European Monitoring Centre for Drugs and Drug Addiction

DROG FÓKUSZPONT

2020 NATIONAL REPORT
to the EMCDDA
by the **REITOX Hungarian National Focal Point**

"HUNGARY"

REITOX

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T0. SUMMARY

The National Anti-Drug Strategy, which came into force in 2013, expired in 2020. No new drug strategy or drug action plan (policy programme) was adopted until September 2021. Until the adoption of the next drug-related or a more comprehensive (covering eg public health, mental health) targeting document, professionals consider the goals and framework of the outdated drug strategy to be followed.

Hungary's strategy document, the 2013-2020 National Anti-Drug Strategy, has set out domestic drug policy since 2013. The second action plan (referred to as a policy programme) was launched in 2017 and includes 27 measures for the purpose of achieving the objectives under the National Anti-Drug Strategy.
Drug affairs coordination tasks come under the purview of the Ministry of Human Capacities (EMMI) and include supporting the work of the Inter-Ministerial Coordination Committee on Drug Affairs (KKB) and the Council on Drug Affairs (KT), as well as performing professional coordination of the ministry's background institutions.
No detailed information is available concerning public expenditure on tackling the drug problem.

T1. NATIONAL PROFILE

T1.1 NATIONAL DRUG STRATEGY

T1.1.1 Previous drug strategies

Time-frame	Title	Focus
2000-2009	National Strategy for Reducing the Drug Problem[2]	Illicit drugs
2010-2020	National Strategy for Tackling the Drug Problem[3]	Illicit drugs
2013-2020	2013-2020 National Anti-Drug Strategy – Clear Consciousness, Sobriety and the Fight against Drug Crime[4]	Illicit drugs

T1.1.2 The current national drug strategy[5]

The National Anti-Drug Strategy, which came into force in 2013, expired in 2020. No new drug strategy or drug action plan (policy programme) was adopted until September 2021. Until the adoption of the next drug-related or a more comprehensive (covering eg public health, mental health) targeting document, professionals consider the goals and framework of the outdated drug strategy to be followed.

[1] Authors of the workbook: Gergely Csaba Horváth and Orsolya Varga
[2] National Assembly Decision 96/2000 (XII. 11.) on approval of the National Strategy for Reducing the Drug Problem
[3] National Assembly Decision 106/2009 (XII. 21.)
on the National Strategy for Tackling the Drug Problem
[4] National Assembly Decision 80/2013 (X. 16.) on the 2013-2020 National Anti-Drug Strategy
[5] National Assembly Decision H/11798 on the 2013-2020 National Anti-Drug Strategy – Clear Consciousness, Sobriety and the Fight against Drug Crime: http://www.parlament.hu/irom39/11798/11798.pdf

After social and public administration consultations, the National Assembly approved National Assembly Decision 80/2013 (X. 16.) titled “2013-2020 National Anti-Drug Strategy – Clear Consciousness, Sobriety and the Fight against Drug Crime”. The National Anti-Drug Strategy sets out objectives for the period between 2013 and 2020. Besides recognising the need to address personal and social risks and harms in connection with substance use, its main objective is the reduction of illicit substance use with the aid of targeted, community-based interventions. The National Anti-Drug Strategy aims to achieve that objective through wide-ranging prevention activities, by reinforcing a recovery-focused approach and reintegration in the field of care and treatment of drug addicts, by means of more effective use of crime-prevention and crime-fighting interventions in the field of supply reduction, as well as by taking strict action against trafficking.
The strategy draws on five basic values (Right to life, human dignity and health; Personal and community responsibility; Community action; Cooperation; Scientific basis) to lay out general and specific objectives in the following fields: Health promotion and drug prevention; Treatment, care, recovery;
Supply reduction.

The Policy Programme for implementation of the current National Anti-Drug Strategy was approved by the Government in its Government Decision 2010/2015 (XII. 29.). The Policy Programme contained 31 measures and 56 tasks. In the field of demand reduction, the programme was designed to provide for the quality-assured, system-wide development of health promotion and general drug prevention, as well as modernisation and capacity building based on the needs of the treatment and care system and reintegration. The main aim of the document on supply reduction was to hinder imports to Hungary of new psychoactive substances liable to be misused and their domestic trade, as well as to step up implementation of crime prevention. To that end, it was particularly important to curb crimes committed online and to protect growing generations in all settings where children and young people are at heightened risk.

The aforementioned policy programme was followed by Government Decision 1669/2017 (IX. 15.) on the 2017-2018 Policy Programme of the National Anti-Drug Strategy[6]. This policy programme contains 27 measures. The four pillars of the policy programme are as follows: I. Development of the health promotion and drug prevention system; II. Development of the treatment, care and recovery system; III. Development of the system for supply reduction interventions; IV. Mobilising human and social resources.
In the 2017-2018 policy programme, the development of the health promotion and drug prevention system is supported by specific professional training, prevention network cooperation and impact assessment of the preventive-consulting service (hereinafter: quasi-compulsory treatment or QCT). The focus of development of the treatment and care system is on elaboration of the professional methodological guidelines (targeted interventions for early intervention, parental training packages, family and community interventions, policy measures) and development of the efficiency and accessibility of the system of institutions. Development of the system of supply reduction interventions in 2017-2018 is to be achieved through the modernisation of methodological and technical conditions. The aims are to mobilise human and social resources with the support of the Coordination Forums on Drug Affairs (KEFs), to strengthen the functioning of the Early Warning System for new psychoactive substances, to evaluate the process of implementation of the National Anti-Drug Strategy, to support research, and to improve cross-sectoral, professional and civil partnerships.

Preparation and implementation of the current policy programme for 2019-2020 are carried out under the State Secretariat for Health of the Ministry of Human Capacities.

[6] Government Decision 1669/2017 (IX. 15.) on the 2017-2018 Policy Programme of the National Anti-Drug Strategy <link>

T1.1.6 DRUG STRATEGY IN THE CAPITAL

A detailed description of the previous Budapest drug policy can be found in chapter 12 of the 2012 National Report under the title: “Drug policy of large European cities”. On 20 February 2019, the Budapest General Assembly passed a decision to establish the Budapest Coordination Forum on Drug Affairs (KEF) with 23 votes in favour, one against and five abstentions, under the leadership of the Mayor and the Chief of the Budapest Police Department. According to the accepted proposal, the creation of the KEF is necessitated by the spread of new psychoactive substances (“designer drugs”) and other additional substances which are not classified as narcotic drugs. The emergence of those trends calls for new approaches and social engagement. The document also states that the established Budapest Coordination Forum on Drug Affairs “will be able to effectively and efficiently meet expectations in the key field of intervention under the National Anti-Drug Strategy by not focusing primarily on law enforcement solutions and sanctions”. The Budapest Coordination Forum on Drug Affairs held its inaugural meeting on 2 May 2019, at which the agenda and work plan of the forum were approved and the various task forces were set up. The following four task forces were established: I. Task Force on Health Promotion and Prevention of Drug Use; II. Task Force on Treatment, Care and Recovery; III. Task Force on Strengthening Cooperation; IV. Task Force on Supply Reduction. (budapest.hu, 2019)

T1.2 EVALUATION OF THE DRUG STRATEGY

T1.2.1 Evaluation of strategies and action plans

The interim (2004-2005) evaluation of the National Strategy (2000-2009)
The final, external evaluation (2009) of the National Strategy (2000-2009)
Government Decision 2010/2015 (XII. 29.) on the Policy Programme (for the period until the end of 2016) of the National Anti-Drug Strategy

T1.2.2 Summary of the latest evaluation

Hungary’s first National Drug Strategy was adopted by the National Assembly with political census by National Assembly Decision 96/2000 (XII. 11.). The national strategic programme to combat the drug problem defined the country’s drug policy between 2000 and 2009. On request of the Hungarian drug coordination officials, interim evaluation of the Strategy, examining the short-term and mid-term objectives and including suggestions for the future, was performed by the Trimbos Instituut, in close cooperation with the National Institute for Drug Prevention, with financial support from the Netherlands Ministry of Foreign Affairs. The results were issued in a two-volume publication in Hungarian and English by the Dutch partner (Galla et al. 2005a, Galla et al. 2005b).
External evaluation of the Strategy was ordered in 2009 by the Ministry in charge of drug coordination. The study was conducted by ‘HealthMonitor’ Research and Consulting Non-Profit Ltd. commissioned by the National Institute for Drug Prevention (NDI) (Vitrai 2009). The results of the evaluation in detail are presented in the 2020 Drugs Policy Workbook under T.1.2.2.

In 2017 – as set by the Parliament Resolution 80/2013. (X. 16.) 2.(d.) – an interim evaluation was conducted about the implementation of the goals and tasks of the National Anti-Drug Strategy. The report in addition to the description of the implementation of the National Anti-Drug Strategy, the review of the system of care and the evaluation of its effectiveness, included an introduction of the measures related to the first term of the strategy.
Several methodologies were used to evaluate the implementation of the tasks included in the National Anti-Drug Strategy and to examine the system of care. The report on the

implementation of the strategic tasks has been prepared in a fundamentally descriptive manner, which provides a limited opportunity to examine the effectiveness and efficiency of the implementation. On the other hand, a mixed methodology was used to prepare the final report on the examination of the system of care (secondary analysis, interviews, professional interviews), which provided a greater opportunity to get to know the identified problems in detail and to evaluate the given interventions.
The main findings of the interim evaluation have been reflected in the second Policy Programme of the National Anti-Drug Strategy, adopted by the Government in June 2017.

T1.3 DRUG POLICY COORDINATION

T1.3.1 Description of drug policy coordination

The Coordination Committee on Drug Affairs set up at the end of the 1990s is a governmental body tasked with making proposals and formulating opinions; its members consist of representatives of the state administration and national institutions and it participates in the discussion and elaboration of responses to the drug problem. It was restructured at the end of 2006 and four of its permanent government delegate members were replaced by members from civil organisations.
Further reorganisation of the Coordination Committee on Drug Affairs was carried out in 2013 on the basis of Government Decision 1158/2011 (V. 23.) on the review of bodies established by a legal act or public body control instrument, as well as Government Decision 1452/2011 (XII. 22.) on implementation of the tasks set out in the former decision. As a result, the Coordination Committee on Drug Affairs continued its work with a new structure and name (Inter-Ministerial Coordination Committee on Drug Affairs – KKB) with the involvement of representatives of ministries and government offices, while the separate Council on Drug Affairs (KT) was set up with civil delegates.
Professional and political control of tasks related to drug prevention and drug affairs coordination is exercised by the State Secretary for Health of the Ministry of Human Capacities (EMMI); the direct state head of the field is the deputy state secretary responsible for professional healthcare management. From 2018, the National Drug Prevention Coordination Unit merged with the newly formed Unit for the Operation of Focal Points, which operates as a part of the Department of Public Health.

The main body for drug coordination in Hungary is the Unit for the Operation of Focal Points under the Department of Public Health of the Ministry of Human Capacities (for more information, see section T1.3.1 of the Drug Policy workbook). The Ministry of Human Capacities (EMMI) in its Organisational and Operational Regulations specifies the tasks of the National Drug Prevention Coordination Unit in connection with drug prevention[7] (among other tasks):

- participates in the development of strategies, programmes and action plans in the field of health promotion and public health;
- participates in defining strategic approaches to health promotion, health education and health protection;
- coordinates mental health tasks;
- coordinates the development and implementation of multi-sectoral drug-related programmes;
- participates in the preparation of budget appropriations for drug treatment, develops their professional content and monitors their use;

[7] Instruction 16/2018. (VII. 26.) of the Ministry of Human Capacities on the Organisational and Operational Regulations of the Ministry of Human Capacities incorporating the amendments set out in Instruction 4/2019 (III. 1.) of the Ministry of Human Capacities.

- prepares reports and briefings to inform the Government and the National Assembly;
- performs tasks concerning functioning of the Inter-Ministerial Coordination Committee on Drug Affairs and the Council on Drug Affairs with the assistance of the National Centre for Public Health;
- performs tasks related to drug prevention and drug coordination that are not within the remit and competence of other public administration bodies or other departments within the Ministry.

Practical tasks related to the prevention and handling of the drug problem (application and grant management, coordination of KEFs and QCT etc.) were carried out by the ministry's background institution, the National Office for Drug Prevention, which operated as a unit of the National Institute for Family and Social Policy until September 2015. Following restructuring, the Office continued its operations as a unit of the National Office for Rehabilitation and Social Affairs (NRSZH). Since 1 January 2017, as legal successor, the Directorate-General for Social Affairs and Child Protection has been in charge of the drug policy tasks. The Unit for Drug Prevention Programmes – within the Directorate-General's Equity Department – operated between 1 April 2017 and 1 August 2019. Under Government Decree 180/2019 (VII. 26.), the functions of the Unit for Drug Prevention Programmes of the Directorate-General for Social Affairs and Child Protection (SZGYF) were merged and transferred to the National Centre for Public Health (hereinafter: NNK) from 1 August 2019 (SZGYF 2018).

The Coordination Forums on Drug Affairs (KEFs) play an important role in the implementation of drug policy and consist of local-level, professional consultation work groups that were created on the basis of local authority commitments, local-level professional collaboration aimed at tackling the drug problem and ministry grants.
There are some 80-90 Coordination Forums on Drug Affairs[8] operating in Hungary, with capital, town, district, small-region, county or regional competence. The role of the Coordination Forums on Drug Affairs is to coordinate the work of the institutions of the four pillars for reducing the drug problem, namely community and cooperation; prevention; treatment and rehabilitation; and supply reduction. The members of the Coordination Forums on Drug Affairs are representatives of state, municipal, NGO and church organisations that are active in management of the drug problem. (SZGYF 2020)

T1.4 DRUG-RELATED PUBLIC EXPENDITURE

T1.4.1 Availability of data on drug-related public expenditure

Data are available on drug-related budget expenditures in Hungary, but they are part of a larger category in many sectors, of which no current data or research results are available on the proportions attributed to the drug problem. In the scope of demand reduction data are available on treatment and care for addicts. Redarding prevention data cover broader focus of health promotion interventions. Dedicated sources in the area are included in the budget of the ministry responsible for coordination of drug affairs, that are spent mainly on methodological and professional developments, support for local coordination and prevention programs.

The results of the study carried out in the past (Hajnal 2009) can no longer be regarded as valid .

[8] According to 2020 data from kef.hu

T2. TRENDS
Not applicable here.

T3. NEW DEVELOPMENTS

T4. ADDITIONAL INFORMATION

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

EMET (Human Resources Funding Manager) (2020): Drug programmes 2019 https://emet.gov.hu/kabitoszerugyi-egyedi-tamogatasok/

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

EMMI (Emberi Erőforrások Minisztériuma) (2017a): Az EMMI Szociális és Gyermekjóléti Szolgáltatások Főosztályának beszámolója.

EMMI (Emberi Erőforrások Minisztériuma) (2018a): Az EMMI Szociális és Gyermekjóléti Szolgáltatások Főosztályának beszámolója.

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

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

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

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

SZGYF (Szociális és Gyermekvédelmi Főigazgatóság) (2017): A Szociális és Gyermekvédelmi Főigazgatóság beszámolója az EMCDDA 2017-es Éves Jelentéshez

SZGYF (Szociális és Gyermekvédelmi Főigazgatóság) (2018): A Szociális és Gyermekvédelmi Főigazgatóság beszámolója az EMCDDA 2018-as Éves Jelentéshez

T6.2 METHODOLOGY
Not applicable here.

LEGAL FRAMEWORK[9]

T0. SUMMARY

Hungarian legislation has been characterised by multiple amendments to the Criminal Code over the past years. The Criminal Code, in force since 2013, determines the country's criminal law in a new structure following the altered drug-situation. The Criminal Code in force provides regulation in connection with illicit drugs and new psychoactive substances in six statutory definitions. Apart from 'acquisition and possession of small amount of new substances' –when infringement procedure is initiated– all stated acts are considered as crime. The possible punishments for drug trafficking can be imprisonment for a term of two to eight years, while for drug possession between one to five years. According to the law, there is a special exemption of culpability in the matter of possession of drugs under a certain limit called 'small amount', if the perpetrator is able to present a document before being sentenced in the first instance to verify that he has participated in treatment for drug addiction (QCT).
The rapid appearance of the new substances forced the country's decision-makers to elaborate a new monitoring and risk assessment system, which can be used to provide the appropriate information to make responsible decisions on the control of designer drugs.
Act XCV of 2005 on Medicines (hereinafter: Medicines Act) lays down the framework of the new legislation, while Government Decree 66/2012 (IV. 2.) (hereinafter: Government Decree) determines the processes and responsible institutions in connection with the reporting of new psychoactive substances, their preliminary assessment, scheduling and risk assessment. The substances considered as new psychoactive substances as a result of the preliminary assessment get listed to Annex I. of Decree no 55/2014 of the Ministry of Human Capacities. The rules of the official procedure and duties concerning drug precursors is defined by the Government Decree no 159/2005. (VIII. 16.).

T1. NATIONAL PROFILE

T1.1 LEGAL FRAMEWORK

T1.1.1 Characteristics of drug legislation

The new Criminal Code (hereinafter: Btk.) accepted by the National Assembly on 25 June 2012 entered into force on 1 July 2013.
Chapter XVII of the Btk. (Criminal offences against health) provides regulations in connection with illicit drugs in six statutory definitions:

1. drug trafficking,
2. possession of narcotic drugs,
3. inciting substance abuse,
4. aiding in the manufacture or production of narcotic drugs,
5. criminal offences with drug precursors,
6. misuse of new psychoactive substances. (For more information see T1.1.3)

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

[9] Author of the workbook: Réka Bálint

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

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

The statutory definition of aiding in the manufacture of production of narcotic drugs (Art. 182) determines a punishment in term between one to five years for the (a) creation, acquisition and transfer, or (b) the release and trade of substances, equipment or facilities needed for the manufacture of production of narcotic drugs.
The criminal offences with drug precursors (Act 183.) regulated also by the European Union, is punished by the Hungarian law by 3 years imprisonment for the basic cases.

The punishment for the basic cases regarding offenses related to the counterfeiting of medicines (Art. 185/A) is imprisonment up to 3 years. In the context of counterfeiting of medicinal products, substances under Annex III and IV. of the Psychotropic Convention are considered more severe.

The Btk. contains the cases and conditions of alternatives to criminal procedure (quasi compulsory treatment, hereinafter QCT) (Art. 180.) which, according to the Hungarian criminal law system, are given as grounds, for exemption from culpability. The text of the law states that if a person who produces, manufactures, acquires or possesses a small amount of illicit drug for own consumption or who consumes illicit drugs ‘is able to present a document before being sentenced in the first instance to verify that he/she has participated in treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service’ then he/she may not be punished or his/her sentence can be reduced indefinitely. The QCT may be initiated either in the prosecution or the court phase of the criminal proceedings. The possibility of QCT is not available for those persons who undertook QCT in the two years previous to the perpetration of the offence or whose criminal liability has been determined in a drug trafficking or drug possession case. In the event of the crimes committed with new psychoactive substances, it is not possible to participate in QCT. (For more information about QCT and people participating in QCT see T1.2.2 and T1.3.1 in the Treatment workbook and T1.2.1 in the Drug Market and Crime workbook.)
Additional official procedures, tasks and competencies regarding drug precursors are listed in Government Decree 159/2005.

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

According to the Hungarian criminal regulations the following substances specified in the law are classified as illicit drugs:
a) the substances specified in the Schedules I and II of the Single Convention on Narcotic Drugs signed in New York on 30 March 1961 ratified by law decree no 4 of 1965, amended and supplemented by the Protocol of 25 March 1972 in Geneva on the amendment of the Single Convention on Narcotic Drugs ratified by law decree no 17 of 1988,

b) the dangerous psychotropic substances specified in Schedule I and II of the convention signed in Vienna on 21 February 1971 on psychotropic substances, ratified by law decree no 25 of 1979 and
c) the psychotropic substances specified in the annex of the Act on Medicines for human use.
The punishments associated with the offences listed in the Btk. may be influenced by several circumstances of the perpetration of the offence, and by the amount of illicit drug; however, the type of drug does not affect the extent of punishment, neither according to the law nor the court practice.
Aggravating circumstances include offences perpetrated in criminal association with accomplices or perpetrated by a public official or a person entrusted with public functions, as well as acts perpetrated by a person over the age of 18 years who offers or supplies illicit drugs to a person under the age of 18 years or who uses such a person to commit other drug-related offences.
In general, it may be said that the Btk. specifies four quantity thresholds for the illicit drugs forming the subject of offences, which quantities relate to the pure active substance content of the illicit drugs. Perpetration with a small amount of illicit drug is treated as a privileged case as compared to the basic case. The act determines the quantity of the substantial amount - treated as an aggravating circumstance - to be twenty times the upper limit of the small amount, while the quantity of a particularly substantial amount is determined to be two hundred times the upper limit of the small amount. The text of the Btk. also includes the specification of the small amount for each of the individual illicit drugs (Art. 461). The following general rule is valid in the case of those substances where the law does not specify a precise active substance content: the illicit drug is considered to be of a small amount if its pure active substance content is not more than seven times the average effective dose of an unaccustomed user.
With respect to drug trafficking (distribution, dealing) the case of small amount as a privileged case was removed, because stricter action was justified in the case of trafficking-type behaviours.
The court has the possibility to take the addiction of the perpetrator into consideration when imposing the punishment, however, drug addiction (similar to alcohol, medicine, etc. addictions) can only be considered an attenuating circumstance if it causes an pathological mental state.

T1.1.3 Control of new psychoactive substances

The rapid appearance of the new substances forced Hungarian decision-makers to elaborate a new monitoring and risk-assessment system, which can be used to provide the appropriate information to make responsible decisions regarding the control of designer drugs.
Act XCV of 2005 (hereinafter: Medicines Act) lays down the framework of the new legislation, while Government Decree 66/2012 (IV. 2.) (hereinafter: Government Decree) determines the processes and the responsible institutions in connection with the reporting of new psychoactive substances, their preliminary assessment, their scheduling and risk assessment. The Medicines Act defines “new psychoactive substances’ as substances or groups of compounds recently appearing on the market that have no medicinal use and that, due to their effect on the central nervous system, are suitable for altering a person’s state of consciousness, behaviour or senses, and therefore represent a threat to public health similar to the substances listed in the illicit drug and psychotropic substance schedules, and so with respect to this, the minister responsible for health, classified them as such materials in a decree. The Medicines Act and the Government Decree created a new schedule (Annex 1 of Decree no 55/2014. (XII. 30.) of Ministry of Human Capacities) for the new psychoactive substances, which contains both individual compounds and compound groups (through this providing both a list of individual compounds and a generic approach).
According to the Medicines Act and the Government Decree, if the EMCDDA sends a notification about a substance on the basis of Directive 2017/2103 of the European Parliament and the Council, the responsible department of the Ministry of Human Capacities subjects it to

a special preliminary assessment to determine whether the substance may be included in the list. In order for a substance to be included in the schedule of new psychoactive substances it must be proved that the Hungarian authorities and professional institutions have no knowledge of any data that refers to the medical use of the substance indicated in the notice, and that excludes that the substance poses a similar risk to public health as the substances included in the schedule of illicit drugs and psychotropic substances. In accordance with Government Decree no. 271/2020, from July 2020 the preliminary assessment has been supplemented by a monthly overview of the first European identifications of new psychoactive substances in the EMCDDA's EDND system. The procedure for the preliminary assessment of substances identified abroad is the same as for the examination of substances identified in the national early warning system.

The individual compounds included in the schedule of new psychoactive substances must be subjected to a risk assessment within one year of their inclusion in the schedule. Depending on the result of the risk assessment, the compound must be transferred to the list of psychotropic substances (one of the schedules of Medicines Act) or to Schedule D of the Government Decree. If there is insufficient data available to complete the above risk assessment according to the findings of the expert body, the classification of the new psychoactive substance may be extended for a further year. This risk assessment obligation is not applicable for compound groups, which remain in the schedule of new psychoactive substances until at least one of the substances in the group complies with the conditions for the preliminary assessment. Activities defined by the relevant legislation in connection with new psychoactive substances may only be performed in possession of a permit issued by the state administration body for health.
The Btk. contains a section entitled "Misuse of New Psychoactive Substances' (Art. 184, 184/A-D), which follows the structure of the previous articles, but regulates the offences related to new psychoactive substances with more lenient punishments. The aggravated cases regarding NPSs are similar to the regulation of narcotic drugs, furthermore according to Act XLIII. of 2020, which came in force on 1st January the commission of a significant or particularly significant amount of new psychoactive substances is already subject to a more serious assessment The lenient cases relate to perpetration with a small amount, the upper limit of which is 2 grams with respect to the active substance (previously 10 grams) of the given substance[10]. Furthermore, small amounts have been established for group of compounds listed in Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities.[11] The punishable acts also include acquisition and possession of new psychoactive substances as long as the amount exceeds the small amount. It was not the purpose of the legislators to establish the criminal liability of users of new psychoactive substances, therefore consumption is not punishable, nor is acquisition and possession of a small amount. If the new psychoactive substance does not reach the small amount, the prosecution will be suspended and an infringement procedure[12] will be initiated against the drug owner of the new psychoactive substance. In addition, according to Act XLIII. of 2020, from January 2021, in the case of offenses falling under Section 184, preparation also becomes punishable, and the same penalty applies to those who provide financial means for the above-mentioned offenses.

The following table summarizes the national criminal law regulations related to illicit drugs and new psychoactive substances:

[10] Amended by Act XXXIX of 2017; in force from 23. May 2017.
[11] Act XLIII of 2020
[12] Act II. of 2012: 199/B §

Table 1. *Regulation of narcotic drugs and new psychoactive substances [13]according to the Penal Code*

Btk.	**imprisonment**	**Btk.**	**imprisonment**
Illicit drugs		**New psychoactive substances**	
Art. 176 (1): Offering, supply, distribution, and trafficking of illicit drugs (base case)	**2-8 yrs.**	Art. 184 (1): offering, supply, distribution, and trafficking of NPS (base case)	**1-5 yrs.**
Art. 176 (3): With substantial quantity	**5-20 yrs. /life imp.**	Art. 184 (2)/a: With substantial quantity	**5-10 yrs.**
Art. 176 (5): Small amount in base case	**max 2 yrs.**	Art. 184 (4): Small amount in base case	**max 1 yrs.**
Art. 177 (1): Adult person gives or offers illicit drugs to a minor	**5-10 yrs.**	Art. 184/A.: Adult person gives or offers NPS to a minor	**2-8 yrs.**
Art. 177 § (2): With substantial quantity	**5-20 yrs./ life imp.**	Art. 184/A. (2): With substantial quantity	**5-10 yrs.**
Art. 177 (4): Small amount (in base case)	**1-5 yrs.**	Art. 184/A.: Small amount (in base case)	**max 3 yrs.**
Art. 178 (1): Manufacturing, production, acquiring, possessing, importing, exporting, transferring in the country (base case)	**1-5 yrs.**	Art. 184/B.: Importing, exporting, acquiring, possessing NPSs over small amount	**max 3 yrs.**
Art. 178. (2)/b: With substantial quantity	**5-10 yrs.**	Art. 184/B (2)/a: With substantial quantity	**2-8 yrs.**
Art. 178 (2)/c: With a particularly substantial quantity	**5-15 yrs.**	Art 184/B. (2)/b: With particularly substantial quantity	**5-10 yrs.**
Art. 178 (5): Possession, offer of small amount (base case)	**max 2 yrs.**	Art 184/B. (5): Possession of small amount	**max 1 or 2 yrs.**
Art. 178 (6): Consumption of small amount	**max 2 yrs.**		
Art. 179 An adult person using a minor (see acts in Art. 178. (1))	**2-8 yrs.**	Art 184/C.: An adult person using a minor (see acts in Art. 184. (1))	**1-5 yrs.**
Art. 179 (3)/b: With substantial quantity	**5-15 yrs.**	Art 184/C. (2)/a: With substantial quantity	**5-10 yrs.**
Art. 179 (3)/c: With particularly substantial quantity	**5-20 yrs. / life imp.**	Art 184/C. (2)/b: With particularly substantial quantity	**5-15 yrs.**
Art. 180 Exemption from culpability: consumption under small amount if the person undertakes **QCT**	**X**	Acquiring, possessing NPS under small amount --> **misdemeanou**r --> Act 2012. II. Art. 199/B.	**X**
Art. 181 (1)/b: An adult who persuades a minor to engage in the consumption	**2 yrs.**	Art. 181 (1)/b: An adult who persuades a minor to engage in the consumption of non-narcotic psychoactive substances	**2 yrs.**
Art. 182 (1): The release and trade of substances, equipment or facilities needed for the manufacture of production of narcotic drugs	**1-5 yrs.**		

[13] The penalty items established in terms of Art. 184 regarding substantial and particularly substantial quantities are in force from 1st January 2020

Art. 183 (1): Holds, brings in, transports, engages in or obtains a false statement without permission or in excess of its limits	**max 3 yrs.**	
Art. 183 (2): in the event of a breach of the obligation to notify	**max 2 yrs.**	

Table 2. *Small amounts established for certain drugs and groups of compounds on the list of new psychoactive substances*

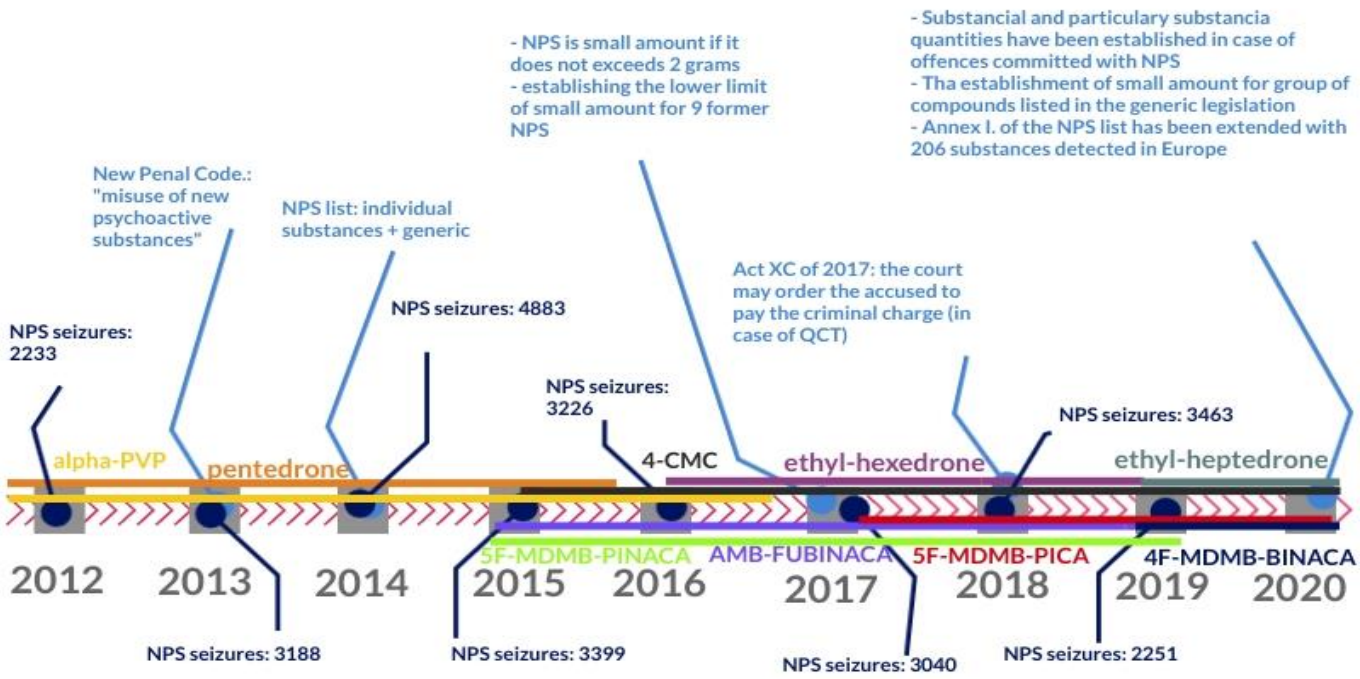
Btk.	**Small amounts established for certain narcotic drugs**		Btk.	**Small amounts established for NPS (Art. 55. of Act XLIII. of 2020.)**[14]	
Art. 461. (1) a)	**Content of pure active substance in base form**		**Art 461. (5)**	**In application of Act 184-184/C. the small amount for NPSs established if its active substance is under**	
aa)	LSD	0.001 g	a)	Substances in the **1st group (synthetic cannabinoids)** of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	0.5 g
ad)	Amphetamine; Methamphetamine; MDPV; Alpha-PVP	0.5 g	b)	Substances in the **2nd group (cathinones)**of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	1.5 g
af)	Heroin	0.6 g	c)	Substances in the **3rd group (triptamines)** of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	2 g
ag)	Morphine	0.9 g	d)	Substances in the **4th group (phenethylamines)** of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	1 g
ah)	Ketamine; Codeine; MDA; MDMA; MDE; MBDB; 1-Pea; N-methyl-1-PEA; mCPPí; methadone; 4-fluoramphetamine; pethidine	1 g	e)	Substances in the **4/a. group (N-fenil-1-(2-feniletil)-4-piperidinamin)** of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	0.1 g

[14] Comes in force from 1st January 2020

ai)	mephedrone; methilon; 4-MEC	1.5 g	f)	Substances in the **5th group (individually names NPSs)** of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	2 g
aj)	Cocaine	2 g			
al)	pentedrone	0.4 g			
Art. 461. (1) b)	in case of GHB its active substance content expressed in acid form	7.5 g			
Art. 461. (1) c)	**THC (TOTAL-THC)**	**6 g**			
Art. 461. (1) d)	active substance content				
da)	GBL	6.2 g			
db)	AB-CHMINACA; MDMB-CHMICA; AM-2201; AB-PINACA; AB-FUBINACA; and ADB-FUBINACA	0.05 g			
Art. 461. (3)	In application of Arts. 176-180. § the narcotic drugs in (1) and (2) is				
a)	with a substantial quantity if the if the upper limit of the small quantity specified for that drug is exceeded by	20x	**Art. 461. (6)**	In application of Art. 184-184/C. the NPS is with substantial quantity if its active content exceeds the upper limit of the small amount by	20x
b)	with a particularly substantial quantity if the if the upper limit of the small quantity specified for that drug is exceeded by	200x	**Art. 461.(7)**	In application of Art. 184-184/C. the NPS is with particularly substantial quantity if its active content exceeds the upper limit of the small amount by	200 X
Art. 461. (4)	In application of Arts. 176-180. § those narcotic drugs not appearing in (1) and (2) is		**Art. 184/D. (2)**	**In application of Art184-184/C. the NPS is small amount if its active substance content does not exceed 2 grams. In case of compounds in the form of a salt, the pure active substance content is to be understood as meaning the active substance content given in the base form.**	
a)	small amount if its net active substance content does not exceed **seven times** the average effective dose for the unaccustomed consumer				

b)	with substantial quantity if its net active substance content exceeds **one hundred and forty times** the average effective dose for an unaccustomed consumer		
c)	with particularly substantial quantity if its net active substance content exceeds **one thousand four hundred times** the average effective dose for the unaccustomed consumer		

Chart 1. *Emergence of new psychoactive substances and measures taken in line with them (2012-2020)*



T1.2 IMPLEMENTATION OF THE LAW

T1.2.1 Sentencing practice

No information available.

T2. TRENDS

T2.1 CHANGES IN THE LEGAL FRAMEWORK SINCE 2000

At the end of 2002, on the basis of its criminal policy endeavours, the government mitigated, differentiated and amended Act IV of 1978 on the Criminal Code (hereinafter: old Btk.) in several places. Along with this, necessary amendments were made to Act XIX of 1998 on Criminal Procedure (hereinafter: Be.).
The new legislation which entered into force on 1 March 2003 by the Act 2 of 2003 on the amendment of criminal and other laws placed the acts with varying risk levels in four separate articles determining different punishments. Acquisition type behaviour, trafficking type behaviours and, similarly to the previous legislation, the acts committed by drug addicts were to be found in different sections, the latter involving the threat of more lenient punishment as compared to the former. The amendment included a new provision: acts committed against minors and those perpetrated with the use of minors were included in a separate statutory definition, the aggravated cases of which were punishable with the most serious, lifetime imprisonment.
The old Btk. also contained the cases and conditions of QCT. The most significant change as compared to the previous legislation was that drug addiction was no longer a condition for using QCT. With respect to persons, any category of users (occasional, regular, addict) had the opportunity to take advantage of QCT (with more favourable regulations for drug addicts).[15]
Non-addict perpetrators only had the possibility for QCT if the amount of drug was not more than the 'small amount' of the given drug. With respect to criminal acts, QCT were typically available in the case of - less serious - use-related offences. However, two trafficking-type behaviours represented an exception, 'offer' and 'hand over', because if the offered and handed over illicit drug was of a small amount, and the act in question took place 'on the occasion of joint drug consumption', the perpetrator of the aforementioned two acts might have also taken advantage of the opportunity of QCT. It was a condition in all cases of QCT that 'the perpetrator is able to present a document before being sentenced in the first instance that verifies that he/she has participated for at least six consecutive months in treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service'. The QCT might have been initiated either in the prosecution or the court phase of the criminal procedure. The wide application of QCT presented in the above text was declared to be unconstitutional by Constitutional Court decision no 54/2004. (XII. 13.), which decision caused the amendment of several points of the old Btk. (Be. Art. 188(1); Art. 222(2); Art. 266(6)). (For details see Chapter 1.1. of the 2005 National Report)
The current Btk. entered into force on 1 July 2013, which presents the statutory definitions under separate subtitles (Art. 176-183), as opposed to the old Btk. which under the subtitle of misuse of narcotic drugs contained six types of perpetrations in four articles. (For details see chapter T1.1.1)
The Act XXXIX of 2017 - which got in force in May 2017 – amended the quantity of small amount regarding new psychoactive substances: In appliance of Art. 184-184/C the new psychoactive substance is a small amount if its pure active substance content does not exceed 2 grams. This Act is amended by Art. 55 of Act XLIII of 2020 to the extent that small amounts of groups of compounds in the first Annex to the list of psychoactive substances have been determined separately for each group (see: Table 2), therefore the 2 grams rule will be applicable for individually named substances.
Article 49 of Act XLIII of 2020 sets out the penalties for offenses committed with new psychoactive substances (Art. 184 of the Criminal Code) in the case of substantial quantity and particularly substantial quantity (see: Table 1).

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

The Act XC of 2017 – in force from 1st July 2018 – created a new Act on Criminal Proceedings (hereinafter new Be). The new Be does not change significantly on the criminal procedures connected to illicit drugs, however transfers QCT to the prosecutor phase from the police phase. Another change related to the former is that according to the new Be. (Art 576), "the court may order the accused to pay the criminal cost or part of the criminal charge, if the proceeding is terminated due to the fact that the accused has ceased to be punishable on the ground set forth in the Special Section of the Criminal Code". Furthermore, according to the new Be (Art 418) in case of adult offenders QCT is applicable without the need of probation service.

Act XLIII. of 2020 has amended the Schedule 184-184/C of the Penal Code from 1st January 2021. The law was clearly intended to bring the assessment of trafficking in new psychoactive substances closer to drug trafficking. Accordingly, the commission of significant or particularly significant amounts of new psychoactive substances, similarly to narcotic drugs, will fall under a more serious assessment. The upper limit of the small amount (previously uniformly 2 grams) has been differentiated according to expert experience, by group of compounds, forming a system proportional to the limit values similarly to narcotic drugs and reducing the limit values for many substances (see Table 2).

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

In the field of drugs, the following licensing authorities carry out law enforcement activities: Police, National Tax and Customs Administration, Government Office of the Capital City Budapest and National Institute of Pharmacy and Nutrition.
Changes experienced in the implementation of the law were caused by the continuous changes to the legislative background. A comparative analysis of sentencing practices over time is impractical due to the multiple amendments to the criminal codes.
In 2012 a survey was carried out to examine legal efficiency in connection with trafficking-related drug offences. The aim of the impact assessment was to examine the assertion, applicability and effects of the legal norms in effect relating to trafficking-related drug offences; while it also examined the indirect effects induced by the use of the legal acts, i.e. how legal practice affects the drug market. (For the results of the study see 2013 National Report, Chapter 9.2.)

T3. NEW DEVELOPMENTS

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

Table 3. *Changes in the legal framework in the last year*

The regulatory document subjected to amendments [16]	The amended regulatory document (current version)		
Title	**Title**	**Summary of changes**	**Remarks**
Government Decree no 623/2021	**Government Decree no 66/2012**	The definition of medical activity and the list of psychotropic substances have been amended.	In force since 25th November, 2021
Decree no 30/2020 of the Ministry of Human Capacities	**Decree 55/2014 of the Ministry of Human Capacities**	Annex I of the list of NPS was expanded with 206 NPSs detected in Europe	In force since 24 September, 2020

[16] Texts and hyperlinks of the documents subjected to amendments are not available.

Government Decree no 271/2020	**Government Decree no 66/2012**	The preliminary assessment of NPS has changed.	In force since 27 June, 2020.
Art. 49 of Act XLIII. of 2020	**Act C. of 2012**	Substantial and particularly substantial quantities has been established in case of offences committed with NPSs	Comes in force in 1st January, 2020
Art. 55 of Act XLIII. of 2020	**Act C. of 2012**	The establishment of small amount for group of compounds listed in the generic legislation	Comes in force in 1st January, 2020

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

As a proportion of the illicit drug cases in process in 2020 fell under the force of the old Btk. and the rest of them under the new Btk. in force (see T.1.1.1), the National Courts Office provided the data relating to 2020 on the basis of the two different structures of the old Btk. and the Btk. in force. (OBH 2021)

In 2020 15 persons were sentenced according to the old Btk. due to drug-related offences according to the following articles:

- Article 282/ A, B, C: 9 persons (illicit drug related offences)
- Article 283/A: 0 person (precursor related offences)
- Article 283/B: 6 persons (NPS related offences)

In 2020 the following punishments and measures were imposed on the 15 persons convicted with final judgement:[17]

- 11 were sentenced to imprisonment (executable and suspended)
- 0 were sentenced to community work
- 2 were fined
- 0 were reprimanded
- 2 was put on probation
- 1 were sent on probation service as a supplementary punishment

3294 persons were sentenced in criminal procedures started in 2020 according to the Btk. in force according to the following articles:

- Drug trafficking (Article 176-177): 489 persons
- Possession of illicit drugs (Article 178-180): 2994 persons
- Inciting substance abuse: Article 181: 10 persons
- Aiding the manufacture of illicit drugs: Article 182: 2 persons
- Criminal offences with drug precursors: Article 183: 4 persons

In 2020 the following punishments and measures were imposed on the 3294 persons convicted with a final judgement:

- 873 were sentenced to imprisonment (executable and suspended)
- 811 were sentenced to community work

[17] When imposing penalties and measures, one person may have been subjected to multiple penalties and measures in the same time, furthermore not all penalties and measures were indicated in the list.

- 1138 were fined
- 8 were reprimanded
- 348 were put on probation
- 136 were sent on probation service as a supplementary punishment

In 2020 407 people were sentenced related to the offence of misuse of new psychoactive substances (Article 184), and the following punishments and measures were imposed on the persons convicted with final judgement:

- 312 were sentenced to imprisonment (executable and suspended)
- 35 were sentenced to community work
- 58 were fined (including suspended fines)
- 0 were reprimanded
- 14 were put on probation
- 25 were sent on probation service as a supplementary punishment

In cases where the active substance content of the seized new psychoactive substance does not reach the small amount, the procedure shall be transferred to the infringement authorities after the investigation into the criminal offense of misuse of the new psychoactive substance has been terminated.
Proceedings for an offense involving a new psychoactive substance were typically preceded by criminal proceedings in which an expert's report found that the substance acquired or held by the person concerned constituted a small amount. Infringement proceedings were subsequently pursued.
In 2020 2522 people were taken under infringement procedure for misuse of new psychoactive substances. By the end of last year, 89% of those reported had been convicted. In 2020, the most frequently applied sanction for infringement procedures was the fine, with an average 70,484 Forint/person (BM 2021).

T3.3 EVALUATION OF LAW IN THE LAST YEAR

No information available.

T4. ADDITIONAL INFORMATION

No information available.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

Ministry of Interiors (2021): Activities on drug issues in 2020

Ministry of Justice (2021): Report on drug issues in 2020

OBH (National Courts Office (2021): Data from the Statistical Analytic Department 2021.

T5.2 METHODOLOGY

Not applicable.

DRUGS[1819]

T0. SUMMARY

T0.1 DRUG USE AND THE MAIN ILLICIT DRUGS

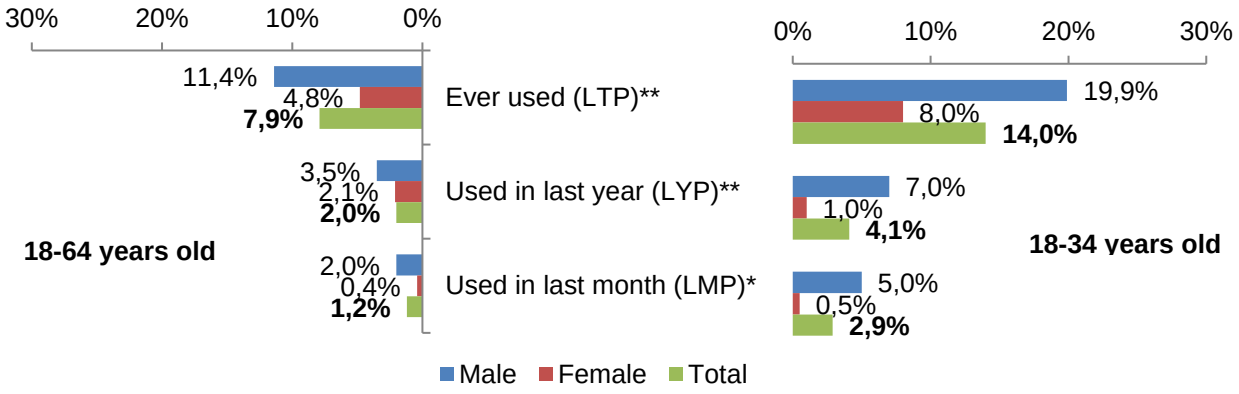
Use of illicit drugs

To determine the prevalence of the various psychoactive substances in Hungary, we can rely primarily on the NSAPH (National Survey on Addiction Problems in Hungary) general population surveys in the adult population (Paksi et al. 2019; Paksi 2020) and the ESPAD (Arnold, Elekes 2020) and HBSC (Paksi 2019) school surveys. These studies are typically conducted every 4 years, with the most recent data available from the 2018 wave in the case of the HBSC and from the 2019 wave in the case of the ESPAD and the NSAPH.

According to the 2019 NSAPH general population survey, every thirteenth[20] (7.9%) adult in the population between 18-64 years and almost every seventh (14%) young adult between 18-34 years has used some type of illicit drug[21] in their lifetime[22]. A quarter of ever-users reported illicit drug use in the last year, corresponding to 2% of the adult population (aged 18–64). 1.2% of the adult population reported illicit drug use in the last month (Paksi et al. 2019; Paksi 2020).

Examining the adult population by gender[23], it can be noted that all aggregate indicators of use of illicit drugs show a significant pattern: a higher proportion of men have used illicit drugs during their lifetime, as well as in the last year and in the last month, than women.

Chart 2. *Prevalence of illicit drug use in the Hungarian adult population in 2019 (%)*



Source: NSAPH 2019 – Paksi et al. 2019

Based on the results of 3 adult population surveys conducted between 2007 and 2019 (Paksi et al. 2009; Paksi et al. 2017, Paksi et al. 2019, Paksi 2020), recent (last year) illicit drug use

[18] Authors of the workbook: Anna Péterfi, Anna Tarján, Borbála Paksi, Petra Arnold, Réka Bálint and Lilla Szabics
[19] With respect to the epidemiological studies on drug use, the National Report in general classifies synthetic cannabinoids and designer stimulants appearing in a larger volume from 2009 under the category of "new psychoactive substances" (NPS) regardless of their current legal status.
[20] Every tenth to fifteenth person, taking into account the margin of error of the measurement.
[21] The following substances were considered to be illicit drugs: herbal cannabis/cannabis resin, synthetic cannabinoids, ecstasy, amphetamine, cocaine, crack, designer stimulants, heroin, other opioids, LSD, magic mushrooms, GHB, injected drugs, other drugs.
[22] Every sixth to ninth young adult, taking into account the margin of error of the measurement.
[23] Excluding the indicators of continuous consumption.

has not moved beyond the margin of error at the 95% confidence level in the young adult population aged 18-34 in the 12-year period studied.

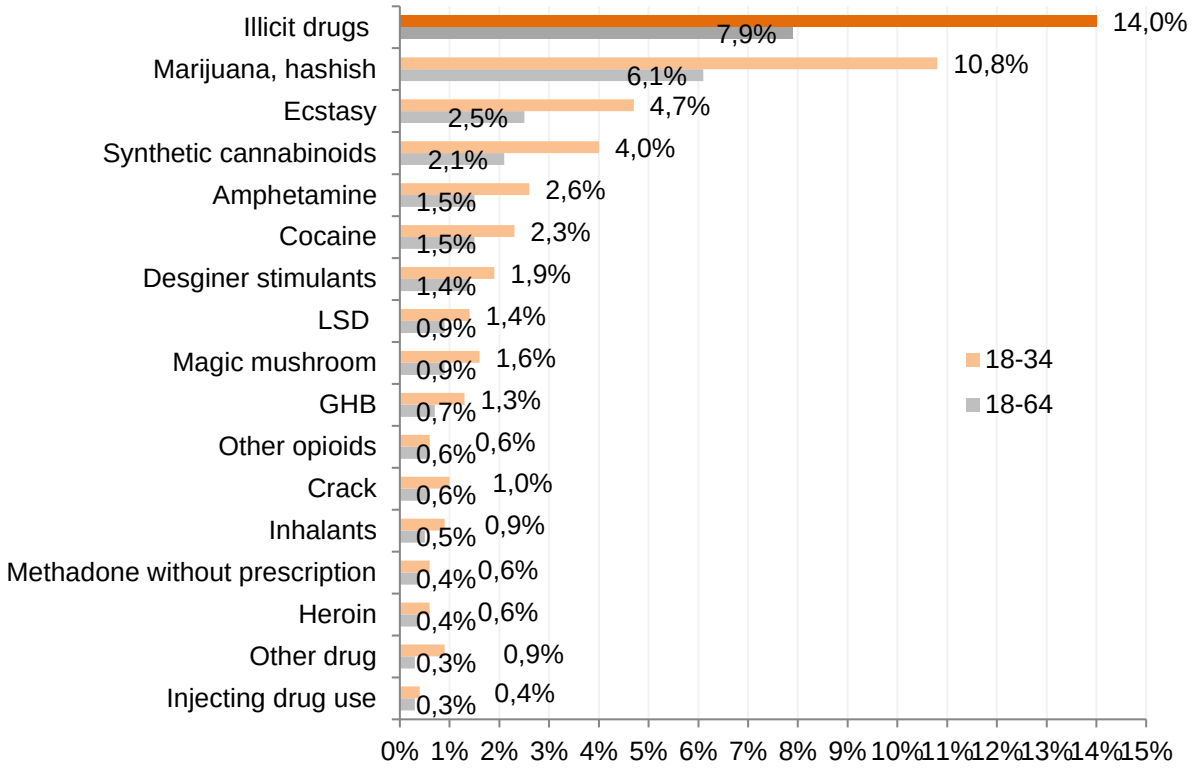
In the population aged 18-64, 44.5% of those who had used any illicit drug in the last year had used only one of the 14 types of drugs studied. However, 36.5% of last year users had used two, and one-fifth (20.1%) had used three or more types of drugs in the last year.

Main illicit drugs

In the adult population, among the illicit drugs studied, the highest proportion have used herbal cannabis or cannabis resin in their lifetime (6.1%). After herbal cannabis/cannabis resin, the most common drugs (which are tied considering the standard error of measurement) are ecstasy (2.5%), synthetic cannabinoids (2.1%), amphetamine (1.5%), cocaine (1.5%) and designer stimulants (1.4%). The lifetime prevalence for the other illicit drugs is lower than 1% (ranging from 0.3% to 0.9%) in the Hungarian adult population. The order of drug preference in the young adult population is essentially the same as in the adult population.

Overall, herbal cannabis/cannabis resin has maintained its leading position in the Hungarian population, followed by established stimulants and new psychoactive substances as the most popular drugs in the adult and young adult population (Paksi et al. 2020; Paksi 2020).

Chart 3. *Lifetime prevalence rates by substance types in the 18-64 and 18-34 year-old adult population in 2019 (%)*



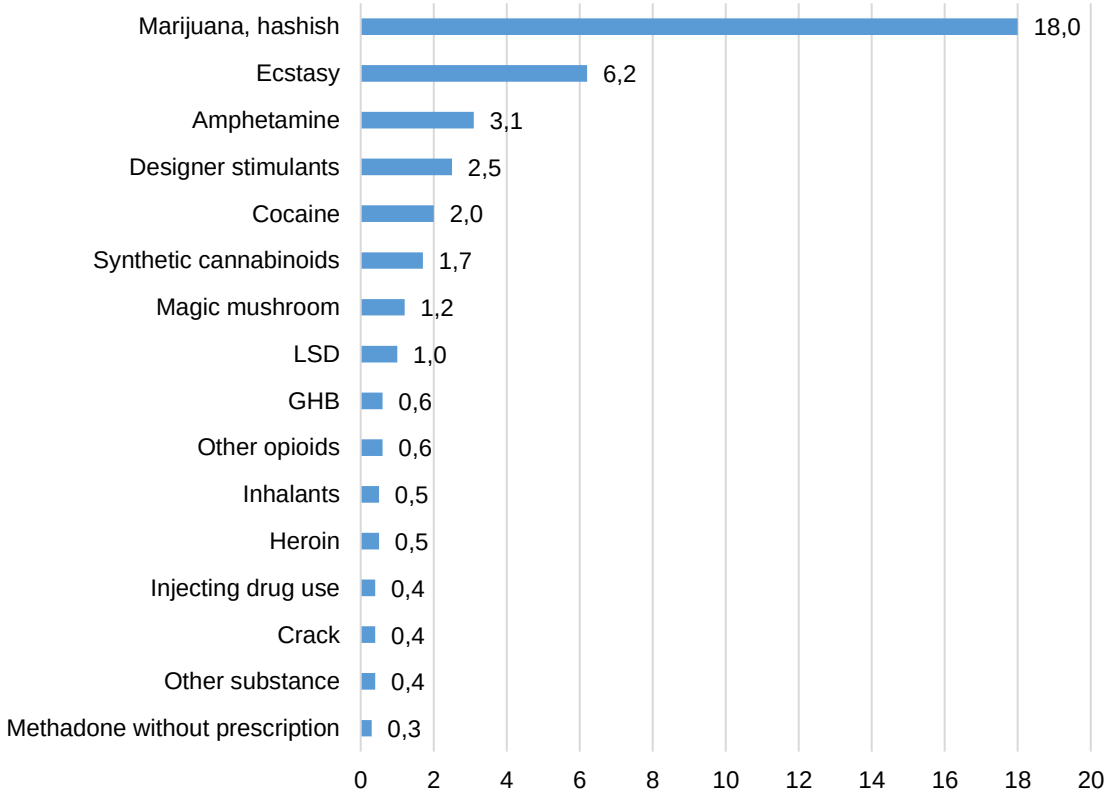
Source: NSAPH 2019 – Paksi et al. 2019

While synthetic cannabinoids rank second after herbal cannabis/cannabis resin in terms of ever-use (taking into account the margin of error, they are tied with ecstasy, amphetamines, cocaine and designer stimulants), in the order of importance based on recent drug use, they are tied for first place with herbal cannabis/cannabis resin in both the adult and young adult populations (Paksi 2020).

More recent data source are the results from the wave 2020 of the Budapest Longitudinal Study in the young adult population aged 19-35. In the young adult population aged 19-35 in Budapest, most, out of the illicit drugs included in the survey, have ever used cannabis in their lives. After cannabis, ecstasy is the most common illicit drug with a higher lifetime prevalence than other drugs, followed by amphetamines, designer stimulants and cocaine in a tie, taking into account the standard error of measurement. Synthetic cannabinoids, magic mushroom and the lifetime prevalence of LSD are also in a tie with the prevalance of ever using designer stimulants and cocaine (when considering the standard error). The prevalance of other drugs remains below 1% in the young adult population in Budapest according to 2020 data (Paksi 2021).

When comparing the hierachy of drugs based on their lifetime peravalance, with the adult population (aged 18-64) survey results (Paksi, Pillók 2021), the use of synthetic cannabinoids is less popular among young adults in Budapest (Paksi 2021).

Chart 4. *Lifetime prevalance rates by substance types for young adults aged 19-35 in Budapest in 2020 (in BLS wave 2, % of respondents)*



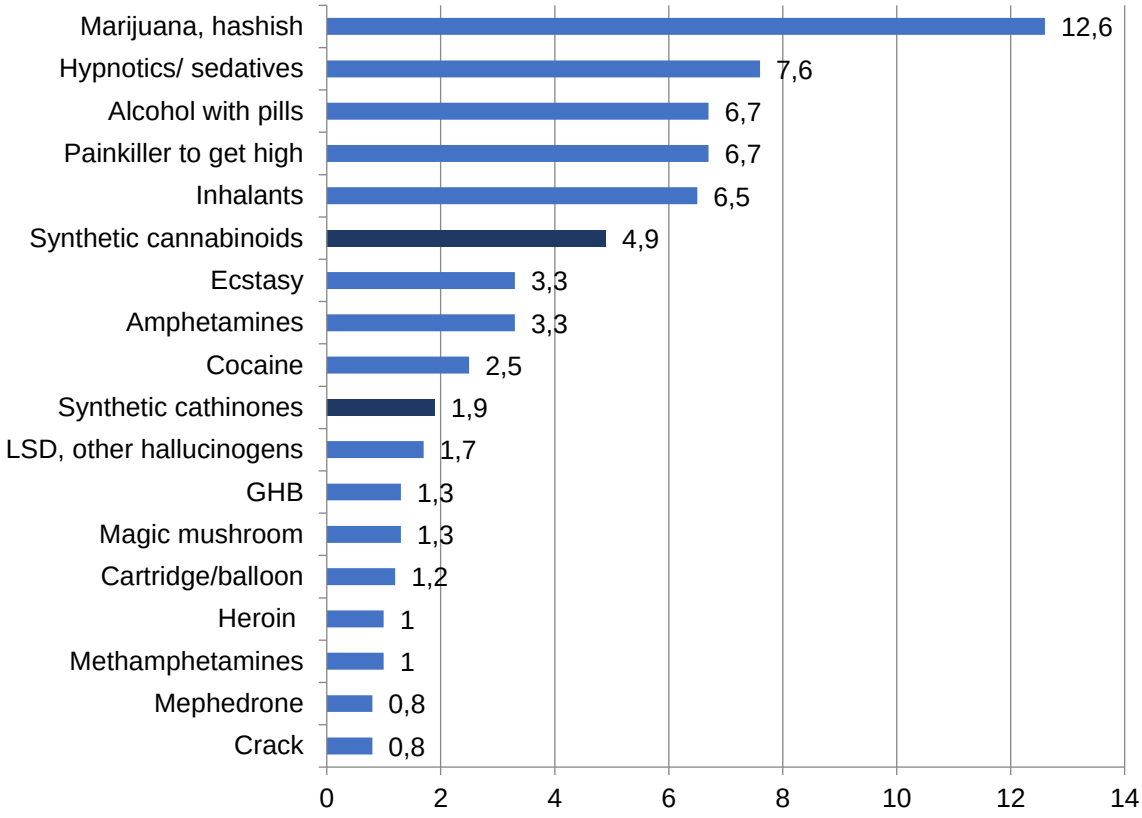
Source: BLS 2020 – Paksi 2021

According to the results of the 2019 national ESPAD survey, the lifetime prevalence of use of illicit drugs among 16 year-old school students[24] was 13.9% (Arnold, Elekes 2020). The proportion of users of medicines without a prescription[25] is somewhat lower (12.9%). Nearly a quarter of young people (23.2%) have used licit or illicit drugs at some point in their lives. There was no significant change in drug use compared to 2015: drug use indicators did not change; only the prevalence of use of new psychoactive substances (NPS) decreased, and there was

[24] Illicit drugs are understood as the following substances included in ESPAD studies from the outset: herbal cannabis/cannabis resin, ecstasy, amphetamines, LSD or other hallucinogens, crack, cocaine, heroin.
[25] Hypnotics/sedatives, painkillers (without a prescription) for the purpose of getting high, alcohol with medication.

a slight increase in the overall use of illicit and licit drugs. As in previous years, cannabis ranked first in the drug use pyramid with a lifetime prevalence of 12.6%, meaning that more than a tenth of 16 year-old students have tried herbal cannabis and cannabis resin in their lives. Following cannabis, the ranking includes medicines without a prescription: 7.6% of students have already used sedatives or hypnotics without a medical prescription, while 6.7% have already used alcohol with medication, or painkillers for the purpose of getting high. In fifth place in the pyramid is still a licit substance, namely volatile inhalants with a 6.5% lifetime prevalence, followed by one of the designer drugs, synthetic cannabinoids: every twentieth student has already tried such a drug. All the other drugs studied had a prevalence of below 5%. Crack, mephedrone, methamphetamines and heroin rank last (Arnold, Elekes 2020).

Chart 5. *Lifetime prevalence rates by substance types among 16 year-old students in 2019 (%)*



Source: ESPAD 2019 – Arnold, Elekes 2020

Routine data collection results and research in the field indicate that patterns of use among high-risk drug users have changed significantly since 2010. That change can be attributed primarily to the emergence and increasing use of new psychoactive substances (NPS) – mainly synthetic cathinones and synthetic cannabinoids – and to the decreased availability of established substances typical of high-risk drug use (heroin and amphetamine).

That pattern change not only affected PWID, but also other socially marginalised groups, such as homeless people; prisoners; people living in segregated areas; and young people in child protection care.

In parallel with the spread of NPS use (2011-2015), HCV prevalence at the national level doubled (to 49%) in PWID. Among primary NPS injectors, the prevalence of sharing injecting equipment and of HCV were significantly higher than among injectors of established substances.

Since 2016, injecting of synthetic cathinones appears to be declining; in parallel with that, recent research results underline a shift in the route of administration and the primary drug used among PWID, namely, increasing inhaling (using foil) of injectable substances and a periodic or permanent shift to synthetic cannabinoid use (smoking). Members of groups that

previously injected primarily are increasingly becoming poly drug users, switching between multiple substances and multiple routes of administration.

The most frequent reason for entering treatment in Hungary is cannabis use; its proportion (79.2%) is especially high among clients entering treatment as an alternative to criminal procedure (QCT). The second most common reason for addiction treatment is use of stimulants. NPS related treatment deamand shows a declining trend in treatment data, however in certain treatment modalities, still a significant treatment demand is linked to them. We can assume that the treatment system has difficulties engaging NPS users in treatment and does not reach a significant proportion of NPS users in need of treatment.

A) CANNABIS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 The relative importance of cannabis

Based on seizure data, in Hungary the most available cannabis derivative is herbal cannabis, followed by cannabis resin. There has been no marked change in the availability of herbal cannabis in recent years, whereas the number of seizures of cannabis resin below 10 g has been increasing since 2010, which may indicate a steady rise in use of cannabis resin. In the same time the authorities identified cannabis resin samples with high CBD and low (below 1%) THC active substance content (NSZKK 2021a). According to the annual survey of street prices (Bálint 2021), the price of cannabis available on the Hungarian market has slightly increased in the 2020s, presumably due to the icreased demand during the COVID pandemic. As a result of the increase the mean price of herbal cannabis and cannabis resin exceeded 8.5 EUR/ g[26]. For further information on cannabis trafficking and seizures of the drug, see the Drug Market and Crime workbook.

16.4% of young adults aged 18-34 perceive the presence of herbal cannabis or cannabis resin in their environment, 9.5% have been offered herbal cannabis or cannabis resin at least once in the last 12 months, and 19.2% believe that they could obtain herbal cannabis or cannabis resin quite easily or very easily[27] (Paksi 2020).

Synthetic cannabinoids, known by the street names “bio” and “herbal”, typically appear as impregnated plant materials or more rarely in powder form on the streets. In recent years, synthetic cannabinoids have been identified as appearing in three new forms: “*magic tobacco”* (instead of using any kind of plant material, tobacco is impregnated with synthetic cannabinoids), *toothpick* (where small pieces of toothpicks or grated toothpicks soaked with the active ingredient are rolled into a cigarette and then smoked) and *paper* (where cigarettes are rolled from impregnated papers or documents). “Magic tobacco” and paper first appeared in detention facilities, but by 2017, magic tobacco had become widely available on the streets as well (NSZKK 2021a; Kaló et al. 2018). In 2020 40% of the impregnated herbal substances seized was magic tobacco (NSZKK 2021a). The range of active agents in products linked to synthetic cannabinoids usually follow changes in legislation dynamically. In general, 1-2 dominant substances are available on the market at the same time. Impregnated plant materials seized in 2020 contained the active agent 5F-MDMB-PICA and MDMB-4en-PINACA in 72% of cases (NSZKK 2021a). Beside, 4F-MDMB-BICA was seized in many cases linked to direct drug related deaths in 2020. It appeared per se or in combination with other substances on objects found in the vicinity of the bodies (NSZKK 2021a) The price of synthetic cannabinoids available on the market has barely changed over the years, with the mode price ranging from HUF 500 to HUF 1000 per gram (Bálint 2021).

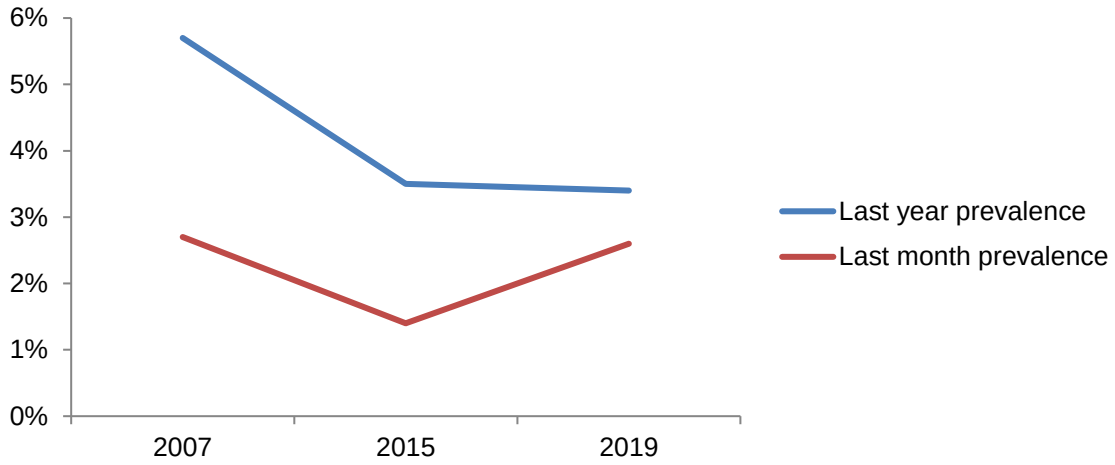
T1.1.2 Cannabis use in the general population

According to the data from the general population survey in 2019 (Paksi et al. 2019), cannabis is the most widespread illicit drug in the 18-64 year-old adult population; the lifetime prevalence rate is 6.1%, the last year prevalence rate is 1.3% and the last month prevalence rate is 0.9%. In the 18-34 year-old young adult population the lifetime prevalence rate for cannabis is 10.5%, the last year prevalence rate is 3.4% and the last month prevalence rate is 2.6%.

[26] Values were calculated using the EUR intermediate exchange rate valid for 2020 (EUR 1=HUF 351.17)

Several of the examined socio-demographic indicators examined showed a significant correlation with cannabis use. Between 2007 and 2015, a downward trend could be observed in cannabis use among the young adult population in the case of last year and last month use. However, in the period between 2015 and 2019, the survey results show a stagnation in the case of last year-prevalence and an upward trend in the case of last month use.

Chart 6. *Changes in the last year and last month prevalence (%) of cannabis use between 2007 and 2019, in the young adult population aged 18-34 years*



Source: NSAPH 2019 – Paksi et al. 2019

Several of the socio-demographic indicators examined showed a significant ($p < 0.05$) correlation with cannabis use (gender, age, urbanisation characteristics, cultural, labour market, economic and relationship status, satisfaction with various aspects of life, religiosity).

The most marked differences are observed in terms of age ($p<0.001$): the lifetime prevalence of cannabis use among young adults is almost three times higher than in the older age group. There is also a marked urbanisation pattern in the case of cannabis use ($p<0.001$). Among those living in settlements of 50,000 people or more, the lifetime prevalence of herbal cannabis/cannabis resin use is more than twice as high as in smaller settlements. However, it is important to note that we cannot speak in general of a linearly higher exposure of those living in settlements with a higher degree of urbanisation, since the capital city (Budapest) was linked to an average prevalence. The lifetime prevalence for males is also significantly ($p=0.001$) higher than for females. Based on the descriptive statistical analysis, the role of religious identity, especially uncertainty in that regard, and multiple deviant behaviours in the family ($p \leq 0.001$) should be highlighted as risk factors.

Table 4. *Lifetime prevalence of herbal cannabis/cannabis resin use across various socio-demographic characteristics in the general population aged 18-64, in 2019 (%) (as a proportion of respondents)*

Socio-demographic characteristics	Sub-group values	N	Herbal cannabis/cannabis resin LTP (%)	sign.
Gender	male	597	**8.4**	p=0.001
	female	680	4.0	
Young adult / adult	18-34 years old	403	**10.9**	p<0.001
	35-64 years old	874	3.9	
Age group	18-24	146	6.8	p<0.001
	25-34	256	**12.9**	
	35-44	330	6.1	
	45-54	288	3.1	
	55-64	256	2.0	
Size of settlement	<50,000 inhabitants	816	4.7	p=0.001
	≥50,000 inhabitants	236	**11.4**	
	capital city	225	5.8	
Region	North-West	231	10.0	p=0.073
	South-West	161	5.0	
	Central-East	241	6.2	
	North-East	239	3.3	
	South-East	178	5.1	
	Budapest	225	5.8	
Highest level of education[28]	year 8 or lower	126	6.3	p=0.032
	vocational school	436	5.0	
	final examination (secondary school)	461	4.8	
	degree	252	**9.9**	
Intergenerational educational mobility	upwardly mobile	661	4.5	p=0.041
	not mobile	536	**7.6**	
	downwardly mobile	50	**10.0**	
Vocational qualification	no	194	4.6	p>0.1
	yes	945	6.3	
Labour market activity	no job	303	6.3	p>0.1
	has job	958	5.7	
Subjective financial situation	we make a comfortable living from our income	108	**12.0**	p=0.009
	we make ends meet	797	6.0	
	we have a hard time making a living from our income	289	3.8	
	we have a very hard time making a living from our income	57	5.8	
Perceived relative financial situation	better than average	260	**10.0**	p=0.012
	average	790	4.9	
	worse than average	213	5.6	

[28] corrected by ongoing studies

Socio-demographic characteristics	Sub-group values	N	Herbal cannabis/cannabis resin LTP (%)	sign.
Net monthly income of household	<EUR 384	34	0	p=0.121
	EUR 385-553	103	6.8	
	EUR 554-784	178	2.2	
	EUR 785-1168	229	7.0	
	EUR 1169-1229	123	4.1	
	above EUR 1229	118	7.6	
Relationship status	not living with a partner	239	7.5	p=0.098
	living with a partner	849	5.1	
Religiosity	religious	624	2.9	p<0.001
	uncertain (cannot tell if religious)	76	**14.5**	
	not religious/atheist	548	**8.8**	

Source: NSAPH 2019 – Paksi et al. 2019

Table 5. *Mean value of various socio-demographic characteristics in ever-herbal cannabis/cannabis resin users and non-users in the 18-64 year-old population, in 2019*

Socio-demographic characteristics	Used		Not used		Difference in mean*	sign.
	Mean	N	Mean	N		
Age (years)	34.48	77	42.24	1197	-7.761	p<0.001
Size of household (persons)	2.97	75	2.91	1197	0.052	p>0.1
Deprivation index[29]	1.86	77	3.15	1199	-1.287	p=0.003
Anomie[30]	17.46	71	18.02	1106	-0.560	p>0.1
Number of deviant behaviours in the close family	3.05	74	1.55	1146	1.500	p<0.001
WHO general well-being	9.07	77	9.19	1171	-0.120	p>0.1
Hours spent working in an average week	30.66	71	31.33	1176	-0.674	p>0.1
Satisfaction: with work	3.43	71	3.69	1121	-0.255	p=0.059
Satisfaction: with financial situation	3.41	77	3.35	1180	0.062	p>0.1
Satisfaction: with family relations	3.96	77	4.20	1181	-0.237	p=0.024
Satisfaction: with partner relationship	3.78	76	4.07	1151	-0.295	p=0.035
Satisfaction: with other social relations	3.91	76	3.98	1178	-0.072	p>0.1
Satisfaction: with health	4.02	77	4.04	1179	-0.015	p>0.1

Differences that are statistically significant are indicated by a grey background
* difference in mean=users – non-users

Source: NSAPH 2019 – Paksi et al. 2019

In the adult population aged 18-64, the first herbal cannabis/cannabis resin use occurred on average between the ages of 19 and 20 (19.45 years-old), although a quarter of ever-users

[29] The deprivation index is an indicator with a multidimensional concept of being disadvantaged that measures the financial status and living conditions of individuals and families as a comprehensive system. The study examined the presence of 16 components of the living environment. The higher the index value, the greater the degree of deprivation.

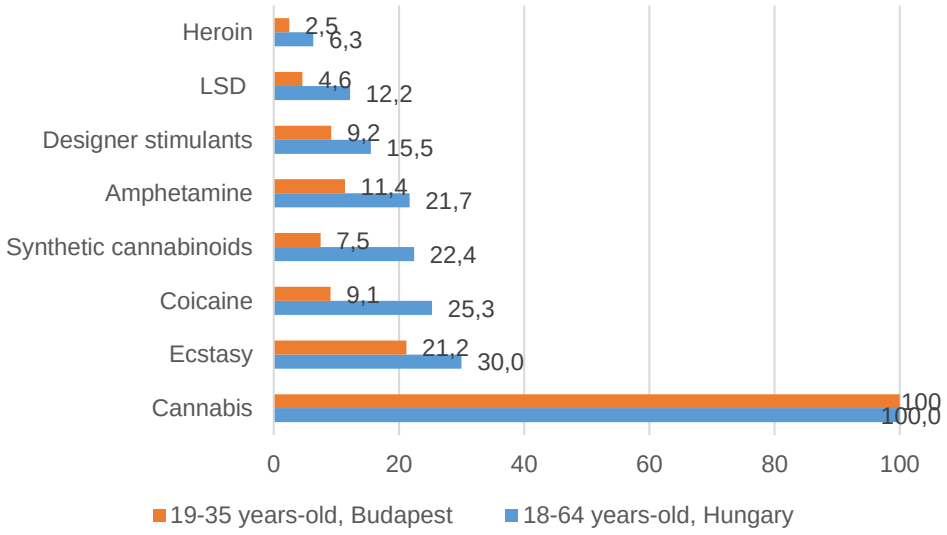
[30] The indicator is a subjective indicator measuring the degree of anomie across the dimensions of violation of norms, powerlessness, lack of orientation and alienation. The higher the value of the indicator, the greater the presence of anomic sensations.

had already tried cannabis by the age of 17, while more than half (58.2%) had already done so by the age of 19 (median age = 19 The earliest use was at the age of 12 and the latest at the age of 30.

Based on the 2020 wave of the BLS study, in the population aged 19-35 living in Budapest, a bit more than one-third (34.7%) of those who had used cannabis in their life had also used another illicit drug. The lifetime prevalence of use of illicit drugs other than cannabis in this population is 10.2%, so the risk for cannabis users to try some other illicit drug is approximately three times the risk measured in the young adult population of Budapest. If we build a drug use pyramid to examine the association between cannabis use and use of other drugs, we can see that among ever-users of cannabis aged between 19 and 35 and living in Budapest, the lifetime prevalence for each other illicit drug is 3-5 times the population average (Paksi 2021).

Compared to the 2019 NSAPH data, the slope of the pyramid among young adult cannabis users in Budapest is smaller compared to the drug use pyramid built for cannabis users in the adult population aged 18-64 (Pakis, Pillók 2021), and the structure of the pyramid is different. Compared to the national average for cannabis users in the adult population, the use of other illicit drugs is generally lower among young cannabis users in Budapest, and the use of synthetic cannabis and cocaine is particularly lower among young cannabis users in Budapest. That is, among young adults in Budapest, cannabis-using behavior is more independent of other substance-using behaviors than among the adult population in Hungary in general (Paksi 2021).

Chart 7. *Drug use pyramid for cannabis users in the 19-35 years-old young adult population of Budapest (based on the 2nd wave of BLS) and 18-64 year-old Hungarian population (based on NSAPH 2019) (as a percentage of cannabis users; N=498/77*)*



**N=number of cannabis users in the BLS/NSAPH sample*
Source: BLS 2020 – Paksi 2021; NSAPH 2019 – Paksi & Pillók 2021

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

According to the results of the HBSC survey carried out in 2018 (Paksi 2019), 19.8% of students in years 9 and 11 had already used cannabis and nearly one in ten (9.5%) had used it in the 30 days prior to the survey. This means that in an average-sized class 4 to 5 students have used herbal cannabis or cannabis resin in their lifetime, of whom around two students are currently using. Perceived cannabis use shows a significant pattern by both school year and gender: a higher proportion of students in senior years and boys perceive herbal cannabis/cannabis resin use in their environment (Paksi 2019).

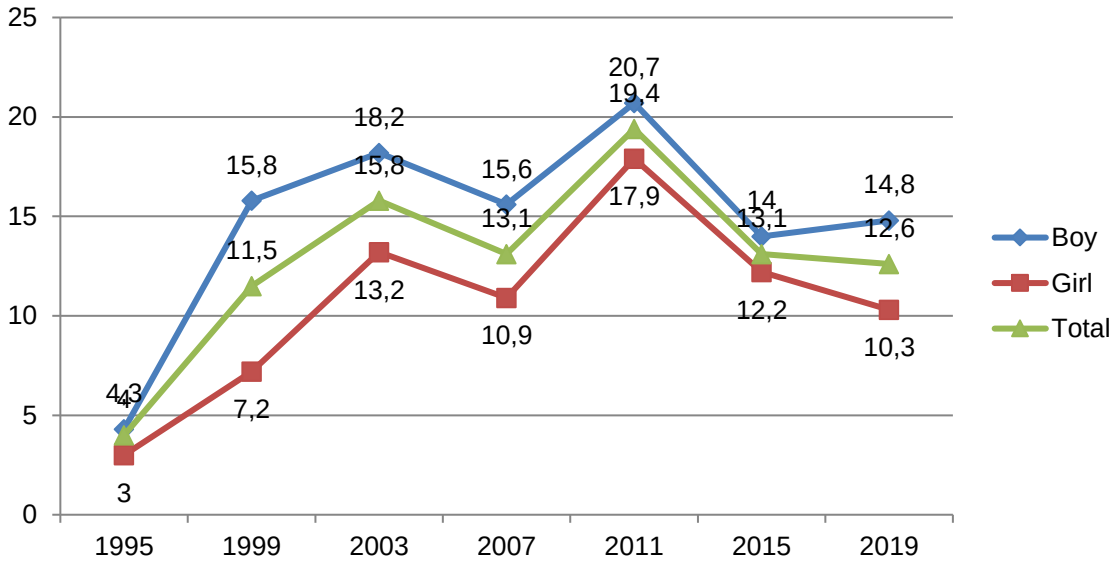
According to the latest ESPAD study (Arnold, Elekes 2020), cannabis was still the most common drug among school-age children in 2019.

More than a tenth (12.6%) of 16 year-old students had used herbal cannabis or cannabis resin in their lives. One in ten students (10.2%) had used the drug in the 12 months prior to the survey and one in twenty students (5.2%) had used the drug in the month prior to the survey. Four-fifths (79.9%) of students who had already tried cannabis had used it in the previous year and more than a third (39.9%) had used it in the previous month as well.

The lowest prevalence of cannabis use (4%) was measured in 1995; that figure nearly quadrupled by 2003. After a slight decline, it started to rise again in 2011, when its prevalence value peaked: nearly a quarter of 16 year-olds had already tried cannabis. By 2015, there was a larger decline; the proportion of ever-users fell by a third. In 2019, the lifetime prevalence for cannabis use among 16 year-olds showed no change compared to 2015, with a prevalence of around 13% in both years.

In all data collection waves, with the exception of 2015, significantly higher lifetime prevalence values were observed among boys than among girls. However, this difference appears to be diminishing over the years: while in 1999 the prevalence values for boys were over twice as high as those of girls, in 2019 the lifetime prevalence for boys was only one and a half times that of girls. In 2015, cannabis use of boys and girls did not differ significantly.

Chart 8. *Changes in the lifetime prevalence of cannabis use between 1995 and 2019 among 16 year-old students, by gender (%)*



Source: ESPAD 2019 – Arnold, Elekes 2020

Cannabis use shows a significant relationship with the majority of the background variables examined (no significant difference was observed with respect to the school's maintainer, parents' education or school type).

Lifetime prevalence values are about one and a half times higher among boys than among girls. Students/residents in Budapest are more likely to try cannabis than students attending school/living in rural areas.

Living with both birth parents (intact family) is a protective factor with respect to trying cannabis. Living in a broken family, or without both birth parents, is also a risk factor for experimentation with cannabis, but living in a patchwork family is associated with the highest risk.

The better the student's financial situation, the more likely he/she is to try cannabis resin or herbal cannabis: among 16 year-old students living in an above-average financial situation, we measured twice the lifetime prevalence of cannabis use as among those living in a below-average financial situation.

Table 6. *Lifetime prevalence of cannabis use across various socio-demographic characteristics among 16 year-old students, in 2019 (%)*

SOCIO-DEMOGRAPHIC CHARACTERISTICS		LIFETIME PREVALENCE OF CANNABIS USE %	sign.
Gender	male	14.8	p<0.01
	female	10.3	
School type	grammar school	12.3	not sign.
	vocational grammar school	11.5	
	secondary vocational school	14.9	
School address	Budapest	18.3	p<0.01
	county seat	10.7	
	other town	12.0	
	village	7.1	
School's maintainer	state	12.8	not sign.
	church	9.4	
	private	15.2	
Residence	Budapest	17.2	p<0.05
	town	12.6	
	village	10.7	
Family structure	intact	10.1	p<0.01
	patchwork	17.1	
	broken	16.8	
	no birth parents	16.4	
Father's education	lower than final examination (secondary school)	11.9	not sign.
	final examination (secondary school)	11.9	
	higher education	14.2	
	not known	11.4	
Mother's education	lower than final examination (secondary school)	11.5	not sign.
	final examination (secondary school)	11.9	
	higher education	13.7	
	not known	14.5	
Subjective financial situation	much better off	14.9	p<0.05
	about the same or better off	11.7	
	less well off	6.9	

Source: ESPAD 2019 – Arnold, Elekes 2020

Around half of the 16 year-old students who have already used cannabis are "one-time users": 48.3% of students have tried the drug once or twice and have not used it more times. However, the proportion of those who have used cannabis several times is relatively high (51.7%): one-fifth of ever-users have used cannabis 3-5 times, more than a tenth have used it 6-9 times, and slightly under a tenth have used it 10-19 times. Nearly one in ten students who have ever used it have used cannabis 40 or more times in their lives. Nearly a tenth of the users can therefore be considered regular users.

There was no significant difference between girls and boys in terms of age at first cannabis use. Boys, girls and the two groups taken together tried cannabis at a mean age of[31] 14.6 years.

For patterns of drug use among clients of harm reduction services in the nightlife/recreational setting, see Drugs/Cannabis/T4.1.

