



Hungary

Country Drug Report 2017

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THE DRUG PROBLEM IN HUNGARY AT A GLANCE

<p>Drug use</p> <p>in young adults (18-34 years) in the last year</p> <p>Cannabis</p> <p>3.5 %</p> <p>1.5 % 5.8 %</p> <p>Other drugs</p> <p>MDMA 2.1 % Amphetamines 1.4 % Cocaine 0.9 %</p>	<p>Treatment entrants</p> <p>by primary drug</p> <p>● Cannabis, 56 % ● Amphetamines, 11 % ● Cocaine, 2 % ● Heroin, 3 % ● Other, 28 %</p> <p>Opioid substitution treatment clients</p> <p>669</p>	<p>Overdose deaths</p> <p>HIV diagnoses attributed to injecting</p>	<p>Drug law offences</p> <p>6 617</p> <p>Top 5 drugs seized</p> <p>ranked according to quantities measured in kilograms</p> <ol style="list-style-type: none"> Herbal cannabis Amphetamine Cocaine Cannabis resin Heroin <p>Population</p> <p>(15-64 years)</p> <p>6 664 153</p> <p>Source: EUROSTAT Extracted on: 26/03/2017</p>
<p>High-risk opioid users</p> <p>3 244 (2 910 - 3 577)</p>	<p>Syringes distributed</p> <p>through specialised programmes</p> <p>188 696</p>		

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

About this report

This report presents the top-level overview of the drug phenomenon in Hungary, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

National drug strategy and coordination

National drug strategy

Hungary's National Anti-Drug Strategy 2013-20, entitled 'Clear consciousness, sobriety and fight against drug crime', focuses on illicit drugs and was adopted in 2013 (Figure 1). It is based on five core values: the right to life, human dignity and health; personal and community responsibility; community action; cooperation; and an evidence-base. The strategy addresses three areas of intervention: (i) health development and drug prevention; (ii) treatment, care and recovery; and (iii) supply reduction. The strategy outlines indicators for monitoring its implementation and the organisations responsible for collecting information. The Policy Program, which is an action plan, supports the implementation of the strategy and was adopted by the government in a decree in 2015.

Like other European countries, Hungary evaluates its drug policy and strategy using ongoing indicator monitoring and specific research projects. In the past, external

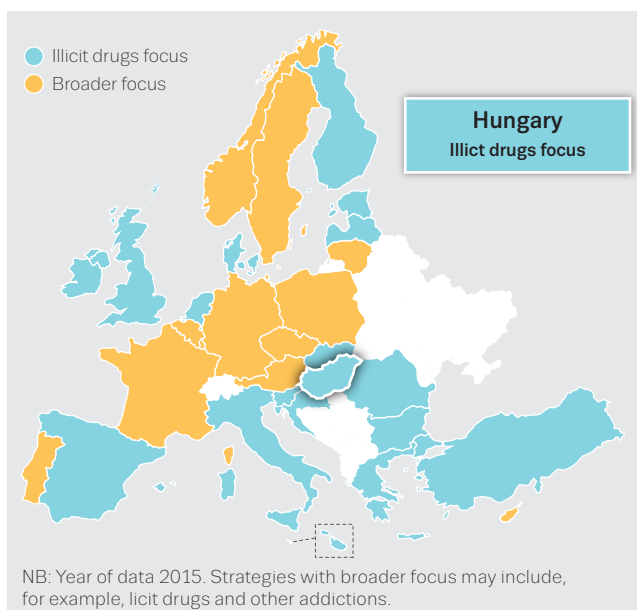
interim and final evaluations of the first national drug strategy for 2000-09 were undertaken.

National coordination mechanisms

The Inter-ministerial Coordination Committee on Drug Affairs (CICDA) advises the government and is chaired by the Secretary of State for Social Affairs and Social Inclusion. It includes representatives from all relevant ministries and national institutions. The National Drug Prevention Coordination Unit is part of the Department for Social and Child Welfare Services. It is responsible for operational and strategic coordination at the national level and the implementation of the drug strategy. The National Office for Rehabilitation and Social Affairs supports the activities of the Coordination Forums on Drug Affairs (KEFs), which are tasked with operational and strategic coordination at local levels. It assists the coordination forums with programmes in the area of prevention and facilitates drug-related research and information dissemination.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



Hungary's National Anti-Drug Strategy 2013-20 is based on five core values: the right to life, human dignity and health; personal and community responsibility; community action; cooperation; and a scientific basis

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy.

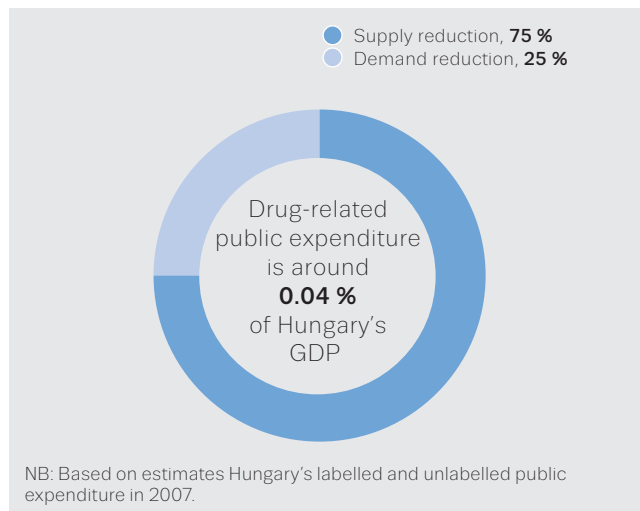
In Hungary, there is no specific budget attached to the National Anti-Drug Strategy, but every year ministries approve an overall budget that takes into account the main goals of the strategy. This budget, however, is estimated by authorities to represent less than 4-6 % of total drug-related expenditure. One study, following a well-defined methodology, estimated total drug-related expenditures for four years (2000, 2003, 2005 and 2007).

In 2007, the total drug-related public expenditure represented 0.04 % of gross domestic product (GDP). The total expenditure, estimated at approximately EUR 39 million, was divided into four main areas: law enforcement (75 %), prevention and research (10 %), treatment (10 %) and harm reduction (4 %).

Long-term trends indicate that, between 2000 and 2007, total drug-related expenditure remained stable as a percentage of GDP (between 0.04 % and 0.05 %). Law enforcement absorbed at least 66 % of these funds, while expenditure on treatment and harm reduction, taken together, did not exceed 15 % of the total. As a consequence of the 2008 economic recession, both the structure and the proportion of GDP allocated to drug-related initiatives have probably changed; however, recent data are not available.

FIGURE 2

Public expenditure related to illicit drugs in Hungary



Drug laws and drug law offences

National drug laws

The new Criminal Code came into force on 1 July 2013. The drug control sections have been organised to cover trafficking, possession, incitement of minors to use drugs or similar substances, assisting production, precursors, new psychoactive substances (NPS) and performance enhancement (doping).

Consumption was reintroduced as a criminal offence, punishable by up to two years in prison (it had been deleted from the 2003 Criminal Code). Possession is still punishable by up to two years in prison if it involves small quantities, but other penalties are now one to five years for a basic offence, increasing to two to eight years if the offence is committed under certain circumstances, and 5-10 and 5-15 years if the offence involves a larger quantity of drugs (Figure 3). Similar sentence ranges are available for supply offences, although they increase to 5-20 years' imprisonment if they involve certain circumstances and life imprisonment if large quantities are involved. Various lower maximum penalties for offences committed by drug users, introduced in 2003, were repealed in 2013; however, the court may take the perpetrator's drug use into consideration when imposing punishment. The option to suspend prosecution in the case of treatment is available to offenders committing drug law offences that involve only small quantities of drugs (production, manufacture, acquiring, possession for personal use); this is not available within two years of a previous suspension.

