the quantity of seized drugs (herbal cannabis, cannabis resin, heroin, amphetamine) is primarily due to the number of bigger seizures. There were not any larger cocaine seizures in transit shipment in 2005, but an increase could be detected in the number of smaller sized cocaine seizures. Both the number of seizures of large quantities of ecstasy and the quantities of seizures increased in the past years.

Figure 20. Number of seized ecstasy tablets (tablets containing ecstasy and amphetamine type active substances)



Source: BSZKI

10.3. PRICE/PURITY

Price of drugs at street level

As a continuation of the survey conducted in 2004, price of drugs at street level (see ST 16) were assessed on the basis of drug users' information in 2005.⁴⁹

Questions were asked about 8 illicit drugs including herbal cannabis, cannabis resin, heroin, cocaine, crack, amphetamine, ecstasy, LSD and methadone obtained illegally.

⁴⁹ The survey covered Budapest and 4 major cities in Hungary: Miskolc, Szeged, Zalaegerszeg and Pécs. Questionnaires structured by the National Focal Point were filled in local outpatient centres. 20 questionnaires were filled in each city, thus the total sample included 100 people. The survey applied self reporting methodology.

Respondents were asked to indicate only the prices of drugs they actually bought in 2005, and for which they had exact information. The questions referred to the minimum, the maximum and the typical prices. Most respondents could indicate an answer concerning cannabis and ecstasy in 2005 again. Response rates in this survey did not significantly change compared to the previous year.

Table 26. Price at street level of some drugs (euros)⁵⁰

EUR	Minimum	Maximum	Mode	Mean	Number of respondents
Herbal cannabis (gr)	6.4	10.4	9.1	8.4	96
Cannabis resin (gr)	7.4	11.1	9.5	9.3	61
Heroin (gr)	36.6	56.8	41.1	46.7	26
Heroin (packet)	14.1	23.1	16.9	18.6	17
Cocaine (gr)	51.4	68.4	60.2	59.9	45
Crack (gr)	39.5	62.1	50.8	50.8	5
Amphetamine (gr)	9.6	15.1	11.7	12.3	61
Ecstasy (tablet)	3.3	6.8	4.9	5.1	74
LSD (dose)	7.9	12.1	10.1	10.0	30
Methadone (5mg)	3.6	6.1	5.4	4.9	17
Methadone (20mg)	5.4	7.6	6.6	6.5	7

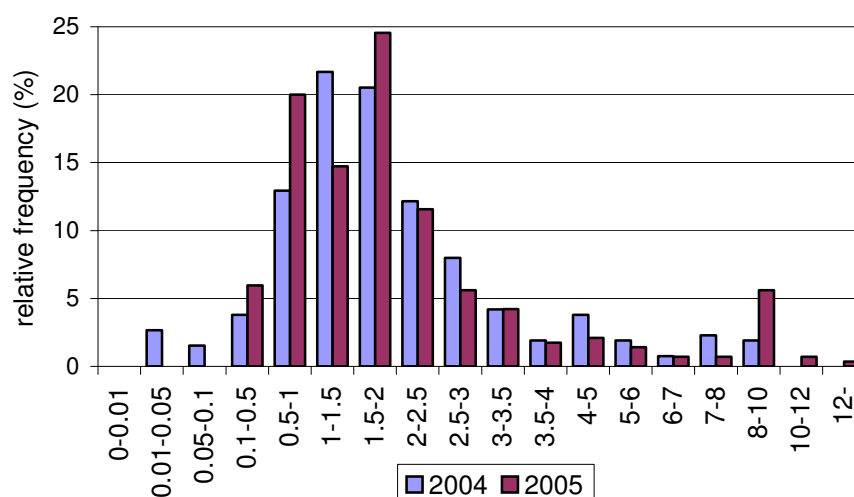
Source: National Focal Point, 2006

The typical price of each drug type does not significantly vary from city to city. The prices at street level did not change notably compared to the prices reported in 2005, so tendencies cannot be defined.

Purity

Analysis show that the content of active substance of seized herbal cannabis increased continuously over the past years. A significant growth in the rate of herbal cannabis seizures containing 1.5-2% of THC was observed in 2005. In the same year, more samples of considerably high THC content (over 6%) were found than in the year before (see ST 14).

Figure 21. THC content of seized herbal cannabis (tops) (m/m% of delta-9-THC concentration)



Source: BSZKI

⁵⁰ Prices indicated in the table were calculated on the basis of an official medium exchange rate of EUR-HUF of 248.05.

Table 27. Purity/potency at street level of some illicit drugs (m/m%)⁵¹

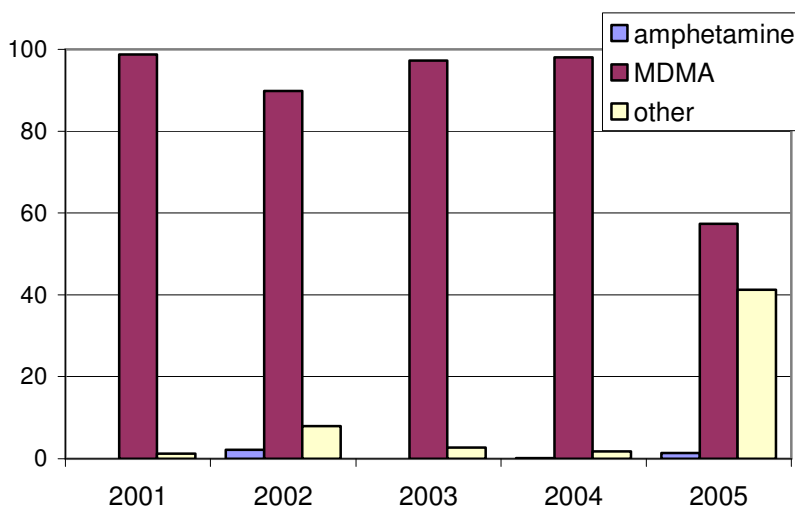
	2004				2005			
	Sample size	Min.	Max.	Mean	Sample size	Min.	Max.	Mean
Cannabis resin	20	0.1	6	4	25	0.1	6	3.5
Herbal cannabis	368	0.01	6	1.7	418	0.01	6	1.7
Heroin	39	5	25	16	59	7	30	20
Cocaine	43	15	70	35	44	20	60	36
Amphetamine	315	2	35	12	221	1	45	14

Source: BSZKI

Rate of tablets (ecstasy) with low content of active substance (20-25 mg/tablet MDMA-basis) grew noticeably among tablets only containing MDMA. These tablets amount to around 60% of seizures of illegally manufactured pills containing narcotic drugs (especially amphetamine-derivates) in 2005. This rate exceeded 90% in the years before.