T1.2 PATTERNS OF USE, TREATMENT AND PROBLEMATIC/HIGH-RISK USE

T1.2.2 Treatment for cannabis

In Hungary, cannabis use is the leading reason for entering treatment for use of illicit drugs (see sections T1.3.1, T1.3.4 and T2.1 of the Treatment workbook). In 2020, 67.2% (2878 persons) of those entering treatment reported cannabis as their primary drug and a further 6.9% (297 persons) indicated the use of cannabis as a secondary drug (Péterfi 2021a - *TDI data 2021)*. From 2016 to 2018, the number of cannabis users entering treatment increased significantly, (2016: 2323 persons; 2018: 3174 persons); that is clearly due to the rise in cannabis users entering treatment as an alternative to criminal procedure (quasi-compulsory treatment). Between 2018 and 2020, the trend was also influenced by the change in the number of clients referred to treatment services from the criminal justice system (for quasi-compulsory treatment). In that two years, the number of cannabis users entering treatment decreased (2018: 3174; 2019: 2942; 2020: 2876 persons), partly due to the effect of the COVID pandemic and partly due to the changing activity of law enforcement authorities.

The majority of cannabis users (2564 persons, 89.3%) entered treatment as an alternative to criminal procedure (QCT) In 2020, three-quarters of the QCT clients (2564 persons, 75.8%) entered treatment because of cannabis use. Among the non-QCT clients, the proportion of clients entering treatment for cannabis use was significantly lower at 34.7% (308 persons).

88.8% of those entering treatment because of cannabis were male, while 11.2% were female. Their mean age was 27.2 years and they had used cannabis for an average of 7.2 years before entering treatment in 2020.
Of those entering treatment for cannabis primarily, 19.9% use it at least 2 days per week, 21.4% use it once or less per week, and 58.8% did not use it in the 30 days prior to treatment, or used it only occasionally. As described above, the vast majority of cannabis users receive treatment as an alternative to criminal procedure; typically they no longer use drugs or only occasionally.

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

T1.2.4 Synthetic cannabinoids

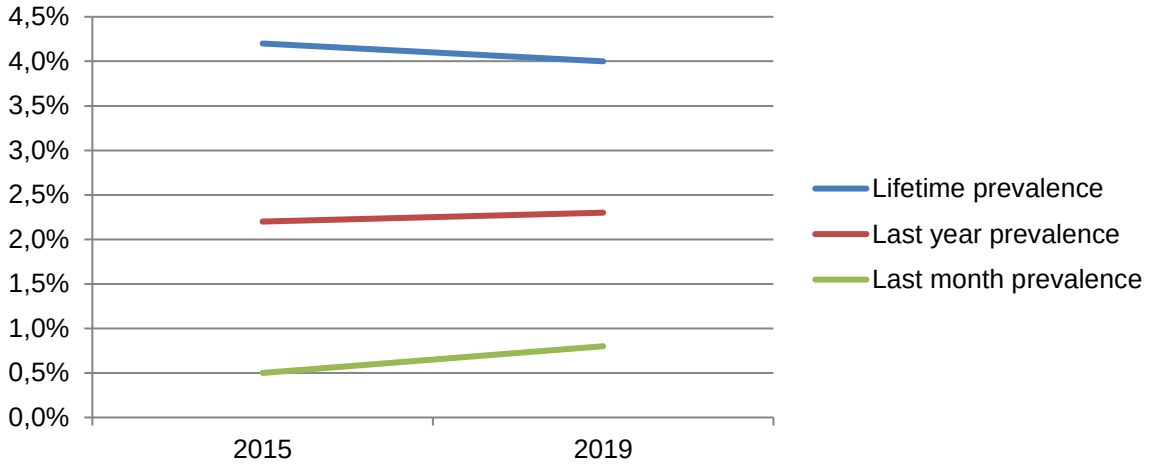
Adult population

According to the data of the NSAPH (National Survey on Addiction Problems in Hungary) general population survey in 2019 (Paksi et al. 2019; Paksi 2020), synthetic cannabinoids were among the most widely used drugs in the 18-64 year-old adult population in Hungary. Based

[31] For the calculation of the mean value, the 9 year-old or earlier category was counted as 9 year-old and the 16 year-old or later category as 16 year-old.

on lifetime prevalence (2.1%) they were the third most popular drug (following cannabis and ecstasy) and based on the last year prevalence rate (1.2%) they were the second most popular drug type after cannabis. Their last month prevalence was 0.3%. Changes in the prevalence of synthetic cannabinoids in the general population can only be monitored from 2015 onwards. Based on the results of the 2015 and 2019 population surveys, there has been no change in the prevalence of the use of synthetic cannabinoids in Hungary in these four years, in either the adult population in general or among young adults.

Chart 9. *Prevalence of synthetic cannabinoid use in the 18–34 year-old young adult population in 2015 and in 2019 (%)*



Source: NSAPH 2019 – Paksi et al. 2019

Using statistical tools to examine the basic socio-demographic patterns of synthetic cannabinoid use, we found significant differences in age, gender, degree of urbanisation of the place of residence, deviant patterns in the family, religiosity and one of the indicators of economic status. The lifetime prevalence of use of synthetic cannabinoids among men is about five times that of women, and the exposure of young adults is nearly four times that of older adults ($p<0.001$). In addition, the data indicate that deviant family patterns ($p <0.001$) and uncertainty regarding religious identity ($p = 0.004$) pose a significant risk; furthermore, people living in cities with more than 50,000 inhabitants are more affected than those living in smaller settlements and the capital ($p = 0.007$). Of the various indicators of economic status, only perceptions related to relative financial status showed a significant association with synthetic cannabinoid use, indicating a higher risk associated with living in above-average circumstances (Paksi 2020).

The mean age of using synthetic cannabinoids for the first time is 19. By the age of 19, almost two-thirds of those who have ever used synthetic cannabinoids have already used them.

Drug use pyramid for synthetic cannabinoid users

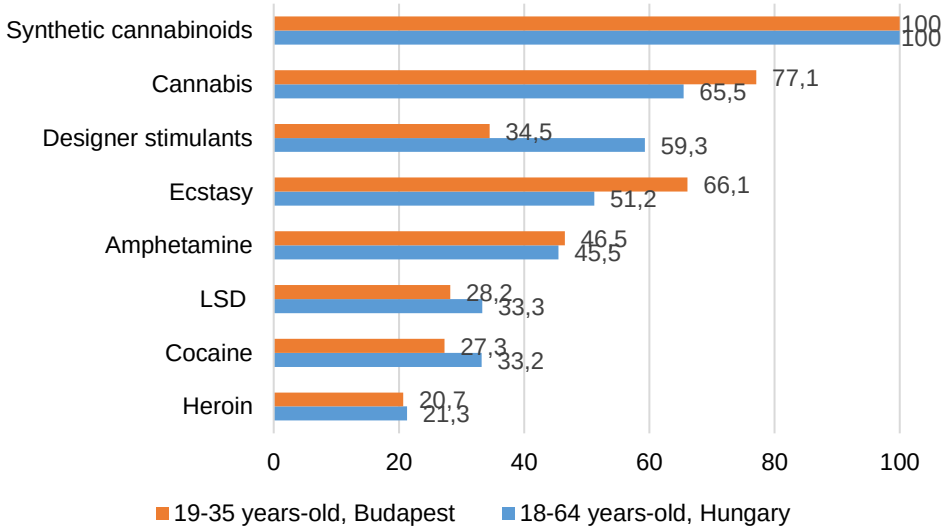
To investigate the relationship between synthetic cannabinoid use and other drug use behaviors, we created a special version of the drug use pyramid traditionally built for cannabis users, constructed for synthetic cannabinoid users based on the results of the 2020 wave of the BLS study in the 19-35 year old population in Budapest. The pyramid shows that of those who have ever used synthetic cannabinoids in their lifetime what proportion have used other drugs (cannabis, ecstasy, designer stimulants, amphetamines, LSD, cocaine and / or heroin) in their lifetime. Based on the pyramid, we can see that among young adults in the capital who have ever used a synthetic cannabinoid between the ages of 19 and 35, the lifetime prevalence of each other illicit drug is several times higher (four times higher in case of cannabis use, ten

to fifteen times in case of designer stimulants, amphetamine, ecstasy and cocaine and in the case of LSD it is almost thirty times, in the case of heroin it is forty times) than in the young adult population aged 19-35 in Budapest (Paksi 2021).

When comparing the pyramid built for synthetic cannabinoid users to the pyramid built for cannabis users, similarly to our previous analysis (Paksi, 2017), the pyramid of synthetic cannabinoid users has a much higher slope, i.e. in the young adult population synthetic cannabinoid users represent a more at risk population in terms of exposure to other drugs compared to cannabis users (Paksi 2021).

Based on NSAPH data from 2019, the slope of the drug use pyramid (Paksi 2020) built on synthetic cannabinoid users in the adult population aged 18–64 years is very similar to that drawn among young adult synthetic cannabinoid users in Budapest, only the location of designer stimulants is a significant difference.

Chart 10. *Drug use pyramid for synthetic cannabinoid users in the 19-35 years-old young adult population of Budapest (based on the 2nd wave of BLS) and 18-64 year-old Hungarian population (based on NSAPH 2019) (as a percentage of synthetic cannabnoid users; N=48/26*)*



**N=number of synthetic cannabinoid users in the BLS/NSAPH sample*
Source: BLS 2020 – Paksi 2021; NSAPH 2019 – Paksi & Pillók 2021

School population

According to the results of the 2019 ESPAD study (Arnold, Elekes 2020) conducted among secondary school students, one in twenty 16 year-olds (4.9%) has already used synthetic cannabinoids, putting them in second place in the drug use structure[32]. The lifetime prevalence of synthetic cannabinoid use decreased by a third, from 7.2% to 4.9%, between 2015 and 2019.

The ever-use of synthetic cannabinoids did not show a significant relationship with most of the socio-demographic characteristics examined. 16 year-olds in secondary vocational schools have about twice the prevalence values compared to their peers in grammar schools and vocational grammar school: secondary vocational school is therefore a clear risk factor for trying synthetic cannabinoids. When examining family structure, having an "intact family" was shown to be a protective factor, while all other forms of family can be seen as a higher risk

[32] In the questionnaire, synthetic cannabinoids were referred to as: a new type of drug with an effect similar to that of herbal cannabis (with street names: "herbál" (“herbal”, "bio" “bio”, "biofű" (“bio weed”), "magic tobacco", "synthetic weed")

factor: while only 3.3% of students living with both birth parents had ever used synthetic cannabinoids, 7.1% of those living in a patchwork or a broken family and 9.6% of those without their birth parents had ever used them.

The vast majority of 16 year-old students who have ever used a synthetic cannabinoid have tried the drug once or twice and have not used it repeatedly; 28.6% of the students have consumed it 3 or more times. Compared to the established drug cannabis, users appear to be more cautious with synthetic cannabinoids: while slightly more than half of those who have ever used cannabis have used it repeatedly, the proportion is lower than 30% for synthetic cannabinoids (Arnold, Elekes 2020).

NPS users in treatment data

For methodological reasons, we cannot distinguish between the different NPS groups (synthetic cathinone and synthetic cannabinoid users) in our treatment data; they can only be identified in the combined category of NPS users[33].
Based on time series data, it can be observed that in total the significance of NPS use has dropped in the treated population from 2014 onwards. Nevertheless, it is still the third most common reason for entering drug treatment in Hungary. 8.2% (349 persons) of those entering treatment in 2020 required treatment primarily for the use of an NPS, and another 6.4% (273 persons) reported an NPS as a secondary drug. In total, 13.9% (594 persons) of the population entering drug treatment had an NPS in their pattern of use. 84.5% (288 persons) of primary NPS users were male and 15.5% were female (53 persons). Their mean age was 29.5 years and they first used NPS an average 7.2 years before entering treatment 2020.
45.8% of the primary NPS users were intensive users: 31.0% used NPS on a daily basis, and another 14.9% used NPS on 2-6 days per week during the 30 days prior to treatment. 15.8% used NPS one or fewer times a week and 38.4% did not use NPS or used NPS only occasionally in the previous month. Trends in NPS users entering treatment are detailed in the time series data presented in section T2.1 of the Treatment workbook. The connection between NPS use and injecting drug use is described in the section Stimulants/T1.2.5. Research on the use of NPS is summarised in section T4.1 of this workbook.

T2. TRENDS

Trend data are presented in section T1.

T3. NEW DEVELOPMENTS

The Hungarian National Focal Point conducted a study also in 2021 regarding the impact of the COVID-19 pandemic and related restrictions on drug use and responses. See section T4.1.3 of the Treatment workbook for the results.

T4. ADDITIONAL INFORMATION

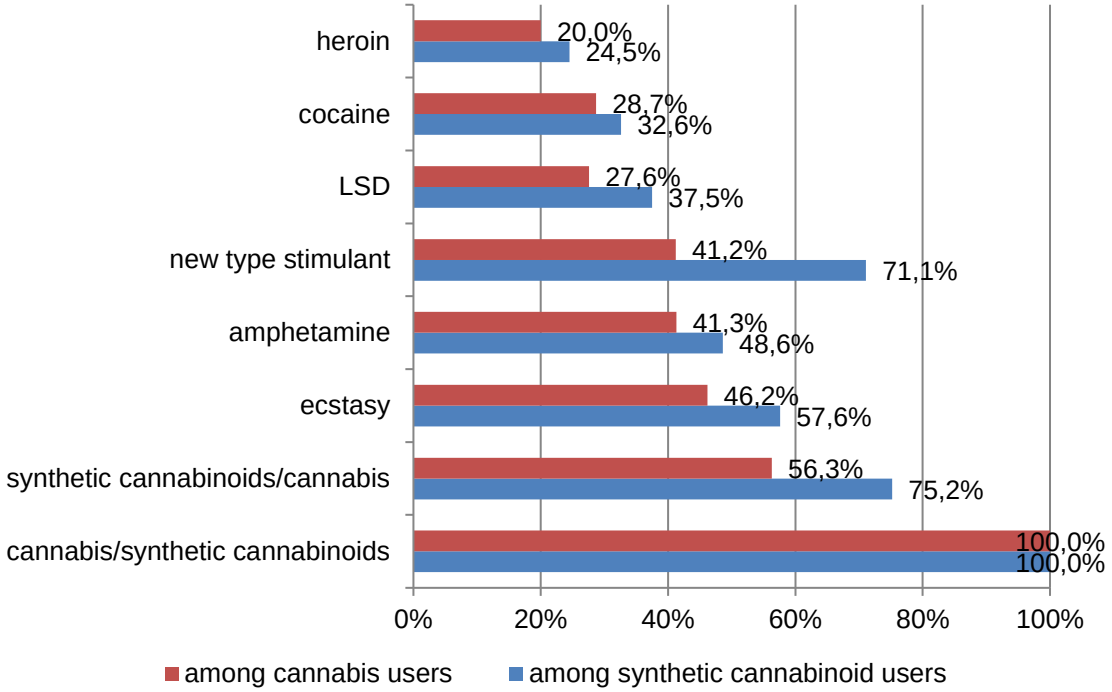
T4.1 ADDITIONAL INFORMATION

[33] In the TDI data collection, synthetic cannabinoid users are not reported in a distinct category, so it is hard to capture them. However, based on consultation with the treatment centres, it can be assumed that these users are typically recorded in the categories of "*other hallucinogens"* or "*other substances that do not come under the specified categories"*. Selecting those with the route of administration "smoke/inhale" within the above two categories we created a client group and compared its composition and characteristics with cannabis users, based on treatment (TDI) data from 2017.

Use of synthetic cannabinoids/NPS in socially marginalised groups

A representative study among the adult homeless population was conducted in 2017 to explore the extent of drug use (for details on methodology, see Drugs/Sources and Methodology/T6.2). Based on lifetime prevalence values, cannabis was the most commonly used illicit drug among the Hungarian homeless population: every fifth to sixth respondent had consumed herbal cannabis or cannabis resin in their life (Paksi, Magi, Gurály 2020). Concerning recent drug use, in the drug use pyramid based on the responses, the use of synthetic cannabinoids preceded cannabis in popularity.
In the homeless population, the drug use pyramid built for synthetic cannabinoid use showed the same results as the pyramid constructed for cannabis use (see the results of the 2015 NSAPH study in section T1.2.4), with the exception that the likelihood of using other illicit drugs among synthetic cannabinoid users was not 4-6 times higher but 5-7 times higher, and the use of designer stimulants (typically synthetic cathinones) was much more common among synthetic cannabinoid users than among cannabis users. (Paksi, Magi, Gurály 2020).

Chart 11. *Drug use pyramid in the homeless population (% of ever-users of cannabis and/or synthetic cannabinoids), 2017*[34]



Source: (Paksi, Magi, Gurály 2020)

According to the experts participating in the qualitative research conducted among child protection workers (Kaló et al. 2018), the use of NPS is becoming the norm in some communities, especially among families with a deprived socioeconomic status. (Further results of this study are reported in section T4.1 of the Drugs/Stimulants workbook. Methodological information concerning the study is described under Drugs/Sources and Methodology/T6.2.

A study involving girls in residential child care and experts working in residential child care facilities (Kaló et al., 2017), and information from the commission reporting on children and young people placed in specialised residential child care facilities (Baráth et al., 2018) both showed that the use of NPS – particularly synthetic cannabinoids – is a serious problem in this population.

[34] Lifetime prevalence values for the most common other drugs among ever-users of cannabis or synthetic cannabinoids.

A survey conducted among juveniles living in detention facilities (Port 2016) also showed that NPS are the most commonly used drug in this population: 58% of those who have ever consumed drugs in their lives reported having primarily used synthetic cannabinoids, while 36% reported having primarily used designer stimulants. (For further results and methodology, see sections T4 and T5.2 of the Prison workbook).

Our knowledge of the characteristics of drug use in socially deprived neighbourhoods first described by Szécsi et al. in 2015 (Szécsi and Sik 2016; presented in the Drugs workbook of the 2019 National Report) is supplemented by the 2017 and 2018 studies of Csák et al. The results of their 2017 study show that among adults living in socially deprived neighbourhoods the use of synthetic cannabinoids ("synthetic weed", "bio", "herbal") is more common than the use of synthetic cathinones ("crystal") (Csák et al. 2017). The study identified two patterns of synthetic cannabinoid use: a use pattern of 1-2 times per month and an intensive use pattern involving at least 3 uses of synthetic cannabinoid per week. The former pattern was characteristic of 36.8% of the respondents and the latter pattern of 41.1% of the respondents. (For information on methodology see Drugs/Sources and Methodology/T.6.2. For further results, see Drugs/Stimulants/T4.1.)

Mono and poly drug use patterns based on analysis of biological samples

According to the examinations of biological samples received by the Institute for Forensic Toxicology of the Hungarian Institute for Forensic Sciences (NSZKK), poly drug use patterns involving several different active substances can be demonstrated). From the co-presence of active substances, not only poly drug use, but also use of the substances close in time to one another (within a few days to a week) can be assumed. The results are not representative for the general population in terms of substance prevalence values due to the nature and recruitment of the database[35]; however, based on data confirmed by forensic toxicological analysis, the most common drugs (active substances) or – if several active substances are detected – the most common poly drug use patterns can be outlined[36].

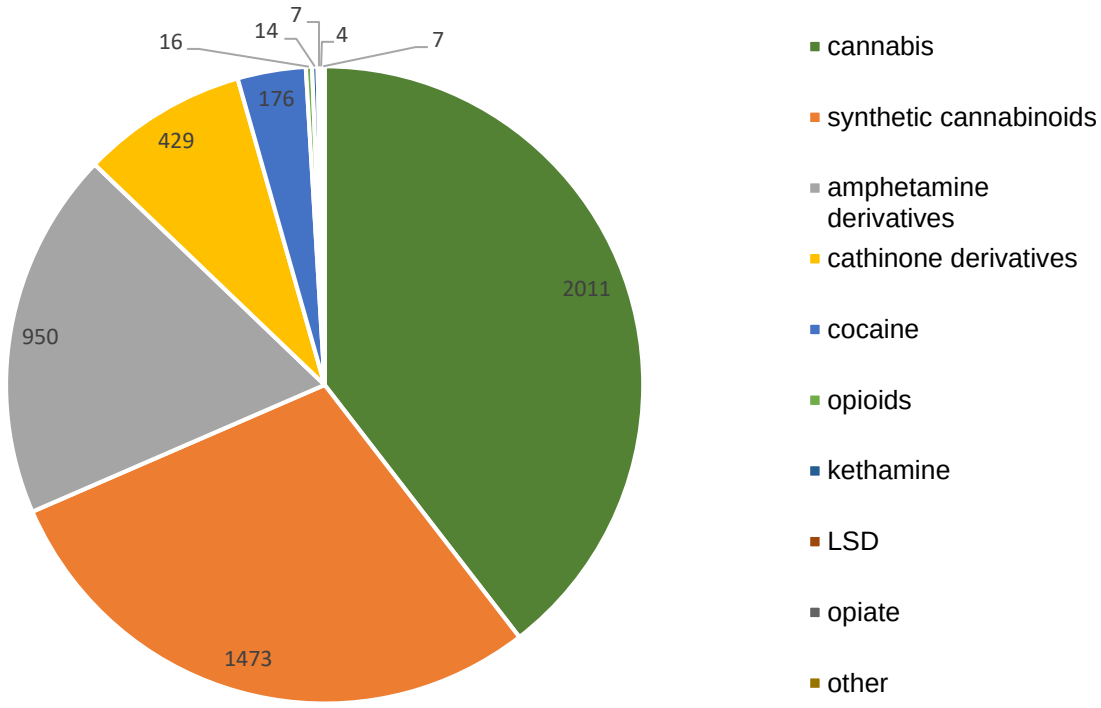
A total of 9695 cases were received in 2020 for analysing mono and poly drug use patterns. In 2020, a total of 7766 biological samples (blood, urine) from living people arrived at the Institute which were positive for narcotic drug and/or new psychoactive substances and/or other non-listed psychotropic substances.

Regarding mono drug use (N= 5086), most of the cases are connected to cannabis use (2011 cases), followed by cases where synthetic cannabinoids were detected as a single active agent or a combination of different synthetic cannabinoids (1473 cases). The third most common substance group was amphetamine and its derivatives (950 cases), followed by cathinone derivates (as a single active agent or a combination of different synthetic cathinones; 429 cases) and the fourth most coomon was cocaine (176 cases). There were 4 cases where exclusively opiates were identified and 16 with synthetic opioids.

[35] In the following cases, the authorities (primarily the police) send blood and/or urine samples to the Institute for Forensic Toxicology of the Hungarian Institute for Forensic Sciences (NSZKK): road accidents; suspected use of narcotic drugs/new psychoactive substances while driving; suspected drug-related deaths (direct or indirect) or acute intoxication; suspicion of other crimes (e.g. extortion; sexual coercion or other related crimes). The data are nationwide, but coverage is not complete in those counties, where medical universities also conduct forensic toxicology examinations (Budapest, Baranya county, Csongrád-Csanád county, Hajdú-Bihar county).

[36] The following groups of compounds can be distinguished in the NSZKK data system: cannabis; synthetic cannabinoids; amphetamine derivatives (amphetamine, methamphetamine, MDA, MDMA); cathinone derivatives; cocaine; opiates (compounds identified by the use of heroin and morphine, semi-synthetic opiates such as dihydrocodeine); synthetic opioids (e.g. fentanyl, methadone), ketamine derivatives; other agents (eg LSD, psilocybin).

Chart 12. *Mono drug use patterns by compound group based on the examination of biological samples received by the Hungarian Institute for Forensic Sciences (NSZKK) in 2020 (N = 5086)*

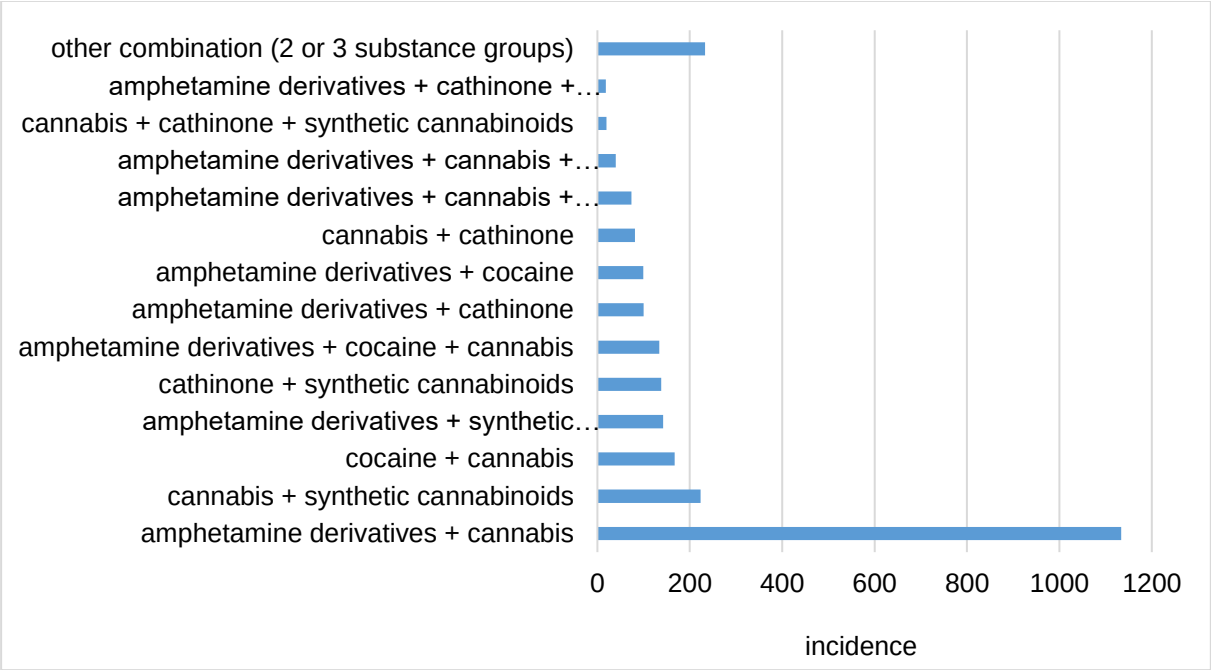


Source: NSZKK 2021

In 2680 cases where several different substance groups were detected in one biological sample; among those cases, the presence of two or three different substance groups was most common (together: 2603 cases).

By analysing the samples containing two or three compound groups, the most common cases were those where cannabis and amphetamine derivatives (1134 cases) were detected together. The co-presence of cannabis and synthetic cannabinoids (223 cases), cannabis and cocaine (167 cases), amphetamine derivatives and synthetic cannabinoids (142 cases), and synthetic-cannabinoids and synthetic cathinones (138 cases) was also prevalent in the total sample.

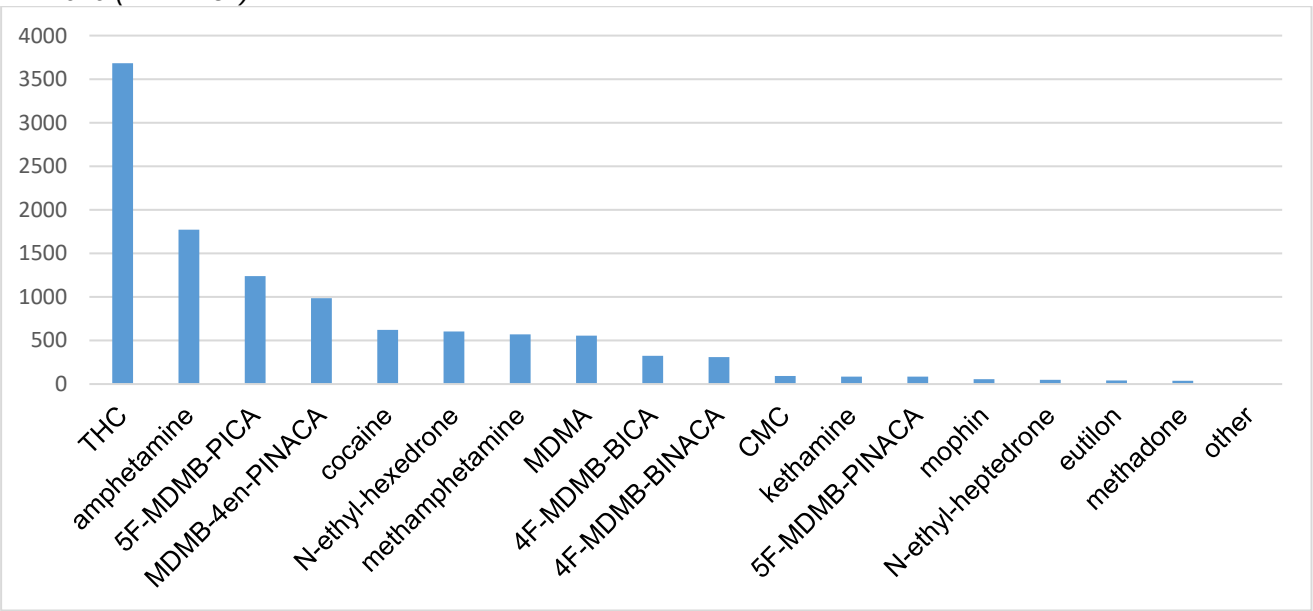
Chart 13. *Most common poly drug use patterns by compound group or compound group combinations based on the examination of biological samples received by the Hungarian Institute for Forensic Sciences (NSZKK) in 2020two or three substance groups; N=2603)*[37]



Source: NSZKK 2021

Examining the prevalence of each established and new psychoactive substance in the overall sample (alone or in combination), the first three most common drugs were cannabis, amphetamine, and 5F-MDMB-PICA in that order.

Chart 14. *The prevalence of substances (established drugs and NPS) in biological samples in 2020 (N=11 237)*[38]



Source: NSZKK 2021

[37] Cases containing two or three compound groups were analysed and the most common combinations are shown in the chart.

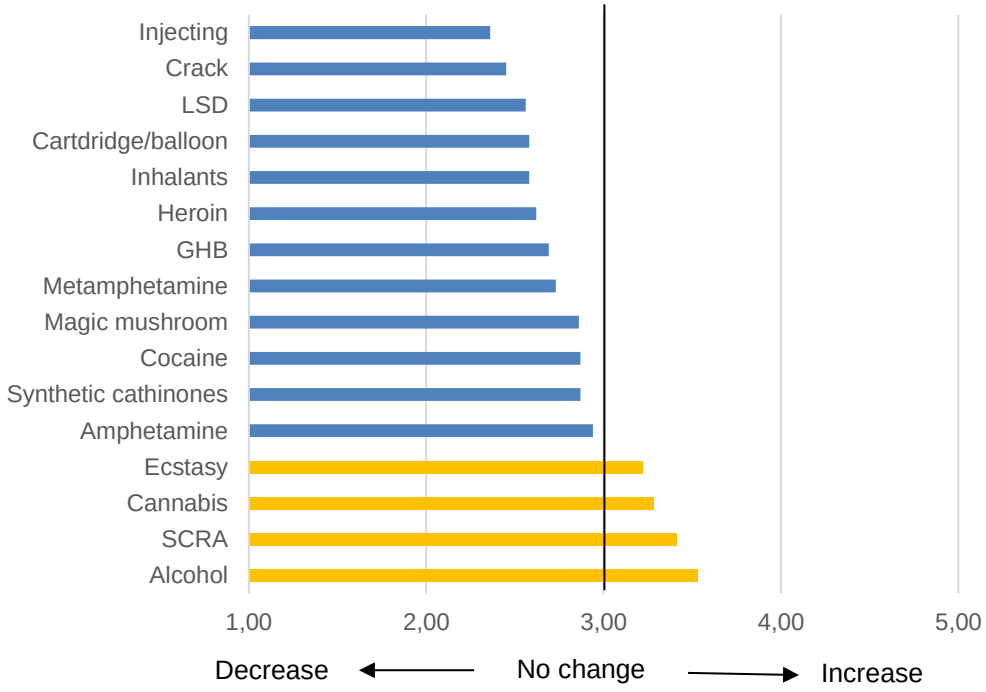
[38] The total number of cases is higher than the number of analysed biological samples due to the fact that in many cases more than one substance could be identified in a single sample.

In 2020, examining only the occurrence of the most common cathinones/cathinone combinations in samples, the most prevalent substance was N-ethyl-hexedrone standing alone (315 cases), followed by CMC (51 cases), while the third most common substance was N-ethyl-heptedrone (14 cases). The use of more cathinone combinations was justified only a few times.
With respect to synthetic cannabinoids, the most common stand-alone substances were 5F-MDMB-PICA (501 cases), followed by MDMB-4en-PINACA (353 cases); 4F-MDMB-BICA (31 cases) and 4F-MDMB-BINACA 20 cases). The most common combinations were 5F-MDMB-PICA + MDMB-4en-PINACA (119 cases), followed by the combination of 4F-MDMB-BICA + MDMB-4en-PINACA (84 cases) and 5F-MDMB-PICA + 4F-MDMB-BINACA (62 eset). The combination of 5F-MDMB-PICA + MDMB-4en-PINACA+4F-MDMB-BINACA and MDMB-PICA + MDMB-4en-PINACA + 4F-MDMB-BICA were also typicall (58; 38 cases).
The most common synthetic cathinone–synthetic cannabinoid combinations were N-ethyl-hexedrone + 5F-MDMB-PICA (21 cases), followed by N-ethyl-hexedrone + MDMB-4en-PINACA (19 cases). Additionally, the combination of N-ethyl-hexedrone + 4F-MDMB-BICA + MDMB-4en-PINACA was also relatively common (16 cases).

Drug use in the nightlife/recreational setting

In 2020, an online questionnaire survey was conducted among organisations providing harm reduction services in the nightlife/recreational setting (Tarján 2020b). The questionnaire covering patterns of drug use among the clients was completed by 21 organisations (for more information and methodology, see sections T1.5.3 and T5.1 of the Harms and Harm Reduction workbook). Based on the responses, the organisations experienced an increase (based on the mean value of all respondents) in use of alcohol, synthetic cannabinoids, cannabis and ecstasy between 2018 and 2019, and a stagnation or slight decrease in the case of the other substances. In the open-ended questions, most highlighted the dominance and increase of[39] SCRA use (9 mentions), and the increase of alcohol; alcohol +medication and cannabis use (7, 4 and 4 mentions respectively). A few service providers reported an increase in cocaine, ketamine, ecstasy and synthetic cathinone (“crystal”) use. Two service providers indicated that the mean age of users of synthetic cannabinoids is decreasing.

Chart 15. *Trends in drug use in the nightlife/recreational setting between 2018 and 2019 as viewed[40] by service providers, by substance based on the mean value of all responses (number of respondents = 20 organisations)*



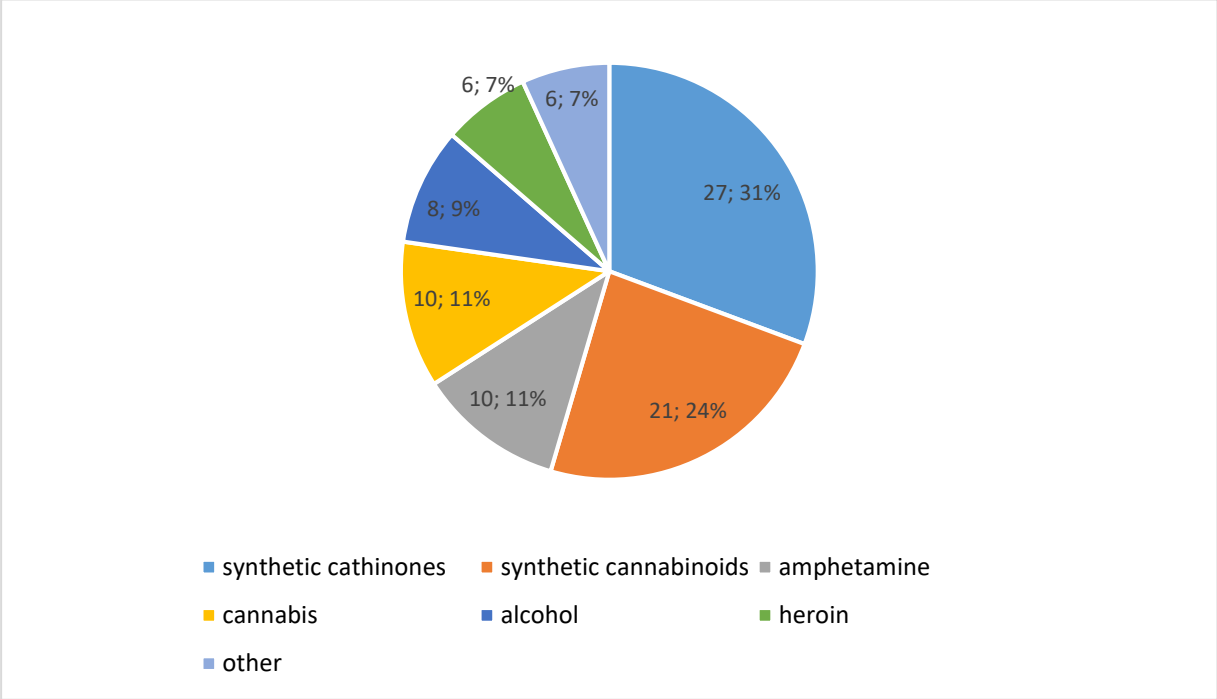
Source: Tarján 2020b

Substance use patterns and the impact of the coronavirus epidemic among clients of a referral program in Budapest

The 2020 HEPAGO-NFP bio-behaviorial study (Tarján et. al. 2021; for methodology see: Harms and harm reduction T5.2.2.) examined the recpondent's substance use patterns, as well as the changes caused by the COVID-19 pandemic in terms of drug use, availability, social stauts and access to care. The study lasted from June to December 2020. Of the respondents (110), 96 had used drugs or new psychoactive substances in their lifetime, of whom 57 were injecting drug users. Of the 96 people, 81% were male and 19% were female. Last year, 64% of them were homeless.

[40] (1: strongly decreased; 2: slightly decreased; 3: no change; 4: slightly increased; 5: strongly increased; "6: does not know" was excluded from the calculation of mean values).

Chart 16. *Distribution of drug users (n = 88 persons) participating in the Budapest biobehaviousial study by primary drug used 4 weeks prior to the survey in 2020*

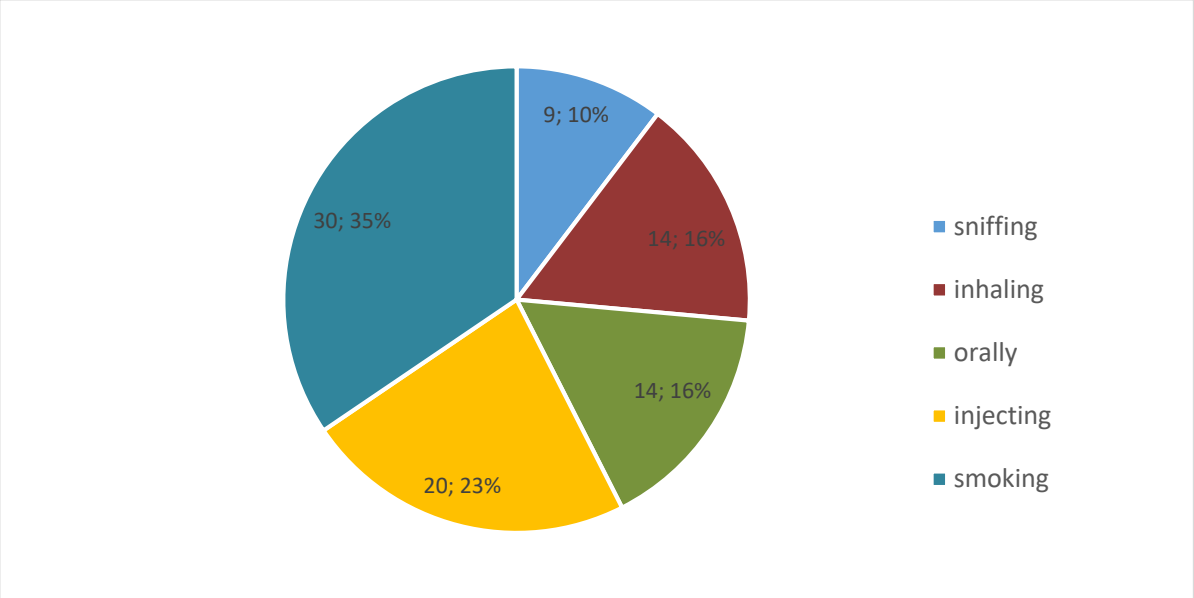


Source: Tarján et al. 2021

Change in the primarly use drug occurred only for a lesser extent due to the epidemic restrictions introduced after March 2020. Information on both drugs (primarly used drug before and after the restrictions) was available in the case of 65 persons: 1 person changed from alcohol to heroin; 3 persons from herbal to crystal/ methamphetamine/ cannabis; 2 persons from cocaine to crystal/cannabis and 4 persons from crystal to amphetamine/ herbal /cannabis.

Most of the recpondents inhaled or injected the primarly used drugs. There has not been a significant change in the drug use technics due to the restrictions after March 2020.

Chart 17. *Distribution of drug users (n = 87 persons) participating in the Budapest biobehaviousial study by the most common drug using technics 4 weeks prior to the survey in 2020*



Source: Tarján et al. 2021

Queries were made to assess whether the individual characteristics of drug use, access to care, availability and social situation changed compared to the pre-pandemic period.

Table 7. *Number of users (n=96) included in the Budapest biobehavioral study showing signs of change for certain social situations, drug use, availability and access to care, 2020*

TOTAL sample=96 persons (NPS/drug users only)	Number of persons markingthe statement	%
My income situation has deteriorated	55	57%
Overall my life situation has deteriorated	48	50%
I have lost my job	43	45%
Difficulties in getting social assistance (food, washing, bathing)	40	42%
The quality of the substance I've used before got worse	37	39%
I find it harder to dissolve where I sleep	35	36%
I became homeless	33	34%
More difficult access to drug treatment/harm reduction services	29	30%
The drugs I used previously are more expensive	28	29%
My alcohol consumption has increased	27	28%
Increased use of drugs (drugs and NPS)	23	24%
Drug use decreased (drug and NPS)	22	23%
I find it harder to acquire the drugs I have used before	20	21%
I share the drug use equipments more often	19	20%
My alcohol consumption has decreased	9	9%
I use different substances than before	7	7%

Source: Tarján et al. 2021

For HIV / HCV data on participants injecting drugs, see Harms and Harm Reduction T1.3.3.

B) STIMULANTS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 The relative importance of the various stimulant drugs

According to survey data, 13.9% of the 18-34 year-old population believe that they could easily or very easily obtain ecstasy and 10.3% of adults believe the same of obtaining amphetamines. The proportion of the population presuming *easy or very easy* access to the given drug is 9.8% for methamphetamines, 7.8% for cocaine and 6.8% for crack (Paksi 2020).

Seizures of all stimulants available on the drug market (amphetamine, methamphetamine, MDMA, cocaine, synthetic cathinones) have been increasing for years. –Although, the number and qunatity of seizures regarding MDMA containing tablets started to decrease in 2020, the powder or crystal MDMA shows a continous and significant increase. (NSZKK, 2021a)According to investigative and seizure data, methamphetamine continues to be prevalent only in some parts of the country (primarily around Pécs and in large towns/cities on the Slovakian border (BM 2020). In the case of cocaine, which still cannot be considered a widely prevalent substance, the police, during its supply reduction activities, has witnessed an increase in its supply in recent years, which seems to stop in 2020, persumably due to the restrictive measure connected to the COVID-19 pandemic.both; Most of the seizures in 2020 were in small (consumer) quntities.(BM 2020; NSZKK 2021a). In addition, according to the Ministry of Interior, a growing number of people are buying cocaine on the Darknet in Hungary (BM 2020). In a study on street prices of drugs (Bálint 2021), the cocaine prices reported by the respondents showed an extremely large variance, suggesting that the quality of available cocaine on the domestic drug market can vary greatly.

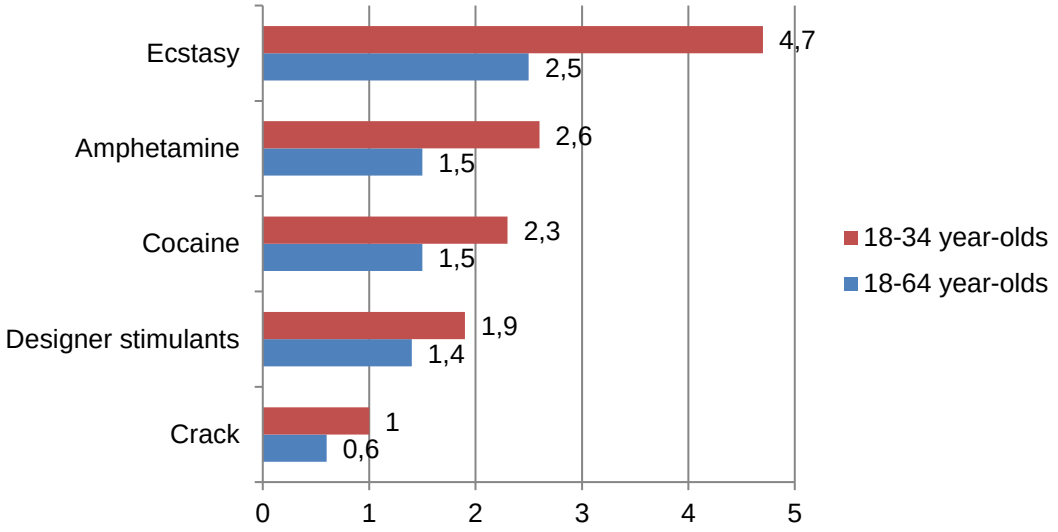
Designer stimulants (typically synthetic cathinones, known by the street names: “kristály” (“crystal”), “kréta” (“chalk”), ”zene” (“music”) usually appear on the market in powder form; among them, after 2018 ethyl-hexedrone was again the most prevalent substance in 2020 (NSZKK 2021a). It is noteworthy that the presence of mephedrone on the black market has been increasing since 2018, despite the fact that in Hungary it was included in the psychotropic schedule in 2011 (NSZKK 2020a; BM 2020). Furthermore, 38 synthetic cathinones scheduled as psychoactive substances were available on the Hungarian market in 2019 (NSZKK 2020a). Overall, the number of seizures related to synthetic cathinones increased until 2014; after a two-year decrease, in 2017 and 2018 the number rose again, followed by a sharp drop in the number of seizures of powders containing synthetic cathinones in 2019, which did not increase significantly in 2020 (2016: 631 cases; 2017: 735 cases; 2018: 885 cases; 2019: 535 cases; 2020: 594 cases) (NSZKK 2021a). (For more information on trends see section T2.1 of the Drug Market and Crime workbook.)

T1.1.2 Stimulant use in the general population

According to the 2019 NSAPH population survey (Paksi 2020), 3.6% of the population aged 18-64 have used a stimulant (ecstasy, amphetamine, cocaine, crack or a designer stimulant) in their lives. The overall last year prevalence of stimulant use was 1.0% and the last month prevalence was 0.6%. At the 68% confidence level in the young adult population aged 18-34, we can say that the overall prevalence values of stimulants tend to be higher than those measured in the population aged 18-64 (lifetime use: 5.5%, last year use: 1.3%, last month use: 1.2%).

In the general population aged 18-64 years and among young adults aged 18-34 years, the order of popularity of the various stimulants (based on lifetime use) is the same. Ecstasy is the most common, tried by 2.5% of the population aged 18-64 in their lifetime. It is followed by amphetamine and cocaine (LTP 1.5%), designer stimulants (LTP 1.4%) and finally crack (LTP 0.6%). In the young adult population, the order of prevalence of the drugs is the same, but for ecstasy and amphetamine the prevalence rates tend to be higher (ecstasy 4.7%, amphetamine 2.6%).

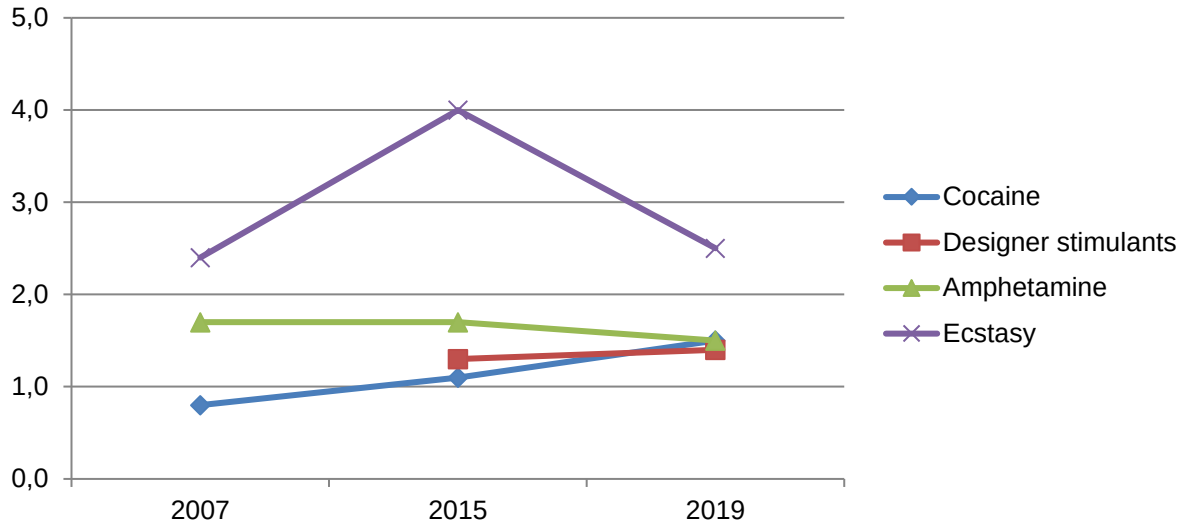
Chart 18. *Lifetime prevalence rates of stimulants by drug type in the adult population aged 18-64 years and 18-34 years, in 2019 (%)*



Source: NSAPH 2019 – Paksi et al. 2019

In the case of established stimulants, we can track the changes over a period of 12 years; in the case of designer stimulants we can only track the changes over 4 years. According to results of the adult population surveys, besides the temporary spike in lifetime prevalence of ecstasy in 2015 and the upward trend in the cocaine LTP between 2007 and 2019, the changes do not exceed the margin of error. Overall, we can say that the prevalence of the various stimulants shows considerable stability in the Hungarian population, both with respect to the years of the study and the period as a whole.

Chart 19. *Changes in the lifetime prevalence of the various stimulants between 2007 and 2019, in the adult population aged 18-64 years (%)*



Source: NSAPH 2019 - Paksi 2020

Using statistical tools to analyse the basic socio-demographic patterns of use of established stimulants[41], we found significant patterns for most of the dimensions examined, despite the low number of cases. The prevalence in young adults is more than two and a half times that in older adults, and those who use established stimulants are on average 7 years younger than non-users (p=0.001). As with other substance use behaviours, the data indicate that multiple deviant family patterns (p <0.001) and uncertainty regarding religious identity (p <0.001) are significant risk factors, and the risk of using established stimulants is higher when living in cities with more than 50,000 inhabitants compared to smaller settlements and the capital (p = 0.003). In addition, a significant and consistent pattern emerged across the majority of the indicators of economic status: in the case of perceptions related to relative financial situation, labour market activity, and vocational skills, those with a lower status are at significantly higher risk. Although objective indicators of social relationships did not show a significant correlation with use of established stimulants, the level of satisfaction with family, partner, and other relationships is significantly lower among those who use established stimulants.

[41] ecstasy, amphetamine, cocaine, crack

Table 8. *Lifetime prevalence of use of established stimulants across various socio-demographic characteristics in the general population aged 18-64 years, in 2019 (%)*

Socio-demographic characteristics	Sub-group values	N	LTP of established stimulants (%)	sign.
Gender	male	579	3.9	p=0.083
	female	679	2.4	
Young adult / adult	18-34 years old	402	**5.2**	p=0.002
	35-64 years old	873	1.9	
Size of settlement	<50,000 inhabitants	814	2.3	p=0.003
	≥50,000 inhabitants	236	**6.4**	
	capital city	225	1.8	
Vocational qualification	no	195	**5.6**	p=0.013
	yes	943	2.2	
Labour market activity	no job	302	**5.3**	p=0.007
	has job	957	2.2	
Perceived relative financial situation	better than average	260	3.8	p=0.008
	average	788	2.0	
	worse than average	215	**6.0**	
Relationship status	not living with a partner	239	3.8	p>0.1
	living with a partner	848	2.2	
Religiosity	religious	624	1.3	p<0.001
	uncertain (cannot tell if religious)	76	**9.2**	
	not religious/atheist	548	4.4	
Variables showing significant patterns are indicated with a grey background; higher LTP values are in bold.				

Source: NSAPH 2019 - Paksi 2020

Table 9. *Mean value of various socio-demographic characteristics in ever-users and never-users of established stimulants in the general population aged 18-64 years, in 2019 (%)*

Socio-demographic characteristics	Used		Not used		Difference in mean*	sign.
	Mean	N	Mean	N		
Age (years)	34.98	38	42.00	1235	-7.01	p=0.001
Size of household (persons)	3.18	36	2.91	1235	0.27	p>0.1
Deprivation index	3.91	38	3.06	1237	0.86	p>0.1
Number of deviant behaviours in the close family	3.86	35	1.58	1185	2.28	p<0.001
WHO general well-being	8.44	38	9.20	1209	-0.76	p>0.1
Hours spent working in an average week	21.89	35	31.57	1211	-9.68	p=0.002
Satisfaction: with work	3.43	33	3.68	1158	-0.25	p>0.1
Satisfaction: with financial situation	3.05	38	3.36	1218	-0.31	p=0.069
Satisfaction: with family relations	3.54	38	4.20	1219	-0.66	p<0.001
Satisfaction: with partner relationship	3.45	38	4.07	1188	-0.62	p=0.001
Satisfaction: with other social relations	3.61	37	3.98	1216	-0.37	p=0.013
Satisfaction: with health	3.77	38	4.04	1217	-0.28	p=0.068
Anomie	20.18	31	17.95	1145	2.24	p=0.059

Socio-demographic characteristics	Used		Not used		Difference in mean*	sign.
	Mean	N	Mean	N		
Differences that are statistically significant are indicated by a grey background * difference in mean=users – non-users						

Source: NSAPH 2019 - Paksi 2020

Age at first use differs considerably among the various stimulants in the 18-64 year-old population. Ecstasy is tried for the first time at the age of 20.5 on average and most often at the age of 23, while the first use of designer stimulants is on average at 21.9 years-old and most often at the age of 20. First use of amphetamines occurs at the age of 22.0 on average and most often at the age of 18. Cocaine is tried for the first time at the age of 23.3 on average and most often at the age of 27.

According to the results of the 2020 BLS study, 2.5% of the young adult population (aged 19-35) in Budapest had ever used designer stimulants (further results of the study see: in Drugs T0.1; A / T1.1.2; A / T1.2.4 D / 4.3 and E / T6.2).

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

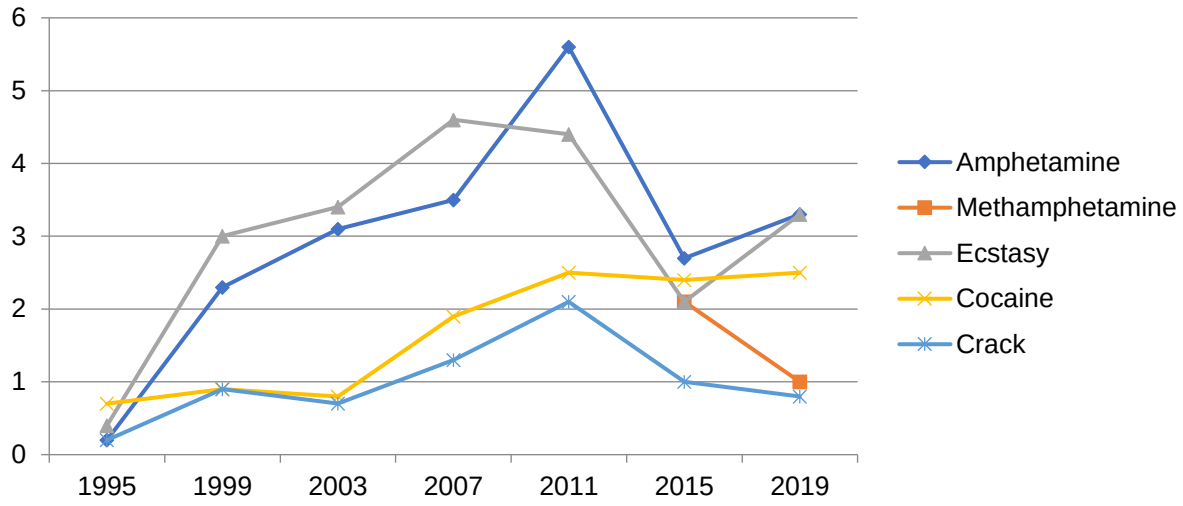
According to the results of the HBSC survey carried out in 2018 (Paksi 2019), 5.0% of students in years 9 and 11 had already tried amphetamine, while 4.4% had already tried MDMA or ecstasy, so both substances were used on average by one student in an average class. Significantly higher prevalence rates could be observed among boys (amphetamine 6.3%; MDMA/ecstasy 5.8%) and among those in the higher school year (year 11: amphetamine 6.4%; MDMA/ecstasy 6.0%) than for girls (amphetamine 3.7%; MDMA/ecstasy 3.0%) and those in the lower school year (year 9: amphetamine 3.6%; MDMA/ecstasy 2.9%).
The proportion of those regularly using amphetamine[42] among ever-users of the drug was 22.8% while in the case of MDMA/ecstasy the proportion of regular users was 28.7% among ever-users of the drug.

According to the results of the ESPAD survey (Arnold, Elekes 2020) conducted in the 16 year-old secondary school population, the lifetime prevalence for established stimulants[43] was 5.4% in 2019, meaning that every twentieth 16 year-old student had already used at least one of the established stimulant drugs. 3.7% of students had used established stimulants in the last 12 months. ESPAD studies over the last 25 years show that the prevalence of use of the various established stimulants increased among 16 year-old students until 2011 (2011: 6.8%), albeit to a varying degree. In 2015, the prevalence of overall use of established stimulants dropped to three-quarters (5.1%) of its previous level, and did not change by 2019 (5.4%).

Of the established stimulants, ecstasy was the leading substance until 2007, replaced by amphetamine in the 2011 and 2015 results. In 2019, the same lifetime prevalence was measured for those two substances. Until 2011, all established stimulants showed a steady increase. Then, by 2015, the proportion of ever-users of each established stimulant – with the exception of cocaine – decreased. Between 2015 and 2019, a more mixed picture emerges for these drugs: while use of ecstasy started to show a clear increase, use of methamphetamine decreased, and use of other established stimulants stagnated.

[42] on at least 30 days or more during their lifetime
[43] ecstasy/MDMA, amphetamine, methamphetamine, cocaine, crack

Chart 20. *Changes in the lifetime prevalence of established stimulants between 1995-2019 among 16 year-old students (%)*



Source: ESPAD 2019 – Arnold, Elekes 2020

The use of established stimulants does not show a significant relationship with the majority of the studied variables, except for school type, family structure and subjective financial situation.

Table 10. *Lifetime prevalence of use of established stimulants across various socio-demographic characteristics among 16-years-old students, in 2019 (%)*

SOCIO-DEMOGRAPHIC CHARACTERISTICS		LIFETIME PREVALENCE OF ESTABLISHED STIMULANTS %	sign.
Gender	male	5.6	not sign.
	female	5.2	
School type	grammar school	3.6	p<0.01
	vocational grammar school	5.8	
	secondary vocational school	8.9	
School address	Budapest	6.8	not sign.
	county seat	4.5	
	other town	5.5	
	village	7.1	
School's maintainer	state	5.6	not sign.
	church	3.4	
	private	4.9	
Residence	Budapest	5.9	not sign.
	town	5.1	
	village	5.3	
Family structure	intact	3.6	p<0.01
	patchwork	7.8	
	broken	6.6	
	no birth parents	12.5	
Father's education	lower than final examination (secondary school)	6.3	not sign.
	final examination (secondary school)	5.0	
	higher education	4.3	
	not known	5.7	
Mother's education	lower than final examination (secondary school)	5.6	not sign.
	final examination (secondary school)	5.6	
	higher education	4.2	
	not known	8.8	
Subjective financial situation	much better off	7.9	p<0.01
	about the same or better off	4.4	
	less well off	4.9	

Source: ESPAD 2019 – Arnold, Elekes 2020

The typical age at first use of stimulants among 16 year-old students is 15 years for amphetamine/methamphetamine, ecstasy and cocaine/crack. The mean age at first use in this population is 13.8 years for amphetamine/methamphetamine, 14.0 years for cocaine/crack, and 14.2 years for ecstasy.

The established stimulants studied were typically used once or twice by 16 year-old students: among those who had ever used amphetamine, ecstasy or cocaine, 78% had consumed those drugs once or twice in their lives, and a fifth had used them 3 or more times, so experimentation is more common with these drugs than repeated use.

T1.2 PATTERNS OF USE, TREATMENT AND PROBLEMATIC/HIGH-RISK USE

T1.2.1 Patterns of use

For data on mono and poly drug use patterns based on the analysis of biological samples carried out by the Institute for Forensic Toxicology of the Hungarian Institute for Forensic Sciences (NSZKK), see Drugs/Cannabis/T4.1.

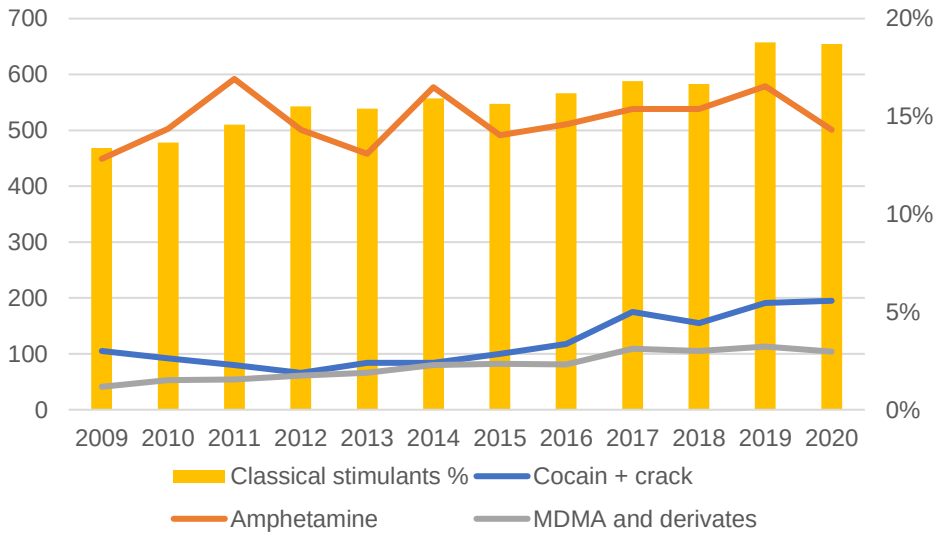
For data in connection with patterns of use relating to injecting stimulants and related risk behaviours, see section T1.2.5 below and section T1.3.4 of the Harms and Harm Reduction workbook. Regarding the patterns of use in stimulant users entering treatment, see section T1.2.2.

For patterns of drug use among the clients of harm reduction services in nightlife/recreational settings see Drugs/Cannabis /T4.1.

T1.2.2 Treatment of stimulant users

In Hungary, stimulant use is the second most common reason for drug users to enter treatment (see sections T1.3.1, T1.3.4 and T2.1 of the Treatment workbook). In 2020, 16.7% (711 persons) of those entering treatment reported having used amphetamine-type stimulants as their primary drug (amphetamine: 501 persons; MDMA and other derivatives: 104 persons; other stimulants 106 persons). A further 4.6% (195 persons) entered treatment due to cocaine use (powder cocaine: 192 persons; crack: 3 persons)
The proportion of those entering drug treatment for all stimulants was 21.2% (906 persons) (Péterfi 2021a – TDI data 2021).
When examining the trends with regard to those requiring treatment in connection with the use of classical stimulants, it can be said that between 2009 and 2020 the proportion of those requiring treatment due to classical stimulants shows an increasing trend among all drug users entering treatment (2009: 13.4%; 2020:18.7%). The number of clients seeking treatment for both amphetamine, cocaine, crack, and MDMA and its derivatives showed an increasing trend during this period, with the exception of 2020, when the total number of people entering to treatment declined as well

Chart 21. *.Proportion of clients entering treatment due to the use of established stimulants among all drug treatment entrants (right horizontal axis: % of all treatment entrants); and the number of clients entering treatment for each stimulant drug between 2009 and 2020 (left horizontal axis: number of clients)*



Source: Péterfi 2021a – TDI data 2021

82.3% of those entering treatment because of stimulants (cocaine, crack, amphetamine/methamphetamine, MDMA and derivatives or other stimulants) were male in 2020. The mean age of this user group was 30.4 years, and the clients had used stimulant substances for an average of 8.9 years before entering treatment in 2020.

Prior to treatment, the typical route of administration for this group was sniffing (56.9%), the most common route for cocaine, crack and amphetamine users. Oral administration was the typical route of administration for 30.5% of stimulant-using clients prior to treatment, that being most common route of administration among users of MDMA and its derivatives. 8.9% of stimulant users typically used the substance by smoking/inhaling (chasing the dragon). This route of administration was most common among users of other stimulants. Injection was reported by 3.0% of stimulant users entering treatment as a typical route of administration. (For more information on injecting drug use, see section T1.2.5.)

When examining stimulant users in terms of frequency of use, the highest proportion (42.4%) of intensive use (at least twice a week in the 30 days prior to entering treatment) was among users of “other stimulants” (synthetic cathinones)., 22.8% of amphetamine users and 16.5% of cocaine (salt) users and 16.0% of the MDMA users had intensive patterns of use. Of the 3 crack users reported as entering treatment in 2020, 2 of them belonged to this group.

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

T1.2.4 Synthetic cathinones

According to the results of the 2019 population survey (Paksi 2020), synthetic cathinones (designer stimulants) are ranked second after ecstasy in the order of preference of stimulants, tied with amphetamine and cocaine, among the adult population aged 18–64. The lifetime prevalence for use of designer stimulants was 1.4% in the 18-64 age group and 1.9% in the 18-34 year-old young adult population. The proportion of those using such substances in the

last year was 0.7% in the 18-64 age group and 0.8% among young adults. Only 0.3% of those aged 18-64 and 0.4% of young adults had used designer stimulants in the last month.
Using statistical tools to examine the social patterns of use of designer stimulants,[44] gender, the degree of urbanisation of the place of residence, deviant family patterns and satisfaction with economic status and some areas of life were identified as defining factors. Men, people living in settlements with over 50,000 inhabitants (but not in the capital), people living in an extreme financial situation (better or worse than average) according to their own perception, people uncertain in terms of religious identity, people observing more deviant patterns in their family environment and those less satisfied with their social relationships and health have a higher prevalence of the use of designer stimulants. The mean age at first use of designer stimulants was 21.9 years; most commonly the first use occurs at the age of 20 among the adult population aged 18-64.

According to the results of the 2019 ESPAD survey (Arnold, Elekes 2020) conducted among 16 year-old secondary school students, the use of synthetic cathinones is not widespread. 1.9% of students had already tried them in their lives; 2.2% of boys and 1.7% of girls had used them (the difference is not significant).

The use of synthetic cathinones shows a significant relationship with school type, family structure and level of parental education, with no significant differences observed in the case of the other variables examined. 16 year-olds studying in a secondary vocational school are more likely to try cathinones than students in vocational grammar schools; however, vocational grammar school is also a higher risk factor compared to grammar school. Among students in secondary vocational schools, the lifetime prevalence of cathinone use is more than ten times higher than among students in grammar schools. Among 16 year-olds living with two birth parents, the lifetime prevalence of cathinones is lowest, while it is highest among those living without birth parents. Young people who grow up without their birth parents are at the greatest risk. Young people living in broken or patchwork families are at lower risk, but still at greater risk than those in intact families. The lower the father's/mother's level of education is, the more likely a 16 year-old student is to try synthetic cathinones (Arnold, Elekes 2020).

For data relating to the injecting use of synthetic cathinones see sections T1.2.5 and T4.1, as well as sections T1.3.1 and T1.3.4 of the Harms and Harm Reduction workbook.

Synthetic cathinone users can be identified in treatment (TDI) data as belonging to the group of NPS users. Data regarding NPS users in treatment are presented under Cannabis/T1.2.4 and in the Treatment workbook.

Based on the national needle and syringe programme (NSP) data collection (for methods see section T.5.1 of the Harms and Harm Reduction workbook) in 2019 NSPs reported the availability of targeted counselling related to NPS injecting: out of the 33 reporting NSPs, 21 organisations provided this specific counselling, while 13 of them provided written material on this topic (Tarján 2020a).

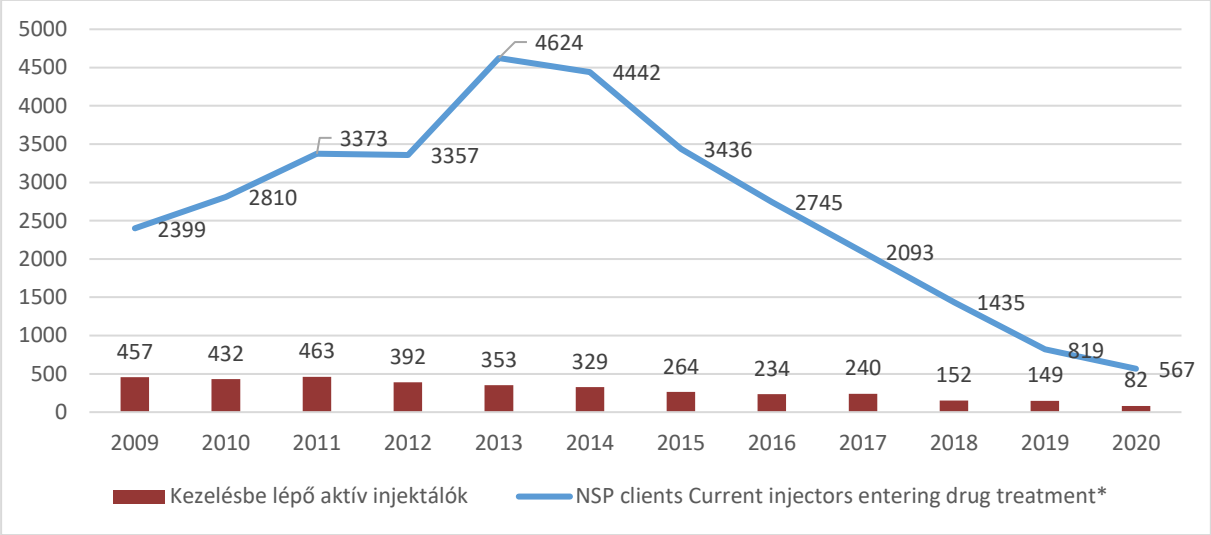
T1.2.5 Injecting drug use

With regard to the injected substances, it can be said that while heroin and amphetamine were the most commonly injected substances before 2010, following 2010 the most popular substances were designer stimulants (primarily synthetic cathinones). By 2015, 80% of the clients of needle and syringe programmes (NSP) reported injecting designer stimulants primarily. That change in pattern of use could be observed in several routine data collections

[44] The social patterns of the use of designer stimulants could only be examined across a few variables due to the low number of cases. Even then, the correlations should be treated with caution, as the number of users of designer stimulants in our sample was 18.

(TDI, DRID and NSP data) and in targeted studies; furthermore drug seizure data also confirmed those changes (for further description of this period see under Drugs/Stimulants/T1.2.5 in the 2018 National Report). It should be noted that the spread of NPS injecting, and the growth of the PWID population (between 2011 and 2014), could primarily be detected on the basis of the client and syringe data of low-threshold NSPs. The number of PWID entering treatment in higher-threshold services has decreased since 2011, when heroin availability dropped in Hungary. It can be assumed that the majority of injecting NPS users do not access higher-threshold services.

Chart 22. *Trends in the number of PWID clients of needle and syringe programmes and those starting treatment for a drug-related problem between 2009 and 2020 (persons)*



** reported injecting drug use in the 30 days prior to treatment, or typically injecting the primary drug*
Source: Tarján 2021a and Péterfi 2021a – TDI data 2021

According to quantitative and qualitative data sources, since 2016 injecting of synthetic cathinones appears to be declining, but that is not primarily due to a large-scale return to injecting of established substances.
The most significant phenomenon identified as a reason for the decline in cathinone injecting is the shift in the route of administration and the primary used drug: more and more now former PWID prefer to use foil (inhaling) when using cathinones, and periodically or permanently shift to synthetic cannabinoid smoking, as also supported by several data sources (Kaló et al. 2018;, Csák et al. 2019; Csák 2018a; Csák 2018b, Tarján 2020a; Tarján et al. 2020). Substance users who previously injected primarily are increasingly varying their routes of administration and switching to poly drug use patterns, so their frequency of injecting is lower. However, due to the decreasing insight into the PWID population, establishing valid trends in pattern change is only possible to a limited extent (Kaló et al. 2018; Tarján 2020a: PWID are becoming more hidden due to increasing presence of the police and decreasing availability of NSP programmes reaching this population, resulting in fewer PWID clients being visible).

The prevalence of injecting established substances remains well below the prevalence of injecting designer stimulants, although some local or low-coverage laboratory analytical data sources reported a slight increase both in 2018 and in 2019 for amphetamine (NSZKK 2019a) and heroin (NSZKK 2020a, Csorba et al. 2020); the increasing prevalence of heroin could also be observed in the 2018 and 2019 biobehavioural surveys (Tarján et al. 2019; Tarján et al. 2020). However, this trend was not backed up by national NSP client data. Despite the upward trend in cocaine seizures, the proportion of primary cocaine injectors remained negligible in 2020 (1% nationally among NSP clients).

In addition to the dominance of cathinones, the misuse of methadone by injecting should be highlighted, as supported by both laboratory-confirmed analytical data and survey results (Péterfi 2016; Péterfi et al. 2017; Tarján et al. 2019; Tarján 2020a).

Prevalence estimate of injecting drug use[45]

At the beginning of 2016, a study (Horváth and Tarján 2016) was conducted on the size of the PWID population (including both opioid and stimulant injectors). For the estimate, the client data for 2014 and 2015 of the national HIV/HBV/HCV seroprevalence survey series run by the National Centre for Epidemiology since 2006 were used.

In 2014 and 2015, using point estimation, in the case of complete statistical independence, the size of the hidden PWID population was estimated at 1594 persons. Given an estimated proportion of intentional participation of 76%, that is $\alpha=0.24$[46], the size of the hidden PWID population was estimated at 6744 persons, and the size of the entire PWID population at 7799 persons.[47] During the survey, besides taking blood samples, a behavioural questionnaire was completed, which contained a question related to the time of last injecting. Based on that, the proportion of recent PWID (those who had injected at least once in the year prior to the question) was 86% in 2015. Extrapolating from that, the size of the recent PWID population was 6707 persons in 2015.

This estimate is no longer considered applicable, for example to estimate service coverage, after 2015 due to the decline in injecting drug use in recent years.

Data regarding clients of needle and syringe programmes

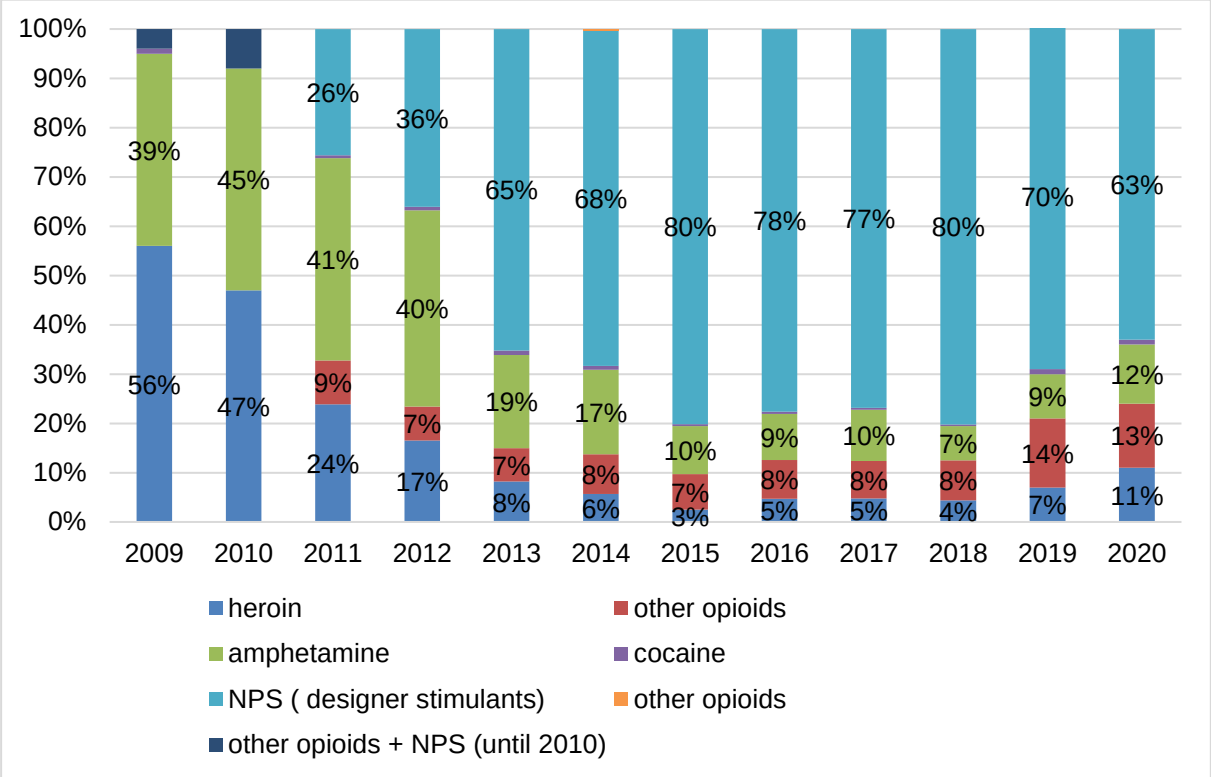
On the basis of NSP data (Tarján 2021a), the appearance of NPS in 2010 completely transformed the structure of patterns of injecting drug use characteristic of the previous years: while in 2009 fewer than 44% of PWID attending NSPs primarily injected stimulants, this proportion was 76% in 2020. It is a slight decrease compared to the 90% measured in 2015-2018, but the dominance of stimulants is unquestionable.
The proportion of those injecting established stimulants, mainly amphetamine, was around 40% between 2009 and 2012, but since 2013 a downward trend has been observed. In 2020, the proportion of primary amphetamine injectors was only 12% among NSP clients. The proportion of cocaine injectors is negligible among PWID attending NSPs (0-1%).

The increase in injecting of designer stimulants (a group of NPS, mainly synthetic cathinones) replaced heroin from 2010 and then even amphetamine from 2013: while in 2010 fewer than 8%[48] of NSP clients used designer stimulants, it started to continously increase in the following years, it had its peak between 2015 and 2018 (with around 80%), which was followed by a slight decrease in 2019 (70%). The decrease continoued in 2020, as it was the primary injected substance of 63% of the clients. In 2020 the use of heroin and other opioids started a slight increase compared to the previous years.. It should be noted that this data source can only measure the primary injected substance; however according to qualitative sources since 2016, injecting of synthetic cathinones appears to be declining, in parallel with which recent research results (Kaló et al. 2018 and) underline a shift in the route of administration and the primary used substance among PWID, namely increased inhaling (using foil) of injectable substances and a periodic or permanent shift to synthetic cannabinoid use (smoking). (See below: DRID

[45] The estimate refers to the entire PWID population. Given that, according to the current trends, injecting use mostly means injecting of stimulants, the estimate is presented in this “Stimulants” section.
[46] For further information, see E/T5.2
[47] Persons who injected at least once between 2013 and 2015.
[48] The figures of 4% for 2009 and 8% for 2010 in the “other” category include both other stimulants and other opioids. Therefore, the proportion of those injecting other stimulants primarily was probably even lower in these two years.

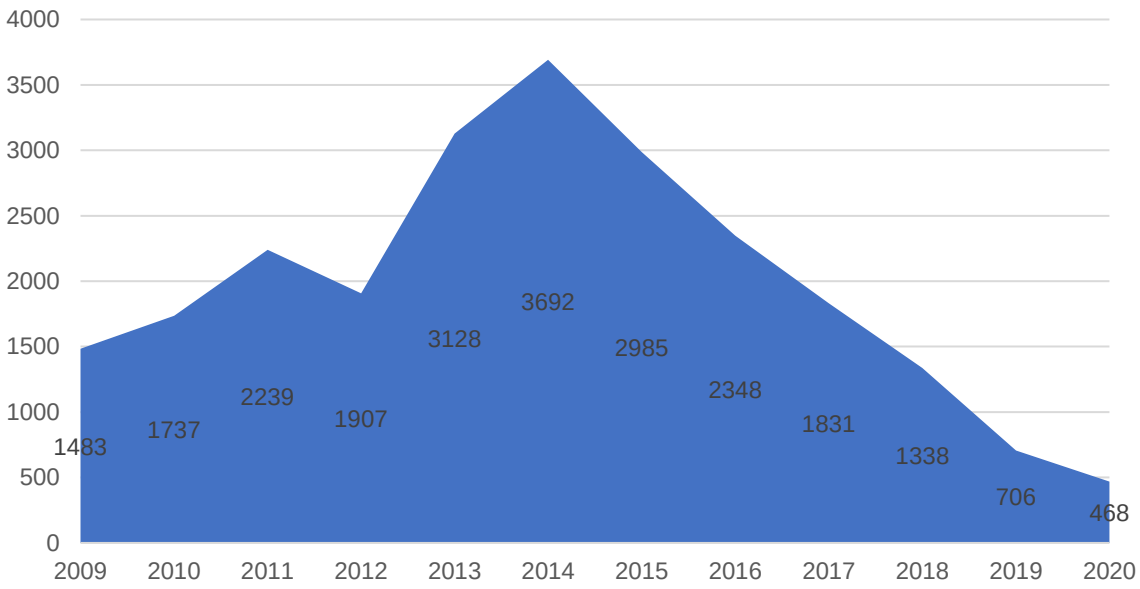
data, Tarján et al. 2019 and Tarján et al. 2020; and also Drugs/Stimulants/T4.1: other studies in the 2020 and 2019 National Reports).
Also, when interpreting the data, it is important to note that we have increasingly limited insight through NSPs into the PWID population regarding patterns of use. According to qualitative data sources, that is probably due to the pattern changes described above (less frequent injecting) and to the increasing number of hidden and hiding PWID – due to the increased presence of police and to the lessening capacity and coverage of NSPs and the restrictions connected to the 2020 COVID pandemic (Kaló et al. 2018, Tarján 2021a; Tarján et al. 2019 and Tarján et al. 2020).

Chart 23. *Breakdown of NSP clients by[49] primary injected drug between 2009 and 2020[50] (upper chart) and total number of NSP clients per year (lower chart)*



Source: Tarján 2021a

[49] for the N of clients per year see the methodology under Drugs/Sources and Methodology/T.6.1
[50] In 2009 and 2010, other stimulants and other opioids were recorded in the "other" category.



Source: Tarján 2021a

Since 2012, the substance with the street name “penta crystal/crystal” has been in first place according to the (street-name based) data self-reported by PWID. Among the injected designer stimulants, “crystal” was the most frequently mentioned street name in 2020 as well.

Prevalence of NPS injecting is the highest among young injecting users aged under 25 years; in 2020, NPS was the primary injected substance of 84% of that group.

According to the National Focal Point research on the effects of the coronavirus epidemic in 2020 and 2021, the decline in access to drop-in services and to sterile equipment during the first wave of the pandeemic might also have contributed to the decline in client numbers (see the 2020 and 2021 Treatment workbook T4.1.3).

