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for Drugs and Drug Addiction



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“HUNGARY”

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

REITOX

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SUMMARY

After the Parliament accepted Resolution of the Parliament on the new national strategic programme to be prepared in order to combat the drug problem, in which it requests the Government to prepare the new national strategic programme due from 2010, the Parliament accepted the document submitted by the government, entitled "National strategy for handling the drug problem" on 14 December 2009.

The new drug strategy determines the realistic professional objectives relating to the years 2010-2018, which may result in interventions having favourable results from the aspect of the national drug problem.

The establishment of the Drug Lists Special Committee enables quicker response when taking measures in respect of newly appearing drugs.

At the end of 2009 a study was performed to identify the treatment costs of the patients receiving antiviral therapy because of hepatitis C. It was revealed by the survey that before starting treatment no HCV genotyping takes place, the most important factor influencing treatment costs is the length of the treatment, it is followed by the type and dose of the antiviral drug applied.

In 2009 again drug screening tests were conducted in the Hungarian Army in order to filter out actual users, reduce use, monitor the efficiency of drug prevention methods and set down the foundations of new action programmes. There were no other population surveys conducted in 2009.

The theoretical framework of prevention in the new National Drug Strategy was determined following internationally accepted evidence based principles, in the field of drug prevention. It also emphasises the utilization of community resources, the use of integrated approaches, the development of skills and the use of innovative techniques, the provision of alternatives and early intervention.

In the academic year of 2008/2009 a total number of 79,865 schoolchildren, that is 8.3% of schoolchildren aged 10-18 attending institutes of primary and secondary education took part in drug prevention sessions in the scope of the joint tender invitation issued by the Ministry of Social and Labour Affairs and the Ministry of Education and Culture to support school-based health promotion and drug prevention programmes, which represents a reduction as compared to the previous year.

According to the results of the survey analysing the changes of the prevention competences and activity of the institutes of public education, in the last 5 years the proportion of schools increased, where there are no institutional capacities at all for performing school-based prevention / health promotion tasks, where currently there is no school psychologist, or drug coordinator, or health promoter, or youth doctor, or district nurse regularly visiting the school. However, despite the unfavourable changes the proportion of schools employing a school psychologist increased.

Progress was made in national drug data collection in the recent years: the use of generated codes – which are permanent in respect of the algorithm of its generation, but are still anonymous – made it possible to link up different databases, with the help of which the occurrences of problem drug users can be monitored in the different systems. As a result of connecting databases using generated codes, in 2010 estimates were made to determine the size of problem drug user groups.

On the basis of the point estimation values, the number of heroin users in the years 2007 and 2008 together was estimated at 3,130 persons. In the same two years the number of amphetamine users was 27,323, and the number of cocaine users was 5,592 on the basis of the point estimates.

The databases of the screening programmes aimed at infectious diseases were used to estimate the number of injecting drug users. Two estimates were made concerning two-year periods, in respect of the years 2007 and 2008 together 6,146 IDUs are presumed, while in respect of the years 2008 and 2009 together 5,699 IDUs are presumed by point estimation.

As a whole it can be determined that as compared to the previous year no significant change took place in the healthcare system providing treatment for patients suffering from addiction. In 2009 4,317 new clients entering treatment were reported by 83 treatment units to the TDI data collection. The majority of the clients entering treatment is still represented by those who enter treatment for the first time in their lives because of their problem caused by drug use. In three-quarters of the cases clients entered treatment as an alternative to criminal proceedings.

The greatest proportion of clients still enters treatment because of cannabis use (both among clients in and outside of diversion), they are followed by clients entering treatment because of the use of stimulants and opiates. At the same time it is important to point out that as opposed to opiate users, the majority of clients entering treatment because of using cannabis or stimulants is still represented by clients joining diversion programmes as an alternative to criminal proceedings.

It can be determined that the number of HIV positive cases among IDUs is still probably very low in Hungary, which is supported by the results of the prevalence surveys performed in 2009 and also by the routine HIV/AIDS surveillance data.

In respect of hepatitis C infection, in the last four years the national prevalence rate in the IDU population was around 25%. The difference between the prevalence rates measured in 2008 and 2009, and between the prevalence rates measured since 2006 and 2009 is not significant at the level of $0.1 < p < 0.2$. Hepatitis C infectious rates show great regional differences, which underlines the importance of harm reduction services, especially in large cities. While in Budapest the rate of HCV infection was 40.5%, outside of Budapest this value was 7.9%.

In the case of ever IDU prisoners, on the basis of the screening programme and questionnaire survey conducted in two prisons outside of Budapest, in 2009 the rate of HCV infection was 40%.

As compared to the great increase in the number of cases in 2008, no outstanding increase could be observed in 2009 in the number of patients needing treatment at the Clinical Toxicology Department of Péterfy Sándor Street Hospital. There was a decrease in the number of heroin and methadone overdoses, at the same time the number of treatments needed because of the overdose of cannabis, cocaine and amphetamine type drugs increased.

On a national scale an increase can be observed in the number of direct drug-related deaths, but probably it is due to the more efficient identification of the cases.

In 2009, 30 persons died because of drug overdose (22 in Budapest), and the majority of the cases (28 cases) was due to heroin overdose. In 2009, 8 natural deaths were reported, which could be associated with drug use, and 11 deaths by violence were reported (suicide, murder, accident), when an illicit drug was detected in the deceased person.

In 2009 the needle/syringe programme coverage of the country continued to increase. On the basis of the totalled data, the number of both distributed and returned syringes increased significantly. The increasing tendency is first of all due to the 2009 data of the fixed NSPs, mostly to the ones located in Budapest.

As a response to the increasing number of clients observed in the NSP in the district VIII and to the hepatitis C prevalence, which has been around 70% for several years, several harm reduction measures were taken in this district.

In the scope of a survey carried out in 2009 the main hindrances of entering antiviral treatment of HCV infected IDUs were examined, and several areas that need to be improved

in connection with their treatment were also revealed: for example personal counselling, referring clients to treatment and keeping them in treatment.

The results of a qualitative survey carried out among pregnant drug users show that the attitude of healthcare service providers, stigmatisation and being afraid of losing guardianship of the child still represent problems in providing care for drug user pregnant women.

In 2009, 89% of the clients registered in the TDI database had a permanent place of residence at the time of filling in the questionnaire, and this proportion indicates an increase as compared to the previous year, at the same time it is the same as the proportions observed in the years before. In respect of school qualifications the proportion of those who completed secondary school studies was higher, and the proportion of those with elementary qualifications is slightly lower. 33.6% of the patients entering treatment in 2009 were permanently employed, which is a slight increase as compared to the proportion measured in 2008.

According to a survey covering 13 member organisations of the Federation of the Hungarian Drugtherapeutic Institutes, at national level the therapeutic institutes can accommodate 353 clients at the same time.

On the basis of the estimates made by the heads of the institutes, the largest proportion of the clients are admitted to the therapeutic institutes because of alcohol problems. The most commonly used illicit drugs are opiates, but the proportion of the primary users of opiates is half the proportion of alcohol consumers. Among the therapeutic objectives of the institutes there are three outstanding objectives: "development of social skills and coping strategies", "development of self-knowledge, self-confidence, self-assurance", and "abstinence from all illicit drugs".

In 2008, in the scope of the project facilitating the resocialisation and reintegration of people suffering from addiction 30 programmes were granted support. 14 organisations were granted support for the implementation of relapse prevention programmes and self-help programmes, a total number of 4,399 persons participated in their programmes.

Due to the change occurring in the system of concepts of criminal statistics, in 2009 the categories of revealed offence and revealed offender were replaced by registered offence and registered offender.

According to the data recorded in the Unified Criminal Statistics System of the Investigation Authorities and Public Prosecution, the number of registered offences concerning the misuse of illicit drugs indicates a decrease (11.5%), and the numerical data of consequent crime also indicate decrease. The persons involved in criminal proceedings are typically persons in the case of whom demand-related perpetration could be proved (83.84%). In 80% of drug-related offences cannabis was the subject of the offence, and it is followed by heroin representing a proportion of 7%. The proportion of offenders below the age of 30 is 82% among offenders committing misuse of illicit drugs, while this proportion is only 47% among all registered offenders.

On the basis of the survey carried out in the Budapest Penitentiary and Prison it can be determined that drugs and drug users are present in the detention facilities, although no exact series of data is available (either in the case of drugs or in the case of drug users). At the same time it is obvious that even in closed settings it is necessary to deal with addiction and addiction treatment as well as addicted persons and their care/treatment. On the basis of the survey it can be seen that drug use prior to imprisonment occurs very characteristically among prisoners.

The extensive HCV screening campaign started in 2007 at detention facilities continued in 2009 too. In the course of the campaign all blood samples were tested for HIV and HBV too, and the imprisoned persons participating in the screening programme were also interviewed about drug use and related risk behaviours.

On the basis of the seizure data it can be determined that in 2009 the number of seizures of tablets containing illicit drugs dropped significantly, classic ecstasy tablets containing the active substance MDMA declined, instead of them tablets containing mCPP, amphetamine or both of these substances represented the majority of the seizures.

In 2009 the number of cannabis plant seizures was more than double of the number of seizures in the previous year. Cannabis plantations cultivated under artificial circumstances were seized in a number and size not seen before, which was preceded by thorough intelligence work by the investigation bodies. Despite this the average price of herbal cannabis remained stable.

The popularity of cocaine still shows an increasing tendency on the basis of the investigation and seizure data, an increasing number of distributors who used to deal with other types of drugs before are switching to distribute cocaine. At the same time price of cocaine at street level continued to decrease according to the survey performed among users.

At the end of 2008 and in 2009 a large number of new synthetic substances occurred within a short period of time, as well as known substances in new forms of appearance.

In Hungary two groups of the guidelines relating to the treatment of drug-related problems are distinguished: guidelines relating to healthcare and guidelines relating to social services. Healthcare and social services are determined in separate legal acts, they are financed from different funds and their quality assurance systems are also different.

Guidelines are elaborated differently in the two fields: the social guidelines are based on professional consensus, while the healthcare guidelines are based on professional consensus and on facts. In connection with the adaptation of the guidelines, we do not have comprehensive and reliable data in either field. At the same time, on the basis of the professional experience it can be said that the main hindrance to their application in practice is the lack of agreement in respect of financing.

1. DRUG POLICY, LEGISLATION, STRATEGY AND ECONOMIC ANALYSIS

1.1. LEGAL FRAMEWORK

Laws, regulations, directives or guidelines in the field of drug issues

- a) Government Regulation 62/2010. (III. 18.)

Government Regulation 162/2003. (X. 16.) on the rules of the cultivation, distribution and use of plants suitable for producing illicit drugs was amended by Government Regulation 62/2010. (III. 18.). The Ministry of Rural Development performs registration, control, data collection and data supply tasks relating to poppy cultivation on the basis of Government Regulation 162/2003. (X. 16.) on the rules of the cultivation, distribution and use of plants suitable for producing illicit drugs.

Government Regulation 162/2003. (X. 16.) was amended with a professional aim to enable further sowing of different species of poppy for food and decorative purposes traditionally cultivated in Hungary for decades, with regards to the fact that in recent years no misuse of poppy-head could be observed.

- b) Directive 4/2009. (III. 20.) IRM of the Minister of Justice and Law Enforcement

In 2009, among legal amendments great significance can be attributed to the enactment of directive no. 4/2009. (III. 20.) IRM of the Minister of Justice and Law Enforcement issued to implement the provisions included in article 4 (3) of joint decree no. 42/2008. (XI.14.) EüM-SZMM of the Minister of Health and the Ministry of Social Affairs and Labour containing the detailed rules of the treatment for drug addiction and the treatment of other conditions with drug use of prisoners or their participation in preventive-consulting services. The detailed rules and practical tasks relating to the participation of prisoners in treatment for drug addiction, treatment of other conditions with drug use or preventive-consulting services, and the application of substitution treatment were included in a measure of the Director General of the Hungarian Prison Service.

- c) Decree 128/2009. (X. 6.) FVM of the Ministry of Rural Development

Decree 28/2009. (X. 6.) FVM of the Minister of Rural Development on veterinary preparations contains detailed regulations relating to the activities that can be performed with such products and to the obligations. The legal act determines the rules of handling substances regarded as illicit drugs or precursors to be followed by employees working in veterinary medicine.

- d) Government Regulation 282/2007 (X. 26.)

On the basis of the provision of Government Regulation 282/2007 (X. 26.) on the designation of the bodies in charge of the special requirements of the special fields and on the bodies exclusively proceeding in certain special issues and providing expert opinions in certain special fields, in force since 01.01.2009, if the investigation is performed by the Hungarian Customs and Finance Guard, the Institute for Chemical Analysis of the Hungarian Customs and Finance Guard issues an expert opinion in respect of the substance-based test.

- e) Joint decree 57/2009. (X. 30.) IRM-ÖM-PTNM of the Minister of Justice and Law Enforcement, the Minister of Local Government and the Minister without a portfolio in charge of civil national security services

The decree is about the health, psychic and physical suitability of the professional staff of certain police organisations, the occupational health suitability of the public servants and civil servants of such organisations, the determination of their incapacity for service or employment, and basic healthcare supply, a part of which is formed by the monitoring of drug use and its consequences.

f) Government Regulation 1196/2009 (XI. 20.)

Government Regulation 1196/2009 (XI. 20.) on the tasks relating to the new classification of new substances or known substances dangerous from the aspect of misuse was accepted in November 2009. The Government Regulation determines the tasks of the minister in charge of healthcare, law enforcement, drug prevention and drug-related coordination tasks in connection with the classification of substances appearing in illegal circulation and dangerous from the aspect of misuse.

According to article 27 (2) of Government Regulation 142/2004 “new substances that are dangerous from the aspect of misuse shall be entered in the appropriate register of illicit drugs or psychotropic substances, if their suitability for pathological enjoyment can be clearly determined”. Government Regulation 1196/2009 settles the process of this regulation.

g) Resolution 106/2009 (XII. 21.) OGY of the Parliament

On 14 December 2009 the Parliament accepted the document submitted by the government, entitled "National strategy for handling the drug problem" (see: chapter 1.2.).

h) Directive 26/2009. (OT 15.) ORFK of the National Police Headquarters

In the scope of special administration, at the Criminal Department of the National Police Headquarters, a National Police Headquarters directive was prepared under no. 26/2009. (OT 15.) on the tasks to be performed by the organisations of the Police during the investigation of criminal offences related to the misuse of illicit drugs. The directive also determines the tasks of the organisational units of the police relating to intelligence and investigation concerning criminal offences related to the misuse of illicit drugs, the rules of seizing substances rising the suspicion of being illicit drugs, and the detailed procedure of confiscation, storage, exhibit handling, annihilation and transportation in the case of finding substances rising the suspicion of being illicit drugs.

i) Directive 43/2009. (OT 26.) ORFK of the National Police Headquarters

The law enforcement service prepared the directive no. 43/2009. (OT 26.) ORFK of the National Police Headquarters on the tasks to be performed in the course of the law enforcement activity of the police against drug-related crime, the aim of which is to provide comprehensive regulations relating to the activities to be performed by the police within its sphere of administrative and law enforcement tasks in connection with illicit drugs and psychotropic substances, as well as chemicals (precursors) used for the illegal production of illicit drugs and psychotropic substances.

j) Measure 167/2009. (HK5.) MH HEK of the Hungarian Army's Health Centre

Measure no. 167/2009. (HK5.) MH HEK issued by the commander of the Hungarian Army's Dr. Radó György Health Centre is about the performance of tasks relating to the monitoring of being under the influence of drugs, drug use and drug possession in respect of the Hungarian Army's staff.

Laws implementation

Based on data from the Public Prosecutor's Office, 2,828 persons were sentenced for drug-related offences in 2009. These offenders committed 3,357 offences, which they were called to account for on the following legal grounds:

- 2,056 offenders (72.7%) were sentenced for drug use related offences prohibited by Section 282 and Section 282/A of the Criminal Code;
- 710 offenders (25.1%) were sentenced for trafficking related offences prohibited by Section 282, Section 282/A and Section 282/B of the Criminal Code;
- 42 persons (1.5%) were sentenced for conducts as prohibited by Section 282/C (drug-addicted persons committing use or trafficking-related offence);
- 20 persons (0.7%) were sentenced for other conducts

In 2009, the following punishments and measures were imposed upon the 2,828 persons against whom final judgements were issued:

- 1124 were sentenced for imprisonment (of this 469 were enforceable and 655 were suspended)
- 219 were sentenced for community work
- 899 were fined
- 57 were reprimanded
- 524 were put on probation
- other individual measures were inflicted in 5 cases.

1.2. NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

National strategy

In March 2009 the Parliament accepted Resolution 18/2009. (III. 4.) OGY of the Parliament on the new national strategic programme to be prepared in order to combat the drug problem, in which it requests the Government to prepare the new national strategic programme due from 2010.

On 14 December 2009 the Parliament accepted the document submitted by the Government, entitled "National strategy for handling the drug problem" (Resolution 106/2009 (XII. 21.) OGY of the Parliament). Unlike in the case of the National Strategy accepted in 2000, the new drug strategy was not accepted by the Parliament unanimously, it was only accepted with a majority of the votes.

The new drug strategy determines the realistic professional objectives relating to the years 2010-2018, which may result in interventions having favourable results from the aspect of the national drug problem. More than 100 measures are named in the document. The new strategy, following the public policy principle determined in the strategy accepted in 2000 with complete political consensus, continues to regard the joint and balanced reduction of drug demand and supply as the most efficient method of approach. It means that the prevention and treatment of drug use is effective when it is applied jointly with acting against illicit drug trafficking.

According to the authorisation granted, the National Strategy deals with illicit drugs, but it does not disregard the presence of the misuse of substances not under control but causing significant harm to public health, such as alcohol, and nicotine, or the presence of behavioural addictions not related to drug use. The document deals with a smaller group of problems, the issue of illicit drugs in an extending way in respect of its approach. It enables the use of cooperation possibilities in handling associated problems, and takes into consideration the interrelations between the different problems.

The main aim of the National Strategy is to create a confident, loyal and productive society, where it is possible to handle the effects of the drug problem in a balanced approach, realising by this the greatest health profit possible for the individuals and for the society.

The practical objectives included in the National Strategy appear on three main pillars. The first one of these is the area of "Prevention". In the strategy the majority of the objectives are concentrated on prevention. On the basis of the strategic approach prevention must be asserted on all settings where young people can be reached. These settings include for example family, school, workplace, the locations of spending spare time, places of entertainment, or even the internet.

The second pillar, "Treatment, care, harm reduction", is aimed at the dynamic development of the healthcare system for people suffering from addiction. In the interest of health protection the basic aim is to ensure access to high-level treatment and care services suiting the demands of the clients. Individual and social risks related to drug use must be reduced, and drug patients' chances for reintegration must be improved.

Finally, the third pillar, which is also very important, is "Supply reduction", the aim of which is to increase the efficiency of combating drug trafficking and distribution in order to increase social security.

Implementation of the action plan

The tasks of the government due in 2009 are included in Government Regulation 1094/2007. (XII. 5.) on governmental tasks relating to the realisation of the objectives of the national strategic programme to combat the drug problem.

The responsible ministry elaborated the action plan belonging to the National Strategy valid from 2010 within 3 months following the acceptance of the strategy, but – with regards to the upcoming elections – it was not proposed to the government. As reconstruction of the central government has an effect on the tasks of the ministries and the relating costs the proposal of the action plan to the government can only be performed in autumn of 2010 on the basis of the knowledge of the new structure and resource allocation.

Coordination arrangements

On 21 January 2009 the civil delegated members of the Coordination Committee on Drug Affairs (CCDA) were elected on the second occasion. The delegated civil members continuously report their observations, critics and proposals in connection with the implementation of the national drug strategy.

In 2009 the CCDA met four times.

From the activity of the CCDA the preparation of the new national strategic programme must be highlighted, which was preceded by the external evaluation of the strategy in force. The CCDA discussed the developments relating to the new strategy at all its meetings.

Setting up the Committee on Controlled Substances

The aim of setting up the Committee on Controlled Substances (subcommittee of the CCDA) is to facilitate professionally founded decisions made by the minister of health and the minister in charge of drug prevention and drug coordination tasks in the course of performing the tasks prescribed in Government Regulation 1196/2009. (XI. 20.) on the new classification of new substances or known substances that are dangerous from the aspect of misuse. Members of the subcommittee also include a person delegated by civil organisations and all institutes concerned with the issue. The subcommittee may request ad hoc and permanent experts to support the work of the special committee.

The establishment of the subcommittee is significant from the aspect of the development of drug coordination mechanisms. If a new dangerous substance occurs on the national market, this body consisting of different specialists collects information and analyses it with scientific

thoroughness, prepares a risk assessment and makes a proposal relating to regulation. This mechanism set up at national level may significantly accelerate or in given cases it may forward the practice of the process of the registration of substances followed so far, according to which substances are entered on the list mainly after regulation issued by the UN or the European Union, which requires a long process in time.

The subcommittee initiates the institution of the necessary examinations at the competent authorities and the requesting of expert opinions, and on the basis of these it realises necessary risk assessment, and after elaborating its professional standpoint it submits a proposal to the competent minister relating to entering the substance in question on the list or relating to the new classification of the given known substance.

The subcommittee started its work by discussing the characteristics of the substances Mephedrone, GBL and MDPV.

1.3. ECONOMIC ANALYSIS¹

Labelled expenditures of the Ministry of Social Affairs and Labour

In 2009, on the basis of Act CII of 2008 on the budget of the Republic of Hungary in 2009, XXVI. Ministry of Social Affairs and Labour, Appropriations handled in accordance with Chapter 16, subtitle 40 “Tasks relating to the prevention of drug use”, an amount of EUR 3.8 million was available for the performance of the tasks of the Ministry of Social Affairs and Labour in charge of drug coordination. The items that are enlisted in the followings does not meet the total, but EUR 3.68 million only. The difference of the sums covered the costs of the coordination tasks, costs of the operation of the tenders’ management and the costs of the operation of the Coordination Committee on Drug Affairs (SzMM 2010).

In 2009 the Ministry of Social Affairs and Labour (SzMM) invited applications in 9 categories, suiting the professional priorities, development and supply needs determined in the National Strategy. The amount of support granted through applications was EUR 2.68 million. There was a total number of 532 winning projects.

Table 1. *The project budget amounts announced by the Ministry of Social Affairs and Labour by target area in 2009*

Supported target area	Project code	Project budget amount (EUR)
Low-threshold institutes	KAB-AL-09-A/B/C	428,571
Substitution treatment	KAB-KRI-09-A/B	142,857
Research programmes	KAB-KT-09	89,286
Communication programmes	KAB-KOM-09-A/B/C	89,286
Resocialisation, reintegration programmes	KAB-RE-09-A/B/C	178,571
Out-of-school Prevention	KAB-PR-09-A/B/C	523,929
Peer-led programmes, training, conferences	KAB-KP-09-A/B/C	125,000
Coordination Forums of Drug Affairs	KAB-KEF-09-A/B/C/D	321,429
School-based prevention (jointly with the Ministry of Education)	KAB-IPP-09	517,857

Source: Ministry of Social Affairs and Labour 2010

¹ The values in this sub-chapter were calculated based on the official mid-rate of the EUR for 2009 (1 EUR = 280.58 HUF).

During the year individual support was granted to 10 programmes in a total amount of EUR 147,714. For the National Institute for Drug Prevention operating as the ministry's background institute within the organisational framework of the Institute for Social Affairs and Labour, and for the ministries and other state organisations in the interest of the realisation of the development aims determined in the national strategic programme on combating the drug problem a total amount EUR 843,307 was delegated.

Costs of the antiviral treatment of HCV positive drug users

At the end of 2009 a study was performed (Gazdag and Horváth 2009) to identify the treatment costs of the patients receiving antiviral therapy because of hepatitis C (HCV) at the largest hepatology clinic of Budapest², which was the cooperating partner for treatment during the national screening programme conducted among IDUs organised by the National Centre for Epidemiology (for more detail see: chapter 6.1.) Between 2006 and 2008, 123 drug-related HCV infections were identified at the outpatient hepatology clinic. 36 out of the 123 persons started combination therapy using pegylated interferon + ribavirin. The treatment (mainly diagnostic) cost of the 87 patients who finally did not receive interferon treatment was EUR 9,628.

During the study, a non-IDU control group adjusted by gender and age was set up beside the group of 36 former IDUs starting treatment, in order to identify the differences occurring between the two groups and affecting treatment costs. During the study the treatment costs were divided into three main areas: The care activity costs included the costs occurred during the treatment activity, consultations, and laboratory tests. The medicine costs included the price of the interferon and ribavirin preparations used during the treatment, and other costs included the fee of the FibroScan test and the expenses of the hospital care.

It was revealed by the study that no HCV genotyping takes place before starting treatment, the most important factor influencing treatment costs is the length of the treatment, and then it is followed by the type and dose of the antiviral drug applied. According to the hepatitis antiviral protocol valid in Hungary at the time of the survey, the term of the treatment is 48 but a maximum of 72 weeks, if the quantitative HCV PCR test – or qualitative test in the case of a low viral load – performed in the 12th or 24th week indicates a response to treatment. Although in the 24th week following the end of the treatment the treatment protocol prescribes a further qualitative HCV PCR test, according to specialists' opinions it is not performed in the majority of the cases, so it was not possible to assess efficiency on the basis of monitoring. In the group of ever IDUs the average length of the treatment was 26.7 weeks, while in the group of non IDUs it was 34.8 weeks, the difference was significant ($p=0.043$). Other aspects of the treatment are described in chapter 7.2.

In respect of the entire term of the treatment, on the basis of the average of the 36 persons the treatment of an IDU-related case cost EUR 12,679, in the group of non IDU patients this value was EUR 14,495, the difference was not significant ($p=0.314$). The average treatment cost per week in the case of former IDUs was EUR 497, while it was EUR 425 in the case of the control group, which difference proved to be significant ($p=0.024$). It can be explained first of all by the greater proportion of consultations in the case of former IDUs.

The cost of supply of the 36 drug-related cases (care activity, medicine costs, other costs) amounted to EUR 456,447, which was covered by social insurance. This cost in the group of non IDU patients was EUR 521,822 due to the longer treatments. The difference between the two groups was not significant ($p=0.314$). The treatment of the infection of the 123 drug-related cases resulted in a total healthcare cost of EUR 466,075.

² Unified Szent István and Szent László Hospital and Outpatient Clinic of the Budapest Municipality, Hepatology and Nephrology Outpatient Clinic

Opiate substitution treatment costs

The financing data of the National Health Insurance Fund (OEP) relating to substitution treatment (OEP 2010) was processed by the National Centre for Addiction. Methadone can be used exclusively in inpatient or outpatient treatment, it cannot be given on the basis of a doctor's prescription. In Hungary in the previous years the health fund spent about EUR 160,714 on opiate substitution methadone treatment per year.

Table 2. Health expenses of opiate substitution treatments using methadone in 2009 (in EUR)

Intervention	ICPM code	2007	2008	2009
Methadone detoxification	96214	4,117	4,654	5,068
Methadone substitution	96215	146,511	158,749	157,717

Source: OEP 2010a

Preparation containing a combination of buprenorphine-naloxone was first used at the end of 2008 for the purpose of opiate detoxification and substitution. According to the data of the National Health Fund, in 2009 in the framework of inpatient and outpatient treatment interventions were performed in the value of EUR 47,592. This preparation can also be used on the basis of a doctor's prescription in the scope of psychiatric care, the value of which is not included in the summary below. The preparation is financed by the OEP up to the amount of 18 mg/day.

Table 3. Health expenses of opiate substitution treatments using buprenorphine-naloxone in 2009 (in EUR)

Intervention	ICPM code	2009
Buprenorphine-naloxone detoxification	96216	5,425
Buprenorphine-naloxone substitution	96217	42,167

Source: OEP 2010

Conclusions

The fact that the acceptance of the new National Strategy received less political support makes the role of the Strategy uncertain after the change of government.

The establishment of the Committee on Controlled Substances enables quicker response when taking measures in respect of newly appearing drugs.

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

2.1. DRUG USE IN THE GENERAL POPULATION

No new information available.

2.2. DRUG USE IN THE SCHOOL AND YOUTH POPULATION

No new information available.

2.3. DRUG USE AMONG SPECIFIC TARGETED GROUPS

The army ³

In 2009 again drug screening tests were conducted in the Hungarian Army in order to filter out actual users, reduce use, monitor the efficiency of drug prevention methods and set down the foundations of new action programmes (MH 2009).

Table 4. Drug screening tests conducted in 2009 in the Hungarian Army

	Number of positive cases					
	Preliminary screening (with automatic laboratory equipment)			Confirmed with laboratory test (GC-MS)		
	THC	Opiate	Amphetamine	THC	Opiate	Amphetamine
Aptitude (N=9123)	36	2	6	0	0	0
Authority (N=1855)	18	1	12	18	0	0
Total (N=10978)	54	3	18	18	0	0

Source: Hungarian Army

Table 5. Breakdown of the positive samples of the screening tests performed by the Hungarian Army per drug type between 2002-2009

Year	THC	Opiate	Amphetamine	Ecstasy
2002	92.8%	6.43%	0.9%	-
2003	86.1%	7.04%	5.0%	1.85%
2004	92.2%	-	7.8%	-
2005	80%	-	20%	-
2006	74.5%	-	25.5%	-
2007	81.8%	-	18.2%	-
2008	96.1%	-	3.9%	-
2009	100%	-	-	-

Source: Hungarian Army

In 2009 exclusively THC was detected among the positive results of the drug screening tests, confirmed by laboratory tests, performed in the Hungarian Army in the scope of aptitude or authority tests. Although there was an increase in the number of tests (there were 9170 tests in 2008), the number of positive cases detected was lower than in the previous year (29 cases in 2008).

³ On the basis of the report by the Hungarian Army

3. PREVENTION

Overview

The National Strategy (2010-2018) accepted on 15 December 2009 defines the main objective of the prevention pillar as below: "The prevention of drug use is a proactive, multi-directional, culturally sensitive activity organised on a community basis and requiring cooperation between several sectors, the aim of which is to enable individuals, families and local communities to combat challenges accompanying life events. Therefore the prevention process supports the creation of circumstances, as a result of which the physical and mental welfare of the affected persons improves and they are able to conduct a safe and healthy life." (National Strategy 2009).

The theoretical framework of prevention was determined following internationally accepted evidence based principles, in the field of drug prevention. It also emphasises the utilization of community resources, the use of integrated approaches, the development of skills and the use of innovative techniques, the provision of alternatives and early intervention.

The new strategy also determines its objectives according different settings, the objectives relating to universal, selected and indicated prevention are determined in each setting separately.. In the strategy the following settings are named: family; school (educational institution); place of work; settings of spending spare time; internet, other media; system of child protection institutes; institutes of the criminal justice system; further target areas that cannot be classified according to settings or target groups.

3.1. UNIVERSAL PREVENTION⁴

School-based prevention

In 2009 the Ministry of Social Affairs and Labour and the Ministry of Education and Culture (SzMM-OKM) jointly issued tender invitations for supporting school-based health promotion and drug prevention programmes (KAB-IPP-09) to the amount of HUF 160,000,000 (EUR 570.247)⁵.

183 out of the 330 applicants were granted subsidies⁶. In the scope of the programme 17,586 schoolchildren studying in primary education (aged 10-14), 53,428 secondary school pupils (aged 14-18) and 8,851 schoolchildren attending 6-8-12 grade schools (aged 12-18) participated in activities dealing with drug prevention⁷, which is a total of 79,865 schoolchildren (94,403 schoolchildren in 2008, 116,794 schoolchildren in 2007, 105,225 schoolchildren in 2006), representing 8.3% of schoolchildren aged 10-18 attending institutes of primary and secondary education (SzMM 2010). Apart from the above SzMM-OKM programme drug prevention activities took place in schools using other sources or without any separate financing.

In 2009 a survey (Paksi 2009a, Paksi 2009b⁸) was made concerning prevention and health promotion programmes implemented in institutes of public education, in order to identify the

⁴ SQ25_2010_HU_01

⁵ The values were calculated based on the official mid-rate of the EUR for 2009 (1 EUR = 280.58 HUF).

⁶ 35 applications were invalid, 107 applications were rejected, 3 failed and 2 were cancelled.

⁷ Based on information provided by the Ministry of Social Affairs and Labour.

⁸ The survey was carried out by Corvinus University of Budapest, Institute of Behavioural Sciences and Communication Theory, Centre for Behaviour Research, and it was ordered and financed by the Ministry of Education and Culture and the National Institute for Drug Prevention.

The survey was carried out on a national representative sample of the institutes of secondary education and the teachers working there. The sample was selected using two-stage stratified random sampling method. Gross sample: 133 institutes, 207 task performance units, 837 teachers. Net sample: 132 institutes, 165 task

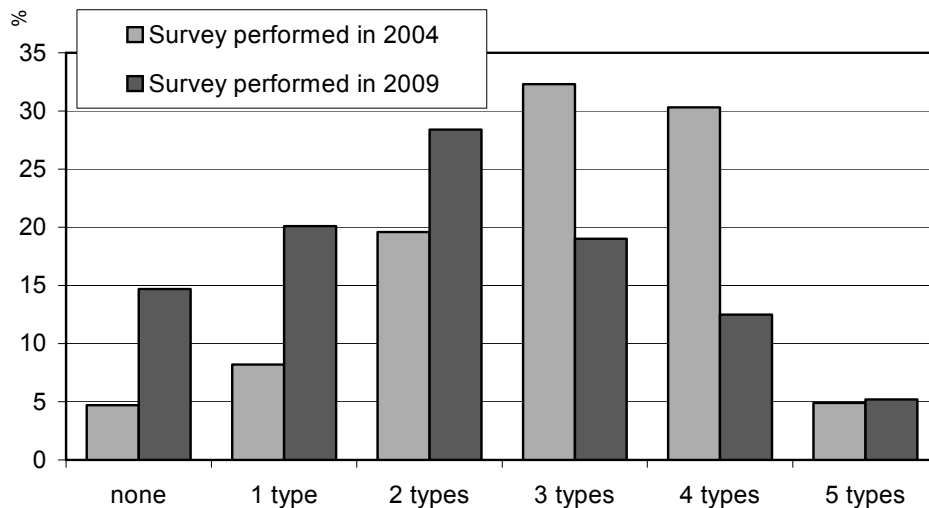
changes occurring in recent years in the prevention and health promotion activities of institutes of public education and in the characteristics determining this activity.

Changes in the prevention⁹ competences and activity of the institutes of public education in the last 5 years

In the academic year of 2009, 85.3% of the surveyed institutes of public education had some sort of staff capacity – school psychologist, drug coordinator, health promoter, youth doctor, or a district nurse regularly visiting the school – for performing school-based prevention / health promotion tasks or a certain partial field of such tasks.

As compared to the situation observed five years before (Paksi et al., 2005), in 2009 there was a significantly higher proportion of schools without any institutional capacities for performing school-based prevention / health promotion tasks, where currently there was no school psychologist, or drug coordinator, or health promoter, or youth doctor, or district nurse regularly visiting the school.

Figure 1. *Distribution of schools according to the number of filled prevention / health promotion functions (school psychologist, drug coordinator, health promoter, youth doctor, or a district nurse regularly visiting the school) in 2004 and in 2009 (in percentage of the institutes)*



Source: Paksi 2009b

Similarly to the earlier survey results (Paksi et al. 2005), according to the type of education provided, the institutes geographical position and the size of the teaching staff, still a significant difference can be observed in respect of the number of prevention / health promotion positions filled, and the earlier differences occur even more prominently. In the last 5 years the greatest decline could be experienced in the institutes that could be characterised with a deficit even before, that is institutes situated outside of Budapest and/or providing primary school training (too), and having a small teaching staff.

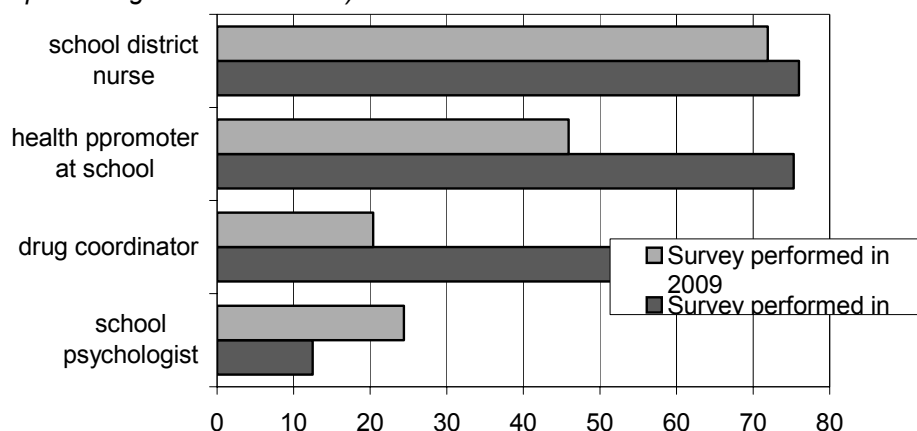
70% of the institutes are still regularly visited by a district nurse, 10.5 hours a week on average. The position of the specialist in charge of health education / health promotion is the next most commonly filled position. Currently the role of the drug coordinator has a much lower significance in schools: while earlier there was a drug coordinator in more than half of

performance units, 692 teachers. The questionnaires were recorded with the participation of field interviewers, in school settings, by making personal contact, typically using the face-to-face technique, in the spring of 2009.

⁹ In the course of the survey the following fields of prevention were examined: nutrition; physical activity; physical hygiene; licit/illicit drug use; family life; growing up, changing, sexuality; environment; safety; mental hygiene; integrated holistic approach.

the schools, today only two out of ten schools has a drug coordinator. However, despite the unfavourable changes the proportion of schools employing a school psychologist increased.

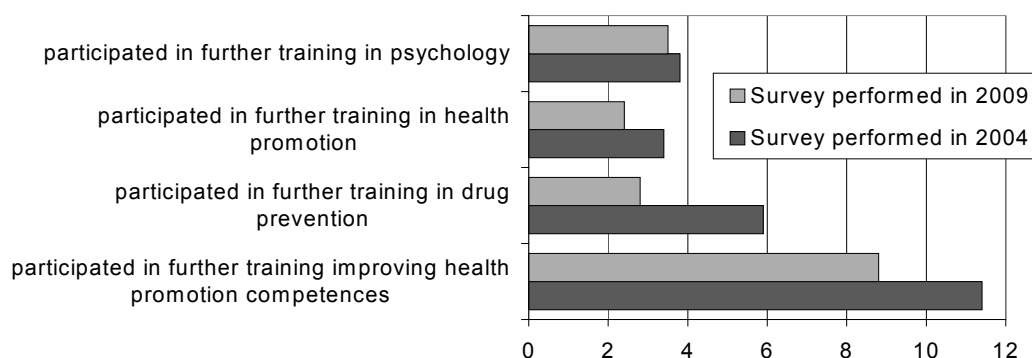
Figure 2. Proportion of filled prevention / health promotion positions at the examined schools in 2004 and in 2009 (in percentage of the institutes)



Source: Paksi 2009b

As compared to the previous years, among teachers working at institutes of public education there is a decreasing tendency¹⁰ in the proportion of teachers participating in further training aimed at improving prevention / health promotion competences. Less than ten percent of the respondents took part in further training courses in health promotion and/or drug prevention¹¹ and/or psychology during the period of 5 years since 2004.

Figure 3. Proportion of teachers participating in further training concerning any field of prevention / health promotion in 2004 and in 2009 (in percentage of the respondents)



Source: Paksi 2009b

Intensity of prevention activity at schools

In any one of the three academic years examined (the academic year of 2008/2009, and the two academic years preceding it) 90.4% of the primary and secondary schools performed some sort of prevention or health promotion activity, in the individual academic years there was some sort of prevention programme in 85-88% of the schools (see: table 5), in the

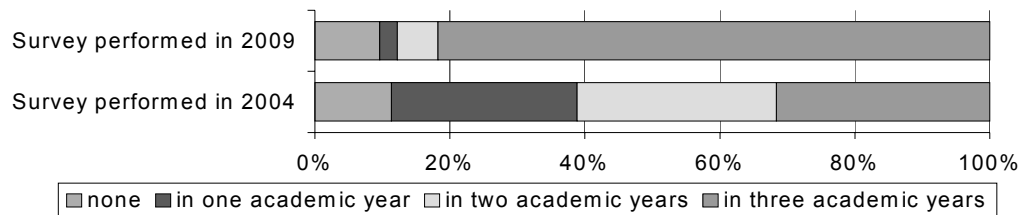
¹⁰ The tendency type statements, beside a two-thirds confidence level, cover changes beyond the margin of error.

¹¹ In respect of further training courses in drug prevention, the statement relating to decrease can be made with 95.5% confidence.

decisive majority of them (in four-fifth of the schools) prevention activities were performed every year.

As compared to the survey performed in 2004 (Paksi et al. 2005), there was no significant change in the proportion of schools, where in the 3 years preceding the survey no prevention activity was performed at all (one-tenth of the schools belongs here), but the regularity of the prevention activity significantly increased: from 30% observed earlier the proportion of schools where some sort of prevention intervention took place every year increased to 80%.

Figure 4. *The number of academic years of the preceding three academic years when prevention / health promotion activity was performed at the schools (in percentage of the schools)*

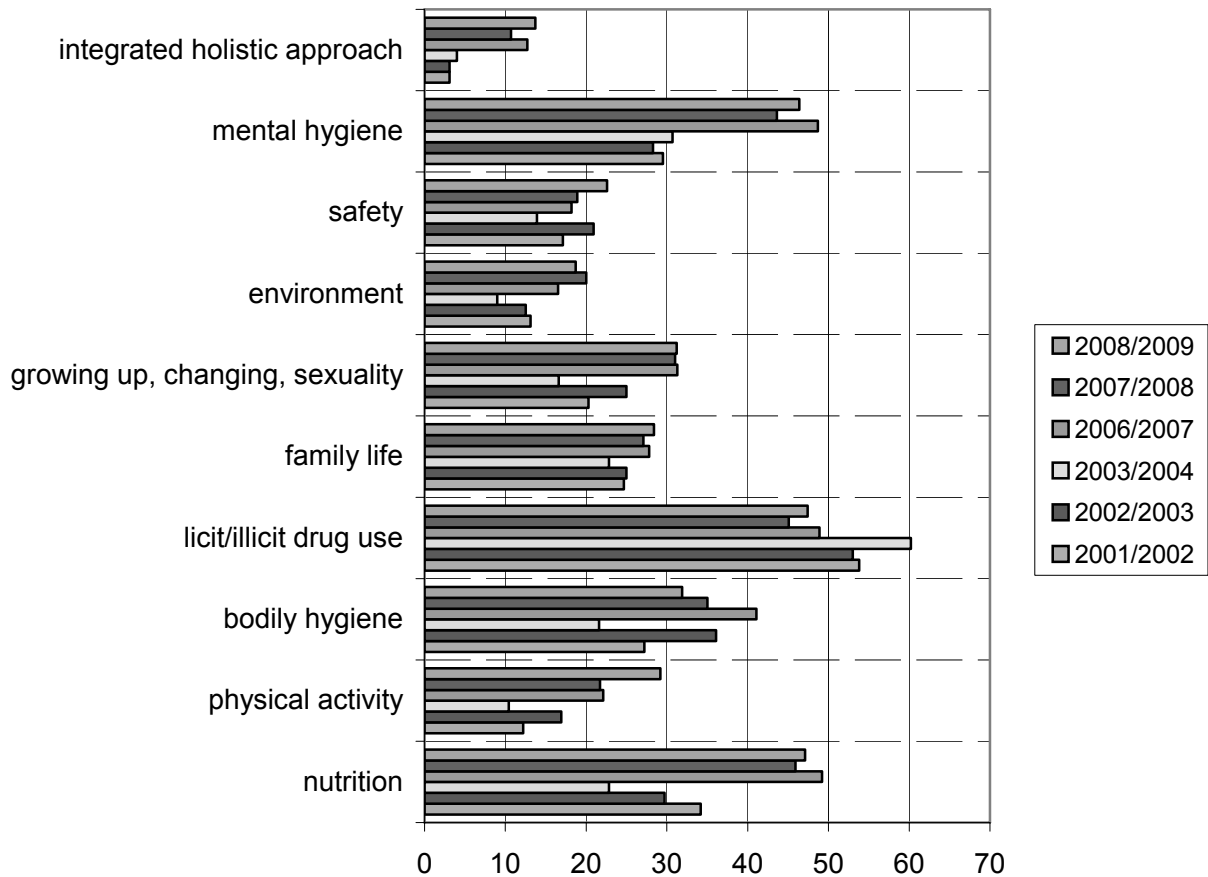


Source: Paksi 2009b

While in the previous years it was the field of licit/illicit drug use that was the most emphasised among the targeted fields (Paksi et al. 2005), presently the prevention interventions dealing with mental hygiene and nutrition are implemented in the school setting in the same proportion as drug prevention programmes. As compared to the earlier years, “physical activity” as well as integrated holistic approach could be observed in a significantly higher proportion among the covered areas, and – with a two-thirds confidence level – the role of a few other areas, which used to be less intensively dealt with, also increased, such as environment, safety or growing up / changing / sexuality.

In respect of the areas covered, generally no significant difference can be observed according to the type, size and geographical position of the schools, but schools also providing primary education more commonly ($p=0.078$) deal with licit/illicit drug use in the course of prevention interventions.

Figure 5. Appearance of the different fields of prevention in school-based prevention programmes between 2001-2003 and between 2006-2009 (in percentage of the schools dealing with prevention, allowing several answers per school)



Source: Paksi 2009b

In half of the schools performing prevention activity – according to the estimates of the heads of the institutes – the proportion of participation was higher than 70-80%, but on average only slightly more than two-thirds of the pupils took part in the prevention programmes in the individual years. The average proportion of participation in programmes aimed at the prevention of illicit or licit drug use was slightly lower than this. Taking into consideration the number of pupils attending institutes of public education at national level in the individual years (KSH 2009), it can be determined that in the last three years an average of 800,000 pupils took part in some sort of school-based prevention programme per year, and from this number an average of 300,000-400,000 pupils took part in drug prevention programmes.

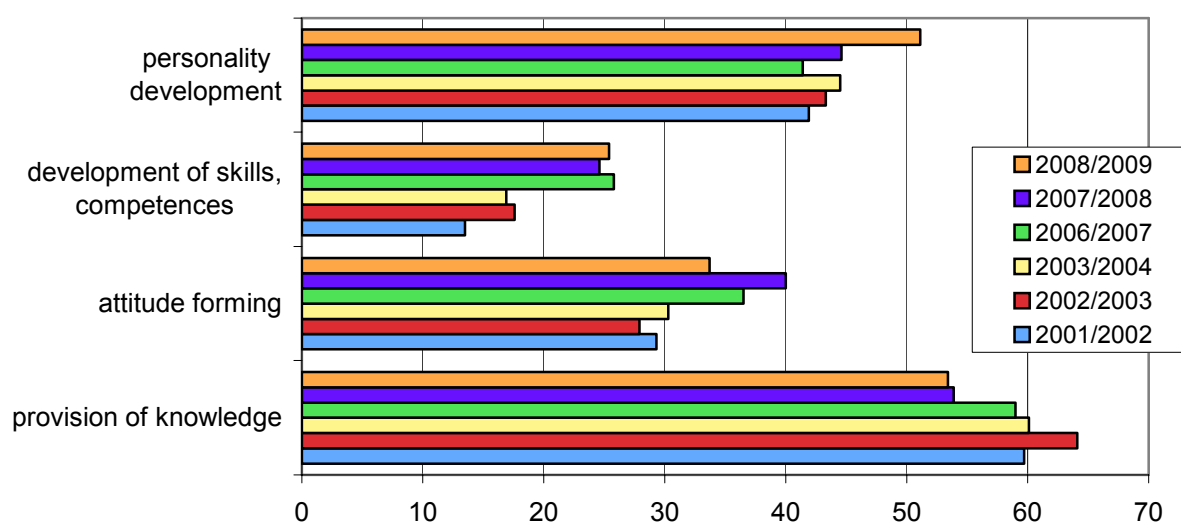
Table 6. *The proportion and estimated number of pupils participating in school-based prevention programmes in the individual academic years and on average between 2006- 2009*

Academic years	Proportion of schools performing prevention activity	Estimated proportion of participants		Number of pupils at national level	Estimated number of pupils participating in prevention programmes at national level
		median	average		
2006/2007	88.0	70	67.1	1,401,455	827,531
2007/2008	86.7	74	67.1	1,384,167	805,729
2008/2009	85.1	80	68.6	1,362,409	794,776
Average year	86.6	75	67.6	1,382,677	809,401
From this in drug prevention programmes					
2006/2007	40.9	70.0	66.1	1,401,455	378,882
2007/2008	37.1	74.6	65.2	1,384,167	334,819
2008/2009	37.4	78.2	63.4	1,362,409	323,049
Average year	38.5	74.3	64.9	1,382,677	345,183

Source: Paksi 2009b

In respect of the objectives of the prevention / health promotion interventions at schools, more than half of the programmes include objectives relating to provision on knowledge. However, the frequency of such objectives shows a reduction, while in respect of other aims (personality development, skills development, attitude forming) an increase can be observed. There is no difference between schools of different types or sizes in respect of the proportion in which they use the different approaches.

Figure 6. *The approach / objective of prevention the programme concentrated on (expressed in percentage of the schools performing prevention programmes, allowing several answers per school)*



Source: Paksi 2009b

The average annual length of school-based prevention interventions has been quite stable since the turn of the millennium, around 15 hours. When examining the most commonly occurring number of hours it can be determined that while in 2001-2002 most interventions were performed in 4 hours per year, in the last 3 years the most common length of the prevention programmes was 20 hours. Obviously it does not mean that the majority of the schools performs prevention programmes of this length: between 2001 and 2002 half of the schools used 8-9 hours for prevention or even less time per year (Paksi et al., 2005), then in the academic year of 2003/2004 the median of prevention programmes increased to 10 hours, and since then in half of the schools the maximum number of annual hours used for prevention has remained the same (that is, in recent years in half of the schools prevention

interventions took place in more than 10 hours per year). In parallel with the favourable tendency of the means and with the fact that today mostly 11-20 hour long prevention interventions rather than 3-5 hour programmes are performed at the schools, in the recent years the proportion of interventions lasting for more than 20 hours reduced.

While in the case of three-fifth of the prevention interventions implemented in the academic year of 2003/2004 the service providers performed prevention activity independently, without involving schoolteachers, presently it happens in less than one-third of the schools, and in the recent years typically – in half of the schools performing prevention – external service providers perform prevention in cooperation with the schoolteachers. At the same time, programmes dealing with the “prevention of licit and/or illicit drug use” are implemented by the schools typically by involving external service providers. As compared to prevention work performed in other fields, it is much more common in the field of drug prevention that the activity is performed by an external service provider independently.

Table 7. *Fields of prevention significantly ($p < 0.5$) different from the proportions characteristic of all schools performing prevention in respect of the involvement of teachers, in 2009, in schools performing prevention programmes (in percentage of the institutes)*

Covered fields	External service provider independently	Teachers of the school	Both
Nutrition (too)	17.3	19.2	63.5
Physical activity (too)	15.6	9.4	75.0
Environment (too)	14.3	14.3	71.4
Licit/illicit drug use	75.0	12.5	12.5
All programmes	30.3	18.3	50.9

Source: Paksi 2009b

School Social Worker Network

The INDIT Public Foundation’s School Social Worker Network ¹² started its operation in the autumn of 2006 in Pécs, with the participation of 3 schools. Since the academic year of 2008-2009, 3 further institutes of public education have been using the services of the network.

According to the experience gained during the 4-year operation of the programme, in primary schools the number of students using the service exceeded the expectations by far. According to the experience of the specialists participating in the programme, the higher number of pupils a school has, the lower the proportion of users is. (In large schools with even more than 1,200 pupils consisting of several member schools, the service is used the most in the member institute where the office of the school social worker is situated.)

In summary, the activity of school social workers is the most efficient, where:

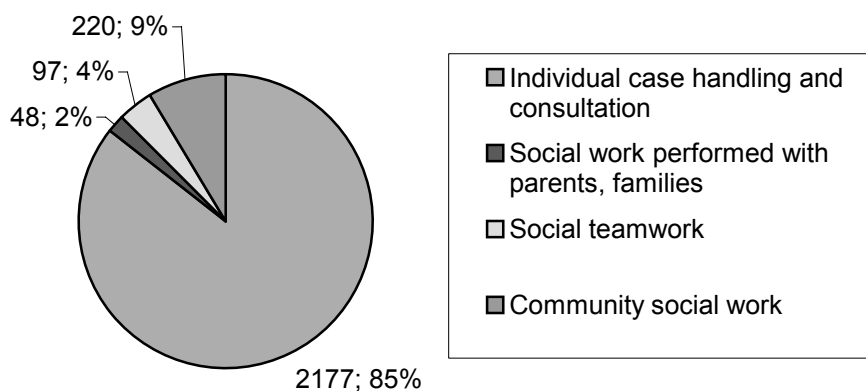
- they have worked for at least 2 years (both the teachers and the pupils know what they work for),
- the number of pupils falling on one school social worker is below 1,000,
- the leaders of the school find their work important (e.g. they regularly consult them, recognise their expertise; their activity is integrated in the school’s educational and health promotion programme),
- basic infrastructural conditions are available for the social workers (their own appropriately sized office; use of telephone).

¹² The program and the theory and practice of school-based social work is described in detail in the publication entitled “Az iskolai szociális munka kézikönyve” [Handbook of school-based social work] published in 2009 by INDIT Public Foundation. (Máté and Szemelyácz 2009)

As compared to other school-based prevention programmes the advantage of this programme is that the presence of the social worker is permanent at the school, and so help is easily accessible both to pupils and teachers. Due to this, in the long term the presence of a social worker can have a favourable effect on the attitude and atmosphere of the school. According to experience it is important that school-based social workers can work in a network, as a part of an integrated system of assistance, in cooperation with other external NGO programmes and youth supporting organisations. Especially in vocational training schools and in vocational secondary schools social workers also operate as school “information-consulting points” that can be contacted by the young people in connection with any question concerning them.

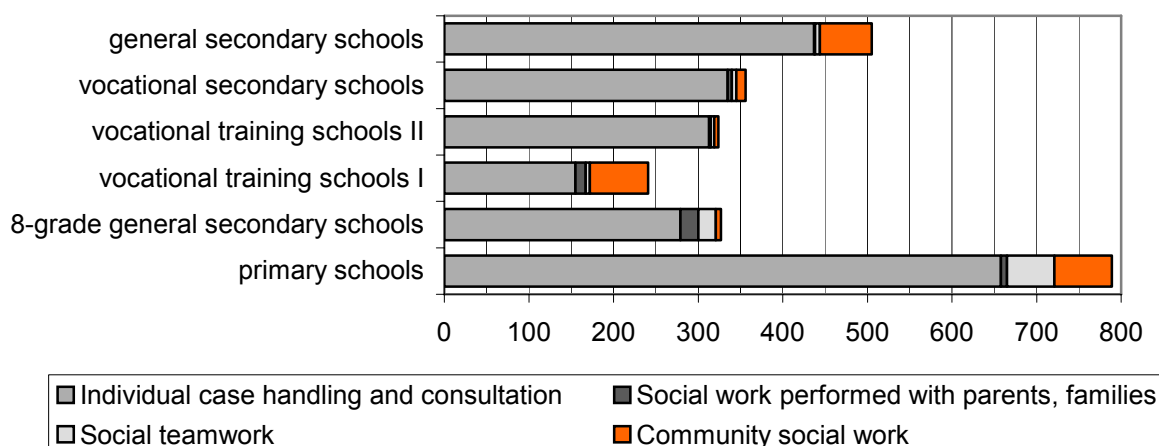
When examining the network’s activity in the academic year 2008-2009 it can be determined that the most common service was individual case handling and consultation (82% of all cases), and it is characteristic of all school types. It is followed by community social work¹³ (11%), while the services provided the lowest proportions are represented by social teamwork (4%) and social work performed with parents, families (3%).

Figure 7. Activity of the school social worker network in Pécs, academic year 2008/2009, 2nd term



Source: INDIT Public Foundation

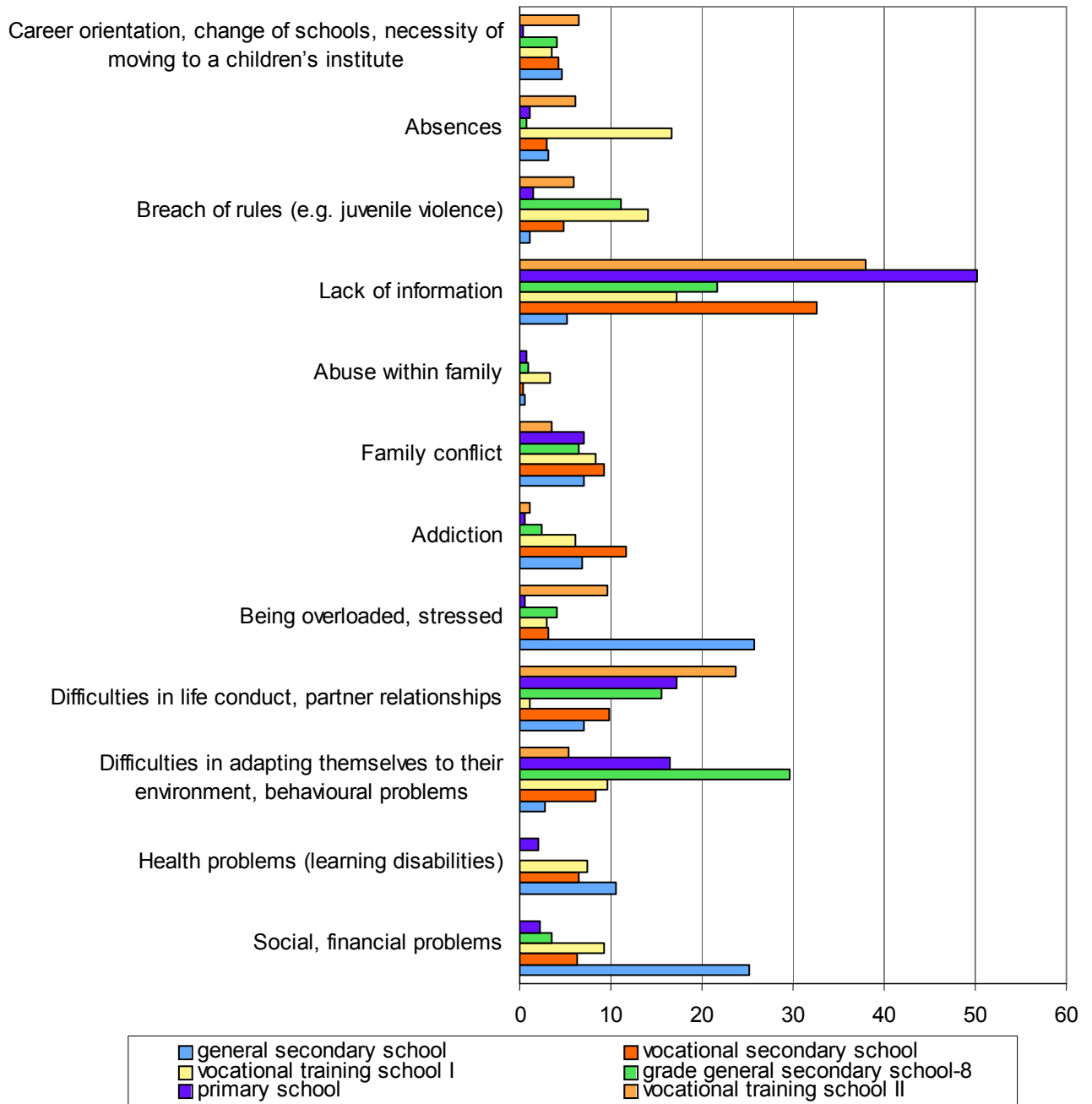
Figure 8. Activity of the school social worker network in Pécs, academic year of 2008/2009, 2nd term, according to school types



¹³ Activities aimed at developing the school’s community, such as work with the student union; cooperation with other youth supporting organisations; school events (Day of Health, Day of Addictions, Day of Human Rights); film club; etc.

In respect of the problems of the pupils using the service there are differences between the individual school types. Pupils attending primary school and vocational school most often turn to the school social worker because they are lacking in information, while the most commonly occurring problems of students attending general secondary school are being overloaded, stressed, and having social and financial problems.

Figure 9. Use of the school social worker network in Pécs, according to the type of problem, academic year 2008/2009, per school type



Accreditation¹⁴

The Drug Prevention Health Promotion Accreditation Committee (DEAB) has been founded, the operation of which is within the responsibilities of the National Coordination Directorate on Drug Affairs. The primary task of the Committee is to assert special drug prevention aspects in the course of determining the quality standards and setting up the accreditation system of the schools-based health promotion programmes. In 2009 the committee met on two occasions.

At the same time as DEAB was founded, the Ministry of Health started to set up the accreditation system of health promotion programmes. The system plan of the accreditation system of health promotion programmes has been prepared (including internal work sharing, obligations and entitlements), as well as the related electronic documentation system, the detailed algorithm of document handling and the plan of the evaluation method needed for the operation of the accreditation system. Furthermore draft guidelines relating to the most important settings (school, workplace, settlement) have been elaborated, including the draft guidelines of schools-based drug prevention programmes that are based on a review of international prevention literature.

The detailed professional concept was not yet accepted in 2009.

Training of professionals¹⁵

The training material entitled “The methodology, good practices and implementation techniques of early problem identification and intervention in schools” has been prepared, which is based on the cooperation of the professionals working in schools (teachers, school-health professionals, educational consultants) and in primary healthcare. Training programmes were organised in 7 regions of the country for school-visiting district nurses, school doctors, family paediatricians, school drug coordinator teachers and child protection professionals concerning the identification of problem drug users and involving them in treatment and indicated prevention programmes.

3.2. SELECTIVE PREVENTION¹⁶

Prevention programmes in shopping centres

In 2005 a model program (entitled “Alternativa” [Alternative]) was launched in Hungary, which was aimed especially at the world of shopping centres, exploring the way of living, social and cultural habits of the young people visiting shopping centres, and elaborating and launching an adequate prevention program suiting young people’s demands and needs on the basis of the experience collected. The aim of the project implemented by now at several locations is to address 13-18 year-old (at other places 14-25 year-old) young people strolling around in shopping centres, to offer them a way of spending their spare time in a more structured and more organised form, and to divert young people struggling with more serious life conduct or maybe drug problems to adequate treatment, and to help them strengthen their motivation and their trust in the treatment system.

In the scope of the Alternativa program in 2009 services were provided at two locations in the country (Pécs and Csepel). In the program located in Pécs 150 contacts were registered on average per month, on weekdays an average of 8-15 persons, while on weekends an average of 20-25 persons visited the office, and the young people spent an average of 1-1.5 hours there. According to the experiences, the services used are mainly prevention and

¹⁴ Based on the report by the Ministry of Health.

¹⁵ Based on the report by the Ministry of Health.

¹⁶ SQ26_2010_HU_02

psychosocial services; harm reduction methods are less frequently used. In the office located in Csepel 15-20 contacts were registered on average per day, the average duration of the visits was 1 hour, but lasting relationships were established less frequently than in Pécs.

Besides the above mentioned two low-threshold programmes realised from normative financing, in the scope of the TÁMOP¹⁷ 5.2.5. project “Integration programs for children and young people”, in March 2009 the Alternatíva program could also be launched in Nyíregyháza and Békéscsaba. The service provided in Nyíregyháza was the most frequently visited in September 2009, when they registered 250 visitors, which was followed by a slow weakening of interest, which, the collaborators believed, was due to the lack of capacities aimed at addressing young people. The office in Békéscsaba was visited by 300 persons per month on average.