FIGURE 3

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)

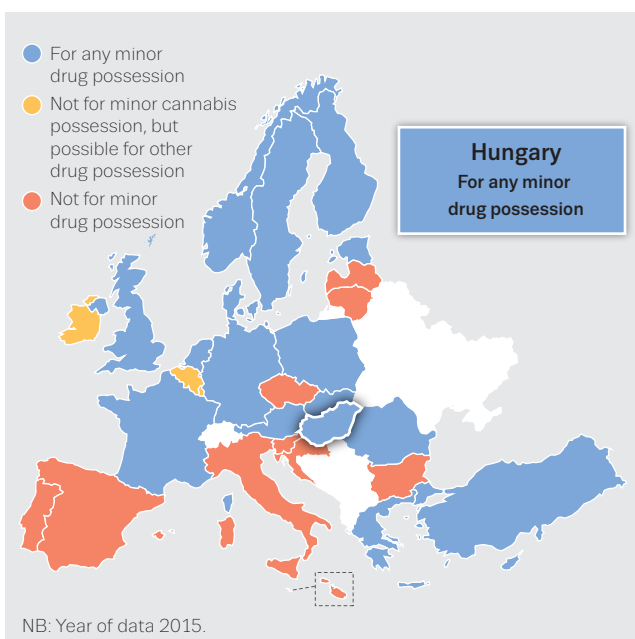
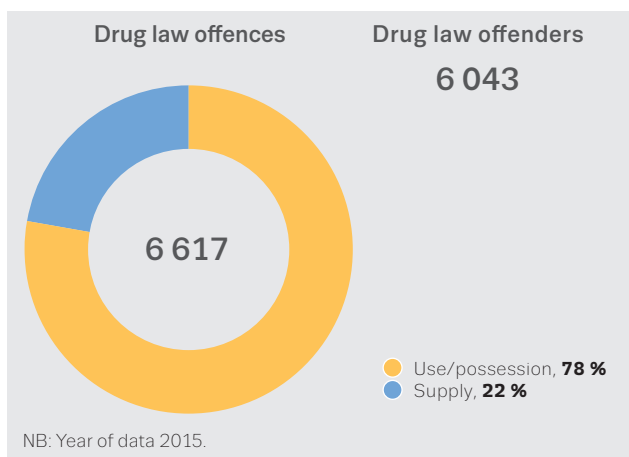


FIGURE 4

Reported drug law offences and offenders in Hungary



To control NPS in Hungary, a government decree set up a formalised rapid assessment in 2012. This could then lead to inclusion of the NPS in Decree 55/2014 of the Minister of Human Capacities. Inclusion would mean temporary control for one year with the possibility of an extension of one year (or until new information emerges). Accordingly, a new section of the 2013 Criminal Code provided for a punishment of up to three years in prison for manufacture and (since January 2014) one to five years for supply and up to three years for possession of more than a small amount (10 g) of NPS. The section penalising the incitement of minors to use 'a substance or agent that has a narcotic effect but is not classified as a drug' is retained, although the maximum penalty has been reduced from three to two years.

Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and they are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on implementation of drug laws and to improve strategies.

The 2015 statistical data on DLOs from Hungary indicate that almost half of them are related to cannabis; the next most prevalent DLOs are those related to stimulants. Since 2012, when a criminal liability for NPS offences was introduced, the proportion of NPS-related supply offences has increased among all supply-related DLOs. In 2015, the majority of DLOs were use/possession related (Figure 4).

Drug use

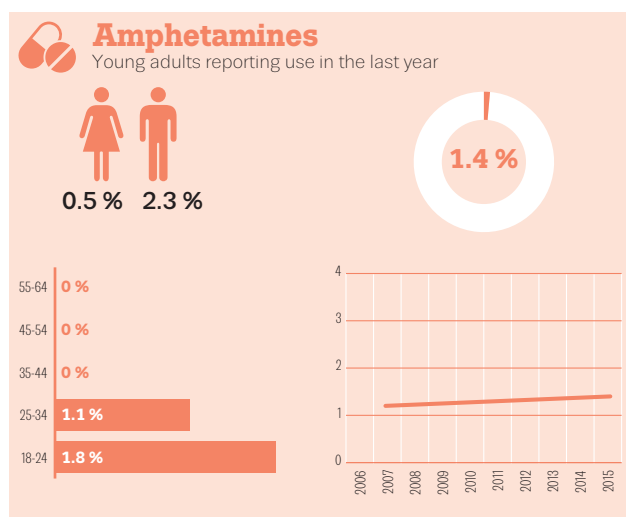
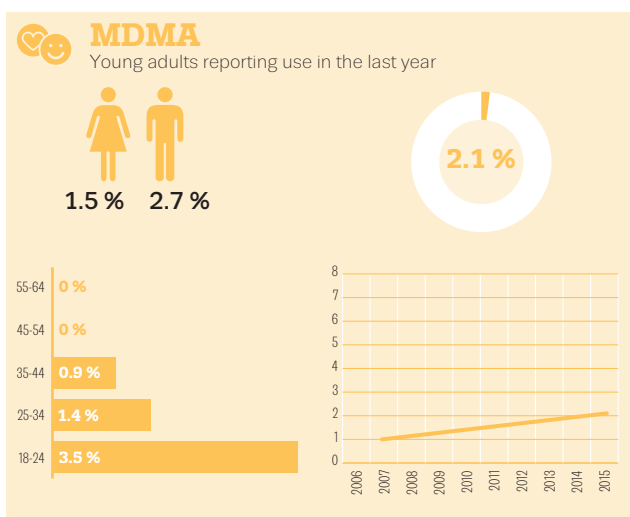
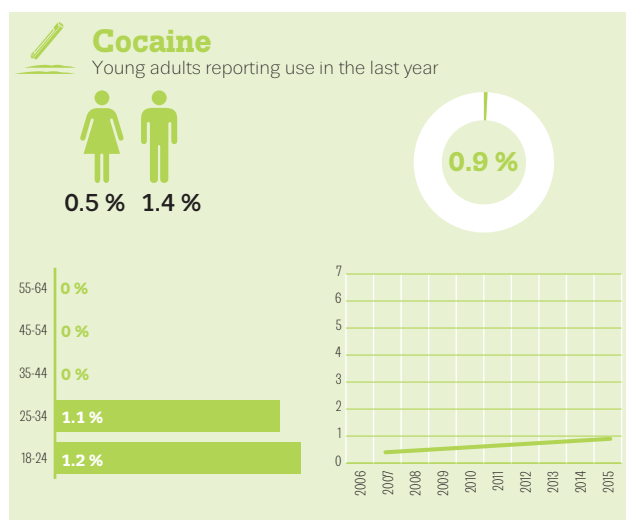
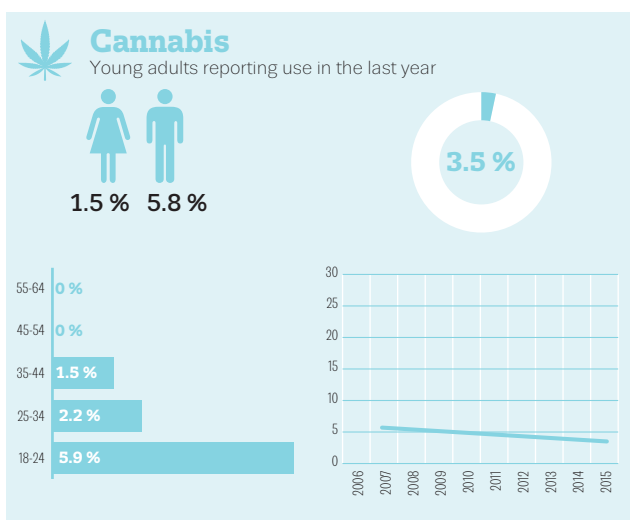
Prevalence and trends

In Hungary, cannabis is the most commonly used illicit substance among the general population and its use is concentrated among young adults aged 18-34 years. The most recent data point to a decrease in last-year cannabis use among young adults. Against this background, use of MDMA/ecstasy, cocaine and amphetamines increased in 2007-15 (Figure 5).

Moreover, following the emergence of NPS in the Hungarian drug market, these substances, which mainly belong to the groups of synthetic cannabinoids, synthetic cathinones or amphetamine derivatives, have become as popular as established illicit drugs, in particular among young adults.

FIGURE 5

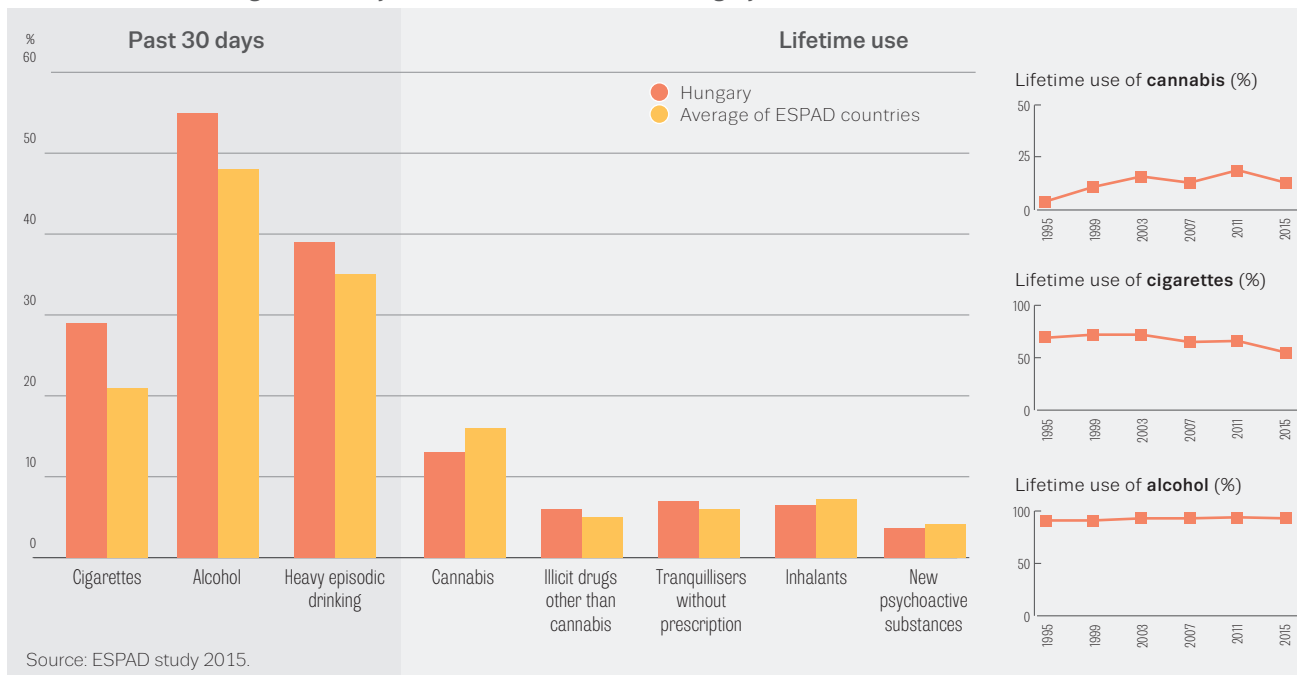
Estimates of last-year drug use among young adults (18-34 years) in Hungary



NB: Estimated last-year prevalence of drug use in 2015.