DRID data

National data

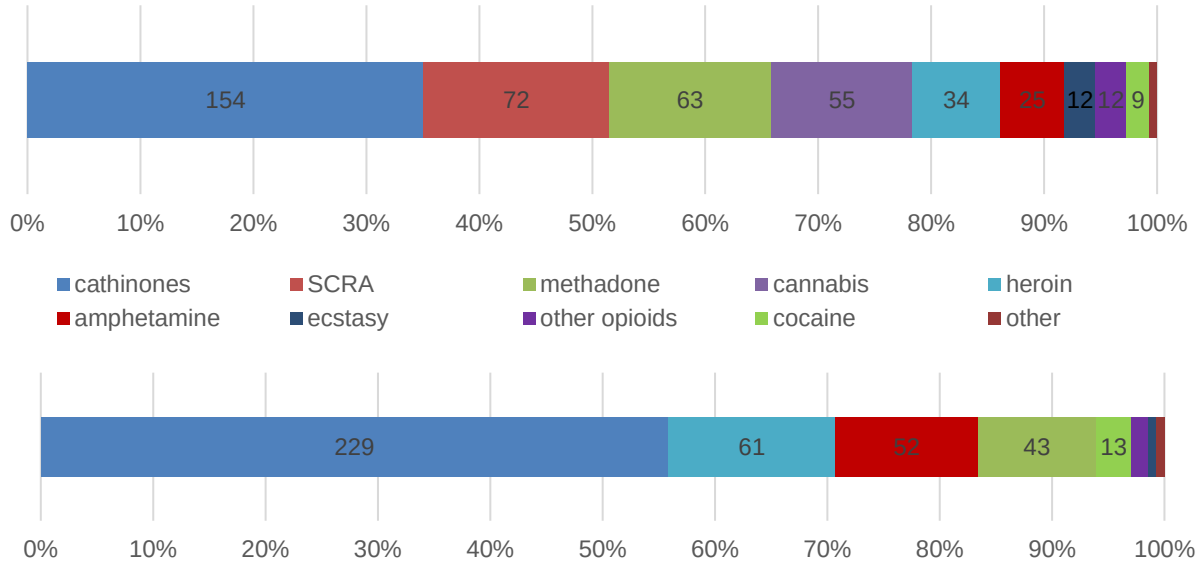
2006-2015:
Upon examining the breakdown of PWID participating in the national HIV/HBV/HCV seroprevalence survey between 2006 and 2015 (Dudás et al. 2015) by primary injected substance, it can be observed that the proportion of those injecting stimulants gradually increased over the years in the sample. While in 2006 13.6% of them injected stimulants primarily, in 2015 61.4% of the sample belonged to that group[51]. For further detailed data on this period see under Drugs/Stimulants/ T1.2.5 in the 2018 National Report)

2018:
Previous HIV/HCV prevalence surveys among PWID (Dudás et al. 2015) and the NSP data collection only record the primary *injected* drug. Due to changes observed in patterns of drug use since 2016[52] (see the introduction to this section T1.2.5), for the first time in the 2018 HNFP-NNK HIV/HCV biobehavioural survey (Tarján et al. 2019; for methodology, see section

[51] Several treatment centres participating in the survey also provided OST (7 out of 19 in 2015), due to which there is a bias towards opioid injecting in terms of prevalence of primary injected drug.
[52] Instead of injecting, an increasing number of former PWID are shifting to inhaling (foil) of injectable substances or periodically/permanently to synthetic cannabinoid smoking. A 2016 syringe residue analysis detected methadone at a higher rate compared to other data sources, underlining misuse of methadone.

T5.1 of the Harms and Harm Reduction workbook) primary drug (regardless of the route of administration) and poly drug use patterns were examined in this population at a national level. According to the data, 35% of the surveyed PWID[53] (440 persons) reported synthetic cathinones as their primary[54] *used* drug (regardless of the route of administration)[55], while 16% named synthetic cannabinoids, [56]14% named methadone and 13% named cannabis as their primary used drug. Established injectable substances were named less often by PWID as their primary used drug (heroin: 8%; amphetamine: 6%; cocaine: 2%).
Regarding the primary *injected* drug, we find a similar breakdown as in other data sources: the most respondents primarily inject synthetic cathinones (56%), followed by heroin (15%), amphetamine (13%), methadone (10%) and cocaine (3%).

Chart 24. *Breakdown of PWID participating in the national HNFP-NNK HIV/HCV biobehavioural survey by primary used drug (upper graph, n = 439) and primary injected drug (lower graph, n = 410) regarding the 4 weeks[57] prior to the survey, in 2018[58]*

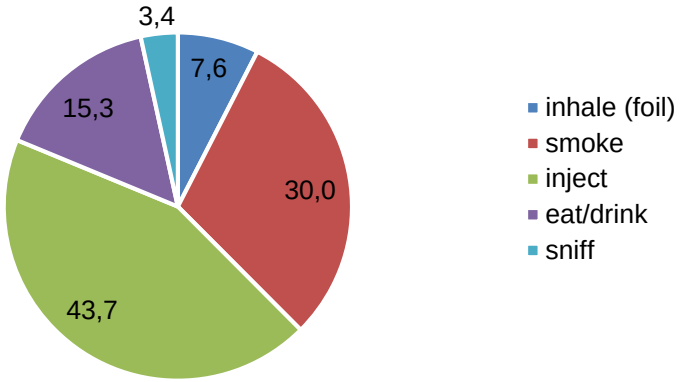


Source: Tarján et al. 2019

Data on the route of administration of the primary drug also support the emergence of new patterns among PWID as described by other data sources. Only 44% of the PWID surveyed injected their primary drug in the last 4 weeks[59], followed by smoking (30%), ingestion (15%), inhalation (foil) (8%) and finally sniffing (3%).

[53] 50% of the sample had injected in the last 4 weeks, 23% in the last year, but not in the last 4 weeks, and 27% more than 1 year ago. 74% of the sample had used drugs or NPS in the last 4 weeks, 14% in the last year, but not in the last 4 weeks, and 12% more than 1 year ago.
[54] most frequently used drug. If a person used/injected drugs more than 4 weeks ago, then the question referred to the last 4 weeks of his/her last drug-using period.
[55] based on self-reported street names: “crystal”, “music” and “chalk” were grouped here.
[56] based on self-reported street names: “herbal”, “bio weed” and “magic tobacco” were grouped here.
[57] If a person used/injected drugs more than 4 weeks ago, then the question referred to the last 4 weeks of his/her last drug-using period.
[58] Based on self-reported street names, the following categories were established: cathinones: “crystal”, “music”, “chalk”; synthetic cannabinoid: “herbal”, ’bio weed”, “magic tobacco”; other opioids: “suboxone”, “codeine”, “other opioids”; other (grouped together due to low case numbers): “GHB”; “white powder”; “Slovakian pikoló”, frontin, Rivotril. The other categories are identical with the reported street name.
[59] If a person used/injected drugs more than 4 weeks ago, then the question referred to the last 4 weeks of his/her last drug-using period.

Chart 25. *Main route of administration of the primary used drug in the last 4 weeks[60] among PWID participating in the HNFP-NNK HIV/HCV biobehavioural survey in 2018 (N=437*; %)



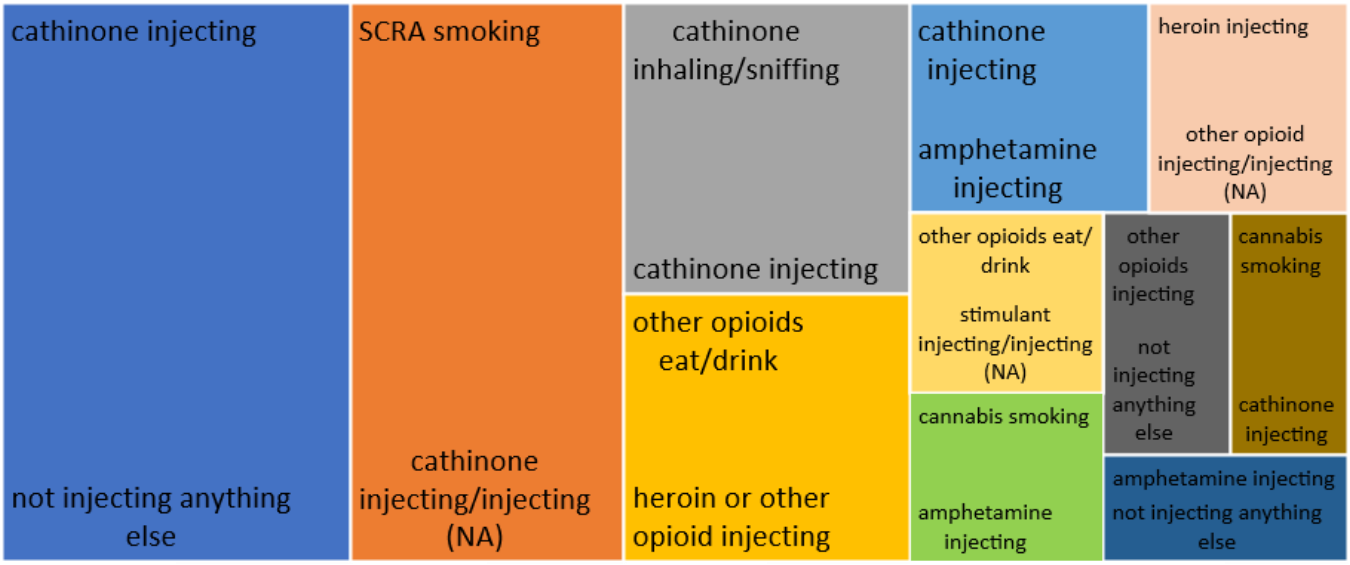
Source: Tarján et al. 2019

Although the comparability of data is limited (see methodology and limitations in section T.5.1 of the Harms and Harm Reduction workbook), it should be noted that there has been a decrease in the proportion of current PWID injecting in the last 4 weeks among all recruited ever-PWID compared to previous national OEK studies (Dudás et al. 2015) (2015 OEK: 66%; 2018 HNFP-NNK: 50%), despite the fact that in 2018 a much higher proportion of participants were recruited from NSPs/low-threshold services. Although trend data are not available in this regard, the decline in injecting may be supported by the finding that 32% of those ever-PWID who used drugs in the last 4 weeks (by any route of administration) did not inject in the last 4 weeks.

In the case of mono and poly drug use patterns, standalone cathinone injection (89 persons 20%) was the most common among the surveyed PWID (437 persons), followed by synthetic cannabinoid smoking and secondary cathinone injection (70 persons, 16%; the injected drug was not known in the case of 10 persons). The third most common pattern was primary cathinone inhaling (foil)/sniffing combined with secondary cathinone injecting (38 persons, 9%). Beside primarily taking methadone orally, secondary injecting was also a typical pattern (secondary injection of heroin or other opioids: 35 persons, 8%; of stimulants or an unnamed drug: 16 persons, 4%). A total of 23 persons reported injecting amphetamine and cathinones in parallel.

[60] If a person used/injected drugs more than 4 weeks ago, then the question referred to the last 4 weeks of his/her last drug-using period.

Chart 26. *Most common mono/poly drug use patterns among PWID participating in the HNFP-NNK HIV/HCV biobehavioural survey in 2018 (N=344[61]) (upper row: primary drug and route of administration; lower row: secondary drug and/or route of administration)[62]*



Source: Tarján et al. 2019

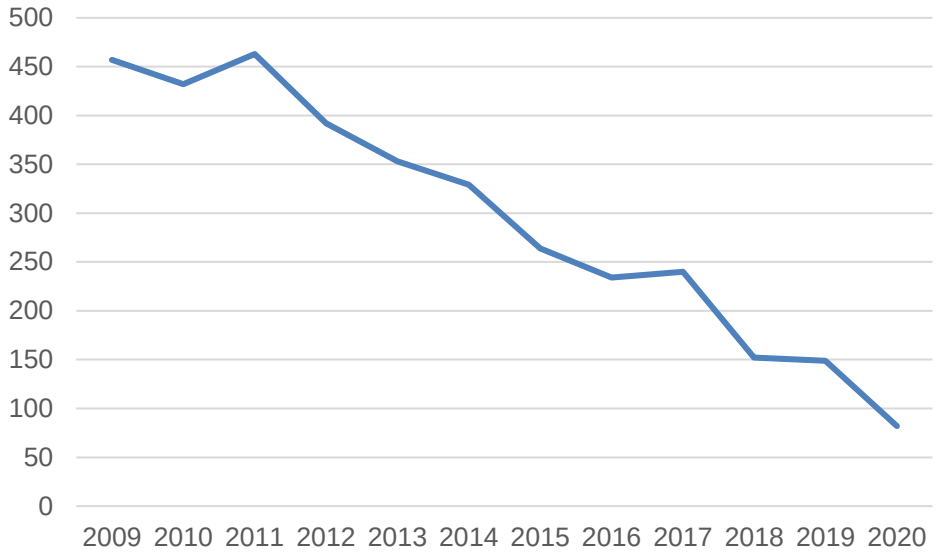
For more details on the 2019 regional HNFP-NNK HIV/HCV biobehavioural survey, see: section T5.1 of the Harms and Harm Reduction workbook).

Treatment (TDI) data

Looking back over the past 10 years, we can see that the number of current PWID entering treatment has been decreasing from 2011 onwards. While 463 current PWID[63] started treatment in 2011, only 82 started treatment in 2020, meaning that the number of current PWID entering drug treatment dropped to less than one-fifth of the 2011 value during the observed years.

[61] A further 93 combinations are not shown here due to low case numbers (under 7) per combination category.
[62] In the present analysis, the entire sample was included irrespective of the time of last use and last injection, so the chart does not illustrate (is not sensitive enough to illustrate) the possible time lag between the primary and secondary patterns of drug use. In cathinone injecting – amphetamine injecting, two groups were combined; cathinones were reported as the primary injected substance in 16 case and amphetamine in 7 cases. Of the total sample (439 persons), 18% (78) were in OST in the last 4 weeks, which also has a distorting effect on opioid-related patterns.
[63] persons who reported injecting drug use in the 30 days prior to entering treatment or the typical route of administration of the primary drug was injecting.

Chart 27. *Number of current PWID[64], between 2009 and 2020 (persons)*



**Those clients are considered current injecting users who injected their primary drug or reported the injecting of any substance in the last 30 days*
Source: Péterfi 2021a – TDI data 2021

For the analysis of the risk behaviours of PWID, see section T1.3.1 of the Harms and Harm Reduction workbook.

For further local studies on injecting drug use see Drugs/Stimulants/T4.1 (for the analytical examination of injected substances in Budapest see <ESCAPE data> Csorba et al. 2019). For information on the active substances detected on injecting paraphernalia, see section T2.1 of the Drug Market and Crime workbook.

T1.2.6 Infectious diseases

See section T1.3.1 of the Harms and Harm Reduction workbook.

T2. TRENDS

Overall, the use of established stimulants (cocaine, amphetamine, MDMA and its derivatives) is increasing according to the available data. There is a more marked increase in seizure data and a slower increase in treatment data, but both data sources indicate an upward trend in recent years.
Regarding seizure data (number of seizures; NSZKK 2020a) for designer stimulants (which in Hungary are mainly compounds belonging to the group of synthetic cathinones), there was a decline between 2014 and 2016, followed by an increase between 2016 and 2018, with a return to the 2014 levels by 2018; however, in 2019, a significant decrease could again be observed in the number of seizures.
For trends in injecting drug use, see section T1.2.5 of this workbook.

T3. NEW DEVELOPMENTS

[64] Regardless of the route of administration of the primary drug.

The Hungarian National Focal Point conducted a study in 2021 regarding the impact of the COVID-19 pandemic and related restrictions on drug use and responses. For the results of the study, see section T4.1 of the Treatment workbook.

T4. ADDITIONAL INFORMATION

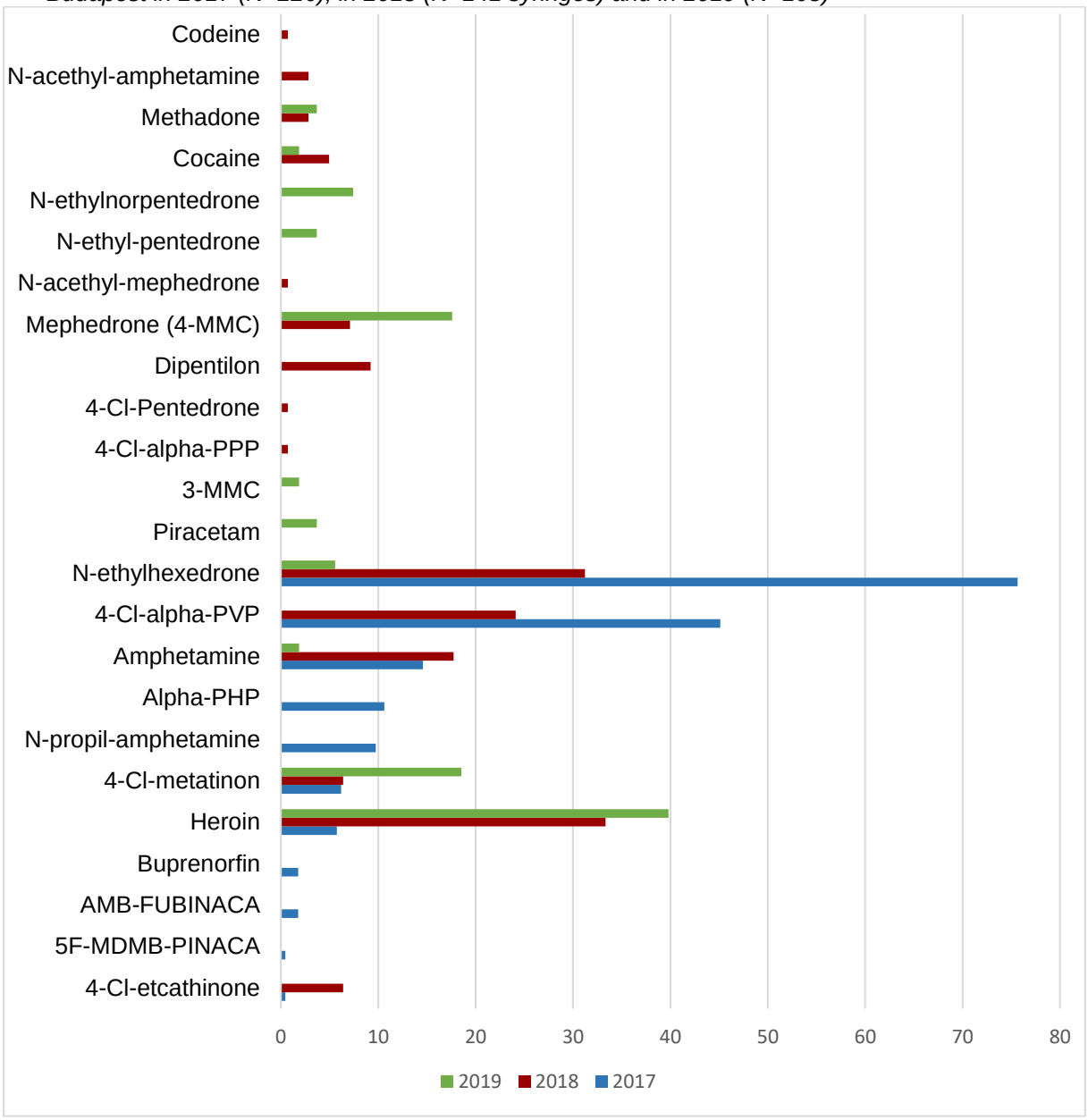
T4.1 ADDITIONAL SOURCES OF INFORMATION

According to the qualitative study (Kaló et al. 2018) conducted among experts working in treatment and harm reduction settings, as well as among current drug users, NPS injecting has become less common or less open. In general, the respondents described the NPS phenomenon as stagnating.
In the field of harm reduction, several experts mentioned a shift from injecting synthetic cathinones to smoking synthetic cannabinoids ("herbal", "bio"); a change from injecting to inhaling (using foil) was also confirmed, as observed in treatment data as well (see section T1.2.5 of this chapter). These changes were perceived to be associated with behavioural changes in drug users, namely becoming more hidden/reclusive. The experts also perceived that poly drug use behaviour is typical of "designer drug users" and that such users are "dependent on a state of intoxication" (the primary aspect when choosing a substance is that it should be potent). The experts gave more control by authorities and police activity as the reasons for the changes (route of administration; hiding). (A methodological description of the survey is provided under Drugs/ Sources and methodology/T6.2).

Results of the study using respondent-driven sampling (RDS) aimed at exploring the impact of the closure of the NSP in District 8 of Budapest (Csák et al. 2019) can be found under Drugs/Stimulants/T4.1 in the 2019 National Report.

According to Hungarian sub-data of the European ESCAPE project (ESCAPE 2017, Csorba et. al. 2020, for methodology, see section T6.2 in the Sources and Methodology section), synthetic cathinones were detected in 80% of the collected and analysed syringes in Budapest in 2017
(N-ethyl-hexedrone: 76% and 4-Cl-alpha-PVP: 45%). In the same year heroin was only found in 6% of the analysed syringes. Synthetic cathinones remained the most frequently detected substance group in the following two years as well, although their detection rate decreased from 80% in 2017 to 43% in 2018 and to 55% in 2019. In parallel, the proportion of syringes in which heroin was identified increased from 6% in 2017 to 33% in 2018 and 31% in 2019. While N-ethyl-hexedrone and 4-Cl-alpha-PVP were the most frequently detected cathinones in 2017 and 2018, in 2019 4-Cl-metcathinone (4-CMC) and mephedrone (4-MMC) became the most frequently detected synthetic cathinones. The proportion of syringes containing 2 or more substance groups has decreased over the past 3 years (from 13% in 2017 to 6% in 2019). Unlike previous studies on the subject (Péterfi et al. 2017), this study found the presence of methadone in syringes to be negligible over the 3 years studied. It is important to note that the data can be extrapolated only to a limited extent due to their local nature; additionally while, in 2017 and 2018 only one NSP was involved in the project, in 2019 three were involved, all located in different districts.

Chart 28. *Breakdown (%) of substance types identified on syringes in the ESCAPE project in Budapest in 2017 (N=226), in 2018 (N=141 syringes) and in 2019 (N=108)*[65]



Source: ESCAPE 2017; Csorba et al 2020; chart created by: Hungarian National Focal Point

For data on mono and poly drug use patterns based on the analysis of biological samples carried out by the Institute for Forensic Toxicology of the Hungarian Institute for Forensic Sciences (NSZKK), see Drugs/Cannabis/T4.1.

[65] More than one type of substance could be detected in some syringes per year.

C) HEROIN AND OTHER OPIOIDS

T1. NATIONAL PROFILE

T1.1 PREVALENCE AND TRENDS

T1.1.1 The relative importance of various opioid drugs

Based on the NSAPH general population survey data in 2019 (Paksi 2020), 5.8% of the 18-64 year-old population believes that they could access heroin easily or very easily. 7.7% of the young adult population reported the same.
According to the survey data, opioid use is very rare in the general population. The cumulative prevalence rate is 0.6%; the lifetime prevalence for heroin is 0.4%, while it is 0.4% for methadone use without a prescription and 0.6% for other opioids.

Based on the results of comparable surveys between 2007 and 2019, the prevalence of opioid use did not change in the observed 12 years, with only a very low proportion of the population having tried opioids.

According to the results of the 2019 ESPAD survey (Arnold, Elekes 2020), in 2019 heroin is the least widespread of the drugs studied among 16 year-old students, with a lifetime prevalence of 1.0%. Based on the trends detected among 16 year-old students in the observed 24 years, few have tried heroin; the lifetime prevalence rate was 1-2% between 1995 and 2019.

During its activities aimed at supply reduction in connection with heroin, the police has found that Hungary's earlier role as a destination country has gradually, and by now almost entirely, disappeared, as the volume of street-level dealing in heroin has been very low for years. However, as a transit country, Hungary still plays a significant role on the European market, although decreasingly so. In addition, an increase in sales of heroin on the Darknet can be observed. (BM 2020; NSZKK 2020a).

With regard to seizure data, between 2009 and 2010 both the number of seizures and the amount of heroin seized decreased significantly compared to previous years. After that drop, there was no significant shift in heroin seizures between 2010 and 2017. However, in terms of transit traffic, there are several relatively large-volume seizures per year: in 2020, in two seizures, altogether 38 kg heroin was seized (NSZKK 2021a). The same trends can be observed regarding samples from equipment related to injecting drug use between 2010 and 2015; the proportion of samples connected to heroin use radically declined (2009: 67%, 2011: 1%), while the prevalence of synthetic cathinones increased sharply (for more details, see Drugs/Stimulants/T1.2.5). That trend seems to have lessened since 2016, with the proportion of heroin-related samples detected on injecting equipment having slightly increased (NSZKK 2020a; Csorba et al 2020).

Besides heroin, methadone is the most readily available opioid-type substance on the Hungarian black market. In addition to the formerly available tablet form, in 2016 liquid methadone sold under the name of Misyo was introduced in Hungary, replacing the tablet form previously used by several OST providers (Csorba 2018). As most clients continue to prefer the tablet form and the released volume of those was reduced, it is likely that there will be decreased availability of methadone in tablet form on the black market as well.

New synthetic opioids are still not widespread in Hungary: only 9 seizures occurred between 2015 and 2020, mostly involving fentanyl derivatives. Aside from fentanyls, U47700 was identified on the Hungarian market (NSZKK 2021a).

T1.1.2. Estimates of opioid use

For the study (Horváth and Tarján 2016) on the estimate of the prevalence of injecting drug use in 2015, see Drugs/Stimulants/T1.2.5.

The prevalence of heroin use was last estimated in 2013, with respect to a two-year interval (2010-2011). The point estimate value for those using heroin at least once in the given two years was 3244 persons. (for detailed information, see chapter 4.2 of the 2013 National Report.) Since then, due to changes on the drug market and patterns of drug use, it can be assumed that the size of this population has fallen significantly and that patterns of use among them have changed.

T1.2 PATTERNS OF USE, TREATMENT AND PROBLEMATIC/HIGH-RISK USE

T1.2.1 Patterns of use

For data in connection with risk behaviours relating to injecting opioid use see Drugs/Stimulants/T1.2.5 and T4.2 and section T1.3.4 of the Harms and Harm Reduction workbook. For the patterns of use of opioid users entering drug treatment, see section T1.2.2.

T1.2.2 Treatment for heroin and other opioids

Opioid use was the primary problem in the case of 3.2% (138 persons) of clients entering drug treatment in 2020 (heroin: 89 persons, misuse of methadone: 19 persons, other opioids: 30 persons). A downward trend in the absolute number of (primary) heroin users entering drug treatment was observed between 2009 and 2020 (2009: 390 persons; 2020: 89 persons). For trends in the treated population see section T2.1 of the Treatment workbook.

The proportion of males among opioid users was 81.2% (108 persons), while 18.8% (25 persons) of opioid users were female. The mean age of this user group entering treatment was 38.1 years and the clients had used opioid-type substances for an average of 16.8 years before entering treatment in 2020. Prior to treatment, the typical route of administration was eating/drinking (34.9%), followed by injecting (28.7%). Chasing the dragon and sniffing were reported by 22.5 and 10.9% of those entering treatment for an opioid problem as typical routes of administration. Regarding frequency of use, 40.0% of the clients used opioids on a daily basis, 16.0% used them 2-6 days per week, 13.6% once a week or less and 30.4% had not used them in the last 30 days prior to entering treatment or had only used them occasionally during that time.

With respect to treatment options, opioid substitution treatment (OST) is available to opioid users as a special treatment programme. In the scope of OST, methadone and buprenorphine/naloxone (Suboxone) are the available medications in Hungary. A total of 508 persons were reported by service providers to be under OST in Hungary in 2020. For information on the availability and take-up of this treatment intervention, see sections T1.4.9-T1.4.11 and T2.1 of the Treatment workbook.

T1.2.5 Injecting drug use

Regarding injecting drug use, NPS injecting continues to be the dominant pattern observed in the population, although it has been declining slightly in recent years. See Drugs/Stimulants/T1.2.5.

Data regarding clients of needle and syringe programmes

On the basis of the NSP data (Tarján 2021a), the increase in NPS injecting from 2010 has completely transformed the structure of patterns of injecting drug use characteristic of previous years: while in 2009, 56% of PWID attending NSPs injected heroin primarily, in 2020 only 11% of the clients self-reported injecting that substance primarily. Between 2013 and 2019, the prevalence of primary heroin injecting has fluctuated between 3% and 8% among NSP clients, so their proportion in 2020 shows a slight increase compared to previous years. (For the chart on trends see Stimulants/T1.2.5; for N of clients per year, see Drugs/T.6.1).
The proportion of those injecting other opioids, primarily methadone, among NSP clients was 13% in 2020. It was the second most prevalent primary injected substance after synthetic cathinones among PWID. The proportion-based trend data can only be interpreted only to a limited degree due to the declining total number of NSP clients.
Opioid injecting is the most common in the over-34 age group: the prevalence of heroin (as the primary injected drug) is 17% and the prevalence of other opioids (primarily methadone) is 22%. In PWID aged under 25, the figures are 4% and 0% respectively, and in those aged 25-34 the figures are 8% and 9% respectively.

DRID data

National data

2006-2015
A decrease in the injecting of opioids from 2009 onwards can also be observed when examining PWID participating in the national seroprevalence survey between 2006-2015 (Dudás et al. 2015) by primary injected substance. While in 2006, 86.4% of the sample[66] injected opioids primarily, by 2015 only 38.3% of them reported an opioid as their primary injected substance[67]. (for more data on this period see Drugs/Stimulants/T1.2.5 in the 2018 National Report).

2018:
Among PWID participating in the 2018 national HNFP-NNK HIV/HCV biobehavioural survey (N=440 persons) (Tarján et al. 2019, for methodology see section T5.1 of the Harms and Harm Reduction workbook, for detailed sample analysis see Drugs/Stimulants/T1.2.5), 56% reported cathinone as their primary injected substance. Unlike in previous studies, heroin ranked second (moving ahead of amphetamine), with 15% reporting it to be their primary injected substance. 11% of the respondents injected other opioids most frequently (methadone 10% + other opiates 1%).
During the study, PWID were asked what their primary used drug was (regardless of the route of administration) or what they injected secondarily, giving a more nuanced picture of patterns of use among PWID.[68]
Among those who named heroin as their primary *injected* substance (61 persons), only 50% said that it was both their primary drug and their main route of administration. Among the remaining 50%, heroin injecting was secondary, while the most common patterns of use were oral administration of other opioids (21 persons), or heroin smoking/inhaling (chasing the dragon) (4 persons), or cannabis/synthetic cannabinoid smoking (5 persons).
Among those who named other opioids[69] as their primary *injected* drug (48 persons), only 50% said that it was both their primary drug and their main route of administration. Among the

[66] ever-injecting users
[67] Several organisations participating in the survey also provided OST (7 out of 19 in 2015) due to which there is a bias towards opioid injecting with respect to prevalence of primary injected drug.
[68] In the present analysis, the entire sample was included irrespective of the time of last use and last injecting, so the analysis is not sensitive to a possible time lag between the primary and secondary patterns of use (e.g. methadone by oral administration currently and earlier heroin injecting). In order to interpret the data, it should be added that the majority of participants (82%) were recruited from NSP or LTS. however, sites providing OST were also included: OST: 14%; NSP and/or LTS and/or OST: 4%.

remaining 50%, injecting of other opioids was secondary, while the most common patterns of use were oral administration of other opioids (14 persons) and cannabis smoking (8 persons) (Tarján et al. 2019).

For patterns of opioid use, see section T1.2.2; for further trends in injecting use see Stimulants/T1.2.5 (national data) and T4.1 (syringe residue analysis: Csorba et al. 2020) and section T2.1 of the Drug Market and Crime workbook for substances identified on seized injecting equipment.

For data on mono and poly drug use patterns based on the analysis of biological samples carried out by the Institute for Forensic Toxicology of the Hungarian Institute for Forensic Sciences (NSZKK), see Drugs/Cannabis/T4.1.

T1.2.6 Infectious diseases

See: Section T1.3.1 of the Harms and Harm Reduction workbook.

T2. TRENDS

For trends in clients entering treatment for opioid use, see section T2.1 of the Treatment workbook; for trends in injecting drug use see Stimulants/T1.2.5 in this workbook; for further trend data, see T1 of this section.

T3. NEW DEVELOPMENTS

The Hungarian National Focal Point conducted a study in 2020 regarding the impact of the COVID-19 pandemic and related restrictions on drug use and responses. For the results of the study, see section T4.1 of the Treatment workbook.

T4. ADDITIONAL INFORMATION

T4.2 FURTHER ASPECTS OF USE OF HEROIN AND OTHER OPIOIDS

In the HNFP-NNK biobehavioural study conducted among PWID (N=440) in 2018, several poly drug use patterns were identified in connection with opioid use: alongside primary oral administration of “other opioids”, secondary injecting drug use (heroin or other opioids: 35 persons; other unspecified drugs: 16 persons) was common. Injecting of other opioids[70] was reported by 67 people (15%). (Tarján et al. 2019)
The proportion of PWID injecting other opioids, mainly methadone, rose to 14% in 2019 among NSP clients, from around 7-9% in 2011-2018[71]. However, proportion-based trend data can only be interpreted only to a limited degree due to the declining total number of NSP clients. (Tarján 2020a)
The study examining residues in syringes in Budapest between 2017 and 2019 (ESCAPE, Csorba et al. 2020) scarcely found methadone and the analyses of the Hungarian Institute for Forensic Sciences (NSZKK) (2020a) (section T.2.1 of the Drug Market and Crime workbook) also barely detected methadone in syringes; by contrast, the increasing presence of heroin was measured in these studies.

[70] methadone: 57 persons; suboxone: 3 persons; other opioids: 7 persons
[71] Prior to 2011, data were reported by service providers in 4 closed categories: heroin; amphetamine; cocaine, other. From 2011, the “other” category became an open-ended question; since then drugs included in that category can be named, so it is only since then that accurate data are available on the injecting of other opioids.

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

T1. NEW PSYCHOACTIVE SUBSTANCES (NPS)

For information on new psychoactive substances see A) Cannabis/T1.2.4 and T4.1, B) Stimulants/ T1.2.4 and T1.2.5 and T4.1 and C) Heroin and other opioids/T4.2.

T4. ADDITIONAL INFORMATION

T1.4.3 NON-SPECIFIC DRUG USE AND POLY DRUG USE

Latent groups distinguished based on illicit drug use and non-medical use of medicines[72]

Based on the 2020 BLS study, a cluster analysis, by K-Means procedure, was conducted to assess the latent user groups on the basis of illicit drug use and non-medical use of medicines in the young adult population of Budapest (Paksi 2021). Eight different substance use behaviors shown in the table below were included in the model, each with a value of 0-1[73].

Among the young adults aged 19–35 in Budapest, five clusters, ie five groups of users, covering 99.8% of the sample, were identified based on the lifetime prevalence values of the examined illicit drug using and non-medical medicine using behaviors. The description of each group is shown in the table below, where the cluster centers for the different user behaviors in each group express the prevalence value of the given user behavior in the given group[74].

1st cluster: The first latent group, representing 4.0% of young adults aged 19-35 in Budapest, is the **'medicine users'** group, all of whom have used sedatives or hypnotics with or without medical advice in their lifetime, and three-quarters (75%) of the group are affected also in medicine abuse. Nearly one-third of those in the group (31%) have ever used cannabis in addition to medicines, but only 17% have tried other illicit drugs overall, including 9% traditional stimulants, 5% opiates, and 4% hallucinogens.

2nd cluster: The second latent group includes 2.8% of young adults in the capital city, who are **'classical stimulant users'**. Of those included, everyone had used a classical stimulant: 80.5% used ecstasy, 36.4% amphetamine, 10.4% cocaine (10% cocaine and 1.3% crack). In addition, 9% had used synthetic cannabinoids and 8% had used designer stimulants in their lifetime. However, none of them used cannabis or opiates.

3rd cluster: The largest group, 76.4% of the categorised cases, were not involved in practically any of the studied drug users' behavior (only 1% of them had already used designer stimulants), they were named the **'non-users'** group.

4th cluster: The fourth latent group is the group of **'polydrug users'[75]** all of whom have used an illicit drug other than cannabis, while 98% have also used cannabis in

[72] Source of the subchapter: Paksi 2021
[73] A score of 1 means the person has used the given drug in his/her life, and a score of 0 means he/she hasn't.
[74] Given that the input variables are 0-1 variables, where 1 means used and 0 means not used, the cluster centres represent the proportion of users.
[75] The literature uses the term polydrug use in several senses: "The simultaneous or sequential consumption of more than one type of psychoactive substance by a person, usually for the purpose of enhancing or counteracting

their lifetime. In this group, all illicit substance use behaviors examined have a significant lifetime prevalence value (LTP above 20%), but the use of cannabis and classical stimulants is most common (LTP in both cases 98%), with the highest prevalance of synthetic cannabinoids (LTP 51%) and designer stimulants use (LTP 51%), nevertheless the NPS are not the dominant drugs in the group. Medicine use is rare (but mostly abusive use 8%).

5th cluster: And finally, the second largest group is the mainly **'cannabis users'** group, where everyone has used marijuana or hashish in their lifetime, and nearly a fifth (19%) have used a classical stimulant too. However, the lifetime use of other drugs was reported by only 1-3%.

Table 11. *Latent drug user groups among young adults aged 19–35 in Budapest (wave 2 of the BLS study distinguished based on lifetime prevalence rates of illicit drugs and medicine use*

Final cluster centres (categorised cases: 2771; missing data: 6)					
	Cluster centres				
	medicine users	classical stimulant users	non-users	polydrug users	cannabis users
Cannabis	0,31	0,00	0,00	0,98	1,00
Synthetic cannabinoids	0,01	0,09	0,00	0,51	0,02
Desginer stimulants	0,00	0,08	0,01	0,58	0,03
Classical stimulants (total)	0,09	1,00	0,00	0,98	0,19
Hallucinogens (total)	0,04	0,02	0,00	0,53	0,01
Opioids (total)	0,05	0,00	0,00	0,22	0,00
Hypnotics/sedatives use with or without prescription	1,00	0,06	0,00	0,05	0,01
Misuse of medicines	0,75	0,04	0,00	0,08	0,01
Number of cases categorised (N)	112	77	2118	57	407
%	4,0	2,8	76,4	2,1	14,7

Source: BLS 2020 – Paksi 2021

Overall, the results of a cluster analysis based on lifetime prevalence values of different illicit drug and medicine use behaviors show that hypnotics/sedatives, classical stimulant use, and cannabis use are present as independent user behaviors among young adults in Budapest, while the use of synthetic cannabinoids and the use of designer stimulants only appears as part of polydrug use. These results are partly consistent with the analysis of the 2015 NSAPH data (Paksi, 2017), which identified three distinct groups of users nationwide in the 18-64 age group: medicine users, cannabis users and polydrug users. In the young adult population, too, these user behaviors were observed. In the adult population data, similarly to our current results, we could not identify a separate group using NPS, as NPS use was most prevalent in

the effects of another substance. It is often used to differentiate between consumers who have a more diverse pattern of use than those who use only one type of drug. It is commonly used to describe the use of several types of illicit drugs, however it is in the research literature that it is sometimes used for the combined use of licit drugs such as alcohol and tobacco. The category is also used when it is not possible to determine the exact drug used or the consumer himself is not aware of what he has taken. Another example of this could be a problem heroin user who is unable to maintain his or her use and may therefore resort to central nervous system sedatives such as alcohol to reduce the symptoms of opiate withdrawal. http://drogfokuszpont.hu/fogalomtar/fogalomtar-ii/#Politoxikom_nia_

The term 'polydrug users' in this analysis is used to name the user group that are caracterised by a more varied pattern of use than those who have used only one or two types of drugs.

the group of polydrug users. At the same time, unlike in our previous analysis, classical stimulant users emerged as a new latent group among young adults in Budapest.

Social-demographic patterns of the latent groups of drug users

Among young adults aged 19-35 in Budapest, the relationship between illicit drug user groups, distinguished based on lifetime prevalence values of illicit drugs and medicine use presented in the previous section, and some social-demographic characteristics is examined in the following with pairwise multinomial logistic regression models[76]. The output variable of the regression models consisted of latent drug user groups distinguishable on the basis of lifetime prevalence values of illicit drugs and medicine use, within which the reference category was those who had never used illicit drugs or medicines in their lifetime.

Our analysis showed that significant patterns with latent drug user groups can be observed along most of the social and demographic characteristics examined. At the same time, we can see that the differences are small in effect size, with only a moderate correlation between the financial situation and the deviant patterns/risk behaviors in the family.

If we review the obtained patterns along the indicator groups representing the different theoretical models, we can say that based on the pairwise analysis the respondent's gender, education, financial status, family/social and religious integration, anomie and the presence of deviant patterns in the family showed a significant correlation. However, we did not find significant differences between different groups of drug users in terms of age, intergenerational educational mobility, and variables describing the labour status.

Based on the pairwise multinominal regression models, the following should be highlighted in respect of the different latent drug user groups when compared to those who have never used any drug:

- Regarding belonging to groups that use illicit drugs, the gender of the respondent plays a significant role. Men are about twice as likely to be classical stimulant users and cannabis users, and three times more likely to be polydrug users than women.
- In terms of educational status, in general we can say that the risk role of low status is most pronounced. Expected educational attainment of 8 primary or lower levels is linked to significantly higher risk for all latent drug use groups when compared to college or university degree. In addition, in the case of classical stimulant users, all lower levels of education compared to college or university degree also play a risk role: the risk of belonging to one of the user groups is significantly higher in the case of secondary level of education and in the case of vocational education. At the same time, the risk of belonging to the group of cannabis users among those with a vocational education is about half that of those with a university or college degree, while the risk of those with a high school final exam tends to be lower. In line with the general risk role of the low educational status, the chances of belonging to the group of classical stimulant and cannabis users are significantly higher even in the absence of vocational training.
- Indicators of economic status (subjective or relative economic situation of the household, deprivation index and the unfavorable financial status index formed on the basis of them) indicated significant differences when compared to non-users, especially in the case of the latent groups of medicine users and cannabis users. In case of the

[76] In order to further analyze the relationship between latent drug user groups and socio-demographic factors, we also attempted to construct a multivariate multinomial logistic regression model in which, similar to pairwise models, the logistic regression model output variable was separated by lifetime prevalence , and within this, the reference category was those who had never used illicit drugs or medicines. However, we failed to develop a model with a classification accuracy that exceeded the predictive power of estimation without explanatory variables (76.4%), and all of our attempts to identify latent drug users were particularly low (0–12%).

cannabis user group, a more favorable status showed an increased risk when compared to an unfavorable economic status. A different correlation was observed only in the case of classical stimulant users, where the higher values of the deprivation index is linked to higher risk.

- Similarly, the group of medicine users and cannabis users showed significant differences when compared to non-users in the presence of anomic sensations, but with a different orientation for the two groups. In the presence of a more intense presence of anomic sensations, the risk of belonging to the group of medicine users is significantly higher, while the higher risk of cannabis use is, on the contrary, associated with a lower overall anomie score.
- The presence of deviant patterns in the family is as a significant risk for all user groups. With the increase in the number of deviant patterns in the family, compared to non-users, the chances of belonging to the group are 70% higher for medicine users and almost 50% higher for polydrug and cannabis users.[77]
- In terms of religiosity, we can observe syngificant patterns only in case of cannabis use, however that is difficult to interpret. Compared to atheists, religious people are one-third more likely to belong to the group of cannabis users, but they are only about half as likely as those who are insecure about their religiosity, and in case of those who are religious on their own way religiosity does not play a protective role.
- Similarly, the correlations along the various indicators of social integration (household size, indicators of the volume and quality of social life, satisfaction with social relationships) are not clear. However, if we try to summarize the risks based on different indicators, we can say that, with the exception of classical stimulant users, the risk of belonging to a drug use groups is significantly higher in the case of higher social integration and lower in the case of greater satisfaction with social relationships.
- The WHO general well-being score showed a relationship with belonging to only one group of drug users: an increase in the general well-being relative to non-users decreases the likelihood of belonging to the group of medicine users.

[77] Multinominal regression also indicated a significant correlation for classical stimulant users, but since the confidence interval in this group contains the value of 1.0, this correlation should be treated with caution.

Table 12. *Pairwise, uncontrolled multinominal logistic regression models: the development of the probability of belonging to different latent drug use groups in the case of different social-demographic characteristics among the young adult population aged 19-35 in Budapest in Hungary (in the 2nd wave of the BLS study)*

	medicine users		classical stimulant users		polydrug users		cannabis users	
	OR [95% CI]	p	OR [95% CI]	p	OR [95% CI]	p	OR [95% CI]	p
Gender (ref.: female)								
Male	0.74 [0.50-1.10]	0.133	2.01 [1.26-3.21]	0.003	3.00 [1.69-5.35]	<0.001	2.17 [1.74-2.71]	<0.001
Age	1.03 [0.99-1.08]	0.110	0.97 [0.93-1.02]	0.276	1.00 [0.94-1.05]	0.876	1.01[0.98-1.03]	0.671
Expected educational attainment[78] (ref.: college/university degree or higher)								
a maximum of 8 years in primary education	3.85 [1.57-9.40]	0.003	8.35 [2.54-27.47]	<0.001	4.50 [1.31-15.43]	0.017	3.37 [1.86-6.10]	<0.001
vocational school	0.68 [0.38-1.23]	0.202	2.19 [0.98-4.88]	0.055	0.89 [0.39-2.02]	0.780	0.53 [0.37-0.76]	<0.001
graduation	0.71 [0.46-1.10]	0.125	2.24 [1.12-4.49]	0.023	0.92 [0.49-1.75]	0.800	0.81 [0.63-1.03]	0.089
Vocational qualification (ref.: yes)								
no	2.31 [0.94-2.31]	0.094	3.32 [1.23-3.32]	0.006	2.71 [0.79-2.71]	0.232	2.33 [1.43-2.33]	<0.001
Intergenerational educational mobility[79] (ref.: downwardly mobile)								
upwardly mobile	1.17 [0.53-2.57]	0.700	3.21 [0.7-14.71]	0.133	0.61 [0.22-1.69]	0.345	1.12 [0.69-1.81]	0.640
not mobil	0.82 [0.38-1.78]	0.620	3.14 [0.7-14.10]	0.135	0.79 [0.31-2.01]	0.614	1.27 [0.80-2.01]	0.310
Labour market acitvity (ref.: have a job)								
no job	0.91 [0.51-1.62]	0.741	1.04 [0.54-2.00]	0.911	1.34 [0.66-2.71]	0.413	1.21 [0.90-1.64]	0.199
Hours spent working an average week	1.00 [0.99-1.01]	0.522	1.00 [0.98-1.01]	0.538	0.99 [0.98-1.01]	0.403	0.99 [0.99-1.00]*	0.040
Subjective financial situation of the household (ref.: we have a very hard time making a living from our income)								
we make a comfortable living from our income	11.70 [3.87-35.39]	<0.001	1.35 [0.38-4.77]	0.645	-**	-	47.15 [9.28-239.68]	<0.001
we make ends meet	2.92 [1.03-8.24]	0.044	1.51 [0.65-3.48]	0.229	-**	-	32.32 [6.61-158.02]	<0.001

[78] Variable created based on the attained educational status and current education, just like in the NSAPH studies (Paksi et al. 2009, 2017, 2021).
[79] Shift of the respondent's expected education compared to the mother's education for women and the father's education for men (Róbert, 1990).

	medicine users		classical stimulant users		polydrug users		cannabis users	
	OR [95% CI]	p	OR [95% CI]	p	OR [95% CI]	p	OR [95% CI]	p
we have a hard time making a living from our income	4.40 [1.46-13.20]	0.008	1.71 [0.65-4.47]	0.276	-**	-	38.27 [7.71-189.91]	<0.001
Perceived relative financial situation of the household (ref.: worse than average)								
better than average	2.89 [1.63-5.13]	<0.001	0.63 [0.23-1.69]	0.356	1.92 [0.85-0.39]	0.116	2.87 [1.86-4.42]	<0.001
average	0.75 [0.44-1.28]	0.289	1.12 [0.61-2.04]	0.721	0.80 [0.39-1.61]	0.527	2.12 [1.47-3.06]	<0.001
Deprivation index[80]	0.96 [0.90-1.02]*	<0.001	1.11 [1.03-1.19]	0.004	1.02 [0.941.11-]	0.664	0.88 [0.85-0.92]	<0.001
Unfavorable financial status index	0.66 [0.53-0.82]	<0.001	1.11 [0.90-1.38]	0.342	0.82 [0.62-1.09]	0.163	0.67 [0.59-0.76]	<0.001
Anomie score[81]	1.05 [1.03-1.08]	<0.001	0.98 [0.95-1.02]	0.346	0.97 [0.93-1.01]	0.143	0.97 [0.95-0.98]	<0.001
Relationship status (ref.: living with partner)								
not living with partner	1.05 [0.64-1.73]	0.839	1.42 [0.80-1.50]	0.232	1.27 [0.67-2.43]	0.462	0.91 [0.68-1.22]	0.525
Size of household (persons)	1.21 [1.00-1.47]	0.048	1.27 [1.01-1.60]	0.038	0.92[0.70-1.20]	0.521	0.78 [0.70-0.87]	<0.001
Number of deviant behaviours on the close family[82]	1.71 [1.54-1.90]	<0.001	1.14 [0.94-1.37]*	<0.001	1.46 [1.24-1.72]	<0.001	1.45 [1.34-1.57]	<0.001
Freqency living a social life (ref.: at least once a week)								
never	0.49 [0.14-1.75]	0.269	1.40 [0.44-4.48]	0.574	0.22 [0.02-2.24]	0.201	0.45 [0.23-0.90]	0.023
less then once a week	0.67 [0.43-1.05]	0.080	0.98 [0.23-1.80]	0.946	0.52 [0.29-0.93]	0.028	0.55 [0.53-0.71]	<0.001
Relative frequency of socializing (ref.: more than others)								
less than others	0.51 [0.28-0.93]	0.029	1.48 [0.52-1.21]	0.460	0.41 [0.16-1.11]	0.079	0.75 [0.48-1.19]	0.226
as much as others	0.32 [0.18-0.58]	<0.001	1.05 [0.38-2.95]	0.920	0.63 [0.26-1.51]	0.295	1.03 [0.67-1.60]	0.888

[80] Complex indicator for multidimensional deprivation (Townsend, 1979). The applied index is based on 16 life circumstances component, its actual value refers to components missing due to financial reasons.

[81] The degree of anomie - combining some elements of Srole and Seeman's definition of anomie and alienation (Robinson, Shaver, & Wrightsman, 1991) - was measured along a 10-point scale (1 - not at all agree; 4 - strongly agree) along 10 items depicting the dimensions of transgression, powerlessness, lack of orientation, and alienation, a subjective indicator created by summarizing the given responses (Andorka, 1994). A higher value of the applied indicator indicates an increased presence of anomic sensations.

[82] Among the types of deviant/risk behaviors (smoking, regular alcohol consumption, heavy sedative / hypnotic or drug use, regular gambling, suicide attempt, completed suicide, inprisonment, psychiatric treatment) examined, the number of behaviours occurring in the narrow family.

	medicine users		classical stimulant users		polydrug users		cannabis users	
	OR [95% CI]	p	OR [95% CI]	p	OR [95% CI]	p	OR [95% CI]	p
How many persons can you discuss your problems with?	1.07 [0.96-1.20]	0.227	1.00 [0.86-1.16]	0.969	1.38 [1.22-1.55]	<0.001	1.26 [1.19-1.33]	<0.001
Satisfaction with relationships and health status index	0.54 [0.46-0.64]	<0.001	0.94 [0.74-1.19]	0.580	0.65 [0.51-0.82]	<0.001	0.75 [0.67-0.83]	<0.001
Satisfaction with work and economic status index	1.04 [0.86-1.27]	0.669	1.16 [0.91-1.47]	0.227	0.76 [0.58-1.01]	0.057	1.03 [0.93-1.15]	0.555
Religiosity (ref.: ateist)								
religious. follows the teaching of the church	1.93 [0.70-5.29]	0.204	2.48 [0.18-34.20]	0.499	0.69 [0.05-8.94]	0.755	0.30 [0.10-0.86]	0.026
religious on his own way	0.50 [0.22-1.16]	0.107	3.94 [0.46-33.40]	0.209	1.40 [0.30-6.62]	0.672	0.90 [0.54-1.50]	0.675
uncertain (cannot tell if religious)	0.90 [0.37-2.21]	0.820	1.90 [0.19-18.85]	0.582	1.72 [0.33-8.88]	0.516	0.53 [0.29-0.98]	0.044
not religious	0.46 [0.20-1.05]	0.066	3.42 [0.41-28.95]	0.258	0.81 [0.17-3.89]	0.793	0.66 [0.40-1.10]	0.110
WHO general well-being scale	0.85 [0.80-0.91]	<0.001	0.95 [0.87-1.03]	0.174	0.94 [0.85-1.03]	0.182	0.99 [0.95-1.03]	0.628

*Notes: OR [95% CI]: Odds ratio with its 95% confidence interval; Ref.: reference category of the given variable; *The confidence interval includes value 1. therefore the correlation should be interpreted with caution; **The case number of the reference category is 0. therefore CI cannot be calculated.*

*Variables with a significant role (p<0.050) in the multivariate model are highlighted in grey (except for those with a * mark).*

Source: BLS 2020 – Paksi 2021

E) SOURCES AND METHODOLOGY

T6. SOURCES AND METHODOLOGY

T6.1 SOURCES – ROUTINE DATA COLLECTIONS

Péterfi 2021a – TDI data collection 2021: see section T5.2 of the Treatment workbook

Péterfi 2021b – OST data collection 2021: see section T5.2 of the Treatment workbook.

Tarján 2021a – NSP data collection:
NSPs reported their 2020 data via the web-based data collection interface operated by the Hungarian National Focal Point since 2008. The service providers have sent data on the demographic characteristics and injecting patterns of clients participating in NSPs to the Hungarian National Focal Point through this interface since 2010. In 2012. the closed "other" substance category was changed to an open-ended question. enabling the service providers to name the other substances. On the basis of previous years' experiences. the list of closed categories (which were mainly the established substance types before) was extended in 2015 to include new closed categories: "penta kristály" ("penta crystal"); "zene" ("music"); methadone; MDPV. The service providers provided information in 2020 on the primary injected substance of a total of 567 clients. (2009: 1483 persons; 2010: 1737 persons; 2011: 2237 persons; 2012: 1907 persons; 2013: 3128 persons; 2014: 3692 persons; 2015: 2985 persons; 2016: 2366 persons; 2017: 2093; 2018: 1435 persons. 2019: 819 persons) Information on the primarly injected substance was provided on 468 clients in 2020. With respect to the number of clients. duplicates were removed at the service-provider level but not at the national level. The same client may be registered at several NSPs. For further details on collection of the data. see: Section T5.1 of the Harms and Harm Reduction workbook.

Tarján 2020b – Data collection among harm reduction services in nightlife settings: see section T.5.1 of the Harms and Harm Reduction workbook.

T6.2 METHODOLOGY

Arnold and Elekes 2020 – ESPAD 2019:
The European School Survey Project on Alcohol and Other Drugs (ESPAD) was launched in 1995 with the aim of regularly collecting internationally comparable data on young people's risk behaviours every four years. Hungary has participated in the international research project for 25 years: seven waves of data collection have taken place so far. most recently in 2019. The 2019 data collection in Hungary was supported by the National Office for Research. Development and Innovation (K127947). the Department of Sociology of Kodolányi János University and the Hungarian National Focal Point. ESPAD data collection in Hungary was conducted by the Department of Sociology and Social Policy. Institute of Communication and Sociology. Corvinus University of Budapest. Principal investigator: Zsuzsanna Elekes. The study was conducted on the nationally representative sample of young people participating in full-time normal school education. using a self-completion method. in spring 2019. Sampling was performed by stratified random sampling. The stratification was performed by region (7 regions). school year (9 and 10) and type of class (grammar school. vocational grammar school. secondary vocational school). The required sample size was determined according to the ESPAD protocol for 16 year-olds. The net sample of 16 year-olds was 2357 persons. The questionnaire included mandatory. as well as optional ESPAD questions. supplemented by some national questions. Csaba Horváth Gergely (Hungarian National Focal Point). Zsolt Demetrovics and Orsolya Király (Department of Clinical Psychology and Addiction. Faculty of Education and Psychology. Eötvös Loránd University) participated in adaptation of the questionnaire to the Hungarian context and development of the national questions.

Csorba et al. 2020 – partial data on the ESCAPE study in Budapest
In 2017. 2018 and 2019. Hungary also participated in the EMCDDA ESCAPE project. which investigated residues on injecting equipment in European cities to determine injected substances (for further information and detailed methodology. see http://www.emcdda.europa.eu/system/files/publications/11287/20191061_TD0119176ENN_PDF.pdf). The Hungarian cooperating partner was Hungarian Interchurch Aid (MÖSZ). The used syringes were collected through the needle and syringe programme of Art Éra Foundation in District 7 of Budapest: the laboratory examinations showed a total of 222 collected syringes with an active substance in October 2017 and a total of 150 in April 2018. In 2019. in addition to the Art Éra Foundation. two other organisations joined the project: AATSZ in District 11. and Válaszút in District 2.The syringes (N=136) were collected in June. During the collection period. duplication of syringes from the same individual may occur. so the data are limited in their ability to determine local prevalence. Chemical examination of the substance and blood residues was carried out at the Institute of Forensic Medicine of the University of Debrecen by the GC-MS method. using a "screening" approach. The Hungarian data were re-analysed by the Hungarian National Focal Point using the Hungarian sub-data included in the EMCDDA ESCAPE project publication and the Hungarian raw data.

Dudás et al. 2015 – National HIV/HBV/HCV seroprevalence survey: see section T5.1 of the Harms and Harm Reduction workbook

Horváth and Tarján 2016 – Prevalence of injecting drug use:
Estimation was performed using the method of capture-recapture recurring in time. For further information about the studies corresponding to the two databases used (2014 and 2015 national HIV/HBV/HCV seroprevalence surveys). see sections T1.3. T2.2 and T5.2 of the Harms and Harm Reduction workbook of the 2015 and 2016 National Reports.
Those tested PWID were included in the estimate who took part in a NSP in the given time interval or received treatment at a specialised outpatient drug treatment centre. 19 service providers participated in the survey in each of the two years. Ever-injecting drug use was a recruitment criterion for participation in the testing.
During the survey series. people who inject drugs (PWID) were identified by means of a "generated code" used in the TDI system. making it possible to monitor the re-occurrence of clients. (For further information on the socio-demographic data of PWID and their patterns of drug use. see section T1.3 of the Harms and Harm Reduction workbook of the 2015 and 2016 National Reports and in sections T1.2.2 under the various substances (primarily under Stimulants. but also under Opioids) in the Drugs workbook.)
It was not possible to break down the estimate by different substance types. The result of the first step of the estimate refers to a two-year interval. i.e. it indicates injecting drug use during the two years specified[83]. As the second step of the estimate. the results were modified according to the question about the time of the last injecting that was included in the questionnaire of the testing. so the estimate refers to the population injecting recently (in the last 12 months). A condition of using the capture-recapture method is independence between the two time points when the measurement is performed. Presumably this condition of independence was not fulfilled in the testing programme. so the basic formula[84] of capture-

[83] Re-occurrence in the testing programmes between 2014 and 2015

Year	**2015**	
Occurrence	**Gender**	**Yes**
2014	Gender	458
	Yes	463	133

[84]The "Lincoln-Petersen" formula was modified, so the formula used for estimating injecting drug use was:

$$x = \frac{a21*a12}{\alpha*a''22} + (1-\alpha)*a'22$$

where:

recapture was modified. distinguishing between accidental and systematic or intended participation as the cause of re-occurrence in the testing programme. By modelling the intention to participate. sensitivity analysis was performed. The coefficient of the intention to participate was determined after interviewing the testing sites. using the method of expert estimation. On the basis of the average of the answers given by the interviewed service providers. 76% of the clients intentionally participated in the seroprevalence survey again.[85] The clients participating in the seroprevalence survey were given an incentive (meal vouchers with a value of around EUR 3). so the proportion of participants who took part in the survey for the second time because of that is presumably high and may even be higher than the estimated value.

Kaló et al. 2018 – Key informant study for the monitoring of NPS:
The focus of the study was on the identification of changes and new phenomena in the use of new psychoactive substances by analysing expert perceptions and data during a 6-month period (June-December 2017) in Hungary. The aim of the study was to carry out an analysis going beyond descriptive indicators. by exploring the new NPS scenes identified by national and international experts (Hungarian LGBT community. child protection and homeless care. online scenes) besides the scenes already identified in the scientific literature (injecting drug use. treatment and care. prison. nightlife). as well as exploring the information available from the media and authorities. The non-representative study used a pragmatist philosophical approach and a mixed method model with primary qualitative data collection and secondary qualitative and quantitative data analysis.
1) Qualitative testing: the (primary) data collection was conducted between January and April 2018 by means of interviews and focus groups. 10 thematic working groups (injecting drug use. treatment and care. prison. nightlife. LMBTQ communities. child protection. homeless care. online scene. media). 20 focus groups (53 participants + 10 working group leaders). 12 interviews (12 people) and 2 expert focus groups (working group leaders + 6 experts) were carried out with a total of 81 participants.
2) Media monitoring: The content analysis of the expert interviews identified 21 keywords. Based on the keywords. a systematic analysis was run on Hungarian online media publications from the research period (which identified a total of 382 media reports).
3) The collection and analysis of secondary data (seizures. epidemiological and research data from the research period) were completed (20 documents). The data analysis was performed using deductive content and document analysis in the Atlas.ti 8.2.0. program.

Paksi 2021 – BLS 2020: Drug use and drug user groups in the 19-35 year old population in Budapest based on the 2020 survey of the BLS (Budapest Longitudinal Study)
The aim of the BLS is to study the development, intensification, stabilisation, reduction or cesession of smoking, alcohol use and the use of other psychoactive substances, as well as of certain potentially addictive behaviors related to non-psychoactive substance use (video gaming, gambling, social media use, work addiction, hypersexuality, compulsive shopping). The present analysis is based on the data of the second wave of the Budapest Longitudinal Study (BLS) conducted in 2020 on a representative sample of young adults aged 18-34 in Budapest between 2019 and 2022.

X = hidden population
a21 = PWID population occurring in one of the years
a12 = PWID population occurring in the following year
a'22 = PWID population re-occurring in testing intentionally
a''22 = PWID population occurring in testing accidentally
α = coefficient of the intention to participate; 100% means that all repeat occurrences were accidental, i.e. the two tests are statistically independent

[85]During the survey the service providers participating in the seroprevalence survey were contacted and requested to estimate the proportion of re-occurring clients, i.e. what proportion of clients who occurred in testing in the two consecutive years returned to the testing programme intentionally and what proportion returned accidentally. All 15 service providers where there were re-occurrences from 2014 to 2015 according to the TDI-generated code answered the question.

The BLS study was conducted with the support of the National Office for Research, Development and Innovation (KKP126835).
The target group of the BLS study series was the population aged 18-34 with a valid address in Budapest (321,974 according to the register of BM NYHÁT on 1 January 2019) at the time of the first survey in 2019 (Paksi, Magi et al., 2021). The initial sample was selected by a one-step random sampling procedure stratified by age groups (18-24, 25-34) and district. The size of the initial gross sample is 4,500 people. During the first sampling wave, a replacement sample selected according to the same principles as the main sample, with three times the number of items, stratified according to the stratification criteria and gender, was used to compensate for the sample loss. In the 1st wave of data collection, 4331 people were reached. The quality control of the data collection of the first wave was performed during the second data collection wave, based on which we finally got rid of 11% of the questionnaires recorded in the first wave, so the actual access rate of the first wave is 86.4%, the final net sample size is 3890 people (standard error at the 95% confidence level is ± 1.57%). The gross sample of the second wave was 4331 persons reached during the first wave, and the net sample size reached in the 2nd wave was 2801 persons (standard error at the 95% confidence level ± 1.85%). Our present analysis is performed on a sample of 2777 individuals reached in both waves, which maximizes the standard error at a confidence level of ± 1.86%. Matrix weighting according to layer categories was used to correct for sample loss, both for the sample of each wave and for the sample that is a common part of them, which is analyzed in the present study. The data collection is primarily done by personal contact of the persons included in the sample, the questionnaire was recorded with a so-called mixed method inculding both face-to-face, and self-filling elements, during the summer of 2020.
Regarding the development of drug-related questions, the research questionnaire was in line with the questionnaire of the latest Hungarian general population drug epidemiological study – NSAPH (Paksi, Pillók et al., 2021), which complies with EMCDDA's European model questionnaire (EMQ) (EMCDDA, 2002), their indicator needs and its recommendations for the general population surveys on NPS and medicine use (EMCDDA, 2013, 2015).

Paksi. Magi. Gurály 2020 – Drug use and homelessness – Study on drug use and other psychoactive substance use of the homeless population:
The purpose of the study was to estimate the use of drugs and other psychoactive substances in the homeless population. a social group that is not covered by general population surveys. and to identify the specific drug use characteristics of the homeless population by interpreting the results in the general population context. Data collection – similarly to in the 2007 study – was performed using the omnibus method. together with the 2017 data collection of the "Február Harmadika" (3 February) (F3)) data collection series. which is the best available estimation of the homeless population. The target population of the research was the homeless population in Hungary and the sampling frame was the 8014 homeless people who were reached during the 2017 F3 data collection in homeless shelters and in public areas. covering the whole country. The research was carried out on a one-sixth random sample stratified according to the sampling frame's access location (specific accommodation and street services). Based on the size of the sample frame. the calculated gross sample size of the study was 1335 persons. and the net sample size was 1302 persons. Because of the high access ratio. sample weighting was not required. In the analyses carried out with this sample size. the theoretical margin of error was ± 2.5% at 95% confidence level. Data were recorded using self-administered questionnaires handed out in closed envelopes – similarly to in the 2007 study and the general population studies. In designing the study material. the recommendations of the EMCDDA. changes in needs related to the indicator (perceived accessibility). recommendations on the monitoring of use of new psychoactive substances (NPS) and comparability with the national general population studies (NSAPH 2007. 2015) were taken into consideration.

Paksi 2019 – HBSC 2017/2018: Drug use
The 9th Hungarian wave of the HBSC study was conducted in the 2017/2018 school year. The aim of the study was to examine the physical. mental. emotional and social well-being of adolescents. The questionnaire is jointly developed by the international HBSC research group and the national HBSC research group. The study was supported by the National Office for Research. Development and Innovation (KKP126835). the Ministry of Human Capacities (1783-3/2018/FEKUTSTRAT) and the WHO Hungarian Office. The data collection took place in April-May 2018. Sampling (by county. the school's settlement type. type of school. and type of school maintainer) was performed using a stratified sampling procedure for national representativeness. The study covered students in school years 5. 7. 9. and 11 in the 2017/2018 school year. The net size of the total sample was 6003 people. Questions related to drug use were included only in the questionnaires of students in the school years 9 and 11; in their case the total sample size was 2766 people. Sampling was done by group sampling. i.e. complete classes were included in the sample. Passive parental consent was requested for the participation of those under 18 years of age. The study was commissioned by the Institute of Psychology of Eötvös Loránd University. with the approval of the Scientific and Research Ethics Committee of the Health Science Council. Students in school year 9 were on average 15.95 years old and students in school year 11 were on average 17.88 years old.

Paksi et al. 2019; Paksi 2020 – NSAPH 2019:
The NSAPH 2019 study (Paksi et al. 2019; Paksi 2020) was conducted on a 1800 gross and 1385 net national representative sample of adults aged 18-64 in Hungary. The sample was selected by random sampling stratified by region. settlement size and age. Layer category weighting was used to correct for bias due to sample dropouts. Data collection was conducted by personal contact with the persons included in the sample. with mixed methodology using both face-to-face and self-filling elements. It took place in spring 2019.
With regard to the development of drug-related questions. the study draws on previous general population drug epidemiological studies in Hungary and on the EMCDDA model questionnaires (EMQ). on EMCDDA's data needs related to the GPS indicator. and on their recommendations regarding new psychoactive substances (NPS) and medication use in general population studies. The calculation of prevalence values. consistently with previous waves of the study. also follows the recommendations of the EMQ.
The study was supported by the National Office for Research. Development and Innovation (K128604).

Paksi et al. 2015 – NSAPH 2015:
The survey was carried out on a representative sample of the Hungarian population aged 18-64. stratified by settlement size. region and age group. with over-representation of the population aged 18-34. The gross sample size was 2477 (net sample 2247 persons). The national representative sample of the 18-64 year-old population consisted of 1490 persons. while the national representative sample of the 18-34 year-old population consisted of 1534 persons. Data were recorded using mixed methodology. meaning a face-to-face technique combined with self-reporting elements. in spring 2015. The survey was financed by the Hungarian Scientific Research Fund (OTKA) (application identification: K.109375) and the Ministry of Human Capacities (EMMI).

Port 2016 – Survey on drug use among juveniles in detention homes: see section T5.2 of the Prison workbook.

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PREVENTION WORKBOOK[86]

T0. SUMMARY

The National Anti-Drug Strategy, which entered into force in 2013, sets out priorities in the field of prevention and tasks in 10 settings. Drug prevention activities – beside several drug-related tasks – have been coordinated by the State Secretariat for Health, Unit for the Operation of Focal Points under the Department of Public Health of the Ministry of Human Capacities from 2019 onwards (see section T1.3.1 of the Drug Policy workbook).
National study data show that the majority of organizations running prevention interventions perform universal prevention in the school setting. 70% of those organizations are NGOs with their funding coming mostly from the state in the form of grants. Among the organizations typically carrying out selective prevention activities outside of school, there are many state or local authority bodies (social care and child protection institutions) that come into contact with the target groups regularly for various purposes. Workplace prevention programmes only occur occasionally. Prevention activities are chiefly funded by the state and European Union sources (TÁMOP (Social Renewal Operational Programme), EFOP (Human Resources Development Operational Programme)).
In recent years, policy efforts have focused on quality assurance. The regulatory materials compiled for the field and the quality assurance process for school prevention programmes are designed with that aim in mind, given the key role of school health development for the health of the growing generations and the staff of education and training institutions, in the field of public education, training programmes and methodological support have been used to develop mechanisms based on scientifically sound methods to help strengthen the health-promoting attitudes and knowledge of pupils, thus making a major contribution to improving the health of the population in the longer term.

T1. NATIONAL PROFILE

T1.1 POLICY AND ORGANIZATION

T1.1.1 Prevention objectives in the National Strategy

The fundamental approach framework of the National Anti-Drug Strategy that entered into force in 2013 expired in 2020. No new drug strategy or drug action plan (policy programme) has been adopted until September 2021. Until the next document setting out the objectives of the next drug strategy - or a more comprehensive one (e.g. public health, mental health) - is adopted, experts consider the objectives and framework of the expired drug strategy to be the guiding framework.

The fundamental approach framework of the National Anti-Drug Strategy that entered into force in 2013 (see also section T1.1 of the Drug Policy workbook) is “the strengthening of health and health support processes, as well as the personal, community and environmental conditions that lead to those”. The Strategy states that “health and a healthy lifestyle, as a value and a resource, should be available to everyone and an example to be followed”. As a result “a community environment will take shape in which the likelihood of development of wide-ranging dependency or psychological health problems having a negative effect on life management and conduct is significantly lower”.

[86] Authors of the workbook: Gergely Horváth, Lilla Szabics and Ágnes Port

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

The Strategy also defines priorities in the field of prevention. According to section V.2. of the Strategy addressing drug prevention: “prevention activities in connection with the drug problem must be conceived in all settings and target groups with respect to health development in the wider sense” and it is important that “instead of a narrower interpretation of drug prevention, the focus of the programmes should be on health development and comprehensive physical, psychological, intellectual and social wellbeing”.
In relation to prevention, the Strategy sets out tasks in 10 settings: local communities, the family, public education and the child protection institution system, higher education, peer groups, the media, the workplace, penal institutions, as well as the institution of “treatment as an alternative to criminal procedure”, or quasi-compulsory treatment (QCT).
The priorities defined in the Strategy in relation to drug prevention are as follows:

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

The Government adopted a policy programme for 2017-2018 in connection with the National Anti-Drug Strategy (2013-2020 – Clear Consciousness, Sobriety and the Fight against Drug Crime) (Government Decree 1669/2017 (XI. 15.). In the field of demand reduction, the policy programme seeks to foster the development of health promotion and drug prevention with priority given to the implementation of universal, selective and indicated programmes in the widest possible target groups and settings. It focuses on involving families and communities, reaching vulnerable target groups (e.g. in the field of child protection), and taking special considerations into account (e.g. in relation to disadvantaged people).

The preparation and implementation of the current 2019-2020 policy programme have been carried out under the auspices of the State Secretariat for Health of the Ministry of Human Capacities.

T1.1.2 Institutional background

The main body for drug coordination in Hungary is the Inter-Ministerial Coordination Committee on Drug Affairs (KKB), and drug coordination activities are carried out by the Department of Public Health of the Ministry of Human Resources responsible for the operation of Focal Points (for more information see chapter on drug policy, sub-chapter T1.3.1). The Ministry of Human Capacities (EMMI) in its organizational and Operational Regulations specifies the tasks of the

National Drug Prevention Coordination Unit in connection with drug prevention[87] (among other tasks):

The Department of Public Health, in the scope of its tasks related to drug prevention:

- participates in the development of strategies, programmes and action plans in the field of health promotion and public health;
- participates in defining strategic approaches to health promotion, health education and health protection;
- proposes health-sector tasks related to the prevention of addictions and participates in HIV/AIDS prevention tasks;
- coordinates mental health tasks;
- participates in the full range of public health tasks related to health development, youth, family and elderly affairs in nurseries/kindergartens and schools.

As a background institution of the Ministry of Human Capacities, tasks related to drug policy are carried out by the Directorate-General for Social Affairs and Child Protection (SZGYF) as well.

Under Government Decree 180/2019 (VII. 26.), the duties of the Unit for Drug Prevention Programmes of SZGYF were merged and transferred to the National Centre for Public Health (hereinafter: NNK) with effect from 1 August 2019. The Unit for Drug Prevention Programmes of NNK took part in the implementation of the National Anti-Drug Strategy, in setting up drug policy programmes or proposals, coordinated the operation of the system of preventive-consulting services (available as an alternative to criminal procedure for drug law offenders), as well as assisting in cooperation between prevention professionals and prevention institutions, and ensure the functioning of drug coordination mechanisms at local level.[88] The professional accreditation system for school health development programmes is also operated by the National Centre for Public Health, involving several relevant departments.

Coordination Forums on Drug Affairs

Drug Policy is implemented through the Coordination Forums on Drug Affairs (hereinafter: KEFs), which are local-level professional consultation working groups set up by the commitment of local authorities, local professional cooperation to tackle the drug problem and supported by a Ministry grant (NNK 2021).

In 2020, there were around 113 KEFs operating in Hungary, with capital, city, district, micro-regional, county and regional competencies. The role of the KEF is to coordinate the work of the institutions involved in the implementation of the four pillars involved in reducing the drug problem: community and cooperation, prevention, treatment and rehabilitation, and supply reduction of the national strategy. The members of the Coordination Forums on Drug Affairs are representatives of state, the local municipality, NGOs and church organizations that play an important role in the management of the drug problem (NNK 2021).

In 2017, the National Centre for Public Health compiled the current KEF database by mapping databases, which included 65 KEFs in that year (NNK 2021). 85 KEFs were registered in 2018, 99 in 2019 and 113 in 2020. The financial background of the KEFs was partly provided by the KAB-KEF grant. In 2017, a "C" category was added to the grant application, which also provided an opportunity for innovation, but this was not successful. In 2017 the annual budget

[87] Instruction 16/2018. (VII. 26.) of the Ministry of Human Capacities on the organizational and Operational Regulations of the Ministry of Human Capacities incorporating the amendments set out in Instruction 4/2019 (III. 1.) of the Ministry of Human Capacities.

[88] 13/2017. (III. 31.) EMMI utasítás a Szociális és Gyermekvédelmi Főigazgatóság Szervezeti és Működési Szabályzatáról, https://www.szgyf.gov.hu/hu/foigazgatosag/szmsz

was 171 thousand EUR[89], in 2018 103 thousand EUR, in 2019 no dedicated funding was available, and in 2020 the area again received 142 thousand EUR in tender funding by strengthening county coordination. A KEF funding concept has been prepared and a survey has been launched in this period to basically map the systemic added value of the network during the 7 years of the Strategy. In 2020, at the request of the EMMI, ELTE launched a training course on the following topics: basics of KEF, local needs assessment, strategy development, local drug communication, as well as on the basics of addiction treatment and drug prevention.

Health promotion offices

With the support of the European Union to strengthen the preventive capacity of the healthcare system, health promotion offices have been established integrated into the healthcare system. The health promotion office (so-called EFI) has a preventive function in healthcare with the aim and task of developing individual behavioural patterns that serve health in general, and among specific, high-risk target groups. Their health promotion tasks include preventing smoking, drugs and excessive alcohol use.
A total of 61 EFIs were set up under the TÁ

MOP grants launched in 2014 and closed in 2015. Expanding the network of EFIs and extending it to all districts was also a sectoral objective in the 2014-2020 planning cycle, therefore, in the 2014-2020 planning cycle, from 2018, thanks to the new EFOP-1.8.19-17 and EFOP-1.8.20-17 and the VEKOP-7.2.2-17 grants, 15.4 million EUR were allocated for the establishment of EFIs in new districts. In this round, in addition to the convergence region (10.5 million EUR), the CHR region (4.8 million EUR) could also submit applications, thus 12 of the 53 newly created EFIs are now in the CHR region.

A novelty was that the functions of the new EFIs were expanded with the Mental Health Centre (so-called LEK) function. A total of 93 health promotion offices (EFIs) have a 'mental health promotion function'. That includes opportunities for individual and community mental health prevention, as well as group programmes (e.g. groups for relatives of addicts and self-help groups). Previously established EFIs could also submit applications to implement the LEK function, so 35 out of the 61 EFIs applied successfully. EFI-LEKs occasionally cooperate with the Coordination Forums on Drug Affairs, e.g. drug prevention lectures given by experts delegated to the KEFs, and some EFIs participate in the work of the KEFs as external experts.

The functioning of the grant-funded EFIs is characterised by the fact that they operate in different forms (organizational and maintenance) and with different funding backgrounds (different maximum grant resources available), maintenance requirements and standards.

Three EFI offices established with TÁMOP funding closed after the end of the maintenance period, so that by 31 December 2020, 111 EFIs were operational.

Their types:

- Hospital EFIs: 42
- Municipal EFIs (maintained by a municipality or a specialised clinic owned by a municipality): 68
- Maintained by Ministry of Innovation and Technology because it belongs to the University of Debrecen: 1

[89] Values in the workbook were calculated using the EUR intermediate exchange rate valid for 2020 (EUR 1=HUF 351.17)

The comprehensive school health development programmes

The EMMI Decree No. 20/2012 (VIII. 31.) on the operation of educational institutions and the use of the name of public educational institutions (hereinafter: the Decree) requires educational institutions (hereinafter: institutions) to define their tasks related to comprehensive health development as part of their local pedagogical programme and to integrate them into the operation of the institution.
Comprehensive health promotion is defined in Article 128 of the Decree. According to Article 128(1), the aim of comprehensive health promotion is that all children in the time spent in the educational institution benefit from activities that effectively improve their overall physical, mental and spiritual well-being, health and health status.

T1.1.3 Funding system

One of the key factors in prevention activities is the method and amount of funding. According to the results of an earlier study, on average four-fifths of the budgets of the prevention programmes came from grants, which creates a great deal of uncertainty concerning continuity of the operation of the programmes. The funding body is mostly the state. Funding from the business sector, foundations and local authorities is significantly less than this. Donations accounted for 2.9% of funding. A stable, permanent budget to improve the reliability and sustainability of operations was typically lacking. (Paksi and Arnold 2010)

Table 13. *Budget expenditure labelled for health development and drugs*

Health promotion and drug prevention				
2016	**2017**	**2018**	**2019**	**2020**
EUR 361,000	EUR 340,000	EUR 315,000	EUR 571,430	EUR 433,745

Source: EMMI 2021

For more information on applications and their funding, see T1.4.2 budget expenditure data in the Drug Policy workbook.

The following EU funds were available:

EFOP-1.8.0 - VEKOP-17 - 2017 - 00001 Professional and methodological development of the health care system: within this, the programme A/III. 'Health Awareness Development Program for 7-18 year-olds'. In the course of the programme, prevention material drafts have been developed for teachers and/or nurses working in school setting with primary and secondary school children. Within the theme of 'Harmful addictions', drug prevention was given special attention. From the 5th grade of primary school to the end of high school, educational materials were produced. At the same time, special intervention plans were developed for early school leavers aged 16-18.

97 settlements applied within the framework of EFOP 1.6.2 Elimination of Segregated Life Situations with Complex Programmes. One of the mandatory elements of the call for proposals is the inclusion of health development programmes in the complex application. All the programmes of the health development block included the provision of various screenings on the spot and passing on information on health-conscious behaviour. In several municipalities, targeted programmes for the prevention and/or treatment of addiction were implemented. These were mainly information transfer, skills development, programmes promoting a sober culture and recreational programmes as an alternative to substance use. In some of them, prevention and/or treatment programmes were provided in group sessions about different substance use problems targeting young people and adults at elevated risk of addiction. This was mostly the case in those settlements where it proved to be a relevant programme element due to the size and the visibility of the problem. The above programmes were supported by

the staff of the EFOP 1.6.1 programme, some of which were followed by training of social workers, field visits and methodological support for the implementation of the programmes. Good practices from the above programmes have been prepared and submitted by local professionals and will be collected, evaluated and made public by the EFOP 1.6.1 programme. These local programmes can thus serve as a model for other municipalities and applicants and can be adapted. A total of 15 good practices aimed at health development and 2 specifically aimed at helping addicts were included.

At the request and under the guidance of the EFOP 1.6.1 programme, the Hungarian Addiction Society conducted a research on a representative sample of the municipalities included in the tender in 2018 entitled 'Research among psychoactive substance users living in rural segregated areas - Drug use and treatment options in municipalities, with special regard to the segregated areas of the municipalities participating in the tender "Elimination of segregated living situations through complex programmes" (EFOP 1.6.2 - 16)'. The main objective of the study was to describe the characteristics of active psychoactive substance use, subjective perception of the problem and their relations with the care system in marginalized rural segregated areas, aged 18 and over, by interviewing people involved in substance use. In addition to the traditional psychoactive substances (alcohol, smoking, misuse of medicines), the study also examined individuals' use of NPS and poly-drug use. The survey was conducted in 30 municipalities of 401 people over 18 years of age using some form of psychoactive substance. Based on the results of the study and the field experience of the methodological working group, the chapter 'Addiction identification and treatment, prevention and health development' of the 'Support for inclusion cooperation - Methodological manual' (2020) provides practical assistance to professionals working in the prevention and treatment of addiction problems in the municipalities. In order to disseminate the results of the study, in 2019, 15 +2 professional consultation forums were organized, during which the researchers reported on the results of the study and then held a professional consultation with representatives of the municipality and/or districts on the usefulness of the study and the options for intervention. This provided actual, practical help to municipalities in organizing and implementing targeted addiction prevention work.

Applications under the Children and Youth Fund Programme 2013-2020

The Fund Programme provided financial support for, among other things, the following eligible objectives, playing a role in drug prevention but also in recovery:

- programmes to support the physical and mental development of children, in particular:
    - healthy leisure activities for children,
    - activities related to children's education outside school,
    - initiatives to combat physical and mental health risks for children,
- youth community initiatives, initiatives and activities of their own organizations and groups,
- programmes to strengthen young people's own problem-solving skills,
- prevention and awareness-raising programmes on the risks of drug, alcohol, tobacco and other harmful substances,
- programmes to the integration of children and young people from disadvantaged backgrounds.

Table 14. *Total annual grant under the Children and Youth Fund Programme 2013-2020*

IFJ-GY-13	IFJ-GY-14	IFJ-GY-15	IFJ-GY-16	IFJ-GY-17	IFJ-GY-18	IFJ-GY-19	IFJ-GY-20
EUR 370 000	EUR 370 000	EUR 370 000	EUR 185 000	EUR 185 000	EUR 230 000	EUR 230 000	EUR 230 000

Forrás: EMMI 2021

EFOP-1.8.7-16 “Selective Prevention Programmes to Prevent Addictions" aimed at development of the health culture of the population, increasing health awareness through effective health communication tailored to the target groups, and implementation of awareness-raising and prevention programmes, with special emphasis on the involvement of communities and families. The available funding was EUR 9.7 million and a total of 43 applications were received. The grant agreements were concluded and implemented in 2019 as part of the tender.