Another program that can be listed among shopping centre based programs, although it does not operate directly inside a shopping centre, is the “Open Doors” program located in Debrecen. During the opening hours of the office they offer a selection of services including individual counselling, psychosocial and life skills counselling, and related case handling and preparation for therapy relationships. The young people can also work in personality development groups (drug and alcohol problems), and they can take part in further spare time programs (e.g. Creative Group, Film Club, Experience oriented music group).

Similarly to the above programmes, programmes supported by the project announced by the National Committee for Crime Prevention were launched in shopping centres in Kecskemét (“Malom-Társalgó” [Mill Lounge]), Győr (“Veled-Érted” [With You – For You]) and Tatabánya (“Kék-Fehér - Ifjúsági, Információs és Szolgáltató Ház” [Blue-White – Youth, Information and Service House]). Although these programmes are independent from the “Alternatíva initiation”, due to the similarity of their implementation settings and target groups they can be listed among prevention programmes realised in shopping centres. The objectives of the above programs are very similar. Among their objectives they determined the protection of children and adolescents, and reducing the possibility of them becoming victims. Their target groups include mainly young people between the ages of 12-18 strolling around in shopping centres. They generally operate an information point open at weekends and they offer programmes such as club sessions aimed at spending spare time usefully, as well as sport and alternative spare time sessions.

Programmes implemented in the framework of the TÁMOP 5.2.5 project

In the framework of the drug component¹⁸ of the TÁMOP-5.2.5 project entitled “Integration programmes for children and young people”¹⁹, organisations were invited to submit applications in two outstanding areas in order to facilitate the social integration of children and young people. Within point “A” the organisations could apply for funds for the implementation of the so-called “Shopping Centre Program” package, while within point “B” they could apply for funds for the implementation of “Drug Alternative” programs.

In the scope of the project 20 organisation were granted support of a total amount of HUF 358,440,051 (EUR 1,277,497). 3 organisations won support for programs realised in shopping centres (point “A”) of a total amount of HUF 59,793,700 (EUR 213,107) (the previously described programmes is Nyíregyháza, Békéscsaba and Debrecen), while among the applications submitted within point “B” 17 programmes were granted support of a total amount of HUF 298,646,351 (EUR 1,064,389) for operation.

¹⁷ Social Renewal Operative Programme

¹⁸ Component “C” was aimed especially at reaching young people between the ages of 14-25, which age group is the most vulnerable from the aspect of drug use.

¹⁹ In the scope of the project 3 components were announced: A) Child protection component, B) Juvenile component, C) Drug component. The project was announced by ESZA Társadalmi Szolgáltató Nonprofit Kft. (the National Development Agency was the principal). The announcement was issued in 2008, and the winning applications were implemented in 2009 and in the first four months of 2010.

No detailed information is available on the actual implementation and efficiency of the projects, the data summarised below is based on the short programme descriptions accessed on the website of the National Development Agency.

Concerning the geographical distribution of the supported programmes, it can be seen that winning applications can be identified in all 7 statistical regions, but they are not evenly distributed. In Budapest and in the region of the Southern Great Plain 5 programmes were implemented each, 3 programmes were implemented in the region of the Northern Great Plain, and 2 programmes in the Southern and in the Western Transdanubian region each. The remaining 3 projects were implemented in 3 further regions.

Concerning the organisations delivering the programmes, it can be seen that 14 programmes were implemented by NGOs (9 foundations, 5 associations), and 6 of the projects could be related to the local authority sector (local authorities, small-region associations, non-profit corporations).

In respect of the target group the three shopping centre based programmes addressed young people visiting shopping centres, while in the case of the drug alternative type programmes a given concrete housing estate or part of district could be identified in the case of only 3 projects. .

During the realisation of the programmes 10 community areas were created – 3 of them related to shopping centres –, which were permanent settings for the realisation of the individual project elements. One programme reached its target group especially by performing outreach activity, while the remaining programmes realised their programme elements at several locations.

Both volunteers and peer helpers participated in the implementation of the programmes. As part of the programmes, trainings were included only in 4 cases. Most of the projects offered different sport events (7) and other spare time activities (9), group sessions were also organised with different contents for the target groups, such as drama education (4), craft and creative sessions (4), experimental education (1) and provision on knowledge (3). Reaching the family could be identified in the case of 1 program, while 5 projects offered the possibility of counselling for the members of the target group. Apart from the above, socio-therapeutic role-playing games, thematic lectures and equine-assisted therapy could also be observed.

Recreational settings

In 2009 harm reduction/prevention activities in the recreational settings were performed in 9 cities / micro-regions²⁰. A change as compared to the previous years is that these types of services terminated in Budapest and Eger. At the same time, as a project, party service operated in Mosonmagyaróvár for nearly a year (October 2008 – June 2009), and party services have also operated in Nyíregyháza and Gyula since 2007. In 2009 party service was started in Debrecen and in the micro-region of Mikepércs by the Hungarian Ecumenical Aid Organisation's Social Centre in Debrecen.

In 2009 the organisations participated in a total of 550 events, in the course of which they contacted more than 16,000 young people. Besides establishing relationships and holding conversations, the staff of the organisations gave out information materials, flyers, drug quiz, as well as drinks and food that reduce the harm caused by drug use to the young people attending the events. The organisations contributed to the safer entertainment of young people with the following goods/materials: mineral water (more than 1,876 litres), condoms (8,257), flyers (8,100), glucose tablets, biscuits, vitamins and fruits.

²⁰ 9 organisations filled in the National Focal Point's questionnaire concerning their activity in 2009.

Drug prevention in the Hungarian Army²¹

In the Hungarian Army's Health Maintenance Programme the health promotion activity does not mean simply the provision of knowledge verbally concentrating exclusively on certain risk factors or groups of diseases, but it is realised in the scope of complex, comprehensive prevention programmes focusing on health problems related to each other. The programme was conducted at the units of the Hungarian Army using the method of interactive sessions held in small groups (20-25 people). In 2009 the prevention programmes reached a total number of 588 people in 12 military units. In order to increase the efficiency of the prevention activity, a billboard exhibition was organised, the central theme was the prevention of the use of licit and illicit drugs. The billboard exhibition was organised at 8 military units and it reached a total number of 2,500 people.

In the framework of the preparation programme for the staff intended for foreign service – with regards to the special circumstances of foreign service, the increased presence of stress factors and frustration factors – since 2008 training relating to the dangers and risks of licit and illicit drug use has been involved in the training programme. The primary aim of the lectures is to prevent alcohol consumption and any type of use of licit or illicit drugs in the target population. In 2009, during the lectures held for the mission troops (UNFYCIP, ISAF, MFO, EUFOR5) 530 persons were trained.

In 2009 the employees of the Health Centre attended 10 important central and other military events (e.g. the Open Day of Zrínyi Miklós University of Defence, National Meeting of Armed Forces Families, Hungarian Army Support Brigade Family Day), where a total number of 6,550 people were reached.

In 2009, the series of health maintenance programmes entitled "Live Your Life" organised in the scope of civil-military cooperation was organised on five occasions, in Budapest and Balatonkenese, with the participation of 2,310 people.

Prevention at the workplace

In 2009 workplace prevention programmes could apply for resources in the scope of the tendering procedure announced by the Ministry of Social Affairs and Labour for supporting complex workplace prevention and health promotion programmes implemented by organisations working with drug users or in the field of drug prevention²². 9 workplaces won support during the tendering procedure, in a total amount of HUF 15,507,00 (EUR 55,268)²³.

The Institute for Social Affairs and Labour published a new methodological booklet relating to the programme entitled "Remain in the Green Zone" dealing with the prevention of drug use and alcohol consumption at work (Kaucsek and Simon 2010). During the discussion of the experiences gained during the programme the experts find that in Hungary employers still show little interest in the prevention of drug use and alcohol consumption at the workplace. Only a few companies introduced programmes relating to prevention at the workplace, and even at companies where they actually did, they do not handle this issue in a sufficiently complex way. Most typically employers regard the issue of drug use first of all as an issue of safety at work, as a result of which the handling of the problem occurs as an issue of behaviour control (Kaucsek and Simon 2010).

A survey analysing the best practices for screening harmful drug use, performed by interviewing 86 companies²⁴ (Farkas 2010) experienced the following among the surveyed companies:

²¹ Based on the report by the Hungarian Army (MH 2010).

²² KAB-PR-09 category "C": Supporting prevention and health promotion programmes facilitating the development and implementation of drug policies at workplaces.

²³ The values were calculated based on the official mid-rate of the EUR for 2009 (1 EUR = 280.58 HUF).

²⁴ At the contacted companies the surveyors made structured interviews with the employees dealing with occupational health. The 86 companies contacted were classed in five different types: manufacturers in foreign

- the companies approach harmful drug use on the basis of the principle of zero tolerance, which is also regarded as an unwritten social norm;
- among harmful substances companies have policies, tools and routine rules of procedures relating to alcohol consumption, while in connection with illicit drug use there are recommendations, and in connection with the excessive use of medicines the medical ethics are governing;
- both the employer's and the employee's attitude relating to the use of harmful substances is determined by the demand to comply with the law and by the fear of legal consequences and penalty, rather than by health awareness;
- in the case of accidents or performance reduction employees struggling with alcohol problems are treated by employers by holding inspections openly, while employees ignore the addiction of hidden excessive medicine users, but they regard both groups as parts of the labour market, even though they are on the peripheries. At the same time, people dealing with occupational health tend to regard illicit drug users as being on the borders of the criminal layer, rather than on the peripheries of the labour market; this approach is supported by the experience that experts are very rarely confronted with any type of drug-related problems at workplaces.

3.3. INDICATED PREVENTION

The team of Béke Gyermekotthon [Peace Children's Home] in cooperation with the National Centre for Addiction elaborated the "Model of indicated and therapeutic programmes for young people living in children's homes who are problem drug users or at a high risk of drug use". The publication consists of 9 modules, the individual modules are based on basic principles of psychology. The modules deal with fields such as: sensitizing of teachers, the role of work in personality development, spare time activities, peer support, communication with families, identifying risk factors, indicated prevention, early intervention. The model programme is implemented by Béke Gyermekotthon.²⁵

3.4. NATIONAL AND LOCAL MEDIA CAMPAIGNS

Internet campaigns

The Blue Point Foundation's Drug Seer Campaign – Do Not Wait for Miracles!²⁶

The primary aim of the guerrilla marketing type campaign also using media promotion hacks and having a social purpose (May-June 2008) was to create a forum for real demands occurring in connection with handling the drug problem and for confronting these demands, in order to demystify the drug phenomenon, and in the final self-revealing phase the Blue Point Foundation itself intended to offer alternative solutions for the arising questions and phenomena.

The "DRUG SEER" Campaign came to existence as the project of the Blue Point Drug Counselling Centre and Specialised Outpatient Treatment Foundation. Their protagonist, János Holló, an inventor, was a person imaged (in a nightmare), who, wrapped in mystery, advertised his miraculous machine, the drug seer on his own website and on street leaflets and stickers for a month. What he promised was that his mechanism, with the help of

ownership (30 companies, 35 %), marketing and service providing companies in foreign ownership (8 companies, 9 %), manufacturers in Hungarian ownership (13 companies, 15 %), marketing and service providing companies in Hungarian ownership (11 companies, 13 %), occupational health service providers and state institutes (24 companies, 28 %).

²⁵ Based on the report by the Ministry of Health.

²⁶ The summary was made by the Blue Point Foundation.

bioresonance, could tell about anyone whether they had used drugs, therefore “it results in a revolution in drug prevention and is able to solve the drug problem”. The inventor recorded preliminary orders, looked for volunteers for testing and promised to hold a public introduction event and a press conference on the World Anti-Drug Day. In fact the DRUG SEER, the machine he dreamt, was a harmless structure assembled from parts bought at the jumble market. The aim of the foundation’s campaign was to point out the necessity of scientific-based aspects of the drug problem, the deficiencies of the current handling of the drug problem and the difficulties of accessing authentic information. The aim of the organisers was to make as many people as possible form an opinion on the social use of a contradictory and mystical invention, according to moral, legal, professional or personal-emotional aspects.

The website www.droglato.com²⁷ was launched on 27 May, and its first phase ended on 26 June, on the World Anti-Drug Day. In the following period the After-Campaign was organised, in the scope of which new information was posted on the website about the real aim of the campaign, about its background, and about the real prevention activities of the organising foundation. Before the reveal the website was visited 12,400 times, and 34,000 downloads took place by 11,500 individual visitors. A total number of 309 visitors filled in the application form or wrote an electronic mail, and 117 of them registered themselves as voluntary testers. In the letters written by the readers 63 people expressed their sympathy and encouragement in connection with the invention, 96 people wrote to us in indignation, 144 people showed great interest in the operation of the machine or in other circumstances of the initiative. Only 6 people suspected a media hack. Among the testing motivations the most common motivation was the intention to “protect young people”, which was reported by parents, relatives, teachers, heads of boarding schools, teachers organising summer camps for children. Some people wanted to use the drug seer at workplaces, the manager of a transportation company, the security manager of a luxury hotel and a building entrepreneur contacted us for this purpose. Some people wanted to assess the situation of drug use in entire cities, settlements with the help of this invention, among the people showing interest there were local authority representatives and even an expert in social politics.

The total budget of the drug seer campaign amounted to HUF 1 million (EUR 3,564), which amount the foundation won from the Hungarian Deloitte in an open tendering procedure announced for communication programmes in the field of prevention.

The Year of Temperance campaign²⁸

The aim of Blue Point Foundation’s project entitled the Year of Temperance is to supplement and allocate new content to issues such as harm reduction and health conscious education (prevention) in the spirit of the holistic approach. The aim of the campaign is to point out social and individual responsibility relating to the use of illicit and licit drugs, to generate a real open discourse about the altered state of consciousness, with the active participation of the concerned social groups, and involving the market participants of the entertaining industry.

Temperance – as they see it, supported by the ideas of ancient Greek philosophers and also Foucault – is not the same as abstinence. Temperance is the optimised experience of joy and pleasures.

The central element of the Year of Temperance campaign is a website providing a forum and framework for a discourse on excessive use during entertainment, on altering the state of consciousness, on the factors generating them, and on consumer society in general (www.mertekletes.hu).

The people who register on the website anonymously can record their drug use habits day after day (relating to licit and illicit drugs and different behavioural addictions too) in the consciousness diary, recognising hidden connections and following the changing of amounts

²⁷ The website is not accessible any more.

²⁸ The summary was made by the Blue Point Foundation.

and pleasures. In the studies that can be found in the storage of knowledge, temperance as a virtue is introduced from historical and philosophical aspects. In the blog recommendations, methods relating to harm reduction and habits of use are published regularly as well as other subjective entries remarking upon daily events.

Two tender projects are also parts of the campaign, one of them is an exhibition of photographs presenting the topic of temperance through the eyes of secondary school pupils, while in the framework of the VJ tender this virtue reaches electronic music parties via audio materials using the modern tools of visual communication.

In the campaign, similarly to the website, the Space of Temperance tent set up for the purposes of harm reduction and presentation has an outstanding role. The Space of Temperance is set up on the scene of large national festivals and smaller one-day events, parties, health days organised in the main season of the entertainment industry between the spring and the autumn. During the day the information materials of the Year of Temperance are promoted in the tent, discussions and dialogues are initiated, while in the evening the emphasis is on traditional harm reduction.

The Year of Temperance campaign is ended directly with a press conference in September 2010, in the course of which a report is made on the events realised. The final even of the campaign is the Temperance conference, the aim of which is to facilitate dialogue between the participants and make recommendations on the basis of the results and experience of the campaign.

The foundation won a grant of HUF 20 million (EUR 71,281) from the Norwegian Civil Fund for the implementation of the project.

Regional, local campaigns²⁹

In April and May the Local Coordination Forum on Drug Affairs (KEF) of Szolnok appeared in the local Radio Aktív twice a week with the aim of sensitizing of the society. The target group of the campaign entitled "MEGÁLLÓ" [STOP] was first of all the generation of young people, and during the programme alternative solutions were offered for spending spare time usefully (recommending cultural and other programmes), and the services of the Human Services Centre, Drug Counselling and Information Centre of the Multipurpose Association of the Small Region of Szolnok (SZKTT) were introduced. In the form of short spots the messages of personalities widely known in Szolnok were conveyed about useful spare time activities instead of drug use.³⁰

On the 1 May 2009 the MI-ÉRTÜNK [For Us] Prevention and Aid Association of Orosháza launched a six-month "campaign"³¹ – entitled Green Point –, the aim of which was to provide information on smoking as an addiction and to make people conscious of it, and at the same time to promote a more health and environmentally conscious attitude. The programme consisted of several elements, in the printed media provoking / debate initiating sentences were published once a week. The blog launched as a part of the campaign is still active and accessible (www.zoldpont.blog.hu).

On 1 January 2010 the Életrevaló Karitatív Egyesület [Resourceful Charitable Association] announced a national competition of short films on drug prevention for young people

²⁹ The National Focal Point requested the help of the Local Coordination Fora on Drug Affairs to survey local media campaigns. The service providing organisations sent answers from several cities and from several districts of Budapest. Apart from the few campaigns described above, information was also received about information publications, about the appearance of organisations on television or radio or in the printed press, and about prevention programmes.

³⁰ The campaign was implemented in the framework of the KAB-KEF-06-A-0006 project, its costs amounted to HUF 200,000 (EUR 713).

³¹ Related to the standpoint of the Social and Health Committee of the Body of Representatives of the Local Authority of the Town of Orosháza accepted at its meeting on 10 February 2009 concerning the creation of so-called green points, which are non-smoking public areas of the town.

between the ages of 13-18³². When announcing the competition the primary aim was to inspire young people to make 2-5 minute long films for their peers using their own knowledge, based on what they heard during school lessons on drug prevention. The films created were uploaded on video sharing websites, where they became accessible to others too. 29 films from 19 settlements in the country, by 117 creators and with the cooperation of innumerable participants were submitted. The films submitted were evaluated by a jury consisting of seven members, one film won the main prize, two films were placed second, two films were placed third, five films were awarded special prizes, and some of the films were shown at the Sziget Festival.³³ The external communication of the programme was realised carried out with the support of the National Civil Fund. The foundation had a short film made for the competition announcement, which was shown on VIVA TV for two weeks, the TV spot was also shown on other television channels (TV10), it also appeared on internet surfaces, and the foundation launched a separate blog for the film competition. The Civil Radio also dealt with the competition, and after the competition they made interviews with the winners.

Conclusions

In the academic year of 2008/2009 a total number of 79,865 schoolchildren, that is 8.3% of schoolchildren aged 10-18 attending institutes of primary and secondary education took part in drug prevention sessions in the scope of the joint tender invitation issued by the Ministry of Social and Labour Affairs and the Ministry of Education and Culture to support school-based health promotion and drug prevention programmes, which represents a reduction as compared to the previous year (in the academic year of 2007/2008: 9.5%).

According to the results of the survey analysing the changes of the prevention competences and activity of the institutes of public education, in the last 5 years the proportion of schools increased, where there are no institutional capacities at all for performing school-based prevention / health promotion tasks, where currently there is no school psychologist, or drug coordinator, or health promoter, or youth doctor, or district nurse regularly visiting the school. 70% of the institutes is still regularly visited by a district nurse, but the role of the drug coordinator has a much lower significance in schools: while earlier there was a drug coordinator in more than half of the schools, today only two out of ten schools have a drug coordinator. However, despite the unfavourable changes the proportion of schools employing a school psychologist increased. In any one of the three academic years examined 90.4% of the primary and secondary schools performed some sort of prevention or health promotion activity, in the individual academic years there was some sort of prevention programme in 85-88% of the schools. While in the previous years it was the field of licit/illicit drug use that was the most emphasised among the targeted fields, presently the prevention interventions dealing with mental hygiene and nutrition are implemented in the school setting in the same proportion as drug prevention programmes.

In 2009 organisations performed harm reduction/prevention activities in the recreational settings in 9 cities / micro-regions, the organisations participated in a total number 550 events, where they contacted more than 16,000 young people.

³² The programme was realised with the support of the Ministry of Social Affairs and Labour.

³³ To see the short films go to: <http://eletrevalo.blog.hu/> (Accessed: 17.06.2010)

4. PROBLEM DRUG USE

Overview

At the end of 2008 research work was started with the participation of specialists, the aim of which was to identify and utilise data sources suitable for estimating the size of the drug user population and sub-groups by reviewing the national drug data collection systems; and, if necessary, to make a proposal relating to their modification. Besides reviewing the different data collections relating to treatment, the data collection system of the National Police Headquarters was also reviewed, and the arrest data relating to problem drug users were processed.

In 2009 the National Focal Point started a new national on-line data collection to record needle exchange turnover data, and the patterns of drug use – first of all injecting – drug users appearing in treatment are also recorded. In 2009, for the fourth time, HIV, HBV and HCV screening took place among IDUs, organised by the National Centre for Epidemiology. For the first time the client data of the last four years was reviewed from an aspect other than the aspect of infectious diseases. During the review of the data of IDUs first of all the proportions of young clients (below the age of 25) and newly entering clients (who started injecting drugs within the last 2 years) were determined in compliance with the EMCDDA definition, which two indicators can be regarded as the indirect indicators of the future treatment demands and the processes taking place in the hidden population.

4.1. PREVALENCE AND INCIDENCE ESTIMATE OF PROBLEM DRUG USE

At the beginning of 2010 a study was made (Bozsonyi and Horváth 2010a) to estimate the number of problem drug users. The estimation covered two areas. On the one part it was aimed at the number of problem heroin, amphetamine and cocaine users, using police and treatment databases, using the capture-recapture method. On the other part the size of the IDU population was estimated using the data of the dried blood spot screening programmes organised by the National Centre for Epidemiology (OEK) (for more detail see chapter 6.2.), using the capture-recapture method on the same database, repeated in time.

PDU prevalence estimate

The definition of problem drug use (PDU) used in the course of the estimation is the same as the definition used by EMCDDA, that is it relates to the occurrence of heroin, cocaine or amphetamine use. Therefore here the phrase “problem drug use” does not relate to an addiction, health or social problem, but it simply indicates the use of the above three drugs at least once during the two-year period. During the study the capture-recapture method³⁴ was used, using two databases, police arrest data and the data relating to appearance in treatment.

The police arrest data were provided for the National Focal Point by the National Police Headquarters, Department of Criminal Analysis. Together with the data of the earlier prevalence estimate aimed at the size of the problem drug user population (Elekes and Nyírády 2006), the police arrest data was available relating to the years 2005, 2007 and 2008. The substances found on the arrested person upon arrest represented the basis of classification per drug type, the substances were recorded in the records of arrest on the

³⁴ The capture-recapture method based on two data sources is based on that in the case of statistical independence the ratio of the number of cases found in both sources and the number of cases in one of the sources is the same as the ratio of the size of the unknown population and the number of cases in the other data source.

basis of the examination performed by the Institute for Forensic Sciences, so they were not based on self-reporting or on police suspicion.

The treatment data originated from the Treatment Demand Indicator (TDI) data collection of the National Centre for Addiction, in a way slightly different from what is described in chapter 5. After treatment database enquiry, instead of the data selection algorithms defined in the TDI protocol, individual selection aspects were used. In order to ensure the independence of the data sources, in respect of the cases included in the treatment source, the cases referred to treatment by the criminal justice system (court, probation, police) (that is: cases in the so-called diversion system) were omitted from the sample used for estimation.

The size of the population was estimated per drug type, because otherwise independence representing one of the most important conditions of using the capture-recapture method could not be reached, as significant differences ($p < 0.001$) were observed in the two data sources between the different drugs. In the police source no primary or secondary drugs were distinguished. During estimation persons possessing two or more drugs suiting the definition of problem drugs appeared in the group of all possessed drug types. Similarly, in the case of the treatment data clients could be classified in several groups because of drugs stated as their secondary drug. The estimates cover the populations of heroin, amphetamine and cocaine users, and the estimates do not include groups – although they appeared in the difference data sources – using ‘other opiates’ (e.g. methadone, poppy tea, morphine, etc.), ‘other cocaine’ (crack) and ‘other amphetamines’ (ecstasy) substances. Due to the simultaneous use of several drugs, there may be overlapping in the hidden groups estimated in connection with the individual substances, it was not possible to determine the size of such overlapping.

The data sources were linked with individual identification codes used for years in the TDI system, which were copied out manually – besides other data – by the police from the arrest database related to the use of heroin, cocaine and amphetamines.

In the two databases together the youngest person was 14, the oldest person was 67. The prevalence estimates related to the age group between 15-64.

The databases used during the survey did not indicate injecting drug use clearly, so the prevalence estimate could not be used for determining the size of the IDU population.

During the estimates, in order to reduce errors caused by the small sample size and the low number of persons appearing in both databases, the data relating to 2007 and 2008 was aggregated, so the estimates relate to two-year periods: namely they relate to the size of the different groups using the given drug at least once during the indicated two-year period.

During the estimates the so-called Chapman (1951) estimator was used in respect of the size of the hidden population and the extent of the variance.

Heroin

In the police database, in respect of the years 2007 and 2008, a total number of 326 persons were found to have been entered because of possessing heroin, among them there were 274 men and 52 women. 682 clients appeared in treatment, in the case of whom heroin was stated as the cause of starting treatment, as a primary drug or among secondary drugs. 7 persons were excluded, because their gender was not known (Bozsonyi and Horváth 2010a).

Table 8. Number of heroin users in the police and the treatment database, in 2007 and 2008 altogether (persons)

		Source		
		Police	Treatment	Total
Gender	Men	274	534	808
	Women	52	148	200
Total		326	682	1,008

Source: Bozsonyi and Horváth 2010a

During the two-year period 8 men appeared in the police database in both years, while 51 men appeared in treatment in the two consecutive years, they were taken into consideration once. In the case of women, in the two consecutive years there were no repetitions in the police source, while in the treatment source 14 cases were found.

During the survey, in respect of the population of users estimates were made separately relating to men and women, because a significant difference ($p=0.019$) could be observed in respect of the genders. In respect of ages the two sources proved to be independent (in the case of 3 categories $p=0.142$, in the case of 5 categories $p=0.103$).

In the aggregate of the years 2007 and 2008, in the case of men 208 persons were stated only in the police database, 425 persons were stated only in the treatment database, and 58 persons were stated in both databases. Using the capture-recapture method, the hidden population of persons using heroin at least once during the two years included 1,508 persons according to point estimation. Within a 95% confidence interval the estimated value can be between 1,207 and 1,808 persons.

In the aggregate of the years 2007 and 2008, in the case of women 46 persons were stated exclusively in the police database, 127 persons were stated only in the treatment database, and 7 persons were stated in both databases. In this case the size of the hidden population was 751 persons in the case of point estimation, with 95% certainty the estimated population was between 317 and 1,184 persons. The entire population is the amount of the number of the estimated hidden drug users and the number of drug users stated in the two different data sources. The total number of men and women using heroin at least once in the given two years altogether is between 2,780 and 3,480, the value of the point estimate is 3,130 persons. (ST7_2010_HU_01)

Table 9. *The estimated size of the population of heroin users in the two years, 2007-2008 (persons)*

	Entire population using point estimation	Hidden population (point estimation)	95% confidence interval: lower limit of the hidden population	95% confidence interval: upper limit of the hidden population	Standard deviation of the hidden population
Men	2,199	1,508	1,207	1,808	153
Women	931	751	317	1,184	221
Total	3,130	2,259	1,908	2,609	178

Source: Bozsonyi and Horváth 2010a

Amphetamines

In the police database, in respect of the years 2007 and 2008, a total number of 1,177 persons were found to have been entered because of possessing amphetamines, among them there were 1,011 men and 166 women. 610 clients, 479 men and 131 women appeared in treatment, in the case of whom amphetamines were stated as the cause of starting treatment, as a primary drug or among secondary drugs. 10 persons were excluded, because their gender was not known (Bozsonyi and Horváth 2010a).

Table 10. *Number of amphetamine users in the police and the treatment database, in 2007 and 2008 altogether (persons)*

		Source		Total
		Police	Treatment	
Gender	Men	1,011	479	1,490
	Women	166	131	297
	Total	1,177	610	1,787

Source: Bozsonyi and Horváth 2010a

During the two-year period 14 men appeared in the police database in both years, while 19 men appeared in treatment in the two consecutive years, they were taken into consideration once. In the case of women, in the two consecutive years there were 3 repetitions in the police source, while in the treatment source 4 reoccurring cases were found.

During the survey, in respect of the population of amphetamine users estimates were made separately relating to men and women, because a significant difference ($p < 0.001$) could be observed in respect of the genders in the two sources. The two sources did not prove to be independent in respect of ages either (in the case of 3 categories $p = 0.015$, in the case of 5 categories $p = 0.017$). However, following separation by gender the sources were independent in respect of age groups too (men: in the case of 3 categories $p = 0.099$, in the case of 5 categories $p = 0.260$; women: in the case of 3 categories $p = 0.293$, in the case of 5 categories $p = 0.207$).

In the aggregate of the years 2007 and 2008, in the case of men 979 persons were stated only in the police database, 442 persons were stated only in the treatment database, and 18 persons were stated in both databases. Using the capture-recapture method, the hidden population of persons using amphetamines at least once during the two years included 22,848 persons according to point estimation. Within a 95% confidence interval the estimated value was between 13,147 and 32,550 persons.

In the aggregate of the years 2007 and 2008, in the case of women 157 persons were stated exclusively in the police database, 121 persons were stated exclusively in the treatment database, and 6 persons were stated in both databases. In this case the size of the hidden population was 2,752 persons in the case of point estimation, with 95% certainty the estimated population was between 942 and 4,564 persons.

The entire population of those, who consumed amphetamines at least once in the given two-year period consisted of 27,323 persons as a result of the point estimation, with 95% certainty between 18,138 and 36,508 persons. (ST7_2010_HU_02)

Table 11. *The estimated size of the population of amphetamine users in the two years, 2007-2008 (persons)*

	Entire population using point estimation	Hidden population (point estimation)	95% confidence interval: lower limit of the hidden population	95% confidence interval: upper limit of the hidden population	Standard deviation of the hidden population
Men	24,287	22,848	13,147	32,550	4,949
Women	3036	2,752	942	4,564	924
Total	27,323	25,600	16,415	34,785	4,686

Source: Bozsonyi and Horváth 2010a

Cocaine

In the police database, in respect of the years 2007 and 2008, a total number of 288 persons were found to have been entered because of possessing cocaine, among them there were 247 men and 41 women. 206 clients, 162 men and 44 women appeared in treatment, in the case of whom cocaine was stated as the cause of starting treatment, as a primary drug or among secondary drugs. 3 persons were excluded, because their gender was not known (Bozsonyi and Horváth 2010a).

Table 12. *Number of cocaine users in the police and treatment database, in 2007 and 2008 altogether (persons)*

		Source		Total
		Police	Treatment	
Gender	Men	247	162	409
	Women	41	44	85
	Total	288	206	494

Source: Bozsonyi and Horváth 2010a

A significant interaction ($p=0.026$) was observed between the genders and the sources, as well as between the ages and the sources ($p<0.001$ both in the case of 3 and 5 age categories). Estimation could not be realised per gender, as according to this arrangement female cocaine users did not have an intersection in respect of the two data sources. For this reason, during the survey cocaine users were broken down into three age groups, and the separate estimates were made accordingly. Within the age groups no significant interaction could be observed in respect of the sources and the genders (below the age of 23: $p=0.396$, between 24-29: $p=0.418$, above 30: $p=0.074$), so there was no need for separation by gender.

Table 13. *Number of cocaine users in the police and treatment database, in 2007 and 2008 altogether (persons)*

Age category			Source		
			Police	Treatment	Total
below 23	Gender	Men	29	40	69
		Women	13	22	35
		Total	42	62	104
between 24-29	Gender	Men	69	57	126
		Women	16	11	27
		Total	85	68	153
30 or above	Gender	Men	149	65	214
		Women	12	11	23
		Total	161	76	237

Source: Bozsonyi and Horváth 2010a

In the category of the persons below the age of 23, 42 persons were stated only in the police database, 64 persons were stated only in the treatment database, and 1 person was stated in both databases. The point estimation relating to the hidden population indicated 1,396 persons. Among persons between the age of 24 and 29, 82 persons were stated only in the police database, 65 persons were stated only in the treatment database, and 3 persons were stated in both databases, here the point estimation relating to the occurrence of hidden cocaine use during the two years indicated 1,368 persons. In the case of persons above the age of 30, 157 persons were stated only in the police database, 73 persons were stated only in the treatment database, and 6 persons were stated in both databases. In this case the hidden population included 2,337 persons. In the case of cocaine reliability of the estimates

because of the small sample size – due to the low probability of being stated either in the treatment or in the police dataset – is limited. Calculating an aggregate confidence interval was not therefore possible. (ST7_2010_HU_03)

Table 14. *The estimated size of the population of cocaine users in the two years, 2007-2008 (persons)*³⁵

	Hidden population (point estimation)	Entire population using point estimation	95% confidence interval: lower limit of the hidden population	95% confidence interval: upper limit of the hidden population	Standard deviation of the hidden population
below 23	1,396	1,503	-124	2,917	775
between 24-29	1,368	1,518	233	2,504	579
above 30	2,337	2,571	559	4,115	907
total	5,101	5,592			

Source: Bozsonyi and Horváth 2010a

Prevalence estimate of injecting drug use

At the beginning of 2010 a study (Bozsonyi and Horváth 2010b) was made relating to the size of the IDU population. During estimation the client turnover data of the HIV/HCV dried blood spot screening organised by the National Centre for Epidemiology since 2006 was used.

The screening programme ran between September and November every year, with the participation of an increasing number of service providers, 20 in 2009. Screened IDUs were involved in the estimate, who took part in a needle exchange programme in the given time interval (14 service providers) or received treatment at a specialised outpatient treatment centers (2 service providers). Although ever injecting drugs was a condition of participating in the screening programme, during the survey it was presumed about all tested clients participating in the screening that they injected drugs during the period of two years preceding the screening programme (on the clients' drug use data see chapter 6.1.). Only the data of the last three years of the screening programme lasting for four years was used for the estimate, because of the low number of service providers and elements in the first year. In the end the data of 16 service providers that took part in the screening programme in each of the three years were used for the estimate. In the screening programme the IDUs were identified using a so-called generated code used in the TDI system, which made it possible to monitor the reoccurrence of clients.

³⁵ In the case of the lowest age group the calculations resulted in a negative bottom limit. Probably the normal distribution presumed when calculating the variance was not reached, but it was not possible to use the Poisson distribution. For this reason the authors refrained from totalled estimation relating to the aggregate of the age groups.

Estimation was carried out using the method of capture-recapture recurring in time. It was not possible to break down the estimate by different drug types. The estimate relate to a two-year interval, that is it indicates injecting drug use during the two years determined.

The socio-demographic data of the clients participating in the screening programme and their data relating to drug use is introduced in chapter 4.2.

Table 15. *The patterns of the appearance of the clients in the screening programme (persons)*

2007	2008	2009	Persons
Yes	Yes	Yes	68
Yes	Yes	No	65
Yes	No	Yes	43
Yes	No	No	379
No	Yes	Yes	88
No	Yes	No	328
No	No	Yes	428
No	No	No	Hidden population

Source: Bozsonyi and Horváth 2010b

A criterion of using the capture-recapture method is independence between the two time points when measurement is performed. Presumably, this condition of independence was not fulfilled in the screening programme, so the basic formula³⁶ of capture-recapture was modified, distinguishing 'random' and 'systematic' or 'intended' participation as the cause of repeated occurrence in the screening programme. By modelling the intention to participate, sensitivity analysis was performed. The coefficient of the intention to participate was determined after interviewing the screening units, using the method of expert estimation. On the basis of the average of the answers given by the interviewed service providers, 74% of the clients intentionally participated in the screening programme repeatedly.³⁷ The clients participating in the screening programme were given a motivation package (meal vouchers in the value of EUR 7.1), so the proportion of participants, who took part in the screening programme for the second time because of this, is presumably high, even higher than the estimated value.

Table 16. *Repeated occurrence in the screening programmes between 2008 and 2009*

Year	2009		
	Occurrence	No	Yes
2008	No		471
	Yes	393	156

Source: Bozsonyi and Horváth 2010b

36 The so-called Lincoln-Petersen formula was modified, so the formula used for estimating injecting drug use is:

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

where:

X = hidden population

a₂₁ = IDU population occurring in one of the years

a₁₂ = IDU population occurring in the next year

a'₂₂ = IDU population reoccurring in screening intentionally

a''₂₂ = IDU population occurring in screening randomly

α = coefficient of the intention to participate, in the case of 100% all repeated occurrences were random, that is the two tests are statistically independent

37 During the survey 16 service providers were contacted and requested to estimate the proportion of reoccurring clients, that is clients who occurred in screening in the two consecutive years, who returned to the screening programme consciously and the proportion of those who returned accidentally. 13 service providers answered the question, 2 service providers could not be contacted, and 1 service provider did not answer the question.

Table 17. *Repeated occurrence in the screening programmes between 2007 and 2008*

Year	2008	
	Occurrence	No Occurrence
2007	No	416
	Yes	133

Source: *Bozsonyi and Horváth 2010b*

In 2008 and 2009, using point estimation (Bozsonyi and Horváth 2010b), in the case of complete statistical independence, the size of the hidden IDU population was estimated at 1,187 persons (Bozsonyi and Horváth 2010b). In the case of the estimated proportion of intended participation of 74%, that is $\alpha=0.26$, the size of the hidden IDU population is 4,679 persons, and the total of the IDU population was estimated at 5,699 persons for the two-year period. (ST7_2010_HU_05)

In 2007 and 2008, using point estimation (Bozsonyi and Horváth 2010b), in the case of complete statistical independence, the size of the hidden IDU population was estimated at 1,320 persons. In the case of the estimated proportion of intended participation of 74%, the size of the hidden IDU population is 5,175 persons, whereas the total IDU population was estimated at 6,146 persons concerning the given two years. (ST7_2010_HU_04)

The two different prevalence estimates relating to two-year periods are not suitable for determining a tendency.

When interpreting the results, the following restrictions must be taken into consideration: it may result in overestimation, if persons also take part in the screening programme, in the case of whom the condition of injecting drug use was not fulfilled during the two-year period. During the screening programme a question relating to the time of the last injection was first asked in 2009. The appearance of such persons in one of the years may result in overestimation, while their appearance in both years may result in underestimation.

4.2. DATA ON PROBLEM DRUG USERS FROM NON-TREATMENT SOURCES

National needle exchange client data

Clients' data of needle/syringe programmes at national level in 2009

For the first time in 2009, in the scope of an experimental project, on the basis of the available data needle exchange organisations operating in Hungary reported the gender and age of their clients using their services, as well as their distribution according to their primary drug. 20 organisations took part in the data collection, they reported data about a total number of 1,559 clients. In the tables below the distribution according to primary drug is presented within the age groups.

53% of the IDUs injected heroin as their primary drug, it was followed by amphetamines (38%), 4% of the clients injected some other drug as their primary drug, while cocaine was represented by 1% of the clients appearing in needle/syringe programmes.

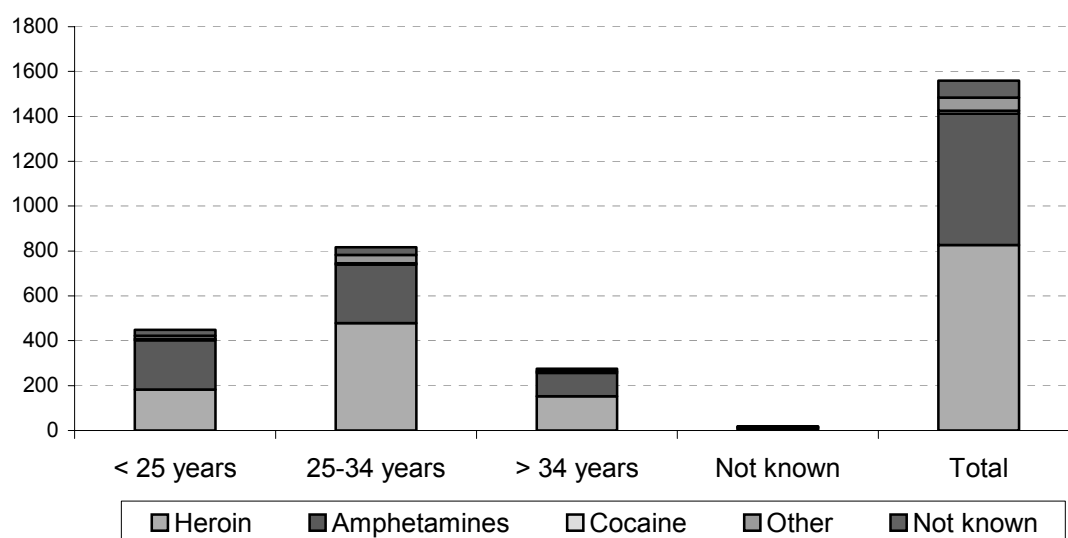
Table 18. *Distribution according to drug type injected as primary drug among clients participating in needle/syringe programmes, broken down by age, in 2009 (persons)*

Drug type	below 25		between 25-34		above 34		not known		Total	
	Persons	%	Persons	%	Persons	%	Persons	%	Persons	%
Heroin	182	41%	479	59%	153	56%	12	63%	826	53%
Amphetamines	220	49%	261	32%	103	37%	3	16%	587	38%
Cocaine	6	1%	6	1%	0	0%	0	0%	12	1%
Other	14	3%	36	4%	7	3%	1	5%	58	4%
Not known	27	6%	34	4%	12	4%	3	16%	76	5%
Total	449	100%	816	100%	275	100%	19	100%	1559	100%

Source: Hungarian National Focal Point

In respect of age categories it can be observed, that while in the age group below 25 the proportion of IDUs injecting amphetamines as their primary drug is higher (49% vs. 41%), between the age of 25 and 34 and above 34 the greatest proportion of IDUs inject heroin as their primary drug.

Figure 10. *Distribution according to age groups among clients participating in needle exchange programmes, broken down by primarily injected drug, in 2009 (persons)*



Source: Hungarian National Focal Point

Distribution according to gender is shown in two tables below. Among women it must be emphasised that while the proportion of heroin is the highest in the first two age groups, above the age of 34 a greater proportion of the women included in the sample injected amphetamines than heroin as their primary drug. In 3 cases the clients' age was not known. IDU women below the age of 25 formed 36.6% of all women participating in needle/syringe programmes.

Table 19. *Distribution according to primarily injected drug among women participating in the needle/syringe programmes, broken down by age, in 2009 (persons)*

Drug type	below 25	%	25-34	%	above 34	%	Total	
Heroin	54	32.5%	86	51.8%	23	13.9%	163	49.8%
Amphetamines	49	39.2%	39	31.2%	37	29.6%	125	38.2%
Cocaine	3	60.0%	2	40.0%	0	0.0%	5	1.5%
Other	5	31.3%	9	56.3%	2	12.5%	16	4.9%
Not known	10	55.6%	5	27.8%	3	16.7%	18	5.5%
Total	121	36.6%	141	42.7%	65	19.6%	327	100%

Source: Hungarian National Focal Point

The tendencies that can be observed among men are characteristic of the entire sample, so the proportion of clients injecting heroin as their primary drug increases parallel to the increasing of age. In 16 cases age was not known. Among men the proportion of IDUs below the age of 25 is lower than among women, it is 27%. Among them the most significant difference can be observed in respect of the primary drug: 37.3% of men below 25 used amphetamines as their primary drug.

Table 20. *Distribution according to primarily injected drug among men participating in the needle/syringe programmes, broken down by age, in 2009 (persons)*

Drug type	below 25	%	25-34	%	above 34	%	Total	
Heroin	128	19.7%	393	60.4%	130	20.0%	651	53.7%
Amphetamines	171	37.3%	222	48.4%	66	14.4%	459	37.8%
Cocaine	3	42.9%	4	57.1%	0	0%	7	0.6%
Other	9	22%	27	65.9%	5	12.2%	41	3.4%
Not known	17	30.9%	29	52.7%	9	16.4%	55	4.5%
Total	328	27.0%	675	55.6%	210	17.3%	1213	100%

Source: Hungarian National Focal Point

The turnover data of the needle/syringe programmes is introduced in chapter 7.2.

Trends among IDUs participating in the national HIV/HBV/HCV screening programme

For the first time in 2009, an analysis was made relating to the characteristics of the IDUs participating in the national HIV/HBV/HCV screening programme (Dudás et al. 2010a) organised by the National Centre for Epidemiology, relating to the last 4 years. During screening data was collected about ever injecting drug user clients appearing in the given years between September and November, involving an increasing number of service providers every year (20 service providers in 2009).

The data relating to the rate of infection among the clients participating in the screening programme and the data relating to risk behaviours is presented in chapter 6.1.

After the first experimental year, when 295 persons were screened, in the course of the screening programmes the needle exchange service providers and the specialised outpatient treatment centers collected data about 555 ever IDUs in 2007, 578 ever IDUs in 2008, and about 675 ever IDUs in 2009.³⁸

³⁸ Cases when data was missing and duplications were filtered out, so the certain cases the element numbers may be different from the ones stated in chapter 6.1.

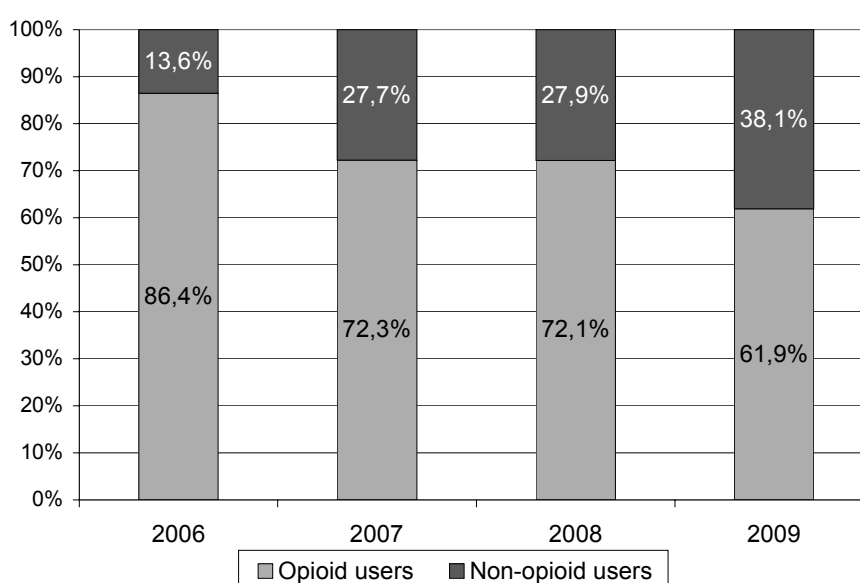
Table 21. The number of IDUs appearing in the screening programme, according to gender, between 2006-2009 (persons)

	2006		2007		2008		2009	
Men	229	77.6%	417	75.1%	417	72.1%	503	74.5%
Women	66	22.4%	138	24.9%	161	27.9%	172	25.5%
Total	295	100.0%	555	100.0%	578	100.0%	675	100.0%

Source: National Centre for Epidemiology; Hungarian National Focal Point

Among the clients participating in the screening programme, the proportion of opiate users decreased year after year, in the different years there was no significant ($p > 0.05$) difference between the drug types and gender. The reduction of the proportion of opiate users is more prominent among men (2006: 87.8%, 2007: 71.5%, 2008: 69.1%, 2009: 61.8%) than among women (2006: 81.8%, 2007: 74.6%, 2008: 80.1%, 2009: 62.2%).

Figure 11. Primary drug type of IDUs appearing in the screening programme, between 2006-2009 (%)

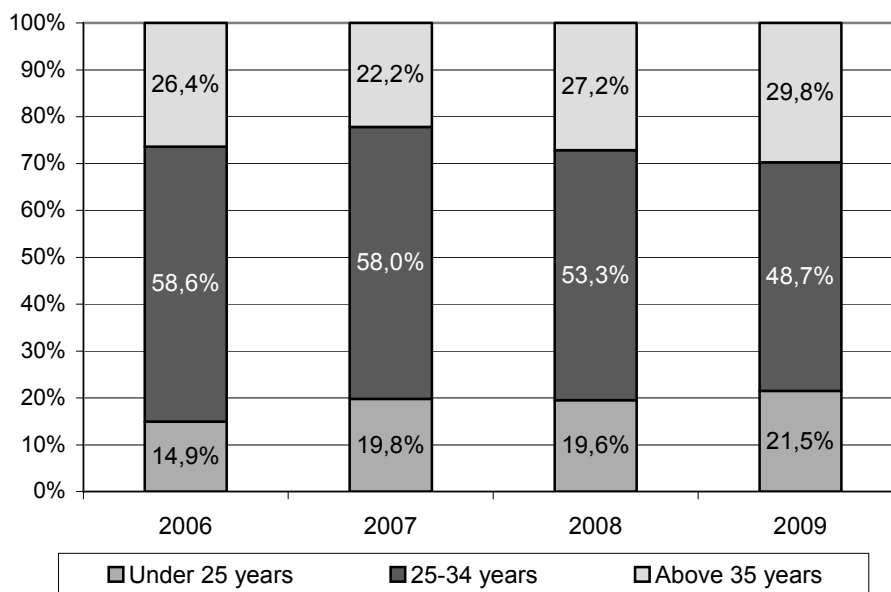


Source: National Centre for Epidemiology; Hungarian National Focal Point

When looking through the data of the four-year period, it turns out that the proportion of drug users below 25 increased during the four years. In 2006 the proportion of young drug users was 14.9%, which indicated a monotonous increase, reaching 21.5% in 2009.

When examining the proportions of the age groups broken down by gender, it turns out that among women there is a higher proportion of IDUs below the age of 25, which difference is significant ($p < 0.001$) in respect of the four years. Among the men participating in the screening programme the increase in the proportion of the persons below the 25 is more prominent (2006: 11.4%, 2007: 17.5%, 2008: 18.2%, 2009: 17.7%) than among women (2006: 27.3%, 2007: 26.8%, 2008: 23%, 2009: 32.6%). Among IDUs above the age of 35 a slight increase by about 3 percentage points could be observed during the four-year period, in the case of men their proportion increased from 27.1% measured in 2006 to 30.6% in 2009, while among women their proportion increased from 24.2% measured in 2006 to 27.3% in 2009.

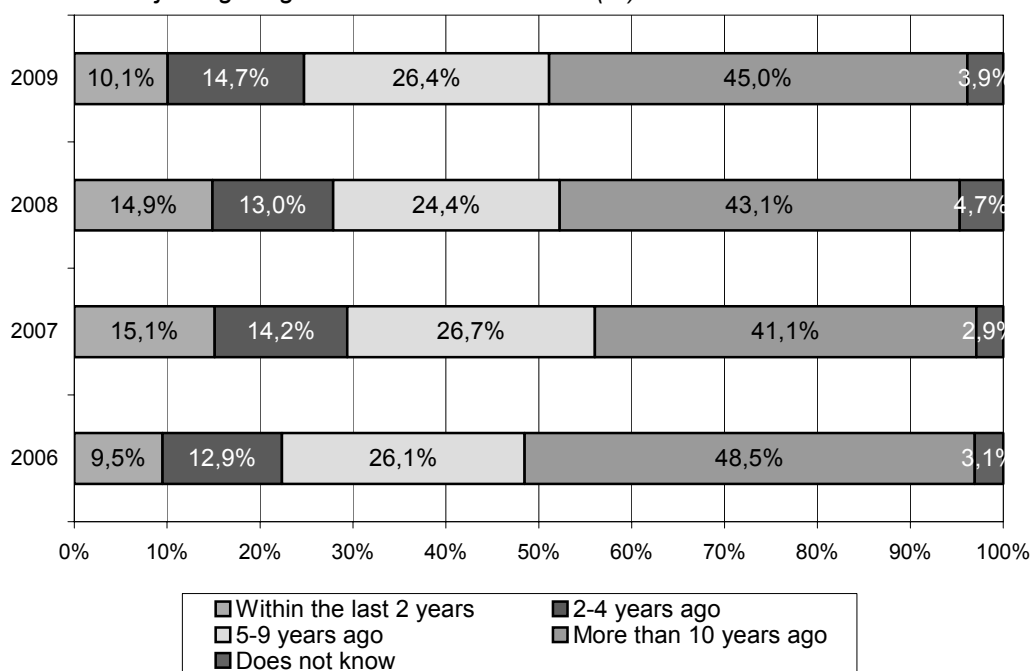
Figure 12. IDUs appearing in the screening programme according to age groups, between 2006-2009 (%)



Source: National Centre for Epidemiology; Hungarian National Focal Point

The questionnaire accompanying the screening (Dudás et al. 2010a) also contained a question relating to the beginning of injecting drug use. Among the clients participating in the screening programme the proportion of those who started to inject drugs within the previous 2 years was around 10-15%. The proportion of clients injecting drugs for 2-4 years can be regarded as stable with a value between 13-15%, similarly to the proportion of clients injecting drugs for 5-9 years, who form about a quarter of all clients. Clients injecting drugs for more than ten years represent the highest proportion, with values of 41.1% and 48.5%.

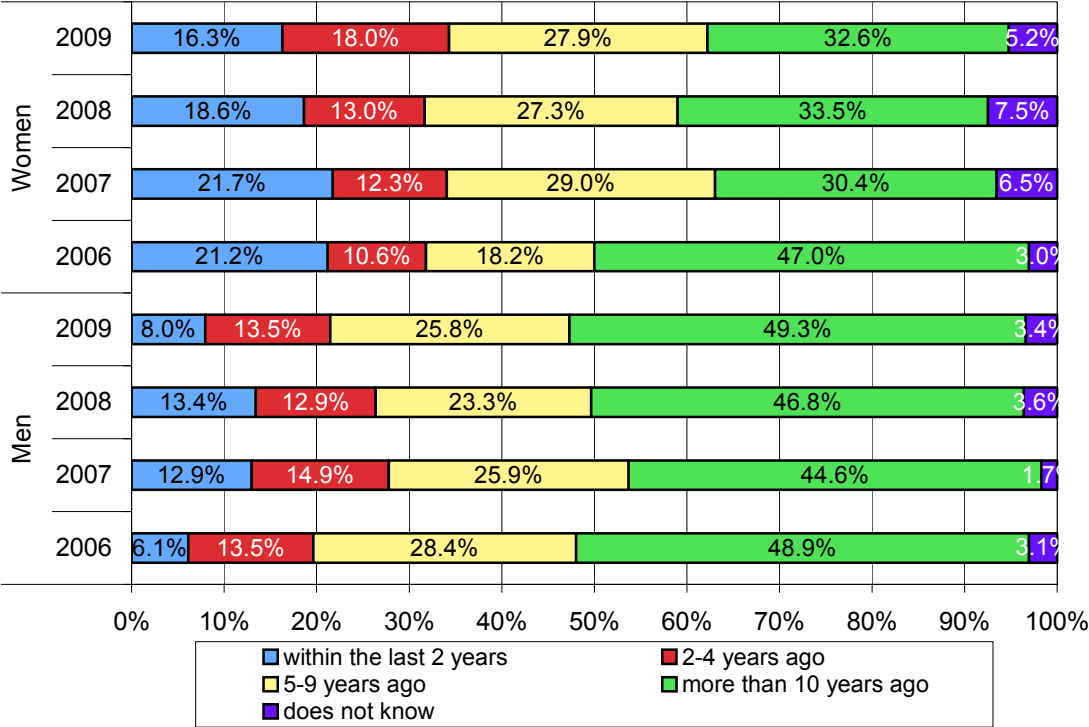
Figure 13. Start of injecting drug use between 2006-2009 (%)



Source: National Centre for Epidemiology; Hungarian National Focal Point

While among male clients no clear tendency can be observed, among female drug users the proportion of those who started to inject drugs within the last 2 years decreases year after year. The differences between the genders are significant ($p < 0.05$) in each year, female drug users have been injecting drugs for a shorter time. Among women from 2006 by 2009 the proportion of those who started injecting drug use within the preceding 2 years decreased by 4.9 percentage points. Among men, after the first screening in 2006 containing a low number of elements, from 2007 by 2009 this proportion also decreased by 4.9 percentage points, but the tendency is not clear.

Figure 14. Start of injecting drug use according to genders between 2006-2009 (%)



Source: National Centre for Epidemiology; Hungarian National Focal Point

A clear interaction ($p < 0.001$ every year) could be observed between the onset of injecting and the drug used. Typically, opiate users have been injecting drugs for a significantly longer time, their proportion is 3-7 times higher in the categories of drug users injecting drugs for 5-9 years, and especially among clients injecting drugs for more than 10 years. In respect of their age there is also a significant ($p < 0.001$ every year) difference between age groups and opiate use: in the four years an average of 28.3% of opiate users were included in the oldest category of clients above the age of 35, as opposed to the 19.3% proportion of amphetamine users.

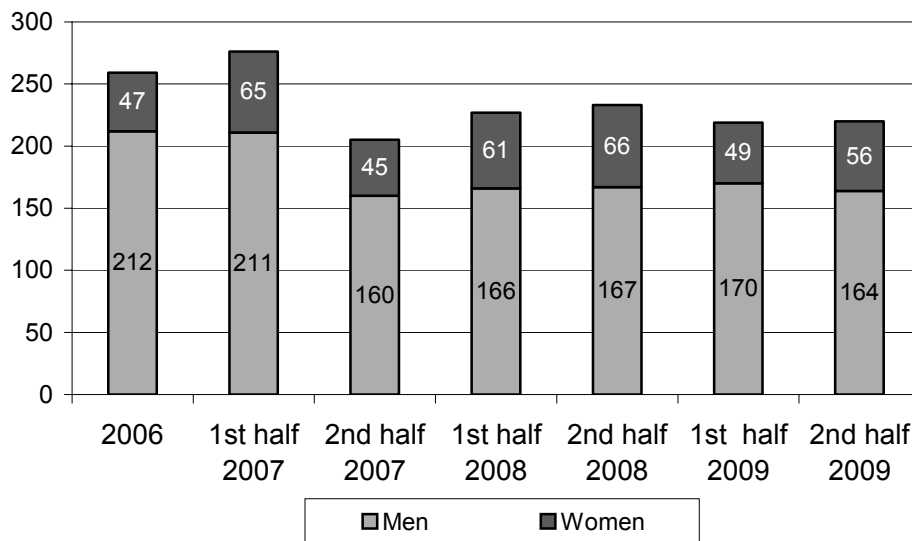
Local needle exchange client data

Client data in the Blue Point Foundation's needle/syringe programme in Kálvária tér

The socio-demographic data of the clients of the Blue Point Foundation's needle/syringe programme in Kálvária tér, district VIII, Budapest, is introduced in a study (Csák and Gyékiss 2010)³⁹.

At the service provider operating since 2006, 1,639 clients registered themselves during the period of 4 years, 1,250 (76.3%) of them were men, and 389 (23.7%) of them were women. Although no significant interaction ($p=0.154$) can be observed, a slight increase can be experienced in the number of female clients.

Figure 15. *The number of newly registered clients broken down to six-month periods between 2006-2009, broken down by gender, N=1639 (persons)*

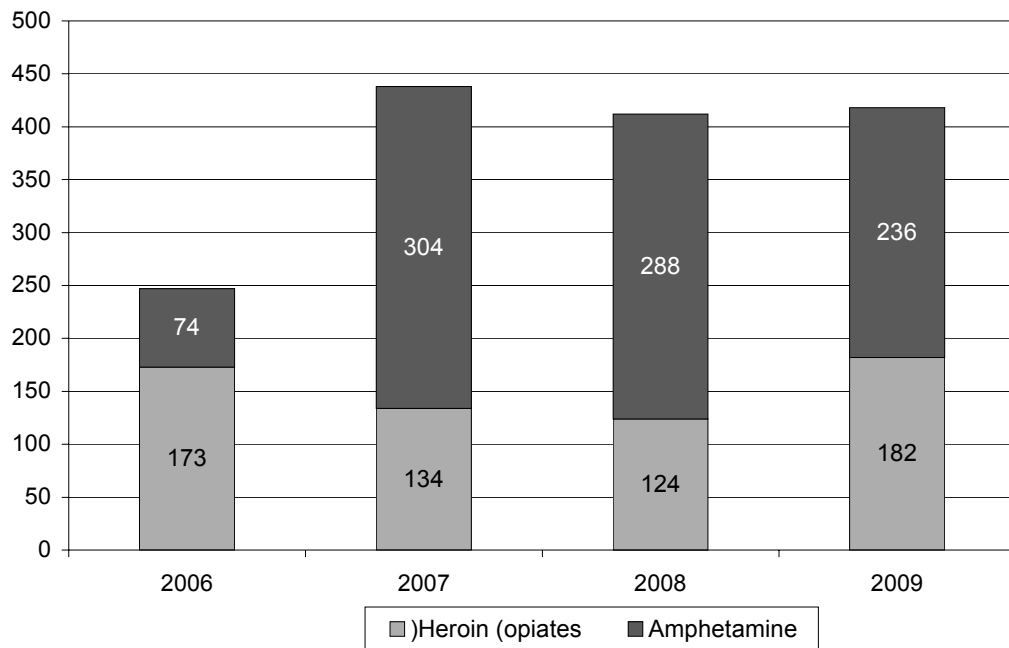


Source: Csák and Gyékiss 2010

The primary drug is known in the case of 1,515 registered clients, in the case of 902 persons (59.5%) amphetamines, in the case of 613 persons (40.5%) some opiate, typically heroin was registered. Although in respect of their number there are more amphetamine users, the proportion of heroin users increased significantly ($p<0.001$) in the last four years.

³⁹ Some of the data examined in the study cover some of the client data in the description of the national needle/syringe programmes above in this chapter, as the Blue Point Foundation's needle exchange programme in Kálvária tér was one of the reporting service providers in the national programme, but only its data relating to 2009 is stated in the description. The service provider's client data relating to a period of 4 years is also introduced separately, because in 2009 several interventions / measures took place, which resulted in the increase observed in the number of clients at the service provider mentioned above and in other associated problems (high HCV infection rate). Further data relating to this can be found in chapters 6.1, 7.1 and 7.2.

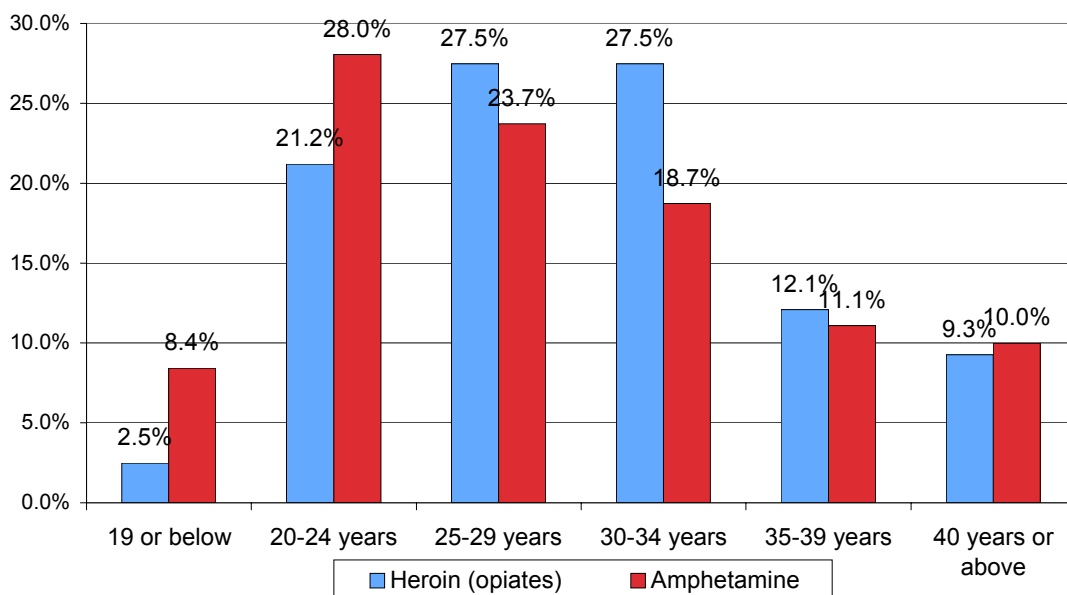
Figure 16. Breakdown by primary drug among the registered clients between 2006-2009, N=1515 (persons)



Source: Csák and Gyékiss 2010

During the period of four years, the connection between the primary drug and the age category became known in the case of 1,506 clients. Among clients below the age of 24, and especially among clients below the age of 19, amphetamine use is more common; among clients above the age of 30 heroin use occurs more prominently. When examining the time-series data of the last years, the increase in the number of opiate users is conspicuous in higher age categories, while about a quarter of amphetamine users who registered in the given year (2007: 29%, 2008: 26%, 2009: 19%) belonged to the category of clients below the age of 19.