FIGURE 6

Substance use among 15- to 16- year-old school students in Hungary



Drug use among students is reported in the European School Survey Project on Alcohol and Other Drugs (ESPAD). This study has been conducted among 16-year-old students in Hungary regularly since 1995. The results of the 2015 ESPAD study confirmed that cannabis remains the most commonly used drug among this group, albeit at a lower level than in 2011, and that lifetime use of cannabis among Hungarian students is somewhat lower than the ESPAD average (35 countries). The prevalence rates of lifetime use of illicit drugs other than cannabis and NPS are similar to the ESPAD averages. In contrast, more Hungarian students reported use of alcohol in the last 30 days, and the reported frequency of heavy episodic drinking was also higher than the average for all countries (Figure 6).

High-risk drug use and trends

Studies reporting estimates of high-risk use can help to identify the extent of the more entrenched drug use problems, while data on the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 8).

In the Hungarian context, high-risk drug use is currently linked mainly to injection of stimulants and NPS. Studies carried out in recent years indicate that there has been a continuous increase in injection of NPS (largely synthetic cathinones) and, in particular, that there has been a shift from injecting established drugs (heroin and amphetamines) to injecting NPS. According to data from clients of needle and syringe programmes, injecting heroin use has decreased significantly (Figure 8).

High-risk drug use is currently linked mainly to injecting stimulants and NPS

The data from specialised treatment centres in Hungary indicate that there has been a continuous increase in the numbers of clients seeking treatment services for NPS and a decrease in heroin treatment demand since 2010. Cannabis was the primary substance most frequently reported by first-time clients entering treatment in 2015 (Figure 8), many of whom entered treatment as an alternative to the criminal procedure system and might not exhibit dependence symptoms.

Injecting remains the primary mode of drug use among those entering drug treatment as a result of the use of heroin, amphetamines or other synthetic stimulants (mainly NPS). Approximately 2 out of 10 clients entering treatment are female.

FIGURE 7

National estimates of last year prevalence of high-risk opioid use

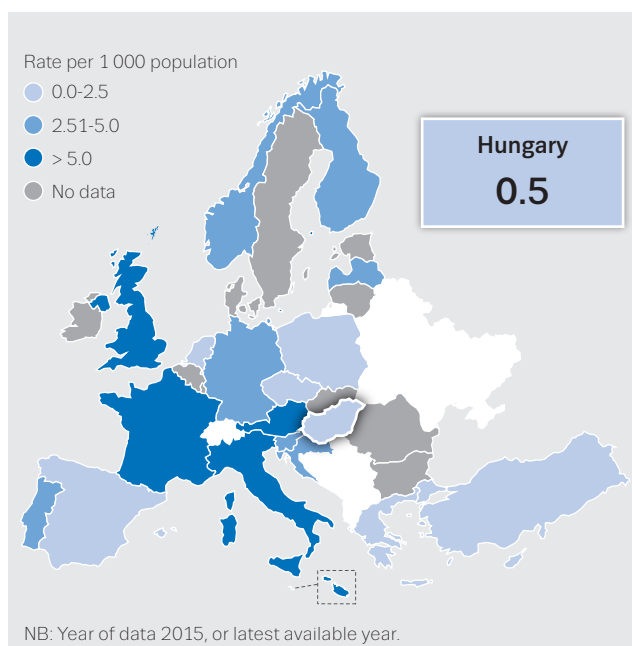
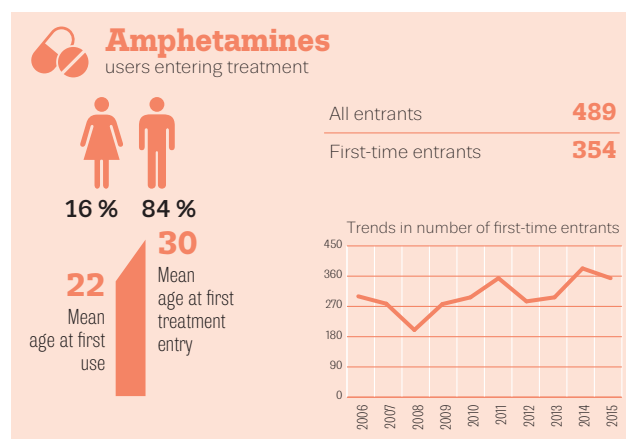
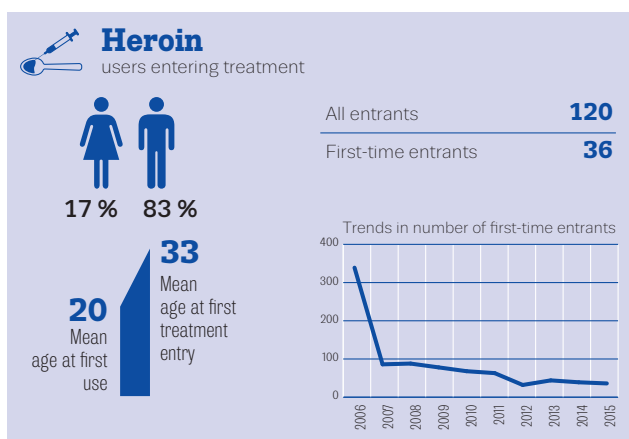
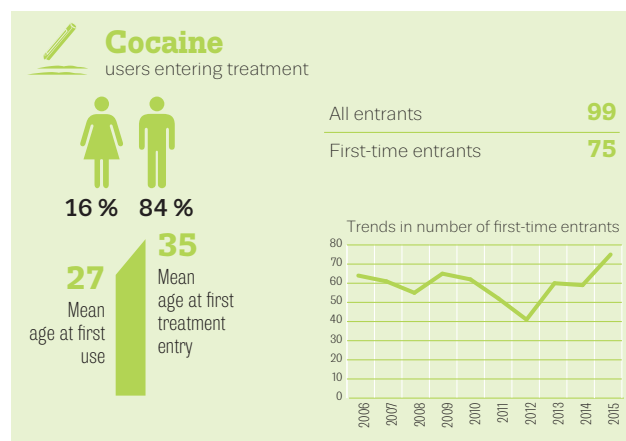
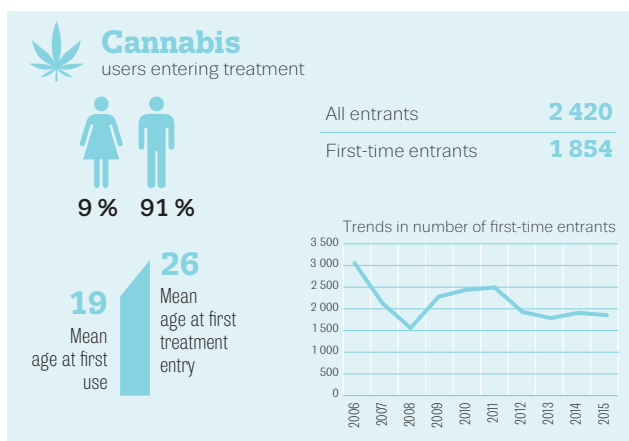


FIGURE 8

Characteristics and trends of drug users entering specialised drug treatment centres in Hungary



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants.

Drug harms

Drug-related infectious diseases

In Hungary, data on drug-related infectious diseases are available from the National Registry of Infected Patients and the special human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and hepatitis surveillance database, which is complemented by the nationwide prevalence surveys on infectious diseases among people who inject drugs (PWID), which have been carried out annually since 2006.

The number of new HIV cases reported annually in Hungary has increased since 2011, but only a few cases are linked to injecting drug use (Figure 9). The number of registered acute hepatitis C virus (HCV) infections due to injecting drug use increased notably between 2006 and 2013.

