REPORT TO THE EMCDDA
by the Reitox National Focal Point

HUNGARY
DRUG SITUATION 2001

REITOX

SUMMARY

I. National strategies: institutional and legal framework

Drug strategy

The Government of Hungary adopted the first draft of a National Strategy to Combat the Drug Problem on 22 February 2000 and released it for public debate taking place at various events to which altogether 1,054 Government agencies, churches, NGOs and institutions were invited. The results of the debate were incorporated in the final document that was approved by the Government of Hungary on 11 June 2000. The document was passed by Parliament in a Resolution (No. 96/2000 OGYh) on 5 December 2000.

In respect of international recommendations, the National Strategy to Combat the Drug Problem is *multidisciplinary* in terms of the models interpreting the phenomenon, and reflects a problem-solving approach based on a *balance between demand and supply reduction.*

The general objective of the National Strategy is formulated as follows: "At the beginning of the third millennium we advocate the vision of a free, self-confident and productive society. In a society like this human dignity as well as physical, mental and social well-being and creativity are considered to be of paramount importance. In order to preserve and promote these factors, society should be capable of managing the health, social and criminal hazards and harms related to drug use and trade. The drug problem is a concern for all of us and should encourage collective action. The Government and its institutions play a key role in such collective action."

Details of the four main objectives:

1. Community and cooperation - Society should become responsive to the effective management of the drug problem, and local communities increase their problem-solving capacities to combat it.
2. Young people should be given the opportunity to develop a productive lifestyle and reject drugs (prevention).
3. Helping individuals and families exposed to drugs and suffering from drug-related problems (social work, therapy, rehabilitation).
4. Reducing access to drugs (supply reduction).

The structure of the National Strategy

- *Long-term objectives* - a collection of all actions to attain the objectives scheduled up to 2009.
- *Medium-term objectives*, which define actions for 2002.
- *Short-term objectives* including the tasks to reach immediate and medium-term objectives.

Criminal law

Articles 282-282/A of the Criminal Code (Act No. IV of 1978) govern the offence of "drug abuse". The latest amendment to the aforesaid legislation became effective as of 1 March 1999. The amendment was explicitly aimed at reducing drug consumption with its concomitant phenomena. The amendment distinguishes and covers as separate offences the acquisition/production and the supply/distribution of drugs, and the use of drugs including use by drug addicts. As the different criminal behaviours are distinguished, the degree of punishment to be imposed on perpetrators has also been differentiated by type of criminal acts. As it is, the law includes stricter provisions in the case of supply and distribution which acts are now punished by substantially more severe sentences.

Provisions regarding drug consumption have also been differentiated in the sense that the amendment distinguishes between occasional drug consumption and consumption by drug addicts.

Treatment as an alternative to criminal proceedings will, to a more limited number of cases than previously, grant impunity only to drug addicts in the case of behaviours set forth in the legislation.

In harmony with changes in the substantive criminal law as described in the foregoing, Act LXXXVIII of 1998 amending the Criminal Procedures Act modified the provisions which had provided for the suspension or termination of criminal proceedings in the case of voluntarily choosing to undergo treatment.
The effectiveness of the respective legal framework is questionable, as the amendment has resulted in more negative consequences than positive impacts. This statement applies both to proceedings and social impacts.
In 2002, codification work, among other things, therefore started aimed to make legislative changes with regard to the offence of drug abuse.

Monitoring the National Strategy - organisational framework

The Coordination Committee on Drug Affairs (CCDA, on which 16 central administrative bodies are represented at a high level) has a mandate to oversee the implementation of the National Strategy; to coordinate the operation of the individual Ministries and Government institutions; and to reconcile the different sectoral approaches. The organisational and administrative work related to the tasks and operation of the Committee is performed by its Secretariat. It is headed by the Deputy State Secretary for the Coordination of Drug Affairs at the Ministry of Youth and Sport. The CCDA reports to the Government on the drug situation in Hungary and the evaluation of the implementation of the National Strategy each year.
At the local level, Co-ordination Forums on Drug Affairs (CFDA) play an important role in the implementation of the National Strategy. Their annual reports are summarised by a co-ordination secretariat reporting to the CCDA.
The CCDA evaluates the implementation of the National Strategy each year and carries out due diligence and efficiency surveys of the Strategy and the institutional system every other year. The findings are reported to the Government and Parliament.

Major achievements and changes

- With regard to the implementation of the National Strategy, considerable progress has been made in attaining several of the medium-term objectives, and the short-term objectives are being met as scheduled. However, it should be noted that there are still many tasks to be completed.
- The National Institute for Drug Prevention was established in February 2001. Its primary task is to support and help the implementation of the National Strategy with a special focus on strengthening community relations and social responsiveness. It is to be developed into a prevention institute focussing on methodology, which should coordinate, and provide a professional background for, preventive actions as well as fostering cooperation with the national institutional system of prevention.
- The Ministry of Youth and Sport developed a support programme to establish and operate Co-ordination Forums on Drug Affairs (CFDA). As a result of the programme, CFDAs were formed in 56 cities altogether (each with a population of over 20 thousand) in the seven regions of Hungary in 2001. The CFDAs receive professional and methodological support from the National Institute for Drug Prevention (NIDP).
- Work has started under a PHARE project to integrate the Hungarian system with the epidemiological and drug database of the European Union. An organisational unit has been set up at the Ministry of Health tasked to make preparations for the development of a Hungarian Focal Point, a secondary information service centre. However, the Government has not issued a decree yet on the establishment and the functions of the National Focal Point.
- Legal provisions governing the applicability of confiscation and forfeiture measures and money laundering as an offence have been amended. Failure to report money laundering has been included in the legislation as a new offence.

- At the request of the Ministry of Youth and Sport, and in line with the short-term objectives of the National Strategy, the National Institute of Criminology has carried out an impact assessment of the amendment of 1 March 1999 to the Criminal Code regarding the offence of drug abuse. The assessment found that the effectiveness of the amendment, which brought about a substantial change in the consideration of drug-related cases from a criminal law perspective, was questionable. The change in the legal framework had not reduced the prevalence of drug use or drug trafficking. The amendment has resulted in more negative consequences than positive effects. This statement equally applies to proceedings and social impacts. The restriction (especially its poor communication) has made a negative impact on changes in the drugs market and the behaviour of drug dealers.

II. Prevalence of drug use – epidemiological situation

Prevalence of drug use

With regard to direct indicators of drug use in Hungary, data that are comparable in time and hence suitable to plot trends – i.e. data derived from research conducted with identical methods and on identical or partly overlapping population samples - are available only on the population of secondary school students (Paksi, 2002).

Based on research into one of the most vulnerable generations, i.e. secondary school students, we can conclude that significant changes have occurred in both the prevalence and the nature of drug use in Hungary in the 90s.

- The life prevalence rate of illegal substance use nearly doubled.
- This quantitative change was coupled with structural and qualitative changes:
    - the intensity of drug use increased and
    - marijuana and various synthetic party drugs became predominant in the consumption structure.

Following stagnation at the beginning of the decade, most of those changes occurred relatively fast, presumably between 1996 and 1998, i.e. 6-8 years after the regime change.

In Hungary, a comprehensive research that focussed specifically on drug use by the general population rather than treating the issue only marginally was first carried out in spring 2001 (ADE 2001) (Elekes-Paksi, 2002). The research was aimed at mapping the prevalence and risk factors of drug and alcohol use, and the population's attitudes towards such substance use. Research findings showed that 6.4% of the Hungarian adult population aged between 18-65 years had already used some kind of illegal substance in their lives. The analysis of life prevalence by substance reveals that different types of drugs play widely varying roles in the structure of substance use. Cannabis derivatives are most widely used (5.7%). Various synthetic drugs such as Ecstasy, amphetamine and LSD are ranked second to fourth (1.6-2%). Users of cocaine and opiates (heroin and/or other opiates) represent the smallest group.

Trends in treatment needs

As an unprecedented change since the beginning of data collection, the number of drug users receiving therapy dropped in 2001 compared to the previous year. A sign of this trend was already noticeable in 2000, when the steeply rising number of patients began to stagnate. The number of patients receiving therapy has essentially remained constant for three years. (The number of drug users treated in health care institutions was 12,765 in 1999, 12,789 in 2000, and 12,049 in 2001). This development can also be explained, among other things, by changes in the statistical data collection system.

Although the number of those receiving therapy for the first time showed a slower increase than the number of treated patients up to 1999, it grew steadily from year to year. However, it dropped by 19% in 2001 compared to 1999. Such a drastic decline was due to a modified definition of

patients receiving therapy for the first time. However, apart from this it is also likely that an 8% decrease in 2001 also marked a falling need for treatment.
In 2001, the number of treated opiate users dropped by 13% compared to the previous year. In spite of the decline, opiate users still account for the highest percentage of treated drug users. The number of cannabis users increased by 25% in 2001 compared to the previous year. Hence, they represent the second largest group of treated patients after opiate users. In 2001, the number of patients receiving treatment on account of amphetamine use continued to decline, even though they represent 6.9% of all patients. It is to be noted that the number of cocaine users rose by 20% among all treated patients.

However, it should be emphasised that the aforesaid trends and the 2001 health statistics should be interpreted with some reservation as they are more likely to indicate changes in the system of data collection and the capacities of health care institutions treating drug patients than changes in the real need for treatment!

Risk behaviours

Intravenous drug users represented 23.6% of the patients treated in health care institutions in 2001. Injections were mainly detected in the case of heroin, amphetamine and cocaine. Since 2000, both statistical data and research findings indicate a sharp increase in the intravenous use of cocaine.
Not only does the number of intravenous drug users rise gradually in Hungary but it is also becoming common in increasingly younger generations.
Intravenous drug use is growing rapidly among Roma drug users and it is accompanied by a number of health consequences. In many instances, they cannot “inject the substance safely", syringes and/or needles are sometimes shared, and as a result the risk of infection has increased among them.
Intravenous drug users occasionally share needles, syringes and filters.
They also resort to prostitution to earn enough money to fund their drug needs. Intravenous drug users rarely use contraceptives during sexual intercourse although most of them are aware of how HIV, hepatitis or STDs spread. They consider the risk of becoming infected during sexual intercourse smaller than from needle sharing. Prejudice against using condoms also has an influence on their apparently irresponsible sexual behaviour.

Incidence of communicable diseases related to drug use - morbidity

HIV is not typical among intravenous drug users in Hungary yet (there are 2 known HIV positive cases), however the prevalence of hepatitis C (HCV) infection is higher than in the general population (9.4-17% in 1996-1997, while in 2001 a survey showed 26% and 20% prevalence among male and female intravenous drug users, respectively).

In 2001, a targeted survey was carried out on the prevalence of infection among intravenous drug users at the Szent László Hospital in Budapest (Bánhegyi, Újhelyi, Zacher, 2002). There was no confirmed HIV positive case. 28% of intoxicated intravenous drug users were HCV positive. Acute HBV infection was detected in 1.4% of the cases. 13% of the women and 8% of the men were confirmed to have had HBV infection previously. Only 7.3% of the drug users in the survey had received Hepatitis B vaccine.
The prevalence of HCV is highest in the generation of 13-19 years, the reason being that they do not realise the risk of sharing needles and syringes, and they "shoot up" the drug jointly, using the same paraphernalia. Hepatitis B vaccination is negligible (2%) in this generation and risk group.

Drug-related mortality

Illegal drug use and hence mortality shows wide geographical variation in Hungary. Similarly to other capital cities, Budapest stands out in every respect. In recent years, 70% of deaths related to illegal drug use were recorded in Budapest.

In addition to legal drugs, illegal substances have also appeared in the statistics on drug-related mortality since 1995. The data should however be interpreted cautiously. Data are reported to the Central Statistical Office immediately after autopsies without any toxicological or other laboratory examination. When data are consolidated at the end of the year, the toxicological results of the last few months are not available yet, therefore it is highly probable that in such cases the direct cause of death is not encoded as drug use or its toxic effect.

Statistical data indicate 37 and 40 deaths caused by illegal drug use in 2000 and 2001, respectively. It is to be noted that most of the registered deaths due to illegal drug use were related to the intravenous use of opiates/heroin.

Drug-related crime

The data of the Uniform Police and Public Prosecutor's Crime Statistics indicate a continued rise in the number of reported, i.e. known cases of drug abuse in 2001. It is to be pointed out that while the number of drug crimes rose by 25.7%, the number of all registered crimes went up merely by 3.3%. Three quarters (74.8%) of drug abuse cases were milder offences. The number of minors among perpetrators of drug crimes increased. While they accounted for 5.9% of all offenders they represented as much as 17.1% of perpetrators of drug crimes in 2001! In practical terms, every sixth perpetrator of drug crimes was a minor according to crime statistics in 2001!

The illegal drug market

In recent years MDMA has been the typical active agent in Ecstasy pills. In 2001, 97% of all pills contained MDMA. New active agents appeared in Ecstasy pills in Hungary: 4-MTA and 1-PEA in 2000, and also PMA in 2001.

It is typical that the concentration of substances marketed in discrete doses such as Ecstasy pills or LSD stamps has remained unchanged and within relatively narrow limits for quite some time.

The active ingredient concentration of "speed" drugs containing amphetamine has shown a declining trend whereby the upper limit has dropped from 45% to 25% in recent years.

However, the THC concentration in marijuana has continuously been increasing. The upper limit of 2% reported in 1996 trebled to 6% by 2001.

The concentration of cocaine and heroin also shows a specific trend. While there used to be a marked difference in concentration between substances smuggled and seized in large quantities and those dealt out in small retail doses for the market and seized as packets for personal use in the case of both drugs, the difference has virtually disappeared since 1998. The difference used to be small in the case of cocaine as it was not diluted or “cut” too much but in the case of heroin there was a major gap between the 50-80% purity of the transited substance and adulterated or “cut” market doses. After 2000, however, the difference disappeared and it made a drastic effect on the market and users alike. Heroin of purity as high as 60-70% came out without dilution in packets for personal use on the market. The trend continued in 2001 so that in our survey we found heroin base concentration in excess of 40% in sixty percent of retail doses.

The aforesaid phenomenon can be an explanation of the rising number of cases of heroin overdose in the past couple of years. A reason behind increased concentration of heroin in retail packets may be a change in consumption habits. Because of the well-known risk of injection, heroin is increasingly inhaled and rolled in cigarettes, which requires higher concentrations.

III. Demand reduction interventions

Strategy for demand reduction

Demand reduction forms the cornerstone of the Hungarian anti-drug strategy. Three of the four objectives formulated in the strategy cover this area. They are the following:

- *Society should become responsive to the effective management of the drug problem, and local communities increase their problem-solving capacities to combat it (community building).*

Local communities play a key role in the prevention and management of drug problems as drug use is essentially the concern of individuals, families and local communities. It is at this level where the phenomenon first arises and becomes visible. Local identification of the problem is critical to its management because the success of any intervention largely depends on the responsiveness, commitment and capacities of local communities.

It is also the local community that can address the drug problem in the most direct manner by mobilising local resources, i.e. families, communities, NGOs, churches, professional helpers and other community agencies.

Local Co-ordination Forums on Drug Affairs (CFDA) are key factors in the National Strategy.

- *Young people should be given the opportunity to develop a productive lifestyle and reject drugs (prevention).*

The National Strategy addresses the issue of prevention in the conceptual context of health promotion. As it is formulated in the Ottawa Charter (1988), "… Health is seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being."

In this spirit, health can only be improved if certain health preconditions (peace, shelter, education, food, stable eco-system, sustainable resources, social justice and equity) are created.

In relation to drug use, health promotion aims to mitigate the risk factors that lead to drug use and reinforce protective factors that reduce the prevalence of drug consumptions, in sum it aims to reduce the prevalence of drug use (legitimate and illegitimate drugs).

Health can be influenced not just directly but first of all through lifestyle (and behaviour) as well as through the environment. The most important scenes of prevention include the family, school, workplace, leisure time, churches, the media, the information society, the army, child protection institutions, the crime prevention activities of the Police, various at-risk groups, high-risk conditions, the Roma population.

- *Individuals and families exposed to drugs and suffering from the drug problem should be provided help (social work, therapy, rehabilitation).*

The treatment of drug users requires cooperation of the supporting professions as the problem affects all aspects of life including physical and mental health, the set of values, personal, family and social relationships. It is caused or accompanied by, or leads to problems that can only rarely be influenced by the representatives of a single profession. Therefore the management of drug problems requires an interdisciplinary and comprehensive approach. Individuals suffering from drug problems should be provided access to treatment facilities and therapy while respecting their personal dignity and fully protecting their personal data, without regard to gender, race, nationality, religion or social standing.

Prevention

- Several professional, media and public communication programmes have been implemented in the field of prevention. Hence, national and local events, public education programmes, publications and leaflets have been supported in relation to prevention. Preparations have begun in order to develop a system of preventive leisure programmes.
- A Programme for Safe Entertainment Venues has been developed and launched, primarily aimed at reducing drug use in music and dance clubs and discos, and managing health hazards resulting from drug use.

- *An Association for Safe Entertainment Venues* has been formed. With the support of the Ministry of Youth and Sport and the National Crime Prevention Council it is active in disseminating the programme to turn it into a movement, asserting professional aspects and providing an umbrella for discos that assume responsibility for the programme.
- In the spirit of *integrated drug prevention at schools*, a health module has been introduced in the curriculum. As a result, health promotion is now one of the subjects at discussion classes. In addition, a number of preventive tools, publications and videos have been distributed to form the basis of prevention programmes at schools.
- Prevention work continues in the army on the basis of the drug strategy of the *Hungarian Army* including programmes such as a "*Programme for a Healthier Garrison*", a complex health promotion programme known as "*Let us give ourselves a chance*" or the "*Health is your most powerful weapon*" programme. The organisational and professional framework of prevention has been implemented, and preventive education is extended to all conscripts in the army.
- Several developments have been initiated in the field of *information society* including the widening drug-related content of the SchoolNet programme, support offered and scheduled or otherwise contracted for various service providers.
- The Prevention Subcommittee of the Coordination Committee on Drug Affairs has formulated its recommendations in consultation with Roma organisations with regard to prevention to be organised for certain Roma groups.
- A cooperation agreement has been signed between the National Self-Government of Gypsies and the Minister of Youth and Sport, under which the national coordinating bodies will support the Roma population in developing their own "drug strategy".
- The Ministry of Youth and Sport and the Ministry of Education have launched a joint grant scheme. The scheme is to support the cooperation between schools and professional organisations (prevention service providers). It is designed to promote programmes that reflect up-to-date professional aspects and apply interactive education techniques at schools (the first phase will cover about one third of secondary schools, i.e. 180,000 students) as well as to provide information to teachers and parents.

Treatment for drug users

- Work has begun to harmonise legislation on cooperation between health care and social care. It provided a framework for eliminating earlier problems resulting from two different sources of funding for therapy institutions. Joint projects have also been developed in the fields of drug therapy for children in institutions and homeless care.
- Services that operate in a comprehensive biopsychosocial framework have been introduced and strengthened. They provide multi-level care (drug outpatient centres including prevention work, programmes aimed to cover the "continuum" of treatment).
- Service capacities are continuously expanded. The number of drug outpatient centres and beds in therapeutic institutions is increasing. Access to such facilities in terms of geographical location and time has also been improved.
- Specific development and support programmes have been launched to reduce health hazards and risks.
- An operational plan for drug treatment units within the prison system for convicts struggling with drug problems and a drug strategy for the prison system have been prepared.

Treatment with substitution drugs (methadone)

- The number of patients receiving methadone treatment is still very small in Hungary. The rate of registered opiate addicts and opiate addicts receiving methadone treatment is approx. 2-2.3% which is far below the average in the European Union.
- In Hungary, methadone is presently used in three types of therapy protocols including a short detoxification treatment, a long detoxification treatment and substitution (long-term maintenance) treatment.

- In October 2001, the Council of the Professional Association of Drug Outpatient Centres coordinated the release of a Hungarian Manual of Methadone Therapy as a manuscript.
- In April 2002, the methodology of methadone therapy was officially published in Issue 9 of the Health Gazette.
- In Hungary, the Government finances methadone treatment so the service is available to patients free of charge.
- Three centres provide maintenance treatment using methadone in the country.

After-care and reintegration

The possibilities of after-care and reintegration of drug users are very weak in Hungary. Such programmes are offered in what is known as halfway houses in rural areas or in NGO-based day care institutions. In this respect the Hungarian network of this form of care requires considerable improvement. There are very few residential reintegration homes compared to the number of drug-addicts.

Programmes aimed at the promotion of after-care and reintegration exist primarily in the form of self-help groups. As the "flagship of the self-help fleet" is represented by groups of organisations and experts in Hungary, they also depend on the intentions and strategies of the given organisations. At the same time "purely" self-help groups are being formed but they are not yet organised at a level whereby they could adequately represent their interests. At best they know of one another, occasionally visit members of other groups but they typically work in isolation. The presence and balanced operation of self-help groups is first and foremost in the interest of addicts who wish to keep their sobriety.

Intervention possibilities in the criminal justice system

Similarly to all treated patients, the number of drug users diverted into treatment increased up until 1998. However, it dropped slightly in 1999 and fell sharply (by 25%) in 2000 while the overall patient number increased or stagnated. The number continued to decline by 14% in 2001 compared to the previous year.

The amendment to Article 282 of the Criminal Code by Act XVII of 1993 made it possible to apply treatment and preventive care as an alternative to criminal proceedings. Points a) and b) of Article 282/A specified the reasons for terminating punishability. Pursuant to Point a) of the aforesaid Article, growing, producing, acquiring or possessing a small amount of drugs for personal use, and, pursuant to Point b), commitment by a drug user of a drug-related offence punishable by not more than two years were grounds for terminating punishability. In this case, the criminal act may be an instrumental offence with a view to acquiring drugs (i.e. crime for acquisition, crime for profit) but it may also serve as a cover-up for drug use.

In such cases, the perpetrator has to produce credible evidence before the judgement of first instance to certify that he has received continuous drug prevention treatment or therapy for at least six months. However, the legislation did not require such treatment to be effective, only the fact of the treatment had to be evidenced.

The amendment of 1 March 1999 narrowed the scope of eligibility for diversion so only offending drug-addicts may now opt for diversion.

The deferral of indictment as a legal institution including diversion from court proceedings may, however, be applied by the prosecutor in the case of occasional drug users provided that the respective conditions are met. So indictment is deferred by one or two years and the prosecutor may stipulate certain rules of behaviour for the offender (which may require participation in therapy or prevention treatment).

Abusers typically undergo therapy or preventive treatment in health institutions, primarily drug outpatient centres and hospitals.

Three prisons have been running various therapeutic groups for years. A methodology has been developed for the operation of drug-free prisons. Diversion into treatment is offered by a special group set up for this purpose at the Budapest Prison.

I. NATIONAL STRATEGY: INSTITUTIONS AND LEGAL FRAMEWORK

1. Developments in Drug Policy and Responses

1.1. Political framework in the drugs field

The drug situation in Hungary has undergone radical changes over the past decade and the need for a strategic plan of appropriate and effective Government interventions has become increasingly imperative. For the first time in 2000, Hungary adopted a national programme based on a series of professional, social, administrative and political consultation covering the problem as a whole and offering considerable opportunities to mitigate the individual and social harms caused by the drug problem; to increase the awareness in the society; to improve the efficiency of interventions; to involve individuals and communities; to make an impact on the views and attitudes of juveniles and those affected towards drugs; to develop effective prevention programmes at the national level; to curb criminal trends related to drug abuse and drug trafficking; and to reduce access to drugs. As a general objective, the national programme is to promote a free, self-confident and productive society that considers human dignity, physical, mental and social well-being and creativity to be of paramount importance, and is capable of controlling health, social and criminal hazards and harms related to the use and distribution of drugs in order to preserve and improve the aforesaid factors.

In respect of international recommendations, Parliament adopted a *multidisciplinary* approach in terms of models interpreting the phenomenon and a problem-solving approach based on a *balance between demand and supply reduction.*

The Strategy specifies the fundamental objectives and values together with the conceptual framework of managing the problem, and at the same time takes stock of the obstacles to and the risks of implementation.

It formulates the main directions and key elements of strategic development; provides orientation for the various settings and actors involved in the implementation of the Strategy; initiates the development of social consensus; aims to mobilise social groups and involve local governments, decision-making bodies, NGOs and local communities in the implementation of the programme; and at the same time serves as a tool to fulfil the conditions of EU accession and international cooperation with regard to the effective control of the drug problem.

The Strategy is based on the following principles:

- **Primacy of facts**

The National Strategy is based on the findings of scientific research rather than assumptions. It advocates intervention methods that are built on firm foundations.

- **Partnership and joint actions**

The National Strategy is based on cooperation between society and the organisations of the central institutional system on the one hand, and relies on the involvement of the creative members of local communities on the other. It recognises that concerted joint actions produce a multiple impact in terms of effectiveness and success. It takes into account the needs of families, schools and local communities, calls for and promotes cooperation at local, regional, national and international levels alike.

- **Comprehensive approach**

The drug problem to be addressed requires a multi-dimensional, well-balanced and articulated approach that provides equally important room for prevention, education, treatment, research, workplace programmes, law enforcement and a number of other areas. For the drug problem to be controlled, it is necessary that the various professions and special fields act in concert. No profession may monopolise the solution to the problem or act on its own.

- **Accountability**

The National Strategy invariably demonstrates efficiency indicators that can be used to measure the implementation of the objectives. Hence, fulfilment will be transparent and costs can be controlled. The National Strategy will be reviewed periodically.

- **Long-term planning**

International experience shows that the drug problem can only be controlled in the long run. Solutions planned for the short term cannot produce results, as we are equally responsible for shaping the attitudes of a new generation towards drugs in addition to addressing current hazards.

The Strategy includes four main objectives as follows:

1. *Society should become responsive to the effective management of the drug problem, and local communities should increase their problem-solving capacities to combat it (community, cooperation).*
2. *Young people should be given the opportunity to develop a productive lifestyle and reject drugs (prevention).*
3. *Helping individuals and families exposed to drugs and suffering from drug problems (social work, therapy, rehabilitation).*
4. *Reducing access to drugs (supply reduction).*

Social consensus with regard to the general and main objectives of the National Strategy may offer a solution to meet the drugs challenge. The comprehensive programme including interrelated and interdependent objectives is designed to minimise individual and social harms and maximise the efficiency of interventions, the institutions of care and joint social actions. The National Strategy must be based on wide-ranging social consensus.
Oversight (monitoring, quality control, the evaluation of progress and achievements) forms an integral part of the strategic programmes.

The Coordination Committee on Drug Affairs (CCDA, on which 16 central administrative bodies are represented at the level of Deputy State Secretary or Deputy Director including the Ministry of the Interior; the Ministry of Health; Social and Family Affairs; the Ministry of Agriculture and Regional Development; the Ministry of Economic Affairs and Transport; the Ministry of Children, Youth and Sport; the Ministry of Defence; the Ministry of Justice; the Ministry of Foreign Affairs; the Prime Minister's Office, the Ministry of Education, the Ministry of Finance, the Public Health Service, the National Police; the National Customs and Finance Guard; and the representatives of the Supreme Court and the Public Prosecutor's Office as invited participants) has a mandate to oversee the implementation of the National Strategy; to coordinate the operation of the individual Ministries and Government institutions; and to reconcile different sectoral approaches. The organisational and administrative work related to the tasks and operation of the Committee is performed by its Secretariat. The head of the Secretariat is the Deputy State Secretary for the Coordination of Drug Affairs at the Ministry of Youth and Sport. The CCDA reports to the Government on the drug situation in Hungary and the evaluation of the implementation of the National Strategy each year.
The CCDA currently operates 8 subcommittees. Four of them are supervised by the Ministry of Children, Youth and Sport, and the other four report to the Ministries of the Interior; Health, Social and Family Affairs; and Justice, respectively.

SUBCOMMITTEE	SUPERVISORY BODY
Subcommittee on Legal Affairs	Ministry of Justice
Subcommittee on Epidemiology	Ministry of Children, Youth and Sport
Subcommittee on Health	Ministry of Health, Social and Family Affairs
Subcommittee on Social Affairs and Children Protection	Ministry of Health, Social and Family Affairs
Subcommittee on Supply Reduction	Ministry of the Interior
Subcommittee on Information and Communications	Ministry of Children, Youth and Sport
Subcommittee on Prevention	Ministry of Children, Youth and Sport
Subcommittee on Laboratories	Ministry of Children, Youth and Sport

Local Co-ordination Forums on Drug Affairs (CFDA) play a key role in implementation. They act as a driving force behind local communities' drug policy by coordinating local actions and initiatives and offering a forum for institutions working in the local communities along the lines of the national objectives. The Forums are an important link in the chain making it possible to turn strategic ideas into reality. The CFDAs receive professional and methodological support from the National Institute for Drug Prevention (NIDP). Their annual reports are summarised by a coordinating secretariat at the CCDA.
The same institute initiates audits and data collection in relation to monitoring (monitoring indicators and instruments). Relying on such information and interviews with key experts in the area, it summarises the findings on the implementation of the National Strategy and its impacts as well as any difficulties that may have arisen during implementation. They are then sent to the CCDA, which will take steps to resolve the problems through inter-ministry consultation. The organisational and administrative work related to the tasks and operation of the Committee is performed by the Secretariat. The head of the Secretariat is the Deputy State Secretary for the Coordination of Drug Affairs at the Ministry of Youth and Sport. The CCDA's Secretariat prepares annual reports on:

- progress and implementation of the National Strategy,
- any changes in the Hungarian drug situation and the operation of the institutions involved in combatting the drug problem.

The CCDA discusses the reports and uses them to prepare its own report to be presented to the Government.
The CCDA evaluates the implementation of the National Strategy each year and carries out due diligence and efficiency surveys of the Strategy and the institutional system every other year. The Government also prepares a report on the implementation of the Programme for Parliament every other year - the first such report was presented to Parliament at its autumn session in 2001.
For this purpose, the CCDA relies on its own findings on methodology as well as the findings of other scientific and research institutes, e.g. technical support from the National Institute for Drug Prevention, which has been set up in the meantime.

The evaluation required by a Parliamentary resolution will be performed on the basis of international standards under the supervision of the Deputy State Secretariat for the Coordination of Drug Affairs at the Ministry of Children, Youth and Sport.

The first annual evaluation of the objectives and tasks in the National Strategy was performed in 2001.
It should be noted that pursuant to Point 2(f) of Government Decree 1039/1998 (31 March) on the establishment of the Coordination Committee on Drug Affairs, “it is the Committee's responsibility to report on the Hungarian drug situation; the implementation of the national anti-drug strategy and the operation of the Committee to the Government each year". The report is prepared and presented by the Secretariat for discussion within the Committee. The Ministry of Youth and Sport will issue annual national reports on the Hungarian drug problem entitled "Report on the drug situation in Hungary" for the fourth time. That report presents the available data, findings and

programmes in a summarised and consolidated form.
Achievements

Strategic objectives

With regard to the implementation of the National Strategy, considerable progress has been made in achieving several of the medium-term objectives, and the short-term objectives are being fulfilled as scheduled. However, it should be noted that there are still many tasks to be accomplished along the lines of the ongoing processes.

Activities related to the establishment and operation of Co-ordination Forums on Drug Affairs

The Ministry of Youth and Sport has assembled a grant scheme to establish and operate Co-ordination Forums on Drug Affairs. As a result of the scheme, CFDAs were established in 56 cities altogether (each with a population of over 20 thousand) in the seven regions of Hungary in 2001. CFDAs receive professional and methodological support from the National Institute for Drug Prevention (NIDP).
CFDAs are local consultation and reconciliation forums operating as professional working groups that coordinate the work of organisations and institutions in the four fundamental areas of combatting the drug problem (i.e. community and cooperation; prevention; therapy and rehabilitation; and supply reduction). They are to implement a uniform professional and methodological approach, and to rationalise and coordinate local drug prevention activities. They help to mobilise local resources, coordinate the activities of local actors, and formulate proposals and recommendations for eliminating duplications. As bodies making professional recommendations they coordinate and promote local participation in national and international bids, and prepare local strategies to address the drug problem. CFDA members include representatives of various central and local Government agencies, NGOs and churches.

The Ministry of Youth and Sport has developed a grant scheme to establish and operate CFDAs. As a result CFDAs were established in altogether 56 cities (each with a population of over 20 thousand) in the seven regions of Hungary in 2001. In the first round of the bidding procedure in March 2001, grants were awarded to 25 cities joined by another 31 in the second round in June. The total amount of grants approved for 2001 was HUF 62,460,000. (249,840 Euro)

CFDAs established in individual regions:

Southern Great Plain	Southern Transdanubia	Central Transdanubia
Szentes	Szekszárd	Veszprém
Szeged	Siófok	Várpalota
Kiskunhalas	Pécs	Székesfehérvár
Hódmez_vásárhely	Paks	Tatabánya
Orosháza	Mohács	Tata
Gyula	Komló	Oroszlány
Kecskemét	Dombóvár	Pápa
Békéscsaba	Kaposvár	Dunaújváros
Baja		
Kiskunfélegyháza		
Kalocsa		
Békés		

Central Hungary	Western Transdanubia	Northern Hungary	Northern Great Plains
Szentendre	Zalaegerszeg	Salgótarján	Szolnok
Gödöll_	Szombathely	Ózd	Nyíregyháza
Dunakeszi	Sopron	Hatvan	Mátészalka
Érd	Mosonmagyaróvár	Eger	Debrecen
Szigetszentmiklós	Gy_r	Miskolc	Törökszentmiklós
Nagyk_rös	Nagykanizsa	Tiszaújváros	Hajdúböszörmény
Gyál	Keszthely	Kazincbarcika	Karcag
Budaörs		Gyöngyös	Jászberény

CFDAs reported on their activities in 2001 by completing questionnaires. In what follows the findings in some key areas will be described:

General operational data

- Average membership: 13 (8 being the lowest and 20 the highest).
- Working groups were formed in half of the cities.
- CFDAs held meetings on 7 occasions on average (minimum 2, maximum 16).
- Half of the cities received grants under bidding procedures other than the grant scheme provided by the Ministry for the objectives formulated in their work plans/strategies.
- Half of the cities received other types of support.

Certain operational aspects as described by CFDAs themselves

- Cooperation among CFDA members varies between acceptable and good.
- The division of labour among CFDA members is only acceptable rather than good.
- Information flows between CFDA members vary between acceptable and good.
- The representation of CFDAs positions towards decision-makers varies between acceptable and good.
- The local work plan/strategy has been implemented for the most part.

Organisations represented in CFDAs

Organisation	As % of CFDAs
Local Government	100
Educational institutions	13
Municipal hospital	50
County hospital	18
Red Cross	18
County Police	36
City Police	82
County Public Health Service	23
Municipal Public Health Service	73
Foundation	18
Drug Outpatient Centre	13
Regional Youth Service Office	18
Media	18
NGOs	50
RÉV Outpatient Centre	10
Church	q
Secondary school	36
Primary school	41
Higher education	9
Public Prosecutor's Office, courts	22
Family Help and Child Welfare Service	64

Activities in the area of prevention:

- data collection on prevention programmes at schools,
- prevention work at schools - intra-curricular and *extra-curricular* programmes (education, presentations, events) peer training,
- organising exhibitions,
- campaign programmes, anti-drug mass events,
- sports programmes, excursions, youth camps,
- presentations, e.g. to teachers, experts in special areas, parents,
- training drug coordinators at schools,
- training teachers in teaching health protection studies,
- preparing publications on drug prevention,
- training of helpers (telephone operators, street work).

CFDAs were active in the following areas of the twelve settings formulated in the National Strategy.

Areas covered by CFDAs' operations

Areas covered by the CFDAs' operation	As % of CFDAs
Family	75
School	100
Workplace	10
Leisure	85
Churches	45
Media	95
Internet, computers	25
Institutional system of child welfare	85
Army	15
Police	95
At-risk groups	55
Roma population	35

General assessment of the operation of CFDAs

The establishment of CFDAs has proved to be a highly promising initiative for the purposes of addressing the drug problem at the local level. In several places, a certain CFDA identity has evolved and the term CFDA has become part of professional thinking. However, difficulties were inevitably encountered. This form of coordination and cooperation often proved to be something completely new and unusual for those involved; it is not common to set up an organisation whose core activity is coordination. The establishment of CFDAs revealed that some cities had already been thoroughly active in several aspects of combatting the drug problem. It also became clear during one year of operation that similarly to NGOs, CFDAs mostly struggled with management problems and had only limited capacities to mobilise local resources. In the light of this experience the dilemma has become particularly pronounced as to whether or not it would be necessary to take steps to give an institutional status to CFDAs within the local administrative system. The experience of the PHARE Twinning project to be launched in 2002 will hopefully help to answer this question.

The establishment and operation of the National Institute for Drug Prevention (NIDP)

The National Institute for Drug Prevention was established in February 2001 with the following objectives:

- to provide professional support for, and facilitate, the implementation of the National Strategy with particular regard to strengthening relations within communities and enhancing social responsiveness;
- to have a prevention institute with a methodological focus that can coordinate and promote the professional aspects as a background for prevention activities;
- to develop cooperation with institutions working in the field of prevention in Hungary;
- to participate in international cooperation to adjust Hungarian drug prevention activities to international standards and adopt best practices;
- to initiate sociological research projects that lead to a better understanding of the nature of drug use and help the preparation of appropriate needs-based prevention programmes and services;
- to issue publications that make international experience accessible to a wider audience as well as making already published technical documents available in a new compilation to satisfy the needs of the target audience.

The operation of the Institute in 2001

- *Activities related to the establishment and operation of Co-ordination Forums on Drug Affairs*

CFDAs receive professional and methodological support from the National Institute for Drug Prevention (NIDP). The staff of the Institute established personal contacts with CFDAs as they were formed; supply their members with useful publications; offer consultation services in person and on telephone; and provide guidance in order to facilitate work and make it more efficient at the local level.
The NIDP has launched a series of methodology papers three of which have already been distributed to the.
The NIDP also organises conferences to help CFDAs in their work and provide opportunities for exchanging their experience. Two events were held in 2001.

- *International relations and cooperation - Phare project:*

The Phare project currently being finalised will include two components:
- A *Twinning Assistance* project which is designed to provide continuous in-house training to the staff of NIDP enabling them to perform the coordination function mentioned in the introduction as efficiently as possible, and to develop a set of instruments that are adapted to local conditions and

can be used for needs assessment, monitoring, evaluation and the expansion of human resources. In the project the Hungarian partner cooperates with the Trimbos Institute in the Netherlands and DrugScope in the United Kingdom. The technical contents and logistics of the project will make it possible for a wider group of experts besides the staff of the Institute as well as for key members of the CFDAs to participate in various seminars and interactive training for shorter or longer periods. We consider the multiplier training to be the most important element of the project. Having learnt from the experience of the previous Phare project, such training focuses on equipping participants with knowledge and skills that can subsequently be made available to a wider group of specialists in the field. As another particularly important aspect, the project will help to develop a mode of operation based on quality assurance for CFDAs. Both the contents and the operation of the project place special emphasis on the aspects of sustainability, i.e. efforts will be made to avoid a situation where viable initiatives wither away as the grant period is closed.
- *Development of a grant scheme* – The other component of the Phare assistance is aimed to develop a grant scheme. On the one hand, we wish to widen the choice of reliable and well-functioning programmes with regard to school programmes, low-threshold services and Safe Entertainment Venues. On the other hand, we wish to help NGOs active in the field of prevention to expand their human resources and thus become more capable of performing their mission, including also the mobilisation of financial resources.
The two components of the Phare project will be launched in two stages with four months difference in 2002. The first phase of the Twinning Assistance project will in a way set the scene for developing the technical contents and organisational framework of the grant scheme.

- *Participation in international events - strengthening relations*

Several experts of the Institute have participated in international conferences and worked as consultants on behalf of international organisations.

- *Participation in the preparation of international projects*

Preparations were made for a bilateral cooperation project between the UK and Hungary, covering two topics:
- promotion of cooperation and exchange of experience between Hungarian Co-ordination Forums on Drug Affairs and British DATs (Drug Action Teams) with particular regard to adopting best practices in Hungary;
- organisation of an expert meeting on the role of the media in prevention and the drug policy.

- *Research*

- HBSC (Health Behaviour among School Children) research in cooperation with the National Health Promotion Centre;
- „Plaza - preliminary study";
- Research focussing on the beneficiaries of institutional state care - substance use attitudes and life history;
- National Research Development Project – "Lights and shades" - Risk factors, prevention needs and possibilities.
(See Part II for research results and research plans.)

- *Publications*

In 2001, the Institute contributed to two publications:
- Demetrovics, Zsolt: " Drug use in dance clubs in Hungary " (Droghasználat Magyarország táncos szórakozóhelyein)
- Report on the drug situation in Hungary, 2001.

The National Focal Point

Under a PHARE project preparations were made to connect to the epidemiology and drug database of the European Union. Under the PHARE project "EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) - Cooperation of Central and East European countries" involving several countries, EMCDDA coordinates the national programmes of Central and Eastern European candidate countries for the establishment of drug information contact points (known as National Focal Points) and the integration of the candidate countries in the activities of the EMCDDA.
A special unit has been set up at the Ministry of Health, Social and Family Affairs with a mandate to make preparations for the Hungarian Focal Point as a secondary information service centre. However, the Government has not decreed yet on the establishment and responsibilities of the National Focal Point.

Following preparations in 2000, the institutionalisation of the Hungarian drug data collection centre and the pilot implementation of effective demand reduction models began under PHARE project HU0006-02 in November 2001 (to be completed in March 2003). The project is implemented in the form of twinning cooperation with the Spanish National Drug Centre. The total budget of the project is 1 million Euros of which 850 thousand Euros will be used for the services of the Spanish twinning partner and 150 thousand Euros will be available for technical equipment for the data collection centre. Legislation on the formal establishment of the centre is still pending. The most important function of the National Focal Point will be to supply harmonised information according to the requirements of the Lisbon-based European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) of the European Union.

The Spanish partner will first of all provide technical assistance for the implementation of the project. The following tasks will be accomplished:
- establishing and equipping the national data collection centre;
- harmonising drug data collection, processing and reporting in accordance with EU requirements;
- providing training for experts involved in data collection at the institutions participating in anti-drug efforts;
- testing and introducing model programmes to reduce the demand for illegal drugs.

The Spanish expert (PAA) arrived in Hungary in November 2001.

1.2. Legal framework

- Articles 282-282/A of the Criminal Code (Act IV of 1978) govern the offence of "drug abuse". The latest amendment to the aforesaid legislation became effective as of 1 March 1999. According to the legislator, the object of the criminal offence is a social interest linked to the inviolability of the health of citizens. As a clear objective, the amendment is designed to combat drug abuse with its concomitant phenomena.
- No changes were made in either the drug-related law enforcement legislation or the criminal legislation regarding drug-related activities in 2001.
- However, the definition of confiscation and forfeiture as possible actions were amended in the Criminal Code. Confiscation and forfeiture may be applied independently instead of punishment or in combination with punishment or other actions. Act CXXI of 2001 transferred forfeiture from secondary punishment into penal actions as of 1 April 2002 with a reference to the fact that the contents of the two legal institutions had already demonstrated duplication. In its present form, the legislation in force complies with the provisions of the Strasbourg Convention of 8 November 1990 on money laundering and the investigation, confiscation and seizure of items originating from criminal activities as it was promulgated in Act CI of 2000.

Confiscation

Article 77

(1) An object
a) actually used or intended to be used as an instrument for the commission of a criminal act,
b) the possession of which constitutes an endangerment to public safety or is illegal,
c) which is created by way of a criminal act,
d) for which the criminal act was committed
shall be confiscated.
(2) Media products, in which a criminal act is realised, shall be confiscated.
(3) In the cases defined under Points a) and d) of Paragraph (1) confiscation shall not be ordered if the object is not owned by the perpetrator, unless the owner was aware of the perpetration of the criminal act, unless confiscation is prescribed mandatory by international convention.
(4) Confiscation shall be ordered, even if the perpetrator is not punishable due to being a minor, to mental disorder or due to the negligible degree of danger that the act represents to society.
(5) No confiscation shall be ordered after the lapse of the statute of limitations for the punishment of the act, or beyond a period of five years.
(6) Confiscation of an object shall not be ordered if it is included in a forfeiture of assets.
(7) Confiscated objects shall become the property of the state.

Article 77/A

(1) In the cases under Points a) and d) of Paragraph (1) of Article 77, confiscation may be foregone in exceptional cases, if it would entail an unreasonable burden to the perpetrator or the owner, disproportionate to the gravity of the criminal act, provided the omission of confiscation is not precluded by any international obligation.
(2) Paragraph (1) shall not apply in connection with crimes committed in affiliation with organised crime.

Forfeiture of Assets

Article 77/B

(1) The following shall be seized subject to forfeiture:

a) any financial gain or advantage resulting from criminal activities, obtained by the offender in the course of or in connection with a criminal act,

b) any financial gain or advantage obtained by an offender in connection with crimes committed in affiliation with organised crime,

c) any financial gain or advantage that was used to replace the financial gain or advantage obtained by the offender in the course of or in connection with a criminal act,

d) any property that was supplied or intended to be used to finance the means used for the commission of a crime.

(2) Any financial gain or advantage resulting from criminal activities, obtained by the offender in the course of or in connection with a criminal act, also if it served the enrichment of another person, shall be seized subject to forfeiture. If a legal person obtained such gain or advantage, it shall be subject to forfeiture.

(3) In the event of death of the perpetrator or the person profiteering as specified in Paragraph (2), or the legal person was transformed, the property transferred by succession shall be seized from the successor in title.

(4) In the case referred to in Point b) of Paragraph (1), all assets obtained by the perpetrator during his involvement in organised crime shall be subject to forfeiture until proven otherwise.

(5) The following property cannot be seized:

a) that of which is reserved to cover any civil claim awarded during the criminal proceeding,

b) that of which was obtained in good faith for consideration,

c) in the case referred to in Point b) of Paragraph (1), if the property is proven legitimate.

Article 77/C

(1) Forfeiture of assets shall be ordered for a specific sum

a) if the property is no longer accessible,

b) if the property to be seized subject to forfeiture under Article 77/B cannot be distinguished from other assets, or it would impose unreasonable difficulties,

c) in the case defined in Point b) of Paragraph (5) of Article 77/B.

(2) Forfeiture of assets shall be ordered, even if the perpetrator is not punishable due to being a minor, to mental disorder or due to the negligible degree of danger that the act represents to society.

(3) Seized assets shall become the property of the state unless prescribed by law to the contrary.

(4) For the purposes of Articles 77/B and 77/C, any profits, intangible assets, claims of any monetary value and any financial gain or advantage shall be deemed assets.

- Definition by the law of the offence of money laundering has been modified and failure to meet reporting obligations as an offence introduced.

Money Laundering

Article 303

(1) Any person who uses items obtained by the commission of criminal activities punishable by imprisonment in his business activities and/or performs any financial or bank transaction in connection with the item in order to conceal its true origin is guilty of felony punishable by imprisonment not to exceed five years.

(2) The punishment shall be imprisonment between two to eight years if money laundering

a) is committed in a pattern of criminal profiteering,

b) involves a substantial or greater amount of money,

c) is committed by an officer or employee of a financial institution, investment firm, investment fund manager, clearing house, insurance institution, or an institution engaged in gambling operations,

d) is committed by a public official,

e) is committed by an attorney-at-law.

(3) Any person who collaborates in the commission of money laundering is guilty of misdemeanour punishable by imprisonment not to exceed two years.

(4) The person who voluntarily reports to the authorities or initiates such a report shall not be punished for money laundering, provided that the act has not yet been revealed, or it has been revealed only partially.

(5) The term "item' referred to in Paragraph (1) shall also cover instruments embodying rights to some financial means and dematerialised securities, that allow access to the value stored in such instrument in itself to the bearer, or to the holder of the securities account in respect of dematerialised securities.

Article 303/A

(1) Any person who uses an item obtained from criminal activities committed by others

a) in his business activities, and/or

b) performs any financial or bank transaction in connection with the item,

and is negligently unaware of the true origin of the item is guilty of misdemeanour punishable by imprisonment not to exceed two years, work in community service or a fine.

(2) The punishment shall be imprisonment for misdemeanour not exceeding three years if the act defined in Paragraph (1)

a) involves a substantial or greater amount of money,

b) is committed by an officer or employee of a financial institution, investment firm, investment fund manager, clearing house, insurance institution, or an institution engaged in gambling operations,

c) is committed by a public official.

The title and the description of the criminal activity were inserted in the Criminal Code with Article 23 of Act IX of 1994 as of 15 May 1994. It was supplemented and amended with Article 45 of Act LXXII of 1997 by introducing perpetration of crimes as a member of a crime organisation as of 15 September 1997. Later on, Article 74 (2) of Act LXXXVII of 1998 amended Article 303 (4), and Article 19 (1) of Act CXX of 1999 amended Article 303 (1) as of 1 March 1999.

Following the aforesaid precedents, Act CXXI of 2001 introduced new provisions regarding money laundering by leaving the title of the criminal activity unchanged.

On 8 November, 1990, the Convention 141/1990 of the Council of Europe was adopted with a view to specifying in concrete terms the principles of international cooperation set forth in the Vienna Convention of 1988 in respect of investigating, seizing and confiscating the proceeds of criminal activities.

The Hungarian Parliament ratified the Convention of the Council of Europe on 5 September 2000 and promulgated it in Act CI of 2000 on money laundering, and the investigation, seizure and confiscation of the proceeds of criminal activities.

Failure to Fulfil Reporting Obligations in Connection with Money Laundering

Article 303/B

(1) Any person who fails to comply with the reporting obligation prescribed for financial service organisations by the Act on the Prevention and Combatting of Money Laundering is guilty of felony punishable by imprisonment not to exceed three years.

(2) Any person who negligently fails to comply with the reporting obligation referred to in Paragraph (1) is guilty of misdemeanour punishable by imprisonment not to exceed two years, work in community service or a fine.

The title and the text of the legislation were included in the Criminal Code with Article 62 of Act CXXI of 2001 as of 1 April 2002. According to the explanatory note of the Minister, the law provides for practically the same punishment of the failure to report money laundering but it is defined as an independent offence as the reporting obligation cannot be included in the definition of money laundering.

- While none in 2001, four new psychotropic drugs were included in 2002 in the list of psychotropic drugs attached to Joint Decree 4/1980 (24 June) of the Ministry of Health and the Ministry of the Interior on the production, processing, marketing, importation, exportation, storage and use of psychotropic drugs. The aforesaid attachment was amended by Article 1 of Joint Decree 20/2002 (25 April) of the Ministry of Health and the Ministry of the Interior. *Hence, 4-MTA was included in List I of psychotropic drugs, 2C-B in List II and GHB and zolpidem in List IV.*
- Following preparations to develop the technical guidelines of methadone treatment in 2001, the "Methadone Protocol" was published as a technical methodology paper in the Health Gazette in April 2002.
  A study on the evaluation and regulation of methadone treatment was published in Psychiatria Hungarica in *March 2001*.
  Under the auspices of the Council of the Professional Association of Drug Outpatient Centres, the Hungarian Manual of Methadone Treatment was published as a manuscript in *October 2001*.
  Issue 9 of the Health Gazette officially published the methodology paper on methadone treatment on *25 April 2002*.
  Issue 10 of the Health Gazette published the National Health Insurance Fund's financing regime of methadone treatment on *12 May 2002*. Since then methadone has been available to patients free of charge.

Methodology paper of the Psychiatric Advisory Committee on the technical guidelines of methadone treatment

General remarks

The present guidelines were elaborated at Consensus conferences convened by the Psychiatric Advisory Committee.

The present guidelines are based on the concept that long-term substitution treatment with methadone is a therapeutic intervention that can be regarded as the symptomatic treatment of a chronic disease, i.e. opioid addiction, a therapy to eliminate the opioid deficiency of the organism (substitution or diabetes model), and as a medical intervention to reduce further harms to patients using opioid (harm reduction model). Methadone is an agonist of exogenous opioid drugs, and due to its favourable pharmacological properties it can be administered as long-term treatment, sometimes for years. Long-term substitution treatment with methadone is part of tertiary prevention of drug addiction (prevention model).

There are two types of methadone treatment: 1. methadone detoxification, 2. long-term substitution treatment with methadone.

1. Methadone detoxification

Methadone detoxification consists of two steps. In the first step, methadone is administered orally for a longer-term effect to substitute opioid drugs with short-term effects. In the second step, the methadone dose tailored to the individual's needs is gradually reduced to zero within preferably one month (ideally ten days) but maximum six months.

2. Long-term substitution treatment with methadone

In recent years, a group of opioid users has been identified to need a sustained dosage of methadone in Hungary. By formulating the present guidelines, the highest professional body of Hungarian psychiatrists and addictologists wishes to manifest that an internationally tested, accepted and recognised method has been adopted to provide therapy for the aforesaid population.

As a typical feature, opioid users requiring sustained methadone treatment cannot actually tolerate total abstinence from opioids.

The head of the institution applying methadone therapy launches motivation programmes to prepare the patients for abstinence periodically (i.e. every six months).

Professional expectations from long-term substitution treatment with methadone include:

- Professional supervision
- Indication
- Institutional framework
- Effectiveness tests
- Funding from social insurance
- The technology and safety of dispensing
- Dosage

1. Professional supervision

A working group of three specialists decide on long-term substitution treatment with methadone on the basis of the patient's case history, clinical status, drug career and psychosocial situation at the therapeutic institution. Two members of the working group are medical specialists who consult an external specialist on the decision if necessary. The third member is another qualified specialist (addictologist, psychiatrist, general practitioner or other medical specialist, psychologist, social worker or consultant). Long-term substitution with methadone is based on the indication by a psychiatrist or an addictologist who applies the therapy following a special training course (see attachment). The specialists of outpatient centres performing methadone treatment form a National Committee, which reviews the effectiveness of ongoing therapies and the need to continue such therapies.

2. Indication

Several years of confirmed opioid dependence (at least three years) and more than 18 years of age.

Dropout from repeated unsuccessful treatment programmes aimed at abstinence. Repeated relapses in drug use (relapse: the drug use returns to the original level after abstinence is reached).

3. Institutional framework

Long-term substitution treatment with methadone is to be applied at drug outpatient centres (methadone therapy institutions) where special staff and material capabilities along with safety conditions are available and where methadone treatment forms part of a complex addictology therapy.

Alternative institutions for methadone therapy:

- special methadone therapy centres with functional relations with psychiatric and addictology services,
- methadone therapy units operating as part of a complex addictology service,
- drug outpatient centres.

4. Record-keeping

The addictology services offering methadone treatment are responsible for keeping records of patients receiving long-term substitution treatment with methadone. Such records are to be kept in accordance with the prevailing drug legislation.

In addition, the institutions are required to report all long-term methadone substitution treatments commenced to the regional addictology specialists.

The patients are entered into a national register with reference to codes to ensure anonymity. The national register is kept at the Drug Outpatient Centre in Jász Street. The head of the Drug Outpatient Centre in Jász Street sends the national aggregate data and the quantity of methadone used monthly to the director of the National Institute of Alcohology (NIA) and the National Public Pharmaceutical Officer.

5. Effectiveness tests

Long-term substitution treatment with methadone is a medical intervention to be performed in accordance with strict professional rules and has to be supplemented with a complex psychosocial intervention. The evaluation of the effectiveness of the treatment requires the analysis of psychosocial factors. Psychic dependence has to be approached with alternative procedures (such as group therapy, lifestyle counselling, etc.). After the therapy is launched, the patient's drug use is expected to drop and his psychosocial status is to improve. It is recommended that periodic random urine samples be taken from the patient to trace any drug in the patient's organism (at least four times a year). It is also necessary to verify the extent to which a patient has been reintegrated in society (work, learning, family life). Such checks are to be carried out on random samples and in cases when therapists suspect parallel drug use.

6. Social insurance funding

The detailed rules of funding are stipulated in the respective legislation of the sector.

7. The technology and safety of dispensing

Methadone may exclusively be given in liquid forms (solution, suspension, dissolved pills or powder, effervescent tablets). As a basic principle of dosage, patients should preferably not get hold of methadone. Therefore, methadone should be dispensed daily and should be administered in the presence of medical specialists even on holidays.

Continuous and regular checks are to be performed throughout the treatment.

To ensure safety of dosage, methadone must be stored at the methadone therapy institutes. Safety conditions have to comply with the provisions of existing drug policing legislation.

8. Dosage

Daily methadone doses are to be determined on an individual basis. The dose should be at the minimum level necessary to reach the desired substitution effect. On the basis of Hungarian and international experience, the average dose is 50-150 mg per day. The necessary minimum substitution dose is to be determined with biological titration by dispensing gradually increased doses over several days (international protocols recommend 30 + 5 mg on the first day to be increased by 5-10 mg daily thereafter). The required level of medication is to be verified on the basis of the patient's clinical check-up (psychic status, vegetative parameters), exploration, urine tests and heteroanamnesis.

A separate professional guideline is being prepared for the treatment of opioid-addict pregnant women, their infants, opiate addicts below 18 years of age and those with HIV, Hepatitis B and C infection.

- Work has started to analyse the legal framework and change it if necessary with regard to music and dance clubs. The most important rules on safe entertainment are being formulated in collaboration with an NGO supported by the Ministry of Youth and Sport, i.e. the Association for Safe Entertainment (its members including operators and owners of discos) and other bodies concerned. Until the appropriate legal background is created, the operators and owners volunteer to comply with the criteria on "safe entertainment" which were jointly elaborated. The respective legislation was amended in 2002.
- In order to facilitate Hungary's accession to the European Union, the legislation on drugs and psychotropic substances have been amended in line with harmonisation requirements, however the objective to create the required balance between harm and supply reduction has not been reached in full. As a backlog in the field of legislative harmonisation it should be noted that the decree on activities where drugs and psychotropic substances can be used legitimately has not been presented to the Government for consideration yet although the Ministry of the Interior already prepared the draft decree in December 2000. The differing position of the Ministry of

Health prevented the publication of the said decree. All the Ministries concerned are aware of the importance of uniform legislation, which requires wide-ranging technical consultations to enable Hungary to fulfil the requirements ensuing from the EU acquis. Further cooperation is needed with regard to rules aimed fully to implement the UN conventions, a new warning system of synthetic drugs, the mandatory destruction of drugs, the amendment and simplification of the list of drugs and psychotropic substances, the institution of monitoring, and the development of norms governing international notification and information supply.

1.3. Laws implementation

Articles 282-282/A of the Criminal Code (Act No. IV of 1978) govern the offence of "drug abuse". The latest amendment to the aforesaid legislation became effective as of 1 March 1999.
One of the short-term objectives of the National Strategy is to analyse criminal law after a certain period and in the light of law enforcement experience, and to amend it if necessary.
Two and a half years after an amendment to the definition of drug abuse as an offence, it was possible to carry out an impact survey of the said amendment to the Criminal Code effective as of 1 March 1999. The survey was carried out by the National Institute of Criminology (Ritter 2002) on behalf of the Ministry of Youth and Sport.

The survey was aimed to determine

- whether the application and enforcement of the legislation could attain the desired social objective and how the roles of other drug policy instruments changed in the management of drug problems;
- how successful the legislative amendment was in combatting drug problems;
- what indirect impacts resulted from the application of the legislation;
- whether the change in the legal framework can fulfil the desired social function, prevent or resolve conflicts.

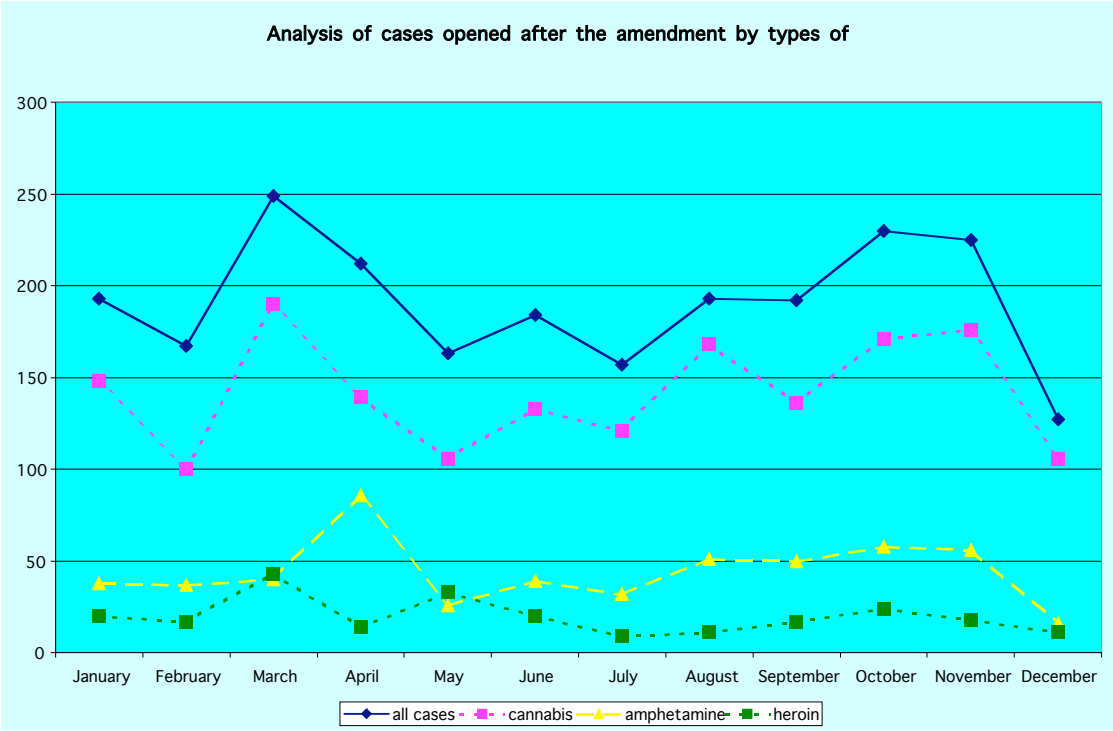
Research methodology and sample selection
The research was aimed to compare the proceedings in drug crimes before and after the amendment was adopted on the basis of Police and Public Prosecutor's Office documents, and interviews with the experts concerned.
The survey had a national coverage, i.e. the total national sample was used as a basis to examine the proceedings and their features in drug crimes on the basis of cases reported in crime statistics in 1999 and 2000.
Hence, research was extended to the cases of all 19 county Police Headquarters, County Prosecutors' Offices, the Prosecutors' Offices and District Police Stations in Budapest, and the Anti-Drug Unit of the Investigations Department's Organised Crime Section of the Budapest Police Headquarters.
4717 cases were examined and processed altogether, 2401 (50.9%) of which. were instituted after the amendment and 2316 (49.1%) before the amendment.
In order to assess the effectiveness of the legislation, the application of the amendment and any problems, it was deemed necessary to conduct interviews with prosecutors and Policemen who were involved in the proceedings.
Hence, semi-structured sociological interviews were conducted with prosecutors and Policemen (detectives and investigators) who were mostly concerned in the proceedings in drug-related cases.
For data processing, the collected information was recorded on computer for an analysis with the help of the SPSS statistical software package.
During the survey, the personal records of 4717 perpetrators of drug crimes were reviewed and 137 interviews were conducted with prosecutors and Policemen.

In known cases of drug crimes, proceedings were typically instituted against perpetrators in larger cities (90.7%). It did not mean, however, that there were no cases in small towns or villages. The analysed sample covered a total of 244 municipalities. As it was also confirmed by the interviews, it seems, however, that the Police are not prepared to handle drug cases either in city Police Headquarters nor in district stations in small settlements. The most important problems are as follows:

- as a result of understaffing it is impossible to institute proceedings against a larger number of drug criminals at the same time even when reliable information is available on the drug penetration of certain places,
- there is a lack of knowledge and technical facilities necessary to investigate drug cases or to detect the problem,
- as forensic expertise is centralised, proceedings in reported cases sometimes have to be suspended because materials for evidence, e.g. urine samples are not sent to the experts in time, and
- certain local actors with economic or political clout may thwart investigations.

The analysis of cases by type of substance as a function of the months of perpetration after the amendment:

Analysis of cases opened after the amendment by type of drugs



It is clear from the chart that the curve representing cannabis derivatives (marijuana, hashish) falls in line with the curve showing all examined cases by the month of perpetration. It indicates that the *proceedings instituted on grounds of abuse with cannabis derivatives, which accounts for more than half of the cases, typically determine the distribution of reported drug-related crimes by the month of perpetration*.

After the amendment, the incidence of cannabis derivatives increased by 19.2% in the analysed cases while the incidence of amphetamine, methamphetamine and heroin decreased. The decline was quite sharp at 33.2% in the case of amphetamine derivatives, which does not necessarily mean that the use of such substances actually dropped as it was borne out by the interviews. Instead, it can be attributed to the limited capacities of law enforcement.

The number of cases reported after the amendment grew by 17%. Those who reported cases generally knew the perpetrators and were related to them as friends, family, parents and even schools that reported more than half of the cases after the amendment.

The amendment made Police investigations more difficult in drug crimes. A negative media campaign communicating the amendment to the public was one of the reasons why some drug users increasingly covered themselves up, and in reported cases they were less cooperative with the Police than before.
There was a shift on the drug scene: the risks of supply and distribution increased, thus making the scene more aggressive. The market price of illegitimate drugs also rose.
The Police force and the current structure are approaching the limits of their capacities in combatting drug-related crime.
From the cases analysed, researchers concluded that the amendment hardly took into consideration the current status of the enforcement system. It posed requirements that enforcement found particularly difficult to satisfy. Hence, it became increasingly difficult to detect drug crimes and produce evidence, as the current investigation system is not prepared to cope.
It was found from the analysis of the cases and was also confirmed by the interviews that similar behaviours were judged and handled in different ways by the different law enforcement bodies. Enforcement also varies from place to place; the application of the law often depends on the interpretation of the respective prosecutor, which often shows wide differences from county to county.
The data indicate that although there was an increase in the number of proceedings initiated on account of supply side behaviours and in the rate of such cases within the total number of drug crimes after the amendment, both the number and the rate of cases representing small quantities or involving seizure of small quantities rose despite the substantial reduction of quantity limits.
Although the number of reported cases of supply and distribution increased, they less often involved seizure of larger quantities of drugs, suggesting that proceedings on account of supply side behaviours were instituted against "petty" dealers or users who either belonged in the lowest echelons of the distribution network or used drugs themselves and traded or gave away drugs to one another.
The average direct forensic costs of proceedings in drug crimes were 327 Euro before the amendment and rose to 396 Euro thereafter.

Even after the amendment, juveniles typically commit most cases as users, however behaviours such as presenting or pushing drugs, and dealing to some extent show a marked increase. Handling such cases presents *a serious problem even for law enforcement officers as many believe that although such behaviours as presenting or pushing drugs are incorrect and wrong, the sentences and procedures imposed on such behaviours are too serious and counterproductive especially in the case of juveniles, therefore they find it hard to accept them.*

The number of reprimands increased among juveniles but unfortunately still half of juvenile delinquents were indicted, the reason being that in cases where they show other behaviours (e.g.

push or give away drugs) in addition to using drugs, the procedural law does not permit the suspension of indictment.
More than 96% of the perpetrators have at least primary school education. About 55% have secondary school education and only a small number of them have not finished elementary school. The perpetrators of drug abuse are typically different from average criminals in terms of age specific features as well as education.
After the amendment, an increasing number of proceedings were instituted on account of drug-related crimes against those who still participated in formal education.
First offenders with no criminal records represented about 70%. *The data show that perpetrators with criminal records who were charged with drug abuse crimes had previously been involved in proceedings not related to drugs but typically on account of crimes against property assets and/or assault.*
There was clear evidence that 24.1% of the perpetrators had already used intravenous drugs.

Law enforcement officers were asked about the negative social consequences of the new legal framework they had encountered. Several of them had the opinion that occasional drug users were unreasonably criminalised. In addition, law enforcement officers experienced that users had increasingly covered themselves up. Only few of them believed that it was right to apply stricter rules to occasional users (3.2%).

The interviewees were asked what they thought the objective of the amendment had been. Altogether 33 different responses were given, indicating that although the legislator had clearly specified the objective of the amendment, it had not come across clearly to law enforcement officers. The widely varying responses suggest that some law enforcement officers understand the objective of the amendment differently from the legislator's original intention.

The majority of the law enforcement officers interviewed did not consider drug use to be a serious act, and tried to apply the mildest sanctions if possible. The attitude of most law enforcement officers towards users and their behaviour (especially in the case of juveniles) is different from the legislator's intention calling for a more restrictive action against occasional users.

What attitude would be more appropriate on behalf of law enforcement to make sure that the legislator's intention is realised? If an increasing number of the interviewees concerned believe that the instruments of criminal law are not conducive to combatting drug abuse, how can the legislator's intention be implemented?

Of the interviewees, 67.8% said that there was no cooperation (even informally) between their organisations and therapeutic institutions while 32.2% reported on typically informal relations with institutions providing treatment for drug users. 78% of the interviewees thought that the framework of cooperation would have to be regulated.

As a common problem, the law is not applied uniformly in practice, which greatly undermines juridical security. One of the reasons should be seen in the problems of the interpretation of the law and classification, and another one lies in the attitudes and routines of law enforcement officers and the way in which they approach the problem and the behaviours of perpetrators.

The lack of knowledge regarding drug problems was also revealed among those acting in such cases at all the organisations concerned. The need was also identified for special training and the creation of special law enforcement jobs dealing with drug cases as they require special skills.