In the scope of EFOP-1.8.9-17 "Have Other Passions! 2." a total of EUR 8.2 million was available for the support of specialised child protection institutions to support the prevention and reduction of drug use. In 2018, there were 17 institutions with valid funding contracts. (EMMI 2018)

Addiction Consultants in Segregates - Pilot Program

On the basis of Annex 1 of Act LXXI of 2019 on the Central Budget of Hungary for 2020, EUR 63,000 has been allocated from the headed appropriation of Chapter XX, Ministry of Human Resources, Chapter 20.14 "Tasks related to the prevention of drug abuse". In 2021, EMMI will spend EUR 200 000 million to continue the programme. In cooperation with the EMMI and the National Association of Addiction Consultants, the staff working in the Presence Programmes (run by the Hungarian Charity Service of the Order of Malta) of the involved municipalities took part in basic addiction training, and in the 4 municipalities with the most serious problems - Tiszabő, Tiszabura, Alsószentmárton and Nógrádszakál - intensive work has been started in close cooperation with the National Crime Prevention Council and the Police to prevent and reduce drug use. In 2020, 10-12 addiction counselors were trained as part of the programme. As part of this, addiction specialists received information about the special characteristics and problems of disadvantaged settlements and people living in deep poverty. After the preparation, a training programme was carried out for social workers (2-2 people) working in the so-called "Presence" programmes in 31 municipalities, with the aim of providing them with an interactive approach to the basic concepts of addiction. The training was provided by the National Association of Addiction Consultants and will be held in 3-4 locations for a total of 62-65 participants. In addition to the training programme, the addiction consultants provided practical tools and professional support to the two social workers participating in the Presence Programme in 27 municipalities (two additional sessions). In the four municipalities with significant addiction problems, 2-2 addiction counselors provided personal consultation opportunity every 2-3 weeks for people with addiction problems and their relatives, and ongoing consultations with the social workers participating in the programme. As an output of the pilot programme, a practical toolkit was produced, in which key lessons learned, practical solutions and intervention methods were formulated. The programme was implemented from spring 2020 until the end of 2020 and will continue in 2021 due to its success and effectiveness.

T1.2 PREVENTION INTERVENTIONS

T1.2.1 Environmental prevention

Policies/initiatives

In 2012, the extension of the legislation relating to new psychoactive substances represented a significant change at the national level. A government decision was made and legislation drawn up in order to set up and introduce generic control. Eliminating the legal distribution of the new psychoactive substances is an important element of the process.

Crime prevention strategies

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

T1.2.2 Universal prevention

National quantitative surveys were carried out up to 2009 on prevention programmes inside and outside school settings, providing information about what type of drug prevention interventions the students came into contact with (a detailed description of the surveys can be found in the previous National Reports). Between 2010 and 2015 only regional or qualitative studies were conducted. In 2015, national data collection was performed again, providing updated information about the features of prevention activities (see section T4). Comparing the results of the two latest national data collections, in both 2009 and 2015 NGOs ran the overwhelming majority of the prevention interventions; however the involvement of state institutions increased by 10%. Compared to the earlier data, in 2015 only half as many organizations ran prevention activities as their main activity. In terms of content, it can be stated that the majority of the programmes/services continued to operate directly among the final target population. In addition, interventions performed by school teachers and teacher training drug use prevention programmes also featured. The objectives of the programmes became more up to date and the service providers met the students for more hours/more times than earlier. While in 2009 a similar proportion of interventions targeted the 10-14 age group as targeted the 15-18 age group, in 2015 most of the interventions targeted those aged over 14 years.

The Act on Public Education requires schools to perform youth protection tasks, and the head of the education institution is responsible for the organization and performance of those tasks.[90] The institution may employ an external expert as an officer for youth protection duties, but this is not mandatory.
Ministry of Human Capacities Decree 2/2018 (I. 18.) on the *Modification of Ministry of Welfare Decree 15/1998 (IV. 30.) on the professional duties and operating conditions of the child welfare, child protection institutions and persons providing personal care* introduces the concept of the nursery and school social assistance service (replacing the former school social work). Under the Decree, from 1 September 2018, the nursery and school social assistance service provides support to the given child attending the public education institution, the child's family and the teachers at the public education institution, in order to prevent the child's vulnerability by means of social assistance work. In the scope of that, it aims to assist:
- detection and exploration of obstacles to the fulfilment of the child's educational obligations;
- identification of the child's vulnerability using preventive tools;
- the operation of a warning system.

Drug prevention activities of the police

Drug prevention is part of the complex crime prevention programmes run by the police. National Police Headquarters (ORFK) Instruction 16/2016 (VII. 21.) on the “Implementation of protection programmes for children and young people” forms the basis of the drug prevention activities of the police and regulates thoroughly police tasks and responsibilities in connection with school and nursery/kindergarten programmes.

[90] Act CXC of 2011. on National Public Education, Art. 69 (2)(f)

Through the OVI-ZSARU, DADA, ELLEN-SZER and School Crime Prevention Counselling Programmes, the police accompany and advise children and adolescents from the age of 5 to the age of 18.
In the 2018/2019 school year, 1015 classes and 21,222 children in 303 schools in 197 municipalities participated in the DADA programme and were instructed by 145 police officers. The ELLEN-SZER programme involved 2683 students in 108 classes in 48 schools in 30 municipalities nationwide; they were instructed by 33 police officers.
In the 2018/2019 school year, 252 secondary education institutions in 105 municipalities participated in the School Crime Prevention Advisory Network programme. The 103 counsellors involved a total of 114,895 students from 4738 classes in prevention activities. Schools are satisfied with the work of the counsellors; the students involved in the programme have requested the daily presence of the counsellors, and based on the feedback, more and more secondary schools want to join the programme.
The aims of the “Police Officers in the School” programme, to promote the road safety of young schoolchildren, increase their road safety awareness and promote the detection and elimination of other factors endangering the safety of children.

Under National Police Headquarters (ORFK) Instruction 20/2010 (OT 10.) on the Crime Prevention Activities of the Police, it is the task of the regional crime prevention units and the police headquarters to co-operate with the regional actors tackling the drug problem, primarily with the Coordination Forums on Drug Affairs (hereinafter: KEFs). Crime prevention specialists play an active role in the operation of all KEFs, which are run on an invitation basis by all county (or Budapest) and city municipalities. This forum allows for constructive cooperation between actors from the health, education, social and youth professions. The cooperation between the KEF and the police involves the organization of joint programmes and events, getting to know the work of the member organizations, exchanging experiences and providing mutual assistance. KEFs meet at varying frequencies (annual, semi-annually, quarterly, monthly). Their establishment is constantly being urged by the police in municipalities where there is no such body, but where there is a manifest need for that kind of cooperation.

The topics of ELBIR (Electronic Population Crime Prevention Information System) include drug prevention content at least once a year, and the contact details of the drug prevention liaison officer active in the area of competence of the regional bodies are always included in the electronic newsletters that are sent out.

In the field of crime prevention, the National Crime Prevention Council (hereinafter: NBT) plays a key role. Crime prevention activities are costly, and it is typical across the country for the relevant police departments to look for opportunities to bring in additional resources in order to carry out their task effectively. The NBT's applications provide an opportunity for that, or the NBT provides direct, targeted support for outstanding, innovative programmes. In addition, with support of the NBT, training sessions for educators and property protection lecturers participating in school-based prevention programmes were implemented.In 2019, the NBT indirectly provided resources for the prevention and treatment of the drug problem; drug prevention, which falls within the remit of the Ministry of Human Capacities (EMMI), has a separate strategy and is therefore not part of the National Crime Prevention Strategy.

The Police Crime Prevention Field also seeks cooperation with churches, NGOs and state actors that play an important role in this area (drugs, victim support). The relationship with the staff of the Hungarian Maltese Charity Service is particularly outstanding, and preparation of a cooperation agreement between the National Police Headquarters (ORFK) and Hungarian Interchurch Aid is underway.

T1.2.3 Selective prevention

Some of the winning programmes mentioned in section T1.2.2 – in accordance with the stipulations of the grants – may be considered selective prevention, since they have designated target groups, such as those living in state care, in penal institutions, those living in socially disadvantaged neighbourhoods, as well as homeless young people and pregnant women. Almost all of the programmes implemented in family settings addressed the relatives of substance users.
As their funding is provided for 1 year in the framework of the grants, the long-term operation of the programmes is doubtful.

Some of the programmes in the nightlife setting may be classed as selective prevention; the majority of them, however, deal with harm reduction, so a detailed description of them can be found in section T1.5.3 of the Harms and Harm Reduction workbook.

In 2019, 4769 inspections were carried out to increase monitoring of nightclubs, music and dance events and the hotel, restaurant and catering industry, involving 11,736 police officers, 313 law enforcement officers, 1171 civilian guards and 1129 persons from the co-authorities. Measures were taken against 41,500 people. 78 security measures, 178 apprehensions and 259 arrests were carried out and 468 violations and 191 offences were reported. Due to the endangerment of a minor, an alert was issued in 44 cases, and in 1 case the minor was removed from the family on a temporary basis. During the inspections, on-the-spot fines totalling HUF 9,263,015 were imposed.

Drug prevention in the Hungarian Army

The main approaches to drug prevention activities within the organizational framework of the Hungarian Army are determined by the National Anti-Drug Strategy 2013-2020 approved by the currently valid National Assembly Decision 80/2013 (X. 16.) and by the Hungarian Army's Drug Prevention Strategy.
On that basis, the Hungarian Army operates a testing system, in the scope of which three types of testing may be carried out to detect drug use: testing as part of suitability assessment (related to an occupational health examination); verification of the ability to perform duty (spot checks for preventive purposes); (official) examination of the influence of drugs if drug use is suspected.

T1.2.4 Indicated prevention

Some of the state-financed programmes (section T1.2.2) are indicated prevention programmes aimed at strengthening the family system and development of parental skills, especially among vulnerable young people, students attending schools for special needs and those living in families where drug use is a problem.

One type of quasi-compulsory treatment available as an alternative to punishment for drug law offenders is the preventive-consulting service, which may be considered analogous to an indicated prevention intervention. Information and data on QCT are presented in section T1.1.1 of the Legal Framework workbook, sections T1.2.2 and T1.3.1 of the Treatment workbook and section T1.2.1 of the Drug Market and Crime workbook.

System of preventive information services

In Hungary, the joint decree 42/2008 (XI. 14.) EüM-SZMM (hereinafter: Decree) provides the legal basis for *preventive information services*, the *treatment for drug addiction*, *other treatment for drug use*, the three types of treatment as an alternative to criminal procedure (NNK 2021). The *prevention and information service* coordinated by the NNK operates under this regulation. Since 2017, an annual professional report has been prepared for the EMMI, which included

detailed statistics and professional reports processed and evaluated. One national conference was held, several professional workshops and a protocol for the methodological letter and professional control was developed with the participation of Eötvös Loránd University (ELTE). NNK developed a procedure for the COVID-19 pandemic situation, with the Attorney General's position statements, and have helped interpret the measures related to the pandemic. According to the database published on kef.hu, in 2017, 52, currently 49 active organizations, provide nationwide coverage, and nearly 3,000 new clients start their *preventive information services* annually (NNK 2021).
The amount paid for the services in a calendar year ranged from EUR 280 000 and EUR 423 000 between 2017 and 2020. With the entry into force of Act XC of 2017 on Criminal Procedure, the external legislative environment of the Decree has changed, which justified a review of the legislation in 2020, including a number of technical and procedural issues. On this basis, a technical concept for the renewal of the *treatment as an alternative to criminal procedure* was developed, the preparation and scheduled implementation of which started in 2021 (NNK 2021).

T1.3 QUALITY ASSURANCE FOR PREVENTION INTERVENTIONS

T1.3.1 Quality assurance standards, guidelines and objectives

Within the scope of the drug-related pillar of the project addressing modernisation of social services (TÁMOP5.4.1) completed in 2011, international and Hungarian research experiences, best practices and regulatory practices with respect to several areas dealing with prevention (selective prevention programmes run in shopping centres/malls, selective prevention programmes established for young people living and hanging out in housing estates and other run-down residential environments, selective prevention and harm reduction programmes established/run in clubs, preventive-consulting services) were reviewed. On the basis of those, methodological letters (specialist regulatory documents) were drawn up for every individual area. (For more information, see chapter 3.2 of the 2011 National Report.)

In the interest of the quality assurance of health development programmes implemented in school settings, from 1 February 2013 a specialist monitoring procedure was introduced to regulate those programmes within the comprehensive school health development system, which was coordinated by the National Institute for Health Development (NEFI) until operation of the institution was terminated in March 2017. From April 2017 coordination tasks came under the remit of the Ministry of Human Capacities (EMMI), the legal successor of the institute. The essence of the introduced system is that only those prevention programmes may operate in schools that have received professional accreditation in the scope of this procedure. The professional accreditation system is a prior assessment system with respect to quality assurance. (For details, see chapter 3.4 of the 2014 National Report.)

According to information provided by the National Centre for Public Health (NNK 2020), the number of applications received in 2019 in relation to the professional accreditation system for drug prevention programmes was 22, while the number of issued certificates in 2019 was 19; a further 2 certificates were issued in 2020. The number of school health promotion programmes with accreditation for drug prevention (valid on 5 August 2020) was 25.

Characteristics of drug prevention programme applications received in 2019

In 2019, a total of 27 professional referral applications were received by the National Centre for Public Health (2020), of which 81.4% (22) requested accreditation of a school health development programme on drug prevention. None of the applications received in 2019 were

rejected; in three cases – following the professional evaluations – the organizations submitting the application were asked to fill in some gaps.
In the field of drug prevention, the health promotion programmes submitted and accredited in 2019 came from 8 counties and Budapest, based on the seat of the submitting organization (21). Budapest is over-represented among applicants for school health promotion programmes on drug prevention. Of the organizations submitting applications and granted accreditation in 2019 (21), 9 were from Budapest (42.8%), 3 from Szabolcs-Szatmár-Bereg county (14.2%), 2 from each of Fejér and Baranya counties (9.5%), and 1 from each of Békés, Hajdú, Jász-Nagykun-Szolnok, Győr-Moson-Sopron and Veszprém counties (4.7%).
47.6% (10) of the programme applications received in 2019 on the topic of drug prevention and later granted accreditation were received by the National Centre for Public Health in January-February 2019.

At the end of 2019 and the beginning of 2020, viewing and discussion of sessions of currently accredited programmes with the organizations concerned was launched on a pilot basis. The purpose of the face-to-face meeting and the session was partly to expand knowledge related to the programme and its application, to get to know the accredited programme in practice and to establish a direct professional relationship. Due to the pandemic, the personal meeting and discussion with four accredited organizations took place in early 2020.

T2. TRENDS

School-based prevention/health development picked up pace in the 2001/2002 school year with the establishment of system-level grant financing. The content, methods, target groups and even duration of the prevention programmes were determined more by the funding entity's expectations (the state in most cases – see section T1.1.3), and less by changes in patterns of drug use and the emergence of new phenomena. That is supported, for example, by the fact that in 2006 a database was set up including over 400 prevention programmes, because registration was a condition of application for funding. A shift from frontal teaching towards interactive personality development and attitude shaping was also included in the grant application specifications. However, there were no significant responses to the noticeable spread of new psychoactive substances in Hungary by the prevention service providers.
The other factor determining the content of the programmes was the legislative environment and the prevailing drug strategy. In 2011, the National Curriculum made it obligatory for schools to perform prevention activities. As of 2012, a ministerial decree prescribes the introduction of comprehensive health development in schools, which includes prevention of drug use. In 2013, the professional approval system was introduced, which, apart from placing considerable emphasis on professional programme structuring, international recommendations and knowledge of good practices, also acts as a strong filter. (See section T1.3.1.)
A number of school-based prevention programmes were externally evaluated in 2003-2005; however, internal evaluation is more common and is mainly limited to measurement of the popularity index and knowledge acquired.

T3. NEW DEVELOPMENTS

The Hungarian National Focal Point adapted the EMCDDA Best Practice Portal for Hungarian speakers in order to disseminate best practices and policy recommendations. The portal is available at bevaltgyakorlat.hu.

T4. ADDITIONAL INFORMATION

In spring 2018, an online survey was conducted (Sárosi, Magi 2018) among young Hungarians participating in drug prevention programmes in secondary schools in the last 5 years. The aim

of the research was to learn more about the types and content of the secondary school drug prevention programmes that young people participated in and how they rate the effectiveness of such programmes. (For methodological data, see section T5.2).

Respondents[91] were asked about the types of drug prevention activities they had participated in (more than one answer could be selected). Most of them had participated in drug prevention lectures (85%); the second most common form – film screening – was far behind (32%). A total of 10% of the students had participated in activities involving games and drama, while 8% had attended exhibitions and 8% had taken part in activities connected with sport. The proportion of participants that had taken part in individual consultations was 4%, and the proportion of those that had attended family sessions was just over 3%. Most students had attended school drug prevention activities organised within the school, and only 15% reported out-of-school attendance.

Regarding the person/organization delivering the drug prevention programme, 54% of respondents had taken part in a programme held by a police officer, 42% in a programme held by an external drug prevention expert, and 37% in a programme held by a teacher.[92] 20% of the respondents had also participated in drug prevention programmes held by former drug addicts, 18% in a programme held by a physician, and 4% in a programme held by a priest. 89 respondents (8%) marked other types of professionals as lecturers (nurse, psychologist, medical student, actor, in the order of frequency of mentions).

According to the respondents, most drug prevention programmes (82%) focused on raising awareness of the dangers of drugs; 68% provided information about the types and effects of drugs, 44% emphasised that drug use was prohibited and 40% educated young people about how to say no to drug use. 30% of students were taught about safer nightlife and how to have fun at lower risk. 27% of students took part in a session including the forms of help they could give to their drug-using peers; 23% learnt about being aware of the choices they have and 15% about alternative ways to spend their free time. Only 12% of the programmes focused on harm reduction methods and 9% on the better understanding of social relationships.

The responses to the questions on the credibility of drug prevention programmes revealed that most of the students found the programmes to be credible. The majority of participants (53%) found the drug prevention programme to be believable and convincing; the minority (29%) did not. 44% of the participants agreed with the statement that the drug prevention programme exaggerated the harms associated with drugs, while 37% did not.

The questionnaire also asked to what extent the programme had changed the students' previous views about drugs. Only 9% agreed totally with the statement "I felt that my views changed a lot as a result of the programme", while 32% did not agree at all. 31% agreed with the statement "I got answers to a lot of questions I had been interested in for a long time", while 47% did not agree.

49% of the students disagreed with the statement "I could speak honestly about my own experiences", and only 10% felt that there was a completely confidential atmosphere during the programme. Among those who fully agreed with this statement, a significantly higher proportion had participated in a peer-led (former drug addict) programme (19% in the whole sample, 31% among those who fully agreed) or in a programme led by an external expert (42% versus 50%) than in the whole sample.

34% of students said they would have liked to participate in similar programmes in the future, but 43% said they would not have liked to.

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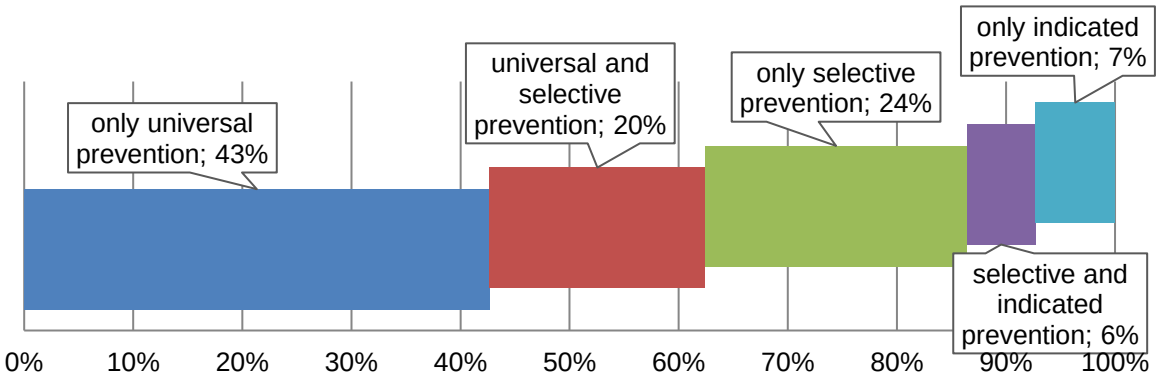
[91] Approximately 95% of the 1133 young people participating in the survey were 14-25 years old and 63% belonged to the 14-18 age group. The proportion of girls was 50%; that of boys was 48%, and 3 respondents described themselves as transgender. Approximately a quarter of the participants (26%) attended secondary school in Budapest, while 33% attended secondary school in a county seat and 36% in other cities. The lowest proportion (3%) attended secondary school in a village. According to school type, the largest group (36%) attended a vocational grammar school (formerly known as vocational secondary school), followed closely by the group of pupils attending a 4-year grammar school (35%), followed by vocational secondary school (formerly vocational school) (11%). 10% attended a 6-year grammar school and 8% an 8-year grammar school.

[92] Several answers could be selected.

The national data collection (Paksi et al 2016, for methodology, see section T5.2) aiming at mapping prevention programmes identified 253 organizations (also) dealing with addiction prevention, operating between 2013 and 2015. Of those, 194 organizations currently run their own prevention programmes (i.e. objectives and methods are homogeneous in each target group). One third of the service providers are located in Central Hungary (Budapest and Pest county). On average 7-8 service providers per county are present in the rest of the country.

Of the 194 organizations, 76 filled in the study questionnaire; we have detailed information about those organizations. According to the results, most of the service providers (85%) run prevention programmes not as their main activity, but as part of their activities, which mainly consist of treatment and care, or other supportive or training/educational activities. The vast majority of the organizations (70%) are NGOs. Local governments and budgetary institutions also account for a relatively high proportion (24%). For-profit organizations only account for 6%. The organizations most often run one prevention programme or intervention; on average they run 1.8 prevention programmes or interventions and the total number of interventions run by them is 139. The study describes 115 interventions in detail. The number of programmes aimed directly at the final target group is 96. Detailed information about those 96 programmes is presented below.
37 programmes are running in Budapest and an average of 24 programmes are running per county in Hungary at present. 21% of the known prevention interventions contact their target groups in the school setting only. Another 49% do so both in and outside the school setting. Almost half of the programmes are implemented in schools; a quarter of them (24%) are implemented in the target population's own setting (too). The interventions mainly target young people aged 14-18.

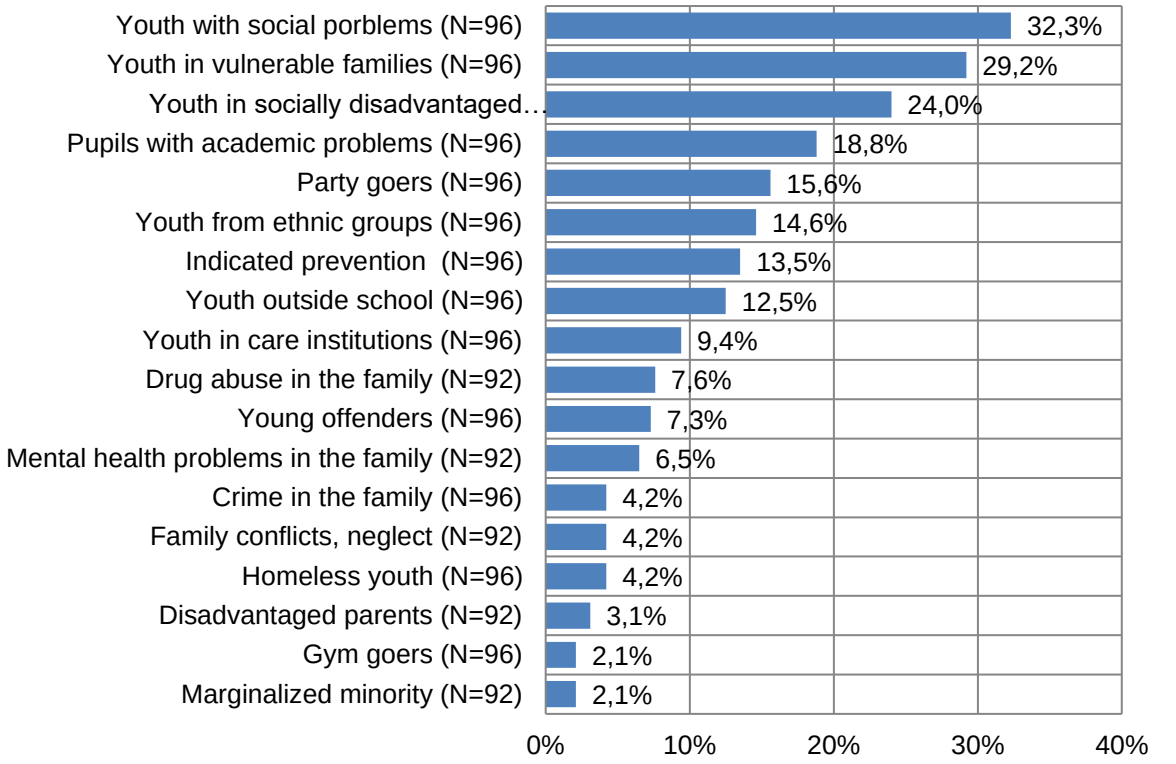
Chart 29. *Types of interventions aimed directly at the final target group (N=96)*



Source: Paksi et al. 2016

Nearly two-thirds of the prevention interventions (62.5%) are (also) targeted at the general population. However, no interventions are aimed at young refugees.

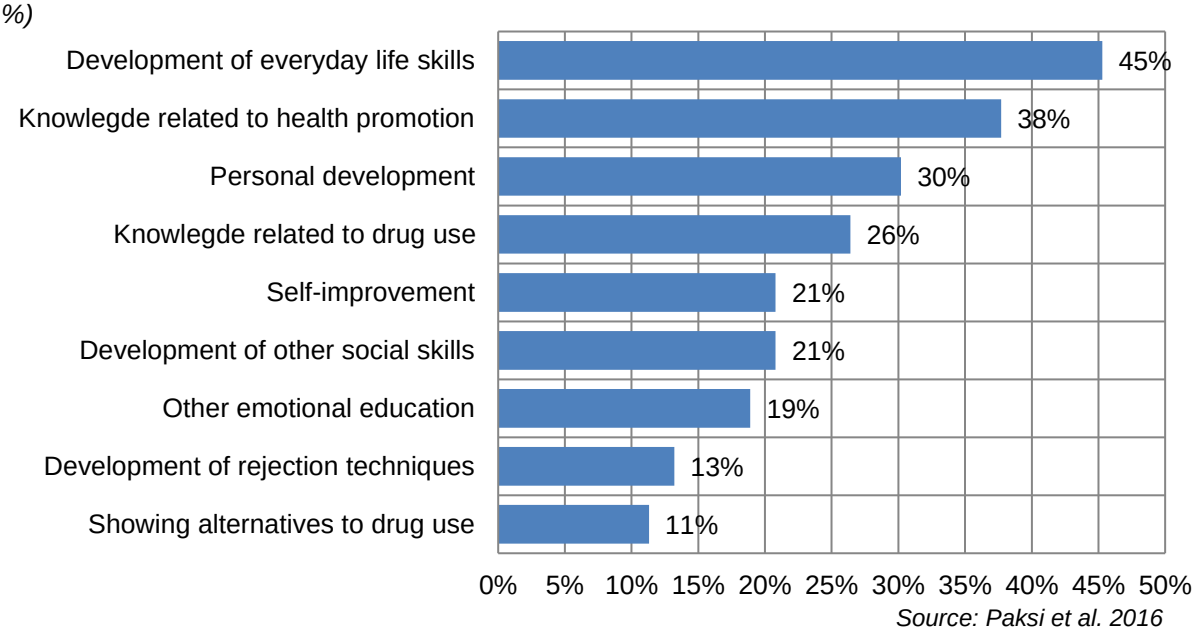
Chart 30. *Specific target groups of interventions aimed directly at the final target group (%)*



Source: Paksi et al. 2016

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

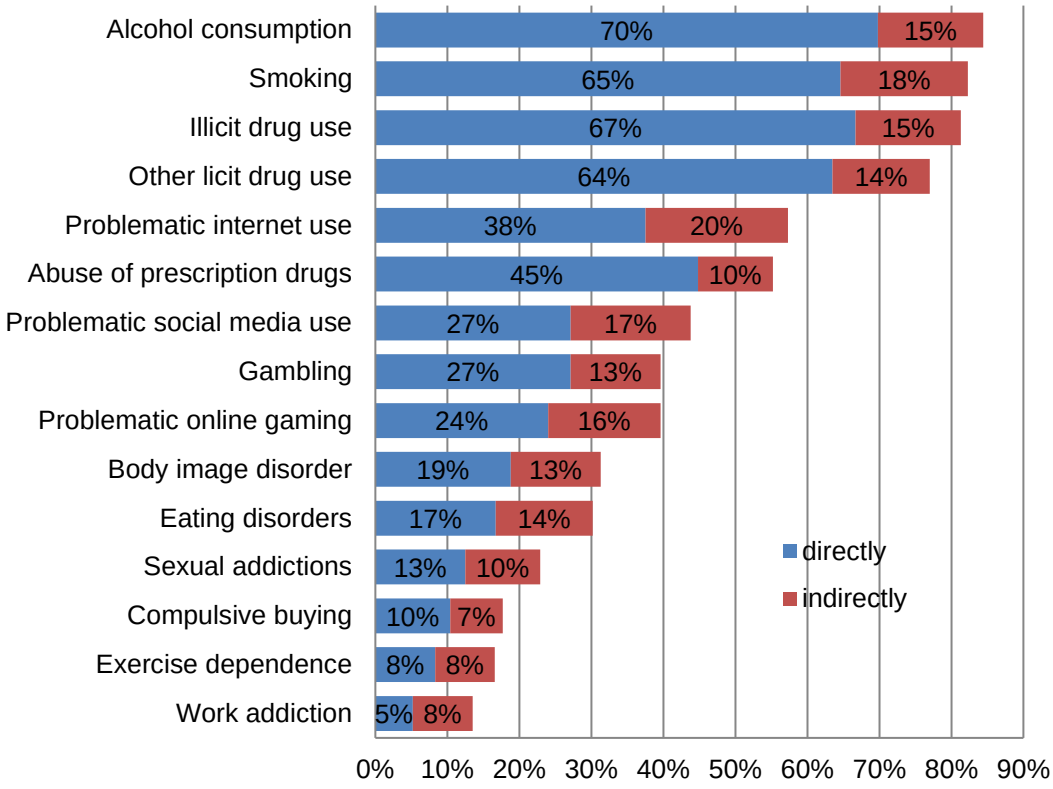
Chart 31. *The various objectives of interventions aimed directly at the final target group (N=53, %)*



Source: Paksi et al. 2016

In terms of the targeted addictive behaviour, the vast majority (82.3%) of the interventions are aimed directly at prevention of a defined form of addiction and two-thirds of them are aimed directly at illicit drug use.

Chart 32. *Addictive behaviours in prevention interventions aimed directly at the final target group (N=96)*



Source: Paksi et al. 2016

Prevention programmes longer than 10 hours are dominant nowadays (60%). Most of the programmes are implemented over a period of 1-4 months, but 40% of them have an even longer duration and 21% of them take a school year. The features of the method of implementation do not differ markedly depending on whether universal, selective or indicated interventions are performed.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

EMMI (2018): Az EMMI Nemzeti Drogmegelőzési Koordinációs Osztályának beszámolója a 2018-as EMCDDA Jelentéshez

EMMI (2021): Jelentés a Nemzeti Drogellenes Stratégia megvalósulásáról

Nemzeti Népegészségügyi Központ (NNK) (2021): A Drogmegelőzési Programok Osztályának beszámolója az EMCDDA 2021. évi Jelentéséhez. Beszámoló.

Nemzeti Népegészségügyi Központ (NNK) (2020): A Drogmegelőzési Programok Osztályának beszámolója az EMCDDA 2020. évi Jelentéséhez. Beszámoló.

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

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

Police (2018): A Rendőrség 2017. évi tevékenységéről szóló beszámolója

Sárosi, P., Magi, A. (2018): Online felmérés a középiskolai drogprevenciós programban részt vett fiatalok körében. Manuscript.

T6.2 METHODOLOGY

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

Paksi, B., Magi, A., Demetrovics, Zs. (2016): from autumn 2015 to spring 2016, national data collection was conducted with the aim of compiling the database of prevention programmes targeting the 9-24 age group. Comparative analysis of eight data sources identified 1766 organizations. During the time of data collection, 773 organizations could be contacted. Of those, 253 service providers ran prevention activities between 2013 and 2015. 194 organizations implemented prevention programmes (i.e. the same objectives and methods implemented each time). The study describes the features of the 115 programmes run by 76 service providers uploaded in the prevention database. Data collection was conducted by the Faculty of Education and Psychology of Eötvös Loránd University (ELTE) and financed by the corporate social responsibility programme of Szerencsejáték Zrt.

Sárosi, P., Magi, A. (2018): Online data collection took place between 23 April and 4 May 2018. The SurveyMonkey online questionnaire consisting of 8 questions was available on drogriporter.blog.hu and Drogriporter's Hungarian Facebook page with 30,000 fans and it was also shared on other thematically relevant sites (CannabisKultusz, Daath.hu). The questionnaire could be downloaded by young people who are currently attending or have attended secondary school in the last 5 years in Hungary and have participated in some form of school drug prevention programme. In order to extend the scope of the survey beyond young people with a special drug-related interest, researchers released post-boosted ads on Facebook for 18 and 24 year-old young people in Hungary for USD 15. The Drogriporter Facebook post reached a total of 46,102 people and generated 2942 clicks. The online questionnaire was filled in by 1144 people, with 1133 responses found to be valid.

TREATMENT[93]

T0. SUMMARY

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

Numerous forms of inpatient and outpatient treatment and treatment units for drug users are accessible all over the country. The need for specialised outpatient treatment of drug addicts was recognised in the 1980s and it was then that the first services were set up. The treatment is generally provided by public institutions operated by the state or local governments (hospitals, clinics) and by non-profit organisations run by churches and NGOs. With regard to the present treatment options, there are no specialised treatment programmes targeted at the users of individual substance types; instead programmes target the users of all substance types or addictions or psychiatric problems in general. An exception to that is opioid substitution treatment (hereinafter OST), which has been available in Hungary since 1994 for substance users struggling with an opioid addiction for an extended period.

A significant element of the treatment system in Hungary is the legal option for treatment/preventive interventions as an alternative to criminal procedure (quasi-compulsory treatment or QCT). The majority of treatment demand is related to that (79.2%% in 2020).

Drug treatment is not a separate category within either the social system or healthcare system; in general, it comes under the group of treatment modalities related to addiction and psychiatric problems. That makes it difficult to monitor the treatment options, capacity and utilisation. Reliable data about the field are available from the drug treatment (TDI) and OST data collections, which are suitable primarily for describing the characteristics of the clients. It is important to note that problem drug use and consequences of drug use (e.g. dependence, injecting drug use, problematic use, coming into view of the criminal justice system) make the users visible in data collections at various points in their “drug careers”. Our treatment (TDI) data can primarily provide a reliable picture on clients starting outpatient treatment; their ability to describe inpatient treatment is limited. Our information on inpatient treatment is complemented by ad-hoc studies conducted in the field.

The majority of clients enter treatment due to problems related to cannabis use. The dominance of that substance is especially marked in the case of clients entering preventive-consulting services as an alternative to criminal procedure. Opioid use played a more significant role among the treatment-seeking population before 2010; since then, due to the restructuring of the drug market (declining heroin availability, emergence of new psychoactive substances), its importance in terms of treatment demand has declined significantly. Demand for treatment related to the use of established stimulants has been increasing over the past 10 years.
The spread of new psychoactive substances (hereinafter: NPS) was first detectable in the data on drug seizures and NSP (needle and syringe programmes), followed by a rise in the number of clients entering treatment due to NPS use. The increase of NPS users in treatment data could be observed between 2010 and 2015. Following that, new treatment episodes associated with primary NPS use started to decline in the outpatient treatment setting. Nevertheless, study results show that in certain groups (e.g. in PWID, homeless people, children in specialised childcare and in residents of socially segregated areas) the use of NPS is still prevalent. Targeted studies of inpatient service providers also indicate that NPS use is the most common reason for treatment among their clients.

[93] Authors of the workbook: Anna Péterfi, Lilla Szabics, Anna Horváth-Tarján. Proofreader: János Szemelyácz

T1. NATIONAL PROFILE

T1.1 POLICIES AND COORDINATION

T1.1.1 Main treatment priorities in the national drug strategy

The 2013-20 National Anti-Drug Strategy (hereinafter Strategy) lays down basic principles of treatment organisation, the elements of which include building the various treatment services provided in different fields onto one another, harmonisation of the professional content and regional coverage of the services, transparent patient pathways between the various treatment types and institutions, as well as preventing clients from getting onto the wrong path, keeping them in treatment and monitoring them.

The Strategy is based on a recovery-oriented approach, the objective of which is the improvement and restoration of clients' health – building also on clients' active personal participation, responsibility taking and mobilisation of personal resources – as well as promoting reintegration into society. The Strategy views low-threshold services as being the first link in the entire treatment chain, which, combined with outreach activities, may help with finding hidden substance users and bringing them into treatment, and in the prevention, screening and reduction of infectious diseases. On the input side, from the first moment of entering treatment, the approach and experiences of the 12-step recovery programmes (NA, AA) also play a role in the professional programmes of the service providers.

With respect to treatment provided for drug users, among its specific objectives, lists the establishment of an institution system that provides services for children and young people that meets their real needs, with national coverage and general access. The Strategy has set the objective of at least 20% of problem drug users and drug addicts being provided with treatment, as well as for the accessibility and national coverage of the institution system providing healthcare and social services to addicted patients to be improved in general; in addition, the objective is that by 2020 there should be a harmonised, comprehensive services system in every district that uses common operational indicators and that applies active outreach techniques to bring clients into treatment. A further priority in the field of treatment and care services is for at least 80% of healthcare and social service providers to perform their activities on the basis of the related professional guidelines and for all the service providers to undergo a clinical or social institution quality assurance audit.

After the expiration of the of the National Anti-Drug Strategy in 2020, no new strategic document with a drug or addiction focus has been produced.

T1.1.2 Governance and coordination of drug treatment implementation

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

The licensing of the accepted specialised (secondary and tertiary) medical addiction treatment services is the responsibility of the National Centre for Public Health. Those services are covered from the budget of the National Health Insurance Fund (NAEK). The primary and specialised social addiction services are granted an operating permit by the local government offices and financed via the Hungarian State Treasury (MÁK) (except for the low-threshold services that are financed by the Hungarian Directorate-General for Social Affairs and Child Protection (SZGYF)). In both sectors the treatment of drug users is not typically a separate category among the funded forms of treatment; instead they are handled as part of a wider patient group along with problem alcohol users, people living with addictions in general and

occasionally psychiatric patients. Nevertheless, there are some treatment centres that primarily target drug users in practice; however, that distinction is not apparent in terms of their funding. (For further information on low-threshold services, see section T1.2.2 of the Harms and Harm Reduction workbook.)

T1.2 ORGANISATION AND PROVISION OF DRUG TREATMENT

Treatment centres are maintained either by the state/local government and provide either healthcare treatment exclusively or both healthcare treatment and social services; alternatively they are maintained by NGOs (including church organisations) and provide both healthcare and social services or just the latter (Péterfi 2015). Preventive-consulting services available as an alternative to criminal procedure may be provided by either of the above service provider types, or by non-governmental, for-profit organisations (for further information on treatment as an alternative to criminal procedure, see section T1.2.2.).

For information in connection with the treatment of prisoners see section T1.3.2 of the Prison workbook.

Outpatient network

T1.2.1 Outpatient drug treatment system

The funding categories that are relevant to the outpatient treatment of drug users are as follows:

- outpatient healthcare treatment (on the basis of Decree 2/2004 (XI. 17.) of the Ministry of Health):
    - outpatient specialised treatment for addiction
    - outpatient specialised addiction treatment for children and young people
    - outpatient specialised psychiatric treatment
    - outpatient specialised psychiatric treatment for children and young people
- outpatient social services (primary care services) (on the basis of Act III of 1993 on Social Administration and Social Services):
    - low-threshold services for addicts
    - community care for addicts
    - day-care services for addicts

Aside from these, preventive-consulting services as an alternative to criminal procedure are funded separately but from the budgetary funds.

Treatment centres with a primarily **healthcare profile**, such as hospital addiction units and clinics, psychiatric units and clinics, as well as some of the specialised outpatient drug treatment centres (DTCs), typically operate as part of an institution with a state or local government background. **Treatment centres with a social profile** that only receive funding from the social budget are typically run by NGOs or church organisations. **Treatment centres with an integrated profile** receive funding from both budgets, such as the outpatient DTCs typically run by NGOs (Péterfi 2015).

Due to the categorisation of drug treatment as part of wider treatment categories, there are no precise numerical data available about the number of treatment centres actually treating drug users. Data on outpatient drug treatment centres are available from the TDI data collection, which, on the basis of expert estimates, has good coverage regarding the number of clients in drug treatment. These data are presented in the table below.

In 2020, a total of 64 treatment centres reported new clients starting outpatient drug treatment out of the 78 treatment centres reporting clients, excluding prison treatment units. Altogether

93.6% (4005 persons) of the reported clients (4277 persons) started drug treatment in specialised outpatient drug treatment centres, in low-threshold services or at general/mental healthcare units. Of those 4005 persons, 3289 (82.1%) entered treatment as an alternative to criminal procedure. A further 67 prisoners received drug treatment provided by an external service provider. All 67 clients entered the treatment as an alternative to criminal procedure.

Table 15. *Network of outpatient treatment facilities (total number of treatment units and clients in 2020)*

	Total number of treatment units	National definition (treatment unit types)	Total number of clients
Specialised drug treatment centres	45	Service providers identifying themselves in the TDI data collection as outpatient treatment units (typically specialised DTCs, outpatient addiction or psychiatric units and clinics, and other outpatient treatment units providing healthcare treatment or preventive-consulting services for drug users). Approximately 20% of those service providers provide OST.	3188 (of whom 2576 persons started treatment as an alternative to criminal procedure)
Low-threshold services[94]	19	Service providers identifying themselves in the TDI data collection as low-threshold/drop-in/outreach units) (typically social service providers providing psychosocial services).	817 (of whom 713 persons started treatment as an alternative to criminal procedure)
General mental healthcare	0	.	
Prisons (inreach and external service providers)	2 external units providing services inside prison	Community outpatient services also reporting on the treatment of prisoners in the TDI data collection.	67 (of whom 67 persons started treatment as an alternative to criminal procedure)

Source: TDI data collection 2021 – Standard table 24

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

In the case of certain drug-related offences, the offender may avoid criminal procedure by participating in treatment/preventive interventions (referred to as QCT **–** quasi-compulsory treatment), providing the offender meets the following conditions:

- he/she produced, manufactured, acquired, possessed or consumed a small amount of illicit drug for personal use;
- he/she admits to committing the offence;
- he/she has not been found guilty in connection with drug possession or trafficking in the previous two years;
- if the proceeding was not terminated, as a result of terminating culpability, within two years prior to commission of the offence, (successfully finishing a treatment as an alternative to criminal procedure) (Criminal Code Article 180).

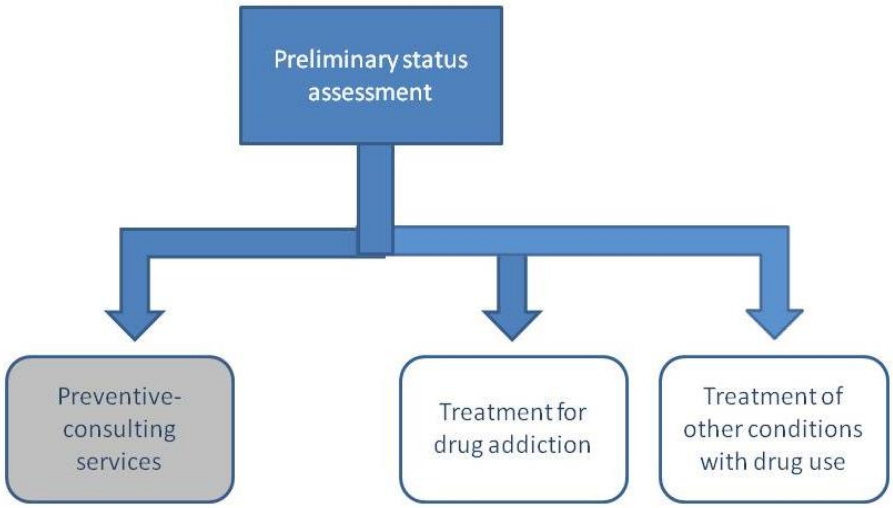
Individuals choosing an alternative to criminal procedure are referred to a preventive-consulting service – which may be regarded as analogous to an indicated prevention intervention – or to a treatment programme by a psychiatrist or a clinical psychologist on the basis of a preliminary status assessment[95]. The content of the treatment interventions is not specified; the healthcare service providers provide these services within the scope of regular outpatient or inpatient drug treatment programmes. The offender is required to participate in

[94] and other treatment units with a primarily social profile

[95] With respect to treatment, the law distinguishes between two types: “treatment for drug addiction” and “treatment of other conditions with drug use”.

the preventive or treatment programme for at least 1.5 hours every two weeks for 6 months in order for the certificate of completion to be issued.
Based on TDI data, in 2020, 79.2% of all clients entered treatment as an alternative to criminal procedure, namely in *preventive-consulting services* and *treatment of other conditions with drug use*.

Chart 33. *Types of quasi-compulsory treatment*



When interpreting treatment data related to QCT, it is important to note that the primary drug recorded in the data collection does not necessarily correspond to the substance that was involved in the offence. Furthermore, due to the link between data reporting and funding in the case of preventive-consulting services (and not in the case of non-QCT treatment), it may be presumed that QCT cases are overrepresented in the national TDI data collection.
The summary of a complex study investigating the operation and effectiveness of preventive-consulting services may be found in section T4.1 of this chapter.
For further information and data on QCT, see section T1.1.1 of the Legal Framework workbook, section T1.2.1 of the Drug Market and Crime workbook and section T1.3.2 of the Prison workbook.

T1.2.4 Ownership of outpatient drug treatment facilities

We have no up-to-date data with national coverage regarding the ownership of Hungarian drug treatment facilities. However, a 2015 study (Péterfi 2015) aimed at exploring the largest Hungarian drug treatment service providers (outpatient, social services and inpatient) may provide an overall picture.

The study found that of the 23 largest outpatient or social service providers, 7 were maintained by the state/local government, 14 units by NGOs or churches, while 1 was a non-governmental private institution and 1 reported “other” maintenance. For further results of the study and for a description of its methodology, see the Treatment workbook of the 2016 National Report.

Inpatient network

T1.2.5 Inpatient drug treatment system

The relevant funding categories with respect to inpatient treatment programmes targeting drug users are as follows:

- inpatient healthcare treatment (based on Decree 2/2004 (XI. 17.) of the Ministry of Health):
    - inpatient acute, chronic and rehabilitative addiction treatment

    - inpatient acute, chronic and rehabilitative addiction treatment for children and young people
    - inpatient acute, chronic and rehabilitative psychiatric treatment
    - inpatient acute, chronic and rehabilitative psychiatric treatment for children and young people
- residential social services (specialised services) (Act III of 1993 on Social Administration and Social Services):
    - institutions providing nursing and care for psychiatric patients and addicts
    - rehabilitation institutions for psychiatric patients and addicts
    - institutions providing temporary accommodation for psychiatric patients and addicts
    - residential homes for psychiatric patients and addicts
    - supported housing.

In the case of inpatient units, there are **treatment centres with** a primarily **healthcare profile** such as hospital addiction and psychiatric departments. Here the treatment is typically provided by psychiatrists, addiction specialists, clinical psychologists and specialised nurses. Traditionally and typically the programmes offered by hospital wards focus on the treatment of patients with psychiatric and alcohol problems; the treatment of drug users is less typical in such wards. Partly due to difficulties of definition and partly because of the low level of treatment monitoring, no appropriate data are available to describe this form of residential care. Besides hospital-based treatment, there are also **mixed-profile treatment centres** (namely providing both social and health services) which receive funding from both budgets. Therapeutic communities or drug treatment institutes working with other approaches are organisational units that typically do not operate within the framework of the traditional system of hospital-based healthcare institutions; they deliver a long-term therapeutic response to the multiple treatment demands of psychoactive drug users and patients suffering from behavioural addictions while living in a therapeutic community; typically they are maintained by the church, NGOs or municipalities. These treatment centres employ a multidisciplinary team, frequently also including recovering or recovered former substance users with relevant qualifications (addiction consultants, social workers, mental care workers etc.). They can also provide a linkage to the 12-step programmes.

There are four therapeutic institutes in the country targeted at the under-18 age group. Two of them (in Ráckeresztúr and Szatymaz) admit boys only (with a capacity of 30 and 15 beds) and two institutions admit both boys and girls (in Budapest and Pécsvárad) (with a capacity of 10-10 beds). Funding of the healthcare elements has been resolved since 2016. The funding scheme for social services in the scope of this treatment setting was introduced in 2020 (as a result of the amendment of Art. 73 of Act III of 1993 on Social Administration and Social Services). Experience shows that the capacity of the youth rehabilitation institutions is not fully utilised. That is due to a lack of services that should precede rehabilitation in the treatment chain. The youth units experience higher rates of drop-out (compared to adult rehabilitation); that prevents or hinders the group of clients becoming a community, thereby rendering the therapeutic process more difficult[96].

As the majority of drug treatment interventions are categorised under professional codes that also include the treatment of problematic alcohol users and patients with psychiatric problems, there are no precise quantitative data available about the number of treatment centres actually treating drug users. Data on inpatient treatment services are available from the TDI data collection, with low coverage. A total of 10 inpatient units and a service provider in prison reported clients entering inpatient drug treatment in 2020 (shown in the table below).

[96] Based on the round table at the conference “Gaps in the treatment system” held by the Civil Drug Coordination Body (KCKT) on 28 February 2019.
<http://madaszsz.hu/289/Feher_foltok_az_ellatrorendszerben_-_eloadasok_es_videok>

47.1% (90 persons) of the drug-using clients starting inpatient treatment were treated in therapeutic communities with a mixed (social and healthcare) profile, while 52.9% (101 persons) were treated in hospital-based residential units. 4.5% (191 persons) of all clients entering treatment in 2020 (4277 persons) started treatment in the scope of inpatient treatment, 10 of them in the form of QCT.

Table 16. *Network of inpatient treatment facilities and prisons (number of treatment units and number of clients) in 2020*

	Total number of treatment units	National definition (treatment unit types)	Total number of clients
Hospital-based inpatient drug treatment	5	Treatment units identifying themselves in the TDI data collection as inpatient hospital addiction or psychiatric departments.	101 (of whom 12 persons started treatment as an alternative to criminal procedure)
Therapeutic communities	5	Therapeutic communities operating in a non-hospital-based setting – drug therapy/drug rehabilitation institutes/homes – identifying themselves in the TDI data collection as inpatient treatment units.	90 (of whom 2 persons started treatment as an alternative to criminal procedure)
Prisons	4	Prison services reporting the treatment of prisoners in TDI.	14 (of whom 14 persons started treatment as an alternative to criminal procedure)

Source: TDI data collection 2021 – Standard table 24

For further information on therapeutic communities in Hungary see *Therapeutic communities facility survey* (Péterfi et al. 2016) in section T4.1 of the Treatment workbook of the 2016 National Report, and the results of an earlier study (Topolánszky et al. 2009) in chapter 11 of the 2012 National Report.

T1.2.6 Further aspects of inpatient drug treatment provision

For information on quasi-compulsory treatment, see section T1.2.2.

The number of addiction and psychiatric departments is significantly higher than those reporting to the TDI data collection; however, only a proportion of them treat drug users, and it may be assumed that only some of those report data to the TDI data collection. Therefore, there are no available data on the number of inpatient units providing drug treatment in the hospital setting. Based on the latest focused study (Péterfi et al. 2016), there were 15 therapeutic communities; that number has since increased by a further two units (see section T3.). Only 5 of the therapeutic communities reported cases in 2020 to the TDI data collection. All in all, it can be said that the TDI data collection is moderately suitable for describing drug users entering inpatient care because the coverage of data collection in the inpatient setting is low both in terms of treatment units and client numbers.

For the latest study on the operation of child and youth addiction rehabilitation institutes (Berényi et al. 2017), see the Treatment workbook of the 2019 National Report.

T1.2.7 Ownership of inpatient drug treatment facilities

We have no up-to-date data with national coverage regarding the ownership of Hungarian inpatient drug treatment facilities. However, a 2015 study (Péterfi et al. 2016) aimed at

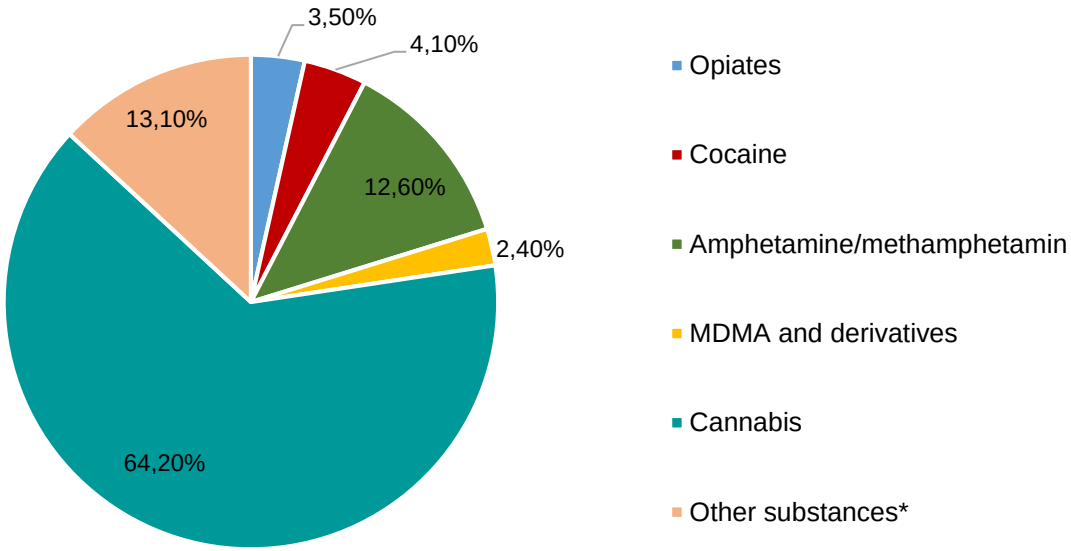
exploring non-hospital-based residential rehabilitation units can provide some information on this element of the treatment range.
In November 2015, the Hungarian National Focal Point conducted a facility survey among non-hospital-based residential rehabilitation units in Hungary. (Péterfi et al. 2016). All 15 non-hospital rehabilitation institutions receiving public funding, primarily targeting drug users, were involved in the study. The questionnaire was completed by all 15 institutions involved. In terms of their maintenance, the study distinguished between four types: (1) public institutions/state, municipal institutions/public foundations; (2) for-profit, non-governmental institutions; (3) non-profit NGOs; and (4) church organisations as a separate category. According to the data provided, of the 15 treatment centres, 8 were non-profit NGOs, 3 were church-based and 4 were public (state or municipal) institutions. For further results of the study and for a description of its methodology, see the Treatment workbook of the 2016 National Report.

T1.3 TREATMENT DATA

T1.3.1 Summary table of key treatment-related data and breakdown of treatment demand by primary drug

The 78 treatment units (also) providing drug treatment and reporting to the TDI reported a total of 4277 clients entering treatment in 2020. The majority (67.2%; 2876 persons) of those starting treatment due to a drug problem – similarly to in previous years – started a treatment programme because of cannabis use. 11.7% (501 persons) entered treatment because of amphetamine (or methamphetamine) use. Opioid use was the reason for entering treatment for 3.2% (138 persons) of clients in drug treatment, and cocaine or crack use for 4.6% of clients (195 persons). The proportion of primary ecstasy users was 2.4% (104 persons). A further 10.8% (463 persons) of treatment entrants indicated the use of “other substances” since their primary drug could not be categorised in the above substance groups.

Chart 34. *Breakdown of treatment demand by primary drug (2020; %; N=4277)*



**”Other drugs”: “other stimulants”, inhalants”, “hallucinogens”, “hypnotics and sedatives” and “other substances that do not come under the specified categories”*
Source: Péterfi 2021a – TDI data 2021

Table 17. *Summary table – clients in drug treatment in 2020 (persons)*

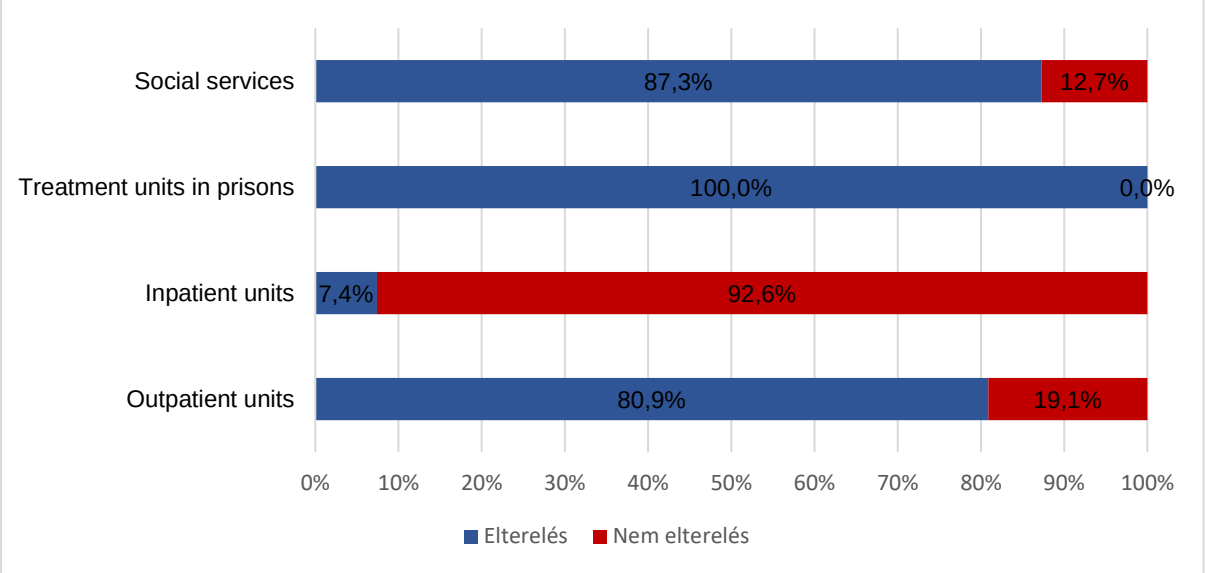
	Number of clients
Total clients in treatment	*no available data*
Total OST clients	*508*
All clients entering treatment	4277

Source: ST24; Péterfi 2021a – TDI data 2021; Péterfi 2021b – OST data collection 2021

T1.3.4 Characteristics of clients in treatment

Avoiding criminal procedure (QCT) was the most common reason for entering treatment among drug users. 79.2% (3384 persons) of all clients entered treatment for that reason in 2020. It is important to note, however, that on examining the treatment centre types, significant differences can be observed in the proportions of those avoiding criminal procedure. While the majority of the clients of outpatient and social service providers entered treatment in this way (80.9%; 2576 persons and 87.3%; 713 persons), only a very small fraction of those entering inpatient treatment (7.4%; 14 persons) started a treatment programme as an alternative to criminal procedure. All prison clients (100.0%; 81 persons) entered treatment as an alternative to criminal procedure in 2020 according to reported data.

Chart 35. *The proportion of those entering treatment as an alternative to criminal procedure (QCT) among those entering drug treatment, by type of treatment centre (2020; N=4271)*[97]



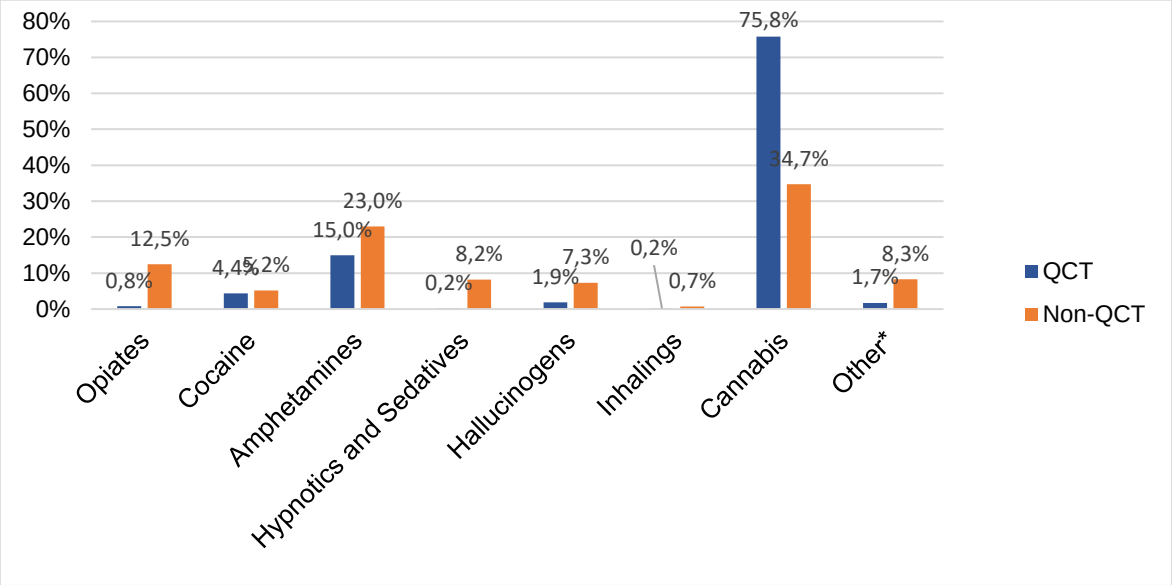
Source: Péterfi 2021a – TDI data 2021

Breakdown by primary drug shows a slightly different picture among those entering treatment as an alternative to criminal procedure (QCT) and those entering for other reasons. Cannabis (2564 persons, 75.8%) was the most prevalent primary drug among all clients entering QCT (3384 persons), followed by amphetamine-type stimulants (507 persons, 15%). cocaine use was characteristic of 4.4% (149 persons) of this client group, while the proportion of all the other drugs was below 5% (4.8%; 164 persons) among QCT clients.

Among non-QCT clients (887 persons), cannabis use was the most frequent reason for entering treatment (17%; 308 persons). The proportion of amphetamine type stimulant and

opiate users among those entering voluntary (non-QCT) to treatment was relatively high (23.0% 204 persons and 12.5% 111 persons).

Chart 36. *Breakdown of QCT and non-QCT treatment entrants by primary drug (2020; $N_{QCT\ clients}$=3384; NNon-QCT clients=887)*[98]



**Other: other substances not included in other categories*
Source: Péterfi 2021a – TDI data 2021

For a more detailed description (by drug type) of the characteristics of clients entering treatment see Drugs/Cannabis/T1.2.2; Drugs/Stimulants/T1.2.2 and T1.2.5, and Drugs/Heroin and other opioids/T1.2.2 and T1.2.5.
For information on the characteristics of clients starting treatment in detention facilities, see section T1.2.2 of the Prison workbook.

T1.4 TREATMENT MODALITIES

T1.4.1 Outpatient drug treatment services

For information available on outpatient drug treatment services, see section T1.2.1. For a detailed description of opioid substitution treatment, see section T1.4.9.

We do not have detailed information on the availability of individual interventions at the various health and social care providers.

T1.4.3 Inpatient drug treatment services

For information available on inpatient drug treatment services, see section T1.2.4.
We do not have detailed information on the availability of specific interventions at the various health and social inpatient units.

T1.4.4 Targeted interventions for specific groups of drug users

Women

[98] In the case of 6 persons, the source of referral was not known.

The Józan Babák Klub (Sober Babies' Club) targets pregnant or child-raising women living with behavioural addictions or drug use, a well as their relatives, by means of tailored interventions. For more information on the interventions and clients of the programme, see sections T1.4.1 and T1.6.1 of the Harms and Harm Reduction workbook.

From 2017 onwards, the Józan Babák Klub has run a halfway house programme, known as the Doll House, for drug-using pregnant women or women with toddlers, where women are provided with accommodation together with their children. For more information on the service, see section T1.6.1 of the Harms and Harm Reduction workbook.

The Academy for Special Parents was established in 2014 within the scope of the Methadone Programme of the Drog Prevenciós Alapítvány (Drug Prevention Foundation) in Budapest. For mothers and fathers in OST, the programme provides the "MENY"/"MEPA" reception hours, during which individual case management is provided, including supervision by a psychiatrist, and clients who are pregnant or have small children are helped to find suitable services in their network of health and social service providers. For more information on the service, see section T1.6.1 of the Harms and Harm Reduction workbook.

There are currently two therapeutic communities in Hungary that specifically target female drug users (possibly prescription drug or alcohol addicts), namely the Rehabilitation Institute of the Emberbarát Foundation and the MPE Hajnalcsillag Rehabilitation Home.

Children and adolescents

There are currently a total of four therapeutic communities targeting young drug users under the age of 18 in the country. Two of them admit boys only (with a capacity of 30 and 15 beds) and two admit both boys and girls (with a capacity of 10-10 beds). Outpatient care specifically targeting children and young people is currently being provided at two institutions: at the "Tiszta Jövőért' Foundation in Budapest and at the "Egészségdokk" Foundation in Székesfehérvár.

The Hungarian Charity Service of the Order of Malta has a page (apaiszik.kimondhato.hu) for children living with addicted parents, in particular addicted users of alcohol, that provides age-appropriate information about the phenomenon for affected children and enables them to join an online or personal peer group.

For special interventions available to prisoners, see section T1.3.3 of the Prison workbook.

T1.4.6 E-health interventions for people seeking drug treatment and support online

Only a few service providers have reported online counselling in recent years. However, since the beginning of the 2020 coronavirus epidemic, there has been a significant increase in the number of interventions provided by using online tools. For more information about remote drug-related services during the first wave of COVID-19 see our study report on the impact of the coronavirus epidemic on the care of drug users in section T4.1 of this workbook.

Opioid substitution treatment

T1.4.9 Main providers of opioid substitution treatment

OST is typically provided in the scope of outpatient treatment, but there are some service providers who provide this pharmacologically assisted therapy in the scope of inpatient treatment (in a hospital or therapeutic community). OST provider treatment units have a healthcare profile and are typically hospital addiction or psychiatric units or clinics, or specialised outpatient units with a mixed profile. In 2020, we identified a total of 12 service providers in the country providing opioid substitution treatment in a non-emergency setting for long-term opioid addicts. Of the 12 treatment centres, 3 institutions were operating in Budapest

and one institution was operating in each of 9 other counties (Baranya, Fejér, Somogy, Veszprém, Békés, Borsod-Abaúj-Zemplén, Csongrád-Csanád, Heves, Nógrád). This intervention is not available in 10 of the country's counties. OST is available from only one service provider in an inpatient setting, but in the scope of outpatient care at all 12 treatment centres. (Péterfi 2021b) (For the methodological description of the OST data collection, see section T5.2.)

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

T1.4.10 Number of clients in OST

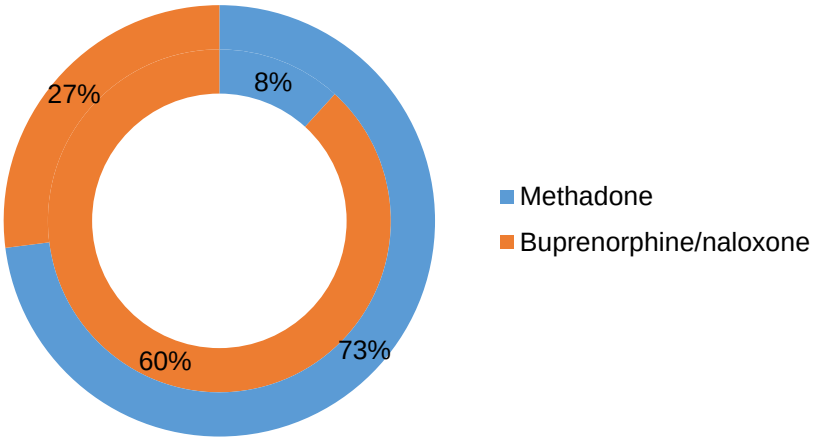
Two types of substitution medication are used in Hungary in OST programmes: methadone and buprenorphine/naloxone. For historical reasons and funding reasons, the use of methadone is more widespread; typically three-quarters of the annual number of clients receive this substitution medication (365 persons in 2020, 72%), while approximately one-quarter of the clients receive the buprenorphine/naloxone combination (143 persons in 2020, 28%). Buprenorphine/naloxone medication may be prescribed by any psychiatrist, whereas methadone is an "institution drug" (procurement and provision are performed by the health service provider). As a result, buprenorphine/naloxone medication may be prescribed in private healthcare, which we do not have information about.

For 2020, service providers reported a total of 557 treatment episodes linked to a total of 508 clients (intra-institutional and inter-institutional duplicates[99] were removed using the anonymous TDI code).

96% (488 persons) of the 508 clients received care in the scope of maintenance treatment. Approximately three-quarters of them (357 persons) received methadone and one-quarter (131 persons) received buprenorphine/naloxone.
4% (20 persons) of clients reported in 2020 underwent detoxification treatment. Of the 20 people, 8 received methadone and 12 received buprenorphine/naloxone.
It is important to note that maintenance and detoxification treatment sometimes alternate, so it is difficult to isolate them from each other. The relevant medical guideline (Methodological Letter of the Ministry of Health on methadone treatment; for details see section T1.5.1) specifies the length of detoxification treatment as between 1 and 6 months.

[99] In 43 cases, several treatment episodes within a facility were associated with a single client. In addition, a further 11 clients were identified who changed location during the year and were therefore identified as inter-institutional duplicates.

Chart 37. *Breakdown of OST maintenance clients (outer curve, N=488) and OST detoxification clients (inner curve, N=20) by substitution medication in 2020 (persons; %)*

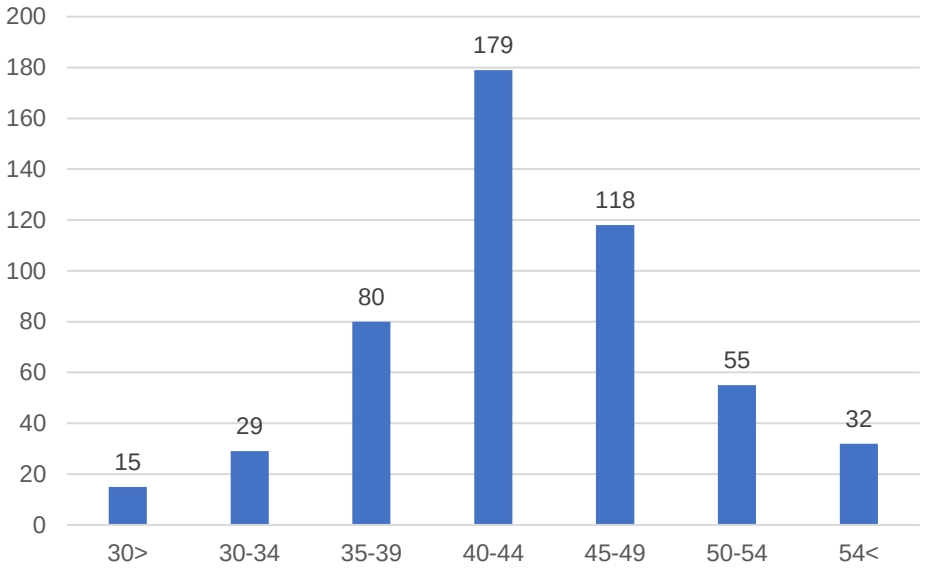


Source: Péterfi 2021b – OST data collection 2021; ST24

T1.4.11 Characteristics of clients in opioid substitution treatment

Of the 508 clients receiving substitution treatment in 2020, 76% (388 persons) were male and 24% (120 persons) were female. The mean age of clients was 43.5 years, with the most clients (179 persons; 35%) being in the 40-44 age group. The youngest client was 20 and the oldest 69.

Chart 38. *Breakdown of OST clients by age in 2020 (N=508; persons)*



Source: Péterfi 2021b - OST data collection 2021

T1.5 QUALITY ASSURANCE FOR DRUG TREATMENT SERVICES

T1.5.1 Quality assurance in drug treatment

Healthcare guidelines

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

- Methodological Letter of the Ministry of Health – On methadone treatment;
- Medical Protocol of the Ministry of Health – On the treatment of diseases related to opioid use;
- Medical Protocol of the Ministry of Health – On the treatment of clinical conditions associated with amphetamine use;
- Medical Protocol of the Ministry of Health – On disorders related to cannabis use;
- Healthcare Guideline – For problem drug use and behavioural addictions in children and young people[100];
- temporary recommendations and procedures regarding the required measures and the provision of addiction-related care and psychiatric care during COVID-19.

All three protocols were drawn up by the National Institute for Addictions primarily for specialists in psychiatry and addiction treatment. They are based on evidence and professional consensus. The protocols contain a description of the disease, the process and recommended methods of diagnosis, treatment, rehabilitation and care and partly the indicators of effectiveness. They are required to be updated every two years.
The methodological letter is a guideline that is much more specific than the protocols and exclusively describes the diagnostic and treatment processes and the indicators of efficiency.
The guidelines on the care of children and minors were prepared by the Board of Health of the Ministry of Human Capacities in 2019. The guidelines are intended primarily for professionals working in the healthcare setting. They are based on evidence and professional consensus. The guidelines contain a description of the disease and patterns of substance use, the process of diagnosis, treatment, care and proposed interventions, the tests that can be used for diagnosis and follow-up, and the process of revising the guidelines.

The *Professional Guideline of the Ministry of Human Capacities on the treatment of prenatal, perinatal and postnatal mental disorders within the baby-mother-father unit*, which are not specifically aimed at the treatment of drug users, also address the healthcare treatment of drug-using/drug-dependent pregnant women (Health Gazette 2017)

Social guidelines

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

- the “Professional Recommendation on day-time care for addicts”,
- the “Professional Recommendation on low-threshold services provided for addicts”
- and the “Professional Recommendation on community social care provided for addicts”.

The social guidelines were drawn up by an expert working group appointed by the Ministry of Human Capacities. The guidelines have no designated target group; their content is based on professional consensus[101]. They describe the aims and guiding principles of the service, the conditions for its quality assurance, the required documentation and the activities covered by the service. In 2018, the revision of the above three professional guidelines was carried out; the new guidelines came into effect on 1 July 2018.
For further information on operation of the quality assurance system, see chapter 11 of the 2010 National Report. On quality assurance for harm reduction interventions, see also section T1.7 of the Harms and Harm Reduction workbook.

[100] Published in the 2 July 2019 (LXIX /10) issue of the Health Gazette
[101] Representatives from the field were consulted on the draft guidelines in the scope of a consensus conference.

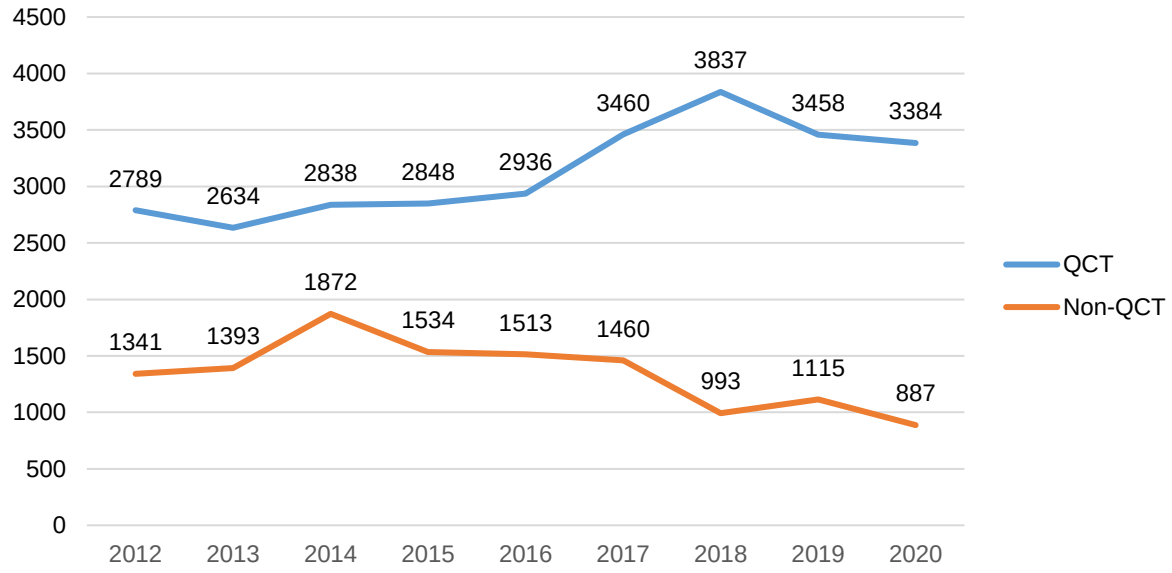
T2. TRENDS

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

TDI data

A particular feature of the Hungarian treatment system already described above (see sections T1.2.2 and T1.3.1) is that the majority of clients enter treatment in order to avoid criminal procedure. A certain proportion of those clients do not require addiction treatment; they are provided with a form of indicated prevention intervention (the "preventive-consulting service"). A noteworthy change is that the number of people entering treatment as an alternative to criminal procedure (and their proportion within all treatment entrants) increased significantly from 2016 to 2018 (by 30.7%). From 2018 to 2020 there is a slight decrease in their numbers, but their proportion did not change within all people entering treatment. At the same time, the number of clients starting drug treatment on a voluntary basis (non-QCT clients) was stable between 2015 and 2017; following a decrease in 2018. The decrease in the number of cases from 2019 to 2020 is in connection with the COVID-19 and the restrictions introduced related to it.)[102].

Chart 39. *Breakdown of clients entering treatment by source of referral between 2012 and 2020 (persons)*



Source: Péterfi 2021a – TDI data 2021

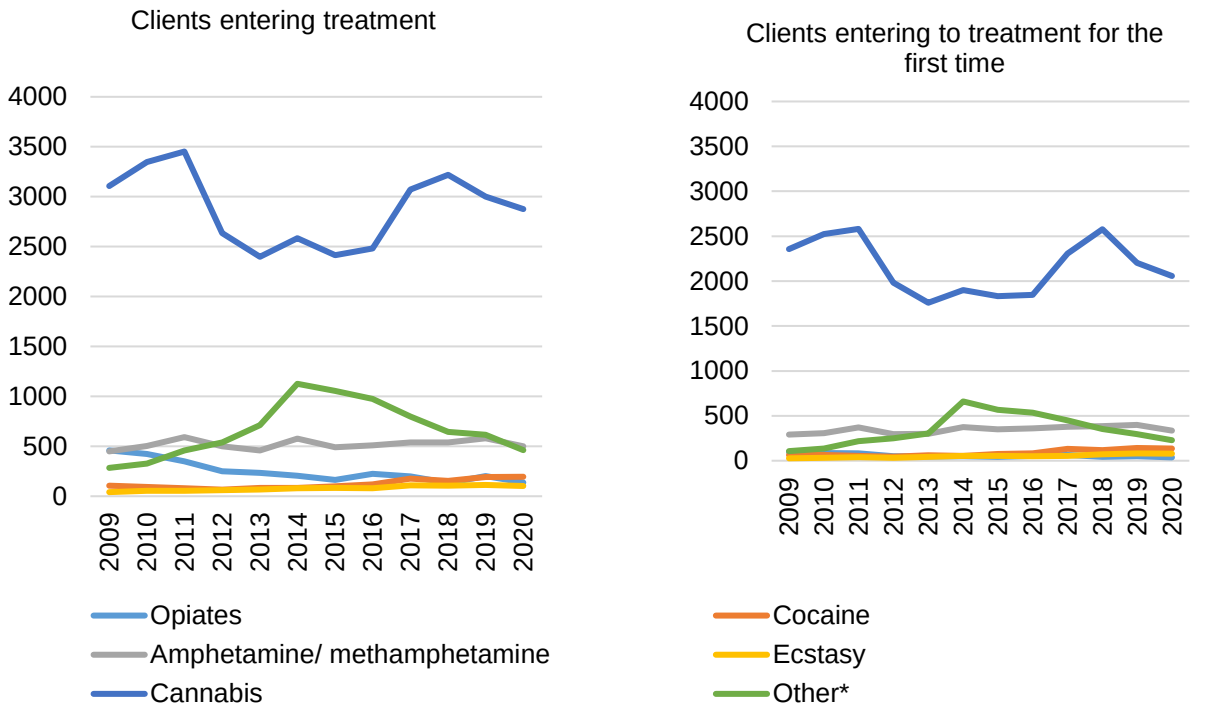
In connection with the increased use of NPS, it is important to note that until these substances are scheduled in the lists of narcotic drugs and psychotropic substances, their use is not a criminal offence and the (infringement) procedures launched in relation to them cannot be avoided by undertaking treatment (QCT). In the years when police activity significantly increased, the number of clients entering treatment, primarily occasional cannabis users, rose significantly. The drop in the number of clients entering treatment in order to avoid criminal procedure resulted in a decrease in occasional cannabis users entering treatment, showing that the regulatory background can have an impact on the composition of the population in treatment.

According to the national TDI data collection, among all treatment entrants, a decrease in treatment demand linked to opioids can be observed from 2009 onwards (2009: 449 persons;

[102] Responses to an enquiry sent to the treatment centres with the most significant decrease in client numbers suggested that the units did not sense that decrease in their daily work.

2020: 138 persons). In parallel, between 2009 and 2014, the number of new treatment admissions linked to "other drugs[103]" (primarily new psychoactive substances) increased (2009: 278 persons, 2014: 1137 persons), followed by a steady decrease between 2014 and 2019 (2014: 1137 persons, 2020: 463 persons). The spread of NPS and reduction in the availability of heroin are also reflected in the seizure data (see section T2.1 of the Drug Market and Crime workbook). Regarding cannabis users entering treatment, there is a fluctuating but relatively stable trend over the examined period which is significantly influenced by the number of clients entering treatment through QCT each year. At the same time, it is important to note the emergence of the number of people entering treatment in connection with cocaine and MDMA (ecstasy), next to the relative stability of the treatment demand related to amphetamine in the examined period. There is no significant difference in the trends by primary drug regarding all clients and clients entering treatment for the first time in their lives. That is largely due to the fact that QCT clients, who are typically entering treatment for the first time, account for a large proportion of treatment entrants in the data.
It seems that the fluctuation in the number of clients entering treatment as an alternative to criminal procedure primarily went hand in hand with the changes in the number of cannabis users entering treatment, meaning that increased police activity affected cannabis primarily, typically herbal cannabis users (based on seizure data).

Chart 40. *Trends in the number of all clients entering treatment (on the left) and all clients entering treatment for the first time (on the right) by primary drug, 2009-2020[104] (persons)*



Source: Péterfi 2021a – TDI data 2021[105]

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

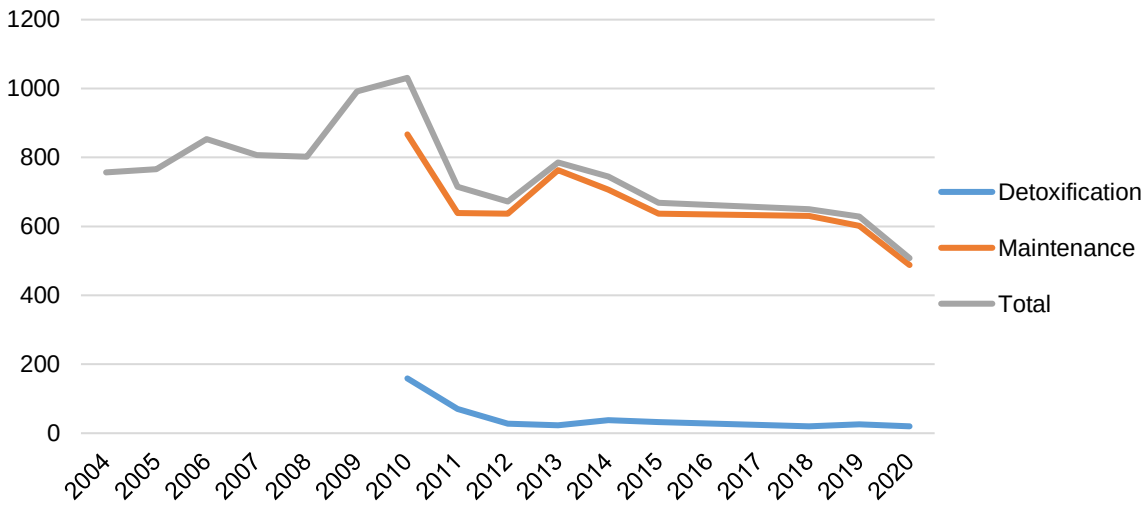
[103] *Other drugs: hypnotics and sedatives, inhalants, hallucinogens, other stimulants, other substances that do not come under the specified categories
[104] Other drugs: hypnotics and sedatives, inhalants, hallucinogens, other stimulants, other substances that do not come under the specified categories
[105] The case numbers between 2007 and 2018 may differ slightly from the case numbers presented in other parts of the chapter, since this chart is updated each year with the current case numbers only, while for the other charts/tables, the most recent data were queried for each previous year.

sources until 2016 (Péterfi 2016; Péterfi 2015; Csák 2012; Horváth et al. 2011), and is still significant, the specific needs linked to the use of NPS (including young people being affected, lack of motivation, more intensive use, more frequent need for emergency treatment) (GDS 2014; Csák 2012; Horváth et al. 2011) may remain partially unmet. Due to this, expert opinions suggest that this user group is probably underrepresented in the treatment data.