Figure 17. The proportion of age categories according to primary drug among clients registered between 2006 and 2009, N=1506 (persons)



Source: Csák and Gyékiss 2010

4.3. INTENSIVE, FREQUENT, LONG-TERM AND OTHER PROBLEMATIC FORMS OF USE

No new information available.

Conclusions

Progress was made in national drug data collection in the recent years: the use of generated codes – which are permanent in respect of the algorithm of its generation, but are still anonymous – made it possible to link up different databases, with the help of which the occurrences of problem drug users can be monitored in the different systems. As a result of connecting databases using generated codes, in 2010 estimates were made to determine the size of problem drug user groups.

The definitions used comply with the EMCDDA definition, that is the occurrence of heroin, cocaine and amphetamine use at least on one occasion was examined, in a period of two years because of the low number of elements. On the basis of the point estimation values, the number of heroin users in the years 2007 and 2008 together was estimated at 3,130 persons. In the same two years the number of amphetamine users was 27,323, and the number of cocaine users was 5,592 on the basis of the point estimates. Among the estimates made at the three different drugs, the reliability of the estimate relating to the prevalence of cocaine use is low, especially in the groups of users below the age of 30, where the intersection of the two databases used during estimation contained a low number of cases. Even according to conservative estimation, the prevalence of cocaine use was twice the prevalence of heroin use, which – in compliance with the increase of the number of seizures and arrests – demonstrates the increasing use of cocaine. The size of the user groups cannot be compared with the results of the earlier prevalence estimate (Elekes and Nyírády 2006) because of the different case-definitions.

The databases of the screening programmes (Dudás et al. 2010a) aimed at infectious diseases were used to estimate the number of injecting drug users. Two estimates were made concerning two-year periods, in respect of the years 2007 and 2008 together 6,146 IDUs are presumed, while in respect of the years 2008 and 2009 together 5,699 IDUs are presumed by point estimation. The two estimates proved to be extremely sensitive on the basis of the sensitivity test in respect of the number of drug users intentionally reoccurring in the screening programs year after year. The estimated values were based on the expert estimation that three-quarters of the returning clients occurred intentionally in the screening program in the next year again, but it was not possible to reveal the regional differences of this value.

On the basis of the data collections performed among IDUs, that is on the basis of the client data of the needle/syringe programmes and on the basis of the annual screening programmes aimed at infectious diseases, among IDUs the proportion of opiate users is higher than the proportion of amphetamine users. Typically, clients participating in needle/syringe programmes rather used some sort of opiate, in a ratio of 5:4, which is valid in respect of both genders, but the tendency is monotonously decreasing, which indicates a slow process of changing over to amphetamines from opiate. In the screening programme aimed at infectious diseases, the proportion of opiate users shows a decreasing tendency, from the initial 7:3 it reduced to 6:4. Both data collections confirm the increase of amphetamine use in the age categories below 25, among both genders.

At national level, the proportion of clients below the age of 25 in needle/syringe programmes is 36.6% among women, and 27% among men. The screening data shows slightly lower proportions, but the tendency is obvious: during the period of four years the proportion of clients below the age of 25 increased from 14.9% to 21.5%. A question relating to starting injecting drug use was asked from the clients participating in the screening programmes. Among men the proportion of those who started to inject drugs within the last 2 years is 10%,

while among women this proportion is high, but decreasing: from 21.2% it reduced to 16.3% during the period of four years.

The data of clients from non-treatment sources – only participating in needle/syringe or screening programmes – indicate that among newly registered IDUs amphetamine use is more characteristic, and the proportion of users below the age of 25 is high. The proportion of opiate use is decreasing, typically IDUs have been injecting drugs for a long time (for 5-9 years or for more than 10 years), and they belong to older age groups (between 25-35, above 35). Among women the proportion of users below the age of 25 is higher, as well as the proportion of users who started injecting drugs within the last 2 years, which indicates an increasing, recent onset of injecting among women, mainly related to amphetamine use. Although the proportion of users who started to inject drugs within the preceding 2 years is decreasing; the high and increasing proportion of users below the age of 25 in both databases forecasts increasing burdens on the healthcare system.

5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

Overview

In 2009, the so-called "OSAP" data collection – related to the no. 1211/06 report of Regulation 76/2004. (VIII.19.) of the Ministry of Health, Family and Social Affairs on the detailed rules of determining, collecting and processing certain sectoral (health, professional) data unsuitable for personal identification – was changed from paper-based data collection to on-line data collection, and the organisational unit performing data collection also changed. As a result of the change the quality assurance system of data collection also changed, communication with the service providers was cancelled. Because of the above, the final, valid data file had not been prepared by the time the report was written, so in 2009 the analysis of the data of drug users in treatment (the so-called treatment prevalence data) was set aside.

5.1. POLICY

In respect of the methodological and professional development of the field of addiction treatment it is of outstanding significance that Regulation 52/2008. (XII.31.) of the Ministry of Health on national advisory boards was created in December 2008, as a result of which the National Advisory Board of Addictions started its operation in April 2009. The Advisory Board prepared a proposal relating to the amendment of Regulation 60/2003. (X.20.) of the Ministry of Health, Family and Social Affairs on the personal and material conditions of providing health services, and on the minimum professional conditions of providing health services.

Following a comprehensive professional and social harmonisation process coordinated by the Ministry of Health, in April 2009 the leaders of the ministry accepted the Mental Health National Programme (LEGOP), which can be regarded as the long-term development programme of psychiatric care.

In 2009, under the coordination of the Ministry of Social Affairs and Labour and with the cooperation of the corresponding Ministries and national level organisations whose sphere of action covers responding drug related problems the new National Drug Strategy was prepared (2010-2018). The new strategy determines long-term goals in certain fields of harm reduction, treatment, care, resocialization and reintegration in the interest of improving capacity, coverage and diversification of services, developing special programmes for groups with special needs, facilitating early interventions, reducing shortages of professionals, facilitating cooperation between healthcare and social service providers and improving professional quality assurance.

On 29 December 2009 the Act CLIV on the amendment of certain acts on healthcare was proclaimed, which also affects Act CXXXII of 2006 on the development of the healthcare system (hereinafter: Eftv.), and the Government, at its meeting held on 23 December 2009, ratified the draft of the proposal relating to the amendment of Government Regulation 337/2008. (XII. 30.) – the implementing statute of the Eftv. As a result of the amendments affecting the Eftv. and its implementing statute, the regulation of the modification of the capacity structure becomes more flexible. The aim of the new provision is to facilitate the elimination of the regional inequalities of the active, rehabilitation and outpatient psychiatric capacity structure beside the already existing regulations, and to promote the efficient realisation of the development aims and the modernisation of the institutional structure.

The revision of the financing of psychiatric and psychotherapeutic rehabilitation inpatient care was started in 2009. The aim is to determine the objective criteria of rehabilitation qualifications (which determine the financing multiplier)⁴⁰. In the meantime the National Advisory Board of Psychiatry prepared its proposal relating to the qualification criteria of psychiatric and psychotherapeutic rehabilitation, its evaluation and the preparation of the effect study is still in process.

Human resources development programmes

In 2009 the Ministry of Health laid special emphasis of on overcoming the problem of the shortages of professionals, which had made the operation of the field difficult for a long time. In order to build up human resources, the special field of psychiatry was named both in the TÁMOP 6.2.2 project entitled “Training programmes for health care employees, training courses for rare professions” and in the TÁMOP 6.2.4 project entitled “Supporting employment”. So far, in the scope of the TÁMOP 6.2.4. project 39 winning applicants have been granted a total support of 5,150,046 EUR⁴¹, so far the planned number of employees is 253, and among there are child and youth psychiatrists and special psychologists too.

In connection with the training of specialists, Government Regulation 122/2009. (VI. 12.) on the advanced level health care educational system was prepared and proclaimed in issue no. 79 of Magyar Közlöny (Hungarian Gazette) published on 12 June 2009, which regulation provides supplementary support for specialists employed in rare professions. In the regulation on the training of residents it is determined that from 2010 those who choose a rare profession will be granted extra support. As psychiatry is regarded as a rare profession, residents choosing this field are now granted additional support of a gross monthly amount of 231 EUR.

Other development programmes

In the scope of the Social Infrastructure Operational Programme (TIOP), applications for facilitating the structural change and the infrastructural development of institutes providing special inpatient care can be submitted in the six convergence regions. The development resources may facilitate the development, integration and equipment modernisation of active and chronic type psychiatric and early rehabilitation care.

In the scope of the Regional Operational Programme (ROP), except for the central region, institutes and their maintaining organisations may submit applications for the development of the institutional system of health rehabilitation inpatient care and outpatient care integrated to the inpatient care, as well as the development of the psychiatric/addiction care network. The aim of the project is to develop medical rehabilitation care, including psychiatric and addiction care, adjusted to needs and suiting the level of development.

⁴⁰ Following a long harmonisation process, the qualification criteria of non-psychiatric rehabilitation were announced at the end of 2009.

⁴¹ The values in this chapter were calculated based on the official mid-rate of the EUR for 2009 (1 EUR = 280.58 HUF).

5.2. TREATMENT SYSTEMS

Organisation and quality assurance

In 2009, with the participation of the National Medical Officer Service the list of healthcare service providers providing treatment for drug addiction, treatment of other conditions with drug use or preventive-consulting service was reviewed. The revised so-called diversion list was published in issue 19 of the Healthcare Gazette.

In 2009, the National Advisory Board of Addictions and OAC jointly reviewed and modified the professional protocol on the treatment of diseases related to opioid use, which was published in issue 7 of the Healthcare Gazette in 2010 (25 March 2010). The methodological letter on methadone treatment, the professional protocols on the treatment of clinical patterns associated with amphetamine use and of disorders related to cannabis use were extended until 31 December 2011.

With the help of the allowance of 124,742 EUR granted by the Ministry of Social Affairs and Labour to the Ministry of Health⁴² development programmes could be initiated at numerous important associated fields using innovative methods, taking into consideration good international practices and the possibilities and development directions of realisation in Hungary⁴³. The most important aim of the programmes was to strengthen and determine the role and place of health structures in the prevention of illicit drug use and in handling problems associated with illicit drug use – with special respect to early recognition, local cooperation, the role of healthcare providers in local professional contexts and improving their efficiency.

The development programmes prepared in 2008 by OAC in connection with the treatment of illicit drug use and early interventions were mainly realised in 2009.

In the scope of the project entitled “Early treatment and re-integration, relapse-prevention support programmes for young drug users and drug user young adults who are disadvantaged, unemployed, at-risk drug users (intensive drug users) or problem drug users, with the close cooperation of the healthcare and employment system” the staff at the employment centres of Zala and Tolna county were prepared to identify clients with drug use problems and facilitate their participation in support service, motivate them to do so. On the other hand, local psychiatry and addiction treatment service providers, as well as social service providers working with addicts were also involved in the activity relating to early treatment and treating clients in need. The favourable experience obtained on the part of healthcare and social service providers may contribute to the increasing of the number of clients and to the spread of the practice of early intervention.

The publication entitled “Care and prevention programme for addicted pregnant women, at-risk neonates and small children” was prepared⁴⁴ (Környey 2009).

The documentation of the so-called quality assurance training was prepared for the participants of the addiction healthcare system. A treatment evaluation quality indicator system was set up, which serves as a basis for treatment evaluation and professional supervision supported by professional protocols.

In the scope of the programme entitled “Organising and holding training courses needed for handling the drugs problem”, with the help of a quality assurance expert, a modern professional training material was prepared and submitted, the aim of which was to pass on knowledge supporting the introduction of the quality assurance system of addiction treatment, especially to experts participating in setting up indicator systems describing

⁴² Source: Summary of the Ministry of Health on the realisation of the tasks determined in Government Decree 1094/2007. (XII.5.) on the governmental tasks in connection with the realisation of the aims of the national strategic programme relating to combating the drug problem – Ministry of Health, December 2009

⁴³ The programmes ended in June 2009.

⁴⁴ For more detail see chapter 7.3.

services in the selected fields. The training material prepared for standardised quality assurance training could be used to offer the experts a uniform approach.

Within the part of the 'TÁMOP 5.4.1 key project' concerning the drugs problem, the element aimed at the prevention of illicit drug use and the development of its treatment systems will be realised in 2009–2011. In the first period (2009–2011) the aim is to set up and test a system of indicators, which can describe the needs occurring at local level and then evaluate how the currently existing treatment system suits such needs.

Evaluating the efficiency of diversion⁴⁵

In 2009 a perception study was carried out on the efficiency of diversion (Vitrai et al. 2009)⁴⁶. In the scope of this cross-sectional study, the efficiency of the services was determined on the basis of the opinions of the leaders of the institutes/organisations realising diversion programmes, the professionals performing diversion programmes and the clients participating in diversion programmes.

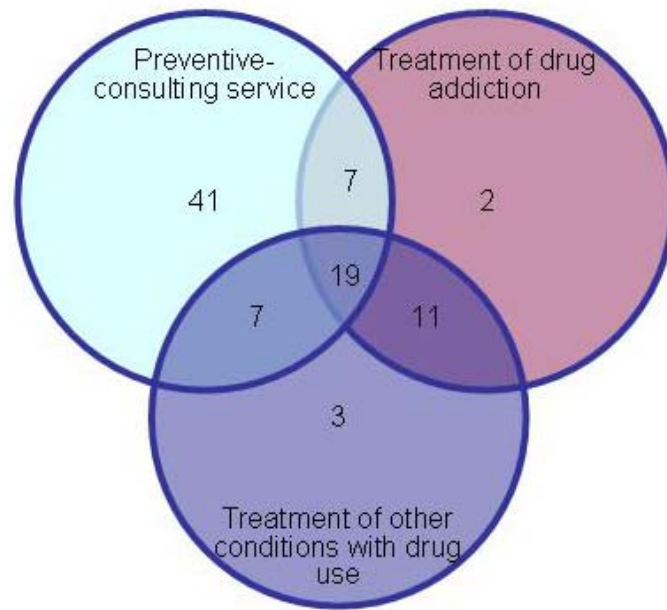
During the study 94 organisations could be identified in the country, which were currently performing diversion programmes. On the basis of the breakdown of these organisations it can be seen that the majority of them (74 organisations) perform preventive-consulting services – exclusively or combined with the two types of diversion defined as health service. Only 15 service providers could be identified, which provided exclusively and especially health services in connection with diversion⁴⁷.

⁴⁵ treatment as an alternative to criminal procedure

⁴⁶ The study was carried out by Egészségmonitor Kft. with the support of the Ministry of Social Affairs and Labour (project identification code: KAB-KT-M-08-02). The three levels of the study comprised (1) the organisations realising diversion programmes, (2) the professionals and leaders of institutes performing diversion programmes (3) and the clients participating in diversion programmes. During the preparation of the study a list of the organisations realising diversion programmes was created by studying different databases, and the list was validated by contacting the organisations on the telephone. Out of the 213 organisations identified by looking through the databases 94 organisations currently performing diversion programmes could be contacted on the telephone. In their case an institutional data sheet was filled in. Sampling during the following 4 phases of the study took place with the help of the list of organisations identified in this way. The following phases of the study were: (1) making an in-depth interview with the leader of 10 institutes/organisations realising diversion programmes, with 10 professionals performing diversion programmes and with 10 clients participating in diversion programmes, (2) surveying 69 institute/service leaders by using questionnaires, (3) surveying 149 professionals performing diversion programmes by using questionnaires, (4) surveying 302 clients participating in diversion programmes by using questionnaires.

⁴⁷ 'Treatment for drug addiction' and 'treatment of other conditions with drug use' can be performed by any service provider entitled to provide addiction treatment services, so it is not exclusively these 15 organisations that are entitled to perform such services. No data is available about the activity of 4 service providers.

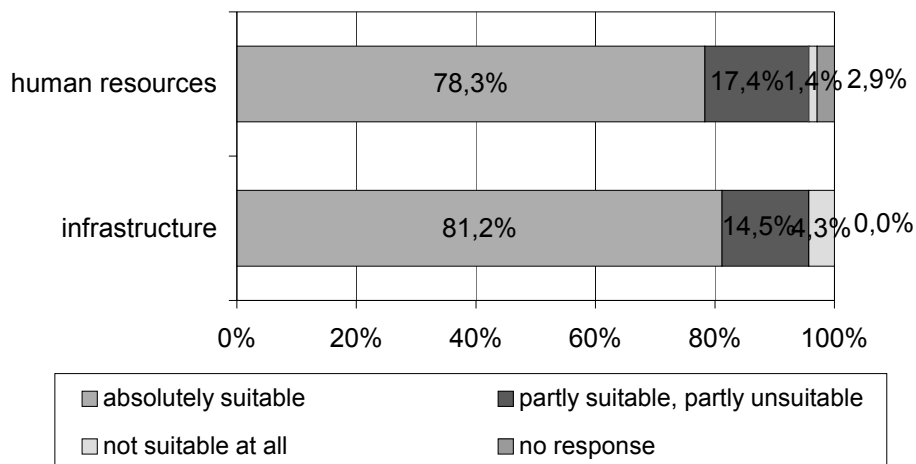
Figure 18. Breakdown of organisations by services provided (organisation) (N=90)



Source: Vitrai et al. 2009

One of the questions examined during the study (Vitrai et al. 2009) in connection with the institutional background was the suitability of the operating conditions. The significant majority of the leaders of the organisations/institutes found that the available human resources were suitable (78%), and that the available infrastructure was suitable (81%). Only 1.4% of the respondents found that the amount of the available human resources was not at all suitable, and 4.3% thought the same about the available infrastructure.

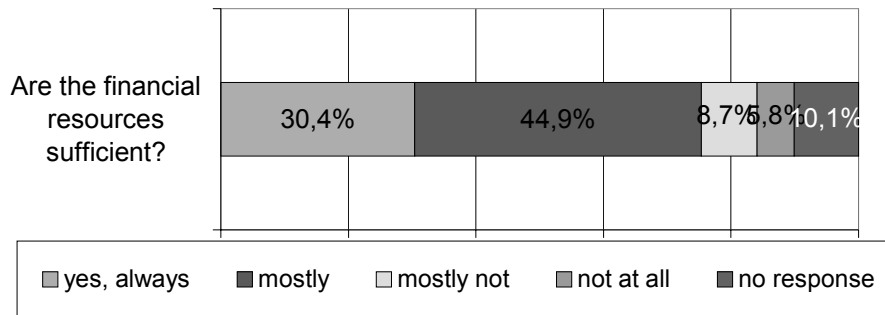
Figure 19. Evaluation of the operating conditions on the basis of the answers given by the leaders of organisations/institutes – human resources and infrastructure (%) (N=69)



Source: Vitrai et al. 2009

In respect of financial resources the picture is less favourable: 5.8% of the respondents found that financial resources were not sufficient at all, and a further 8.7% found that financial resources were mostly insufficient. However, the great majority of the respondents, 75.3%, found that the conditions were favourable – always or mostly sufficient.

Figure 20. Evaluation of the operating conditions on the basis of the answers given by the leaders of organisations/institutes – financial resources (%) (N=69)

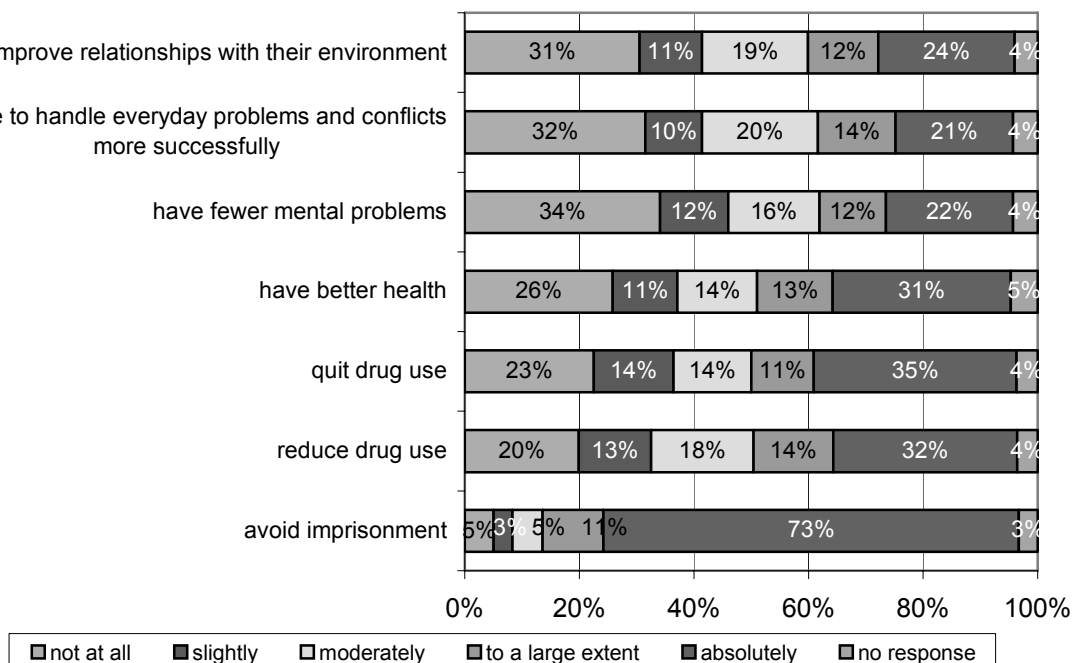


Source: Vitrai et al. 2009

Naturally, the different participants may have different expectations from the interventions. For this reason the study attempted to describe the expectations from three different aspects: on the part of the leaders of the organisations/institutes, on the part of the professionals performing the diversion programmes, and on the part of the clients participating in the diversion programmes.

At the time of carrying out the survey 17% of the clients participating in the study (50 persons) were receiving treatment for drug addiction, 24% (73 persons) were receiving treatment of other conditions with drug use, and 55% (166 persons) were provided with preventive-consulting service. In the case of the majority of the clients the only expectation they shared in common in connection with the efficiency of the diversion programme was avoiding imprisonment, 73% of them found that it was absolutely important and 11% of them found that it was very important. A relatively significant conformity could be observed in the field of quitting and reducing drug use, which expectations were found absolutely important or very important by 46-46% of the respondents.

Figure 21. Clients' expectations in connection with the outcome of the diversion programme (%) (N=302)



Source: Vitrai et al. 2009

In the case of all types of diversion programmes both the leaders of the organisations/institutes and the professionals performing the diversion programmes determined the reduction of drug use or quitting drug use as the most important criterion of efficiency⁴⁸. In the case of the second and third most important criteria the expectations of the two interviewed samples showed a less uniform picture.

Table 22. *The most important criteria of efficiency on the basis of the judgement of the leaders of the organisations/institutes and the professionals working in the diversion programmes*

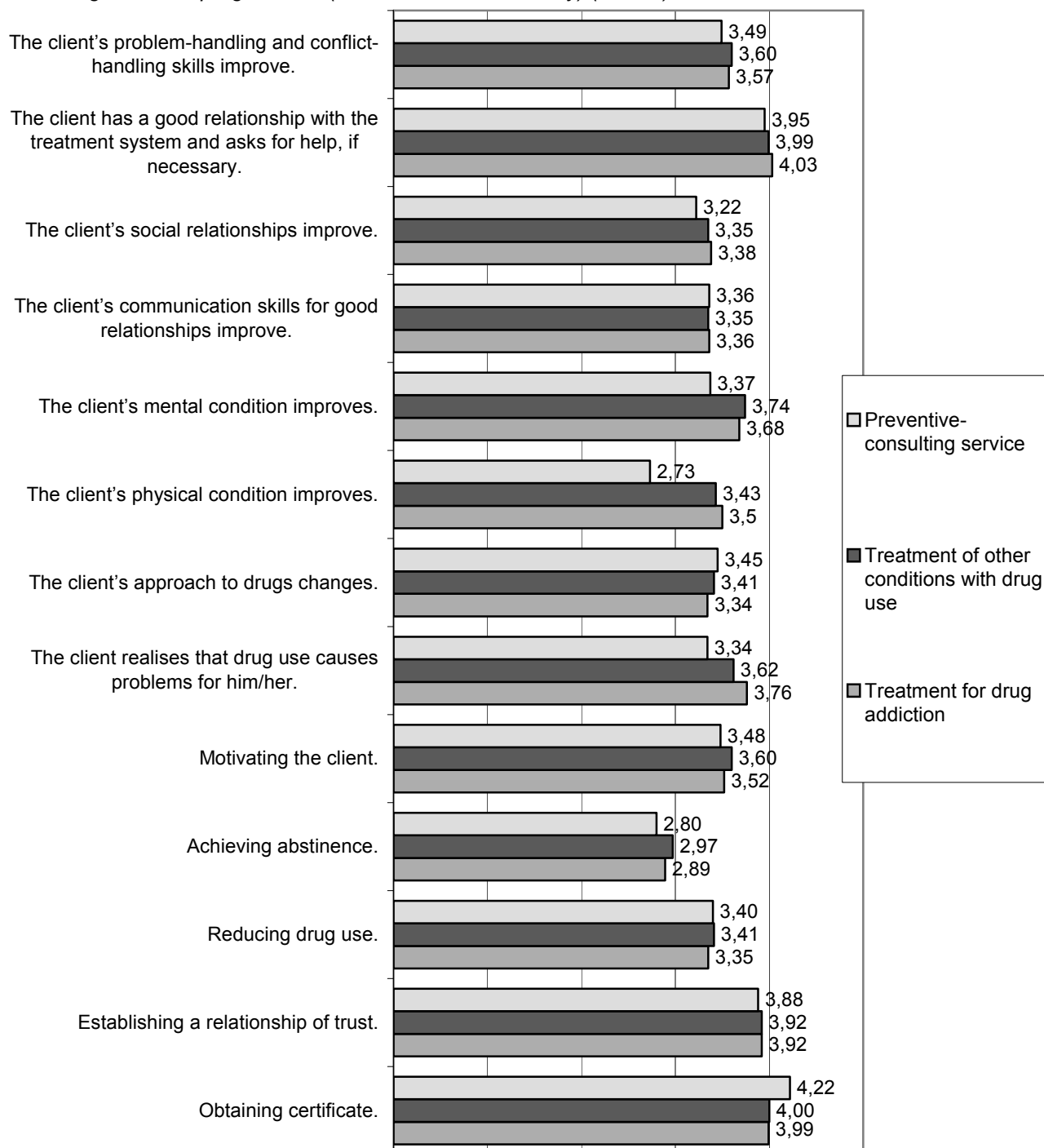
	Treatment for drug addiction	Treatment of other conditions with drug use	Preventive-consulting service
Leaders of organisations/institutes (N=69)	<ol style="list-style-type: none"> 1. reducing/quitting drug use 2. reintegration/resocialisation 	<ol style="list-style-type: none"> 1. reducing/quitting drug use 2. reintegration/resocialisation 	<ol style="list-style-type: none"> 1. reducing/quitting drug use 2. positive changes in the client's life 3. issuing certificate
Professionals working in diversion programmes (N=149)	<ol style="list-style-type: none"> 1. achieving abstinence 2. creating motivation 3. the client's approach changes 	<ol style="list-style-type: none"> 1. achieving abstinence 2. creating motivation 3. reducing drug use 	<ol style="list-style-type: none"> 1. achieving abstinence 2. the client's approach changes 3. a lasting relationship of trust is established between the client and the treatment unit

Source: Vitrai et al. 2009

The 149 professionals interviewed found that the most accomplished aim among the set aims was obtaining the certificate in the case of all three types of diversion programmes. They found that the least accomplished aim was achieving abstinence in the case of the diversion programmes defined as healthcare services, while in the case of the preventive-consulting service the improvement of the clients' physical condition was accomplished with the least success.

⁴⁸ It is difficult to compare the answers, because while the leaders of the organisations/institutes were asked a multiple choice question and they could select the criteria from previously determined alternative answers, the professionals were asked an open-end question.

Figure 22. Accomplishing the aims of diversion according to the judgement of the professionals performing diversion programmes (1=not at all, 5=absolutely) (N=149)



Source: Vitrai et al. 2009

The leaders of the organisations and institutes estimated that among all clients entering treatment at their service unit the proportion of obtaining the certificate that can be issued by the service provider at the end of the diversion programme was 63.1% in the case of treatment for drug addiction, 73.9% in the case of treatment of other conditions with drug use, and 82.5% in the case of the preventive-consulting service.

Evaluating the efficiency of buprenorphine-naloxone maintenance therapy

Demetrovics et al. carried out a study⁴⁹ (Demetrovics et al. 2009) to monitor and evaluate the effects of Suboxone (buprenorphine-naloxone) treatment. The sample included 80 clients entering treatment between November 2007 and March 2008. During the 6-month period of treatment, data were collected 4 times.

According to the results of the study nearly fourth of the altogether 80 heroin dependent patients (18 persons, 22.5%) dropped out of treatment during the first month (the majority, 12 persons – 15% – during the first week) or chose methadone substitution instead. Following this period however, drop-out rate decreased and the six-month treatment period was completed by 32 patients (40%). During the first month of treatment significant positive changes were experienced in all examined psychological and behavioural dimensions that proved to be stable throughout the assessed period.

Based on the early experience with Suboxone treatment – according to the authors' findings –, it is a well tolerable and successfully applicable drug in the substitution therapy of opiate addicts. A critical phase seems to be the first one or two weeks of treatment. Drop-out rate is high during this early period, while after a successful conversion clients presumably remain in therapy for a long period.

Availability and diversification of treatment

Outpatient treatment

In 2009 financing consisting of a fixed fee and performance financing remained in force in outpatient treatment, which continued to create unfavourable conditions for healthcare service providers, as there are only restricted opportunities for influencing patients' motivation and cooperation.

There is not much financing data available about 2009, but the data of the third quarter of 2009 indicate a further reduction in the number of cases, number of interventions and number of 'financing points allocated to certain procedures'⁵⁰. However, with regards to the fact that in outpatient treatment the performance volume limit is determined at institutional level, this phenomenon might not be observed at institutional level too.

Regarding diversion (treatment as an alternative to criminal procedure), the lack of adequate healthcare service providers (e.g. specialised outpatient treatment centre) and proper competency (expertise, experience, attitude) is still a problem in several counties and county towns. The skills shortages in the field of addiction treatment and psychiatry cause difficulties in the provision of preliminary status assessment and the two types of diversion defined as health services.

⁴⁹ 6 outpatient centres participated in the study: 3 from Budapest and 3 from smaller cities in Hungary. At these centres, all patients entering Suboxone maintenance therapy between November 2007 and March 2008, altogether 80 persons (55 males, 35 females, mean age = 30,2 years, SD=5,48) were included in the study sample. During the 6-month period of treatment, data were collected 4 times; when entering treatment, 1 month, 3 months, and 6 months after entering treatment. Applied measures were the Addiction Severity Index, SCID-I, SCID-II, Hamilton Depression Scale, Hamilton Anxiety Scale, STAI-S State Anxiety Inventory, Beck Depression Inventory, Heroin Craving Questionnaire, WHO Well-being Inventory, Perceived Stress Scale, ADHD retrospective questionnaire, TCI short version, and Ways of Coping questionnaire.

⁵⁰ Source: Ministry of Health

Substitution treatment

In 2009 a further organisation, the Blue Point Outpatient Treatment Centre of Békásmegyer joined the group of service providers providing substitution treatment, as a result of which the number of treatment units available in the country increased to 10. Although at the Blue Point Outpatient Treatment Centre of Békásmegyer only 6 persons received buprenorphine-naloxone treatment during the year, and all 6 clients received medicine on prescription⁵¹, from the aspect of geographical coverage the appearance of the outpatient treatment centre as a substitution service provider is important, as there is no other service provider in Budapest operating in the districts of Buda. There was a change in respect of the substitution drug too: while in 2008 there were 5 service providers performing buprenorphine-naloxone treatment, in 2009 this type of treatment was available at all of the 10 service providers.

In 2009, for the first time, data is available on the nature of the substitution treatment⁵². 80% of the known cases⁵³ received maintenance treatment, while 20% of them received detoxification treatment. In the case of nearly half of the clients treated with buprenorphine-naloxone (46.3%, 164 persons) the substitution drug was not funded by the National Health Insurance Fund (OEP), but it was prescribed for the clients and they purchased it at their own cost. The reason for this was that in the case of the buprenorphine-naloxone treatment the funded amount is determined by the performance volume limit per service provider, and above this amount the medicine can be given exclusively on prescription, which is not funded.

In 2009 a total number of 992 people received substitution treatment, which represents a 24% increase as compared to the 802 cases in 2008. This increase is due to the increase of the number of clients treated with buprenorphine-naloxone, which is mainly due to the number of cases when a prescription was written out. The distribution of the cases treated with methadone and buprenorphine-naloxone also changed from 2008 to 2009, and the proportion of the cases treated with buprenorphine-naloxone continued to increase (2008: 15%; 2009: 36%).

The proportion of men and women receiving substitution treatment in 2009 was 76:24, which does not indicate a change as compared to 2008 (77:23).

Table 23. Number of persons receiving methadone (met.) and buprenorphine-naloxone (b.n.) treatment by treatment unit in 2009 (N=992)

	Budapest Nyíró		Budapest Soroksár		Budapest Drogoplex		Budapest Békásmegyer		Eger		Veszprém		Pécs		Gyula		Miskolc		Szeged		Total	
	met.	b.n.	met.	b.n.	met.	b.n.	met.	b.n.	met.	b.n.	met.	b.n.	met.	b.n.	met.	b.n.	met.	b.n.	met.	b.n.	met.	b.n.
men	161	120	0	0	70	7	0	5	4	1	14	0	7	31	10	26	56	10	54	30	376	230
women	63	45	0	0	17	4	0	1	8	0	2	0	7	5	2	3	4	3	20	11	123	72
not known	0	0	139	52	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	139	52
total	224	165	139	52	87	11	0	6	12	1	16	0	14	36	12	29	60	13	74	41	638	354

Source: Nyíró Gyula Hospital Specialised Outpatient Treatment Centre

⁵¹ that is not financed by the National Health Insurance Fund (OEP)

⁵² Maintenance treatment is defined as a treatment lasting for more than 3 months, and detoxification treatment is defined as a treatment the aim of which is detoxification and lasts for less than 3 months.

⁵³ In the case of the two treatment units realising the greatest turnover the nature of the treatment is not known. In this way the number of not known cases is 590, while the number of known cases is only 435. The estimated proportion of maintenance treatments among not known cases is 90%.

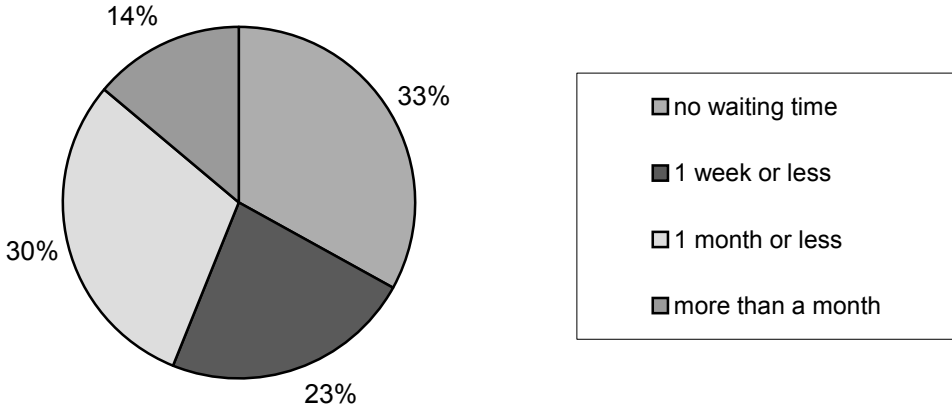
In 2009 two studies were carried out among clients receiving substitution treatment. The aim of the study carried out by Rácz et al. (Rácz et al. 2009) was to monitor and evaluate the methadone maintenance programmes in Hungary (also see chapter 11). The study carried out by Csorba et al. (2009) attempted to present a more detailed picture about injecting drug user women in Budapest (for more detail see chapter 6).

The monitoring and evaluation of the methadone maintenance programmes in Hungary⁵⁴

In 2009 Rácz et al. carried out a survey (Rácz et al. 2009) on methadone maintenance programmes in Hungary by asking clients and specialists. The main aim of the survey was to show how much the treatment practice follows the instructions described in the methodological letter⁵⁵. The summary of the results of the survey relating to this can be read in chapter 11. Below the results of the survey relating especially to the availability of the service are described.

During data recording a total number of 150 clients (115 men and 35 women) belonging to the group of clients of 8 treatment units (3 in Budapest and 5 outside of Budapest) were interviewed. In connection with clients applying for treatment for the first time it can be said that 33% of the respondents were admitted to the programme immediately, without any waiting time, and another 23% of them were admitted within a week. 30% of the respondents had to wait for a month, while 14% of them had to wait for more than a month before they were admitted to substitution treatment.

Figure 23. Breakdown of clients receiving methadone treatment on the basis of the waiting time before entering treatment (%) (N=150)



Source: Rácz et al. 2009

52% of the respondents who waited at least a week for being admitted to treatment were not invited for a talk at all during the period of waiting 14% of them were invited once, 14% were invited a few times, while 17% of them were invited on several occasion for a talk.

⁵⁴ The survey was carried out by the Hungarian Academy of Sciences, Institute for Psychology, with the support of the National Institute for Drug Prevention. The survey was carried out in two target groups: among clients receiving substitution treatment and among specialists controlling the substitution programmes and issuing methadone. The group of clients was selected from the clients of 3 treatment units in Budapest and 5 treatment units outside of Budapest, on the basis of the gender distribution of the national substitution data collection of 2008. A total number of 150 clients were included in the sample (115 men, 35 women). The specialists were selected from the same treatment units, two specialists per treatment unit were included in the sample, a total number of 16 persons. In both target groups anonymous questionnaire data recording took place using face-to-face technique at the given treatment unit.

⁵⁵ The Methodological Letter of the Ministry of Health on Methadone Treatment

Among the different services available during the maintenance programme the most typical form of service used at least once by the respondents receiving treatment was the medical control, and examination (69%). More than one-third of the respondents (35%) had already consulted a psychologist, and 41% had talked to a psychologist⁵⁶. Nearly one-third of them had talked to a social worker and about the same proportion had consulted a social worker. The use of psychotherapy, family or couples therapy was less characteristic among the respondents.

Table 24. Use of services available during methadone maintenance programmes (%) (N=150)

Type of service	Proportion of users
Medical control, examination (physician specialised in addiction treatment, psychiatrist)	69.3%
Specialist in internal medicine	10%
Surgeon	8%
Gynaecologist	29% ⁵⁷
Consulting a psychologist	35.3%
Talking to a psychologist	41.3%
Consulting a social worker	29.3%
Talking to a social worker	32%
Administration of affairs via a social worker (legal affairs, residence, etc.)	12.6%
Psychotherapy	4.6%
Family therapy	2%
Couples therapy	0%

Source: Rácz et al. 2009

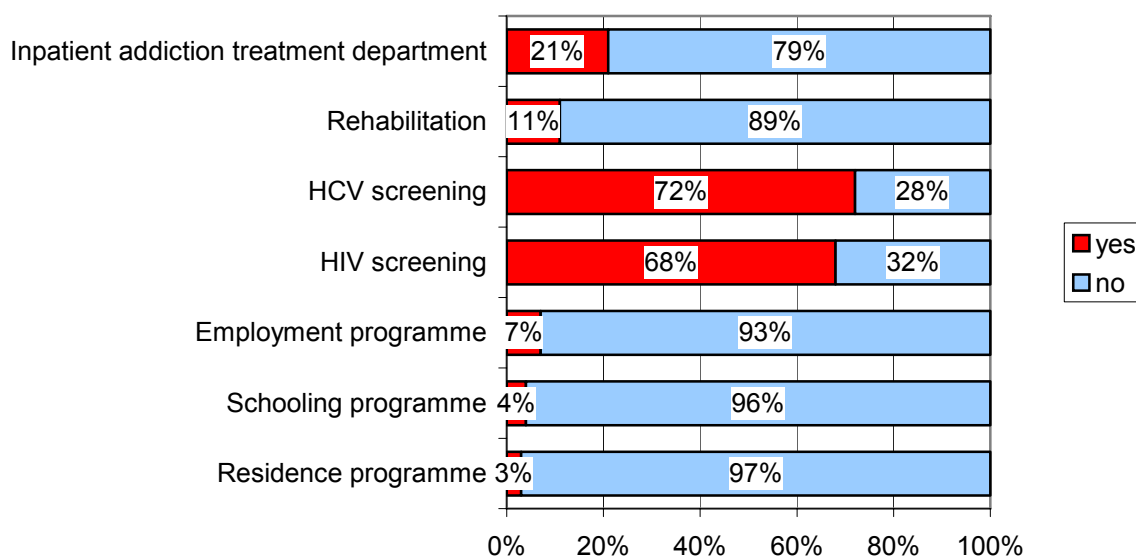
Among those who did not use the individual services, the proportion of those who did not know about the availability of the given service at the treatment unit was between 6 and 10% per service.

In respect of referrals to different services it can be stated that the respondents were mostly referred to HCV screening (72%) and HIV screening (69%) during the maintenance programme. Each fifth respondent (21%) was referred to an inpatient addiction treatment department, while each tenth respondent (11%) was referred to rehabilitation. Referral to social type services was less characteristic.

⁵⁶ During the interviews the experts carrying out the survey were trying to make a clear distinction between consultation and informal conversation.

⁵⁷ In percentage of the interviewed women.

Figure 24. Breakdown of clients receiving methadone treatment by referral to the individual treatment forms (%) (N=150)



Source: Rácz et al. 2009

Inpatient treatment

On the basis of the available data in 2009 there was no real change in active and chronic inpatient specialised treatment either in respect of the number of beds or financing, as the relating legal regulations did not make it possible.

On examining the utilisation of bed capacities in the addiction and psychiatric treatment system in 2009, it can be seen that in active addiction treatment the utilisation of bed capacities was 92%, in chronic inpatient specialised treatment it was 90.7%, while in active psychiatric care it was 81.6% and in chronic treatment it was 83.6%⁵⁸.

The lack of certain forms of treatment – inpatient departments providing, youth rehabilitation centres, institutes – is still an existing problem.

Youth and child addiction treatment

The number of problem drug users and young addicts below the age of 18 is gradually increasing, presently they are treated mainly at adult addiction outpatient clinics, or to a lesser extent at child psychiatric outpatient clinics or treatment centres. No real change took place in child psychiatry or child addiction treatment capacities in 2009.

⁵⁸ Source: Ministry of Health

5.3. CHARACTERISTICS OF TREATED CLIENTS

On the basis of the Treatment Demand Indicator (TDI)⁵⁹

Summary of the most important characteristics of the treatment units reporting to the TDI system and the reported cases

In 2007 TDI datasheets on new patients treated for illicit drug use were recorded by 105 treatment units, in 2008 only by 93 treatment units, and this number is continued to decrease in 2009, when a total number of 83 treatment units recorded TDI datasheets in their OAC system (OAC 2010).

66% of the 4317 patients reported in 2009 (2844 persons) entered treatment for the first time in their lives. 91% of all patients starting treatment (3959 cases) were reported by outpatient units, 4.5% (197 cases) by inpatient units, 1.5% (64 clients) by low-threshold service providers and 2.2% (97 clients) by treatment programmes operating in detention facilities^{60,61}.

Among all clients starting treatment (including both clients not participating in diversion programmes and clients in diversion programmes) the most commonly reported primary drug was cannabis (3,013 cases, 70.2% of all cases), the following most common drug types were stimulants (484 cases, 11.3%) and opiates (449 cases, 10.5%).

The characteristics of clients reported in the TDI system – clients outside diversion

Clients starting treatment are divided in two groups, first of all because clients using the preventive-consulting service provided in the course of diversion – which service is used by the majority of clients participating in diversion – form a separate group distinguished from the rest of the clients. The preventive-consulting service is a marginal service, the content of which fits the treatment definition of TDI system, and this is why it is reported. However, in the range of services in Hungary it is closer to the indicated preventive services provided for high-risk groups, and it is to be regarded clearly as a non-health service. In this part of the chapter we deal with the characteristics of clients outside diversion⁶².

Service providers reported 1,054 cases (775 men and 270 women, in 9 cases the clients' gender was not known) as new cases in 2009. As compared to the previous year it does not represent a significant change, in 2008 the service providers reported 1,032 new cases.

Among patients starting treatment 542 persons have been treated before for illicit drug use, while 405 persons demanded treatment for the first time in their lives (in the case of 107 persons it is not known whether they have been treated earlier). This data, in respect of its internal proportions, is very similar to the previous year's data.

Among clients not participating in diversion programmes the most common drug type requiring treatment was cannabis, in 2009. 33% of all clients entered treatment because of this drug, which proportion is the same as in 2008. Nearly the same proportion started treatment because of opiate use (32%). The use of hypnotics, sedatives and the use of

⁵⁹ The group of parties obliged to report to the TDI data collection system includes participating organisations determined in Regulation 76/2004 (VIII.19.): healthcare treatment units (treatment units providing outpatient, inpatient and rehabilitation services, low-threshold service providers, services providers related to providing preventive-consulting services within diversion, detention facilities having a treatment programme).

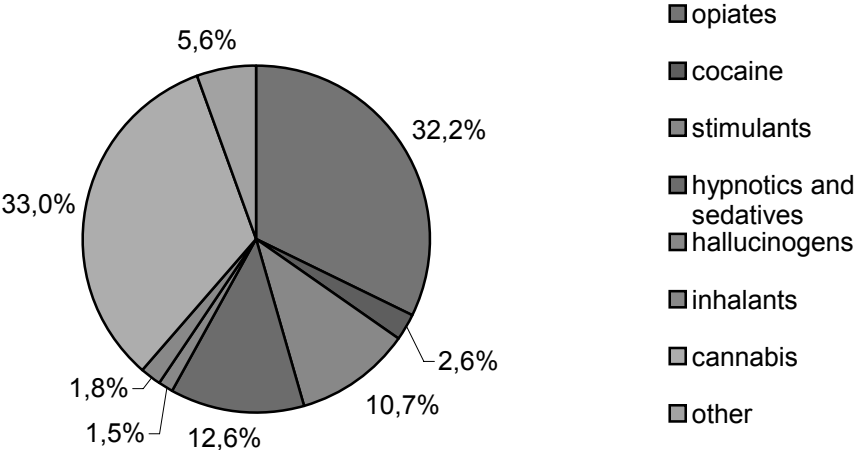
⁶⁰ For the detailed description of these cases see chapter 9.

⁶¹ During duplicate filtering always the last TDI datasheet of the given year was taken into consideration, so for example in the case of changing institute types the TDI datasheet recorded at the second treatment unit was left in the statistics in accordance with the EMCDDA recommendations.

⁶² These cases are selected on the basis of the question relating to the "origin of referral" on the TDI questionnaire (7. – excluding the cases indicating the answers: court, police, administration of justice) or on the basis of the existence of the diversion datasheet relating to the TDI questionnaire (cases when no such datasheet exists are regarded as cases outside of diversion), clients entering treatment because of diversion are examined in a different chapter.

stimulants is the third and fourth most common type of drug use (13% and 11%) serving as a cause for starting treatment. Among stimulants the most commonly used drug is amphetamine, 85% of all clients starting treatment because of the use of stimulants entered treatment because of amphetamine use. As compared to the previous year there is a slight increase in the proportion of clients entering treatment because of opiate use (from 29% to 32%), there is a minimal decrease in the proportion of stimulant (in 2008 this proportion was 13% representing a total number of 131 persons), and the number of clients entering treatment because of the hypnotics and sedatives increased (to 133 from 106 observed in 2008).

Figure 25. Primary substance among all clients (not participating in diversion programmes) entering treatment in 2009 (%) (N=1054)



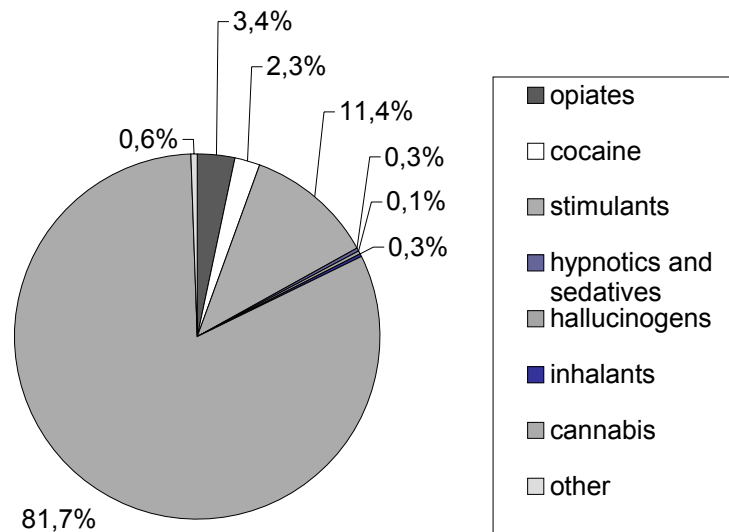
Source: OAC 2010

Characteristics of clients reported in the TDI system – clients participating in diversion programmes

The characteristics of clients participating diversion programmes were identified on the basis of answer given to question 7 of TDI questionnaire relating to the source of referral, and/or on the basis of the existence of the recorded diversion questionnaire. In 2009 the service providers recorded the TDI datasheets of a total number of 3,263 clients, who entered treatment as a result of diversion – this is 76% of the clients entering treatment during the year. As compared to the previous year this number indicates a prominent, 33% increase (in 2008 the number of treatment entrants in diversion was 2,452) (OAC 2010).

The distribution of the primary substances of clients entering diversion programmes is different to that of clients not participating in diversion programmes. The most common drug is cannabis (82%), it is followed by stimulants (11%) and opiates (3%), and then by cocaine (2%). The distribution of drug types is similar to that observed in the previous year, stimulants as well as opiates users are present in more or less the same proportion. Sedatives, hypnotics and inhalants users hardly appear.

Figure 26. Primary substance among all clients in diversion programmes entering treatment in 2009 (%) (N=3263)



Source: OAC 2010

Characteristics of the individual drug user groups

In this part of the chapter groups in and outside of diversion are not separated, but clients entering treatment are examined exclusively on the basis of primary drug.

Opiate users⁶³

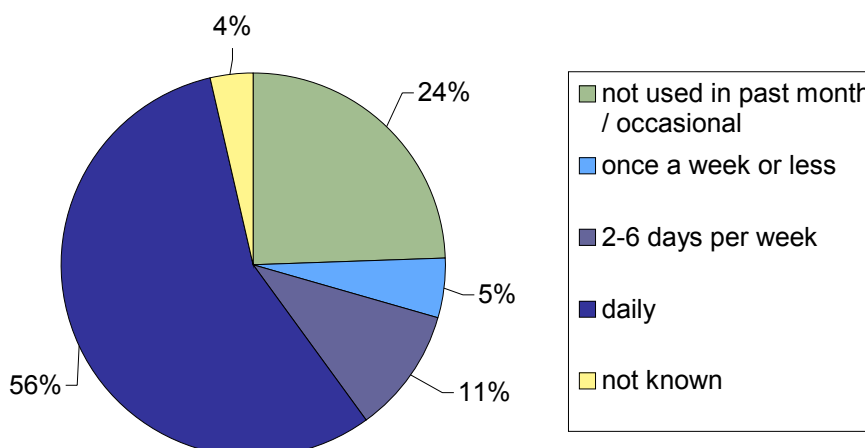
In 2009 449 opiate users were reported by the service providers (OAC 2010), 339 (76%) of them were not participating in diversion programmes, and 110 (24%) of them were participating in diversion programmes. The majority of them (364 persons, 81%) were men. A significant proportion of them – 328 persons – had been treated before, 87 of them started treatment for the first time, and in the case of 34 persons the service providers did not report on the fact or lack of earlier treatment. The average age of clients was 31.4 years (standard deviation: 6.5 years), their age at first opiate use was 21 years on average (standard deviation: 5.6 years).

Consequently clients entering treatment because of opiate use were very probably adult men above the age of 30, who had been treated before, three-quarters of them entered treatment at their own initiative, on the basis of the recommendation of their family or closer environment, and one-fourth of them entered treatment as an alternative to criminal procedure (clients in diversion).

Their drug use pattern is characterised by intensive use, two-thirds (67%) of them use drugs at least 2 days a week. On the basis of the route of administration first of all injecting drug use is characteristic – 71% of them are injecting drug users.

⁶³ Primary heroin, methadone or other opiates users.

Figure 27. Frequency of use among all treated clients entering treatment with primary opiate use in 2009 (%) (N=449)



Source: OAC 2010

In the case of opiate users the most common secondary substance was nicotine, it was mentioned in a total of 183 cases (41%), it was followed by cannabis with 127 mentions (28%), and then by stimulants with 111 mentions (25%) – first of all amphetamine with 85 mentions (19%)⁶⁴. At the same time, the abuse of hypnotics and sedatives with a relatively low number of mentions is unusual: 53 mentions (12%). It is also important to mention cocaine mentioned in 41 cases (9%) as a secondary substance and alcohol mentioned 56 times (12%). In 24 cases (5%) the drug used for substitution treatment – methadone – was the secondary substance.

Cocaine users⁶⁵

Similarly to the previous years, a low number of cocaine users entered treatment programmes (OAC 2010). One of the reasons for this is that – presumably because of their better financial position – they contact private clinics rather than specialised outpatient treatment centres or outpatient addiction treatment centres⁶⁶ –, the same conclusion was drawn in the survey of Gerevich and Bacskai carried out in 2004 (Gerevich, Bacskai 2004). In 2009 data suppliers reported a total number of 101 cases to the TDI, 65 persons of these entered treatment for the first time in their lives, 27 persons had been treated before, and in the case of 9 persons the data supplying institute did not determine the status of earlier treatment. The majority of them – 79 clients – were men, and there were only 22 women. Their average age was 30 years (standard deviation: 6.5 years), Their age at the time of using cocaine for the first time was 22.7 years on average (standard deviation: 5.6 years). Nearly three-quarters of the clients starting treatment with primary cocaine use (74 persons) were participating in diversion programmes, and 27 clients entered treatment who were not participating in diversion programmes.

Injecting drug use was observed among cocaine users too, in 9 cases (9%) this route of administration was reported.

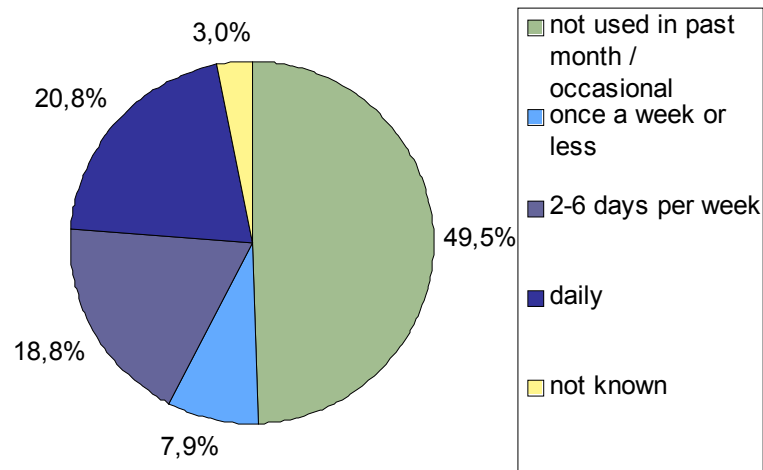
⁶⁴ The same client can determine several secondary drugs, and it is also possible that they do not determine any secondary substances. The rough case numbers stated indicate the number of mentions of secondary drugs, while the percentage data indicate the percentage of the users of the given primary substance who mentioned the given substances as a secondary substance (consequently, when adding up the percentage data – within the individual group of primary substance users – it may exceed 100% because of the possibility of multiple mentions).

⁶⁵ Primary cocaine or crack users.

⁶⁶ Drug users contacting private clinics do not appear in TDI data collection.

Concerning the frequency of use half of this group (50%) was occasional users. At the same time, 40% of cocaine users were characterised by intensive drug use.

Figure 28. Frequency of use among all treated clients entering treatment with primary cocaine use in 2009 (%) (N=101)



Source: OAC 2010

Among primary cocaine users the most commonly mentioned secondary substances were stimulants with 50 mentions (50%) (including 33 mentions of amphetamines of these, that is 33%), it was followed by cannabis with 32 mentions (32%), and then by nicotine with 26 mentions (26%). Alcohol was mentioned in 10 cases (10%) as a secondary substance causing problems.

Stimulant users⁶⁷

A total number of 484 stimulant users joined treatment programmes in 2009. 309 of them entered treatment for the first time in their lives, 126 clients had been treated before (in 49 cases the status of earlier treatment is not known). The majority of the clients entered treatment in the scope of diversion programmes (371 clients, 77%), 113 clients (23%) were not participating in diversion programmes (OAC 2010).

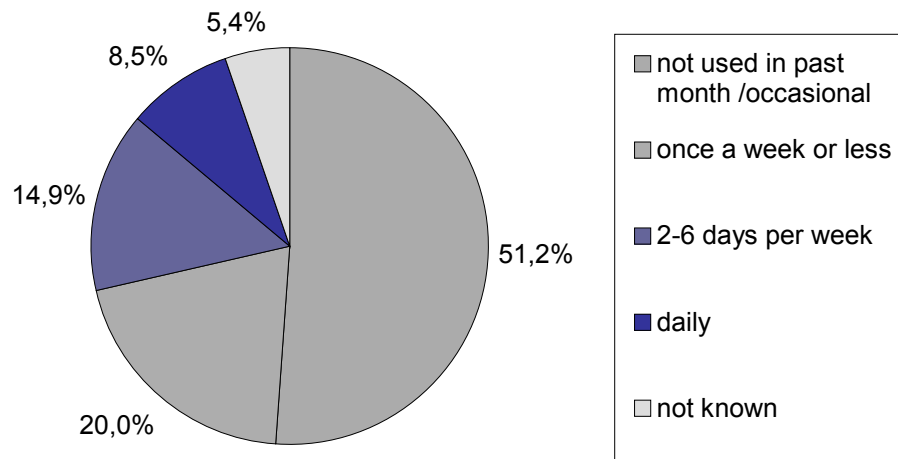
The majority of the clients were men (381 persons, 79%), the proportion of women was only 20% (98 persons) among the known cases (in 5 cases the gender of the clients was not known). The average age of clients entering treatment with primary stimulant use was 27.4 years (standard deviation: 6.5 years), their age at first use of primary drug was 20.3 years on average (standard deviation: 5.8 years).

20% of stimulant users (97 clients) primarily use the injecting route of administration.

From the aspect of the frequency of use 23% of them are intensive drug users (daily or 2-6 days per week), but the majority of them (51%) can be regarded as occasional users.

⁶⁷ Primary amphetamine, MDMA and other derivatives or other stimulants (other than cocaine) users.

Figure 29. Frequency of use among all treated clients entering treatment with primary stimulant use in 2009 (%) (N=484)



Source: OAC 2010

Among secondary substances the most commonly mentioned drug is cannabis with 189 mentions (39%), it is followed by nicotine with 168 mentions (35%) and alcohol with 78 mentions (16%). In 65 cases (13%) a stimulant was mentioned as a secondary substance, and practically in each case it meant the use of MDMA by amphetamine users. Another phenomenon observed among amphetamine users was the use of cocaine as a secondary substance – it was mentioned in 42 cases (9%) by clients entering treatment.

Cannabis users⁶⁸

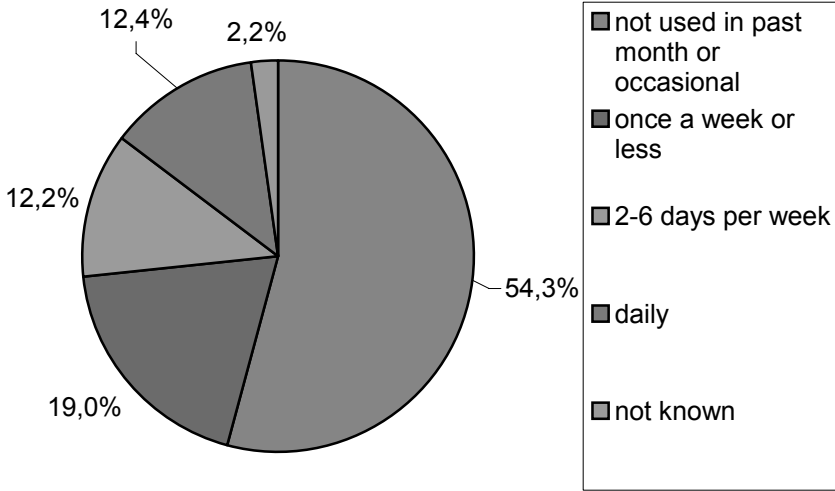
Both among clients in and outside of diversion, clients starting treatment programmes with primary cannabis use form the largest group, although their proportion is significantly higher among clients starting treatment as an alternative to criminal procedure (participating in diversion programmes) (OAC 2010).

In 2009 a total number of 3,013 persons entered treatment programmes defining cannabis as their primary drug. 508 of them had been treated before, but 2,281 clients entered treatment for the first time in their lives in 2009 (in 224 cases the existence of earlier treatment records is not known). A great majority of clients starting treatment (2,665 persons, 88%) joined a treatment programme as an alternative to criminal proceedings, while 348 persons entered treatment for other reasons. The proportion of genders shows the greatest difference in the case of cannabis users: 91% of the clients were men (2730 persons), 9% (274 persons) were women (in 9 cases the data suppliers did not indicate the gender of the client). The average age of the clients at the time of starting treatment was 24.3 years (standard deviation: 5.7 years), while their average age at first use of cannabis was 18.2 years (standard deviation: 4.3 years).

One-fourth (24%) of the clients entering treatment with primary cannabis use can be regarded as intensive drug users, slightly more than half of the clients (54%) are occasional users.

⁶⁸ Primary cannabis users

Figure 30. Frequency of use in among all treated clients entering treatment with primary cannabis use in 2009 (%) (N=3013)



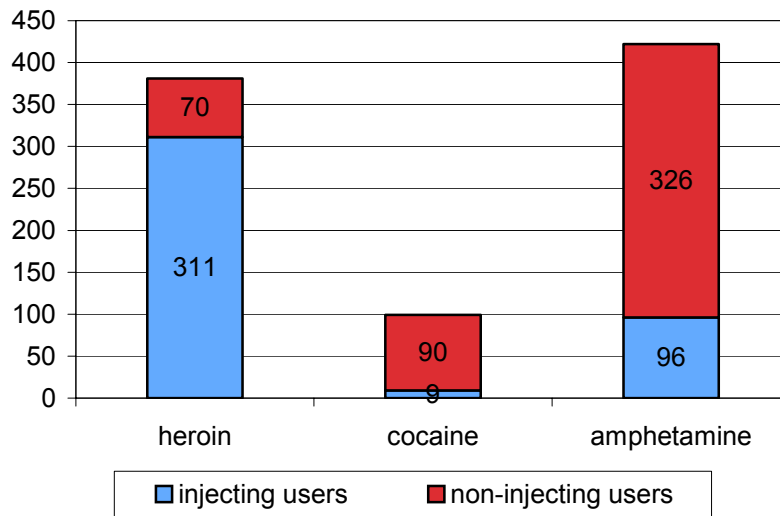
Source: OAC 2010

Among secondary drugs nicotine is the most common with 1,142 mentions (38%). The second most frequently mentioned drug types are stimulants with 716 mentions (24%) – within this group amphetamine is the most common secondary substance with 493 mentions (16%) –, and they are followed by alcohol with 524 mentions (17%). The use of hallucinogens must also be mentioned (a total number of 131 mentions, 4%), as well as the secondary cocaine use in 105 cases (3%).