The interviewees typically disagree that sentences should be increased. They were, however, rather uncertain on the issue of punishing users. Law enforcement officers were split on this issue, and about the same number would consider it necessary as those opposing the punishment of drug users.

However, they do not regard people afflicted with drug problems as criminals and they were also united on the issue that drug use could not be controlled with legal instruments. In fact, they believe it unlikely that the rising number of revealed cases would have a deterring effect on drug users or reduce the incidence of drug use.
The interviewees thought that the procedures were extremely slow in drug-related cases.
The majority did not agree that stricter sentencing would have a deterring impact on supply side behaviours.
Law enforcement officers were also asked if they considered the amendment of the Criminal Code (Articles 282 and 282/A on drug abuse) necessary. More than half of the interviewees (53.6%) agreed that it had been necessary to change the earlier definition by law of the offence.
A further question was related to the enforceability of the current legislation. 65.8% of the interviewees indicated that the provisions do not lend themselves to being enforced.
They were also interviewed about whether they thought *further amendments would be needed*. 82.4% of the interviewees answered in the affirmative.

Conclusion

On the basis of the respective statistical data and the findings of the research, it can be concluded that the effectiveness of the amendment (Act LXXXVII of 1998), which brought about a drastic change in the legal treatment of drug crimes, can be questioned.
Assuming that the desired social objective was to combat the phenomenon of drug abuse (drug use and trafficking in particular), and analysing the effectiveness along the lines of statistical data and research findings in the period since the amendment, it can be seen that neither the incidence of drug use nor drug trade could be reduced. The relationship between the legislation and its actual enforcement is fraught with conflicts.
The new legislation as part of the legal framework fails to facilitate the satisfactory operation of the system, hence its operating disturbances have a feedback effect on the legal system.
On the basis of the respective statistical data and the results of the impact survey, it can be stated that the amendment has produced more negative consequences than positive effects. This statement equally applies to procedures and social impacts.
It has made legal qualification more difficult, turned procedures more complicated rather than simple, and the restrictions (especially the poor communication thereof) have made a negative impact on the trends in the drug market and the behaviours of the drug market participants as well as the need for therapy.
Certain criminal behaviours and the related high sentence rates (on presenting and pushing drugs) are unrealistic and do not take into account the age-specific habits and behaviours of perpetrators, and excessively criminalise the phenomenon. As a result, they have no deterring effect.

1.4. Developments in public attitudes and debates

- No targeted study has been prepared to explore the public opinion or attitude towards drug use or drug problems in general in Hungary yet. Although certain studies concentrating on other areas such as epidemiology, crime prevention or victimology have also addressed drug problems in the context of those issues, there are no validated results regarding the public attitude towards drug use or drug problems.

In 1997, the National Crime Prevention Council commissioned the National Institute of Criminology to carry out a survey based on a national representative sample on the fear of crime among the population (Kó, 1998). The interviewees were asked to indicate in a questionnaire how they would punish twelve types of crimes on a scale of five (whereby five was the most severe punishment and one was the lightest).

It was interesting to see in the ranking order of crimes by the severity of the act that drug use, which had previously been considered rather dangerous, was ranked last but one (it preceded tax fraud, corruption or economic crime). The picture is just the opposite with regard to punishment. Economic crimes and corruption are considered dangerous acts of crime but the interviewees would not punish them more severely.
Interviewees in Budapest and county seats would not prefer more severe punishment of drug users even though people living in larger cities are more likely to encounter drug problems. Special mention must be made of young people (between 18 and 29 years) and high-income people who would not think more severe punishment necessary either since a great part of potential users belong in those social groups.
The attitude to drug use is influenced by the concern for family members, first of all children. In other words, having a child greatly affects a person's opinion about drug users. Childless people would tend to mitigate punishment as against those who have several children and would thus prefer greater severity.
More educated people are significantly more tolerant towards drug use and would consider it less necessary to impose stricter punishment. For example, 22% of university graduates answered the question by indicating "much lighter" punishment. Unlike non-religious people, those who regularly go to church would punish even the use of drugs more severely. Alcohol users are also split on this issue. Those who admit to be social drinkers would apply lighter punishment as against regular drinkers and teetotallers who would prefer more severe punishment. Naturally, those who have already tried some drug would also be more lenient in punishing drug use.
The greatest variation with regard to drug use also indicates the wide differentiation of opinions.

- In 2001 the issues of demand reduction, especially primary prevention and harm reduction were given main emphasis in the programmes supported by central administration as well as in the media.
- The Pepsi Island Festival was again organised in 2001.
  The Deputy State Secretariat for the Coordination of Drug Affairs at the Ministry of Children, Youth and Sport attaches particular importance to the involvement of NGOs in combatting drug abuse and encourages them to participate in several aspects of the National Strategy.
  A good example of this cooperation is an initiative known as the Civil Village, which, as a result of over 300 people's coordinated efforts, encompassed 27 NGOs specialising in drug and AIDS prevention as well as harm reduction.
  Following preparations for nearly a year, EUR 280,000 provided by the Ministry of Youth and Sport supported the appearance of the Civil Village at the Pepsi Island Festival.
  The Pepsi Island Festival is Europe's biggest youth festival, which is organised on Budapest's Shipyard Island every year. The one-week programme hosting an audience of some 400.000 every year is visited by many young people from abroad as well.
  Therefore the Festival is an important scene of prevention and increasingly, especially in recent years, of harm reduction.
  The programmes presented by the Civil Village offered everyone a pleasant way to spend time. Apart from raising awareness of the perils of drug use, they offered constructive alternatives to the 14-25-year age group, which is most exposed to drug-related risks. The Civil Village also gave an opportunity to those in need to find the help they wanted or to know where to go should they end up in a particular life situation.
  The Civil Village was made up of 18 tents and a Drug Bus, which were arranged to look like a real village. Just as an active village has a community centre, health centre, bar, church, theatre and craft workshop so did these institutions appear in the Village. The Village 'bar' was a Tea House, its church the Tent of World Religions. The Health Centre provided AIDS screening free of charge, while a needle exchange programme and a mobile Party Service were available nearby. The Craft House and a drama tent called KÁVA featured as the creative scenes of the Village. The NGO tents were open to those interested and also offered individual counselling. In many cases, the Village received positive feedback from both visitors and professionals attending different programmes, and then, after the Festival, the Festival organisers themselves. The press also gave good reviews of the event, particularly its drug

prevention and harm reduction programmes and especially praised the partnership between the close to 30 NGOs.

- In 2001, linked to the UN International Anti-Narcotics Day, a whole week was devoted to a series of events conveying the same 'Message' in the full spectrum of the media mobilising the whole of society.

Based on arrangements with the leaders of the Hungarian Television, the m1 channel hosted a drug prevention week, which included reports about various events taking place all over Hungary, drug prevention films, interviews etc., and related studio discussions.

The drug prevention week ensured a uniform image through the Message, its logo, TV spots and key events.

- Several media events and programmes that addressed drug problems were also given targeted support in 2001. Special mention must be made of the programme 'Drug Store' on Radio Pet_fi, which has been broadcast to give an overall picture of the drug phenomenon for years. On the basis of the National Strategy, the programme relied on the knowledge of the respective Articles on drug crimes in the Criminal Code. The social environment surrounding drug use had changed substantially in the past years, therefore they particularly focussed on educating parents and teachers. The programme knowingly avoided examples that would be humiliating, shocking or frightening. As the philosophy of the programme said, "Do not ask why somebody is using drugs but ask why somebody is not!"
- The Foundation for a Clean Future organised an exhibition, unusual in its theme and instruments, for adults and children over the age of 14 years. There are several programmes aimed at reducing or controlling drug use in Hungary but only few of them are addressed to parents or adults in general. For this reason, the organisers decided to focus the exhibition on the most important setting of primary prevention, i.e. the role of families. This unusual exhibition using unconventional tools such as video films, audio materials, computer animation, showed the reasons for and effects of drug use, the development of addiction, the everyday life of addicts and the characteristics of drug use in Hungary in a credible way so as to make an impact not only on the visitors' senses but also on their emotions. The first exhibition was open at the Hungarian Museum of Natural Sciences until 17 June 2001. Several hundreds of visitors were recorded daily. As a sign of success, the exhibition could no longer receive new bookings of groups after March. Given the outstanding interest, the interactive material of the exhibition was shown in various other cities around Hungary to offer a possibility for an even wider audience to visit it.
- An increasing number of NGOs and professional groups have opened and operate interactive professional websites on health promotion and the prevention of drug use providing easy access to young Internet users and helpers. Such websites mostly include up-to-date and reliable information based on facts and not on threats by presenting activities and model persons attractive to young people and offering chat rooms and games.
- In 2001 a National Drug Portal linked to the Government portal was opened to help people affected by drug problems or otherwise interested in the subject. The programme includes website accreditation that maps the contents and services of websites dealing with drug problems and accessible in Hungary. The Drug Portal provides quick access for users to the required information by ensuring accessibility and transfer to the accredited websites with controlled contents. The National Drug Portal became operational in 2002. (www.drogportal.hu)

1.5. Budget and funding arrangements in 2001

Since several Government departments, Government institutions and NGOs are involved in the management of the drug phenomenon in Hungary and several other institutions also deal with the drug problem as part of their mandates, no reliable data are available on the annual overall (aggregate) costs of controlling the drug problem at the national level. In several instances, such costs cannot even be determined at the level of institutions.

For example, the Police cannot provide information on the expenditure of investigations of drug crimes or the proceedings instituted against perpetrators (expert fees) although the costs of investigations as well as expert fees are shown as separate items in the Police budget. Since however the individual Police bodies with independent budgets keep no separate financial records of the types of crimes, they cannot produce aggregate information on this particular category.
Considering this, it is an imperative to undertake special studies to identify the costs and annual budgets of the particular fields of the drug problem and to prepare costs estimates.

Following is a presentation of the direct expenditure of the most important central Government departments and institutions on the control of the drug problem in 2001. The tasks outlined in the National Strategy for 2001 were typically *financed from the budgetary allocations of the respective Government agencies or institutions*.

Deputy State Secretariat for the Coordination of Drug Affairs, Ministry of Youth and Sport (Ministry of Children, Youth and Sport)

The Deputy State Secretariat for the Coordination of Drug Affairs under the Ministry of Children, Youth and Sport had close to HUF 1 billion available to support professional and NGOs active in the field of preventing and controlling the drug problem in 2001. The grants provided by the Deputy State Secretariat for the Coordination of Drug Affairs of the Ministry of Children, Youth and Sport as presented below were fully in line with the spirit and objectives of the National Strategy.

Scheme	Grant available through bidding (HUF million)	Individual grant (HUF million)	Total (HUF million)	Total Euro
1. Support for training and peer training in relation to drug problems	48.5	36.5	85	340.000
2. Drug prevention programme	115	453	568	2.272.000
3. Support for drug research and surveys	16	34	50	200.000
4. Support for the development of services at low-threshold institutions	66	129	195	780.000
5. Support for the operation of the Co-ordination Committee on Drug Affairs and the Co-ordination Forums on Drug Affairs	31	34	65	260.000
TOTAL:	**276.5**	**686.5**	**963**	**3.852.000**

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

Health care: The budget resources available for improving health care for drug patients were used to upgrade the health services for drug patients and to reduce regional disparities. In agreement

with the Health Commission of the Co-ordination Committee on Drug Affairs, the main objective was to reduce regional disparities and eliminate the most serious service deficiencies for which the 2001-2002 funds were combined and used in open tendering procedures. The budget allocation of HUF 30m + 20m was used to finance new drug outpatient centres in the eight counties where there were no such facilities.

Target	Amount of the grant (HUF million)	Amount of the grant (EURO)
Upgrading health care for drug patients	50	200.000

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

The tasks specified in the National Drug Strategy for 2001 were implemented from the targeted budget allocation of the Ministry of Social and Family Affairs *without any additional allocations* approved.

Target	Amount of the grant (HUF million)	Amount of the grant (Euro)
Upgrading day care institutions open to addicts	37	148.000
Introducing new procedures, instruments and programmes of therapy in institutions treating addicts, among else	39	156.000
Upgrading psychiatric community care, special and basic care	12	48.000
Upgrading community care, training and retraining of specialists	18,6	74.400
Support for alternative leisure programmes (to drugs)	15	60.000
Improving social work on streets, outreach programmes	40	160.000
Establishing rehabilitation institutions for addicts	25	100.000
Upgrading day care institutions for psychiatric patients	12	48.000
Support for social retraining and training under accreditation systems	4	16.000
TOTAL:	**202.6**	**810.400**

The grant targets of the Ministry of Social and Family Affairs did not only include actions aimed at providing services to drug patients and controlling drug problems. It is also an area where it is difficult to quantify the expenditure exclusively used for this purpose at the level of institutions.

National Health Insurance Fund

The following table gives a summary of the payments made by the National Health Insurance Fund by types of services with regard to drug rehabilitation in 2001.

Types of services	Costs (HUF)	Costs (Euro)
Specialised outpatient care and after-care	74.888.200	299.553
Specialised inpatient care - acute	67.352.000	269.408
Specialised inpatient care - chronic	155.599.000	622.396
TOTAL	**297.839.200**	1.191.357

The aforesaid amounts do not include any sickness benefits, pharmaceutical subsidies or the costs of treating complications due to drug abuse.

Administration of Justice

In 2000 the National Institute of Criminology carried out a study on the social costs of law enforcement and policing measures to combat drug abuse and related behaviours (the production, distribution and supply of drugs) in 1999. (Ritter, 2001)
According to their estimates, drug-related investigations cost approximately HUF 500 million (Euro 2 million)- based on direct material costs - for the Customs and Finance Guard, HUF 458 million (Euro 1,320,000) for the National Police Headquarters, HUF 121 million (Euro 484,000) for the Budapest Police Headquarters and about HUF 60 million (Euro 240,000) for district Police stations. These sums would certainly be higher if the indirect costs were also included.
Whenever a perpetrator is charged with drug abuse, i.e. the case is not terminated or suspended, proceedings cost an additional HUF 927,934 (Euro 3,712) over and above HUF 397,392 (Euro 1,590) investigation costs for the society. It altogether means HUF 1,325,326 (Euro 5,302), in other words, it is the average social cost of a case of drug abuse being investigated which has not yet reached the trial stage.
The direct forensic costs of a drug crime under investigation were HUF 81,650 (Euro 327) on average before the amendment, and HUF 98,798 (Euro 396) thereafter.
In 1999, taxpayers would have had to pay HUF 272 million (Euro 1,088,000) as the direct costs of executory imprisonment on account of drug-related crimes assuming that the convicts serviced their full sentence. Thus, the average cost per convict was HUF 3,023,933 or Euro 12,096.

Sources:

Bánhegyi D. - Újhelyi E. - Zacher G. (2002). Az intravénás droghasználat fert_zési kockázatai. Kézirat.
Csorba J. (2002). Ártalomcsökkent_ programok Magyarországon. Kézirat.
Egészségügyi, Szociális és Családügyi Minisztérium (2002). Az Egészségügyi, Szociális és Családügyi Minisztérium 2001. évi drogprevenciós, illetve a nemzeti drogstratégia megvalósítása terén végzett tevékenységének összefoglalója.
Felvinczi K. (2002). A Kábítószerügyi Egyeztet_ Fórumok megalakulásával és m_ködtetésével kapcsolatos tevékenységek 2001-ben. Kézirat.
Felvinczi K. (2002). Nemzeti Drogmegel_zési Intézet 2001. évi tevékenysége. Kézirat.
Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Kézirat
Ifjúsági és Sportminisztérium (2001). Jelentés a magyarországi kábítószer-helyzetr_l – 2001. Budapest.
Ifjúsági és Sportminisztérium (2001). *Beszámoló az Országgy_lés számára a kábítószer-probléma visszaszorítása érdekében készített nemzeti stratégiai program végrehajtásáról. Kézirat.*
Keller É. (2002). A kábítószer-használattal összefügg_ halálozások alakulása. Kézirat.
Kó J. (1998). Vélemények a b_nözésr_l – egy közvélemény-kutatás tanulságai. Kriminológiai és kriminalsztikai Tanulmányok, 35.sz. Országos Kriminológiai és kriminalisztikai Intézet, Budapest. 9-46. old.
Miletics M. (2002). Reintegrációs programok Magyarországon, 2001-ben. Kézirat.
Nagy G. (2002). Az illegális kábítószer-piac jellemz_i(lefoglalások, hatóanyag-tartalom változása). Kézirat.
Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.

Országos Egészégbiztosítási Pénztár (2002). Az Országos Egészégbiztosítási Pénztár jelentése a 2001. évi drogrehabilitációs OEP kifizetésekr_l.
Olaszy Cs. (2002). Re-integrációs önsegít_ csoportok m_ködése Magyarországon. Kézirat.
Paksi B. (2002). A drogfogyasztás prevalencia értékei, mintázata, tendenciái. Kézirat.
Porkoláb L. – Grézló O.(2002). Egészségügyi statisztikai adatok a kábítószer-fogyasztásról - 2001. Kézirat.
Ritter I. (2001). A kábítószer-fogyasztás és az azzal összefügg_ b_ncselekmények társadalmi költségei. Országos Kriminológiai Intézet. Kutatási beszámoló, kézirat. 89-93. old.
Ritter I. (2002). A Büntet_ Törvénykönyv visszaélés kábítószerrel b_ncselekmény törvényi tényállására vonatkozó 1999. március 1-én hatályba lépett módosítás hatásvizsgálata. Miskolci Doktoranduszok Jogtudományi Tanulmányai (Szerk. Stipta István). Bíbor Kiadó, Miskolc. 255-287.old.
Ritter I. (2002). A kábítószer-b_nözés jellemz_i a b_nügyi statisztikai adatok tükrében- 2001. Kézirat

II. EPIDEMIOLOGICAL SITUATION

2. Prevalence, patterns and tendencies of use

2.1. Main developments and emerging trends in the light of epidemiological studies

With regard to the direct indicators of drug use in Hungary, data are only available on the population of secondary school students to outline trends, i.e. data comparable in time and derived from research that was carried out with identical methods and on the basis of identical or partly overlapping population samples. Such data nevertheless make it possible to identify fairly detailed trends especially for the second half of the nineties.

Data were collected on the basis of the methodological recommendations of the Pompidou Group of the Council of Europe, and local questionnaires were used in Budapest (Elekes, Paksi, 1994) and in some counties such as Baranya, Tolna, Zala (Paksi, Kó, 1994) and Szabolcs-Szatmár-Bereg (Murányi, Seres, 1994) in the 1992-1993 school year. Later in 1995, a national representative survey was undertaken as part of the ESPAD'95 when the sample was big enough to enable data analysis by counties (Elekes, Paksi, 1996). Parallel to the national survey, similar research was also carried out in some large cities in accordance with the ESPAD standards in 1995-1996 (Paksi, Kó, 1996). A preliminary methodological study was conducted in Budapest in preparation for ESPAD'99 in 1998 to be followed by a repeated national data survey as part of ESPAD'99 in 1999 (Elekes, Paksi, 1999, 2000a). Finally in 2000, the last survey was carried out on a sample identical with the Budapest sub-sample of ESPAD'99 using the same methods (Elekes, Paksi, 2000b).

The following table indicates the summary data of the comparable Hungarian samples analysed in accordance with the ESPAD methodology protocols in the nineties.

Table 2.1. Summary of the samples analysed in Hungary in the nineties

GEOGRAPHICAL UNIT	YEAR OF DATA COLLECTION	UNIVERSE	SAMPLE-TAKING METHOD	SAMPLE UNIT	SAMPLE SIZE	SAMPLE RATE[1]
National research						
Hungary	1995	total universe of secondary school students in form 2 in Hungary	Stratified random sample-taking according to school type and geographical location (county)	School class	17085 students	11%
Hungary	1999	total universe of secondary school students in forms 1 and 2 in Hungary	Stratified random sample-taking according to form, school type and geographical location (Budapest and rural)	School class	6421	2.5%
Regional and local research						
Budapest	1992/93	total universe of secondary school students in form 3 in Budapest	Stratified random sample-taking according to school type	School class	4518 students	17%
County Baranya	1992/93	total universe of secondary school students in County Baranya	Stratified random sample-taking according to form, town size and school type	School class	4531 students	33%
Zalaegerszeg	1992/93	total universe of secondary school students in Zalaegerszeg	Stratified random sample-taking according to form and school type	School class	3918 students	54%
County Tolna	1992/93	total universe of secondary school students in County Tolna	Stratified random sample-taking according to form, town size and school type	School class	3475 students	33%

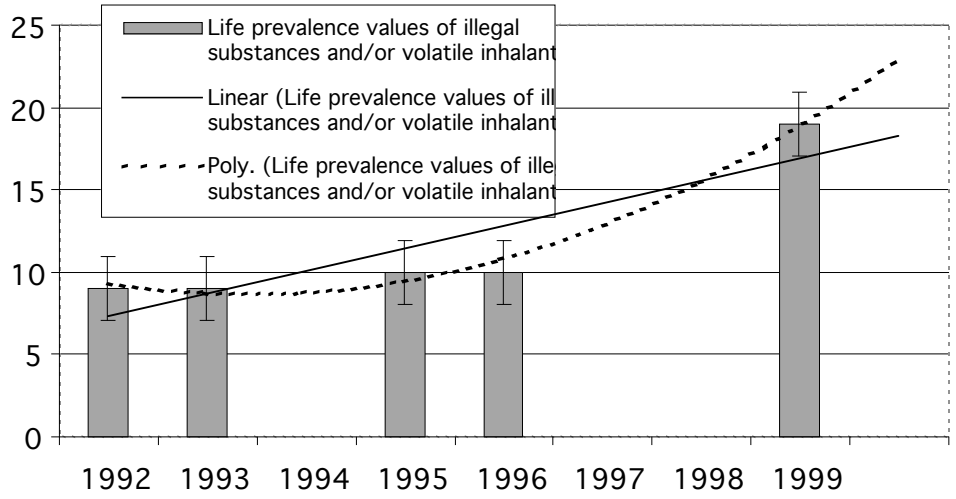
Summary of the samples analysed in Hungary in the nineties (continued)

GEOGRAPHICAL UNIT	YEAR OF DATA COLLECTION	UNIVERSE	SAMPLE-TAKING METHOD	SAMPLE UNIT	SAMPLE SIZE	SAMPLE RATE[2]
County Szabolcs-Szatmár	1992/93	Students of grammar schools, vocational secondary schools and apprentice schools in Nyíregyháza, Mátészalka and Kisvárda (59% of all students in the county)	Stratified random sample-taking according to town, school type and form	School class	1165 students	-
Zalaegerszeg	1995/96	total universe of secondary school students in Zalaegerszeg	Stratified random sample-taking according to form and school type	School class	2875 students	44%
Nagykanizsa	1995/96	total universe of secondary school students in Nagykanizsa	Stratified random sample-taking according to form and school type	School class	1121 students	-
Budapest	1998	Secondary school students in form 2 in Budapest	Simple sample-taking	School class	597 students	2
Budapest	2000	total universe of secondary schools students in forms 1 and 2 in Budapest	Stratified random sample-taking according to form and school type	School class	1970 students	3.7%

[1] As a percentage of the universe.
[2] As a percentage of the universe.

Although the aforesaid surveys were carried out on somewhat different populations, they all covered the universe of secondary school students in second form, with the exception of the survey in Budapest in 1992. The following trend analysis has, therefore, been prepared by extraction from student samples in second form. (In terms of age, 85-90% of the secondary school students in second form are aged 16-17)
Thus we only have nationwide data for 1995 and 1999, according to which the combined life prevalence rate[3] of illegal drugs[4] and volatile inhalants almost doubled in the second half of the decade across the country, i.e. from 10% to 19%, among secondary school students in second form.
The trend emerging in the second part of the 90s, however, is presumably not part of some steady growth process that would have started with the political changes. Various local surveys (in Baranya, Tolna, Zala, and Szabolcs-Szatmár-Bereg Counties) indicated life prevalence levels of 7-12% for illegal substances and/or volatile inhalants as early as the beginning of the decade. The local surveys undertaken in 1996 suggest that life prevalence may have stagnated at approximately 10% from the early 90s to 1996.
The chart below indicates what the trend would have been like if the use of illegal substances and/or volatile inhalants had grown linearly between 1992 and 1999. This hypothetical trend visibly differs from research data. Growth was actually less than linear in the early part of the decade and above linear in the second half.

Life prevalence of illegal drugs and/or volatile inhalants during the 90s (with the trend and standard deviation) [5]



(Elekes, Paksi 2000b)

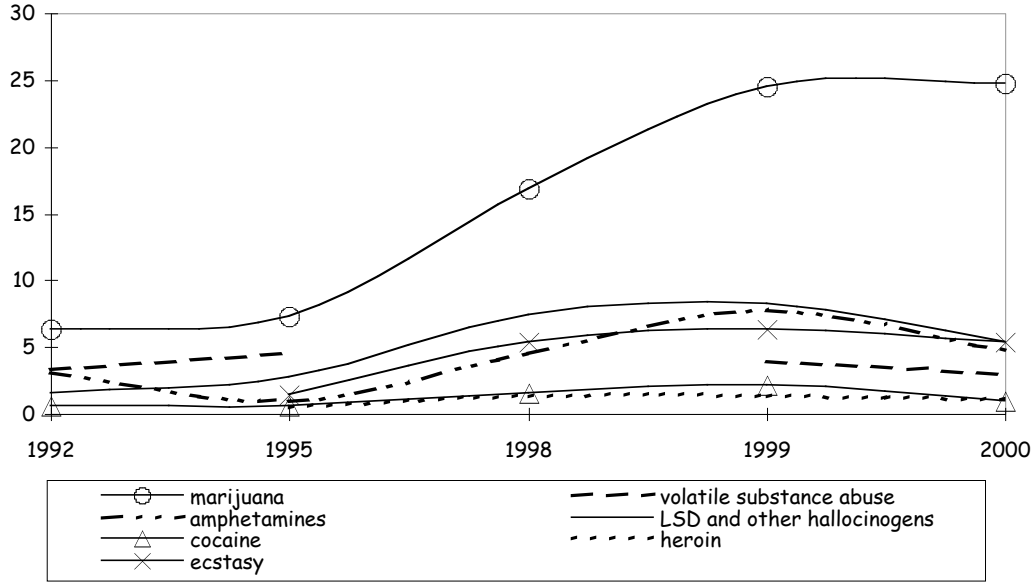
As far as changes in Budapest are concerned, we have more detailed information than the above for 1992, 1995, 1998, and 2000, so we can provide quite a detailed view of the developments. Budapest saw significantly higher growth during the decade than the national average, the life prevalence rate of illegal substances and/or volatile inhalants increased by

[3] Our practice in Hungary is to calculate the combined life prevalence rate of illegal substances and/or volatile inhalants, and to use them as „substance abuse in the form of definite drug use".
[4] Illegal substances include marijuana or hashish, LSD, Ecstacy (as of 1995), amphetamines, crack (as of 1995), cocaine, heroin, other opiates, psilocybe magic mushrooms (as of 1999), intravenous drugs, and other illegal drugs not listed here (the unlisted category enables comparisons between the totals).
[5] The black line represents the linear trend, and the broken line depicts a polynominal correlation.

some 140% between 1992 and 2000 (where 100% is the level at the beginning of the decade), 138% of which occurred between 1995 and 1999. The life prevalence rate of all illegal substances increased during this period, especially that of cannabis derivatives, but LSD and other hallucinogens, amphetamines, and Ecstasy also demonstrated significant growth. Yet, the outcome of a methodological study undertaken in 1998 suggests that growth for the majority of the substances actually occurred between 1995 and 1998, after which only marijuana use increased. Between 1999-2000, each substance moved only within the tolerance range.

The chart below depicts the values measured at various points in time among secondary school students in second form, and the accompanying table indicates the actual value ranges with 99% accuracy.

Aggregate life prevalence rate trends among secondary school students in second form in Budapest during the 90s (breakdown by substance)



(Elekes, Paksi 2000b)

Data from surveys concerning secondary school students in second form in Budapest during the 90s, variance ranges, and highlighted out-of-range variances (the accuracy of the ranges is 99%)

Substances	**1992**	**1995**	**1998**	**1999**	**2000**
MARIJUANA, HASHISH	5,4-7,2	6,0-8,6	12,9-20,9	20,9-28,1	21,1-28,3
VOLATILE SUBSTANCE ABUSE	2,7-4,1	3,5-5,5		2,3-5,5	1,6-4,4
AMPHETAMINES	2,4-3,8	0,5-1,5	3,3-6,7	5,5-10,1	3,0-6,6
LSD AND OTHER HALLUCINOGENS	1,0-2,0	2,0-3,6	4,6-10,2	5,9-10,5	3,5-7,3
CRACK		0,2-0,8	0,3-2,9	0,5-2,5	0,2-1,8
COCAINE	0,3-0,9	0,2-1,0	0,2-2,8	0,9-3,3	0,2-1,8
HEROIN		0,2-0,8	0,1-2,5	0,3-2,3	0,2-2,0
ECSTASY		0,8-2,0	3,0-7,8	4,3-8,3	3,5-7,3
SYRINGE-INJECTED DRUGS		0,2-0,8	0,2-2,8	0-1,1	0,3-2,1
LIFE PREVALENCE RATES OF ILLEGAL DRUGS AND/OR VOLATILE INHALANTS	**10,4-12,8**	**10,5-13,7**		**25,0-32,6**	**23,4-30,8**
(N)	4518	2762	597	932	946
STUDENTS IN FIRST AND SECOND FORMS COMBINED					
LIFE PREVALENCE RATES OF ILLEGAL DRUGS AND/OR VOLATILE INHALANTS				**22,8-28,8**	**20,8-25,5**
(N)				1985	1970

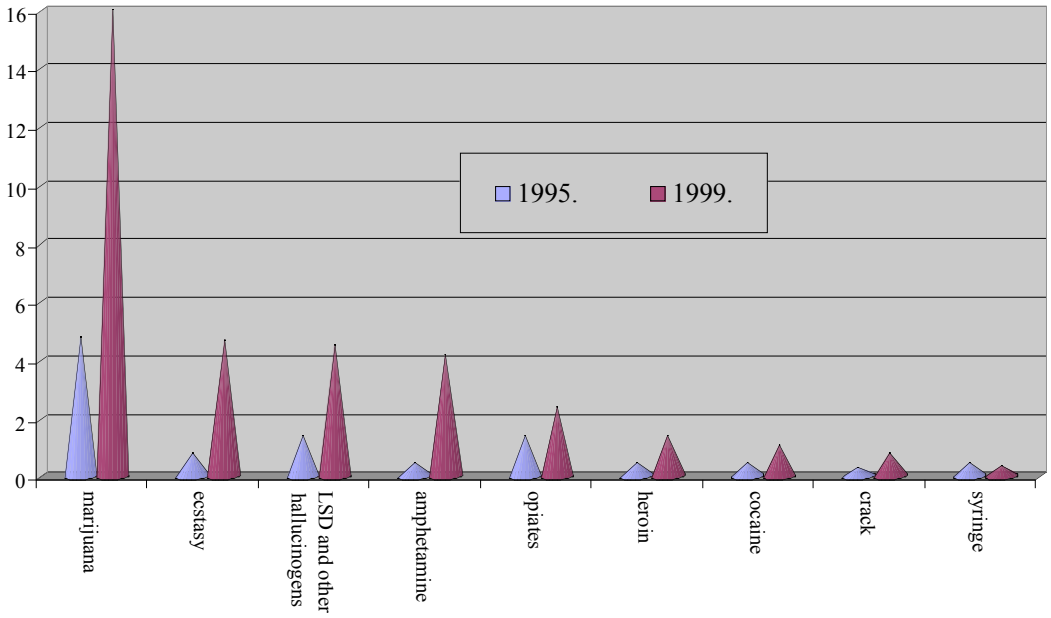
(Elekes, Paksi 2000b)

Based on data from the surveys during the decade among Hungarian secondary school students, it can be assumed that the actual growth in the use of illegal substances occurred in 1997-1998, then it became less dynamic in 1999 – except for cannabis derivatives – and we find no substantial change between 1999 and 2000.

Between 1995 and 1999, however, we see the problem getting broader, and there are indications that the nature of drug use also changed. (Paksi 2001)
The proportion of users who only tried the substance once or twice in their lives grew by just above 50%, that of 3-5 time users doubled, and the number of users who used the substance more than 5 times quintupled. Varying growth rates in different frequency brackets suggest that the general prevalence growth trends were accompanied by another tendency, i.e. usage patterns among Hungarian youth shifted toward more frequent use.

Looking at the structure of illegal substance use, it can be said that marijuana remained the predominant drug at the end of the decade – similarly to the mid-90s – but it became more predominant in overall substance use. While in 1995, the rate of marijuana use was only 4 percentage points above the national average of other substances, this edge was in excess of 10 percentage points by 1999. On the other hand, synthetic party drugs seem to be catching up with marijuana – though with significantly lower life prevalence rates.

Life prevalence rate of various illegal drugs in 1999
(nationwide data, secondary school students in second form)



All in all, based on research among secondary school students – one of the most vulnerable age groups – it can be concluded that the prevalence and nature of drug use changed significantly in Hungary during the 1990s.

- The life prevalence rate of illegal substance use more than doubled.
- This quantitative change was accompanied by qualitative changes too:
  - the intensity of use increased
  - marijuana and various synthetic party drugs assumed an outstanding role in the structure of use
- The majority of these changes – after stagnation early in the decade – occurred relatively suddenly, presumably between 1996 and 1998, i.e. 6-8 years after the political changes.

Sources:

Elekes Zs. - Paksi B. (1994). Adalékok a magyarországi drogfogyasztás alakulásához, *In. Moksony F.-Münnich I.(szerk.)*: *Devianciák Magyarországon,* Közélet Kiadó, Budapest
Elekes Zs. - Paksi B. (1996). A magyarországi középiskolások alkohol és drogfogyasztása, Népjóléti Minisztérium, Budapest
Elekes Zs. - Paksi B. (1999. Fiatalok szenvedélyei?! (Alkohol- és drogfogyasztás valamint dohányzás a budapesti középiskolások körében 1999-ben), *Századvég* Új folyam 13. szám.
Elekes Zs. - Paksi B. (2000a). Drogok és fiatalok – Középiskolások droghasználata, alkoholfogyasztása és dohányzása az évezred végén Magyarországon,. ISM, Budapest
Elekes Zs. - Paksi B. (2000b). Önbevallásos vizsgálatok Magyarországon a kilencvenes években. Ritter i (szerk): Jelentés a magyarországi kábítószerhelyzetr_l, ISM, Budapest
Murányi István – Seres Ildikó (1994). Lebegéshez nem kell pótszer. Drogfogyasztás a Szabolcs-Szatmár-Bereg megyei középiskolások körében, Nyíregyháza
Paksi B. - Kó J. (1994). A drogfogyasztás elterjedtsége és a beavatkozás lehet_ségei Zalaegerszegen, Kézirat
Paksi B. - Kó J. (1994). Baranya megyei középiskolások drogfogyasztása, dohányzása, és alkoholfogyasztása, Kézirat

Paksi B. - Kó J. (1994). A drogfogyasztás elterjedtségének f_bb jellemz_i a Tolna megyei középiskolás populációban, Kézirat
Paksi B. - Kó J. (1996). A drogfogyasztás elterjedtsége Zalaegerszegen, Kézirat
Paksi B. - Kó J. (1996). A drogfogyasztás elterjedtsége Nagykanizsán, Kézirat
Paksi Borbála (2001). A magyarországi droghelyzet az európai adatok tükrében. In. Ritter I. (szerk): Jelentés a magyarországi kábítószerhelyzetr_l, ISM, Budapest

2.1.1. Samples of substance use, drug user groups - cannabis user population

Similarly to Europe, cannabis derivatives are the most popular and most widely used illegal drugs in Hungary.
Users are mostly supplied from local plantations. The THC concentration of marijuana is constantly rising. The upper limit reported at 2% in 1996 trebled to 6% by 2001 due to the decreasing importance of cannabis sativa on the one hand and the growing production of cannabis indica ('hashish') on the other hand. It is to be noted that the Criminal Forensic and Research Institute of the National Police Headquarters measured as much as 7-8% and even 11% THC concentration in 2001, which is presumably due not only to the plant species grown but also to the especially efficient artificial conditions of growing the plant (occasionally indoors).

Growers largely relied on the technical instructions available on the Internet to grow cannabis. Proceedings were first instituted against a Hungarian internet user in 2000 whereby sufficient evidence was found that he had placed 'useful' information on growing cannabis and using marijuana on the website of a limited liability company. Plantations also showed a wide spectrum this year. Young plants and grown cannabis were found in household gardens, forests, feed stores and garages. Apart from local production, imports are also significant first of all from the Netherlands.

The population of cannabis users

Although drug users or perhaps more specifically marijuana users are often referred to as a sub-cultural group, the term is by no means appropriate. The data available on the population of drug users in general and on marijuana users specifically reveal great heterogeneity rather than a particular subculture that could be described with uniform parameters.

In the case of marijuana users, heterogeneity is primarily reflected in the intensity of use. About half of the people interviewed in a survey of dance clubs (Demetrovics, 2001) said that they had already tried one or another cannabis derivative. Every fifth of them had stopped using such substances more than a year before the survey while somewhat more than every second reported to have used marijuana or hashish the month before. Even the latter group revealed wide differences in the intensity of use. Hence, 16.2% of those using the substance the month before reported daily use and another 22.1% more than once a week. On the other hand about every fourth or fifth person said that they had not smoked marijuana or hashish at all in the month before the interview. Men were found to have used substances more intensively.

Two distinctly different groups could be identified among marijuana users as a result of the same survey. One group included those who had never used other substances parallel to marijuana, and the other were those who had tried other drugs in addition to marijuana. In theory there may be a third group of those who had used other illegal substances but marijuana, however there are hardly any such cases in practice. Not more than 42 people

(2.8%) of the total 1507 interviewees at dance clubs indicated that they had never used cannabis derivatives but had tried other drugs. (Of them, 19 reported the use of other illegal drugs more than one year before.) The same result was found not only among recreational drug users but also in clinical practice. Gerevich et al (2001) analysed the data of 1007 people receiving treatment at drug outpatient centres. As a result, they identified seven types of drug users. As an important finding of their research, marijuana was the only drug that all drug user types had had experience with to a greater or lesser degree. The first group of only cannabis users as described in the foregoing was found in the sample.

Going back to the population visiting clubs and using drugs as a form of recreation, the first two groups clearly indicated differences in terms of their drug use habits. 38% of those having used drugs had never tried other substances than marijuana. Apart from drug use habits, however, no other parameters could be used to distinguish the two groups. Applying the appropriate statistical procedure (step-by-step discriminance analysis[6]), it was found that considering socio-demographic and recreational variables even the best estimate had a high error rate, i.e. it would classify 40% of the members of both groups incorrectly in the other group (meaning that classification is not much better than random). The comparison of these two groups with those who never use drugs indicates that the two groups of drug users are similar to one another in terms of most parameters and both are different from those who do not use drugs whatsoever (Demetrovics, 2001). Hence, in our sample, those who do not use drugs are on average two years younger than either the first group of only marijuana users or the second one of those using other drugs as well, and they are more likely to be males than females. Marijuana users as well as other drug users were found to be more likely to live in Budapest. Both groups of drug users, and especially the one using other drugs besides marijuana, were more likely to live in single-parent families and less likely in full families than non-users. It was interesting and perhaps surprising to see that both groups of drug users (and their parents) had typically higher degrees of education and higher per capita monthly income than non-users. Members of both drug user groups more frequently went out, spent their leisure time at dance clubs and spent more money there on nights out. However, the two drug user groups showed significant differences in terms of the type of entertainment preferred and the amount spent on entertainment. Those who use other drugs besides marijuana tend to frequent dance clubs and spend more lavishly on nights out. On the whole it appears that in the sample[7] the two groups of drug users are not significantly different from one another except for their habits of drug use whereas they are different in several respects, and often in a favourable direction (e.g. education, income) from their peers who do not use drugs. When the aforesaid results are interpreted, however, it should not be forgotten that the survey analysed recreational drug users, i.e. people who for the most part use illegal substances weekly, fortnightly or even less frequently and only in social settings (Demeterovics, 2001). Although Demeterovics et al (2001) also found on the basis of their clinical sample that the group of marijuana users typically had better financial circumstances, looked more orderly and their parents had higher education, this relatively more favourable picture is not necessarily seen in every respect in the problem group of marijuana users in the clinical practice[8].

Social relations

[6] The procedure is used to determine which of the large number of variables analysed can best distinguish the two groups.

[7] It is important to note that the data were not collected on a representative sample for the survey of dance clubs.

[8] It should be noted that marijuana users who received treatment in Hunary in recent years form a special group insofar as a large number of them did not volunteer for treatment because they recognised their own problems but underwent treatment as an alternative to criminal proceedings. Although many of them do not consider themselves problem users, they in fact struggle with a number of lifestyle problems while some others have no lifestyle or other difficulties than legal problems.

The social relations of drug users including users of marijuana and other hallucinogens were analysed on the basis of a clinical sample using Fonyó's contactometric method in 1996. The analysis compared the social relations of hallucinogen users, opiate users and the control group. The results indicated that the field of social relations in the two groups of drug users had narrowed in comparison to non-users. The control group listed on average 29.2 (minimum 25, maximum 33) people important to them, while opiate users mentioned an average 29.7 (minimum 16, maximum 45) as against not more than 10.6 (minimum 5, maximum 19) in the case of hallucinogen users[9]. The members of the latter group not only mentioned much fewer relations but they also used much fewer categories than the available 18 to classify the people they listed (5.2 categories on average compared to 8.3 in the case of opiate users). Although relations linked to drug use were predominant for both user groups, their roles were different. Whereas in the case of opiate use, cooperation in the acquisition of the drug appeared to be a highly important factor in maintaining such relations (and consequently such relations were more extensive), in the group of hallucinogen users, shared use rather than cooperation in the acquisition played the main role in the relations because such drugs are cheaper and easier to buy. All this can also be seen as an explanation why opiate users classified substantially more people (11.8) in this category on average than hallucinogen users (3.8).

The interviews with drug users revealed that the differences are mostly attributable to the difficulties of acquiring the drug, the differences in the nature of use and effect. Perhaps the last one is the most important factor. It appears that the mild hallucinogenic effect of marijuana taken daily for a long period of time will lead to a more or less constantly changed state of mind whereby the user's relation to the surrounding rational world may considerably weaken. As a result, relations with people not using drugs will lose their significance for drug users as they cannot share the way they see the world with such people. Parallel to this, they make friends with a closer group where marijuana use becomes a daily routine and one of the most important forces that keep the group together. In such a group there are no communication barriers that may represent insuperable difficulties (on both sides) in maintaining relations with non-users. It is at the same time a self-stimulating process as the drug user withdrawing into his own world will find the outside 'rational' world even more depressing, which in turn will only further alienate him from the world in the long run. This phenomenon is strengthened by the dichotomy in the effect of marijuana. While the drug itself creates anxiety (Stephens, 1999), the acute effect may reduce anxiety by distancing the user from the rational factors of the outside world.

The circumstances of marijuana use

The aforesaid research at dance clubs also supplied a number of data on the circumstances of marijuana use. Of all the illegal substances, the first use of marijuana can be linked to the youngest age; in the sample of analysis more than half of the interviewees first used the substance before they reached 16 years of age while other drugs were first tried at the age of 18 or more. Three quarters received the drug from an acquaintance or a friend for the first time, and first use typically took place in the home of an acquaintance (38.5%). (It is important to note that although it changes considerably later on, about 40% of the users, especially less intensive users still said that they received marijuana free of charge.) Other settings are also typical in the case of first as well as subsequent uses; in practice any setting may be possible for marijuana use. Unlike amphetamine derivatives for example, dance clubs are not predominant but about one third of users said that they used the substance in any setting with equal probability, and in somewhat more than 50% of the cases, it is not used in places of entertainment. However, use in groups is by all means predominant. Three out of four interviewees said they primarily used marijuana and hashish

[9] They were given the instruction to list, categorise and describe the 30 people that were most important to them.

in the company of friends and acquaintances and further 16.5% together with their partners. Not even 2% said they first of all smoke marijuana on their own.

Sources:

Demetrovics Zs. (1996). Drogfogyasztók társas kapcsolatainak személyközpontú felmérése: kezdeti eredmények. *Szenvedélybetegségek*, 4(6):424–435.
Demetrovics Zs. (2001). Droghasználat Magyarország táncos szórakozóhelyein. L'Harmattan Kiadó, Budapest.
Demetrovics Zs. (2002). Drogfogyasztási trendek az Európai Unióban 2001-ben. Addiktológia, (megjelenés alatt).
Gerevich, J., Bácskai E. és Rózsa S. (2001). Máktea-fogyasztók: egy önálló drogfogyasztó populáció. *Psychiatria Hungarica*, 16(1):21-30.
Nagy G. (2002). Az illegális kábítószer-piac jellemz_i(lefoglalások, hatóanyag-tartalom változása). Kézirat.
Stephens, R. S. (1999). Cannabis and Hallucinogens. In: McCrady, B. S. and Epstein, E. E. (eds.) Addictions. A Comprehensive Guidebook. Oxford University Press, Oxford. 121-140.

2.2. Drug use in the general population

The first research specifically targeted to analyse the drug use in the general population and not only taking a sweeping view of the issue (Elekes, 1999) was conducted in Hungary in spring 2001. Research was aimed to map the incidence, risk factors of and public attitude with regard to the use of drugs and alcohol (Paksi, 2001; Elekes, 2002; Paksi, 2002).

Research methodology
The target population of the research were Hungarian citizens between 18 and 65 years of age. The total target population included 7780 thousand persons. The population of Budapest of 1196 thousand was considered an independent target group addressed specifically within the overall target population.
Research was carried out on a gross sample of 2500 people of the target population, which consisted of two sub-samples: one of 1000 persons in Budapest and another one of 1500 persons outside the capital city.
The sample was selected at random using the stratified method. For the sub-sample covering the country less Budapest, first towns were selected at random with reference to regional location and town size using the stratified method, then simple random samples were taken to select individuals to be interviewed in the towns. The Budapest sub-sample was taken in a single step using the simple random method stratified by districts[10].
Data collection reached out to a net sample of 2359 persons (1497 in the country and 862 in Budapest). To adjust for dropouts from the sample, the resulting uneven distribution of the Budapest sub-sample in terms of the main demographic characteristics and for the over-representation of interviewees in Budapest, the samples were subsequently weighted by age groups and genders as well as along the Budapest-country dimension.

The research questionnaire was edited on the basis of the recommendations of EMCDDA for surveys among the adult population (EMCDDA, 1999), the health research criteria of the

[10] Two additional samples were selected for both sub-samples to comply with the prevailing Hungarian practice in accordance with the sampling principles described in the foregoing.

WHO (Simpura et al, 2000) and the core questions of IRGGA's programme 'Culture and Alcohol: A Multinational Study' (Wilsnack et al, 2000), taking into account national specifics and research traditions. The questions used in the survey were divided into two groups. Questionnaire A included socio-demographic and other background variables and was used in a face-to-face situation with the help of interviewers. Questionnaire B inquiring about various social and/or legal deviations - drug and alcohol use - was given to the interviewees to complete voluntarily in order to reduce the rejection rate and increase the reliability of responses. Interviewees were asked to hand over the completed Questionnaires B in sealed envelopes to the interviewers.
For data collection, interviewees were visited, and the combination of face-to-face interviews and voluntary questionnaires was applied. The interviewees selected to the sample and notified in advance were visited by interviewers who were close in age and had received preliminary training. [11]
The interviews were conducted between 15 February and 20 March 2001 in a period when there are no major holidays that would distort short-term prevalence rates from the generally typical consumption habits.
Control variables were included in the questionnaires to study the size and distribution of exogenous errors with the help of database tools. It resulted in a positive experience, and the reliability and validity of the responses given were quite favourable as a whole and in their trends. [12]

Conclusions
As a result of the survey, 6.4% of the Hungarian adult population between 18-65 years were found to have used illegal drugs of some kind in their lives[13].
The life prevalence rate of drug use demonstrates wide differences in the main demographic groups of interviewees. Significant variations can be noted in the number of users in terms of age group, gender and residence.

- The life prevalence rate of drug use shows marked differences in the individual age groups of the survey population ($p<0,001$). Life prevalence of drug use is 20% among the youngest age group (18-24 years) and is declining with age so that it is not more than 1.6% in the age group over 35 years.
- The suddenly declining trend of prevalence rates in the different age groups of the adult population reflects the age-specific nature of first use[14]. On the other hand, it indicates

[11] Previous research experience suggested that interviewees were more willing and open to answer delicate and especially age-specific questions such as drug use to people who were closer in age (Elekes-Paksi, 1999)

[12] On the basis of the consistent responses given with regard to life prevalence and the age of first use, the reliability of data on marijuana use was particularly good (91.6% consistent responses within the range of interviewees compared to 99.6% users). Similarly to the data on alcohol consumption, drunkenness and smoking in general, the reliability of admitting to illegal substance use indicating substantial life prevalence was around 70-80%, and major inconsistencies were found only in the case of substances where marginal use was indicated and sedative or hypnotic drugs.
Inconsistencies in the prevalence rates with regard to the periods of illegal drug use were undoubtedly low. Only one interviewee gave inconsistent responses for the prevalence of different periods in the case of Ecstacy and amphetamine, respectively. No inconsistencies were found in the responses regarding other illegal drugs and volatile inhalants.
Missing and invalid responses showed a stable rate in drug-related questions. It was around 12% for the monthly prevalence rates of most drugs, 11.4% for the annual prevalence rates in general and 10% for life prevalence, and the missing rate was typically below 1% only in the case of questions related to marijuana use. The rejection rates were significantly higher compared to the ESPAD surveys using the interviewing technique of voluntary completion of questionnaires in groups.
The dummy drug indicating the validity of the data indicated a similar problem to what ESPAD surveys show (Elekes-Paksi, 1996, 2000; and Hibbel et al, 1997, 2001).

[13] Illegal substances included marijuana or hashish, LSD, Ecstacy, amphetamines, crack, cocaine, heroin, other opiates, intravenous drugs and other drugs not listed here. The life prevalence of illegal drugs is based on the number of interviewees who reported to have used one or another type of those substances in their lives. The question relating to illegal substances is compatible with the EMCDDA (1999) and ESPAD (2001) standards.

the social trend of the increasing incidence of first drug use over time, which was also borne out by the drug epidemiology surveys among young cohorts (of secondary school students) in the 1990s (Elekes-Paksi, 2000a, 2000b). The surveys concluded that drug use trends showed a sudden significant increase and prevalence rates almost doubled in the second half of the 1990s. Thirdly, it also reflects the short history of drug use in Hungary.

Aggregate life prevalence rates of illegal drugs by age groups

Age group	N	Illegal drugs
18-24	318	20.1
25-29	246	13.0
30-34	214	7.9
35-39	178	3.9
40-49	510	0.8
50-65	629	1.1
		p<0,001

- The Hungarian data show the same gender-specific pattern that can be drawn from previous Hungarian and international research experience of drug use in different populations. Male life prevalence is about two and a half times higher than the rate of first use among females.

Aggregate life prevalence of illegal drugs by genders

Gender	N	Illegal drugs
Male	1033	9.0
Female	1068	3.7
		p<0,001

- In line with the experience of research among secondary school students in recent years (Elekes-Paksi, 1996, 2000a, 2000b), substantial differences were noted in the drug consumption of the adult population between Budapest and other parts of the country (p<0,0001). The prevalence of drugs in the adult population in Budapest is about four times of the value in the rural population.

Aggregate life prevalence of illegal drugs in Budapest and the country

Residence	N	Illegal drugs (P=0,002)
Budapest	863	16.0
Country	1702	4.1

- Although to a lesser extent, urbanisation differences can also be seen within the rural sample. With the exception of the largest cities, the life prevalence rate of drug use increases with town size. While first users are less than 1% in towns with less than 1000 population, the rate is 8.2% on average in towns with a population of over 50,000. At the same time there are no significant regional or geographic differences in the rural population, only some trends may be depicted.

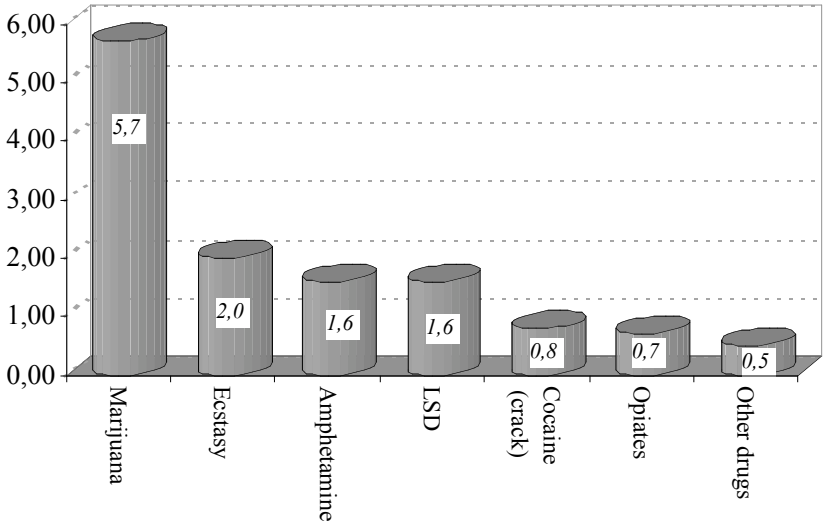
On the whole, the difference is about eighty times in the life prevalence rates of the mostly and least affected demographic groups identified along the aforesaid three dimensions such as age, gender and residence. Males below 35 years living in Budapest and females over 35

[14] Today's adult population first encountered drugs mostly below 25 years of age, at 20 years on average. Nine out of ten who have used drugs of some kind in their lives first tried it before they reached 25 years of age. In that group, first use most frequently occurred at 17-18 years, and one third of the users had their first experience with drugs at the end of secondary school.

years in rural areas are found at the two extremes of the scale. While two fifth of the former group have already used illegal substances of some kind in their lives, merely half a percent of women over 35 in the country have ever tried drugs.

The analysis of life prevalence rates by types of substances indicates a widely varying role of the individual drug types in the pattern of drug use. The prevalence of the various drugs can be illustrated in a pyramid structure. Cannabis derivatives are most widely used. 5.7% of the interviewees, i.e. the majority 87.7% of those who have already had experience with drugs, have used marijuana or hashish. The prevalence of the other substances was much lower among the adult population. Second to fourth are various synthetic drugs, their prevalence shows no difference in practical terms considering the standard deviation of estimates which is 0.5-0.6% in these cases. They include Ecstasy, amphetamine and LSD (1.6-2%). Cocaine, opiates (heroin and/or other opiates) and other drug users represent the smallest group at 1% or below[15].

Life prevalence rates of the various types of drugs in the order of importance (in the population of 18-65 years of age, as a percentage of interviewees)

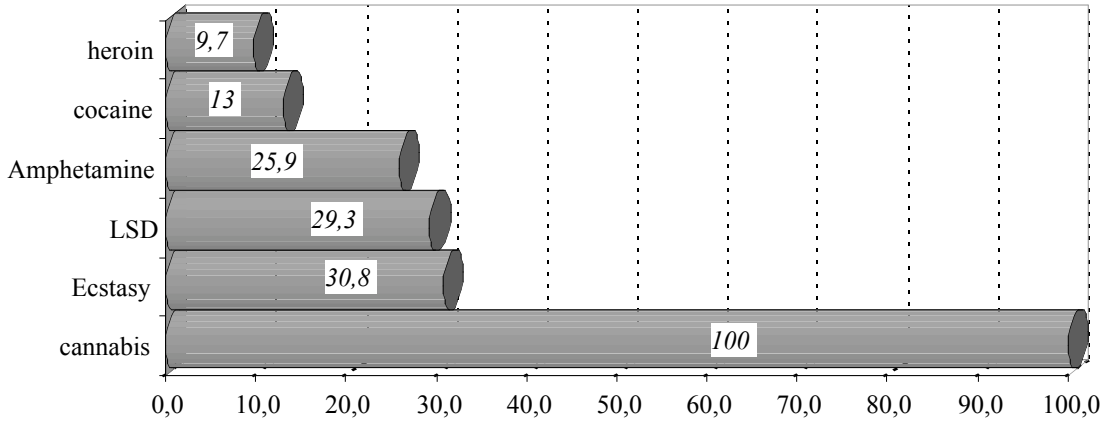


A '*pyramid of illegal drug use*'[16] has been constructed on the basis of the life prevalence rates of the various illegal drugs to illustrate the structure of use and the relationship of the use of the different drugs. The pyramid below indicates the overlap in the life prevalence of the most widely used substance, i.e. marijuana (hashish) and other drugs, i.e. how many of those who have used marijuana (hashish) in their lives have resorted to other drugs.

[15] The life prevalence rates of those drugs are particularly negligible considering that the life prevalence rate of the dummy drug was 0.3% (see the description of the methodology results).

[16] EMCDDA (1999), pp. 77-79

Pyramid of illegal drug use
Life prevalence rates of the various drugs as a percentage of cannabis users



From the comparison of the values in the pyramid to the life prevalence rates found in the normal population, it can be concluded that the various drug-using behaviours are closely correlated. The estimated values of cannabis use are a multiple (of about ten times) the values found in the normal population. Overall, more than half (54.4%) of cannabis users have already used other illegal substances, mostly Ecstasy and/or LSD and/or amphetamine, and the least often heroin.

2.5% of the interviewees used some illegal drug in the previous year and 1.2% in the previous month. About two fifth of those who have used some kind of drug in their lives said they used an illegal drug in the previous year and about one fifth of them did so in the previous month.

Aggregate prevalence rates of the various periods (as a percentage of interviewees)

	Illegal drugs
Life prevalence rate (N=2100)	6.4
Annual prevalence rate (N=2070)	2.5
Monthly prevalence rate (N=2047)	1.2

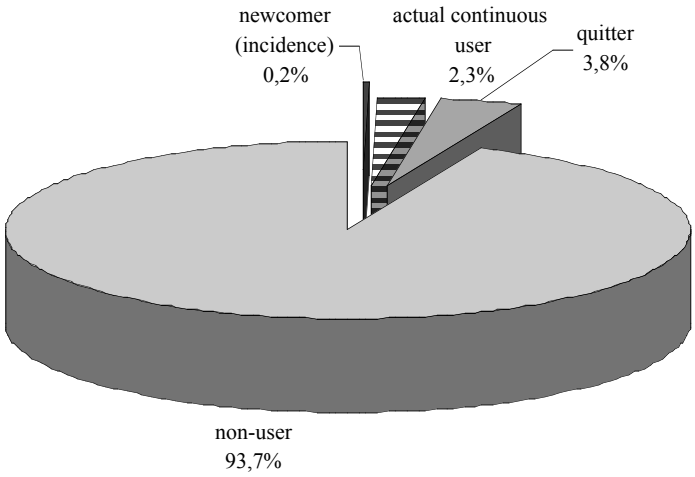
The correlation of the various prevalence rates formed a basis to separate those who have not used any drug (quitters) for the past year and to calculate the *'continuous drug use rate'*[17] The continuous drug use rate or continuation rate represents the rate of users responding consistently to life and annual prevalence questions who still use substances. Since part of the current users are in fact not continuous users but first users, it is possible to separate 'newcomers' from the current users, i.e. to calculate the continuation rate without incidence showing the rate of users who began to use drugs more than a year ago and still use them in the survey year.

The chart below indicates that in the population of 18-65 years of age, 3.8% have used drugs in their lives but not for the last year, and 2.5% are 'continuous' users. As 0.2% of the interviewees began using drugs in the last year, the rate of those who first tried drugs more

[17] EMCDDA (1999), pp. 80-81

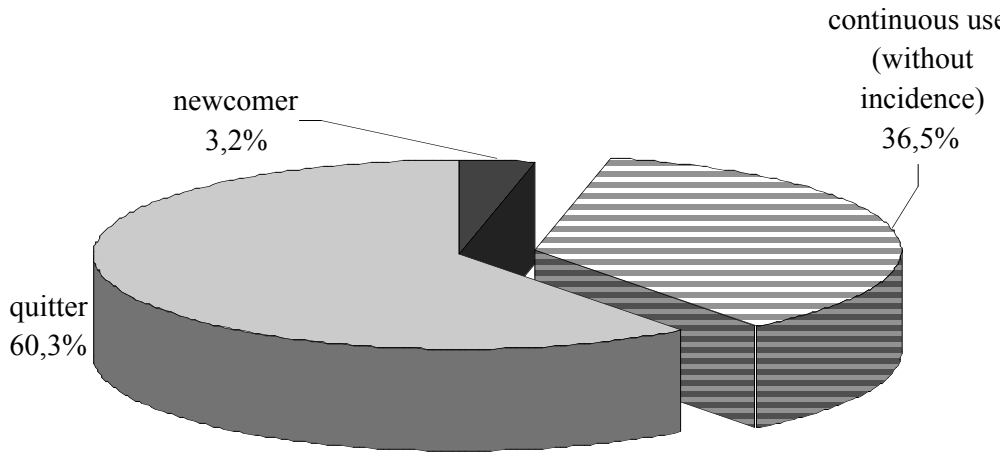
than a year ago and are still using them is 2.3%, i.e. they are the actual continuous users (continuation rate without incidence).

The rate of quitters, continuous drug users and newcomers as a percentage of interviewees



All this shows that three fifths of the population between 18-65 years who have had experience with drugs at one point in time did not use any in the last year. Two fifths, however, still use drugs of some kind, including a negligible group who first used drugs in the last year (3.2% of the users are newcomers). All in all, actual continuous users represent 36.5% of those with drug experience, i.e. 2.3% of the interviewees.

The continuation rate among drug users



Sources:

Elekes Zs. (1999). Önbevallásos vizsgálatok Magyarországon a kilencvenes években. In: Jelentés a magyarországi kábítószer-helyzetr_l. (szerk.: Ritter Ildikó) ISMertet_ 5. Budapest. Ifjúsági és Sportminisztérium. P: 121-153
Elekes Zs. (2002). Ivási szokások és fogyasztói típusok Magyarországon az ADE'2001 alapján. Addiktológia 1.
Elekes Zs., Paksi B. (1996). A magyarországi középiskolások alkohol- és drogfogyasztása. Népjóléti Minisztérium, Budapest.
Elekes Zs., Paksi B. (1999). Középiskolások droghasználata és alkoholfogyasztása Magyarországon. Kutatási beszámoló.
Elekes Zs., Paksi B. (2000a). Drogok és fiatalok. Középiskolások droghasználata, alkoholfogyasztása és dohányzása az évezred végén Magyarországon. ISMertet_ 8. Budapest. Ifjúsági és Sportminisztérium
Elekes Zs., Paksi B. (2000b). Önbevallásos vizsgálatok Magyarországon a kilencvenes években. In.*: Jelentés a magyarországi kábítószerhelyzetr_l.* (szerk: Ritter Ildikó) ISMertet_ 12. Budapest. Ifjúsági és Sportminisztérium
Elekes Zs., Paksi B. (2002). A feln_tt népesség droghasználata és alkoholfogyasztása Magyarországon. Kutatási beszámoló. ISM
European Monitoring Centre for Drugs and Drug Addiction (1999). Co-ordination of an expert working group to develop instruments and guidelines to improve quality and comparability of general population surveys on drugs in the EU. Follow up of EMCDDA project CT.96.EP.08 (CT.97.EP.09), Lisbon, EMCDDA, September 1999.
Hibell, B .- Andersson, B. - Bjarnasson, T. - Kokkevi, A. - Morgan, M. – Narusk, A. (1997). The 1995 ESPAD Report. Alcohol and Other Drug Use Among Students in 30 European Countries. The European School Survey Project on Alcohol and Other Drugs. CAN, Stockholm, Sweden.
Hibell, B .- Andersson, B. – Ahlström, S. – Balakireva, O. - Bjarnasson, T. - Kokkevi, A. - Morgan, M. (2001). The 1999 ESPAD Report. Alcohol and Other Drug Use Among Students in 30 European Countries. The European School Survey Project on Alcohol and Other Drugs. CAN, Stockholm, Sweden.
Paksi B. (2001). Drogfogyasztás a feln_tt népesség körében a 2001. évi országos lakossági alkohol- és drogepidemiológiai vizsgálat alapján. "Veszélyek és esélyek – Fert_zés, drog és társadalom" c. konferencia. MTA. 2001. november 27-28.
Paksi B. (2002). A feln_tt népesség droghasználata Magyarországon. *Addiktológia* 2
Polonyi G. (1998). Empirikus felmérés a népesség egészségi állapotának meghatározottságáról. Zárójelentés. TÁRKI, Budapest.
Simpura, J., Knibbe, R., Kraus, L., Helasti K. (2000). Behind the questions: intercultural differences in answering questions on drinking behaviour in health Interview Surveys. Paper presented at the 26th Annual Alcohol Epidemiology Symposium, Kettil Bruun Society for Social and Epidemiological Research on Alcohol, Oslo, Norway 2000 June.
Wilsnack, S., Bloomfield. K., Monteiro, M., Room, R. (1999). Gender, Culture, and Alcohol: A Multi-National Study. Grant Application. University of North Dakota.

2.2.1. Prevalence of drug use in the Hungarian Army

The experience of the past years has demonstrated that the trend of drug use in both the civil population and the army ranks is on the rise. This increasing trend can be noted in not only the number of users and types of drugs used but also in geographical distribution. The surveys among civilians showed that the young age groups are particularly vulnerable as they are most sensitive to new and unknown possibilities. Given their age, the same applies to young recruits drafted and serving in the army.

Questionnaire surveys

The Health Protection Institute of the Hungarian Army conducted the first survey of drug use habits on a sample of 3000 using questionnaires in **1996**. The target group included young

males serving as regulars. The variables of the interviewees such as age, residence and education were compared upon the evaluation of the questionnaires.

The survey was aimed at identifying drug use habits, prevalence rates, access to drugs, the intensity of attraction, the judgement about the hazards in drug use as well as the protective or conducive role of family and friends.

Analysing the survey results, experts will be able to set up a problem catalogue based on which they can design and perform target-oriented preventive activities among the army ranks. As a result of the survey, it was found that every tenth regular had already tried one or another type of drug.

First use of drugs by age (on the basis of 2700 questionnaires that could be evaluated)

Age / Substances	**Below 10 years**	**14 years**	**15 years**	**16 years**	**17 years**	**Over 18 years**	**Total**
Marijuana, hashish	1	5	14	27	34	83	164
LSD	2	1	3	11	13	37	67
Amphetamine	1	1	8	13	17	37	77
Opium and deriv.	1	2	1	4	10	22	40
Cocaine	1	3	3	2	6	21	36
Other drugs	4	9	8	16	20	38	95
Volatile inhalants	12	7	14	34	17	23	102
Total	**22**	**28**	**51**	**107**	**117**	**261**	**581**

The second survey was undertaken in 1997, covering again 3000 interviewees. The results of the follow-up survey showed that by then every tenth regular had had experience with some types of drugs in the period under survey.

The survey was again repeated on a sample of 3000 in 2000. The results confirmed what had been found in 1997, i.e. the rate of drug use was over 20% in this case.

Another survey followed on a sample of 1000 in 2001. The same results were concluded as in 2000, i.e. the rate of drug use again exceeded 20%.

Objective complex combined laboratory test system

The Hungarian Army developed objective measuring procedures to determine the rate and geographical distribution of drug use. The measuring method ensures that all relevant facts of drug use can be detected and evidenced with high-capacity laboratory instruments. The tests were carried out anonymously on a voluntary basis by observing personal rights.

The following tests are to be carried out in order to check the influence of drugs in the ranks of the Hungarian Army, prevent service (work) under the influence of drugs and prevent drug use:

1) Checking the ability for service (work)

The officer or commander in charge of the unit or their duly authorised representatives may order screening tests.

Screening is performed by the health service using rapid immune chromatography tests.

2) Checking the state under the influence of drugs

Tests are to be ordered if there is a suspicion of drug use and when the clinical symptoms typical of drug influence are detected at any member of the ranks.
Screening is performed by the health service using rapid immune chromatography tests.

3) Random screening tests to prevent drug use

a) Tests at the troops:

To be performed in proportion to the staff of armed forces twice each month.
Screening tests may be ordered by the commander in charge in accordance with the test plan.
Screening is performed by the health service using rapid immune chromatography tests.
The laboratory of the Health Protection Institute of the Hungarian Army will identify and verify the positive results of any screening test performed with rapid immune chromatography at the corps.

b) Central (random) screening

- for the purposes of preventing drug use (at corps preliminary selected centrally, to examine the entire staff of the Hungarian Army),
- for research purposes to identify drug use habits and detect new types of drugs.

The annually rising trend shown by the questionnaire surveys was also confirmed by laboratory urine tests performed on 628 individuals between 1996 and 1999. Substance residues suggesting drug use were found in 24.8% of the urine samples taken from regulars returning from leave.