Opioid substitution treatment (OST)

The number of those treated in OST was relatively stable over the studied years: there was a slight increase following 2008, which can be linked to the introduction of buprenorphine/naloxone (and establishment of the possibility of self-financed treatment); subsequently enhancement of the data collection methodology (enabling removal of duplicates at the national level) led to a decrease in 2011 There was a gradual decline in the number of clients between 2013 and 2015 in parallel with the stability of accessibility of OST; that may be presumed to have been connected to the significant reduction of the heroin market, resulting in a decrease in treatment demand. Although we have no data on the years 2016 and 2017, the 2018 and 2019 OST data[106] indicate stabilisation of the annual client number at the 2015 level. In 2020, we can see a 19% decline in the number of clients per year, which is presumably related to the effects of the coronavirus epidemic on the care system.

Chart 41. *Trends in numbers of clients in OST by type of OST, 2004-2020* (persons)*



*Data collection was suspended in 2016 and 2017
Source: Péterfi 2021b – OST data collection 2021; ST24

For the trends in injecting drug use, see Drugs/Stimulants/T1.2.2 and T1.2.5 and the Harms and Harm Reduction workbook.

T3. NEW DEVELOPMENTS

Information regarding the changes in the drug treatment system is presented as part of the baseline information in section T1.
A report on the impact of the 2020 coronavirus epidemic on the care of drug users can be found in section T4.1 of this workbook.

[106] In 2019, instead of 12, only 11 service providers sent their data; the slight decrease in the number of cases can be attributed to that.

T4. ADDITIONAL INFORMATION

T4.1 ADDITIONAL SOURCES OF INFORMATION

T4.1.1 The content and effectiveness of preventive-consulting services (PCS) provided as an alternative to criminal procedure (Felvinczi et al. 2017 and Paksi et al. 2018)

In 2017-2018, a study was conducted to explore the content and direct effects of one type of treatment as an alternative to criminal procedure: "preventive-consulting services" (PCS) (Felvinczi et al. 2017 and Paksi et al. 2018).
The aim of the study was partly to map the providers of PCS and the programmes operated by them, primarily in terms of their compliance with the methodological letter[107] and compliance with other professional guidelines. Another main objective of the study was to understand the direct effects of PCS interventions. The largest institutions and actors providing PCS in Hungary were involved in the study, with 16 of the service providers who met the eligibility criteria agreeing to participate in the study.

Compliance with professional guidelines, such as the methodological letter, was examined by means of semi-structured interviews with staff and by completing a programme information sheet. The surveys and interviews aimed at describing the service providers and their operations were conducted in 2016-2017 (Felvinczi et al. 2017).
Treatment in order to avoid criminal procedure is an option available to those who have not made use of that option in the previous two years. The study showed that this rule is difficult to enforce in practice. Based on the results of the study, the flow of information between the investigating authorities and the QCT service providers should be improved, and the procedural steps and responsibilities related to the initiation of the QCT should be clarified. Clients in PCS are extremely diverse in terms of social background, age and substance use patterns. According to the representatives of the service providers, although most of them receive clients who justifiably enter this form of care, sometimes the real reason for being referred to PCS is that there is no adequate treatment unit in the area capable of providing the other forms of treatment as an alternative to criminal procedure that are better suited to more severe drug problems. A further problem reported by organisations with the preliminary status assessment is that an assessment consisting of a single meeting provides insufficient information for identifying individual needs.
One of the central problems related to the provision of PCS is that, due to the nature of the funding, the contract is signed annually with the service providers, but this contract is usually delayed. Therefore, for part of the year organisations have to perform PCS without a service contract, i.e. without legal authorisation (posing a problem when issuing a certificate, for example). A further problem with funding is that the service fee is delayed by months each year, which is a major operational problem, especially for smaller organisations solely focused on PCS. A further problem with the current funding scheme is that the service fee paid to the service providers has remained unchanged since 2003 and does not reflect any additional costs (e.g. for providing consultation in foreign languages to foreign nationals).
Lack of flexibility is a major problem with regard to the length of quasi-compulsory treatment defined by the legislation. Clients referred to PCS are not a uniform group either, so their specific life situation and specific problems would call for different methods of intervention, which is not legally possible for the organisations under the current legislation.
The study also found that a significant number of organisations do not have supervision available for their staff. Furthermore, the professional/content-related auditing of PCS providers and programmes is not provided for, as the audit is limited to checking whether the documentation is compliant (Felvinczi et al. 2017).

The researchers (Paksi et al. 2018) compared the characteristics of those who drop out of PCS between the two study stages (pre-questionnaire and post-questionnaire) to the characteristics of the clients remaining in the PCS (and willing to fill in the post-questionnaire) (Paksi et al. 2018).[108] It was found that among those dropping out of PCS, the proportion of those who had completed year 8 of school at most was significantly higher (more than twice as high). Examining their position in the labour market, they found that treatment dropouts are less likely to be in full-time employment (dropouts: 46.5%; non-dropouts: 56.9%); one quarter of dropouts were employed on an occasional basis (24.8% vs. 15.1%) and they were significantly more likely to be unemployed (9.9% vs. 4.3%) or a dependant (13.9% vs. 4.8%). The above is also consistent with the results of comparison of the deprivation index of those who remained in the PCS (and in the study) and those who dropped out. Although the data show that the majority of clients did not experience financial deprivation across the examined dimensions (housing, IT, entertainment, social relations, travel), when comparing those who started PCS with those who completed it, the latter group reported fewer living conditions in which they perceived a lack ($F = 3.076$, $p=0.080$); by comparison the mean deprivation index of those who dropped out was significantly higher ($F=7.819$, $p <0.001$). Based on the indicators used to characterise the social status of clients, researchers have concluded that among PCS clients (who in general have a lower cultural status than average drug users) the most disadvantaged in terms of cultural, socio-economical and labour status and the most vulnerable tend to drop out (Paksi et al. 2018).

When examining the differences in substance use between dropout and non-dropout PCS clients, it can be seen that, although drug use in the last 30 days was lower among dropouts, their patterns of drug use varied in many respects. Lifetime prevalence of NPS use (new stimulants, synthetic cannabinoid and mephedrone) and GHB use was higher among them. The prevalence of current cannabis use (in the last 30 days) was lower among them, but that of current synthetic cannabinoid use was higher. In addition, poly drug use was found to be more prevalent among dropouts: 48.8% reported the use of 2 or more substances in the last month, compared with 38.5% among non-dropouts. There was no significant difference between the two groups in terms of tools measuring problematic drug use (CAST and SDS). The characteristics typical of dropouts point to the fact that the current PCS system is unable to retain those clients who are the most vulnerable, have a lower cultural, employment and socio-economic status and who are in greatest need of help.

The study also examined the effectiveness of PCS interventions. This element of the study looked at the achievement of the goals set out in the methodological letter and defined by the organisations[109] as measured by the data recorded in the pre-questionnaire and post-questionnaire. Furthermore, the study examined what client characteristics and service-related factors increase the likelihood of attainment of each goal and what the defining factors of effectiveness are.
Based on current PCS practices, when looking at the goals defined by the service providers and the methodological letter, the largest service providers achieve significant results in reducing clients' drug use/regular drug use, with a significant proportion of clients stopping their current substance use. At the same time, there is no statistically measurable change achieved by PCS providers in reducing problem drug use, preventing addiction, developing a healthy lifestyle and in improving life skills. In the case of the goal “improving self-reflection” (which was defined as a goal by relatively few PCS providers), PCS programmes seem to be counterproductive based on the changes measured in all PCS clients throughout the programmes.

[108] The two groups were compared on the basis of the status recorded in the pre-questionnaire.
[109] prevention of regular use, reduction of problem drug use, prevention of addiction, development of a healthy lifestyle, development of life management skills, development of self-reflection, reduction of substance use, abstinence

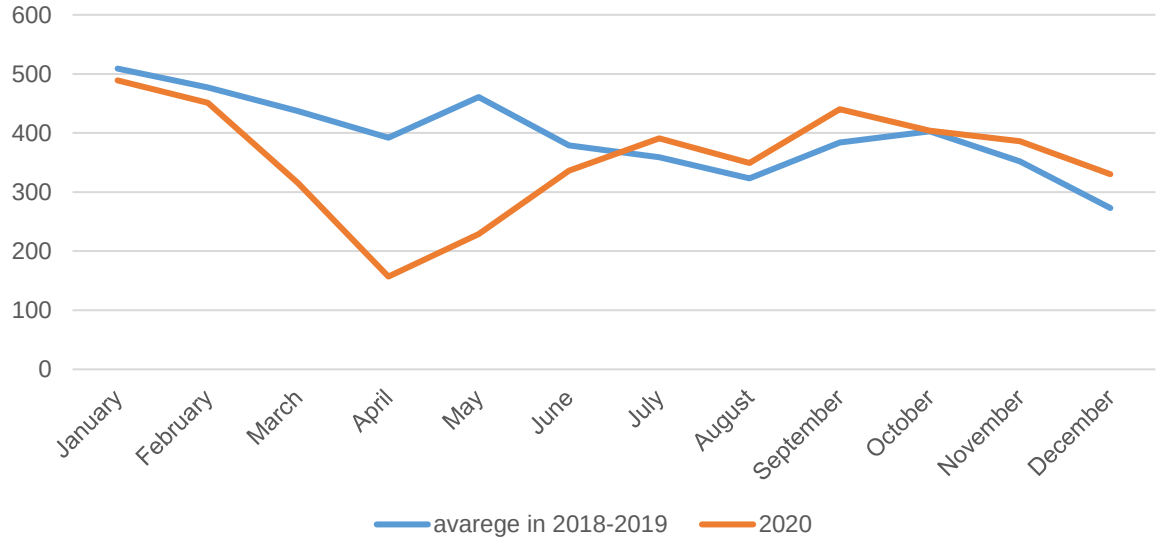
However, attainment of the goals is not independent of the various characteristics of the PCS services. According to the results of the study, the human resources aspect of the programmes should be highlighted: an increase in the number of employees without a qualification in the field has a negative effect on the achievement of all the final goals. On the other hand, a rise in the number of full-time psychologists, psychiatrists and addiction counsellors aids the attainment of a number of the final goals. The positive effect of the programme's harmonisation with the methodological letter could also be identified with respect to several of the goals. "Providing the opportunity for individual consultation" was the most beneficial according to the results, but with respect to attainment of 1-2 goals, "developing the methods and goals together with the client", "recording the key client rights identified in the methodological letter" and "providing a group consultation opportunity" also proved to be beneficial.
Based on the results of the study, in addition to the features of the PCS programmes, the baseline characteristics of the client at the start of the programme in terms of the defined objectives are also important with respect to attainment of the objectives. With respect to most of the objectives, more favourable changes can be expected if the baseline status of clients is more disadvantaged in terms of the target variables. That highlights the importance of individual needs assessment for the effectiveness of services (Paksi et al. 2018).

T4.1.2 Impact of the COVID-19 epidemic on those entering treatment in 2020

Those who are entering treatment due to drug use as a primary problem were affected by the first wave of the COVID-19 pandemic and the related restrictions. A we have presented in the 2020 National report, the different service types were affected diversely in this period, there were institutes/ programmes which have been forced to temporarily close, limit the capacity to their services, or temporarily suspend the admission of new clients. The TDI data collection provides information on those who enter to the treatment process and is not suitable for describing the evolution of treatments already in progress.

Examining the number of people entering treatment on a monthly basis, in 2020 we can say that from February to May we can see an increasing decline in the number of monthly cases, while between May and July there is already a decreasing decline, reaching the average number of monthly cases of previous years by July. In the months between July and December, the number of cases slightly higher than the typical average monthly number of cases in 2018 and 2019. Overall, the number of cases in 2020 is 9% lower than the number of cases reported in 2019.

Chart 42. *Monthly number of clients entering drug treatment in 2018/2019 (mean monthly client number of the two years) and in 2020 (persons)*



Source: Péterfi 2021a – TDI data collection 2021

T4.1.3 Substance use and treatment during the COVID-19 pandemic in Hungary until February 2021-– experiences of the second wave

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has launched several studies throughout Europe since the outbreak of the COVID-19 pandemic to map its effects. In January 2021, most countries experienced a rise in new COVID-19 infections, and infection rates were higher than during the first lockdown in 2020. Several countries again introduced strict lockdown measures on a local, regional or even national level.

The Hungarian National Focal Point, on behalf of the EMCDDA, conducted its first survey among service providers for drug users in 2020 on the effects of the first wave of the coronavirus pandemic and the restriction measures prompted by it. Another survey in the first months of 2021 studied the effects of the second wave of the pandemic on substance use and care.

Several service providers, when giving an overall assessment of the period between the two waves of the pandemic, reported some form of a restructuring regarding the price, purity and source of supply of substances. Regarding the price of substances, they reported increases, decrease and returns to the previous level alike: an increase was experienced in the prices of classic substances and NPS-synthetic cathinones, no change was experienced in the prices of new psychoactive substances, and a decrease was experienced in the prices of medicines without a prescription. In terms of availability, three different trends were observed: an expansion of sources of supply; difficulties in acquisition; and stagnation; that can likewise be explained by different trends for the various types of substances. Service providers agree, however, that the purity of substances became less reliable between the two waves of the pandemic.

In terms of specific substances, only benzodiazepine was reported by the majority of service providers to have become more available; the availability of all the other illicit substances or medicines used without a prescription was mostly thought not to have changed by the second wave of the coronavirus pandemic.

Regarding use itself, they said that compared to the first wave of the pandemic, during the second wave, *tobacco and alcohol use,* as well as *benzodiazepine misuse*, increased

considerably, and, to a lesser extent, the use of *herbal cannabis, synthetic cannabinoid* and *synthetic cathinone ("bath salts")*. A pronounced decrease was observed in the use of *ecstasy/MDMA* and *amphetamine,* most probably due to the lack of nightlife.

Substance change patterns were mostly caused by changes in the availability and prices of substances, the financial means of consumers and changes in living spaces related to restrictions of movement (staying at home and a lack of nightlife): from amphetamine to cannabis, from amphetamine to synthetic cathinone, and in the case of several herbal cannabis users, to synthetic cannabinoids. An increase in polydrug use was also typical.

In spring 2020, disease control measures restricted in-person contact, to which the service providers responded by rapidly switching to telemedicine; that provided a good opportunity for maintaining care, but decreased the accessibility of services for some client groups during the first wave. Those tendencies continued to prevail in the first months of 2021.

During the second wave, the services that had returned to the pre-pandemic level at most service providers were *status assessment (for quasi-compulsory treatment)* and *opioid substitution treatment, prevention and information programmes* and *needle and syringe programmes.* The accessibility of all other services besides the above had decreased in comparison with the situation before the pandemic.

The pandemic affected *services delivered in penal institutions (prisons), street outreach service delivery*, *hospital inpatient care* and *drop-in services* the most adversely; those were the services that had recovered the least. The complete termination of a given service was mostly reported in the fields of *services delivered in penal institutions (prisons)* and *HIV/HCV testing.*

Compared to the situation before the pandemic, in the second wave *individual counselling, prevention and information service delivery, group counselling* and *prescription appointments* were the services most often switched from in-person care to telemedicine.

The challenges to service delivery at the beginning of 2021 can be grouped around nine topics. The biggest challenges for service providers in this period were *maintaining the continuity of the various types of services and treatment processes* and, within that category, the lack of groups and other community-related activities in particular. The second biggest challenge was considered to revolve around *referral problems, the difficulty of getting people into higher-threshold services* and specialised care and the accessibility of healthcare institutions. The third biggest challenge was *keeping, accessing and maintaining contact with clients*, taking on new clients, accessing the target group and difficulties in outreach activities.

Among the various harms related to substance use, the proportion of service providers experiencing an increase was the highest in relation to *psychiatric co-morbidities*, as well as *emergencies related to substance use* (e.g. acute intoxication; withdrawal; suicide attempts; accidents), *COVID-19 infection and illness*, as well as *(gender-based/domestic) violence* related to substance use during the second wave of the pandemic in comparison with the first wave.

Service providers said that during the second wave of the pandemic, the three main problems for substance users were the *mental, psychological effects of the pandemic* (depression, insecurity and loneliness, lack of human relationships, stress, isolation, reduced recreational opportunities), difficulties related to their *socio-economic situation* as a result of the pandemic (unemployment, lack of employment opportunities, problems of subsistence) and *access to healthcare services* (overburdened health care system, difficulty of getting into rehabilitation institutions and addiction departments).

The aim of the study

Since the outbreak of the COVID-19 pandemic, service providers have repeatedly had to adapt to a new and continually changing environment.

The experiences of the first wave were summed up in relation to substance use, changes in the accessibility of services and in treatment demands, as well as the shift to telemedicine.
The aim of the present study is the continued monitoring of the effects of the pandemic and mapping of the tendencies evolving by January-February 2021:

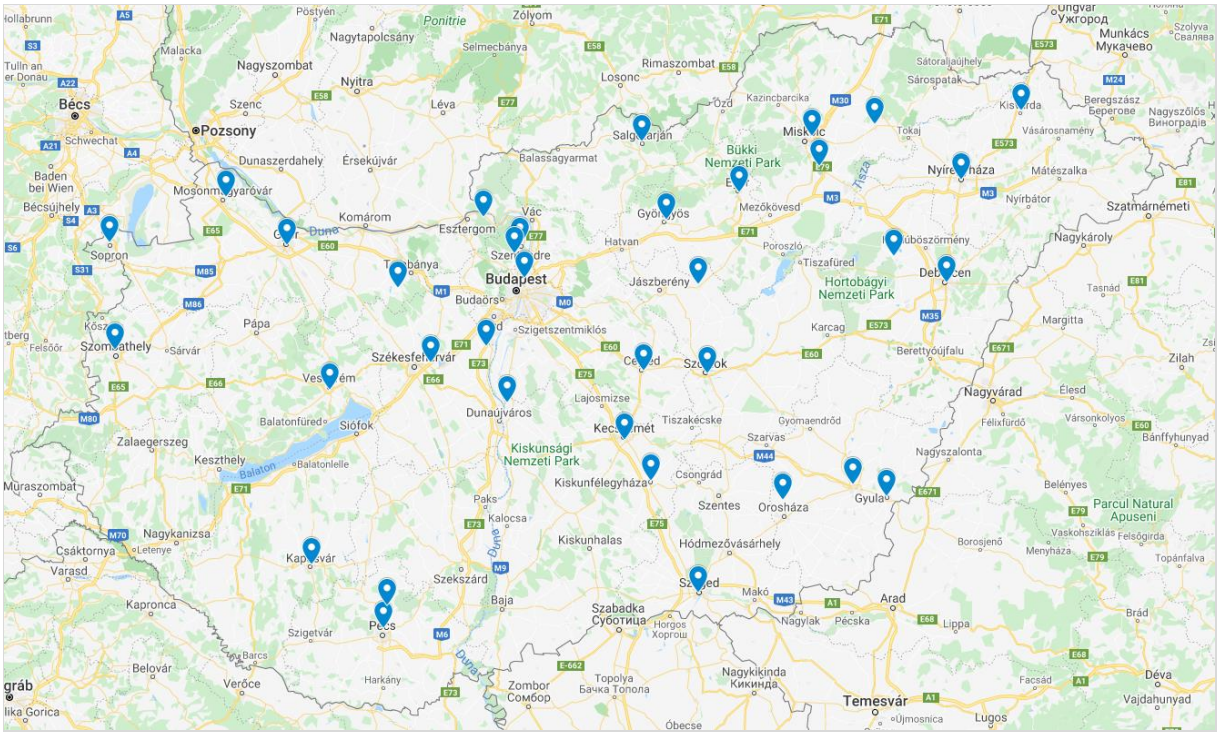
- How did the availability of substances change as a result of restrictions related to the coronavirus pandemic?
- How did the use of the various substances change? What new patterns of use, harms, health and social consequences emerged as a result of the coronavirus pandemic and the related restrictions?
- To what extent did services provided for substance users recover?
- How were telemedicine services delivered?
- What challenges were identified in service delivery and how were they managed?
- What problems were experienced among substance users during the second wave of the pandemic?

In the survey, the questions refer variously to the following four time periods:

- at present (January-February 2021);
- during the second wave of the pandemic (June-December 2020) in comparison with the first wave of the pandemic (March-May 2020);
- between the first two waves of the pandemic" (no specific dates given);
- during the second wave of the pandemic (June-December 2020) in comparison with the situation before the pandemic (before March 2020).

Composition of respondents

A total of 61 organisations, delivering services in 35 settlements in Hungary, responded to the survey; all regions and a total of 18 counties were represented.



Results

Availability of substances

In an open question, we asked service providers about their experiences regarding the changes in the price, purity, active ingredient content and sources of supply of substances between the two waves of the pandemic. Of the 61 organisations who completed the survey, 32 provided information on this:

With regard to availability, experiences vary; roughly the same number of organisations mentioned each of the three trends: obtaining substances became more difficult (8 mentions), became easier (7 mentions) or did not change (6 mentions). However, there may be different trends for different substances, even from the perspective of the same service provider.

> "The unemployment of clients and the related decrease in income made obtaining substances difficult."
>
> "It was around the time of the second wave that some clients said they had more difficulty obtaining 'bath salts."
>
> "Sources of supply expanded over the summer."
>
> "Dealers became more readily accessible."
>
> "Clients say the pandemic wave did not influence the purchase of the substances they use. After local dealers are caught, there is a few weeks' lag in availability, but time and time again a rearrangement takes place and matters are resolved."
>
> "No substantial change was reported in either availability or price. Only speed was reported to have been offered in several forms (powder, tablets) and types of composition."

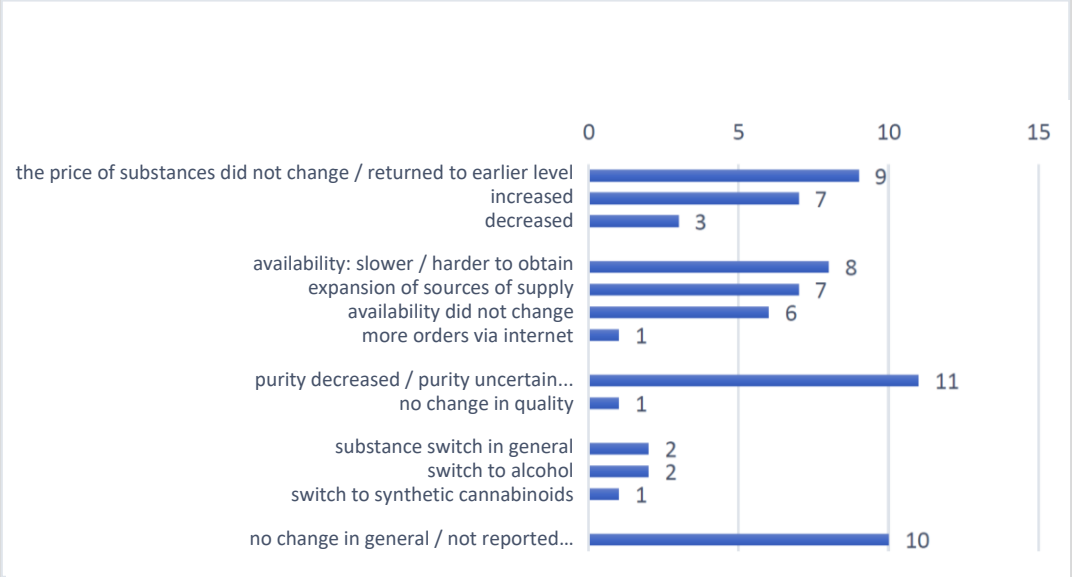
With regard to prices, two opinions dominate: roughly the same number of respondents reported no change in price levels (9) as reported an increase in prices (7); only 3 reported a decrease. Here again, trends varied from substance to substance:

> "The prices of classic substances increased; the availability and price of new psychoactive substances did not change."
>
> "The price of medicines (sedatives) decreased. No price change was reported for the other substances."
>
> "Our clients report an increase in the price of 'bath salts'; we have no information about the other substances."
>
> "During the first wave, several people could not access the substance they use, but dealers adapted fast to the circumstances, so there was no such lag in availability during the second wave. With regard to benzodiazepines, loosening of the regulations on obtaining prescription drugs meant they became more accessible for misuse as well. We know of no change in prices. We had a few reports of worsening purity; established drugs are being mixed with new psychoactive substances or substances unknown to the consumer."

In contrast to 1 respondent, 11 organisations reported that the purity of substances decreased and the active ingredient content was uncertain.

10 organisations said there was no change in the factors mentioned or that they had no information about it.

Chart 43. *Changes between the two waves of the pandemic regarding the price, purity / active ingredient content and sources of supply of substances as reported by clients (number of mentions)*

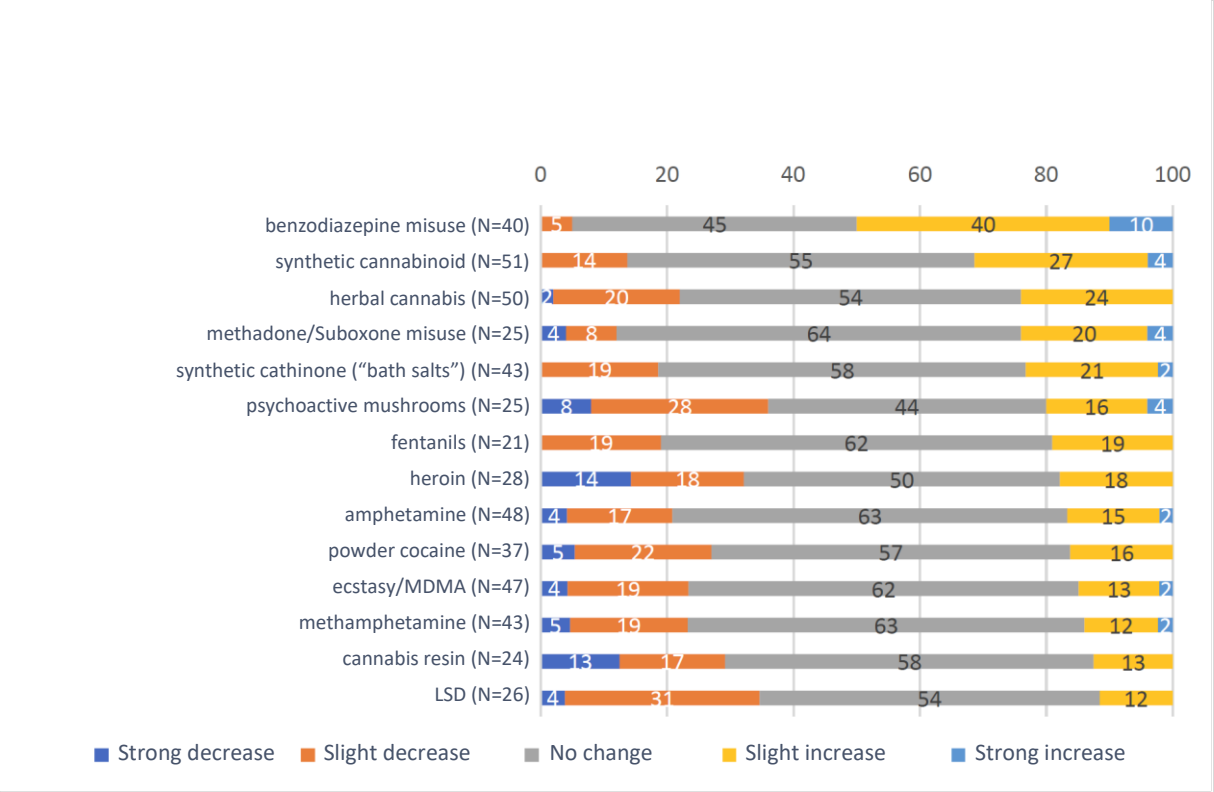


Source: HNFP 2021

In terms of specific substances, only *benzodiazepine* was reported by most service providers to have become more available, the availability of all the other substances examined was mostly thought not to have changed by the second wave of the coronavirus pandemic; in addition, to a lesser extent, some respondents experienced either an increase or a decrease. With regard to some substances, such as herbal cannabis, amphetamine, synthetic cathinone ("bath salts") and fentanils, the same number of respondents experienced an increase as experienced a decrease. More service providers experienced an increase than experienced a decrease in the case of two substances: synthetic cannabinoid and methadone/Suboxone.

A decrease tended to be reported regarding LSD, cannabis resin, psychoactive mushrooms, heroin, powder cocaine, ecstasy/MDMA and methamphetamine; among these, a substantial decrease was experienced in the case of heroin and cannabis resin.

Chart 44. *Changes in the availability of substances during the second wave of the pandemic (June-December 2020) in comparison with the first wave of the pandemic (March-May 2020) as reported by clients (%, basis: those who assessed the availability of the given substance)*

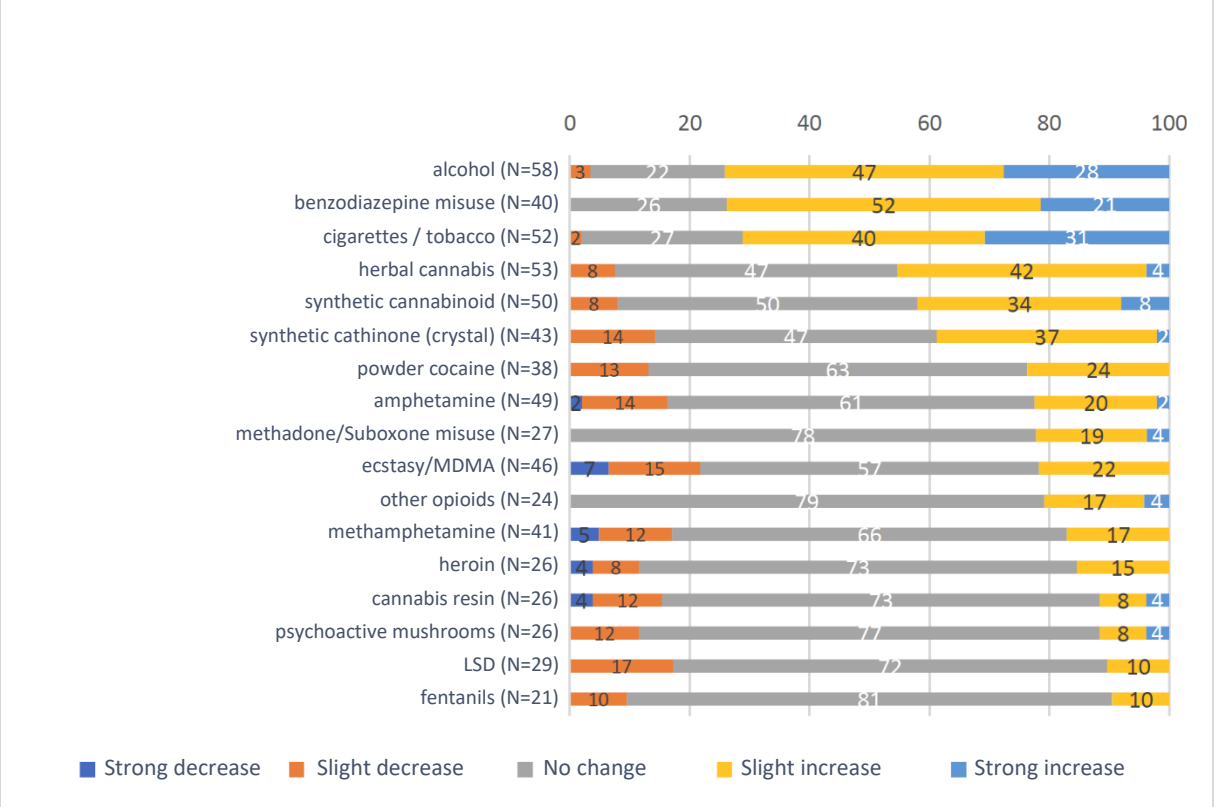


Source: HNFP 2021

Changes in the patterns of use

Compared to the first wave of the pandemic, during the second wave, *tobacco and alcohol use*, as well as *benzodiazepine misuse,* increased considerably. So too did the use of *herbal cannabis, synthetic cannabinoid* and *synthetic cathinone (“bath salts”) to a lesser extent.* The majority of the service providers reported no change in the use of the other substances; a pronounced decrease was mostly observed in the use of *ecstasy/MDMA* and *amphetamine,* most probably due to the lack of nightlife.

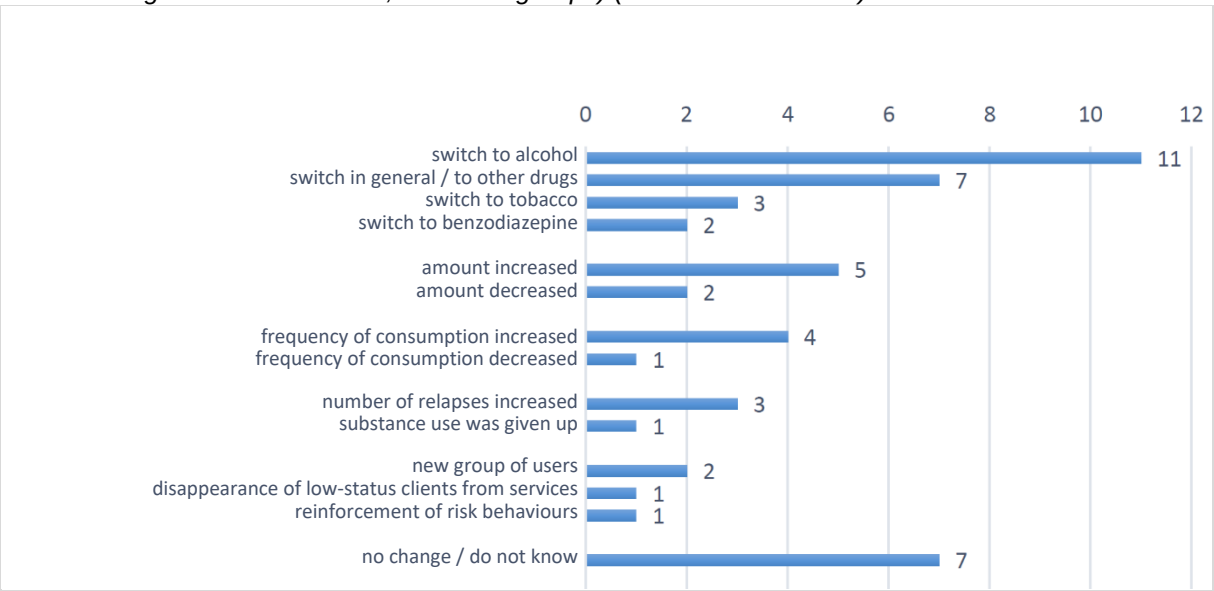
Chart 45. *Did the extent of use of the following substances change during the second wave of the pandemic (June-December 2020) in comparison with the first wave of the pandemic (March-May 2020) as reported by clients? (%, basis: those who assessed the given substance)*



Source: HNFP 2021

Of the 61 organisations, 31 shared their experiences about changes in the patterns of substance use: besides a shift to alcohol and tobacco between the two waves (11 and 3 mentions, respectively), an increase in polydrug use was also experienced (7 mentions). Substance change pattens were mostly generated by changes in the availability and prices of substances, the financial means of consumers and changes in living spaces related to restrictions of movement (staying at home and a lack of nightlife): from amphetamine to cannabis, from amphetamine to synthetic cathinone, and in the case of several herbal cannabis users, to synthetic cannabinoids. In terms of amount, more service providers experienced an increase than experienced a decrease (5 mentions vs. 2), and more frequent consumption was mentioned more often than decreased consumption (4 service providers vs. 1 service provider). In addition, the following phenomena were mentioned by service providers with regard to patterns of use: an increase in the number of relapses (3 mentions), new groups of substance users (2 mentions), giving up of substance use, low-status users dropping out of services, reinforcement of risk behaviours (1 mention each). 7 of the 31 service providers mentioned no changes.

Chart 46. *Changes to be highlighted in terms of patterns of use between the first and the second wave of the pandemic as reported by clients (amount used at a time; route of administration; switching to other substance; new user groups) (number of mentions)*



Source: HNFP 2021

The connections between changes in substance use are described by service providers as follows:

- "The consumption of alcohol and tobacco products strongly increased, as these are legal substances and some of them are cheaper to obtain than other substances used, so their consumption also increased."

- "Alcohol as a stress reduction method appeared on an everyday basis, in response to the uncertainty of the situation."

- "Alcohol use increased – the number of sleepover parties increased. On such occasions, young people mostly consume alcohol."

- "Among our clients of a lower social status, the consumption of alcohol, nicotine and benzodiazepine increased slightly. They attribute that to the restricted availability of the services used by them. Many relapsed in the absence of helpers. We are seeing a constant increase in benzodiazepine misuse. Latency is probably high as well, but this will likely become manifest in the treatment system only years later."

- "An increase in the amount used at a time and use of several substances one after the other occurred more frequently."

- "Several herbal cannabis users switched to synthetic cannabinoids. Several amphetamine users switched to cathinols. The amount of alcohol use increased."

- "Among those clients who became unemployed as a result of the pandemic, the frequency of substance use increased (from occasional to daily use)."

- "In the case of occasional substance users, a decrease in the frequency of consumption was most often reported due to limited social interactions, the lack of events and venues, and the restrictions on movement."

- “New patterns of use were observed in the case of 3 of our drug-dependent clients.” The acquisition of higher-quality substances (amphetamine, cannabis) became harder and there was a slight increase in the use of synthetic cannabinoids. In the closed home environment, herbal cannabis replaced stimulants in 3 cases/once a week. The amount of alcohol use increased. We observed an increase in social isolation due to pandemic-related restrictions, which increased the isolation of our clients and may have contributed to reinforcing risk behaviours.”

- “The use of less readily available substances decreased and the use of more readily available ones increased; there was no considerable change in the group of users.”

- “Some users said they had decided to give up substance use because it is harder to obtain and it is harder to earn enough money to afford it (mostly users of ‘bath salts’).”

Accessibility of services, challenges, telemedicine
Regarding the accessibility of services, we asked service providers to say to what extent, expressed in percentages, their services had recovered in comparison with the situation before the first wave of the pandemic.

In most cases, the services that had recovered to almost the earlier level were *status assessment (for quasi-compulsory treatment*) and *opioid substitution treatments*.

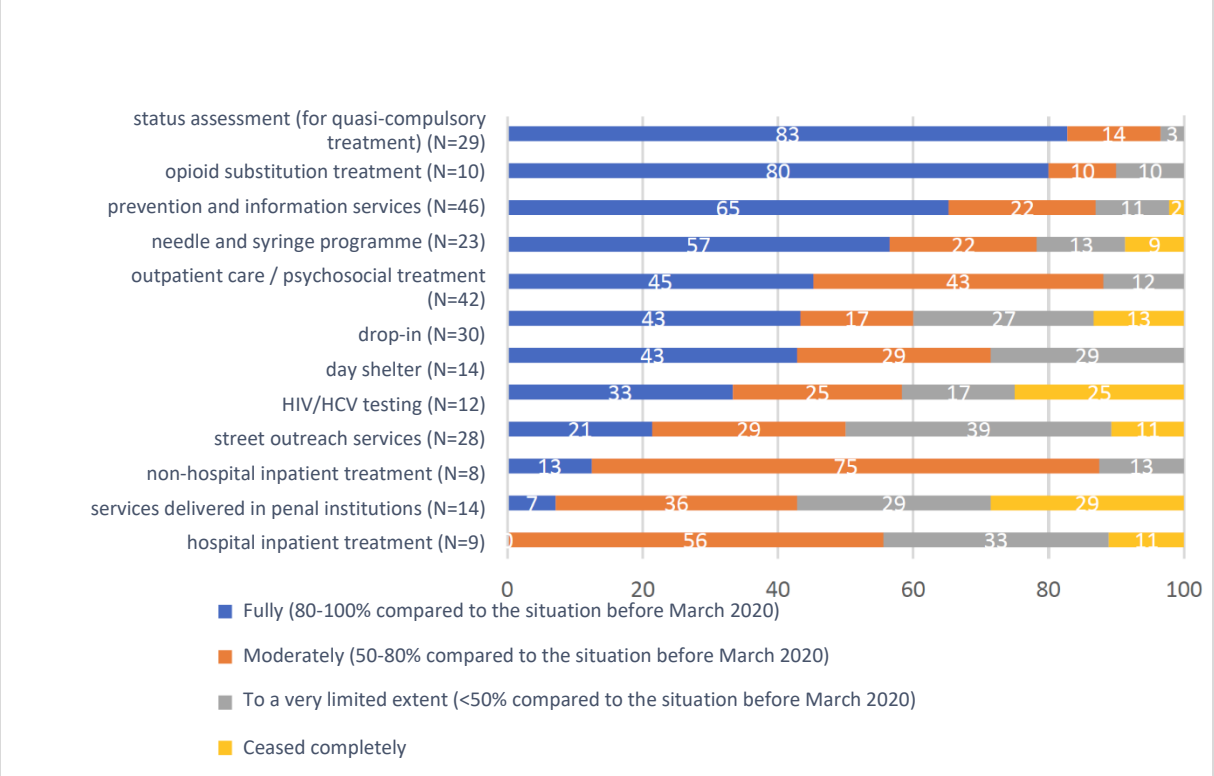
Prevention and information services, as well as *needle and syringe programmes* had fully recovered at about two-thirds of service providers and moderately recovered at another one-fifth.

The accessibility of all the other services besides the above had decreased in comparison with the situation before the pandemic; a fairly significant proportion of *outpatient services / psychosocial treatment*, *drop-in services* and *day shelters* had recovered; that was the case at around 40% of service providers.

The pandemic affected *services delivered in penal institutions (prisons), street outreach service delivery*, *hospital inpatient care, HIV/HCV testing* and *drop-in services* the most adversely; these were the services that had recovered the least. The complete termination of a given service was mostly reported in the fields of *services delivered in penal institutions (prisons)* and *HIV/HCV testing.*

The complete termination of a given service occurred in the fields of *services delivered in penal institution (prisons)* and *HIV/HCV testing,* at a quarter of the service providers delivering those services.

Chart 47. *To what extent did services recover during the second wave of the pandemic (June-December 2020) in comparison with the situation before the pandemic (before March 2020)? (%, basis: those who assessed the given service)*



Source: HNFP 2021

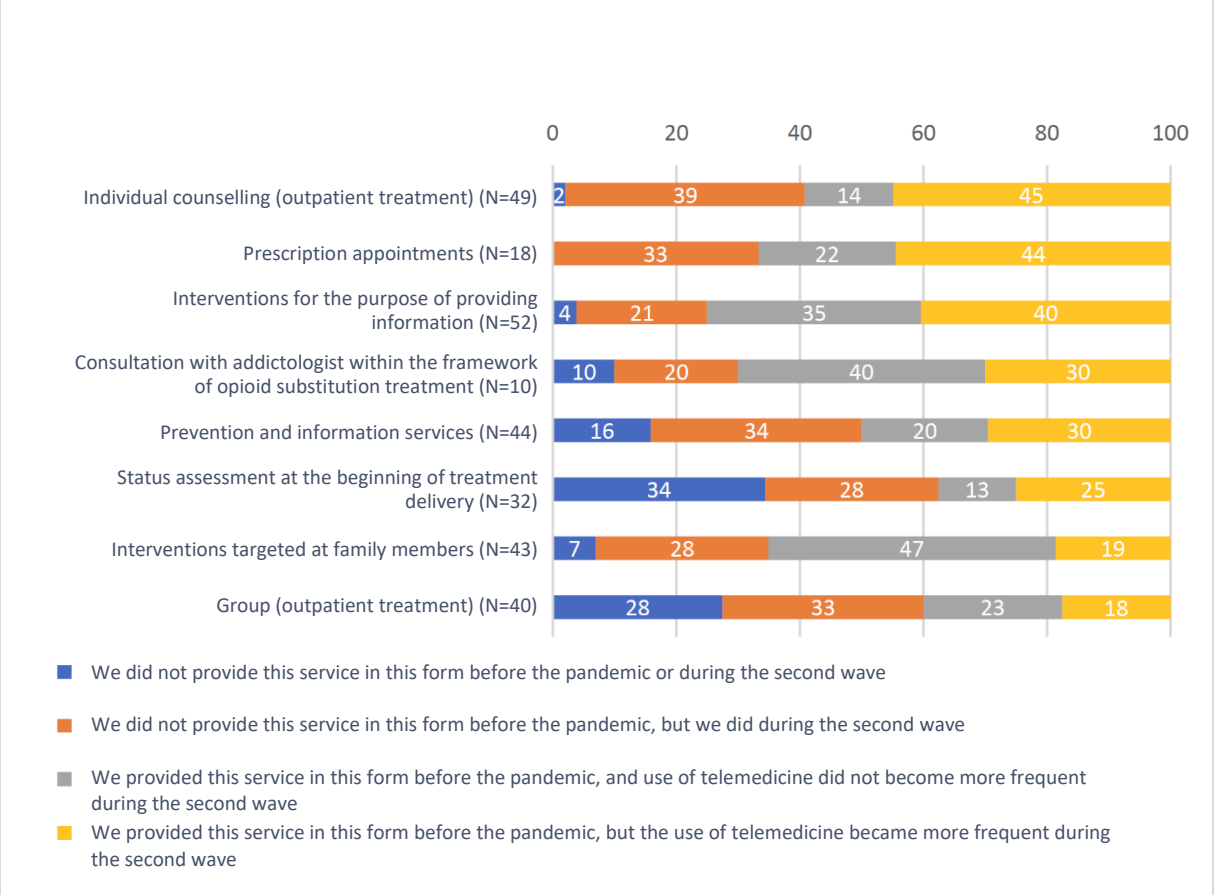
When disease control measures were introduced in spring 2020, the majority of service providers rapidly created online alternatives to their interventions in order to reduce in-person contact and deliver safer services, thus shifting most of the work with clients to telephone and online communication. At the beginning of 2021, we asked them to compare the frequency of providing telemedicine[110] services during the second wave in comparison with the situation before the pandemic.

Switching to telemedicine affected individual counselling and prescription appointments the most, among service providers for whom those services are relevant; around 80% of the service providers switched to telemedicine or began to use it more frequently during the second wave of the pandemic. To a lesser extent, that was also true of two-thirds of service providers providing the given service in the case of prevention and information services and interventions for the purpose of providing information.

Individual counselling, prevention and information service delivery, group counselling and prescription appointments were the services most likely to be switched from in-person care to telemedicine.

[110] Telemedicine is the delivery of healthcare services without the client and the healthcare provider meeting in person, communicating instead through some form of remote data transmission system. Telemedicine is thus a diagnostic or therapeutic remote surveillance process supported by information and communication devices in which the necessary co-presence of patient and healthcare providers is substituted remotely by online electronic communication. Source: https://fogalomtar.aeek.hu/index.php/Telemedicina

Chart 48. *Use of telemedicine during the second wave of the pandemic (June-December 2020) in comparison with the situation before the pandemic (before March 2020) (%, basis: those who assessed the given form of telemedicine)*



Source: HNFP 2021

Of the 61 service providers who completed the survey, 49 gave feedback on what they thought the biggest challenges were for them or their clients in terms of service delivery at the time of completing the survey (January-February 2021). The 150 mentions by the 49 respondents can be grouped around nine topics. The biggest challenges for service providers in this period were *maintaining the continuity of the various types of services and treatment processes*, and within that especially the lack of groups and other community-related activities (31 mentions). The second biggest challenge was considered to revolve around *referral problems, the difficulty of getting people into higher-threshold services* and specialised care, and the accessibility of healthcare institutions (25 mentions). The third biggest challenge involved *keeping, accessing and maintaining contact with clients*, taking on new clients, accessing the target group and difficulties in outreach activities (23 mentions).

> "There were no more in-person consultations. Due to the lack of nonverbal communication, we cannot sense changes in or deterioration of the client's health. We have less of an overview of our client base. There is also a decrease in the accessibility of our services, e.g. we can only meet new clients in person on the first occasion; we cannot receive family members, so we cannot always take users into early care. The framework is loosened; clients do not always follow the rules and there might be more opportunity for misuse. The quality and efficiency of service delivery / telephone consultations does not match up to that of in-person consultations and case treatment."

At the time of the survey, 19 service providers reported problems with moving services to the online setting or with keeping in touch; these were partly related to the difficulty of using the

online setting, partly to the lack of personal connection and partly to the lack of devices (lack of smartphone or internet).

> "There are a lot more conversations on the phone and by email, we have to explain to clients how to use the online setting and how quasi-compulsory treatment will take place. Online groups can only be effective with fewer participants than in-person groups. Due to the smaller group size, we have to start more groups and pay more salaries from the service fee, which is expected to remain the same. There is also a rise in overhead costs due to the increase in the phone bill."

16 service providers mentioned the emotional and mood-related effects of the pandemic situation and the restrictions, such as confinement, isolation, lack of maintaining or building relationships; growing psychological burdens related to confinement and restrictions, increased mistrust, impatience, fear and insecurity; 15 mentioned the difficulty of complying with and ensuring that others comply with the disease control measures (such as hygiene measures and physical distancing).

> "Managing psychological burdens related to life difficulties; clients require more attention and support."

Challenges in clients' lives were reported by service providers to include keeping their job / lack of work opportunities and housing problems (12 mentions), effects of the restrictions on treatment and care (6 mentions) and financing difficulties (3 mentions).

Chart 49. *What are the three main challenges at present (January-February 2021) in terms of service delivery and/or for your clients? (number of mentions)*

Source: HNFP 2021

Maintaining or breach in the continuity of the various types of care / treatment services (31 mentions)

lack of group sessions	10
maintaining the continuity / undisturbed functioning of care / availability of service delivery / including for rural clients	8
community activities are restricted / fewer participants at club events	4
providing a venue / scheduling a time	2
organisation of family visits / inability to organise family consultation weekends	2
in-person prevention in relation to any institution / prevention opportunities have been pushed into the background by the virus situation	2
starting new service elements / continued training	2
no possibility to organise external programmes, attend NA/AA meetings and organise open programmes at the institute	1

Referral difficulties / client pathways (25 mentions)

difficulty of getting patients into higher-threshold services / specialised care, psychiatric treatment hard to access / accessibility of healthcare institutions	15
getting into a therapy home has been made more difficult due to the need to get PCR tests / setting the requirement of two PCR tests for entry has decreased the number of clients coming for entry interviews / we need to provide help to clients in getting PCR tests	5

service delivery has been suspended / the addictology department has ceased to exist / treatment delivery has been delayed	3
Starting quasi-compulsory treatment due to status assessment / lower number of clients in quasi-compulsory treatment	2

Keeping clients / accessing clients / entry of new clients / keeping contact / accessing the target group / work with relatives (23 mentions)

outreach activities have been suspended / difficulty in performing outreach activities due to restrictions of movement / we have less of an overview of our client base	8
effectiveness / keeping in touch / involving clients in individual treatment / maintaining clients' interest	4
caring for an increased number of clients / keeping clients / adequate care for clients and referral if needed	3
restrictions on visits to the usual contact places / closure of entertainment and catering venues / frequent presence of the police at the service delivery site, punishments and threats towards clients	3
work with relatives has ceased / young people are difficult to mobilise / organising discussions with the family	3
entry of new clients / appearance of a higher number of new clients with mental difficulties	2

Advantages and disadvantages of online / telephone consultations (18 mentions)

we cannot keep clients in the online setting effectively / the quality and efficiency of service delivery / telephone consultation does not equal that of in-person consultations / fields of online service delivery: holding group sessions, education, family consultation / contact via telephone instead of in person, harder to keep up clients' interest / more limited toolkit	6
lack of in-person contact / missing having in-person contact / return to in-person contact	5
use of the online setting needs to be explained / technical difficulties: lack of equipment to access online contact (lack of smartphone / internet)	4
increased need for telephone counselling	1
ensuring the quality of online service delivery	1
potential breaches of confidentiality	1
some clients are still afraid to meet in person	1

Effects of the pandemic situation on clients' psychological state / mood (16 mentions)

confinement, isolation / lack of opportunity to meet and maintain and form relationships / growing psychological burdens due to confinement / restrictions	8
increased mistrust, impatience, fear, insecurity	5
managing psychological burdens related to life difficulties; clients require more attention and support	1
in-patients cannot leave the institution due to restrictions	1
it is hard for clients to keep strictly defined appointments	1

Introducing and ensuring compliance with disease control measures (15 mentions)

health protection / preventing infection	4
special attention to the use of personal protective equipment / complying with increased hygiene measures / wearing masks	4
physical distancing / minimising the number of people in the same room / relatives cannot accompany the client in person	4
preventing COVID infection	2
continuous testing	1

Effects of the restrictions on clients and their environment (unemployment) (12 mentions)

loss of job / keeping job / lack of job opportunities / reintegration onto the labour market	10
transport / housing	2

Effects of the restrictions on service delivery (6 mentions)

potential breaches of confidentiality / creating a sense of safety during in-person consultations	2
decrease in staff / taking on/keeping employees	2

adequate room for online consultations	1
we can only deliver information to a few people	1

Financing difficulties (3 mentions)

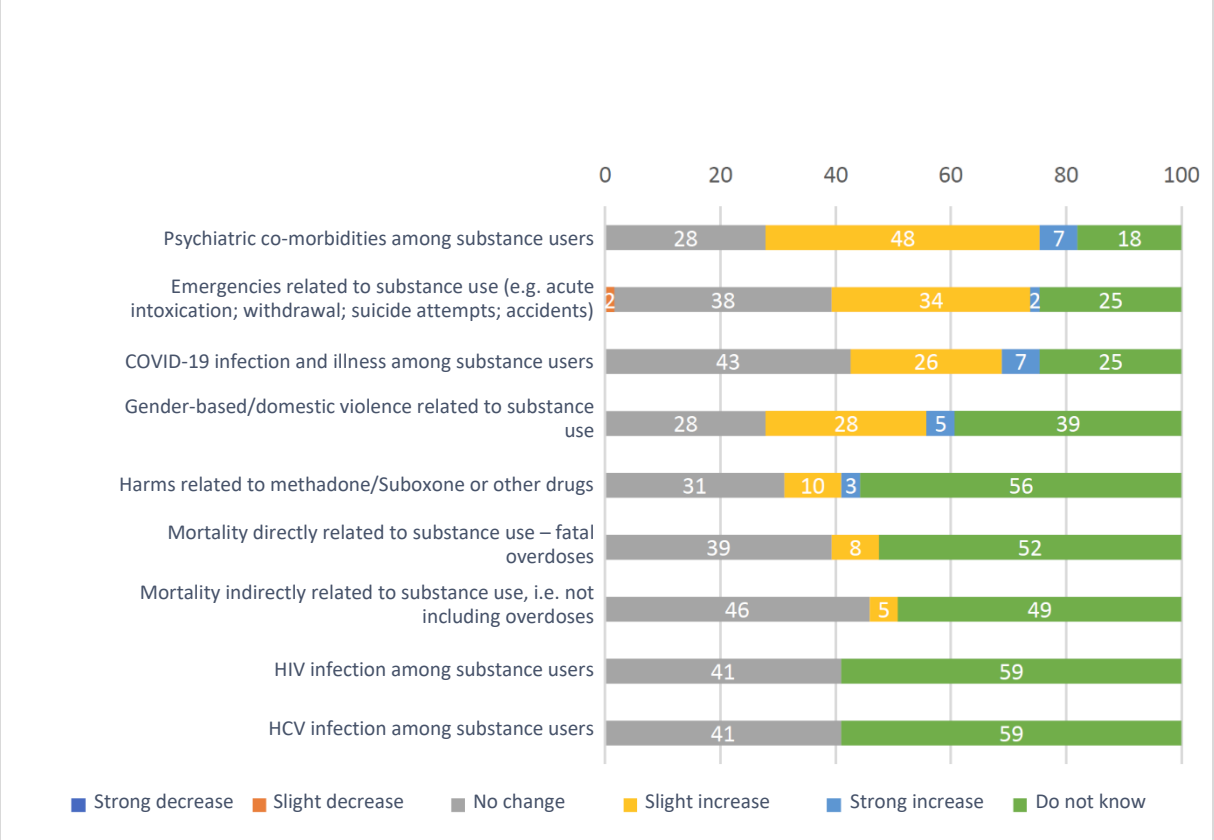
uncertainty concerning finances and applications	1
financial difficulties	1
increase in phone bills due to considerable increase in telephone and email communication	1

Prevalence of harms related to substance use and measures for their prevention

We asked service providers to assess how they think the prevalence of harms related to the use of different substances had changed by the second wave of the pandemic. They experienced the highest increase in comparison with the first wave in the prevalence of *psychiatric co-morbidities,* with 48% experiencing a slight increase and 7% experiencing a substantial increase. A considerable increase was reported with respect to three other harms; around one-third of service providers experienced an increase in *emergencies related to substance use* (e.g. acute intoxication; withdrawal; suicide attempts; accidents), *COVID-19 infection and illness*, as well as *(gender-based/domestic) violence related to substance use*.

Harms related to the use of *methadone/Suboxone and other medicines* had risen to some extent according to 13% of service providers; *mortality directly or indirectly connected to substance use* was reported to have risen by 8% and 5% of respondents respectively, but with regard to these harms, just like with regard to *HIV and HCV infection*, most service providers did not experience an increase or did not know.

Chart 50. *Did the prevalence of harms related to substance use change during the second wave of the pandemic (June-December 2020) in comparison with the first wave of the pandemic (March-May 2020)? (%, basis: full sample, N=61)*



Source: HNFP 2021

The three main priorities or measures for the purpose of preventing or reducing further harms related to substance use

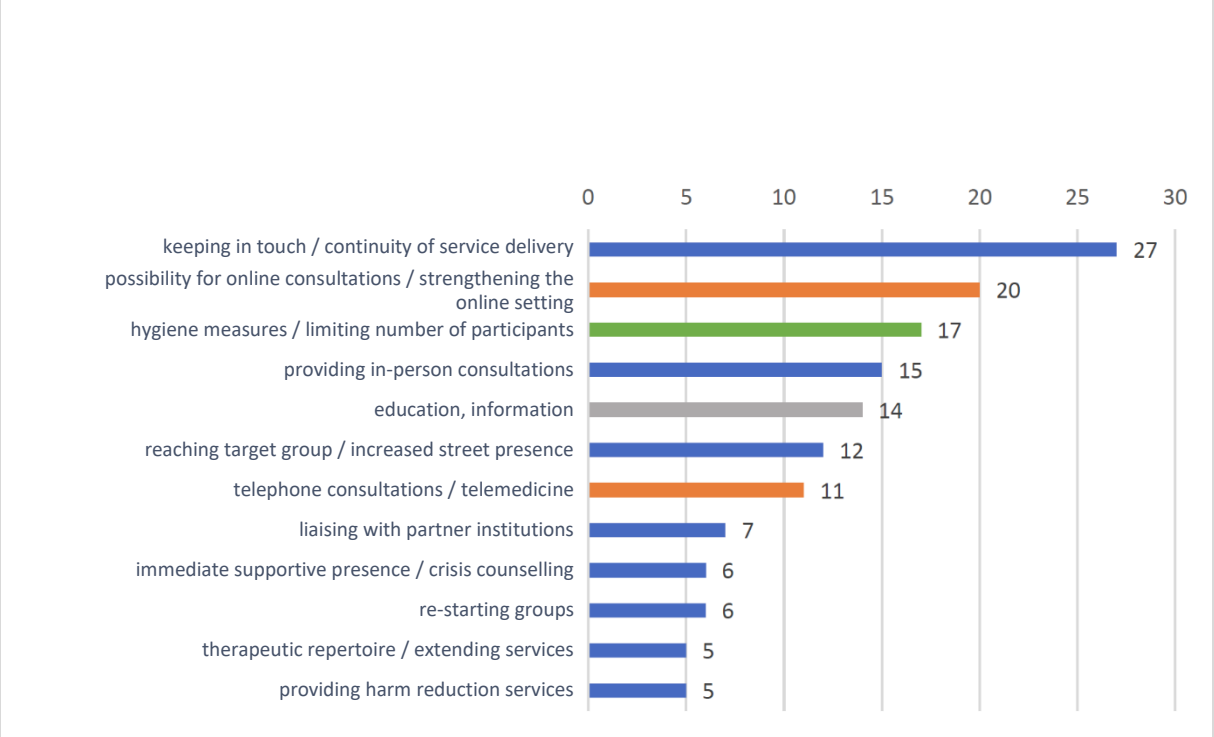
The 61 organisations made 147 mentions of main priorities or measures at the time of the survey (January-February 2021) at their service to prevent or reduce further harms related to substance use during the pandemic.

These mentions can be grouped around three topics. The main priority in this period was ensuring the continuity of service delivery; most service providers were also striving to ensure telemedicine service delivery and compliance with the relevant hygiene and disease control measures.

Ensuring the continuity of service delivery was mentioned in detail regarding the following areas: continuity of contact, staying open, ensuring individual consultations, outreach, liaising with partner institutions, crisis intervention, extending the therapeutic repertoire, re-starting groups, providing harm reduction tools.

Chart 51.

Chart 52. *What are the three main priorities/measures at present (January-February 2021) at your service to prevent/reduce further harms related to substance use during the pandemic?*



Source: HNFP 2021

Keeping in touch / continuity of service delivery / more frequent controls (27 mentions)

maintaining contact / continuous contact with substance users/authorities for the purpose of communication and information in order to ensure the continuity of service delivery and so that nobody's quasi-compulsory treatment would be interrupted	11
ensuring the continuity of service delivery / round-the-clock availability / we ensure the availability of our professionals / staying open around the clock / providing our clients with the continuous possibility of phone consultations, rather than by appointment only / continuous availability	8
possibility for more frequent controls / increased contact / enhanced monitoring of clients, more frequent consultations	8

Possibility of online consultations / stepping up online services / more active participation in social media (20 mentions)

stepping up online services (messenger, face, telephone, meet) / ensuring online availability	10

online individual sessions / consultations / counselling / telemedicine	7
holding groups online	3

Hygiene measures / limitation of the number of participants / protecting the health of carers (17 mentions)

complying with regulations / hygiene measures / disease control measures	7
regular disinfection, wearing masks, airing rooms / ozone disinfection of rooms	3
information about protective measures / calling attention to mandatory mask use	3
limiting the number of participants / physical distancing	2
continuous availability of protective equipment / making equipment (masks, disinfectants, gloves, needles) available to clients	2

Providing in-person consultations (15 mentions)

individual therapy / participation in psychotherapy / increased number of individual consultations	8
providing in-person consultations / maintaining consultation processes both online and offline	6
expanding the possibility of addictology consultation in an individual form	1

Education, information (14 mentions)

education, information / providing information / fast and useful information	8
information about the accessibility of treatment services / calling attention to the importance of early signs related to substance use / information about the pandemic situation and the disease control measures / psychoeducation / we call attention to the importance of screenings / information about possibilities of assistance	6

Reaching / involving the target group / re-starting outreach programmes / increased street presence (12 mentions)

reaching the target group / outreach work / re-starting outreach programmes / involving the target group / building a contact network	8
keeping existing clients / early interventions / building stronger cooperation between street workers and needle and syringe programme clients	4

Telephone consultations / telemedicine (11 mentions)

ensuring the possibility for telephone consultations / more frequent and closer telephone contact	10
ensuring the possibility for requesting information and for brief interventions via telephone	1

Liaising with partner institutions / enabling residential treatment (7 mentions)

liaising with partner institutions: with existing rehabilitation departments, enabling residential drug treatment	4
more frequent telephone consultation with specialists and psychologists / stronger cooperation with nursery and school social workers	2
it is extremely important to keep in touch with and inform authorities to enable continuous service delivery / continuity of quasi-compulsory treatment	1

Immediate supportive presence / crisis counselling (6 mentions)

crisis counselling / immediate supportive presence in a crisis / crisis intervention at the emergency department	4
strengthening outpatient care instead of hospital care	1
treating drug-induced psychoses	1

Re-starting groups / small-group meetings in person (6 mentions)

continued group sessions based on the relevant measures / small-group meetings in person	3
holding groups online	2
re-starting groups	1

Therapeutic repertoire / extending services (5 mentions)

creativity in shaping therapy programmes / adapting therapy programmes to the present circumstances / expanding therapeutic repertoire / expanding services according to client needs	4
increasing the number of supervisions and case discussions for colleagues	1

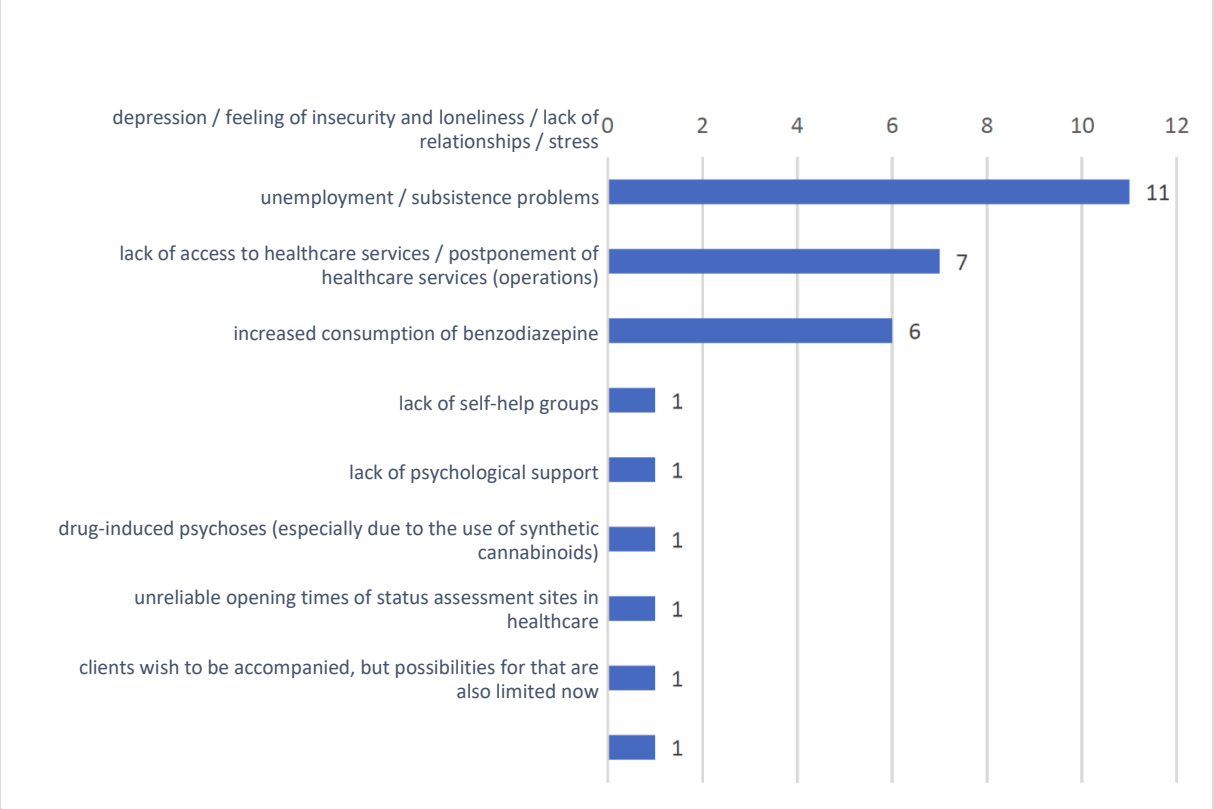
Providing harm reduction tools / continuous availability of all necessary tools (5 mentions)

providing harm reduction tools / needle and condom machines must be operating / making needle and syringe exchange available	4
HIV/HCV testing	1

Problems and harms experienced among substance users and from a public health perspective during the second wave of the pandemic

In the survey, 28 organisations gave their opinions about what problems they observed among substance users during the second wave of the pandemic. They said that the three main problems for substance users were the *mental, psychological effects of the pandemic* (depression, insecurity and loneliness, lack of human relationships, stress, isolation, reduced recreational opportunities), difficulties related to their *socio-economic situation* resulting from the pandemic (unemployment, lack of employment opportunities, problems of subsistence) and *access to health care services* (overburdened health care system, difficulty of getting into rehabilitation institutions and addiction departments).

Chart 53. *At present (January-February 2021) is there a harm or problem among substance users you would highlight? (number of mentions)*



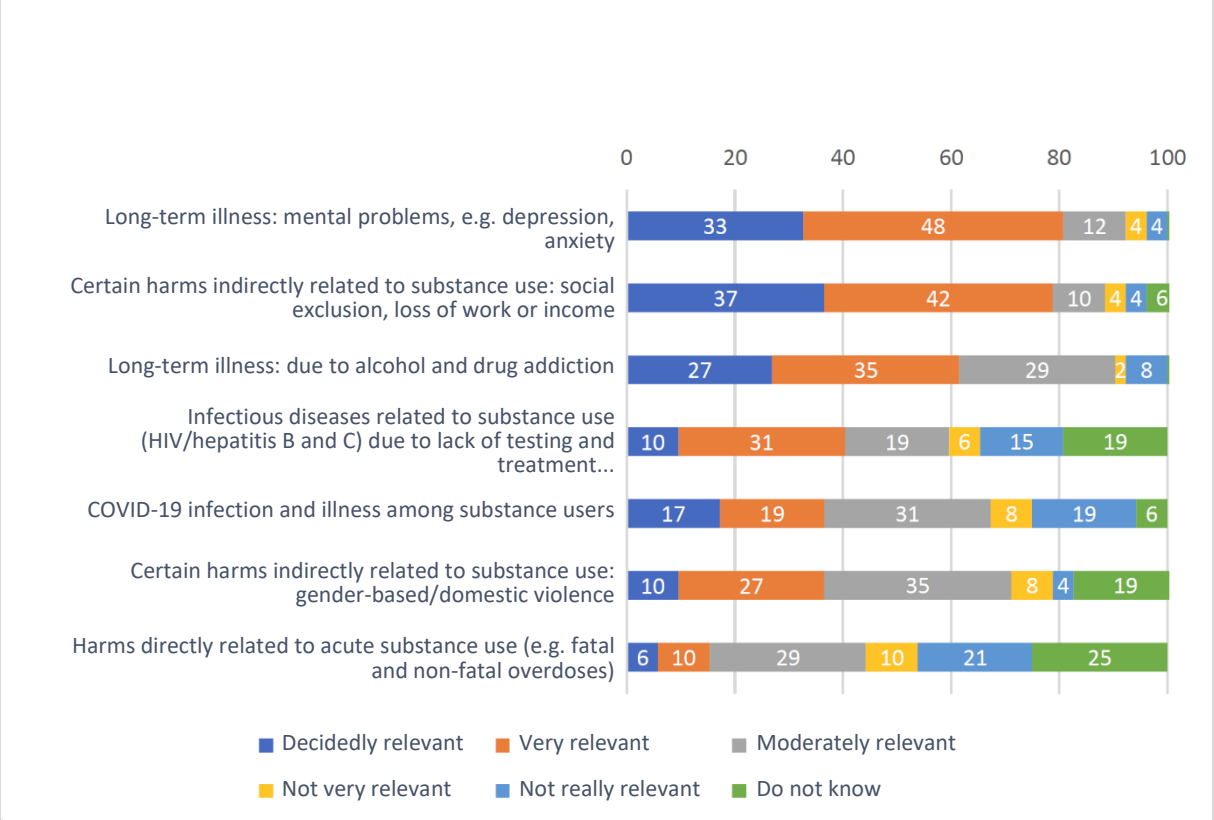
Source: HNFP 2021

In line with the previous results, service providers considered the possible long-term consequences to be the most acute problems from a public health perspective, such as mental problems, the socio-economic negative effects of the pandemic, and to a lesser extent, diseases resulting from alcohol and drug addiction.

By contrast, short-term effects and effects directly linked to the pandemic were considered less relevant at the beginning of 2021, such as harms related to acute substance use. The respondents were divided regarding three other possible effects – a similar number said that they were currently relevant and that they were not:

- infectious diseases related to substance use (HIV/hepatitis B and C) due to lack of testing and treatment
- COVID-19 infection and illness among substance users
- gender-based/domestic violence indirectly related to substance use

Chart 54. *What do you think are the relevant problems from a public health perspective at present (January-February 2021)? (%, basis: full sample, N=61)*



Source: HNFP 2021

T5. Sources and methodology

T5.1 Sources

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T6.2 METHODOLOGY

Felvinczi et al. 2017; Paksi et al. 2018 – The content and effectiveness of preventive-consulting services (PCS) provided as an alternative to criminal procedure

The aim of the study was to investigate the content and direct effects of preventive-consulting service (PCS) programmes (a type of treatment serving as an alternative to criminal procedure), as well as a structured description of PCS and the characteristics of their clients. The study also aimed to investigate the compliance of PCS with the relevant professional guidelines (with the methodological letter published in 2011), and to analyse the effectiveness and direct effects of the interventions. The selection of service providers was based on the 2015 and 2016 client numbers of the National Office for Rehabilitation and Social Affairs (NRSZH). A total of 16 service providers met the eligibility criteria (service providers with at least 100 clients in their PCS programme whether in 2015 or 2016 and still running a PCS programme at the time of the study) and agreed to participate in the study. Of the 16 organisations involved in the study, 6 primarily specialised in PCS and other preventive interventions, while the other 10 also provided services other than PCS or preventive interventions. Organisations and programmes were studied by means of semi-structured interviews with staff and by completing a programme information form. Enquiries aimed at describing service providers and their operations took place in 2016-2017.

In the first phase of the study, pre-data (baseline data) were recorded among the clients of the 19 PCS programmes provided by the 16 organisations participating in the study. In the second phase of the study, 13 of the 16 organisations previously involved agreed to participate. Those organisations operated a total of 14 PCS programmes; post-data were collected among the clients of those programmes. Both pre-data and post-data were collected by means of questionnaires, mainly self-filled. The pre-survey – which took place between November 2016 and May 2017 – had a net sample size of 708 persons, and the post-survey – which took place between May 2017 and November 2018 – had a net sample size of 420 persons. Both the pre-data and post-data collection questionnaires included questions that mapped the general final objectives of the PCS programmes as defined in the methodological letter, as well as the specific objectives identified in the programme information forms and in the interviews with staff. In addition, the pre-questionnaire included questions about clients' socio-demographic characteristics, and the post-questionnaire included indicators of liking.

HNFP 2021 – Substance use and treatment during the COVID-19 pandemic in Hungary until February 2021 – experiences of the second wave:
In order to obtain feedback as quickly as possible on the situation of treatment facilities, substance use, availability of the various forms of treatment and providers' experiences, the Hungarian National Focal Point launched an online cross-sectional survey among service providers in spring 2020. Another survey in the first months of 2021 studied the effects of the second wave of the pandemic on substance use and care. The questionnaire was based on a survey sent to Member States as part of the trendspotter study on COVID-19 and drugs by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), which was adapted to the local situation and posted on the questionpro online survey portal. The survey was targeted at treatment and care providers dealing with addicts, especially drug users, in the healthcare and social fields; the service providers were asked to complete one questionnaire per treatment facility. The questions on the questionnaire were designed to provide insight into changes in and availability of the services provided to substance users, trends in demand for them, the patterns of substance use observed among clients, risk behaviours, harms and the experiences of service providers operating during the crisis. Recruitment took place in several ways. We contacted outpatient and inpatient health care providers, social care providers and QCT units involved in the routine data collection of the Hungarian National Focal Point by direct e-mail, and also drew attention to the study through the Hungarian National Focal Point's website. Service providers could complete the questionnaire between 27 January and 3 February 2021. A total of 61 respondents filled in the questionnaire during this period.

Péterfi 2021a – TDI data 2021
The TDI (Treatment Demand Indicator) data collection was coordinated by the National Centre for Addictions until April 2017, and the data were processed and analysed by the Hungarian National Focal Point. Since April 2017 the professional coordination of the data collection has been carried out by the Hungarian National Focal Point, and the maintenance by the National Public Health Centre. On the basis of Ministry of Health, Social and Family Affairs decree 76/2004. (VIII. 19.), Hungarian service providers must report every drug user who enters treatment to the TDI. The data collection questionnaire was developed in line with the guidelines of the TDI 2.0 protocol (EMCDDA 2000). The data is collected using anonymous identifiers, so duplication can be controlled in the annual statistics – in other words one person appears just once in the national data per year. In the report the category of "clients starting treatment as an alternative to criminal procedure" (or "quasi compulsory treatment" - QCT) refers to those who reported to be referred to treatment by "court/probation/police". Annual case numbers may differ from the annual TDI case numbers reported in the previous National Reports/Workbooks, as the raw data was retrieved at a different time, allowing data recorders to modify their institution's data following annual data exports. Control for double counting was performed on the basis of calendar year; therefore each client appears in each year's data up to one time, while the same client may appear in the database in different years. Data was

processed by SPSS, by the application of descriptive statistics. In 2020, a total of 78 providers reported data to TDI.

Péterfi 2021b - OST data collection 2021
The OST data collection was coordinated by the National Centre for Addictions until 2016. Since 2019 the data collection is carried out by the REITOX Hungarian National Focal Point. Reporting the data is voluntary. In 2021 9 out of the 11 substitution treatment centres identified in the country provided data, providing 82% coverage for treatment centres and an estimated 85% coverage for the clients. Data is recorded monthly by the service providers through face-to-face interviews with clients. Each client is listed in the database only once (based on the last report for that year).

HARMS AND HARM REDUCTION[111]

T0. SUMMARY

Overview of drug-related harms

With respect to drug-related deaths, over the past 10 years in Hungary there have been some 20–30 deaths per year directly related to overdoses. Prior to 2010, the annual change in the number of deaths was mainly due to the changing purity of street heroin. With the drastic decrease in heroin availability in 2010, the number of deaths associated with the drug also declined. That downward trend was counterbalanced in 2012 and 2013 by an increase in the number of deaths associated with new psychoactive substances. Overall, the shift in the structure did not cause a change in the number of deaths between 2015 and 2019, with around 35-43 deaths per year. In 2020, there were slightly more cases (48) of fatal intoxication and it is a worrying phenomenon that the majority of the intoxication cases involve some form of designer drugs. The role of synthetic cannabinoid derivatives is significant in particular; in 2020, 34 cases included at least one synthetic cannabionoid (4F-MDMB-BICA, 5F-MDMB-PICA, MDMB-4en-PINACA). Among synthetic cathinoes etil-hexedrone and etil-heptedrone were identified in the fatal overdoses. In 2020, the cannabinoid 4F-MDMB-BICA was involved in at least 27 fatal drug-related intoxication cases. However, in cases where several substances are combined, the role of each substance in the cause of death is difficult to determine.

No detailed statistical data are available on provision of clinical toxicology treatment. Anecdotal information refers to high treatment demand related to the use of synthetic cannabinoids in both 2019 and 2020.

In the case of drug-related infectious diseases, in the national HIV/HBV/HCV seroprevalence survey carried out since 2006, cases of HIV infection were identified for the first time among the tested people who inject drugs (PWID) in 2014 (2 persons, 0.3%). In 2015 and in 2018, 1 person tested positive for HIV in each year (0.2% in each year). In 2019, during a regional survey, 3 persons tested positive for HIV (3%).
The national HCV prevalence rate among PWID was around 25% until 2011; however, the figure in 2014 was 48.7%, which is twice the national HCV prevalence value measured in the previous years. Research results show that doubling of the HCV prevalence can largely be attributed to the dynamic increase in high-risk NPS injecting and a decrease in the availability of needle and syringe programmes (NSP) during the period in question. In 2015, a similar proportion (49.7%) of the national sample tested positive for HCV as in 2014; however, trend analysis should take the termination of the two main testing sites (NSPs) between these years into careful consideration (see T1.3.). The 2018 national biobehavioural survey found a HCV prevalence of 43.5% among PWID. Due to a different methodology and increasingly more difficult access to the target population, the study failed to involve a PWID population with a similar composition to in previous years, so the data cannot be compared to prevalence rates measured in previous years (see T1.3 for a detailed explanation). In 2019, in a regional survey (with a focus on Budapest) among PWID, 48% of the sample tested positive for HCV.

Overview of harm reduction services

In the field of responses, the number of syringes distributed by NSPs rose sharply in 2011 as compared to previous years, the cause of which was the spread of NPS starting in 2010 since these substances are injected much more frequently than established illicit drugs. The upward trend lasting until 2011 was halted in 2012 by a decrease in resources; the organisations distributed around 220,000 fewer syringes in that year despite the increasing demand for

[111] Authors of the workbook: Gergely Csaba Horváth, Anna Tarján, Lilla Szabics and Zsófia Almádi

syringes due to the new patterns of use. Although, as a result of one-time ministry funding, the number of distributed syringes increased in the period until 2014, the number was still well below the 2011 figure. Contrary to the change in the number of distributed syringes, the number of clients attending NSPs and the number of contacts rose steeply after 2012.
Due to the closure of the two largest NSPs in Hungary, there was a further significant decrease in syringe and client numbers in 2015 at the national level. The downward trend between 2016 and 2019 continued, albeit to a more moderate degree; that decrease may be attributed to the closure of further programmes, capacity problems at Budapest-based NSPs, as well as to changing patterns of use among PWID (more hidden injecting drug use due to increased presence of the police, increased synthetic cannabinoid use (smoking) and increased inhaling (foil) of injectable substances.)
While in 2011 nearly 650,000 syringes were distributed, in 2020 the figure was 43,244. The number of clients dropped from 4624 in 2013 to 567 in 2019.
Based on 2018 and 2019 research results, purchasing syringes at pharmacies has become more prevalent among PWID.

T1. NATIONAL PROFILE

T1.1 DRUG-RELATED DEATHS

T1.1.1 Overdose deaths

Direct drug-related deaths

In 2020, 48 deaths directly related to drug use were reported to the Special Registry of Drug-Related Deaths, representing an increase compared to previous years (2019: 43; 2018: 33; 2017: 33;).[112] Of the 48 deaths, in 1 case the deceased was female and in 34 cases the deceased was male.

Table 18. *Breakdown of direct drug-related deaths in 2020 by gender and substance type (persons)*

	male	female	total
intoxication caused by opioids and other substances[113]	5	0	5
intoxication caused by other, non-opioid drugs or new psychoactive substances	42	1	43
unknown/unidentified substance	0	0	0
total	47	1	48

Source: HNFP 2021a

Among fatal overdose cases, the mean age of males was 30.5 years ; for both groups together the mean age was 30.3 years. The mean age in the case of deaths linked to opioids was 39.2 years, while the mean age in non-opioid cases was 29 years. Because of the increasing role of novel psychoactive substances in the deaths the mean age shows a tendency of decrease over the years.

[112] Cases linked to tramadol were excluded.
[113] In 2020 in the two cases the deaths were related to methadon use.

Table 19. *Breakdown of direct drug-related deaths by age group and substance type in 2020 (persons; N=48)*

	>15	15-19	20-24	25-29	30-34	35-39	40-44	45-65	>=65	total
overdose/intoxication caused by heroine/morphine (not including methadone and other substances)						1				0
overdose/intoxication caused by opioids and other substances[114]			1			1	1			3
overdose/intoxication caused by methadone							1	1		2
intoxication caused by other, non-opioid drugs[115]		1		2	1	2	1	4		7
intoxication caused by other substances[116]		2	7	12	6	5	2	1		36
total	**0**	**0**	**5**	**10**	**7**	**8**	**7**	**6**		**48**

Source: HNFP 2021a

Of the 48 deaths, 12 of the deceased (25%) were residents of Budapest. In six cases the deceased were homeless people; in eight cases the deceased were willagers, in two cases they were from larger villages and in 11 cases they lived in towns; no foreigner was reported among the deaths.

Indirect drug-related deaths

In 2020, 35 indirect drug-related deaths were reported to the Special Registry of Drug-Related Deaths. Among the deceased, 33 (94.2%) were male and 2 (5.8%) were female.
In 5 of these cases the drug users were victims of murder, in 7 cases a suicide occurred, and in the other cases, some (mainly traffic) accidents occurred.

T1.1.2 Toxicology of overdose deaths

There were no deaths exclusively related to heroin use in 2020 either. The polydrug use of an opioid and other illicit drugs was fatal in 3 cases (together with cathinones or herbal cannabis). Other non-opioid drugs caused intoxication in 7 cases (in 2019: 18). In this category, the most prevalent drugs were amphetamines (6 cases), ecstasy (2 cases) and cocaine (4 cases).

