



European Monitoring Centre  
for Drugs and Drug Addiction



**2022 NATIONAL REPORT  
to the EMCDDA  
by the REITOX Hungarian National Focal Point**

**“HUNGARY”**

**REITOX**

**CONTRIBUTORS:**

ARNOLD, PETRA (MTA-BCE Social Epidemiological Research Centre)

BÁLINT, RÉKA (Hungarian National Focal Point)

BÁNFAI, EDINA Hungarian Institute for Forensic Sciences

CSESZTREGI, TAMÁS Hungarian Institute for Forensic Sciences

GASTEIGER, NÓRA (Hungarian Prison Service Headquarters)

HORVÁTH, GERGELY CSABA

PAKSI, BORBÁLA (Eötvös Loránd University)

PÉTERFI, ANNA (Hungarian National Focal Point)

TARJÁN, ANNA

**EDITORS:**

ANNA, PÉTERFI

RÉKA, BÁLINT

**REVISED BY** (IN CERTAIN SECTIONS, AS INDICATED):

SZEMELYÁCS, JÁNOS

## TABLE OF CONTENTS

<b>DRUG POLICY .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T0. SUMMARY .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T1. NATIONAL PROFILE.....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T2. TRENDS .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T3. NEW DEVELOPMENTS .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T4. ADDITIONAL INFORMATION .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T5. SOURCES AND METHODOLOGY .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>Legal framework.....</b>	<b>10</b>
<b>T0. SUMMARY .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T1. NATIONAL PROFILE .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T2. TRENDS .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T3. NEW DEVELOPMENTS .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T4. ADDITIONAL INFORMATION .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>T5. SOURCES AND METHODOLOGY .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>
<b>DRUGS .....</b>	<b>23</b>
<b>T0. SUMMARY .....</b>	<b>23</b>
<b>A) CANNABIS.....</b>	<b>28</b>
<b>T1. NATIONAL PROFILE.....</b>	<b>28</b>
<b>T2. TRENDS .....</b>	<b>38</b>
<b>T3. NEW DEVELOPMENTS .....</b>	<b>38</b>
<b>T4. ADDITIONAL INFORMATION .....</b>	<b>38</b>
<b>B) STIMULANTS.....</b>	<b>47</b>
<b>T1. NATIONAL PROFILE.....</b>	<b>47</b>
<b>T2. TRENDS .....</b>	<b>64</b>
<b>T3. NEW DEVELOPMENTS .....</b>	<b>64</b>
<b>T4. ADDITIONAL INFORMATION .....</b>	<b>65</b>
<b>C) HEROIN AND OTHER OPIOIDS.....</b>	<b>67</b>
<b>T1. NATIONAL PROFILE.....</b>	<b>67</b>
<b>T2. TRENDS .....</b>	<b>70</b>
<b>T3. NEW DEVELOPMENTS .....</b>	<b>70</b>
<b>T4. ADDITIONAL INFORMATION .....</b>	<b>70</b>
<b>D) NEW PSYCHOACTIVE SUBSTANCES (NPS) AND OTHER DRUGS NOT COVERED ABOVE.....</b>	<b>71</b>
<b>T1. NEW PSYCHOACTIVE SUBSTANCES (NPS).....</b>	<b>71</b>
<b>T4. ADDITIONAL INFORMATION .....</b>	<b>71</b>
<b>E) SOURCES AND METHODOLOGY .....</b>	<b>78</b>
<b>T6. SOURCES AND METHODOLOGY .....</b>	<b>78</b>
<b>TREATMENT.....</b>	<b>115</b>
<b>T0. SUMMARY .....</b>	<b>Hiba! A könyvjelző nem létezik.</b>

T1. NATIONAL PROFILE .....	Hiba! A könyvjelző nem létezik.
T2. TRENDS .....	Hiba! A könyvjelző nem létezik.
T3. NEW DEVELOPMENTS .....	Hiba! A könyvjelző nem létezik.
T4. ADDITIONAL INFORMATION .....	Hiba! A könyvjelző nem létezik.
T5. SOURCES AND METHODOLOGY .....	Hiba! A könyvjelző nem létezik.
HARMS AND HARM REDUCTION .....	Hiba! A könyvjelző nem létezik.
T0. SUMMARY .....	Hiba! A könyvjelző nem létezik.
T1. NATIONAL PROFILE .....	Hiba! A könyvjelző nem létezik.
T2. TRENDS .....	Hiba! A könyvjelző nem létezik.
T3. NEW DEVELOPMENTS .....	Hiba! A könyvjelző nem létezik.
T4. ADDITIONAL INFORMATION .....	Hiba! A könyvjelző nem létezik.
T5. SOURCES AND METHODOLOGY .....	Hiba! A könyvjelző nem létezik.
DRUG MARKET AND CRIME.....	<b>193</b>
T0. SUMMARY .....	Hiba! A könyvjelző nem létezik.
T1. NATIONAL PROFILE .....	Hiba! A könyvjelző nem létezik.
T2. TRENDS .....	Hiba! A könyvjelző nem létezik.
T3. NEW DEVELOPMENTS .....	Hiba! A könyvjelző nem létezik.
T4. ADDITIONAL INFORMATION .....	Hiba! A könyvjelző nem létezik.
T5. SOURCES AND METHODOLOGY .....	Hiba! A könyvjelző nem létezik.
PRISON .....	<b>219</b>
T0. EXECUTIVE SUMMARY .....	Hiba! A könyvjelző nem létezik.
T1. NATIONAL SITUATIONAL PICTURE .....	Hiba! A könyvjelző nem létezik.
T2. TRENDS .....	Hiba! A könyvjelző nem létezik.
T3. NEW DEVELOPMENTS .....	Hiba! A könyvjelző nem létezik.
T4. ADDITIONAL DATA AND INFORMATION .....	Hiba! A könyvjelző nem létezik.
T5. SOURCES AND METHODOLOGY .....	Hiba! A könyvjelző nem létezik.
Sources .....	<b>235</b>
Annex .....	<b>242</b>
LIST OF TABLES .....	<b>242</b>
LIST OF CHARTS .....	<b>247</b>

# DRUG POLICY<sup>1</sup>

## T0. SUMMARY

The last strategy focusing on drugs in Hungary, was the The National Anti-Drug Strategy of 2013-2020. 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 December 2022. Until the adoption of the next drug-related or a more comprehensive (covering eg public health, mental health) strategic document, professionals consider the goals and framework of the outdated drug strategy to be followed.

Since July 2022 drug affairs coordination tasks come under the purview of the Ministry of Interiors (BM) 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 <sup>2</sup>	Illicit drugs
2010-2020	National Strategy for Tackling the Drug Problem <sup>3</sup>	Illicit drugs
2013-2020	2013-2020 National Anti-Drug Strategy – Clear Consciousness, Sobriety and the Fight against Drug Crime <sup>4</sup>	Illicit drugs

#### T1.1.2 The current national drug strategy<sup>5</sup>

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 December 2022.

#### 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<sup>th</sup> February 2019, the Budapest General Assembly passed a decision to establish the Budapest

<sup>1</sup> Author of the workbook: Anna Péterfi

<sup>2</sup> National Assembly Decision 96/2000 (XII. 11.) on approval of the National Strategy for Reducing the Drug Problem

<sup>3</sup> National Assembly Decision 106/2009 (XII. 21.) on the National Strategy for Tackling the Drug Problem

<sup>4</sup> National Assembly Decision 80/2013 (X. 16.) on the 2013-2020 National Anti-Drug Strategy

<sup>5</sup> 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>

Coordination Forum on Drug Affairs (BKEF) under the leadership of the Mayor and the Chief of the Budapest Police Department. According to the accepted proposal, the creation of the BKEF 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 BKEF held its inaugural meeting on 2<sup>nd</sup> 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**

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 covering the time period between 2013-2020. 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 an 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.

Since 2022, the 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 Interiors (BM); the direct state head of the field is the deputy state secretary responsible for professional healthcare management.

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 Interiors. The Ministry of Interiors in its Organisational and Operational Regulations specifies the tasks of the National Drug Prevention Coordination Unit<sup>6</sup> (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;
- 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

---

<sup>6</sup> Instruction 12/2022. (VI. 28.) of the Ministry of Interior on the Organisational and Operational Regulations of the Ministry of Interior

created on the basis of local authority commitments, on local-level professional collaboration aimed at tackling the drug problem and on ministry grants.

Until 2021 113 Coordination Fora on Drug Affairs<sup>7</sup> were established in Hungary, with capital, town, district, small-region, county or regional competence (NNK 2022). The role of the Coordination Fora on Drug Affairs is to coordinate the work of local stakeholders involved in reducing the drug problem, along the four pillars of the former drug strategy namely community and cooperation; prevention; treatment and rehabilitation; and supply reduction. The members of the Coordination Fora on Drug Affairs are representatives of state, municipal, NGO and church organisations that are active in the management of the drug problems. (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. Regarding 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. (for more information, see Chapter 1.3 in the 2009 Policy Workbook).

## **T2. TRENDS**

Not applicable here.

## **T3. NEW DEVELOPMENTS**

## **T4. ADDITIONAL INFORMATION**

## **T5. SOURCES AND METHODOLOGY**

### **T5.1 SOURCES**

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.

Nemzeti Népegészségügyi Központ (NNK) (2022): A Drogmegelőzési Programok Osztályának beszámolója az EMCDDA 2022. évi jelentéséhez. Beszámoló.

---

<sup>7</sup> According to 2020 data from [kef.hu](http://kef.hu)



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<sup>8</sup>

### T0. SUMMARY

Hungarian legislation has been characterised by multiple amendments to the Criminal Code over the past years. The Criminal Code, in force since 2013, determines the country's criminal law in a new structure following the altered drug-situation. The Criminal Code in force provides regulation in connection with illicit drugs and new psychoactive substances in seven 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, in case of cultivation, production, acquisition or possession for personal use or consumption of drugs under a certain quantity called 'small amount', if the perpetrator is admitting the perpetration of the offence and able to present a document before being sentenced in the first instance to verify that (s)he has participated in treatment as an alternative to criminal procedure (a quasy compulsory treatment – hereinafter: 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 new psychoactive substances (known also as 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 drugs, their preliminary assessment, scheduling and risk assessment. Substances that are scheduled in Annex I. of Decree no 55/2014 of the Ministry of Human Capacities as a result of the preliminary assessment *considered as new psychoactive drugs*<sup>9</sup>. The rules of the official procedure and duties concerning drug precursors is defined by the Government Decree no 159/2005. (VIII. 16.).

---

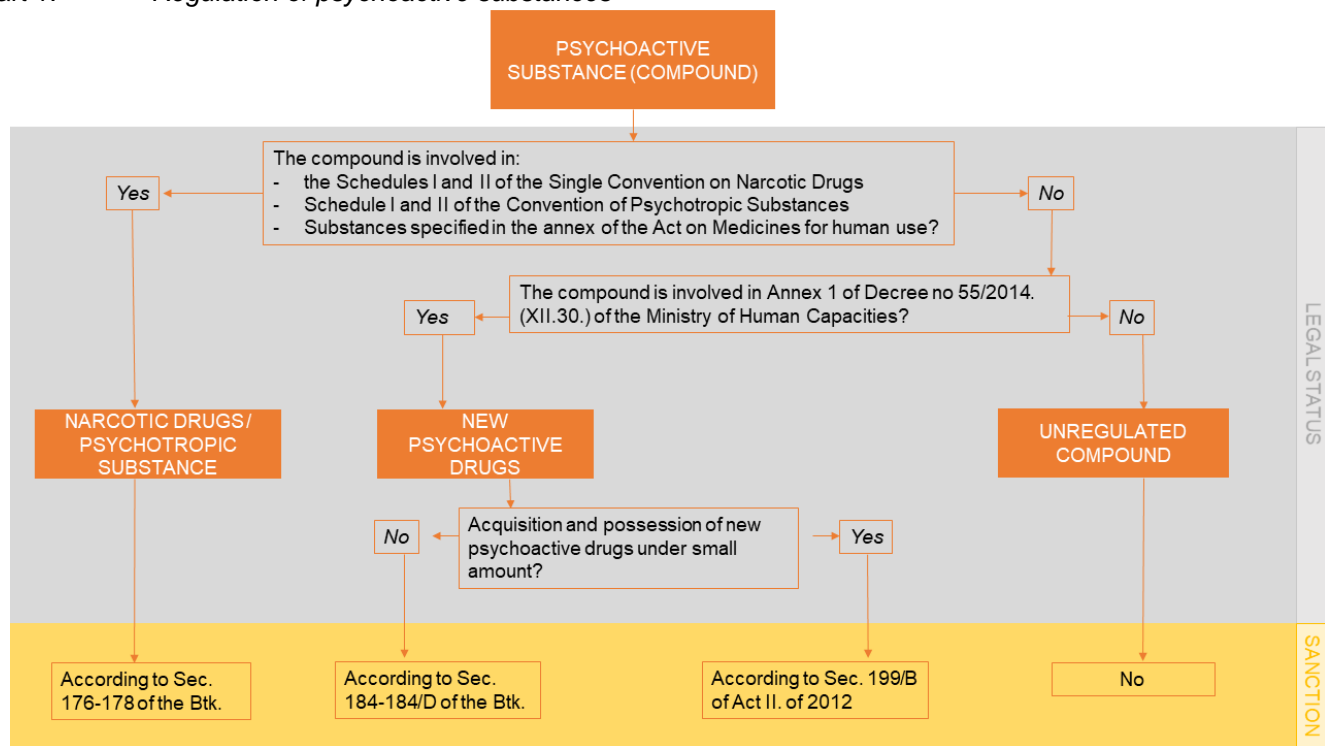
<sup>8</sup> Author of the workbook: Réka Bálint

<sup>9</sup> In the workbook we use the term „new psychoactive substance” or NPS (referring to the expression „új pszichoaktív szer” in Hungarian) in a general meaning to new substances regardless of their legal status, while we use the term „new psychoactive drug” (referring to the expression „új pszichoaktív anyag” in Hungarian) referring to those new psychoactive substances that are scheduled in Annex I. of Decree no 55/2014 of the Ministry of Human Capacities

## T1. NATIONAL PROFILE

### T1.1 LEGAL FRAMEWORK

Chart 1. *Regulation of psychoactive substances*



#### T1.1.1 Characteristics of drug legislation

The new Criminal Code (Act C of 2012; hereinafter: Btk.)<sup>10</sup> 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 seven 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 drugs*. (For more information see T1.1.3)
7. medicine counterfeiting

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

Perpetrations involving the possession of illicit drugs (Sec. 178-180) include cultivation, production, 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 the act of illicit drug consumption, with the punishment of up to two

<sup>10</sup> See its English version at: [https://thb.kormany.hu/download/a/46/11000/Btk\\_EN.pdf](https://thb.kormany.hu/download/a/46/11000/Btk_EN.pdf)

years, same as the punishment for the acquisition of a small amount for personal use, in case no other more severe crime is committed.

The Btk. orders the offence of inciting substance abuse (Sec. 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 for up to two years.

The statutory definition of aiding in the manufacture or production of narcotic drugs (Sec. 182) determines a punishment in a term between one to five years for the (a) cultivation, production, acquisition, import, export and transfer, or (b) the distribution and trade of substances, equipment or facilities for the cultivation or 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 customs authorities of the NAV control the export, import and transit of drug precursors, narcotic drugs, psychotropic substances and new psychoactive substances to third countries, as well as the transport (transfer) of the mentioned substance groups within the European Union.

The punishment for the basic cases regarding offenses related to the counterfeiting of medicines (Sec. 185/A) is imprisonment up to 3 years. In the context of counterfeiting of medicinal products, certain acts involving 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 (QCT) (Sec. 180.) which, according to the Hungarian criminal law system, are reasons for eliminating criminal liability. 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 and “is admitting the perpetration of the offence and 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 drugs*, 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.)

### **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<sup>11</sup>.

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 in several acts. 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 (Sec. 461). The following general rule is valid in the case of those substances where the law does not specify a precise "small amount": 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 - among other mitigating and aggravating circumstances - to take the addiction of the perpetrator into consideration when imposing the punishment, however, drug addiction (similar to alcohol, medicine, and other addictions) can only be considered an attenuating circumstance if it causes a pathological mental state.

### **T1.1.3 Control of *new psychoactive drugs***

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 new psychoactive substances.

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 drugs*" 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 drugs*, which contains both individual compounds and compound groups (through this applying both the individual listing and the generic approach).

---

<sup>11</sup> Act. XCV of 2005 aka Act on Medicines for Human Use

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 Interior, the National Institute for Pharmacy and Nutrition (OGYÉI) and (since November 2021) the National Food Chain Safety Office (NÉBIH) subjects it to a special preliminary assessment to determine whether the substance may be included in the schedule of *new psychoactive drugs*. In order for a substance to be included in the schedule of *new psychoactive drugs* 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 first time abroad is the same as for those identified in Hungary.

Individual compounds included in the schedule of *new psychoactive drugs* must be subjected to a risk assessment within one year of their scheduling. Depending on the result of the risk assessment, the compound must be rescheduled to the schedule 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 (generic definitions), which remain on the schedule of *new psychoactive drugs* 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 drugs* 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 Drugs" (Sec. 184, 184/A-D), which follows the structure of the previous articles, but regulates the offences related to *new psychoactive drugs* with more lenient punishments. The definition of aggravated cases regarding *new psychoactive drugs* are similar to the regulation of narcotic drugs, furthermore according to Act XLIII. of 2020, which came in force on 1st January 2021, acts committed by a significant or in a particularly significant quantity of *new psychoactive drugs* is already subject to a more serious punishment. The lenient cases relate to perpetration with a small amount, the upper limit of which is 2 grams with respect to the active agent (previously 10 grams) of the given compound<sup>12</sup>. Furthermore, small amounts have been established for generic groups defined in Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities.<sup>13</sup>

Act CXCVII of 2017 defined the upper limit of small amount in case of nine substances scheduled as psychotropic substances.

The punishable acts also include acquisition and possession of *new psychoactive drugs* 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 drugs*, therefore consumption is not punishable, nor is acquisition and possession of a small amount. If the *new psychoactive drug* does not reach the small amount, the prosecution is suspended and an infringement procedure<sup>14</sup> is initiated against the owner of the *new psychoactive drug*. In addition, according to Act XLIII. of 2020, from January 2021, in the case of offenses falling under Section 184, engagement in preparation also becomes punishable, and the same penalty applies to those who provide financial means for the above-mentioned offenses.

---

<sup>12</sup> Art 461 of the Btk. In force since January 1<sup>st</sup>, 2021.

<sup>13</sup> Act XLIII of 2020

<sup>14</sup> Act II. of 2012: 199/B §

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

Table 1. Regulation of narcotic drugs and new psychoactive drugs<sup>15</sup> according to the Penal Code

Btk.	imprisonment	Btk.	imprisonment
<b>Illicit drugs</b>		<b>New psychoactive substances</b>	
Sec. 176 (1): Offer, supply, distribution, and trafficking of illicit drugs (base case)	<b>2-8 yrs.</b>	Sec. 184 (1): Offer, supply, distribution, and trafficking of new psychoactive drugs (base case)	<b>1-5 yrs.</b>
Sec. 176 (3): In a substantial quantity	<b>5-20 yrs. /life imp.</b>	Sec. 184 (2a): In a substantial quantity	<b>5-10 yrs.</b>
Sec. 176 (5): In small amount (offer, hand over)	<b>max 2 yrs.</b>	Sec. 184 (4): In a small amount (offer, hand over)	<b>max 1 yrs.</b>
Sec. 177 (1): A person above 18 hands over or offers illicit drugs to a minor	<b>5-10 yrs.</b>	Sec. 184/A.: A person above 18 hands over or offers new psychoactive drugs to a minor	<b>2-8 yrs.</b>
Sec. 177 § (2): In a substantial quantity	<b>5-20 yrs./ life imp.</b>	Sec. 184/A. (2): In a substantial quantity	<b>5-10 yrs.</b>
Sec. 177 (4): In a small amount (in base case)	<b>1-5 yrs.</b>	Sec. 184/A.: In a small amount (in base case)	<b>max 3 yrs.</b>
Sec. 178 (1): Manufacture, cultivation, acquisition, possession, import, export, transfer (base case)	<b>1-5 yrs.</b>	Sec. 184/B.: Manufacture, import, export, acquisition, possession a new psychoactive drug in excess of a small amount	<b>max 3 yrs.</b>
Sec. 178. (2)/b: In a substantial quantity	<b>5-10 yrs.</b>	Sec. 184/B (2a): In substantial quantity	<b>2-8 yrs.</b>
Sec. 178 (2)/c: In a particularly substantial quantity	<b>5-15 yrs.</b>	Sec. 184/B. (2b): In a particularly substantial quantity	<b>5-10 yrs.</b>
Sec. 178 (5): Possession, offer of a small amount (base case)	<b>max 2 yrs.</b>	Sec. 184/B. (5): Possession of a small amount	<b>max 1 or 2 yrs.</b>
Sec. 178 (6): Consumption of a small amount	<b>max 2 yrs.</b>		
Sec. 179 A person above 18 using a minor (see acts in Sec. 178. (1) )	<b>2-8 yrs.</b>	Sec. 184/C.: A person above 18 using a minor Sec.	<b>1-5 yrs.</b>
Sec. 179 (3)/b: In a substantial quantity	<b>5-15 yrs.</b>	Art 184/C. (2a): In a substantial quantity	<b>5-10 yrs.</b>
Sec. 179 (3)/c: In a particularly substantial quantity	<b>5-20 yrs. / life imp.</b>	Art 184/C. (2b): In a particularly substantial quantity	<b>5-15 yrs.</b>
Sec. 180 Exemption from culpability: consumption under small amount if the person undertakes <b>QCT</b>	<b>X</b>	Acquisition, possession of new psychoactive drugs under small amount -> <b>misdemeanour</b> --> Act 2012. II. Sec. 199/B.	<b>X</b>
Sec. 181 (1)/b: A person above 18 who persuades a minor to engage in the consumption of illicit drugs	<b>2 yrs.</b>	Sec. 181 (1)/b: A person above 18 who persuades a minor to engage in the consumption of non-narcotic psychoactive substances	<b>2 yrs.</b>

<sup>15</sup> The penalty items established in terms of Sec. 184 regarding substantial and particularly substantial quantities are in force from 1st January 2020

Sec. 182 (1): Production, acquisition distribution, import, export transport and trade of substances and equipment for the manufacture of narcotic drugs	1-5 yrs.		
Sec. 183 (1): Possession, distribution transports or engagement in intermediary activities with precursors without permission or in excess of its limits or by making a false statement Sec. 183 (2): in the event of a breach of the obligation to notify	max 3 yrs. max 2 yrs.		

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

Btk.	Small amounts established for certain narcotic drugs		Btk.	Small amounts established for new psychoactive drugs (Sec. 55. of Act XLIII. of 2020.) <sup>16</sup>	
Sec. 461. (1) a)	Content of pure active substance in base form		Sec. 461. (5)	In application of Act 184-184/C. the small amount for new psychoactive drugs established if its active substance is under	
aa)	LSD	0.001 g	a)	Substances in the <b>1st group (synthetic cannabinoids)</b> 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 <b>2nd group (cathinones)</b> 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 <b>3rd group (triptamines)</b> of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	2.0 g
ag)	Morphine	0.9 g	d)	Substances in the <b>4th group (phenethylamines)</b> of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	1.0 g

<sup>16</sup> Came into force on 1st January 2021



ah)	Ketamine; Codeine; MDA; MDMA; MDE; MBDB; 1-Pea; N-methyl-1-PEA; mCPPi; methadone; 4-fluoramphetamine; pethidine	1.0 g	e)	Substances in the <b>4/a. group (N-fenil-1-(2-feniletil)-4-piperidinamin)</b> of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	0.1 g
ai)	mephedrone; methilon; 4-MEC	1.5 g	f)	Substances in the <b>5th group (list of individual compounds)</b> of Annex I. of Decree no. 55/2014. of the Ministry of Human Capacities	2.0 g
aj)	Cocaine	2.0 g			
al)	pentedrone	0.4 g			
Sec. 461. (1) b)	in case of GHB its active substance content expressed in acid form	7.5 g			
<b>Sec. 461. (1) c)</b>	<b>THC (TOTAL-THC)</b>	<b>6.0 g</b>			
Sec. 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			

Chart 2. Evolution of the regulation of new psychoactive substances dominant in domestic seizures in 2021 (2010-2021)\*



\*In the diagram, the "x" indicates the time when the compound was scheduled as a psychotropic drug, while the ♦ indicates the time when the substance was scheduled as new psychoactive drug (Decree no. 55/2014 of the Ministry of Human Capacities). If at the time of the appearance of the given compound it was already regulated (individually or by group definition), the ♦ sign indicated before its appearance.

Source: NSZKK 2022a, edited by NFP

## T2. TRENDS

### T2.1 CHANGES IN THE LEGAL FRAMEWORK SINCE 2000<sup>17</sup>

The regulation of crimes committed with *new psychoactive drugs* –those scheduled on the schedule of *new psychoactive drugs* - was first introduced in the 2012 amendment of the old Btk. According to Sec. 283/B "Misuse of New Psychoactive Drugs" the import, export, transit, production, offer, hand over distribution and trade of new psychoactive drugs can be punishable by up to 3 years imprisonment. The regulation was in effect until the adoption of the current Btk.

The current Btk. entered into force on 1 July 2013, which presents the statutory definitions under separate subtitles (Sec. 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 entered into force in May 2017 – amended the quantity of small amount regarding *new psychoactive drugs*: In appliance of Sec. 184-184/C the new

<sup>17</sup> The current Btk. entered into force on July 1, 2013, while the current BE entered into force on July 1, 2018, therefore, the legislative amendments of the old Btk and the old BE are no longer relevant. For amendments to already repealed legislations relating to drugs and new psychoactive drugs see Chapter T2.1 of 2021 Legal Framework Workbook.

psychoactive drug is a small amount if its pure active substance content does not exceed 2 grams. In the case of compounds occurring in salt form, pure active ingredient content should be understood as the active ingredient content given in base form. This Act was amended by Sec. 55 of Act XLIII of 2020 to the extent that small amounts of the compound groups defined in the schedule of *new psychoactive drugs* have been determined separately for each group (see: Table 2), therefore the 2 grams rule is applicable only for individually scheduled compounds. Article 49 of Act XLIII of 2020 sets out the penalties for offenses committed with *new psychoactive drugs* (Sec. 184-184/C of the Criminal Code) in the case of a substantial quantity and a particularly substantial quantity (see: Table 1).

The Act XC of 2017 on Criminal Proceedings (hereinafter Be.)<sup>18</sup> came into force on 1<sup>st</sup> July 2018. The Be. does not change significantly the criminal procedures connected to illicit drugs, however it should be noted that in the case of successful QCT, the institution called postponement of prosecution in the old Be. (Sec. 222), the Be renames it as conditional prosecutorial suspension. The renamed institution differs from the previous one in that the Be. defines two investigative stages, of which the second is led by the prosecution. The conditional prosecutorial suspension occurs after the investigational phase led by the prosecution, therefore the decision to terminate the criminal proceedings cannot be made by the police, but by the prosecutor's office. Another change related to the former is that according to the Be. (Sec. 575), the court may oblige the accused to bear all or some of the criminal costs, provided that the proceeding was terminated because the liability to punishment of the accused was terminated for a reason that depends on the behaviour of the accused and is specified in the Special Part of the Criminal Code". Furthermore, according to the Be - similarly to the old Be., after its 2011 amendment - (Sec. 418) in case of adult offenders, QCT is applicable without the need of probation service.

Act XLIII of 2020 has amended sections 184-184/C of the Penal Code from 1<sup>st</sup> January 2021. The law was clearly intended to bring the assessment of trafficking of *new psychoactive drugs* closer to the trafficking of narcotic drugs. Accordingly, as a result of the amendment acts with a significant or a particularly significant quantity of *new psychoactive drugs*, similarly to narcotic drugs, are subject to a more severe judgement. The upper limit of the *small amount* (previously uniformly defined as 2 grams) has been differentiated according to expert experience, by group of compounds, forming a system proportional to the values defined in case of narcotic drugs and reducing the limit values for many substances (see Table 2).

---

<sup>18</sup> See its English version at: <https://njt.hu/jogszabaly/en/2017-90-00-00>

### T3. NEW DEVELOPMENTS

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

Table 3. *Changes in the legal framework in 2021*

The regulatory document subjected to amendments <sup>19</sup>	The amended regulatory document (current version)		
Title	Title	Summary of changes	Remarks
<a href="#">Sec. 49 of Act XLIII of 2020</a>	Act C of 2012	Substantial and particularly substantial quantities has been established in case of offences committed with <i>new psychoactive drugs</i>	In force since 1 <sup>st</sup> January, 2021
<a href="#">Sec. 55 of Act XLIII of 2020</a>	Act C of 2012	The establishment of <i>small amount</i> for group of compounds scheduled by generic definitions in the schedule of <i>new psychoactive drugs</i>	In force since 1 <sup>st</sup> January, 2021
<a href="#">Government Decree no. 620/2020</a>	Government Decree no. 66/2012	The schedules of narcotic drugs and psychotropic substances were amended.	In force since 1 <sup>st</sup> January 2021.
<a href="#">Government Decree no. 232/2021</a>	Government Decree no. 66/2012	The schedule of psychotropic substances was amended.	In force since 3 <sup>rd</sup> June 2021.
<a href="#">Government Decree no. 623/2021</a>	Government Decree no. 66/2012	The definition of medical use and schedule of psychotropic substances were amended.	In force since 25 <sup>th</sup> November 2021.
<a href="#">Sec. 11 of Act LXXIX of 2021</a>	Act CXC of 2011	The number of external stakeholders that can provide drug prevention in schools has narrowed significantly (see also Prevention Workbook)	In force since 8 <sup>th</sup> July 2021.
<a href="#">Government Decree no. 724/2021</a>	Government Decree no. 66/2012	The definition of clinical examination was amended	In force since 31 <sup>st</sup> January, 2022

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

As a small proportion of the illicit drug cases in process in 2021 fell under the force of the old Btk. and the rest of them under the Btk. in force (see T.1.1.1), the National Courts Office provided the data relating to 2021 on the basis of the two different structures of the old Btk. and the Btk. in force. (OBH 2022)

In 2021 only 5 persons were sentenced based on the old Btk. due to drug-related offences according to the following articles:

- Article 282/ A, B, C: 5 persons (illicit drug related offences)
- Article 283/A: 0 person (precursor related offences)

<sup>19</sup> Texts and hyperlinks of the documents subjected to amendments are not available.

- Article 283/B: 0 persons (offences related to *new psychoactive drugs*)

In 2021 the following punishments and measures were imposed on the persons convicted with final judgement:<sup>20</sup>

- 4 persons were sentenced to imprisonment (executable or suspended)
- 1 person was reprimanded

3593 persons were sentenced in criminal procedures started in 2021 based on the Btk. in force according to the following articles:

- Drug trafficking (Article 176-177): 568 persons
- Possession of illicit drugs (Article 178-180): 3008 persons
- Inciting substance abuse: Article 181: 8 persons
- Aiding the manufacture of illicit drugs: Article 182: 7 persons
- Criminal offences with drug precursors: Article 183: 2 persons

In 2021 the following punishments and measures were imposed on the 3593 persons convicted with a final judgement:

- 1187 were sentenced to imprisonment (executable or suspended)
- 826 were sentenced to community work
- 1264 were fined
- 8 were reprimanded
- 311 were put on probation
- 150 were sent on probation service as a supplementary punishment

In 2021 410 people were sentenced related to the offence of misuse of new psychoactive drugs (Article 184), and the following punishments and measures were imposed on the persons convicted with final judgement:

- 347 were sentenced to imprisonment (executable or suspended)
- 21 were sentenced to community work
- 40 were fined (including suspended fines)
- 0 were reprimanded
- 3 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 drug does not reach the 2 grams in case of individually scheduled substances and the respective limit for small amount in case of substances covered by a generic definition, the procedure shall be transferred to the infringement authorities after the investigation into the criminal offense of misuse of the new psychoactive drug has been terminated.

Proceedings for an offense involving a new psychoactive drug were typically preceded by criminal proceedings in which an expert's report found that the substance acquired or possessed by the person concerned constituted a small amount. Infringement proceedings were subsequently pursued.

---

<sup>20</sup> 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.

In 2021 1659 infringement proceedings were initiated due to the misuse of new psychoactive drugs. The most frequently applied sanction for infringement procedures was the fine, with an average 72,617 HUF/person among the proceedings resulted in fine (ENYÜBS 2022).

## **T5. SOURCES AND METHODOLOGY**

### **T5.1 SOURCES**

ENYÜBS (2022): A Belügyminisztérium Egységes Nyomozóhatósági és Ügyészségi Bűnügyi Statisztikai Rendszerének kábítószer-bűnözéssel kapcsolatos 2021. évre vonatkozó adatai

IM (2022): Az Igazságügyi Minisztérium 2021-re vonatkozó beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez.

NAV (2022): A Nemzeti Adó- és Vámhivatal 2021-re vonatkozó beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez

OBH (National Courts Office (2022): Az Országos Bírósági Hivatal Statisztikai Elemző Osztályának adatai 2022-es EMCDDA Jelentés elkészítéséhez

## T0. SUMMARY

### T0.1 DRUG USE AND THE MAIN ILLICIT DRUGS

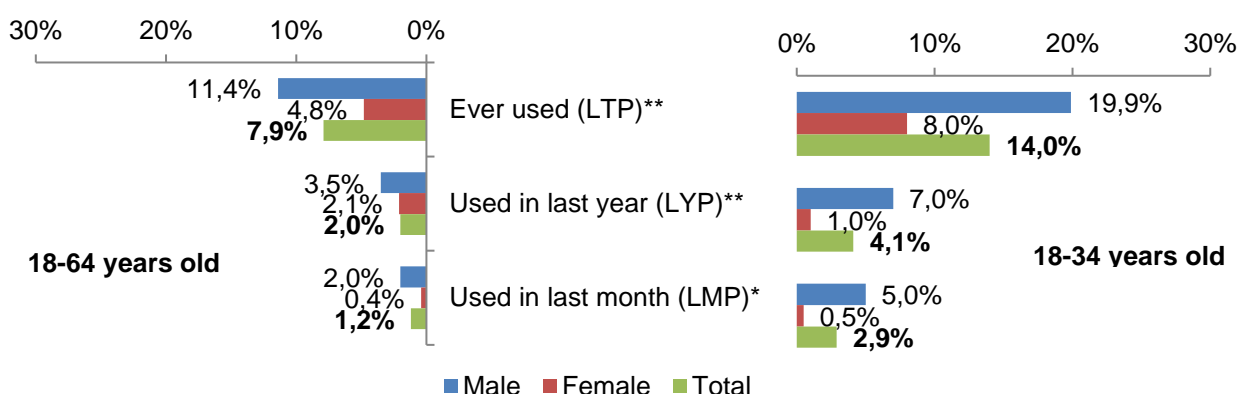
#### *Use of illicit drugs*

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<sup>23</sup> (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<sup>24</sup> in their lifetime<sup>25</sup>. 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<sup>26</sup>, 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 3. *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

<sup>21</sup> Authors of the workbook: Anna Péterfi, Anna Tarján, Borbála Paksi, Petra Arnold, Réka Bálint and Lilla Szabics

<sup>22</sup> 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.

<sup>23</sup> Every tenth to fifteenth person, taking into account the margin of error of the measurement.

<sup>24</sup> 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.

<sup>25</sup> Every sixth to ninth young adult, taking into account the margin of error of the measurement.

<sup>26</sup> 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.

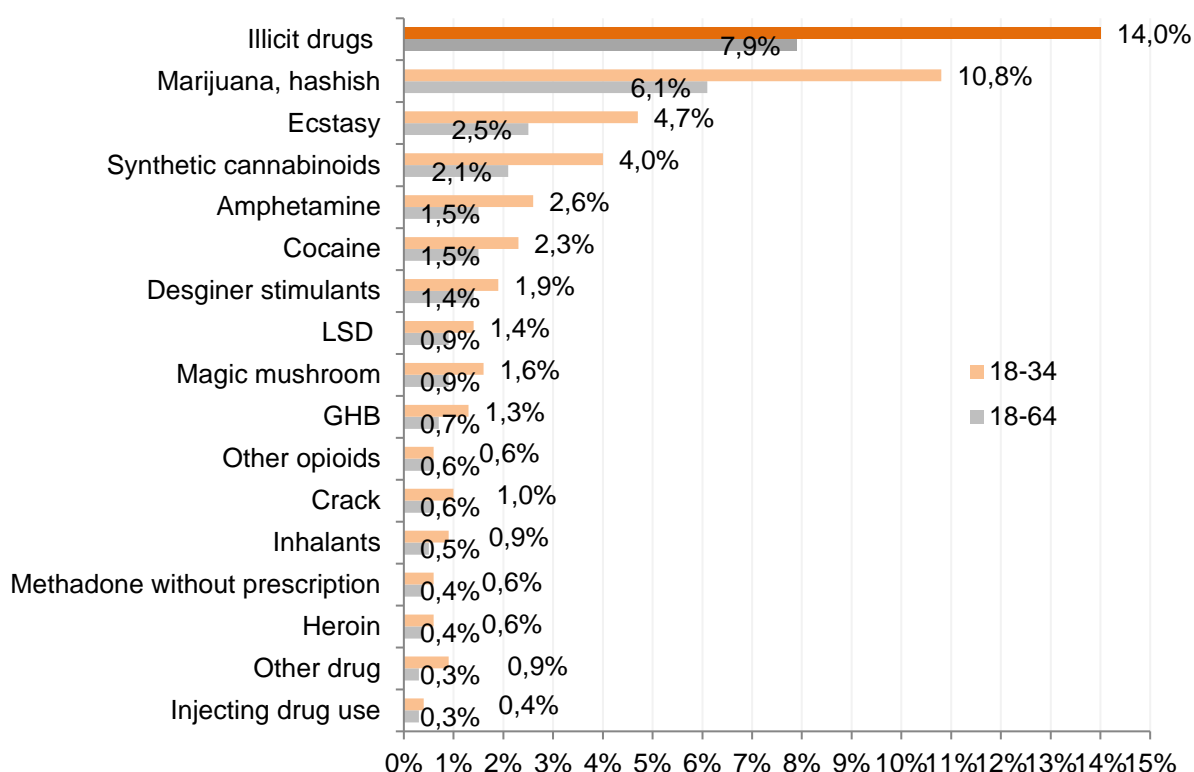
In the population aged 18-64, 44.5% of those who had used any illicit drug in the last year had used only one of the 14 types of drugs studied. However, 36.5% of last year users had used two, and one-fifth (20.1%) had used three or more types of drugs in the last year.

### *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 4. *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

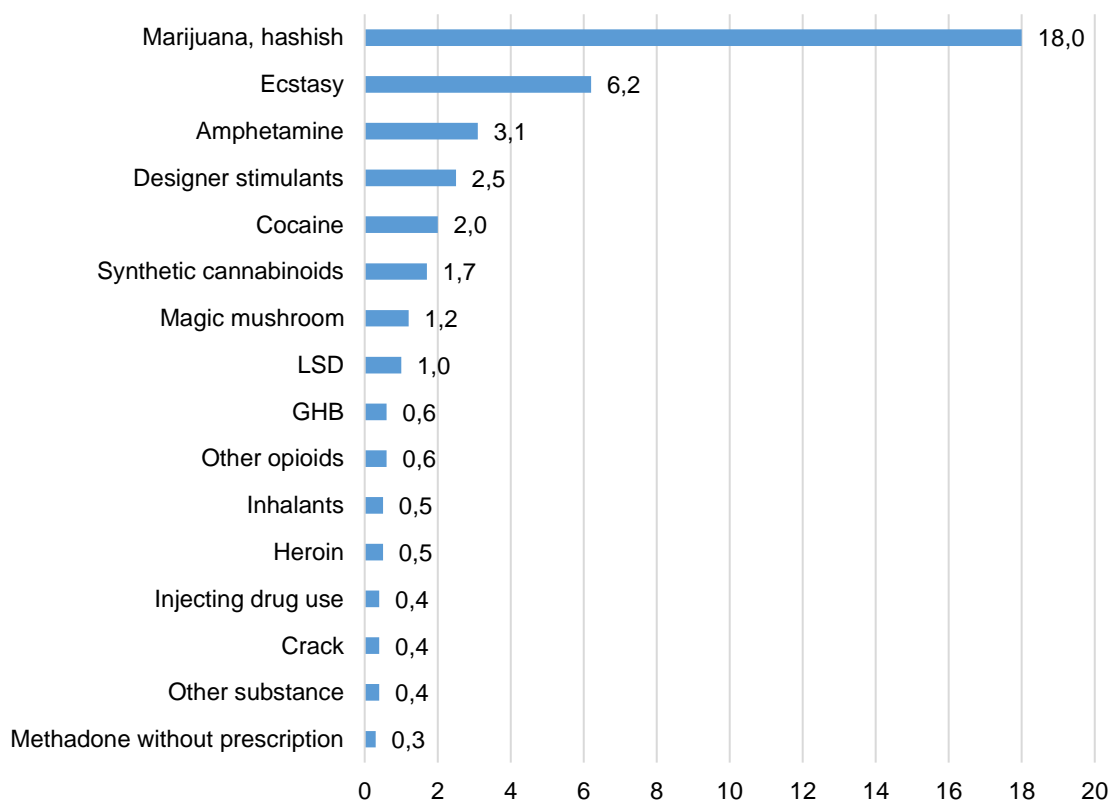
While synthetic cannabinoids rank second after herbal cannabis/cannabis resin in terms of ever-use (taking into account the margin of error, they are tied with ecstasy, amphetamines, cocaine and designer stimulants), in the order of importance based on recent drug use, they are tied for first place with 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 prevalence of ever using designer stimulants and cocaine (when considering the standard error). The prevalence of other drugs remains below 1% in the young adult population in Budapest according to 2020 data (Paksi 2021).

When comparing the hierarchy of drugs based on their lifetime prevalence, 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 5. *Lifetime prevalence 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

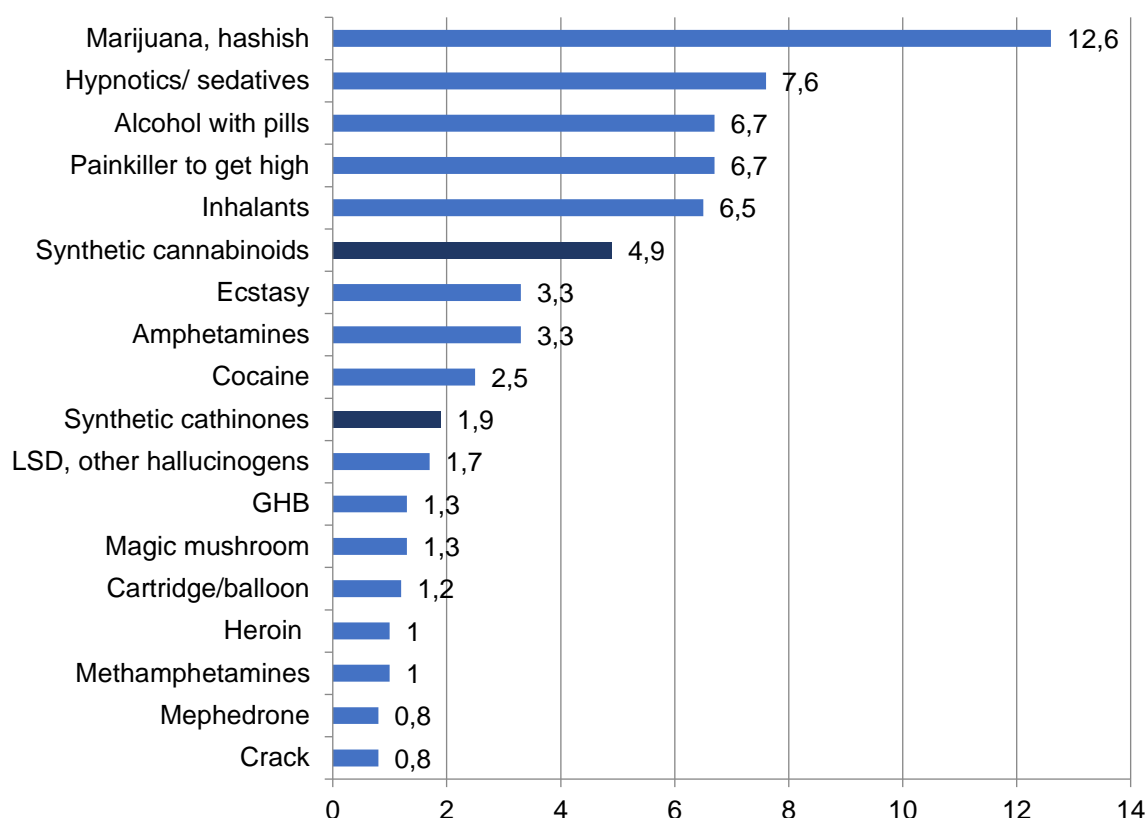
According to the results of the 2019 national ESPAD survey, the lifetime prevalence of use of illicit drugs among 16 year-old school students<sup>27</sup> was 13.9% (Arnold, Elekes 2020). The proportion of users of medicines without a prescription<sup>28</sup> is somewhat lower (12.9%). Nearly a quarter 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

<sup>27</sup> 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.

<sup>28</sup> 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 6. *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 demand 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 increased 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<sup>29</sup>. 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<sup>30</sup> (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

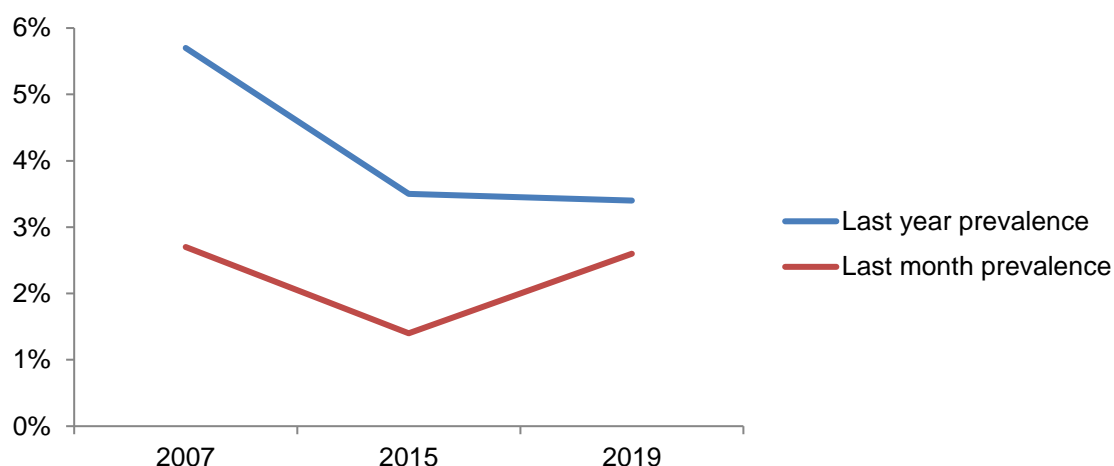
According to the data from the general population survey in 2019 (Paksi et al. 2019), cannabis is the most widespread illicit drug in the 18-64 year-old adult population; the lifetime prevalence rate is 6.1%, the last year prevalence rate is 1.3% and the last month prevalence rate is 0.9%. In the 18-34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

---

<sup>29</sup> 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 7. *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)*

<b>Socio-demographic characteristics</b>	<b>Sub-group values</b>	<b>N</b>	<b>Herbal cannabis/cannabis resin LTP (%)</b>	<b>sign.</b>
<b>Gender</b>	male	597	<b>8.4</b>	p=0.001
	female	680	4.0	
<b>Young adult / adult</b>	18-34 years old	403	<b>10.9</b>	p<0.001
	35-64 years old	874	3.9	
<b>Age group</b>	18-24	146	6.8	p<0.001
	25-34	256	<b>12.9</b>	
	35-44	330	6.1	
	45-54	288	3.1	
	55-64	256	2.0	
<b>Size of settlement</b>	<50,000 inhabitants	816	4.7	p=0.001
	≥50,000 inhabitants	236	<b>11.4</b>	
	capital city	225	5.8	
<b>Region</b>	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	
<b>Highest level of education<sup>31</sup></b>	year 8 or lower	126	6.3	p=0.032
	vocational school	436	5.0	
	final examination (secondary school)	461	4.8	
	degree	252	<b>9.9</b>	
<b>Intergenerational educational mobility</b>	upwardly mobile	661	4.5	p=0.041
	not mobile	536	<b>7.6</b>	
	downwardly mobile	50	<b>10.0</b>	
<b>Vocational qualification</b>	no	194	4.6	p>0.1
	yes	945	6.3	
<b>Labour market activity</b>	no job	303	6.3	p>0.1
	has job	958	5.7	
<b>Subjective financial situation</b>	we make a comfortable living from our income	108	<b>12.0</b>	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	
<b>Perceived relative financial situation</b>	better than average	260	<b>10.0</b>	p=0.012
	average	790	4.9	
	worse than average	213	5.6	

<sup>31</sup> 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 <sup>32</sup>	1.86	77	3.15	1199	-1.287	p=0.003
Anomie <sup>33</sup>	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

<sup>32</sup> 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.

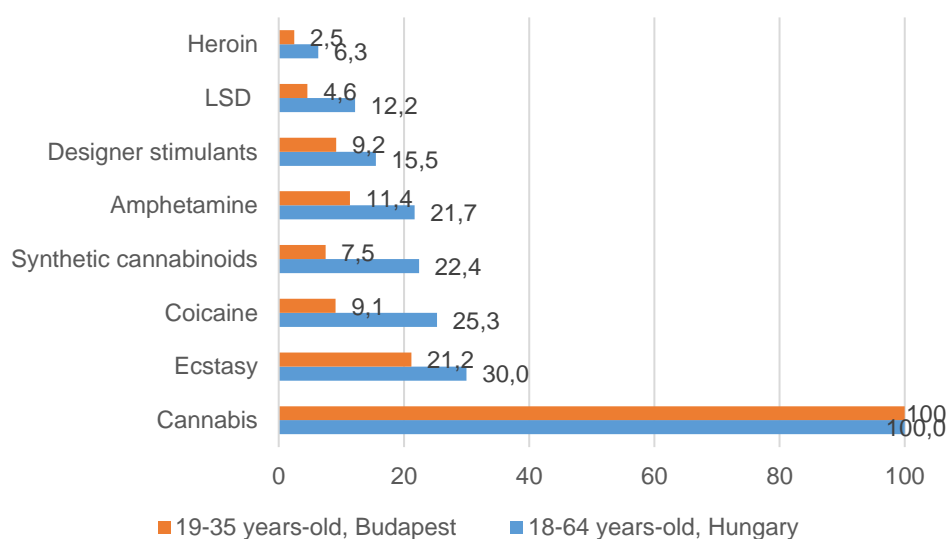
<sup>33</sup> The indicator is a subjective indicator measuring the degree of anomie across the dimensions of violation of norms, powerlessness, lack of orientation and alienation. The higher the value of the indicator, the greater the presence of anomic sensations.

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 (Paksi, 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 8. *Drug use pyramid for cannabis users in the 19-35 years-old young adult population of Budapest (based on the 2<sup>nd</sup> 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.

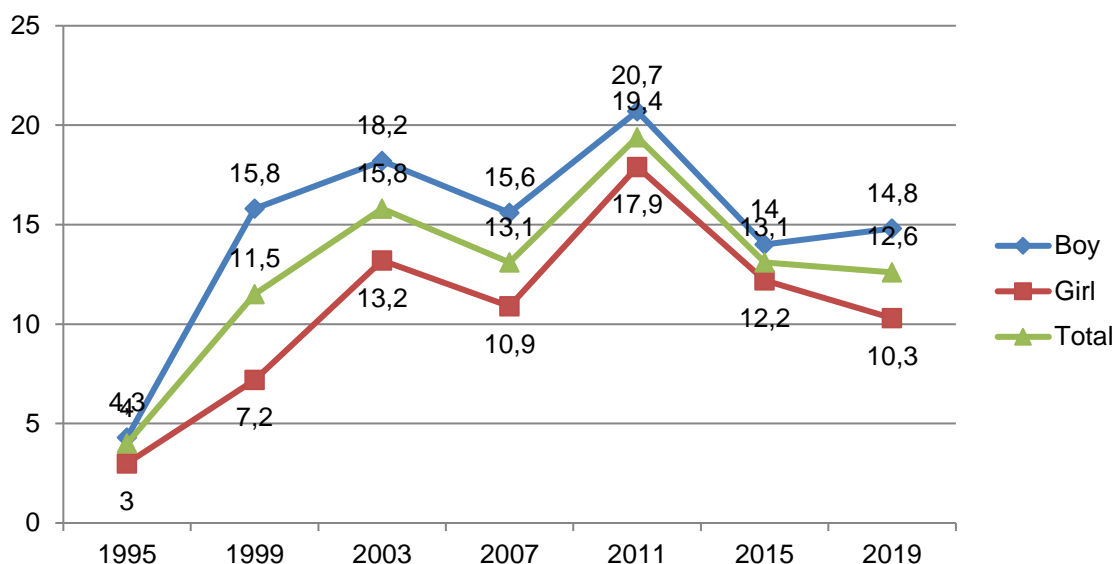


More than a tenth (12.6%) of 16 year-old students had used herbal cannabis or cannabis resin in their lives. One in ten students (10.2%) had used the drug in the 12 months prior to the survey and one in twenty students (5.2%) had used the drug in the month prior to the survey. Four-fifths (79.9%) of 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 9. *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 (%)*

<b>SOCIO-DEMOGRAPHIC CHARACTERISTICS</b>		<b>LIFETIME PREVALENCE OF CANNABIS USE %</b>	<b>sign.</b>
<b>Gender</b>	male	14.8	p<0.01
	female	10.3	
<b>School type</b>	grammar school	12.3	not sign.
	vocational grammar school	11.5	
	secondary vocational school	14.9	
<b>School address</b>	Budapest	18.3	p<0.01
	county seat	10.7	
	other town	12.0	
	village	7.1	
<b>School's maintainer</b>	state	12.8	not sign.
	church	9.4	
	private	15.2	
<b>Residence</b>	Budapest	17.2	p<0.05
	town	12.6	
	village	10.7	
<b>Family structure</b>	intact	10.1	p<0.01
	patchwork	17.1	
	broken	16.8	
	no birth parents	16.4	
<b>Father's education</b>	lower than final examination (secondary school)	11.9	not sign.
	final examination (secondary school)	11.9	
	higher education	14.2	
	not known	11.4	
<b>Mother's education</b>	lower than final examination (secondary school)	11.5	not sign.
	final examination (secondary school)	11.9	
	higher education	13.7	
	not known	14.5	
<b>Subjective financial situation</b>	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<sup>34</sup> 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*

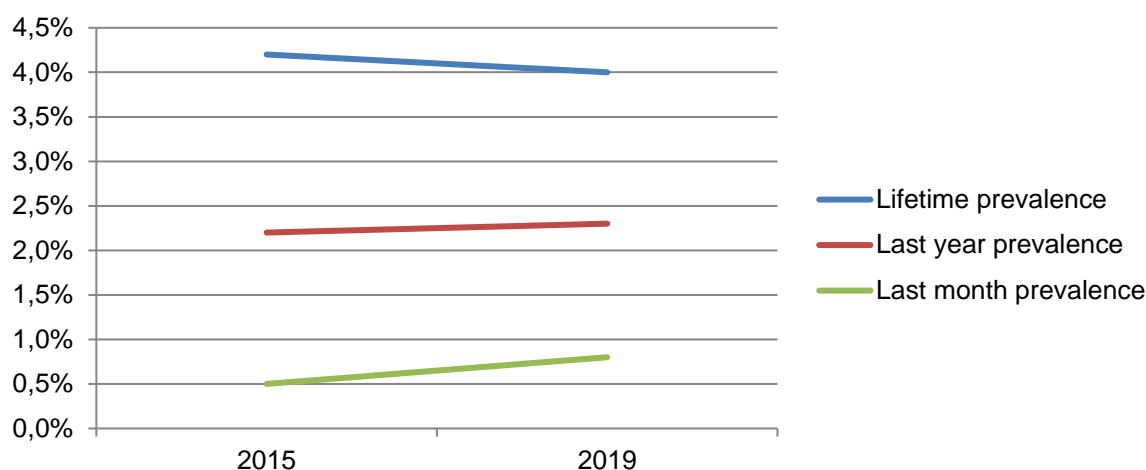
According to the data of the NSAPH (National Survey on Addiction Problems in Hungary) general population survey in 2019 (Paksi et al. 2019; Paksi 2020), synthetic cannabinoids were among the most widely used drugs in the 18-64 year-old adult population in Hungary. Based

---

<sup>34</sup> 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 10. *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*

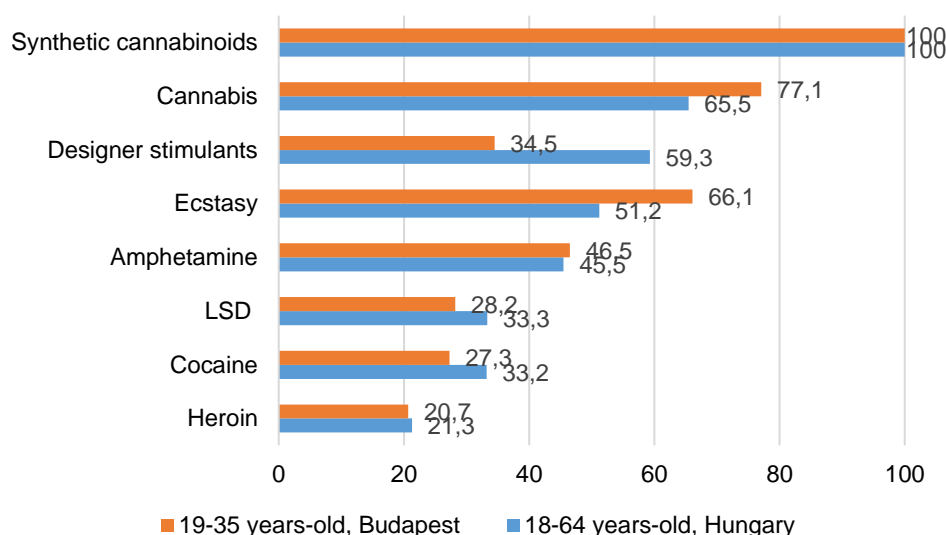
To investigate the relationship between synthetic cannabinoid use and other drug use behaviors, we created a special version of the drug use pyramid traditionally built for cannabis users, constructed for synthetic cannabinoid users based on the results of the 2020 wave of the BLS study in the 19-35 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 11. *Drug use pyramid for synthetic cannabinoid users in the 19-35 years-old young adult population of Budapest (based on the 2<sup>nd</sup> wave of BLS) and 18-64 year-old Hungarian population (based on NSAPH 2019) (as a percentage of synthetic cannabinoid 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<sup>35</sup>. 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

<sup>35</sup> 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<sup>36</sup>.

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**

---

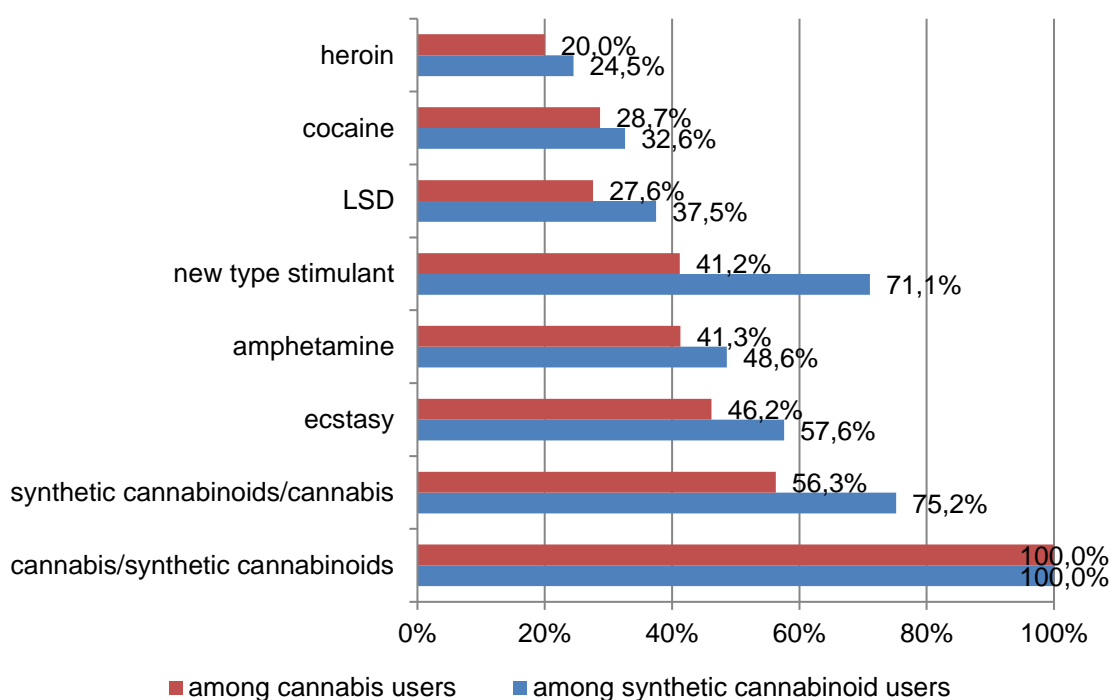
<sup>36</sup> In the TDI data collection, synthetic cannabinoid users are not reported in a distinct category, so it is hard to capture them. However, based on consultation with the treatment centres, it can be assumed that these users are typically recorded in the categories of “other hallucinogens” 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 12. *Drug use pyramid in the homeless population (% of ever-users of cannabis and/or synthetic cannabinoids), 2017<sup>37</sup>*



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.

<sup>37</sup> 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<sup>38</sup>; 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<sup>39</sup>.

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 derivatives (as a single active agent or a combination of different synthetic cathinones; 429 cases) and the fourth most common was cocaine (176 cases). There were 4 cases where exclusively opiates were identified and 16 with synthetic opioids.