The prevalence of drug-related infections among PWID in Hungary was stable until 2011, with only HCV and hepatitis B virus infections detected, mainly among opioid injectors. However, since 2011, the HCV infection rates among PWID have almost doubled. The most recent study indicated that 8 out of 10 PWID reporting recent injection of NPS were HCV positive. In 2015, an HIV-positive individual was identified in the prevalence survey carried out among PWID (Figure 10). The increase in HCV prevalence is explained by new patterns of injecting drug use; in particular, NPS are injected more frequently and, as a result, sharing and reusing injecting equipment has become more common.

FIGURE 9

Newly diagnosed HIV cases attributed to injecting drug use

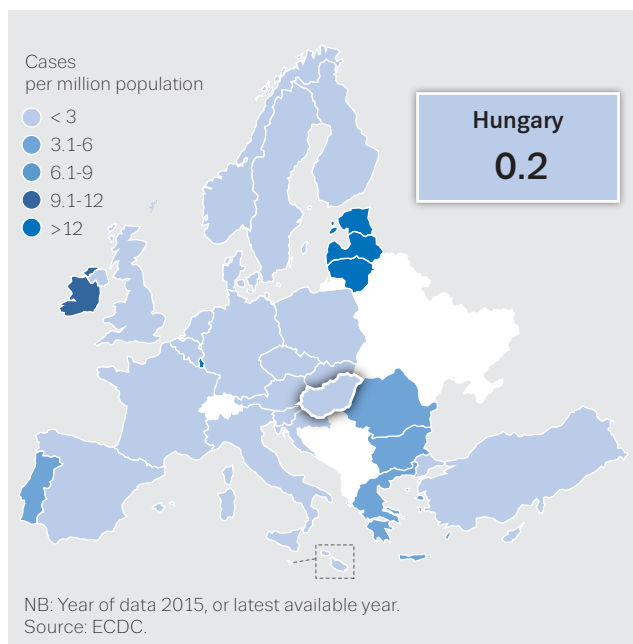
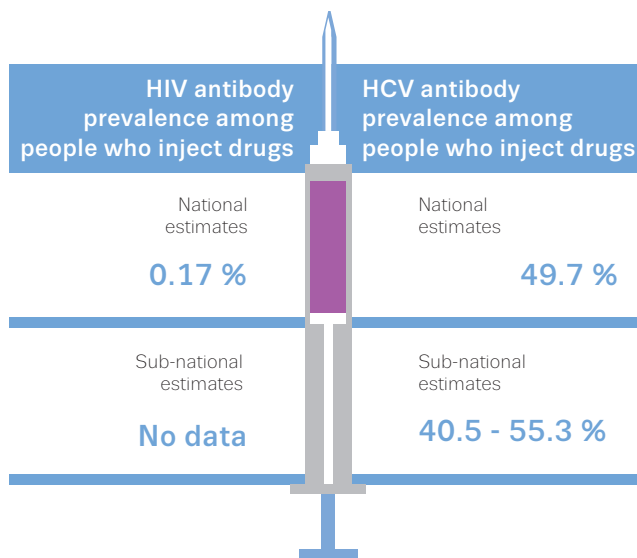


FIGURE 10

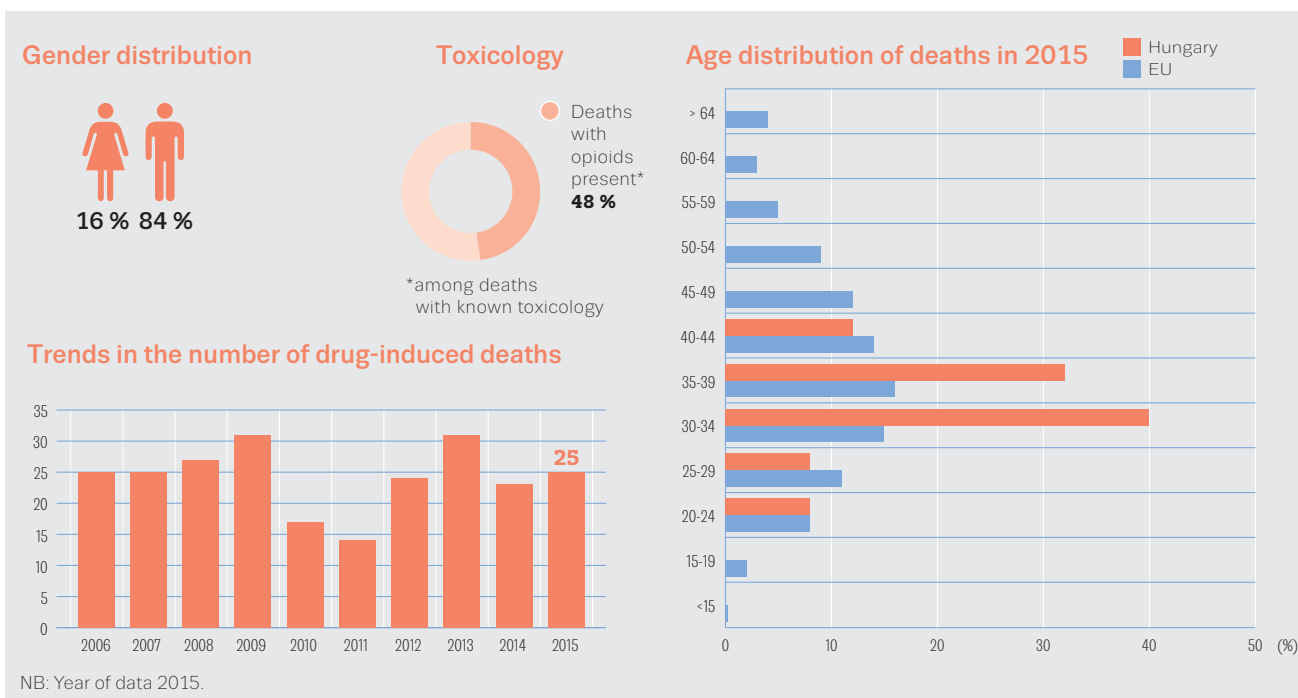
Prevalence of HIV and HCV antibodies among people who inject drugs in Hungary



NB: Year of data 2015.

FIGURE 11

Characteristics of and trends in drug-induced deaths in Hungary



Drug-induced deaths and mortality

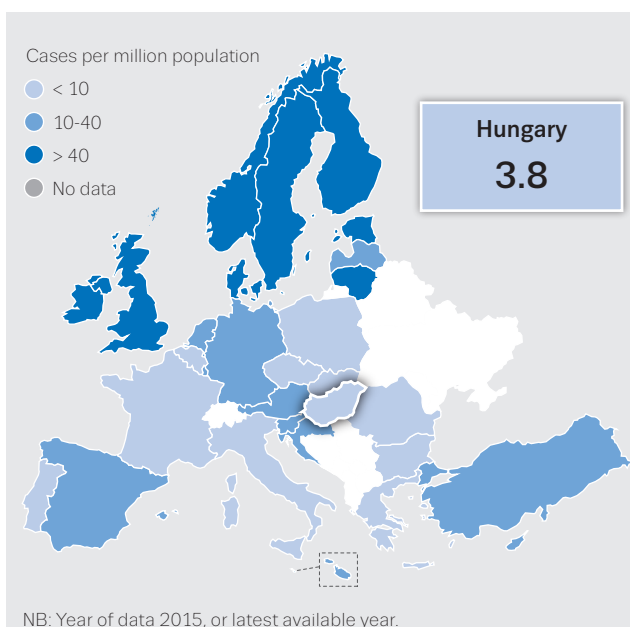
Drug-induced deaths are deaths that can be attributed directly to the use of illicit drugs (i.e. poisonings and overdoses).

Overall, Hungary has reported between 20 and 30 drug-induced deaths annually for the past 10 years. The fluctuation in the number of deaths reported before 2010 was attributed to the purity of heroin. Availability of heroin fell significantly after 2010 and, as a result, other opioids started to dominate in drug-related death data. In 2015, according to the toxicological results, opioids were involved in approximately half of all deaths and were always found in combination with other psychoactive substances. In the remaining cases, stimulants, including NPS, were detected. Currently, toxicological examination of victims of drug-related deaths in Hungary typically reveals the presence of NPS in combination with other drugs. The majority of victims are male and the average age at the time of death is 33 years (Figure 11).

The drug-induced mortality rate among adults (aged 15-64 years) in Hungary was 3.8 deaths per million in 2015 (Figure 12), which is below the most recent European average of 20.3 deaths per million.

FIGURE 12

Drug-induced mortality rates among adults (15-64 years)



Prevention

The Hungarian National Anti-drug Strategy 2013-20 prioritises drug prevention activities and defines 10 main settings where they should be carried out: local communities, family, general education and child protection institution systems, higher education, peer groups, media, workplace, prisons and institutions administrating treatment as an alternative to criminal procedure.