Among the direct deaths, there were 36 deaths related to the consumption of a new psychoactive substance. Deaths were typically associated with polydrug use. Synthetic cannabinoids (4F-MDMB-BICA, 5F-MDMB-PICA, MDMB-4en-PINACA) were identified in 34 cases and cathinones (ethyl-heptedrone and ethyl-hexedrone) in 7 cases. Alcohol consumption may have played a role in 18 cases, and benzodiazepine consumption in 2 cases. In cases related to synthetic cannabinoids, two such substances usually appeared in the

[114] In all three cases in 2020, in addition to heroin / morphine, additional opiates were detected (tramadol, home made opiate, codeine, 6-MAM) without the involvement of other “non-opiate” drugs.
[115] Including new psychoactive substances legally classified as narcotic drugs (psychotropic substances) according to the national law.
[116] Including substances legally classified as ’new psychoactive substances’ according to the national law.

samples at the same time, and it can be said that drugs or other substances were present in low numbers.

Table 20. *Number of direct drug-related deaths in 2020*[117]

	total
overdose/intoxication caused by heroin/morphine (not including methadone and other substances)	0
overdose/intoxication caused by opioids and other substances[118]	3
overdose/intoxication caused by methadone[119]	2
intoxication caused by other, non-opioid drugs[120]	7
intoxication caused by other substances[121]	36
total	48

Source: HNFP 2021a

T1.1.4 Trends in drug-related deaths

Regarding drug-related deaths, there have been around 25-35 direct overdose deaths per year in Hungary in the last 10 years. Prior to 2010, the annual change in the number of deaths was mainly due to the changing purity of street heroin. With the drastic decrease in heroin availability in 2010, the number of deaths associated with the drug also declined. That downward trend was counterbalanced in 2012 and 2013 by an increase in the number of deaths associated with new psychoactive substances. Overall, the shift in the structure did not cause a change in the number of deaths between 2015 and 2019, with around 35-43 deaths per year. In 2020, there were slightly more cases (48) of fatal intoxication and it is a worrying phenomenon that the majority of the intoxication cases involve some form of designer drugs. In particular, synthetic cannabinoid derivatives played a significant role. In 2020, 34 cases included at least one synthetic cannabionoid (4F-MDMB-BICA, 5F-MDMB-PICA, MDMB-4en-PINACA). Among synthetic cathinoes etil-hexedrone and etil-heptedrone were identified in the fatal overdoses. Among synthetic cathinones ethyl-heptedrone and ethyl-hexedrone appeared in the fatal intoxications.
In 2020, the cannabinoid 4F-MDMB-BICA was present in at least 20 fatal drug-related intoxication cases. However, in cases where several substances are combined, the role of each substance in the cause of death is difficult to determine.
Although the trends can only be extrapolated to a limited degree due to the low number of cases in Hungary, the European decrease in the mean age of the deceased also found as opioid use of the older user population is less and less responsible for the mortality.The increase in the number of deaths among women are not demonstrated by our national data.

Since 2012, the use of new psychoactive substances can also be seen in the biological samples of the diseased. Initially mephedrone, and then later MDPV, pentedrone and 4-MEC were associated with a number of deaths. Occasionally, the appearance of certain, especially dangerous new psychoactive substances was linked to several deaths: in 2012 the use of 5-API, and in 2013 the use of 4,4′-dimethylaminorex (4,4'-DMAR) caused the death of several people. In 2014, no especially dangerous NPS appeared that could have caused the deaths of several people; typically α-PVP and synthetic cannabinoids were detected. In 2015, in addition to pentedrone and α-PVP, there were several occurrences of α-PHP in biological samples; synthetic cannabinoids were not detected in that year. In 2016 ethyl-hexedrone was the most prevalent novel substance in biological samples; after 2018 ethyl-hexedrone was still

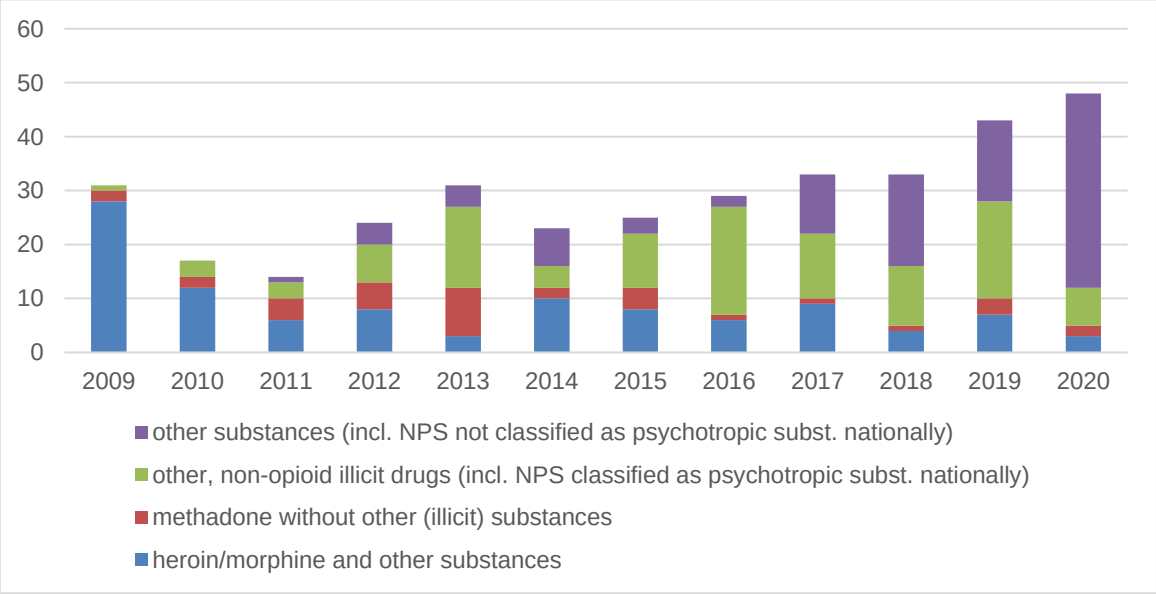
[117] Special Register Selection D.
[118] In all three cases in 2020, in addition to heroin / morphine, additional opiates were detected (tramadol, home made opiate, codeine, 6-MAM) without the involvement of other "non-opiate" drugs.
[119] Alongside the occurrence of alcohol and/or benzodiazepines.
[120] Including new psychoactive substances legally classified as narcotic drugs (psychotropic substances) according to the national law.
[121] Including substances legally classified as 'new psychoactive substances' according to the national law.

the most prevalent cathinone but the relevance of cathinones decreased in general. From 2018, synthetic cannabinoids have often been found in the samples of the deceased, previously typically AB-FUBINACA and CUMYL-MEGACLONE, in 2019 5F-MDMB-PINACA and 5F-MDMB-PICA and in 2020 4F-MDMB-BICA and MDMB-4en-PINACA became dominant.

The role of NPS in the cause of death could not be clearly determined due to poly drug use and limited pharmacological knowledge. The patterns of use of the deceased include injecting use and polydrug uses and alcohol played a role in many cases as well. Role of injecting drug use show some decrease too.

Overall, the decreasing tendency explained by the drop in heroin use after 2011 was counterbalanced by a rise in the number of deaths linked to new psychoactive substances in 2012 and 2013. In 2014 the number of deaths related to opioids – primarily heroin – rose slightly. In 2016, a significant increase could be observed in the number of deaths linked to other, non-opioid substances (including new psychoactive substances classified as illicit psychotropic substances). After 2017, new psychoactive substances not classified as psychotropic drugs played a dominant role in the fatalities; that is explained initially by the steady involvement of ethyl-hexedrone in intoxication cases and after 2018 by the growing prevalence of synthetic cathinones.

Chart 55. Breakdown of direct drug-related deaths, between 2009 and 2020 (persons)



HNFP 2021a

T1.2 DRUG-RELATED ACUTE EMERGENCIES

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

Concerning drug-related emergency cases reported by harm reduction services in nightlife settings, see section T1.5.3 of this workbook.

T1.3 DRUG-RELATED INFECTIOUS DISEASES

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

Notifications

In 2020 a total of 201 newly diagnosed HIV-positive cases were reported in Hungary; the incidence rate was 20 cases/1 million population. The transmission route was known in the case of nearly 77% of the registered HIV-positive persons. Among the HIV-positive persons belonging to the identified risk groups, one person belonged to the risk group of PWID. (written communication, Dudás 2021)

Table 21. *Breakdown of newly registered HIV-positive persons (N) by risk group between 2013 and 2020*

	2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
homosexual/bisexual	160	171	133	117	110	145	167	**127**
heterosexual	24	28	21	28	22	13	28	**26**
haemophiliac	0	0	0	0	0	0	0	**0**
transfusion cases	0	0	0	0	0	0	0	**0**
PWID	1*	1	2	3	1*	1*	1	**1**
nosocomial	0	0	0	0	0	0	0	**0**
perinatal	1	1	2	1	2	0	0	**0**
unknown	54	70	113	79	88	70	42	**47**
total	240	271	271	228	223	229	238	**201**

** Imported cases*
Source: National Centre for Public Health, Department of Epidemiology and Vaccination Surveillance (Dudás 2021)

In 2020, 14 cases of acute hepatitis B were reported; the incidence rate was 0.1%ooo. The transmission route was known in the case of 1 patients, none of whom belonged to the risk group of PWID.

In 2020, 5 cases of acute hepatitis C were reported; the incidence rate was 0.05%ooo. The transmission route for the five patients was not known (written communication, Dudás 2021)

HIV/HBV/HCV prevalence among PWID

The results of the national HIV/HBV/HCV seroprevalence survey coordinated by the former National Centre for Epidemiology (OEK) from 2006 to 2015 are summarised under Trends.

Of the 440 PWID tested in the national HIV/HCV biobehavioural survey conducted by the Hungarian National Focal Point (HNFP) and the National Centre for Public Health (NNK) in 2018[122] (Tarján et al. 2019), 332 (75.5%) were male and 108 (24.5%) were female. Among the three age groups (<25, 25-34, 34<) the age group above 34 represented 47% of the study participants and the 25-34 age group represented 33% of the study participants, while the smallest group (20%) was composed of participants aged below 25 years. For patterns of use, see Drugs/Stimulants/T1.2.5 and Drugs/Heroin and other opioids/T1.2.5.
In 2019, the study was repeated only in Budapest and Kecskemét at 5 needle and syringe programmes, with participation of 102 PWID (Tarján et al. 2020). 16% of the sample were female. Of the three age groups (<25, 25-34, 34 <), those over 34 years of age accounted for 50% of the study participants and those between 25-34 years of age accounted for 37% of the study participants, while persons under 25 years of age formed the smallest age group (14%). For patterns of use, see Drugs/Stimulants/T1.2.5 and Drugs/Heroin and other opioids/T1.2.5.

HIV

On the basis of the HIV/HBV/HCV seroprevalence survey in 2018, one male out of the 439[123] persons tested HIV positive (0.2%), he belonged to the age group above 34. He had last injected within the past four weeks prior to the survey and self-reported being HIV negative in the questionnaire.
In 2019, during the regional HIV/HCV survey, 3 persons tested positive for HIV (3%). (ST9P2_2020_HU_02)

HBV

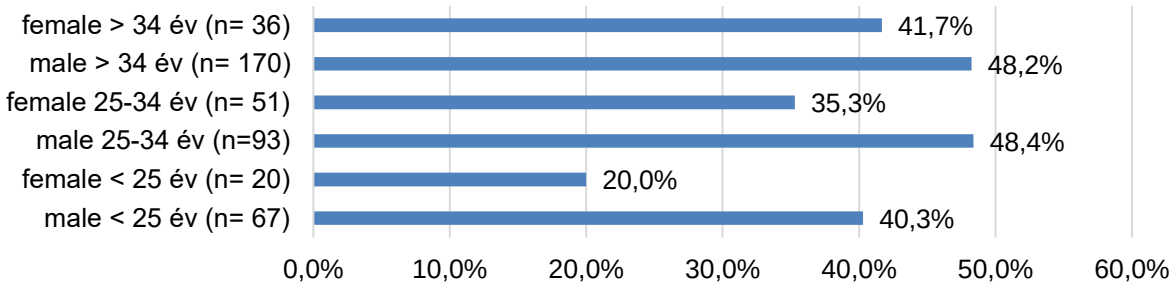
HBV testing was not included in the 2018 and 2019 biobehavioural surveys.
During the national HIV/HBV/HCV prevalence survey conducted in 2015, 13 persons (2.2%) tested positive for the hepatitis B surface antigen among 596 tested PWID. 12 of the 13 HBV-positive persons were also HCV antibody positive at the same time. (ST9P2_2016_HU_02)

HCV

2018 national data

191 PWID (44%)124 tested positive for HCV antibodies. (ST9P2_2019_HU_01). The difference between the prevalence rates of HCV infection among males and females (47% and 34% respectively) was significant. The HCV prevalence rates of males in the 25-34 age group and above the age of 34 were above the average prevalence rate. In addition, it should be noted that the HCV prevalence among young male PWID below the age of 25 was 40%.

Chart 56. *Breakdown of HCV prevalence (%) among PWID tested during the national HNFP-NNK HIV/HCV biobehavioural survey, by gender and age group in 2018*



Source: Tarján et al. 2019

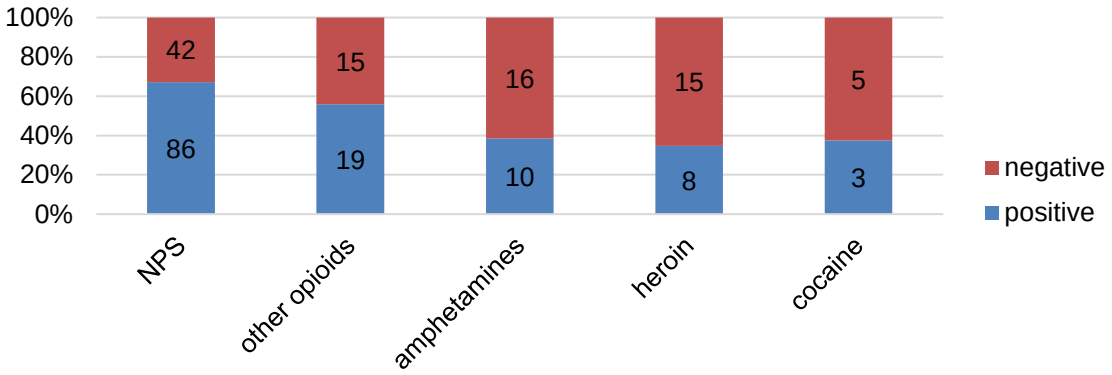
HCV prevalence rates above the national average were measured among those injecting for 5-9 years (52%) and those injecting for more than 9 years (50%). The prevalence of HCV among those injecting for less than 2 years was 29%, and 31% among those injecting for 2-4 years.

The HCV prevalence rate among those injecting stimulants primarily[125] (300 persons) was 47%, while it was 34% among PWID injecting opioids primarily (110 persons). (ST9P2_2019_HU_01)

[123] In the case of 1 person out of the total sample (440), the HIV test result was missing.
[124] In the case of 1 person of the total sample (440 persons), the HCV test result was missing.
[125] synthetic cathinones (street names grouped here: “crystal”; “chalk”, “music”); methamphetamine (street names grouped here: “Slovakian pikoló”), amphetamine, ecstasy, cocaine, GHB.

Among current PWID injecting in the last 4 weeks prior to the survey (220 PWID), 58% (127 persons) tested positive for hepatitis C antibodies. The rate of HCV infection was the highest – similarly to in previous years – among those injecting NPS primarily (67%), followed by the group injecting other opioids primarily (56%).

Chart 57. *Breakdown of HCV prevalence among current PWID tested during the national HNFP-NNK HIV/HCV biobehavioural survey by primary injected drug in 2018*



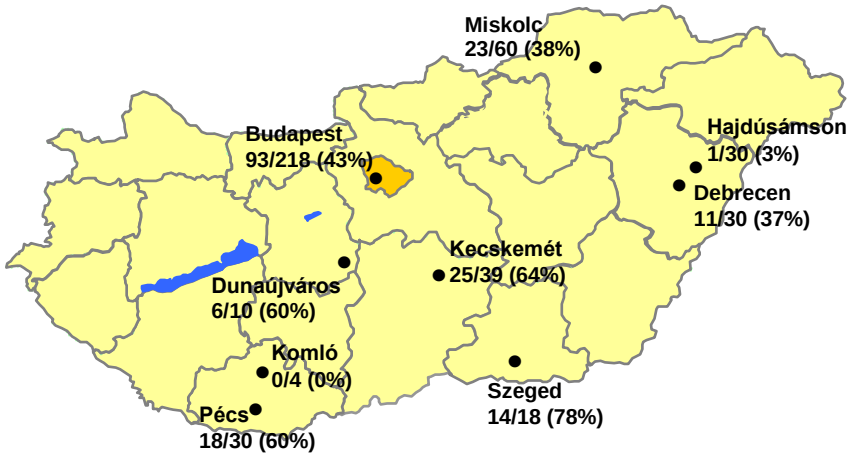
Source: Tarján et al. 2019

For changing patterns of injecting use,[126] see Drugs/Stimulants/T1.2.5 and Drugs/Heroin and other opioids/T1.2.5; for risk behaviours see below in this workbook.

With respect to geographical breakdown, 93 of the 218 samples from Budapest were found to be hepatitis C positive, corresponding to a 42.7% rate of infection (ST P2_2019_HU_03). Among the samples coming from outside of Budapest, 44.3% were tested hepatitis C positive (98/221 samples) (ST9P2_2019_HU_04). Outside of Budapest, the highest HCV prevalence rates were measured in Szeged (78%) and Kecskemét (64%).

[126] Since 2015, an increasing number of former PWID have shifted to inhaling (foil) cathinones instead of injecting them or to smoking synthetic cannabinoids periodically or permanently instead of injecting cathinones. In addition, a 2016 syringe residue analysis project identified the presence of methadone in syringes at a higher rate than measured in our other data sources.

1. Map Number of HCV tests and HCV prevalence among PWID in the HNFP-NNK national HIV/HCV biobehavioural survey by city, 2018[127]



Source: Tarján et al. 2019

According to the 2019 regional, HIV/HCV biobehvioural study antibody prevalence was 48% among the tested PWID (49 out of 102). Further data available in the 2020 National Report Harms and Harm reduction Workbooks / subchapter T1.3.1.

Trends: HIV/HCV prevalence among PWID

HIV

During the national HIV/HCV seroprevalence survey series carried out among PWID since 2006, it was in 2014 for the first time that there were positive test results for HIV (2 persons; 0.3%), while in each of 2015 and 2018 one person tested positive (0.2% in both of the years).

HCV

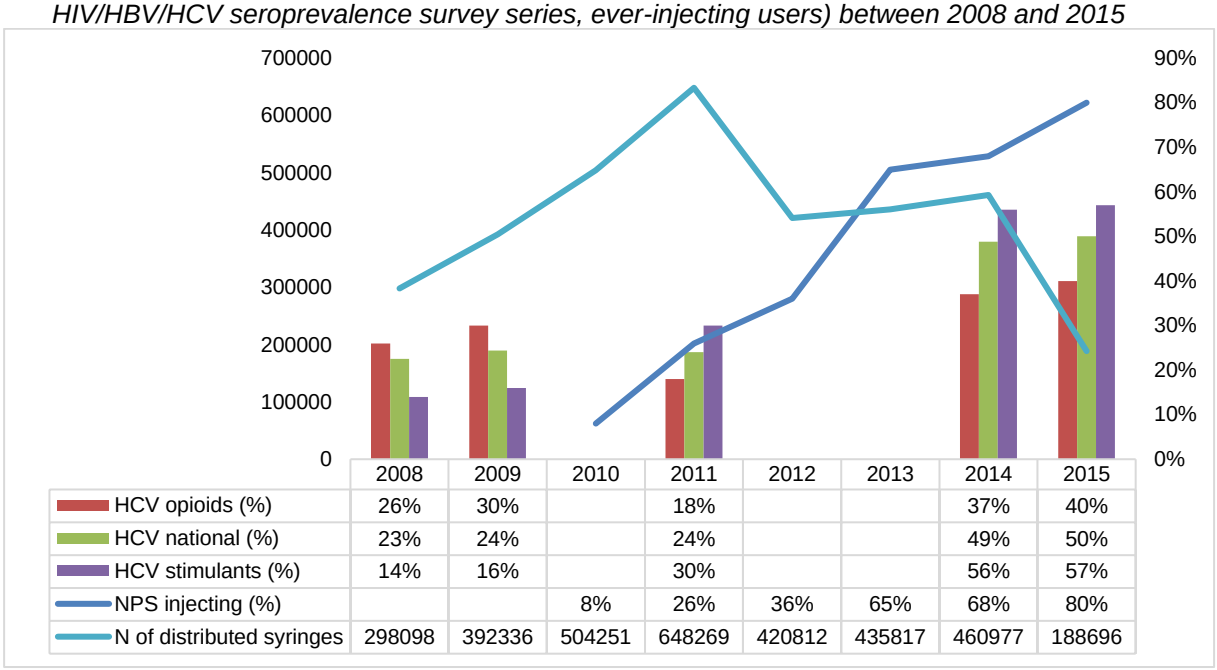
2006-2011:
With respect to primary injected substances, a restructuring has been observed since 2010 among PWID: the proportion of those injecting stimulants, primarily NPS, has risen from year to year. (For further data on injecting patterns, see Drugs/Stimulants/T1.2.5.) According to the national HIV/HBV/HCV seroprevalence survey data, before 2011 the proportion of opioid injectors was higher in the sample than that of stimulant injectors (see Drugs/Stimulants/T1.2.5 in the 2018 National Report), and the prevalence of HCV was consistently higher in the group of opioid injectors. The situation, however, reversed: in 2011, at 30% the HCV prevalence rate was significantly higher among those injecting stimulants primarily. As the national HCV prevalence rate did not change significantly in 2011, the restructuring of the HCV prevalence rates by substance types is probably a consequence of new patterns of use, namely PWID switching from opioid injecting to injecting amphetamine or NPS (For more information on

[127] In the case of Hajdúsámson, the service is based in Hajdúsámson, but 21 of the 30 tests were performed in Hajdúhadház and 9 were performed in Hajdúsámson.

changing patterns see chapters 4.3 and 4.4 of the 2012 National Report and chapter 4.3 of the 2011 National Report.)

2011-2015:
In 2014 the proportion of stimulant injectors – more specifically injectors of designer stimulants (synthetic cathinones) – further increased in the sample, just as in the PWID population (on the basis of national NSP data). By 2014 two-thirds of the sample were primary stimulant injectors (see also: Drugs/Stimulants/T1.2.5.). With respect to HCV infection, it can be noted that HCV prevalence doubled both among opioid injectors and stimulant injectors, just as it did in the total sample from 24% to 49%. Besides the major increase in injecting of NPS, which are injected more frequently, so sharing and reusing of injecting equipment are also more prevalent, another important factor behind the steep increase in the HCV prevalence rate could be the decreased availability of NSP services since 2012 (see section T1.5.4). In 2015, HCV prevalence at the national level (50%) and by substance type (in stimulant injectors: 57%, in opioid injectors: 40%) was similar to that in 2014. However, comparability of the data is limited in the case of Budapest and thus at the national level due to the closure of the two largest NSPs in the second half of 2014; those were also the 2 largest recruitment sites in the National Centre for Epidemiology (OEK) national HIV/HCV seroprevalence survey series between 2006 and 2014. (For detailed information, see section T1.3.6 of the Harms and Harm Reduction workbook of the 2018 National Report).

Chart 58. *The impact of the spread of NPS injecting (among NSP clients) and the decrease in the number of distributed syringes on HCV prevalence by primary injected drug type (OEK national HIV/HBV/HCV seroprevalence survey series, ever-injecting users) between 2008 and 2015*



	2008	2009	2010	2011	2012	2013	2014	2015
HCV opioids (%)	26%	30%		18%			37%	40%
HCV national (%)	23%	24%		24%			49%	50%
HCV stimulants (%)	14%	16%		30%			56%	57%
NPS injecting (%)			8%	26%	36%	65%	68%	80%
N of distributed syringes	298098	392336	504251	648269	420812	435817	460977	188696

Source: Tarján 2018

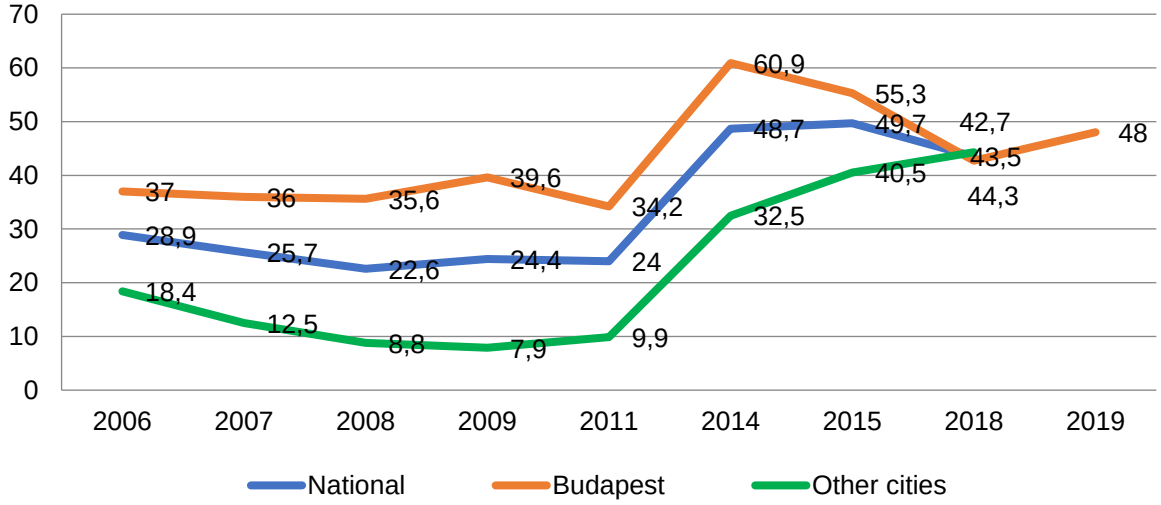
2016-2019:
After 2015, it was not until 2018 that a new national HIV/HCV biobehavioural study could be conducted. (HNFP-NNK national HIV/HCV biobehavioural survey 2018, Tarján et al. 2019; for the methodology, see T5.1); however, only some elements, rather than the entire methodology of the National Centre for Epidemiology (OEK) seroprevalence survey series (2006-2015) could be implemented. Given the different methodological features and circumstances of the study[128] (see also T. 5.1.), it can be concluded that in 2018, the previously reached PWID

[128] Similarities: The questionnaire was nearly identical in the two studies. For recruitment sites, we contacted sites that were included in the 2015 national survey (a list that had already undergone significant changes compared to 2014 due to the closure of the two major NSPs), with the difference that low-threshold services were given priority

population (fully: 2006-2014, partially: 2015) could not be recruited in Budapest so the data are not comparable. Based on research and routine data (Kaló 2018, Fóti and Tarján 2018, Csák et al. 2019), the main reasons for that are: (1) closure of the 2 largest NSPs in 2014; (2.) further weakening of capacity and shorter opening hours at the still operating NPSs after 2015; (3) fewer visits to NSPs by PWID due to the shift to synthetic cannabinoid smoking and inhaling of injectable substances, and increased police presence. In 2019, the HCV prevalence was 48% in Budapest, representing an increase of 5 percentage points compared to the 2018 data for Budapest.

In the cities outside of Budapest, there were no major changes in the case of participating service providers[129]: Although the data collection methodology was different in certain respects[130] between 2015 and 2018 (see T.5.1), the sampling sites were almost the same. HCV prevalence in cities other than Budapest (aggregated data) increased by 4% compared to 2015 (2018: 44.3%).

Chart 59. *HCV prevalence (%) among PWID participating in the national OEK HIV/HCV seroprevalence survey series (2006-2015) and the HNFP-NNK HIV/HCV biobehavioural survey (2018 national and 2019 regional) in Budapest and in cities outside of Budapest, 2006-2019*



Source: Dudás et al. 2015 and Tarján et al. 2019
limited comparability after 2014!

It should be noted – bearing in mind the limited comparability – that HCV prevalence among females was higher between 2008 and 2011. However, between 2011 and 2014, when

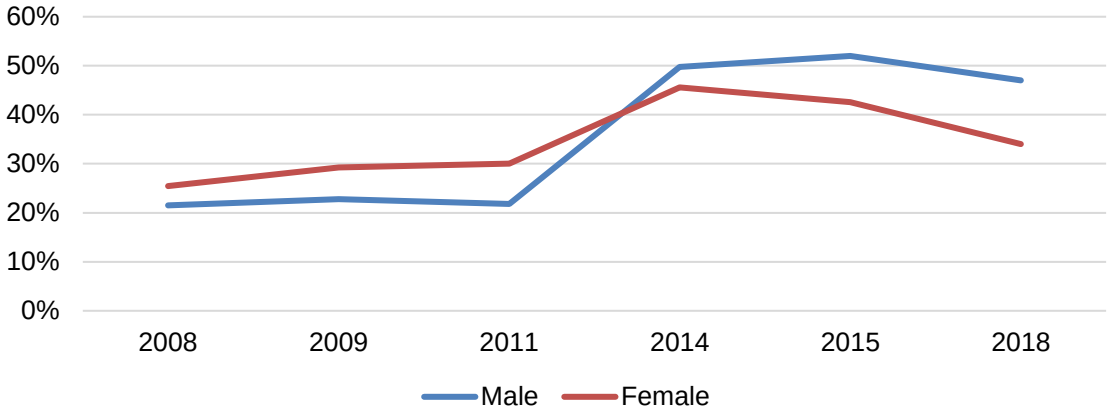
in the selection because of the specific features of the HAREACT project and in order to chiefly reach current PWID. Differences: Participants did not receive incentives (National Centre for Epidemiology (OEK) surveys: meal voucher worth HUF 1000-2000 / EUR 3-6). In 2018, a rapid saliva-based test was used, while between 2006 and 2015, laboratory examination of a dried blood sample (DBS) drawn from the fingertip was performed. The composition of the available organisations changed and the accessibility of the PWID population in Budapest was greatly reduced (see methodology). That is well illustrated by the fact that the study was planned in 2016, but the start was delayed by two years due to institutional changes affecting coordinating institutions. In 2016, Budapest-based organisations committed to collecting a total of 480 samples for half a year, while in the case of organisations outside of Budapest, 120 samples were distributed. Sample sizes per site were proportional to the number of PWID clients in participating organisations in 2016. By the time the study began in 2018, one Budapest-based organisation was no longer available for the project, while the remaining organisations were only able to test below half the number of people they committed to in 2016 due to capacity problems, reduced opening hours and changed patterns of use among PWID (2018: 219 valid questionnaires in Budapest). The interviewer received a fee for each questionnaire, whereas between 2006 and 2015 a fee was only introduced in the last survey year.

[129] Two smaller service providers from 2015 did not participate in 2018, but a new LTS provider joined. In 2018, service providers outside of Budapest recruited a total of 221 PWID instead of the sample size of 120 planned for them in 2016.

[130] an incentive was not provided. The presence of HCV antibodies was determined by a rapid saliva test.

significant HCV transmission in the population took place, HCV prevalence rates by gender were reversed and since then the HCV prevalence has been found to be higher among males.

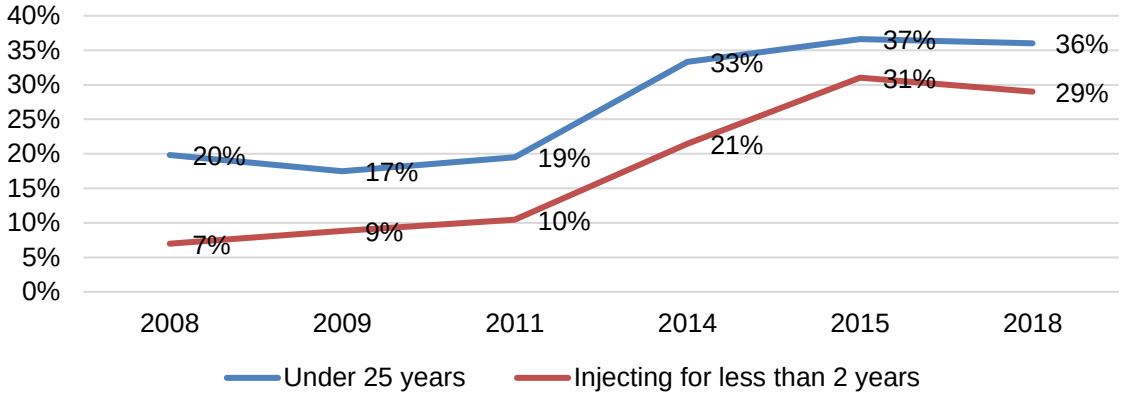
Chart 60. *HCV prevalence (%) among PWID participating in the national OEK HIV/HCV seroprevalence survey series (2006-2015) and the HNFP-NNK HIV/HCV biobehavioural survey (2018) by gender, 2008-2018*



Source: Dudás et al. 2015 and Tarján et al. 2019
limited comparability after 2014

In summary, following the dynamic HCV transmission between 2011 and 2014, comparable prevalence data are not available for Budapest, while a further slow increase was observed in the case of cities outside of Budapest. The 2010-2015 dominance of NPS injecting associated with frequent injecting episodes seems to have eased since 2015, in parallel with a shift towards inhaling (foil) and towards synthetic cannabinoid smoking. That suggests less injecting and that HCV transmission has probably slowed down in the population; however no reliably comparable data are available, particularly in the capital, where a constantly narrowing population can be studied via service providers due to the decreasing number of services and the lower geographical coverage and/or lower capacity of the services still in operation (see T1.5.3 and T1.5.4). The fact that HCV transmission is still ongoing is backed by the data – used as a proxy indicator for HCV incidence – showing HCV prevalence among young (under 25) and new (less than two years) injecting users. In 2018, HCV prevalence among young PWID was 36%, while it was 29% among those who have been injecting for less than 2 years, which is likely to indicate recent infections. In 2019 these values were 43% and 25% respectively in the regional survey.

Chart 61. *HCV prevalence (%) among young and new PWID participating in the national OEK HIV/HCV seroprevalence survey series (2006-2015) and the HNFP-NNK national HIV/HCV biobehavioural survey (2018), 2008-2018*



Source: Dudás et al. 2015 and Tarján et al. 2019
limited comparability after 2014!

T1.3.3 Prevalence data of drug-related infectious diseases outside of routine monitoring

Results of screenings among inmates and previous sero-behavioral studies (Treso et al. 2011 and Ritter 2013) examining the prevalence of HIV / HBV / HCV and related risk behaviors among inmates with a history of injecting drug use are available in the Prison Workbook / chapters T1 .2.2 and T1.3.3.

This year, for the first time, data were also requested from needle exchange organizations in terms of how many people were screened for HIV and Hepatitis C and how many infected people were identified (Tarján 2021a).
Regarding HIV infection, 464 people were screened by organizations (5 organizations reporting out of 34), 7 of them were positive (1.5%), in case of HCV 360 people took part in screening (6 organizations reported figures among 34 organizations) and 79 people were found positive (22%).

In the 2020 HEPAGO-NFP biobehavioural study in Budapest (Tarján et al. 2021, see Methodology: Health Consequences and Harm Reduction T5.2.2), 57 reported that they had ever been injected in their lifetime. Among them, the prevalence of HIV infection was 7% (4/56 subjects), while the prevalence of HCV antibody was 55% (30/55 subjects). Among last year injectors, the same proportion was 7% (2/27 people) and 54% (14/26 people), respectively.
In the last 4 weeks of their injecting career, 23/55 people (41%) shared their syringe with someone else, while 26/54 people (48%) shared their other injecting paraphernalia.
52% of valid responders (55) were last screened for HIV in 2019 or 2020, while 47% were screened for HCV.
Among HCV antibody-positive individuals with a valid response (26 individuals), 16 (61%) had never received antiviral therapy, while 10 had ever participated in antiviral therapy.
7 out of the 10 subjects responded to treatment success, 4 were successful, 1 was in treatment at the time of data collection, and 2 were unsuccessful.
After the restrictions, based the answers of 32 respondents, PWIDs obtained their syringes most often in needle exchange (14 people), pharmacy (10 people) or mixed pharmacy and needle exchange (7), with negligible purchases from a dealer or friend.
Due to the local nature of the study and the lack of a developed recruitment method, the interpretation of the data is limited. For drug use pattern data for the complete sample, see Drugs Workbook / Cannabis / T4.1.

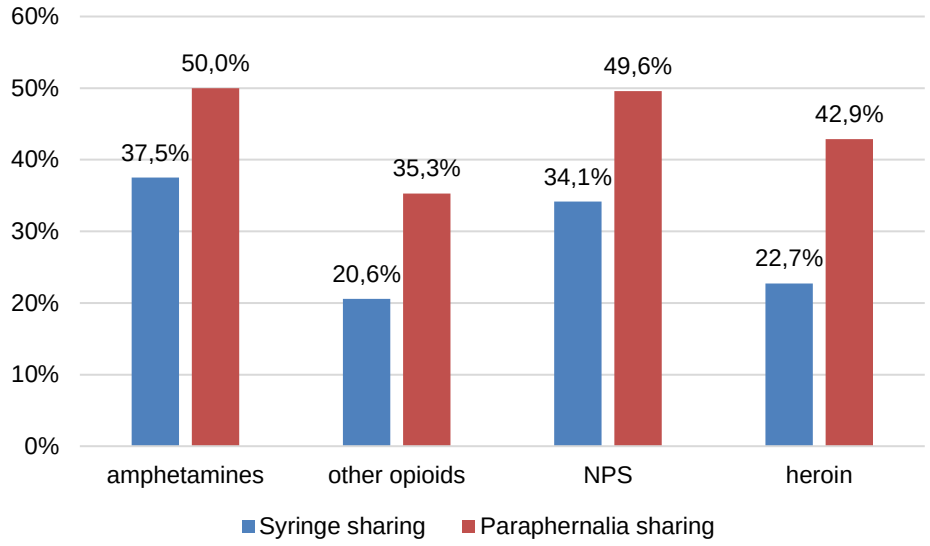
T1.3.4 Drug-related infectious diseases – behavioural data

The results of the national HIV/HBV/HCV seroprevalence surveys coordinated by the former National Centre for Epidemiology (OEK) from 2006 to 2015 are summarised under Trends.

National HNFP-NNK HIV/HCV biobehavioural survey (2018)

According to the results of the HIV/HCV seroprevalence survey, 32% of current PWID had shared syringes in the last 4 weeks, while the prevalence of sharing any injecting equipment in the last 4 weeks was 47%. While in previous years (2014-2015), sharing of syringes and of any injecting equipment was significantly higher and also highest among NPS injectors compared to the group of injectors of other substances, in 2018 prevalence rates per substance user group were much more even. The data support the findings of other studies that the frequency of injecting in the population has probably decreased, and thus so too have the associated risk behaviours due to the *shift* towards inhaling (foil) of injectable substances and synthetic cannabinoid smoking. (ST9P3_2019_HU_01)

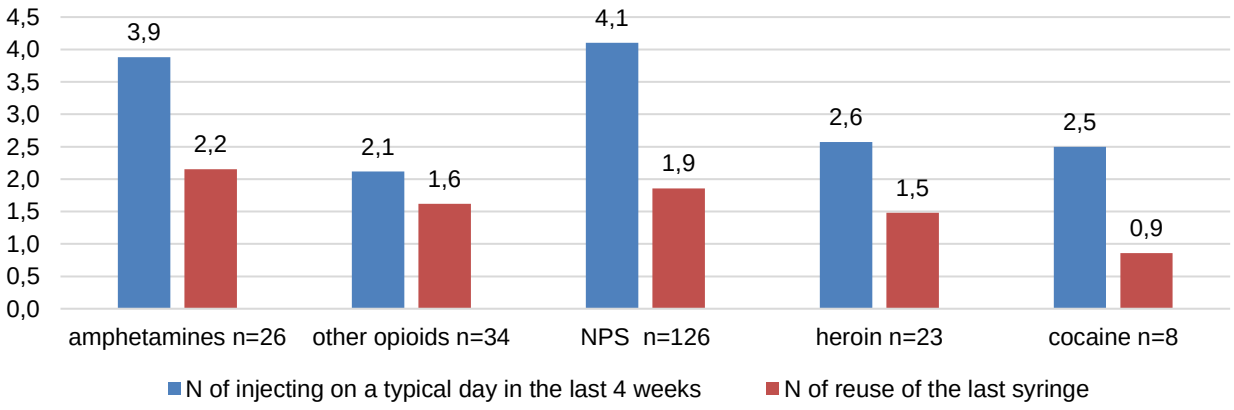
Chart 62. *The prevalence of sharing needles/syringes and sharing any injecting equipment in the last 4 weeks (%) among current PWID participating in the national HNFP-NNK HIV/HCV biobehavioural survey by primary injected substance in 2018*[131]



Source: Tarján et al. 2019

As regards current injecting users, the number of injecting episodes per day was the highest among NPS injectors, while the number of reuses of the last syringe was the highest among amphetamine injectors.

Chart 63. *The number of injecting episodes on an average day and the number of reuses of the last discarded syringe (group mean) among current PWID participating in the national HNFP-NNK HIV/HCV biobehavioural survey by primary injected drug, in 2018*



Source: Tarján et al. 2019

39.5% of current PWID self-reported injecting every day[132]. 84.2% of current PWID injected using a sterile syringe on the last occasion; 64.4% of current PWID obtained 15 or more sterile syringes for personal use in the last 4 weeks.[133]

18.4% (69/375 persons) of PWID who had had sexual intercourse in the last year had provided sex for money or drugs or other benefits in the last 4 weeks. 68% (257/377 persons) of PWID

[131] Number of respondents (N): NPS=125; other opioids=34; heroin=21; amphetamine=24.
[132] Injecting once or several times a day
[133] When interpreting the data it is important to bear in mind that the study was carried out in outpatient DTCs, LTSs and NSPs, so it involved PWID who were participating in treatment or harm reduction services.

who had had sexual intercourse in the last year had not used a condom during the last sexual intercourse. (ST9P3_2019_HU_01)

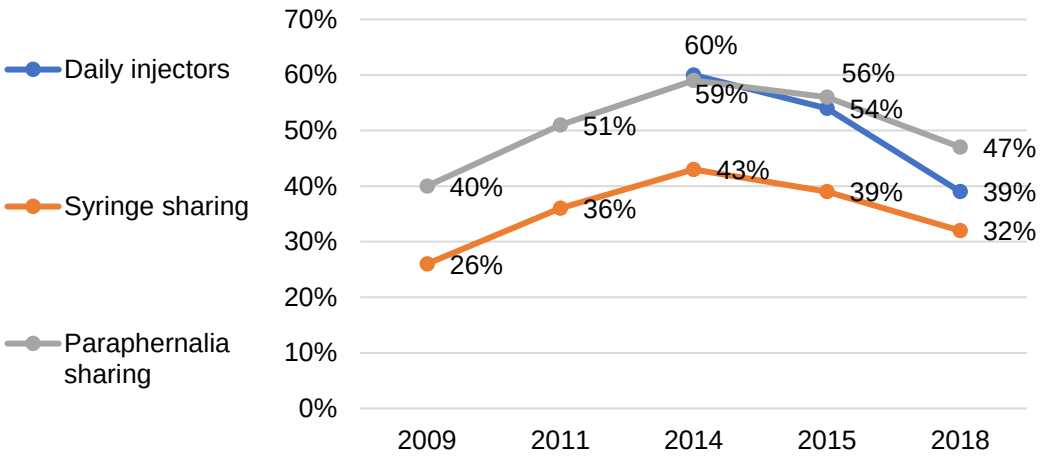
32% of the respondents had lived in a homeless shelter or on the streets without a stable address for more than 1 week during the last year. Nearly every second PWID (42%) had already been in prison. (ST9P3_2019_HU_01)

The results of the regional HIV/HCV biobehavioural survey (Tarján et al. 2020) are available in the Harms and Harm Reduction Workbook / T1.3.1.

Trends on the basis of the national biobehavioural surveys (2009-2018)

Prevalence data on sharing of needles/syringes and of injecting equipment in the last four weeks among current PWID participating in the national HIV/HBV/HCV seroprevalence survey showed a significant and steady increase between 2009 and 2014. Trends in sharing of syringes/injecting equipment reflect the spread of NPS injecting, which is associated with more frequent injecting, and the decreasing availability of NSPs during the study period; they also explain the doubling of HCV prevalence within the population between 2011 and 2014 (see T1.3.1.) Although data are only comparable to a limited degree after that period[134], data between 2014 and 2018 indicate a decrease in both indicators and in the proportion of people who inject daily, which supports the pattern changes observed in recent years in the PWID population (less injecting, shift to inhaling and synthetic cannabinoid smoking).

Chart 64. *Proportion of people who inject daily and prevalence of equipment sharing (last 4 weeks) among current PWID participating in the national OEK HIV/HCV seroprevalence survey series (2006-2015) and the HNFP-NNK national HIV/HCV biobehavioural survey (2018), 2009-2018*



Source: Dudás et al. 2015 and Tarján et al. 2019
limited comparability after 2014!

In a secondary analysis, Tarján et al. (2017) investigated the prevalence of certain risk factors among current PWID participating in the national HIV/HBV/HCV seroprevalence survey series, focusing on changes in NPS injectors between 2011 and 2014, and comparison between different PWID groups in 2014 in terms of individual and environmental risk factors and exposure to HIV/HCV infection. For results, see section T1.3.4 of the Harms and Harm Reduction workbook of the 2018 National Report.

[134] In 2015 and 2018, a group of PWID with the same composition as in 2014 could not be recruited. For a more detailed description, see HCV trends in section T1.3.1; and section T.5.1.

T1.3.6 Additional information on drug-related infectious diseases

Additional information is presented with HCV trend analysis in section T1.3.1 for easier interpretation of data and trends.

T1.4 OTHER DRUG-RELATED HEALTH HARMS

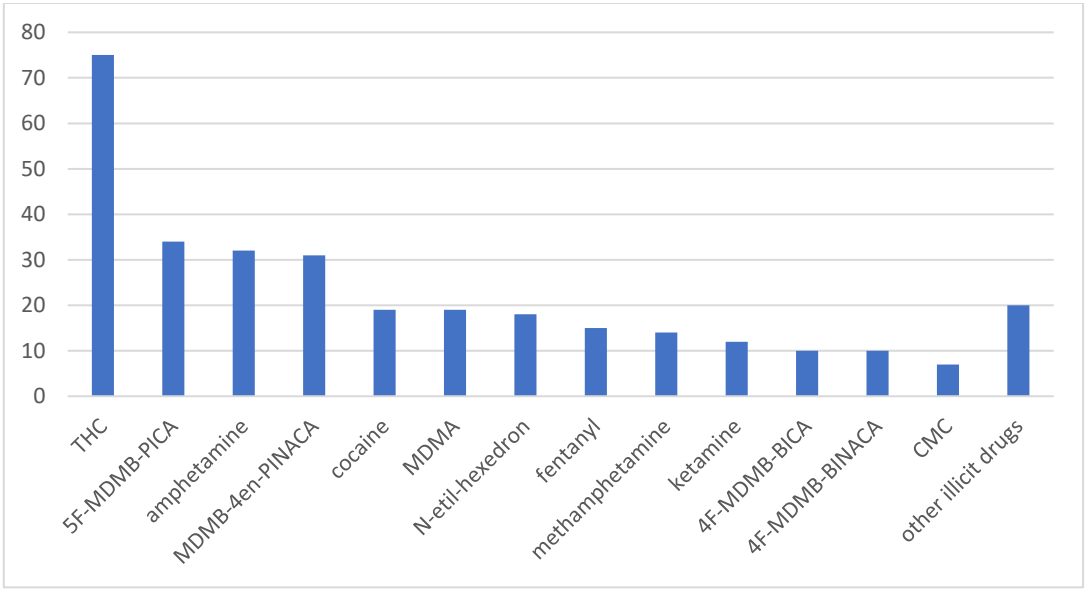
T1.4.1 Other drug-related health harms

Road accidents

In 2020, in the case of 226 road accidents the police sent blood and/or urine samples to the Institute for Forensic Toxicology of the Hungarian Institute for Forensic Sciences (NSZKK) for forensic toxicology examination, on suspicion of drug-impaired driving. Of the 226 samples, the institute found a positive result for illicit drugs and/or NPS in 169 cases.

The most frequently identified active substances alone or in combination were: THC (75 cases), amphetamine (32 cases). The most prevalen designer drugs were synthetic cannabinoids: 5F-MDMB-PINACA and MDMB-4en-PINACA (34 and 31 cases). The most common cathinone was the N-ethyl-hexedrone (18 cases). The high number of the mentions of ketamine and fentanil may be connected to emergency care occuring after cases of accidents[135].

Chart 65. *The presence of NPS and established substances in blood and/or urine samples in relation to road accidents in 2020 (N=316; number of cases)*[136]



Source: NSZKK 2021a

For a more detailed, broader analysis of biological samples by the Institute for Forensic Toxicology of the Hungarian Institute for Forensic Sciences (NSZKK) in 2020, see Drugs/Cannabis/T.4.1.

Pregnancies and children born to drug users

[135] These substances have therapeutic use in the care of people involved in accidents.
[136] A sample may contain several active substances, so the total number of cases according to the chart is higher than the number of examined biological samples.

In Budapest in 2020, 72 female drug users participated in the low-threshold service of the Józan Babák Klub (Oberth et al. 2020) who were pregnant in the year in question (32 persons), had given birth between 2017-2020 (21 persons), or participated in the follow-up programme (19 persons). The breakdown of primary used substances among clients was as follows: misuse of prescription drugs: 14 persons, alcohol: 19 persons, combined use of alcohol and prescription drugs: 6 persons, herbal cannabis: 12 persons, amphetamine: 10 persons, heroin: 3 persons, cocaine: 1 person, synthetic cannabinoid: 7 persons.

For a description of the programme, see section T1.6.1.

T1.5 HARM REDUCTION INTERVENTIONS

T1.5.1 Drug policy and the main harm reduction objectives

The Health Promotion and Drug Prevention chapter of the National Anti-Drug Strategy (hereinafter Strategy) (for further details see the Drug Policy workbook), which entered into force on 2013, emphasises the importance of harm reduction activities in nightlife/recreational settings (clubs, music venues), i.e. the involvement of clubs in the implementation of safer nightlife, ensuring the conditions for safer nightlife and clubbing by providing training for the staff, the provision of supporting services in the clubs and monitoring the implementation of minimum standards of these services.
The Treatment, Care, Recovery chapter of the Strategy emphasises that harm reduction programmes are also parts of the treatment network operating on the basis of a recovery-oriented approach and represent the first step in that. It identifies the following objectives in connection with the operation of such services: reaching hidden drug users, providing an opportunity for them to enter treatment; decreasing infectious diseases and crime; and preventing overdoses. At the same time, the Strategy emphasises that harm reduction programmes should be integrated with recovery-oriented complex programmes and should cooperate closely with treatment and rehabilitation centres.
In connection with NSPs, the Strategy states that in many cases only those services have the ability to reach hidden drug user groups at risk; furthermore, the document names needle and syringe programmes in its list of definitions as an intervention for the prevention of infectious diseases. In the case of opioid users, it highlights the importance of maintenance treatment (OST), which should be provided within the framework of a comprehensive programme aimed at complete recovery.

T1.5.2 Organisation of harm reduction services

The study surveying the integration of NSPs and harm reduction services in nightlife settings within the treatment/care system in 2014 is described in section T1.5.2 of the Harms and Harm Reduction of the 2018 National Report; although numerical results are outdated due to the closure or institutional reorganisation of some programmes since then, it still provides an outline of the layout and network of the treatment and care system.

For a description of opioid substitution treatment, see section T1.4.9 of the Treatment workbook.

The funding of harm reduction services

The operating licence for low-threshold services, which are typically social services, is issued by the capital and county government offices. The funding of low-threshold services (including needle and syringe programmes and harm reduction services in nightlife settings) is carried out via tenders. The Hungarian Directorate-General for Social Affairs and Child Protection decides on the services admitted via tendering and signs the grant agreement for a fixed term

providing fixed annual funding from the central state budget. The normative funding was increased to EUR 26,881 in 2019 (EMMI 2020) and to EUR 25.145 in 2021 (Szocokos 2021)[137]. Low-threshold services target all kinds of addictions (including alcohol and other dependencies); funding available for drug-related services (and broken down by subtypes) cannot be specified.

No new service provider was accepted by tender between 2012-2017; the contracts of the organisations accepted in 2012 were renewed annually, as in 2018. Additionally, in October 2018, another 7 organisations were invited through a restricted call. Service providers[138] were invited that operate in non-serviced or under-serviced areas outside of Budapest. Of the 7 organisations, 4 included NSPs among their planned activities (see section T1.5.3 for details). Based on the 2018 amendment to Decree 1/2000 (I. 7.) of the Ministry of Family and Social Affairs (SzCsM) on the Professional Tasks and Conditions of Operation of Low-Threshold Services, low-threshold services for addicted people provide counselling, case management, skills development, outreach, household or household replacement assistance and community development as service elements[139]. The 2018 restricted call for tenders further defined the scope of activities; in addition to the 6 main activities listed, it identified the following as optional core activities: reducing health harms (with particular regard to NSPs); linkage to medical care; crisis intervention, health screening; linkage to higher-threshold services. Prevention and harm reduction in nightlife settings was defined as a further optional activity.[140] No new low-threshold service provider was accepted in 2019 and 2020.

During expert meetings, several large organisations reported that it would be difficult to maintain their harm reduction services without the financial assistance of their integrated institutional background (HNFP 2015).
Besides the fixed funding, it was possible until 2018 for low-threshold service providers to apply for supplementary operational support in the scope of the annual ministerial call for tenders titled “Support for the recovery processes of addicts” (KAB FF). That financial resource was not available in 2019 and 2020.

A total of 13 NSPs provided information on sources of funding with respect to a total of 18,095 syringes in 2020. The biggest proportion (52%) of syringes acquired in 2018 were purchased in the scope of the low-threshold fixed funding. (Tarján 2021a)

T1.5.3 Harm reduction interventions

(a) Testing for infectious diseases[141]

HIV testing

Anonymous, free-of-charge HIV testing is available in every county in Hungary in the general population. Under Decree 18/2002 (XII.28.) of the Ministry of Health, Social and Family Affairs (ESzCsM), voluntary HIV testing is available at local sexual health clinics, as well as at HIV/AIDS counselling centres operated by the capital and county government offices.[142]

[137] 1 EUR = 365 HUF.
[138] specified areas: • Hajdúsámson; Szerencs; • Vásárosnamény; • Mórahalom district; • Győr and Csorna districts; • Sopron and Kapuvár districts; • Székesfehérvár and Mór districts; • Jászapát and Jászberény districts; • Érd, Siófok
[139] Activities featuring as part of a service in a professional programme
[140] Until 2018 the provision of two out of the following three basic services was a requirement at LTSs: psycho-social interventions; counselling services; street outreach services. The supplementary services for which service providers could submit an application only in conjunction with the basic services were the following: telephone counselling; harm reduction in the recreational setting; needle and syringe programme services; drop-in centre.
[141] Revised by Mária Dudás MD (NNK) and Sándor Takács (AATSZ)
[142] for the list of testing sites, see https://anonimaids.hu/hasznos-informaciok/szuroallomasok/

In 2020, anonymous HIV/AIDS counselling centres were run by government offices in 13 counties and the capital and further 5 service providers operate as part of other institutions. Beyond the HIV/AIDS counselling centers 'Anonim AIDS Councelling Center' provides services in the capital and 'Debrecen University KEK Infection Institution' operates county Hajdú-Bihar. In the remaining counties of Bács-Kiskun, Fejér, and Somogy , HIV testing was available in STD clinics. The service is available at the centres for around 6 hours per week. The tests are performed by doctors, epidemiological supervisors and nurses who have completed a counselling course. Anonymous HIV testing is available in all counselling centres. In 2020, a total of 7058 persons participated in counselling at the HIV/AIDS counselling centres run by government offices. Testing was carried out in 6251 cases, of which 943 were initiated anonymously. HIV positive cases were referred to treatment (written communication Dudás 2021).

At low-threshold services providing support to PWID, HIV testing is usually carried out in the scope of centrally coordinated projects or through individual projects. A Budapest-based NSP permanently offers HIV testing to its clients (AATSZ – Anonim Aids Tanácsadó Szolgálat, fixed-site NSP). According to the NSP data collection (Tarján 2021a), in 2020, HIV testing was available at 18 of the 34 reporting organisations.

In the HNFP-NNK national HIV/HCV biobehavioural survey conducted in 2018 (Tarján et al. 2019, for methodology see T.5.1) – excluding HIV-positive cases – among the 386 PWID giving valid responses, 162 persons (39%) had never been tested for HIV before this seroprevalence survey. 22% (86 persons) stated that they had last been tested for HIV in 2017 or 2018 before the survey in question. (ST9P3_2019_HU_01)

In the HNFP-NNK national HIV/HCV biobehavioural survey conducted in 2019 (Tarján et al. 2020, for methodology see T.5.1) – excluding HIV-positive cases – among the 88 PWID giving valid responses, 29 persons (33%) had never been tested for HIV before this seroprevalence survey.

For further local data please consult T1.3.3. in this Chapter.

HCV testing

Systematic, anonymous, free-of-charge HCV testing regulated by decree (such as is the case with HIV testing) is not available in Hungary either for the general population or for the risk groups. Due to earlier – already outdated – legislation, capital and county government offices provide free-of-charge HCV testing for PWID in an ad-hoc manner[143].
At low-threshold services providing support to PWID, HCV testing is usually carried out in the scope of centrally coordinated or individual projects (e.g. national HIV/HCV seroprevalence surveys, HAREACT project, ALTALAP HIV/STI programme), or with the support of pharmaceutical companies (e.g. in Southern Transdanubia – see the description below under HCV treatment.) A Budapest-based NSP permanently offers HCV testing to its clients (AATSZ, fixed-site NSP). According to the NSP data collection (Tarján 2021a), in 2020, HCV testing was available at 8 out of the 34 reporting organisations.
According to NSPs, if HCV testing is not available at a particular organisation, the client is referred to the AATSZ – as a grassroot-level solution.
The methodological and legal background for testing at low-threshold services is ambiguous and unsettled. According to the present legislation,[144] only healthcare providers can provide HIV/HCV testing (if they meet the minimum requirements); the type of test is not distinguished (e.g. between blood tests and rapid tests such as saliva tests). By contrast, guidelines of the

[143] In 2005, the National Medical Officer ordered the laboratories operated by the former National Public Health and Medical Officer Service (NPHMOS) to provide free-of-charge HIV and HCV screening tests for samples of PWID if the risk group is indicated in the submitted request.
[144] Decree 60/2003 (X. 20.) of the Ministry of Health, Social and Family Affairs (ESzCsM)

former National Centre for Epidemiology on rapid HIV/HCV testing only set out HIV/HCV counselling training of staff and cooperation with a healthcare provider as conditions for testing. The decisions of the relevant regional government offices responsible for authorising testing are therefore not uniform.
In the case of higher-threshold healthcare providers (DTC/OST), HCV testing is also ad-hoc. The National Health Insurance Fund only funds diagnostic HIV/HCV testing (provided that the client's health insurance is in order). There is no protocol for annually offered, service provider-initiated routine HIV/HCV testing for PWID. The number of tests performed depends on the service provider (based on available funding and the attitude of the service provider).
In some rehabilitation centres, a recent HIV/HCV test result is a condition of entry; testing is usually organised by DTCs or LTSs in the scope of pre-treatment.

In the HNFP-NNK national HIV/HCV biobehavioural survey conducted in 2018 (Tarján et al. 2019, for methodology see T.5.1) – excluding those who self-reported being HCV-positive from the analysis – there were 304 valid responses relating to HCV testing uptake. 156 (51%) PWID stated that they had never been tested for HCV before the survey. Among those who had been tested for HCV at some time in their lives in the past, 58 persons stated that they had last been tested for HCV in 2017 or 2018, accounting for 19% of those giving valid responses. (ST9P3_2019_HU_01)

In the HNFP-NNK regional HIV/HCV biobehavioural survey conducted in 2019 (Tarján et al. 2020, for methodology see T.5.1) – excluding those who self-reported being HCV-positive from the analysis – there were 73 valid responses relating to HCV testing uptake. 30 (41%) PWID stated that they had never been tested for HCV before the survey. Among those who had been tested for HCV at some time in their lives in the past, 27 persons stated that they had last been tested for HCV in 2018 or 2019, accounting for 37% of those giving valid responses. (ST9P3_2020_HU_01)

For further local data please consult T1.3.3. in this Chapter.

For more information on the declining access to the PWID population via low-threshold services, see T1.3.1 and Drugs/Stimulants/T1.2.5

For HIV/HBV/HCV testing in prison, see Prison/T1.3.3.

b) Distribution of sterile syringes (needle and syringe programmes (NSPs))

In 2020, 34 service providers operated NSPs in 24 cities, covering 16 counties out of 19 and all the 7 regions; coverage did not change compared to 2019. (Tarján 2021a) (17.HU_ST10_NUTS_DCR_THN (2020)) There were 4 relatively large NSPs in Budapest in 2019, in Districts 10, 7, 2 and 11 (out of 22 districts in Budapest). Two further organisations are still operating NSP in the capital; one of them, however, has been focusing in recent years on other activities and risk groups (Alternatíva Alapítvány). The other service provider (Drog Prevenciós Alapítvány (Drug Prevention Foundation)) only collected used syringes as part of street outreach work; other sterile devices, excluding syringes, are distributed at its fixed site. The 'Hepago' street outreach program was launched in 2020. The organization does not distribute sterile syringes, but collects used ones during street work, their main activities being screening for infectious diseases and referring clients into treatment.

In 2020, 29 fixed-site NSPs operated in the country (2019: 29); this was the most typical form of NSP provision; however it should be noted that 13 service providers[145] reported that no one used their services in the year in question. 13 organisations performed street outreach work (2019: 13), 1 organisation ran a mobile NSP (2019: 1), and in 3 cities PWID could purchase syringes from syringe vending machines (2019: 3).
10 organisations operated two types of programmes; in most cases those were street outreach work connected to a fixed-site NSP. One service provider operated three different programme types (fixed site + street outreach + syringe vending machine) at the same time, and 23 service providers only had one type of NSP service, which was typically a fixed-site NSP.

In 2020, NSPs distributed a total of 43,244 sterile syringes. The number of returned and collected syringes was 43,037.[146] The return rate was 100%. 567 PWID used NSP services on a total of 4571 occasions.[147] A total of 125 new clients were registered by the programmes in the course of the year.[148] On average 76 syringes were distributed and 76 returned per client; the mean number of contacts per client was 8 in the year in question. (ST10_2021_HU_01)
According to the breakdown of client and syringe data by programme type, fixed-site programmes distributed the majority of syringes (66%) and reached the majority of clients (76%) in 2019.

Table 22. *Syringe and client numbers of NSPs in 2020*

	fixed site	mobile NSP	street outreach	syringe vending machine	total
distributed	28754	14082	112	296	43244
returned (+collected)	22497	11783	8640	117	43037
return rate	78%	84 %	7714%	40%	100%
number of clients	430	134	3	0	567
number of new clients	108	17	0	0	125
number of contacts	3526	1039	6	0	4571
number of NSPs*	29	1	13	3	34

**The same NSP may run several types of programme at the same time, so the number of NSPs per programme type is not equal to the total number of NSPs.*
Source: Tarján 2021a

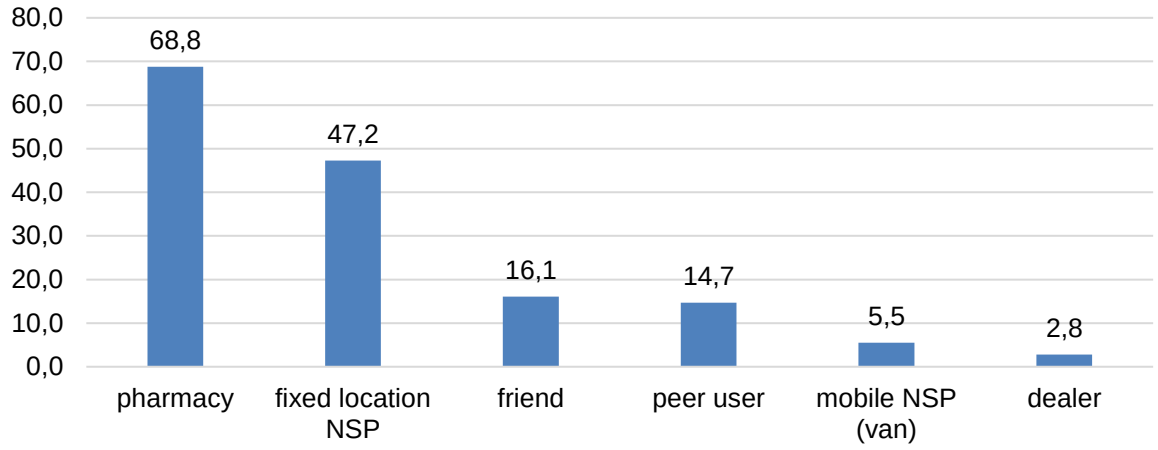
On examining the geographical breakdown, NSPs located in Budapest accounted for the vast majority of both distributed/returned and collected syringes and clients/contacts in 2019 as well (Budapest accounted for 70%; 72%; 70%; and 74% respectively).

In Hungary, pharmacy-based NSPs are not available.

According to results of the 2018 national HNFP-NNK HIV/HCV biobehavioural survey (Tarján et al. 2019, for methodology see T.5.1), 69% of current PWID (150/218 person) (2015: 67%; 2014: 58.4%) had purchased syringes in pharmacies in the last 4 weeks, while only 47.2% of those surveyed had obtained a syringe from fixed NSPs in the last 4 weeks.

[145] Cities: Debrecen, Hajdúsámson, Kaposvár, Kazincbarcika, Nagykanizsa, Nyíregyháza, Orosháza, Pécs (Tér), Salgótarján, Szerencs, Szolnok, Veszprém; Békéscsaba (but the vending machine).
[146] Including syringes obtained from syringe vending machines and disposed of in the special waste containers placed near the vending machines.
[147] With respect to the number of clients, duplicates were removed at the service-provider level but not at the national level. The same client may be registered at several NSPs.
[148] With respect to the number of clients, duplicates were removed at the service-provider level but not at the national level. The same client may be registered at several NSPs.

Chart 66. *Source of syringes (%) in the last 4 weeks among current PWID participating in the HNFP-NNK national HIV/HCV biobehavioural survey in 2018[149] (N=218)*



Source: Tarján et al. 2019

More than half of the respondents identified the pharmacy as their main source[150]of sterile syringes (53.9%) in the last 4 weeks, while 32.3% reported fixed-site NSPs as the main source. 4.6% reported friends as their main source and 4.6% reported peers as their main source of sterile syringes.

Results of the 2019 regional biobehaviour study are available in 2020 National Report / Harms and Harm Reduction Workbook / section T1.3.1.

For the results of the 2018 study on the consequences of closing the NSP in District 8, see section T1.5.5. of the Harms and Harm Reduction workbook of the 2019 National Report.

For trend analysis of NSP data, see section T1.5.4

The pharmaceutical wholesalers Hungaropharma and PHOENIX Pharma, which together account for 95% of the pharmacy syringe trade, were requested to provide sales data for the 1 ml insulin syringe most frequently used by PWID for the period 2010-2020; for trend analysis, see T1.5.4.

c) Availability of further sterile drug use paraphernalia and harm reduction services

Beside sterile syringes, most NSPs provided condoms (22/34) and counselling on safe injecting (22/34). The majority of NSPs provided pads to disinfect the skin,vitamins and selective counselling about the safe injection of novel psychoactive substances. .
HIV and HCV testing are offered by roughly one-third of organisations, and information and support relating to HIV and HCV treatment is available at 12 and 16 organisations respectively.

Table 23. *Distribution of injecting and harm reduction equipment and provision of other services by NSPs, in 2020 (N=34)*

Type of equipment/service	N of NSPs providing it	N of equipment or occasions	N of service providers reporting (occasions

[150] A respondent could name only one location.

		of service use	/ equipment)
Condoms	25	6210	9
Counselling on safer injecting (oral information)	25	12	2
Pads to disinfect the skin	22	9318	6
Vitamins	21	2790	6
Targeted counselling on NPS injecting (oral information)	21	0	0
Linkage to HCV treatment (by means of counselling and/or case management)	14	1	1
HCV testing	13	106	6
Targeted counselling on NPS injecting (written material)	13	315	3
HIV testing	11	8	2
Vein protection cream	10	334	4
Linkage to HIV treatment (by means of counselling and/or case management)	10	5164	3
Sterile filters	9	0	0
Counselling on safer injecting (written material)	8	406	3
Citric/ascorbic acid	5	0	0
Tourniquets	5	360	6
Sterile injecting equipment in a pre-assembled package	5	590	1
Individual risk assessment	5	464	5
Foil	4	1464	3
Dry wipes	3	628	2
Disinfectant for cleaning equipment	3	0	0
Sterile mixing container	3	136	1
Syphilis testing	2	0	0
Hand disinfectant gel	1	0	0
Wet wipes	1	200	1
Band aids	1	255	1
Distilled water for dissolving drugs	1	50	1

Source: Tarján 2021a

Table 24. *Coverage of injecting and harm reduction equipment and provision of other services by NSPs, in 2020*[151]

	Type of equipment	Routinely available	Rarely available, available in a	Not available	Information not known
pads to disinfect the skin		x			
dry wipes			x		
distilled water for dissolving drugs				x	
sterile mixing container			x		
filters			x		
citric/ascorbic acid			x		

[151] Routinely available: available at > 70% of NSPs; often available, but not routinely: available at 30%-70% of NSPs; rarely available, available in a limited number of settings: available at <30% of NSPs.

disinfectant for cleaning equipment			x		
condoms		x			
lubricants					x
low dead-space syringes					x
HIV home testing kits					x
non-injecting paraphernalia: foil, pipes, straws			x		
list of specialist referral services: e.g. drug treatment; HIV, HCV, STI testing and treatment					x

Source: Tarján 2021a

d) Prevention of drug-related deaths and emergencies

Take-home naloxone programmes are not available in Hungary.

e) Supervised drug consumption facilities

Not available in Hungary.

f) Post-release/transition management from prison to community, provided by drugs facilities

For information on this, see Prison/T1.3.3 Prevention, testing and treatment of infectious diseases and Reintegration, preparation for release.

g) Vaccinations

Specific, targeted vaccination programmes are not available for drug users.

Hepatitis B vaccination has been compulsory for people aged 13 since 1999. As described in the Vaccination Methodological Letter of 2019[152], voluntary, free-of-charge vaccination against hepatitis B has been available to PWID – among other risk groups – since 2007.

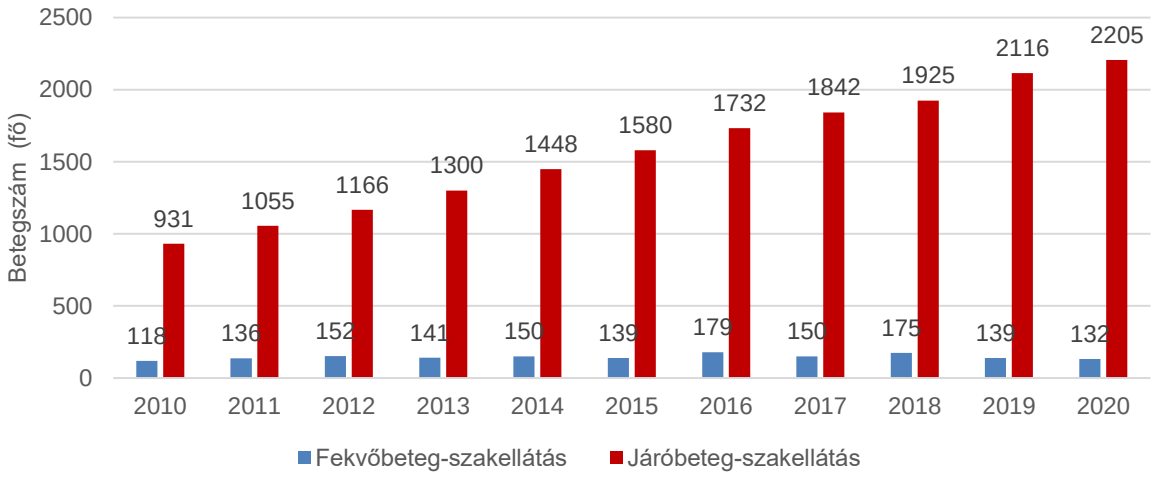
h) Treatment of infectious diseases[153]

HIV treatment in the general population

The treatment of verified HIV-positive persons in Hungary is carried out in four cities: in Budapest and, since 2014, in three decentralised clinics in Miskolc, Pécs and Debrecen. Linkage to care and treatment are based on Decree 18/2002 (XII. 28.) of the Ministry of Health, Social and Family Affairs (ESzCsM) and the HIV treatment protocol issued in 2017 by the expert group of the Central Hospital of Southern Pest[154]. Drug use is not a contraindication to the initiation of HIV treatment.

[152] https://www.antsz.hu/data/cms92651/VML2019_NNK_2019_05_08.pdf
[153] Revised by Mária Dudás MD (NN) and Sándor Takács (AATSZ)
[154] "Antiretroviral treatment, vaccination and primary and secondary prophylaxis of opportunistic diseases in adults infected with HIV"

Chart 67. *Number of specialised treatment in HIV indication by treatment modalitites in 2020 (person)*



Source:NEAK 2021

In addition to the above centers, the care of diagnosed HIV patients and the treatment of secondary complications caused by the viral infections (eg. other infections) are provided by general infection clinics with nationwide coverage. (NEAK 2020)

Over the last ten years, there has been a gradual increase in the number of people receiving publicly funded specialist care for HIV. The increase is primarily due to the number of patients in outpatient care. (NEAK 2021)

HCV treatment

The national professional consensus on HCV treatment in effect since May 2018 (Hunyady et al. 2018) no longer includes the previously prescribed 3-month abstinence from drugs; however, it requires individual case assessment for current drug users.

Since the arrival of DAA treatment, there is no longer a waiting list for HCV treatment, and according to the 2016 position of leading hepatologists (Horváth et al. 2016), the new medications enable more than 90% of patients to be cured effectively – in a shorter period of time and with fewer side effects compared to the previous treatment – even in the case of hard-to-treat populations. Only taking medical aspects into consideration, treatment of all HCV infected persons is indicated.

In December 2018, the Minister for Human Capacities set up the National Hepatitis Committee to draw up a national action plan and recommendations in order to achieve hepatitis elimination goals in Hungary.

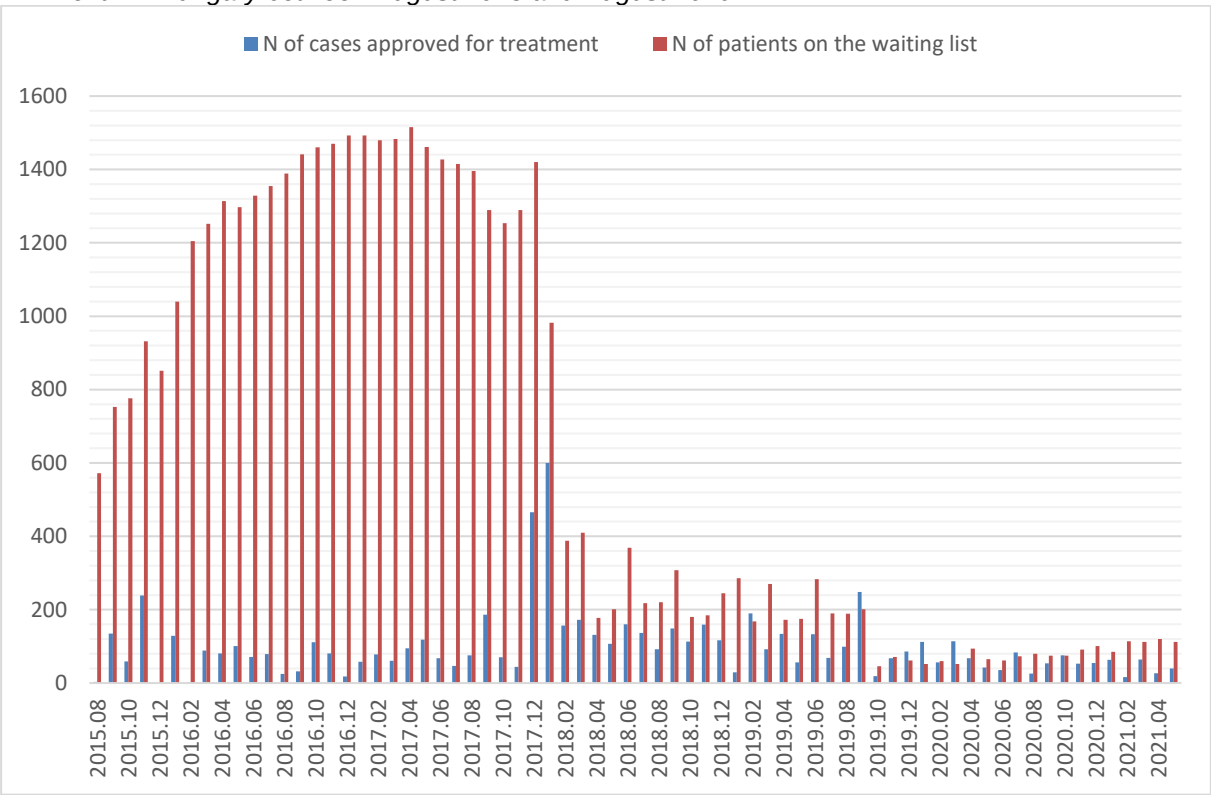
HCV treatment in the general population

By 2019, 1500 people entered HCV treatment each year on average. Since the introduction of DAA treatment, waiting lists have been reduced and patients can enter treatment immediately. However, initiation of treatment was set back in the course of 2020 by the COVID-19 pandemic, and 750 clients initiated treatment contrary to 1200 in the previous year.AS a result of the third COVID wave a further decrease was experienced in the request for treatment, thus, a further decrease is anticipated in 2021. DAA is the first-line treatment and the cost per treatment is under EUR 4000[155]. The allocated budget is sufficient for all patients seeking treatment. An

[155] Personal consultation with the Hungarian National Health Insurance Fund (NEAK)

important remaining barrier for PWIDs is to settle their health insurance, which they often lack, before entering HCV treatment.

Chart 68. *Number of approved HCV treatments and number of patients on the waiting list by month in Hungary between August 2015 and August 2020*



Source: NEAK 2021

HCV treatment in PWID

In the 2019 regional HIV/HCV biobehavioural survey (Tarján et al. 2020, for methodology and prevalence data, see sections T5.1 and T1.3.1), information on HCV treatment among participants was surveyed for the first time. Of the 45 HCV antibody-positive PWID who responded with a valid answer, 40 persons (89%) had never been treated before for HCV. Of the remaining 5 persons, 2 successfully completed treatment, while 3 discontinued treatment due to their own fault.

Further local scope data are available in T1.3.3. in the chapter.

Linkage to HCV treatment

In the HAREACT project, low-threshold services conducting the HIV/HCV testing participated in training sessions in 2016 and 2018 in connection with linkage of PWID to HIV/HCV treatment. In the framework of regionally organised working groups, various stakeholders (social workers, hepatologists, infectious disease specialists) operating in the same city met in order to elaborate and implement linkage to care at the local level.
In addition, there are individual initiatives: Drog Prevenciós Alapítvány (Drug Prevention Foundation) has developed its “Follow-Up" programme, which, in a case-management framework, follows the client from testing to treatment and also through to SVR24. For HCV-positive clients, the organisation arranges an appointment at a hepatology centre and for other medical visits, and also helps such clients with settling their health insurance and other necessary administrative issues, as well as accompanying them on the client’s. In this

programme 12 clients participated in 165 occasions. in 2020.Clients were enrolled in the hepatology clinics of Szent János Hospital, Nyírő Gyula Hospital and Szent László Hospital where – on request – they were also accompanied to (3 clients).The number of PWID referred for treatment was 13 in 2021. The number of PWID referred for treatment was 15 in 2019 (personal communication Varga M. 2021).

According to the NSP data collection, in 201920 linkage to HCV treatment (counselling and/or case management) was available at 16 of the 34 reporting organisations. (Tarján 2021a)

Linkage of PWID to the HCV treatment project in Budapest was prepared in 2018 and launched in 2019 June as a collaboration between the pharmaceutical company MSD and an NGO called Válaszút Misszió with support from the National Centre for Public Health (NNK); social workers accompany PWID throughout the HCV treatment path (from the HCV antibody test to the SVR24 blood test after the end of treatment). The project is supplemented by a questionnaire survey conducted by Hungarian National Focal Point, which records the substance use characteristics and psycho-social status of those entering the project at key stages of the treatment pathway. Closure of the project was postponed until December 2020 since in 2020 client paths were disrupted and new treatments were temporarily not started due to the COVID-19 pandemic and related restrictions.

Between July 2018 and March 2019, 312 persons belonging to at-risk groups were tested for HCV and then linked to treatment in Southern Transdanubia, with the support of the Abbvie pharmaceutical company, coordinated by the INDIT Foundation. For the data and the project description see section T1.5.3 of the Harms and Harm Reduction workbook of the 2019 National Report.
See sections T1.3.1 and T1.5.4, and Drugs/Stimulants T1.2 for more information on the declining access to PWID through low-threshold services and new patterns of use among them.

For information on the HIV/HCV treatment of prisoners, see Prison/T1.3.3.

i) Sexual health counselling and advice; condom distribution

For information on condom distribution, see T1.5.3 c) and d). In Hungary, there are two low-threshold services (NSPs) providing support to drug users (ALTALAP and AATSZ), which – besides harm reduction related to drug use – provide counselling explicitly on sexual health.

In 2020, 22 service providers that distributed NSP provided condoms out of the 34 organisations.