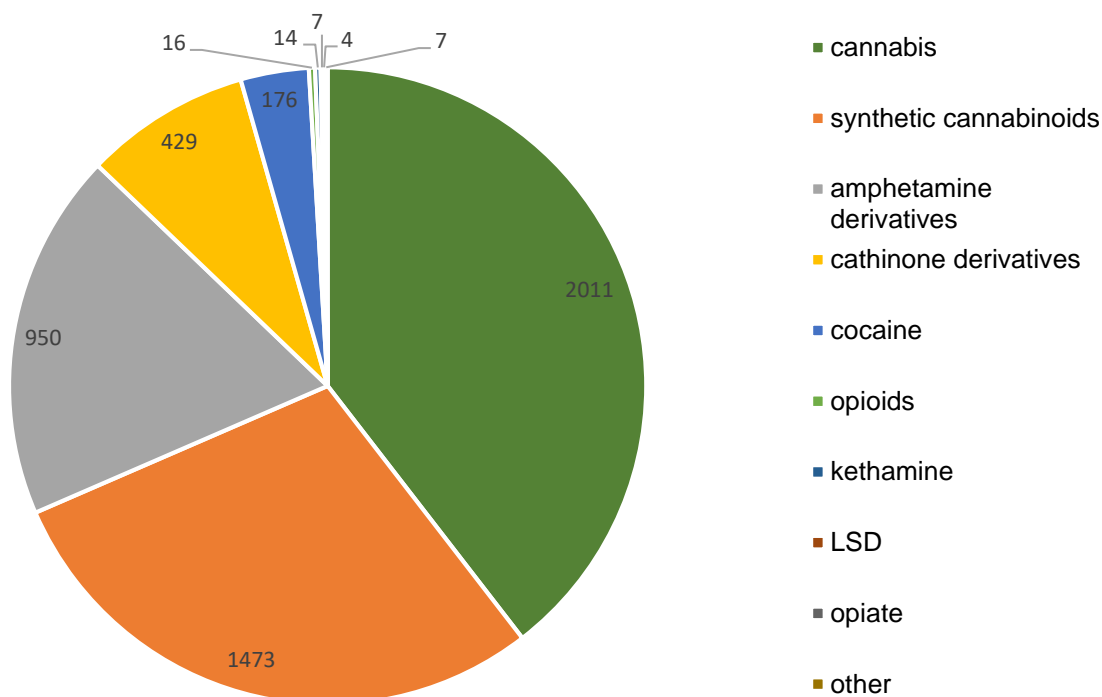
---

<sup>38</sup> 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).

<sup>39</sup> 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 13. *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)*

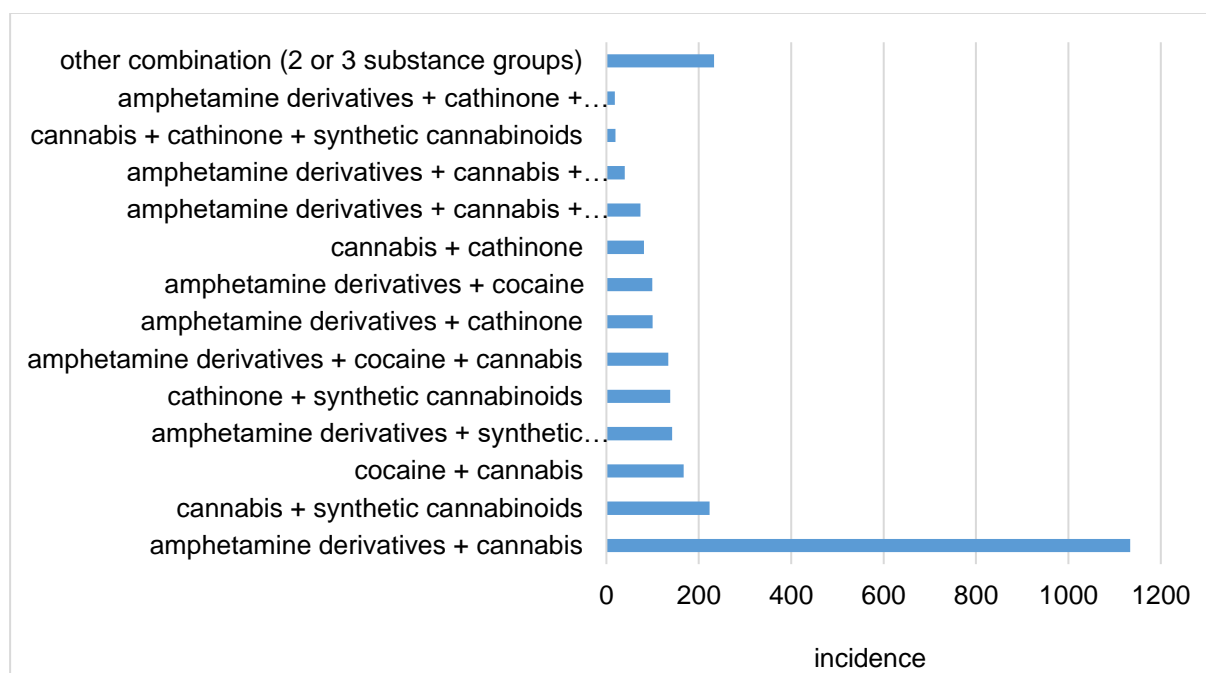


Source: NSZKK 2021

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.

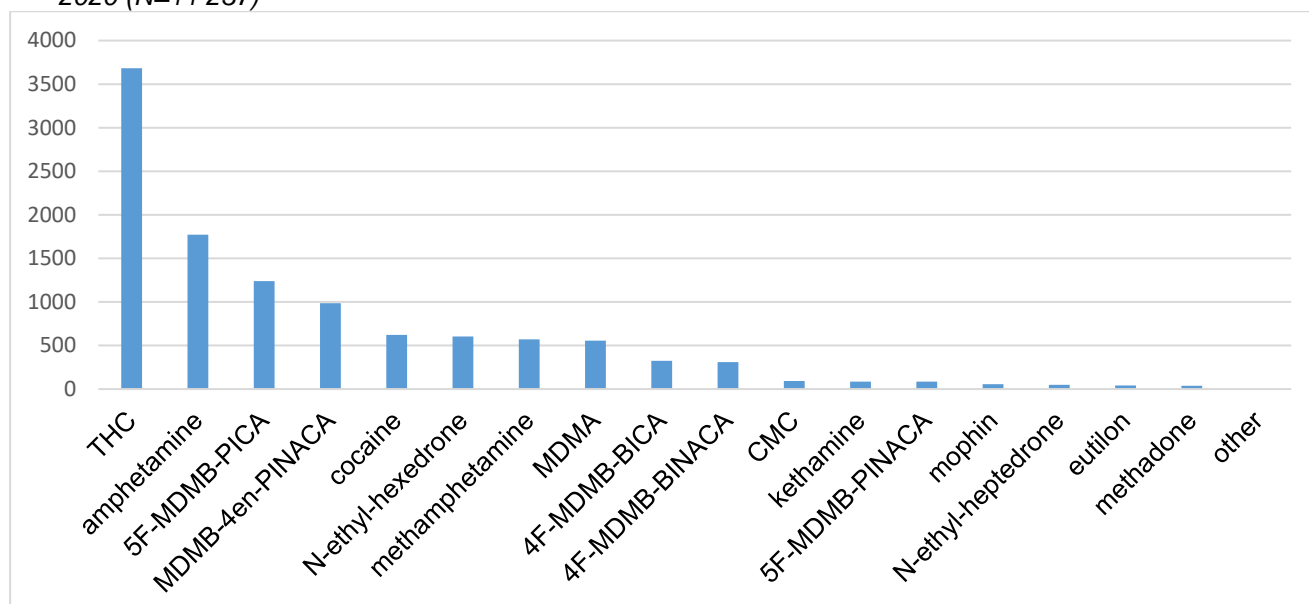
Chart 14. *Most common poly drug use patterns by compound group or compound group combinations based on the examination of biological samples received by the Hungarian Institute for Forensic Sciences (NSZKK) in 2020 two or three substance groups; N=2603*<sup>40</sup>



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 15. *The prevalence of substances (established drugs and NPS) in biological samples in 2020 (N=11 237)*<sup>41</sup>



Source: NSZKK 2021

<sup>40</sup> Cases containing two or three compound groups were analysed and the most common combinations are shown in the chart.

<sup>41</sup> 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.

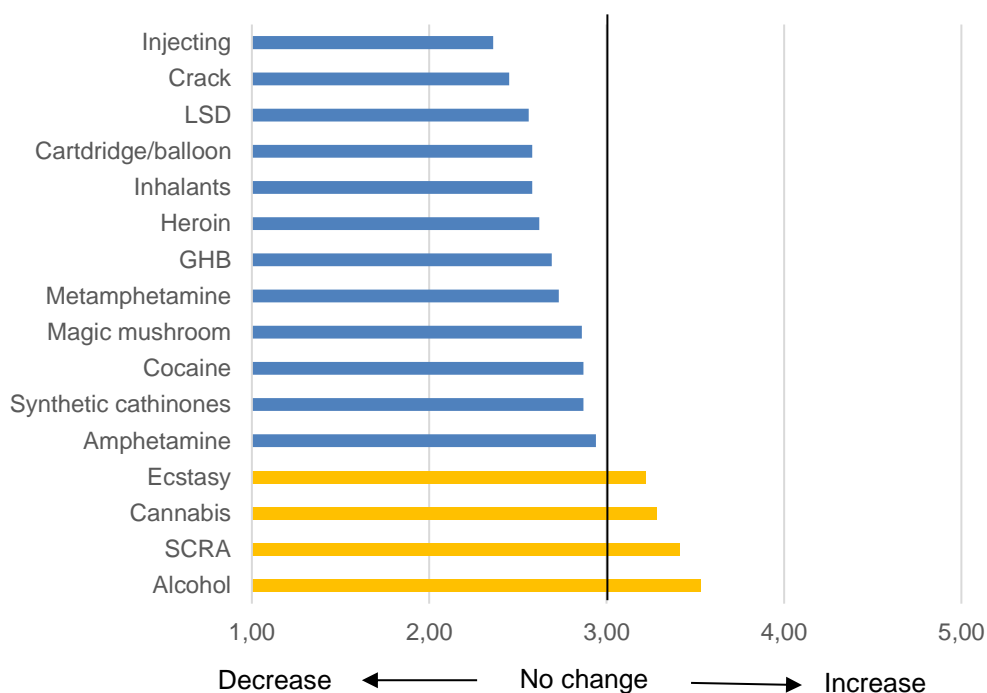
With respect to synthetic cannabinoids, the most common stand-alone substances were 5F-MDMB-PICA (501 cases), followed by MDMB-4en-PINACA (353 cases); 4F-MDMB-BICA (31 cases) and 4F-MDMB-BINACA (20 cases). The most common combinations were 5F-MDMB-PICA + MDMB-4en-PINACA (119 cases), followed by the combination of 4F-MDMB-BICA + MDMB-4en-PINACA (84 cases) and 5F-MDMB-PICA + 4F-MDMB-BINACA (62 cases). The combination of 5F-MDMB-PICA + MDMB-4en-PINACA+4F-MDMB-BINACA and MDMB-PICA + MDMB-4en-PINACA + 4F-MDMB-BICA were also typical (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<sup>42</sup> 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 16. Trends in drug use in the nightlife/recreational setting between 2018 and 2019 as viewed<sup>43</sup> by service providers, by substance based on the mean value of all responses (number of respondents = 20 organisations)



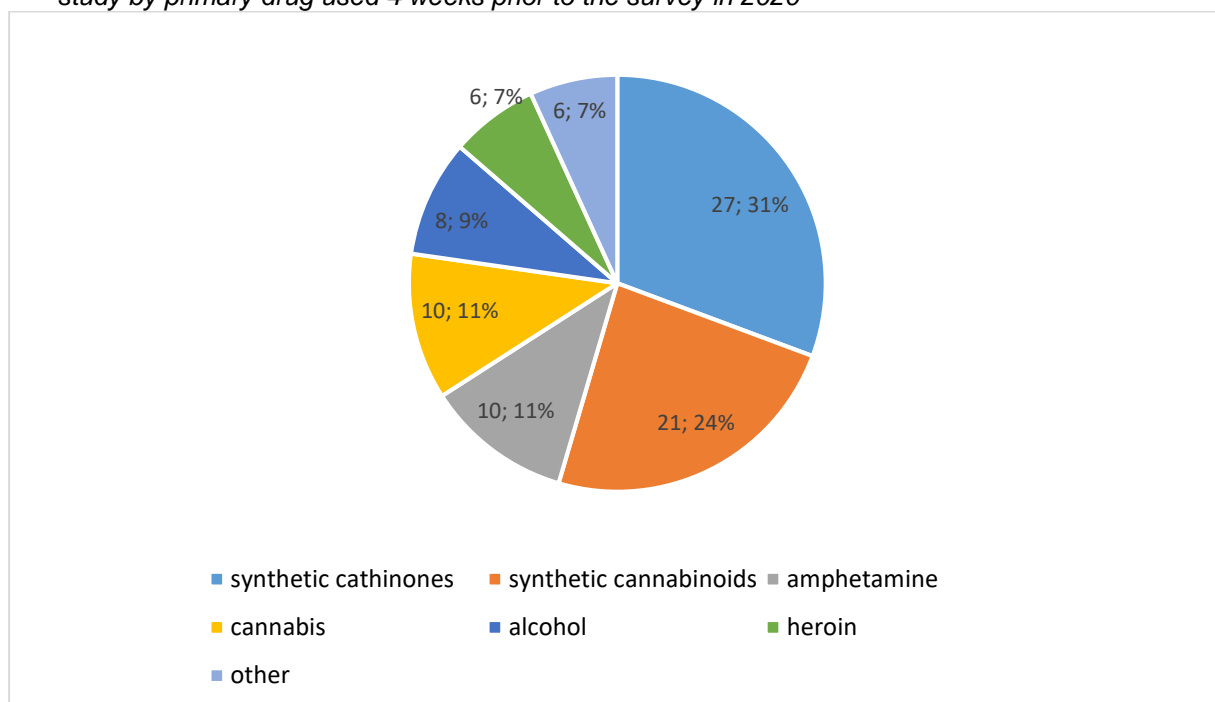
Source: Tarján 2020b

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

The 2020 HEPAGO-NFP bio-behavioral study (Tarján et. al. 2021; for methodology see: Harms and harm reduction T5.2.2.) examined the respondent's substance use patterns, as well as the changes caused by the COVID-19 pandemic in terms of drug use, availability, social status 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.

<sup>43</sup> (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 17. *Distribution of drug users (n = 88 persons) participating in the Budapest biobehavioural study by primary drug used 4 weeks prior to the survey in 2020*

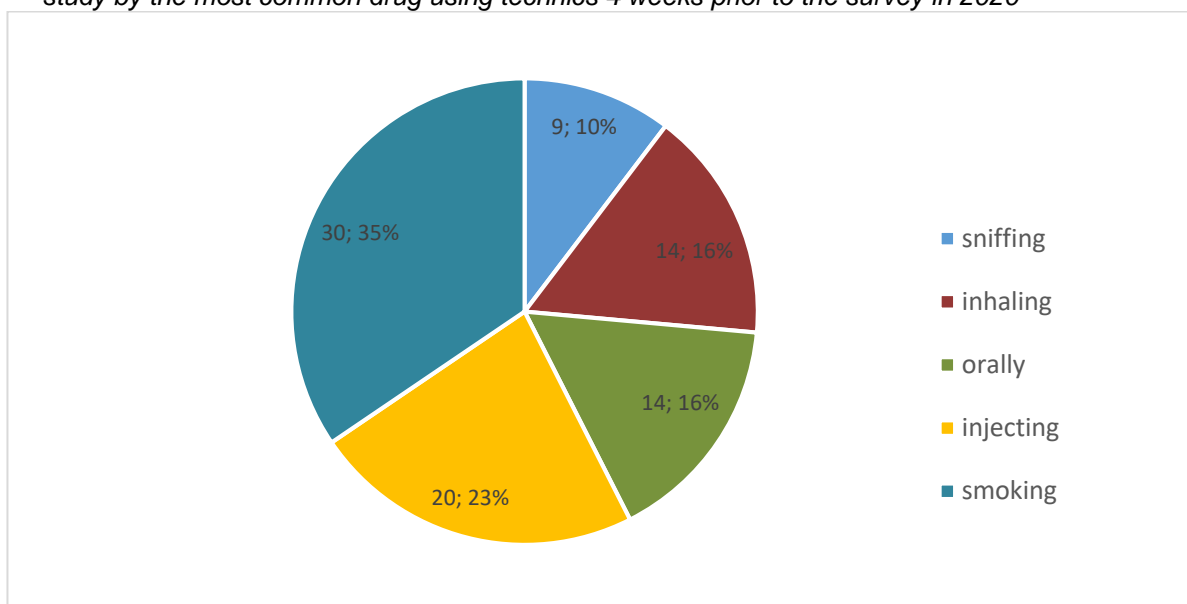


Source: Tarján et al. 2021

Change in the primary use drug occurred only for a lesser extent due to the epidemic restrictions introduced after March 2020. Information on both drugs (primarily 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 respondents inhaled or injected the primarily used drugs. There has not been a significant change in the drug use techniques due to the restrictions after March 2020.

Chart 18. *Distribution of drug users (n = 87 persons) participating in the Budapest biobehavioural 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*

	Number of persons marking the statement	%
TOTAL sample=96 persons (NPS/drug users only)		
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 quantity of seizures regarding MDMA containing tablets started to decrease in 2020, the powder or crystal MDMA shows a continuous 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, presumably due to the restrictive measure connected to the COVID-19 pandemic. Both; Most of the seizures in 2020 were in small (consumer) quantities. (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.

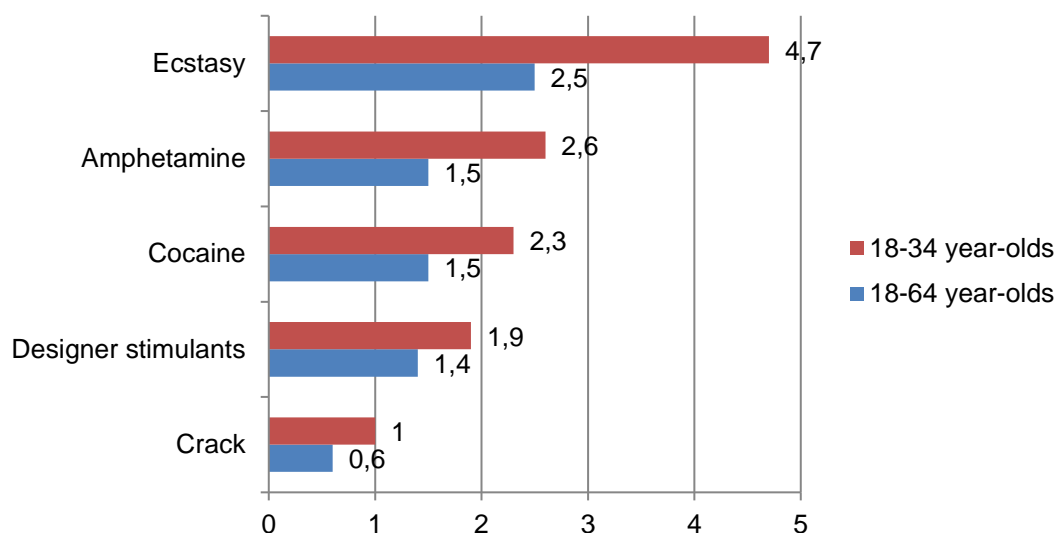
Designer stimulants (typically synthetic cathinones, known by the street names: “kristály” (“crystal”), “kréta” (“chalk”), “zene” (“music”) usually appear on the market in powder form; among them, after 2018 ethyl-hexedrone was again the most prevalent substance in 2020 (NSZKK 2021a). It is noteworthy 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 19. *Lifetime prevalence rates of stimulants by drug type in the adult population aged 18-64 years and 18-34 years, in 2019 (%)*

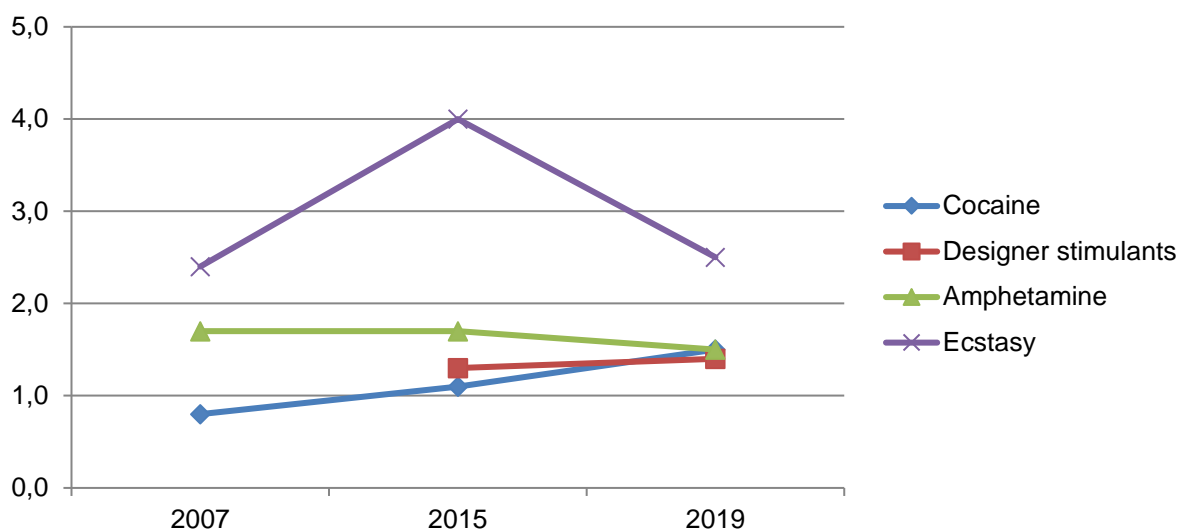


Source: NSAPH 2019 – Paksi et al. 2019

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 20. *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<sup>44</sup>, 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.

<sup>44</sup> 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<sup>45</sup> 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.

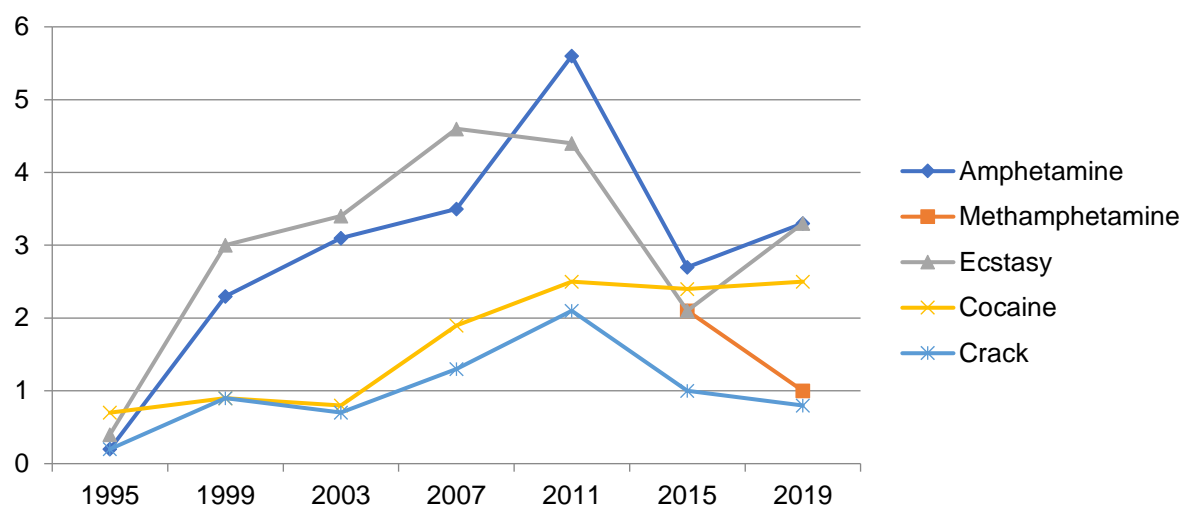
According to the results of the ESPAD survey (Arnold, Elekes 2020) conducted in the 16 year-old secondary school population, the lifetime prevalence for established stimulants<sup>46</sup> was 5.4% in 2019, meaning that every twentieth 16 year-old student had already used at least one of the established 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.

<sup>45</sup> on at least 30 days or more during their lifetime

<sup>46</sup> ecstasy/MDMA, amphetamine, methamphetamine, cocaine, crack

Chart 21. *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 school	5.8	
	secondary 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.

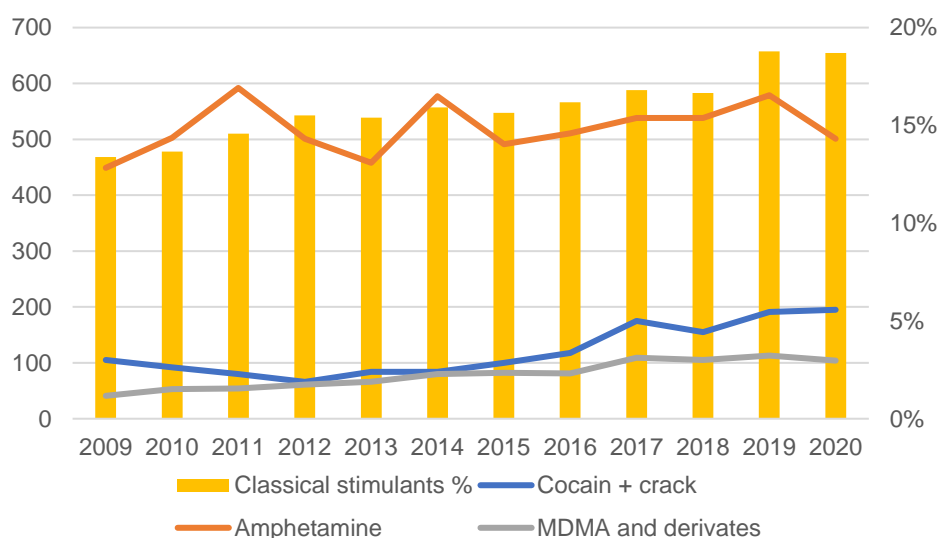
### **T1.2.2 Treatment of stimulant users**

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 22. .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,<sup>47</sup> 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

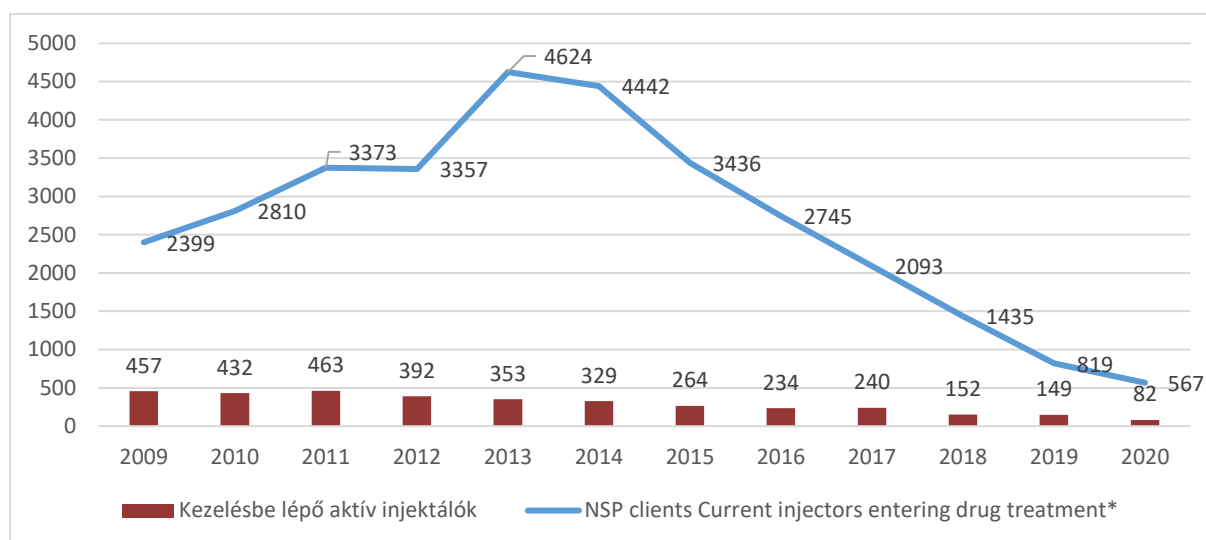
---

<sup>47</sup> 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 23. *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<sup>48</sup>*

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  $\alpha=0.24^{49}$ , the size of the hidden PWID population was estimated at 6744 persons, and the size of the entire PWID population at 7799 persons.<sup>50</sup> 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%<sup>51</sup> of NSP clients used designer stimulants, it started to continuously 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 continued 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

---

<sup>48</sup> 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.

<sup>49</sup> For further information, see E/T5.2

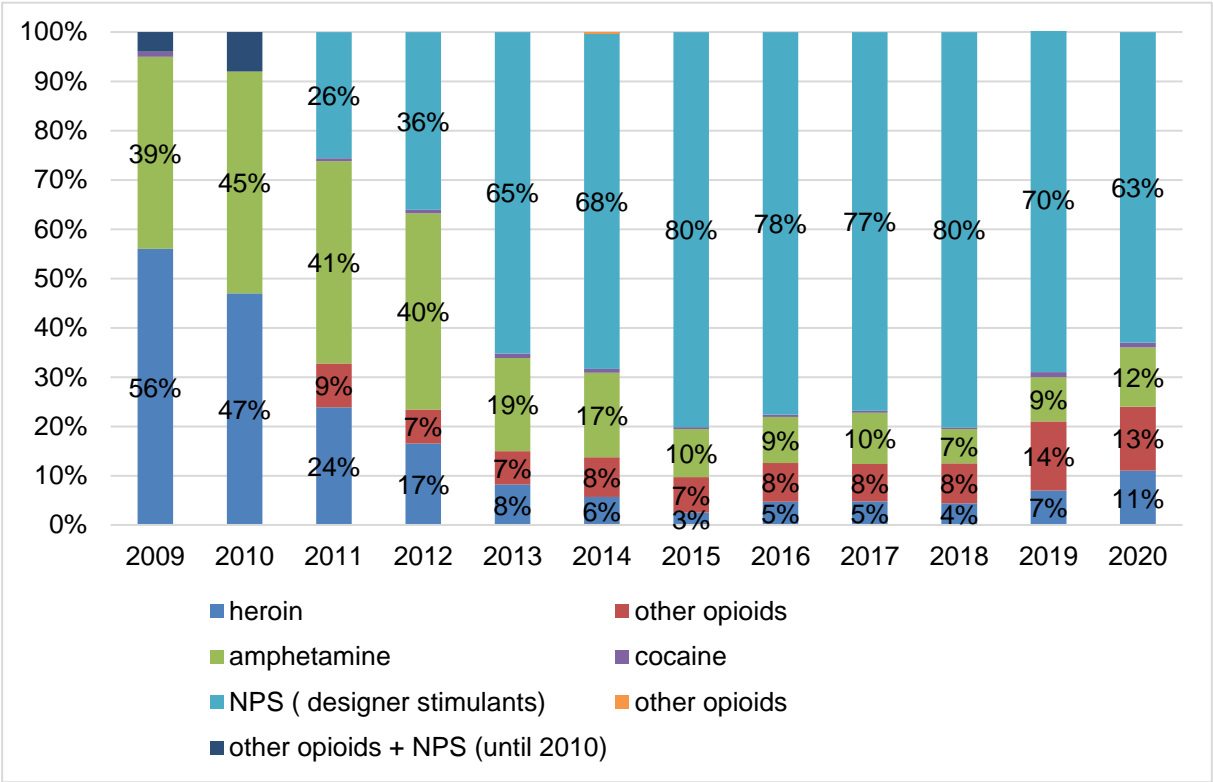
<sup>50</sup> Persons who injected at least once between 2013 and 2015.

<sup>51</sup> 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).

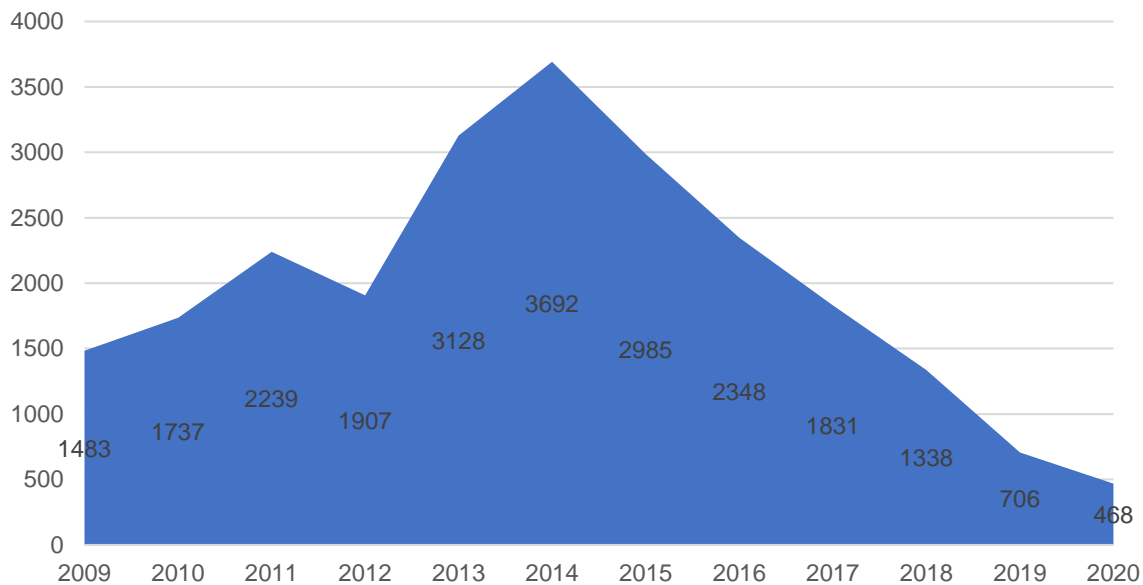
Chart 24. Breakdown of NSP clients by<sup>52</sup> primary injected drug between 2009 and 2020<sup>53</sup> (upper chart) and total number of NSP clients per year (lower chart)



Source: Tarján 2021a

<sup>52</sup> for the N of clients per year see the methodology under Drugs/Sources and Methodology/T.6.1

<sup>53</sup> 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 pandemic 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<sup>54</sup>. 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<sup>55</sup> (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

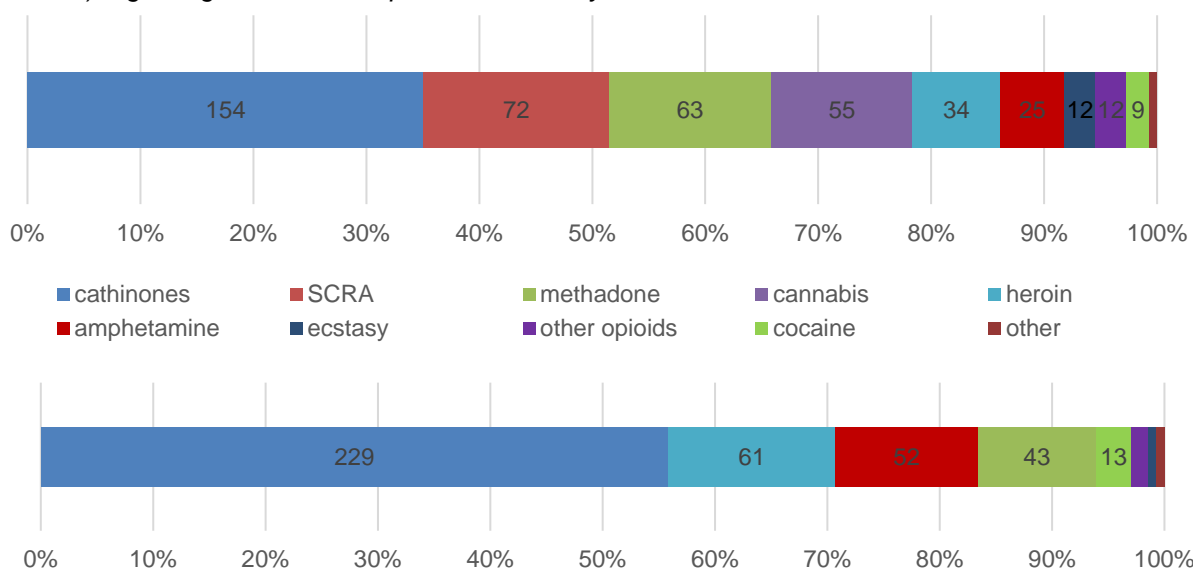
<sup>54</sup> Several treatment centres participating in the survey also provided OST (7 out of 19 in 2015), due to which there is a bias towards opioid injecting in terms of prevalence of primary injected drug.

<sup>55</sup> 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<sup>56</sup> (440 persons) reported synthetic cathinones as their primary<sup>57</sup> used drug (regardless of the route of administration)<sup>58</sup>, while 16% named synthetic cannabinoids, <sup>59</sup>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 25. 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<sup>60</sup> prior to the survey, in 2018<sup>61</sup>



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<sup>62</sup>, followed by smoking (30%), ingestion (15%), inhalation (foil) (8%) and finally sniffing (3%).

<sup>56</sup> 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.

<sup>57</sup> 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.

<sup>58</sup> based on self-reported street names: "crystal", "music" and "chalk" were grouped here.

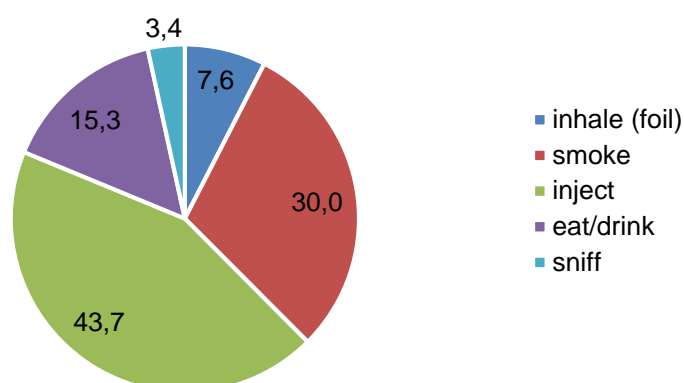
<sup>59</sup> based on self-reported street names: "herbal", "bio weed" and "magic tobacco" were grouped here.

<sup>60</sup> 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.

<sup>61</sup> 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.

<sup>62</sup> 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. Main route of administration of the primary used drug in the last 4 weeks<sup>63</sup> among PWID participating in the HNFP-NNK HIV/HCV biobehavioural survey in 2018 (N=437; %)



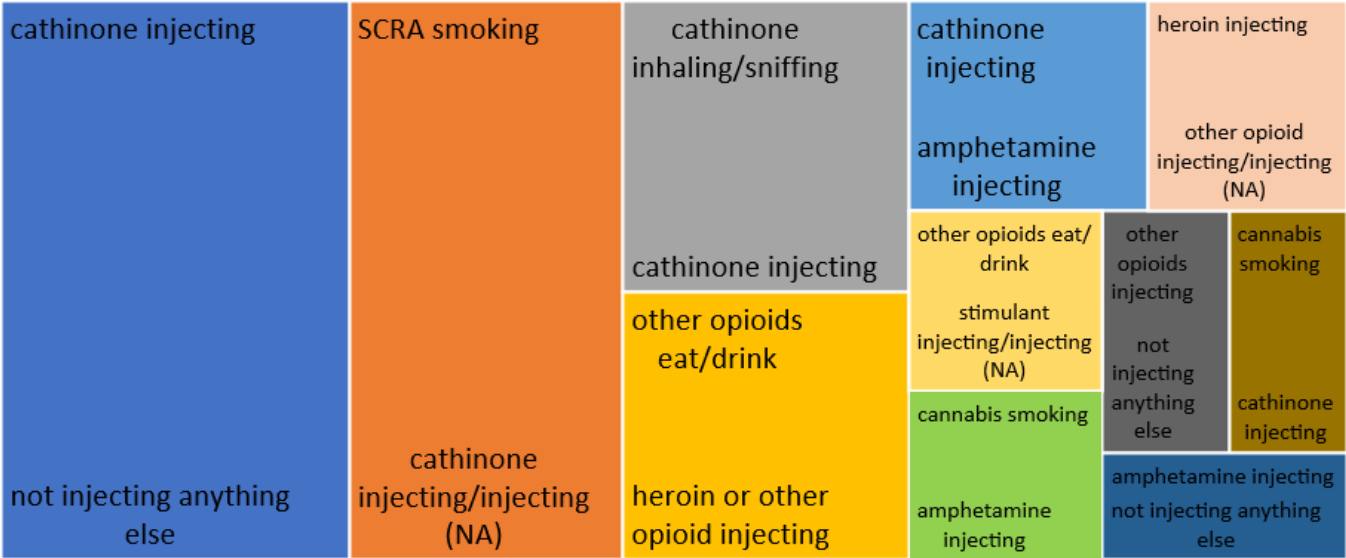
Source: Tarján et al. 2019

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.

<sup>63</sup> 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 27. Most common mono/poly drug use patterns among PWID participating in the HNFP-NNK HIV/HCV biobehavioural survey in 2018 (N=344<sup>64</sup>) (upper row: primary drug and route of administration; lower row: secondary drug and/or route of administration)<sup>65</sup>



Source: Tarján et al. 2019

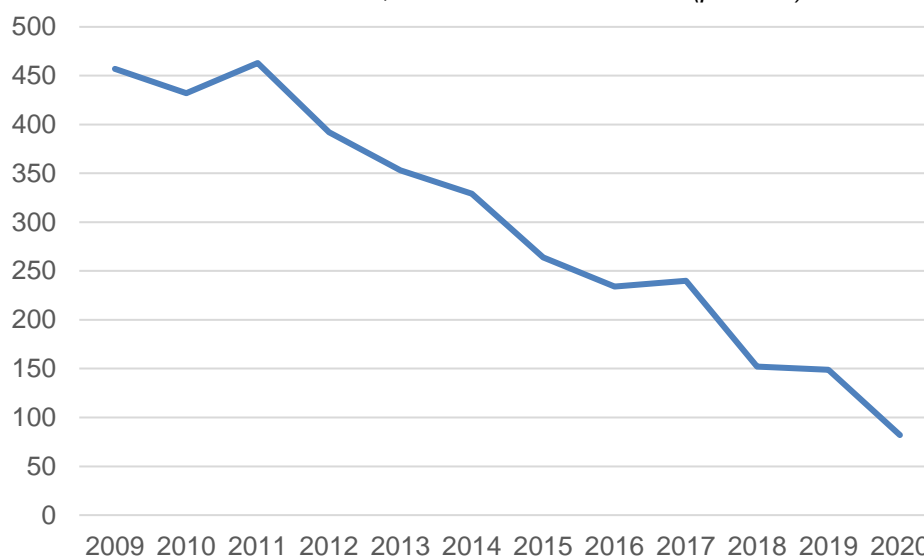
For more details on the 2019 regional HNFP-NNK HIV/HCV biobehavioural survey, see: section T5.1 of the Harms and Harm Reduction workbook).

### 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<sup>66</sup> 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.

<sup>64</sup> A further 93 combinations are not shown here due to low case numbers (under 7) per combination category.  
<sup>65</sup> 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.  
<sup>66</sup> 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 28. *Number of current PWID<sup>67</sup>, 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**

<sup>67</sup> 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.

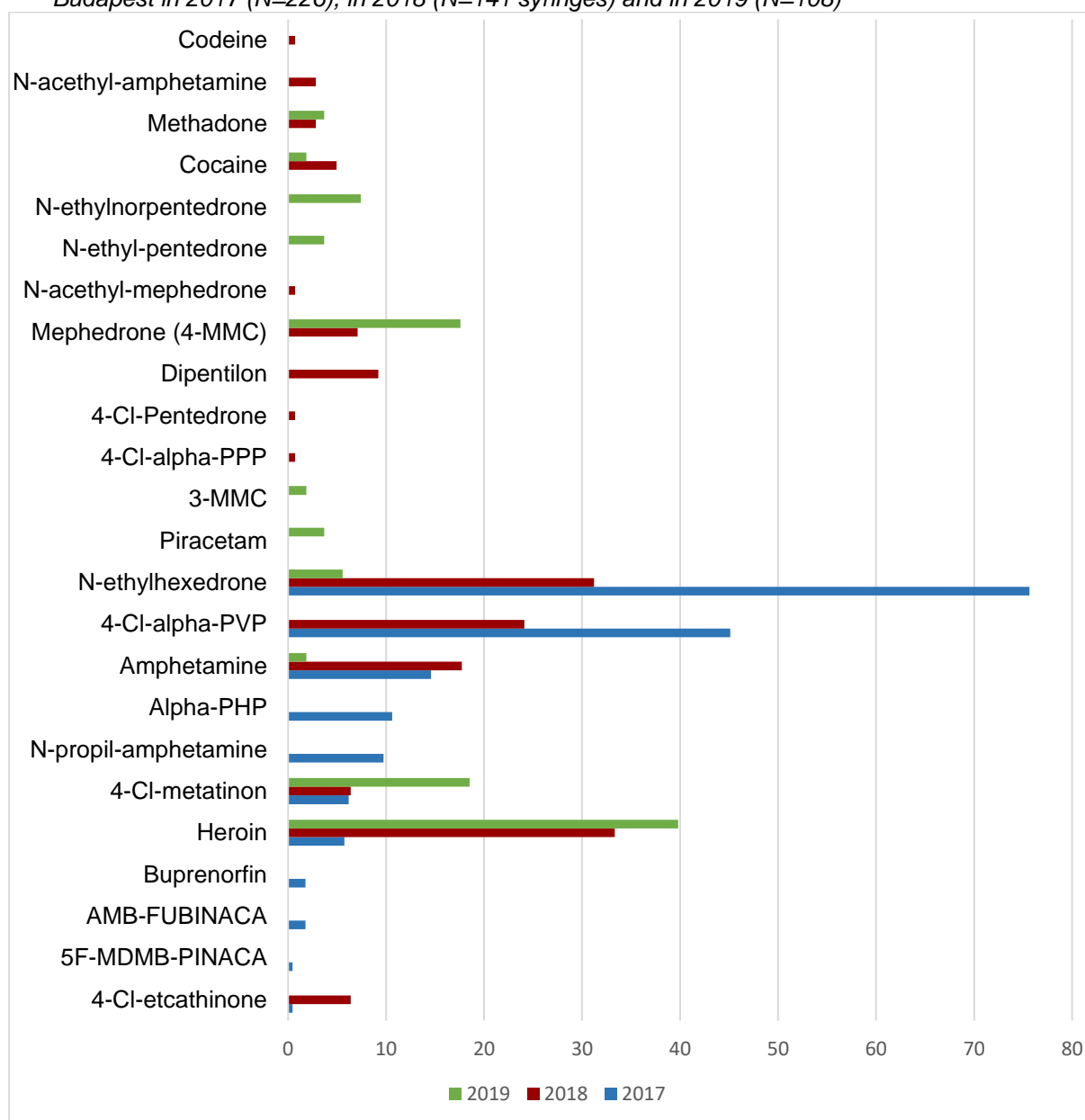
In the field of harm reduction, several experts mentioned a shift from injecting synthetic cathinones to smoking synthetic cannabinoids (“herbal”, “bio”); a change from injecting to inhaling (using foil) was also confirmed, as observed in treatment data as well (see section T1.2.5 of this chapter). These 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 29. 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)<sup>68</sup>



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.

<sup>68</sup> 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<sup>69</sup> injected opioids primarily, by 2015 only 38.3% of them reported an opioid as their primary injected substance<sup>70</sup>. (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.<sup>71</sup>

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<sup>72</sup> 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

---

<sup>69</sup> ever-injecting users

<sup>70</sup> 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.

<sup>71</sup> 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<sup>73</sup> 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<sup>74</sup>. 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.

---

<sup>73</sup> methadone: 57 persons; suboxone: 3 persons; other opioids: 7 persons

<sup>74</sup> 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<sup>75</sup>

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<sup>76</sup>.

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<sup>77</sup>.

- 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**'<sup>78</sup> all of whom have used an illicit drug other than cannabis, while 98% have also used cannabis in

<sup>75</sup> Source of the subchapter: Paksi 2021

<sup>76</sup> 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.

<sup>77</sup> 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.

<sup>78</sup> 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 prevalence 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
Designer 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\\_](http://drogfokuszpont.hu/fogalomtar/fogalomtar-ii/#Politoxikom_nia_)

The term 'polydrug users' in this analysis is used to name the user group that are characterised 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<sup>79</sup>. 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 multinomial 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

---

<sup>79</sup> 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.<sup>80</sup>
- 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.

---

<sup>80</sup> Multinomial 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 multinomial 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 <sup>81</sup> (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 <sup>82</sup> (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

<sup>81</sup> Variable created based on the attained educational status and current education, just like in the NSAPH studies (Paksi et al. 2009, 2017, 2021).

<sup>82</sup> 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 <sup>83</sup>	0.96 [0.90-1.02]*	<0.001	1.11 [1.03-1.19]	0.004	1.02 [0.941-1.11-]	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 <sup>84</sup>	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 <sup>85</sup>	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
Frequency 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

<sup>83</sup> 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.

<sup>84</sup> 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.

<sup>85</sup> Among the types of deviant/risk behaviors (smoking, regular alcohol consumption, heavy sedative / hypnotic or drug use, regular gambling, suicide attempt, completed suicide, imprisonment, 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.: atheist)								
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
<p>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.</p> <p>Variables with a significant role (<math>p &lt; 0.050</math>) in the multivariate model are highlighted in grey (except for those with a * mark).</p>								

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 primarily 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](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<sup>86</sup>. As the second step of the estimate, the results were modified according to the question about the time of the last injecting that was included in the questionnaire of the testing, 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<sup>87</sup> of capture-

<sup>86</sup> Re-occurrence in the testing programmes between 2014 and 2015

Year	2015		
	Occurrence	Gender	Yes
2014	Gender		458
	Yes	463	133

<sup>87</sup>The “Lincoln-Petersen” formula was modified, so the formula used for estimating injecting drug use was:

$$x = \frac{a_{21} \cdot a_{12}}{a_{11} \cdot a_{22}} + (1 - \alpha) \cdot a'_{22}$$

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.<sup>88</sup> 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 cessation 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

$\alpha$  = coefficient of the intention to participate; 100% means that all repeat occurrences were accidental, i.e. the two tests are statistically independent

<sup>88</sup>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  $\pm 1.57\%$ ). 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  $\pm 1.85\%$ ). 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  $\pm 1.86\%$ . 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 including 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  $\pm 2.5\%$  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.

*Tarján et al 2019. HNFP-NNK HIV/HCV national biobehavioural survey 2018:* see section T5.1 of the Harms and Harm Reduction workbook.

### T6.3 BIBLIOGRAPHY

Andorka R. (1994): Deviáns viselkedések Magyarországon – általános értelmezési keret az elidegenedés és az anómia fogalmak segítségével. In: Münnich I., Moksony F.(szerk.). Devianciák Magyarországon (32-77). Budapest. Közélet Kiadó.

Arnold P., Elekes Zs. (2020): Drogfogyasztási szokások a 16 évesek körében – ESPAD 2019. Tanulmány a Drog Fókuszpont számára. 2020. Manuscript.

Bálint. R. (2021): A kábítószeres utcai árának alakulása 2020-ban. Hungarian National Focal Point. questionnaire-based data collection. (For methodology. see section T5.2 of the Drug Market and Crime workbook)

BM (2020): A Belügyminisztérium 2019-re vonatkozó beszámolója a 2020-as EMCDDA Jelentés elkészítéséhez.

Csák R., Magyar. É., Márványkövi. F., Rácz. J. (2018a): Kvantitatív kutatás a községi szegregátumokban élő pszichoaktív szerhasználók körében – Drogfogyasztás és kezelésének lehetőségei községekben, különös tekintettel a „Szegregált élethelyzetek felszámolása komplex programokkal” elnevezésű pályázatban (EFOP 1.6.2 – 16) résztvevő települések szegregátumaira. MAT-SzGyF. 2018. Manuscript.

Csák. R., Kassai. Sz., Márványkövi. F., Szécsi. J., Rácz. J. (2018b): Új Pszichoaktív Szerhasználat városi szegregátumi környezetben: hiányelemzés és szükségletfelmérés a hazai ellátórendszerre vonatkozóan. MAT-EMMI. 2018. Manuscript.

Csák. R., Molnar. I., Sárosi. P., Arsenijević. J., Arsenijević. B. (2019) How the closing of a needle exchange programme affected the access to harm reduction services in two cities. Belgrade and Budapest. Rightsreporter. Manuscript.

Csorba J., Figezki T., Posta J., Puy T., Takács S., Soós D., Tarján A. (2020) Az európai ESCAPE projekt budapesti részadatai 2017-2019. Manuscript.

Csorba. J (2018): Metadon dózis és terápiás hatékonyság. VIII Szubsztitúciós Fórum Budapest. 7 June 2018

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

EMCDDA (1999). Co-ordination of an expert working group to develop instruments and guidelines to improve quality and comparability of general population surveys on drugs in the EU. Follow up of EMCDDA project CT.96.EP.08 (CT.97.EP.09). Lisbon. Por: EMCDDA. [http://www.emcdda.europa.eu/attachements.cfm/att\\_1385\\_EN\\_expert\\_group\\_comp\\_report.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_1385_EN_expert_group_comp_report.pdf)

EMCDDA (2002). Handbook for surveys on drug use among the general population. EMCDDA project CT.99.EP.08 B. Lisbon. EMCDDA.

EMCDDA (2013). Towards a new EMQ Module – Questions on Availability of Illicit Drugs. Lisbon. EMCDDA. Letöltve: 2020.10.10. <https://www.emcdda.europa.eu/system/files/attachements/10592/EMQ-availability-module.pdf>

EMCDDA (2015). Voluntary EMQ Module for monitoring use of New (and not so new) Psychoactive Substances (NPS) in General Adult Population Surveys and School Surveys.

Lisbon. EMCDDA. Letöltve: 2020.10.10.  
<https://www.emcdda.europa.eu/system/files/attachments/10582/EMQ%20Voluntary%20Module%20on%20New%20Psychoactive%20Substances%20%28NPS%29.pdf> .

Horváth G.Cs.; Tarján A. (2016): Az intravénás szerhasználat prevalencia becslése. Hungarian National Focal Point. Manuscript.

Horváth. G. Cs.. Péterfi A.. Tarján A. (2011): A kábítószer-fogyasztással kapcsolatos új jelenségek 2010-ben az ellátóhelyek tapasztalatai alapján. Hungarian National Focal Point. Manuscript.

Kaló Zs.. Szabó R.. Bálint R.. Péterfi A.. Port Á.. Szatmári D.. Tarján A.. Horváth G. (2018): Az új pszichoaktív szerek monitorozása kulcsszakértők bevonásával Magyarországon 2017-2018-ban. Hungarian National Focal Point. Research report. manuscript.

Kapitány.Fővény. M.. Farkas. J.. Pataki. P.A.. Kiss. A.. Horváth. J.. Urbán. R.. Demetrovics Zs. (2017): Novel psychoactive substance use among treatment-seeking opiate users: The role of life events and psychiatric symptoms. Human Psychopharmacol. May 2017; 32(3) doi: 10.1002/hup.2602.

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

Martos. T.. Csordás. G. (2021). WHO Jólét Kérdőív rövidített változata. In. Zs. Horváth. R. Urbán. Gy. Kökönyei & Zs. Demetrovics (Eds.). Kérdőíves módszerek a klinikai és egészségpszichológiai kutatásban és gyakorlatban I. Medicina Könyvkiadó. Budapest.

NFP (2015): Tűcsere szolgáltatók országos szakmai találkozója. Hungarian National Focal Point.

NFP (2016): Tűcsere szolgáltatók országos szakmai találkozója Hungarian National Focal Point.

NFP (2020): 2020-as ÉVES JELENTÉS (2019-es adatok) az EMCDDA számára. Budapest. Hungarian National Focal Point.

NSZKK (2020a): A lefoglalások laboratóriumi vizsgálati eredményének adatai 2009 és 2019 között.

NSZKK (2021a): A lefoglalások laboratóriumi vizsgálati eredményének adatai 2009 és 2020 között.

NSZKK (2020b): NSZKK Toxikológiai Szakértői Intézetének biológiai mintákra vonatkozó vizsgálati eredményei 2019-ben

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

Paksi B. (2019): Drogfogyasztási szokások. In: Németh Á.. Várnai D. (szerk.) Kamaszéletmód Magyarországon. Az iskoláskorú gyermekek egészségmagatartása elnevezésű. az Egészségügyi Világszervezet együttműködésében megvalósuló nemzetközi kutatás 2018. évi felméréséről készült nemzeti jelentés. ELTE PPK - L'Harmattan Kiadó. Budapest. ISBN 978-963-414-582-0

Paksi B., Demetrovics Z., Griffiths M. D., Magi A., Felvinczi K. (2020): Estimating and managing the changing methodological parameters of self-report surveys of addictive behaviors - based on the waves of the National Survey on Addiction Problems in Hungary (NSAPH) in 2007 and 2015. *Neuropsychopharmacologia Hungarica* XXII (1) <http://mppt-nph.hu/images/magazin/pdf/vol22issue1/v22i1p29.pdf>

Paksi B., Pillók P., Magi A., Demetrovics Zs., Felvinczi K. (2019): Drogfogyasztás a magyarországi felnőtt népesség körében - a 2019. évi „Országos Lakossági Adatfelvétel Addiktológiai Problémákról” (OLAAP 2019) első eredményei. Magyar Addiktológiai Társaság XII. Országos Kongresszusa 2019. november 28-30., XV. Siófok. Supplementum kötet. pp. 40-41. <http://www.mat.org.hu/dok/kongresszus/00001.pdf>

Paksi. B. (2007). A drogepidemiológia alapjai: a drogfogyasztás elterjedtségének mérése. In: Demetrovics Zs. (szerk.). *Az addiktológia alapjai I* (229-253). Budapest. Eötvös Kiadó.

Paksi. B. (2017). ÚPSZ-használattal kapcsolatos epidemiológiai tapasztalatok az Országos Lakossági Adatfelvétel Addiktológiai Problémákról (OLAAP 2015) című kutatás alapján. In: Felvinczi K. (szerk.). *Változó Képletek –ÚJ(abb) szerek: kihívások, mintázatok, megoldások* (45-68). Budapest. L'Harmattan Kiadó.

Paksi. B. (2020): OLAAP 2019 – GPS adatok elemzése. Kézirat

Paksi. B. (2021): Droghasználat és szerhasználó csoportok a budapesti 19-35 éves populációban a BLS (Budapesti Longitudinális Kutatás) 2020. évi adatfelvétele alapján. 2021. Kézirat

Paksi. B., Demetrovics. Zs., Magi A., Felvinczi. K. (2018): A Magyarországi felnőtt népesség droghasználata – Az országos lakossági adatfelvétel az addiktológiai problémákról 2015 (OLAAP 2015) reprezentatív lakossági felmérés alapján. In: Magyar Pszichológiai Szemle 73(4):541-565.

Paksi. B., Demetrovics. Zs., Magi. A., Felvinczi. K. (2017). Az Országos Lakossági Adatfelvétel az Addiktológiai Problémákról 2015 (OLAAP 2015) reprezentatív lakossági felmérés módszertana és a minta leíró jellemzői. *Neuropsychopharmacologia Hungarica*. 19(2). 55-85.

Paksi. B., Magi. A., Gurály. Z. (2020): Hajléktalan emberek pszichiaktív szerhasználata. *Esély* (megjelenés alatt)

Paksi. B., Magi. A., Pillók. P., Kótyuk. E., Felvinczi. K., Demetrovics. Zs. (2021). Módszertani háttér. In: Paksi B., Demetrovics Zs. (szerk.). *Addiktológiai problémák Magyarországon a lakossági kutatások tükrében*. Budapest. ELTE PPK - L'Harmattan.

Paksi. B., Pillók P., Magi. A., Demetrovics. Zs., Felvinczi. K. (2021). Az Országos Lakossági Adatfelvétel az Addiktológiai Problémákról 2019 reprezentatív lakossági felmérés módszertana. *Neuropsychopharmacologia Hungarica*. 23(1). 184-207.

Paksi. B., Pillók. P. (2021). Drogfogyasztás. In: Paksi B., Demetrovics Zs. (szerk.). *Addiktológiai problémák Magyarországon a lakossági kutatások tükrében*. Budapest. ELTE PPK - L'Harmattan.

Paksi. B., Rózsa. S., Kun. B., Arnold. P., Demetrovics. Zs. (2009). A magyar népesség addiktológiai problémái: az Országos Lakossági Adatfelvétel az Addiktológiai Problémákról (OLAAP) reprezentatív felmérés módszertana és a minta leíró jellemzői. *Mentálhigiéné és Pszichoszomatika* 10 (4). 273—300.

Péterfi A. (szerk.) (2016): Tisztább Kép. Projekt zárókiadvány. Magyar Ökumenikus Segélyszervezet.

[http://www.segelyszervezet.hu/sites/default/files/documents/tisztabb\\_kep\\_egyben.pdf](http://www.segelyszervezet.hu/sites/default/files/documents/tisztabb_kep_egyben.pdf)

Péterfi A., Major M., Dunay M. (2016): Kezelőhely vizsgálat terápiás közösségek körében. Nemzeti Drog Fókuszpont. Kézirat.

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

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

Péterfi. A. (2021a): TDI adatok 2021.

Péterfi. A. (2021b): Szubsztitúciós adatgyűjtés 2021.

Péterfi. A., Csorba. J., Figezki. T., Kiss. J., Medgyesi-Frank. K., Posta. J., Gyarmathy. V.A. (2017): Drug residues in syringes and other injecting paraphernalia in Hungary. Drug Testing and Analysis doi: 10.1002/dta.2217

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

Port. Á. (2016): A magyarországi javítóintézetben elhelyezett fiatalok kábítószer-használatának vizsgálata. Unpublished manuscript.

Róbert. P. (1990). Társadalmi mobilitás. In: Andorka R., Kolosi T., Vukovich Gy. (szerk.). Társadalmi Riport (356-372). Budapest. TÁRKI.

Robinson. P., J., Shaver. R., P., Wrightsman. S., L. (1991). Measures of Personality and Social Attitudes. San Diego. Academic Press.

Susánszky. É., Konkoly. T., Stauder. A., Kopp. M. (2006). A WHO Jól-lét Kérdőív rövidített (WBI-5) magyar változatának validálása a Hungarostudy 2002 országos lakossági egészségfelmérés alapján. Mentálhigiéné és Pszichoszomatika. 9(1). 247-255.

