REPORT ON THE
DRUG SITUATION IN HUNGARY

Ministry of Children, Youth and Sports

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STRATEGY FOR DECREASING DEMAND

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NATIONAL STRATEGY: INSTITUTIONAL AND LEGAL FRAMEWORK

Principles of the National Strategy Programme

The Hungarian drug situation has changed significantly over the last decade and working out an effective strategy for state involvement has become ever more urgent. Hungary first adopted a national programme covering the overall problem in 2000. The programme, which was prepared on the basis of a wide range of professional, social, administrative and political discussions, affords a serious opportunity for reducing the individual and social harms caused by the problem, for conscious and effective societal intervention, for the involvement of individuals and communities, for influencing the drug-related views and attitudes of youth and those affected, for developing appropriate and nationwide prevention programmes, and for decreasing criminal processes related to drug abuse and trafficking as well as reducing access to drugs. The general aim of the programme is the development of a free, self-confident and productive society that considers human dignity, as well as physical, mental, and social well-being and creativity as especially important and, to this end, is able to handle the health, social, and criminal harm and disadvantages related to the use and spread of drugs.

Parliament, in line with international recommendations, adopted a multidisciplinary approach to understanding the syndrome and an approach to influencing the problem that builds on the balance of reducing supply and demand.

The Strategy defines the basic objectives and interests, the framework for understanding the problem, but also takes account of the limits and risks of its implementation.

The Strategy identifies the main directions and principal elements of strategic development, gives guidance to the arenas and players for the implementation of the aims of the Strategy, initiates the creation of a social consensus, endeavours to achieve the involvement of society and its groups, local governments, policy-makers, NGOs and local communities in the implementation of the programme and, at the same time, fulfils the requirements of European Union accession and international cooperation in respect of effectively handling drug problems.

The Strategy is based on the following main principles:

• Primacy of facts
  The National Strategy builds on facts found by scientific studies and not opinions. It favours well-grounded methods for interference.

• Partnership, joint action
  The National Strategy builds on the cooperation between society and public institutions and also counts on cooperation with active members of local communities. The Strategy recognises that coordinated and joint action has increases effectiveness and efficiency. The Strategy considers the needs of families, educational institutions, and local communities, and requires and promotes cooperation at the local, regional, national, and international levels.

• Overall approach
  The drug problem must be handled through a multidimensional, balanced, and well-structured approach in which prevention, education, treatment, research, workplace programmes, criminal investigations, and various other areas each have a key role. Containing the drug problem requires the joint, coordinated action of various professions and areas. No single profession should appropriate or try to solve the problem alone.

• Accountability
  In each case, the National Strategy designates indicators of success with which achievements can be measured, thereby enabling transparent performance and controllable costs. The National Strategy is reviewed from time to time.
• Long-term planning
On the basis of experiences abroad, the drug problem can only be contained in the long run. Short-term solutions cannot be successful when, in addition to handling current dangers, we are also responsible a new generation’s relationship to drugs.

The Institutional System for the Implementation of the Strategic Programme

The Coordination Committee on Drug Affairs

The Coordination Committee on Drug Affairs (CCDA) plays a key role in the implementation of the National Strategy and the coordinated operation of the relevant processes. (16 central administrative departments are represented at the state secretary or deputy director level in the CCDA. These are the Ministry of the Interior; the Ministry of Health, Social and Family Affairs; the Ministry of Employment and Labour; the Ministry of Agricultural and Rural Development; the Ministry of Economy and Transport; the Ministry of Children, Youth and Sports; the Ministry of Defence; the Ministry of Justice; the Ministry of Foreign Affairs; the Prime Minister’s Office; the Ministry of Education; the Ministry of Finance; the National Public Health and Medical Officer Service; the National Police; the Hungarian Customs and Finance Guard; the National Directorate of Penal Authorities; as well as representatives of the Supreme Court, the Attorney General, and the National Crime Prevention Committee). The CCDA is chaired by the Minister of Children, Youth and Sports and co-chaired by the Minister of Health Social and Family Affairs. The secretary of the Committee is the deputy state secretary of the Ministry of Children, Youth and Sports Responsible for the Coordination of Drug Affairs. The main tasks of the CCDA are to control the enforcement of the National Strategy, to coordinate the work of the various ministries and public institutions, and to approximate the views of the various branches. The CCDA reports annually to the Government on the drug situation in Hungary and evaluates the implementation of the National Strategy.

The Coordination Committee on Drug Affairs currently operates 8 expert subcommittees, of which four are managed by the Ministry of Children, Youth and Sports (MCYS), and one each by the Ministry of Health, Social and Family Affairs, the Ministry of the Interior, and the Ministry of Justice.

The Work of the Coordination Committee on Drug Affairs in 2002: the implementation of plans

The work of the Coordination Committee on Drug Affairs consists of the work of the Committee and the expert subcommittees, on which the Secretary reports regularly. Unfortunately, the activities of the year 2002 were strongly influenced by the transitional situation arising from parliamentary and local elections; therefore, much less work was performed over the year than was expected, especially on the expert subcommittee level. We must point out, however, that the Deputy State Secretariat for the Coordination of Drug Affairs of the MCYS regularly kept in touch with each expert in the subcommittees during the preparation of the National Report and the report for EMCDDA, as well as daily contact with all the relevant ministries within the framework of cooperation in grant applications, publications and conferences.

After the elections, a review of the statutes of the Committee became necessary, which the Committee discussed on November 21, 2002, and after interdepartmental approval, the proposal for the amendment was presented to the Government (Government Decision 1035/2003. [IV. 24.]). When the new Government was set up, the new members of the CCDA were appointed by the ministries and the national institutions.

The principle that participating ministries should ensure the work of the Committee in every respect, continues to be important. This also means that representation at the appropriate level should be provided in each case and properly authorised representatives of each ministry should participate at the meetings. This level was defined as Deputy State Secretary or Deputy Director in Government Decision no. 1039/1998. (III. 31.) On the Creation and Operation of the CCDA. The Decision did not
define the order of member substitutions, though in the 2003 amendment a substitute was defined as “a representative entitled to take a position”.

Meetings and Agenda of the Coordination Committee on Drug Affairs

1. March 14, 2002

Agenda of the meeting:

1. Review of the enforcement of legal harmonisation tasks related to European Union accession, specifically defining tasks yet to be performed.  
   Presented by: Ministry of Justice (MJ)
2. Discussion of the proposed regulation on the legal and illegal use of drugs and psychotropic materials.  
   Presented by: Ministry of the Interior (MI)
3. Discussion of the Mini Dublin Group report, comparison with the report on the enforcement of the national strategic programme prepared for reducing the drug problem.  
   Presented by: MI
4. Regulation of the activities performed with various chemicals related to the prohibited manufacturing of drugs; overview of the regulatory situation.  
   Presented by: Ministry of Economy (ME)
   Presented by: Ministry of Youth and Sports Affairs (MYSA)
6. Report on the work of the Coordination Committee on Drug Affairs in 2001 and on the implementation of its working plan.  
   Presented by: MYSA
7. Proposal for the preparation of sector-specific strategies for the implementation of the National Strategic Programme for the reduction of the drug problem.  
   Presented by: MYSA
8. Supreme Court Uniformity Ruling 5/1998 BJE; review of Court Position BK 155; evaluation of the experiences affecting the application of the new uniformity ruling related to the debated issues arising in connection with the application of the provisions of the Criminal Code on drug abuse.  
   Presented by: the Supreme Court
9. Extension of the objective drug screening system to young people being conscripted to the Army.  
   Presented by: Ministry of Defence (MD)

2. August 28, 2002

Agenda of the meeting:

1. Discussion of the Government’s motion on the amendment of the criminal laws and the various related acts.  
   Presented by: MJ
   Presented by: MD
3. Discussion of the Government Decision prepared with the involvement of the affected Ministries for the amendment of the regulations relating to the international provision of data on drugs.  
   Presented by: MCYS
4. Information on Hungary’s letter of intent to join the European Monitoring Centre for Drugs and Drug Addiction.
   
   Presented by: Ministry of Foreign Affairs (MFA)

5. Motion on the uniformisation of the Hungarian names of the international organisations, institutions and programmes related to the Coordination of Drug Affairs.
   
   Presented by: MFA

   
   Presented by: Ministry of Health, Social and Family Affairs (MHSFA)

7. Proposal on the steps to be taken for the implementation of the National Strategic Programme for the reduction of the drug problem in the 2003–2004 budget period.
   
   Presented by: MHSFA

8. Establishment of a fund necessary for the reduction of the drug supply. The fund can potentially be used for the training of personnel from criminal investigation authorities, for improving their equipment, and for acquiring new technical equipment.
   
   Presented by: Hungarian Customs and Finance Guard (Customs Authority)

9. Police experiences, tendencies and indicators related to the illegal trafficking of precursor substances in the field of drug sales in public areas.
   
   Presented by: National Police

3. November 21, 2002

Agenda of the meeting:

1. Discussion of the proposed regulation of the legal and illegal use of drugs and psychotropic materials (motion postponed from the 14. 03. 2002 meeting).
   
   Presented by: MI, MHSFA

2. Regulation of the activities involving various chemicals related to the prohibited manufacturing of drugs; overview of the regulatory situation.
   
   Presented by: ME

   
   Presented by: Attorney General

   Information on the current amendment of the Criminal Code
   
   Presented by: MJ (verbal)

4. The role of the Police in decreasing the demand for drugs; experiences with drug prevention and educational programmes, possibilities for expansion.
   
   Presented by: National Police

5. Information on the uniform accreditation of the professional programmes involving drug prevention services
   
   Presented by: MCYS

6. Report on the work of the Expert Subcommittees of the Coordination Committee on Drug Affairs, proposed changes
   
   Presented by: MCYS

7. Information on the time-scaled achievements of the National Strategic Programme for the reduction of the drug problem
   
   Presented by: MCYS

8. Information on the Government Report on the Hungarian drug situation and the related annual report to be prepared for the EU
   
   Presented by: MCYS
The Work of the Expert Subcommittees of the Coordination Committee on Drug Affairs

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<thead>
<tr>
<th>Expert Subcommittee</th>
<th>Responsible Entity</th>
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<tr>
<td>Legal Expert Subcommittee</td>
<td>Ministry of Justice</td>
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<td>Epidemiological Expert Subcommittee</td>
<td>Ministry of Children, Youth and Sports</td>
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<td>Health Expert Subcommittee</td>
<td>Ministry of Health, Social and Family Affairs</td>
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<td>Social and Child Protection Expert Subcommittee</td>
<td>Ministry of Health, Social and Family Affairs</td>
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<td>Supply Reduction Expert Subcommittee</td>
<td>Ministry of the Interior</td>
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<tr>
<td>Prevention Expert Subcommittee</td>
<td>Ministry of Children, Youth and Sports</td>
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<td>Laboratory Expert Subcommittee</td>
<td>Ministry of Children, Youth and Sports</td>
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<tr>
<td>Local Government Expert Subcommittee</td>
<td>Ministry of the Interior; Ministry of Children, Youth and Sports</td>
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The following Expert Subcommittees held meetings in 2002:
1. Legal Expert Subcommittee
   - on February 22, 2002
   - on August 1, 2002
2. Prevention Expert Subcommittee
   - on October 10, 2002
3. Epidemiological Expert Subcommittee
   - on December 16, 2002

The National Focal Point

(Report of the Ministry of Health, Social and Family Affairs)


Since 1995, the EU Member States have been providing drug-related data to the EMCDDA in the form of an annual report on the drug situation, while the Central and East European countries (including Hungary) have been preparing and submitting such reports since 1997. In 2002, 26 countries, that is the 15 EU Member States, Norway, and 10 Central and East European countries submitted reports to the EMCDDA. The EMCDDA compiles an Annual report on the state of the drug problem in the European Union from the country reports, which it then publishes throughout Europe.

The natural term of production of the report is two years, as national data are always compiled in the quarter following the subject year; the centres process and analyse the data from the various sectors in the subsequent six months, which they submit to the EMCDDA in autumn, which in turn prepares the European annual drug report in the subsequent year from the reports of the 26 countries. What this means in practice is that the data from the year 2001 are published in the European report in 2003.

The aim of the EMCDDA is to provide the Community and the Member States with objective, reliable and Europe-wide comparable data with the help of the REITOX network on drugs, drug addiction, and the consequences thereof. The statistics, documentation, and scientific information processed and prepared by the EMCDDA provides the Community and the Member States with an...
overall picture on the drug and drug addiction situation, useful in taking measures in their own jurisdiction or when deciding on taking steps against the drug problem.

The data are collected in each Member State by a REITOX Focal Point, that is, a national drug data collection and contact point forming part of the European drug data collection network, which compiles and forwards the data to the EMCDDA in the form of annual national reports. The centres collect the data from primary data collection points (mainly relevant national institutions, centres or places of research) or in some cases, directly. The national centres may only send validated (that is valid, controlled, and objective) data to the EMCDDA in the form it requires, and also should provide an analysis for the Centre in Lisbon.

The European Union expects the institutionalisation of the focal point from May 2004, and reports in standard form from the year 2004. In 12 of the EU Member States, the focal points are smaller (3-4 persons) institutional/organisational units, with an independent budget operating within health-care institutions (the relevant ministry, or a public health or addiction research institute). In Hungary, the contact point since 1994 has been the Ministry of Health. While earlier, the report to the EMCDDA was prepared by the Ministry of Health, as of the years 2000–2002, the report was also prepared by the Ministry of Children, Youth and Sports. From January 2004, the tasks of the national centre will be performed by a unit forming part of the Johan Béla National Centre for Epidemiology of the National Chief Medical Bureau pursuant to Government Decision 1091/2003. (IX. 9.).

One problem at the EU level was that the data from the various countries related to the drug problem are not comparable; therefore, one of the main tasks of the Lisbon Centre and the national centres, in addition to the compiling of data and guaranteeing their validity, is to ensure their comparability. The form of drug-related data collection must be transformed in Hungary accordingly. We must introduce, for example, the treatment demand indicator, as the current treatment data collection (National Statistical Data Collection Programme Report No. 1627 on Drug Users and their Treatment) does not comply with EU standards in several respects. The Multi-City Project of the European Council Pompidou Group is aimed at introducing the treatment demand indicator at a city level in the big cities of Europe. 3 Hungarian researchers were involved in this project between 1994–1999, and although the project yielded several important results, the treatment demand indicator has not been tested and introduced in Hungary. This is a task for the coming two years. The indicator is essentially a statistical data sheet following the relevant European protocols for each client, to be filled out by treatment personnel when a client enters treatment (naturally on an anonymous basis). The data thus collected are then forwarded to the national centre quarterly. Data must also be provided regarding the diseases contracted as a result of drug use (such as HIV/AIDS, hepatitis B, C, and tuberculosis) and occurrences of drug-related deaths.

Although the data on the supply side of drugs, such as the price and chemical composition of illegal drugs, the amounts impounded and confiscated, and drug-related crime and sentences must be reported primarily to Europol, (which is the responsibility of the International Criminal Cooperation Centre formed by the National Police), in order to be able to present an overview of the drug situation in the annual report, the EMCDDA also demands such data. Data must be provided regarding the so-called designer drugs appearing on the illegal market, more specifically their launch on the illegal market, the chemical composition and the toxic effects on the human body of these new synthetic drugs and psychotropic materials manufactured in illegal drug laboratories.

The system of requirements of the EMCDDA is different from that used by the Hungarian authorities over the last few decades, which were based on the requirements of other international organisations (such as the UN, WHO, Interpol). The data must be provided in accordance with the mode and form defined by the EMCDDA (that is, type of substance, gender, age groups, diagnosis of related disease, crime category, etc.). For this reason, a number of changes need to be introduced in the collection of data.

However, when speaking of the harmonisation of data collection, we do not only mean the kind of table that the provider of the data (e.g. the institution treating the client, the judicial medical expert or the
police officer investigating the case) must fill out, but also refer to the conducting of certain investigations that are indispensable for gaining the data. By this we mean that according to EU requirements, an autopsy and toxicological examination must be performed in the case of each death where the suspicion arises that it was drug-related, or that for the purposes of prevention, early recognition and treatment of HIV/AIDS and hepatitis B, and C infections or tuberculosis among drug users, it would be advisable to conduct regular, voluntary national screening campaigns.

Two years ago, the Council of the European Union obligated the Member States to report on the 5+1 most important drug-epidemiological indicators in a consistent form (these are what we call “mandatory indicators”). In addition to the mandatory indicators, the EMCDDA requires numerous other data and information, which each Member State currently reports as they become available, although the standardisation of the data collection is also under way.

With the involvement of the ministries/national institutions responsible for data collection, all data collection must be harmonised, since in the opinion of the EMCDDA there is only a single collection event that complies with the requirements. This is the European school review introduced under the auspices of the Pompidou Group of the European Council, which gives a picture of the alcohol and drug consumption of 16 year olds triennially (ESPAD).

The EMCDDA annually renews the system of factors of the annual report and annually concludes a contract with the national centres for the preparation of the report. Half of the budget of the centres is obtained from performing such contracts. In the annual report, in terms of form, in addition to the detailed verbal analytical portion, the data are in structured tables (with text) and in at least 20 types of tables containing numerical data. The conclusions are also based on research data.

For example, the EMCDDA requires structured tables on prevention programmes in schools or harm-reduction measures. In these, they expect short, specific, written responses to targeted questions because this is the only way to reliably compare information arriving from 26 different countries.

It is apparent from the above that after the formation of the REITOX Focal Point, its main task will be to follow the requirements of the EMCDDA by preparing a report with the appropriate structure and meeting the required quality, which cannot be done without the cooperation and accurate reporting work of the professionals working in the field. In order to achieve this, courses and professional conferences will take place in the near future.

The European Union assisted this by supporting two projects. The PHARE Multi-country programme EMCDDA-I project, involving 10 countries ran from March 2001 to November 2002, while the bilateral PHARE COP’2000 programme HU-0006 twinning project ran from November 2001 to November 2002. The aim of the former was the direct involvement in the activities of the EMCDDA of the Hungarian professionals responsible for data provision, while the main goals of the latter was the creation of the national REITOX Focal Point, the new-data-collection-training of a wide range of professionals in the field, and the introduction of 9 demand-reduction model projects.

Although the change in the data collection will presumably impose additional burdens on the institutions during the transitional period, we must consider that this will not only facilitate the work of policy makers at the national or European level, but that it will also do so locally. The policy-makers of the local governments will be able to base their decisions regarding community developments, institutional expansion, and programme financing on this data. In addition, it will give an advantage to the given institution in the analysis of its own performance, in the quality of its work, and in developing its methods and making plans. Thus, the change serves the interests of all institutions alike, which many people will recognise and presumably, a good level of cooperation will develop between the professionals working in the field, the data collections centres, and the staff of the National Drug Data Service and Coordination Centre in connection with the introduction of data collection methods compatible with the EU in Hungary.
Co-ordination Forums on Drug Affairs (CFDAs)

(Report of the National Drug Prevention Institute)

The document entitled the National Strategy for the Reduction of the Drug Problem, which the Hungarian Parliament accepted almost unanimously on December 5, 2000, states as a basic objective that “Society should become sensitive to the effective treatment of drugs and the local communities should increase their problem-solving ability in the reduction of the drug problem.” Community and cooperation are key concepts here, which are basic pillars of the implementation of the objective. As a result, the Co-ordination Forums on Drug Affairs (CFDAs) have a key role in the implementation of the strategy. The CFDAs must operate as the engine of local drug policies, their main task being to ensure that the strategic ideas become reality.

At the local level, an CFDA is an advisory and arbitration forum as well a professional working group, which was called to life through the commitment of local governments and the professional and financial support of the Government. With its activities, it endeavours to create harmony between organisations, institutions, and work related to the four key areas in the reduction of the drug problem: community and cooperation; prevention; treatment and rehabilitation; and the reduction of supply. The CFDA attempts to create a uniform professional and methodological approach and to rationalise and coordinate local activities related to the prevention of drug use. It helps to mobilise local resources, coordinates the activities of local players, and makes recommendations to avoid any overlap. The CFDA coordinates and promotes local applications for national and international grants as a professional point of reference, and one of its main activities is to work out a local strategy for the handling of the drug problem. Members of the CFDA are those representatives of various public bodies, local governments, NGOs and churches that play a key role in the treatment of the drug problem.

The objective is to initiate a dialogue and to strengthen such discourse between the parties interested in, and with a responsibility for, the drug question. The most important task is to create communication between players who may at times have opposing interests. It is important to highlight the significance of communications both in the figurative and the literal sense. It is clear that the reconciliation of interests, and effective interventions with the same direction always presume the clear wording of and successful delivery of messages. Accordingly, CFDAs are professional workshops with a catalyst role: the exposure and understanding of local features and needs in the development of local strategies and forms of implementation. Thus, CFDAs are not “organisations” for the implementation of programmes, but forums of effective communication. Nowadays, the view is widespread that successful prevention must always rely on local resources and encourage their effective mobilisation. In other words, effective prevention is community-based and relies on the opportunities and resources arising from the organisation of existing and natural “living spaces” – scenes.

The former Ministry of Youth and Sports Affairs, now called the Ministry of Children, Youth and Sports, worked out a support programme for the creation and operation of CFDAs. As a result of the programme, by 2002, in the seven Hungarian regions and Budapest, altogether 66 Co-ordination Forums on Drug Affairs were formed: in addition to the 58 CFDAs in cities and towns, there are 2 county level, 3 small-regional, 1 regional and 2 Budapest district CFDAs. The aggregate amount of support in 2002 was HUF 68 million. The National Drug Prevention Institute (NDPI) assists and coordinates the professional work of the CFDAs on the national level.

Below, we provide the summary of the 2002 annual reports of the CFDAs. The summary covers operations within an CFDA, as well as the work being done in cities for containing the drug problem and the professional relationship with the National Drug Prevention Institute.

Due to the discrepancies between the programmes of the Forums and the countless variations of local events, summarising the experiences is relatively complicated. The reports – similarly to the previous year – are difficult to unify and compare and for the moment it is difficult to avoid subjective
elements (e.g. evaluation of own activities). For this reason, we believe that rather than quantitative data, the qualitative elements are more important.

Of the currently existing 66 CFDA\textsc{s}, we asked the 58 city and town CFDA\textsc{s} to prepare annual reports. The remaining 8 CFDA\textsc{s} only started to operate in 2002.

**General Data on Co-ordination Forums on Drug Affairs**

As we mentioned in the introduction, various organisations and institutions each send a representative to the CFDA\textsc{s}. The number of participating organisations thus almost equals the number of CFDA\textsc{s}. The average number of members is currently 17, with the smallest Forum having 8 and the largest 37 members. In 2001, the average number of members was lower: 13 persons, with Forums ranging from 8-20 members. We are of the view that the increase in membership reflects the increase of the prestige of the CFDA\textsc{s}. With the growing participation of the various institutions and organisations, the CFDA plays an ever more important role in the life of the local community. We believe that the members have come to realise the significance of the fact that the organisations participating in the work of the CFDA have more direct contact with each other, communications between them may improve, opportunities for cooperation increase, and this can definitely affect the quality of their work.

The number of working groups within the CFDA\textsc{s} also continues to be on the rise. In the year 2001, a working group operated in every other Forum, while today about 60\% of CFDA\textsc{s} have various working groups dealing with specific issues (e.g. prevention, therapy, rehabilitation, supply reduction). The direction of the change is favourable, since in the working groups experts analyse the various phenomena in more detail, thereby helping to prepare decisions and improving the work of the CFDA\textsc{s} in general.

The frequency of meetings has not changed significantly: on average, CFDA\textsc{s} held meetings 7 times per year, but there is a big discrepancy between towns in the frequency of meetings. In some CFDA\textsc{s}, the members only met twice per year, while in others they had things to discuss and problems to solve on 20 occasions in one year.

An important question is how the Forums manage to secure the funds for their operation. In addition to grants, two-thirds of the CFDA\textsc{s} received local support, generally from local governments. This somewhat exceeds the year 2001-proportion of CFDA\textsc{s} receiving funds other than grants. The increasing support of the work of the CFDA, the contribution to their performance indicates to us that the local governments are coming to realise the importance of the Forums. This is also proven by the fact that in addition to the preparation of the annual report, about 70\% of town Forums reported to the Local Government on their activities and work performed.

**The activities of the Co-ordination Forums on Drug Affairs**

One of the main tasks of the CFDA is to prepare local strategy on the basis of the guidelines provided in the National Strategy. In order to work out the local drug strategy, however, we believe it is indispensable that the CFDA be aware of the drug situation in their town. Two-thirds of the towns prepared a survey on the local situation in terms of the drug situation and how affected they are, and this is also the proportion of cities which have an independent local strategy.

The table below shows that the surveys of the drug situation and strategy are not closely related, as there are several surveys which were not followed by the preparation of a strategy, and a significant number of strategies were not preceded by an assessment of the situation.
Table 1: The division of the preparation of a local strategy and the occurrence of a survey of the situation by the CFDA expressed in numbers and as percentages

<table>
<thead>
<tr>
<th></th>
<th>survey occurred</th>
<th>no survey occurred</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>local strategy prepared</td>
<td>17 towns</td>
<td>8 towns</td>
<td>25 towns</td>
</tr>
<tr>
<td>68%</td>
<td>32%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>8 towns</td>
<td>3 towns</td>
<td></td>
<td>11 towns</td>
</tr>
<tr>
<td>72.7%</td>
<td>27.3%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>25 towns</td>
<td>11 towns</td>
<td></td>
<td>36 towns</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

Evaluation of the work performed in the Co-ordination Forums on Drug Affairs

The work performed was evaluated in the form of a self-assessment. The CFDA evaluated the quality of their work on a scale of five (where 5 is the top grade and 1 is the lowest. The last two factors in the table were only graded as part of the 2002 annual reports – this is why the boxes are empty for the year 2001.)

Table 2: Evaluation of work performed on the basis of the 2001 and 2002 annual reports

<table>
<thead>
<tr>
<th>Evaluation Category</th>
<th>Average Grade 2002</th>
<th>Average Grade 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperation between CFDA members</td>
<td>3.6</td>
<td>3.6</td>
</tr>
<tr>
<td>Division of work among CFDA members</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>Exchange of information between CFDA members</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Lobbying power of CFDA toward policy-makers</td>
<td>3.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Implementation of objectives of strategy</td>
<td>3.5</td>
<td>–</td>
</tr>
<tr>
<td>Satisfaction with the help of the NDPI</td>
<td>3.9</td>
<td>–</td>
</tr>
</tbody>
</table>

The results show that there is room for improvement, as the towns themselves gave a medium grade for cooperation, division of work, flow of information, and lobbying power within the CFDA. However, if we consider how new the working methods within the CFDA are, we believe that the current results are already very positive.

The CFDA also provided written comments besides the grades. The following are the most typical responses:

- cooperation is generally better than previously;
- the division of tasks and the inactivity of certain members was a general problem at the CFDA;
- without a high-level local government representative, the lobbying power of the CFDA is significantly reduced;
- financial problems are common;
- there is difficulty in agreeing on a time to hold CFDA meetings.
Activities for reducing the drug problem in cities

The various services available in cities and towns to assist drug users

Of the activities going on in cities and towns, we shall first summarise the proportion of services available to drug users. There are various institutions for treating drug users in 60% of cities and towns. The graph below summarises the existence of other services in the cities/towns.

Graph 1: Proportional distribution of the support institutions and programmes operated in cities/towns

As evidenced above, in most cases, child-raising advisory services, family aid organisations and other support institutions help the work of the CFDA in towns. Still, we believe that the 60% coverage is low, since maintaining such institutions would be the responsibility of the local governments. The number of special drug treatment and support institutions is also not sufficient, because apart from a telephone hotline, such activities exist only in a small number of cities/towns.

Implementation of the aims of the National Strategy at the local level

The National Strategy contains one general and four main objectives. The questionnaire forming the basis of the assessment focused primarily on questions regarding the implementation of the four main objectives at the local level. These objectives are the following:

1. Society should become sensitive to the efficient treatment of drug issues and local communities should increase their problem-solving ability in reducing the drug problem (community, cooperation).
2. Create an opportunity for youth to be able to develop a productive lifestyle and reduce drug use (prevention).
3. Assist individuals and families who come into contact with drugs or suffer from drug problems (Social work, treatment, rehabilitation).
4. Decrease access to drugs (supply reduction)
Table 3: Frequency of mentioning the various activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and cooperation</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>Prevention work</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>Social work, treatment, rehabilitation</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Supply reduction</td>
<td>28%</td>
<td>72%</td>
</tr>
</tbody>
</table>

The above table shows the percentage of cities/towns that have achieved significant results in these areas. Most activities took place in the areas of community and cooperation and prevention. This is closely related to the fact that Co-ordination Forums on Drug Affairs have been appearing continuously over the past two years and paid significant attention to operating efficiently and professionally in order to ensure that their aims are realised. An indispensable condition of this is the coordinated work of the experts of the institutions participating in the CFDAs. Prevention is considered a priority almost everywhere.

In the areas of social work, treatment, rehabilitation, and supply reduction, the biggest problem is posed by the lack of a suitable institutional network.

In the four main areas, the responses frequently mentioned the following activities:

**Community, cooperation:**
- organisation of various events, conferences (in 2002, typically in the areas of establishing and reinforcing contacts);
- professional meetings;
- courses on organisational development;
- continuous operation of parent groups;
- increase of the role of the media since last year.

**Prevention:**
- training of peers;
- courses organised for teachers and professionals working in other areas;
- various radio and television programmes;
- conferences;
- exhibitions;
- presentations on prevention organised for students (usually these are one-off occasions and are done continuously only in a few places);
- the “DADA” programme.

**Social work, treatment, rehabilitation:**
- strengthening of activities for seeking out victims in at-risk groups;
- training of professionals;
- operation of drug info hotline.

**Supply reduction:**
- increased inspections at entertainment venues (clubs, discos, etc);
- cooperation between police, local government, and the civil guard.

If we examine the various activities in terms of which preventative area of the National Strategy they are linked to, we find the following results:
Based on the responses received, it can be determined that from the spheres defined in the National Strategy, the Co-ordination Forums on Drug Affairs have done the most in families, schools, useful recreational activities, in the media, the Internet and police work.

The most frequent programmes were the following:

- organisation of recreational programmes (events, quizzes, club events, cultural and sports events);
- parent-teacher conferences;
- peer training,
- drug prevention programmes;
- teacher training,
- forums for the local population;
- continuous presence in the media with reports and independent documentary and report programmes;
- launching independent homepages;

Naturally, initiatives were started in other realms of prevention, but these are usually in the early phase of establishing contacts or concepts.

One example is the prevention project in the army which was done in Hódmez vásárhely, where they organised the “Drug–Alarm and Substance-Free Base” programme series, while in Kecskemét a series of conferences entitled “The Family Is Our Future” was organised together with area churches.

In several cities, the response given to the question on Romas was that they do not differentiate between Roma and non-Roma, and organise integrated programmes in spite of the fact that the Strategy recommends special prevention programmes that consider the cultural characteristics and multiple disadvantages of Romas.

In two-thirds of the cities/towns, information and materials were published and distributed over the past year. These materials cover information primarily for students, young people, and parents, but also included materials for teachers.
The professional relationship between the CFDA and the National Drug Prevention Institute

The Co-ordination Forums on Drug Affairs are relatively satisfied with the work and role of the National Drug Prevention Institute. They indicated satisfaction in the following areas of cooperation:

- provision of professional materials;
- personal professional assistance;
- organisation of conferences;
- contacting foreign partners;
- training and courses;
- seeking financial resources.

The CFDA asked for more assistance from the NDPI in the areas listed below:

- information on and provision of methodologies for reducing the supply of drugs;
- more opportunities for personal meetings;
- professional assistance in preparing local strategy.

The CFDA asked for more professional assistance in the following areas:

- professional materials, information, methodological materials;
- conferences, courses, training;
- provision of appropriate approaches to prevent stagnation;
- information on the programmes of other CFDA;
- round table discussions;
- more feedback, evaluation of the work of the CFDA;
- development of a national general and professional database of presenters;
- raising awareness of the tasks of the local government.

PHARE TWINNING PROJECT

Support for the Development and Institutionalisation of the Co-ordination Forums on Drug Affairs (CFDAs) in Hungary

The basic aim of the PHARE programmes is to prepare the accession countries for European Union membership. Within the framework of PHARE projects, there were programmes where reputable EU Member State institutions sent representatives to Hungary for example, who spent a year assisting their Hungarian colleagues with their experience and knowledge.

The National Strategy for the Reduction of the Drug Problem (Chapter 7), pays special attention to international cooperation. (“The success of anti-drug activities demands the development of a wide range of international cooperation.” “Hungary will continue the drug-related programmes of the PHARE-programme… and will extend the opportunities for cooperation in this area.”)

Accordingly, in September 2002, the PHARE Twinning Project was launched with the cooperation of Hungary, The Netherlands and the United Kingdom. The basic aim of the project is to assist the work of the Ministry of Children, Youth and Sports and the National Drug Prevention Institute (NDPI) in realising the programme entitled the National Strategy for the Reduction of the Drug Problem in line with the Drug Strategy of the European Union, the European Union Action Plan on the Fight Against Drugs, and Article 152 of the Amsterdam Treaty.

The Dutch Trimbos Institute, and the British organisation DrugScope were partners in the implementation of the project. These two Institutes are Europe’s most notable professional centres concerned with the treatment of drug problems. Both Institutes also serve as National Focal Points, which is especially important for the purpose of Hungary’s accession to the European Union.

Partners:

- Hungary:
  - Ministry of Children, Youth and Sports
  - National Drug Prevention Institute
- The Netherlands:
The project consists of two elements, of which the first is part of the 2002 reporting year.

The twinning assistance project, the aim of which is to strengthen and develop the professional capacity of the Institute and to support and make the professional operation of the CFDA more efficient.

Under the programme, foreign experts give presentations and training courses to the personnel of the NDPI and the CFDA on the subjects of management, the collection of information, building networks, quality assurance, prevention strategies, and policies.

The training courses are organised in small groups. First, those CFDA were selected which preliminary showed special interest in the various courses. (The other CFDA receive continuous information on the status of the project at conferences and regional meetings held several times yearly.) During consultation after the training, curricula, manuals, and protocols were developed, which form the basis of the CFDA’s training to be given in the future to wider audiences. During the seminars, the NDPI gets a picture of which CFDA can later be involved in spreading the information learned or in training work. This type of “multiplier” training ensures that the results achieved in the project can be upheld.

Guaranteed results / expected output of the project:

• The creation of a group of professionals who are able to effectively coordinate the players responsible for the implementation of drug strategies both at the local and at the central level.
• Working out of the protocols of qualitative and quantitative data collection methods and a plan for their introduction – setting up a custom-made system for gathering information and surveying the situation in light of local resources, needs, and circumstances.
• Working out a local drug strategy that fits flexibly with the problems that arise in every city/town with an CFDA.
• Developing of a horizontal and vertical system of relationships among the CFDA, and between the CFDA and the NDPI.
• Development of a quality assurance system aimed at the regulation of day-to-day work for the CFDA and the NDPI.
• Widening the scale and increasing the number of planned and implemented prevention programmes.

The project’s goal is to reach the above objectives in 2002 with the following training courses:

• Rapid Assessment and Response (RAR) Participants were introduced to the RAR technique. Based on experience, this method has proven appropriate for the collection of actual information and data on the nature and extent of drug use in areas where
  – there is insufficient time for performing survey-type research,
  – qualitative study methods (questionnaire techniques) would usually not be able to adequately – reflect or reveal the magnitude and depth of the drug problem,
  – we do not know the drug using population very well, and
  – rapid changes are expected in the nature of drug use.
The technique applies various, mostly qualitative methods, such as interviews, observation, focus groups, and various estimation techniques.

Participants in the training agreed to test the method in their own cities/towns between March and May 2003. A manual will be prepared on the basis of their experiences with this experimental phase, which will provide guidance for the use of the method under Hungarian circumstances.
• **Lunch table**
  During the training, participants were introduced to the various models of establishing and maintaining horizontal and vertical contacts, as well as the application and implementation techniques for these models. One of the models is the “Lunch table”, the aim of which is regular meetings between local drug prevention professionals for the purposes of training and exchanging experiences “hidden in an informal gown”. The trial introduction of the method (nationwide in all regions) was due at the beginning of 2003.

• **Implementation of the drug strategy of the United Kingdom: introduction to the organisation and activities of the English Drug Action Teams (DATs)**
  Participants in the training were introduced to the local-level implementation of the United Kingdom National Drug Strategy. The various organisational and institutional cooperative efforts in the United Kingdom were described, as well as the way in which the obligations connected to the relevant tasks and the resources are divided. Participants were given guidance and assistance with the preparation of an annual work plan, defining local objectives and the preparation of reports on work completed. The training introduced the English DATs, their operation and activities, as well as the minimum standards necessary for their operation, including various negotiation and discussion techniques.

• **Project Management**
  Main topics: Management tools, coordination techniques; Preparation of draft projects; Assessment of needs; Definition of objectives; Selection of target groups; Selection of appropriate intervention techniques; Preparation of activity plans; Monitoring, evaluation; Preparing a budget.

• **Human Resources Management**
  Main topics: The basis of human resources management; Establishment and management of groups; Establishing contacts; Negotiation and discussion techniques; Conflict resolution; Multidisciplinary group work; Individual and group assistance, tools of support; “intervision”, supervision.

**Feedback from the CFDAs in relation to the courses**
  The participants in the training courses were given an opportunity to express their opinions and comment on the training by filling out evaluation forms. A summary of these shows that the participants were exceptionally satisfied with the standard of the courses and the trainers, and they appreciated being able to learn of foreign experiences and methods directly from foreign experts. They emphasised that the courses were a good opportunity for strengthening and personalising the relationships among the CFDAs, as well as between the CFDAs and the NDPI.

  The total budget of the twinning assistance project is EUR 500,000, which covers all the expenses of the long-term 12 month stay in Hungary of one person (Lieneke Austie), the short- and medium term stays in Hungary of various experts, the preparation and translation of materials, and professional protocols, as well as “multiplicator” courses primarily in the areas of organisational development, human resources management, negotiation techniques, quality assurance, programme evaluation and early assessment of the situation. An additional element of this part of the project is two shorter study tours to Holland and the United Kingdom. As a result of the project, the National Drug Prevention Institute will be able to improve its coordination and professional support tasks toward the CFDAs, and a broader group of experts will be formed around the Institute, as a result of which it will be a better partner of European institutions in several areas of the treatment of drug problems. Additional advantages should stem from the fact that in addition to the staff of the Institute, the experts of partner institutions and ministries also receive training, thus enabling the form and contents of institutional cooperation to develop in desirable directions.
## List of Co-ordination Forums on Drug Affairs by region, as registered by the National Drug Prevention Institute

<table>
<thead>
<tr>
<th>Midwestern Hungary</th>
<th>North-eastern Hungary</th>
<th>South-western Hungary</th>
<th>South-eastern Hungary</th>
<th>Northern Hungary</th>
<th>Mid Hungary</th>
<th>Western Hungary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fejér County</td>
<td>Debrecen</td>
<td>Kecskemét</td>
<td>Ozd</td>
<td>Gödöll</td>
<td>Győr-Moson-</td>
<td></td>
</tr>
<tr>
<td>Tata</td>
<td>Hajdúböszörmény</td>
<td>Baja</td>
<td>Tiszaujváros</td>
<td>Szentendre</td>
<td>Sopron County</td>
<td></td>
</tr>
<tr>
<td>Tatabánya</td>
<td>Törökszentmiklós</td>
<td>Szeged</td>
<td>Kazincbarcika</td>
<td>Gyál</td>
<td>Győr</td>
<td></td>
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<td>Oroszlány</td>
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<td>Orosháza</td>
<td>Miskolc</td>
<td>Szigetszentmiklós</td>
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<td>Várpalota</td>
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<td>Eger</td>
<td>Érd</td>
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<td>Jászberény</td>
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<td>Gyöngyös</td>
<td>Nagykőrös</td>
<td>Sopron</td>
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<td>Nyíregyháza</td>
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<td>Dunakeszi</td>
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<td>Kiskunfélegyháza</td>
<td>Salgótarján</td>
<td>Budaörs</td>
<td>Zalaegerszeg</td>
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<td>Dunaújváros</td>
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<td>Hódmez vásárhely</td>
<td></td>
<td></td>
<td>Nagykanizsa</td>
<td></td>
</tr>
</tbody>
</table>

Budapest

13th District
21st District – Csepel
The legislative environment defining the framework of the drug policy in Hungary in 2002

1. Amendments to the Criminal Code and other related criminal regulations

Each and every narcotics-related activity performed without authorisation is classified as a criminal offence.

The statutory definition of the “abuse of narcotic drugs” in the Criminal Code (Law No. IV of 1978) has been amended a total of three times over the past ten years. As a result, the position on user-type conduct became either tougher or more permissive, however, the legislators clearly wanted to make the rules on trafficking and dealing ever more stringent.

The first Hungarian criminal law provisions on narcotic drugs were born as early as 1930, over seventy years ago.

The only significant amendment to the original provision was in 1933. The amended regulations allowed persons demonstrating user-type conduct to be relieved from criminal liability and the possibility to use diversion into therapy as an alternative to sentencing.

The first mention of quantity thresholds governing the classification of the offence was in a 1996 Supreme Court ruling.

On March 1, 1999, Section 282 of the Criminal Code, containing the statutory offence of abuse of narcotic drugs, was amended, so that the possibilities for diversion into therapy were limited to addicted users only and the use of drugs, as a criminal offence, was named in the act.

On the basis of the research paper entitled “The effect of drug-related criminal offences on society and youth in 1999–2001 in connection with the amendment of the criminal laws” in relation to the amendment of the Criminal Code that took effect on March 1, 1999, it was determined that the efficiency of Law No. LXXXVII (1998) is questionable: if the expected result of the amendment was to reduce the abuse of narcotic drugs and the consumption and circulation of drugs, this aim was not achieved.

The statistical data and surveys prepared after the amendment show that the number of people trying drugs and the number of registered offences and offenders continued to rise.

The amendment of the law made legal classification more difficult and legal proceedings more complicated, while the increased severity had a negative effect on the conduct of the participants of the drug market. The excessively rigorous punishments were not realistic, they did not follow judicial practices or consider the customs and behaviour of those young people who are most likely to be drug users.

The effective date of the new amendment was March 1, 2003. The legislator’s intention this time was in line with professional experiences that the majority of drug users are not criminal personalities, but were induced into using drugs by their circumstances.

The Criminal Code (Law No. IV of 1978)

The definition of the criminal offence of abusing narcotic drugs was last amended through Law No. II (2003) and the provisions have been in effect since March 1, 2003.

(Summary of the Ministry of Justice)

1.1. The aims of the amendment of the Criminal Code were the following:

a) to create a criminal law environment suitable for the implementation of the National Strategy prepared for the reduction of the drug problem,

b) to halt the unfavourable tendencies of drug-related crimes,

c) to enable more differentiated criminal judgement/sentencing of the various players of the drug arena,
d) to introduce criminal law provisions suitable for more efficient special prevention in the case of drug-user offenders (referring equally to the prevention of renewed drug use and to the commission of crimes related to drug use),
e) to ensure legal continuity.

The Criminal Code – for the purposes of differentiation – distinguishes between drug users and drug dealers (traffickers); therefore the two actions have different legal consequences both in terms of penalties and in the definition of aggravated offences.

The Criminal Code has separate regulations for abuse of narcotic drugs by a person under the age of eighteen separately.

The Criminal Code links inducement to pathological indulgence and the abuse of narcotic drugs detrimental to a person under the age of eighteen.

The Criminal Code contains separate provisions on acts committed by drug addicts.

The criminal provisions on materials necessary for the manufacturing of drugs (precursor chemicals) have also been amended.

The amended Criminal Code allows diversion into therapy not only for addicts, but in general.

Partly in line with the requirements of legal continuity and partly in order to realise the 3rd aim of the National Strategy, in the new definitions of the offences on the demand-side and on addicts (Sections 282, 282/B and 282/C) the offence of “using narcotic drugs” does not appear. This does not mean that using drugs is not a punishable act, as use is still punishable through the offences of “acquiring” and “possessing” narcotic drugs, and drug users are also punishable.

1.2. A new aggravated offence is the commission of an offence as part of a criminal conspiracy under Section 282 of the Criminal Code for an event where commission in a criminal organisation cannot be determined. At the same time, commission of the offence as a public official or a person performing public duties, was removed from the Law. However, this can be judged in the sentencing depending on the other circumstances of the commission of the offence.

The Criminal Code omits commission of the offence with a weapon as an aggravated offence, as the occurrence of arrests, production, acquisition, possession with weapons is very low, while if drugs are smuggled, that is, imported or exported together with the use firearms, the offence of smuggling of firearms (Criminal Code Section 263/A) can be determined together with the abuse of drugs.

In the case of offences by drug users, the punishment for an offence with a substantial quantity was reduced by one degree, in line with the principles of differentiation (five to fifteen years’ imprisonment was replaced by five to ten years’ imprisonment).

1.3. The Criminal Code contains a separate provision, Section 282/A, regulating the offences of trafficking and dealing in narcotic drugs, and maintains the principle that these are punishable more severely than personal drug use.

Conducting an offence in a business operation was removed from the list of aggravated offences. In the case of dealing offences, this aggravated offence is superfluous because it is inherent in distribution and trafficking, distinguishing offering or transfer of drugs that is within a business operation is unrealistic, as this means any trafficking or distribution.

Similarly to Section 282 of the Criminal Code, commission of an offence as part of a criminal conspiracy became an aggravated offence in the case of drug abuse through trafficking.

Commission of an offence as a public official or a person performing public duties continues to be treated more severely (this was an aggravated offence earlier as well), but this aggravated offence was supplemented with the term “acting in an official capacity”. This solution follows the wording of the United Nations Convention signed in Vienna on December 20, 1988.

With the commission of supply-type offences involving a substantial quantity, the earlier possible punishment of ten to fifteen years’ imprisonment was replaced by five to fifteen years, or life
imprisonment in the amended Criminal Code. This allows courts more room for discretion in tailoring judgments.

1.4. Section 282/B of the Criminal Code contains an independent and uniform definition of the commission of an offence against or with the use of persons under eighteen for protecting such persons from abusing narcotic drugs, or substances or agents that have a narcotic effect but are not classified as narcotic drugs. The justification for this is the need for special protection of persons under eighteen, and the regulation of the offences in places that are closely related to such persons.

1.5. Section 282/C of the Criminal Code contains special rules relating to drug-addicted persons. This is in essence identical word-for-word to Paragraphs 1–5 of Section 282/A of the Criminal Code in force until March 1, 2003.