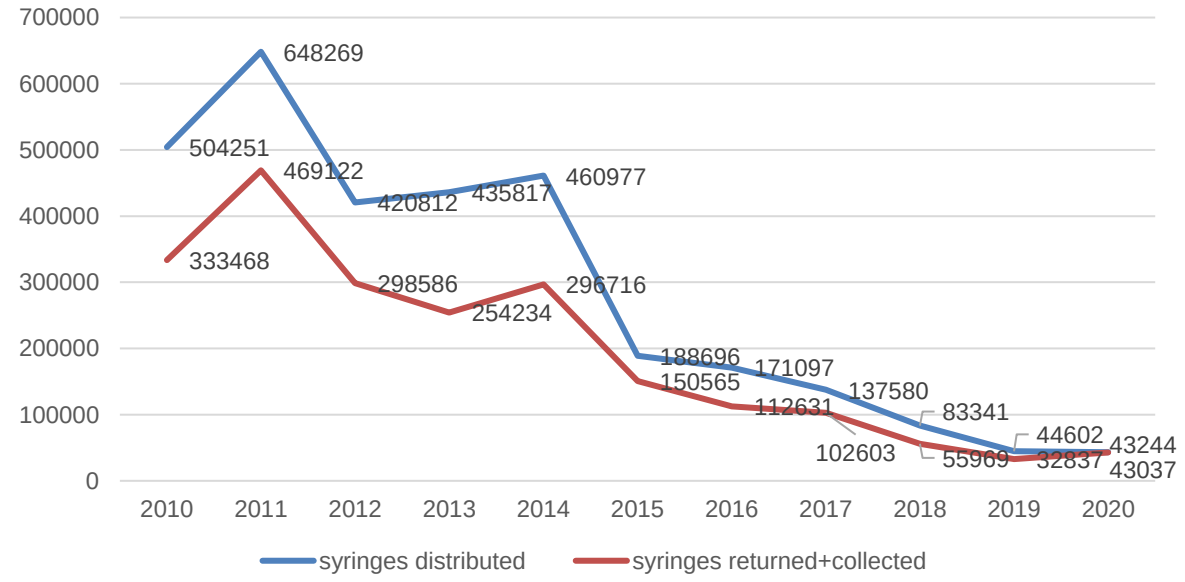
T1.5.4 Harm reduction services: availability, access and trends

The number of syringes distributed to PWID

In 2011 the number of distributed syringes significantly increased compared to previous years; behind that change lies the increased use from 2010 onwards of new psychoactive substances, which are injected much more frequently than established illicit drugs (see Drugs/Stimulants/T1.2.1). The upward trend lasting until 2011 was interrupted in 2012 by reduction of the resources available to low-threshold services when a new, three-year funding period started (see section T1.5.2). Compared to the previous year, around 220,000 fewer syringes were distributed by NSPs at that time. In order to be able to maintain the services, NSPs with the highest turnover limited the number of syringes that could be distributed per contact, and in certain cases reduced their opening hours. Some programmes had to either shut down their operations temporarily or completely. In 2013 and then in 2014 the number of

syringes distributed rose slightly, which is primarily the consequence of the one-off grants provided by the Ministry of Human Capacities (see section T1.5.2), however, the number still did not reach the 2011 level and probably still did not satisfy the current syringe needs of PWID. That is supported by the drop in the return rate observed in 2013, which suggests that a significant proportion of the used syringes not returned to the programmes – primarily in Budapest – were reused by the clients or were shared (HNFP 2015). The closure of the two largest NSPs in the second half of 2014 (see T1.5.3) caused a significant decrease in the number of distributed syringes (59%) and returned syringes (49%) in 2015; that trend continued at a more moderate level between 2016 and 2018. The research of Kaló et al. (2018) and Csák et al. (2019) and the changes that can be observed in routine data collections (for relevant results see Drugs/Stimulants/T1.2.5 and T4.1) reveal factors behind that decrease: among PWID a moderate change in patterns of use has been taking place for the last 3 years. (increasing synthetic cannabinoid use, increasing inhaling (using foil) of injectable drugs as the route of administration). Furthermore, according to NSPs, PWID have become more hidden and harder to reach due to the growing police presence (Kaló et al. 2018). Several organisations indicated (Kaló et al. 2018, Tarján 2019a) that due to the lack of capacity at existing NSPs and the limited coverage of NSPs, a smaller proportion of PWID come into view of the services, especially in Budapest. In other regions of Hungary untreated PWID groups can be identified[156] in locations that are not covered and reached by NSPs. However, it should be noted that at the end of 2018, 4 new NSPs were launched in non-serviced or under-serviced areas outside of Budapest. (See T1.5.3/b)

Chart 69. *Syringe-related data of NSPs, between 2010 and 2020*



Source: Tarján 2021a

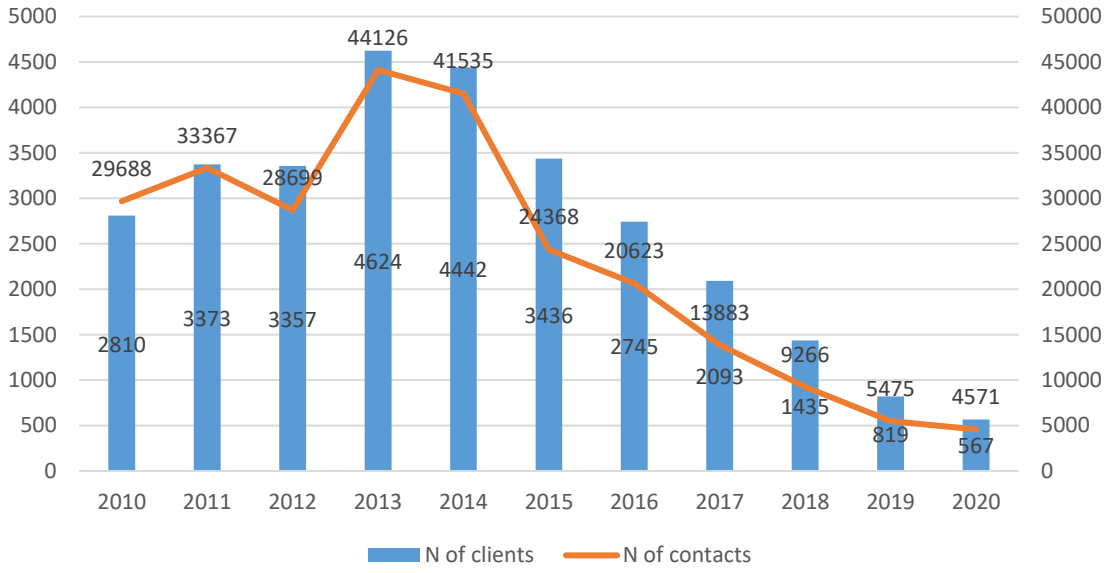
In contrast to the changes in the number of distributed syringes, the number of clients and the number of contacts showed a steep rise between 2012 and 2014[157]. It may be assumed that the restriction of the availability of sterile syringes per day was compensated for by clients with a greater number of contacts and the involvement of PWID peers who had not attended NSP programmes before. Due to the closure of the two largest NSPs in the second half of 2014, the number of clients and contacts decreased significantly in 2015. This trend also continued between 2016 and 2020 due to reasons explained above relating to the decrease in distributed

[156] on the basis of information originating from organisations not targeted at drug users (e.g. child welfare and family support services)

[157] Between 2013 and 2014, both client and contact numbers dropped slightly due to the closure of the two largest NSP providers during the year, without which the number of clients would probably have been higher by the end of 2014.

syringes in the same time period. Altogether 567 persons contacted NSPs in 2020 compared to 4624 persons in 2013. The number of contacts dropped from 44,126 in 2013 to 4571 in 2020. While in past years (2011-2016) 1100-1800 new NSP clients were registered annually, in 2020 only 125 new clients were recorded.
The trends in NSP client numbers in recent years suggest – in spite of changing patterns of use and thus probably a slightly decreasing frequency of injecting drug use – that NSP services are not accessed by a significant proportion of the PWID population (in 2015, the estimated number of PWID injecting in the last year was 6707 persons at the national level) (see also data on syringe sales data in pharmacies below.)

Chart 70. *Number of NSP clients and number of contacts, between 2010 and 2020*



Source: Tarján 2021a

Examining the geographical breakdown, it can be concluded that the proportion of the turnover taking place outside of Budapest increased between 2014 and 2019. While in previous years, with respect to the various indicators, Budapest accounted for a proportion of 86-89%, in 2020 it was around 70% (80% for returned+collected). Looking at the trend data by geographical breakdown, it can be concluded that the decline in the total number of NSP clients and distributed syringes at the national level stemmed from the drop experienced in Budapest. All in all, a decrease was experienced in the four indicators (distributed syringes/returned syringes, number of clients/number of contacts) both outside of Budapest and in the capital, which may be mainly due to the aforementioned changes in patterns of drug use.
Based on the client recruitment experiences in the biobehavioural study (Tarján et al. 2019) conducted in 2018, it is easier to reach the population of PWID outside of Budapest, where NSPs remained more stable (see section T1.3.1 of this workbook).

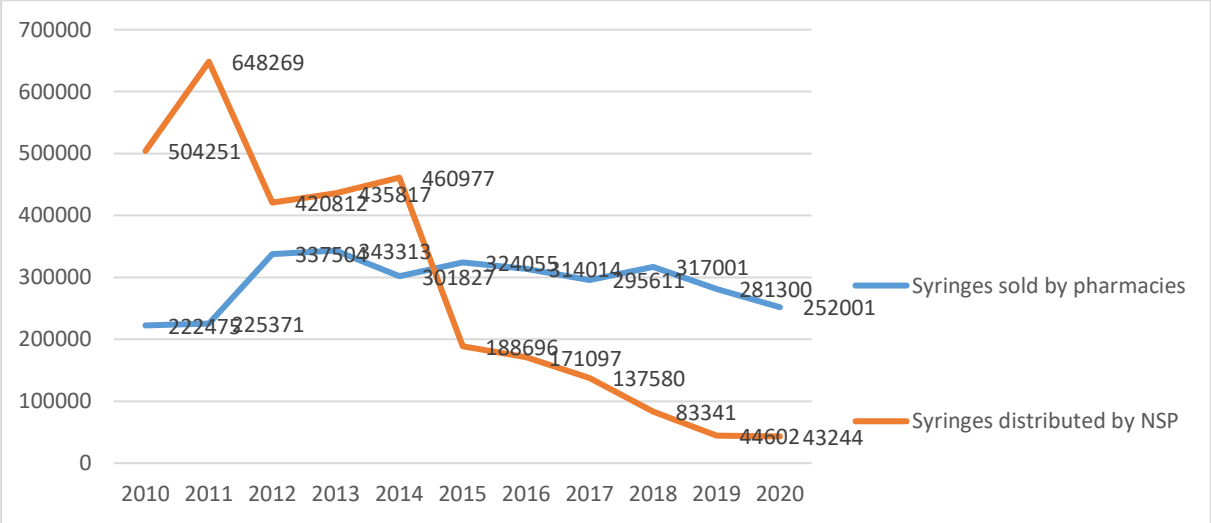
Regarding access to PWID in Budapest, see also Csák's study in 2018 (Csák et al. 2019) in section T1.5.5 of the Harms and Harm Reduction workbook of the 2019 National Report; that study explored the impact of closing the NSP in District 8 in Budapest.

Based on studies conducted in recent years (Dudás et al. 2015; Tarján et al. 2019; Tarján et al. 2020; Csák et al. 2019), syringe acquisition in pharmacies is increasing (pharmacy-based NSP per-se is not available in Hungary, see section T1.5.3 for details).

Pharmacy syringe sales data (2010-2020)

The pharmaceutical wholesalers Hungaropharm a and PHOENIX Pharma, which together account for 95% of the pharmacy syringe trade in Hungary, were asked to provide sales data on the 1 ml insulin syringe most frequently used by PWID for the period 2010-2020.[158][159] Those syringes are now only purchased to a negligible degree for insulin administration[160], so they can be used as an indirect indicator to assess the extent to which PWID purchase syringes at pharmacies. HIV/HCV biobehavioural studies in recent years (2018/2019) among PWID attending NSPs show that pharmacies have overtaken NSPs to become the most common source of supply of sterile syringes (see section T1.5.3 for details). Examination of the 10-year trend data shows that when the number of syringes provided at NSPs declined in 2012 despite growing demand (see the background data earlier in this chapter), pharmacy syringe sales increased by more than 100,000 syringes and stabilised at that level in the following years. A slight increase was also observed after 2014, when the 2 largest programmes in Budapest were forced to close down. While the number of syringes distributed via NSPs decreased significantly in the subsequent period (2015-2020), the number of pharmacy syringe sales remained relatively stable. Due to pattern changes (after 2016, some of the PWID population switched intermittently or completely to synthetic cannabinoid smoking or inhaling of injectable drugs, see also Drugs/Stimulants/T1.2.5), a decline in injecting as a route of administration can be assumed; however, in the light of pharmacy syringe sales, this is not as large as indicated by NSP syringe and client figures alone. Some of the PWID population probably did not change patterns, but became more hidden to the monitoring system due to decreasing access to NSPs and their less frequent visits to such programmes, through which we can primarily track trends in this population.

Chart 71. *Number of distributed syringes in NSPs and number of sold syringes in pharmacies, national, 2010-2020*



Source: Hungaropharma and PHOENIX Pharma 2021, Tarján 2021a

[158] HungaroPharma only provided data from 2012; in its case a breakdown by sales channel was available, so only syringes sold to pharmacies were taken into account in its case (hospitals and other customers were excluded). However, due to the fact that only 2000-3000 syringes per year are sold in the case of HungaroPharma, the large increase in 2012 was not due to the lack of their pre-2012 data.

[159] Syringe types retrieved by HungaroPharma: Chirana U100 1ml 100x + needle 29g; Omnican syringe U100 100x + needle 30g 8mm; Omnican syringe U100 100x + needle 30g 12mm; Romed syringe u100 100x + needle; Syringe types retrieved by Phoenix Pharma: Syringe Chirana (U 40) 1ml + 29G needle 1x; Syringe Chirana (U100) 1ml + 29G needle 1x; Syringe e.h. 1ml Import 3r.luer insul 1x; Syringe e.h. 1ml WOLF 3r.tuberculin 1x; Syringe Romed insulin + needle 1ml 100x; Syringe Romed tuberculin + needle 1ml 100x

[160] Personal consultation with OGYÉI (National Institute of Pharmacy and Nutrition)

T1.5.5 Additional information on harm reduction interventions

Within the framework of the EU-funded HAREACT project (for information on Hungary's participation, see section T1.5.5 of the Harms and Harm Reduction workbook of the 2018 National Report), 11 organisations providing low-threshold services[161] participated in the training supported by the project in 2016 and 2018, which covered the following topics: HIV/HCV testing (rapid testing) and counselling; harm reduction and specialised care targeted at female clients; linkage to HIV/HCV treatment; the model of integrated care; overdose prevention.
The project-funded HIV/HCV testing and associated behavioural survey[162] (for data see section T1.3.1 of this workbook) were conducted in 2018 and in 2019 at the participating organisations. Training on linkage to HIV/HCV treatment in April 2018 was attended by hepatologists and infectious disease specialists, as well as organisations providing low-threshold services. The aim of the training was to establish local cooperation between different fields and to develop feasible client pathways from testing to care at the local level.

Information on counselling, testing and treatment of prisoners can be found in section T1.3.3 of the Prison workbook.

Research on the consequences of the closure of the NSP in District 8 was conducted in 2018 among former clients of the programme (Csák et al. 2019). The results can be found in section T1.5.5. of the Harms and Harm Reduction workbook of the 2019 National Report.

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

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

Interventions targeting drug-using pregnant women and their children

For a description of the low-threshold programme of the Józan Babák Klub located in District 8 called “Alternative Prenatal and Family Care” see chapter 7.4 of the 2012 National Report. This programme provides services to drug-using pregnant women or women with babies living in District 8 and the surrounding are. In 2020 a total of 72 persons participated in the programme (Oberth et al. 2020) (for patterns of drug use of clients see T1.4.1).
The Józan Babák Klub, with the cooperation of the Hungarian Human Rights Foundation and the Hungarian Association of Child Health Visitors, has operated a crisis telephone hotline since 2014 for pregnant drug-using women in crisis situations with the purpose of providing them with effective help in entering treatment. The crisis telephone hotline service helps drug-using pregnant women or drug-using mothers and their children who live in any region of Hungary, but seek help in Budapest.
In 2017, Józan Babák Klub launched a new supported housing programme. The halfway house programme “Babaház” provides accommodation for 8 drug-using/drug-dependent pregnant women or women with children (together with the children) in District 23 of Budapest. In 2020, 4 adults and 4 children used this service.
By vote of the National Assembly on 12 December 2018, a new legal relationship was established (Act CXVII of 2018 amending certain social, child protection and other related laws, prepared by the Ministry of Human Capacities, Józan Babák Klub and the Hungarian Human Rights Foundation). Under the amendment, the supported housing institution has evolved into a multi-generational form of care, allowing adults and children with addictions, psychosocial, vision, mobility or hearing impairments to establish institutional relationships that provide the basis for long-term co-living on an official footing.[163]

[161] Budapest: 4 NSPs and 2 LTSs; Pécs: 2 NSPs; Debrecen, Kecskemét and Miskolc: 1 NSP each
[162] drawn up and funded by the Hungarian National Focal Point

From 2020, as an independent program of the Sober Babies Club ("Deport XXI."), a multidisciplinary team will support parents who, due to their health condition, do not live with their children, in relation to the 2006 UN Convention for the Protection of Human Rights and Fundamental Freedoms, which prohibits the separation of parents and children on grounds of health and obliges the state to provide assistance.[164]

The Academy for Special Parents was established in 2014 within the scope of the Methadone Programme of the Drog Prevenciós Alapítvány (Drug Prevention Foundation) in Budapest. For mothers and fathers in OST, the programme provides the "MENY"/"MEPA" reception hours, during which individual case management is provided, including supervision by a psychiatrist, and clients who are pregnant or have small children are helped to find suitable services in their network of health and social service providers. The consultations covered specific topics, such as telling the nursery/kindergarten, child welfare or family support services or child psychologist about the disease (opioid dependence) and the treatment (OST), HCV testing of babies with HCV-positive parents; safer drug use in the family environment, disorders and diseases of the baby linked to substance use of the parents. A total of 10 women and 8 men (among them 2 couples) participated in the special consultation in 2020; in total they were raising 15 children. (personal communication by Varga M. 2020).
In addition to the MENYA/MEPA programme, the ALNYA and ALPA programme/reception hours were also launched. The programme provides counselling to drug-using pregnant women and their partners, and to parents who become homeless, as a low-threshold service and, if necessary, refers them to healthcare services (doctors, health visitors) and other social institutions (Józan Babák, maternity homes). In 2020, 4 people were involved in the programme. Condoms and pregnancy tests are also distributed as part of this low-threshold service (personal communication Varga, M. 2021).

T1.7 QUALITY ASSURANCE FOR HARM REDUCTION INTERVENTIONS

T1.7.1 Quality assurance for harm reduction interventions

Harm reduction activities taking place in the scope of social services, including the service provided in needle and syringe programmes, are governed by Act III of 1993 on Social Administration and Social Services and Decree 1/2000 (I. 7.) of the Ministry of Social and Family Affairs on the tasks and operational conditions of social institutions providing personal care.

The social guidelines titled "Professional recommendation – Low-threshold services provided to addicted persons" was drawn up by the Specialised Task Force on Addictions in 2007 (for more details, see chapter 11 of the 2010 National Report). The revised version is effective as of July 2018 under the title "Professional recommendation for low-threshold services providing support to addicted persons" (EMMI 2018). The recommendation describes the main types, objectives, guiding principles, characteristics and quality assurance conditions of the services and the activities they cover. The publication then follows the structure and topics of Decree 1/2000 (I. 7.) of the Ministry of Social and Family Affairs (SzCsM) (amended in February 2018) and lists interventions accordingly (see also section T1.5.2). This document serves as a basis in the call for and the assessment of applications for the fixed state financing (see section T1.5.2).

Furthermore, in 2011, within the framework of the TÁMOP 5.4.1 project aimed at drug-related developments, national guidance documents were elaborated setting out recommendations based on wide expert consensus for harm reduction programmes operating in recreational settings and for needle and syringe programmes (chapter 3.2 of the 2011 National Report).

[164] XCII of 2007 Article 23 (2) and (4) of the Act promulgating the Convention on the Rights of Persons with Disabilities and the Optional Protocol.

The recommendations in the documents are in line with the objectives of the social guidelines issued in 2007.

Details of Government Decree 23/2011 (III. 8.) on increasing the safety of music and dance events can be found in chapter 1.2 of the 2012 National Report.

T2. TRENDS

Trend data are presented in section T1.

T3. NEW DEVELOPMENTS

The Hungarian National Focal Point conducted a study in 2021 regarding the impact of the COVID-19 pandemic and related restrictions on drug use and responses. See section T4.3 of the Treatment workbook for the results.

T4. ADDITIONAL INFORMATION

No new information available.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

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T5.2 METHODOLOGY

Drug-related DRD:
mortality (HNFP 2021a): The data relating to deaths are taken from the Special Mortality Registry. The data have been collected by the Hungarian National Focal Point with the support of the Hungarian Institute for Forensic Sciences (NSZKK) (former National Forensic Medicine Institute) and the Institute of Forensic and Insurance Medicine of Semmelweis Medical University since 2009. This nationwide register is anonymous, includes ICD-10 codes and is case-based; in all cases it contains detailed toxicology data besides the circumstances of the deaths. The case definitions and the recorded characteristics in the register fully comply with the requirements of the EMCDDA DRD protocol (Drug-Related Deaths (DRD) Standard Protocol, version 3.2 2009; Selection D). The case definitions and the recorded characteristics in the register fully comply with the requirements of the EMCDDA DRD protocol (Drug-Related Deaths (DRD) Standard Protocol, version 3.2 2009; Selection D).

DRID:

Notifications of HIV/AIDS, HBV, HCV:
Data of reported HIV/AIDS cases related to injecting drug use and the incidence of acute cases of hepatitis caused by HBV or HCV in Hungary related to injecting drug use are taken from the national registry of infectious patients at the Department of Epidemiology and Vaccination Surveillance at the National Centre for Public Health (NNK) (former National Centre for Epidemiology, Department of Epidemiology) and from the special HIV/AIDS and hepatitis surveillance database.

HIV/HBV/HCV prevalence data:
National HIV/HBV/HCV seroprevalence survey among PWID 2006-2015 (Dudás et al. 2015) (ST9_2016_HU_01): Between April and September 2015, the National Centre for Epidemiology (NCE) repeated the HIV/HBV/HCV national seroprevalence survey among PWID. The study was financed by the State Secretariat for Health. (previous study years: 2006-2009 annually; 2011; 2014).
In 2015, 19 organisations were involved: three NSPs, three DTCs, one LTS and one DTC with LTS in Budapest, while outside of Budapest six NSPs, three DTCs and two DTCs also running NSPs took part in the study. Persons who had ever injected illicit drugs/new psychoactive substances were recruited in the study. Apart from the testing for HIV/HCV, socio-demographic characteristics, injecting patterns and risk behaviours were also recorded. The questionnaire was based on the EMCDDA DRID guidelines, and on parts 2 and 3 of Standard Table 9, which was jointly drawn up by the Hungarian National Focal Point and the National Centre for Epidemiology (OEK). The questionnaires and the blood samples were given unique identifiers generated from the personal data but which cannot be traced back; that makes it possible to link the serological and questionnaire data and remove duplicates from the sample. Participating organisations were assigned a target sample size based on their number of PWID clients between 2006 and 2014; however this had to be modified in 2015 due to the closure of the two largest testing sites in 2014 (see T1.3.6.). During the study period, the organisations invited all their PWID clients – after informed consent – to participate until the target sample size at each location was reached. The PWID participating in the study received an incentive in the form of food vouchers (HUF 1000/EUR 3).
The laboratory results were sent back from the National Centre for Epidemiology (OEK) to the organisations and results were given back to clients; in conjunction with that, post-test counselling was also provided if requested by clients.
A dried blood sample was used for the serological tests – after taking blood from the client’s fingertip. The Vironostika HIV Ag/Ab ELISA (bioMérieux) test was used for the HIV test.

Samples giving a reactive result were checked using another test suitable for demonstration of the virus antigen: the combined ELISA test (Genscreen Ultra HIV Ag-Ab; BIO-RAD). In addition, the INNO-LIA HIV I/II Score (FUJIREBIO) Line Immuno Assay, using the Immuno blot principle, was also carried out. In the case of hepatitis C virus, the HCV Ab Screening ELISA kit manufactured by DiaPro and the INNOTEST HCV Ab IV kit manufactured by Innogenetics were used. The anti-HCV positive results were verified using the INNO-LIA HCV Score test (Line Immuno Assay technique) manufactured by Fujirebio.
After removal of duplicates, the data of 596 persons were analysed. Inconclusive test results were excluded from the analysis (37 samples in the case of HCV; 0 in the case of HIV; 0 in the case of HBV). The electronic recording and statistical analysis of the data were performed using the Epi Data and the Epi Info Windows 3.5 programme packages, as well as the SPSS programme package.

The national seroprevalence survey has not been repeated since 2015. One reason was that the study did not receive any further funding, as Hungary was included as a target country in the HAREACT international project starting in 2015 (see T1.5.5) and one of its work packages provided rapid HIV/HCV saliva testing kits. In relation to the HAREACT-funded HIV/HCV testing, a one-time, new biobehavioural survey was launched in 2018. The second reason was that comparability issues emerged in the national seroprevalence survey series in 2015 after the closure of the two largest NSPs – which were also the main testing sites – and hence the continuation of the survey series was hampered.

National HNFP-NNK HIV/HCV biobehavioural survey 2018:
Prevalence study of HIV and HCV infections and related risk and protective factors among PWID in Hungary (Tarján et al. 2019):
In 2016, Hungary was included as a target country in the EU-funded Joint Action on HIV and Co-Infection Prevention and Harm Reduction (HA-REACT) project, which funded HIV and HCV testing kits (rapid saliva test) and counselling among PWID clients of low-threshold services. The project was coordinated in Hungary by the National Centre for Public Health, Department of Epidemiology and Vaccination Surveillance. The Hungarian National Focal Point supplemented the testing programme with a biobehavioural survey. The study covered 6 regions, but it is called a national study as attempts were made to involve organisations from all regions; however, no potential organisation was available in Western Transdanubia. 17 organisations participated in the study (NSP: 13; 1 of which also provided OST; LTS: 3; 1 of which also provided OST; DTC providing OST: 1). Distribution of samples: NSP + other LTS: 82%; OST: 14%; NSP and/or other LTS and/or OST: 4%.
The survey was conducted between May and December 2018. The study participants were individuals who had ever injected drugs/new psychoactive substances in their lives, voluntarily participated in the HAREACT HIV/HCV rapid test during the study period and agreed to answer the questionnaire after informed consent. The organisations offered participation to all of their PWID clients during the study period until they reached the sample size assigned to them. Exclusion criteria: if the individual was not in a condition to give oral consent and answer the questionnaire.
A total of 440 people participated in the study[165]. Data were received from 11 organisations concerning the testing refusal rate, which was 36% (164 rejections /456 invitations). The study was planned in 2016, but the start was delayed by two years due to institutional changes affecting the coordinating institutions. In 2016, Budapest-based organisations committed to collecting a total of 480 samples for half a year, while in the case of organisations outside of Budapest, 120 samples were distributed. Sample sizes per site were proportional to the number of PWID clients at participating organisations in 2016. By the time the study began in 2018, one Budapest-based organisation was no longer available for the project, while the remaining organisations were able to test only less than half the number of people they committed to in 2016 due to capacity problems, reduced opening hours and changed patterns

[165] Number of samples received after removing duplicates and subtracting invalid questionnaires.

of drug use among PWID (2018: 219 valid questionnaires in Budapest). In 2018, service providers outside of Budapest performed a total of 221 tests instead of the 120 they were assigned in 2016.
The questionnaire was prepared according to the guidelines of the EMCDDA and adapted to the national profile. The earlier, almost identical version of the questionnaire was used by the National Centre for Epidemiology in previous surveys for several years. The slightly modified questionnaire used in this study was reviewed by 5 experts and, in 2016, reviewed and approved by staff from 11 organisations providing low-threshold services. The questionnaire does not record personal information; it is anonymous. The questionnaire was provided with a unique, but non-decryptable identifier, which was generated from personal data and was used only to remove duplicates from the entire database, thus improving the reliability of the results. Based on the EMCDDA's methodological recommendation, in order to protect anonymity and maintain client confidence, the consent was an oral statement, which was indicated by the interviewer on the questionnaire. Participants did not receive incentives. The interviewer was paid separately for each questionnaire.
For HIV and HCV testing, a rapid saliva-based test (Oraquick HCV rapid antibody test; OraQuick ADVANCE Rapid HIV-1/2 Antibody Test) was used; the questionnaire was completed while waiting for the test result (20-30 minutes).

The limitations of comparability with the previous national seroprevalence survey series (2006-2015) are as follows (which are also described in section T1.3.1 along with data analysis):
Similarities: The questionnaire was nearly identical in the two studies. For recruitment sites, we contacted sites that were included in the 2015 national survey (a list that had already undergone significant changes compared to 2014 due to the closure of the two major NSPs), with the difference that low-threshold services were given priority in the selection because of the specific features of the HAREACT project and in order to chiefly reach current PWID.
Differences: Participants did not receive incentives (National Centre for Epidemiology (OEK) surveys: meal voucher worth HUF 1000-2000 / EUR 3-6). In 2018, a rapid saliva-based test was used, while between 2006 and 2015, laboratory examination of a dried blood sample (DBS) drawn from the fingertip was performed. The composition of the available organisations has changed and the accessibility of the PWID population in Budapest has greatly decreased (see methodology). The interviewer received a fee for each questionnaire, whereas between 2006 and 2015 a fee was only introduced in the last survey year.

Regional HNFP-NNK HIV / HCV biobehavioural survey 2019:
Biobehavioural study of HIV and HCV infections and related risk and protective factors among PWID in Budapest and Kecskemét (Tarján et al. 2020):
The methodology of the study was exactly the same as for the 2018 national study (Tarján et al. 2019) except for geographical coverage. In 2019, the testing and recording of questionnaires took place at 4 NSPs in Budapest and at 1 NSP in Kecskemét, involving 102 PWID (92 persons in Budapest; 10 persons in Kecskemét) who had ever injected drugs. Questionnaires were recorded between July 2019 and March 2020. The 2018 questionnaire was supplemented in 2019 by a module on HCV treatment history.

In the previous years, the results of ad-hoc research projects (including the prison setting) (Csák and Rácz 2018; Altalap 2017; Tresó et al. 2012) and of the regional HIV/HBV/HCV testing programme 2010-2013 supplemented the data of the national seroprevalence survey series (see relevant chapters of the previous National Reports).

Harm Reduction

Needle and syringe programme (NSP) data collection (Tarján 2021a): In 2021 too, NSPs (100% coverage) reported their 2020 data via the internet-based data collection tool set up and operated by the Hungarian National Focal Point. The organisations have been providing data to the Hungarian National Focal Point through this interface since 2008 on the number of

syringes provided (based on categories set in ST10), the provision of other harm reduction services and their syringe supply management, as well as about the demographic characteristics and injecting patterns of their clients. Management, quality assurance and analysis of the national, aggregate data are carried out by the Hungarian National Focal Point. The same client may be registered at several NSPs. For methodology on client data collection (demographic characteristics and injecting patterns) see Drugs/Sources and Methodology/T.6.2.)

Data collection on harm reduction services in nightlife settings (Tarján 2020b): The Hungarian National Focal Point has been collecting the operational and turnover data of organisations performing harm reduction services in the recreational setting since 2007, with the help of a structured questionnaire, which was filled in online in 2015. After 2015, the survey was only re-continued annually from 2018. 21 organisations completed the questionnaire in 2019.

T5.2.3. Methodology of further studies and data sources

Monitoring of new psychoactive substances involving key experts in Hungary 2017-2018 (Kaló et al. 2018): See methodology in Drugs/Sources and Methodology/T.6.2.

HEPAGO-NFP HIV / HCV bioavailability study in Budapest (Tarján el al., 2021):
The survey was conducted between June and December 2020 among the clients of the HEPAGO mobile (van) program in Budapest. The organization offered a rapid HIV and HCV test to its clients, and in addition to the screening, the National Drug Focal Point developed a short questionnaire examining the drug use patterns of the clients in the study, and the changes caused by the coronavirus epidemic to social status, drug purchase and use, and access to care.
The study was open to people who had ever used a drug / new psychoactive substance or abused drug or alcohol in their lifetime. 110 people were interviewed, 96 of whom had used NPS / drugs in their lifetime, 57 of whom had ever injected.

DRUG MARKET AND CRIME[166]

T0. SUMMARY

Besides the Hungarian Institute for Forensic Sciences (NSZKK), in instances when the samples are taken during customs control or the investigations falling within its competence, the National Tax and Customs Administration's expert laboratory (NAV SZI) performed the analysis of substances suspected of being illicit drugs in Hungary. A detailed picture of the Hungarian drug market can be obtained by analysing the seizure data and the police reports.
On the basis of seizures and user information, the drug market has gone through a large-scale restructuring process since 2010. New psychoactive substances (NPS) had a significant presence next to 'classical' drugs, and their continuous replacement on the market still represents a serious challenge to supply reduction efforts. The market share of NPS has been increasing from 2010 to 2014, and in 2014, about 60% of the police seizures were made of these substances. This proportion has declined steadily since 2015, to around 30% in 2019 and 2020.
In Hungary, large quantities of narcotics are less likely to be t cultivated or produced; only small plantations or labs have become known to the authorities. This means that Hungary is mostly considered as a transit country with many trafficking routes going through. As a destination country, cannabis, amphetamine, NPS and ecstasy tablets are the most common trafficked substances.
The characteristics of drug law offences are monitored on the basis of the data recorded, when investigations are completed, in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS). In Hungary, the number of registered drug offences committed in a year is between 5-7000, the largest proportion of which are related to cannabis (2020: 53.1%) while a smaller proportion to stimulants (2020: 29.6%). (Supply) offences related to NPS have involved criminal liability since 2012, and from this point onwards they have been the subject of perpetrations in a constantly increasing proportion. The large majority of drug related offences are consumption-related especially among offences committed with a small amount of drug, 90% of which cases belong to this perpetration type. The proportion of supply related offences tends to remain around 20%.
Procedures to reduce drug supply were set out in the National Anti-Drug Strategy, which has been expired by 2020, along with other policy strategies. The tools that have been formulated to reduce the supply are - among other things - enhancing the efficiency of law enforcement and investigative work, enhancing forensic expertise, and increasing the number of procedures initiated for supply-related offences.

T1. NATIONAL PROFILE

T1.1 DRUG MARKET

T1.1.1 Domestic drug cultivation and production

With respect to Hungarian illicit drug cultivation, the investigating authorities typically discovered small cannabis plantations in the greatest number[167]. In 2020 during the procedures launched due to the 189 discovered cannabis cultivation sites, a total of 3649 plants were seized. The presence of smaller populations is also confirmed by the fact, that less than 5% of the discovered plantations involved more than 100 plants (NSZKK 2021a).

[166] Authors of the workbook: Bálint Réka, Edina Bánfai and Tamás Csesztregi

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

The production of synthetic substances is not widespread in Hungary, only a few laboratories get eliminated every year by the police. In the course of 2020 two illegal synthetic drug laboratories were discovered, where amphetamine was being manufactured. Amphetamine was produced through benzaldehyde and phenyl-2-nitropropene.
Amphetamine preparations appearing in smuggling and on the black market contain the active ingredient in the form of a solid, chemically stable amphetamine sulphate salt. Recently, however, solid amphetamine sulphate salt has been produced on several occasions from liquid smuggled amphetamine base ("amphetamine oil"), in 2020 a total amount of 57.1 kg "amphetamine oil" was seized from 5 seizures. In 3 cases, larger quantities of methanol (105 litres in total) and sulphuric acid (28 litres in total) were seized (NSZKK 2021a).

In 2020 25 acetone seizure cases happened, of which in 19 cases herbal or paper materials impregnated with synthetic cannabinoids and also synthetic cannabinoids in powder form were found. As synthetic cannabinoids are generally seized in a powder form as a pure active ingredient which came through international postal services, it is believed that a significant part of the impregnations occurs within the country. No laboratories producing new psychoactive substances were discovered. (NSZKK 2021a)

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

According to the data provided by the Ministry of Interior (2019) - which also includes the experience of the police on the drug market – herbal cannabis arrives to Hungary via a changed rout, mainly through Italy and Slovenia. The advantage of shipping to Italy is that it is possible to transport larger quantities of herbal cannabis over short distances. After delivery to Italy, trafficing to several European countries occurs through local criminal organizations (BM 2021)
In Hungary, recent years there has been no change in the wholesale purchasing, smuggling, or distribution structure of synthetic drugs (ecstasy, amphetamine). Smaller dealers buy the drugs themselves, mainly through contacts from the Netherlands. In regards with the smuggling and distribution of these substances, it can be conducted by organized but also by ad hoc criminal groups. The detection is quite hard due to the growing number of courier and parcel services, both internationally and domestically, whose activities, despite the established cooperation, have not been solved. (BM, 2019) In addition, due to the difficulty of tracing postal packages containing narcotic drugs or psychoactive substances and the low chance of being caught, the number of such consignments, mainly from the Netherlands, seems to be increasing. (NAV 2019) The distribution of methamphetamine from the Czechia to Austria, Germany and the Scandinavian countries still does not have a significant impact on the Hungarian market, the presence of the substance can only be detected in the counties bordering Slovakia (BM 2020).
Drug users switched from heroin to designer drugs from 2010, but this did not mean that Hungary's role in heroin transit had been drastically changed with that. Distribution in large batches is mostly carried out by Turkish, Albanian and, to a lesser extent, Vietnamese nationals, while heroin street trade is carried out by Hungarian citizens (BM 2020).
Concerning cocaine, in the recent years there has been a clear increase in the number of both the consumers and distributors in Hungary. Cocaine's origins, trafficking routes and modes can be varied: shipments arriving in Europe get to Hungary usually from Spain and the Netherlands. Although, smuggling directly from South America in packages and by the so-called "swallowing method" also remained typical. Furthermore, it is important to note that couriers recruited in Hungary do not usually transport drugs to Hungary, but to other European countries or to the Far East, and that the Serbian-Croatian-Montenegrin organization called the "Balkan Cartel" is very strong in the region. In addition, the ordering of cocaine from the Darknet is getting more widespread in Hungary. (BM 2019)

T1.1.3 Trafficking within the country

The technical improvements of recent years and the acceleration of everyday life have also largely determined the commission of drug-related crimes. The use of the Internet and cryptocurrency accounting are becoming more common, especially at lower levels, even among groups already involved in local crime, especially in the trafficking of new psychoactive substances. Illegal materials are ordered through an online channel and then delivered to consumers using legal parcel delivery services without personal encounter.
For the first time in the history of Hungarian law enforcement, the National Anti-Crime Department of the Emergency Police (KR NNI) liquidated an entire distribution network using Internet application and social network. According to the data obtained during the criminal proceedings, the perpetrators carried out a significant part of the drug trade using an Internet application they had created. Drugs were regularly sold to other members of the group via the Internet, and members of the group also sold drugs from other sources to each other (BM 2021).

T1.1.4 Wholesale drug and precursor market

Regarding wholesale trafficking, seizures data show that the trafficking of heroin in Hungary became again significant. In 2020, about 41 kg powder, containing heroin was seized (NSZKK 2021).

Regarding precursors, 1,871 kg of pseudoephedrine tablets were seized in 2018. These seizures were typically near to the Serbian border, indicating a new precursor supply route.
The state authority supervising the activities that can be carried out legally with drug precursors, BFKH KHENF (for more information on the tasks of the authority, see T1.3.1) banned the import of 7298.5 kg non-listed substance (MAPA, Methyl alpha-phenylacetoacetate) in 5 cases. The consignor was in all cases a Hong Kong company, and the final recipients were Hungarians in 3 cases, and in 1-1 cases the recipient was of Slovakian and Lithuanian citizens. Consultations were held with the Slovak and Lithuanian authorities before the import ban was banned (BFKH 2021). Following customs control, the NAV initiated the ban on import of the concerned substances. Previous to the ban in question, consultations took place with the Slovak and Lithuanian authorities and with the relevant bodies of the NAV, additionally NAV consulted with the Office for the Protection of the Constitution and the Police (KR NNI) (NAV 2021).

T1.1.5 Retail drug market

Street prices

As compared to previous years, the Hungarian National Focal Point performed a survey among clients of outpatient drug treatment centres, regarding the street level prices of drugs in the summer of 2021 (Bálint 2021) (for the methodology see: T5.2). (ST_16_2021_HU_01). Apart from the classical drugs, the questionnaire also asked about the prices of designer stimulants (known as “crystal”) and bio-weed” (herbal mixtures treated with synthetic cannabinoids, known as “herbal”) when last purchased.
The most common street prices for cannabis derivatives such as herbal cannabis and cannabis resin were 10.5 and 9 EUR while Ecstasy and amphetamine cost around 9, EUR. The most common price of “synthetic weed” in 2020 was 3 EUR, while of designer stimulants 12 EUR.

Table 25. *Price of drugs at street level in 2020 in HUF*

substance	lowest	highest	mean	mode	sample
herbal cannabis(g)	2000	4 500	3 102	3 000	110
cannabis resin(g)	2000	5 000	3 264	3 000	36
heroin (g)	8 000	30 000	17 444	15 000	9
heroin (packet)	3 000	5 500	4 375	5 000	7
cocaine (g)	15 000	35 000	25 902	25 000	46
amphetamine (g)	2 500	7 000	3 790	3 000	55
methamphetamine (g)	2 500	10 000	4 692	5 000	13
ecstasy (1 tabl.)	2 000	4 000	2 844	3 000	54
MDMA crystal (g)	4 500	20 000	9 781	6 000	16
“herbal” (g)	500	2 000	1 217	1 000	29
“herbal” (cigarette)	200	1 000	620	500	17
designer stimulants (g)	3 000	9 500	4 523	4 000	21
methadone (20mg)	1 000	5 000	2 667		3
methadone (5mg)	500	1 000	667	500	3
liquid methadone (ml)	1 000	2 000	2 500		2
suboxone (1 tabl)	2 000	3 000	1 700		2
LSD (1 dose)	2 500	6 000	3 827	3 000	26
psychoactive mushroom (g)	2 000	5 000	3 166	3 000	30
ketamine	4 000	17 000	7 769	4 000	13
GHB/GBL	4 000	10 000	5 800	5 000	5

Source: Bálint 2021

Table 26. *Prices of drugs at street level in 2020 in EUR*[168]

substance	lowest	highest	mean	mode	sample
herbal cannabis (g)	6	13.5	9.3	10.5	110
cannabis resin(g)	6	15	9.8	9	36
heroin (g)	23.9	89.7	52.2	44.9	9
heroin (packet)	9	16.5	13	15	7
cocaine (g)	44.9	104.7	77.5	74.8	46
amphetamines (g)	7.5	20.9	11.3	9	55
methamphetamines (g)	6	29.9	14	15	13
Ecstasy (1 tabl).	6	12	8.5	9	54
MDMA crystal (g)	10.5	59.8	29.3	15	16
“herbal” (g)	1.5	6	3.6	3	29
“herbal” (1 cigarette)	0.6	3	1.9	1.5	17
designer stimulants (g)	9	28.4	13.5	12	21
methadone (20mg)	3	15	8		3
methadone (5mg)	1.5	3	2	1.5	3
liquid methadone (ml)	3	15	4.5		2

[168] The prices in the table were calculated using the EUR intermediate exchange rate valid for 2020 (EUR 1=HUF 334.3).

suboxone (1tabl)	6	9	7.5		2
LSD (1 dose)	7.5	17.9	11.4	9	26
psychoactive mushroom (g)	6	15	9.5	9	30
ketamine	12	50.9	23.2	12	13
GBH/GBL	12	29.9	17.4	15	5

Source: Bálint 2021

Purity

The active substance content of the seized substances in 2020 did not differ from the proportions detected in the previous years (for methodology see T5.2) (ST_14_2020_HU_01). However, an increase was observed with goods containing lower concentrations (more diluted) of MDMA and methamphetamine.
Substances have appeared containing high percentage of cannabidiol (CBD) among hemp-derived drugs on the Hungarian black market. For example, a store was opened during the year selling CBD-containing plant materials as “legal-weed” with only 0.1-0.2% delta-9-THC (THC) content. Goods containing mainly CBD, have been seized also in border traffic. Such substances are also becoming more common among plant branches seized in street traffic, and in many cases we found two types of herbal cannabis (both THC- and CDB-dominant) within one seizure. In several cases, branching was found containing unusually high levels of delta-8-THC, with no evidence of subsequent interference (e.g., heat treatment or chemical transformation).
Among new psychoactive substances consumed in powder form, typically sold under the street name “crystal”, ethyl-hexedrone was the most dominant substance in 2020. In many cases, cathinone derivatives have been marketed undiluted, but in many instances lower-dose formulations are also present.
In 2020, as in the previous year, the typical concentration of the active substance of synthetic cannabinoids applied on plant materials fell between 0.1 and 5%. The active substance content of sheets of paper impregnated with synthetic cannabinoids, typically seized in prisons, was in the range of 0.1-4%. Compared to previous years, the number of cases where unprocessed or undiluted synthetic cannabinoid was seized from drug users in small batches has increased. The most common of these was the orange sticky substance or sticky, lumpy powder containing 5F-MDMB-PICA (NSZKK 2021).

T1.2 DRUG RELATED CRIME

T1.2.1 Drug law offences

The characteristics of drug offences and their perpetrators are presented on the basis of the data recorded when investigations are completed in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor’s Office (ENYÜBS). The data are analysed by the Hungarian National Focal Point.
In 2013 the Special Part of the Hungarian Criminal Code was significantly amended, including the statutory definitions related to drug offences. Offences committed after 1 July 2013 fall under the force of Act C of 2012 on the Criminal Code (hereinafter new Btk.), while offences committed before 1 July 2013 fall under the effect of Act IV. of 1978 on the Criminal Code (hereinafter old Btk.). (For details see the Legal Framework Workbook Chapter T1.1.1, and the 2014 National Report, Chapter 1.2.)

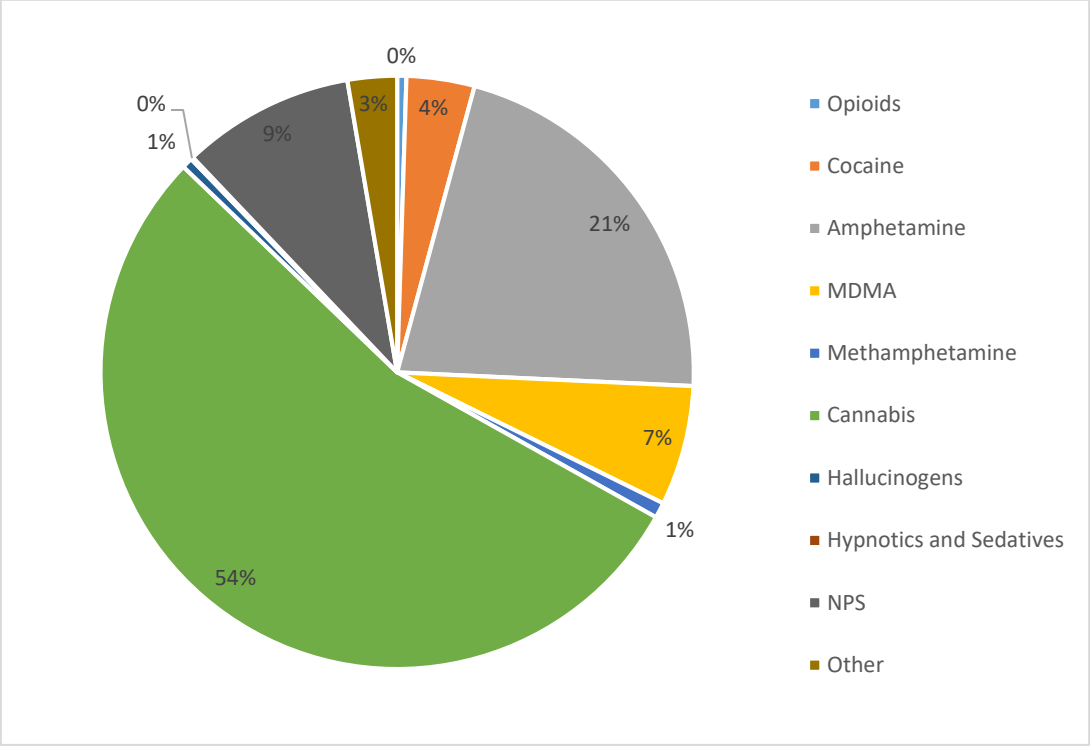
The investigation phase of a total of 7113[169] offences related to drugs or new psychoactive substances was closed in 2020.
Misuse of new psychoactive substances has involved criminal liability since March 2012. (For details see the Legal Framework Workbook, Chapter T1.1.3, and the 2012 National Report, Chapter 1.2.) A total of 592 (8.3%) drug related offences involved substances classified as new psychoactive substances, all of which fell under the force of the new Btk. Following the close of investigations in offences related to the misuse of NPS 2522 cases were transferred to infringement procedure in 2020. (BM 2021)
Drug related offences represented 4.4% of all offences registered in Hungary.
Most drug offences were committed in Budapest (37.8%) or Pest county (8.1%). Among the other counties the share of Győr-Moson-Sopron county (6.3%), lying along the northern border was the highest, followed by Fejér (5%) and Komárom-Esztergom (4.6%) counties.

Substance types

In 2020 more than half of the registered drug offences[170] (53.1%, 3777 cases) were committed with cannabis, the second largest group was that of stimulants[171] (29.6%, 2084 cases). Among stimulants, the most frequently occurring substance was amphetamine (72.2%), followed by MDMA (ecstasy) (21.9%) and methamphetamine (2.8%). New psychoactive substances were recorded in 9.3% (657 cases) of the registered cases, which is – similarly to last year data - a significant increase compared to previous years (in 2018 2,4%; 197 cases; in 2019 8.9%; 628 cases).[172] Among NPS mostly substances under "Other" category (56%); cathinone derivatives (6.1%) and synthetic cannabinoids (16.4%) were recorded.
Cocaine was registered as the subject of the offence in 3.6% (259 cases) of the cases, opioids in 0.5% (35 cases), hallucinogens also in 0.6% (41 cases) and other substances in 2.6% (188 cases).[173] (ST_11_2020_HU_01)

[169] Of the 7113 registered crimes, only 1 fell under the old Criminal Code.
[170] Excluding cases linked to precursors (1) and those offences where the substance type was not recorded (382).
[171] Stimulants other than cocaine.
[172] The number of cases committed with new psychoactive substances broken down by statutory definitions of the Criminal Code and by substance types does not match. The reason for this is that the categorisation by substance type took place according to the substance categories defined by the EMCDDA DLO data collection protocol where substances not listed on the UN drug schedules were classed as new psychoactive substances, while in case of categorisation by statutory definition offences committed with substances scheduled as new psychoactive substances according to Hungarian law were classified here. The Hungarian legislation is stricter in places than international legislation and certain substances not included on the UN lists - and hence categorized as NPS according to the EMCDDA protocol - are classed as illicit drugs in Hungary. For this reason, the number of offences committed with new psychoactive substances is different when totalled according to statutory definitions and when categorized by substance types.
[173] The substance type was not recorded in 382 cases (4.5% of all registered drug offences). Precursors were the subject of the offence in 1 case.

Chart 72. *Breakdown of registered drug offences (N=7113)[174] by substance type in 2020*



Source: ENYÜBS 2021, analysed by HNFP

Perpetrations[175]

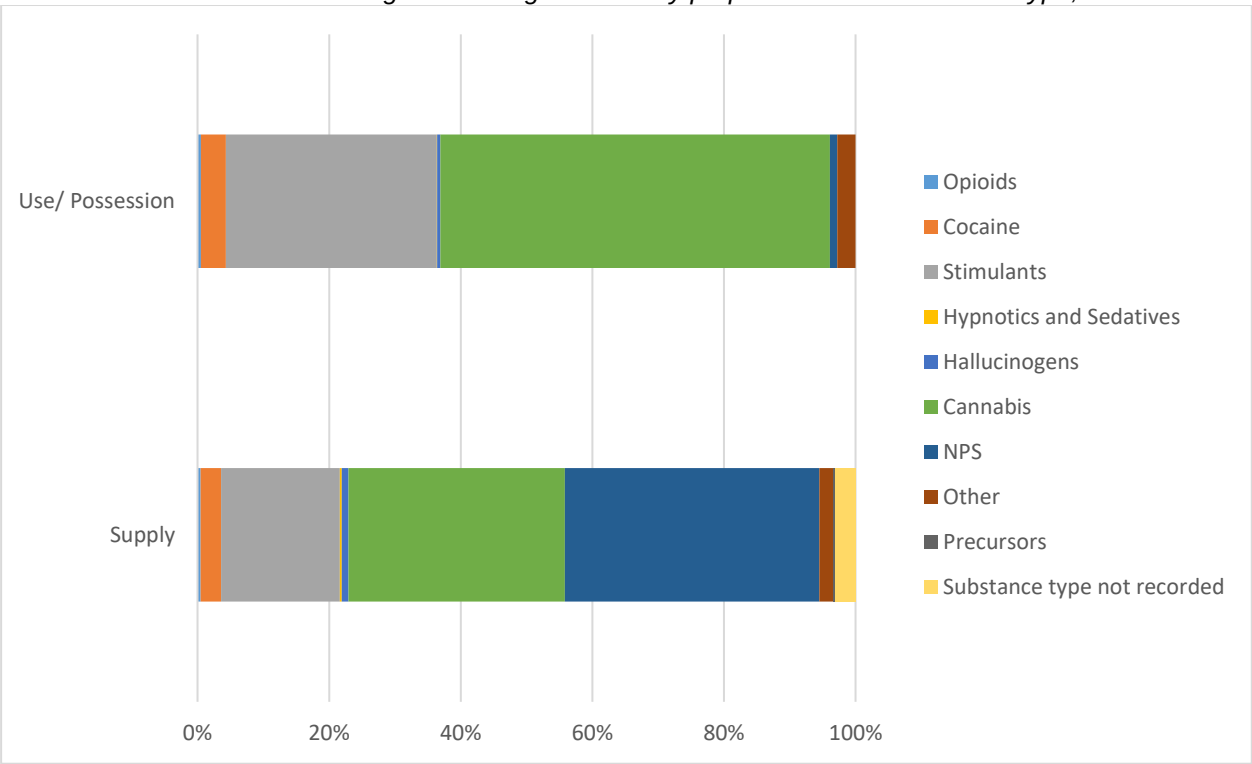
Of the offences registered in 2020, 5519 offences (77.6%) were linked strictly to possession of an illicit drug (acquisition or possession for personal use). 59.2% of these cases were committed with cannabis, 32% with stimulants. Other types of substances appeared as the subject of use related offences in relatively low proportions (opioids 0.5%, cocaine 3.8%, other substances 2.8%, NPS 1.1%). (ST_11_2020_HU_01)

Perpetrations classed as supply-related offences[176] made up 22.1% of registered drug offences (1575 cases). 26.6% (419 cases) of supply related offences involved trafficking with a small quantity of drugs. Offences committed with a substantial or particularly substantial quantity were recorded in 206 cases (representing 13.1% of supply related offences and 2.9% of all drug offences). Cultivation or production of drugs was the type of perpetration in 105 offences, accounting for 6.7% of supply related cases. The number of cases in the "other supply group" was also relatively high, accounting for more than half of the all supply cases (53.7%; 845 cases).
The large majority of trafficking related perpetrations were linked to new psychoactive substances (37.8%; 595 cases), which counts as a significant change compared to 2018 data (2018:7.8%) . The second largest proportion related to perpetrations was linked to cannabis with 32.1% (506 cases). Stimulants were involved in 17.7%, cocaine in 3%, opioids in 0.4%, and other substances in 2.2% of supply related cases. The proportion of offences where the substance type was unknown or unspecified was also relatively low in 2020 (3%).
Among offences committed with a substantial amount of drug, cannabis (39.8%) and stimulants (21.8%) were recorded most frequently as the subject of the perpetration. Cocaine was recorded in 9.7%, opioids in 2.4% and NPSs 1.9% of the cases. Among supply related

[174] Excluding precursors and those offences where the substance type was not recorded.
[175] Starting from 2014 offence types are categorized according to the EMCDDA's new drug law offences data collection protocol, which is different from the reporting structure used in previous years in several aspects.
[176] Trafficking related behaviours include: cultivation, production, offer, supply, distribution, dealing, import, export, transport through the country, and all offences committed with a substantial or particularly substantial quantity.

offences committed with small amounts of drugs NPS were the subject of the offence in 42% of the cases, 37.2% was related to cannabis and stimulants were involved in 15%.
93.3% of cultivation/production offences involved cannabis.
Other perpetration types listed under a separate title in the Criminal Code (inciting substance abuse, aiding the production of illicit drugs) were recorded in 16 cases (0.2%). (ST_11_2020_HU_01)

Chart 73. *Breakdown of registered drug offences by perpetration and substance type, 2020*



Source: ENYÜBS 2021, analysed by HNFP

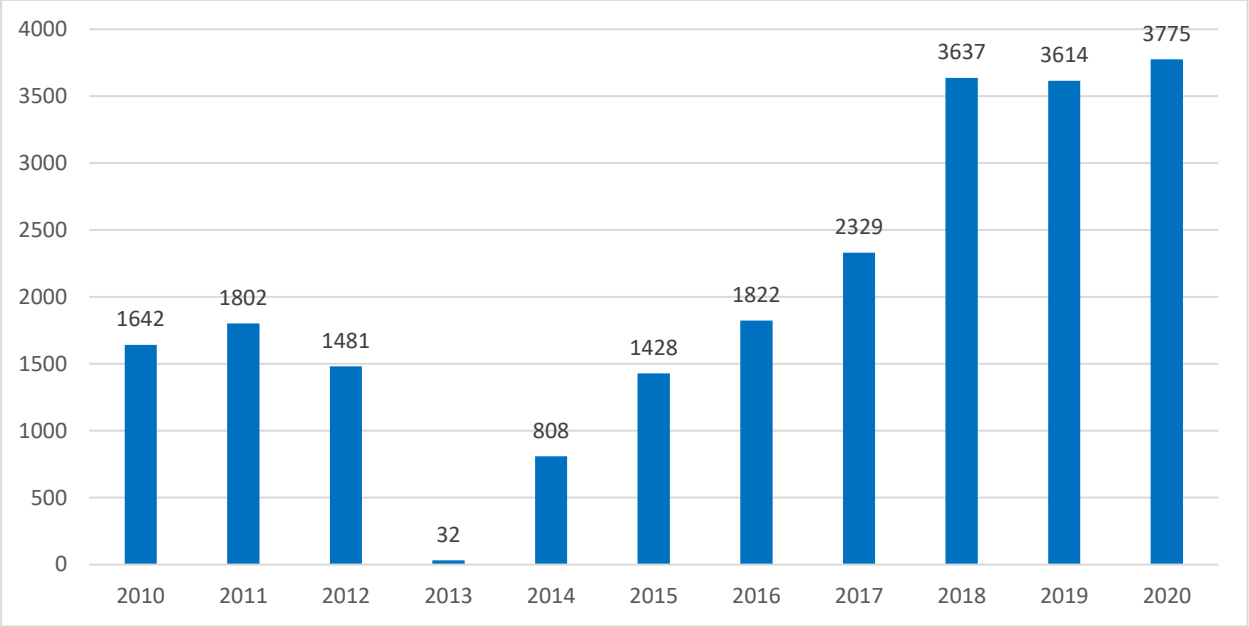
Alternatives to criminal procedure

The large majority of criminal procedures[177] launched in drug related cases are closed before the court phase starts, as a result of the institution of quasi compulsory treatment (QCT), which may be undertaken as an alternative to punishment. (The legislative background of the alternatives to criminal procedure is described in the Legal Framework Workbook, Chapter T2.1, the data of those entering treatment in the scope of QCT are presented in the Treatment Workbook, Chapter T1.3.1., while the data of prisoner clients entering QCT is reported in the Prison workbook, Chapter T1.2.2 and T1.3.2.) Only a smaller part of those participating in QCT will have a criminal record (for example, if the offender only starts QCT during the court phase of the procedure), the majority will not be registered in the criminal statistics, because when a

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

perpetrator starts QCT the criminal proceedings are terminated and the case is not registered as an offence.
In 2020 a total of 14282 drug-related criminal proceedings were commenced, of these, formal accusation was made in just 3677 cases (26.7%). The remaining 75% (10578 cases) of criminal proceedings were closed before the court phase due to procedural decisions 'termination of the procedure' (41%), 'suspension of the procedure' (30.3%), 'termination of investigation' (0.2%) 'rejection of complaint' (2%), or 'diversion' (0.2%). The criminal proceedings were closed in relation to diversion (treatment as an alternative to criminal procedure) in only 27 cases (0.2%), as the new Law on Criminal Proceedings no longer contains decision similar to the previous 'diversion''. Therefore, from 2019, the proportion of decisions ending in diversion within all initiated proceedings became difficult to determine.
Data on diversion can be found only in ENYÜBS, which is a follow-up statistic, so the data is determined not by the actual offense but by the date of entry. Based on the data received from ORFK (police), it can be said that in the period between 2010 and 2020, the number of diversions fluctuates (increasing-decreasing) but shows a continuous increasing trend. The exceptionally low number in 2013 (32) is presumably in line with the issue of the new Penal Code the follow-up nature of the ENYÜBS and the different legal regulations on use of new psychoactive substances.
Examining the period between 2014 and 2020, it can be said that the number of people getting into QCT among juveniles continuously increased (59→326), while among young adults (18-24 yo.) it has been an increase until 2018, but after it started to slightly decrease (1571→1385). Regarding adults (25-59 yo.) the number of people in QCT increased sharply until (390→1873), while from 2018 it has only a slight increase. It can be seen that the diversion typically affects the young adult and the adult population.
The reported data only include cases in which the person in the procedure has undertaken treatment for at least six months. If the participation in the treatment, care or service was terminated prematurely, it was not possible to apply the favourable legal effect of the diversion to the person subject to the procedure (ORFK 2021).

Chart 74. *Number of registered offenses in the case of an offense specified in Section [282/C. (1); 282/C. (5) a)] of the Police Proceedings (called: postponement pf prosecution according to the old; and conditional prosecution parole according to the new code of criminal proceedings)*



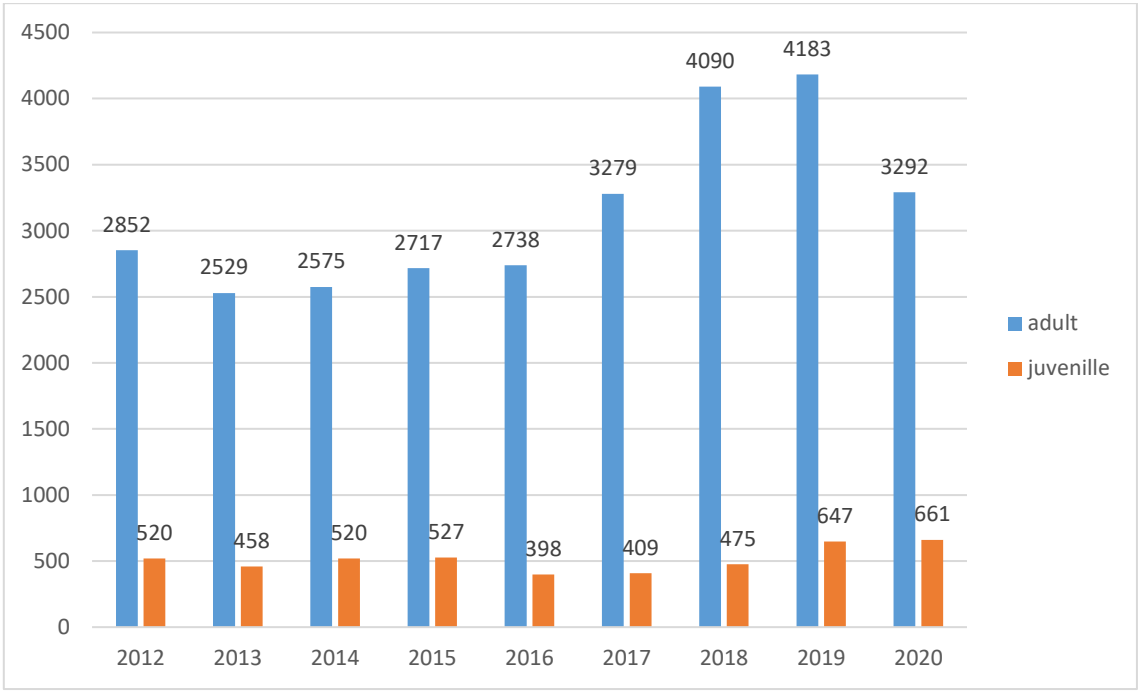
Source: ENYÜBS 2021, analysed by ORFK

Probation supervision ordered or established in connection with a diversion is a special case where the primary purpose is to monitor and support the fulfilment of the diversion. The general rules of probation supervision play a different role in this case. While in other cases there are legal consequences primarily for violating the general rules of probation, in the case of diversion, the outcome of the conditional suspension of the prosecution - termination of the proceedings or continuation of the proceedings - depends on the fulfilment of the special obligation.
Probation service linked to diversion[178] was provided in 3953 cases. 80% of the offenders of these cases were adults and 20% were juveniles (IM 2021).

No diversion has been initiated for new psychoactive substances, as the small amount of possession of NPS entails an infringement procedure in which diversion is not possible. (See more: Legal Framework workbook, Chapter T1.1.2 and T1.1.3) In 2020 2522 people were taken under infringement procedure for misuse of new psychoactive substances. By the end of last year, 89% of those reported had been convicted. In 2020, the most frequently applied sanction for infringement procedures was the fine, with an average 70,484 Forint/person (BM 2021).

[178]The new Be. (Act XC of 2017) introduces a new legal institution, called the 'prosecutors suspension': Pursuant to section 417, the prosecution suspends the proceedings of its own motion or at the request of the defendant for one year in order to comply with the statutory condition, under grounds of the Btk (diversion Act 180). The new Be. Allows diversion for adult suspects without the need of probation service. Probation service ordered in connection with QCT is a special case of probation service the primary aim of which is to support and monitor the fulfillment of the additional obligation.

Chart 75. *Number of probation services provided in connection with quasy compulsory treatment (QCT), 2012-2020*



Source: IM 2021

Drug law offenders

In 2020 the criminal statistics registered 7113 offenders linked to the 7710 registered drug offences[179]. 90% of the offenders were males and 10% were females, similarly to previous years.

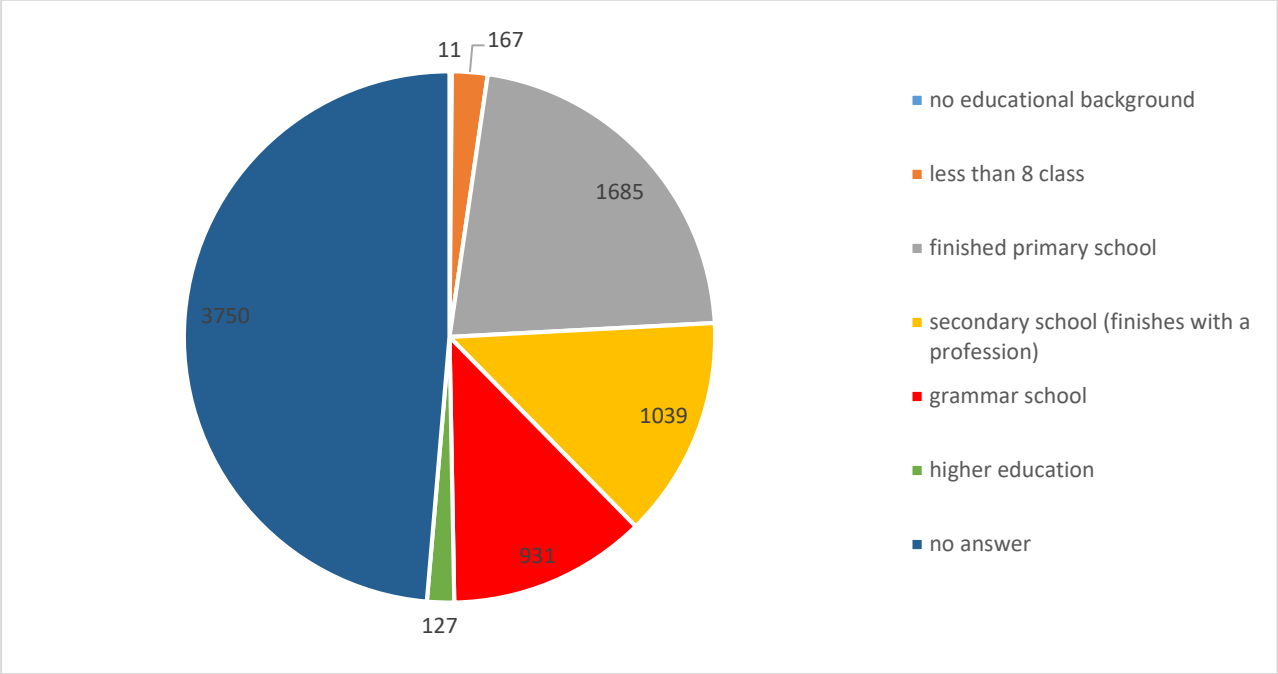
Regarding distribution by age groups, 10.9% of drug law offenders were under 18 years, 30.2% of them were between 19 and 24 years, and 25.9% were between 25 and 30. Overall, 66% of drug law offenders were 30 years old or younger, while among all criminal offenders the proportion of those under 30 years of age was 43% and of those between 19-24 years was 16.5% which implies that drug offenders are significantly younger than other offenders.

21.9% of drug offenders had elementary school qualifications, 25.6% completed secondary school and only 1.7% had higher school qualifications.[180]

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

[180] In the case of 3750 persons (39%) school qualification was unknown.

Chart 76. *Distribution of drug offenders by education (N=7710)*



Source: ENYÜBS (2021), analysed by NFP

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

In 2020 a total of 7259 persons committed offences under the influence of illicit drugs, which made up 9.4% of all registered offenders. The large majority of those committing offences under the influence of illicit drugs committed a drug related offence (6392 persons, 88.1%), and a total of 867 persons (11.9%) committed other types of offences.

In the highest proportion (694 persons, 80.1%) the perpetrators committing non-drug related offences under the influence of illicit drugs committed traffic offences, of these 683 persons committed the offence of driving under the influence of alcohol or other substances. 61 persons (7%) committed offences against property, 35 persons (4%) committed offences against persons[181], 17 persons (1.9%) committed the act of disturbing the peace, and 60 persons (6.9%) committed other offences. Of the crimes against the persons, 9 homicides were committed under the influence of drugs while attempted homicide was registered in 4 cases.

T1.3 DRUG SUPPLY REDUCTION ACTIVITIES

T1.3.1 Drug supply reduction activities

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

The National Security Strategy specifies in detail the challenges and adequate responses at national level arising in connection with drug trafficking. It states that the preconditions of rapid and more effective action against drug related crime are the following: increasing the effectiveness of the work performed by the police, improving the equipment used by the

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

competent bodies and the training of personnel, as well as effective information exchange and collaboration with the competent international bodies. In the interest of this, according to the Strategy the effectiveness of the countermeasures must be increased, the bodies responsible for action against organised crime groups and the personnel, material and technical resources of forensic experts must be strengthened. Apart from the above, a national level anti-drug crime service must be set up. The fight against drugs also represents a comprehensive social task, therefore, from the point of a successful action, the use of the crime prevention possibilities is especially important. In addition, there is a need to step up cooperation between authorities on chemicals most commonly used in the illicit manufacture of narcotic drugs and psychotropic substances, furthermore to promote the training of law enforcement agencies, regulators and prosecutors in the field of drug precursors in new crime trends and tendencies; and to support the continuous training of economic organizations and professional interest groups engaged in the legal activity of drug precursors and to increase inspections of economic entities engaged in the import, export and placing on the market of non-listed drug precursors or non-listed substances established by the European Commission.
Based on above, the main strategic objective of supply reduction is to prevent any psychoactive substance suitable for misuse getting into Hungary and prevent access to the substances appearing in the country and realise the crime prevention aspects related to this.

The National Police Anti-Drug Strategy entered into force in February 2014. Apart from reducing supply, the document lists the priorities as strengthening the activities of forensic experts, reducing the number of road accidents related to drug use and increasing the effectiveness of investigations. According to the main priorities stated, the number of procedures launched due to trafficking behaviours needs to be increased and collaboration between the Hungarian Post and delivery companies must be established that assists the restriction of distribution made in this way.
The primary participant in the supply reduction activity is the criminal and public order protection service of the Police, also involved in this activity is the drug policing work performed by the police administration service, which reduces and prevents diversions by inspections among those with permits (healthcare service providers, manufacturers, wholesalers).Drug enforcement is carried out by the ORFK RFI Department of Public Administration, as a central body, along with a stable drug enforcement network (23 persons).The department conducted 6534 inspections in 2020, although the efficiency was heavily affected by the two waves of COVID-19 pandemic. In addition to the widespread workload of the health care system, in view of the rapid spread of the epidemic, significant tightening and restrictions were introduced in the areas affected by the sector, therefore it was not possible to carry out the tasks set out in the control plan. During the inspections, deficiencies were identified in 144 cases, which were sanctioned by a criminal procedure in 3 times and infringement procedure in 6 times. The partner authorities were informed of the discovery of deficiencies in 3 cases. The central body has carried out registration procedures in 141 cases, so it registers more than 2,000 veterinary institutions, retail distributors and private veterinarians, which is a significant crime prevention activity.
In 2020, the field supervised 17 destructions, during which more than 12,000 kg of drugs, psychotropic substances and drug precursors were burned in a controlled manner, the extraction of which resulted in a significant reduction in public safety risks (BM 2021).
The National Tax and Customs Administration (NAV) carries out supply reduction tasks by monitoring the legal traffic of illicit drugs, new psychoactive substances and drug precursors. NAV is also responsible for detecting illegal substances at border crossing points and at postal and courier services. The NAV also plays an active role in national and international operations and actions aimed at curbing the illicit trafficking of narcotic drugs, which enables the NAV to gain access to international information and experience (NAV 2019). In 2020, the customs authorities of NAV performed 1404 procedures regarding narcotic drugs, psychotropic and new psychoactive substances, and 1549 procedures for drug precursors. According to NAV seizure data, in 2020, 408 cases regarding narcotic drug, psychotropic substance and new psychoactive substance offenses were detected. Among these detections, 282 cases were

connected to possession, 70 were connected to misuse of NPS while 56 cases were connected to the facilitation of production of narcotic drugs. 94% of the detections took place in air traffic. According to the data, perpetrators of drug-related offenses often use the services of postal or courier providers. The number of seizure data in 2020 is lower than in 2019 due to restrictions related to the coronavirus epidemic (NAV 2021).
The Department of Commerce, Military Technology, Export Control and Precious Metals Verification (hereinafter: BFKH KHENF) of the Government Office of the Capital City of Budapest performs administrative and liaison tasks in the field of drug precursors as a designated national authority. Authorization of activities regulated by the EU regulations on drug precursors, registration of notifications, granting of individual and export authorizations for export and import under simplified procedure, as well as the control of legal activities are among the primary tasks of the BFKH KHENF. In 2020, the BFKH KHENF carried out joint on-site inspections with the partner authorities at major drug precursor users, distributors, manufacturers, exporters, importers, mainly under the framework of an annual inspection program (in accordance with Government Resolution 2103/1999. (V.5.)), in some cases the office was also involved in the issuance of activity licenses and in the investigation and clarification of anomalies detected during data request inspections. 16 compliance checks planned in the control program were performed, in addition 1 extraordinary check was performed for non-listed substances, destruction of drug precursors by incineration was checked 8 times. . The BFKH KHENF also carried out consultations on non-scheduled substances during several inspections. In regard of the epidemic situation, the control plan was not fully implemented and the BFKH KHENF did not participate in the incineration in person, but a report on it was available in all cases. (BFKH 2021).

T2. TRENDS

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

Seizures

During 2010-2011, the authorities seized more than 10000 plants per year at large-scale cannabis plantations of more than 100 plants. This amount significantly dropped in the period 2012-2014. However, no outstanding change can be seen in the number and proportion of plantations of under 10 plants and between 10–100 plants over the period between 2010 and 2020.
The amount of herbal cannabis seized in large quantities jumped significantly in 2012, then dropped continuously until 2016. In 2017 significant seizures happened again in the border traffic from Serbia to Hungary. While during the 2010-2011 period a few hundred kilograms of herbal cannabis was seized, in 2012 the amount seized was nearly 1.8 tonnes, which fell back to 529 kg in 2014, 590 kg in 2015 and 494 kg in 2016, then in 2017 the amount rose to 2.1 tonnes again. In 2018 the seized amount was 868 kg, 714 kg in 2019 and 632 kg in 2020.
The number of cannabis resin seizures has been rising continuously since 2010. In 2020, 43 kg of hashish were seized, of which 39 kg were seized in one crime case. The majority of cases are smaller seizures of less than 10 grams, suggesting a steady increase in cannabis resin consumption. In addition, hashish bricks with different proportions of cannabinoid components have appeared on the black market. Hashish samples with high CBD and low (less than 1%) THC were found in several cases.
In 2009/2010 the number of heroin seizures and the amount of seized material dropped significantly as compared to previous years. During the following time period the seizures per year did not rise significantly, and the total amount of substance seized was just a few kilograms per year. In 2016 there were no major seizures, in 2017 in 6 cases the seizures were close to 1 kg, while in 2018 there were 8 cases like this. In 2019, the largest quantity seized in Hungary was a 67-kilogram lot, while in 2020, a total of 38 kilograms of heroin was seized in

2 cases. In addition to larger items, the number of street seizures remained low in 2019, suggesting that the volume of heroin use did not increase significantly.
With respect to cocaine seizures, a continuous rising trend can be identified in the number of seizures in the 2011–2019 period, which stopped in 2020. While nearly 30 kg of cocaine were seized in 2019, in 2020 that number was only 12 kg. The major part (80%) of seizures were on retail level.
The number of amphetamine seizures – due to the trend of small seizures under 10 grams – showed an increase since 2010
There were only 7 seizures of tablets containing MDMA in 2010, but the number of seizures increased continuously from 2012. Between 2017 and 2019 MDMA tablets were seized in 502, 586 and 584 cases. In 2020, both the number of cases (419) and the number of tablets seized (approximately 50,000) are lower than in the previous year. The number of powder or crystal MDMA cases also show a continuously rising tendency, with a total number of 133 seizures of 3,6 kg in 2020.
The number of LSD seizures and the quantity seized also showed an increasing tendency in the last few years, however in 2020 there was a decline both in the cases and the blotters seized. The so-called “LSD stamps” in several cases contained “designer” LSD derivatives instead of LSD. The number of cases has been steadily increasing since 2016, with the most common drugs being 1P-LSD and 1cP-LSD. Seizures of such products have already exceeded 20% of seizures of LSD-containing stamps in 2020. (ST 13_2019_HU_02)

Table 27. *Number of seizures between 2016-2020*[182]

type of drug	**2016**	**2017**	**2018**	**2019**	**2020**
herbal cannabis	2673	3674	3492	3 111	3 184
cannabis plants	153	158	169	158	189
cannabis resin	149	153	164	185	117
heroin	34	34	49	37	30
cocaine	229	276	303	365	301
amphetamine	778	900	1026	917	1 021
methamphetamine	54	68	120	157	154
ecstasy tablets /MDMA, MDA, MDE/	332	502	586	584	419
LSD	32	54	73	102	55
plant materials with synthetic cannabinoids	*2373*	*2177*	*2438*	*1 559*	*1 333*
synthetic cannabinoids in powder	*113*	*120*	*134*	*151*	*177*
cathinone derivatives in the form of powder	*671*	*735*	*885*	*535*	*594*
cathinone derivatives in tablets	*70*	*8*	*6*	*6*	*15*

Source: NSZKK 2021a

Table 28. *Quantity seized between 2016-2020*[183]

type of drug	**2016**	**2017**	**2018**	**2019**	**2020**
herbal cannabis (kg)	494.12	2139.91	868.42	714.66	632.16
cannabis plants (plant)	6482	5287	4769	7128	3 649
cannabis resin (kg)	3.69	114.46	20.02	1.97	43.19
heroin (kg)	2.11	20.56	34.94	77.38	40.04
cocaine (kg)	25.06	5.87	25.07	29.65	11.73
amphetamine (kg)	24.78	24.71	21.54	44.76	81.30
methamphetamine (kg)	0.19	0.74	0.88	1.4	1.97
ecstasy tablets (tablet) /MDMA, MDA, MDE/	79702	51836	43984	66 824	50 368

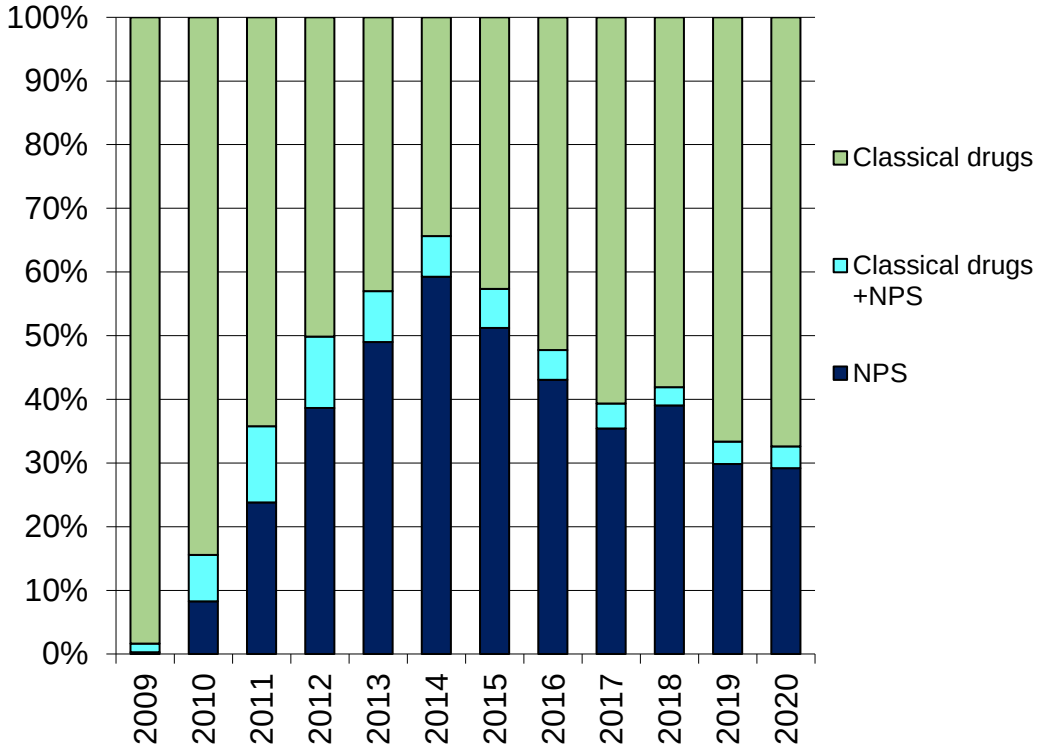
[182] The following table contains the data of the seizures analysed in the drug testing laboratory of the Hungarian Institute for Forensic Sciences, and the data of the cannabis plantations seized on site on the basis of the botanical examination.
[183] The following table contains the data of the seizures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

LSD (dose)	928	1476	1293	2 755	1 660
plant materials with synthetic cannabinoids (kg)	*29.13*	*11.79*	*18.95*	*10.56*	*6.06*
synthetic cannabinoids in powder (kg)	*3.47*	*3.09*	*2.51*	*3.95*	*12.92*
cathinone derivatives in the form of powder (kg)	*36.14*	*30.76*	*29.16*	*47.04*	*16.43*
cathinone derivatives in tablets (tablet)	*3256*	*551*	*534*	*178*	*1 697*

Source: NSZKK 2021a

From 2010 NPS completely restructured the Hungarian drug market. Following the large-scale increase in the amount of mephedrone available in the summer of 2010, the proportion of new psychoactive substances as compared to the classical drugs rose continuously for years. In 2014 NPS constituted nearly 60% of all police seizures. The continuously increasing trend of seizures turned back in 2015, in 2019 NPS seizures only represented 30% of all seizures. This proportion did not change in 2020.