Injecting users

Injecting use – as a route of administration involving an especially high risk – appeared intensively in the case of 3 drug types. In 2009 the proportion of injecting drug use was the highest among heroin users (82% of them were injecting users). A prominent group of injecting amphetamine users can also be observed, they form nearly one-fourth (23%) of the clients entering treatment with primary amphetamine use. At the same time, injecting use also appeared among cocaine users – they determined injecting use as a primary route of administration in 9% of the cases (OAC 2010).

Figure 31. *The proportion of injecting users within the individual drug types in 2009 (persons)*



Source: OAC 2010

On examining all drug types, intensive drug use (daily or several times a week) is the most characteristic among injecting drug users, which involves further risks. 66% of injecting users and 26% of users applying other routes of administration reported intensive use.

5.4. TRENDS OF CLIENTS IN TREATMENT

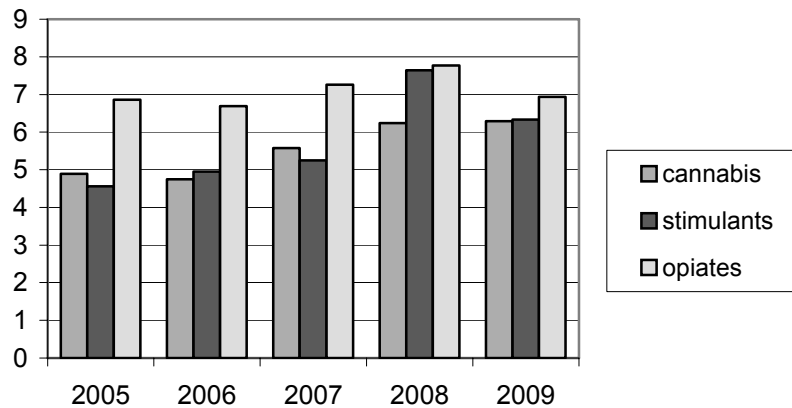
No OSAP data is available from 2009, so this time the trends are examined on the basis of the treatment demand indicator data.

The latency period, which indicates the period between the first drug use (relating to the primary substance) and the first appearance in treatment, is an indicator suitable for examining the changes of the treatment demand and availability. As the date of entering treatment for the first time in life is available only from 2005, the period between the first drug use and the first appearance in treatment can only be examined among those who entered treatment for the first time in their lives between 2005 and 2009. The latency period, if it is used for measuring a demand or availability, can only be interpreted in the case of clients entering treatment voluntarily (not due to diversion). Consequently exclusively clients not participating in diversion programmes, entering treatment for the first time in their lives between 2005 and 2009 were included in the present study.

The most important tendency that can be observed is the gradual increasing of the latency period between 2005 and 2008 in the case of all examined drug types.

Presumably the most important cause of this was the negative effect of the so-called healthcare reform measures realised in 2006 and 2007 on the healthcare system, especially on addiction treatment and care provision activity. The other reason behind the increase – though less determining – might be the changes in the funding of social services in past years. Another important phenomenon is that opiate users enter treatment at a later point as compared to the other two drug types examined.

Figure 32. Average latency period in the case of the different drug types between 2005–2009 (years)



Source: OAC 2010

Conclusions

In 2009 the amendment of the Eftv. and the acceptance of the relating implementing statute can be highlighted as significant events. The above legal acts may provide help for the regrouping of capacities suiting local needs and for eliminating regional inequalities.

The Ministry of Health still finds it necessary to continue to improve access to the treatments and services, but instead of formal capacity increase they intend to lay greater emphasis on the quality improvement of treatment and other outreach services. By this the Ministry first of all mean improving cooperation between the treatment units and units providing other services, reviewing and developing professional standards, developing further professional protocols, the professional quality assurance of the services provided for patients, and eliminating treatment overlaps.

As a whole it can be determined that as compared to the previous year no significant change took place in the healthcare system providing treatment for patients suffering from addiction. In outpatient care the effect of the reduction of the fixed fee realised in 2007 could still be perceived, and the effect of the revision of the professional codes that is in process did not result in a significant change. In inpatient care, although the amendment of the Eftv. created more favourable conditions for the reallocation of capacities, in 2009 its positive effect could not be realised yet.

In 2009 no OSAP prevalence data was available about clients in treatment because of drug use due to the changes occurring in the data collection system.

In 2009 4,317 new clients entering treatment were reported by 83 treatment units to the TDI data collection. The majority of the clients entering treatment are still represented by those who enter treatment for the first time in their lives because of their drug use. In three-quarters of the cases clients entered treatment as an alternative to criminal procedure (the reason for this is that the so-called preventive-consulting service is interpreted as a treatment programme). The greatest proportion of clients still enters treatment because of cannabis use (both among clients in and outside of diversion), they are followed by clients entering treatment because of the use of stimulants and opiates. At the same time it is important to point out that as opposed to opiate users, the majority of clients entering treatment because of using cannabis or stimulants is still represented by clients joining diversion programmes as an alternative to criminal procedure.

On the basis of the period between starting drug use and entering treatment for the first time it can be stated that it is still opiate users who enter treatment at the latest point, although as compared to the previous years there is less difference in comparison with the other drug types.

6. HEALTH CORRELATES AND CONSEQUENCES OF DRUG USE

6.1. DRUG-RELATED INFECTIOUS DISEASES

Reported cases of HIV/AIDS, HBV, HCV

In 2009, the data referring to reported HIV/AIDS cases among injecting drug users (IDU) and the incidence of acute cases of hepatitis caused by HBV or HCV in Hungary – similarly to previous years – originate from the national registry of infectious patients operating in the National Centre for Epidemiology and from the special HIV/AIDS and hepatitis surveillance database (Csohán et al. 2010).

HIV/AIDS

In 2009 in Hungary a total number of 140 newly diagnosed HIV positive cases were reported, the incidence rate was 14 cases/1 million inhabitants. The transmission route was known in the case of nearly four-fifth of the registered HIV positive persons. Within the identified risk groups of the HIV positive persons no one was IDU. In 2009 23 cases of AIDS were diagnosed, and none of these 23 patients belonged to the risk group of IDUs.

Table 25. Breakdown of registered HIV positive persons by risk groups

Risk group	1985-2004	2005	2006	2007	2008	2009	Total
Homo/bisexual	599	56	38	62	93	85	933
Heterosexual	213	20	14	15	17	23	302
Haemophiliac	32	0	0	0	0	0	32
Transfusion recipient	22	0	0	1*	0	0	23
Injecting drug user	15*	2**	0	3*	2	0	22
Nosocomial	12*	3*	0	1*	0	0	16
Maternal	3	2	0	2	0	2	9
Unknown	284	23	29	35	33	30	434
Total	1,180	106	81	119	145	140	1,771

* Imported cases, ** Together with imported cases

Source: National Centre for Epidemiology (Csohán et al. 2010)

Acute hepatitis B

In 2009, 66 acute hepatitis B infections were reported, 25% less than in the previous year. The incidence rate was 0.66‰. The transmission route was known in the case of half of the patients, and among them two men between the age of 25-34 belonged to the risk group of IDUs. (ST9P2_2010_HU_02)

Table 26. Number and proportion of IDUs among reported acute hepatitis B cases with an identified risk group between 2004-2009

Year	Reported acute HBV infections			
	number		IDUs	
	Total	Identified risk group	number	%
2004	131	67	6	9
2005	119	47	1	2.1
2006	83	29	-	-
2007	81	36	2	5.6
2008	88	55	2	3.6
2009	66	30	2	6.6

Source: National Centre for Epidemiology (Csohán et al. 2010)

Acute hepatitis C

In 2009, 31 acute hepatitis C infections were reported, the incidence rate was 0,3‰, which practically did not change as compared to the previous year. The transmission route was known in the case of nearly two-thirds of the patients, and 4 of them became infected through injecting drug use. Among these patients there were 3 men and 1 woman, two of them below the age of 25, and two of them between the age of 25-34. (ST9P4_2010_HU_01)

Table 27. Number and proportion of IDUs among reported acute hepatitis C cases with an identified risk group between 2004-2009

Year	Reported acute HBV infections			
	number		IDUs	
	Total	Identified risk group	number	%
2004	40	29	11	37.9
2005	22	12	1	8.3
2006	29	15	4	26.7
2007	22	15	5	33.3
2008	34	17	6	35.3
2009	31	17	4	23.5

Source: National Centre for Epidemiology (Csohán et al. 2010)

Prevalence of HIV, HBV and HCV infections among IDUs

National survey

In 2009 the National Centre for Epidemiology continued the sentinel screening programme aimed at measuring the prevalence rate of HIV, HBV, HCV infections (Dudás et al. 2010a). In 2009 the screening programme using the same method under similar circumstances was performed for the fourth time. Dried blood samples drawn from the fingertip were used for the virus serological examinations, the costs were covered by the Ministry of Health.

While in 2008 18 organisations participated in the programme, in 2009, between 5 September 2009 and 15 December 2009, blood samples were drawn from 676 IDUs at 20 different service providers.

Four needle/syringe programmes (NSPs) and two outpatient treatment centres in Budapest, and nine NSPs and five outpatient treatment centres outside of Budapest were involved in the programme.

Persons were screened who visited one of the institutes during the period of screening and declared themselves IDUs or could recall ever injecting drugs, disregarding whether they had ever subjected themselves to HIV, HBV or HCV screening.

The selection of patients, the method of sampling, coding and the examination of the samples took place in the same way as in the preceding three years (ST9_2010_HU_01).⁶⁹

In the course of the laboratory tests, with the applied methods, reliable results could be released regarding HIV or HBV infection in the case of all 676 tested persons. In respect of antibody tests conducted in order to detect virus infection, the result was inconclusive in nine cases in respect of the hepatitis C virus, therefore these cases were excluded from statistical processing.

⁶⁹ See: National Report 2007, chapter 6.2.

In order to detect the presence of HIV, samples drawn from a total number of 676 IDUs were examined, and in two of these cases a reactive result was obtained and confirming tests were performed. The confirming tests gave a negative result, so in the end all 676 examined persons proved to be HIV negative. (ST9P2_2010_HU_01)

5 of the 676 tested persons (0.7%) proved to be positive for HBV surface antigens, and 671 persons tested negative for HBsAg. Four of the five persons carrying HBV was anti-HCV positive at the same time. (ST9P2_2010_HU_02)

The samples of 504 out of the 676 examined persons proved to be anti-HCV negative. Among the samples giving a reactive result with anti-HCV ELISA reagents, in 163 cases (24.4%) the confirming tests proved anti-HCV positivity. (ST9P2_2010_HU_03)

Table 28. Breakdown of the HIV, HCV, HBV positive IDUs by gender and age group in 2009

Age group		People tested for the presence of HIV antibodies		People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
		number	positive	number	positive number	%	number	positive number	%
< 25 years	male	89	0	89	0	0	87	17	19.5
	female	56	0	56	0	0	56	8	14.3
25-34 years	male	261	0	261	1	0.4	258	61	23.6
	female	69	0	69	0	0	68	25	36.7
> 34 years	male	154	0	154	2	1.3	151	35	23.2
	female	47	0	47	2	4.3	47	17	36.2
Total	male	504	0	504	3	0.6	496	113	22.8
	female	172	0	172	2	1.2	171	50	29.2
male+female		676	0	676	5	0.7	667	163	24.4

Source: National Centre for Epidemiology (Dudás et al. 2010a)

Among the 676 persons providing samples there were 504 (74.6%) men and 172 (25.4%) women. Out of the three age groups, nearly half of the persons providing blood samples (330 persons, 48.8%) were in the age group 25-34, 29.7% (201 persons) of the participants in the survey were above the age of 34, and the smallest group consisted of 145 persons (21.4%) below the age of 25. The difference between the infection ratio of men and women (22.8% and 29.2%) was significant at the level of $p < 0.01$. The HCV prevalence rates of women between the age of 25-34 and above the age of 34 exceed the average prevalence rate by 12.3% and by 11.8%. The difference between these prevalence rates and the average prevalence rate is significant at the level of $p < 0.001$.

Four intervals could be selected as years since first injection (<2 years, 2-4 years, 5-9 years, >10 years), 26 out of the 676 persons could not remember when they had started to inject drugs. 45% (304 persons) of the people providing samples said that they had been injecting drugs for more than 10 years. 24.7% of the examined clients (179 persons) had been injecting drugs for 5-9 years, 14.6% for 2-4 years (99 persons), and 10.1% (68 persons) for less than two years.

The proportion of HCV infection was the highest (32.2%) among IDUs who had started to inject drugs more than 10 years before. Among them, in the case of 4 persons HBV co-infection was also detected. This group was followed by the group of people injecting drugs for 5-9 years, one-fourth of whom were HCV infected. The rate of infection among IDUs injecting drugs for 2-4 years was 13.3%, while among new IDUs only 6 persons (8.8%) were infected with the virus. (ST9P2_2010_HU_03)

Table 29. Breakdown of HCV, HBV positive IDUs by years since first injection in 2009

Years since first injection	People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
	number	positive		number	positive	
		number	%		number	%
< 2 years	68	0	0.0	68	6	8.8
2 - 4 years	99	0	0.0	98	13	13.3
5 - 9 years	179	0	0.0	177	45	25.4
> 10 years	304	5	1.6	298	98	32.9
Not known	26	0	0.0	26	1	3.8
Total	676	5	0.7	667	163	24.4

Source: National Centre for Epidemiology (Dudás et al. 2010a)

Among drug users primarily injecting opioids the rate of HCV infection was 29.5%, while among those who were primarily injecting drugs other than opioids the rate of infection was 16.3%. On comparing the prevalence rates of opioid users with the prevalence rates of drug-users using drugs other than opioids the difference is significant at the level of $p < 0.001$. (ST9P2_2010_HU_03)

Table 30. Breakdown of HCV, HBV positive IDUs by the type of primarily injected drug in 2009

Type of drug	People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
	number	positive		number	positive	
		number	%		number	%
Opioid	418	4	1	410	121	29.5
Other than opioid	258	1	0.3	257	42	16.3
Total	676	5	0.7	667	163	24.4

Source: National Centre for Epidemiology (Dudás et al. 2010a)

For the first time in 2009 ever IDUs involved in the sample were asked when they had injected drugs last before the screening test⁷⁰. 4.9% of the clients could not remember when they had injected drugs last. Among drug users who had last injected drugs within the last 4 weeks 35.7% were HCV antibody positive. Those who had last injected drugs more than 4 weeks before but within the last 12 months, this proportion was 12.7%, while among IDUs who last injected more than 12 months before this proportion was 17.2%. The difference between the prevalence rate of IDUs who had last injected drugs within the last 4 weeks and the prevalence rates of the other two groups is significant at the level of $p < 0.001$.

⁷⁰ It was necessary to be able to separate the subsample of current IDUs (last injecting drugs less than 4 weeks before) from the total sample when examining risk behaviours (needle/syringe sharing; equipment sharing), as the monthly prevalence of risk behaviours is to be analysed only among them. (See: EMCDDA, standard table 9, part 3, guide).

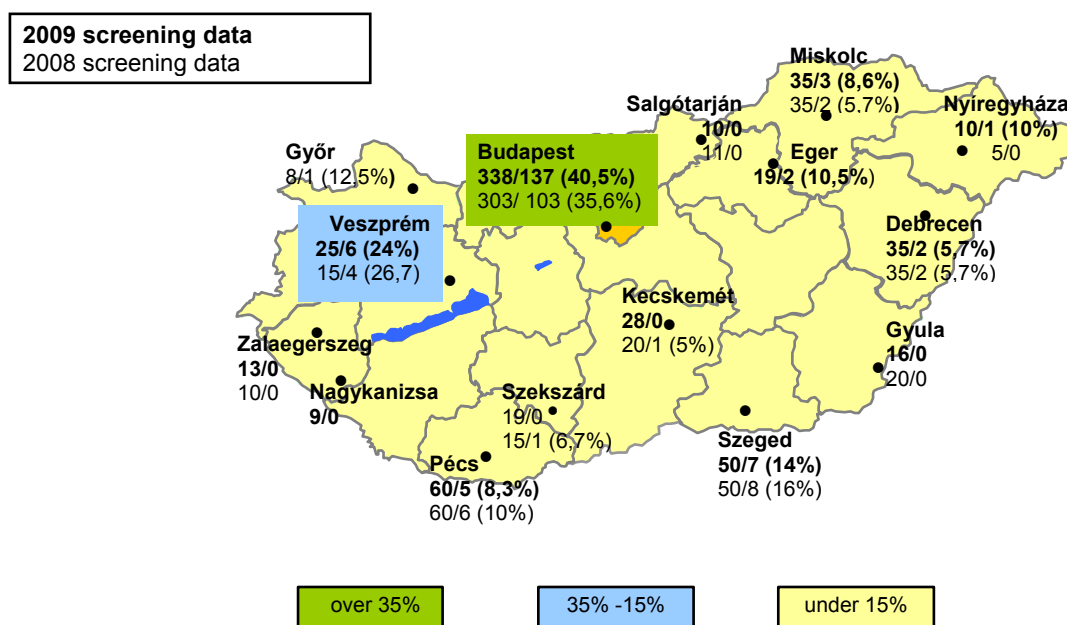
Table 31. Breakdown of HCV, HBV positive IDUs by time of last injection in 2009

Time of last injection	People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
	number	positive		number	positive	
		number	%		number	%
< 4 weeks	316	3	1.0	311	111	35.7
4 weeks – 12 months	166	0	0.0	166	21	12.7
> 12 months	161	2	1.2	157	27	17.2
Not known	33	0	0.0	33	4	12.1
Total	676	5	0.7	667	163	24.4

Source: National Centre for Epidemiology (Dudás et al. 2010a)

Regarding the geographical breakdown, 137 of the 338 samples deriving from Budapest proved to be HCV positive, which represents a 40.5% infection rate (ST9P2_2010_HU_07). As opposed to this, HCV positivity was diagnosed in the case of 7.9% of the samples from outside of Budapest (26 out of 329 samples) (ST9P2_2010_HU_08). The difference between the HCV prevalence rates of Budapest and the regions outside of Budapest is significant at the level of $p < 0.001$. Outside of Budapest the rate of infection of the IDU population in Veszprém was the highest, where 24% of the received samples were HCV positive, while in Szeged HCV antibodies were found in 14% of the samples.

Map 1. Geographical breakdown of the number of HCV screening tests and the proportion of positive cases by region in 2008 and 2009



Source: the National Centre for Epidemiology (Dudás et al. 2010a) and Hungarian National Focal Point

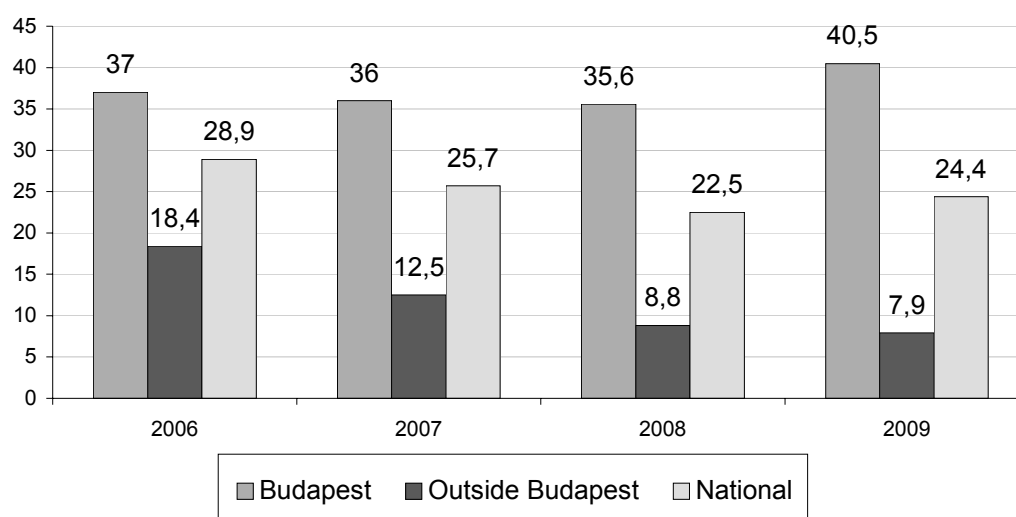
Table 32. Number of HCV screening tests and the proportion of positive cases by region between 2007-2009

Region/city	2007			2008			2009		
	People tested for the presence of HCV antibodies								
	number	positive number	%	number	positive number	%	number	positive number	%
Budapest	308	111	36.0	303	108	35.6	338	137	40.5
Szeged	48	12	25.0	50	8	16.0	50	7	14.0
Pécs	59	11	18.6	60	6	10.0	60	5	8.3
Miskolc	30	0	0.0	35	2	5.7	35	3	8.6
Gyula	15	0	0.0	20	0	0.0	16	0	0.0
Kecskemét	20	0	0.0	20	1	5.0	28	0	0.0
Szekszárd	15	0	0.0	15	1	6.7	19	0	0.0
Veszprém	14	6	42.9	15	4	26.7	25	6	24.0
Debrecen	37	1	2.7	35	2	5.7	35	2	5.7
Nyíregyháza	2	0	0.0	5	0	0.0	10	1	10
Győr	-	-	-	8	1	12.5	-	-	-
Salgótarján	-	-	-	11	0	0.0	10	0	0.0
Zalaegerszeg	-	-	-	10	0	0.0	13	0	0.0
Eger	-	-	-	-	-	-	19	2	10.5
Nagykanizsa	-	-	-	-	-	-	9	0	0.0
Total (excluding Budapest)	240	30	12.5	285	25	8.8	329	26	7.9
Total	548	141	25.7	588	133	22.5	667	163	24.4

Source: the National Centre for Epidemiology (Dudás et al. 2010a)

On examining the last 4 years it can be determined that in Budapest the rate of HCV infection, which was nationally high but stagnating between 2006-2008, increased by 4.9% by 2009 (despite this in the last two years the difference between the hepatitis C prevalence rates was not significant at the level of $p > 0.05$ in Budapest). As opposed to this, in respect of the data deriving from outside of Budapest a continuous decrease can be observed starting from 2006. The national HCV prevalence rate, due to the opposite trends in and outside of Budapest, has been around 25% for 4 years. A significant difference can be observed only between the years 2006 and 2008, at the level of $p < 0.001$.

Figure 33. HCV prevalence rate (%) among IDUs between 2006-2009



Source: the National Centre for Epidemiology (Dudás et al. 2010a); Hungarian National Focal Point

In the course of the screening a so-called generated code was used, which is not suitable for personal identification but is an individual identification code.⁷¹ As the code does not change, it is suitable for following changes in the serostatus of cases screened year after year. Recurrences based on the generated code were controlled by gender and age categories.

From the 676 cases tested in 2009, 172 (25.4%) also took part in the screening performed in 2008. In the case of these 5 clients who proved to be HCV antibody negative in 2008, HCV antibody positivity was detected in 2009. In the case of 1 person, who was HCV negative in 2008, an inconclusive result was obtained in 2009.

The data was also analysed in respect of the four-year period of the national prevalence study. From the 676 cases tested in 2009, 232 persons took part at least once in the screening programme between 2006 and 2008. During this period the change of serostatus could be observed in the case of 8 persons. Between 2006-2008 these clients were HCV antibody negative, but in 2009 their sample gave a positive result.

The drug use and socio-demographic trends of the programme lasting for 4 years are described in chapter 4.2.

A survey in Budapest among IDUs participating in a needle/syringe programme

At the end of 2008 a budget was labelled for the HIV/HBV/HCV testing of 150 blood samples by the National Centre for Epidemiology and the Blue Point Foundation needle/syringe programme. The samples were collected in the period between September 2008 and July 2009, during which IDUs contacting the NSP were offered the test as a permanently available service⁷². (For the reasons for introducing permanent screening see: chapter 7.2.) The procedure of drawing blood, coding, and analysing the samples took place according to the methodology of the national survey⁷³ (Dudás et al. 2010b). (ST9_2010_HU_03)

In the course of the laboratory tests, with the applied methods, reliable results could be released regarding HIV and HBV infection in the case of all 150 persons tested. In the case of antibody tests conducted in order to detect virus infection, the result was inconclusive in four cases in respect of the hepatitis C virus, therefore these cases were excluded from processing.

⁷¹ See: National Report 2007, chapter 6.2.

⁷² As opposed to the national annual prevalence test, in this case no motivation fee was paid to the clients.

⁷³ See: National Report 2007, chapter 6.2.

Each of the 150 samples proved to be negative in respect of HIV infection (ST9P2_2010_HU_04). HCV antibodies were detected in 75 persons (51.4%) (ST9P2_2010_HU_05), and in one case (0.7%) hepatitis B surface antigens were detected (ST9P2_2010_HU_06). The person carrying the hepatitis B virus proved to be HCV antibody positive at the same time.

Table 33. Breakdown of HIV, HCV, HBV positive IDUs tested at the Blue Point Foundation by gender and age group in 2008-2009

Age group		People tested for the presence of HIV antibodies		People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
		number	positive	number	positive number	%	number	positive number	%
< 25 years	male	31	0	31	0	0.0	29	14	48.3
	female	15	0	15	0	0.0	15	7	46.7
25-34 years	male	48	0	48	0	0.0	47	28	59.6
	female	19	0	19	0	0.0	19	6	31.6
> 34 years	male	18	0	18	1	5.6	17	12	70.6
	female	12	0	12	0	0.0	12	5	41.7
Total	male	97	0	97	1	1.0	93	54	58.1
	female	46	0	46	0	0.0	46	18	39.1
male+ female		143	0	143	1	0.7	139	72	51.8

Source: National Centre for Epidemiology (Dudás et al. 2010b)

Among the persons providing samples there were 97 (67.8%) men and 46 (32.2%) women. Out of the three age groups, nearly half of the persons providing samples 67 persons (46.9%) were in the age group between 25-34, 46 persons (32.2%) below the age of 25, and 30 persons (21%) above the age of 34.⁷⁴

The difference between the hepatitis C infection ratio of men (58.1%) and women (39.1%) is significant at the level of $p < 0.001$. The HCV prevalence rates of men between the age of 25-34 and above the age of 34 exceed the average prevalence rate. The difference between the average prevalence rate and the prevalence rate measured in the age group 25-34 is not significant at the level of $p > 0.05$. However, the difference between the average prevalence rate and the prevalence rate measured in the age group above 34 is significant at the level of $p > 0.05$. In the case of women none of the hepatitis C prevalence rates of the different age groups exceed the average prevalence rate.

Four intervals could be selected as years since first injection (<2 years, 2-4 years, 5-9 years, >10 years), 10 out of the 150 persons could not remember when they had started to inject drugs. The rate of infection increased with the years since first injection. Among IDUs, who started to inject drugs more than 10 years before, two-thirds of the drug users were HCV infected. While the proportion of infection among persons injecting drugs for 5-9 years was 63.3%, and 51.6% among persons injecting drugs for 2-4 years, one-third of the new drug users were infected with the virus. (ST9P2_2010_HU_05)

⁷⁴ In the case of 7 out of the 150 persons providing samples the data relating to gender or age group was missing.

Table 34. Breakdown of HCV, HBV positive IDUs tested at the Blue Point Foundation by years since first injection in 2008-2009

Years since first injection	People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
	number	positive number	%	number	positive number	%
< 2 years	37	0	0	36	12	33.3
2 - 4 years	32	0	0	31	16	51.6
5 - 9 years	31	0	0	30	19	63.3
> 10 years	40	1	2.5	39	25	64.1
Not known	10	0	0	10	3	30.0
Total	150	1	0.7	146	75	51.4

Source: National Centre for Epidemiology (Dudás et al. 2010b)

In respect of drug type and hepatitis C infection it can be observed that while 61.2% of IDUs primarily injecting opioids were infected, among drug users injecting drugs other than opioids this proportion was 47.7%. The difference between the two proportions is significant at the level of $p < 0.01$. (ST9P2_2010_HU_05)

Table 35. Breakdown of HCV, HBV positive IDUs tested at the Blue Point Foundation by drug type in 2008-2009

Type of drug	People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
	number	positive number	%	number	positive number	%
Opioid	69	1	1.4	66	41	62.1
Other than opioid	66	0	0.0	65	31	47.7
Total	135	1	0.7	131	72	55.0

Source: National Centre for Epidemiology (Dudás et al. 2010b)

Infectious diseases in detention facilities⁷⁵

The HCV screening campaign started in 2007 in detention facilities continued in 2009.⁷⁶ In 2009 a total number of 2,936 persons, 19% of the average number of prisoners (15,373 persons) were involved in the screening program, 118 (4%) of them were HCV antibody positive, 97 (82.2%) of whom were also HCV carriers at the same time.

Hepatitis B infection was examined in the case of 2,276 prisoners, among whom 38 prisoners (1.7%) tested positive for HBsAg.

HIV screening was performed in 24.8% (3,806 persons) of the average number of prisoners (15,373 persons), among whom 3 persons (0.08%) tested positive for the virus.

⁷⁵ On the basis of the report by the Hungarian Prison Service Headquarters and the National Centre for Epidemiology, and the survey of the Hungarian National Focal Point.

⁷⁶ For further details see: National Report 2008, chapter 6.2.

Table 36. *Number of HIV tests in detention facilities and the number of HIV positive cases detected between 2001-2009*

Year	Number of screened persons	Number of positive cases	Incidence (%)
2001	15,936	7	0.04
2002	15,537	3	0.02
2003*	2,773	2	0.07
2004	2,921	3	0.10
2005	2,294	0	0
2006	943	1	0
2007	2,992	0	0
2008	3,367	2	0.06
2009	3,806	3	0.08

* Since 2003 on a voluntary basis

Source: Hungarian Prison Service Headquarters

This year it was possible in two detention facilities to survey the possible history of drug use / injecting drug use and related risk behaviours of the prisoners participating in the screening programme. The methodology of the survey was the same as in the previous year.⁷⁷ (ST9_2010_HU_02)

Table 37. *The average number of prisoners in detention facilities participating in the screening programme and the survey of risk behaviours, and the number of prisoners tested in 2009*

Name of facility	Type (gender) of facility	Average number of prisoners in 2009	Number of persons participating in the screening, filling in the questionnaire	Participants in the screening and filling in the questionnaire, in percentage of the average number of prisoners (%)
Baracska	male	800	470	58.8
Nagyfa	male	250	115	46
All participating facilities		1,050	585	55.7
All facilities		15,373	585	3.8

Source: Hungarian Prison Service Headquarters

A total number of 585 male prisoners were involved in the sample. 12.1% of the sample (68 persons) were below the age of 25, 39.5% (222 persons) were between 25 and 34, and 48.4% (272 persons) were above 34. The average age was 36.2 years.⁷⁸ 227 of all respondents (38.3%) had ever used drugs in their lives, and 85 of them (14.5%) reported ever injecting drugs as well.

In the case of 37 (6.3%) of the 585 persons examined hepatitis C positivity was detected during the serological tests. 36 of these persons had already used drugs in their lives, and 34 of them also reported injecting drug use, in other words 92% of the 37 prisoners found to be hepatitis C positive had injected drugs in their lives.

Among ever drug user prisoners the rate of HCV infection was 15.9%, in the case of ever IDUs (85 persons) the rate of hepatitis C infection was 40% (ST9P2_2010_HU_09). Among the ever IDUs nobody tested positive for HIV and hepatitis B (ST9P2_2010_HU_10; (ST9P2_2010_HU_11).

⁷⁷ See: National Report 2009, chapter 6.1.

⁷⁸ The age was not known in the case of 23 persons.

Table 38. Breakdown of HCV infection (HCV antibodies) by the total sample, ever drug users and ever injecting drug users in 2009

	Total sample		Ever drug users		Ever injecting drug users	
	number	%	number	%	number	%
HCV antibody positive	37	6,3	36	15,9	34	40
Total	585	100	227	100	85	100

Source: Hungarian National Focal Point

On examining ever injecting drug user respondents (85 persons) according to their age, it can be determined that the rate of hepatitis C infection is the highest among persons above the age of 34: 57.1% (8 persons). In the case of prisoners between the age of 25 and 34 this proportion is lower: 40% (20 persons), and in the case of persons below 25 it is 28.6% (6 persons). (ST9P2_2010_HU_09)

Table 39. Breakdown of HCV infection among ever IDU prisoners by age group in 2009

Age group	Ever injecting drug user prisoners		
	HCV positive		
	number	number	%
<25 years	21	6	28.6
25-34 years	50	20	40
>34 years	14	8	57.1
Total	85	34	40

Source: Hungarian National Focal Point

During the survey the prevalence rates relating to injecting drug use prior to imprisonment and inside prison were also measured. 45.9% (39 persons) of ever IDU prisoners had last injected drugs within the period of 1 month before imprisonment, 29.4% of them (25 persons) within the period of 12 months before imprisonment, 21.2% of them (18 persons) more than 12 months before imprisonment, while 3.5% of them (3 persons) had last injected drugs inside the prison. The majority of the infected persons (47.1%) had last injected drugs within the period of 1 month before imprisonment. (ST9P2_2010_HU_09)

Table 40. Breakdown of HCV infection among ever IDU prisoners by time of last injection in 2009

Time of last injection	Ever injecting drug users		
	HCV positive		
	number	number	%
Within 1 month prior to imprisonment	39	16	47.1
within 12 months prior to imprisonment	25	9	26.5
more than 12 months prior to imprisonment	18	6	17.6
inside prison	3	3	8.8
Total	85	34	40

Source: Hungarian National Focal Point

It was also analysed what type of drugs the prisoners had injected in their lives, and what the proportion of hepatitis C positive persons was in the case of the different drugs. Several drugs could be marked, no information is available on primary substance. The highest rate of infection could be observed among injecting methadone users, 13 out of 23 persons (56.5%) had become infected. A similarly high proportion could be observed among heroin users: 19 out of 37 persons (51.4%) were infected with hepatitis C.

Table 41. Breakdown of HCV infection among ever IDU prisoners by drug type in 2009 (N=85)

Type of injected drug	Persons mentioning the given drug type number*	HCV antibody positive persons among them	
		number	%
amphetamine	72	29	40.3
heroin	37	19	51.4
cocaine	33	12	36.4
ecstasy	31	13	41.9
methadone	23	13	56.5

* Several drug types could be mentioned by the same person

Source: Hungarian National Focal Point

During the study years since first injection was also surveyed. Among those who had been injecting drugs for less than 2 years (3 persons) 2 persons were infected with hepatitis C. Among prisoners who had been injecting drugs for 2–4 years (26 persons) there were 9 infected persons. 7 persons of those who had been injecting drugs for 5–9 years (27 persons) and 13 of those who had been injecting drugs for more than 10 years (25 persons) were infected with the hepatitis C virus. (ST9P2_2010_HU_09)

For data on treatment of HCV positive prisoners see: chapter 9.5.

Infectious diseases among drug-related deaths

In 2009, serologic tests were performed at the National Institute of Forensic Medicine in association with 7 death cases directly (6 heroin overdoses, 1 methadone overdose) and 3 death cases indirectly (natural deaths, where in two cases methadone and morphine/heroin and in one case cocaine and cannabis was detected) related to drug use in Budapest. (For mortality data see: chapter 6.3.). Out of the 10 cases HCV positivity was proved in 6 cases, and one of these persons was also HBsAg positive at the same time. All of the 6 infected persons were men and they all belonged to the age group between 25-34.

In 2009, 8 of the 31 persons whose death was directly related to drug overdose had participated in the national screening campaign organised by the National Centre for Epidemiology in the last 4 years (7 in Budapest, 1 in Szeged). In 4 cases HCV positivity was detected during the screening. All 4 of them were men, three of them were above the age of 34, and 1 of them was between the age of 25-34.

Infectious diseases in other risk groups

In 2009 a survey (Dudás et al. 2009) was conducted among homo-/bisexual men on the prevalence of HIV and other sexually transmitted infections associated with HIV. The survey was coordinated by the department of epidemiology of the National Centre for Epidemiology. Between 20 November 2008 and 28 February 2009, 388⁷⁹ blood samples were submitted to the laboratories of the National Centre for Epidemiology. The blood samples were tested for HIV, syphilis, hepatitis B and hepatitis C.

During the epidemiologic study, 2.6% (10 persons) HIV prevalence was found in the examined homo- and bisexual male population. 2.1% (8 persons) were infected with hepatitis B and 0.8% (2 persons) with hepatitis C. Early infectious syphilis was diagnosed in the case of 28 persons (7.2%), and a further 28 clients were found to be IgG positive, therefore a total

⁷⁹ 225 samples were provided for the purposes of the survey by the Anonymous AIDS Counselling Services of Budapest, 101 samples by the Józsefváros Healthcare Service's outpatient clinic for dermatovenerological diseases in Budapest, 50 samples by Jóna András Hospital and Outpatient Clinic's department for dermatovenerological diseases in Nyíregyháza, and 12 samples by Szent Sebestyén '97 Kft. in Budapest. Those men declaring themselves homo-/bisexual were involved in the survey who turned up at the above mentioned places, gave their informed consent to blood sampling and filled in the anonymous questionnaire of the survey.

number of 56 persons (14.4%) were involved in the study in the case of whom *Treponema pallidum* infection had ever occurred or was currently in process. In the case of two of the 10 HIV positive clients active infectious syphilis was diagnosed, and in one of them the presence of HbsAg was also proved. No HIV - hepatitis C coinfection was detected.

During the survey questions were also asked about the clients' drug use⁸⁰. 19.8% of the respondents (77 persons) had already used drugs in their lives, 5 persons out of them had already injected drugs too. These clients indicated heroin (3 persons), amphetamine (1 person) and cocaine (1 person) as their primarily injected drug. 66 out of the 77 clients revealed what type of drug they used other than intravenously. The decisive majority of the clients naming the type of drug used cannabis (65%), and 16.6% used ecstasy. In the remaining cases the clients indicated amphetamine, GHB, cocaine and LSD use.

The connection between drug use and sexually transmitted infections is described below:

Table 42. Breakdown of HIV, HCV, HBV and *Treponema pallidum* infections among homo-/bisexual men according to ever using drugs in 2009

Drug use	HIV antibody positive persons		HBsAg antigen positive persons		HCV antibody positive persons		Patients with early infectious syphilis	
	yes	no	yes	no	yes	no	yes	no
yes	5	72	2	75	0	77	5	72
no	4	300	6	298	2	302	22	282
Total	9	372	8	373	2	379	27	354

Source: National Centre for Epidemiology (Dudás et al. 2009)

From the aspect of HIV infection drug use represented a risk nearly five times higher (RR: 5.21 95% CI: 1.18-23.78) than in the case of persons not using drugs.⁸¹ In respect of hepatitis B infection and early infectious syphilis the statistical analyses showed that drug users did not have a higher risk of acquiring certain infections than persons not using drugs.⁸² In the case of hepatitis C no relative risk could be calculated⁸³, as during the survey no positive homo-/bisexual ever drug user man was found.

The 5 IDUs proved to be negative in respect all 4 infectious agents.

Tuberculosis and drug use

On the basis of the epidemiology data from the institutes of pulmonology it can be stated that in 2009 2 new persons infected with TB were found, who self-reported using drugs. Among the 1,448 new patients with TB there were a total number of 286 persons in the case of whom a risk group became known, most of them belonged to the group of the alcohol-dependents and the homeless. In the case of 2 persons HIV coinfection was detected.

⁸⁰ The question related to whether the clients involved in the survey had ever used drugs/ had ever injected drugs, and if yes, what drugs they had used.

⁸¹ 1 is within the 95% confidence interval, so the risk of acquiring HIV is higher among drug user homo-/bisexual men.

⁸² In the case of hepatitis B infection the relative risk is 1.32 (95% RR 0.18-7.44), as 1 is within the 95% confidence interval, it is statistically possible that drug use does not involve a higher risk from the aspect of acquiring the hepatitis B virus among homo-/bisexual men. In respect of early infectious syphilis the relative risk is 0.9 (95% CI:0.35-2.29)⁸², so drug users do not have a higher risk of acquiring *Treponema pallidum* than persons who do not use drugs.

⁸³ One-fourth of the 2X2 table was 0 (among the drug users no HCV antibody positive persons were found).

Table 43. Risk factors identified in new patients with TB in 2009

Risk factor	Number of patients	% of patients
Alcohol dependent	201	16.8
Homeless	137	8.1
Contact person	57	3.5
Immigrant	11	1.0
Healthcare worker	29	1.4
With diabetes	43	3.6
Treated with steroids	11	1.1
Closed community ⁸⁴	32	2.0
Drug user	2	0.1
HIV infected	2	0.1
Prison	10	1.4
Total number patients in risk groups	286	25.8
No risk factor	1,160	74.1
Incidence: Total	1,448	100

Source: National Korányi TB and Pulmonology Institute

At the detention facilities 11,404⁸⁵ imprisoned persons were screened for tuberculosis in 2009, and 11 new TB patients were found among them during the tests.⁸⁶

Risk behaviours

National survey

On the basis of the EMCDDA protocol⁸⁷, during the HIV/HBV/HCV prevalence survey performed by the National Centre for Epidemiology (Dudás et. al 2010a) in 2009, questions were also asked about risk behaviours. The questions regarded HIV/HCV testing uptake in the last 12 months, sharing needles/syringes within the last 4 weeks, or sharing any injecting equipment within the last 4 weeks. Using the generated code the answers could be linked to the serological test results (for the serological results see: this chapter, above).

On the basis of the processed data, in the previous year nearly half of the 676 drug users did not participate in HIV screening (49.6%).⁸⁸ Among those who had been tested in the last 12 months (50.4%) more than 90% knew that their HIV serostatus was negative. 1 person thought that he/she was HIV positive, and 3.3% of them did not know whether they were HIV positive, all they knew was that they had participated in HIV screening in the previous year. (ST9P3_2010_HU_01; ST9P3_2010_HU_04; ST9P3_2010_HU_05)

48.1% of the clients did not participate in HCV screening in the previous year.⁸⁹ 75.3% of the persons participating in the screening (259 persons) self-reported being HCV negative, but during the laboratory tests 12.7% of them (33 persons) turned out to be positive. 16.9 % (58 persons) self-reported being HCV positive, and it was proved in the case of 55 persons.

⁸⁴ Social welfare home, hospice, children's home.

⁸⁵ 74% of the average number of prisoners in 2009 (15,373 persons).

⁸⁶ On the basis of the report by the Hungarian Prison Service Headquarters.

⁸⁷ Protocol for the implementation of the EMCDDA key indicator: Drug-related infectious diseases (DRID), draft version 6 October 2006, Project CT.04.P1.337

⁸⁸ The data relating to participation at screening in the previous year was based on self-reporting by the respondents.

⁸⁹ The data relating to participation at screening in the previous year was based on self-reporting by the respondents.

Among those who had participated in HCV screening but were not aware of their serostatus (7.8%), more than half of the clients were HCV antibody positive (15 out of 27 persons). 18.6% of the drug users who had not participated in hepatitis C screening in the previous year proved to be HCV positive, and they represented one-third of all cases. (ST9P3_2010_HU_01; ST9P3_2010_HU_04; ST9P3_2010_HU_05)

Table 44. Breakdown of HCV positive IDUs tested during the HCV prevalence survey in 2009 by HCV testing uptake in the last 12 months

HCV testing uptake in the last 12 months and self-reported results	Persons tested for HCV antibodies in 2009		
	number	number	positive %
yes, the result was positive	58	55	94.8
yes, the result was negative	259	33	12.7
yes, not knowing test result	27	15	55.6
no	323	60	18.6
Total	667	163	24.4

Source: the National Centre for Epidemiology (Dudás et al. 2010a); Hungarian National Focal Point

The last 4 week prevalence of sharing needles/syringes and injecting equipment was analysed only among current IDUs.⁹⁰ 26.3% of current IDUs (309 persons) had shared needles/syringes in the last 4 weeks, and the monthly prevalence of sharing injecting equipment was 40.5%. The difference of the HCV prevalence rates between those sharing and those not sharing needles/syringes or equipment is not significant either in the case of sharing needles/syringes or in the case of sharing injecting equipment ($p > 0.05$). In both cases 1 is included in the odds ratio (in the case of needles/syringes sharing: OR:0.82, 95% CI: 0.46-1.45; sharing injecting equipment: OR:1.09 95% CI: 0.66-1.8), thus correlation between last month needles/syringes and/or equipment sharing and Hepatitis C infection could not be supported by this survey. (ST9P3_2010_HU_01)⁹¹; (ST9P3_2010_HU_04; ST9P3_2010_HU_05)

Table 45. Breakdown of current IDUs sharing needles/syringes and sharing needles/syringes or other injecting equipment in the last 4 weeks by HCV infection in 2009

Sharing needles/syringes	Persons tested for the presence of HCV antibodies			Sharing any injecting equipment	Persons tested for the presence of HCV antibodies		
	number	number	positive %		number	number	positive %
yes	81	26	32.1	yes	125	46	36.8
no	227	83	36.6	no	184	64	34.8
Total:	308	109	35.4	Total:	309	110	35.6

Source: the National Centre for Epidemiology (Dudás et al. 2010a); Hungarian National Focal Point

A survey in Budapest among IDUs participating in a needle/syringe programme

On the questionnaires attached to the blood samples collected at the Blue Point Foundation between September 2008 and July 2009 (for the serological results see this chapter above) there were questions on risk behaviours (needle/syringe sharing, sharing any injecting

⁹⁰ On the basis of the EMCDDA guideline of ST9P3.

⁹¹ Figures in the National Report slightly differ from figures reported in the ST9P3_2010_HU_01/ 1.4.2, 1.4.4, as from the analysis (in the NR) regarding correlates of needles/syringes/equipment sharing and HCV infection those cases were excluded where HCV test results were inconclusive.

equipment in the last 4 weeks/ HIV/HCV testing uptake in the last 12 months), injecting habits⁹², sexual behaviour⁹³ and further supplementary information⁹⁴.

In the case of nearly one-third of the respondents (47 persons) there is no information relating to HIV testing uptake in the last 12 months. 35% (36 persons) said that they had been tested for HIV in the last 12 months and their result was negative. 9.7% (10 persons) had been tested for HIV in the last 12 months, but they did not know their result, and 57 persons (55.3%) were not tested for HIV in the last 12 months. (ST9P3_2010_HU_02)

After excluding inconclusive HCV results, in the case of 45 clients there is no data relating to HCV testing uptake in the last 12 months. 23 persons said that they had been tested for HCV in the last 12 months and their result was negative. Among them 6 persons proved to be HCV antibody positive. 13.9% (14 persons) said that they had been tested positive for HCV in the last 12 months, and the laboratory tests supported it in each case. 57 persons (56.4%) said that they had not been tested for HCV in the last 12 months, and nearly half of these IDUs (47.4%) turned out to be HCV positive. More than one-third of all infected persons belonged to this group (27 out of 75 persons). (ST9P3_2010_HU_02)

Table 46. Breakdown of HCV positive IDUs tested at the Blue Point Foundation in 2008-2009 by HCV testing uptake in the last 12 months

HCV testing uptake in the last 12 months and self-reported results	Persons tested for the HCV antibodies in 2009		
	number	number	positive %
yes, the result was positive	14	14	100.0
yes, the result was negative	23	6	26.1
yes, not knowing test result	7	4	57.1
no	57	27	47.4
Total	101	51	50.5

Source: the National Centre for Epidemiology (Dudás et al. 2010b); Hungarian National Focal Point

51 clients did not respond to whether they had shared needles/syringes in the last 4 weeks. 62.5% of the IDUs who had shared needles/syringes in the last 4 weeks were HCV positive, while 44.6% of those who had not shared needles/syringes were HCV positive. The difference between the two prevalence rates is significant at the level of $p < 0.01$.

51 clients did not report on sharing any injecting equipment in the last 4 weeks. 60% of the IDUs who shared injecting equipment in the last 4 weeks were HCV positive, while 41.3% of those who did not share injecting equipment were HCV positive. The difference between the two prevalence rates is significant at the level of $p < 0.01$. (ST9P3_2010_HU_02)⁹⁵

⁹² On the basis of the questions included in EMCDDA ST9P3: injecting frequency in the last 4 weeks; personal reuse of needles/syringes; number of sharing partners in the last 4 weeks; number of sterile needles/syringes in the last 4 weeks.

⁹³ Sexual intercourse in the last 4 weeks, condom use at last intercourse, sex work

⁹⁴ Opioid substitution treatment in the last 4 weeks; homelessness in the last 12 months.

⁹⁵ Figures in the National Report slightly differ from figures reported in the ST9P3_2010_HU_02/ 1.4.2, 1.4.4, as in the Standard Table regarding 1.4.2, 1.4.4 only data of current IDUs was reported, while the analysis on correlates of needles/syringes/equipment sharing and HCV infection was carried out regarding all IDUs tested in the NSP of the Blue Point Foundation.

Table 47. Breakdown of IDUs sharing needles/syringes and sharing needles/syringes or other injecting equipment in the last 4 weeks by HCV infection at the Blue Point Foundation in 2008-2009

Sharing needles/syringes	Persons tested for the presence of HCV antibodies			Sharing any injecting equipment	Persons tested for the presence of HCV antibodies		
	positive				positive		
	number	number	%		number	number	%
yes	32	20	62.5	yes	50	30	60.0
no	65	29	44.6	no	46	19	41.3
Total:	97	49	50.5	Total:	96	49	51.0

Source: the National Centre for Epidemiology (Dudás et al. 2010b); Hungarian National Focal Point

12.5% of the IDUs had not injected drugs in the last 4 weeks, 15.3% of them had injected drugs once a week or less. 19.4% injected drugs 2-6 times per week, and 14.6% of them injected drugs daily. The largest group was represented by those, who injected drugs several times a day, they formed 38.2% of all IDUs.

The respondents reused their last discarded syringes 1.78 times on average (Range: 0-10; SD: 1.55). 12.59% of the sample received a used syringe from 2 or more persons in the last 4 weeks. The respondents used 36 sterile needles/syringes on average in the last 4 weeks (Range: 0-150; SD: 41).

In the last four weeks nearly three-quarters of the IDUs (71.5%, 103 persons) had had a sexual intercourse, and 81.6% (84 persons) of them did not use a condom during the last sexual intercourse. Only one of the sexually active persons (0.1%) had provided sex for money, drugs or other benefits in the last 4 weeks.

In the last 12 months 20.8% of the sample lived in a hostel, without a steady address or on the streets during more than 1 week. (ST9P3_2010_HU_02)

Risk behaviours in detention facilities

In the course of the survey analysing drug use and risk behaviours simultaneously with the screening programmes carried out in detention facilities (for the serological results see this chapter above), ever IDU prisoners were also asked whether they had ever been engaged in sharing needles/syringes or sharing any injecting equipment. The rate of infection was 45.5% among prisoners ever engaged in sharing needles/syringes, while among prisoners not engaged in sharing needles/syringes this proportion was only 35.5%. Among prisoners engaged in sharing injecting equipment the proportion of HCV infection was 36.7%, while among prisoners not engaged in sharing injecting equipment this proportion was 40%. Neither ever sharing needles/syringes nor ever sharing injecting equipment was significantly associated with hepatitis C infection. (ST9P3_2010_HU_03)

Table 48. Breakdown of HCV positive ever IDU prisoners by ever sharing needles/syringes and ever sharing needles/syringes or other injecting equipment in 2009

Sharing needles/syringes	Persons tested for the presence of HCV antibodies			Sharing any injecting equipment	Persons tested for the presence of HCV antibodies		
	positive				positive		
	Number	number	%		number	number	%
yes	33	15	45.5%	yes	47	17	36.2
no	51	18	35.3%	no	35	14	40%
Total:	84	33	39.3%	Total:	82	31	37.8%

Source: Hungarian National Focal Point

All prisoners (ever and non IDUs) were asked whether they had any tattoos and where they had received their last tattoos. 63.4% (365 persons) of the sample had tattoos, and 51 persons of the sample (8.9%) had received their last tattoo inside prison.

86.5% of the infected persons (37 persons) had tattoos, and 8.1% of these 37 persons had received their last tattoo inside prison.

Table 49. Breakdown of HCV positive prisoners by tattooing prior to imprisonment or inside prison in 2009

Tattooing	Entire sample		HCV positive persons	
	number	%	number	%
yes, prior to imprisonment	314	54.5	29	78.4
yes, inside prison	51	8.9	3	8.1
no	207	36.2	5	13.5
Total	572	100	37	100

Source: Hungarian National Focal Point

In 2009 a pilot-study on community-based street outreach model programme among IDUs in Budapest (Rácz et al. 2009) was carried out in which risk behaviours of current IDUs participating in the survey were also examined, for data see: Chapter 7.2.

6.2. OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

Drug intoxications

Similarly to the previous year, in 2009 again the data generated at the Clinical Toxicology Department of Péterfy Sándor Street Hospital⁹⁶ is presented in connection with cases of drug intoxication.

In 2009, 1,808 persons were treated for intoxication of illicit drugs or organic solvents (in 2008: 1,692 persons, in 2007: 672 persons, in 2006: 670 persons) at the department of toxicology.

After the significant increase observed in the previous year, in 2009 the number of clients did not increase significantly, there was a decrease in the number of male patients (in 2009: 1,042 persons, in 2008: 1,078 persons), but the number of female patients increased (in 2009: 766 persons, in 2008: 614 persons).

More than one-third of the 642 cases of overdose caused by opiate type drugs were due to heroin use (241 cases), but the proportion of cases caused by drugs without any separate designation was even higher, typically these were cases of overdose of cough suppressants containing dextromethorphan, or the combined use of such drugs with alcohol, but cases of intoxication caused by GHB⁹⁷ are also included in this category. As compared to the previous year, there was a lower number of cases treated because of heroin overdose (in 2009: 241 cases, in 2008: 299 cases) or methadone overdose (in 2009: 12 cases, in 2008: 30 cases).

At the same time, the number of cases of overdose caused by opiate type drugs was exceeded by the number of cases of overdose caused by amphetamine type drugs (in 2009:

⁹⁶ On the problems of data collection see: National Report 2007 <http://drogfokuszpont.hu/?pid=96> (20.10.2009)
Up until recently the data originating from the department used to be collected by the National Centre for Addictions in the scope of OSAP data collection, but this year the cases were not selected from the final OSAP database (for the description of the problems see chapter 5.3), the department of toxicology sent the data directly to the National Focal Point. On the OSAP datasheet different substances are listed in the following categories: Opiate type substances are: opium, heroin, morphine, other opiates, synthetic narcotic analgesics, methadone, opiate without any separate designation. Cocaine type substances are: cocaine (hydrochloride), cocaine base (crack), cocaine without any separate designation. Cannabis type substances are: herbal cannabis, cannabis resin, cannabis without any separate designation. Hallucinogens are: LSD, hallucinogens without any separate designation. Amphetamine type substances are: amphetamine, methamphetamine, other amphetamines (ecstasy, MDA, MDMA, MDE, MBDB, 4-MTA), amphetamine without any separate designation.

⁹⁷ GHB is not included in the OSAP datasheet.

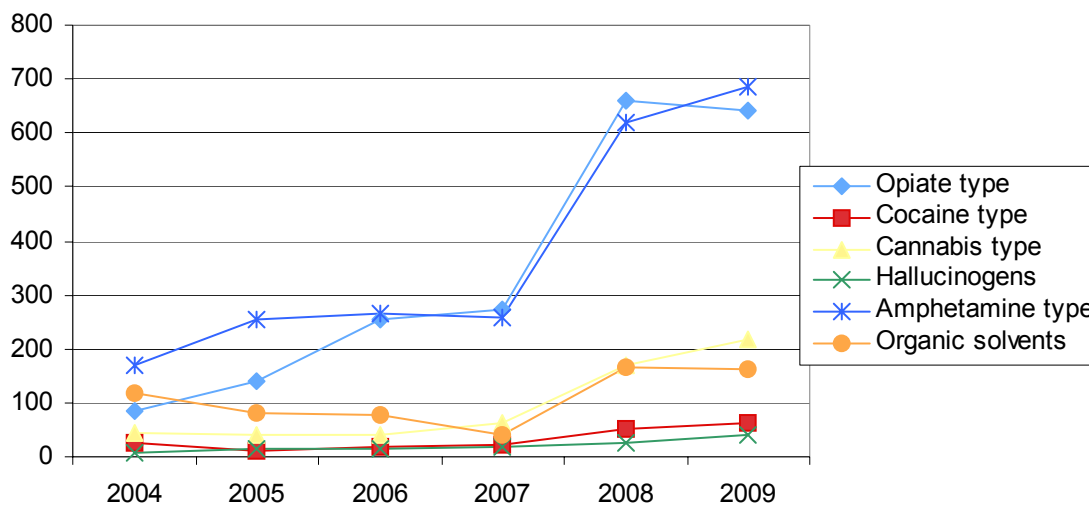
685 cases, in 2008: 620 cases). The number of cases of amphetamine overdose slightly increased (from 108 to 116), which increase is due to women, at the same time there was a decrease in the number of cases occurring because of other types of amphetamine or ecstasy use. However, in this category equalisation can be observed between men and women (in 2009: 54 men, 51 women, in 2008: 79 men, 35 women). Among amphetamine type drugs the proportion of cases without any separate designation is still high (64.6%). According to the information provided by the head physician of the department of toxicology, in many cases it was due to an overdose of different sexual enhancers or herbs of Chinese origin (containing ephedrine).

In 2009, 217 persons were admitted to the department because of an overdose of cannabis type drugs, which represents an increase as compared to the 170 cases in the previous year. The number of cases treated because of cocaine use also increased, first of all due to the increase observed in the case of women (in 2009: 34 men, 30 women, in 2008: 36 men, 17 women).

No significant increase could be observed in the number of intoxications caused by organic solvents, but the equal proportion of genders observed in the previous year changed (in 2009: 119 men, 42 women, in 2008: 82 men, 83 women).

The data collection does not make it possible to select cases occurring because of the misuse of drugs. In connection with cases of intoxication with opiate and amphetamine type drugs at an old age it is important to point out that presumably a significant number of such cases are due to drugs used on the basis of a doctor's indication, some of them are not even intended, but they are cases of accidental intoxication or overdose.

Figure 34. *The number of patients treated for drug intoxication at the Clinical Toxicology Department of Péterfy Sándor Street Hospital between 2004-2009 (persons)*



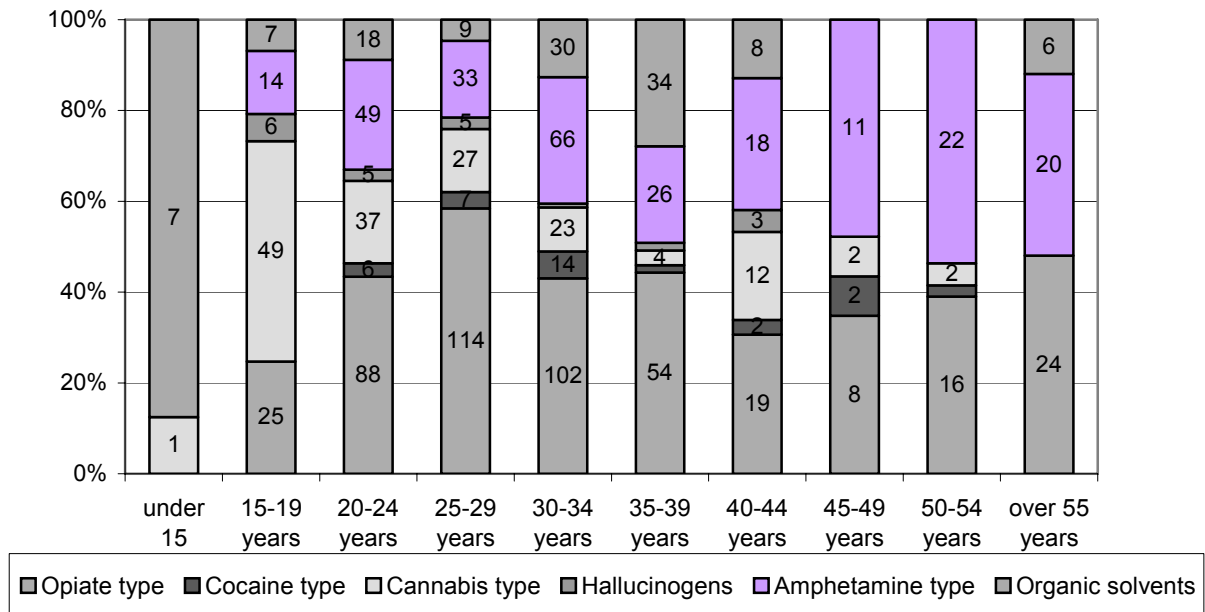
Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health (Ministry of Health, Family and Social Affairs)⁹⁸

Concerning distribution by age groups it can be stated that in the case of both genders the age groups between the ages 20-24, 25-29 and 30-34 are the most affected (men: 203, 195, 237 cases; women: 125, 114, 127 cases). The cases of overdose of opiate and amphetamine type drugs in older age groups are presumably cases of overdose of drugs used on the basis of a doctor's indication.

As compared to the previous year the overdose of cannabis type drugs among girls below the age of 15 is conspicuous (there were no such cases in 2008), as well as the appearance of the overdose of cannabis type drugs among men above the age of 40.

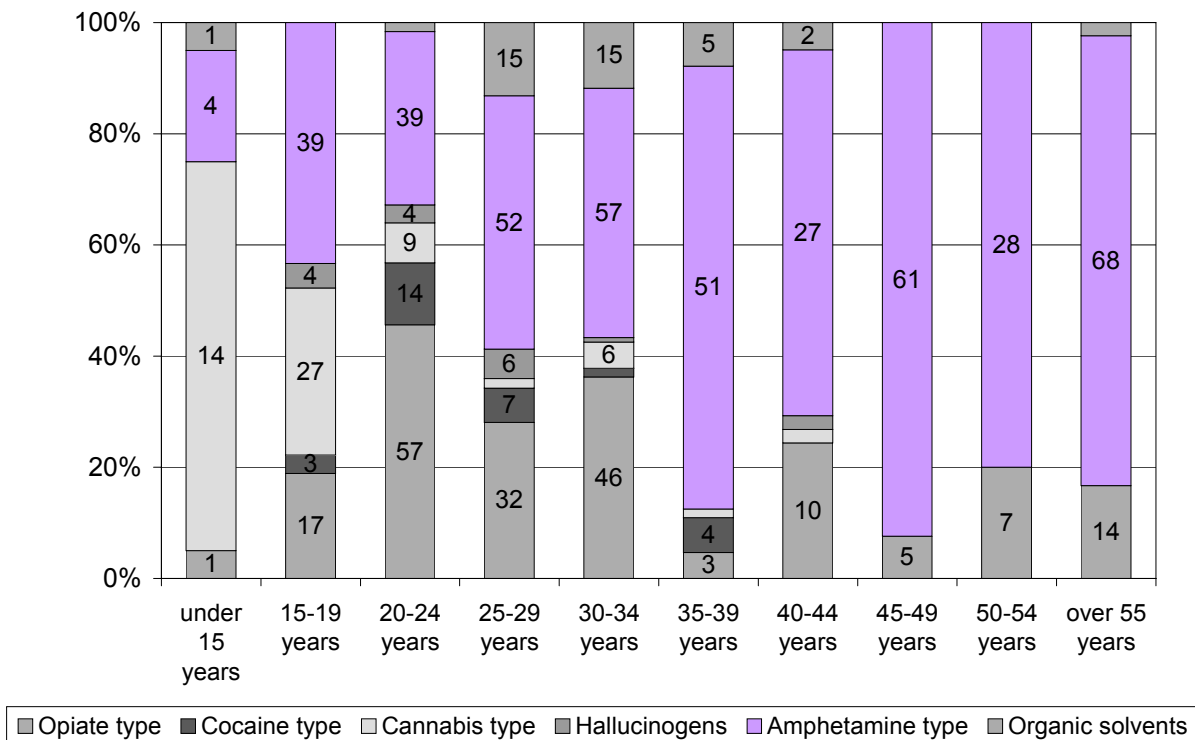
⁹⁸ Data reported by the Clinical Toxicology Department of Péterfy Sándor Street Hospital in the scope of OSAP data collection, which data was sent to the Hungarian National Focal Point at special request.