Another 20% of the tablets contained a combination of MDMA and other active substance. Tablets containing amphetamine re-appeared in considerable quantities in 2005. A large number of further combinations of different active substances (such as MDMA+MDE, MDMA+amphetamine, amphetamine+metamphetamine) were also found in tablets. A new active substance, mCPP emerged and was found in 6% of tablets on its own. A combination of mCPP and MDMA was traceable in 4% of the tablets.

Figure 22. Active substances found in seized ecstasy tablets (frequency %)



Source: BSZKI

Conclusions

The structure of the drug market in Hungary did not substantially change in the past year. Change in purity of drugs at street level varies by substance. The most significant change could be observed related to ecstasy tablets. Tablets containing unusual active substances emerged in a larger amount on the market.

⁵¹ The intervals do not include extremely high or low contents of active substances occurred in a low number. Content of active substances was within these intervals in 90% of the cases.

11. DRUG USE AND RELATED PROBLEMS AMONG VERY YOUNG PEOPLE

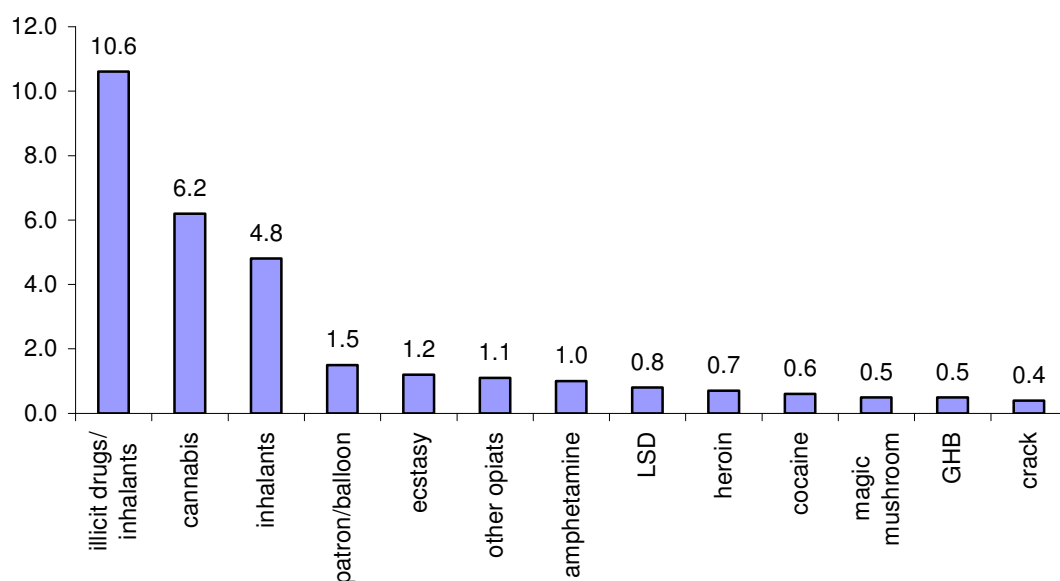
11.1. DRUG USE AMONG VERY YOUNG PEOPLE

ESPAD 2003 survey among students in grade 8

The objective of the survey (Elekes and Paksi 2003b) conducted in the spring of 2004 was to analyse drug use patterns of a so-far non-surveyed population, i.e. students in grade 8⁵² According to the survey, 10.6% of students in grade 8 have ever abused drugs⁵³ (13% of boys, 8.2% of girls) and 7.4% of them have used an illicit drug (9.5% of boys and 5.4% of girls). Last year prevalence of drug abuse reached 6%, and last month prevalence was at 3.2%. Results show that among students studying in the 8th grade 7.9% of students aged 14 and 11.1% of students aged 15 have ever abused drugs.

In the 8th grade, 42% of students who have ever used illicit drugs did so once or twice, and 29.3% of them used illicit substances 3-9 times. 28.8% of students have ever used illicit drugs more than 10 times in their lives. A further 15.3% have already used illicit drugs 40 times or more.

Figure 23. Lifetime prevalence of drugs abused among students in grade 8 in 2003 (in % of respondents)



Source: Elekes and Paksi (2003b)

The use of cannabis derivatives is the most widespread among students in the 8th grade, with 6.2% of respondents have ever used cannabis. After cannabis, the most frequently used

⁵² The research was conducted by the Behaviour Research Centre at Corvinus University of Budapest. The research was carried out on a representative sample stratified by the type and location of schools. Data were collected through self-reporting class questioning method. The research followed the questionnaire and methodological guideline set by the ESPAD survey in 2003. The gross sample size of the students in grade 8 was 3,072 and its net size accounted for 2,587. The age-based breakdown of the weighted sample: 29.8% at the age of 14, 62.4% at the age of 15, 5.8% 16 years of age, 1.7% aged 17 and over.

⁵³ Cannabis, heroin, other opiates, cocaine, crack, amphetamine, ecstasy, LSD, magic mushroom, GHB, inhalants, patron/balloon

substances are all legally available: inhalants rank second and are followed by patron/balloon. Lifetime prevalence of all the other drugs is around or below 1%. In contrast to students in higher grades and older populations, ecstasy, amphetamine and cannabis derivatives do not play an important role in youths' lives in this age group yet. The use of other drugs was indicated by 1% of the respondents; 1.8% used alcohol combined with cannabis and 0.7% reported injecting drug use.

No significant gender differences can be observed in the lifetime prevalence of each illicit drug, except for cannabis derivatives where the typical gender-pattern – higher exposure of boys – can be detected (boys: 8.1%, girls: 4.5%).