Chart 77. *The number of seizures of 'classical drugs'[184] and NPS between 2009-2019*

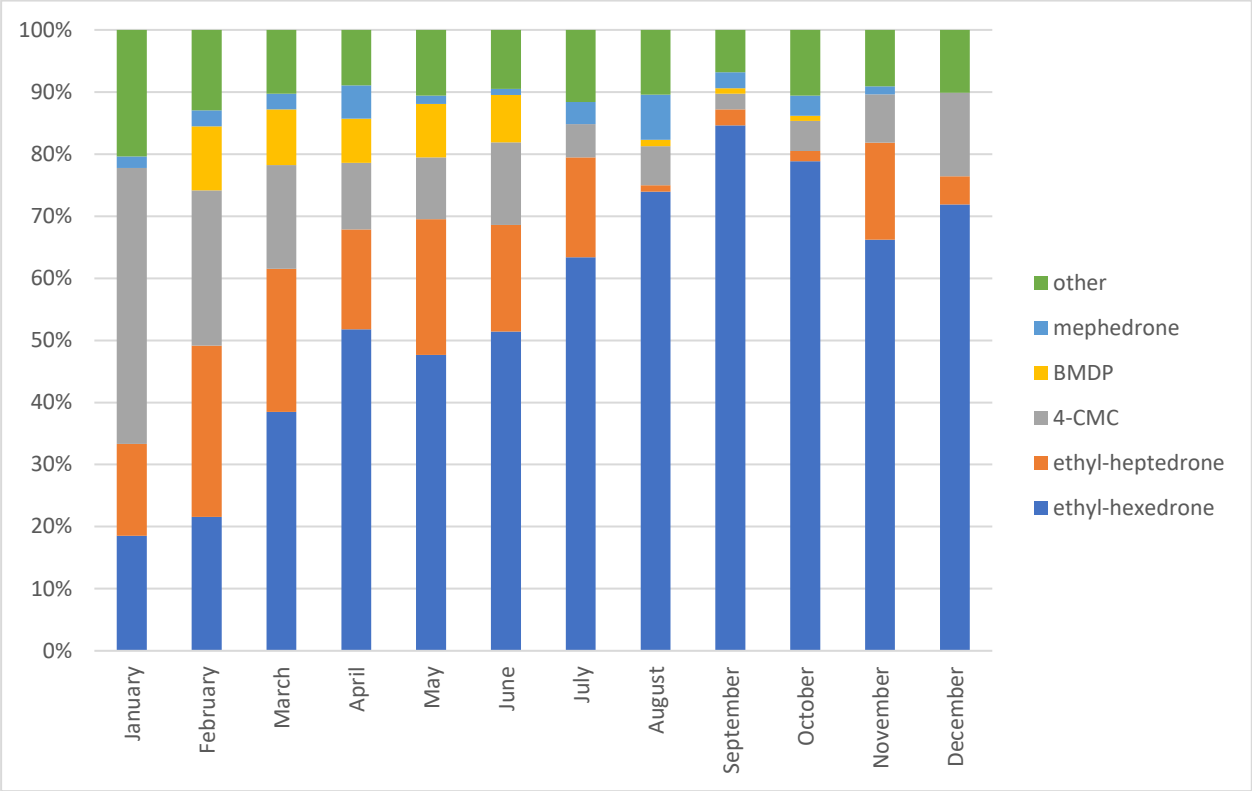


Source: NSZKK 2021a

The share of two large groups of the new substances, cathinone derivatives and synthetic cannabinoids was the largest in the seizures. Cathinones are usually distributed in the form of powders. The most frequent active substances were: mephedrone in 2010, 4-MEC and MDPV in 2011, and pentedrone from 2012. During 2014 the proportion of alpha-PVP in the seizures rose significantly for a time, but by the end of the year it was pentedrone again that was the most characteristic substance. In 2015 besides pentedrone and alpha-PVP the substance called alpha-PHP appeared in seizures with a larger proportion typically in the period January-August. From August 2016 and also in 2017/2018 ethyl-hexedrone seemed to be the most popular cathinone on the market, in 2018 90% of the cathinone powders were this substance. During 2017 and 2018 a small amount of 4-Cl-alpha-PVP was also detected in nearly quarter of the investigated ethyl-hexedrone powders. From February 2019, the number of ethyl-hexedrone cases significantly decreased, and the substance was replaced by ethyl-heptedrone. In 2020, the number of ethyl-hexedron-containing powders increased significantly again, accounting for more than half (57%) of the seizures. Powder containing ethyl heptron was supressed to second place with a seizure rate of 14%. Powders containing 4-CMC were found in a similar number of cases (13% of the seizures). In 2020, a total number of 21 different cathinone counts occurred in seizures, all of which were controlled substances as drugs or new psychoactive substances.

[184] Substances listed in the schedules of the UN Drug Conventions were categorised as 'classical'.

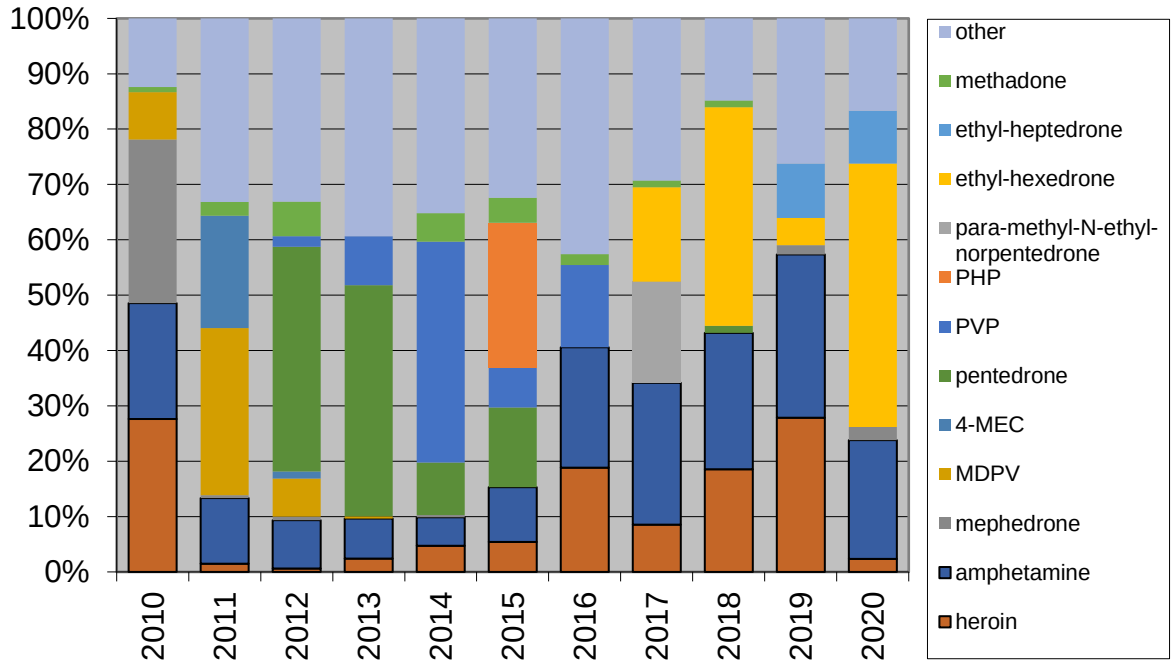
Chart 78. *Incidence of cathinone derivatives in seizure items in 2020*



Source: NSZKK 2021a

On the basis of the active substances detected in/on injecting drug use related equipment subjected to laboratory testing, it is possible to monitor trends in the types and prevalence rates of substances injected by IDUs. While the dominancy of cathinone derivatives could be detected in the past years, between 2016 and 2019 amphetamine and heroin were detected in 20-30% of the analysed subjects. Para-methyl-N-ethyl-norpentedrone and ethyl-hexedrone were the most frequently injected substances in 2017. In 2018 ethyl-hexedrone was the most prevalent injected substance, while in 2019 it was ethyl-heptedrone, in 2020 ethyl-hexedrone returned to as the most frequently injected substance It should be noted that these data only include cases in which objects contaminated with residues were examined and were clearly related to intravenous drug use. In many cases, residues present on the surface of objects are not tested or intravenous drug use is unlikely.
(The changing picture of substance use among IDUs can be followed in the data of clients attending needle/syringe programmes as well as in the data of those entering treatment due to drug use – see: Drugs /Stimulants, T1.2.1)

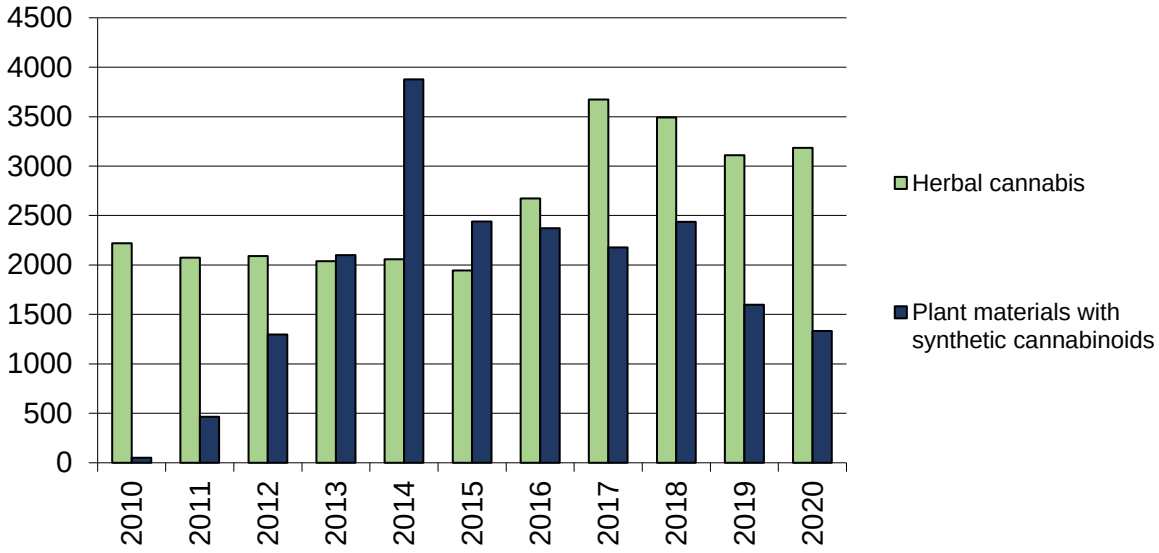
Chart 79. *Prevalence of active substances (%) detected in/on injecting drug use related equipment between 2010-2020*



Source: NSZKK 2021a

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

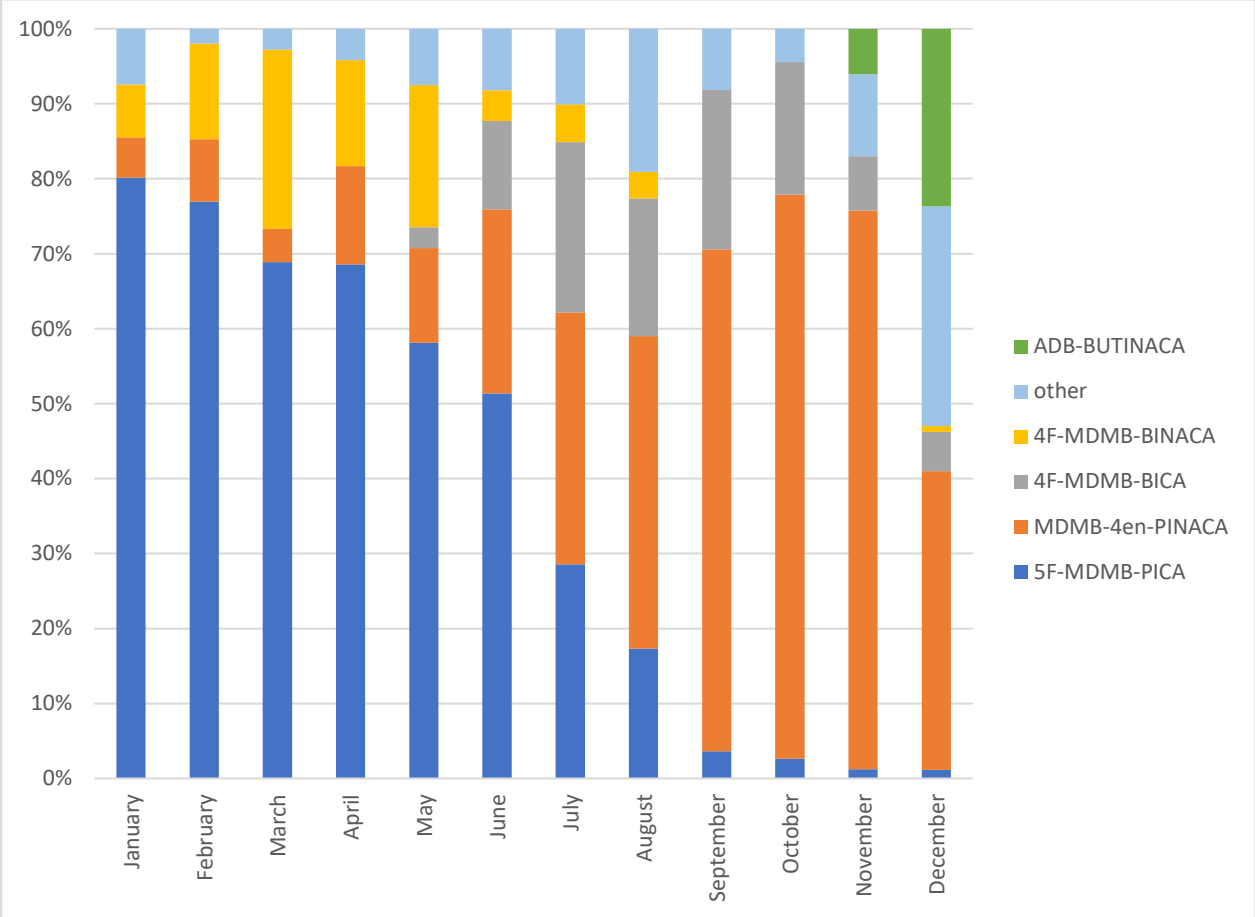
Chart 80. *The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between2010-2020*



Source: NSZKK 2021a

The range of active substances found in the products follow the changes in legislation dynamically, in individual periods characteristically 1–2 dominant active substances can be found on the market. After the individual active substances had become regulated, usually within 1–3 months their occurrence dropped significantly in the period 2011-2014 and their places were taken over by new active substances that were not yet regulated. In 2015 the dynamics of these processes changed, and the number of herbal cannabis seizures was higher in 2016 than the number of seizures of products impregnated with synthetic compounds. The most frequent active substances were ADB-FUBINACA, AMB-FUBINACA and 5F-MDMB-PINACA in 2017. In 2018 the most prevalent substance was the 5F-MDMB-PINACA which took nearly 70% of the detected substances. In 2019, 63% of the impregnated herbal materials contained 5F-MDMB-PICA. In 2020 the most prevalent components on herbal materials were 5F-MDMB-PICA and MDMB-4en-PINACA (72% of all cases). Additionally, 4F-MBMB-BICA and 4F-MDMB-BINACA were quite frequent with around 10% of all cases. 4F-MDMB-BICA has been seized in a number of death-related cases. It has appeared on substances found next to the corpse alone and in combination with other active ingredients.

Chart 81. *Prevalence rate of synthetic cannabinoids in seizure batches 2020*



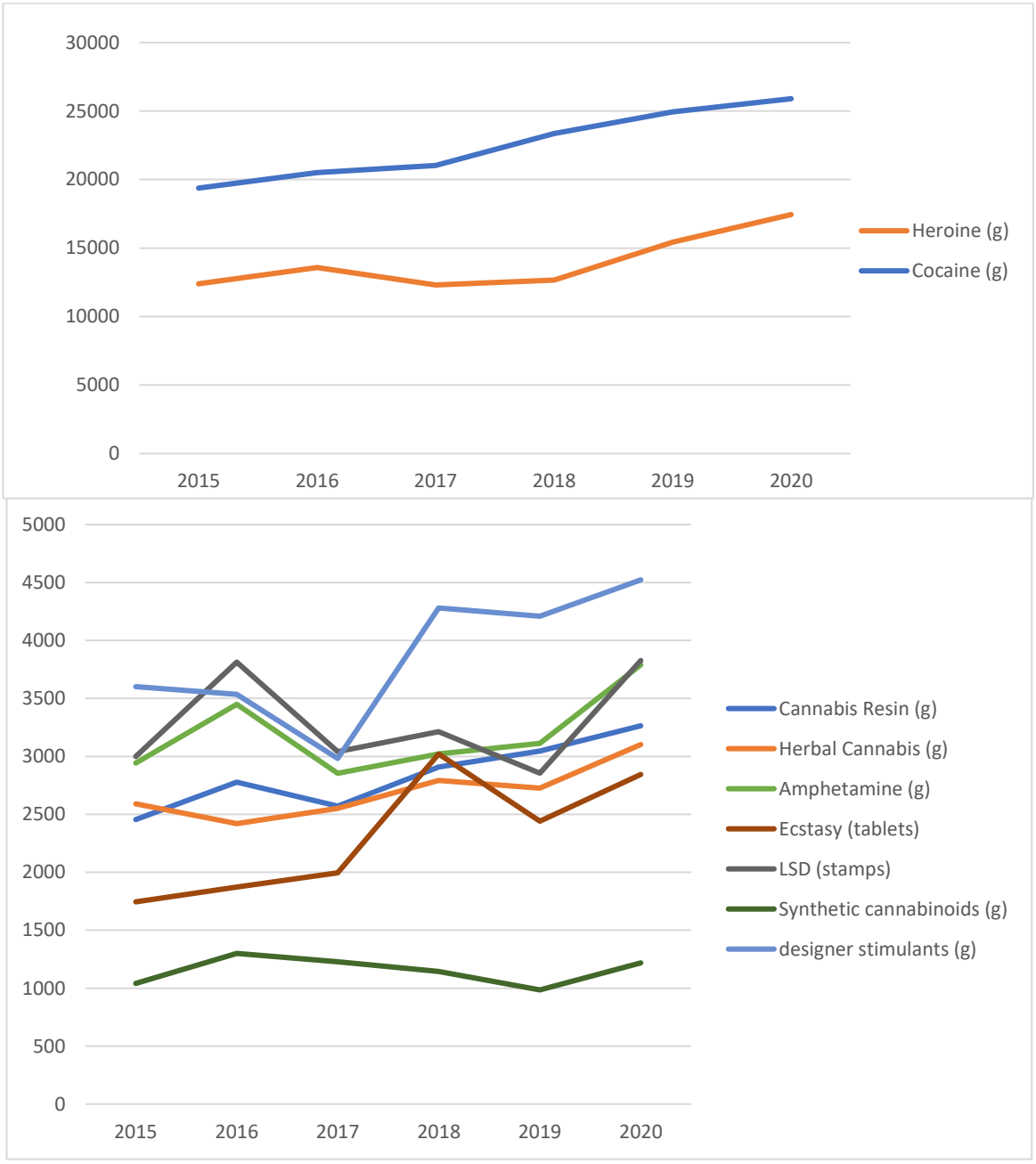
Source: NSZKK 2021a

Synthetic cannabinoids are usually impregnated into commercially available herbal materials, but they are also applied on tobacco. In recent years, the proportion of products otherwise known on the street as “magic tobacco” has been steadily increasing. In 2017, they accounted for about 15% of impregnated plant materials, 30% in 2018 and 2019, and 44% in 2020.

Street prices

According to the research carried out by the Hungarian national Focal Point (Bálint 2021), it can be stated that in 2020 the street prices of the drugs examined started to slightly increase, compared to 2018 and 2019. In case of mean prices of stimulant-type new psychoactive substances (under the street name “crystal”), a slight decline in 2017 was followed by an increase in 2018, which continued in 2020 as well. . The price of ecstasy tablets continued to increase in 2018, followed by a slight decrease in 2019, which turned into a moderate rise in 2020. Furthermore, comparing to last year, the average price of LSD started to strongly increase in 2020. For years, there has been a steep increase in the average price of cocaine, however, the variance of the prices reported by the respondents is extremely large, suggesting that the quality of cocaine in the market varies widely. The street prices of herbal cannabis and cannabis resin have been almost the same for years, however there has been a slight increase in the most common prices in 2020, potentially due to the increased demand in the COVID-19 pandemic. they are still far higher than the also constant prices of synthetic cannabinoid products.

Chart 82. *Street prices (mean value) of illicit drugs in HUF between2015-2020*



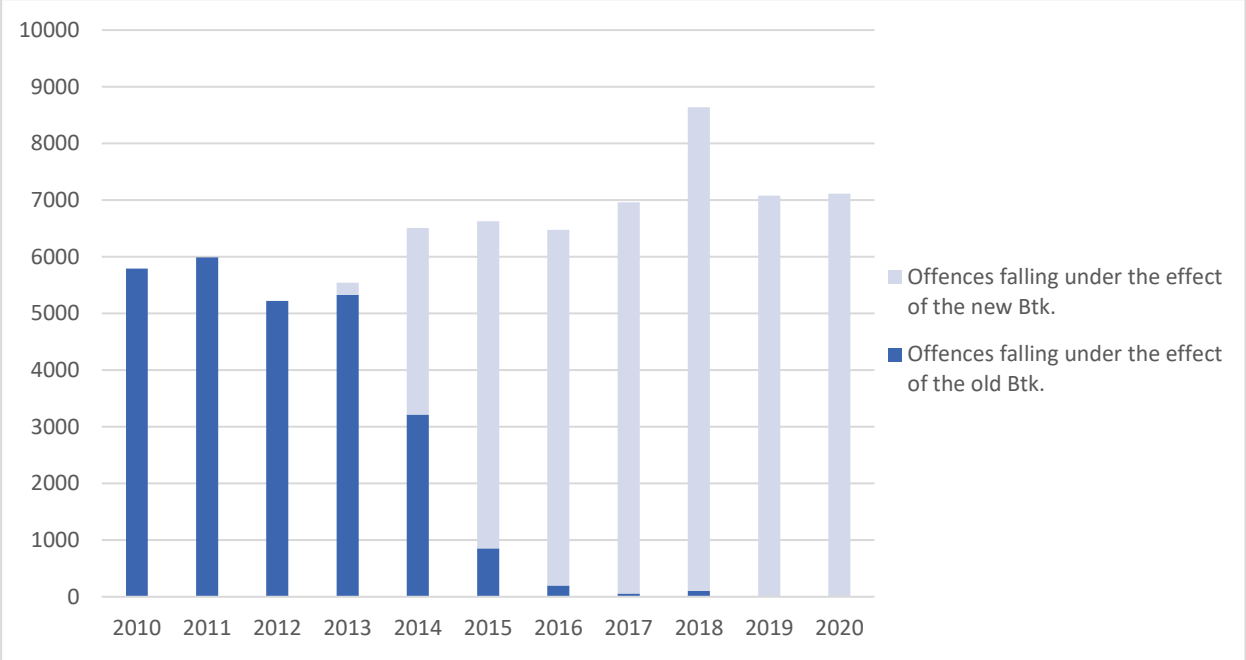
Source: Bálint 2021

T2.4 DRUG LAW OFFENCES – SHORT TERM TRENDS

A chronological analysis of the number of drug related offences over the past 10 years is only partly possible, as offences committed before 1 July 2013 fall under the force of Act IV. of 1978 (old Criminal Code Btk.), while offences committed after this date fall under the force of Act C. of 2012 (new Criminal Code Btk.) and in the drug crime statistics the categories covering the statutory definitions of the old and the new Btk. do not always comply with each other. (For more information see 2014 National Report, Chapter 9.1). Furthermore, starting from 2014, offence types are sorted according to the categories of the new EMCDDA drug law offence protocol, which differs significantly from the reporting structure followed in the past. As a consequence, data are only partially suitable for comparison and chronological analysis.

Examining the last ten years the annual number of registered drug law offences rose slightly till 2017, however between 2017 and 2018 a more significant increase of 19% can be observed, which was followed by another decline in 2019.

Chart 83. *The number of registered drug offences in Hungary between 2010-2020*



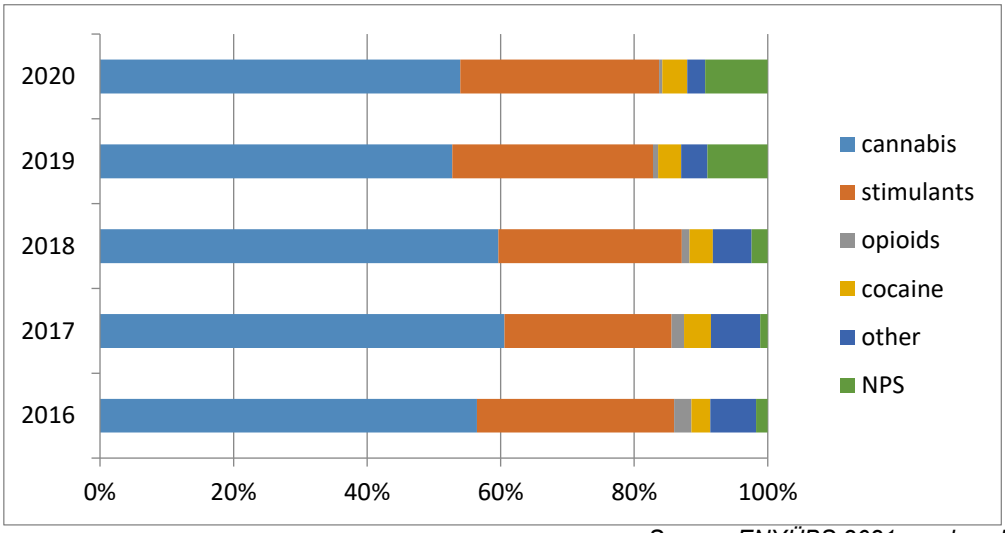
Source: ENYÜBS 2021, analysed by HNFP

With respect to perpetration types, in the past 5 years the majority of drug offences were consumption related, committed in connection with personal use. The proportion of trafficking type supply related offences was usually around 20%. The large majority (80-90%) of the offences were committed with a small amount of illicit drug, substantial amounts of illicit drug occurred in only about 2-3% of cases. There was no change in the data in 2020 either.

Examining the past five years, the majority of drug related offences were committed with cannabis (2020: 53.6%). Following a decline until 2016, the proportion of cannabis among the substance types started to rise again in 2017, however, in 2018 there is again a slight decrease that continued also in 2019 and 2020. The change in the distribution of drug related offences according to substance types followed to a certain extent the changes observed on the drug market (see Chapter T2.1) and in drug use patterns (see the Drugs/Stimulants and Drugs/Heroin and other opioids Workbook, Chapters T1.2): between 2015 and 2017 the proportion of cases involving opioids did not exceed 3%, while in 2020 the proportion does not reach the 1%. Stimulants (typically amphetamine) at the same time appeared as the subject of perpetration in an increasing proportion from year to year, in 2016 offences committed with them represented 29.5% of all registered drug offences. After the small drop of 2017, in 2018 the number of stimulant related cases increased again slightly, while in 2019 the proportion of stimulant related cases reached the 2016 level (2019: 29.5%), which did not change in 2020 either (2020:29.6%).
Offences (trafficking type) with new psychoactive substances involve criminal liability since April 2012, such cases appeared in the criminal statistics in 2013. (See 2013 and 2014 National Report, Chapter 9.3.) Offences committed with new psychoactive substances constituted an increasingly larger proportion of drug law offences until 2015 (2013: 3.5%, 2015: 6.8%), but in 2016 and 2017 they accounted for less than 2% of drug offences. This decreasing tendency was followed by a slight increase in 2018 (2.5%), which continued in 2019, with an increase of

6 percentage points comparing to the last year (8.9%), this increase continued in 2020 as well (2020:9.3%).

Chart 84. *Breakdown of drug offences[185] by substance type between 2016-2020*



Source: ENYÜBS 2021, analysed by HNFP

T2.7 CHANGES IN DRUG SUPPLY REDUCTION ACTIVITIES

See Chapter T1.3.1.

T3. NEW DEVELOPMENTS

This year all current, available data and information, including data relating to 2018, is presented as part of the baseline information in Chapter T1 and T2.

T4. ADDITIONAL INFORMATION

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

Bálint, R. (2021): A kábítószerek utcai árának alakulása 2020-ban. Nemzeti Drog Fókuszpont. Manuscript.

BFKH (2021): Budapest Főváros Kormányhivatala: Kereskedelmi, Haditechnikai, Exportellenőrzési és Nemesfémhitelesítési Főosztályának beszámolója a 2021-es EMCDDA Jelentés elkészítéséhezBM (2019): A Belügyminisztérium 2018-ra vonatkozó beszámolója a 2019-es EMCDDA Jelentés elkészítéséhez

BM (2020): A Belügyminisztérium 2019-re vonatkozó beszámolója a 2020-as EMCDDA Jelentés elkészítéséhez

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

BM (2021): A Belügyminisztérium 2020-ra vonatkozó beszámolója a 2021-es EMCDDA Jelentés elkészítéséhez.

ENYÜBS (2021): A Belügyminisztérium Egységes Nyomozóhatósági és Ügyészségi Bűnügyi Statisztikai Rendszerénekkábítószer-bűnözéssel kapcsolatos adatai.

IM (2021): Az Igazságügyi Minisztérium 2020-ra vonatkozó beszámolója a 2021-es EMCDDA Jelentés elkészítéséhez.

NSZKK (2021): A lefoglalások laboratóriumi vizsgálati eredményének adatai 2009 és 2020 között.

ORFK (2021): Kábítószer-függőséget gyógyító kezelésben, kábítószer-használatot kezelő más ellátásban, vagy megelőző-felvilágosító szolgáltatásban résztvevő eltereltek számának alakulása 2010 és 2020 között.

T5.2 METHODOLOGY

Drug law offences (ENYÜBS data collection): The investigating authority and public prosecutor collect and process the criminal statistics data on the rejection of accusation, and the data generated between the launching of criminal proceedings until the suspension of investigation or formal accusation, in the Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office (ENYÜBS).
ENYÜBS issues a 17-digit statistic code under Act IV of 1978, while under Act C of 2012 it issues a 35-digit statistic code to each of the forms of the offence., in the interest of detailed and legally precise differentiation of the individual perpetration behaviours according to the different statutory definitions. When the investigation is closed two separate statistics datasheets are filled in relating to the offence and the offender. With regard to criminal offenses, the data obtained are complete, but with regard to offenders whose procedure is under the Act XIX. of 1998 (old Act on Criminal Proceedings) the most serious crime was recorded, while regarding those who fall under Act XC of 2017 (new Act on Criminal Proceedings) all crimes are recorded. However, the national report only deals with the most serious criminal offense and the connected characteristics of the perpetrators. After the new Act on Criminal proceedings came to force (1st July 2018.) up to ten types of drugs can be recorded per crime on the datasheet relating to the offence.

Seizures:(NSZKK 2021): The information regarding the substances seized was collected on the basis of the results of forensic analysis. Analysis on the active substance content is carried out if the active substance content of the given case is above the limit of the small amount set in the criminal legislation (amphetamine: 0.5 g, heroin: 0.6 g, MDMA: 1 g, cocaine: 2 g, THC: 6 g).The Institute carries out the analysis of injecting equipment related to injecting drug use only in the most necessary cases because of the high HCV prevalence among injecting drug users.

Street level prices (Bálint 2021): 7 outpatient drug treatment centres from 8 cities participated in the study. Each organization recruited approximately 10-30 clients who used drugs in 2020 before entering treatment, the total sample was 133 persons. The clients only gave the price of those drugs that they personally purchased in 2020. In the self-administered questionnaire, clients had to give the price at the last purchase. The lowest, highest, mean and mode prices for each type of drug were calculated from last purchase prices by the HU-NFP.

PRISON[186]

T0. EXECUTIVE SUMMARY

In Hungary, 15 national prisons and 14 county-based prisons, as well as 2 penitentiary healthcare institutions[187] were operating in 2020.
According to the data as of 31 December 2020, a total of 16 490 people were held in prisons, of which 15772 (96.6 %) were men and 718 (4.4 %) were women, and 0.8 % of the prison population were juvenile. In addition, there were 262 prisoners in the two health care facilities, with a female ratio of 14%.
The indicator of prison saturation decreased compared to the figures reported in previous years, with an average saturation of 122 % in 2018, compared to 110 % at the end of 2019, and 96 % in 2020 as a result of space expansion projects. In 2020, a total of 1 638 people (9.93 %) were admitted to prisons with at least one recorded drug-related offence in the public registry.

Available data on the use of drugs in prison settings show that 50 % of prisoners in domestic prisons have consumed some type of drug during their lifetime before entry. In terms of drug consumption within the institute, the use of new psychoactive substances (NPS), including synthetic cannabinoids, has increased among prisoners in the recent years.
The prevalence of HIV and hepatitis B and C virus infections is higher among prisoners than among the general population. Research in prisons indicates that most HCV-infected prisoners are likely to have been infected through previous injecting drug use and related risk behaviours.
Typically plant-base products as well as NPS are smuggled into prisons via impregnated paper or other impregnated products (tobacco, tea). As for impregnated paper typically synthetic cannabinoids are smuggled according to laboratory confirmed data.
The National Anti-Drug Strategy, which expired in 2020, identifies prisoners as a specific target group in the field of prevention and treatment/care, who should be provided with programmes and services that meet their individual needs and take into account the special conditions of the prison system.
The Ministry of Interior is responsible for the central administration of the prison system; it therefore manages and coordinates the prisons and further institutions belonging to the prison system (including 2 healthcare institutions), in the course of which it cooperates with regional specialist institutions, governmental and non-governmental organisations.

The most important elements of the treatment service in prison include: the “Drug prevention” training programme that was developed centrally by the prison service, a multi-level system of treatment as an alternative to criminal procedure (quasi-compulsory treatment, QCT), drug prevention units and general healthcare services of relevance to drug users. In the case of the last element, the prison healthcare services and the healthcare system outside of the prison system (mainly specialised outpatient drug treatment centres) both play a role. This system is supplemented by the programmes offered by various NGOs (which, however, due to their tender-based financing, have diverse and ad-hoc content) and by projects supported by pharmaceutical companies to test for infectious diseases.

T1. NATIONAL SITUATIONAL PICTURE

T1.1 INSTITUTIONAL CONTEXT

In Hungary in 2020 29 prisons and 2 prison healthcare institutions were in operation[188]. Of these establishments, 15 have a national authority, and 14 have a county-level authority. The

[186] Authors of the workbook: Anna Tarján, Nóra Gasteiger and Réka Bálint
[187] The Judicial Observatory and Psychiatry Institute, hereafter: IMEI), Central Prison Hospital

county facilities are mainly used for the pre-trial detention of prisoners; females, males and minors may be accommodated there.

The capacity of all prisons was 17402 places in 2019, while that of the prison healthcare institutions was 580 places. On 31 December 2020, the number of prisoners placed in prisons was 16490 while 262 in prison healthcare institutions. The proportion of women in prisons was 4.4% and 14% in healthcare institutions. The percentage of juveniles among all prisoners was 0.8 %. The rate of prison saturation decreased compared to previous years, with an average saturation of 122 % in 2018 and 110 % at the end of 2019, compared to 96 % in 2020 as a result of space expansion projects. In 2020, 1638 people were placed in law enforcement institutions related to drug law offences[189]. (BVOP 2021a)

T1.2 DRUG USE AND RELATED PROBLEMS AMONG PRISONERS

T1.2.1 Drug use among prisoners

Drug use prior to imprisonment

Predictive Meter (PME) data (2020):

As part of the development of the data recording system in relation to the risk assessment system implemented in 2015 in Hungarian prisons (see section T1.3.3), questions on drug use were also analysed in a sample of 11,092 persons was interviewed for use-related questions in November 2020 (BVOP 2020b). (For methodology, see section T5.2., for 2015 and 2018 data see section T1.2.1 of the Prison workbook of the 2018 and 2019 National Reports).
50 % of the prisoners in the sample self-reported having ever used drugs in their lives prior to imprisonment.
Among those prisoners who had ever used drugs (5542 people), information was available on the most frequently used drug [190] prior to imprisonment and the frequency of use in the case of 5515 and 5531 persons respectively.

Table 29. *Breakdown of prisoners who have ever used drugs by the most frequently used substance prior to imprisonment (N=5515) in 2020*

Name most commonly used	N	%
Cannabis	1606	29.1
Polydrug use	1410	25.6
Stimulants (amphetamine, ecstasy)	942	17.1
Synthetic cannabinoids	565	10.2
Synthetic cathinones	462	8.4
Cocaine, crack	301	5.7
Opioids (heroin, methadone and other opioids)	128	2.3
Sedative and anaesthetic medicines (benzodiazepines, barbiturates)	34	0.62
Organic solvents	27	0.49
Other	22	0.4

[189] Possession of drugs, facilitation of drug preparation, Drug trafficking, drug precursor abuse, Demonstration of pathological addiction, Misuse of new psychoactive substance, Misuse of substances used for the manufacture of drugs, Abuse of drugs

[190] The values provided here are non-serially lifetime values; based on the PME questionnaire structure, this variable cannot be measured. The values indicate the percentage of prisoners who report that specific drug to be the most frequently used prior to imprisonment. Those who self-reported having used drugs in their lives could only select one drug or indicate poly drug use in the response.

Hallucinogens (LSD, magic)	18	0.33
Total	5515	100

Source: BVOP 2021b

Table 30. *Breakdown of prisoners who have ever used drugs by frequency of use prior to imprisonment (N=5531) in 2020*

Consumption frequency before entry	**N**	**%**
Occasionally (1 or 2 times per month)	814	14.72
Have tried only (up to a few times in lifetime)	1036	18.73
A few times per year	343	6.20
1-2 times a week	878	15.87
3 or more times per week or daily	2460	44.48
Total	5531	100

Source: BVOP 2021b

10% (1 107) of the total sample had ever injected before entry.

Drug use inside prison

In 2020, based on the annual report of the Hungarian Prison Service Headquarters (hereinafter: BVOP), one case of drug possession came to light, involving 1 person in detention. A drug-related extraordinary event has been detected 2 times, during which 6 people were identified as being implicated, however no further accurate information is available, because according to the prison protocol, the relevant police department must be notified of any suspected drug seizure by the prison, so that it can be seized by the police as soon as possible to start criminal proceedings. (see also T.1.2.3 for seizures).
Prisoners typically used new psychoactive substances, non-banned compounds, psychoactive substances of unknown origin and consumer products impregnated with new psychoactive substances (tea, tobacco) or impregnated paper. Additionally, the misuse of psychiatric medicines such as Rivotril and other sedatives is also common. Based on the data from the PME system, it can be stated that compared to previous years, the number of NPS users or users of as yet uncontrolled substances prior to imprisonment has increased. (BVOP 2021b)
Equipment related to injecting drug use was not found during checks and safety inspections in prisons in 2020.

For the sub-results on ever-imprisoned PWID in the 2018 and 2019 HIV/HCV bio-behavioural surveys, see section T1.2.2.

Prison seizures, which are indirect indicators of substance use during detention, are described in section T1.2.3.

T1.2.2 Drug-related problems among prisoners

Risk behaviour, health consequences

According to PME data (BVOP 2021b), 5.7% (626 persons) of the interviewed prisoners have ever experienced overdose before entry.[191] 12% (1,331) experienced physical or psychological withdrawal symptoms after imprisonment.

[191] The total sample was 11092 persons, but the percentages have been calculated for that variable by excluding the answers ‘not known’.

According to BVOP's central report (2021a), 479 prisoners were treated with withdrawal symptoms in the current year, of which 415 with medicines, 7 with psychotherapeutic approaches only, and 57 with combinations of pharmacological and psychotherapeutic methods.

According to the BVOP central report (2021a), 633 people participated in HIV testing, 535 in HBV testing, 1 340 in HCV testing and 9 525 in TB testing. No HIV/HBV infected people were identified in the studies, while HCV antibody (9.8%) was detected in 131 individuals, 104 of whom were also HCV RNA positive (7.8%) (active viral carrier). Furthermore, 2 persons with active tuberculosis (0.02%) and 22 with passive tuberculosis (0.2%) were detected[192].

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HNFP-NNK HIV/HCV bio-behavioural surveys (2018 and 2019)

Based on data from the national HNFP-NNK HIV/HCV bio-behavioural survey 2018 (Tarján et al. 2019; for methodology and additional data, see section T.5.1 of the Harms and Harm Reduction workbook), 42% of interviewed PWID (182/438 persons) had ever been imprisoned. Among them, HCV prevalence was 62% (among those who had never been in prison, while HCV prevalence was 30%) and HIV prevalence was 0.5% (among those who had never been in prison HIV prevalence was 0%).
Of the 181 people (number of valid answers), 18 said (10%) that they had injected during imprisonment, 12 of whom had also shared their injecting equipment while in prison. Of those 18 prisoners, 13 were HCV antibody positive.
Based on data from the regional HNFP-NNK HIV/HCV bio-behavioural survey 2019 (Tarján et al. 2020; for methodology and additional data, see section T.5.1 of the Harms and Harm Reduction workbook), 48 persons (48%) among the interviewed PWID had ever been imprisoned. Among them, HCV prevalence was 71% (among those who had never been in prison HCV prevalence was 27%), while HIV prevalence was 2% (among those who had never been in prison HIV prevalence was 4%).
Of the 46 people (number of valid answers), 6 said (13%) that they had injected during imprisonment, 4 of whom also had shared their injecting equipment while in prison. All the 6 prisoners were HCV antibody positive.

The prevalence of HIV and hepatitis B and C virus infections is higher among prisoners than among the general population. Previous researches from prisons indicates that most HCV-infected prisoners subjected to the test sample are likely to have been infected by previous injecting drug use and related risk behaviours (For more details, see the descriptions of previous researches: 2019 Annual Report/ Prison Chapter/ T.1.2.2).

T1.2.3 Drug supply in prison

Seizures – BVOP data

Most of the substances suspected to be drugs are transported to the prisons via mail, previously hidden in food, tobacco, placed in personal grooming cosmetics (toothpaste, stick, ear-cleaning rod), while since the change in parcel delivery rules they are concealed in the soles of footwear, hidden in clothes, via impregnated mail and newspapers. It is also common for illicit substances to be thrown into the courtyard of prisons, or handed over by visiting relatives. (until the introduction of COVID-19 restrictions). New psychoactive substances are found to be smuggled via various impregnated postal items (mainly letters, children's drawings and other paper goods). Among other things, reflecting on this issue, legislation has changed regarding the parcel delivery (see below).

[192] Due to the nature of the data collection, data may include duplication, it may be that one main query was performed several times in the reference year.

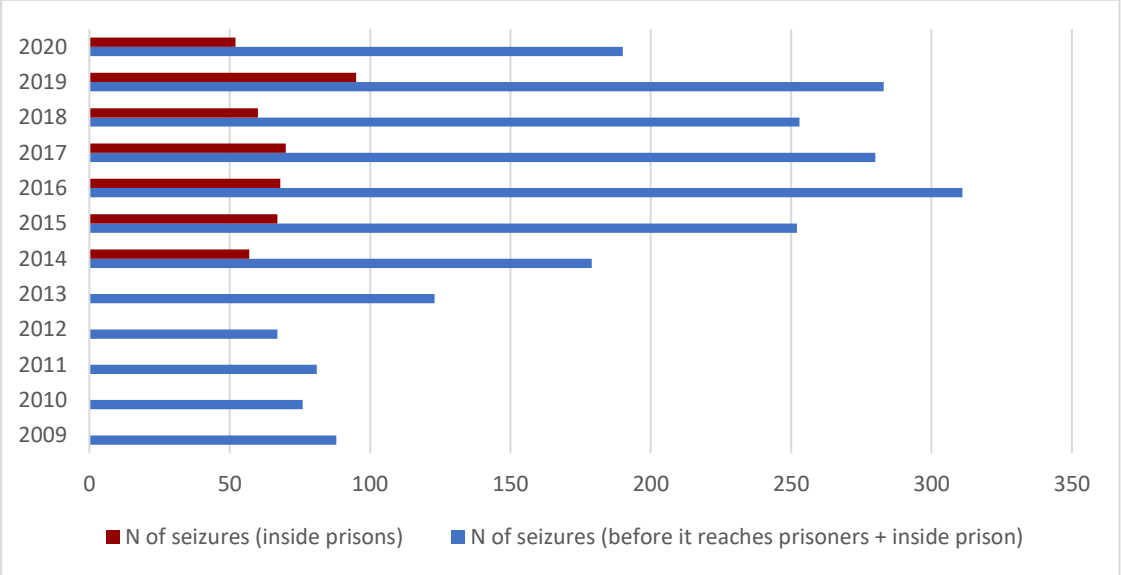
According to BVOP data (BVOP 2021a), suspected drugs were seized in 190 cases in 2020, of which 138 were detected before reaching the prisoners. There is no uniform reporting obligation for seized drugs. According to the Hungarian Prison Service Headquarters (BVOP) annual report, attempts were typically made to smuggle plant derivatives and NPS in the form of impregnated paper or impregnated consumer products (tobacco, tea) into the prisons (see also T1.2.1/Drug use inside prison). There is no feedback on the exact chemical composition of the substances seized. The table below shows the form of smuggling.

Table 31. *Number of seizures of suspected drugs by form of smuggling into Hungarian prisons in 2020*

Total	Plant derivative	Powder	Tablet	Resin, crystal, gel	Impregnated material	
					Consumer item	Other
190	7	20	7	3	1	152

Source: BVOP 2021a

Chart 85. *Number of seizures of suspected drugs in Hungarian prisons (2009-2020)*



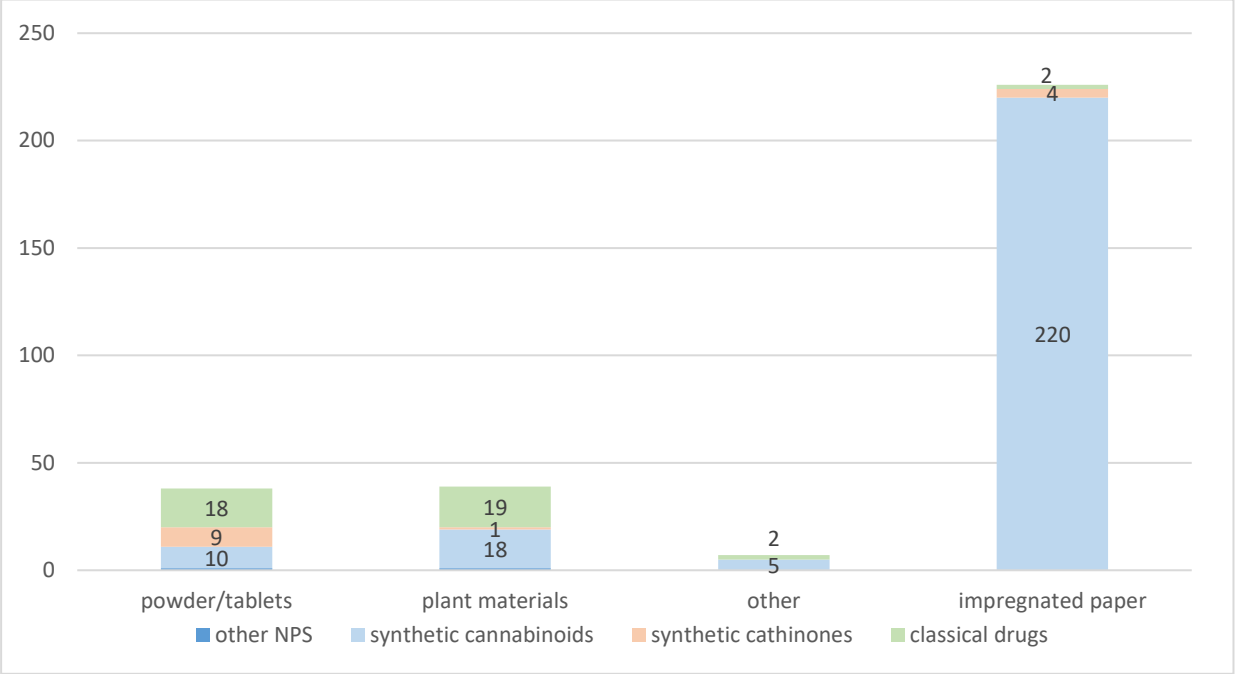
Source: BVOP 2021a

Seized substances (laboratory confirmed) – data from the Hungarian Institute for Forensic Sciences (NSZKK)

In Hungary, the NSZKK is responsible for investigating psychoactive substances seized by law enforcement agencies.
In Hungary the overall yearly case number of seizure is around 7500 - 9500 and only a few of them is connecting to prisons. In the most recent period studied (2018-2020), a total of 472 cases were related to prisons, of which 299 were seizures of controlled drugs. Most positive cases were related to synthetic cannabinoids (275 cases), while classical drugs (47 cases) or designer stimulants (20 cases) represent a smaller part of seizures. The proportion of negative cases which means that the examined materials did not contain new psychoactive substances, nor classical drugs were 33% (155 cases). Out of 299 positive cases, 226 got into prisons in the form of impregnated paper (mail, envelopes, photographs, children's drawings, puzzle books, newspaper). In most cases these were treated with synthetic cannabinoids. In 39 cases, the authorities seized plant debris, teabags, leaves and resins, containing classical drugs (mainly THC) or synthetic cannabinoids. Among substances found in powder or tablet

form 18 contained classical drugs, 10 were synthetic cannabinoids, while 9 contained designer stimulants.

Chart 86. *Different forms of seized materials based on the proportion of identified substances (2018-2020)*



Source: NSZKK 2021c

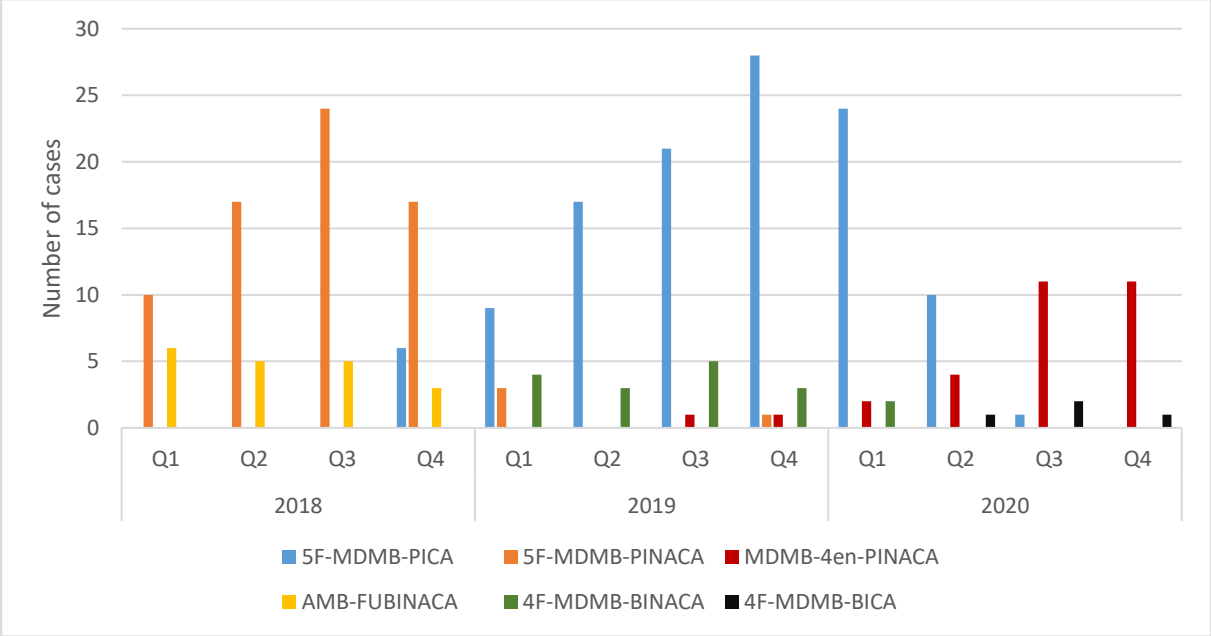
Table 32. *Active substances/active substance combinations identified by NSZKK on impregnated papers seized in prisons (2018-2020)*

	Cases					
Identified active substance/ combinations	**2018**	**%**	**2019**	**%**	**2020**	**%**
5F-MDMB-PICA	6	5	75	70	35	45
5F-MDMB-PINACA	68	59	4	4	-	-
MDMB-4en-PINACA	-	-	2	2	28	36
AMB-FUBINA	19	17	-	-	-	-
4F-MDMB-BINACA	-	-	15	14	2	3
THC	12	10	6	6	3	4
amphetamine	5	4	2	2	5	6
ethylhexedrone	4	3	2	2	1	1
4F-MDMB-BICA	-	-	-	-	4	5
5F-CUMYL-PeGaClone	4	3	-	-	-	-
NM-2201	4	3	-	-	-	-
ethyl heptedron	-	-	3	3	1	1
5F-EMB-PICA	-	-	-	-	3	4
MDMA	1	1	2	2	1	1
FUB-144	1	1	2	2	-	-
4-CMC	1	1	1	1	1	1
4-Cl-alpha-PVP	2	2	-	-	-	-
ketamine	2	2	-	-	-	-
Cumyl-CH-MeGaClone	-	-	2	-	-	-
Cumyl-Cb-MeGaCloone	-	-	-	-	1	1

deschloro-N-ethyl ketamine	-	-	-	-	1	1
methamphetamine	-	-	1	1	1	1
4-CEC	1	1	-	-	-	-
mephedrone	1	1	-	-	-	-
isopropylphenidate	1	1	-	-	-	-
cocaine	1	1	1	1	-	-
N-ethylnorpentedron	1	1	-	-	-	-
butyl hexedron	-	-	1	1	-	-
MMB-4en-PICA	-	-	1	1	-	-
Number of positive cases	**115**	**100**	**107**	**100**	**77**	**100**

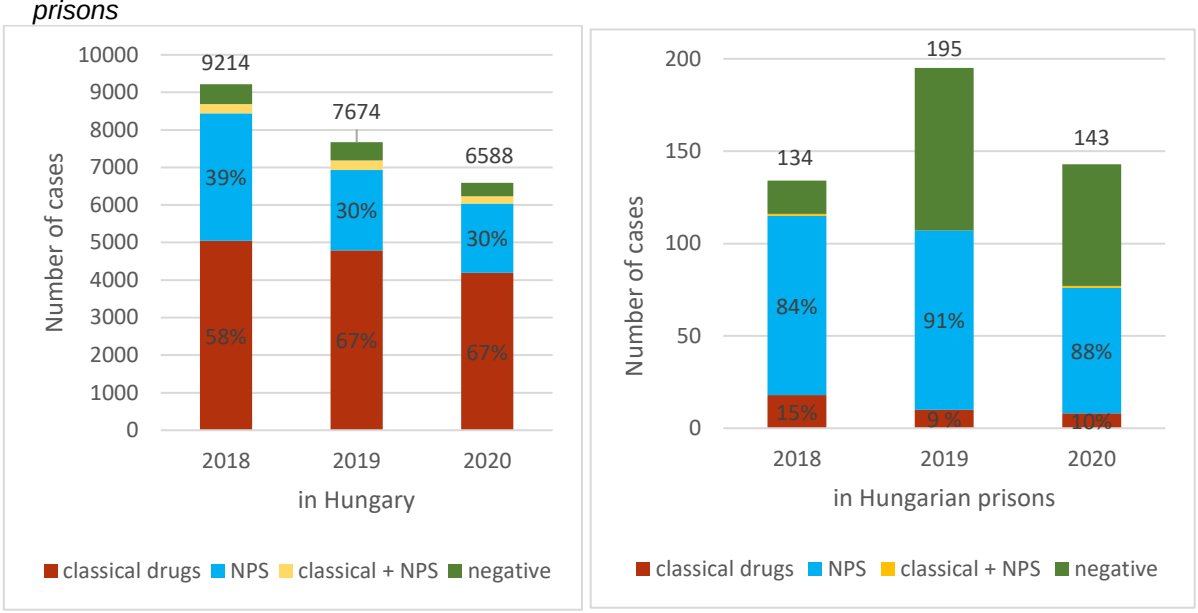
Source: NSZKK 2021c

Chart 87. *Distribution of the most commonly occurring synthetic cannabinoids over the period 2018-2020, by quarter*



Source: NSZKK 2021c

Chart 88. *Distribution of classical and new psychoactive substances in Hungary and Hungarian prisons*



Source: NSZKK 2021c

The appearance of certain new psychoactive substances in prisons follows international and Hungarian market trends. In 2018, the materials examined showed a reduction of AMB-FUBINACA and, on the contrary, the increase of 5F-MDMB-PINACA, while in 2019, 5F-MDMB-PINACA disappeared from the seizures and, instead, 5F-MDMB-PICA became the most dominant synthetic cannabinoid. In 2020, 5F-MDMB-PICA remained dominant until the end of the third quarter of the year, after which MDMB-4en-PICA became the most dominant substance.

Table 33. *The dates of first identification of certain new psychoactive substances in Europe, Hungary and the Hungarian prisons. (2014-2020)*

Identified substances	First filing		
	Europe	Hungary	Hungarian prisons
AMB-FUBINACA	2014/12/10	2015/07/02	2015/12/17
FUB-144	2015/02/09	2019/01/24	2018/12/27
deschloro-N-ethyl ketamine	2016/08/11	2020/01/28	2020/11/23
5F-Cumyl-PeGaClone	2017/12/21	2018/03/20	2018/01/29
MDMB-4en-PINACA	2018/08/23	2019/12/02	2019/09/17
CUMYL-CH-MeGaCloone	2018/11/14	2018/11/14	2019/05/03
4F-MDMB-BINACA	2018/11/20	2018/11/13	2019/01/17
butyl hexedrone	2018/12/07	2019/01/04	2019/04/29
ethyl heptedrone	2019/02/05	2019/02/05	2019/03/27
5F-EMB-PICA	2020/03/03	2020/07/17	2020/06/24
Cumyl-Cb-MeGaCloone	2020/03/17	2020/03/17	2020/11/23
4F-MDMB-BICA	2020/07/02	2020/05/27	2020/06/17

Source: NSZKK 2021c

Legislative change regarding package deliveries

CCXL of 2013 on Implementation of Punishments, Measures, Certain Coercive Measures and Detention for Infringements and IM Decree 16/2014 (XII. 19.) on the detailed rules for the

implementation of imprisonment, pre-trial detention and imprisonment replacing a fine were amended on 1 July 2018, which also affected the prisoners' package delivery and catering system. That amendment to the law is aimed at reducing the smuggling of prohibited items into prisons, including narcotic drugs and mind-altering substances.[193] (BVOP 2019a)

T1.3 DRUG-RELATED HEALTH RESPONSES IN PRISON

T1.3.1 Strategy

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

Under its Statutes, the Ministry of Interior is responsible for the central administration of the prison system as of 2010; accordingly, the Hungarian Prison Service Headquarters governs and coordinates the operation of the prison institutions and other prison facilities (4 facilities related to education and training and 2 healthcare facilities) under the supervision of the Ministry of Interior.

T1.3.2 Structure of drug-related prison health responses

Treatment and care are fundamentally organised on the basis of a medical model; the system treats drug use primarily as a medical problem. Certain elements of the care system are provided by the health service of the prison system, including the National Institute for Forensic Observation and Psychiatry (IMEI), the prisons designated to provide treatment as an alternative to criminal procedure and the doctors and psychologists providing primary care, while other elements are provided by the relevant regional external service providers (mostly outpatient drug treatment centres). In the course of performing its tasks, the prison system closely cooperates with numerous governmental or local governmental research and training organisations, as well as with non-governmental organisations that provide relevant programmes. In response to drug problems (in the fields of prevention, treatment, harm reduction, infectious diseases) during 2020 a total of 19 prisons cooperated with 23 external organisations (NGOs or outpatient DTCs) (Gasteiger and Tarján 2021).

[193] Since the entry into force of the aforementioned legislation, no food, toiletries, tobacco, pharmaceuticals (with exceptions), medical aids or medicinal products may be sent from outside to the prisons; parcels may contain any other items that the prisoner can carry with him/her with permission. With the tightening of the established package sending and receiving system, the prison system had to provide another mechanism. Ministry of Interior (IM) Decree 16/2014 (XII. 19.) made it possible for contact persons/visitors to order packages on the web interface or during a visit, thus replacing the established package delivery system by a new, "closed-circuit" delivery system. The package can only include items from the assortment of the prison-based outlets; that means a package containing groceries and toiletries can only be ordered via the internet or during the visit. (BVOP 2019a)

Apart from the medical model,[194] the approach to the drug problem is also characterised by the security model, which represents the greatest obstacle to the introduction of harm reduction interventions.
Within the prison service system there is no dedicated unit dealing with drug-related matters.

QCT within prisons

The Hungarian legal system provides the opportunity for prisoners who committed an offence involving drug possession prior to their imprisonment[195] to participate in QCT (quasi-compulsory treatment) as an alternative to criminal procedure – in the case of the possession of a small quantity of illicit drug for the purpose of personal use, on one occasion within two years (for a more detailed description see the section T1.2.2 of the Treatment workbook). A medical expert's opinion or, in the absence of that, the preliminary status assessment of the National Institute for Forensic Observation and Psychiatry (IMEI) determines which of the three types of QCT[196] should be applied. The preliminary assessment is carried out by the psychiatrist, addiction medicine physician or clinical psychologist employed by the prison. Following that, the prison providing the service is designated.

These services are typically implemented in cooperation with external organisations, but in some cases they are provided with the involvement of a clinical psychologist from the prison staff.
According to data from BVOP, in 2020, 32 persons participated in treatment for drug addiction, 65 persons underwent treatment of other conditions with drug use, and 164 persons took part in a preventive-consulting service.[197] It is very difficult to organise QCT during preliminary custody, because the fluctuation of detainees is high and there is considerable transportation between facilities. Due to that, many QCTs are interrupted or take place in parallel. The vast majority of QCT takes place in Budapest, i.e. the institution of QCT is centralised within the prison service. (The TDI data for persons entering drug treatment in prisons are presented in section T1.2.2.)

T1.3.3 Drug-related healthcare services and other services in prisons

Table 34. *The availability of drug-related interventions in Hungarian prisons in 2020*

Intervention name	Sub-types of specific intervention	YES/NO/NT (Formally available or not, NT – do not know/do not have aggregated data)	Number of BVs where the respective intervention operates/Number of BVs with a valid response	Note, detail

[194] According to this model, the drugs and paraphernalia related to drug use found in prisons are primarily classified as "prohibited articles". It is the obligation of the security staff to find and seize these, even in spite of contraindications originating from any demand reduction or harm reduction programmes.
[195] Prisoners imprisoned for offences other than drug offences who committed a drug-related offence before their imprisonment in which no judgment was pronounced in the first instance.
[196] 3 forms of treatment are available in the scope of QCT: preventive-consulting service; treatment for drug addiction; and treatment of other conditions with drug use.
[197] The data cannot be compared with the TDI data because the prison institutions record the aggregated number of completed, ongoing and interrupted treatments, while TDI records the number of prisoners entering treatment in a given time period. Furthermore, duplicates are not removed from data recorded in the prison administration system, meaning that a prisoner might be recorded more than once, e.g. as a client continuing and then terminating treatment, or if he/she is transported to another institution, or if the treatment is temporarily suspended and then restarted.

Assessment of drug use and related problems at prison entry		Yes	29/30	See also: T.1.3.3
Counselling on drug-related problems		Yes	22/30	See also: T.1.3.3
	Individual counselling	Yes	22/30	
	Group counselling	Yes	14/30	
Residential/Inpatient drug treatment services		Yes	19/30	
	Drug prevention division without therapeutic elements	Yes	8/30	See also: T.1.3.3
	Drug prevention section with therapeutic elements	Yes	8/30	
	therapeutic community	not	0/31	See also T.1.3.3.
	residential/inpatient drug treatment	Yes	1/30	See also T.1.3.3.
Pharmacologically assisted treatment		Yes	15/31	
	Detoxification	Yes	7/30	See also: T.1.3.3
	OST continuation from the community to prison	Yes	3/31	See also: T.1.3.4: *3 persons reported having been on OST before imprisonment, but of those only 1 person received OST in 2019 after entering prison* [198]
	OST initiation in prison	Yes	1/31	See also: T.1.3.4
	OST initiation close to release	not	1/31	
	OST continuation from prison to	not	0/30	See also: T.1.3.4

[198] According to professional guidelines, substitution treatment is not available to prisons and prisons, and it may be implemented by healthcare providers with the right to addiction treatment. 17/2020 (V.29) BVOP instruction)

	the community			
	Other pharmacological treatment targeting drug-related problems	Yes	9/30	See also: T.1.3.3
Preparation for release		Yes	17/30	See also addendum: T.1.3.3
	Referrals to external services on release	Yes	6/30	
	Intervention on social reintegration	Yes	8/30	
	Overdose intervention before release (Training, counselling)	Yes	3/30	
	Naloxone distribution	not	0/30	
	Other interventions to prepare prisoners who have a history of substance use for release	Yes	8/30	For example: probation supervision, general briefing by the reintegration officer, EFOP project, see: T1.3.3
Infectious disease intervention		Yes	25/31	
	HIV testing	Yes	15/31	See also: T.1.2.2
	HBV testing	Yes	8/31	See also: T.1.2.2
	HCV screening	Yes	12/30	See also: T.1.2.2
	Hepatitis B vaccination	8/30	11/28	46 in 2020
	Hepatitis B treatment	Yes	9/30	See also: T.1.3.3
	Hepatitis C treatment with interferon	not relevant		This medicine is no longer used in Hungary.
	New type of hepatitis C treatment (DAA)	Yes	16/31	See also: T.1.3.3

	ART treatment for HIV	Yes	5/29	Typically involving an external provider; See also: T.1.3.3
	Linkage to HIV treatment (if treatment was started in prison)	Yes	4/29	See also: T.1.3.3
	Linkage to HCV treatment (if treatment was started in prison)	Yes	6/30	See also: T.1.3.3
Needle and syringe programme		No	0/31	
Condom distribution		No	0/31	

Source: Gasteiger and Tarján 2021

Admission procedure

The new Prison Code[199], in effect from January 2015, introduced the "Risk Assessment and Management System" (KEK system). A standardised questionnaire has been recorded for all new prison entrants in the relevant areas of prison settings (reintegration, psychology, health and criminal records) since June 2018. For a detailed description of the system, see T.5.2., Risk Assessment and Management System (KEK system) (BVOP 2020b).
According to the data of the BVOP-HNFP national prison facility survey (Gasteiger and Tarján 2021), in 83% of the cases, data collection upon admission is exclusively conducted by the internal prison staff; in the remaining cases the use of external human resources is also necessary (there are some prisons where the risk assessment related to drug use upon admission is carried out by an external addiction medicine physician).

Prevention

As part of the Risk Assessment and Management System (KEK system) introduced in 2015, institutions have the opportunity to provide a 12-session drug prevention training programme to address problems related to drug use. The Central Institution for Analytical Examination and Methodology trains prison reintegration officers, social assistant lecturers and EFOP counsellors (from 2019) at the national level for these 12-session risk management training programmes called "Prevention of Drug Use" and "Reduction of alcohol use and related problems" (launched in 2019) through a 3-5 day course (hereinafter called KEK programme). This training material is then applied and the content is conveyed by the trained staff to the prisoners concerned in a group session. Prison psychologists can hold the group sessions on the basis of a manual without the aforementioned training.
By the end of 2020, 47 people (reintegration officers, social assistant officers and EFOP consultant) were eligible to participate in drug prevention and alcohol abuse reduction trainings[200]. The programme mainly uses cognitive methods. The participants of the programme learn to identify and modify thinking errors that support the repeated use of drugs, and familiarise themselves with the cognitive model of substance use. Awareness-raising and processing techniques in a group context can help to frame the action of previous drug users

[199] Act CCXL of 2013 on the Enforcement of Sentences, Measures, Certain Coercive Measures and Non-compliance
[200] In some cases, these programmes were implemented under programmes in the drug prevention sectors.

and to plan their future substance-free lives, taking other aspects into account. In the course of 2020, 12 eligible trainings (including alcohol and drug prevention) were held for 32 groups, involving a total of 264 prisoners (Drug prevention training: 30 groups; 250 people; 20 prisons, and training to reduce alcohol consumption problems: 2 groups; 14 people; 2 prisons) (Gasteiger and Tarján 2021).

In 2020, 16 prisons operated drug prevention units, with total capacity for 255 prisoners. The occupancy rate of the divisions as of December 31, 2020 was 71%. A total of 5 prisons have a maximum length of stay in the divisions, ranging from 3 months to one year (BvOP-NFP facility survey; Gasteiger and Tarján 2021).
According to the current BvOP instruction[201], the placement in the drug prevention units should primarily be permitted for persons who were convicted for drug-related offences, who have had a history of drug use , who have already used drugs in prison or those who have not been associated with drugs, but there is a risk of possible drug use. The programs of the drug prevention units are typically implemented both individually and in groups. According to the BVOP-NFP facility survey, detainees placed in the drug prevention units are also included in KEF programmes (Gasteiger and Tarján 2021). In the drug prevention units, a total of 30 programmes were implemented by reintegration officers, probation officers, prison psychologists and EFOP consultants.

In addition to KEK programmes, additional programmes are provided in both individual and group forms in the drug prevention units (only group:6 institutions, only individual: 2 institutes; mixed: 7 institutions), the individual sessions are carried out by a psychologist from the registered institution or a reintegration consultant. The programmes tended to focus on personality development/ self-awareness; stress management; conflict management; development of individual and social competences; to provide knowledge generally on health development; prevention of retrogression of drug use; and on the prevention of drug-related harms. These programmes are not subject to central coordination, the management, organisation, development and implementation of them fall within institutional remit. (Gasteiger and Tarján 2021)
In addition to the programmes of drug prevention units, 11 institutions implemented drug prevention or other programmes with drug prevention elements (67 units), which were conducted mainly in a group format (group-only:7 institutions, individuals only: 1 institute; mixed: 3 institutes). These programmes are also not subject to central coordination, management, organisation and development and implementation are the responsibility of the institutions themselves. According to BVOP data, 347 participants took part in these programmes. In terms of content, they were in line with the programmes taking place in the drug prevention units.
It should be noted that the restrictive measures put in place to prevent the spread of COVID-19 have limited the reach of group and individual occupations in prisons compared to previous years.
An information letter was issued to the prison staff in 2020 to notice them of the appearance of a new synthetic cannabinoid, called 'bika' (4FMDMB-BICA), which has resulted in many deaths among users outside prisons. (See also: Health Consequences and Harm Reduction T.1.1)

Treatment

According to central data of the BVOP (BVOP 2021a), outpatient care related to drug use was provided to 648 prisoners, of whom 635 persons were treated in-house, while 13 persons received treatment at external service providers. Inpatient care of drug-related problems was provided for 132 prisoners, of whom 131 persons were treated in-house, while 1 person was

[201] (IV. 16.) BVOP Instruction on the execution of tasks related to convictions placed in other special sectors for prisoners with special needs.

treated at an external service provider. These figures overlap with the TDI data of prisoners entering treatment in section T1.2.2 and the QCT data reported by the Hungarian Prison Service Headquarters (BVOP) (section T1.3.2). [202]

Withdrawal symptoms are typically treated medically, by means of pharmacologically assisted therapy. Of the 18 reporting prisons, 8 use only medication, 7 prisons provide medication and psychotherapeutic treatment together, 3 prisons use only psychotherapeutic treatment. For data on treatment of withdrawal symptoms, see T1.2.2. (BVOP 2021a)

A description of QCT used as an alternative to criminal procedure can be found in section T1.3.2, the TDI data of prisoners entering treatment can be found in section T1.2.2, and information on opioid substitution treatment for prisoners is presented in section T1.3.4.

Prevention, testing and treatment of infectious diseases
Upon entry all prisoners are offered HIV/HBV/HCV testing, while TBC testing is mandatory. In addition, testing campaigns (mainly for HCV) supported by pharmaceutical companies linked to information sessions and then linkage to treatment are organised for prisoners (see below for more details).
In 2020, 2437 persons (in 6 prisons) participated in HIV/HBV/HCV related information sessions; 1217 prisoners (in 6 prisons) received individual counselling (information/awareness-raising) and 1425 persons (in 6 prisons) were given written information. (Gasteiger és Tarján 2021).

For information on HIV/HBV/HCV/TB testing and results among prisoners, see T1.2.2.
In 2020, 24 prisoners with HIV, 21 with tuberculosis, 3 with HBV and 64 with HCV received treatment. With regard to HCV, a further 7 persons did not consent to undergo treatment, 12 persons did not enter into treatment due to health reasons, while in the case of 2 persons the treatment was interrupted due to release. (BVOP 2021a)

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

For a detailed description of the 2018/2019 HCV testing programme, , see the 2020 Prison Workbook; , section T.1.3.3 [203]:

Harm reduction, prevention of overdose after release

In the scope of the facility survey carried out in Hungarian prisons (Gasteiger and Tarján 2021), the institutions reported that 1681 people participated in presentations in connection to harms related to substance use (overdose, infections), while 781 were involved in individual counselling and education.

Reintegration and preparation for release

[202] All three data sources use different aspects/case definitions/categorisation in recording drug-related treatment of prisoners.
[203]Same data overlaps with filtering data reported in T.1.2.2

According to the results of the survey carried in Hungarian prisons (Port and Tarján 2014, Port 2016, Arzenovits 2018, Gasteiger et al. 2019) usually there is no formal procedure in the prisons relating to prisoners receiving drug-related treatment before release; however, several prisons mentioned (2020: 17/30, Gasteiger and Tarján 2021) that they had informed the prisoners about how to contact the appropriate organisations or referred them to the local outpatient drug treatment centres or psychiatric departments – with which the institutions also have a cooperation contract in many cases – and that they provide an opportunity for individual/group counselling regarding this issue.

In 2020, 8 prisons (out of 30 prisons giving valid answers) provided reintegration programmes in group sessions or individually that specifically targeted prisoners with a history of drug use. The programmes reached 181 prisoners. (Gasteiger and Tarján 2021)

The possibility of being placed in drug prevention units is also recognised as a service in preparation for release, as in several prisons the requirement for admission to this specific unit is that the prisoner is to be released in 2.5 years. (Gasteiger et al. 2019)

Within the scope of probation supervision operating in prisons, the probation officers also assist with reintegration – as prescribed by law – for sentenced prisoners and perform after-release duties if requested by the released individual. Among the forms of support provided in the scope of individual case management, the relevant decree separately mentions “the reduction of harmful consequences of addictions by dealing with social and mental deficits linked to them”. In the scope of follow-up care (after release), the probation officers help newly released prisoners who seek help with their social reintegration by means of the forms of support detailed above. In 2020, reintegration care (preparation for release) was provided to 2612 prisoners.

In the project introducing the method of the Family Group Conference (hereinafter: FGC), a total of 95 main staff members were trained (reintegration officers, probation officers, psychologists) in 2019. Staff members have successfully applied the FGC method in a total of 47 cases. Application of the FGC method contributes to the improvement of reintegration care, thereby reducing the risk of recidivism and relapsing in the long run. (BVOP 2020a) Due to the strong outbreak of the coronavirus epidemic, certain ongoing group programs as well as visitor admissions and out-of-institution placements had to be suspended, thus in 2020 and 2021 these kind of trainings were not provided and the method was not used.

A cooperation agreement was concluded between the Hungarian Prison Service Headquarters (BVOP) and the foundation named Váltó-sáv Alapítvány for the operation of a halfway house service for released convicts, whose task is to provide a service that combines the four pillars of relapse prevention (housing, human relationships, labour market services, training/learning) in a complex and synergistic way, with a strong emphasis on psychosocial support/resocialisation/reintegration and care (social work). In addition, the foundation maintains an information database where released persons, their families and professionals can find relevant information. (BVOP 2020a)

T1.3.4 Opioid substitution treatment in prisons

Rules regarding opioid substitution treatment (OST) of prisoners are set out in Hungarian Prison Service Headquarters (BVOP) Instruction 17/2020. (V. 29.). Under that Instruction, prisoners receive OST if it is advised by a community specialised outpatient treatment centre or if it is recommended by a specialist at the National Institute for Forensic Observation and Psychiatry (IMEI) and the prisoner concerned gives his/her written consent. The treatment must be carried out – in accordance with the respective methodological letter – at specialised

drug treatment centres in the community (to where the prisoner is transported); prison institutions are not entitled to provide OST. According to data from the national prison facility survey (Gasteiger and Tarján 2021), in 2020, opioid substitution treatment (OST) could be continued in 3 prisons (provided at external service providers). There were 3 prisoners in 2 prisons. In the preceding years OST was also provided only occasionally according to survey data (2019: 1 person; 2018: 0 persons; 2017: 2 persons, 2006: 2 persons, 2005: 3 persons). It should be noted that opioid use has been stagnant in Hungary in the recent years among the problem drug user population. (See also Drugs / Heroin and other opioids).

T1.4 Quality assurance for drug-related health prison responses

In 2017, a manual was published for prison staff in collaboration between the Department of Detention, the Department of Health and the Central Institute for Analytical Examination and Methodology at the Prison Service Headquarters to help identify and respond to drug use and related problems within prison facilities. It was designed for internal use only. NPS are addressed in a separate section.

In 2018, a professional protocol was published for the health units of prisons that focuses specifically on the differential diagnosis and treatment of withdrawal symptoms in addiction-related disorders.

T2. Trends

Lately, an increasing number of guidelines are available for prison staff on how to identify and respond to drug use/NPS use and related problems.
One of the major achievements of the last 5 years has been the implementation of the Hungarian Prison Service Headquarters Risk (BVOP) Assessment and Management System (KEK system) starting in 2015, which aims to identify individual detention and relapse risks upon entry, analyse and manage them and develop appropriate responses.
There are no time-series data and/or reliably comparable data on drug use and related health harms among prisoners. The Risk Assessment and Management System (KEK) data indicate an increase in the proportion of prisoners who were regular NPS users prior to imprisonment. (BVOP 2021b).
Indirectly, the higher HCV prevalence in the prison population compared to the average population may be due to the significant increase in the prevalence of HCV among PWID beyond the walls (in the community) in recent years, as well as due to the high prevalence of ever imprisonment among them. Injecting – as a route of drug administration – is not common in Hungarian prisons.

T3. New developments

For key information on NPS, see T2 and T1 for further details.

Impact of COVID-19 and related restrictions on people who use drugs and drug-related services in prison

The BVOP-NFP facility survey also asked the prisons about the three main phenomena (challenges/obstacles/changes) in connection with the restrictive measures related to the COVID-19 epidemic. The Government Degree no. 90/2020 related to the emergency ordered in connection with protection against the coronavirus amended several prison legislations, restricting and suspending the reception of visitors, departures (for work or other leaves) in order to protect the health of the inmates and the prison staff. The transition for skype

communication was barrier-free, although it was also a new challenge for the prison stuff. In addition to the correspondence and telephone contact, the inmates communicate with the relatives through the skype application, which is generally assessed among the inmates. Epidemiological measures such as the use of protective clothing, the medical segregation of new detainees, ongoing testing and disinfection meant additional tasks for the staff. The prisoner's movements between units, the reduced contacts with other providers, as well as the suspension of deliveries and receptions, also led to changes in the trafficking of suspected drugs. In order for the protection against the coronavirus, the IMEI and other psychiatric clinics outside of prisons did not admit detainees for acute care only, in addition the group sessions and access to civil service providers was severely restricted, although some providers switched to online services. (Gasteiger and Tarján 2021).

In Hungary, measures related to the coronavirus pandemic did not affect the release of detainees from that provided by the court ruling. (BVOP 2021c)

Table 35. *Changes in the impact of the coronavirus epidemic and related restrictive measures on drug use and related benefits, compared to the first wave after June 2020 (March - May 2020)*

	Strong increase	Slight increase	Unchanged	Slight decrease	Strong decrease	Don't know
Drug availability			x			
Drug use			x			
Use of benzodiazepines and other hypnotics/sedatives			x			
Drug-related medication			x			
Psycho-social drug treatment					x	
Harm reduction interventions				x		

Source: BVOP 2021c

The 2020 BvOP-NFP facility survey covered the vaccination status in institutions, both among inmates and the prison staff. The answers show that 75.4 % of the prisoners and 65 % of the staff received vaccination against COVID-19 (BVOP 2021c).

T4. ADDITIONAL DATA AND INFORMATION

For more details on the questionnaire survey on Hungarian juvenile detention homes see under Prison/T4 in the 2018 National Report.

T5. SOURCES AND METHODOLOGY

T5.1 SOURCES

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T5.2 METHODOLOGY

Comprehensive, drug-related research in prisons with national coverage is relatively rare in Hungary; a national study on drug use among prisoners was last performed in 2008. In the absence of such research, information on the drug problem within prisons is obtained regularly from the data registered centrally by the Hungarian Prison Service Headquarters (BVOP), from the Risk Assessment and Management System (KEK system) implemented in 2015 by BVOP and from further small-scale, specific data collection projects. Among those last named projects, it is worth highlighting the TDI data collection, in the scope of which the data of those entering drug-related treatment in prisons are also recorded. With respect to recent years, the other significant, comprehensive sources of information were the facility surveys covering all

Hungarian prisons carried out in the scope of a collaboration between the Hungarian National Focal Point (HNFP) and the Hungarian Prison Service Headquarters in 2013, 2016, 2018 and 2019. The purpose of the studies was to assess the extent of the drug problem in prisons, as well as the coverage, characteristics and content of drug-related services available in each Hungarian prison.

BVOP-HNFP facility survey series on the drug problem and responses in Hungarian prisons (Port and Tarján 2014; Port 2016a, Arzenovits 2018, Gasteiger et al. 2019; Gasteiger és Tarján 2020; Gasteiger és Tarján 2021):
The purpose of the studies was to assess and map the extent of the drug problem in prisons, as well as the coverage, characteristics and content of drug-related services available in each Hungarian prison. The former standard questionnaires 23 and 27 of the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction), current Prison workbook guidelines and previous EMCDDA guidelines for the National Report workbook on prisons served as the basis for the questionnaire used in the survey, that was designed and is reviewed annually by the Hungarian National Focal Point and the Hungarian Prison Service Headquarters (BVOP) (in collaboration). All Hungarian prisons operating in Hungary participated in the survey in the given years (national coverage). In the survey year data were collected on the previous calendar year. In 2020 and 2021, questions related to COVID-19 were also included in the questionnaire. Data years: 2012 (Port és Tarján 2014); 2015 (Port 2016a); 2017 (Arzenovits 2018); 2018 (Gasteiger et al. 2019); 2019 (Gasteiger és Tarján 2020); 2020 (Gasteiger és Tarján 2021):

Risk Assessment and Management System (KEK system) (BVOP 2021b)
Since 2015, the prison service has been operating a Risk Assessment and Management System (hereinafter referred to as KEK) to assess, analyse and manage the risk of relapse and detention of prisoners. The purpose of the Risk Assessment and Management system is to increase the efficiency of the prison service, to facilitate effective reintegration, to identify, analyse and manage individual detention and re-offending risks by motivating prisoners and to reduce the number of re-offences.
The two main pillars of the KEK system are assessment of individual risks and risk management programmes that respond to each risk factor. Risk analysis, involving various departments, provides a complex analysis to assess the given prisoners' criminal history, family background, socio-economic situation, behaviour during imprisonment, psychological and health status, and other characteristics to help decision-making mechanisms. The tool for risk analysis is the Predictive Measurement Tool (PME), a standardised questionnaire supported by an IT interface. The interface provides the background for a standardised assessment of prisoners. The PME questionnaires include questions related to substance use (separately in the fields of health, psychology and reintegration).
First, the risk assessment procedure can serve as a basis for grouping prisoners by risk levels; second, it provides a database for further analysis, due to the standardised questionnaire. The implementation of the questionnaire took place in stages, and after its gradual extension, it is now mandatory (from June 2018) to record: all newly admitted persons with a final conviction transferred from pre-trial detention, convicted persons subject to individual instructions, special detainees, first offenders, as well as detainees involved in serious adverse/extraordinary events. Due to the covered prison population, inmates belonging to higher risk categories from a detention point of view are overrepresented in the merged database related to the PME questionnaire. Administering the PME questionnaire – within the prisoner population defined above – is mandatory in all prisons.
The reported PME data are the results of a data extraction conducted in November 2020 containing the responses of prisoners who were imprisoned in December 2019 (N=11092 persons); however, this does not mean that all the information was recorded in 2020, since the questionnaires were recorded between 2015 and 2020. The development and coordination of the data collection system, as well as the data management and analysis, were performed by

the Central Institution for Analytical Examination and Methodology of the Hungarian Prison Service Headquarters.

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ANNEX

LIST OF CHARTS

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BSI – Brief Symptom Inventory
Btk. – Criminal Code
BVOP – Hungarian Prison Service Headquarters
DCO – Civil Ombudsman on Drug Affairs
EFOP – Human Resources Development Operational Programme
ELTE – Eötvös Loránd University
EMCDDA – European Monitoring Centre for Drugs and Drug Addiction
EMMI – Ministry of Human Capacities
EMQ – European Model Questionnaire
ENYÜBS – Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office
ESPAD – European School Survey Project on Alcohol and Other Drugs
GDS – Global Drug Survey
Medicines Act – Act XCV of 2005
HBSC – Health Behaviour in School-Aged Children
HBV – hepatitis B virus
HCV – hepatitis C virus
HIV – human immunodeficiency virus
HNFP – Hungarian National Focal Point
IMEI - National Institute for Forensic Observation and Psychiatry
KEF – Coordination Forum on Drug Affairs
KEK – Risk Assessment and Management System
KKB – Inter-Ministerial Coordination Committee on Drug Affairs (formerly: Coordination Committee on Drug Affairs)
KKMI – Central Institute for Analytical Examination and Methodology
KT – Council on Drug Affairs
LEQ – Life Events Questionnaire
MÁK – Hungarian State Treasury
NBT – National Crime Prevention Council
NCSSZI – National Institute for Family and Social Policy
NDI – National Office for Drug Prevention (former National Institute for Drug Prevention)
NEFI – National Institute for Health Development
NNK – National Centre for Public Health
NRSZH – National Office for Rehabilitation and Social Affairs
NSZKK – Hungarian Institute for Forensic Sciences
OAC – National Centre for Addictions
OBH – National Office for the Judiciary
OEK – National Centre for Epidemiology
OGY – National Assembly
NSAPH – National Survey on Addiction Problems in Hungary
ORFK – National Police Headquarters
OTKA – Hungarian Scientific Research Fund
QCT – quasi-compulsory treatment (treatment as an alternative to criminal procedure) SZGYF – Directorate-General for Social Affairs and Child Protection
TÁMOP – Social Renewal Operational Programme
TB – Tuberculosis
TDI – Treatment Demand Indicator
NPS – New psychoactive substances