1.6. Section 283 of the Criminal Code ensures differentiated treatment and the possibility for diversion into therapy for more minor misdemeanours by persons who are not addicts. Compared to the earlier rules, this rule extends the application of the reasons terminating punishment, as the 1998 amendment of the Criminal Code only allowed diversion in the case of addicted users. This rule on diversion into therapy in the Law is in line with the multidisciplinary principles defined in Section 4.5. b) of the National Strategy as well as the contents of the UN Conventions on the drug problem.

Section 283 Paragraphs a) and c) of the Criminal Code both include the wording “for personal consumption” as part of the definition of the offence; in addition, with supply-type conduct, Section 283 Paragraph b) only grants the possibility for diversion into therapy in cases of offering or supplying if such are done together with the consumption of drugs.

Obviously the Criminal Code also sets a strict time limit, and diversion into therapy cannot be applied if offering or supplying takes place for the purposes of later joint use, nor if the acts of trading or distribution are part of subsequent or simultaneous trafficking in narcotics.

It should also be noted that if a person engages in this kind of activity inside or in the proximity of a building serving the purpose of education, public learning, child welfare, child protection, or cultural and educational activities, the Civil Code further narrows the possibility for diversion into therapy by providing that it shall only be applied if the offender is under the age of twenty-one. The Civil Code essentially limits diversion into therapy to cases where students give drugs to each other within such buildings during joint consumption.

However, in light of the fact that diversion into therapy cannot be offered an unlimited number of times in the case of drug-related offences involving offering or supplying drugs, the provision on diversion into therapy cannot be applied if the criminal liability of the perpetrator has been established within the framework of criminal proceedings initiated owing to the perpetrator’s abuse of narcotic drugs on at least one occasion within the two years preceding the commission of the act or if the indictment against the perpetrator has been suspended.

Alternative sentencing is not available in cases of trafficking or distributing narcotic drugs.

1.7. Effect from March 1, 2003, Law II (2003) amended the Law On Criminal Procedures (Law I of 1973), which was in force until July 1, 2003. As a result, if a police investigation can be terminated due to reasons of the termination of punishability as defined in Section 283 of the Criminal Code, the investigation must be suspended for one year if the drug-using perpetrator agrees to undergo continuous treatment for drug addiction or other therapy for treating drug use, or attend prevention-information sessions. However, the proceeding has to be continued if the perpetrator can not certify with a document that for at least six months within one year of the suspension, he continuously participated in treatment for drug addiction or other therapy for treating drug use, or attended prevention-information sessions, or if a new criminal proceeding was initiated for drug abuse against the perpetrator during the suspension of the proceeding and the investigation could not be suspended or terminated.

Another section of Law I (1973) was also in force between March 1, 2003 and July 1, 2003: if the proceeding could be terminated due to a reason for the termination of punishability as defined in Section 283 of the Criminal Code – and if the investigation was not suspended for this purpose on the basis of the above section – the court of first instance could suspend the proceeding for one year on one
occasion, if the drug-using perpetrator agreed to undergo continuous treatment for drug addiction or other therapy for treating drug use, or attend prevention-information sessions. However, the proceedings had to be continued if the perpetrator did not certify with a document that for at least six months within one year of the suspension, he continuously participated in treatment for drug addiction or other therapy for treating drug use, or attended prevention-information sessions, or if the prosecutor filed a new indictment against the perpetrator for the abuse of drugs.

Law XIX (1998) On Criminal Proceedings (“LCP”) entered into force on July 1, 2003. The new LCP allows the legal institution of postponement of the indictment if the proceeding can be terminated due to a reason for the termination of punishability as defined in Section 283 of the Criminal Code. On the basis of the LCP, the prosecutor may postpone indictment for a one year period if the drug-using perpetrator agreed to undergo continuous treatment for drug addiction or other therapy for treating drug use, or attend prevention-information sessions.

Before postponing the indictment, however, the prosecutor must hold a hearing to ascertain that the conditions for postponing the indictment exist. If the drug-using perpetrator does not agree to undergo continuous treatment for drug addiction or other therapy for treating drug use, or attend prevention-information sessions, then the rules on the mandatory postponement of indictment naturally do not stand.

In his ruling on the postponement of indictment, the prosecutor orders the perpetrator’s supervision by a probation officer, considering that Sections 82 and 119 of the Criminal Code provide that in the case of a postponement of indictment, supervision by a probation officer is mandatory. As a condition for the option of treatment for drug addiction or other therapy for treating drug use, or attending prevention-information sessions is the existence of a reason for the preclusion of punishability as listed in Section 283 of the Criminal Code. If indictment is postponed for such a reason, participation at one of the above options is mandatory. The probation officer, in line with the rules on supervision by a probation officer, checks and assists compliance with rules on conduct and the obligations and the probation officer may use the help of other bodies and institutions for the performance of such tasks. If the perpetrator does not comply with the required obligations, the prosecutor will file charges.

1.8. The joint decree of the Ministry of Health, Social and Family Affairs and the Ministry of Children, Youth and Sports (Decree 26/2003. (V. 16.) EszCsM-GyISM) contains the rules on treatment for drug addiction, other therapy for treating drug use, or prevention-information sessions. This Decree provides that the Ministry of Health, Social and Family Affairs; the Ministry of Children, Youth and Sports; and the Ministry of Justice must, in their official journals, issue a quarterly list of institutions performing a preliminary assessment of the situation and those providing treatment or services. The first such publication was in the issue following the effective date of the Decree.

In light of the short time that has elapsed since the effective date of the above amendments, we do not yet have any data as to the significance of the changes that have occurred since.

2. The Law on Public Education

The Hungarian Parliament voted to modify the following major points of Law no. LXXIX (1993):

(The following is a summary by the Ministry of Education)

Section 8, Paragraph 9:
The National Curriculum (NC) describes the educational and welfare goals of institutions of primary education, and makes it possible for students to transfer between schools. The NC may also contain mandatory directives related to learning and instruction; it may, for instance, regulate the daily and weekly workload of students. The NC must also contain provisions for the tasks of schools in the
field of **health issues**, and consumer and environmental protection issues. Implementation of NC regulations are aided by the curricular frameworks handed down by the Minister of Education.

**Section 8/A, Paragraph 1:** The curricular frameworks contain recommendations in the following areas:

- general educational and pedagogical goals; courses; subject matter of individual courses; requirements of individual courses; frameworks for these requirements; **health issues in schools**; and tasks related to consumer and environmental protection.

**Section 17, Paragraph 7:** Course modules (dance and drama, national and social studies, general health, film and media studies, ethics and society, etc.) must be taught by instructors who possess not only a teacher’s degree in the appropriate field, but who have also completed **further professional training** relevant to the subject matter of the courses to be taught.

**Section 48, Paragraph 3:** Each school, as part of its general pedagogical programme, must work out a programme for health promotion and environmental education. The **health promotion programme of the school must specify** tasks to be completed daily, in school, by the students, including a physical education programme. In drawing up this programme, each school must consult the director of its health service.

**Section 52, Paragraph 10:** From grade one to grade four, students must have the opportunity for physical exercise every single school day. This exercise may take the form of at least three physical education classes per week, and further playful exercise sessions. These playful **exercise sessions for the development of health** must be appropriate for the given age group, and must be organised every day when regular physical education classes are not held (in the case of boarding schools, this must be done every morning when regular physical education classes are not held). These sessions must be **no shorter than 30 minutes** per day; the sessions may be divided into several 15-minute units. The exercise sessions may be held during regular class hours, or may take up at most one-half of one recess period held between classes.

**Section 95, Paragraph 3:** The development of **health promotion programmes in learning institutions** is to be further encouraged through publications, training sessions, and tenders organised by the Minister of Education and the Minister of Health.

**In Appendix no. 1 of the Law:**

- Child and youth welfare workers, **health officers**, in
  - elementary schools,
  - secondary schools, and
  - vocational schools

  may be those individuals with all necessary qualifications for the given school type (according to Section 17, Paragraph 1/b-e, and j, and Paragraph 2), as well as other professionals with the necessary degrees and training in social and family pedagogy, psychology, or social work.

  These health officers may have dual status, and may be employed, for instance, as part-time teachers, while working also part-time as child and youth welfare workers, health officers, etc.

**In Appendix no. 2 of the Law:**

**Data management in public education institutions:**

1. Teachers (and/or other faculty members) directly involved in pedagogical and educational work have an **obligation of official confidentiality** related to all information, facts, and data about students and their families which might have come to their knowledge in the process of their work. This obligation of confidentiality is independent of employment status, and shall remain permanently in effect even after the termination of employment at the given institution. The obligation can be considered void if a student has given, in writing, an instructor express permission to divulge information to the parents; information may likewise only be shared with a third party if both the student and the parents have given express permission in writing. The teachers (and/or faculty members) of a minor are not breaking the obligation of confidentiality if they choose to divulge information to the parents without the student’s permission;
however, they may only do so in a way so as not to reveal specific facts or data to the parents, and after having ascertained that they are not endangering the child in any way. The obligation of confidentiality does not include meetings of school faculty; faculty members may discuss matters related to a student in the interests of the student. The obligation of confidentiality also does not pertain to data which, according to the present law, is not deemed confidential. The obligation of confidentiality also applies to all individuals participating in faculty meetings.

2. Public education institutions may only manage students’ data for the following purposes: for pedagogical records, for pedagogical and rehabilitation purposes, for child and youth welfare reasons, for school health reasons, for the keeping of records in accordance with the present law, and for determining possible guilt and degree of guilt in criminal proceedings.

3. Teachers and other instructors, through the principal of the given institution, are required to inform child welfare authorities (in accordance with Section 17 of the Law On Child Protection and Welfare) if, in their judgment, the child or (minor) student is, or may be, in serious danger (due to the behaviour of the student, or that of other students). In such cases, the consent of the parties involved is not required for information to be passed on legally.

4. Public education institutions may keep their employees’ data on record for the following purposes only: to use in determining fees, salaries, and benefits; to keep a record of the fulfilment of these; for national security reasons; and in accordance with all pertinent legal regulations.

5. Data may only be given out by the principal of a given institution, or with express written permission, by another employee of the institution.

6. The procedures for maintaining and giving out such data must be specified in an appendix to the rules of procedure of the institution or, if they exists, in separate regulations for data management. The time frame for data management may not exceed that of data archiving. When drawing up these regulations for data management, the parents’ association and the student body have a right to preview the material.

7. In cases where providing data is voluntary, the student, and the parents of minors must be informed of the fact that divulging the given data is not mandatory. In such cases, minors must obtain consent from their parents.
Monitoring the National Strategy

Implementation of the National Strategy – Major Results and Changes

Timeframe for the implementation of the “National Strategy” adopted by resolution no. 96/2000 of the Hungarian Parliament

The tasks related to the short and long-term projects of the above resolution are detailed in government resolution no. 1036/2002. The following section has been prepared in accordance with reports of the Ministries involved and other national organisations.


• Collection of Hungarian data related to the issues, and making national databases accessible.
  – Each year, the Ministry of Children, Youth and Sports publishes a Report on the Drug Situation in Hungary. This report contains the most important data and initiatives taken. In 2001, this publication included a more detailed analysis of amphetamine abuse; in 2002, the emphasis was placed on cannabis. The report is published in four thousand copies, and every effort is made for all national, church, professional, and non-governmental organisations (NGOs) involved with drug abuse and Co-ordination Forums on Drug Affairs to receive copies. The 2003 report is due out at the end of the year.
  – The Ministry of Children, Youth and Sports supported the publication of a CD-ROM that was included with every copy of the hit “Egyetlen szó” (A Single Word) by the popular music group “TNT”. The interactive disc, entitled “Drog-kör-kor-kép” (Drug Outlook) was designed to provide a unique and authentic forum for informing those affected by drugs about treatment possibilities and where to turn for help.
  – Preparations for the creation of a Hungarian centre for the collection of drug abuse data – and for experimental research to help combat the growing problem – were begun in 2000, and the project (completed in the year 2003) was launched in 2001 with PHARE funding (no. HU0006-02). The project was conducted in cooperation with the National Drug Centre of Spain, and had a total budget of EUR 1 million. Of this sum, EUR 850,000 were paid for services rendered by the Spanish partners, and EUR 150,000 were dedicated toward equipping the centre in Hungary. A division was organised in the Ministry of Health, Social, and Family Affairs to provide assistance in setting up the Hungarian National Focal Point, the secondary data centre for the project. A government resolution of September 9, 2003 (no. 1091/2003) enabled the creation of the Hungarian branch to maintain contact and exchange information with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The most important task of the National Drug Data Service and Coordination Centre Service and Coordination Centre is to provide and manage information in accordance with the standards of EMCDDA headquarters in Lisbon.
  – In the third quarter of the year 2003, the Ministry of Defence conducted a survey of one thousand individuals, exploring drug and alcohol abuse issues, and possible background factors. The results and conclusions of that study are due in the fourth quarter of the year 2003. The Ministry of Defence also runs a highly successful drug information network.

• Application of international standards
Under the umbrella of MATRA, the social reform programme of the Netherlands aimed at Central and Eastern Europe, Dutch officials have been training and will continue to train corrections officers with respect to handling drug abuse cases. Adapting the Dutch methods for use in Hungary is underway.

- Initiating epidemiological research in smaller communities:
  - This year, the Ministry of Education has been in the process of evaluating the findings of a research study conducted in the year 2001 among students studying in public schools and in institutions of higher education, and aimed at acquiring data on their drug consumption habits. The Ministry is now evaluating the results of programmes initiated since the above study, which also provides excellent grounds for further research, and for the modification of existing approaches.

- Creation of local drug prevention centres in the community:
  - Wide-ranging financial and other support has been made available over the course of the past three years; this has led to considerable progress in the field. Night-time sporting events have been organised, local drug-prevention programmes have been launched in communities, programmes and publications were offered to groups at particular risk, etc.

- Co-ordination Forums on Drug Affairs
  - Support, both in the form of financial aid as well as professional assistance, has regularly been offered to Co-ordination Forums on Drug Affairs. The goal of these Forums is to pinpoint local problems and create a local strategy for drug abuse prevention. The Forums work with the support of the National Drug Prevention Institute. In November 2003, the scale of the project was widened, and districts of Budapest have also been invited to participate.

2. Prevention – *Giving young people the chance to lead productive lives and say no to drugs*

- The Ministry of Defence has been continuing its prevention programmes:
  - “Drogriadó” (Drug Alarm) a prevention programme of the Ministry, is now in its third year of existence. Local programmes include drug prevention days (lectures, sports events, contests), a project entitled “Szer nélküli lakanyákért” (No Drugs in Our Barracks), and a complex health development project, entitled “Az egészség a legersebb fegyvered” (Your Health is Your Greatest Weapon).
  - Professional members of the military employed at training bases for conscripts undergo special sensitivity training, which aims to provide guidelines for recognising drug abuse and treating it effectively.
  - Coordinated publications and leaflets dealing with drug abuse are made available in ample quantities, and a new series is being prepared; a well-structured set of materials related to health issues will thus be available.
    - Drug prevention manual
    - HIV/AIDS manual
    - Smoking prevention manual
    - Nutrition information manual
  - Other Hungarian-language publications include ones entitled, “A drog” (Drugs), “Mit l és miért félünk” (What We are Afraid of and Why), “Ne dobd el az életed” (Don’t Waste Your Life), and “Szenvedélyeink” (Addictions).
  - A telephone counselling service continues to be in operation; staff members working the phones are subject to ongoing training.
The Hungarian Defence Forces created a Drug Prevention Committee, conducting work according to annual plans drawn up based on drug abuse prevention strategies in the military.

**Drug prevention in school – A joint project of the Ministry of Children, Youth and Sports, and the Ministry of Education**

This project is intended to further cooperation between schools and professional organisations (prevention services). For the past three years, the aim of the project has been to realise modern and need-based programmes in schools, through a method involving interactive educational techniques. Another goal is to foster greater dialogue and information flow between parents and teachers. Support is offered for schools to develop their own drug prevention and health development strategies. The project includes an initial survey, to be conducted in each participating school, to map all information pertinent to the drug situation in the institution. This database, as well as the data related to attitudes and behavioural intentions, as well as questionnaires to be filled out continuously, is suitable for analysis even in connection with the short-term effects of the programme. This project provides insight into major aspects of the National Strategy, which aim at accountability and transparency. The project is funded by the Ministry of Children, Youth and Sports, through some HUF 220-250 million annually.

Drug prevention groups are already in place and operating in juvenile correctional facilities, with the support of county drug centres, and with the participation of staff members of the correctional facilities. The juvenile offenders incarcerated at the correctional facilities in Kecskemét and Szirmabesny regularly participate in drug prevention lectures held by the local police departments. The juvenile correctional facilities also host ongoing health promotion and drug prevention programmes.

**Education**

The Ministry of Defence, along with several organisations, (the István Széchényi University Distance Education Centre, the Aladár Petz County Training Hospital, Health and Social Centre, the Health Division of the Defence Staff of the Hungarian Defence Forces), has developed a professional training programme entitled “Drogmegelzés Alapjai” (The Basics of Drug Prevention), as well as a professional training programme for doctors, bearing the same title. These programmes were developed in accordance with regulation no. 73/1999 of the Ministry of Health. Preparation is underway, and accreditation has been completed, of a programme for doctors, to be entitled “Drogmegelzés Integratív megközelítése” (The Integrative Approach to Drug Prevention).

The Ministry of Education intends to broaden the scope of postgraduate psychologist training, launched in 2002 at three universities and involving 100 graduate students who are already practicing teachers, and whose distance education studies are financed by the government. The Ministry hopes to raise further interest in these opportunities. The Ministry of Education supports the employment of further psychologists to work in schools. Graduate and postgraduate mental health and health education programmes are in the process of being mapped, and introducing university majors related to this field is being considered. In addition, the following are some of the programmes already in existence:

- A national teachers’ conference entitled, “Az iskola, mint mentálhigiénés er forrás” (The School as a Source of Mental Health).
- Postgraduate school psychologist training at three universities.
- Providing financial support for the School Psychology Department, Methodology Group, at the Faculty of Humanities, ELTE University.
- Recognising certain mental health-oriented professional training courses as equivalent to completed teacher training.
- Providing financial support for practicing teachers to continue professional training in the field of mental health.
The goal of the Ministry of Children, Youth and Sports' education programme, launched in 2002, is to familiarise those providing peer-assistance with a drug prevention methodology based on peer influence. The programme also aims to prepare volunteers for working with at-risk young people, and to develop peer-support techniques and leadership skills through modern approaches; another goal is to encourage new volunteers to join the project. Of the 113 applications received, the Ministry has deemed 73 worthy of support, offering a total of some HUF 35 million.

- The Ministry received 28 applications for the financial support of the following: low-threshold programmes, supervision of institutions treating drug addicts, clarifying professional questions related to drug prevention problems, and organising monthly training sessions. The sum handed out in support is HUF 9,380,000. The target group of this project is the staff of institutions treating drug addicts in low-threshold programmes.
- The Ministry of Children, Youth and Sports handed out financial aid in the amount of HUF 14,070,000 in the year 2002, supporting the operations of 32 programmes in the process.

**Drug coordinators in schools**

- The Ministry of Education has developed and continues to operate a system of training accredited drug coordinators in schools through regional drug coordinator networks. Maintaining this programme and its network is considered a top priority; to make the programme even more effective, and to raise the standard of professional training, certain corrections to the current structure have been introduced.
- Professional training of teachers acting as drug coordinators in their schools has continued with unchanged success. Starting in the year 2003, these training programmes have been conducted at more than three locations in the country, organised by the Teacher Training Methodological and Information Centre, and financed by the Ministry of Education. One of the goals is to have at least one teacher in each school trained as a drug coordinator.
- In 2002, the Ministry of Education launched a 30-hour professional training programme entitled “Mentálhigiénés Alapképzés Pedagógusoknak” (The Basics of Mental Health for Teachers). The training is conducted at the Child and Youth Centre at Zánka, and was funded in 2003 by the Ministry. In the fall of 2003, some one hundred teachers completed the programme.
- Development of regional mental health case study workshops continued. These workshops, intended as a follow-up to the abovementioned basic course in mental health, were accredited by the Teacher Training Methodological and Information Centre, and four meetings per year of ten groups are financed by the Ministry of Education. The great interest in the programme, as well as its benefits, has prompted its continuation and expansion (both in terms of group number and the number of meetings annually).
- The conditions necessary for the operation of the school drug coordinator system (including teachers, healthcare workers, school psychologists, and youth nurses) are laid out in Law no. 1993/LXXIX, and in Appendix no. 1 of the same law, as modified by the Hungarian Parliament. The tasks of staff involved in this work shall be specified in the upcoming modification to regulation no. 11/1994.
- Supervision of teachers who have already completed the training and are acting as drug coordinators in their schools is extremely important. The initiative of the Ministry of Education enables, (four times a year, under the supervision of the Ministry, and with the assistance of outside professionals), continued consultation, training, and case studies for teachers who have completed the 30-hour training course (some 1200 teachers thus far). Starting in the year 2003, this professional training continues on a county-level, for elementary and secondary school teachers, organised by the Teacher Training Methodological and Information Centre, through four six-hour sessions, and through regional conferences. The programme is being launched in
the 2003–2004 academic year (due to the delay of government funding, to be appropriated in accordance with government regulation no. 1036/2002). However, organisational work for the project has been well underway already.

• **Drug prevention packages distributed to schools by the Ministry of Education:**
  
  – The Ministry of Education, based upon consultation with both in-house and external professionals, has been sending publications to schools dealing with drug prevention and health education in schools. These publications and other media events are often timed to coincide with different prevention programmes, in an effort to reach as wide an audience as possible, via means appropriate for the target age group. Just a sampling of the Hungarian-language publications realised in the year 2002:
    
    • "Légy észnél" (Be Smart) – programme and publication,
    • "Szertelenül" (Drugless) – regional radio broadcast,
    • "KIDS" – magazine,
    • “Vészcseng “ (Alarm bell) – drug prevention options for teachers, and
    • “Droginformációs lapok” (Drug Information Pages) – 2003 publication of the Ministry of Education dealing with amendments to the Hungarian criminal code and their pertinence on young people using drugs.

3. **Treatment, Rehabilitation, Social Work – Helping individuals and families affected by drugs**

• **Material on problems related to drug abuse is taught at education institutions affiliated with corrections and law enforcement authorities, as well as at the Corrections and Law Enforcement Department of the Police College. Personnel in direct contact with incarcerated persons (social workers, psychologists, wardens) receive training at all correctional facilities. Several staff members employed at correctional facilities have received postgraduate degrees in addiction research. This practice is to continue in the future. A special group has been created at the Budapest Corrections Facility and Jail to provide treatment for drug addicts.**

• **Substitution (methadone substitution therapy)**
  
  – Substitution therapy may only be resorted to in serious cases of opiate (heroin) dependence, and only if therapy aimed at achieving total abstinence has failed. Several countries around the world successfully use a method of methadone substitution when treating heroin addicts. Methadone substitution treatments were first tried in Hungary in 2001, after the process had been registered for use to treat heroin addiction. The methodological description of methadone substitution appeared in the journal “Egészségügyi Közlöny” (Medical Journal). Treatment is offered free of charge to patients, financed by the National Health Insurance Fund. Presently, methadone substitution is available at seven locations nationwide; in the year 2002, 208 persons participated in such treatments.
• Low-threshold programmes and outreach projects supported by the Ministry of Children, Youth and Sports:

  – In the year 2002, the Ministry of Children, Youth and Sports paid special attention to supporting low-threshold institutions and outreach projects. The Ministry provided financial support for projects in two rounds, one in February, one in November. The greatest emphasis was placed on the development and implementation of needle-exchange and methadone substitution programmes. In addition, further low-threshold and harm-reduction programmes were instituted; and unprecedented emphasis was placed on the development and maintenance of drug abuse institutions, telephone counselling services, personal treatment options for drug addicts, the creation of consultation centres, etc. The number of organisations dealing with low-threshold programmes far surpassed that of previous years, but the number of addicts has also increased.

  – The construction of several new rehabilitation centres has begun or continued with the support of the Ministry. The number of individuals who can thus be treated should prove sufficient compared to the demand; the quantitative and qualitative improvements in this field and their pace are in tune with the goals set out in the National Strategy.

  – A mental health programme series, entitled “Ariadné fonala” (Ariadné’s Thread), has been launched in cooperation with the University of Debrecen. This programme series is intended for college and university students who are dealing with various problems.

  – In the year 2002, the Ministry of Children, Youth and Sports handed out HUF 81 million (through 40 different tenders) to support low-threshold institutions and programmes dealing with drug addicts.

4. Reducing Supply – Limiting and reducing access to drugs

• The Ministry of Defence has developed a system of objective drug screening. The accreditation of the laboratory to be used in this screening is underway. Tests to screen for drug use are done by the Toxicological Research Department of the Hungarian Defence Forces, using immuno-chemical methods.

• The effectiveness of the Hungarian Customs and Finance Guard in discovering drugs must be increased. The technical, staffing, and professional capacities must also be expanded.

  – Significant advances have been made in the fields of training and education. Personnel serving in drug reconnaissance units undergo special training in order to better perform their duties. Furthermore, in addition to the continuous training of dogs and dog handlers, cooperation is now also possible between other related organisations and branches. In the year 2002, with the broadening of their investigative rights, special training of the Customs and Finance Guard personnel involved in drug reconnaissance also began; in 2003, the Guard began developing its own detective service. Under the auspices of the PHARE Regional Drug Law Enforcement Project, a training programme is underway between January 2003 and March 2004 to further the cooperation between soon-to-be EU member countries’ border and customs guards, police forces, and prosecution authorities, and to increase the effectiveness and readiness levels of these organisations.

  – The Hungarian Customs and Finance Guard has begun a process of procuring equipment and vehicles necessary to combat the drug trade. This procurement process was made possible partly through internal staff reforms, partly with the aid of international partner organisations, and partly with PHARE funding. The equipment used by reconnaissance teams was also
modernised, vehicles used to transport drug-sniffing dogs were acquired, and three mobile truck-X-ray machines have also been purchased.

- The budget of the Customs and Finance Guard for the year 2003 included HUF 684.5 million to be used to combat the drug trade. This covered the wages and related expenses of the 209 individuals employed in the field of drug reconnaissance. The 2003 budget of the Ministry of Children, Youth and Sports sets aside HUF 28.3 million to be used by Border and Customs Guards in the fight against the drug trade; this sum will be used to procure equipment and vehicles.

- Several Hungarian organisations signed an agreement on April 17, 2002 regarding the legal inspection of the trade of materials used in the production of drugs and psychotropic materials. The signatories were: the Hungarian Customs and Finance Guard, the Hungarian National Police, the Office of Certification and Public Administration of the Ministry of Economy, the Hungarian Chemical Industry Association, the Hungarian Pharmaceuticals Manufacturers Organisation, and the Hungarian Association of Pharmaceutical Wholesalers.


• The reconnaissance and investigative work of the police forces must become more effective in the field of combating the drug trade, and in the field of investigating criminal activities related to drugs.

  - A programme for the professional treatment of drug addicts in police custody has been developed, and its implementation is already underway.
  
  - The legal framework for monitoring and controlling the trade of certain chemicals used in the manufacture of drugs and psychotropic materials has been established with the relevant authorities, according to the stipulations of government regulation no. 272/2001 (XII. 12). Preparations for the monitoring of materials on the United Nations’ ECOSOC list are also underway.
  
  - Personnel at Police Health Services are in the process of standardising procedures related to drug abuse, and are creating a standardised system for the evaluation of drug addiction.
  
  - In the year 2002, forensic laboratories equipped to participate in the screening of drug consumption were established in four different Hungarian cities (Veszprém, Szeged, Pécs, Győr).

Summary:

Significant programmes have been launched within the process of implementing the National Strategy; many short-term and mid-term goals will have been realised during the year 2003. The effectiveness of coordination has improved, cooperation between participating organisations is greater, and these organisations and other central structures are finding it possible to continuously coordinate their efforts. The available finances continue to increase, though the level of funding that would make the realisation of all goals and aims possible has yet to be reached.

It is clear, however, that significant efforts must still be made in certain fields in order to produce the kinds of results sought from this structure by the community. The consensus formed through professional, administrative, social, and political channels, and related to the problems at hand and their solutions, provide for an excellent starting point for further efforts.
STUDIES RELATED TO THE DRUG SITUATION IN HUNGARY IN THE YEAR 2002

1. Introduction

Though the “publish or perish” mentality typical of most universities and research institutions in the United States and in Western Europe is now making its presence felt in Hungary as well, it is still not nearly as intense as it is in other countries. This is especially true in the field of addiction research, where the number of researchers (at universities and research institutions) is still relatively low, since a large percentage of those involved in this area choose to put their knowledge to the test in the real world (and conduct work in the fields of prevention, treatment, etc.). It is possibly a consequence of this fact that though the number of research studies is relatively high, (as evidenced, for instance, by the tenders submitted to the Ministry of Children, Youth and Sports and to other organisations, by the financial aid handed out according to these submissions, as well as by the number of relevant conferences, lectures, and posters), the number of publications dealing with addiction research nonetheless remains relatively low. An explanation for this phenomenon might be that many completed and evaluated studies are never written up scientifically, and are thus never published. Scientific interests and goals only go as far as getting one through the preparatory phases and through applying for financial aid, and may even last during the actual study, but stop short of preparing the findings for publication (though it should be noted that an occasional lecture or two are held). This is a major hurdle to overcome, since the profession must be kept informed of events and results; methods and questions must be brought to the surface to serve as the basis of meaningful scientific dialogue, criticism, or praise.

The following pages contain summaries of the major studies conducted in 2002. The results of these studies have been made available either in journals, or through other means of disseminating knowledge amidst the ranks of the profession. In a few instances, studies which concluded in the year 2003 will also be touched upon.

2. Epidemiological Studies

National epidemiological studies were conducted in the spring of 2003 involving two age groups: secondary school-aged children, and adults from 18 to 35 years old. The studies were directed by Borbála Paksi and Zsuzsanna Elekes. Though the work of Pikó (2002) and Kiss and Lisznyai (2003) also provide epidemiological data, the purpose of these studies was not mainly the collection of these data, but the examination of the health standards and behaviour of young people, and will therefore be discussed in a later chapter.

Rapid Assessment and Response (RAR) Method

Aside from large-scale studies conducted through questionnaires, the first epidemiological study in Hungary focusing its methods on qualitative prevention was conducted last year, specifically concentrating on intravenous drug users. This study of Rácz and Ritter (2003) was an effort at creating a general map of the situation in Hungary. In five regions of the country (five county seats: Budapest, Miskolc, Szeged, Pécs, and Veszprém, as well as their surrounding regions), researchers conducted interviews with intravenous and non-intravenous drug users, local experts, and with key local figures. The interviews were followed up with focus groups led by experts who deal with intravenous drug use. This study, in addition to the particular results obtained, is significant for having been the first to use the rapid assessment and response (RAR) method in Hungary. A study was conducted using similar methods in Kazincbarcika, Győr, and Debrecen by Fábián (2003). The aim of the first study was to explore some questions related to drug use in the given city. Insight into these issues is crucial to the development of the drug strategy of the given city and any possible intervention steps.
Studies of cocaine users

A study by Gerevich and Bácskai (2003) examined the treatment demands of cocaine users. Based on a quantitative study of 210 cocaine users and interviews conducted with 9 individuals, the study divides cocaine users into three groups: (1) party group (weekend drug use, as part of social integration); (2) marginalised drug consumers; (3) therapy group (presently undergoing treatment for drug use). The findings of the survey indicate that users usually opt to discontinue cocaine use when they perceive the costs of consumption as radically outweighing the benefits. In addition to financial and existential costs, the costs can include sleeping disorders, psychological problems and symptoms (depression, acute sensitivity, paranoia, panic attacks, overt anxiety, sexual disorders, etc.), symptoms typical of acute somatic diseases (heart and chest pains), and interpersonal problems. Cocaine users seek professional treatment only indirectly, through friends, for instance, and prefer to get by without treatment at official (state-run) organisations. As the issue of confidentiality is one of the most important concerns for these users, they are more likely to consult private physicians – but mostly only after abstinence has already been achieved. The physician is usually consulted to provide assistance in remaining drug-free. In terms of maintaining the achieved abstinence, several factors are crucial: the user’s level of involvement in the subculture of drugs, the moral support available to the user, his or her relationship to working and employment, the extent of physical problems after achieving abstinence, and the quality of the physician-patient relationship. Interviews conducted with professionals working with drug users, drug policy makers, and counsellors also confirm that in seeking treatment, cocaine users prefer private practices where their anonymity is guaranteed (and where the quality of service is also greater) rather than public medical and treatment institutions.

3. Monitoring the programmes; efficiency analysis

Monitoring preventative programmes

In the year 2002, most of the studies related to the effectiveness of different forms of intervention dealt with the effectiveness of preventative programmes. Paksi and Demetrovics (Paksi and Demetrovics, 2002; Paksi, Demetrovics and Czakó, 2002a and 2002b) conducted research on and evaluated the performance of the drug prevention programmes in Budapest schools. The project included all programmes, and an evaluation of their theoretical background. The stated aims of each given programme were looked at, the applied methodology was examined, and the programmes were categorised based on some of these findings. Social-structural analysis of each programme was also carried out. And in the case of seven programmes, the study also included evaluations of the processes used and the results attained. In terms of the former, information was acquired through observations conducted during the programme itself, questionnaires were filled out by those involved in the project, and surveys were conducted among students after completion of the programme. Programmes were evaluated by questionnaires filled out both before and after the programme, and covering both long-term goals as well as specifics of the programme. Focus group interviews provided further grounds for quantitative analysis of students participating in the prevention programmes. The results indicated that the different evaluation methods can best be used side by side, and that an exact understanding of the characteristics of the target audience is indispensable in the planning of such preventative programmes.

Nyírády (2003a), in a focus group study, examined the drug-prevention effectiveness of fashion photographs published in magazines. The result of the community reaction study demonstrated that fashion photographs are not an effective means of conveying drug prevention messages. One of the reasons for this lies in the debated relationship of fashion trends and drug use, and in the contradictions of depicting illicit activity in magazine photographs. The young people participating in the focus groups agreed that drug prevention will only be successful if the target audience of the message can identify with the characters portrayed in the message. Two other, similar methodological studies (Nyírády [2003b and 2003c]) examined other methods of preventative intervention. These studies featured qualitative (focus group) methods as well as qualitative/quantitative (survey) methods, and compared the effectiveness of these with different films, broadcasts, and exhibitions.
Monitoring treatment and harm-reduction intervention programmes

The Kun study (2003) examined a needle-exchange programme launched in the 9th district of Budapest in November of 2000. The study also included data on the population segment served by this programme – mostly Roma amphetamines users. The study describes how the programme got off to a somewhat slow start, but in two years of operation has become widely known in the target population; in the year 2002 already, over 4000 new needles were handed out. Convincing drug users of the importance of exchanging and handing in needles was a difficult part of the project, but in 2002, some 1500 used needles were exchanged. The interviews conducted show that intravenous amphetamine use is significant in the population segment being targeted by this service; but it is also apparent that needle sharing is not as widespread as might be expected given the “communal” nature of drug use in this community.

Demetrovics et al (2002) examined the effectiveness of methadone maintenance therapy. Preliminary findings indicate that significant improvements can be observed in the psychological state of the patient (lower anxiety and depression, higher general satisfaction than at the beginning of treatment) during the initial phases of methadone maintenance therapy; these effects are less clear in later stages of the treatment. Further confirmation is in the process of being worked out, through studies done on a larger scale.

4. Examining changes in the psychological and social background of drug consumption

Surveys of secondary school student opinions of the reasons for drug use

In their study, Pikó and Piczil (2003) used qualitative research methods and focus groups to examine the background of drug consumption among youth. The study, involving 150 students between the age of 16 and 18, was aimed at acquiring an accurate picture of participants’ attitudes toward drug consumption. The responses of the students made it clear that the students understand the contradictions of the current period of social and economic change. The students are faced with considerable insecurity, and it is this insecurity that is one of the main causes of stress in their lives; some of the coping strategies they resort to include smoking and alcohol and drug consumption. As in other qualitative studies, peer pressure was one of the most important factors that encouraged drug consumption.

Drug use and the findings of personal psychology

Bettina Pikó (2002), in a comparative study conducted with Hungarian, American, Polish, and Turkish participation, examined the correlations between health-attitudes and the psychological traits of secondary school students. The Hungarian sample was comprised of 560 individuals, with an average age of 16.7 years. 57% of the participants were male, and all attended secondary school in Szeged, Hungary. In the three months preceding the study, 11.8% of those surveyed had used marijuana. 5.4% (of the total sample) had used it only occasionally, 3.2% had used it on more than a few occasions, 0.4% had used it frequently, and 2.9% were regular consumers of marijuana (using it roughly every week). 5.7% of the total sample had used other drugs (8.2% of males, 2.5% of females). A weak correlation could be established between marijuana use and lack of confidence in a better future and the use of other drugs and the same issues. Using regression modelling, one of the most evident indicators of potential marijuana and other drug use was the behaviour of peers and friends.

A study by Kiss and Lisznyai (2003) conducted a survey among some three hundred college and university students examining their drug use, their social background, their integration into the college/university scene and relevant coping mechanisms and skills, their mental health status, and their expectations for treatment possibilities and other assistance. The study was especially significant for its role in mapping drug use and other factors, the understanding of which was necessary for the establishment of a college and university counselling network.

Results showed that drug use does not necessarily indicate dysfunctional mental health status. Only neurotic functions (NCS test sheet) showed significant correlation to drug use. A set of general
factors, showing a direct link to drug use, was discovered, which can be used as a basis for training programmes: these factors were more common in the cases of those leading healthy lives and those showing signs of deficient functions.

The research group of the University of Debrecen conducted significant studies in this field. Results were published in 2003, edited by Münnich.

**Drug use and religious beliefs**

A study by Pikó (2003, and Pikó and Fitzpatrick, 2003) examined the correlations between religious beliefs and the abuse of legal and/or illegal drugs among elementary and secondary school students in Szeged, Hungary. 1240 students participated in the study, between the age of 11 and 19. All three examined dimensions of religious beliefs (1.: professed religiosity; 2.: prayer; 3.: attendance of religious events) showed significance in terms of current marijuana and amphetamine consumption. In the case of marijuana, 7.6% of students who professed religious beliefs were users, compared with 14.5% of those who cited no religious affiliations. 6.2% of students claiming to pray regularly were drug users, while 11.7% of students who never prayed were. Only 4% of students who claimed to attend religious events regularly used marijuana; 13.6% of students who never attended such services used the drug. Tendencies were similar in the case of amphetamine use; in the case of smoking and alcohol consumption, professed religiosity did not show significant correlations with use. Those engaging in prayer and attending religious events, however, were less likely to use drugs (even if the difference in the case of legal drugs such as tobacco and alcohol was smaller compared to illegal drugs).

**Researching the changes brought about by therapy**

Researchers in Pécs examined the liberation rituals of drug users exiting therapy, and analysed the "celebrating their release" speeches given by users who achieved abstinence through treatment (B. Erdős, Kelemen, and Csürke, 2003; Kelemen and B. Erdős; 2003). The research was aimed at discovering any significant communicative elements in these texts that might allude to a change of mentality on the part of the patient, and which would enable treatment staff to distinguish between cases of real and temporary abstinence (with the potential for a relapse) in the future. 27 speeches given by users who have achieved abstinence were examined, as well as 7 given by relapsed drug users. A summary of the study concluded that users achieving true abstinence tended to use more metaphors, while relapsing users not only used significantly less, but also more "everyday" metaphors, which they saw as fitting for these occasions. Relapsed patients also tended to speak of a desired state, without touching upon any of the difficulties which might be encountered in the process of coming clean; they also tended to allude to "being on the road," symbolic of a not yet completed journey. Those achieving true abstinence, on the other hand, often spoke about some of the experiences they shared with their peers in therapy. Relapsing patients focused more on delivering a speech fit for the occasion, and were thus more ceremonious, it can be said. In conclusion, the results of the study indicate that drug users who have achieved abstinence tend to demonstrate, even in their speech, that they are in a period of transition, and that they are likely to maintain the abstinence achieved through therapy.

**5. Research on other types of addiction – Internet addiction**

In recent years, one of the most quickly expanding research areas of addiction research has proven to be the area of addiction to the Internet, and problematic Internet usage. Due to space constraints, we will only mention some of the most important findings of the field; but the problems of this new type of addiction are indeed worthy of further attention. Using a questionnaire developed by Young, a survey conducted by Fábián et al (2002) divided Internet users into several groups; a Hungarian-language questionnaire was drawn up by Demetrovics et al (2003), and was used to assess problematic Internet use and examine some of its most important psychometric characteristics. Three factors were identified: obsession (thought processes confined to the Internet and related topics), control problems, and neglect of other non-Internet-related duties. These results mostly match those

6. Summary

It should be emphasised that the present report does not contain a description of each and every study conducted in Hungary in the year 2002 (or ending in the year 2003). To date, several studies have not (yet) had their findings published. While every effort was made to acquire the data of these studies (unpublished and/or not available in journals either), the picture may not necessarily be considered complete.

Perhaps two major sets of conclusions can be drawn from the above studies. One is that use of the qualitative method in surveys is obviously spreading: both in the field of epidemiological research (two studies conducted last year introduced RAR [Rapid Assessment and Response] methods), and in terms of the efficiency and spread of focus group and interview programmes. The other noteworthy and laudable observation is that in recent years, the number and significance of research studies emphasising the survey of preventative and treatment programmes has been on the rise.

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INCIDENCE OF DRUG USE – AN EPIDEMIOLOGICAL REPORT

Prevalence of Drug Consumption

2. Epidemiological report
2.1. Prevalence of drug consumption; patterns and trends in the Hungarian population

2.1.a. Trends in drug consumption

Hungarian data on the drug consumption habits of secondary school students (one of the groups exposed to the greatest risk) over the past ten years is now available; data covering the over-18 population of Hungary also exists, covering the years since 2000. These data have been collected and are organised according to international standards.

Trends among secondary school students

Drug epidemiological studies were conducted in Hungary in the years 1995, 1999, and 2003 (Elekes-Paksi, 1996, 2000a) under the auspices of the European School Survey Project on Alcohol and Drugs (ESPAD)4, and involving a nationally representative sample of secondary school students. In the 2001-2002 academic year, data was collected under the study “Health Behaviour in School-Aged Children” (HBSC)5. The evaluation of the data obtained in the 2003 studies is still in the works, so the national trends outlined in the present report only apply to the years between 1995 and 2002.

As has already been published in the reports of previous years, the ESPAD-based local and regional studies of the early 1990s indicated that approximately 7-12% of all secondary school students have experimented with at least one kind of drug. The nationwide ESPAD study conducted in 1995 also revealed that roughly 10% of tenth grade students had tried drugs. Studies conducted subsequently in certain counties and towns of Hungary also support this figure of around 10%, held to be typical of the early 1990s until 1996. In subsequent years, the nationwide prevalence6 of tenth grade students who have tried some form of illegal substance7 or inhalants nearly doubled, reaching 19% (Elekes, Paksi 2000b, Paksi 2002).

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1 The comprehensive study prepared by Borbála Paksi – scientific advisor, Budapest University of Economic Sciences and Public Administration, Centre for Behavioural Studies

2 According to Hungarian and foreign research, the first instance of drug use occurs usually during secondary school years. (for examples, see Bácskai-Gerevich 1997; Elekes-Paksi,1996, 2000a, 2000b; Hibell, et al., 1997, 2000; Murányi-Seres, 1994; Murányi, 1996, Demetrovics, 1998, 2001; Paksi 2003a, b)

3 The 1995, 1999, and 2003 secondary school studies were conducted based on ESPAD (for a detailed methodological description of the programme, see Hibell et al., 1997; 2000 and Elekes-Paksi,1996, 2000a). The 2001-2002 studies were based on HBSC protocol (Sebestyén 2003), and studies examining the general population were organised in accordance with the recommendations of the EMCDDA and the World Health Organisation (EMCDDA 1999; Simpura et al. 2000, and Elekes, 2002, Paksi, 2003a, b).

4 European study on the drug and alcohol consumption habits of secondary school students (Hibell et al., 1997, 2000, Hibell- Andersson, 2002).

5 Health Behaviour in School-Aged Children

6 Studies conducted in Hungary often calculate the total percentage of drug users together with the percentage of inhalant users, leading to a percentage used in describing the overall prevalence of drug use.

7 Illegal substances are: marijuana, hashish, LSD, ecstasy, amphetamines, crack, cocaine, heroin, other opiates, and magic mushrooms.
The HBSC study of 2002 indicated that 21.5% of ninth and eleventh grade students have tried at least one type of illegal drug or inhalant in their lives. The figure for ninth graders is 15.5%. ESPAD studies conducted in the year 1999 put this figure at 16.6%. At a reliability rate of 68%, the findings of the two studies do not differ significantly, which indicates either a tapering of drug consumption in the past three years, and/or a combined margin of error in the ESPAD and HBSC studies.

A separate drug epidemiological survey was conducted in Budapest in the spring of 2003, in association with the 2003 Hungarian ESPAD project. Thus, data now available on the situation in Budapest spans eleven years and has been collected according to unchanged methodology.

In the first half of the 1990s, no significant changes were observed in Budapest in terms of drug use penetration, (similar to general trends in the rest of the country). Between the years 1995 and 1999, however, an increase of 16.7% (from 12.1% to 28.8%) was observed in terms of illegal substance use. If the figure observed at the beginning of the decade is considered 100%, then the total increase among tenth grade students in Budapest was 140%. In this timeframe, the consumption of all drug types showed an increase, but this growth was especially significant in the case of cannabis-type drugs, but it was also noteworthy in the case of LSD and other hallucinogens, amphetamines, and ecstasy. Intermediary studies (conducted between the two ESPAD studies) in 1998 revealed that this increase most likely took place between the years 1995 and 1998 (or, citing the data of other, smaller studies, between 1996 and 1998), and that between 1998 and 1999, it was only the use of marijuana which continued to rise (Elekes, Paksi, 2000b).

In the following years, between 1999 and 2000, the growth in drug consumption (of all substances) was within the studies’ margins of error. However, looking back at the past four years, this tapering proved to have been only temporary. Data for 2002 show that in the case of certain drugs, (ecstasy, amphetamines, LSD, and cocaine and heroin derivatives), consumption again began to increase beyond the possible margin of error (Paksi, 2002). In the last year, this slow but steady increase has continued in the case of marijuana/hashish and amphetamines, but the use of LSD has shown a marked decline. The use of other substances did not show significant change.