Positive cases shown by rapid tests and confirmed by high-capacity instruments on the basis of urine samples between 1996 and 1999 (Toxicology Research Department, Health Protection Institute, Hungarian Army)

Number of samples	Amphetamine	Opiate	THC	Methadone	Total pcs. /%
50	13	2	4	3	22 / 44
50	0	3	2	0	5 / 10
50	12	4	4	6	26 / 52
37	5	1	2	5	13 / 35
50	7	2	4	6	19 / 38
50	0	0	7	3	10 / 20
50	14	1	4	0	19 / 38
50	2	1	6	1	10 / 20
50	2	0	0	0	2 / 4
41	3	1	2	0	6 / 15
150	3	8	13	0	24 / 16
628	61	23	48	24	156 / 248

Surveying drug use habits (amphetamine, methamphetamine, opiate, THC and cocaine) were continued with objective methods among the ranks of the Hungarian Army in 2000 and 2001.
As a neuralgic point of the system of random screening, tests to identify drug residues and verify drug use objectively (i.e. using high-capacity instruments) can only be started eight days following the accreditation specified in the laboratory instructions

Positive cases identified with rapid tests and confirmed with high-capacity instruments on the basis of urine samples taken in 2001

Number of individuals tested	Drug		Total no. (%)	Purpose of the test
	Used	Suspected*		
200	26	-	26 (13.0)	Research
100	2		2 (2.0)	Research
150	4	-	4 (6.5)	Research
200	13	-	13 (5.45)	Research
200	6	-	6 (3.0)	Research
200	6		6 (3.0)	Research
200	4	-	4 (2.0)	Research
200	11		11 (5.5)	Research
100	5	-	5 (5.0)	Research
200	8		8 (4.0)	Research
200	8		8 (4.0)	Research
192	13		13 (6.8)	Research
21	8		8 (38.0)	Ordered
69	3	3	3 (4.4)	Ordered
24	5	1	5 (20.8)	Ordered
602	6	2	6 (1.0)	Health Protection Service
2858	128	6	128 (4.5)	

Note:* - 'suspected' means that the volume of drug found in urine samples has not reached the value that would evidence drug use, however the volume measured suggests that drugs have been used.

It was clear from the measurements listed in the previous table that the rate of drug use dropped at places where screening tests were repeatedly performed. This phenomenon was particularly visible at training centres where the substance concentration of urine samples were invariably higher upon drafting than upon repeated tests.

Sources:

Magyar Honvédség Dogprevenciós Bizottság (2002). A Magyar Honvédség Drogprevenciós Bizottság 2001. évi beszámolója a drogprevenció helyzetér_l a Magyar Honvédségben. Jelentés.

2.3. Problem drug use

No prevalence tests on problem drug users have been made in Hungary. Research at the local level will become possible next year, however, it may take 2-3 years before the country's institutional data collection system can be transformed so as to accommodate a nation-wide prevalence test.
Quite apart from the above, health statistics and other research findings are available and so the issues related to problem drug use and high-risk behaviour patterns are amply demonstrated and documented.

2.3.1. High-risk behaviour patterns among intravenous drug users

Research into high-risk behaviour related to intravenous drug users continued in 2001. This time, the researchers used an abridged Hungarian version of a package of questionnaires, which the National Institute on Drug Abuse (NIDA) had prepared and used to explore intravenous drug use patterns.
The questionnaire was intended to explore modes of behaviour representing a risk of transferring blood-borne diseases (primarily HIV and hepatitis viruses).
The research project involved a sample of 95 persons. Interviews were made at the following institutions: Kék Pont Drogkonzultációs Központ és Ambulancia Budapest (Blue Point Drug Counselling and Outpatient Centre, Budapest) (4 outpatients and 47 street interviews), Szegedi Drogambulancia (Drug Outpatient Centre of Szeged) (17 street interviews), Pécsi Drogambulancia (Drug Outpatient Centre of Pécs) (27 patients).
The rationale of using that particular questionnaire was that there has been a steep rise in the number of intravenous drug users in this country over the past decade and a half. Intravenous drug users are at multiple risk with respect to blood-borne diseases: they either use paraphernalia either without disinfection or share such instruments; also, when in an altered state of mind, they are likely to enter into either hetero or homosexual relationships without using condoms.
Although 105 persons were originally interviewed, 10 of them gave such incomplete answers that their replies were eventually omitted from the analysis.
The respondents were between 18 and 42 years of age at the time of the interviews (2001). 70.5 % of them (67 persons) were male. 37 persons had secondary school qualifications, 43 had lower education, while 14 were more highly qualified (unfinished higher education studies: 11 persons, graduates: 3 persons). 6 respondents described themselves as homeless.
Drug use during the 30 days preceding the interviews was described as follows: 14 persons had not consumed any drugs at all, 4 persons had done so 1-9 times, 34 on 10-49 occasions, 24 on 50-99 occasions, and 7 persons had injected themselves 100 or more times. No valid data are available about 12 persons. Regarding the same time-period, 41 reported that they had not used any devices that other persons had used before, while 17 reported 1-9 occasions, and another 6 persons, 10-40 occasions on which they had resorted to used needles.
Of all the persons employing used devices, 50 (73.5% of valid respondents) do not clean the needles at all, (or clean them with water only), 18 persons use disinfectants, alcohol, peroxide or a flame to clean the needles. The sharing of auxiliary devices, such as vessels used for preparing the substance, filters and diluent water, all capable of transmitting blood-borne diseases is even more widespread: only 35 persons (59.3%) of the 59 valid respondents refrained from sharing these devices in the 30 days preceding the interviews, while device-sharing was reported by 18 persons on 1-9 occasions, and 6 persons on 10-60

occasions. The rate of *do not know/uncertain* answers is exceptionally high in respect of this question (29 persons, 30.5%).
As to sexual relations, it was found that during the 30-day period before the interviews, 26 persons had not had sex, while 44 persons had conducted (vaginal, oral or anal) sex on 1 to 150 occasions. On the number of sex partners we received a higher number of valid responses: the above 26 persons had none, while 40 persons had 1, a further 20 had 2-5 and 1 person had 50 partners in the given period.
Of those that had sex in the 30 days before the interviews, 16 persons did not have intravenous drug-using partners, while 44 persons (73%) had at least 1 such partner, (16 of whom had more than one). 91% of the respondents described themselves as heterosexual, 1% as homosexual and 8% as bisexual.
Responses to a question on prostitution:

	Drug for sex	**Money for sex**
Have you ever received	Yes: 20 persons No: 72 persons	Yes: 16 persons No: 76 persons
Have you ever given	Yes: 10 persons No: 82 persons	Yes: 23 persons No: 71 persons

Responses to questions on HIV and Hepatitis:

	How many times in your whole life have you been screened	**How many times have you received a report on the screening**	**Subjectively perceived risk of infection**	**Have you ever been vaccinated for Hepatitis**	**Have you ever received information or some protective device against HIV**
HIV	0 times: 48 persons 1-3 times: 36 persons 4-8 times: 6 persons	0 times: 54 persons 1-3 times: 33 persons 4-8 times: 65persons	0%: 23 persons low, 25%: 41 persons medium, 50%: 12 persons high, 75%: 7 persons		No: 10 persons Yes: 77 persons
Hepatitis A/B/C	0 times: 55 persons 1-3 times: 33 persons 4-8 times: 4 persons	0 times: 58 persons 1-3 times: 31 persons 4-8 times: 5 persons	0%: 14 persons low, 25%: 41 persons medium, 50%: 17 persons high, 75%: 10 persons already infected: 4 persons	No: 77 persons Yes: 13 persons	

49 of the respondents were never arrested, while 40 were arrested 1-3 times, and 3 persons 4-10 times. 64 persons had never been to prison, 17 persons spent 1-30 days, 8 persons 64-365 days and 3 persons spent more than a year in prison.
The partial results of the project led researchers to conclude that intravenous drug users continue to engage in high-risk behaviour in Hungary. Since the method of sampling used in this project was different from the one employed in 1999-2000, the data obtained in the two research projects are incomparable and allow no conclusions to be made on any trends on the drugs scene. Data on the prevalence on high-risk behaviour are now available both for Budapest and other regions of the country.
The researchers find it important to point to the very low number of persons that have been screened. It is therefore imperative to facilitate access to screening tests and to motivate intravenous drug users to have themselves tested.

Sources:

Rácz, J. (2002). Kockázati magatartások injekciós droghasználók körében. Kézirat.

3. Health consequences

3.1. Drug treatment demand – Health statistics on drug use in 2001

3.1.1. Features of health statistics on drug use

Responding to an initiative by the Interdepartmental Committee on Drugs and the then Ministry of Welfare, the Government brought a decree on a new and compulsory data collection project on drug users and their treatment in 1994. Although former compulsory health data provision projects had covered drug addiction and abuse, the new report is much more detailed and is targeted at the consumption of narcotic drugs. Compulsory data provision is covered by a chapter in OSAP, the National Statistical Data Collection Programme under registration No. 1627, which forms part of a Government decree issued annually. Data provision for the year 1994 was not all-inclusive: it should be regarded as a trial run of the new data collection system – therefore, data produced in that year have not been used in our comparative analyses.

Changes in data collection 1994 to 2001		
The year in which the change was introduced	1996	2000
First annual data collected under the new system	1997	2000
Scope of change		
Definitions		Notion of registered patient replaced by that of patient under treatment
		New patient means a self-reported patient treated for the first time in his/her life
Data providers	Both lay and church-run care institutions provide data	
Recipient of data		NIPN transfers aggregated data to Division III of Ministry of Health only
Breakdown by age	New age group: Under-13s	New age groups: further breakdown of over-35s
		New category: age unknown
		Full breakdown by age also for new patients
Classification of drugs		Drugs not precisely specified must be shown as Other under the appropriate type-heading (e.g., other opiate)
		Persons covered only by the needle exchange programme must not be shown
		Methadone used without a doctor's prescription
Frequency of drug use		New category: weekly users
Mortality figures	Reported no longer by the treating institutions but by morgues and the Police	

Data collection

Data are obtained from about 470 data providers once every year, but because of some overlaps their real number is put at about 400. The types of data providers are specified in a decree of law, which, however, fails to contain a detailed list and so it is the responsibility of the data collection centre to register, update and, if necessary, pass on the information to other agencies that might require such data for their work. The data collection centre is a unit of the NIPN, the National Institution for Psychiatry and Neurology; the centre is currently called Department of Information Technology and Organisation, a unit that has its roots in the former Department of Organisation and Methodology. The forms are produced at annual intervals at the NIPN's own printing office, they are then sent to the data provider institutions together with a brief methodological guide which calls attention to current problems. The questionnaires are circulated in December every year. As to the content and form of the questionnaire, the NIPN submits its proposal but the Ministry decides any modifications to the document for Health, Social and Family Affairs. Any changes to the questionnaire will effectively change methods of data collection and processing only two years after submission.
The data providers transfer the annual figures in their own filing system to the reporting form, which they send over to the processing centre (NIPN). There are no regional processing centres but one copy of the report is sent by the data providers to the medical supervisory officer employed by the NPHS, the National Public Health Service. The regional medical supervisory officers do not aggregate the data for their county: instead, they receive feedback from the NIPN in the form of processed regional and national data. Data providers are obliged to make their data available before 31 January of next year. The NIPN's offer to help prepare the report either by phone or in personal consultations is taken up by about 10% of data providers.
The NIPN will then pass on the national aggregate figures and the breakdown by county in a series of tables to the Ministry of Health, Social and Family Affairs. All other Government agencies receive the data from the Ministry, as is provided for in the law. The NIPN also provides feedback to the data providers by conveying county, regional and national figures, or, if requested on an ad-hoc basis, it processes available data into specialised statistical information for the benefit of other Government bodies or NGOs.

Types of data providers and data for 2001

Underneath is a list of types of institutions obligated by law to provide information: those in the first group provide data on treatment, while those in the second group on mortality figures.
Types of institutions providing data on treatment for drug users:

- drug outpatient centres and drug care centres,
- psychiatric care centres (for adults and children),
- psychiatric departments and specialised outpatient clinics,
- crisis intervention departments,
- alcohology and addictology care centres, departments and special outpatient clinics,
- drug therapy institutions.

Types of institutions providing data on drug-related mortality:

- institutes of forensic medicine,
- institutes for medical specialists,
- medical Police offices (Health Service of the National Police)

The following table employs 2001 figures to show the relative share of types of institutions in the provision of treatment. While addictology care centres have retained their traditional functions, drug outpatient centres are playing an ever-increasing role. Inpatient treatment

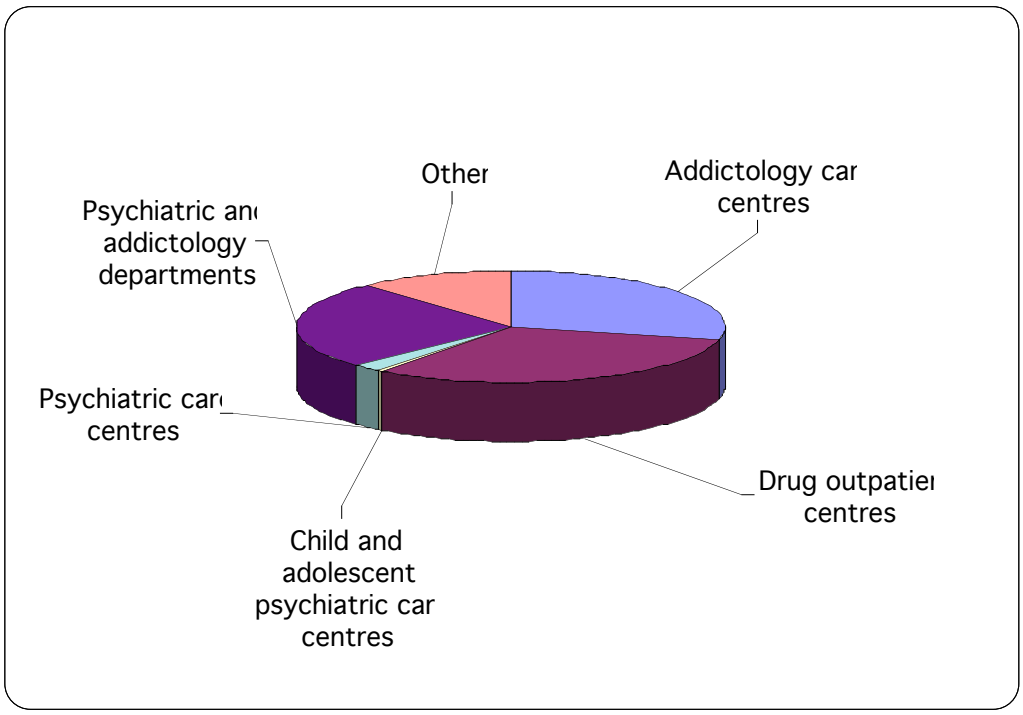
also has a substantial share since it represents a stage in the treatment: outpatients are treated in a large number of care centres and drug outpatient centres, inpatient treatment however is conducted exclusively at psychiatric and addictology departments.

Drug users according to type of treatment institutions in 2001

TYPE OF INSTITUTION		Patients under treatment		Of which, new patients	
		Number	%	Number	%
AC	Addictology care centres	3,447	28.6	1,052	24.2
DO	Drug outpatient centres	3,807	31.6	1,672	38.5
CC	Child and adolescent psychiatric care centres	28	0.2	24	0.6
PC	Psychiatric care centres	267	2.2	105	2.4
PD	Psychiatric and addictology departments	3,103	25.8	1,031	23.7
OT	Other	1,397	11.6	458	10.5
TOTAL		12,049	100.0	4,342	100.0

It has to be noted that the method of data collection does not allow for a breakdown into outpatients and inpatients since psychiatric and addictology departments report patient numbers that include figures received from the special outpatient centre attached to the departments.

Drug users according to type of treatment institution in 2001



Methodology of data processing

The law provides for rather pressing time limits in which to process the data: information obtained from all over the country must be transformed into an annual report within a month, and this includes control, data recording, follow-up corrections made by the data providers, aggregation and primary analysis. The data are checked in several stages: a statistics expert first checks the reports received from individual data providers and will usually find some contradictions and computing errors. He then selects data sheets with grave errors that would jeopardise correct interpretation and sends them back to the data provider for corrections, while the data from the usable portion of sheets will be fed into 2 data recording Excel programs. Preparing the data input surface is an annually recurring job and although the basic frame of the program has remained the same, slight modifications are made to it every year in order to incorporate new checking methods and eliminate errors generated in processing. By the help of control formulae built into the processing files, the recorded data pass through a number of additional filters designed to eliminate internal contradictions in the reports of individual data providers. In the next step, current data are compared with data provided by the same provider in previous years, which enables the analysts to identify any under or over-reporting of a different order of magnitude. Data from mixed profile care centres (psychiatric and addictology centres) are checked for any double reporting to prevent the same patient from appearing twice in the statistics. The aggregated figures are then grouped by region, institution, type, etc. and presented in table format. After the figures have been checked, corrected and aggregated, the NIPN sends them to the county supervisory medical officers to help them prepare their annual reports to be submitted to the NIPN. After all data have been aggregated, graphic illustrations and expert analyses are added to the annual report. The report also serves as a source for the list of institutions to which next year's questionnaires are to be circulated; the list thus obtained will most probably be up-to-date, although the NIPN sometimes obtains accidental information on a newly established data provider. It can be difficult to classify drug outpatient centres because some of them simultaneously operate as addictology care centres, or have evolved from such a centre. The most reliable information about drug outpatient centres can be obtained from the Professional Association of Drug Outpatient Centres.

Data evaluation

The statistical data obtained are very detailed in terms of the types of substance used by drug-takers, breaking down major types into various subgroups (e.g., types of amphetamine derivatives). Also, users of illegal and legal drugs (e.g., sleeping pills, tranquillisers) are covered. Patients are always grouped by the dominant kind of drug they use but there is a separate table to show combined usage patterns. Information on the mode of consumption is vitally important in the case of intravenous users as they pose a special threat in terms of public health and epidemiology on account of associated infectious diseases, such as hepatitis of AIDS. Regarding frequency of use, the two categories in former use have now been replaced by three.

The institutions of treatment provide aggregate figures on drug patients and so it is impossible to screen persons treated and registered in several institutions (double-counting). Medical experts agree that the community of drug users in Hungary is a population of patients that tend to move from one treating institution to another. It may happen that the same person calls at a Budapest care centre, then a Pest county centre, and then may be admitted to an inpatient department within the same year. The aggregate statistics will treat this person as three different persons, thereby distorting figures on the number of patients treated. Since data collection methods were modified in 2000, patients' self-reported date of first treatment has been accepted as authoritative. Statistical tables including a detailed breakdown by age and type of drug used abundantly cover first-treated patients.

Compliance with obligatory data provision has gradually improved since its introduction; overdue reporting accounts for about 10%. Errors resulting from misinterpretation and computation continue to be persistent problems. Various errors lead to different degrees of

distortions, however, it can be said that most reports require follow-up correction and data control. The tables of the report contain various breakdowns of all patients treated at a given institution, so the figures must eventually be in agreement.
In fact, that is very seldom the case. In addition to computing errors, certain interests related to financing may explain poor data validity in inpatient treatment. An institution of treatment may decide to use a data management technology with a view to concealing drug patients, who represent a drawback to the institute from a financing point of view. Institutions with large patient turnover figures generally rely on their computerised database, one primarily set up for financing purposes, for obtaining data to be used in compiling their annual reports. Under the DRG system currently in force, institutions are very poorly reimbursed for patients diagnosed for drug addiction, therefore the management is interested in producing a medically acceptable main diagnosis for an addicted patient with a view to obtaining a higher rate of social security reimbursement. Such practices are aided by frequent co-morbidity. This, by the way, is a problem afflicting all kinds of epidemiological data collection in health care: since it stretches beyond drug-related statistics, the problem can only be resolved or mitigated by comprehensive high-level action.
The quality of data transfer could be improved, and processing accelerated, if electronic methods of data provision were to be introduced. As a first step, the NIPN sent out questionnaires at the end of 2000 to find out whether data providers were equipped with appropriate electronic equipment and willing to participate in the project. Our summary of the findings leads us to the conclusion that about one half of the institutions have advanced computers enabling electronic data provision. The institutes' willingness to try out the new method was apparently ahead of their technical potentials: 65% turned in a definitely affirmative answer. Drug outpatient centres seem keenly interested: practically all would like to participate, which is a happy coincidence since their large patient turnover figures call for the earliest possible introduction of electronic data provision.

Since 2001 figures were collected by a different methodology from that employed in earlier years, comparing figures obtained in different years would distort any perceived trend characterising Hungary's drug scene, nevertheless an attempt will be made to map general trends emerging from health data. It might be said in justification that the distribution of figures along certain variables of patients treated in health institutions do provide the reader with meaningful information on treatment needs (e.g., distribution by drug type, patients given treatment as an alternative to criminal proceedings). However, the absolute figures of patients treated in health care institutions do not allow for any valid conclusions regarding the prevalence of drug use in this country.
It is to be stressed that the trends emerging from the data must be treated with reservations since they primarily reflect modifications to the data collection system and drug treatment institution capacities rather than real need for treatment!

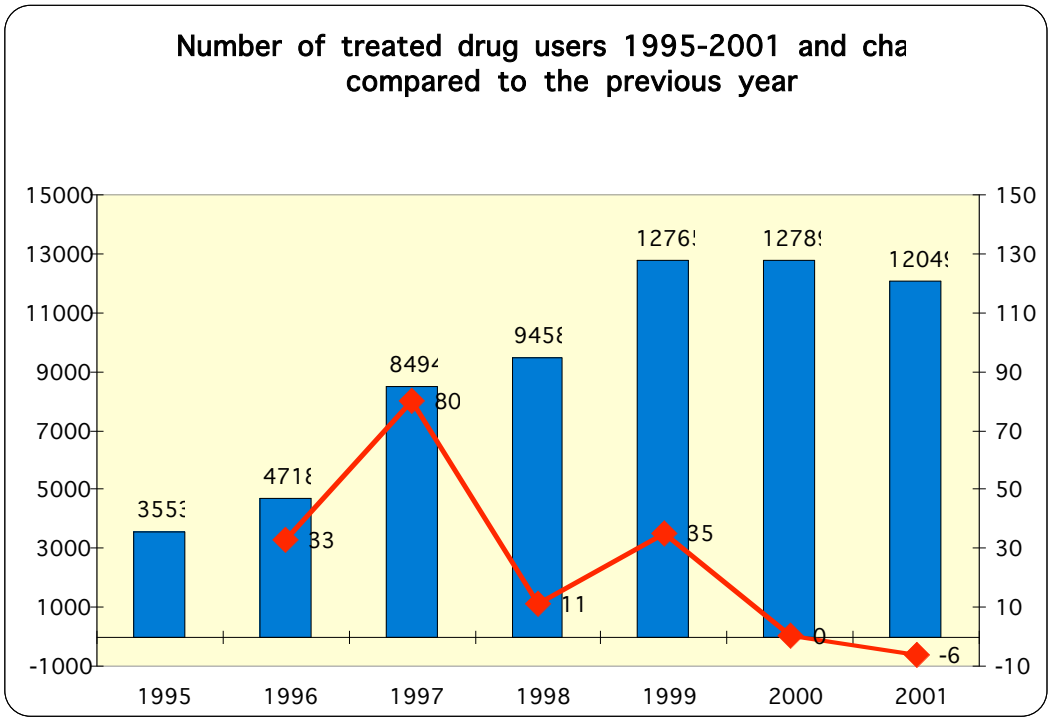
3.1.2. Trends in the number of drug users

Treated patients and new patients

The *number of drug users treated at health care institutions dropped in 2001, an unprecedented development since data collection was introduced.* The first signs came in 2000 when the formerly steeply rising number went into stagnation. The methodological error of data collection is estimated at 2-3%, so the 5.8% drop in the 2001-year figures should be regarded as a noteworthy achievement. It should be remembered, however, that a major cross-checking opportunity has been lost in respect of addictology care centres, therefore, it is doubtful whether the 2-3% margin of error specified for methods employed in previous

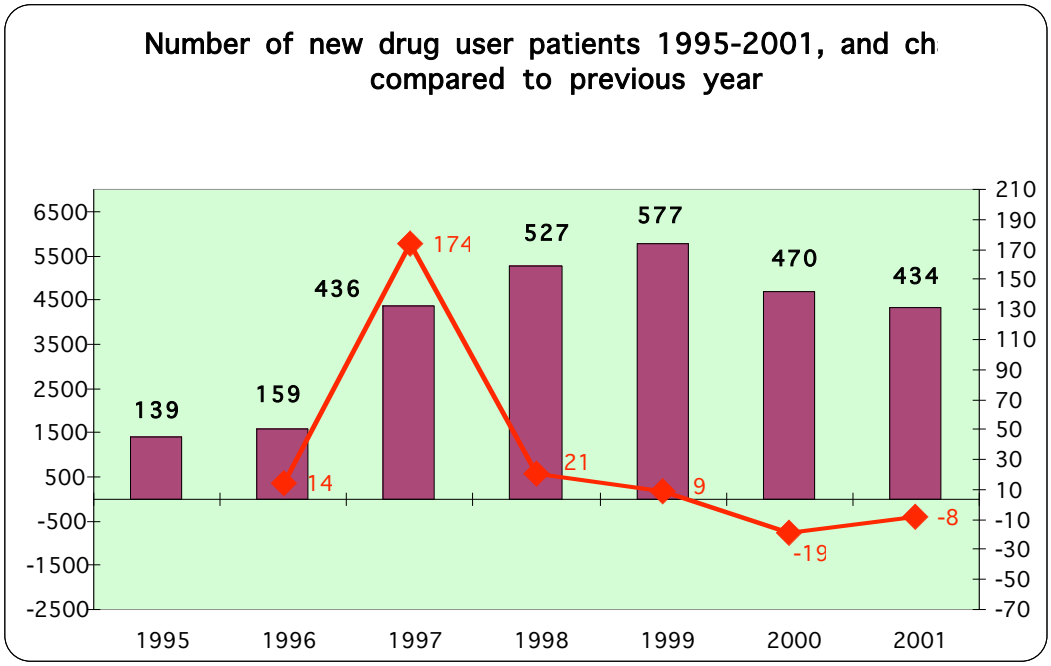
years is still valid, since addictology care centres account for 29% of total turnover. A conservative analyst might conclude that *there has been no rise in the number of treated patients; the figure has been practically stagnant for the past three years.*
Another factor that should not be ignored is that only a small proportion of drug users find their way to a health care institution. International epidemiological surveys put the life prevalence of drug problems at 1-3% worldwide, which translates into about 100-300 thousand persons within Hungary's population. However, the information conveyed by life prevalence figures is totally different from that indicated by the number of patients in health care treatment, which latter figure primarily enables *monitoring of problem drug use.* If a drop in the number of treated patients indeed reflects a reduced need for treatment, it should be viewed as a positive development. It is to be noted that there was a higher-than-average drop in the use of illicit substances: in 2001, 9.7 % fewer drug users were treated for problems related to the use of illegal drugs than in the previous year. By contrast, there was only a 3.5 % drop in the context of legal substances. 15% of the total decrease of 740 in the number of treated patients came from a drop in the number of diverted patients, i.e. persons receiving treatment as an alternative to criminal punishment.

Number of treated drug users 1995-2001



The number of new patients continued to decrease. This was partly due to a change in methodology and partly due to a real drop as there was a fall in the total number of treated patients as well. The number of first-time patients grew more slowly than the number of all patients under treatment until 1999, but it did grow from one year to another all the same. In 2000, however, it dropped 19% from 1999. This sharp and substantial decline is to be put down to the fact that the notion of first-time patient had been redefined to denote, as of 2000 (year under review), patients self-reporting to have received treatment for the first time in their lives. Nevertheless, the 2001 drop is very likely to be an indication of a real decline in the need for treatment.

Number of first-time treated drug users 1995-2001

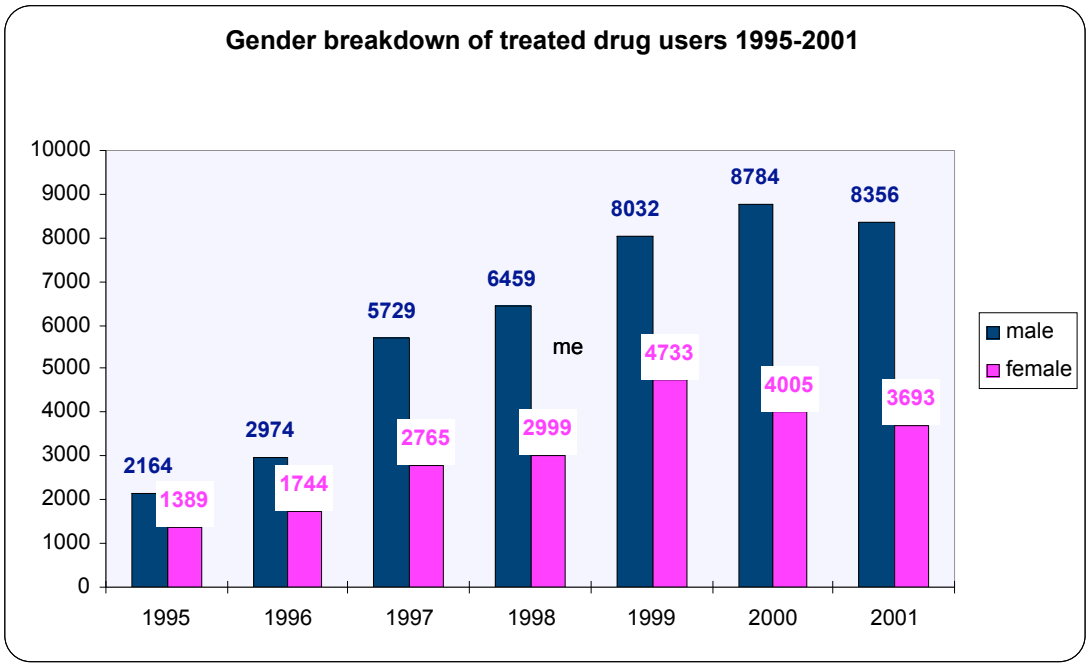


Gender breakdown

The number of male drug users treated at health care institutions has consistently been higher than that of women since 1995. The gender division between men and women has ranged from 61 – 39% to 69 – 31%, and a similar picture is presented for 2001, when over two-thirds of treated drug patients were male. Except for tranquilliser-type substances, each drug category contained a much higher number of male than female patients in the period 1995 – 2001. Women, however, dominated the segment of tranquillisers and sleeping tablets, while the slightly rising trend in male tranquilliser-user patients seems to point to a trend of levelling in the period under review.

Of all treated drug users, 69% were men and 31% women in 2000: the number of men rose by 700, while that of women fell by the same amount from the year before. The proportion between men and women in the total number of patients treated in 2001 did not change, while there was a drop in the number of both men and women, a decline of 5% and 8%, respectively, from the previous year (2000). The breakdown according to type of drug demonstrates that the aggregate national decrease comes from a decline in the use of certain types of drugs offset by growth in the use of other drugs. For most types of drugs there seems to be no gender-related difference in either growth or decline. The only exception is the use of volatile substances (inhalants), where a 28% drop was recorded among adult women from 2000 to 2001, while the number of men remained practically unchanged.

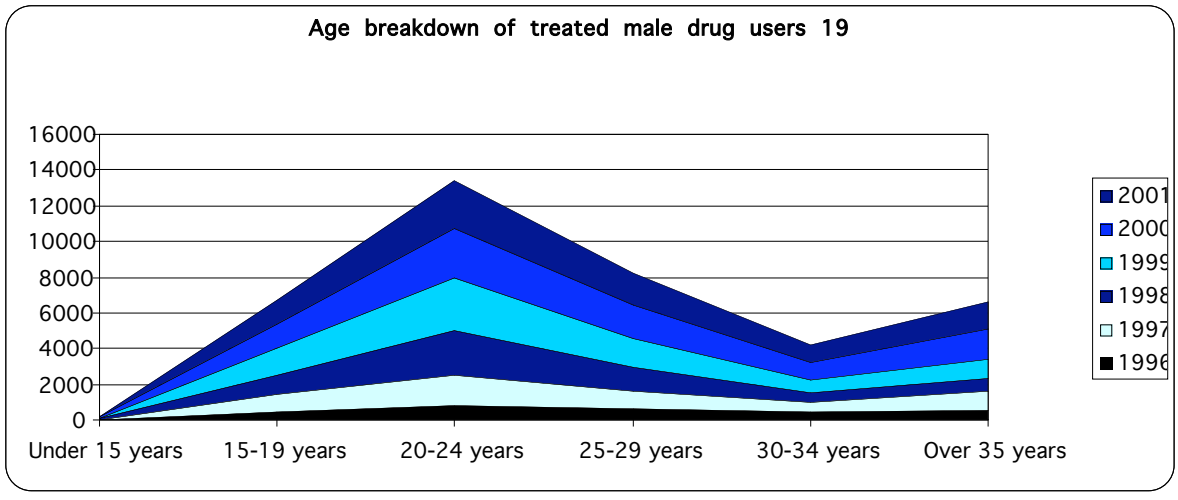
Gender breakdown of treated drug users 1995-2001



Breakdown by age

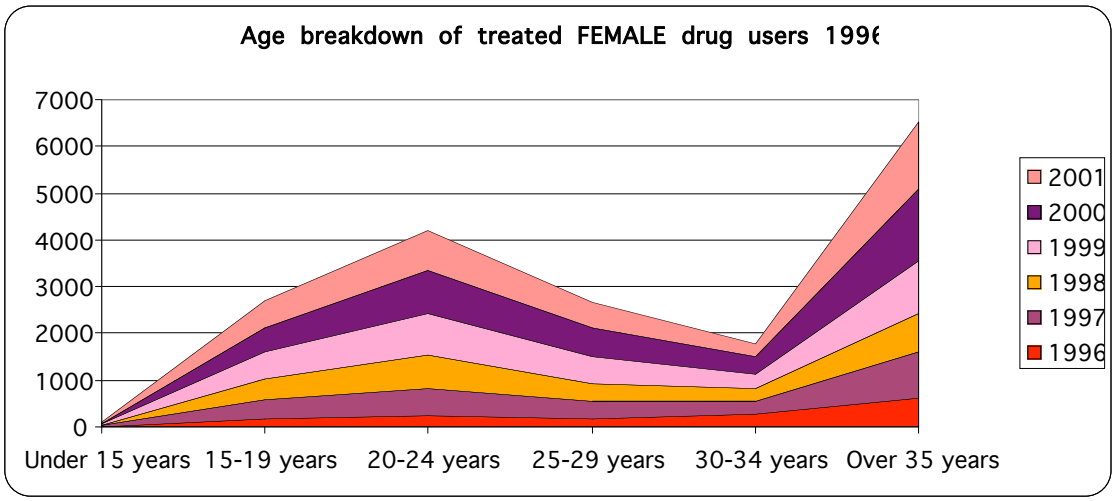
In analysing trends in age breakdown, one should not ignore a change in methodology: up to 1999, only registered patients' data were processed for age-breakdown; as of 2000 all treated patients have been processed for age. The number of registered patients in 1995-1999 was generally lower than that of treated patients, which means that if there is a rise in a given age bracket both in 2000 and 2001, then at least part of the increment is due to a change in method rather than real growth.
Trends in male and female age breakdown are similar every year but different according to gender. For males, the age group 20-24 years is the most populous every year, while the largest number of women are found in the over-35 age group, though the age group 20-24 years for women is a very large one too. The 35-plus age group is characterised by women taking tranquillisers and sleeping tablets, often in combination with alcohol.

Age breakdown of treated male drug users 1996-2001



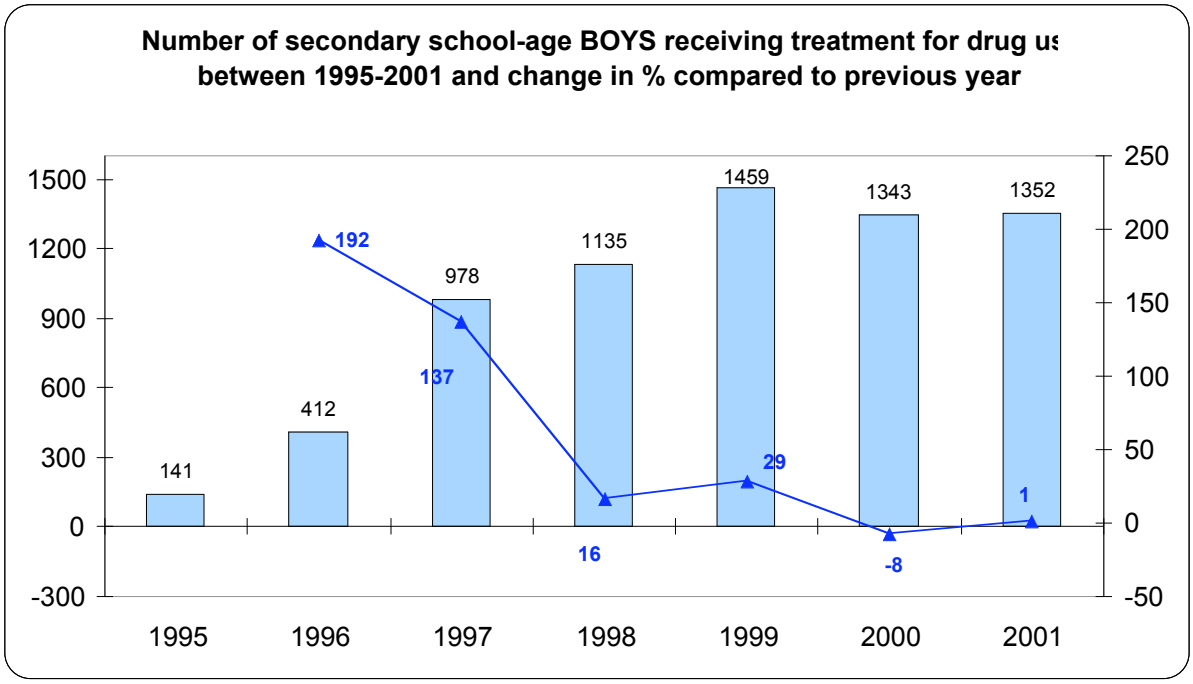
The number of treated patients for both men and women dropped from the previous year in every age bracket. Women produced a more marked drop than men in all age groups except that of over-35 years.

Age breakdown of treated female drug users 1996-2001



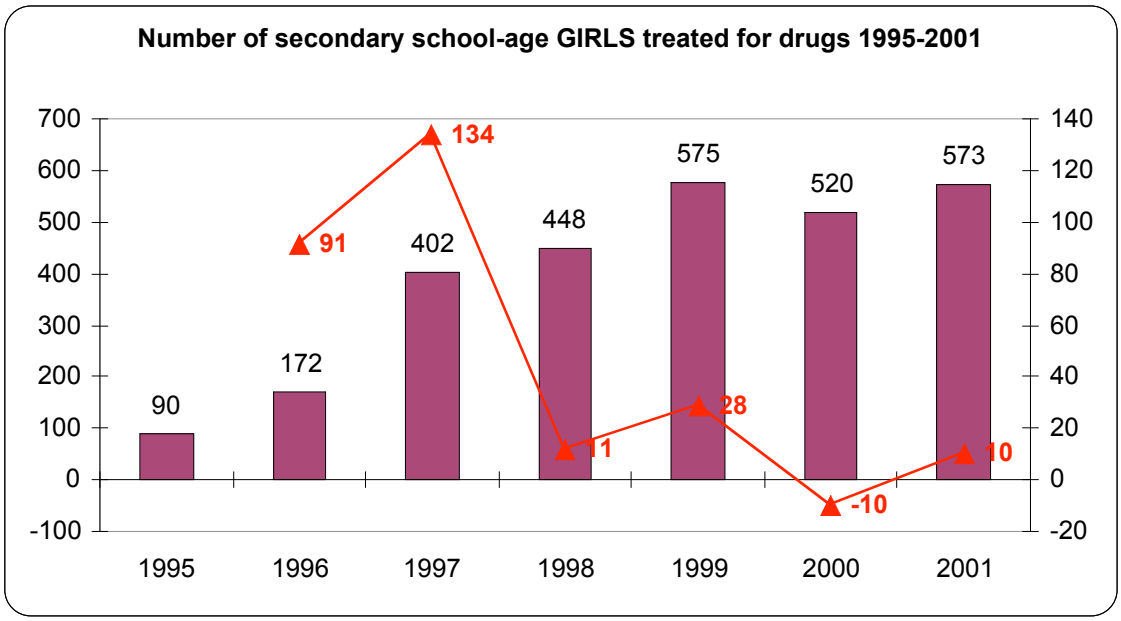
The increase in the number of registered patients in the 15-19 age group (secondary school age) grew 10.3 times for boys and 6.4 times for girls in the period 1995-1999. An 8-9% drop was registered for boys and girls alike in 2000. The trend continued for boys in 2001: although the figure did not decline any further but at least the number of male secondary school students receiving treatment did not begin to rise. The 0.7% growth on the previous year is within the margin of error so the number of boys in this category should be regarded as unchanged. The number of under-15 boys fell from the previous year just as the number of treated adults in every age bracket.

Number of secondary school-age boys receiving treatment for drug use, 1995-2001



The number of secondary school-age girls receiving treatment began to grow: a 10% rise means that 53 more girls were treated in 2001 than in the year before. There was also a slight increase in the number of girls under 15, while the number of all adult women receiving treatment dropped in every age group.

Number of secondary school-age girls treated for drugs 1995-2001

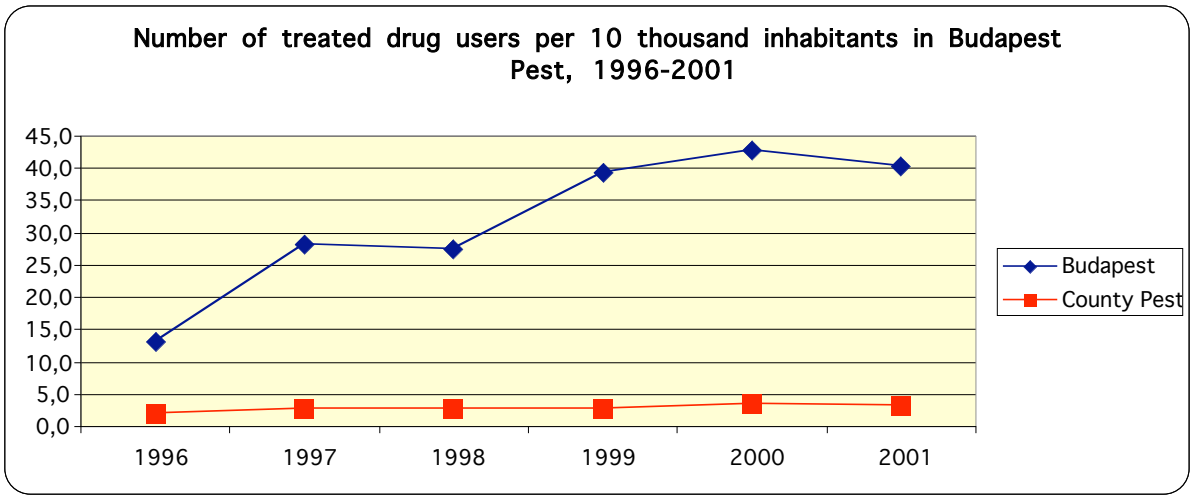


Over a period of 5 years, the gender distribution in the secondary school age group is almost identical with that for the adult population: over two-thirds of secondary school children receiving drug treatment are boys. The respective figures for boys and girls receiving drug-related treatment in 2001 were 1,352 and 573.

Breakdown by region

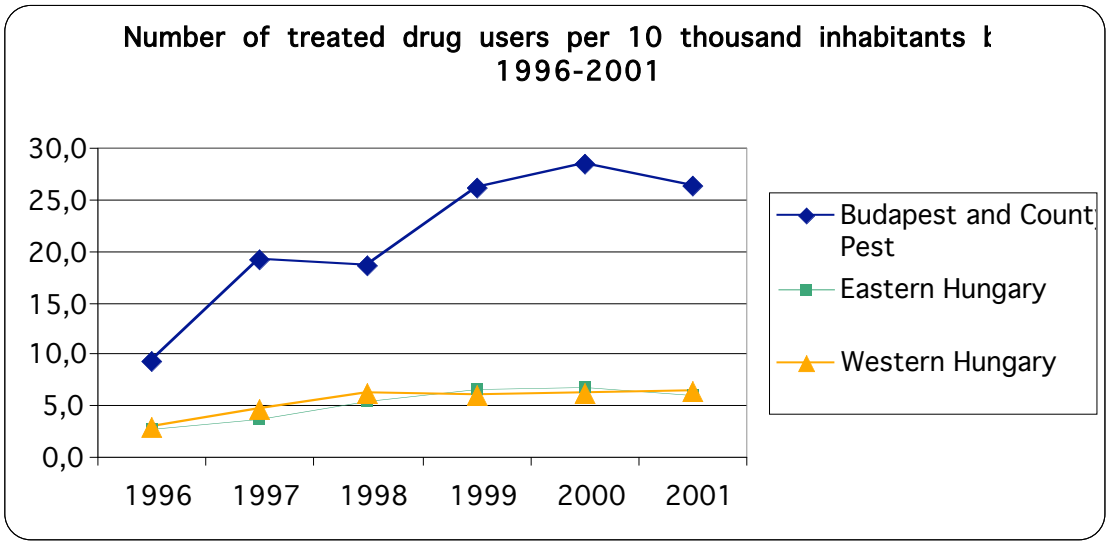
In current health care drug statistics, data on regional distribution are based on the place of the institutions giving treatment. The information provided for central processing does not contain any indication of where the patient lives. The average size of the area from which patients are admitted varies with the type of institution providing treatment. The country and its counties are relatively densely covered with addictology care centres and psychiatric departments, which consequently tend to admit patients from the vicinity. Drug outpatient centres are a different matter: there is still a low number of this kind of specialist institutions offering sub-special progressive treatment to patients within psychiatry departments. This means that general psychiatric and addictology institutions will want to transfer their patients to a drug outpatient centre if there is one within reach. Thus, a drug outpatient centre may take patients from as far away as a neighbouring county. A case in point is Budapest and county Pest: in the period 1996-2001, the Budapest figure for treated patients per 10 thousand inhabitants showed great annual fluctuations, while the figure in county Pest remained almost unchanged.

Number of treated drug users per 10 thousand inhabitants in Budapest and county Pest, 1996-2001



It can be concluded from the diagrams of eastern and western Hungary, Budapest and county Pest that there is no major difference between the eastern and western part of the country regarding the number of treated drug users per unit of population. There is, however, a striking disparity between Budapest conurbation and the rest of the country. The difference has multiplied since 1996 but data from the past few years seem to indicate that the gap has more or less stabilised.

Number of treated patients per population in eastern and western Hungary and in the capital and its conurbation, 1996-2001

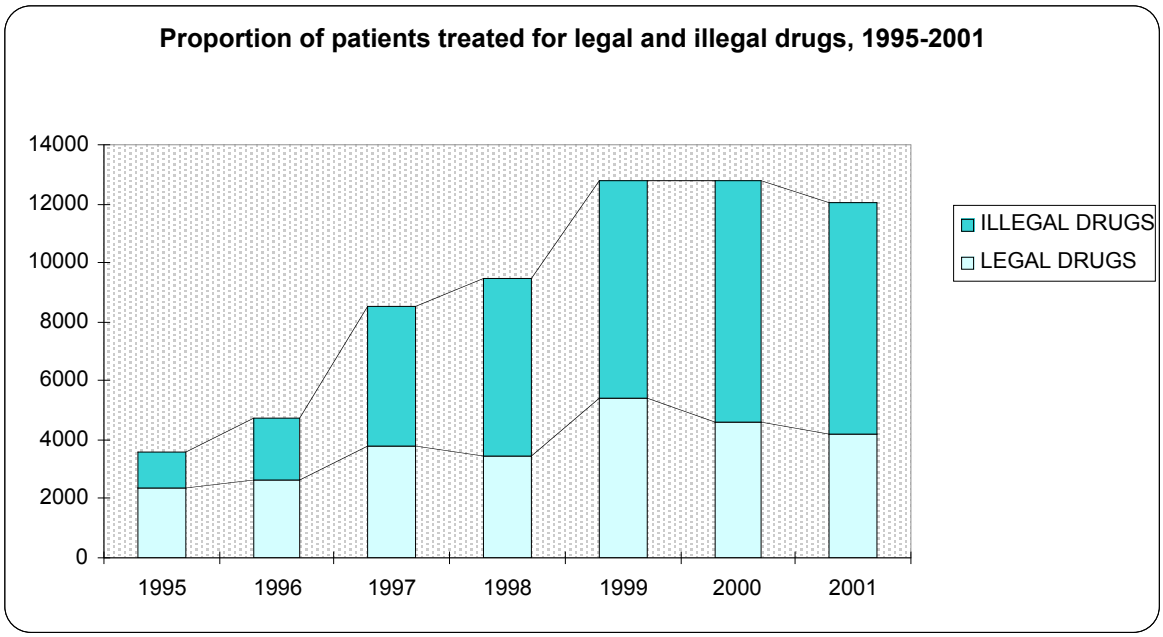


Trends in the types of drugs used by treated patients

The proportion of treated patients using illegal substances steadily grew between 1995 and 1998, while that of legal substance users was virtually stagnant. In 1999, there was a 59% rise in the number of patients using legal drugs from 1998, but the figure dropped 15% in 2000. These figures should be considered against the background of a continuous increase

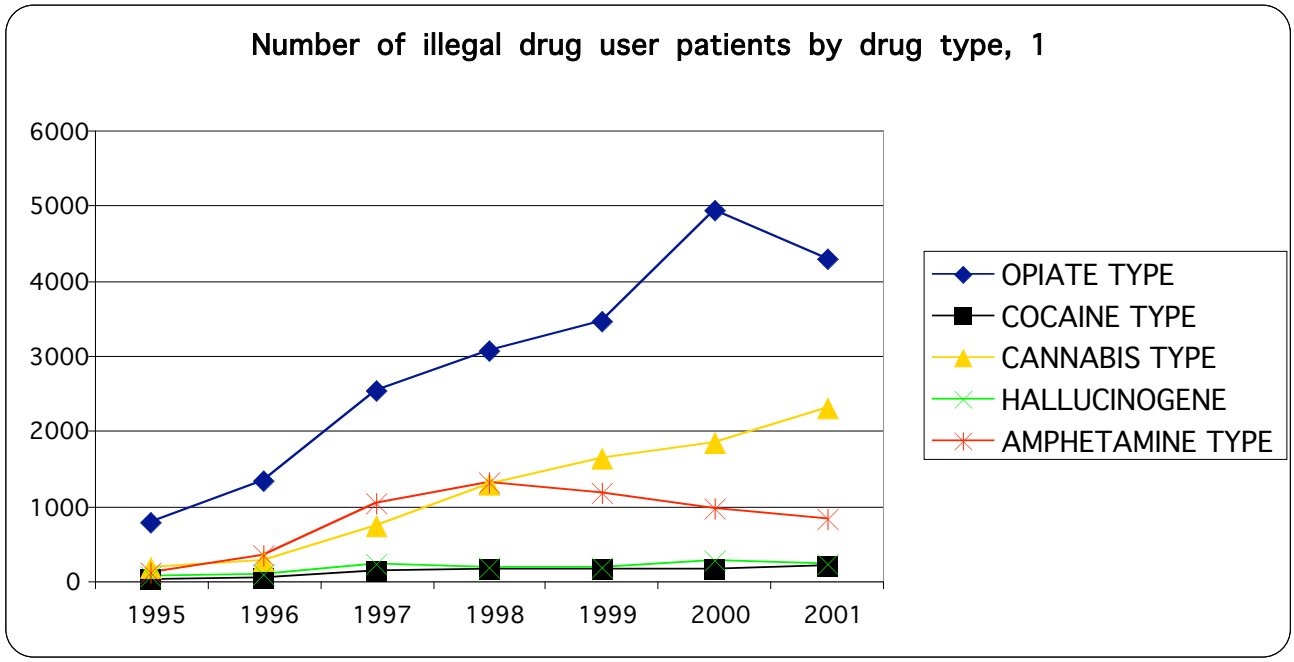
in the total number of treated patients up to 1999 and an unchanged number of total patients in 2000.

Proportion of patients treated for legal and illegal drugs, 1995-2001



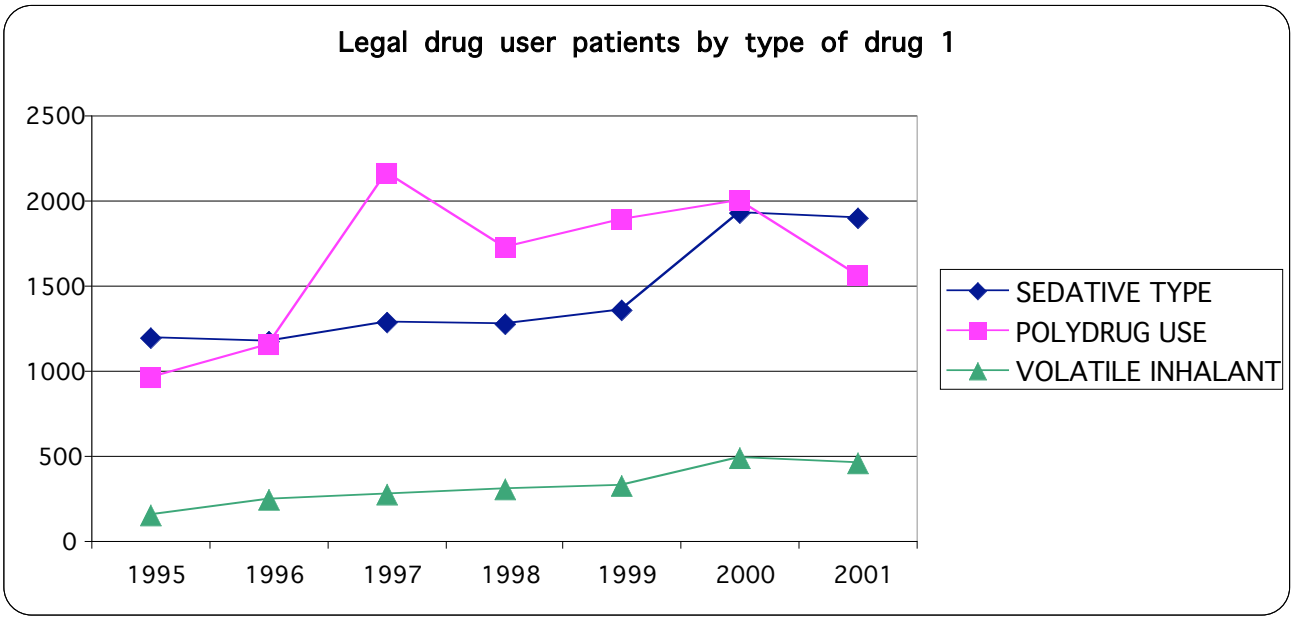
The figures lead to the conclusion that *the proportion between the users of illegal and legal drugs has been reversed since 1995:* the proportion of legal drug users has dropped from 67% to 35%, while that of illegal drug users has grown from 33% to 65%. The reversal had occurred by 1998 and, except for a slight shift in the opposite direction in 1999, this inverted proportion (i.e. compared to the state of affairs in 1995) has remained more or less stable.
The total number of treated drug users unexpectedly fell from 2000 to 2001. This drop is a product of declining use in some substances and growth in the use of others.

Number of illegal drug user patients by drug type, 1995-2001



Opiate (opium, heroin, poppy infusion, etc.) users grew both in number and proportion up to 2000. Opiate users accounted for 22% of all treated patients in 1995; their proportion grew to 30% in 1999 and 39% in 2000. In 2001 the number of opiate users treated dropped 13% from the preceding year bringing the ratio of opiate users 36% of all treated patients, which means that this category still represents the largest group of treated drug users despite the decrease.
Cannabis (marijuana, hashish) users slightly grew in proportion to the total treated population in 2000: their relative share grew from 5% in 1995 to 13% in 1999, their number rose by 25% in 2001 and accounted for 19% of all treated patients. Cannabis users come second after opiate users on the list of treated drug users.
Amphetamine user patients halted growth in 2000: the proportion of amphetamine users to all treated patients grew from 3% in 1995 to 11% in 1999, but the figure dropped to 7.5% in 2000 and declined further in 2001, currently standing at 6.9% of all patients.
Cocaine users grew 20% from 2000 to 2001, accounting for 1.7% of all treated patients. The proportion of this tiny circle of users relative to all treated patients has remained virtually unchanged in recent years.
Hallucinogen users have always been similarly low within the total population of treated patients and their actual number dropped by 13% from 2000 to 2001.

Legal drug user patients by type of drug, 1995-2001



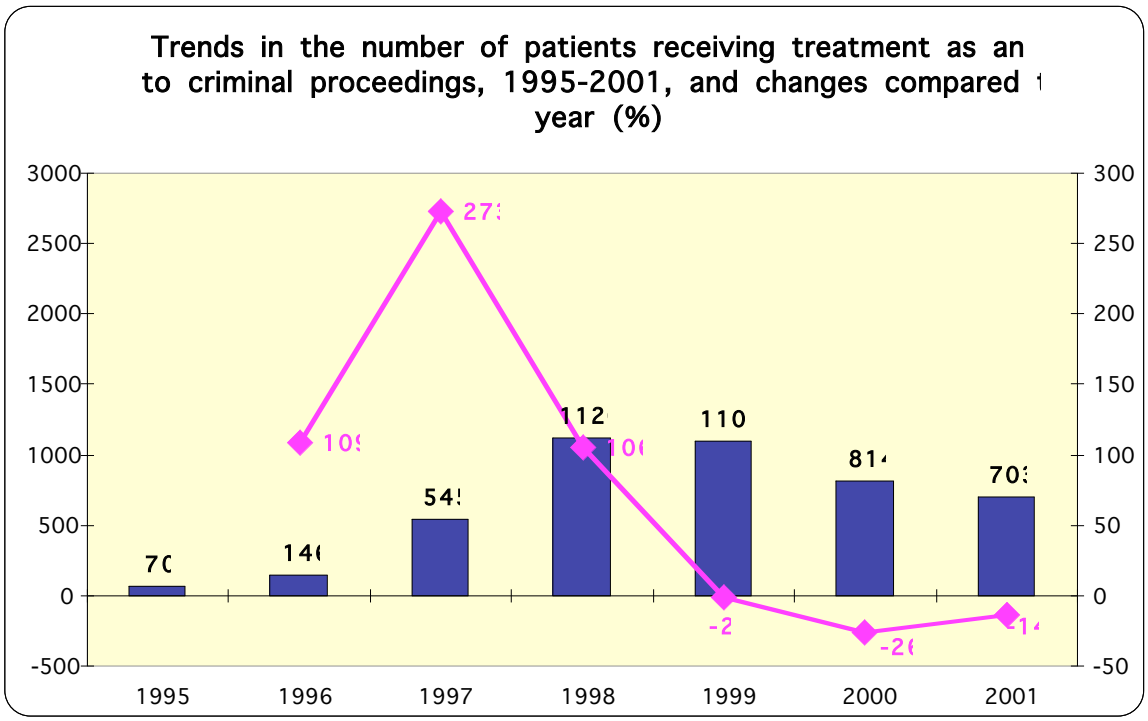
Volatile substance abusers have grown in number in recent years but they are still a minority in the total drug user population. Their share (4% in 2001) within the total has virtually remained unchanged. There was a slight drop, albeit only among women, in the number of volatile substance abuser patient from 2000 to 2001.
Sedatives and sleeping pills abuse affects 16% of all treated patients, putting these medicaments at the top of the list of abused legal substances and at third place after opiates and cannabis on the list of all narcotic drugs. There was no significant change in the number and proportion of patients treated for the abuse of tranquilliser-type substances within the total population of treated patients in 2001.
Polydrug use (combined use of tranquillisers and sleeping pills with alcohol) patients grew more than twofold from 1995 to 1997, and have shown considerable fluctuation since 1998. That year saw a 20% drop followed by a 10% rise in 1999 and another 6% rise in 2000, only to drop 22% in 2001. The reason for the drop in the final year is not known: some of it can be

explained by the fact that there is much confusion about how the notion of polydrug use is to be interpreted.

Trends in the number of patients receiving treatment as an alternative to criminal proceedings

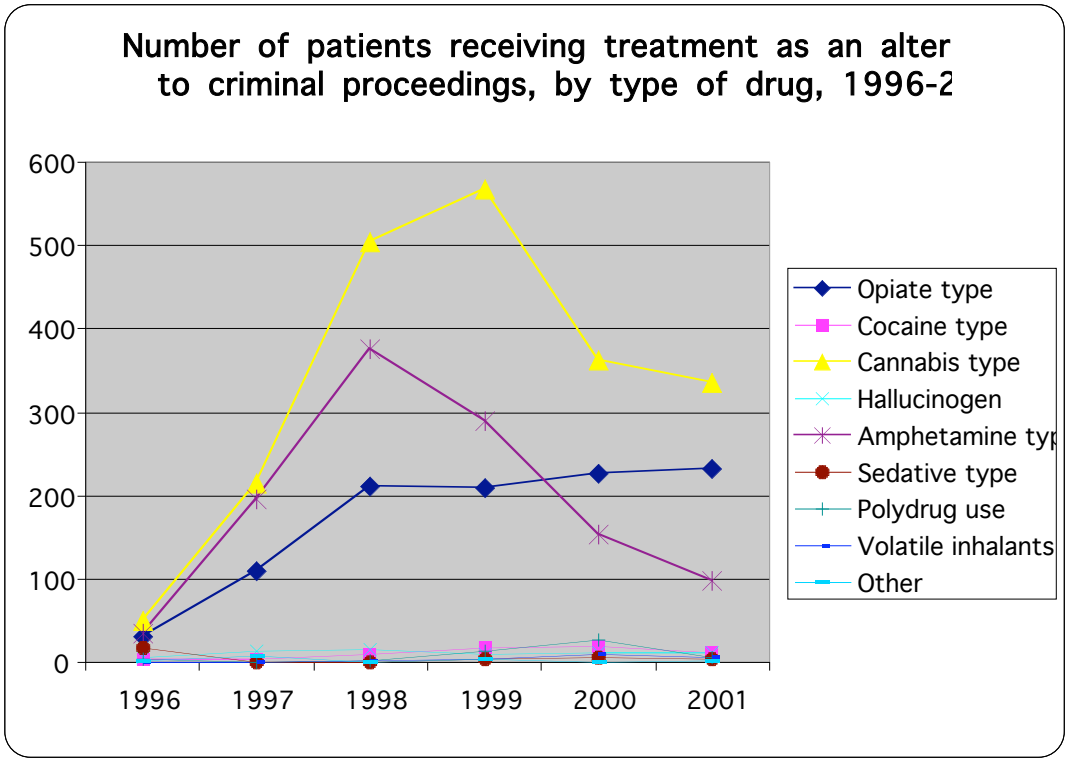
The number of patients receiving alternative treatment (diversion) grew with the total number of treated drug patients up to 1998. Their number, however, dropped slightly in 1999 and, remarkably, by 25% in 2000, while the total patient number kept growing or stagnated. In 2001, a 14% drop on the previous year was recorded.

Trends in the number of patients receiving alternative treatment, 1995-2001



Much of the decline in the number of patients receiving treatment as an alternative to criminal punishment in 2000 is a result of a 36% and 45% drop in cannabis and amphetamine users, respectively; the number of patients treated for other drugs among those receiving alternative treatment slightly grew or remained static. In 2001, there was a drop in the number of cannabis and amphetamine users given alternative treatment and so did the number of cocaine and polydrug user patients within the same population.

Number of patients receiving alternative treatment by type of drug



There is a conspicuous disproportion between the genders in the total population of patients receiving treatment as an alternative to criminal proceedings. Women accounted for as little as 10-15% of all patients receiving alternative treatment, while the share of women in the total population of treated patients is about one-third in 1996-2001.

Breakdown of all drug users receiving treatment by major drug categories and gender
In 2001

MAIN DRUG CATEGORIES	1.		2.		3.				4.		5.	
	NUMBER OF TREATED PATIENTS during the year		Of the number in Column 1, **new patients** (first registration for treatment)		Of all patients the number of those referred to				Number of patients receiving treatment as an alternative to criminal proceedings (on the basis of BTK 282/A §)		Of the number in Column 4, the number of patients completing a continuous 6-month treatment in the year under review	
					hospital		other institutions					
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. OPIATE TYPE	**3,241**	**1,059**	**1,105**	**411**	**242**	**137**	**188**	**78**	**204**	**28**	**91**	**11**
2. COCAINE TYPE	**150**	**56**	**44**	**19**	**22**	**13**			**9**	**3**	**4**	**1**
3. CANNABIS TYPE	**1,872**	**429**	**814**	**179**	**122**	**38**	**18**	**1**	**312**	**24**	**158**	**10**
4. HALLUCINOGENES	**184**	**52**	**71**	**16**	**16**	**1**			**11**		**2**	
5. AMPHETAMINE TYPE	**619**	**218**	**277**	**104**	**64**	**37**	**15**	**5**	**78**	**19**	**29**	**9**
6. SEDATIVE TYPE	**821**	**1,081**	**244**	**319**	**100**	**88**	**26**	**33**	**2**	**2**	**2**	**2**
7. POLYDRUG USE (other than the above categories)	**914**	**649**	**275**	**189**	**110**	**69**	**36**	**25**	**4**	**1**	**2**	**1**
8. INHALANTS	**389**	**75**	**132**	**22**	**27**	**2**	**5**	**2**	**3**	**2**	**1**	
9. OTHER DRUGS	**166**	**74**	**85**	**36**	**12**	**4**	**2**	**1**	**1**		**1**	

Sources:

Porkoláb, L. – Grézló, O.(2002).). Egészségügyi statisztikai adatok a kábítószer-fogyasztásról - 2001. Kézirat.

3.2. Drug-related mortality

Legal drugs

Analysing statistical data related to deaths caused by drug abuse requires extreme care.
Drug related mortality has in the past few years stayed at more or less the same level according to the NIPN figures. The mortality register is based on the BNO 10 code system currently in use, but the data providers i.e. institutions, Police doctors, institutes of forensic medicine and the forensic institutes of the Ministry of Justice use a variety of methods for data presentation. What makes data evaluation even more difficult is that the above institutions often provide overlapping data and there is no way in which the data management centre could screen the information for double counting.

Act CLIV of 1997 on Health Care, which came into force in October 1999, and its implementing legislation, Joint Decree 53/1999 (IX.24.) of the Ministries of the Interior, Health and Justice, call for a pathological post-mortem rather than a forensic post-mortem in the case of natural death (i.e. 'nothing out of the ordinary') that occurs in a public area. This further complicates work on drug-related mortality research. There are very few pathology departments in Hungary with the money and equipment required for basic toxicology tests.
It follows from this that it is impossible to estimate the number of cases where the doctor who filled in the data sheet – with or without a pathological examination – indicated some natural disease as the final cause of death whereas the person died from an overdose of sleeping tablets or some other legal substance. The tables below provide evidence to support this assumption since there was a 17% decline from 1999 to 2000 in the total number of deaths related to drug abuse, and this drop resulted *exclusively* from the fact that there was a decrease in the number of recognised deaths caused by an overdose of sleeping tablets, tranquillisers, or a combination of the two. To respond to the situation, the NPHS, the Budapest Police Headquarters Homicide Section and the Semmelweis University Forensic Institute agreed that the university's Forensic Institute would take in all deceased persons and carry out either a pathological or a forensic post-mortem, as agreed with the competent authorities. As a result, a 10% rise was recorded in the number of drug-related deaths in 2001.

Type of drugs	**1997**	**1998**	**1999**	**2000**	**2001**
Opiate type	46	23	40	35	39
Cocaine type	-	3	-	-	-
Cannabis type	-	-	1	1	-
Hallucinogens	-	1	-		-
Amphetamine type	1	4	1	2	1
Illegal drugs total	***47***	***31***	***42***	***37***	***40***
Sedatives	255	210	281	198	214
Polydrug use	36	65	4	35	37
Volatile inhalants	1	32	10	9	20
Others	-	-	-		
Total	***339***	***338***	***337***	***280***	***311***

Illegal drugs

Illegal drugs have since 1995 become increasingly prevalent in drug-related mortality statistics. However, these data must be viewed with reservations: the Central Statistical Office provides data immediately after the post-mortem, i.e. without any toxicology or other complementary laboratory analysis. When the NIPN receives aggregate data at the end of each year, the toxicology results of the past few months are still unavailable and it is very likely that in such cases the cause of death will be mis-coded, i.e. the code will indicate something other than a narcotic drug or its toxic effect.

The following aspects need to be considered if drug related mortality is to be evaluated correctly:

a. drug overdose

accidental
intentional
cannot be established

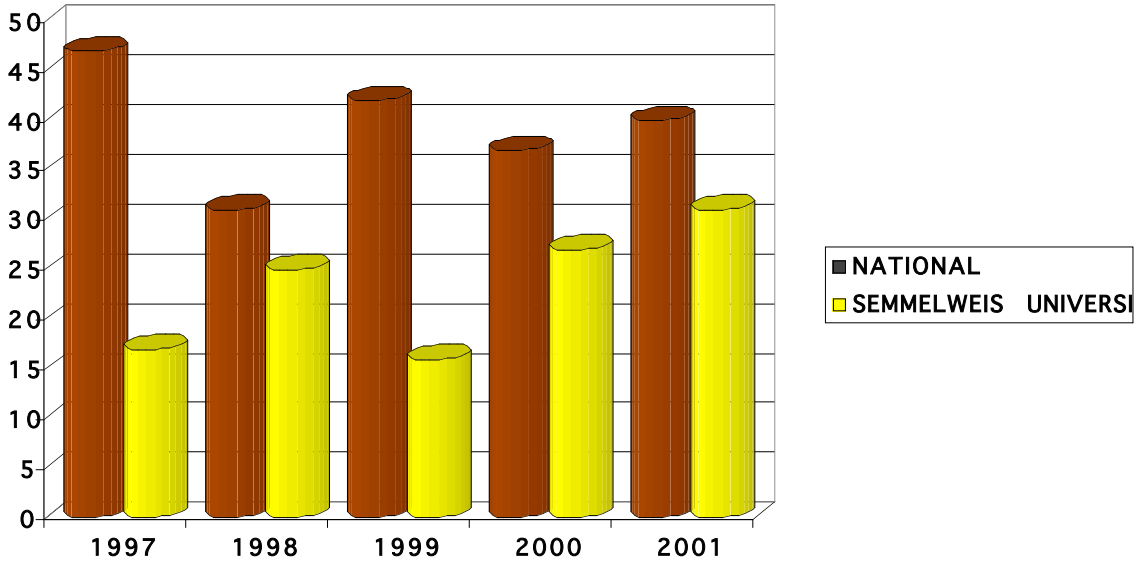
b. caused by chronic drug use
c. suicide – related to drug use but committed in some other manner (jump from a height, slashing one's veins, etc.)
d. accident under the influence of drugs
e. disease related to drug abuse
f. homicide caused by drug use

Working along the above list, however, requires a very detailed medical history, on-the-spot examination and a uniform post-mortem protocol backed up by sufficient funding for laboratory tests.