Lifetime prevalence of pharmaceuticals abuse⁵⁴ is 10.2%, compared to last year's prevalence of 4.9%. The lifetime prevalence of tranquillisers abuse reaches 6.8%, which is the most widespread within pharmaceuticals abuse. Of the respondents, 4.6% have tried combined use of alcohol and pharmaceuticals, whereas 4.1% have tried sedatives without a doctor's prescription.

Similarly to the patterns revealed by other Hungarian and international surveys, pharmaceuticals abuse is more typical among girls: 12.7% have tried it, compared to 7.6% of boys. Within pharmaceuticals abuse the use of tranquillisers without a doctor's prescription is the most common (boys: 4.7%, girls: 8.9%). Lifetime prevalence of combined use of alcohol with pharmaceuticals is 3.5% among boys and 8.9% among girls. Significant gender-differences may also be observed in the abuse of sedatives: twice as many girls (5.4%) have tried sedatives without a doctor's prescription than boys (2.7%).

Initial abuse of drugs most often happens at the age of 13 (34.4%) to 14 (29.2%). It happened at or below the age of 12 among 26.6% of users (15.1% of children at the age of 12, and 29.2% of children aged 11). Half of the drug abusers who indicated a substance first used mentioned cannabis, 22% inhalants, and 6.5% tranquillisers. A notable 2-3% of drug abusers reported ecstasy, amphetamine or heroin as a substance first used. All the other substances represent 1% or less among drugs first used.

There is a significant correlation between lifetime prevalence of drugs and school types. Drug abuse, illicit drug use and pharmaceuticals abuse are more widespread among students studying in six- or eight-grade grammar schools (20.4%, 13.8%, and 17.5%, respectively) than among those who attend traditional eight-grade elementary schools (9.6%, 6.8%, 9.5%, respectively).

Similar to prevalences in different school-types, a marked difference is observed in the drug abuse of students studying in the capital (14.8%) and in other cities (9.8%).

Individual variables (e.g. school record) also show a significant correlation with drug abuse. Students who have abused a substance usually have performed weaker in both elementary and grammar school than those who have never tried any drugs. There is also a significant correlation between the frequency of school attendance and drug use. Frequency of truancy rises in direct ratio to prevalence of drug use.

Drug abuse among students in grade 8 is significantly less frequent where children live in families with both birth parents (7.9%). By comparison, children who live in any other family-type are more exposed. Lifetime prevalence of drug abuse is similar in re-structured⁵⁵ and one-parent families (16.9%, 16%, respectively), whereas it is higher in other family-types⁵⁶ (23.9%). Lifetime prevalence of pharmaceuticals abuse is lower compared to drug abuse in all four family-structures.

There are significant differences in the spread of substance use behaviour along the socio-economic status indicator of a family' (e.g. education of parents). Risk factors of the two

⁵⁴ Tranquillisers/sedatives combined use of tranquillisers/sedatives with alcohol.

⁵⁵ A family with one birth parent and a step parent.

⁵⁶ A family without birth parents.

patterns of drug use are different in this respect. As regards to pharmaceuticals abuse, parents who at least graduated from secondary school represent preventive factor. Parents who finished vocational school provide a preventive factor against drug abuse, and it is only the lowest education level (elementary school) that apparently represents a risk factor.

Results along family's relative economic status⁵⁷ show that higher status has preventive role against pharmaceuticals abuse, average status has preventive role against drug abuse, and worse circumstances are risk factors.

There is also a significant correlation between the drug use of a respondent and deviations or risk behaviours⁵⁸ in the family.

Lifetime prevalence of pharmaceuticals abuse and drug abuse are significantly higher than the average among those who have deviant or risk behaviour in the family, except for smoking.

This impact is stronger in a close family and when there is substance use behaviour in the family.

Drug use among very young people facing mental problems

The objective of a survey⁵⁹ (Kiss et al. 2005) conducted in the period of June 2004 and July 2005 was to study tobacco, alcohol and drug use in 7-19 year old children population suffering from depression. Former surveys hardly examined this specific population and this group of relatively young people. According to the survey 12.1% of respondents under the age of 15 are regular smokers and 6.3% regularly drink alcohol. Additionally, 1.3% use amphetamine, 1.8% use cannabis, 0.9% use inhalants and 0.4% use other illicit drugs.⁶⁰

Children using several substances scored higher points on a questionnaire inspecting the severity of their depression. The quantity of regularly consumed alcohol increases in the same ratio to the severity of depressive symptoms. Children showing severe depressive symptoms are increasingly vulnerable to tobacco use. No significant correlation can be seen between each of the risk factors and drug use which may be attributed to a low number of cases.

11.2. PROFILE OF VERY YOUNG PEOPLE IN TREATMENT

Within the Hungarian health care system, 39 child-psychiatric outpatient centres and 6 inpatient departments provide care for children facing drug problems. Child-psychiatric outpatient centres are responsible for providing care for patients younger than 14.

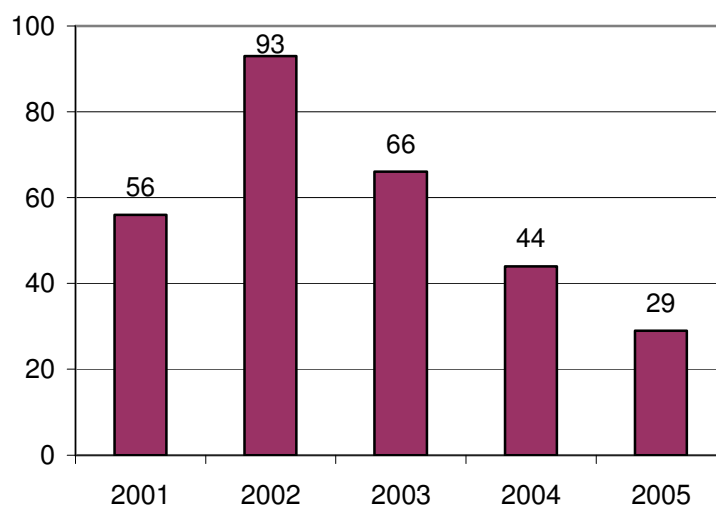
⁵⁷ A family's financial status based on the subjective judgement of the respondent.

⁵⁸ Behaviours being examined are the followings: smoking, regular alcohol use, attempted suicide, committed suicide, former imprisonment, use of considerable amounts of tranquillisers/sedative, psychological treatment, and drug use.