8 The black line indicates the trends to be expected in the case of a linear relationship; the dotted line shows the so-called polynomial relationship.
9 Using a reliability rate of 68%, the ESPAD values obtained for ninth graders in 1999 was 15-17.2%, while the HBSC values were 14.8-16.2% in reality. Using a reliability rate of 99%, these figures are 15-18.2%, and 13.1-17.9%, respectively.
10 Studies conducted prior to 1999 pertain to tenth grade students; thus, long-term changes can best be presented using this age group.
Trends in the consumption of different substances among tenth grade secondary school students in Budapest, from 1992 to 2003

The changes taking place during the second half of the 1990s in the overall consumption of drugs follows changes in the specific consumption of various substances. The use of marijuana and different synthetic party drugs showed a marked increase and, though the level of consumption remained fairly constant, the use of inhalants began to decline (Elekes, Paksi, 2000b). No major changes in this area was observed over the course of recent years (Paksi 2002, and Sebestyén, 2003). Marijuana use remains most prevalent, followed by the different party drugs; only the consumption of LSD has shown a decrease. Even so, LSD remains one of the leading drugs, being one of the four most popular substances.

Over four years, the total consumption of drugs by tenth grade students in Budapest increased by 20% as compared to the figures observed in 1999 and 2000, if the original numbers are considered to be 100%. A line to indicate this trend in the 1999 and 2003 data shows that the figures are within the margin of error, meaning that the increase was fairly steady, at an average of 1.575% per year. The increase found in Budapest after 1999 is less than two-fifths of what was observed in the same segment of the population during the second half of the 1990s. (The following graph shows this, through the differences in the slope of the two lines drawn on the pre-1999 figures, and the figures after this year.) However, as has already been mentioned in this and earlier reports, the 1995 and 1999 ESPAD studies (both for Budapest and the rest of the country) show that the increasing trend during the second half of the 1990s was not steady, and that the changes (increases) rather took place in cycles that were 2-3 years long. In cases where the increase occurred in a shorter time, the pace of growth was greater than what is indicated in the figures. This increase may have been as high as 5-6% annually; compared to this figure, the current changes in the usage trend can be called even more significant, since in the past four years the increase in drug consumption in Budapest has slowed to about a fourth of what had been seen in previous years.
The growth of the drug consumption problem was accompanied in the 1990s by changes in the other characteristics of illegal substance consumption as well (Paksi 2002).

Between 1995 and 1999, the intensity of drug use increased. In this period, the number of students using drugs on only one or two occasions fell to about half of the previous figures, and the share of occasional and regular drug users increased. Between 1999 and 2002, the percentage of experimenters and occasional drug users did not show significant change; at the same time, the number of intensive drug users (40 or more occasions in their lives) grew by a third between 2000 and 2002. This past year did not bring about drastic changes; in 2003, as in 2002, some 30% of tenth grade students regularly used illegal substances.

One change typical of the years between 1995 and 2003 was the lowering of the average age at which secondary school students first experimented with drug use. While the first occurrence of drug use is still usually in the secondary school years (at the age of 15 or 16), the second half of the 1990s showed a trend pushing this average age even earlier still, to 15. Between 1999 and 2002, the number of students experimenting with drugs at the age of 14 or lower increased. This trend has apparently not continued in Budapest over the past year; today, little more than a third of tenth grade drug users claim to have already had contact with drugs in elementary school.
Trends in the over-18 segment of the population

We have only a limited opportunity for examining the trends of the over-18 segment of the population, on the one hand because drug epidemiological surveys targeting them have only been conducted in 2001 and then in 2003, and on the other hand because the analysis of the 2003 study was still underway at the time of publication of this report. Therefore, trends can only be described with respect to the situation of young adults in Budapest, who actually happen to be the most affected group.

In the year 2001, one third of Budapest residents between the age of 18 and 34 had used illegal drugs on at least one occasion before. Today, this figure is closer to 40%. Considering the overlap in the confidence interval of these two studies, it can be said with two-thirds accuracy that, between 2001 and 2003, the increase in the drug use of the Budapest sample was greater than the margin of error of the method used to conduct the study.\(^{11}\)

The measured and actual percentage of drug consumption in people between the ages of 18 and 35 in 2001 and in 2003

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PERCENTAGE MEASURED THROUGH THE SURVEY</th>
<th>ACTUAL PERCENTAGE, WITH 68% ACCURACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>33.2</td>
<td>30.3 – 36.1</td>
</tr>
<tr>
<td>2003</td>
<td>39.4</td>
<td>36.9 – 41.9</td>
</tr>
</tbody>
</table>

While the percentage claiming to have used drugs did increase, the change amongst regular users was smaller than the margin of error of the study. The reason for this was that the percentage of drug users who have achieved abstinence increased from 15% to 20%, which, in terms of all drug consumers, means a cessation rate of 46.5% and 52%.

\(^{11}\) In the 2001 study, a sample of 262 Budapest residents between the ages of 18 and 35 was used. Using a reliability percentage of 68%, the confidence interval here is ±2.88%. In the 2003 study, the number of people surveyed was 369, and the confidence interval here was ±2.55. The difference in drug use found in the two studies is greater than the standard margin of error, so the results indicate – with two-thirds reliability – a true change.
The measured, and actual, percentage of drug consumption in people between the ages of 18 and 35 in 2001 and in 2003

<table>
<thead>
<tr>
<th></th>
<th>IN THE YEAR 2001</th>
<th></th>
<th>IN THE YEAR 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER OF DRUG CONSUMERS WHO QUIT</td>
<td>PERCENTAGE OF RESPONDENTS</td>
<td>PERCENTAGE OF CONSUMERS</td>
<td>PERCENTAGE OF RESPONDENTS</td>
</tr>
<tr>
<td>Continuous usage</td>
<td>15.1</td>
<td>46.5</td>
<td>16.5</td>
</tr>
<tr>
<td>NUMBER OF FIRST-TIME USERS</td>
<td>1.8</td>
<td>6.0</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Over the course of the past two years, the age at which young adults in Budapest typically first encountered drugs has gone down by, on average, one year. While in the year 2001 one-third of drug users claimed to have first come into contact with illegal drugs at the age of 17 or lower, data for 2003 indicate that by the age of 17, fifty percent of drug users had already tried drugs for the first time. At the same time, (due to the abovementioned trend), the percentage of drug users who first tried illegal substances between the ages of 18 and 20 has been decreasing. The percentage of those who first tried drugs at an older age remained unchanged.

![Graph showing age of first encountering drugs as a percentage of total drug users](image)

The data for both the 2001 and 2003 studies indicate that the substance first used by drug consumers is usually marijuana and hashish; the percentage of those who try these substances first has been increasing, however. THC was the drug first tried by a little over two-thirds of the given age group in the year 2001; in 2003, 8 or 9 out of 10 users started with marijuana or hashish. The percentage of individuals trying other drugs in their first instance of drug use is usually not high enough for studies to show true changes in the statistics for the entire population. However, the decrease in first-time use of amphetamines and inhalants most probably (with two-thirds accuracy) signals a real decline.
Drugs tried by first-time consumers
(Individuals living in Budapest between 18 and 34 years of age; as a percentage of total drug users)

The ranking of drugs, in terms of consumption trends, has not changed in the past two years. In the case of most substances, the changes are not statistically significant. Ecstasy and amphetamines are the exception, because in their case, the changes indicated by the data most probably (with two-thirds accuracy) show a true change.¹²

Use of different substances
(In the segment of the Budapest population between 18 to 34 years of age; as a percentage of all respondents)

If the use of different substances is compared during the two years of the studies and the percentage of marijuana users who have used other drugs in their lives is examined, an even stronger correlation can be observed between marijuana use and the use of other drugs. In the case of two substances – ecstasy and amphetamines – the changes indicated in the data most probably (with two-thirds accuracy) show a true increase in use.¹³

¹² With two-thirds accuracy, the standard margin of error in the data for amphetamine use in 2001 is ±1.7%; in the case of ecstasy, this figure is ±1.8%; in the year 2003, these numbers are a maximum of ±1.6 and ±1.8% (sample size in the 2001 survey was 262; in the 2003 survey it was 369).

¹³ With two-thirds accuracy, the standard margin of error in the 2001 data for amphetamine use in THC users was ±4.6%; in the case of ecstasy, this figure was ±5%; in the year 2003, it was a maximum of ±4.1 and ±4.3% (sample size in the case of THC users was 77 in the 2001 study, and 121 in the 2003 study).
2001 data is from Paksi, 2003a, b

2.2.c. Drug use among secondary school students

Data of the 2001-2002 HBSC study (Sebestyén, 2003)

Summary of the methodology of the study

<table>
<thead>
<tr>
<th>DATE OF DATA COLLECTION</th>
<th>March and mid-April, 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>GEOGRAPHIC SAMPLE</td>
<td>National</td>
</tr>
<tr>
<td>SCHOOL TYPE</td>
<td>Secondary schools (4, 6, and 8-grade schools) + vocational secondary schools + vocational training schools, + technical institutes</td>
</tr>
<tr>
<td>GRADE LEVEL</td>
<td>Ninth and eleventh graders</td>
</tr>
<tr>
<td>METHOD OF DATA COLLECTION</td>
<td>In-class surveys, administered by external professionals</td>
</tr>
<tr>
<td>TYPE OF SURVEY</td>
<td>2001-2003 HBSC survey, filled out by the students themselves</td>
</tr>
<tr>
<td>SAMPLE SIZE</td>
<td>3034 individuals</td>
</tr>
<tr>
<td>SELECTION CRITERIA</td>
<td>Type of school (based on the type of funding the school receives), geographic location, type of town/city, random sampling based on school type and grade level</td>
</tr>
<tr>
<td>SAMPLING UNIT</td>
<td>Class selected at random within the chosen school</td>
</tr>
<tr>
<td>WEIGHTING</td>
<td>No weighting was necessary</td>
</tr>
</tbody>
</table>

Major findings

The data of the HBSC study showed that roughly one-fourth (24.3%) of ninth and eleventh grade students had engaged in some kind of legal or illegal substance abuse at some point. 9.3% of those surveyed admitted to having abused some sort of prescription or over-the-counter (OTC) drug at one point without a doctor’s permission, or to having used a combination of medicine and alcohol with the same intent. Over two-thirds, 69.6%, of those who had abused medical drugs also admitted to having used illegal drugs and/or inhalants at one point. Thus, the percentage of those who had not used illegal drugs but had abused medical drugs, possibly combined with the use of alcohol, is 2.8%. Over one fifth, 14 Legal drugs here are defined as medications specifically used with the intent to abuse, possibly combined with the consumption of alcohol. (Question posed in the survey: “Have you ever used alcohol and drugs [medications] together, to get high?”) Thus, the criteria for abusing prescription or OTC drug is tighter in the HBSC study than in the ESPAD study.
21.5% of all students surveyed had consumed some kind of illegal substance and/or inhalant at one point.\textsuperscript{15}

**Different forms of substance abuse among ninth and eleventh grade Hungarian secondary school students**

(percentage)

<table>
<thead>
<tr>
<th>Form of substance abuse</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total use of legal and illegal substances</td>
<td>24.3</td>
</tr>
<tr>
<td>Abuse of prescription and OTC drugs among users of illegal substances</td>
<td>9.3</td>
</tr>
<tr>
<td>Abuse of prescription and OTC drugs alone</td>
<td>2.8</td>
</tr>
<tr>
<td>Total use of illegal substances and/or inhalants</td>
<td>21.5</td>
</tr>
</tbody>
</table>

Examining usage habits broken down according to individual drug types, it becomes clear that marijuana and hashish are the most used substances. Nearly one out of five students surveyed admitted to having used them at one point. In addition to general indicators of use, the use of cannabis-derivatives in the year preceding the study was also widespread: 15.8% of students surveyed had used marijuana or hashish. Following these substances are ecstasy and amphetamines, with consumption at 4.3% and 3.6%, respectively. The use of solvents, glue, LSD, and other hallucinogens, opiates, and cocaine was relatively low, with consumption figures between 0.7% and 2.1%.

**Nationwide use of different drugs among ninth and eleventh grade Hungarian secondary school students, 2002**

(percentage of respondents)

The HBSC study reflects what is considered the traditional patterns in gender: 17% of female respondents and 26% of male respondents admitted to having used some type of illegal drug or inhalant. In the case of female respondents, however, the abuse of prescription and/or OTC drugs seems to be more prevalent.

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\textsuperscript{15} List of illegal substances compiled according to ESPAD standards.
Significant differences in consumption can be found between genders in the case of four substances; the greatest difference is in the use of marijuana and hashish (24.5% of male respondents admitted to its use, while 15.9% of females did).

### Nationwide substance abuse among ninth and eleventh grade secondary school students according to gender, 2002 (percentage of respondents)

<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>MALES</th>
<th>FEMALES</th>
<th>SIGN. (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARIJUANA, HASHISH</td>
<td>24.5%</td>
<td>15.9%</td>
<td>0.001</td>
</tr>
<tr>
<td>AMPHETAMINES</td>
<td>4.8%</td>
<td>2.7%</td>
<td>0.01</td>
</tr>
<tr>
<td>INHALANTS</td>
<td>2.8%</td>
<td>1.6%</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Data of the ESPAD’03 study conducted in Budapest

At the time of the publication of this report, the evaluation and compilation of the drug epidemiological data collected among a nationally representative sample of secondary school students during the ESPAD’03 project has not yet been completed; only the results of the supplementary study conducted in Budapest are ready for publication here.16

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16 The Ministry of Child, Youth, and Sports Affairs supported the supplementary collection of data in Budapest (tender no.: KAB-KT-02-018)
**Summary of the methodology of the study**

<table>
<thead>
<tr>
<th>DATE OF DATA COLLECTION</th>
<th>March 5, 2003 – March 31, 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>GEOGRAPHIC SAMPLE</td>
<td>Budapest</td>
</tr>
<tr>
<td>SCHOOL TYPE</td>
<td>Secondary school and vocational secondary school (vocational training school) + training institutes (vocational training school)</td>
</tr>
<tr>
<td>GRADE LEVEL</td>
<td>Ninth and tenth grade students</td>
</tr>
<tr>
<td>METHOD OF DATA COLLECTION</td>
<td>In-class surveys, administered by external peer counsellors</td>
</tr>
<tr>
<td>TYPE OF SURVEY</td>
<td>ESPAD’03 questionnaire, filled out by the students themselves</td>
</tr>
<tr>
<td>SAMPLE SIZE</td>
<td>Total: 2590 individuals, Net: 2074 individuals</td>
</tr>
<tr>
<td>SELECTION CRITERIA</td>
<td>Random sampling according to school type and grade level</td>
</tr>
<tr>
<td>SAMPLING UNIT</td>
<td>School class</td>
</tr>
<tr>
<td>WEIGHTING</td>
<td>Correction of distortions occurring during sampling, according to representation criteria</td>
</tr>
</tbody>
</table>

**Major findings**

Two out of five (40.4%) ninth and tenth grade secondary school students have used some type of substance at one point. 22.2% have abused prescription or OTC drugs, perhaps in combination with the consumption of alcohol. Nearly two-thirds (61.1%) of those who have abused prescription or OTC medications\(^{18}\) have also tried some type of illegal substance. Thus, the percentage of those who have abused legal medicines but have not tried other illegal substances is 8.5%. Another nearly one-third (31.9%) of respondents admitted to having used illegal substances and/or other, legally-available substances (with the purpose of drug abuse), such as inhalants, propellant and balloon gases, etc. The majority of these individuals (30.6%, but 96% of all drug users) admitted to having used some type of illegal drug as well. Three-fourths of the individuals admitting to using drugs have experimented with some type of illegal substance at one point.

Some 70% of respondents who have abused some sort of illegal or legally-available substance admitted to having used some of these substances in the year preceding the study; roughly 40% admitted to having done this in the month preceding the study. These percentages show a decrease in the case of individuals abusing prescription or OTC drugs (and perhaps combining their use with alcohol consumption); 12% of respondents admitted to having used some substance in the year preceding the study, and 6% had done this in the month preceding it. Of all respondents who claimed to have used some type of illegal substance at one point, over three-fourths (76.9%) had done so in the twelve months preceding the study, and nearly half (45.1%) had used something this year as well. On a yearly level, 23.1% of respondents had used illegal substances; this figure is 13.3% on a monthly level.

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\(^{17}\) For details see Paksi-Elekes (2003)

\(^{18}\) In the ESPAD study, abuse of prescription or OTC drugs does not necessarily signal drug abuse. The question posed in the survey applied to using a combination of medications and alcohol, which may also take place with actual healing purposes.
Combined statistics on the different forms of substance abuse over different periods of time, among ninth and tenth grade Budapest secondary school students, 2003 (percentage of respondents)

<table>
<thead>
<tr>
<th>Substances</th>
<th>Percentage of Respondents</th>
<th>Percentage of Those Who Have Used Some Substance at One Point in their Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of Legal and/or Illegal Substances – Combined Statistics:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used it at one point in their life</td>
<td>40.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Used it in the previous twelve months</td>
<td>28.5</td>
<td>70.6</td>
</tr>
<tr>
<td>Used it in the past thirty days</td>
<td>16.5</td>
<td>41.6</td>
</tr>
<tr>
<td><strong>Drug Abuse:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used it at one point in their life</td>
<td>31.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Used it in the previous twelve months</td>
<td>24.2</td>
<td>75.8</td>
</tr>
<tr>
<td>Used it in the past thirty days</td>
<td>13.9</td>
<td>43.9</td>
</tr>
<tr>
<td><strong>Abuse of Prescription or OTC Drugs:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used it at one point in their life</td>
<td>22.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Used it in the previous twelve months</td>
<td>12.5</td>
<td>54.3</td>
</tr>
<tr>
<td>Used it in the past thirty days</td>
<td>6.0</td>
<td>26.1</td>
</tr>
</tbody>
</table>

The data for the different time periods indicate that among ninth and tenth grade Budapest secondary school students, the most prevalent form of substance abuse is the use of illegal drugs. It can be concluded from the above that the consumption of illegal drugs is not only the form of substance abuse affecting the most students, but is also the form with the greatest frequency in terms of occurrences of usage. Over one-fifth of those admitting to having used an illegal substance at one point (6.5% of all respondents) claim to have done so on just one or two occasions; nearly one-third cited multiple occasions, but still less than ten occasions in total. Nearly half (46.4%, 7.5% of all respondents) of those admitting to having used an illegal substance at some point claim to have already done so on over forty occasions.

Number of occurrences of illegal drug use
(among respondents claiming to have tried drugs; 9th and 10th grade secondary school students, Budapest, 2003)

Repeat usage is much less frequent in the case of legally available substances. Three-fourths of those who admitted to having abused prescription or OTC drugs (perhaps combined with the consumption of alcohol) have done so on ten separate occasions or less. Roughly every second individual (38.7% of all who claim to have tried these substances at least once) said they had done so on only one or two occasions. About one-fourth or one-fifth (23.8%) of users have consumed these substances on ten or more separate occasions; only one out of every eleven consumers had done so
on 40 separate occasions or more. The use of inhalants is characterised to an even greater extent by experimentation; 60.5% of those admitting to having used inhalants on at least one occasion claim to have done so only once or twice total. Only one out of every five had used inhalants ten times or more.

Breaking down drug use according to individual drugs, the exceedingly high usage rate of cannabis becomes apparent from the data of the present study. The figures of this report, which are typical of other studies (both Hungarian and international), show that 28.4% of consumers had used cannabis-derivatives on at least one occasion; 21.4% had used it in the twelve months preceding the study; and 12.2% had done so in the one month preceding the study. 89% of drug users had used marijuana or hashish on at least one occasion, and the THC usage rates for shorter time periods are similar. 88.8% of drug users had used marijuana and hashish in the twelve months preceding the study; 87.7% of had done the same in the month preceding the study. The so-called “club drugs” are the next most widespread substances (amphetamine, ecstasy): figures for these drugs are similar, considering the confidence interval of the study, and are around 8% each. The prevalence of LSD, while demonstrating a decline as compared to previous years, is also significant, as is that of other legally available, yet abused, substances (inhalants, propellant and balloon gases, etc.). The usage figures for these are around 4-5%, and around 2% in the case of all other illegal drugs – 1.8% of respondents cited the use of some other substance. The percentage of those using marijuana combined with alcohol is 15.1%; 0.7% of them indicated intravenous drug use.

In the area of prescription and OTC drug abuse, the use of sedatives (without a doctor’s permission) is most widespread, at 15.3%. 11.4% of the students surveyed indicated combining prescription or OTC drugs with alcohol; 9.3% of respondents admitted to having taken sedatives without a doctor’s prescription.

**Abuse of different substances in 2003**

(Among ninth and tenth grade Budapest secondary school students; percentage of respondents)

Both in the case of illegal drug consumption and in the case of prescription or OTC drug abuse, the earliest age at which most respondents claimed to have come into contact with the substance was 14-15. However, the first instance of using sleeping pills and/or sedatives, or of abusing a combination of medicines and alcohol, occurred before the age of 14 in nearly one-fourth of the cases; as regards the first use of illegal drugs, one out of every six consumers had his or her first encounter before the age of 14 (15% of drug users claimed to have come into contact with drugs before the age of 14).
Age at the time of first encounter with drugs  
(Budapest, ninth-tenth grade secondary school students, 2003)

consumption of illegal drugs

<table>
<thead>
<tr>
<th>Age at the time of first encounter with drugs</th>
<th>Male</th>
<th>Female</th>
<th>Sign. (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before age 14, 17.7</td>
<td>18.9</td>
<td>18.7</td>
<td></td>
</tr>
<tr>
<td>At age 14, 29.6</td>
<td>33.8</td>
<td>31.4</td>
<td></td>
</tr>
<tr>
<td>At age 15, 26.3</td>
<td>29.6</td>
<td>23.5</td>
<td></td>
</tr>
<tr>
<td>At age 16, 18.9</td>
<td>16.9</td>
<td>17.7</td>
<td></td>
</tr>
</tbody>
</table>

No significant difference between genders is apparent in the case of illegal substance use; the figures for male and female students tend to match. Only in the case of cannabis-derivatives is there a significant difference, as is typical. At the same time, the abuse of prescription or OTC drugs (possibly combined with the consumption of alcohol) is more common among female respondents than among males.

The use of different substances or types of substances according to gender; ninth and tenth grade Budapest secondary school students, 2003 (percentage of respondents)

<table>
<thead>
<tr>
<th>Substances</th>
<th>Male</th>
<th>Female</th>
<th>Sign. (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal or illegal substances combined</td>
<td>39.8</td>
<td>41.1</td>
<td>n/a</td>
</tr>
<tr>
<td>Illegal substance abuse, total</td>
<td>34.9</td>
<td>28.6</td>
<td>0.001</td>
</tr>
<tr>
<td>Illegal drugs, total</td>
<td>33.0</td>
<td>27.2</td>
<td>0.003</td>
</tr>
<tr>
<td>Cannabis</td>
<td>30.9</td>
<td>25.3</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Alcohol with marijuana/hashish</td>
<td>17.4</td>
<td>12.3</td>
<td>0.007</td>
</tr>
<tr>
<td>Opiates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>1.1</td>
<td>0.9</td>
<td>n/a</td>
</tr>
<tr>
<td>Other opiates</td>
<td>2.5</td>
<td>2.1</td>
<td>n/a</td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td>2.3</td>
<td>1.4</td>
<td>n/a</td>
</tr>
<tr>
<td>Crack</td>
<td>2</td>
<td>0.6</td>
<td>0.046</td>
</tr>
<tr>
<td>Ampthamines</td>
<td>7.9</td>
<td>7.2</td>
<td>n/a</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>8.4</td>
<td>8.3</td>
<td>n/a</td>
</tr>
<tr>
<td>GHB</td>
<td>1.1</td>
<td>0.8</td>
<td>n/a</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSD</td>
<td>5.0</td>
<td>4.3</td>
<td>n/a</td>
</tr>
<tr>
<td>Other hallucinogens (magic mushroom)</td>
<td>3.1</td>
<td>0.7</td>
<td>0.001</td>
</tr>
<tr>
<td>Inhalants</td>
<td>4.4</td>
<td>3.4</td>
<td>n/a</td>
</tr>
<tr>
<td>Propellant and balloon gases</td>
<td>6.7</td>
<td>3.8</td>
<td>0.049</td>
</tr>
<tr>
<td>Total use of prescription or OTC drugs</td>
<td>16.0</td>
<td>29.0</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Sleeping pills (without doctor’s prescription)</td>
<td>5.2</td>
<td>13.2</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Sedatives (without doctor’s prescription)</td>
<td>0.9</td>
<td>21.1</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Alcohol and medicine</td>
<td>8.2</td>
<td>14.5</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Anabolic steroids</td>
<td>2.2</td>
<td>0.4</td>
<td>0.043</td>
</tr>
<tr>
<td>Other drugs</td>
<td>1.8</td>
<td>1.6</td>
<td>n/a</td>
</tr>
</tbody>
</table>

19 The line “illegal substance abuse, total” includes – in addition to illegal drugs – the use of inhalants, propellants and balloon gases.

20 The list of illegal drugs includes the following substances: cannabis, heroin, other opiates, cocaine, crack, amphetamines, LSD, magic mushroom, GHB.
2.2.b. Drug consumption in the adult population

The results of the spring 2003 representative survey examining drug use among the segment of the population aged 18-54 were still being evaluated at the time of the publication of this report. Thus, only the results of a study conducted among younger members of this age group living in Budapest (who happen to be the most affected by drugs) can be discussed here.21

Summary of the methodological details of the study

<table>
<thead>
<tr>
<th>DATE OF DATA COLLECTION</th>
<th>From February 28, 2003 – April 18, 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>GEOGRAPHIC SAMPLE</td>
<td>National, with a focus on Budapest</td>
</tr>
<tr>
<td>SAMPLE SUBJECTS</td>
<td>Hungarian citizens between the age of 18 and 54.</td>
</tr>
<tr>
<td>TYPE OF QUESTIONNAIRE</td>
<td>Compatible with EMCDDA, WHO, IRGA, and ADE 2001 studies</td>
</tr>
<tr>
<td>METHOD OF DATA COLLECTION</td>
<td>Background data of the respondents was recorded in person; the questionnaire on drug and alcohol consumption was filled out by the respondents themselves.</td>
</tr>
<tr>
<td>SAMPLE SIZE</td>
<td>National sample: total: 4012 individuals; Net: 3675 individuals</td>
</tr>
<tr>
<td></td>
<td>Budapest sample: total 854 individuals, Net: 604 individuals</td>
</tr>
<tr>
<td>METHOD OF SAMPLE SELECTION</td>
<td>Random sampling of members of the age group, based on geographic location and type of city, town, etc. Two-tier selection in the countryside, single-tier in Budapest.</td>
</tr>
<tr>
<td>WEIGHTING</td>
<td>Done according to demographic factors (age group and gender) in order to correct for lost samples and to correct for the focus on Budapest.</td>
</tr>
</tbody>
</table>

Major findings

One-fourth (25.2%) of the adult population of Budapest has used some type of illegal drug at some point. The target population of 18–34 year-olds was, at 40%, some four times more likely to have used drugs than the older segment of the population.22

<table>
<thead>
<tr>
<th>Use of illegal drugs in the main age groups (p&lt;0.000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-34</td>
</tr>
<tr>
<td>39.4</td>
</tr>
</tbody>
</table>

The following pages will describe other characteristics of drug use among this – very much affected – segment of the population.

In a majority of cases, the first time Budapest residents between 18 and 34 encountered drugs was in secondary school (see figure). Two-thirds of individuals claiming to have used drugs on at least one occasion did so at or before the age of 18. Half had first tried drugs by the age of 17. Among these, the first experimentation most likely took place between the age of 16 and 17; nearly two out of five substance abusers first tried drugs at this age.

21 The research was comprised of a number of subprojects. The MCYSF supported those projects that targeted young adults in Budapest. (grant programme code: KAB-KT-02-14)
22 With 95.5% accuracy, the measured figures for drug use in the 18 to 34 segment of the population is correct within a margin of error of ±5.1%. 

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Age at the time of first trying drugs, expressed as a percentage of substance abusers (Budapest residents between 18 and 34 years of age)

In a majority of cases, the first substance used was marijuana/hashish. 85.6% of those who claimed to have already tried some type of drug cited cannabis as the first substance that they had tried. One out of every twenty users started with ecstasy. No respondent cited cocaine, heroin, or other opiates as the drug they first encountered.

The findings of the study indicate that the role of different drugs and drug types varies widely, and that their prevalence is arranged according to a pyramid structure. Most widespread is the use of cannabis-derivatives. Over one-third of respondents, or the majority (86.5%) of those having used some kind of drug, have tried marijuana or hashish. The prevalence of all other substances is much smaller in the adult population. Ecstasy and amphetamines are in second and third place (considering the standard margin of error of the study, about 3%, there is no real difference between the placement of the two). LSD is in fourth place, not far behind, with a value of 8%. The drugs used least frequently are heroin and other opiates, cocaine, crack, and GHB, as well as inhalants and other – here unspecified – drugs, with 1-2% figures.23

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23 The value of "Relevin," used as a "dummy-drug" was 0.3%.
Abuse of different substances, in order of prevalence, among Budapest residents between the ages of 18 and 34 (percentage of respondents)

Relationships between the consumption of various substances were drawn up on the basis of the percentage of respondents citing use of the specific illegal drug. A so-called illegal drug pyramid (a term used in addiction literature) was created. The pyramid below shows how the values of the most widely used substances, marijuana (hashish), overlap with the figures of other drugs; in other words, what percentage of marijuana users have also tried different substances at one point.

“Illegal drug pyramid”: Use of different substances among cannabis users (percentage of Budapest respondent between the ages of 18 and 34)

Comparing the values shown in the pyramid, it is apparent that the abuse of different substances among young people in Budapest is closely interconnected. Roughly three times as many marijuana or hashish users have tried other illegal substances as those (“average”) Budapest residents who have never used cannabis derivatives.

18.8% of respondents had used some type of illegal substance in the year preceding the study; 8.8% had done so in the month preceding it. Nearly half of those who had used some type of illegal drug at one point in their lives had also done so in the year preceding the study; about one-fourth or one-fifth of them had also done so in the month preceding the study.

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25 The figures for abuse of any substance and the figures for the consumption of illegal drugs do not show a marked difference.
Use of illegal substances according to different periods of time
(percentage of Budapest respondents between the ages of 18 and 34)

<table>
<thead>
<tr>
<th>Illegal substances</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Used it at one point in their life</td>
<td>39.4%</td>
</tr>
<tr>
<td>Used it in the last year</td>
<td>18.8%</td>
</tr>
<tr>
<td>Used it in the last month</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

Those respondents who have used drugs on at least one occasion previously but have not done so in the last year, and are not abusing any substance currently, are referred to as quitters. The respondents who first tried some illegal substance in the year preceding the study are referred to as new users. Separating these from current users, the true continuation rate can be obtained, which shows the number of respondents who began substance abuse over one year before the study, and who have continued to used drugs in the year preceding the study.

One-fifth of the 18 to 34 year-old segment of Budapest respondents qualify as quitters; 1.8% of respondents are new users, having begun to use drugs in the year preceding the study. Thus, the continuation rate without incidence for Budapest respondents is 16.5%.

Quitters, new users, and continuous users among Budapest residents between the ages of 18 and 34
(percentage of respondents)

The above data show that about one-half (52.2%) of all Budapest residents between the age of 18 and 65 who have used drugs on at least one occasion in their life did not consume any in the year preceding the study. 4.8% of users first tried drugs in the year preceding the study, and can thus be considered new users. Altogether, 43% of Budapest residents who have used drugs at one point can be considered truly continuous users.

BIBLIOGRAPHY

Drug overdoses – the situation in Budapest

Compared to trends in previous years, the year 2003 brought about some changes. It can be stated that the number of patients treated after overdosing on illegal drugs decreased by about 25%. This decrease was most apparent among opiate users. The number of patients admitted because of overdosing on other drugs has remained unchanged. The possible explanations for the decreasing trend are manifold, and any one of several is possible.

– The number of intravenous drugs users has not changed compared to previous years; but due to an aggressive media campaign, the method of administering intravenous drugs has become safer, the substances to inject have become more diluted, and users tend to use less of substances they do not know the origins of.

– The number of intravenous drug users has decreased; this is definitely not due to an increase in mortality, but may be due to an increase in the number of patients treated. No definitive data exist.

– The number of intravenous drug users has not changed, but medical institutions are seeing fewer of them in treatment.

These, however, are all suppositions; a complex campaign would be necessary to provide more exact answers.

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This summary is by Dr. Gábor Zacher, head physician of the Emergency Unit and Clinical Toxicological Unit of the Sándor Péterfy Street Hospital.
This year had its share of medical events for our department. One unfortunate event was the first “body packer” death in Hungary. The 25-year-old young man entered the country with some 25 capsules of cocaine (he did not know the exact number) in his bowels. One capsule became lodged in the lower part of his stomach, and the contents spilled into the stomach and small intestines. Approximately 6 grams of cocaine (of 90% purity) entered his bloodstream. The lodged capsule was removed using an endoscope, but the patient had to be resuscitated due to a myocardial infarction. The resuscitation proved successful, but the patient suffered severe brain damage and passed away fifteen days after the event, due to multiple organ failure and septic shock. The toxicological examination, conducted at the National Forensic Toxicological Institute, revealed that a significant dose of cocaine was present in the patient’s brain fifteen days prior to the fatal accident. Further study of the case is pending.

Another significant event of the last year was also related to cocaine. A young man, having overdosed on cocaine, was treated with malignant hyperpyrexia (body temperature reaching 41 degrees Centigrade). After two days on life support equipment, and fifteen days after having intravenously injected the cocaine, he was able to leave the hospital.

Amphetamine use also led to some interesting cases. Spontaneous rhabdomyolysis of the lower limbs was diagnosed in the case of a minor patient. He was treated successfully for renal deficiencies, and eventually left the hospital.

The number of complications arising as a result of snorting cocaine has been on the increase. The patients treated have been, almost exclusively, well-to-do young people, with a stable background, between the age of 25 and 38. These cases provide proof of the suppositions that there is a readily available and ample supply of cocaine present today in Hungary. It is, however, mostly the affluent layer of society who can afford its use, as well as those engaging in criminal activity.

The two HIV-positive cases identified among intravenous drug users underscore that screening is indeed necessary, from the interests of both patients and the staff members treating them. The patient needs to understand the disease (or diseases) he is carrying, and he or she must take this fact into consideration during his or her everyday activities (making efforts to use sterile needles; not sharing needles with others, using condoms for sexual intercourse, etc.). From the perspective of staff members treating such patients, the saying that it is most difficult to contract a disease from people who are known to be carriers holds true. In such cases, all instances of invasive intervention are done using appropriate protection.

The studies conducted show that the percentage of individuals carrying the Hepatitis B virus is holding at 30%, which is an acceptable figure even compared to the more developed Member States of the European Union.

It is unfortunate that the Ministry of Children, Youth and Sports decided against providing funding for our bid related to financial aid for screening. This, however, does not mean that the tests can not go on.

Sniffing (of the butane gas found in cigarette lighters, for instance) continues to spread among those between the age of 12 and 15, as a form of non-invasive drug use. This is sometimes done by breaking off the top of the lighter (using a pair of pliers, for example) and then inhaling the quickly evaporating vapours. The gas, however, is often inhaled straight from the canister, too. Butane gas quickly leads to a state of euphoria, but also induces heart disorders. The latter effect led to the clinical death of two minors, after having been diagnosed with disorders in the heart ventricles. Though resuscitation proved successful, the extent of brain damage brought about by the lack of oxygen eventually led to death in both cases.

One important characteristic of such sniffing is that the readily noticeable odour of solvents that are usually used is not apparent here, so toxicological evidence is difficult to obtain. The only indication may be the signs of frostbite visible on the tongue and in the mouth of the patient. These are results of the continuous evaporation of the liquid butane gas, which leads to a cooling of the surroundings.
It can be considered fortunate that our department has more and more opportunities to train physicians in the treatment of drug overdose patients. This year, our department is due to publish a professional guide detailing the diagnosis and therapy of drug overdose cases.

However, it is our unfortunate observation that the treatment of patients suffering from acute withdrawal symptoms – though regulated by the Budapest chapter of the National Public Health and Medical Officer Service – is not functioning properly. Our department regularly treats young people who describe not having been admitted to other hospital departments that are supposed to be dealing with them, and having been sent off to register at an outpatient drug clinic.

The treatment of cases related to marijuana use has not changed. Patients are most often admitted with an acute panic reaction, rapid heart beat, and high blood pressure, in cases when the drug “did not do the trick.” They are usually able to leave after a few hours spent in the hospital under observation and treatment with medications.

Since the availability of the tablet Noxyron has ceased, many users of multiple drugs have switched to Rivotril, Tegretol, Leponex, and Barbamid. Patients using these drugs are usually less well off, and often physically weak as well.

Many of the patients we encountered as a result of sniffing are ones that are growing up in state-run homes. Establishing any relationship with them is exceedingly difficult, as they tend to reject any offers of assistance and/or treatment.

Unfortunately, our department is lacking a strong presence from non-profit organisations dealing with drug abuse and homelessness. Due to the high number of patients we treat, our department would be prime territory for these organisations. We welcome any and all assistance, and individuals can assist us on a daily or weekly basis, helping out with our patients.
DEVELOPMENTS IN TREATMENT NEEDS

Health statistics on drug use in the year 2002

Characteristics of the healthcare system's statistics on drugs

Changing methods of data collection from its introduction to now

In 1994, based on a proposal by the Intergovernmental Committee on Drug Affairs and the then Ministry of Welfare, the government ordered a new mandatory method of data collection regarding drug users and the treatments they receive. Data service was ordered by the relevant chapter of the National Statistical Data Collection Program (NSDCP) published under registry number 1627 in the annual government decree. Data service for the year 1994 was incomplete, it can only be regarded as an experimental phase of data collection; for this reason we do not use the data collected for that year in comparative studies.

Table 1 Changes in data collection between 1994–2002

<table>
<thead>
<tr>
<th>Effective year</th>
<th>1996</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>First year of data collected using the new method</td>
<td>1997</td>
<td>2000</td>
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</table>

<table>
<thead>
<tr>
<th>Areas affected by the change</th>
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</thead>
<tbody>
<tr>
<td>Definitions</td>
</tr>
<tr>
<td>Data providers</td>
</tr>
<tr>
<td>Recipient of collected data</td>
</tr>
<tr>
<td>Breakdown by age</td>
</tr>
<tr>
<td>Categorisation of drugs</td>
</tr>
<tr>
<td>Frequency of drug use</td>
</tr>
<tr>
<td>Mortality data</td>
</tr>
</tbody>
</table>

Summary prepared by Orsolya Grézló and Lajos Porkoláb
**The process of data collection**

Data is supplied by approximately 470 data providers once a year but as some of them overlap, only around 400 data providers shall be considered. The types of data providers are regulated by a statute, which fails to include a detailed list; the data collection centre is responsible for maintaining, updating and forwarding such lists to the authorities that require the data for their work. The data collection and processing centre is a unit of the National Psychiatric and Neurological Institute (NPNI) and is coordinated by the Controlling and IT Department, which was formed from the previously existing Department of Information Technology and Management. The NPNI prepares the forms in its own printing shop and sends them to the data provider institutions along with a brief methodological guide focusing on current issues. However, while the form and content of the report form may reflect the recommendations of the NPNI, it is actually determined by the Ministry of Health, Social and Family Affairs (MHSFA), which decides on the required changes published in the yearly specified NSDCP government decree.

Data providers transfer the annual figures from their databases to the reporting form, which they then send to the data processing centre. There are no regional data processing centres, but a copy of every report is sent to the regional medical supervisory officers of the National Public Health and Medical Officer Service. The regional medical supervisory officers do not summarise the results, but they only receive the county and national figures processed by the NPNI. Data providers must submit their data to the centre by January 31 following the base year.

The NPNI then sends the national aggregate figures and the breakdown by county in a series of tables to the Ministry of Health, Social and Family Affairs. According to the prevailing statutes, the Ministry forwards the data to all other governmental authorities. The NPNI also provides feedback to the data providers by sharing county, regional, and national figures and, if requested, it often prepares special reports to other government authorities or NGOs on an ad-hoc basis.

**Types of data providers and their data traffic in 2002**

According to the prevailing statutes, the following types of institutions are data providers, with the first group gathering data on treatments and the other on drug-related mortality.

Types of institutions providing data on the treatment of drug patients:

- drug outpatient clinics and drug care centres,
- psychiatric care centres (for adults and children),
- psychiatric departments and specialised outpatient clinics,
- crisis intervention departments,
- alcohol and addiction care centres, departments and special outpatient clinics,
- drug therapy institutions;

Types of institutions providing data on drug-related mortality:

- institutes of forensic medicine,
- institutes for medical specialists,
- Police Health Services

Table 2 shows the ratio of patients treated by each type of institution based on the figures for 2002. In addition to the traditional role filled by addiction care centres, drug outpatient clinics are increasingly gaining a more significant role in the treatment of drug users. Inpatient treatment also accounts for a significant percentage of the total figure, since it represents a treatment stage as well. While outpatient treatments are distributed among the various care centres and drug outpatient clinics, inpatient treatment is conducted exclusively at psychiatric and addiction departments.
Table 2: Breakdown of drug users according to type of institution providing treatment

<table>
<thead>
<tr>
<th>TYPE OF INSTITUTION</th>
<th>Patients treated</th>
<th>New cases (of total treated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>%</td>
</tr>
<tr>
<td>ATF Addiction treatment facilities</td>
<td>3088</td>
<td>24.2</td>
</tr>
<tr>
<td>DOC Drug outpatient clinics</td>
<td>3060</td>
<td>23.9</td>
</tr>
<tr>
<td>CYP Treatment facilities specializing in child and youth psychiatry</td>
<td>16</td>
<td>0.1</td>
</tr>
<tr>
<td>PTW Psychiatric treatment wards</td>
<td>117</td>
<td>0.9</td>
</tr>
<tr>
<td>PAT Psychiatric and addiction treatment wards</td>
<td>2451</td>
<td>19.2</td>
</tr>
<tr>
<td>OT Other</td>
<td>4045</td>
<td>31.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12777</td>
<td>100.0</td>
</tr>
</tbody>
</table>

It should be noted, however, that the methodology of data collection does not allow for a breakdown into outpatients and inpatients since psychiatric and addiction departments report patient numbers that include figures received from the special outpatient centres attached to the departments.

Figure 1: Breakdown of drug users according to type of institution providing treatment

Assessment of data

Statistics on the drugs used by treated drug users contain detailed information and differentiate subcategories within the main categories of drugs (e.g. types of amphetamine products). The figures also include the number of patients using illegal and legal drugs (e.g. sleeping pills and sedatives). Patients are classified by the dominant kind of substance they use, but there is a separate table that contains the data referring to their combined-usage habits. Information on the method of drug consumption is primarily important in the case of intravenous drugs, since the associated illnesses (hepatitis, AIDS) have a bearing on public health and epidemiology. As for the frequency of drug use, statistics now lists three categories instead of the previously used two.
Institutions providing treatment publish only aggregate figures on drug patients and therefore double-counting of patients registered by more than one institutions is inevitable. Medical experts agree that the community of drug users in Hungary is a population of patients that tend to move from one treatment institution to another. The same patient, therefore, may for example visit a treatment centre in Budapest, another in Pest County and may even be admitted to an inpatient department all within the same year. This means that the person is listed in the aggregate annual statistics three times, which obviously distorts figures on the number of patients treated. Ever since data collection methods were modified in 2000, patients’ self-reported date of first treatment has been accepted as authoritative. Statistical tables including a detailed breakdown by age and type of drug used abundantly cover first-time patients.

Compliance with obligatory data provision has gradually improved since it was introduced: now only about 10 percent of all reports submitted are overdue. Errors resulting from misinterpretation and computational errors continue to be persistent problems. Although the types of errors and the resulting degrees of distortions are different, the vast majority of reports require follow-up correction and data control. The tables of the report contain various breakdowns of all the patients treated at a given institution, so the figures must eventually be in agreement.

In addition to computing errors, certain interests related to financing may explain poor data validity in inpatient treatment. Under the current DRG system, institutions receive low reimbursement for patients diagnosed for drug addition. Therefore, the management of inpatient institutions may become interested in producing a medically acceptable main diagnosis for an addicted patient with a view to obtaining a higher rate of social security reimbursement. Such practices are aided by frequent comorbidity. The quality of data provision and the speed of data processing could be improved with the introduction of electronic data collection.
Trends in the number of drug users

The number of treated patients and new patients

The number of drug users treated at health care institutions dropped in 2001, a development that is unprecedented since data collection was introduced. This tendency failed to continue in 2002 and even a slight increase was registered. Based on the figures of the past four years, we can conclude that the sharp increase in the number of treated patients has come to a halt and appears to have levelled out at around 12,000-13,000 patients annually.

Figure 2: The number of treated drug users, 1995-2002
The number of new patients has also increased compared to last year’s figure. Until 1999, the number of first-time patients grew more slowly than the number of all patients under treatment, but it did grow from one year to the next overall. In 2000 however, it dropped by 19% compared to 1999. This sudden and substantial decline can be attributed to the fact that the concept of first-time patient had been redefined and beginning with the base year of 2000, institutions report patients (self-reporting) to have received treatment for the first time in their lives under this category. In view of the past three years, the number of new patients is likely to stabilise at a certain level.

Figure 3: Number of treated first-time drug users, 1995-2002
Gender breakdown

Since 1995, the number of male drug users treated at health care institutions has consistently been higher than that of female users. The gender division between men and women used to range from 61:39% to 69:31% but this tendency has turned around. Currently the gender breakdown is 59:41%, which reflects a 10 percent drop among men but a stunning 42 percent increase among women! Except for sedative-type substances, each drug category saw a much higher number of male patients than female patients during the period between 1995–2002. Women, however, have always dominated the segment in which patients use sedatives and sleeping pills as drugs. While the number of men as well as women treated has dropped in each substance category compared to the previous year, there is a sharp 124% increase among men and a shocking 197% increase among women in the use of sedative-type substances. Statistics alone cannot explain the causes behind such changes and it is within the competence of addiction experts to answer these questions; nevertheless such a significant change definitely requires further studies.

Figure 4: Gender breakdown of treated drug users, 1995-2002

Breakdown by age

In analysing trends broken down according to age, one should not ignore a change in methodology: up to 1999 only registered patients’ data were processed for age breakdown; as of 2000, all treated patients have had their age registered. The number of registered patients between 1995–1999 was generally lower than that of treated patients, which means that if there was an apparent rise in a given age group throughout 2000-2002, then at least part of the increase can be attributed to a change in methodology rather than real growth.