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

Tarján A. (2020a): Tűcsere programok adatai. 2019. Hungarian National Focal Point. Manuscript.

Tarján A., Dudás M., Rácz J., Horváth G. (2019) HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalencia vizsgálata a hazai intravénás szerhasználók körében 2018-ban. Publikálás alatt.

Tarján. A (2020b): A rekreációs színtéren ártalomcsökkentő/prevenációs tevékenységet végző szervezetek 2019. évi működési és forgalmi adatai. Hungarian National Focal Point.

Tarján A., Dudás M., Rácz J., Horváth G. (2019): HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalenciavizsgálata a hazai intravénás szerhasználók körében 2018-ban. Under publication.

Tarján A., Dudás M., Horváth G.. (2020) HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalenciavizsgálata a budapesti és kecskeméti intravénás szerhasználók körében 2019-ben. Under publication.

Townsend. P. (1979). Poverty in the United Kingdom: a survey of household resources and standards of living. Harmondsworth. Penguin Books.

## T0. SUMMARY

The National Anti-Drug Strategy 2013- 2020, was the last policy document setting out the priorities and tasks in the field of drug prevention. 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 Interior from 2022 onwards (see section T1.3.1 of the Drug Policy workbook).

National study data show that the majority of organizations operating prevention programmes perform universal prevention in the school setting. 66% of those organizations are NGOs. The funding of these prevention programmes are coming mostly from the state in the form of grants (Paksi et al. 2022). In recent years, policy efforts have focused on quality assurance of prevention interventions. The regulatory documents compiled for the field and the quality assurance process for school prevention programmes are designed with that aim in mind. The availability of prevention programmes in the school setting significantly decreased as a result of a 2021 legislative change, according to which only teachers and health professionals<sup>91</sup> employed by the given educational institution are permitted to provide prevention interventions in schools.

## T1. NATIONAL PROFILE

### T1.1 POLICY AND ORGANIZATION

#### *Regulations on prevention interventions in school setting*

Act LXXIX of 2021<sup>92</sup> (in force since July 2021) amended the framework for prevention activities that can be carried out in public educational institutions, originally defined by Act CXC of 2011 on National Public Education. According to the amendment: "classes or other activities (...) about the consequences of drug use (...) cannot be held for students by a person or organization other than an employee of the educational institution working as a teacher and a specialist providing school health services at the institution and a state body with a cooperation agreement with the institution unless it has been registered by a body designated by law." Therefore, until the register is published, drug prevention activities in public educational institutions can only be carried out by the school's teachers, health workers and state bodies. Since the amendment of the law, there is no possibility for external organizations to provide prevention intervention in schools.

#### *Comprehensive school health development*

The Regulation 20/2012 of the Ministry of Human Capacities on the operation of education institutions and the use of names of public education institutions (hereinafter: Regulation), obligatorily stipulates that educational institutions (hereinafter: Institutions) define their tasks related to comprehensive health promotion as part of their local pedagogical programme and integrate them into the operation of the institution.

---

<sup>89</sup> Authors of the workbook: Anna Péterfi, Borbála Paksi, Réka Bálint

<sup>90</sup> We have no information regarding the questions included in the tables in 1.1.3; 1.2.0; 1.2.1 and we have only partial information regarding the questionnaire included in the tables in 1.3 of the EMCDDA Prevention WB guidelines, therefore we did not include these tables in the WB.

<sup>91</sup> prevention sessions can be provided in a public educational institution by the teachers or specialist providing school health services of the given institution or by state bodies who have a cooperation agreement with the given institution

<sup>92</sup> Act LXXIX of 2021 Art 11 (2)



According to Section 128 (1) of the regulation, the goal of comprehensive health promotion is to develop the children's entire physical, mental, and cognitive well-being, during the time spent in the educational institution, and the participation in health development programmes operating systematically in the everyday life of the educational institution.

#### *Kindergarten and school social assistance service*

The Regulation 2/2018 of the Ministry of Human Capacities amending NM Regulation 15/1998 on the professional tasks and conditions of their operation of child welfare and child protection institutions and persons providing personal care establishes the kindergarten and school assistance services.

### **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 2022. Until the next document setting out the objectives of the next drug strategy, or a more comprehensive strategic document is adopted, experts consider the objectives and framework of the expired drug strategy to be the guiding framework.

### **T1.1.2 Institutional background**

The main body for drug coordination in Hungary is the Inter-Ministerial Coordination Committee on Drug Affairs (KKB), and since 2022 drug coordination activities are carried out by the Department of Public Health of the Ministry of Interior responsible for the operation of Focal Points (for more information see chapter on drug policy, sub-chapter T1.3.1). The Ministry of Interior (BM) in its Organizational and Operational Regulations specifies the tasks of the National Drug Prevention Coordination Unit in connection with drug prevention<sup>93</sup> (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 Interior, tasks related to drug policy are carried out by the Unit for Drug Prevention of the National Centre for Public Health (hereinafter: NNK). Regarding prevention it takes part in the in the development of drug policy programmes or proposals, coordinates the operation of the system of preventive-consulting services (available as an alternative to criminal procedure for drug law offenders), assists in cooperation between prevention professionals and prevention institutions, and ensures the functioning of drug coordination mechanisms at local level.<sup>94</sup> The professional accreditation system for school

---

<sup>93</sup> Instruction 12/2022. (VI. 28.) of the Ministry of Interior on the Organizational and Operational Regulations of the Ministry of Interior

<sup>94</sup> 18/2019. (VI. 6.) EMMI utasítás a Nemzeti Népegészségügyi Központ Szervezeti és Működési Szabályzatáról, [https://nnk.gov.hu/attachments/article/152/18-2019--vi-6--emmi-utasitas%20\(1\).pdf](https://nnk.gov.hu/attachments/article/152/18-2019--vi-6--emmi-utasitas%20(1).pdf)

health development programmes were also operated by the National Centre for Public Health, until their termination in 2021 (NNK 2022).

### *Coordination Fora on Drug Affairs*

Drug Policy is implemented through the Coordination Fora 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).

By 2021, 113 KEFs were established in Hungary. According to a study conducted by self-reported questionnaires among the KEFs around half of them operated stably in 2021. The fora are operating 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 of the former drug strategy, namely: (1) community and cooperation; (2) prevention; (3) treatment and rehabilitation; and (4) supply reduction. The members of the Coordination Fora 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 problems at the local level (NNK 2022).

According to a survey of the above mentioned Unit for Drug Prevention of the NNK, in 2021 7% of the KEFs had less than 5 member organizations, 55% had 6-15 member organizations and 38% had more than 15. The composition of the membership of KEFs is mixed. According to the KEFs responding to the survey, 89% had as member organization a regional institution of basic child protection and/or social care, 93% a police organization, 74% an elementary school, 74% a secondary school, 30% a local health promotion office (EFI), 57% the local government's office, 34% a local youth club and 58% a health care institution. 78% of the responding KEFs had a local strategy, out of which 94% were adopted by the local municipality as well. 72% of the respondents had an accepted action plan (NNK 2022).

The funds for the operation of KEFs are primarily provided by the counties/towns/districts' local-government, therefore the amount can be very different for each KEF. In addition, the ministry responsible for drug coordination provides some additional resources in the form of tenders for the implementation of their activities for the given year. In 2021 50 million HUF funding was provided by the responsible ministry (NNK 2022).

### *Health promotion offices*

Starting from 2014, with European Union support, health promotion offices (hereafter EFIs) were established in several steps linked to the health care system to support its prevention capacity. The main goals of the network's establishment were to support the prevention of diseases that pose a serious burden on public health, and to influence the population's health awareness and health behaviour in a positive direction. The task of EFIs is to provide health promotion and prevention services that respond to local needs and are easily accessible to local communities. The EFIs occasionally cooperate with the local Drug Coordination Fora (BM NÉPEÜ 2022).

In 2022 110 EFIs were operating. The territorial national coverage of EFIs is 58%. Regarding the 19 counties + Budapest, there is one county where no health promotion office has been established (BM NÉPEÜ 2022).

The mandate of the EFIs was supplemented with a mental health function based on the methodology and pilot developed by a Norwegian mental health project entitled "Methodological, structural and capacity development to support interventions aimed at improving the mental health of the population". Currently 87 health promotion office has a so-called Mental Health function. EFIs with such function provide for individual and community-

level mental health-related prevention interventions, and other group programmes (e.g. support groups for relatives of addicts, self-help groups etc.) (BM NÉPEÜ 2022).

Considering that the individual EFIs were established at different times and with different financing structures, the structure of maintenance is quite fragmented: among the maintainers there are local level (municipalities, companies of local-governments) and also state funded (outpatient and inpatient healthcare providers) institutions. By December 2022, 67 EFIs operated with local level maintenance and 43 so-called hospital EFIs maintained by OKFÖ. Among the 43 hospital EFIs, 23's financing has already been integrated into the funding of the mother institution (the maintaining health care unit) (BM NÉPEÜ 2022).

### *The comprehensive school health development programmes*

The educational institutions are required to define their tasks regarding health promotion in the framework of their pedagogical programme (for further details see Chapter T1.1).

### *Kindergarten and school social assistance service*

The Regulation 2/2018 of the Ministry of Human Capacities amending NM Regulation 15/1998 on the professional tasks and conditions of their operation of child welfare and child protection institutions and persons providing personal care established the so-called kindergarten and school assistance services.

<b>At which level are strategic decisions (contents, priorities) <u>predominantly</u> made?</b>	<b>Multi-level (Only use if it is not possible to set a predominant level)</b> (if other ↓)
Explanations, if applicable describe: On national level, the State Secretariat for Health of the Ministry of Interior provides strategic management in the field of drug problems. Strategic decisions at the local, municipal level, such as the development of a local drug strategy, fall within the competence of the local governments	
<b>At which level are prevention funds predominantly located and spent?</b>	<b>National</b> (if other ↓)
Explanations, if applicable describe: The ministry responsible for drug coordination and its background institutions have a labelled budget for, among other things, the development and support of health promotion and drug prevention programmes, which is allocated in the framework of annual tenders. For a long time, these grants were the main source of income in the area. In the last 5 years, however, most of the resources have typically come from EU projects.	
<b>Factual cooperation of the different policy sectors ministries at national level (real: not on paper):</b>	Low
Explanations, if applicable describe: The main body for drug coordination in Hungary is the Drug Coordination Committee (KKB), whose members are ministries concerned with drug matters (permanent members: representatives of ministries responsible for police, health, relations with churches, developing social and civil relations, education, social and pension policy, justice and tax policy). The KKB has meetings several times a year. This platform was the source of many inter-ministerial initiatives during the 2000s (e.g. for the development of the domestic regulation	

of new psychoactive substances), but in recent years its role has become symbolic.	
--	--

### Needs assessment:

<b>Diagnosis of risk/protective factors at local level: do (some) municipalities / districts have a system of establishing risk profiles of certain geographic areas or of population segments? (Please, tick 2 most relevant)</b>	<input type="checkbox"/> By youth surveys (e.g. <a href="#">CTC<sup>95</sup></a> , <a href="#">Planet Youth<sup>96</sup></a> ) <input type="checkbox"/> By rapid qualitative assessment methods (stakeholder meetings, key informants) <input type="checkbox"/> By having access to the sub-datasets of national surveys <input checked="" type="checkbox"/> Other, please specify: <input checked="" type="checkbox"/> Does not apply
<b>Explanations, if applicable describe:</b>	
When creating a strategy at the local level, studies and secondary analyses of existing data may occur on a case-by-case basis, but there is no system in place for the development of local-level risk profiles.	

### 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 a study examining the prevention programmes in Hungary between 2017 and 2020 (Paksi et al. 2022), on average two-fifths (39.6%) of the budgets of the prevention programmes have a stable permanent source, 50% came from tenders (occasional sources), and one-tenth is performance-based funding. As before (Paksi and Arnold, 2010), state resources dominate in the source composition of the drug prevention programmes/services: in the budget of the interventions, on average two-third (67%) is state funding, 11-11% is provided by foundations or by the local-government, the average share funding provided by the market is only 7% while the share of funding by donors is even lower (4%) (Paksi 2022). All in all, it can be said that the field depends and builds on state tender opportunities to a large extent. Further information on the operation and financing of prevention programmes can be found in Chapter T4.1, in the subsection detailing the results of the study by Paksi et al. (2022). Until 2019, the ministry responsible for drug coordination provided support for prevention interventions in the scope of tenders. In 2020, this was replaced by the support of one complex prevention programme, which was implemented by the Hungarian School Sport Federation in close cooperation with the ministry responsible for public education and the ministry responsible for drug coordination.

The goal of the programme implemented by the Hungarian School Sport Federation initiated in 2020 was to preserve and improve the mental health of children and to provide mental health and professional support to teachers in school setting. The programme operated with HUF 299.7 million in 2020 and HUF 199.9 million in 2021.

<b>How important are non-public sources of funding (health insurance, charities, foundations, industry)? Choose an item.</b>	<b>Up to 50% of available prevention funds</b>
--	--

<sup>95</sup> The CTC Youth Survey is a tool to provide community-based partnerships with reliable information about the prevalence of youth behavior problems as well as the prevalence of underlying factors risk and protective factors.  
<sup>96</sup> Planet Youth questionnaire: This comprehensive survey examines the lives and lifestyles of young people (15-16 year olds) in the target community and asks questions about the risk and protective factors that influence their behaviors.

<b>Explanations, if applicable describe:</b>
Research data related to the financing of prevention programmes are presented in Chapter T4.1.

## T1.2 PREVENTION INTERVENTIONS

### T1.2.1 Environmental prevention

#### *Crime prevention*

The National Crime Prevention Council was set up by the Government in 2011. Its most important task was to develop the National Crime Prevention Strategy. The Strategy defines crime prevention objectives for ten years, until 2023. The key priorities of the Strategy include prevention of child and juvenile crime, that indirectly contributes to the objectives drug and alcohol prevention objectives (for more information see Chapter 9.5 of the 2014 National Report).

In order to achieve the above objectives is, among other things, they collect and disseminate crime prevention best practices and provide training for teachers. Their training palette includes, among others, "experiential pedagogy", "crime prevention in school" and "solution-focused mediator training", all of which are trainings for teachers.

based on the 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 Fora on Drug Affairs. Crime prevention specialists play an active role in the operation of all KEFs, which were established by the local government or county level governments.

### 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/Prevention Workbooks). Between 2010 and 2015 only regional or qualitative studies were conducted. Following this, in 2015 and in 2021, national studies were conducted, providing information about the features of prevention activities (see section T4).

According to the Act on Public Education<sup>97</sup>, the head of the educational institution is responsible for the organization and provision of child and youth protection tasks, and for coordinating the tasks of the child protection alert system related to the given institution.

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 kindergarten and school social assistance service (replacing the former school social work). Under the Decree, from 1 September 2018, the kindergarten and school social assistance service provides support to children 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:

---

<sup>97</sup> Act CXC of 2011 on National Public Education, Art. 69 (2)(f)

- in the detection and exploration of obstacles to the fulfilment of the child's educational obligations;
- in the identification of the child's vulnerability using preventive tools;
- in the operation of a warning system.

#### *Drug prevention activities of the police*

Drug prevention is a priority area of the complex crime prevention programmes run by the police. In the scope of its crime prevention activities the police provide information and school based programmes. The tasks of the central, regional and local police organisations are defined by the National Police Headquarters' (ORFK) Instruction 16/2016 (VII. 21.) on the implementation of protection programmes for children and young people..

The Police operates complex crime prevention programmes, which, in addition to other important topics (e.g. violence, internet security), also cover drug prevention. 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.

On the drug prevention sub-portal of the Crime Prevention portal of the police, short films and useful YouTube videos for education, and also the contact information of drug prevention officers active in the country are available. In order to facilitate the work of colleagues, unified presentations have been prepared, which serve as a guide for presentations to parents and teachers.

#### *Universal preventive interventions supported from the central budget*

The goal of the program implemented by the Hungarian School Sport Federation initiated in 2020 was to preserve and improve the mental health of children and to provide mental health and professional support to teachers in the school setting. Between January 1 2020, between and December 31 2021, the program achieved the following results within the framework of its four subprograms::

1. Subprogramme: Mental Health Basic Training for Teachers (MAP): until mid-December of 2021, a total of 32 30-hour long accredited teacher training programmes were conducted to improve the personal and professional skills and abilities of teachers. In the programme 478 people obtained certificates.
2. Subprogramme: The primary goal of the pilot programme "Van kihez fordulnod" ("We are here for you") is to create a knowledge base and a support network for teachers in order to provide them with methodological and professional help in dealing with difficult pedagogical and behavioural situations. Within the framework of the programme, an internet-accessible knowledge base interface and database, as well as an online support network (mental health and psychologist specialists) were created. There were 202 new user registrations for online assistance in 2020 and 2021, providing support in a total of 41 cases. On-site assistance (on the school scene) took place in a total of 10 different locations (several times per institution).
3. Subprogramme: Support for a Comprehensive School Health Development (TIE) through the implementation of prevention programmes.

The following results were achieved within the framework of the subprogrammes:

- A representative study via telephone was completed and evaluated (1000 schools contacted, 700 completed questionnaires). The survey focused on problems, difficulties and needs related to health promotion in the institutions.

The results of the evaluation served as a basis for the targeted implementation of prevention programmes (corresponding to the needs and requirements of the given institutions).

- With the involvement of 17 organizations with a professional recommendation issued by the National Public Health Centre (NNK), school prevention programmes were implemented between April and June 2021, in a total of 27 schools, for a duration of 1074 X 45 minutes.
  - Related to the fact that the subprogramme entitled "Supporting Comprehensive School Health Development (TIE) through the implementation of prevention programmes" could not continue with the originally planned content due to the changed legal environment (amendment of Act CXCV of 2011 on National Public Education (Nkt.)), from June 2021, the programme was implemented with a new programme element, as follows.
  - In a pilot programme for vocational schools, physical exercise programmes aimed at preventing addictions were implemented with the involvement of seven schools, in order to reduce addictions. Potentially at-risk secondary school (NSZFH-maintained vocational schools, technical schools) students had the opportunity to participate in alternative exercise programmes with the help of mentor teachers.
4. Subprogramme: Physical exercise programmes. In 2021, a total of 115 programmes promoting school sports were implemented.

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

A national survey conducted in 2021 among prevention programmes, aimed to map the preventive interventions carried out (detailed results: Chapter T4, Methodology: Chapter T5). Among the achieved programmes, 60 programmes/services (39.7%) formulated objectives (selective intervention) in relation to various vulnerable populations (Paksi et al. 2022; Paksi 2022).

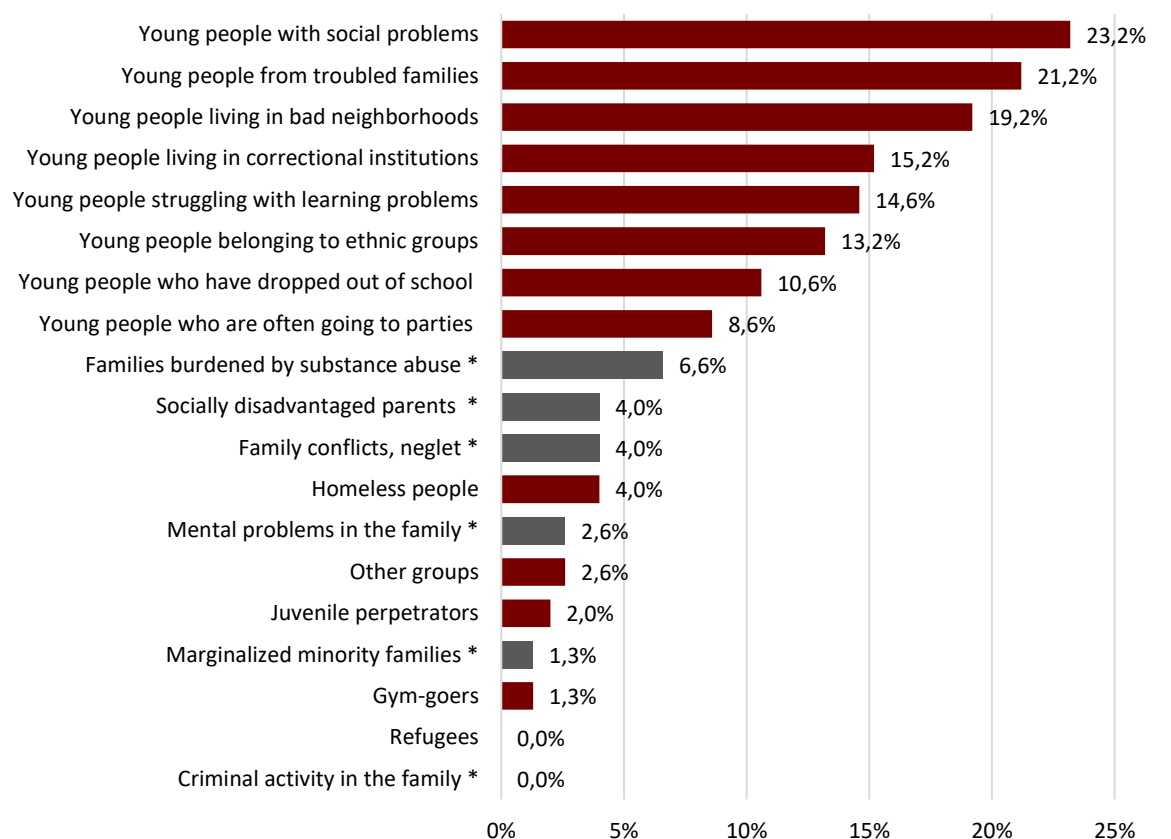
In addition to the general population, the target population of the interventions mostly includes young people with social problems and/or from troubled families and/or living in bad neighbourhoods. Every fourth or fifth programme/service aims to reach these groups. Approximately every sixth or seventh intervention aims to reach young people living in correctional institutions and/or struggling with learning problems and/or belonging to some ethnic group. Young people who have dropped out of school and who are often going to parties appear less frequently in the target population of the revealed interventions, they are targeted by approximately one in ten programmes/services, and families burdened by substance abuse are targeted by one in fifteen programmes/services. Only 4-4% of the interventions are aimed at homeless people, disadvantaged families, or families characterized by conflicts or neglect. It is very rare to find a programme/service that deals with young people who commit crimes or marginalized minority families<sup>98</sup>, or young people who go to the gym, and we have not found any programmes that target refugees or families affected by criminal activities (Paksi 2022).

---

<sup>98</sup> The target groups appearing in the other categories also cover family prevention: in 1-1 cases there were single-parent families, foster parents, or families with disabilities.



Chart 30. The proportion of interventions targeting different special (vulnerable) groups among prevention interventions aimed directly at the final target group (%; N=151)



\* Rows marked in grey are the target groups of family prevention  
Source: Paksi et al. 2022

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

### *Drug prevention in the Hungarian Army*

The priorities regarding drug prevention activities within the organizational framework of the Hungarian Army are determined 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 (in the scope of occupational health examinations); verification of the ability to perform duty (spot checks for preventive purposes); (forensic) examination of the influence of drugs if drug use is suspected.

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

Among the programmes achieved in the 2021 national survey, 42 (27.8%) interventions aimed to influence the behaviour of people who are addicts, but show early signs of addiction (indicated prevention).

### *System of preventive consulting services*

One type of quasi-compulsory treatment available as an alternative to punishment for drug law offenders who are not affected by problem drug use is the preventive-consulting service, which



may be considered analogous to an indicated prevention intervention. Detailed information about these programmes are provided in the 2021 Treatment Workbook, where the results of the latest national study conducted by Paksi and Felvinczi on these programmes are presented.

In Hungary, the joint decree 42/2008 (XI. 14.) EüM-SZMM (hereinafter: Decree) provides the legal basis for *preventive-consulting services*, the *treatment for drug addiction*, and the *treatment for other conditions of drug use*, the three types of treatment as an alternative to criminal procedure. The so-called *preventive-consulting service* are coordinated by the NNK.

In Hungary in 2021, 49 organizations provided *preventive-consulting services* with a total of 232 professionals. A total of HUF 140,032,000 was provided to these services from the dedicated funding of the Ministry of Human Capacities. In 2021 the number of new clients was 2779, and the total number of client taking part in these services was 4632 (NNK 2022).

Summarizing the experiences of the organizations providing these services, it should be emphasized that the services have adapted to the situation caused by the coronavirus pandemic. Initially, the *preventive-consulting services* could only operate online due to COVID-19 restrictions. As the situation improved the organizations step-by-step returned to their original operating order based on personal meetings with the clients, but the online operation partially remained. Based on the position of the Attorney General, the use of online tools was allowed until the end of the health emergency. After the end of the health emergency, the previous operating order was in effect. (NNK 2022).

In 2021, the NNK developed the professional concept for the renewal of diversion (NNK 2022).

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.

### **T1.3 QUALITY ASSURANCE FOR PREVENTION INTERVENTIONS**

#### *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 the information provided by the National Centre for Public Health (NNK 2022), the number of issued certificates in 2021 was 18 (10 of them were drug prevention programmes). As a result of the amendment of the Act CXC of 2011 on National Public Education that came into force on the 8<sup>th</sup> of July 2021 the operation of the system of professional recommendations have been suspended.

### *Best practices*

The Hungarian National Focal Point developed the Hungarian language adaptation of the EMCDDA Best Practice Portal in order to disseminate best practices and policy recommendations. The portal is available at [bevaltygyakorlat.hu](http://bevaltygyakorlat.hu).

## **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) in the past 20 years, and less by changes in patterns of drug use and the emergence of new phenomena. 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 typically limited to measurement of the popularity index and knowledge acquired.

A comparison of the results of studies mapping prevention programmes in 2015 (Paksi et al., 2015; 2016) and 2021 (Paksi et al. 2022) provides information on the changes that can be observed in the prevention programmes. Based on this, it can be said that the majority of prevention programmes aimed at addictive behaviours continue to target substance use problems, and the prevention of behavioural addictions and disorders appears less among the goals of the programmes. At the same time, within behavioural addictions, the proportion of problems covering problematic online gaming, compulsive shopping, and social media use increased at a certain level (Paksi et al. 2022). For more details see Chapter T4.1 presenting the study results.

## **T3. NEW DEVELOPMENTS**

### *Addiction consultants in socially disadvantaged neighbourhoods – Pilot programme*

With the support of the Ministry of Human Capacities, in cooperation with the National Association of Addiction Consultants, the staff working in the “Jelenlét” programme of the involved settlements took part in a training related to basic addiction knowledge, and in the 4 settlements presenting the most serious problems - Tiszabő, Tiszabura, Alsószentmárton and Nógrádszakál – an intensive work began to prevent and reduce drug use in close cooperation

with the Hungarian Charity Service of the Order of Malta. In 2020, as part of the programme, 10-12 addiction consultants were trained as a starting point. 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 conducted for social workers working in the so-called “Jelenlét” programme in the 31 settlements reached by the programme (2-2 people), with the aim that field workers learn the basic concepts for understanding addictions in an interactive way. The training was provided by the National Association of Addiction Consultants, which was conducted at 3-4 locations for a total of 62-65 people. In addition to the training programme, in 27 settlements (in an additional two occasions), the addiction consultants provided practical tools and professional support to the two social workers participating in the “Jelenlét” programme at each location. In the four settlements with significant addiction problems, 2-2 addiction consultant specialists provided personal consultations every 2-3 weeks for people living with addiction problems and their relatives, and they also helped the social workers participating in the programme with continuous consultations. As an output of the pilot programme, a practical guidance was compiled, in which the most important experiences, practical solutions and methods of intervention were described. In 2022, two training programmes developed in the framework of the project got official accreditation.

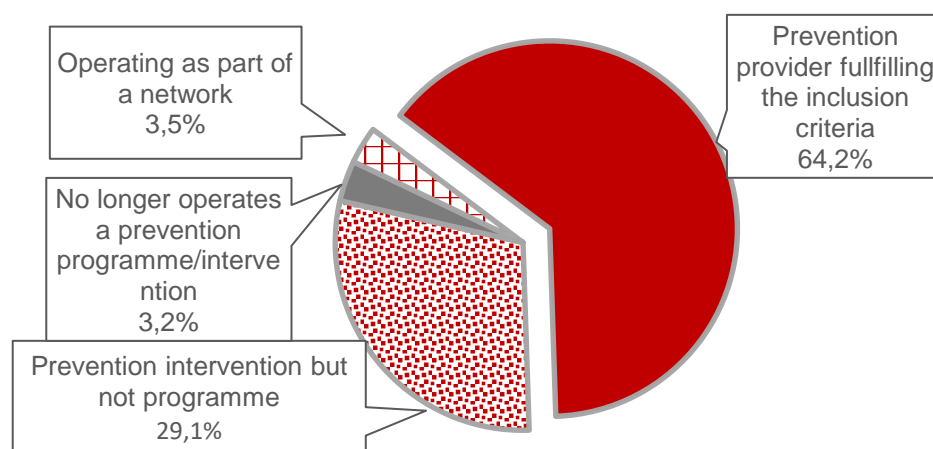
The experiences of the project are positive, however, it is very important to note that the pilot programme reached only a few dozen socially disadvantaged neighbourhoods out of more than 1600 socially disadvantaged neighbourhoods in Hungary.

#### T4. ADDITIONAL INFORMATION

##### T4.1 ORGANIZATIONS PERFORMING PREVENTION ACTIVITIES BETWEEN 2017 AND 2020

The most recent data collection aimed at exploring prevention programmes in Hungary (Paksi et al. 2022) took place in 2021 and identified a total of 430 organizations in the country that carried out some form of prevention activity in the field of addiction prevention between 2017 and 2020 (for the method of the study see T5.2). Among them, 276 organizations (64.2%) currently offer their own<sup>99</sup> *programme-like prevention intervention*, that is, *homogeneous in each target group in terms of the goals and methods applied* (Chart 1).

Chart 31. *Distribution of service providers identified as prevention providers for addictive behaviours operating between 2017 and 2020, according to whether they currently offer their own preventive intervention (%; N=430)*



Source: Paksi et al. 2022

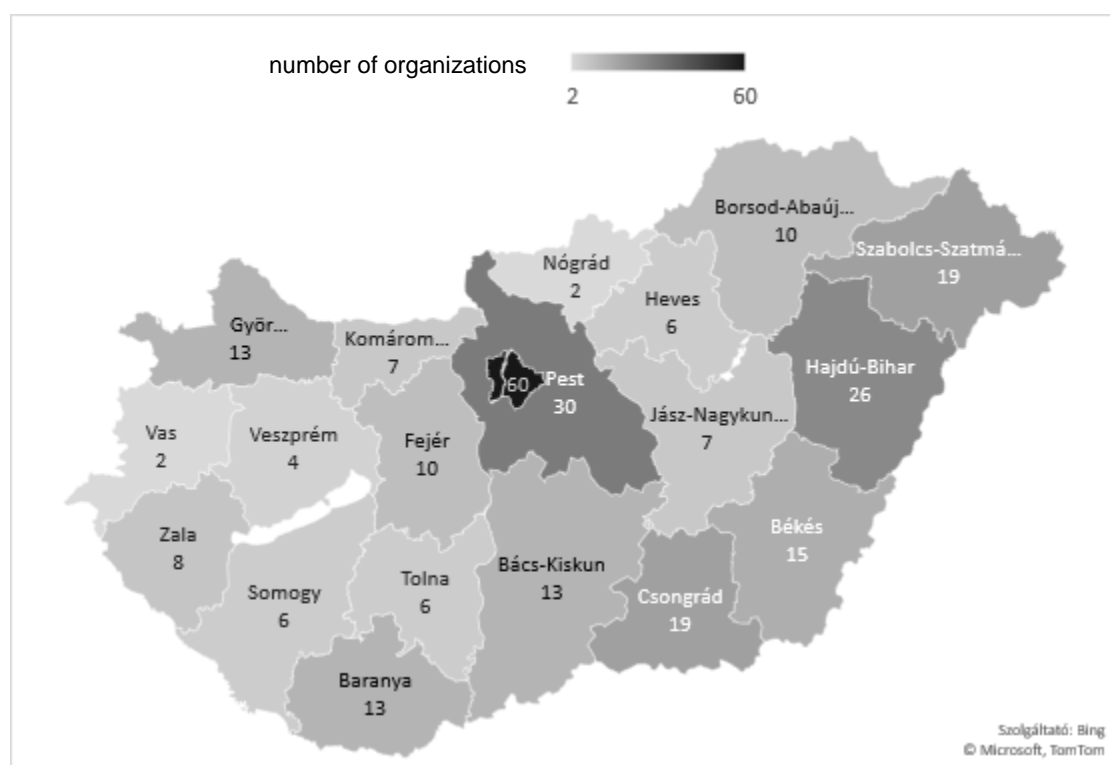
<sup>99</sup> In the same way as previous researches (Paksi & Demetrovics, 2005, 2011; Paksi, Magi, Kó & Demetrovics, 2016), the database only includes those service providers that brings together the network, and which only carry out prevention within the framework of a national or smaller regional network.

### *Service providers currently offering their own programme-like prevention interventions*

The vast majority of the 276 organizations reached in the study, currently carrying out their own, programme-like prevention interventions, offer prevention activities (among others) for the final target population. 250 organizations (90.6%) currently offer some kind of prevention intervention developed by the organisation, directly aimed at the final target population, and there were only 26 organizations that offer interventions that reach the final target group via an intermediary group (e.g. peers, teachers, other professionals, parents).

More than one-fifth of the organizations operate in the capital, and a total of one-third of them (90 organizations; 32.6%) are located in the Central Hungary region (Budapest and Pest County). An average of 11 (4.0%) organizations performing programme-like prevention interventions are active in one county. Among the counties, apart from Pest County, where 30 organizations are operating currently, the number of the identified programme-like prevention interventions was especially high in Hajdú-Bihar County with 26 organizations, as well as Csongrád-Csanád, Szabolcs-Szatmár-Bereg, Békés, Bács-Kiskun, Baranya, and Győr-Moson-Sopron counties with 13-16 organizations operating which exceeds the national county average.

Chart 32. *Geographical distribution of service providers that are currently operating and offering their self-developed programme-like preventive interventions aimed at preventing addictive behaviours (number of service providers per county and Bp; N=276)*



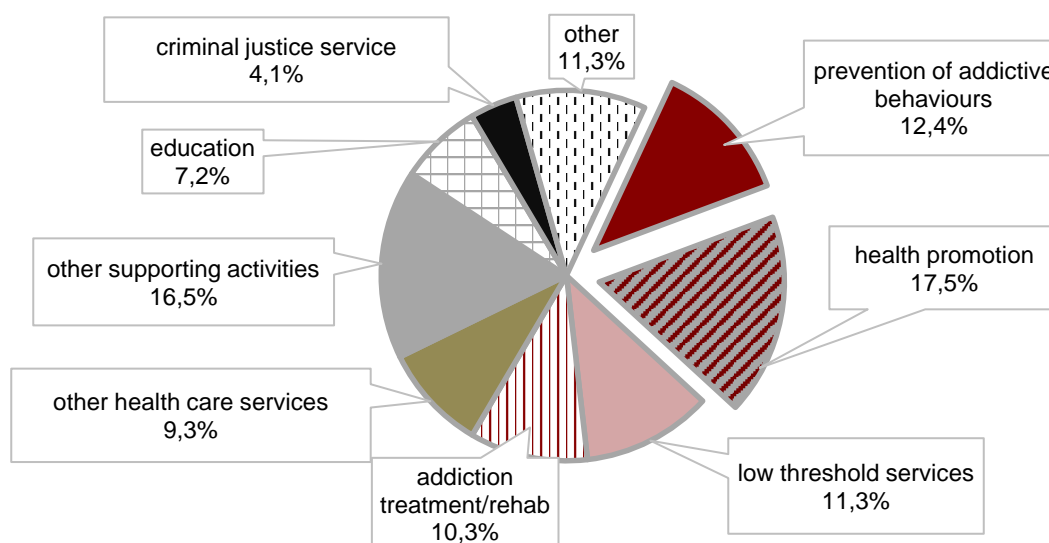
Source: Paksi et al. 2022

Slightly more than a third of the 276 organizations (35.1%), 97 organizations filled in the Programme Information Sheet (PIAD) developed by the study in order to collect detailed information on the operation and content of prevention interventions. Therefore, we have more detailed information about these prevention services and their prevention programmes. Based on this, two-thirds (66%) of the organizations carrying out prevention activities related to addictive behaviours are non-profit organizations, and within this, the majority operate as foundations (23%) and associations (21%). In addition to NGOs, budgetary and local

government organizations are present in a relatively significant proportion (together 28%), however, the role of the for-profit sector is very rare (6% in total).

The majority of the organizations performing prevention activities (87.6%) do not perform the prevention of addictive behaviour(s) as their main activity. Only less than third of the organizations (29.9%) were oriented towards to perform some kind of prevention/health promotion tasks as a main activity. Approximately one fifth (21.6%) of the service providers are represented by those whose main activity is in other areas of addiction care, together with those, whose main activity is low threshold service provision (11.3%) a total of 34.0% of the organizations dealing with the prevention of addictive behaviours have some kind of addiction-type activity as their main profile.

Chart 33. *Distribution of prevention organizations according to main activity (%; N=97)*



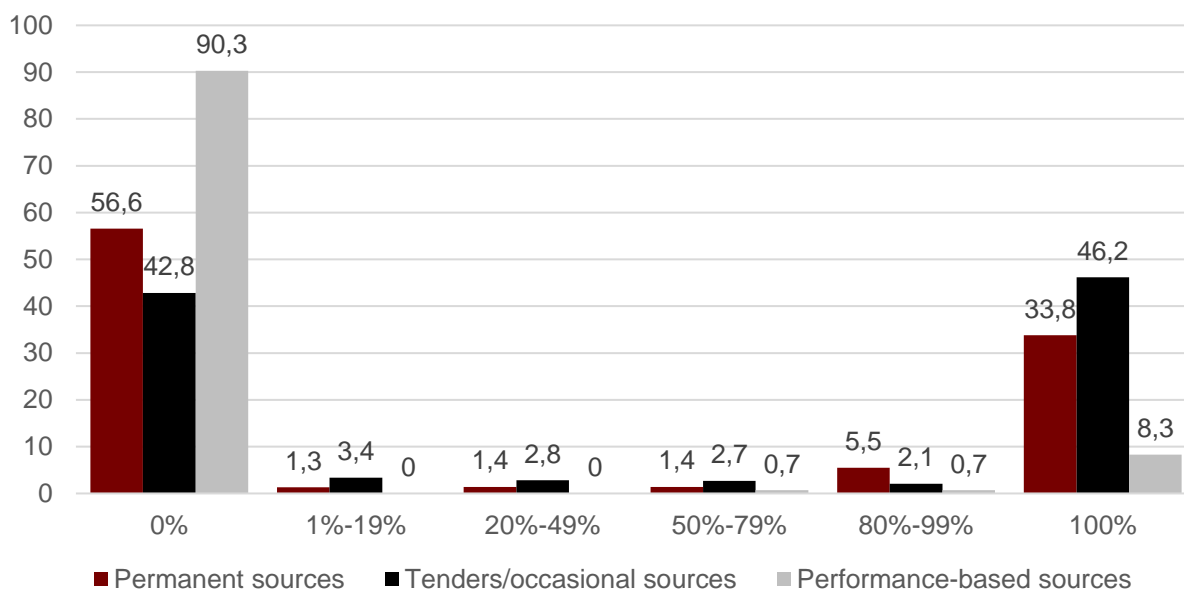
Source: Paksi et al. 2022

The prevention organizations that filled in the so-called Programme Information Data Sheet operate an average of 1.7 prevention programmes/services.

#### *Financing of prevention programmes/services*

Regarding the continuity of the financing of the programmes/services, extremes are typical. A third of the interventions (33.8%) have some kind of permanent source to fully finance its expenses, but 56.6% do not have a permanent source at all. Almost half of the programmes/services (46.2%) operate exclusively in the scope of tenders / occasional financing, while more than two-fifths (42.8%) do not use tenders as resources at all. The presence of performance-based funding is not typical in the field, 9 out of ten interventions do not have such resources at all. Overall, we can say that, on average, two-fifths (39.6%) of the income of prevention programmes/services comes from permanent sources, half (50.5%) from tenders/occasional sources, and only one-tenth is performance-based.

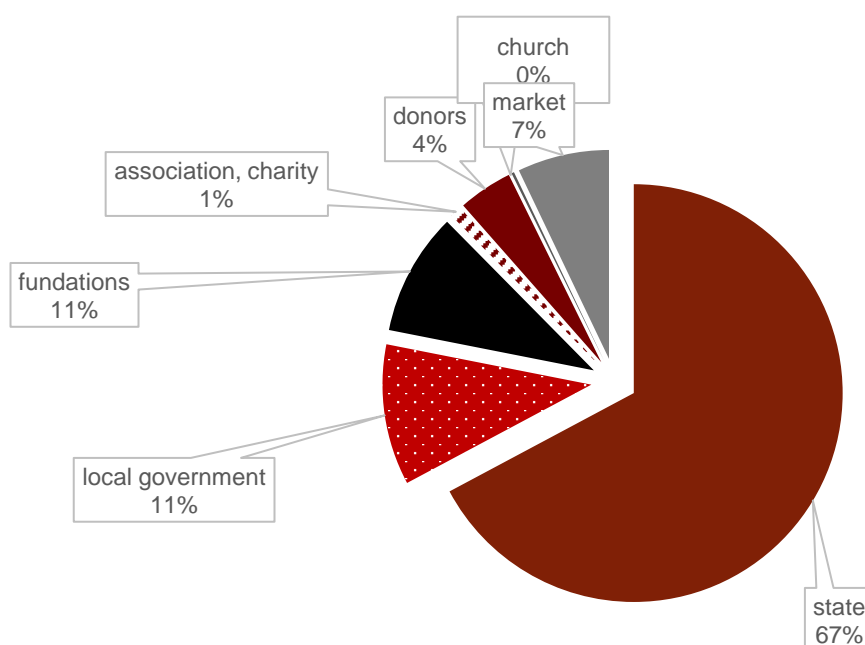
Chart 34. *Distribution of the resources of the programmes / services in respect of continuity (%)*  
N=145)



Source: Paksi et al. 2022

Similarly to what have been identified by an earlier study (Paksi and Arnold, 2010), the resource composition of the programmes / services is dominated by state resources: on average two-thirds (67%) of the interventions' budgets are state funding, 11-11% are provided by foundations and the local-government. The average proportion of market financing is only 7%, donor contribution to the resources is even lower (4%).

Chart 35. *Average distribution of the source composition of programmes/services (average %)*  
N=143)



Source: Paksi et al. 2022

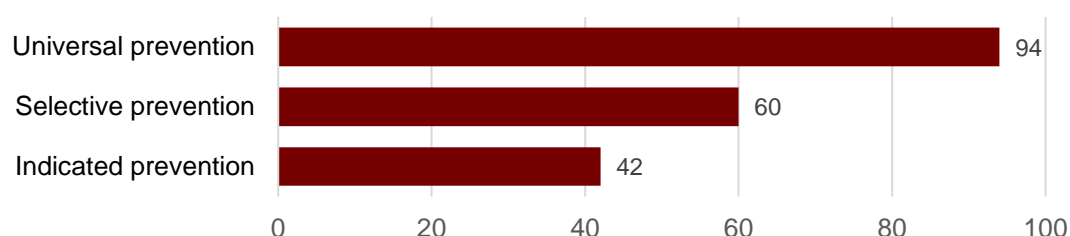
### *Characteristics of prevention interventions*

Those prevention organizations that filled in the Programme Information Sheet operate an average of 1.7 programmes/services, which we have detailed information about. The vast majority (90.4%) of the 167 programmes/services, a total of 151 interventions, directly address the final target population to be intervened. Another 16 programmes/services (9.6%) want to reach the final target group of the through an intermediary group (with the involvement of peers, teachers, other professionals, parents).<sup>100</sup>

### *Characteristics of programmes/services aimed directly at the final target population*

About three-fifths of the programmes/services directly aimed at the final target population (62.3%; 94 programmes/services) are interventions aimed at the universal population (too). 60 programmes/services (39.7%) set objectives (selective intervention) in relation to various vulnerable populations, and 42 (27.8%) interventions aim to change the behaviour of people who are not addicts, but who show early signs of (indicated prevention).

Chart 36. *The number of universal, selective and indicated prevention programmes/services among interventions aiming directly the final target group (pcs; N=151)*

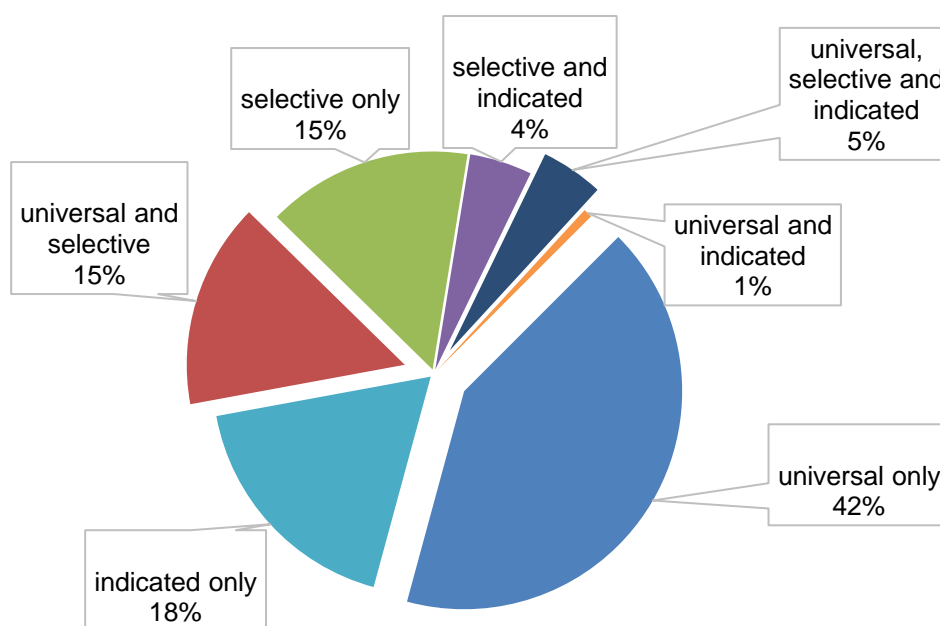


Source: Paksi et al. 2022

However, individual programmes/services are not clearly differentiated according to whether they provide a universal, selective or indicated intervention. Of the 94 interventions that (also) target the general population, only 63 programmes/services carry out activities aimed exclusively at the general population, and 23 of the 60 selective interventions are directed exclusively at some vulnerable population (Chart 5).

<sup>100</sup> These can be programmes that are raising awareness / sensitivity towards addictive behaviours or train an intermediary stakeholder to provide such interventions for the final target population or provide support for the drug users' environment.

Chart 37. Classification of programmes/services aimed directly at the final target group based on target groups (%; N=151)



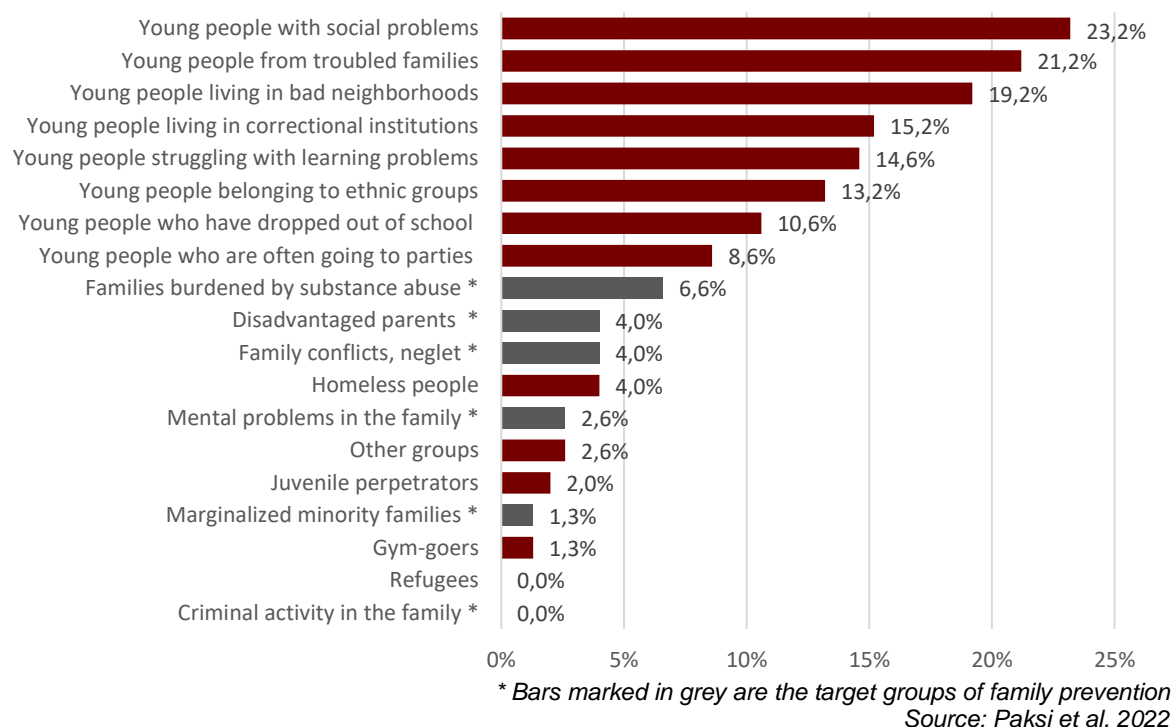
Source: Paksi et al. 2022

In addition to the general population, the target population of the interventions mostly includes young people with social problems and/or from troubled families and/or living in bad neighbourhoods. Every fourth or fifth programme/service aims to reach these groups. Approximately every sixth or seventh intervention aims to reach young people living in correctional institutions and/or struggling with learning problems and/or belonging to some ethnic group. Young people who have dropped out of school and who are often going to parties appear less frequently as the target population of the identified interventions, they are targeted by approximately one in ten programmes/services, and families burdened by substance abuse are targeted by one in fifteen programmes/services. Only 4-4% of the interventions are aimed at homeless people, socially disadvantaged families, or families characterized by conflicts or neglect. It is very rare to find a programme/service that deals with young people who commit crimes or marginalized minority families, or gym-goers, and we have not found any programmes that target refugees or families affected by criminal activities.

15.9% of the interventions (24 programmes/services) aiming the final target population, provide family prevention, and 8 of them only carry out universal prevention among families. The study identified a total of 16 interventions that address vulnerable families (among other target populations). The target groups of family prevention (indicated by grey bars in Chart 9) are located in the back range of the priority structure of the target groups, i.e. the effort to reach different families at risk is not typical among the known prevention interventions. Interventions that (also) provide family prevention mostly try to reach families characterized by substance abuse, social disadvantage, and conflicts.

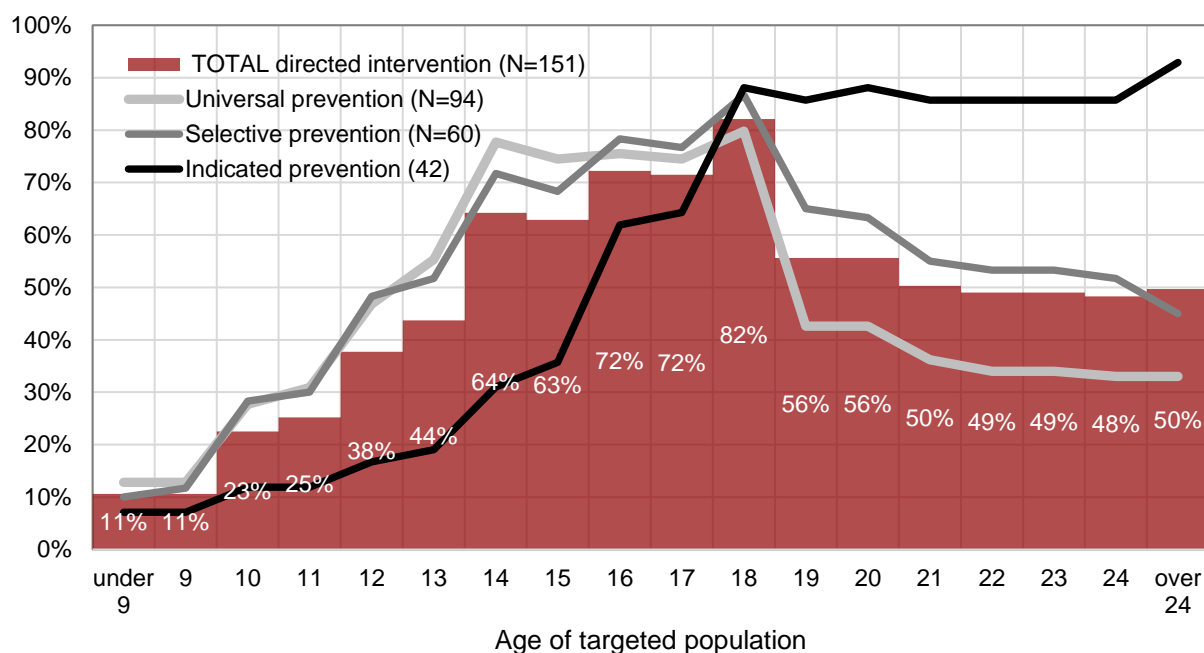


Chart 38. The proportion of interventions targeting different special (at-risk) groups among prevention interventions aimed directly at the final target group (%; N=151)



Prevention interventions that deal directly with the final target population mostly target young people aged between 14 and 18. Only 13.9% of the identified programmes/services target children under 10, above that with the each year added to the age of targeted population more and more interventions are available. 82.1% of the programmes/services is available for the 18-year-old population. After that, the range of programmes suddenly decreases, only 55% of the programmes/services target young people aged between 19 and 20, and only half of the interventions target young adults older than 20 years old (burgundy area in the below chart). However, the age characteristics of the population targeted by the universal, selective and indicated prevention interventions are somewhat different.

Chart 39. Prevalence of available universal (N=94), selective (N=60) and indicated (N=42) interventions according to the age of the target population among programmes aiming the final target group (N=151; %)



The percentages show the proportion of programmes aiming the final target population belonging to the given age group. Data captions show the proportion of interventions for all final target populations. Source: Paksi et al. 2022

Almost two-thirds of the interventions aimed directly at the final target population (77 programmes/services; 64.2%) indicated that they conducted a needs assessment before starting the programme/service.

In 2019, the programmes/services we obtained detailed information about reached a total of 169,393 people, with an average of 1,201 people. Data for an average year are similar to 2019 (Table 2).

Table 13. The size of the population reached by prevention interventions in 2019 and in an average year (person)

	In 2019	In an average year
<b>N</b>	141	136
<b>Average</b>	1201,37	1.230,99
<b>Median</b>	105,00	100,00
<b>Minimum</b>	0,00	0,00
<b>Maximum</b>	100.000,00	100.000,00
<b>Total number of people reached</b>	169.393,00	167.414,00

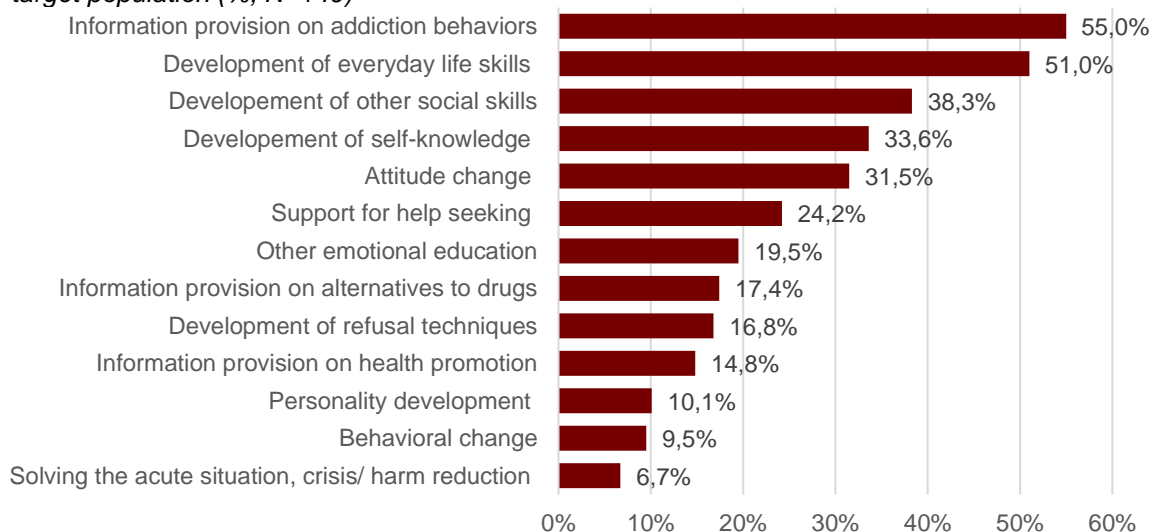
Source: Paksi et al. 2022

The programmes/services mostly set goals in respect of information provision related to addictive behaviours, followed by the development of everyday life skills. These two objectives appeared in at least half of the interventions (55.0% and 51.0%, respectively). In three to four cases out of ten, goals related to other social skills (38.3%), development of self-awareness

(33.6%), and attitude change (31.5%) appear among the studied programmes/services. About every fourth to fifth intervention formulated goals related to support for help seeking (24.2%) and emotional education (19.5%). On average, every sixth-seventh (14.8%-17.4%) programme mentioned information provision of alternatives, the development of refusal techniques, and information provision related to health promotion, and every tenth intervention mentioned objectives related to personality development and behavioural change. The least popular goals seems to be the goals related to solving the acute situation, crisis, and harm reduction (6.7%).

Providing information related to addictive behaviours and the development of everyday life skills are among the prioritized objectives in all three types of prevention. However, while in the case of universal prevention, the role of increasing knowledge about addictive behaviours is more significant, in the selective and especially indicated prevention interventions, the development of everyday life skills is given greater emphasis, and in indicated prevention interventions other social skills and self-awareness development are also prominently emphasized. In the case of universal and selective interventions –similarly to programmes/services aimed at the final target population – goals related to behavioural change, solving the acute situation, crisis, and harm reduction appear the least. However, in the case of indicated prevention interventions, the information provision related to health promotion and the development of rejection techniques are the least typical

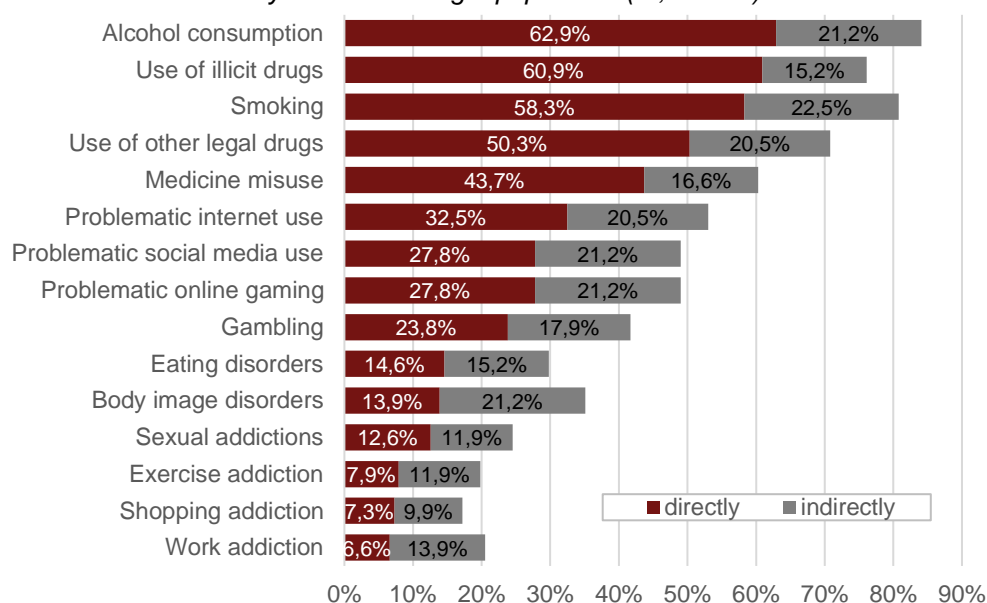
Chart 40. *Appearance of different objectives in prevention interventions aiming directly the final target population (%; N=149)*



Source: Paksi et al. 2022

Among substance abuse behaviours, alcohol consumption, the use of illicit drugs, and smoking are the directly discussed topics in the largest proportion of the programmes/services, these topics are directly discussed in about three-fifths of the programmes/services, and at least three-fourths or four-fifth of them mention these subjects. Among the behavioural addictions, problematic internet and social media use, and online gaming and gambling are the most popular topics among current prevention programmes/services, but only a third to a quarter of the interventions discuss these topics directly. In respect of other behavioural addictions and disorders only 7-15% of the programmes discusses them directly. With the exception of problematic internet and social media use, and online gaming - which are topics that participants encounter directly or indirectly in approximately half of the programmes/services - the overwhelming majority of interventions do not cover any behavioural addictions at all.

Chart 41. *Chart 12: Addictive behaviours directly or indirectly targeted by prevention programmes/services aimed directly at the final target population (%; N=151)*

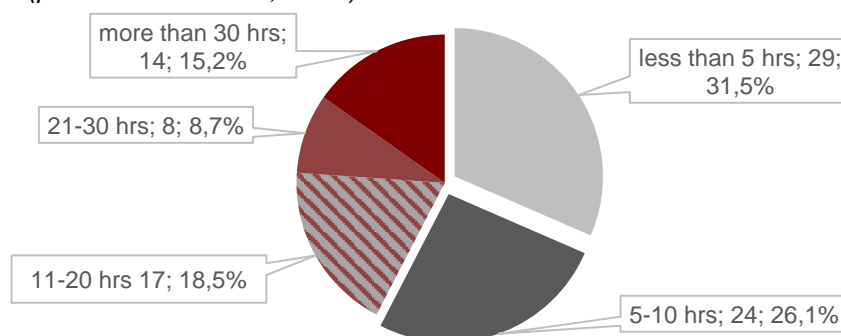


Source: Paksi et al. 2022

Four-fifths of the interventions aimed directly at the final target population (120 interventions; 79.5%), takes place in the form of a programme, while the other one-fifth (31 interventions; 20.5%) is implemented as a service. The study provides information on the implementation method of the 120 programmes.

The programmes aimed at the final target population range quite widely in terms of the duration, the shortest programme is 1 hour long while the longest one is 200 hours long. The average duration is 18.2 hours (calculated with 45-minute long hours), and almost a third of the programmes (29 programmes; 31.5%) takes less than 5 hours.