⁵⁹ The survey was conducted by the Children Psychiatric Department and the Behaviour and Psychology Tutor Group of the Psychiatric Clinics of the Szeged University. The institutes in this survey (10 psychiatric outpatient centres) were not randomly selected (but based on experts opinion and availability). Individual samples included children from the age of 7-19 who were tested over the course of the one survey year at responding centres and whose test results were positive, (i.e. they were not mentally-retarded, suffered from no chronic somatic diseases and were diagnosed with major or minor depression). Gross sample size: 267, net sample size: 222, 85.8% were in the 7-15 age group and 14.2% were in the 16-19 age group. Psychiatric diagnosis was set up through a half-structured interview (ISCA-D). Children provided data on their risk behaviour by self reporting.

⁶⁰ The prevalence shows the proportion of the respondents under the age of 15 using drugs at any frequency at the time of the data collection.

Figure 24. Number of children in treatment under the age of 15



Source: Report no. 1627 and report no. 1211 by the Ministry of Health

The total number of visits by clients under the age of 15 in child-psychiatric outpatient centres has been decreasing since 2002. The number of clients in treatment decreased by 75.3% by 2005. With two exemptions all 29 clients (8 girls and 21 boys) were aged 13-14 in 2005. Eight boys used inhalants, 6 of them used cannabis, 3 of them used benzodiazepine, 1 used amphetamine, 1 used heroin and 2 of them used other drugs as primary substance. Four girls used cannabis, 2 used benzodiazepine and 2 used inhalants. Only benzodiazepine users entered inpatient treatment, the others were treated in outpatient care centres. There are no data available on the route of administration and the frequency of use.

11.3. VERY YOUNG PEOPLE AT RISK OF DRUG USE

Drug use during pregnancy in the family

Public health nurses are responsible for recognising illicit drug use during prenatal care. Pregnant women spend more time with a public health nurse than with their doctor. This relationship may also be more personal, because nurses regularly visit registered pregnant women in their own homes or they meet in prenatal care centres from the start of pregnancy until after the childbirth. Public health nurses inform pregnant women about drug-related risks and harms done by drug use. If the to-be-born child is at risk, it is reported to the doctor and the child-welfare service.

Public health nurses register smoking habits; alcohol, drug, and pharmaceutical abuse by any family member in the visited families⁶¹. The table below shows data on use of illicit drugs and alcohol and smoking in families visited by a public health nurse in 2004.

Collection of data on illicit drug use by the public health nurses' service ceased in 2005.

⁶¹ There is a pregnant woman and/or a family member aged 0-16 in the family.

Table 28. Data on drug use in families visited by a public health nurse (capita)

	Illicit drug use	Alcohol use	Tobacco use	Number of families visited by a public health nurse
Budapest	89	4,445	47,390	158,293
Counties total (excluding Budapest)	830	83,014	328,972	997,373
Total	919	87,459	378,962	1,155,666

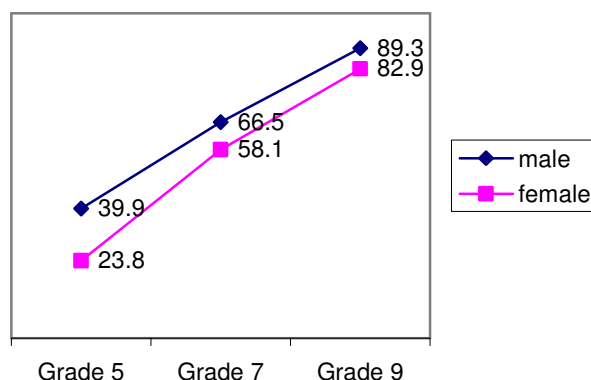
Source: Report by the Public Health Nurses' Service, 2004

11.4. CORRELATES AND CONSEQUENCES OF SUBSTANCE USE AMONG VERY YOUNG PEOPLE

Alcohol use among very young people

The objective of the survey carried out in 2002 (Aszmann 2003) was to study health behaviour of the school population in Hungary.⁶²

Figure 25. Lifetime prevalence of alcohol use by gender (%)



Source: Aszmann (2003)

Results of this survey show that the rate of students indicating initial alcohol use increases with age and reaches a level of 80% among students in grade 9.

Table 29. Proportion of students using alcohol daily or weekly (%)

	Grade 5		Grade 7		Grade 9	
	male	female	male	female	male	female
Beer	4.8	0.6	8.1	2.5	30.5	8.5
Wine, champagne	6.6	1.2	9.3	2.9	26.4	10.6
Spirits	2.7	0.9	6.1	2.1	23.4	14.9

Source: Aszmann (2003)

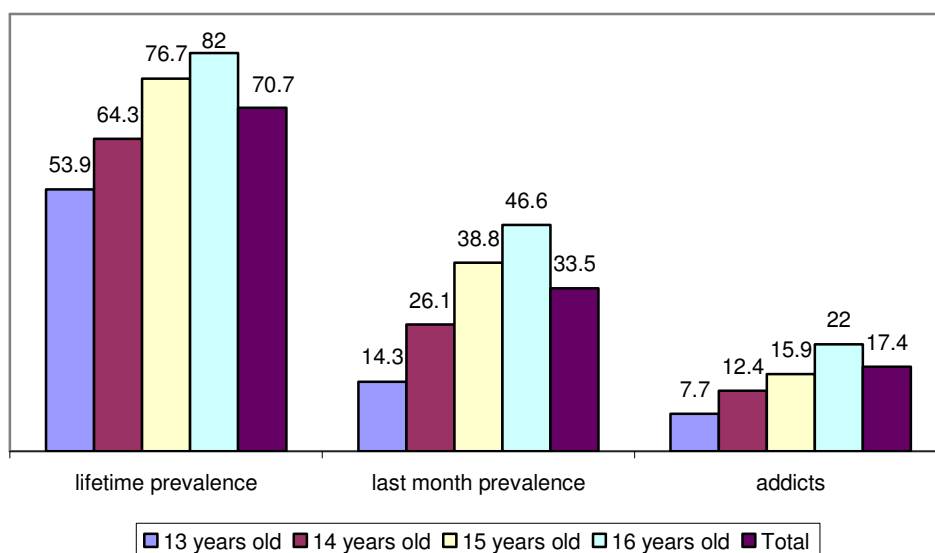
Prevalence of alcohol is higher with age among both boys and girls. The rate of alcohol users in grade 9 is significantly higher than among younger students.