Trends in male and female age breakdown are similar every year, but different by gender. For males, the 20-24 year-old age group is the most populous every year, while the largest number of women is found in the over-35 age group, although the segment containing 20-24 year-old female drug users is a very large one too. The 35-plus female age group is characterised by patients taking sedatives and sleeping pills, often in combination with alcohol.
The number of treated males under 15 and over 35 has significantly increased (by 26% and 14%, respectively), while figures were lower in the other age groups. Though figures for both males and females usually follow a similar tendency, in 2002 the number of treated female drug users increased in all age groups except for the 20-24 year-old group!

The increase in the number of registered patients in the 15-19 age group (secondary school age) grew by 10.3 times for boys and 6.4 times for girls between 1995–1999. An 8-10% drop was registered for both boys and girls in 2000. Although the figure did not decline any lower in 2001, the number of male secondary school students receiving treatment did not begin to rise again. 2002, however, saw a significant drop amounting to about 20 percent.
Figure 7: Number of secondary school-aged boys receiving treatment for drug use

Number of secondary school-aged BOYS receiving treatment for drug use between 1995-2002 and the change compared to previous year (%)


-50 0 50 100 150 200 250

141 412 978 1135 1459 1343 1352 1075


192% 137% 16% 29% -8% 1% -20%
The number of secondary school-aged girls receiving treatment, however, began to rise again: the figures were 10% higher in 2001 and a year later another 8% increase was registered. There was also a significant increase in the number of girls under 15 (159%), and the number of adult women receiving treatment also went up in all age groups except for the 20-24 age group.

Figure 8: Number of secondary school-aged GIRLS treated for drug use

Over a 5-year period, the gender distribution in the secondary school-aged group is almost identical with that for the adult population: over two-thirds of secondary school children receiving drug treatment are boys but the proportion of girls is steadily rising! The respective figures for boys and girls receiving drug-related treatment in 2002 were 1078 and 619.
Breakdown by region

In the current health care drug statistics, data on regional distribution are based on the location of the institutions providing treatment. The information submitted for central processing does not include any indication of the patient’s place of residence. The average size of the area from which patients are admitted varies with the type of institution providing treatment. The country and its counties are relatively densely covered with addiction care centres and psychiatric departments, which consequently tend to admit patients from nearby settlements. Drug outpatient clinics are a different matter: there are still only a few of them and they offer special treatment. Drug outpatient clinics offer sub-special progressive treatment to patients within psychiatry departments, meaning that general psychiatric and addiction research institutions will want to transfer their patients if there is such an institution within reach. Thus, a drug outpatient clinic may take patients from as far away as the neighbouring county. The best example for this is the situation in Budapest and Pest county: during the period between 1996-2002, the Budapest figure for treated patients per 10,000 inhabitants showed great annual fluctuations while the figure in Pest county remained almost unchanged.

Figure 9: Number of treated drug users per unit of population of Budapest and Pest County

![Graph showing number of treated drug users per 10,000 inhabitants in Budapest and Pest County, 1996-2002.](image-url)
We can conclude from the charts of Eastern and Western Hungary, Budapest and Pest County that there is no major difference between the eastern and western part of the country regarding the number of treated drug users per unit of population. There is, however, a striking disparity between Budapest and its metropolitan area and the rest of the country. The difference has multiplied since 1996.

Figure 10: Number of treated patients per population in Eastern and Western Hungary and in the capital and its metropolitan area

Regional breakdown of the number of treated drug users per 10,000 inhabitants, 1996-2002

- Budapest and Pest County
- Eastern Hungary
- Western Hungary
Trends in the types of drugs used by treated patients

The proportion of treated patients using illegal substances steadily grew between 1995 and 1998, while that of legal substances was essentially stagnant. In 1999 there was a 59% increase in the number of patients using legal drugs compared to 1998, but the figure dropped by 15% in 2000. These figures should be considered against the background of a continuous increase in the total number of treated patients up to 1999 and an unchanging number of total patients in 2000.

Figure 11: Proportion of patients treated for legal and illegal drugs
The figures lead to the conclusion that the proportion between users of illegal and legal drugs reversed between 1995–2001: the proportion of legal drug users dropped from 67% to 35%, while that of illegal drug users grew from 33% to 65%. In 2002, however, the proportion of illegal substances significantly dropped and there was an increase in the use of legal drugs as well as a slight rise in the number of treated patients. This trend requires some professional explanation.

Figure 12: Number of treated illegal drug users by drug type, 1995-2002

Opiate (opium, heroin, poppy infusion, etc.) users grew both in number and proportion until 2000. Opiate users accounted for 22% of all treated patients in 1995; this figure grew to 30% in 1999 and to 39% in 2000. In 2001, the number of treated opiate users dropped by 13% and in 2002 there was another 36% decrease from the preceding year bringing the ratio of opiate users down to 22% of all treated patients, which is now lower than the proportion of treated sedative-users!

Treated cannabis (marijuana, hashish) users grew slightly in proportion to the total treated population in 2000: their relative share grew from 5% in 1995 to 13% in 1999. While in 2001 their number rose by 25% and accounted for 19% of all treated patients, 2002 saw a 22% drop resulting in a proportion of 14% of all treated patients. Cannabis users come third after consumers of sedatives and opiates on the list of treated drug users.

The earlier increase in the number of treated amphetamine-using patients came to a halt in 1999 and has been decreasing ever since. The proportion of amphetamine users to all treated patients grew from 3% in 1995 to 11% in 1999, but it dropped to 7.5% in 2000, then 6.9% in 2001 and in 2002 down to 6.3% of the total population of treated drug users.

The number of treated cocaine users grew by 20% between 2000–2001, but in 2002 there was a 34% decline resulting in a proportion of 1.1% of all treated patients. Over the past few years, the proportion of this tiny circle of users relative to all treated patients has remained virtually the same. The proportion of hallucinogen users has always been similarly low within the total population of treated patients, with a 13% decrease in 2001 and another 48% drop in 2002 from the previous year.
Solvent abusers have grown in number in recent years, but they are still a minority within the total drug user population. Their proportion has virtually remained unchanged and stood at 3.6% in 2002.

Sedative and sleeping pill abuse affected 39.5% of all treated patients, putting these medications at the top of the list of abused legal substances and placing them even higher than opiates in 2002. There was such a significant increase in the number and proportion of users of sedative-type substances in 2002 that this trend requires further studies and analyses in the field of addiction research!

Polytoxicomania (combined use of sedatives and sleeping pills with alcohol) grew more than twofold between 1995–1997, and has produced considerable fluctuation since 1998. Compared to the previous year, there was a 20% drop in 1998, a 10% rise in 1999, then another 6% increase in 2000 followed by a 22% drop in 2001, and another 10% reduction in 2002. The reason behind that significant fluctuation is still unknown and requires further study just as the phenomenon pointed out in the case of sedatives.
Trends in the number of patients receiving treatment as an alternative to criminal proceedings

The number of patients receiving treatment as an alternative to criminal proceedings (diversion into therapy) grew together with the total number of treated drug patients until 1998. There was a slight decrease in 1999 and a remarkable drop of 25% in 2000, while the total number of patients kept growing or stagnated. In 2001 another 14% drop was recorded, but 2002 saw a 7% increase!

Figure 14: Trends in the number of patients receiving treatment as an alternative to criminal proceedings
Much of the decline in the number of patients receiving treatment as an alternative to criminal proceedings in 2000 was a result of a 36% and 45% drop in cannabis and amphetamine users respectively; the number of patients treated for other drugs among those diverted into treatment as an alternative to criminal proceedings grew only slightly or remained the same. In 2001 the number of cannabis and amphetamine users diverted into treatment dropped and so did the number of cocaine and polytoxicomaniac patients. In 2002, however, the proportion of patients treated for cannabis and amphetamine use significantly increased along with the number of sedatives users receiving treatment.

Figure 15: Number of patients diverted into treatment, by drug type

There is an even more conspicuous disproportion between genders among patients diverted into treatment as an alternative to criminal proceedings than there is within the total population of treated drug users. Women accounted for as little as 10-15% of all patients receiving alternative treatment while they made up about one-third of all treated patients during 1996-2002 and as much as 41% in 2002!

Figure 16: Breakdown of patients receiving treatment as an alternative to criminal proceedings by gender
RISK BEHAVIOURS

Assessment of intravenous drug use in Hungary with the application of the “Rapid Assessment and Response” (RAR) method

Ever since the mid-1990s, methods based on rapid assessment have become widespread (Rhodes et al., 1999). Large international organisations recommend these methods as cost-efficient and pragmatic programmes for mapping of various public health problems such as malaria, diarrhoea, water purification, the spread of HIV, illegal drug use and intravenous drug use (Rhodes et al., 1999). In their 1999 summary published in Lancet, Rhodes and associates emphasise primarily rapidity (a few weeks or months can produce results), methodological pluralism (quantitative and qualitative methods applied) and the planning of efficient, multi-sector public health intervention in using the method of Rapid Assessment and Response (RAR). They also stress the exploratory, discovery-oriented, and inductive aspects of the method. Such an approach is specifically important with regards to drug issues and the HIV problem because they all may be influenced by “ethical outrage” or populist rhetoric (aimed at covering up or misinterpreting the issues). Only those who are connected to specific institutions are listed in the databases (if there is a database, often hidden groups are not listed), and when forming an opinion, control, and preferences for the status quo they are favoured as opposed to innovative community responses. RAR, however, attempts to avoid the abovementioned traps by combining various methods and inviting several expert and social groups to participate in the analysis. In 1998 the World Health Organisation (WHO) and the United Nation’s AIDS organisation (UNAIDS) prepared methodological guides for illegal drug use and intravenous drug use as well as the related hazardous sexual behavioural patterns (UNODCCP, 1999; WHO, 1998). Stimson and associates (1999) summarises positive experiences gained from over 20 countries and notes that intervention programmes related to intravenous and sexually transmitted risks are organised on the basis of RAR in Eastern Europe. In several cases, RAR researches started cooperation between various organisations, institutions, and key individuals (e.g. in Russia the novel involvement of NGOs and drug users created quite an uproar). Such was the case in countries where the drug issue surfaces exclusively as one related to criminal law (e.g. Brazil, Argentina) and where public health services have only minimal participation in the handling of issues (from data collecting to working out “responses”; e.g. in India).

The HIV boom in our neighbours the Ukraine and other Eastern European countries, which is primarily attributed to intravenous users as well as the lack of information and sometimes antagonism in Hungary with regards to intravenous drug use, prompted us to use the RAR method in order to map intravenous drug use and the related interventions in Hungary. Among our goals was the education of professionals who would acquire the necessary skills to conduct similar studies on a local level.

The method

The research procedure, the focus of research, and even the presentation of results were set up on the basis of the WHO RAR Guide (1998) targeting intravenous drug use. The RAR Guide is a detailed, 255-page document. The method of Rapid Assessment and Response follows the following procedure: 1. country and city profile; 2. contextual (macro-social) assessment; 3. assessment of drug use; 4. assessment of drug-related health effects; 5. assessment of risk behaviours; 6. assessment of existing strategies (policies) and interventions. Finally, the last section of the Guide also contains a plan to work out a “response” (action plan).

28 Research was completed within the framework of NRDP 5/118/2001.
29 Summary prepared by József Rácz and Ildikó Ritter
The RAR procedure

The RAR study covered five regions in Hungary. We believe that the five cities and their outskirts are representative of Hungary. Regions were used in a sense of “area of influence”. When defining cities and their regions, we cannot be more specific; according to the plans, we were to study county capitals, their counties, and the neighbouring counties, but it turned out that three out of the five places did not have an overall picture of the base counties, much less the neighbouring counties. The selected cities were: Budapest (Hungary’s capital and the focal point of all drug problems), Miskolc (the second most populous city, an industrial centre of socialism, and a hotbed of all socio-economic problems related to the sudden halt of industrial development), Szeged (a typical city of the Great Plains, a border town with prior industrial functions), Pécs (a characteristic city in the southern Trans-Danubian region with functions extending beyond the border; the county used to have a significant industrial capacity), and Veszprém (a characteristic city in the middle section of the Trans-Danubian region, with once flourishing industrial projects nearby; it was also selected because of the proximity of Lake Balaton, whose region has no drug outpatient centre and therefore Veszprém receives the patients from that area as well). One significant selection criterion was that all the cities had to have a history of treating drug problems and they all must have well-developed infrastructures to facilitate the completion of the study.

1. Formation of the RAR team: a total of 11 individuals participated in the study30.
2. Using existing information: this primarily meant summarising the publications entitled “Report on the Hungarian Drug Situation” prepared by the Ministry of Youth and Sports Affairs (MYSA) and the related studies that served as a basis for the ministry’s publications.
3. Samples: taking samples from local key individuals and drug users (intravenous and non-intravenous) in the five cities and arranging for access to the samples. In terms of the RAR Guide, we conducted “targeted sampling” and although the samples are not representative of the total population of drug users, but all individuals included had some work-related connection with the base city.
4. Interviews: as specified in the RAR Guide, most of the interviews were taped (semi-structured interviews); the interview transcript was 40 pages long. About 15-20 interviews were done in each city (with professionals, key individuals, and drug users). The conclusions of interviewers were summarised by city.
5. Focus group studies: in each city there was a focus group of 8-20 members each that was interviewed for 3-6 hours. The invited guests included professionals in daily contact with intravenous drug users as well as experts with (supposedly) decisive roles in preparing decisions for local drug policies. Another way of bringing together these focus groups was through the local Co-ordination Forums on Drug Affairs (DFC) with help from the National Drug Prevention Institute.
6. The results gained from the five cities, i.e. the country, were presented before the Epidemiological Sub-Committee of the Drug Coordinating Committee.

Experiences

Only a few of the experiences gained from the study shall be discussed here.

Macro-social impact related to intravenous drug use and prevalence

Experts agree that the use of cannabis-type substances is the most widespread throughout the country, which is followed by amphetamine-type drugs and opiates. The intravenous use of prescription drugs is also increasing. The growth in intravenous drug use is facilitated by the generally lower social status and socio-cultural background of drug users. The seemingly hopeless situation of young adults and the difficulties of acquiring a family home also help the spread of intravenous drug use.

30 Members of the RAR workgroup: Emese Balogh, Viktória Belány, Mrs. Juhászné Tünde Ceglédi, Lívia Jurinkovics, Ignác Kovács, Tamás Mike, Péter Nemes, Kinga Som, Judit Wölcz and the authors.
As one of the restraints on intravenous drug use, the interviewees mentioned their knowledge of risk factors (e.g. contagious diseases), which through rational thinking mainly deter young people who never used drugs in such a fashion and/or who are not drug-addicts. Another deterrent for intravenous drug use might be young people's positive outlook on the future, their self-knowledge, and a stable family background.

The interviewees ranked drug outpatient centres and harm-reduction programmes high on the list of factors countering the negative health effects related to intravenous drug use, though the number of such facilities and the professionals working there is thought to be insufficient for the extent of the problem. Local media also covers this issue. Local churches typically have the potential of providing aid to drug users, but they operate mostly in isolation and therefore they are hard to utilise. The negative social attitude against intravenous drug users surfaces as an aggravating factor, and so does the practice at certain healthcare institutions where patients without a social security card are rejected. The social services system is unprepared for providing help to drug users.

The interviewees ranked drug outpatient centres and preventative programmes high on the list of factors countering the negative health effects related to intravenous drug use. On the plus side, professionals have never met an HIV positive patient. The health-related consequences of intravenous drug use may worsen with shared needle usage and with the practice where some chemists refuse to sell syringes and needles to patients.

Intravenous drug use is typically localised almost everywhere; not only is there no national subculture, but such a subculture cannot be found even within the cities (if such ever existed related to the drinking of tea brewed from poppy-tops in the early 1990s, they have disappeared by now). This phenomenon has advantages and disadvantages as well: a diversified presence somewhat prevents intravenous drug use, yet each group and each local network requires a different interventionalist approach. Uniform services are harder to operate.

As for local differences, in certain areas the rise in unemployment and the shutdown of industrial plants resulted in increased intravenous drug use while in other areas impoverishment led to decreased intravenous drug use (users did not have the money to pay for heroin or amphetamines). The same areas, however, are experiencing an increase in the intravenous application of medications. The Yugoslavian wars had a deep impact on the border region (the areas around Szeged and Pécs). Among the relevant factors, we found some that appear unrelated to the phenomenon at first. One such factor is the road network. Experts say that the number of intravenous drug users is lower in Pécs and in Baranya County because the network of narrow bypass roads makes traffic slow, while in Szeged the lack of a well-developed road network (the M5 motorway ends at Kecskemét) was given as a reason for the shutdown of industrial plants, the rise of unemployment, hopelessness, and even intravenous drug use. Budapest is one of the transit and target destinations of the “Balkan heroin traffic” since heroin can be easily distributed along the M1 motorway. Tourism around Lake Balaton obviously influenced the Veszprém region, while legal and illegal traffic had an impact on the settlements along the border. The mafia also had an interesting impact. Wholesale illegal heroin traffic is controlled by only a few groups in Budapest while the interviewees revealed that the controlling clan in one of the cities have banned the distribution of heroin (but not that of synthetic substances).

Experts believe that intravenous drug use is also influenced by political factors, which means that if the local government of a city is mainly composed of politicians belonging to the parliamentary opposition, the city does not receive sufficient funds (which lowers the level of services).

The big poppy fields around Szeged cause an intravenous “epidemic” in the summer and early autumn every year. During such periods, drug addicts usually preferring other methods of drug use tend to favour intravenous use.

Many of the interviewees explained that the only way to “stand out” among intravenous drug users is to share your portion or money with others. They revealed that in many cases the sole purpose of “community” among drug users is to get the substance and consume it. The only accepted method of drug use is intravenous. The most common related diseases are AIDS and Hepatitis C. Intravenous
drug users are increasingly younger (13-16 years of age). It is also becoming common that first-time
drug users consume substances intravenously. This trend is most prevalent among young adults. In
particular, males are affected, though intravenous drug use has spread among women in recent years.
Intravenous drug users mostly turn to organisations providing aid only after a longer drug history (2-
5 years).

**Special findings of the RAR study**

The following section will cover findings related to special areas. We would like to emphasise that
the interviewees can only describe the “perceived” image of drug use; our “objective” outlook is only a
hypothesis. The perceived image of this problem group is significant because the ones in contact with
such phenomenon are also influenced by it in their behaviour. Since we are summarising our findings,
which are critical in nature and may result in debates, we shall present our interviewed subjects
anonymously.

**Perceived severity of the problem**

The experts and drug users as well as the members of focus groups interviewed declined to provide
absolute figures for the number of individuals involved in intravenous drug use. In most cases they
believed it was impossible to give such figures as a result of various methodological problems. The
opinion saying that “everyone has an interest against the state” (a police officer) is a clear indication of
the problems that may surface in such assessment studies: neither drug users nor aid workers are
interested in making the issue visible. This way, drug users can avoid sanctions; some of the aid
workers fear that their work would be perceived in a negative way while some others tend to magnify the
problem in order to receive more financial support.

**Harm-reduction and low-threshold programmes**

The Hungarian Parliament’s decree entitled “National Strategy for the Reduction of the Drug
Problem” outlined the goals related to harm-reduction. The Ministry of Youth and Sports Affairs has
projects for low-threshold programmes that have been in operation in some places for years, yet there is
significant doubt about them. With regards to the methadone programme, for instance, participants in
the study mentioned the programme’s poor reception by professionals and the government. They also
remembered that in 2001 the national medical officer banned the use of methadone and reported
doctors prescribing the substance to the police (but the police did not take any further steps). In another
case, when a psychiatrist was on holiday his colleagues refused to provide his patients with methadone
thereby forcing them into withdrawal. Nevertheless, focus groups showed a clear demand for the
expansion of the practice of harm-reduction and the somewhat overlapping low-threshold programmes.
In addition to the antipathy of the profession and the general public, professionals also have to fight
against a lack of available resources: these services receive inadequate funding and very often there
are no educated professionals or professional training programmes. Some methods, such as outreach
and street social services, are practically unknown in Hungary. In some other instances, local
governments attempt to control these programmes in a manner accepted in the fields of healthcare and
social services, but in this context it appeared as a drawback (leader of an outpatient drug centre). In
this kind of work, a trusting relationship between the client and the worker is more important. We have
also experienced, especially among those without any contact with intravenous drug users, situations
where some methods of harm-reduction and local drug policies targeting intravenous drug users are
only present in slogans but not in real deeds. It is not clear what the interviewees meant by street work
and how they imagine treatment with sustained methadone. This is a methodological problem since the
RAR interview allows for some responses. Therefore, whoever has only a word-of-mouth contact with
the programmes, they may simply say “it would be good” without any real background or context. In
addition to the lack of educated and specialised professionals, the lack of knowledge of certain methods
is less apparent in focus groups. Interestingly enough, counterarguments of the harm-reduction
approach rarely surface, if at all, and they mostly target certain specific programmes (e.g. a police
officer’s opinion on the workers of needle exchange programmes whom he described as drug dealers and he called the institutions providing methadone maintenance treatment “gathering places of drug addicts”. Such remarks, however, mostly highlighted the issues to be solved instead of providing an overall criticism of the approach.

Needle exchange programmes are the most widely known programmes among the interviewed professionals and drug users, (one possible explanation is that the majority of interviewed intravenous drug users are patients of such programmes). Except for one or two individuals, the interviewees believed that these services were useful and efficient. This positive opinion was even shared by those, (usually an interviewee or sometimes a member of a focus group), who otherwise raised doubts about the harm-reduction approach. It also turned out that needle exchange programmes were not easily accepted by the representatives of the local political and professional elite (sometimes it took years) and many emphasized the need for an appropriate application of media in the process. There was an opinion that the paranoia of those working in the controlling system (unreal fear of losing control over patients) prevented the spread of such programmes (a leader of an outpatient drug centre). Intravenous drug users also expressed their own fears about the needle exchange programmes: they were afraid that the police were monitoring the programme areas. Due to police checks, they also believe that walking in the street with used needles is risky (one objective of the needle exchange programme is to collect used needles).

Some of the professionals (primarily in Budapest) expressed a need for injection rooms.

Most interviewees stressed the anomalies related to the screening of diseases that are usually sexually transmitted that can also be contracted through intravenous drug use (STD/STI): in many places HIV screening is free of charge and anonymous, but hepatitis screening is not free nor is it linked to hospital referrals (no outpatient care). Drug users have difficulty understanding the screening institutions; they often fear that screening would destroy their anonymity. Most professional use the above proposition to explain why there are no authentic records on hepatitis infection, even though we can probably safely assume that the number of HIV positive intravenous drug users is low. We also do not have a clear picture of other infections.

Healthcare institutions

The relationship between drug users and supporting institutions is often characterised by defeatism: either the drug user is “unmotivated” or “only wants medication” and consequently is not admitted to the caregiver institution, or the supporting facility operates under norms (policies) that prevent the admission and care of drug users. The latter theses were asserted by professionals in daily contact with the caregiver institution or employees of those facilities themselves. Their opinions touched upon almost all the problems of the Hungarian healthcare system: the institutions are not accessible, they do not consider the special status of drug users, they do not diagnose the symptoms of drug use (in extreme cases even overdosing is unrecognised) and they do not have adequate knowledge of treatment methods. Physicians are not trained for such cases, their number is insufficient and there are no special units to provide appropriate treatment for drug users. In some existing units (psychiatry departments) patients have to pay for treatment and those without a social security card are rejected. At most, only two drug users are treated at a time and therefore waiting lists are long. If a physician committed to the treatment of drug users goes on holiday, his/her patients are released and no new drug users are admitted. Admission to hospital units and further treatment are a matter of personal contacts: “I really need to suck up to be admitted to a hospital” (unskilled city worker). There is no communication among the various institutions and therefore they cannot follow a therapy treatment “from A to Z”. Drug users can only sneak into institutions through back entrances because of the institution’s fear of “related” contagious diseases (a hospital physician). There are no outreach programmes that would make admission easier. The “substance” is brought into the hospital; the whole treatment is fruitless (a police officer). Some began to use heroin intravenously while in hospital and some of our interviewees went to give themselves a shot in the bathroom in the middle of the interview. The presence of dealers in the
hospital department was apparent; in one case you could even order drugs and have the dealer hand-deliver them to your home (bed). No wonder that outpatient drug centres are believed to be “group forming venues of consumers” by many (a police officer). In a best-case scenario, institutions specialise in one particular issue, which is simply not enough to solve the bigger problem: one of our interviewers received the following answer from a hospital psychiatrist when asking about the occurrence of sexually transmitted diseases: “this is not the gynaecology department, do not ask.” We cannot be really surprised then at hearing such a down-to-earth summary: “there is not a single dedicated and efficient professional in state-run institutions” (a police officer).

Drug users are treated as if they had leprosy… If someone happens to be a C-type (hepatitis C) and goes to the dentist or the gynaecologist for a screening, they won’t go next time because of the attitude they have to face there (an aid worker at an outreach drug centre).

Everyone wants to have his/her share and fights for his/her own proposal; there is no cooperation and medications are prescribed without proper consideration; drug users visit the outpatient drug centres one after the other and then sell the medications they were given (forensic medical expert).

A common feeling among aid workers and even police officers in contact with drug users is that in addition to proper healthcare services, they would welcome low-threshold methods (needle exchange, methadone maintenance treatments, shooting-up rooms), social services (e.g. temporary housing for the homeless,) and facilities for screening examinations. Other problems related to aid workers that help drug users include issues of mental health and a quick burnout rate.

**Popular beliefs and myths**

The findings of the RAR examination (interviews and focus groups) suggest that there are significant differences between the opinions of professionals and drug users. A closer look, however, reveals that professionals form two groups: the ones in daily contact with intravenous drug users (aid workers and detectives) and others without such contact. The simplified view has a particular presence in certain issues.

**Linear addiction model and the treatment chain**

A significant number of those participating in the RAR study think along the lines of what we call a “linear addiction model”. This means that they believe that drug users move from “softer” substances (such as cannabis products) to “harder” drugs (e.g. synthetic substances), then on to intravenous drug use, which typically means heroin injections. Heroin can quickly lead to a regular, daily habit and a severe level of addiction. Such drug users either make a heroic effort and stop this lifestyle or die.

When they are around 15 they start with marijuana, then have their first taste of ecstasy or speed whenever they start going to discos or find bad company. Then they begin to use upper-type substances.

They get used to it and feel great. After a while these drugs do not provide any boost, drug users just do it to inject themselves. After about another year they begin to feel increasingly lethargic as the effects of the drug begin to disappear. At this point they either try and quit or have their first go at heroin. This new substance is generally a big hit. They then begin to use it every 2-3 days or even daily, depending on when they can get the money. After about a year and a half they try to quit one more time; if they fail they may start in a different group and get completely addicted to it.

Another year passes by before they ask for help. They can only quit if they really mean it. If they don’t, sooner or later they’ll have their “golden shot” (an intravenous drug user, Miskolc).

“Linear” means a continuous, gradually increasing rate of deterioration where quitting is impossible in any stage (e.g. the various patterns of causal drug use), and progression onto the next level is inevitable. The “end result” is either death or abstinence, i.e. a drug-free condition resulting from persistent treatment. The latter one is believed to happen only rarely; the most typical result is “the golden shot”, i.e. death. Some experts say that the drug “career” immediately starts with heroin, although they add that even though they have seen such cases several times before, it is still not the “classic” or “typical” history of drug use.
Experience suggests that simple drug users—as time and the amount of drug used increase—become intravenous drug users if they have the necessary contacts and networking to get into another group. Or when groups move to other groups, they begin to apply intravenous drug use (a healthcare worker).

Typically physicians, social workers, and police officers in closest contact with drug users deny that there is a “typical” drug career; they are also the ones most likely to say that such careers start with the intravenous use of heroin.

The model presupposes that drug users are not capable of quitting, decision-making, or changing their behaviour pattern, and that they cannot recover or quit on their own or even with external help. The model is somewhat faulty because it says that drug users can be helped if they want to quit themselves—this, however, is not likely due to the deterministic nature of the model. One version of the model states that in the minority of cases (1-10%) “one can live without drugs but cannot fully recovered” (by a police officer), meaning that addiction will remain with the patient for the rest of his life, and that merely a drug-free condition can be accomplished.

I believe it is often very tragic. I mean that someone dies either as a result of an overdose or practically becomes a permanent drug user and continues his habit until his body quits. Or in some rare cases, I believe, he chooses the better option and asks for help, which may get him out of this situation (teacher, Miskolc).

Intravenous drug users: they must be quarantined, they are all lost and going to die anyway. They simply cannot be forced to change their behaviour patterns. Only 1 percent of them quit and it’s impossible to help them from outside. Those who really need our attention are the speed users under 20; we have to intervene before they move on to heroin. Heroin: they either die or quit (drug user, Budapest).

A unique asymmetry exists in terms of the causes leading to drug use, to a drug-free condition or to recovery. Many point to socio-economic-cultural factors (such as impoverishment, hopelessness, quick enrichment or fast wash-out) when talking about the causes of drug use and addiction. In terms of quitting and recovery, however, the individual and personal characteristics of drug users are emphasised: their decision, “will” and willingness to assume responsibility. These cannot be influenced from the outside. The same opinion surfaces in terms of relying on harm-reduction methods: the personal characteristics of drug users determine whether they will take advantage of these possibilities instead of the socio-cultural atmosphere presented in such detail within the try-something-and-become-addicted process.

The concept of the treatment chain for drug users fits this linear addiction mode. Although all interviewees agree that this chain is incomplete, they would also like to see it in place. The addicted intravenous drug user (mainly heroin consumer) enters the chain at the very beginning of the treatment: both the drug user and the treatment system aim at abstinence. The various elements of the chain try to reach that stage with different methods: through hospital detoxification, several months or years of rehabilitation along with at-home treatment, similarly long outpatient treatments, and in some cases even with residence monitoring. The treatment is declared a success if it results in abstinence. Abstinence can only be achieved if the chain remains intact: if the drug user does not drop out of the chain; if the transition mechanisms between the various elements of the chain can guarantee continuous passing of the drug user from one caregiver institution to the next.

This theory assumes permanent and easily accessible institutions that provide treatment; entering the chain is easy as long as the drug user is motivated and willing to undergo treatment. This blueprint of the treatment chain presupposes drug users who are helpless, incapable of change, and who only depend on the “saving capacity” of the institutions. The drug user either follows the chain at every step of the way or drops out and consequently falls back or dies. Interestingly enough, the image of the helpless drug user is complemented with his “will”: if he has no will there is no help. This model is incoherent because if you have the “will” why would you need external help?
Summary

In presenting the findings of the RAR study, we have stressed some of the lessons. We believe that one of the most important lessons is that the concept of intravenous drug use (and the related healthcare and social harms, as well as the intervention methods aimed at this phenomenon) is barely known to those not in working contact with intravenous drug users. We have interviewed professionals whom we expected, due to their job, to have knowledge of a particular aspect of the phenomenon, but besides their theoretical preparedness they lacked concrete information relevant to the local community. Local communities do not possess a signal mechanism that could perceive such phenomenon and its changes, and that could signal in time of danger. This statement applies not only to intravenous drug use, but also to the other components on the drug scene. There are no low-threshold treatment methods helping to reach drug users; nor are drug users provided with easy access to the institutions that help them. In certain places in the RAR study, we often found that the existing and perhaps well-working services do not communicate with each other and the services themselves (or their leaders) fail to have any real influence on formulating local drug policies. We have also asserted that low-threshold programmes and other forms of treatments with higher threshold (outpatient drug centres, hospital treatment, rehabilitation) operate at low capacity, and that due to their structures, they are incapable of adapting to the quickly-changing drug scene. There are basic problems in the financing of low-threshold programmes and in terms of the opposition the operators of these programmes must face.
THE ILLEGAL DRUG MARKET – DRUG-RELATED CRIME

Experiences gained in executing the supply reduction functions of the Police – the status of the illegal drug market

(A report by the Ministry of the Interior and the National Police Headquarters)

1. General assessment

Substances affecting the human mind have been in use for cultic, medical, and pleasure-oriented purposes for thousands of years. In retrospect, it is obvious that no civilization was ever completely void of psychoactive substances. Their use has always been significantly influenced by a number of circumstances. Among these were the time period, geographic location, social structure, traditions, beliefs and, last but not least, ethical and religious standards.

In the second half of the 20th century, drug use and distribution as a social problem surfaced in Western European and overseas countries decades before Hungary had to face the same problem. Drug use in Hungary has primarily been a sensitive issue and social problem over the past fifteen years, with a growing number of people in contact with these dangerous substances.

By now, the spread of drugs has become a phenomenon that endangers both our society and us individuals. The impact of drugs is visible in terms of its dangers to the next generation, the healthy functioning of families, and communities, as well as in terms of the spread of drug-related crimes.

An analysis of the Hungarian situation reveals that there is a significant number of young people among drug dealers. They undertake the risk in the hope of getting rich quickly and they hope to find financial stability. Some dealers are drug users themselves who are members of the network only so that they can get their regular drug portions.

The real movers and controllers of drug trafficking are obviously not from this circle. The men behind the scenes mostly have a criminal history and experience in organised crime; they often have contacts with international crime circles and build up a high degree of defensive security through a multi-level network of distributors. The past few years have proven that these criminals are not afraid of using even the most drastic measures in the hope of big profits. Drug-related crime is primarily part of organised crime and therefore bears all the connected characteristics (hierarchy, task sharing, high-level conspiracy, etc.).

The above statements are supported by the fact that the number of gun-related crimes has increased and that the market is regularly flooded with drugs of questionable quality. The drug mafia often employs wretched or exploited individuals, or those who can be easily blackmailed. There is a growing number of cases when these circles bribe members of the authorities to help distribute drugs or even cover up their operations. It is a well-known fact that because of its geographical location, Hungary is strongly involved in international drug trafficking as a transit country between Asia and Europe in both directions.

Analyses of drug-related crimes point out that in an increasing number of cases, so-called “indirect crimes” are committed each year.

Drug users commit crimes against property (e.g. theft, robbery) in part to provide financing for drugs and in part to directly access drugs (forgery of prescriptions, burglaries in pharmacies, etc.).

In view of these facts, there are “fences” specialised in quickly purchasing stolen goods.

In light of the experience gained from foreign countries as well as in Hungary over the past few years, the following developments may be forecasted:

The consumption ability of the current demand, i.e. the consumer market, may come close to saturation. This proposition is based on the fact that the number and frequency of first-time drug use is no longer rising as heavily as it used to during the mid to late-1990s.
In the future, first-time users are likely to come from among a younger generation; illegal drugs are likely to become a part of everyday life, an increase is likely in terms of the frequency of drug use and the number of drug-related crimes.

2. Criminal records registered by the Police

In terms of the drug problem, the Uniform Crime Statistics of the Police and Attorneys Office (UCSPAO) registration system is primarily suitable for providing data on drug abuse (Paragraphs 282, 282/A, 282/B, 283/A and 283/B of the Criminal Code).

In 2002 a significant portion of drug-related crimes (almost 100%) fell into the category of abuse of drugs (Paragraphs 282 and 282/A of the Criminal Code). Tendencies in crime data are shown in the table covering registered statistical data between 1992–2002.


Compared to 1998, the number of criminal cases related to drug abuse has risen by 38.3 percent, then by an additional 20.5 percent in 2000, and 25.7 percent more in 2001.

Available data show that the number of drug-related crimes in 2002 continued to rise, although the increase was slower than in previous years. The total figure stood at 4775 cases, a 9 percent increase compared to 2001.

The proportion of drug abuse cases compared to all crimes has continuously risen with figures of 0.3% in 1998, 0.56% in 1999 and 0.97% in 2000. Although it dropped somewhat in 2001 down to 0.93%, it was over 1% (1.134%) in 2002.

In 821 of all drug-related crimes the perpetrators were juveniles. Figures for juvenile drug abuse crimes for the previous years were as follows: 277 in 1998, 375 in 1999, 492 in 2000, 705 in 2001 and 821 in 2002.

We must note that while in 2000 there were 9 cases filed regarding inducing a pathological addiction (Paragraph 283 of the Criminal Code), this figure rose to 82 in 2001. Although last year there was a drop in the number of such offences, the total figure stood still at 22. This category of offences includes cases when an adult induces or helps a minor use substances that are not drugs, but substances such as glue, solvents, or gas, which can cause intoxication.

Among the investigations started because of drug abuse crimes, the capital still takes the lead with a proportion of around 25-30% ever since 1995.

In view of the legal standings of registered crimes, in 2001, 3124 (72.11%) of criminal proceedings were initiated on the basis of Paragraph 282 of the Criminal Code on crimes committed as a result of non-addicted consumer behaviours, while there were 301 cases (6.95%) investigated for the same offences that were committed by drug-addicts. The two figures add up to 3425 cases, which constitute 79.06% of all drug-abuse offences.

In 2002, 3439 legal proceedings were started for consumption-behaviour (Paragraph 282 of the Criminal Code) while 517 investigations were conducted on the basis of Paragraph 282/A.
Thus, last year, in 82.84% of all registered cases, investigations were started for non-trafficking behaviour.

Drug-related crime is primarily linked to big cities. Areas, districts and even smaller units of big cities can become the venue of street drug distribution and consumption (typically of heroin). The usual locations for the distribution and consumption of synthetic drugs are entertainment venues with music and parties which are primarily visited by young adults.

Drug-related crime lowers the level of security and deteriorates crime indicators of public places, as residents can more easily perceive such activities. Drug-related crimes have an indirect impact on areas outside the crime scene. The so-called supply crimes (when drug users commit smaller offences, primarily against property) have an impact upon the whole region. At the locations of drug distribution and consumption and their immediate surroundings, the number of car break-ins and thefts, shopliftings, pockets picked, and tricky thefts has also increased. We should not neglect those assault crimes damaging the perception of public safety and committed by drug users under the influence of drugs.

This form of criminal behaviour is characterised by unscrupulous actions, unmotivated aggression and unreasonable risk taking.

**UCSPA0’s breakdown of crimes committed under the influence of drugs is as follows:**

<table>
<thead>
<tr>
<th>Crime category</th>
<th>2001</th>
<th>2002</th>
<th>Tendency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical assaults</td>
<td>15</td>
<td>18</td>
<td>120%</td>
</tr>
<tr>
<td>Traffic offences</td>
<td>12</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>Crimes against marriage, family, youth</td>
<td>6</td>
<td>4</td>
<td>66.70%</td>
</tr>
<tr>
<td>Crimes against state administration or the legal system</td>
<td>8</td>
<td>10</td>
<td>125%</td>
</tr>
<tr>
<td>Crimes against public safety</td>
<td>219</td>
<td>270</td>
<td>123.30%</td>
</tr>
<tr>
<td>Economic crimes</td>
<td>3</td>
<td>2</td>
<td>66.70%</td>
</tr>
<tr>
<td>Crimes against property</td>
<td>153</td>
<td>147</td>
<td>96.10%</td>
</tr>
</tbody>
</table>

In comparison with the figures for 2001, there was an increase in the number of drug-related crimes. Especially worth noting is the number and higher percentage of crimes against public safety and those involving physical assault.

The drop in economic crimes and crimes against marriage, family, youth and property is an illusion and can be explained with two factors.

One is that the year-end data may have been affected by the high number of open proceedings; the other is widespread government and social programmes dealing with drug issues. Maybe it is not an exaggeration to say that the continuous, more intensive and concentrated preventative actions on behalf of the government and NGOs in the past years as well as the increase in the number of such services available and in their quality are the causes for the drop in the number of registered cases in the crime categories mentioned above.

We must note, however, that a more accurate assessment of the causes behind the figures is not possible until a more comprehensive comparative study can be done in a few years.
3. Statistical data on the perpetrators of drug-related crimes

(The following graph is entitled: Number of Drug-Related Criminal Proceedings, 1992–2002)

Based on UCSPAO records, the annual figures for perpetrators indicted for drug abuse crimes are as follows: 116 in 1992, 247 in 1993, 260 in 1994, 459 in 1995, 483 in 1996, 926 in 1997, 1800 in 1998, 2701 in 1999, 3164 in 2000, 4025 in 2001, and 4370 in 2002. The figures show a steadily rising tendency, which is worrying just like the straight increase in the number of drug-using juvenile offenders and their proportion to the overall population of juvenile offenders, which began to slightly decrease only last year and only with respect to the percentage of those cases.

The annual figures for minors committing drug-related crimes are as follows: 51 in 1996 (0.38%), 92 in 1997 (0.66%), 223 in 1998 (1.73%), 354 in 1999 (3.07%), 456 in 2000 (4.12%), 680 in 2001 (5.9%), and 771 in 2002 (5.66%).

Drug-related mortality

In 2001 the Police recorded 36 cases of mortality where death was caused by a drug overdose. The good news is that this figure dropped down to almost half of that in 2002, with 19 recorded cases. Until June 30 there were only 6 registered cases of death in 2003 where the preliminary investigation found a drug overdose as the cause of death.

We believe that the drastic reduction in drug-related mortality is a result of the steadfast work of all participants in the prevention programmes.

4. The illegal drug market

In recent years MDMA has been the typical active-ingredient in ecstasy pills, with a proportion of 97% in 2001. New active-ingredients appeared in ecstasy pills in Hungary: 4-MTA and 1-PEA in 2000 and PMA in 2001.

It is typical that the concentration of substances marketed in discrete doses such as ecstasy pills (with a concentration of 5-15% or even 20%) and LSD stamps has remained unchanged and within relatively narrow limits for some time.

The active ingredient concentration of speed-type drugs containing amphetamines has shown a declining trend resulting in a drop from 45% to 25% as to the upper limit of concentration. (50% of all amphetamine powders confiscated had an active-ingredient concentration ratio of around 5%). The THC concentration in marijuana, however, has continuously been increasing. The upper limit of 2% reported in 1996 had tripled to 6% by 2001.

The concentration of cocaine and heroin follows a specific trend. While there used to be a noticeable difference in concentration between substances smuggled and seized in large quantities and
those distributed in small retail doses for the market and seized as packets for personal use, the difference has virtually disappeared since 1998.

The difference used to be small in the case of cocaine as it was not diluted significantly but in the case of heroin there was a major gap between the 50-80% purity of the transited substance and the adulterated or “cut” market doses. After 2000, however, the difference disappeared and it made a drastic effect on the market as well as on the users.

Heroin purity as high as 60-70% appeared on the market undiluted in packets for personal use. The trend continued in 2001 — so much so that in our survey we found heroin base-concentrations in excess of 40% in sixty percent of retail doses.

The phenomenon above can be an explanation for the rising number of cases of heroin overdoses in the past couple of years. One possible reason behind the increased concentration of heroin in retail packets is a change in consumption habits.

Due to the well-known risk of the intravenous method, heroin is more increasingly inhaled and rolled in cigarettes, which requires higher concentrations.

The figures in the first quarter of 2003 reveal that the active-ingredient concentration has diversified and the concentration level of the retail packets distributed in the street dropped down to 5-15%.

The years 2000-2001 brought significant changes to the Hungarian drug market. The use of the so-called “party drugs” (mainly ecstasy pills) was believed to present a rising tendency. Another worrying trend was the influx of amphetamines from Western Europe (mainly from the Netherlands) and the uncontrolled regions of the Balkans.

Available statistical data suggest that the internal drug market continued to grow in 2002, although at a significantly lower pace than before.

Marijuana is the most popular drug in Hungary, and domestic crops remain the key source of supply for domestic users. The ratio of imported marijuana (around 20%), smuggled mainly from the Netherlands and the regions of the former Yugoslavia, has remained unchanged in recent years.

Experience suggests that marijuana is grown in an increasingly larger area. The methods are more sophisticated and there is an increasingly expanding market for the cheap domestic “weed” especially among younger consumers. In addition to domestic production, there are records of significant cannabis production in Albania targeting the drug market. The “material” from Albania directly reaches the Italian market, but for the rest of the countries of Western Europe it is smuggled across Hungary.

The national spread of amphetamine products presents favourable investment opportunities for certain Hungarian crime groups. The symptoms of organised crime are especially pronounced here. Investors’ funds are used to procure large shipments of amphetamine powder and ecstasy pills at extremely low prices through proven Dutch connections, and the drugs are delivered to end-users by dealer networks. Typical consumption sites include weekend musical events, and professionals in the healthcare sector indicate the existence of a sphere of regular consumers.

Budapest and Miskolc continue to be the focal points of heroin-related criminal and public-safety problems.

Quantities for distribution on the domestic market are still supplied by Albanians, who buy the substance from Turkish traffickers. A number of Arab groups are also involved in distribution, but direct sales are mostly managed by Hungarians.

A fundamental change in the heroin market in Hungary involves the contamination of rural areas in addition to the abovementioned two major cities and their metropolitan areas, despite the absence of the former among the cases detected by the Police.
The quantitative distribution of drugs as examined by the Institute for Forensic Sciences of the Hungarian National Police Headquarters between 1999-2002 yields the following results (the records for the year of 2002 are incomplete as a result of ongoing legal proceedings).

<table>
<thead>
<tr>
<th>Drug type</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002 (incomplete)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin (kg)</td>
<td>166.5</td>
<td>670</td>
<td>154.41</td>
<td>13.8</td>
</tr>
<tr>
<td>Cocaine (kg)</td>
<td>115</td>
<td>10.9</td>
<td>6.02</td>
<td>54.88</td>
</tr>
<tr>
<td>Marijuana (kg)</td>
<td>99.9</td>
<td>112</td>
<td>131.03</td>
<td>71.6</td>
</tr>
<tr>
<td>ecstasy pills (tablets)</td>
<td>11143</td>
<td>15154</td>
<td>18663.5</td>
<td>23606</td>
</tr>
<tr>
<td>Amphetamine powder (kg)</td>
<td>4.6</td>
<td>10.5</td>
<td>1.48</td>
<td>2.96</td>
</tr>
</tbody>
</table>

The data above clearly indicate a significant increase in the volume of ecstasy pills.

**The drug market in light of seizures records for 2002–2003**

Over the past few years many new phenomena have diversified the Hungarian drug market, including the crisis in Afghanistan and the resulting heroin influx in the country, the consolidation of the Balkan routes and their impact on the drug trade, and an increasing level of organisation among smugglers. One thing is certain: it is hard to provide exact figures on the domestic drug market even today. Statistics based on surveys and criminal records in Hungary reveal that the largest group of drug users consume cannabis and cannabis products. About 4-5 years ago, experts found that “weed” users tended to come from the younger generation; by now this tendency has come to a halt to include the broad age group of 14 and above, who do not consider marijuana use dangerous and even believe it to be an indispensable means of entertainment. I won’t try to estimate the exact figure, but I will state that the proportion of soft-drug users is rather significant. I intentionally use this phrase, even though I do not really agree with it, since it has been transferred from the dictionaries of pro-legal activists to the streets. By “soft” I mean drugs that represent a lesser danger or harm. I am not supposed to take sides in the debate but I would like to note that as a result of non-professional and popular debates, the number of marijuana users has increased in Hungary. The number of smugglers, dealers and weed growers has grown parallel with this. Over the past one or two years, increasingly larger quantities of marijuana were seized, where the substance was of good quality and was smuggled primarily from the Netherlands. The members of this crime group were mainly Hungarian citizens who regularly arranged shipments through their Dutch contacts, in each case a minimum of 25-30 kilograms. The group was specialised in the marijuana trade and did not even attempt to procure other substances, even though they had their own distribution network. They no longer simply lived off the profits of this lucrative trade but also looked into various forms of investments such as leasing an old industrial hall in hope of domestic marijuana production. The same principle was followed in a plantation system organised at family houses close to Budapest that were managed and controlled by a similarly hierarchical organisation.