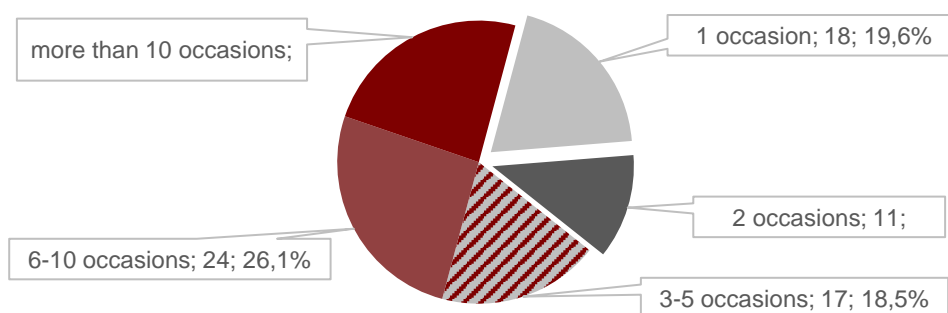
Chart 42. *The number and distribution (%) of programmes aimed directly at the final target population by the duration (total number of hours calculated with per 45-minute classes) of the programme (per 45-minute class; N=92)*



Source: Paksi et al. 2022

Almost one-third (31.6%) of the programmes (aimed at the final target population) consists of 1-2 sessions, fifth of the programmes (18 programmes, 19.6%) are provided in the scope of a "prevention day" or other one-time intervention. Overall, half of the programmes (50.1%) consists of 5 meetings. Half of the programmes consisting more than 5 occasions, consist of 6-10 meetings, and half of them of more than 10 meetings.

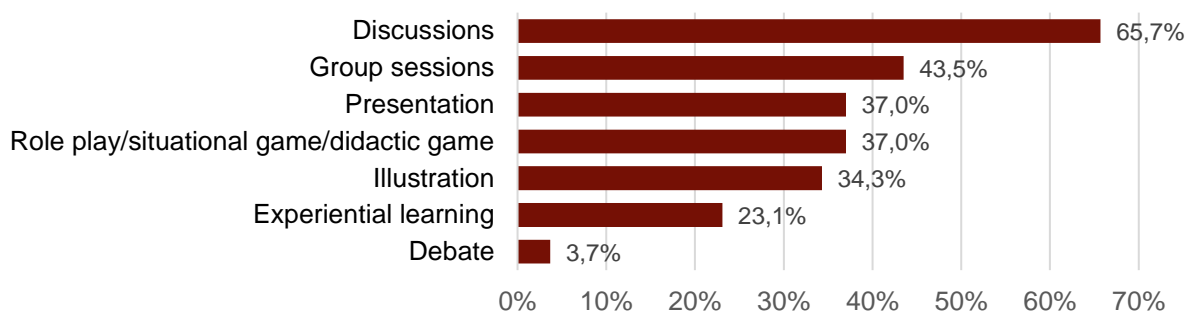
Chart 43. The number and distribution (%) of programmes aimed directly at the final target group according to the number of occasions (N=92)



Source: Paksi et al. 2022

In terms of the applied methods, “discussions” are the most prevalent with two-thirds of the programmes applied this method. All other methods are applied in less than half of the programmes. Nevertheless, different “group techniques”, “presentation”, and “games” and “illustration” (visual, material or otherwise) appear in more than a third of the programmes as well. However, only every fourth or fifth programme indicated the application of the “experience-based learning methods”, and based on the answers, the debate method is extremely rare in prevention programmes.

Chart 44. Incidence of methods used during programmes aimed directly at the final target group (%; N=108)

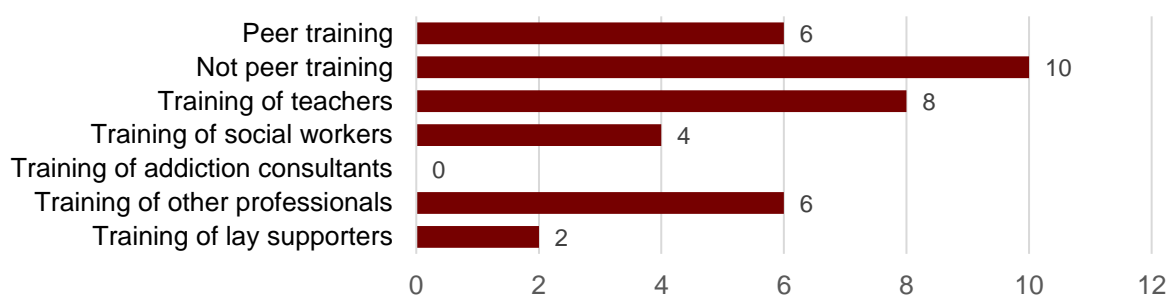


Source: Paksi et al. 2022

### The target group of the training programmes/services

A little more than one-third of the training programmes/services aimed at an intermediary target group (6 trainings; 37.5%) are peer trainings, and almost two-thirds (10 trainings; 62.5%) are aimed at training professionals and/or lay supporters. The trainings of non-peer trainers are primarily aimed at teachers (8 trainings), social workers (4 trainings), or other non-addiction specialists working mainly in the youth social field (6 trainings). The programme/service aimed at two intermediary target groups addressed (also) non-professional helpers in the general population, without qualifications.

Chart 45. *The main characteristics of training programmes/services aimed at the intermediary target groups (no; N=16)*



Source: Paksi et al. 2022

In 2019, a total of 525 people with an average of 43.8 people, were involved in the training programmes/services. The data for an average year are similar to 2019.

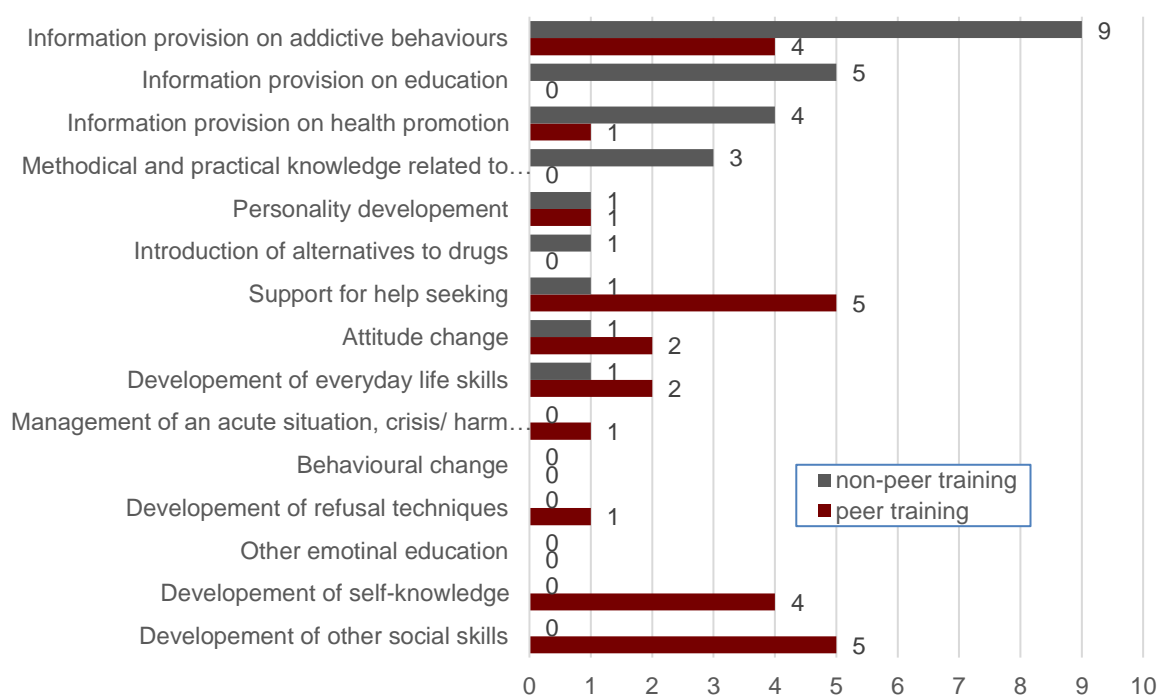
Table 14. *The size of the population reached by prevention interventions in 2019 and in an average year (person)*

	In 2019	In an average year
<b>N</b>	12	12
<b>Average</b>	43,8	45,3
<b>Median</b>	39	40
<b>Mode (double)</b>	30/40	30/40
<b>Minimum</b>	12	15
<b>Maximum</b>	100	100
<b>Reached persons (TOTAL)</b>	525	544

Source: Paksi et al. 2022

In the case of programmes/services aimed at the intermediary target group, a different structure of goals emerges in the case of peer and non-peer trainings. The non-peer training courses, which are mainly aimed at training professionals, are focusing on providing information related to addictive behaviours (9 training courses) and, less often on health promotion (4 training courses) and on educational methods (5 training courses). Behavioural change, goals related to the development of refusal techniques, emotional education, other social skills and acute situation/crisis management do not appear at all in the non-peer trainings. However, in the case of peer training, in addition to providing information related to addictive behaviours, the development of other social skills, support for asking for help, and self-awareness development are emphasized, and methodological and practical knowledge related to education is not covered by these programmes.

Chart 46. *Appearance of different objectives in peer and non-peer training programmes/services aimed at the intermediary target group (%;  $N_{peer}=6$ ;  $N_{non-peer}=10$ )*

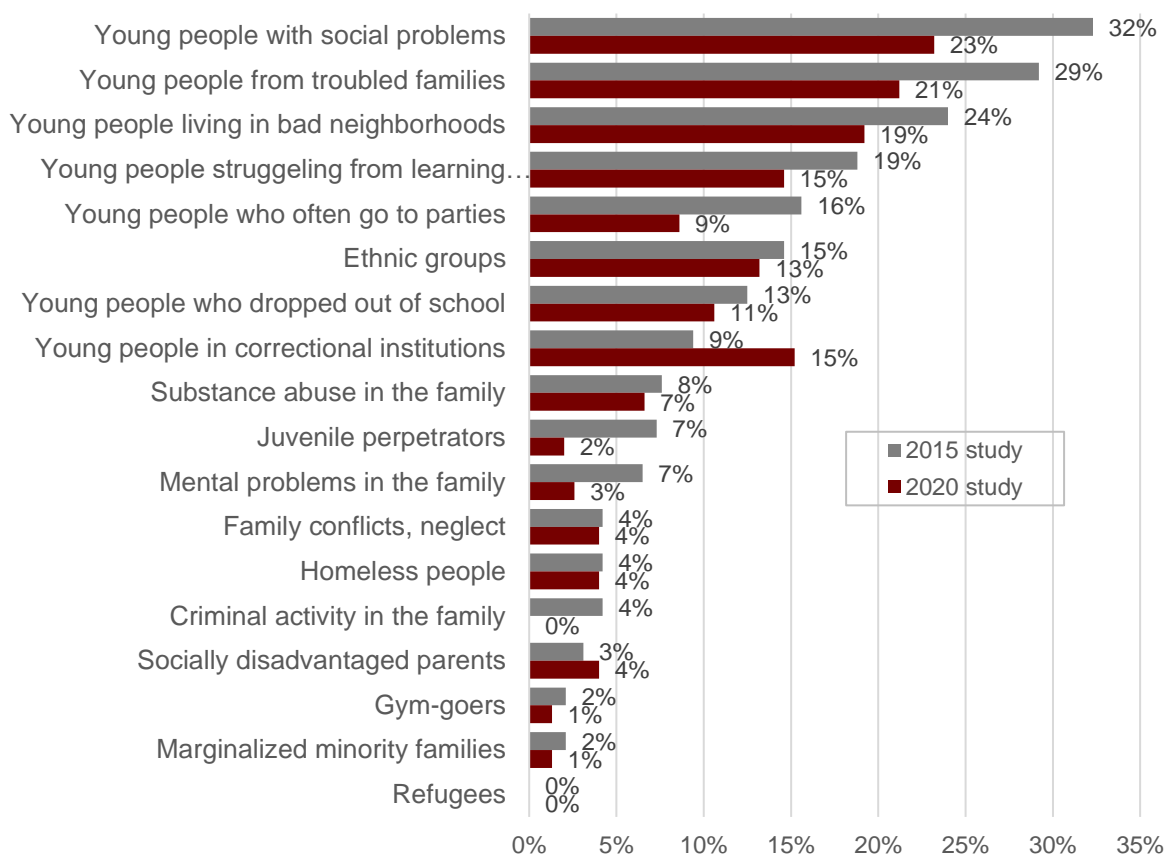


Source: Paksi et al. 2022

#### *Changes in the available prevention interventions*

Compared to the data from the study conducted 5 years earlier (Paksi et al., 2015; 2016), it can be concluded that among the programmes/services directly aimed at the final target population, there is a similar proportion of interventions targeting the general population: in both periods, nearly two-third of the identified programmes (2015: 62.5%; 2020: 62.3%) defined the general population as their target group. At the same time, in the current study there were a smaller proportion of interventions targeting vulnerable populations, meaning that the proportion of interventions carrying out selective prevention (per se or in combination with an other type of prevention) decreased by 10% (2015: 50%; 2020: 40%). On the other hand, the proportion of programmes/services targeting young people in correctional institutions almost doubled.

Chart 47. *Proportion (%) of interventions targeting special groups among prevention programmes/services directed at the final target group in the 2015 (N=96) and 2020 (N=151) studies*

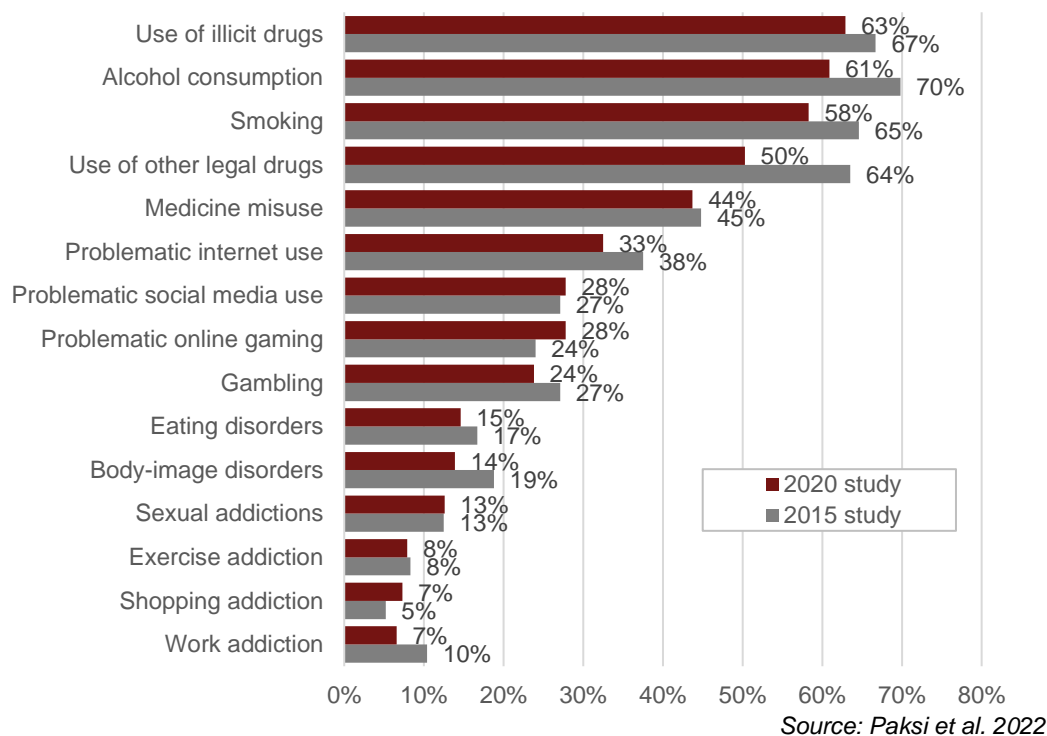


Source: Paksi et al. 2022

The results of the 2015 and 2020 studies show no marked differences in the structure of the intervened behaviours. In both studies, interventions aiming substance use are much more popular than those targeting behavioural addictions. Within behavioural addictions, the proportion of problematic online gaming, shopping and social media addictions increased for some extent.



Chart 48. *Proportion (%) of directly targeted addictive behaviours among prevention programmes/services aimed at the final target group in 2015 (N=96) and in the current research (N=145)*



## T5. SOURCES AND METHODOLOGY

### T5.1 SOURCES

Belügyminisztérium Népegészségügyi Főosztály (BM NÉPEÜ) (2022): Összefoglaló az EFI-k hálózatáról. Kézirat.

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

EMMI (2021): Jelentés a Nemzeti Drogellenes Stratégia megvalósulásáról

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

Paksi B. (2008): Nem iskolai szintűen megjelenő prevenciós programmeok feltérképezése. Kutatási Beszámoló, SzMM

Paksi B. (2022): Prevenció. 2022. Kézirat.

Paksi B. & Demetrovics Zs. (2002): A prevenciós gyakorlat megismerése. A budapesti középiskolai drogprevenciós programmeok felmérése és értékelése. Szakmai forrás sorozat. 2. L'Harmattan. Budapest.

Paksi B. & Demetrovics Zs. (2003): Budapesti Drogprevenciós Adattár. CD. ISM, Budapest.

Paksi B. & Demetrovics Zs. (2005) Országos Drogprevenciós Adattár. CD. L'Harmattan Kiadó, Budapest.

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*. Hozzáférhető: <http://www.madaszsz.hu/images/doksik/szervtev1.pdf>

Paksi B. & Demetrovics Zs. (szerk) (2011): *Drogprevenció és egészségfejlesztés az iskolában*. NDI. Budapest: L'Harmattan.

Paksi B., Magi A., Kó J. & Demetrovics Zs. (2015): Szakértői tanulmány - A Szerencsejáték Zrt. társadalmi felelősségvállalási programjához kapcsolódóan, a fiatal 14-24 év közötti populáció körében tervezett, a szerencsejáték tevékenység kockázatainak csökkentésére irányuló prevenciós tevékenység szakmai megalapozása. Kutatási Beszámoló. Szerencsejáték Zrt, Kézirat.

Paksi B., Magi A. & Demetrovics Zs. (2016): Szenvedélymagatartásokra irányuló prevenciós beavatkozások országos katasztere, Magyar Pszichológiai Társaság XXV. Jubileumi Országos Tudományos Nagygyűlése, 2016. június 2-4., Budapest. In: Vargha A. (szerk) Kivonatkiötet. pp. 56-57. [http://mptnagygyules.hu/images/MPT\\_Ngy2016\\_kivonatkiötet\\_0509.pdf](http://mptnagygyules.hu/images/MPT_Ngy2016_kivonatkiötet_0509.pdf). [Letöltve: 2016-09-01]

Paksi B., Demetrovics Zs. & Felvinczi K. (2022): A szenvedélymagatartások megelőzésével foglalkozó beavatkozások országos katasztere 2017-2020. Kutatási Beszámoló. Budapest:

## T6.2 METHODOLOGY

*Paksi (2022) and Paksi et al. (2022):*

The aim of the study was the exploration of prevention interventions on addictive behaviours in Hungary. The registry of organizations belonging to the target group of the study was created using 7 different data sources - in addition to the final dataset of the previous registry (Paksi et al., 2015; 2016), various drug professional and civil data sources, as well as applicant lists of tenders aimed at (also) supporting the field were studies. After controlling the database for double counting it contained a total of 1221 organizations. The contact with the organizations and the identification of the organizations belonging to the target group took place with the help of a short telephone screening questionnaire. Data collection was carried out online, supported by a professional and an IT helpdesk. The data collection questionnaire is based on international programme description standards/recommendations (PERK, EDDRA, EMCDDA) and previous national registry building experiences (Paksi & Demetrovics, 2002, 2003, 2005, 2011; Paksi, 2008; Paksi & Arnold 2010, Paksi, et al. 2015; 2016). The Programme Information Sheet (PIAD), which served as the data collection tool, covered the following topics: characteristics of the organization operating the programme/service; a comprehensive description of the activity carried out within the framework of the programme/service; information about the target group; the objectives of the programme/service; its concept (theory); applied methods; evaluation of the intervention; human resources background. The data collection focused on prevention programmes/services provided between 2017-2020.

## TREATMENT<sup>101</sup>

### 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 Responsible for Care Policy* and the *State Secretariat for Health* of the Ministry of Interiors (BM) 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 (81.6%% in 2021).

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.

---

<sup>101</sup> Author of the workbook: Anna Péterfi. Proofreader: János Szemelyácz

## **T1. NATIONAL PROFILE**

### **T1.1 POLICIES AND COORDINATION**

#### **T1.1.1 Main treatment priorities in the national drug strategy**

The last defining strategic document was the 2013-20 National Anti-Drug Strategy (hereinafter Strategy).

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 adopted.

#### **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 Responsible for Care Policy* and the *State Secretariat for Health* of the Ministry of Interiors (BM) 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 Slachta Margit National Social Policy Institute). 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 in respect of the outpatient type health and social care services targeting 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 2021, a total of 61 treatment centres reported new clients starting outpatient drug treatment out of the 77 treatment centres reporting clients, excluding prison treatment units. Altogether 92.4% (3957 out of the 4283 persons) of the reported clients started drug treatment in specialised outpatient drug treatment centres, in low-threshold services or at general/mental healthcare units. Of those 3957 persons, 3387 (85.6%) entered treatment as an alternative to criminal procedure. A further 64 prisoners received drug treatment provided by an external service provider. All 64 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 2021)*

	Total number of treatment units	National definition (treatment unit types)	Total number of clients
<b>Specialised drug treatment centres</b>	44	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.	3137  (of whom 2675 persons started treatment as an alternative to criminal procedure)
<b>Low-threshold services<sup>102</sup></b>	17	Service providers identifying themselves in the TDI data collection as low-threshold/drop-in/outreach units) (typically social service providers providing psychosocial services).	820  (of whom 712 persons started treatment as an alternative to criminal procedure)
<b>General mental healthcare</b>	0	.	
<b>Prisons (inreach and external service providers)</b>	3 external units providing	Community outpatient services also reporting on the treatment of prisoners in the TDI data collection.	64

<sup>102</sup> and other treatment units with a primarily social profile

	services inside prison		(of whom 64 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

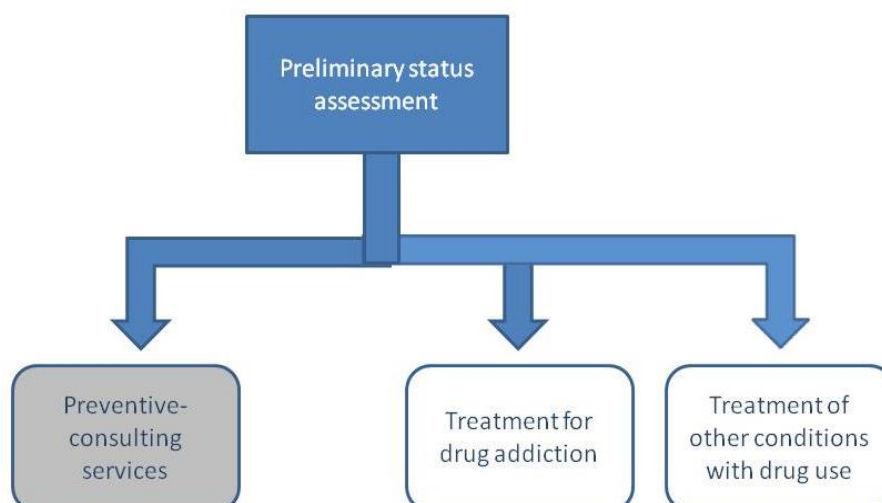
In the case of certain drug-related offences, the offender may avoid criminal procedure by participating in treatment/preventive interventions (referred to as QCT – quasi-compulsory treatment), providing the offender meets the following conditions:

- 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 suspended, 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<sup>103</sup>. The content of the treatment interventions is not specified; the healthcare service providers provide these services within the scope of regular outpatient or inpatient drug treatment programmes. The offender is required to participate in the preventive or treatment programme for at least 1.5 hours every two weeks for 6 months in order for the certificate of completion to be issued.

Based on TDI data, in 2020, 81.6% 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 49. 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

<sup>103</sup> With respect to treatment, the law distinguishes between two types: “treatment for drug addiction” and “treatment of other conditions with drug use”.

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 or residential health and social care services 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 five<sup>104</sup> therapeutic institutes in the country targeted at the under-18 age group. One of them (in Ráckeresztúr) admits boys only (with a capacity of 30), one institution admits girls only (in Székesfehérvár, with a capacity of 10 beds) and three institutions admit both boys and girls (in Budapest, Szatymaz and Pécsvárad) (with a capacity of 10; 15; 10 beds respectively). 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<sup>105</sup>.

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 12 inpatient units and 4 service providers in prison reported clients entering inpatient drug treatment in 2021 (shown in the table below).

64.7% (156 persons) of the drug-using clients starting inpatient treatment were treated in drug therapeutic institutions with a mixed (social and healthcare) profile, while 35.3% (85 persons) were treated in hospital-based residential units. 5.6% (241 persons) of all clients entering treatment in 2021 (4283 persons) started treatment in the scope of inpatient treatment, 12 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
<b>Hospital-based inpatient drug treatment</b>	6	Treatment units identifying themselves in the TDI data collection as inpatient hospital addiction or psychiatric departments.	156  (of whom 6 persons started treatment as an alternative to criminal procedure)
<b>Therapeutic communities</b>	6	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.	85  (of whom 6 persons started treatment as an alternative to criminal procedure)
<b>Prisons</b>	4	Prison services reporting the treatment of prisoners in TDI.	21

<sup>104</sup> A unit in Székesfehérvár (Edokk Junior Tinirehab) was opened in September 2021.

<sup>105</sup> 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](http://madaszsz.hu/289/Feher_foltok_az_ellatrorendszerben_-_eloadasok_es_videok)>



			(of whom 21 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 drug therapeutic institutions; that number has since increased by a further three units (see section T3.). Only 6 of the therapeutic communities reported cases in 2021 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.

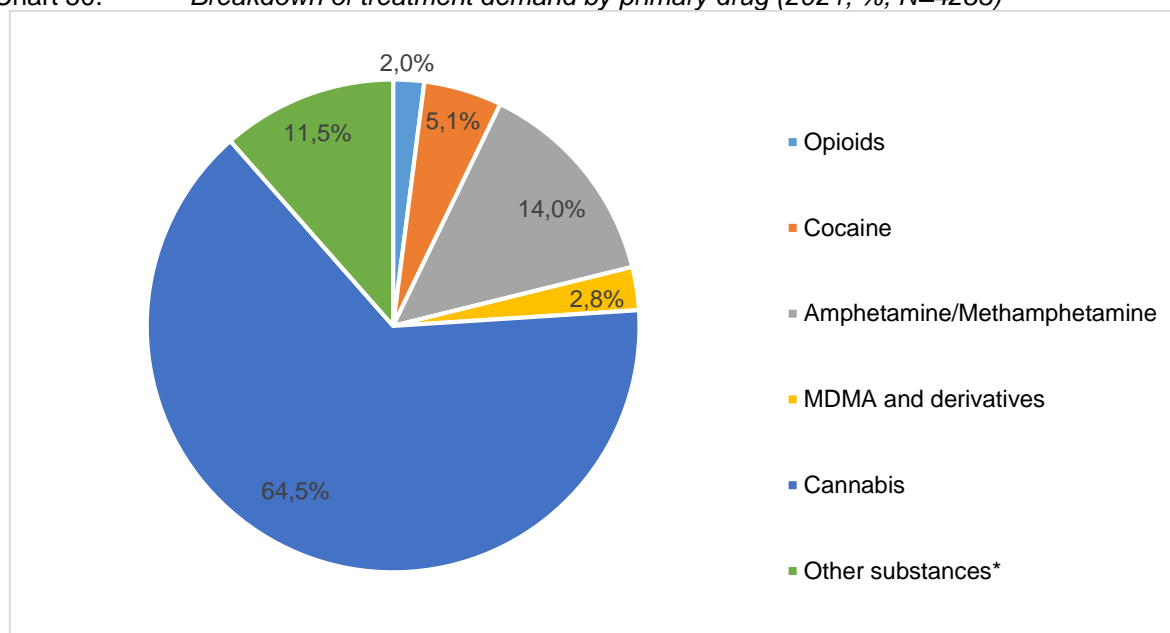
## **T1.3 TREATMENT DATA**

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

The 77 treatment units (also) providing drug treatment and reporting to the TDI reported a total of 4283 clients entering treatment in 2021. The majority (64.5%; 2764 persons) of those starting treatment due to a drug problem – similarly to in previous years – started a treatment programme because of cannabis use. 14.0% (599 persons) entered treatment because of amphetamine (or methamphetamine) use. Cocaine or crack use was the reason for entering treatment for 5.1% of clients (220 persons). The proportion of primary ecstasy/MDMA users

was 2.8% (121 persons). For opioid use 2.0% of (87 persons) started treatment. A further 11.5% (492 persons) of treatment entrants indicated the use of “other substances” since their primary drug could not be categorised in the above substance groups.

Chart 50. Breakdown of treatment demand by primary drug (2021; %; N=4283)



\*"Other drugs": "other stimulants", "inhalants", "hallucinogens", "hypnotics and sedatives" and "other substances that do not come under the specified categories"  
Source: Péterfi 2022a – TDI data 2021

Table 17. Summary table – clients in drug treatment in 2021 (persons)

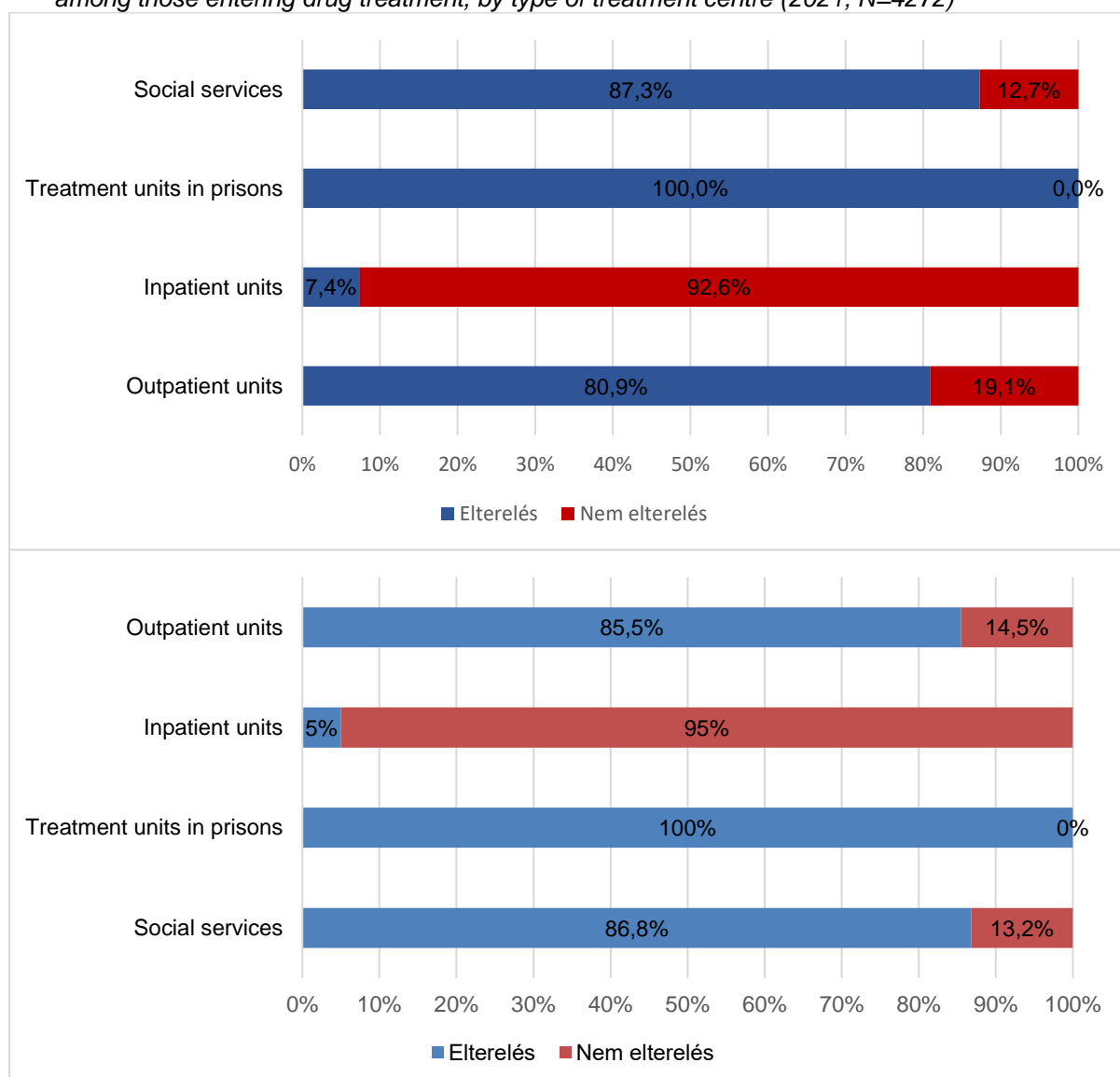
	Number of clients
Total clients in treatment	no available data
Total OST clients	577
All clients entering treatment	4283

Source: ST24; Péterfi 2022a – TDI data 2021; Péterfi 2022b – 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. 81.6% (3484 persons) of all clients entered treatment for that reason in 2021. 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 social service and outpatient service providers entered treatment in this way (86.3%; 712 persons and 86.5%; 2675 persons), only a very small fraction of those entering inpatient treatment (5.0%; 12 persons) started a treatment programme as an alternative to criminal procedure. All prison clients (100.0%; 85 persons) entered treatment as an alternative to criminal procedure in 2021 according to reported data.

Chart 51. The proportion of those entering treatment as an alternative to criminal procedure (QCT) among those entering drug treatment, by type of treatment centre (2021; N=4272)<sup>106</sup>

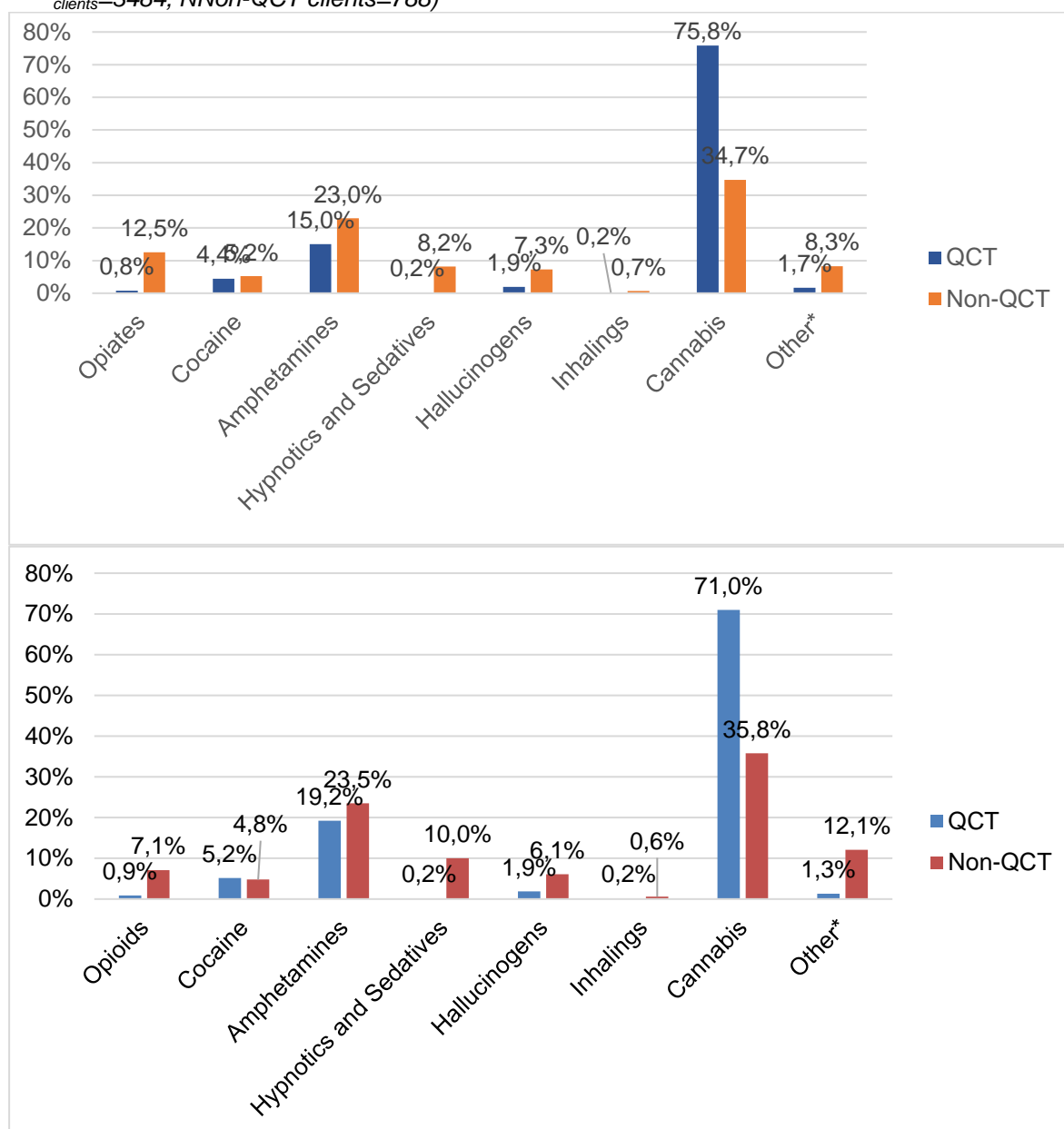


Source: Péterfi 2022a – TDI data 2021

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 (2475 persons, 72.0%) was the most prevalent primary drug among all clients entering QCT (3484 persons), followed by amphetamine-type stimulants (668 persons, 19.2%). cocaine use was characteristic of 5.2% (182 persons) of this client group, while the proportion of all the other drugs was below 5% (4.6%; 159 persons) among QCT clients.

Among non-QCT clients (788 persons), cannabis use was the most frequent reason for entering treatment (35.8%; 282 persons). The proportion of amphetamine type stimulant and hypnotics/ sedatives users among those entering voluntary (non-QCT) to treatment was higher (when compared to QCT clients) (23.5% 185 persons and 10.0% 79 persons).

Chart 52. Breakdown of QCT and non-QCT treatment entrants by primary drug (2021;  $N_{QCT}$  clients=3484;  $N_{Non-QCT}$  clients=788)<sup>107</sup>



\*Other: other substances not included in other categories

Source: Péterfi 2022a – TDI data 2021

## 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.

<sup>107</sup> In the case of 11 persons, the source of referral was not known.

### **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*

The Józan Babák Klub (Sober Babies' Club) targets pregnant or child-raising women living with behavioural addictions or drug use, as 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 Prevenációs 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 one therapeutic community in Hungary that specifically target female drug users (possibly prescription drug or alcohol addicts), namely the MPE Hajnalcsillag Rehabilitation Home. In addition, a drug therapy institute namely the Edokk Junior Teen Rehab, which opened in 2021, targets girls between the ages of 12 and 18.

#### *Children and adolescents*

There are currently a total of five therapeutic institutions targeting young drug users under the age of 18 in the country. One of them admits boys only (with a capacity of 30), one institution admits girls only (in Székesfehérvár with a capacity of 10 beds) and three admit both boys and girls (with a capacity of 10; 15 and 10 beds respectively). Outpatient care specifically targeting children and young people is currently being provided at three institutions: at the "Tiszta Jövőért" Foundation in Budapest, at the "Egészségdokk" Foundation in Székesfehérvár and one at the "Kamasz Addiktológiai Regionális Centrum (K-ARC)<sup>108</sup>" provided by the INDIT Foundation in Pécs.

The Hungarian Charity Service of the Order of Malta has a page ([apaiszik.kimondhato.hu](http://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.

---

<sup>108</sup> K-ARC in Pécs opened in November, 2022.

#### **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.

#### *Opioid substitution treatment*

#### **T1.4.9 Main providers of opioid agonist treatment (OAT)**

OAT 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). OAT 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 2021, we identified a total of 12 service providers in the country providing opioid agonist 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. OAT is available from only one service provider in an inpatient setting, but in the scope of outpatient care at all 12 treatment centres. (For the methodological description of the OAT 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 OAT. 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 OAT**

Two types of substitution medication are used in Hungary in OAT 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 (429 persons in 2021, 74%), while approximately one-quarter of the clients receive the buprenorphine/naloxone combination (148 persons in 2021, 26%). 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 2021, service providers reported a total of 604 treatment episodes linked to a total of 577 clients (intra-institutional and inter-institutional duplicates<sup>109</sup> were removed using the anonymous TDI code).

95% (550 persons) of the 577 clients received care in the scope of maintenance treatment. Approximately three-quarters of them (412 persons) received methadone and one-quarter (138 persons) received buprenorphine/naloxone.

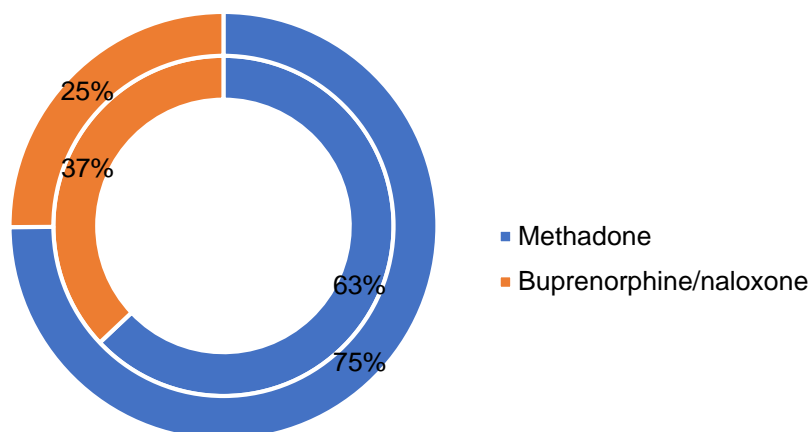
5% (27 persons) of clients reported in 2021 underwent detoxification treatment. Of the 27 people, 17 received methadone and 10 received buprenorphine/naloxone.

---

<sup>109</sup> In 22 cases, several treatment episodes within a facility were associated with a single client. In addition, a further 5 clients were identified who changed location during the year and were therefore identified as inter-institutional duplicates.

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.

Chart 53. Breakdown of OAT maintenance clients (outer curve, N=550) and OAT detoxification clients (inner curve, N=27) by substitution medication in 2021 (persons; %)

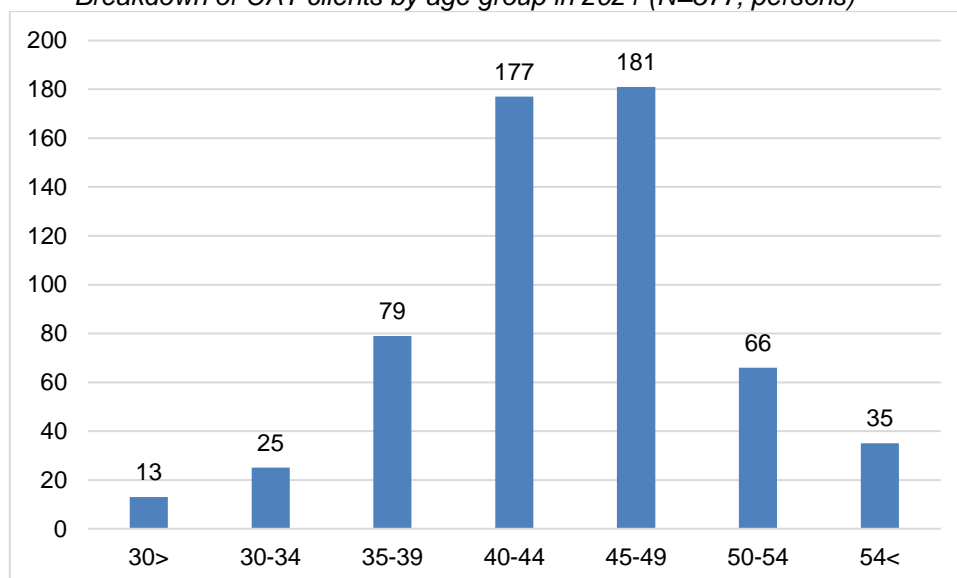


Source: Péterfi 2022b – OST data collection 2021; ST24

#### T1.4.11 Characteristics of clients in opioid agonist treatment

Of the 577 clients receiving substitution treatment in 2021, 77% (443 persons) were male and 23% (134 persons) were female. The mean age of clients was 44.2 years, with the most clients (181 persons; 31%) belonging to the 45-49 age group. The youngest client was 21 and the oldest 70.

Chart 54. Breakdown of OAT clients by age group in 2021 (N=577; persons)



Source: Péterfi 2022b - 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<sup>110</sup>;
- 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<sup>111</sup>. 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.

<sup>110</sup> Published in the 2 July 2019 (LXIX /10) issue of the Health Gazette

<sup>111</sup> Representatives from the field were consulted on the draft guidelines in the scope of a consensus conference.



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.

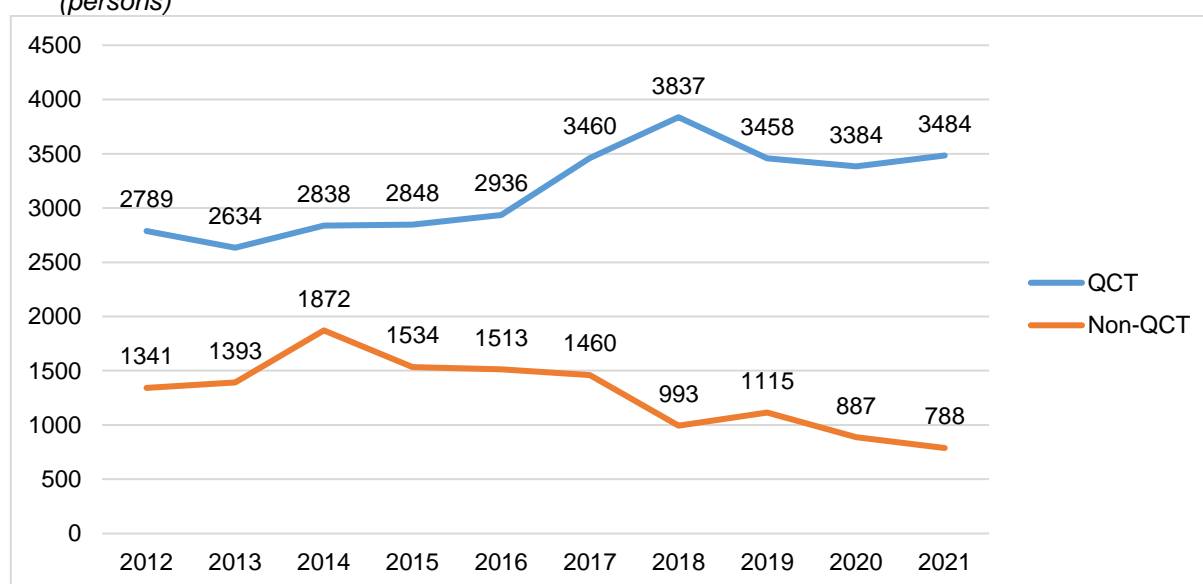
## T2. TRENDS

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

*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”). Between 2013 and 2018, the number of people starting treatment as an alternative to criminal procedure (QCT) increased significantly, with the biggest growth between 2016 and 2018. Between 2018 and 2019 a decline can be observed in their number while between 2019 and 2021 their number remained relatively stable. At the same time, the number of those referred to treatment in other routes (non-QCT clients) showed a decreasing trend between 2014 and 2021.

Chart 55. *Breakdown of clients entering treatment by source of referral between 2012 and 2021 (persons)*



Source: Péterfi 2022a – TDI data 2021

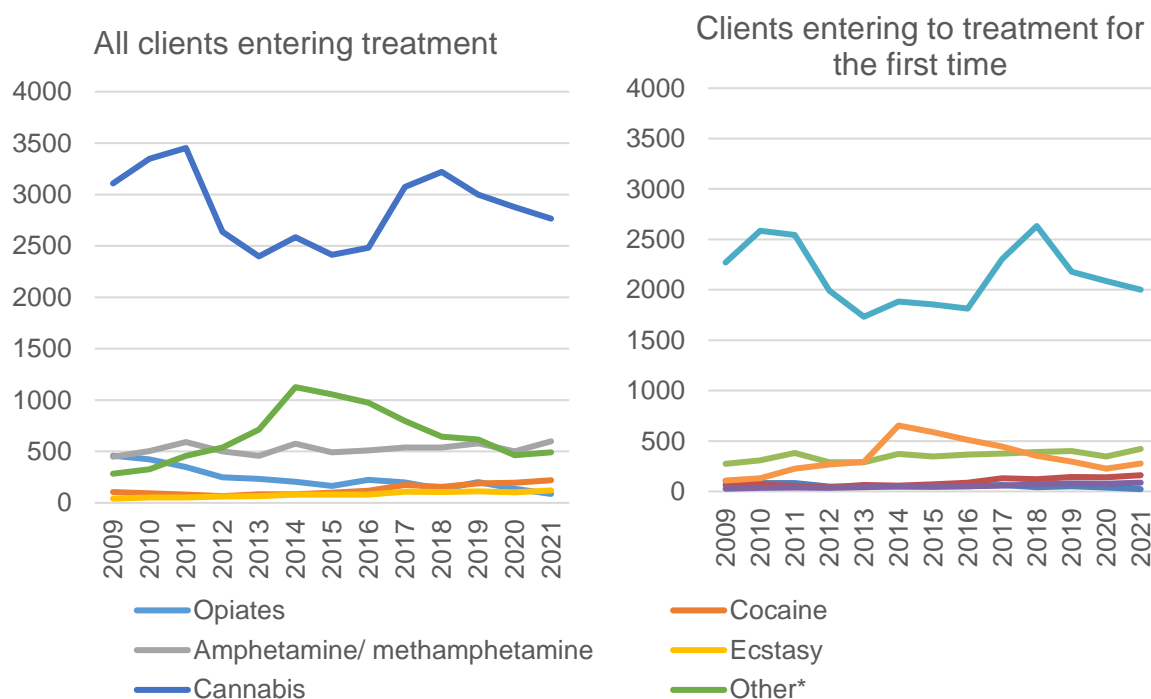
In connection with the increased use of NPS, it is important to note that until these substances are scheduled in the lists of narcotic drugs and psychotropic substances, their use is not a criminal offence and the (infringement) procedures launched in relation to them cannot be avoided by undertaking 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;

2021: 87 persons). In parallel, between 2009 and 2014, the number of new treatment admissions linked to “other drugs”<sup>112</sup> (primarily new psychoactive substances) increased (2009: 278 persons, 2014: 1137 persons), followed by a steady decrease between 2014 and 2021 (2014: 1137 persons, 2021: 492 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 56. Trends in the number of all clients entering treatment (on the left) and clients entering treatment for the first time (on the right) by primary drug, 2009-2021<sup>113</sup> (persons)



Source: Péterfi 2022a – TDI data 2021<sup>114</sup>

<sup>112</sup> \*Other drugs: hypnotics and sedatives, inhalants, hallucinogens, other stimulants, other substances that do not come under the specified categories

<sup>113</sup> Other drugs: hypnotics and sedatives, inhalants, hallucinogens, other stimulants, other substances that do not come under the specified categories

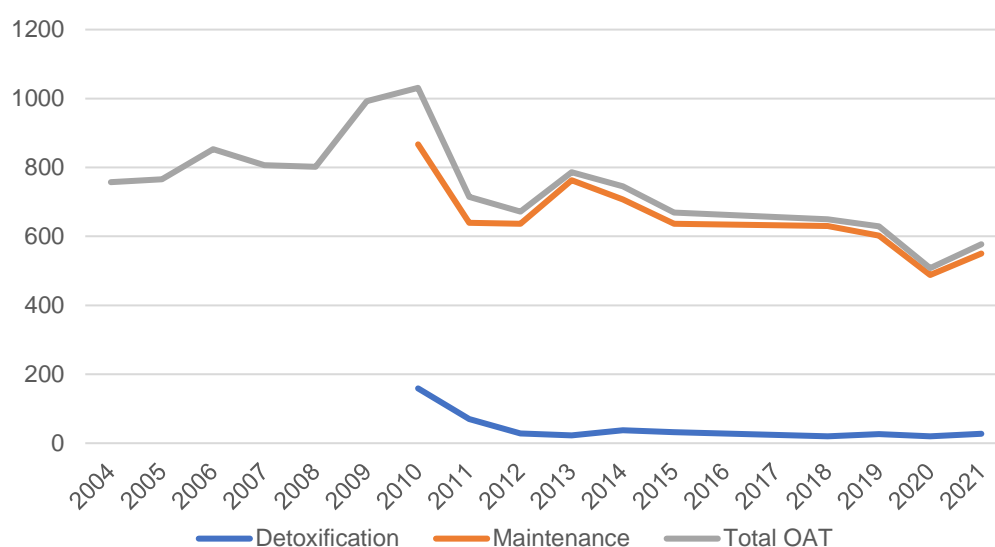
<sup>114</sup> The case numbers between 2007 and 2018 may differ slightly from the case numbers presented in other parts of the chapter, since this chart is updated each year with the current case numbers only, while for the other charts/tables, the most recent data were queried for each previous year.

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 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 agonist treatment (OAT)*

The number of those treated in OAT 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 OAT; 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 OAT data<sup>115</sup> 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 was followed by a 14% increase in 2021. The 2020 decrease is presumably related to the effects of the coronavirus epidemic on the care system.

Chart 57. *Trends in numbers of clients in OAT by type of OAT, 2004-2021\* (persons)*



\*Data collection was suspended in 2016 and 2017  
Source: Péterfi 2022b – OAT 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**

<sup>115</sup> 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.

Information regarding the changes in the drug treatment system is presented as part of the baseline information in section T1.

A last report on the impact of the coronavirus epidemic on the care of drug users can be found in section T4.1 of this workbook.

## **T4. ADDITIONAL INFORMATION**

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

#### **T4.1.1 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?



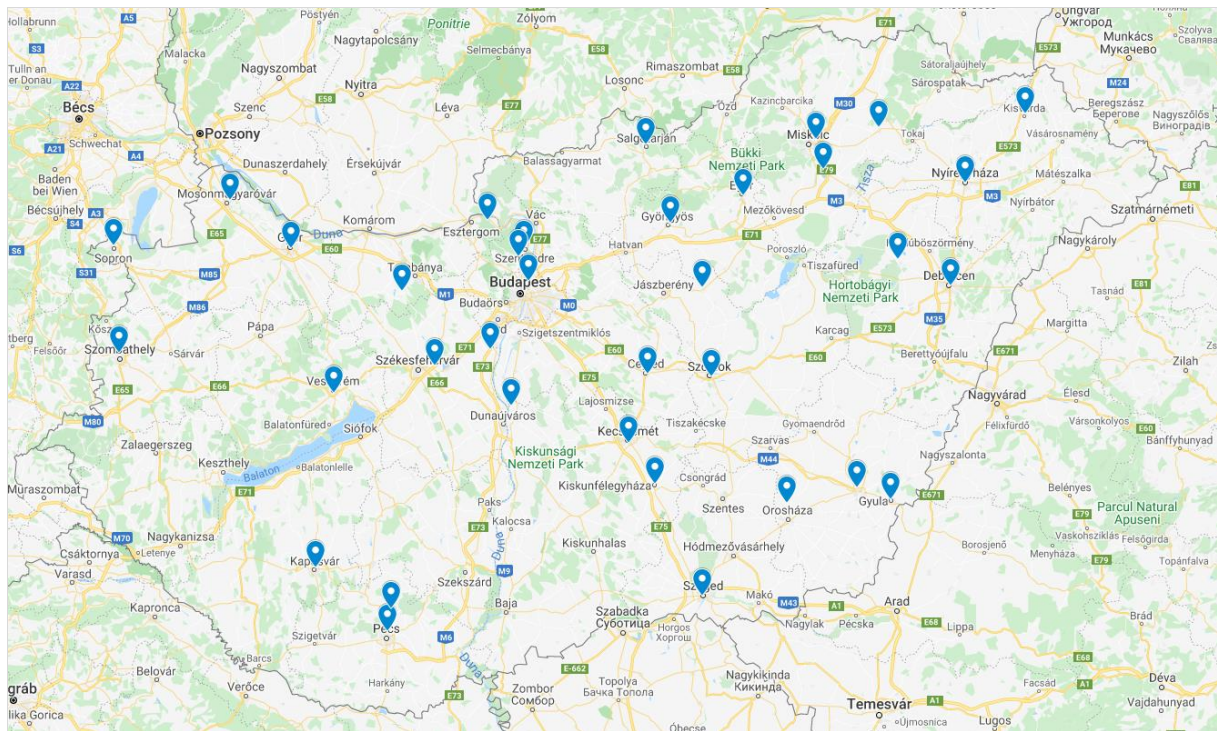
- How did the use of the various substances change? What new patterns of use, harms, health and social consequences emerged as a result of the coronavirus pandemic and the related restrictions?
- To what extent did services provided for substance users recover?
- How were telemedicine services delivered?
- 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.”

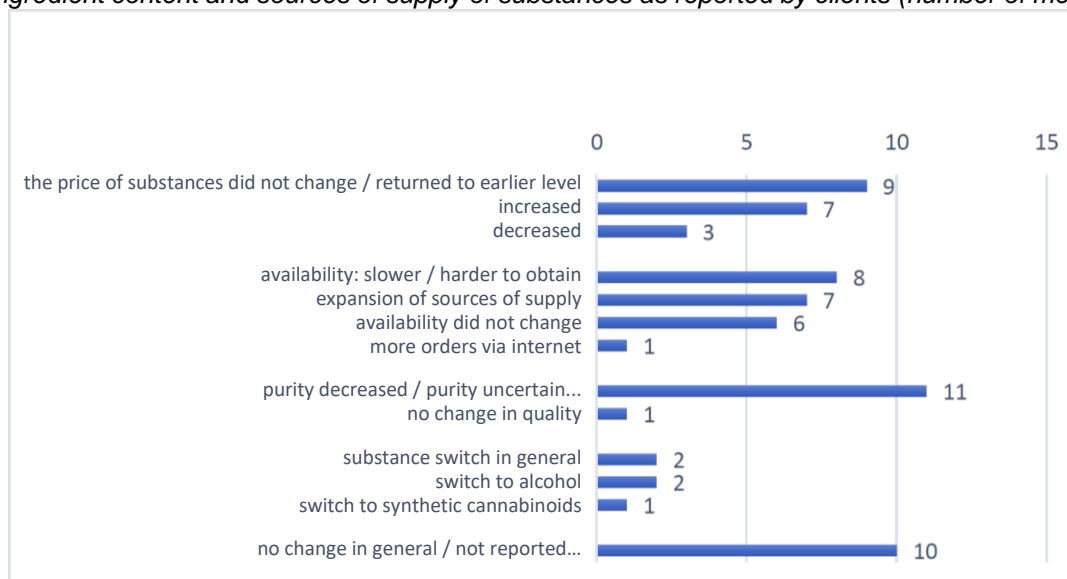
“Our clients report an increase in the price of ‘bath salts’; we have no information about the other substances.”