⁶² The survey was conducted in the frames of the international research series HBSC on a representative sample stratified by the type of school and settlement. Net sample size of students was 1,419 in grade 5 (mean age: 11.5 years), 1,512 in grade 7 (mean age: 13.5 years) and 1,413 in grade 9 (mean age: 15.5 years). Gross sample size was 1,500 in all three cases. Data were collected with self reporting class questioning method according to the HBSC protocol.

Tobacco use among very young people

The objective of the survey in February, 2003 (Németh 2003) was to study patterns of tobacco use among youths aged 13-16 as well as to assist planning, implementing and evaluating anti-smoking programmes.⁶³

Figure 26. Lifetime and last month prevalence of tobacco use and share of addicts among children aged 13 to 16 (%)



Source: Németh (2003)

According to the survey, 70.7% of students have ever tried tobacco. Last month prevalence (recently smoking) is 33.5%. Addiction developed with 17.4% of those who have recently been smoking⁶⁴. There is no significant gender-based difference. As regards to those who have tried smoking, 17.7% smoked their first cigarette at an age below 10. Lifetime and last month prevalence as well as addiction increases with age. Of students who have not tried tobacco, 20% reported that they would likely smoke in the future. This rate is much higher among girls (27.9%) than among boys (15%). Twenty percent of both smokers and non-smokers have a tolerant attitude towards tobacco use. More than 75% of tobacco-using adolescents have never had difficulties buying cigarettes for personal use.

Minor offenders

Table 30. Number of minor offenders (under the age of 14) committed misuse of narcotic drugs, 2002-2004

	Number of cases	Rate in terms of all cases (%)
2003	7	0.2
2004	9	0.1
2005	9	0.1

Source: ERÜBS

⁶³ The survey was conducted by the National Institute of Child Health in the frames of the Global Youth Tobacco Survey series, according to internationally standardised methodology on a multi stage, stratified, national representative sample among elementary- and secondary-school students in grades 7 to 10 (in the 13-16 age group). Data were collected by self-reporting questionnaires. Gross sample size: 5,410, net sample size: 4,484.

⁶⁴ Recent tobacco users are those who light a cigarette first every morning, or must light one.

The share of minor offenders among all offenders who have committed misuse of narcotic drugs did not change in the past two years. It is not typical for minors to commit such crimes.

11.5. LEGAL FRAMEWORK

Act III of 2005 promulgated the WHO Framework Convention on Tobacco Control that includes measures prohibiting the sales of tobacco products to minors.

In accordance with Act CLXIV of 2005, it is prohibited to serve or to sell spirits, products of sexually arousing nature and tobacco products to anyone under the age of 18. When in doubt, vendors may also ask buyers of such products to prove their age with official documents. In case of inadequate evidence of the buyer's age, sales of such products must be denied.

Restrictions and prohibitions on advertising specified by Act I of 1996 on radio and television broadcasting also contains provisions for the protection of minors. Accordingly, "advertisements popularizing and describing tobacco goods, weapons, ammunition, explosives (...) cannot be broadcast", and "advertisements of alcoholic beverages cannot be addressed to minors and cannot show minors consuming alcohol...".⁶⁵

Act LVIII of 1997 on business advertising activity claims that "advertising of alcoholic beverages is prohibited immediately before any programmes for children or juveniles, during the programme, and immediately afterwards, on toys and the packaging thereof and in institutions of public education, in health institutions and within a distance of 200 meters from their entrance"⁶⁶.

In Hungary, juvenile offences (under the age of 14 years) cannot be punished, as the offenders fall within the competence of child protection. Pursuant to Subsection (3) of Section 145 of the Joint Decree of the Minister of Interior and the Minister of Justice No. 23/2003 (VI.24.). the child-welfare service and the court of guardians, competent as per residence of a child or a minor concerned, shall be notified by the investigating authority: immediately upon the announcement of an established suspicion about a proceeding filed against the minor offender, or of a parent or a legal representative who committed an offence to the injury of a child or a minor.

Objectives, framework and special formats of child protection care are specified by Act XXI of 1997 on the protection of children and child welfare administration:

- Care providing home to children placed in temporary or permanent custody for an indefinite period of time, follow-up care of young adults and complex care of children in need for special care for any other reason shall be ensured in the framework of child protection care.
- Care providing home to children may be ensured in cooperation with the foster-parents or, if it is not available, by support of the operator of a children's home, a nursing and care home for disabled people under the Social Act, a home for the mental impaired and psychiatric patients as well as local units of the child welfare service especially by means of family care and legal representation of children.
- In the framework of care providing home, special care has to be provided to children placed in temporary or permanent custody for an indefinite period of time and who are having problems with alcohol, drugs or other psychoactive substance use.
- A professional adoptive parent may classify as a special professional adoptive parent if he/she meets the qualification requirements and is capable of providing a balanced

⁶⁵ Subsection (1) of Section 13 of Act I of 1996 on Radio and Television Broadcast

⁶⁶ Subsection (1) of Section 12 of Act LVIII of 1997 on Business Advertising Activity

upbringing for a child who has mental or antisocial symptoms, faces problems with psychoactive substance use and requires special care, and who can foster the child to return to his/her family. An adoptive parent is entitled to a fee, which shall be a higher amount in case of a child with drug problems.

- The Minister of Youth, Family and Social Affairs and Equal Opportunity ensures the establishment of proper conditions for the care of children in temporary or permanent custody who have severe mental or antisocial symptoms and/or face drug problems, provided such children's care cannot be insured otherwise or their special placement is not necessary in the opinion of a national experts' committee on child protection. In compliance with this, the minister maintains and operates special children's homes.