Of course, there are still groups working alone and on a small scale, or individual dealers who can satisfy various demands and in addition to marijuana sell amphetamines, ecstasy and cocaine. These groups of three or four criminals constitute the main supply system of the domestic market. The groups are loosely organised into a network system that helps out the member groups in market trading and arranges for transactions between them at wholesale prices in times of drug shortages. Besides these smaller groups, however, the really big crime groups who operate on the international drug market, trade in large quantities, and try to cover the whole market instead of specialising in some particular type of drug have also surfaced. These are mainly Turkish, Albanian, Serbian, Ukrainian, and Arab organisations whose targets for drug trade and smuggling are not only Hungary but especially Europe or even farther regions of the world. They are not particularly interested in the Hungarian market; they focus on supplying the markets of Western Europe, primarily with heroin and cocaine. They have
realised that transporting smuggled shipments across Hungary is still less risky than other alternatives, and that their convincingly mislabelled goods can sometimes reach their Western European destinations even without another search. One such example was a 50 kg shipment of pure cocaine that an uncovered Italian ring tried to smuggle across Hungary. Crime groups at such a level of organisation can only be uncovered through effective international cooperation, since the shipments often cross the borders of several countries. In many cases, these organisations only have agents in Hungary (often Hungarian citizens or assimilated foreigners) who have no contact with the top management. They only complete smaller tasks and organise the domestic supply chain. There has been a very recent and quite interesting tendency in the domestic heroin trade. Even though domestic heroin demand is stagnating, it is becoming increasingly clear that ever-larger quantities of heroin shipments are smuggled into Hungary. Smugglers have changed their tactics too. They no longer make attempts with shipments of hundred of kilograms but rather prefer to transport smaller and therefore safer quantities. Numerous shipments of 5, 10 and 20 kilograms each enter the country, and they no longer arrive in trucks, which present the greatest risk of all. Smugglers tend to prefer railway cars, passenger automobiles, and tourist coaches, which not only lower their risks but also minimize losses in case they are caught. Under the current conditions, catching smaller but more numerous shipments is less likely to happen. These smaller shipments are more suitable for distribution on the domestic market or for transporting in a larger, Hungarian shipment, which is less likely to undergo further screenings.

There are significant changes in the synthetic drug market as well. These changes are so new that we do not actually know the driving forces behind them. The problem, however, is rather serious. Ecstasy pills are very cheap in Hungary. You can buy a table for as low as HUF 300-400, which means a very low profit over the net cost of EUR 0.90. This can mean the existence of one of two factors: either there are too many smuggler groups specialised in this particular drug, or a very large shipment has arrived in Hungary. Seizures in 2002 were significantly higher than those in the previous years; in the first quarter alone over 100,000 pills were seized in two related cases. Cocaine, too, is beginning to have a stronger presence on the Hungarian drug market. Over the years, effective demand has steadily grown and so have the Hungarian and foreign organisations involved in smuggling. The most typical and least risky method is to hide the shipment in a postal package. This tactic is the least risky, yet from year to year there have been more Hungarians involved in the “swallowing” method. It is also worth noting that the number of Hungarians serving prison terms abroad for drug smuggling has been continuously on the rise.

Hungary is increasingly demanding a more pronounced role in the international drug trade. Domestic data and information also support this supposition. Crime groups appear to have realised that the once significant heroin market cannot expand any further and they have consequently redirected their interests towards cocaine and amphetamine products. Ever more warning sings suggest that the number of people involved in domestic drug production is growing, even though it is without economic significance since the Hungarian market is still overloaded with these drugs. In some seizures, signs of home drug production have been found but they were always individual, small-scale, and isolated cases.

The drug market still operates within the same framework as before, although there is an ongoing and significant rationalisation process both on the distributor and the consumer sides. The first members of the “early” distribution groups sent behind bars are being released from prison just now. Based on our experiences, they are going to return to their “profession” and having learned from their mistakes, they are going to operate with a higher level of secrecy/conspiracy. The common factor in all these cases is that low-level distributors refuse to speak when they are caught, and therefore the organisation still counts on them. Those who can regain their freedom after paying a bond will shortly join this first wave of ex-prisoners; these criminals have even more up-to-date experiences with the police methods that are currently used. All this is going to make effective detection even more difficult. Dealer habits have undergone the most significant changes. Transactions used to take place out in the street, but now they
normally happen elsewhere, e.g. at “plaza”-type shopping centres where dealers and customers can meet unnoticed. Youngsters no longer go out to have fun and buy something from somebody. They now have their own suppliers who provide them with the necessary quantities in advance. Perhaps heroin dealers have changed the least, although even they are now using more sophisticated methods.

Another problem is that foreigners, especially of Asian origin, have appeared on the lower levels of the dealer network, and they are harder to locate and are simply different from Hungarian drug dealers.

The constantly changing drug market requires a continuous renewal of detection methods, which often does not follow the market changes.

**Changing the active-ingredient contents of illegal drugs: trends in the black market in 2002 – the year of amphetamine products**

The number of drug-related criminal cases has increased from year to year. The chart below illustrates different volumes of growth but there is clearly a rising tendency. The chart shows that over the past ten years, drug-related cases have risen tenfold and a stunning increase is visible in terms of positively drug-related investigations (see lower columns).

The following chart illustrates the quantities of drugs that were seized and sent to the Central Laboratory for testing over the past eight years. The amount of marijuana sent to the laboratory is only a representative sample of much larger quantities of marijuana seized and destroyed by the police. As for other drugs, the incoming quantity is proportionate to the net weight of the seized substance and therefore differs from the figures published and totalled by other agencies. One reason for such a difference is that the authorities only know the gross weight (with wrapping material) of a seized drug shipment, and this is the only thing they can publish.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin (kg)</td>
<td>230</td>
<td>190</td>
<td>937</td>
<td>166.5</td>
<td>670</td>
<td>154.41</td>
<td>159.65</td>
</tr>
<tr>
<td>Cocaine (kg)</td>
<td>8</td>
<td>7.6</td>
<td>20</td>
<td>115</td>
<td>10.9</td>
<td>6.02</td>
<td>54.90</td>
</tr>
<tr>
<td>Hashish (kg)</td>
<td>782</td>
<td>4</td>
<td>2.8</td>
<td>3.6</td>
<td>19</td>
<td>0.88</td>
<td>3.35</td>
</tr>
<tr>
<td>Marijuana (kg)</td>
<td>45</td>
<td>2338</td>
<td>146*</td>
<td>68.9*</td>
<td>112*</td>
<td>131.03*</td>
<td>103.44*</td>
</tr>
<tr>
<td>Morphine, opium (kg)</td>
<td>0.9</td>
<td>1</td>
<td>0</td>
<td>0.9</td>
<td>16.6</td>
<td>0.01</td>
<td>1.73**</td>
</tr>
<tr>
<td>Amphetamine powder (kg)</td>
<td>0.5</td>
<td>12.7</td>
<td>10.3</td>
<td>4.6</td>
<td>10.5</td>
<td>1.48</td>
<td>3.51</td>
</tr>
<tr>
<td>LSD stamps and discs (piece)</td>
<td>1023</td>
<td>1607*</td>
<td>4416</td>
<td>3115</td>
<td>1519</td>
<td>972.5</td>
<td>623</td>
</tr>
<tr>
<td>Ecstasy pills (tablets)</td>
<td>7052</td>
<td>5505</td>
<td>11785</td>
<td>11143</td>
<td>15154</td>
<td>18663.5</td>
<td>24854</td>
</tr>
</tbody>
</table>

31 Summary prepared by Dr. Gábor Nagy, Institute for Forensic Sciences of the National Police Headquarters
Quantitative distribution of black market drug products examined at the Institute for Forensic Sciences, 1996–2002

quantities marked with an asterisk (*) contain only representative samples
quantities of morphine marked with a double-asterisk (**) were seized in a case where morphine was extracted from poppy-straws by way of solvents. The table contains the measured morphine content of the seized poppy-straw and extract.

Of all seized synthetic drugs, quantities of ecstasy pills have continuously increased over the years as opposed to a decline in “classic” drugs such as hashish and opium. 2002 was the year of ecstasy; the quantities seized and the frequent occurrence of the drug signal a rising tendency.

Seizures of Ecstasy pills, 1994-2002

In recent years, MDMA tended to be the active-ingredient in ecstasy pills, although in 2002 there was an increasing number of “other” amphetamine products as well as compounds belonging to the group of amphetamine-type stimulants (ATS).
Other active-ingredients occupy a wide spectrum. The following chart demonstrates the types of active-ingredients in ecstasy pills and the number of tablets seized. Right behind MDMA, the most common active-ingredients in the pills were methamphetamines, MDA, and amphetamines.

“Other” ecstasy pills without MDMA as the active-ingredient

The same tendency can be observed in the following chart demonstrating the frequency of occurrence of drug types in forensic cases. The chart reveals a restructuring compared to previous years. Although cannabis-type drugs, especially marijuana, are still the most common in these cases, ecstasy has taken second place and speed, an amphetamine product, is in third place before heroine.
While the combined number of cases involving ecstasy and speed was lower in 2001 than the number of cases related to heroin, in 2002 the two synthetic drugs were found in three times more cases than heroin.

The purity and active-ingredient content of black market drugs is an important issue for a number of reasons. Calculations made based on depositions, for instance, reveal the average active-ingredient content of drugs available on the Hungarian market at a given time.

For these reasons the institute keeps records of concentration figures, aggregates the results and makes an assessment. Those data are shown in the table below.
### Average concentration of active-ingredients in black market drugs tested in the Institute for Forensic Sciences of the National Police Headquarters, 1996–2002

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MDMA (ecstasy pills)</td>
<td>72-102 mg/pill</td>
<td>50-100 mg/pill</td>
<td>50-100 mg/pill*</td>
<td>50-100 mg/pill*</td>
<td>50-100 mg/pill*</td>
<td>20-100 mg/pill</td>
</tr>
<tr>
<td>MDA (ecstasy pills)</td>
<td>46-48 mg/pill</td>
<td>46-48 mg/pill</td>
<td>50-80 mg/pill*</td>
<td>50-80 mg/pill*</td>
<td>50-80 mg/pill*</td>
<td>N/A</td>
</tr>
<tr>
<td>MDE (ecstasy pills)</td>
<td>85-113 mg/pill</td>
<td>85-113 mg/pill</td>
<td>85-113 mg/pill</td>
<td>85-113 mg/pill</td>
<td>85-113 mg/pill</td>
<td>40-100 mg/pill</td>
</tr>
<tr>
<td>Amphetamine powder (kg)</td>
<td>5.5-30 mg/pill</td>
<td>5-40 mg/pill</td>
<td>5-25 mg/pill*</td>
<td>5-25 mg/pill*</td>
<td>5-25 mg/pill*</td>
<td>same</td>
</tr>
<tr>
<td>Amphetamine (speed powder)</td>
<td>5-45 %</td>
<td>5-45 %</td>
<td>2-35 %*</td>
<td>1-20 %*</td>
<td>1-25 %*</td>
<td>4-50 %*</td>
</tr>
<tr>
<td>Cocaine (dose for consumption)</td>
<td>N/A</td>
<td>25-60 %</td>
<td>10-65 %*</td>
<td>20-80 %*</td>
<td>20-80 %*</td>
<td>20-80 %*</td>
</tr>
<tr>
<td>Cocaine (large samples)</td>
<td>52-91 %</td>
<td>60-80 %</td>
<td>50-80 %*</td>
<td>20-80 %*</td>
<td>20-80 %*</td>
<td>20-80 %*</td>
</tr>
<tr>
<td>Heroin (dose for consumption)</td>
<td>10-50 %</td>
<td>10-50 %</td>
<td>5-65 %*</td>
<td>10-65 %*</td>
<td>10-65 %*</td>
<td>10-55 %*</td>
</tr>
<tr>
<td>Heroin (large samples)</td>
<td>50-75 %</td>
<td>40-80 %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana (THC)</td>
<td>0.01-2 %</td>
<td>0.01-2.5 %</td>
<td>0.01-4 %</td>
<td>0.01-6 %</td>
<td>0.01-6 %</td>
<td>0.01-6 %</td>
</tr>
<tr>
<td>Hashish (THC)</td>
<td>2-20 %</td>
<td>1-15 %</td>
<td>1-20 %</td>
<td>1-20 %</td>
<td>1-20 %</td>
<td>0.5-10 %</td>
</tr>
<tr>
<td>LSD</td>
<td>50-100 µg/stamp</td>
<td>60-170 µg/stamp</td>
<td>60-170 µg/stamp*</td>
<td>60-170 µg/stamp*</td>
<td>60-170 µg/stamp*</td>
<td>20-70 µg/stamp</td>
</tr>
</tbody>
</table>

* in 90% of cases, the active-ingredient content is within the limits specified above.

The table allows for several conclusions about the changes in the illegal drug market.
Compared to the previous year, there was no significant change in terms of the active-ingredient content of ecstasy pills, although the frequency of occurrence as well as the active-ingredient content of LDS stamps has dropped.

Compared to previous years, there was a significant increase in 2002 of the active-ingredient content of speed-type amphetamine powders, while the limits of the THC content in marijuana have stabilised. The upper limit of 2% reported in 1996 has tripled to 6% in 2001 and 2002. It is worth noting that a THC content of 7-8% and even 11% has been measured in a few cases, which is attributable to specifically efficient cultivation in artificial circumstances. (These extreme values are not shown in the table above because they represent less than 1 percent of all cases.)

Despite the tendencies of the previous years, the maximum active-ingredient content of heroin powder has somewhat declined. In 2000-2001, packets of heroin appeared on the market that were not diluted and had a purity of up to 60-70%; in our survey we found heroin base concentrations in excess of 40% in sixty percent of retail doses!
The average heroin concentration in 2002 fluctuated between 30–40%, and the frequency of occurrence of heroin with 50-60% purity has significantly dropped. Distribution appeared to have gone back to the "normal" level:
**Perpetrators convicted of drug abuse**

Social and criminal-law opinions on drug use have stirred sharp professional and political debates. The professional content of the debates can only suffer as a result of increasing political involvement in the issues.

The changing intensity of interest in the phenomenon was in part a result of our regular statistical analyses related to drug use, which in addition to examining perpetrators’ demographic and social characteristics, also reflected the opinion of criminal law on the issue. We suppose those reports are known to all concerned and therefore we shall only analyse the data of convicted cases in 2002.

**Juvenile convicts**

In 2002, 181 underage persons (2.47%) were convicted of drug abuse, out of a total of 7321 juvenile offenders. An increased in juvenile drug offenders was inevitable, though by a small measure (in 2001, 177 juveniles were convicted of such crimes).

The proportion of girls at 9.94% (18 individuals) was somewhat higher than among all convicted juveniles (8.95%). This difference, however, is not significant. With regards to the analysis of data, we must note that because of the low ratio of those convicted of drug abuse, we do not deduct their number from the total figure when we make comparisons to the total number of convicted juveniles. Such calculations would not lead to a considerable difference in the end result.

The age distribution of convicted juveniles is significantly different from the average figures for juvenile convicts and the underage population in general. The figures expressed in percentages are as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of juveniles convicted</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>8</td>
<td>4.42</td>
</tr>
<tr>
<td>15</td>
<td>27</td>
<td>14.92</td>
</tr>
<tr>
<td>16</td>
<td>48</td>
<td>26.52</td>
</tr>
<tr>
<td>17</td>
<td>98</td>
<td>54.14</td>
</tr>
<tr>
<td>Total</td>
<td>181</td>
<td>100.00</td>
</tr>
</tbody>
</table>

In comparison, the age distribution of the overall underage population (as of January 1, 2002) was 24.08% for 14 year-olds and 24.86% for 17 year-olds, while 13.71% of juvenile convicts were 14 and 36.19% 17 years old.

When calculated according to the proportion of an underage population unit of 10,000, the frequency indicator returns the same results, although we must note the following: these calculations may be subject to some doubt because the age distribution differs among those committing drug abuse and those who are convicted for that crime.

With regards to family background, juveniles convicted of drug abuse are in a somewhat better position than the average of all juvenile convicts. The difference is most obvious when considering the number of juveniles living outside the family household.

<table>
<thead>
<tr>
<th>Family background</th>
<th>D</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household maintained by both parents</td>
<td>62.43</td>
<td>60.14</td>
</tr>
<tr>
<td>Household maintained by one parent</td>
<td>29.28</td>
<td>25.00</td>
</tr>
<tr>
<td>Living outside the family household</td>
<td>8.29</td>
<td>14.86</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**TOTAL NUMBER =** 181 7.321

---

32 Summary prepared by VAVRÔ
Column “D” denotes juveniles convicted of drug abuse, while column “C” shows the percentage values relevant to all juvenile convicts.

There are significant differences in terms of education between the juvenile convict population as a whole and those convicted of drug abuse. There was only one illiterate in this group whose distribution by education is better than the average of all juvenile convicts. The ratio of those completing only the first seven grades of elementary school is 36.32% among the total population, but only 11.05% among those convicted of drug abuse. While only 63.16% of the first group completed the eighth grade, the average is 88.40% in the smaller group of drug users. While 5.14% of the total population completed only the first four grades of elementary school, the same figure was 1.66% among drug users; students in secondary education had a proportion of 16.53% among all juvenile convicts and 33.15% of those convicted of drug abuse, which means that about twice the proportion of drug users entered secondary education than the proportion among all convicted juveniles. Of course, the data above cannot provide clear-cut conclusions with regards to the social distribution of juvenile drug users, because there may be a discrepancy between drug use habits and the probability of detection.

There is a significant difference in terms of repeat offenders as well. While one in every four (25.73%) juvenile offender already had a criminal record, the occurrence of such individuals among drug users was only 17.13%.

There is a very significant difference between the two groups in terms of cumulative perpetration as well. The relative frequency of cumulative perpetration in the overall population of juvenile convicts was 49.24%, in comparison with 14.92% among those convicted for drug abuse.

Based on the analysis of juveniles convicted of drug abuse in terms of family background, level of education, criminal record, and cumulative perpetration, our conclusion is that this group differs from the overall population of juvenile convicts. This phenomenon continued to exist in 2002.

In terms of other statistical data, it appears that 9 out of all convicted drug abusers were foreign citizens (4.97%), a ratio that is higher than that of the total convicted juvenile population (0.75%). Another 9 juveniles were taken into custody, which is significantly lower than among the total convicted under-aged population (8.41%). Only 3 persons committed crimes under the influence of alcohol among drug users (1.66%). The ratio was higher in the total population (5.64%).

Interestingly enough, and in all likelihood a result of pure coincidence, the proportion of those cases where the corrective stage was applied was exactly the same in both groups (2.21%).

As to the legal consequences, probation takes the lead with 75.14%. (The occurrence of probation among all juvenile convicts was 64.25%.) Only 4 juveniles (2.21%) received enforceable prison sentences, which is a lower proportion than among the total population (6.86%). Suspended prison sentences were served to 31 individuals, 9 were given fines and 1 minor was sentenced to community service. When analysing the various ratios in comparison with previous years and other crimes, one must not forget about the small size of this group.

**Adult convicts**

In 2002, 2098 adults (2.29%) out of 91,573 convicted individuals overall were convicted of drug abuse. The proportion matches the one observed with juvenile offenders almost exactly. The increase, however, is more significant among adult offenders (31.21% compared to 2.26%). (In 2001 a total of 1599 adults were convicted of drug abuse.)

In making comparisons, we applied the same principle of calculation as was already specified with regards to juvenile convicts.

143 females (6.82%) were convicted of drug abuse, which is almost half of the ratio of women convicted in general offences (12.57%). By making an analysis of age distribution, the high percentage of young adults is quite noticeable.
<table>
<thead>
<tr>
<th>Age</th>
<th>D</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 29</td>
<td>89.47</td>
<td>48.06</td>
</tr>
<tr>
<td>30 – 39</td>
<td>8.34</td>
<td>25.91</td>
</tr>
<tr>
<td>40 – 49</td>
<td>1.67</td>
<td>17.41</td>
</tr>
<tr>
<td>50 and over</td>
<td>0.52</td>
<td>8.62</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

TOTAL NUMBER = 2.098 91.573

Column “D” denotes adults convicted of drug abuse while column “C” shows the percentage values relevant to all adult convicts.

The family status of the convicts results from their age distribution. The most populous category is that of single adults.

<table>
<thead>
<tr>
<th>Family status</th>
<th>D</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>89.90</td>
<td>49.82</td>
</tr>
<tr>
<td>Married</td>
<td>6.34</td>
<td>33.58</td>
</tr>
<tr>
<td>Widowed</td>
<td>0.09</td>
<td>1.56</td>
</tr>
<tr>
<td>Divorced</td>
<td>3.29</td>
<td>14.17</td>
</tr>
<tr>
<td>Separated</td>
<td>0.38</td>
<td>0.87</td>
</tr>
<tr>
<td>Total</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

TOTAL NUMBER = 2.098 91.573

In terms of education, there are also dissimilarities. There were only 4 illiterate adults among drug abusers (0.19%), compared to another 912 (equalling a total of 916) among other convicted adults. There is a smaller proportion of offenders with only elementary school education among convicted drug users (52.86% compared to the overall average of 61.79%), while a greater proportion of drug abusers completed some form of secondary school (44.71% compared to 32.58%). Those with college degrees constituted 2.24% of drug abusers (47 individuals), compared to 4.62% (4234 persons) of all convicted adults. It must be noted, however, that of those 4234 adults 1603 (37.86%) were traffic offenders.

There is a significant difference in terms of the criminal history of convicted adults. 31.2% of drug abusers had a criminal history compared to 40.71% of the overall population of convicted adults.

In terms of cumulative perpetration, drug abusers had only an 11.01% average compared to the 27.94% figure of all convicted adults.

In terms of other statistical data, it appears that 4.53% (95 persons) out of all convicted drug abusers were foreign citizens, a ratio that is higher than that found among the total convicted adult population (3.50%).

The correctional phase was applied in 228 cases (10.87%) of drug users as opposed to an average of 11.67% among all offenders. Although the difference is not significant, it still appears that judges opted for the correctional phase less frequently when trying drug abusers. Only 1.81% of all drug abusers were convicted of a crime related to alcohol consumption, a proportion significantly lower than the overall average of 20.94%. As for the latter, we need to keep in mind that the general offenders category also include those convicted of a traffic offence, and that there is a much higher rate of alcohol-related crime among those individuals.

14.35% of drug abusers (301 individuals) were taken into custody, which is a higher proportion than the overall average (8.31%).

In terms of legal consequences, 266 drug-related convicts (12.68%) received enforceable prison sentences, a percentage that is almost identical to that of general offenders (12.84%). The ratio of suspended prison terms among drug abusers was 11.53% (in comparison with the overall average of 20.48%); 67 individuals were given community service, and the 725 drug users receiving fines as their
major punishment made up 34.56% of their population, compared to the average of all adult convicts at 46.36%. (We must note that of all the 42,450 general convicts receiving fines, 13,750 were among those who were found guilty of some traffic offence.) Separately applied second punishments were served to 38.04% of drug abusers (798 individuals) compared to the overall average of 15.89%.

Summary

The number of convicted drug abusers continued to rise in 2002. The increase was more significant in the adult population than among minors. As to their number and age distribution, both the overall population of convicted individuals as well as the circle of convicted drug abusers have undergone some significant changes. Within a decade, the total number of minors has dropped by 200,000 and this population is gradually moving into the age groups of young adults.

The age distribution of drug abusers is characterised by a high percentage of young individuals. Of all the 2279 minors and adults convicted of drug abuse, 2058 were under 30, an unparalleled 90.30%. Only one out of two (51.90%) general offenders fall into this age group. Among minors, there are striking differences between those convicted of drug abuse and those convicted of other crimes in terms of their family background. In the adult population, distribution by family status is primarily a consequence of the age structure. In terms of education, convicted drug abusers are better educated than the overall average. Proportionately, there are fewer drug users with a criminal history and cumulative perpetration.

By considering the social characteristics of the convicted individuals (prehistory, education, qualifications), we can conclude that the vast majority of those convicted of drug abuse, especially among minors, still do not belong to the circle of traditional criminal offenders.

Activities of forensic medicine experts

(Report of the National Forensic Toxicological Institute)

The number of cases related to drug use has increased exponentially and has already reached its upper limit. The institute has exceeded a healthy limit of its capacity, which means that such a large number of cases have sometimes resulted in significant delays and the failure to contribute to maintaining the quality of examinations at the required level. The physical and intellectual burdens have distracted resources from the planned accreditation of the institute, from the more intensive modernisation of the laboratory's infrastructure, from meeting the technical and work safety standards required by law, from increasing the number of experts employed, from the training of our experts and from much-needed research and development. (The issue mentioned last became painfully obvious when the Ministry of Education was willing to provide HUF 8 million funding for a project which the institute failed to get because the Office of Institutes of Forensic Sciences (OIFS) could not come up with the HUF 2.2 million from their own resource that the project required.)

Despite the 2003 legal modifications, the institute still remains overburdened: the police still order the institute to perform examinations, mostly to prove drug use, on the basis of Paragraph 282 of the Criminal Code. There are increasingly more cases where the forensic expert has to diagnose the influence of drugs along with a medical expert.

There is growing suspicion of the use of newer drugs (GHB, ketamine, phencyclidine, etc.) but the institute could not yet confirm it from their biological samples. Suspicion is based primarily on prehistory data, as the institute does not have a direct screening system for less common substances.

The modernisation of the infrastructure that took a slow start about a decade ago continued in 2002, as much as financial resources permitted. Most of the expenses were covered by OIFS, some other elements were financed through public tenders. As a result of such developments, some laboratory accessories and valuable instruments were purchased (liquid chromatograph/mass spectrometer
(201/2002)) or refurbished (gas-chromatograph mass-spectrometer [200]). Two researchers at the institute received short-term foreign scholarships abroad.

The institute continues to participate in the circulated sample analysis coordinated by UNDCP, and since 2001 they are supported by the agency’s literature service. The institute regularly completes circulated sample analyses with 100% performance. The circulated sample programme, however, does not cover all examination types of the institute. Preparations are underway to join the serum-circulated sample system of the German Forensic and Toxicological Chemists’ Society, although there are still some financial and technical issues to resolve first.

One representative of the institute participated in meetings related to the European Union’s EMCDDA National Focal Point, organised by the International Resource Management Department of the Ministry of Health. At these meetings the institute participated in the workgroup discussing the “key indicators connected to drug-related mortality”. Later, the institute was not asked to continue to be directly involved in the project, which is understandable since data related to drug-related mortality converge at the offices of the forensic medical experts and police medical experts. The institute believes that its consultation data provided in the so-called “prevalence indicator” tests (statistical data related to the frequency of occurrence of certain drug types) would nevertheless be useful, as their researchers have not yet had the chance to participate in this workgroup. This is why they have suggested that the institute be included in the future projects of the workgroup.

The “monitoring” (statistical drug monitoring) of broadly-interpreted professional projects similar to the activities of the institute is also important, even if a separate key indicator has to be found for this purpose. The first step could be an analysis of the general condition of forensic toxicology in connection with international developments, primarily in the European Union. To the best of the institute’s knowledge, there has never been such a comprehensive analysis from the institutional network through professional procedures for analysis regarding professional training, even though at least two key indicators build upon on the work of forensic experts.
STRATEGY FOR DECREASING DEMAND

Prevention Institutions

National Institute for Drug Prevention

Reasons behind establishing the National Institute for Drug Prevention, its achievements so far and challenges ahead:

The Institute was established in February 2001 with the following definitive aims:

(i) to provide professional support and assistance for implementing the National Strategy, while paying special attention to enhancing community relations and social sensitivity;

(ii) to create a methodology-oriented prevention institution that will coordinate and promote the professional foundations of prevention activity;

(iii) to build cooperative relationships within the system of domestic prevention institutions;

(iv) to participate in international cooperative efforts that will allow domestic drug prevention activities to adhere to international standards and accepted practices that are regarded as effective;

(v) to initiate social-science oriented research aimed at bringing a genuine understanding of the natural history of drug use within reach, and thereby contributing to developing appropriate preventative programmes and services to meet needs that arise;

(vi) to publish materials that will, on the one hand, make experiences and findings from abroad more widely accessible, and that will, on the other hand, allow access to already published domestic professional material in a rearranged format that takes the needs of the target community into account.

1. Co-ordination Forums on Drug Affairs (CFDAs): Establishment and operation

A CFDA is a local consulting and coordination forum, a professional work team whose existence is due to commitment on behalf of the municipal government along with governmental support – both professional and financial. Its activities are geared towards coordinating the work of organisations and institutions in the four areas fundamental to reducing the drug problem: community and cooperation; prevention; treatment and rehabilitation; and decreasing the drug supply. The Forum’s aims include the implementation of a unified professional and methodological perspective as well as the rationalisation and coordination of locally-run drug use prevention activities. CFDA members include representatives of various governmental, municipal, non-governmental and church organisations that play a key role in dealing with the drug problem.

The aim is to initiate and strengthen dialogues among parties with a vested interested in and responsibility for dealing with the drug problem. Of utmost importance is the task of establishing communication among players that may have potentially conflicting interests. Stressing the significance of communication is important on both a concrete and an abstract level. After all, the reconciliation of interests and effective, targeted intervention always presuppose that messages are worded clearly and have been successfully conveyed. Accordingly, CFDAs are supposed to be the kinds of professional workshops that function as catalysts: they have to explore and appropriately interpret local peculiarities and needs while local strategies and implementation configurations are being worked out. This way, they are forums for efficient communication rather than programme-implementing “organisations”.

The former Ministry of Youth and Sports Affairs, currently called the Ministry of Children, Youth and Sports has worked out a support programme for establishing and operating CFDAs. As a result, by 2002, 66 Co-ordination Forums on Drug Affairs were established throughout the seven Hungarian
regions and Budapest. Besides 58 municipal CFDA s, two were established at the county level; three small regional, one regional, and two district CFDA s were also started in Budapest. Support in 2002 amounted to HUF 68,000,000. At the national level, professional work by the CFDA s is facilitated and coordinated by the National Drug Prevention Institute, through the following:

- publishing methodological newsletters
- launching a book publication programme (professional resource series–CFDA methodological materials)
- providing continuous consultation
- organising and running training sessions free of charge
- initiating research

2. International relationships and cooperation

Ever since the Institute was established, one of its continued aspirations has been to become substantially involved in the Hungarian and international professional and particularly scientific community's work. So far, three aspects of this effort have been developed:

(i) conference participation
(ii) involvement in international projects: HBSC (Health Behaviour in School-aged Children–international research), ENHPS (European Network of Health Promoting Schools)
(iii) development projects based on two and three-way cooperation (PHARE Twinning Assistance, MATRA Pre-accession Project)

Now more than ever, the fate of the Institute is determined by the PHARE project, which is currently being implemented, and which serves the simultaneous fulfilment of several objectives:

(i) Institutional development of the Drug Prevention Institute
(ii) Making the operation of Co-ordination Forums on Drug Affairs more efficient
(iii) Strengthening the professionalism of (drug)-prevention activities operating in Hungary and widening the range of prevention options.

The PHARE project is implemented through cooperation with the Dutch Trimbos Institute and the UK's DrugScope. This project consisting of two elements (Twinning Assistance, Grant Scheme), has a total budget of EUR 1.9 million, of which EUR 400,000 comes from Hungarian co-financing. Various components are coordinated to implement the following objectives:

- Expanding the management capacities of the Institute and CFDA s in three areas: (a) technical management and (b) human resources management, and (c) quality-assurance approaches in productivity management
- Formulating data collection techniques which will help develop and implement more effective solutions for intervention
- Developing the range of tools for vertical and horizontal communication – tools for network-building (building and maintaining databases of information, developing new and modern coordination patterns)
- Using the grant fund to develop services to fill existing gaps, promoting the application process, especially its monitoring and professional support

Until this point, the implementation and history of the PHARE project can be regarded as successful. It is one of just a few projects that have been developing in accordance with a previously planned schedule in terms of its starting point as well as later steps. Although it has not yet been possible to give an overall evaluation of the project at training sessions, feedback from participants in pilot projects indicate that genuine and substantive information has been conveyed, and the knowledge and experiences gleaned have contributed to speeding up local processes, launching other processes, and enhancing institutional self-awareness, all of which are irreplaceable prerequisites for further development.
3. Research

National Research and Development Programme – “Fények és árnyak” (Lights and Shadows)–
Risk factors and the need for and possibility of prevention

In October 2001, our Institute applied for a national research and development grant that was part of the Széchenyi Plan. Our proposed project is a complex research and development project unlike any other. We managed to get HUF 100 million in grant support, and the entire budget for the project is HUF 156 million. Our goal in this project is to conduct basic and applied research, implement service development based on that research, and comprehensively register and assess prevention programmes. What makes this enterprise unique is, on the one hand, its complex approach, and on the other hand, significant cooperation among institutions (indispensable for successful implementation). We began collaborative work with several institutions: the Institute for Psychology at the Hungarian Academy of Sciences; the Centre for Behavioural Research at the Budapest University of Economic Sciences and Public Administration; and the Budapest Social Resource Centre. We are just past the first six months of implementation, and expect to complete it in July, 2005.

Plaza pilot study

In connection with the previously described National Research and Development Programme, we conducted exploratory pilot studies in five shopping malls. Our primary goal was to prepare for the “larger” study by more precisely defining the considerations about the form and type of questions we will select.

Substance use and attitudes towards health among those who live in state foster care

Studies on the average population and on students at vocational institutes highlight the importance of examining attitudes towards health, substance consumption habits, and prevention needs among those who live in state foster care. After all, we know fully well that effective prevention cannot but take into account the target group’s lifestyle, unique history, and individual and social-psychological characteristics. Based on this recognition, we conducted a study that did not rely on sampling techniques, but instead comprehensively examined within certain areas the health attitudes, drug consumption habits, and lives of 14-21 year-olds living in various forms of state care. The research findings are included in the appendix.

HBSC study

Since 1985, Hungary has been participating in a research project entitled Health Behaviour in School-aged Children (HBSC), initiated in the early 1980s by Scandinavian researchers. The objective is to monitor those habits of school-aged children that affect their health, to find out about students’ general state of health, to identify factors connected with certain types of behaviour, and based on all this information, to influence student behaviour in a positive direction.

From the beginning, Hungarian participation within the research has been realised within the framework of institutional cooperation. Since its inception, our institute has taken part in carrying out this highly significant activity. During our 2002 data collection phase, we asked a series of questions that dealt with characteristics specific to substance use in a way that allowed comparisons with other research (ESPAD). Our Institute’s responsibility included the development of this question series and the analysis of the data thus collected. The findings are included in the appendix.

4. Involvement in publishing

There are two levels at which the Institute is involved in publishing:

(i) It has its own book publication programme with a twofold objective: on the one hand, to promote the development of CFDAs, and on the other hand, to provide for a wider professional audience as well as lay person points of reference that will favourably influence societal attitudes towards the drug problem, to allow for its treatment. In this regard, our goal is to present a realistic picture and deconstruct attitudes to the phenomenon that are at times mystical, and at other times overly politicised.
Our colleagues attend various professional events and publish their research results in professional journals. This way, they personally contribute to enhancing professionalism within the field.

5. Organising events

Over the years, as a background institution of the Ministry of Children, Youth and Sports, we have participated in organising and planning the professional programme for numerous events that were of key importance with respect to the coordination of drug affairs. The list below mentions but a few of these:

- February, 2002: “Válaszd az életet” (Choose Life) church conference attended by prominent representatives of each historic church as well as representatives of church-run organisations that deal with the drug problem.
- March, 2002 and April, 2003: “Vészcseng” (Alarm Bell) Conference in cooperation with the Central Bureau for Pedagogical Methodology and Information.
- December, 2002: “Veszély vagy esély?” (Danger or Opportunity?) expert discussion regarding the modification of the Hungarian Criminal Code, its professional consequences, and requirements
- May, 2003: National conference for safe entertainment venues, held in Sófok

Apart from events initiated by the Ministry, we organised and conducted numerous expert discussions that helped implement our professional objectives.

- Biannual expert discussions with CFDAs participating. These occasions are good opportunities for “horizontal” communication; they also provide opportunities for discussing current professional policy problems.
- National conference for prevention organisations—the purpose of this event was to prepare “cadastre-building” and evaluation activities conducted within the framework of the National Drug Prevention Institute’s project (mentioned above).

6. Other projects

The Institute supervises and organises the implementation of further projects. Below are some examples:

- Developing and running the National Anti-drug Film Archives
- Purchasing and installing needle exchange dispensers to be set up throughout Budapest
- Requesting and processing applications from institutions aimed at diversion through prevention and instruction; providing professional support for this service as well as financial monitoring
- Requesting and processing applications from panels of experts to be set up by the MCYS Deputy State Secretariat for the Coordination of Drug Affairs.

7. The Institute’s future perspectives and possible directions for development

The last two and a half years have made it clear that to deal with the drug problem efficiently, one of the most important tasks is to develop opportunities and a toolkit for dialogue. From the perspective of advancing dialogue, it is indispensable to conduct comparative analyses of organisations and services that aim to reduce the drug problem, and to keep track of this information and make the results accessible to professionals as well as those who take advantage of the services. Realising this has inspired the most significant concept for development in the upcoming period: creating a complex database that will serve as a source of reliable information for both Internet-based and in-person advising about organisations offering prevention programmes, treatment, rehabilitation, and about
research, particularly in the social sciences, related to the drug problem. At the same time, operating a help desk – with services that include in-person consulting – will enable us to detect areas that call for further development. This way, as a “by-product” of the information service, drug policy will obtain reliable points of orientation. These developments will enable links to international databases (EDDRA) and will work out accreditation criteria for prevention programmes. Last but not least, these developments can also enable us to better arrange and formulate our funding priorities.

It is in large part a consequence of the PHARE project that a multi-step training programme has been worked out, which we would like to make available to those who work at municipal CFDA\s. On the one hand, this training programme serves to make daily operations more productive (management issues, network building, strategic planning, quality-assurance approaches). On the other hand, it provides CFDA\s with access to the methodology of research techniques that place intervention in the centre of interest.

**Deputy State Secretariat for the Coordination of Drug Affairs; Ministry of Children, Youth and Sports (MCYS): Preventions Programmes**

In accordance with the National Strategy, the Ministry of Children, Youth and Sports has been announcing prevention-related calls for tenders since 2000. In 2002, 572 projects in twelve categories were awarded funding, totalling approximately HUF 350 million. The objectives of these applications are: reducing drug use and drug-related crime, harm-reduction, prevention and providing information. These will serve to enhance societal sensitivity about the efficient handling of drug affairs and enable local communities to develop their problem-solving skills in reducing the drug problem.

The Ottawa Charter established that health development is a precondition for prevention. In terms of drug use, first risk factors have to be reduced and societal sensitivity about drug affairs has to be enhanced. Instruction must begin at the elementary-school level, through informing students as well as preparing them emotionally. Through prevention, we wish to delay the first time drugs are tried and also reduce the frequency of drug use. We have to prepare and assist children and adolescents so they can make responsible decisions throughout their lives. We have to provide them with adequate information about harmful and potentially addictive habits (such as smoking, alcohol and drug consumption) so that they become aware of their consequences. Young people are the ones who decide, in the light of their knowledge about what it is that they can win and lose in terms of health and human relationships. It is therefore important to enable children and adolescents (and last but not least, their parents) to develop responsible behaviours and attitudes, and to preserve and develop their health.

**MCYS–ME joint drug prevention grant projects for schools**

Having already run grant projects for secondary schools, in 2002, the Minister of Children, Youth and Sports and the Minister of Education announced grant projects for elementary schools, specifically, for grades 6-8. The grant project was designed to fund programmes for health development and drug prevention activities, the goal being to advance and support health development programmes with an emphasis on drug prevention.

Projects to be funded by this grant project are based on the drug strategies in schools, which are integral parts of the schools’ educational programme. Within this framework, funds awarded can be spent on educational materials and health-development programmes to be incorporated into the class curriculum. These curriculum-based programmes are integrated into the directions and objectives set forth by the National Strategy and the National Curriculum.

In 2002, HUF 110,000,000 in funding was distributed in the joint MCYS-ME grant project. Projects that received funding were based on the drug strategies of schools, as well as the schools’ overall education programme, under the guidance of designated professional organisations. These experts must have appropriate training and experience, and together with the school coordinator on drug affairs,
they must organise presentations and training sessions on health development at least five times during the school year.

In 2002, the *Deputy State Secretariat for the Coordination of Drug Affairs’ grant projects* provided support for prevention and harm-reduction within twelve categories. These involved non-curriculum-based health development programmes (National Health Day, National Sports Day, etc. which promote communication about drugs). Outside of the grant project, there was also support for large-scale projects that extended beyond the level of local communities to attract a wide audience and achieve a high level of efficiency.

“*Köztes Átmenetek – a Drog*” (*Transitions – About Drugs*) An interactive travelling exhibit:
The exhibit’s intended audience is adults and youth over 14.

One of the main aims of the organisers was to emphasise the importance of the role of family in prevention. The first exhibit was on view until June 17, 2001 at the Hungarian Natural History Museum. There were about 100 visitors per day and children’s groups indicated their plans to visit in advance. A sign of the exhibit’s success is that from March on, they could not accept any more reservations for group visits. In view of the exhibit’s success, the interactive material travelled around to various towns to reach a wider audience. Since September, 2001, the exhibit has been shown in Gyula, Győr, Bonyhád, Székesfehérvár, Szabadka, Szeged, Sopron, Hódmezővásárhely, Békéscsaba, Marosvásárhely, Kecskemét, Pécs and in the Lurdy Ház in Budapest. Experience has shown that the exhibit made a deep impact on children and adults alike. It is important that they feel that there is a way out, that it is possible to recover from addiction. This unique exhibit showcases the causes and effects of drug use, how and why addiction develops, along with characteristics of drug use in a Hungarian context. The display conveys information through unusual media (including film, audio-material, computer animation) in an authentic way that affects the senses as well as emotions. The directors of the exhibit are seasoned experts who have been working in drug prevention and with drug patients for many years. The directors or their aides carry on a continuous dialogue with interested visitors. This project also provides opportunities for training experts, to affect and shape the population’s opinion about addiction and addicts, and ensures a venue for treatment facilities and NGOs to introduce, through publications, brochures, and posters, their activities to those who need help.

“*HÁLÓ-MOZI*” (**NET-MOVIE**) Programme:
Since January 2002, the Ministry has been providing this new drug prevention service for secondary schools in Budapest. Based on positive international experiences, the programme provides information about preventing drug use in a unique, new, youth-friendly, and interactive way. In effect, NET-MOVIE is a health education class on drug prevention run by experts, which happens to take place in a movie theatre. Students watch a movie compilation consisting of documentary and educational material, and then they can think and talk things over with peer-helpers with experience in drug issues, with recovered drug addicts, doctors, and experts in narcotics. With the help of experts, students can better process their thoughts, feelings, problems, and doubts.

Themes to be shown are gathered from already existing material (projects funded by the Ministry, documentaries, material downloaded from the Internet, etc.). On each occasion, the programme can include an entire class of students from a given school—about 100-120 students per occasion. This way, within half a year, the programme can reach as many as 10,000 students along with their teachers.

“*DrogPortál*” (**Drug Portal**):
The Drug Portal is an Internet-based centre for Hungarian homepages dealing with drug coordination, prevention, and serving as information sources. It currently includes targeted content for five target groups: Teenagers, Adults in their twenties, Parents, Teachers, and Professionals. For each target group, the content and wording of articles varies. Some of the services are independent of any given target group; an example is S.O.S. real-time chat, through which visitors can get immediate
assistance and answers with respect to their queries about a topic. Another example is the Drug Portal forum, which can be launched from any article or independently of articles. A third example is the Drug Ring, which is of interest to those visitors who wish to visit pages about a certain topic without visiting the central portal.

Through its Internet presence, the Portal is an excellent prevention tool. Its chief purpose is to provide information, and to raise awareness about making the decision to say no. Information ranges from simple case descriptions to professional essays, from an event calendar to downloadable books in pdf-format.

**2002 grant projects at the Ministry of Children, Youth and Sports:**
The Government supported prevention programmes from the following four sections of its budget:
- 5/3/1 Support for drug problem-related training, continued training, peer training (codes SZ, KS, SV)
- 5/3/3 Drug prevention programme (codes MA, ÖN, PP, KA, ES)
- 5/3/5 Support for drug-related research and scientific investigation (code KT)
- 5/3/6 Support for developing services at low-threshold therapy and drug treatment institutions (codes AL, T-A, B).

Grant categories for each budget brings together short-term, mid-term, and long-term goals put forth in the National Strategy, the implementation of which is a task for the individual and the community, with help and control from the government.

The Ministry’s grant projects primarily focused on the most high-risk groups: students and young adults.

In 2002, we received 241 applications for funding for events related to drug-use prevention. Of these, 229 were approved. Generally, a bid’s unacceptability and subsequent rejection was usually due to faults in formatting. Of the assessable applications, 130 were awarded funding for a total amount of HUF 41,000,000. Most programmes were conducted within schools, but numerous NGOs also ran valuable and useful projects. Of these, two kinds stand out: events related to the International Day against Drug Abuse and Illicit Trafficking, and professional conferences:

1. **The Jász-Nagykun-Szolnok County’s Foundation for Prevention, Third Professional Drug Prevention Conference:**

   The conference’s objective was to develop active communities within the county that are sensitive to drug-related problems. By providing information, these communities should set local resources into motion and perform prevention tasks in keeping with local characteristics and possibilities:
   - providing information
   - assessment
   - information exchange
   - introducing professional literature and supplementary materials
   - spreading professional knowledge (with help from collaborating experts, presentation of up-to-date knowledge, solution models and innovation techniques)
   - opportunities for professional consultation (various organisations introduce themselves, thereby providing a basis for more coordinated and effective prevention activity that takes full advantage of other organisations’ strengths)

2. **National Conference of Student Unions – series entitled “Drug Prevention Days”:**

   The event’s prevention programme was built upon a collective foundation: the active cooperation of NGOs, organising presentations, and developing small-group sessions and experience-sharing workshops. Several sections ran simultaneously, and of these, the greatest emphasis was on the Drug Section. Participants could attend round table discussions with experts and organisations, and join in debate about the European drug situation and drug culture.