“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 58. *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)*



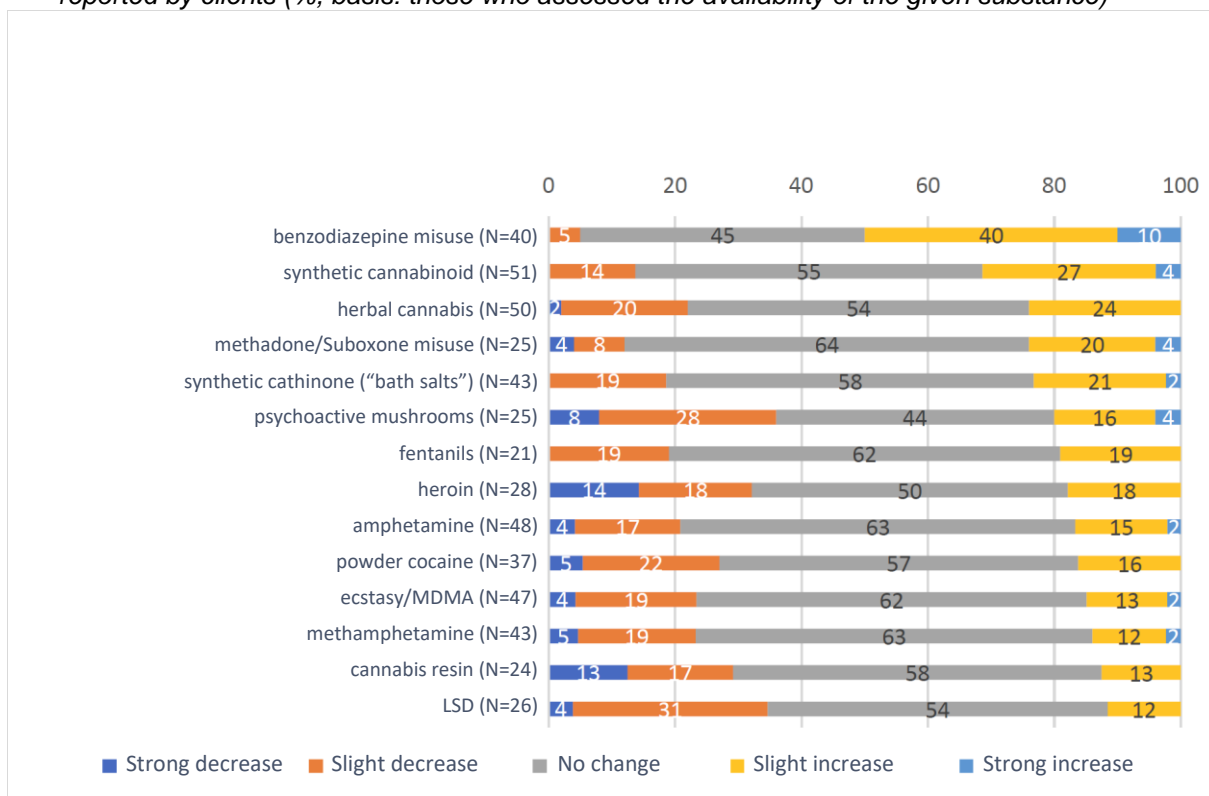
Source: HNFP 2021

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 59. *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)*

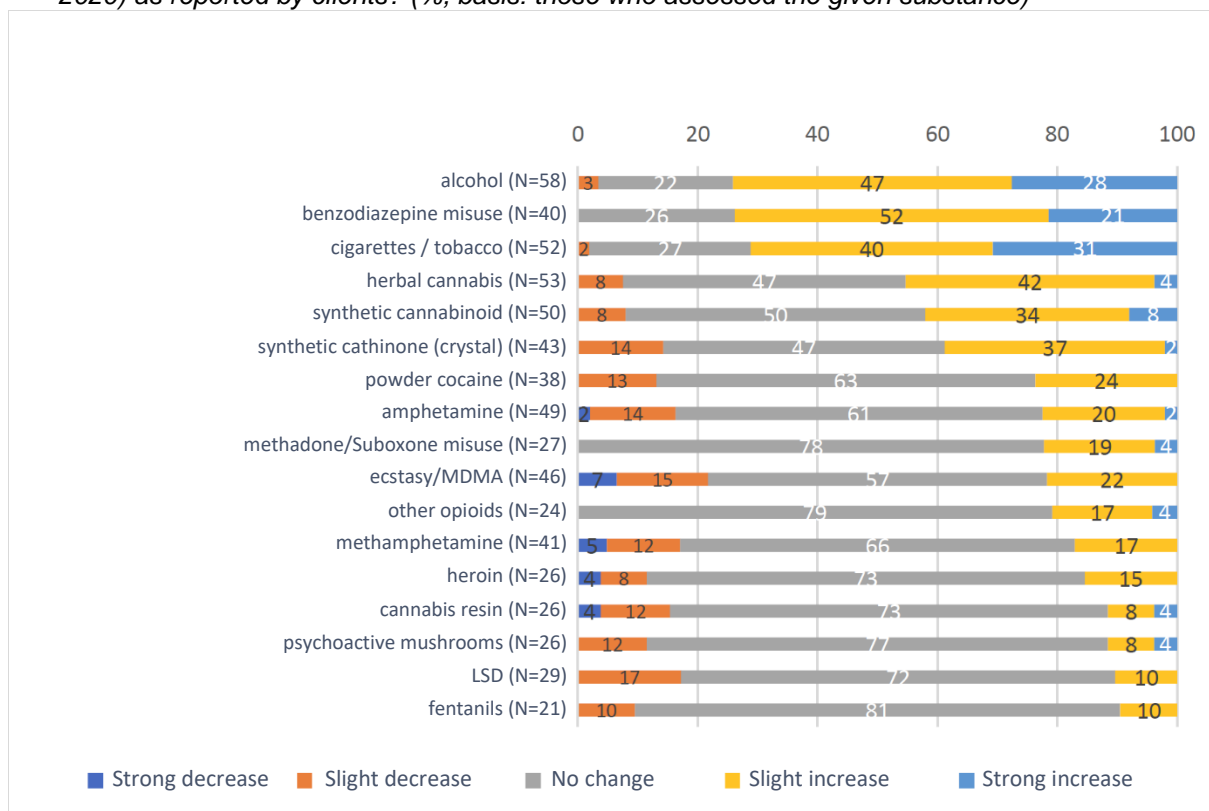


Source: HNFP 2021

### 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.

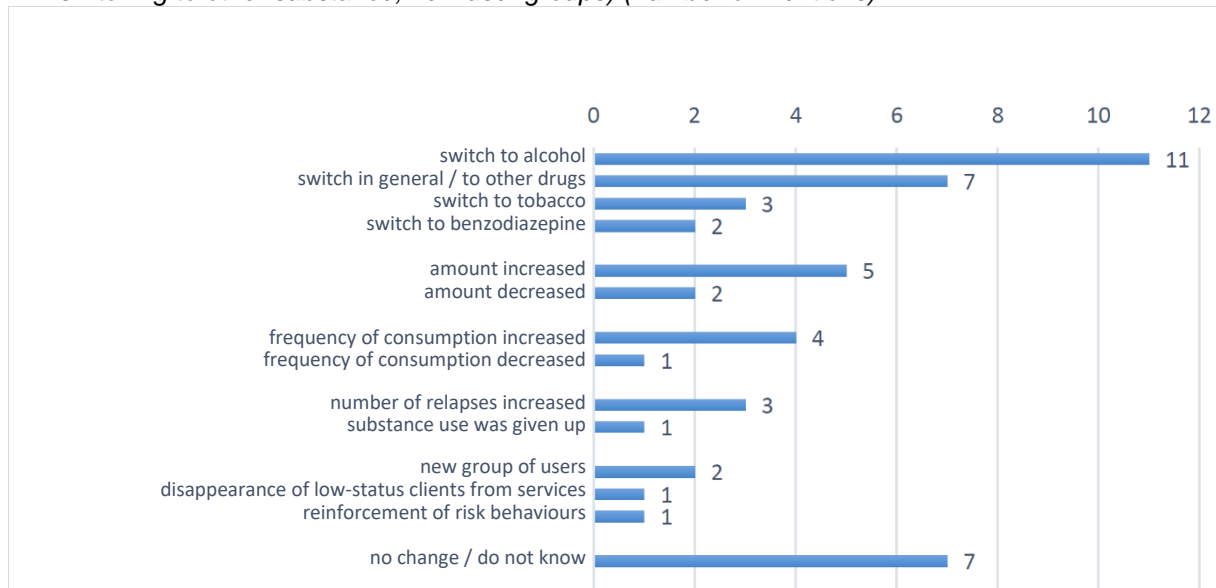
Chart 60. *Did the extent of use of the following substances change during the second wave of the pandemic (June-December 2020) in comparison with the first wave of the pandemic (March-May 2020) as reported by clients? (% basis: those who assessed the given substance)*



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 patterns 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 61. *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*.

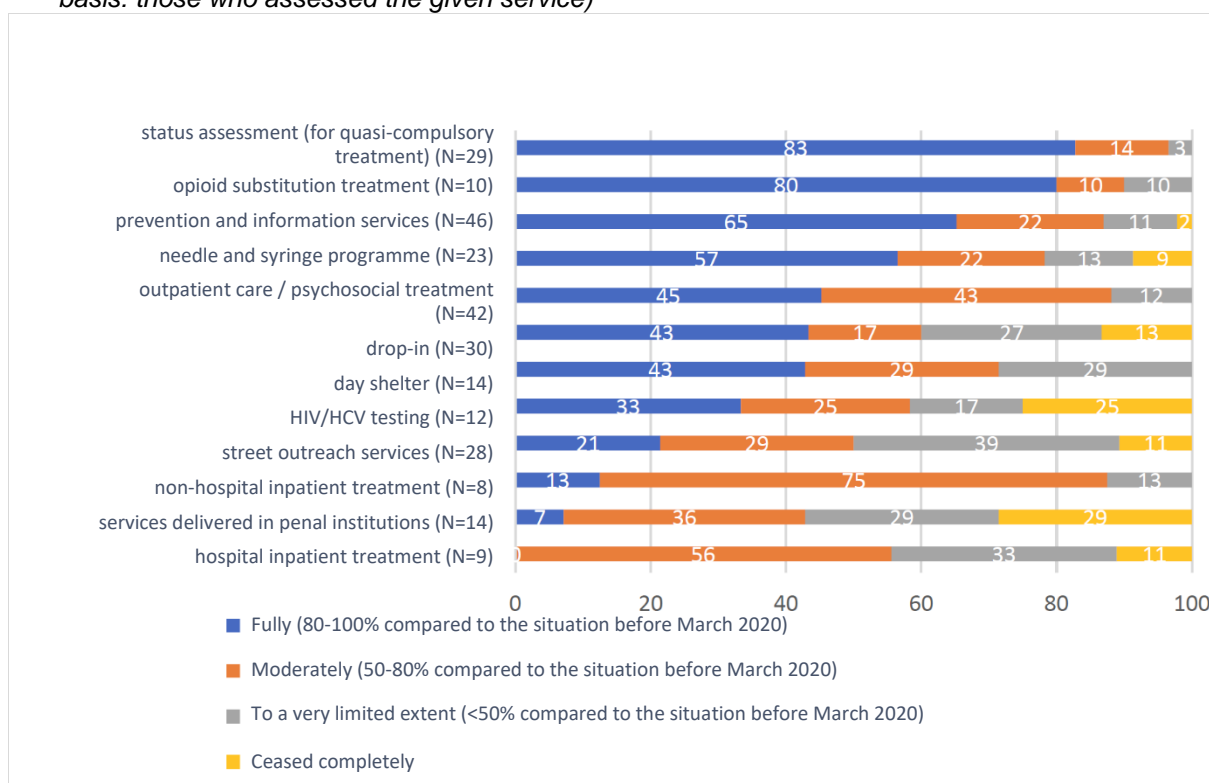
*Prevention and information services*, as well as *needle and syringe programmes* had fully recovered at about two-thirds of service providers and moderately recovered at another one-fifth.

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 62. *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

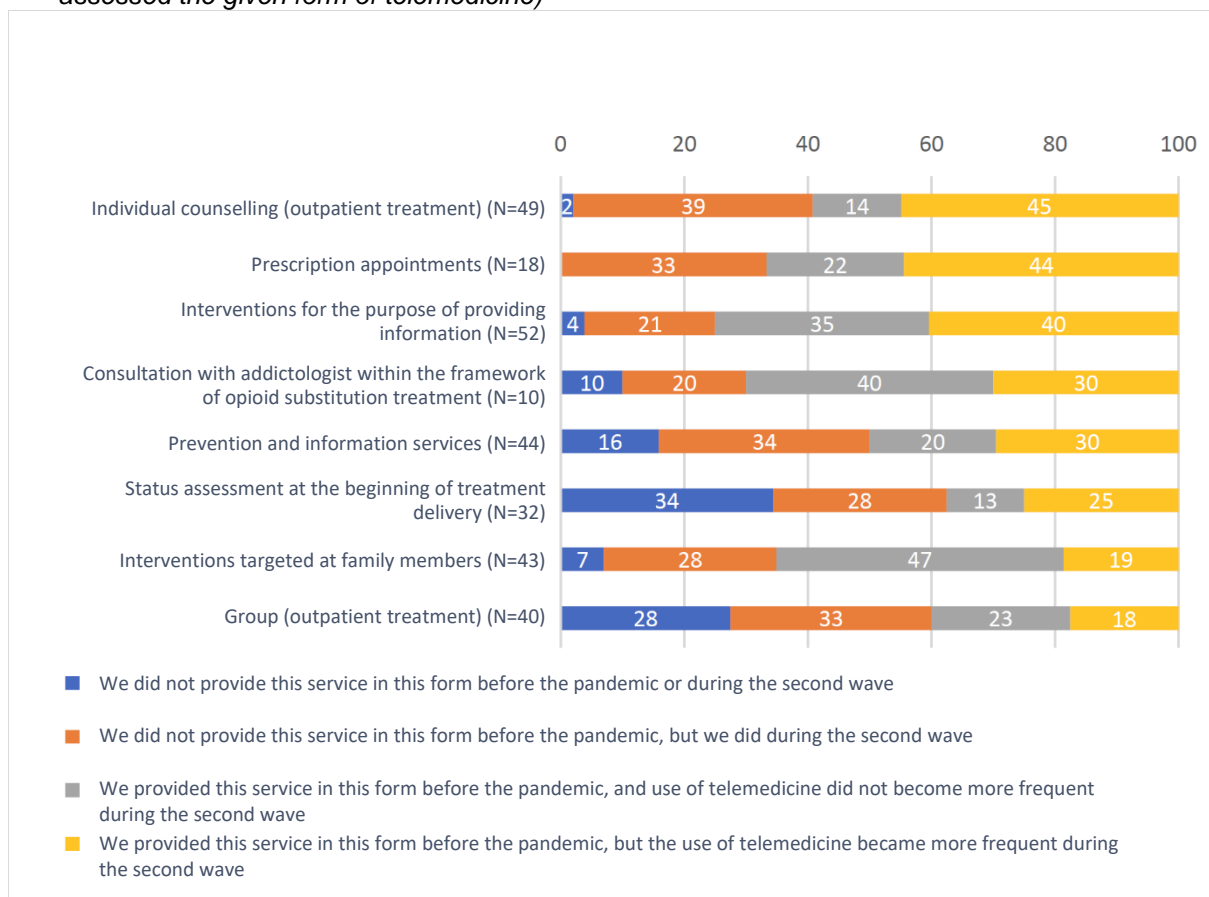
When disease control measures were introduced in spring 2020, the majority of service providers rapidly created online alternatives to their interventions in order to reduce in-person contact and deliver safer services, thus shifting most of the work with clients to telephone and online communication. At the beginning of 2021, we asked them to compare the frequency of providing telemedicine<sup>116</sup> 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.

<sup>116</sup> 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 63. *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).

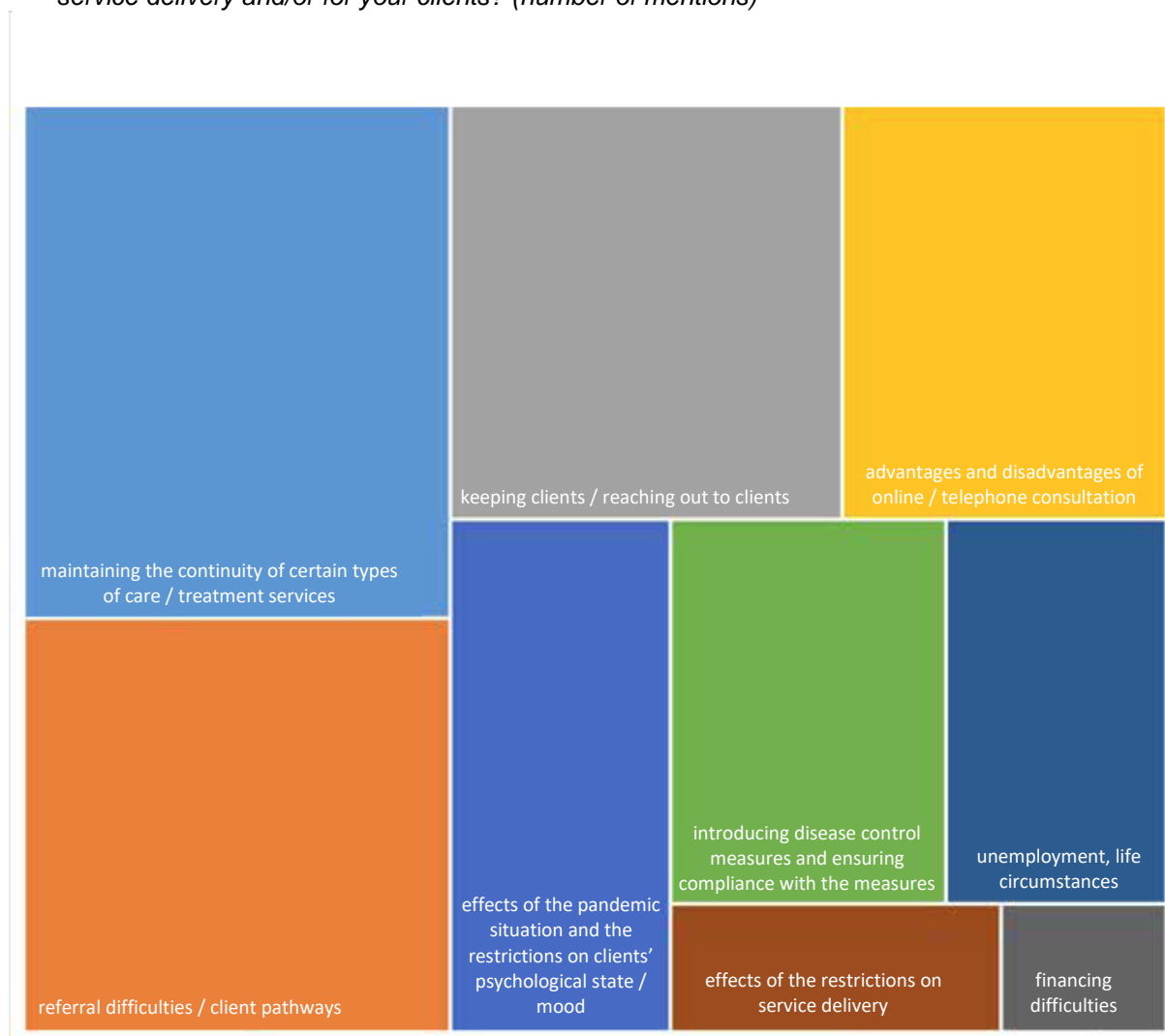
“There are a lot more conversations on the phone and by email, we have to explain to clients how to use the online setting and how quasi-compulsory treatment will take place. Online groups can only be effective with fewer participants than in-person groups. Due to the smaller group size, we have to start 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 64. 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)

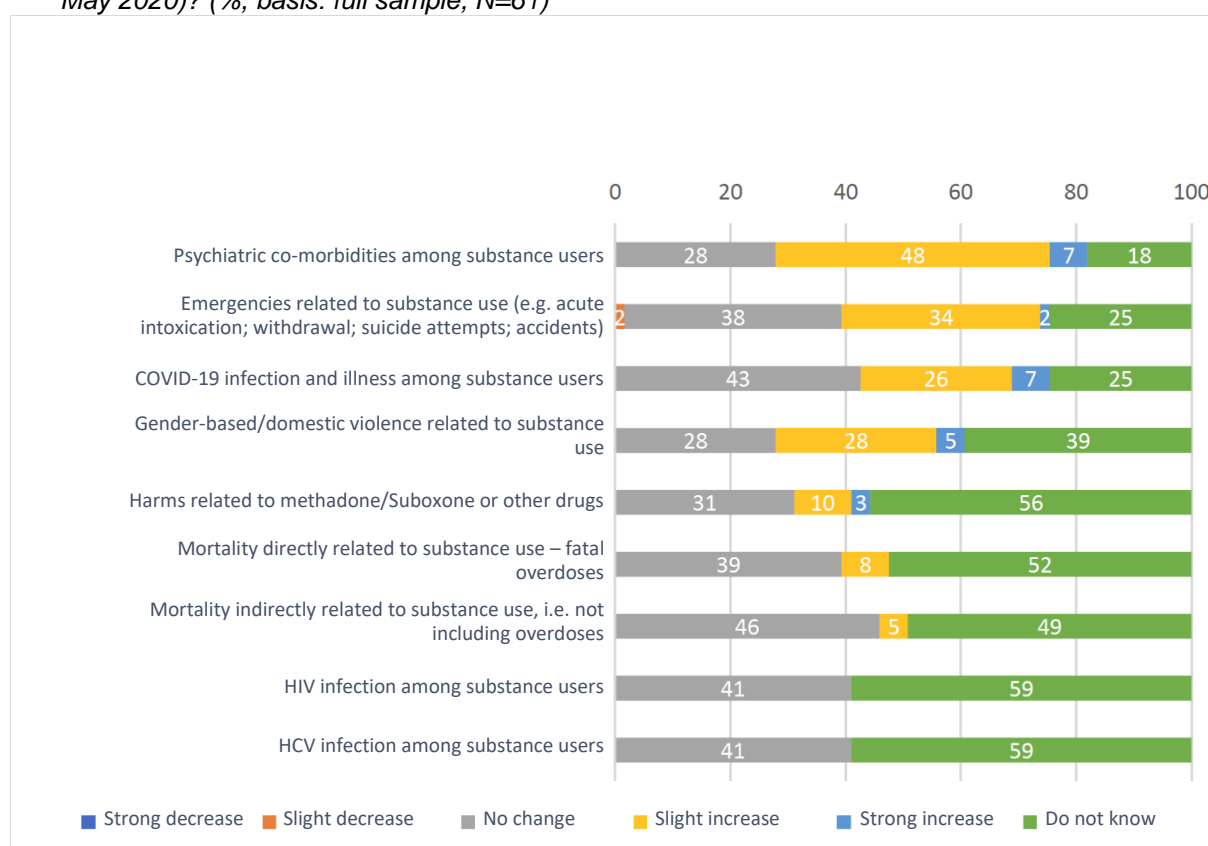
uncertainty concerning finances and applications	1
financial difficulties	1
increase in phone bills due to considerable increase in telephone and email communication	1

### 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 65. *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

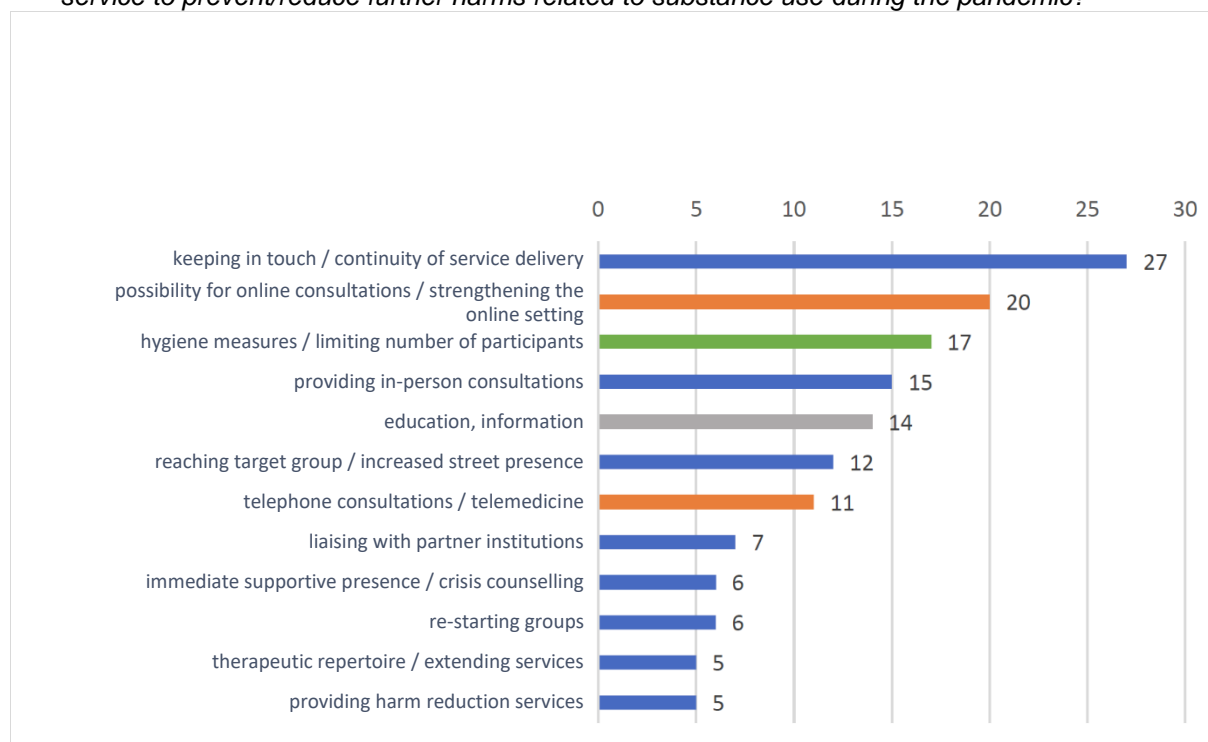
### The three main priorities or measures for the purpose of preventing or reducing further harms related to substance use

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 66. *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

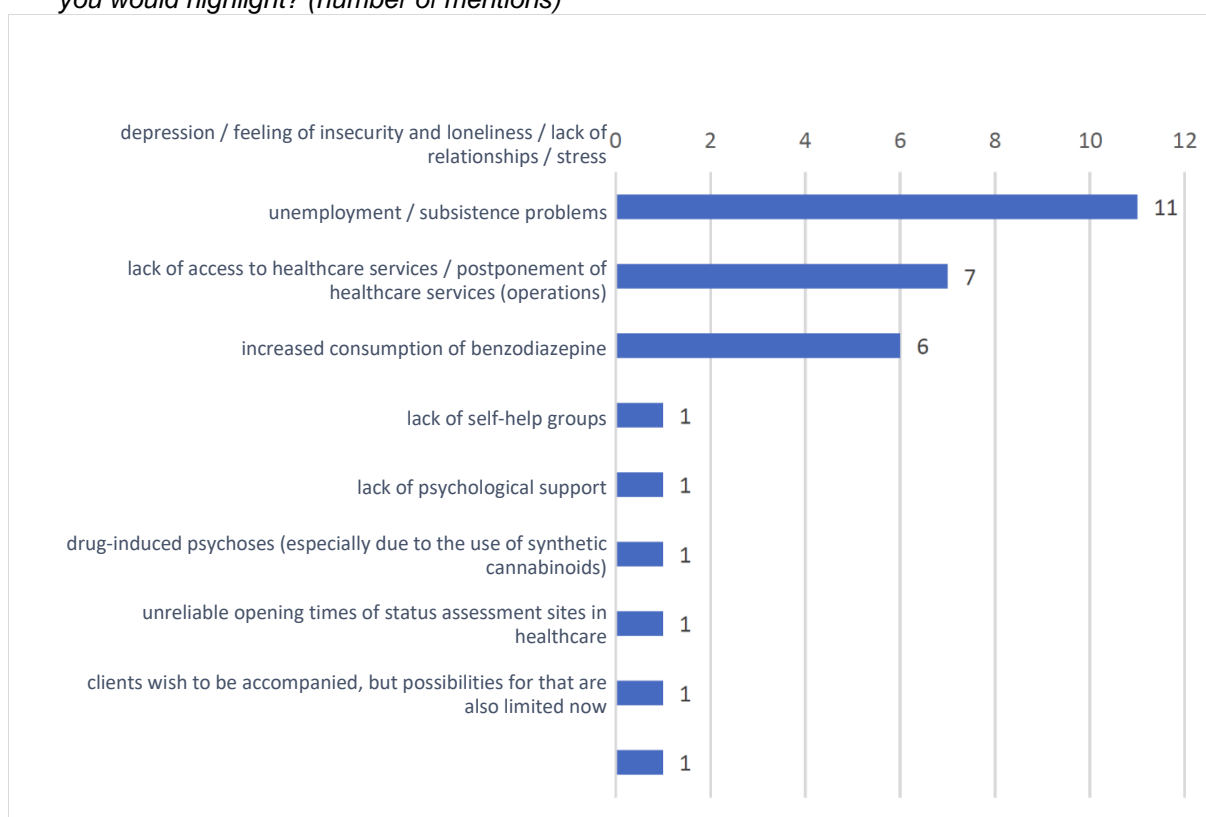
#### Therapeutic repertoire / extending services (5 mentions)

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



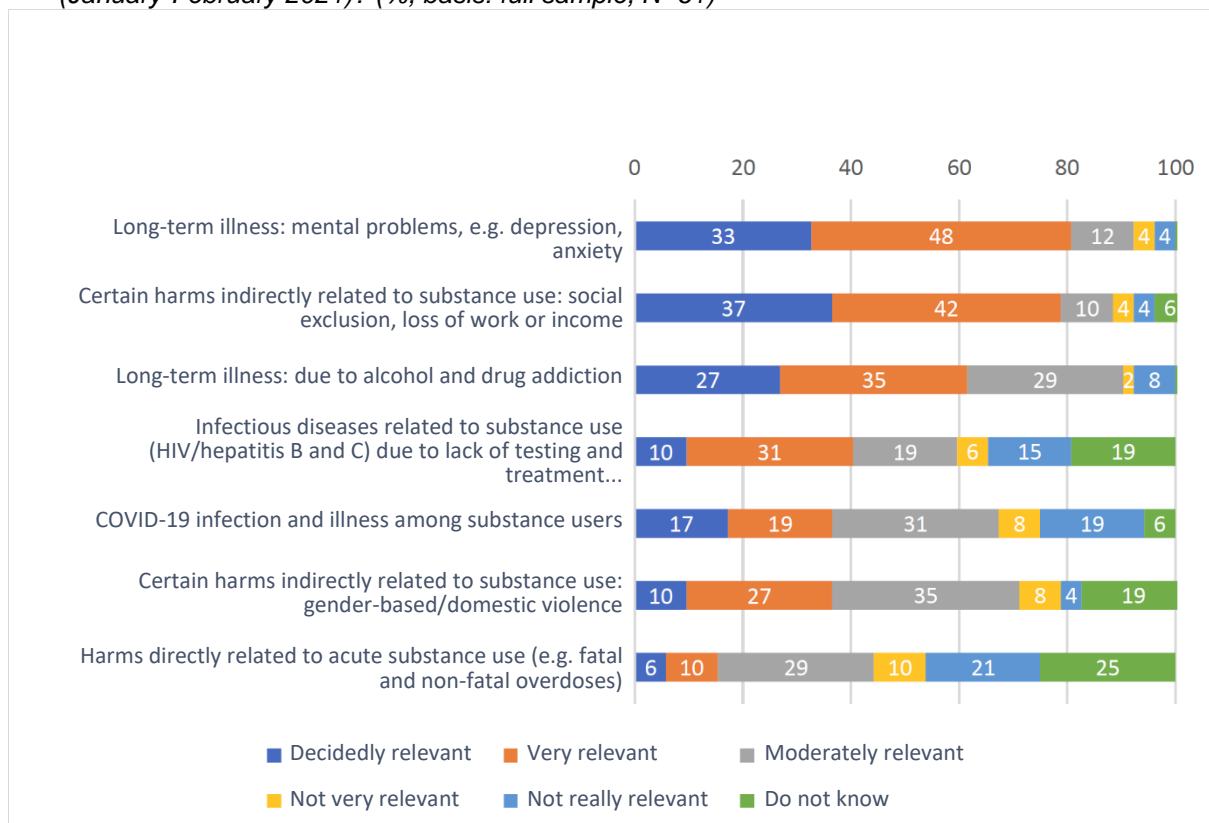
Source: HNFP 2021

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 68. *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

Berényi, A., Batizi, I., Tóth, B. A., Holb, G. (2017): Gyermek- és fiatalkorúak addiktológiai ellátásának az Emberi Erőforrások Minisztériuma által támogatott monitorozása. Forrás Lelki Segítők Egyesülete. 2017. Manuscript.

Csák, R. (2012): A 2011-ben tapasztalt új jelenségek a különböző típusú szolgáltatók megkérdezése alapján. Hungarian National Focal Point. Manuscript.

Egészségügyi Közlöny (2017): Az Emberi Erőforrások Minisztériuma szakmai irányelve a pre-, peri- és posztnatális mentális zavarok baba-mama-papa egységében történő kezeléséről. 2017. issue 4, p. 1120.

Available at:  
[http://www.hbcs.hu/uploads/jogszabaly/2485/fajlok/EEMI\\_szakmai\\_iranyelve\\_a\\_pre\\_peri.pdf](http://www.hbcs.hu/uploads/jogszabaly/2485/fajlok/EEMI_szakmai_iranyelve_a_pre_peri.pdf)

EMCDDA (2000): Treatment demand indicator, standard protocol 2.0.  
<http://www.emcdda.europa.eu/html.cfm/index65315EN.html> (last accessed: 4 June 2019)

Felvinczi, K., Paksi, B., Magi, A., Sebestyén, E. (2017): Az elterelés keretében végzett megelőző-felvilágosító szolgáltatás tartalmának és közvetlen hatásainak vizsgálata – című kutatás első fázisának eredményei. Manuscript.

Horváth, G. Cs., Péterfi, A., Tarján, A. (2011): A kábítószer-fogyasztással kapcsolatos új jelenségek 2010-ben az ellátóhelyek tapasztalatai alapján. Hungarian National Focal Point. Manuscript.

HNFP – Hungarian National Focal Point (2021): Drug use and drug treatment during the second wave of the COVID-19 pandemic in Hungary. until February 2021. Research report.

Paksi, B., Magi, A., Felvinczi K. (2018): Az elterelés keretében végzett megelőző-felvilágosító szolgáltatás tartalmának és közvetlen hatásainak vizsgálata – című kutatás második fázisának eredményei. A szolgáltatások folyamat- és eredményértékelése. Manuscript.

Péterfi A. (2015): Kezelőhely vizsgálat 2015. Hungarian National Focal Point. Manuscript.

Péterfi A., Major M., Dunay M. (2016): Kezelőhely vizsgálat terápiás közösségek körében. Hungarian National Focal Point. Manuscript.

Péterfi A. (2022b): Szubsztitúciós adatgyűjtés 2021. Manuscript.

Péterfi, A. (2022a): TDI data 2021. Manuscript.

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

## **T6.2 METHODOLOGY**

*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 2022a – 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 2021, a total of 77 providers reported data to TDI.

#### *Péterfi 2022b - 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 12 out of the 12 substitution treatment centres identified in the country provided data, providing 100% coverage for treatment centres and an estimated between 90-100% 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<sup>117</sup>

### T0. SUMMARY

#### *Overview of drug-related harms*

With respect to drug-related deaths, over the past 5 years in Hungary there have been some 30-40 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 patterns of use did not cause a change in the number of deaths between 2015 and 2020, with around 35-43 deaths per year. In 2021, there were 42 fatal intoxications and it is still a worrying phenomenon that half of the intoxications involve at least one new psychoactive substance. The role of synthetic cannabinoids was significant in past years, that is a striking phenomenon in a European context (beside Hungary only Germany and Turkey reported deaths cases linked to these substances<sup>118</sup>). In 2021 at least one synthetic cannabinoid (e.g. ADB-BUTINACA, MDMB-4en-PINACA) was identified in 16 cases (2020:34 cases)<sup>119</sup>. Among synthetic cathinones etil-hexedrone and etil-heptedrone were identified in fatal overdoses. However, in cases where several substances are combined, the role of each substance in the cause of death is difficult to determine.

Among the 18-64-year-olds, 6 deaths directly related to drug use occurred in 2021 per one million inhabitants (6.1 cases / 1M people), making it one of the countries with the lowest measured prevalence in Europe in terms of drug related deaths. The prevalence rate in Budapest (12.9 cases / 1M people) far exceeds the rate of the countryside (5.6 cases / 1M people).

Anecdotal information refers to high clinical toxicological treatment demand related to the use of synthetic cannabinoids since 2019.

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 the HCV antibody 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

---

<sup>117</sup> Authors of the workbook: Gergely Csaba Horváth, Anna Tarján, Róbert Csák and Zsófia Almádi.

<sup>118</sup> See EMCDDA: European drug report 2022

<sup>119</sup> In 2020, the cannabinoid 4F-MDMB-BICA was identified in at least 27 fatal poisonings characterized by polydrug use.

survey (with a focus on Budapest) among PWID, 48% of the sample tested positive for HCV antibody.

### *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 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 2021 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 2021 the figure was 39,925. The number of clients dropped from 4624 persons in 2013 to 526 persons in 2021.

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 2021, 42 deaths directly related to drug use were reported to the Special Registry of Drug-Related Deaths, showing a stable situation compared to the previous years (2020: 48, 2019: 43).<sup>120</sup> Out of the 42 deaths, 12 were women (3.9 cases/1 million people), while 30 were men (10 cases/1 million people). In Hungary, there were 6 deaths among 18-64-year-olds per one million inhabitants in 2021 (6.1 cases / 1M people), prevalence rate in Budapest (12.9 cases / 1M people) far exceeds rate of the countryside (5.6 cases / 1M people)<sup>121</sup>.

---

<sup>120</sup> Cases linked to tramadol were excluded.

<sup>121</sup> Per 1 million people, among the age group of '18-64' years.

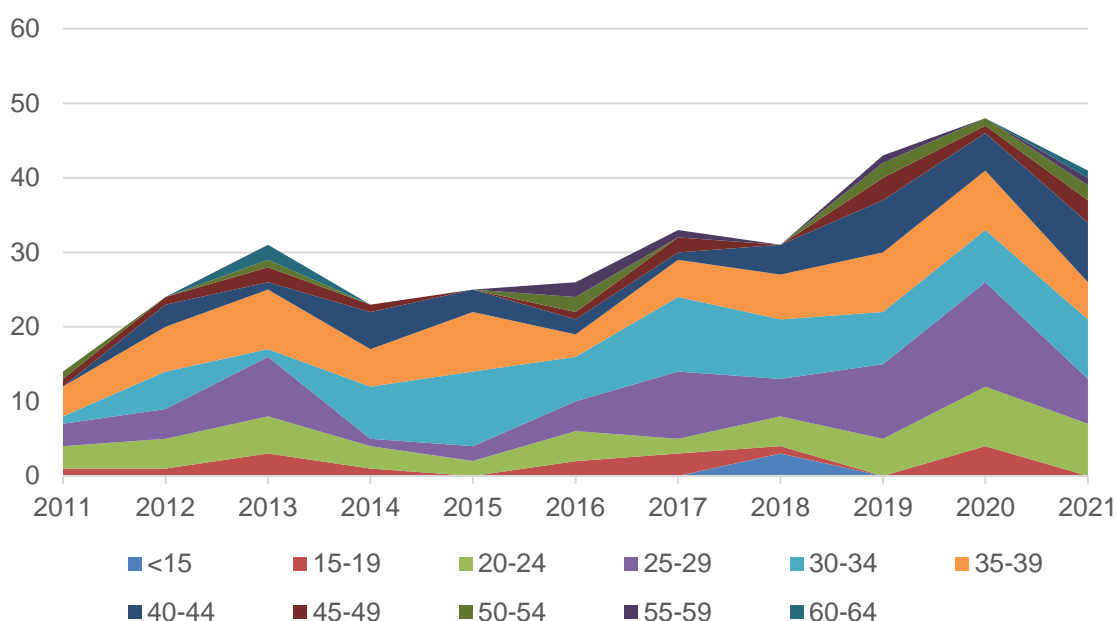
Table 18. Breakdown of direct drug-related deaths in 2021 by gender and substance type (persons)

	male	female	total
intoxication caused by opioids and other substances <sup>122</sup>	11	6	17
intoxication caused by other, non-opioid drugs or new psychoactive substances	19	6	25
unknown/unidentified substance	0	0	0
<b>total</b>	<b>30</b>	<b>12</b>	<b>42</b>

Source: HNFP 2022a

Among fatal overdose cases, the mean age of males was 34.5 years; mean age of women was 41.8, for both groups together the mean age was 36.6 years. The mean age in the case of deaths linked to opioids was 37.2 years, while the mean age in non-opioid cases was 34 years. The mean age of those who died in overdose deaths previously showed a decrease due to the increasing role of new psychoactive substances, but this decrease did not continue in 2021, presumably due to the greater role of opioids. No deceased under the age of 20 was identified in 2021.

Chart 69. Trend of the direct drug-related deaths by age groups between 2011-2021 (cases)



Source: HNFP 2022a

Of the 42 deaths, 14 of the deceased (33.3%) were residents of Budapest. In two cases the deceased were homeless people; in five cases the deceased were villagers, in nine cases they lived in towns; in six cases in cities and in three cases in counties' capitals. One foreigner person was reported among the deaths in 2021.

### Indirect drug-related deaths

In 2021, 78 deaths indirectly related to drug use were reported to the mortality register. In about half of the cases the medical experts detected some illicit substance: in 34 cases in the victims of traffic accidents and in six additional cases in the victims of homicides. 25 cases of suicide were recorded, as well as 12 cases where death could be related to the complications of long-term drug use.

<sup>122</sup> In 2020 in the two cases the deaths were related to methadon use.

### T1.1.2 Toxicology of overdose deaths

There were three deaths exclusively related to heroin use in 2021, while there was no such case in 2020. In 17 of the 42 cases, some opioids were present, which can be described as an increase compared to the previous years: heroin in 5, methadone in 8, while buprenorphine, oxycodone and fentanyl were detected in one-one case each. Other non-opioid drugs (incl. other illicit drugs and NPS) caused intoxication in 25 persons (in 2020: 7 cases). In this category, the most prevalent drugs were synthetic cannabinoid receptor agonists (16 cases), cannabis (10 cases), amphetamines (9 cases), synthetic cathinones (7 cases), cocaine (4 cases), and ecstasy (3 cases)<sup>123</sup>.

Among the direct deaths, there were 21 deaths related to the consumption of a new psychoactive substance, in 12 cases no 'classical' drugs were present. Deaths were typically associated with polydrug use. The most prevalent synthetic cannabinoids were: MDMB-4en-PINACA and ADB-FUBINACA, and among cathinones the most frequently detected substances were ethyl-heptedrone and ethyl-hexedrone. Alcohol consumption may have played a role in 28 cases, and benzodiazepine consumption in 6 cases. In cases related to synthetic cannabinoids, usually two such substances appeared in the samples at the same time.

Table 19. Number of direct drug-related deaths in 2021<sup>124</sup>

<b>overdose/intoxication caused by...</b>	<b>total</b>
<b>heroin/morphine (not including methadone and any other substances)</b>	3
opioids and other substances	14
...of these by methadone only <sup>125</sup>	2
<b>other, non-opioid substances<sup>126</sup></b>	<b>25</b>
...of these by NPS only (SCRAs or cathinones)	12
<b>total</b>	<b>42</b>

Source: HNFP 2022a

### T1.1.4 Trends in drug-related deaths

Regarding drug-related deaths, there have been around 30-40 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 patterns of drug use did not cause a change in the number of deaths between 2015 and 2019, with around 35-43 deaths per year. There were slightly more cases of fatal intoxications recorded in 2020 (48 cases) and in 2021 (42 cases). It is a worrying phenomenon that in the past years the majority of the intoxications involved some kind of new psychoactive substances. In particular, synthetic cannabinoid derivatives played a significant role. In 2020, 34 cases included at least one synthetic cannabinoid (4F-MDMB-BICA, 5F-MDMB-PICA, MDMB-4en-PINACA). In 2021, the most commonly identified synthetic cannabinoids were 4F-MDMB-BICA and MDMB-4en-

<sup>123</sup> Including metabolites indicative of these substances.

<sup>124</sup> According to EMCDDA's protocol of Special Register 'Selection D'.

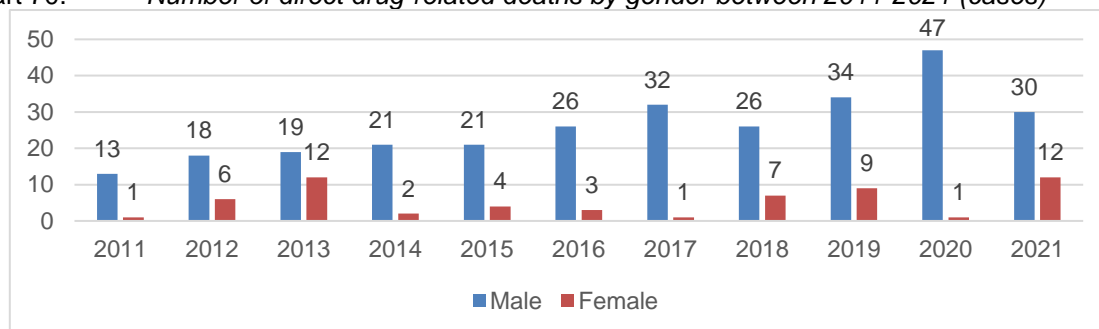
<sup>125</sup> Alongside the occurrence of alcohol and/or benzodiazepines.

<sup>126</sup> Deaths due to new substances identified exclusively for the first time after 2010, regardless of whether the compounds are legally classified as 'narcotic drugs' or 'new psychoactive substances' at the time of death..

PINACA, with 17 of the 42 deaths (40.5%) identifying this type of substances. Among synthetic cathinones etil-hexedrone and etil-heptedrone were identified in the fatal overdoses in a total of 9 cases (21.4%). 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 interpreted to a limited degree, the decrease in the mean age of the deceased people, as seen in the European data, and also in Hungary in the past years, did not continue in 2021 because the share of opioids – that are more prevalent among the older drug users – slightly increased in fatal intoxication cases. The increase in the number of deaths among women in Europe could not be concluded at this stage in the national data.

Chart 70. *Number of direct drug-related deaths by gender between 2011-2021 (cases)*



Source: HNFP 2022a

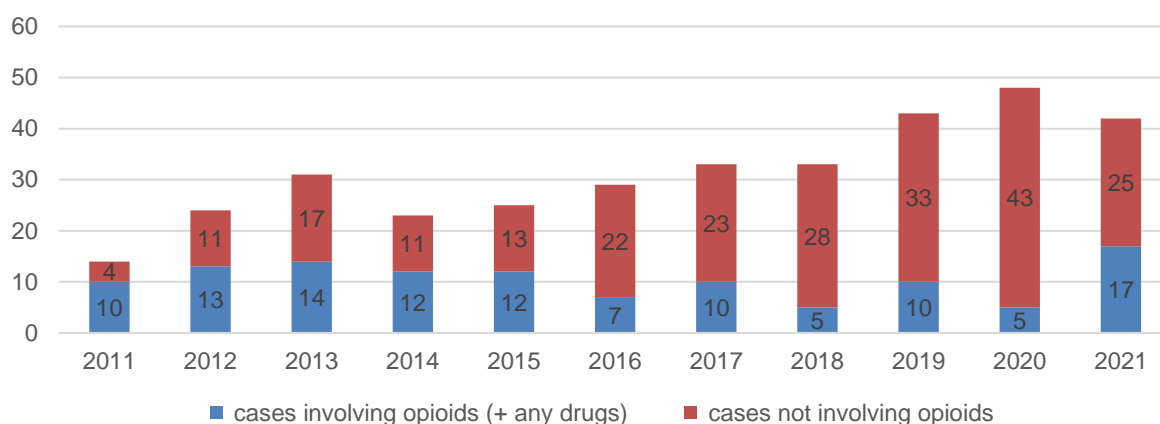
Since 2012, the use of new psychoactive substances can also be seen in the biological samples of the deceased. Initially mephedrone, and then later MDPV, pentedrone and 4-MEC were associated with a number of deaths. Occasionally, the appearance of certain, especially dangerous new psychoactive substances 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  $\alpha$ -PVP and synthetic cannabinoids were detected. In 2015, in addition to pentedrone and  $\alpha$ -PVP, there were several occurrences of  $\alpha$ -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 the most prevalent cathinone but the significance of cathinones decreased in respect of fatal intoxications. 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 latter being the most prevalent cannabinoid still in 2021.

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 based on the data processed for the special registry.

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. In 2019, there was an increase in the number of cases due to 5F-MDMB-PINACA, while in 2020, there was an increase in the number of cases due

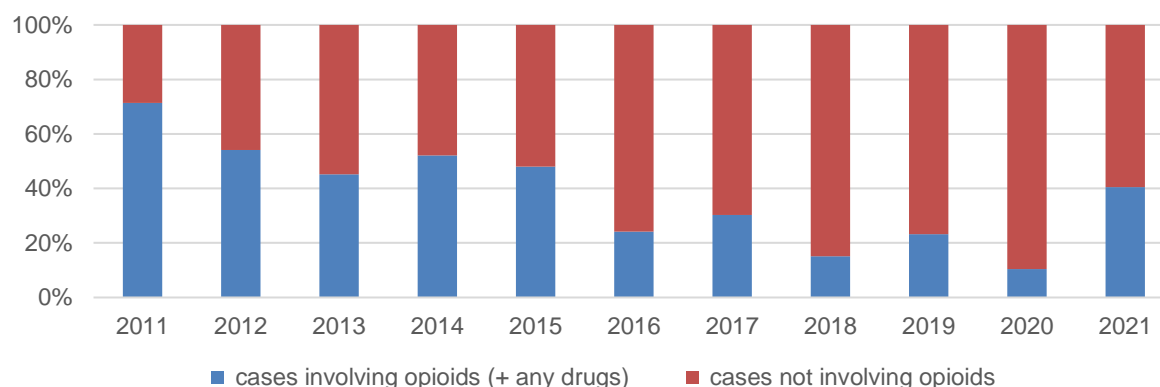
to 4F-MDMB-BICA. In 2021, however, the opposite phenomenon can be seen, the role of synthetic cannabinoids has decreased and that of opiates has increased, while the number of all cases has stagnated.

Chart 71. *Number of direct drug-related deaths by the type of drugs involved between 2011-2021 (cases)*



HNFP 2022a

Chart 72. *Breakdown of direct drug-related deaths among „cases involving opioids” and „cases not involving opioids” between 2011-2021 (%)*



HNFP 2022a

## 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 2021, the number of newly diagnosed HIV-infected persons was 223, the number of acute HBV-infected persons was 14 persons, and the number of acute HCV-infected persons was 10 persons nationally, among the entire population. Regarding HIV-positive persons, according to the physicians reporting no cases identified associated with injecting drug use in 2021. Regarding acute HBV and HCV patients, one case of HCV can be associated with injecting drug use (NNK 2022).

#### *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<sup>127</sup> (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<sup>128</sup> 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**

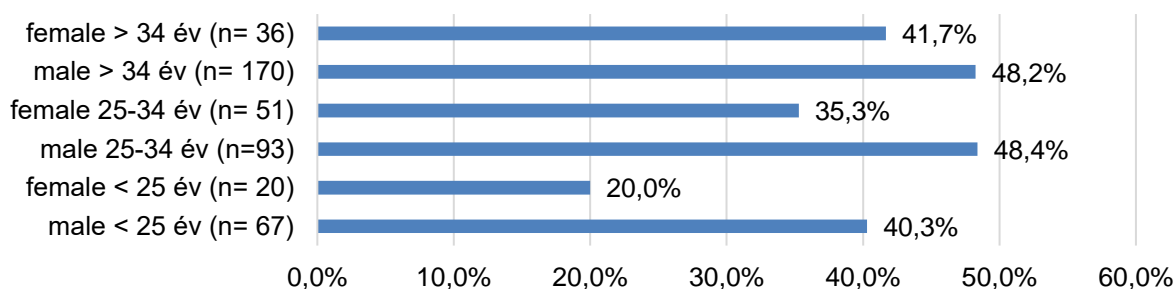
#### *2018 national data*

---

<sup>128</sup> In the case of 1 person out of the total sample (440), the HIV test result was missing.

191 PWID (44%)<sup>129</sup> 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 73. Breakdown of HCV prevalence (%) among PWID tested during the national HNFP-NNK HIV/HCV biobehavioural survey, by gender and age group in 2018



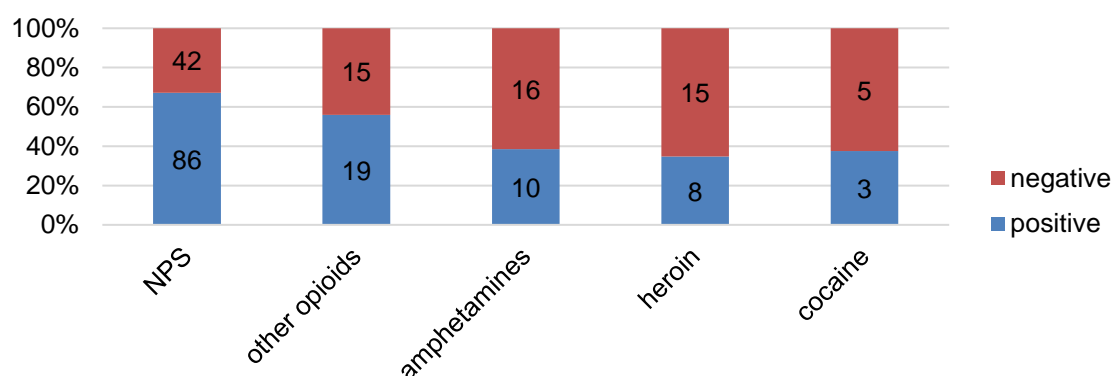
Source: Tarján et al. 2019

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<sup>130</sup> (300 persons) was 47%, while it was 34% among PWID injecting opioids primarily (110 persons). (ST9P2\_2019\_HU\_01)

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 74. 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

<sup>129</sup> In the case of 1 person of the total sample (440 persons), the HCV test result was missing.

<sup>130</sup> synthetic cathinones (street names grouped here: "crystal", "chalk", "music"); methamphetamine (street names grouped here: "Slovakian pikoló"), amphetamine, ecstasy, cocaine, GHB.



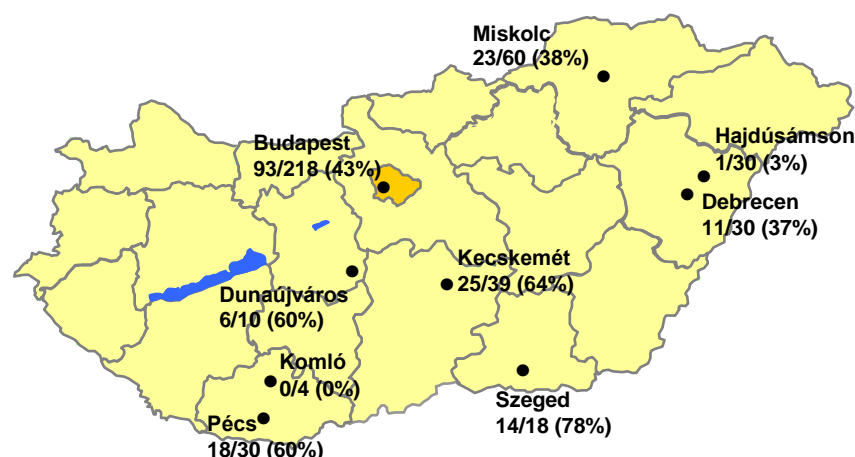
For changing patterns of injecting use,<sup>131</sup> see Drugs/Stimulants/T1.2.5 and Drugs/Heroin and other opioids/T1.2.5; for risk behaviours see below in this workbook.

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%).

---

<sup>131</sup> 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<sup>132</sup>



Source: Tarján et al. 2019

According to the 2019 regional, HIV/HCV biobehavioural 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

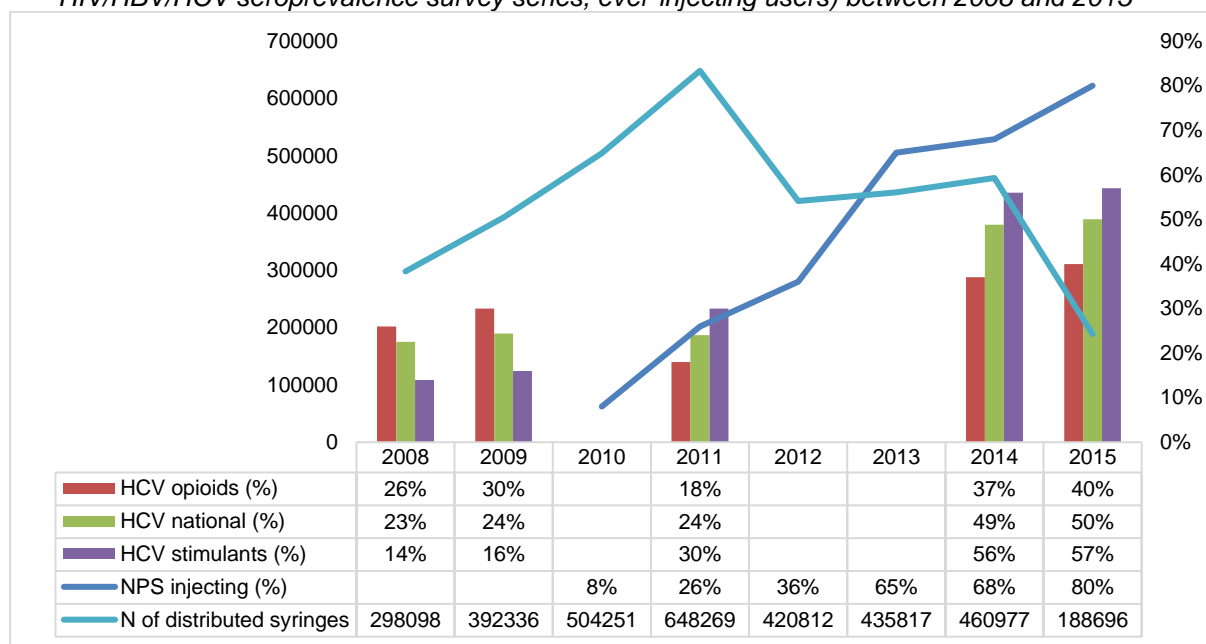
<sup>132</sup> In the case of Hajdúsámson, the service is based in Hajdúsámson, but 21 of the 30 tests were performed in Hajdúhadház and 9 were performed in Hajdúsámson.

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 75. *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*



Source: Tarján 2018

2016-2019:

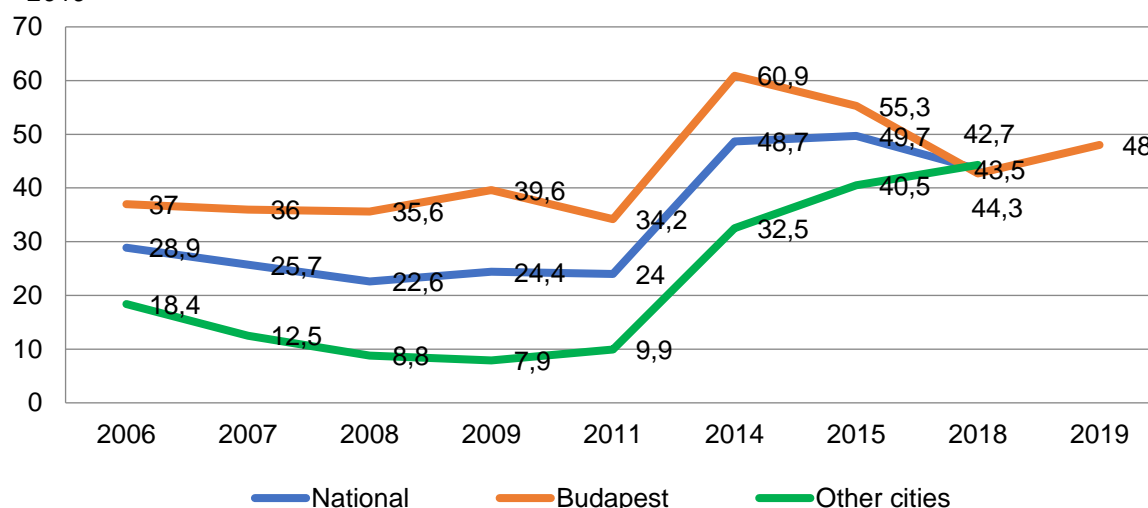
After 2015, it was not until 2018 that a new national HIV/HCV biobehavioural study could be conducted. (HNFP-NNK national HIV/HCV biobehavioural survey 2018, Tarján et al. 2019; for the methodology, see T5.1); however, only some elements, rather than the entire methodology of the National Centre for Epidemiology (OEK) seroprevalence survey series (2006-2015) could be implemented. Given the different methodological features and circumstances of the study<sup>133</sup> (see also T. 5.1.), it can be concluded that in 2018, the previously reached PWID

<sup>133</sup> 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<sup>134</sup>. Although the data collection methodology was different in certain respects<sup>135</sup> 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 76. *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 Budapest results) in Budapest and in cities outside of Budapest, 2006-2019\**



Source: Dudás et al. 2015 and Tarján et al. 2019, Tarján et al. 2020

\*Limited comparability after 2014

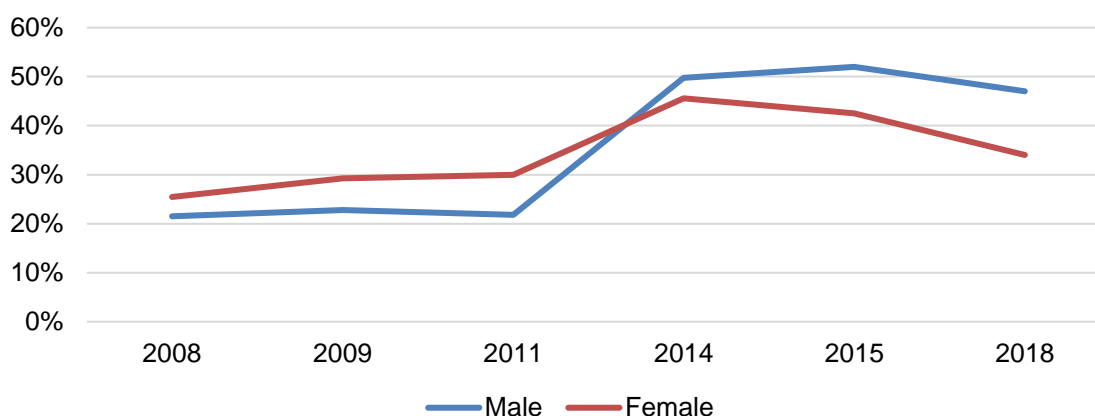
in the selection because of the specific features of the HAREACT project and in order to chiefly reach current PWID. Differences: Participants did not receive incentives (National Centre for Epidemiology (OEK) surveys: meal voucher worth HUF 1000-2000 / EUR 3-6). In 2018, a rapid saliva-based test was 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.

<sup>134</sup> 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.

<sup>135</sup> an incentive was not provided. The presence of HCV antibodies was determined by a rapid saliva test.

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 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 77. *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\**

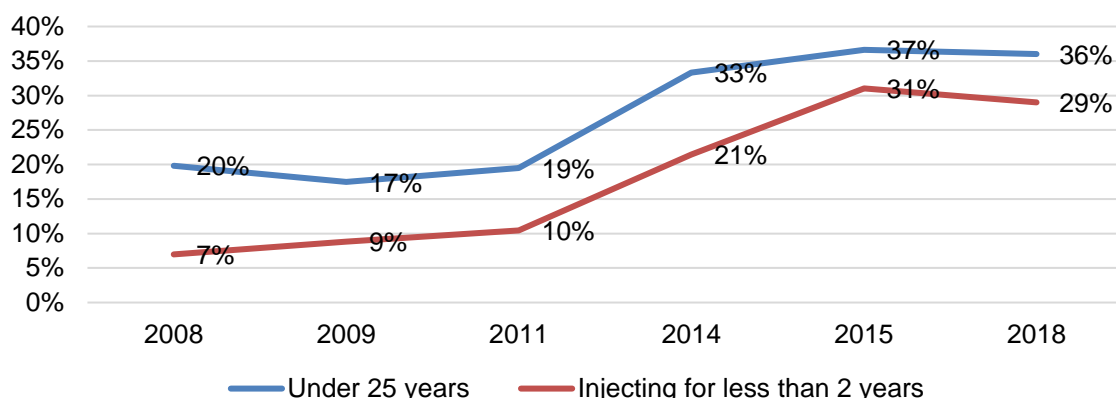


Source: Dudás et al. 2015 and Tarján et al. 2019

\*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 the studied year. 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 78. *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-behavioural studies (Treso et al. 2011 and Ritter 2013) examining the prevalence of HIV / HBV / HCV and related risk behaviours among inmates with a history of injecting drug use are available in the Prison Workbook / chapters T1 .2.2 and T1.3.3.