In Hungary, prevention activities are mainly financed by the state-supported annual grant system. However, the one-year cycle adopted for awarding grants has been seen as a challenge in terms of sustainability and continuation of prevention activities, particularly those implemented by non-governmental organisations (NGOs). Financing from various European Union funding sources is used to increase the capacity of prevention professionals and to support the implementation of larger prevention campaigns.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups who may be at greater risk of developing drug use problems and indicated prevention focuses on at-risk individuals.

In Hungary, environmental prevention activities in recent years have focused on the regulation of the availability of tobacco and the restriction of smoking in public places.

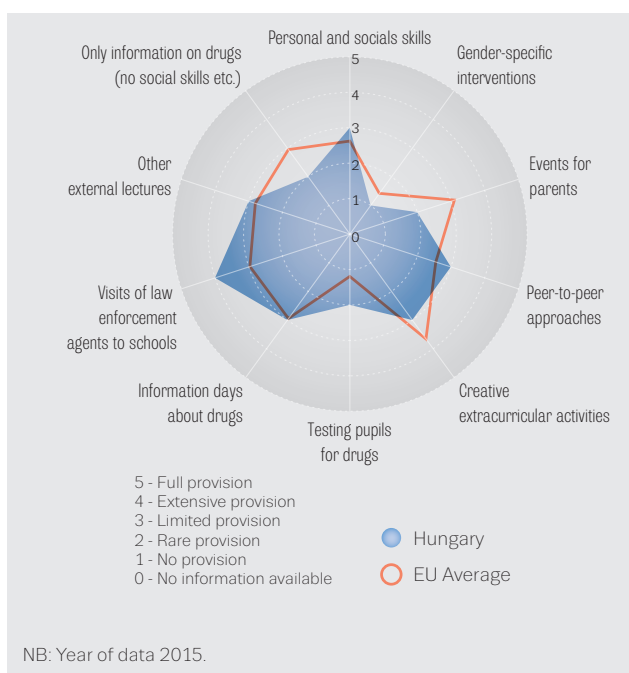
Universal prevention activities are mainly implemented in educational settings within a framework of comprehensive health promotion programmes and are frequently run by NGOs. The police are actively involved in prevention activities in educational settings through several initiatives. Only programmes recommended by the National Institute for Health Development (NEFI), which is in charge of the accreditation and monitoring of prevention activities in schools, are permitted to be implemented. In recent years, a shift from one-way information provision towards more interactive programmes that attempt to influence the attitudes and beliefs of the target audience has been noted (Figure 13).

With regard to selective prevention, these activities target young people living in state care, prisons and disadvantaged neighbourhoods, as well as homeless young people and pregnant women and families with substance use problems.

Indicated prevention programmes have the aims of strengthening the family system and developing parental skills among at-risk young people, students attending schools for those with special needs, and those living in families affected by drug use.

FIGURE 13

Provision of interventions in schools in Hungary (expert ratings)



Harm reduction

The current National Anti-drug Strategy defines harm reduction as an entry point and an integrated part of the entire treatment chain operating on the basis of a recovery-based approach.

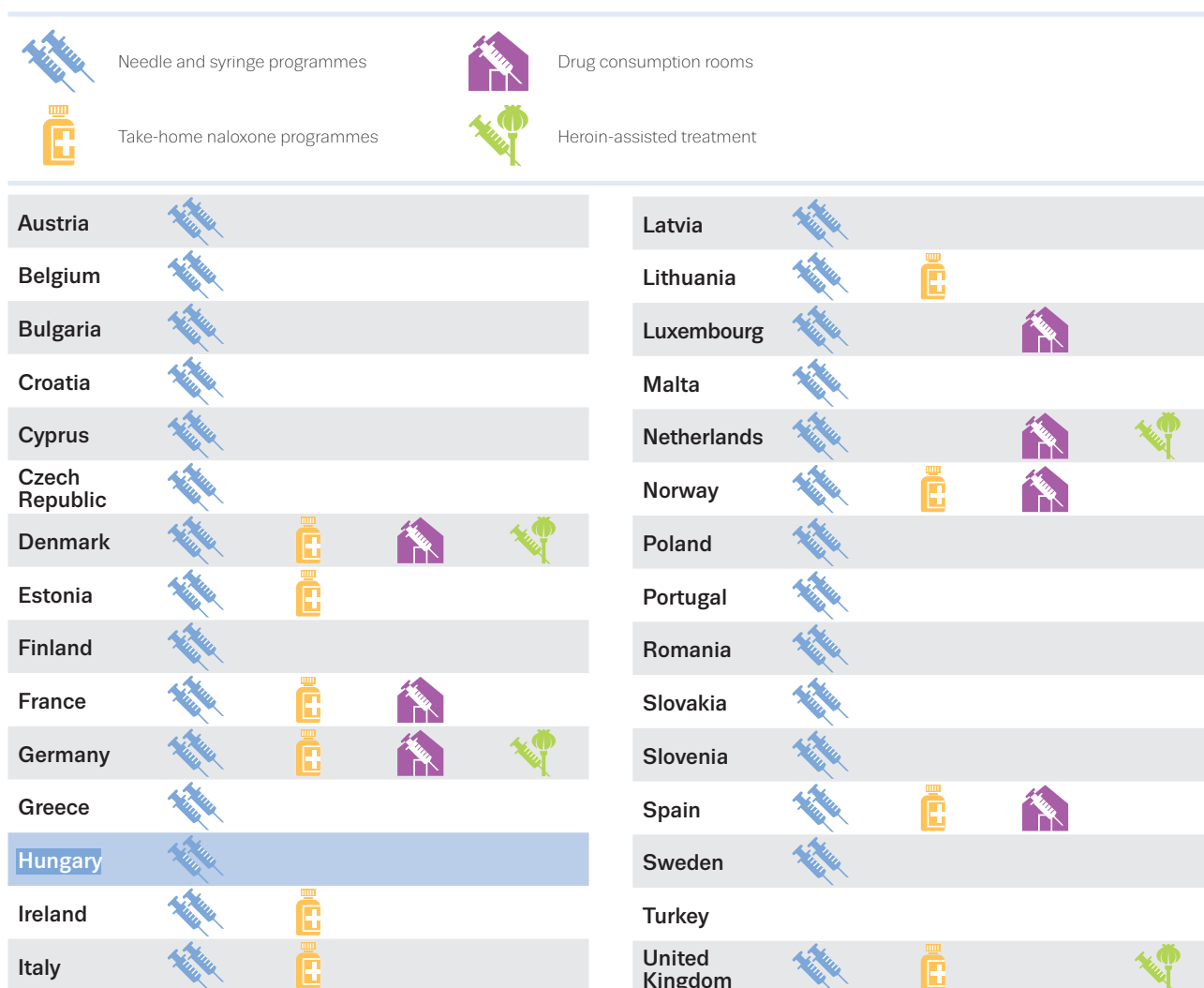
The National Office for Rehabilitation and Social Affairs funds low-threshold services under three-year contracts with service providers that are selected through a tendering procedure. To be eligible for funding, the applicant must deliver at least two of three basic services: psychosocial interventions, counselling services or street outreach. Needle and syringe exchange is a complementary service, which can be funded in combination with the basic services. The last three-year support cycle covered 2012-14 and, in 2015, national financing of all the organisations selected in 2012 was continued. Complementary funding for low-threshold activities may come from local governments and other ministry tendering procedures.

Harm reduction interventions

Needles and syringes are available throughout the country through the needle and syringe exchange programmes that are operated separately or integrated within the treatment system in conjunction with other low-threshold community services. Although the overall number of service providers has remained stable over recent years, each year there are reports of the opening or closure of such programmes. Harm reduction services are delivered at fixed locations, by mobile units and through outreach activities. In four cities, clean needles and syringes are also available from vending machines. In addition to sterile needles and syringes and counselling on safer injecting, most programmes also provide other injecting paraphernalia and condoms (Figure 14).

FIGURE 14

Availability of selected harm reduction responses



NB: Year of data 2016.

In the last five years, the annual number of syringes distributed in Hungary has fluctuated as a result of changing drug use patterns, decreases in funding or the closure of services; the 2016 EMCDDA HIV risk assessment indicated that the number of syringes distributed by specialised programmes was low.