3. **Creative Community at the Studium Theatre – Theatre sessions for health education:**

   Operating as an amateur theatre group, the Creative Community runs health education sessions in Zalaegerszeg and in Zala County, based on the methods of the English groups TIE (Theatre in
Education), THE (Theatre in Health in Education), and DIE (Drama in Education). On average, they hold 35 sessions every year, with about 1000 elementary and secondary school students participating.

4. Tenu Mahanaim Congregation – “PALÁNTA” (SEEDLING) Evangelical Child and Youth Mission:

It is part of the programme’s goals to provide practical help in developing a healthy self image, communication skills, and establishing friendships.

5. Catholic Caritas – Caritas Hungarica:

For the third time, in the 11th District of Budapest, the “Rév” (Harbour) Addiction Support Service organised its Conference on Drug Prevention, a venue for professionals working with youth to share and express their experiences and problems, and together help one another in developing proposals. The number of participating professionals increases every year.

Starting in adolescence, the primary point of reference becomes one’s peer groups; regular activities with others are therefore of great importance from the perspective of drug prevention. Shared peer experiences enhance the power to sustain a community, and this creates an effective protective mechanism against groups with negative influence. The Ministry’s attempt to reduce these risk factors is embodied by its grant programme entitled Support for peer-helper training for the prevention of drug use. The overall objective of this training programme is to spread information about peer-influence-based drug prevention among peer-helpers from various parts of the country, and to prepare youth volunteers for prevention work with youth at risk; to secure, through training, successors who will carry on with peer-helper activities; to develop peer-helper and group leadership skills; and to convey up-to-date approaches and knowledge. Of the 113 applications received, 73 were awarded funding of a total amount of HUF 35 million.

1. Peer Support Workshop Foundation: “Fiatalok a Fiatalokért” (Youth for Youth) – Peer Health Development and Outreach:

Their aim is to approach young people needing support and help, who are not otherwise reached by the conventional socio-political, healthcare, family-help or child welfare system, or who, for various reasons, dropped out of the system.

2. Forrás (Source) Association for Spiritual Helpers – Elementary School Training Programme for Peer Help

The training programme is specifically oriented towards developing a drug-free, positive lifestyle; improving self-confidence and competence required to take charge of one’s life; and providing accurate information about drugs and related harm. To achieve this, they ran training sessions in a small-group format, in order to bring individual development into focus and to provide young people with an opportunity to express and formulate their own opinions about the topic.

3. Kapocs (Link) Foundation for Youth Self-help Service:

Group sessions and training to prepare young people who volunteer to help peers at risk and living under dangerous circumstances. Sources of danger to peers and specific environments, along with their interconnections and consequences, were covered.

In accordance with the objectives formulated in the document entitled the National Strategy for the Reduction of the Drug Problem, we must provide young people with extracurricular recreational activities revolving around drug use prevention, presenting positive examples against drug use. The objective of the grant programme entitled Support for extracurricular programmes for the prevention of drug use was to support and assist extracurricular programmes. Of the 362 applications received, we supported 135 applications for a funding total of HUF 36,505,000. All of the funded programmes opposed drug use and contained specific elements for preventing drug use, and presented positive alternative examples to follow:

1. “Tiszta Jóv ért Közhasznú Alapítvány” (Public Service Foundation for a Clean Future):
Through organising extracurricular programmes that offered alternatives to drug use, they directly reached close to 1000 students. During these sessions, students were exposed to activities geared towards awakening interest in the joys of life, recognising the joys offered by a healthy lifestyle, and constructing a positive self image and sense of fulfilment.

2. Solymár Reformed Church Congregation, Meglepetés (Surprise) Theatre, Self-awareness Training:

A self-awareness group methodology based on socio-drama with themes from the Bible. Through stories inspired by societal problems and the Bible, participants experience their own roles within the stories and discussions provide an opportunity for them to process these and think about how the stories might continue. In the improvisational theatre, members of the group open the gates to display these experiences to an audience.

The Ministry provides funding within five grant categories to organisations and professionals, supporting projects in the following areas: widening the range of local drug prevention services, training professionals on drug issues, and analysing research results, data, and facts.

The National Strategy for the Reduction of the Drug Problem lists among its short-term goals the examination of the effectiveness of prevention programmes, together with the development of examination methods. We are currently in the process of working out the evaluation protocol for the applications. In 2002, the Ministry used close to HUF 26 million towards Support for scientific investigation and research related to the drug problem. Of the 43 applications received, we supported 22 well-grounded research projects that analyse the extent, methods, and more or less well-known effects of drug use in Hungary.

1. András Jelky Boarding School for Vocational Training and Educational Consultation Service “Research on the connections between depression and drug use”:

Recent increase in the number of students who use drugs demonstrates the need for this study. The problem under investigation has been acquiring greater and greater social significance. Recorded interviews conducted with adolescents who show symptoms of depression as well as interviews with their parents help uncover life events that contributed to the complaints. The survey was based on a self-assessment questionnaire developed by Beck and Kovács in 1977. With extensive depression screening and by keeping track of the results, it will be much easier to provide subsequent psychiatric care to these students. The assessment method for measuring mood disorders was based on the Beck Depression Inventory.

2. Advisory Association for Higher Education “Survey of lifestyle and learning problems among college students – developing an alternative to negative coping techniques”:

Anonymous questionnaire; a combination of psycho-diagnostic and drug-use-related questionnaire methods. A complex study of drug use, lifestyle and mental health-related characteristics among college and university students. Results from previous studies constituted the starting point: within the relevant population, circumstances at home factor significantly less than had been previously supposed. Taking this to be their point of departure, the data-governed research emphasised numerous factors that can impact on drug use. Data-governed prevention does rely on theoretical models and information gathered through theoretical approaches, but only to the extent that there is support for the theoretical background from available data on the topic. The results include elements directly relevant to prevention: with respect to drug prevention, relevant interconnections between psychological risk factors and drug use and the importance of skills for making lifestyle decisions.

3. Budapest University of Economic Sciences and Public Administration, Department of Sociology and Social Policy “The effects of religious beliefs on drug use among adolescents”:

This research was aimed at the epidemiological assessment of drug consumption among secondary school students. Questions were either based on a questionnaire and asked directly, or answered in anonymous tests. The survey was conducted in Budapest and in Kolozsvár, with a total of
1047 tenth-grade students participating. An overall, representative model of drug consumption in those surveyed was formulated.

4. Ro-Net Ltd. “Drugs and drug use on the Internet”:
The study examined Internet homepages, their size, and approach. The Internet plays an increasingly greater role in the lives of young people, shaping their opinions and values. There are no regulations for Internet-based materials, along with their intended and unintended messages and suggestive content that can shape opinions and attitudes. The study included 1400 homepages; during the data collection process, they visited each page, filled out an information sheet for each, and analysed the data obtained.

In 2002, MCYS spent HUF 80 million to fund 40 applications to support low-threshold institutions and programmes working with drug users. As a result, several new institutions and programmes were established. Low-threshold service means that drug users are not expected to give up on using drugs right away and obey strict therapy contracts and rules set by abstinence-based treatment centres. Low-threshold services include:

- social care
- clubs
- overnight shelters
- placement in treatment homes for inpatients
- basic healthcare provision
- screening tests
- health assessments
- referrals to treatment institutions
- social services
- legal help services
- support for self-help groups
- outreach work
- consultation centres
- telephone help-lines
- needle exchanges
- methadone maintenance therapy

Upon returning to their homes in cities, addicts who had successfully quit through outpatient or inpatient treatment or at rehabilitation care centres often exhibit signs of loneliness and circumstances that can lead to increased drug use, both of which can lead to a relapse. Institutions running low-threshold services aim to prevent this through their programmes and also help with reintegration into society.

1. University of Debrecen “Ariadné fonala” (Ariadne’s Thread) – Launching a Low-threshold Mental Health and Drug Consultation Service for Students at the University of Debrecen:
The great demand for mental health and psycho-social care among college and university students indicates the need for this programme. Ariadne’s Thread provides ready access to low-threshold services for students. The programme is available throughout the year for those who struggle with conflicts, lifestyle and learning problems, or have addiction-related questions.

70% of students at the Tanoda use various types of drugs and some of them are addicted. The main objective of the tailored work is to create a mutually-accepting community that enforces a sense of belonging and motivation on the way towards giving up drugs. Through active support from helpers, Tanoda applicants are drawn into a help-based relationship during which strict refusal disappears and students manage to reduce their drug consumption or stop altogether. Deviant behaviour, problems with social acceptance, and hardships encountered through their lives are frequent among drug users.
arriving at the Tanoda. These in turn lead to severe learning problems. Study and learning disabilities are frequent. Group sessions that promote self-awareness form the basis of the school’s operation.

3. The Békés County Board’s Kálmán Pándy Hospital “Drug Outpatient Clinic – Developing Methadone Treatment”

About a third of the patients at the Gyula drug outpatient clinic are addicted to opiates. Conventional treatments used in the Eastern European region have worked to some extent, but they were not effective enough. Through methadone treatment, the number of opiate addicts has gone down. Many of those who underwent detoxification or are receiving maintenance therapy were trying to stop altogether or signed up for treatment. Thanks to the programme, the number of toxic cases has been reduced. Thanks to continued medical supervision, patient health has improved through early detection and effective intervention.

For institutions treating drug users and providing low-threshold programmes, a support programme for providing supervision is in place to help clear up professional questions related to their work and provide regular training at least once a month. 28 applications were received and the total amount of funding awarded was HUF 9,380,000. The targeted group consists of professional helpers working within low-threshold programmes and in drug treatment centres. In order to make their work more effective, beyond knowledge about drug types, drug use, and associated symptoms, helpers must also be aware of appropriate forms of care and overall information. To train these professionals, MCYS provided HUF 24 million in 2002 to fund 32 applications under the grant programme entitled Support for training helpers and professionals working with drug users.

1. “Drog Stop” (Drug Stop) Association of Budapest “Complex Training Programme for Employees at the Drog Stop Association”:

The Association’s chief activity involves operating a free, 24-hour, anonymous telephone service. Besides training and supervising operators, employees were also assigned secondary tasks and tried to contribute to prevention work through participation in various events that would increase public awareness of the telephone service. Supervising group sessions included psycho-dramatic elements as well. Due to turnover among operators, training is continuous.


The themes and pacing of the training are formulated to allow step by step advancement to the next level through teamwork, participants’ joint efforts, and through thoroughly adapting their perspectives with respect to the material. They work on solving situational tasks that they encounter on an everyday basis. By systematising their practical experiences, professionals return to their work with a better sense of the limits of their competence, and with more effective intervention techniques.

The Ministry provided HUF 16,370,000 to fund solutions for lifestyle-related problems as well as reintegration problems resulting from drug use. 27 programmes received support under the grant programme entitled Support for launching new self-help groups and for operating already existing ones working on the prevention of drug use.

1. Municipal Government of Budapest’s Gyula Nyír Hospital, Drug Outpatient Clinic and Prevention Centre, “Metadon Csoport” (Methadone Group):

The Drug Outpatient Clinic launched a self-help group for participants in the methadone-programme. The objective of the group was to help participants receiving methadone maintenance therapy to stop using opiates altogether, to strengthen their psycho-social background, and aim at total abstinence. The group operated and still operates as a free-interaction, open-ended group. Based on pre-formulated themes, sessions cover societal attitudes towards patients undergoing methadone maintenance therapy, the biochemical effects of methadone, the use of drugs on the side, family and social relationships, and the possibility of giving up methadone maintenance therapy:

This group’s aim is to help local communities develop problem-solving skills for reducing the drug problem. Assistance must be provided for individuals and families that have come in contact with the drug problem or are struggling with it. Parents must be enabled to prepare youth for life without drugs. Through discussions, situational games, and role-playing games, they try to understand and find answers to drug use, its causes, and the lifestyle associated with it. They discussed human values and weaknesses, their attitudes in connection with this, and their relationships with people who possess these qualities. Conversations raised the issue of differences between the sexes from the perspective of providing help. To wrap up the interactive gatherings, they analysed their findings.

Promoting communication through broadcasting and electronic media projects, along with publications and tools related to preventing drug use, are funded through MA-type and KA-type grant programmes. Media projects primarily serve to enhance sensitivity towards the problem and play a role in communication about the problem within society. They can have a preventative effect in some special areas, with well-defined target groups and the use of the right media tools. The media is capable of conveying messages that directly or indirectly advertise drug use to young people. Such an impact has to be countered and prevented, these types of messages have to be restricted, and media influences conveying drug-free values have to be backed by community support. In 2002, the Ministry used HUF 33,815,000 to support 29 projects within the scope of its grant programme entitled “Support for broadcasting and electronic media programmes related to the prevention of drug use”. The grant programme provides partial support for fully or partially developed projects that help implement TV/radio series, programmes, and messages dealing with health development and drug prevention. The grant programme entitled “Support for publishing material and developing tools related to the prevention of drug use” provided a total amount of HUF 26 million to fund 41 projects aimed at publishing health-oriented, up-to-date, effective prevention materials and developing similar tools that address aid-workers and young people at risk with respect to drug use. The contents of the publications were not allowed to involve determent, but instead had to present information about drug use phenomena in an objective way. All publications and tools fill existing gaps by providing useful knowledge about topics that we are unlikely to encounter on an everyday basis, or do not encounter at all.

1. DUE Producers Ltd. “Fben járó b n” (Weeding Sin):

They presented examples of youth lured into drug use whose stories made the radio programmes’ messages authentic. Students working at radio stations participated in preparing the programmes, developing them, and approaching serious issues that their peers face, based on their own perspectives. The programme was primarily intended for those who have not yet gotten into drug-related crises but are at risk of becoming potential users through the seductive pressure they keep encountering in schools, and at entertainment venues. Each broadcasted programme included an educational segment entitled Droglexikon (Drug Lexicon), with a compilation of facts about drugs and their effects.

2. Baranya County Municipal Foundation for the Treatment and Employment of Addicted Youth “Drogveszélyben” (in Drug Danger):

The purpose of this publication is to provide information about available institutions and services run by the “INDIT” Public Service Foundation, and to demonstrate the relationship of a chemical substance and its user from first encounter to the potential development of addiction. The publication includes uncensored and unedited accounts by three recovering addicts, describing their lives with and without drugs.


This publication is a basic textbook for focused training of specialised psychologists and for secondary schools that train healthcare workers. It analyses attitudes towards health, health-preserving
behaviour, the psychology of the helping profession, and empathy from the perspective of personal psychology and development. It has been proven useful in ensuring quality training and practical successes in trained professionals' work.

Section 6.2.2.12. of the National Strategy for the Reduction of the Drug Problem, entitled *prevention programmes for the Roma*, states that “The multiple-disadvantaged backgrounds and cultural characteristics of certain groups within the Roma population call for the establishment of special programmes. In order to use these programmes effectively, there is a need for social workers and NGOs accepted and trusted within the Roma community.

In the light of these considerations, in 2002 we developed our support programme and used HUF 43 million. We consulted experts in the evaluation of incoming applications.

The Ministry has continued to carry on with the implementation of professional objectives with respect to minorities, started in 2001.

In 2002, our first highlighted programme – launched in February – can be viewed as a first step of a multi-year training programme. On the one hand, the programme is intended for teachers of Roma youth and trains drug affairs coordinators; on the other hand, it provides peer-helper training for Roma youth. The training implements the “train the trainers” method and adapts an accredited thirty-hour free continued training programme for teachers entitled “Training drug affairs coordinators for schools”, developed by the Pilisborosjen Methodology and Information Centre for the Continued Training of Teachers.

Within this framework, over 100 ethnic Roma professionals and peer-helpers involved in drug affairs were trained in 2002. Secondly, peer-helper training projects were supported based on applications and on an individual basis. As a result, projects were organised by NGOs throughout the country. We also supported lifestyle camps, conferences, self-help groups, and contributed to the operating costs of NGOs.

*“Diótorés” (Nut Cracking) Foundation*

To address the problem, the Diótorés Foundation was established in 1997. Its goal is the complex re-socialisation of single homeless youth who were previously in state foster care. Among homeless youth (aged 18-30), 40% had been in state foster care. The Foundation’s target group is exclusively ethnic Roma youth who identify themselves as Roma and who are greatly affected by the drug problem. They are at once ill, uneducated, prone to committing crimes and potential victims as well.

Roma peer-helper training is among the Foundation’s main activities. Since 1999, 75-100 new helpers have been trained each year in Budapest. The Foundation works with the Roma Minority Self-governments. Roma peer training differs from other forms of peer training in that it takes into account the habits, unique traditions, and features of Roma families, and deals with the social integration of Roma youth alongside drug prevention issues accordingly. Both programmes are monitored and accredited by the Ministry. In 2002, the Ministry funded the operating costs of the Foundation.

*“Megismerve Elfogadni” (Admit and Accept) Foundation*

For several years, MCYS has been providing support for two drug prevention programmes run by the Foundation. Both aim at promoting the integration of Roma children. Since 1999, the Foundation has been working with elementary school fifth graders in Budapest (160 in all) providing curriculum-based classes for them as well as personality and talent-developing programmes and tutoring in various subjects. This four-year programme was formulated in advance, providing small group sessions for two hours a week. Continuously updating the programme is crucial.

Peer training is special in that it takes into account the habits, unique traditions, and features of Roma families and deals accordingly with the social integration of Roma youth alongside drug prevention issues.

Both programmes are monitored and accredited by the Ministry.

*Collegium Martineum*
The Collegium Martineum Foundation was established in the summer of 1996 by Hungarian and foreign church-based relief organisations as well as private individuals whose goal was to provide a programme and institutional background for the higher education of socially disadvantaged youth (primarily Roma) at the bottom 10% of the societal hierarchy in terms of income and prestige. Its boarding school educates students based on a jointly-developed humanistic set of values based on democratic principles, values that respect the love of children, and the student’s integrity.

Their conception is realised through the model of a rural household. The family atmosphere, bringing elements of the middle-class lifestyle within everyday reach, make it possible for students to get to know and practice the roles, tools, obstacles and joys of the planned operation of a multigenerational household. We supported the boarding school’s operation in 2002.

“Tisza Jövőért Közhasznú Alapítvány” (Public Service Foundation for a Clean Future)

Two kinds of training programmes are offered: drug affairs coordinator training provided for teachers of Roma youth and peer-helper training for Roma youth. The objectives of the training are:

- Contributing to the expansion of the educational system’s health development resources, with a focus on drug prevention.
- Expanding teachers’ knowledge and skills related to health development and drug prevention. Through the three-day training of “drug affairs coordinators”, develop a central base for long-term drug prevention programmes among Roma youth by creating a group that can offer individualised help to Roma youth about drug-related problems, prevention options and ways out, as well as special knowledge and skills to help them fit into society.

Romano Glaszo Gypsy Association

The Association has been training and employing Roma social workers involved in prevention work in the streets to combat drug use, AIDS, and homelessness. Their professional programmes were developed by the Department for Handling the Disadvantaged at the National Institute for Health Preservation, which also provides professional supervision for the programmes. The Association has shown outstanding results in many areas. It operates a folklore band, a radio station, organises camps, actively participates in fieldwork conducted by the Cultural Anthropology Department of the Eötvös Loránd University, and it also runs several children’s clubs.

In 2002, our support also helped fund a drug prevention programme called “Drogfoci” (Drug Soccer) for disadvantaged children.

Pásztó Municipal Government

For several years, the Pásztó Municipal Government has been organising lifestyle camps. Each year, significant emphasis is placed on in-depth acquaintance with Roma culture through presentations by invited experts, and through learning about and understanding new creative work. The camp hosts the public interest forum “Gyermekszáj” (Child-speak) along with programmes on Roma ethnography, health preservation, drug prevention as well as crafts workshops. Invited guests have contributed to the professional quality of the programmes: Ervin Telek, Judit Berki, László Reviczki.

Béke (Peace) Children’s Home run by the Municipal Government of Budapest

The Home houses eighty multiple-disadvantaged young people aged 12 through 24, all of them affected by behavioural, drug, and school-related problems. Prevention work – the final goal of which is social integration and re-socialisation – places great importance on introducing various colourful programmes into the lives of young people, so that they will spend their free time more creatively and productively. Such programmes – like the creative arts and music workshop for drug prevention, available for students in state foster care – contribute to young people’s physical, spiritual, and moral development. Thanks to support from the Ministry, the children’s home arranged several drug prevention programmes in 2002, and in addition, the Fifth Conference for Continued Training on Health Development and Drug Prevention was also organised.
**Dzsumbuj (Project Slums)**

Established in 1937, the Dzsumbuj has been offering housing in the 9th District of Budapest for all sorts of non-standard lifestyles, including many forms of deviance. Currently, its inhabitants are mostly Roma families.

Since 1998, the Dzsumbuj Help Centre for Community Development has been hosting an outreach-based needle exchange programme supplemented with a harm-reduction information service. This programme is run by the Civil Harm-reduction Social Contact Programme, with the “Kék Pont – Kettspont (Blue Point – Double Point) Drug Consultation Centre having joined the project in mid-2002.

In 2002, we supported the organisations running this programme.

**Activities of the Crime Prevention Service of the Hungarian Police**

The Police play a definitive role in reducing the supply of drugs and also in reducing demand for them. The prevention of drug use and drug-related crime has for long been a priority among the objectives of the Police’s Crime Prevention Service. Our colleagues have launched numerous programmes, organised events, and held presentations in order to familiarise young people with indispensable information for constructing a healthy, drug-free, and crime-free approach to life.

The Crime Prevention Service tries to seize every opportunity to convey information to certain societal groups, based on valid and precise police work about the drug phenomenon, its dangers and its legal and social background.

In connection with drug prevention, county departments for crime prevention strive to reach a wide range of young people, conveying to them behavioural patterns to follow and calling on them to do so.

Their chief target is the 7-20 age group, teachers, parents, and helpers. Related to this is the Police’s continuous programme called the “DADA” Programme (Primary School Drug Prevention Programme of the Hungarian Police) renewed in 2001, and the Police’s Safety Instruction School Programme, which was listed in the National Drug Strategy. Based on existing practice and applicable internal norms, we have secured the continuous operation of this Programme and have organised training to prepare newly-enrolled police officer instructors. Inasmuch as resources allow, we wish to increase the number of schools, classes and participating police officers in the 2003/4 school year. We have also started developing an elementary school version of the “DADA” Programme.

In 2002, we implemented the methods we had developed over the previous years and we have developed them further, both in terms of quantity and quality. In that year, the Crime Prevention Service made publications, information brochures, professional literature, posters, and video materials available to everyone interested. In order to inform the public, we have also taken advantage of channels provided by the media. We have participated in conferences, professional forums, and debates. We stressed continued training for the police force and we also organised a national training on guidelines for youth protection and drug prevention. We ran programmes of our own in connection with the UN International Day against Drug Abuse and Illicit Trafficking (June 26), including an entire day’s professional programme complete with music at the Aszód Juvenile Home for Boys. Our representatives were present at the Sziget Festival, running a joint stand with researchers from the AIDS laboratory of the László Hospital, and meeting young people together. We also paid special attention to drug prevention among Roma youth. We developed our nation audiovisual programme about drugs and the law, entitled “Jogodban áll ismerni” (You have the Right to Know). We took part in the preparation of a specialised book entitled “Ne legyen több áldozat” (No More Victims). We participated in preparing teachers as part of the Ministry of the Interior’s drug programme. We cooperated with all those governmental, municipal and non-governmental organisations whose goals and methods we identified with and shared.

We submitted a report to the Coordination Committee on Drug Affairs about the Police’s experiences with drug prevention programmes. We continued to participate in the work of expert
committees, and we represented the Police whenever we were asked to do so. We also took part in preparing drug affairs coordinators in schools.

**Telephone support services: 2002**

Over the past years, drug use has spread considerably among young people. Approaching the problem and dealing with the phenomenon takes place in a multi-layered, interconnected system. One ingredient in the prevention system is the national help-line telephone service, which has its own tools for assistance and views the range of problems at hand through this filter.

**Aims of telephone services:**

The slogan for telephone services as well as NGOs and health institutions receiving phone calls could be the following: “Assisting individuals and families that have encountered drugs and are struggling with drug problems”. Through securing anonymity, the telephone service is genuinely suited for a national drug strategy objective; after all, besides those who consume illegal substances (addicts), members of their nuclear environment (parents, siblings, relatives, friends, teachers, colleagues, or even passers-by) can call the service.

Assistance over the phone goes beyond simple information provision (recognising symptoms; consequences of substance use; addresses of treatment locations including drug outpatient clinics and hospital units; NGO-run low-threshold options and their availability) to conversations with addicts, and addressing treatment options. Help over the phone spans the entire length of the crisis and often means more than just a single phone conversation. We wish to stress the importance of “conversation”, for its socio-psychological effects are becoming more and more clearly discernible to us. Young people living in urban and rural areas make numerous calls to the phone services starting with the sentence “Will you talk to me a little?” They have a real and acute need to approach someone they regard as competent in order to talk through issues, values, and problems occupying them.

A secondary goal of telephone services is to have addicts enter the treatment chain at the most optimal point, where they can receive professional help that meets their needs.

**Professional background:** Telephone services are staffed by trained volunteer operators, addiction helpers, social workers, psychologists, teachers, as well as college and university students. Having completed the training cycles that had been developed, the volunteer helper can assume the role of telephone operator. Their training is continuous: there are presentations by practicing professionals, professional events, studies, and specialised literature.

Supervising groups further help telephone operators in their work. At these group meetings selected cases and calls are discussed – calls that were educational or emotionally too intense for the operator. Thinking together allows operators to develop attitudes that will highlight the image and unique features of a telephone service.

The features of telephone services operating throughout the country: Among telephone services currently in operation, the help line run by the “Drog Stop” Budapest Association stands out; it targets addicts (users of illegal substances) with call answering available non-stop and free of charge throughout the country. The help line receives calls from all area codes and networks. Through its free availability, this telephone service is indeed the very first link within the drug prevention network.

The Gyöngyház (Pearl House) Association in Pécs is another free phone service available throughout the country. But in order to keep it sustainable, the service has to work with periodic constraints and the exclusion of certain area codes and mobile networks.

In the case of these two services, the protocols regarding how calls are received and handled at classic help lines are followed.

Several drug outpatient clinics receive drug-related calls for help. But these numbers can be reached during work hours only, and they often accept only calls initiated within the same area code.

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32 This summary was prepared by Dániel Somogyi.
Most calls come from addicts undergoing treatment are checking in or calling back. We have at our disposal data from the drug outpatient clinics in Pécs, Debrecen, and Miskolc. These outpatient clinics accept calls in such a way that those taking the calls (usually assistants) introduce themselves so callers know who is at the other end of the line. On many occasions, callers also introduce themselves over the phone; after all, they tend to maintain some sort of personal contact with the outpatient clinic.

We extrapolate from data on phone calls to the drug outpatient clinics just mentioned, in order to reflect the activities of other drug outpatient clinics in operation; these results will be displayed below.

Several NGOs involved in rehabilitation work receive phone calls, but these are not available non-stop and the calls are not free of charge. Of these, we include data from the Drogfree Association.

Some civil youth organisations also have telephone-related experiences. Perhaps the most widely known is the Kapocs (Link) Youth Self-help Service, which also accepts calls. Their service has a time limit and calls are not free of charge. We should also emphasise the fact that there is no direct line, so callers must be transferred from the central number of the Petfi Csarnok (Petfi Hall) to the person on duty. Callers must therefore be extremely motivated to withstand all these transfers just to be able to discuss their problems.

Several help lines, such as spiritual help phone services, and the “Blue Line” targeting a young audience, receive calls about drug-related topics, but we have no available data on these calls.

Help offered over the phone is diverse, with unique features, depending on the organisational framework within which the services operate. The framework allows callers to select information and programmes according to what they need. The relevant NGOs’ main activities are phone inquiry-oriented, and the majority of calls received inquire about entering their programmes.

Data from telephone services – let us review available data based on various types of organisational structures: healthcare (drug outpatient clinics), NGOs, and help-line telephone services.

**Drug outpatient clinics**

- Miskolc Drug Outpatient Clinic: 2,960 calls
- Pécs Drug Outpatient Clinic–Drug Rehabilitation Home: 4,000 calls
- Drug Outpatient Clinic Debrecen: 3,848 calls
- 10 other Drug Outpatient Clinics total (estimated value): 39,000 calls
- Total: 49,808 calls/year

**Distribution of calls by content** (based on data from J. Szemelyác M.D. at the Baranya County Municipal Foundation for the Treatment and Employment of Addicted Youth, similar call volumes can be assumed at other drug outpatient clinics as well):

- new clients average numbers: 10-15 persons/week x10 drug outpatient clinics
- appointment requests from therapy participants: 20-25 persons/week x10 drug outpatient clinics
- calls for assistance from therapy participants: 15-20 persons/week x10 drug outpatient clinics
- inquiries from friends and relatives: 10 persons/week x10 drug outpatient clinics
- anonymous inquiries about the effects of substances: 5-10 persons/week x10 drug outpatient clinics
- professional consultations: 10 persons/week x10 drug outpatient clinics

**Distribution of used substances by kind** (Based on data from Mrs. Ferenc Dula, assistant department manager at the Miskolc Drug Outpatient Clinic, similar distribution can be assumed to hold for other drug outpatient clinics as well):

- club drugs: 25%
- heroin: 20%
- marijuana: 15%
- organic solvents: 10%
- polytoxicomania: 10%
- alcoholism: 10%
- gambling: 10%
No information about sex and age distribution was available.

**Data from the national phone service “Drog Stop” help line.** The data below, recorded by MATÁV Hungarian Telecommunications Company, shows calls by area code.

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It is important to emphasise the number of calls from mobile phones, because these have been linearly increasing year after year, indicating changes in communication habits. The area codes from which most calls are made are assumed to correspond to the most infected areas.

Below we will analyse calls registered at “Drog Stop”. (Data from the Gyöngyház (Pearl House) Association were not available.) In each case, distribution of data is in terms of percentages.

**Distribution of callers by sex**

![Pie chart showing gender distribution of callers. 27.4% female, 20.4% male.](chart.png)
Age distribution among callers. Despite the fact that the callers are not always substance users, we can still detect that the 18-20 and 21-23 age groups call most frequently. A smaller but still significant number of calls come from the 14-17 and 24-27 age groups.

Who called? 71% of callers are seeking solutions and help for their own problems.

Who called? II: We can see from the further division of the “Other person” category that there is an almost even distribution of parents, and members of the same age group calling, both male friends and female friends. There is a lesson to be learned from the fact that a mere 1% of callers are teachers. Perhaps we should make it a point to reach them and call their attention to the telephone service?
The nature of the conversation

Outcome of the conducted conversations, based on consensus achieved.
Since when have they been using drugs? The picture we see can seem frightening, because we lack data about 26% of callers (they declined to reveal information), so they are the only group that we can count on as being non-users. This number coincides with data collected among secondary school students.

Distribution by drug type I: users. Based on information from the telephone service, we see that the most widely used drugs are marijuana and hashish. Ecstasy and speed place second, together accounting for 24% of drug use. Alcohol and medication consumption (the incidence of sedatives and mood-enhancers) is surprisingly high.
Distribution by drug type II: requests for information

Call distribution I: by the hour.
Despite a high call volume throughout the afternoon, the increase in the number of calls at 9 p.m. is striking.

Call distribution II: by the days of the week.
The increase in call volume marks days off; compared to other days, more calls come in on Tuesdays and Saturdays.
Call distribution III: by month.

Spring time, with time spent outside and with friends, coincides with an increase in call volume. This is followed by the end of the school year, when other tasks might become more prominent. Then comes the time for summer vacation spent with friends; after that, fall depression at the beginning of the school year sets in. All these are left behind during the last month of the year.

Treatments for Drug Users

Sobriety-based Treatments Targeting Abstinence

No longer can we find progressive practices for addiction treatment that regard achieving abstinence as a satisfactory therapeutic goal in and of itself, without follow-up treatment. At the same time, there are several prominent therapeutic approaches and programmes in which abstinence is not a necessary condition for therapeutic change. But such programmes are not considered sobriety-based. Unlike the meaning of the term in everyday usage, “sobriety” in addiction literature does not simply mean a state of abstinence from drugs and alcohol, but involves a drug-free or alcohol-free state combined with a productive lifestyle and continuous development. Even in a best-case scenario, achieving abstinence and stopping substance use are no more than early steps in the course of treatment; by themselves, they do not alter the habits of substance use. Good therapeutic programmes are systematic, multi-layered, multidimensional, inclusive, and offer a colourful palette of services. The National Strategy for the Reduction of the Drug Problem places the task of treating withdrawal symptoms and achieving abstinence within the context of the chain of treatments from first contact to rehabilitation. Depending on the intensity of withdrawal symptoms, abstinence can be achieved with or without special detoxification. One option is medication-based special detoxification, another known option is the practice of medicine-free detoxification at home. After achieving abstinence, psycho-social and community support guidelines for treating addiction offer directions for promoting and formulating changes that will lead to a productive lifestyle.

The dynamic model of recovery distinguishes the detoxification phase as well as early and continued recovery phases. (Brown, 1985) Significant recovery factors are encompassed by the physical, psychological and social dimensions, as well as the addictive dimension, narrowly construed. The Prochaska–DiClemente recovery model, influential in the 1990s, also relies on recovery in phases. (Rácz, 1999)

The detoxification abstinence-adjustment period includes the weeks following the last occasion of substance use. Quitting substance use can produce unpleasant and at times potentially life-threatening physical withdrawal symptoms. Not every mind, mood or sensation-altering drug results in withdrawal symptoms upon discontinuation. Such symptoms are rare among users of hallucinogens,

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34 This summary was prepared by Gábor Kelemen M.D., director of the Drug Rehabilitation Institute of the Leo Amici Foundation.
cannabis derivatives, and inhalants, but relatively common among users of alcohol, opiates, sedatives and stimulants. Medical therapy for withdrawal symptoms, which also serves to reduce the extent and frequency of complications, is never applied as a sole method of treatment but is always accompanied by supportive empathic care. Providing appropriate nutrition, sleep, and quiet are also part of the physical treatment. Within the scope of drug patient treatment in Hungary (in outpatient and hospital inpatient care alike) treatments for detoxification and stabilising abstinence are available. In medical treatments of withdrawal symptoms, benzodiazepines are common, while in the case of adrenergic substances and opiates, methadone is widely used, and in the case of smokers, nicotine-replacement therapy has become widespread. In treating alcoholics, disulfiram, naltrexone and antidepressant pharmacotherapy have gained acceptance. Various pharmacotherapeutic attempts exist and are implemented for reducing cravings for the substance, but reflex conditioning and aversion treatments with emetics (vomit-inducers) have by now been universally discontinued. A narrow circle of opiate users receive methadone maintenance therapy. Conceptions in alternative medicine have inspired occasional ear acupuncture treatments for drug users and alcoholics alike.

Switching from substance use to abstinence results in significant psychological (emotional, cognitive and behavioural) changes. Despite the fact that at the beginning of the abstinence period the patient's life revolves around the substance just as before, now the goal is entirely different: it involves discontinuing substance use. Beforehand, the substance itself used to provide the principle for organising the patient's time and life; by contrast, at the beginning of abstinence, life almost entirely revolves around tasks having to do with avoiding the substance. In terms of developmental psychology, the person who switches to abstinence is in many respects similar to the extremely dependent newborn who is in need of extensive outside support. During this period, social learning based on model-following and imitation plays a key role. Drug addicts are under the impression that the substance is an inevitable part of their life. In such circumstances, the trustworthiness of a recovered substance user participating in the treatment can provide irreplaceable hope for patients. It is therefore particularly important that the multi-professional treatment staff include at least one sober addiction patient. In this phase of the treatment, the patient simply cannot understand sober ways of thinking and talking, and cannot yet internalise sober discourse.

A characteristic of this phase is regression, the temporary return to an earlier, more primitive state. This can liberate and trigger latent forces of development that are otherwise impeded, thus freeing up the personality's creative potential, which is in turn fundamental in correcting mental distortions, faulty integration, and false associations. In a safe and supportive environment, the patient is given the opportunity and is encouraged to try out new behaviour and attitudes in an "as if" format which is therefore retractable. These can be the beginning of "deciding again" and "growing up again". Substance use is often accompanied by comorbid states surfacing as externalisation (e.g. hyperactivity) or internalisation (e.g. anxiety, depression) disorder which play the role of mediator in the aetiology of substance use. (Tarter, Vanyukov, 2001) Often the diagnosis of a comorbid state cannot be reliably confirmed until a later phase, that of early recovery.

Losses during the period of substance use (e.g. a spoiled relationship, lost job) will not be automatically recovered through abstinence. The first social task of the abstinence-stabilisation phase is awakening curiosity about and need for new, healthy, sober relationships. In the case of inpatient treatment within a rehabilitation institution, one fundamental goal behind group work and occupational therapy is to dissolve the patient's earlier isolation through dynamic social relations. For outpatients embarking on abstinence, daily intensive, inspirational group therapy is recommended. Besides group therapy, it is also important to develop a psychologically different kind of sobriety-supporting relationship (e.g. with a therapist or self-help sponsor). Family relationships of addicts tend to be dysfunctional. Relatives have grown used to acting in place of the patient and bearing the consequences of substance use. Such attitudes do not serve to aid recovery. Assistance provided by professionals and peer-helpers carefully follows the principle of "good enough", offering only a minimal amount of social support that does not yet thwart the patient's powers to self-activate and self-organise. The "art" of attentive
treatment and confrontational cooperative care (carefronting) is a matter of not just knowing what to do, but also knowing what not to do. The goal of systematic family therapy is to develop healthier psychological boundaries and activating the family’s healing resources. Relationships with peers provide greater and more secure resources in recovery than do family members who are struggling with hostility-dependent relationship patterns.

Within the dimension of narrowly construed addiction-work, the main task at the beginning of the recovery process is reducing denial. Denial is a primitive avoidance mechanism by means of which the patient systematically excludes and distorts information about the consequences of substance use. Denial had helped sustain substance users’ basic mistaken belief that they are not addicted and can freely control their use of the substance. Patients primarily ask for treatment of pain and suffering. They would rather preserve the possibility of substance use which they regard as vital, than want to give up on it. It is important to determine whether their motivation to participate in treatment goes beyond “escape”. Breaking denial requires developing new, sober logical structures, attitudes and lifestyle. Patients in less denial begin to see their own story in a different light, and this process slowly leads to a change in their narrative identity. The new life story reinterprets events and experiences, endowing them with coherence, and thus foreshadows a hope for a favourable change in the future.

Recent research has shown that double addiction (e.g. the patient is simultaneously addicted to alcohol and drugs) is a frequent phenomenon. (Volkow, 2003) These data emphasise integrated treatment for drug dependence and alcoholism along with the task of preparing for combined treatment of double addiction.

Recovery requires personality changes (internal) and lifestyle changes (external). In sustaining the process, improving coping mechanisms and creating new ones becomes inevitable. The early recovery period is often characterised by a sense of being filled with strength and freedom. This tends to be a defence to keep lack of confidence and self-evaluation troubles lurking in the background, away from conscious awareness. Freedom from barriers, getting rid of gnawing hardship, and freedom from feeling negative are favourable factors in efforts geared towards physical and social improvement. But the strategic task of maintaining sobriety can overwrite and temporarily suppress these efforts.

After the “honeymoon” of early recovery passes, patients often become bored, anxious, irritable, enervated, have problems concentrating, and can develop powerful cravings. At this stage, patients are often haunted by guilt and shame. These are signs of doubt and ambivalence about the new changes in personality as well as resistance towards those changes. New relationships based on mutual assistance, together with regular work can, in time (along with the new tools of coping with stress and anger) get patients past the ambivalence to make a commitment to a lifestyle seeking drug-free, new sources of joy.

According to Martha Morrison’s (1990) formula:

Sobriety = abstinence + adopting the tools of rehabilitation

Rehabilitation tools include, among others, developing an awareness of warning signs and factors that can lead to relapse; developing the ability to avoid risky situations; continued, regular attendance of a self-help group; taking advantage of a sponsor; and following the rehabilitation programme. Abstinence is a necessary but not a sufficient condition of sobriety. Maintaining sobriety takes relationships that offer inspirational partnership, roles and tasks; a modified self-determination that promotes adjustment and emotional balance; an altered, systematic approach to and explanation of phenomena and problems; and assumed responsibility for self-transforming development.

The most secure foundation for maintaining abstinence is attendance at self-help group meetings and active participation in their programmes. Over the past decade, the number of self-help groups in Hungary has been steadily increasing. Alongside AA (Alcoholics Anonymous) and NA (Narcotics Anonymous), ACA (Adult Children of Addicts) groups have appeared. Besides these self-help groups that follow the 12-step programme, there are also alternative self-help groups. During the phase of continued recovery, a drug-free lifestyle remains a priority. The identity of the addict solidifies through reinterpreting the past and through learning to avoid substance use (where previously substance use
itself used to be definitive). In the patients' system of values, altruistic values (e.g. selfless giving and volunteering) become increasingly significant. The task of taking care of themselves and their own well-being (health, development) becomes central. Self-care is a matter of avoidance mechanisms (sublimation, humour, willingness to compromise, delayed satisfaction, etc.); a balanced way of life (financial and time management, recreation); and membership in a sober local community providing intimate social relationships that are optimally nurturing and frustrating. Peers continue to play a defining role in individuation and identification. For individuals who have become productive citizens committed to and integrated into a sober local community, abstinence becomes a self-integrated adjustment: a routine attitude harmonious with their personalities. They possess sufficient self-power and self-confidence to readily ask for help when they encounter difficulties. Continued recovery is marked by positive freedom, which means acknowledging the dependence of the part on the whole (supervisory centres), resisting unrealisable desires, and obeying the kind of law that we have prescribed for ourselves. Those who live sober lives are completely aware that unhealthy habits and substance use thwart positive freedom.

In Hungary, as elsewhere in the world, professionals accept the multidisciplinary nature of models interpreting addiction as well as multi-professionalism in treatment. In connection with interpretation models of substance use, widely accepted are the ethical, the disease-based, the theoretical social learning, the public health and the existential approaches. (Pols, Henry-Edwards, 1991) In contrast with old moralising attitudes, the ethical approach lends meaning to the narrative of recovery and provides a pattern through a coherent narrative frame for deciding again and starting over. Experience has shown that metaphorical stories—about the “return of the prodigious son”, about the “butterfly emerging from its cocoon”, about awakening consciousness, about breaking the negative trend that has lasted several generations, and about the victory of reason, serve to provide a feeling of empowerment for patients. (Hyanninen, Koski-Jyannes, 2002)

Ildikó Ritter’s study about Hungarian abstinence-based treatment institutions provides a good overview (Ritter, 2002). Of the major therapeutic guidelines, it is within 12-step programmes that abstinence is regarded as most prominently inevitable. 12-step programmes, based on the conception of lost control, take their goals to be the following: integration into self-help groups, accepting one’s identity as an addict, changing negative attitudes characterised by denial, and following the sober programme. Cognitive behaviour therapy programmes stress self-control and self-efficacy. These programmes try to enforce patients’ abstinence through skills development, helping to avoid alternative substance use, correcting faulty reasoning schemes, all without enforcing patients’ identity as addicts. The conception behind motivational therapy aims to illuminate the process of treatment, to provide reasons for its principles and main work methods, and to adjust to the needs of clients. The aim of the kind of motivational therapy that expresses empathy and creates discrepancy through motivational interviews is to bring about favourable changes in substance consumption habits. That change can be abstinence, but it can also be reduced use or a change in the nature of consumption. Provided that the substance is not illegal, it is only in the case of addicts that commitment to abstinence can be regarded as an unconditional goal. Because the incidence of excessive consumption in society far exceeds that of addicts, in the majority of cases, the goal is not abstinence but the less radical alternative: supporting change. (Carroll, 1997)

Up until now, apart from self-help groups, abstinence-based treatment has largely been confined to health institutions. Besides drug rehabilitation institutions that have, for the most part, been operating as therapeutic communities, there has been virtually no abstinence-based treatment conducted at social institutions or within the social care framework. At the same time, unlike in the practice of industrially developed countries, social work has been neglected in the activities of most Hungarian drug treatment institutions.

Since 2003, with the inception of community-based addiction treatment, a marked change began in one important area of cooperation between social and healthcare. Starting January 1, 2003, with the 2002 modifications of Law no. III (1993) On Social Management and Services, the range of tasks for
municipal governments has been extended to include addiction treatment. Community-based addiction treatment is a so-called special form of basic care constituting an objective independent of basic social care objectives in some ways, and dependent on them in other ways (e.g. family support). These special care objectives can be handled within the scope of a treatment centre or a family support service. Occasionally there is no treatment centre or family support service operating in an area. In these cases, the municipal government takes care of special basic care on an individual basis and can issue contracts to other organisations, thereby allowing for better access to special services for those who need it. The work involved in special basic care takes a well-prepared professional. The services to be arranged for special basic care have to be complex and integrated, and they must function cooperatively with other operating groups and treatment centres in providing services for clients. Based on individual treatment plans, community-based treatment is collectively provided by a group of professionals and helpers, taking into account the individual needs and condition of clients, building on their (and their environment’s) willingness to be active and responsible. Through skills development, psychological-education, and improved stress management, their joint aim is to assist clients in realising their goals. That goal might be to target abstinence-based sobriety or to reduce substance use. Community social workers and community coordinators are in charge of community-based addiction treatment. Even though training for community social workers and community coordinators is only now being organised, we can expect that addiction community treatment will bring together social, healthcare, municipal government and civil services, and that it will promote more efficient and human-centred uses of resources, thereby setting in motion community resources in an efficient, integrated, flexible and auxiliary way.

The principle of community-based treatment for addiction has substantive ties to a new movement in health development which within Hungary has had great impact on mental health. Ever since the mid-1980s, public health has witnessed a gradual shift from the earlier biomedical orientation to an ecological approach that focuses on the social and environmental aspects of health. The WHO’s Ottawa Charter, published in 1986, formulated this point succinctly “Health is a resource for everyday life, not the object of living”. The following principles behind the new programme of health development were formulated at that point: strengthening and developing individual and community skills and actions; reorientation of healthcare services while concentrating on availability, access and use; local society participating in collective actions; developing a local environment conducive to healthy individual and community life; and finally, developing community policies to support health. On the one hand, working with the community means reducing the community-level risks associated with drug traffic, prostitution, intravenous substance use, adverse living and transportation conditions, unemployment, inadequacies in education, etc., instead of blaming victims. On the other hand, the task involves making a sober life without substance use seem attractive. Enhancing social justice and equal opportunity is fundamental in health development as well as harm-reduction. Modern health development programmes have room for abstinence along with efforts towards abstinence as well as harm-reduction.