Since 2021 data were also requested from needle and syringe programmes of the number of people screened for HIV and Hepatitis C in their services and on the number of infected people identified (Tarján 2021a).

In 2021 regarding HIV infection, 899 persons were screened by the reporting organizations (6 organizations reporting out of 32), 5 of them were tested HIV positive (0.6%). In respect of HCV 1345 persons took part in screening (9 organizations reported figures among 32 organizations) and 110 persons tested HCV positive (8.2%). There was a significant increase in the number of screenings compared to 2020 (in 2020, needle and syringe programmes screened 464 people for HIV and 360 people for HCV), this increase is mainly due to the HepaGo organization, which focuses specifically on providing HIV and HCV screening for injecting drug users within the framework of a low-threshold application program. In 2021, the HepaGo program performed 412 HIV screenings and 556 HCV screenings, during which 2 HIV-positive and 62 HCV-positive cases were identified.

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

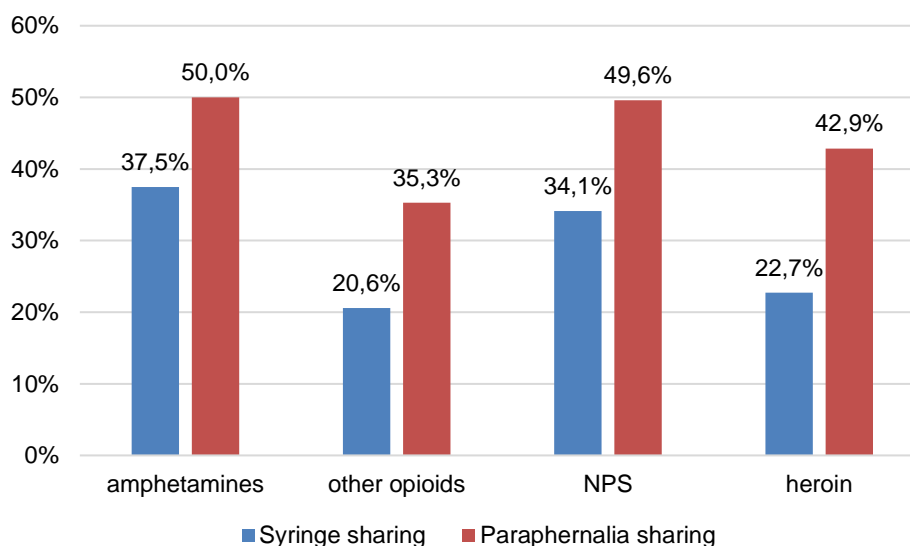
The results of the national HIV/HBV/HCV seroprevalence surveys coordinated by the former National Centre for Epidemiology (OEK) from 2006 to 2015 are summarised under Trends.

#### *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)

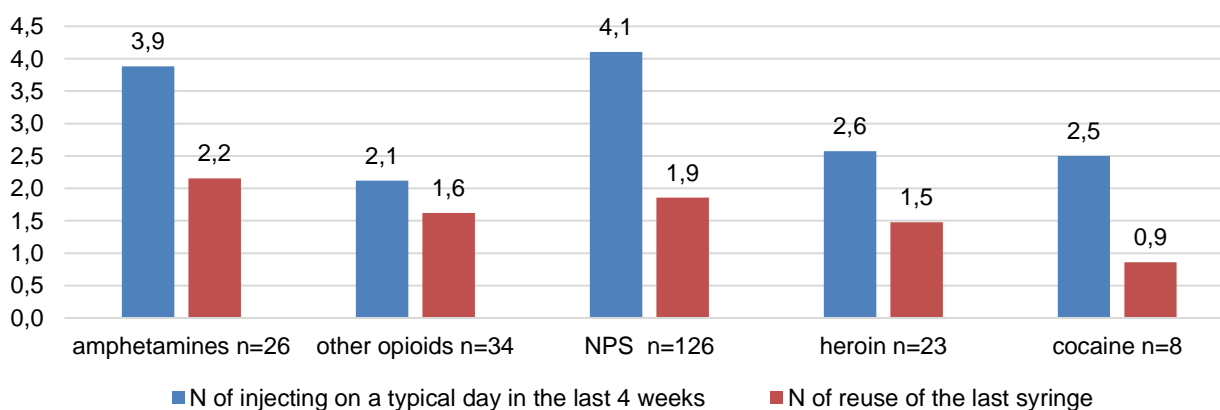
Chart 79. *The prevalence of sharing needles/syringes and sharing any injecting equipment in the last 4 weeks (%) among current PWID participating in the national HNFP-NNK HIV/HCV biobehavioural survey by primary injected substance in 2018<sup>136</sup>*



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 80. *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<sup>137</sup>. 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.<sup>138</sup>

<sup>136</sup> Number of respondents (N): NPS=125; other opioids=34; heroin=21; amphetamine=24.

<sup>137</sup> Injecting once or several times a day

<sup>138</sup> 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.



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 who had had sexual intercourse in the last year had not used a condom during the last sexual intercourse. (ST9P3\_2019\_HU\_01)

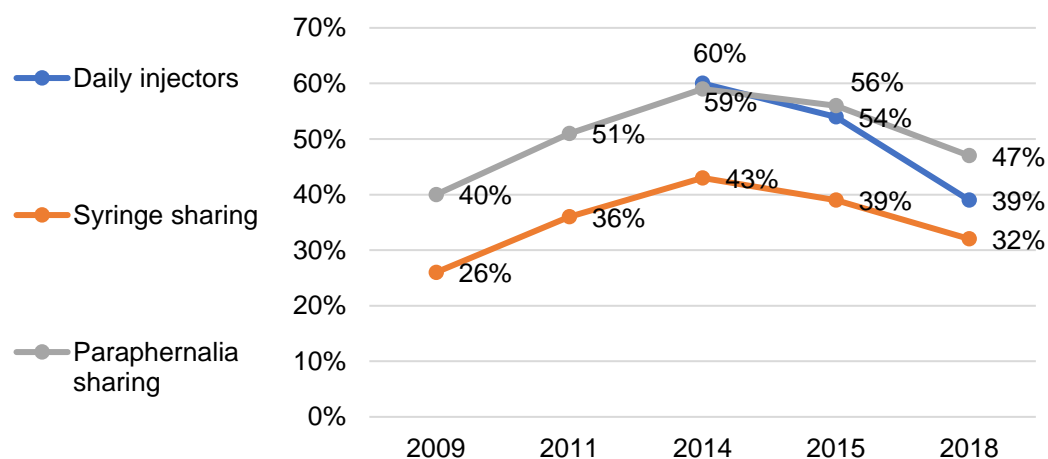
32% of the respondents had lived in a homeless shelter or on the streets without a stable address for more than 1 week during the last year. Nearly every second PWID (42%) had already been in prison. (ST9P3\_2019\_HU\_01)

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<sup>139</sup>, 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 81. *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

<sup>139</sup> 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.



exposure to HIV/HCV infection. For results, see section T1.3.4 of the Harms and Harm Reduction workbook of the 2018 National Report.

#### *Risk behaviours of injecting drug users in Budapest (2020)*

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 drugs in their lifetime. Among them, the prevalence of HIV infection was 7% (4/56 people), while the prevalence of HCV antibody was 55% (30/55 people). 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 respondents (55) were last screened for HIV in 2019 or 2020, while 47% were screened for HCV in 2019 or 2020.

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 the question of treatment outcome: 4 were successful, 1 was in treatment at the time of data collection, and 2 were unsuccessful.

After the COVID related restrictions, based on the answers of 32 respondents, PWIDs obtained their syringes most often in needle and syringe programmes (14/32 people), in pharmacy (10/32 people) or mixed pharmacy and needle and syringe programmes (7/32 people), 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.

### **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**

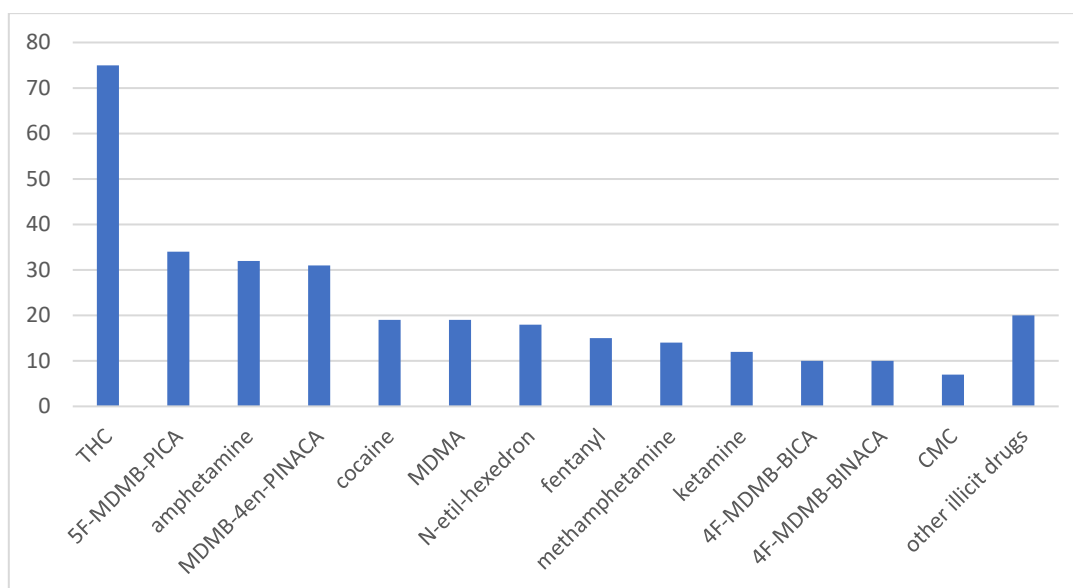
#### *Road accidents*

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 prevalent 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 fentanyl may be connected to emergency care occurring after the accidents.

Chart 82. *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)<sup>140</sup>*

<sup>140</sup> 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.



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.

## T1.5 HARM REDUCTION INTERVENTIONS

### T1.5.1 Drug policy and the main harm reduction objectives

The National Anti-Drug Strategy (for further details see the Drug Policy workbook) that came into force in 2013 expired in 2020. At present there is no strategic document in effect with a focus on drugs problems.

### 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 Slachta Margit Nemzeti Szociálpolitikai Intézet 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)<sup>141</sup>. Low-threshold services

<sup>141</sup> 1 EUR = 365 HUF.

target all kinds of addictions (including alcohol and other dependencies); funding available for drug-related services (and broken down by subtypes) cannot be specified.

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 since 2019.

In 2021 a total of 14 NSPs provided information on sources of funding with respect to a total of 55,740 syringes obtained in the year. The biggest proportion (64%) of syringes was acquired in the scope of a corporate cooperation and only 6% were purchased from the low-threshold services’ fixed funding. (Csák 2022)

### **T1.5.3 Harm reduction interventions**

#### *(a) Testing for infectious diseases*

##### HIV testing<sup>142</sup>

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.<sup>143</sup>

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 centres ‘Anonym AIDS Counselling Centre’ 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.

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 in 2021, HIV testing was available at 7 of the 32 reporting organisations (Csák 2022).

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.

<sup>142</sup> No data is available on the state coordinated HIV testing in 2021.

<sup>143</sup> For the list of testing sites, see <https://anonimaids.hu/hasznos-informaciok/szuroallomasok/>

For further local data please consult T1.3.3. in this Chapter.

#### HCV testing<sup>144</sup>

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<sup>145</sup>.

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 in 2021, HCV testing was available at 10 out of the 32 reporting organisations (Csák 2022).

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,<sup>146</sup> 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 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)

---

<sup>144</sup> No data is available on the state coordinated HCV testing in 2021.

<sup>145</sup> 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.

<sup>146</sup> Decree 60/2003 (X. 20.) of the Ministry of Health, Social and Family Affairs (ESzCsM)

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 2021, 32 service providers operated NSPs in 22 cities, covering 16 counties out of 19 (+ Budapest) and all the 7 regions. Four organisations terminated its NSP in four cities (Debrecen, Hajdúsámson, Komló and Kazincbarcika) (Csák 2022). (17.HU\_ST10\_NUTS\_DCR\_THN (2022)) There were 4 relatively large NSPs in Budapest in 2021, in Districts 10, 7, 2 and 11 (out of 23 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 Prevenációs Alapítvány - Drug Prevention Foundation) only collected used syringes as part of street outreach work, though in 2021 they stopped collecting used syringes as part of their activities; other sterile paraphernalia, excluding syringes, are still distributed at their fixed location programme. 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. They continued their activities with the same focus in 2021, but very few used syringes were collected at the programme during the year.

In 2021, 25 fixed-site NSPs operated in the country (2020: 29); this was the most typical form of needle and syringe provision; however, it should be noted that 9 service providers reported that no one used their services in the year in question. 8 organisations performed street outreach work (2020: 13), 1 organisation ran a mobile NSP (2020: 1), and in 2 cities PWID could purchase syringes from syringe vending machines (2020: 2).

6 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 22 service providers only had one type of needle and syringe service, which was typically a fixed-site NSP.

In 2021, NSPs in Hungary distributed a total of 39,925 sterile syringes (2020: 43,244; (8% decrease). The number of returned and collected syringes was 30,604<sup>147</sup> (2020: 40,037; 29% decrease) The visible decrease in the number of syringes returned and collected is largely the result of the elimination of the street outreach programme of the Drug Prevention Foundation, which collected more than 8,000 syringes in 2020, but in 2021 the organization did not carry out such activities. Since the number of syringes returned and collected decreased more in 2021 than the number of syringes distributed, the exchange rate worsened to 77% for the year 2021 (that was 100% in 2020).

In 2021 a total of 526 PWID used NSP services on a total of 4230 occasions.<sup>148</sup> A total of 127 new clients were registered by the programmes in the course of the year.<sup>149</sup> On average 76

---

<sup>147</sup> Including syringes obtained from syringe vending machines and disposed of in the special waste containers placed near the vending machines.

<sup>148</sup> 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.

<sup>149</sup> 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.

syringes were distributed and 58 returned per client; the mean number of contacts per client was 8 in the year in question. (ST10\_2022\_HU\_01)

According to the breakdown of client and syringe data by programme type, fixed-site programmes distributed the majority of syringes (65%) and reached the majority of clients (80%) in 2021.

Table 20. *Syringe and client numbers of NSPs in 2021*

	fixed site	mobile NSP	street outreach	syringe vending machine	total
<b>distributed</b>	26,134	13,555	1	235	39,925
<b>returned (+collected)</b>	18,604	11,769	105	126	30,604
<b>return rate</b>	71%	87%	10,500%	54%	77%
<b>number of clients</b>	422	103	1	0	526
<b>number of new clients</b>	121	6	0	0	127
<b>number of contacts</b>	3,291	932	7	0	4,230
<b>number of NSPs*</b>	26	1	8	2	32

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

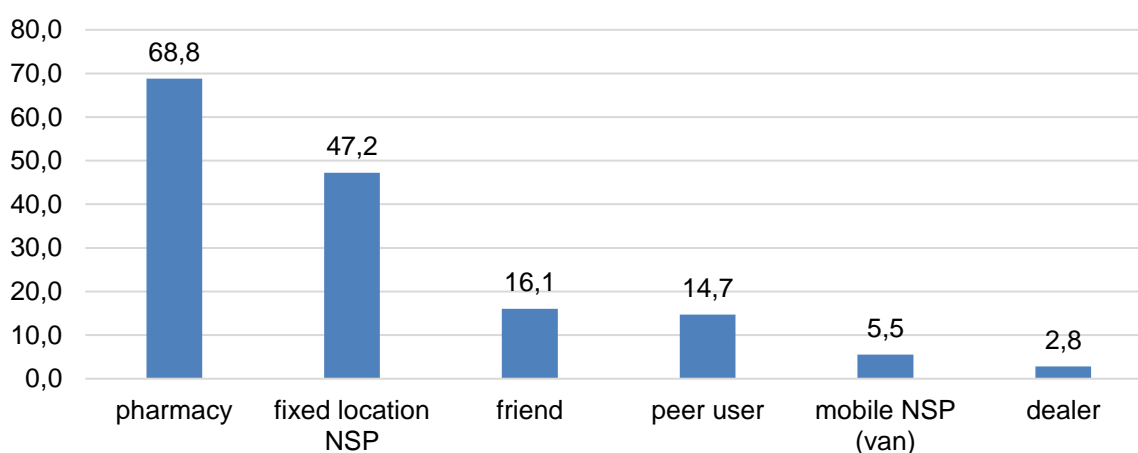
*Source: Csák 2022*

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 2021 as well (Budapest accounted for 78%; 81%; 63%; and 70% 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.

Chart 83. *Source of syringes (%) in the last 4 weeks among current PWID participating in the HNFP-NNK national HIV/HCV biobehavioural survey in 2018150 (N=218)*



*Source: Tarján et al. 2019*

More than half of the respondents identified the pharmacy as their main source<sup>151</sup> 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.

<sup>151</sup> A respondent could name only one location.

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*

In 2021, beside sterile syringes, most NSPs provided condoms (21/32) and counselling on safe injecting (16/32). The majority of NSPs provided pads to disinfect the skin, vitamins and selective counselling about the safe injection of new psychoactive substances.

HIV and HCV testing were offered by 7 (2020: 7) and 10 (2020:8) organisations, and information and support relating to HIV and HCV treatment was available at 6 and 8 organisations respectively out of the 32. The availability of the latter services has decreased compared to 2020, counselling related to access to HIV treatment was provided by 12 organizations in the previous year, while in the case of HCV, 16 organizations provided counselling.

Table 21. *Distribution of injecting and harm reduction equipment and provision of other services by NSPs, in 2021 (N=32)*

Type of equipment/service	N of NSPs providing it	N of equipment or occasions of service use	N of service providers reporting on occasions / equipment
Condoms	21	5424	11
Counselling on safer injecting (oral information)	16	12	2
Pads to disinfect the skin	14	6019	9
Vitamins	14	1391	5
Targeted counselling on NPS injecting (oral information)	13	9	1
HCV testing	10	1102	9
Sterile filters	9	5125	5
Linkage to HCV treatment (by means of counselling and/or case management)	8	70	4
Vein protection cream	7	280	3
Targeted counselling on NPS injecting (written material)	7	9	1
Individual risk assessment	7	0	0
HIV testing	7	854	6
Counselling on safer injecting (written material)	6	5	1
Linkage to HIV treatment (by means of counselling and/or case management)	6	256	2

Sterile mixing container	5	357	2
Citric/ascorbic acid	4	1284	1
Sterile injecting equipment in a pre-assembled package	4	560	2
Foil	3	274	1
Disinfectant for cleaning equipment	3	0	0
Dry wipes	2	1274	1
Tourniquets	2	0	0
Distilled water for dissolving drugs	1	2	1

Source: Csák 2022

Table 22. Coverage of injecting and harm reduction equipment and provision of other services by NSPs, in 2021<sup>152</sup>

	Type of equipment	Routinely available	Rarely available, available in a limited number of settings	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		
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: Csák 2022

#### 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

<sup>152</sup> 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.



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<sup>153</sup>, voluntary, free-of-charge vaccination against hepatitis B has been available to PWID – among other risk groups – since 2007.

#### *h) Treatment of infectious diseases*

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<sup>154</sup>. Drug use is not a contraindication to the initiation of HIV treatment.

In addition to the above centres, the care of diagnosed HIV patients and the treatment of secondary complications caused by the viral infections (e.g. other infections) are provided by general infection clinics with nationwide coverage. (NEAK 2020)

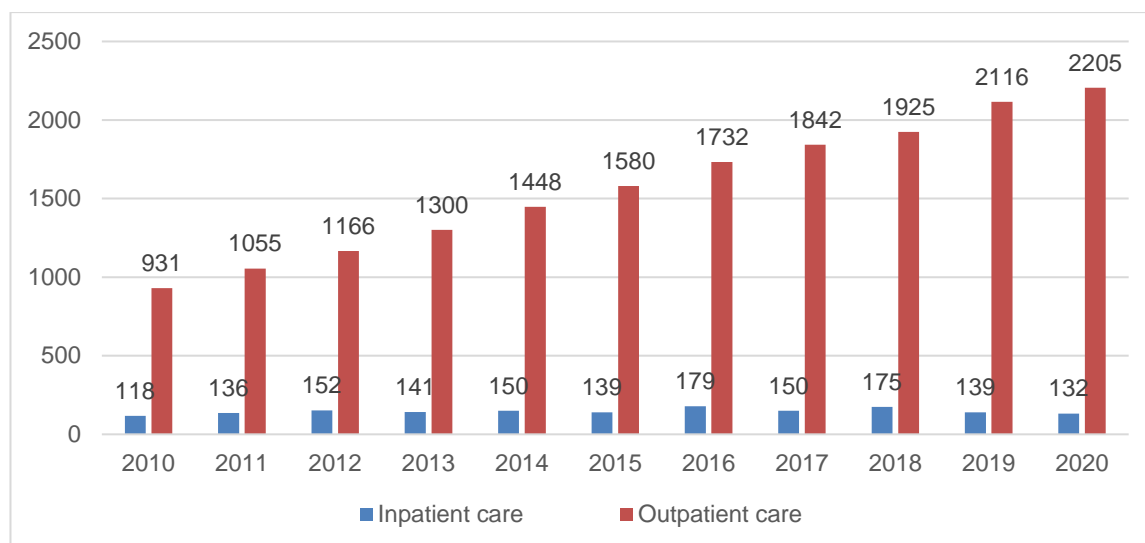
Over the last ten years, there has been a gradual increase in the number of people receiving publicly funded specialist care for HIV. The increase is primarily due to the number of patients in outpatient care. (NEAK 2021)

---

<sup>153</sup> [https://www.antsz.hu/data/cms92651/VML2019\\_NNK\\_2019\\_05\\_08.pdf](https://www.antsz.hu/data/cms92651/VML2019_NNK_2019_05_08.pdf)

<sup>154</sup> "Antiretroviral treatment, vaccination and primary and secondary prophylaxis of opportunistic diseases in adults infected with HIV"

Chart 84. *Number of specialised treatments in HIV indication by treatment modalities in 2020 (person)*



Source: NEAK 2021

Among the total of 2,214 infected people treated in 2020, men represent a much higher proportion (1,945 people, 88%), and the majority of the treated HIV infected people belong to the 30-49 age group (1,325 people, 60%). (NEAK 2021)

According to the NSP data collection, 'counselling and referral to HIV treatment' as a service was available in 6 of the 32 organizations in 2021 (Csák 2022).

### *HCV treatment*

43 hepatology centres are available in the country in 24 cities.<sup>155</sup>

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.

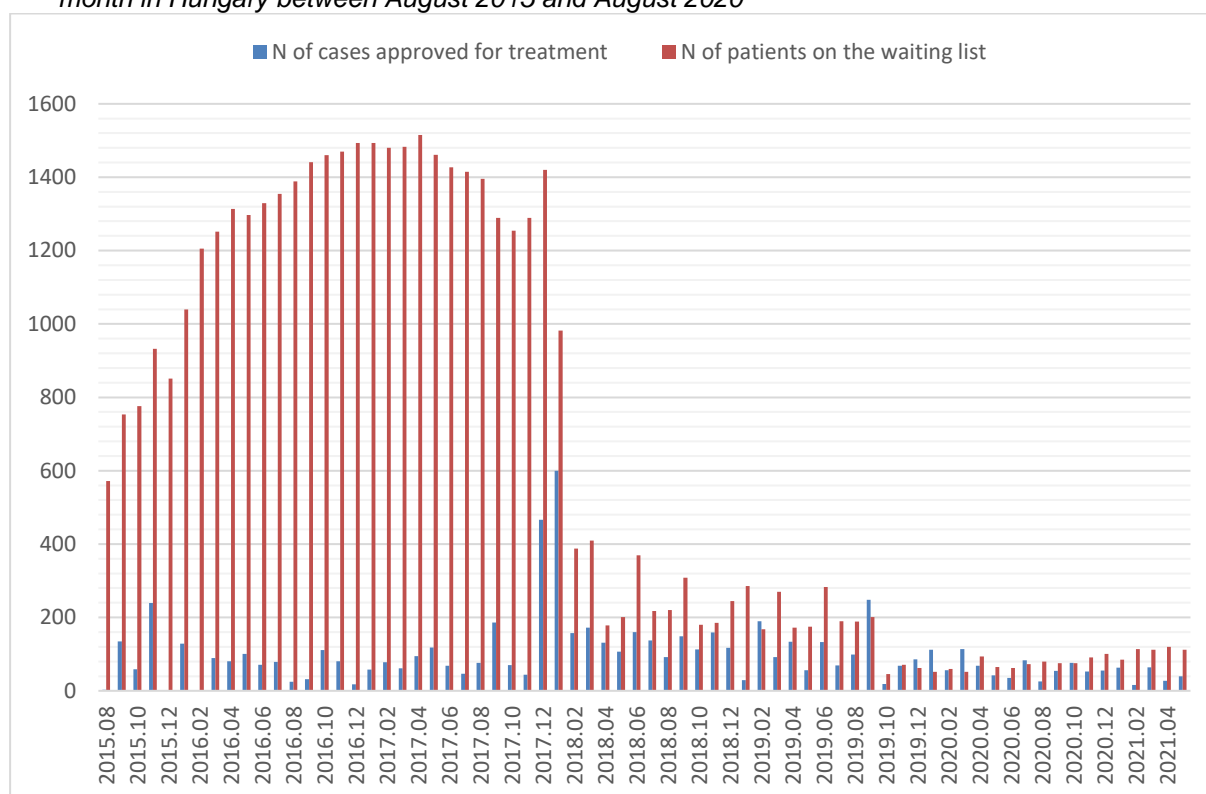
### *HCV treatment in the general population*

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 clients in the previous year. DAA is the first-line treatment and the cost per treatment is under EUR 4000<sup>156</sup>. The allocated budget is sufficient for all patients seeking treatment. An important remaining barrier for PWIDs is to settle their health insurance, which they often lack, before entering HCV treatment.

<sup>155</sup> [https://hepreg.hu/custom/hepreg/doc/hepatologiai\\_centrumok.pdf](https://hepreg.hu/custom/hepreg/doc/hepatologiai_centrumok.pdf)

<sup>156</sup> Personal consultation with the Hungarian National Health Insurance Fund (NEAK)

Chart 85. *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 Prevenció 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, Nyíró 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, 'counselling and referral to HCV treatment' as a service was available in 8 of the 32 organizations in 2021 (Csák 2022).

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). In the scope of the project social workers accompanied 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 the Reitox Hungarian National Focal Point, which records the substance use characteristics and psycho-social status of those participating in the project at key stages of the treatment pathway. Closure of the project was postponed since in 2020 and partly in 2021 client paths were disrupted and new treatments were temporarily not started due to the COVID-19 pandemic and related restrictions. The results of the study are being processed, will be presented in the next year's workbook.

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 2021, 21 out of the 32 NSP service providers distributed condoms (Csák 2022).

### **T1.5.4 Harm reduction services: availability, access and trends**

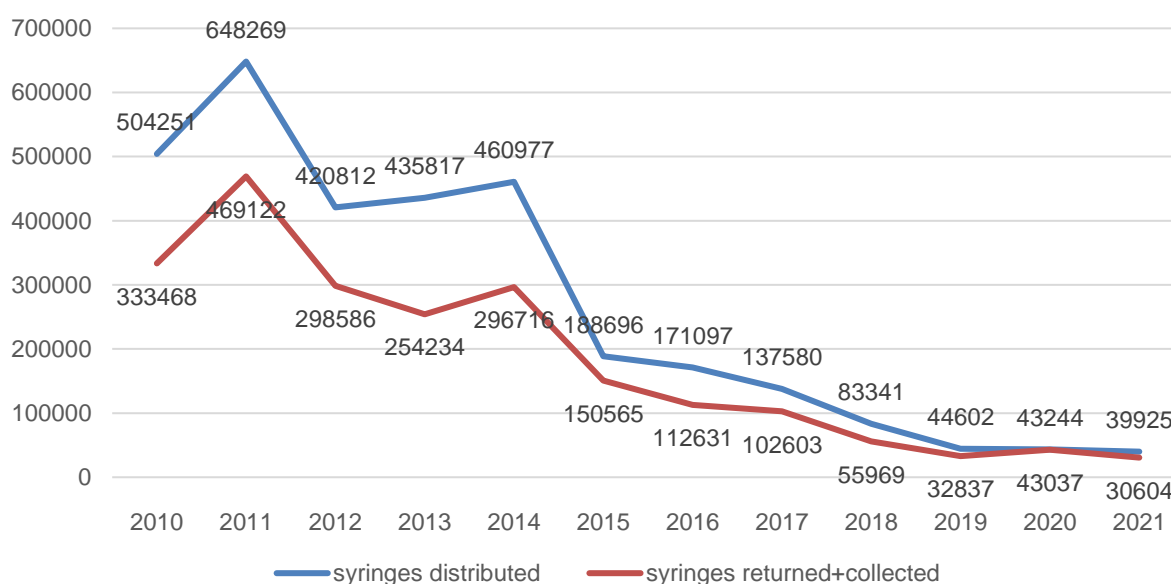
#### *The number of syringes distributed to PWID*

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<sup>157</sup> 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)

In 2021, four programmes discontinued due to lack of clients. In one of the cities where a programme terminated, the service identified drug use but not injecting therefore clients did not expressed a need for injecting paraphernalia. In another city the situation is similar, the overwhelming majority of their clients use non-injecting routes of administration, with very little need for injecting equipment which they can access through another programme (50 syringes in 2021). (Csák 2022)

Chart 86. Syringe-related data of NSPs, between 2010 and 2021



Source: Csák 2022

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<sup>158</sup>. It may be assumed that the restriction of the availability of sterile syringes per day was compensated for by clients with

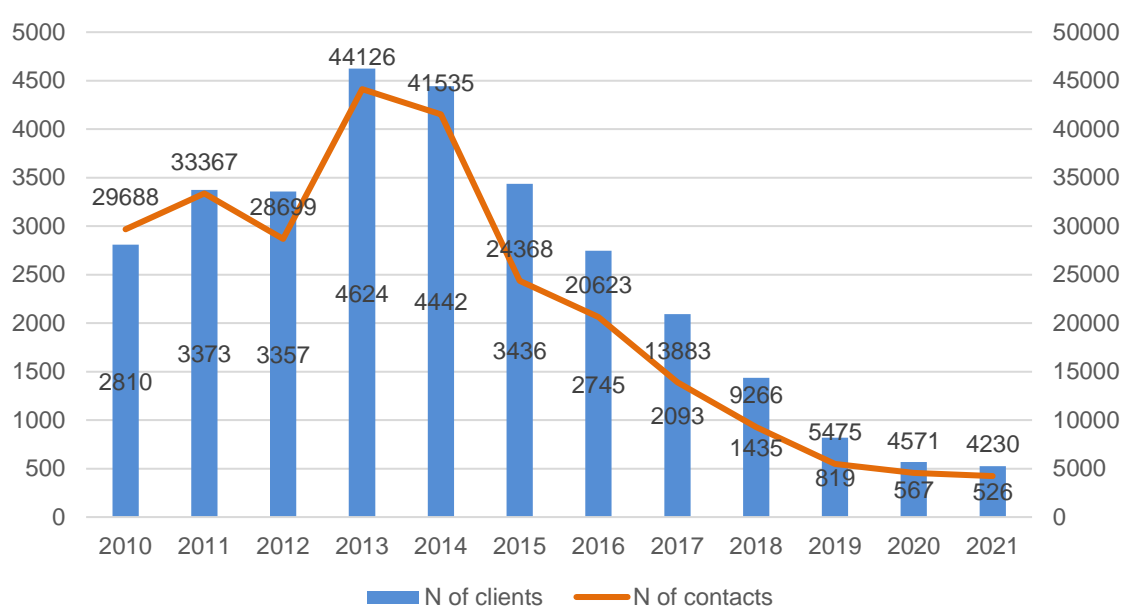
<sup>157</sup> on the basis of information originating from organizations not targeted at drug users (e.g. child welfare and family support services)

<sup>158</sup> 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.

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 2021 due to reasons explained above relating to the decrease in distributed syringes in the same time period. Altogether 526 persons contacted NSPs in 2021 compared to 4624 persons in 2013. The number of contacts dropped from 44,126 in 2013 to 4230 in 2021. While in the earlier years (2011-2016) 1100-1800 new NSP clients were registered annually, in 2021 only 127 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 87. *Number of NSP clients and number of contacts, between 2010 and 2021*



Source: Csák 2022

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 2021 the 78% of distributed syringes and 81% of returned + collected syringes were reported by services located in Budapest. Looking at the trend data by geographical breakdown, it can be concluded that the decline in the total number of NSP clients and the distributed syringes at national level originated from the drop in the access of these services in Budapest. All in all, a decrease was experienced in the number of distributed syringes, in the returned+collected syringes and in the number of client contacts both in and outside of Budapest. Regarding the client turnover the services in Budapest showed a decrease while outside of Budapest an increase. The changes in the turnover may be partly 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.<sup>159</sup><sup>160</sup> Those syringes are now only purchased to a negligible degree for insulin administration<sup>161</sup>, 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.

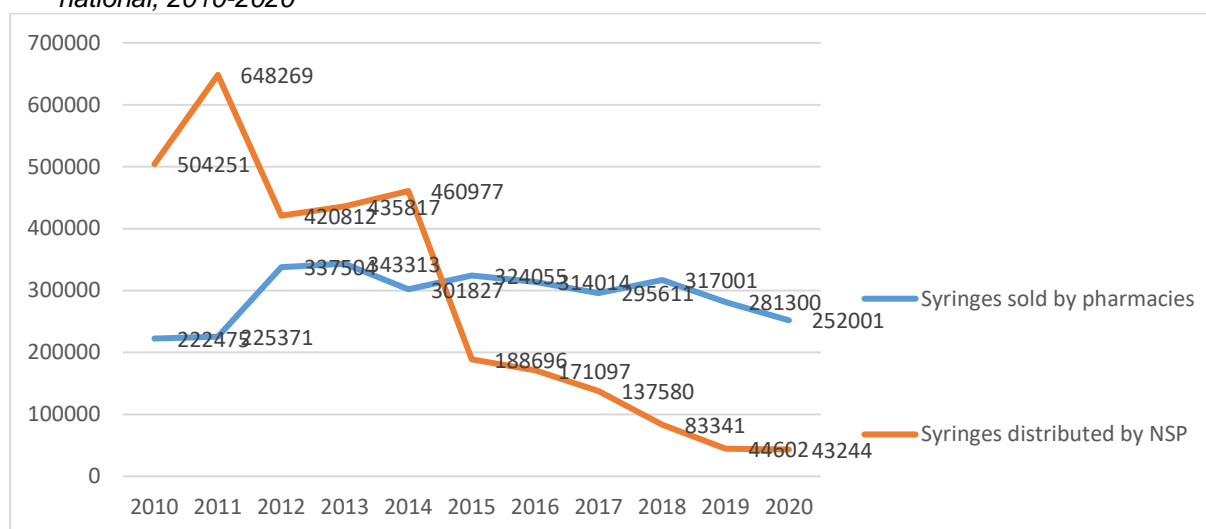
---

<sup>159</sup> 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.

<sup>160</sup> 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

<sup>161</sup> Personal consultation with OGYÉI (National Institute of Pharmacy and Nutrition)

Chart 88. *Number of distributed syringes in NSPs and number of sold syringes in pharmacies, national, 2010-2020*



Source: Hungaropharma and PHOENIX Pharma 2021, Tarján 2021a

### 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<sup>162</sup> 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<sup>163</sup> (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.

<sup>162</sup> Budapest: 4 NSPs and 2 LTSs; Pécs: 2 NSPs; Debrecen, Kecskemét and Miskolc: 1 NSP each

<sup>163</sup> drawn up and funded by the Hungarian National Focal Point



This programme provides services to drug-using pregnant women or women with babies living in District 8 and the surrounding area.

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.

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.<sup>164</sup>

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.<sup>165</sup>

The Academy for Special Parents was established in 2014 within the scope of the Methadone Programme of the Drog Prevenációs 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.

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).

## **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.

---

<sup>165</sup> 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 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). 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**

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

Csák, R., Molnar, I., Sárosi, P., Arsenijević, J., Arsenijević, B. (2019) How the closing of a needle exchange programme affected the access to harm reduction services in two cities, Belgrade and Budapest. Rightsreporter. Manuscript.

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

Dudás, M., Horváth, G., Szabó, R., Tarján, A. (2022): HIV/HBV/HCV biobehavioural study among active injecting drug users using RDS methodology, 2021. Under publication.

EMMI (2018): Szakmai ajánlás szenvedélybetegek alacsonyküszöbű ellátása részére. [http://szocialisportal.hu/documents/10181/154042/005\\_SZAKMAI+AJANLAS\\_szenvedelybetegok\\_alacsonykuszuu\\_ellatasa\\_reszere.pdf/f997c0fa-e28c-1ec2-f887-bf0051854f19/](http://szocialisportal.hu/documents/10181/154042/005_SZAKMAI+AJANLAS_szenvedelybetegok_alacsonykuszuu_ellatasa_reszere.pdf/f997c0fa-e28c-1ec2-f887-bf0051854f19/)

EMMI (2021): Annual report of the Deputy State Secretary for Social Affairs.

Horvath G., Halasz T., Makara M., és Hunyady B. (2015) [New era in the treatment of chronic hepatitis C – novel direct acting antivirals]. Orv Hetil, 156: 841-848.

Hunyady B., Gerlei Zs., Gervain J., Horváth G., Lengyel G., Pár A., Péter Z., Rókusz L., Schneider F., Szalay F., Tornai I., Werling K., Makara M. (2018): Hepatitis C-vírus fertőzés szűrése, diagnosztikája, antivirális terápiája, kezelés utáni gondozása. Central European Journal of Gastroenterology and Hepatology, Vol 4, 2: 53-68.

Kaló Zs., Szabó R., Bálint R., Péterfi A., Port Á., Szatmári D., Tarján A., Horváth G. (2018): Az új pszichoaktív szerek monitorozása kulcsszakértők bevonásával Magyarországon 2017-2018-ban. Hungarian National Focal Point. Research report, manuscript.

NFP (2016): Tűcsere szolgáltatók országos találkozója. Nemzeti Drog Fókuszpont.

NEAK (2020): AIDS elleni világnap. [http://neak.gov.hu//data/cms1027815/AIDS\\_Elleni\\_Vilagnap\\_\\_\\_\\_december\\_1.pdf](http://neak.gov.hu//data/cms1027815/AIDS_Elleni_Vilagnap____december_1.pdf) (Utolsó hozzáférés: 2020. 12. 15.)

NFP (2021a): Kábítószer-fogyasztással összefüggő halálozási adatok 2020-ban.

HNFP (2022a): TDI drug-related mortality module: Special Mortality Register – number of drug-related deaths in 2019.

NSZKK (2020b): Kábítószer/pszichotróp anyag/új pszichoaktív szer jelenléte a közúti balesetekből származó vér- és/vagy vizeletmintákban 2019-ben. NSZKK.

Oberth J., Bíró Zs., Mándi B. (2020): Beszámoló a Józan Babák Klub 2019. évi várandósgondozási tevékenységéről

Hungaropharma és PHOENIX Pharma (2020): A gyógyszertárak fecskendő eladási adatainak alakulása 2010-2020.

Szocokos (2021): Szociális ágazati tájékoztató közösségi portál. [http://tamogatoweb.hu/letoltes2020/2021kvty\\_melleklet.pdf](http://tamogatoweb.hu/letoltes2020/2021kvty_melleklet.pdf) (Utolsó hozzáférés: 2022.01.10.)

Tarjan, A., Dudas, M., Wiessing, L., Horvath, G., Rusvai, E., Tresó, B., & Csohan, A. (2017). HCV prevalence and risk behaviours among injectors of new psychoactive substances in a risk environment in Hungary – An expanding public health burden. Int J Drug Policy, 41, 1-7.

Tarján A., (2018). A hazai intravénás szerhasználók HIV/HCV-fertőzéssel összefüggő kockázati tényezői 2008-2015 között. Doctoral thesis. Available at:

[http://phd.semmelweis.hu/mwp/phd\\_live/vedes/export/horvathtarjananna.d.pdf](http://phd.semmelweis.hu/mwp/phd_live/vedes/export/horvathtarjananna.d.pdf); short version in English: [http://phd.semmelweis.hu/mwp/phd\\_live/vedes/export/horvathtarjananna.e.pdf](http://phd.semmelweis.hu/mwp/phd_live/vedes/export/horvathtarjananna.e.pdf) (last accessed: 17 September 2018)

Tarján A. (2021a): Tűcsere programok adatai, 2020. Manuscript. Hungarian National Focal Point.

Tarján, A (2020b): A rekreációs szintéren ártalomcsökkentő/prevenációs tevékenységet végző szervezetek 2019. évi működési és forgalmi adatai. Hungarian National Focal Point.

Tarján A., Dudás M., Rácz J., Horváth G., (2019): HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalenciavizsgálata a hazai intravénás szerhasználók körében 2018-ban. Under publication.

Tarján A., Dudás M., Horváth G., (2020) HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalenciavizsgálata a budapesti és kecskeméti intravénás szerhasználók körében, 2019-ben. Under publication.

Tarján, A., Kovács, E., Galló, R., Tóth D., Takács, S., Sabjanics, A., Rácz, R., Szabó, R. (2021) HEPAGO-NFP budapesti HIV/HCV biomagatartás vizsgálat. Under publication.

Vincziczki, Á., 2020 „NEAK tájékoztató”, Hepatológia 2020 konferencia, Visegrád

## T5.2 METHODOLOGY

DRD:

*Drug-related mortality (HNFP 2022a):* 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<sup>166</sup>. 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 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

---

<sup>166</sup> Number of samples received after removing duplicates and subtracting invalid questionnaires.

(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.

*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 (Csák 2022): In 2022 too, NSPs (100% coverage) reported their 2021 data via the internet-based data collection tool set up and operated by the Reitox Hungarian National Focal Point. The organisations have been providing data to the Reitox Hungarian National Focal Point through this interface since 2008 on the number of syringes provided (based on categories set in ST10) and returned, collected, the provision of other harm reduction services and their syringe supply management, as well as about the number and demographic characteristics and injecting patterns of their clients. Management, quality assurance and analysis of the national, aggregate data are carried out by the Reitox Hungarian National Focal Point. Double counting control is carried out by the reporting services; therefore, the same client may be registered at more than one NSPs.)

### **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 et 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.



### 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 Forensic Institute of National Tax and Customs Administration (NAV SZI) performs 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% between 2019 and 2021.

In Hungary, large quantities of narcotics are less likely to be cultivated or produced; only small plantations or labs have become known to the authorities. Hungary is mostly considered as a transit country with many trafficking routes going through its territory. 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 5000 and 7000, a striking number of cases were recorded in 2018 (more than 8500 cases). The largest proportion of cases are related to cannabis (2021: 55.1%) while a smaller proportion to amphetamine type stimulants (2021: 28.0%). 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 prevalence. The large majority of drug related offences are consumption-related 77.2%. The proportion of supply-related offences was 22.2% in 2021.

Procedures to reduce drug supply were set out in the National Anti-Drug Strategy, which expired in 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<sup>168</sup>. In 2021 in the scope of the procedures launched due to the 184 discovered cannabis cultivation sites, a total of 4701 plants were seized. The presence of smaller plantations is also confirmed by the fact, that less than 4% of the discovered plantations involved more than 100 plants (NSZKK 2022a).

The production of synthetic substances is not widespread in Hungary, in 2021 no illicit synthetic drug laboratories had been discovered.

---

<sup>167</sup> Authors of the workbook: Bálint Réka, Edina Bánfai and Tamás Csesztregi

<sup>168</sup> In the case of cannabis plantation seizures, it is possible to launch criminal procedures only on the basis of an analysis performed by a botanical specialist. The police authority involved has information on the amounts seized.

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 smuggled amphetamine base smuggled in liquid format ("amphetamine oil"), in 2021 a total amount of 20 kg "amphetamine oil" was seized in 8 seizures. In 2 cases, larger quantities of methanol (100 litres in total) and sulphuric acid (2.5 litres in total) were seized (NSZKK 2022a).

In 2021 8 acetone seizure cases happened. In all of the 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 in 2021. (NSZKK 2022a)

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

According to the data provided by the National Police Headquarters (ORFK) (in previous years based on the reports of the Ministry of Interior (BM)) 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, trafficking to several European countries occurs through local criminal organizations (BM 2021). Despite the fact that Röszke is the first external Schengen border crossing the Balkan route is ideal for drug smugglers, due to its proximity to the highway and the significant passenger and freight traffic associated with it, the national authorities found that in the past period very little cannabis was seized on this rout (ORFK 2022).

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 is partly 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. The control of these 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 new 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 amphetamine and MDMA trade is typically in the hands of Hungarian individuals, and the number of Darknet orders is increasing (ORFK 2022). 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 counties bordering Slovakia (ORFK 2022). The majority of heroin users switched to the use of new psychoactive substances from 2010, but this did not mean that Hungary's role in heroin transit had been drastically changed. 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 users and dealers in Hungary. The place of origin, smuggling routes and methods of cocaine can be diverse: shipments arriving to Europe get to Hungary usually from Spain and the Netherlands. Although, smuggling directly from South America by drug mules swallowing the packages also remained typical. Furthermore, it is important to note that drug mules 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 organized crime group called the "Balkan Cartel" is very strong in the region. In addition, purchasing cocaine from the Darknet is also an identified route of acquisition in Hungary. (BM 2019)

In most cases, new psychoactive substances are ordered online directly from China, and to a lesser extent from India. Ordering via open-access websites, through chat rooms and in

various closed groups (Facebook, Instagram, etc.) are also prevalent. The control of these purchases with the available law enforcement resources is difficult and also time-consuming (ORFK 2022).

Based on the general experiences of investigations in drug cases, it can be established that in the relevant time period the primary method for drug smuggling is via vehicles and, especially on the Balkan route, via trucks. Smuggling with drones has also appeared in Hungary as a new method. In addition to the use of their own vehicles (trucks), traditional courier services are still generally used. We do not have specific data on the destination country of drug shipments seized in Hungary arriving from the Balkan region, more specifically from Serbia. However, it can be stated, that based on the information obtained during the interrogation of the suspected perpetrators and the information generated during the criminal detective work, in addition to the transit through the country, a significant amount of drugs ends up in the hands of local criminals engaged in distribution activities. The small scale drug mules living along the Serbian-Hungarian border are usually dual citizens (Hungarian and Serbian) and typically live in poor financial conditions (ORFK 2022).

Within the organization of the NAV, the detection activity is supervised by the Law Enforcement Department. Based on the seizure data registered by this department, in 2021, violations related to narcotic drugs, psychotropic and new psychoactive substances were detected in 1114 cases. Among these detections, 685 cases were related to drug possession, 146 to misuse of a new psychoactive substances, while 283 cases can be linked to facilitating narcotic drug production. These cases were handed over to the regionally competent police authority. 98% of the detections were carried out in air traffic: in 2021, a total of 1,095 cases were related to narcotic drugs, psychotropic substances or new psychoactive substances. Of these, 666 cases were related to possession, 146 cases were related to misuse of new psychoactive substance and 283 cases to facilitating narcotic drug production. Based on the data, it is clearly visible that the perpetrators of drug-related violations most often use the services of the universal post or courier service providers. In all cases the proceedings were initiated against an unknown perpetrator (NAV 2022).

### **T1.1.3 Trafficking within the country**

Based on the experiences of regional bodies of the police, it can be generally said that regarding smaller quantities the dealers are able to hand them over anywhere, while regarding larger quantities indoor places and apartments are more preferred. Frequent places for drug handover between dealers and couriers are gas stations' parking lots, underground garages of shopping centres, and garages used as parking places for vehicles used for smuggling, especially if the drug needs to be removed from a hidden place (ORFK 2022).

### **T1.1.4 Wholesale drug and precursor market**

Regarding wholesale trafficking, seizures data show that the transit trafficking of heroin through Hungary became significant since 2016. In 2021, about 13 kg powder, containing heroin was seized (NSZKK 2022a).

Regarding precursors, there was one big MAPA (Methyl-alpha-phenyl-acetoacetate) seizure in 2021 (the seizure took place in 2020 but the analytical confirmation of its content in 2021). The authorities found a total of 2 tons of MAPA powder in 80 packages in a shipment from Hong Kong (NSZKK 2022a)

### T1.1.5 Retail drug market

#### *Street prices*

The Reitox Hungarian National Focal Point, in collaboration with the INDIT Foundation conducted an online survey on the retail prices of drugs in the spring of 2022 (Bálint 2021, for the methodology see T5.2) (ST\_16\_2021\_HU\_01). Unlike previous years, the survey was online, the respondents were recruited (with convenience sampling) on social media by the INDIT Foundation. The inclusion criteria for participation were the consent to participation, an age of 18 or over and being a resident of Hungary. Participation in the study was anonymous and voluntary. With the online data collection it was possible to reach a significantly larger sample than in previous years, when data was collected with the cooperation of treatment facilities, therefore we had a larger amount of valid answers for each drug type. However, it is important to note that due to the nature of the sampling, the results of the study are not representative. 69% of those who completed the survey were men, while 30% were women, and 1% did not answer this question. In terms of age distribution, the majority of respondents belonged to the 18-24 age group, followed by the 25-29 age group. Regarding older users, the fewer people filled in the questionnaire, with only 4% belonging to the age group of 45 and older. According to the place of residence, almost half of the respondents were from Budapest (47%), followed by Pest county (12%) and Baranya county (8%). The fewest respondents were from Tolna county (4 responses). Apart from the classical drugs, the questionnaire also asked about the prices of designer stimulants (known on the street name “crystal”) and synthetic cannabinoid (herbal mixtures treated with synthetic cannabinoids, known on the street name “bio” or “herbal”) when last purchased.

The most common street prices for cannabis derivatives such as herbal cannabis and cannabis resin were 9.8 EUR while Ecstasy and amphetamine cost around 8.4 EUR. The most common price of synthetic cannabinoids in herbal format (g) in 2021 was 3 EUR, while of designer stimulants (g) 13.9 EUR.

Table 23. *Retail drug prices in 2022 in HUF*

<b>substance</b>	<b>lowest</b>	<b>highest</b>	<b>mean</b>	<b>mode</b>	<b>sample</b>
herbal cannabis(g)	2 500	5 000	3 404	3 500	635
cannabis resin(g)	2 500	6 000	4 556	3 500	239
heroin (g)	15 000	30 000	26 615	30 000	13
heroin (packet)	4 000	20 000	10 000	5 000	9
cocaine (g)	20 000	40 000	27 747	30 000	295
amphetamine (g)	2 000	6 000	3 193	3 000	396
methamphetamine (g)	2 800	25 000	9 008	3 000	43
ecstasy (1 tabl.)	1 500	5 500	2 941	3 000	452
MDMA crystal (g)	5 000	25 000	14 158	15 000	146
synthetic cannabinoids (g)	500	2 000	1 196	1 000	35
synthetic cannabinoids (cigarette)	100	1 000	578	500	27
designer stimulants (g)	2 500	15 000	7 323	5 000	62
methadone (20mg)	1 500	5 000	2 944	1 500	9
methadone (5mg)	500	2 000	1 100	500	5
LSD (1 dose)	2 000	7 000	3 387	3 000	180
magic mushroom (g)	2 000	6 000	3 182	3 000	249
ketamine	4 000	25 000	15 492	20 000	112

Source: Bálint 2022

Table 24. Retail drug prices in 2022 in EUR<sup>169</sup>

substance	lowest	highest	mean	mode	sample
herbal cannabis (g)	7	13.9	9.5	9.8	635
cannabis resin(g)	7	16.7	9.9	9.8	239
heroin (g)	41.8	83.7	71.5	83.9	13
heroin (packet)	11.2	55.8	27.9	13.9	9
cocaine (g)	55.8	111.6	77.4	83.7	295
amphetamines (g)	5.6	16.7	8.9	8.4	396
methamphetamines (g)	7.8	69.7	25.4	8.4	43
Ecstasy (1 tabl).	4.2	15.3	8.2	8.4	452
MDMA crystal (g)	13.9	69.7	39.5	41.8	146
synthetic cannabinoids (g)	1.4	5.6	5.6	3.3	35
synthetic cannabinoids (1 cigarette)	0.3	2.8	2.8	1.6	27
designer stimulants (g)	7	41.8	41.8	20.4	62
methadone (20mg)	4.2	13.9	13.9	4.2	9
methadone (5mg)	1.4	5.6	5.6	1.4	5
LSD (1 dose)	5.6	19.5	19.5	8.4	180
magic mushroom (g)	5.6	16.7	16.7	8.4	249
ketamine	11.2	69.7	69.7	55.8	112

Source: Bálint 2022

### Purity

The active substance content of the seized substances in 2021 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 methamphetamine. The powders, typically diluted with dimethyl sulfone, often contained less than 5% methamphetamine.

Substances have appeared containing high percentage of cannabidiol (CBD) and low THC among hemp-derived drugs on the Hungarian black market in 2020. These materials did not disappear from the black market either in 2021. In many seizures, the plant material contained only small amounts of delta-9-THC, along with large amounts of CBD content. CBD-dominant herbal cannabis samples with synthetic cannabinoids have also appeared. In two instances, CBD dominant, low THC hashish samples contained the synthetic cannabinoid ABD-FUBINACA. In several cases, there were branch endings that did not show the usual cannabinoid profile, meaning that they contained cannabinoid components that are otherwise naturally present in the plant, but which were not previously seen in this type of herbal materials.

Among new psychoactive substances consumed in powder form, typically sold under the street name “crystal”, similarly to 2020 ethyl-hexedrone was the most dominant substance in 2021. In several cases, cathinone derivatives have been marketed undiluted, but in many instances lower-dose formulations are also present.

In 2021, as in the previous years, the typical purity of herbal fragments treated by synthetic cannabinoids fell between 0.1 and 5%. Last year, herbal materials appeared also with more than 5% of synthetic cannabinoid concentration. The same tendency can be observed in the

<sup>169</sup> The prices in the table were calculated using the EUR intermediate exchange rate valid for 2021 (EUR 1=HUF 358.5).

case of sheets of paper impregnated with synthetic cannabinoids, typically seized in prisons. In previous years the purity of these fell into the range of 0.1-4%, but in 2021 products with a 7-8% purity also appeared. Similarly to previous years, the cases where unprocessed or undiluted synthetic cannabinoids were seized from drug users in small batches were also prevalent. The most common format of these were the yellow sticky substance or sticky, lumpy powder containing ADB-Butinaca and MDMB-4-en-Pinaca. In 2020, the most typical active agent in powders containing synthetic cannabinoids was 5F-MDMB-PICA. The occurrence of 5F-MDMB-Pica on the black market decreased significantly in 2021, probably due to its classification as narcotic drug from January 1, 2021. (NSZKK 2022a).

## **T1.2 DRUG RELATED CRIME**

### **T1.2.1 Drug law offences**

The characteristics of drug law 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.

The investigation phase of a total of 7504 offences related to narcotic or psychotropic drugs or new psychoactive drugs was closed in 2021.

Misuse of new psychoactive substances involves 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 589 (7.9%) drug related offences involved substances classified as new psychoactive drugs, all of which fell under the force of Btk. (Criminal code).

Drug related offences represented 4.9% of all offences registered in Hungary.

Most drug offences were committed in Budapest (40.9%) or Pest county (7.7%). Among the other counties the share of Komárom-Esztergom county (5.8%), and Győr-Moson-Sopron (5.6%), lying along the northern borders of Hungary (with Slovakia), was the highest and Baranya (4.1%) county.

#### *Substance types*

In 2021 more than half of the registered drug law offences<sup>170</sup> (55.1%, 4090 cases) were committed with cannabis, the second largest group was that of stimulants<sup>171</sup> (28.0%, 2080 cases). Among amphetamine type stimulants, the most frequently occurring substance was amphetamine (75.1%), followed by MDMA (ecstasy) (20.1%) and methamphetamine (2.4%). New psychoactive drugs were recorded in 7.9% (589 cases) of the registered cases.<sup>172</sup> Among NPS most cases belonged to the "Other" category (48.9%); followed by cathinone derivatives (10.0%) and synthetic cannabinoids (21.9%) within the cases when new psychoactive drugs were recorded in the case.

---

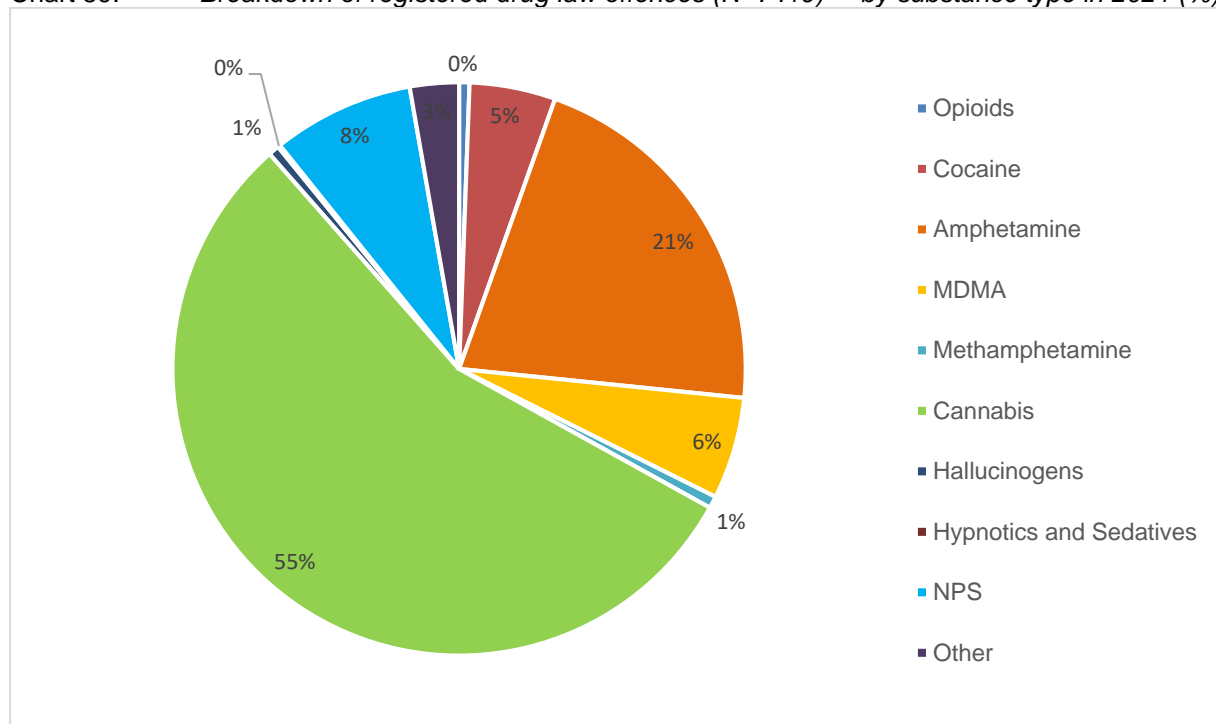
<sup>170</sup>Excluding cases linked to precursors (6) and those offences where the substance type was not recorded (79).

<sup>171</sup> Stimulants other than cocaine.

<sup>172</sup> The number of cases committed with new psychoactive drugs 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 drugs 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 schedules - and hence categorized as NPS according to the EMCDDA protocol - are classified as illicit drugs in Hungary. For this reason, the number of offences committed with new psychoactive drugs is different when totalled according to statutory definitions and when categorized by substance types.

Cocaine was registered as the subject of the offence in 4.8% (358 cases) of the cases, opioids in 0.6% (43 cases), hallucinogens also in 0.6% (45 cases) and other substances in 2.7% (204 cases).<sup>173</sup> (ST\_11\_2022\_HU\_01)

Chart 89. Breakdown of registered drug law offences (N=7419)<sup>174</sup> by substance type in 2021 (%)



Source: ENYÜBS 2022, analysed by HNFP

### Perpetrations<sup>175</sup>

Of the offences registered in 2021, 5791 offences (77.4%) were linked strictly to possession of an illicit drug (acquisition or possession for personal use). 61.5% of these cases were committed with cannabis, 28.9% with amphetamine type stimulants. Other types of substances appeared as the subject of use related offences in relatively low proportions (opioids 0.6%, cocaine 4.8%, other substances 2.3%, NPS 1.4%). (ST\_11\_2021\_HU\_01)

Perpetrations classed as supply-related offences<sup>176</sup> made up 22.3% of registered drug law offences (1668 cases). 23.7% (396 cases) of supply related offences involved trafficking with a small quantity of drugs. Offences committed with a substantial or a particularly substantial quantity were recorded in 210 cases (representing 12.6% of supply related offences and 2.8% of all drug law offences). Cultivation or production of drugs was the type of perpetration in 108 offences, accounting for 6.5% of supply related cases. The number of cases in the group of "other supply related offences" was also high in 2021, accounting for more than half of all supply related cases (57.2%; 954 cases).

The large majority of trafficking related perpetrations were linked to herbal cannabis (31.5%; 527 cases) and new psychoactive drugs (30.2%; 506 cases). Amphetamine type stimulants were involved in 24.3%, cocaine in 4.7%, opioids in 0.4%, and other substances in 3.9% of

<sup>173</sup> The substance type was not recorded in 79 cases (1.1% of all registered drug offences). Precursors were the subject of the offence in 6 case.

<sup>174</sup> Excluding precursors and those offences where the substance type was not recorded.

<sup>175</sup> Starting from 2014 offence types are categorized according to the EMCDDA's new drug law offences data collection protocol, which is different from the reporting structure used in previous years in several aspects.

<sup>176</sup> Trafficking related behaviours include: cultivation, production, offer, supply, distribution, dealing, import, export, transport through the country, and all offences committed with a substantial or particularly substantial quantity.

supply related cases. The proportion of offences where the substance type was unknown or unspecified was also relatively low in 2021 (2.8%).