In the last five years, the number of syringes distributed in Hungary has fluctuated as a result of changing drug use patterns, decreases in funding or the closure of services

Treatment

The treatment system

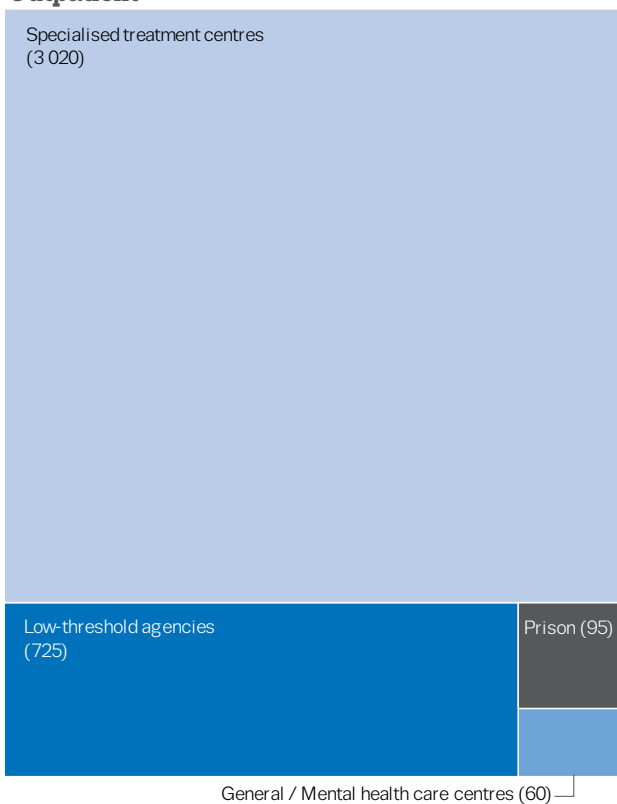
The treatment-related objectives of the current Hungarian National Anti-drug Strategy are built on a recovery-oriented approach and place emphasis on enhancing the availability and quality of treatment services, with a particular focus on young people. In Hungary, treatment of drug users is a task shared by the healthcare system and social services, with the participation of the non-governmental institutions. The State Secretariat for Health Care is responsible for all aspects related to drug users' healthcare, while the State Secretariat for Social Affairs and Social Inclusion is in charge of issues related to social care. Both secretariats are located at the Ministry of Human Capacities. Treatment services at a regional level are primarily provided by public bodies and, to a lesser extent, by non-governmental drug service providers.

A clear separation exists between the financing, definition, regulation and inspection of social and health services.

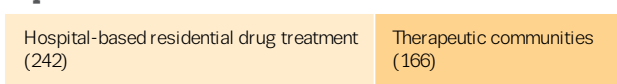
FIGURE 15

Drug treatment in Hungary: settings and number treated

Outpatient



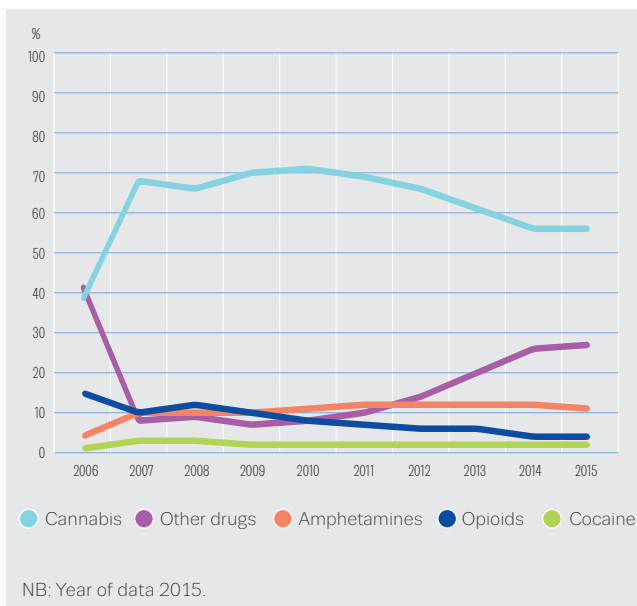
Inpatient



NB: Year of data 2015.

FIGURE 16

Trends in percentage of clients entering specialised drug treatment, by primary drug, in Hungary



The health services for drug users are mainly financed by the National Health Insurance Fund, while the majority of social services are financed using a fixed financing model through the social budget, which may be supplemented with additional resources allocated through tendering.

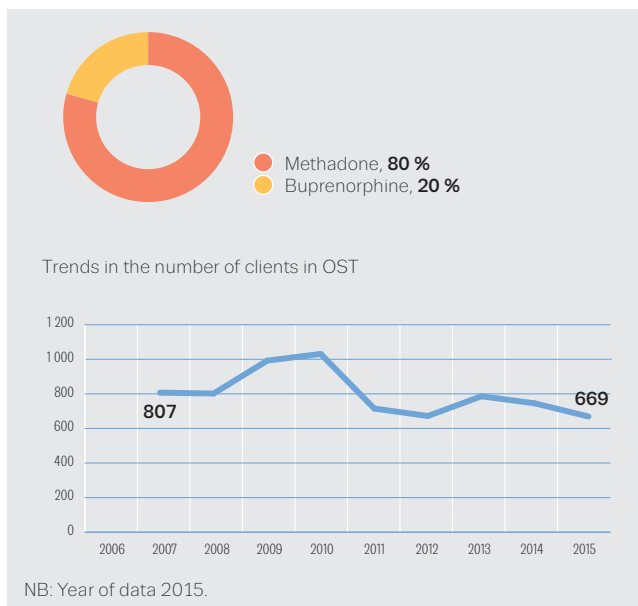
In Hungary, drug treatment is not substance based and covers licit and illicit substances, other dependencies and psychiatric problems. Treatment is offered to drug users at various outpatient and inpatient facilities throughout the country. Some treatment units provide only health or social services, while others provide mixed services. The Hungarian treatment system includes specialised inpatient and outpatient drug treatment units, inpatient and outpatient units for addiction or mental health, therapeutic communities and crisis intervention departments.

Quasi-compulsory treatment (QCT) as an alternative to criminal procedures and long-term rehabilitation are provided mostly by NGOs. The latter services are only partially medical or healthcare-related, and are dominated by social and welfare elements, such as work therapy and social reintegration. In addition, a supported housing service is funded by the state and an online self-help programme for problem cannabis users is offered by some outpatient centres in Budapest.

Opioid substitution treatment (OST) has been available since 1994 (with methadone), while buprenorphine-based treatment was introduced in 2007. Both methadone and buprenorphine-based treatment are financed by the state. Methadone is provided only at specialised

FIGURE 17

Opioid substitution treatment in Hungary: proportions of clients in OST by medication and trends of the total number of clients



outpatient treatment centres, whereas buprenorphine can be prescribed by any psychiatrist. OST is provided within the remit of outpatient treatment services, but it is also provided by some inpatient treatment providers, mostly for detoxification purposes.

Treatment provision

Of all treatment clients entering drug treatment services during 2015, most entered treatment as an alternative to criminal procedures and they were mainly treated in outpatient units (Figure 15). Cannabis remained the primary substance of use among all treatment clients entering treatment in 2015, followed by other drugs (mainly NPS), amphetamines and opioids. Cannabis is also the most frequently noted primary substance for those who enter the treatment through the criminal justice system. The long-term analysis indicates a decrease in heroin-related treatment demands and an increase in the number of clients entering treatment for NPS use. Synthetic cannabinoids and synthetic cathinones are the most common groups of NPS for which treatment is sought (Figure 16).

The long-term analysis indicates a decline in the number of OST clients in Hungary, which is explained by the reduction of the amount of heroin in the market and therefore in the related treatment demand. The majority of OST clients were treated with methadone in 2015 (Figure 17).

Drug use and responses in prison

Prisons in Hungary are the responsibility of the Ministry of Interior.

According to the available national data on drug use among prison inmates, 30-40 % of inmates in Hungarian detention facilities had used an illicit drug at some point in their lives prior to imprisonment. Cannabis was the most commonly used drug, followed by stimulants, mainly amphetamines. Data from a 2008 study indicated that 14 % of inmates had used drugs while in prison. The increasing use of NPS (mainly synthetic cannabinoids) among inmates has been observed in recent years, mirroring increasing consumption in the community, although reliable data are not available.

The prevalence of HIV, hepatitis B virus (HBV) and HCV infections is higher among inmates than in the general population. Based on a 2009 study, HBV and HCV prevalence among inmates is approximately 2 % and 5 %, respectively. HCV prevalence is higher among those who have used drugs (9 %) and even higher among those who had injected drugs (23 %). Recent studies on HIV/HCV prevalence among PWID have reported that almost half of PWID have been in prison at some time in their lives.

Drug treatment and care in prisons is organised on the basis of a medical model, in which drug use is seen primarily as a medical problem. The Hungarian legal system provides the opportunity for those committing a drug-related offence to participate in the three-level system of treatment as alternative to criminal procedure (QCT), comprising preventive consulting services, drug treatment and treatment for other conditions related to drug use.

Drug treatment is available in prison mainly as part of an alternative to a criminal procedure and is provided by the prison system health services and external treatment providers, mainly outpatient services. This system is supplemented by the prevention programmes offered by different NGOs, which, because of their tender-based financing, provide heterogeneous and ad hoc content.

Prison inmates may receive drug treatment in the form of psychosocial intervention, counselling or pharmacologically assisted treatment. OST, which can be initiated or continued in prison, is available at outpatient centres, although the number of those receiving OST in prison remains very low.

Infectious disease testing, counselling and treatment are available in prison. Few prisons have post-release overdose prevention programmes. There is no formal pre-release procedure for inmates receiving drug-related treatment, although they may be referred to appropriate services. Reintegration programmes aimed specifically at drug users are available in approximately half of prisons.