Drug related mortality in Budapest, 2000-2001

Illegal drug use and drug-related mortality both present a highly varied pattern in Hungary. As most capital cities, Budapest plays a crucial role in this respect. 70% of deaths related to illegal drug use have been recorded in Budapest in recent years.
Since one of the key indicators of drug use is the number of deaths related to illegal drug use, it is important to look into its causes and specific features.

COMPARISON OF DEATHS RELATED TO ILLEGAL DRUG USE, 19



The Forensic Medical Institute of Semmelweis University * investigated deceased patients in 2000-2001 either at the request of the Police or because the post-mortem indicated the presence of illegal drugs.
The cases were processed as follows:

- instruction for an immediate (out-of-turn) post-mortem
- post-mortem protocol
- detailed histology of all organs complemented by a neuropathology test
- laboratory tests
  - toxicology
  - blood/urine alcohol
- serology (if applicable)
  - HIV
  - Hepatitis B and C
  - Lues
- Social background study (interviews with relatives)

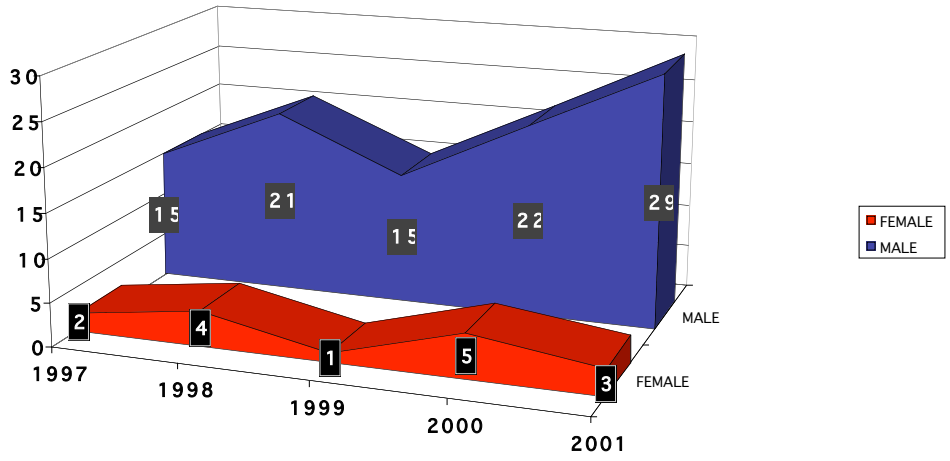
The validity of the study is endorsed by the fact that the post-mortems and complementary examinations were conducted and evaluated by the very same person in 95% of cases. Major findings from the project are listed below.

32 post-mortems were conducted for drug-related deaths in 2000. 27 of the 32 subjects tested positive for toxicology, 5 cases were negative but drugs were found to have contributed to their deaths or the deceased was a chronic drug user. All positive toxicology tests indicated some opiate derivative such as morphine, codeine, or monoacetylmorphine, and in one case both opiate and a THC derivative were found.
While average age was 26 years, the table shows that the highest number of cases fell into the age group 20-29 years. The following table demonstrates a breakdown by age of illegal drug users autopsied at the Forensic Medical Institute of Semmelweis University between 1997 and 2001:

Age	1997	1998	1999	2000	2001
15-19	1	4	2	2	-
20-24	10	11	8	12	15
25-29	4	5	6	9	10
30-34	2	3	-	1	2
35-39	-	-	-	-	2
40-44	-	2	-	-	1
45-49	-	-	-	3	-
50-54	-	-	-	-	-
55-X	-	-	-	-	1
Total	***17***	***25***	***16***	***27***	***31***

There is a prevalence of men among illegal drug users as is evidenced by mortality figures, since only five of the cases examined in 2000 were female.

BREAKDOWN BY GENDER OF DRUG-RELATED DEATHS INVOLVING
TOXICOLOGY TEST, 1997-2001



Combined use of illegal drugs and alcohol was insignificant in 2000; one case showed signs of a slight degree of alcoholic intoxication, while all other cases proved negative.
The serology tests found no HIV infection. Five positive HCV and 2 positive Lues tests were given positive evaluations.
42 drug-related deaths led to post-mortems in 2001.
Of these, **32** positive toxicology test results were found, but even in the **10** negative cases drug-related deaths could be suspected on account of the circumstances or the persons' medical history. Cases in point were suicides committed by known drug users who tested negative for toxicology (hanging, jump from a height, medicaments), as well as cases where circumstances indicated an overdose of drugs (syringes, lemon salt, sooty spoon, brown powder etc. found at the scene), even though the persons tested negative for toxicology.
The ages are distributed between 20 and 46 years with an average of 25 years and all deceased persons except 3 were male.
Toxicology tests pointed to an opiate derivative in 29 cases, cocaine in 2 cases and a volatile substance in one case.

Although Hungarian heroine users were previously noted for consuming practically no alcohol, the trend seems to have been broken in the year 2001, when there was a rise in the number of illegal drug users whose blood/urine alcohol concentration reached a slight to medium level. It has been discovered that those heroine users who have given up the substance will often turn into legal drug users and take alcohol after the drug.
We managed to test for serology 21 out of the 32 persons and 3 out of the 11 persons, i.e. 24 out of the 42 persons.
We found 8 subjects infected with HCV, each testing positive for toxicology. This translates into an infection level of **30%** of all tested persons.
We found 3 persons to have been vaccinated for Hepatitis B, 4 had had a previous Hepatitis B infection, 2 cases of chronic or acute infection were found, and no HIV cases were detected.
Notable pathological lesions included enlargement of the heart, premature coronary arthritis, affected vessels around the cardiac muscle, chronic and acute inflammations in the liver with or without HCV infection, infection-induced inflammation of cardiac valves, or chronic oxygen deficiency in the brain.
It is to be noted that in the case of a chronic heroin user, we found a lesion in the brain (degeneration of the substantia nigra) that indicated the likelihood that the deceased had at an unspecified time given himself a shot of synthetic heroin containing MTPT (N-methyl-4-phenyl-1, 2,3,6 tetrahydropyridine). MTPT, a neurotoxin, produces Parkinson's disease as a long-term effect. A retrograde anamnesis did confirm symptoms of Parkinson's disease.
The two-year study established that the overwhelming majority of registered deaths related to illegal drug use had to do with the intravenous use of opiates/heroin. The question may be raised as to whether our data truly reflect the situation in the light of data from other countries, or it was because of the omission of toxicology tests in cases of sudden death that only opiate/heroin-related mortality was found. It is hard to imagine that no deaths related to "disco drugs" or their effects occur in Hungary. This would be in clear contradiction to international experience. In order that valid or at least broadly reliable data might be obtained, it would be necessary to test for toxicology at least all persons under 40 who died unexpected, sudden, or violent deaths.
The pathological lesions found in the materials reviewed point to a need to consider both the immediate, i.e. acute, as well as the long-term effects of drugs, which in turn requires the health status of illegal drug users to be strictly monitored. Lesions to organs, the heart, liver or the brain tend to affect their re-integration into society, their working abilities and may affect the future generation too.

The serology study calls for further development in education projects aimed at the young generation, in particular young people under disadvantageous circumstances, as well as for the establishment of more free of charge screening centres.

Sources:

*The study conducted at the Forensic Medical Institute of Semmelweis University received support from OTKA T32227, and FKFP 0114/2000, and the Ministry of Youth and Sport.
Keller, É. (2002).). A kábítószer-használattal összefügg_ halálozások alakulása. Kézirat

3.3. Drug-related infectious diseases

Epidemiology

International epidemiology data indicate that the infection level of our community of intravenous drug users (IDU) for HBV and particularly HCV may be in the 70% to 90% range. In some countries where IDU is prevalent, 40% to 60% of HIV infection/AIDS cases are attributable to IDU, e.g. Italy (62.5%), Spain (65.3%), Portugal (44.4%), etc. It is often a source of secondary HIV infection that IDU is often accompanied by prostitution, leading to secondary heterosexual infection affecting a broad clientele. In women, HIV infection accompanying IDU is expected to produce a rise in the number of HIV-infected babies *(HIV/AIDS Surveillance in Europe 1998).*

HIV epidemiology has undergone dramatic change in our region and we have to look at soaring IDU prevalence figures to find the causes. The situation in Ukraine, Moldova, Russia and the Baltic states is best described by the terms "HIV explosion". The scanty information available suggests that the number of HIV-infected persons has risen from a few hundred in 1994 to 100,000, a development almost exclusively attributed to IDU. Cases have been reported where HIV infection in an IDU community rose from about 1% to 52% within 12 months. Researchers succeeded in isolating three HIV-1 sub-types in this epidemic responsible for the infection, notably an HIV 1 A, B and a recombinant variant of these two, HIV-1. The secondary epidemic is put down to IDU-linked prostitution and the birth of infected babies (ca. 25 – 30%) of infected mothers. It is also to be assumed that there has been a hepatitis B and C epidemic similar to the HIV epidemic, although information on this subject is scanty *(UNAIDS/WHO Report 1998).*

Acting on an EMCDDA recommendation, the European Union member states introduced a new type of reporting system in 2001. In Germany, diagnosed hepatitis carriers are centrally registered according to hepatitis type, mode of infection and clinical severity. Drug users treated for intoxication tested positive in the following percentage figures: 2 % for HbsAg, 52 % for anti HBc, 62 % for anti-HBs, 66 % for anti-HCV, and 3.3 % for anti-HIV. A survey of outpatients in Belgium produced the following positive tests among IDU's: anti-HBc 43 %, anti-HCV 80 %, and anti-HIV 6 %. In Sweden, 67% of diagnosed HCV infected persons are IDU's (16). In Greece, 5-6% of IDU's are HBV infected, and 60% HCV infected, while in Spain, the HCV infection rate of IDU's is 88 % *(EMCDDA Report 2001).*

This risk group was studied in Hungary several years ago. Volunteers who remained anonymous offered blood and saliva samples for examination *(Újhelyi, 1997, Újhelyi-Szomor, 2000).* More than 30 drug outpatient centres joined the survey. In **1996-97,** 126 saliva samples and 188 blood samples were tested. The saliva tests were taken from 67 male and 40 female patients and 9 unknown patients, all treated anonymously. Age indications were found to be rather scanty: one sample came from an under-13, 12 samples from the age group 15-19 years, 36 samples from the age group 20-24 years, 11 samples from the age group 25-29 years, 6 samples from the age group 30-34 years, 2 samples from the age group over-35 years and 77 samples were taken from intravenous drug addicts of unknown age. (All these samples were received from the 30-plus drug outpatient centres referred to above.) In 1996-1997, the Toxicology Department of Erzsébet Hospital sent in 188 blood samples. The patients were overdosed intoxicated intravenous drug addicts. No patient was under 14, 34 belonged to the age group 15-19 years (of which 29 were men, 1 a woman, 4 of unknown gender). 67 samples (56 men, 11 women) were taken from the age group 20-24 years, 38 samples (33 men, 5 women) from the age group 25-29 years, 22 samples (18 men, 4 women) from the age group 30-34 years and 22 patients (12 men, 9 women, 1 unknown gender) from the age group over 35. Of the intravenous drug users of unknown age, 2 were male and 3 female. Neither the saliva nor the blood samples tested positive for HIV, no

hepatitis B surface antigens were found in the saliva samples, but 4.4% of the blood samples contained infectious hepatitis B surface antigens. 16% of both the saliva and blood samples tested positive for HCV. The blood samples taken from the various age groups tested positive for HCV in the following percentage terms: 15-19 years – 24%, 20-24 years – 9%, 25-29 years – 24%, 30-34 years – 36%, and the HCV infection rate for the age group 35 and over was 23% *(Újhelyi 1997).*

In **1998-99,** the tests were repeated but the samples were mainly taken from saliva. This time, the Toxicology Department of Erzsébet Hospital did not participate. 335 saliva samples together with a questionnaire analysing drug use patterns and 55 blood samples were sent in by students at the Belvárosi Tanoda (City School), an institute for young people with behaviour disorders, most of them drug users. The 335 saliva samples were taken from 224 men, 99 women, and 12 persons of unknown gender. None of them were under 13, 1 patient (female) was in the age group 13-14 years, 34 persons (19 male, 15 female) in the age group 15-19, 141 drug addicts (105 male and 36 female) in the age group 20-24, 78 (59 male, 19 female) in the age group 25-29, 32 (23 male, 9 female) in the age group 30-34 years and 37 patients (18 male and 19 female) in the age group over 35 years. No HIV infection was found in this survey, the number of HBsAg positive persons was under 1%, and 33 persons were found to be definitely positive for HCV, while in 5 cases the results were uncertain. This series of tests, performed on drug addicts both intravenous and others, detected an HCV infection rate of 10%. (3% in the age group 15-19, 3% in the age group 20-24, 12% in the age group 25-29, 28% in the age group 30-34 and 16% in the age group of over 35.) *(Újhelyi and Szomor, 2000).*

Current surveys

Persons surveyed:
433 samples were taken and tested from various groups of IDU's in 2001 *(Bánhegyi-Újhelyi, Zacher, 2002).*

Supported by the Ministry of Youth and Sport, a new survey was launched in **2001,** chiefly in response to alarming HIV/hepatitis infection figures regularly received from Eastern Europe. There is a constant rise in the number of intravenous drug users, in particular heroin users, who have gone into hiding since a new drug law was introduced and are very difficult to approach.

1./ During the three months of the study (February-May 2001), the Toxicology Department of Erzsébet Hospital sent in 136 blood samples taken from comatose overdosed intravenous drug patients who were taken by ambulance to the hospital for detoxification. They all had several years of drug history. 320 overdosed, unconscious intravenous drug patients were examined until the end of 2001.

2./ The same 3-month-period produced 60 intravenous drug user saliva samples from the Pécs and Budapest Drug Outpatient Centres. These people regularly call at the drug centres for treatment and care. Since they were "repulsed" by the idea of another person pricking them with a needle, they only offered saliva samples, which were then taken by a special device.

3./ The programme extended to intravenous heroin addicts, who kept a secretive lifestyle and were not present in any health care system.
They were approached by social workers, most of them former drug users, and persuaded to agree to sampling. Only saliva samples were taken.
57 intravenous drug users were contacted in Budapest, Szeged and Pécs in the 3-month period.

Since only Erzsébet Hospital was able to furnish relevant data, only 136 patients were broken down by gender and age. The remaining 184 patients' data are being processed and

final data will be available when the one-year survey period is completed. 74% of overdosed drug addicts were men, 26 % were women.
The *age breakdown* presents an alarming picture: nearly half of overdosed intravenous drug patients belong to the age group 20 to 24 years, with the male/female ratio at 2:1. No female patient was found in the age group over 35 years. The data point to the conclusion that the younger the age group, the higher the number of patients affected. It is also to be observed that there are a very high number of very young (13-19 year-old) intravenous drug patients, most of them young boys. Compared with data from 1996-1997 and 1998-1999, this new finding indicates a major shift in this area.

Test protocol
Following HBV infection, the surface antigen HbsAg takes 8 to 24 weeks to become detectable under laboratory circumstances. The first antibody to appear is that against nuclear protein, and this usually happens after 11 to 12 weeks. After every HBV infection, this antibody will be detectable throughout the person's life. The serum, called aHBs, produced against the surface antigen becomes detectable in about 26 weeks after infection, at which time the antigen can no longer be detected. This antibody will also stay with the person for his or her entire life. In the case of anti-HBV vaccination, only anti-HBs is measurable, while anti-HBc is not. In the case of chronic HBV infection, the surface antigen and anti-HBc appear almost simultaneously and remain detectable side-by-side for the rest of the person's life. In a chronic infection, no anti-HBs is ever measurable.
Under the programme, the following tests were made on both the saliva and blood samples: HIV antibody (anti-HIV), HCV antibody (anti-HCV), HBV surface antigen (HbsAg), anti-HBc and anti-HBs tests in order to distinguish between acute and past infections and verify successful vaccination. Primary tests were made by the ELISA method and, where necessary, other tests to confirm the differentiation were performed.

Results

No confirmed HIV positive results were obtained from the 136 blood samples. 28% of intoxicated intravenous drug users were found HCV positive (to be compared with the earlier figure of 16-17%). 1.4% were found to have confirmed acute HBV infection. 13% of women and 8% of men tested positive for an earlier HBV infection. The number of HCV positive persons rose steeply in the period May-December, rising from 27-28 % at the beginning of the year to 31% in May!
Only 7.3% of the drug users tested *were vaccinated against Hepatitis B.*
3.6% of the 136 intoxicated intravenous drug users were found to have had previous HBV infection and were also infected with HCV. From another angle it can be concluded that 5 (38%) of the 13 intravenous drug patients who had been infected with Hepatitis B were infected also with the Hepatitis C virus.
HCV infection prevalence in overdosed intravenous heroin addicts gives rise to some concern. 25% of women and 40% of men in the age group 13-19 years are HCV infected. 50% of women and 10% of men in the age group 30-35 years were found HCV positive. It appears that the higher the age group women belong to, the more they are likely to be HCV positive, while the opposite seems to apply to men.

The summary results of the survey on 386 intoxicated drug patients were as follows:
0/386 HIV infected, 104/386 (27%) HCV positive, 11/386 (3%) HBsAg positive, 68/386 aHBc positive, 75 /386 aHBs positive. This means that 11 drug users (3%) had acute HBV infection, 68 (18%) had an earlier infection of HBV, and only 7 (i.e. 2%) were vaccinated against HBV. (A control group of college students of similar age scored 99% on HBV vaccination.) *(Újhelyi, 2001).* The following table presents a comparative analysis of current and earlier data:

	Number	Sample	Anti-HCV	HBsAg	Anti-HIV
1966/67	146	serum	17 %	4 %	0
1966/67	182	saliva	16 %	4 %	0
2000	140	saliva	30 %	6 %	1*
2000/01	506	serum	30.6 %	4.3 %	0

Conclusions

- Intravenous heroin use is not only on the increase in Hungary but seems to affect ever younger age groups.
- HCV is most prevalent in the age group 13-19 years. (The picture has completely changed since 1996!) The underlying reason is that they do not realise the danger posed by needle and syringe sharing and so they "shoot up" together, using the same devices. Future primary prevention programmes should target this age group in the first place.
- Intravenous drug addicts belong to the most sexually active age group and they seem to be unaware that these infections are sexually transmitted.
- It is also a noteworthy conclusion that this at-risk group in this particular age group received hardly any vaccination for Hepatitis B (2%).
  The HBV vaccination programme should be stepped up and intensified in this at-risk group.
- In an attempt to mitigate the harmful complications resulting from IDU-related infections, harm reduction programmes have been devised. One of these is the needle exchange programme, which is intended to provide drug users with sterile syringes and needles and, more importantly, collect blood-soiled devices, improve self-injection practices (sterility), as well as provide information and counselling and even direct drug users towards substitution programmes. Maintenance treatment with methadone has the double advantage of rendering IDU socially accepted and eliminating infectious complications. IDU's calling at health care institutions should be informed and then their approval sought for conducting serology tests (HBV, HCV, HIV), and should be given active vaccination if found HBV sero-negative. All this would require detailed professional protocols that take infectology considerations into account.

Sources:

This chapter was written on the basis of a manuscript *Risks of infection in intravenous drug use* by Bánhegyi, D., Újhelyi, E., Zacher, G. (2001).

Bánhegyi, D., Füst, Gy. (1998). A HIV-betegség kezelése antiretrovirális

Chandrasekar, P.H., et al. (1986). Bone and joint infections in intravenous drug abusers *Rev Infect Dis* 8:904-910.

Cherubin, C.E. (1971). Infectious disease problems of narcotic addicts *Arch Intern Med* 128:309-316.

Desmet, JV, et al. (1994). Classification of viral hepatitis. Diagnosis, grading and staging *Hepatology* 19:1513-1520.

EMCDDA Report (2001).,Lisbon, 30 November – 2 December 2001.

HIV/AIDS Surveillance in Europe (1998). 1998/2.

Johnson, J.R., et al. (1983). Mycotic aneurism: New concepts in therapy *Arch Surg* 118:577-587.

Klatt, E.C. et al (1990). J*ournal of Forensics Sciences* 35:1143-48.

Levin, D.P., et al. (1986). Bacteremia in narcotic addicts at the Detroit Medical Center: II. Infectious endocarditis. A prospective comparative study. *Rev Infect Dis* 8:374-395

Marantz P.R., et al(1987). Inability to predict diagnosis in febrile intravenous drug abusers *Ann Intern Med* 106:823-828

Martinez F., Watson R.R. (1990). Effects of cocaine and morphine on IgG production by human peripheral blood lymphocytes in vitro. *Life Sci* 47:59-64

Nicolini R., Rubinstein R. (1991). Psychiatric aspects in the management of the hospitalized intravenous drug abuser. In Levine DP, Sobel JD, eds. Infections in Intravenous Drug Abusers New York, Oxford University Press, 68-80.
Peterson P.K., et al (1991). Opiates, human peripheral blood mononuclear cells and HIV. In Friedman, et al. Drugs of Abuse, Immunity and Immunodeficiency, New York, Plenum press, 171-178.
Samet J.H., et al (1998). Hospitalization decision in febrile intravenous drug abuser (1990) *Am J Med* 89:53-57
Selvyn P.A., et al. (1989). A prospective study of the risk of tuberculosis among intravenous drug users with human immunodeficiency virus infection. N Engl J Med 320:545-550
Shehab T.M., Moselay R.H. (1998). Viral hepatitis. *Curr Opin Gastroenterol* 14:228-233
Szomor, K., Ujhelyi, E. (2000). WHO report
Ujhelyi, E. (2001). EMCDDA conference. Lecture. 30.11.-02.12 Lisbon
Ujhelyi E. (1997). A Nemzeti AIDS Bizottság éves jelentése.
UNAIDS/WHO Report (1998).
Wallace R, et al. (1986). Social, economic and surgical anatomy of a drug-related abscess. *Am Surg* 52:398-401.

3.4. Other drug-related morbidity – Drug overdoses in Budapest

The Emergency Internal and Clinical Toxicology Department of Erzsébet Hospital are in a special situation: being the only Toxicology Department in the capital, it receives all toxicology cases in Budapest and its conurbation. This means 7,500 patients yearly, 10-12% of whom are drug-overdosed or drug-diseased. The two notions are not the same since a drug diseased patient means a person addicted to drugs, while a portion of overdosed persons may be occasional or even first-time users.
Drug-related morbidity primarily afflicts towns and cities. As we move away from Budapest, we will find fewer and fewer regular users and overdosed patients. The capital city produces 90% of patients, while only two-thirds of the people treated live here.

Opiates
80% of overdosed patients are heroin addicts. The number of intravenous heroin addicts in Budapest is estimated at 7,000 to 8,000. 25% of them have been our patients in the past 4 years. They have been screened for hepatitis and HIV since 15. 02. 2001. 35% have been found HCV positive, while not a single HIV positive has been found so far.
The patients are most often found in their homes or out on the street. Drug users often frequent squares, open spaces and deserted unlit streets. The third most obvious place to find them are health care institutions, which normally do very little to attend to these people; they prefer to call an ambulance and have them transferred to our department. There have been about equal numbers of patients brought to the department from shopping centres, fast food restaurants, Police stations and staircases.
Staircases deserve special mention because that is where most deaths occur. To explain this phenomenon, it should be recalled that people rarely use the roof exit in large blocks of flats and so the top floor landing offers a safe haven for shooting up. The high figures found in shopping malls and fast food restaurants are attributable to the fact that they are relatively safe places both for dealers and buyers. Also, these places have the highest number of young people per square metre; it is easy to vanish in the crowd but a deserted toilet cubicle is an excellent place for self-injection. It is interesting to note that no opiate-overdosed patients have been brought in from a disco bar. The reason is that the sale of opiates in such places is minimal, while other drugs are in abundance there.

The level of pre-hospital treatment for opiate-overdosed patients can only be highly commended. Intubations, artificial breathing and administration of Narcanti are almost routinely done in the case of patients in need. The outpatient unit of the Toxicology Department of Erzsébet Hospital is fully equipped to attend to patients. The patients received here are soon stabilised, their brains clear up and breathing returns to normal. These patients leave the department after a brief period of hospitalisation. About 5% are afflicted with complications, such as heroine-induced breathing problems, rhabdomyolysis, followed by renal insufficiency, infection of the viscera, cysts and superficial infections of veins.
Every female patient received is tested for pregnancy and in the event of a positive result the patient is informed that termination of her pregnancy would be medically advisable.
As opposed to death on location, mortality at the ward is very low: only one or two patients are lost yearly, and always on account of sepsis.
Only very few patients are sent from the department to detoxification in an acute condition. The department detoxifies 25-30 patients a year. It is regrettable that only a small proportion of drug-diseased people are willing to undergo this difficult treatment. About 10-15% of them call at a drug outpatient centre where they receive treatment or are given a future date for admission to an addictology department.
Methadone overdose or poppy infusion consumption are very rare occurrences. Their combined annual figure is not more than 25. Heroin sniffing or overdose following sniffing did not happen last year.

Marijuana
This substance causes mild physical symptoms. Most of those brought to the department are first-time users in a mildly disturbed state of mind with a rapid pulse and elevated blood pressure. They are mostly young people who panicked, just like the company they were in, and called the ambulance. With the use of beta-blockers and mild sedatives they are restored to normal status in 4-6 hours. No serious complications have been recorded at the department. The patients are routinely warned of the dangers of drug use before they leave. It is interesting to note that the department has had no returning patients. These youngsters are mostly brought in at weekends or during school holidays.

Hashish
Hashish plays no role on the domestic drug scene: it is simply alien to the local drug consumption culture. 2-3 patients admit to regular hashish use on an annual basis.

Amphetamine derivatives
The patients primarily use tablets or sniff powder. Intravenous users number 2-3 annually. They are admitted usually at weekends in a confused state of mind, with a high body temperature, usually dehydrated and with a rapid pulse. The therapeutic strategy used in such cases meets international standards. Haemodialysis has so far been used only once when an under-aged patient took 6 Ecstasy tablets out of curiosity and the toxin had to be eliminated. No lasting psychic damage has been recorded, however, psychosis has sometimes occurred but these patients eventually recovered. Half of our patients had a talk with our psychiatrist or psychologist before they left hospital. We have had three returning patients so far.

Cocaine
Cocaine is the dark horse in Hungary. There are no reliable figures on regular and occasional users and related damage to health. The department admits 4-6 patients yearly, who complain of chest pains, a confused state of mind and other complications following cocaine use.
How is this to be explained? Cocaine is primarily a class drug. (We have not met a crack user yet): it is only affordable for the well-off. Many patients will not call a doctor, or if they do, they will pay a private doctor to come to their homes. Patients admitted to hospitals with chest pains or other circulatory failure will not be suspected of cocaine use, which the

patients are reluctant to disclose of their own accord. This situation is not covered in domestic methodology briefs or diagnostic protocols, even though administration of beta-blockers for cocaine-induced acute myocardial infarction is contraindicated.
This is a problem that needs to be remedied by all means as cocaine is present in this country and the health care system is not prepared either to diagnose or treat the patients.

Body packers
This is a commonly used form of drug trafficking. Body packers primarily smuggle high-quality cocaine and heroin across airport border crossing points. 8-10 persons are treated annually: except for one or two of them, they are foreign nationals, mostly Romanian. The drug couriers are taken to the department to enable safe extraction of the capsules. The patient has his bowels washed and receives laxative treatment and excretes the 40-100 capsules in 2-3 days. We have not encountered any complications (intestinal obstruction, capsule burst). The detainees are placed in an isolated ward and receive constant Police attendance. Their treatment is in conformity with the rights of citizens and the laws of the country.

Phytotoxins
For purposes of this survey, it is primarily atropine, a toxin containing vegetable alkaloids, that needs to be considered in Hungary. It is very rare for mescaline or psilocybin-containing plants (Liberty cap - Lophophora Williamsii, inocybe) to be consumed in this country. Overdosing has not been encountered. Most cases involving phytotoxins are caused by the accidental or intentional consumption of thorn apple, henbane or deadly nightshade. Accidental overdosing often occurs because the patient mistakes deadly nightshade for cornel. Chewing the seeds of deadly nightshade or drinking an infusion made from them are forms of drug-taking practised mostly by the age group 13-15 years. The effects include very strong hallucinations, rapid heartbeat, high blood pressure and dry mucous membrane. It is one of the few cases of poisoning for which there is an antidote, since the symptoms will quickly disappear if physostigmine is administered while circulation is constantly monitored. All patients recovered. The young people accepted recounted that they had been curious to try the effects of the substance. Some of them inadvertently poisoned themselves simply for lack of appropriate knowledge of plants.

LSD
Not particularly common in Hungary. Rarely found in overdose cases. Patients are most frequently accepted to the department on account of hallucinations or disturbed states of mind. Slight physical symptoms are usually accompanied by wild hallucinations. Patients' somatic recovery is rapid while psychic effects take much longer to disappear. Some patients at the department have retained lasting psychic disorders.

Ketamines
Consumed mainly by health care staff who have rather easy access to the drug. When under ketamine influence, users tend to behave in an aggressive manner. Its effects can be neutralised by intravenous administration of benzodiazepines. 2-3 overdosed ketamine patients are received annually.

PCP, GHB, Khat
These drugs play no role in drug overdose cases in Hungary.

Inhalants
Sniffing had become quite widespread in this country before the change of regime. It came with the emergence of youth gangs, chiefly recruited from the newly formed stratum of housing-estate kids. Inhalant abuse is more often found among the Roma population than among Hungarians. Originally confined to traditional glues and inhalants, sniffing has since spread to substances such as nitrous oxide (as found in cartridges for making whipped

cream), butane (in recharge cartridges for lighters), ether and various alkyl nitrites. Patients are picked up predominantly in public areas, where they are found in a confused or dazed mental state. Sniffing is responsible for a large number of deaths on account of suffocation (sniffer's head stuck inside the plastic bag) or burning (patient lights a cigarette after sniffing). One case of sudden sniffer death involving an under-aged victim has regrettably been recorded. Lasting inhalant use produces dementia similar to early Alzheimer's disease. Like opiate addicts, sniffers are also difficult to approach. Although their social status has deteriorated, they refuse to accept help. Therapy for overdose is symptomatic, specific treatment is required only for complications (burns).

Polydrug use

This group contains persons using several types of medicines or narcotic drugs and medicines at the same time. (This study does not include non-drug addicts, i.e. chiefly benzodiazepine and meprobamate users.)

In addition to sniffing or drinking poppy infusion, or in an effort to reduce withdrawal symptoms when drugs are unavailable, addicts often take large doses of various benzodiazepines, carbamazepine derivatives or glutethimide (production of the latter was discontinued in November 2001). Their effects include restricted mental capacities, coma or slightly difficult breathing. Administering flumanezil can quickly relieve benzodiazepine-related affects, although its half-life is rather short so its effect runs out quite quickly.

Drug-overdose cases related to the capital and County Pest make up at least 90% of all cases in Hungary. Patients from the country mainly come from large university towns whose combined population however is less than that of the capital alone.
In the capital city, the inner parts of Districts IV, VI, VII, IX, XI, XII, XIII are most affected and 70% of all overdosed patients are brought in from these areas. The average age of overdosed patients is 23 and 2/3 of them are male. All intravenous opiate users are jobless and 40% of them have a Police record.

The largest group of hospitalised overdosed patients is that of opiate users, the second is that of inhalant users. Although THC-containing cigarettes are smoked in the largest numbers, their users hospitalised for their somatic or psychic effects represent the smallest group, in terms of relative share, of hospitalised addicts.
0.5% of drug-users, in particular intravenous heroin users, die from an overdose in Budapest. This is mainly due to the fact that some new 'stuff' of higher-than-usual purity unexpectedly appears on the market. Premeditated 'golden shots' are infrequent. The first intravenous use of heroin is a high-risk affair. Several drug patients do so in an effort to get admitted to a hospital partly for social reasons (they are homeless) and partly with a view to stealing medicines or property from their fellow patients. These are probably some of the factors that render drug-addicted and drug-overdosed patients difficult to deal with.

There has been a rising trend in the number of drug-overdosed patients treated at the department since 1996. The trend climaxed in 2000, and has since slightly reversed. The department is currently capable of attending exclusively to these patients but their detoxification and rehabilitation are not properly organised. This problem should be remedied by all means.

Sources:

Zacher, G. (2001). Drogtúladagolások – f_városi helyzetkép. Kézirat.

4. Social and Legal Correlates and Consequences

4.1. Social problems

Social correlates of drug abuse

The literature written on research into the social correlates of drug abuse would fill libraries. Rather than attempting to summarise the literature, it will suffice to refer to the 1999 report of the United Nations Commission on Narcotic Drugs[18], which tackles the issue from the point of view of the international community. The report notes that the universal spread of illicit drug use has in its background a number of rapid social and technological changes that young people are unable to adjust to and an increasingly competitive society. There is an explicit pressure on the person to be successful and a pronounced pursuit of individual goals. All this is accompanied by a weakening of traditional values and family ties. Young people are increasingly exposed to the effects of popular youth culture and the mass media, which project messages of tolerance for the consumption of some illicit substances. These messages create an illusion to the effect that recreational drug use is acceptable and even advantageous in the context of consuming material goods for its own sake and satisfying individual needs. A sizeable minority of young people experiment with illegal drugs as part of a search for personal independence and identity, but they usually abandon such practices when they reach a mature age. The outcome is largely dependent on the person's problem-solving capacity. Persons with underdeveloped problem-solving and coping skills are more likely to develop and maintain drug abuse.

Drug abuse has appeared in all strata of society; in the case of youth excluded from social integration, however, there is an increased likelihood of drug use with all its negative implications. Combatting drug use therefore requires a complex package of economic and social policy, educational and health care measures. Economic and social policies may prevent sizeable strata of the population from being excluded from education, the labour market and social integration in a general sense. A substantial rise in the living standard across society will, however, not be enough to check the spread of drug abuse (the large-scale use of drugs in Western Europe occurred in the 1950-1960-1970s, i.e. the period in which welfare societies emerged). Thus, it is important to lay emphasis on social and community values, family and institutional education and prospects of individual progress.
Some issues related to illicit drugs – production, trafficking, distribution, money-laundering, accumulation of unlawful wealth, etc. – are not only (or not at all) related to youth: they are the concern of the entire society or even the international community. Also, issues related to drug use and addiction must not be viewed as youth-related, even thought they are most prevalent in young age groups: they have far-reaching social, health and criminological effects. Prevention, this crucial method of social intervention, will only be effective if all sectors and strata of society participate in it.

[18] United Nations: Economic and Social Council (11 January 1999), Commission on Narcotic Drugs, Forty-second session, Vienna, 16-25 March 1999: Reduction of demand for illegal drugs: world situation with regard to drug abuse, with particular emphasis on youth and drug abuse. Youth and drugs: a global overview. Report of the Secretariat.

4.2. Drug offences and drug-related crime in Hungary

4.2.1. Drug-related crime as reflected in crime statistics

The registration system of Hungarian crime statistics (Uniform Crime Statistics of the Police and the Attorneys Office – ERÜBS) is output-driven, i.e. data are recorded only after the Police and attorney's procedures have been terminated. The data produced will, therefore, relate to offences for which prosecution was terminated in the given year. Proceedings can be terminated for a variety of reasons and in various manners. The following are the most usual methods of terminating criminal proceedings: refusal to investigate (e.g., the act is not a crime, the person is not punishable), termination of investigation (e.g., perpetrator remained unknown, perpetrator was discovered to be not punishable, reprimand, the suspect did not commit the crime), indictment (e.g., written charge, motion to prosecute, waiver of trial), others (e.g., non-suit, suspension of investigation, deferral).

The crime registration system is so devised that a perpetrator is filed for only one (the most serious) crime. So if a person has perpetrated the offence of drug abuse but is being prosecuted for some other, more serious, crime, then he or she will be registered for this latter (more serious) crime in the statistical system, provided that the two crimes are regarded as cumulative. This explains why such cases are outside drug-related statistics and cannot be analysed.
On terminating proceedings, the prosecuting authority fills out a statistical data sheet on each crime and each perpetrator. This is where data collection is "individualised". When completed, "B" sheets (for B_ncselekmény = crime) and "T" sheets (Terhelt = respondent) are processed. In these, data about the crime perpetrated and the person suspected of perpetration are laid down according to certain criteria.

Criminal offences

In Hungary's crime statistics system, drug-related crime falls under two categories, abuse of drugs (282. §, and 282/A. §) and induction of a morbid passion (283. §). 2001 crime statistics feature 4,332 cases of drug abuse and 82 of induction of morbid passion, which means that these cases were terminated in the year under review. This survey will only tackle the crime of drug abuse (282. § and 282/A: §) and related perpetrators.
ERÜBS data lead to the conclusion that there was a further rise in the number of detected (discovered) cases of drug abuse in 2001.

To put Hungary's drug-related crime scene in proper prospective, it should be noted that the share of the crime "abuse of drugs" within the total number of crimes committed had never been higher than 0.1% before 1996. The figure rose to 0.3% in 1998, 0.56% in 1999 and 0.76% in 2000. It nearly reached 1% (0.93%) in 2001. The figures show that between 1996 and 1998 the number of drug abuse cases almost doubled from one year to the next but the trend somewhat slackened in 1999. The overall increase can be put down to restraints on law enforcement practices.

The table shows the frequency of detected drug abuse cases and the increase from one year to the next.

Year	Cases of drug abuse	Growth (%)
1990	34	64.15
1991	46	135.29
1992	135	293.48
1993	223	165.19
1994	256	114.80
1995	429	167.58
1996	440	102.56
1997	943	214.32
1998	2,068	219.30
1999	2,860	138.30
2000	3,445	120.45
2001	4332	125,74

The number of detected drug abuse cases grew further in 2001. Having dropped from 38% in 1999 to 20% in 2000, the annual rate of growth rose to 25% in 2001. This figure, however, should not lead one to any conclusion as to overall trends on the country's drug scene.
It is noteworthy that the 25.7% rise in drug abuse cases coincided with a mere 3.3% growth in the total number of criminal offences registered. Although drug-related crime has increased in relative terms it is still not particularly significant.
Given that the ERÜBS system is output-based, the data produced always lag behind the events they represent, something that should not be ignored in the analytical process. The following table breaks down crime figures according to the year of perpetration:

Year of perpetration	*Number of cases*	*%*
1994-1996	23	0.4
1997-1998	228	5.3
1999	579	13.4
2000	2,242	51.8
2001	1,260	29.1

A breakdown by year of perpetration presents relative proportions similar to those in previous years. Just a little over one-fourth of 2001 data are crimes actually committed in 2001. Three-quarters of the crimes in this box were committed in previous years, mostly in 2000. The legal proceedings were delayed partly because several expert opinions (from the toxicologist, chemical expert, forensic medical expert) had to be obtained, and partly because a number of perpetrators were diverted to therapeutic treatment as an alternative to criminal proceedings. Ritter's survey of 2001 shows that the average length of proceedings was 12.7 months before the amendment to the law took effect on 1 March 1999, while the average length was subsequently reduced to 7.7 months. That is, it took this long for an average-length investigation of a drug abuse case to be terminated. Termination means that the case was dropped, the investigation completed or suspended, or again charges were brought against the perpetrator.
There was a continued decline in the share of criminal offences to minor offences within the total of criminal acts. The proportion of misdemeanours stood at 65% in 1994-1198, dropping to 45.6% in 1999, and rising again to 62.5% in 2000. The upward trend continued in 2001. *Three-quarters (74.8%) of detected drug-related criminal acts fall into the category of misdemeanour,* where the perpetrator either consumed or passed on the drug, and even though the tolerance limits have been raised, the quantities involved were relatively small.
The 2001 figures lead to the conclusion that judges have by now adjusted to the new legislation enabling a more differentiated sentencing practice. This partly explains why the

frequency of certain drug-related crimes has been found to increase or decrease substantially:

- The number of proceedings initiated for consumption of drugs – Article (9) point a) – more than doubled from 2000 to 2001. This type of crime accounts for 39.4% of all drug abuse cases. (The figure was 26.5% in 2000.)
- The number of terminated cases of soliciting, inducing or undertaking to perpetrate an act of drug abuse – Article (7) – was almost halved in 2000. The decline continued in 2001: there were only 20 proven cases of this type of crime in that year.
- There was a rise in the number of cases on the supply side. These are chiefly related to more vigorous activity on the part of persons either passing on or, to a lesser extent, marketing drugs.
- 7 cases of perpetration in a criminal organisation were proved in 2001.
- There was also a rise in the number of cases perpetrated in a protected place.
- All kinds of drug abuse perpetrated by drug addicts were detected in higher numbers.
- Crime figures of 1999 and 2000 indicated a trend, confirmed by data from 2000, that there has been a constant rise in supply-side criminality in the form of distribution (principally passing drugs on), as is evidenced in the rising number of prosecuted cases, however, the *major driver in the rising number of drug abuse cases is criminality on the demand side, in particular acts committed by occasional users*.

Territorial distribution

The following is a breakdown by region (place of perpetration) of drug abuse crime:

PLACE OF PERPETRATION	2000		2001	
	Cases	%	Cases	%
Budapest	1,197	34.8	1,520	35.1
Baranya county	167	4.6	197	4.5
Bács-Kiskun county	89	2.3	133	3.1
Békés county	202	5.9	122	2.8
Borsod-Abaúj-Zemplén county	164	4.7	232	5.4
Csongrád county	227	6.7	291	6.7
Fejér county	103	3.1	193	4.5
Gy_r-Moson-Sopron county	253	7.4	171	3.9
Hajdú-Bihar county	99	2.9	84	1.9
Heves county	55	1.6	157	3.6
Komárom-Esztergom county	100	2.9	179	4.1
Nógrád county	61	1.7	61	1.4
Pest county	157	4.6	295	6.8
Somogy county	95	2.8	176	4.1
Szabolcs-Szatmár-Bereg county	85	2.5	59	1.4
Jász-Nagykun-Szolnok county	72	2.1	79	1.8
Tolna county	131	3.9	62	1.4
Vas county	98	9	89	2.1
Veszprém county	63	1.8	177	4.1
Zala county	22	0.6	48	1.1
Abroad	5	0.2	7	0.2
Total:	3,445	100.00	4,332	100.0

(Source: ERÜBS)

Under Hungarian law, a Hungarian citizen committing a crime in a foreign country is punishable provided that the act qualifies as a forbidden deed under any provision of the Hungarian Criminal Code. Abuse of drugs is, therefore, a criminal offence whether it was perpetrated in Hungary on in a foreign country. 2001 crime statistics show 7 crimes of this type perpetrated abroad.

Detected drug abuse criminality has grown all over the country and the trend continued in 2001. The rate of prevalence is, however, different from one region of the country to another.

Most drug abuse cases take place in the capital city. About one-fourth of detected crimes featuring in criminal statistics are perpetrated in Budapest (the exact figure was 22.2% in 2001). The prevalence of drug-related crime in the capital is even higher: 35.1% of all criminal acts related to drug abuse were committed in Budapest in 2001.

Pest, Csongrád and Borsod-Abaúj-Zemplén head the crime list of counties. Except for counties Hajdú-Bihar, Nógrád, Gy_r-Moson-Sopron, Békés and Tolna, the county level figures for detected drug abuse cases have risen. The steepest growth figures were recorded in counties Pest, Somogy, Heves and Veszprém.

It should not be forgotten that crime statistics cannot be used in a direct manner to measure the extent to which a given area is affected by drug consumption and distribution: the number of detected criminal offences largely depends on targeted action by, and the drug-related sensitivity of, local law enforcement, which is not necessarily proportional to the local prevalence of this type of crime.

Police detection work and its effectiveness are strongly influenced by the given personnel and technical conditions.

Drug-related crime types as detected in 2001

TYPE OF CRIME	2000 Criminal acts		2001 Criminal acts		2000 Perpetrators		2001 Perpetrators	
	Cases	**%**	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
282. § /1/: Drug abuse **(DA**): grow, produce, obtain, hold, import, export	315	9.14	240	5.54	244	7.99	179	4.57
282.§ /2/: DA: offer, pass on, market, trade	105	3.05	134	3.09	94	3.08	130	3.32
282.§ /3/: DA: on a business-like scale, with firearms, official or functionary /1/	31	0.90	38	0.88	34	1.11	33	0.84
282.§ /3/: DA: on a business-like scale, with firearms, official or functionary /2/	79	2.29	147	3.39	79	2.59	144	3.68
282.§ /4/: DA: in a protected place of building /2/	28	0.81	43	0.99	30	0.98	30	0.77
282.§ /5/a: DA: significant quantity of drugs /1/	81	2.35	78	1.80	73	2.39	69	1.76
282.§ /5/a: DA: significant quantity of drugs /2/	30	0.87	49	1.14	30	0.98	46	1.17
282.§ /5/b: DA: as a member of criminal organisation /1/	2	0.06	7	0.16	3	0.10	19	0.49
282.§ /5/b: DA : as a member of criminal organisation /2/	2	0.06	0	0.00	3	0.10	0	0
282.§ /6/: DA for pecuniary remuneration /1/	388	11.26	134	3.09	353	11.55	132	3.37
282.§ /6/: DA: for pecuniary remuneration /2/	18	0.52	13	0.30	16	0.52	9	0.23
282.§ /7/: DA: perpetrate by offering, inducing undertaking	38	1.10	20	0.47	31	1.01	16	0.41
282.§ /8/: DA: perpetration involving insignificant quantity /1/	862	25.02	916	21.15	755	24.71	803	20.5
282.§ /8/: DA: perpetration involving insignificant quantity /2/	243	7.05	358	8.27	227	7.43	322	8.22
282.§ /9/a: DA: with drug consumption	915	26.56	1711	39.49	836	27.36	1601	40.87
282.§ /9/b: DA: public incitement for consumption	35	1.02	30	0.69	26	0.85	30	0.77
282/A.§ /1/: Drug addict: grow, produce, hold	45	1.31	52	1.20	38	1.24	40	1.02
282/A.§ /2/: Drug addict: offer, sell…	31	0.90	37	0.85	28	0.92	34	0.87
282/A.§ /3/: Drug addict: perpetrated on a business-like scale/1/	8	0.23	7	0.16	7	0.23	7	0.18
282/A.§ /3/: Drug addict: perpetrated on a business-like scale/2/	25	0.73	39	0.90	22	0.72	35	0.89
282/A.§ /4/: Drug addict: significant quantity /1/	13	0.38	20	0.47	14	0.46	16	0.41
282/A.§ /4/: Drug addict: significant quantity /2/	17	0.49	21	0.48	16	0.52	22	0.56
282/A.§ /5/a: Drug addict: with consumption of drugs	80	2.32	193	4.46	53	1.73	163	4.16
282/A.§ /5/b: Drug addict: consumption of insignificant quantity	36	1.04	29	0.67	29	0.95	22	0.56
282/A.§ /5/c: Drug addict: offers insignificant quantity to adults	18	0.52	16	0.36	14	0.46	15	0.38
Total:	**3,445**	**100.00**	**4,432**	**100.00**	**3,055**	**100.00**	**3,917**	**100.0**

Termination of proceedings

The case was dropped (non-suit) in a total of 16 cases. The investigation was discontinued mostly because the authorities issued a reprimand or the perpetrators had documented evidence of diversion (treatment as an alternative to punishment), or the perpetrators were found to be not punishable for some reason.
43 cases were discontinued because of the death of the perpetrator in 2001. Charges were brought against the perpetrators in 2,865 cases. The prosecution often called for a pecuniary fine or asked for the trial to be waived and the perpetrator put on probation.

Modes of termination	2000		2001	
	Cases	%	Cases	%
Non-suit	5	0.1	16	0.4
Termination of investigation	1,131	32.9	849	21.1
Indictment	2,141	62.1	2,865	71.2
Other	168	4.9	295	7.3
Total	3,445	100.0	4,025	100.0

The number of indictments sharply rose in 2001, coupled with a drop in discontinued investigations. This is mostly explained by the fact that an amendment to the law that took effect in 1999 restricted the circle of perpetrators eligible for diversion. The former practice of diversion where the perpetrator was given medical treatment as an alternative to criminal proceedings followed by suspension of the investigation and by subsequent termination provided that completion of the treatment was documented, was now restricted to drug-addicted perpetrators.
Of other modes of termination, *deferral of indictment* was the most frequent. While prosecutors resorted to this institution in 151 cases in 2000, the figure rose to 280 in 2001.
The share of under-aged persons among all drug-related perpetrators with deferred indictment was 53.6% in 1999, 56.3% in 2000, and 44.3% in 2001.

Cases of deferred indictment

	1999	2000	2001
Total number of deferred indictments	1,992	2,426	
Of which, under-aged drug-crime perpetrators	30	85	124
Of which, adult drug crime perpetrators	26	66	156
Of which, drug crime perpetrators total	56	151	280

(Source: ERÜBS)

There was a major rise (85.4%) in the number of deferred indictments in 2000. Prosecutors seem more and more inclined to resort to this legal institution in the case of minor offences perpetrated on the demand side. While young offenders previously dominated this group, there were more adults than under-aged whose indictments were deferred in 2001.

Perpetrators

Drug-abuse is age-specific. Most affected are under-aged persons and young adults.

- The number of detected criminal offences related to drug abuse rose by 25.7% from 2000 to 2001, while the number of perpetrators of drug abuse, by 28.2%. Growth slowed down in 2000, but picked up again in 2001. It is well-known that crime statistics are indicators of the efficiency of law enforcement and their capacity limits rather than those of real trends in drug consumption or in the drug markets. There has been no rise in the number of law enforcement units specialising in drug-crime since 1999, nor has there been any

substantial change in related technology and financing. Given the present resources, neither a substantial improvement in drug policing nor higher crime detection figures are to be expected.

- It should be noted that there is a further rise in the number of under-aged perpetrators of drug-related criminal offences. Their proportion of all criminal offenders was 3.9% in 2000, while they constituted 14.88% of all drug abuse offenders. The respective figures had grown to 5.9% and 17.1% by 2001! *In other words, 2001 crime statistics demonstrate that practically one in six perpetrators of the criminal offence of drug abuse was under-aged*!
- The growth rate of young people affected by drug-abuse criminality surpasses that of all perpetrators of such crimes. This means that the age gap between drug-related criminals and other perpetrators has broadened. This type of crime is perpetrated typically at a lower age than are other types of crime. While 93% of drug criminals perpetrated their offences before they reached 31 years of age, the relevant figure for perpetrators of other crimes is below 60%.

Crime statistics break down perpetrators of some criminal act into two categories. The term *criminal perpetrators* denotes those persons who can be punished for criminal acts perpetrated by them, while the other group of *perpetrators* cannot be punished for their deeds for some reason. The following tables will present the distribution of perpetrators by age, gender and schooling. This means that the above socio-demographic data will include all persons who, according to crime statistics issued for the year 2001, perpetrated the crime of drug abuse (irrespective of whether they were punishable or not).

Breakdown by gender

The percentage figures for gender breakdown are similar to those of earlier years: 90% of drug abuse perpetrators were male, 10% female.

Breakdown by age

Trends in detected under-aged perpetration of drug abuse:

Year	Number of perpetrators of drug crimes	Of which, under-aged	Share of under-aged (%)
1990	38	10	26.3
1991	53	2	3.8
1992	116	11	9.5
1993	247	29	11.7
1994	260	8	3.0
1995	459	17	3.7
1996	483	52	10.8
1997	926	94	10.2
1998	1,800	227	12.6
1999	2,718	378	13.9
2000	3,562	530	14.8
2001	4,025	689	17.1

It can be concluded that both the number and the share of young people perpetrating drug-related crimes increase every year.

The following table shows the breakdown by age of drug abuse perpetrators:

Age groups	1999		2000		2001	
	Cases	%	Cases	%	Cases	%
Minor	9	0.33	5	0.14	13	0.3
Juvenile	378	13.91	530	14.88	689	17.1
18–24 years	1,664	61.22	2,086	58.56	2,334	58.0
25–30 years	459	16.89	618	17.35	707	17.6
31–40 years	157	5.78	204	5.73	215	5.3
41–50 years	34	1.25	48	1.35	46	1.1
51–60 years	11	0.40	12	0.34	11	0.3
61 years or over	6	0.22	59	1.66	10	0.2
Total	2,718	100.00	3,562	100.00	4,025	100.0

Distribution by age has not changed substantially. There is a slight rise in the number of drug abuses in the under-30 age group. The steepest rise is found in the age group 14-18 years, i.e. that of juvenile persons. The age groups over 30 show a slight decline. *The trend whereby the highest number of legal proceedings is brought against young adults (18-24 years) has continued.*

Breakdown by schooling

48.2% of drug abusers had general school certificates, 28.6% were skilled workers, and 21.3% had other secondary school certificates in 2001. The "average" drug-criminal has higher schooling than the "average" criminal offender.

	1999		2000		2001	
	Cases	%	Cases	%	Cases	%
None	110	4.0	128	4.0	4	0.1
8 forms of general school	1,113	41.0	1,316	41.6	1,942	48.2
Vocational school	846	31.1	1,009	31.9	1,152	28.6
Secondary school	598	22.0	646	20.4	856	21.3
University, college	51	1.9	67	2.1	71	1.8
Total	2,718	100.00	3,166*	100.00	4,025	100.0

*****- Data related to schooling were not always available for collection, therefore the aggregate number of cases is lower than the total number of detected perpetrators.

The number and share of those having general school certificates have substantially grown in the light of 2001 crime figures. There were hardly any perpetrators without at least a general school certificate, or else they were attending general school at the time of perpetration.
There was also a substantial increase from 2000 to 2001 in the number of perpetrators with either a technical secondary school or a grammar school certificate.
This means that drug crime perpetrators have retained or improved the advantage over other perpetrators in terms of schooling.

Breakdown by criminal record

There has been a steady rise in the proportion of persons with a criminal record in the number of drug abuse perpetrators since the early 1990s. Their share was 20% at the beginning of the decade; it rose to 25% by the mid-1990s and reached 29.3% in 1999. The figure remained virtually unchanged in 2001: The proportion of persons with a criminal record

stood at 29.4%. On the other hand, there was a rise in the proportion of repeat offenders (persons who had been punished before, but for non-drug related offences): their share stands at 81.7%.
The most frequent types of crime previously perpetrated include theft, causing of public nuisance, bodily harm and robbery. Available data indicate that repeat offenders charged with the crime of drug abuse had been typically prosecuted earlier for non-drug-related crimes, in particular crimes against property and/or the offence 'breach of the peace'.
This can be attributed to the following:

- a proportion of repeat offenders charged with drug abuse are regular drug users or drug addicts and engage in criminal activity to obtain the money, or some of it, with which to buy drugs (crime for financial gain);
- crime or criminal conduct often precedes drug use and/or drug addiction. This shows that perpetrators or criminal groups engaging in traditional types of crime are increasingly affected by drug consumption.

However, the majority of drug-abuse perpetrators are first-time offenders, i.e. they have not been sentenced for a crime before. The proportion of perpetrators with a clean Police record (70.6%) is higher than in the case of other criminal offences. It follows from this that most drug users come from non-criminal circles.

Summary

- ERÜBS data indicate that there was a rise in the number of detected (discovered) crimes related to drug abuse. The 25.7% increase in drug-crime was accompanied by only a 3.3% growth in the number of all registered criminal offences.
- The share of felonies (serious crimes) dropped against a rise in the share of petty crime. *Three quarters (74.8%) of all detected drug-crimes fall into the category of misdemeanour*. This means that most drug-related crime fall into the class of petty offence.
- The number of proceedings initiated for consumption of drugs – Article (9) point a) – more than doubled from 2000 to 2001. This type of crime accounts for 39.4% of all drug abuse cases.
- is criminality on the demand side, in particular acts committed by occasional users. The major driver in the rising number of drug abuse cases
- Most drug abuse cases take place in the capital city. Pest, Csongrád and Borsod-Abaúj-Zemplén head the crime list of counties. The steepest growth figures were recorded in counties Pest, Somogy, Heves and Veszprém.
- There was a major rise in the number of cases leading to indictment in 2001 and a declining number of cases dropped.
- There was a major rise (85.4%) in the number of deferred indictments in 2000. While young offenders previously dominated this group, there were more adults than under-aged whose indictments were deferred in 2001.
- There is a further rise in the number of under-aged perpetrators of drug-related criminal offences. Their share in all criminal offenders was 3.9% in 2000, while that in drug abuse offenders, 14.88%. Had risen the respective figures had grown to 5.9% and 17.1% by 2001! *In other words, 2001 crime statistics demonstrate that practically one in six perpetrators of the criminal offence of drug abuse was under-aged*!
- The growth rate of young people affected by drug-abuse criminality surpasses that of all perpetrators of such crimes. This means that the age gap between drug-related criminals and other perpetrators has broadened
- The number and share of those having general school certificates substantially grew in the light of 2001 crime figures. There were hardly any perpetrators without at least a general school certificate, or else they were attending general school at the time of perpetration.

Sources:

Ritter, I. (2001). A kábítószer-b_nözés jellemz_i a b_nügyi statisztikai adatok tükrében.

4.2.2. Characteristics of perpetrators convicted of drug abuse in 2001

177 minors/juveniles and 1,599 adults were convicted of drug abuse in 2001.
The rise in the number of drug-related convictions exceeded that in any other crime category in the period 1991–2000. The trend continued in 2001, presenting figures that are in striking contrast to the total number of drug-related convictions for the entire decade 1991–2000: 185 for under-aged and 2,909 for adults. Regarding the first half of the decade, it is found that 11 minors/juveniles, i.e. an average of 2 per year, were convicted between 1991 and 1995. In the second half of the period, the total number rose to 174, which translates into an average of 35 convictions yearly. Adult convicts numbered 323 (65 on a yearly average) in the first five years, and the figure in the second half rose to 2,586, (an average of 517 yearly).
It is highly probable that this extremely steep rise in convictions is due to stepped-up Police action rather than a spread of the phenomenon. The two factors are of course not mutually exclusive, however, the increase is most probably a product of increasingly intensive and efficient law enforcement work.

Juvenile convicts

Under-aged persons convicted of drug abuse in 2001 accounted for 2.52% of all juvenile convicts. Their age distribution is different from that of average figures for juvenile convicts in general, with each year of age showing a steep increment over the previous one:

14 years	4 persons	2.3 %
15 years	43 persons	24.3 %
16 years	59 persons	33.3 %
17 years	71 persons	40.1 %

Since as few as 18 girls are involved in this issue, figures are given for both genders combined.
The family status of young drug convicts is much the same as that of other convicted juveniles:

In the same household with both parents	109 persons	61.6 %
In the same household with one parent	50 persons	28.2 %
Outside parental household	18 persons	10.2 %

A breakdown of convicted under-aged by schooling demonstrates that the overwhelming majority of these youths do not come from traditional criminal circles. To support this assumption it should be noted that the proportion of perpetrators with at least a general school certificate (including, of course, those with higher schooling) was 91.0%, a figure indicating an educational pattern that is much closer to that of the entire population than that of convicted minors in general.

Figures about their criminal history provide further evidence of this. These data show that only 9.0% of young drug-related convicts were repeat offenders, while the relevant figure for the total population of juvenile convicts is 24.5%. In other words, one in every four juvenile convicts, as opposed to one in eleven youths convicted of drug abuse, has a criminal record.
Further corroborative information is obtained from figures on cumulative perpetration. The share of cumulative perpetrators within the total of drug-related convicts was 17.5%, while it was 48.8% in the case of all juvenile convicts.

Legal consequences
As to legal consequences, probation heads the list at 75.7%, followed by suspended prison sentences (32 persons – 18.1% and enforceable prison sentences (3 persons – 1.7%). 3 minors were sentenced to community service, another 3 were given fines as their major punishment and 2 persons were sent to houses of correction.
5 convicts were held in pre-trial custody and 2 were diverted for alternative treatment.
4 convicted minors were foreign nationals.

Adult convicts

The number of adults convicted of drug-abuse was 1,599 in 2001, or 1.8% of all convicted adults. Of them, 1,462 were male (1.9% of all male convicts), and 137 female (1.3% of all female convicts).
Age breakdown figures indicate that this type of crime continues to be prevalent in the young age groups: 1,410 persons or 88.2%, of all convicts were under 30. The relevant figure in the entire population of persons convicted in public prosecution was 49.5%. What is even more striking is that only 5 persons (0.31%) of all persons convicted on drug-related charges belong to the age group 50 years and over, while the relevant figure for all adults convicted in public prosecution is 7,400 or 8.0%.
The distribution by family status of convicted persons is a consequence of their age distribution. The proportion of single persons is 88.7% (89.3% for men, and 82.5% for women). The insignificant difference between the two ratios is most probably a result of a difference in the average age of men and women at the time of their first marriage.
6.8% were married and 4.2% divorced. 3 persons were separated from their spouses, and 2 were widowed.
A distribution by schooling shows that the majority had general school certificates (923 persons – 57.7%). 40.1% (641 persons) had secondary school certificates. 2 persons were illiterate and 33 convicts were college graduates.
The criminal history of adult convicts was found to be similar to that of minors in that adult drug-related convicts do not belong to traditional criminal circles. Only 28.5% repeat offenders were found, which compares interestingly with the figure (41.5%) for all adult persons convicted in public prosecution.

Legal consequences
The list is headed by probation, which is normally used as a secondary punishment. 635 persons (39.7%) received sentences on probation. This was followed by pecuniary fines used as a main punishment for 478 persons (29.9%). Suspended jail sentences were served to 15.4% (247 persons).
Experts of criminal justice have often voiced their concern that there is a danger that enforceable prison terms for drug abuse might be overused. This is not borne out by figures. 205 drug-related criminals (12.8%) were given enforceable prison sentences, which is a lower figure than the 13.8% registered in the total population of adults convicted of criminal offences.
The respective figures for men and women convicted of cumulative perpetration were 11.5% and 8.8%. Both are lower than the relevant figures for adults of appropriate age and gender convicted in public prosecution. This goes to show that convicts sentenced for drug abuse belong to a class of their own.

On other aspects of legal consequences it should be noted that 157 persons were diverted for alternative treatment and 275 persons were taken into pre-trial custody.
125 persons (109 men and 16 women) of drug-related convicts were foreign nationals.

Sources:

Vavró, I. (2002). A kábítószerrel visszaélés miatt elítéltek jellemz_i 2001-ben. Kézirat

4.3. Social and economic costs of drug consumption

No targeted survey designed to explore the health-related costs of drug consumption has been made in Hungary to date. Drug-patient care in health institutions is financed by the National Health Insurance Fund, which disbursed HUF 297,839,200 (Euro 1,191,357) under the heading of drug rehabilitation in 2001. (See Chapter 1.5 for details) This sum is exclusive of sick pay, reimbursement for medicines, or costs of treating complications caused by drug abuse.
In order that the drug problem is tackled in a cost-effective manner, it will be absolutely necessary to conduct targeted studies and produce estimates regarding the public costs (expenses) of drug abuse (including costs related to health care, justice and welfare).

5. Drug Markets

5.1. Availability and supply

Open borders have introduced new participants and new methods into organised international and Hungarian drug crime. New threats have evolved and require long term, multilateral and effective international co-operation from Police forces that prosecute criminals. It would, however be important to develop and make applicable in Hungary a concept that enhances the current efficiency of prosecuting drug trafficking and of the co-operation among the various law enforcement organs involved.
No single law enforcement body, no individual country can combat international crime cartels and their local forces alone.
Drug traffickers have constructed their comprehensive network and have developed the techniques of money laundering against a domestic backdrop of decade long impasse in the organisation and strategy level of taking action.
The year 2000 has brought substantial changes in the Hungarian drug market in many respects. The spread of ”party drugs”, mainly Ecstasy pills, is suggestive of an increasing trend. The influx of amphetamine mainly from Western Europe (the Netherlands) and from uncontrolled regions in the Balkans is worrying.
Available figures suggest that the internal drug market is still on the rise, keeps expanding, but the rate of enlargement is substantially slower than in earlier periods.

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

The national spread of amphetamine derivatives presents favourable investment opportunities to certain Hungarian crime groups. The symptoms of conspiracy are especially pronounced here. Investors' funds are used to procure large consignments of amphetamine powder and Ecstasy pills at extremely low prices through proven Dutch connections, and the drugs are delivered to end-users by dealer networks. Typical consumption sites include weekend musical events, and health sector professionals indicate the existence of a number of regular consumers.
Budapest and Miskolc continue to be the focal points of heroin related problems of crime and public safety. Quantities for distribution in the inland market are still supplied by Albanians, who buy the substance from Turkish traffickers. A number of Arab groups are also involved distribution, but direct sales are mostly managed by Hungarians. By December 2001, the Police learnt about the same number of fatalities (31 cases) due to heroin overdose as in the previous year. The direct cause of death involved the use of higher than normal purity heroin in each of the cases. The number of fatalities seems to be constant year after year, but data that would actually reveal root cause are not available.
A fundamental change in the heroin market in Hungary involves the contamination of rural areas in addition to the aforementioned two major cities and their metropolitan areas, despite the absence of the former among the cases detected by Police.

The internal heroin market showed clear shifts in October and November in connection with the events in Afghanistan. Major drug shortages occurred as some dealers ran completely out of stock and drug users were forced to exert major effort to get their daily doses, the price of which rose heavily by 30-35%.

The reduction in supply associated with the Afghan crisis was transitional only and there were no signs of heroin shortages in either the Hungarian market or in transit shipments later on.

The Hungarian scene of drug related organised crime typically involves smuggling transit shipments across the country by separate foreign, Hungarian and mixed groups as well as a broadening of the domestic market of certain narcotic drugs and meeting existing demand. Heroin from Western Asia continues to top the list of drugs transiting the country for consumption in Western Europe. It is hauled by Turkish truck drivers and coach owners that have set up tourist offices and are complemented in the main by smaller groups with Serbian, Kosovar Albanian and Hungarian members that accept orders to smuggle narcotic drugs using a variety of vehicles.

In terms of quantity, Hashish ranks second form among the drugs entering the country along the Balkans route.
In contrast with preceding years, a dynamic rise in the domestic distribution of cocaine in addition to transit shipments is seen as a typical change. This phenomenon is not only characteristic of certain establishments in the hospitality trade such as restaurants and nightclubs, it has also appeared in 'high society' companionships and their affiliations.
Furthermore, it has ad hoc presence among representatives of lower social status. The dealers come from former perpetrators of car theft and other property related crimes of greed.
The methods and directions of smuggling cocaine keep changing. Quantities have become 15-20 times larger in recent years based on a comparison with European data and a major portion is distributed for sale in Hungary or is shipped form here to European markets. It is worrying to see the recent surge in the number of Hungarian couriers who smuggle 'swallowed' packets of cocaine from South America. Most of those involved are young people who entered employment in a foreign country, who are complemented by a significant number of visitors of the source countries and 'tourists'. The target country is not always Hungary, several Hungarian couriers have been apprehended in other major cities in Europe or even in South America.

Although there were more cocaine investigations in the year discussed in this report than in 2000, the substance is only used regularly by substantially affluent circles. It is mostly procured in the Netherlands (along with amphetamine). The role of Hashish and LSD stamps is complementary in the domestic market and the quantities are not significant.

Hungary continues to be a significant transit country for contraband heroin produced in the Middle East region and shipped by Turkish and Albanian criminal groups to Western Europe via the Balkans route, which also dissects the territory of Hungary. There is a major reduction in the volumes of heroin seized at border crossing stations in the wake of partial route alterations by criminal gangs as political and security conditions stabilised in Macedonia and the revival of use of the 'Middle Balkans Route'. Intelligence experience suggests that the territory of Hungary – not unlike Bulgaria and Romania – is also used at increasing frequency for storing major quantities of heroin.

As far as contraband cocaine is concerned, Ferihegy International Airport remained a transit station for several smaller shipments bound from South America to Western Europe in 2001. Investigation into these cases revealed that the parties ordering and organising these shipments continue to be affiliated with criminal organisations in Western Africa (primarily Nigeria).

In addition to the most typical features of the trends in drug related crime mention must be made of the vast circle of users taking medical drugs with or without alcohol at entertainment

establishments playing alternative music, where the sale of marijuana, hashish and sporadic LSD sales have practically become regular.
The number of marijuana users has increased drastically and the size of land where the plant is cultivated in Hungary keeps growing. Cultivation methods are becoming more sophisticated and there the demand with purchasing power for cheap 'pot' from Hungary is on the rise especially in younger generations.
It is noteworthy that official opinions are suggestive of the increasing presence of marijuana in the Hungarian market, whilst seizure and procedural figures of the organs involved in the drug crime related law enforcement fails to show evidence of this in detected cases.