11.6. PREVENTION AMONG VERY YOUNG PEOPLE

In total, 139 school-based prevention programmes were identified through a survey that was aimed to reveal and describe drug-prevention programmes in the school-based prevention scene (Paksi 2006). Regarding prevention programmes that are available to specific age groups, the study claims that the widest variety of programmes (102) are provided to students in upper grades (to students aged 10-14). The number of programmes aimed at secondary school students at an age of 14-18 is 95. The number of programmes targeted at elementary school students in lower grades (6-10 year old) is much lower (19). A more detailed description of these programmes can be found in National Report 2004.

12. COCAINE AND CRACK – SITUATION AND RESPONSES

12.1. COCAINE AND CRACK USE IN THE POPULATION

Cocaine and crack use in the general population

National surveys conducted in 2001 and 2003 (Elekes and Paksi 2004, Paksi 2003a) provide data on cocaine and crack use among the adult population.⁶⁷

Table 31. *Lifetime, last year and last month prevalence of cocaine and crack use among the adult population in the 18-54 age group in 2001 and 2003 (%)*

	Cocaine			Crack			All illicit drugs ⁶⁸		
	LTP	LYP	LMP	LTP	LYP	LMP	LTP	LYP	LMP
2001	0.9	0.2	0.1	0.3	0.1	0.1	7.7	2.5	1.2
2003	0.9	0.4	0.2	0.4	0.3	0.2	11.4	4.4	1.6

Source: Elekes and Paksi (2004), Paksi (2003a)

Prevalence of cocaine and crack use among the adult population is below 1% which results in low reliability. Therefore, on the basis of these data, no statements can be made on cocaine and crack use among the adult population, and on their users' profile.

Cocaine and crack use in the school and youth population

National data are available on cocaine and crack use among the youth population from ESPAD surveys conducted in 1995, 1999 and 2003 (Elekes and Paksi 2003a).⁶⁹

Table 32. *Lifetime prevalence of cocaine and crack use among students at the age of 16 in the period of 1995 to 2003 (%)*

	Cocaine	Crack	All illicit drugs ⁷⁰
1995	0.2	0.1	4.8
1999	0.8	0.8	12.5
2003	0.8	0.8	16.2

Source: Elekes and Paksi (2003a)

Cocaine and crack use shows the lowest prevalence among youths at the age of 16 in the years observed. Due to the low number of cases, no reliable data are available on cocaine and crack use among youths, and on their users' profile.

⁶⁷ Both surveys were conducted on national representative samples by face-to-face interviewing and self-reporting methods. Sample was taken from the 19-65 age group in 2001, and from the 18-54 age group in 2003. Gross sample size in 2001 was 2,500, the net sample included 2,359 people in 2001. In 2003, the gross sample size was 4,012 and the net sample included 3,675 people.

⁶⁸ Illicit drugs cover the followings: cannabis, heroin, other opiates, cocaine, crack, amphetamine, ecstasy, LSD, magic mushroom, GHB.

⁶⁹ This research was conducted by the Behaviour Research Centre at Corvinus University of Budapest on a national representative sample. Data were collected according to ESPAD standards with self-reporting method in classes.

⁷⁰ Illicit drugs include cannabis, heroin, other opiates, cocaine, crack, amphetamine, ecstasy, LSD, magic mushroom, GHB.

12.2. PROBLEMS RELATED TO COCAINE AND CRACK USE

Profile of clients in treatment for cocaine use

Table 33. *Number of cocaine users in treatment, 2001-2005*

	Number of clients using cocaine			Number of all clients using illicit drugs
	Total	Male (%)	Female (%)	
2001	206	72	28	7880
2002	136	74	26	5638
2003	131	76	24	7786
2004	113	77	23	8028
2005	138	72	28	9219

Source: Report no. 1627 and report no. 1211 by the Ministry of Health

The number of clients using cocaine decreased between 2001 and 2004, whereas the number of clients using illicit drugs showed an increase from 2002 onwards. This decrease may be due to several private psychiatric and specialised addiction-treatment clinics opened in the past years. These clinics are not obliged to provide data on clients who therefore are probably not included in OSAP. Male-female ratio did not significantly change during five years observed. The majority of clients using cocaine were between ages 25 and 34.

Deaths related to cocaine use

As regards to deaths related to cocaine use, we only have data on deaths caused by direct overdose in the past few years.

Following 4 deaths in 2003, the number of deaths related to cocaine use decreased, thus the share of such deaths among all deaths also decreased. This apparent decrease should be interpreted with precaution because in several cases cocaine causes death in an indirect way, through heart-attack and other myocardial degenerations or arrhythmia. These cases, however, remain hidden.

12.3. RESPONSES AND INTERVENTIONS TO COCAINE AND CRACK USE

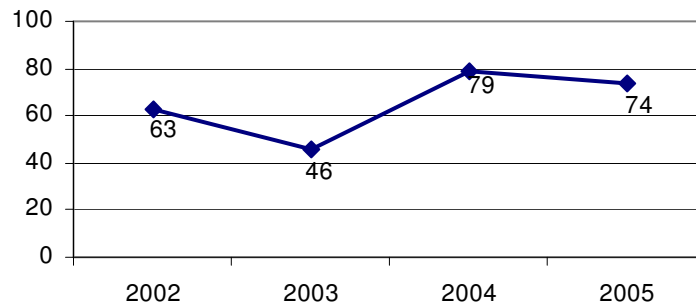
In case of misuse of narcotic drugs, the Criminal Code does not distinguish objects of perpetration. So is the case with cocaine and crack. The pure content of active substance of each drug type is considered when deciding on the severity of punishment. Small quantity varies according to drug types. Considering drug offences regulated by the Criminal Code, pure content of active substance of cocaine falling under 2 grams is qualified as small quantity Paragraph a) of Subsection (1) of Section 23 of Law-regulation no. 5 of 1979.

There are no activities specifically aimed at supply reduction of cocaine or crack.

12.4. COCAINE-RELATED CRIME, COCAINE AND CRACK MARKETS

Cocaine-related crimes amount to only a small share of all cases of misuse of narcotic drugs. The number of arrests does not show any clear trends in the previous years, and future increases or decreases of their number cannot be forecasted either.

Figure 27. Number of arrestees for misuse of cocaine



Source: National Police Headquarters

The breakdown of persons arrested for misuse of cocaine (74) by gender and age in 2005:

- 68 males and 6 females;
- 32 persons between 15-24 years and 42 persons over 25 years.