**In recent years, increase
NPS use among prison
inmates has been
observed, mirroring
increasing consumption
in the community**

Quality assurance

The Hungary's National Anti-drug Strategy 2013-20 lists among its objectives the development of quality assurance mechanisms and the necessary institutional background regarding both prevention and treatment services.

The professional accreditation procedure was introduced in 2013 for health development programmes implemented in schools. According to the procedure, only those health development programmes (including drug prevention programmes) that had previously received professional approval under this procedure can be implemented in schools. The institution responsible for the coordination of the programme accreditation procedure is the NEFI. Accreditation criteria are based on structural characteristics of the facility or service and the accreditation may be acquired in the scope of a tender on the basis of legislative authorisation.

In the field of treatment and harm reduction, methodological guidelines and protocols are available to promote best practice and higher-quality services. Three protocols for the treatment of drug users have been developed, and these are updated every two years. In addition, a methodological letter has been issued by the Ministry of Health. Professional recommendations on low-threshold services for drug users have also been developed and form the basis of calls for and assessments of applications for three-year fixed state funding. Professional recommendations for harm reduction programmes operating in recreational settings and for needle and syringe programmes also exist.

Currently, there is no specific education system for the training of drug demand reduction professionals.

The professional accreditation procedure was introduced in 2013 for health development programmes implemented in schools

Drug-related research

The Ministry of Human Capacities coordinates drug-related research through an open tendering mechanism. Research priorities are included in the National Anti-drug Strategy 2013-20 and focus mainly on data collection through the national focal point for the EMCDDA and on the assessment of the effectiveness and efficiency of treatment and care. The development of methodology to assess the impact of the treatment and care system on mental health is also mentioned. Furthermore, the policy programme relating to the anti-drug strategy encourages international and regional research collaboration, in addition to nationally initiated research.

The national focal point conducts and initiates small research projects, collects all research reports available in Hungary and disseminates their results through its website and newsletter. Research results are usually available from public institutions and from funding institutions' and researchers' websites. Recent drug-related studies have focused primarily on population-based and clinical epidemiology studies, but studies of basic biological, demand reduction, supply and crime and policy research have also been carried out.

The national focal point to the EMCDDA conducts and initiates small research projects, collects all research reports available in Hungary and disseminates their results through its website and newsletter

Drug markets

In recent years, the Hungarian drug market has been restructured considerably. Most notably, NPS are increasingly replacing the established drugs, thus posing challenges to law enforcement agencies. In addition, as demonstrated by a recent national study, a tendency towards fragmentation of the retail market is occurring, with separate retail markets for stimulants and cannabis products.

Cannabis products remain the most frequently seized established drug in Hungary (Figure 18). Herbal cannabis is increasingly being smuggled into the country by Vietnamese-led criminal groups from the Czech Republic, from the West Balkan countries and by Hungarian offenders from the Netherlands. Cannabis is also cultivated in Hungary, albeit on a small scale.

Hungary has traditionally been a transit country for heroin originating from Afghanistan and trafficked across the Middle East via the Balkan route to West Europe. However, a 'heroin shortage' was observed in the Hungarian market in 2011-13, when the number of heroin seizures was very low compared with the period before 2010, and the

amounts seized were relatively small. Synthetic drugs, such as amphetamines and MDMA, are smuggled from Belgium and the Netherlands. In 2015, several large seizures of MDMA tablets were reported, which resulted in the largest amount being reported for the period 2011-15.

In addition, two small-scale amphetamine production sites were dismantled in 2015. In recent years, the cocaine seized in Hungary had been transported in cars through Spain and the Netherlands, or has been smuggled directly from South America by drug mules. The data indicate an increasing trend in cocaine seizures, while the amounts seized show large annual fluctuations (Figure 18).

China is the main source of NPS, and these substances usually arrive in Hungary by post, although some raw materials are shipped from Slovakia, the Netherlands and Spain. The proportion of all seizures accounted for by NPS has increased steadily since 2010. These substances were involved in nearly 60 % of all seizures in 2014, while, in 2015, NPS were seized as frequently as established drugs. Herbal substances treated with synthetic cannabinoids and cathinone derivatives are the most commonly seized NPS. Long-term detailed analysis indicates that the NPS market is changing rapidly, which has

FIGURE 18

Drug seizures in Hungary: trends in number of seizures (left) and quantities seized (right)

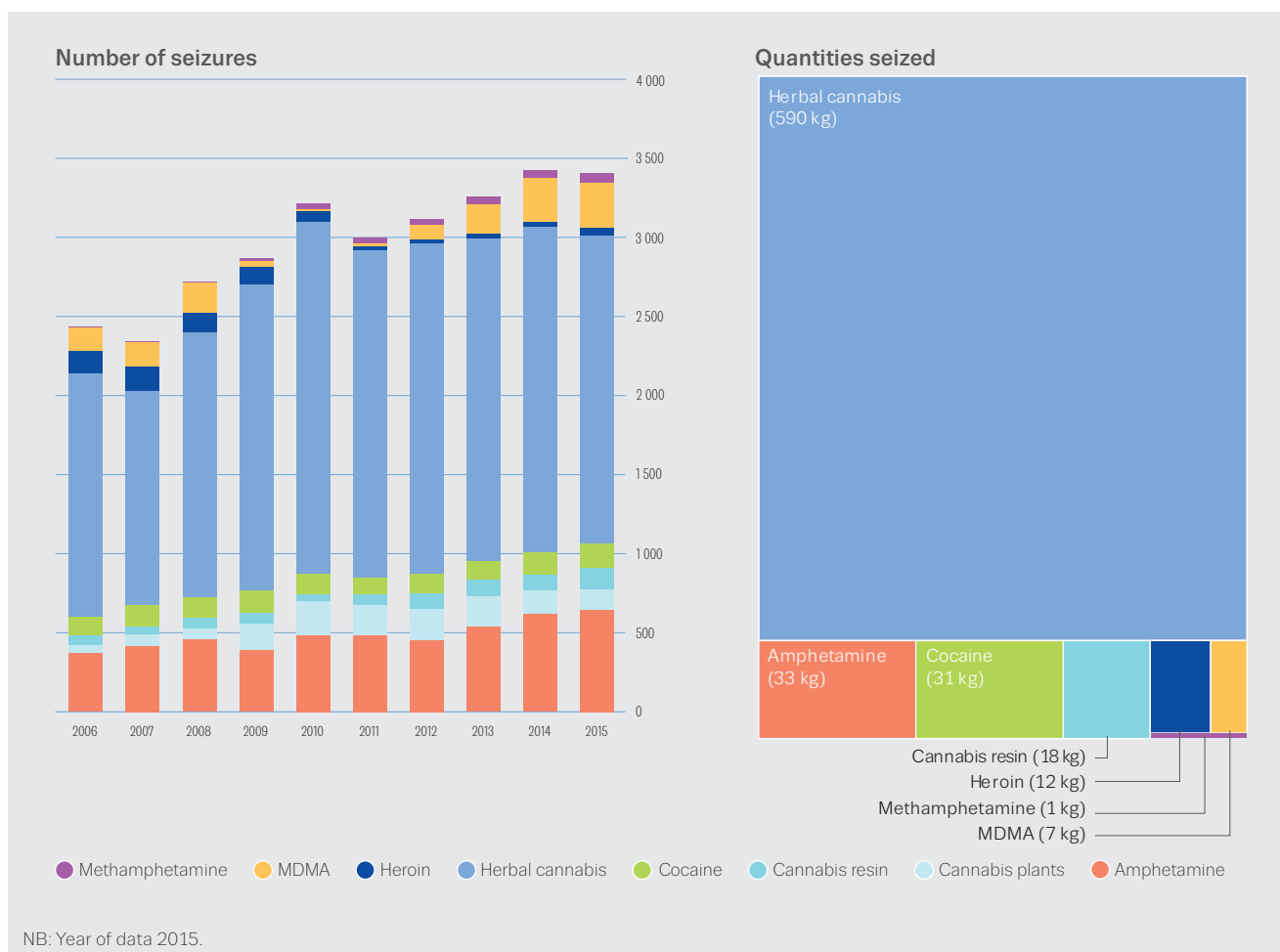


FIGURE 19

Price and potency/purity ranges of illicit drugs reported in Hungary



NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum. Year of data 2015.

been determined mainly by the introduction of new control mechanisms. In 2015, several seizures of untreated herbal material and synthetic cannabinoid preparations were reported, indicating that some packaging/mixing of NPS products may have taken place in the country.

The retail price and purity of the main illicit substances seized are shown in Figure 19.