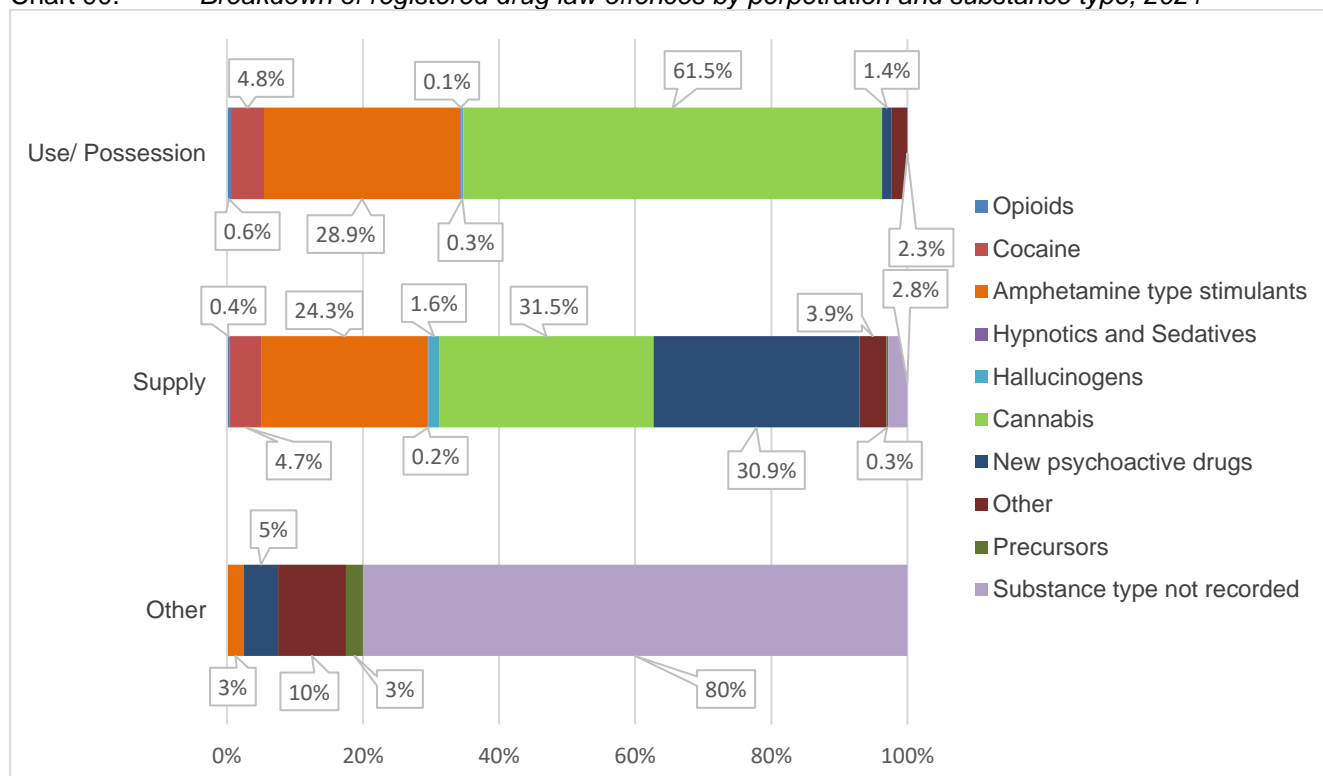
Among offences committed with a substantial amount of drug, cannabis (34.8%) and amphetamine type stimulants (46.2%) were recorded most frequently as the subject of the perpetration. Cocaine was recorded in 12.9%, opioids in 1.9% and new psychoactive drugs 0.5% of the cases. Among supply related offences committed with small amounts of drugs new psychoactive drugs were the subject of the offence in 35.1% of the cases and 35.1% was related to cannabis. Amphetamine type stimulants were involved in 14.4% of such cases.

96.0% of cultivation/production offences involved cannabis, while 2.8% involved amphetamine type stimulants.

Other perpetration types listed under a separate title in the Criminal Code (inciting substance abuse, aiding the production of illicit drugs) were recorded in 39 cases (0.5%).  
(ST\_11\_2022\_HU\_01)



Chart 90. Breakdown of registered drug law offences by perpetration and substance type, 2021



Source: ENYÜBS 2022, analysed by HNFP

### Alternatives to criminal procedure

The large majority of criminal procedures<sup>177</sup> launched in drug related cases are closed before the court phase starts, as a result of the institution of quasi compulsory treatment (QCT), which may be undertaken as an alternative to punishment. (The legislative background of the alternatives to criminal procedure is described in the Legal Framework workbook, Chapter T2.1, the data of those entering treatment in the scope of QCT are presented in the Treatment workbook, Chapter T1.3.1.) Only a small part of those participating in QCT will have a criminal record (for example, if the offender only starts QCT during the court phase of the procedure), the majority will not be registered in the criminal statistics, because when a perpetrator starts QCT the criminal proceedings are terminated and the case is not registered as an offence. In 2021 a total of 15,241 drug-related criminal proceedings were commenced, of these, formal accusation was made in just 4105 cases (36.9%). The remaining 73% (11,129 cases) of criminal proceedings were closed before the court phase due to procedural decisions 'termination of the procedure' (54.3%), 'suspension of the procedure' (42.7%), 'termination of investigation' (0.04%), 'rejection of complaint' (3.0%), or treatment as an alternative to criminal procedure (QTC) (0.06%). The criminal proceedings were closed in relation to treatment as an alternative to criminal procedure in only 7 cases, as the Law on Criminal Proceedings no longer

<sup>177</sup> The number of registered offences and criminal proceedings data must be treated separately. The data relating to criminal proceedings show how many criminal proceedings were launched due to a specific act in the given period, irrespective of how the proceedings were closed, 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.

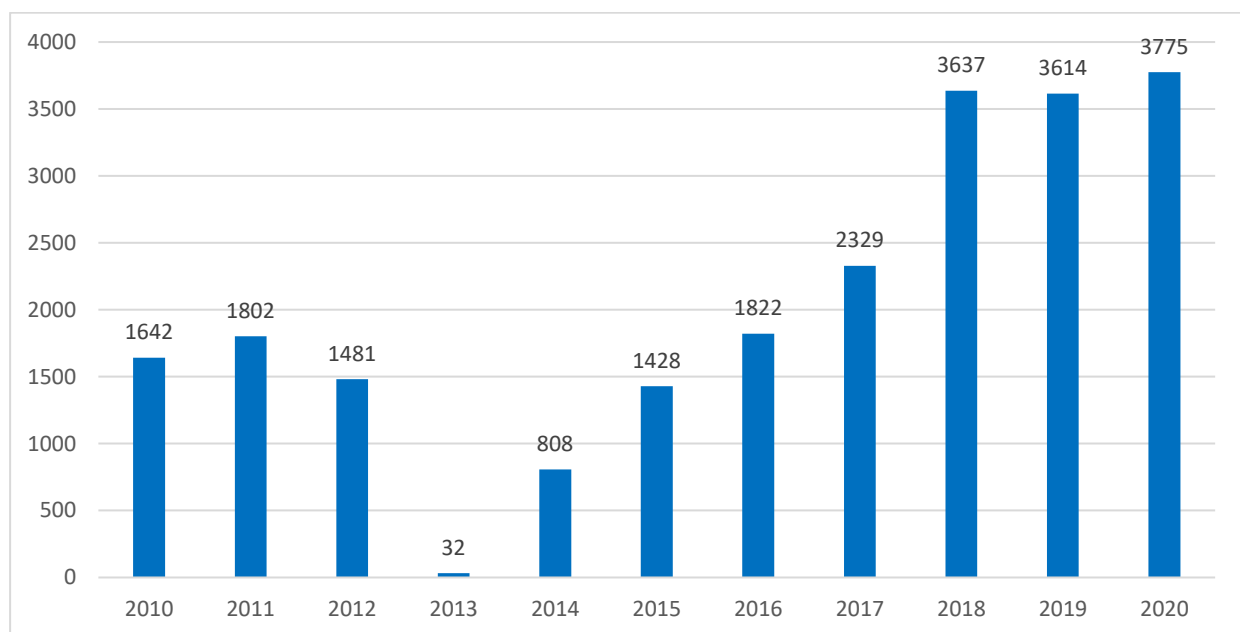
contains decision similar to the previous 'QTC. Therefore, from 2019, the proportion of decisions ending in QCT within all initiated proceedings became difficult to determine.

Data on QCT 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 QCTs 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 Criminal Code the follow-up nature of the ENYÜBS and the different legal regulations on use of new psychoactive drugs.

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 y) the number of people in QCT increased sharply until 2018 (390→1873), while between 2018-2020 the number of QCTs was relatively stable.. It can be seen that the QCT typically affects the young adult and the adult population.

The reported data only include cases with a completed QCT, namely 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 91. *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 of prosecution according to the old; and conditional prosecution parole according to the current code of criminal proceedings)*

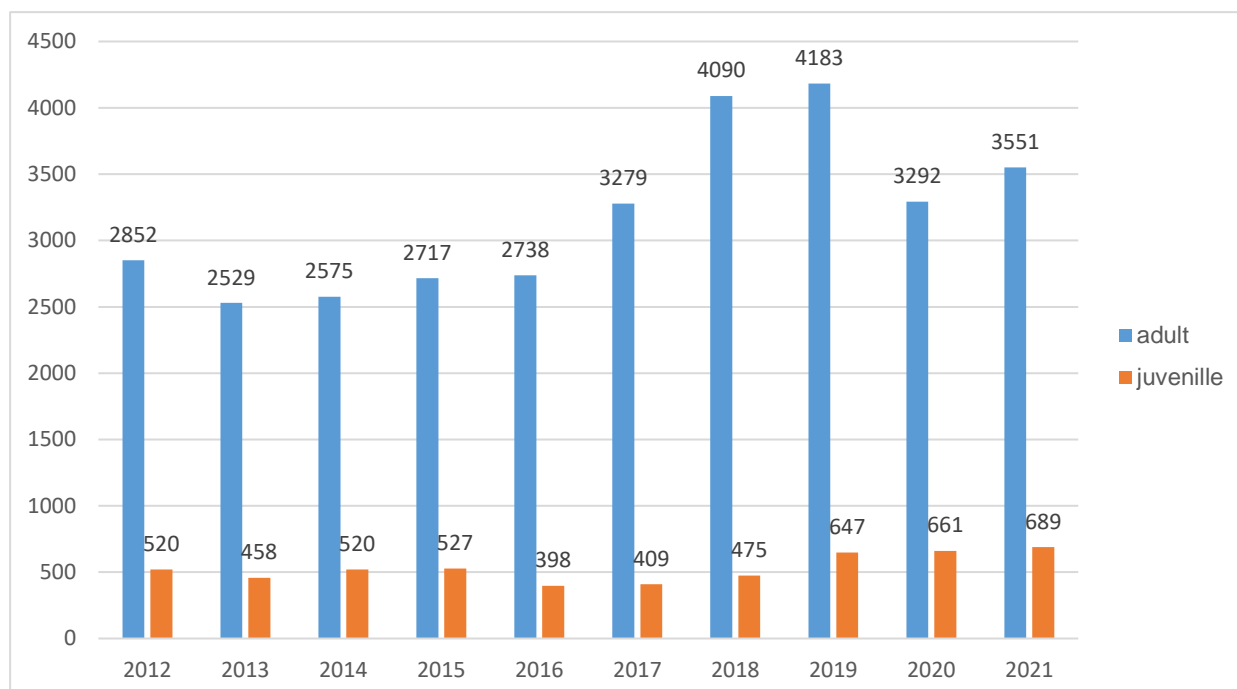


Source: ENYÜBS 2021, analysed by ORFK

Probation supervision ordered or established in connection with a QCT is a special case where the primary purpose is to monitor and support the fulfilment of the QCT. 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 QCT, 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. There is no reference in the Be. regarding that QCT can only be applied as a rule of conduct for probation, instead in the case of an adult defendant, QCT can be applied without ordering probation, whereas in the case of juveniles, in addition to QCT, probation supervision is established in all cases. Between January 1, 2021 and December 31, 2021, the regional probation services carried out a total of 4,240 probation cases ordered or established under

conditional prosecutorial suspension in connection with QCT (3551 adult suspect cases and 689 juvenile suspect cases).<sup>178</sup> (IM 2022).

Chart 92. *Number of probation services provided in connection with quasy compulsory treatment (QCT), 2012-2021*



Source: IM 2022

No diversion has been initiated for new psychoactive drugs related offences, 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 2021 1659 people were taken under infringement procedure for misuse of new psychoactive drugs. In 2021, the most frequently applied sanction for infringement procedures was the fine, with an average 72,616 HUF/person (ENYÜBS 2022).

<sup>178</sup>The 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 (QCT Section 180).

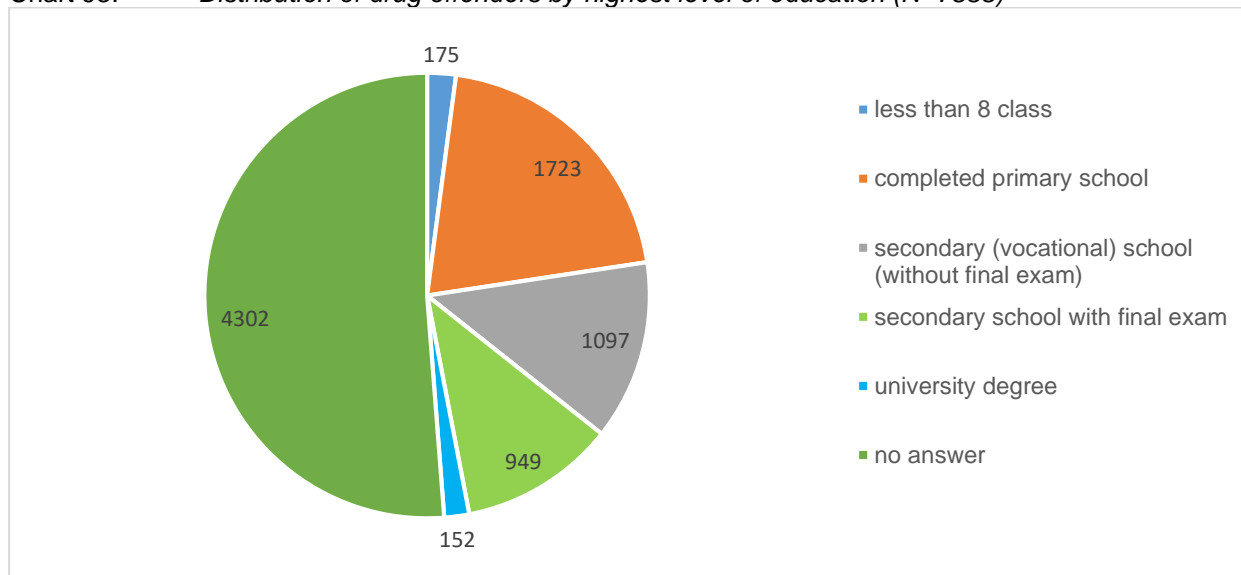
## Drug law offenders

In 2021 the criminal statistics registered 8398 offenders linked to the 7504 registered drug law offences<sup>179</sup>. 88% of the offenders were males and 12% were females, similarly to previous years.

Regarding distribution by age groups, 6.6% of drug law offenders were under 19 years, 33.1% of them were between 19 and 24 years, and 25.1% were between 25 and 30. Overall, 65% of drug law offenders were 30 years old or younger, while among all criminal offenders the proportion of those in the same age group was 43% 24.09% of the perpetrators of drug-related crimes belonged to the 31-40 age group, 9.37% to the 41-50 age group and 1.39% to the 51-60 age group. Perpetrators over 60 committed only 0.32% of offences related to drugs.

In case of more than half of drug law offenders no data was recorded on their highest educational status. 22.5% of drug offenders had maximum a completed elementary school qualification, or did not finish elementary school. 13.1% completed maximum a secondary (vocational) school (without final exam), 11.3% had completed secondary school with final exam and only 1.8% had university qualifications<sup>180</sup>

Chart 93. *Distribution of drug offenders by highest level of education (N=7838)*



Source: ENYÜBS (2022), analysed by HNFP

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

In 2021 a total of 7979 persons committed offences under the influence of illicit drugs, which made up 10.2% of all registered offenders. The large majority of those committing offences under the influence of illicit drugs committed a drug related offence (7139 persons, 89.5%), and a total of 840 persons (10.5%) committed other types of offences.

Looking at those committing other types of offences, the highest proportion (672 persons, 80.0%) of perpetrators committing non-drug related offences under the influence of illicit drugs committed traffic offences, of these 658 persons committed the offence of driving under the influence of alcohol or other substances. 57 persons (6.8%) committed offences against property, 29 persons (3.5%) committed offences against persons<sup>181</sup>, 24 persons (2.9%)

<sup>179</sup> One offender may commit several offences. The data on offences are complete, however, they are not with respect to the perpetrators, as an offender is recorded only with the most serious offence or if the offender is a minor.

<sup>180</sup> In the case of 4302 persons (51%) school qualification was unknown.

<sup>181</sup> It contains all the cases falling under the force of the old Btk., but only some of those under the force of the current 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 current Btk.

committed the act of disturbing the peace, and 58 persons (6.9%) committed other offences. Of the crimes against the persons, 2 homicides were committed under the influence of drugs while assault was registered in 21 cases.

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

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

It was an objective specified in the National Anti-drug Strategy (expired at the end of 2020) 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. No new strategic document has been adopted since 2020 with a focus on drug problem.

The primary responsible in the supply reduction activity is the criminal and public order protection service of the Police, and certain types of cases belong to the narcotics law enforcement activities of the administrative law enforcement service, which performs licensing, registration and control tasks in the case of companies legally operating with narcotic drugs, psychotropic drugs, new psychoactive drugs, drug precursors and pre-precursors...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).

In recent years, beside to prevent crimes related to narcotic drugs and new psychoactive drugs and to identify the perpetrators, the tasks of the police bodies has been supplemented by mapping the income and other assets of crimes in order to financially weaken the criminal organizations by confiscating illegally acquired assets. While previously asset recovery was primarily carried out in connection with economic crimes, it has now become an effective tool to fight against drug-related and property crimes.

Due to the closing of the borders in 2021 in connection with the COVID-19 restrictions, drug trafficking became more risky and significantly limited a period of time. However, with the reopening of the borders traffickers aimed to restock, therefore in the second half of the year, there were several seizures with large quantities (ORFK 2022).

The National Tax and Customs Administration (NAV) carries out supply reduction tasks by monitoring the legal traffic of narcotic and psychotropic drugs, new psychoactive drugs and drug precursors. NAV is also responsible for detecting illicit 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 the case of drug precursors, the NAV controls the export and import of the mentioned substances in relation to third countries, as well as their transit within the territory of Hungary, in accordance with EU and national legislations (NAV 2022).

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 2021, 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

programme (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. 22 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. Based on the findings of the on-site inspections, neither criminal proceedings nor fines were imposed in 2021. In all cases, the BFKH KHENF called on those who ignored the administrative regulations to comply with the law and demanded report on the taken measures (BFKH 2022).

## **T2. TRENDS**

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

#### *Seizures*

During 2010-2011, the authorities seized more than 10,000 plants per year at large-scale cannabis plantations of more than 100 plants. This amount significantly dropped in the period of 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 2021.

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. Between 2018 and 2021 the yearly seized amount was between 600 and 800 kg.

Regarding cannabis resin the seized quantity from 2010 until 2021 was between 2 and 20 kg (in 2021 3.3 kg), except for 2017 with 114 kg and 2020 with 43 kg. In both instances one-one huge case was responsible for the high seizure quantities (2017: 109 kg; 2020: 39 kg).

In the majority of the cases, there are smaller seizures of less than 10 grams, suggesting a steady increase in cannabis resin consumption. In addition, hashish bricks with content different from the average have appeared on the black market. Hashish samples with high CBD and low (less than 1%) THC were found in several cases. Additionally in 2021, the authorities seized hashish samples with unusual (low) THC content containing synthetic cannabinoids as well.

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 such cases. 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 2021 one big seizure occurred, with 20 block of 0.5 kg (all together 10 kg) dark brown, resin-like substance. The shipment was hidden in the car of a foreign citizen. The substance contained only a small amount of heroin, but a significant concentration of heroin metabolites. In addition to larger seizures, the number of street seizures remained low in 2021, 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 was seized in 2019, in 2020 only 12 kg. In 2021 26 kg of cocaine was seized. The major part (80%) of seizures were retail level seizures.

The number of amphetamine seizures – due to the trend of small seizures under 10 grams – shows a continuous increase since 2010.

The number of seizures of tablets containing MDMA showed an increasing trend between 2010 and 2019 (2010: 7; 2019: 584 cases). In 2020, 419, while in 2021 334 seizure cases occurred. The quantity of seized tablets also decreased in 2020 and in 2021, which is presumably related to the significant restrictions and closing of nightlife venues and mass events in connection with the coronavirus epidemic. The number of powder or crystal MDMA cases also showed a continuously rising tendency in the previous years, with a total number of 133 seizures of 3,6 kg in 2020. In 2021, both the number of cases (114) and the amount seized (0.85 kilograms) decreased.

(ST 13\_2022\_HU\_02) (NSZKK 2022a)

Table 25. Number of seizures between 2017-2021<sup>182</sup>

type of drug	2017	2018	2019	2020	2021
herbal cannabis	3674	3492	3 111	3 184	2 811
cannabis plants	158	169	158	189	184
cannabis resin	153	164	185	117	103
heroin	34	49	37	30	41
cocaine	276	303	365	301	325
amphetamine	900	1026	917	1 021	928
methamphetamine	68	120	157	154	192
ecstasy tablets /MDMA, MDA, MDE/	502	586	584	419	334
LSD	54	73	102	55	80
plant materials with synthetic cannabinoids	2177	2438	1 559	1 333	923
synthetic cannabinoids in powder	120	134	151	177	122
cathinone derivatives in the form of powder	735	885	535	594	853
cathinone derivatives in tablets	8	6	6	15	8

Source: NSZKK 2022a

Table 26. Quantity seized between 2017-2021<sup>183</sup>

type of drug	2017	2018	2019	2020	2021
herbal cannabis (kg)	2139.91	868.42	714.66	632.16	847.34
cannabis plants (plant)	5287	4769	7128	3 649	4 701
cannabis resin (kg)	114.46	20.02	1.97	43.19	3.32
heroin (kg)	20.56	34.94	77.38	40.04	13.13
cocaine (kg)	5.87	25.07	29.65	11.73	29.95
amphetamine (kg)	24.71	21.54	44.76	81.30	54.43
methamphetamine (kg)	0.74	0.88	1.4	1.97	1.93
ecstasy tablets (tablet) /MDMA, MDA, MDE/	51836	43984	66 824	50 368	20 788
LSD (dose)	1476	1293	2 755	1 660	1 559
plant materials with synthetic cannabinoids (kg)	11.79	18.95	10.56	6.06	34.13
synthetic cannabinoids in powder (kg)	3.09	2.51	3.95	12.92	3.03
cathinone derivatives in the form of powder (kg)	30.76	29.16	47.04	16.43	20.4
cathinone derivatives in tablets (tablet)	551	534	178	1 697	321

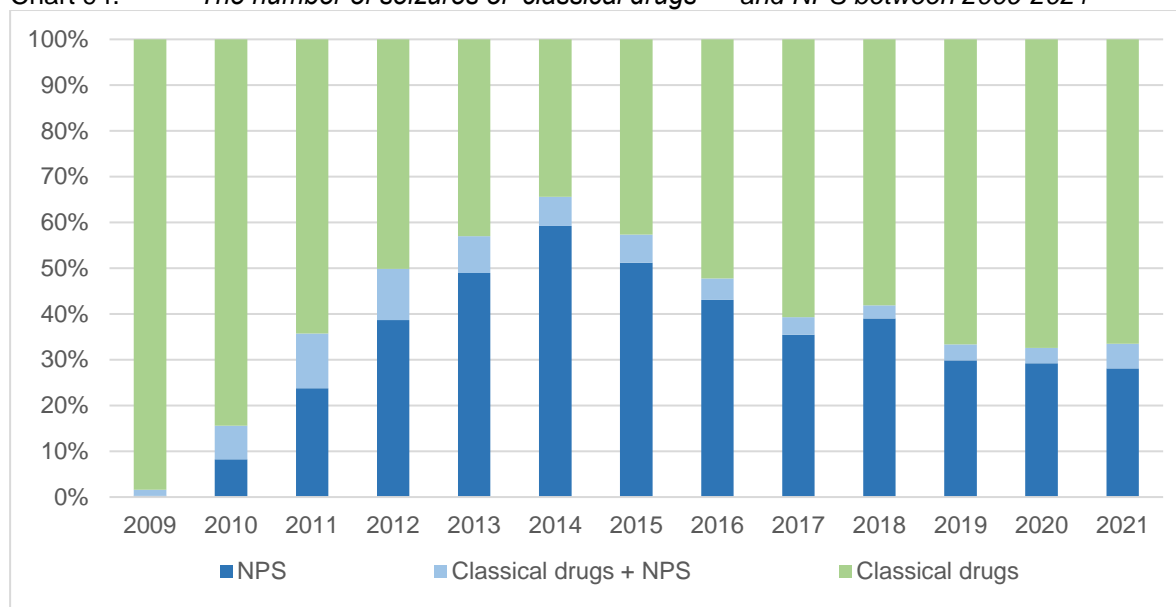
Source: NSZKK 2022a

<sup>182</sup> The following table contains the data of the seizures analysed in the drug testing laboratory of the Hungarian Institute for Forensic Sciences, and the data of the cannabis plantations seized on site on the basis of the botanical examination.

<sup>183</sup> The following table contains the data of the seizures analysed in the drug testing laboratory of the Hungarian Institute for Forensic Sciences, and the data of the cannabis plantations seized on site on the basis of the botanical examination.

From 2010 NPS significantly 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 illicit drugs rose continuously for years. In 2014 NPS seizures constituted nearly 60% of all police seizure cases. The increasing trend of seizures changed to decreasing in 2015, and then stabilised around 30% between 2018 and 2021 of all seizures cases.

Chart 94. *The number of seizures of 'classical drugs'<sup>184</sup> and NPS between 2009-2021*



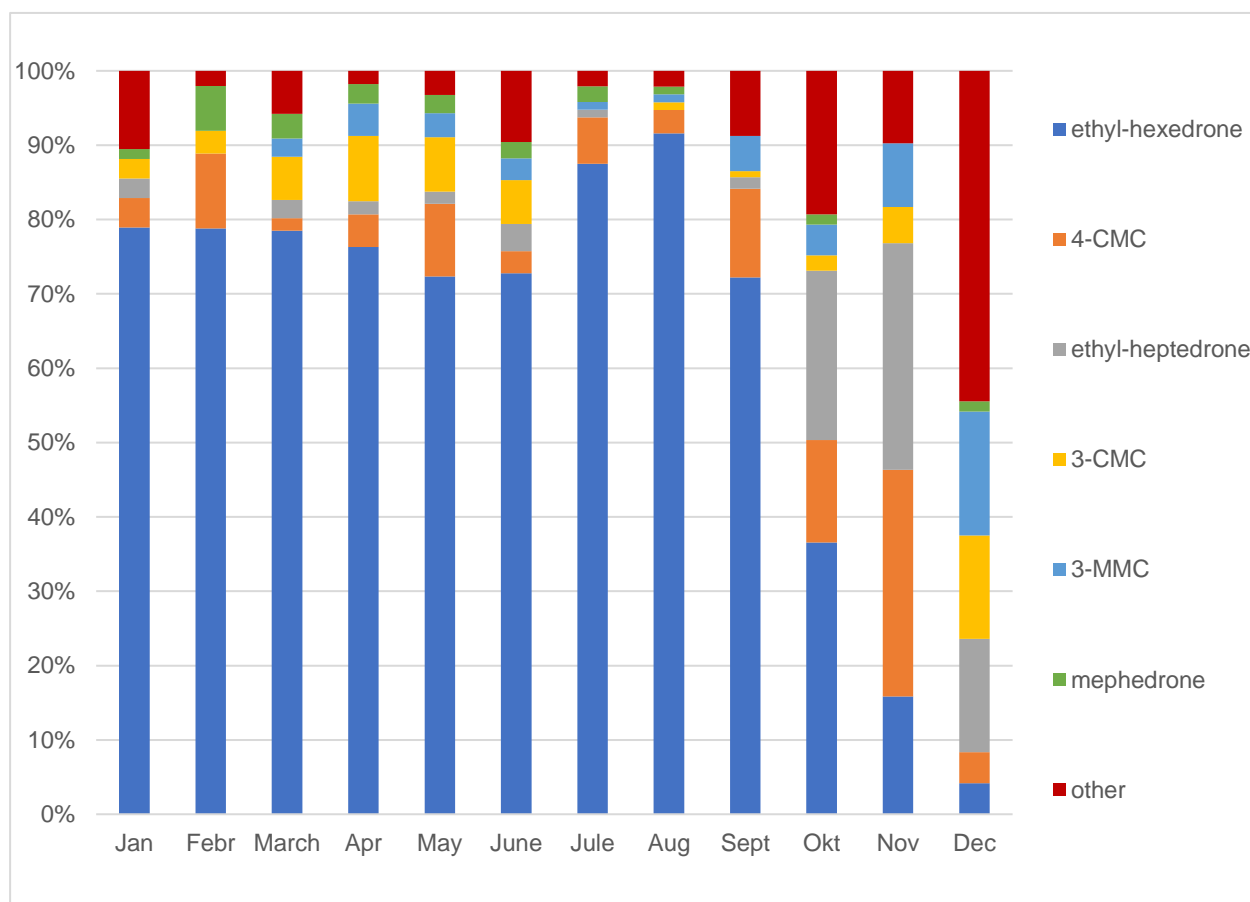
Source: NSZKK 2022a

The share of two large groups of the new psychoactive substances, cathinone derivatives and synthetic cannabinoids was the largest in the seizures. Cathinones are usually distributed in the form of powder. The most frequent synthetic cathinone active substances in seizures 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 period, but by the end of the year it was pentedrone again. 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 this substance was identified. During 2017 and 2018 a small amount of 4-Cl-alpha-PVP was also detected in nearly quarter of the investigated powders containing ethyl-hexedrone. From February 2019, the number of ethyl-hexedrone cases significantly decreased, and the substance was replaced by ethyl-heptedrone. In 2020 and 2021, the number of ethyl-hexedrone-containing powders increased significantly again, accounting for more than half of the synthetic cathinone seizures (57% in 2020; 62% in 2021). In 2021 a total number of 25 different cathinone compounds occurred in seizures, all of which were controlled as psychotropic drugs or new psychoactive drugs (NSZKK 2022a).

<sup>184</sup> Substances listed in the schedules of the UN Drug Conventions were categorised as 'classical'.



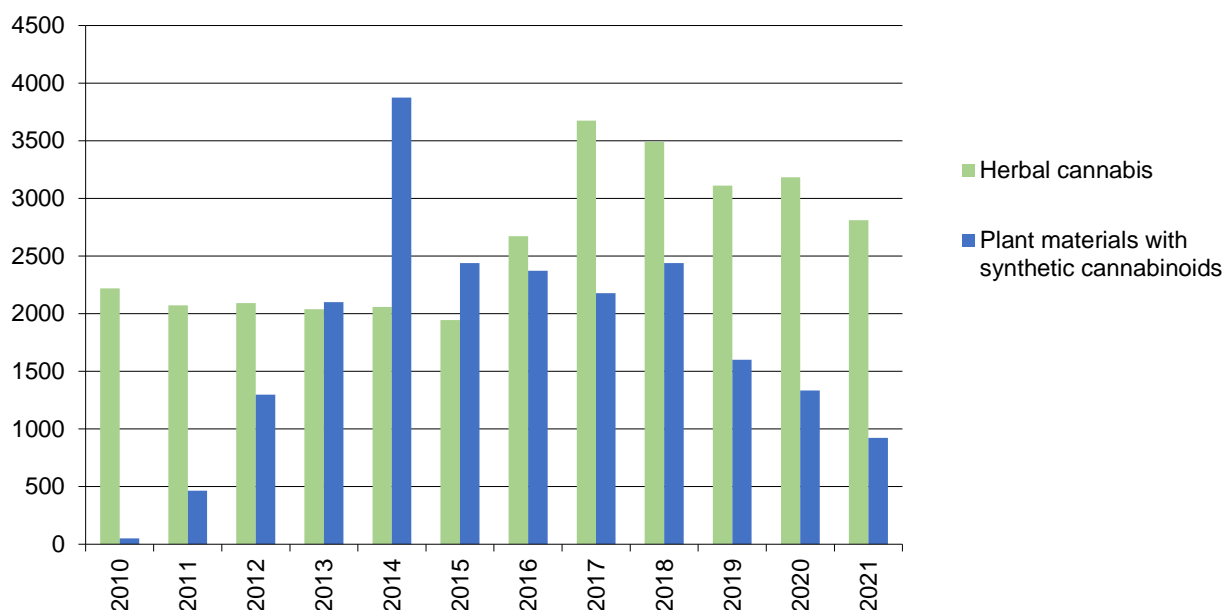
Chart 95. *Monthly breakdown of the different synthetic cathinone derivatives in seizures containing any synthetic cathinones in 2021 (in the percentage of cathinone seizure cases of the given month; %)*



Source: NSZKK 2022a

Since autumn 2010 there has been a rise in the seizures of plant material impregnated with synthetic cannabinoids. The number of seizures of the products known as 'herbal', 'bio weed' or 'magic tobacco' in 2014 was nearly double the number of seizures of herbal cannabis, however, a considerable drop can be observed since 2015 (NSZKK 2022a).

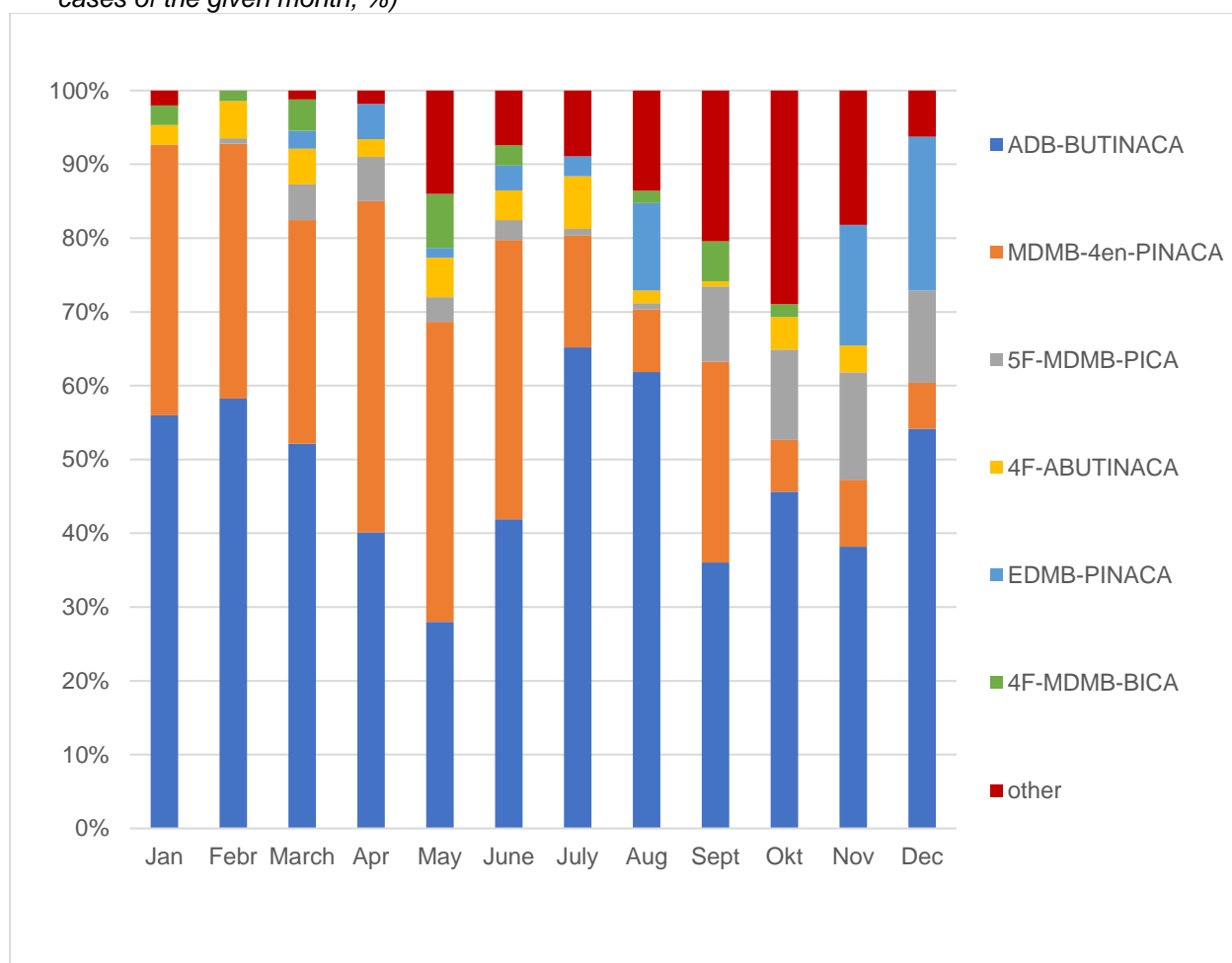
Chart 96. The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between 2010-2021



Source: NSZKK 2022a

The range of active substances identified on herbal fragments impregnated with synthetic cannabinoids follow the changes in legislation dynamically. At the same time typically 1–2 dominant substances are prevalent on the market. In the period between 2011 and 2014, after the substances became controlled usually within 1–3 months their occurrence dropped significantly 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 seizure of herbal 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 synthetic cannabinoid was the 5F-MDMB-PINACA which was identified in nearly 70% of the synthetic cannabinoid seizures. In 2019, 63% of the cases with impregnated herbal materials contained 5F-MDMB-PICA. In 2020 the most prevalent compounds on herbal materials were 5F-MDMB-PICA and MDMB-4en-PINACA (72% of all synthetic cannabinoid cases). Additionally, 4F-MBMB-BICA and 4F-MDMB-BINACA were quite frequent with around 10% of all cases. In 2021, more than 60% of the synthetic cannabinoid seizures were related to ADB-BUTINACA (48%) and MDMB-4-en-PINACA (28%).

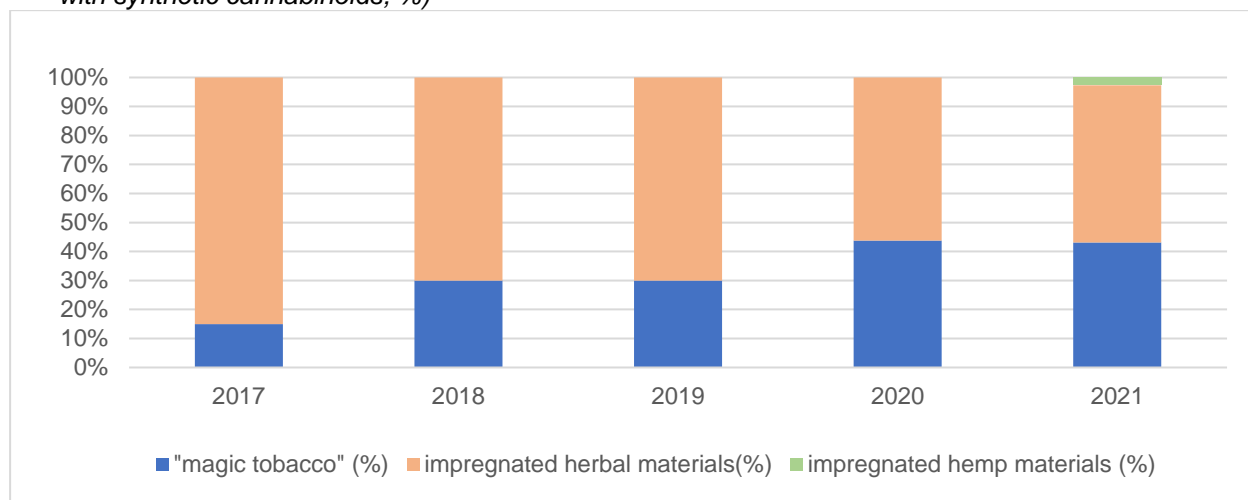
Chart 97. *Monthly breakdown of the different synthetic cannabinoid compounds in seizures containing any synthetic cannabinoid in 2021 (in the percentage of synthetic cannabinoid seizure cases of the given month; %)*



Source: NSZKK 2022a

Synthetic cannabinoids are usually impregnated into commercially available herbal materials or on tobacco, but the application on CBD dominant herbal cannabis is also identified in some cases. The role of tobacco as carrier material had been steadily increasing until between 2017 and 2021: it accounted for 15% of impregnated plant materials seized in 2017, and 43% of the ones seized in 2021. Beside herbal materials and tobacco hemp also appeared as carrier material in 3% of seized products impregnated with synthetic cannabinoids in 2021 (NSZKK 2022a).

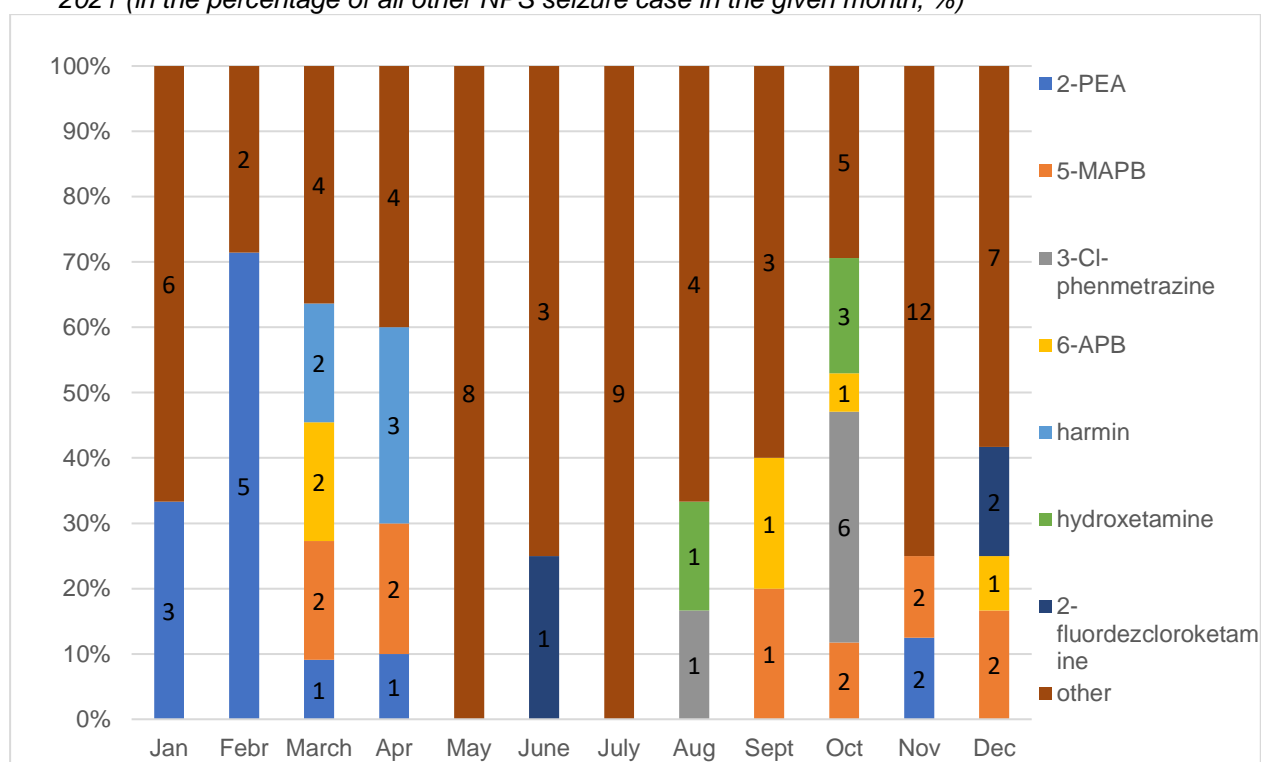
Chart 98. Annual breakdown of plant materials impregnated with synthetic cannabinoids by carrier material (magic tobacco = tobacco) (in the percentage of annually sized plant products impregnated with synthetic cannabinoids; %)



Source: NSZKK 2022a

Apart from synthetic cannabinoids and synthetic cathinone derivatives, a large number of other type of NPSs also appear in seizures.

Chart 99. Monthly breakdown of other NPSs identified in the seizures of powders and tablets in 2021 (in the percentage of all other NPS seizure case in the given month; %)



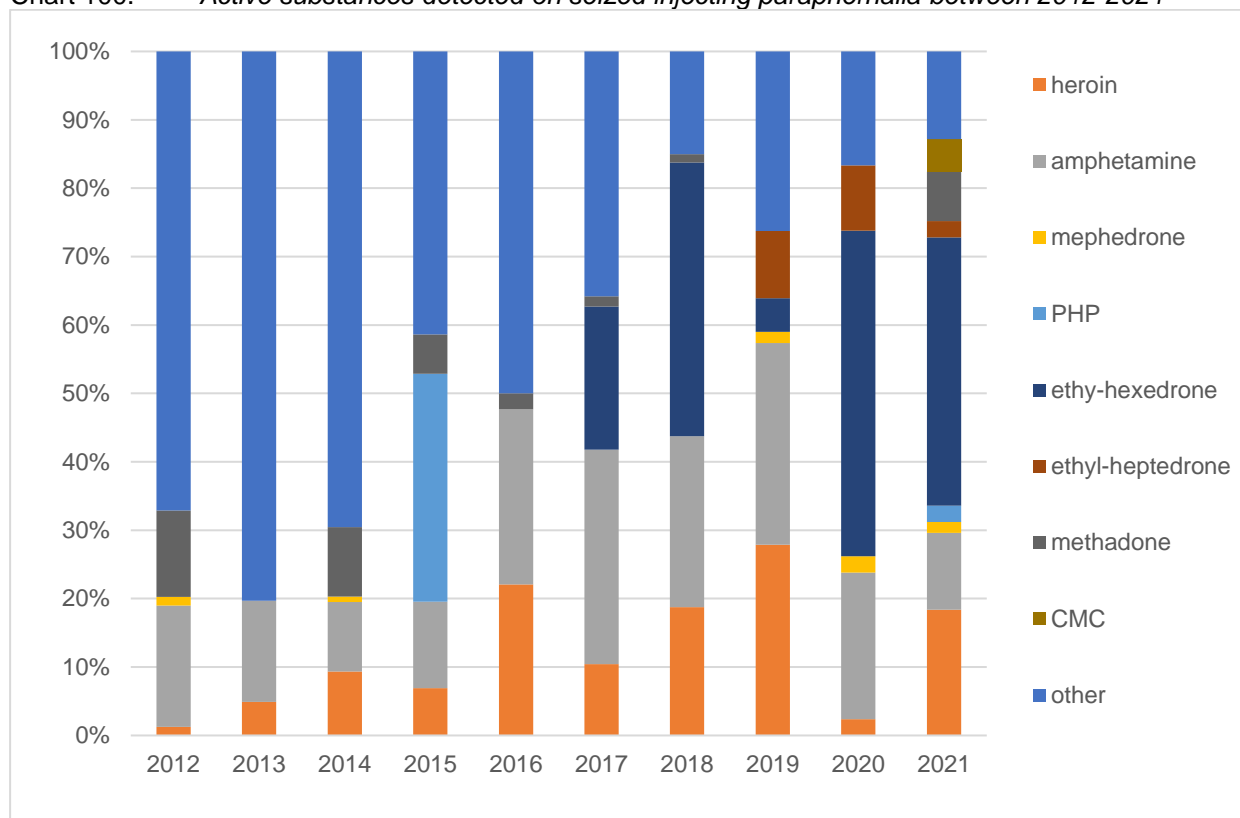
Source: NSZKK 2022a

On the basis of the active substances detected in/on seized injecting paraphernalia subjected to analytical testing, it is possible to monitor trends in the types and the relative prevalence rates of substances injected by PWIDs (people who inject drugs). While the dominance of cathinone derivatives could be detected until 2016, between 2016 and 2019 amphetamine and heroin were detected in a total of 48-57% of the analysed subjects. Para-methyl-N-ethyl-norpentedrone and ethyl-hexedrone were the most frequently injected substances in 2017, ethyl-hexedrone in 2018 ethyl-heptedrone in 2019 and again ethyl-hexedrone in 2020 and

2021. It should be noted that these data only include cases in which objects contaminated with residues were examined and were clearly related to injecting drug use. In many cases, residues present on the surface of objects are not tested or injecting drug use is unlikely, therefore the presented data is not representative for the substances injected by PWIDs.

(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 100. *Active substances detected on seized injecting paraphernalia between 2012-2021*

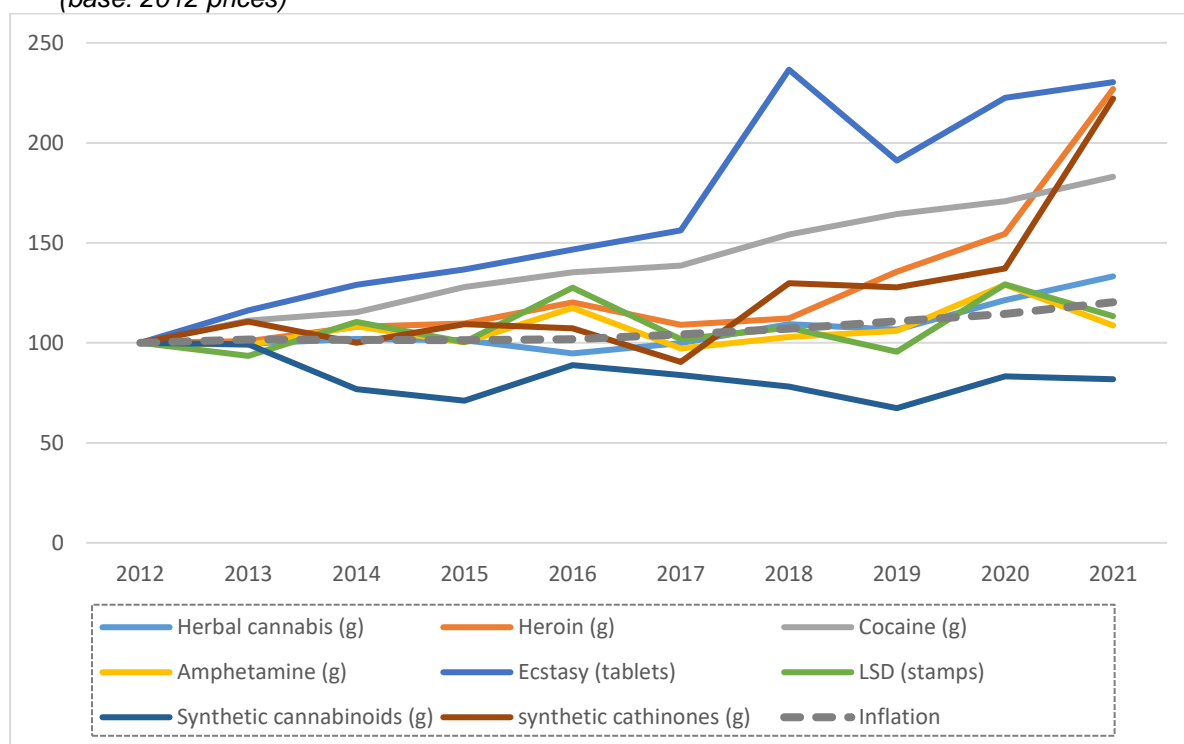


Source: NSZKK 2022a

### Street prices

In relation to the change of the sampling method regarding the 2021 retail drug prices, the chronological analysis of the retail drug prices is only partially possible. Regarding several drug types that seem popular based on the 2021 results, such as ketamine and MDMA purchased in powder or crystal form, the low number of responses in previous years do not yet allow to determinate any trend analysis in their case. According to the study carried out by the Reitox Hungarian National Focal Point and the INDIT Foundation (Bálint 2022), it can be stated, the real value of the average prices for certain drugs, such as herbal cannabis, amphetamine and LSD, has remained unchanged in the past years. The real value of ecstasy tablets and cocaine has been increasing to a greater or lesser extent since 2012, while the real value of heroin (g) started to increase in 2018, which is probably related to the low availability of heroin on the Hungarian retail drug market. Starting from 2017, the real value of synthetic cathinone derivatives available under the street name "crystal" has also been steadily increasing. In contrast, the real value of synthetic cannabinoids with the street name "herbal", "bio" or "magic tobacco" has even decreased in the recent years.

Chart 101. Indexed trends of retail drug prices, based on their mean price between 2012 and 2021 (base: 2012 prices)



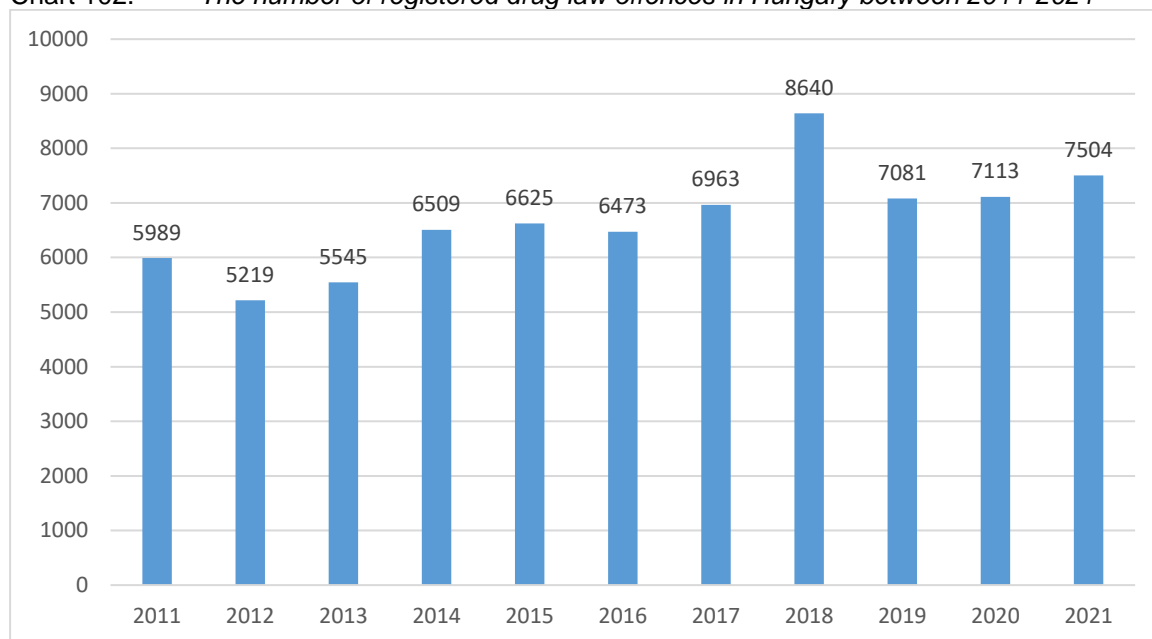
Source: Bálint 2022; KSH (2022)

\* KSH calculations were used as the basis for the annual inflation rate

## T2.4 DRUG LAW OFFENCES – SHORT TERM TRENDS

Examining the last 10 years, the number of drug-related crimes showed an overall increasing trend between 2012 and 2021. Apart from one extremely high number of case in 2018, the annual number of cases increased by approximately 40% from 2012 to 2021. We do not have information about the reason for the extremely high number of cases for 2018.

Chart 102. *The number of registered drug law offences in Hungary between 2011-2021*



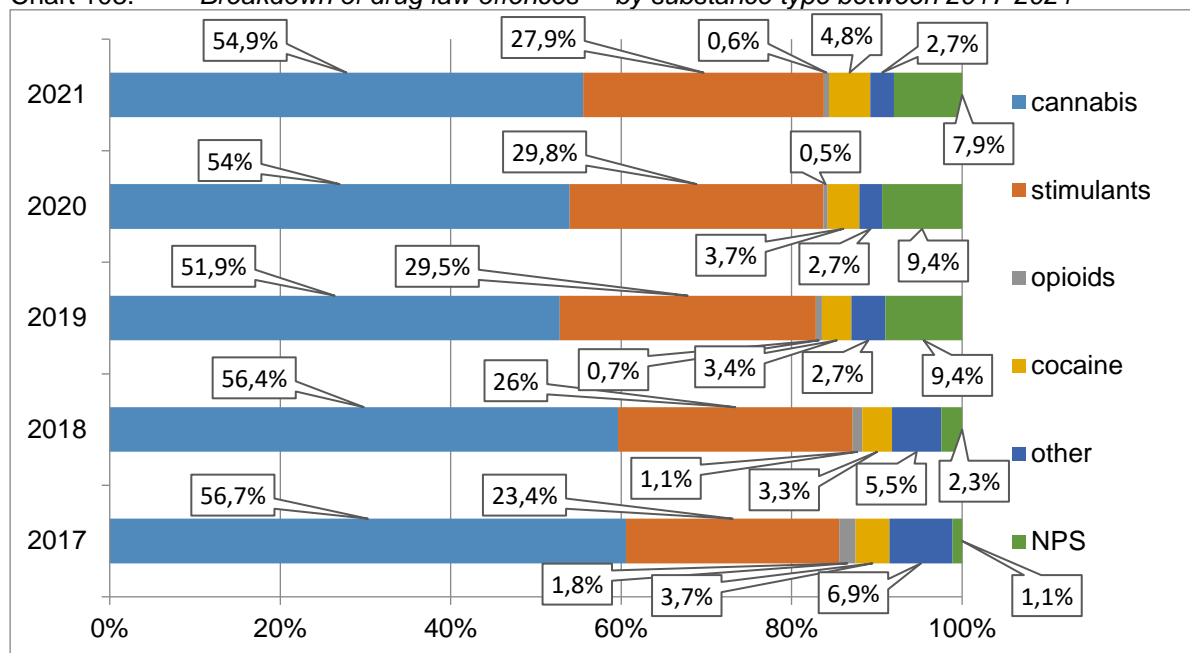
Source: ENYÜBS 2022, analysed by HNFP

With respect to perpetration types, in the past 5 years the majority of drug law offences were consumption related, committed in connection with personal use. The proportion of trafficking type supply related offences was usually around 20%. The majority 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 2021 either.

Examining the past five years, the majority of drug related offences were committed with cannabis (2021: 55.1%). In the last 5 years, 5-6 out of 10 cases were related to cannabis. 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 2021 Drugs/Stimulants and Drugs/Heroin and other opioids Workbook, Chapters T1.2): from 2019 the proportion of cases involving opioids remained under 1%, before that it did not exceed 3%. Amphetamine type stimulants (typically amphetamine) at the same time appeared as the subject of perpetration in an increasing proportion from year to year. After a small drop in 2017, the cases related to amphetamine type stimulants remained between 20-30%. The number of registered offenses committed with cocaine has been steadily increasing since 2017.

Offences (trafficking type) with new psychoactive drugs involve criminal liability since April 2012, such cases appeared in the criminal statistics in 2013 for the first time. (See 2013 and 2014 National Report, Chapter 9.3.) Offences committed with new psychoactive drugs, similarly to their seizures, has been decreasing since 2016. 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%). In 2021, the proportion of crimes committed with new psychoactive drugs decreased (2021: 7.9%) compared to the previous years, but it is still higher than in 2018.

Chart 103. Breakdown of drug law offences<sup>185</sup> by substance type between 2017-2021



Source: ENYÜBS 2022, 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. (2022): A kábítószeres utcai árai 2021-ben. Az INDIT Közalapítvány és a Nemzeti Drog Fókuszpont kérdőíves adatgyűjtése. Manuscript.

BFKH (2022): Budapest Főváros Kormányhivatala: Kereskedelmi, Haditechnikai, Exportellenőrzési és Nemesfémhitelesítési Főosztályának beszámolója a 2021-es EMCDDA Jelentés elkészítéséhez

BM (2019): A Belügyminisztérium 2018-ra vonatkozó beszámolója a 2019-es EMCDDA Jelentés elkészítéséhez

<sup>185</sup> Without cases committed with precursors and without those cases where the type of the substance was not recorded. Substance types were categorized in accordance with the EMCDDA 2014 data collection protocol on drug law offences, new psychoactive substances include substances not listed in the UN drug schedules.



BM (2020): A Belügyminisztérium 2019-re vonatkozó beszámolója a 2020-as EMCDDA Jelentés elkészítéséhez

BM (2021): A Belügyminisztérium 2020-ra vonatkozó beszámolója a 2021-es EMCDDA Jelentés elkészítéséhez.

ENYÜBS (2022): A Belügyminisztérium Egységes Nyomozóhatósági és Ügyészségi Bűnügyi Statisztikai Rendszerének kábítószer-bűnözéssel kapcsolatos adatai.

IM (2022): Az Igazságügyi Minisztérium 2021-re vonatkozó beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez.

NAV (2022): A Nemzeti Adó- és Vámhivatal 2021-re vonatkozó beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez

NSZKK (2022a): A lefoglalások laboratóriumi vizsgálati eredményének adatai 2009 és 2021 között.

ORFK (2021): Kábítószer-függőséget gyógyító kezelésben, kábítószer-használatot kezelő más ellátásban, vagy megelőző-felvilágosító szolgáltatásban résztvevő eltereltek számának alakulása 2010 és 2020 között.

ORFK (2022): Az Országos Rendőr-főkapitányság 2021-re vonatkozó beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez.

## **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 2022a):* 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 2022):* The National Focal Point, in collaboration with the INDIT Foundation, prepared an online survey on retail drug prices in the spring of 2022

(ST\_16\_2022\_HU\_01). Unlike previous years, the survey was online, the respondents were recruited on social media by the INDIT Foundation in the scope of convenience sampling. The inclusion criteria were: (1) informed consent to the participation, (2) being 18 years old or over and (3) being a resident of Hungary. Participation in the study was anonymous and voluntary. With the online data collection, it was possible to reach a significantly larger sample than in previous years, when data was collected with the cooperation of treatment facilities, therefore we had a larger amount of valid answers for each drug types. However, it is important to note that due to the nature of the sampling, the results of the study are not representative. Prior to the 2022 survey, retail drug prices were studied using a paper-and-pencil, self-completed questionnaire among clients of treatment as an alternative to criminal procedure of service providers operating in different parts of the country (approximately 10 locations). The present study, on the other hand, took place with an online data collection and aimed to reach active users (active buyers). A total of 753 responses were received to the questionnaire, of which the number of valid responses was 748. The respondents only reported the price of those drugs that they personally purchased in the past 12 months. In the self-administered questionnaire, respondents 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<sup>186</sup>

### T0. EXECUTIVE SUMMARY

In Hungary, 15 national prisons<sup>187</sup> and 14 county-based prisons, as well as 2 penitentiary healthcare institutions<sup>188</sup> (hereinafter: healthcare facilities) were operating in 2021.