Cocaine market

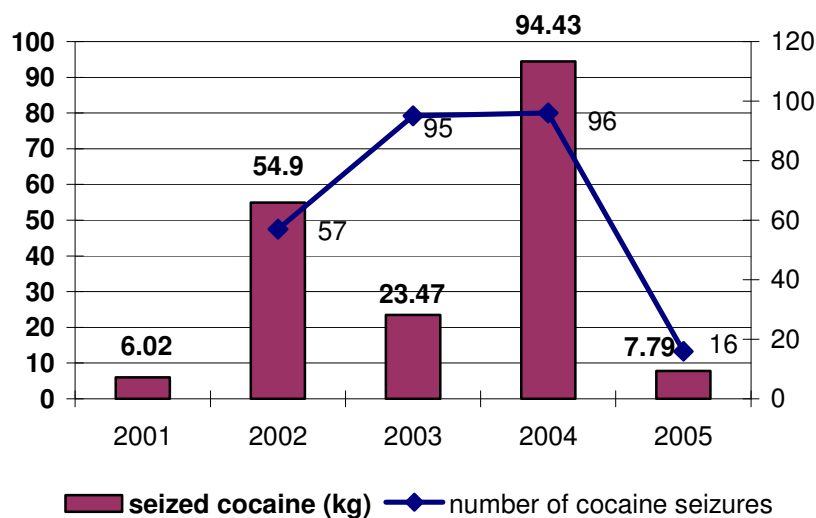
Supply⁷¹

Cocaine does not have such a high demand in Hungary than in other Member States of the European Union, but a segment is forming who can afford more expensive drugs as well. Cocaine sold on the Hungarian market is usually smuggled from the Netherlands. Availability of crack is not measurable, therefore we have data neither on seizures, nor on content of active substance.

Seizures

No tendency can be detected in seized quantities of cocaine, which is largely dependent on police investigations.

Figure 28. Number of cocaine seizures and seized quantities in Hungary⁷²



Source: BSZKI

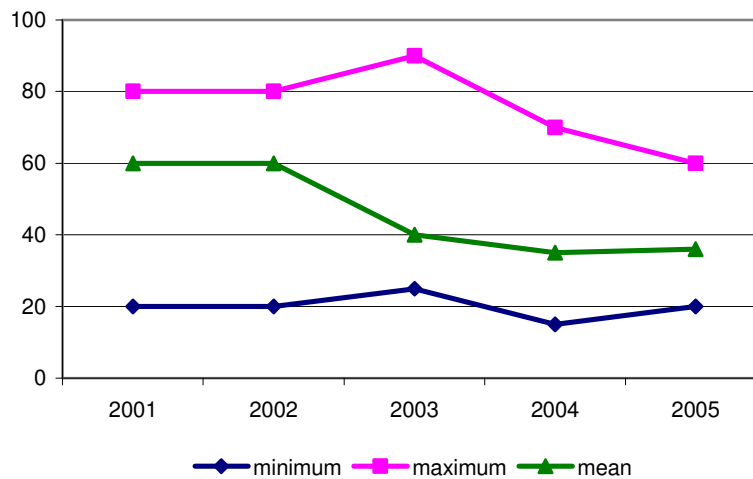
⁷¹ Based on a report of the National Bureau of Investigation.

⁷² No data are available on the number of seizures in 2001.

Purity

When testing content of active substance, quantity of a powdered drug falling under 100 grammes is regarded as „street” quantity. Cocaine samples will only be selected for a laboratory analysis if their quantity exceeds 2 grammes. The average pure content of active substance of seized cocaine shows a decreasing tendency in the previous years. This decrease in purity may be explained by the fact that larger quantities of undiluted cocaine were not seized.

Figure 29. Change in content of active substance of cocaine at street level 2001-2005 (%)



Source: BSZKI

Price of cocaine and crack at street level

Surveys were conducted on the price of drugs at street level only in 2004 and 2005. For this reason, long-term conclusions cannot be drawn on their results. The typical price that respondents most often quoted is around EUR 60 per gram.

13. DRUGS AND DRIVING

13.1. POLICY AND STRATEGY

The National Strategy to Combat the Drug Problem emphasises the importance of traffic control in the prevention of accidents caused by driving under the influence of illicit drugs in two different contexts. The statements cited below are from the short and medium-term objectives of the subchapter "Community, co-operation":

"Establishment and control of local forms of checks (e.g. checking driving under the influence of drugs, the licensing procedures of music and dance places of entertainment, that is to say, controlling these places of entertainment to see whether or not they meet the requirements)"

"Reduction in the number of "disco accidents" deserves particular attention. Checks on public roads by the police should be intensified to safeguard the health and safety of the community; facilities should be organised so that the young would be able to use public transportation or special services when going to and returning from places of entertainment."

13.2. PREVALENCE AND EPIDEMIOLOGIC METHODS

Frequency of accidents caused by driving under the influence of drugs has not been estimated in Hungary so far.

13.3. DETECTION, MEASUREMENT AND LAW ENFORCEMENT

According to Paragraph c) of Subsection (1) of Section 4 of the Joint Regulation of the Minister of Transport and Post and the Minister of Interior No. 1/1975 (II. 5.) on the Rules of Road Traffic (Highway Code), "a motor vehicle may only be driven by a person who is not under the influence of any substance having a detrimental effect on one's driving ability and one's body does not contain any alcohol as a result of consuming alcoholic beverage." Based on this and according to Paragraph c) of Subsection (1) of Section 44 of Act XXXIV of 1994 on The Police, the Police have the right to test any driver to ensure their condition is safe for driving.

Driving under the influence of alcohol or other psychoactive substances is punishable in accordance with Section 188 of Act IV of 1978 on the Criminal Code:

Subsection (1) of Section 188 declares that „any person who drives a railway vehicle or aircraft, or a motorized vessel or water machinery, or a motor vehicle under the influence of alcohol or a substance having a detrimental effect on one's driving ability, commits a misdemeanour offence and is punishable with imprisonment of up to 1 year, public work or a fine."

The above-mentioned provisions clearly indicate that the Hungarian legal system does not make any distinction which psychoactive substance has influenced the driver. Therefore, data collection according to different illicit drug types, tranquillisers and sedatives it is not possible. Furthermore, these drug types do not have an effect on culpability and the degree of punishment.