In recent years, we have witnessed a rise in the value attributed to sobriety within the European Union. Since 1997, more and more has been written about the issue of improving the quality of society, how this can be done, and how citizens can become more active and prepared to participate in the social and economic lives of their communities in order to enhance their well-being and opportunities. Sobriety, which enhances the individual’s regeneration and reintegration potential, is intimately connected to these themes about the quality of society.

The National Strategy builds on cooperation among members of local communities and has realised that coordinated collective efforts can greatly magnify the effects and results. One example of this is the establishment of Coordination Forums for Drug Issues (CFDI) based on the National Strategy. Sober local communities – based on self-help principles and often motivated to volunteer – are great resources for CFDIs as well as community-based addiction treatment. Members of these groups have experienced suffering and have transformed it into an educational experience. Having thus preserved the experience of suffering and transformed their lives into unique protective filters, these tolerant, sober
individuals who are sensitive to difference and disability can act as engines of rehabilitation and progress within addiction treatment.

In closing, it should be noted that abstinence-based treatments are tightly wound up with sober efforts geared at developing a productive lifestyle. In theory as well as in practice, trends that admit and express integrative tendencies are in the forefront. On the theoretical plane, considerable integrative force is possessed by the psycho-social, systematic, and community support-based approach, which includes the dynamic model of recovery in terms of phases and dimensions. Approaches that determine treatment practices include those that target abstinence along with others within which abstinence is a possible but not necessary therapeutic goal. Community-based addiction treatment is a new development resulting from cooperation of and interaction between social and medical care. This new approach harmonises with goals that are prevalent within health development and mental health and geared towards improving the quality of life and of society. In realising these goals, sober local communities can play significant roles.

Sources:

Social work with drug users on the streets

National overview

Social work with drug users on the streets of Hungary still lacks the necessary professional protocol. The organisations involved in the training of social workers have, however, integrated social work on the streets into their curricula as an independent discipline.

Currently, there are over 20 organisations in Hungary that perform social work on the streets, mainly supporting the homeless. In 2002, drug users were the target group of 2 organisations in Budapest, and of a further 3 in the country. These organisations include specialist NGOs as well as street worker squads maintained by departments of various drug outpatient clinics. One new organisation has started street outreach activities since last year. On-site work normally includes not only volunteers but also former addicts who have quit their habit. Social work with drug users on the streets is in some cases intertwined with anonymous and free needle exchange programmes.

Funding:

Social work with drug users on the streets is still not regularly subsidised by the state. In 2002, only those street worker organisations that perform their contact activities under the umbrella of a day-time shelter for the homeless were entitled to receive state subsidies. This way, social work on the streets aimed at aiding prostitutes, disaffected youth, and drug users as well as at the operation of needle-exchange services are without regular subsidies. The organisations that perform social work with drug
users on the streets and needle exchange programmes are subsidised by the Ministry of Children, Youth and Sports and the Ministry of Health, Social and Family Affairs through grant programmes. Such subsidies granted through competitive tenders are very often the only means to cover operating costs – especially in the case of organisations based in the countryside. The organisations in the capital have a wider range of tendering opportunities. In its plan aimed at the reduction of drug use, the Municipal Government of Budapest treats social work with drug users on the streets and needle exchanges as matters of high priority, and, accordingly, issues a tender to provide funding for the operation of organisations in the city. In addition, from 2003, the Municipal Government of Budapest will provide the two Budapest-based organisations involved in street work with a new option for a regular subsidy, within the framework of a public utility agreement.

Cooperation, protection of interests:

The National Association of Street Social Workers, which was founded a few years ago, developed uniform professional guidelines for street social work as a methodology aid. The methodology covers street work with drug users only in part. Thus, there is still no workshop in Hungary to act specifically as a professional forum and a means to protect the interests of social workers who deal with drug users.

The Budapest-based organisations involved in street social work and needle exchanges have made a cooperative agreement in an effort to ensure their effective and coordinated operations. Cooperation covers the regular exchange of information and the division of city areas.

Overview in Budapest 2002, on the basis of the activities of Hungarian Baptist Aid

The Baptist Aid Endowment has been performing street social work with homeless drug users in Budapest since October 2001. In 2003, we introduced a street needle exchange as a service.

Description of the people using the service:

Our clients generally face desperate and hopeless situations with no real prospects. The overwhelming majority are unemployed, they are forced to make a living by begging, scavenging through litter, forging prescriptions, prostitution, distributing drugs, or committing petty theft, very often living day-by-day. In most cases, they form small groups of 2-5 people or larger ones with a headcount of 10-15, and spend both day and night together. It is also a very common and very important factor for new members of these groups to seem to have orderly backgrounds.

We do have, however, some clients who avail themselves primarily of organic solvents, who live in the solitude of, for example, caverns, abandoned houses, and staircases. In addition to their addiction, they often suffer from other psychiatric disorders, as well. Most of our clients were children-in-care, with an imperfect or no family background at all. Homelessness may also be due to unbearable family atmosphere or family relationships deteriorating due to the drug addiction.

Similar history and common life situations lead to a very strong internal cohesion within the groups of homeless drug addicts. For them, the primary goal is not to quit and achieve a life without drugs, but to obtain and use drugs together, and to share their individual situation/addiction with their peers. Most of our clients have attempted suicide on several occasions. The internal cohesion of the groups and the strong influence of key figures make it very difficult to quit the group and the habit, even more so since official treatment centres (hospitals, rehabilitation homes, reintegrating organisations) seem out of their reach. Out of their reach because they have no social security, no appropriate clothes, no hygienic appliances, no money, no cigarettes, because the services are subject to charges, because the clients are only on a waiting list and because they do not the answer to the question “and what to do when I return to the streets”?

99 % of our clients have no contact with any aid organisations. The remaining 1 % make use of needle exchanges.

The clients complain of being physically abused by the police on a regular basis, and that, being homeless, they are treated differently in hospitals and rehabilitation homes, too.
Drug use habits, health status:

Homeless drug addicts very often use more than one drug at a time. Only among those using organic solvents did we find clients that restricted themselves to a single substance. The most common combinations among our polytoxicomaniac clients are organic solvents and alcohol, alcohol and medicines, opiates and medicines, all supplemented with marijuana, heroin and amphetamines. We have no reports of cocaine usage. It is also very common for the members of our target group to switch between substances rather easily, depending on what they can obtain.

According to their reports, they frequently use a shared syringe and needle! 90 % of our clients who use intravenous drugs are infected with hepatitis, and we have one client who claims to be HIV positive, though this is yet to be evidenced. TB is also present, as are to deep abscesses resulting from intravenous drug use. The clients are further characterised by malnutrition, a lack of proper hygiene, and various skin diseases, such as the presence of parasites.

Cooperation:

We have experienced largely varied extents of readiness to cooperate. Apart from motivation, cooperation is, unfortunately, greatly influenced by the current status of the target group. It is impossible to hold a supportive talk or arrange a social issue if the client is suffering from withdrawal symptoms, is high, is busy obtaining their daily dose, or is hungry.

We have a client with multiple addictions who – in addition to our donation of food and clothes – only asked for help in the replacement of lost documents, but we have been unable to take any steps for nearly half a year, because the client does not come to the meeting at the agreed time or we find them in state that makes cooperation impossible.

On the other hand, we had a homeless heroin-addicted client, with respect to whom we were able to establish and apply the steps of the classic aid procedure after only one discussion.

Establishment and maintenance of a relationship, work method:

Generally, the members of our target group are happy to accept our approach, and we consider it a great achievement that many are even counting on us. However, we often face distrust and rejection with new clients.

Work method:
- research, data collection, analysis
- receiving homeless dispatcher calls
- reliance on existing old relationships
- getting in touch with local contact people
- ensuring a continuous presence, distributing donations at the discovered sites/hot spots, dealing with individual cases, and social work

We are currently involved in the mapping of the drug scenario in Budapest. Parallel to this, following the establishment of suitable relationships at the locations already discovered and a needs assessment, we have commenced establishing aiding relationships by means of distributing warm clothing, shoes, food, soft drinks and vitamin products. The distribution of donations help us get in contact even with clients who are the most reluctant to cooperate.

In addition to listening to individual cases, providing moral support, offering motivation and securing safer drug use, we help fulfil the following needs:

Arrangement of referrals to withdrawal treatments in hospitals or to rehabilitation homes, accompaniment to the entrance interview, location of lost family members through the Red Cross, helping to replace personal ID cards, social security cards, and birth certificates, transportation to lung examinations and public baths, distribution of blankets and other donations, assistance in obtaining disability pension, transportation to a needle exchange, binding wounds, arranging for admission to a hostel, providing information and help in applying for benefits, helping with the restart subsidy of former children-in-care, contact with the Institution for the Protection of Children and Youth, organisation of HIV
and hepatitis screening examinations, arranging for the vaccination of dogs, visiting in hospitals and rehabilitation homes, and providing information on what kind of support is available and where.

Our street workers always work in pairs, and are all equipped with a cell phone so that they can easily make necessary arrangements on the spot.

Form, time, and content of the service:

In the first few months, which were primarily focussed on the mapping of the drug scenario in Budapest, we worked normal hours, from 9 a.m. to 5 p.m. Later, however, in an effort to harmonise with the lifestyle of our clients, we had to make certain changes. We start every working day with a team discussion, where the experiences of the previous day and the tasks for the coming day are reviewed. Our street workers document each of their working days. The supervision kept every 2-3 weeks is very helpful to our work.

Number and age of people using the service:

In the course of our activities, we have visited nearly 180 different locations in Budapest. We have talked with police, street-sweepers, street orderlies, dog-walkers, park supervisors, toilet attendants, caretakers, pharmacists and a lot of homeless people. In 2002, we managed to enter an assisting relationship with a total of 67 homeless drug users, mostly men between the ages of 14 and 35.

Out of our 67 clients, we sent 4 to hospital, one of whom is currently participating in rehabilitation treatment. Another 3 clients were not motivated enough to go any further than the introductory talk, thus their problems could not be sorted out. 3 of our clients died, due most probably to drug overdoses, but our staff managed to intervene successfully in the case of 1 client, when they shook them out of their unconscious state in their hiding place.

Efficiency and effectiveness:

Effectiveness is very difficult to measure in the field of street social work, not unlike aid in general. The effectiveness of the work is largely dependent on the current status and motivation of our clients. Success may vary along a wide scale. We consider it an achievement if verbal contact is established and our donations are accepted. Going one step further, a trusting relationship must be established in order to secure that the clients share their problems with us. Maintaining contact and giving aid on a regular basis is a great success. The most comprehensive indicator of our effectiveness and success – one for which the utmost cooperation of the client is indispensable – is aid provided in quitting, preparation for hospital treatment, accompanying the client to the admission interview, and subsequent visits, keeping in touch.

Public benefit:

The street social work we carry out is primarily aimed at reducing the individual and social harm that occurs due to drug use, the problems of the target group, and at social work. Our staff are trained in all three of these fields.

In the course of our work, we have collected over 500 pcs. of used needles and syringes as well as potentially infectious accessories of intravenous drug use, such as spoons and filters from parks, playgrounds, and hidden corners of housing estates. The majority of the discarded syringes were collected in large housing estates in city outskirts.

In the course of collecting syringes and needles, we have collected several of these items from the sandpits of playgrounds. We have met children living in a housing estate who told us that one of them copied their elders and stuck a needle they had picked up from the ground into their arm.

While collecting the syringes we also notice that they are continuously replenished.

Summary:

Currently, most of the street social worker organisations deal with the homeless under the umbrella of aiding the same group, and occasionally aiding other groups. The system lacks sufficient funding,
most organisations cover their operating costs relying on their own resources and on subsidies granted in tenders, which usually proves rather difficult.

The direction of development may be the establishment of the methodology, coordination, and regular funding of street social work with drug users, the strengthening of cooperation among organisations, and the improvement of the protection of interests.
Harm reduction

Harm-reduction drug policy and harm-reduction programmes in Hungary:
Overview 2002

Introduction

Harm-reduction in Hungary is in a mixed situation even today, in the autumn of 2003. Mixed, since the situation can be assessed differently depending on if we look at current conditions as a candid picture or if we consider prevailing circumstances in light of the events of the past fifteen years. In the previous case, we must not forget to list a number of shortcomings, while in the latter, dynamic improvements are striking. The following short overview will attempt to provide a brief summary of the topic from both viewpoints. I will introduce the current situation of harm reduction in Hungary through a consideration of historical developments. Before that, however, it may be worth summing up the most important principles of harm-reduction drug policy.

Harm reduction and low-threshold programmes

Though the largely disputed harm-reduction approach is usually associated with the appearance of HIV in the early 80s, the approach itself is actually far older than that. This method has been applied in various other fields of medicine not related to addiction for centuries and millennia – even if under a different name. This approach is present in all the intervention modules which, recognising that a given problem or disease cannot be cured (at least not within the given time or period) will apply solutions that can reduce the harm that occurs, without the cessation of the illness. In the case of drug use, the basic foundation of the harm-reduction principle is that, accepting the fact that certain drug users will be unable or unwilling to quit drug use in a particular period of their lives, intervention is to be aimed at reducing the individual, community, and social harms occurring from the maintained drug use (see for example Inciardi and Harrison, 1999; Nemzeti Stratégia (National Strategy), 2001; Demetrovics, 2000 and 2003).

MacCoun (1998) defines two possible directions of drug policy. The first one is aimed at reducing prevalence, while the other focuses on reducing harm. In his system, the first school includes strategies serving for the reduction of both demand and supply. Although research shows that measures aimed at reducing supply may have a similar effect on prevalence due to shrinking availability (albeit sometimes they only lead to the restructuring of the market), they do not represent the ideal solution in dealing with the problem of drugs. On one hand, despite the sheer amounts utilised, they are not, on their own, effective in reducing drug use (Nadelmann, 1989), but, even more importantly, even if they do succeed to reduce prevalence, a side-effect is usually an increase in harm. The stricter persecution of drug users, for instance, leads to more secrecy, which has a negative effect on the number of users who seek treatment or request aid in an emergency. Similarly, the reduction of the availability of drugs leads to an increase in prices, and thus a rising crime rate among users, which obviously means more serious harm to the individual and society.

The most important characteristics of harm reduction – mainly on the basis of the works of Riley and O’Hare (2000) – can be summarised as follows:

• Pragmatism, i.e. accepting that drug use is present in the society and is, to an extent, a normal component of the same. Emphasising at the same time that realistic, attainable

35 The summary was compiled by Zsolt Demetrovics, researcher of the Psychological Institute and the National Drug prevention Institute of the Faculty of Education and Psychology of ELTE University
goals are to be set in the treatment of drug use (such as the reduction of harm) rather than desirable and ideal, unfeasible targets (such as a drug-free society).

- Focusing on humanistic values, that is, accepting the decision of the user to use drugs, and to refrain from passing moral judgment.

- Harm-centeredness. Understanding that the fact of using drugs is secondary to the harm caused thereby. This means that the problem is not drug use in and of itself, but rather the related harm acting on an individual, community, and societal level and its health, social, and economic connotations. The primary goal, therefore, must be the reduction of the negative effects of drug use.

- Inclusive nature. In order to attain its goal, the harm-reduction approach accepts rather than excludes different methods of intervention. This is based on the understanding that different cases require different intervention methods, in order to secure the most effective reduction of harm. Accordingly, harm reduction does not exclude, but does not expect the attainment of abstinence.

- Hierarchy of goals. In relation to the first clause, one of the most important characteristics of the harm-reduction approach is that it is capable of forming its goals in a flexible manner, taking into consideration the requirements, abilities, and opportunities of the target population and the client. Accordingly, goals may change even in the course of the intervention. In this approach, therefore, if the achievement of total abstinence from drug use is not a realistic target, the cessation of intravenous usage may be the goal. If even this seems infeasible, then going “one step lower”, we may specify safe intravenous usage (e.g. the application of sterile syringes, avoidance of shared needles, etc.) as the next goal. Apart from theoretical reasons, the realistic and hierarchical treatment of goals may prove crucial in order to avoid continuous failures and to secure success.

- Balancing costs and benefits. In the past few decades, cost-effectiveness and the analysis of costs vs. benefits have become increasingly important in social and healthcare work. The harm-reduction approach – partly due to its realistic and pragmatic nature – places great emphasis on the assessment of the proportion of results for a given investments.

Harm-reduction intervention methods are sometimes referred to as low-threshold services since these services set the threshold, i.e. the level of requirements towards the client at a far lower level than those treatment centres that consider it a basic prerequisite of admission to be devoted to abstinence. Apart from the fact that the use of the expression is made necessary by the low political and social acceptance of the harm-reduction approach (Rácz, 1999), “low-threshold service” does actually express the core of these programmes fairly precisely. The primary goal of setting the threshold lower is to maximise the number of drug users who can be involved in treatment. As numerous surveys suggest, a drug user involved in treatment is characterised by a more favourable somatic health and mental status, a lower risk of infection and death, as well as a lower likelihood of participating in crime (Sells and Simpson, 1980). If the threshold is set high, and abstinence is required, those drug users who are not capable or willing to cooperate with a given programme to attain abstinence, but are ready to make endeavours to quit intravenous usage or to achieve other harm-reduction goals, will be excluded from the treatment centres (Demetrovics, 2003).
Historical development in Hungary

In Hungary's relatively short 15-year history of the treatment of drug users, the harm-reduction approach has been present almost since the outset, without, however, spreading or gaining professional and drug policy support until recent years.

Needle exchange programmes have existed in Hungary since the early 90s, the first substitution treatments were administered in 1989, applying Codeine at the time (Dénes and Nyízsnyánszky, 2003; Demetrovics, Honti, Csorba and Szemelyácz 2001). In the course of the decade, contact activities that moved services to a site and attempted to move clients to the place of treatment also appeared. No organisations have, however, been set up for the protection of the rights of drug users, and grave shortcomings are evident with respect to day-time shelters and drop-in centres. Despite some initiatives, the operation of self-help institutions is far from well established. In 2003, the association of professional organisations and individuals who apply the harm-reduction principle and practice was founded, the aim of which is to inform professional circles and society, to organise trainings, to support the achievement of a professional consensus, and to protect the interests of this professional field. Even the areas which are relatively more established – such as methadone maintenance therapies and needle exchanges – do not operate appropriately. The proportion of drug users who receive methadone maintenance treatment in Hungary is extremely low in comparison not only with the European Union, but also with the Central and Eastern European region, while needle exchanges are only feasible in large cities (EMCDDA 2000 and 2002). An automated needle exchange device was set up in Budapest in the summer of 2003. Considering the entirety of the past 15 years, we are looking at a continuously strengthening and developing area, with a still high number of shortcomings at present.

Apart from the establishment of the abovementioned association, it is considered a professional achievement that the Psychiatric Professional College (1998, 2001a and 2001b) accepted the professional guidelines of methadone maintenance therapy and needle exchanges, while the ad hoc committee of the college prepared a manual covering the principles of methadone treatment (Gerevich et al., 2001). With respect to publications, harm-reduction is scarcely present. With the exception of a few comprehensive studies (see e.g. Demetrovics, Honti, Szemelyácz and Csorba, 2001) and some collections of studies dealing with a particular area (Rácz, 2002; Dénes and Nyízsnyánszky, 2003), there are very few works published. Similarly, research is lacking, there are hardly any initiatives for the monitoring or at least for the introduction of harm-reduction interventions. It is an important achievement, however, that in addition to Blue Point Drug Counselling Centre and the Outpatient Clinic, there are a number of organisations that set the provision of low-threshold services as the basic principle of their programmes.

Having considered the above, with the exception of a few organisations operating in Budapest and some county capitals, the harm-reduction approach has not become the basic framework for interventions and operation. Treatment solutions that require abstinence are still the most accepted both by treatment centres and by society. Despite this, the parliamentary Decree of December 2000 entitled National Strategy for the Reduction of the Drug Problem lays down the necessity of integrating the harm-reduction approach and harm-reduction programmes. The majority of professionals still approach this concept cautiously. The strange situation that has arisen is that instead of a clear drug policy-level subsidy relying on large-scale tendering (National Strategy, tendered grants, supporting the commencement and maintenance of concrete low-threshold programmes, etc.) both the professional circles and politicians think and act cautiously, in certain cases shyly, and in a more rejecting manner. This is most certainly due to the general social animosity towards the drugs issue. In this latter respect, it is crucial to communicate the purposes of harm reduction in a clearer and more comprehensible manner, reaching a wider public. According to international experience, it is a prerequisite of the
successful integration of harm-reduction programmes that public opinion accept this approach and, parallel to that, these programmes.

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“Dzsumbuj” (Project Slums)

The purpose of the following brief study is to provide information on the main characteristics of a programme that took into account special local needs when targeting harm reduction among Roma users of intravenous drugs.

The “Dzsumbuj” (Project Slums)

In 1937, a housing estate consisting of three buildings was built in the 9th district of Budapest, in an effort to alleviate the poverty related to the ever so common slums of the time. The estate soon became famous (and later infamous) under the name of “Dzsumbuj”. Local inhabitants established a unique way of life, which included various forms of deviance. The Dzsumbuj still exist, and although residents, most of whom are Roma, are mostly new, the estate has not lost its ghetto features and independent system of values.

Background

In 1998, as a result of the cooperation of the “Dzsumbuj Help” Community Development Centre (CDC) and the Civil Harm-Reduction Social Contact Programme (CHP), a harm-reduction programme (needle exchange) operated for a few months on the basis of contacting clients on the streets.

From mid-1999, the necessity of a new needle exchange programme at the estate became increasingly evident. The number of cast-aside used syringes found in the Dzsumbuj was growing, worrying the staff of the Dzsumbuj Help CDC and parents alike.

Concerns were intensified when it became known that several inhabitants of the estate are infected with hepatitis. In order to launch the programme, the Community Development Centre once more contacted the CHP. It should be noted that the re-introduction of the programme was justified by previous and indirect experience, no direct assessment of demand had been carried out.

In order for the basement room in the Dzsumbuj where the club operated by the Community Development Centre was located to be used as the site for the needle exchange according to the plans, permits had to be obtained from the municipality and the National Public Health and Medical Officer Service (NPHMOS).

The NPHMOS granted its permit relatively easily.

On the other hand, winning the consent of the municipality proved a bit more difficult. There was a significant difference between the circumstances of the previous needle exchange and the programme to be held, namely, the introduction of the Drug Act of 1998. Due to the severity of the law and the lack of any documentation analysing the law, as well as the municipality’s uncertainty concerning drug issues, the authority was reduced to a difficult dilemma. It was as a result of long negotiations that in October 2000, the Vice-Mayor did eventually agree to the commencement of the programme.

The commencement of the programme

Following the obtainment of the necessary permits and the signing of the cooperative agreement between the two organisations, the programme was launched on November 3, 2000. (In practice, the programme acts as the seat of the CHP.)

The actual site is the basement club of the “Dzsumbuj Help” Community Development Centre. In the early period, the programme was available on Fridays (excluding bank holidays) from 4 p.m. till 6 p.m., with the help of one, later two, volunteers. Since February 2003, the programme has been available on Wednesdays also. The tools and methods applied in the course of the programme are primarily focused on the exchange of syringes, the provision of accessories required for drug use, and

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36 As of May 13, 1998, the NPHMOS of the 9th district had already permitted the operation of a needle exchange programme with the cooperation of CHP, but this programme was terminated due to personal and governmental reasons. In the period between the commencements of needle exchange programmes in 1998 and 2000, practically the entire staff of the Community Development Centre was replaced.

37 Law LXXXVII (1998) on the Modification of Penal Regulations
the exchange of information and education (prevention). Thus, in the classical sense, no individual cases are necessarily dealt with under the problem, or only in very special cases and to a limited extent. If individual help is required, the programme acts as a mediator towards other programmes. The scheme is anonymous, which is secured by the application of personal codes.

It is important to note that from mid-2002 until July 2003, the “Blue Point – Double Point” Programme organised by the Blue Point Drug Counselling Centre joined the work in the Dzsumbuj by offering advice on harm reduction.

**Target group**

The members of the client group that we assume to be intravenous drug users are mostly within the same age group. The core of this community consists of 6-8 people, most of them between the ages of 20 and 23. By means of direct discussions, concrete information has been collected about them, but there were only estimates concerning the actual headcount and age range of the group.

It was of great help during both the planning and the commencement of the programme that some of my colleagues and I had had previous work experience in the Dzsumbuj. (Some of my colleagues had participated in the 1998 programme, while I was spending my six months of university professional internship in the Community Development Centre.)

**Opinions on drug use in the Dzsumbuj**

The Dzsumbuj has its own system of values, almost all components of which are seen as deviant by the outside world (Ambrus, 1988). Due to the nature of the estate, there exists a sense of community tolerance (primarily among men) towards alcohol consumption. If alcohol can be used as a solution to problems, then other substances can as well. In this case, the “solution” is drugs. It should be noted, however, that the acceptance of drug use is significantly lower than the acceptance of alcohol consumption, but this does not mean that users of these substances would be expelled from the community. Negative opinions on drug use mostly exhibit themselves on a verbal level.

The question of when drugs first appeared on the estate cannot be answered. It is certain that they were already present by 1994-95, and they were most intensely used by youth in the succeeding years. It is of great importance that those who had abused substances belonged almost without exception to a small circle, and they still do. Only estimates can be offered to assess the current intensity of drug use.

**Who uses the programme**

Up to now, the services offered by the programme have mainly been used by young men between the ages of 20 and 26. Some of the clients have a history of drug use that goes back for years, certainly at least to several months.
close group and are on the second or third highest level in the hierarchy. It is extremely difficult to find a stable position for these young adults in the system of relationships in the Dzsumbuj.

The programme involves not only inhabitants of the estate. Though rare, it is not unheard of for clients from the neighbouring districts or from a farther point of the 9th district to visit us on the recommendation of an acquaintance.

A becomes clear from discussions, the majority of the needles taken are distributed in the 8th district through the extensive network of relationships of our clients.

It is important to note that the attention of the next generation (those at the ages of 15-18) is increasingly drawn to drugs. There are numerous behavioural characteristics totally accepted in the Dzsumbuj that are considered risk factors for drug use, such as alcohol consumption, smoking, family and demographic factors, etc.

As for the gender distribution of clients, it is evident that the overwhelming majority is young men. Only two female patients were registered in the course of 26 months. In addition to the international experience of men's more frequent usage, the low number of female clients may also be due to the fact that the hierarchy of the sexes is very strong in the estate, and this is also evident during visits to the club. It may also be a restricting force that on any question, women in the estate are judged more severely than men. Having considered the above, I do not believe there are no female users of intravenous drugs in the Dzsumbuj, but it seems that the obtaining of both drugs and sterile equipment is up to men.

### Number of Clients 2002

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<td>Clients</td>
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### Client Traffic 2002

(Client Traffic = the overall number of client visits during the year)

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Most common methods of drug use

On the basis of reports by clients, it can be established that amphetamine derivatives are either snorted or intravenously administered. Drug use in most cases is considered as a social event. It is
important to note that unlike in other groups, the usage of amphetamines is not linked to party culture among the clients. Usage is practically a part of the daily routine. It cannot be attached to a sole location or event. The only exception is, for some clients, nightlong playing with slot (fruit) machines. Intravenous drug use is accompanied by marijuana use in all cases.

Clients claim that they inject drugs together, but use separate needles. If needed, they help each other out with sterile syringes, thus syringes are collected in the common “pool” of a closed company. Sterile syringes represent a value and their lack sometimes leads to conflicts within the group. I believe that in the course of shared usage, caution is still easily cast aside if clients cannot obtain sterile devices.

As became evident from the interviews, the youth close to the group who wish to try speed only snort the substance on the first few occasions, but then switch over to intravenous application shortly. Usually, new members are assisted by older users in the preparation and injection of the drug, with novice drug addicts switching over to self-injection once they have gained appropriate proficiency in the procedure.

The drug itself is probably also considered joint property, thus they do not use it at the same time, but divide it among themselves nonetheless.

Intravenous clients suspend amphetamine usage for a few weeks or even some months almost without exception, but carry on with marijuana over these periods.

The classic method of using solvents, i.e. sniffing them from a plastic bag is still present on the estate. This method is definitely rarer now than in the mid-90s, or at least it has become less apparent in the daily life of the Dzsumbuj. No users of this method attend the programme, thus it is very difficult to form an objective picture of the situation. Despite the information received so far from clients, local residents and colleagues, as well as my own experience, I dare not form a definitive opinion on this area of drug use.

Marijuana is widespread and commonly used on the estate. Unlike intravenous drugs, it is used by both the younger and the older generations. As for those above the age of 26, it is the most dominant drug next to alcohol. It is a regular part of everyday life, just like amphetamines, and its recreational value is not as strong as in other groups.

Needle turnover of the programme

When analysing the needle turnover, it should be taken into consideration that before the evaluated period, i.e. in 1998, there had also been a needle exchange programme in the Dzsumbuj. It is also an important factor in needle turnover that the programme was not at all times available to clients in the early period.

In the first 14 months, we witnessed a slow learning process. The first needle was collected four months after the programme was commenced. At the initial stage of the programme, we had to continuously try to make clients understand that the programme was not aimed solely at handing syringes out, but also at collecting them. It was a very slow process for the clients to understand that the risk factors to themselves and their environment can be reduced not only by using a sterile needle but also by collecting used accessories. The first breakthrough in this respect occurred when clients started to collect and return their syringes used for injecting insulin. Needles were continuously collected after 2001. (None were returned in six months of the first nine, and only 36 pieces in the remaining three.)

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38 Needle turnover shall in all cases mean the exchange of 1 ml insulin injectors.
In 2002, there was no month without a returned syringe. Clients noted the problem that they could not always safely store the used needles for several days and then bring them to the club. This was particularly difficult for those whose families are unaware of their drug use, but they do use intravenous drugs at home or outside the housing estate. In order to bridge this problem, in October 2002 we set up a collecting system where clients could dispose of their used syringes outside office hours. We collected a total of 101 needles between October and December 2002 with this method.

There was no month without needles given out. Our experience provides us with no clear reason for the changes in the number of needles handed out and returned.

By the year 2002, the circle of clients had relatively stabilised. Nine clients out the thirty-three took a hundred or more syringes. 79 % of the total number of needles handed out can be attributed to these people. As for returns, there are only three people who brought back at least a hundred syringes. These represent 67.5 % of collected needles. In 2002, there was only one client who used the services of the programme in every month. That client made up 34.5 % of syringes taken and 49.8 % of returned
syringes. In the course of an interview we found out that the client did not take all of these needles for personal use, but also to share with peers. The client acts as some sort of a mediator, a gatekeeper between the programme and the intravenous users in their group.

Needle Turnover 2002

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(blue section: Needles collected, red section: Needles given out)

**Experience summary**

The omission of a preliminary assessment of demand did not prove to be a loss in the programme; we could say that our estimates of the volume of demand were correct.

It was definitely a good idea to take the unique subculture of the Dzsumbuj into consideration. This is particularly true with respect to the range of services of the programme.

I would like to point out that available data and experiences are not sufficient to form a comprehensive picture of the circle of users. This would prove extremely difficult since the programme is still in the phase of integration – since it is a contact programme, it needs to find its place in the Dzsumbuj and become accepted by the local community – and the circle of clients is constantly changing. New clients use the programme, and through their participation we gain new experiences, which often lead us to revise out former conclusions.

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Workbook no. 27
Needle exchange programmes

According to a WHO statement issued in 1989, “needle exchange is the most effective tool in preventing the HIV and hepatitis infection of drug users”. In the countries that have modern treatment systems, it is beyond question that needle exchange programmes are necessary. “The most important methods of harm reduction (contact work, maintenance therapy, and needle exchange programmes) are applied in all countries of the European Union, and action plans emphasise their importance (from The anti-drug action plan of the European Union 2000-2004. National Strategy for the Reduction of the Drug Problem)

In relation to the spread of HIV, the importance of outreach work and needle exchange programmes is pointed out in the recommendation of the WHO European Office prepared for Eastern European countries as well as the anti-AIDS initiatives of the UN in Eastern and Central Europe (meeting and agreement in Geneva and Kiev, autumn 1999).

According to a survey carried out in 1994 in New York, participation in a needle exchange programme cuts the risk of HIV infection by half. Out of intravenous drug users who suffer from diabetes – and have access to sterile syringes – the ratio of HIV is 9.8%. But among those without diabetes, 24.3% of those with the same drug use habits are infected by the virus.

In Hungary, the “National Strategy for the Reduction of the Drug Problem” accepted by Parliament on December 5, 2000, places particular emphasis on harm reduction and its development. The short-term goals of the Strategy include (among others) the establishment and development of low-threshold services and harm reduction programmes (such as contact services, telephone services, providing advice, legal counselling, needle exchange, etc.) In addition, Government decree no. 1036/2002. (April 12) specified the significant development of harm-reduction methods (such as needle exchange programmes) as a priority task.

The needle exchange service available to intravenous drug users is a preventative intervention whose primary goal is to prevent the complications of intravenous drug use. According to extensive international experience, the most common of these consequential problems are infections transmitted in blood, HIV, hepatitis C, hepatitis B as well as dermatological problems related to inappropriate self-injection practices and surgical problems, among them ulceration, phlegmone, sepsis, and sclerotisation of the veins, which are common among both those who inject themselves regularly, (on a daily basis), and those who only use this method occasionally, for recreational purposes. The source of these complications is very often a ritual connected to drug use such as the application of a shared syringe, needle, or pot, or a lack of knowledge concerning sterility, resulting in, e.g., neglecting the disinfection of the skin. Thus even a single self-injection may lead to an incurable disease.

Apart from the above objective, needle exchanges are also a method of harm reduction, and it can only attain its intended target if applied within a complex low-threshold form of treatment. The purpose of harm-reduction treatment is to contact and monitor the patient who is (at the given stage of their drug use) not yet prepared for abstinence, and to secure a change in habits that pose a large threat, such as intravenous drug use, and to utilise tertiary prevention to promote a drug-free life. Considering that only 5-10 % of drug addicts attend examinations under the treatment system, harm-reduction intervention plays an important role in finding the drug user population that does not participate in treatment, the so-called hidden addicts.

The situation in Hungary:

The necessity for harm reduction among intravenous users, and especially for needle exchanges is underlined partly by the increasing proportion of this manner of administering drugs, especially among

39 This summary was prepared by Balázs Majzik and Dr Balázs Molnár, representatives of the Deputy State Secretariat for the Coordination of Drug Affairs at the MCYSA.
users of opiates, and partly because, in addition to the current 10-30% rate of hepatitis infection, HIV has also appeared.

Harm-reduction programmes were launched in 1996 in the cities of Pécs, Szeged, Veszprém, and Budapest. The organisational background is varied, and so is the scope and intensity of the service. At some places, needle exchanges are carried out as a secondary activity added to the original tasks of the institution, while other organisations, such as the Budapest-based Drug Prevention Foundation or the Drug Outpatient Clinic of Szeged, have a separate harm-reduction project with a needle exchange in the focus, covering a wide range of clients and supplemented by various other services.

In 2002, the Ministry of Children, Youth and Sports issued a tender for the establishment and development of harm-reduction organisations and services, and granted a total of HUF 44,795,000 to the 15 winning applicants.

Out of the tenders received regarding subsidising the services of low-threshold institutions and programmes, the Ministry granted a total amount of HUF 19,000,000 in the area of needle exchanges. It granted a total of HUF 31,080,294 in the framework of individual subsidies for needle exchange programmes.

Four-phase types needle exchange programmes:

- a) needle exchange project linked to a contact programme (outreach)
- b) needle exchange centres
- c) needle exchange bus
- d) automated needle exchange

**Needle exchange project linked to a contact programme:**

**Drug Outpatient Clinic in Szeged**

The Drug Outpatient Clinic in Szeged has operated a needle exchange programme since the early 90s. In the early stages, during the months of the poppy seed season, syringes (an annual total of 1,000 pieces) were exchanged in the facility of the clinic. Thanks to the assistance of the Soros Foundation from 1996, an outreach needle exchange programme was launched, relying on the professional training provided by the Integrative Drogenhilfe Institute of Frankfurt. Social worker students and active drug users are employed following specialist training under the needle exchange and peer training programme, both performed primarily in the course of street work. In 1999, the harm-reduction staff founded the Harm-reduction, Drug use Research, and Further Training Association of Southern Hungary (HDTA), and since then, the harm reduction programme has been provided within the framework of this NGO.

The purpose of developing the service is to secure the provision of low-threshold outreach needle exchanges for intravenous drug users who are not covered by institutional treatment. The drug outpatient clinic bidding for the implementation of the programme plans to target the intravenous drug user population that is excluded from institutional care with harm-reduction intervention. Of the interventions recommended by the World Health Organisation, the amount granted shall be utilised to carry out “information/communication”, an outreach programme and needle exchange scheme.

In the course of the “information/communication” intervention method, the target group, those intravenous drug users who are excluded from institutional treatment, are provided with customised informational material appropriate for their age and lifestyle, either in a written or an Internet-based form. The informational material shall be evaluated by volunteers from the target group utilising the “focus group” method. The informational material is divided into two parts: information on and availability of drug clinics and other services in the city; and a presentation of the risks of intravenous drug use. Considering the habits of the target group, an Internet portal has been set up, which contains information for users as well as professional materials. In the course of community outreach programmes, street social workers and former or current drug users who have received specialist training (so called peer tutors) contact the hidden population in their most common gathering points, in
subways, clubs, and flats and present information on the safer use of drugs. They get in touch with active drug users, groups, and networks, and establish relationships of trust. They provide information on risk behaviour and propose alternatives. According to Dr Judit Honti, the alternatives to intravenous drug use are organised in the following hierarchical order: “1.) the first recommendation is to cease using drugs, and we should provide the necessary basic information, treatment centres, treatment methods and conditions; 2.) if the client has not yet resolved to do this, they should switch from administering drugs intravenously to other modes of administering the drug; 3.) if that is not possible, they should be provided with sterile accessories for each injection; 4.) if that is not possible, they should only use their own apparatus repeatedly, always disinfect and never share their drugs or appliance with anyone; 5.) if they do share their apparatus, always be sure to apply antiseptics, and regularly take HIV and hepatitis tests.”

In the course of outreach programmes, street social workers also distribute publications on safe drug use, safe sex, treatment centres, emergency help centres, and anonymous telephone help services. During the several months of outreach contact, the street social worker will have the chance to see the downslide of the drug user’s career, and, thanks to their position, may intervene in the process at numerous points by providing assistance and proposing alternatives. The worker may motivate the client to attend examinations, counselling, or a withdrawal treatment, to accept legal and social help, and as an ultimate goal, to choose drug-free life.

Needle exchange programmes also serve as a collective name for all harm-reduction intervention strategies that not only provide education for healthier living, but also remove infectious appliances and offer sterile tools as well as apparatus aimed at securing sterility and preventing infection. The goal of this is to make intravenous injections administered outside the framework of healthcare treatment safer. Applied tools: syringes, needles, insulin syringes, wipes to disinfect skin, condoms.Used syringes are collected and forwarded to a hazardous refuse burner. The proportion of exchanged needles varies. According to international experience, 70-75% of the sterile syringes handed out may be collected.

Since 1996, five street workers have performed such tasks in four hours on five days of the week. In the course of their activity, they keep in regular contact with drug user clients, currently a total of about 500 people. Street social workers can be contacted by mobile phone and they also regularly visit the flats and other public places most often frequented by drug users. Street social workers offer counselling and needle exchanges, and they try to orient clients towards healthcare and social treatment. Every street social worker receives a protective inoculation for hepatitis B. They accompany clients to free and anonymous HIV and hepatitis examinations, keep in touch with treatment systems, provide early warnings about changes in the drug scenario and the status and condition of clients. On a voluntary basis, the programme also provides clients with a hepatitis B (Engerix) inoculation free of charge, administered by a professional nurse. Street social workers use previously-developed coding for the registration of contacts and the number of syringes handed out and returned.

The directors of the programme summarise collected data, provide continuous training to the staff, and coordinate operations with partner organisations and the authorities. The programme director and his/her assistant head staff meetings where street social workers report on their weekly work, changes in the drug scenario and the status of their clients, and they also regularly attend further training courses.

**Gyöngyház (Pearl House) Group Pécs**

Needle exchanges in Pécs have a history of eight years. The issue of a needle exchange programme first arose in a group of youth in 1994, who then contacted intravenous drug users on their own initiative, without any institutional background. The volunteers distributed sterile needles to drug user acquaintances of theirs in the flats of the latter, and soon had to realise that there is great need of a needle exchange programme in Pécs. They started operating within the framework of an organisation in the summer of 1996, headquartered in the facility of the Drug Outpatient Clinic in Pécs. They have maintained good relationships with the Drug Prevention Foundation of Budapest from the outset, and received packages
of sterile needles, syringes, and wipes from the same. In the early stages, they only exchanged needles in the streets and in practice, in flats. Initially there were 4 street social workers in the programme. Apart from their work, contact with a total of approximately 20-25 drug users was established through a secondary needle exchange relying on the contacts of social workers. In this period, they handed out approximately 100-200 syringes every week, but they always collected more than they distributed. At the time, this represented coverage of approximately 70 %.

The programme was moved to a new building and became independent of the Drug Outpatient Clinic in 1997. (This was the time when they obtained the NPHMOS permit for the operation of a programme that served as a day-time shelter for up to 20 addicts.) The staff and some drug users teamed up to redecorate the facility on their own, as volunteer work. After the completion of the work, they operated 24/7 for some years, but due to several factors, office hours had to later be reduced. The clientele consisted of about 12-17 people with whom continuous contact was maintained by 6-8 social workers. Thanks to the well-established system of relationships, they exchanged 1,000 needles monthly, which is a large amount for this size of a city. Between 1997 and 2000 an unofficial “injection room” also operated in the facility, 2-3 intravenous drug users administered their daily dose in this room, which otherwise served for duty purposes, in the presence of a social worker. There was only one instance of an overdose, and the client was taken to hospital.

It is characteristic of the needle exchange operating in Pécs – and of those in the country in general – that using the service is often rather dependent on the mobility of the intravenous drug user population. While the high number of drug users in the capital results in the 100 % utilisation of Budapest-based services, the “disappearance” of a user with a wide range of contacts may basically influence needle exchange operations in a countryside city. Since maintenance methadone treatments were launched in the Drug Outpatient Clinic of Pécs, the number of people who use the needle exchange scheme has been dropping drastically. In 2001, for instance, the primary focus group of the needle exchange programme was that of opiate addicts, until three intravenous drug users who had all played an important role in secondary needle exchanges died of overdose. In the same year, a further 12 drug users were referred to a rehabilitation institution, nine of them intravenous drug users. The collapse was also helped by the fact that another four contact persons exited the programme in Pécs after being referred to rehabilitation, and the needle exchange staff lacked the relationships necessary to “rope in” new contacts. By the beginning of last year, practically the entire clientele had vanished. In 2002, the number of regular clients who use the needle exchange service of the programme 2-3 times a week was around 4-5.

The programme utilises several sources to fund its operations.

Sponsors: Municipal government of Pécs; Ministry of Health, Social and Family Affairs and the Ministry of Children, Youth and Sports

**Needle exchange centres**

**Drug Prevention Foundation**

**Civil Harm Reduction Social Contact Programme (CHT):**

Apart from its Drug Bus programme, the foundation (established in 1994) created a harm-reduction programme in late 1995. The primary activity of the CHT programme is harm reduction among drug addicts, with special attention to intravenous users. This task is performed at its site of operation, during set office hours. Thanks to a subsidy received in 2002, opening hours were extended, and now clients are welcome between 4 p.m. and 8 p.m. and between 8.30 p.m. and 10 p.m. on weekdays, and from 4 p.m. to 8 p.m. on weekends.

Information is provided on treatment centres, rehabilitation homes, the nature and conditions of the services of these institutions (acting as a mediator between the client and the organisation). They distribute informational material on HIV and hepatitis, offer assistance in social and legal cases (social security card, personal ID card, benefits) and provide hygienic facilities free of charge. Due to their
addiction, the clients who contact the foundation lead a life that necessarily isolates them from their families. When they make the resolution to go through detoxification and rehabilitation, there is no one by their side to support them in solving problems that arise. This is one of the tasks of the programme staff, and they also monitor the progress of the patient over the course of the hospital treatment and rehabilitation.

The clients who use the harm-reduction programme do not make use of the services offered by healthcare institutions. In order to preserve the health of drug patients who participate in the programme, a doctor visits the needle exchange room on a weekly basis. It is important to note that the foundation has a permanent agreement with the Erzsébet Hospital, where detoxification is performed.

Until the client is ready to start their way towards re-socialisation, it is important to reduce the harm related to drug use as much as possible. This end is served not only by sterile accessories but also by providing informative material. In 2002, 11,118 syringes were given out, and 4,402 were returned.

They maintain extensive good relationships with social organisations and treatment centres, especially NGOs involved in harm reduction. Thanks to these good relationships, a number of joint projects were implemented, such as the needle exchange programme operating since November 2000 in the Dzsumbuj, in the facility of the “Dzsumbuj Help” Community Development Centre. The process was joined by the “Blue Point – Double Point” programme of the Blue Point Drug Counselling Centre, which provided harm-reduction counselling from mid-2002 until July 2003.

The Drug Prevention Foundation had 208 new clients in 2002, raising the total headcount of registered patients to 700. Naturally, the foundation performs its activities respecting the anonymity of the participants; they know none of the clients’ personal data, and identification is done through codes. The oldest clients are around 46-50, and there are 13 minor clients, 8 girls and 5 boys. The average age is around 20-25, boys are in a majority by 2.5%. 4 of their clients died in 2002.

**Drug Outpatient Clinic in Miskolc**

The Drug Outpatient Clinic was opened in Miskolc in 1996, and 40% of its clientele (a total of 1,300 people) are intravenous drug users, who mostly use heroin, and to a lesser extent, amphetamines. According to the clients, it is common to use a needle four or five times, thus the risk of infection is very high.

Previous experience justified the continuation of the scheme, made possible by an operational grant received in 2002. Over the course of the programme, each visiting youth receives a sterile needle and condoms. Efforts are made to involve these clients in treatment and to motivate them to change their lifestyle. Service is available 2x2 hours a week, and the staff of the clinic also carry out street social work at the locations that surveys show to be potentially infected. There are 7 experts in the project; their primary fields include social work, mental health, education and administration.