Similarly, there the number of actions taken in synthetic drugs cases is out of proportion with the estimated figures of the volumes of narcotic drugs present in the Hungarian market.
The efficiency of controlling precursors is not compatible with the standard practice in Europe. That may be seen as a somewhat inferior problem but it definitely does not promote the detection and control of the persons and the 'business' circles involved in processing the illicit substances. It has been known for years that several unemployed chemists and professionals trained in chemical industry procedures have fled the Balkans regions in search of a job and were helplessly affiliated with criminal organisations and joined their operations. Similarly, Hungarian experts may have also become involved. Hence, all the conditions are given for 'effective' operations in the field of illicit production, whilst this organisation is a blank spot for law enforcement.

The level of efficiency in reducing supply is also extremely low, which is due to the lack of a uniform system of processing which prevents even local – not to mention national – units from organising detection. The criminal organisations in the different regions communicate actively with each other, whilst similar information flow among law enforcement agencies fails to occur due to the lack of central intentions. There is no uniform central reporting system, and except for a few 'zealots' supporting laboratories do not perform comparative analyses. Occasional tests of this nature could, however, give momentum to cases running their own course separately, and could – importantly – demonstrate to professionals in the field that Hungary is not only a territory of use any more, it has grown into a producer.
Street distribution can work efficiently due to the lack of a uniform system of records, and acting in well organised conspiracies, pushers run hardly any risk as law enforcement is clumsy and not target oriented in identifying and detecting them.

Although the Criminal Code contains serious sanctions and punishment, there is very little personal risk associated with detecting and taking to court a single person as the organiser of the whole racket. The detection of 'what seem to be isolated groups' is halted at low levels due to lack of efficiency. Total eradication fails. Similarly, the financial background is not detected, nor is it liquidated; hence organisations continue to operate as the resources needed for dealing in drugs are incessantly available.

Sources:

Oláh, M. (2002). A magyarországi illegális drogpiac jellemz_i 2001-ben. Kézirat.

5.2. Seizures

Intelligence Activities of the National Customs and Finance Guard in 2001

The number of cases detected by the National Customs and Finance Guard has increased since 2000, but the amount of drugs seized in these cases has decreased to a third. Whilst the officers of the Guard found drugs of a certain kind in 146 cases in 2000 and seized altogether 790 kg of substances, the number of detected cases rose to 206 in 2001 and the quantity seized came to 237 kg.
Hungarian and international analyses suggest that the reason behind the drop in seized quantities, also observed in several countries and Eastern and Western Europe, was due to the modification of smuggling routes and to certain changes in the methods of shipment.
Detecting contraband heroin bound from Southwest Asia for distribution in Europe remains a top priority in the fight against international drug trafficking. The aforementioned changes in routes also brought a reduction in seized quantities of narcotic drugs in countries along the Balkans route, which recorded substantial seizures earlier. On the other hand, seized quantities jumped in the main in Italian and British ports. That is indicative of the increased use of routes that pass by our region towards the south, which involves shipping heroin on board of ferryboats from Turkish ports to Italy and to the UK. The combined mainland and marine route along Turkey – Bulgaria – Macedonia – Albania – Italy also showed increased transportation activity. The events in Afghanistan also contributed to the strengthened flow of contraband heroin shipments along the route passing to the north of Central and Eastern Europe, including the former Soviet republics in Middle Asia, Russia, the Baltic States and Poland.
Although the 186 kg of heroin seized by Hungarian customs authorities in 2001 is far below the volume of 747 kg seized a year earlier, the Hungarian Customs and Finance Guard ranks fifth among the 15 customs administrations along the Balkans Route even with such a small quantity.

Although the majority of heroin shipments seized were in transit for distribution in Western Europe, most of the ***cannabis products*** found at the border were intended to supply drugs to the Hungarian market. The officers of the guard seized marijuana in 67 cases in 2000 and in 102 cases in 2001. Seized quantity increased three and a half times (from 12.5 kg in 2000 to 42.3 kg in 2001).
The majority of seizures involved confiscating minor quantities sufficient for personal consumption or use by a smaller group mainly from Hungarian citizens returning from Western Europe. The cases detected on board of international express trains were particularly numerous. There was also a simultaneous increase in the number of seizures involving over a kilogram of marijuana in the year discussed in this report. Experience suggests that these more significant contraband shipments are mainly connected to vehicles and passengers arriving from Yugoslavia, and were intended for sale in Western Europe rather than in Hungary in some of the cases.
The illegal market of marijuana in Hungary is mainly supplied by from the crop of cannabis plantations grown in this country. The Customs and Finance Guard also participated in detecting these, the officers of Central Patrol located 2 illegal plantations and a total of 10,3000 cannabis plants or seedlings in the course of checking other aspects of domestic land.

The number of cases involving the seizure of ***hashish*** was 27, which is identical to that in 2000, but seized quantities (1.78 kg) reduced substantially. This is due to a single airport seizure (of 7.1 kg) making up 88% of the total quantity (8.09 kg) in 2000, whilst there was only one case in 2001 when the Guard found more than 1 kg of hashish. The majority of detected cases revealed quantities below 100 gram smuggled from the Netherlands or

Yugoslavia and intended for domestic consumption, but there were also instances of contraband transit of hashish into Western Europe, like in with marijuana.

Nut unlike in previous years, customs officers noticed ***synthetic drugs*** mostly on the western borders of Hungary and at Ferihegy International Airport, particularly in the possession of Hungarians returning from Western Europe. Amphetamine detection increased 50% on 2000 (286 grams of amphetamine was seized in 15 cases), whilst the quantity of Ecstasy pills seized reduced (a total of 1,033 pills in 9 cases).

The volume seized in 2000 already reflected diminishing interest of the Hungarian drug market in LSD, and the low annual quantity seized in 2001 (115 LSD 'discs' and 4 stamps in 2 cases) also supports the same trend.
Just as in previous years, the vast majority of ***cocaine*** seizures by the National Customs and Finance Guard were related to Ferihegy International Airport and airborne transit contraband. Both the number of cases (12) detected and the quantity seized (4.8 kg) increased in 2001 as compared to 2000, yet both fall substantially short of the magnitude of seizures in the period between 1997 and 1999. The reason for the reduction involves altered shipment routes and methods, which is clearly reflected by the cases of Hungarian cocaine smugglers apprehended abroad.
In former years, Hungarian couriers left Budapest for holidays in South America and returned to Hungary with cocaine in their possession only to transfer the drug to other people who carried it to other destinations in Western Europe. In the past one or two years, couriers typically departed on return trips for South America from airports in Western Europe to get back in the possession of the illicit substance, which increased the likelihood of being detected. Ferihegy International Airport is at present used as a transit station by citizens from Eastern Europe (Yugoslavs, Romanians, Bulgarian) who wish to smuggle cocaine into their home countries. A relatively high number of them are 'swallowers'.

The responsibilities of the National Customs and Finance Guard regarding the chemical substances required for producing drugs and also needed for making legal products (***precursors***) are complex and involve duties of controlling legal trade in addition to detecting contraband shipments. In 2001, there were 2 seizures of a total of 13,649 contraband ephedrine pills from Romania and Yugoslavia. One of the shipments was intended for Austria, whilst the other was bound for Hungary.
The regulatory control of the legal trade in drug precursors was performed in line with an annual plan drafted and reconciled by the Ministry of Economic Affairs. The audits covered 7 companies in 2000 and 12 firms in 2001 to check legal compliance in trading the substances specified in the competent Government regulation but failed to find signs of diverting precursors to illegal channels.

The table below shows the distribution of the volume of drugs seized and delivered to the laboratory of the Police Headquarters, Institute of Forensic Sciences for analysis over the past eight years. Marijuana quantities frequently indicate the volume of the delivered representative sample only, and the volume actually seized and destroyed by Police was substantially larger. The quantities of other substances are based on measuring the net weight of the volumes seized, and hence are at variance with the values reported and totalled by other bodies. The reason for the difference is that authorities receive the gross weight figures of seizures measured with packaging materials, which is the only type of information they can have available for public disclosure.

Drug types and quantities (in kilos and grams) seized by the National Police Headquarters and the Customs and Excise Authority between 1994-2001

Type of Drug	1994	1995	1996	1997	1998	1999	2000	2001
Heroin (kg)	1088	565	230	190	937	166.5	670	154.4
Cocaine (kg)	25	16.1	8	7.6	20	115	10.9	6.02
Hashish (kg)	26.3	0.6	782	4	2.8	3.6	19	0.88
Marijuana (kg)	1281	113	45	2338	146*	99.9*	112*	131*
Morphine, opium (kg)	105	19.5	0.9	1	0	0.9	16.6	0.01
Amphetamine powder (kg)	28	0.8	0.5	12.7	10.3	4.6	10.5	1.48
LSD stamps and discs	650	299	1023	1607	4416	3115	1519	972.5
Ecstasy pills	15	2929	7052	5505	11785	11143	15154	18663.5

Quantities marked * include representative samples only

In the category of synthetic drugs, the seized volume of Ecstasy pills kept increasing year after year in contrast with 'classic' substances such as hashish or opium.

Sources:

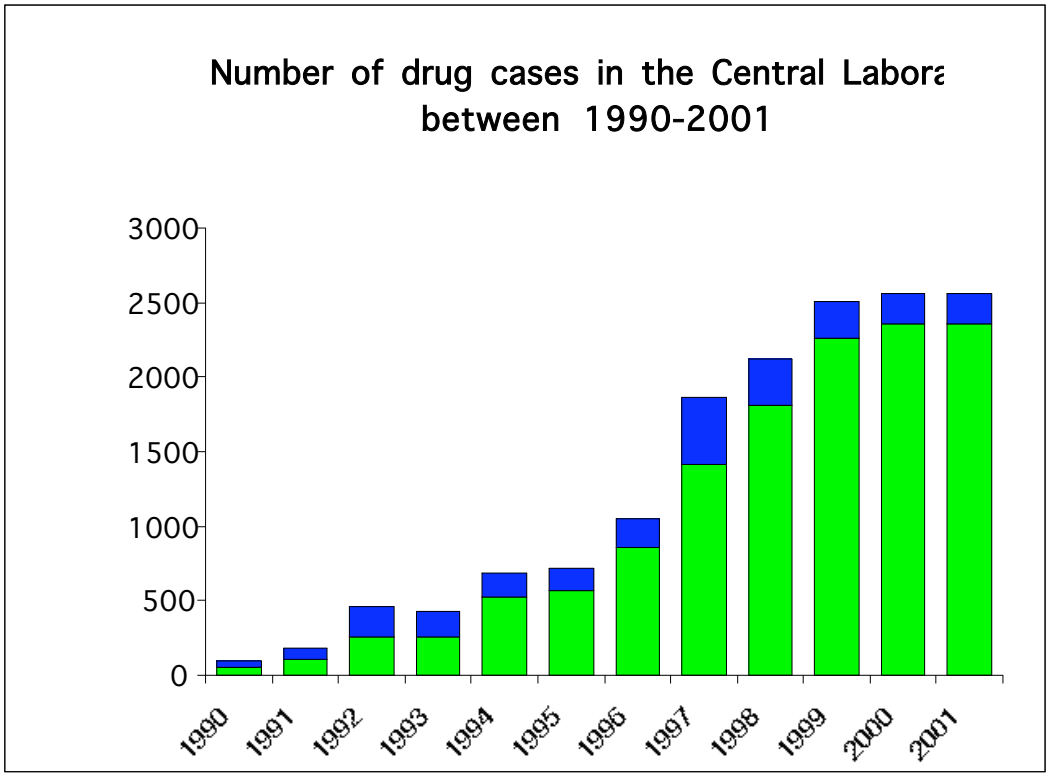
Nagy, G. (2002). Az illegális kábítószer-piac jellemz_i. Kézirat.
National Headquarters of the Customs and Finance Guard (VPOP) (2002). Summary Report on Drug Detection by VPOP in 2001 by György Hollósi.

5.3. Active ingredient contents and illicit drug market prices of seized narcotic drugs

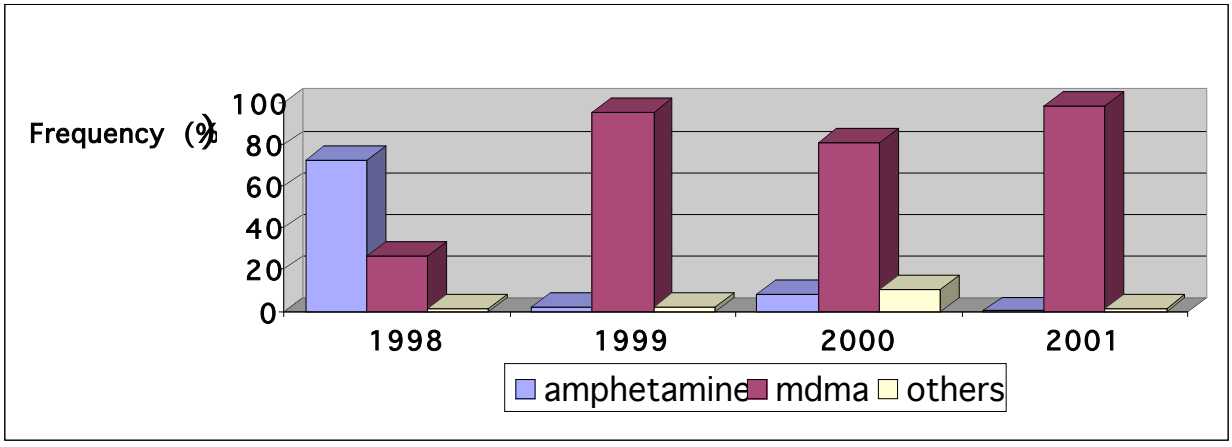
Active Ingredients in Seized Drugs

The Police Headquarters, Institute of Forensic Sciences and its legal predecessor, the Technical Institute of Crime have been involved with studying drug-suspect substances since 1968. The central laboratory has national competence to analyse substances primarily upon request by the authorities. As effective regulations require the participation of this laboratory in the analysis of substances which are deemed to be drugs and in the handling of exhibits in procedures conducted by the Police, the National Customs and Finance Guard, penal institutions, prosecutor's offices and courts and all the data relating to drugs seized in this country are kept in the database of the Institute, this database is considered to be uniform, accurate and reliable and is sound support for drawing conclusions.
The number of drug cases keeps increasing year after year. The figure below shows continuous rise, although at varying rates. The diagram demonstrates clearly that the number of drug cases have increased by more than twenty-five times in a matter of ten

years, including an even higher rate of increase in the number of positive cases, i.e. those actually involving some drug (cf. bottom column). The rise in the ratio of positive cases is due on the one hand to the spread of drug use and to the knowledge and skills of investigators regarding narcotic substances:



In recent years, MDMA tended to be the active ingredient in Ecstasy pills, 97% of all pills contained MDMA in 2001. The figure demonstrates a clear and ongoing reduction in the ratio of other active ingredients compared to MDMA.



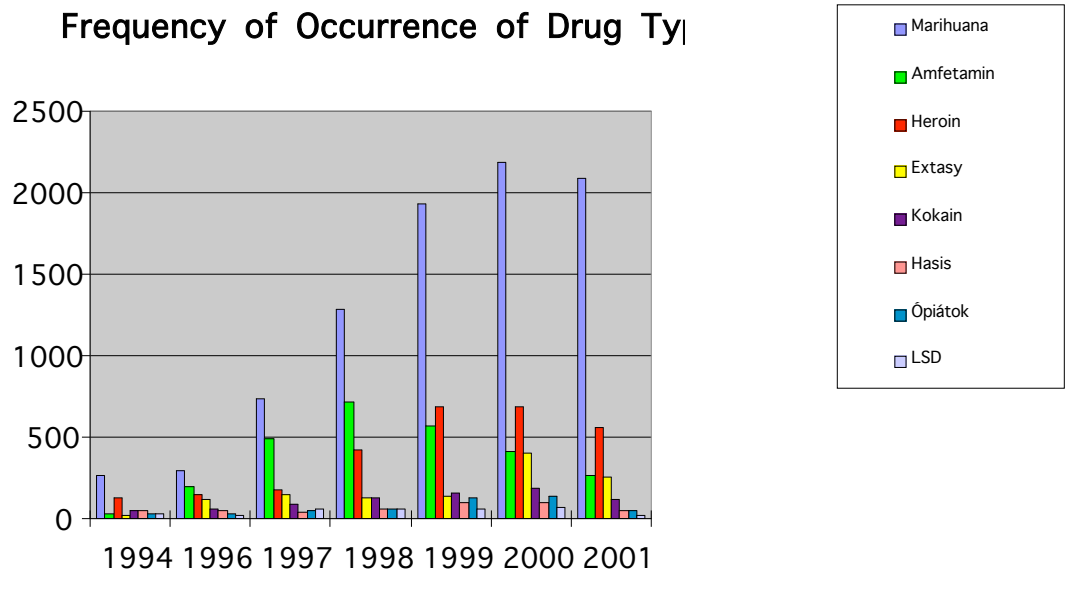
Yet, there is great variety in other active ingredients. The table below shows the active ingredient types used in Ecstasy pills and the number of pills seized by type.

Frequency of Occurrence of Active Ingredient Types in Ecstasy Pills, 1998-2001

Active Ingredient	1998	1999	2000	2001
Amphetamine	8587	229	1264	4
MDMA	3090	10694	12298	18102
MDE	16	96	110	176
MDA	2	69	1276	33
Methamphetamine	90	20	203	15
2-CB (nexus)	0	35	3	0
4-MTA	0	0	3	0
1-PEA	0	0	7	0
PMA	0	0	0	334

In 2000, 4-MTA and 1-PEA appeared as new active ingredients in Ecstasy pills in Hungary, and the newcomer of 2001 was PMA, a dangerous substance that have proved fatal in several cases abroad.

The extremely high values of heroin seizures can be associated with the periods when war waged in Yugoslavia, which diverted transits to follow routes in Hungary rather than move across dangerous southern territory. A continuous decline in the popularity and frequency of LSD is also clearly visible from the late 90s onwards.
The following diagram of the frequency of substance types in drug cases shows tendencies that are identical to those presented above. The graph presents a single significant realignment. Although most of the cases involve cannabis based substances, primarily marijuana as the most frequent and most popular drug, heroin has been clear runner-up overcoming synthetic substances since 1999, what is more its ratio to the latter keeps increasing. The frequency of occurrence and the likely popularity of heroin have been on the increase, which is indicative of a dangerous tendency.



The purity of and the active ingredients in black market substances are typical factors from many respects. Firstly, they have epidemiological significance; secondly, the severity of punishment in Hungarian law depends on the exact quantity of, i.e. the amount of pure active ingredient contained in the drugs held by a suspect. The average concentration of active ingredients typical of the Hungarian market at the time could also be important in calculations based on testimonies by witnesses.
That is why records of the concentration levels measured at the Institute are kept, compared and evaluated annually. The table below shows these figures.

Average Concentration of Active Ingredients in Black Market Drugs Tested in the Police Headquarters, Institute of Forensic Sciences of the National Police Headquarters between 1996 and 2001

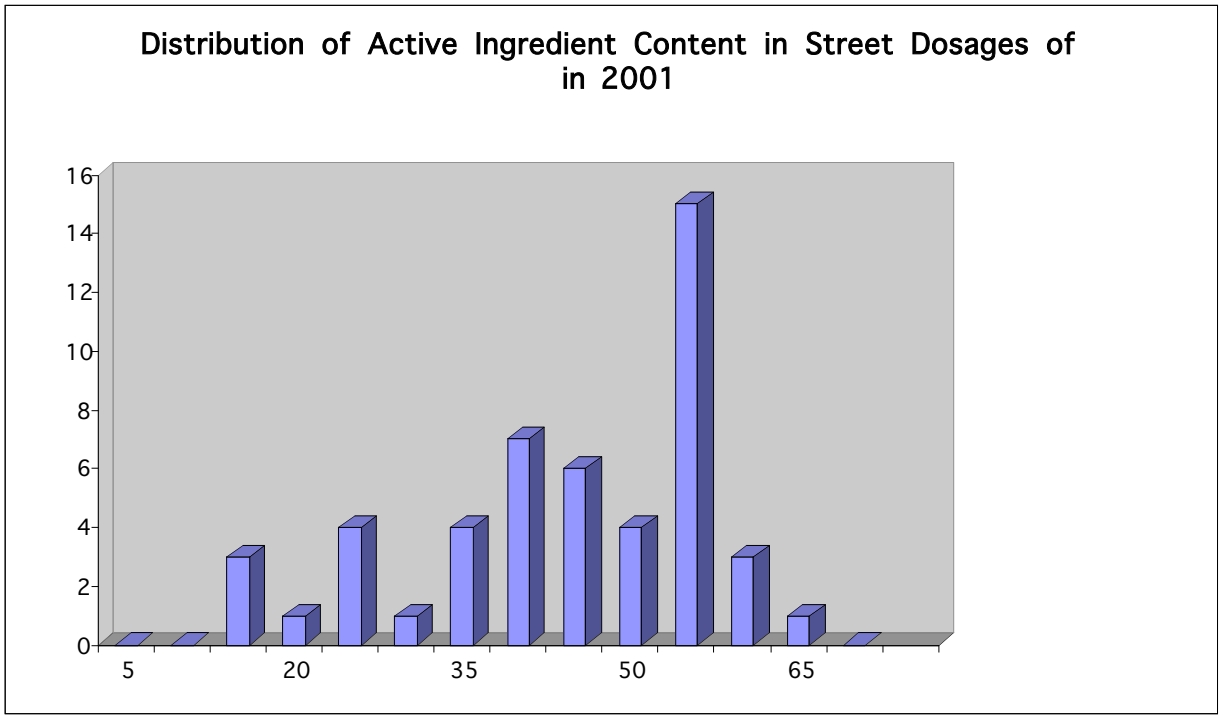
Active Ingredient	**1996**	**1998**	**1999**	**2000**	**2001**
MDMA (Ecstasy pill)	72-102 mg/pill	50-100 mg/pill	50-100 mg/pill*	50-100 mg/pill*	50-100 mg/pill*
MDA (Ecstasy pill)	46-48 mg/pill	46-48 mg/pill	50-80 mg/pill*	50-80 mg/pill*	50-80 mg/pill*
MDE (Ecstasy pill)	85-113 mg/pill	85-113 mg/pill	85-113 mg/pill	85-113 mg/pill	85-113 mg/pill
Amphetamine (pill)	5,5-30 mg/pill	5-40 mg/pill	5-25 mg/pill*	5-25 mg/pill*	5-25 mg/pill*
Amphetamine (speed powder)	5-45 %	5-45 %	2-35 %*	1-20 %*	1-25 %*
Cocaine (dose for consumption)	N. a.	25-60 %	10-65 %*	20-80 %*	20-80 %*
Cocaine (large samples)	52-91 %	60-80 %	50-80 %*		
Heroin (dose for consumption)	10-50 %	10-50 %	5-65 %*	10-65 %*	10-65 %*
Heroin (large samples)	50-75 %	40-80 %			
Marijuana (THC)	0,01-2 %	0,01-2,5 %	0,01-4 %	0,01-6 %*	0,01-6 %*
Hashish (THC)	2-20 %	1-15 %	1-20 %	1-20 %	1-20 %

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

The table is informative and allows several conclusions about the changes in the market of illicit drugs.
It is typical that the active ingredient content of substances in hand-to-hand dosages, such as Ecstasy pills or LSD stamps has remained constant and has varied within relatively narrow limits for quite some time.
The purity of 'speed' dusts containing amphetamine has decreased in recent years from a top limit peak of 45% to 25%.
On the contrary, the THC content of marijuana keeps increasing. The top limit of 2% reported in 1996 had risen threefold to 6% by 2001, which is on the one hand due to the

decline in the proportion of wild hemp and also to the rise in cultivating Indian plants known as 'hash-hemp'. It is worth noting that THC contents of 7-8% and even 11% have also been measured in a few cases, which is deemed to be attributable to both a change in variety and cultivation in especially efficient, artificial circumstances, possibly indoors. (These extreme values are not shown in the table above because they represent less than 1 percent of the cases.)

The changes in the concentration of cocaine and heroin are also typical. Whilst formerly there used to be a marked difference for both drugs in the concentration of contraband substances seized in large quantities and street dosages in packets, this difference started to obliterate in 1998 and has practically ceased to exist. With cocaine, this difference was marginal as the substance was not diluted heavily, but the purity of heroin in transit, at 50-80%, was at marked variance with the concentration of active ingredient in diluted or "cut" street dosages. Since 2000, this difference has disappeared in a manner that had a dramatic effect on both the market and addicts. *Street dosages or packets started to contain undiluted heroin of high purity, even at 60-70%! That process continued in 2001 in a manner that the heroin base active ingredient content of sixty percent of dosages for consumption surpassed 40%!*



The diagram above shows that the samples tested by the laboratory did not even include highly diluted substances with concentration levels below10%!

The phenomenon described above explains the increase in the number of heroin overdose cases in the past two years. It is obvious that addicts who had grown used to purchasing and taking heroin of 5-10% purity, subjected their organisms to 5-7 times the quantity of heroin if upon consuming the same volume of powder which they could buy in the street after a longer period of 'abstinence', which resulted in the 'golden shot' or fatal overdose.

The increase of the purity in packet dosages of heroin is deemed to reflect a change in consumption habits. The well-known hazards associated with needle use promoted other forms of taking heroin such as inhaling or heroin laced cigarettes, which requires higher purity substances. The number of laboratory specimens of aluminium foil contaminated with burnt heroin residue keeps increasing.

Street Price of Illicit Drugs

Drug Prices in Hungary in 2001

Drug Type	Retail (Street) Price of gram or unit Euro
Heroin	21-62
Cocaine	49-82
Hashish	9-11
Marijuana	7-9
Amphetamine (powder)	13-25
Ecstasy (pill)	9-13
LSD	7-11

(Source: National Police Headquarters)

Clearly visible changes swept across the domestic market of heroin in the wake of the events in Afghanistan in October and November. There was a major shortage of material and some dealers ran completely out of stock, whilst consumers were had pressed to obtain their daily doses, the price of which rose substantially by 30-35%.
The reduction in supply associated with the crisis in Afghanistan was transitional, as there was no subsequent sign of the shortage of heroin either in the domestic market or in transit shipments.

Sources:

Nagy G. (2002). Az illegális kábítószer-piac jellemz_i. Kézirat.
Oláh M. (2002). A magyarországi illegális drogpiac jellemz_i 2001-ben. Kézirat.

6. Trends per drug

6.1. Cannabis Derivatives

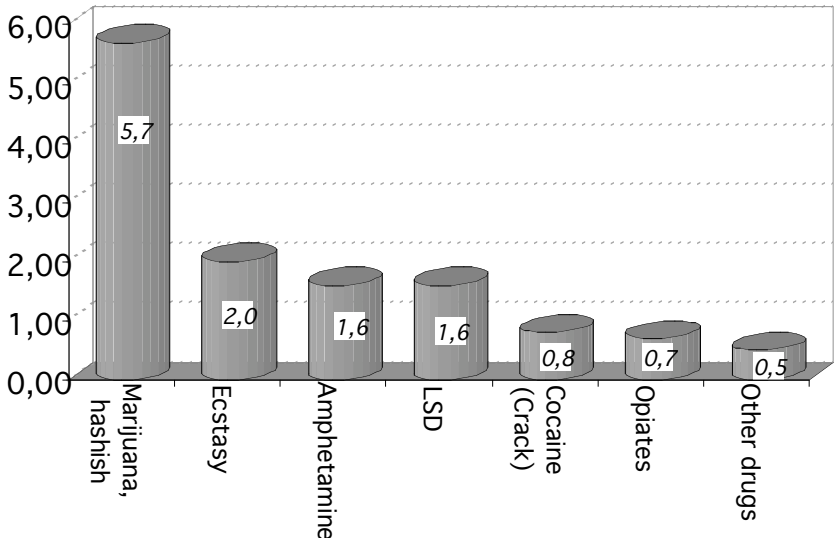
Cannabis derivatives are the most popular illicit drugs of the widest uptake in Hungary as much as anywhere else in Europe.
The major source of supply for users is the crop of domestic plantations. The THC content of marijuana keeps increasing. The top limit of 2% reported in 1996 had tripled to 6% by 2001 as a result of both the decrease in the ratio of wild hemp and the growing use of the Indian variety, known as 'hash-hemp' for cultivation purposes.
Although drug users, or more specifically marijuana users are frequently called a sub-cultural group, this name is not at all fortunate. Available data about the population of drug users in general and marijuana users in particular are suggestive of a sub-cultural group that exhibits heterogeneous rather than uniform features.
With marijuana users, this heterogeneous character is prevalent first of all in the intensity of use. About half of the respondents of a survey of entertainment facilities offering music and dance (Demetrovics, 2001) reported having tried one or another cannabis derivative. About one fifth of the respondents had not used these substances for a year before the survey, whilst somewhat more than every other person was found to used marijuana or hashish in the preceding month. But the intensity of use differed widely even in this later group, where 16.2% reported daily use and 22.1% mentioned using the drug more than once a month. Simultaneously, almost every fourth or fifth respondent reported to have smoked marijuana or hashish on a single occasion in the month before the survey. More intensive use was clearly typical among men.
The same survey differentiated between two relatively separate groups of marijuana users: those (1) that have never taken substances other than marijuana, and (2) that have experimented with other substances as well.

Cannabis Use by the Average Population

The first study targeted first of all and not only tangentially at drug use by the general population was conducted in Hungary in spring 2001 (Elekes, 1999). Examining life prevalence by substance suggests that different drugs and drug types play widely different roles in the structure of drug use, and that there is a pyramidal structure in the spread of different drugs. The consumption of cannabis derivatives is the widest. 5.7% of the respondents, i.e. 87.7%, or a great majority of persons that have used some kind of drugs, have experimented with either marijuana or hashish. The frequency of occurrence of all other drugs is much lower among adults. Different synthetic drugs are ranked second to fourth and are seen to be practically of equal spread, taking into account the standard error of the estimate, which is 0.5-0.6% in these cases, including Ecstasy, amphetamine and LSD (1.6-2%). Cocaine, opiates (heroin and/or other opiates) and other drugs claim the smallest circle of users, the ratio of people who have tried these substances is below 1%[19].

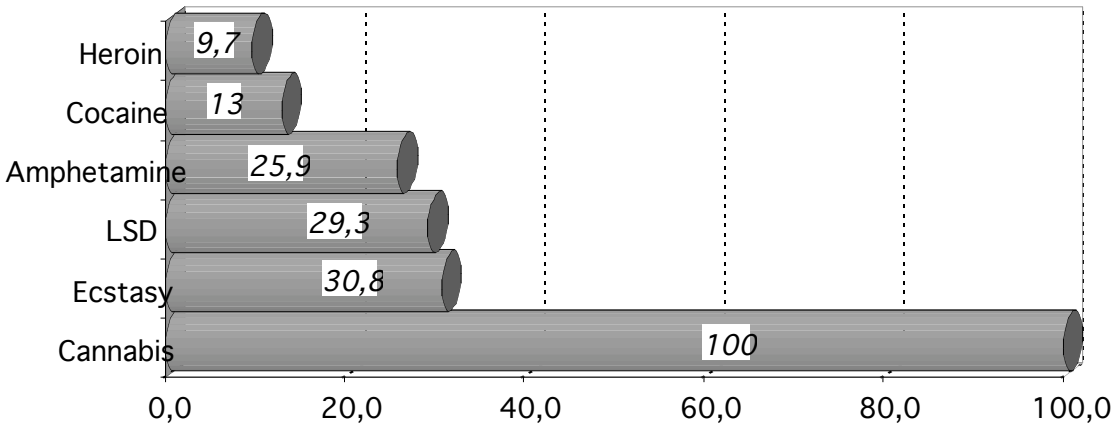
[19] The life prevalence rate of these drugs is especially low if we take into account that the life prevalence rate of a dummy-drug was 0.3% (see the discussion of methodology).

Life Prevalence Rates of Different Drugs ranked by Spread (Importance) (in a population of 18-65 year old persons, expressed as a percentage of responses)



A '*pyramid of illicit drugs*'[20] has been constructed from the life prevalence rates of illegal drugs to show the structure of consumption and the relationship between the uses of different substances. The pyramid below presents the overlap between marijuana (hashish) as the most popular illicit drug and the life prevalence rates of other substances, i.e. the ratio of consuming other drugs among those who have already had at least a single lifetime experience with marijuana (hashish).

The Pyramid of Illicit Drug Use
The Life Prevalence Rates of Various Substances Expressed as a Percentage of Persons Who Have Tried Cannabis



A comparison of the values in this pyramid to the life prevalence rates of calculated for the normal population shows a strong connection between different substance consumption behaviours. The consumption values calculated for cannabis users are multiples (by about a factor of ten) of values received for the normal population. All in all, more than half (54,4%) of

[20] EMCDDA (1999) pp. 77-79

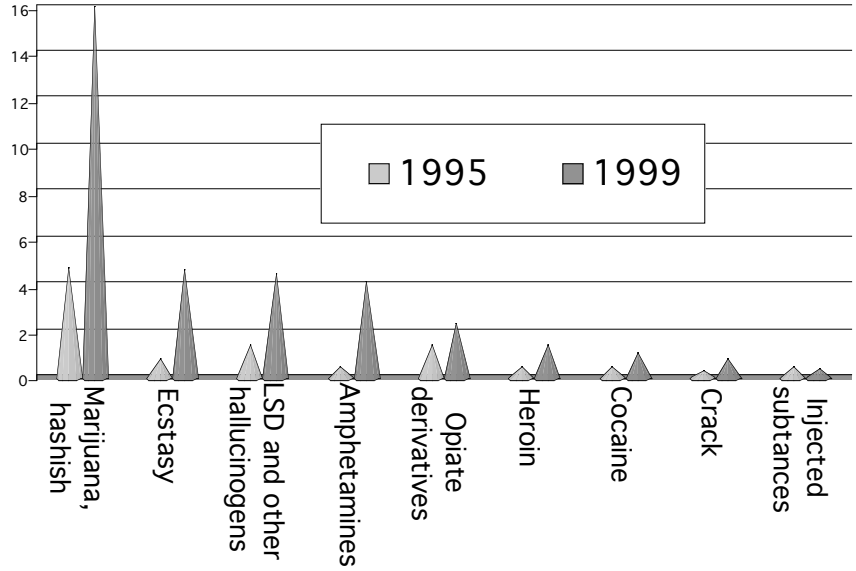
cannabis users have taken illegal substances other than cannabis, mostly Ecstasy and/or LSD and/or amphetamine, with heroin trailing the list.

Cannabis Use Among Secondary School Pupils

As far as the direct indicators of drug usage in Hungary are concerned, available comparative data derived from studies using identical methodology to cover identical or partially overlapping populations are limited to the secondary school age population; hence these are the only data suitable for setting trends, but they are available in sufficient detail for calculating highly detailed trends especially about the second half of the nineties.
Data were collected during the 1992/93 academic years in Budapest (Elekes, Paksi, 1994) and several counties such as Baranya, Tolna, Zala (Paksi, Kó, 1994) and Szabolcs-Szatmár-Bereg (Murányi, Seres, 1994) along the methodological guidelines of and using the questionnaire developed by the Pompidou Group of the Council of Europe. In 1995, a countrywide representative study was conducted as part of ESPAD'95 on sample sizes large enough to support even county level analysis (Elekes, Paksi 1996). To complement the national program, research was also conducted in certain cities under ESPAD standards in 1995-96 (Paksi, Kó, 1996). Thereafter in 1998, a pilot study of methodological nature was performed in Budapest in preparation for ESPAD'99 to be followed by the next national data collection round in 1999 as part of ESPAD'99 (Elekes, Paksi, 1999, 2000a). Finally, the most recent study was conducted in 2000. There the sample was identical to the Budapest sub-sample of ESPAD'99 and the same methods were used (Elekes, Paksi , 2000b).

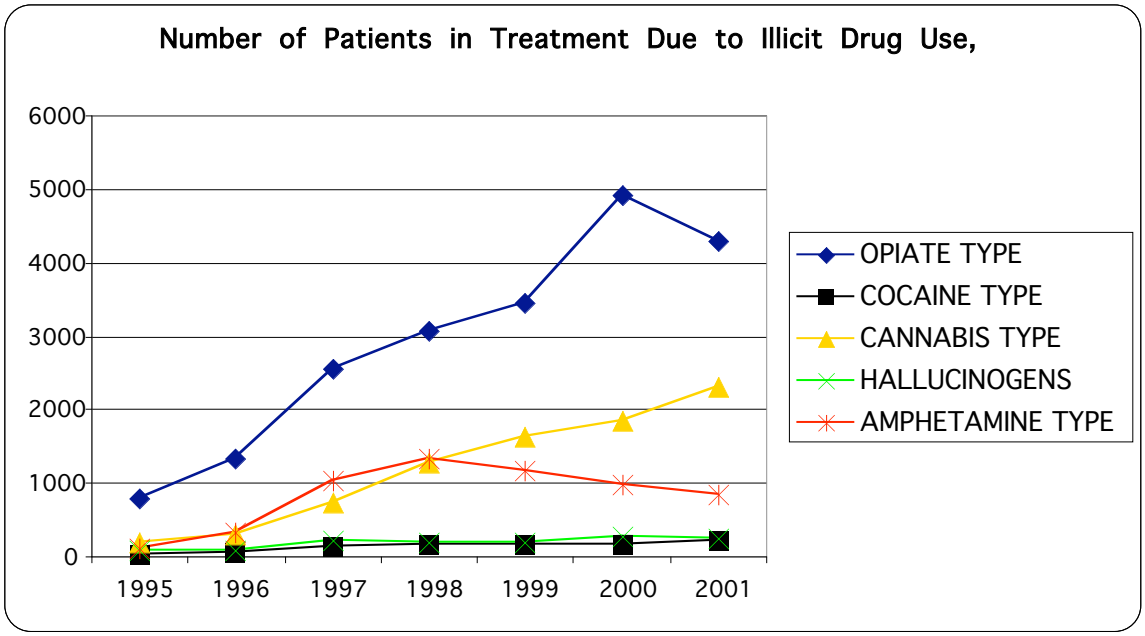
Studying the structure of consuming illicit substances suggests that marijuana continued to be the dominant substance for this age group in Hungary throughout the middle and through to the end of the decade, and its significance within total drug usage is becoming more and more pronounced. Whilst the usage rate of marijuana topped the average usage rate of other substances by no more than 4 percentage points in 1995, the gap had widened to over 10 percentage points by 1999. Along with marijuana, synthetic party drugs also seem to gain ground, although the related life prevalence rates are much inferior.

The Life Prevalence of Various Illicit Drugs in 1995 and 1999
(national data, sophomore secondary school students)



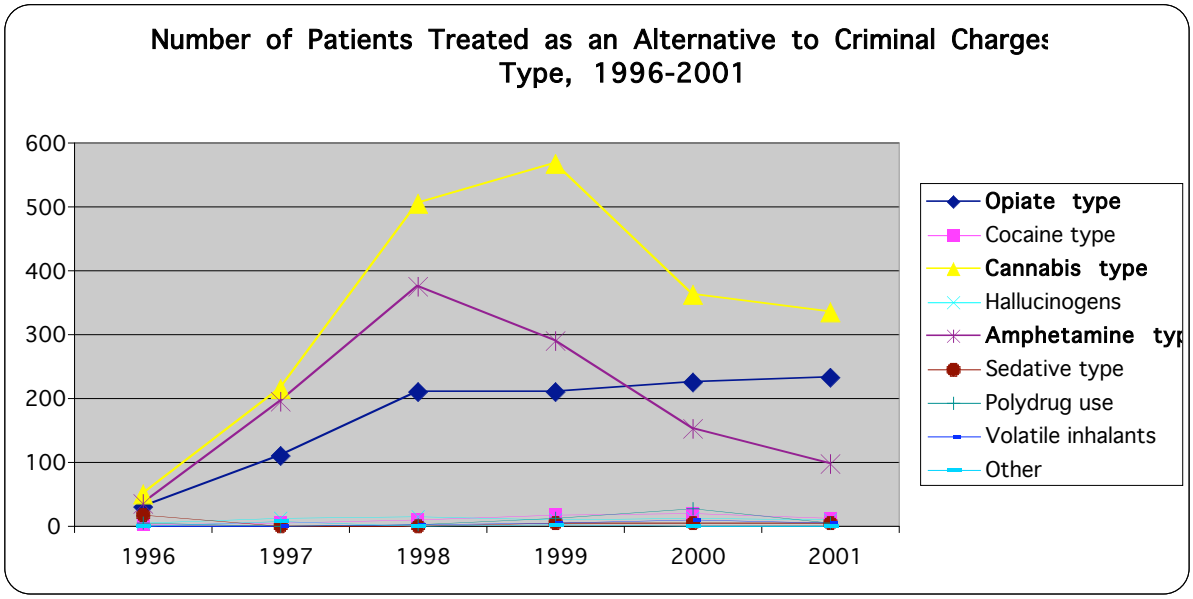
Number of Cannabis Users Treated in Health Institutions

Number of Illicit Drug Use Patients in Treatment by Drug Type, 1995-2001



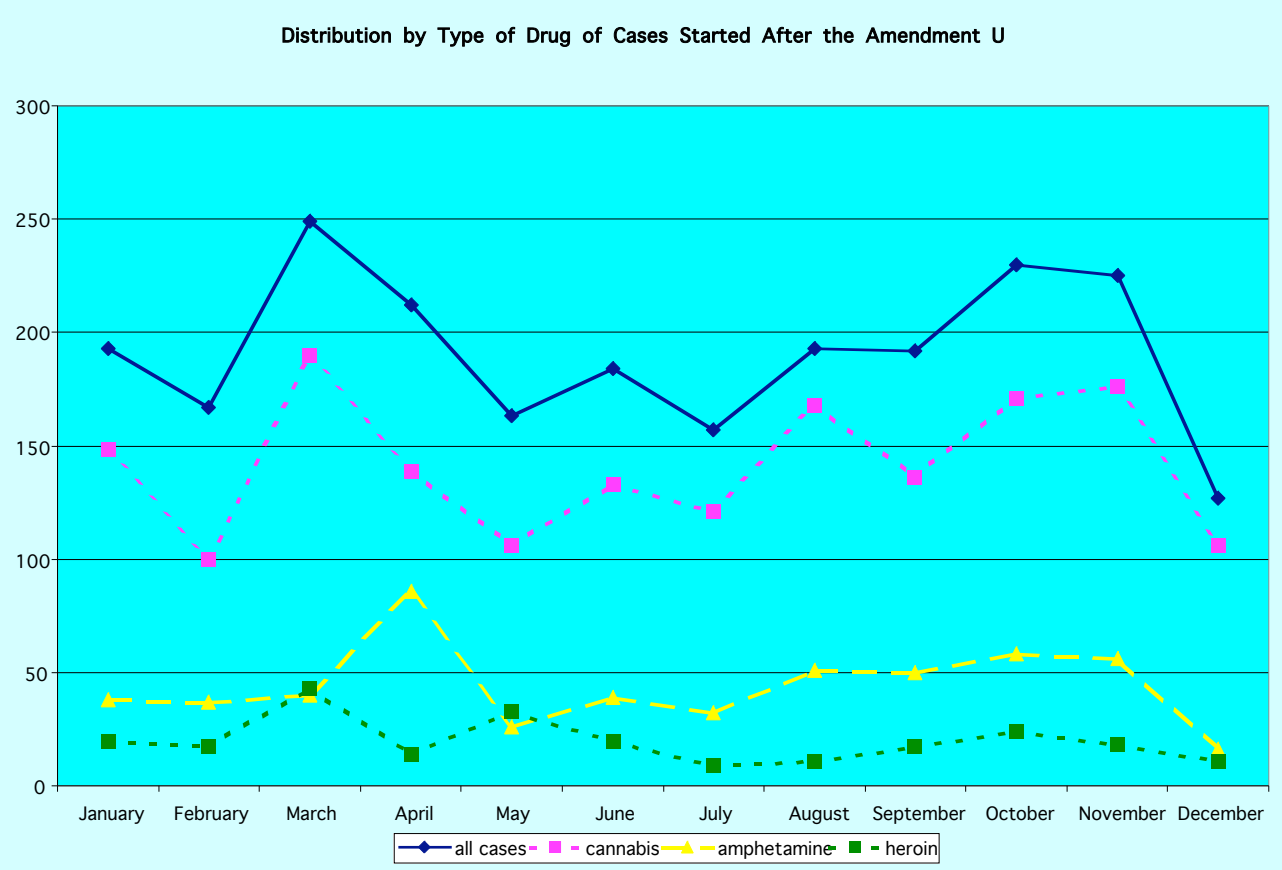
The number and the ratio to the total number of patient of **cannabis** (marijuana, hashish) users increased only slightly in 2000 as opposed to a rise from 5% to 13 % between 1995 and 1999. In 2001, their number increased 25% on the preceding year and cannabis users represented 19% of all patients in treatment, or the second largest group of treated patients after opiate users.
The decrease in the number of those treated as an alternative to criminal charges in 2000 was due to a reduction in the number of cannabis and amphetamine users by 36% and 45%, respectively, there was a slight corresponding increase or no change in the number of patients treated for the use of other drugs in a diversion treatment arrangements.

Number of Patients Treated as an Alternative to Criminal Charges by Drug Type



Number of Criminal Cases Started Due to the Abuse of Cannabis Derivatives

Two and a half years after amending the definition of the facts of the case of drug abuse as a criminal act, we are now in the position to analyse the impact of the amendment in the Criminal Code of the facts of the case of drug abuse, effective as of March 1, 1999. The study was performed by the National Institute of Criminology under an assignment by the Ministry of Youth and Sport (Ritter 2002).
Cannabis derivatives have been involved in more than half of the detected drug abuse misdemeanour cases for years now.
After the legislative changes, the distribution by drug type of drug abuse misdemeanour cases across the months when the acts were committed showed the following pattern.



A look at the graph shows clearly that the curve of cannabis derivatives (marijuana, hashish) is almost completely in line with the curve for the distribution in each month of the total of analysed cases. That indicates that *criminal procedures started in cannabis abuse cases, which involve more than half of all the cases, shape the curve plotted for the distribution by months of known and detected drug related criminal acts.* The frequency of occurrence of cannabis derivative cases was up 19.2% after the amendment of the law, whilst there was a corresponding decrease in amphetamine, methamphetamine and heroin cases.

6.2. Synthetic Drugs

Trends in the Use of Amphetamine Type Substances in the 90s

The study of the trends in amphetamine use, and its direct indicators relies first of all on the ESPAD research (Elekes and Paksi, 1996 and 2000). The ESPAD study suggests a major increase in the use of stimulants in the late 1990. The number of those who tried amphetamine increased by more than eight times (from 0.5% to 4.2%) in the period between the two ESPAD surveys in 1995 and 1999. There was a corresponding six fold increase from 0.8% to 4.7%) in the number of those experimenting with Ecstasy among sophomore secondary school students. These trends made these substances the second most popular drug after marijuana (16%), in a tie with LSD (4.5%). The extremely high degree of growth is also indicated by the fact the rate of growth in the use of other substances was at most three times and only two fold among those that have experimented with some drug[21] irrespective of type.

The ESPAD survey of 1999 suggested that 17.3% of junior and sophomore secondary school students had used some illicit drug and/or volatile substance. Synthetic party drugs22 follow marijuana and volatile inhalants in popularity: 4.3% have used LSD or some other hallucinogen, 4.2% and 3.5% have tried Ecstasy and amphetamine, respectively. 7% of all the respondents have tried one of the three substances (Paksi, 2000b). It is typical that every second respondent (49.2%) of the latter category has tried at least two of the three drugs and every fifth person (21.5%) has experimented with all three drugs23. It may also be stated that the great majority (92.3%) of those experimenting with these substances has used some other drug in addition to LSD, amphetamine or Ecstasy. The ratio among the respondents of those who have tried one of the three substances but have never used other drugs is a mere 0.5%. Marijuana and hashish (86%) are the most frequent other substances tried by those that have experimented with synthetic party drugs.
Similar results were reported in two additional studies, analysing adult populations. A survey of visitors to dance clubs (1507 persons, average age: 21.3 years) shows that 22.3% of the respondents have used some stimulant (amphetamine, Ecstasy, cocaine or crack). Amphetamine proved to be the most popular stimulant: every fifth respondent (20.1%) have tried this drug. Substantially fewer respondents have had a single lifetime experience with Ecstasy (12.9%), cocaine (8.8%) or crack (1.4%). Amphetamine proved to be the dominating substance as 90.2% of the respondents who have had at least a single lifetime experience with some stimulant reported to have used it. Also only 7.7% of Ecstasy users, 12.1% of cocaine users and 19% of crack users reported not to have used amphetamine at all. The great majority of persons with a single lifetime experience with stimulants have tried other substances, which brings the ratio of those using stimulants only to 1% of the total sample. Almost all of them (94.1%) have used marijuana or hashish at least once in their lives and two out of three (67.1%) used those drugs in the month preceding the survey. The ratio of LSD experience (65%) is also high among the respondents and every fourth stimulant user (26.4%) has tried opiates (Demetrovics, 2001). These figures are consistent with the results of a survey conducted with a similar sample in Budapest two years earlier (Demetrovics, 2000a).
Ritter and Kó (2001) show a similar polydrug user picture of this group. Each of the 101 amphetamine users the authors managed to reach using the snowball method has had lifetime experience with another drug. Almost all of them have used marijuana (98%),

[21] The term 'some drug' refers to using illicit substances and/or volatile inhalants
[22] Following the author's definition synthetic party drugs are interpreted to mean amphetamine, Ecstacy and LSD
[23] No data are available for simultaneous use in 3.6% of the cases

hashish (97%) or LSD (92%), but the ratio of cocaine (76%), heroin (53%) and other opiate (43%) use was also high.

The results of a study conducted in spring 2001 of drug use by the average Hungarian population suggest that synthetic drugs are ranked second to fourth on a scale of life prevalence rates after cannabis derivatives. Taking the standard error of the estimate into account (0.5-0.6% in these cases), there is practically no difference between the popularity of these drugs, which include Ecstasy, amphetamine, and LSD (1.6-2%).

Studies of Clinical Populations

Although the studies presented above seem to suggest that the users of amphetamine type substances form a rather polydrug user group, other studies seem to contradict this view to a certain degree. For instance, Gerevich et al. (2001), who performed latent class analysis of the data of 1007 drug addicts seeking assistance from the *Drug Prevention Methodological Centre and Outpatients Department* between 1994 and 1999, identified seven categories of substance use three of which showed material degrees of amphetamine use. Of the seven categories of substance use the first included polydrug users, the fourth comprised party drug users, and the fifth was made up of amphetamine users. Whilst the latter is characterised by hardly ever mixing amphetamine with other substances (MDMA has very low probability), the groups including party drug users and polydrug users tend to use marijuana, LSD and Ecstasy (MDMA) in addition to amphetamine. Party drug users include instances of experimentation with cocaine and heroin but each of the substances have a lower probability here than in the group of polydrug users. On the other hand, the smaller significance of the latter group is indicated by the number of persons classified here (11, or 1.1% of the sample), whilst the groups of party drug users (119 persons, 12%) and amphetamine users (106 persons, 10.7%) were more populous.
These results raised a question whether or not amphetamine users form two basic groups. The first includes addicts using more or less amphetamine only whilst the second group is more likely to present symptoms of using other psychostimulants, marijuana and hallucinogen substances in addition to amphetamine. Addicts in the latter group, i.e. those that must have appeared in the studies reviewed above, are equally likely to use any of the substances known as party drugs. As seen above, the group using amphetamine only is essentially not present in the clinical samples. As the analysis reports no data regarding the intensity and duration of use, it is impossible to decide whether that group comprises a group of addicts with stable drug preferences[24].

A Few Features of Using Amphetamine Type Substances

All the available data indicate that marijuana and hashish are the illicit drugs people experiment with for the first time. Ritter and Kó (2001), however, worked with samples where 8% of the respondents reported to have used amphetamine as the first drug in their experience and first lifetime drug experience with amphetamine or Ecstasy was as high as 12.3% and 12.8%, respectively, among party drug users reached in the secondary school sample. Paksi (2000b) points out that the age at which drugs are used for the first time is earlier among those using synthetic drugs than among the users of other drugs (first of all marijuana), who do not take amphetamine, LSD or Ecstasy. Hence while a more than half (54.2%) of the former group used drugs of some kind at the age of 14 or earlier, the same ratio is 38.9% for those using other drugs. Nevertheless, the ratio of those that tried drugs before 15 years of age is as low as 22% among the amphetamine users reached by the snowball method, and there is not a single person among them who used amphetamine under the age of 14. But 6% injected the substance for the first time. 13% of the respondents at dance clubs have reported at least a single lifetime case of intravenous amphetamine use.

[24] The authors analysed actual drug use.

The Intensity of Using Amphetamine Type Substances

As the ESPAD survey studied junior and sophomore secondary school students whose (actual or potential) drug history was short, the analysis of their data reveals very little about the intensity of and the long term changes in use.
The intensity of using amphetamine type substances can be derived first of all from surveys conducted at dance clubs. About one third (34.7%) of the 337 people who have tried stimulants reported not to have use these substances in the year preceding the survey, whilst approximately the same proportion (30.6%) said they had used amphetamine, Ecstasy, cocaine or crack in the month before the survey. Of those who have ever used stimulants, the ratio of those that used such substances is higher than a quarter in the case of Ecstasy and amphetamine (28.7% and 26.1%, respectively) whilst almost every fifth (18.2%) cocaine user, and fewer than every twentieth (4.8%) crack user reported to have used the drug in the month before the survey. Four out of ten persons taking the drug in the preceding month mentioned a single instance, and a third (34.2%) reported less frequent than weekly use. Weekly use was at 12% and more frequent use reached a similar percentage, but no person reported daily frequencies of usage. Although increasing intensity of use cannot be excluded, this assumption seems to be contradicted by the fact that the average length of use was 3.3 and 3.2 years among amphetamine and Ecstasy users, respectively.
All that is suggestive of the social, recreational nature of stimulant use in dance club like entertainment facilities, i.e. the dominating form of drug use is less frequent than weekly use and is related to leisure and entertainment. This is supported by the finding that more than three quarters of stimulant users would typically do so among friends and acquaintances and, additionally, one in every 6 or 7 persons reported using the substances together with their partners. The ratio of lone users is 3% for amphetamine and 1.9% for Ecstasy.
The dominance of social, recreational use is indicated by the failure of the questionnaires targeted at the psychology of the personality to detect a difference between stimulant users and those not using drugs or those using other substances in terms of depression, self-esteem and the degree to which they are satisfied with life. The only personality dimension to show a difference among them was the search for sensory pleasure. Young stimulant users report more intensive search for pleasure and excitement than those not using drugs. This finding is not surprising, if we taking to account that the search for new experience and excitement is regarded to be the major drive behind drug use, particularly stimulant use in addition to self-healing tendencies (Leshner, 1999).

The Location of Using Amphetamine Types Substances

Amphetamine type drugs and a few other substances (first of all LSD and other hallucinogens) are often described as party drugs or disco drugs. Several Hungarian studies (Demetrovics, 1998 and 2001; Fejér, 2000) and a number of foreign authors (Boys et al., 1997; Forsyth, 1996; Cohen, 1998) prove close interconnection between these substances and certain musical trends (techno, acid house, jungle, goa, trance, etc.) and the related disco-party-rave sub-culture. The Hungarian study reviewed above also confirmed these findings. About half of the respondents (43.8% and 57.3%) who reported using amphetamines or Ecstasy said they used these drugs at entertainment facilities, dance clubs only, and every fourth or fifth user connects the likelihood of use to these locations rather than to other venues. It is important to highlight, however, that visiting entertainment facilities, discos does not necessarily couple with drug use as 81.7% of Ecstasy users and 82.6% of amphetamine users reported less frequent use than fifty percent of the number of times they visit entertainment facilities. The ratio of those who use Ecstasy or amphetamine (almost) all the time that they go dancing is less than 10% of the total number of uses.
Reference has been made to the fact that these findings are not derived from the analysis of clinical samples, which is why we cannot conclude that the intensified or addictive type of

mainly intravenous use of these substances does not exist. The increase in health statistics of the number of young users of these substances seeking treatment definitely confirms the assumption that this form of use is also present in the Hungarian population. This is indicated by both clinical case histories and the study by Honti and Temesváry (2000), who traced down and contacted 100 intravenous drug users in Szeged. The authors report 23 persons who used amphetamine first of all and 10 additional swapped users of amphetamine and heroin.
Addictive use, however, is more likely with amphetamine. Several studies of the effects of Ecstasy report that the intensity of experiences (euphoria, feeling of proximity to others, etc.) decreases substantially as consumption becomes regular and that there is a simultaneous surge in the dominance of negative symptoms such as exhaustion, depression, lethargy, sleep disorders and concentration problems during the acute stage and in the days after use (Peroutka et al., 1988; Vollenweider et al., 1998). Accounts by Ecstasy users also suggest that a more reserved and less frequent usage pattern normally follows even if high intensity weekly or more frequent use happens to appear in the early stages of consumption.

Features of the Users of Amphetamine Type Substances

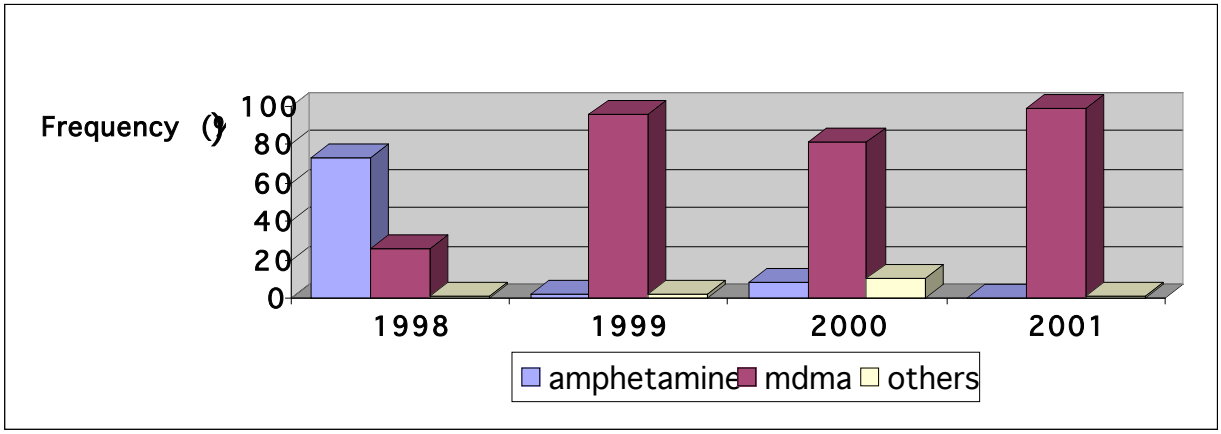
The domestic studies refer to above offer a mixed picture of the population that uses stimulants. Based on the findings of the secondary school study Paksi (2000) summarises the features of synthetic party drug (amphetamine, Ecstasy, LSD) users as follows. This type of drug use, just as the use of illicit substances in general, is more frequent among boys than among girls and is higher in village schools, the schools of the capital city and in vocational schools and apprentice training. Synthetic drug users tend to have lower grades on average and absenteeism is more typical among them than among their peers who do not use drugs. Fathers who dropped out of primary school before completing the eight forms are more frequent among synthetic drug users. The ratio of those that regard their families more favourable than average, and those that regard them as less favourable is both higher among the users of such drugs, who tend to come from single parent families or families with deviant parents. It should be highlighted, however, that the same features also appear in the case of other (non-synthetic) drug users, but the differences that set them apart from those that do not use drugs are less marked.
The disco study suggests a higher ratio of men among stimulant users, who are older on average, and the probability that they live in Budapest is higher but they are less likely to live in an unbroken family than non-drug users. Their parents and the users themselves are more likely to have a degree of higher education[25], the per capita income is higher in the family and they spend more money when they go out to have a night of fun. Just as the secondary school study this research also suggests that all these features appear, though in a less marked manner at times, with the users of other (non-stimulant) drugs. It is an important signal, that the discrimination analysis of social-demographic variables in appropriately categorises every third (30.1%) stimulant user as a non-drug user, regardless of the 75% probability of setting stimulant users and non-drug users apart.
As far as employment is concerned, no more than 2% of the respondents in the sample of Ritter and Kó (2001) reported joblessness. The ratio of white-collar employees without a degree was 21%, whilst white-collar degree holders represented 16% with 7% in management positions. Every second person (52%) does semi-skilled or skilled work. Similar ratios were observed among the respondents in the disco survey.

Active Ingredient Content in Seized Synthetic Drugs

Ecstasy is the most popular drug among young people in Hungary too. Originally, the name Ecstasy denoted a certain amphetamine derivative, notably MDMA (3,4-methylene-dioxi-

[25] The study by Gerevich et al. (2001) of a clinical sample does not indicate this tendency of higher qualification of the parents (mother).

methamphetamine) and has since become a collective term for *pills containing amphetamine and amphetamine derivatives.*
A smaller number of these pills are sold without imprint or marking in the black market, but the great majority of the pills display a mark.
The pills sold as Ecstasy in the market of illicit drugs do not have easily distinguishable external features but the type and quantity of active ingredient they contain may differ widely.
There were nine different types of active ingredient to pills seized between 1998 and 2001, but it is true that the majority of most recent pills contain MDMA. The graph below shows continuous reduction in the ratio of other active ingredients to MDMA. Other active ingredient types continue to exhibit great variety.



Active ingredient
Amphetamine
MDMA
MDE
MDA
Methamphetamine
2-CB (nexus)
4-MTA
1-PEA
PMA

Ecstasy pills may contain different additives, such as caffeine, ephedrine, antipyretic and analgesic compounds e.g. paracetamol and acetyl-salicylic acid in addition to or in certain cases instead of the active ingredient.
Substances with biological effect generally make up no more than 40% of the weight of the pills, and the bulk of the pills contain filler substances and additives needed for pelleting. These include starch, lactose, fructose or dextrose and calcium carbonate.

In 2000, 4-MTA and 1-PEA appeared as new active ingredients in Ecstasy pills in Hungary, and the newcomer of 2001 was PMA, a dangerous substance that have proved fatal in several cases abroad.

6.3. Opiates

A tea brewed from dry poppy-heads has been widely used in popular medicine for a long time and at places this continues up until the present day. Drinking the tea brewed from dried poppy-skin or poppy-heads was a recommended cure for sleeplessness and other symptoms.
Drug using behaviour appeared in the late 70s in Hungary. Teenagers did not try or take the illicit drugs which were popular in Western Europe due to limited access here, they tended to inhale the fumes of glues which could be purchased legally in Hungary, they used an anti-Parkinson substance branded Parkan and codeine containing preparations. Do it yourself opiates processed from green poppy and dry poppy-stalks started to grain ground in the early 80s. These were taken orally or administered intravenously. Oral accounts suggest that Hungarian drug users imported these methods from Poland. However, intravenous drug use, which appeared and became widely known in the second half of the eighties, involved few drug users.
Heroin, which appeared in the market of illicit drugs in the early 90s (the first seizure is dated 1992), was first sold to Hungarian users by Crossover Albanian Yugoslav citizens who stayed or had settled down in Budapest, but Budapest based Arab groups soon got involved with distribution.
Some of the poppy users converted to heroin after it was introduced, but whenever the financial position of a heroin user or access to heroin is limited, poppy is resorted to as a substitute substance. The brew from boiling poppy-heads is normally taken orally as a drink or is occasionally injected. This is the cheapest drug, because empty poppy-heads, which are necessary for making the brew, are relatively easy to obtain.

After heroin was introduced in the market of illegal drugs in Hungary in the 90s the number of users of this substance kept increasing. Although the rate of increase slowed down in recent years, professionals in the field come across more and more frequently with heroin use by children (under 14 years of age). Hungary has also witnessed the phenomenon when the carrier in drugs of a young person starts off with heroin and intravenous administration has also been found as the first form of consumption.

The results of the first study seeking to survey the degree of popularity of drug use by the general population showed in 2001 that the ratio of those trying opiates (heroin and/or some other opiate) was below 1%.
The next table presents the findings of a study conducted in the nineties of sophomore secondary school students in Budapest. The table shows error tolerances and highlights changes in excess of error limits (the reliability level associated with the ranges is 99%).

Substances	1992	1995	1998	1999	2000
HEROIN		0.2-0.8	0.1-2.5	0.3-2.3	0.2-2.0
INJECTED DRUGS		0.2-0.8	0.2-2.8	0-1.1	0.3-2.1
LIFE PREVALENCE RATE OF ILLICIT SUBSTANCES AND/OR INHALANTS	10.4-12.8	10.5-13.7		25.0-32.6	23.4-30.8
(N)	4518	2762	597	932	946

(Elekes, Paksi 2000b)

Studies of secondary school students found that the life prevalence rates of opiate or heroin use are very much inferior to the values measured for cannabis derivatives and synthetic drugs. No major shift is observed on the basis of values measured in the nineties.

The number and ratio of patients treated in health institutions due to *opiate* (opium, heroin, poppy-brew, etc.) use had kept increasing before 2000. In 1995, 22% of the patients in treatment used opiates, which grew to 30% in 1999 and to 39% in 2000. In 2001 the number of opiate users treated dropped 13% from the preceding year bringing the ratio of opiate users to 36% of all treated patients, which means that this category still represents the largest group of treated drug users despite the decrease.

The findings of a study seeking to show the impact of the amendment in the Criminal Code of the facts of the case of drug abuse, effective as of March 1, 1999, that the curve of detected heroin abuse cases is practically stable, i.e. there are no peak months as far as the time of committing criminal abuse of heroin is concerned. That is undoubtedly the consequence of the features associated with taking this substance. Heroin addicts are practically easy to catch. It is interesting that the behaviour of heroin users in the illicit drug market maybe characterised by inelastic demand at least up to a certain point of major increase in offered prices, and 'inelastic detection' is also typical of domestic heroin abuses. This may also come as a consequence of the inability of the authorities to handle these drug users and the action taken against them is quite time consuming and is regarded to be pointless by many legal practitioners.

6.4. Cocaine, crack

Although cocaine is seen as a high society drug and using it is a status symbol in certain organised criminal groups, occasional use of the substance is also detectable among some groups of young persons.
There have been no seizures of crack by the authority in Hungary, but professionals have indicated that the substance has become available in the domestic market of illicit drugs, a statement that is confirmed by the studies into drug use among the population in general and by secondary school students.
Studies of the population at large and secondary school students suggest that the life prevalence rates of cocaine and crack are low (below 1%). Nevertheless the number and ratio of those that have tried these substances are on the rise.
This is underpinned by health statistics: there was a 20% increase in the number of cocaine users in 2001, which brings the ratio to the number of treated patients to 1.7%. The ratio of this relatively narrow group to the total number of patients has not changed essentially in recent years.

Intravenous cocaine application is observed as a new phenomenon. Experts and studies started in the past year indicated that intravenous cocaine use was detectable in certain groups. Health statistics suggest that 15% of cocaine patients treated in health institutions administered the substance intravenously in 2001.

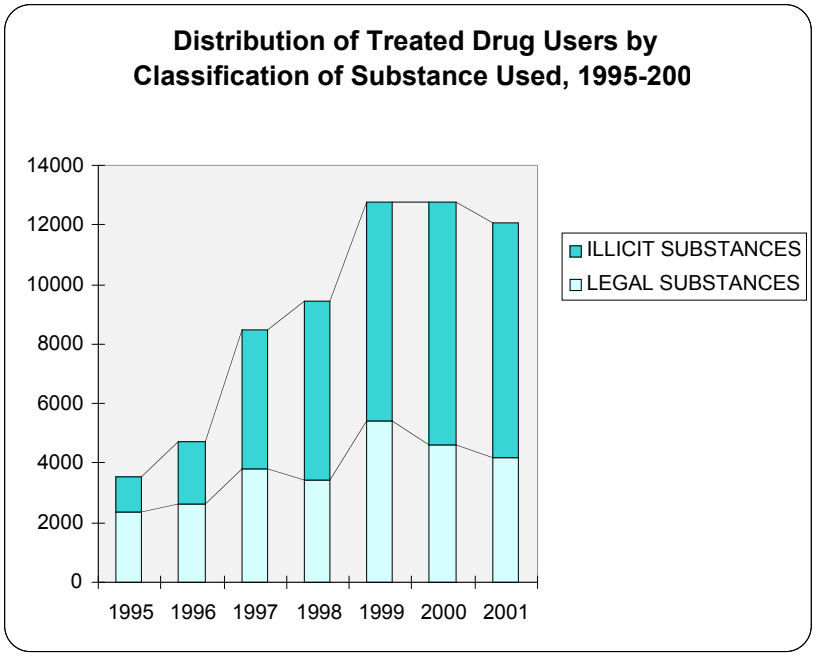
There has been no targeted study of the popularity of and features of use of this type of substance in Hungary. Nevertheless, the detectable changes in cocaine use indicate the need for such research.