Figure 35. Breakdown of drugs among men treated at the Clinical Toxicology Department of Péterfy Sándor Street Hospital for drug intoxication by age (N=1042) (persons)



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health (Ministry of Health, Family and Social Affairs)

Figure 36. Breakdown of drugs among women treated at the Clinical Toxicology Department of Péterfy Sándor Street Hospital for drug intoxication by age group (N=766) (persons)



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health (Ministry of Health, Family and Social Affairs)

Driving accidents

In 2009, in the case of 83 road accidents the Police sent urine samples to the National Institute for Toxicology for further testing, suspecting the presence of a drug in the body having an unfavourable influence on the ability to drive, while the preliminary screening test was positive.

Out of the 83 samples, the Institute for Toxicology determined positivity in the case of 52 samples, and in the case of 22 of these samples the presence of a drug could be detected in the blood as well.

Table 50. *The presence of drugs in urinary samples deriving from road accidents by active substance content in 2009*

Active substance	Number of cases
THC	8
Amphetamine	4
Cocaine	2
Morphine (Heroin)	2
Morphine + methadone	1
Amphetamine + THC	4
Amphetamine + THC + cocaine	2
Amphetamine + THC + benzodiazepine	2
Amphetamine + cocaine + GHB	1
Amphetamine + cocaine	2
Morphine (Heroin) + THC	1
MDMA + THC	1
Benzodiazepines + THC	3
Benzodiazepines + cocaine	1
Benzodiazepine + barbiturate	1
Benzodiazepines	15
Benzodiazepines + amphetamine	2
Total	52
Demonstrated in the blood too	22

Source: National Institute for Toxicology

Pregnancies and children born to drug users

In the scope of the annual substitution data collection coordinated by Nyíró Gyula Hospital Specialised Outpatient Treatment Centre the number of pregnant women appearing in the service was surveyed again. The 10 service providers reported a total number of 9 such cases in respect of 2009, 8 of them received substitution treatment at a service unit in Budapest, and 1 of them at a service unit outside of Budapest.

Quantitative survey of problem drug user women in Budapest

Csorba (Csorba et al. 2009; Csorba et al. 2010) performed a questionnaire survey⁹⁹ among injecting and/or opiate user women that are resident in Budapest (175 persons). The aim of the survey was to provide a closer picture of this special group of drug user women, with special respect to pregnancy.

⁹⁹ The survey was carried out by H-Reports Kft. and financed by the Ministry of Social Affairs and Labour (SZMM) (project code: KAB-KT-M-08-01). The sample included all women participating in substitution treatment at the time of data collection in Budapest, who intended to take part in the survey (4 persons did not intend to take part) – a total number of 106 persons –, and 69 persons from the clients of needle exchange service providers in Budapest. The questionnaire survey was performed using the face-to-face method at the location of the service providing units.

The average age of the examined sample was 32 years, the youngest respondent was 16, while the oldest respondent was 52.

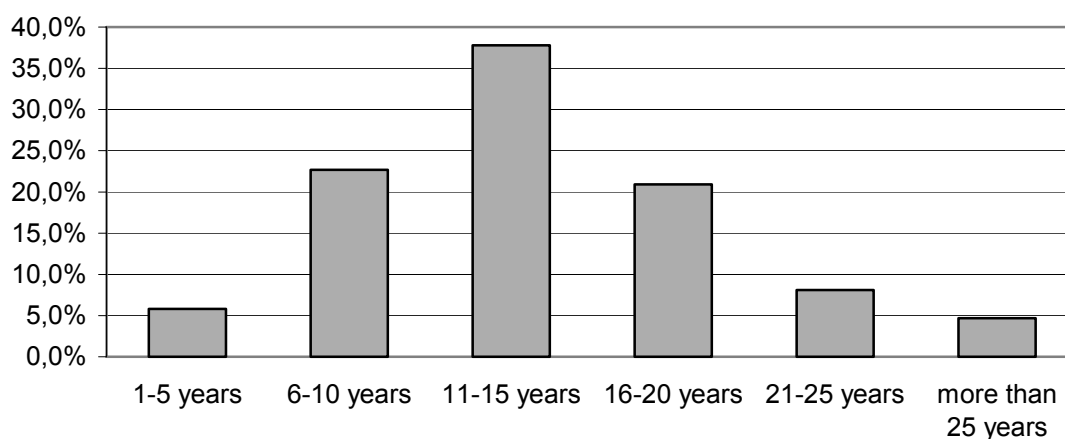
10% of the respondents did not complete the 8 years of elementary education, in the case of 36% the highest school qualification were 8 years of elementary school education. 46% had some sort of secondary school qualification, and 8% had higher qualifications.

In respect of housing conditions 26% lived in rented accommodation, 56% lived in their own accommodation or in local authority accommodation, 13% lived in friends' accommodation as a favour, and 6% said that they were homeless.

31% of them was a regular employee, 26% lived on occasional employment, 10% said that they were economically inactive, and one-third of the sample (33%) self-reported being unemployed.

83% of the sample self-reported using opiate as a primary substance, 12% self-reported using amphetamine and 4% self-reported using other drugs as their primary substance. The average length of the history of drug use¹⁰⁰ was 14.1 years in the sample (15.1 years among users participating in substitution treatment, 12.4 years among the clients of needle exchange programmes). In the case of nearly three-quarters of the sample (72%) the respondents had a history of drug use of more than 10 years. The majority of the respondents (38%) had a history of drug use of 11-15 years.

Figure 37. Breakdown of the respondents by the length of the history of drug use (persons, N=172)



Source: Csorba et al. 2009

23% of the respondents (41 persons) had established a sexual relationship in their lives in return for money or other benefits, 35 of these people (85%) did this for the first time after first drug use (any drug). At the same time, 26 out of the 41 persons (63%) established a sexual relationship in return for money or other benefits for the first time after the first use of their primary drug.

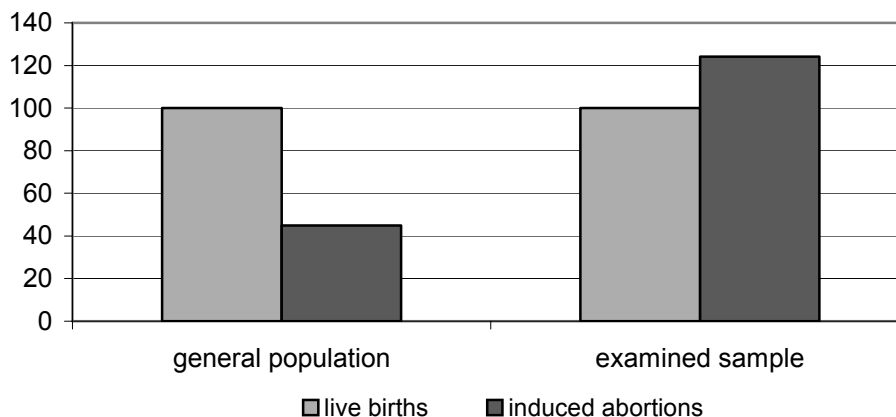
80% of the sample (140 persons) reported on being pregnant in their lives. 57% of the known pregnancies occurred after first drug use. 56% of the pregnancies ending in live births occurred following the mothers' first drug use.

Women ever getting pregnant (140 persons) reported a total number of 418 pregnancies, which means an average of 3 pregnancies per person. 36.3% of the pregnancies with a known outcome ended in live births, and 48% ended in abortion. The proportion of pregnancies ending in stillbirths was 4.4%, while spontaneous abortion occurred in 11.4% of the cases.

¹⁰⁰ Average difference between the age at first drug use and the age of the respondent, in the entire sample.

One of the most warning results of the survey is that while in the general population in Hungary the number of induced abortions for every 100 live births is 44.5 (Central Statistics Office 2009), the value measured in the sample is nearly three times this number: 124.2.

Figure 38. *The number of induced abortions for every 100 live-births in the general population and in the sample*



Source: Csorba et al. 2009

6.3. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

We define drug-related death as death caused by direct intoxication, i.e. direct overdose, on the one part; and indirect drug-related death by nature or violence on the other part.

In 2009 there was a significance change in the data collection relating to drug-related death. Instead of the earlier OSAP data collection containing exclusively aggregate data, the information relating to death cases occurring in 2009 derive from the mortality module of the reporting system of the National Centre for Addictions (OAC) relating to illicit drug use. The module's datasheet contains detailed information for example on the deceased persons' circumstances of death, known history and toxicology results. In November 2009 the National Centre for Addictions and the Hungarian National Focal Point organised a meeting for the data suppliers, in the scope of which the new system was introduced. The reported data was evaluated with the help of the National Institute of Forensic Medicine. In the interest of the comprehensive analysis of the deceased persons the National Institute of Forensic Medicine discussed with ISZKI National Institute for Forensic Toxicology¹⁰¹ drug-positive toxicology results. The National Institute of Forensic Medicine requested information relating to positive cases from the responsible institutes, taking into consideration the rules of data protection, i.e. anonymously, using generated codes. The institutes in charge could not always enter drug-positive cases in the system (in the lack of human or material resources), these cases were entered by the National Institute of Forensic Medicine.

Due to the new data collection system a case-based database is available on drug-related death cases, which database, with the help of a generated code, can be connected with treatment data. This year, for the first time we also have detailed information on indirect cases of death as well, which we can be analysed broken down into further categories (death by nature or by violence).

¹⁰¹ The institutes examines all organic samples taken all over Hungary except for Szeged and Debrecen.

Direct overdoses

National data

In 2009, 31 cases directly related to illicit drug use were reported, which represents an increase as compared to the previous years (in 2008: 27 cases, in 2007: 25 cases, in 2006: 25 cases) (ST5_2010_HU_01, ST5_2010_HU_02, ST6_2010_HU_01). However, in respect of cases occurring in Budapest exclusively, no significant change can be observed (in 2009: 22 cases, in 2008: 20 cases, in 2007: 25 cases), so the increase in the number of cases is probably due to the more thorough identification of the cases occurring outside of Budapest. Outside of Budapest cases of direct drug overdose were reported from Győr (4 cases), Kecskemét (1 case), Miskolc (1 case), Szeged (1 case), Székesfehérvár (1 case) and Szolnok (1 case).

Table 51. Number of direct drug-related deaths in 2009¹⁰² (persons)

	Male	Female	Total
Heroin	25	3	28
Methadone	2	0	2
Amphetamine	1	0	1
Total	28	3	31

Source: National Centre for Addiction

The average age of the persons deceased because of direct overdose was 32 years, there was no difference between the average age of men and women (men: 32 years, women: 32.7 years), the youngest deceased person was 21 years old (heroin overdose), and the oldest deceased person was 47 years old (heroin overdose).

Table 52. Breakdown of direct drug-related deaths by age in 2009 (persons)

	15-19	20-24	25-29	30-34	35-39	40-44	45-49	total
Heroin	1	4	7	7	6	2	2	28
Methadone	0	0	0	1	1	0	0	2
Amphetamine	0	0	1	0	0	0	0	1
Total	1	4	8	8	7	2	2	31

Source: National Centre for Addiction

Indirect drug-related deaths

The effectiveness of the statistical data collection in 2009 is indicated by the fact that a large number of so-called indirect deaths were entered in the database, and two groups of indirect deaths could be distinguished. In the case of one of the groups, during the investigation of the scene equipment needed for drug use (injection) was found, during the examination of the deceased person the signs of recent and old injections could be seen, but during autopsy drugs or their decomposition products could only be detected from the urine. In these cases the expert performing the autopsy determined that the direct cause of death was myodegeneration or pneumonia. The other group included victims of death by violence, in the case of whom the urine test confirmed that they had used drugs before they died.

Natural deaths, presence of illicit drugs in the urine

In 2009, 8 cases of natural death were reported, where in the course of the toxicology test illicit drugs were detected, and on the basis of the circumstances forensic experts also presumed that drug use may have contributed to the death, but no direct overdose took

¹⁰² Special register Selection D

place. The average age of the deceased persons was 33.6 years, the youngest person was 21, while the oldest person was 42 years old.

Table 53. *Natural deaths, the presence of illicit drugs in the urine, in 2009*

Gender	Age	Toxicology ¹⁰³	Direct cause of death
Female	42	cocaine	Congestive heart failure
Male	28	amphetamine	Cardiac, heart or myocardial failure N.O.S.
Male	39	methadone, heroin (morphine) other opiates	Cardiac, heart or myocardial failure N.O.S.
Male	32	heroin (morphine), methadone	Cardiac, heart or myocardial failure N.O.S.
Male	38	cannabis	Respiratory arrest
Male	21	cocaine, cannabis	Cardiac, heart or myocardial failure N.O.S.
Male	31	heroin (morphine), methadone	Respiratory arrest
Male	38	cannabis	Acute myocardial infarction, N.O.S.

Source: National Centre for Addiction

Even in the case of deaths occurring soon after drug use it is not always obvious how the medical expert determines the exact cause of death. In many cases death may be protracted (Horvath et al. 2006), which means that during the process of dying there is enough time for the drug to leave the blood. The detected drug types may also support that it was not a case of accidental drug use, and on the basis of the amount detected in the urine it can often be held probable that the drug was consumed soon before the occurrence of death (within 24 hours). In order to determine the exact cause of death the medical experts must take into consideration all circumstances of the death case.

Deaths by violence, the presence of illicit drugs in the urine

Three categories of deaths by violence can be distinguished: suicide (other than intoxication), crime of violence (murder) and (driving) accident. In 2009, in the case of the 11 deaths by violence reported the presence of cannabis (THC) was detected in the majority of the cases (5 cases), and in one case it was detected together with amphetamine. In two cases the decomposition product of cocaine and heroin was detected, in one of these cases it was detected together with methadone. Three of the persons who committed suicide hanged themselves, and one of them jumped from a height.

Table 54. *Breakdown of drug-related deaths by violence by drug type, in 2009 (persons)*

	Suicide	Accident	Murder	Total
Amphetamine	1	0	0	1
Morphine/heroin	1	0	0	1
Cannabis	0	4	1	5
Cocaine	1	0	1	2
Heroin/morphine and methadone	0	1	0	1
Amphetamine and cannabis	1	0	0	1
Total	4	5	2	11

Source: National Centre for Addiction

¹⁰³ Morphine is the decomposition product of heroin, on the basis of the investigation of the scene heroin use could be presumed.

The average age of the victims of death by violence was 29.7 years, the youngest victim was a 19-year-old man (heroin and methadone, car accident), the oldest victim was a 61-year-old man (cannabis, bicycle accident).

Circumstances of drug-related deaths

Due to the data available in the new system we have a more comprehensive picture of the circumstances of drug-related deaths. The tables below present the information available on the cases according to direct, natural or violent causes of death.

In respect of the location discovered, in the cases of direct overdose and natural death the largest proportion of the deceased persons were discovered in their own accommodation, while in the case of deaths by violence public roads and other scenes occurred in similar proportions. Among other scenes stairways, public washrooms, different parks were mentioned in several cases in connection with direct deaths.

Table 55. Breakdown of direct, natural and violent deaths by location discovered, in 2009

	Own apartment	Somebody else's apartment	Place of entertainment	Public road	Other public area	Hospital	Other	Total
Direct	14	1	2	0	1	1	12	31
Natural	5	2	1	0	0	0	0	8
Violent	2	0	0	4	1	0	4	11
Total	21	3	3	4	2	1	16	50

Source: National Centre for Addiction

In the case of the majority of the victims blood and urine alcohol tests were performed too. In more than half of the cases the result was negative, the highest concentration was measured in the case of deaths by violence.

Table 56. Alcohol levels¹⁰⁴ measured in direct, natural and violent drug-related deaths in 2009, in percentage of the different causes of death¹⁰⁵

	<0.2 ‰ (negative)		0.2-0.5 ‰		0.5-0.8 ‰		0.8-1.5 ‰		>1.5 ‰	
	Blood alc.	Urine alc.	Blood alc.	Urine alc.	Blood alc.	Urine alc.	Blood alc.	Urine alc.	Blood alc.	Urine alc.
Direct	66.7%	57.1%	16.7%	14.3%	4.2%	4.8%	4.2%	14.3%	8.3%	9.5%
Natural	62.5%	57.1%	0.0%	14.3%	25.0%	0.0%	0.0%	28.6%	12.5%	0.0%
Violent	40.0%	50.0%	10.0%	0.0%	20.0%	10.0%	10.0%	0.0%	20.0%	40.0%
Total	59.5%	55.3%	11.9%	10.5%	11.9%	5.3%	4.8%	13.2%	11.9%	15.8%

Source: National Centre for Addiction

In 2009, on the basis of the TDI data 17 of the persons who died in connection with drug use had appeared in some type of treatment at an earlier point (12 cases of overdose, 2 natural deaths, 3 deaths by violence). Four persons had appeared on two or even more occasions in the treatment system during the preceding 4 years. Upon starting first treatment in the case of 13 out of the 17 persons heroin was the primary substance, 10 of them were active injecting users (9 heroin users, 1 amphetamine user).

When examining the age of the deceased persons when they first started to use drugs it can be determined that the deceased persons who had appeared in the treatment system died 11 years after first drug use on average. At the same time a difference can be observed in

¹⁰⁴ <0.2 ‰ = alcohol consumption is not proved, 0.21-0.50 ‰ = consumed alcohol but not under the influence of alcohol, 0.51-0.80 ‰ = very slightly, 0.81-1.50 ‰ = slightly, 1.50-2.50 ‰ = medium, 2.51-3.50 ‰ = severely, above 3.51 ‰ = very severely influenced by alcohol.

¹⁰⁵ In 8 cases no blood alcohol test was performed, while in 12 cases no urine alcohol test was performed.

respect of the causes of death. Those who died of direct overdose died 13 years after first drug use on average, while those who died of natural or violent causes died 8 years after first drug use on average¹⁰⁶.

Table 57. *Characteristics of the persons who died of drug-related death in 2009 and appeared in treatment between 2005-2009*

	gender	age at death	primary drug	start of treatment ¹⁰⁷	source of referral	previous treatment	age at first use of primary drug
Direct	female	29	heroin	2005	self-referred	had been treated before	14
	male	31	heroin	2005	self-referred	not known	26
	male	23	amphetamine	2005	court/probation/police	had been treated before	17
	male	39	heroin	2007	self-referred	had been treated before	18
	male	35	amphetamine	2005	not known	had been treated before	16
	male	29	heroin	2008	Other drug treatment centre	had been treated before	17
	male	33	heroin	2007	self-referred	had been treated before	25
	male	30	heroin	2007	family / friends	had been treated before	16
	male	22	heroin	2008	self-referred	not known	16
	male	34	heroin	2006	family / friends	had been treated before	15
	male	32	heroin	2008	court/probation/police	never	28
Natural	male	46	heroin	2005	court/probation/police	not known	22
	male	32	heroin	2005	court/probation/police	had been treated before	19
Violent	male	31	heroin	2008	self-referred	never	28
	male	27	cannabis	2007	court/probation/police	never	18
	male	19	heroin	2007	self-referred	had been treated before	17
	male	42	cannabis	2007	court/probation/police	never	28

Source: National Centre for Addiction

¹⁰⁶ The interpretability of the data is limited because of the low number of cases.

¹⁰⁷ TDI data collection, in the course of which new cases appearing in the treatment system are recorded, has been operating since 2005. We have no information about treatment events before 2005. For more detail on TDI data collection see chapter 5.

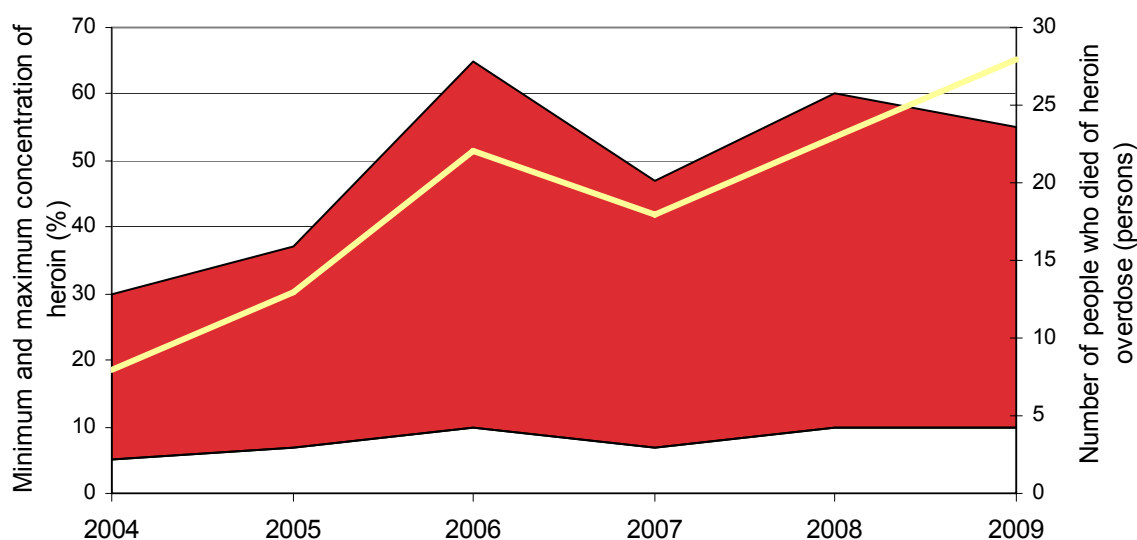
Arrest data

Examining data relating to arrests¹⁰⁸ it can be said that in 2009 10 of the persons who deceased in connection with drug use had been under arrest between 2005 and 2009. All of these 10 persons were men (in the case of all of them heroin use could be determined when they died), in 9 cases heroin and in one case amphetamine was mentioned in their files. With one exception all the deceased persons were under arrest in 2008.

Heroin concentration and heroin-related deaths

The development of concentration of street heroin surveyed by the Institute for Forensic Sciences shows a trend-like relationship with the development of the number of heroin overdoses.¹⁰⁹

Figure 39. Connection between the changing of the number of heroin overdoses and the changing of heroin concentration between 2004-2009 (the red area indicates the minimum and maximum concentration of heroin purity, while the yellow line indicates the changing of the number of people who died of heroin overdose)



Source: Institute for Forensic Sciences, Horvath et al. 2009, OAC

Mortality and causes of deaths among drug users

No information available.

Conclusions

It can be determined that the number of HIV positive cases among IDUs is still probably very low in Hungary, which is supported by the results of the prevalence surveys performed in 2009 and also by the routine HIV/AIDS surveillance data. In Hungary homosexual men are exposed to the greatest risk of acquiring HIV. The low rate of hepatitis B infection measured among IDUs is mostly due to the hepatitis B immunisation of adolescents turning 14 year old

¹⁰⁸ At the Hungarian National Focal Point information is available about cases, when a problem drug is (also) mentioned in the files. The cases could be connected with the help of a generated code.

¹⁰⁹ However, when interpreting the data it must be taken into consideration that in earlier years reliable data was only available about Budapest in respect of heroin-related deaths.

introduced in the general population in Hungary in 1999. In respect of hepatitis C infection, in the last four years the national prevalence rate in the IDU population was around 25%. The difference between the prevalence rates measured in 2008 and 2009, and between the prevalence rates measured since 2006 and 2009 is not significant at the level of $0.1 < p < 0.2$. It is worth highlighting that among women a higher HCV prevalence rate was measured than among men. Among women the prevalence rates measured in the age group between 25-34 and above 34 was significantly even higher than the average prevalence rate. Hepatitis C infectious rates show great regional differences, which underlines the importance of harm reduction services, especially in large cities. While in Budapest the rate of HCV infection was 40.5%, outside of Budapest this value was 7.9%. Among cities outside of Budapest, the rate of infection was outstandingly high only in Veszprém (24%). Comparing it to the total prevalence outside of Budapest (7.9%) the difference is significant at the level of $p < 0.01$.

During the national prevalence survey in case of the samples provided by the Blue Point Foundation NSP located in the VIII district of Budapest, the prevalence rate measured in 2006 and 2007 was 75%. In 2008 this rate of hepatitis C infection was 63.2%, while in 2009 it was 68.3%. At national level, the rate of hepatitis C infection is the highest among the IDU population residing in and around the district VIII of Budapest. During the continuous screening programme between September 2008 and July 2009 initiated in this particular NSP due to the described phenomenon, 51.4% of 150 samples proved to be HCV positive. This hepatitis C prevalence is significantly lower ($p < 0.05$) as compared to the prevalence rates observed in the previous years in the national prevalence survey. It may also be due to the fact that during national prevalence surveys the clients receive an incentive, therefore probably even those IDUs are tested who are otherwise do not attend the NSP.

In the case of ever IDU prisoners, on the basis of the screening programme and questionnaire survey conducted in two prisons outside of Budapest, in 2009 the rate of HCV infection was 40%. In the two institutes nearly all of the HCV positive prisoners, 34 out of 37 persons, had reported ever injecting drug use.

Among all the prisoners the prevalence rate of hepatitis C infection is fairly low, 4%, ever injecting drug use among prisoners shows significant relationship with hepatitis C infection. In prisons the rate of HIV and hepatitis B infection is very low.

On the basis of the survey performed in the VIII district of Budapest and the national survey, nearly 50% of IDU respondents had been tested for HIV or HCV in the last 12 months before the survey. The incentive provided to the participants in the annual national surveys may have a positive influence on the willingness to participate.

Sharing needles/syringes or injecting equipment among IDUs showed higher prevalence rates during the survey in Budapest (district VIII) (sharing needles/syringes: 33.1%; sharing any injecting equipment: 52.9%) as compared to the national survey (sharing needles/syringes: 26.3%; sharing injecting equipment: 40.5%).

As compared to the great increase in the number of cases in 2008, no outstanding increase could be observed in 2009 in the number of patients needing treatment at the Clinical Toxicology Department of Péterfy Sándor Street Hospital. There was a decrease in the number of heroin and methadone overdoses, at the same time the number of treatments needed because of the overdose of cannabis, cocaine and amphetamine type drugs increased.

In connection with pregnancy during drug use, the results of a survey performed in Budapest among injecting and opiate user women called the attention to a significant problem, the necessity of the more efficient prevention of undesired pregnancies. According to the results of the survey, in the examined population the number of induced abortions for every 100 live births is nearly three times higher than in the general population.

On a national scale an increase can be observed in the number of direct drug-related deaths, but probably it is due to the more efficient identification of the cases. When examining the data in Budapest no significant changes can be observed as compared to the previous years, but here in the last ten years the cases were processed in close cooperation with the police authority and the Institute for Forensic Sciences. In 2009, 30 persons died because of drug overdose (22 in Budapest), and the majority of the cases (28 cases) was due to heroin overdose. In 2009, 8 natural deaths were reported, which could be associated with drug use, and 11 deaths by violence were reported (suicide, murder, accident), when an illicit drug was detected in the deceased person. 17 out of the 50 persons whose death was directly or indirectly related to drug use in 2009 had attended some sort of treatment programme in the preceding four years.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

Overview

In 2009 again needle/syringe programmes (NSP) reported turnover data to the Hungarian National Focal Point on the internet portal set up for data collection in the previous year (See: National Report 2009, chapter 7: Overview). In respect of 2009, in the frame of a pilot project data collection on client data was started on this site beside turnover data. Organisations reported the clients' gender, age and primarily injected drug in the breakdown of different programmes types, which data may provide help at national and local level for more adequate planning and development of programmes aimed at the IDU population.

In 2009 two surveys were carried out regarding harm reduction services in the district VIII of Budapest due to the continuously increasing number of clients and high rate of HCV infection in the area.

7.1. PREVENTION OF DRUG-RELATED EMERGENCIES AND REDUCTION OF DRUG-RELATED DEATHS

Intensive monitoring of the active substance content of hazardous drugs¹¹⁰

In the interest of the prevention of drug-related deaths a project was launched entitled "Intensive monitoring of the active substance content of hazardous drugs". During the investigation of the tragic events of 2008 associated with drug use¹¹¹, the series of deaths due to overdose, the Institute for Forensic Sciences (BSZKI) recommended that a monitoring system be introduced. On the basis of the contract concluded between the National Institute for Drug Prevention (NDI) and the Institute for Forensic Sciences, they started to set up the system in March-April 2009 and started to operate it in May. The costs of the monitoring are ensured from a separate budget with the cooperation of the Drug Coordination Committee and (KKB) and the National Institute for Drug Prevention. The first Monitoring Newsletter was published in July 2009, the second in November.

The aim of the system is to monitor continuously the changing of the purity of drugs in user doses available on the black market and especially dangerous from the aspect of overdose (first of all heroin and amphetamine), as well as the occurrence of rare and hazardous components in drugs available on the black market, and to inform the concerned organisations about the tendencies on a quarterly basis and send immediate warning, if necessary.

In the scope of the project, even in cases not justified for analyzing from the aspect of criminal law, the active substance content of all the heroin and amphetamine seizures is examined, therefore even in a quarterly summary a reliable picture of black market trends can be described due to the amount of measurement results available.

The results collected are evaluated on a quarterly basis (for the data see: chapter 10.3.), but in the case of the occurrence of an outstandingly high percentage of active substance content or a new dangerous compound, immediate warning is issued. The evaluations and warnings are sent to the organisations, outpatient treatment centres, NGOs, NSPs, official and private persons subscribing for the newsletter directly, in an e-mail, and the information collected in the scope of the project are also accessible on the website of the Institute for Forensic Sciences¹¹². The list of subscribers presently contains 117 organisations and persons. The feedback received so far emphasises the usefulness of the monitoring system and the gap-filling effect of its introduction.

¹¹⁰ Based on the report by the Ministry of Justice and Law Enforcement on 2009.

¹¹¹ See: National Report 2009, chapter 6.3.

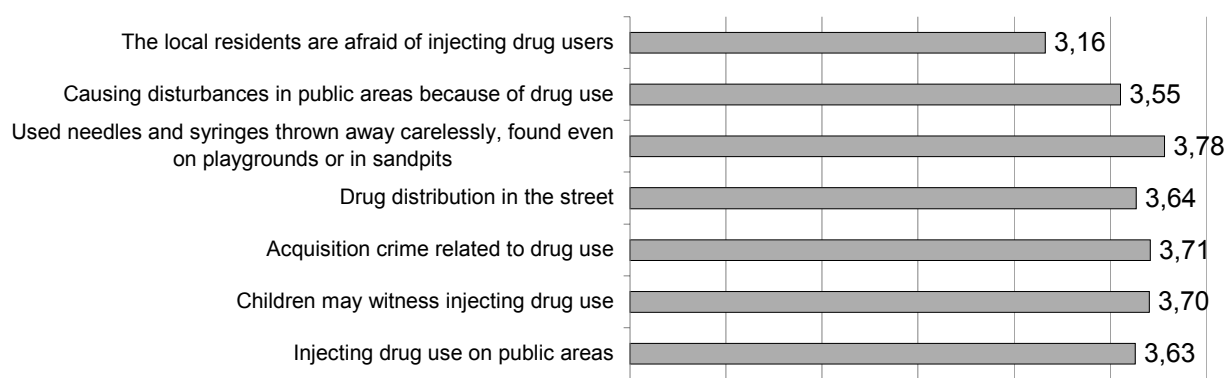
¹¹² www.bszki.hu

Survey of attitudes towards drug consumption rooms among experts and the population

Between July and October 2009 a survey¹¹³ (Rácz et al. 2010) with the support of the National Institute for Drug Prevention was made relating to the attitudes and opinions concerning drug consumption rooms among experts and the residents¹¹⁴ in the district VIII of Budapest. The aim of the survey was to examine the attitudes of the population residing in the area and the experts and politicians of the municipality of Budapest and district VIII concerning the possible establishment of a drug consumption room on Kalvaria square¹¹⁵ in the future. The other aim was to survey the local population's and the experts' perception of the problem of street drug use observed in the area. On the basis of the results proposals are to be prepared concerning necessary professional and methodological criteria and conditions for setting up a drug consumption room. The selection of the location was justified by the characteristics of the increasing injecting drug user scene observed on the area in the recent years (see: chapter 4.2.; chapter 6.1.; chapter 7.2.).

Local residents regard the injecting drug use observed on the area as a problem, as well as the accompanying phenomena, such as the risk to which children are exposed, scandals on public areas, drug distribution, acquisition-related crime. At the same time, they are less afraid of the drug users themselves.

Figure 40. Attitudes observed towards drug use (mean value) among the population residing in the district VIII (N=150), (1=not a problem at all, 2=a little problem, 3=a moderate problem, 4= a huge problem)



Source: Rácz et al. 2010

The experts interviewed have a similar opinion, with the difference that they find causing scandals and public indecency less serious problems.

The residents' attitudes concerning consumption rooms lead to the conclusion that local residents understand the advantages of such rooms, while to a certain extent they are afraid of attracting other users to the area too, and that it would legitimise drug use in people's mind. At the same time – according to their opinion – it would not generate illicit activities

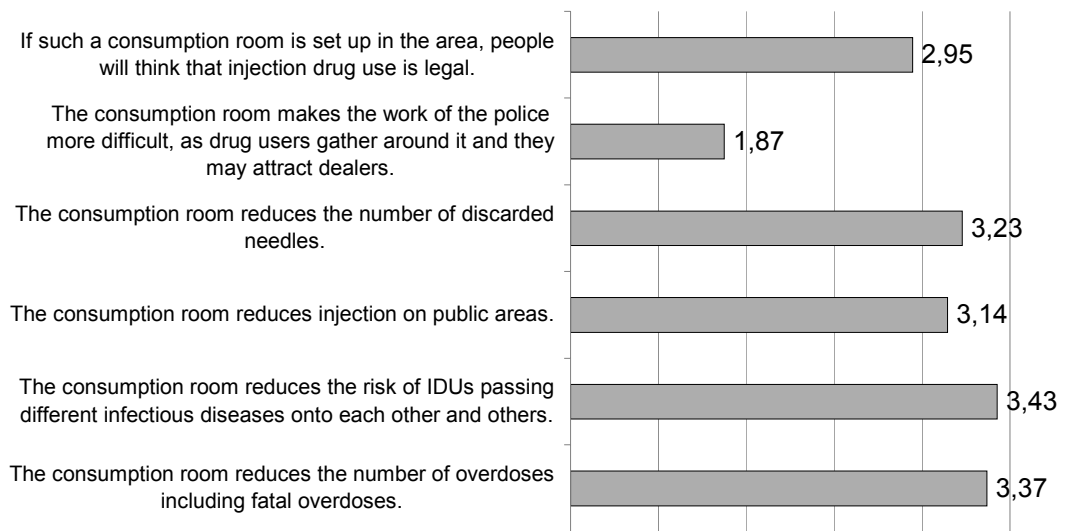
¹¹³ One single measuring tool (hereinafter: questionnaire) was made to survey the attitudes observed in connection with the consumption room and street drug use, which questionnaire was used both among the local residents and the experts. The attitude statements included in the questionnaire were put together on the basis of measuring tools used in the international effect studies (Hedrich, 2004). The sampling method used during the population survey was the "random walking" method. The surveyors asked 150 residents living in the surroundings of the Kalvaria square and 20 experts in the district or in Budapest. In the course of analysing the data – besides the frequencies – the mean of the scale values were calculated, and cross-table, ANOVA and cluster analysis was used.

¹¹⁴ The socio-demographic data of the local residents included in the sample indicate that they can be regarded more disadvantageous basically from several aspects as compared to both the national and the district data. It is especially true in respect of the respondents' disadvantageous employment situation and school qualifications.

¹¹⁵ Square in the district VIII, where at present the NSP of the Blue Point Foundation is operated.

such as drug use or drug dealing so much. The same can be stated in respect of the experts too.

Figure 41. Attitudes observed towards drug consumption rooms (mean value) among the population residing in the district VIII (N=150) (1=does not agree at all; 2=slightly agrees; 3=moderately agrees; 4=very much agrees)



Source: Rácz et al. 2010

The local residents interviewed can be divided into three groups on the basis of how big a problem they find street drug use is, or what they think about the consumption room. Residents within the first cluster (29%) find that nearly all aspects of street drug use are problematic, and they do not recognise the basic advantages of the consumption room. The members of the second cluster (44%) are characterised by an even stronger problem perception than the first cluster, while they understand certain advantages of the consumption room: first of all its possible functions aimed at reducing public health risks occurring as a result of drug use. The members of the third cluster (27%) find street drug use in the area the least problematic, while they think that the consumption room would provide an answer to numerous problems perceived by them too.

7.2. PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

Prevention

Needle/syringe programmes

In 2009 the number of organisations running needle/syringe programmes increased from 18 to 21. Last year NSPs were launched in two new cities, in Nagykanizsa and Ajka, improving by this the coverage of the Western and Central Transdanubian region. As a result of this it can be said that NSPs were available in Budapest and in 13 other cities.

(16_HU_ST10_pilot)

Map 2. Geographical breakdown of NSP service providers in 2009



Source: Hungarian National Focal Point

The service providers distributed a total number of 392,336 syringes, the number of returned+collected syringes was 248,881 (including syringes obtained from syringe vending machines and disposed in the special waste containers placed near the vending machines). The exchange rate was 63% in 2009.

In respect of the number of both returned+collected and distributed syringes, further significant increase could be observed continuing the tendency of the previous years. In 2009, as compared to 2008, 32% more syringes were distributed by the service providers, and the number of returned+collected syringes shows an increase by 41%. The increasing trend is first of all due to the significant increase of the number of syringes distributed / collected in the scope of the programmes with a fixed location, but the increase observed in the number of syringes distributed / collected in the scope of mobile exchange programmes is not insignificant either.

In 2009 the number of clients and contacts indicated a tendency opposite to the reducing tendency observed in the previous year: as compared to 2008 the number of clients participating in NSPs increased by 23%, and the number of contacts increased by 44%. The increase is due to the sudden increase of the client and contact number of fixed NSPs.

(ST10_2010_HU_01)

Table 58. Syringe and client turnover data of NSPs between 2005-2009

	Fixed location	Mobile syringe exchange	Street outreach	Syringe vending machines	Total
2005					
distributed	58,804	5,500	20,823	20,263	105,390
returned (+collected)	32,941	3,722	15,343	496	52,502
exchange rate	56.0%	67.7%	73.7%	2.4%	49.8%
number of clients	440	131	388	-	959
number of contacts	5,172	2,148	1,380	-	8,700
2006					
distributed	102,981	16,689	22,763	22,090	164,523
returned (+collected)	53,907	14,789	12,613	1,002	82,311
exchange rate	52.3%	88.6%	55.4%	4.5%	50.0%
number of clients	900	232	636	-	1,768
number of contacts	6,013	3,117	1,758	-	10,888
2007					
distributed	151,960	16,885	17,687	27,242	213,774
returned (+collected)	75,498	16,848	11,787	1,180	105,313
exchange rate	49.7%	99.8%	66.6%	4.3%	49.3%
number of clients	1,333	145	541	-	2,019
number of contacts	14,570	3,158	10,239	-	27,967
2008					
distributed	234,191	19,567	19,993	24,347	298,098
returned (+collected)	143,458	19,148	12,889	1,174	176,669
exchange rate	61.3%	97.9%	64.5%	4.8%	59.3%
number of clients	1,407	170	367	-	1,944
number of contacts	15,349	1,641	3,786	-	20,776
2009					
distributed	317,579	34,326	23,033	17,398	392,336
returned (+collected)	196,541	32,375	19,694	271	248,881
exchange rate	62%	94%	86%	2%	63%
number of clients	2,020	148	231	0	2,399
number of contacts	21,661	2,515	5,800	0	29,976

Source: Hungarian National Focal Point

As the client and contact data increased in line with the number of distributed and returned+collected syringes, the number of distributed and returned+collected syringes per client did not increase as significantly as in the previous year. The number of distributed syringes per person increased to 156 (in 2008: 141 syringes), and the number of distributed syringes per contact remained 13. The same tendency can be observed in the case of returned+collected syringes: in 2009 the number of returned+collected syringes per client slightly increased, it was 103 (in 2008: 90), while the number of returned+collected syringes per contact remained 8. In 2009 the mean number of contacts per client increased as compared to 2008, the number of contacts per client was 13 (in 2008: 11).

Table 59. The number of distributed and returned+collected syringes per client/contact in 2009

Type of programme	distributed / client	(returned+collected) / client	distributed / contact	(returned+collected) / contact	contact / client
Fixed location	157.2	97.3	14.7	9.1	10.7
Mobile (by van)	231.9	218.8	13.6	12.9	17.0
Street Outreach	99.7	85.3	4.0	3.4	25.1
Total	156.3	103.6	12.5	8.3	12.5

Source: Hungarian National Focal Point

In 2009 fixed NSPs were operated by 17 organisations as compared to the previous year's 12 organisations, 3 of them were located in Budapest and 14 were located outside of Budapest. In Budapest the Art Éra Foundation started its operation in the VII. district, beside

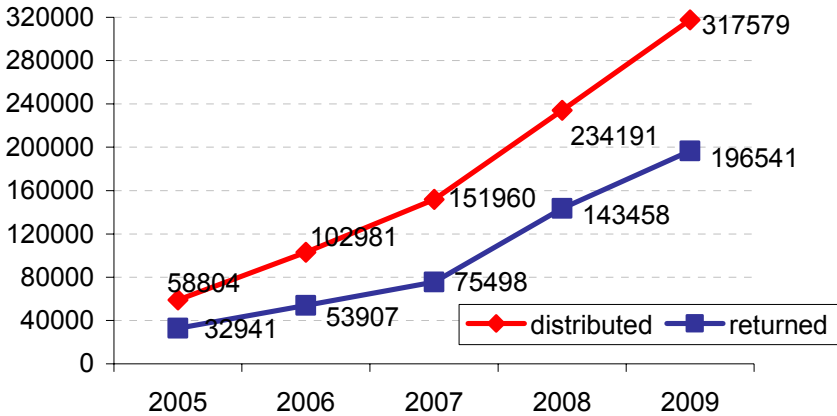
the two other NSPs operating for several years with a large turnover (in the district VIII and the XIII. district). In Nagykanizsa the Zala County Organisation of the Hungarian Red Cross started its programme with a fixed location, which is the first NSP in the Western Transdanubian region. Besides Veszprém, the Alcohol-Drug Specialised Outpatient Treatment Centre also started to operate a fixed NSP in Ajka. In Gyula the Independent Association started a fixed NSP beside its street outreach programme. In Szeged the Dr. Farkasinszky Terézia Youth Drug Centre took over tasks relating to needle exchange services from the South Hungarian Harm Reduction Association, and in 2009 it performed these tasks in the scope of a fixed-location service.

The total number of syringes distributed in the scope of the 17 programmes was 317,579, which represents an increase by 36% as compared to the previous year. The number of returned syringes was 196,541, which also indicates a significant (37%) increase as compared to the previous year.

First of all the change is due to the Budapest data, especially the two largest service providers. In 2009 the Blue Point Foundation distributed 37% more syringes (145,294 syringes), and the number of returned syringes increased in the same proportion (66,878 syringes). At the Drug Prevention Foundation the number of distributed syringes increased by 20% (151,429 syringes), and the number of returned syringes increased by 27% (116,802 syringes). Furthermore, the increasing tendency is also due to the data of a new service provider in Budapest, which started its operation in 2009 (Art Éra Foundation: distributed syringes: 6,418; returned syringes: 3,979).

Outside of Budapest, there was a significant increase in the scope of two fixed NSPs based in Miskolc, both in respect of distributed and returned syringes. In Szeged only a fixed NSP were operated in 2009, so the turnover data there appear only under this programme type. At the other organisations the number of distributed / returned syringes is relatively stagnating, significant decrease could only be observed in the case of the Alcohol-Drug Specialised Outpatient Treatment Centre in Veszprém.

Figure 42. Number of syringes distributed and returned at fixed NSPs between 2005-2009



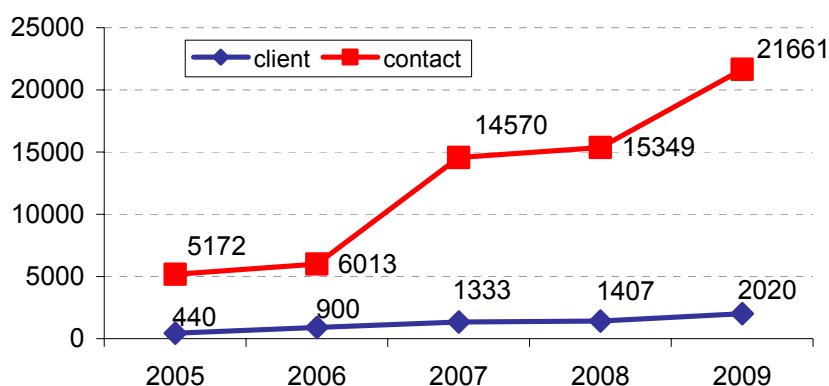
Source: Hungarian National Focal Point

By 2009 the number of clients at fixed NSPs increased significantly as compared to the previous year, the organisations registered a total number of 2,020 clients, which indicates a 43% increase as compared to 2008. The number of contacts also increased, nearly in the same proportion (by 41.3%) as the number of clients. Consequently the number of contacts per client was nearly the same as in the pervious year (10.7).

Besides the newly launched programmes, the significant increase is first of all due to the increase in client / contact numbers in the programmes of the two large service providers in Budapest again. The number of clients at the Blue Point Foundation increased by 35% (in

2008: 833; in 2009: 1,128), as a result of which the number of their contacts also increased nearly in the same proportion. A less substantial, but still significant increasing tendency could be observed in the case of the Drug Prevention Foundation too: by 2009 the number of their clients increased by 27% (615 clients) and the number of contacts increased by 21%. In respect of 2009, a stable increasing tendency could also be observed in the client and contact numbers of most of the programmes launched in 2008 outside of Budapest (Specialised Outpatient Treatment Centre Foundation – Miskolc; MI-ÉRTÜNK [For Us] Prevention and Aid Association – Orosháza; Micro-regional Social and Child Welfare Service Centre, Low-Threshold Addiction Treatment Service – Salgótarján). Exceptions from this are the INDIT Public Foundation’s Tükör Somogy County Outpatient Treatment Centre and Kaposvár Day Treatment Unit for Addicts, where the number of clients and contacts dropped to a minimal level in 2009.

Figure 43. Number of clients and contacts in fixed NSPs between 2005-2009



Source: Hungarian National Focal Point

In 2009 again mobile NSP was realised only by 2 organisations, 1 in Budapest and 1 in Miskolc. The number of distributed syringes indicated an increase by 75% as compared to 2008, and the number of returned+collected syringes increased by 69%. The increase was due first of all to the data of the Hungarian Baptist Aid in Budapest (distributed syringes: 33,094; returned+collected syringes: 31,983).

In 2009 the number of clients reduced, but as opposed to this, the number of contacts increased, so one client used mobile NSPs more frequently as compared to 2008. While in 2008 the number of contacts per client was 10, in 2009 it increased to 17.

The number of street outreach programmes facilitating the discovery of hidden IDUs and making needle/syringe exchange available to them the most efficiently increased from 11 to 12 in 2009, in Budapest there are 5 programmes, and outside of Budapest there are 7 programmes. From 2009 the Drug Prevention Foundation operates 2 street outreach programmes in Budapest, one of them still in the district called “Dzsumbuj”, in cooperation with the Blue Point Foundation, and the other one in district XV. Furthermore, starting from 2009 the Specialised Outpatient Treatment Centre Foundation in Miskolc extended its services by adding the street outreach programme, so now the organisation deals with all four programme types. In Szeged the street outreach programme provided by the South Hungarian Harm Reduction Association had terminated, the tasks relating to needle exchange services were taken over by the Dr. Farkasinszky Terézia Youth Drug Centre in the scope of a fixed NSP.

In the scope of street outreach programmes a total number of 23,033 syringes were distributed at national level, as a result of which the increasing tendency first observed in the previous year continued. The number of returned+collected syringes increased at a much higher rate than this – by 53% –, so in 2009 the exchange rate was 86%. It is due to the fact

that several organisations only collect used syringes in the scope of the outreach programmes, while they divert their clients to their fixed NSPs and provide sterile syringes for them in the scope of fixed NSPs. The increasing tendency is due to the data of the Hungarian Baptist Aid in Budapest, the Drug Prevention Foundation and the Specialised Outpatient Treatment Centre Foundation in Miskolc.

The number of clients continued to decrease, the rate of decrease was 37%, and one of the practical reasons for this is, as it has been mentioned above, that several organisations divert their clients to their fixed NSPs, so many clients are registered under fixed programmes. As opposed to this, the number of contacts increased significantly, by 53%, this tendency is mainly due to the data of the Hungarian Baptist Aid in Budapest, where the contact numbers increased in both street outreach programmes realised in Buda and in Pest.

The syringe turnover of vending machines reduced by 29%, and the number of returned+collected syringes also indicates a significant reduction. The most significant reduction in the number of sold syringes can be observed in the case of the syringe vending machines operated by Nyíró Gyula Hospital in Budapest and by the Specialised Outpatient Treatment Centre Foundation in Miskolc. In the case of both vending machines it can be stated that in the given cities other types of NSPs were started in 2009, and the number of syringes distributed and returned in the scope of other types of programmes significantly increased. In Budapest the decreasing tendency may also be due to that the vending machine was sometimes out of service.

In the scope of most NSPs, besides sterile syringes and injecting equipment, condoms are also distributed for clients.

On the internet portal collecting the turnover data of NSPs, pilot project of collecting information about clients was started in 2009. Clients' gender, primary substance and age were recorded by the organisations broken down per programme type; for the data see chapter 4.2.

In the scope of the NSP with the greatest turnover in Hungary¹¹⁶ the clients' drug use patterns were surveyed in 2009. For the data see chapter 4.2.

Counselling, testing

The 676 IDUs providing samples during the HIV/HBV/HCV national screening programme¹¹⁷ organised by the National Centre for Epidemiology between 5 September and 15 December 2009 were informed about their test results by the staff of the 20 participating specialised outpatient treatment centres and NSPs. In the case of a positive result persons infected by HBV or HCV were provided with appropriate information about what can be done to prevent the spreading of the infection and where they can turn to for further medical care.

Before starting the screening programme in 2009, the National Centre for Epidemiology held a coordination meeting and organised a three-day counselling training for the staff of the specialised outpatient treatment centres and NSPs collecting blood samples. A total number of 25 participants attended the training course from several parts of the country. At the meeting the practical issues of the screening programme of 2009 were also discussed (dried blood spot testing, using aseptic technique), and specialists gave lectures on the possible bacterial and viral infections related to injecting drug use and on sexually transmitted diseases. In the following, the staff taking samples and issuing test results acquired the theory and practice of counselling and testing. The training courses in small groups were

¹¹⁶ The NSP of the Blue Point Drug Counselling Centre and Foundation.

¹¹⁷ For the results of the 2009 screening programme see: chapter 6.1.

held by highly experienced specialists. One of the training materials was the publication issued by EMCDDA in 2009¹¹⁸.

Since 2006 the Ministry of Health has continuously ensured the financial background for the annual screening of IDUs lasting for 2 months for the purpose of the HIV/HBV/HCV prevalence survey.

The NSP of the Blue Point Foundation based in the district VIII contributed to the screening programme with 20 samples in 2006, and with 70 samples in 2007. In both cases the highest rate of HCV positivity was found among the samples provided by this particular NSP, 75% of the IDUs proved to be HCV antibody positive in both years.

In order to handle the critical situation, the National Centre for Epidemiology and the Blue Point Foundation labelled a separate amount for examining 150 samples. The 150 samples were collected by the staff of the foundation in the period between September 2008 and July 2009, by offering the possibility of the screening test to the clients contacting the NSP, as a continuously available service. During the screening the procedure of dried blood spot testing¹¹⁹ used during the national screening programme was followed. (For the results see chapter 6.1.)

On 1 December 2009, on the World AIDS Day, the Blue Point Foundation organised a conference¹²⁰ discussing the situation observed in the district VIII: rapid increase in the number of clients participating in the NSP and HCV infection of an average rate of 70% observed for years (for further information on the situation see: chapter 4.2.; chapter 6.1.). The conference entitled "Injecting drug user scenes in Józsefváros" was organised in order to start a cooperation process in the district and initiating a dialogue between the decision makers in the district. Before the conference, in September 2009 an information campaign was launched, and official letter was written to the decision makers of the district VIII, that is to the vice mayors of the district, to the National Public Health and Medical Officer Service (ÁNTSZ), to the police commander, to the drug coordinator and the chief mayor of Budapest, and to the National Coordination Directorate on Drug Affairs of the Ministry of Social Affairs and Labour. One of the long-term aims of the conference was to draw people's attention to the current situation and to point out that the situation can only be solved or improved, if the local government, ÁNTSZ and the local NGOs collaborate. As a part of the solution they made a proposal relating to the development and extension of the already existing harm reduction services and to the introduction of missing harm reduction services.

In 2009, on the World AIDS Day the event in Budapest entitled "Protect Yourself" was organised by the civil AIDS Forum. The programme included lectures for young adults, individual counselling, and free and anonymous HIV testing.

In the interest of the early diagnosis of HIV infection, the National Medical Officer Service operates 17 anonymous HIV/AIDS counselling services to ensure the availability of voluntary and free HIV/AIDS screening tests for the individuals.

In 2009 again, during the period of the largest Hungarian music festival (Sziget festival), the Ministry of Health provided anonymous HIV testing and counselling for the participants on the site, with the help of a rapid test indicating the result within half an hour. The screening was performed by the experienced employees of the National Centre for Epidemiology (3 doctors and 3 assistants) at the location of the festival. Before testing and on handing over the results the specialists provided counselling. Besides dried blood spot testing and

¹¹⁸ Blystad H., Wiessing L., Guidance on Provider-initiated Voluntary Medical Examination, Testing and Counselling for Infectious Diseases in Injecting Drug Users. Pre-final unedited version 5.5. Lisbon, EMCDDA, 2009. The publication was translated into Hungarian by the Hungarian National Focal Point.

¹¹⁹ See: Annual Report of 2007, chapter 6.2.

¹²⁰ Source: Press material: Intravénás droghasználói szcénák a Józsefvárosban <http://www.kekpont.hu/narkogetto.htm> (5 July 2010)

counselling, in the tent of the organisations leaflets providing information on infections could also be obtained. Clients could wait for the result of the test on the site, and while they were waiting they were asked to fill in a questionnaire on risk behaviours prepared by the Hungarian National Focal Point. During the period of three days a total number of 111 persons took part in HIV testing and counselling and filled in the questionnaire. The rapid test indicated a negative result in the case of all clients.

Besides the National Centre for Epidemiology, the Pluss Foundation also performed testing and counselling activity during the Sziget Festival.

With the collaboration of the Foundation for Patients with Liver Disease, visitors could take part in free HBV and HCV testing and counselling as well during the Sziget Festival, the blood samples were tested in the Szent László Hospital, and on the following day the participants were informed about their results on the basis of serial numbers. During the period of 3 days a total number of 322 persons took part in the free testing and counselling, in the case of 3 persons hepatitis C positivity, in the case of 1 persons hepatitis B positivity was detected, and in the case of 2 persons the result of the hepatitis B test was inconclusive.

Community-based street outreach model programme among IDUs in Budapest

In 2009 a survey was carried out entitled “Pilot-study on community-based street outreach model programme among IDUs in Budapest” (Rácz et al. 2009). The most important aim of the survey was to elaborate and realise a model programme, currently not operating in Hungary, aimed at the prevention of blood-borne infectious diseases (HIV and HCV) for IDUs living in the district VIII in marginalised circumstances. The other main aim was to analyse the effect of the intervention aimed at changing the attitudes and awareness relating to infections.

In accordance with this, during the survey, in February 2009 an information and counselling programme relating to HIV and HCV infection was started with the participation of 87 disadvantaged IDUs¹²¹ living in the district VIII in marginalised circumstances. Random sampling method was applied.¹²² The programme (data recording and counselling) ended in July 2009.

The participants were classified in two groups. Half of the IDUs formed the intervention group, where they took part in a special counselling programme based on a community-based street outreach model programme developed by the National Institute on Drug Abuse (NIDA) for drug users, aimed at the reduction and prevention of different blood-borne infectious diseases. The other half of the sample formed the control group, where they completed a general counselling programme also aimed at HIV and HCV infection. Finally, 43 persons started the programme in the control group, and 44 persons in the experimental group. During the programme 12 persons dropped out of the experimental group, and 11 persons from the control group, which means that they did not participate in all three counselling sessions. Statistically there were no significant differences between the two groups in respect of socio-demography, drug use or their knowledge on HIV/HCV infections, which were basic criteria for being able to realise any type of intervention and being able to measure its effect.

¹²¹ Those IDUs were recruited in the sample, who were in a socially excluded situation, had lower school qualifications or lower employment status, were exposed to residential segregation (certain parts of the district VIII in Budapest), who injected drugs at least once within the period of 30 days before the interview who had never attended HIV or HCV screening, or they had attended such screening but did not return for their results (that is they did not know the result of the test, therefore no health-conscious attitude could be presumed on their part). A further criterion was that the persons included in the sample had to be over the age of 18.

¹²² From a methodological aspect no representative sample was required for the present survey, a much more significant aspect was the parallel use of the intervention and the control group, in other words ensuring the similarity of the two groups in the main dimensions (socio-demographic characteristics). This similarity was ensured by random selection, but during the survey the changes in the composition of the intervention and control sample was continuously monitored with statistical analyses. Data recording was realised in the NSP of the Blue Point Drug Counselling and Specialised Outpatient Treatment Centre.

The short-term effect of the programme was surveyed with the help of a follow-up study. The educators held three counselling sessions for the participants.¹²³

In respect of distribution by gender, 80% of the 87 persons were men and 20% were women. The average age of the persons included in the sample was 30.7 years. 47% of the sample self-reported being Hungarian, while 64% self-reported being Roma or Roma and Hungarian. 46% of the sample had already been in prison. (For further socio-demographic data see: chapter 8.1.)

Most of them (85%) had already used herbal cannabis in their lives, which was followed by ever amphetamine use (80%) and ever heroin use (78%). The lifetime prevalence rate of cocaine use is also significant (52%), while 17% had used crack in their lives.

The data relating to the last 30 days indicate that the frequency of heroin use is outstanding (average value: 33 occasions), which is followed by other opiates with 13 occasions. In respect of injecting in the last 30 days, there is no significant difference ($p=0.74$; $p=0.16$) between the two groups either in the case of heroin (37 occasions in the total sample), or in the case of amphetamines (11 occasions in the total sample).

Herbal cannabis was tried at the earliest point in their lives (mean age: 18), it was followed by amphetamines (mean age 19.8). The age at first use of amphetamines and heroin (mean age: 21.5), cocaine (mean age 21.7) and heroin and crack (mean age: 22.5 years, 22.3 years) are all represented by similar values. Mean years since start of regular use in the sample was 11.8 years.

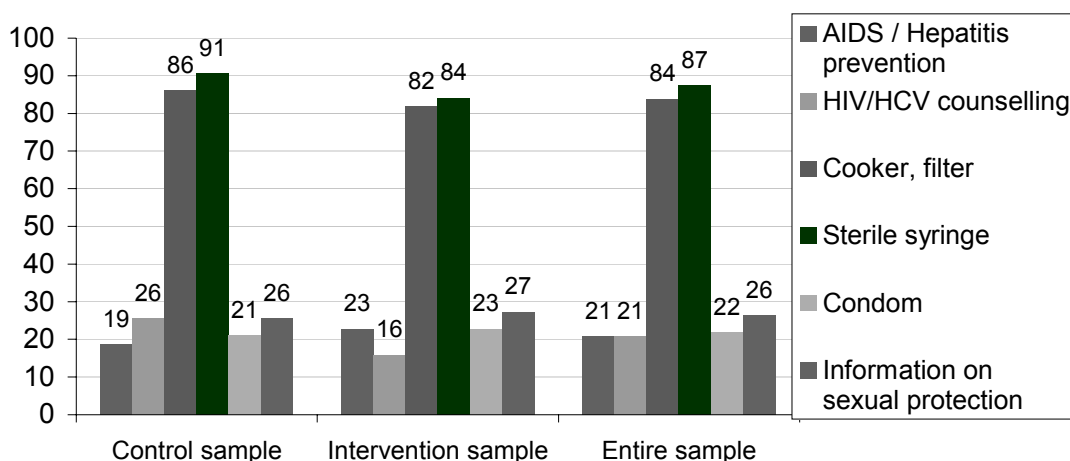
In respect of the addiction indicators of both heroin and amphetamine the composition of the two groups was identical, which means that individuals with the same degree of dependence were included in both groups. It is also valid in respect of the members of both groups that their heroin dependence index was medium strong (9.3 and 9.5), while their amphetamine dependence was average (7.8 and 7.6).¹²⁴

A significant number of the participants in the programme said that during the last 30 days they had access to sterile syringes and injecting equipment. At the same time, a significant part of the sample had not obtained either condoms or information on safe sexual behaviour.

¹²³ The questionnaire used for evaluating the programme (face-to-face, structured interview) had been elaborated earlier. The basic data was collected at the first counselling session, while follow-up took place 30 days after the end of the programme. The counsellors took part in a training course, where they acquired the content of the counselling with the help of "NIDA cards" (NIDA, 2000). The "NIDA cards" contained thoroughly structured information on HIV and hepatitis infection, testing, and the prevention of infection. The translations were revised by a Hungarian specialist. Certain cards belonged to the individual counselling sessions, and the counsellors had to educate the clients about the content of the cards. The content of the "control" counselling (unstructured "conversation) followed the ordinary topics of the Blue Point Foundation's programmes on hepatitis C infection, testing and the prevention of infection. During the elaboration of the survey tool the experience obtained from surveys was used, which were carried out for similar objectives (programmes relating to HIV, HCV testing and counselling) and provided reliable results. The recording of the questionnaires took 45-60 minutes each. The questionnaires were recorded by 9 educators participating in the programme. The interviewers were employees of the Blue Point Foundation, who took part in a 2x2-hour interviewer training course at the beginning of the programme.

¹²⁴ In the dependence index, on a scale of 1-16, 16 represents the strongest dependence.

Figure 44. Services received in the last 30 days among the respondents (%)



Source: Rácz et al. 2009

22% of the sample had never attended HIV testing, while 61% had participated in HIV testing on 1-4 occasions, and 17% on 5 or more occasions. In this respect there was no significant difference between the two groups ($p=0.66$). The proportions are similar in respect of earlier participation in hepatitis C screening too.¹²⁵

More than one-third of the sample (34.5%) was infected with HCV. Among the members of the intervention group the proportion of infected persons was 27%, while in the control group their proportion was 42%. Although the difference seems great, it is not statistically significant ($p=0.11$).

It was also examined what preliminary information the clients in the programme had in connection with the different infections and the transmission of infections.¹²⁶ The result shows that the preliminary knowledge of the participants in the programme is at an average level of 11.5 points, which can be regarded as a strong intermediate level of knowledge. At the same time, the high standard deviation value ($SD=3$) indicates that participants starting the programme had quite different levels of knowledge.

30% of the sample said that they had never shared needles/syringes in their lives, 48% shared needles/syringes on 1-10 occasions, and 22% on more than 10 occasions. In the last 30 days only 18% of the sample had used someone else's needle/syringe, and the two groups were not different from each other in this respect ($p=0.62$).

37% of the sample said that they had never used cookers, filters and/or water for dissolving, which had been used by someone else before, 36% had used on 1-10 occasions, and 28% on more than 10 occasions. In the last 30 days slightly more than one-third of the sample had shared injecting equipment, their proportion is similar among the members of both the intervention and the control group ($p=0.71$).