According to the data as of 31 December 2021, a total of 18,345 people were held in prisons, of which 16,953 persons (92.4%) were men and 1392 persons (7.6%) were women, and 0.57% of the prison population were juvenile. In addition, there were 278 prisoners in the two health care facilities, with a female ratio of 13.7%.

The indicator of prison saturation showed the following changes in past years: compared to the average saturation was 122% in 2018 that decreased to 110% at the end of 2019. As a result of space expansion projects of 2020, at the end of that year the average saturation decreased to 96%, and it was 98% in 2021.

In 2021, a total of 3133 persons (17% of the total prison population) were admitted to prisons with at least one recorded drug-related offence in the public registry, out of them 1815 persons (10% of the total prison population) were convicted primarily for drug related offences at the time of the current detention. Available data on drug use among prisoners show, that 48% of prisoners in Hungarian prisons have consumed some type of illicit drug during their lifetime before entry. In terms of drug consumption within the prisons, the use of new psychoactive substances (NPS), especially 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-based products as well as NPS are smuggled into prisons, the latter in the form of impregnated papers (letters, photos). According to analytical data the impregnated papers typically contain synthetic cannabinoids.

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 facilities), 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” and “Reduction of alcohol problems” risk reduction 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 provide testing for infectious diseases.

---

<sup>186</sup> Authors of the workbook: Nóra Gasteiger and Réka Bálint, Anna Tarján

<sup>187</sup> Tököl National Prison Institute and Adolescents Prison Institute (Tököl) provides data jointly

<sup>188</sup> The Judicial Observatory and Psychiatry Institute, hereafter: IMEI, Central Prison Hospital

## **T1. NATIONAL SITUATIONAL PICTURE**

### **T1.1 INSTITUTIONAL CONTEXT**

In Hungary in 2021 29 prisons and 2 prison healthcare facilities were in operation<sup>189</sup>. Of these establishments, 14 have a national authority, and 15 have a county-level authority. The county facilities are mainly used for the pre-trial detention of prisoners; females, males and minors may be accommodated there, strictly separated. In case of the national facilities, the executorial level is the primary criteria for the placement, with special consideration to the proximity of the place of residence and regionality, however, with the current saturation, these conditions do not apply in all cases.

The capacity of all prisons was 18,713 places in 2021. On 31 December 2021, the number of prisoners placed in prisons was 18,345 while 278 in prison healthcare facilities. The proportion of women in prisons was 7.6% (1392 persons) and 13.7% in healthcare facilities. The percentage of juveniles among all prisoners was 0.57%. The indicator of prison saturation showed the following changes in past years: compared to the average saturation was 122% in 2018 that decreased to 110% at the end of 2019. As a result of space expansion projects of 2020, at the end of that year the average saturation decreased to 96%, and it was 98% in 2021. In 2021, 1815 persons were placed in law enforcement institutions related to drug law offences<sup>190</sup>. (BVOP 2022a)

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

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

##### ***Drug use prior to imprisonment***

*Data from the risk assessment system (Predictive Meter (PME) data) in (2021)*

As part of the development of the data recording system in relation to the risk assessment and treatment system implemented in 2015 in Hungarian prisons (see section T1.3.3), questions on drug use were also analysed in a sample of 15,523 persons were interviewed regarding their drug use in December 2021 (BVOP 2022b). (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).

48 % 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 (6392 people), information was available on the most frequently used drugs<sup>191</sup> prior to imprisonment and the frequency of use in the case of 6381 and 6350 persons respectively.

---

<sup>189</sup> The Judicial Observatory and Psychiatry Institute, hereafter: IMEI), Central Prison Hospital

<sup>190</sup> 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

<sup>191</sup> 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.

Table 27. Breakdown of prisoners who have ever used drugs by the most frequently used substances prior to imprisonment (N=6381) in 2021

Name most commonly used	N	%
Cannabis	1768	27.71
Polydrug use	1783	27.93
Amphetamine type stimulants (amphetamine, ecstasy)	1012	15.86
Synthetic cannabinoids	675	10.79
Synthetic cathinones	560	8.95
Cocaine, crack	324	5.08
Opioids (heroin, methadone and other opioids)	138	2.16
Sedative and anaesthetic medicines (benzodiazepines, barbiturates)	44	0.69
Organic solvents	26	0.42
Other	37	0.58
Hallucinogens (LSD, magic)	14	0.22
<b>Total</b>	<b>6381</b>	<b>100.00</b>

Source: BVOP 2022b

Table 28. Breakdown of prisoners who have ever used drugs by frequency of use prior to imprisonment (N=6350) in 2021

Consumption frequency of the most commonly used substances (before entry)	N	%
Occasionally (1 or 2 times per month)	1013	15.95
Have tried only (up to a few times in lifetime)	1152	18.14
A few times per year	392	6.17
1-2 times a week	1111	22.17
3 or more times per week or daily	2682	53.52
<b>Total</b>	<b>6350</b>	<b>100.00</b>

Source: BVOP 2022b

7.4% of the total sample (1154 persons) had ever injected before entry.

### Drug use inside prison

We still do not have accurate information on data related to drug use inside prisons, as according to the protocol of measures the local police body must be notified in case of any suspected drug seizure and provide it to the police. Information on the seized material, including the carried out examinations and the results of analytical examination does not provided routinely back to prison services but only on an ad-hoc basis.

Prisoners typically used new psychoactive substances, non-controlled substances, psychoactive substances of unknown origin and consumer products impregnated with new psychoactive substances (tea, tobacco) or impregnated paper or textiles. 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 2022b)

Equipment related to injecting drug use was not found during checks and safety inspections in prisons in 2021.

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 2022a), 11.3% of the interviewed prisoners have ever experienced overdose in their life before entry, with 1.8% self-reporting it to be intentional. Among the respondents, 1338 (21.1% of the respondents) experienced physical or psychological withdrawal symptoms after imprisonment, from which 582 people have received treatment for it. While in 2020, 132 in 2021 only 3 inmates received inpatient care related to drug problems.

According to the BVOP Central Report (2022a), 48 people participated in HIV testing, 12 in HBV testing, 79 in HCV testing and 11,126 in TB testing. Positivity for HIV was detected in 4 cases, while HBV was detected in 6 individuals. HCV antibody was detected in 25 individuals, 8 of whom were also HCV RNA positive (active viral carrier). Furthermore, 1 person with active tuberculosis and 1 with passive tuberculosis were detected<sup>192</sup>. There is no information regarding the way of infection.

### 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 soles of footwear, and clothes. It is also common for illicit substances to be thrown into the courtyard of prisons. In 2021, due to the measures taken to prevent the spread of the coronavirus epidemic, the possibility of receiving visitors in person was limited, accordingly, illicit drugs could not be handed over during the reception of visitors. New psychoactive substances are found to be smuggled by contact persons via various impregnated postal items (mainly letters, children's drawings and other paper goods). Reflecting on this issue, legislation has changed regarding the parcel delivery (see below) and also new kind of detection devices (such as UV-lamps, laser-spectrometers) were introduced.

According to BVOP data (BVOP 2022a), suspected drugs were seized in 139 cases in 2021, of which in 98 cases they 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 based products 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.

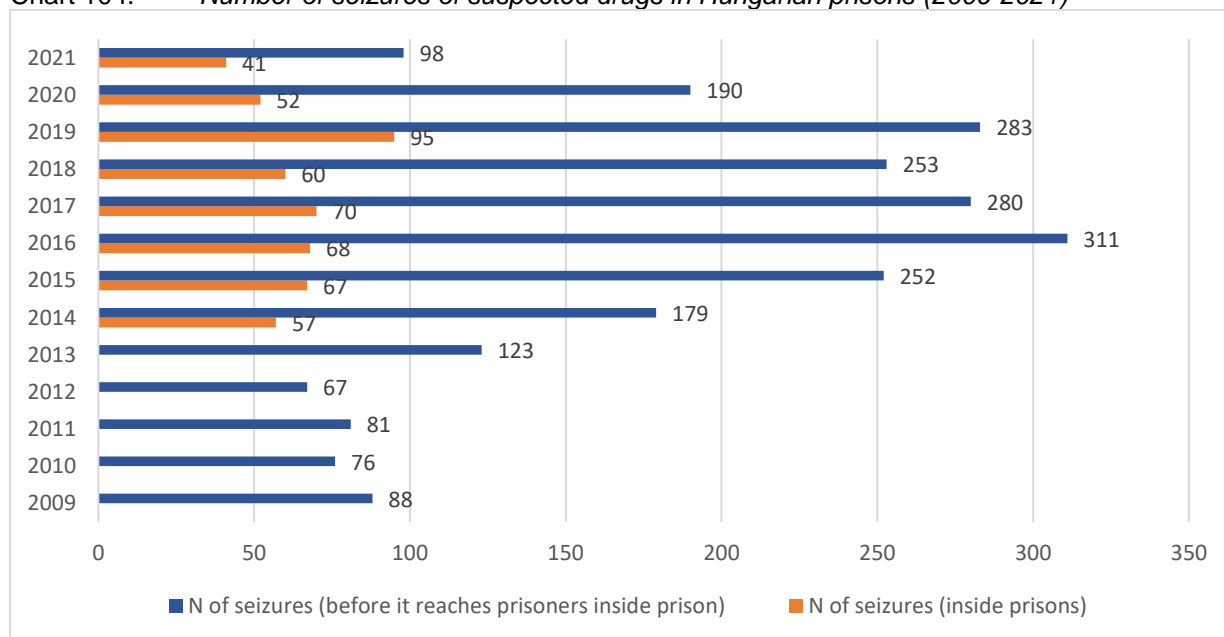
Table 29. Number of seizures of suspected drugs by form of smuggling into Hungarian prisons in 2021

Total	Plant based product	Powder	Tablet	Resin, crystal, gel	Impregnated material	
					Consumer item	Other
139	5	5	9	3	1	116

Source: BVOP 2022a

<sup>192</sup> 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.

Chart 104. *Number of seizures of suspected drugs in Hungarian prisons (2009-2021)*



Source: BVOP 2022a

*Seized substances (laboratory confirmed) – data from the Hungarian Institute for Forensic Sciences (NSZKK)*

The NSZKK (Hungarian Institute for Forensic Sciences) can identify prison-related seizures in its national seizure database by selecting cases when impregnated paper was the seized equipment, thus the following data only applies to this smuggling method in prisons. Due to the stricter package delivery rules introduced, there was a decrease in the number of cases identified by prison services and confirmed by NSZKK data (in 2019: 104 cases, while in 2021 only 54 cases). Laboratory analysis of impregnated papers identified almost only synthetic cannabinoids: while in 2016, the most commonly identified substance was AMB-FUBINACA, in 2017 and 2018 5F-MDMB-PINACA, then in 2019 the 5F-MDMB-PICA (with 78 cases). In 2021 the most commonly detected substance was 5F-MDMB-PINACA with 19 cases. Synthetic cathinones were rarely detected in the laboratory analysis, in 2021 altogether 2 cases (1 with 3-CMC and 1 with ethyl-hexedrone) were identified in papers. In 2021 amphetamine was also detected in one single case.

Table 30. *Active substances/active substance combinations identified by the NSZKK on impregnated papers seized in prisons (2015-2021)*<sup>193</sup>

Active substances/active substance combinations	2015	2016	2017	2018	2019	2021	TOTAL
3-CMC						1	1
4-CEC; ADB-FUBINACA			1				1
4F-MDMB-Bica						1	1
4F-MDMB-BINACA					12		12
4F-MDMB-BINACA; 5F-MDMB-PICA					2		2
4F-MDMB-BINACA; nikotin					1		1
5F-AMB	1	1		5	78	1	2
5F-AMB; AMB-FUBINACA	1					1	1
5F-MDMB-PICA				1	2		83

<sup>193</sup> The table does not contain data from 2020. For the study and analysis containing 2020 data see T1.2.3. Drug supply in prison in 2021 Prison WB.

5F-MDMB-Pica					3		1
5F-MDMB-Pica, ADB-BUTINACA					2		1
5F-MDMB-PICA; 5F-MDMB-PINACA		19	53	1			3
5F-MDMB-PICA; FUB-144			4				3
5F-MDMB-PICA; MDMB-4en-PINACA			1				2
5F-MDMB-PINACA	2					19	75
5F-MDMB-PINACA; AMB-FUBINACA						1	4
5F-MDMB-PINACA; NM-2201						1	1
ADB-BUTINACA						1	19
ADB-BUTINACA, 4F-MDMB-Bica						1	1
ADB-BUTINACA, 5F-3,5-AB-PFUPPYCA		10					1
ADB-BUTINACA, MDMB-4en-PINACA		1					1
ADB-BUTINACA, 5F-BZO-Poxizid		9	9				1
ADB-FUBINACA	1	8		1			19
ADB-FUBINACA; AMB-CHMICA; AMB-FUBINACA		1	1				1
ADB-FUBINACA; AMB-FUBINACA		4				1	4
ADB-FUBINACA; FUB-PB-22; MDMB-CHMICA		1				1	1
AMB-CHMICA		2				2	2
AMB-CHMICA; AMB-FUBINACA					1		1
AMB-FUBINACA	1	11				1	30
AMB-FUBINACA; ethyl-hexedrone				1			1
AMB-FUBINACA; NM-2201						2	1
amphetamine					1	8	1
DOB						1	1
EDMB-PINACA						1	2
ethyl-heptedrone					1		1
ethyl-hexedrone						1	1
FUB-144				1			1
FUB-PB-22; MDMB-CHMICA		1					1
MDA 19						2	2
MDMB-4en-PINACA					1	8	9
MDMB-4en-PINACA						1	1
MDMB-4en-PINACA, ADB-BUTINACA						1	1
MDMB-CHMICA	2	2					4
MMB-4en-PICA					1		1
NM-2201		2					4
<b>TOTAL</b>	<b>6</b>	<b>35</b>	<b>41</b>	<b>77</b>	<b>104</b>	<b>54</b>	<b>307</b>

Source: NSZKK 2022c

#### *Legislative change regarding package deliveries*

Act 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 buffet services system. That amendment to the law is aimed at reducing the smuggling of prohibited items into prisons, including narcotic drugs and mind-altering substances.<sup>194</sup> (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 defines 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 for those with special needs, including prisoners that are adapted to the individual needs of the group and the unique characteristics of the institution system. Currently in Hungary, there is no anti-drug strategy in force.

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 2021, only a few programmes could be realized, due to the COVID-19 restrictions. The rules for entering prison facilities also changed due to the pandemic, therefore some collaborations with external service providers had to be suspended, while some were implemented in the form of online assistance via video conference.

---

<sup>194</sup> 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,<sup>195</sup> 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 the Central Research and Methodology Institute (hereinafter KKMI) is the dedicated unit responsible for drug-related matters, although it can vary in certain cases.

### *QCT within prisons*

The Hungarian legal system provides the opportunity for prisoners who committed an offence involving drug possession prior to their imprisonment<sup>196</sup> 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<sup>197</sup> 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.<sup>198</sup> In all cases QCT is provided within the institution.

Regarding QCT, in accordance to Instruction 4/2009 of the IRM, in 2021 7 penitentiary institutions were eligible to preventive-consulting service, while only IMEI is eligible to treatment of drug addiction (a type of QCT).

As of January 1, 2017, preventive and educational services for prisoners participating in QCT must be provided through an (external) service provider determined by the National Centre for Public Health with a territorial obligation, according to the cooperation agreement concluded between the institute and the service provider. In 2021 this service was available in 10 prisons (see: BVOP Instruction no. 7/2020). These services are typically implemented in cooperation with external organizations, but in some cases, the psychologist staff members of the prison with specialized qualifications are also involved (in the case of the QCT, a clinical psychologist) (Gasteiger and Tarján 2020).

According to data from BVOP, in 2021, 32 persons participated in treatment for drug addiction, 61 persons underwent treatment of other conditions with drug use, and 131 persons took part in a preventive-consulting service.<sup>199</sup> It is very difficult to organise QCT during preliminary custody, because the fluctuation of detainees is high and there is considerable transportation

---

<sup>195</sup> 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 programs.

<sup>196</sup> 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.

<sup>197</sup> 3 forms of treatment are available in the scope of QCT: preventive-consulting service; treatment for drug addiction; and treatment of other conditions with drug use.

<sup>198</sup> Instruction 7/2020 of the BVOP contains which QCT service is available in which institution.

<sup>199</sup> 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.

between facilities. Due to that, many QCTs are interrupted or take place in parallel. The vast majority of QCTs 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**

#### *Admission procedure*

The new Prison Code<sup>200</sup>, 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 2021b).

#### *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 2021, 47 people (reintegration officers, social assistant officers and EFOP consultant) were eligible to participate in drug prevention and alcohol abuse reduction trainings<sup>201</sup> in a total 22 institutions. 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 and to plan their future substance-free lives, taking other aspects into account. In the course of 2021, trainings with 12 session (including alcohol and drug prevention) were held for 24 groups, involving a total of 177 prisoners (Drug prevention training: 23 groups; 169 people, and training to reduce alcohol consumption problems: 1 group; 8 people) (BVOP 2022b).

In 2021, 16 prisons operated drug prevention units, with total capacity for 276 prisoners. The occupancy rate of the divisions as of December 31, 2021 was 70% (BVOP 2022a). According to previous data collections, 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<sup>202</sup>, 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

---

<sup>200</sup> Act CCXL of 2013 on the Enforcement of Sentences, Measures, Certain Coercive Measures and Non-compliance

<sup>201</sup> In some cases, these programmes were implemented under programmes in the drug prevention sectors.

<sup>202</sup> (IV. 16.) BVOP Instruction on the execution of tasks related to convictions placed in other special sectors for prisoners with special needs.

KEF programmes (Gasteiger and Tarján 2021). In the current year, group sessions were restricted and then suspended in the drug prevention units due to the COVID-19 restrictions. Generally, it can be said, if there are no restrictions due to the pandemic situation, sessions are carried out by a psychologist from the registered institution or a reintegration consultant. According to last year's national facility survey, the programmes tend 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 (57 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. In terms of content, they were in line with the programmes taking place in the drug prevention units.

### *Treatment*

According to central data of the BVOP (BVOP 2022a), inpatient care of drug-related problems was provided for 3 prisoners who were treated in-house. Regarding outpatient treatment in 2021 we have no available data.

Withdrawal symptoms are typically treated medically, by means of pharmacologically assisted therapy. According to 2020 data, 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<sup>203</sup>. 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).

There is no available central data regarding informative campaigns related to HCV/HBV/HIV from 2021.

For information on HIV/HBV/HCV/TB testing and results among prisoners, see T1.2.2.

In 2021, 12 prisoners with HIV, 6 with tuberculosis, 6 with HBV and 46 with HCV received treatment. With regard to HCV, a further 2 persons did not consent to undergo treatment, 2 persons did not enter into treatment due to health reasons or was interrupted due to release. We have no information on the route of transmission in neither case (BVOP 2022a)

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

---

<sup>203</sup> According to the amendment for Decree 18/1998, since 2013 the TB testing is mandatory for all inmates after admission, followed by check-ups once a year.

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.

For a detailed description of the 2018/2019 HCV testing programme, see the 2020 Prison Workbook; section T.1.3.3 <sup>204</sup>:

#### *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 in 2020. There is no available data regarding 2021.

#### *Reintegration and preparation for release*

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 into 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 2021, reintegration care (preparation for release) was provided to 4961 prisoners.

Due to restrictions related to the COVID-19 pandemic, training programmes applying the method of Family Group Conference (hereinafter: FGC) was not accessible. In 2021 the members of the staff successfully used the GC method in a total of 2 cases via Skype. 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)

---

<sup>204</sup>Same data overlaps with filtering data reported in T.1.2.2

### **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.

### **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 staff. 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 31. *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**

7/2020. (III. 25.) BVOP utasítás a fogvatartottak elterelés szolgáltatásban való részvételéről. BVOP. [http://njt.hu/cgi\\_bin/njt\\_doc.cgi?docid=218706.381063](http://njt.hu/cgi_bin/njt_doc.cgi?docid=218706.381063)

17/2020. (V. 29.) BVOP utasítás az opiátfüggő fogvatartottak szubsztitúciós kezeléséről. BVOP. [http://njt.hu/cgi\\_bin/njt\\_doc.cgi?docid=219775.383895](http://njt.hu/cgi_bin/njt_doc.cgi?docid=219775.383895)

4/2009. (III. 20.) IRM utasítás a fogvatartottak számára kábítószer-függőséget gyógyító kezelés, kábítószer-használatot kezelő más ellátás vagy megelőző-felvilágosító szolgáltatás biztosításáról. BVOP. [http://njt.hu/cgi\\_bin/njt\\_doc.cgi?docid=123425.176683](http://njt.hu/cgi_bin/njt_doc.cgi?docid=123425.176683)

20/2021. (IV. 16.) BVOP utasítás - a sajátos kezelési igényű fogvatartottak számára kialakított és az egyéb speciális részlegeken elhelyezett elítéltekkel kapcsolatos feladatok végrehajtásáról <https://njt.hu/jogszabaly/2021-20-B0-3M>

Arzenovits (2018): A Büntetés-végrehajtás Országos Parancsnoksága és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben végzett kérdőíves felmérés. Kutatási beszámoló.

BVOP (2021a): A BVOP 2020-ra vonatkozó beszámolója

BVOP (2021a): A BVOP 2020-ra vonatkozó beszámolója.

BVOP (2022a): A BVOP 2021-re vonatkozó beszámolója.

BVOP (2022b): Az elítéltekre vonatkozó kockázatértékelési rendszer bevezetése kapcsán végzett kérdőíves vizsgálat 2021-es eredményei. BVOP - Központi Kivizsgáló és Módszertani Intézet, Kézirat.

BVOP (2021c): Impact of COVID-19 on people who use drugs and drug services in the European Union

Prisons – Completed EMCDDA questionnaire. Manuscript.

Gasteiger, N., Tarján, A., (2021): A Büntetés-végrehajtás Országos Parancsnoksága és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben végzett kérdőíves felmérés (2020-as adatok). Kutatási beszámoló.

NSZKK (2022c): A Nemzeti Szakértői és Kutató Központ adatai a bv. intézetekben lefoglalt kábítószergyanús anyagokra vonatkozóan.

Port, Á. (2016a): A Büntetés-végrehajtás Országos Parancsnoksága és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben 2016 júniusában végzett kérdőíves felmérés eredményei.

Somogyvári Mihály (2022): Aspects of Substance Use in Prisons. [https://epa.oszk.hu/04400/04497/00006/pdf/EPA04497\\_id\\_2021\\_04\\_107-137.pdf](https://epa.oszk.hu/04400/04497/00006/pdf/EPA04497_id_2021_04_107-137.pdf)

Tarján A., Dudás M., Rácz J., Horváth G., (2019) HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalenciavizsgálata a hazai intravénás szerhasználók körében 2018-ban. Publikálás alatt.

Tarján A., Dudás M., Rácz J., Horváth G., (2020) HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalenciavizsgálata a budapesti és kecskeméti intravénás szerhasználók körében 2019-ben. Publikálás alatt.

## 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 2022b)*

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 December 2021 containing the responses of prisoners who were imprisoned in December 2019 (N=15,523 persons); however, this does not mean that all the information was recorded in 2021, since the

questionnaires were recorded between 2018 and 2021. 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.

## SOURCES

- 17/2020. (V. 29.) BVOP utasítás az opiátfüggő fogvatartottak szubsztitúciós kezeléséről. BVOP. [http://njt.hu/cgi\\_bin/njt\\_doc.cgi?docid=219775.383895](http://njt.hu/cgi_bin/njt_doc.cgi?docid=219775.383895)
- 20/2021. (IV. 16.) BVOP utasítás - a sajátos kezelési igényű fogvatartottak számára kialakított és az egyéb speciális részlegeken elhelyezett elítéltekkel kapcsolatos feladatok végrehajtásáról <https://njt.hu/jogszabaly/2021-20-B0-3M>
- 4/2009. (III. 20.) IRM utasítás a fogvatartottak számára kábítószer-függőséget gyógyító kezelés, kábítószer-használatot kezelő más ellátás vagy megelőző-felvilágosító szolgáltatás biztosításáról. BVOP. [http://njt.hu/cgi\\_bin/njt\\_doc.cgi?docid=123425.176683](http://njt.hu/cgi_bin/njt_doc.cgi?docid=123425.176683)
- 7/2020. (III. 25.) BVOP utasítás a fogvatartottak elterelés szolgáltatásban való részvételéről. BVOP. [http://njt.hu/cgi\\_bin/njt\\_doc.cgi?docid=218706.381063](http://njt.hu/cgi_bin/njt_doc.cgi?docid=218706.381063)
- Andorka, R. (1994). Deviáns viselkedések Magyarországon – általános értelmezési keret az elidegenedés és az anómia fogalmak segítségével. In: Münnich I., Moksony F.(szerk.), *Devinanciák Magyarországon* (32-77). Budapest, Közélet Kiadó.
- Arnold P., Elekes Zs. (2020): Drogfogyasztási szokások a 16 évesek körében - ESPAD 2019. Tanulmány a Drog Fókuszpont számára. 2020. Kézirat.
- Arzenovits (2018): A Büntetés-végrehajtás Országos Parancsnoksága és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben végzett kérdőíves felmérés. Kutatási beszámoló.
- Bálint, R. (2021): A kábítószeres utcai árának alakulása 2020-ban. Nemzeti Drog Fókuszpont kérdőíves adatgyűjtés. (Módszertant lásd: Kábítószer-piac és kábítószer bűnözés fejezet T5.2)
- Bálint, R. (2022): A kábítószeres utcai árai 2021-ben. Az Indít Közalapítvány és a Nemzeti Drog Fókuszpont kérdőíves adatgyűjtése.
- Belügyminisztérium Népegészségügyi Főosztály (BM NÉPEÜ) (2022): Összefoglaló az EFI-k hálózatáról. Kézirat.
- Berényi, A., Batizi, I., Tóth, B. A., Holb, G. (2017): Gyermek- és fiatalkorúak addiktológiai ellátásának az Emberi Erőforrások Minisztériuma által támogatott monitorozása. Forrás Lelki Segítők Egyesülete. 2017. Kézirat.
- BFKH (2022): Budapest Főváros Kormányhivatala: Kereskedelmi, Haditechnikai, Exportellenőrzési és Nemesfémhitelesítési Főosztályának beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez
- BM (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.
- BM (2021): A Belügyminisztérium 2020-ra vonatkozó beszámolója a 2021-es EMCDDA Jelentés elkészítéséhez.
- BVOP (2021a): A BVOP 2020-ra vonatkozó beszámolója.
- BVOP (2021c): Impact of COVID-19 on people who use drugs and drug services in the European
- BVOP (2022a): A BVOP 2021-re vonatkozó beszámolója.

BVOP (2022b): Az elítéltekre vonatkozó kockázatértékelési rendszer bevezetése kapcsán végzett kérdőíves vizsgálat 2021-as eredményei. BVOP - Központi Kivizsgáló és Módszertani Intézet, Kézirat.

Csák R., (2022): Tűcsere programok adatai, 2021. Nemzeti Drog Fókuszpont. Kézirat.

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

Csák R., Magyar, É., Márványkövi, F., Rácz, J. (2018a): Kvantitatív kutatás a községi szegregátumokban élő pszichoaktív szerhasználók körében – Drogfogyasztás és kezelésének lehetőségei községekben, különös tekintettel a „Szegregált élethelyzetek felszámolása komplex programokkal” elnevezésű pályázatban (EFOP 1.6.2 – 16) résztvevő települések szegregátumaira. MAT-SzGyF, 2018. Kézirat.

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

Csák, R., Kassai, Sz., Márványkövi, F., Szécsi, J., Rácz, J. (2018b): Új Pszichoaktív Szerhasználat városi szegregátumi környezetben: hiányelemzés és szükségletfelmérés a hazai ellátórendszerre vonatkozóan. MAT-EMMI, 2018. Kézirat.

Csák, R., Molnar, I., Sárosi, P., Arsenijević, J., Arsenijević, B. (2019) How the closing of a needle exchange programme affected the access to harm reduction services in two cities, Belgrade and Budapest. Rightsreporter. Kézirat.

Csorba J., Figezki T., Posta J., Puy T., Takács S., Soós D., Tarján A. (2020) Az európai ESCAPE projekt budapesti részadatai 2017-2019. Kézirat.

Csorba, J (2018): Metadon dózis és terápiás hatékonyság. VIII Szubsztitúciós Fórum Budapest, 2018.06.07

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

Egészségügyi Közlöny (2017): Az Emberi Erőforrások Minisztériuma szakmai irányelve a pre-, peri- és posztnatális mentális zavarok baba-mama-papa egységében történő kezeléséről. 2017. 4. szám, 1120. o. Elérhető: [http://www.hbcs.hu/uploads/jogszabaly/2485/fajlok/EEMI\\_szakmai\\_iranyelve\\_a\\_pre\\_peri.pdf](http://www.hbcs.hu/uploads/jogszabaly/2485/fajlok/EEMI_szakmai_iranyelve_a_pre_peri.pdf)

EMCDDA (1999). *Co-ordination of an expert working group to develop instruments and guidelines to improve quality and comparability of general population surveys on drugs in the EU*. Follow up of EMCDDA project CT.96.EP.08 (CT.97.EP.09), Lisbon, Por: EMCDDA. [http://www.emcdda.europa.eu/attachements.cfm/att\\_1385\\_EN\\_expert\\_group\\_comp\\_report.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_1385_EN_expert_group_comp_report.pdf)

EMCDDA (2000): Treatment demand indicator, standard protocol 2.0. <http://www.emcdda.europa.eu/html.cfm/index65315EN.html> (utolsó elérés: 2015.06.04.)

EMCDDA (2002). *Handbook for surveys on drug use among the general population*. EMCDDA project CT.99.EP.08 B, Lisbon, EMCDDA.

EMCDDA (2013). *Towards a new EMQ Module – Questions on Availability of Illicit Drugs*. Lisbon, EMCDDA. Letöltve: 2020.10.10. <https://www.emcdda.europa.eu/system/files/attachments/10592/EMQ-availability-module.pdf>

EMCDDA (2015). *Voluntary EMQ Module for monitoring use of New (and not so new) Psychoactive Substances (NPS) in General Adult Population Surveys and School Surveys*. Lisbon, EMCDDA. Letöltve: 2020.10.10. <https://www.emcdda.europa.eu/system/files/attachments/10582/EMQ%20Voluntary%20Module%20on%20New%20Psychoactive%20Substances%20%28NPS%29.pdf> .

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

EMMI (2018): Szakmai ajánlás szenvedélybetegek alacsonyküszöbű ellátása részére. [http://szocialisportal.hu/documents/10181/154042/005\\_SZAKMAI+AJANLAS\\_szenvedelybeteg\\_alacsonykuszu\\_ellatasa\\_reszere.pdf/f997c0fa-e28c-1ec2-f887-bf0051854f19](http://szocialisportal.hu/documents/10181/154042/005_SZAKMAI+AJANLAS_szenvedelybeteg_alacsonykuszu_ellatasa_reszere.pdf/f997c0fa-e28c-1ec2-f887-bf0051854f19) / Utolsó hozzáférés: 2019. 10. 14.)

EMMI (2021): Jelentés a Nemzeti Drogellenes Stratégia megvalósulásáról

ENYÜBS (2022): A Belügyminisztérium Egységes Nyomozóhatósági és Ügyészeti Bűnügyi Statisztikai Rendszerének kábítószer-bűnözéssel kapcsolatos 2021. évre vonatkozó adatai.

Felvinczi, K., Paksi, B., Magi, A., Sebestyén, E. (2017): Az elterelés keretében végzett megelőző-felvilágosító szolgáltatás tartalmának és közvetlen hatásainak vizsgálata – című kutatás első fázisának eredményei. Kézirat.

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.

Gasteiger, N., Tarján, A., (2021): A Büntetés-végrehajtás Országos Parancsnoksága és a Nemzeti Drog Fókuszpont által a magyarországi büntetés-végrehajtási intézetekben végzett kérdőíves felmérés (2020-as adatok). Kutatási beszámoló.

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

Horvath G., Halasz T., Makara M., és Hunyady B. (2015) [New era in the treatment of chronic hepatitis C - novel direct acting antivirals]. Orv Hetil, 156: 841-848.

Horváth G.Cs.; Tarján A. (2016): Az intravénás szerhasználat prevalencia becslése. Nemzeti Drog Fókuszpont. Kézirat.

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

Hungaropharma és PHOENIX Pharma (2020): A gyógyszertárak fecskendő eladási adatainak alakulása 2010-2020.

Hunyady B., Gerlei Zs., Gervain J., Horváth G., Lengyel G., Pár A., Péter Z., Rókus L., Schneider F., Szalay F., Tornai I., Werling K., Makara M. (2018) Hepatitis C-vírus fertőzés szűrése, diagnosztikája, antivirális terápiája, kezelés utáni gondozása. Central European Journal of Gastroenterology and Hepatology, Vol 4, 2: 53-68.

IM (2022): Az Igazságügyi Minisztérium 2021-re vonatkozó beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez.

Kaló Zs., Szabó R., Bálint R., Péterfi A., Port Á., Szatmári D., Tarján A., Horváth G. (2018): Az új pszichoaktív szerek monitorozása kulcsszakértők bevonásával Magyarországon 2017-2018-ban. Nemzeti Drog Fókuszpont. Kutatási beszámoló, Kézirat.

Kapitány-Fövény, M., Farkas, J., Pataki, P.A., Kiss, A., Horváth, J., Urbán, R., Demetrovics Zs. (2017): Novel psychoactive substance use among treatment-seeking opiate users: The role of life events and psychiatric symptoms. Human Psychopharmacol. 2017 May; 32(3) doi: 10.1002/hup.2602.

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

Martos, T., Csordás, G. (2021). WHO Jólét Kérdőív rövidített változata. In. Zs. Horváth, R. Urbán, Gy. Kökönyei & Zs. Demetrovics (Eds.), *Kérdőíves módszerek a klinikai és egészségpszichológiai kutatásban és gyakorlatban I.* Medicina Könyvkiadó, Budapest.

NAV (2022): A Nemzeti Adó- és Vámhivatal 2021-re vonatkozó beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez

NEAK (2020): AIDS elleni világnap.

[http://neak.gov.hu/data/cms1027815/AIDS\\_Elleni\\_Vilagnap\\_december\\_1.pdf](http://neak.gov.hu/data/cms1027815/AIDS_Elleni_Vilagnap_december_1.pdf) (Utolsó hozzáférés: 2020. 12. 15.)

Nemzeti Népegészségügyi Központ (NNK) (2022): A Drogmegelőzési Programok Osztályának beszámolója az EMCDDA 2022. évi jelentéséhez. Beszámoló.

NFP – Nemzeti Drog Fókuszpont (2021): Szerhasználat és ellátás a Covid-19 járvány idején 2021. februárjáig – a második hullám tapasztalata. 2021. Kutatási beszámoló

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

NFP (2016): Tűcsere szolgáltatók országos szakmai találkozója. Nemzeti Drog Fókuszpont.

NFP (2016): Tűcsere szolgáltatók országos találkozója. Nemzeti Drog Fókuszpont.

NFP (2020): 2020-as ÉVES JELENTÉS (2019-es adatok) az EMCDDA számára. Budapest, Mo: Nemzeti Drog Fókuszpont.

NFP (2022a): Kábítószer-fogyasztással összefüggő halálozási adatok 2020-ban.

NSZKK (2020a): A lefoglalások laboratóriumi vizsgálati eredményének adatai 2009 és 2019 között.

NSZKK (2020b): NSZKK Toxikológiai Szakértői Intézetének biológiai mintákra vonatkozó vizsgálati eredményei 2019-ben

NSZKK (2021a): A lefoglalások laboratóriumi vizsgálati eredményének adatai 2009 és 2020 között.

NSZKK (2022a): A lefoglalások laboratóriumi vizsgálati eredményének adatai 2009 és 2021 között.

NSZKK (2022b): A Nemzeti Szakértői és Kutató Központ adatai a bv. intézetekben lefoglalt kábítószeranyagok anyagokra vonatkozóan.

Oberth J., Bíró Zs., Mándi B. (2020): Beszámoló a Józan Babák Klub 2020. évi várandósgondozási tevékenységéről

OBH (2022): Az Országos Bírósági Hivatal Statisztikai Elemző Osztályának adatai 2022-es EMCDDA Jelentés elkészítéséhez

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

ORFK (2021): Kábítószer-függőséget gyógyító kezelésben, kábítószer-használatot kezelő más ellátásban, vagy megelőző-felvilágosító szolgáltatásban résztvevő elterelték számának alakulása 2010 és 2020 között.

ORFK (2022): Az Országos Rendőr-főkapitányság 2021-re vonatkozó beszámolója a 2022-es EMCDDA Jelentés elkészítéséhez.

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.* Hozzáférhető: <http://www.madaszsz.hu/images/doksik/szervtev1.pdf>

Paksi B. & Demetrovics Zs. (2002): A prevenciós gyakorlat megismerése. A budapesti középiskolai drogprevenciós programok felmérése és értékelése. Szakmai forrás sorozat. 2. L'Harmattan. Budapest.



- Paksi B. & Demetrovics Zs. (2003): Budapesti Drogprevenciós Adattár. CD. ISM, Budapest.
- Paksi B. & Demetrovics Zs. (2005) Országos Drogprevenciós Adattár. CD. L'Harmattan Kiadó, Budapest.
- Paksi B. & Demetrovics Zs. (szerk) (2011): *Drogprevenció és egészségfejlesztés az iskolában. NDI*. Budapest: L'Harmattan.
- Paksi B. (2008): Nem iskolai szinten megjelenő prevenciós programok feltérképezése. Kutatási Beszámoló, Kézirat.
- Paksi B. (2019): Drogfogyasztási szokások. In: Németh Á., Várnai D. (szerk.) *Kamaszéletmód Magyarországon. Az iskoláskorú gyermekek egészségmagatartása elnevezésű, az Egészségügyi Világszervezet együttműködésében megvalósuló nemzetközi kutatás 2018. évi felméréséről készült nemzeti jelentés*. ELTE PPK - L'Harmattan Kiadó. Budapest. ISBN 978-963-414-582-0
- Paksi B. (2022): Prevenció. 2022. Kézirat.
- Paksi B., Demetrovics Z., Griffiths M, D., Magi A., Felvinczi K. (2020): Estimating and managing the changing methodological parameters of self-report surveys of addictive behaviors - based on the waves of the National Survey on Addiction Problems in Hungary (NSAPH) in 2007 and 2015. *Neuropsychopharmacologia Hungarica* XXII (1) <http://mppt-nph.hu/images/magazin/pdf/vol22issue1/v22i1p29.pdf>
- Paksi B., Demetrovics Zs. & Felvinczi K. (2022): A szenvedélymagatartások megelőzésével foglalkozó beavatkozások országos katasztere 2017-2020. Kutatási Beszámoló. Budapest:
- Paksi B., Magi A. & Demetrovics Zs. (2016): Szenvedélymagatartásokra irányuló prevenciós beavatkozások országos katasztere, Magyar Pszichológiai Társaság XXV. Jubileumi Országos Tudományos Nagygyűlése, 2016. június 2-4., Budapest. In: Vargha A. (szerk) *Kivonatkiötet*. pp. 56-57. [http://mptnagygyules.hu/images/MPT\\_Ngy2016\\_kivonatkiötet\\_0509.pdf](http://mptnagygyules.hu/images/MPT_Ngy2016_kivonatkiötet_0509.pdf). [Letöltve: 2016-09-01]
- Paksi B., Magi A., Kó J. & Demetrovics Zs. (2015): Szakértői tanulmány - A Szerencsejáték Zrt. társadalmi felelősségvállalási programjához kapcsolódóan, a fiatal 14-24 év között populáció körében tervezett, a szerencsejáték tevékenység kockázatainak csökkentésére irányuló prevenciós tevékenység szakmai megalapozása. Kutatási Beszámoló. Szerencsejáték Zrt, Kézirat.
- Paksi B., Pillók P., Magi A., Demetrovics Zs., Felvinczi K. (2019): Drogfogyasztás a magyarországi felnőtt népesség körében - a 2019. évi „Országos Lakossági Adatfelvétel Addiktológiai Problémákról” (OLAAP 2019) első eredményei. *Magyar Addiktológiai Társaság XII. Országos Kongresszusa 2019. november 28-30.*, XV. Siófok, Supplementum kötet, pp. 40-41. <http://www.mat.org.hu/dok/kongresszus/00001.pdf>
- Paksi, B. (2007). A drogepidemiológia alapjai: a drogfogyasztás elterjedtségének mérése. In: Demetrovics Zs. (szerk.), *Az addiktológia alapjai I* (229-253). Budapest, Eötvös Kiadó.
- Paksi, B. (2017). ÚPSZ-használattal kapcsolatos epidemiológiai tapasztalatok az Országos Lakossági Adatfelvétel Addiktológiai Problémákról (OLAAP 2015) című kutatás alapján. In: *Felvinczi K. (szerk.), Változó Képletek –ÚJ(abb) szerekek: kihívások, mintázatok, megoldások* (45-68). Budapest, L'Harmattan Kiadó.
- Paksi, B. (2020): OLAAP 2019 – GPS adatok elemzése. Kézirat
- Paksi, B. (2021): Droghasználat és szerhasználat csoportok a budapesti 19-35 éves populációban a BLS (Budapesti Longitudinális Kutatás) 2020. évi adatfelvétele alapján. 2021. Kézirat
- Paksi, B., Demetrovics, Zs., Magi A., Felvinczi, K. (2018): A Magyarországi felnőtt népesség droghasználata – Az országos lakossági adatfelvétel az addiktológiai problémákról 2015

(OLAAP 2015) reprezentatív lakossági felmérés alapján. In: Magyar Pszichológiai Szemle 73(4):541-565.

Paksi, B., Demetrovics, Zs., Magi, A., Felvinczi, K. (2017). Az Országos Lakossági Adatfelvétel az Addiktológiai Problémákról 2015 (OLAAP 2015) reprezentatív lakossági felmérés módszertana és a minta leíró jellemzői. *Neuropsychopharmacologia Hungarica*, 19(2), 55-85.

Paksi, B., Magi, A., Felvinczi, K. (2018): Az elterelés keretében végzett megelőző-felvilágosító szolgáltatás tartalmának és közvetlen hatásainak vizsgálata – című kutatás második fázisának eredményei. A szolgáltatások folyamat- és eredményértékelése. Kézirat.

Paksi, B., Magi, A., Gurály, Z. (2020): Hajléktalan emberek pszichiaktív szerhasználat. Esély (megjelenés alatt)

Paksi, B., Magi, A., Pillók, P., Kótyuk, E., Felvinczi, K., Demetrovics, Zs. (2021). Módszertani háttér. In: Paksi B., Demetrovics Zs. (szerk.), *Addiktológiai problémák Magyarországon a lakossági kutatások tükrében*. Budapest, ELTE PPK - L'Harmattan.

Paksi, B., Pillók, P., Magi, A., Demetrovics, Zs., Felvinczi, K. (2021). Az Országos Lakossági Adatfelvétel az Addiktológiai Problémákról 2019 reprezentatív lakossági felmérés módszertana. *Neuropsychopharmacologia Hungarica*, 23(1), 184-207.

Paksi, B., Pillók, P. (2021). Drogfogyasztás. In: Paksi B., Demetrovics Zs. (szerk.), *Addiktológiai problémák Magyarországon a lakossági kutatások tükrében*. Budapest, ELTE PPK - L'Harmattan.

Paksi, B., Rózsa, S., Kun, B., Arnold, P., Demetrovics, Zs. (2009). A magyar népesség addiktológiai problémái: az Országos Lakossági Adatfelvétel az Addiktológiai Problémákról (OLAAP) reprezentatív felmérés módszertana és a minta leíró jellemzői. *Mentálhigiéne és Pszichoszomatika* 10 (4), 273—300.

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

Péterfi A. (2022a): TDI adatok 2021. Kézirat.

Péterfi A. (2022b): Szubsztitúciós adatgyűjtés 2021. Kézirat.

Péterfi A. (szerk.) (2016): Tisztább Kép. Projekt zárókiadvány. Magyar Ökumenikus Segélyszervezet.

[http://www.segelyszervezet.hu/sites/default/files/documents/tisztabb\\_kep\\_egyben.pdf](http://www.segelyszervezet.hu/sites/default/files/documents/tisztabb_kep_egyben.pdf)

Péterfi A., Major M., Dunay M. (2016): Kezelőhely vizsgálat terápiás közösségek körében. Nemzeti Drog Fókuszpont. Kézirat.

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

Péterfi, A. (2021a): TDI adatok 2021.

Péterfi, A. (2021b): Szubsztitúciós adatgyűjtés 2021.

Péterfi, A., Csorba, J., Figeczki, T., Kiss, J., Medgyesi-Frank, K., Posta, J., Gyarmathy, V.A. (2017): Drug residues in syringes and other injecting paraphernalia in Hungary. *Drug Testing and Analysis* doi: 10.1002/dta.2217

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

Prisons – Kitöltött EMCDDA kérdőív. Kézirat.

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

Róbert, P. (1990). Társadalmi mobilitás. In: Andorka R., Kolosi T., Vukovich Gy. (szerk.), *Társadalmi Riport* (356-372). Budapest, TÁRKI.



Robinson, P., J., Shaver, R., P., Wrightsman, S., L. (1991). *Measures of Personality and Social Attitudes*. San Diego, Academic Press.

Somogyvári Mihály (2022): A kábítószer-kérdés vetületei a börtönökben [https://epa.oszk.hu/04400/04497/00006/pdf/EPA04497\\_id\\_2021\\_04\\_107-137.pdf](https://epa.oszk.hu/04400/04497/00006/pdf/EPA04497_id_2021_04_107-137.pdf)

Susánszky, É., B Konkoly, T, Stauder, A., Kopp, M. (2006). A WHO Jól-lét Kérdőív rövidített (WBI-5) magyar változatának validálása a Hungarostudy 2002 országos lakossági egészségfelmérés alapján. *Mentálhigiénié és Pszichoszomatika*, 9(1), 247-255.

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

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

Szocokos (2021): Szociális ágazati tájékoztató közösségi portál. [http://tamogatoweb.hu/letoltes2020/2021kvtv\\_melleklet.pdf](http://tamogatoweb.hu/letoltes2020/2021kvtv_melleklet.pdf) (Utolsó hozzáférés: 2022.01.10.)

Tarján A. (2021a): Tűcsere programok adatai, 2020. Kézirat. Nemzeti Drog Fókuszpont

Tarján A., (2018). A hazai intravénás szerhasználók HIV/HCV-fertőzéssel összefüggő kockázati tényezői 2008-2015 között. Doktori értekezés. elérhető: [http://phd.semmelweis.hu/mwp/phd\\_live/vedes/export/horvathtarjananna.d.pdf](http://phd.semmelweis.hu/mwp/phd_live/vedes/export/horvathtarjananna.d.pdf); short version in English: [http://phd.semmelweis.hu/mwp/phd\\_live/vedes/export/horvathtarjananna.e.pdf](http://phd.semmelweis.hu/mwp/phd_live/vedes/export/horvathtarjananna.e.pdf) (2019. 10. 04.) (utolsó hozzáférés: 2018. szeptember 17.)

Tarján A., (2020a): Tűcsere programok adatai, 2019. Nemzeti Drog Fókuszpont. Kézirat.

Tarján A., Dudás M., Rácz J., Horváth G., (2019) HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalencia vizsgálata a hazai intravénás szerhasználók körében 2018-ban. Publikálás alatt.

Tarján A., Dudás M., Rácz J., Horváth G., (2020) HIV- és HCV-fertőzések és azokkal összefüggő kockázati és védő tényezők prevalenciavizsgálata a budapesti és kecskeméti intravénás szerhasználók körében 2019-ben. Publikálás alatt.

Tarján, A (2020b): A rekreációs színtéren ártalomcsökkentő/prevenációs tevékenységet végző szervezetek 2019. évi működési és forgalmi adatai. Nemzeti Drog Fókuszpont.

Tarjan, A., Dudas, M., Wiessing, L., Horvath, G., Rusvai, E., Tresó, B., & Csohan, A. (2017). HCV prevalence and risk behaviours among injectors of new psychoactive substances in a risk environment in Hungary-An expanding public health burden. *Int J Drug Policy*, 41, 1-7.

Tarján, A., Kovács, E., Galló, R., Tóth D., Takács, S., Sabjanics, A., Rácz, R., Szabó, R. (2021) HEPAGO-NFP budapesti HIV/HCV biomagatartás vizsgálat. Publikálás alatt.

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

## ANNEX

### LIST OF CHARTS

Chart 1.	Regulation of psychoactive substances .....	11
Chart 2.	Evolution of the regulation of new psychoactive substances dominant in domestic seizures in 2021 (2010-2021)* .....	18
Chart 3.	Prevalence of illicit drug use in the Hungarian adult population in 2019 (%).....	23
Chart 4.	Lifetime prevalence rates by substance types in the 18-64 and 18-34 year-old adult population in 2019 (%).....	24
Chart 5.	Lifetime prevalence rates by substance types for young adults aged 19-35 in Budapest in 2020 (in BLS wave 2, % of respondents) .....	25
Chart 6.	Lifetime prevalence rates by substance types among 16 year-old students in 2019 (%)	26
Chart 7.	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 .....	29
Chart 8.	Drug use pyramid for cannabis users in the 19-35 years-old young adult population of Budapest (based on the 2 <sup>nd</sup> wave of BLS) and 18-64 year-old Hungarian population (based on NSAPH 2019) (as a percentage of cannabis users; N=498/77*).....	32
Chart 9.	Changes in the lifetime prevalence of cannabis use between 1995 and 2019 among 16 year-old students, by gender (%).....	33
Chart 10.	Prevalence of synthetic cannabinoid use in the 18–34 year-old young adult population in 2015 and in 2019 (%) .....	36
Chart 11.	Drug use pyramid for synthetic cannabinoid users in the 19-35 years-old young adult population of Budapest (based on the 2 <sup>nd</sup> wave of BLS) and 18-64 year-old Hungarian population (based on NSAPH 2019) (as a percentage of synthetic cannabinoid users; N=48/26*)	37
Chart 12.	Drug use pyramid in the homeless population (% of ever-users of cannabis and/or synthetic cannabinoids), 2017 .....	39
Chart 13.	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) .....	41
Chart 14.	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 2020 two or three substance groups; N=2603) ...	42
Chart 15.	The prevalence of substances (established drugs and NPS) in biological samples in 2020 (N=11 237) .....	42
Chart 16.	Trends in drug use in the nightlife/recreational setting between 2018 and 2019 as viewed by service providers, by substance based on the mean value of all responses (number of respondents = 20 organisations) .....	44
Chart 17.	Distribution of drug users (n = 88 persons) participating in the Budapest biobehavioural study by primary drug used 4 weeks prior to the survey in 2020 .....	45
Chart 18.	Distribution of drug users (n = 87 persons) participating in the Budapest biobehavioural study by the most common drug using techniques 4 weeks prior to the survey in 2020	46
Chart 19.	Lifetime prevalence rates of stimulants by drug type in the adult population aged 18-64 years and 18-34 years, in 2019 (%).....	48
Chart 20.	Changes in the lifetime prevalence of the various stimulants between 2007 and 2019, in the adult population aged 18-64 years (%).....	49
Chart 21.	Changes in the lifetime prevalence of established stimulants between 1995-2019 among 16 year-old students (%).....	52
Chart 22.	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) .....	55

Chart 23.	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) .....	57
Chart 24.	Breakdown of NSP clients by primary injected drug between 2009 and 2020 (upper chart) and total number of NSP clients per year (lower chart) .....	59
Chart 25.	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 prior to the survey, in 2018 .....	61
Chart 26.	Main route of administration of the primary used drug in the last 4 weeks among PWID participating in the HNFP-NNK HIV/HCV biobehavioural survey in 2018 (N=437; %).	62
Chart 27.	Most common mono/poly drug use patterns among PWID participating in the HNFP-NNK HIV/HCV biobehavioural survey in 2018 (N=344) (upper row: primary drug and route of administration; lower row: secondary drug and/or route of administration).....	63
Chart 28.	Number of current PWID, between 2009 and 2020 (persons) .....	64
Chart 29.	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).....	66
Chart 30.	The proportion of interventions targeting different special (vulnerable) groups among prevention interventions aimed directly at the final target group (%; N=151).....	96
Chart 31.	Distribution of service providers identified as prevention providers for addictive behaviours operating between 2017 and 2020, according to whether they currently offer their own preventive intervention (%; N=430) .....	99
Chart 32.	Geographical distribution of service providers that are currently operating and offering their self-developed programme-like preventive interventions aimed at preventing addictive behaviours (number of service providers per county and Bp; N=276).....	100
Chart 33.	Distribution of prevention organizations according to main activity (%; N=97)	101
Chart 34.	Distribution of the resources of the programmes / services in respect of continuity (%; N=145) .....	102
Chart 35.	Average distribution of the source composition of programmes/services (average %; N=143) .....	102
Chart 36.	The number of universal, selective and indicated prevention programmes/services among interventions aiming directly the final target group (pcs; N=151)	103
Chart 37.	Classification of programmes/services aimed directly at the final target group based on target groups (%; N=151).....	104
Chart 38.	The proportion of interventions targeting different special (at-risk) groups among prevention interventions aimed directly at the final target group (%; N=151) .....	105
Chart 39.	Prevalence of available universal (N=94), selective (N=60) and indicated (N=42) interventions according to the age of the target population among programmes aiming the final target group (N=151; %) .....	106
Chart 40.	Appearance of different objectives in prevention interventions aiming directly the final target population (%; N=149) .....	107
Chart 41.	Chart 12: Addictive behaviours directly or indirectly targeted by prevention programmes/services aimed directly at the final target population (%; N=151) .....	108
Chart 42.	The number and distribution (%) of programmes aimed directly at the final target population by the duration (total number of hours calculated with per 45-minute classes) of the programme (per 45-minute class; N=92) .....	108
Chart 43.	The number and distribution (%) of programmes aimed directly at the final target group according to the number of occasions (N=92) .....	109
Chart 44.	Incidence of methods used during programmes aimed directly at the final target group (%; N=108).....	109
Chart 45.	The main characteristics of training programmes/services aimed at the intermediary target groups (no; N=16) .....	110
Chart 46.	Appearance of different objectives in peer and non-peer training programmes/services aimed at the intermediary target group (%; N <sub>peer</sub> =6; N <sub>non-peer</sub> =10) ....	111

Chart 47.	Proportion (%) of interventions targeting special groups among prevention programmes/services directed at the final target group in the 2015 (N=96) and 2020 (N=151) studies	112
Chart 48.	Proportion (%) of directly targeted addictive behaviours among prevention programmes/services aimed at the final target group in 2015 (N=96) and in the current research (N=145)	113
Chart 49.	Types of quasi-compulsory treatment	118
Chart 50.	Breakdown of treatment demand by primary drug (2021; %; N=4283)	122
Chart 51.	The proportion of those entering treatment as an alternative to criminal procedure (QCT) among those entering drug treatment, by type of treatment centre (2021; N=4272)	123
Chart 52.	Breakdown of QCT and non-QCT treatment entrants by primary drug (2021; N <sub>QCT clients</sub> =3484; N <sub>Non-QCT clients</sub> =788)	124
Chart 53.	Breakdown of OAT maintenance clients (outer curve, N=550) and OAT detoxification clients (inner curve, N=27) by substitution medication in 2021 (persons; %)	127
Chart 54.	Breakdown of OAT clients by age group in 2021 (N=577; persons)	127
Chart 55.	Breakdown of clients entering treatment by source of referral between 2012 and 2021 (persons)	129
Chart 56.	Trends in the number of all clients entering treatment (on the left) and clients entering treatment for the first time (on the right) by primary drug, 2009-2021 (persons)	130
Chart 57.	Trends in numbers of clients in OAT by type of OAT, 2004-2021* (persons)	131
Chart 58.	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)	136
Chart 59.	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)	137
Chart 60.	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)	138
Chart 61.	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)	139
Chart 62.	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)	141
Chart 63.	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)	142
Chart 64.	What are the three main challenges at present (January-February 2021) in terms of service delivery and/or for your clients? (number of mentions)	144
Chart 65.	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)	146
Chart 66.	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?	147
Chart 67.	At present (January-February 2021) is there a harm or problem among substance users you would highlight? (number of mentions)	149
Chart 68.	What do you think are the relevant problems from a public health perspective at present (January-February 2021)? (%; basis: full sample, N=61)	150
Chart 69.	Trend of the direct drug-related deaths by age groups between 2011-2021 (cases)	155

Chart 70.	Number of direct drug-related deaths by gender between 2011-2021 (cases)	157
Chart 71.	Number of direct drug-related deaths by the type of drugs involved between 2011-2021 (cases)	158
Chart 72.	Breakdown of direct drug-related deaths among „cases involving opioids” and „cases not involving opioids” between 2011-2021 (%)	158
Chart 73.	Breakdown of HCV prevalence (%) among PWID tested during the national HNFP-NNK HIV/HCV biobehavioural survey, by gender and age group in 2018	160
Chart 74.	Breakdown of HCV prevalence among current PWID tested during the national HNFP-NNK HIV/HCV biobehavioural survey by primary injected drug in 2018	160
Chart 75.	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	163
Chart 76.	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 Budapest results) in Budapest and in cities outside of Budapest, 2006-2019*	164
Chart 77.	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*	165
Chart 78.	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*	166
Chart 79.	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	167
Chart 80.	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	167
Chart 81.	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	168
Chart 82.	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)	169
Chart 83.	Source of syringes (%) in the last 4 weeks among current PWID participating in the HNFP-NNK national HIV/HCV biobehavioural survey in 2018 (N=218)	174
Chart 84.	Number of specialised treatments in HIV indication by treatment modalities in 2020 (person)	178
Chart 85.	Number of approved HCV treatments and number of patients on the waiting list by month in Hungary between August 2015 and August 2020	179
Chart 86.	Syringe-related data of NSPs, between 2010 and 2021	181
Chart 87.	Number of NSP clients and number of contacts, between 2010 and 2021	182
Chart 88.	Number of distributed syringes in NSPs and number of sold syringes in pharmacies, national, 2010-2020	184
Chart 89.	Breakdown of registered drug law offences (N=7419) by substance type in 2021 (%)	199
Chart 90.	Breakdown of registered drug law offences by perpetration and substance type, 2021	201
Chart 91.	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 of prosecution according to the old; and conditional prosecution parole according to the current code of criminal proceedings)	202
Chart 92.	Number of probation services provided in connection with quasy compulsory treatment (QCT), 2012-2021	203

Chart 93.	Distribution of drug offenders by highest level of education (N=7838).....	204
Chart 94.	The number of seizures of 'classical drugs' and NPS between 2009-2021 ....	208
Chart 95.	Monthly breakdown of the different synthetic cathinone derivatives in seizures containing any synthetic cathinones in 2021 (in the percentage of cathinone seizure cases of the given month; %) .....	209
Chart 96.	The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between 2010-2021 .....	210
Chart 97.	Monthly breakdown of the different synthetic cannabinoid compounds in seizures containing any synthetic cannabinoid in 2021 (in the percentage of synthetic cannabinoid seizure cases of the given month; %) .....	211
Chart 98.	Annual breakdown of plant materials impregnated with synthetic cannabinoids by carrier material (magis tobacco = tobacco) (in the percentage of annually sized plant products impregnated with synthetic cannabinoids; %) .....	212
Chart 99.	Monthly breakdown of other NPSs identified in the seizures of powders and tablets in 2021 (in the percentage of all other NPS seizure case in the given month; %) ....	212
Chart 100.	Active substances detected on seized injecting paraphernalia between 2012-2021	213
Chart 101.	Indexed trends of retail drug prices, based on their mean price between 2012 and 2021 (base: 2012 prices) .....	214
Chart 102.	The number of registered drug law offences in Hungary between 2011-2021	215
Chart 103.	Breakdown of drug law offences by substance type between 2017-2021.....	216
Chart 104.	Number of seizures of suspected drugs in Hungarian prisons (2009-2021) ...	223

## LIST OF TABLES

Table 1. Regulation of narcotic drugs and new psychoactive drugs according to the Penal Code	15
Table 2. Small amounts established for certain scheduled substances and groups of compounds on the schedule of new psychoactive drugs	16
Table 3. Changes in the legal framework in 2021	20
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)	30
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	31
Table 6. Lifetime prevalence of cannabis use across various socio-demographic characteristics among 16 year-old students, in 2019 (%)	34
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	46
Table 8. Lifetime prevalence of use of established stimulants across various socio-demographic characteristics in the general population aged 18-64 years, in 2019 (%)	50
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 (%)	50
Table 10. Lifetime prevalence of use of established stimulants across various socio-demographic characteristics among 16-years-old students, in 2019 (%)	53
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)	72
Table 12. Pairwise, uncontrolled multinomial 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)	75
Table 13. The size of the population reached by prevention interventions in 2019 and in an average year (person)	106
Table 14. The size of the population reached by prevention interventions in 2019 and in an average year (person)	110
Table 15. Network of outpatient treatment facilities (total number of treatment units and clients in 2021)	117
Table 16. Network of inpatient treatment facilities and prisons (number of treatment units and number of clients) in 2020	120
Table 17. Summary table – clients in drug treatment in 2021 (persons)	122
Table 18. Breakdown of direct drug-related deaths in 2021 by gender and substance type (persons)	155
Table 19. Number of direct drug-related deaths in 2021	156
Table 20. Syringe and client numbers of NSPs in 2021	174
Table 21. Distribution of injecting and harm reduction equipment and provision of other services by NSPs, in 2021 (N=32)	175
Table 22. Coverage of injecting and harm reduction equipment and provision of other services by NSPs, in 2021	176
Table 23. Retail drug prices in 2022 in HUF	196
Table 24. Retail drug prices in 2022 in EUR	197
Table 25. Number of seizures between 2017-2021	207
Table 26. Quantity seized between 2017-2021	207
Table 27. Breakdown of prisoners who have ever used drugs by the most frequently used substances prior to imprisonment (N=6381) in 2021	221
Table 28. Breakdown of prisoners who have ever used drugs by frequency of use prior to imprisonment (N=6350) in 2021	221

Table 29. Number of seizures of suspected drugs by form of smuggling into Hungarian prisons in 2021 .....	222
Table 30. Active substances/active substance combinations identified by the NSZKK on impregnated papers seized in prisons (2015-2021) .....	223
Table 31. 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) .....	231



## LIST OF ABBREVIATIONS

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  
KSH – Hungarian Central Statistical Office  
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