6.5. Multiple use

Alcohol is the most popular psychologically active substance in Hungary. The current DRG system of financing hospitals by health insurance contains low amounts of reimbursement for diagnosed alcohol addiction cases, which is why institutions treating bed riding patients are interested in registering patients with alcohol addiction under some other better paid and medically justifiable main diagnosis with health insurance, which is easily feasible given the frequency of co-morbidity. That is the reason why the number of registered alcohol addicts does not reflect the truth. Nevertheless, the majority of experts agree that about one tenth of the population in Hungary has a drinking problem.
Abuse of a variety of tranquillisers and barbiturates is more popular than illicit drugs. The number of suicide cases is very high in Hungary in global comparison and most suicides are committed using tranquillisers and/or barbiturates.
These substances are easy to access and are often used in conjunction with a variety of narcotic drugs (mostly opiates). Also they are regarded to be substitutes due to the difficulty involved in obtaining drugs. Drug users (particularly amphetamine users) have been shown to relieve the unpleasant consequences of substance use by taking a variety of benzodiazepines.
There is a new surge in the use of inhalants after what seemed to be a declining trend in the mid 90s. The reasons include cheap and easy access, the widening in the supply of these substances and the sophistication and larger knowledge base of the users of such substances.
Although it is generally held that the bulk of volatile substance abusers are typically of lower social status, one cannot ignore the frequent instances of using narcotic substances e.g. sniffing glues or some other intoxicating volatile liquid or gas.

In 2001 health institutions treated 9.7% fewer users of illicit drugs with drug related problems than in the preceding year, whilst the corresponding drop in the users of legal substances was only 3.5%.
The ratio of illicit substance users kept increasing among treated drug users in the period between 1995 and 1998, whilst the ratio of those using legal substances stagnated essentially. In 1999 there was an increase of 59% in the number of users of legal substances on 1998. The ratio dropped yet again by 15% in 2000. This should be evaluated by taking into account a continuous increase in the total number of treated patients before 1999 and stagnating totals in 2000.

The Ratio of Patients Treated due to Using Legal or Illicit Substances, 1995-2001



All in all, *the ratio of using illicit and legal substances has reversed since 1995*: the ratio of those using legal substances dropped from 67% to 35% along with a simultaneous increase in illicit substance use from 33% to 65%. This reversal had set in by 1998 and was re-established again in 2000 after a shift in 1999. In effect, the present situation is an inverted mirror image of the initial status in 1995.

Sources:

Boys, A. - Lenton, S. - Norcross, K. (1997). Polydrug use at raves by a Western Australian sample. Drug and Alcohol Review, 16. 227-234.

Cohen, R. S. (1998). The Love Drug. Marching to the Beat of Ecstacy. The Haworth Medical Press, an imprint of The Haworth Press, Inc., Binghamton, NY, USA.

DEMETROVICS ZS. (2001). AMFETAMIN TÍPUSÚ DROGOKAT HASZNÁLÓK MAGYARORSZÁGON A KUTATÁSOK TÜKRÉBEN. IN. RITTER I. (SZERK.). JELENTÉS A MAGYARORSZÁGI KÁBÍTÓSZERHELYZETR_L – 2001. IFJÚSÁGI ÉS SPORTMINISZTÉRIUM, BUDAPEST.

Demetrovics Zs. (1998). Drog és Disco Budapesten. Táncos szórakozóhelyeket látogató fiatalok szociodemográfiai jellemz_i és drogfogyasztási szokásai. Budapesti Szociális Forrásközpont, Budapest.

Demetrovics Zs. (2000a). Amfetamin és Ecstacy használat budapesti diszkókban. In: Demetrovics Zs. (szerk.) A szintetikus drogok világa. Diszkódrogok, drogfogyasztók, szubkultúrák. Animula, Budapest. 159-169.

Demetrovics Zs. (2000b). Ecstacy: szakirodalmi áttekintés. Szenvedélybetegségek, 8. 2. 84-114.

Demetrovics Zs. (2001). Droghasználat Magyarország táncos szórakozóhelyein: 1997-1999. L'Harmattan Kiadó, Budapest.

Elekes Zs. - Paksi B. (1996). A magyarországi középiskolások alkohol és drogfogyasztása. Népjóléti Minisztérium, Budapest.

Elekes Zs. - Paksi B. (2000). Drogok és fiatalok. Középiskolások droghasználata, alkoholfogyasztása és dohányzása az évezred végén Magyarországon. ISM – Aula. Budapest.

Forsyth, A. J. M. (1996). Places and patterns of drug use in the Scottish dance scene. Addiction, 91. 4. 511-521.
Gerevich J. – Bácskai E. – Rózsa S. (2001). Máktea-fogyasztók: egy önálló drogfogyasztó populáció. Psychiatria Hungarica, 16(1):21-30.
Griffiths, P. - Vingoe, L. - Jansen, K. - Sherval, J. - Lewis, R. - Honti J. – Temesváry B. (2000). Intravénás drogfogyasztás és öngyilkos magatartás. Szegedi Önkormányzat Kórház, Pszichiátriai és Addiktológiai Osztály, El_adás kézirat, Szeged.
Honti J. (2000). Az ópiát-származékok "házi" el_állításának módjai. In. Ritter I. (szerk.). Jelentés a magyarországi kábítószerhelyzetr_l – 2000. Ifjúsági és Sportminisztérium, Budapest.
Hollósi Gy. (2001). A magyarországi illegális drogpiac jellemz_i. In. Ritter I. (szerk.). Jelentés a magyarországi kábítószerhelyzetr_l – 2000. Ifjúsági és Sportminisztérium, Budapest.
Hoyer M. – Tremkó M. (2000). Istenkeresés helyett egyszerhasználatos kapcsolat, avagy a drogfogyasztó magatartás, mint a társadalmi változások tükre. In: Demetrovics Zs. (szerk.) A szintetikus drogok világa. Diszkódrogok, drogfogyasztók, szubkultúrák. Animula, Budapest. 199-216.
Leshner, A. I. (1999). Science-Based Views of Drug Addiction and Its Treatment. Journal of the American Medical Association, 282. 1314-1316.
Nagy G. (2002). Az illegális kábítószer-piac jellemz_i. Kézirat.
Paksi B. (2000a). A „lázadó értelmiség" szigete. Kutatási beszámoló az „Egy speciális populáció szenvedélyszer használata – Pepsi sziget 2000" kutatásról. Kézirat.
Paksi B. (2000b). A szintetikus drogok epidémiája Magyarországon a 90-es évek végén. In: Demetrovics Zs. (szerk.) A szintetikus drogok világa. Diszkódrogok, drogfogyasztók, szubkultúrák. Animula, Budapest. 124-158.
Paksi B. (2002). A drogfogyasztás prevalencia értékei, mintázata, tendenciái. Kézirat.
Porkoláb L. – Grézló O.(2002). Egészségügyi statisztikai adatok a kábítószer-fogyasztásról - 2001. Kézirat.
Ritter I. (2002). A Büntet_ Törvénykönyv visszaélés kábítószerrel b_ncselekmény törvényi tényállására vonatkozó 1999. március 1-én hatályba lépett módosítás hatásvizsgálata. Miskolci Doktoranduszok Jogtudományi Tanulmányai (Szerk. Stipta István). Bíbor Kiadó, Miskolc. 255-287.old.
Ritter I. – Kó J. (2001). A magyarországi illegális amfetamin-piac jellemz_inek feltárása. Kutatási beszámoló.

7. Discussion

Available statistics and research findings suggest that the demand for illegal drugs has not decreased in spite of the drop since the previous year in the number of patients treated with drug use problems by health institutions in 2001. Such a decline is unprecedented since the introduction of data collection. The tendency had been visible already in 2000 when the number of patients, which had increased sharply in former years, started to flatten out. The number of treated patients has been stagnating essentially for three years now. (The number of drug users treated in health institutions stood at 12765 in 1999, at 12789 in 2000 and at 12049 at 2001.) This phenomenon, however, could be associated on the one hand with a change in the system of data collection, with the capacity limits of treating drug users in health institutions as well as with social effects caused by a change in the role of certain drug policy measures. The latter include for instance the amendment of the criminal code, the increase in the Governments contribution to finance the operation of institutions active in treating drug patients. However, treatment is financed from social security funds, which requires the provision of the patient's social security ID and hence renders the drug addict seeking healthcare assistance easy to identify.
Statistics kept by institutions and research findings justify that there has been a *significant decline in the rate of increase* in drug use.
The direction of changes in Hungary falls in line with general European trends.

Starting 1999, both the number of drug users treated in health institutions and the number of drug abuse misdemeanours continued to increase, along with a simultaneous decline in the rate of increase. The trend continued in 2000 and 2001.
Marijuana is the most popular substance and is followed by amphetamine derivatives and opiates (namely heroin).
Although, the frequency of occurrence of amphetamine derivatives decreased substantially in relation to both the patients treated in health institutions and to detected criminal cases that does not at all mean a reduction in the consumption of substances of this type. Habitual drug users tend not to contact a health institution with their problem and as the scope of diversion offered as an alternative to criminal charges narrowed, there was a drop in the number of habitual users that contacted health institutions, furthermore the Police seems to pay limited attention to amphetamine users (there are hardly any disco raids).

Along with the favourable development that the growth rate of the use of illicit substances is on the decline, there are changes in the quality aspects of the problem. Such as:

- Intravenous drug users spreading – information is piling up about the rise in the number of young people who choose intravenous application when they first try the drug; cocaine injection is also of a detectable order of magnitude;
- Hepatitis B, C infection rate is on the rise among intravenous drug users. In Hungary HIV/AIDS infection is not typical among intravenous drug users (there are 2 known HIV positive cases), but Hepatitis C (HCV) infection is higher than average (9.4-17% in 1996-1997, 26% among men and 20% among women according to a 2001 study of intravenous drug use). The frequency of occurrence of HCV is highest among the 13-19 year old. The first instance of using drugs occurs at an earlier age, and statistics show the largest rate of increase among young people;
- Drug use is spreading substantially in the Roma population, accounts by experts suggest that there is a major increase of intravenous heroin use among Roma children (>14 years) and young people;

- Drug use is on the rise among the perpetrators or conspiracies committing traditional crimes; the number of criminal acts perpetrated to obtain drugs is increasing;
- The growth rate of the number of drug abuse misdemeanours perpetrated by young people (14-18 years of age) is more than twice as high as the rate of growth in the total number of drug abuse misdemeanours. Every sixth person that perpetrates a drug abuse misdemeanour is a minor.

The first study targeted first of all and not only tangentially at drug use by the general population was conducted in Hungary in spring 2001 (Elekes-Paksi 2002). The study aimed at mapping the popularity and the risk factors of and the opinion of the population on drug use. The study found that 6.4% of Hungarian adults between the ages of 18 and 65 have used some illicit drug. An analysis of life prevalence rates by drug type shows that there is a different role of substance types in the structure of drug use. The use of cannabis derivatives (5.7%) tops the list.

In 2001, the National Institute of Criminology performed a study of the impact of the amendment in the Criminal Code of the facts of the case of drug abuse, effective as of March 1, 1999. The findings of the study substantiate that the effectiveness of the amendment of the legislation, which brought a major shift in the evaluation of drug crimes under criminal law (by imposing more restrictive rules), is questionable.
If it is assumed that the desired social effect of the amendment was to drive back drug abuse (including drug use and trafficking), and in case effectiveness is measured in the light of statistics and research findings of the period that has elapsed since, it is obvious that the attempt to drive back the popularity of drug use and drug trafficking failed. The regulations and the enforcement of law in practice are burdened with contradictions. The study justifies that the amendment brought more negative consequences than positive outcomes. This assertion is valid for both procedures and for social effect. The increased austerity of the act (and especially poor communication) triggered adverse changes in the behaviour of the drug market and drug market participants.

7.1. Consistency Between Indicators

EMCDDA key indicators, if related data are available, and criminal statistics offer a fairly uniform picture of the increase in drug use in the late 1990s and of the subsequent decrease in growth rates in 2000 and 2001. The exceptions include the changes in demand for treatment and drug related fatalities where the situation seems to be relatively stable despite the gaps in available data. Favourable developments are observed with infectious diseases although the rate of Hepatitis C seems to increase. Certain indicators frequently offer a mosaic like coverage of drug phenomena: data collection is not comprehensive; there are significant modifications to the definition of an indicator at times (such as with the collection of health statistics in 2000).

7.2. Methodological Limitations and Data Quality

One of the principles of the National Strategy to Combat the Drug Problem is *the primacy of facts*: the National Strategy relies on facts supported by research findings and not on

assumptions. Nevertheless facts are frequently derived from data that are at times not so easy to interpret.

It is quite problematic to see why the findings of different studies are at variants with the trends plotted from data collected and analysed by individual organisations and institutions.
The data used most frequently in connection with the popularity of drugs are collected by different organisations (health sector, criminal justice, social welfare) and also come from research findings. Both data sources are useful and are complementary to each other in our attempt to map the popularity of drug use, the characteristics of the problem, consumption habits and changes in the drug scene. Both methods of data collection have advantages and drawbacks: for instance, questionnaire based surveys offer and advantage in that they can be applied to a relatively representative sample of the population and deliver information about parts of the population that have never been visible for an institution in connection with their problem but have already taken drugs or are using it with a certain intensity at the time of data collection. That is to say, they offer an overview of the drug habits and the popularity of drug use of the population at large or of a certain group.
The disadvantage of research of this kind is the unwillingness of some of the respondents to answer as well as the inability to test the truth value of responses and in case the subject matter is a punishable criminal act it is appropriate to assume that some of the respondents will refuse to give an honest answer to certain questions even if anonymity is guaranteed. The validity of questionnaire-based research depends practically on the quality of data collection and the sophistication of the methods applied. Naturally, sampling problems and those related to methodology as a consequence of the willingness to respond may be adjusted using a variety of statistical methods, but the truth-value of responses cannot be tested for certain.

The data collected by a variety of organisations and institutions originate from a part of a population that has contacted these organisations. As the drug users there are visible for these organisations do not necessarily reflect the population of drug users, these data are representative only of the population of drug users registered in the given institution. In Hungary, there are databases of drug users registered with health institutions and the perpetrators of drug abuse misdemeanours.
It seems, however, that there is a time lag between the onset of drug use and the time at which a user contacts one of the aforementioned institutions. That introduces distortions to the databases of these organisations as the majority of newly registered people with drug problems look back on a longer career with drugs.
As the databases kept by institutions only contain the number and parameters of people they have contact with and as the volume of these figures depends heavily on the capacity of and the number of beds in these institutions, on the quantity and quality assets, funds and personal resources, which is why the data collected by such institutions are indicative of the operation of such organisations rather than the actual trends in drug use.

Data collected by various organisations and data collection systems reflect the aspirations and the interests of the organisation or institution collecting the data and these in turn may modify the data themselves. For instance, the data from the system of the **Uniform Criminal Statistics of the Police and the Prosecutor's Office** are also used for evaluating the performance of the Police force. It is obvious therefore that those providing the data are consciously or unintentionally interested in generating a favourable image of their own performance. That could introduce a certain element of selection and distortion.

Similar problems are seen in the **Hungarian system of health statistics** where the data collected by an institution are also intended for measuring the success rate of the given institution. In addition to other problems of the system used for collecting data, there are conflicts of interest associated with the anomalies of financing the health system. The current DRG system of financing hospitals by health insurance contains low amounts of reimbursement for diagnosed addiction cases, which is why institutions treating bed riding patients are interested in registering patients with addiction under some other better paid and medically justifiable main diagnosis with health insurance. This problem is practically manifest in all the systems of collecting epidemiological data by the health system.

It should be pointed out that the system of collecting health statistics regarding the number and parameters of drug users treated in health institutions has changed. Accordingly the form and content of the report has been modified and certain terms have new interpretations. Consequently the effects of the change in the data collection system should be mentioned as one of the reasons why the number of patients treated has changed (increased, decreased) as compared to data taken in previous years. (E.g. participants of the needle exchange programme have been excluded from the recipients of treatment.)
The data collected about drug users treated in health institutions in 2001, the ratios of variance with previous years and any plotted trends can only be interpreted correctly if the changes of the data collection system and the related effects are shown.

Each of the malfunctions of the data collection system should examined separately, because awareness of how the figures were calculated and what they mean exactly helps a lot during the interpretation of the data.
That is why statements representative of the phenomenon as a whole cannot be formulated about the popularity of drug use in the population and the trends of consumption with reliance only on data collected by the National Institute of Psychiatry and Neurology on drug users treated in health institutions and by the Uniform Criminal Statistics of the Police and the Prosecutor's Office on detected drug abuse cases and the related perpetrators.
Consequently, statements about the popularity and features of drug use made exclusively on the basis of these institutional databases should not by any means be regarded well-founded.

Armed with practical experience, professionals working in a variety of fields associated with the drug problem and drug users, however, have a good general sense of changes in the arena of drugs. Collecting and analysing what they offer could add to our knowledge base about the popularity and parameters of the phenomenon.
What are known as qualitative studies could add 'finer touches' to the factors behind the data available on certain areas of the drug problem.
If we wish to describe the current popularity of drug use or to plot trends it is necessary that we examine and interpret the available databases and research findings.

The data collection system used in Hungary in connection with drug users treated in Hungary is only partially compatible with EMCDDA guidelines; changes are necessary and case per case data collection should be introduced in healing institutions (instead of annual summaries). Comparison with previous years is ad-hoc because of the introduction of the first treatment need indicator introduced in 2000 which does not support valid conclusions to be drawn regarding 2001.
Criminal statistics ratios only describe the shifts in direct drug crime. There are no valid data about indirect drug crime cases such as criminal acts motivated by generating income, procurement and consequential crimes (i.e. crimes under the effect of drugs).

Epidemiological studies should be expanded to cover different groups at risk (e.g. the Roma, convicts, prostitutes) and special forms of data collection are needed with problematic drug users. Communicable diseases should also be monitored more accurately.

The section below offers a summary of data quality problems as they relate to each EMCDDA indicator. The unit responsible in the organisation of the Ministry of Health for setting up the national Focal Point set up working groups in 2001 to explore the problems of the Hungarian data collection system with a view to the individual indicators and to introduce the system of data collection and data processing recommended by EMCDDA. The working groups have embarked on realising these objectives. The reports and plans of the working groups are presented below.

Treatment Demand Indicator (TDI) – health statistics

The data collection and processing system introduced in 1994 was adopted by more and more institutions as years passed to reach comprehensive application finally in 2000. There are annual reports by institutions of data derived in arrears from medical and financial documents for the past year, which are forwarded for processing next February.

Unfortunately data reporting suffers from lack of proper discipline, some of the data are received upon several requests after submission deadline (January 31 of the following year), mistaken entries due to misinterpretation and erroneous calculations are frequent. The form has always included instructions, which few providers of data seem to read, however. It is due to these delays and the often time consuming reconciliation that the IT and Organisation Department of the National Institute of Psychiatry and Neurology (NIPN) fails to meet the deadline for processing (February 28), when only preliminary results and statistics calculated from these figures can be made available regularly. The unpleasant consequence of this is the mix up and distribution by word of mouth of several versions of the figures once preliminary results are adjusted later on.

The obligation to report data is provided in a Government regulation issued each year since 1994 in the related chapter of the National Program of Collecting Statistics (hereinafter: NPCS) (**NPCS report No. 1627**). Data were collected and processed in essentially the same form between 1996 and 1999.

Changes in the Form of the Report in 2000

The form of the report changed in 2000 in response to the experience of previous years and upon the initiative of the Ministry of Health. One of the obvious aspirations during the modification involved maintaining comparability with earlier data as much as possible. One of the most important elements of the modification requires the entity reporting data to enter in the new tables 1/a and 1/b the number of male and female drug users that contacted the institute and were accorded treatment in the given year in a breakdown by age groups identified in the form, regardless of whether or not the such users were actually registered. The age breakdown, which is of major technical importance, used to be included in the table showing the number of registered patients at year end, which is not identical to the number of patients treated in the course of the year. Furthermore, neither the interpretation of the term, nor the related practical applications were uniform. The number of registered patients also appears in other health care reports, e.g. annual reports by care centres, where the nature of the activity requires accurate registration and patients that do not appear for a year

are uniformly deleted and information about their subsequent fate (deceased, moved, cured, etc.) is added. On the contrary, in-patient departments do not have such records, whilst drug outpatient centres maintain the records of patients for a number of years even if a patient is not treated in the year subject to the report. That is why it was so difficult to interpret the number of registered patients.
Another important modification involves the introduction of the new tables 2/a and 2/b, which contain particulars broken down by age group of men and women that receive treatment for the first time. The definition 'showed up for treatment for the first time' does not mean that the person contacted the particular institution for the first time, instead it means that a drug user makes a statement upon admission that it is the first time he or she appears for treatment in his/her life. Such depositions by affected persons are obviously not always reliable and the modified form is likely to filter the cases when the status of drug users (e.g. a set of withdrawal symptoms) makes it unquestionable that they are not new patients, although they actually show up at the particular institution for the first time.
What seems to be another important modification involves the narrowing of the scope of the term 'treatment': the new guidelines for using the form say that recipients of replacement needles need not be recorded among the recipients of treatment. Age groups have also been modified and what used to be a single group for individuals above 35 years of age is now broken into age brackets of 5 years terminating at 55, over which there is no further breakdown by age.
The report has been expanded to cover additional drug types (or psychotropic substances) (e.g. methadone used without prescription), and the new form does not allow the reporting entity to enter cases belonging to an undefined kind of drug of a certain category in the row for the category. In addition to entries about drug categories, the number of users of sub-types in a category also has to be identified (e.g. the category OPIATES, the number of opium, heroin, morphine, other opiates and synthetic analgesic drugs, if known). If the name of the drug a user has taken is unknown, the entry will have to be made in the 'Nondescript' box of the appropriate category. That way 'category totals' will be identical to the sum of breakdown figures.
As far as the frequency of drug use is concerned, 'weekly' use has been added to the former categories of 'daily' and 'occasional' use.

Data Processing

Data are double-checked in several cycles: first, a statistician checks the reports received from reporting entities. These ***will almost always contain internal contradictions and miscalculations.*** Once unintelligible, serious errors are eliminated some of the forms are returned to the reporting entity for correction, whilst 3 computer operators capture the data in reports that lend themselves to processing in Excel tables. Data entry interfaces need to be created each year and although the concept has been maintained since the very beginning, each year has brought some minor modifications in order to insert new checks and to eliminate the problems that arise in the processing stage. Captured data are filtered yet again using sub-routines containing checksum formulae in the processing files to **flag internal contradictions in reports by a single entity**. The next stage is designed to eliminate positive or negative deviations in orders of magnitude in the figures by comparing reported data with those furnished by the same entity a year earlier. Reports by mixed profile (psychiatry and addictology) care centres are subjected to an additional check to see if they really report different figures or have entered the same number of patients twice. Data are summarised to create totals from a variety of perspectives, i.e. by region, by type of institution, etc. **Care centre figures are actually reconciled with the National Statistical Office, where reporting entities also have to send a copy of their report, and the two**

sets of data are normally found to deviate because of the checks and corrections made by the NIPN. Once summarising is finished, graphs and written analysis are added to annual reports. In addition to the annual figures reported to the Ministry of Health, the NIPN creates reports from several perspectives from its database upon request. This part of its work is continuous and is unrelated to the month-long period of processing. Reports are also used to generate the address lists for mailing the report forms to reporting entities for the next year. This way most of the changes become manageable, but it still happens occasionally that the NIPN is informed almost 'by accident' of the creation of anew reporting entity. The classification of drug outpatient centres is also problematic, as some of these institutions also operated at the same time and at the same site as care centres of addictology, or 'evolved' from such centres. At present, a list provided by the Professional Association of Drug Outpatient Centres is used to identify existing drug outpatient centres.
Treating institutions report aggregate data about drug addicts so it is impossible to eliminate from the statistical system patients that sign up with and are registered by several institutions (**double-counting**). These institutions only have on-site means to find out whether or not a patient has visited them earlier or is regarded to be a drug user that was accorded treatment for the first time. Medical specialists have found that drug users form a population of patients in Hungary at present that frequently move from one treatment site to another. IN a single year, they may turn up, for instance, at a Budapest care centre and at one in Pest county and may be admitted to an in-patients department, and the statistical records of a single year will count the same person three times.

Due to the problems associated with methodology and reporting data, the NIPN performed a semi-annual check in 1999 and requested reporting entities with the largest turnover to submit data pertaining to drug use in the fist six months of the year. In February 2000, the institute compared the data thus received to data reported for 1999 as a whole and was shocked to find that about 20% of the reports suggested that the reporting entity treated fewer patients throughout the whole year than in the first half only. The corrections and verifications that followed indicated one or another of the aforementioned methodological problems.

Frequent erroneous reporting due to misinterpretation and **recurrent miscalculations** continue to pose serious problems. Although the nature of the mistakes and the degree of the resulting distortion vary but the majority of the reports need adjustment and data reconciliation in arrears. A comparison of data before and after adjustments, the variation in the number alcohol addicts was 52% altogether, whilst the total variation in the number of drug addicts was 1.5%. The number of alcohol addicts is reported for the purposes of studying simultaneous use, and the extreme distortion results from the failure by many reporting entities to fill in this box. Most institutions normally supply the missing data upon clarification over the phone. The tables in the reporting form provide information in a variety of breakdowns about all of the patients treated at an institution, which is why they should not contain contradictory figures. Yet, it is very rarely the case.
The validity of the figures could also suffer from the supremacy of financing needs in addition to miscalculations. It depends on the technology of managing data at a treatment institution whether or not drug patients 'hidden' to avoid conflict with funding requirements will actually appear in the data collected for statistical reporting purposes. The institutions with larger turnover of patients generate information for annual statistics from the financing module of their computer databases. The current DRG system of financing hospitals by health insurance contains low amounts of reimbursement for diagnosed addiction cases, which is why institutions treating bed ridden patients are interested in registering patients with an addiction under some other better paid and medically justifiable main diagnosis with

health insurance, which is easily feasible given the frequency of co-morbidity. This problem influences all attempts to collect epidemiological data in the health sector and is not limited to the data related to drug use, which is why the solution or alleviation of the problem would require high level comprehensive measures.

At year-end 2000, the NIPN administered a questionnaire-based survey of reporting entities to map the technical conditions of electronic reporting and to measure the willingness to participate. A brief summary of the results suggests that the great majority of reporting entities have a computer of some kind. Half of the electronic equipment is obsolete, whilst the other half comprises modern machines capable of electronic reporting and data transfer. The willingness of the employees at these institutions to try the new method is higher than the level of technical capability: 65% responded in the affirmative. Yet, 20% of the institutions would not like to participate in testing and 15% are uncertain. The interest shown by drug outpatient centres is extremely high, and almost all of them intend to participate, which is a very lucky coincidence, as it is practical to involve them anyway because of the large turnover of patients there. The results confirm our opinion that the experimental stage of electronic data collection may start on a voluntary basis. The necessary technical conditions for testing the method exist at a high number of institutions and comprehensive introduction may be realised at minimum cost in a few years' time.

Drug Use Related Mortality

A Government regulation in force makes the NIPN responsible for collecting information on drug related mortality cases. NIPN uses a questionnaire developed in accordance with UNCDT guidelines to perform this survey with purely statistical methods. The questionnaire covers classic drugs (opiates, amphetamine and derivatives, THC, cocaine) as well as psychoactive substances (barbiturates, benzodiazepines and other substances) and volatile substances. Data are reported by sex in age brackets of 5 years by university clinics of forensic medicine, institutions with related expertise in the Ministry of Justice and Police physicians. As data collection is limited to statistical reporting of the number of cases, there is no opportunity to test data validity and no information is available regarding the actual cause of death. The nature of the data collection restricts findings to overdoses of drugs and psychotropic substances and to suicide cases and leaves other questions uncovered. As data do not lend themselves to identification, it is impossible to filter possible overlaps.

The deadline for reporting data is January 31, each year. That means reports will be based on diagnoses noted in death certificates and will not show the findings of toxicology examinations related to autopsies performed in the ultimate third or second half of the year subject to the report.

Data reported this way will describe mortality cases related directly to drugs and psychotropic substances – without even partial findings of toxicological nature –, but will not differentiate overdoses of drugs and psychotropic substances and related dependency cases from suicides. Processing the data by age brackets shows two peaks, one between the ages of 20 and 30, including mainly deceased males, where the cause of death is an overdose of opiates (rarely other drugs), and another peak around 60 years of age, involving a group composed mainly of deceased females, where the direct cause of death is an overdose of medication with direct effect on the central nervous system, i.e. these are suspected suicide cases.

In order to achieve higher data purity, a working group of the Co-ordination Committee on Drug Affairs developed the following set of parameters in 2000 for surveying drug related deaths:

The survey covers deaths caused by all the substances covered by the convention on narcotic drugs and those covered by Annexes I and II on psychotropic substances in the following breakdown:
- suicide or homicide committed using the above substances,
- accident or accidental overdose,
- violent death (fatal traffic or other accident, suicide, etc.), where the cause of death is not attributable to an overdose of narcotic drugs or psychotropic substances, but the presence of such substances in the organism had a role to play in eventual death,
- death of natural causes arising from causes the development of which is also attributable to the deceased person's former use of narcotic drugs, without the actual presence or with the presence of a by no means fatal dose of drugs or psychotropic substances in the organism at the time of death.

The National Institute of Forensic Medicine has surveyed the mortality cases of 2000 using the parameters described above and processing year 2001 data is also in progress.

Data reported by the NIPN and the National Institute of Forensic Medicine do not cover the same target group, but there are obvious overlaps. Both institutes have identified several disadvantages in terms of a comparison to EMCDDA recommendations.
Both data systems and indeed the whole Hungarian system suffer from ignoring in general the mortality information of addicts treated in hospitals or elsewhere. Reported data only cover deaths in extraordinary circumstances, whilst the autopsies of the aforementioned cases are normally performed at pathology departments rather than in the network of forensic medicine.

Objectives:
Taking EMCDDA guidelines into account:
- making the present system compliant with European standards
- transforming the present system, obtaining valid data for international comparison.

Tasks:
1. Comprehensive reporting requires more than the present system of collecting the mortality data of extraordinary cases, departments of pathology, or at least those also performing autopsies for departments of addictology will need to be included as reporting entities. In order to ensure that reporting is comprehensive and uniform, the system of autopsies will need to be reorganised in a statute or a measure by the regulatory authority.
   The legislative provisions governing extraordinary death list the cases when autopsy has to be performed by the authorities or a unit of forensic medicine rather than by a department of pathology. Our position is that the present statute may be interpreted to mean that death occurring in connection with the use of a narcotic drug or psychotropic substance must be classified as extraordinary mortality. That is seen as sufficient reason to have the autopsies of patients exiting at addictology departments or during follow-up also performed by forensic science specialists.
2. The form developed by the National Institute of Forensic Medicine more or less contains all the responses that facilitate the classification of cases according to the DRD system. Some questions should, however, be added to the questionnaire and the algorithm for

ICD X coding, which has been in effect in Hungary for years, has to be procured for EMCDDA.

3. Once data are processed after validation, classification must be performed in line with the EMCDDA system.
4. Although protocols taken in compliance with the effective letter on methodology and the recommendations of the Council of Europe regarding autopsies contain all the necessary data, Hungarian practice is still not in full compliance. It is necessary therefore to develop an autopsy protocol with reliance on the aforementioned requirements to ensure that the data needed for evaluation (autopsy protocol, histology tests, toxicology) are available for every case.

It seems justified to conduct a retrospective pilot study of the period between 1997 and 2001 in H2 2002 using the form of the National Institute of Forensic Medicine once it is modified in line with the above. The National Institute of Pathology will also have to be included among the reporting entities so as to avoid data loss due to the factors discussed above.

The findings of the pilot study will have to be compared with NIPN data reports to allow conclusions to be drawn regarding which groups had been left uncovered by earlier statistics.

The results will in part contribute to the finalisation of the method of reporting data and will in part serve as the basis for the development of proposed amendments to exiting legislation. It is easy to foresee that it will be more practical to issue legislation that makes the National Institute of Forensic Medicine rather than the NIPN responsible for collecting and reporting mortality data, and that potential amendments to the law will also be required to ensure that whenever death is caused by drugs and psychotropic substances, autopsies should be performed under the rules pertaining to extraordinary mortality.

After the pilot study, 2-3 years of experimental reporting of data will be necessary, and once the result are evaluated, an EU conform system of registration may be introduced nationally – in all likelihood simultaneously with EU accession.

Communicable Diseases Related to Drug Use

Accurate information about the user habits of Hungarian IDUs (frequency, dosage, sterility of instruments, place of administration, IDU communities, etc.) is scarce, and no correlation can be established between available data and the frequency of virus infections. Taking EMCDDA recommendations into account, it is indispensable that we enlarge the scope of information in Hungary in this regard in line with the program of key indicators for communicable diseases.

New Synthetic Drugs (NSD)

The joint action concerning NSD includes 3 stages:

1.*/ Early Warning System (EWS)*

Obtaining detailed information as soon as possible about new substances in the drug market so as to be able to forward the information to member countries via EMCDDA and Europol.

2.*/ Risk Assessment Report*

Drafting this report in collaboration with appropriate experts on the basis of collected information.

3.*I Decision on necessary legislation on the basis of the report*

Present situation: The Police Headquarters, Institute of Forensic Sciences (ICCR) of the National Police Headquarters maintains a uniform database of the findings of tests performed on suspected narcotic substances seized by law enforcement bodies (Police, Customs, Border Guard). (Substances are delivered ICCR)
Of the materials tested as part of the Joint Action program, there have been several seizures of MBDB, 4-MTA, PMA and ketamine in Hungary, and the database already holds detailed information about these seizures – number and venue of seizures, the appearance, quantity, purity of the substance seized. No GHB seizures have occurred yet.

Objective:
The priority objective calls for the creation of a domestic information network to support an early warning system:
It is necessary to set up an information centre to hold and analyse all information related to (new synthetic) drugs available in this country, if possible.

- The first assignment of the working group could be to study this question in detail and to prepare an accurate survey.
- Police: it would be important to enlarge the ICCR database to cover Police information – black market names for new substances, prices, methods of use, etc. – based on depositions and investigation materials
- Health sector: (hospitals, clinics, departments of traumatology, institutes of forensic medicine, university laboratories – although some of these may not belong to the Ministry of Health) poisoning cases, unusual symptoms, health effects, risk factors
- Ministry of Justice – National Research Institute of Neurosurgery: potential new substances identified (from the presence of metabolites) in body fluids, statistical findings regarding materials (MBDB, 4-MTA, etc.) tested in the Joint Action so far (identification methods, e.g. GHB is not easy to identify.
- Drug outpatient centres, different associations operated by NGOs, etc. (e.g. Blue Point, social workers doing the streets) information delivered by drug users contacting them (new substance has appeared, existing substance with a new effect, accounts of new user habits, etc.)
- National Institute of Pharmacology: report on new preparations with potential black market presence sooner or later.
- Monitoring international literature on drugs, collecting information on potential new substances (EMCDDA publications, Microgram – data of analyses to support ease of identification of new substances)

Setting UP EWS Information Centre:

Setting up the centre in the laboratory for narcotic drugs at the ICCR is conceivable but the necessary human and financial resources need to be created first. It would be useful to add relevant Police information to the present database.
It would be practical to group, screen and evaluate data from the Ministry of Health, drug outpatient centres, etc. in a single ‘sub-centre’ –it could even be a role for the local CFDAs, which would also need human and other resources and assets to do the job.
Ideally, the development of a computer network could be identified as an objective for implementation, which would promote the ease of collecting (and downloading to a server on weekly, for instance) information generated in these areas in the most effortless manner,

e.g. by selecting from among possible responses offered by the program, or by responses containing a few words only.
In a less than ideal case, information could be collected on printed forms.
Writing the programme or making the forms is a future responsibility.
The Police could derive very important pieces of information from these data, e.g. could map how a new substance spreads in the country, or could even get assistance for discovering the location of an illegal laboratory.

The working group has clarified that the provisions of the Joint Actions of the EU Council and the related recommendations and interpretations laid down in the EMCDDA publications on Risk Assessment of NSDs, EWS on SND form the legal basis for this work. During implementation, additional information could be derived from the decisions of the Council of the European Union on the admission of new organisations identified within the EWS so far.
The Joint Action describes in detail the substances classified as new synthetic drugs, lists the kind of data certain organisations have to obtain if these substances appear in the drug market. Next, organisations forward these data using one channel to Drug Unit of Europol the also notify EMCDDA through the national contact point of the REITOX network.

The working group separated and analysed the components of the full scope of data to be included in the notification to see which of the existing Hungarian organisations in health care criminal prosecution and other affected areas are in a position to report the data in the required form and whether or not an existing organisation in the Hungarian system that generates or is required or allowed under law to collect and report similar data and is suitable by merit of its function for providing the requested information.

The working group concluded that the following organisations are capable of obtaining, collecting and reporting the required data and data types, acting under their current authorisation:

1) The chemical composition, name, active ingredient and other components of new substances: the drug laboratory network of the Police Headquarters, Institute of Forensic Sciences of the National Police Headquarters,
2) A physical description, colour, weight, size, shape, logo and other marks of newly introduced substances: the drug laboratory network of the Police Headquarters, Institute of Forensic Sciences of the National Police Headquarters, the laboratories of the Ministry of Defence, penal institutions and the National Finance and Customs Guard.
3) Name of seizing (submitting) agency, date and venue of seizure (submission), weight and number of the substance: the drug laboratory network of the Police Headquarters, Institute of Forensic Sciences of the National Police Headquarters, the laboratories of the Ministry of Defence, penal institutions and the National Finance and Customs Guard.
4) Circumstances of seizure (access), production, transportation, distribution, abuse, frequency and trend of occurrence, accessibility and its trend, wholesale and street price in illegal market: the drug laboratory network and health care services of the Police Headquarters, Institute of Forensic Sciences of the National Police Headquarters, the laboratories of the Ministry of Defence, penal institutions and the National Finance and Customs Guard, the Police Physician Service, drug outpatient centres, health care institutions, Co-ordination Forums on Drug Affairs, Drug Department of the National Police Headquarters,
5) Early warning of potential risk factors, short term effects, potential health risks: health care institutions, institutes of toxicology, detoxifying units, drug outpatient centres, Institute of Forensic Medicine, Institutions of Child Protection and Correction, sports physicians' services,

6) Potential social risks: health care institutions, institutes of toxicology, detoxifying units, drug outpatient centres, Institute of Forensic Medicine, Institutions of Child Protection and Correction, sports physicians' services,
7) Chemical precursors of the substance (if information is available or accessible), method and popularity of production, expected consumption, other application and related degree: the drug laboratory network of the Police Headquarters, Institute of Forensic Sciences of the National Police Headquarters, the laboratories of the Ministry of Defence, penal institutions and the National Finance and Customs Guard and criminal intelligence organisations.
8) Additional information on health and social risks: laboratories and health services of the Ministry of Interior, Ministry of Defence, penal institutions, National Finance and Customs Guard, Police Physician Service, drug outpatient centres, health care institutions, Co-ordination Forums on Drug Affairs, Drug Department of the National Police Headquarters.

By providing this list, the working group has, in essence, identified the existing elements of the data-reporting network to be set up in Hungary. Linking these elements to form a network is a task for the future and it is indispensable that these organisations play a role in the future assignments of the working group.

Estimated Prevalence Indicators

Statistics kept by institutions offer no real description of the current status of the prevalence and character of drug use, particularly problematic drug use, which justified the need for studies and analyses capable of making inferences about the degree, dynamism and other features of the prevalence of certain phenomena.
As the validity of statistics kept by certain Hungarian institutions is questionable, there is no point in conducting prevalence studies targeted at e.g. the national prevalence of problematic drug use or at the demand for treatment in this country before the system of data collection changes. That is so because the results and conclusions from the present body of data could not at all be regarded relevant.

Hence, the activities of the prevalence working group depend heavily on the progress made by working groups addressing other key indicators, first of all those engaged with treatment, morbidity and mortality. If changing the data collection system succeeds and if institutional data collection of communicable diseases and drug mortality cases may get started up, the obstacles in the way of prevalence studies in the respective areas will be removed.
The prevalence working group is thus 'at the mercy of' the progress made by other working groups.

The objective of the working group calls for estimating the prevalence of problematic drug use, addiction, the use of categories of substances and the trends in demand for treatment.

However, despite the problems and the incapacity to provide national prevalence estimates of problematic drug use and demand for treatment, etc., it is possible to come up with reliable prevalence estimates (pilot studies) using the statistics kept by institutions and the data collected in other qualitative research in some cities of the country, first of all Pécs and Miskolc, if the funds are provided for completing the available data and for targeted data collection.

Prevalence estimation in these cities may resort to capture-recapture and the multivariate methods from among those recommended by EMCDDA. If additional data are obtained to complete the available data and the findings of qualitative and quantitative research, reliable estimates could be provided in a relatively short time.

First of all, however, it will be necessary to explore what type of data are available at present, which areas should be covered by additional data collection, it will also be necessary to define the target of the prevalence estimate and to specify exactly the target group or groups subjected to the study. The first assignments will include specifying data sources, defining the problem area and identifying the target group. Here, the published EMCDDA guidelines offer assistance and if the guidelines are observed, research findings may also comply with the expectations of the association.

III. DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level

8.1. Major Strategies and Activities

Two of the four main objectives set forth in the document 'National Strategy to Combat the Drug Problem' are directly related to the area of demand reduction and in fact explicitly concentrate on primary prevention:
1. Community, co-operation - Society should become responsive to managing drug-related issues efficiently and local communities should increase their problem-solving capabilities in combatting the drug problem.
2. Young people should be given the chance to develop productive lifestyles and to reject drugs (prevention).

1. **Society should become responsive to managing drug-related issues efficiently and local communities should increase their problem-solving capabilities in combatting the drug problem – community, co-operation**

Local communities play an outstanding role in tackling the drug problem as the phenomenon of drug use is fundamentally the problem of individuals, families and local communities. This is where symptoms first appear and the phenomenon is recognisable. If it is identified locally, it can later make a decisive impact on tackling the problem as the effectiveness of any intervention largely depends on the responsiveness, commitment and readiness of the local community.
The national Government is to provide all possible support to local Governments to carry out their activities in the most efficient manner. It is important to implement actions in local communities in the spirit of international co-operation and on the basis of all the recommendations that have been formulated first of all on the grounds of European experience. Hence, international co-operation will manifest itself in the form of joint local action in the given community.
Co-ordination Forums on Drug Affairs are key factors in the National Strategy. Such committees of 8-10 members collect information on drug problems, monitor changes, identify the most important risk groups, set targets for prevention in the community, outline possible therapies and keep records of prevention, community development and therapeutic capacities. They provide access for members of the local community to information on local services. They draft annual plans on local tasks in line with the objectives of the National Strategy and produce reports on the work they have done at the end of each year. They present the reports

Community levels:

- family
- living quarters
- workplace
- local community, local Government
- society as a community
- international cooperation

to the members of the local community and send them to the Co-ordination Committee on Drug Affairs.

Long-term objectives

- *To develop functioning communities increasingly sensitive to the management of the drug problem.* The development of communities capable of combatting drug problems efficiently concerns the role of families in socialisation and their values just as school life, workplaces, leisure activities, local micro-communities, religious groups, etc.
- *Families should be made increasingly sensitive to recognising and tackling drug problems.*
- *Drug policies should be prepared at workplaces; the programme for drug-free workplaces should be broadened.*
- *Drug-free entertainment possibilities should be encouraged; the number of safe entertainment facilities should be increased.*
- *Drug users released from penal institutions should be reintegrated in the community;* their social exclusion should be avoided.
- Care for the homeless - a wider social policy context is needed to ensure support services to control radically emerging hazards in this field, and social reintegration should be made possible by incorporating re-socialisation elements.
- *Data collection and reorganisation of research.* Local communities can be effective in responding to the drug problem if realistic information is available.

Medium-term objectives

- *Collection of national data that can be used by communities, access to international databases.*
- *Support for the development of drug-free programmes and scenes:* with regard to local communities, schools, workplaces and entertainment.
- Special attention is to be given to *reducing the number of disco accidents.*
- The development and operation of local institutional, functional units in order to implement the National Strategy in line with local needs.
- International recommendations and methods that various (Hungarian and international) professional organisations or national authorities have prepared or are preparing in relation to local drug problems, community prevention and intervention as well as community development. The aim is
- to make them accessible and
- to use them in the implementation of effective community programmes.
- It is necessary to develop a social support system for rehabilitated drug users, those who have been released from penal institutions or receive therapy.

Short-term objectives

- *To initiate community epidemiological research.* The aim is to make the data available to key persons and policy-makers in the local community.
- *Administrative measures:* to create local Co-ordination Forums on Drug Affairs (in cities, counties, regions) together with the necessary legal and administrative conditions, to coordinate and help the work of those committees in cooperation with the organisational units of the Co-ordination Committee on Drug Affairs and with the involvement of local Governments.

- *To analyse the legislative framework* and change it if necessary (e.g. by reviewing the legislation regarding the licensing procedures of music and dance clubs, exercising local administrative and inspection competencies).
- *Adjustment to the international environment,* i.e. by providing access to, and if necessary, training in, the documents of first of all the European Union and specialised international organisations (UNDCP, WHO) on the local community response to drug problems.
- *To increase the number of training events and improve their quality.*
- *To assess and evaluate the institutional system.*
- *To develop local prevention services:* to create a wide spectrum of leisure possibilities that help to prevent (or substitute) drug use: drug-free clubs and discos, entertainment facilities that offer help at the same time, night sports events, occupation to idling children and gamins. Law requires child welfare services to organise leisure programmes, to keep records of, and report on, such programmes. In big cities, such services can also be relied on in street work with idling dropouts. It is important to ensure safe return from nightclubs (e.g. by organising disco buses, home transport services, etc.). Such solutions may occasionally lead over to social policy and youth policy, and demonstrate the multidimensional and multidisciplinary character of the drug problem. Help line services play an important role in warning and preventing drug problems, informing those who encounter such problems and referring them to specialists. It is important to maintain such lines toll-free.
- To facilitate the operation of *local community forums*. Particular importance is attached to churches and congregations, popular scientific events and other institutions offering useful forms of leisure activities.
- Reintegration programmes are to be developed for *drug users discharged from penal institutions*.
- *Adjustment to the international environment*, international relations. It is of prime importance to create the institution of European Union cooperation in Hungary, known as the Focal Point.

2. Young people should be given the chance to be able to develop productive lifestyles and to reject drugs - prevention

The National Strategy places drug prevention in the complex issue of *health promotion*. Health promotion is aimed to lower the impact of *risk factors* that lead to drug use and to strengthen *protective factors* that reduce the incidence of drug use and in general the use of (legitimate and illegitimate) drugs. Health is the sum of protective and risk factors whereby the former outweigh the latter. Health promotion influences it in a designed form that affects the individual's *lifestyle*. The term 'lifestyle' combines the interaction of the different forms of behaviour and their impact on health as well as the role of the social and physical environment.
The most important scenes for health promotion: - the family, school, workplace, leisure activities, churches, the media, the army, crime prevention, drug prevention, at-risk groups, hazardous conditions, and prevention programs for the Roma.

Long Term Objectives

- *To stop the spread of drug use in the following areas.*
  - To slow down the increase in the number of drug users to reverse the growing trend.
  - To reduce the number of first-time drug users.

- It is also noticeable in Hungary that the average age of first-time drug users has dropped in recent years. It is vital to reverse this trend.

- *Drug use should not be culturally acceptable to young people.*
- *A healthy, drug-free lifestyle should become attractive.*
- *A health strategy should be developed at schools.*

Medium-term objectives

- Well-functioning programmes for *health promotion* and *drug prevention* in all scenes where young people grow up (family, public education - junior and senior classes, higher education, part-time education systems, leisure and other community activities, sports, churches).
- Health promotion and drug prevention programmes should cover *the widest possible circle of Hungarian youth*.
- Long-term prevention and health promotion at schools should focus on *skills development.*
- Financial support should be provided for formal prevention programmes organised for students in public education and available to schools.
- *Drug co-ordinators should be institutionalised at schools.*
- *Drug prevention should be integrated* in the school curriculum related to health promotion and lifestyle (focussing on skills development).
- Prevention should be represented at expert level in the local (city, county, regional) *Co-ordination Forums on Drug Affairs*.
- The possibilities of drug prevention at the army should be recognised and implemented on the basis of the Hungarian Army's drug strategy.
- It is necessary to improve the working conditions of prevention and create more effective forms of co-operation for school doctors, nurses, other specialists than teachers (psychologists, social workers) at schools, local youth helpers, drug specialists. The role of *peer helpers* is particularly important in approaching a particular age group and communicating relevant information.

Short-term objectives

- *Surveys* on the prevalence of drug use among young people and monitoring. Such surveys will be co-ordinated and supervised by the *Drug Research Council* to be set up within the Co-ordination Committee on Drug Affairs.
- *Surveys on the prevalence of prevention programmes and their effectiveness.*
- To develop the financial support system for prevention programmes organised for students in public education and available to schools.
- It is particularly important to adapt and evaluate research and *efficiency studies* as well as appropriate programmes.
- *Uniform quality assurance and accreditation* of prevention programmes on the basis of the criteria defined by the ministries concerned (i.e. the Ministries of Health, Education, Youth and Sport, and the Ministry of Social and Family Affairs in child protection and the social field).
- The use of and access to *international experience*.
- To develop *the organisational and co-ordination framework*.
- Support for *publications, media events,* help lines.
- *Training.* Emphasis is placed on health promotion and drug prevention training that specialises in the problems of adolescence and youth.

8.2. Approaches and new developments in 2001

The strategic objectives implemented in the area of demand reduction are presented below. We have often achieved good results even in medium-term objectives, and we are on schedule in the implementation of short-term goals. However, it is important to note that there is far more to be done than what has been accomplished so far even along the lines of the ongoing work.

1. Society should become sensitive to managing drug-related issues efficiently and local communities should increase their problem-solving capabilities in combatting the drug problem (community, co-operation)

Medium-term objectives

- *Collection of national data that can be used by communities, access to international databases.* Each year the Ministry of Youth and Sport publishes a Report on the Drug Situation in Hungary that contains the most important national data and initiatives. Last year, the publication included a detailed analysis of the amphetamine situation (the presentation of international trends), and this year the situation of cannabis derivatives will be described. The Ministry of Youth and Sport plans to cover the individual drug groups in subsequent years. The report was published in 4000 copies in 2000, and was circulated among practically all Governmental, professional organisations and NGOs that are concerned with the drug problem. Sufficient copies were also made available to the Co-ordination Forums on Drug Affairs that had been formed in the meantime.
- Under the PHARE project, steps were taken to link up to the epidemiological and drug database of the European Union. The Hungarian focal point, the secondary data supply centre will start operation under the auspices of the Ministry of Health in 2002.
- *Support for the development of drug-free programmes and scenes: The Programme for Safe Entertainment* has been prepared, primarily aimed at reducing drug use in music and dance clubs and discos, and managing health hazards resulting from drug use. A non-Governmental organisation has been established under the name 'Association for Safe Entertainment' which enjoys the support of the Ministry of Youth and Sport and the National Crime Prevention Council and is active in disseminating the programme to turn it into a movement, asserting professional aspects and providing an umbrella for discos that assume responsibility for the programme
- Steps have been taken to set up *county and regional Co-ordination Forums on Drug Affairs*. In many instances, similar forms of co-operation were developed on a voluntary basis at lower as well as higher organisational levels.

Short Term Objectives

- Initiating *community epidemiological research*: Several epidemiological studies have been financed. Special mention must be made of the ESPAD research projects of 1999 with national focus and of 2000 for Budapest and the follow-up surveys, the ongoing research among adults or the surveys on particular at-risk groups such as poppy users and intravenous heroin users. In addition, several surveys were supported at county and city levels.
- A study to evaluate the legal efficacy of institutionalised diversion and of the criminal regulations in force.

- A wide range of grant schemes and other *operational support programmes* were available to establish local prevention services in the past three years, marking a considerable progress compared to previous years. All this meant support for night sports events, local prevention programmes, programmes aimed at particular at-risk groups and various publications, etc.
- Local *Co-ordination Forums on Drug Affairs* (CFDA) were set up in 25 cities in three regions of the country (with the support of the Ministry of Youth and Sport through a grant scheme). Local Governments showed keen interest in the scheme.
- The *analysis of the legislative framework* regarding music and dance clubs has begun together with changes where necessary. The most important regulations governing safe entertainment are drafted with the involvement of the non-Governmental Association for Safe Entertainment supported by the Ministry of Youth and Sport (including disco operators and proprietors as members) and other partners concerned. Before the appropriate legislative background is put in place, the operators and owners of such facilities volunteered to comply with the criteria on "safe entertainment" formulated in a consensus.

2. Young people should be given the chance to be able to develop productive lifestyles and to reject drugs (prevention)

Medium Term Objectives
- The grant scheme launched by the Ministry of Youth and Sport for local (city, county and regional) Co-ordination Forums on Drug Affairs required inter alia the presence of prevention organisations in such forums.
- More than Euro 200,000 was spent on the support of training peer helpers in two years.
- Several development projects were launched in the area of *information society*, such as the information platforms on the Ministry's homepages, the support for various service providers, already available, planned or contracted. The toll-free "Drogstop" help line will be extended to a national advisory network accessible via the Internet, and several homepages will receive support (e.g. the "Drognet", internet network for general practitioners, etc.). We also financed several CD programmes and supported the development of Internet and other computer programmes for schools.

Short Term Objectives
- *Surveys on the prevalence of prevention programmes and their effectiveness.* The Ministry of Youth and Sport provides support for the ongoing efficiency study of prevention programmes soon to be completed. Organisations involved in prevention at schools are being screened under the study.
- The development of an *organisational and co-ordination framework*: a Special Taskforce on Prevention has been set up at the Co-ordination Committee on Drug Affairs to ensure the representation of prevention specialists working at the local (city, county, regional) Co-ordination Forums on Drug Affairs.
- Prevention related to *certain Roma groups*:
    - The self-government bodies of ethnic minorities delegated members to the Co-ordination Forums on Drug Affairs.
    - The Special Taskforce on Prevention at the Co-ordination Committee on Drug Affairs formulated recommendations in consultations with the Roma organisations with regard to preventive actions addressed to certain Roma groups. The recommendations can be summarised as follows:

- Shaping teachers' attitudes, training them in Roma studies

- Involving Roma professionals and university students in prevention (most young Roma do not go to secondary school, therefore outreach work and social work on the streets are particularly important just as the involvement of Roma professionals, i.e. programmes based on direct contacts and communication)

1. Training of Roma peer helpers;
2. Presenting famous Roma personalities as positive role models;
3. Involving rehabilitated Roma drug users in prevention;
4. Involving Roma/Gypsy organisations in prevention and communication;
5. Avoiding segregation, i.e. "Roma for the Roma" approach in all this;
6. The respective parts of the National Health Promotion Programme should give room to training Roma professionals in prevention;
7. Credible communication:

- *to the public at large*
- *to Gypsies/Roma with a view to approaching and contacting them and providing information.*

The National Self-Government of Gypsies and the Minister of Youth and Sport will sign a co-operation agreement whereby the Gypsy population will receive support from the national co-ordination agencies to develop their own "drug strategy".

Several prevention support projects aimed at the Gypsies have been finance recently. They are designed to provide assistance for the efficient prevention and control of special problems affecting the Gypsies.

- *Training*. Prevention and health promotion should be given special emphasis in continued teacher training. This kind of training is linked to the accredited compulsory system of continued teacher training. In 2000, the Ministry of Youth and Sport provided Euro 134,000 support through tenders for accredited continued training and its upgrading to broaden access to such programmes.
- Under the higher education programme, higher education consultants are trained, and a programme will be launched this year to set up lifestyle outpatient centres as high-capacity university campuses. The prevention support and programme development system embracing primary, secondary and higher education institutions will offer integrated, professionally competent and quality-oriented prevention training for the most important target groups for the first time.

9. Prevention

The traditional interpretation of prevention whereby the goal is to prevent a disease or problem is gradually being replaced by a broad (holistic) health-promotion-based approach, i.e. different behaviours jeopardising health are considered to have common roots, while naturally the importance of varying and specific aetiogenesis is taken into account especially in treatment and rehabilitation. The different models of influencing behaviour work with

varying degrees of effectiveness, which is a key determinant of how different methods and techniques are used in prevention. There is a shift from information provision towards an integrated health promotion approach, although there is no shortage of programmes relying on emotional education and peer pressure in the Hungarian 'prevention market' either.

National institutions:

- National Institute for Drug Prevention (formed on 1 February, 2001 in accordance with the National Strategy).
- National Public Health Service headed by the Chief Public Health Officer, with institutes in counties and cities. The National Public Health Service is responsible for organising and coordinating all health promotion activities including - only in principle though - drug prevention activities in accordance with the Health Act adopted in 1997.
- The National Health Promotion Centre, which is part of the National Public Health Service, is mandated to create the professional methodological background to health promotion, formulate policy recommendations on behalf of the professional community and widen the scope of available methodologies. The individual departments of the National Health Promotion Centre may cover drug prevention in their briefs. This work is, however, carried out by the mental health units/departments in the first place, and its contents are not very well-known.
- National Family and Social Policy Institute. As a background institute of the Ministry of Social and Family Affairs, its activities in drug prevention are only partially known.
- Continued Teacher Training and Methodology Public Benefit Company. As a background institute of the Ministry of Education, they operate certain programmes (e.g. early warning conference, drug coordinator training) that are clearly aimed at drug prevention.

NGO initiatives:

It is estimated that there are about 60 NGOs (associations, foundations) involved in drug prevention programmes, teacher training and continued teacher training in the country. Only limited information is available on the operation of such NGO-based initiatives, and they mostly receive financial support under grant schemes.
There are several public administrative bodies along with many public agencies and NGOs cooperating in order to prevent drug consumption. Drug prevention is only one area among the activities of many institutions, so there are no reliable data on the total cost implications of these efforts. In many cases, even spending by individual institutions on these activities cannot be identified.
That is explained by, among other things, the provision of specially targeted grants by individual public administrative organisations to individual public agencies for their drug prevention activities, and these agencies will either spend those moneys on their own or distribute them by inviting bids.
Since there has not been a focussed audit in this area there are no valid figures concerning public expenditures on drug prevention, while reliable data are impossible to obtain from the records of individual agencies.

Drug prevention activities of the Ministry of Youth and Sport in 2001

The Government pays special attention to combatting drug abuse and is determined to provide comprehensive support for strengthening, among other things, drug prevention and education. Drug prevention grants schemes cover all those programmes that do not necessarily concern other Ministries' competence but are designed to combat drug abuse.

The purpose of the drug prevention grant scheme
This scheme is aimed to support the conduct of nationwide professional, media and mass communication programmes needed primarily in the drug prevention field to counter the threat posed by drugs.
Grants were available for creating a wide range of drug-prevention-related events, awareness programmes, publications, leaflets and other preventive tools, along with developing a system of preventive leisure programmes. The drug prevention programme includes a book publication initiative that is designed for specific target groups and specialists. The scheme was also used to subsidise the staging of the UN International Anti-Narcotics Day and Hungary's Anti-Narcotics Week, along with the development of computer and Internet-based prevention programmes.

In terms of figures, this scheme allowed to support ***grant procedures in 304 cases (totalling about HUF 115m)*** *and* ***792 individual applications (amounting to about HUF 453m)****.*
As a result,

drug prevention programmes were implemented through broadcast and electronic media;
accredited training courses were developed in relation to drug prevention;
preventive leisure programmes were realised serving as models;
up-to-date and efficient health-promotion-driven publications and tools were developed; and
events focussed on responding to questions concerning drug use took place.

Joint grant scheme of the Ministries of Youth and Sport and Education for drug prevention in schools

A joint initiative worth HUF 205m entitled 'Grant Scheme for Supporting School-Based Health Promotion and Drug Prevention', which was issued by the Ministry of Youth and Sport and the Ministry of Education to target elementary school children in 6-8, was an initiative of key importance. The grant scheme was designed to develop and support health promotion with a special focus on drug prevention and was an integral continuation of a similar request for proposals from secondary schools in 2000.
School programmes have as an objective to make a complex health promotion and drug prevention programme part and parcel of curricula as well as increasing the range of such programmes together with their quality assurance and improved availability to schools.

Aggregated data on grants schemes successfully conducted to date:

	SUBMISSION DEADLINE	NUMBER OF WINNING SCHOOLS	AMOUNT AWARDED	NUMBER OF CHILDREN COVERED BY PROGRAMME
First grant scheme (targeting secondary schools)	31 January 2001	331	HUF 217,782	181,485
Second grant scheme (targeting elementary schools)	15 June 2001	555	HUF 105,402	87,835
Third grant scheme (targeting secondary schools)	31 October 2001	154	HUF 26,442,400	22,035
Fourth grant scheme (targeting elementary schools)	31 May 2001	159	HUF 109,165,200	90,971

The Ministry of Youth and Sport released a number of publications on drug prevention in 2001, including 'Evaluation of Prevention Programmes' by J Rácz.
The author discusses the evaluation of drug prevention programmes aiming as an overall goal to delay first-time drug use and minimise the frequency of use. The book is intended as a guide primarily for specialists, teachers, school drug coordinators and organisers with a view to maximising the efficiency of drug prevention programmes.

9.1. School-based drug prevention in 2001

A key priority of the National Strategy is school-based prevention as part of demand reduction and community strengthening efforts. At the national level, the National Strategy's guidelines are applicable. Under these guidelines schools are obliged to formulate their own institutional drug prevention strategies.

There are 3 key factors determining school-based prevention. These are:

- The Public Education Act, which was last amended in 1999. The Act has left the National Core Curriculum unchanged except for the addition of provisions on the framework curriculum, which took effect on 1 September 2000. Under these provisions, every school must include 18 hours of health promotion studies ('health studies') in forms 6-8. These health promotion studies reflect a modern public health approach based on what is known as the eco-holistic or salutogenic approach. In other words, health is not separated from life-style as a whole but is an overall concept including mental health problems as well. Under the Act and the Minister's Decree, apart from a standalone subject module there is also an obligation to devote 10 discussion classes to health studies in forms 5-12. By 2000, schools had to develop their own health promotion/drug prevention

strategies as part and parcel of the syllabus. Thus the regulatory environment creates an opportunity to pursue professionally sound prevention activities in public education institutions.

- The addition of substance to the regulatory framework was to a great extent facilitated by the fact that the Ministry of Youth and Sport and the Ministry of Education launched a large-scale bidding process in 2001. As part of that, over 200,000 secondary school students participated in prevention classes (5 times), which were held by different prevention service providers of the country.
- Mention must be made of the launch of school drug coordinators' training as part of school-based prevention activities, which involved approximately 600 teachers in a 30-hour accredited training course within the scope of teachers' professional upgrading in 2001.

The scope and extent of resources and prevention

Ad hoc school-based prevention activities are funded from resources obtained through bidding. In this respect a change is anticipated in the future whereby trained school drug coordinators will be exempted from teaching to a certain extent as a result of regulatory changes. The above-mentioned grant scheme allocated over HUF 200m for drug prevention purposes. Recurring components of prevention activities will be implemented as part of classes so the required resources will be secured against the schools' annual budget. Importantly, 80% of the costs of teachers' accredited upgrading courses is subsidised from central and local funding sources. In some cases the amount of subsidy can be as high as 100% if a given course is deemed of particular importance to the school or is part of a specific nationwide development programme.

Training

In pursuing their higher education studies, teachers do not receive compulsory training in drug prevention or health promotion/public health. Certain universities offer degree courses in mental health and health promotion (University of Physical Education, Budapest; Szeged University). Other universities (e.g. Faculty of Humanities, Budapest University) are launching courses that provide this kind of knowledge to students. As part of psychological/pedagogical studies forming a key element of teacher training important areas related to the subject are covered but their contents or level of professionalism cannot be determined and are not regulated centrally.

The goals of schools

There are schools in Hungary that attach special importance to the issue of health promotion. They include institutions that belong to the Hungarian Association of Health Promoting Schools (including roughly 250 schools). The programmes of these institutions are based on the assumption that through its ethos the school contributes to the formation and consolidation of health-conscious behaviours. These institutions have long-term and comprehensive health promotion plans and prevention strategies. However, drug prevention in most schools is limited to responses to specific danger situations and 'fads'.

Standards and guidelines concerning the implementation of school-based prevention policies

After a certain period of time teachers must meet their obligation to undergo professional upgrading. Since the number of courses in mental health, health promotion and drug prevention is increasing teachers with a 'shortage' of credits tend to choose them more often. Unfortunately, while under the Public Education Act and other lower-level regulations teachers have an obligation to teach in these subject areas, qualification requirements fail to support these provisions. Thus it can easily happen that teachers do not think they have the competence in these areas.

Information on currently available prevention programmes
A recent study (Paksi, Demetrovics, 2002) aimed at evaluating school-based prevention programmes attempted, among other things, to classify 43 drug prevention programmes available in Budapest into categories approved by international literature. These categories are as follows:

1. *Information provision*: provision of factual, sometimes deterring information about drugs, their effects and dangers;
2. *Emotional education*: development of self-esteem and life-skills mostly in the form of group training;
3. *Social influence approach*: development of resistance to social influence, peer pressure, and the effects of the mass media and advertisements;
4. *Life skills development programmes:* development of primarily coping, decision-making and general social skills;
5. *Alternatives to drugs*: creating alternative opportunities to meet needs for risk-taking and altered states of mind (e.g. via extreme sports, yoga, meditation etc.);
6. *Health promotion*: its purpose is to improve the quality of life by way of influencing and improving behaviour, life style, the environment, and hence the health status.

However, based on the 'self-description' and declared objectives of these programmes, the researchers had to depart from the classic categorisation because of the diversity of programmes.
In the final classification several criteria were considered either simultaneously or by attaching different weights to them, in the latter case taking into account programme objectives, the duration of intervention; and the prevailing methodology. In this way they formed categories with negligible overlaps and each of the 43 programmes was thus able to be put into one typical category.

CATEGORY	**TOTAL NUMBER OF PROGRAMMES**
Short information provision programme	12
Extended health promotion programme	11
Extended integrated drug prevention programme	5
Drama pedagogy	4
Drug prevention targeting at-risk groups	4
Anti-drug or health day	3
Peer education	2
Programmes offering alternatives	2

There is still limited information about the actual contents of the programmes, although it is encouraging that a quarter of the programmes operating in Budapest describe themselves as long-term health promotion initiatives. It must be noted that in all the programmes covered by the study, prevention service providers reach out to children through their own staff, i.e. the study did not involve programmes that were implemented via teachers.

Drug prevention activities of the Ministry of Education in 2001

The Ministry of Education defined its drug prevention responsibilities for 2001 based on the National Strategy so the spending of different subsidies also took place in the spirit of the Strategy.
In the allocation of grants, primarily those programmes and events were treated as priorities that reached out to the largest number of those in at-risk age groups, handled the problem of

licit and illicit drugs together and contained professional elements that would prove to be of maximum efficiency, as experience has so far shown.

1. Grants for publications and media events are included among the Strategy's objectives. Accordingly, those organisations were given grants against a list of criteria assembled by the Ministry of Education whose programmes met those objectives. As a core principle, educators and young people must receive information that contains professionally sound and reliable data.
   Grants were awarded to the following publications, media events and prevention programmes:
   – 'Stay with us' (Maradj velünk) - a drug prevention radio magazine,
   – 'Get a grip' (Légy észnél) – a health promotion programme for schools,
   – KIDS magazine,
   – 'Alarm bell – Educators' opportunities in drug prevention' (Vészcseng_ – Pedagógusok lehet_ségei a drogprevencióban) - a conference and methodological exchange,
   – 'Organising School-Based Drug Prevention and Health Promotion Education' – a seminar.
2. The support of professional organisations' and schools' prevention programmes was a key priority since educational institutions have few qualified staff. In institutional prevention a lead role is played by health promotion. The Ministry of Education is responsible for coordinating and conveying to institutions a wide range of prevention methodologies.
3. The Ministry of Education encourages teachers' upgrading courses in health promotion in order for each school to have at least one teacher responsible for drug coordination and health-education-related activities. School drug coordinator training is a task stemming from the National Strategy.
   In order for each educational institution to have a qualified teacher as specified by the National Strategy, the Ministry of Education developed, with help from external experts, a 30-hour accredited school drug coordinator training course. The severity of the drug problem and the funding constraints of the teacher upgrading system warrant access to this training *free of charge*. The high-pressure 4-day residential course provides basic training and serves as a basis of starting work in schools.
   A network of regional drug coordinators was established with training organised in each region.
4. In 2001, the Ministries of Youth and Sport and Education issued a joint call for bids twice for elementary schools with a view to supporting the implementation of drug prevention programmes.
5. The Ministry of Education worked out its terms of reference for health promotion and drug prevention between 2003-2006.

Drug prevention activities of the National Public Health Service (NPHS) in 2001

The competence and jurisdiction of the NPHS include - as part of its health promotion responsibilities - support, coordination and oversight of primary, secondary and tertiary prevention; health education; provision and dissemination of health information (e.g. on alcohol, tobacco, drugs, AIDS etc); promotion of health preservation programmes (including the Public Health Programme for a Healthier Nation); and cooperation with all Government agencies, NGOs and municipal organs pursuing health protection activities.
Within its institutional network, specialised units of NPHS institutes both in Budapest and at the county level are responsible for coordinating these activities often with the involvement of NPHS' local institutes. Apart from that, 2001 saw the establishment of a background institution known as the National Health Promotion Centre (NHPC) within the NPHS organisation serving as a professional and methodological basis for health promotion work

as well as for primary, secondary and tertiary prevention targeted at children's and youths' age groups.

NPHS institutes both in Budapest and the counties perform their diverse professional activities mostly by winning tenders and partly on their own, in cooperation with other organisations and authorities (e.g. the Police).
Its staff participates in the work of Co-ordination Forums on Drug Affairs wherever they have been established.
Within the scope of the *'Programme to Promote the Development of a School Drug Strategy'* supported by the Ministry of Youth and Sport, several NPHS institutes submitted their bids for the role of what is called a *'professional organisation'* – and they did succeed.
Health Protection Departments organised accredited training courses for teachers in the following subjects:

- drug epidemiology
- national drug strategy
- social and health consequences of drug use
- prevention in schools (etc.).