KEY DRUG STATISTICS FOR HUNGARY

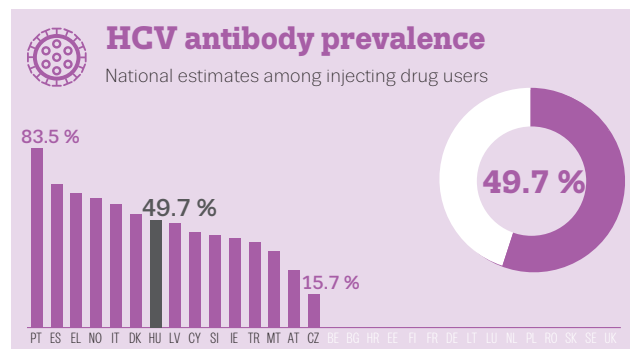
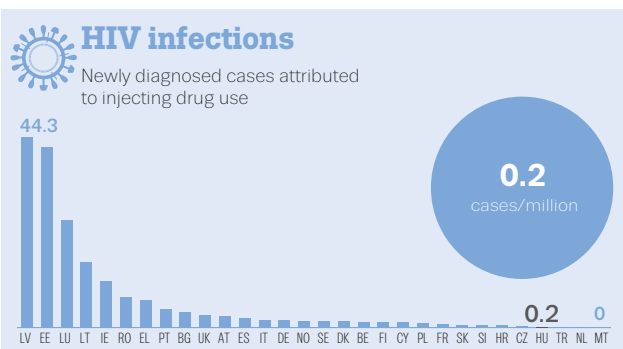
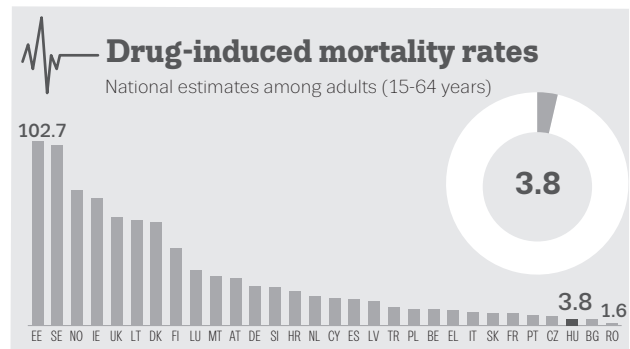
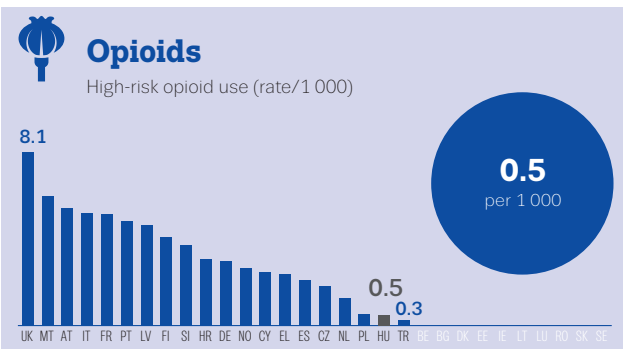
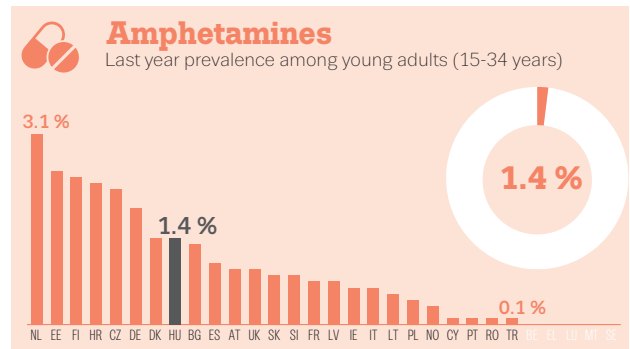
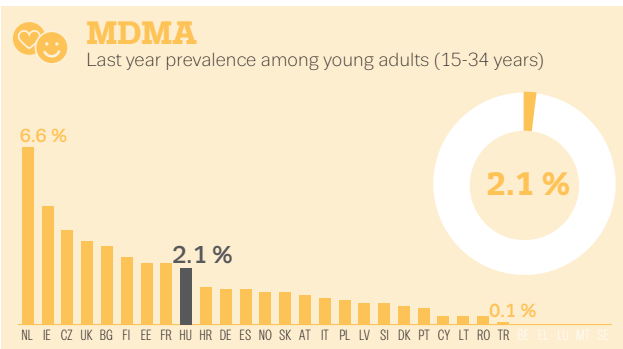
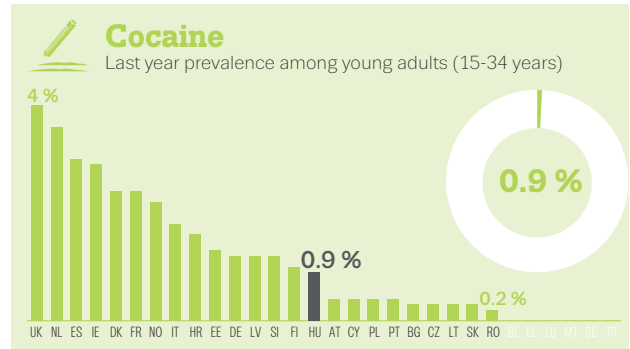
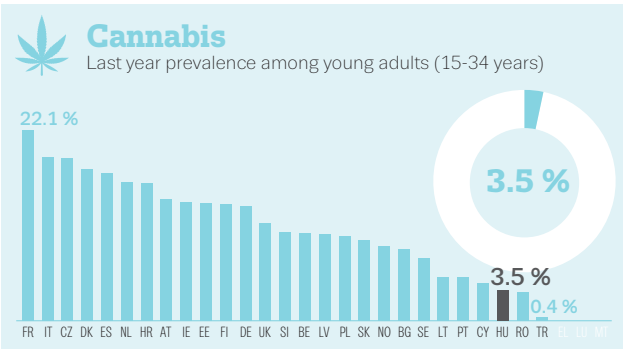
Most recent estimates and data reported

	Year	Country data	EU range	
			Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	13.1	6.5	36.8
Last year prevalence of use — young adults (%)	2015	3.5	0.4	22.1
Last year prevalence of drug use — all adults (%)	2015	1.5	0.3	11.1
All treatment entrants (%)	2015	56	3	71
First-time treatment entrants (%)	2015	63	8	79
Quantity of herbal cannabis seized (kg)	2015	589.6	4	45 816
Number of herbal cannabis seizures	2015	1 945	106	156 984
Quantity of cannabis resin seized (kg)	2015	18.1	1	380 361
Number of cannabis resin seizures	2015	141	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	0.2-20	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	0.5-30	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	3.2-16.1	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	3.2-16.1	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.4	0.9	4.9
Last year prevalence of use — young adults (%)	2015	0.9	0.2	4
Last year prevalence of drug use — all adults (%)	2015	0.3	0.1	2.3
All treatment entrants (%)	2015	2	0	37
First-time treatment entrants (%)	2015	3	0	40
Quantity of cocaine seized (kg)	2015	30.5	2	21 621
Number of cocaine seizures	2015	153	16	38 273
Purity (%) (minimum and maximum values registered)	2015	10-80	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	32.3-96.9	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.7	0.8	6.5
Last year prevalence of use — young adults (%)	2015	1.4	0.1	3.1
Last year prevalence of drug use — all adults (%)	2015	0.5	0	1.6
All treatment entrants (%)	2015	11	0	70
First-time treatment entrants (%)	2015	12	0	75
Quantity of amphetamine seized (kg)	2015	33	0	3 796
Number of amphetamine seizures	2015	644	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	1-70	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	3.2-16.1	1	139.8

	Year	Country data	EU range	
			Minimum	Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.1	0.5	5.2
Last year prevalence of use — young adults (%)	2015	2.1	0.1	6.6
Last year prevalence of drug use — all adults (%)	2015	0.9	0.1	3.4
All treatment entrants (%)	2015	2	0	2
First-time treatment entrants (%)	2015	2	0	2
Quantity of MDMA seized (tablets)	2015	56 420	54	5 673 901
Number of MDMA seizures	2015	287	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	40-200	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	1.6-12.9	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	2010-11	0.5	0.3	8.1
All treatment entrants (%)	2015	4	4	93
First-time treatment entrants (%)	2015	2	2	87
Quantity of heroin seized (kg)	2015	12	0	8 294
Number of heroin seizures	2015	48	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	15-50	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	9.7-80.7	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	0.2	0	44
HIV prevalence among PWID* (%)	2015	0.2	0	30.9
HCV prevalence among PWID* (%)	2015	49.7	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2015	1.0	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2015	3.8	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2015	188 696	164	12 314 781
Clients in substitution treatment	2015	669	252	168 840
Treatment demand				
All clients	2015	4 308	282	124 234
First-time clients	2015	2 956	24	40 390
Drug law offences				
Number of reports of offences	2015	6 617	472	411 157
Offences for use/possession	2015	4 985	359	390 843

* PWID — People who inject drugs.

EU Dashboard



NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.



About our partner in Hungary

The Hungarian national focal point has been located within the National Institute for Health Development since 1 January 2016. Its legal basis was confirmed by an adoption of a governmental resolution in September 2003. The Inter-ministerial Coordination Committee on Drug Affairs oversees the work of the national focal point.

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