Only 15% of the sample had ever used injecting equipment about which they knew that it had been used before by a person infected with HCV. This high-risk group is distributed in more or less similar proportions in the two groups ($p=0.34$).

When examining the results it can be determined that in the examined dimensions practically no factors were found that would significantly influence dropping out from the counselling programmes. Despite this – in respect of dropping out – certain associations and patterns can be observed. Among the ones who dropped out a higher proportion of men and

¹²⁵ Although a significant part of the sample had been tested for HIV or HCV in their lives, the high rates of testing uptake are also due first of all to the systematic annual screening campaigns started in 2006 (see: chapter 6.1.).

¹²⁶ It was measured with the help of a question providing several attitude statements. In the scope of data reduction, one single variable / indicator was created from the 16 attitude statements: one point was granted for each right answer, so the maximum number of points that could be reached was 16. Each statement related to the circumstances of transmitting HIV or HCV.

unemployed persons were found. The former fact may be explained with women's stronger disposition to follow norms: they seemed less inclined to discontinue the already started programme and counselling. Among those who dropped out there was also a higher proportion of persons who had never been tested before. Possible it may be due to that these clients – as opposed to the ones who had been persuaded to participate in screening as having more favourable client-service provider relationships during earlier screening campaigns – could not establish such a relationship with the staff working in the counselling programme, which could help them stay in the programme. It can also be presumed that they did not attend the screening because they were afraid or not interested: the clients did not want to know whether they were infected; at the same time this fear or the lack of interest may catalyze further non-attendance of the programme. Among those who dropped out there was also a higher proportion of persons who had less preliminary knowledge about infectious diseases. In connection with this it is interesting that the lack of knowledge did not strengthen the continuation of the programme, it did not encourage the clients to learn more about infectious diseases. Another fact, which is difficult to interpret is that among the persons who dropped out there was a higher proportion of those who had a shorter history of drug use and of those whose heroin dependence was slightly stronger. The hypothesis may be that these drug users are not (yet) in the phase of their history of drug use where they show interest for prevention/counselling programmes. However, further additional studies are needed to prove the validity of these hypotheses.

In connection with the efficiency of the programme a change was experienced basically in three respects within the groups: the most prominent change was observed in respect of knowledge, actual action, and – although less typically – perception. Another important statement is that between the two groups – except for a few indicators – practically the same efficiency rate can be determined, that is the two different forms of interventions had very similar effects.

The knowledge level of those who participated in the special counselling programme increased significantly after the intervention, while the standard deviations between the knowledge levels decreased, that is the intervention group became more homogenous in respect of the level of knowledge. Nearly the same can be said about the members of the control group too. At the same time, on comparing the final knowledge level of the two groups, it can be seen that there is no significant difference regarding the knowledge indicators, that is the knowledge of the two groups increased to practically the same level by the end of the intervention, so in this respect the two forms of intervention seemed identically efficient.

More favourable efficiency indicators were experienced in the control group in connection with reduced injecting drug use, both in respect of comparison within the group and between the groups. At the same time, reduced drug use by itself does not represent reduced risk. It can be determined that the members of the intervention group reduced needle/syringe sharing to a greater extent during the period of 30 days following the intervention, than the members of the control group. Although the change is not significant, but it is remarkable: 100% of the members of the intervention group and 78% of the members of the control group reduced needle/syringe sharing.

After the intervention, in the control group significantly better indicators were observed in other, so-called prevention and risk dimensions too, such as reducing the number of sex partners or the proportion of participants in screening (the difference is not significant). Furthermore, in the case of both groups the proportion of those who participated in further HIV / HCV counselling programmes after the intervention increased significantly, at the same time there is no difference between the two groups in this respect either. Consequently in respect of the latter it can be stated that the clients' motivation for participating in testing and counselling programmes could be increased independently from the form of intervention.

A further result was that after the intervention the members of the control group felt to a significantly greater extent that they were more exposed to HCV infection because of injecting.

It was also observed that the increasing of knowledge was not necessarily accompanied by actual action: in respect of important dimensions such as needle/syringe and equipment sharing, the frequency and intensity of drug use, or polydrug use, no significant changes could be observed. On the one part it may be due to the relatively high dependence and strong tendency to use drugs in both groups, and on the other part it may be due to that these changes in attitude cannot be expected as a short-term effect, after only one month. Although a six-month follow-up study could answer this question too, and more favourable indicators would be experienced in these dimensions too, however, regular help and further counselling, motivation training courses would also be definitely needed for this. At the same time it is worth the attention that in smaller risk dimensions, such as the inclination to participate in testing and further counselling, the success of the programme can be detected. A further deficiency, which was revealed and must be pointed out is that both forms of counselling was organised in the NSP of the Blue Point Foundation, where a regular needle/syringe programme (involving an average of 30 clients a day) and counselling on other issues also operates in the same space. The survey had to be performed in this environment, so it was not possible to have personal face-to-face conversations separated from the others. This issue also points out the necessity of several separate rooms for the operation of a possible multi-function needle/syringe programme.

Treatment

In 2009 again, the Unified Szent István and Szent László Hospital and Outpatient Clinic of the Budapest Municipality organised an accredited training course for GPs and specialists in internal medicine entitled "HIV Infection in Everyday Medical Practice".

Antiviral treatment among HCV positive ever IDUs

In 2009 a research (Gazdag and Horváth 2009) was carried out to determine the antiviral treatment costs of HCV positive clients who used to inject drugs. Among the patients who appeared at the Hepatology Department of Szent László Hospital, Budapest, between 1 January 2006 and 31 December 2008, the medical records of those were selected, in the history of whom injecting drug use was mentioned. In the above period the appearance of 123 persons was identified, who had ever injected drugs. The cases were selected on the basis of individual judgement.

Besides the costs (for the calculations relating to treatment costs see chapter 1.3.), the study also analysed the barriers of entering treatment in respect of ever IDU patients. In the case of 36 persons (29.2%) out of the 123 identified cases a combination therapy using pegylated interferon and ribavirin was started. In Hungary the alternative conditions of entering treatment are: elevated liver function (GOT, GPT, GGT) parameters measured on three occasions within a period of six months, or if liver biopsy or a FibroScan test indicates inflammation. In Hungary contraindications of the treatment may be addiction diseases and untreated psychiatric diseases, besides other factors. In accordance with the above, the main identified barriers to entering treatment among former IDUs were: lack of abstinence¹²⁷, discontinuation during the period of the treatment authorisation procedure (about 3 months), unsettled health insurance, occurrence of comorbid psychiatric conditions, and being deterred by the side effects of the treatment or by liver biopsy. The National Health Insurance Fund does not refund the costs of the FibroScan test (EUR 68.44), and for drug users it may represent a further hindrance to access. Among the 123 cases that could be associated with injecting drug use, there were 97 men and 26 women, their average age was 30.4 years. A significant difference ($p < 0.001$) could be observed in respect of the average age of clients

¹²⁷ In the HCV treatment protocol valid at the time of the survey the following is listed among the contraindications: Addiction disease: obviously existing drug or alcohol dependence. (HCV Protocol 2009)

entering treatment and not treated clients, those who did not enter antiviral treatment were typically younger (28.8 years) than those who finally entered treatment (34.3 years).

Beside the group of 36 patients, in the case of whom the combination therapy using pegylated interferon and ribavirin was started, a control group of the same size consisting of patients who were not drug users was set up adjusted by gender and age, in order to identify differences. The antiviral treatment was shorter in the ever IDU group (26.7 weeks), than in the non-IDU group (34.7 weeks), the difference was significant ($p=0.043$). In the group of former IDUs, by the 12th week of the treatment 50% of the surveyed population and by the 24th week of the treatment 61% of the surveyed population responded to the treatment, that is they became HCV-PCR negative. As opposed to this, in the control group 25% responded to the treatment in the 12th week and 47% in the 24th week. In the 12th week the ever IDU group showed an improvement of a significantly higher proportion ($p=0.004$) than the control group. By the 24th week this difference was not significant any more, which indicates more rapid viral response in the case of former drug users. Another factor indicating that former IDU patients respond to the antiviral treatment more favourably is that among them it occurred less frequently that the treatment had to be discontinued because of inefficiency, and cases in which the treatment needed to be lengthened to 18 months were also less common, though these differences did not reach the significance level.¹²⁸ Among former IDU patients the treatment was discontinued significantly ($p=0.016$) more frequently, in the case of 10 persons, than in the control group.

Due to the available data, a further aspect of the survey was to examine how many patients entered treatment from the patients who proved to be antibody positive during the national screening programmes aimed at the prevalence of HCV, performed between 2006 and 2008 among IDUs (for more detail see chapter 6.1.). The counselling and treatment of hepatitis C antibody positive ever IDU clients tested in Budapest was undertaken by the Hepatology Department of Szent László Hospital. During the 3 years of the screening programmes a total number of 234 persons proved to be HCV positive (in 2006: 59 persons, in 2007: 94 persons, in 2008: 81 persons) at the testing sites in Budapest, and only 23 of them (10%) consulted a hepatologist¹²⁹. Although the surveyed hepatology outpatient clinic is the largest institute specialised in this field in Budapest, it is possible that tested IDUs contacted a different hepatology clinic, or applied for treatment in 2009, the year after the study was finished. In any case, the results justify the need for development of the counselling, case-management and follow-up of patients tested positive for HCV on the service providers' part.

7.3. INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES

Prevention of road accidents related to drug use

In 2009 again Hungary participated in the TISPOL international road monitoring campaign, the aim of which was to force back driving under the influence of alcohol or illicit drugs. Monitoring took place on 3 days in June and on 3 days in December, it lasted for 8 hours every day and covered the whole territory of the country. In June 4 out of the 621 tests were positive for substances indicating drug use according to the preliminary screening (rapid tests) of urine samples, while in December none of the 2,098 tests was positive.

¹²⁸ This survey did not cover the causes of the more rapid and more favourable viral response.

¹²⁹ The cases were identified on the basis of anonymous individual identification codes used during the screening. For information on the methodology of the screening see: Annual Report 2007, chapter 6.2.

Interventions concerning drug-using pregnant women and their children

Care provided for pregnant women

In 2009 the low-threshold services provided by the Sober Babies self-help group of drug user parents established in 2006 were extended with psychotherapy and family law counselling.

Since autumn 2009 the Sober Babies Club has been using a three-step model, which is based on the experience gained on the site. The programme is entitled “Alternative Prenatal Care”, in the first step of which a member of the Sober Babies self-help group on duty can be contacted, in the second step the local anonymous professional counselling service can be used, and in the third step, with the cooperation of a self-helper and/or professional helper, the participants of “ordinary” prenatal care can be contacted (district nurse, family doctor, obstetrician-gynaecologist).

The staff working in the programme performs case management, and – with the clients’ approval – they organise case conferences involving relatives and participants of the healthcare system. In 2009 case conferences were organised in the case of 3 clients, on 4 occasions. The relationship established in this way between the different participants of the healthcare system proved to be useful, as the participants not having experience in addiction treatment (guardianship authority, district nurses, etc.) may regard it as some sort of guarantee, if an addiction service provider also takes part in handling a critical case. Furthermore, by this clients can also prevent legal problems occurring in connection with the placement of a child.

In the scope of the family law counselling launched in 2009, the service was contacted typically in connection with issues such as child placement, right to parental control, communication, controlled communication. Family law aid may be supplemented with psychotherapy, addiction or family counselling, social work, or – upon request – the personal participation of a member of the Sober Babies group in any element of the service system.

In 2009 again, in the scope of their low-threshold service, rapid pregnancy tests were available free of charge, during the year they distributed 40 of these tests.

The fact that there is demand for the services provided by the Sober Babies Club and that the club is becoming more widely known is demonstrated by that in 2009 their low-threshold services were contacted on 10,770 occasions, which represents an increase in turnover by nearly 50% as compared to 2008 (7,318 occasions). They can be contacted in person, via a representative or on the telephone. In 14-15% of the cases, in the case of 70-80 persons, the pregnant condition of drug user women, or the drug user status of mothers with a maximum 12-month old child could be identified.

Qualitative survey of the prenatal care provided for drug user pregnant women in Budapest

In 2009 Kaló and Rácz carried out a survey¹³⁰ (Kaló és Rácz 2009) among drug user pregnant women and specialists participating in prenatal care. Active drug user women or

¹³⁰ The survey was performed by the Hungarian Academy of Sciences, Institute for Psychology, and it was financed by the Ministry of Social Affairs and Labour (project code: KAB-KT-M_08_09). 20 persons were included in the drug users’ sample, the conditions of being included in the sample were the coexistence of drug use and pregnant condition. The respondents were selected at the location of a low-threshold service provider based in the district VIII, from the clients of the service, from persons contacting the service because of the survey (because of the motivation fee offered even drug users suiting the conditions contacted the service, who had not been among the clients of the service before), and from persons recruited during fieldwork. The specialists were selected from the staff of Gynaecology Clinics No.1, the Sober Babies Club and the network of district nurses in the district VIII.

women who used drugs during their pregnancy living in the district VIII were included in the drug users' sample, who were pregnant at the time when the data was recorded or had a baby within the period of 6 months preceding data recording. Health specialists working in the district VIII, selected at random or on the basis of recommendation were included in the specialists' sample.

The average age of the 20 drug user women included in the sample was 28.8 years, the youngest respondent was 18, the oldest respondent was 43 years old. The majority of the respondents already had at least one child, so they had been in contact with the healthcare system before as pregnant women (1 woman had three children, 5 women had two children, and 5 women had one child). 3 women planned their current pregnancy, 16 women did not plan it, and one person did not answer the question. From the aspect of drug use 12 women said that they had used an illicit drug within the preceding 30 days, and due to the conditions of being included in the sample, obviously all the respondents had used drugs in their lives.

On the basis of the qualitative survey, in the case of drug user pregnant women one of the typical sources of ambivalence was the acceptance of the pregnancy and informing their environment. The reaction of the majority of the people surrounding the pregnant women was that they should quit drug use immediately, and they were condemned, if they did not do so. At the same time, the origin of drug use can often be associated with methods of struggling/surviving/adaptation, so quitting drug use may cause serious problems at an emotional-psychological level (besides the physical one).

Some women thought that drug use had made them infertile, and the fact that they were pregnant made them feel positive, which gave them a reason for having the child (a positive turn). In the case of other women, denying their ability to become pregnant enabled them to maintain drug use. Often they did not even accept the fact of being pregnant until the second trimester. This uncertainty may also affect the health of the mother and the foetus. Keeping their pregnancy in secret also means that emotional ambivalence (distress) increases, they cannot discuss it with anyone at a safe place where they could be provided with information on healthcare and prenatal care. Intervention is made even more complicated by social, family, moral, financial affairs, which are often in contradiction with each other too.

Motherhood increased the responsibilities undertaken by women, at the same time their uncertainty was maintained. What they feared the most was that as a result of drug use they would lose their child, they would be despised in the healthcare system, or maybe they would be reported to the police. The stigmatisation of the "bad mother" resulted in personal, social disturbances, often to social isolation, which led back to the original functions of drug use.

The attitudes of the healthcare system were surveyed on the basis of interviews made with 20 specialists. This sample included 5 men and 15 women, their average age was 36.4 years. In respect of their profession there were 9 midwives, 6 obstetrician-gynaecologists, 1 anaesthetist, 2 specialised assistants in intensive therapy and 2 district nurses among them. 19 out of the 20 specialists had met drug user clients during their career.

The representatives of the healthcare system are also characterised by ambivalence. The specialists' attitude is influenced by the social construction of pregnancy/motherhood, as a result of which their behaviour is characterised by a positive approach. At the same time, due to the lack of information on drug use and being afraid of the unknown, they show a negative or uncertain or maybe neutral behaviour. Most typically the institute does not help in resolving uncertainty either, as there is no protocol that they could lean on when making decisions, there are no specialists that they could turn to. The positive attitude and the intention to provide help are first of all focused on the child.

Steps taken to develop healthcare service

In March 2009 a publication entitled “Care provided for drug user pregnant women and their children”¹³¹ was issued, which is the first publication in Hungarian dealing with the topic of drug use and having children, covering several areas (obstetrics-gynaecology, addiction treatment, social work, self-help).

In 2009, on the initiative of the Sober Babies Club, the self-helpers and the staff of the service, together with specialists from other organisations, started to elaborate a professional proposal entitled “Drug use and having children”, which describes the aiding activities of informal and formal anonymous services. The final wording of the proposal is expected to be prepared by the beginning of 2011.

In 2009 a publication entitled “Care and prevention programme for addicted pregnant women, at-risk neonates and small children” was issued in the scope of the quality improvement project coordinated by the National Centre for Addictions (OAC), to prepare the different participants of the healthcare system and provide care for pregnant drug users and their children.

The new National Drug Strategy accepted in 2009 deals with the improvement of the care provided for drug user women and their children at several points.

Conclusions

In 2009 the needle/syringe programme coverage of the country continued to increase. On the basis of the totalled data, the number of both distributed and returned syringes increased significantly. The increasing tendency is first of all due to the 2009 data of the fixed NSPs, mostly to the ones located in Budapest.

As a response to the increasing number of clients and to the hepatitis C prevalence, which has been around 70% for several years in the NSP in the district VIII, several harm reduction measures were taken in this district. At the location of the programme continuous on-site testing was made available, the efficiency of a pilot counselling model programme was examined, and attitude survey was also carried out among residents of the district in connection with possible setting up of a drug consumption room.

In the scope of a survey carried out in 2009 the main hindrances of entering antiviral treatment of HCV infected IDUs were examined, and several areas that need to be improved in connection with their treatment were also revealed: for example personal counselling, referring clients to treatment and keeping them in treatment.

There is still intensive professional concern shown towards care provided for pregnant drug users, which is demonstrated by the fact that the new National Drug Strategy deals with this problem at several points. The OAC publication issued in 2009 and dealing with care provided for drug user pregnant women and their children may represent a good basis for improving care provided for this special group. The results of a qualitative survey carried out among pregnant drug users show that the attitude of healthcare service providers, stigmatisation and being afraid of losing guardianship of the child still represent problems in accessing treatment for drug user pregnant women.

¹³¹ Rigó János – Oberth József – Sógorka Ildikó (editor), *Droghasználó várandós nők és gyermekeik ellátása*. Centre for Defence of Human Rights – Hungary, 2009

8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

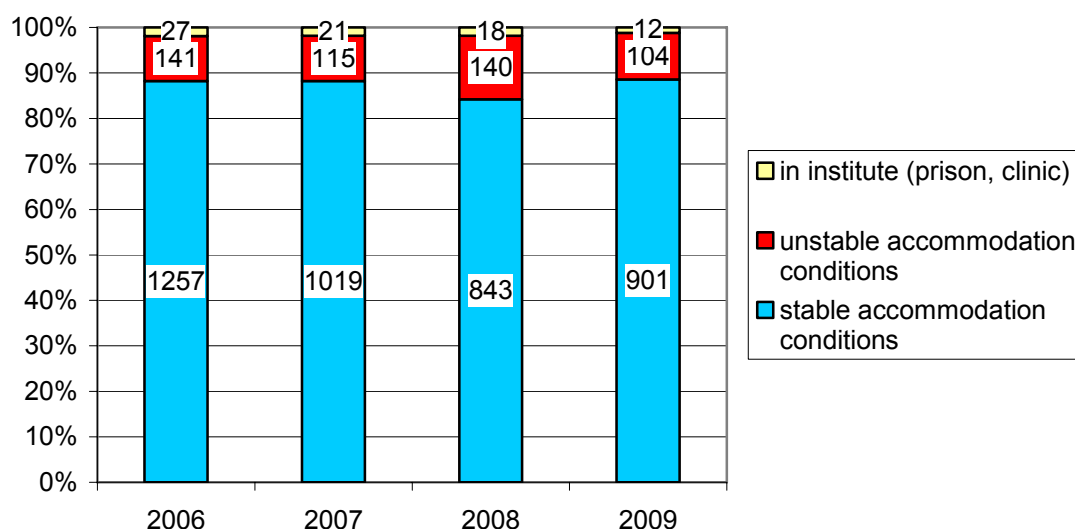
8.1. SOCIAL EXCLUSION AND DRUG USE

In the previous year no surveys were carried out dealing especially with the issue of the social exclusion of drug users, but several surveys were carried out among drug user groups also examining the social situation of the respondents¹³². From these surveys, in this chapter we present the characteristics of the respondents interviewed in the course of the survey carried out among IDUs in Budapest¹³³. Furthermore, the social exclusion of drug users is described using information available on clients entering treatment (from the TDI database¹³⁴).

Housing

In 2009, 89% of the clients appearing in treatment had stable accommodation conditions, which represents an increase by 5 percentage points as compared to the previous year (in 2008: 84%), but at the same time this proportion conforms to the proportions observed in the previous years.

Figure 45. *Housing conditions among clients entering treatment between 2006-2009 (persons)*



Source: OAC 2010

In the survey carried out among IDUs in Budapest (Rácz et al. 2009), 21% of the participants lived in their own flat, 29% of them said that they lived in somebody else's flat, 16% of them said that they lived in lodgings, and 22% said that they lived in a flat provided and owned by the local authority. 8% of the respondents lived in a shelter for the homeless, while practically nobody lived in the street or in a squat.

¹³² Among IDU and/or opiate user women living in Budapest (Csorba et al. 2009; Csorba et al. 2010), for the results see chapter 6.2; among drug user pregnant women in Budapest (Kaló, Rácz 2009), for the results see chapter 7.3; among persons imprisoned in the largest prison in Budapest (Mészáros et al. 2009), for the results see chapter 9.4.

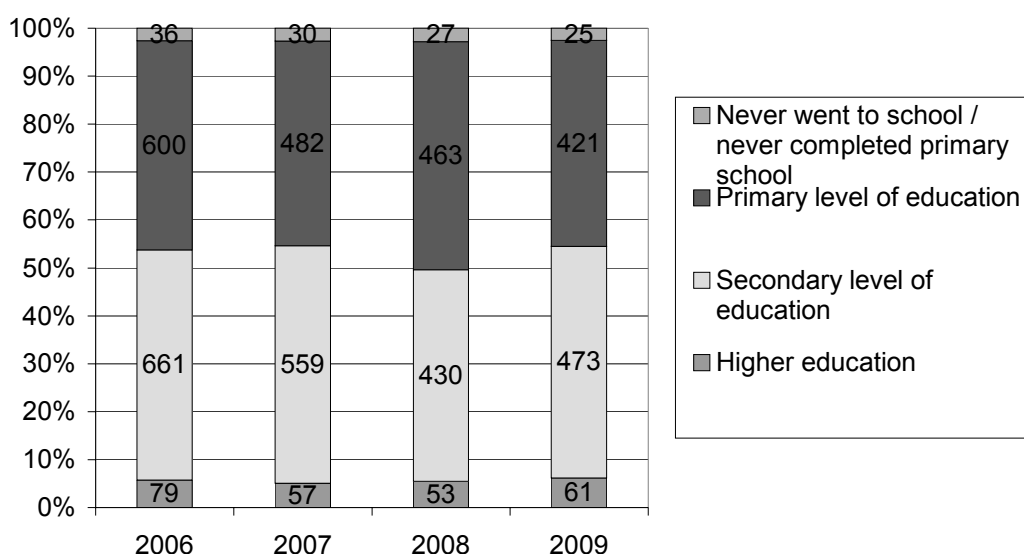
¹³³ For further results of the survey and for the methodology see chapter 7.2.

¹³⁴ In 2009 the service providers reported the data of 1,054 clients entering treatment outside of diversion into the TDI database (for the detailed description of the characteristics of the clients in treatment see chapter 5.3.). The changing of the number of new clients: in 2006: 1,472 persons, in 2007: 1,185 persons, in 2008: 1,032 persons.

Education, training

As compared to the previous year, among the clients entering treatment in 2009 the proportion of clients with secondary school qualifications was higher (48%, in 2008: 44%), and the proportion of clients with elementary qualifications was slightly lower (43%, in 2008: 48%). At the same time, the proportions observed in 2009 conform to the proportions observed in 2006 and 2007. The proportion of clients who do not even have elementary qualifications has been stable, around 3% during recent years, while the proportion of clients with higher education qualifications has been around 5-6%.

Figure 46. Completed school qualifications among clients entering treatment between 2006-2009 (persons)



Source: OAC 2010

In the survey carried out among IDUs in Budapest (Rácz et al. 2009), 13% of the respondents did not complete the 8 grades of elementary school, in the case of 62% of them the highest school qualifications were the 8 grades of elementary school. 20% of them said that they had completed vocational training school or vocational secondary school, 3% of them took part in a training course listed in the National Training Register. 2% completed general secondary school.

Labour status

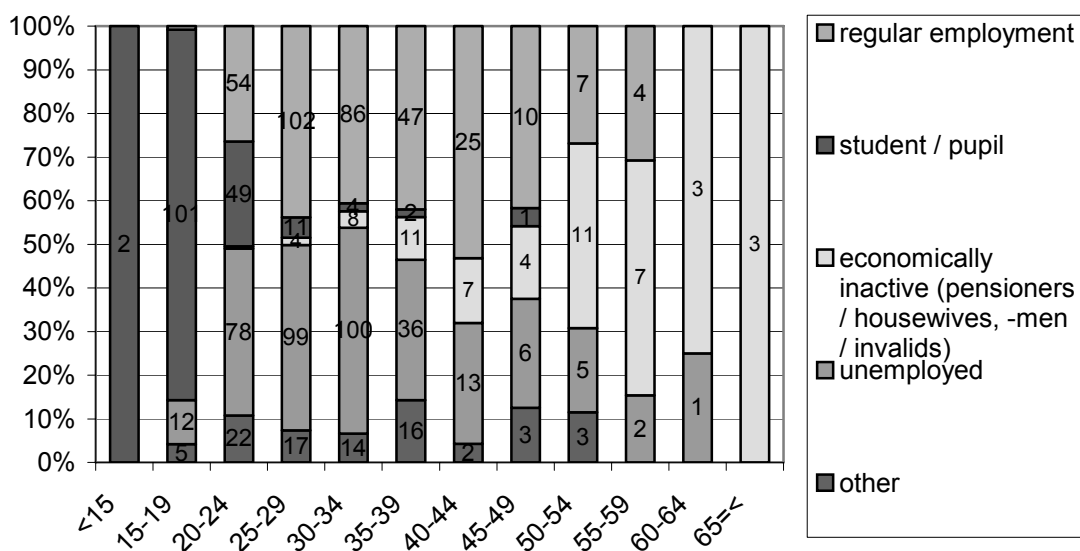
In 2009 33.6% of the new clients entering treatment had a regular employment, which represents a slight increase as compared to the proportion measured in 2008 (30.1%). As compared to the previous year a change by only 1-2 percentage points can be observed in the proportion of students (from 19% to 17%), economically inactive clients (from 5.5% to 5.9%), unemployed clients (from 36.8% to 35.2%) and clients with other labour status (from 8.9% to 8.2%).

When examining the clients' labour status, an analysis according to age groups provides a more interesting picture. In the age group of clients below the age of 20 obviously the proportion of students was the highest, unemployed clients representing 10% were all 18-19 years old, and in the youngest age groups only one person had a permanent job. The proportion of the unemployed was the highest in the age groups between 20-34 (38.2%, 42.5% and 47.2%), in the age groups between 20-24 and 30-34 it even exceeded the proportion of regularly employed clients (26.5% and 40.6%), and even in the age group

between 25-30 it was only one percent below the proportion of clients with regular employment.

When examining the connection between the labour status of clients entering treatment between the age of 20-49¹³⁵ and their primary substance the following can be determined: nearly half of the heroin users (271 persons) were unemployed (48%), and one-third of them were regular employees (33.6%). Similar proportions could be observed among clients treated because of using other opiates (34 persons) (52.9% unemployed, 35.3% regular employees). Among clients treated because of cocaine use (25 persons) and amphetamine use (83 persons) the proportion of clients with regular employment and unemployed clients was nearly the same (in the case of cocaine: 36% and 36%, in the case of amphetamine: 43.4% and 45.8%). Half (49%) of the cannabis users (251 persons) were regular employees, a quarter of them were unemployed (27.1%), and the proportion of students was 15.5%. 85.1% of the clients below the age of 20 (121 persons) were students, nearly two-thirds of them (64.5%) entered treatment because of cannabis use.

Figure 47. Labour status among clients entering treatment, by age group, in 2009 (N=999) (persons)



Source: OAC 2010

In the survey carried out among IDUs in Budapest (Rácz et al. 2009), two-thirds of the respondents (66%) were unemployed, 14% of them had some kind of job, and 21% of them had a different labour status.

15% of the respondents received some sort of financial aid (5% lived on unemployment benefit). One-third of the participants received financial help from their marital partner, family or friends, 28% of them dealt with selling and buying goods. 16% stated theft as their source of income, 5% received childcare allowance. No one was engaged in prostitution.

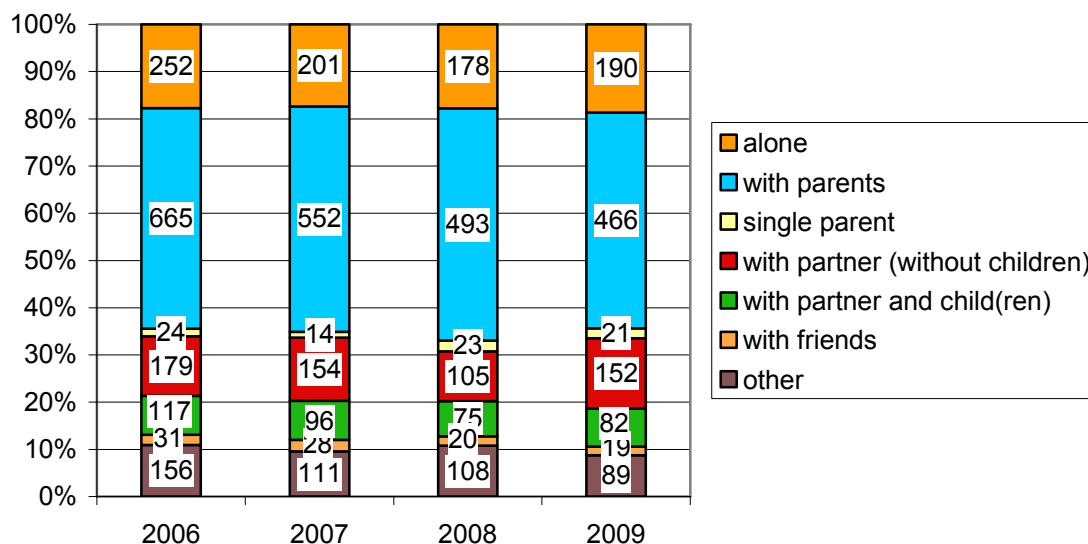
Social network

On examining the social network, during the recent year no remarkable changes took place in the clients' family status. In 2009 again, the largest proportion of the clients entering treatment lived with their parents (45.7%, average age: 25.1 years). The proportion of clients living alone was 18.6% (average age: 33.4 years), the proportion of people living with a partner was 14.9% (average age: 34.3 years), the proportion of people living with a partner and children was 8% (average age: 36.9 years), and the proportion of people classed in the

¹³⁵ 83.4% of the cases (879 persons) belong to this age group.

"other" category was 8.7% (average age: 28.4 years). Among the clients the lowest proportions were represented by people living alone with children (2.1%, average age: 33.9 years) and by people living with friends (1.9%, average age: 29.5 years).

Figure 48. Family status among clients entering treatment between 2006-2009 (persons)



Source: OAC 2010

In the survey carried out among IDUs in Budapest (Rácz et al. 2009), the majority of the respondents (61%) were single, nearly one-third of them had a life companionship or partner relationship.

Most of the clients lived with their parents (39%) or their partners (23%), 17% of the respondents lived alone.

8.2. SOCIAL REINTEGRATION

Drug therapeutic institutes

In the summer of 2009¹³⁶ a survey was carried out to study the operation of drug rehabilitation institutes providing long term inpatient therapy in Hungary and to provide a structured description of the work performed in the institutes (Topolánszky et al. 2009a, b).¹³⁷ Besides surveying the objectives determining the activity of the therapeutic institutes and the methods used, the survey also extended to studying the organisational characteristics of the institutes, their available human resources and their structural integration into the system of institutes aimed at handling the drug problem, as well as studying the clients' characteristics.

At national level the therapeutic institutes are able to accommodate 353 clients at the same time. The number of beds financed by the National Health Insurance Fund (OEP) is 269, the

¹³⁶ Between 1 June and 31 July.

¹³⁷ The survey extended to the 13 (drug rehabilitation) member organisations of the Federation of the Hungarian Drug Therapeutic Institutes (MADRISZ) performing active therapeutic activity at the time of data recording. The survey was financed by the National Institute for Drug Prevention. During data recording 13 heads of institutes were interviewed, which means that a complete survey could be realised. At the time of data recording, in the 13 drug therapeutic institutes 180 employees looked after 253 clients. From these persons 146 employees and 240 clients could be interviewed. The questionnaires of the heads of institutes were filled in using face-to-face technique, with the participation of professionally competent field interviewers. The employee questionnaires were filled in using individual self-reporting method, while the client questionnaires were recorded using group self-reporting method.

number of beds financed from the social normative support is 340. In 2008 a total number of 738 clients were registered (715 persons are registered in an average year), 160 of them were clients, who had not been in treatment before at all. In 2008 the patient turnover data per institute is not significantly different from the data estimated in respect of an average year, only the number of clients participating in pre-care was significantly higher in 2008 than in the earlier years on average.

Table 60. *Client turnover data of the therapeutic institutes (persons)*

	In 2008	Data per institute		2008/an average year
		In 2008	In an average year ¹³⁸	
Registered clients	738	56.8	55.0	103.3%
Clients only in pre-care	34	2.8	2.1	133.3%
Clients admitted several times	102	7.9	7.2	109.7%
Clients not treated in the given therapeutic institute before	475	36.5	39.6	92.2%
Clients not treated before in any therapeutic programme	160	16.0	15.2	105.3%
Clients on waiting list	25	2.1	1.9	110.5%

Source: *Topolánszky et al. 2009a, b*

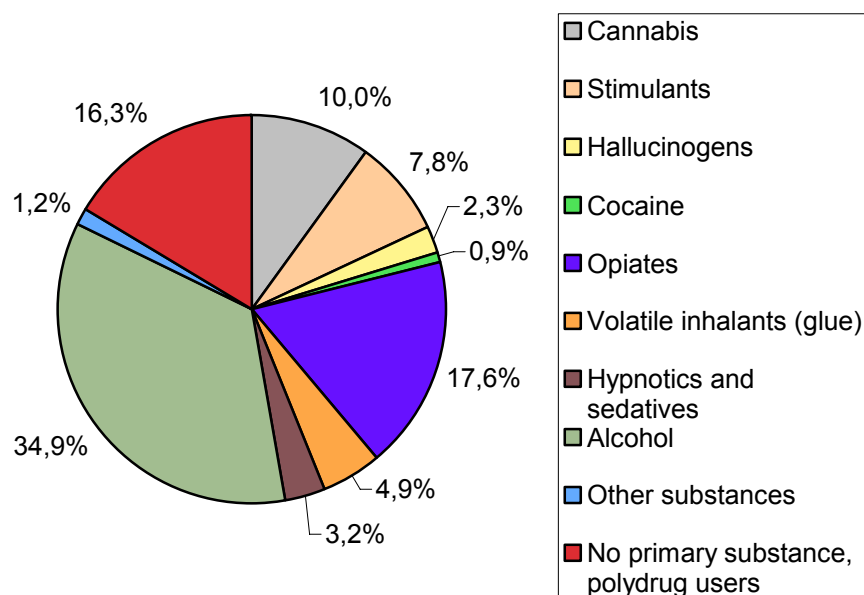
7 of the 13 institutes admit only men and 1 admits only women. The remaining 5 institutes admit both men and women.

In 2008, in the 11 therapeutic institutes dealing with the adult population above the age of 18, the average age of the clients varies within a relatively wide range, between 24 and 43, the totalled average age is 31.2 years, which is practically the same as the average of the most common ages occurring in the individual institutes (30.8 years). The oldest client found in the drug therapeutic institutes of Hungary was 63 years old. In the two institutes dealing with clients below the age of 18 the average age was 15, and the most commonly occurring age was 16.

On the basis of the estimates made by the heads of institutes, the largest proportion of clients was admitted to the therapeutic institutes with alcohol problems. The most commonly used illicit drugs were opiates, but the proportion of the primary opiates users was half of the proportion of alcohol consumers. According to estimates made by the heads of institutes, the primary substance of more than two-fifths of the clients admitted to the drug therapeutic institutes is not an illicit drug. However, there are significant differences between the individual institutes in respect of the clients' primary drug: in some institutes more than half of the clients are opiate users, or 80% of them use cannabis as primary drug (Szegletkő Children's Home), or the decisive majority of them are primarily alcohol consumers.

¹³⁸ Average year = the average of the observed years (2006-2008)

Figure 49. Breakdown of clients by primary drug used at the time of admittance (the average values of the percentages estimated by the heads of institutes)



Source: Topolánszky et al. 2009a, b

Table 61. Breakdown of clients by primary drug used at the time of admittance (the average values of the percentages estimated by the heads of institutes, and – in brackets – the minimum and maximum values of the estimates)

Primary drug	Average value of the estimated percentages
Opiates	17.58 (0-55)
heroin	16.75
methadone	1.50
other opiates	0.38
Cocaine	0.92 (0-3)
cocaine	0.92
crack	0
Stimulants	7.81 (0-30)
amphetamines	6.58
MDMA and other derivates	1.00
other stimulants	0.23
Hypnotics and sedatives	3.23 (0-11)
barbiturates	1.08
benzodiazepines	1.83
others	0.17
Hallucinogens	2.31 (0-30)
LSD	1.27
other hallucinogens	1.58
Volatile inhalants	4.88 (0-25)
Cannabis	10.04 (0-80)
Alcohol	34.88 (0-98)
Other substances	1.17 (0-10)
No primary substance, polydrug user	16.25 (0-50)

Source: Topolánszky et al. 2009a, b

Generally the therapeutic institutes welcome different groups in special life situations – regarding social, cultural, legal or health aspects – having therapeutic needs different from the average clients of drug therapeutic institutions (hereinafter referred to as groups with special needs). Each institute is open to national and ethnic minority groups, and the decisive majority of them admit clients supervised by a probation officer, clients infected with HCV,

homeless people, or even clients suffering from a behavioural addiction. 5 out of the 6 institutes accessible to women admit drug user mothers¹³⁹. In respect of the therapies offered, the appearance of special treatments indicates that the institutes in Hungary are also starting to follow the more client-oriented treatment planning practice of the so-called third-generation therapeutic communities (Topolánszky et al. 2009a, Topolánszky et al. 2009b). At the same time, the institutes do not typically provide special services for these groups with special needs.

Table 62. *Number of institutes admitting and providing treatment for groups with special needs*

Groups with special needs	Number of institutes	
	They are admitted to the programme	Special services are provided for them
Clients with dual diagnosis	9	2
Minority groups	13	3
Homeless	11	4
Clients under probation officer's supervision	12	3
Clients infected with HCV	12	6
Clients suffering from a behavioural addiction	11	3
Drug user mothers	5	2
Clients infected with HIV/AIDS	9	5

Source: Topolánszky et al. 2009a, b

Among the therapeutic objectives of the institutes there are three outstanding objectives: "development of social skills and coping strategies", "development of self-knowledge, self-confidence, self-assurance", and "abstinence from all illicit drugs". All the institutes without any exception "lay a significant emphasis" on these objectives, all the institutes rated them 5 on a 5-level scale in respect of the emphasis laid on the objectives. However, examining the priority of the objectives, that is the order of importance set up in respect of the 5 most important objectives, "abstinence from all psychoactive substances" has the most important role in the institutes' structure of objectives, which indicates that the therapeutic institutes in Hungary still define themselves as abstinence oriented service providers, although in this respect shifts of emphasis can be observed between the institutes. Apart from the above, among the therapeutic objectives of the institutes "development of everyday life conduct skills" and "remaining in treatment" also receive a significant emphasis and a relatively high priority in the order of importance. At the same time, issues such as abstaining from smoking, changing the social environment, or avoiding drug-related infectious diseases were not mentioned among the 5 most important objectives in any of the institutes.

¹³⁹ The question on the admittance of drug user mothers was not specified whether mothers are admitted with or without their child.

Table 63. *The emphasis laid on the different therapeutic objectives in the therapeutic programmes*¹⁴⁰

Therapeutic objective	Scale ratings indicating emphasis		Rank-order points
	average	standard deviation	
Development of self-knowledge, self-confidence, self-assurance	5.00	0	<u>23</u>
Development of social skills and coping strategies	5.00	0	<u>22</u>
Abstaining from all illicit drugs	5.00	0	5
Development of everyday life conduct skills	4.92	0.277	<u>18</u>
Remaining in treatment	4.85	0.376	<u>15</u>
Abstaining from alcohol consumption	4.85	0.376	8
Restoring family and other partner relationships	4.77	0.599	10
Abstaining from all psychoactive substances	4.69	0.855	<u>26</u>
Good physical health and good general condition	4.62	0.650	4
Integrating clients in self-help groups	4.23	1.301	4
Avoiding sexually transmitted diseases and hepatitis B, C	4.15	1.281	0
Improving labour market position	3.85	1.345	1
Changing the social environment	3.31	1.251	0
Improving academic progress	2.92	1.553	3
Abstaining from smoking	2.38	1.387	0
Conversion	2.31	1.494	4

Source: Topolánszky et al. 2009a, b

In the institutes the greatest emphasis is laid on group therapy, on the “therapeutic community model” and on occupational therapy. These therapeutic techniques are emphatic in all institutes (they received ratings of 3, but mostly 5). Similarly, in 80% of the institutes relapse prevention had a “very emphatic role”, but the institutes tend to show different attitudes towards this technique, as in 2 of the institutes it is “not at all emphasised”. In the majority of the therapeutic institutes bibliotherapy and the 12-step programme are among the “rather not emphasized” techniques, and in the great majority of the institutes medicinal or aversion therapy methods are not emphasised at all.

Table 64. *The emphasis laid on the different therapeutic techniques in the therapeutic programmes*¹⁴¹

Therapeutic techniques	average	standard deviation
Group therapy	4.92	.277
Therapeutic community model	4.77	.599
Occupational therapy	4.62	.650
Relapse prevention	4.38	1.502
Behaviour and cognitive therapy	4.38	1.121
Individual support, counselling	4.23	1.235
Motivation therapy	4.00	1.528
Sport and adventure therapy	3.92	1.320
Art therapy	3.38	1.325
Individual psychotherapy	3.15	1.676
Family therapy	3.15	1.625
Bibliotherapy, evangelisation	2.85	1.676
12-step programme	2.23	1.589
Medically assisted therapy	1.85	1.281
Aversion therapy methods	1.54	.877

Source: Topolánszky et al., 2009a, b

¹⁴⁰ The emphasis was expressed on a 5-level scale, where 1 meant that in the therapy the given objective was “not emphasised at all” and 5 meant that it was “very much emphasised”. In respect of the 5 most important aims the heads of institutes were asked to determine an order of importance. The rank-order points show the amount of points indicating importance, where rank 1 is worth 5 points, rank 2 is worth 4 points, etc.

¹⁴¹ The emphasis was expressed on a 5-level scale, where 1 meant that the given objective was “not emphasised at all” and 5 meant that it was “very much emphasised” in the therapy.

In compliance with the regulations relating to the operating conditions of the therapeutic institutes all of the institutes provide basic healthcare services, psychological treatment and legal counselling for the clients. Furthermore, help is often provided in finding jobs, places of residence, possibilities of further education. The institutes' resources/possibilities seem to be the most limited in respect of providing sheltered employment.

Table 65. *Other treatments and services provided for clients by the drug therapeutic institutes*

Types of services	Number of institutes providing service
General healthcare services (GPs)	13
Psychiatric care	13
Legal counselling	13
Employment services	11
Housing support	10
Possibilities of further education	10
Work rehabilitation programme	9
Halfway housing programme	9
Labour market training	8
Financial advice	8
Sheltered employment	4

Source: Topolánszky et al. 2009a, b

In the case of the majority of the clients, the therapeutic institutes plan their therapeutic programmes to last for an average term of 15 months, most often for 13 months, although in about half of the cases on average a different individual therapy term is determined. In all institutes – in accordance with the professional regulations – a personal treatment plan is prepared for each client. In the course of which – in the case of the majority of the institutes – the client also has a significant role beside the client's mentor and/or the case discussion group.

The institutes mentioned an average of 1.6 different criteria of the successful completion of the therapy¹⁴². The majority of these were criteria relating to the clients' partner relationship or their relationship to their social environment (family relationships, labour market position, housing conditions, supporting community – a total of 12 mentions), while individual characteristics (abstinence, self-knowledge, social skills – a total of 6 mentions) and mentions relating to the completion of the therapy occurred less emphatically among the criteria of the success of the therapy.

Table 66. *Criteria of the successful completion of the therapy*

Criteria	Number of institutes mentioning the criterion
Restoring family relationships	4
Creating housing conditions	3
Restoring labour market position	3
Integration in a supporting community	2
Completion of the therapy	3
Total abstinence	3
Acquiring social skills, strategies	2
Self-knowledge, self-confidence, self-assurance	1

Source: Topolánszky et al. 2009a, b

The greatest proportion of the clients treated in the therapeutic institutes (an average of more than two-thirds of the clients treated in the institutes in an average year, in 2008: 58.8% of the clients) drop out before completing the therapy. The greatest number of clients drop out

¹⁴² The question relating to the criteria of the successful completion of the therapy was an open question in the survey questionnaire.

in the first month after starting the therapy. However, when comparing the drop-out data of an average year and the data of 2008, it can be observed that as compared to the previous years the average proportion of clients dropping out after the sixth month reduced significantly. At the same time, discontinuing the therapy because of dismissal before completion occurs less typically.

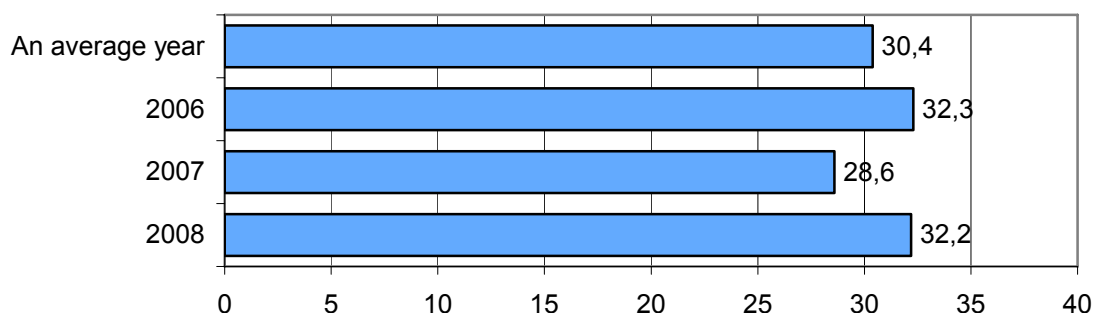
Table 67. Average proportion of dismissed clients and clients dropping out from the institutes (%)

Time spent in the therapy	Dismissal		Dropping out	
	In 2008	In an average year	In 2008	In an average year
Within 1 month	2	1.8	28.8	23.2
Within 3 months	4.2	2.3	14.3	11.8
Between 3 and 6 months	2	1.7	11.6	16.7
After 6 months, but before completing the therapy	1.9	2.3	4.1	17.2
Total	12	27	2083	86

Source: Topolánszky et al. 2009a, b

As a whole, on an annual level a bit less than one-third of the clients leave the therapeutic institutes after successfully completing the therapy.¹⁴³ In this respect no changes indicating a tendency or no significant differences between the institutes could be observed.

Figure 50. Average proportion of clients successfully completing the therapy in the institutes (%)



Source: Topolánszky et al. 2009a,b

Employment

The abstinent café situated in Pécs, the only place in the country providing help in the social reintegration for people suffering from addiction operated by Mérföldkő Egyesület [Milestone Association] since 2006 was closed down in 2009. The café was a sheltered employment programme providing jobs for abstinent clients leaving the association's rehabilitation home operating in Kovácsszénája.

Programmes implemented in the scope of the KAB-RE project¹⁴⁴

The tender aimed at developments facilitating the resocialisation and reintegration of people suffering from addictions was announced in the spring of 2008, with a budget of HUF 50,000,000 (EUR 178,202)¹⁴⁵. 30 out of the 63 applications submitted were granted support, the average amount of support granted was HUF 1,666,000 (EUR 5,938).¹⁴⁶ The project was announced in 3 different categories: the aim of sub-category "A" was the infrastructural

¹⁴³ Obviously, the proportion of clients completing the therapy is not an exclusive indicator of the success of the therapy.

¹⁴⁴ Based on the summary by the Ministry of Social Affairs and Labour

¹⁴⁵ The values were calculated based on the official mid-rate of the EUR for 2009 (1 EUR = 280.58 HUF).

¹⁴⁶ The supported programmes were realised between 1 June 2008 and 31 May 2009.

development of the system of institutes ensuring follow-up care for currently abstinent addicted persons, the aim of sub-category “B” was to provide support for relapse prevention programmes for currently abstinent addicted persons and for self-help programmes, and the aim of sub-category “C” was to provide support for complex training programmes for currently abstinent addicted persons.

5 institutes gained support for infrastructural development, two out of them operate in the South Transdanubian region, two in the northern region of Hungary and one in the central region of Hungary. The organisations were granted support for financing the rental fee of a halfway house, for purchasing a car, for renovating a halfway hostel, and for buying furniture and equipment. 14 organisations were granted support for the realisation of relapse prevention programmes and self-help programmes. A total number of 4,399 persons participated in the programmes realised. The smallest programme reached 15 people, while the largest programme (Sober Babies self-help group) reached 2,500 people. Among the supported programmes there were programmes aimed at families, internet self-help group, a programme using art therapy tools, and even an equine-assisted therapy. 9 organisations were granted support for training programmes. A total number of 207 currently abstinent addicted persons took part in the skills development training courses. As a result of the training courses 43 persons successfully found jobs, and several persons continued their studies.

Table 68. *Training courses for currently abstinent addicted persons, provided in the scope of sub-category “C” of the KAB-RE-08 tender*

Name of organisation, applicant	Number of currently abstinent addicted persons participating in training	Type of training, training modules	Result indicators, expectations relating to the training
Megálló Csoport Alapítvány [Stop Group Foundation]	28 persons	special training programme, preparing for secondary school final examinations	2 persons successfully passed their history exam, 3 persons their Hungarian language and literature exam, 3 persons their mathematics exam, 2 persons completed their secondary school studies after successful final examinations
Drogambulancia Alapítvány [Specialised Outpatient Treatment Foundation]	10 persons	CV writing, communication, self-knowledge, career orientation, basic labour market skills, labour law, conflict handling, development of individual strategy	More efficient further training, future planning
Belvárosi Tanoda Alapítvány [City School Foundation]	33 persons	Personal preparation for secondary school final examinations, communication training, abstinence maintenance group	Every participant passed their examinations every third-year
Szombathelyi Egyházmegyei Karitatív Alapítvány [Szombathely Diocese Charitable Foundation]	8 persons	88-hour information technology training course	8 persons successfully completed the course

Forrás Lelki Segítők Egyesülete [Spring Association of Mental Helpers]	18 persons	Communication and conflict handling training, job-finding group, group counselling, psycho-educational skills	7 persons found jobs
Kék Pont Drogkonzultációs Központ és Drogambulancia Alapítvány [Blue Point Foundation]	31 persons	Individual, personalised training	12 persons found jobs, 9 persons took part in further training courses
Khetanipe a Romák Összefogásáért Egyesület [Khetanipe Association for the Union of the Roma People]	16 persons	Personality development, conflict handling, career orientation, labour market skills, job-finding techniques, strategies, labour law, social and training skills, Dialogue club, visiting institutes	6 persons found jobs
Szertelen Egyesület [Drugless Association]	20 persons	Labour market and job-finding skills, career orientation, communication training	3 persons took part in further training courses
Szt. Cirill és Method Alapítvány [Saint Cyril and Methodius Foundation]	43 persons	Personality development, job-finding, communication training in individual and group form	18 persons found jobs, 1 person took part in further training courses

Source: SzMM

Conclusions

In 2009, 89% of the clients registered in the TDI database had a permanent place of residence at the time of filling in the questionnaire, and this proportion indicates an increase as compared to the previous year (in 2008: 84%), at the same time it is the same as the proportions observed in the years before. In respect of school qualifications the proportion of those who completed secondary school studies was higher (48%; in 2008: 44%), and the proportion of those with elementary qualifications is slightly lower (43%; in 2008: 48%). 33.6% of the patients entering treatment in 2009 were permanently employed, which is a slight increase as compared to the proportion measured in 2008 (30.1%).

According to a survey covering 13 member organisations of the Federation of the Hungarian Drug Therapeutic Institutes, at national level the therapeutic institutes can accommodate 353 clients at the same time. In 2008 they registered a total number of 738 clients, and 160 of these clients had not been treated anywhere else before. On the basis of the estimates made by the heads of the institutes, the largest proportion of the clients are admitted to the therapeutic institutes because of alcohol problems. The most commonly used illicit drugs are opiates, but the proportion of the primary users of opiates is half the proportion of alcohol consumers. Among the therapeutic objectives of the institutes there are three outstanding objectives: "development of social skills and coping strategies", "development of self-knowledge, self-confidence, self-assurance", and "abstinence from all illicit drugs". In the institutes the greatest emphasis is laid on group therapy, on the "therapeutic community model" and on occupational therapy, while in 80% of the institutes relapse prevention also

has a “very emphatic role”. All of the institutes provide basic healthcare services, psychological care and legal counselling for the clients. Furthermore, help is often provided in finding jobs, places of residence, possibilities of further education. The highest number of clients drop out in the first month after starting the therapy, but discontinuation because of dismissal before completing the therapy is less typical. On an annual level a bit less than one-third of the clients leave the therapeutic institutes after successfully completing the therapy.

In 2008, in the scope of the project facilitating the resocialisation and reintegration of people suffering from addiction 30 programmes were granted support. 14 organisations were granted support for the implementation of relapse prevention programmes and self-help programmes, a total number of 4,399 persons participated in their programmes. 9 organisations were granted support for the realisation of skills development training programmes, and a total number of 207 currently abstinent addicted persons took part in the training courses organised by them. As a result of the training courses 43 persons successfully found jobs, and several persons continued their studies. 5 institutes gained support for infrastructural development.

9. DRUG-RELATED CRIME, PREVENTION OF DRUG-RELATED CRIME, AND PRISON

Overview

In the Unified Criminal Statistics System of the Investigation Authorities and Public Prosecution (ENYÜBS) criminal statistical data of the investigation authorities and the public prosecution is collected and processed concerning rejecting charges, instituting criminal proceedings, until investigations are suspended or terminated or until a formal accusation is made. On the basis of article 63 (4) of the Act on Criminal Proceedings, uniform criminal statistics cover the development of crime per criminal offence and per accused person.

Due to the change occurring in the system of concepts of criminal statistics, in 2009 the categories of revealed offence and revealed offender were replaced by registered offence and registered offender. From the aspect of describing the trends the new categories comply with each other.

The data collection method of the Unified Criminal Statistics System of the Investigation Authorities and Public Prosecution introduced in 2009 attach a 17-figure statistical code to the individual forms of crimes, which enables a more detailed and legally more accurate distinction according to the individual perpetrations and legal expressions, than the 4-figure codes used before. Therefore, the data collection performed on the basis of the new crime codes provides more information. Furthermore, due to the extension of the code dictionary, it is also possible to report the breakdown of drug offences in 2009 according to drug type.

9.1. DRUG-RELATED CRIME

Using the data of the Unified Criminal Statistics System of the Investigation Authorities and Public Prosecution, registered offences and registered offenders are reported, because of which offences and against which offenders the charges were rejected, the investigations were terminated or suspended, were treated as an alternative to criminal procedure, or formal accusation was made in 2009.

The data relating to drug-related crime reported on the basis of the ENYÜBS data collection include the offences concerning the misuse of illicit drugs described in sections 282, 282/A, 282/B and 282/C of the Criminal Code and also the offence of the misuse of substances used for producing drugs regulated in section 283/A of the Criminal Code.

The data obtained from the criminal statistical system about offences forms a complete group. The data obtained about offenders is only approximate data as in the system of statistical data collection, on form "T" used for recording offenders' data the main offence or the offence committed as an infant or juvenile offender must be stated.¹⁴⁷

Drug offences

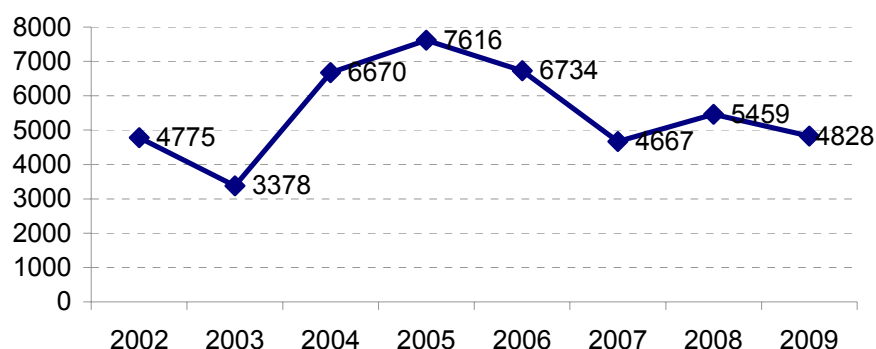
According to the statistical data of 2009, 4,828 criminal proceedings concerning the misuse of illicit drugs were concluded in the year in question. (ST11_2010_HU_01)

The data of ENYÜBS indicate that in 2009 – similarly to the number of all registered offences – the number of registered offences concerning the misuse of illicit drugs decreased. The rate of decrease was about 11.5%.

Among all criminal offences the proportion of offences concerning to the misuse of illicit drugs also decreased: from 1.34% in 2008 to 1.23%.

¹⁴⁷ In a possible case, an adult person committing the offence concerning the misuse of illicit drugs, if he/she also committed manslaughter besides the misuse of illicit drugs, then he/she is registered in the database as an offender committing manslaughter.

Figure 51. The number of registered offences concerning the misuse of illicit drugs between 2002-2009



Source: ENYÜBS

On the basis of the data of the initiators of criminal proceedings it can be seen that in 2009 the police, as the investigating authority having a general sphere of authority, instituted criminal proceedings in the case of 91.16% of the offences concerning the misuse of illicit drugs.

Among the initiators of criminal proceedings, the Hungarian Customs and Finance Guard is represented in connection with 49 offences, prisons without the right to investigate appear prominently, in connection with 23 offences, and the Hungarian Army also appears with 19 offences.

Illicit drugs, as the subject of criminal offences, occur in a low number of other types of offences: 3 offences against public order, 1 case offending the order of economy, and 17 offences against property were registered.

Breakdown of drug offences by substance

In 2009, in connection with the offence concerning the misuse of illicit drugs, the type of drug was recorded in the criminal statistics in relation to 4,651 offences. Below, the offences concerning the misuse of illicit drugs are shown in a breakdown of the main substance types, and perpetration types (4,497 cases). (ST11_2010_HU_01)

Table 69. Breakdown of the number of registered criminal offences concerning the misuse of illicit drugs by substance and perpetration type in 2009

Type of substance	Use/ possession		Dealing/trafficking		Use and trafficking		Total	
	Number	%	Number	%	Number	%	Number	%
Cannabis	3,102	80.6	455	77.1	35	61.4	3,592	79.9
Heroin	273	7.1	22	3.7	14	24.6	309	6.9
Cocaine	115	3.0	19	3.2	2	3.5	136	3.0
Amphetamine	114	3.0	4	0.7	1	1.8	119	2.6
Metamphetamine	82	2.1	20	3.4	2	3.5	104	2.3
Ecstasy	156	4.1	70	11.9	3	5.3	229	5.1
LSD	8	0.2	0	0.0	0	0.0	8	0.2
Total	3,850	100.0	590	100.0	57	100.0	4,497	100.0

Source: ENYÜBS

Furthermore, it is worth mentioning that in 34 cases morphine, in 27 cases ketamine, in 9 cases mCPP, and in 8 cases GHB was determined as the subject of the offence.

In most cases (79.9%) cannabis was the subject of offence of registered cases concerning the misuse of illicit drugs. It is followed by offences committed with heroin represented by

6.9%, and then by ecstasy represented by 5.1%. The proportion of offences concerning the misuse of illicit drugs committed with amphetamine and cocaine is around 3% in case of both substances.

On the basis of the further analysis of the data it can be seen that while demand- and supply-related perpetrations are dominated by cannabis, in the case of drug addicts (section 282/C) heroin is dominant with a proportion of 46% on the demand side.

*Perpetrations*¹⁴⁸

83.84% of all registered offences concerning the misuse of illicit drugs is represented by demand-related perpetrations (4,048 cases), while 14.02% is represented by supply-related perpetrations (677 cases). The proportion of demand-related perpetrations slightly increased as compared to 83.4% in 2008, while the proportion of supply-related perpetrations decreased by 2% (in 2008: 16.14%).

Perpetrations endangering persons below the age of 18 were registered in 0.8% of the cases (39 cases). Punishable preparations are represented by 0.37% of the cases (18 cases), financing perpetrations by 0.74% (36 cases), while perpetrations realised by supplying substances needed for producing drugs were represented by 0.2% (10 cases).

A more accurate picture is provided, if the amount of drugs involved in the perpetrations is analysed too.¹⁴⁹ Small amounts were involved in 76.09% and significant amounts were involved in 1.63% of the demand-related perpetrations. The amount according to the punishable basic case was involved in 22.28% of the demand-related perpetrations.

Within supply-related perpetrations small amounts were involved in 68.39% of the cases, while significant amounts were involved in 10.78% of the cases. The amount according to the punishable basic case was involved in 20.82% of the cases.

Table 70. *Breakdown of registered offences concerning the misuse of illicit drugs by perpetration type and amount of substance in 2009*

Perpetration	Small amount		Basic case		Significant amount		Total	
	N	%	N	%	N	%	N	%
Demand-related	3,080	76.09	902	22.28	66	1.63	4,048	100
Supply-related	463	68.39	141	20.83	73	10.78	677	100
Total	3,543	74.98	1,043	22.07	139	2.94	4,725	100

Source: ENYÜBS

Habitual offence and conspiracy, as qualifying circumstances substantiating more severe punishment occurred in 5.9% of the supply-related perpetrations.

Typically, on the demand-related side offences committed for small amounts, by occasional users or by drug addicts were registered.

Place of offence

As compared to the data registered in 2008 slight restructuring can be observed. The highest number of offences concerning the misuse of illicit drugs was still registered in Budapest (25.31%). Győr-Moson-Sopron county is the second with 405 registered offences (8.4%), while Pest county dropped back to the third place with 388 registered offences (8.05%).