Regional NPHS institutes' main activities in the field of school-based drug prevention in 2001:

1. as part of school health care provision, obtaining information by way of questionnaire surveys about school-based health promotion programmes (including drug prevention, health promotion, peer education, family life skills development)
2. prevention research among apprentices to explore personality traits that might lead to drug use
3. survey on knowledge about drugs and on drug use in particular circles of secondary school students (in Hajdú-Bihar County)
4. *'An empirical sociological study of youths at risk of drug use and institutions dealing with them'* - a survey initiated and assisted by the NPHS
5. Implementation of a Complex Integrated and Differentiated Programme designed for dropouts
6. development and implementation of, or contribution to the implementation of, school-based health promotion and drug prevention programmes, and/or complex health education programmes for students, teachers and parents (including group sessions, personality development training, lectures, interactive discussions, Q and A games, literature or fine arts contests, and *'drug tents'* at events attracting large numbers of people)
7. training of peer trainers and school drug coordinators
8. professional upgrading for teachers in methodologies
9. organisation of school-based drug prevention and health promotion training for school doctors, social workers, health educators, etc.

School drug prevention activities of the National Police Headquarters in 2001

- 2001 saw fundamental changes in the D.A.D.A. programme, which was introduced 10 years ago and plays a key role in the Police's drug prevention activities in elementary schools. The organisation's staff came to the conclusion that in a new social situation and in view of crime trends there was a need to revise and update the programme. As a result of modernisation, which now took into account EU recommendations and the principles of the National Drug Strategy adopted on 5 December 2000, as well as being geared to the special characteristics of the schooling system and giving up-to-date responses to new criminal phenomena, the junior and senior school syllabuses now include 14 and 23 lectures, respectively. About 25% of the senior school syllabus deals with drugs and

drug-related issues. The programme is designed to develop in young people an attitude of resistance to pressures from the drug supply side. They learn the techniques of saying no to influences through role-plays and interactive discussions. In addition, the programme lays emphasis on introducing pupils to the connection between drugs and crime.

- Last year, the Crime Prevention Units of the National and County Police Headquarters had as a priority task to participate in the implementation of the drug prevention and health promotion programme worked out by the Ministries of Youth and Sport and Education for elementary and secondary schools. They contributed as cooperating organisations to the successful completion of the programme in 36 secondary and over 50 elementary schools.
- By 15 September last year, as in every year before, the Crime Prevention Service of the Police (i.e. all Crime Prevention Units at both national and county levels) contacted educational institutions in their respective areas of geographical competence in order to offer lectures and information sessions. Most schools and informed institutions took this opportunity this year as well and asked for prevention lectures and discussion classes. Besides verbal information provision schools were also supplied with different publications and leaflets.
- An accredited training programme known as 'Ariadne's thread', which has been developed by the National Police Headquarters' Crime Prevention Unit, was available to teachers last year as well. Apart from the process of becoming a perpetrator and victim, the updated programme placed primary focus on the drug issue.
- Another programme entitled 'Frankly speaking about drug use', which again has been assembled by the National Police Headquarters' Crime Prevention Unit for 15 and 16-year-olds, ran at the Vocational Secondary School of Fine and Applied Arts in Budapest early this year.

Sources:

Állami Népegészségügyi és Tisztiorvosi Szolgálat (2002). Az Állami Népegészségügyi és Tisztiorvosi Szolgálat (ÁNTSZ) 2001. évi drog-prevenciós tevékenysége. Kézirat.

Csendes L. (2002). Az Országos Rend_r-f_kapitányság 2001. évben végzett iskolai drogprevenciós tevékenysége. Kézirat.

Felvinczi K. (2002). Az iskolai prevenció helyzete 2001-ben. Kézirat.

Felvinczi K. (2002): Kereslet csökkentési intervenciók. Kézirat.

Ifjúsági és Sportminisztérium (2001). *Beszámoló az Országgy_lés számára a kábítószer-probléma visszaszorítása érdekében készített nemzeti stratégiai program végrehajtásáról. Kézirat.*

Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.

Oktatási Minisztérium (2002). Beszámoló az Oktatási Minisztérium 2001. évi drogprevenciós, illetve a nemzeti stratégia megvalósítása terén végzett tevékenységér_l. Kézirat.

Paksi B. - Demetrovics Zs. (2002). A drogprevenciós gyakorlat megismerése - budapesti iskolai drogprevenciós programok felmérése és értékelése. Nemzeti Drogmegel_zési Intézet, Szakmai forrás sorozat Kutatások II.

9.2. Youth programmes outside the school

Extra-curricular drug prevention programmes in Hungary fall into 6 categories:

- health promotion programmes
- anti-narcotics events and programmes
- leisure time programmes as an alternative to drug use
- visual information provision programmes (e.g. exhibitions)
- peer helping programmes
- specially targeted youth programmes for school dropouts.

In 2001, there were a number of NGOs, Government and educational institutions organising drug-prevention-related programmes for the young.
In what follows the features of extracurricular youth drug prevention programmes in Hungary will be introduced through **specific examples.** It needs to be stressed that the programmes described below illustrate activities only in their respective areas and that many other remarkable initiatives have been implemented which are not included in this report because of limited space.

1. Health promotion programmes

Life Education Centre

The Island Drug Information Foundation (Sziget Droginformációs Alapítvány) offered health promotion and drug prevention programmes to children and youths. The venue of the training was the Life Education Centre, a moving classroom.
The idea of the programmes was conceived in the late 1970's by Ted Noffs, a helping professional treating drug addicts in Australia. Currently there are some 3.5m children participating in the programme in dozens of countries every year.
The Life Education Centre is a unique non-profit health preservation and drug prevention initiative that targets children aged between 3-15 years all over the world (between 3-12 years in Hungary). The programme raises children's awareness of the wonderful workings of the human body with a special focus on how and why licit and illicit substances can upset the organism's fragile balance. The Centre seeks to supply these children with knowledge, skills and self-confidence, which they need for healthy decisions concerning their future.

2. Anti-narcotics events and programmes

Youth Self-Government of Királyhegy: a series of programmes entitled 'Szer-telenül' ('Drug-less')

At 16 consecutive weekends, the self-government implemented 49 preventive leisure programmes that were held in the spirit of rejection of drugs. The events included film presentations, discussion of films and of drug use (with the involvement of experts), creative houses and biking and hiking tours.

3. Leisure time programmes as an alternative to drug use

There are many organisations and educational institutes in the country offering the young programmes with a rich variety of experiences. They include school skiing camps, survival camps, night excursions, and various extreme sport camps.
The tracing of dropouts is still an unresolved issue, hence personalised prevention cannot be implemented. Where there is the only chance of their appearing is alternative prevention programmes. An example of them is the Midnight Championship, which is operated in several towns by the Association of Hungarian Midnight Championships.

The municipality of Túrkeve. Drugs pose a threat to everyone – Preventive Leisure Time Programme for all the Inhabitants of the Town
The programme participants were informed about the dangers and consequences of drug use. A full-day sport programme was devoted to raising awareness of alternatives to drug use and strengthening positive patterns. The high number and positive response of visitors confirmed the organisers in their conviction of the success of the programme.

4. Visual education programmes

'Interim Transitions – On Drugs' – a national interactive travelling exhibition

The exhibition of the 'Foundation for a Clean Future' targeted primarily adults and the 14 plus age group. As the main purpose of the exhibition, the organisers placed emphasis on the role of the family as the most important location of prevention. The first exhibition was open at the Museum of Natural Sciences until 17 June 2001. Hundreds of people visited the exhibition every day including children's groups, which had indicated their intention of seeing the exhibition a long time in advance. In view of increased interest in the event, the interactive material travelled to different towns of the country. In 2001, it was set up in Gyula, Gy_r and Bonyhád, where it was visited by 6,600 people. By August 2002, the towns of Szabadka, Székesfehérvár, Szeged, Sopron and Hódmez_vásárhely had requested and been granted the right to present the exhibition. Experience has shown that the contents of the exhibition have made a profound impact on children and adults alike. What is important is for them to feel that there is a way out of, and it is possible to overcome, drug addiction. Through its non-conventional tools including films, audio materials and computer animation, the exhibition illustrated the causes and effects of drug use, the development and inferno of addiction as well as the features of drug consumption in Hungary in a vivid and credible manner in order to have an impact on visitors' senses and emotions alike. The exhibition leaders are specialists with many years of experience in working with drug addicts and expertise in prevention. The leaders and helpers continue dialogue with those interested. Cooperating partners include: Self-Control Association (Önkontroll Egyesület), Blue Point Drug Counselling Centre (Kék Pont Drogkonzultációs Központ) and the 'For Yourself' Foundation for the Protection of Freedom from Drugs (Magadért Drogmentességet Véd_ Alapítvány).

5. Peer help programmes

Company Foundation (Kompánia Alapítvány)

The Foundation was established in 1989 with the involvement, and on the basis, of Teen Chain (Tini Lánc), a peer-help network formed in 1997. It is designed to develop non-institutional, network-based forms of peer and community help for drifting young people and support them in coping more effectively with their own and their peers' problems.
The programme participants are youths aged between 16-22 years living in and around Budapest. The programmes reach out to approximately 220-250 young people a year and run 12-15 hours a week.
Prevention programmes support both personal and community development at the same time. Each is conditional on the other.
Programmes supported in 2001 included:

Youth Club (Ifjúsági klub) - An inclusive group that was held once a week led by experienced peer helpers in semi-structured programmes (including self-knowledge talk groups, games, creative sessions).

Open days - These included methodological days, workshops, and forums for teachers and youths on drug prevention and other issues concerning young people.

Personality development groups (sociodrama) – These are mixed groups attended by youths studying to become helpers or struggling with personal and/or family problems. The purpose is to develop coping strategies, empathy and tolerance through shared experiences.

Street drug prevention activities – They are aimed to reach out to groups of youths using drugs and involve their members in alternative programmes along with rearranging their peer relationships.

The Foundation engages in diverse activities, which are coupled with an efficiency study in order to enhance service quality.

6. Specially targeted youth programmes (for dropouts)

There are gaps in many areas of provision including specially targeted youth programmes, which also indicates an opportunity for intensive and marked development.

Among the areas of provision covered by the National Strategy, the 'family' and the 'school' are expected to undergo the most dynamic development. Apart from that, from the perspective of the issue in question, almost all other areas are concerned, in particular 'at-risk groups' and 'high-risk conditions'.

General experience and difficulties include the following:

1. Separating primary from secondary prevention in programmes for education dropouts is difficult since this group mostly includes at-risk or disadvantaged youths.
2. Direct outreach or contact is basically impossible – only indirect programmes can be organised.
3. The effectiveness of programmes and services is hard to measure and they are almost impossible to follow up.
4. There has been no research into this particular target group.
5. Educational institutions lack traditions to build on in developing prevention activities required for education leavers. Experience has shown that relationships tend to weaken between pupils in their last year before leaving school and their teachers, which is particularly true of students with disadvantages or even multiple disadvantages.
6. Continued follow-up and preventive support of education dropouts occur on an ad-hoc basis. If the reason for dropping out of school is drugs, stigmatisation rather than support will intensify.

Programmes for school leavers

As a result of the joint grant scheme of the Ministry of Youth and Sport and the Ministry of Education in 2000 and 2001, a significant number of youths participated in school-based prevention programmes. Participants included senior students before school-leaving who had undergone at least 5 prevention classes. Most programmes provided information, exposure to experiences and useful knowledge to the participants including those who had finished their studies in formal education temporarily or for good.

A great number of young people were exposed to profound experiences offered by 2 programmes entitled 'Web Cinema' (Hálómozi) and 'Interim transitions' (Köztes átmenetek). Direct exposure to experiences, the intensity of involvement and an opportunity for dialogue were part of both programmes. In addition, these programmes also offered to keep up the relationships.

Preventive initiatives in Budapest were also successful. The events held at different shopping malls (plazas) combined prevention with a career choice element, which was a spontaneous attraction for many youngsters. Following their evaluation, these programmes using indirect effects will have to be repeated.

A recurring event attracting both groups is the Island Festival (Sziget Fesztivál), which has been organised in Budapest every year for 10 years. It includes an initiative known as 'Civil Village' (Civil Falu), which delivers a set of complex services.

Reasons for dropping out of school cannot be discussed at this point. However, young dropouts are worth classifying:

1. those discontinuing studies in formal education (perhaps continuing in adult education);
2. those temporarily discontinuing studies because of exposure to risks or committing crimes and continuing in institutions;
3. those stopping studies then continuing/finishing in alternative institutions;
4. those suspending studies temporarily and often changing schools.

Individual reasons and motives call for personalised support and care, and hence personalised prevention.

Apart from the association mentioned above, some cultural institutions, with the involvement of specialists, provide information and opportunities for direct communication at alternative events or events belonging to specific stratum-cultures.

Prevention programmes in foster homes and institutes take place in a school setting. However, there is a growing need for secondary prevention, which is now being piloted at certain model institutes. The special composition of young people and their increased exposure to risks make what is traditionally known as primary, secondary and often tertiary prevention impossible to separate.

Alternative educational institutions mostly operate as voluntary organisations, most often as foundations. School dropouts can continue their previously suspended studies at these institutions without losing academic years. Those disadvantaged young people end up here who have interrupted their studies because of high-risk, deviant behaviours violating social norms. The longest traditions and most experience are boasted by the City School Foundation's Grammar School (Belvárosi Tanoda Alapítványi Gimnázium) in Budapest. Primary prevention is based on a mentor system, which is standard practice in these institutions. Every student has a 'counterpart teacher'. This relationship, which is built on trust, offers room for working through learning problems as well as exploring and resolving personal (self-knowledge-related) problems. Since there are often drug users, addicts or clean drug addicts among pupils, all levels of prevention must be present simultaneously in these institutions.

There are similar but fewer than required institutions operating in Budapest and in some provincial towns.

Frequent school changes, which occur for differing reasons and are sometimes aggravated by lost academic years, present increased difficulties to students and teachers alike. In this case, too, primary prevention must be personalised and if this process involves juveniles then prevention must extend to their families as well. The school can involve the Child Welfare Service as a partner. It is safe to say that a positive change has occurred in this field resulting in reduced exposure to risks.

Sources:

Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Szerk. Varga M. – Majzik B. Kézirat.

Kály-Kullai K. (2002). Célzott ifjúsági programok. Kézirat.

9.3 Family and childhood

The National Strategy refers to the family as a primary setting of prevention:
As an important objective, families must become suitable to prepare children for a drug-free life. Parents must convey values and norms that demonstrate the benefits of a drug-free life enabling the child to establish a constructive life-style and reject drugs. The family must become suitable to prevent drug problems from arising, which also means the treatment of other addiction(s) occurring in the family. The family must be able to deal with persons with drug problems within it, involving, if necessary, external laypersons or specialists. All this requires the provision of appropriate information to the family – primarily the parents -, their participation in parent groups as well as in NGO-based and church activities, and raising awareness of family and parental responsibilities and opportunities. The tools and institutions of a family-friendly social policy are designed to strengthen this process. It is also necessary for family doctors to give more support than what is currently available to families both in preventing drug-related problems and in treating them at an early stage. Support must be provided for prevention-oriented training for parents who are members of school boards.

9.3.1. Drug Prevention in Kindergartens

The preventive work in kindergartens can first of all be regarded as prevention related to the use of legal drugs. There are several programmes that are linked to the developmental psychological needs of a particular age group and formulate drug prevention targets (‘Heart - Treasure Chest’, ‘Adventures in the Land of Fragrances’, etc.). Such programmes highlight the hazards of legitimate drugs (primarily those of smoking) in the context of health promotion despite what has been described in the previous paragraph, and they mostly communicate knowledge as the main tool. As a positive feature, they require children's active involvement and they do reach out to them.
For the purposes of drug prevention, it is important to note the core programme of kindergarten education (1997), which also formulates expectations and requirements in relation to health promotion in kindergartens. Under the core programme, all Hungarian kindergartens had to prepare their own educational programmes. As a result of the legal framework, the act on the protection of non-smokers (November, 1999) and the Public Education Act as it has been amended (the last amendment having been adopted in 1999), child institutions (schools, kindergartens) were required to designate separate rooms for smokers. This legislative provision guarantees that institutions develop their own smoking policies that can in turn be audited.

9.3.2. Self-help parent groups

There are several parent groups in Hungary (e.g., ’Parents Anonymous’ (Anonim Szül_k), ’Matrix’, ’Self-Control’ (Önkontrol), ’Shelter’ (Rév), ’Island’ (Sziget)). However, they still do not maintain permanent contact with each other. Parent groups are designed to prevent drug use and a drug career, besides providing effective help to children struggling with drug problems.
Today’s therapeutic options available to parents having special problems are not particularly diverse even after 10 or 20 years. Parents have known the benefits and disadvantages of individual psychotherapy for a long time. Individual counselling and therapy can help the parent overcome difficulties, yet can prove insufficient on their own, in terms of both quality and quantity, to solve all parental problems. What is perhaps the closest thing to self-help groups operating effectively worldwide for several decades is parent groups led by psychologists at drug outpatient centres.

Parents can have a major part to play in both creating and solving the problem. This is of course true with the qualification that ultimately it is the young person, the child who decides to try or use drugs. But the road that leads to this situation is a shared one. For the parent is always an example, good or bad, to the child. In prevention terms, until the child's individual personality fully develops, clearly a parent who would not like their children to use any drugs will act wisely if they refrain from excessive substance consumption and reject illegal drugs altogether. However, if a long-established habit dictates the use of nicotine or alcohol, or, in the case of young parents, the occasional use of marijuana, then the growing up young person will be more than likely to try one or the other.
And once the use of licit or illicit drugs has appeared in a family's life then the best way forward is straight and frank talk. As parents, our responsibility is to pass on our knowledge and experience to our children in such a way as to enable them to make responsible decisions and possibly seek pleasure in activities other than drug use.

Sources:
Pusztaházi I. (2002). Szül_i szerep a droghasználat és a gyógyulás ideje alatt - lehet-e a szül_ is "segít_" vagy csak önsegít_ a folyamatban. Kézirat.
Felvinczi Katalin (2002): Kereslet csökkentési intervenciók. Kézirat.

9.4. Other prevention programmes

9.4.1. Peer-help programmes

Peers play a decisive role in the formation of drug use in adolescence, especially in those cases where ties to the parents or society (e.g. school) already weakened at an earlier stage. Among peer influences, the following factors have an important role in the formation and persistence of drug use:

1. smoking, and alcohol and drug consumption by peers, along with related attitudes
2. an identity peers attribute to drug use ('If you do drugs you will be a somebody')
3. avoidance of being stigmatised or discounted, hence an appreciation in the value of the peer group
4. peer help in avoiding drug use and peer pressure towards using drugs.

The *social effect model* is based on the assumption that drug use is a learned behaviour in which social effects and model-imitation play a key role. Therefore these factors can be used in prevention as well. It has two widely used applications. One is known as social 'immunisation' whereby youngsters are 'inoculated' or 'immunised' against drug use with anti-drug messages before they are exposed to peers or (hidden) media messages (media messages, i.e. TV commercials, primarily promote the use of licit substances, i.e. tobacco and alcohol). So when they are exposed to these effects they can protect themselves from them. The other method is the development of skills to reject drugs. A typical example of this is to teach how to say no to temptations. Saying no is a complex form of social communication that can be developed through practising. These programmes are relatively effective, they take a shorter time to learn but will remain effective only for a limited period (2-3 years) then gradually become extinct.

Peer-help programmes operate in many scenes in Hungary, including schools, universities, and leisure events and among parents.

'Knowing is Accepting' Foundation (Megismerve Elfogadni Alapítvány): Peer-help training for young Roma

The multiple disadvantages and cultural features of certain Roma groups warrant the launch of special programmes. These programmes can be effective if communicated by credible and recognised NGOs representing the Roma population. In 2001, the *'Knowing is Accepting' Foundation* organised a peer-help training course.
The sessions were attended by disadvantaged Roma elementary school children. Two thirds of classes were devoted to theory, one third to practice. Theory classes covered information about drugs, the consequences of drug use, and legislation related to drug consumption and sale. In the practical classes, pupils learned to reject drugs and give the right responses in different situations. From the programme evaluation it was concluded that this approach had made a significant contribution to changing their attitudes. The objective is now to disseminate the acquired skills and knowledge.

Association of Street Social Workers: Peer-help training for young people in Tatabánya

This training programme held in 2001 was attended by elementary and secondary school pupils. Many of them were already members of existing peer-help groups, but some of the participants were drifting youngsters who were clients of the Association's 'street kids' project. The training had as a primary objective to make use of the acquired knowledge since by the end of the course the participants had to decide specifically which helping activities they would pursue regularly during the year. The relationship between the trainers and trainees was not ceased after the training. Trainees hold case conferences and have supervision on a biweekly basis.

Sources:

Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Szerk. Varga M. – Majzik B. Kézirat.
Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.

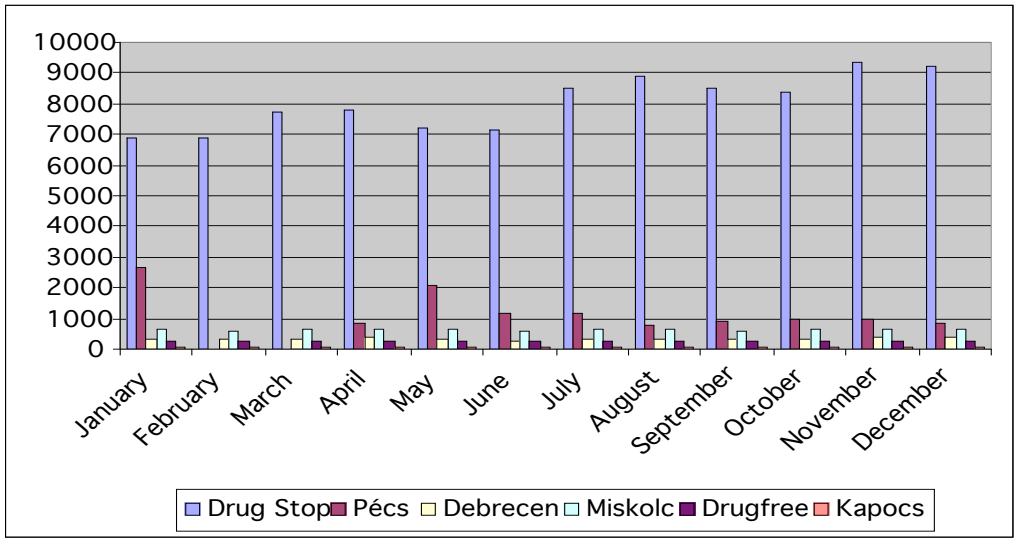
9.4.2. Telephone help line

In closing, an overview is given of the objectives of the National Strategy and the role and place of the help line service below:
1. 'Sensitise society to drug issues and their handling'. A telephone help line is available to the entire society free of charge from all mobile networks anywhere in Hungary 24 hours a day. Through its attitude-shaping behaviour and the provision of reliable information, the help line service seeks to promote an attitude whereby drug use is accepted as an addiction and the drug addict is decriminalised by society. This attitude change will enable the drug problem to be treated as a real problem and allow effective solutions to be found and used.
2. 'Help individuals and families exposed to drugs and struggling with drug problems.' The help line service meets this objective by ensuring anonymity and open access, since it can be called not only by illegal drug users (addicts) but also the members of their micro-environments (friends and relatives, teachers, colleagues), or ordinary people in the street.
Help over the phone ranges from information provision on symptoms, consequences of drug use, addresses of drug outpatient centres and hospitals, and the availability of low-threshold programmes to conversation and dealing with the addict. It extends to the full period of the

crisis and in many cases involves more than just one conversation. As a secondary objective, the help line service is designed to refer the addict to the most optimal point in the treatment chain where personalised specialist help is available to the client.

Help line services are run by trained voluntary operators, addictological assistants, social workers and psychologists. The service operators' work is supported by group supervision sessions. In these groups they discuss those cases and challenges that for some reason caused a problem, convey an important learning point, or are too stressing emotionally for the operator. These group sessions also shape and strengthen the operators' personal qualities.

Telephone help line services in Hungary – A hot line run by the Drug Stop Budapest Association is of key importance among currently functioning help line services. It works on a 24-hour basis and receives calls from all parts of the country. Its availability free of charge makes it truly one of the first links in the drug treatment chain.
There are several drug outpatient centres operating drug help lines in the country. However, these help lines work only in surgery hours and take calls only from their own areas. Most of the calls come from first and repeated contacts by addicts. Available figures include the telephone data of the drug outpatient centres in the towns of Miskolc and Debrecen.
The Drug-Free Association also receives phone calls but it is not available free of charge and does not operate non-stop.
The 'Link' Youth Self-Help Service (Kapocs Önsegít_ Ifjúsági Szolgálat) takes calls too. Again, there is limited availability of the service and calls are not toll-free. It is to be noted that there is no direct line available, which means that the caller is connected to the help line operator through the Pet_fi Hall's (Pet_fi Csarnok, where the service is based) switch operator. The caller has to have very strong motivation to go through this procedure if they are to discuss their problems with someone.
Last year the only service to operate a toll-free telephone line was the 'Mother-of-Pearl' Association (Gyöngyház Egyesület) in the town Pécs.
Several help line services like for instance psychological help lines and the Blue Line (Kék Vonal), which targets the young, also take calls about drug problems but data on these are not available.



The figures below reflect the number of calls taken by help line services.
In 2001, Drug Stop and the Mother-of-Pearl Association in Pécs received a total of 96,394 and 12,434 calls, respectively.

Drug-Free took 12 calls a day on average. These calls break down as follows:

5 calls from those who ceased habit but maintained contact
3-4 calls to get information
2 calls from parents
1-2 calls to inquire about how to cease habit.

Link (Kapocs) got an average 15-20 calls a week about the problems below:

parent-child conflicts
drug-related problems
problems over violence and other forms of abuse.

The Drug Outpatient Centre in Miskolc received calls about the following issues:

inquiries about effects of combined use of medicines and alcohol
health problems arising from opiate use
problems related to 'disco drugs'
problems related to using grass
problems related to glue sniffing

The breakdown by the nature of calls of figures from the Drug Outpatient Centre in Debrecen presents the following picture:

1.36% - from substance users to make first contact and request information about consequences of drug use and treatment options
2.14% - inquiries from parents about consequences of drug use and treatment options

1. 11% - inquiries from helping professionals (e.g. teachers, family helpers etc.)
2. 34% - counselling for patients in treatment (including therapeutic talks also for callers from provincial locations)

4.15% - hoax calls.

Telecommunications companies provide figures that include the area codes of calling parties. From those data, areas where for some reason there is an increased demand for help lines can be identified. This we use as circumstantial evidence with regard to the level of prevalence of drug use and related problems in a particular area. The data will become supplementary figures if they are consistent with the data of low-threshold programmes, care centres, drug outpatient centres and possibly the Police.

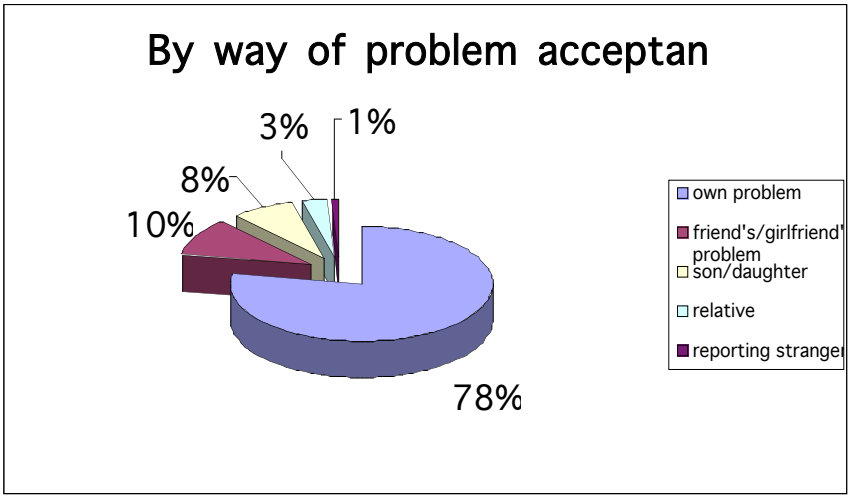
From the data it can be concluded that it is youth groups aged between 15-20 and 20-25 years that call help line services the most often. It is both surprising and thought-provoking that 3% of calls should come from youths aged below 15 years.
Parents and teachers, i.e. those over 30 and 40 years of age, have a 7% and 10% share in calls, respectively.

Breakdown of calls by content:

Request for information	**32%**
Coaching conversation	18%
Friendly conversation	11%
Search for help location	3%
Giving up drugs	8%
Feeling sick	1%
Parental conversation	10%
Emotional problems	5%
Problems with relationships	2%
Psychological problems	3%
Family problems	3%
Inquiry about drug tests	2%
Drug law	1%
Illness	1%

‘Emotional problems’ include the caller’s being stuck in a crisis; ‘Psychological problems’ refer to problems requiring psychiatric intervention, while ‘Illness’ covers physical diseases. ‘Friendly conversation’ means empathetic, supportive or confrontative conversations of a therapeutic nature.

How the caller describes their problems in drug use is also analysed in terms of whether they admit that they have those problems themselves or hide them pretending to try and help another ‘junkie’.



It is a fact, though, that protected by anonymity 78% admit that they are calling the service about their own problems. It comes as a surprise, and may also indicate a possible intervention opportunity, that relatives and helping strangers represent society only up to 3% and 1%, respectively. Strengthening social responsiveness, cooperation and support can be a possible next step in effective prevention.

Substance use
The table below shows what percentage of callers has ever tried the listed psychoactive substances:

Cannabis derivatives	**36%**
Heroin	11%
Ecstasy	9%
Amphetamine	9%
Alcohol	10%
Medicine	9%
LSD	5%
Cocaine	3%
Inhalants	2%
Tobacco	1%
Multiple substances	5%

Cannabis-derivative use prevails. It is to be noted that hashish represents 6% among these drugs. Heroin has an 11% share, which is not insignificant considering the total number of calls. Ecstasy and amphetamine make up a total of 18%.

The high percentage of stimulants and anxiolitics (9%) is surprising and thought-provoking considering the age range! (Pharmaceuticals that feature in this case are Xanax, Rivotril, Elenium, Zoloft, etc.)
'Multiple substances' refer to what is known as 'polydrug use', i.e. the use of several substances.

Source:

*Somogyi D. (2002).*Telefon segélyszolgálatok m_ködése 2OO1-ben. Kézirat.

9.4.3. Community programmes

As a key objective, the National Strategy aims to develop communities more responsive to the prevention and treatment of drug problems. The recognition and management of drug problems is inseparable from the existence of a functioning community. Drug problems do not arise in isolation but are linked to the circumstances, opportunities, leisure-time habits (even if these in fact concern a limited circle of drug users) and mental health status of young people. The establishment of communities capable of combatting the drug problem effectively will impact on the socialisation mechanisms and value systems of families, the world of education, jobs, leisure opportunities, smaller local communities, church groups, etc.

Pepsi Island Festival 2001

The National Drug Strategy points out in many of its sections the importance of voluntary organisations' increased role in combatting drugs.
A good example of this cooperation is an initiative known as the Civil Village, which, as a result of over 300 people's coordinated efforts, encompassed 27 NGOs specialising in drug and AIDS prevention as well as harm reduction.
Following preparations for nearly a year, the appearance of the Civil Village at the Pepsi Island Festival was supported by EUR 280,000 provided by the Ministry of Youth and Sport.
The Pepsi Island Festival is Europe's biggest youth festival which is organised on Budapest's Shipyard Island every year. The one-week programme hosting an audience of some 400.000 every year is visited by many young people from abroad as well.
Therefore the Festival is an important scene of prevention and increasingly, especially in recent years, of harm reduction.
The programmes presented by the Civil Village offered everyone a pleasant way to spend time. Apart from raising awareness of the perils of drug use, they offered constructive alternatives to the 14-25-year age group, which is most exposed to drug-related risks. The Civil Village also gave an opportunity to those in need to find the help they wanted or to know where to go should they end up in particular life situtations.
The Civil Village was made up of 18 tents and a Drug Bus, which were arranged to look like a real village. As an active village has a community centre, health centre, bar, church, theatre and craft workshop so did these institutions appear in the Village. The Village 'bar' was a Tea House, its church the Tent of World Religions. The Health Centre provided AIDS screening free of charge, while a needle exchange programme and a mobile Party Service were available nearby. The Craft House and a drama tent called KÁVA featured as the creative scenes of the Village. The NGO tents were open to those interested and also offered

individual counselling. In many cases, the Village received positive feedback from both visitors and professionals attending different programmes, and then, after the Festival, the Festival organisers themselves. The press also gave good reviews of the event, particularly its drug prevention and harm reduction programmes and especially praised the partnership between the close to 30 NGOs.

Sources:

Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Szerk. Varga M. – Majzik B. Kézirat.
Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.

9.4.5. Media programmes

Media programmes primarily increase sensitivity to the problem and can play a role in communicating the issue to society. Using appropriate tools, they can even have a preventive effect in the case of specific issues and target groups. Mostly they are expensive, and poorly prepared campaign-type programmes tend to be inefficient (and apart from being costly they can be counterproductive by increasing 'curiosity' about drugs). What is efficient is 'messages' that focus on alternatives to drug use and places where help is available rather than deterrence, and come from multiple sources and through multiple channels.

Types of media programmes:

1. *National mass media campaigns* – These feature mass media advertisements.
2. Programmes that combine *mass media advertisements with other components* like community initiatives and school programmes.
3. Programmes that *do not use mass media advertisments* but rely on other media tools e.g. videos, leaflets etc.
4. Interventions that are built on *free* (public) opportunities and *spontaneous media interest*.

The National Drug Strategy has 4 objectives concerning media campaigns:

1. increase responsiveness – an achievable objective
2. provide information – an achievable objective but may not - in fact, will certainly not - produce behavioural changes; it is possible that increased knowledge may in fact lead to more experimentation
3. change attitudes – an achievable objective but is not sufficient to change behaviour
4. change behaviour – mostly not achievable; the media reach out to those who do not use drugs and least of all to those who do, and even then they will not change their behaviour.

At the same time, the media can convey messages that will, directly or indirectly, encourage youths to use drugs. These effects must be eliminated and such messages restricted while moral and community support must be provided for messages conveying drug-free values.

International Anti-Narcotics Day

In 2001, linked to the UN International Anti-Narcotics Day, a whole week was devoted to a series of events conveying the same 'Message' in the full spectrum of the media mobilising the whole of society.
Based on arrangements with the leaders of the Hungarian Television, the m1 channel hosted a drug prevention week, which included reports about various events taking place all over Hungary, drug prevention films, interviews etc., and related studio discussions.
The drug prevention week ensured a uniform image through the Message, its logo, TV spots and key events.

9.4.6. Internet

The computer plays an ever increasing role in young people's communication. The world of prevention must take very seriously the challenges posed by the development of information technology and must make use of it. The key areas include Internet- and computer-based prevention programmes. These tools can be highly effective but take special skills and techniques to produce. It is important to develop Internet-based counselling and information services but the risks of the Internet world must also be reckoned with. For young people are exposed to many impacts that are unchecked and can often be harmful. NGOs must take a lead role in preventing the dissemination of contents encouraging drug use. These are especially dangerous when made to look like information provision. It is to be considered that Hungarian websites that have been verified professionally should receive some certification.

It is now clear that global and free electronic communication also gives opportunities to disseminate anti-social and immoral values and information. These effects have by now reached the worldwide web and include the promotion of drug abuse. These phenomena give rise to concern and point out the urgency of measures that effectively counter the risks and dangers of this tendency by providing correct (or corrective) information.

National drug portal – www.drogportal.hu

2001 saw the beginning of the development of a National Drug Portal designed to provide help to those affected by drug problems or any social segment interested in the issue including, primarily, specialists, educators, parents, young people in their 20's and teens.
The plan is for professionals specialising in the drug problem to have undergone accredited addictological consultant training through distance education by the end of 2002.
The programme also includes the accreditation of websites, through which it will map websites dealing with the drug problem with a focus on their contents and services. Links to websites with accredited contents will be accessible through the Drug Portal, so that users seeking help can have access to the information they need.

Foundation for a Clean Future (Tiszta Jöv_ért Közhasznú Alapítvány): www.szertelenul.hu

The website has been designed to convey professional knowledge to young people and helpers (youths aged between 13-21 years, but also teachers, drug coordinators, specialists, and organisations) in the subject areas of health promotion and primarily drug prevention. The information provided is non-deterring but is aimed to be regularly updated and present in a credible and factual manner skills, leisure activities and role models in a way that is geared to the taste of the young. Chat facilities and games are also attached to it. The main page includes links to all websites providing access to information on drugs or to other organisations. Current drug-related news, statistics, notices, training and bidding

opportunities are also accessible from the main page by reaching the contents of a magazine called 'Get a grip' (Légy észnél!) and as part of special subjects. All information is regularly updated. There are several virtual chat rooms for interactive communication where a specialist is available for 1 hour every day to answer questions, which is similar to anonymous 'drug-info' phone numbers.

Sources:

Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Szerk. Varga M. – Majzik B. Kézirat.
Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.

10. Reduction of drug related harm

The National Strategy to Combat the Drug Problem attaches special importance to harm reduction and related developments. The short term objectives of the strategy include, inter alia, the creation and development low threshold services, harm reduction programs (outreach services, telephone lines, counselling, legal assistance, needle exchange, etc).

Short Term Objectives

- ***Creation and development of low threshold services and harm reduction programs (outreach services, telephone lines, counselling, legal assistance, needle exchange, etc.)***
  The term 'low threshold service' means drug users are not expected to give up using drugs immediately – during more or less the first stage of contact – or to adapt to the austere house rules and the terms provided in the therapeutic contracts of treatment facilities that insist on abstinence. This special group of users would anyway be unwilling to do so in the given stage of drug use. As regards HIV infection, outreach and needle exchange programmes and substitution and maintenance treatment (with methadone, buprenorphine, LAAM) are of great significance among intravenous users. The importance of all these is emphasised in the recommendations by the WHO European Office for Central an Eastern European countries and the initiatives of the UNO to combat AIDS in Central and Eastern Europe (the Geneva and Kiev meetings and agreements in autumn 1999). It is practical to make treatment facilities responsible for the technical control of these programmes, and it is necessary to draw up the protocol of application in Hungary for each case in addition to adapting the method. (The Psychiatric Advisory Committee has approved the therapy protocol of methadone maintenance.) The organisation of programmes does not only affect assistance work, it also has a bearing on the Police, which is why it is reasonable to involve the Police force in the development of protocols.
  International research suggests that harm reduction methods are applied successfully if they are related organically to other forms of prevention and therapy. *It is reasonable and justified to promote low threshold services in the man and to develop a network of model institutions.*
- **Substitution therapy (methadone, buprenorphine, LAAM).** Methadone (Depridol) has been internationally recognised as synthetic drug of therapeutic utility and application and is the most widely used substitute with opiate addicts. Therapeutic application may take the form of short or long term maintenance treatment after detoxification. It would be practical to introduce methadone maintenance treatment in Hungary because of the increased frequency somatic complications and the spread of communicable diseases (such as virus infection with first of all hepatitis C and the HIV virus – which foreign experience suggests is expected) and so as to reduce other individual and social harms (e.g. crime) associated with substance use. The profession has officially formulated its position about this, which outlines the course of introduction: a specific group of heroin users presenting a set of indications would be subjected to this treatment in a few national centres. It seems practical to expand the protocol to cover other substitute substances (such as the synthetic opiate derivatives buprenorphine and LAAM) which are used successfully at an increasing number of locations. *It is reasonable to set up and operate at least a single maintenance treatment centre in each region in the short term.*
  The medium term objective calls for the development of a network with institutions in each county.

In 2001, the Ministry of Youth and Sport spent a total of HUF 195 million (Euro 780,000) on this objective, including 35 grant procedure (approx. HUF 66 million) and 17 individual

applications received support from the budget allocation know as 'Subsidised development of institutions offering low threshold services'.
As a result of all of the above, new programmes designed to develop low threshold institutions and programmes have been set up and now offer the opportunity to construct and launch new projects geared to hard-to-reach and high risk drug user groups.
Mention must, however, be made of the persistently low number of drug users that get into contact with low threshold services despite these efforts, which shows the need for further development in this domain.

Harm Reduction – Low Threshold Services in Hungary

The concept of harm reduction stems from the recognition of drug use as an existing phenomenon in society. A drug-free society is an illusion and we need to face reality to be able to manage the drug problem efficiently.
Harm reduction hinges on three fundamental principles: 1) reduce the number of drug users as much as possible, 2) whoever uses drug should take least dangerous substances at the lowest possible frequency, 3) and should follow the least dangerous user habits.
Harm reduction is targeted at minimising the individual and social harms associated with drug use and drug related crime. *(Csorba 2002a, Csorba 2002b, TASZ 2002)*
Each society is obliged to provide a longitudinal system of institutions with multiple tiers so as to be able to offer efficient care to drug users.

Hungarian Programmes Recognised as Low threshold type Services
Care type services:

- social care (day care): stay with supervision, hygienic services (laundry, wash-up), meals
- services at 'drop-in' clubs (day care, club type activities, 24 hour clubs)
- night time shelter
- halfway homes

Counselling type services:

- provision of basic health care (co-operation with health care institutions, family doctors, on-site nurses and first aid)
- to assist screening (hepatitis, HIV, TBC, VD)
- client check-up (from addictological, psychosocial perspectives)
- motivation and short intervention based on status check
- referral to treatment institution
- social services (social work): dealings with authorities, leisure programmes, assisted job placement, supervision of children (e.g. during therapy), etc.
- liaison with therapeutic health care and social institutions
- legal assistance
- support for self assistance groups

Outreach work:

- outreach work
  - work in the streets, in entertainment facilities
  - harm reduction work in entertainment facilities
  - visits to institutions and establishing contact (correctional facilities, child protection facilities, care for the homeless, emergency departments, etc.)

Complex Services Centre:

- counselling centre
  (consultation + social work
  + access to basic care and psychiatric services
  + social care: day and/or overnight)

Special low threshold programmes:

- needle exchange
- methadone maintenance therapy

1. Social and health care type outreach programmes offered in the street

Drug users often tend to belong to sub-cultures operating along relatively strict rules. About 10-20% of drug addicts sign up voluntarily with a counselling or therapeutic centre. Outreach work in the streets is essentially designed to get into touch with clandestine drug users and addicts and to try to involve them in a programme aimed at harm reduction or abstinence.
Outreach activities in Hungary are in the fledgling stage as yet. There are relatively well-organised programmes in Budapest, Pécs, Debrecen, Miskolc and Szeged. Coverage is not full in these cities either. Other settlements run scarce street work programmes for drug users and addicts alongside with other social activities*.(Csorba 2001a, Csorba 2001b).*

2.Needle exchange programmes

The World Health Organisation adopted a position in 1989 suggesting that "needle exchange is the most efficient method in the prevention of HIV and hepatitis infection among intravenous drug users". No country with a modern care system raises doubts about the need for needle exchange programmes. The process of needle exchange may involve four stages: a) needle exchange associated with an outreach programme, b) automatic needle exchange vendors, c) needle exchange coaches, d) needle exchange centres. In Hungary, the following centres offer needle exchange programmes: Budapest, Miskolc, Szeged, Pécs, Veszprém. These centres reported the following turnover for 2001:

Turnover in needle exchange programmes in 2001

City	Persons/year	Needles/syringes/year
Budapest	653	20,000
Miskolc	22	3,000
Szeged	280-350	25,000
Pécs	110	3,700
Veszprém	15	-

A pilot programme in Budapest involves needle exchange in addition to the distribution of condoms to prostitutes.
At present, the installation of automatic needle exchange vendors is in progress in Budapest.
The Hungarian Baptist Charity has covered significant ground in its attempt to start up a needle exchange coach service to be operated in Budapest. *(Csorba 2001a, Csorba 2001c, ISM 2001)*

3. Injecting rooms, heroin substitution therapy

In Hungary, neither injecting rooms nor heroin substitution therapy exist, and such centres are not likely to get established in the near future. Also, the system of drug tests is not currently available in Hungary, although there are signs of a need for such a service.

Sources:

Csorba J.(2001a). Ártalomcsökkentés – harmadlagos prevenció. In. Ifjú -Kór 330-334, Pax Vobis, Budapest.
Csorba J. (2001b). Methadon szubsztitúciós kezelés. Hipocrates, 1/ III, 62-64
Csorba J. (2001c). Drogbetegek gondozása, különös tekintettel a Methadon kezelésre. El_adás, Országos Alapellátási Kongresszus, Budapest.
Csorba J. (2002). Ártalomcsökkentés Magyarországon. El_adás MPT V. Nemzeti Kongressus, Budapest .
Demetrovics Zs., Honti J., Csorba J., Szemejácz.J.(2001). A szubsztitúciós metadonkezelés, Történeti áttekintés. Psychiatia Hungarica, 1/ XVI, 57-69.
Gerevich J., Demetrovics Zs., Csorba J., Honti J., Szemjácz J. (2000). A metadon kezelés Magyar Manuálja. Budapest, Drogambulanciák Szakmai Szövetségének Tanácsa.
Jelentés a magyarországi kábítószerhelyzetr_l – 2001 (2001). (szerk. Ritter I.). Ifjúsági és Sportminisztérium, Budapest.
Rácz J. (2002). Ártalomcsökkentés és alacsony-küszöb_ szolgáltatások. Kézirat.
TASZ (2002). A TASZ az Ártalomcsökkent_ drogpolitikáról. TASZ kiadvány.
WHO, Regional Office for Europe (1999). Priciples for Preventing Hiv Infection among Drug Users, Copenhagen.

10.1 Description of interventions – outreach programmes

In Hungary, almost every low threshold programme of harm reduction is connected organically to some other form of therapy or prevention. Such programmes are conducted mainly by institutions treating drug addicts, and the few establishments that operate independently are in constant contact with several therapeutic institutions and are also involved in preventive work.
A summary of the types of outreach programmes and programmes designed to prevent communicable diseases operated in Hungary are summarised. (Substitution programmes are discussed in the next chapter.)

Outreach programmes

Street work with drug users

In Hungary there is no precedent to nor a professional protocol of street work with drug users.
Workers frequently include volunteers and former addicts who have kicked the habit.
Street work with drug users is frequently associated with needle exchange, which is anonymous and free of charge.
In Hungary, there are about 20 different organisations active in doing social work in the streets, including 2 in the capital and 2 in the country-side that specialise in the target group of drug users. Three of these organisations are also engaged in needle exchange.
One of the organisations in the country-side indicated its intent to start up its own programme in the autumn, but three large cities in the country-side have suspended social work in the streets with drug users for a variety of reasons.

a) Target groups and organisations: The most likely target groups of organisations involved in doing social work in the streets comprise the homeless, drug users and rambling and straggling young people.

Most of the organisation in the capital and in the country-side have been set up to offer care to the homeless and also address the problems of other handicapped and helpless social groups. Street work with drug users exists in its own right only in a few larger cities in the country and in the capital.
The organisations include a variety of NGOs specialising in this line of work only and units of social workers on street assignments at drug outpatient centres.

b) Funding: There is nor Government, head quota type funding of doing social work in the streets with drug users. Head quota funding depends on a set of legal provisions, which at present cover only street work associated with taking care of the homeless. In practical terms, that means head quota type Government funding is restricted to groups of social workers active in the streets who pursue their outreach activities as part of operating daytime warm-up shelters for the homeless.
Head quota type Government funding is not available for either street work with prostitutes, rambling, straggling young people and drug users or for needle exchange.
Most recently, the Board of Ten, an organisation set up by elected professionals engaged in caring for the homeless in Budapest, have taken definite measures to get the related legal provisions amended so as to make head quota type Government funding available for social worker arrangements targeting other groups.

Co-operation, representation of interests: the National Association of Outreach Workers was set up in Tatabánya a few years ago. The association developed uniform guidelines for outreach work in the streets to offer methodological assistance. These uniform guidelines are only partially related to outreach work with drug users.
At present, there is no professional workshop or methodological centre in the country that could act as the professional or interest advocacy forum for social workers reaching out to drug addicts.
Organisations involved in social work and needle exchange in the capital have concluded a co-operation agreement so as to be able to pursue their activities efficiently and in an orchestrated manner. Co-operation covers regular exchange of information, joint discussion of cases and the division of the city into areas of responsibility.

Funding opportunities: The Ministry of Children, Youth and Sport invites applications for the distribution of subsidies to outreach organisations of social workers active with drug users in the country, provided such organisations comply with technical requirements and the tender terms of reference. These subsidies granted upon application by the Ministry are frequently the only source available to organisations in the country-side for funding their operating costs.
Organisations active in the capital have a wider array of funding options they may apply for. The Municipality of Budapest attaches high priority to outreach to drug users and needle exchange in its action plan to combat drug use, hence organisations active in the capital can apply for funding to support their operations under tenders invited year after year by the local Government. Furthermore, the Municipality of Budapest will also ensure a new form of support for two Budapest based organisations under a public service contract starting 2003.

Overview of the situation based on the activities of the Baptist Charity

The Baptist Charity Foundation and Blue Point Drug Counselling Centre are engaged in outreach activities in Budapest. Both organisations are to launch their mobile needle exchange programme in autumn 2002, which will hopefully cover all the territory of Budapest.
The organisation tried to identify co-operating partners as the first step of embarking on this activity. They contacted social workers with long years of experience in street based outreach in Tatabánya and shared views on working methods and achievements. They met the competent commanders at the National Police Headquarters and the Civil Guard to inform them of the work they started and to collect information. They concluded a co-

operation agreement with the Civil Drug Prevention Foundation, which furnishes them with the containers required for collecting needles in a professionally sound manner, whilst the Charity donates food and clothing to their clients. They are also in close contact with the Menhely (shelter) Foundation, where the help line operator transfers and connects each drug related call to them. Most recently, the Charity has concluded a co-operation agreement with Blue Point Drug Counselling Centre.

Features of the recipients of the service: Their clients are typically hopeless, desperate people with blank outlook to the future. Clients are normally unemployed and subsist on begging, sifting garbage cans, falsifying prescriptions, prostitution, pushing drugs and petty larceny, mostly from one day to the next.
The majority typically congregate in smaller groups of 2-5 members or larger gangs of 10-15 people and spend days and nights together. It is also highly typical and important that young people who seem to be of sound background normally team up with these existing groups.
Outreach workers also have clients the get high first of all on volatile inhalants and live as loners in e.g. caves or desolate ruinous buildings or staircases. These lonesome figures frequently complain of miscellaneous psychiatric ailments in addition to being addicted to drugs. Most clients had been raised in Government run orphanages and have no or hardly any family background. Homelessness could be a result of intolerable atmosphere in the family, or the deterioration of family relations due to drug use.
Sharing fate and the same outlook to life create strong internal cohesion among people affiliated to groups of drug addicts. Kicking the habit and leading a drug free life are not the desired objectives to be attained among these circumstances. Group members give each other reinforcement for joint substance use rather than for abstaining. The key figures in groups are normally loud-mouthed, extravagant people who are instrumental in either falsifying prescriptions or in procuring the substance or in leading the social affairs of the pack. The majority of clients had attempted suicide a number of times.

The internal cohesion and the forceful influence of key figures make it extremely difficult for group members to detach themselves and kick the habit, all the more so because official treatment facilities (hospitals, rehabilitation homes, institutes of reintegration) seem out of reach for them. These are inaccessible because they have no social security card, no proper clothing, no means of hygiene, no money, no cigarettes, or because they cost money or there is a waiting list, and 'what am I to do afterwards? Hit the streets again?'
99% of the clients would typically have not contact whatsoever with any aid institution. The remaining 1% attend a needle exchange programme.
Clients keep complaining that the Police keep manhandling them and are differentiated against as homeless even in hospitals and halfway houses.

Drug habits, health status: Simultaneous of several types of drugs is especially typical of homeless drug addicts. Homeless people who zone in explicitly on using a single substance are met only in the group of volatile substance users.
The most common substance combination among polydrug users is volatile substance plus alcohol, alcohol and medicine, opiates and medication with additional doses of marijuana, heroin and amphetamines. There was no mention whatsoever of cocaine use. It is also especially typical that the members of this target group switch between substances with relative ease, depending on what they can get to.
They give account of frequent instances of shared syringe and needle use! Hepatitis infection is present in 90% of IDU clients and there is only one client who claims to be HIV positive, although this has not yet been verified, despite all efforts. TBC has also been diagnosed, just like deep abscesses developing from intravenous drug use. Their health status is characterised furthermore by being underfed, lack of proper hygiene and the presence of a variety of dermatological diseases and parasites.

Low Threshold Programmes of the Blue Point Drug Counselling Centre and Outpatient Service, Budapest

a) The :colon: Harm Reduction Programme

The Blue Point Drug Counselling Centre and Outpatient Service started a new service in September 2000. The :colon: harm reduction programme is a low threshold service which is available to anonymous drug users unconditionally provided they observe house rules. It intends to change the health attitudes of drug users (safer use of substances, safer sex, etc.) and to prevent them from being driven completely to the peripherals of society. Club activities:

1.) Outreach

Social workers doing outreach work in the streets are responsible for providing information on the services of the :colon: harm reduction club and for delivering harm reduction and prevention information to what are known as clandestine (untreated) drug users. A special outreach programme is conducted at the Emergency Department of the Hospital in Péterffy Street where outreach workers try to establish contact with and deliver information to heroin users taken to the hospital for detoxification and motivate them to use the services of support institution. A second programme is in progress in a part of town in the outskirts populated mainly by the Roma and wishes to reach out to drug users and extend the coverage of services to them. This programme co-operates with the local family support centre and the needle exchange programme of the Drug Prevention Foundation.

2.) :Colon: Harm Reduction Club

The services of the club include social work, supporting discussions, leisure time activities, medical and legal assistance. Clients who are motivated to receive abstinence therapy are directed to outpatient care, i.e. the programme serves as a bridge between active use and therapy. Both activities are supervised with social workers in charge and the involvement of a large number of volunteers. The latter receive special training and are monitored by supervision.

In 2000-2001 the outreach service managed to maintain contact with 133 active drug users and had occasional brief contact with 200-300 people (contacts shorter than 15 minutes are not registered). They succeeded and involving 5 active users in the outreach work who proved to function very well both as contact persons and as couriers of information (publications and oral communication) and are known as peer educators. A total of 61 persons have been registered at :colon: including 26 regular returnees and 16 people who attend the service up until the present day. The people who do not attend include 8 persons transferred to an outpatient service and 6 people who are abstinent at present. The programmes of :colon: are supported by the Ministry of Youth and Sport.

b) 'Party Service'

Parties with electronic music have been around in the countries of Western Europe and the United States of America for two decades now and they also became popular and a prevalent form of entertainment among young people starting 1993.

Attending parties and being present there are strongly related to the use of a variety of psycho-active drugs. The occasional or regular use of disco drugs is associated with the development of several forms of physical and psychological harm. Supporting organisations engaged in the creation of safer entertainment opportunities and focussing on harm reduction and drug problems may play an important role here.

The Blue Point Drug Counselling Centre has operated its 'Party Service' since January 1999. The purpose of the service is to reduce harm, offer education, information and help (at parties and discos). The personnel of the Centre worked 61 days/nights at 44 parties in 2000-2001 and their indirect ratios (leaflets, use of biscuits and vitamin pills) suggest that they established more than 23 thousand contacts. It is even more difficult to estimate the number of people that participated in their programmes as the order of magnitude is around 100 thousand.

In addition to working on location, the Centre pays much attention to educating party organisers and disco operators about ventilation, avoiding extreme crowds, availability of free drinking water, setting up a chill-out room. These aspirations fall in line with the international guidelines and with the programme of the Safe Places of Entertainment Association. The people working in this programme are volunteers who used to be or still are participants of one of the segments of the party culture. The 'Party Service' is also supported by Levi's Hungary.

Sources:

Miletics M. (2002). Utcai szociális munka a drogfogyasztók körében. Kézirat.
Rácz J. (2002). A Kék Pont Drogkonzultációs Központ és Ambulancia, Budapest, alacsony-küszöb_ programjai. Kézirat.

10.2 Standards and evaluations

The staff working in harm reduction programmes participate in special training courses, which are either organised by the units themselves or the units rely on programmes operated by other organisations (see above).
The Medical College of the Semmelweis University of Medicine offers accredited postgraduate courses that award a degree to consultants of addictology.
A letter on methodology on the professional guidelines of methadone treatment by the Psychiatric Advisory Committee was published in Issue 9 of the Health Gazette (25.04.2002). The curriculum for training people who administer methadone therapy or wish to work in this area and the structure of the course form part of an annex published with the gazette. The accreditation of the course is in progress.

The theory and practice of methadone treatment

Subjects
A historical overview of substitution treatment
Substitution treatment in practice in the USA
Substitution treatment in the EU
An overview of the Hungarian situation
Psychopharmacological issues
Efficiency studies of substitution treatment
Practical considerations of substituion treatment
Methadone and alternative substitution substances
Legal and ethical issues

Course structure
20 hours of theory
30 hours of practice
10 hours of supervision
The course ends with the submission of a case study and an examination.

Proposed locations for practice: Nyír_ Gyula Hospital Drug Outpatient Centre and Prevention Centre of the Municipality of Budapest, Pécs Drug Outpatient Centre,

Veszprém Alcohol and Drug Outpatient Centre, - where methadone maintenance therapy is already offered.
Course design follows the CME training system.

Harm reduction programmes and low threshold services have not yet been evaluated in Hungary. Although several programmes are looking forward to such and audit in the near future, it seems reasonable to perform a comprehensive evaluation to cover each service.

11. Treatment

11.1. Drug-free treatment and health care at national level

The National Strategy to Combat the Drug Problem defines the conceptual frame work for the treatment of drug addicts on the basis of the psychiatric model of disease, the psycho-social model and the community treatment of addicts. Consequently the strategy formulates three therapeutic objectives concerning addicts (including drug addicts):

1. *Reach a life free of psycho-active substances:*
    a, generate and increase motivation towards abstinence
    b, develop a life style without psycho-active substances
2. *Support the realisation of a variety of activities in life with the highest possible rate of satisfaction*
    a, reach and maintain optimum health status
    b, diagnose and treat psychiatric symptoms and disorders
    c, learn skills and acquire knowledge required for daily conduct
    d, solve problems with marriage and family
    e, set straight issues related to working, employment and livelihood
    f, arrange issues related to homelessness
    g, meet spiritual needs, shape a set of values that conform to those of society

3. Prevent relapse and reduce the harm associated with drug use

Drug addiction is a chronic disease with frequent relapses. The likelihood of relapse is greater due to the absence of the factors described in the preceding section. Relapses can be prevented if appropriate methods are used. This approach has become an independent therapeutic goal which relies on proper methodology.

The conceptual framework of the therapy:

The *psychiatric (illness) model* of illicit drug use lends itself first of all to describing the conditions of addiction, particularly in cases where severe (mainly physical) withdrawal symptoms, long term dependence, co-morbidity (other psychiatric disorders) and other health complications are expected. In such cases the active role of a psychiatrist (addictologist) is indispensable and a part of the therapy is likely to include treatment (sessions) administered to in-patients. The natural objective of this model calls for reaching abstinence and for developing additional psycho-social conditions for abstinent life-styles.

The *psycho-social (sociological, anthropological) model* of illicit drug use can first of all be used in prevention and with addiction conditions not classified in the section above (e.g. when addiction is not severe, there is no 'dual diagnosis') and after reaching stable abstinence. The same approach is also effective in the attempt to reduce the health and social harm caused by drugs. Several professionals play a role in the support relationships established in line with the psycho-social model, including social workers, addictology counsellors, psychologists, psychiatrists, priests, religious social workers, recovered addicts and self-supporting groups as well as co-operating institutions not specifying in delivering care to addicts. The institutionalised forms of participation by psychologists and psychiatrists (accessibility, supervision) should also be taken into account here.

Community therapy of addicts fits in well with the therapeutic aspect of this model. That requires integrated co-operation of the experts listed above (e.g. with the help of a case manager system). Other institutional forms may also play a role here e.g. day hospitals and convalescent homes, halfway houses and transitional homes, rehabilitation centres.

Abstinence is not reached in the first step which is why programmes designed to reach motivation and (in an other approach) to reduce the health and social harms of drug use also play a role. At the same time this model promotes the formulation of conditions needed for leading a substance free life after abstinence is reached.
The goal of the therapy is to regain or acquire control over 'addiction', to develop a productive lifestyle and to promote the changes needed to do so in the spirit of the holistic model of health. One of the ways to achieve this involves giving up the addictive behaviour and if that does not occur the alternative way includes controlling the addictive behaviour and reducing the harms it brings to the individual and society.
Strengthening positive attitudes in the process of improvement of addicts is a necessary factor for addicts, on the one hand and clinicians and the public at large on the other hand as it comes as positive reinforcement to 'initiating' change and to following through with the therapy.
Therapy means rendering assistance to clients so that they reach optimum functioning in life for as long as it is possible. At the same time we live in a world where financial and human resources available for therapy are limited and clients, at least in theory, demand more than what society could meet. That is why while keeping in mind the obvious objectives described above we are always forced to decide which therapeutic tool to apply, which group of clients is most suitable for a given therapy and which is the most effective and most cost efficient form of therapy.

Nowadays a modern (bio-psycho-social) therapeutic programme is not only expected to have the recipient reach abstinence or at least reduced physical, psychological and social costs of drug use at least in the short term but it should also make that person capable of playing out his or her capabilities in as many areas of life as possible and of retaining his or her health status without relapse.

The Operation of Institutes Involved in Drug Therapy in Hungary

Therapeutic care of drug users is offered at the following healthcare institutions:
Outpatient consulting hours:

- Drug outpatient centres
- Addictology care, TÁMASZ care
- Psychiatric care
- Child and youth psychiatric centres.

Inpatient care at hospitals:

- Departments of psychiatry
- Departments of addictology
- Departments of crisis intervention
- Detoxification departments (departments of internal medicine)

Rehabilitation care is offered at units of healthcare institutions or by institutes operated by social organisations or NGOs.

Outpatient care
The need for developing institutions specialising in caring for drug addicts was identified in the 1980s when these addicts were still catered for by psychiatric or alcohol addiction departments. The Drug Outpatient Centres in Szeged and Pécs were set up in a pilot project supported by the Ministry of Health in 1986-1987, followed by the creation of the Klapka Street Drug Outpatient Centre in Budapest and a series of drug outpatient centres set up in response to local needs in the nineties.
Modernising the network of addictology care units started in 1993. The programme also aspired to meeting the actual treatment needs of drug users at the time. Consequently TÁMASZ outpatient units were involved in offering care to drug addicts and hence these units of even geographic distribution supplemented the existing drug outpatient centres. TÁMASZ outpatient units employ specialist physicians, psychologists as well as social and welfare workers.

Larger TÁMASZ outpatient units are suitable for offering outpatient care to both alcohol and drug addict patients, however, the majority of these units is small where the low number of specialists and the circumstances disallow the treatment of drug addicts, which is why locations where there are functional TÁMASZ units frequently refer drug addicts that contact them to the nearest drug outpatient centre (which is often quite far away).

Drug Outpatient Centres
Drug outpatient centres have traditionally offered services in addition to healthcare such as assistance in social and legal problems, counselling, etc. That is why these outpatient centres employ specialists and psychologists as well as welfare workers, outreach workers, teachers and occasionally request help from legal counsels. Furthermore drug outpatient centres started to play a role in the dissemination of information and prevention in response to local needs, which have complemented healthcare functions since the early nineties.

The specification of the minimum technical requirements was a fundamental condition for setting up new drug outpatient centres and operating the existing ones. These requirements were developed under an assignment of the Psychiatric Advisory Committee by a working group made up of staff members at drug outpatient centres. The document specified the requirements of consulting rooms and the required specialists in addition to outlining the major responsibilities. In the meantime, the competent Psychiatric Advisory Committee wrote the methodological letters of technical nature. The new professional colleges to be operated by the Hungarian Medical Chamber have been set up recently. A Commission of Addictology has been created as part of the Psychiatric Advisory Committee. The Hungarian Society of Narcology, the Professional Association of Drug Outpatient Centres and the Hungarian Association of Drug Therapy Institutes are the umbrella organisations for theoretical experts and practitioners engaged in the drug problem. These associations support the work of professional colleges and committees in the main.

Some of the drug outpatient centres are not independent. They are integrated into a healthcare institution, normally a hospital. Furthermore, there are drug outpatient centres operated as NGOs.
The National Health Insurance Fund (NHIF) used to apply the indicators of turnover in specialist care rather than of welfare services, which created problems in maintaining their operations. Convincing the NHIF to finance drug outpatient centre operations as welfare centres required long reconciliation.
Practically, drug outpatient centres are financed under agreements concluded with county level Health Insurance Funds, which is why some outpatient centres are better off whilst others are poorer.
In 1999 drug outpatient centres set up an association to represent their interests at higher efficiency. This professional association counts 17 members that are outpatient institutions offering therapy to drug addicts. Of the 17, there are institutions that still do not have a final licence from the Chief Public Health Officer's Office and operate under temporary licenses. A few TÁMASZ welfare centres are also members of the Professional Association of Drug Outpatient Centres. Practically the 17 member institutions cater for the vast majority of drug addicts in an outpatient system.

TÁMASZ outpatient units
Another pillar of outpatient care for drug addicts involves a network of welfare centres of addictology, 38 of which are operated as TÁMASZ outpatient units. This network caters for alcohol addicts and drug users. The addictology network treated 3,874 patients according to 1999 statistics. However, one should not ignore that this high figure results from the operation of a few TÁMASZ outpatient units with high turnover in drug addicts and the majority of these units treats only a few addicts.

Inpatient care at hospitals
This form of care focuses on treating psychiatric complications after diagnosis and detoxifying. At 11.41 days, the average period of care is relatively short. Additional care is administered in an outpatient system and at rehabilitation centres.
The treatment of 'dual diagnosis' patients is problematic as these use drugs to alleviate the symptoms of a psychiatric disease and develop an addiction. If these patients are placed in rehabilitation homes after detoxification, their psychiatric problems will continue to exist and they will be incapable of sticking with the rehabilitation programme. On the other hand there is no opportunity to resolve their psychiatric problems during detoxification. This is a frequently recurring controversy which the current health system is not yet in the position to tackle.

Treating emergency cases
Emergency care practically involves detoxification which is performed mostly at a department of general psychiatry or addictology, and there are a few larger detoxification departments (e.g. Erzsébet Hospital). The average staying time at detoxification departments is 2.54 days.
Practically only departments of general psychiatry can accommodate and hospitalise patients for detoxification before rehabilitation. These departments, however, have the capacity to treat only a few drug addicts simultaneously. Hence drug addicts find it difficult to get hospitalised and there are long waiting lists at these departments.
It would be worth separating forms of detoxification that could be performed at a department of internal medicine from detoxification before referral to a rehabilitation home. Higher capacities would be needed as the requirements arise.

Long therapy homes and rehabilitation
Rehabilitation homes that offer long term care play an important role in treating drug addicts. These institutions are normally operated by NGOs receiving funding from churches, foundations, local Governments and other sources.
The services they deliver are only partially of medical/health care in nature and are dominated by social-welfare elements (work therapy, social reintegration). Funding by the NHIF and the head quota of the Ministry of Social and Family Affairs helped resolve their ongoing operating problems after their activities were classified as chronic care (which uses a low multiplier, however). Additionally, these institutions that work as rehabilitation units for drug addicts within an institution delivering personal care have been eligible for social head quota based financing since January 1, 2000. There are altogether 11 rehabilitation centres operating.

The conflicts between insufficient funding and twofold financing caused problems. Healthcare rehabilitation cannot be separated from social and employment rehabilitation, which is normal with other types of illnesses, the two forms of rehabilitation should practically be performed simultaneously, and that requires special forms of financing.
The introduction and development of more modern therapeutic and employment programmes and increased efficiency should be taken into account as parameters in the funding of both newly set up rehabilitation homes and existing ones. Evaluation according to EU standards will be required.

The accommodation capacity of a rehabilitation centre depends at present on the agreement between the institution and the Health Insurance Fund of the county. Nevertheless, there are areas in the country (e.g. Baranya county) where numerous, mostly non-resident drug addicts are treated in rehabilitation centres.
The County Health Insurance Fund is forced therefore to reduce the capacity elsewhere so as to ensure that the capacity for drug therapy exists in counties where drug users frequently contact rehabilitation centres.
Whether or not it would be more practical to distribute the funded capacity centrally rather than separately in each country is a question for future consideration.

The effective operation of the addictology network requires the review of funding principles and practices. At present, detoxification is a co-payment based service, which is loss making everywhere (when the ambulance picks up someone off the street for instance). Technical experts think that the DRG scores of administering care to drug addicts are too low, so low in fact that (they claim) that there are instances when due to financing reasons an accompanying or symptomatic diagnosis is given priority over drug addiction as the main addictological diagnosis as the former earns a higher score. This phenomenon has a major role in the distortion of statistical figures.

Regardless of the turns that health insurance funding of the inpatient and outpatient network of addictology takes, substantial financial support will be needed from other sources. This should include funds for both improving the equipment needed for modern treatment and for testing and introducing new efficient models. Additionally other solutions required under EU directives may also become necessary.