The experience of 2002:

We inform clients about the needle exchange opportunity by distributing leaflets and through discussions in person. We consider it an “achievement” that the number of youth who visit our clinic is continuously rising, and they also participate in talks. The needle exchange programme enables us to keep in touch with drug users who have not yet contacted us for therapy, and these meetings serve for discussion and consulting purposes. Most of the clients are intravenous heroin users, the rest mainly consists of occasional speed users. The number of clients who use opium extracted from poppy seeds rose in the summer. The shared use of needles is common practice among our clients, and only about 5-10% insist on using a sterile needle every time. It is also common to use a single needle 5-10 times, this is why clients are referred to HIV and hepatitis tests at the laboratory of the Semmelweis Hospital in Miskolc. Data collected so far suggest that there has been no client infected with HIV so far. The Clinic exchanges a total of approximately 300-350 needles a month, always at a 1:1 ratio of returns. There are currently 28 clients who use the programme. Patients consider it an advantage that they receive a condom in addition to the needle. Experience shows that though there are a lot of clients who use the service on several occasions, there are also many who know about the programme but are afraid to make use of it, probably due to a sense of shame and geographical distance.
Alcohol – Drug Aid Outpatient Clinic in Veszprém

The counselling service operating since 1988 under the name of Alcohol-Drug Aid Service became independent in 1993 and changed its name to Alcohol-Drug Aid Outpatient Clinic in the same year. The institution was granted a permit for permanent operation on April 11, 2000. As a not for profit organisation for the public good, the institution performs health preservation, illness prevention, curing and rehabilitative tasks in the course of its healthcare and social activities. In addition, the organisation undertook to found and maintain institutions that deal with addiction. Its purpose is to establish a continuous treatment chain, and to operate various levels and fields of treatment in a coordinated and effective manner. To this end, not only does it offer ambulatory (outpatient) treatment, but it also runs the Day-time Catering Institution of Addicts, the Night-time Shelter for the Homeless and the Rehabilitation Home of Addicts in Noszlop. The activities of the Alcohol-Drug Aid Outpatient Clinic cover the area of Veszprém County.

Medication, psychotherapy, addiction counselling, and harm reduction are offered under the umbrella of a bio-psycho-social team, namely 3 psychiatrists including an addiction expert, 1 clinical psychologist, 1 psychologist, 2 social workers and 2 nurses. Legal advice is provided by a lawyer free of charge, thus comprehensive alternative to criminal sentencing (diversion) options are possible.

The harm reduction programme has been operating since 1997. The purpose of the service is identical with the goals set out in Section 6.3.2. (Harm reduction) of the National Strategy for the Reduction of the Drug Problem.

The needle exchange has been running on a daily basis since 1997, available in the afternoons. The service may be used anonymously, administration is code-based. The clearly-defined purposes are the following: prevention of the harm caused by intravenous drug use, such as viral infections (HIV, hepatitis C, B), dermatological, and surgical problems. Contacting and monitoring the drug user who is currently excluded form institutionalised treatment. Reduction of risk factors, securing behavioural changes, promotion of a drug-free lifestyle. Referral to other forms of treatment.

In the course of the past years, approximately 20 people participated in the programme, on an average of 30-40 occasions, with 7 people making use of the service in 2002 on a total of 20 occasions. 113 needles were handed out, 49 returned.

Street Front Division of Baptist Aid:

Over the past 20 years, needle exchange programmes have proven to have a place in several large cities of Europe (Zurich, Amsterdam, Rotterdam, Frankfurt etc.), and now it is obvious that they have a significant role in effectively reducing the individual and social harm related to drug use, in preventing HIV and hepatitis infection, and in promoting the cessation of drug use through early contact. Baptist Aid was the first to run a mobile needle exchange system in Budapest, which commenced operation in September 2002 under the name “Cserebogár” (“May-beetle”, but also a pun meaning “exchange bug”) as a further improvement of the street social work already performed among homeless drug users. The outreach service is still primarily focussed on homeless drug users. Operations were funded from their own sources for nearly six months, later with the help of grants offered by the municipal government of Budapest. Subsidies are currently received from the MCYS and the MHSFA. Cooperation is particularly strong with the Civil Drug Prevention Foundation, the Blue Point Drug Counselling Centre and the Drug Outpatient Clinic in Jász Street. The programme is present in five areas of Budapest that are affected by intravenous drug use through a special residential van equipped with a rear entrance, a fridge, a hand-wash basin, and tea and coffee making facilities; the passenger area has a corner for relaxation and talking. The residential van is also capable of storing food and clothing donations. They are in regular contact with about 25-30 people, which represents only an infinitesimal number compared to the affected population. (representing approximately 1-5 %). 148 syringes and needles were handed out and approximately 500-600 used accessories were collected in 2002. (The data represent the period between September 2002 and December 2002.) On one occasion, 117 syringes were collected from a single rooftop. Clients primarily use heroin and speed, they are of an average age of 20-35 years. The
youngest client is a 16-year-old girl who has been using heroin for two years on a regular basis. The members of the focus group are rarely available, and establishing a relationship of trust with them requires great effort. Usually, they have no contact with aiding institutions and are not motivated to quit.

**Definition of purposes:**

1. Early treatment:
The activities should reach drug users who have no contact with other aiding institutions. The staff make healthcare and social services available by means of supporting talks, motivation, individual case treatment, and social administration.

2. Reduction of individual and social harm related to drug use:
Prevention of HIV/hepatitis: provision of sterile accessories, promotion of safer drug use through communication and education, the professional collection and destruction of used syringes and needles.

3. Satisfaction of basic human needs:
Continuous provision of relaxation, hot tea, food and clothes donations in order to ensure that clients feel a bit better.

**Basic principles:**

**DOs:**
- the programme can be used anonymously and free of charge
- used syringes are to be replaced with sterile ones
- assistance may be requested and will be provided regarding drug use, quitting, and all other individual and social issues
- talking and relaxation
- drinking tea
- receive condoms and informational materials

**DON'Ts:**
- usage and distribution of drugs
- any form of aggression

**Blue Point Drug Counselling Centre and Outpatient Clinic**
The Blue Point Drug Counselling Centre and Outpatient Clinic has been performing outreach activities since 1998 (Party Service). The “Blue Point – Double Point” Harm-reduction Programme was set up in 2000 as a street outreach scheme.

The purpose is to reach a wide group of drug users, and with regular contact, to secure positive changes in their lifestyle concerning health (safer drug use, safer sex). Early admission to treatment and an increase in the chance of rehabilitation are long-term goals.

Focus population: the three groups of drug users who are considered to be in the highest danger are Romas, the so-called hidden intravenous heroin users, and amphetamine users.

Outreach work in the groups that do not prefer institutionalised care – Romas, the so-called hidden intravenous heroin users, and amphetamine users.

The goal is partly to reach a wider group and to perform harm reduction, that is, to seek out hidden drug users, provide information and assistance to the same in an effort to prevent and reduce the harm related to drug use. In addition to reducing the frequency of infection among drug users, helping with their legal and social problems, and achieving a drop in the number of overdose cases, the goal of the organisation is to ensure a change in risky behaviour in order to reduce social harm (crime, extra healthcare costs, infections, etc...).

The grant awarded in 2002 was utilised to prepare for the needle exchange programme which was launched in September 2003. The goal is to reach drug users who live in relative isolation in the outskirt areas of Budapest where drug use is widespread, but only a small number of clients contact the programme from there. The mobile needle exchange bus stops at three sites for an hour and a half every day, and services are provided by a social worker and a volunteer. Active drug users are involved in the course of the relationship-establishment stage of the outreach work, the task of the staff is to seek
out the focus population (this phase has been launched already), and to distribute information (on the harm of drug use, alternatives and treatment centres, etc.) and risk-reducing tools (sterile insulin syringe, condom, vein care ointment, vitamins, etc.) and to collect used equipment, relying on their network of contacts. It is up to the social worker to initiate discussions with participants of the programme and to provided assistance in the resolution of the problems that prevail after the provision of information (proceeding in social cases, legal and medical counselling). The provision of information is assisted by the leaflets on harm reduction prepared by Blue Point staff (on 7 different kinds of drugs, and 24 alternative harm-reduction methods). The services may be used anonymously and free of charge, clients and the type of service administered are registered using special codes.

The main purpose of street work is the boosting of the needle exchange club and referrals to professional help, if necessary (medical, legal, and social assistance). Accepting incoming notices, the service visits affected locations and collects scattered syringes, and offers alternatives to drug users concerning the appropriate use and destruction of syringes. The programme relies on the help of a participant psychiatrist, an addiction expert, a lawyer, a social worker, a social tutor, and 15 volunteers.

**Automated needle exchange device**

Preparations for the installation of needle exchange devices were commenced in Hungary in February 2001. The first such machine was set up in front of the Drug Outpatient Clinic and Prevention Centre of the Gyula Nyír Hospital (1135 Budapest, Jász u. 14. Tel. no.: 236-0787, 452-9460) in September 2003. Thanks to the support received from the MCYS, several similar machines were installed in other cities (Gyula, Kecskemét and Pécs) as early as the autumn of the same year. Apart from dispensing sterile needles, the machine is capable of storing the used needles safely until destruction, reducing the risk of infection caused by syringes left on the streets, playgrounds and in parks. When operated, the device delivers a 11.5 x 2 x 3 cm box.

The box contains the following items:

- 1 pc 1ml sterile syringe
- 1 pc filter
- 1 pc wipe

This automated needle exchange device was installed under the harm-reduction programme. Its purpose is to ensure that both the drug user and society are prevented from as much harm related to drug use as possible. We would like to see fewer people use drugs in Hungary, but we would also like to see that those who do, and cannot change at the time being, do so with as little risk as possible and with minimum harm. We hope this machine will serve the above purposes.
Substitute drug (methadone) treatment

In general, harm reduction improved more rapidly in the reporting period than in previous years. The following events are to be highlighted as the most significant milestones:

- The Baptist Aid commissioned a needle exchange bus in Budapest
- An automated needle exchange device was installed on the premises of the drug outpatient clinic in Gyula
- Commencement of methadone treatment in Szeged
- Establishment of a new place of methadone treatment in Budapest by the Hungarian Ecumenical Aid

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The summary was prepared by Dr József Csorba, Head of the Drug Outpatient Clinic and Prevention Centre of the Gyula Nyír Hospital of the Municipality of Budapest
In November 2002, the drug outpatient clinic in Szeged launched a methadone programme.

Taking into account countrywide data, the Budapest and Szeged centres are characterised by continuous expansion. The other treatment centres see an unchanged number of participants.

Demand for methadone treatment is still the strongest in Budapest and Miskolc.

Professional and infrastructure preparations for the commencement of a methadone programme are currently underway in the Drug Outpatient Clinic of Miskolc. Hopefully, treatment will also commence in the course of this year.

Substitution treatments are also planned in Budapest, at a drug outpatient clinic located on the premises of the National Psychiatric and Neurological Institute.

Despite larger headcounts and developments, still only a minority of opiate-dependent clients receive substitution treatment.

Methadone programmes need be launched in the northeast and northwest regions of the country in the near future.

In order to secure sufficient treatment in Budapest, at least two more centres need to be set up (in the inner city and in Northern Buda), or perhaps a mobile Methadone programme (Methadone bus) could also prove effective.

The range of substances applicable as substitutes also needs to be extended.

**DATA FOR PATIENTS UNDER METHADONE TREATMENT IN HUNGARY – 2003**

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<td>4</td>
</tr>
<tr>
<td>April</td>
<td>175</td>
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<td>14</td>
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<tr>
<td>May</td>
<td>172</td>
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<tr>
<td>June</td>
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<tr>
<td>July</td>
<td>169</td>
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<td>28</td>
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<td>August</td>
<td>182</td>
<td>13</td>
<td>12</td>
<td>26</td>
<td>10</td>
</tr>
</tbody>
</table>

*In November 2002, the drug outpatient clinic in Szeged launched a methadone programme.*

*Taking into account countrywide data, the Budapest and Szeged centres are characterised by continuous expansion. The other treatment centres see an unchanged number of participants.*

*Demand for methadone treatment is still the strongest in Budapest and Miskolc.*

*Professional and infrastructure preparations for the commencement of a methadone programme are currently underway in the Drug Outpatient Clinic of Miskolc. Hopefully, treatment will also commence in the course of this year.*

*Substitution treatments are also planned in Budapest, at a drug outpatient clinic located on the premises of the National Psychiatric and Neurological Institute.*

*Despite larger headcounts and developments, still only a minority of opiate-dependent clients receive substitution treatment.*

*Methadone programmes need be launched in the northeast and northwest regions of the country in the near future.*

*In order to secure sufficient treatment in Budapest, at least two more centres need to be set up (in the inner city and in Northern Buda), or perhaps a mobile Methadone programme (Methadone bus) could also prove effective.*

*The range of substances applicable as substitutes also needs to be extended.*
Aftercare and reintegration

REHABILITATION

Description of rehabilitation institutions and the participants of rehabilitation programmes

Alcohol and Drug Rehabilitation Institute of the Altruist Foundation in Budapest

The Alcohol and Drug Rehabilitation Institute of the Altruist Foundation has been in operation since 1991. This organisation is the largest of its kind in Hungary.

Goals: The institute offers complex rehabilitation to alcohol and drug addicts who wish to recover. The institute operates under a therapeutic community model. Patients are prepared for an alcohol-free or drug-free lifestyle and reintegration into society in the course of a programme that spans over one and a half to two years. The programme consists of two parts: medical rehabilitation (with the help of psychiatrists, addiction experts, internal specialists, GPs and labour health specialists) and social rehabilitation (full service, accommodation, social, legal and psycho-social rehabilitation, work therapy, protected employment.)

Patient admission: The institution admits men between the ages of 18 and 60 who are motivated towards recuperation and apply voluntarily. "Preliminary treatment" is administered in the Addiction Treatment Centre (Mental Health Centre). A waiting list is set up in case of too many applications.

In our medical rehabilitation practice, the addiction expert psychiatrist of the Institution organises therapy on the basis of the diagnosis, and recommends admission in the course of a medical conference. The internal specialist of the Institute deals with public health issues and treats somatic disorders. The responsibility of the labour health specialist is the treatment of patients with an altered capacity for work. In the course of the controlling procedure, doctors' meetings are regular. Patients are admitted following detoxification, and they are then accommodated in double or three-bed rooms. The first three months of the treatment are spent in isolation, with the purpose of stopping their drug career. Patients may only leave the premises of the Institute if accompanied by a member of staff. The Institution has a basic inventory of medicines, capable of supplying flexible and well-constructed medication therapies. Wards serve for the safe treatment of acute cases.

Specialist treatment of chronic inpatients: The role the doctor (psychiatrist, addiction expert, GP or labour health specialist) plays in the process of rehabilitation is to make it more effective and safer, to prevent treatment failures arising from the illness, and to administer psychotherapy. Therapy groups are made up of drug addicts who are more sensitive to certain diseases, may have chronic disorders and are used to turning to a doctor (the addicted lifestyle is the source of a lot of health problems). To this end, the cooperation of the addiction specialist psychiatrist, the GP (for everyday health problems), the internal specialist and the labour health specialist is indispensable.

Treatment methods: The goal is for patients to recover their mental (e.g.: stress resistance, conflict resolution), emotional (handling of moods, joy and angst), physical (medication, work and sport), social (integration into a community, establishment of relationships), intellectual (sense of responsibility, problem-solving) and spiritual (love, recognition of the meaning of life) health. The patients admitted to the Institution join therapy communities to prepare for a new start in the course of a long-term programme, (lasting 1-2 years), aimed at transforming their distorted personality into an identity that can act in a responsible manner, and at preparing them for reintegration into society. Community members participate in thematic group courses. The topics brought forward in large-group discussions are further elaborated in small-group classes and as coursework (e.g.: the prevention of recidivism, problem solving, expressing emotions).

This summary was prepared by Dr Csaba Timár, Chairman of the AHDTI and the LEO AMICI Endowment
**Monitoring and assessment** (carried out at drug outpatient clinics): The monitoring system monitors the progress of former patients’ lives and the effectiveness of rehabilitation over the long term (for 6-12 months). Former clients are assisted in reintegration into their families and the society. Those who have completed the rehabilitation programme will receive further aftercare, mental health support and monitoring at their local drug outpatient clinic. On the basis of ten years of monitoring, 41% are abstinent and have a permanent job and residence. 10% of the patients admitted in 1991 were opiate-dependents (poppy seed tea, hydrocodine, etc.). Today, 90% of admitted drug addict use heroin.

“Transfer House” Institute of the Public Endowment of the Municipality of Baranya County in Pécsvárad

The institute was opened in January 1990 as a department of the Baranya County Children’s Hospital, under the name of Work Therapy Home Employing Drug-Addicted Youth.

The organisation was transformed into a public endowment in January 2000.

The goals of the recovery programme are attained within the framework of a therapy community, with primary emphasis on group sessions, and decisions are only made taking a consensus between the staff and the patients into account.

The basis of the therapeutical approach is the illness principle maintained by Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and the American Psychiatric Association (APA).

According to this principle, narcomania is an incurable disease, but the programme may help clients gain the ability to live with it in a constructive manner and without symptoms. The therapy is based on the 12-step method of Narcotics Anonymous, which show how to establish a new type of balanced lifestyle without drugs. The programme promotes joining the self-help group of Narcotics Anonymous. (There are NA groups in Budapest and Pécs, patients of the Institute do attend their meetings, and the founding of the Pécs club is largely due to their initiative.)

The Institute primarily admits opiate-dependents, but there are several clients who used to use amphetamine and other drugs. According to the experience of past years, opiate-addicts represent approximately 2/3 of all patients.

Applications are accepted via phone, mail, and in person, followed by a short admission interview with the participation of patients who have experience concerning the recuperation process.

Applications are accepted from any part of the country from anyone who has drug problems and would like to change.

Available documents show that the 199 drug addicts entered therapy in the Institute were men and women between the ages of 18 and 35. Some of them quit and left the Institute, others had to be expelled, and the rest completed the course in accordance with the therapy agreement. The previously applied therapy method did not cover the field of monitoring effectively, and the present approach places great emphasis on continuous contact.

The program has been operating since January 2000, and is not yet able to provide information on the ratio of patients who recover, but joining the NA community promises a very good chance of remaining sober throughout the whole world.

The Institute is the legal successor of the organisation employing drug-addicted youth in Keszű.

The public endowment also runs the rehabilitation institute in Kovácsszénája (Baranya County).

Mission Support Foundation for Saving “Kallódó” (Disaffected) Youth (MSFSKY), Zsibrik

Zsibrik Home opened in May 1990 as a centre for drug addicts who wished to recover. Its foundation is primarily thanks to the efforts of the pastoral couple of the time in Hidas, especially Rev. Eszter Erdős Victor, the reform pastor who was a widely renowned expert thanks to her contribution to the foundation of the Rákkeresztúr Home several years ago, and to the activities of the “Kallódó” Foundation.

Zsibrik has from the very outset emphasised the positive effect of work on forming personality.
Accordingly, the buildings of the Home and the attached gardens, fields and animals are looked after jointly by the mentors and the patients.

Present operation of the Home:
Zsibrik has a capacity of up to 20 patients, filled up mostly by drug addicts, (since alcohol is also considered a drug, alcoholics are also admitted). Experience shows that although patients are of various ages and cultural backgrounds, the cooperation of those who succeed in other aspects of the therapy can be secured. Emphasising differences is mostly characteristic of the patients who find it difficult to turn away from their own identity as a drug-addict or alcoholic.

The mission of the home is to show that the effect of active faith on personality is more important than any method or therapy, since it goes beyond human capacities and reaches beyond life. If somebody finds a religious community, their re-socialisation is aided by a nationwide network. Furthermore, they may select the denomination most fitting to their habits and requirements. (There are both charismatic and conservative churches in Hungary.) At the highest level, the therapy will help the patient to recover from their specific personality problems, return to God, and find a religious community.

Since the Mission makes a contract with the patients for recovery from a drug addiction, the most important task in Zsibrik is the strengthening of the dependent personality and achieving emotional and mental independence.

The staff perform this task on the basis of their religious devotion and in a responsible and motivated manner. The daily routine of the Home is strongly interwoven with a Christian lifestyle and values, (compulsory morning devotion, Bible lessons, evangelisation and worship) since they wish to introduce pious life in practice. In addition, a safe environment, continuous employment in work therapy as well as individual spiritual assistance, support and guidance to invoke a change in the personality are all provided. The Home also serves as a self-help group, since those who are more advanced in the therapy help beginners. Every patient prepares a summary assessment of themselves, their progress and system of relationships at the end of the first, fourth, and eighth months, to be read out loud in the presence of all the others. The patients and mentors then evaluate the report together. During leaves, patients may meet their friends and realise how much stronger they have become. After three months have passed, special anti-recidivism sessions that last 90-120 minutes are held weekly, in the course of which the topics that represent the greatest risk factors in remaining “clean” are discussed. If requested, and if the Home deems the request justified, patients may participate in faith strengthening practices and preparation for confirmation and baptism are also available on request.

Belonging to the Reformed church is not a prerequisite either on admission or during or after the therapy, but (due to the nature of the Home) the characteristics of this devotion are dominant during the 8 months of treatment.

Those who have left the Home and current patients join together for the Old Boys Day held every two months by the German-tongue community in Budapest. Parents and relatives are invited to the Relatives Day held twice every year.

Operational data of the institution:
Number of patients in 2002 44 people
Completed 1 year of the therapy 4 people
Voluntary leave 17 people
Agreement terminated 10 people
Permanently sober 15 people
Currently in therapy 13 people

In 2003, the Institute introduced the Canadian Portage system of therapy, which in practice means the promotion of self-help elements and the establishment of a Therapeutic Community. The maximum capacity is still 20 patients.
Drug Rehabilitation Home of the Mission of the Reformed Church of Hungary for Saving “Kallódó” (Disaffected) Youth

The Mission of the Reformed Church of Hungary for Saving “Kallódó” Youth (MRCHSKY) was founded in 1983.

The Drug Therapy Home in Ráckeresztúr was established in 1986 with the aim of curing and treating drug-user youth as well as protecting their interest and providing support. Most of our clients use opiates, with an evident majority of heroin-addicts in the recent years.

Theoretical principles: Drug addiction is considered an illness or a situation of confinement that affects the entire person, and one that reaches far beyond the biochemical effects of the drug. According to their religious beliefs and addiction-related experience, they see drug therapy as an integrated unit of the liberating gospel of God, with professional expertise and experience as well as the binding commandments of humanitarianism and love, and with a wish to perform the tasks within the framework of a therapy community.

The purpose of the Home: Following physical detoxification, the Home (defining itself as a drug-free community) provides applicants with professional and moral help in order to help them get rid of their addiction according to their own resolve, with assistance received from the staff and the therapy community. The goal is not only a drug-free lifestyle, but also self-maintenance and liberation from susceptibility to addiction.

Main pillars of the therapy:

Christian programme, family atmosphere, work therapy, clearly structured community life.

The basis of community life is solidarity originating from love. No form of aggression (neither physical nor spiritual), consumption of alcohol or usage of drugs (in any form) is therefore tolerated in our Institute.

Structure of the therapy programme:
The therapy agreement is valid for 1 year.

The Programme may be terminated at any time and the patient may leave the Home since cooperation and voluntary participation are crucial to the execution, maintenance, and success of the therapy agreement. The programme consists of a trial period and three further phases. Following the trial period, a mentor is assigned to the patient from the members of staff. The mentor will act as a most personal aid and supporter during the therapy, protecting the interests of the patient as well as providing necessary criticism.

The maximum patient capacity of the Ráckeresztúr Drug Therapy Home of the Mission for Saving “Kallódó” Youth remained unchanged in 2002. 21 people used the services (broken down according to type of drug: 17 opiate-dependents, 3 amphetamine-dependents and 1 other). Treatment was completed by 9 people in 2002, while 3 others quit prematurely. Of the patients who participated in the programme in 2002, there are 7 currently that are abstinent.

In September 2002, the long-term process of reconstructing the therapy programme of the Home was begun, and it is currently underway. The programme of a Canadian therapy institute – Portage – serves as the backbone of the new scheme. The idea is that various therapeutic methods are applied to help clients stick to abstinence after leaving the Home.

“Dr Terézia Farkasinszky” Youth Drug Centre of the Municipality of the County City of Szeged

Background:
The Drug Outpatient Clinic commenced operation on March 1, 1987.

Services:
Rehabilitation (therapy community model, primarily for those who have used opiates for several years, in the course of a 12-18 month programme), the service is free, admission criteria are voluntary resolve, successful detoxification, and the acceptance of the institutional framework.
Statistical data of the Institute:

Two thirds of applicant use opiates.
- 60% of the patients who use opiates are regular intravenous users.
- 10% of the intravenous users share needles.

The strengthening of the supply side not only results in the continuous availability of opiates but also in an amount that reduces the average age of drug users.
- The high ratio of unemployed patients is apparent.
- Due to their opiate-dependency, 50% of the young clients did not complete their education.
- Over 40% of applicants use drugs on a daily basis.
- 45% of patients have used drugs for at least two years.

Nearly 50% of our clients started to administer drugs intravenously before the age of 18.

LEO AMICI 2002 ADDICTION ENDOWMENT

The Leo Amici Endowment is headquartered in Pécs. It has been operating as a centre for drug rehabilitation since 1992, when the rehabilitation institution of the endowment was set up in Komló.

The rehabilitation institute of the Leo Amici Endowment is open primarily to drug addicts who have evidently deteriorated psychologically, morally, personally, and physically due to drug use, and who require long treatment including the correction of personality.

Staff: Recovered former addicts, social worker, lawyer, psychiatrist, addiction expert, and an internal specialist doctor. Restrictions and frameworks are loving, caring, the promotion of the maturing of the personality. Spiritual values, humility, and respect are considered to be of great significance as the most important characteristics of our institution, and the same are represented by recovered addicts in an effort to secure the recuperation of current patients. Our institution operates as a therapeutic community. The theoretical basis of their work is the social learning principle, they believe the major therapy force is modelling.

In the course of these rehabilitation activities that rely greatly on, utilise, and synthesise appropriate Western European therapy protocols, the group, the environment, and socio-therapy are just as important as drama therapy.

The most important therapy forms are music and drama therapy, which originally had chiefly recreational and community-developing purposes in our work. We soon realised, however, that music and drama therapy can play an important overall role in therapy, and the community started to actively research underlying possibilities. Our professional relationship with the French psychologist and theatre director Georges Baal began in 1994 and has been maintained ever since. The drama therapy training sessions he held enabled both the staff and patients to get familiar with and experience first-hand the unique curative powers of drama and motion therapy. The method is based on searching for the possibilities of creative expression through body and voice, on improvisation and a kind of continuity that, starting from spontaneous expressions arches to staging and a theatrical performance. Techniques are subject to teamwork, which focuses on the development of trust, on getting to know others, on the establishment of constructive relationships between participants, and on the analysis of things hidden deeply in the past. Performances represent an important area of preventative work. The pieces rehearsed by the community are often performed at places (such as schools and community centres) which are attended by youth greatly at risk of drug use, and at locations which have a high likeliness of a drug presence (e.g. the army).

Another priority area of prevention work is the group of parents and relatives. We organise regular weekend parent groups for the relatives of the patients. Addiction always affects relatives as well, and they attempt in various ways to adapt to a problem that cannot be adapted to healthily. The purpose of our work performed in cooperation with the relatives of addicts is to help them gain more comprehensive control over the addiction patterns and co-dependent features that influence and affect their lives. “Loving distinction” means setting up psychological boundaries between people, which leads
to a kind of repeated maturation, a new star, a significantly more effective acceptance of the unavoidable aspects and paradoxes of life. The rehabilitation work to be performed by the family is inseparably intertwined with family prevention, since the impact affects healthy family members and the larger family as well as relatives and friends.

Relapse prevention group therapy: This kind of group therapy is applied for those who have successfully completed the treatment and leave the institution. Permanent abstinence can only be maintained by preserving the new attitude and new ways of thinking, which should be supported by the regular strengthening of new behavioural patterns and habits so as to prevent old behaviour and thinking from returning and reviving. Self-help groups are in Budapest and in Komló. The Budapest group operates within the framework of the Stop Association, relying on the active participation of the recovered addicts of the Leo Amici Endowment.

The Leo Amici Endowment has established a therapy environment that is unique in Hungary, appropriate for the admission and curing of patients who wish to enter the treatment system.

The mission statement of the institute states that: "In this community, we are together for better, for worse. We learn to live and develop by establishing new, healthy methods of living together. We share our experiences, strengths, and hopes openly and frankly. We learn to look after ourselves, our environment and the community. Despite our differences, the ties that bind us together are strong: we all wish to recover. We extend our arms and open our hearts to support each other in abstinence."

The therapy and professional concept and practice of the Leo Amici 2002 Endowment are inclusive (open to examination and accepting all useful methods), based on the principles of social learning (copying models) and the interpersonal effect (empathic confrontation, feedback, devotion) and the 12-step approach and traditions, which all have an important role in therapy work, with the community itself acting as the major therapist.

Particularly close work relationships have been established with the Downtown School headquartered in Budapest, and among others with the Stop Association, also in Budapest, which specialises in drug prevention.

In January 2003, the Leo Amici Foundation changed its name to the Leo Amici 2002 Addiction Endowment. It operates as a public-benefit organisation.

Statistical data of the institution:

The endowment was able to arrange for the treatment of 14 people in 2001, and it is capable simultaneously treating up to 18 people.

A total of 150 people had been treated between 1993 and December 31, 2002.

- quit treatment: 98 people
- completed treatment: 52 people
- quit but drug-free: 26 people
- completed and drug-free: 41 people
- completed and relapsed: 11 people

Rehabilitation Department of the Social Home for Addicts in Békés County

The Rehabilitation Department of the Social Home for Addicts in Békés County offers rehabilitation services to drug-addicts, gambling-addicts, and alcohol-addicts between the ages of 18 and 40.

The department has a boarding facility, a two-story building located on the edge of the village of Nagyszénás, with a capacity of up to 36 people.

Our staff include: a psychiatrist, a psychologist, a doctor, a social worker, a social tutor, an addiction expert counsellor, a social administrator, a social nurse and a former addict who has been abstinent for several years.

Admission is preceded by an interview, which should make it possible to discover whether the applicant is truly motivated.
**Professional programme:**

Tem of rehabilitation: 6-18 months

The Therapy Community helps the distorted personality of the patients transform into an identity that can act in a responsible manner, thus clients are prepared for re-integration into society (regular daily routine, thematic group sessions, therapy work)

Aftercare, relapse prevention:

Aftercare is provided for at least 6 months following the rehabilitation period.

Parent meetings are held for relatives on a monthly basis.

The relapse-prevention groups enable all to clarify and understand their own difficulties, awkward or worrying feelings and thoughts as well as their entire behaviour, and thus enables them to learn to help themselves and others. Participants may extend the range of subjects discussed in the course of rehabilitation, and may make their independent lives more successful.

It is a significant achievement if a former patient remains abstinent and psychologically balanced after leaving the institution, with permanent employment and re-integrated into their close environment and the large community.

**Data from 2002:**

- number of beds and capacity have not changed
- treated: 72 people
- completed treatment: 7 people
- left: 32 people
- permanently recovered: 19 people

**“Diótörés” (Nut-cracking) Endowment**

The Nut-cracking Endowment, a public-benefit organisation, is headquartered in Budapest. It operates the Walnut Rehabilitation Home under Petőfi Street 4 in Lulla.

The institution was opened on March 8, 2002 with a capacity of up to 18 people, (10 homeless addicts participating in rehabilitation, and 8 in aftercare rehabilitation), for use by polytoxicomanic representative of both sexes, but primarily glue-sniffing, homeless young adults and former children-in-care, covering the entire country. Activities were based on a permanent operating permit.

Self-contained double rooms and a land parcel of 2 ha. Utilisation: 60-85%.

**Rehabilitation Home in Noszlop**

The Rehabilitation Home in Noszlop commenced operation on March 1, 2002 as the only boarding drug rehabilitation institution in the region. The facility has a maximum capacity of 20 male addicts (primarily opiate-dependents and alcoholics, as well as dependents on other substances), for whom a long-term rehabilitation and re-socialisation programme is provided in a boarding system.

The institute is run by the Veszprém-based Alcohol-Drug Aid Outpatient Clinic that has been in operation since 1993, acting as professional and financial supervisor and covering the continuous preservation of programmes.

**Admission criteria:**

- voluntary application
- motivation
- successful detoxification
- verified attendance of medical tests (hepatitis, AIDS, TB)
- attendance of an admission interview where the staff and programme participants decide on the suitability of the applicant

In 2002, the Alcohol-Drug Aid Outpatient Clinic, which runs the Drug Rehabilitation Home, had an opportunity to purchase a land parcel of 1 ha. The size and geographical location of the property (being only a few hundred metres from the residence) allow it to be cultivated. Preparations were commenced, and the work is currently in the final stage of completing the buildings.
The entire programme of our Rehabilitation Home is based on the application of socio-therapeutic methods, all set in the community as the smallest social unit, where the re-socialisation process can take place. Rallying primarily on the undamaged ego-function, it serves to rebuild and improve social capacities. This is performed in various scenarios of the therapy process. The basic components of this complex system are the following:

- Therapy community
- Group sessions
- Exercise therapy
- Work therapy
- Medical rehabilitation
- Learning

The basic elements of the above processes are community and group therapy, which enable the patient to accept the correcting efforts of reactions from the staff and fellow patients who suffer from similar problems, and thus to establish and learn reintegration into society.

<table>
<thead>
<tr>
<th></th>
<th>drug-addict</th>
<th>alcoholic</th>
<th>medicine-dependent</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied up to December 31, 2003</td>
<td>19 people</td>
<td>23 people</td>
<td>2 people</td>
<td>44 people</td>
</tr>
<tr>
<td>Currently in therapy</td>
<td>1 person</td>
<td>7 people</td>
<td>-</td>
<td>8 people</td>
</tr>
<tr>
<td>Spent less than 1 month in therapy</td>
<td>4 people</td>
<td>3 people</td>
<td>-</td>
<td>7 people</td>
</tr>
<tr>
<td>Spent 1-3 months in therapy</td>
<td>7 people</td>
<td>10 people</td>
<td>2 people</td>
<td>19 people</td>
</tr>
<tr>
<td>Spent 3-6 months in therapy</td>
<td>7 people</td>
<td>2 people</td>
<td>-</td>
<td>9 people</td>
</tr>
<tr>
<td>Spent over 6 months in therapy</td>
<td>-</td>
<td>1 person</td>
<td>-</td>
<td>1 person</td>
</tr>
</tbody>
</table>

Monitoring is currently being developed, and our information suggest that 10 former patients lead a drug-free life while 8 relapsed.

G. P. C. AGAPAY “Hajnalcsillag” (Morning Star) Rehabilitation Home

The institution is capable of hosting addicted women and young mothers (with alcohol, drug or medicine dependencies) who wish to recover and are ready to cooperate.

The home was established by the AGAPAY Congregation of the Gospel Pentecost Community (Budapest XIV, Dózsa Gy. út 7.) in 1985, relying on the help of the Teen Challenge organisation run by the American Pentecost denomination which similarly deals with addicts. Since 1994, the home has operated as an independent legal entity belonging to the GPC. In 1997, the National Health Insurance Fund made an agreement with the home for the subsidy of 14 chronic beds in excess of the regional normative allowance. This contract was modified on January 1, 2000 to cover a total of 18 beds. The Childcare Authority of Pest County granted a temporary permit for the operation of a transitory family home on January 1, 2000, which made possible the hosting of 7 children whose mothers are involved in the addict treatment programme of the home. The mother’s recuperation is further enhanced by her being together with the child beginning from a certain stage of the therapy. The permit was extended for 2003.

The home is open to all (from any part of the country), but admission is only granted if voluntary application, motivation, and the readiness to cooperate are demonstrated. Further conditions:

- age between 15 and 55;
- honest disclosure of the situation (8-10 sheets of a life-path, but not an autobiography);
- obtaining certificates;
- psychiatric (medical) referral or final hospital report verifying the addiction;
- proof of AIDS, hepatitis B and lung examinations;
- detoxification prior to moving in

The activities of the institution cover the entire country, since this is the first and so far the only rehabilitation home that offers hosting exclusively to women and where young mothers need not be
separated from their children in the course of the treatment. This specialty alone justifies our continued operation, future improvement, and expansion.

The chart below shows total patient numbers for 2002. Patients who leave the institution include both recovered people and some clients with whom rehabilitation did not prove successful.

<table>
<thead>
<tr>
<th>Patient numbers in 2002</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients as of January 1</td>
<td>18 people</td>
</tr>
<tr>
<td>New admissions</td>
<td>21 people</td>
</tr>
<tr>
<td>Treated in 2002</td>
<td>39 people</td>
</tr>
<tr>
<td>Left (Success)</td>
<td>7 people</td>
</tr>
<tr>
<td>(No success)</td>
<td>17 people</td>
</tr>
<tr>
<td>Total</td>
<td>24 people</td>
</tr>
<tr>
<td>Patients as of December 31</td>
<td>15 people</td>
</tr>
</tbody>
</table>

The institutes listed above have founded the Association of Hungarian Drug Therapy Institutes (AHDTI), whose aim is to coordinate the Hungarian organisations that operate in the field of drug therapy, to enhance their professional consciousness, and to establish professional solidarity. Its task is to represent and protect the interests of institutions, staff, and clients, and promote the scientific and professional training of members.

Any entity can join AHDTI, provided that their activities have been performed mainly by drug therapy organisations and their personnel.

### Treatment, rehabilitation, and social re-integration of drug users

(*MHSFA report*)

Parliamentary decree no. 96/2000 (December 1) On the Ratification of the National Strategy for the Reduction of the Drug Problem provides the legal framework for defining the medium-term and long-term development tasks of the healthcare system.

The institutional background of drug user treatment consists of the following components:

- **Acute treatment**: hospital wards that offer emergency treatment, detoxification (withdrawal) treatment, psychiatric treatment and addiction-related treatment
- **Ambulatory treatment**: number of drug outpatient clinics, the addiction treatment network and especially the SUPPORT workers, and in some cases psychiatric care: 228
- **Drug rehabilitation**: long-term therapy which is usually performed in homes run by a foundation, church, or (less frequently) by a municipality

The drug addict is entitled to receive treatment under all three of the above methods of treatment free of charge.

The goal of treatment is to secure abstinence (a lifestyle free of psychoactive substances), or, if that is not feasible, to ensure partial improvement by reducing related problems and promoting reintegration (regular work, self-maintenance, cessation of criminal life). The purpose of harm-reduction interventions
is to minimise the adverse effects of drugs on health, while the use of drugs itself is not the primary focus.

The national drug strategy sets out the goals of the establishment of a comprehensive range in both healthcare and social treatment of dependent patients and the improvement of the geographical distribution of the treatment network to promote better access to the services. The implementation of these targets requires the introduction of modern and cost-effective models, including the testing and evaluation of the model as well as the training of affected personnel. These goals may only be achieved over the long term.

**Ambulatory treatment:**

In the period between 1997 and 1999, intensive developments took place, aimed mainly at the improvement of asset background at existing drug outpatient clinics. Following that, in 2001 and 2002, the objective was to establish new drug outpatient clinics in an effort to abolish geographical imbalance of treatment centres. The ministry of health managed to provide HUF 30 million in 2001 and HUF 20 million for these areas from its dedicated small budget.

Apart from the scarcity of tangible assets, faster development was and still is also greatly hindered by the chronic lack of experts in the field of psychiatry and addiction sciences. A new drug outpatient clinic can only be established where other funds (mainly a municipal contribution) are also available.

The funding of drug outpatient clinics varies greatly depending on their individual contracts with the County Health Insurance Fund.

The work hour developments required for the operation of drug outpatient clinics and the SUPPORT helpers were not in accordance with the development capacities of the ministry of health, and the budget did not provide any additional funds in either 2001 or 2002.

**Regulation of professional activities:**

The Psychiatric Professional College prepared a recommendation for the minimum requirements of drug outpatient clinics in 2000; following this, already existing and newly established drug outpatient clinics were granted a temporary or permanent operating permit by the regional NPHMOS. Taking into account the changes in the past period, the revision of the professional guidelines became necessary.

In order to be able to represent their interests in a more effective manner, ambulatory treatment centres formed a professional association (Professional Association of Drug Outpatient Clinics. 17 institutions joined in 2001-2002.)

**Hospital treatment:**

**Emergency treatment:**

Mainly carried out on general psychiatric and addiction wards and large detoxification departments. Average treatment term: 1-2 days.

Small capacities represent a common problem, only a few clients may participate in detoxification simultaneously.

**Treatment of psychiatric problems:**

After a short detoxification stage, the next step is to cure the serious psychiatric disorders developed in connection with drug use (treatment of cases with a dual diagnosis).

The costs of treatment administered to drug addicts is part of the healthcare system, and is thus based on the HIG scores. The treatment of addiction has a relatively low score, which means less subsidies to be received from the National Health Fund, and this is why it is not without precedent that a related psychiatric disease is specified on hospital entrance documentation instead of the primary problem, (i.e. drug use). This makes it difficult to evaluate the total amount of expenses utilised for the treatment of drug users.

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42 HIG = Homogenous Illness Group
Long-term therapy treatment opportunities:

In 2001, there were 7 drug rehabilitation institutes with a total of 174 beds. Unevenness concerning their geographical location and the quality of services is a common characteristic. Average bed utilisation is about 70%, while some organisations had a usage rate of 100% (in 2000-2001).

Significant developments were implemented in 2002, since the national drug strategy set as a target the duplication of the number of beds over a short time. The expansion from 174 beds to 400 beds was implemented partly through the improvement of existing organisations, but also thanks to the establishment of new rehabilitation institutions.

The funding of drug rehabilitation programmes relies on a dual source: a social normative, as well as a supplement thereto, computed on the basis of the classification of treatment of chronic problems with a multiplier of 1.2.

The introduction of modern therapies (behaviour therapy and/or psychotherapy, applied in the form of daily group therapy), labour therapy, and social reintegration programmes needs to be established to ensure a drug-free life in the clients and to reduce the risk of relapse.

Tasks:

The introduction of effectiveness assessments and the application of a differentiated, performance-based funding system instead of the current flat grants would be a great incentive for making curative and rehabilitation tasks more effective.

In order to improve treatment effectiveness, the utilisation of modern diagnostic tools (EASI, DSM-IV) is unavoidable, along with improving the professional level of medical and paramedical staff, the promotion of a continuous training system, and international courses43. The Canadian institute is based on the therapy community model and offered a further training opportunity for only a small number in May 2001. The personnel of the organisations that take part in treatment could make good use of high-quality professional training.

Therapy opportunities in the criminal justice system

On the basis of a survey carried out in sentence execution (hereinafter: SE) institutions in 1997, the SE organisation has prepared its anti-drug strategy. The goals and tasks specified were also in compliance with the national strategy issued later. The drug strategy of SE was discussed by the Drug Coordinating Committee in 2001.

In Government decree no. 1036/2002 (April 12) issued for the implementation of the medium- and long-term targets set out in Parliamentary resolution no. 96/2000 (December 11) On the Ratification of a National Strategy Programme for the Reduction of the Drug Problem, the Minister of Justice defines specific tasks for the SE system.

In August 2002, the Drug Coordinating Committee accepted a proposal concerning the practical measures related to this area regarding the 2003-2004 budget period with the addition that the expense requirements of the tasks in the remaining part of 2002 and those in 2003 are to be assessed. The implementation schedule of the SE system for 2002-2003 was prepared on that basis. This details all tasks deadlines and responsibilities, and states predictable costs. The schedule was submitted to both the Ministry of Justice and the Ministry of Youth, Child and Sport Affairs by the Sentence Execution Headquarters (hereinafter SEHQ).

The various professional areas have commenced the implementation of the programme. As a result, the following has been achieved:

43 Introduction to Canadian Portage short-term therapy community treatment model for the personnel of some drug rehabilitation community homes
in compliance with the instructions issued to SE organisations, the Duty Division of SEHQ is further informed of all revealed instances of drug use. There was a total of 8 occurrences in 2002 (on 5 occasions on a confined, in 2 cases in luggage, and once in another area of the institute). The most often revealed drugs were amphetamines and cannabis-derivatives, and heroin in a syringe was confiscated from a convict on one occasion;

the legal prerequisites for the establishment of the recommended drug prevention departments have been met. The Ministry of Justice decree no. 18/2002 On the Modification of the Ministry of Justice decree no. 6/1996 (July 12) on the Rules of Imprisonment and Pre-trial Confinement (hereinafter: the Decree) came into effect on January 1, this allows for the establishment of prevention departments;

SE institutions regularly organise informative lectures and workshops aimed at revealing the drug problem, which the majority of the imprisoned attend;

the drug prevention procedure information so crucial for the reduction of demand has begun. To this end, the SE system has purchased an informative series of 9 video tapes. The tape packages were then sent to SE institutions, where the films are watched in the course of a community programme every 3-5 weeks. Wardens have been assigned the task of introducing and discussing the films with the convicts in groups. According to the notes made of experience gained, approximately 4,000 convicts have so far participated in the programme;

under the umbrella of the MATRA programme, the Dutch partners trained 6 members of our SE staff regarding the handling of drug issues;

the skilled trainers will present their knowledge to SE personnel in 3 rounds;

in the Budapest Penitentiary and Jail, drug addiction treatment therapy is implemented. Practical execution thereof was supervised by the SEHQ last year, experiences gained were discussed in a directors’ meeting. Taking into account the country-level importance of the tasks, the National Head of Sentence Execution modified a resolution of the national commander and provided budget sources for the operation of the Alterative Drug Therapy Group (ADTG);

currently, 7 drug-sniffing dogs are used in 7 SE institutions (in the Budapest Penitentiary and Jail, the Budapest SE Institution, the Sopron k. Penitentiary and Jail, the National SE Institute in Állampuszta, the Szeged Penitentiary and Gaol, the National SE Institute in Pálhalma, and the SE Institute in Borsod-Abaúj-Zemplén County). Dogs and their partners are trained by the Police and, more recently, also by the Customs and Financial Supervisory Authority, at a total cost (including the obtaining and training of the dog and the training of the dog’s partner) of HUF 650,000 (excluding the partners’ expenses that are redeemed by the institution such as the daily wage, fares, etc., constituting another HUF 200,000). The application of drug-sniffing dogs became regular practice in Pálhalma over the course of 2003, and we hope to have similar activities in two further institutions in 2004: the National SE Institution in Baracska and the SE Institution for Minors in Tőkől.

According to the current concept, we plan to assign a drug-sniffing dog to each region, and later to each country-level SE institution. The dogs and their partners will participate in two-week supplementary training sessions on an annual basis, and will have to participate in at least 3 or 4 drills in the SE institutions every week.

Luggage inspection devices were also purchased within the framework of the programme, and currently a total of 24 are operational. The device projects organic materials on a screen in various colours depending on density and ingredients. Such a machine has been installed in 4 SE houses and 8 county SE institutions.

In summary, the SE organisation continuously fulfils the requirements set out in the drug strategy. Expenses are covered partly from the organisation’s own funds, but chiefly from central subsidies.