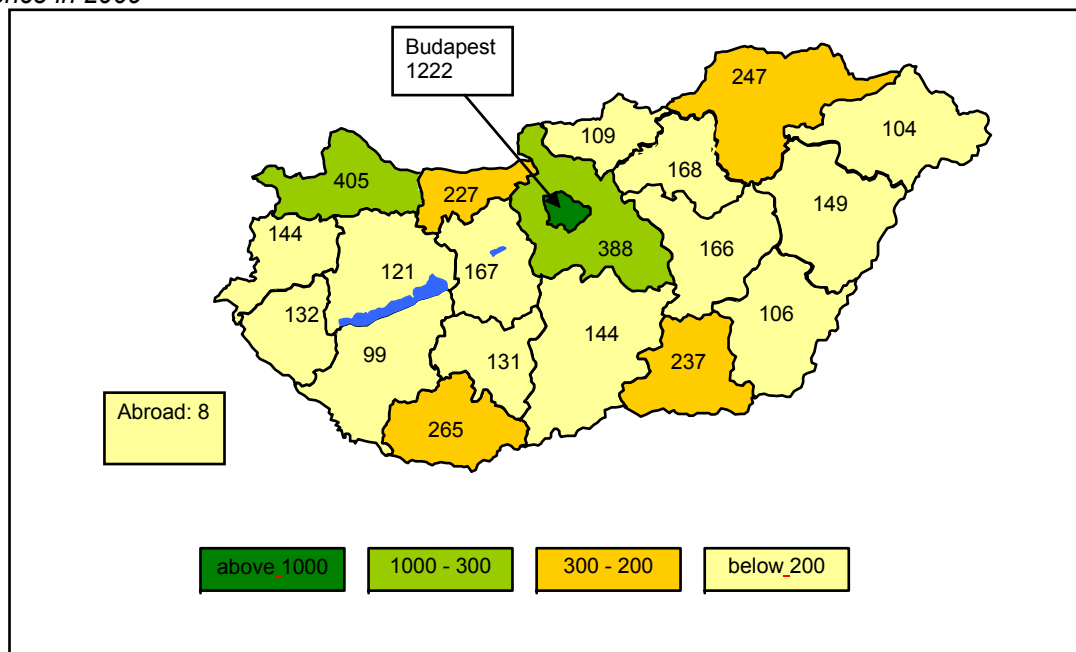
¹⁴⁸ In order to introduce the perpetrations of the offence concerning the misuse of illicit drugs more accurately, several groups were created: 1. demand-related perpetrations (production, manufacturing, acquisition, possession, importing, exporting, transiting through the country); 2. supply-related perpetrations (offering, supplying, distributing, trafficking); 3. punishable preparations (section 282 (3) a, section 282/A (4), section 282/B (4) of the Criminal Code); 4. financing perpetrations (section 282 (4), section 282/A (5), section 282/B (6) of the Criminal Code); 5. perpetrations endangering persons below the age of 18 (section 282/B (2) locution I and its qualified forms, and section 282/B (5) of the Criminal Code); 6. perpetrations facilitating the production of drugs (section 282 (3) b and section 283/A of the Criminal Code).

¹⁴⁹ The quantity definitions are included in Statutory rule 5 of 1979 on the enforcement and implementation of Act IV of 1978 on the Criminal Code.

Borsod-Abaúj-Zemplén county, which was the third in 2008, took the fifth place in 2009 with 247 offences (5.12%).

The proportion of registered offences shows an increasing tendency in the counties situated along the northern and western country border as compared to the data observed in 2008, while in the case of the rest of the counties generally a decreasing tendency can be observed.

Map 3. Breakdown of the number of criminal offences concerning the misuse of illicit drugs by place of offence in 2009



Source: ENYÜBS, Hungarian National Focal Point

Offenders

Suiting the decreasing tendency of the number of registered offences concerning the misuse of illicit drugs, the number of registered offenders also decreased. From 4,692 persons measured in 2008, the number of registered offenders decreased to 4,382 in 2009 (ST11_2010_HU_01). The rate of decrease was 9.33%. According to the criminal statistical data the offenders have the following socio-demographic and criminological characteristics:

Breakdown by gender

In respect of breakdown by gender among registered offenders committing misuse of illicit drugs, the proportions are similar to the proportions observed in the previous years. In 2009 the proportion of men was 90.5% (3,969 persons), and the proportion of women was 9.5% (413 persons), just like in 2007 and 2008. Practically these proportions have been the same for years, and are similar to the proportions characteristic among all offenders in respect of breakdown by gender.

Breakdown by age

47.24% of the 4,382 registered offenders committing misuse of illicit drugs belong to the category of young adults, the second most significant age group is the group of offenders between the age of 25-30 represented by a proportion of 25.63%, while the third most significant age group is the group of offenders between the age of 31-40 represented by a proportion of 15.2%. The juvenile age group (between the age of 14-18), which is regarded

an extremely at-risk population, is the fourth age group among offenders committing misuse of illicit drugs, with 413 offenders (9.42%).

Table 71. Breakdown of offenders committing misuse of illicit drugs by age in 2008 and 2009

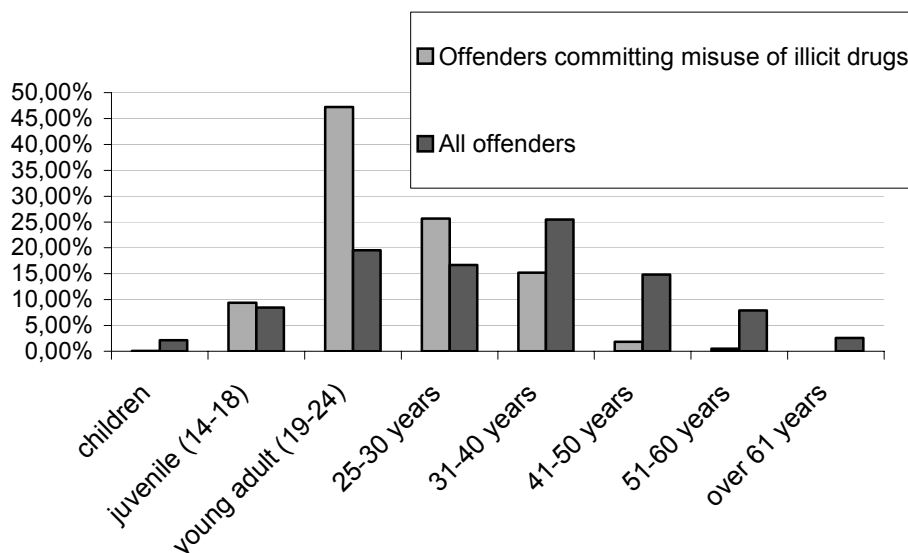
Age groups	2008		2009	
	cases	%	cases	%
Child (0-14)	11	0.2	4	0.09
Juvenile (14-18)	519	11.1	413	9.42
18–24 years	2,308	49.2	2,070	47.24
25–30 years	1,148	24.5	1,123	25.63
31–40 years	575	12.2	666	15.20
41–50 years	101	2.2	81	1.85
51–60 years	26	0.5	23	0.52
Above 61 years	4	0.1	1	0.02
Total	4,692	100.0	4,381	100

Source: ENYÜBS

When examining the breakdown of all registered offenders according to age, it can be seen that the two largest groups of offenders are formed by the age group between 31-40 (25.48%) and the age group of young adults (aged 19-24) (19.53%). If breakdown of all registered offenders by age group is compared with the breakdown of registered offenders committing misuse of illicit drugs a contrasting tendency can be observed, as in the second case the two largest age groups are the age group between 18-24 (47.24%) and the age group between 25-30 (25.63%).

The proportion of offenders below the age of 30 is 82.39%, which represents a slight reduction as compared to the proportion of 86% measured in 2007 and the proportion of 84.9% measured in 2008. Among all registered offenders this proportion is only 46.83%.

Figure 52. Breakdown of offenders committing misuse of illicit drugs and all registered offenders by age group (%) in 2009



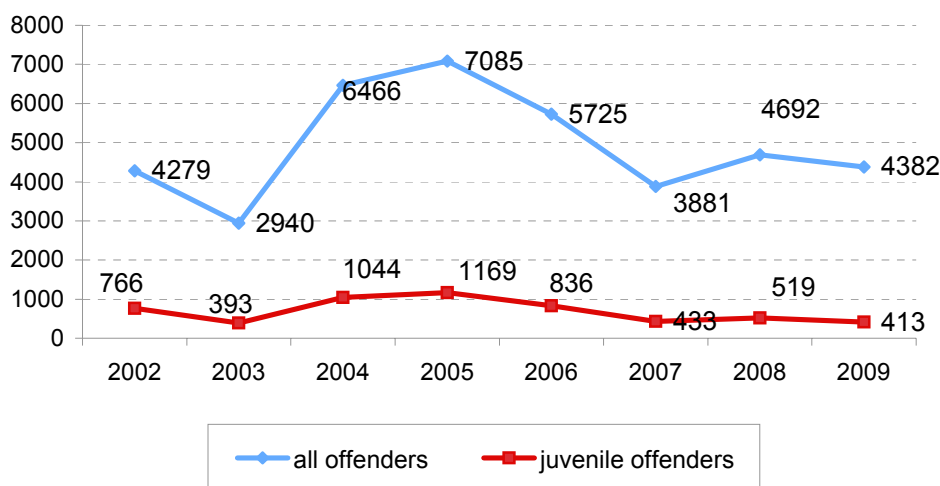
Source: ENYÜBS

Juvenile offenders

In 2009, 413 offenders were registered as juvenile offenders in connection with the offence concerning the misuse of illicit drugs. Since 2005 the proportion of juvenile offenders has shown a continuously decreasing tendency.

Among all offenders registered in 2009 the proportion of juvenile offenders was 8.48%. It can be seen that although the proportion of juvenile offenders committing misuse of illicit drugs (9.42%) is still higher than the proportion of the same age group among all offenders, the difference between the two proportions decreases continuously year after year, and it seems to be levelling off.

Figure 53. Number of registered offenders committing misuse of illicit drugs between 2002-2009



Source: ENYÜBS

Breakdown by education

The proportion of offenders with elementary school qualifications was 40.8%, 2.9% did not have any school qualifications. The proportion of offenders who were currently studying at or had completed vocational secondary school was 36.8%, while 9.4% of the offenders had completed or were currently studying at general secondary school. 2.2% of them had graduated from university or college.¹⁵⁰

Breakdown by previous convictions

As compared to the proportion measured in 2008 (31.2%), 37.43% (1,640 persons) of the offenders committing the misuse of illicit drugs had been previously convicted. As opposed to this, the proportion of first offenders who had not been convicted before was 61.78% (in 2008: 68.8%). Among registered offenders the proportion of repeat offenders¹⁵¹ was 5.13%, the proportion of multiple repeat offenders¹⁵² was 1.71%, while the proportion of special

¹⁵⁰ The reported rates do not equal 100%, as it is not compulsory for offenders to declare level of education.

¹⁵¹ Repeat offenders are offenders who had been sentenced to imprisonment as offenders before committing a voluntary crime, and a period of less than 3 years passed between serving the last punishment or the termination of the executability of the punishment and the commission of their most recent offence threatened with imprisonment.

¹⁵² Multiple repeat offenders are offenders who had been sentenced to imprisonment as repeat offenders before committing a voluntary crime, and a period of less than 3 years passed between serving the last punishment or the termination of the executability of the punishment and the commission of their most recent offence threatened with imprisonment.

repeat offenders¹⁵³ was 1.64%, and the total proportion of repeat offenders was 8.49%. Among the offenders committing misuse of illicit drugs the proportion of former convicts is increasing at a slow rate.

Table 72. *Breakdown of offenders by previous convictions in 2009*

Previous conviction	Persons	%
No	2,707	61.78
No, but under investigation	34	0.78
All former convicts	1,640	37.43
From them:		
<i>multiple repeat offenders</i>	75	1.71
<i>special repeat offenders</i>	72	1.64
<i>repeat offenders</i>	225	5.13
<i>not repeat offenders</i>	1,268	28.94

Source: ENYÜBS

Suspension of accusation

In 2009 a cause terminating culpability was determined in the case of 951 crimes (19.7%), which indicates further increase as compared to 2008 (in 2008: 933 cases, 17.08%)¹⁵⁴.

In 2009 the suspension of accusation took place in connection with 1,523 offences, in 31.55% of the registered offences concerning the misuse of illicit drugs, which proportion also shows an increasing tendency as compared to the previous year (in 2008: 29.76%).

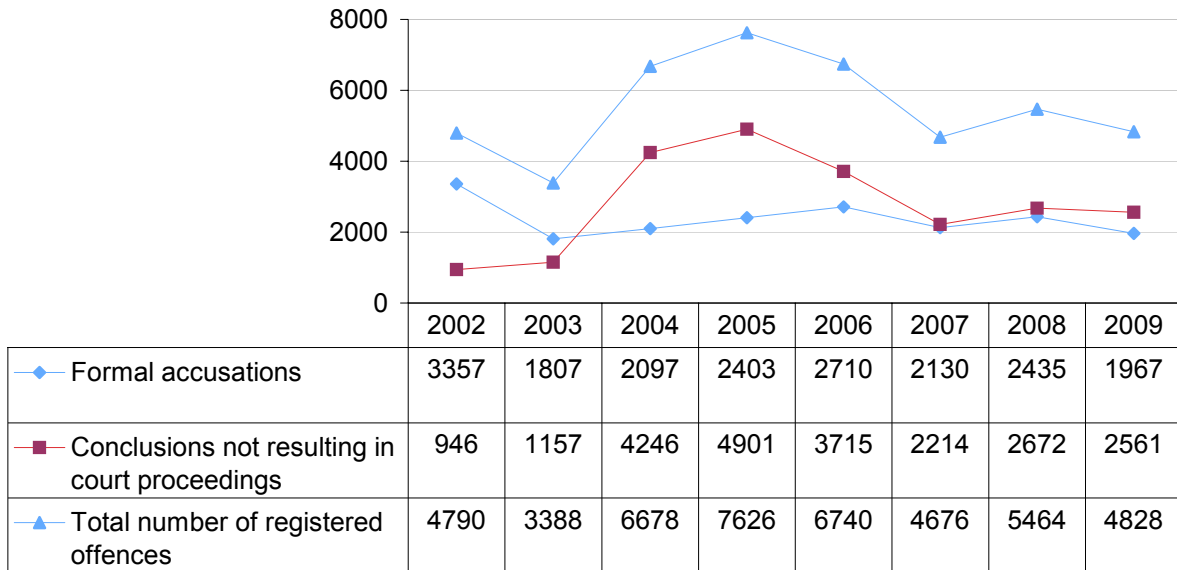
Diversion, as an alternative to imprisonment and its effect on procedural law can be clearly detected in the changing of the numerical and proportion values of the suspension of accusation as a method of conclusion and the determination of a cause terminating culpability as a method of conclusion.

When comparing the methods of conclusion such as reprimand not resulting in formal accusation (87 cases), termination of investigations because of other causes terminating culpability and the suspension of accusation, it can be seen that in 2009 the proceedings were concluded in connection with 2,561 offences using the above mentioned methods of conclusion, in 53.4% of all registered offences concerning the misuse of illicit drugs. As a result of the use of these possibilities of procedural law, a greater proportion of the registered offenders do not appear in court. In the figure showing time-series data it can be seen that the trends of applying procedural forms not resulting in court judgement follow the trends of the number of offences.

Figure 54. *Breakdown of procedural forms not resulting in court proceedings and formal accusations among registered offences concerning the misuse of illicit drugs between 2002-2009*

¹⁵³Special repeat offenders are offenders, who had been sentenced to imprisonment because of an identical or similar offence, and a period of less than 3 years passed between the date when the judgement became non-appealable and the date when the executability of the previous judgement terminated.

¹⁵⁴It is due to the Act LI of 2006 that amended the Act XIX of 1998 on Criminal Procedure (see: National Report 2006, chapter 1).



Source: ENYÜBS

Consequent crime – offences committed under the influence of illicit drugs

In 2009, 637 persons committed an offence – excluding the offences concerning the misuse of illicit drugs – under the influence of illicit drugs or other psychoactive substances. In 2008 the number of such offenders was 905.

If the data of offences committed under the influence of illicit drugs or other psychoactive substances are examined, it can be seen that drug use appears prominently in committing traffic offences, with special respect to committing the offence of driving under the influence of illicit drugs or psychoactive substances. In respect of consequent crime, 66% of the offenders committed traffic offences, and 65% of the offenders committed the offence of driving under the influence of illicit drugs or psychoactive substances.

The dominance of traffic offences can be explained with the intensive monitoring used in connection with the principle of zero tolerance¹⁵⁵.

Among the offenders, the number of offenders committing offences against property was 125 (19%). A significant decrease can be observed in offences against another person, as after the 187 offences (20.6%) against another person observed in 2008, in 2009 29 offences against another person (4.5%) were registered. In respect of consummated homicide and attempted murder, the influence of illicit drugs or psychoactive substances was registered in the case of 1 offender each, which also indicates a significant decrease as compared to the 18 and 13 cases registered in the previous year.

In respect of offences against public order, drug use as an influencing factor was registered in the case of 24 offenders, who committed vandalism.

Analysis on the characteristics of different groups of offenders conducted on the basis of criminal intelligence information can be found in chapter 10.1.

¹⁵⁵ The 2/2008. (I.12) Regulation of the Minister of Justice and Law Enforcement was introduced on 20 January 2008 that is if the driver is found to be driving under the influence of alcohol the police can take away the driving licence immediately at the place of offence.

9.2. PREVENTION OF DRUG-RELATED CRIME¹⁵⁶

Directives 26/2009. (OT 15.) ORFK and 43/2009. (OT 26.) ORFK of the National Police Headquarters issued in the interest of the more efficient prevention of drug-related crime can be found in chapter 1.1.

In 2009 a publication entitled “Training on the Drug Problem for Law Enforcement Units” was issued with the support of the National Drug Coordination Directorate and the National Committee for Crime Prevention. The training book is a gap-filling summary of specialized information and institutions’ experience on issues such as drug-related crime, prevention, healthcare, reintegration and also sincere expert opinions in several topics. The basic task of the publication is to help those who participate in law enforcement training to acquire elementary and special professional skills that are essential for their work.

In 2009 the National Committee for Crime Prevention supported 3 complex crime prevention programmes, which also included drug prevention elements.

9.3. INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

Alternatives to prison

For the detailed analysis of data of clients in diversion programmes see chapter 5.3. For the data of clients in diversion programmes within detention facilities see chapter 9.5.

In the case of clients in diversion programmes the Hungarian Probation Service of the Office of Justice is to be mentioned, which performs tasks aimed at handling the drug problem in connection with probation service provided besides the suspension of accusation (diversion) according to section 222 (2) of the Act on Criminal Procedure.

Probation officers perform supervision and tasks supporting social integration. The tools used during case management are determined by the special features of the case, by the type of offence and by the needs of the offender. Case management basically involves individual case management, the basic elements of which are determined by the probation officer in the probation plan. In the case of juvenile offenders and young adults group case management techniques aimed at improving social skills are also used. Furthermore, restorative justice administration methods are also applied, which may involve for example conference models or mediation, or it may involve community compensation realising symbolic compensation. (For further activities performed by the Hungarian Probation Service of the Office of Justice see chapter 9.6.)

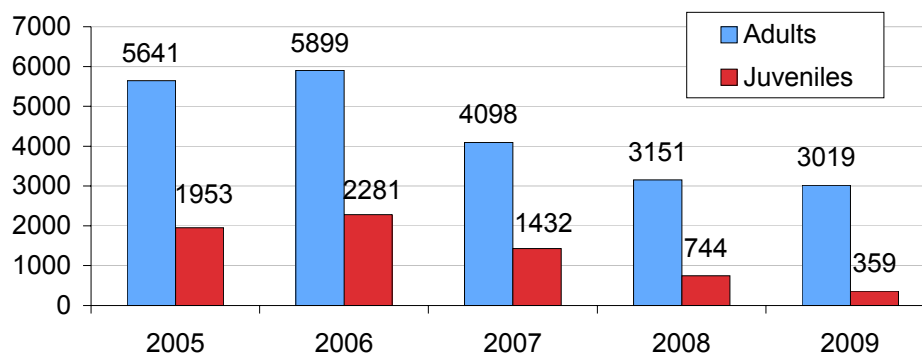
The term of probation is determined by the public prosecutor or court ordering probation. The frequency of meeting the probation officer depends on the severity of the case and the needs of the offender. In the case of juvenile offenders the frequency recommended in the methodology is minimum once a month, in the case of adults once in two months. Besides the offenders committing drug-related crime the service supports numerous clients affected by drug use. In order to handle their problems, probation officers have established intensive cooperation with healthcare organisations and NGOs involved in the treatment and rehabilitation of drug users and in providing prevention programmes.

Since 2007 the number of probation services has been decreasing, as the amendment¹⁵⁷ valid since 1 July 2006 affecting section 188 (1) h) of the Act on Criminal Procedure made it possible to suspend the procedure already in the investigation phase, if necessary treatment is started voluntarily. Further decreasing of the number of cases can be expected, as it is not compulsory to order probation any more besides the suspension of accusation.

¹⁵⁶ Based on the report by the Ministry of Justice and Law Enforcement

¹⁵⁷ For Act LI of 2006 on the amendment of Act XIX of 1998 on criminal procedure see: National Report 2006, chapter 1.

Figure 55. The number of probation services relating to cases of misuse of illicit drugs between 2005-2009



Source: Report by the Ministry of Justice 2010

Other interventions in the criminal justice system ¹⁵⁸

Prevention

In 2009, similarly to 2008, out of the 34 detention facilities prevention units operated at 23 locations. These units can accommodate 350 prisoners, the average number of the prisoners accommodated here was around 220-250. The realisation of the prevention programmes and the setting up of the drug-prevention units in the detention facility of Hajdú-Bihar county and in the detention facility of Győr-Moson-Sopron county was financed to a modest extent from the central budget and from the amount appropriated from the support granted by the Ministry of Social Affairs and Labour and also from support won through project financing, but the cooperation of local NGOs was also used. In 2009, 7 applications submitted by detention facilities were granted support.

Table 73. The list of detention facilities granted support through application in 2009

Applicant	Title of program	Financed activity
Pálhalma National Detention Facility	'A free life with a clear head' 'Get rid of drugs too!' 'Stop being a slave of drugs!'	health improvement programmes for drug prevention groups
Balassagyarmat Penitentiary and Prison	'Health improvement model programme'	health improvement
Detention Facility for Juvenile Delinquents (Pécs); Non profit Ltd for the Youth in Baranya	'First step'	drug prevention programmes
Heves County Detention Facility	'Alternatives within the prison walls'	sports programmes, training, lectures for groups of prisoners
Győr-Moson-Sopron County Detention Facility; Szombathely National Detention Facility; Human Harmony Foundation	'From Szombathely to Győr along the bars'	complex prevention and health improvement programmes for persons imprisoned because of the misuse of illicit drugs
Márianosztra Penitentiary and Prison; HUMAN Psycho 2002 Public Company	'Take off your mask!'	training courses based on drug prevention

Source: Hungarian Prison Service Headquarters

¹⁵⁸ Based on the report by the Hungarian Prison Service Headquarters

9.4. DRUG USE AND PROBLEM DRUG USE IN PRISONS

Prevalence, patterns of use, risk behaviours

In 2009 a survey was carried out (Mészáros et al. 2009), the aim of which was to reveal the main characteristics of drug users imprisoned in the largest prison in Budapest, and, as a consequence, to make concrete professional recommendations on how to support, help, and treat the target group.

The survey was carried out in Budapest Penitentiary and Prison between April-June 2009.¹⁵⁹ On the one part the qualitative method was used in the survey, semi-structured interviews were made with 30 persons, on the other part 201 prisoners were asked to fill in a questionnaire.¹⁶⁰ Hereby the data of the questionnaire survey is reported only.

Only male prisoners were included in the sample. 34 persons (17.1%) were below the age of 25, 104 persons (52.3%) were between the age of 25-34, 30.7% (61 persons) were above the age of 34. The oldest respondent was 53, the youngest one was 21 years old.

73% of the respondents were imprisoned again as repeat offenders or special repeat offenders.

Table 74. Breakdown of prisoners by previous convictions (N=200)

Previous convictions	persons	%
Not repeat offenders	54	26.9
Repeat offenders	87	43.3
Special repeat offenders	17	8.5
Multiple repeat offenders	22	10.9
Special multiple repeat offenders	20	10

Source: Mészáros et al. 2009

Drug use prior to imprisonment

32% (44 persons) of all respondents (136 persons) said that they had used hypnotics/sedatives, typically Rivotril prior to imprisonment. 20.5% of them only tried these drugs, 18% used them occasionally, and 61.2% used them regularly¹⁶¹, often not in compliance with the doctor's indications.

Table 75. Frequency of hypnotics/sedatives use prior to imprisonment among prisoners (N=136)

Frequency of use	Distribution of users		
	persons	%	(%)
Tried	9	6.6	20.5
Occasionally	8	5.9	18.2
Monthly	2	1.5	4.5
Weekly	2	1.5	4.5
2-3 times a week	3	2.2	6.8
Daily	7	5.1	15.9
Several times a day	13	9.6	29.5
All users	44	32.4	100
Did not use drugs	92	67.6	

Source: Mészáros et al. 2009

¹⁵⁹ The survey was performed by the Change Lane Foundation.

¹⁶⁰ 14% of the 1,400 prisoners imprisoned in Budapest Penitentiary and Prison filled in the questionnaire, the surveyed fields were: the target group's socio-demographic data, licit and illicit drug use, drug use patterns, applying for help and its availability. Although it was a self-administered questionnaire, generally 2 helpers were present during filling in the questionnaires. The prisoners were selected at the institute by penal experts using simple random sampling. The sample is not representative. Data recording and analysis was carried out by SPSS.

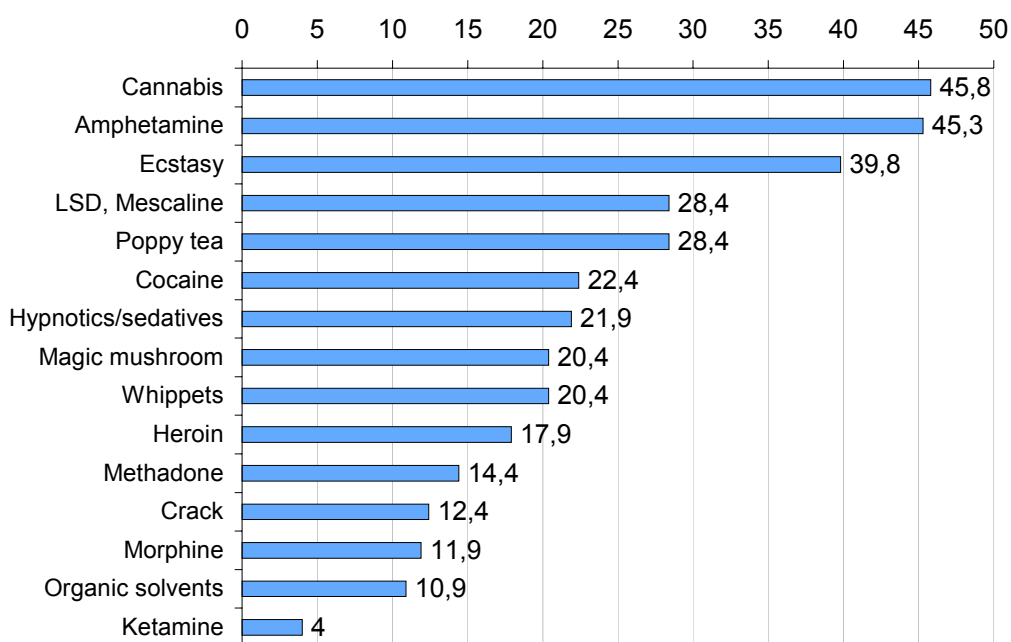
¹⁶¹ Adding up the values of several times a day, daily, weekly, 2-3 times a week and monthly.

58.2% of the respondents¹⁶² (113 persons) had used drugs prior to imprisonment. 35% of the respondents used drugs regularly prior to imprisonment. (ST12_2010_HU_01)

Among the prisoners the order of drugs used most frequently before imprisonment is the same as the drugs indicating the highest prevalence rates in the general population¹⁶³. Cannabis is the first, and it is followed by amphetamine and ecstasy.

As compared to the general population in Hungary, in the case of the persons surveyed in the prison the proportion of herbal cannabis use was 4.5 times higher prior to imprisonment. In the case of other drugs the situation is similar, so in the case of the imprisoned population the probability and occurrence of drug use is higher than in the general population.¹⁶⁴ (ST12_2010_HU_01)

Figure 56. Lifetime prevalence rates per drugs (%) in the period prior to imprisonment among prisoners (N=194)



Source: Mészáros et al. 2009

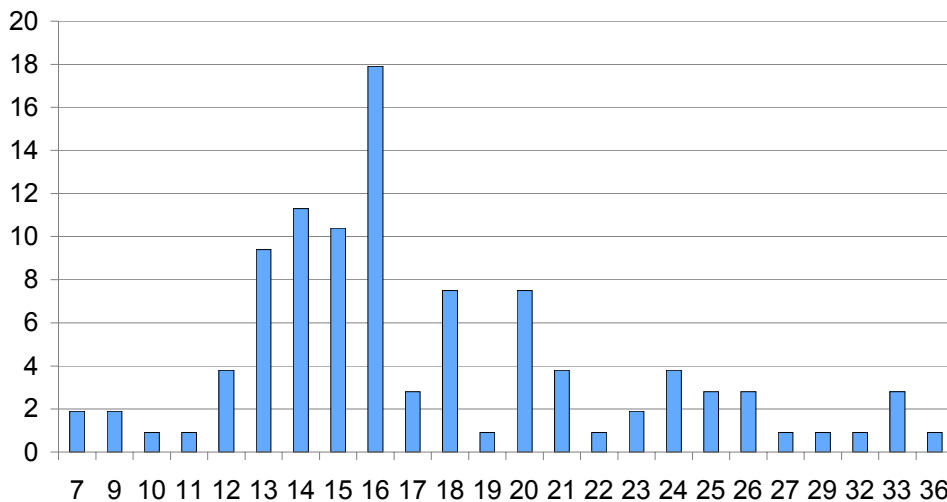
106 persons reported their age at the time when they first tried drugs. At the time of first drug use the youngest respondent was 7 and the oldest one was 36 years old. Of all respondents 32 persons (30.2%) first tried drugs before the age of 14 and 38.6% (41 persons) between the age of 15-18. 33 persons (30.8%) first tried drugs above the age of 18. Most commonly the first drug use took place between the age of 13-16.

¹⁶² 194 out of the 201 persons answered this question.

¹⁶³ See: National Report 2008, chapter 2.1.

¹⁶⁴ See: National Report 2008, chapter 2.1.

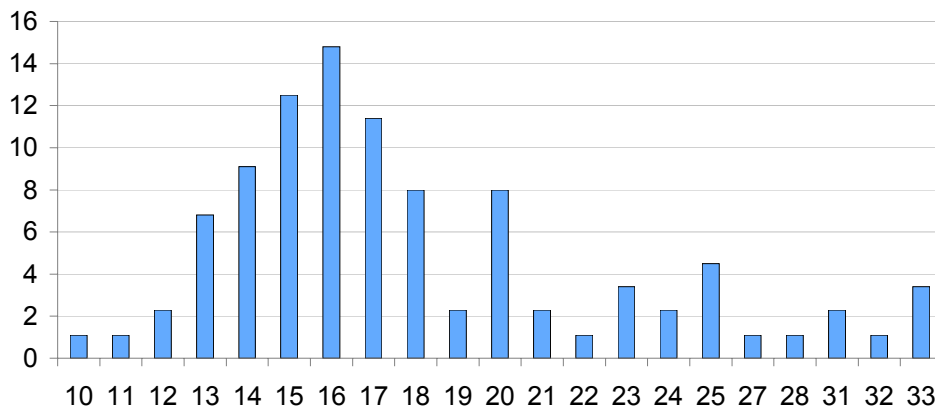
Figure 57. Breakdown of age at first drug use in percentage (%) of the respondents (N=106)



Source: Mészáros et al. 2009

88 of the respondents reported their age when their drug use became regular. Typically regular drug use started between the age of 15-18, with a delay of 3 years as compared to the first drug use. These results are the same as the data measured in the general population¹⁶⁵, that is imprisoned persons do not start drug use at an earlier point.

Figure 58. Breakdown of age at start of regular drug use in percentage (%) of the respondents (N=88)



Source: Mészáros et al. 2009

The route of administration among ever drug user imprisoned persons used drugs prior to imprisonment first of all was smoking, secondarily injecting, thirdly eating/drinking or sniffing or placing drugs on the mucous membranes, and finally inhaling.

¹⁶⁵ Elekes, Zs. (2009). Egy változó kor változó ifjúsága – A fiatalok alkohol- és egyéb drogfogyasztása Magyarországon - ESPAD 2007. NDI - L'Harmattan. In process of publishing.

Table 76. Breakdown of prisoner by route of administration prior to imprisonment (N=113)

Route of administration	persons	%
smoking	65	57.5
injecting	53	46.9
eating/drinking	42	37.2
sniffing	39	34.5
placing on mucous membrane	22	19.6
inhaling	16	14.8

Source: Mészáros et al. 2009

25 persons (47.2%) out of the 53 ever injecting drug users said that they had shared needles/syringes with their injecting partner during drug use.

Drug use inside prison

During the survey it was also examined whether and how the patterns of drug use changed after imprisonment.

A total number of 109 ever drug user prisoners answered the question relating to whether their drug using habits changed inside prison. 60.6% of the 109 persons said that their drug use had changed inside prison, at the same time 39.4%¹⁶⁶ did not report changes after imprisonment.

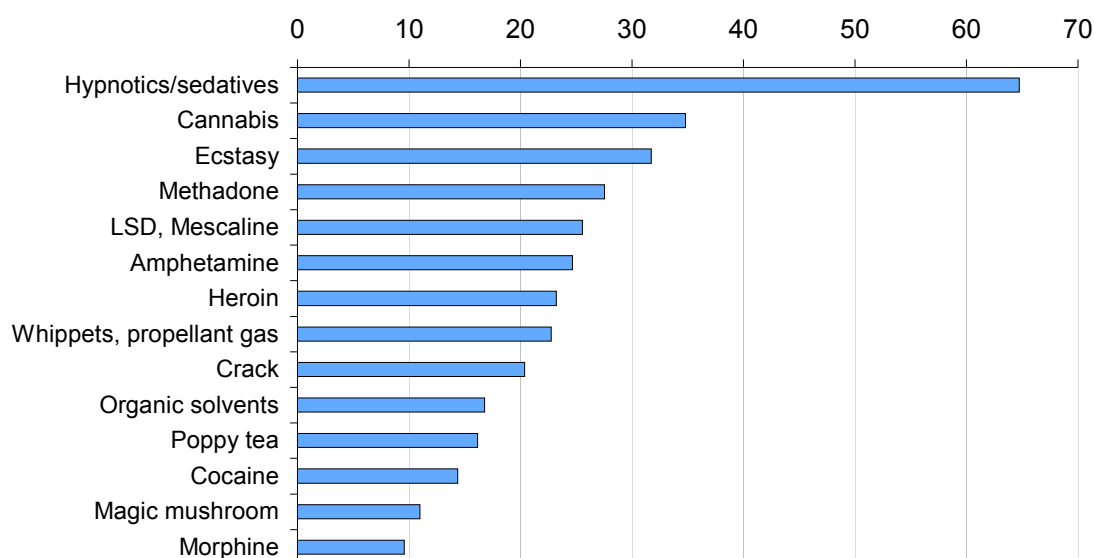
Very low number of answers were received about the direction of the change, 36 answers altogether, and the direction of the change was dominantly pointing towards giving up drugs, there was an insignificant number of cases involving change of drugs or starting drug use in prison, in most cases no change took place. Only one-third of those whose drug using habits had changed received help inside the prison in respect of handling their drug problems. In the case of 65.9% the drug using habits changed mostly because the closed institute and its strong control helped them to quit, rather than because of the series of proactive measures.

In the questionnaire the respondents were asked to estimate the proportion of prisoners who use different drugs in prison. In this case the misuse of medicines was also listed here.

The mean values of estimated prevalence rates, according to which there is a high proportion of the misuse of medicines and it becomes the most prevalent in prison, indicate clearly the structural change of drug use prior to imprisonment.

¹⁶⁶ The 40% proportion is formed by persons whose drug use prior to imprisonment was not significant, and by persons in the case of whom no change took place after imprisonment, because inside the prison they were able to continue to use the drugs that were important for them, it was not a problem to obtain these drugs.

Figure 59. The mean value (%) of estimated prevalence rates of drug use per drug types in prison according to the prisoners¹⁶⁷



Source: Mészáros et al. 2009

In the scope of the hepatitis C screening programme realised in the detention facilities, the risk behaviours related to infectious diseases and drug use was also surveyed. For the data see chapter 6.1.

Availability of drugs inside prison

During the survey carried out in a prison in Budapest in 2009 (Mészáros et al. 2009), 176 persons (87.6%) out of the 201 persons filling in the questionnaire answered the question relating to the availability of drugs in prison. According to 39.2% of the sample it is easy or very easy to obtain drugs in prison. 34.1% said that it was difficult or very difficult to obtain drugs, while according to 26.7% of the sample it was impossible to obtain drugs inside the prison.

Table 77. Availability of drugs inside prison (N=176)

Availability	Persons	%
very easy	35	19.9
easy	34	19.3
quite difficult	34	19.3
very difficult	26	14.8
impossible	47	26.7

Source: Mészáros et al. 2009

The availability of drugs inside prison was also examined in the course of the survey¹⁶⁸ on drug use and risk behaviours relating to hepatitis C screening programmes at detention facilities. 61.1% (295 persons) of all respondents (483 persons) found that it was impossible to obtain drugs at the institute. 14.5% (70 persons) found it very difficult, 14.3% (69 persons)

¹⁶⁷ The number of valid answers given by the respondents was 58 in the case of cannabis, 20 in the case of heroin, 7 in the case of poppy tea, 14 in the case of morphine, 21 in the case of cocaine, 11 in the case of crack, 37 in the case of amphetamine, 11 in the case of methadone, 57 in the case of hypnotics/sedatives (typically Rivotril), 31 in the case of ecstasy, 18 in the case of LSD/mescaline, 13 in the case of magic mushroom, 19 in the case of organic solvents and 19 in the case of whippets/propellant gas.

¹⁶⁸ For the description and methodology of the survey see chapter 6.1.

found it moderately difficult, while only 3.9% (19 persons) found it easy and 6.2% (30 persons) found it very easy to obtain drugs inside the prison.¹⁶⁹

Table 78. *Availability of drugs at detention facilities according to prisoners participating in the screening programme and the survey of risk behaviours in 2009 (N=483)*

Availability of drugs	Number of answers	%
impossible	295	61.1
very difficult	70	14.5
moderately difficult	69	14.3
easy	19	3.9
very easy	30	6.2

Source: Hungarian National Focal Point

According to the report of the Hungarian Prison Service Headquarters, in 2009, 28 out of the 34 detention facilities had luggage scanning equipment and only 15 facilities had drug detection dogs. While in 2008 substances raising the suspicion of being illicit drugs were found at the detention facilities in 38 cases involving 36 prisoners, in 2009 such substances were found in 88 cases involving 91 prisoners.¹⁷⁰ Also, at one of the detention facilities, on the courtyard designated for the prisoners' outside exercise periods packages containing injecting equipment were found on 2 occasions (probably they had been thrown over the main wall).

9.5. RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS

Treatment

For the legal act amendments relating to treatment in prison see chapter 1.1.: Directive 4/2009. (III. 20.) IRM of the Minister of Justice and Law Enforcement.

Clients treated inside detention facilities

The treatment for drug addiction of adult male prisoners was realised at the National Institute for Forensic Observation and Psychiatry (hereinafter: IMEI), treatment of other conditions with drug use was realised at Budapest Penitentiary and Prison. In the case of adult female prisoners treatment for drug addiction and treatment of other conditions with drug use were realised at Kalocsa Penitentiary and Prison, in the case of juvenile male imprisoned persons at the Detention Facility for Juvenile Delinquents (Tököl), in the case of mothers accommodated together with their child in a mother-child unit at Bács-Kiskun County Detention Facility, in the case of juvenile female and juvenile male imprisoned persons at the Regional Detention Facility for Juvenile Delinquents (Kecskemét), and in the case of women under preliminary arrest at Budapest Detention Facility. Budapest Detention Facility also realised treatment of other conditions with drug use for imprisoned persons accommodated therein, kept under preliminary arrest.

All detention facilities – having a cooperation agreement concluded with a service provider having the obligation of regional supply determined by the National Institute for Drug Prevention – provided drug preventive-consulting service for the prisoners.

On the basis of the report by the Hungarian Prison Service Headquarters (Ministry of Justice and Law Enforcement, 2010), in 2009 50 persons received treatment for drug addiction, 26 treatments were completed, in the case of 14 persons the treatment remained in process and

¹⁶⁹ The reasons for the difference between the results of the two surveys examining availability are: the surveys were carried out at different detention facilities; different sampling methods were used.

¹⁷⁰ There is no accurate information regarding the type of drugs.

in the case of 10 persons the treatment was interrupted. 62 persons received treatment of other conditions with drug use, 37 treatments were completed, in the case of 17 persons the treatment remained in process and in the case of 8 persons the treatment was interrupted. 194 persons were provided with preventive-consulting service, 88 persons completed the treatment, in the case of 39 persons the treatment was in process and in the case of 67 persons the treatment was interrupted.

Besides diversion, the specialists of IMEI also treated the withdrawal symptoms of a further 32 problem drug users.

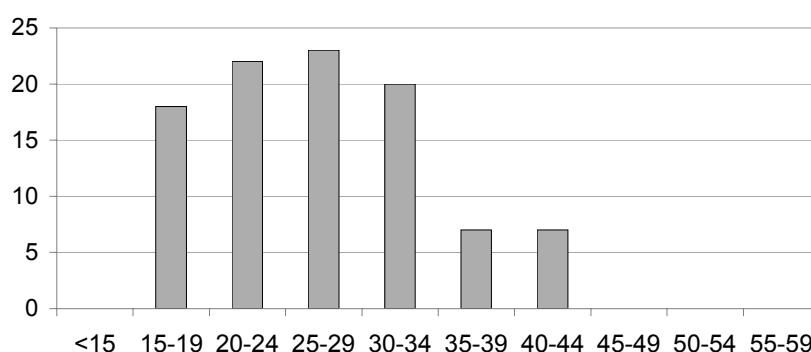
In the TDI database of the National Centre for Addiction (OAC) cases when treatment¹⁷¹ because of illicit drug use is started at the detention facilities are also collected in compliance with the TDI protocol, using a method unsuitable for personal identification but suitable for control of double counting. In respect of 2009 the TDI database of the National Centre for Addiction contained the TDI datasheets of a total number of 97 clients who entered treatment in prison. Due to the low number of cases the case numbers are stated when analysing the individual TDI data tables, the possibility to carry out percentage calculations – similarly to last year’s statistics – is restricted.

Among the 97 clients treated there were 96 men and there was 1 woman. In the case of the only woman the detention facility providing the data did not supply information relating to whether she had been treated before, 39 of the men entered treatment for the first time, and 29 men had been treated before. In the case of 28 there was no information about whether they had been treated before. (TDI_2010_HU_04)

Nearly all clients entered treatment in the scope of some sort of diversion programme, in 95 out of the 97 cases the question relating to the “Origin of referral” was the court, the public prosecution or the police. In 2008 all clients entering treatment at the detention facilities were participating in a diversion programme.

As compared to 2008, the age distribution slightly changed; while in 2008 most prisoners entering treatment were in the age group between 20-24, in 2009 persons between the age of 25-29 were represented in the highest number, and the number of persons between 30-34 was approaching the number of persons between the age of 20-24. (TDI_2010_HU_04)

Figure 60. Breakdown of clients entering treatment at detention facilities by age groups in 2009 (all clients, persons, N=97)



Source: OAC 2010

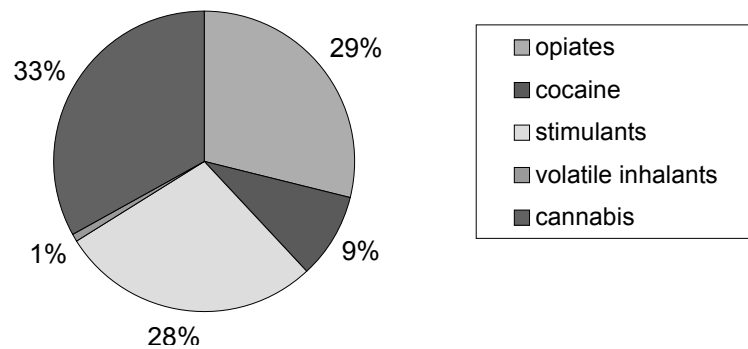
Most of them had completed elementary school – 65 out of all clients – and 18 persons had completed secondary school. 8 persons had not even completed elementary school.

The most common cause of entering treatment was cannabis use (in 32 cases), in the case of 28 persons the primary substance was an opiate (in 27 cases heroin and in 1 case other opiate), 27 persons used stimulants, first of all amphetamine (25 clients). The only woman entering treatment at a detention facility started treatment because of amphetamine use. It needs to be pointed out that the cause of entering treatment is not necessarily the same

¹⁷¹ The definition of treatment is the same as the definition stated in the EMCDDA TDI-protocol.

substance as the substance in connection with the criminal proceedings were instituted. It is important to highlight that – although because of the low numbers it is difficult to make a comparison – as compared to 2008 the number of cocaine users increased both in respect of the number of cases and in respect of proportion (in 2008 there were 3 cases out of the 62 cases, while in 2009 there were 9 cases out of the 97 cases). (TDI_2010_HU_04)

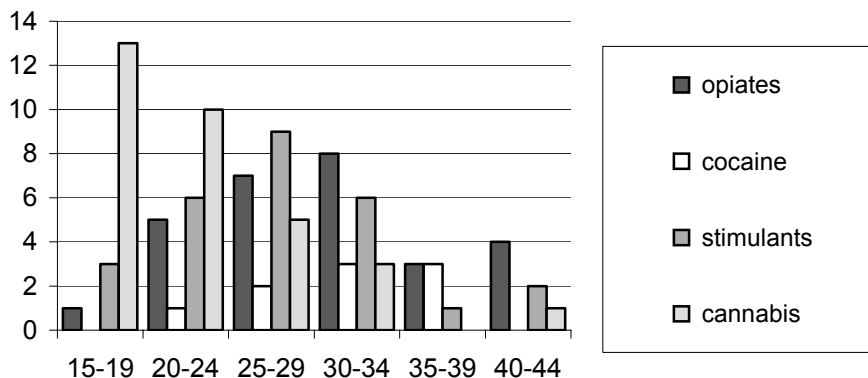
Figure 61. Breakdown of prisoners entering treatment at detention facilities by the primary substance in 2009 (persons; %)(N=97)



Source: OAC 2010

As opposed to 2008 – when half of the cannabis users were above the age of 30 –, in 2009 cannabis users are significantly younger than other drug users. Practically the age distribution among opiate users and stimulant users is the same. (TDI_2010_HU_04)

Figure 62. Breakdown of prisoners entering treatment at detention facilities by age group and the primary substance in 2009 (persons, N=97)



Source: OAC 2010

Regarding route of administration nearly all opiate users were IDUs¹⁷² (24 persons). At least one-third of amphetamine and cocaine users (3 persons among cocaine users and 10 persons among amphetamine users) injected drugs prior to imprisonment. The appearance of injecting cocaine users among persons starting treatment in prison at a later point is to be highlighted, even though for the time being they appear in a low number of cases.

The time of starting using the primary substance because of which treatment is started (that is the age when the drug user first started to use the given illicit drug) is the earliest in the case of cannabis: of the mean age is 16.8 years. Drug users starting treatment because of the use of stimulants first started to use this drug type at the age of 19 on average. The mean age of first starting to use heroin (20.5 years of age) and cocaine (21.2 years of age) is

¹⁷² Drug using habits among imprisoned persons on the basis of the TDI protocol

in the next age group among prisoners entering treatment in the prison setting. (TDI_2010_HU_04)

The most common secondary substances among heroin users were stimulants (19 mentions including 13 mentions of amphetamine) and cannabis (17 mentions). Among amphetamine users cannabis was the most common secondary substance with 14 mentions. Users of cannabis as a primary substance mentioned nicotine the most commonly as their secondary substance (17 mentions), it was followed by stimulants (10 mentions), and then alcohol (7 mentions). The structure of secondary drug use is similar to the one in the case of clients entering treatment not in detention facilities. As compared to the general population entering treatment hallucinogens is more common (11 cases) first of all the presence of LSD is significant, in 10 cases. (TDI_2010_HU_04)

Prevention, treatment and care of infectious diseases

Immunisation

Since 1999 the hepatitis B vaccination has been a compulsory scheduled vaccination (school-based vaccination project) in grades 7-8 of elementary school, so imprisoned persons who turned 13-14 in or after 1999 have been immunised. In practice it means that prisoners below the age of 25 were vaccinated against hepatitis B at elementary school, in the case of the currently imprisoned persons it means 3,526 persons¹⁷³.

Hepatitis B vaccination can be given free of charge if on the basis of the Methodological Letter of the National Centre for Epidemiology on vaccinations the imprisoned person belongs to the indicated age group for whom compulsory vaccination (supplemental vaccination) is to be provided and/or exposed to a high morbidity risk. The imprisoned person can also finance his/her own vaccination.

At an annual level a maximum number of 20 persons are vaccinated against hepatitis B at detention facilities on the basis of the criteria listed above.

Imprisoned persons working on areas of healthcare (e.g.: Central Penal Institution Hospital, National Institute for Forensic Observation and Psychiatry, etc.) (e.g.: cleaning, washing equipment) are also vaccinated, which also affects a maximum number of 20 persons at an annual level.

Prevention, testing

In 2009 5,850 prisoners took part in the lectures about hepatitis infection after which 2,936 persons were tested on a voluntary basis for HCV. (For more detailed information see National Report 2009, chapter 9.5.) Generally doctors from the local hepatology clinics gave lectures before the tests.

Using the funds provided with the cooperation of the Ministry of Social Affairs and Labour, it was also possible to test the blood samples for hepatitis B, and from the budget of the National Centre for Epidemiology HIV tests were also performed (for detailed data on prevalence see: chapter 6.1.). The laboratory tests were performed at the reference laboratory of the National Centre for Epidemiology (OEK).

¹⁷³ According to the situation on 09.04.2010, on the basis of the prisoners' data recorded in the IT system, It is 22.94% of the average number for total prison population.

Map 4. *Geographical breakdown of HIV/HBV/HCV screening programmes carried out in detention facilities between 2007-2009*



Source: Hungarian Prison Service Headquarters and Hungarian National Focal Point

In order to survey drug use and related risk behaviours, the Hungarian National Focal Point continued data collection in line with the hepatitis C screening programme organised at detention facilities. On the basis of serial numbers the anonymous questionnaires could be related to the serological results (for the data see chapter 6.1.). Tuberculosis screening is also accessible within detention facilities (for the prevalence data see chapter 6.1.).

Treatment, care

Measures were taken to start providing for HCV positive prisoners care and antiviral treatment complying with the valid guidelines on therapy. In 2009 among the diagnosed cases (see chapter 6.1.), 47 HCV positive persons started the antiviral treatment. The others did not undertake the treatment or quitted the treatment while in process because of its side effects. Since 2007 antiviral treatment was started in the case of a total number of 107 persons.

Imprisoned persons with HIV/HCV/TB were treated in 2009 as described in the previous years. (For more detailed information see National Report 2009, chapter 9.5.)

9.6. REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON

Resocialisation, reintegration programmes

In points 10 and 17 of Government Regulation 1094/2007. (XII. 5.) on governmental tasks relating to the realisation of the objectives of the National Strategy to Combat the Drug Problem tasks are prescribed for the Hungarian Probation Service of the Office of Justice. In both points the realisation of resocialisation and follow-up programmes is prescribed for persons released from prison.

Furthermore, the Probation Service performs tasks aimed at handling the drug problem first of all by providing probation service beside the suspension of accusation (diversion) according to section 222 (2) of the Act on Criminal Procedure. (For more detail see chapter 9.3.)

In 2009 the pilot project was continued aimed at using the method of family and small community conference talk among imprisoned persons before release and among persons under probation affected by the drug problem. (For further information see: National Report 2009, chapter 9.6.)

On 1 September 2009 a new project entitled "Probation service programmes for imprisoned persons, persons participating in follow-up programmes and persons under probation with addiction problems" was launched also financed from restructuring funds. In the scope of the project the programmes aimed at clients with addiction problems are to be developed in two directions:

The programme aimed at using family and small community conference talk will be continued, in the scope of which they realise 10 further family and small community conference talks, which, according to the plans, will result in the stabilisation of the methodology. As a supplementation to the motivation interview method, the family and small community conference talk programme unit also includes training preparing for the use of techniques applied as the final elements of the motivation interview ("Problem-Solving Models and Ending Client Relationships in the case of persons with addiction problems"). The training course entitled "Problem-Solving Models and Ending Client Relationships in the case of persons with addiction problems" was organised on 3 occasions in October-November 2009, for 3 groups, in 20 hours per occasion, and a total number of 60 probation officers took part in the training courses.

On 25 May 2009 a conference was organised to introduce the professional programme entitled "Using the method of family and small community conference talk among imprisoned persons, persons participating in follow-up programmes and persons under probation with addiction problems", in the scope of which training films made during the programme were shown, and the probation officers facilitating family and small community conference talks shared their experience with the professional audience.

Furthermore, in 2009 the programmes aimed at the target group with addiction problems were extended with a new element, the method of experiential education.

Experiential education sessions, using the age group characteristics of adolescents and young adults, base intervention on the clients' need for searching for experience, excitement and adventure in groups. Young people have a good time during the programme, they experience excitement, and without noticing it they acquire a whole series of skills and abilities, which are essential from the aspect of crime prevention, undertaking responsibility and finding safety. E.g.: cooperation, mutual understanding, acceptance, group norms, scale of values, mutually undertaking responsibilities, providing help, improving self-knowledge and self-confidence via the social mirror held up by other members of the group during the sessions.

As a special behavioural rule of probation service, obligatory participation in the group sessions can be prescribed. The group sessions are aimed at handling the most common crime repetition risks occurring among juvenile offenders, first of all by developing different social skills (e.g.: communication, problem solving, conflict handling skills). The aim is to integrate experiential education sessions in the system of group probation sessions, that is to make it possible to prescribe participation in such sessions as a special behavioural rule of the probation service. First of all they intend to use this method with clients, in the case of whom drug use or alcohol consumption occurs as a crime repetition risk.

In the interest of this a trainer course was organised for 18 probation officers, who can hold experiential education sessions in the future themselves for groups of persons under probation. In the scope of the project, in 2010 two experimental groups are organised, one in Budapest at Jóvá-Tett-Hely Community Centre and one in Miskolc in the scope of the Green

House Integration Programme. Mentors help the trained probation officers in their work, in organising and conducting the sessions.

Conclusions

According to the data recorded in the Unified Criminal Statistics System of the Investigation Authorities and Public Prosecution, the number of registered offences concerning the misuse of illicit drugs indicates a decrease (11.5%), and the numerical data of consequent crime also indicate decrease. The persons involved in criminal proceedings are typically persons in the case of whom demand-related perpetration could be proved (83.84%). In 80% of drug-related offences cannabis was the subject of the offence, and it is followed by heroin representing a proportion of 7%. The proportion of offenders below the age of 30 is 82% among offenders committing misuse of illicit drugs, while this proportion is only 47% among all registered offenders. The proportion of juvenile offenders among all offenders committing misuse of illicit drugs is decreasing year after year, and it is slowly approaching the proportion measured among all registered offenders.

On the basis of the survey carried out in Budapest Penitentiary and Prison it can be determined that drugs and drug users are present in the detention facilities, although no exact series of data is available (either in the case of drugs or in the case of drug users). At the same time it is obvious that even in closed settings it is necessary to deal with addiction and addiction treatment as well as addicted persons and their care/treatment. On the basis of the survey it can be seen that drug use prior to imprisonment occurs very characteristically among prisoners. The structure of drug use is similar in the case of the general population and in the case of imprisoned persons prior to imprisonment: cannabis use is the most common, and it is followed by amphetamine and ecstasy use. The structure of drug use changes significantly inside the prison: benzodiazepines, first of all Rivotril, become the most commonly used drugs. One of the reasons for this may be that these drugs can be received/prescribed as a part of a therapy, in a legitimised way, so they are easier to access. According to the TDI data collection, in 2009, 97 imprisoned persons entered treatment in prison because of their drug use problem. Nearly all clients entered treatment in the scope of a diversion programme. The most common cause of entering treatment was cannabis use, it was followed by opiate use and then by the use of stimulants.

The extensive HCV screening campaign started in 2007 at detention facilities continued in 2009 too. In the course of the campaign all blood samples were tested for HIV and HBV too, and imprisoned persons participating in the screening programme were also interviewed about drug use and related risk behaviours.

In 2009 the Hungarian Probation Service of the Office of Justice continued its pilot project aimed at using the method of family and small community conference talk among imprisoned persons before release and among persons under probation affected by the drug problem.

10. DRUG MARKETS

Overview

Starting from 2009, beside the laboratories of the Institute for Forensic Sciences (BSZKI) – in the case of drugs seized by the Hungarian Customs and Finance Guard – the laboratory of the Institute for Chemical Analysis of the Hungarian Customs and Finance Guard (VPVI) is also entitled to analyse substances, which raise suspicion that they may be illicit drugs¹⁷⁴. In the interest of operating the data collection system at the same quality, VPVI operating since 1 January 2009 also had to be integrated in the reporting system. Upon the initiation of the Drug Affairs Coordination Committee's Specialized Laboratory Committee, the Hungarian National Focal Point conducted harmonisation discussions between BSZKI and VPVI relating to the harmonisation of the data collection system and to the further efficient operation of high-quality and reliable data supply at national level. As a result of the harmonisation, the data of the substances analysed in VPVI is evaluated together with the data of BSZKI, and the data is submitted by BSZKI to the Hungarian National Focal Point in the form of a unified national database suitable for analyzing national trends.

In June 2009 BSZKI – with the support of the Drug Affairs Coordination Committee and the National Institute for Drug Prevention – launched a project entitled “Intensive monitoring of the active substance content of hazardous drugs” (for details see: chapter 7.1.).

10.1. AVAILABILITY AND SUPPLY

Availability

Availability on the basis of investigation data

On the basis of the report by the police authority¹⁷⁵ it must be emphasised that GHB and GBL are still widely used and problematic, first of all because in the great majority of the cases the substance is found in the form of GBL, which is presently not qualified as an illicit drug. GBL can even be obtained by ordering it through the internet, it is cheap, and no proceedings can be instituted against the acquiring groups in the lack of criminal offence. (For further data on GBL see: chapter 10.2.)

Drugs origin: national production versus imported

National production on the basis of seizure data¹⁷⁶

In July 2009 an illicit drug laboratory was seized in an apartment in Budapest. At the time of the seizure they were producing amphetamine, but 2C-B, a basic substance suitable for the production of 2C-B and BZP were also found at the same location.

In the case of cannabis, as according to expert estimates more than half of the amount consumed in Hungary is produced domestically, the police laid special emphasis on the discovery of such illicit plantations. In connection with this they monitored the distribution of equipment needed for the operation of such plantations, and they communicated with electricity and water suppliers, as these two public services are highly necessary for the operation of plantations.

¹⁷⁴ See: chapter 1.1.: Government Decree 282/2007 (X. 26.)

¹⁷⁵ The 2009 Annual Report of the Ministry of Justice and Law Enforcement

¹⁷⁶ On the basis of the 2009 Annual Report of the Institute for Forensic Sciences and the Ministry of Justice and Law Enforcement.

In 2009 the number of cannabis plantation seizures increased significantly as compared to the previous years. At the end of 2008 the police obtained information about an organised group of Vietnamese citizens producing or planning to produce cannabis in large quantities in Hungary. As a result of collecting information purposefully, in 2009 20 persons were put under preliminary arrest and criminal proceedings were instituted against a Vietnamese organisation, which has been identified to produce cannabis in 26 houses so far, and several warehouses have been successfully seized too. A significant part of the plantations were found in houses equipped for the purpose of cannabis production, in which the plants were cultivated using professional indoor cultivation technology. The investigations are still in process in international cooperation. Concrete connections can be identified with the Czech Republic, Germany and the United Kingdom. Apart from this group several smaller Vietnamese organisations and Hungarian plantations have been liquidated too.

National production methods

In 2009 a survey was performed¹⁷⁷ (Ritter 2009) entitled “Drug dealer careers”, in the course of which the course of life and criminal career of prisoners serving their sentence as a result of committing supply-related criminal offences concerning the misuse of illicit drugs were analysed. The survey also covered the methods of domestic drug production. On the basis of analysing the answers given by the interviewed persons, in respect of cannabis it can be said that the national cannabis supply market has two poles: on the one part it is characterised by domestic production, on the other part by import. An increasingly more significant part of herbal cannabis available at the level of retail level derives from domestic production. Cannabis is grown by offenders of both Hungarian and foreign citizenship; the production of some plants for personal use is just as characteristic as cultivation on plantations for wholesale purposes.

According to the respondents two production methods are used in Hungary: one of them is the Dutch model, the hydroponic system. In this system serious equipment is used, which involves lamps, the ventilation system (supplying carbon-dioxide for the plants, filtering undesired pollens from the air, extractor fan), and the watering system (ensuring water supply and the ideal humidity content). Most commonly it is arranged on shelves, like a small horticultural nursery. It can be associated with Hungarian offender groups.

The other method is the Vietnamese soil-ball method (typically associated with Vietnamese groups): the young trees are planted in soil, the roots are covered with a canvas bag. They are sprayed and watered, and obviously light is also ensured, it is a much less demanding cultivation method. At the same time it does not require careful plantation like the Dutch method. If necessary, cultivation can be started immediately, and possible removal (because of escaping) does not represent a loss either. If they have to escape, after a quick harvest they leave the soil where it is, as the harvested stems cannot be used any longer. The Dutch method is more professional, they even cultivate young plants for new plantations.

¹⁷⁷ In the course of the survey entitled “Drug dealer careers” the aim was to analyse the course of life and criminal career of prisoners serving their sentence as a result of committing supply-related criminal offences concerning the misuse of illicit drugs, and to compare and reveal the factors and markers appearing in all examined courses of life as a common characteristic feature, and also to examine the organisation-sociological aspects of domestic drug trafficking. The method of the survey involved document analysis, course of life interview and in-depth interview. The survey was performed in Hungarian detention facilities in April and May 2009, among prisoners sentenced with a final judgement for drug trafficking, distribution, production. More exactly, a course of life interview was made with all convicted persons who had committed supply-related criminal offences concerning the misuse of illicit drugs and were serving their sentence at the time of the survey, gave their consent and could be interviewed at the Vác Penitentiary and Prison, at the Kalocsa Detention Facility, at the National Detention Facilities in Szombathely and Budapest and at Detention Facility for Juvenile Delinquents in Tököl. These were the chosen institutes as according to the registers the highest number of persons imprisoned due to committing supply-related criminal offences concerning the misuse of illicit drugs could be found in these ones. The sample size was 47 persons, 4 women and 43 men. Notes were taken during and after the interviews, then they were analysed. The data of case files and course of life interviews were recorded on the computer and were analyzed using SPSS. (The preliminary results of the survey have been published in National Report 2009 chapter 11.)

In the case of other drugs cutting, the dilution of the substance, is performed in nearly all cases, except if the drug has been measured out and packed, moreover tablets, LSD stamps, microtrips are not diluted either.

The most commonly used cutting agents, i.e. caffeine tablets and lactose, are easy to obtain because of their distribution at pharmacies. Generally only smaller doses, i.e. only 100 grams are purchased at the same place, so the dealers must visit several pharmacies for the necessary amount. In many cases lactose is obtained from hospitals. One to one dilution with lactose is the most typical, amphetamines are easy to mix, cocaine is ground first and then mixed with lactose and heated in special equipment to achieve perfect blending.

Mixing with sedatives, antidepressants can also be observed, but it is less commonly used because it is dangerous. A more commonly used method is dilution with Algopyrin and other pirin tablets. Mixing with pharmaceutical preparations is characteristic of foreign offenders. Antidepressants and sedatives also intensify the effect of the substance, pirin tablets are typically popular because of their consistency.

In many cases powdered sugar or cocoa powder is used for dilution, but flour, calcium tablets, other vitamin preparations available in pharmacies or in free trade, baking powder and baking soda are also used as diluting agents. The main point is that they should be relatively cheap and easy to obtain. Distributors are not interested in the physiological effect of the cutting agent, all they care about is that it should not be fatal. According to the respondents cocoa – which may even be fatal when administered intravenously – is typical only of Vietnamese and Chinese offenders.