The improvement of the effectiveness of treatment requires the necessary number of treatment facilities first of all. Furthermore wide scale introduction of modern diagnostic tools, the strengthening of multi-disciplinary team work, cognitive and behaviour therapy, the regular application of psychotherapy, the improvement of supervision, the specification of training requirements for non-medical staff and their recognition as health care employees, the improvement of assets and superior data entry at treatment sites should feature on the agenda.
Drug addicts will have to be screened regularly for HIV, hepatitis and TBC in the future.

Another problem to be solved involves social security funding of medication used in the therapy of drug addicts. The patients can only purchase these special medicines at production cost, which restricts the number of people using them to a great degree and deprives financially handicapped drug addicts from the opportunity to receive medication based treatment despite their need for such therapy. Such medicines are for instance Naltrexon, Lofexidin or Clonidin.

The Execution of the Programme of the National Strategy to Combat the Drug Problem

The Ministry of Youth and Sport supported the operation and the introduction of programmes designed to eliminate the use of psycho-active substances and facilities catering for drug addicts in an attempt to manage the problems discussed above and to realise the objectives set forth in the National Strategy to Combat the Drug Problem.

Portage Training Programme (to promote more efficient co-operation between the actors in public administration, NGOs and drug rehabilitation centres)
The Canadian Portage organisation is a leading organisation catering for drug addicts in North America. Portage has been widely recognised in this region. Using the community therapy model, the institutes of the organisation accord treatment to and educate thousands of drug users each year and they also co-operate actively in follow up schemes designed to develop positive lifestyles with their clients.
Philosophically speaking, Portage is a not for profit, politically independent institution that has grown to become a leading organisation of the profession in a number of years. Technical experience and the application of the most up-to-date methods coupled with regular supervision and programme development are guarantees for high quality work.
The first stage of Portage training was conducted between May 28 and June 1, 2001. The target group included first of all the managers and employees of Hungarian drug rehabilitation institutions. A total of 30 people attended. Accordingly the training course focussed on presenting an efficient form of internal operations in a rehabilitation home/therapeutic community and on reviewing the steps it takes to develop good relations

with an integration into the community at large. Simultaneously, the course allowed participants to reconcile the difference between a variety of methods and to discuss the necessary modifications and adaptation of the Canadian methodology to make it applicable in Hungary.

Grant applications and individual support schemes offered funds for development to several institutions and paved the way to starting up several new drug outpatient centres. Relying on these sources the project to double the present number of beds available for drug therapy (from 200 to 400) by expanding the capacity of existing institutions and by creating new ones. Several new capital expenditure programmes have been started to construct new therapeutic homes (including ones catering for minors) and to develop (methodological) centres for low threshold services.
Subsidised organisations will make available to drug users certain services that play an important role in the reduction of risks and in reaching out to those in need. A few examples of the funds granted in 2001 are listed below:

construction of a building at Ráckeresztúr for the Mission for Saving Rambling Youth,
commissioning the Drug Rehabilitation Home at Pécsvárad and increasing its capacity,
renewing the halfway house at Noszlop,
constructing the rehabilitation home destined for assisting drug addicts of the Bezerédi Castle Therapy Fundation,
expanding the drug rehabilitation institute of the Leo Amici Foundation,
donating funds to the rehabilitation home catering for homeless addicts of Government operated orphanages,
creation of drug rehabilitation institutes among others at Lulla, Debrecen and Kovácsszénája.

The results achieved in an effort to realise the medium term objectives of the National Strategy in the treatment of drug addicts

- Harmonisation of the laws promoting **co-operation between healthcare and welfare** has started. As part of the programme, former problems of financing therapeutic institutions from two sources have been resolved. Also joint projects are being formulated in providing drug therapy to institutionalised children and in caring for the homeless. The Government called upon the Ministry of Social and Family Affairs and the Ministry of Health to perform a round of reconciliation within the year to establish the most efficient solutions in the whole domain of care delivery. Forms of care operated in comprehensive bio-psycho-social conceptual framework have been created and strengthened and now provide several levels of care (drug outpatient centres also engaged in prevention programmes aspiring to deliver continuous treatment). Multi-disciplinary approaches that rely on differentiated levels of technical and professional competencies of therapeutic staff seem to have gathered strength.
- **The community approach is also receiving more emphasis.** Several programmes designed to mediate between and beyond levels of care have been launched.
- Care capacities keep increasing. The number of beds at drug outpatient centres and therapeutic institutes is on the rise. Accessibility has improved both in terms of geographical distribution and timely delivery.
- Preparations have been made to explore the drug habits of the **homeless** and to plan the necessary action. A special research project studies the features of ragamuffins and their needs to see the required increase of institutional capacity.
- An evaluation of drug outpatient centres has been completed under the direction of the Ministry of Health and will be followed by the screening and evaluation of other health institutions involved with drug users.
- Research programmes have received major funds in an attempt to develop quality controls for NGOs. The Association of Hungarian Institutions of Drug Therapy has also embarked on writing therapy manuals.

- Independent development and support programmes have been launched to reduce health hazards and risks.
- In 1999 and 2000 the National Health Insurance Fund made three new drug outpatient centres operated as NGOs eligible for financing and more than 20 extra beds have been added in the area of long term therapy. Significant shifts occurred and this domain in 2001 when six institutes were either established or expanded. The Ministry of Health invited applications for setting up new drug outpatient centres (for HUF 50 million) which will hopefully get started up next year. The initial steps in setting up a complex set of institutions for paediatric addictology (drug outpatient centre for young people, drug therapy institute for young people, half way house, day care).

Sources:

Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Szerk. Varga M. – Majzik B. Kézirat.
Jelentés a magyarországi kábítószerhelyzetr_l – 2000 (2000). (szerk. Ritter I.). Ifjúsági és Sportminisztérium, Budapest.
Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.

11.2 Substitution and Maintenance Programmes

European Union

Almost every member state of the EU gave account of the expansion of methadone programmes between 1995 and 2000. The number of drug users in maintenance therapy increased three times in the region between 1993 and 1999 and is estimated to have reached about 300 thousand clients in 2000. At the same time methadone treatment protocols used inside the EU also vary.
Seeking to standardise programmes, EMCDDA issued a study entitled 'Euro Methadone Guidelines'. These guidelines have been incorporated into the Hungarian protocol.

Hungarian Professional and Legal Overview

The Hungarian history of methadone treatment started about 10 years ago. The following major milestones are worth mentioning:
1992 – the start up of methadone treatment in a pilot project at the Drug Outpatient Centre of the Nyír_ Gyula Hospital in Klapka-Jász Street, Budapest. Furthermore two hospital departments also started using methadone (Addictology Department, Nyír_ Gyula Hospital, NIPN)
1995 – the Drug Outpatient Centre in Pécs starts using methadone in the treatment of heroin addicts
1994 – the Budapest Chief Public Health Officer's Office issues regulations about Methadone-Depridol treatment
1998, 1999, 2001 - the Psychiatric Advisory Committee formulates professional guidelines
2000 – the Drug Outpatient Centre in Veszprém launches methadone maintenance treatment
October 2000 – the Chief Public Health Officer's Office questions the necessity of this therapy

November 2000 – the National Pharmaceutical Institute issues a distribution licence (No. T-7691/01) for Methadone-EP 5 mg and Methadone-EP 20 mg pills explicitly for opiate addiction as indication
December 5, 2000 – The National Assembly passes the National Strategy to Combat the Drug Problem, including the application and development of methadone programmes
2001 – methadone therapy is used for two patients under the co-ordination of the Psychiatry Department of a hospital in Szeged
March 13, 2001 – joint workshop with all the stakeholders (Ministry of Health, Ministry of Youth and Sport, Drug Police, Chief Public Health Officer's Office, National Health Insurance Fund, National Institute of Alcohology, representatives of drug outpatient centres, producers of pharmaceuticals). The workshop discusses the regulation and financing of methadone therapy.
March 2001 – Psychiatria Hungarica publishes a study on methadone treatment and the related regulations
October 2001 – the Professional Association of Drug Outpatient Centres issues the Hungarian Manual of Methadone Treatment in manuscript form
April 25, 2002 – the methodological letter of methadone treatment is published officially in Issue 9 of the Health Gazette
May 12, 2002 – the funding regime of methadone treatment by the National Health Insurance Fund is published in Issue 10 of the Health Gazette

However, mention must be made of the downsides in the history of methadone treatment in Hungary. The professional, legal and social acceptance of maintenance therapy suffered major blows from the procedure launched a few years ago against a chief physician, Mr. Sándor Funk, who also applied methadone treatment, from the temporary ban on methadone maintenance therapy by the Chief Public Health Officer in October 2000 and from the reports to the Police of managers of drug outpatient centres applying methadone treatment.

Before publishing the methodological letter on methadone therapy, methadone had been used in three therapeutic protocols in Hungary:

1) *Short detoxification therapy* involving high rate reduction of dosage during a maximum period of 30 days. The therapy is aimed at detoxification and reaching opiate free status rapidly.
2) *Long term detoxification therapy* where the rate of reduction is slower, more gradual and is applied with patients with a long history of opiate addiction. The duration of the treatment varies from 1 month to 6 months. In these cases the aim of the therapy is also opiate free status.
3) *Substitution therapy (long term maintenance)* where methadone doses are administered in the long term because attempts at reduction are always associated with recurring relapses. Substitution treatment may in certain cases continue for years and is indicated with opiate user populations where opiate free status is impossible to reach within a foreseeable period of time.

Methadone is used for detoxification purposes at the Drug Outpatient Centre in Jász street, the Drug Outpatient Centre in Pécs, at certain departments of psychiatry in the NIPN, at the Addictology Department of the Balassagyarmat Hospital and in rare cases at certain departments of psychiatry and addictology.
Methadone maintenance treatment is applied at three centres, including the Drug Outpatient Centres in Jász street, in Pécs and in Veszprém.
Taking the national database at the Drug Outpatient Centre in Jász street into account the number of patients treated with methadone in the period between April 2001 and May 2002 is as follows:

Number of patients treated with methadone between April 2001 – May 2002

Month	Veszprém		Pécs		Budapest		Total	
	Maintenance	Detoxification	Maintenance	Detoxification	Maintenance	Detoxification	Maintenance	Detoxification
April	6	-	8	4	59	18	73	22
May	7	-	8	4	54	15	69	19
June	6	-	8	9	56	22	70	31
July	7	-	10	8	62	15	79	23
August	7	-	10	5	58	18	70	28
September	9	-	10	6	60	18	79	24
October	8	-	10	6	71	19	89	25
November	10	-	11	5	67	17	88	22
December	13	-	12	5	67	13	92	18
January	9	-	12	6	89	11	110	17
February	9	-	12	3	81	26	102	29
March	9	-	12	5	87	29	108	34
April	9	-	14	7	87	19	110	26
May	9	-	16	4	99	16	124	20

The data presented above show that the number of patients receiving methadone treatment is still relatively low in Hungary. The ratio of officially registered opiate addicts to opiate addicts in methadone treatment is about 2-2.3% which falls substantially short of the average in the European Union (50%) or even Slovenia (24%) and the Czech Republic (19%). (2,3,5, 10, 13,)

As the legal and financial conditions of methadone treatment are completely clear now, this area is expected to develop heavily: several methadone centres will start up in Budapest, a methadone dispensing coach is expected to operate, methadone programmes are planned to begin in larger regional centres (Szeged, Miskolc, Gyula, Sopron).

In the long run, family doctors and the system of dispensing chemists could be involved in methadone treatments and there are plans for introducing alternative substances for substitution therapy.

Sources:

Csorba J. (2002). Szubsztitúciós kezelések. Kézirat.

Egészségügyi Közlöny 9. sz. (2002). Pszichiátriai Szakmai Kollégium módszertani levele a Metadon kezelés szakmai irányelveir_l.

11.3. After-care and reintegration

The long-term goals of the strategy include improving accessibility, openness and efficiency of health and social care delivery in addressing drug problems (i.e. in the treatment of drug users and family members), and implementing the full "treatment spectrum" with sufficient capacity.
As the National Strategy concludes in several places, each link of the therapeutic chain is underdeveloped quantitatively and, in a way, also qualitatively. Also, there are a number of missing links in the "chain". The "treatment spectrum" is grappling with severe capacity bottlenecks, rendering early treatment and rehabilitation/aftercare nearly impossible. Eliminating the shortages is an urgent issue in the short run, but the handicap is so big – including the lack of qualified and financially rewarded experts – that the implementation of the full "treatment spectrum" can only be envisaged in a longer timeframe.
Improving social care for addicts and public subsidies for a set of more differentiated institutional forms of care (primarily the extension of social care in the field and day-care) are prioritised objectives in the National Strategy.

Programmes like that are currently underway in the countryside under the name of Halfway Houses, and also in various day-care institutions (which belong mainly to the NGO sector). But the domestic care delivery network needs major improvement in this regard. The number of residential reintegration institutions is very small in proportion to the number of drug addicts.

Residential reintegration programmes

There are only two institutions to provide reintegration care after drug user rehabilitation in Hungary at the moment.

Keszü Halfway House
The first such institution was opened in January 2000 by the Pécsvárad Rehabilitation Home with a capacity of 8. The institution is called Halfway House and admits patients from the founding rehabilitation home, primarily addicts who have kicked the habit and whose cleanness would be jeopardised by any other mode of accommodation. The residents have access to various programmes, such as work in an outside job, training courses, and also protected in-house employment in jobs created by the institution. They receive wages in exchange for work in protected employment. The length of their stay at the Halfway House is subject to their individual contracts.

Nut-Cracking Foundation
The Foundation was established in 1997 as an integral part and extension of a PHARE-funded pilot project, which had won support in 1995. The Foundation's mission statement is best reflected in the choice of its name, since Nut-Cracking (Diótörés) was coined jointly by staff and members of the target group (homeless people, including young adults, single persons and people formerly in state care with substance abuse and personality problems) The Foundation aims to implement a complex range of social/rehabilitation services for the above target group. The PHARE-funded project that made the development of know-how possible won support in the innovative proposals category. The Foundation owns the know-how and made the operation of a complete service line with nationwide access for the above target group its mission, in order to ensure permanent ways out of homelessness. Its strategy focuses on implementing, operating, and disseminating this complex system. The complete service line consists of the following elements:

- A. Communication/dispatch level
- B. Self-help group level with peer helpers (Nut Thrasher Group)
- C. Training level
- D. Rehabilitation home and Halfway House level (Nutshell Home and Walnut Tree Home)
- E. Subsidised independent accommodation level.

The Nutshell Home Halfway House was inaugurated in April 1999 and has since then ensured Level D care for the target group with a capacity of 11 and nationwide access. Since March 8, 2002, the Walnut Tree Home has been delivering rehabilitation home level services with a capacity of 18.
The applicable laws allow for the normative funding of reintegration institutions in the form of addict residential homes starting January 1, 2003.

The Foundation currently provides its services using its own expert team, including social workers with a college degree, sociologists, special needs educators, drama educators, laypeople and peer helpers, mental health experts, addictologists, etc. In addition to delivering the above services to the primary target group, they also aim to communicate with as broad a professional and lay audience as possible, in order to shape public mentality.

In 2001, the Foundation helped some 200 homeless single youths formerly in state care through accommodation in its facilities and through its ongoing services, including day-care and residential care, one-off and continuous service.
The Nut-Cracking Foundation operated its services on an ongoing basis in 2001, in order to ensure the complex social rehabilitation of homeless youths formerly in state care and using substances or affected by substance use.
The Nut-Cracking Foundation operates the Nutshell Home using public normative funding. In their case the municipal Government provides no funding, unlike the nationwide funding practice for institutions that fulfil social and child protection tasks, i.e. in whose case the municipal Government supplements the normative funding of the institution to cover the actual cost of operation.

In 2001, the Foundation provided the existing range of services with the enhanced capacity of the Nutshell Home and in subsidised lodgings.
Walnut Tree Rehabilitation Home was established earlier this year with a capacity of 18 – but its development started in 2000 – to deliver permanent and thus socially cost-effective rehabilitation services to homeless youths formerly in state care (generally of Roma descent), who are defined in the literature as polydrug users but are actually sniffers (sniffing volatile inhalants) and who have strong ties with the Foundation's activities and staff.

Of all substance users, volatile substance sniffers are the ultimate pariahs. They are poor youths with no connections, the lowest of qualifications, and low assertiveness levels, a very high portion of whom was raised in state care. Most of them wind up in homeless hostels after leaving the child care system. They do not receive relevant care anywhere, since the childcare system is glad to have got rid of these problem youths – and they are not offered aftercare even if it exists. Likewise, the youths are also happy to get rid of their loathed institution. The social sector does not regard them as clients either, since they appear there as a medical problem. The health care system – according to our experience – cannot dig down to the root of the problem, since conventional therapeutic means are not designed for this target group.
Lost between the institutions, these youths conspicuously sniff in the streets and squares, and frighten the public. They are, at the same time, threatened and threatening. They are both potential victims and perpetrators of crime.

The youths without care do not receive effective and lasting help from any of the various institutions, since each one addresses just a single aspect of a complex problem. Since our Foundation uses a holistic and interdisciplinary approach and staff are not selected on a sector-specific basis, it has been and will be flexible to respond to such problems.

The youths learnt many things while in state care – many of them were raised there all their life – a major part of them also have vocational certificates, but they did not master the basic skills required for independent life and are unable to make even everyday decisions. For many, even the choice of trade was determined by the facilities available at the institution.
They do not have the bare minimum of employment skills, their conflict tolerance levels are low, they are easy to influence. A major part of them regularly use drugs and many are bordering on criminality.
On the one hand, they clearly understand that their situation is untenable, but on the other, they see no role models for change.

The implementation of normative funding as of 2003 will allow a growing number of NGOs to apply to establish residential reintegration homes.

The third such institution in Hungary will be opened by the Baptist Charity Service Foundation in Debrecen on January 1, 2003 under the name Boldogkert (Happy Garden) Residential Home.
The institution is complete in turn-key condition, awaiting the operating licence after the required administrative procedure. The implementation of Boldogkert Residential Home was supported by the Ministry of Children, Youth and Sport.

Reintegration programmes providing day-care, self-help groups

The first contradiction between Hungarian practices and the literature surfaces in the definition of self-help. The most common definition, perhaps, is that of Katz and Bender (1976), who defined self-help groups as follows: „Self-help groups are voluntary small group structures established in order to provide mutual assistance and to reach a special goal. They are generally established by people in the same life situation in order to help each other mutually. The purposes of their association are to satisfy a common need, to overcome a common disability or essential problem, and to make the desired social or individual changes. The initiators and members of such groups believe that the existing social institutions do not or cannot fulfil their needs…"

Though the above definition quite clearly delineates the notion of self-help groups, one would be in trouble to apply the above criteria to self-help groups in Hungary, since one would then find no more than 2-3 self-help groups looking after drug users. This statement is not meant as depressing criticism at all, it merely is an indication that self-help groups – like many other things – have hardly been able to evolve in our young democracy as they have in the West. We are only at the beginning of this particular process in this country.
We lack traditions and models to support the „birth" of self-help groups.
So we often try to bridge the tradition gap by imposing traditions on a top-down basis. This may explain why self-help groups – which typically evolve spontaneously elsewhere – very rarely emerge spontaneously in our country. In Hungary, they are mostly established by external groups, institutions or experts.
The absence of traditions does not only keep addicts from establishing groups courageously and with a view to their own vested interests in order to support each other and themselves, but the profession also received the emergence of such groups

with skepticism. There are efforts to try and limit competences on the basis of qualifications, scientific research and college degrees.
The first programme expressly designed for the support and funding of the creation and operation of self-help groups was included in the Ministry of Youth and Sport's tender notices in 2001. A great benefit of this programme was that it also accepted proposals from groups not supported by a legal entity or any similar background. 51 bids were received under the programme, of which 27 were granted support. This nationwide figure would suggest that there are at least 27 self-help groups operating in the country, but the groups defined as self-help groups are actually not that at all.
In conclusion, it must be stated that the flagship self-help groups in Hungary are mainly created by various organisations and experts, so their existence depends on the organisation's intentions and strategy, or the dedication, faith, and recommendation of the expert concerned. Nevertheless, „genuine" self-help groups are also emerging on a self-organised basis, but they are not sufficiently organised to represent their interests adequately. At best they know about each other and the members occasionally attend the sessions of the other groups, but they typically work in isolation, with the members seeking to reinforce and protect the ideology of their own group. In the past 1-2 years both the profession and politicians have made visible efforts to support and facilitate the formation of self-help groups. The nature of this field – namely, that drug users and those who have kicked the habit are supposed to do, rather than use, the self-help groups – is counterproductive to the creation of self-help groups, since the clients prefer to "occupy the house when it is ready", though the existence and balance operation of self-help groups is in the interest of former addicts who want to retain their cleanness in the first place.

Day-care rehabilitation and community programmes at City School Stop House

The City School Stop Group operates a multi-functional open house where programmes and services are geared to the current needs. Visits may be occasional, but those who choose to receive daily care can get it on a regular basis. The key objective is to establish a day-care social institution for addicts with a professional programme that is much more complex than the minimum requirement under law, and with the required resources. The programme is designed to operate a Rehabilitation and Community House with activities throughout the day, including person-centric methods and group therapy (work, self-knowledge, creative and self-help groups, sports, and keeping each other company), complex lifestyle development and personal development. These activities require the participants to focus and give them motivation to kick the habit, offering person-centric care, individual development and community action. The rehabilitation and community programme falls into two complementary parts in terms of content and participants.
Some commonly known programmes include: Stop Evening, independent groups (NA), open cleanness group, the Halfway Programme, Theatre Stop at La Chesnaie. The House is open 9 a.m. through 9 p.m. on weekdays.

Evaluation, statistics

There are no accurate statistics about the number of people participating in the reintegration programmes. The number of participants in residential programmes is determined by the capacity (see above). However, it is nearly impossible to provide any figures about the clients receiving day-care and participating in self-help reintegration programmes, since the notion of self-help is implemented differently in our country.
As the incorporation of this field in Hungary's drug addict care has barely started, an evaluation study would make no sense as yet. The foremost objective is to develop these programmes.

Sources:

Csépányi G. (2002). A Diótörés Alapítvány 2001. évi tevékenysége. Kézirat.
Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Szerk. Varga M. – Majzik B. Kézirat.
Katz, H. A. (1989): Önsegítés és kölcsönös segítés. Új társadalmi mozgalom. In: Önsegít_ csoportok. Laikusok önkéntes társulásai a humán szolgáltatásban. Szerk. Fridli Judit. Közread. az Országos Egészségvédelmi Tanács Bp.,(Drogproblémák, 6.)
Miletics M. (2002). Bentlakásos reintegrációs programok. Kézirat.
Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.
Olaszy Cs. (2002). Re-integrációs önsegít_ csoportok. Kézirat.

12. Interventions in the Criminal Justice System

The *short-term objectives of the National Strategy* include the establishment of reintegration programmes for drug users released from penal institutions. Other objectives are the extension of health wards and the implementation of special withdrawal, therapeutic and aftercare programmes within the prison system. Special care must also be provided for the drug users detained, those in custody, in correctional institutions and under the supervision of probation officers (both in terms of health care and social services).

It is a *medium-term goal* to make sufficient reintegration and aftercare programmes of appropriate quality available to drug users released from penal institutions. The development of programmes requires the cooperation of several institutions (including criminal justice, social, employment, and health care institutions). It is important to make sure that these people are not socially marginalized and driven out of the training and labour markets, in order to minimise the probability of recidivism.

The *long-term objectives* are to reintegrate drug users released from penal institutions in the community and to prevent their social exclusion. This requires an extensive network of institutions in cooperation with the health and social care delivery organisations (such as protected jobs and hostels, retraining programmes, rehabilitation programmes, etc.).

Therapy and preventive treatment as an alternative to criminal prosecution was made possible by the amendment to Article 282 of the Criminal Code by virtue of Act XVII of 1993.
Under Article 282/A of the Criminal Code, legislators allowed for a differentiated judgement of drug users when the seriousness of and penalties for their drug abuse are determined. Article 282/A amended the provisions of Article 282 of the Criminal Code regarding this type of offenders.
The differences – according to legislators – are to be found in the behaviour patterns, purposefulness, quantities, and the circumstances and result of the offence.
Points a) and b) of Article 282/A stated criminal liability exemption criteria. Point a) of the above article grants exemption from criminal liability on grounds that the person grew, produced, acquired or possessed drugs for their own use in small quantities; and Point b) exempts drug users who committed an offence related to drug use for which the penalty is less than two years. The offence in this case can be an action aimed at getting drugs (access crime, income-generating crime), but it may also be related to covering up drug use.
In such cases the offender must present conclusive documentary evidence of participating in continuous drug prevention treatment or therapy for at least six months before the verdict of first instance is handed down. However, the law did not require the treatment to have been successful, all that was required was evidence that treatment was received.

Articles 282 and 282/A of the Criminal Code were amended by virtue of Article 62 of Act LXXXVII, effective as of March 1, 1999.
The scope of diversion was narrowed down, so this possibility is only available now to addicted offenders. By virtue of the effective law, exemption from criminal liability is granted to drug addicts who use drugs illegally or possess drugs for their own use or grow or produce or acquire small quantities of drugs for their own use; or commit another offence related to drug use the penalty for which is less than two years, provided that they present evidence of participating in continuous drug therapy for at

six months before the verdict of first instance is handed down. The fact of addiction is to be established by a forensic expert.
Diversion was also possible in the case of occasional users prior to March 1, 1999, but the amendment excluded this category from diversion.
The legal instrument of deferred prosecution – which includes diversion from court proceedings – can be used by prosecutors also with occasional users if the requirements are met. Namely, the prosecution is deferred by 1 or 2 years and the prosecutor prescribes rules of conduct for the offender (which may include participation in therapy or preventive treatment) and places the person under the supervision of a probation officer.
Drug users typically receive addict therapy or preventive treatment in a health care institution, mainly a drug outpatient centre or a hospital.

Operational plans were developed for the wards that deliver the required therapy to prisoners with a drug problem *in the prison system*, and the correctional drug strategy was also elaborated. Drug prevention programmes have also started. A three-step prevention/therapy system will be developed in the penal institutional system to address special drug-related needs.
Planning has begun – with support from the U.K. – for special care for drug users in custody, and legal and technical problems are being sorted out.

- The correctional development concept also includes the correctional anti-drug strategy, which set out to reduce the demand for illegal drugs in addition to supply reduction (i.e. keeping drugs out of the institutions). A proposal has been submitted regarding the amendment to the Ministry of Justice Decree 6/1996 (VII.12.) on the implementation rules for prison terms and custody (henceforth Decree). This would allow for establishing drug prevention wards in penal institutions.
- The National Headquarters of the Prison Service purchased drug prevention videos and sent them to all penal institutions, including juvenile correctional facilities. The prisoners watch the videos with the participation of educators and psychologists and discuss the learnings afterwards. Minutes of these sessions are sent to the Department of Detention Affairs.
- Training on drug problems is an integral part of the curriculum in penal training institutions and the Police Academy Correctional Department.
- National Prison Headquarters staff studied the organisation and operation of drug-free prison quarters on location in Austria and the U.K.
- Dutch partners trained and are training correctional experts on drug issues under the MATRA programme. The methods used in the Netherlands are continuously adapted to the Hungarian circumstances.
- Correctional staff regularly take part in the training sessions organised by the International Law Enforcement Academy (ILEA) where FBI experts from the US teach drug-related knowledge.
- Three penal institutions (the Juvenile Correctional Facility, the Heves County Prison and the BAZ County Prison) have operated various drug therapy groups for several years. The solution in terms of accommodation would be the implementation of drug rehabilitation quarters. This is suggested in the proposed amendment to the Decree.
- A number of penal institution staff (physicians, educators, social workers) earned postgraduate degrees in addictology.
- The methodology was developed for the operation of drug-free quarters as part of the proposed amendment. Addiction (diversion) treatment is underway in a special dedicated group of the Budapest Penitentiary and Prison.
- A drug prevention group is already operational in the Juvenile Correctional Facility. It was organised by the drug outpatient centre in the county seat with the involvement of correctional staff.

- There are no plans in the prison system to implement either a needle exchange or a methadone programme, since neither is justified in light of the existing situation.

Sources:

Büntetés-végrehajtás Országos Parancsnoksága (2002). A kábítószerprobléma visszaszorításáról szóló nemzeti stratégia program rövid és középtávú céljainak végrehajtásával kapcsolatos kormányzati feladatokról kiadott 1036/2002. (IV.12.) Korm. határozat (a továbbiakban: Korm. hat.) egyes pontjaiban az igazságügyminiszter irányítása alá tartozó büntetés-végrehajtási szervezetre meghatározott feladatok végrehajtásáról. Feljegyzés.
Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.

13. Quality Assurance

Accountability is a key principle in the National Strategy. The National Strategy invariably specifies effectiveness indicators to help gauge the extent to which the goals are achieved. This makes the implementation process transparent and the outlays accountable. The National Strategy is reviewed at predefined intervals.
The multi-dimensional object of the National Strategy is a comprehensive approach to the drug problem, based on the target-setting approach that has been tried and proven in many countries, and also on the World Health Organisation's Health for All strategic initiative. A key benefit of the approach is that it helps identify clear strategic directions and related targets, it identifies the means required for achieving these targets, and states the effectiveness indicators for measuring the achievement of strategic targets and the related monitoring system. It is an important feature of the approach that it promotes accountability through regular monitoring and evaluation. This, in turn, allows for corrections.

The National Strategy formulated a comprehensive goal and four detailed objectives in light of an analysis of Hungary's drug situation and expected trends. The National Strategy defines „long-term" and „medium-term targets", and „short-term targets".

- Long-term targets: all of the actions required to achieve the stated aims by 2009. The next ten years can be decisive in terms of addressing the drug issue in Hungary. This makes it essential to have a set of clear-cut targets aimed at achieving the general aim. This leads to
- Medium-term targets that define the tasks for the budgetary years 2000-2002.

Short-term targets enumerate the immediate tasks designed to achieve the medium-term targets.
There is a natural relationship between the individual sets of targets, namely, short-term targets are subordinated to the medium-term targets, which are subordinated to the long-term targets. Some of the long-term targets rely on the indirect impact of the National Strategy, i.e. they take into account not only the implementation of the short-term targets but also their indirect effects of public actions.
However, there is no one-to-one linkage between the individual targets for the long term, medium term and short term: an action included in the action plan may contribute to several targets, and a long-term target may sometimes be achieved only through a number of actions and several sub-aims (medium-term targets). Indicators have been developed for assessing the achievement of targets, and methods have been developed to measure or at least estimate these indicators.
Each indicator – similarly to the achievement of short-term targets – may monitor complex processes and achievements, while in other cases several indicators need to be monitored in order to assess the achievement of a single indicator. In many cases – since there is not always precise and reliable basic data to begin with – target achievement may not be quantified. Then general terms are used, such as a given indicator should be „improved" or the scope of users for a service should be „extended". The cost related to the implementation of short-term targets and monitoring, along with the administrative agencies to contribute, is included in the Annex to the National Strategy.

Implementation, monitoring and efficiency assessment of the National Strategy

The National Strategy must be based on a broad public consensus. The Co-ordination Committee on Drug Affairs is responsible for controlling the implementation of the National Strategy, coordinating the operations of individual Ministries and public institutions, and for approximating the views of the sectors. The Committee is to present an annual report to the

Government on the Hungarian drug situation and to assess the implementation of the National Strategy.

The local Co-ordination Forums on Drug Affairs play an important role as an implementation vehicle. The annual reports of the Forums are summarised by the Coordination Secretariat reporting to the Co-ordination Committee on Drug Affairs. The same institution initiates and implements assessment and data collection in the monitoring process (in relation to monitoring indicators and tools). Relying on this data and interviews with the key persons of the area concerned, it establishes the findings regarding the implementation and impact of the National Strategy, and identifies the difficulties encountered during the implementation process. It forwards them to the Co-ordination Committee on Drug Affairs, which will strive to eliminate the problems through inter-ministerial coordination. The Co-ordination Committee on Drug Affairs Secretariat prepares an annual report on the implementation of the National Strategy and the changes in the Hungarian drug situation, as well as in the operation of the institutions addressing the drug issue in the country. The Co-ordination Committee on Drug Affairs discusses this report and uses it when drafting its report for the Government.

The Committee evaluates the implementation of the National Strategy annually, and commissions an audit and efficiency inquest into the Strategy and care delivery institutions biannually. The Government – also biannually and first during the Parliamentary session of autumn 2001 – prepares a report on the implementation of the Programme for Parliament.

To that end, the Co-ordination Committee on Drug Affairs relies on the results of methodology and other scientific and research institutions.

The implementation of the targets set out in the National Strategy was evaluated in Parliament in May and October 2001.

Evaluation of programmes and drug policy tools

Several programmes and assessments were undertaken in 2001 with the aims of monitoring and evaluating individual drug policy tools and/or areas that address the drug problem. They served quality assurance purposes and also established the basis for the need and direction of adjustments.

The operation of some drug policy tools had to be corrected with a view to more cost-efficient programme implementation and also effectiveness.

It must be pointed out, however, that development has only started over the past one or two years in certain fields, and some of the fields have only been included in the scope of addressing the drug problem in that timeframe, so it is neither justified nor possible to evaluate or monitor these programmes – due to their small numbers and low capacity.

- School-based prevention programmes were monitored *in 2001*. The assessment – among other objectives – attempted to classify the (43) prevention programmes available in Budapest using the categories accepted in the international literature. It also set out to evaluate the theoretical background to the programmes based on the descriptive information in the classified register, to select the programmes to evaluate as a result of these processes, and to assess the organisational characteristics and effectiveness of the programmes.(Paksi – Demetrovics 2002).
- Monitoring was undertaken with regard to the amendment to the Criminal Code effective as of March 1, 1999 (Ritter 2002)
- The implementation of international standards began. A research project sponsored by the Ministry of Health looked into the possibility of using the ASI (Addiction Severity Index) on a nationwide basis. The implementation of the EU REITOX Focal Point served the same goal. European epidemiological, treatment, therapy and evaluation criteria are being adopted and implemented on an ongoing basis in the framework of international cooperation.
- The implementation of the Droginfo database (a database for the organisations and institutions dealing with the drug problem that is updated and published in a book format

annually) also serves to evaluate community programmes, among other things. In addition, the implementation of an application system and the launching of support programmes allowed for the compilation of almost all-round data.

- The discipline of Health Studies and the health promotion curriculum for class-master classes were developed in the spirit of school-based integrated drug prevention. As a result, forms 6-8 in primary school must spend 18 classes and forms 5-12 must devote about a third of class-master classes each year to the subject and focus expressly on drug prevention issues. In addition, schools were sent a number of prevention tools, publications and videos to serve as the basis for prevention programmes.
- An evaluation survey was undertaken regarding the entire population (183 000 students) reached under the secondary school prevention programme with the aim of assessing the efficiency of prevention programmes. The survey used ex ante and ex post tests to help evaluate the programmes and measure their efficiency. The general principle was the systematic implementation of prevention programmes should invariably be linked to an evaluation of the process and the outcomes.
- Research, efficiency assessment, and the adaptation and evaluation of relevant programmes are the responsibility of the National Institute for Drug Prevention. The same applies to methodology consultation and the development of new methods and technologies in the field. A number of other activities also took place in this context, including the organisation of conferences, professional consultation sessions, and the publication of an important paper (József Rácz: Evaluation of Prevention Programmes, ISMertet_, 2001).
- Ministry of Education prevention packages for schools: in the spirit of good inter-ministerial cooperation, all Hungarian public educational institutions (primary schools, grammar schools and vocational schools) received a prevention package from the Ministry of Education, which contained a teaching aid (a videotape titled „Before you…"), the related teacher's book, and a methodology paper to help develop the school's drug strategy. The Ministry contributed to the implementation of many publications, prevention tools and prevention events.
- Drug outpatient services were developed and reinforced to operate in a comprehensive biosocial and psychosocial framework, and to ensure care at several levels (drug outpatient centres that also do prevention programmes striving to ensure the "continuum of care"). A multi-disciplinary mentality seems to be gaining strength, assuming a variety of qualifications on the part of treatment staff in the interest of care delivery.
- An evaluation of the drug outpatient centres dealing with drug users was undertaken under the supervision of the Ministry of Health, and this exercise will be followed by an audit of the other health care institutions that deal with drug users.
- In order to implement the quality control of NGOs, research programmes have recently received major funding. The Association of Hungarian Drug Therapy Institutions has also started to develop rehabilitation treatment manuals.
- Specialised and accredited professional (credit-based) courses have begun for family doctors (in the framework of a Hungarian programme and an adapted American programme).

Sources:

Ifjúsági és Sportminisztérium (2001). Beszámoló az Országgy_lés számára a kábítószer-probléma visszaszorítása érdekében készített nemzeti stratégiai program végrehajtásáról. Kézirat.
Nemzeti Stratégia a Kábítószer-probléma Visszaszorítására – A kormány kábítószer-ellenes stratégiájának koncepcionális alapjai. A 96/2000. (XII. 11.) OGY határozat melléklete.

IV. Key issues

14. Demand reduction expenditures on drugs in 1999

Three of the key goals set out in the National Strategy have to do with demand reduction.

1. The public should be sensitised to the effective management of drug issues, and local communities should enhance their problem resolution capability in tackling the drug problem (community, cooperation).
2. Giving youth a chance to lead a productive lifestyle and reject drugs (prevention).
3. Helping the individuals and families that use or are affected by drugs (social work, treatment, rehabilitation).

The key principles of the National Strategy include that of a comprehensive approach, which means that the management of the drug problem requires a multi-dimensional, balanced, and clearly articulated approach – with important contributions expected in the fields of prevention, education, treatment, research, programs at the workplace, law enforcement, and a number of other areas. Tackling the drug problem calls for joint and concerted actions in different professions and fields. No professional community may vindicate or undertake the resolution of the matter on its own.

Which leads to the fact that a number of administrative agencies, state institutions and NGOs work together in the fields of drug prevention and demand reduction in Hungary, and for many of them, these activities only represent one part of their operations, so no reliable data is available about the total (aggregate) annual level of public expenditures. In many cases even a single institution's expenditures for this purpose cannot be identified or set aside.

Among other reasons, because certain administrative agencies grant earmarked subsidies for the demand reduction operations of certain state institutions, which they either use them directly or distribute them in the form of earmarked grants for proposals.
Since no targeted assessment of expenditures was undertaken in this field, there are no valid data either about the overall drug prevention or demand reduction expenditures. The expenditures of individual organisations make it impossible to extract reliable data.

The Deputy State Secretariat for the Coordination of Drug Affairs started to operate in the Ministry of Youth and Sport in 1999. In 1999, some 150 million HUF (€600.000) was available for grants to organisations whose activities and programmes indirectly promoted demand reduction.

The expenditures of the Ministry of Youth and Sport on demand reduction grant schemes are set out in the table below.

Scheme	Number of successful applications	Grants (HUF)	Grants (Euro)
Grants for the publication of drug prevention documents, leaflets and other tools	*23*	*23.000.000*	*92.000*
Grants for media programmes designed to promote drug prevention	*20*	*21.600.000*	*86.400*
Peer training grants	*45*	*11.350.000*	*45.400*
Grants for drug prevention-related events	*117*	*23.497.000*	*93.988*
Grants for research projects into drug use	*14*	*11.500.000*	*46.000*
Grants for the publication of scientific papers and documents on the drug problem	*12*	*6.000.000*	*24.000*
Total	*231*	*96.947.000*	*387.788*

Parliament adopted the document entitled National Strategy to Combat the Drug Problem, a long-term action programme for Hungary based on a *multi-disciplinary interpretation model* of the phenomenon, and a *balanced demand and supply reduction* approach in terms of addressing the problem.
The Strategy defines the fundamental goals and values, and the framework of reference for managing the problem, but also enumerates the limitations and risks associated with its implementation.
It states the key strategic development directions and major components. It provides guidance for the areas and players regarding the implementation of the strategic goals and proposes a public consensus. It also strives to involve the public at large and various community groups, municipal Governments, decision-making bodies, NGOs and local communities in the programme implementation process, and helps meet the European Union accession criteria and the requirements of international cooperation with regard to the effective management of the drug problem.

The budget for implementing the strategic goals in 2001 was significantly higher than in the previous year (see Part 1), and cost estimates were prepared regarding the implementation of long-term targets and programmes involving major investments.
But for 1999, in the absence of a National Strategy at the time, there is no data concerning demand reduction expenditures and there will probably not be any either.
As for the expenditures in 2001, see Part 1.

The *harmonisation of legislation to promote the cooperation of the health service and social care began in 2001*, in which framework the problems resulting earlier from the fact that the therapeutic institutions were funded from two different sources were resolved. Also, joint projects were established regarding the drug therapy care for institutionalised children and the homeless. The Government asked the Ministry of Social and Family Affairs and the Ministry of Health to coordinate the entire range of services with a view to developing the most effective solutions.
Drug patient care is funded or reimbursed by the National Health Insurance Fund, so this organisation also has the data concerning annual expenditures. Addictions are reimbursed at very low rates in the currently effective DRG system, so the inpatient institutions are interested in reporting the patients to the health insurer with a main diagnosis that secures better funding and is also medically justifiable, which practice is made possible by frequent co-morbidity.

There are a number of ways to fund the implementation of demand reduction programmes and events, as well as the operation of the institutions dealing with this field (please note that mixed funding, i.e. operations funded from various sources, is the typical pattern):

- the institution's own budget,
- earmarked subsidies,
- grants for proposals,
- normative public funding,
- sponsors and donors,
- support from volunteers.

However, since the institutions may distribute some of the subsidies received to other organisations, and many organisations are also engaged in activities unrelated to the reduction of demand for illegal drugs, it is impossible at present to determine the exact expenditures for this purpose.
The aim is to undertake target assessments to identify the expenditures related to demand reduction and also to other drug policy measures.

Sources:

Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Szerk. Varga M. – Majzik B. Kézirat.
Ifjúsági és Sportminisztérium (2001). Beszámoló az Országgy_lés számára a kábítószer-probléma visszaszorítása érdekében készített nemzeti stratégiai program végrehajtásáról. Kézirat.

15. Drug use among young people aged 12-18

No targeted assessment has been undertaken in our country to look at the prevalence of drug and alcohol use in the 12-18 age group. The life prevalence rates and substance use data concerning students in the second form of secondary schools are taken from the ESPAD surveys referred to earlier on.
Data are also available from institutional statistics, so the substance use patterns of young people aged 12-18 can be assessed among institutionalised drug users and youths prosecuted for drug abuse.
Some research also concerns the 12-18 age group and substance users, but it should be emphasized again that no assessment results are available as yet for this specific population.
(Please note that the states preparing the reports should be informed 1-2 years ahead of time on the data collection requirements concerning special target groups and areas, in order to allow them to carry out the assessment and acquire the desired data and information. Since the claim is still valid that we are somewhat different from most Member States in terms of the quantitative and qualitative indicators related to the drug problem, and we have had to face this phenomenon for a shorter period, we also have significantly fewer assessment results in this field. Our targeted assessments, on the other hand, relate to topical problems and are designed to make good for some of the shortcomings in the understanding of the drug phenomenon.
But with a bit of help and timely information, we would have the opportunity to assess selected segments as target groups or target areas, and we could thus inform the organisation about the related results. Even if the assessment of other areas is more justified in our case and receives greater attention.)

Key data related to the epidemiological assessments in the various counties and cities

Assess-ment site	Time of assess-ment	Persons asked	Sample	Number of persons asked	Type of questionnaire	proportion of those trying illegal substances and volatile inhalants	proportion of those trying marijuana	life prevalence rate of pharmaceutical drug abuse
Tolna County	Autumn 1999	10th form	Not available	1869	Based on Pompidou	24,6	8,9	Not available
Baranya County	Spring 2000	9-12th forms	Not available	810	Not available	18,6 (some drug)	Not available	Not available
Békés County	1999 / 2000	Students aged 13-22	Not available	6605	Not available	Not available	5,6	12,4
Miskolc	Autumn 1999	9th form 1-12th forms	representative secondary school sample	443 3	Not ESPAD type	5, 0 16,0	Not available Not available	Not available Not available
Zala-egerszeg	Autumn 1999	9-12th forms	representative secondary school sample random	2627	ESPAD	17,0 (11.9 in 9-10th forms)	12,1	16,2

Comparing the results of local assessments with the ESPAD data for the county concerned, one may say that the outcomes – except for the assessment in Zalaegerszeg – are questionable in all cases and suggest the need for more thorough methodological investigations. In certain cases even the authors refer to data acquisition problems (Miskolc) while in other cases, the poor reliability of the data may have to do with the methodology.

Life prevalence rates in the counties assessed with regard to substance abuse in the form of definite drug use, error margins based on ESPAD'99 (secondary school students in 9-10th forms, average age 16.3 years)

county / *substance abuse in the form of definite drug use*	N	life prevalence	error margin
Tolna County	74	9,5	2,7 – 16,3
Baranya County	376	16,0	12,2 – 19,8
Békés County	287	16,7	12,3 – 21,1
Borsod-Abaúj-Zemplén County	424	17,2	13,5 – 20,9
Zala County	79	20,3	11,25 – 29,35

Drug use in entertainment facilities with music and dancing

Research was done into the drug use patterns of youth in entertainment facilities with music and dancing (Demetrovics, 2001). A total of 1507 persons in 27 establishments of Budapest, Pécs, Debrecen, Szombathely, and Miskolc were interviewed by the project between October and December 1999. The average age of the respondents was 21.25 years, with two thirds aged between 17 and 24. The sexes were almost equally represented in the sample (the proportion of males was 51.4%). The study found that the interviewees had (or were going to have) above-average qualifications and better-than-average social and family backgrounds.

52.6% of the youngsters admitted to having used some illegal drug or volatile substance before. The proportion of those who used drugs in the previous year was 43.1%, and almost one in three persons (29.5%) also used drugs in the previous month. This essentially means that over half (56.1%) of those who have used drugs before can be considered as current users (of the previous month). 21% of the interviewees admitted to abusing medicaments, but in almost one in two cases (49.4%) the person had not used medicaments in the previous year. Marijuana and hashish had the highest life prevalence rate; almost one in two persons (49.2%) had tried these substances before, and their life prevalence for the previous month was 27.6%. The next substances in the order of trial frequency were amphetamine (20.1%) and LSD (19.5%), followed by Ecstacy (12.9%), psilocybe fungus (9.2%), cocaine (8.8%) and Nitrogen-Oxidule (9.8%). The life prevalence rates of LSD (3%), and especially of the psilocybe fungus (1%) were low for the previous month, while current use was higher in the case of amphetamine and Ecstacy (5.2% and 3.7%, respectively) . 7.7% had tried opiates; the most popular substances were poppy infusion (4.9%) and heroin (4%).

The life prevalence rate of definite drug use was the highest in Budapest (72,5%) and Pécs (59,9%), while the lowest values were found in Szombathely (16,4%), and Miskolc (24,9%). Debrecen ranked in between (at 42.7%).

Comparing the results of the survey with the data acquired at the end of 1997 in Budapest only, one may say that the life and monthly prevalence rates were lower for all drugs and drug groups than two years earlier. The decline is the smallest in the case of cannabis derivative trial (64.9% in 1997 vs. 58.8% in 1999), while synthetic stimulant trials declined to 70-80% (regarding 1997 levels as 100%), and experiments with cocain, heroin, poppy products and volatile inhalants dropped to 60%. The decline is even more significant regarding current use. However, since the composition of the two samples was different in many ways (and there is no perfect method to eliminate the impact of those differences) care should be taken when handling the variances in outcome.

This data is comparable with the outcome of ESPAD in Hungary – for the appropriate age groups (Elekes and Paksi, 2000a; Paksi 2000). Concerning *substance abuse in the form of definite drug use*, we can say that entertainment facilities demonstrated higher life

prevalence levels in all age groups (by 1.5 – 2 times) than in the normal secondary school student population. However, if we extract the youngsters born between 1981 and 1984 and interviewed in Budapest-based establishments from the total, then the life prevalence rate in that population is 76.3%, precisely triple that in the normal population (25.3%).

Life prevalence rates for substance abuse in the form of definite drug use in the Hungarian secondary school student population based on the ESPAD study and the assessment of entertainment facilities with dancing (secondary school student data based on Elekes and Paksi, 2000a, and Paksi, 2000)

age	secondary school students in Hungary	secondary school students in Pest County	secondary school students in Budapest	those visiting dance facilities
15	12,7	11,0	14,0	20,0
16	15,4	15,6	19,8	25,5
17	21,1	22,1	30,5	36,4
18	33,2	24,8	42,7	48,3
total	17,3	20,2	25,3	34,9

Vingender and Sipos (2001) looked at the relationship between sports and smoking, alcohol use, and drug use. Dividing a secondary school sample of 1103 students into four groups (students doing sports to *compete*; those doing sports as a *hobby*, students who used to do sports but *no longer did sports* at data acquisition; students doing *no sports*), the authors compared the intensity of using various substances. The results indicate the highest proportion of students who have smoked cigarettes before and those who regularly smoke in the no-sport category and the lowest proportion in the sports-to-compete category. Notwithstanding, the last group also featured almost one out of two interviewees who have smoked before, and about one out of five students can be considered a regular smoker. The negative correlation was very weak (-0.1) between the frequency of smoking and regularity of doing sports. Though regular use of alcohol is somewhat lower in the sporting population than in the no-sport group, there was no significant difference between the groups in terms of occasional drinking. Similar results were shown for drug use, i.e. regular sports proved to be a protective factor against regular drug use, but no clear relationship was established with trials. It should be highlighted, on the other hand, that the use of all substances – and especially the use of drugs – regarding both trial and frequent use was the highest in the group that quit sports. Based on the findings, it seems that it is not so much sports acting as a protective factor against substance use, but much rather, quitting sports is a predictive factor in this regard. But the correlation is not strong, and the step-by-step regression analysis did not add any sports-related variables to the model concerning drug use.

Distribution of young people aged 12-19 treated in health care institutions in 2001 according to substance type

Type of substance	Under 13s	13-14s	15-19s	Total
Opiate derivatives		5	577	582
Cocaine			37	37
Cannabis derivatives	2	10	661	673
Hallucinogens		1	49	50
Amphetamine derivatives	1	4	221	226
Tranquillisers	1	4	71	76
Polydrug use	1	1	114	116
Inhalant	2	12	168	182
Other	3	8	27	38
Total	10	45	1925	1980

Since data is only available about the age groups included in the table, the following statements only apply to the population of under-19s treated in health care institutions.
Under-19s represented 16.4% of the drug patients treated in health care institutions in 2001. Practically one out of six patients belonged in this age group.
Most of them were treated with problems related to the use of cannabis derivatives (mainly Marijuana) and opiates (mainly heroin). It is important to note that a significant portion of youth under 19 did not take treatment voluntarily but were taken to the institutions by their parents, they chose treatment as an alternative to prosecution or they required an emergency intervention.
Examining the proportions represented by the people in treatment under 19 yields an amazing result.
Under-19s amounted 39.2% of the volatile substance users treated in health care institutions in 2001. They represent 27.0% of the amphetamine derivative users and a similar portion (27.6%) of cannabis derivative users in treatment. 13.5% of the opiate users receiving treatment was under 19 in 2001.
Although the data collection methods make comparisons between this data and the data from earlier years impractical, i.e. any trend that would emerge would not provide relevant information or an adequate understanding of how the number of characteristics of the treated drug patients under 19 have evolved, we still cannot disregard that fact that these youths represent a relatively high portion of even the treated users.

Drug offenders

17.4% of the perpetrators of drug abuse were minors or children, i.e. under 18 years of age, (please note that offenders under 14 are exempted from criminal liability).
In 2001, the authorities learnt about the drug abuse offences of 689 minors aged 14-18, and 13 children (i.e. under 14).
46.7% were prosecuted for drug use and 21.9% were prosecuted for acquisition and possession of small quantities.

Age groups	1999		2000		2001	
	cases	%	cases	%	cases	%
Children	9	0,33	5	0,14	13	0,3
Minors	378	13,91	530	14,88	689	17,1
18–24	1 664	61,22	2086	58,56	2334	58,0
25–30	459	16,89	618	17,35	707	17,6
31–40	157	5,78	204	5,73	215	5,3
41–50	34	1,25	48	1,35	46	1,1
51–60	11	0,40	12	0,34	11	0,3
above 61	6	0,22	59	1,66	10	0,2
Total	2 718	100,00	3562	100,00	4025	100,0

The number of juvenile offenders committing drug abuse continued to grow in 2001. In 2001, they represented 5.9% of all offenders and 17.1% of drug abusers! *Crime statistics from 2001 indicate that practically almost one in six criminal drug abuse offenders were minors!*
The growth rate of juvenile involvement in drug abuse is above the overall growth in the number of criminal drug abuse cases. This gave drug abusers a growing age edge over other offenders.

Substance types and patterns of use

The most frequent plant poisoning cases are caused by the accidental or purposeful use of datura, henbane and belladonna. Accidental overdose is primarily caused by mistaking belladonna for cornel. Chewing of datura seeds and use of their infusion serve as dope for the 13-15 age group in the first place. Hospitalised youths said they wanted to test the impact of the substance. Accidental poisoning cases, on the other hand, resulted from incomplete plant knowledge.

Volatile substance use has to do with children living on housing estates. Regular use is more prevalent in Roma communities than in the Hungarian population. In addition to sniffing conventional glues and volatile inhalants, a growing number of sniffers use Nitrogen-Oxidule (cream cartridges), butane (lighter refill cans), ether and various alkylnitrites. Unfortunately, sudden sniffer death cases have also been reported.
In addition to sniffing and poppy infusion, addicts often use various benzodiazepids, carbamazepine derivatives and glutethimid (whose production stopped in November 2001) in large quantities to handle their withdrawal symptoms in the absence of drugs.

Drug-related mortality

Of the 40 deaths related to the use of illegal drugs in 2001, 2 of the victims were under 19. One of them died of amphetamine-related causes and the other's dealth was related to heroin use. Another 2 youths died as a consequence of using volatile inhalants and 1 person died of a sedative overdose.

Communicable diseases

In 2001, studies were undertaken among the IDUs treated in various drug outpatient centres and the Toxicology Department of Erzsébet Hospital. (Bánhegyi-Újhelyi-Zacher 2001).
The programme included the following examinations on the blood and saliva samples. HIV antibody test (anti-HIV) and HCV antibody test (anti-HCV), HBV surface antigene test (HbsAg), anti-HBc and anti-HBs test. In order to tell acute infections from historical infections and verify successful vaccination, the primary tests were performed using the ELISA method. Other differenciation and control tests were performed where necessary.

The incidence of HCV infection in overdosed heroin IDUs was disconcertingly high. 25% of the women and 40% of the men aged 13-19 was infected with HCV. The data suggest that the older the women the higher the prevalence of HCV positivity, while men indicate the reverse.
The test results show that heroin IDU numbers are not only rising gradually in Hungary too, but the entry level is also getting lower in age.
The incidence of HCV is the highest in the 13-19 age group. (The picture has changed completely since 1996!) The reason is that they don't realise the risk of needle and syringe sharing, and they „shoot themselves" jointly, sharing the equipment. Primary prevention programmes should be targeted at this age group in the first place in future!
Finally, a key observation is that the Hepatitis B vaccination level of this age and risk group is negligible (2%).
The HBV vaccination programme should be made much more intensive and effective for the risk groups.

Low threshhold programmes

Party Assistance - Pécs

The functions of the Party Assistance Programme rest on 3 fundamental pillars.
1. Objective information about legal and illegal drugs.
Objectivity is important, since one-sided information that emphasizes only the negative aspects is not considered pragmatic. So staff admit in the discussions that the ability to use substances on a social basis exists; or that it is a mistake to think that all light drug users turn into hard drug addicts just because most heroin addicts started off with Marijuana (or alcohol).
At the same time, objective information also includes the negative effects of the substance, the nature of addiction, the self-defence mechanisms (trap) that work in parallel with the development of addiction (substance use learning curve), or the essence and risk of the catharsis when using a substance for the first time, etc…
In addition, they also provide information about the criminal laws regarding the use of illegal drugs.
2. Treatment of the acute physical and mental symptoms and problems that arise in the course of drug use – which all the experts working in the programme mastered adequately in a theoretical and practical course dedicated specifically to the Party Assistance service.
Training was provided by professional oxyologists, phychiatrists, addictologists and social workers.
3. In serious cases or if the problem is beyond their competence, the main task is to get the client to the appropriate institution. (E.g. Drug Outpatient Centre, Educational Counselling Centre, Mental Health Institute, Employment Service, Mother-of-Pearl Association, etc.)

The Party Assistance service has been operating from the start at the Pécs University Club, with opening hours every Wednesday during exam periods from 10 p.m. to 4 a.m. the next day. The University Club is one of the city's largest entertainment facilities, attended mainly by college and secondary school students. Given the circumstances, the service undoubtedly plays a key role. College and secondary school students are risk populations in light of the epidemiological data, and they also include a high proportion of active substance users.

The service has also been present at Hárd Rák Cáfé of Pécs since December 2001. Based on the registration data and feedback, one can conclude that the service fills a gap and satisfy a growing need. As of October 2002, the service is continuously available at Dante Cáfé too.
The philosophy, theoretical background and purpose of the Party Assistance service focus on harm reduction. Addressing acute physical problems has only occasionally been

necessary in the course of practical work. They believe it is important to create an atmosphere of trust (often even in difficult circumstances) in which they can be more effective. This is promoted by the fact that young people know they can always find them and take peer advice in the same entertainment facilities at the same time. Posters, leaflets and university media help create awareness of the service and its operations. There are plans to implement a website and launch a radio programme on the university radio station (Publikum).
They succeeded in convincing the distributor of Masculan condoms to sponsor their programmes as of November 2000, which helps enhance the means available for harm reduction.

Prevention

(See Section 9)
The drug prevention magazine published by Target 2000 Youth Office Ltd. titled „Légy észnél" (Get a Grip) is one of the most popular and most widely circulated publications today.
„Légy észnél" magazine fills a gap in helping primarily the 14-18 age group to address physical and mental problems and develop a healthy lifestyle. The tone and approach used in the articles of the magazine reflect the young people's perception of healthy lifestyle and the risks of health-damaging behaviour patterns. The interviews with well-known public personalities present young people who are searching for their way with positive and motivating alternatives.
The publication is an integral part of the campaigns featuring full-day drug prevention events that are held at secondary schools. The magazine is free for students. The nationwide distribution of the magazine is assisted by the National District Nurse Association. The publication is also available on the Internet. The magazine is a useful prevention tool not only for students but – based on feedback – also for health and youth protection helpers.

The role of public service advertisements in drug prevention

In March 2000, Nyírádi conducted a focus group study in four secondary schools of Budapest to find out the extent to which the students were familiar with certain elements of the public service anti-drug ads published in the previous year and what they thought about them. Research focussed on the following advertisements: TV spots on Z+ titled „*Neglect them!*" (Ministry of Youth and Sport), an information series published in Pesti Est (Ministry of Education), posters titled „*No drugs*…" (Ministry of Education), giant billboards (Ministry of Education), free postcards about the legal implications of drug use (TASZ).
The study involved four classes in 10th form with 10 students each. The schools were selected based on the entertainment and TV viewing patterns identified in the ESPAD'99 research project. The selected schools included one grammar school and one comprehensive from a district with the lowest value and another grammar school and comprehensive from a district with the highest value, i.e. the extremes were represented.
The researcher looked to find out from the focus groups whether the youngsters had come across the ads, what they thought they depicted, who they thought they were addressing, whether they had taken a closer look, what they thought about the ads, how effective they thought they were, and to what extent they thought the ads could influence drug use in their age group. The study relied on interviews and voting to rank the optional answers.
The results indicate that of the five types of public service advertisement, the 40 students asked were the most familiar with the giant billboards, i.e. the study confirmed the theory formulated earlier on that that advertising medium could achieve the best coverage. Next in the raking were the TV spots titled „Neglect them!" and the programme guide Pesti Est. The posters titled No drugs… came in third place in terms of awareness. The author thought the reason was probably their inappropriate placement. The study showed free postcards in „sit-down" entertainment facilities and cafés as having the poorest outreach regarding the target

audience (probably because they did not match the entertainment patterns of the age group). Dividing the awareness percentage by the number of advertising devices, the leading form of advertising was the No drugs… posters, i.e. outdoor media was still shown to generate the highest awareness.
Responses concerning *effectiveness* put TV spots in first place. The explanation is that the advertising profession regards television as one of the most effective and most manipulative medium, since it can transmit images, sound and movement at the same time. In terms of effectiveness, TV spots were closely followed by giant billboards. The students thought the series in Pesti Est was more effective than the No drugs… posters, though fewer of them knew about the posters. One reason may be that this programme guide represents a reliable source of information for them, and the other reason may be that printed media – unlike TV spots – can carry large amounts of information – provided that people take time to read it. Postcards came in last place in terms of effectiveness. The graphical representation was difficult to make out, which substantially compromised its ability to get the message home.
Based on the results, the author points out that while *awareness* is primarily influenced by the type of medium used to convey the message, opinions about *effectiveness* were much more driven by what is represented and how.

Sources:

Bánhegyi D. - Újhelyi E. - Zacher G. (2002). Az intravénás droghasználat fert_zési kockázatai. Kézirat.
Békés Megyei Drogprevenciós Munkacsoport (2000). Békés megyei fiatalok drogfogyasztó magatartásának vizsgálata – 1999/2000. Kézirat.
Demetrovics Zs. (2001). Droghasználat Magyarország táncos szórakozóhelyein: 1997-1999. L'Harmattan Kiadó, Budapest.
Domokos T. – Kulcsár L. (2000). Kábítószer használattal kapcsolatos tanulói és pedagógus vizsgálat Miskolcon. ECHO Oktatáskutató M_hely – Miskolc Városi Pedagógiai Intézet - Miskolc Városi Rend_rkapitányság, Miskolc.
Elekes Zs. - Paksi B. (1996). A magyarországi középiskolások alkohol és drogfogyasztása. Népjóléti Minisztérium, Budapest.
Elekes Zs. - Paksi B. (2000). Drogok és fiatalok. Középiskolások droghasználata, alkoholfogyasztása és dohányzása az évezred végén Magyarországon. ISM – Aula. Budapest.
Gyermek-, Ifjúsági és Sportminisztérium (2002). A Gyermek-, Ifjúsági és Sportminisztérium Kábítószerügyi Koordinációért Felel_s Helyettes Államtitkárságának beszámolója a 2001. évben megvalósult támogatásairól. Kézirat
Keller É. (2002). A kábítószer-használattal összefügg_ halálozások alakulása. Kézirat.
Kis M. – Hangay I. (1999). A drogfogyasztás terjedésének f_bb jellemz_i Tolna megye 16 éves középiskolás tanulóinak körében. Kézirat.
Nyírády A. (2000). A társadalmi célú reklám szerepe az els_dleges drog-prevencióban. Budapest, Kézirat.
Paksi B. (1999a). A zalaegerszegi fiatalok drogfogyasztása. Kézirat.
Porkoláb L. – Grézló O.(2002). Egészségügyi statisztikai adatok a kábítószer-fogyasztásról - 2001. Kézirat.
Ritter I. (2002). A kábítószer-b_nözés jellemz_i a b_nügyi statisztikai adatok tükrében- 2001. Kézirat.
Szemelyácz J. (2002). Az INDIT (INtegrált Drogterápiás InTézet) Közalapítvány ártalomcsökkent_ tevékenysége.
Tistyán *L. – Füzesi Zs. (1998).* Kábítószer-fogyasztás a középiskolások körében. Fact Intézet, Pécs.
Vingender, I. – Sipos, K.(2001). Social integration – deviances – drug consumption (with due regard to the potential protective and predictive factors of sports). In: Mészáros, I. (ed.) Kalokagathia. Review of the Faculty of Physical Education and Sport Sciences. Semmelweis University, Budapest.
Zacher G. (2002). Drogtúladagolás – f_városi helyzet. Kézirat.

16. Social exclusion and reintegration

Segregation means the separation and isolation of a group that may occur as a result of social sanctions and laws, peer pressure or personal preferences.
Drug use as deviant behaviour does not in itself lead to the segregation of drug users as individuals, since drug users do not form a homogenous group.
Since this is a behaviour pattern that is present at all levels of social hierarchy, negative social attitudes and bias against problem drug users, social groups and pariah groups are expressed primarily in relation to the groups that belong in segregated and deprived social groups in the first place and also feature drug use (i.e. the homeless, the Roma, prostitutes, released offenders, etc.).
Since no-one is born as a problem drug user but becomes one, people get segregated as a consequence of substance use, social status, position or role, which may also influence the development of their drug use patterns. While in the first case – i.e. isolation as a consequence of drug use – disintegration as used by Castel is a more fortunately term to cover the notion, in the second case is clearly about segregation.
(Disintegration means the process in which certain groups lose their social contacts and jobs and thus fall away from majority groups.)

Disintegrated or segregated drug users and drug user groups are not only facing social prejudices but also discrimination in treatment institutions.
No targeted study has been undertaken in this field in Hungary, but a fact that indicates the growing presence of the problem is that there is an increasing number of institutions and programmes that offer targeted assistance to disintegrated or segregated drug users.
Please refer to the programmes and institutions described earlier, such as the Nut-Cracking Foundation and the Baptist Charity Service Foundation.
The reason why disintegrated or segregated drug users are treated separately from other drug users lies not only in a desire to address their problem in a differentiated way, but also has to do with the inability – and apparent reluctance – of the country's current treatment network to deal with them.
These clients often complain of regular beatings by the Police, and also that they are handled differently in hospitals and rehabilitation homes because they are homeless or of Roma descent.
These people cannot use the conventional treatment system – nor do they want to – so they are difficult to reach.

As mentioned earlier, no targeted studies have been undertaken in our country to measure the prevalence of drug use in these risk groups. They must start soon. This way no data is available about either the prevalence or the patterns of substance use. The information available to the experts indicates that homeless drug addicts are typically affected by several drugs at the same time. Homeless people who use only a single kind of substance can only be found in the volatile substance user group.
The most frequent substance combinations among polydrug users are volatile inhalants and alcohol, alcohol and pharmaceutical drugs, opiates and pharmaceuticals, sometimes supplemented by Marijuana, heroin and amphetamines. There is no talk of cocaine use at all. Also, members of the target group relatively easily switch between substances depending on what is available.
They report frequent needle and syringe sharing! The prevalence of Hepatitis infection is 90% among IDU clients. Various forms of TBC are also present, along with deep abscesses as a consequence of intravenous drug use. As for their health status, they are typically undernourished and unclean, and also carry various skin diseases and parasites.

The clients of the Nut-Cracking Foundation – which provides services to young adults formerly raised in state care who are mainly of Roma descent – typically sniff volatile

inhalants for the most part. They are poor youths with no connections, the lowest of qualifications, and low assertiveness levels, a very high portion of whom was raised in state care. The majority wind up in homeless hostels after leaving the child care system. They do not receive relevant care anywhere, since the child care system is glad to have got rid of these problem youths – and they are not offered aftercare even if it exists. Likewise, the youths are also happy to get rid of their loathed institution. The social sector does not regard them as clients either, since they appear there as a medical problem. The health care system – according to our experience – cannot dig down to the root of the problem, since conventional therapeutic means are not designed for this target group.

Lost between the institutions, these youths conspicuously sniff in the streets and squares and frighten the public. They are, at the same time, threatened and threatening. They are both potential victims and perpetrators of crime.
The youths without care do not receive effective and lasting help from any of the various institutions, since the treatment in each one address just a single aspect of a complex problem.

Aims of the National Strategy regarding the reintegration of disintegrated and segregated individuals

The programme entitled National Strategy to Combat the Drug Problem *includes the following long-term targets*

- To *reintegrate drug users released from penal institutions in the community* and to prevent their social exclusion. This requires an extensive network of institutions in cooperation with the health and social care delivery organisations (such as protected jobs and hostels, retraining programmes, rehabilitation programmes, etc.).
- The problem of volatile substance and drug use has a growing presence in *homeless care*. Care must be provided by helpers to address the harms that are radically present here and opportunities must be created using reintegration elements to promote reintegration in a broader social policy context

Medium-term targets:

- To make sufficient reintegration and aftercare programmes of appropriate quality available to drug users released from *penal institutions*. The development of programmes requires the cooperation of several institutions (including criminal justice, social, employment, and health care institutions). It is important to make sure that these people are not socially marginalized and driven out of the training and labour markets, in order to minimise the probability of recidivism.
- A social support system must be implemented for drug patients who are cured, released from penal institutions or receiving maintenance treatment. Accommodation must be provided under *targeted social programmes* to allow these people to develop and maintain an orderly lifestyle without drugs.
- The prevalence of drug use must be decreased among the homeless, and forms of care must be provided to address harm in all areas of institutions dealing with the homeless. The drug use patterns of the homeless and the prevalence of the problem in this group must be identified.

Short-term targets:

- Reintegration programmes must be developed for drug users released from *penal institutions*.
- Other objectives include the extension of health wards and the implementation of special withdrawal, therapeutic and aftercare programmes within the *prison system*.

Sources:

Ifjúsági és Sportminisztérium (2001). Beszámoló az Országgy_lés számára a kábítószer-probléma visszaszorítása érdekében készített nemzeti stratégiai program végrehajtásáról. Kézirat.
Csépányi G. (2002). A Diótörés Alapítvány 2001. évi tevékenysége. Kézirat.
Miletics M. (2002). Bentlakásos reintegrációs programok. Kézirat.
Ritter I. (2002). Szegregáció és kiilleszkedés. Kézirat.

Contents