The police inspect whether a driver is under the influence of alcohol and whether there is any alcohol in one's body on occasions of traffic controls and accidents. The fundamental difference is that inspection of a driver is obligatory in case of accidents but on traffic controls, the police may inspect a driver's status without any suspicion on misdemeanour or offence. On such controls, the police routinely inspect whether a driver is under the influence of alcohol by using a breath-alcohol test. Police staff do not carry out any routine inspections on whether a driver is specifically under the influence of illicit drugs, tranquillisers or sedatives. Police staff are basically trained to be able to recognise the influence of any psychoactive substances in Hungary. There is no special training for staff in this field.

If a breath-alcohol test has a negative result, but the controlling policeman suspects the influence of any substance that has a detrimental effect on the driver's driving ability, a drug test may be performed. In this case, the driver may be obliged by the police to give a urinary sample in an official room, on which pre-screening is done.

If the pre-screening test has a positive result, the remaining urinary sample and a blood-sample taken afterwards will be sent to the National Institute of Forensic Toxicology where a new test will be carried out. Results of the blood test provided by the National Institute of Forensic Toxicology can only be used as evidence in a criminal proceeding.

There is a basic difference in the culpability of being under the influence of alcohol or another substance having detrimental effect on one's driving ability. It is a misdemeanour if alcohol is traceable in the driver's blood. Should one also be under the influence of alcohol, one commits an offence. Accordingly, culpability may be claimed through proving content of alcohol first by a breath-alcohol test, then by a blood-test.

In case of any other substance having a detrimental effect on one's driving ability such as illicit drugs, tranquillisers or sedatives, it is only the influenced status that is prohibited, but not the traceability of such substance in the driver's blood. Thus driving in a state under the influence of a substance having detrimental effect on one's driving ability qualifies as a traffic offence.

If illicit drug use is revealed during a control, the police will initiate a proceeding on misuse of narcotic drugs irrespectively of the traffic offence.

As a consequence of the above, drug content in blood does not affect the fact of culpability and the degree of punishment.

The following punishments may be inflicted:

- In accordance with Section 188 of the Criminal Code, driving under the influence of alcohol or other psychoactive substances can be punished by imprisonment of up to 1 year in case of a misdemeanour, or imprisonment of up to 10 years in case of aggravating circumstances (e.g. if the crime causes the death of more than one person);
- if the case is as described in Section 188, the suspension of the driver's driving licence for a period of 1-10 years or on a temporary basis (until later review) may be applicable also as a punishment.

The number of crimes denoting „driving under the influence of psychoactive substances” accounted for 162 in 2005. This number increased compared to the previous years.

Table 34. *Number of revealed crimes committed by driving under the influence of alcohol or other psychoactive substances in the period of 1999 to 2005*

	1999	2000	2001	2002	2003	2004	2005
driving in a reckless state	53	86	135	151	94	114	162
driving under the influence of alcohol	12623	11669	11621	13318	12737	13758	14417

Source: ERÜBS

For the afore-mentioned reasons, these data do not clearly show which substance influenced the driver at perpetration.

In contempt of the increase in the number of cases, it is important to note that traffic crimes committed by driving under the influence of alcohol amount to 63% of all traffic crimes, whereas the share of crimes committed through driving in a reckless state does not reach 1% (0.71%).

In 2005, Hungary also joined 24 European countries in an international traffic safety action, TISPOL *Alcohol Drug Action* and carried out increased control on the roads. This action was implemented between December 14 and 17, 2005. A total of 2,180 policemen were on the roads and controlled 22,703 drivers. They found no positive drug tests, but 274 positive breath-alcohol tests.

Before the implementation of the TISPOL action in Hungary there was an intensive press campaign. Thus a wide circle of drivers were informed about the controls in advance and the preventative effect could clearly be seen. It is also true that the underlying reason for heavy traffic before Christmas is shopping, that's why the ratio of driving under the influence of alcohol or other psychoactive substances is lower than usual.⁷³

In 2006, Hungary took part in two TISPOL actions in June and December.

13.4. PREVENTION

There are no special prevention programmes running in driving schools.

Use of pharmaceuticals may have a detrimental effect on one's driving abilities (through foreseen side effects), which therefore must be noted in documentation of such pharmaceuticals. This documentation includes information for patients and rules of prescribing for doctors. When examining the side effects of a medicine, manufacturers must also study its possible effects on one's driving abilities. Should such a side effect be revealed, it must also be noted in the indication of the medicine.

In accordance with subsection (1) of section 17 of the Regulation of the Minister of Health No. 52/2005 (XI.18), rules of application must include data listed in Annex 2 of the regulation.⁷⁴

Over the course of licensing a pharmaceutical product, the National Institute of Pharmacy verifies the accuracy of the documentation and the complexity of side effects described based on clinical experiences.

⁷³ Source: Spokesman's Office of the National Police Headquarters

⁷⁴ Paragraph 4.7 of Annex 2. „Product's effects influencing one's abilities to drive and/or operate machinery”

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LIST OF ABBREVIATIONS

ÁNTSZ - National Public Health and Medical Officers Service

BSzE - Association of Safe Entertainment Venues

BSzKI – Criminal Professional and Researcher Institute

KEF – Coordination Forum on Drug Affairs

ICsSzEM – Ministry of Youth, Family, Social Affairs and Equal Opportunity

ISM – Ministry of Youth and Sports
KKB – Coordination Committee on Drug Affairs
ERÜBS – Uniform Police and Prosecutors' Criminal Statistics
ESzCsM – Ministry of Health, Family and Social Affairs
ETTSZ - Health Toxicological Information Service
EüM – Ministry of Health
GyISM – Ministry of Children, Youth and Sports
MH – Hungarian Army
MH- EVI – Hungarian Army's Health Institute
NDI – National Institute for Drug Prevention
NIH - National Institutes of Health, USA
OAI – National Institute for Addictology
OEK – National Centre for Epidemiology
OEP – National Health Insurance Fund
OM – Ministry of Education
OSAP – National Statistical Data Collection Program
OTH - National Chief Medical Officer
OTKA – National Scientific Research Found