Trafficking routes, organisation of domestic drug markets

Heroin

On the basis of the data of the National Bureau of Investigation (NNI) and the Budapest Police Headquarters (BRFK) (IRM 2010) no significant change can be observed in the quantity of heroin transported through Hungary. It is due to the fact that for decades Hungary has been a part of several routes on which drugs are transported from Afghanistan, the largest illicit opium producing country supplying Europe. Heroin is mostly transported to the Netherlands, Germany, France, Italy and England. According to the latest data of the NNI so-called barter transactions have appeared on the heroin market. It affects Hungary in such a way that in the case of such transactions a part of the route there and back passes through Hungary too.

Mostly persons of Turkish, Serbian or Albanian origin deal with the trafficking and wholesale distribution of heroin, while the street distribution of heroin is mainly performed by Vietnamese and Hungarian citizens. In respect of Hungarian citizens dealing with heroin distribution it can be stated that a large proportion of them are addicts themselves, and criminal proceedings have been already instituted against the majority of them because of the same offence. The so-called “acquisition” crime can be typically associated with heroin users too. Mainly addicted users commit crimes – especially in and around Budapest – to obtain money to buy drugs. Such crimes first of all include pickpocket theft and shoplifting, but there is also a significant number of thefts of vehicles in this respect. It also happens that violent crime is committed in order to obtain money to buy drugs, such crimes mostly include lower-value robberies. Because of the tendencies described above in connection with trafficking and wholesale domestic distribution, the activity of offenders of Turkish and Albanian origin living in Budapest and in the country in large numbers requires a separate direction of intelligence. The majority of them are well known by the police, as criminal proceedings have been instituted against a significant proportion of them because of the misuse of illicit drugs, so their activity is monitored continuously. As certain groups are specialised in trading the main diluting agent of heroin (called “monitor”, which contains paracetamol and caffeine) monitoring the distribution of this agent may lead to persons possessing large amounts of heroin.

The so-called street trade is being investigated continuously. Besides Vietnamese citizens this activity is performed first of all by Hungarians, who have been convicted before because of drug-related offences. In the majority of the cases these retail dealer groups are related to Vietnamese and Albanian wholesalers investigated separately.

According to the results of the survey made in 2009 examining drug dealer careers (Ritter 2009) the Vietnamese typically bring heroin from their home country and Pakistan, and Arabians and Albanians also distribute drugs from Pakistan, Yemen and Afghanistan. In many cases the Chinese sell drugs deriving from Vietnam. Generally Roma dealers trade with drugs originating from Chinese groups in the districts VIII and XIII in Budapest.

Cocaine

On the basis of the investigation data (IRM 2010) the sudden increase of the cocaine demand can be observed as a tendency, as a consequence of which different groups smuggle increasing amounts of cocaine to Hungary. Hungarian groups, which also smuggle synthetic drugs first of all from the direction of the Netherlands and Belgium, are dealing with importing and distributing cocaine. Generally these Hungarian groups can be reached from a lower level by revealing the distributor network, and human intelligence service can also be used against them efficiently.

As cocaine is becoming increasingly more popular, in respect of this substance African, first of all Nigerian organisations are gaining a leading role, the members of which organisations are staying in Hungary mostly as refugees. Their organisation consists of several small cells, which organise the transportation of cocaine to Hungary from Spain, the Netherlands or directly from South America independently from each other, but being aware of each other's activity. Their progress is due to that because of the strict control at European ports, today the majority of the large consignments shipped from South America first to Africa, and from there they are transported to Europe. In connection with this Africans who have been involved in trafficking were paid in cocaine by large South American criminal organisations, and in this way they could establish direct South American relationships. These groups continuously organise the transportation of cocaine to Hungary and its distribution in Hungary, they employ couriers of Hungarian nationality, who transport drugs from South America to Europe and within Europe. The police continuously monitors these groups of offenders in permanent cooperation with European authorities. In connection with African groups the greatest problem is that they use tribal languages for communicating with each other.

Furthermore it can be determined that dealers are concentrating more and more on the distribution of cocaine too. It can be observed that in many cases those who used to sell amphetamine or cannabis have switched to selling cocaine.

Synthetic drugs

In Hungary and Budapest synthetic drugs are among the most popular and most commonly used drugs, and in most cases offenders deal with the trafficking of these drugs in line with other drugs. In general people of Hungarian nationality deal with this type of drugs, so human intelligence service can be used in respect of them efficiently. The groups of offenders participating in the trafficking and distribution of synthetic drugs are becoming increasingly more organised, work sharing within the organisation has become more differentiated (groups ensuring financial means, organisers with good network, couriers, depositors, wholesale distributors, retail dealer).

Usually cannabis and cocaine is also related to the smuggling of synthetic drugs coming from Western Europe, they reach the users' level through the distribution network of synthetic drugs. The increased level of conspiracy observed in respect of synthetic drugs has resulted in the increasing quantity of drugs to be smuggled, and in the improved efficiency of the illicit activity. (IRM 2010)

The structure of the domestic market

On the basis of the interviews made during the survey performed in 2009 concerning drug dealer careers (Ritter 2009) the organisation-sociological aspects of domestic drug trafficking have also been analysed. It can be determined that the domestic drug market is not dominated and controlled by only one or two large organised groups of offenders. The market is fragmented, there is competition between the smaller groups. However, the internal structure of the groups is not homogenous, several groups may use the same dealer or courier.

Drug trafficking is realised in Hungary at 3 levels: the first level is the classic dealer level. Dealers earn less, they distribute drugs only within their own small circle, they typically supply a few groups of friends or their wider circle of friends. It means about 20-50 users, that is permanent user clients. Generally the dealers themselves are addicted drug users. They can work with a minimal, 5-10% price margin, often they only earn enough money to cover their own use and living. Dealers are rarely independent, most often they are employees working for a distributor or wholesale trader.

At the second level there is the distributor, with average earnings (about 3,500-5,500 Euros per month). Distributors supply dealers, about 5-15 persons with drugs. Usually they also store drugs, and they can work with a price margin of about 20%. Typically distributors are only occasional drug users.

At the third level there is the trader, who organises the wholesale acquisition of drugs and also deals with the couriers. Traders provide serious investments, they undertake the cost and risk of the acquisition of large quantities. They work with a profit margin of 50-70%. Generally they also deal with measuring out and cutting drugs. They are in contact with distributors, but not with dealers or users. Many of them do not even use drugs.

Typically there is no mobility within the structure of the drug market. However, on rare occasions changes can take place in the following three forms: typically dealers do not become distributors or traders, they can only progress if they do not use drugs. Distributors can become traders in several cases, but those who become addicted to drugs fall back on the level of dealers. Generally traders maintain their position, but in their case too drug use may result in decline.

There are two basic types of couriers: those who transport and work for their own profit to cover their own needs, and those who are employed by somebody else to deliver consignments. Often, employed couriers do not even know what or how much they are transporting. Frequently several couriers are sent to transport a larger amount of drugs in order to divert attention or to test the reliability of the other transporting person.

10.2. SEIZURES

The table below contains the total amount of drugs seized by the Police and the Hungarian Customs and Finance Guard. (ST13_2010_HU_01; ST13_2010_HU_02; ST13_2010_HU_03)

Table 79. Number and quantity of seizures of illicit drugs in 2008 and 2009¹⁷⁸

Type of drug	2008		2009	
	number of seizures	quantity seized	number of seizures	quantity seized
Herbal cannabis (kg)	1,670	254.6	1,939	293.4
Cannabis plant (pieces)	73	1,523*	171	20,501
Cannabis resin (kg)	63	2.8	67	16.1
Heroin (kg)	128	28.6	110	124.7
Cocaine (kg)	134	23.1	139	19.9
Amphetamine (kg)	456	61.8	388	52.3
Ecstasy tablets (tablet) /MDMA, MDA, MDE/	186	144,618	33	5,413
LSD (dose)	18	266	16	389

* only includes the amount of the representative sample sent to the laboratory

Source: Institute for Forensic Sciences

On the basis of the number of seizures herbal cannabis is still the most widely used drug. In 2009 the number of cannabis plant seizures was more than double of the number seized in the previous year, cannabis plantations cultivated under artificial circumstances were seized in a number and size not seen before. The amount of the representative samples sent for laboratory tests was 3.5 times the amount sent in the previous year, the total number of the seized plants – on the basis of the information available for the laboratories – was 20,501 (for further information on seizures see chapter 10.1.).

The second most commonly seized drug was amphetamine, which occurred both in a powdered form and as the active substance of ecstasy tablets.

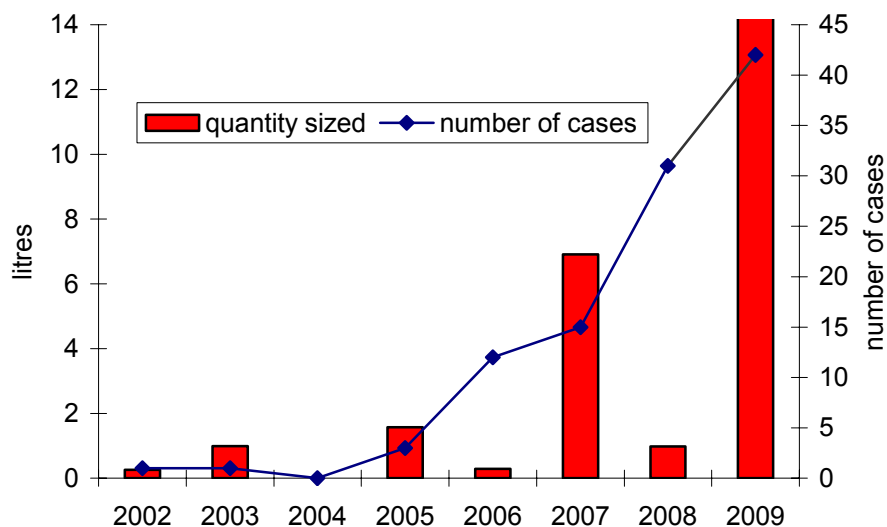
The occurrence of cocaine and heroin – on the basis of the seizure data – is more or less the same. In respect of the number of seizures of powders containing heroin or cocaine, cocaine is more common, but when examining it together with the number of occurrences of the active substances detected in other seized substances and in the contamination on the examined objects, the frequency of heroin is slightly higher. As compared to 2008 no significant change can be observed.

There is a more conspicuous change in the case of ecstasy tablets (MDMA, MDA, MDE), where the seized quantity decreased from 144,618 in 2008 to 5,413 in 2009. (On the changing of the active substances of the tablets see chapter 10.3.)

In 2009, in association with 42 cases, a total amount of more than 16 litres of GBL (gamma-butyrolactone), which is not regarded as an illicit drug, was seized, which exceeds the level of the earlier years both in respect of the number of seizures and the seized amount. The seizure data indicates further continuous increasing of the misuse of GBL.

¹⁷⁸ In 2009, unlike the previous years - when only the quantity of the representative sample sent to the laboratory was stated – the Institute for Forensic Sciences had reliable data about the total number of seized cannabis plants.

Figure 63. The number and quantity of GBL seizures between 2002-2009



Source: Institute for Forensic Sciences

As compared to the previous years, the number of seizures of powders containing ketamine and the quantity of the seized substance did not change significantly, in 2009 a total amount of 87 grams of such powder was seized in association with 40 cases. However, the quantity of seized ketamine solutions in pharmaceutical packaging is continuously increasing year after year. In 2009, on 19 occasions a total amount of 285 bottles¹⁷⁹ of such solution was seized.

On the basis of the seizure data methamphetamine occurred mainly in Komárom-Esztergom county, and in a lower amount in Baranya county. Typically methamphetamine is distributed in a pure or diluted form, in plastic syringes with a welded-seal end.

Among the substances regularly appearing in association with seizures, in the case of LSD the typical form of appearance was a stamp showing the picture of a cyclist, but on one occasion small granules impregnated with LSD, so-called microtrips, were also seized.

At the end of 2008 and in 2009 – similarly to other European countries – several new synthetic active substances appeared on the Hungarian black market too.

Among substances not regarded as illicit drugs from the aspect of penal law the appearance of a preparation distributed in the form of incense sticks under the brand name “Spice” called the experts’ attention to that in the form of legal or semi-legal products (incense sticks, bathing salt, vacuum cleaner freshener not suitable for human consumption on the basis of their label) containing new synthetic agents of a psychoactive effect had been put into circulation. These substances can be obtained through the internet or in specialised shops without any risk of punishment. In Hungary the preparation called “Spice” has been analyzed only on a few occasions, the active substances detected in it were the compounds named JWH-018 and CP-47497 belonging to the group of synthetic cannabinoids.

The active substance 4-fluoroamphetamine occurred in ecstasy tablets and in “speed” powders beside or instead of amphetamine. MDPV (3,4-methylenedioxypropylone, MDPK), mephedrone (4-methylmethcathinone 4-MMC) also appeared as the active substances of tablets and powders, and a compound named buthylone (bk-MDBD) occurred as the active substance of tablets.

The new active substances occurring in high numbers not experienced before and the legal/semi-legal marketing channels occurring beside the selling activity performed by

¹⁷⁹ Typically 50 ml bottles.

dealers (internet purchasing, “head-shop”) may indicate the increasingly free access to substances with a psychoactive effect.

10.3. PRICE / PURITY

Price of drugs at street level

In 2009 the price of drugs at street level was surveyed again. During data collection a new methodology was used, and the number of organisations participating in the survey increased too. (ST16_2010_HU_01)

In 2009, 7 organisations¹⁸⁰ from 7 cities participated in the survey¹⁸¹. In the questionnaire the respondents were asked to determine the price at last purchase in 2009 per drug type. The maximum, minimum, mean and mode prices of the individual drug types were calculated from the price of the last purchase.

In respect of the proportions of answering the questions, the most people could give answers in the case of herbal cannabis. It was then followed by amphetamine, cannabis resin, ecstasy and cocaine.

Table 80. Price of drugs at street level in EUR¹⁸² in 2009

EUR	Minimum	Maximum	Mode	Mean	Number of respondents
Cannabis resin (g)	3.2	17.8	8.9	8.4	67
Herbal cannabis (g)	1.8	10.7	8.9	8	128
Heroin (g)	10.7	89.1	35.6	43	45
Heroin (packet)	10.7	35.6	17.8	18.5	43
Cocaine (g)	28.5	71.3	53.5	50	59
Crack (g)	49.9	89.1	89.1	69.5	6
Amphetamine (g)	3.6	21.4	10.7	10.6	93
Ecstasy (tablet)	1.1	10.7	3.6	4.4	64
LSD (dose)	5.3	17.8	8.9	10.1	44
Methadone (20 mg)	1.4	14.3	7.1	5.8	33
Methadone (5 mg)	0.7	7.1	1.8	2.6	16

Source: Hungarian National Focal Point 2010

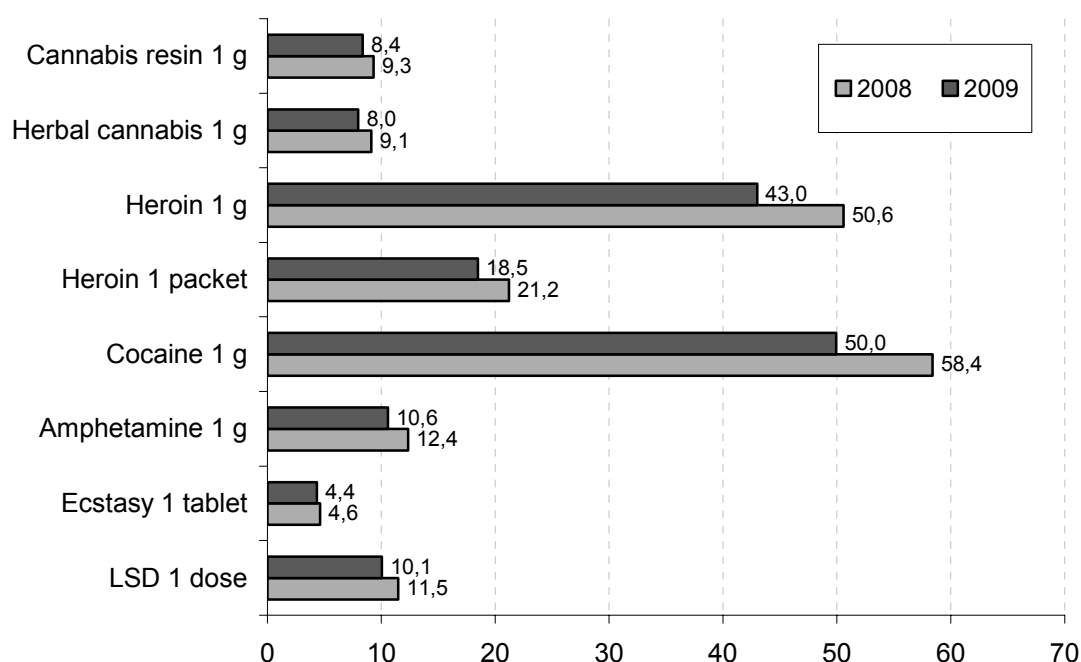
The tendencies are described on the basis of comparing the mean prices collected in 2009 using the new methodology and the mean value of the most common price determined by the users per drug type collected in 2008. It can be determined that the mean price of nearly all drugs were similar to that observed in the previous year. An exception from this is cocaine on the one part, the average price of which continued to decrease following the tendency of the previous two years, while on the other part the price of heroin by gram shows a decrease as opposed to the increasing tendency observed in the previous year.

¹⁸⁰ 1 specialised outpatient treatment centre per city took part in the survey (Budapest, Szeged, Győr, Debrecen, Miskolc, Pécs, Zalaegerszeg).

¹⁸¹ The questionnaires were recorded using self-administration method, between 1-31 December 2009. Each organisation provided 20 questionnaires filled in by clients using drugs in 2009 before entering treatment, thus the total sample included 140 persons. The clients only stated the price of the type of drug they purchased in the year in question.

¹⁸² The prices in the table were calculated on the basis of the official exchange mid-rate of the EUR for 2009 (EUR 1 = HUF 280.58).

Figure 64. Mean prices of drugs at street level in Euro in 2008 and 2009



Source: Hungarian National Focal Point 2010

During the survey analysing drug dealer careers (Ritter 2009, for methodology see: Chapter 10.1.) the respondents were asked about the street prices of the individual drugs. After summarising the answers, the following price categories can be determined in the case of drug types where sufficient information was available:

Figure 65. Prices of drugs at street level on the basis of interviewing persons who had committed supply-related criminal offences concerning the misuse of illicit drugs and had been sentenced to imprisonment (EUR)

Amphetamine (1 gram)	Cocaine (1 gram)	Herbal cannabis (1 gram)	LSD (stamp/microtrip)	Brown heroin (1 gram)	White heroin (1 gram)	Ketamine ¹⁸³ (vial)
6.4– 10.7	16 – 28.5	6.4– 10.7	5.3 – 8.9	17.8 – 28.5	24.9 – 42.8	12.5 – 17.8

Source: Ritter 2009

Purity

In 2009, 149,374 tablets containing illicit drugs or new active substances not regarded as illicit drugs were seized, which represents an insignificant decrease in respect of seized quantity as compared to the 181,942 tablets seized in the previous year, but at the same time the number of seizures¹⁸⁴ fell from 517 to 242, which is a significant change.

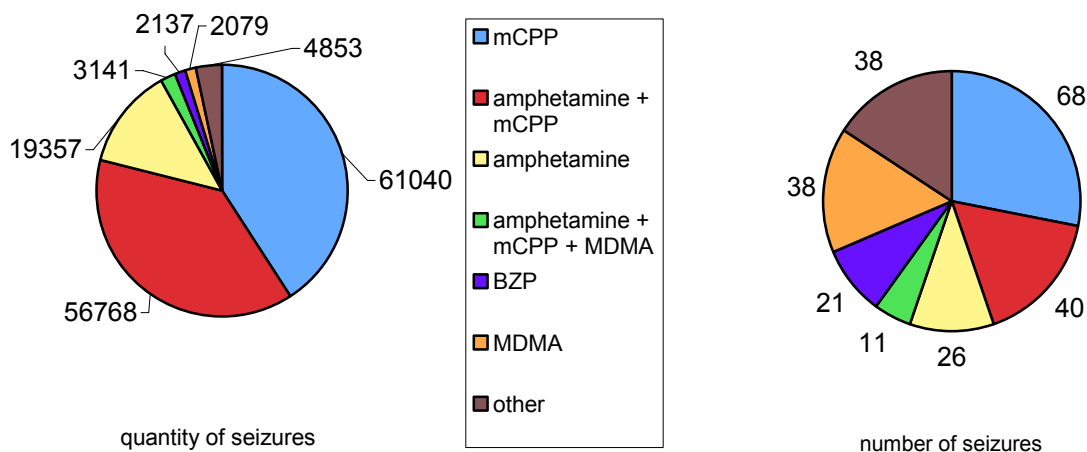
From the aspect of active substance content, in 2009 again the most prominent change could be experienced on the market of ecstasy tablets. In the period between 1999-2008 a large proportion of the seized tablets contained MDMA as active substance, but by the beginning of 2009 this situation changed. The number of tablet seizures dropped significantly, among the active substances MDMA was less significant. While at the end of the nineties the empty space created by the lack of MDMA was filled in by tablets containing amphetamine, in 2009 most typically the tablets contained mCPP or amphetamine. Tablets containing BZP as an active substance, which has been regarded as a controlled substance since 2009, were seized on several occasions at the beginning of 2009, typically in Hajdú-

¹⁸³ This data derives from a distributor, there is no control data.

¹⁸⁴ Identical tablets of the same packaging seized at the same location form a seized item.

Bihar county. A remarkable tendency is that besides the most common active substances several new active substances or active substances not used before in this form appeared in the tablets (methamphetamine, GHB, MDPV, 4-fluoroamphetamine, 2C-B, buthylone, ketamine). (ST15_2010_HU_01)

Figure 66. Breakdown of seized tablets containing illicit drugs or new active substances not regarded as illicit drugs, by quantity (tablet) and number of seizures in 2009



Source: Institute for Forensic Sciences

Generally, in the case of cocaine the powders packaged in small items were significantly diluted preparations, pure cocaine was found only in a few cases. While in the earlier years the lower limit value of the active substance content of diluted powders was generally 5-10%, in 2009 active substance content below 5% was detected among the seized powders several times.

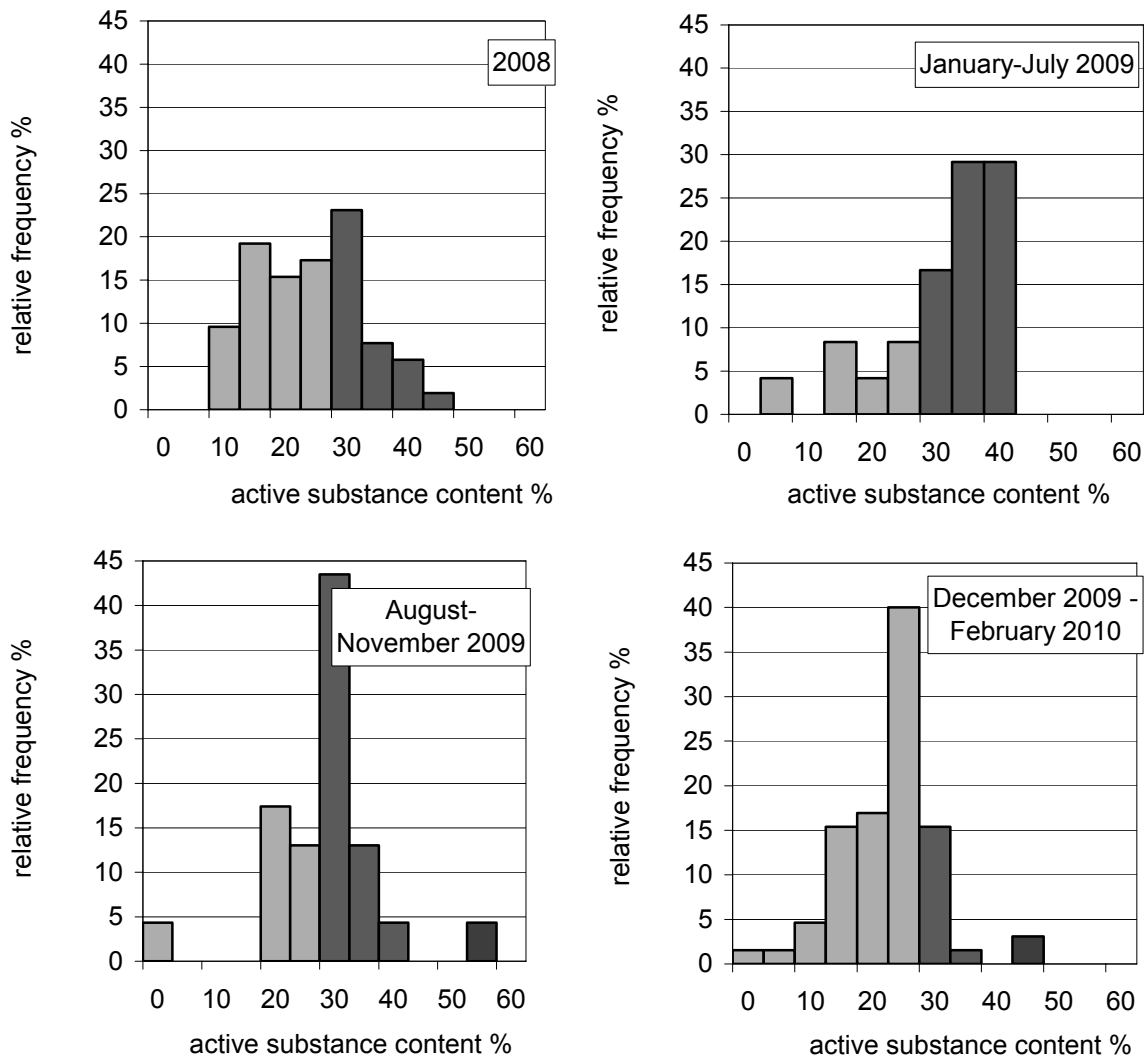
Results of the intensive monitoring of heroin and amphetamine active substance content

In respect of the active substance content of powders containing heroin and amphetamine packaged in user doses a significant amount of data was collected during the project entitled "Intensive monitoring of the active substance content of hazardous drugs" (for more detail see: chapter 7.1.). The active substance content of all heroin and amphetamine user doses submitted to the Institute for Forensic Sciences during the term of the project was measured.¹⁸⁵

In the case of heroin, in 2009 the characteristic active substance content was 10-45%. The increasing of the active substance content, which started in 2008, reversed in the second half of 2009 on the basis of the results of the monitoring system.

¹⁸⁵ The data of the monitoring project – due to the specific nature of the operation of the project – is available in a different time breakdown as compared to the data of routine analysis at an annual level. However, the results are published in this form, so they are the same as the data/diagrams in the national newsletters issued during the year (see chapter: 7.1.).

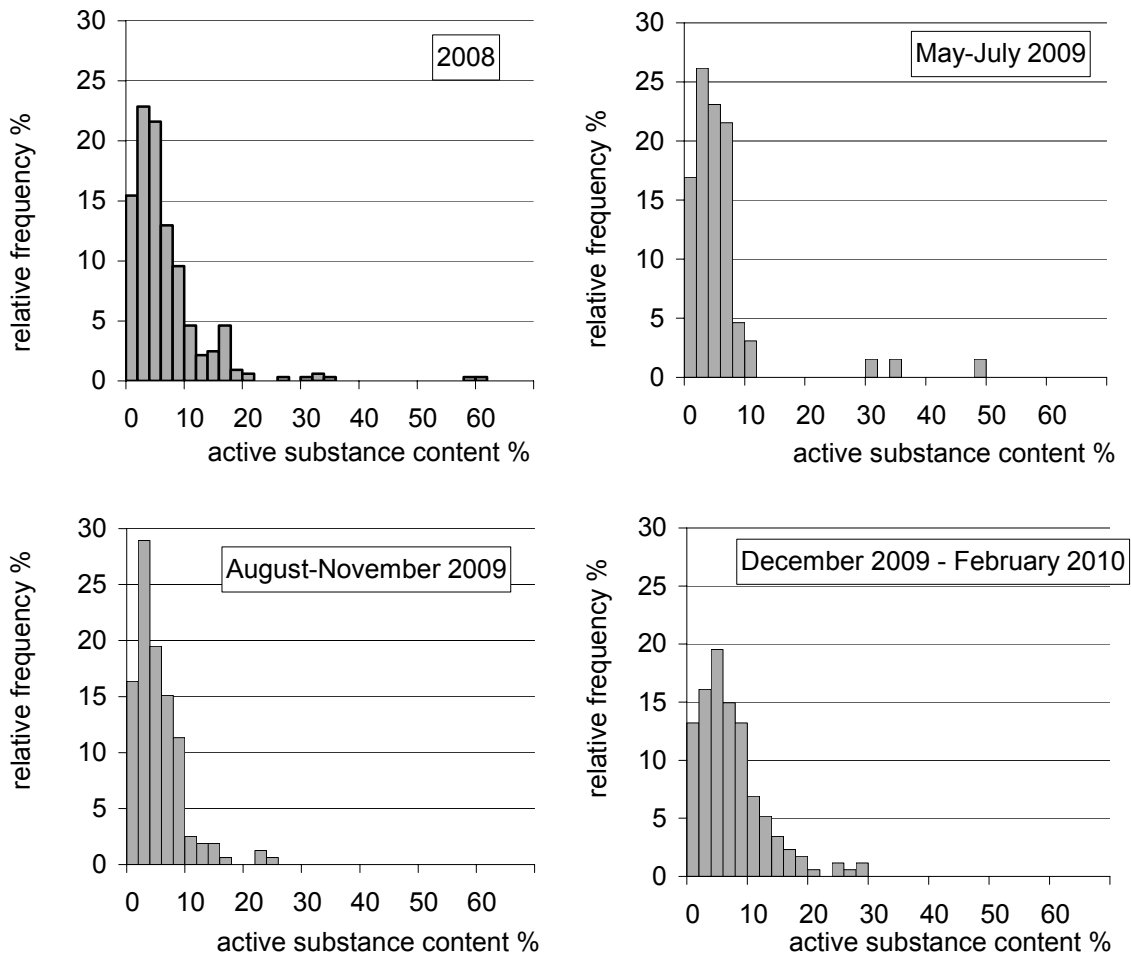
Figure 67. Active substance content of powders containing heroin seized in user doses, between 2008 and February 2010



Source: Institute for Forensic Sciences

In the case of powders containing amphetamine no significant change could be observed as compared to the previous years. The average active substance content of the samples examined in 2009 shows a slow increase. While in the case of the samples examined in the first six months there was no significant amount of substances with an active substance content above 10%, in the last period such substances represented more than 20% of the examined substances.

Figure 68. Active substance content of powders containing amphetamine seized in user doses, between 2008 and February 2010



Source: Institute for Forensic Sciences

Conclusions

On the basis of the seizure data it can be determined that in 2009 the number of seizures of tablets containing illicit drugs dropped significantly, classic ecstasy tablets containing the active substance MDMA declined, instead of them tablets containing mCPP, amphetamine or both of these substances represented the majority of the seizures.

In the case of powders containing heroin, the increase in the active substance content observed in 2008 reversed in the second half of 2009, and by the end of the year the proportion of preparations with a heroin content above 30-40% detected in the case of overdose-related deaths before decreased significantly. At the same time the mean price of heroin at street level also dropped as compared to the price observed in 2008.

In 2009 the number of cannabis plant seizures was more than double of the number of seizures in the previous year. Cannabis plantations cultivated under artificial circumstances were seized in a number and size not seen before, which was preceded by thorough intelligence work by the investigation bodies. Despite this the mean price of herbal cannabis remained stable.

The popularity of cocaine still shows an increasing tendency on the basis of the investigation and seizure data, an increasing number of distributors who used to deal with other types of drugs before are switching to distribute cocaine. At the same time price of cocaine at street level continued to decrease according to the survey performed among users.

The number of GBL seizures increased continuously, which relates to the further increase of the cases of misuse committed in connection with this substance. The increasing popularity of GBL is also supported by investigation data.

At the end of 2008 and in 2009 a large number of new synthetic substances occurred within a short period of time (synthetic cannabinoids, 4-fluoroamphetamine, mephedrone, buthylone, MDPV), as well as known substances in new forms of appearance (methamphetamine, GHB in tablets). The channels undertaking a role in the propagation of the new substances not regarded as illicit drugs from the aspect of penal law (internet purchasing, "head-shops") indicate an increasingly easier access to the substances with a psychoactive effect.

11. HISTORY, METHODS AND IMPLEMENTATION OF NATIONAL TREATMENT GUIDELINES

Overview

In Hungary two groups of the guidelines relating to the treatment of drug-related problems are distinguished: guidelines relating to healthcare and guidelines relating to social services. Healthcare and social services are determined in separate legal acts, they are financed from different funds and their quality assurance systems are also different. Because of all these, below the healthcare and social guidelines are described separately.

11.1. HISTORY AND OVERALL FRAMEWORK

Healthcare guidelines

In Hungary the methodological standardisation of addiction treatment was started in the years following the change of the political regime. In 1991 it became possible to take a specialised exam in addiction treatment, at the same time the National Institute for Addiction (hereinafter: OAI) and the National Advisory Board for Addictions was established. In 1995 the Advisory Board was terminated, and the professional work performed by it was then carried out by the specialised addiction workgroup operating within the National Advisory Board for Psychiatry. As a result of this, the professional representation of addiction treatment was passed on to the National Institute of Addictions until the institute was terminated in 2008. The first professional guidelines focusing on the treatment of drug users were elaborated between 2002 and 2007 under the coordination of the National Institute of Addictions.

Presently the tasks relating to the quality control of addiction treatment are primarily performed by the National Centre for Healthcare Audit and Inspection (hereinafter: OSZMK). Since 2005 the inspection and monitoring of the implementation of the guidelines has been performed by the 'national inspector of addictions' commissioned by OSZMK.

The healthcare guidelines (protocols, professional guidelines and methodological letters) are elaborated and updated, if necessary, by the so-called national advisory boards having the most expertise on the given special field. In 2008 the Institute for Healthcare Quality Improvement and Hospital Engineering (hereinafter: EMKI) was established, and the Ministry of Health referred the coordination of the elaboration and updating of healthcare guidelines within its sphere of action. Since April 2009 the re-established National Advisory Board for Addictions has been elaborating and updating the guidelines relating to addiction treatment, collaborating with the other advisory boards concerned in this field.

The advisory board submits the prepared/updated guidelines to the Ministry of Health for approval. EMKI also takes part in the process of granting approval to the guidelines by making a methodological evaluation about the new guidelines as a part of which the guidelines are evaluated from a professional aspect as well as from the aspect of their form and applicability. However, in the lack of finances a methodological evaluation is not made in respect of all materials.

On the basis of the professional guidelines of the Ministry of Health, Social and Family Affairs relating to the development of evidence based professional guidelines¹⁸⁶ and on the basis of Regulation 23/2006. (V. 18.) of the Ministry of Health on the rules of procedure relating to the elaboration, compilation and professional harmonisation of examination and therapeutic guidelines, four different guidelines are distinguished (among which the local guidelines are beyond the issue dealt with in this chapter).

¹⁸⁶ Its term of validity has expired, but it can still be used for preparing guidelines.

The professional guidelines are a series of systematically developed decision recommendations supported with available scientific evidence for determining the different treatment methods of a given group of diseases, the aim of which is to improve the quality, efficiency, successfulness of healthcare and provide help for doctors and patients in choosing the most suitable treatment.¹⁸⁷

Methodological letters include the descriptions of prevention, diagnostic, therapeutic or rehabilitation procedures, which are elaborated as directives for healthcare service providers by acknowledged personalities of the given profession on the basis of expert opinions. Generally methodological letters do not contain alternative recommendations, they do not provide information in connection with the negative effects of the recommended procedures or the probability of the occurrence of such effects, they do not contain a cost analysis, and they provide help only for healthcare service providers.¹⁸⁸

The professional protocol, in respect of a certain group of diseases and a certain treatment level, is a systematic list of activities relating to the treatment process of a disease or condition – including preventive, diagnostic, therapeutic, treatment, care and rehabilitation process supported with accessible scientific evidence –, which forms the basis of the professional inspection and financing of healthcare services, and the aim of which is to ensure the safety and even standards of the healthcare services.¹⁸⁹

The local guidelines include the description of the local practice applied at the given healthcare service provider and at the given healthcare service level, based on professional guidelines and professional protocols, or in the lack of these on the practice of the given healthcare service provider, relating to the treatment of the given disease or condition.¹⁹⁰

Social guidelines

The Ministry of Social Affairs and Labour ordered and financed the elaboration of the currently valid three guidelines relating to the treatment of addicted clients. The three professional guidelines were published in 2007 in *Kapocs füzet* (booklet) No. 5 of the Institute for Social Policy and Labour (hereinafter: SZMI). Although this booklet was published as a result of the collaboration between the Ministry of Social Affairs and Labour and the Specialised Workgroup of Addictions of the National Institute for Family and Social Policy (presently SZMI), up until the present the guidelines have not been issued in the *Social Gazette*, which is the ministry's official gazette. At the same time Government Regulation 191/2008 (VII. 30.) on the financing of helping services and community services refers to them as professional recommendations.

At an operative level, the social professional guidelines – including the three guidelines dealing with the treatment of addicted clients – are registered by the Employment and Social Office (hereinafter: FSZH).

The elaboration and updating of the guidelines, standards and service protocols is within the sphere of action of the SzMI¹⁹¹, but presently there is no standardised system of these processes. The content of the three guidelines published in 2007 has not changed since.

¹⁸⁷ Source: Regulation 23/2006. (V. 18.) of the Ministry of Health on the guidelines relating to the elaboration, compilation and professional harmonisation of examination and therapeutic guidelines

¹⁸⁸ Source: professional guidelines of the Ministry of Health, Social and Family Affairs relating to the development of evidence based professional guidelines

¹⁸⁹ Source: Regulation 23/2006. (V. 18.) of the Ministry of Health on the guidelines relating to the elaboration, compilation and professional harmonisation of examination and therapeutic guidelines

¹⁹⁰ Source: Regulation 23/2006. (V. 18.) of the Ministry of Health on the guidelines relating to the elaboration, compilation and professional harmonisation of examination and therapeutic guidelines

¹⁹¹ Based on "Regulation 3/2008. (IV. 15.) of the Ministry of Social Affairs and Labour on the designation and tasks of social methodological institutes and on the expert fee of the licensing procedure of social service providers and institutes".

11.2. ADDICTION CARE GUIDELINES IN HUNGARY

Healthcare guidelines

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

- The methodological letter of the Ministry of Health – The methadone treatment,
- The professional protocol of the Ministry of Health – On the treatment of diseases related to opioid use,
- The professional protocol of the Ministry of Health – On the treatment of clinical conditions associated with amphetamine use, and
- The professional protocol of the Ministry of Health – On disorders related to cannabis use.

All three protocols were elaborated by the National Institute of Addictions primarily for specialists in psychiatry and addiction treatment. They are based on evidence and on professional consensus. The protocols contain the description of the disease, the process and recommended methods of diagnosing, treatment, rehabilitation and care and partly the indicators of efficiency. They need to be updated every two years.

The methodological letter is a guideline, which is much more specific than the protocols, it exclusively describes the diagnostic and treatment processes and the indicators of efficiency.

Social guidelines

Presently there are three professional guidelines dealing with social services provided for addicted patients:

- the “Daytime care for addicted persons – Professional recommendation”,
- the “Low-threshold services provided for addicted persons – Professional recommendation”
- and the “Community social care provided for addicted persons - Professional recommendation”.

The social guidelines were elaborated by the Specialised Workgroup of Addictions. The guidelines have no designated target group, their content is based on professional consensus¹⁹². They describe the aims and guiding principles of the service, its quality assurance conditions and the activities covered by the service.

Other guidelines

Besides the healthcare and social guidelines, in 2009 the draft of the guidelines entitled “The professional guidelines relating to school-based health promotion programmes aimed at the prevention of drug use” and the preparatory material entitled “Study for the guidelines relating to interventions aimed at the prevention of alcohol consumption and illicit drug use in settlements and communities (except for workplaces and schools)” was also elaborated on behalf of EMKI. The draft and the preparatory study includes recommendations in connection with the prevention relating to the formal components and intervention elements, which have proved to be efficient in prevention at schools, in settlements and in communities on the basis of the literature reviews and meta-analyses.

¹⁹² The draft guidelines were harmonised with the representatives of the field in the scope of a consensus conference.

11.3. IMPLEMENTATION PROCESS

Healthcare guidelines

If the ministry grants its approval to new or revised guidelines, they are published in the official gazette of the Ministry of Health, in the Healthcare Gazette and on the ministry's website. At the same time the new guidelines are also published on the website of EMKI.

In accordance with Regulation 23/2006. (V. 18.) of the Ministry of Health, healthcare service providers, in their organisational and operational rules, must determine measures needed for the implementation of the professional protocol, furthermore the professional control and financing of the healthcare services are also based on the professional protocol.

Consequently, it is the healthcare service providers' obligation determined in the legal act to implement the guidelines. OSZMK is responsible for controlling the quality of the services – and the compliance of the practices with the guidelines – in the scope of planned or ad hoc auditing. The conditions of auditing have been created since the first addiction inspector was appointed in 2005, so no audit has been carried out in this field yet. With regards to the fact that in many places addiction treatment is realised within psychiatric treatment defined in a certain number of hours, it was very difficult to identify the units providing addiction treatment. At the same time the professional protocols of addiction treatment were elaborated (concerning the treatment of opiate, amphetamine and cannabis use related problems).

In 2009, under the coordination of the National Centre for Addictions¹⁹³, the system of indicators needed for the evaluation of the process and results of the services was elaborated in the fields of addiction with a treatment protocol (cannabis, amphetamine, opiate, substitution). In the individual service fields the indicators determined will be directly suitable – after professional legitimation (that is the approval of the advisory board) is granted – for starting to prepare the implementation in respect of the individual service providers. On the one part, in the long run it provides help for addiction service providers in modifying their own internal monitoring and documentation system accordingly, on the other part it enables addiction inspector chief physicians to start the auditing of the individual service providers.

It was a problem in the course of the preparation of quality control when the financing system changed from fixed financing to performance-based financing¹⁹⁴.

On the basis of the specialists' experience gained so far, the main barriers for adapting healthcare guidelines to the practice of addiction treatment is the disharmony between the guidelines and financing. This problem occurs in the deficiencies of the financing of the medicines and procedures recommended in the professional protocols, and in the lack of expertise, which is also due to financing problems.

*Methodological letter and practice in opiate substitution with methadone*¹⁹⁵

¹⁹³ Task entitled "Organising and holding training courses needed for handling the drug problem" in the framework of the sub-task entitled "Quality training for addiction healthcare service providers".

¹⁹⁴ For further details see National Report 2008 and 2009, chapter 5.

¹⁹⁵ The survey was performed by the Hungarian Academy of Sciences, Institute for Psychology, with the support of the National Institute for Drug Prevention. The survey was carried out in two target groups: among clients in substitution treatment and among professionals leading the substitution programmes and handing out methadone. The group of clients was selected from the clients of 3 treatment units located in Budapest and 5 treatment units outside of Budapest, on the basis of the gender distribution observed in the 2008 national substitution data collection. A total number of 150 persons were included in the sample (115 men, 35 women). The professionals were selected from the same treatment units, two professionals per treatment unit were included in the sample, a total number of 16 persons. In both target groups anonymous questionnaire data recording was carried out using face-to-face technique at the given treatment unit.

The survey (Rácz et al. 2009) relates to the practical implementation of the healthcare guidelines; in this survey they examined how much the practice of opiate substitution with methadone complies with the content of the methodological letter. During the survey 150 clients participating in methadone maintenance treatment at the time of the survey and 16 professionals controlling the treatment programme and handing out methadone were asked to fill in questionnaires.

The client questionnaire examined issues such as the accessibility of the location of the programme, handing out methadone (dose, taking it home), the attitude of the treatment staff, the protocol, sanctions, criminality, fear, subjective changes. The respondents were also asked to make recommendations relating to the further development of the service. Besides this questionnaire, the TDI questionnaire was also recorded in order to describe the socio-demographic situation and drug use habits of the sample¹⁹⁶. 10 of the professionals included in the sample represented treatment units outside of Budapest, and 6 of them represented treatment units located in Budapest. The questionnaire covered issues such as the characteristics of the organisation operating the treatment unit, the special features of the content of the service, the professional staff, the criteria of success and the professional methodological letter. Apart from the data deriving from the questionnaire data recording, the secondary analysis of the data of an earlier survey concerning the efficiency of the methadone treatment was also performed (Demetrovics 2005).

One of the problems identified as a result of the survey was that the methodological letter did not define the exact aim of the substitution treatment, consequently it is difficult to determine indicators for monitoring the efficiency of the treatment.

The results of the survey indicated that the methadone dose given to the patients is not high enough. The reason for this – according to the authors – is that although in respect of doses the methadone protocol determines exact numbers, it does not extend to when, how and under what circumstances the dose must be, can be or should be changed.

The survey showed that in many cases the clients are not provided with sufficient information. The methodological letter contains prescriptions relating to this, but as there are no consequences, many treatment units do not observe the instructions.

Social guidelines

After the publication of the guidelines (2007) until the end of 2008 the three guidelines were accessible only in the booklet entitled *Kapocs fűzet*, in return of payment. During this period the use of the guidelines in professional practice was not a direct condition of issuing the operation licence or financing the operation.

Since the end of 2008 the guidelines¹⁹⁷ as professional recommendations have been accessible on the internet, on the website of the Employment and Social Office (FSZH). On 1 January 2009, in the social field normative financing was replaced by a system of state supports granted via applications¹⁹⁸, since then the guidelines have formed a part of the tender documentation, which also means that partly represent a condition of financing.¹⁹⁹

¹⁹⁶ In the scope of the survey they compared the TDI questionnaire filled in during data recording with the TDI questionnaire filled in when the client entered substitution treatment, in order to identify the changes occurring since then. In 199 cases the questionnaire filled in upon admission was available.

¹⁹⁷ Guidelines relating to low-threshold services and community services.

¹⁹⁸ This tendering system is handled by the FSZH on the basis of Government Regulation 191/2008 (VII. 30.).

¹⁹⁹ Guidelines relating to low-threshold services and community services.

At an official level FSZH, while at professional level – at the request of the Public Administration Office – the so-called Social Methodologies control whether a given service provider provides its services in compliance with the guidelines.

11.4. PHARMACOLOGICAL TREATMENT OF OPIOID DEPENDENCE – COMPARING NATIONAL AND WHO GUIDELINES²⁰⁰

In Hungary there are two different treatment guidelines relating to the pharmacological treatment of opioid dependence. One of them is the professional protocol of the Ministry of Health on the treatment of diseases related to opioid use (hereinafter: opioid protocol), and the other one is the methodological letter of the Ministry of Health on methadone treatment (hereinafter: methodological letter). The opioid protocol provides a review of the possibilities of the non-pharmacological and pharmacological treatment of opioid dependent patients, while the methodological letter deals exclusively with methadone and with the process of the substitution treatment itself.

Choice of treatment

The two relating national guidelines partly contain the WHO recommendation, according to which “For the pharmacological treatment of opioid dependence, clinicians should offer opioid withdrawal, opioid agonist maintenance and opioid antagonist (naltrexone) treatment, but most patients should be advised to use opioid agonist maintenance treatment.” The listed treatment possibilities are all included in the opioid protocol, but in the lack of a sufficient number of high-quality evidence, it does not contain a recommendation in respect of which treatment possibility should be used first of all.

The two relating national guidelines contain the WHO recommendation, according to which “For opioid-dependent patients not starting opioid agonist maintenance treatment, consider antagonist pharmacotherapy using naltrexone following the completion of opioid withdrawal”, but naltrexone is stated only as a possibility and not as a preference, as the use of the pharmaceutical preparation is not supported by the National Health Insurance Fund, and it is not widely used in practice.

Opioid agonist maintenance treatment

The two relating national guidelines do not contain the WHO recommendation, according to which “For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine.” One of the reasons for this is that at the time of elaborating the protocol buprenorphine (which is accessible in Hungary even presently exclusively in a combination with naloxone) was not available. Furthermore, the opioid protocol simply provides a list of the preparations that can be used during pharmacological treatment, but it does not make recommendations or preferences in respect of the different preparations. Several of the listed preparations and therapies are still not available in Hungary.

The two relating national guidelines mostly comply with the WHO recommendation, according to which “During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30 mg”, still the initial dose is set between 10-40 mg.

²⁰⁰ In this part of the chapter the questions of the EMCDDA questionnaire are dealt with.

The two relating national guidelines determine the range of the recommended daily dose in compliance with the WHO recommendation, according to which “On average, methadone maintenance dose should be in the range of 60–120 mg per day.”

As opposed to the WHO recommendation – according to which “Average buprenorphine maintenance doses should be at least 8 mg per day” – the opioid protocol recommends 8 mg as the most efficient dose, and it does not determine the minimum dose.

The WHO recommendation, according to which “Methadone and buprenorphine doses should be directly supervised in the early phase of treatment” appears in the national guidelines only in the case of methadone.

The two relating national guidelines contain the WHO recommendation, according to which “Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review.” In the national methodological letter it is recommended to provide take-away doses for several days in a justified or especially justified case.

The two relating national guidelines contain the WHO recommendation, according to which “Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence”.

Management of opioid withdrawal

The two relating national guidelines contain the WHO recommendation, according to which “For the management of opioid withdrawal, tapered doses of opioid agonists should generally be used, although alpha-2 adrenergic agonists may also be used”. But in this case too, it is only listed among the recommended treatment methods, and no preferences are determined.

The two relating national guidelines do not contain the WHO recommendation, according to which “Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal”.

The two relating national guidelines do not contain the WHO recommendation, according to which “Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal”.

The two relating national guidelines contain the WHO recommendation, according to which “Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal”.

Pregnancy

The WHO recommendation relating to pharmacological treatment during pregnancy – according to which “Opioid agonist maintenance treatment should be used for the treatment of opioid dependence in pregnancy” – is not included in the national guidelines. In the application order relating to methadone pregnancy is regarded as an absolute contraindication, application is recommended only in exceptional cases, after careful consideration of the advantages and risks²⁰¹. This may be the reason why it is not stated separately in the protocol. Nevertheless, cooperation has started between the National Advisory Board of Gynaecology and the National Advisory Board of Addictions in the interest

²⁰¹ It is because the manufacturers did not examine the applicability of methadone in the case of pregnant women.

of elaborating recommendations relating to the treatment of drug user / opioid dependent pregnant women.

The WHO recommendation, according to which “Methadone maintenance should be used in pregnancy in preference to buprenorphine maintenance for the treatment of opioid dependence; although there is less evidence about the safety of buprenorphine, it might also be offered”, is not included in the relating two national guidelines, for the reasons described above.

Conclusions

Presently there are 7 guidelines / protocols / methodological letters in the field of addiction treatment, 3 of them cover social service forms and 4 of them cover healthcare service forms. In the interest of the standardisation and development of addiction treatment the first guidelines were elaborated in 2002, so quality assurance in the field does not have a long history.

Guidelines are elaborated differently in the two fields: the social guidelines are based on professional consensus, while the healthcare guidelines are based on professional consensus and on evidence. While the healthcare guidelines are revised every 2 years, in respect of the social guidelines the term of validity is not restricted.

In connection with the adaptation of the guidelines, no comprehensive and reliable data is available in either field. At the same time, on the basis of the professional experience it can be said that the main barriers for their application in practice is the lack of harmonisation with financing.

BIBLIOGRAPHY

Bozsonyi, K., Horváth, G. Cs. (2010a). A problémás szerhasználat prevalenciájának becslése Magyarországon, 2008-2009. Unpublished thesis..

Bozsonyi, K., Horváth, G. Cs. (2010b). Az intravénás szerhasználat prevalenciájának becslése Magyarországon, 2008-2009. Unpublished thesis.

BVOP (Büntetés-végrehajtás Országos Parancsnoksága) (2010). Éves beszámoló.

Csák, R., Gyékiss, R. (2010). Kliens adatok a Kék Pont Alapítvány Kálvária téri tűcsere programjában, 2006 és 2009 között. Unpublished thesis.

Chapman, DG. (1951). Some properties of the hypergeometric distribution with applications to zoological sample censuses. Berkeley, CA: University of California Publications in Statistics 1951;1:131–60.

Csohán, Á., Krisztalovics, K., Molnár, Zs., Dudás, M., Horváth, K., Szilágyi, A., Fogarassy, E., Lendvai, Gy., Kaszás, K., Molnárné, Kozma E. (2010). Magyarország járványügyi helyzete 2009. OEK, Budapest

Csorba, J., Pataki, Z., Péterfi, A. (2009). Kábítószer-függő kismamák Budapesten. Kutatási beszámoló. H—Reports Kft. Unpublished thesis.

Csorba, J., Pataki, Z., Péterfi, A. (2010). Terhesség és droghasználat – budapesti problémás szerhasználó nők kvantitatív vizsgálata. Droghasználó várandós nők és gyermekeik ellátása konferencia. Budapest, 2010. március 26.

Demetrovics, Z.(2005). Two-year follow up of methadone maintenance in Hungary: focusing on psychological aspects. Paper presented: The Inaugural European Association of Addiction Therapy Conference (pp. 10-11), Budapest, Hungary. 06-08.07.2005.

Demetrovics, Zs., Farkas, J., Csorba, J., Németh A., Mervó, B., Szemelyácz, J., Fleischmann, E., Kassai-Farkas, Á., Petke, Zs., Oroján, T., Rózsa, S., Rigó, P., Funk, S., Kapitány, M., Kollár, A., Rácz, J. (2009): Early experiences with Suboxone maintenance therapy in Hungary. In: Neuropsychopharmacologia Hungarica 2009:XI/4.

Dudás, M., Rusvai, E., Győri, Z., Minárovits, J., Takács, M., Csohán, Á. (2010a). A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HBV, HCV) 2009. évi prevalenciájának vizsgálata. OEK.

Dudás, M., Rusvai, E., Győri, Z., Minárovits, J., Takács, M., Csohán, Á. (2010b). A hazai intravénás kábítószer-használattal összefüggő fertőzések (HIV, HBV, HCV) monitorozása a Kék Pont Alapítvány klienseinél, 2008-2009. Unpublished thesis.

Dudás, M., Rusvai, E., Győri, Z., Minárovits, J., Takács, M., Csohán, Á. (2009). A HIV prevalencia és a HIV-hez társuló szexuális úton terjedő fertőzések homo/biszexuális férfiak körében. Unpublished thesis.

EÜM (Egészségügyi Minisztérium) (2010). Minisztériumi beszámoló.

Farkas, J. (2009) A káros szerfogyasztás szűrésének legjobb gyakorlatai a hazai és külföldi tulajdonú piacorientált cégek és a közszféra mintavételezésével. In: Helyzetkép és fejlesztési lehetőségek – „Maradj a Zöld Zónában” munkahelyi drog- és alkohol-megelőzési program. Módszertani füzetek, 2. Kaucsek, Gy., Simon, P. (eds.). SZMI, Budapest.

Gazdag, G., Horváth, G. Cs. (2009). Kábítószer-fogyasztással összefüggő hepatitis C fertőzések antivirális kezelésének költségei. KAB-KT-M-08-003. Kutatási beszámoló. <http://www.szmm.gov.hu/download.php?ctag=download&docID=21757> [accessed: 14.09.2010]

Gerevich, J., Bacskai, E (2004): A magyarországi kokainfogyasztók igénye a segítségre: egy kvalitatív kutatás eredményei. In: Orvosi Hetilap, 145: 445-452.

Horvath, M. Cs., Hurd, Y.L., Rajs, J., Keller, E. (2006). Variations in respiratory distress characterize the acute agonal period during heroin overdose death: relevance to postmortem mRNA studies. In: Brain Res Bull. 2006 Jul 31;70(3):251-9. Epub 2006 Jun 15.

Horvath, M., Fuzi, A., Keller, E. (2009). Demographical, toxicological, and serological characterization of drug-related death cases in the Budapest, Hungary between 1996-2008. 17th Nordic Conference on Forensic Medicine, Bergen, Radisson SAS Hotel Norge, June 17-20, 2009.

IRM (Igazságügyi és Rendészeti Minisztérium) (2010). Minisztériumi beszámoló.

Kaló, Zs., Rácz, J. (2009): Budapesti droghasználó várandós nők ellátásának kvalitatív vizsgálata. Unpublished thesis.

Kaucsek, Gy., Simon, P. (2009) „Maradj a Zöld Zónában” munkahelyi drog- és alkohol-megelőzési program aktuális helyzete és fejlesztési lehetőségei. In: Helyzetkép és fejlesztési lehetőségek – „Maradj a Zöld Zónában” munkahelyi drog- és alkohol-megelőzési program. Módszertani füzetek, 2. Kaucsek, Gy., Simon, P. (eds). SZMI, Budapest..

Környey Edit (ed.) (2009). Szenvedélybeteg terhesek, veszélyeztetett újszülöttek, kisgyermek gondozási és megelőzési programja. OSZMK, Budapest.

KSH (Central Statistics Office) (2009): Egészségügyi statisztikai évkönyv, 2008. KSH

Márványkövi, F. (2009). Felügyelt injekciós helyiségekkel kapcsolatos attitűdök és vélemények vizsgálata szakértők és a lakosság körében. Unpublished thesis.

Máté, Zs., Szemelyácz, J. (2009). Az iskolai szociális munka kézikönyve, INDIT Könyvek, Pécs.

Mészáros, M., (2009). Fogvatartott drogfogyasztók főbb jellemzői. Kutatási beszámoló. Unpublished thesis.

MH (Magyar Honvédség) (2010). Beszámoló a kábítószerügyi Éves jelentéshez. Unpublished data.

OAC (Országos Addiktológiai Centrum) (2010). TDI adatbázis 2009. Unpublished data.

OEP (Országos Egészségbiztosítási Pénztár) (2010). Tájékoztatás az opiát helyettesítő kezelés költségeiről az Országos Addiktológiai Centrum részére. Unpublished data.

Paksi, B., Arnold, P., Schmidt, A. (2009a). Felmérés a közoktatás rendszerében alkalmazott prevenció/egészségfejlesztő programokról és az agresszióval kapcsolatban megjelenő vélekedésekről, reagálásokról. Kutatási beszámoló, OKM, http://www.okm.gov.hu/letolt/kozokt/iab_paksi_091124.pdf [accessed: 14.09.2010]

Paksi, B., (2009b). A közoktatási intézmények prevenciók kompetenciáinak és tevékenységének változásai az utóbbi 5 évben. In: Addiktológia (Addictologia Hungarica), 2010/2. In press.

Paksi B., Felvinczi K., Schmidt A. (2005): Prevenciók/egészségfejlesztési tevékenység a közoktatásban OM. 2005.

http://www.om.hu/doc/upload/200507/prevencios_tevekenysege_20050710.pdf

[accessed: 14.09.2010]

Rácz J., Márványkövi F., Melles K. (2009a). Közösség-alapú utcai megkereső modell-program pilot-study vizsgálata budapesti intravénás kábítószer-fogyasztók körében. In: Addiktológia (Addictologia Hungarica), 2009/3: 219-253.

Rácz, J., Melles, K., Márványkövi F., Vadász V. (2009b). A magyarországi metadonfenntartó programok monitorozása és értékelése szakértői vélemények és kezelésbe bevont kliensekkel felvett kérdőívek alapján. Kutatási beszámoló. Unpublished thesis.

Ritter, I., Mike T., (2009). Drogkereskedő karrierök. Kutatási beszámoló. Unpublished thesis.

Strausz, J., Böszörményi, N. Gy., Csekeő, A., Csoma, Zs., Herjavec, I., Kovács, G., Nyári L., Ostoros, Gy., Zsarnóczai, I. (2009). A pulmonológiai intézmények 2009. évi epidemiológiai és működési adatai. Országos Korányi TBC és Pulmonológiai Intézet, Budapest.

SzMM (Szociális és Munkaügyi Minisztérium) (2010): Minisztériumi beszámoló.

Topolánszky, Á. (2009a). A terápiás közösségek új generációi. In: Az addiktológia alapjai III. Demetrovics Zs. (ed.) ELTE Eötvös Kiadó, Budapest.

Topolánszky, Á. (2009b): Terápiás közösségek kezelési modalitásainak fejlődése. In: Polihistória Buda Béla 70. születésnapja alkalmából. Bagdy, E., Demetrovics, Zs., Pilling, J.(eds). Akadémiai Kiadó, Budapest.

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

Topolánszky, Á., Felvinczi, K., Paksi, B., Arnold, P. (2009b). Drogterápiás Intézetek körében végzett kutatás főbb megállapításai. KEF Országos Konferencia. Budapest, 2009. december 8.

Vitrai, J., Busa, Cs., Füzesi, Zs., Kesztyűs, M., Szilágyi, J., Tistyán, L. (2009). Az elterelés hatásosságának vizsgálata. Kutatási beszámoló.

http://www.egeszsegmonitor.hu/dok/eltereleskutatas_2010.pdf

[accessed: 14.09.2010]

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LIST OF ABBREVIATIONS

ÁNTSZ – National Public Health and Medical Officer Service
APEH – Hungarian Tax and Financial Control Administration
BRFK – Budapest Police Headquarters
BSZKI – Institute for Forensic Sciences
BVKSZB – Professional Committee for Drug Affairs within the Hungarian Prison Service
BVOP – Hungarian Prison Service Headquarters
CCDA – Coordination Committee on Drug Affairs (KKB)
CI – Confidence interval
CSR – Corporate Social Responsibility
DRID – Drug-related infectious diseases
EDDRA – Exchange on Drug Demand Reduction Action
Eftv. – Act CXXXII of 2006 on the development of the healthcare system
ENYÜBS – Uniform Criminal Statistics System of the Investigation Authority and the Public Prosecutor's Office
ERÜBS – Uniform Criminal Statistics System of the Police and the Public Prosecutor's Office
ESPAD – European School Survey Project on Alcohol and Other Drugs
ESzCsM – Ministry of Health, Social and Family Affairs
EüM – Ministry of Health
FSZH – Employment and Social Office
GyISM – Ministry of Children, Youth and Sport
HCLU – Hungarian Civil Liberties Union (TASz)
HUNFP – Hungarian National Focal Point
IDU – Injecting drug user
IMEI – National Institute for Forensic Observation and Psychiatry
IRM – Ministry of Justice
KEF – Coordination Forum on Drug Affairs
KIMMTA – Mission Aid Foundation for Saving Wasted Young People
KSH – Hungarian Central Statistical Office
MEJOK – Centre for Defence of Human Rights - Hungary
MH – Hungarian Army
NDI – National Institute for Drug Prevention
NNyI – National Bureau of Investigation
NSP – Needle/syringe programme
OAC – National Centre for Addictions
OAI – National Institute of Addictions

OEFI – National Institute for Health Development
OEK – National Centre for Epidemiology
OEP – National Health Insurance Fund
OKM – Ministry of Education and Culture
OORI – National Medical Rehabilitation Institute
OPNI – National Institute of Psychiatry and Neurology
ORFK – National Police Headquarters
OSAP – National Statistical Data Collection Programme
OSZMK – National Centre for Healthcare Audit and Inspection
OTKA – National Scientific Research Found
PDU – Problem Drug Use
PEX – Public expenditure
SE – Semmelweis University
SZBEKK – Co-ordination Centre Against Organized Crime
SZIP – Drug Information Portal for Professionals
SzMM – Ministry of Social Affairs and Labour
TÁMASZ – Regional Universal Preventive Addiction Treatment
TB – Tuberculosis
TDI – Treatment Demand Indicator